Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 25 May 2017

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 25 May 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 30 March 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	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:05	**FOR INFORMATION**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Sustainability and Transformation Plan Update	Receive	Mr Pallot	**I.**
11:15	**GOVERNANCE**				
	14.	Approval of the Quality Account	Approval	Dr Cusack	**J.**
	15.	Corporate Governance Report	Receive	Mr C Thorne	**K.**
	16.	Self-certification	Receive	Mr C Thorne	**L.**
11:30	**ANNUAL REPORTS**				
	17.	Annual Report, Accounts and Annual Governance Statement and Auditors Letter of Representation	Receive	Mr Lazarus	**M.**
11:45	**COMMITTEE REPORTS**				

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**
	19.	Highlight Report from Quality Governance Committee	Assurance	Ms O Clymer	**Verbal.**
	20.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Verbal.**
	21.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**O.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 27 July 2017 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 30 March 2017 at 09:30 in the Board Room at Northampton General Hospital

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

TB 16/17 092 Introductions and Apologies

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

Apologies for absence were recorded from Mr P Farenden, Mr C Pallot and Mr G Kershaw.

TB 16/17 093 Declarations of Interest

No new Declarations of Interest were noted.

TB 16/17 094 Minutes of the meeting 26 January 2017

The minutes of the Trust Board meeting held on 26 January 2017 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 26 January 2017 as a true and accurate record of proceedings.

TB 16/17 095 Matters Arising and Action Log 26 January 2017

The Matters Arising and Action Log from the 26 January 2017 were considered.

Action Log Item 69

Ms Fox confirmed that the General Wards column did not add any additional value to the table. She has clarified this with informatics and the column has subsequently been removed.

Action Log Item 70

Mrs Needham reported that the update was given at Februarys Board of Directors. The report has also gone to March's Finance Committee.

The Board **NOTED** the Action Log and Matters Arising from the 26 January 2017.

TB 16/17 096 **Patient Story**

Ms Fox presented the Patient Story.

Ms Fox advised of a complaint from the husband of an elderly lady who was a patient at the Trust.

The patient was told that she waswas to be discharged but needed a care package in place which would be discussed once the patient had been seen by a physiotherapist. The lady's condition deteriorated and she was noted to be sleeping more often. The Consultant advised she would be better when she was in her own surroundings and she was discharged home.

Once home the patient struggled to eat, drink and was barely able to stand. Care workers visited the patient but stated that they were unable to lift her. She was visited by an emergency doctor who reported that she not have been discharged from hospital. An ambulance was called and she was readmitted to the hospital.

The Board **NOTED** the Patient Story.

TB 16/17 097 **Chairman's Report**

Mr Zeidler presented the Chairman's Report.

Mr Zeidler informed the Board that he had attended the Resus Committee, the STP Scrutiny Group and done Infection Prevention Rounds.

Mr Zeidler commented that as a thank you to the Trust from Carlsberg, two of the Executive Team were invited to attend a Northampton Saints rugby game.

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

TB 16/17 098 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart discussed the pressures within Urgent Care. The first 2 weeks in February 17 were the busiest that the Trust had experienced for the time of year, which coincided with the visit from the CQC. The Emergency Department and Urgent Care are continuing to focus their efforts on keeping our patients safe and providing the best possible care.

Dr Swart noted that the focus groups held by the CQC were positive.

Dr Swart commented that her biggest concern is in relation to discharge and the constant pressure to send patients home earlier. This will be the focus of ongoing work.

Dr Swart advised that prior to the CQC visits Compass Check Events had been held to make staff aware of what is happening in the NHS and how it affects the Trust. The first initiative was to improve staff engagement and is aimed at improving understanding is a series of regular lunchtime listen and learn/question time-style events where a topic will be introduced by a member of the executive team and staff are invited to submit questions to be answered by a panel chosen by the executive. Dr Swart stated the first session ran very well with staff noting that they had enjoyed the event. The 'Question Time' events will continue to run as topic based listen and learn/question event as part of a planned programme of work.

Dr Swart commented that the Trust will be starting a series of 'get to know you' tea

and cake sessions where the Trust will be asking divisions to invite a range of 30 staff from across their area to a session where they can meet both executives and members of the divisional team.

Dr Swart reported that the new NGH website will be launching mid-April. The website will also be mobile friendly.

Dr Swart stated that the Trust is encouraging the wards to put staff forward for awards. The Trust has been shortlisted for 2 HSJ Patient Safety Awards, for Quality Leadership and the Governance Dare to Share events. It was also discussed that the Trust was shortlisted at the Patient Experience National Network Association awards ceremony with NGH winning an award for the work on Staff Engagement with the project entitled 'Staff Experience – Compliments Collation A recipe for Success'. The Trust was notably awarded 'Excellence in Sustainability Reporting' as recommended by the Sustainable Development Unit.

Dr Swart advised that the Trust had one of the best uptakes for flu vaccinations.

Dr Swart stated that NGH also won the award for work with patients with learning disabilities and this is the result of some excellent work in this area over some years now. This reflects a sustained effort to ensure that the Trust makes the best use of learning from compliments as well as from complaints.

Mr Zeidler shared his delight at the number of awards the Trust had recently won and queried whether further recognition could be given to the winners. Dr Swart confirmed that she writes to the winners and suggested that the winners could also be mentioned at the Trust's Best Possible Care Awards.

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

TB 16/17 099 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack reported on IR35 which will affect the current pay locum Doctors receive due the Trust applying the doctor's tax rather than the PSCs. Dr Cusack stated that in the last week there has been a noted change in the behaviour of the medical staff. Doctors have not been booking onto shifts within ED and urgent care with a small amount of doctors cancelling previously booked onto shifts.

Dr Cusack assured the Board that daily Silver and Gold Command meetings have been scheduled and a robust contingency plan is in place. A number of doctors have come across onto the medical bank which helps to ensure consistency with the same doctors providing the same service.

Ms Gill queried whether this risk could have been anticipated. Dr Cusack clarified that the Trust wrote to all locum doctors affected in the previous months however the change in behaviour has only occurred within the last week. Dr Swart noted that the change in tax was national law and was a national issue. The Trust had planned for the changes as much as possible.

Mrs Brennan commented that IR35 also affects Therapies and OPD nurses, with Doctors being the main risk. Mrs Needham stated that Surgery and Oncology are the main areas of risk.

Mrs Needham shared with the Board that the current doctors are very supportive of the Trust holding the line with the locum doctors. The Trust may need to take outpatient appointments and elective procedures down to compensate for cancelled shifts. Mr Lazarus noted that work that the Trust had done with a number of locum

doctors encouraging them to come across to the bank.

Mrs Needham reported that she has set up communication with COO's within the East Midlands to help mitigate the risk.

Mrs Brennan stated that the Finance Team had gone out and explained the new rules to the locum doctors.

Dr Cusack advised since the last report to the Board, during the reporting period 1/01/2017 – 28/02/2017 three new Serious Incidents were reported. These were an In-patient Fall, a Missed Scaphoid Fracture and an Influenza outbreak. The serious incident on 28 February 2017 which remains open and under investigation is a Delay in diagnosis in ED. An external review is underway by an external ED Consultant.

Dr Cusack reported that within 2016/17, 14 Serious Incidents have been reported and the categories are listed on page 24 of the report pack. It was noted that category Slips/Trips/Falls has had a large focus on with a new Falls Lead in place.

Dr Cusack discussed learning from Serious Incidents with the Board. The Governance Team facilitate a quarterly Trust wide 'Dare to Share' Learning Event where learning from serious incidents is shared. The last Dare to Share took place in January where a Serious Incident relating to the use on non-invasive ventilation (NIV) was discussed and the new Trust NIV guidelines were launched. There was a second discussion on Health and Safety focussing on the safe use of sharps which had been highlighted in an incident. The next Dare to Share will take place on March 31st which will include a presentation on MRSA bacteraemia and a complex incident related to the use of DOLS and MCA/MHA.

Dr Cusack stated that the Governance Team have been nominated at the HSJ awards for their Dare 2 Share events.

Dr Cusack commented that the HSMR for the year to November 2016 remains within the 'as expected' range. The SMR for the month of November was 'better than expected'. The longer term variation in HSMR for Jan'15/Dec'15 to Dec'15/Nov'16 continued to show a downward trajectory.

Dr Cusack noted that the current Trust crude mortality rate for the 'all diagnosis' basket is 1.3% (Midlands & East Peer group rate is 1.5%).

Dr Cusack advised that the HSMR for emergency admissions to the Trust on weekdays and weekends remains in the 'as expected' range. As with the overall HSMR, this has exhibited a downward trajectory in recent months. Dr Cusack commented that Trust continues to not see a weekend effect.

Dr Cusack drew the Board to page 27 of the report pack which detailed the CQUINs. Dr Cusack noted that Sepsis CQUIN would be very challenging for the Trust to achieve. From a Finance perspective the Antimicrobial Resistance and Stewardship CQUIN will be difficult. The CQUIN will start from a historic baseline and will need to reduce from there. The global shortage of Tacozin will require the Antibiotic guidance to change.

Dr Cusack reported that EPMA went 'live' in the ED and Assessment Units (for patients referred to Medicine) on 27 February 2017. Across the Division of Medicine more than 95% of patients are now on the EPMA system. The roll out was very successful and the feedback has been good. Dr Cusack stated that preparation is underway to roll-out EPMA in Surgery. The system will initially be used in Trauma and Orthopaedics prior to a larger scale roll-out across the Surgical Division, with Gynaecology at the end of April.

Dr Cusack advised that the CQC identified VTE risk assessment as an area of concern. A comprehensive action plan has been put in place and a Task & Finish Group is meeting fortnightly to monitor its progress. Dr Cusack hoped that accurate live data will be available with the next 2 weeks.

Mr Noble discussed the Antimicrobial Resistance and Stewardship CQUIN. The CQUIN will be missed but will the patients be receiving the correct treatment and how will the Trust establish that it is not over prescribing. Dr Cusack stated that NHSI have accepted that the CQUIN is not ideal but however has been set. The CCG are also of the same opinion. Dr Cusack confirmed that Pharmacy audit the usage of anti-biotics.

Ms Fox commented that she chairs the Infection Prevention Control Committee and in relation to antibiotic reviews, this stands at 96%. The consumption of antibiotics is already low which is what makes it hard to reduce further. The Trust has changed the antibiotics prescribing policy to ensure patients are kept safe.

Mr Zeidler requested that evidence is shared with Quality Governance Committee of the current level of antibiotic prescribing. Ms Fox confirmed that she would do this.

Action: Ms Fox

Mr Archard-Jones queried when the Trust would be fully compliant with VitalPAC. Dr Cusack noted that it is key to ensure that the data in VitalPAC is accurate and meets the 8 quality standards. Dr Cusack believed that this should be achieved within the next 1 – 2 weeks and hoped that there would be an increase in performance demonstrated within 6 month's time.

Mr Archard-Jones asked who inputs the data onto VitalPAC. Dr Cusack confirmed that the doctor will input the initial assessment and informatics extract the data.

Dr Swart commented that until PAS and EPMA are also both fully embedded the Trust will not be able to get 100% accurate data.

Ms Thorne advised that Board that the Dare 2 Share event on the 31 May was to be held 12 – 2pm at the Cripps centre and will be focused on data sharing.

Mr Zeidler queried how well attended was the Dare 2 Share events and how is the learning disseminated. Dr Cusack stated that the events were well attended and following the events information is distributed to staff. In October 2016 a Ground Round was also organised following a Dare 2 Share event.

Ms Thorne commented that during the events the attendees are requested to complete a post it note stating what learning they would take back to their department. Learning is also shared in the Quality Street newsletter.

Mr Zeidler noted that the CQUINs listed on page 28 of the report pack used comparative language and queried whether the Trust is comfortable regarding their measurability. Dr Cusack clarified that work was started on the draft CQUINs a few months ago with scoping exercises done to establish who would lead the CQUIN and how the CQUIN would be delivered. In Q1 of a CQUIN the data baseline is set then a 25% reduction would be required for Q2.

Ms Spellman confirmed that the Trust had met with the CCG, KGH and NHFT to establish how the joint CQUINs can be delivered from a collaborative approach.

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

TB 16/17 100 **Director of Nursing and Midwifery Care Report**

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

Ms Fox advised that in February 2017 the Trust achieved 98.13% harm free care (new harm). Overall harm free care was 94.39% in February 17 and broken down there were 12 incidents with new harms.

Ms Fox stated that 15 patients with 15 pressure ulcers were harmed in February 2017 and this is an increase from 11 patients in January 2017. The number of patients still falls below the mean line and March 2017 is noted to be a positive position. Ms Fox confirmed going forward work will be done on continence management, End of Life and Moving & Handling.

Ms Fox commented that the Trust has now reported 22 cases of cdiff against the trajectory set of 21. There has been a positive reduction of 28% on last year's figure of 31 reported cdiff cases. Ms Fox confirmed that to date there been no lapse in care in the reported cdiff cases.

Ms Fox reported that currently, there is no national target set for E.coli bacteraemia. However, due to the national increase relating to Gram-negative bacteraemia the Department of Health are reviewing this for 2017-2018. A 10% reduction will be applied to the Health Economy but not to the acute Trust's. Ms Fox commented that the reduction would be hard to measure and identify.

Ms Fox stated that the Trust's Falls/1000 bed days are below the national average 6.63/1000 bed days and the internally set trust target of 5.5/1000 bed days. The work of the new Inpatient Falls team has been beneficial at meeting these targets. Ms Fox confirmed that additional work from the Inpatient Falls team would be done with the Dickens Unit to rude the number of falls following a recent increase.

Ms Fox noted that the FFT Trust wide results continued to be above the mean line for February at 92.8%. The past 4 months have all been above the mean of 92%.

Ms Fox shared with the Board that the Clinical Commissioning Group (CCG) has confirmed achievement of both John's Campaign and Discharge Summaries milestones for Q2 as part of the CQUIN schedule.

Ms Fox advised that there are some inconsistencies in the level 3 data for safeguarding children. A new Head of Safeguarding will be joining the Trust on 03 April 2017 who will review the data and also interpret the guidance for the requirement of level 3 safeguarding of children training.

Ms Gill queried whether a patient's family can sleep on the ward. Ms Fox commented that this is not currently in place and assured the Board the family is encouraged to be part of the patients care package.

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

TB 16/17 101 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that the overall I&E YTD position is a deficit of £13.4m, £23k better than plan. The Trust is on track to deliver its plan for the year and estimates the final position to be about £0.3m better than plan due to the STF incentive funding.

Mr Lazarus reported that SLA income continues to outperform plan and accounts for a net favourable variance of £2.2m, mainly due to over performance on non-elective

and outpatient income.

Mr Lazarus noted that going forward the Finance Department will continue to support the organisation. A recent survey was sent out to 200 of its customers with 65 responses received with the feedback positive. Mr Lazarus stated that improvements to training are required. It has been agreed by the SLR that financial experts will train the Changing Care team to help achieve the large saving target.

Mrs Needham stated that the Trust is into its 3rd year of the clinical led structure and it is now noted how the Divisions are taking account of their finances. If a Division goes off track the Division will meet monthly with the Director of Finance until the issue is resolved.

Mr Archard-Jones complimented the year end position and queried whether the £200k CQUIN risk had been factored in. Mr Lazarus confirmed that it had.

The Board **NOTED** the Finance Report.

TB 16/17 102 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity increased in February 2017 and Annual Trust turnover increased in February to above the Trust target.

Mrs Brennan reported that Sickness absence for February 2017 remains the same as last month. It was noted that sickness absence is below the East Midlands average which is positive.

Mrs Brennan stated that the current rate of Appraisals recorded for February 2017 is a decrease from last month's figure. Mandatory Training compliance also decreased in February 17 and this is the first time that mandatory training compliance has fallen below Trust target since March 2016. However Mrs Brennan pointed out that this had not occurred for some time and given it was only 1 data point she was not concerned at this stage.

Mrs Brennan commented that Role Specific Essential Training compliance increased in February 17.

Ms Gill queried whether the turnover and appraisal compliance rates had any correlation. Mrs Brennan advised that this had not been analysed at local levels.

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

TB 16/17 103 Staff Survey Results 2016

Mr Brennan presented the Staff Survey Results 2016.

Mrs Brennan shared with the Board that NGH is one of the top 5 most improved acute Trusts in the 2016 survey. Of the 32 key findings the Trust has four in the top 20%, when compared to other Acute Trusts which is an improvement from last year. The Trust had 2 in the lowest (worse) 20% when compared to other Acute Trusts an improvement from last year, which stood at 9 key findings. Mrs Brennan stated that within those overall 32 areas, there are 11 results (12 in total) that have statistically significant improvement.

Mrs Brennan commented that overall staff engagement score (which is a combined score rather than an individual key finding increased from 3.75 (out of 5) to 3.83 which is a statistically significant improvement.

Mrs Brennan drew the Board to page 91 of the report pack when the trend analysis is included. This demonstrated that there has been a steady improvement from 2012 to 2016.

Mrs Brennan advised that the 2016 National Staff survey results by key findings are listed by staff pledge of page 96 to 99 of the report pack. Mrs Brennan explained that statistically significant changes are highlighted in yellow and top 20% and bottom 20% in Green and red respectively. The Trust Leadership Model findings are included on page 101 of the report pack. There is a noted improvement in all ratings from 2013 to 2016 bar 2 which had remained unchanged. The positive improvement is as a result of organisational wide change programme aimed at culture change, staff engagement and quality improvement.

Mrs Brennan welcomed her colleagues to share with the Board what they believe to have influenced the improved staff survey results.

Mrs Needham advised from the operational team there had been a big focus on safety and quality. The clinically led structure has enabled the clinicians to have a voice and become part of the discussions. Many clinicians have also expressed their pride in working for NGH.

Dr Cusack echoed Mrs Needham's opinion. The medical staff feel like they are part of the system and which has encouraged more engagement. In the CQC focus groups it was noted from the medical staff that they have a positive experience of working at NGH.

Mr Lazarus commented that the Changing Care programme was introduced in 2014/15 and a steering group has helped this programme. The programme is now embedded within the Trust and colleagues are now leading the workstreams.

Ms Fox stated that including the nursing team with the development of the Nursing and Midwifery strategy has been positive. The Pathway to Excellence initiative has also motivated the nursing staff across the Trust.

Mrs Watts believed that the Trust had changed the way messages are communicated to staff to ensure the information is accessible to all.

Mr Abolins shared his pleasure that the Organisation and Managements interest score on Health & Wellbeing within the staff survey had improved. The positive work has been recognised by the staff which are further motivating and Mr Abolins pointed out that there was a separate report on actions taken under the health and well-being programme on the agenda.

Ms Spellman noted that Divisional plans which are fed through have all embedded the Trusts values.

Mrs Brennan stated that from a Governance staff engagement perspective it is good that the approach to governance good Governance and arrangements that areled by Mrs Thorne was to ensure the governance structure kept the organisation as safe as it could be whilst not stifling that support openness without stifling innovation, such as through the 'Dare to share' initiative.

Mrs Brennan commented that it was encouraging to see staff enthusiasm in supporting change and embedding the trust values.

She advised that her concern from the results were in in relation to staff behaviours and informed the board that work was underway to address.

Mrs Brennan thanked the Non-Executive Directors for their patience and support when, in 2013 a shift from an approach of developing annual plans in response to the staff survey was set aside in favour of a long term programme of organisational change and in accepting that this would take time to bring about the changes that were required.

Mr Zeidler stated that he has noticed an improvement with staff and organisational culture and congratulated the Executive Team on their fantastic achievement with the staff survey results.

The Board **NOTED** the Staff Survey Results 2016.

TB 16/17 104 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that the Integrated Performance Report had been discussed at all relevant sub-committees.

Mrs Needham reported that Urgent Care dipped in performance to below 80% in February 2017. Performance has improved to 86% in March 2017 (to date). Mrs Needham reported that in relation to benchmarking the Trust was currently raking middle and was doing better than some of the surrounding organisations.

Mrs Needham shared with the Board that the Trust had been put into segment 2 for A&E performance. The Trust will receive weekly scrutiny of the Trust's action plan and weekly performance.

Mrs Needham stated that the Trust's DTOC number was still high and was in the bottom quartile nationally. The Executive Team will have a discussion on whether finances can be committed to reduce the DTOC number for 2017/18.

Mr Archard-Jones asked what the relationship was with the social care providers. Mrs Needham commented that it was positive and that they appeared willing to communicate and engage and that they are currently aware of the number of patients at NGH who are delayed.

Ms Gill shared with the Board that she had recently attended a NHS Non-Executive event on A&E and it was suggested at the event that Epsom & Surrey were currently demonstrating best practice in A&E. Mrs Needham confirmed she would explore this.
Action: Mrs Needham

Ms Fox advised that in relation to DTOC a 90 day rapid improvement collaborative was underway. The wards are being asked to challenge what is within their gift to discharge and how could the ward reduce discharge time by a couple of hours.

Mr Noble queried would this be reflected in the number of patients discharged before midday. Ms Fox confirmed that it would be measured in hours.

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

TB 16/17 105 Update to Quality Governance and Workforce Terms of Reference

Ms Thorne presented the Update to Quality Governance and Workforce Terms of Reference.

Ms Thorne advised that the Quality Governance and Workforce Committee Terms of Reference have been amended to reflect that the Corporate Risk register is reviewed quarterly by each Committee

The Board **APPROVED** the Update to Quality Governance and Workforce Terms of Reference.

TB 16/17 106 Care Quality Commission Inspection

Ms Thorne presented the Care Quality Commission Inspection.

Ms Thorne advised that a focused, short-notice, announced CQC inspection of the trust took place on 7-9 February 2017. Ms Thorne believed that the CQC were on track to deliver their report within the timescales set. The last data request was submitted last week.

Ms Thorne reported that an initial improvement plan has been developed in response to the immediate concerns raised at the end of the inspection. This is monitored by the Executive Team weekly and all actions are on track to meet the deadline completion dates.

Ms Thorne confirmed that any further actions will be merged into a formal improvement plan that will be formally overseen by the Quality Governance committee.

Ms Thorne noted that it was encouraging the Trust had not received an improvement notice to date.

The Board **NOTED** the Care Quality Commission Inspection.

TB 16/17 107 Health & Wellbeing Annual Report

Mr Abolins presented the Health & Wellbeing Annual Report.

A video was shown to the Board discussing the health & wellbeing benefits staffs have experienced working for the Trust.

Mr Abolins advised that Trusts Health and Wellbeing Strategy which was approved the Board in November 2015 and subsequently launched in April 2016. In September 2015 a health and wellbeing survey, developed in conjunction with Public Health Action Support Team (PHAST) was circulated to all staff. The survey results determined the next steps NGH needed to take to improve access to activities and advice.

Mr Abolins stated that a repeat survey was carried out in February/March 2017. The survey is currently being analysed and two interesting prelimary results were discussed. It was noted that 83.4% of staff are aware of the positive action the Trust is taking towards health & wellbeing and 25.4% of staff feel that their line manager could do more to support their health and wellbeing. There were will be work focused on improving manager support.

Mr Abolins drew the Board to page 144 of the report pack which listed the activities undertaken in 2016/17. The weight watchers meetings at NGH were attended by 21 members of staff.

Mr Abolins shared with the Board that the Health & Wellbeing team have been Time to Change which is a national campaign run by charities Mind and Rethink Mental Illness. On 3 February 2017 the Trust signed the Pledge to demonstrate our commitment. The Trust will be enhancing its resources to support all staff through our Health and Wellbeing Steering group. Mr Abolins stated that training will be given to staff and managers to address both ends of the spectrum. There will be awareness sessions open to all staff and a specialist training manager will run the

sessions.

Mrs Abolins advised that to improve staff engagement Health and wellbeing is promoted through display boards located in key areas across the site, slot in the weekly staff bulletin and also through Trust monthly core briefings for senior managers to take to local team briefings. There is also a Health and Wellbeing wall located at the South Entrance which is prominent visual containing key pledges to patients, staff, visitors and the wider community taken from within the Health and Wellbeing Strategy.

Mr Abolins explained that in addition there are dedicated health and wellbeing intranet pages and Trust health and wellbeing initiatives have been promoted at the events. The Trust was invited to present its health and wellbeing journey at Healthy Workplace Conference 2016, Northampton University and NHS Employers National Health and Wellbeing Leads Conference, London.

Mr Abolins stated whilst the 2016 CQUIN focused on health and wellbeing, food services and improving uptake of flu vaccinations, the 2017 CQUIN will only focus on flu vaccinations. A key indicator within the 2016 CQUIN was that at least 10% of the Trust's staff should have taken up some of the health and wellbeing initiatives on offer. To date 27% of staff has participated in a health and wellbeing initiative.

Mr Abolins discussed the plans for the coming year which are on page 146 of the report pack. Mr Abolins thanked the Charities Committee for funding the Health and Wellbeing Co-ordinator post for a period of 12 months. Ms Gill queried whether the Health and Wellbeing Co-ordinator would also look at improving patient Health & Wellbeing. Mr Abolins confirmed that role will initially address staff engagement with Health & Wellbeing and later move on to patients.

Ms Fox noted that work described also formed part of the evidence for Pathway to Excellence.

Mr Abolins shared with the Board another video on Health & Wellbeing.

The Board **NOTED** the Health & Wellbeing Annual Report.

TB 16/17 108 Highlight Report from Finance Investment and Performance Committee

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

The Board were provided a verbal update on what had been discussed at the Finance Investment and Performance Committee meeting held on 22 March 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.

Mr Zeidler advised of the key points –

- 2017/18 Changing Care Plans
- 17/18 budget previously approved has been validated in a 'bottom up' review
- Congratulations to Procurement for finishing 8/155 Purchase Price Benchmarking Index
- PAS system implementation is delayed by 3 months, now due in June

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

TB 16/17 109 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 24 March 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 –

- Right Time Survey producing real time information
- AKI presentation
- Winter Pressures update
- Approval of the IG Toolkit
- Maternity report to be brought back to April's Committee

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

TB 16/17 110 **Highlight Report from Workforce Committee**

Mr Zeidler presented the Highlight Report from Workforce Committee

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

Mr Zeidler advised of the key points –

- OD capability back to full strength
- Apprenticeship levy which results in the Trust to invest £1m on apprentices. There were 3 options presented to the Committee with a further report coming in May 17
- Medical workforce strategy and action plan is being developed for presentation in May 17

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

TB 16/17 111 **Highlight Report from Hospital Management Team**

Dr Swart delivered the Highlight Report from Hospital Management Team.

Dr Swart advised the Clinical and Estates Strategy was presented to the HMT. There were business cases presented from Dermatology and Rheumatology.

Dr Swart stated that issues with capacity for MRI/CT scans in Radiology were also discussed and plan will be shared with the Executive Team in the following week.

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

TB 16/17 113 **Any Other Business**

Mr Zeidler noted that the financial year ends tomorrow (31 March 17) and felt it appropriate to thank the Executive Team and their fellow colleagues on the brilliant outcome.

Date of next meeting: Thursday 25 May 2017 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Zeidler called the meeting to a close at 12:00

Public Trust Board Action Log							Last update	10/04/2017
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
71	Mar-17	TB 16/17 099	Medical Director's Report	Mr Zeidler requested that evidence is shared with Quality Governance Committee of the current level of antibiotic prescribing. Ms Fox confirmed that she would do this.	Ms Fox	Apr-17	On agenda	Ms Fox to confirm that this has been discussed at QGC in **Matters Arising**
71	Mar-17	TB 16/17 104	Integrated Performance Report	Ms Gill shared with the Board that she had recently attended an NHS Non-Executive event on A&E and it was suggested at the event that Epsom & Surrey were currently demonstrating best practice in A&E. Mrs Needham confirmed she would explore this.	Mrs Needham	Apr-17	On agenda	Update to be given in **Matters Arising**
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**25 May 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	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	

Enclosure C

Public Trust Board
25 May 2017

Chief Executive's Report

1. **Channel Four Series – Confessions of a Junior Doctor**
This four part-series was filmed at NGH during August 2016 – January 2017 and sought to show the reality of what it is like to be a junior doctor in today's NHS. Both I and the communications team were very much involved in this series and were actively involved and consulted during the editing process.

I believe the series is an open and honest portrayal of both NGH and the commitment and passion for patient care shown not only by our junior doctors but also everyone who is part of team NGH.

There was a great deal of coverage around the first episode, which aired just after the General Election was announced, and also subsequent episodes. Overall the feedback has been extremely positive and complimentary regarding our hospital and everyone at team NGH.

Following the second episode, which covered A&E, the team received a number of messages of thanks from members of the public. Comments on social media have included:

'*Amazing series. Really good viewing. Such a good insight to the NHS.'*

'I don't know if these #ConfessionsOfAJuniorDoctor drs are on twitter bt if u are: you're amazing. Good enough and we are so lucky to have u.'

'In awe of our NHS staff. Staying calm in impossible situations. Saving lives every day;

'Time for #ConfessionsOfAJuniorDoctor probably the most important thing on TV right now.'

I must thank all the junior doctors and their colleagues in team NGH who agreed to be part of this series. They certainly portrayed the essence of what it means to be a member of team NGH and their commitment to providing the best possible care and the support we provide to one another shines through every episode.

2. **60-bed Assessment Unit and GP Unit**
Board members will be aware that we recently received confirmation from NHS Improvement that approval had been given for us to proceed with our new £12million 60-bedded emergency assessment unit.

This is one of the most important developments the Trust Board has supported in recent years and we are all delighted that it is now going ahead. It represents a very significant investment to support a new model of care in much improved surroundings and will help us improve the way we treat those patients who require emergency care. Our hospital has responded well to the rising numbers of emergency patients in recent years but despite the incredible commitment of all of our staff we continue to struggle to see, treat, admit and discharge patients as smoothly as we would like. This new unit will help us to do that

A week earlier we had received confirmation of an additional £858k to provide a GP-led streaming unit located in Springfield, where we will be leasing space in the building which has been purchased by the Northamptonshire Healthcare Charitable Fund. Work is underway to plan the necessary refurbishment required with a view to ensuring the facility is up and running by the late autumn.

The opening of the new 60 bed unit will enable us to use the existing assessment wards partly as an escalation area, avoiding the need to place patients in day case areas. And importantly we will have a decant area we can use so we can undertake essential ward refurbishments which we are unable to do at the moment due to the level of bed occupancy.

We have seen huge improvements in the environment in A&E and alongside this investment we have been able to improve processes and care. We have all seen the benefits in terms of patient care and staff morale in the emergency department. I am confident we can use the opportunities provided by the new assessment unit and the GP streaming service to transform urgent care and we are looking forward to some exciting multidisciplinary work to prepare the ground for this.

We are aware that the development of the new assessment unit will mean the loss of some car parking provision on the site. We are purchasing additional spaces in other car parks to replace this, but there will inevitably an impact. The majority of traffic will be banned from the development area, with priority given to emergency vehicles. The communications team will be working closely with our estates team to ensure accurate messaging and advice is available to staff, patients and visitors so they are aware.

3. Staff Engagement

We have now held three question time @NGH sessions for staff. These events, which are open to all staff, have covered topics as diverse as urgent care, culture and finance. More than fifty staff have attended each session. We have had a number of questions submitted to our 'panel of experts' before the session and the panel also takes questions on the day. The Q&A session is written up and distributed via our weekly bulletin, along with a copy of the presentation used on the day so that staff who were unable to attend have an overview of what was discussed.

Future topics to be covered during 2017 include: our clinical and estates strategies; respect and support in the workplace; Pathway to Excellence and the STP/clinical collaboration. Additional QT@NGH sessions may be set up to cover key issues such as our CQC rating once it is known.

These sessions, with their focus on providing face to face discussion along with opportunities for questions and feedback, augment our existing corporate internal communications and engagement activities. We are also exploring other options to improve staff communication and engagement utilising mobile devices.

4. Quality Improvement and Patient Safety

In recent years we have clearly set out the aim of providing Best Possible Care. A key component of this has been to align our organisational efforts around quality improvement with patient safety as the overriding consideration and key value. This work has started to gain more pace in the last 12 months as engagement with projects improves and our efforts are gaining success. In June 2016 we won the Innovation prize at the East Midlands Quality Improvement event. At the national

patient safety congress in July we had 6 shortlisted projects, the Patient Safety First congress in September 2016 attracted17 poster submissions with 6 shortlisted and further presentations were made at the RCP excellence in patient care and a number of other events. In April 2017 we had 25 submissions all shortlisted to the International Forum on Quality and Safety. This summer we not only had 2 shortlisted projects for the HSJ safety awards including the Dare to Share project and the Recipe for Success on QI (complete with our own tea towel design) but we also successfully submitted 12 posters and are thus leading the hospitals with the number of shortlisted projects with 3 times as many shortlisted as any other hospital. This very much supports our key value of patient safety. To assist us further in bringing to life the key value of respect and support in our quality improvement efforts, our next initiative which starts in June 2017 will launch the 'what matters to you' campaign which will bring patient, carers and staff voices together. This will be used to ensure we provide all of these stakeholders with an effective platform so that we listen effectively to their voices and supplement our current QI work as effectively as we can.

5. **Ransomware and IT issues**

   Also on 12 May the celebratory atmosphere at nurses' day merged into the reality of the current NHS IT problems as posed by Ransomware. Although NGH did not report any infections with this issue, in order to prevent this all IT systems linking in any way to external environments, had to be shut off presenting us with a raft of operational problems as manual systems were set up. We liaised closely with NHS England, commissioners and partners in the system in order to ensure that we had as robust an understanding as possible of the possible threats and risks. Our own team NGH pulled together to ensure that patients were kept safe and plans were communicated effectively whilst best practice advice was followed. This included putting in a number of manual systems. There are likely to be a number of issues arising out of this situation and a full debrief will be complied in due course but for the moment all issues are being managed effectively and all clinical systems were restored within 2 days . Full links for critical external systems were opened after around 56 hours once all checks had been made and all available 'patches 'were in place. Restoration of email has taken a little longer. Huge thanks are due to IT staff as well as to all the clinical staff who pulled together to minimise the risks to patient safety.

6. **NGH Dancing Stars**

   The Northamptonshire Healthcare Charitable Fund (NHCF) is supporting our third ballroom and Latin dance challenge. We have eighteen dancers taking part this year, each of whom has agreed to raise a minimum of £300 each for the NHCF local fund of their choice. All profits from the event will go towards the provision of a unit for children aged between 11 - 16 on our children's wards.

   Tickets are on sale for the event, which takes place on Saturday 17 June 2017 from 7pm at The Deco Theatre, Northampton and I encourage board members to come along and support this.

7. **Nurses' Day**

   Friday 12 May was a day to celebrate nursing with a lively series of displays in the Board room and the chance to showcase some of the excellent work that has gone on this year. It was organised and supported with enthusiasm by our NGH volunteers who are growing in number and confidence and by our Health and Wellbeing champions as well as by many others. It was good to see the pride and

enthusiasm shown by all the nurses who like many NHS staff do feel the current pressures in the system but are determined to provide excellent nursing care

Dr Sonia Swart
Chief Executive

Enclosure C

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 May 2017**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Sponsoring Director	Dr Michael Cusack, Medical Director
Author(s) of Report	Dr Michael Cusack, Medical Director Dr Amanda Bisset, Associate Medical Director Mrs Louise Simms-Ward, Clinical Governance Manager
Purpose	Assurance

Executive summary

Since the last report to the Trust Board, during the reporting period 1/03/2017 – 30/04/2017, 3 new Serious Incidents have been reported onto STEIS. One of these incidents relates to a Never Event:

2017/10359	Never Event - Wrong Site Surgery	Manfield Theatre

The two remaining serious incidents were:

2017/7487	Incorrect Diagnosis (Pathology result in correct)	Histopathology
2017/5530	Inpatient Fall (#Elbow)	Discharge Lounge

There are currently no further Serious Incidents that still remain open and under investigation. Where appropriate, immediate actions have been agreed at the SI Group to mitigate against recurrence.

Four External Serious Incident Reports were submitted to Review of Harm Group (RoHG) for closure in March & April 2017:

2016/24735	Pressure Ulcer – Grade 4	Victoria Ward
2016/32625	Delay in Diagnosis	Emergency Department
2017/1071	Missed Scaphoid Fracture	Emergency Department
2017/1745	Influenza	Dryden Ward

The learning from theses is described in the report.

Dr Foster data showed overall mortality expressed as the HSMR and SHMI remains within the 'as expected' range.

The National Guidance for Learning from Deaths is described in the report. The outcome of the 4th Mortality Case Note Review for patients with learning disability is outlined and the Trust approach to the National Learning Disabilities Mortality Review.	
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.	

Northampton General Hospital NHS
NHS Trust

Public Trust Board
May 2017

Medical Director's Report

1. Clinical Risks

The purpose of this report is to highlight areas of concern in respect to clinical quality and safety at NGH to the Trust Board.

The principal risks to clinical care relate to the following areas and are reflected on the Corporate Risk Register. One of the key challenges to the Trust remains the acute pressures on the urgent care pathway. The risks and actions taken in mitigation are reviewed in the Quality Governance and Finance & Performance Committees as described here:

1.1 Pressure On Urgent Care Pathway

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk to outcomes when demand exceeds capacity within the ED and the Trust.	15	15	Finance and Performance
96	Inconsistent in-patient capacity due to delays in the discharge process resulting in an increased length of stay.	12	16	Finance and Performance
421	Risk to quality due to utilisation of Gynae day care as an escalation area.	16	16	Quality Governance
619	Risk to quality due to utilisation of Heart Centre as an escalation area.	25	16	Quality Governance
731	Risk to quality of haemodialysis service for in-patient and outlier/emergency patients when Northamptonshire Kidney Centre used an escalation area.	20	16	Finance and Performance

The Trust has and continues to undertake substantial work in order to mitigate the risk to patients posed by the urgent care pressures. This is coordinated through the Urgent Care Working Group led by the Chief Operating Officer with representation from each of the clinical Divisions. Significant progress has been made through this group across a broad range of actions including the on-going roll out of the SAFER Bundle and 'Red to Green'.

1.2 Difficulties in Securing Sufficient Nursing & Medical Staff

Recruitment of appropriate trained nursing and medical staff is a further on-going risk to the Trust. These risks and mitigating actions are reviewed at the Workforce Committee:

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
100	Insufficient nurses and HCAs on a number of wards & insufficient skill mix.	25	25	Workforce
979	Difficulty in recruitment and high turnover in nursing staff groups.	16	16	Workforce
81	Inability to maintain effective service levels due to reduced skilled nursing workforce for the existing	9	16	Workforce

	bed base.			
111	Risks to quality and outcomes due to inability to recruit sufficient medical staff.	16	16	Workforce

The Trust is impacted upon by the nationwide challenges in recruiting clinical staff. The impact of this is particularly acute during periods of pressure on the organisation through urgent care. A wide range of measures have been adopted to increase staff recruitment and retention with some success.

There is further work underway to reduce agency expenditure, a key part of which seeks to enhance recruitment of medical staff in particular. It is recognised that there have been reductions in the number of doctors taking up training posts and this has impacted adversely on rotas in Medicine and Anaesthesia. As gaps in these rotas emerged at relatively short notice it was not possible to fully mitigate the impact of this on service provision. These have improved with targeted recruitment in these areas

The potential impacts of these issues are also described in items BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2 within the Board Assurance Framework.

2. Serious Incidents

The Trust is committed to identifying, reporting and investigating serious incidents, and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. The Trust is determined, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk to ensure safe care is provided to patients, through the promotion of a positive reporting and investigation culture.

A report on Serious Incidents (SI) is presented to the Committee on a monthly basis to provide assurance that incidents are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

This element of the report paper focuses on those incidents determined to be Serious Incidents following the guidance from the NHS England's 'Serious Incident Framework" published in March 2015 which requires reporting externally via STEIS.

The patient safety incidents that do not fulfil the criteria for reporting onto STEIS but where there are thought to have been omissions or concerns over the care the patient received, are now declared as a "Concise Investigation". This allows for a thorough root cause analysis investigation and provision of a concise report outlining the investigation and findings.

2.1 Summary Serious Incident Profile

Shown in the table are the numbers of Serious Incidents and Never Events which have been reported on the Strategic Executive Information System (StEIS) by year since 2010:

	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	1

Never Events	2	2	1	0	1	3	1	1

2.2 Never Event(s) in 2017/18:

There was one incident in April that met the criteria of a Never Event:

2017/10359 Never Event - Wrong Site Surgery Manfield Theatre

After an initial review of this incident immediate actions were put in place. The incident is under investigation through a root cause analysis. The panel for this investigation includes an external clinician and a governance director from an outside Trust.

2.3 New Serious Incidents

Since the last report to the Board, during the reporting period 1/03/2017 – 30/04/2017 2 new Serious Incidents have been reported onto STEIS:

2017/7487 Incorrect Diagnosis (Pathology result in correct) Histopathology

2017/5530 Inpatient Fall (#Elbow) Discharge Lounge

A Root Cause Analysis (RCA) is being undertaken into each of these incidents. The Trust has a contractual agreement with the CCG to submit all RCA reports to them within a 60 working day timeframe; provide evidence to support the Duty of Candour requirement; and provide evidence to support the completion of RCA action plans via the Serious Incident Assurance Meetings (SIAM).

In **2016/17** there were 14 Serious Incidents that have been reported under the following categories:

- Surgical/invasive procedure
- Sub-optimal care
- Delay in treatment/referral to specialist team
- Slips/Trips/Falls
- Complication during surgery
- Diagnostic incident
- Abuse/alleged abuse
- Maternity/Obstetric incident
- Pressure ulcer
- HCAI/Infection control incident

2.4 Open Serious Incidents

There are currently no further Serious Incidents that still remain open and under investigation other than the two that are detailed above.

2.5 Serious Incidents Submitted for Closure

During the reporting period there were four serious incident reports that were submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure.

- **Four External Serious Incident Reports were submitted to Review of Harm Group (RoHG) for closure in March & April 2017:**

2016/24735	Pressure Ulcer – Grade 4	Victoria Ward
2016/32625	Delay in Diagnosis	Emergency Department
2017/1071	Missed Scaphoid Fracture	Emergency Department
2017/1745	Influenza	Dryden Ward

STEIS Number	Directorate
2016/24735	Outpatients, Elderly & Stroke Services
Brief Description of Incident	
Pressure Ulcer – Grade 4	
Actions	

Cliftonville Ward

Review and consideration of the introduction of the Waterlow Risk Assessment tool for NGH patients on Cliftonville Ward to ensure continuity of care for transferred patients.

As part of this review process, Cliftonville will undertake a trial of the use of the Waterlow Risk Assessment tool alongside the Braden scale to assess their respect efficacy.

Review process for Intentional Rounding and use of the SSKIN care bundle at Cliftonville Ward.

All diabetic in-patients will be referred to the Diabetic foot service for any concerns in relation to skin/nail integrity below the ankle.

All wounds/breaks in skin integrity will be photographed on Cliftonville ward to allow monitoring and accurate record keeping.

Victoria Ward

Relaunch of Intentional Rounding on Victoria Ward
Use of the SSKIN care bundle to be monitored on Victoria Ward through audit

General

Clinical Librarian to to undertake a literature review of the evidence base for the two pressure area risk assessment tools focussing on evidence for their relative clinical effectiveness

Assurance to be provided that Pressure Ulcer Risk is being included in handover and Ward Based Safety Huddles through audit

STEIS Number	Directorate
2016/32625	Emergency Department
Brief Description of Incident	

Sub-optimal care of the deteriorating patient meeting the SI criteria
Actions
A multidisciplinary Task and Finish group will be established to review the 'red flag' system and the use of initial assessment tools in ED. This will include: • The process whereby red flags are determined and applied • Consideration of an automated system to identify 'triggers' and apply red flags • The appropriate level of senior review in response to individual red flags • The introduction of a re-attendance trigger Only trained medical staff will use the ultrasound machine (FAST scan) unsupervised Medical staff who have not completed training in FAST scanning will only carry out this imaging when supervised as per the medical equipment policy Review of the process for storing images from FAST scan Inclusion of 'differential diagnoses' in training/induction sessions relating to chest pain for ED staff

STEIS Number	Directorate
2016/1071	Emergency Department
Brief Description of Incident	
Missed identification of a scaphoid fracture	
Actions	
ED will pilot a process of adding notes onto UV Web when reviewing images which will be visible to the reporting radiographer/radiologist The Radiology Task & Finish Group will produce a standard operating procedure for the agreed, auditable process of communicating results between the Radiology Dept and ED Introduction of a documented process, agreed with radiology, of signing off ENPs as competent in x-ray interpretation All ENPs will be updated in the necessary physical examination and documentation, where a scaphoid fracture is considered possible The ED will produce a generic 'fit for discharge', patient information leaflet that will be given to all patients who are discharged from the Department	

STEIS Number	Directorate
2016/32625	Inpatient Specialises
Brief Description of Incident	
Influenza Outbreak	
Actions	
Re-iterate to all staff the importance of having the flu vaccine annually Support and encourage vulnerable patients to have flu vaccines in the community setting Ensure that wherever possible patients who are swabbed with suspected flu are isolated until a negative	

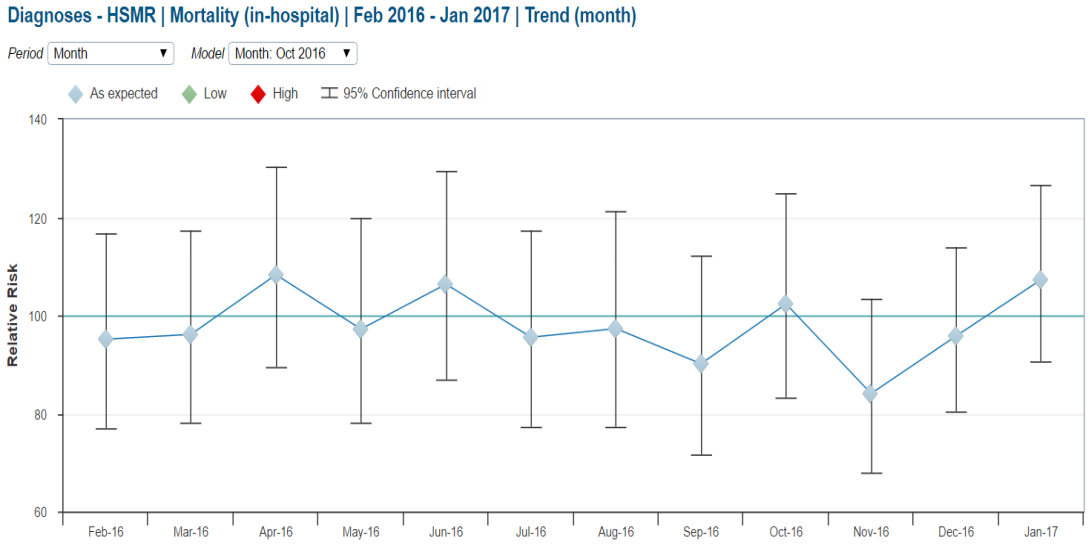
swab is obtained

Continue to emphasise the World Health Organisation 5 moments of hand hygiene as per the Trust code of practice

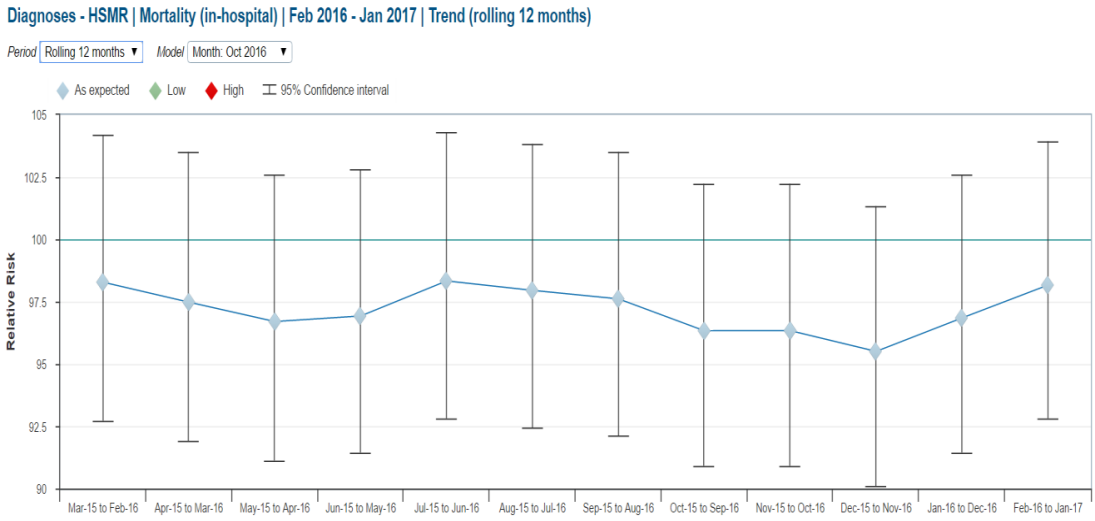
Take all actions to maintain patient flow to help reduce bed occupancy

3. Mortality Monitoring

The HSMR for the year to January 2017 remains within the 'as expected' range at **98.2**. The variation in HSMR during the year to January 2017 is shown below:



Each data point in the following graphic represents the value of the HSMR during the preceding 12 month period. The increase observed in SMR during December and January is reflected in the most recent HSMRs below:



The crude (unadjusted) mortality for the HSMR group of diagnoses remains stable at NGH is 3.4% (peer group rate has increased to 3.7%).

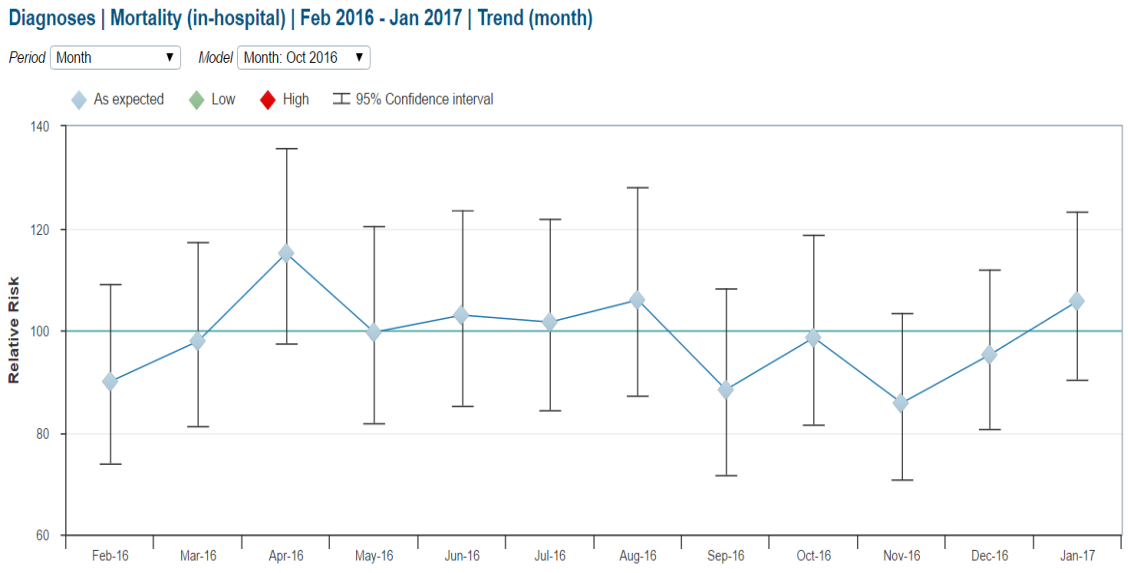
The HMSR for NGH and the East Midlands peer group is shown in the table below:

Diagnoses - HSMR | Mortality (in-hospital) | Feb 2016 - Jan 2017 | Midlands and East

Peers Midlands and East ▾ *Measure* Relative risk ▾ *Show* All ▾

Midlands and East	Superspells	Spells	Observed	%	Expected	%	O-E	RR
All	409,292	411,985	15,211	3.7%	14964.7	3.7%	246.3	101.6
Nottingham University Hospitals NHS Trust	78,183	78,897	2,898	3.7%	2675.4	3.4%	222.6	108.3
Kettering General Hospital NHS Foundation Tru..	31,213	31,491	1,035	3.3%	966.0	3.1%	69.0	107.1
United Lincolnshire Hospitals NHS Trust	54,158	54,323	2,160	4.0%	2076.7	3.8%	83.3	104.0
University Hospitals Of Leicester NHS Trust	84,235	84,979	2,724	3.2%	2729.7	3.2%	-5.7	99.8
Derby Teaching Hospitals NHS Foundation Trust	48,704	48,865	1,997	4.1%	2009.9	4.1%	-12.9	99.4
Sherwood Forest Hospitals NHS Foundation Trust	29,728	29,878	1,284	4.3%	1298.9	4.4%	-14.9	98.8
Chesterfield Royal Hospital NHS Foundation Trust	24,554	24,632	1,142	4.7%	1156.1	4.7%	-14.1	98.8
Northampton General Hospital NHS Trust	35,546	35,605	1,212	3.4%	1234.7	3.5%	-22.7	98.2
Milton Keynes University Hospital NHS Founda...	22,971	23,315	759	3.3%	817.3	3.6%	-58.3	92.9

The SMR for the All Diagnoses Metric for the rolling year to January 2017 was also 'as expected' (SMR=**98.9**). The monthly variation in the SMR for All Diagnoses is shown below:



The long term trend for the All Diagnoses Metric mirrors that seen for HSMR. The current Trust crude mortality rate for the 'all diagnosis' basket remains 1.3% (Midlands & East Peer group rate is 1.5%).

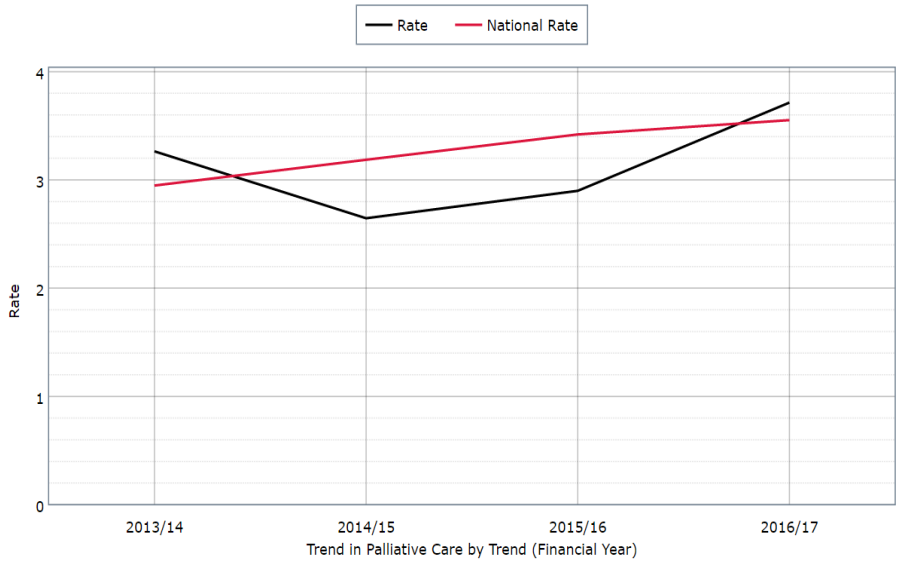
3.1 High Risk Diagnoses – Mortality

The seven 'high risk diagnoses' are monitored quarterly in line with NHS England recommendations. Mortality for the rolling year to December '16 was significantly better than expected (SMR **92**). The SMR for pneumonia is significantly below the national average (SMR **82**).

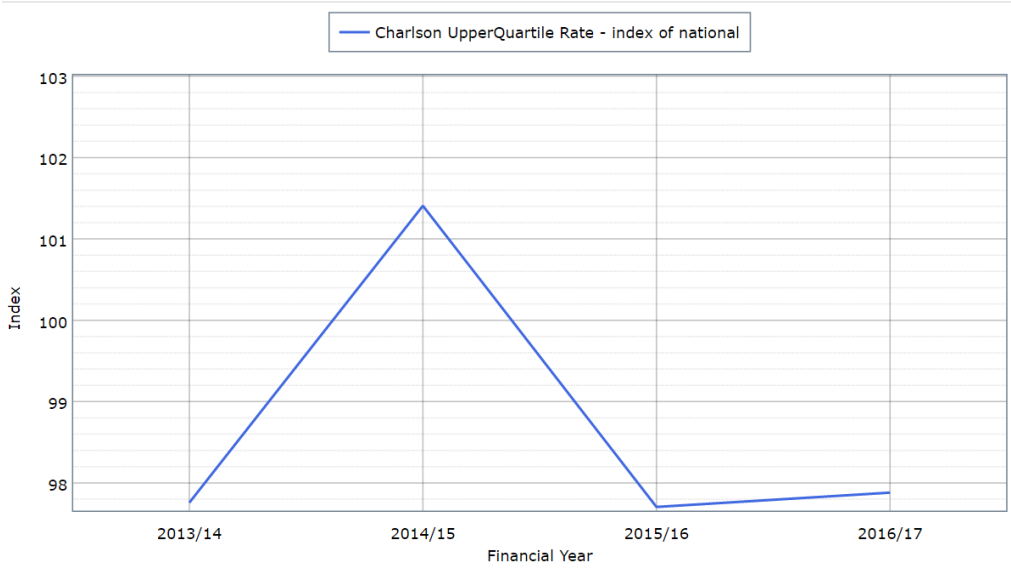
The standardised mortality rates for acute cerebrovascular disease (**92**), acute MI (**75**), fractured neck of femur (**94**), congestive cardiac failure (**110**), acute kidney injury (**115**) and sepsis (**114**) are all within the range expected.

3.2 Coding

The Trust rate of specialist palliative care coding has increased to 3.71% (national rate is 3.55%). This may reflect the appointment of a full time consultant in palliative care to the Trust:



There has been an improvement in the depth of coding reflected in the Charlson co-morbidity upper quartile rate (24.5%) though this still lies below the national average rate of 25%:



3.3 National Guidance for Learning from Deaths

In December 2016 the CQC published a report "Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England". The review found that learning from deaths was not given sufficient priority in some organisations and opportunities for improvements were being missed as a result. It also highlighted that Trusts could do more to engage families and carers and use their insights as a further source of learning.

The Secretary of state for Health subsequently delivered a parliamentary statement announcing his intention that NHS Trusts should collect and publish data on all deaths which occur in hospital including:

- An estimate of the number of deaths assessed as more than likely to have been due to problems in care (i.e. "avoidable" deaths),
- An assessment of the potential causes of any variation from the national average, and
- Evidence of learning and the actions taken as a result.

In March 2017, the National Quality Board published a document entitled "National Guidance on Learning from deaths – a framework for NHS Trusts and Foundation Trusts on Identifying, investigating and Learning from deaths in care". The key points within this document were:

1. By September 2017, each Trust should publish a policy on how it responds to and learns from the deaths of patients who die under its management and care, including its approach to undertaking case record reviews.
2. Trusts should ensure that they share and act upon learning derived from the review and the investigation of deaths.
3. Staff must have appropriate skills and protected time to review and investigate deaths.

4. From April 2017, Trusts will be required to publish specific information on deaths quarterly through a paper and agenda item to the Public Board meeting which includes:
    a. The total number of deaths,
    b. The number subjected to a case record review, and
    c. The number deemed to have been avoidable.
    d. In Q2 the board paper should set out the Trusts policy and approach, and
    e. By Q3 should include the publication of data and learning points.
5. There should be a clear policy for engagement with bereaved families and carers, including giving them the opportunity to share concerns, raise questions, and involving them in the investigation process to the extent that they wish to be involved.

In response to this, the Trust has developed a policy "Reviewing, investigating and learning from mortality" which is being consulted upon. This policy includes details of sharing and learning from reviews of patients who have died, and engagement with bereaved families and carers.

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Members from the Mortality review group have received training in the preferred method of case record review (structured judgement review case note methodology) and are cascading this to all mortality and morbidity groups within the Trust.

The majority of deaths are considered to be expected and unavoidable. It is recognised from available evidence that approximately 4% of deaths which occur in hospital are considered have an element of 'avoidability'. A process has been developed to allow these patients to be identified. This will allow for an in-depth review of each case and ensure that learning is identified.

The principles underlying this process are:

1. The assessment must be both clinically and cost effective, and consistent.
2. Senior clinical staff must be involved to ensure that concerns are identified and investigated adequately and that appropriate action plans are formulated and lessons learnt.
3. Relatives and carers must be given the opportunity to express any concerns they have or to ask questions. Their feedback will be taken into account when deciding on the need for further review.

A small number of consultants (medical screeners) are being appointed to review all deaths using a screening tool and pass those notes to the specialty M&M meeting for further scrutiny if potential problems in care are identified.

These screeners will be experienced senior medical staff who will use a standard screening tool to identify those cases where they have concerns and that require further case note review using the structured judgement review form.

The process will be tracked by a mortality administrator who will collate the outcome of each death (including a judgement on the degree of 'avoidability') and provide data for the quarterly report to the Board.

The screening tool will also be used to identify areas of notable care which can then be shared across specialties. Medical screeners will also be able to speak to relatives/carers and other members of staff to that any issues in care are identified.

3.4 Mortality Case Note Review - Patients with a Learning Disability (Meeting 4)

The first meeting of the Learning Disability M&M was held in September 2015 following recommendations from the CIPOLD report. Meetings have since been held biannually with the aim of reviewing and discussing all deaths of patients with a learning disability in detail.

The review team included the project co-ordinator (Specialty Doctor), the Learning Disability Liaison Nurse, two consultants (both with experience of the Trust wide Mortality Case Note Reviews and directorate morbidity and mortality meetings) and the Dementia Liaison Nurse.

The care of five patients with learning difficulties was reviewed. There were many examples of notable care identified in the review.

Consultant and senior review:

- In line with the 'Seven Day' standard, the first consultant review occurred within 14 hours of arrival at NGH for all of the patients
- Communication with the next of kin and delivery of end of life care was prompt and of a very high quality.
- Two patients were managed on the Critical Care Unit and the standard of consultant review and communication with the next of kin was noted to be excellent also.

Reasonable adjustment and diagnostic overshadowing:

- "Reasonable adjustments" were consistently made.
- No evidence of 'diagnostic overshadowing' was seen.

Communication and consent:

- Care was well documented in the notes.
- Where appropriate, families and carers were actively involved in shared decision making.

Overall Quality of care:

- Overall the care was judged to be "Excellent" for 2 patients, "Good" for 2 patients and adequate for 1 patient. During the discussion, the care of the latter patient was considered to be adequate as it was felt there had been a missed opportunity to discharge the patient who was at the end of their life back to their normal place of residence.
- Using the Likert Scale, the reviewers (with the support of the discussion at the challenge meetings) classified the deaths into one of the following categories:

Hogan/ Likert Scale for identifying preventable deaths		Results
Definitely not preventable	1	5
Slight evidence of preventability	2	0
Possibly preventable but not very likely, less than 50-50 but close call	3	0
Probably preventable, more than 50-50	4	0
Strong evidence of preventability	5	0
Definitely preventable	6	0

3.5 National Learning Disabilities Mortality Review (LeDeR)

The LeDeR will beginning collecting data in Q1 of 2017/18 and will require the Trust to report all deaths of patients with a learning disability. Each patient will be assigned to a trained reviewer from the locality (not someone from the Trust).

All cases will initially have a “light touch” review which will include a conversation with someone who knew the patient well and will look at the care provided by all of the health care providers involved. Following this, the reviewer will decide if a more detailed Multi-agency Review is required (this will be mandatory for certain demographics). The findings will be shared at a Steering Group and fed back to individual healthcare providers.

The National Mortality Review described above uses a standard proforma (Structured Judgement Review Tool) to review deaths so that there is a consistent approach between organisations.

At NGH, the initial assessment using the Structured Judgement Review Tool will be followed up with a second review by a member of the LD Mortality Review Team. This will continue to meet biannually to discuss all cases and produce a report to ensure that the current high standard of local review is maintained and the learning disseminated.

There is concern that the LeDeR may initially be slow to report. Local case review has been very beneficial as it allows learning specific to NGH to be identified. It is intended that the current learning disability proforma will be retained for the second stage of the local review.

4. Next Steps

The Review of Harm Group meets on a weekly basis to expedite the agreement & external notification of Serious Incidents.

Mortality within the Trust is closely monitored and reported through the Quality Governance Committee. The Mortality Surveillance Group model has been adopted in accordance with NHSE recommendations and will continue to provide assurance to Trust Board.

This Board is asked to seek clarification where necessary and assurance regarding the information contained within this report.

Title of Meeting	**TRUST BOARD**
Date of Meeting	**25 May 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	Fiona Barnes, Deputy Director of Nursing Debbie Shanahan, Associate Director of Nursing Senior Nursing & Midwifery Team
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.

Key points from this report:

- Safety Thermometer - The Trust achieved 98.55% harm free care (new harms) this is the fifth month above 98%
- Pressure Prevention - 7 patients were harmed in April 2017with 9 pressure ulcer harms
- Infection Prevention - There were no MRSA bacteraemia April 2017. There were 2 patients identified with Clostridium Difficile Infection a 50% reduction from March, 1 patient was identified with MSSA bacteraemia and 4 patients identified with E.coli bacteraemia. From April 2017 the Department of Health has set guidance and the Trust has to report on further Gram-negative bacteraemia, Klebsiella species and Pseudomonas Aureginosa. In April 2017 there were 0 Trust attributable for both these microorganisms.
- Falls during the month of April 2017, 1 moderate harm fall and 3 severe harm falls, all cases being reviewed and investigated.
- Friends and Family Test (FFT) - Trust wide results continued above the mean line for April 2017 at 92.6%. The past 6 months have all been above the mean of 92%.
- There is an update on the Safeguarding and the Nursing and Midwifery Dashboard.
- Safe Staffing, the overall fill rate for April 2017 was 95%

Enclosure E

• The report also includes a summary of the most recent regional update of safe staffing from January 2017.	
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 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 Board 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
May 2017

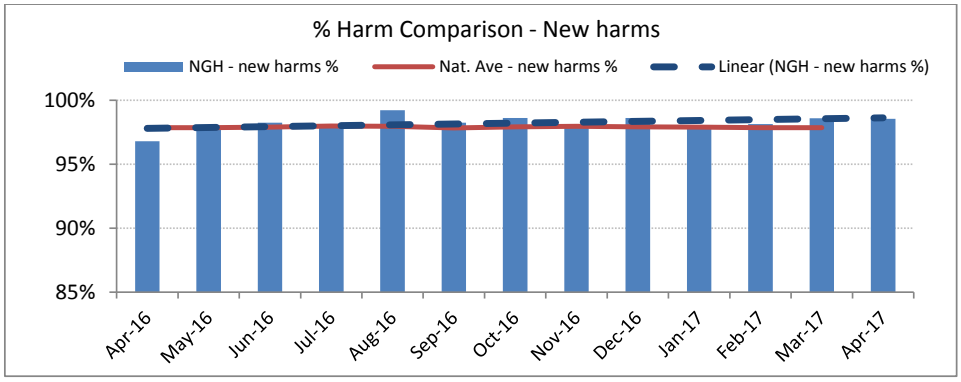
Director of Nursing & Midwifery Report

1. Introduction

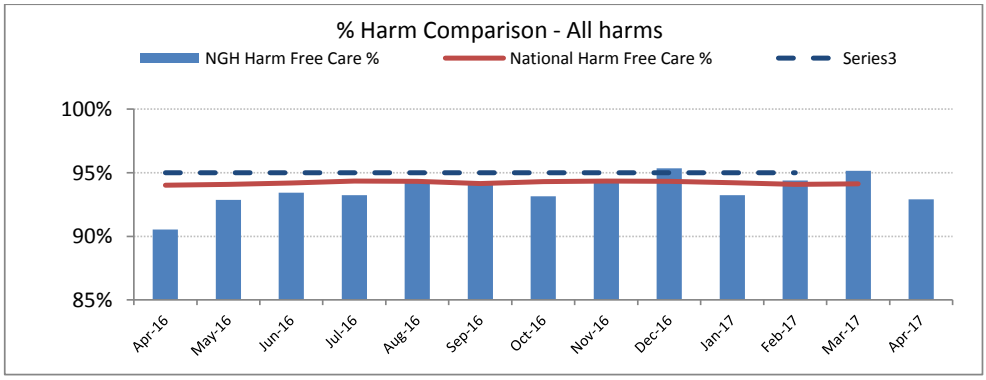
The Nursing & Midwifery (N&M) Care Report presents highlights from services, audits and projects during the month of April 2017. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This monthly 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 April 2017 the Trust achieved 98.55% harm free care (new harm); this is the fifth month above 98%. This relates to 8 new pressure ulcers, and 1 patient fall.



The graph below illustrates overall harm free care was 92.12% in April this is a percentage decrease from March, broken down there were 9 incidents with new harms (Appendix 1 provides the National Safety Thermometer Definition).



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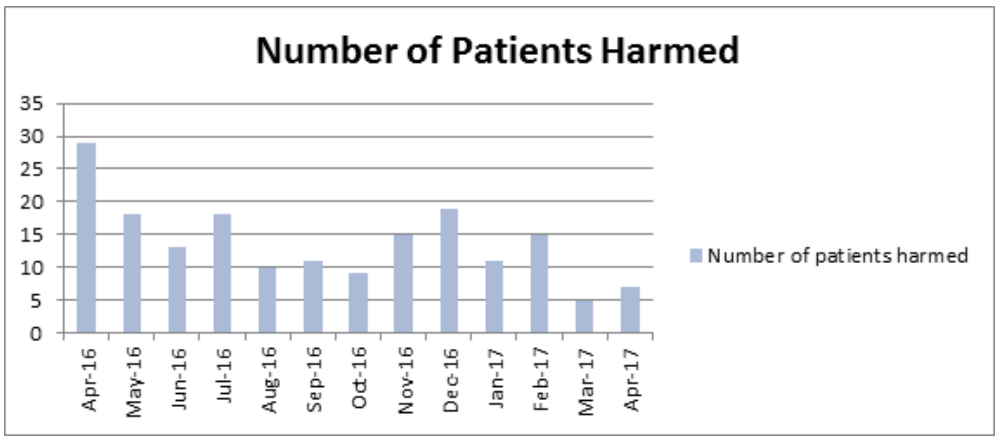
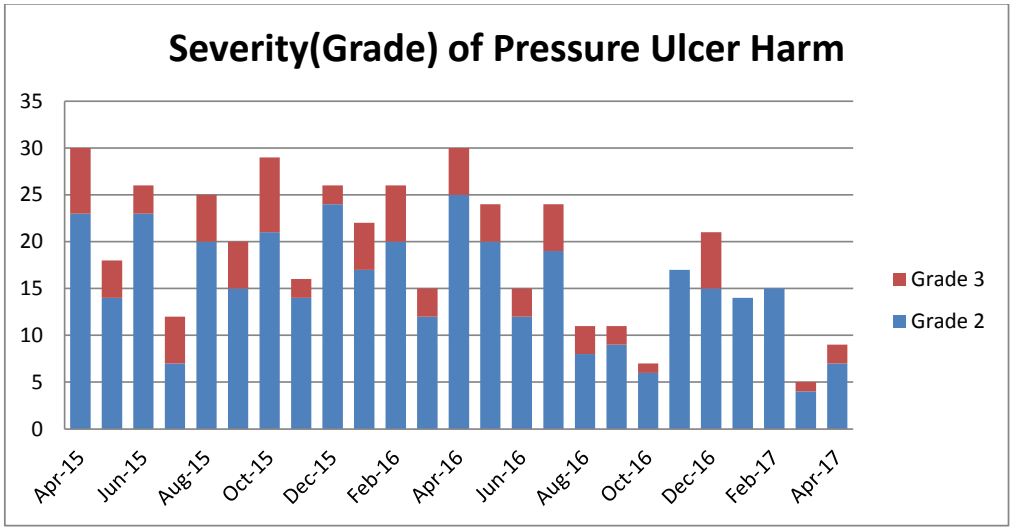
3. Pressure Ulcer Incidence

In April 2017 the Tissue Viability Team (TVT) received a total of 310 Datix incident reports relating to pressure damage. Of the 310 datix reports, 52 were duplicated, a figure higher than usual, this may be related to the issues with Datix reporting system. 4% (13) patients were not seen as they were either discharged or deceased. Of the remaining 245 incidents reported, 75% were validated by the TVT on the wards; the remainder were validated from photographs.

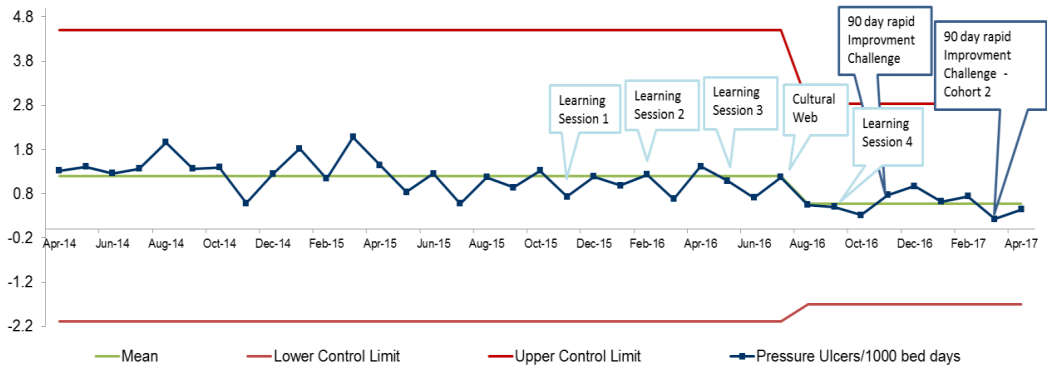
The graph below shows that 7 patients developed 9 pressure ulcers and were harmed in April 2017; this is a slight increase from 5 patients developing hospital acquired pressure damage in March 2017.



The graph below illustrates the severity of harm to patients recorded as either Grade 2 or 3 pressure ulcers. Two patients developed an unclassified Grade 3 pressure ulcer during April.



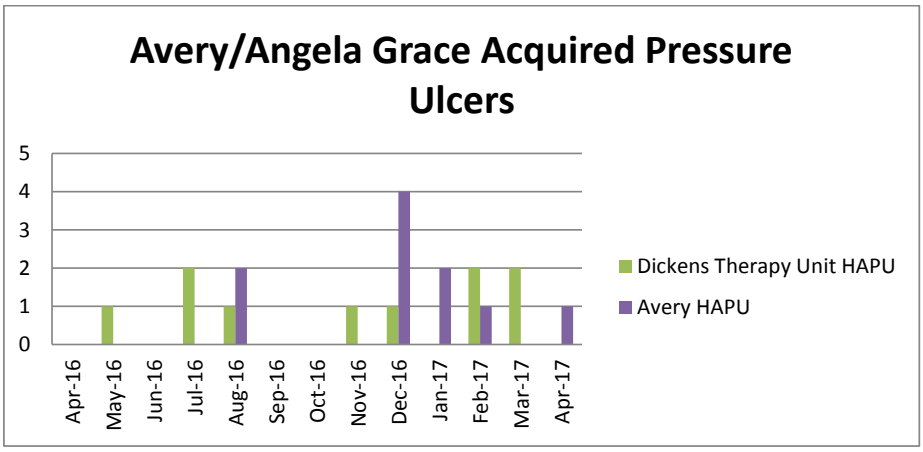
Number of Pressure Ulcers per 1000 bed days



The chart above shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers and demonstrates the improvement made. The mean line has been rebased in August 2016 from 1.20 to 0.60 pressure ulcers per 1000 bed days.

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. There was one Grade 3 acquired pressure ulcer validated in April.



Pressure Ulcer Prevention April Update

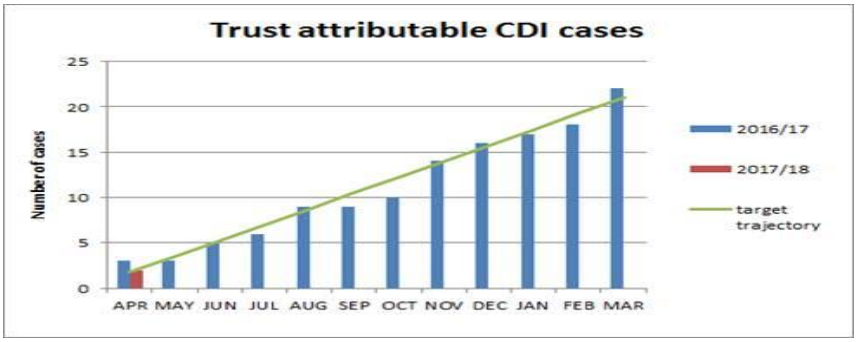
90 Day Pressure Ulcer Rapid Improvement Challenge

The second cohort of the 90 day Pressure Ulcer Rapid Improvement Challenge has continued throughout April 2017 with Brampton, Dryden, Holcot and Talbot Butler taking part. Dryden and Brampton have remained pressure ulcer free since the challenge started, whist Talbot Butler achieved 97 days pressure ulcer free, unfortunately one patient developed a heel pressure ulcer.

4. Infection Prevention and Control

Clostridium difficile Infection (CDI)

The graph below shows the cumulative total of the number of patients with Trust apportioned CDI and for April 2017 the Trust had 2 patients who developed CDI.

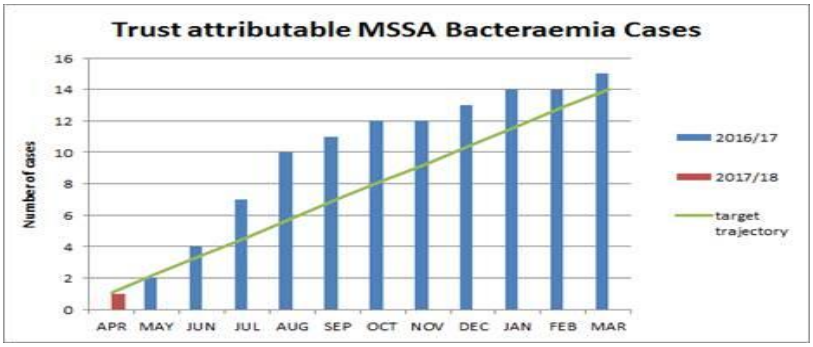


MRSA Bacteraemia

In April 2017, there were no MRSA bacteraemia.

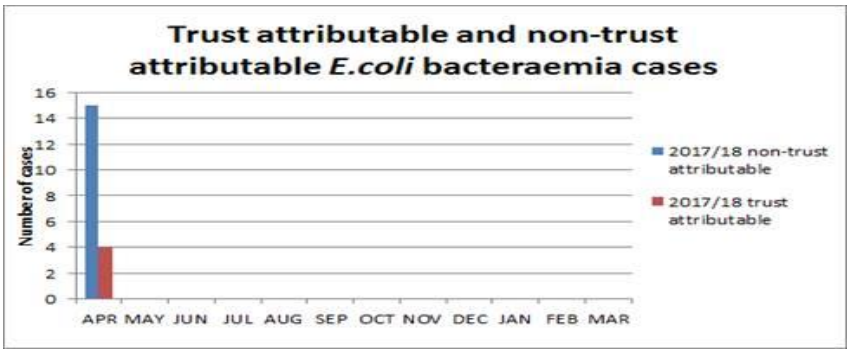
MSSA Bacteraemia

As part of the Healthcare Associated (HCAI) Reduction Plan. The Trust has an internal ceiling of 14 or less patients in 2017-2018 to acquire a trust attributable MSSA bacteraemia. April 2017 had 1 patient with a Trust attributable MSSA bacteraemia. Following the review the source of the infection was found to be from the patient's chest.



Escherichia coli (*E.coli*) Bacteraemia

Currently, there is no national target set for *E.coli* bacteraemia. However, due to the national increase relating to Gram-negative bacteraemia the Department of Health are reviewing this for 2017-2018. As reported last month Public Health England (PHE) have advised not to set a Trust reduction target, as the work to reduce the number of patients with *E.coli* bacteremia's will be a Whole Health Economy (WHE) approach, led by the local Clinical Commissioning Group (CCG). For April 2017 there were a total of 19 patients with *E.coli* bacteraemia, 15 patients were admitted to the Trust and 4 were Trust attributable.



The table below shows the breakdown of source and the number of trust attributable *E.coli* bacteraemia cases for April 2017.

Source of Infection April 2017	
Unknown	2
Urosepsis	1
Relapse	1

the Trust have been asked to report on further Gram- negative bacteraemia, Klebsiella species and Pseudomonas Aureginosa, as per the Department of Health guidance. April 2017 there were 0 Trust attributable for both these microorganisms.

The Infection Prevention Team are also collecting numbers of patients with Trust attributable Enterococcus species and Acinetobacter Baumannii. April 2017 there was 1 trust attributable Enterococcus species and 0 trust attributable Acinetobacter Baumannii.

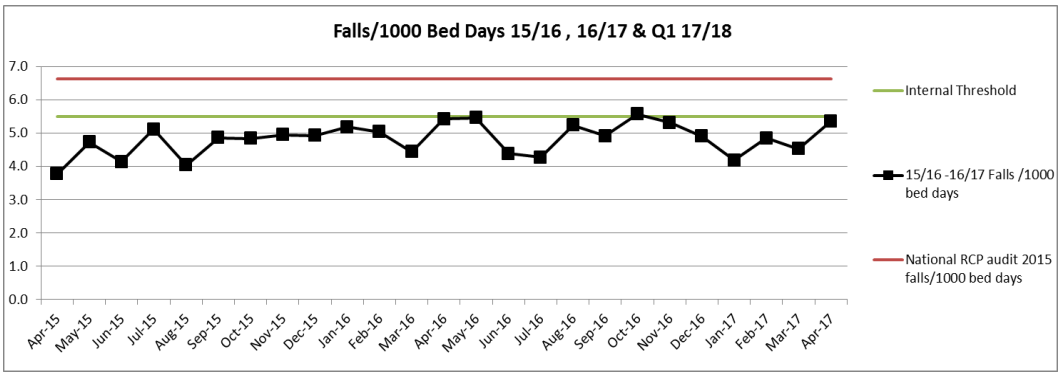
Catheter Related Urinary Tract Infections (CRUTI)

In April 2017 there were 0 CRUTI's in accordance with the safety thermometer.

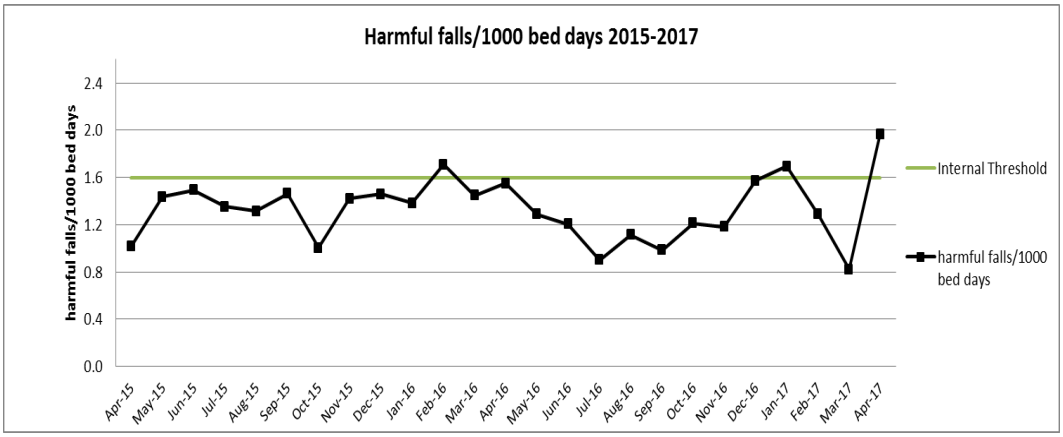
5. Falls Prevention

Falls/1000 bed days

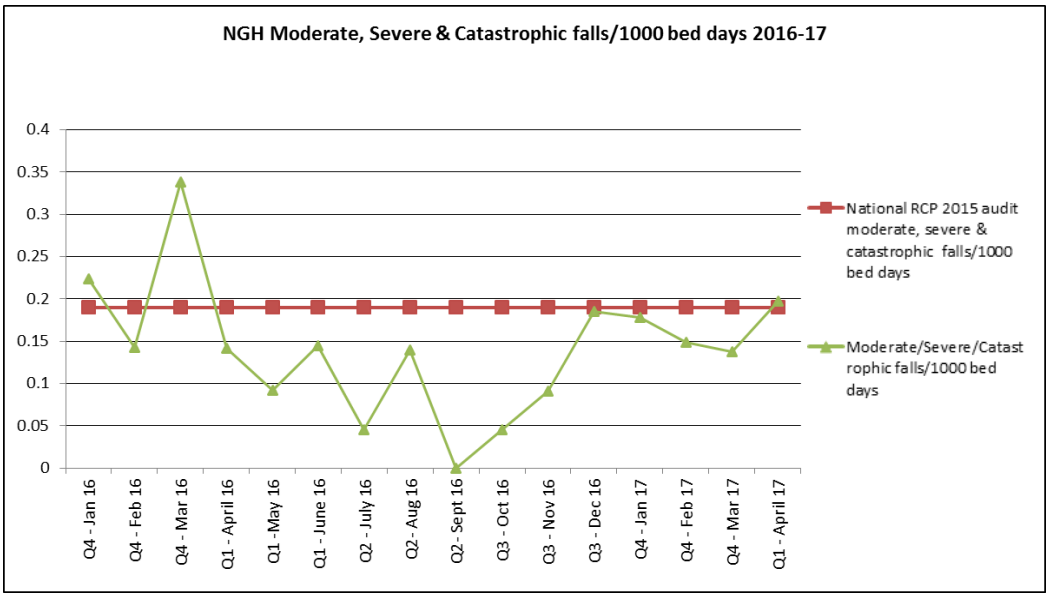
The Trust's falls/1000 bed days are below the national average of 6.63/1000 bed days and the internally set Trust target of 5.5/1000 bed days. There was an increase in the number of falls/1000 bed days of 0.83 compared to the previous month of March 2017.



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 April 2017, harmful falls/1000 bed days have increased by 1.15, in total the Trust recorded 1.97 harmful falls/1000 bed days compared to 0.82 harmful falls/1000 bed days in March 2017. The Trust has an internally set target of 1.6 harmful falls/1000 bed days. The increase of harmful falls is due to an increase in low harm falls where extra observations have been required and an increase in moderate and severe falls recorded.



Falls resulting in moderate, severe or catastrophic harm
The following graph shows that moderate, severe and catastrophic falls/1000 bed days have increased in April 2017 above the national threshold of 0.19. The total numbers of falls have also increased. During the month of April, 1 moderate harm fall and 3 severe harm falls were reported, compared to March where 2 moderate and 1 severe.



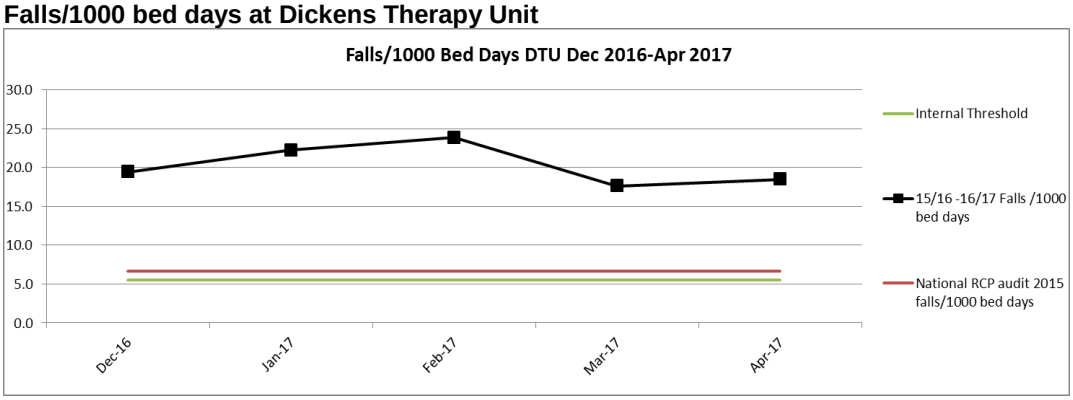
Dickens Therapy Unit

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. It is recognised nationally that the rehabilitation of patients does increase the risk of falls due to the promotion of independence. Due to the different speciality, bed days and falls have been recorded separately since December 2016. The falls/1000 bed days for DTU have been calculated separately from the other Trust data.

Falls/1000 bed days on DTU remain higher than the national threshold and the Trust's internal target. The total number of falls is the same as recorded in March, which is 18, however due to a reduction in occupied bed day's falls/1000 bed days has shown an increase of 0.84.

From the 18 falls recorded through the month of April at DTU; 15 were no harm falls, 2 low harm falls and 1 severe harm fall.

Falls/1000 bed days at Dickens Therapy Unit



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6. 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. The proposal is to reduce the QCI dashboard as once the Assessment & Accreditation programme is 'rolled-out' across the Trust.

Please see (Appendix 2) for a definition of the Nursing Midwifery Dashboard, (Appendix 3) for the Nursing dashboard, (Appendix 4) for the Paediatric dashboard and (Appendix 5) for the Maternity dashboard.

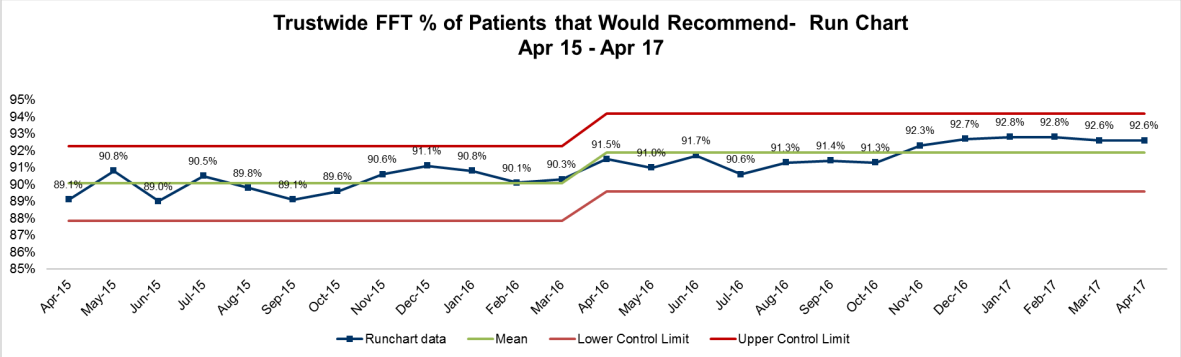
The QCI for April 2017 shows the following:

- Compliance with falls assessments and pressure prevention assessment has been high focus for the teams with improvement seen in the last 2 months data, review continues in the 'collaboratives' and at the 'share and learn' meetings
- There has been a decrease in April in the number of reds on the dashboard from 10 to 8. There has been focused attention on first impression.
- Surgical Division has maintained their improvement to their QCI data. There are 2 reds on the dashboard. Ward Sisters, Matrons and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas to work on.
- Medical Division has 6 reds on the dashboard an increase to the previous month. Collingtree Ward has 4 reds. There is currently focused leadership attention on Collingtree from the Ward Sister and Matron. Ward Sisters, Matrons and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas to work on.
- Women's Children's and Oncology Division, Talbot Butler and Spencer Ward have no reds, for the second month. Paediatrics have 1 red on Disney Ward for incompletion of documentation. Maternity Observation Ward have 2 reds, they have checked the emergency equipment daily and 1 member of staff questioned as part of the QCI audit did not understand the relevance of the data on the patient safety board and did not know who their safety Champions are for the ward. Ward Sisters, Matrons and the ADN are aware of the varied results they are monitored and themes are highlighted. Maternity
- Theatre, Critical Care, and Emergency Department (ED), have updated their QCI data set and going forward this will also be uploaded onto the HIVE.

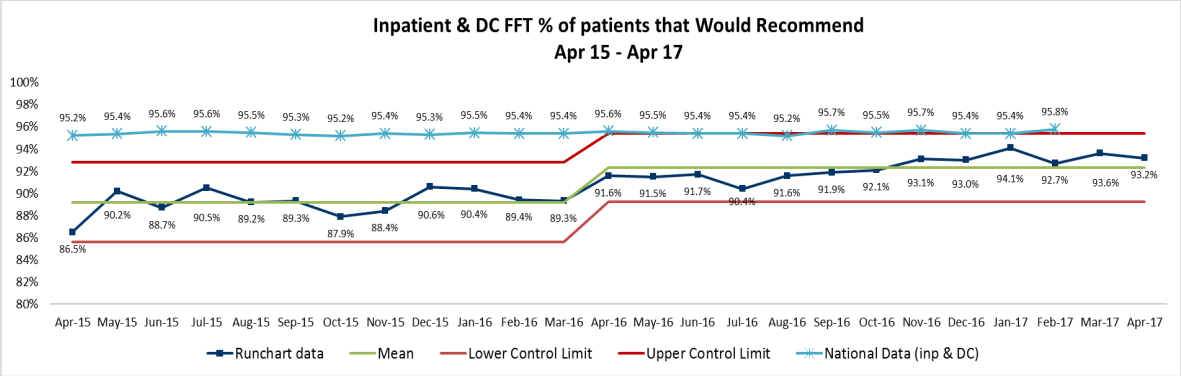
7. Friends & Family Test (FFT)

FFT Overview- % Would Recommend Run Charts

Trustwide results continued above the mean line for April at 92.6%. The past 6 months have all been above the mean of 92%. Once this reaches 8 consecutive points the mean will again be rebased to identify the improvement that has been made to the average recommendation rates.

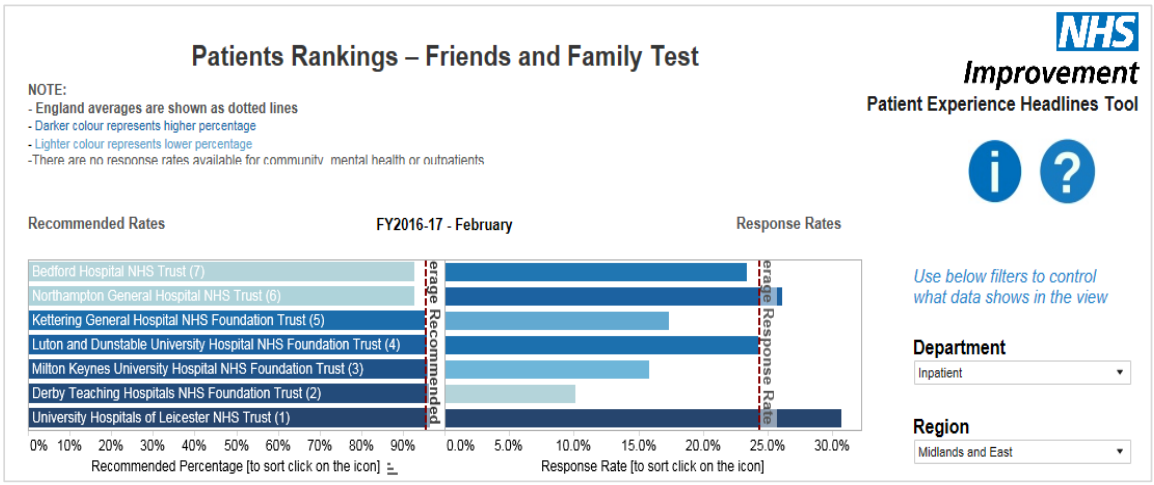


The Inpatient & Day Case results continue above the mean line for April equalling 6 points above in total. The Mean was previously rebased from April 16, if satisfaction rates continue above the mean for a further 3 months, this will again be rebased.



FFT National Data – Response Rates

To provide further reassurance on the improvements made within Inpatient & Day Case areas, it is evident when reviewing the national headline tool for February (most recent data available) that the hospital is performing above the national average for response rates. This indicates that the sample is representative.



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National Inpatient Survey & Right Time Survey comparative results

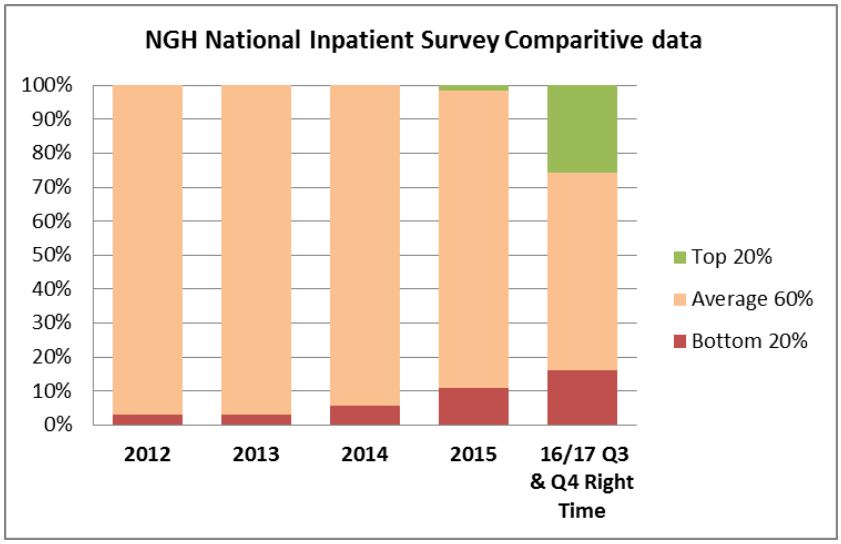
The Right Time survey has been running within inpatient and day case areas since November 2016 and has provided 5 months of data. As the survey is a shorter version of the national inpatient survey it has been possible to ascertain year on year performance for the inpatient survey alongside the Right Time survey results.

Before reviewing the results, it is important to note that the Right Time survey is shorter, with 31 questions compared with the 73 seen in the national survey for 2015. A number of the questions picked for the Right Time survey are based on areas that the Trust does not perform well in, and therefore are likely to make up a higher percentage.

It is evident looking at the table and graph below that there has been an increase in the amount of questions where the Trust has performed within the 'bottom' of the trusts nationally. In 2015 the Trust gained its first ever Top 20% rating for the question *'Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?'*

Questions where the Trust has performed within the 20% have remained consistent in certain areas, Noise at Night from patients, Noise at Night from staff, information at discharge including explanation of medication side effects, Information on how to complain, being asked about quality of care, and more recently, being given enough support with meals.

	2012	2013	2014	2015	16/17 Q3 & Q4 Right Time
Bottom 20%	2	2	4	8	5
Average 60%	68	68	66	64	18
Top 20%	0	0	0	1	8
Total	70	70	70	73	31



8. Safeguarding

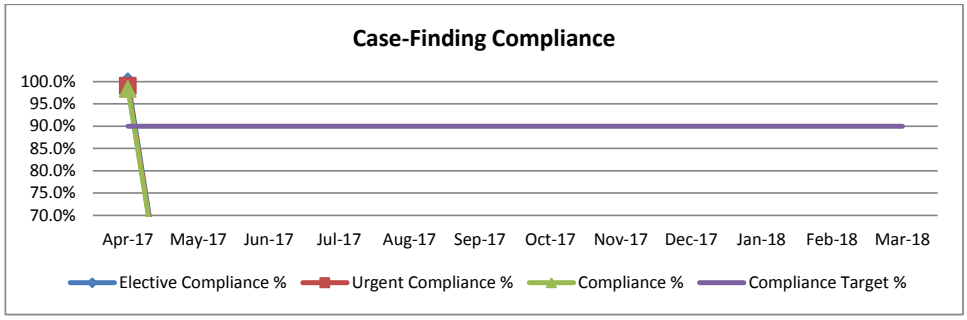
Dementia CQUINS

The Clinical Commissioning Group (CCG) has confirmed achievement of both the John's Campaign and the discharge summaries milestones for Quarter 3 as part of the CQUIN schedule. The Quarter 4 schedule has been submitted to the CCG and the Trust is awaiting confirmation that the agreed milestones have been achieved.

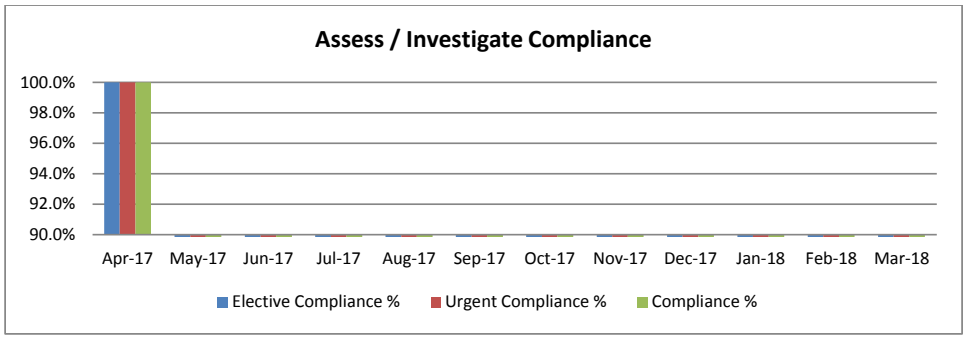
There is not a Dementia CQUIN in place for 2017-18. However the associated data will continue to be collated to provide assurance that assessment and services are in place for dementia patients.

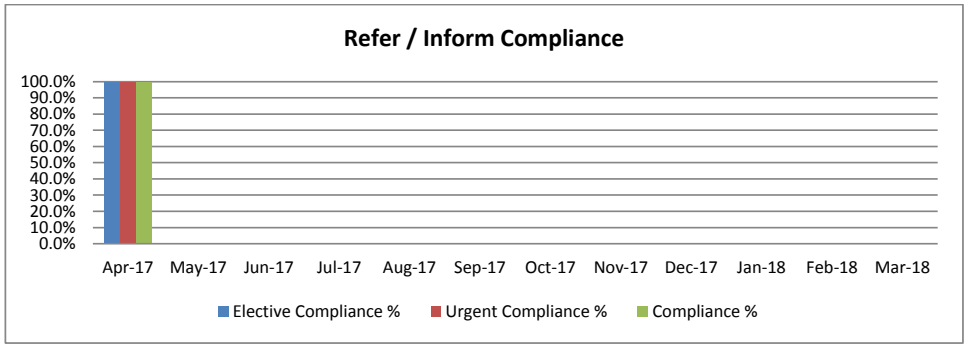
Discharge Summaries

The overall compliance target remains above 90%, which is illustrated in the three graphs below:



The elective and non-elective areas both remain above the 90% threshold for compliance and the total Trust compliance for April is 98%.





Enclosure E

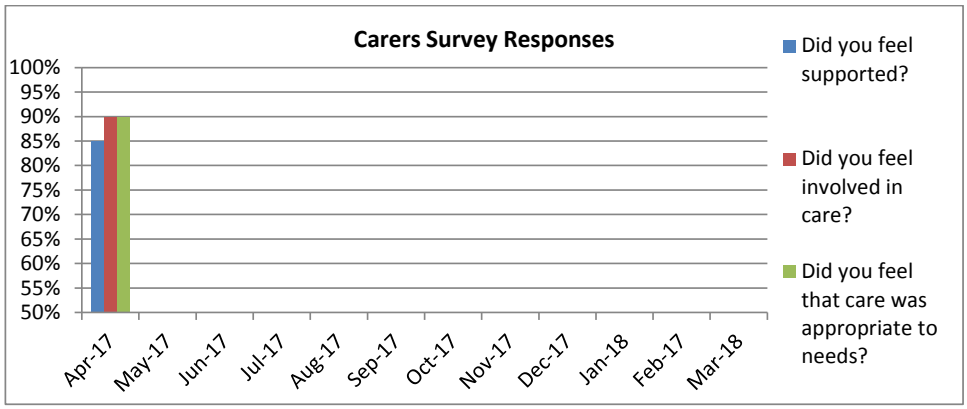
The compliance for the additional elements of the CQUIN remains consistent at 100% as illustrated in the two graphs above.

John's Campaign

The John's campaign has been successfully rolled out across all areas, in accordance with the delivery plan.

Carers Survey

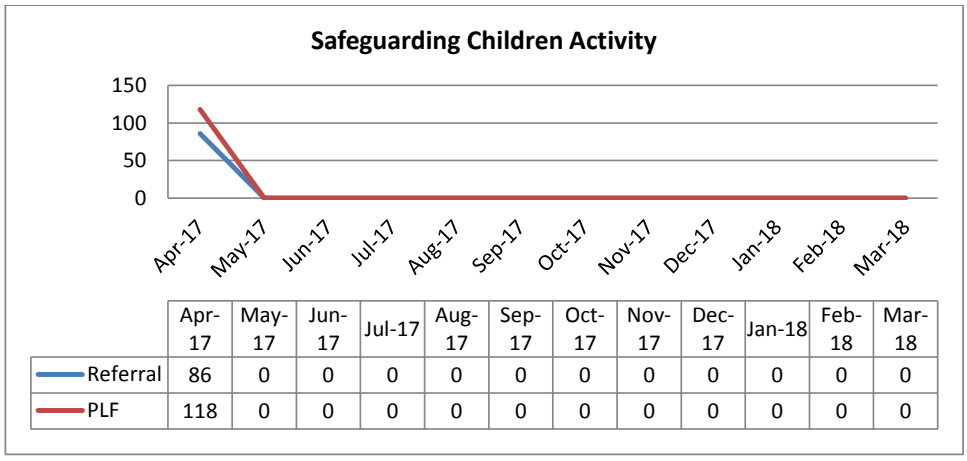
The carer's survey continues and the key responses are illustrated in the graph below.



A significant improvement has been maintained for responses relating to 'did you feel supported' and did you feel that care was appropriate to the person's needs.'

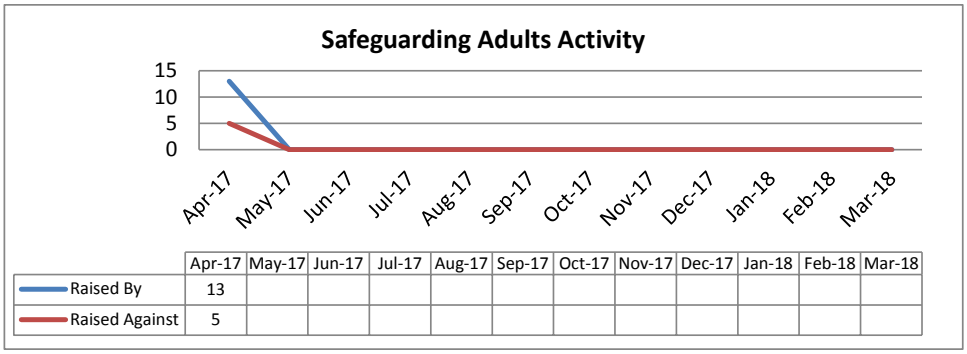
Safeguarding Children and Adult Referrals

The graph below shows the number of referrals made by the Trust for children and young people, at risk of, or suffering, significant harm and in addition to the number of Paediatric Liaison Forms (PLF's) processed. Overall the number of referrals to the Multi-Agency Safeguarding Hub (MASH) and the PLF's remain consistent which demonstrates good practice in terms of information sharing with external colleagues/agencies.



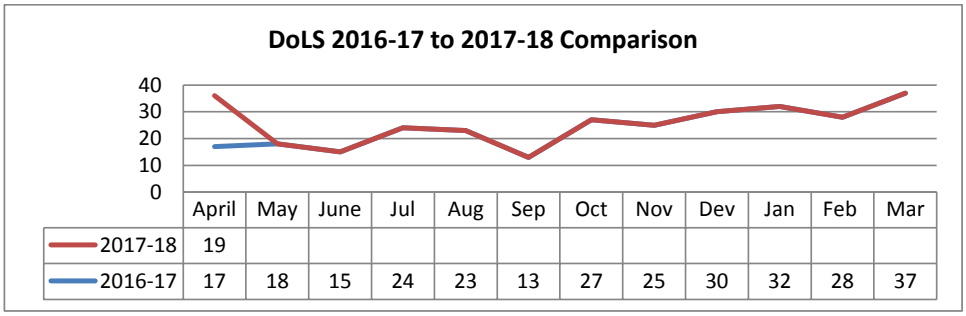
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Referral	86	0	0	0	0	0	0	0	0	0	0	0
PLF	118	0	0	0	0	0	0	0	0	0	0	0

In terms of safeguarding adults referral activity has shown a reduction in the number of safeguarding allegations against the Trust. Staff have continued to recognise potential safeguarding concerns and this is illustrated in the graph below.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Raised By	13											
Raised Against	5											

Deprivation of Liberty Safeguards (DoLS)

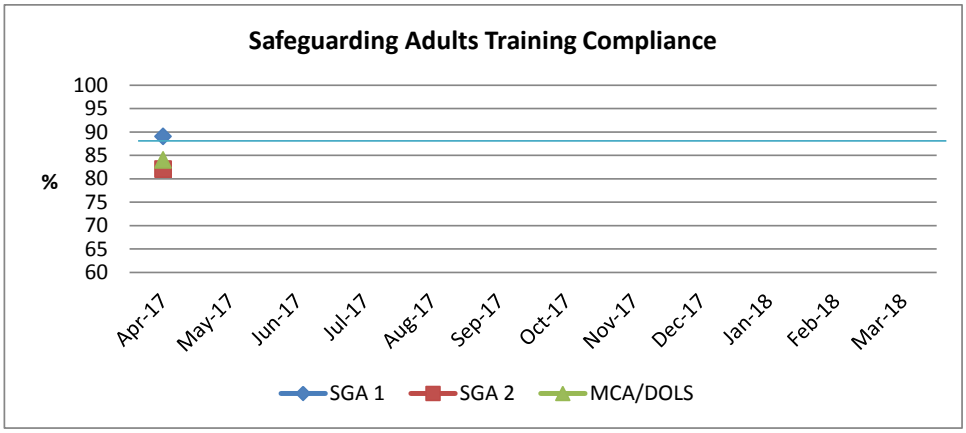


	April	May	June	Jul	Aug	Sep	Oct	Nov	Dev	Jan	Feb	Mar
2017-18	19											
2016-17	17	18	15	24	23	13	27	25	30	32	28	37

Applications for authorisations to Northamptonshire County Council (NCC) under the DoLS framework continue despite no completed authorisations by Best Interests Assessors (BIA). 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 manner possible.

Safeguarding Training Compliance

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



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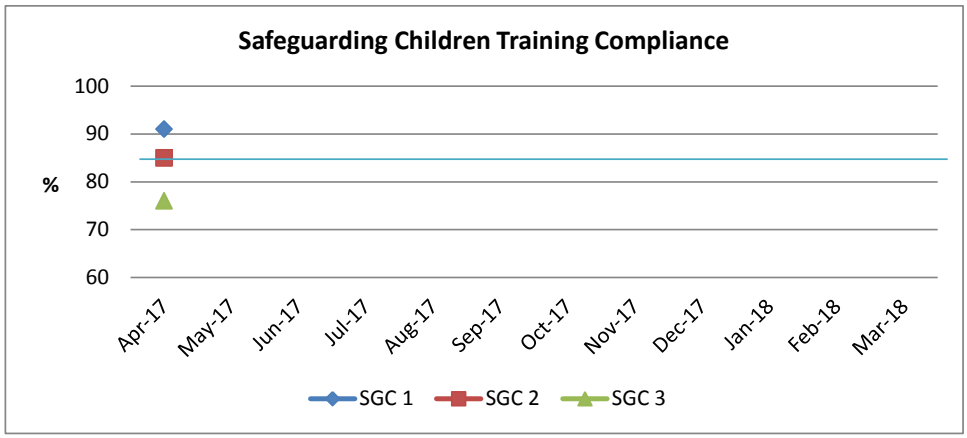


An increased training offering has been provided to target those areas requiring Level three Safeguarding Children Training and Mental Capacity Act training. This is in addtion to the pre-existing schedule of training events throughout the year.

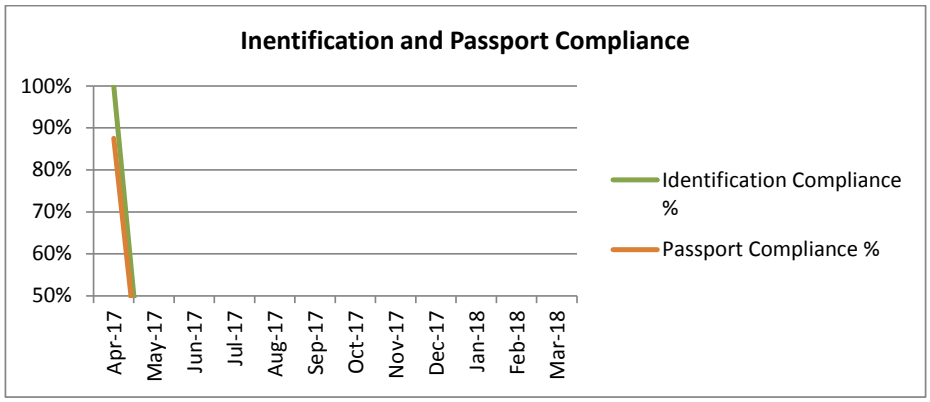
Safeguarding training compliance is a standing agenda item at the SAG and is included in subsequent reports to CQEG. Compliance levels remain a specific risk on the risk register, currently rated at 12. A safeguarding training analysis is currently beng undertaken to ensure that the training is delivered as per national legislation and guidance.

Learning Disability

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

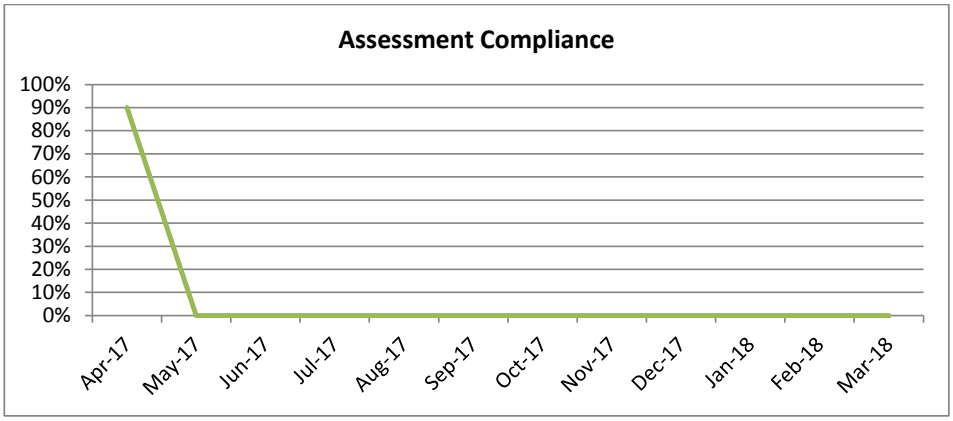
- The identification of people with a learning disability who are admitted to hospital; and of those:
- The use of the hospital passport;
- The use of a specific LD admission checklist;

In April, 100% of patients with a Learning Disability who were admitted to the Trust were identified and 88% of those who required a hospital passport received one within the first twenty-four hours of admission as illustrated in the graph below:



For April assessment compliance was 90%. The Learning Disability Steering Group continues to focus on the CCG quality schedule to benchmark and increase improvement.

When targets are not achieved the Learning Disability Liaison Nurse reviews individual scenarios which include feedback to the ward area



9. Safe Staffing

Overall fill rate for April 2017 was 104%, March was 106% and February 2017 was 105%. Combined fill rate during the day was 101% compared with 102% in March 2017. The combined night fill rate was 109% in April compared with 111% in March 2017. RN fill rate during the day was 95% and for the night 95%. Please see appendix 6.

10. Regional Safe Staffing / Care Hours per Patient Day (CHPPD)

The latest Safe Staffing Report for January 2017 from the regional has been provided by NHS England. Having reviewed the acute Trusts' data our Trust has a CHPPD of 8.5 compared with the regional variance between 31.1 and 6.4 CHPPD. Further scrutiny of the CHPPD data for our organisation demonstrates that work needs to be undertaken to understand our CHPPD for our Maternity and Paediatrics services before true benchmarking can be interpreted and actioned upon. This work is already underway.

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

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.

Appendix 2

Nursing and Midwifery Dashboard Description

The Nursing & Midwifery dashboard is made up of a number of metrics that provide the Trust with "at a glance" RAG rated position against key performance indicators including the quality of care, patient experience, 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 3

Apr-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	93%	83%	92%	100%	64%	100%	100%	93%	97%	83%	100%	100%	93%	100%	88%	100%	100%	100%	100%	88%	93%	100%	97%
Pressure Prevention Assessment	100%	97%	97%	100%	57%	100%	100%	100%	97%	89%	91%	94%	100%	100%	80%	100%	94%	97%	100%	97%	100%	97%	97%
Nutritional Assessment	97%	100%	93%	100%	100%	100%	97%	97%	87%	93%	97%	83%	97%	100%	97%	100%	100%	100%	100%	100%	83%	93%	97%
Patient Observation and Escalations	100%	95%	95%	86%	71%	100%	100%	100%	95%	100%	95%	100%	100%	100%	90%	95%	100%	95%	100%	90%	100%	95%	100%
Pain Management	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%
Nursing & Midwifery Documentation - Quality of Entry	98%	87%	91%	87%	89%	88%	97%	97%	90%	93%	100%	98%	100%	90%	82%	100%	100%	87%	83%	98%	95%	100%	100%
Medication Assessment	100%	100%		100%	100%	100%	100%	100%		96%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
Patient Experience - Protected Mealtimes (PMT) Observations	100%	100%	100%	100%	80%	100%	100%	100%	67%	100%	100%	100%	100%	80%	83%	100%	100%	67%	100%	83%	100%	100%	83%
Patient Experience - Care Rounds Observe patient records	100%	91%	100%	82%	73%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%	88%	100%	100%	100%	100%
Patient Experience - Environment	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	80%	100%	100%	100%
Patient Experience - Privacy and Dignity	100%	95%	85%	96%	82%	98%	99%	96%	92%	95%	94%	96%	96%	96%	93%	99%	98%	91%	96%	99%	93%	96%	99%
Patient Safety and Quality	100%	100%	100%	100%	95%	100%	100%	100%	100%	81%	100%	100%	95%	100%	86%	100%	80%	100%	100%	95%	87%	100%	95%
Leadership & Staffing observations	100%	100%	98%	98%	80%	96%	100%	100%	100%	100%	100%	100%	98%	98%	96%	100%	89%	96%	100%	96%	100%	98%	98%
EOL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%
SOVA/LD/Cognitive Impairment	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		96%	100%	100%	100%	100%
First Impressions/15 Steps	86%	91%	91%	80%	80%	77%	91%	86%	80%	80%	94%	89%	83%	89%	83%	89%	86%	86%	83%	66%	94%	97%	100%
Safety Thermometer – Percentage of Harm Free Care	92.9%	88.5%	96.4%	79.3%	92.7%	88.9%	82.1%	96.2%	100.0%	100.0%	88.9%	89.7%	95.2%	94.4%	92.9%	100.0%	96.7%	96.6%	83.3%	100.0%	92.9%	96.3%	100.0%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	0	0	0	2	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	2	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Patient Overdue Observations frequency - <7%	5.9%	5.9%	6.6%	7.2%	7.8%	3.8%	1.9%	5.3%	8.1%	6.7%	8.8%	3.0%	7.3%	5.8%	4.9%	8.2%	5.6%	6.6%	5.5%	4.3%	6.8%	4.5%	5.2%
Caring																							
Complaints – Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Number of PALS concerns relating to nursing care on the wards	1	1	0	0	3	1	2	0	2	0	1	0	1	0	0	0	1	0	0	2	0	0	0
Friends Family Test % Recommended																							
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	93%	91%	98%	100%	100%	105%	94%	90%	99%	98%	98%	99%	100%	96%	79%	99%	101%	99%	101%	104%	100%	104%	98%
Staff Nurse Staffing - Support Worker (day & night combined)	114%	101%	173%	143%	140%	169%	120%	108%	171%	135%	117%	159%	164%	171%	131%	117%	104%	111%	149%	202%	118%	109%	98%
Staffing related datix	0	0	1	1	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0

Appendix 4

Apr 17	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	78%	100%	nil
Pressure Prevention Assessment (Q)	43%	100%	95%
Child Observations [documentation] (Q)	93%	100%	100%
Safeguarding [documentation] (Q)	100%	100%	100%
Nutrition Assessment [documentation] (Q)	69%	77%	73%
Medication Assessment (Q)	92%	100%	96%
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	100.00%	100.00%	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%	100%	86%	N/A
Patient Experience			
Friends Family Test % Recommended	94.4%	91.3%	100.0%
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	0	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Saftey & Quality Environment Observations Observe patient records (Q)	100%	100%	#N/A
Privacy and Dignity (Q)	98%	92%	97%
Management			
Staffing related datix	0	0	0
Monthly Ward meetings (Q)	100%	95%	100%
Leadership & Staffing observations (Q)	90%	100%	96%

Ward Overall Results
0
2

Enclosure E

Appendix 5

Apr-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)	87%	Nil	100%	100%
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	Nil	Nil	100%	100%
Medication Assessment (Q)	Nil	Nil	100%	100%
Environment Observations (Q)	Nil	Nil	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	Nil	Nil	0%	100%
Patient Quality Boards (Q)	Nil	Nil	100%	100%
Controlled Drug Checked (Q)	Nil	Nil	Nil	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	Nil	Nil	Nil	Nil
Patient Experience (Q)	Nil	Nil	70%	85%
Patient Safety and Quality (Q)	Nil	Nil	33%	100%
Leadership & Staffing (Q)	Nil	Nil	100%	100%
Management				
Staffing related datix	0	0	0	0
Monthly Ward meetings (Q)	Nil	Nil	100%	100%
Saftey and Quality (Q)	Nil	Nil	93%	100%
Leadership & Staffing (Q)	Nil	Nil	100%	100%

Ward Overall Results

0
4

Appendix 6

Safe Staffing – April 2017

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — **April 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)	1,827.50	1,828.00	1,358.50	1,405.75	1,035.00	1,035.00	1,035.00	1,407.92	100.0%	103.5%	100.0%	136.0%	830	3.4	3.4	6.8		
Allebone Ward (Stroke)	1,551.50	1,412.50	1,035.00	1,105.75	1,380.00	1,310.25	690.00	855.25	91.0%	106.8%	94.9%	123.9%	835	3.3	2.3	5.6		
Althorp (T&O)	916.50	878.32	632.50	609.75	690.00	690.00	368.00	368.00	95.8%	96.4%	100.0%	100.0%	201	7.8	4.9	12.7		
Barratt Birth Centre	1,749.20	1,651.67	690.00	612.00	1,357.00	1,208.75	661.50	616.75	94.4%	88.7%	89.1%	93.2%	164	17.4	7.5	24.9		
Becket Ward	1,955.00	1,757.25	1,374.00	1,363.50	1,725.00	1,604.25	690.00	713.00	89.9%	99.2%	93.0%	103.3%	807	4.2	2.6	6.7		
Benham (Assess Unit)	1,721.25	1,662.17	861.50	1,310.92	1,380.00	1,378.08	690.00	1,374.58	96.6%	152.2%	99.9%	199.2%	766	4.0	3.5	7.5		
Brampton Ward	1,372.50	1,383.92	1,016.50	1,303.00	1,035.00	1,023.50	690.00	1,136.08	100.8%	128.2%	98.9%	164.6%	862	2.8	2.8	5.6		
Cedar Ward (TRAUMA)	1,754.25	1,871.25	1,691.00	1,589.75	1,035.00	1,035.00	1,035.00	1,394.25	106.7%	94.0%	100.0%	134.7%	888	3.3	3.4	6.6		
Collingtree Medical (40)	2,260.00	2,294.08	1,718.42	2,014.92	1,713.50	1,682.00	690.00	1,360.50	101.5%	117.3%	98.2%	197.2%	1196	3.3	2.8	6.1		
Compton Ward	1,035.00	1,119.67	686.00	1,030.25	690.00	690.00	345.00	713.00	108.2%	150.2%	100.0%	206.7%	540	3.4	3.2	6.6		
Creaton SSU	1,713.50	1,540.75	1,607.25	1,727.25	1,023.50	1,034.58	690.00	1,036.00	89.9%	107.5%	101.1%	150.1%	837	3.1	3.3	6.4		
Disney Ward	1,715.50	1,619.80	887.50	791.83	1,023.50	871.75	345.00	345.00	94.4%	89.2%	85.2%	100.0%	227	11.0	5.0	16.0		
Dryden Ward	2,054.50	1,701.75	919.00	912.75	1,380.00	1,391.50	674.25	810.25	82.8%	99.3%	100.8%	120.2%	759	4.1	2.3	6.3		
EAU New	2,006.00	1,981.42	1,028.50	1,741.92	1,713.50	1,713.42	1,011.75	1,742.42	98.8%	169.4%	100.0%	172.2%	850	4.3	4.1	8.4		
Eleanor Ward	1,022.75	994.25	687.25	900.50	690.00	690.00	678.50	946.50	97.2%	131.0%	100.0%	139.5%	323	5.2	5.7	10.9		
Finedon Ward	2,070.00	1,999.05	345.00	401.50	1,035.00	1,034.50	345.00	402.50	96.6%	116.4%	100.0%	116.7%	480	6.3	1.7	8.0		
Gosset Ward	2,461.00	2,404.87	598.00	587.42	2,364.25	2,325.58	529.00	324.25	97.7%	98.2%	98.4%	61.3%	439	10.8	2.1	12.9	The numbers of HCA night duty has decreased this month due to an unpresidented amount of short term sick. Staffing monitored daily by the Sister and Matron and reallocation as required, no patients came to harm aand care was safe. All staff are bneing monitored by the HR sickness process	
Hawthorn & SAU	1,888.50	1,905.58	1,030.75	1,472.58	1,380.00	1,380.75	918.92	1,433.58	100.9%	142.9%	100.1%	156.0%	868	3.8	3.3	7.1		
Head & Neck Ward	1,049.75	1,119.25	483.00	901.00	862.50	879.00	345.00	770.50	106.6%	186.5%	101.9%	223.3%	406	4.9	4.1	9.0		
Holcot Ward	1,368.00	1,343.75	1,380.00	1,668.25	1,035.00	1,035.00	690.00	1,633.00	98.2%	120.9%	100.0%	236.7%	856	2.8	3.9	6.6		
ITU	4,871.00	4,345.58	713.00	678.50	4,485.00	4,216.25	690.00	700.00	89.2%	95.2%	94.0%	101.4%	374	22.9	3.7	26.6		
Knightley Ward (Medical)	689.00	763.25	849.75	1,175.23	1,034.25	954.50	345.00	779.25	110.8%	138.3%	92.3%	225.9%	626	2.7	3.1	5.9		
Paddington Ward	2,657.75	2,148.00	1,146.50	1,031.75	2,173.50	1,885.75	676.25	655.25	80.8%	90.0%	86.8%	96.9%	447	9.0	3.8	12.8		
Robert Watson	1,031.00	1,099.33	1,232.00	1,226.50	1,023.50	943.30	1,035.00	883.50	106.6%	99.6%	92.2%	85.4%	499	4.1	4.2	8.3		
Rowan (LSSD)	1,892.25	1,957.33	1,035.00	1,031.25	1,725.00	1,682.92	690.00	760.00	103.4%	99.6%	97.6%	110.1%	869	4.2	2.1	6.3		
Spencer Ward	921.50	910.25	523.50	591.25	690.00	691.00	345.00	426.17	98.8%	112.9%	100.1%	123.5%	290	5.5	3.5	9.0		
Sturtridge Ward	4,086.50	3,769.00	1,760.75	1,625.75	3,911.25	3,639.50	1,207.50	1,075.00	92.2%	92.3%	93.1%	89.0%	446	16.6	6.1	22.7		
Talbot Butler Ward	2,415.25	1,953.67	1,315.00	1,344.25	1,380.00	1,034.25	690.00	1,272.75	80.9%	102.2%	74.9%	184.5%	825	3.6	3.2	6.8	The numbers of HCA increased on night to support patient care. RN recruitment successful awaiting start dates . Staffing monitored daily by the Matron and reallocation as required to maintain patient safety.	
Victoria Ward	1,150.50	1,073.25	674.50	997.50	690.00	690.00	345.00	742.50	93.3%	147.9%	100.0%	215.2%	536	3.3	3.2	6.5		
Willow Ward (+ Level 1)	2,240.25	2,287.33	1,035.00	1,049.50	2,070.00	1,992.58	690.00	860.67	102.1%	101.4%	96.3%	124.7%	840	5.1	2.3	7.4		
TOTAL																7.3		

Enclosure E

Report To	**Public Trust Board**
Date of Meeting	**25 May 2017**

Title of the Report	Financial Position - April (FY17-18)
Agenda item	10
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Bola Agboola, Deputy DoF
Purpose	To report the financial position for the period ended April 2017/18.

Executive summary

This report sets out the financial position of the Trust for the period ended 30th April 2017. The overall I&E YTD position is a deficit of £2.4m, £594k worse than plan.

Key points:

- The main reason for the reported position against plan is the impact of the number of working days in April. There were 5 weekends in the month and the 2 Easter bank holidays and this did impact on the reported income variance in a manner that should not recur in future months.
- Pay spend is a favourable variance of £35k and has been achieved in the main because of the reduction in agency spend.
- STF income is included in the position, but only the finance element of £305k.
- The reported position in month 1 should be interpreted cautiously as it is only based on one month's data.
- The main risk to financial delivery of the plan over the course of the year is capacity constraints as previously reported.

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 F

Actions required by the Board

The Board is asked to note the financial position for the period ended April 2017/18 and to consider the actions required ensuring that the control total of £13.5m is delivered.

Northampton General Hospital NHS
NHS Trust

Financial Position

Month 1 (April)
FY 2017/18

Report to:
Trust Board
May 2017

Enclosure F

Content

1. Overview

	RAG	This Month Apr	Last Month Mar
I&E Position			
In-Month Position - Variance to Plan (£000's)	⊗	(594)	551
Year to Date Position - Variance to Plan (£000's)	⊗	(594)	368
Forecast End of Year I&E Position (£000's)		(13,546)	(13,847)
STF YTD Actual (£'000)		305	9,619
STF - Variance to Plan (£000's)	⊗	(131)	(81)
EBITDA %	⊗	-5.5%	-0.2%
Income			
Elective variance to plan (£000's)	⊗	(15)	(913)
Daycase variance to plan (£000's)	✓	9	165
Non-Elective variance to plan (£000's)	⊗	(498)	5,211
Outpatients variance to plan (£000's)	⊗	(187)	3,168
MRET Penalty - YTD Variance to Plan (£000's)	✓	0	(5,040)
Readmissions - YTD Variance to Plan (£000's)	✓	0	(3,475)
Contract Fines & Penalties - Variance to Plan (£000's)	✓	0	(165)
Operating Costs			
Pay - YTD variance to plan (£000's)	✓	35	(8,664)
Agency Staff Costs - YTD variance to Cap (£000's)	✓	437	(3,039)
Non-Pay - YTD variance to plan (£000's)	✓	144	(1,622)
Cost Improvement Schemes			
Year to Date Variance to Plan (£000's)	✓	245	(700)
Forecast Delivery (£000's)	⊗	7,410	12,200
Capital			
Year to date expenditure (£'000s)		143	13,554
% of annual plan Committed	!	7%	100%
Annual Capital Expenditure Plan (£000's)		25,491	13,560
Cash			
Closing Cash Balance (£000's)		4,143	(2,469)
New PDC / borrowing (£000's)		1,106	1,128
Debtors Balance > 90 days (£000's)	✓	1,310	1,016
Creditors % > 90 days	✓	1%	0%
Cumulative BPPC - by volume (%)	✓	98.7%	99.1%

Key issues for this report

This report sets out the financial position of the Trust for the period ended April 2017. The I&E position YTD is a deficit of £2.4m, which is £594k adverse to plan.

Income

- Income is the main contributor to the adverse positon. Income was an adverse variance of £855k mainly due to issues with the phasing of the plan. The CCG contract plan took insufficient account of the impact of the unusual combination of a high number of 5 weekends and 2 bank holidays for the Easter holidays. The variance is also based on only one months data.

- We have analysed the actual daily income levels achieved in April and compared these to the daily levels required over the course of the year to achieve the income plan. Our conclusion is that the main reason for the reported variance relates to the profiling of the plan and the effect of the April variance should therefore ease out over the course of the year. We therefore expect significant improvement in the reported income variance in future months.

Pay

- Pay position was a favourable variance of £35k.
- Agency spend was significantly lower than the cap target by £437k. We saw the effect of the IR35 legislation in April which led to some unfilled shifts and therefore reduction in agency spend.
- Some of the medical agency staff moved onto the Trust's bank and this should have a recurrent effect on medical agency expenditure.

Non-pay & Reserves

- Non-pay was a favourable variance of £144k, mainly due to underspends on pacing devices.
- Unspent reserves of £288k contributed to the I&E position.

Capital

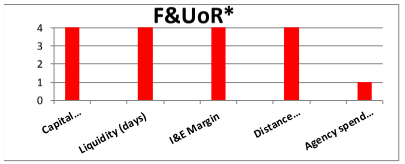
- The Trust achieved a committed capital spend of 7% of its plan, and has secured NHS Improvement approval for its planned Assessment Hub development to be funded via a finance lease.

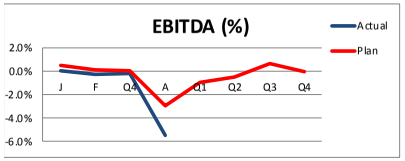
Liquidity

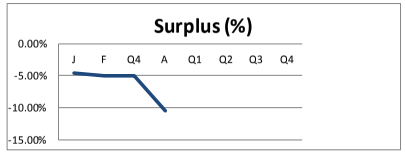
- The Trust continued to access deficit financing as planned.
- STF funding of £305k is included in the position.

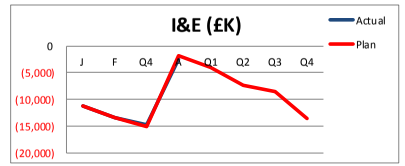
2. KPI & Trend Analysis

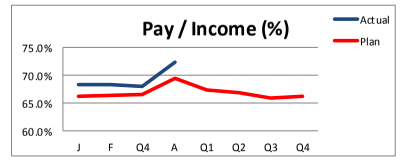
1. Key Metrics

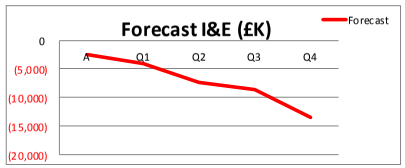




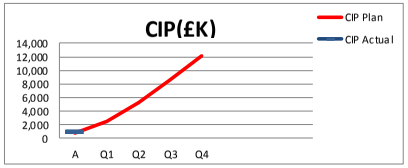


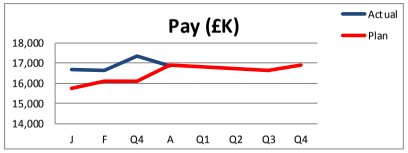


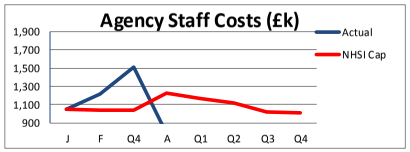


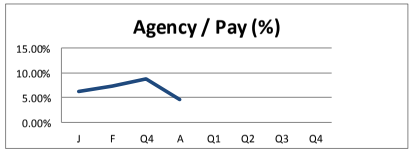


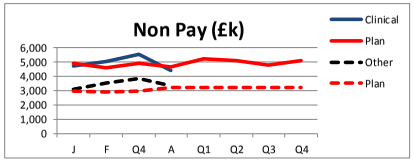
2. I&E Performance

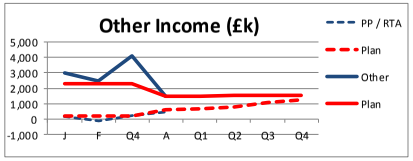




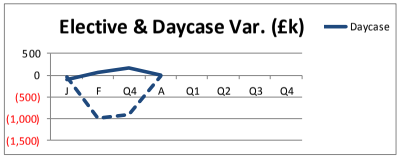


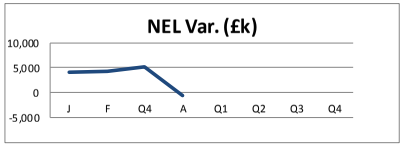


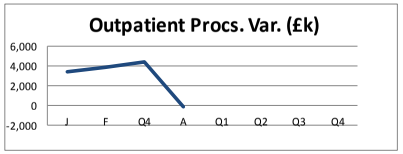


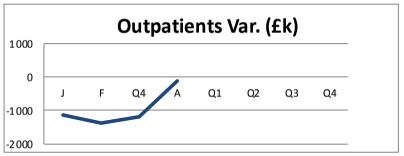


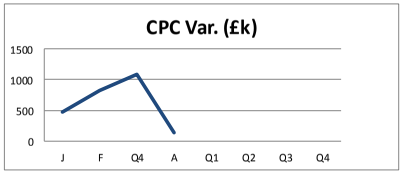
3. SLA Income

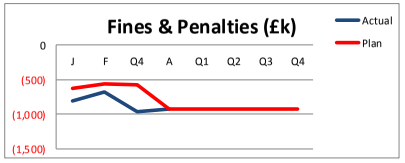




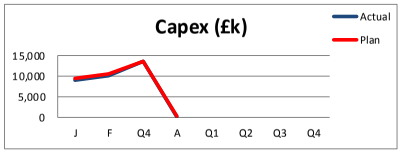


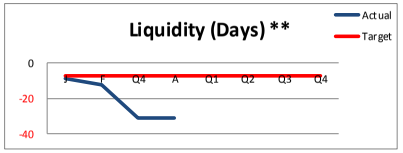


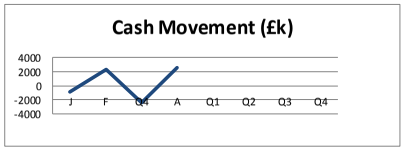


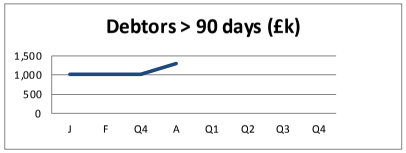


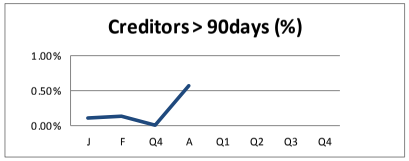
4. Working Capital

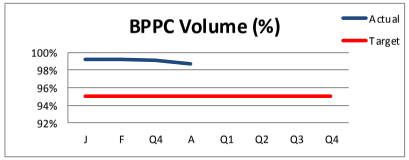












** F&UoP = Finance and Use of Resources metrics*

*** 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	Apr 17	Mar 17
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	274,353	22,156	21,301	(855)	21,301	22,567
Other Clinical Income	2,373	11,455	648	473	(174)	473	244
Other Income	31,824	18,282	1,515	1,512	(3)	1,512	4,077
Total Income	294,525	304,090	24,319	23,287	(1,032)	23,287	26,888
Pay Costs	(199,813)	(201,428)	(16,897)	(16,862)	35	(16,862)	(17,328)
Non-Pay Costs	(94,406)	(99,383)	(7,845)	(7,701)	144	(7,701)	(9,401)
Reserves/ Non-Rec		(3,274)	(288)	0	288	0	0
Total Costs	(294,219)	(304,085)	(25,030)	(24,563)	467	(24,563)	(26,729)
EBITDA	306	5	(711)	(1,276)	(565)	(1,276)	159
Depreciation	(9,703)	(10,205)	(814)	(814)	(0)	(814)	(841)
Amortisation	(9)	(9)	(1)	(1)	(0)	(1)	(1)
Impairments	(1,732)	(1,826)	(1,014)	0	1,014	0	266
Net Interest	(720)	(790)	(66)	(136)	(70)	(136)	(98)
Dividend	(3,307)	(2,669)	(222)	(228)	(6)	(228)	(285)
Surplus / (Deficit)	(15,165)	(15,494)	(2,828)	(2,454)	374	(2,454)	(800)
NHS Breakeven duty adjs							
Donated Assets	(414)	122	(23)	23	46	23	(43)
NCA Impairments	1,732	1,826	1,014	0	(1,014)	0	(266)
I&E Position (breakeven duty)	(13,847)	(13,546)	(1,837)	(2,431)	(594)	(2,431)	(1,109)

Key Issues

Income

- SLA clinical income is lower than plan by £855k due to the phasing issues in the plan described in the report. In general, the activity levels in April are comparable to activity levels in the past 3 months. Detailed analysis carried out concludes that if the activity levels are maintained, the planned income for the year should be met. This is however only based on one months data and there are very significant capacity constraints that are likely to impact on elective activity going forward.
- Other Clinical Income is £174k adverse to plan mainly due to STF operational A&E performance trajectory not achieved.

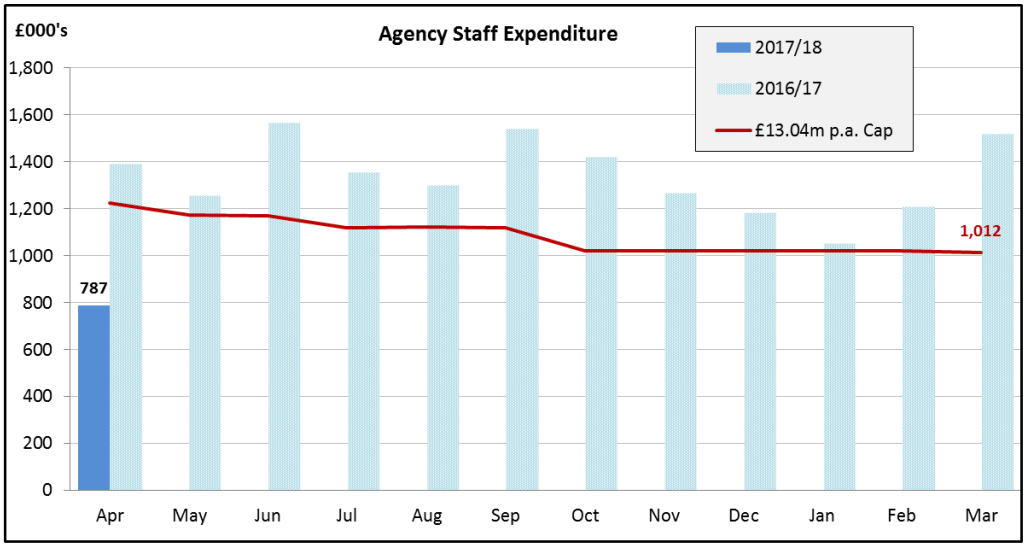
Pay

- Pay is a favourable variance of £35k; as with income this should be interpreted cautiously as it is only based on one months data.

Non-Pay

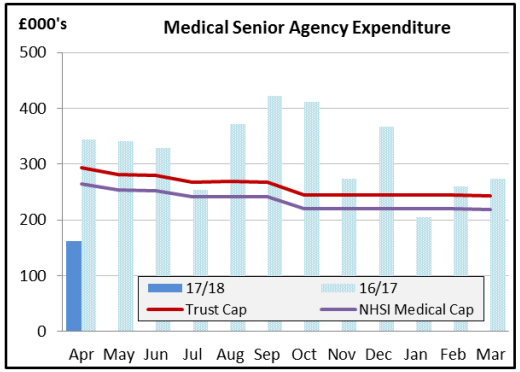
- Non pay is a favourable variance of £144k mainly due to underspends on pacing and cardiology expenditure.

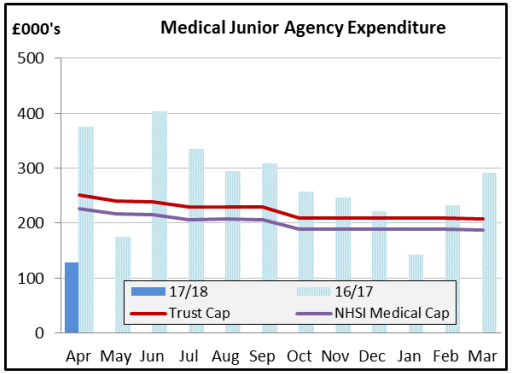
3.1 Agency Staff Expenditure

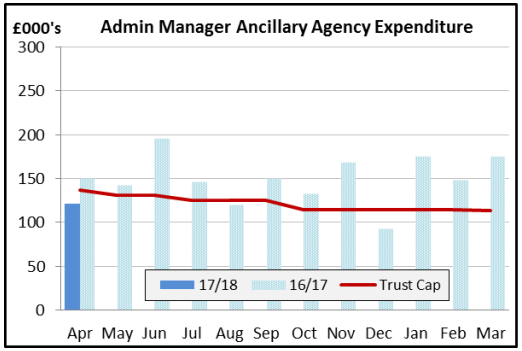


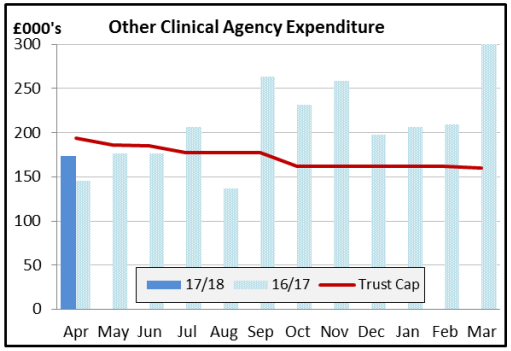
Key Issues

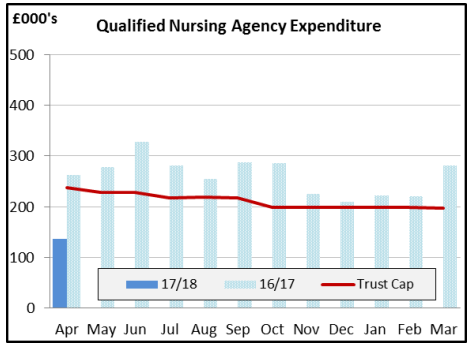
- **The Trust total expenditure for agency staff in 2016/17 was £16.1m.**
- NHS Improvement issued an expenditure limit of £13.04m for the financial year 2017/18, equivalent to a 19% reduction year-on-year across all staff groups.
- Phasing this annual limit across the year on a graduated basis gives a £1.2m cap in April which dovetails to £1.01m per month as from October.
- NHS Improvement have also issued an expenditure limit of £1.9125m for medical agency expenditure, equivalent to a 27% reduction year-on-year.
- In April, the Trust's agency spend was £437k below the target of £1.2m, mainly due to the effects of IR35 which resulted in a number of unfilled shifts as well as an increase in the medical bank. The transfer from agency to bank should be recurrent.

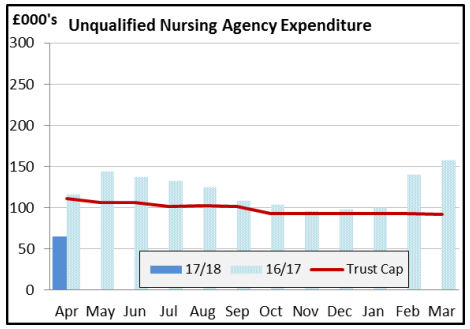












4. Clinical Income

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	9,890	9,342	(548)	1,259	1,169	(90)
Block	-	-	-	1,141	1,141	0
Cost per Case	205,134	235,588	30,454	2,348	2,490	142
CQUIN	-	-	-	406	406	0
Day Cases	3,308	3,075	(233)	1,978	1,987	9
Elective	513	395	(117)	1,461	1,461	1
Elective XBDs	92	28	(64)	23	8	(15)
Excluded Devices	-	-	-	151	134	(17)
Excluded Medicines	-	-	-	1,566	1,621	55
Non-Elective	4,777	4,368	(408)	8,357	7,879	(478)
Non-Elective XBDs	1,833	1,774	(59)	462	442	(20)
Outpatient First	5,175	4,518	(657)	908	854	(54)
Outpatient Follow UP	16,612	15,302	(1,310)	1,333	1,285	(49)
Outpt Procedures	12,380	10,400	(1,980)	1,438	1,353	(85)
CIP / Other				253	(0)	(253)
SLA Clinical Income	**259,713**	**284,791**	**25,078**	**23,084**	**22,230**	**(855)**
Contract Penalties				(19)	(19)	0
Challenges				(150)	(150)	0
Readmissions				(266)	(266)	0
MRET				(493)	(493)	0
Fines & Penalties				**(928)**	**(928)**	**0**
Total SLA Clinical Income	**259,713**	**284,791**	**25,078**	**22,156**	**21,301**	**(855)**

Other Clinical Income	Finance £000's		
	Plan	Actual	Variance
Private Patients	82	31	(51)
Overseas Visitors	11	69	58
RTA / Personal Injury Income	119	69	(50)
STF Funding	436	305	(131)
Total Other Clinical Income	**648**	**473**	**(174)**

SLA Clinical Income

SLA income was reduced in April due to the five weekends in April and two bank holidays. The plan took insufficient account of the impact of this unusual combination of a high number of weekends and bank holidays as it was partly based on monthly profiles from previous years. The plan was worked up by the CCG and some sense checks were performed on it by us and on review it appeared correct but in view of the variance in month 1 we have now done some deep dive analysis which shows that the extent of the reduction built into the April plan did not fully reflect the reduced number of working days. A process has been put in place to ensure more thorough checking of the CCG monthly plan profiling in future.

The income plan also includes the uplifts for planned growth by point of delivery for the new financial year which we expect to come through over the course of the year.

We have analysed the actual daily income levels achieved in April and compared these to the daily levels required over the course of the year to achieve the income plan and our conclusion is that the main reason for the reported variance relates to the profiling of the plan and the April variance should therefore not be seen as a reliable indicator of the monthly variance going forward. We are expecting that as long as the actual levels of daily performance continue through the year that the reported income position will significantly improve. The key risk to the plan is still capacity.

The reported income is also affected by the timing of discharges and as previously reported there were a significant number of discharges of long stay patients in March.

Overall the reported position for month 1 does not mean the Trust will be off plan going forward. The position will become significantly clearer when we have a further month's data and we will continue to analyse the position carefully and report accordingly.

Fines and Penalties

Readmissions and MRET have been negotiated as blocks in 17/18 based on the Indicative Activity Plan (IAP) agreed in the contract. These deductions will stay on plan unless changes to IAP are agreed in contract variations. This mitigates the risk of increasing MRET and readmissions if non elective activity increases above plan later in the year. Contract challenges and other penalties have not been received from the CCG yet so are currently estimated to plan.

Other Clinical Income

Private and Overseas visitors were slightly better than plan in total. RTA income is subject to fluctuation. The STF funding income shortfall is due to the missing of the A&E trajectory in month 1. We have assumed the finance component of the STF will be achieved by recovering our financial position back to plan by the end of quarter 1. This assumption is important to note but seemed appropriate in view of the causation of the income variance as described above.

4.2 STF Funding

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre STF	(22,261)	(2,273)	(2,736)	(463)
STF	8,715	436	305	(131)
Post STF	(13,546)	(1,837)	(2,431)	(594)

Key issues

- This month's position consisted of a pre-STF adverse variance of £463k, in addition to STF loss of £131k, bringing the in-month deficit variance to £594k.
- We are yet to receive the final guidance on the STF criteria for 17-18, however we have been informed that the criteria in 17-18 will be weighted 70% towards financial performance and 30% towards A&E.
- Based on the above and the cause of the income variance, we have accrued for the financial element as we expect the Trust to recover its financial position to plan and therefore earn the financial element on a cumulative basis.
- A&E performance may pose a bigger challenge given capacity issues, therefore we have not accrued for the A&E performance STF of £131k at this stage.

5. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET MONTH 1 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	0	0	0	(5,434)	(5,434)
IN YEAR MOVEMENTS	0	0	144	144	25,651	25,651
LESS DEPRECIATION	0	0	(815)	(815)	(10,205)	(10,205)
NET BOOK VALUE	159,809	159,809	159,138	(671)	169,821	10,012
CURRENT ASSETS						
INVENTORIES	5,770	5,770	6,321	551	5,494	(276)
TRADE & OTHER RECEIVABLES	23,887	23,887	20,943	(2,944)	24,020	133
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,621	1,621	4,143	2,522	1,500	(121)
TOTAL CURRENT ASSETS	31,278	31,278	31,407	129	31,014	(264)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	24,112	24,112	25,159	1,047	27,824	3,712
FINANCE LEASE PAYABLE under 1 year	124	124	124	0	1,124	1,000
SHORT TERM LOANS	20,334	20,334	20,334	0	1,536	(18,798)
STAFF BENEFITS ACCRUAL	753	753	753	0	800	47
PROVISIONS	4,808	4,808	4,577	(231)	3,500	(1,308)
TOTAL CURRENT LIABILITIES	50,131	50,131	50,947	816	34,784	(15,347)
NET CURRENT ASSETS / (LIABILITIES)	(18,853)	(18,853)	(19,540)	(687)	(3,770)	15,083
TOTAL ASSETS LESS CURRENT LIABILITIES	140,956	140,956	139,598	(1,358)	166,051	25,095
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,121	1,121	1,111	(10)	12,325	11,204
LOANS over 1 year	30,489	30,489	31,595	1,106	62,938	32,449
PROVISIONS over 1 year	1,055	1,055	1,055	0	750	(305)
NON CURRENT LIABILITIES	32,665	32,665	33,761	1,096	76,013	43,348
TOTAL ASSETS EMPLOYED	108,291	108,291	105,837	(2,454)	90,038	(18,253)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258	0	120,096	838
REVALUATION RESERVE	37,392	37,392	37,392	0	33,795	(3,597)
I & E ACCOUNT	(48,359)	(48,359)	(50,813)	(2,454)	(63,853)	(15,494)
FINANCING TOTAL	108,291	108,291	105,837	(2,454)	90,038	(18,253)

Key Movements

The key movements from last month are:

Non Current Assets

- Movement arising from capital additions £143k less depreciation for the month of £815k.

Current assets

- Inventory - £0.5m mainly relates to increase in stockholding of pacing devices and cardiology devices.
- Trade & Other Receivables – £2.9m predominantly relates to reduction in NHS receivables.
- Cash – increase of £2.5m based on timing of loan draw down and will be adjusted back in May.

Current Liabilities

- Trade & Other Payables - £1.0m movement mainly relating to increase in accruals including £0.3m accrued PDC dividend, £0.2m Tax and NI owed, £0.4m NHS & Other Payables.

Non Current Liabilities

- Loans – increase of £1.1m relating to the revenue support loan to fund the in-month deficit.

Financed By

- I & E Account - £2.4m deficit in month

6. Capital Expenditure

Capital Scheme	Plan 2017/18 £000's	M1 Plan £000's	M1 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Replacement Imaging Equipment (Loan - Tranche 1)	570	40	0	-40	0%	6	1%
Replacement Imaging Equipment (Loan - Tranche 2)	651	0	0	0	0%	471	72%
Additional Imaging Equipment (Loan)	2,309	0	1	1	0%	10	0%
Replacement NPfIT Systems	1,145	173	16	-157	1%	598	52%
Stock / Inventory System (Loan)	282	0	-2	-2	-1%	70	25%
A&E / Orthopaedics	41	0	0	0	0%	2	5%
Contingency	20	0		0	0%	0	0%
Medical Equipment Sub Committee	756	0	0	0	0%	185	24%
Estates Sub Committee	3,154	53	51	-2	2%	58	2%
IT Sub Committee	2,308	87	23	-64	1%	298	13%
60 Bedded Ward	13,440	0	0	0	0%	0	0%
A&E GP Streaming	858	0	0	0	0%	2	0%
Other	157	50	54	4	35%	5	3%
Total - Capital Plan	**25,691**	**403**	**143**	**-260**	**1%**	**1,706**	**7%**
Less Charitable Fund Donations	-200	-50	0	50	0%	-25	13%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**25,491**	**353**	**143**	**-210**	**1%**	**1,680**	**7%**

Funding Resources	
Internally Generated Depreciation	10,205
Finance Lease - 60 Bedded Ward	12,685
Capital Loans - Imaging Equipment Tranche 1	570
Capital Loans - Replacement Imaging Tranche 2	2,309
Capital Loans - Additional Imaging Equipment	651
Capital Loans - Stock / Inventory System	282
A&E GP Streaming	858
Capital Element - Finance Lease	-363
Capital Loan - Repayment	-1,624
Other Loans - Repayment	-82
Total - Available CRL Resource	**25,491**
Uncommitted Plan	**0**

Key Issues

- The Trust spent/receipted £143k in M1, with further commitments of £1,706k including £25k Charitable Funds.
- We received confirmation that NHSI will provide additional CRL cover in support of the Assessment Hub development via a finance lease.
- The Trust has been awarded £858k funding for A&E GP Streaming, with the proviso that it is completed before Winter 2017.
- Replacement Imaging Equipment update - The Multipurpose Fluoroscopy room 4 was successfully installed and is being used. The CT Scanner has also been successfully installed and should be up & running w/c 15th May. The second MRI works has now started on site and is due to be completed by November 2017.
- Charitable Donation assumptions total £200k for 2017/18. The refurbished Chemotherapy Suite opened 6th May 2017.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at April £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,578	692	503	99	283
Receivables NHS	9,458	7,796	499	137	1,026
Total Receivables	**11,036**	**8,487**	**1,002**	**236**	**1,310**
Payables Non NHS	(4,502)	(4,462)	(8)	(1)	(32)
Payables NHS	(1,041)	(1,041)	0	0	0
Total Payables	**(5,543)**	**(5,502)**	**(8)**	**(1)**	**(32)**

Narrative	Total at March £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,698	1,020	242	172	264
Receivables NHS	14,179	12,960	150	317	752
Total Receivables	**15,877**	**13,980**	**392**	**489**	**1,016**
Payables Non NHS	(6,073)	(6,030)	(21)	(22)	0
Payables NHS	(901)	(900)	0	(1)	0
Total Payables	**(6,974)**	**(6,930)**	**(21)**	**(23)**	**0**

Receivables and Payables

- Continued focus on reducing age profile of non current debt.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £231k, of which £110k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover and £27k relating to private patients.
- NHS over 90 day debt predominantly relates to NCA's £690k (£627k), of which £518k is due from Kettering General, University Hospitals of Coventry & Warwickshire NHS Trust £181k and Nene CCG £27k

Narrative	April 2017	Cumulative 2016/17	Cumulative 2015/16
NHS Creditors			
No.of Bills Paid Within Target	170	2,085	2,132
No.of Bills Paid Within Period	174	2,127	2,154
Percentage Paid Within Target	**97.70%**	**98.03%**	**98.98%**
Value of Bills Paid Within Target (£000's)	2,073	20,858	19,746
Value of Bills Paid Within Period (£000's)	2,075	20,938	19,783
Percentage Paid Within Target	**99.90%**	**99.62%**	**99.82%**
Non NHS Creditors			
No.of Bills Paid Within Target	5,005	92,303	96,360
No.of Bills Paid Within Period	5,068	93,148	97,099
Percentage Paid Within Target	**98.76%**	**99.09%**	**99.24%**
Value of Bills Paid Within Target (£000's)	7,543	109,534	103,534
Value of Bills Paid Within Period (£000's)	7,589	111,972	104,056
Percentage Paid Within Target	**99.40%**	**97.82%**	**99.50%**
Total			
No.of Bills Paid Within Target	5,175	94,388	98,492
No.of Bills Paid Within Period	5,242	95,275	99,253
Percentage Paid Within Target	**98.72%**	**99.07%**	**99.23%**
Value of Bills Paid Within Target (£000's)	9,616	130,392	123,281
Value of Bills Paid Within Period (£000's)	9,664	132,910	123,839
Percentage Paid Within Target	**99.51%**	**98.11%**	**99.55%**

Better Payment Practice Code

- The BPPC performance was achieved for all targets in April.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	FORECAST OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	261,342	22,512	21,499	22,540	21,999	21,599	21,599	21,599	21,599	21,599	21,599	21,599	21,599
STF Funding	9,160	81	0	3,545	0	1,176	0	0	1,743	0	0	2,615	0
SLA Performance/ Other CCG Investment	1,138	873	264	0	0	0	0	0	0	0	0	0	0
Health Education Payments	9,740	762	809	817	817	817	817	817	817	817	817	817	817
Other NHS Income	17,301	801	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	883	610	273	0	0	0	0	0	0	0	0	0	0
PP / Other	13,970	1,044	927	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC - Capital	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Loan	3,611	0	0	0	0	811	0	0	0	2,230	0	0	570
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	22	2	2	2	2	2	2	1	2	2	1	2	2
TOTAL RECEIPTS	**339,429**	**30,237**	**25,678**	**31,018**	**26,622**	**29,389**	**26,775**	**26,275**	**28,034**	**28,825**	**27,622**	**30,951**	**28,003**
PAYMENTS													
Salaries and wages	188,959	15,598	15,711	15,701	15,711	15,901	15,711	15,701	15,911	15,701	15,711	15,701	15,901
Trade Creditors	98,086	6,781	8,923	9,812	7,926	8,527	6,425	7,971	6,686	8,830	8,702	9,978	7,525
NHS Creditors	23,159	2,079	2,120	2,120	2,120	2,120	2,120	2,120	2,120	2,120	2,120	1,000	1,000
Capital Expenditure	13,590	843	1,509	960	784	980	663	442	1,562	2,167	996	984	1,700
PDC Dividend	2,754	0	0	0	0	0	1,374	0	0	0	0	0	1,380
Repayment of Revenue Loan - STF funding	10,515	2,425	0	2,425	0	1,307	0	0	1,743	0	0	2,615	0
Repayment of Loans (Principal & Interest)	2,378	0	0	0	81	554	444	20	12	8	92	673	494
Repayment of Salix loan	83	21	0	0	0	0	38	21	0	0	0	0	3
TOTAL PAYMENTS	**339,524**	**27,747**	**28,263**	**31,018**	**26,622**	**29,389**	**26,775**	**26,275**	**28,034**	**28,826**	**27,621**	**30,951**	**28,003**
Actual month balance	-95	2,490	-2,585	0	0	0	0	0	0	-1	1	0	0
Cash in transit & Cash in hand adjustment	0	58	-58	0	0	0	0	0	0	0	0	0	0
Balance brought forward	1,595	1,595	4,143	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,143**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- Payment of Qtr 3 Over-performance was received from Central Midlands Commissioning in April. The Qtr 2 & 3 outstanding performance invoices/credit notes are forecast to paid in May.
- Following a successful appeal, the balance of Qtr 3 STF Funding relating to Cancer targets was received in April. Borrowing relating to Qtr 3 STF Funding was repaid to the DH in April. The Trust is currently forecasting Qtr 4 funding, including the incentive & bonus elements, to be received & corresponding borrowing to be repaid in June.
- The Trust has drawn down a further £3.6m against the new 1.5% Uncommitted Interim Revenue Support Facility (ISUCL) in April. A further draw down of £0.4m has been approved for May. Due to the re-phasing of the monthly deficit position in the Plan submitted in March, the excess funding drawn down to date will be repaid in May.
- Creditor payments in April were significantly less than forecast, as a result of the high level of payments made in March.

9. Conclusion

Key Points:

- The Trust has performed £594k worse than plan in the period ended April 2017.
- The main reason for this is the underperformance on income which is as a result of phasing issues in the plan as identified in this report. Based on the detailed work done to review activity levels, our conclusion is that the adverse position in April is not an indication of the Trust's income position going forward. We expect that the phasing issues will smooth out and the income position should recover in the coming months.
- Pay spend is in line with plan and has seen a significant decrease in agency spend, mainly as a result of the introduction of the IR35 legislation. The Trust must continue to accelerate its plans at reducing agency spend, including developing a robust Medical Bank.
- STF income is accounted for in the position, but only the finance element of £305k. The Trust must continue to develop necessary plans to meet its performance targets so that this element of STF can be recovered in future months.

Report To	**Trust Board**
Date of Meeting	**25 May 2017**

Title of the Report	**Workforce Performance Report**
Agenda item	**11**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues
Executive summary • The key performance indicators show a decrease in contracted workforce employed by the Trust, and a further decrease in sickness absence from March 2017. • Increase in compliance rate for Mandatory Training and a decrease in compliance for Role Specific Essential Training and Appraisals.	
Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No 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 Report

Thursday 25 May 2017

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from April 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 decreased by 15.20 FTE in April 2017 to 4308.21 FTE. The Trust's substantive workforce is at 88.50% of the Budgeted Workforce Establishment of 4868.19 FTE.

Annual Trust turnover decrease by 0.02% to 9.85% in April which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased by 0.31% to 6.35%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover increased in Medical & Dental, Allied Health Professionals and Additional Professional, Scientific and Technical staff groups. Turnover decreased in Additional Clinical Services and Healthcare Scientists, Administrative and Clerical and Estates and Ancillary staff groups.

- Medical Division: turnover increased by 0.12% to 8.07%
- Surgical Division: turnover decreased by 0.17% to 9.54%
- Women, Children & Oncology Division: turnover increased by 0.36% to 9.11%
- Clinical Support Services Division: turnover increased by 0.03% to 11.65%
- Support Services: turnover decreased by 0.47% to 11.87%

The vacancy rates for all staff groups increased in April 2017. Add Prof Sci & Tech staff group has seen the largest vacancy rate increase of 6.63% to 16.16%.

Sickness absence for April 2017 decreased again this month from 3.70% to 3.29% which is below Trust target of 3.8%. All Divisions are below Trust target except for Women, Children & Oncology at 4.25% with the Women Directorate showing the highest sickness rate of 4.77%. In total 14 directorate level organisations were below the trust target rate in April 2017 compared to 12 directorates in March 2017.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for April 2017 is 83.70%; this is a decrease of 0.57% from last month's figure of 84.27%.

Since January 2017 at which point appraisal compliance was 85.36% there has been an overall decrease of 1.66%.

Since March 2017, of the 22 Directorates reported upon, 11 have seen a decrease in compliance, 9 have seen an increase and 2 Directorates compliance have remained the same. This will continue to be monitored and intervention and support will be provided to those 11 areas that have experienced a decrease since March 2017.

Mandatory Training compliance increased in April 2017 from 85.33% to 85.58%, this is an increase of 0.25% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased slightly in April 2017 to 81.05% from last month's figure of 81.28%.

3.0 Policies

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

- Maternity, Adoption, Paternity & Shared Parental Leave – minor update
- Alcohol, Drugs and Substances Misuse in the Workplace – full review

4.0 Assessment of Risk

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

5.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

6.0 Next Steps

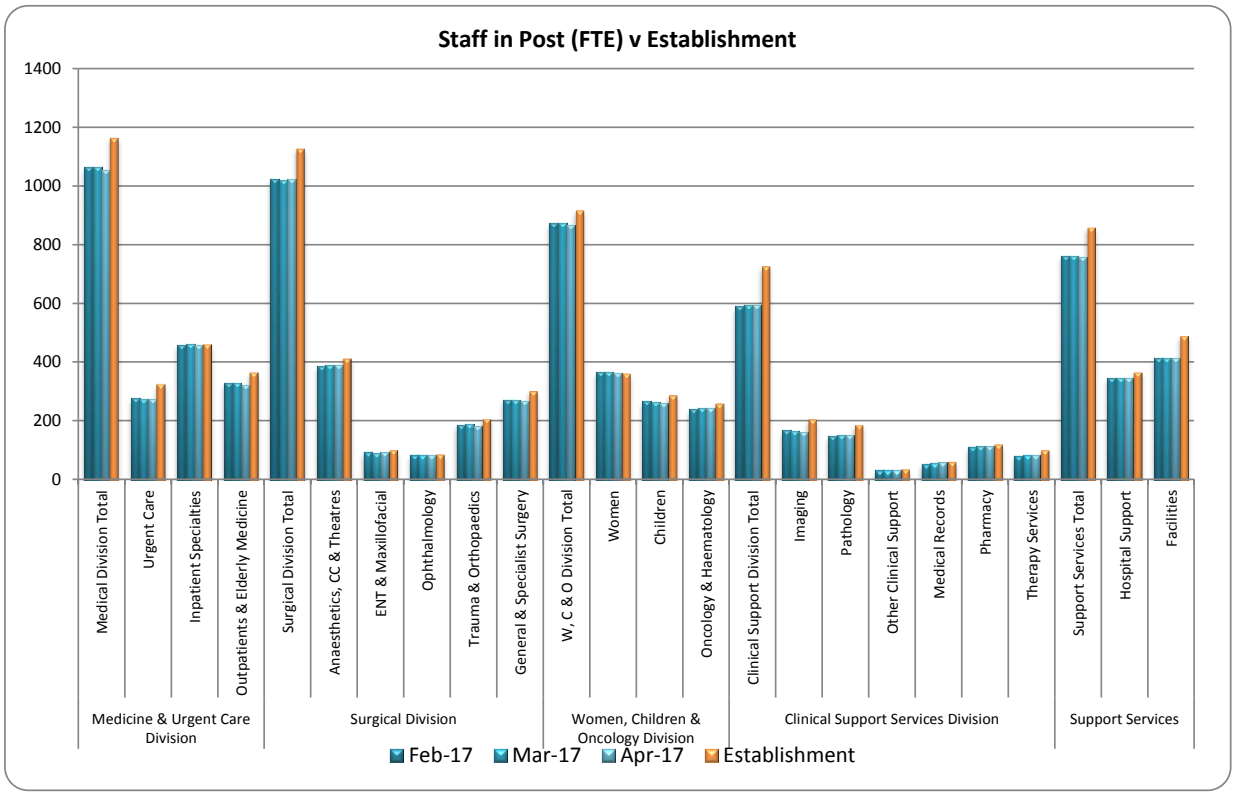
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as and when required.

Workforce Committee: Capacity, Capability Report - April 2017

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Feb-17		Mar-17		Apr-17	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1063.13	↑	1063.94	↓	1053.73	1164.17	90.51%
	Urgent Care	275.19	↓	273.86	↓	272.64	328.84	82.91%
	Inpatient Specialties	458.04	↑	461.75	↓	457.66	463.81	98.67%
	Outpatients & Elderly Medicine	328.89	↓	327.33	↓	322.42	368.52	87.49%
Surgical Division	Surgical Division Total	1024.01	↓	1021.87	↑	1022.20	1127.93	90.63%
	Anaesthetics, CC & Theatres	386.27	↑	387.72	↑	390.59	414.58	94.21%
	ENT & Maxillofacial	91.89	↓	89.90	↑	92.67	103.60	89.45%
	Ophthalmology	84.04	↓	82.44	↑	83.69	88.77	94.28%
	Trauma & Orthopaedics	184.94	↑	186.34	↓	182.80	210.00	87.05%
	General & Specialist Surgery	272.06	↓	270.66	↓	267.64	304.18	87.99%
Women, Children & Oncology Division	W, C & O Division Total	875.04	↓	874.01	↓	866.02	918.68	94.27%
	Women	365.51	↑	366.00	↓	362.43	364.31	99.48%
	Children	266.84	↓	263.60	↓	258.16	290.19	88.96%
	Oncology & Haematology	240.75	↑	242.47	↑	243.49	261.33	93.17%
Clinical Support Services Division	Clinical Support Division Total	588.75	↑	595.39	↑	596.02	727.91	81.88%
	Imaging	166.69	↓	164.13	↓	161.85	207.91	77.85%
	Pathology	148.89	↑	149.89	↑	150.27	189.90	79.13%
	Other Clinical Support	32.42	↑	32.90	↑	33.01	38.36	86.05%
	Medical Records	51.23	↑	55.16	↑	57.83	64.03	90.32%
	Pharmacy	109.86	↑	111.97	↓	111.73	123.72	90.31%
	Therapy Services	79.66	↑	81.34	↑	81.34	103.99	78.22%
Support Services	Support Services Total	760.84	↓	760.21	↓	758.44	860.22	88.17%
	Hospital Support	346.32	↓	345.84	↓	345.05	368.19	93.72%
	Facilities	414.52	↓	414.36	↓	413.39	492.03	84.02%
Trust Total		4319.77	↑	4323.41	↓	4308.21	4868.19	88.50%



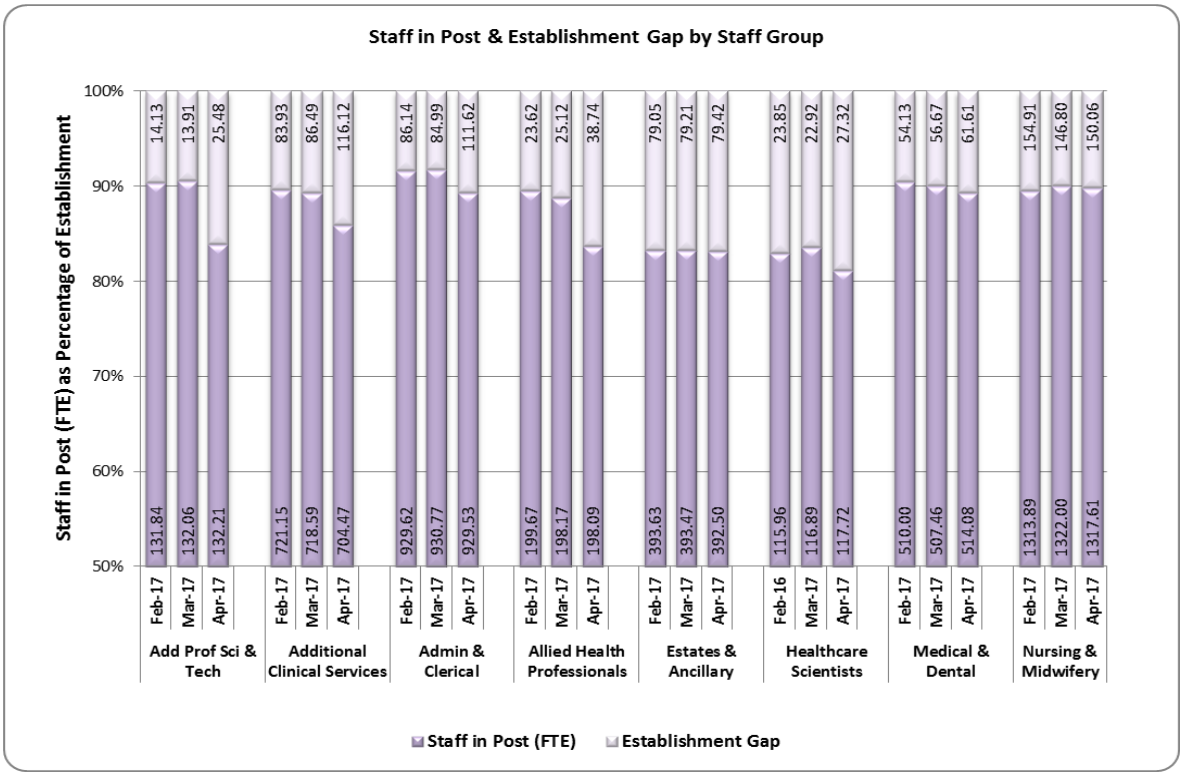
Workforce Committee: Capacity, Capability Report - April 2017

CAPACITY
Staff Group (FTE v Est)

Vacancy RAG Rates:	> 12%	7 - 12%	< 7%

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Feb-16	Mar-17	Apr-17
Add Prof Sci & Tech	9.68%	9.53%	16.16%
Additional Clinical Services	10.43%	10.74%	14.15%
Admin & Clerical	8.48%	8.37%	10.72%
Allied Health Professionals	10.58%	11.25%	16.36%
Estates & Ancillary	16.72%	16.76%	16.83%
Healthcare Scientists	17.06%	16.39%	18.84%
Medical & Dental	9.59%	10.05%	10.70%
Nursing & Midwifery	10.55%	9.99%	10.22%



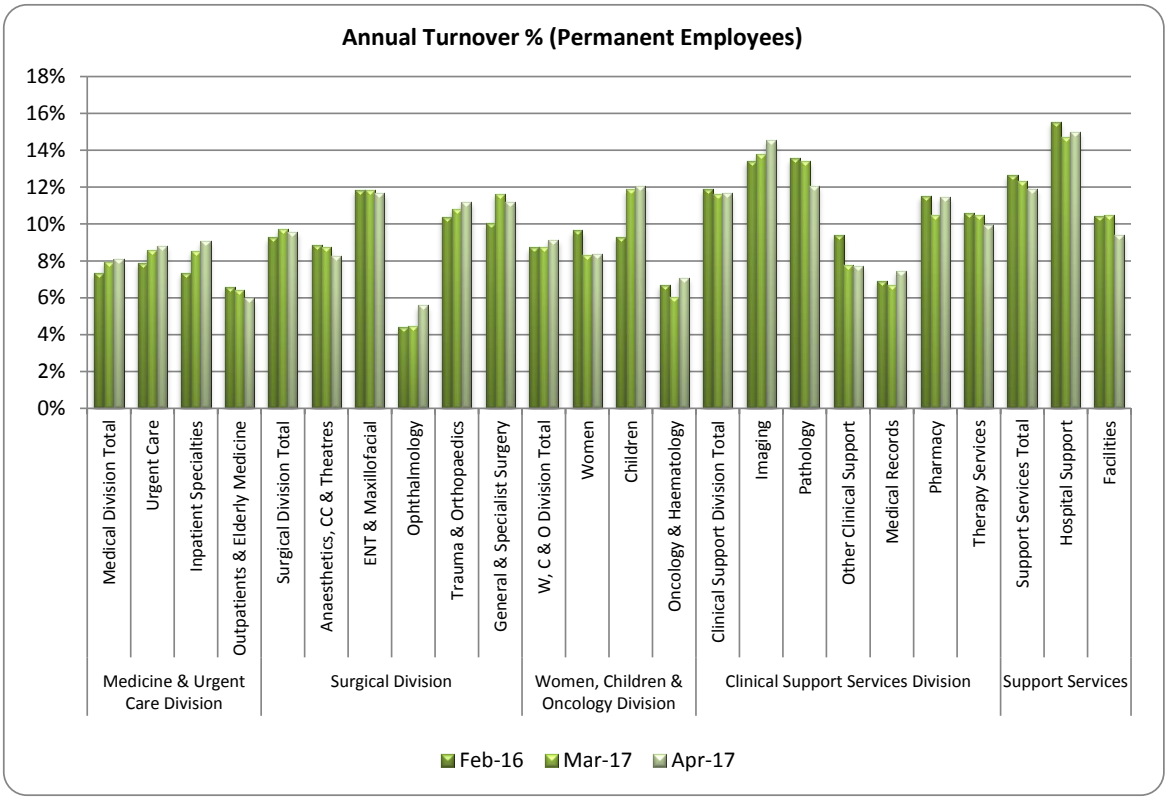
Workforce Committee: Capacity, Capability Report - April 2017

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

Annual Turnover (Permanent Staff)		Feb-16		Mar-17		Apr-17
Medicine & Urgent Care Division	Medical Division Total	7.33%	↗	7.95%	↗	8.07%
	Urgent Care	7.87%	↗	8.58%	↗	8.79%
	Inpatient Specialties	7.36%	↗	8.54%	↗	9.06%
	Outpatients & Elderly Medicine	6.56%	↘	6.40%	↘	5.95%
Surgical Division	Surgical Division Total	9.26%	↗	9.71%	↘	9.54%
	Anaesthetics, CC & Theatres	8.86%	↘	8.74%	↘	8.24%
	ENT & Maxillofacial	11.84%	↘	11.82%	↘	11.68%
	Ophthalmology	4.41%	↗	4.45%	↗	5.58%
	Trauma & Orthopaedics	10.35%	↗	10.81%	↗	11.19%
	General & Specialist Surgery	10.06%	↗	11.64%	↘	11.17%
Women, Children & Oncology Division	W, C & O Division Total	8.72%	↗	8.75%	↗	9.11%
	Women	9.64%	↘	8.30%	↗	8.35%
	Children	9.28%	↗	11.86%	↗	12.04%
	Oncology & Haematology	6.67%	↘	6.01%	↗	7.09%
Clinical Support Services Division	Clinical Support Division Total	11.87%	↘	11.62%	↗	11.65%
	Imaging	13.41%	↗	13.78%	↗	14.52%
	Pathology	13.54%	↘	13.41%	↘	12.07%
	Other Clinical Support	9.38%	↘	7.75%	↘	7.73%
	Medical Records	6.89%	↘	6.68%	↗	7.42%
	Pharmacy	11.52%	↘	10.49%	↗	11.48%
	Therapy Services	10.57%	↘	10.46%	↘	9.95%
Support Services	Support Services Total	12.65%	↘	12.34%	↘	11.87%
	Hospital Support	15.51%	↘	14.71%	↗	14.97%
	Facilities	10.43%	↗	10.47%	↘	9.38%
Trust Total		9.70%	↗	9.87%	↘	9.85%



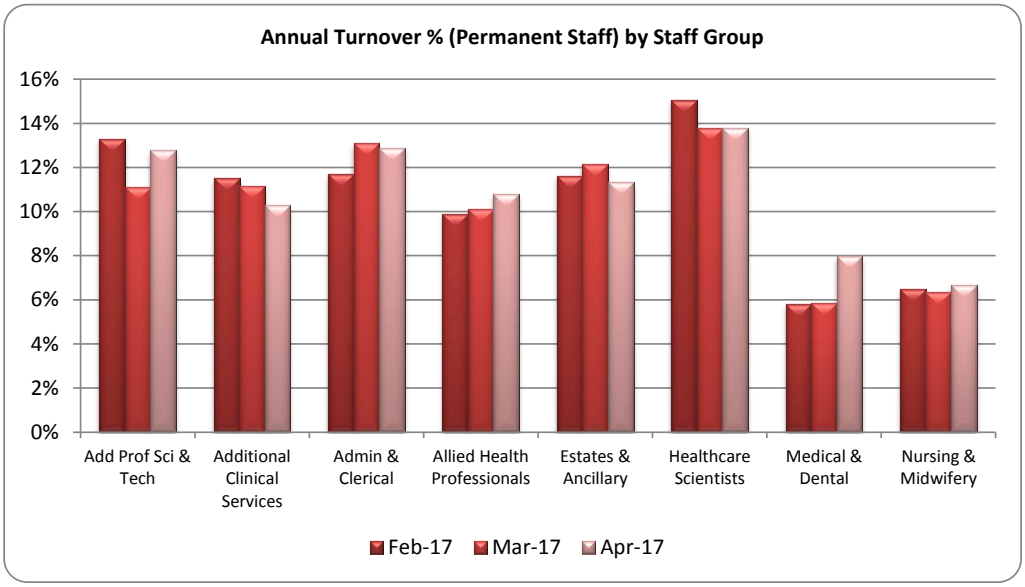
Workforce Committee: Capacity, Capability Report - April 2017

CAPACITY
Turnover by Staff Group

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

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

Staff Group	Feb-17		Mar-17		Apr-17
Add Prof Sci & Tech	13.30%	↘	11.13%	↗	12.78%
Additional Clinical Services	11.53%	↘	11.16%	↘	10.27%
Admin & Clerical	11.69%	↗	13.09%	↘	12.87%
Allied Health Professionals	9.88%	↗	10.12%	↗	10.79%
Estates & Ancillary	11.61%	↗	12.17%	↘	11.31%
Healthcare Scientists	15.04%	↘	13.80%	↘	13.77%
Medical & Dental	5.80%	↗	5.87%	↗	7.99%
Nursing & Midwifery	6.48%	↘	6.34%	↗	6.65%



Capacity: Substantive Workforce Capacity decrease by 15.20 FTE in April 2017 to 4308.21 FTE. The Trust's substantive workforce is at 88.50% of the Budgeted Workforce Establishment of 4868.19 FTE.

Staff Turnover: Annual Trust turnover decrease by 0.02% to 9.85% in April which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased by 0.31% to 6.35%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover increased in Medical & Dental , Allied Health Professionals and Additional Professsional, Scientific and Technical staff groups. Turnover decreased in Additional Clinical Services and Healthcare Scientists, Administrative and Clerical and Estates and Ancillary staff groups.

Medical Division: turnover increased by 0.12% to 8.07%
Surgical Division: turnover decreased by 0.17% to 9.54%
Women, Children & Oncology Division: turnover increased by 0.36% to 9.11%
Clinical Support Services Division: turnover increased by 0.03% to 11.65%
Support Services: turnover decreased by 0.47% to 11.87%

Staff Vacancies: The vacancy rates for all staff groups increased in April 2017. Add Prof Sci & Tech staff group has seen the largest vacancy rate increase of 6.63% to 16.16%.

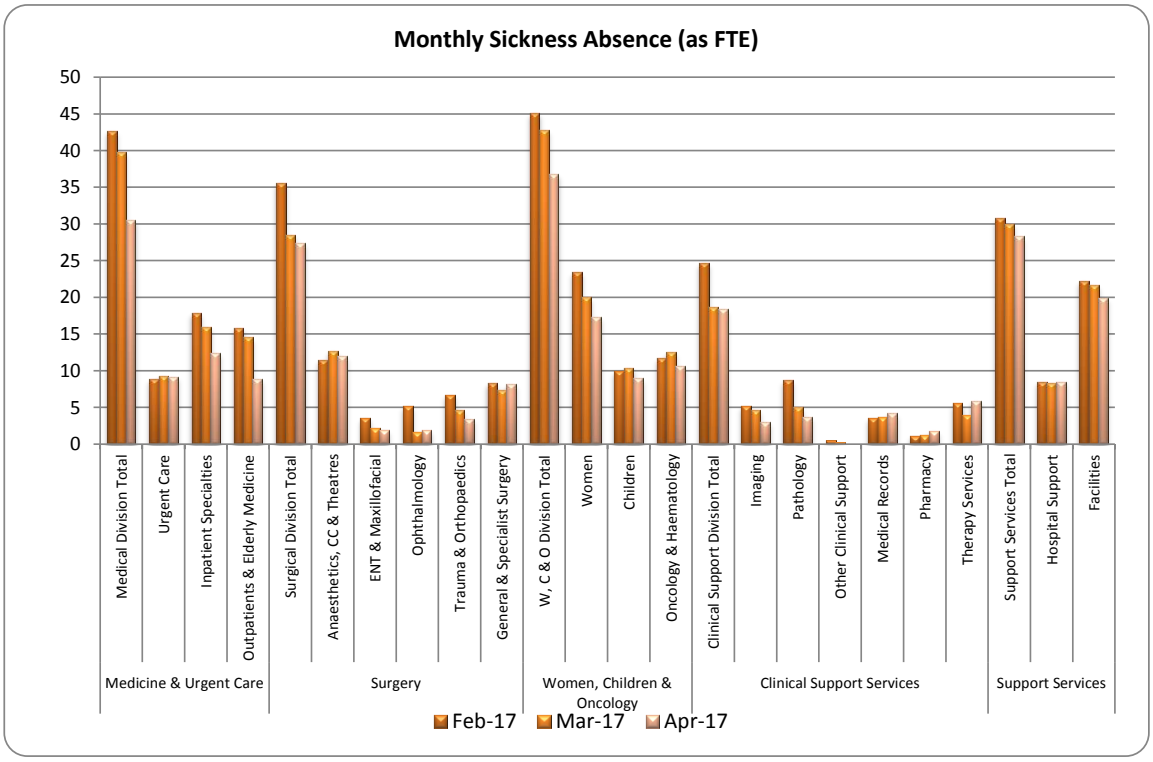
Sickness Absence: Sickness absence for April 2017 decreased again this month from 3.70% to 3.29% which is below Trust target of 3.8%. All Divisions are below Trust target except for Women Children & Oncology at 4.25% with the Women DIrectorate showing the highest sickness rate of 4.77%. In total 14 directorate level organisations were below the trust target rate in April 2017 compared to 12 directorates in March 2017.

Workforce Committee: Capacity, Capability Report - April 2017

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Feb-17	Mar-17	Apr-17	Apr-17	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	42.63	39.79	30.56	2.90%	2.01%	0.89%
	Urgent Care	8.83	9.26	9.19	3.37%	2.26%	1.11%
	Inpatient Specialties	17.91	15.98	12.45	2.72%	1.90%	0.83%
	Outpatients & Elderly Medicine	15.82	14.50	8.87	2.75%	1.96%	0.79%
Surgery	Surgical Division Total	35.53	28.51	27.39	2.68%	1.70%	0.98%
	Anaesthetics, CC & Theatres	11.47	12.64	11.95	3.06%	1.47%	1.59%
	ENT & Maxillofacial	3.57	2.14	1.94	2.09%	1.00%	1.09%
	Ophthalmology	5.17	1.69	1.87	2.24%	2.24%	0.00%
	Trauma & Orthopaedics	6.69	4.60	3.35	1.83%	0.85%	0.99%
	General & Specialist Surgery	8.35	7.42	8.22	3.07%	2.68%	0.38%
Women, Children & Oncology	W, C & O Division Total	45.15	42.83	36.81	4.25%	2.31%	1.95%
	Women	23.43	19.98	17.29	4.77%	2.73%	2.04%
	Children	9.98	10.39	8.91	3.45%	1.82%	1.63%
	Oncology & Haematology	11.70	12.49	10.62	4.36%	2.21%	2.15%
Clinical Support Services	Clinical Support Division Total	24.61	18.64	18.42	3.09%	1.83%	1.26%
	Imaging	5.20	4.63	2.96	1.83%	0.85%	0.98%
	Pathology	8.74	4.99	3.67	2.44%	1.37%	1.07%
	Other Clinical Support	0.46	0.23	0.00	0.00%	0.00%	0.00%
	Medical Records	3.54	3.72	4.17	7.21%	4.78%	2.42%
	Pharmacy	1.12	1.25	1.75	1.57%	0.73%	0.85%
	Therapy Services	5.52	3.89	5.91	7.27%	4.81%	2.46%
Support Services	Support Services Total	30.74	30.03	28.29	3.73%	2.29%	1.44%
	Hospital Support	8.52	8.37	8.52	2.47%	1.64%	0.83%
	Facilities	22.26	21.71	19.84	4.80%	2.85%	1.95%
Trust Total	*As FTE*	178.84	159.97	141.74			
	As percentage	4.14%	3.70%		3.29%	2.02%	1.27%



Workforce Committee: Capacity, Capability Report - April 2017

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Feb-17	Mar-16	Apr-17
Medicine & Urgent Care Division	Medical Division Total	81.43%	83.20%	83.89%
	Urgent Care	79.84%	82.48%	83.59%
	Inpatient Specialties	80.49%	81.87%	82.35%
	Outpatients & Elderly Medicine	83.94%	85.51%	86.16%
Surgical Division	Surgical Division Total	81.31%	83.35%	83.21%
	Anaesthetics, CC & Theatres	79.24%	81.99%	82.10%
	ENT & Maxillofacial	75.26%	76.51%	76.54%
	Ophthalmology	79.59%	81.92%	81.88%
	Trauma & Orthopaedics	85.22%	85.58%	86.36%
	General & Specialist Surgery	84.19%	86.51%	85.49%
Women, Children & Oncology Division	W, C & O Division Total	86.45%	87.60%	86.48%
	Women	84.98%	85.33%	83.15%
	Children	89.63%	91.72%	90.88%
	Oncology & Haematology	85.32%	86.48%	86.86%
Clinical Support Services Division	Clinical Support Division Total	86.07%	87.88%	88.81%
	Imaging	82.16%	82.47%	82.52%
	Pathology	86.99%	91.38%	92.70%
	Other Clinical Support	88.63%	87.86%	90.70%
	Medical Records	84.62%	85.02%	92.59%
	Pharmacy	90.20%	92.42%	92.16%
	Therapy Services	86.67%	88.41%	85.87%
Support Services	Support Services Total	82.86%	86.11%	87.41%
	Hospital Support	87.33%	88.62%	87.96%
	Facilities	79.46%	84.21%	86.99%
Trust Total		**83.35%**	**85.33%**	**85.58%**

Workforce Committee: Capacity, Capability Report - April 2017

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Feb-17	Mar-17	Apr-17
Medicine & Urgent Care Division	Medical Division Total	77.69%	79.40%	78.79%
	Urgent Care	77.17%	78.42%	76.16%
	Inpatient Specialties	75.09%	77.02%	77.10%
	Outpatients & Elderly Medicine	81.81%	83.76%	83.97%
Surgical Division	Surgical Division Total	79.94%	82.12%	81.70%
	Anaesthetics, CC & Theatres	76.56%	80.04%	80.33%
	ENT & Maxillofacial	71.04%	73.60%	73.30%
	Ophthalmology	76.41%	80.18%	78.56%
	Trauma & Orthopaedics	83.63%	84.14%	84.91%
	General & Specialist Surgery	85.62%	86.46%	84.64%
Women, Children & Oncology Division	W, C & O Division Total	82.89%	84.21%	84.29%
	Women	81.18%	82.86%	83.12%
	Children	87.79%	88.41%	89.33%
	Oncology & Haematology	79.82%	81.22%	79.66%
Clinical Support Services Division	Clinical Support Division Total	81.29%	81.94%	82.84%
	Imaging	77.25%	79.61%	79.97%
	Pathology	84.18%	89.10%	88.67%
	Other Clinical Support	80.13%	78.38%	78.47%
	Medical Records	95.38%	94.20%	95.83%
	Pharmacy	82.83%	82.79%	83.23%
	Therapy Services	83.33%	79.65%	82.65%
Support Services	Support Services Total	72.68%	72.69%	72.31%
	Hospital Support	77.81%	78.61%	77.90%
	Facilities	66.77%	65.96%	66.06%
Trust Total		**79.74%**	**81.28%**	**81.05%**

Capability

Appraisals
The current rate of Appraisals recorded for April 2017 is 83.70%; this is an decrease of 0.57% from last month's figure of 84.27%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in April 2017 from 85.33% to 85.58%, this is an increase of 0.25% from last months figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased slightly in April 2017 to 81.05% from last month's figure of 81.28%.

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

Workforce Committee: Capacity, Capability Report - April 2017

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Feb-17	Mar-17	Apr-17
Medicine & Urgent Care Division	Medical Division Total	82.61%	82.78%	81.45%
	Urgent Care	89.55%	89.55%	82.40%
	Inpatient Specialties	79.00%	79.67%	79.90%
	Outpatients & Elderly Medicine	81.82%	81.46%	82.87%
Surgical Division	Surgical Division Total	86.81%	88.86%	88.35%
	Anaesthetics, CC & Theatres	84.00%	83.52%	84.23%
	ENT & Maxillofacial	89.04%	89.04%	85.33%
	Ophthalmology	75.64%	83.12%	79.22%
	Trauma & Orthopaedics	92.49%	95.40%	95.93%
	General & Specialist Surgery	89.84%	93.85%	92.59%
Women, Children & Oncology Division	W, C & O Division Total	87.61%	88.26%	86.80%
	Women	84.60%	84.11%	82.47%
	Children	91.73%	92.48%	91.41%
	Oncology & Haematology	88.48%	90.95%	89.43%
Clinical Support Services Division	Clinical Support Division Total	79.91%	82.16%	80.79%
	Imaging	77.27%	77.33%	76.02%
	Pathology	86.16%	88.13%	85.09%
	Other Clinical Support	70.00%	71.05%	81.58%
	Medical Records	69.23%	91.30%	80.56%
	Pharmacy	86.61%	84.80%	84.25%
	Therapy Services	76.67%	75.00%	77.17%
Support Services	Support Services Total	78.84%	78.41%	80.32%
	Hospital Support	78.05%	78.73%	79.51%
	Facilities	79.44%	78.18%	80.92%
Trust Total		**84.40%**	**84.27%**	**83.70%**

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**25 May 2017**

Title of the Report	**Apprenticeship Levy Update**
Agenda item	11.1
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services & Becky Sansom, Learning & Development Manager
Purpose	This report provides an update in respect of the Apprenticeship Levy
Executive summary • Update and costings in respect of the options available to the Trust to utilise the Apprenticeship Levy	
Related strategic aim and corporate objective	Enable excellence through our people.
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 2.1
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.	

Apprenticeship Levy Update

Background

Further to the submission of a briefing paper to the Workforce Committee on 22 March 2017, which detailed the options available to the Trust to utilise the Apprenticeship Levy, this paper aims to provide further exploration into the options detailed and how the money is likely to be allocated between each of the three options. Details of any further investment required are also provided within the paper.

For ease of reference a brief summary of the three options presented to Workforce Committee on 22 March 2017 is as follows.

Option 1

All staff recruited to a band 2 position has to complete an apprenticeship during the first 12 months.

Option 2

This option would require departments to give up a band 2 post to convert into a 'true apprentice'. (A true apprentice is likely to be someone of school leaving age and whom the Trust would pay an apprenticeship salary of approximately £130 per week over the course of a fixed term 12 month contract)

Option 3

Conversion of existing training courses to apprentice standards e.g. CIPD, Leadership and Management, IT etc.

The annual levy funds available to the Trust is anticipated as totaling £1,029,972, however this figure has yet to be definitively confirmed and may therefore be subject to adjustment.

The new apprenticeship funding system will be made up of 15 funding bands, (detailed below) with the upper limit of those bands ranging from £1,500 to £27,000. Employers are expected to negotiate a price for their apprentice's training and assessment.

Number	Band Upper Limit
1	£1,500
2	£2,000
3	£2,500
4	£3,000
5	£3,500
6	£4,000
7	£5,000

8	£6,000
9	£9,000
10	£12,000
11	£15,000
12	£18,000
13	£21,000
14	£24,000
15	£27,000

NB: The costs detailed within this paper have had to be based on the Trusts historical use of apprenticeships and the funding bands detailed above. As such the vast majority of the costs detailed within the paper and the associated cost modelling relate to apprenticeship funding Bands 2-4. Whilst it is anticipated that these funding bands will be those predominantly used for options 1 & 2, it is impossible to rule out the possibility of some apprenticeship standards falling within a higher funding band. As a result it will be crucial to closely monitor the monthly expenditure in order to ensure the Trust does not exceed the funds drawn down from the apprenticeship levy and it is therefore possible that the costs proposed within this paper may fluctuate significantly throughout the year. As such these costs are an indicative approximation only.

Known/Anticipated Costs - Option 1

Option 1

Indicative costings for this option have been modelled on the number of Band 2 new recruits that the Trust appointed between January 2016 and December 2016.

Within this period of time a total of 143 Band 2 members of staff were recruited into posts that would lend themselves to apprenticeship standards associated with Business Administration, Receptionists and HCAs.

Had apprenticeship standards been funded for each of these new recruits, the total cost would have been £419,340.00, which based on the anticipated annual levy would have constituted 40.71% of the overall levy.

It is important to note that these figures are based on last year's band 2 recruitment activity which if exceeded this year would increase the associated expenditure for this option. As such there is a risk associated with implementing this option as a pre-requisite for all band 2 positions.

In order to meet the apprenticeship standard requirements in respect of Math's and English, dialogue is underway with the HR Service Centre to establish the method of assessment at the point of recruitment. Evidence will need to be provided that a candidate has Math's & English GCSE (at D or C grade depending on the level of Apprenticeship) or otherwise undertake an assessment as part of the recruitment process.

The HCA recruitment, which Practice Development facilitates already has their own HCA math's and English test, and the introduction of this assessment at the point of recruitment is not therefore anticipated to adversely affect the numbers of HCAs

recruited. This assessment is a pre-requisite for HCAs wishing to progress to the nursing associate or nursing degree and is closely associated to the need to ensure that potential nurses have a level of Math's and English that enable them to complete the calculations that they will have to carry out.

Option 2

22 Apprentices were recruited which based on anticipated apprenticeship costs would total £50,000

Option 3

Existing staff that accessed apprenticeships totaled 15, which based on anticipated apprenticeship costs would total £48,000.

A meeting has taken place with the Divisional Managers to brief them on the apprenticeship levy and to request that their managers begin to consider and identify training opportunities for which the apprenticeship levy could be utilised in a way that will support service development.

For the current financial year this will need to be facilitated through the promotion of the apprenticeship levy and supporting managers to identify training opportunities.

However, in order to ensure an ability to evidence how this meets the strategic needs of the organisation and service development it is proposed that by year two of the levy any training identified is factored into the annual business planning cycle so that a Trust wide education plan can be aggregated and agreed on an annual basis.

In the event of the demand for training being greater that the resource available from apprenticeship levy, it is envisaged that an educational decision making body would be required to determine what constitutes key priorities for the Trust and therefore what should be approved.

Work is underway with finance to try to identify the level of internal Divisional expenditure on training and development initiatives for staff in order to determine the extent to which this expenditure could be accessed through the apprenticeship levy. Initial figures have been obtained however further analysis is required in order to determine a definitive figure and also what training could be transferred to apprenticeship standards and therefore funded via the apprenticeship levy.

Summary of Option Costs 2017/18

Apprenticeship Levy Utilisation	Amount	Unit cost	2017/18
Option 1	143	£2,932.44	£419,339
Option 2	22	£2,272.72	£50,000
Option 3	TBC	TBC	£560,633
Total			

			£**1,029,972**

Nursing Initiatives in isolation (Options 1, 2 & 3)

Dialogue is on-going with Nursing Practice Development colleagues to specifically quantify the level of funding that the various planned initiatives for training new and existing nurses are likely to require. Subject to the outcome of this dialogue, it may be necessary to reconsider the level of funding apportioned to each of the options detailed above.

However, for illustrative purposes, based on last year's funding of apprenticeships that were specifically aimed at developing HCAs, the costs below have been split out from the overall figures detailed above.

Option 1

Of 143 Band 2 Recruits, 108 were HCAs, which if replicated over the next 12 months, would equate to an overall cost of approximately £324,000.

Option 2

A total of 6 true HCA Apprentices were recruited last year at a total cost of £18k (based on current costs)

Option 3

10 HCAs who were already employed by the Trust undertook an apprenticeship at a total cost of £30,000.

Total Nursing spend on apprentices last year: £372,000
(73.2% of last year's total modelled apprenticeship spend/36.1% of total anticipated annual apprenticeship levy.

Additional Resource & Support

Support to identify appropriate and available apprenticeship standards would need to be provided to managers and it is envisaged that this is something that can be provided by the Learning & Development team through the recruitment of a Band 5 Apprenticeship Coordinator. A Job Description has been drafted and included at appendix 1. Please note that this job description has yet to be banded and that the banding detailed is therefore indicative only.

It is acknowledged that the introduction of this post will required a Business Case and that it will therefore be subject to approval.

To provide some context, examples of the additional resource other Trusts have invested in the administration and support of the apprenticeship levy are as follows:

- NHSBT – Band 7 Manager and Band 4 Co-ordinator
- NHFT – Band 7 Manager and Band 5 Co-ordinator (TBC)

- Nottingham University Hospitals - Band 7 Manager
- Berkshire Healthcare NHS Foundation Trust – band 5 Co-ordinator

It has been stated through all of the webinars and conferences provided in relation to the apprenticeship levy that posts will be required to oversee the management and administration of the levy.

In order to maximise a return on investment from the levy and to ensure that the Trust retains those staff in which an investment has been made, there is a clear benefit to be gained in developing workshops to assist managers in the development of career pathways.

In addition to this, it is recommended that a talent management approach to identifying those members of staff who would be best suited to investment would also be a worthwhile consideration.

Local and departmental resource for supporting apprentices.

Any department supporting an apprenticeship would have to provide a mentor who would work closely with the apprentice. There is an appreciation that an apprentice needs a lot of support specifically in the first 3 months.

The manager may also be involved with evidencing the 20% off the job learning and would be the nominated signatory for the Apprentice contract which states that the apprentice will be released for 20% of their working hours and that they will attend study days etc. The manager would also have to keep in regular contact with the L&D dept.

For option 1 & 2 apprentices the manager would need to be involved in the recruitment of the band 2 member of staff undertaking the apprenticeship or the true apprentice respectively and also meet with the training provider on a bi-monthly basis.

For unusual and specific apprenticeships (such Finance, IT, Clinical Coding or other bespoke standards that would require development and negotiation with the training provider) they would have to work with the L&D dept. in finding an apprenticeship standard that meets their requirement and would help the L&D dept. when meeting with the Training Provider to negotiate what was included in the standard.

Procurement of Training Providers

Following advice from NHS Employers and the Trusts procurement department, it is necessary to go through a procurement exercise to identify education providers.

Current advice is that this entails obtaining quotes from several providers prior to commissioning an education provider.

A specification form that has been devised for this purpose can be found at appendix 2.

Appendix 1

Northampton General Hospital NHS
NHS Trust

JOB DESCRIPTION

POST TITLE:	Apprenticeship Co-ordinator
DEPARTMENT:	Learning & Development
DIRECTORATE:	Workforce & Transformation
DIVISION	Hospital Support
BAND:	5 (indicative)
ACCOUNTABLE/REPORTS TO:	Learning & Development Manager
PROFESSIONALLY ACCOUNTABLE TO:	N/A
DATE:	April 2017
WRITTEN BY:	Learning & Development Manager

1. JOB SUMMARY

- Responsible for the co-ordination for the Apprenticeship Service. This will include using the Digital Account Service to register new Apprentices, keep track of the levy money to ensure that we are not over spending. Plan new starts to fit in with the levy money.

- Arranging and co-facilitating Awareness and Induction Days for existing employee intakes, administering the whole process from new starts, regular reviews and completions. Monitoring and reporting on information and progress throughout the whole of the apprenticeship pathway.

- Act as the first point of contact for queries raised about apprenticeships.

- Responsible for maintaining regular contact with all apprentices and training Providers throughout programmes to ensure learning pathway is positive. Raising any issues to the Learning & Development Manager when required.

- Assist the Learning & Development Manager with planning and administration support, including providing reports, for training Providers. This includes attending meetings, taking minutes/notes, providing updates on progress and challenging information where necessary.

Provide effective input into the work of the Trust, to support the achievement of our vision and values:

Best possible care for our patients			
We put patient safety above all else	*We aspire to excellence*	*We reflect, we learn, we improve*	*We respect and support each other*

2. ROLE AND RESPONSIBILITIES

- Keep up to date with new Apprentice Standards as they become available. This includes regular contact with the Education Skills Funding Agency and keeping abreast of standards that are in the development phase so that the Trust can decide if they wish to be part of the 'Trailblazer'. To be aware and research what other Trusts are doing and analyse how well standards are working across the NGH and other Trusts.

- Maintain communication with managers on apprentice standards as they become available and that may be applicable to their staff and/or contributes to the development pathways of exiting staff. This will include explaining the complex information of apprenticeships where barriers to understanding exist.

- To work with the Learning & Development Manager to identify a Provider for the apprenticeship standard. This includes ensuring that they are on the 'Providers List' (LOAP) and keeping up to date with new Providers.

- To initiate the procurement process with the 'Specification Paperwork' and work with Procurement to ensure that this is added to the portal. Monitor the quotes that are received and once the deadline has been met, work with the Learning and Development Manager and the manager of the apprentice to decide on which Provider will be given the business.

- To work with the Learning & Development Manager to negotiate the price with the Provider and assist with what will be included in the apprenticeship standard as this will differ depending on the standard and prior learning of the apprentice. The final decision of negotiation and contracts will be the responsibility of the Learning & Development Manager. Keep and maintain extensive documentation of all decisions made for internal audit and audit by the Education Skills Funding Agency. Ensure that all decisions are transparent and available for inspection.

- Using the on-line Digital Account Service (AS) identify a registered End Point Assessment (EPA) centre for the relevant standard that has been selected. This may include communicating with the End Point Assessment Centres to clarify any issues or queries relating to the standard. Ensure that the End Point Assessment Centre has no links with the Provider as this constitutes as unlawful funding of the apprenticeship.

- To maintain the complex Digital Account Service (AS). This will need to be completed at least once a week to ensure that the funds are going through to the Provider and the End Point Assessment (EPA) Centre. The levy as it stands currently is £85,000 per month.

- Work with Finance and Payroll to ensure that they complete the particular fields within AS at the designated times each month to ensure that the account is accurately reflecting the Trust's paybill. To notify the Learning and Development Manager immediately if this isn't being completed or if the funds are not accurate.

- To monitor and verify the financial aspect of the AS and on a weekly basis inform the Learning & Development Manager of the money available or if we are in danger of spending over the levy as the excess will have to be paid in addition to the levy. This will enable both you and the Learning & Development Manager to plan for new apprenticeship starts over the year or duration of the apprenticeship to ensure that we do not run out of funds.

- Ensure all the relevant paperwork is completed for advertising new apprenticeship posts. This includes liaising with the apprenticeship manager and Finance to ensure that the Financial Authorisation Form, Job Description and Person Specification are completed.

- Work with HR Service Centre and the National Apprenticeship Service to advertise the apprentice post. In conjunction with the Learning & Development Manager shortlist those applications and invite to assessment days.

- Help co-facilitate the assessment days ensuring that all the relevant paperwork and setting up of the days is completed. Liaising with the managers to ensure that they are present on the day and to cover in the absence of any manager.

- Ensure that the initial assessments; Math's and English are carried out and then mark and score these. Work with the managers and Learning and Development Manager to look at the overall scores of the assessment day which includes; observation, initial assessment and short interview to identify who will be invited to the formal interview. Communicate with all those applicants which will involve disappointment and questioning as informing them that they were not successful and the reasons.

- Co-ordinate all of the recruitment process; completing references, occupational health checks and DBS to ensure that all the clearances have been completed. This information will be sensitive and on occasions distressing due to the results of the DBS checks. You will be contacting the applicant to withdraw them from the process due to the reference or DBS clearance. This will also include communicating with the managers to keep them informed of timescales and then working with HR Service Centre once all the clearances have been completed. Arrange a start date to fit in with the manager/dept and the funding.

- Ensure all the relevant contracts for the apprentice have been signed and ensure an efficient filing system is kept. To answer any queries arising from the contract and in complex situations notify the Learning and Development Manager.

- Receive feedback on a monthly basis from the Provider on the progression of the individual. Liaise with the manager if any problems.

- Liaise with the Provider on progression and timeframe for gateway. Register for the End Point Assessment (EPA) 90 days prior to completion. Co-ordinate the End Point Assessment (EPA) with the apprentice and the manager as this involves written questions, observations, portfolios of evidence and interviews. Monitor the completion of the EPA and record the decision.

- Communicate with the manager and apprentice on whether they have passed the EPA or not. This will include giving highly contentious results to apprentices that may be at a much higher band than this post. Ensure that the Learning & Development Manager is kept aware and they accompany the Apprentice Co-ordinator if required to do so. If the apprentice fails inform Learning and Development Manager to work with the apprentice's manger on whether to fund a re-sit of the exam or not. Identify the significant additional skills that need to be taught in order to secure funding.

- Responsible for the planning of specific apprenticeship projects as agreed. This will involve working with managers across the Trust which may be training using motivation and high communication skills.

- Responsible for maintaining the internal reporting spreadsheet to capture personal data and information on all apprentices, from start to end of the apprenticeship, including destination and diversity monitoring.

- Responsible for regularly maintaining all external reporting spreadsheets for all apprenticeship programme intakes. Reports will be produced based on this information to various Managers across the Trust and other external stakeholders e.g. NHS Employers and Health Education England.

- Ensure all necessary monitoring is completed of the programme. This includes a system of identifying the 20% off the job learning for each apprentice. This needs to be audited internally and externally and available for inspection.

- Monitoring apprenticeship performance and business information such as number of learners on each programme, and as necessary, liaise with the Learning and Development Manager to arrange to promote or cancel the activities to ensure efficiencies of resources.

- Communicate with external training Providers on a regular basis to ensure the whole of the apprenticeship pathway, in terms of administration, planning and arrangements are actioned in a timely manner in accordance with agreed contracts.

- Responsible for planning and the arrangement of internal Apprenticeship Awareness and Induction Days. This includes ensuring venues (including external venues) are booked, catering and equipment is arranged and by organising the registration of those attendees on the BKSB computer system to undertake the initial assessment.

- Co-facilitate with the training Provider apprenticeship briefings and Apprenticeship Awareness and Induction Days, in the absence of the Learning & Development Manager.

- Produce and maintain internal marketing and communication systems to all staff to inform them of apprenticeship pathways, apprenticeship standards and new standards as they become available.

- Be the first point of contact for an apprentice query from manager, staff, external Providers and awarding bodies. Deal with all queries within the limits of the role, referring anything else to the Learning & Development Manager.

- Provide initial pastoral care by being the first point of contact for apprentices, this may include problems and issues they are having with their manager on being released to complete work through to problems with the Providers. Use initiative on what can be dealt with and refer highly complex situations to the Learning and Development Manager. This will include persuasive, motivational and negotiation skills.

- Be responsible for maintaining regular contact with all apprentices and training Providers throughout programmes to ensure learning pathway is positive. Raising any issues or opportunities to the Learning and Development Manager when required.

- To support and attend Apprenticeship marketing events and career fairs including School and College open days. This involves working in collaboration with other Trust's in the county and further afield. Some of these events will occur outside of the normal working day and will take place in the evenings and very occasionally at a weekend.

3. OTHER INFORMATION

- The postholder may be required to carry out other relevant duties as required.
- The postholder will adhere to the duties specified under the Staff Responsibilities of the NHS Constitution in their day to day work and behaviours.
- The postholder will be expected to aspire to the Values of the Trust in their day to day work and behaviours in order to support the Trust in achieving its Vision.
- The postholder will adhere to, at all times, any Professional, NHS Code of Conducts and legislation relevant for their area of work.
- The postholder will make themselves familiar with, and adhere to, at all times, the policies and procedures of the Trust, and their area of work.
- The postholder will be expected to work to any Corporate/Division/Directorate/Department objectives and standards in order to provide an acceptable level of service.
- The postholder will be expected to undertake training, including mandatory and role specific training, relevant to their role and ensure it is renewed as required.

This job description reflects the present requirements of the post and it does not form part of the contract of employment. As the duties of the post change and develop the job description will be reviewed and will be subject to amendment, in consultation with the postholder. It is the Trust's aim to reach agreement on reasonable changes, but if agreement is not possible the Trust reserves the right to effect changes to the postholders job description after consultation with them. Appropriate notice of such changes will be given.

Northampton General Hospital NHS
NHS Trust

PERSON SPECIFICATION
Apprenticeship Co-ordinator

ATTRIBUTES & REQUIREMENT	ESSENTIAL	DESIRABLE
Education, Training & Qualifications	• Educated to a level 5 diploma qualification in a relevant subject area or equivalent demonstrable experience plus further knowledge/expertise in this field • Advanced administration skills • Assessing (A1) and Internal Verification (V1) qualification	
Knowledge & Experience	• Knowledge of the Education Skills Funding Agency • Knowledge of the Apprenticeship Frameworks and the new Apprenticeship standards • Have extensive knowledge of planning schedules, recording of activities, compilation of statistics, including an awareness of required quality assurance of externally accredited programmes. • Experience of co-ordinating and facilitating the NVQ programmes and recruiting, monitoring of 'True' Apprentices • Administrative experience at a senior level to include diary management, typing of documents, booking and arranging meetings and events, minute/note taking • Experience of facilitating Awareness Sessions and Induction days • Demonstrates the ability to administer and monitor a budget or financial systems • Knowledge and experience of using web based systems, e.g. The Apprenticeship Service and DAS • Knowledge of procurement process of Apprenticeships • Knowledge and experience of BKSB (computer system for Math's and English) and initial assessments	

Skills & Abilities	• Excellent presentation skills • Excellent verbal and non-verbal communication skills • Advanced written communication skills. Including presentation of complex information to audiences with little or no knowledge of the subject • Demonstrable motivation in developing new skills and knowledge. Embraces changes and innovation positively and with enthusiasm • Microsoft Office including Microsoft Intermediate Word, Intermediate Excel and PowerPoint • Ability to manage and analyse data and to translate/report it into meaningful information • Ability to frequently concentrate on work that will be both predictable and unpredictable • Planning and organisation skills especially in relation to own work agenda • Ability to build effective partnerships across the organisation • Able to influence people within the organisation, using persuasive and negotiation skills in difficult situations • Able to seek out solutions to problems and deliver effective outcomes • Ability to work autonomously and with confidence. Work under own initiative and without direct supervision within responsibilities of role • Ability to actively listen to and hear peoples issues and concerns. Ability to communicate difficult, complex and contentious information in a way that is heard and understood • Experience of acting as the first point of contact for a service and providing advice to internal and external customers • Advanced keyboard skills • Ability to deal with potential upset and/or distressed apprentices • To be able to work across the whole of the Hospital site and externally attending external career events, fairs and conferences	

	• Ability to use a VDU daily on a continuous basis • To be able to transport equipment, literature and materials across the Trust and external to the Trust	
Personal Qualities & Attributes	• Excellent interpersonal skills • Flexible and adaptable to deal with changing priorities • Motivated • Enthusiastic • Organised • Attention to detail • Team worker	

Appendix 2

Northampton General Hospital NHS
NHS Trust

Apprenticeships

Details about the Apprenticeship Standard

Name of Training Provider/ End Point Assessment Centre	Click here to enter text.			
Award / Standard quoting for e.g. Senior Healthcare Assistant	Click here to enter text.			
Level of Award/Standard/Framework	Choose an item.			
Name of Qualification as part of Award e.g. Diploma in health	Click here to enter text.			
Level of Qualification	Click here to enter text.			
Additional qualifications as part of the quote e.g. diploma, IT classes	Click here to enter text.			
If providing Health can you provide:	Peri-Op	☐	Maternity	☐

Any additional Information	Click here to enter text.

Costings and Number of Apprentices

Cost per Apprentice	Click here to enter text.	Which funding band?	Choose an item.
Minimum number in Cohort	Click here to enter text.	Maximum number in Cohort	Click here to enter text.
Number of Cohorts able to provide per year	Click here to enter text.	If additional cost, what is the reason?	Click here to enter text.

Any additional Information	Click here to enter text.

Details about the Training Provider

Are you Ofsted registered?	Choose an item.	If yes, which level?	Click here to enter text.
Are you on the Approved List of Providers?	Choose an item.	Do you have a NHS Specific National Framework Contract?	Choose an item.
How long have you been providing this award/standard	Click here to enter text.		
What quality checks are there for your assessors?	Click here to enter text.		
What internal quality assurances do you have?	Click here to enter text.		

Any additional Information	Click here to enter text.

Assessment and support for Apprentice

Do you use an e-portfolio?	Choose an item.		Will you provide face to face assessors?	Choose an item.
No of Visits per apprentice through the duration of the award/standard	Click here to enter text.		Are the progress reviews 3 way? E.g. Apprentice, Manager and Provider	Choose an item.
Do you accept any Prior Learning?	Choose an item.		What is the length of time that you would expect an apprentice to be on programme for?	Click here to enter text.
Will you run workshops and if so what is the frequency?	Choose an item.		Frequency:	Choose an item.
Will you include a teaching element as part of the award/standard?	Choose an item.	If yes, what does this look like?	Click here to enter text.	
How long to you accept a break in learning?	Choose an item.			
What is your method of maintaining communication with the Apprentice Lead? What				

would you notify the Apprentice Lead of?	

Any additional Information	Click here to enter text.

Functional Skills and Initial Assessments

What are the minimum entry requirements	Choose an item.	Do you provide Math's and English classes?		Choose an item.	
What support do you give for functional skills?	Face to Face	☐	E-learning only	☐	Combination ☐
What is the lifespan of initial assessment that you will accept?	Choose an item.	Do you use BKSB?	Choose an item.	If no, what functional skills portal do you use?	Click here to enter text.

Any additional Information	Click here to enter text.

End Point Assessment

Who is the End Point Assessment Centre that you would recommend?	Click here to enter text.		
What is your recommended notification period for the EPA?	Click here to enter text.		
If they fail the EPA, what would you do?	Click here to enter text.		
Do you charge additional money for re-sits/re-takes?	Choose an item.	If yes, cost:	Click here to enter text.

Any additional Information	

Thank you for completing this specification. The Apprentice Lead will contact you, notifying you of the outcome of this specification.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 MAY 2017**

Title of the Report	**Integrated Performance Report**
Agenda item	**12**
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 and 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 Amber/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 and 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

Enclosure H

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	FEB-17	MAR-17	APR-17
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	96.8%	88.0%	67.4%
	Friends & Family Test % of patients who would recommend: A&E	>=87.4%	86.7%	88.9%	90.2%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	92.7%	93.6%	93.2%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97.1%	98.6%	94.0%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.3%	93.7%	92.7%	92.5%
	Mixed Sex Accommodation	=0	0	6	0
	Total deaths where a care plan is in place	>=50%	57.9%	52.5%	50.5%

	Indicator	Target	FEB-17	MAR-17	APR-17
Operational Performance	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	98.2%	96.5%	90.1%
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	98.4%	94.1%	85.2%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	95.8%	96.8%	96.2%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.2%	100.0%	96.1%
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	93.3%	100.0%	81.8%
	Cancer: Percentage of patients treated within 31 days	>=96%	100.0%	97.3%	94.7%
	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	70.0%	100.0%	80.0%
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	92.0%	90.0%	96.1%
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	79.6%	76.3%	80.0%
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.7%	99.6%	99.4%
	RTT over 52 weeks	=0	0	0	0
	RTT waiting times incomplete pathways	>=92%	92.5%	92.3%	92.3%
	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	78.1%	86.7%	87.4%
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	303	159	91
	Ambulance handovers that waited over 60 mins	<=10	61	23	12
	Average Ambulance handover times	=15 mins	00:15	00:13	00:12
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	1	1	1

	Indicator	Target	FEB-17	MAR-17	APR-17
Quality of Care: Effective	Crude Death Rates	1	1.4%	1.0%	1.2%
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.0%	3.5%	2.6%
	Emergency re-admissions within 30 days (non-elective)	<=12%	14.5%	16.0%	12.0%
	Length of Stay by Specialty - All	<=4.2	5.3	4.6	4.2
	Maternity: C Section Rates - Total	<27.1%	25.0%	28.9%	28.2%
	Mortality: HSMR	100	95	96	98
	Mortality: SHMI	100	95	95	95
	Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	56.2%	51.7%	49.3%
	# NoF - Fit patients operated on within 36 hours	>=80%	86.3%	85.7%	68.7%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	84.6%	83.3%	88.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	81.0%	72.6%	85.4%

	Indicator	Target	FEB-17	MAR-17	APR-17
Finance and Use of Resources	Bank & Agency / Pay %	<=7.5%	14.0%	14.2%	
	CIP Performance	>=0	(377) Adv	(377) Adv	
	Income	>=0	3,417 Fav	6,390 Fav	
	Non Pay	>=0	(76) Adv	(1,620) Adv	
	Pay	>=0	(7,446) Adv	(8,664) Adv	
	Surplus / Deficit	>=0	10,965 Fav	13,106 Fav	
	Waivers	=0	2	8	4
	Waivers which have breached	=0	2	3	3

	Indicator	Target	FEB-17	MAR-17	APR-17
Quality of Care: Safe	Dementia: Case finding	>=90%	94.5%	97.5%	99.0%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	98.7%	99.2%	98.3%
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	77	125	60
	VTE Risk Assessment	>=95%	95.6%	95.8%	93.3%
	Ward Moves (>2)	=0	124	163	108
	Ward Moves (>2) Context	=0%	3.9%	4.5%	3.5%
	Delayed transfer of care	=23	0	92	59
	Falls per 1000 occupied bed days	<=5.5	4.8	4.5	5.3
	Harm Free Care (Safety Thermometer)	>=94.1%	94.3%	95.1%	92.9%
	Never event incidence	=0	0	0	1
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	1	1	0
	UTI with Catheters (Safety Thermometer-Percentage new)	<=0.2%	0%	0.4%	0%
	C-Diff	<=1.75	1	4	2
	MRSA	=0	0	0	0

	Indicator	Target	FEB-17	MAR-17	APR-17
Leadership & Improvement Capability	Medical Job Planning	>=90%	74.3%	76.5%	0%
	Percentage of all trust staff with mandatory training compliance	>=85%	83.3%	85.3%	85.5%
	Percentage of all trust staff with role specific training compliance	>=85%	79.7%	81.2%	81.0%
	Percentage of staff with annual appraisal	>=85%	84.4%	84.2%	83.6%
	Sickness Rate	<=3.8%	4.0%	3.6%	3.2%
	Staff: Trust level vacancy rate - All	<=7%	10.7%	10.6%	11.1%
	Staff: Trust level vacancy rate - Medical Staff	<=7%	9.5%	10.0%	10.7%
	Staff: Trust level vacancy rate - Other Staff	<=7%	11.0%	11.1%	13.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=7%	10.5%	10.0%	10.2%
	Turnover Rate	<=8%	9.7%	9.8%	9.8%

Run Date: 10/05/2017 14:39 Corporate Scorecard Run by: FrancisS

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

	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: A&E Performance	Externally mandated	Finance, Investment & Performance committee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	90.0%	94.6%	90.5%	92.2%	89.1%	84.8%	83.3%	83.2%	81.3%	78.1%	86.7%	87.4%
A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	=0	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	95	87	83	214	237	168	170
% being triaged in less than 20 mins	>=95%	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	69.1%	71.5%	70.9%	68.8%	64.0%	66.9%	72.2%

Driver for underperformance:

Main driver for underperformance is bed capacity

- Bed capacity
- Vacancies within medical staffing equating to 18 WTE across all of the grades (2 WTE in post since March 2017 report).
- Increased acuity is still well above baseline and in upper quartile.
- Capacity within department
- Increased attendances
- Decreased discharges in assessment areas throughout April.
- Specialty waits

Actions to address the underperformance:

- First assessment delay action plan in place, reduction seen in first assessment breaches.
- A&E trackers role defined, ensure they are now tracking each patients against ED operational standards and escalating.
- Overnight review meeting taking place if performance less than 90%
- Medical staffing rota reviewed and changes being implemented
- Consultant and NIC ‘on a string’ now in place
- Therapies trial in the ED continuing with good working and positive results, trial period extended.
- Advert out for Consultant in Emergency Medicine (sub speciality in paediatrics) applications received, interviews to be arranged.
- Early escalation to speciality teams should patients be waiting more than 30minutes (professional standards).
- Urgent Care Tracker trial on assessment areas as ‘non-clinical ward co-ordinators’, commencement 15th May for 8 weeks.
- NIC now carry a bleep to ensure contactable throughout department, and to ensure aware of all cardiac arrest, trauma and security calls (early escalation of multiple incidents).

	• Safety huddles increased to twice daily from 9th May 2017 • UCWG led by COO in place and meets fortnightly - Action plan presented in main body of report

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:
Average Ambulance Handover Times	Externally mandated	Finance, Investment & performance commitee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	547	405	275	239	151	229	220	247	147	303	159	91
Ambulance handovers that waited over 60 mins	<=10	253	130	47	15	11	47	21	36	35	61	23	12

Driver for underperformance:	Actions to address the underperformance:
Main area of underperformance is due to exit block in ED and the inability to off load ambulances quickly • Bed capacity within Trust • Multiple ambulance arrivals in quick succession • Increased attendances to A&E based on previous years data	• In absence of HALO crews to be requested to double up. • Clinical guidance being written to support crews remotely with GP advice between 0800-2300hrs, awaiting access to System One • Explore options to use ACC pathways so crews can directly refer into ACC (headache pathway being explored) • Two FIT bays (F9, F10) designated for ambulance off load and handover in place • Early escalation to EMAS silver to request HALO should the need arise. • 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. • Early escalation to EMAS/Ops room if multiple ambulance arrivals in quick succession (10 or more per hour). • If Trust status BLACK corridor to be staffed to support ambulance turnaround. • Black breaches escalated to Director on call

Lead Clinician:	Lead Manager:	Lead Director:

Dr Tristan Dyer	Paul Saunders	Deborah Needham

Enclosure H

Scorecard - Exception Report

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

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	52.4%	53.8%	51.8%	50.8%	56.4%	51.4%	55.5%	55.6%	52.6%	56.2%	51.7%	49.3%

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. • 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 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 closed then reopened.	• Focus Matron Group for SAFER bundle started within the trust and embedding continues. Red to Green implemented aims to ensure all patients have a senior review daily. • Project manager to be recruited for SAFER • 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. • Training continues organised across wards by Discharge Team around Trust Discharge Policy to reduce internal delays further. • Discharge Matron supporting the Stranded patient meeting with support and clear process. • Stranded patient >75yrs (LOS>7days) now at lowest percentage in last 12 months. Pro-active drive to continue positive trends in place.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Christopher Field	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	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Ward Moves (>2)		Not applicable until Nov 2016						124	142	122	124	163	102
Ward Moves (>2) Context								3.8%	3.9%	3.7%	3.9%	4.5%	3.5%

Driver for underperformance:	Actions to address the underperformance:
• High bed occupancy driving the use of escalation areas. The use of escalation areas increases the number • DTOC numbers / Discharge pathways meaning use of interim beds requires more patient moves. • Some patients moved to accommodate infection control precautions.	• Number of medical outliers has reduced from >100 over winter to <50 as we move into May. • Further embedding of Red/Green days to drive down LOS will enable patients to get to the most appropriate ward first time. • Pull model in Medicine to be strengthened to ensure the 'right patients are pulled to the 'right ward'. • Operational site team focus on daily process with inpatient capacity management in attempts to minimise any unnecessary moves.

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Chris Field	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Complaints responded to within agreed timescales	Externally mandated	Quality Governance Committee	April 2017

Performance and Trajectory:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Complaints responded to within agreed timescales	=>90%	88.6%	84.4%	87.5%	80.3%	88.6%	93.2%	93.2%	96.9%	88.0%	96.9%	88.0%	67.4%

It should be noted that the figures have been pulled forward by two months to show a completed scorecard. In this respect April's % relates to the complaints that were received in February but were responded to in April.

Driver for underperformance:

For Februarys complaints the following should be noted:

43 complaints received
6 complaints agreed up to 20 days (lower complexity)
36 complaints agreed up to 30 days (high complexity)
1 complaint agreed up to 40 days (significantly high complexity)
29 extension requests issued
14 holding letters sent

Reasons for underperformance:

- Newly appointed Complaints Officer still in training (reduced level of competency at this stage)
- Seconded Complaints Officer returned to substantive post (2 week gap)
- Complaints Officer returned from Maternity leave with a short induction period and reduced level of competency, improving weekly to date.
- Annual leave of other staff members, previously agreed
- 3 week period of sickness of senior Complaints Officer (ongoing at present)
- 14 extension requests required due to complaints resources

Actions to address the underperformance:

- Review of processes and workload undertaken to look for further efficiencies
- Prioritise Complaints Services activities
- Currently looking at contingency planning moving forwards
- Temporary staff utilised to cover unexpected sickness which currently is unknown in terms of length of time
- Weekly complaints report is issued to highlight any complaints out of time

• 15 extension requests required due to divisional / directorate pressures		
Lead Clinician:	**Lead Manager:**	**Lead Director:**
Not Applicable	Lisa Cooper	Carolyn Fox

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	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	91.5%	91.7%	90.5%	91.5%	91.8%	92.1%	93.0%	92.9%	94.0%	92.7%	93.6%	93.2%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.3%	91.7%	92.3%	91.6%	91.3%	91.8%	91.7%	92.6%	93.2%	93.0%	93.7%	92.7%	92.5%

Driver for underperformance:

- It is evident when reviewing the data set across the past 12 months that despite underperformance there is a continued upward trajectory, this is particularly evident within Inpatient and Day cases where we see a month on month improvement and have done for a number of months consecutively.
- As with Inpatient & Day Case areas we have also seen improvements within Outpatients. Following a number of static months, December and February saw levels reach above the national averages. It should be noted that results for Outpatients are around 1% lower than the national average.
- January saw the FFT Inpatient & Day Case results reach their highest levels to date of 94.1% satisfaction. When comparing 15/16 results to 16/17, there has been 3.1% increase in the average recommendation rates.

Actions to address the underperformance:

- Many actions are being undertaken to address performance all of which are evidently having an effect, particularly within Inpatient and Day Case areas.
- Two further local surveys have now commenced 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.
- Patient Experience now has a number of volunteers helping with card collections and data entry meaning data sets are becoming increasingly more representative of our population.

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:
Clostridium difficile Infection Trust attributable (post 3 days)	Externally Mandated	Quality Governance committee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
C-Diff	<=1.75	0	2	1	3	0	1	4	2	1	1	4	2

Driver for underperformance:	Actions to address the underperformance:
• The driver for underperformance is the trust trajectory for *Clostridium difficile* infection (CDI) for 2017-2018 which is 21 trust attributable CDI	• Post Infection reviews (PIR) are performed on all of the patients who have trust attributable CDI. These are reviewed by the Clinical Commissioning Group (CCG). The CCG decide if there has been any lapse in care. The Trust will continue the HCAI reduction Plan.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Harm Free Care (Safety Thermometer)	Externally mandated	Quality Governance Committee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Harm Free Care (Safety Thermometer)	>=94.1%	92.9%	93.4%	93.2%	94.3%	94.0%	93.1%	94.1%	95.3%	93.2%	94.3%	95.1%	92.9%

Driver for underperformance:	Actions to address the underperformance:
• Hospital acquired Pressure Ulcers remain above national target	• Actions are in place to continually reduce pressure damage • Second 90 day rapid improvement project commenced working with 4 wards. • Wards are trialling 'tests of change' specifically focussing on early identification, devices to reduce shearing and friction damage • Proactive changes to Manual Handling training to support clinical staff develop knowledge and skills associated in the reduction of pressure areas

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Fiona Barnes	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	April 2017 for Validated March 17

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	98.8%	100%	98.1%	97.8%	98.6%	100.0%	100.0%	98.3%	98.4%	95.8%	96.8%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	76.5%	81.8%	80.0%	76.9%	71.5%	81.6%	81.6%	85.9%	80.4%	79.6%	76.3%

Driver for underperformance:

7 out of the 9 Cancer Waiting Times Standards have been met by the Trust for March 2017.

It reached 76.4% (rounded down for internal reporting) against the required 85% for the 62 day standard. Radiology capacity has been a significant challenge to securing a diagnosis for patients, with particular issues for MRI, up to 4 weeks for an appointment and up to 5 weeks for some CT appointments. However, additional MRI capacity will be in place from the first week in May which should show an improvement on clearing the backlog of appointments pending and a new CT scanner will be operational by mid-May.

The Trust undertook 72 treatments for March a 22% increase on February performance but due to the 17 breaches for the month performance is currently lower than last month.

The Trust has failed to reach the standard for subsequent drug treatment reaching 96.8% against a standard of 98%. this was failed due to 2 patients not being treated on time, both due to fitness for treatment.

Actions to address the underperformance:

The Cancer services team are currently conducting a review of all new practices and tools developed in the past 8 months in order to support teams delivering cancer pathways, to ensure they are relevant and effective, this includes the support of our Information team to ensure forecasting and reporting of performance is robust.

The Trust continues to drive forward through individual site action plans and the overarching Trust recovery plan identified improvements in order to improve and sustain performance.

A full report is attached

Enclosure H

62 Day Standard –17 breaches 76.4% 7 tumour sites breached the standard in March Urology-5.5 breaches 3 patients initiated delays to their pathways, .1 patient had co-morbidities and was undecided on which treatment option which caused delays, 1 patient had numerous investigations which did have delays at each stage, 1 patient had an investigation cancelled by the Trust which caused a two week delay and would have been treated in time. Colorectal – 2 breaches 1 patient was unwell at the start of their pathway which caused significant delays, 1 patient had co-morbidities, had a complex diagnostic pathway and patient initiated delay. Head and Neck – 3.5 breaches 2 patients had a complex diagnostic pathway, 1 patient was due to diagnostic delays and 1 patient was delayed due to psychological issues related to the treatment plan on offer. Haematology – 2 breaches 1 patient was delayed due to an admin error as logged as a recurrence but was treated within 6 days of identification. 1 patient was transferred from the Head & Neck pathway and had a complex diagnostic pathway. Upper GI –1 breach This patient had a complex diagnostic pathway. Gynaecology –2.5 breach 1 patient was a late tertiary referral and we treated within 24 days, 1 patient was delayed as they had two hospital numbers with an investigation not being tracked on the correct id, 1 patient was due to	

investigation delay. Sarcoma 0.5 breach This patient was referred from the Breast site, had tertiary discussions and was treated at a tertiary provider which included delays from discussions between the two parties **Subsequent Drug Treatments – 2 breaches – 96.8%** The Trust failed to meet this standard due to 2 patients being unwell and unable to commence treatment in time.	

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	Quality Governance Committee.	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Medical Job Planning	>=90%	Not applicable until Sept 2016					0%	4.3%	51.5%	66.3%	74.3%	76.5%	0.0%

Driver for underperformance:	Actions to address the underperformance:
• Commencement of cycle year	• Support guidance developed and cascaded • Trust requirements discussed with Directorates • Clinical lead reviewing on-call with Directorate leads. • Medical Job Plan Assurance Group established to ensure consistency and an even-handed approach across the Trust, as well as compliance with the framework, the contract and all national guidance

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw	Sue Jacobs	Dr Mike Cusack

Scorecard - Exception Report

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

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Percentage of all trust staff with role specific training compliance	>=85%	75.2%	76.1%	77.0%	76.4%	75.1%	76.5%	77.1%	78.1%	79.0%	79.7%	81.2%	81.0%

Driver for under performance:	Actions to address the underperformance:
• Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. • The target to be achieved by March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Further work is being carried out on Blood Training by reviewing the positions that require this. • Work continues in aligning Role Specific subjects to positions, after managers have queried whether their staff require the training • We are investigating the possibility of setting role specific training against assignment as opposed to position.

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	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Percentage of staff with annual appraisal	>=85%	83.0%	83.0%	80.4%	81.4%	83.5%	81.8%	80.8%	82.0%	85.3%	84.4%	84.2%	83.6%

Driver for underperformance:	Actions to address the underperformance:
• The Trust set a target of 85% compliance for appraisals in line with the CCG's expectation. The CQC requirement was for an improvement, which we have made with compliance ratings increasing from 41% in March 2014 to 84.2% in March 2017, although the Trust met the 85% in January 2017.	• Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested. • All Divisional Directors and Divisional Managers will be reminded to have as one of their objectives that at least 85% of their staff must have an in-date Appraisal.

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 Turnover Rate	Internally set	Workforce Committee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Turnover Rate	<=8%	10.1%	10.0%	9.8%	9.6%	9.9%	9.8%	9.6%	9.2%	9.4%	9.7%	9.8%	9.8%

Driver for underperformance:	Actions to address the underperformance:
• Lack of opportunities for progression • Increase in numbers of staff retiring and returning • Increased Trust activity and effect on areas used as escalation areas	• Development of education initiatives via the apprenticeship levy. • OD undertaking work to improve the working environment • Staffing being provided with employee voice / Friends and Family Tests • Management Leadership programmes • Introduction of Flexible Retirement policy

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	April 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Staff: Trust level vacancy rate - All	<=7%	10.0%	9.8%	9.8%	11.1%	11.9%	11.1%	10.9%	10.6%	10.9%	10.7%	10.7%	10.6%	11.1%
Staff: Trust level vacancy rate - Medical Staff	=<7%	13.3%	11.8%	11.7%	11.6%	12.90%	10.00%	10.3%	11.0%	9.9%	9.0%	9.7%	10.0%	10.7%
Staff: Trust level vacancy rate - Other Staff	=<7%	10.8%	10.6%	10.8%	10.6%	11.50%	11.10%	11.3%	10.8%	11.0%	10.9%	11.0%	11.1%	13.8%
Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	11.6%	11.4%	11.2%	12.2%	12.10%	11.50%	10.5%	10.1%	10.9%	11.1%	10.5%	10.0%	10.2%

Driver for underperformance:	Actions to address the underperformance:
• There is a national shortage of nursing staff along with a shortage within other professional allied specialities • A General Hospital is not as attractive as Teaching Hospitals	• Trust Open Days in difficult to recruit areas • Forging links with local University to recruit Students • Dedicated roles within HR for recruitment and retention • More structured approach to Medical Staffing recruitment • Increased use of social networking and web site development. • Monthly meetings with managers to support clearance processes developing enhanced working relationships • 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 / 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	April 2017

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	6	4	2	0	2	2	0	0	2	2	1	1	1

Driver for underperformance:	Actions to address the underperformance:
28-day breach patient • TCI cancelled 7th March due to no beds. • No further capacity due to holidays and urgent cases. • All of subsequent theatre lists had major oncology cases, urgent patients and a 28-day patient on. There was no capacity to get this patient in before their 28-day breach date.	• All options were explored but there was no resolution on this occasion.

Lead Clinician:	Lead Manager:	Lead Director:
Mike Wilkinson	Fay Gordon /Julie Kelly	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
# NoF - Fit patients operated on within 36 hours	Externally mandated	Quality Governance Committee	April 2017

Performance:

Indicator	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
# NoF - Fit patients operated on within 36 hours	>=80%	84.6%	85.7%	57.1%	88.5%	80.0%	96.0%	48.5%	93.9%	63.1%	86.3%	85.7%	68.7%

Driver for underperformance:	Actions to address the underperformance:
• Excess trauma • 2 x no hip surgeon available at weekend for total hip replacement • Inability to transfer from ED to appropriate ward delaying theatre • 1 x too high risk to operate	• Extending trauma operating (will not commence until Oct 17) • Prioritising fractured NOF where possible • Improve pre-optimisation of fractured NOFs to ensure ready for theatre

Lead Clinician:	Lead Manager:	Lead Director:
Mr D Gidden	Lyndsay Woodbridge / Fay Gordon	Dr M Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated	Quality Governance Committee.	April 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Maternity: C Section Rates - Total	<27.1%	28.8%	25.2%	27.0%	27.8%	29.6%	28.1%	26.3%	27.5%	28.4%	24.5%	25.0%	28.9%	28.2%

Driver for underperformance:	Actions to address the underperformance:
• Total CS rate amber for last 2 months	• Continue monitoring – discussed at Governance meeting, Consultant meeting and Midwifery Leads meeting • Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making. • CTG training to be updated to further improve CTG interpretation and decision making – half day training now well established and first full day session was held in April with good feedback. • Matron – Intrapartum Lead to work on labour ward to support normality and provide challenge and support in clinical decision making • Continue with debriefs following all Caesarean Sections – work ongoing to improve documentation of this – Agreement to utilise Medway, awaiting Medway software update. • Ongoing Elective Caesarean Section audits – good compliance • Birth After Caesarean Clinic – working towards multidisciplinary clinic.

Lead Clinician:	Lead Manager:	Lead Director:
Mr Owen Cooper	Sandra Neale	Dr Mike Cusack

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 May 2017**

Title of the Report	**Sustainability and Transformation Plan Update**
Agenda item	13
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 papers 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.	
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 I

Actions required by the Trust Board/Committee

The Board to note the update

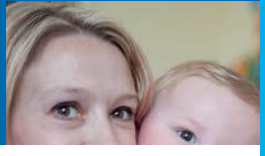
Northamptonshire's Sustainability and Transformation Plan 2016-2021

April 2017

Newsletter: Issue 1







Enclosure I

Complex patient care & urgent care

Urgent Care

The aim is to ensure people get the right care, first time – based on services closer to home. This will help to reduce A&E attendance, emergency admissions and the length of time people have to stay in hospital. This should result in greater patient satisfaction and a better quality of life. For urgent but non-life threatening care needs, highly responsive services will be provided outside hospital or as close to home as possible. For more serious or life threatening emergency needs, people will be treated in centres with high expertise, delivering the best possible outcomes – enabling as many patients as possible to return safely to their own homes.

Complex care

An increasing number of people have a range of long-term health conditions, such as a mental illness, diabetes, or heart failure. Their care is complex. Such people are often frail, vulnerable and potentially in need of a lot of support from both health and social care. Complex care can also be needed by some people who have been in an accident. The aim is to ensure that the care system identifies those considered to be most at risk and has the right services in place to keep them well. This gives people a better quality of life by keeping them independent and avoiding deteriorations in health so they don't have to be admitted to hospital.

Through this plan, there will be:

- Rapid access to GPs and community services such as physiotherapy, working together around the clock to provide support on the day people need it, so avoiding hospital care. Care homes will get more support to meet the needs of those they look after.
- More joined-up community care, including more services which allow people to leave hospital quickly. This will involve greater use of technology to monitor people at home and access to community support groups (for example, for those with eating disorders or alcohol issues).
- Co-ordinated urgent response when required. The joint working of NHS 111, carers and social care will be key to arranging the most appropriate service for their needs – so avoiding unnecessary visits to A&E.
- Efficient emergency care, with people streamed in A&E to direct them to the right place. GPs and the ambulance service will have direct access to services to avoid A&E attendance. The flow in hospitals will be managed better, with consistent standards seven days a week. New models of care will be introduced, and some services may be changed so they work better for patients and are more efficient.

For those identified as at risk, there will be:

- Proactive care targeted at those who most need it. Each of these individuals will have a personalised care plan in which they and their families have had a say, and support from integrated teams of health and social care professionals.

- Intermediate care for people recovering from an acute hospital stay – either at home or in a local bed. Different professionals working together will provide rehabilitation and other support for up to six weeks, to help patients return to their home (adapted if necessary) or to avoid unnecessary admission to hospital in the first place.
- Specialist care, re-designed to meet the needs of people with complex physical and mental health issues. Services will provide adequate access to specialist input with care that is safe, compassionate and person-centred.

Examples of Complex and urgent Care areas of works

Primary care same day access

A group of GPs are working together to make sure that patients who need to see a GP urgently on the same day are able to. This means releasing GP time to deliver care to those patient with complex care needs. An evaluation of the service is currently being scoped and will be undertaken in the next 3months. Primary care same day access, we will have 2 more networks delivery primary care same day access in the next 3 months.

Collaborative Care Teams

Through Multi community providers (MCPs) will deliver a coordinated care working at GP network level to those patient in the community with complex needs. From April 2017 the CCTs will align the work of existing health and care professionals towards personalised goals set by each patient, proactively managing their needs to avoid unnecessary admission to and enabling timely discharge from hospital.

In the next 3 months we will

- Establishing governance arrangements for delivery the urgent and complex patient care programme.
- Improving flow into and out of hospital through the development of new models of care and 'at scale primary
- Developing clearer solutions for individuals with long term conditions

Programmes of work

Prevention, community engagement & behaviour change

We already have some great work going on in the county to support people to manage their wellbeing. Through our plan, there will be a growing focus on staying well – helping people to make positive lifestyle choices, giving them the confidence to manage their health, and encouraging them to engage with the many local community and voluntary support networks which already exist. The aim is to create a healthier Northamptonshire population, improve the quality of people's lives and ease the demand for care services.

Through this plan, there will be:

- Prevention of ill health – both county-wide through information campaigns and at a personal level, through direct intervention by health and social care professionals.
- Effective prevention services, such as screening and immunisation programmes and support to make healthier lifestyle choices such as stopping smoking.
- Voluntary organisations with the right capacity to provide care services, building resilient and engaged communities.
- Social prescribing – people being directed to community support to improve population health and wellbeing.
- Individuals or their carers supported and empowered to be proactive in managing their own wellbeing.

Voluntary, Community and Social Enterprise (VCSE)

We are working towards the development of a common assurance framework for all VCSE organisations to facilitate improved acceptability and credibility for clinician referrals. The model process is likely to include the use of the PQASSO accreditation, a PQASSO lite version and small VCSE protocols. Current work includes intelligence gathering around current processes in Northamptonshire and detailing options and assessing the clinical appetite for risk. The impact of this work will be that there will be a level of assurance attached to services that is commensurate with the risk involved.

Social Prescribing

First for Wellbeing has a system (Octigo) established that is able to offer a single point of contact for social prescribing in the County, a range of services are already available through this route and GP's as well as other stakeholders are referring patients/customer through the system. This approach needs to be widened across the system to enable social prescribing to be accessed systematically across Northamptonshire. Work is underway with Comsortia, a Company Limited by Guarantee has been established to bring together the work of 19 individual contracts to remove duplication and to

ensure ease of access for patients/customers. There is an intention for all of these contractors, through Comsortia, to use Octigo for the administration and monitoring of these contracts.
The initial work is underway in the development for prevention, diversion, care-in-the-community and discharge services.

We are also creating a Northamptonshire-wide information hub.

We are also developing a therapeutic and low-level clinical social prescribing model to enhance the current offer that will facilitate faster discharge and lower the levels of readmission. Initial work has included a discharge needs survey and we are presently triangulating the survey findings with other available intelligence.

Northamptonshire Sustainable Development Unit (NSDU)

We are developing the NSDU, where sensible to do so, on the model for the national unit. The project lead has been identified and is now communicating with stakeholders having an interest in sustainability. A launch event is being planned for June 2017 with national experts and national and local case studies.

Carers Overnight Sitting Service

Age UK are providing a single point of access difficult discharge solution to discharge teams across all of Northamptonshire's main providers.

Patient Comments

'I'd been unhappy with my weight for a long time, and have other issues such as depression and anxiety stemming from this. Talking to my wellbeing advisor gave me the confidence to believe I can make a change, and made it easy for me to get started. For that, I will always be grateful. I've now started at Weightwatchers and I'm feeling good about taking control of the situation. This is a brilliant service'. FfW Customer

'Going home is daunting, can't walk well, need to learn to use new equipment to help with movement and mobility'. Patient perspective on hospital discharge concerns collected to inform Social Prescribing Programme development (VIN, 2017)

2 Things to Be Achieved in the Next Three Months

1. Agreement regarding a Social Prescribing Policy Statement for the whole County to ensure a shared understanding of what social prescribing means in Northamptonshire and what the programme aims to achieve in the short and long term.

2. Establishment of a Task and Finish Group to develop a system-wide Social Prescribing Programme for Northamptonshire, governed by the Health and Wellbeing Board.

Programmes of work

Scheduled care

Not all care is given in response to an urgent need. While it may require input from a specialist, a lot of care is routine. The aim is to ensure that these services are consistently of high quality, operate efficiently and can be easily accessed by those who need them.

Through this plan, we will be:

- re-designing care in ten different specialties, to create single streamlined county-wide services operating across organisations, with less duplication.
- Ensuring closer collaboration between medical teams at both our main hospitals and in other settings.
- Offering more specialist clinics in community settings, so people don't always have to travel to hospital for outpatient appointments.

This means that people receiving services will benefit from

- The same quality of care wherever they receive services in the county with clinical teams working more closely together, sharing expertise
- Increased use of skill mix e.g. specialist nurses
- Improved patient experience with improved access, telephone clinics and reduced waiting times
- Better use of system resources

Progress to date

Dermatology: Underpinning work has continued to ensure that pathways go live end Q1 including the identification of primary care service delivery, governance and administrative process.

Rheumatology: Underpinning work has continued to ensure that pathways go live end Q1 including development of nurse competency framework, new consultant in post NGH, and ongoing work on administrative pathway.

Orthopaedics: Governance established and baseline finance and patient activity scoping underway. IT solutions being investigated for 'hub' delivery with a potential activity shift from acute services. Clinical pathways and develop a standardised referral form e.g. physiotherapy and consultant triage. starting with spinal services and rolling out.

Cardiology: NGH consultant now working in KGH. Continued work on business planning related to finance and activity. Work progressing on catheter lab efficiencies. Clinicians looking at job roles required for shared services.

Pathology: The project initiation document has now been agreed by the CSB. The workstream is exploring options for digital histopathology, and have also ratified options for combining supplies.

Key Actions Next Period Q1 2017-18

Over the next quarter we will …

1. 'Go Live' with dermatology and rheumatology services
2. Meeting with GP Federations to develop clinical pathways for MSK 'hub'
3. Agree pathway of care for electrophysiology, and draft countywide business case
4. Draft business case for MRI
5. Analysis of consumables used in pathology services

How we are going to achieve this

Enablers

Communication and Engagement update

Since publishing the STP and public facing summary Dec 2016, we have been moving at pace to develop our thinking and plans around communication and engagement.

Strengthening leadership: The Programme Board have agreed Tansi Harper, Lay Member, Corby CCG as Board lead for communications and engagement, with Simon Deacon, Head of Communications and Marketing, Northamptonshire County Council as SRO.

Communication and engagement strategy: A draft is now out for discussion.

Website under development and quarterly reporting introduced

Stakeholder engagement: We have had early conversations with Healthwatch and are due to attend their April Board. We are also supporting a joint workshop with District and Borough Council teams in April, and are starting to plan a structured programme with the Health and Wellbeing Board.

Clinical Engagement: We are working closely with our Medical directors to re-launch and re-define our clinical oversight group. This is the group that ensures that all the changes proposed within our STP are safe for patients and will improve outcomes. We have also run a series of roadshows for GPs in Northamptonshire.

Patients and the Public: We are working with the East Midlands Academic Health Sciences Network (EMAHSN) to help us to evaluate where we are in terms of patient and public engagement, and to help us to plan our next steps. EMAHSN exists to spread best practice across the NHS, and they have a number of resources that will help us develop our approach. We have invited Northamptonshire Healthwatch to be part of those discussions. We have started to identify key actions across the programme and to embed leads within the working groups.

Next Quarter we will ….

- Meet with EMAHSN to plan our PPE approach
- Hold a workshop with the District and Borough Council Teams, and start to plan our approach to the Health and Wellbeing Board
- Finalise our strategy and delivery plan
- Launch our website and quarterly report.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**25 May 17**

Title of the Report	**Quality Account 2016/17**
Agenda item	**14**
Presenter of the Report	Dr Michael Cusack, Medical Director
Author(s) of Report	Mr Simon Hawes, Corporate Governance Manager Dr Michael Cusack, Medical Director
Purpose	To provide an overview and update of 2016/17 Quality Account

Executive summary

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services and look forward, explaining the Trusts priorities for quality improvement over the coming year.

The report contains a final draft of the Quality Account 2016/17. This report details the sections contained therein and the information that is required. The relevant NGH leads have been contacted for their relevant pieces of information (such as Clinical Audits and Information Toolkit information). Some of this information is still being collated and other parts will need to be updated prior to the final copy.

As with last year's Quality Account it will be a standalone document and not part of the Annual Report.

The draft is mainly text based to allow the Medical Illustration team to format and provide a desk top published version.

Related strategic aim and corporate objective	All
Risk and assurance	Provides assurance that the statutory requirement to produce a Quality Account with mandated content by the due deadline will be met.
Related Board Assurance Framework entries	

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	The Health Act 2009 requires all NHS providers of healthcare services in England to provide a Quality Account each year.

Actions required by the Trust Board

The Board is asked to:

- note the draft 2016/17 Quality Account
- provide any further improvements made during 2016/17 to include in the Account

Public Board

May 2017

Quality Account 2016/17

1. Introduction

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. It also identifies areas for quality improvement in the coming year which should focus on all the domains of quality;

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality or services and look forward, explaining the Trusts priorities for quality improvement over the coming year.

2. Timeline

The Quality Account must be uploaded to the NHS Choices website by ***30 June 2016***; but prior to this will be required to be signed off by Trust Board, Audit Committee and our external auditors. The Quality Account should be sent for engagement with patients, staff, shadow governors and it must also be submitted for review and comment by local partners/ stakeholders, including:

- NHS Nene and Corby Clinical Commissioning Group
- Healthwatch Northamptonshire
- Northamptonshire County Council Health Social Care Overview and Scrutiny Committee

3. Quality Account 2016/17

In preparing the 2016/17 Quality Account attention is given to a number of documents:

- The Quality Accounts toolkit (Toolkit)
- NHS England letter dated 6 January 2017 on Reporting Arrangement 2016/17 (NHSE)
- Guidance for NHS Trusts on arrangements for external assurance 2014/15 (External)
- Quality Accounts: a guide for Local Involvement Networks (LINks); Quality Accounts: a guide for Overview and Scrutiny Committees;
- Other NHS Trusts Quality Accounts (Others (Stakeholders)
- Health Act 2009 (HA Reg)
- Previous NGH Quality Accounts including comments from external stakeholders in previous Quality Accounts (Previous)

The table below details the current draft Quality Account contents and whether a draft for that part is complete.

Part	Title	Requirement	Comments
Intro	What is a Quality Account	Toolkit 4.10	Written by Governance to explain what a Quality Account is and why it has been produced
	Northampton General NHS Trust	Previous	Written by Governance to inform readers about NGH and what services we offer
One	A statement on quality from our Chief Executive	HA Reg. 1 & 6	In progress with the Medical Director
	Statement of Directors' Responsibilities	HA Reg. 1 & 6 & NHSE	The wording for this is taken from the Guidance for NHS Trusts on arrangements for external assurance 2014/15 published in January 2015 and will be required to be signed prior to uploading to NHS Choices by deadline of 30 June
Two	Priorities for improvement 2015/16	Toolkit 4.87	This provides an opportunity to report back on the progress of the previous year's priorities.
	General Improvement in 2015/16	Previous	The Director of Nursing, Medical Director and Governance have provided this
	Priorities for improvement 2016/17	Toolkit 4.13 & HA Reg. 1 & 6	It is a requirement to include at least three priorities for improvement in this forward looking section. The priorities were chosen after consultation with staff, stakeholders and the public.
	Learning from Patient Feedback (Encompassing the Friends & Family Test, Complaints & PALS)	Toolkit 5.17 & Toolkit 5.21	This has been provided as a joint report from PALs, Complaints and Patient Experience and covers the wording mandated by the Toolkit
	NHS Staff Survey	NHSE	This was provided by Human Resources
	Statement of assurance from the Board	Toolkit	Mandated content
	Review of Services and Review of Quality	Toolkit 4.26 & previous	This was provided contracting, strategy, governance and informatics
	Participation in clinical audits and national confidential enquiries	Toolkit 4.31 & 4.36	This was provided by Clinical Audit and covers the wording mandated by the Toolkit
	Local Audits	Toolkit 4.32	
	Participation in Clinical Research	Toolkit 4.57	This was provided by Clinical Research and covers some of the wording mandated by the Toolkit
	Use of Commissioning for Quality and Innovation	Toolkit 4.64	This was provided by Governance and covers the

	(CQUINs) payment framework		wording mandated by the Toolkit
	Local Quality Requirements	Previous	
	Statements from the Care Quality Commission (CQC)	Toolkit 4.71 & NHSE	
	Implementing Duty of Candour	NHSE	
	Hospital Mortality Monitoring	Previous	In progress
	Patient Safety Improvement Plan	NHSE	
	NHS Staff Survey	NHS	This was provided by Human Resources
	NHS Number and General Medical Practice Code Validity	Toolkit 4.78	This was provided by Informatics and uses the wording mandated by the toolkit
	Information Governance Toolkit attainment levels	Toolkit 4.82	This was provided by Governance and covers the wording mandated by the Toolkit
	Clinical Coding Error Rate	Toolkit 4.84	This was provided by Coding and covers the wording mandated by the toolkit
	Performance against national quality indicators	Toolkit 4.77 & NHSE	The NHS England letter dated 16 February 2012 on Reporting Requirements for 2011/12 and Planned Changes for 2012/13 introduced mandatory reporting against a small core set of quality indicators. These indicators were introduced in 2012/13 and have been developed since then. The requirement is now set out in the NHS England letter mentioned above. It not only sets out those indicators which must be included but also mandates it should be in table format with the score shown for at least the last two reporting periods and they must be compared against national averages and high/low scores. The letter further dictates that for each of the indicators the following statement must be included: • The [name of trust] considers that this data is as described for the following reasons [insert reasons]. • The [name of trust]

			[intends to take/has taken] the following actions to improve this [percentage/proportion/score/ rate/number], and so the quality of its services, by [insert description of actions]. The data was taken from the NHS Digital website by Governance. The Quality Account has used the wording above as a guide with the Core Quality Indicators still covering the requirements.
	Review of Activity 2015/16	Previous	This was provided by Informatics
Three	Review of quality performance (2015/16 Corporate Scorecard)	Previous	To be provided by Informatics
	Stakeholder statements	Toolkit 4.104 & 8.2 & HA Reg. 5, 8, 9 & 10 & Stakeholders & NHSE	A draft Quality Account will be sent to NHS Nene and NHS Corby CCGs, HealthWatch Northamptonshire and Northamptonshire County Council Overview and Scrutiny Committee. Once comments have been received from them they will be included in the next draft.
	Independent Auditors Limited Assurance report	External & NHSE	A draft will be sent to our external auditors (KPMG) to provide an assurance report. Governance will work with them to ensure the mandated contents of the Quality Account are covered. The auditors have to audit two indicators (from four) and the trust decided that the following would be audited: • Rate of clostridium difficile infections • FFT patient element score The auditors are yet to conduct this audit but leads have been notified.
	Abbreviations	Previous	Included to assist readers with abbreviations contained with the report.

4. Recommendations

The Board is asked to:

- note and approve the final draft of the 2016/17 Quality Account

5. Next steps

- Commence and finalise medical illustration input
- Upload to NHS Choices by 30 June 2017.

Northampton General Hospital
NHS Trust

QUALITY ACCOUNT 2016/17

Contents

Northampton General Hospital NHS Trust

Introduction

What is a Quality Account?

A Quality Account is a report about the quality of services we provide. The report is published each year and made available to the public. We believe our quality account is important because it provides us with a way of letting people know about the improvements we have made to our services as well as their overall quality. We measure the quality of services by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

The Department of Health requires organisations like Northampton General Hospital to submit their quality account to the Secretary of State by uploading it to the NHS Choices website by 30th June each year.

Northampton General Hospital NHS Trust (NGH) – about us

NGH is an 800-bedded hospital providing general acute services for a population of 380,000 and hyperacute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 692,000. There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. We employ 4, 800 staff, which includes 496 doctors, 1,074 nursing staff and 2,587 other healthcare professionals and non-clinical staff.

Our principal activity is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a small amount of healthcare to private patients.

We are an accredited cancer centre, providing cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, we provide outpatient and day surgery services at Danetre Hospital in Daventry and have dedicated beds at the Cliftonville Care Home, Spencer Care Home and Angela Grace Care Home for patients who no longer require acute inpatient care. We are responsible for the medical care of patients transferred to those care homes, whilst all nursing care and management is the responsibility of the home.

We are constantly seeking to expand our portfolio of hyperacute specialties and to provide services in the most clinically effective way. Examples are developments in vascular surgery and laparoscopic colorectal surgery, which place us at the forefront of regional provision for these treatments.

We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals. Our training and development department offers a wide range of clinical and non-clinical training courses within our own excellent training facilities which were recently upgraded.

Division: Medicine & Urgent Care

Directorate	Services			
Urgent Care	A&E	Benham Assessment	Emergency Assessment	Ambulatory Care
In patient Specialities	Cardiology	Nephrology	General medicine	Gastroenterology
	Endoscopy	Thoracic medicine		
Outpatient & Elderly & Stroke Medicine	Neurology	Rheumatology	Dermatology	Geriatric Medicine
	Stroke services	Rehabilitation	Main Outpatients	Neurophysiology
	Diabetes	Endocrinology	Day Case Area	Danetre Outpatients

Division: Surgery

Directorate	Services			
Anaesthetics, Critical Care & Theatres	Anaesthetics	Critical Care	Theatres	Pain Management
	Pre-operative assessment			
Head & Neck & Trauma and Orthopaedics	Audiology	ENT	Maxillo Facial Surgery	Opthalmology
	Oral Surgery	Orthodontics	Restorative Dentistry	Trauma & Orthopaedics
General & Specialist Surgery	Colorectal Surgery	General Surgery	Plastic Surgery	Upper GI Surgery
	Vascular	Urology	Endocrine Surgery	Breast Surgery

Division: Women's & Children's and Oncology / Haematology services and Cancer Services

Directorate	Services			
Women's	Gynaecology	Obstetrics	Gynaecological Oncology	
Children's	Neonatology	Paediatrics	Community Paediatrics	Paediatric Audiology
	Paediatric Physiotherapy	Community Paediatric Nursing		
Oncology / Haematology services and Cancer Services	Clinical Oncology	Medical Oncology	Haematology	Radiotherapy
	Palliative Care	Cancer services		

Division: Clinical Support Services

Directorate	Services			
Imaging	Breast Screening	Imaging Physics	Interventional Radiology	Radiology
	Nuclear Medicine	Medical Photography		
Pathology	Microbiology	Histopathology	Biochemistry	Immunology
	Infection Prevention			
Clinical Support	Therapies	Pharmacy	Medical Education	Research & Development

Northampton General Hospital NHS Trust

Part One

A statement on quality from our Chief Executive

At Northampton General Hospital we are committed to providing the very best possible care for each of our patients. This is underpinned by a focus on our key values, all of which have a critical role in providing high quality care. As we build a culture where patient safety stands out as our overarching concern and where every member of staff understands their role in improving this, we have also made a commitment to continual quality improvement in an atmosphere of respect and support.

Our Quality Account gives an overview of the Trust's performance in providing high quality care for our patients and their families and also sets out our priorities for improvement.

The experience that our patients and visitors have however goes well beyond the things we can measure in terms of outcomes of treatment. We are proud of the motivation our staff show for the delivery of the care and compassion they would like a member of their own family to receive.

Whilst the pressures on the NHS are obvious and the demand for our services continues to grow, our staff have continued to provide the best care they can and have increasingly worked towards a 'team NGH' approach to support ambitious programmes of work which will support better care for our patients and a better working environment for staff.

The views of our staff, patients and their carers have been brought together in our Quality Improvement Strategy which forms the basis of our quality priorities over each of the next three years. On the understanding that better quality care is better value for patients and the taxpayer, we have committed to support a culture where quality improvement drives programmes of change to ensure the care we provide is better for patients, better for staff and are resources are used most efficiently.

We have made significant progress against the priorities we set ourselves for 2016/17 which was year one of our Quality Improvement Strategy. For example:

- We have improved the safety of our patients through a reduction in falls which result in harm and the number of patients who develop a pressure ulcer whilst we are caring for them.
- Infection prevention is an important issue for us and we have seen a further reduction in the number of patients who develop and infection as a result of the care they receive at NGH.
- We have improved the timeliness of treatment for those patients who have developed a serious infection (sepsis) where any delay can adversely affect the outcome.
- We have continued to invest in our staff though programmes of leadership and development focussed on improving quality. This has contributed to the positive work that we have done on the safety culture in key areas of the Trust.

The Trust has been recognised nationally through a number of awards and continues to actively support our doctors in training, medical students and student nurses in quality improvement with many being invited to make national and international presentations. This is part of our plan to extend our role in education and training, understanding that it not only has a positive impact on patient care but is also an investment in the workforce of the future. We recognise the need to

continue the work to ensure that quality improvement priorities underpin all of our change programmes and that in these and other endeavours, we remain focussed on the things that matter most to patients and staff.

Dr Sonia Swart
Chief Executive

Statement from the Director of Nursing & Midwifery and the Medical Director

The cornerstone of Northampton General Hospital NHS Trust's philosophy is to provide the best possible care for all our patients, underpinned by our values:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each other

We have successfully delivered Year 1 of our three year Quality Improvement Strategy with programmes aligned to our Quality Priorities to make our care safer, more effective and to improve the experience of our patients and families.

We have achieved the majority of our key performance indicators including the Referral to Treatment Time but did not achieve the national access standard of 95% for patients being treated within four hours in the Accident and Emergency Department. Although this was disappointing, our patients have rated their experience highly and we were assured that patient care was not adversely affected.

The focus on patient safety remains a priority for all our staff and this culture is embedded throughout the Trust. We continued to make significant progress in reducing the numbers of hospital-acquired pressure ulcers and consistently improved the delivery of harm free care as measured by the "Safety Thermometer".

We continue to encourage our staff to report incidents so that we are able to improve the care given to our patients as a result of learning from incident reports and investigations. During the year, we focussed our work in infection prevention and control on reducing the number of patients contracting C Difficile and MRSA.

Our improvements in patient experience have been recognised nationally with a prestigious award from the Patient Experience Network. Our patients are telling us the care we are providing is improving, with 92.3% recommending our services to their family and friends in comparison to 89.2% last year.

The results of the National Staff Survey were exceptionally positive this year which continues to build on the year improvements that we have made since 2013. The survey showed 12 statistically significant improvements including overall levels of staff engagement with no areas of deterioration. There were significant improvements in staff recommending the Trust as a place to work, staff agreeing that their role makes a difference to patients and their carers and the satisfaction of staff with the quality of the work that they are able to deliver. Overall, we were in the top 5 most improved Trusts in the country.

One area of concern that has come through from the survey is that not all of our staff are consistently living our Trust value of 'we respect and support each other'. This will be an area of focus for us in the coming year.

We welcomed the sustained improvement in the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) which are among the lowest in our peer group and reflect our aim to place patient safety above all else. Building on our work in this area we are

further improving engagement with bereaved families and carers and extending reviews to all patients who have died to ensure that we are capturing learning wherever possible.

In March 2017 the Board reaffirmed its commitment to the Trust values which ensure that behaviours underpin the strong patient-centred culture at Northampton.

We would like to pay tribute to the hard work and dedication of staff at Northampton General Hospital and the invaluable assistance provided by our many supporters, including volunteers, and support groups. The improvements our staff continue to make to ensure that patients receive the care they deserve are inspiring. The Director of Nursing and Medical Director are fully committed to the delivery of the improvements described in the Trust's Quality Strategy and this Quality Account describes those achievements and our plans for next year.

Ms Carolyn Fox
Director of Nursing, Midwifery & Patient Services

Dr Michael Cusack
Medical Director

Northampton General Hospital
NHS Trust

Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors have taken steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

30 June 2017
Paul Farenden
Chairman

30 June 2017
Dr Sonia Swart
Chief Executive

Part Two

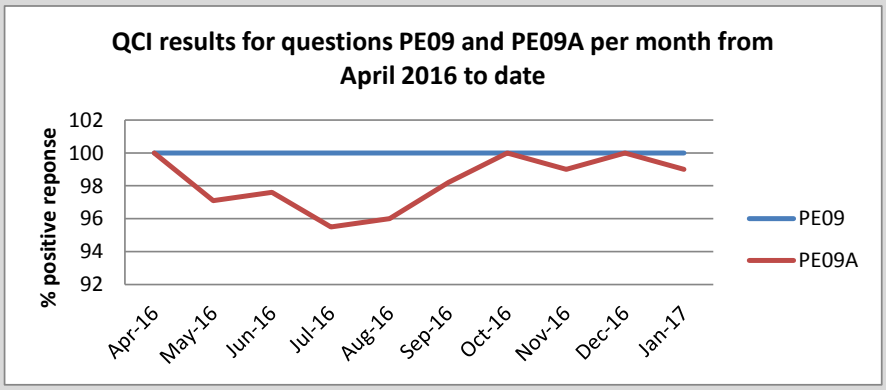
Priorities for Improvement 2016/17

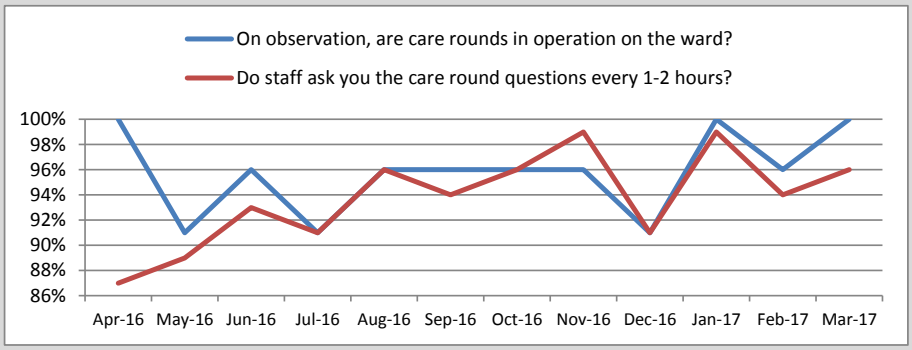
Patient safety is the cornerstone of our philosophy at Northampton General Hospital - it is at the heart of everything we do. Our Quality Improvement Strategy sets out our ambition and aim to provide the best possible care to all our patients. Our quality priorities are focused on improving the safety, efficiency and effectiveness of the care we provide, as well as improving our patients' experience.

The information presented within this report summarises the progress made on the priorities we set ourselves in the first year of our Quality Improvement Strategy.

We said we would: *Provide care that is clinically effective by delivering reliable care by increasing compliance with Intentional Rounding. Intentional rounding (also known as essential care rounds) are regular, planned 'nursing care rounds', to check on patients and ensure that their essential care needs are met.*

What we achieved:

What:	Improving compliance in key process measures for Intentional Rounding
How Much:	Greater than 90% as measured on a monthly basis via Quality Care Indicators (QCI's)
When:	March 2017
Outcome:	All inpatient adult wards use the Intentional Rounding tool which incorporates the main questions asked to patients around pain, the need for food/ fluid and their toileting needs, plus safety checks within the environment such as having call bells to hand, and moving aids available. As well as repositioning checks, our charts also allow staff to plan and record the delivery of care given for personal hygiene, patient moving, prevention of pressure damage, and checking of equipment and aids. Compliance with this is monitored on the monthly QCI audits with the following questions: **PE09 – Are care rounds in operation on ward?** **PE09A – Do staff ask you the care round questions every 1-2 hours?**  The results during 2016/17 show that care rounds are in operation on our adult

	wards and that staff ask the care round questions with a high degree of consistency. Further data has been obtained from direct observation of ward practice. A snapshot of the data from 2016/17 Quarter 4 shows a compliance rate of 98.6% with Intentional Rounding against a target of 90%. We also asked our patients whether Intentional Rounding is undertaken 1-2 hourly and our compliance with this was 96.3%:  The key actions are in place to support further improvements in the reliable completion of Intentional Rounding are: • A task and finish group for Intentional Rounding (essential care rounds) has been established. A revised Intentional Rounding tool is being developed using Quality Improvement methodology. • An Intentional Rounding Best Practice Guideline is being developed, incorporating guidance for completion. • Placemats are on each Adult in-patient bed table with information for patients and carers on Intentional Rounding. • A Patient bedside booklet including information on Intentional Rounding has been developed.

We said we would: *Provide care that is safe by reducing in-patient falls with harm.*

What we achieved:

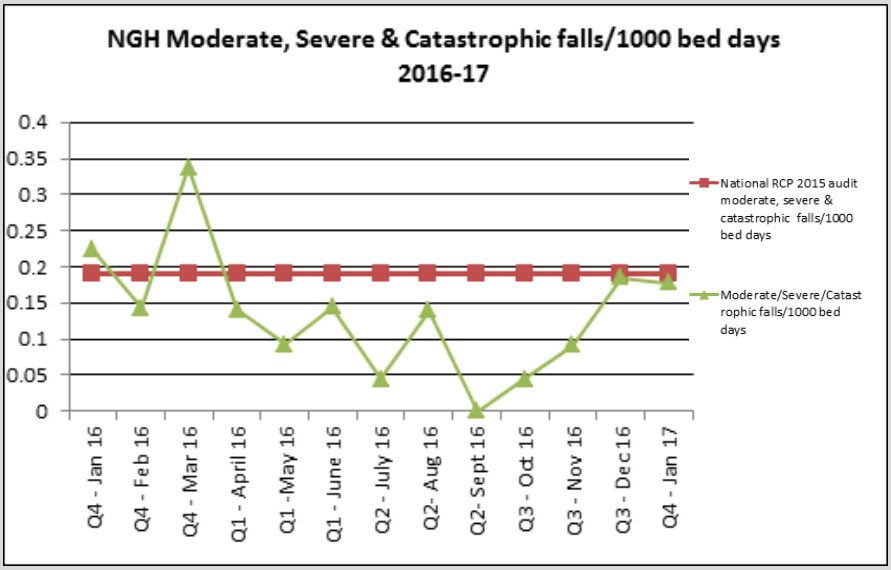
What:	To reduce the number of in-patient falls with harm
How Much:	The falls assessments will be completed within 12 hours of admission for 92% or more of our patients Falls care plans will be completed within 12 hours of admission of 87% or more of our patients We will review and improve the current process for post-fall reviews We will develop a delirium policy to improve the management patients with confusion We will improve the medication review process for patients who are admitted with

	a fall and those at risk of falls We will ensure that more than 85% of relevant staff have had Falls Prevention Training Examples of harm occurring from falls includes: Low harm – a graze or a bruise Moderate harm – a fracture of a wrist or a laceration that requires sutures Severe harm – a fracture of the hip Catastrophic – death as a direct result of the fall
When:	March 2017
Outcome:	There were 306 inpatient falls with harm in 2016/17 compared to 354 in 2015/16. This is a reduction of 13.6%. In the year to date the Trust has achieved the target for Falls Risk Assessment completion with an average of 93% recorded. A new post-fall medication form to support patient assessment was developed and trialled in quarter 2. This has since been reviewed and further changes made in response to feedback. A further trial is planned which will coincide with the rotation of our junior doctors. The Delirium Policy has been developed and is progressing towards ratification. Pharmacy processes to undertake medication reviews for those who are at risk of falling have been reviewed. The process has been embedded on each ward and makes use of specific stickers, documentation and verbal handovers. Adjustments have also been made to the electronic prescribing system so that high risk medications are highlighted. The compliance with falls training has improved during 2016/17. It remains below our target of 83% and we have work underway to address this: . We remain on a continual improvement journey in the reduction of patient harm from falls which we are working on through: • Working with NHS Improvement as part of a National Collaborative • A review of the falls risk core care plan that has been ratified and awaiting launch • Development of a multifactorial/multidisciplinary risk assessment document • Key targeted support for areas of high incidents of falls • Supporting wards to develop tests of change using quality improvement methodology • Working collaboratively with the frail and elderly team • Review of bedrail risk assessments • Introduction of quarterly bedrail compliance audits • Monitoring of training compliance with bespoke training delivered as required • Development of role specific training • Relaunch of the falls Multidisciplinary Team Meetings with increased input from clinical areas

	A Falls Collaborative has been planned to take place in Quarter 2 (2017/18)

We said we would: Reduce Avoidable Harm from Failures in Care: Falls with Harm

What we achieved:

What:	To reduce moderate, severe and catastrophic falls/1000 bed days
How Much:	Reduction of 0.02 moderate, severe and catastrophic falls/1000 bed days and maintain rates below the Royal College of Physicians (RCP) national threshold of 0.19 moderate severe and catastrophic falls/1000 bed days
When by:	31st March 2017
Outcome:	In the year to date: • The Trust has reduced the rate of moderate, severe and catastrophic falls/1000 bed days by a mean average of 0.03. • The Trust has consistently remained below the RCP national threshold up to the year to date.  Over the last year the Inpatient Falls Prevention Team have focussed on best practice and developing care plans to reduce each patient's risk of a fall. A trust-wide quality improvement project on Lying and Standing Blood Pressure was commenced which included: • A trust wide audit of availability of manual sphygmomanometers and stethoscopes - all wards now have these, • Lying Standing Blood Pressure guidelines have been reviewed, updated and new laminates are available on all wards as part of the SilverLinks folder and are available on the intranet • A Lying Standing Blood Pressure workshop was held as part of a Frailty seminar as well as continuing ward based training To improve Staff knowledge and practice with Neurological observations a training programme has commenced and been delivered in conjunction with the Simulation Suit.

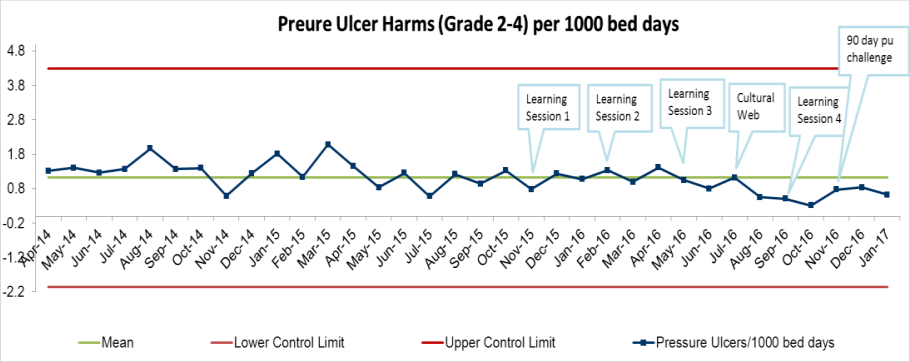
	A new head injury poster and neurological observations poster has been completed and has been circulated to all ward areas and is available on the intranet. A new Falls Care Plan has been trialled and continues to be developed across the Trust. The Bed Rails care plan has also been updated and reviewed. This continues to be trialled across inpatient ward areas. A 'Top Six' task and finish group established in September 2016 has involved the six wards across the Trust with the highest number of falls. Each of these ward areas has developed action plans and initiated 'Tests of Change'. Positive results have resulted from this approach with a reduction in falls on three of these wards during this period. Specific Health Care Assistant and International Nurse Training has been commenced alongside the Trust wide training programme with work underway to support areas to identify their role specific training needs. Ward level information is analysed for trends to focus further improvement work to reduce the future risk of falls. Quarterly Bed Rail Audits have commenced allowing practice to be reviewed, informal teaching and learning to commence, and areas for improvement to be identified.

We said we would: Reduce harm from hospital acquired pressure ulcers

What we achieved:

What:	To reduce the number of Hospital Acquired Grade 2 & 3 Pressure Ulcers. The Trust will have no Hospital Acquired Grade 4 Pressure Ulcers
How Much:	A reduction on 2015-2016 incidence
When By:	By March 31st 2017
Outcome:	From April 2016 to March 2017 there were a total of 164 grade 2 hospital acquired pressure ulcers. When compared to the same time period for 2015/2016 this represents a reduction of 22% Between April 2016 and March 2017 there have been a total of 31 grade 3 hospital acquired pressure ulcers. When compared to the same period for 2015/2016 this represents a reduction of 45% There have been no grade 4 pressure ulcers since May 2013 Overall the Trust has achieved a 28% reduction in pressure ulcers in 2016/2017

Hospital Acquired Pressure Ulcers	Grade 2	Grade 3	Total
2015-2016	210	59	265
2016-2017	164	31	194
% reduction	22%	45%	28%



We achieved this reduction in harm by:

- A change in culture. Openly acknowledging the challenges we faced in relation to the harm caused to our patients through the development of a pressure ulcer.
- Quality Improvement session led by the Director of Nursing was designed to challenge well-established cultural norms with the express purpose of re-establishing patient focused care by creating new norms and a fundamental belief that zero harm can be achieved. This included the removal of terminology such as avoidable/unavoidable pressure ulcers and focused on lapses in care.
- Development of a grade 2 pressure ulcer post incident report (PIR) tool to identify the reasons why the pressure ulcer developed and to identify lessons learnt.
- Sharing and learning from incidents at the Pressure Ulcer Prevention Group.
- Increased training for all nurses and allied health professionals, including simulation suite work.
- Development of a 'SWOT' team to provide prompt targeted support for areas of increased incidence of pressure ulcers.
- Successful tests of change developed from the pressure ulcer collaborative are being implemented across the Trust.
- 90 day rapid improvement model has been commenced to support teams to develop changes using quality improvement methodology
- Practice Development Team are currently undertaking a review of training in relation to continence management and skin care.
- Raised awareness through a monthly newsletter.
- Compliance with positional changes for at risk patients as part of Intentional Rounding.
- Trust wide SSKIN compliance audit with learning from the results shared across the Trust.

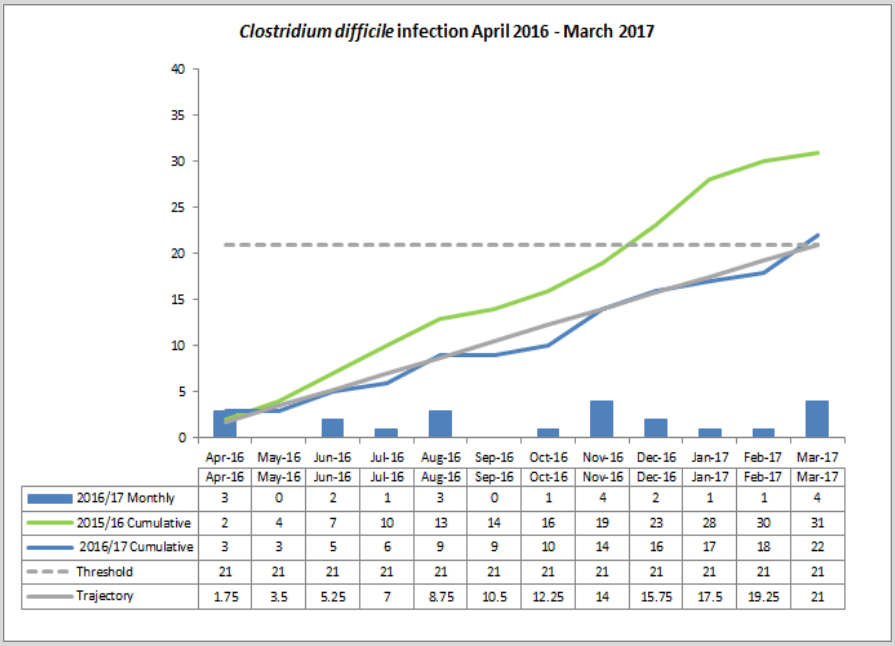
Whilst there has been a reduction in the overall number of patients developing pressure ulcer harms over the last 6 months, we are clear that there is still work to do.

	A Pressure Ulcer Collaborative using a 'Breakthrough Series Model' commenced in October 2015 with representation from relevant clinical professional groups and most wards. A series of learning sessions have been held through the year and the work will culminate in a pressure ulcer prevention summit in spring 2017.

We said we would: Reduce the number of patients with Trust attributable *Clostridium difficile* infection

What we achieved:

What:	Reduce the number of *Clostridium difficile* infection (CDI)
How Much:	Less or equal to 21 cases 2016/2017
When:	March 2017
Outcome:	Between April 2016 and March 2017 there have been 22 patients with CDI infection (this figure includes 1 patient who had a false positive result – they were subsequently found to have a negative result CDI result on external review). The 22 patients have been reviewed by the Trust local Clinical Commissioning Group (CCG) and there were no lapses in care identified. In 2015 /2016 there had been 31 patients with CDI. The outcome in 2016/17 represents a 32% compared with the previous year.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
2016/17 Monthly	3	0	2	1	3	0	1	4	2	1	1	4
2015/16 Cumulative	2	4	7	10	13	14	16	19	23	28	30	31
2016/17 Cumulative	3	3	5	6	9	9	10	14	16	17	18	22
Threshold	21	21	21	21	21	21	21	21	21	21	21	21
Trajectory	1.75	3.5	5.25	7	8.75	10.5	12.25	14	15.75	17.5	19.25	21

Northampton General Hospital (NGH) Trust progressed this priority by:

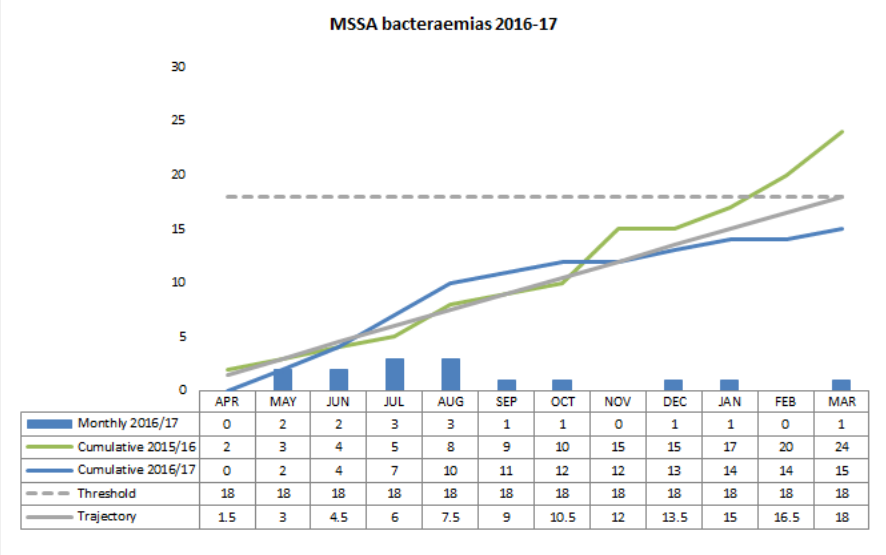
- Development of a *Clostridium difficile* infection improvement plan which has also been monitored through IPSG.
- NGH Trust became part of the NHS Improvement 90 day Healthcare Associated Infection (HCAI) reduction collaborative with 22 other trusts from across the country.
- The weekly C.diff round continues where patients with C.diff acquisition are reviewed by the Consultant Gastroenterologist, Consultant

	microbiologist, Antimicrobial pharmacist, a member of the Infection Prevention Team and now in addition our newly appointed Nutritional Nurse Specialist. • In January 2016, the Infection Prevention Team and in collaboration with the domestic services team commenced enhanced cleaning. This procedure ensures that when a ward has a patient or patients who present a high risk of cross-infection, enhanced environmental cleaning support is implemented to reduce the risk.

We said we would:

Provide care that is safe by reducing harm by reducing hospital acquired methicillin sensitive Staphylococcus aureus (MSSA) bloodstream infections.

What we achieved:

What:	Reduce the number of patients with MSSA
How Much:	In 2015/2016 24 patients developed a Trust attributable MSSA bacteraemia. For 2016/2017 the Infection Prevention forward plan was to have no more than 18 patients with Trust attributable MSSA bacteraemia,
When:	March 2017
Outcome:	Between April 2016 and March 2017 there were 15 patients with a Trust attributable MSSA bacteraemia. This represents a reduction of 38% on the previous year:  Northampton General Hospital Trust progressed this priority through: • The implementation of the MSSA bacteraemia reduction plan for 2016/2017. • Post Infection review meeting within 48 hours for every case of NGH trust attributable MSSA bacteraemia • Discussion of all incidents at the monthly Infection Prevention Operational Group.

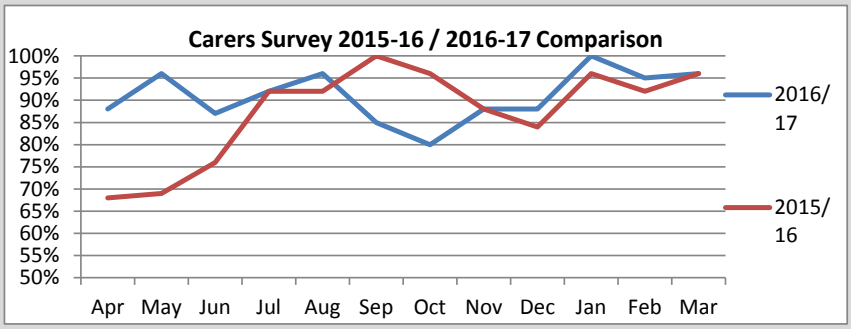
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Monthly 2016/17	0	2	2	3	3	1	1	0	1	1	0	1
Cumulative 2015/16	2	3	4	5	8	9	10	15	15	17	20	24
Cumulative 2016/17	0	2	4	7	10	11	12	12	13	14	14	15
Threshold	18	18	18	18	18	18	18	18	18	18	18	18
Trajectory	1.5	3	4.5	6	7.5	9	10.5	12	13.5	15	16.5	18

	• Lessons learnt and MSSA patient cases shared across the Trust through Infection Prevention Team patient safety alerts and ward huddle sheets • ANTT(Aseptic Non-Touch Technique) refresher training for any ward that has a line-related MSSA bacteraemia

We said we would:

Aim to Deliver Patient and Family Centred Care Using the Dementia Carers' Survey Results.

What we achieved:

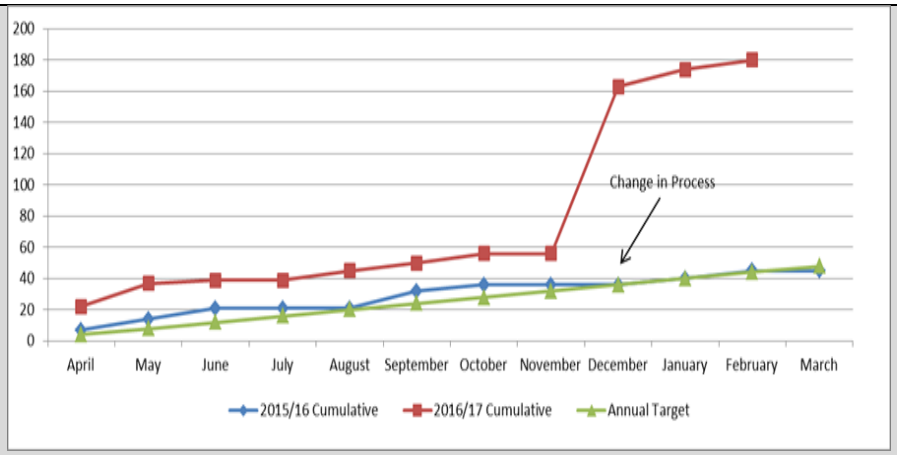
What:	Understand the needs and improve the experience of carers of those living with Dementia when they are admitted to hospital. A minimum of 25 carers of patients living dementia are asked each month if they feel supported and involved with the care of their loved ones.
How Much:	Continuous improvement
When:	March 2017
Outcome:	 A snap shot of the Quarter 4 data shows that in 2016/2017 97% of carers felt supported and involved in the care of their loved ones compared to 94.6% in 2015/2016 We are improving the care of people living with dementia by: • Developing survey feedback mechanisms to the clinical areas • Incorporating the feedback into teaching plans • Share the feedback in Dementia awareness sessions, inside and outside of the Trust • Review of the patient profile/passport to improve communication • Developing relationship/communication channels with care homes • Carers and outside agencies are an integral part of the Dementia steering group • Support of John's campaign, which is based on a simple belief that carers of patients living with dementia should be welcomed into our hospital, and that collaboration between the patients and all connected with them is crucial to their health and their well-being

We said we would:

Provide care that is safe by reducing harm through increasing the number of Executive Safety rounds.

What we achieved:

What:	Executives and Non-Executive Board Members will visit clinical and non-clinical areas speaking with staff and patients. Speaking with patients and their carers during the safety rounds provides a timely opportunity to capture real time patient and carer feedback capturing good practice and areas for improvement. Executive Safety rounds have been shown to have a positive effect on the safety climate and are a promising tool to improve the broader construct of safety culture.
How much:	Monthly as part of Trust Board Business. In 2014/15 there were 40 Board to Ward visits. The target set for 2015/16 was for a minimum of 48 executive safety visits. We undertook to: • Monitor the number of areas visited per month • Provide Divisional feedback via patient safety and quarterly report • Demonstrate progress via improved safety climate results
When:	Executive safety rounds have been in progress from January 2009. A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical and non-clinical areas as part of monthly Trust Board Business. Target date was April 2016 – March 2017 inclusive.
Outcome:	Where regular Board to Ward visits have occurred, the operational staff and directorate management boards have acknowledged the benefit of senior leaders regularly spending time with them. They welcome the opportunity to discuss the safety issues which concern them and receiving feedback on action that would be taken forward to address these. The purpose of the safety round has allowed us to send a message of commitment to a culture for change focused on patient safety. When all executives commit to regular visits (walk rounds), it creates a shared insight into organisational safety issues. **During 2016/17 180 executive safety rounds were completed**:

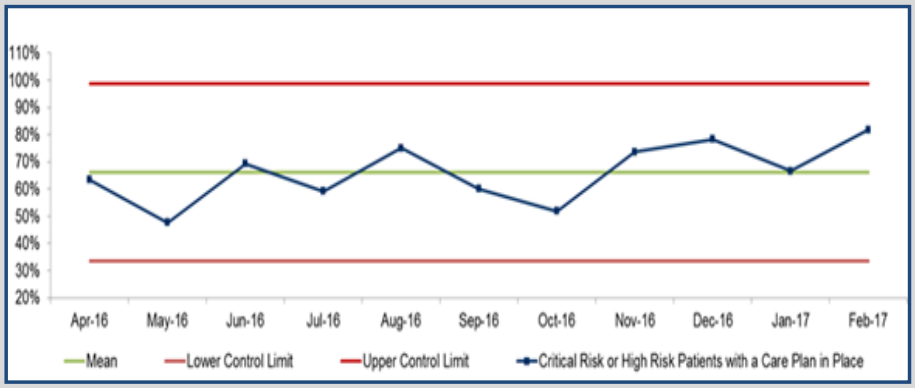
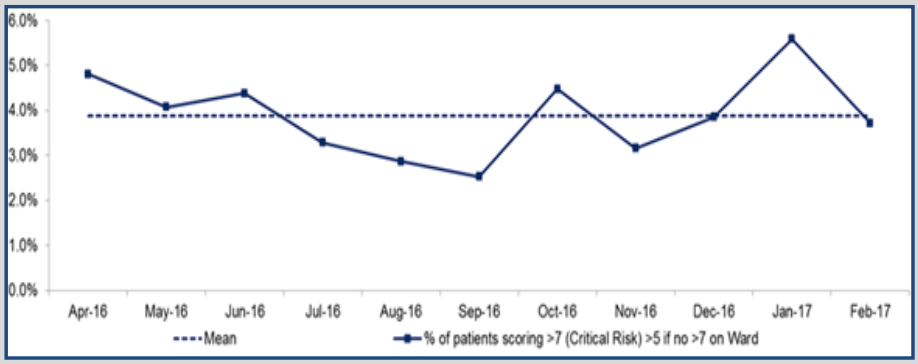
	 In December 2016 a change to the process was adopted whereby each member of the Bard made a ward visit on a monthly basis.

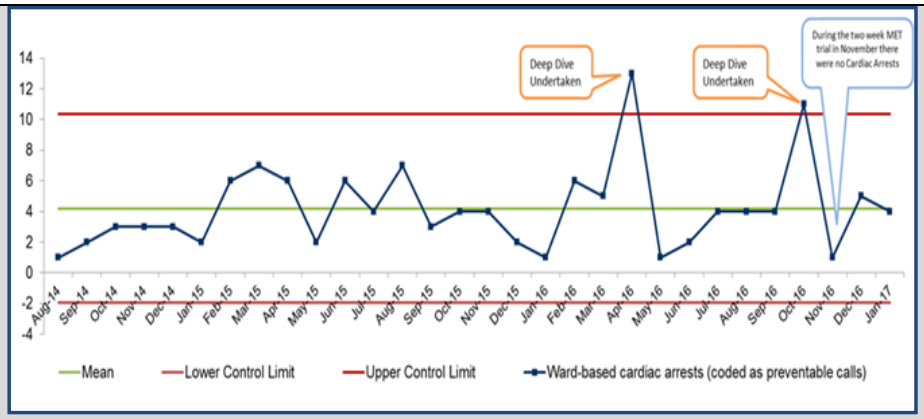
We said we would:

Provide care that is safe by reducing harm through improving the early identification & management of the deteriorating patient.

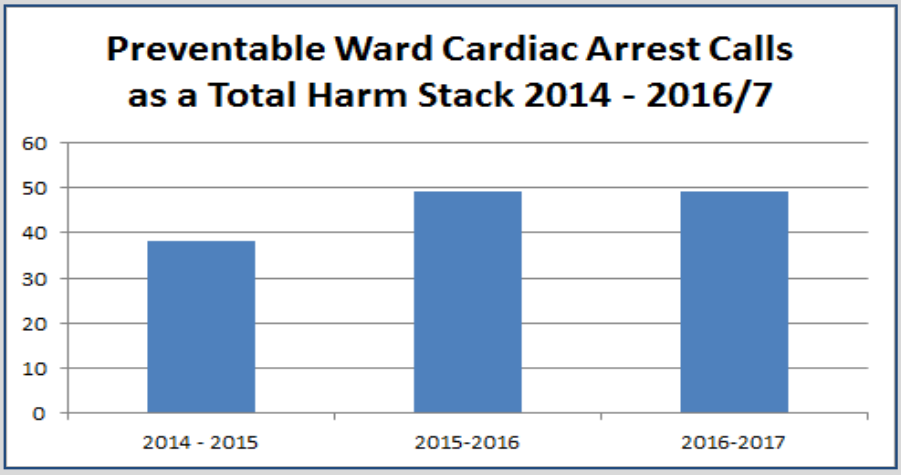
What we achieved:

What:	Failure to identify areas of deterioration in patient observations can potentially lead to delayed or missed escalation and treatment. The 2012 report "Time to Intervene", published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) indicated that for many acutely ill people better assessment and action early in their hospital admission may have led to: • Intervention that may have prevented progression to cardiorespiratory arrest, or • Recognition that the person was dying and that attempted resuscitation would be inappropriate The NCEPOD report also states that in a substantial number of cases a patient's condition was not 'escalated' appropriately for assessment by a senior doctor. That assessment may have led to intervention to try to reverse deterioration, or may have led to recognition that the treatment would not result in recovery and to a decision that attempted CPR would be clinically inappropriate.
How much:	The NCEPOD report reflects that many in-hospital cardiac arrests are predictable events, often following a period of slow and progressive physiological derangement that is often poorly recognised and treaded. Therefore it was recommended that each hospital should set a local goal for reduction in cardiac arrests leading to CPR attempts. It has been reported that up to a third of hospital cardiac arrests could be preventable. We have aimed to reduce the number coded preventable cardiac arrest calls by 15% from the previous year.
When:	Monthly point prevalence audit data continues to be collected and circulated. The audit measures: • % of patients scoring within the critical risk category with an appropriate plan in place (if no critical risk patients at time of audit the high risk category are used).

	• Numbers of cardiac arrest calls that have been coded as preventable following full clinical review
Outcome:	1. Monthly EWS audits: The focus of the monthly audit and compliance awarded is based upon identifying patients scoring within the critical level >7 EWS and of those how many have received an appropriate level of escalation and management plan. During the audit, if no patients are scoring in this critical risk category then the high risk category is reviewed instead (5>).   2. Preventable Cardiac Arrest Calls: Members of the Resuscitation Committee review all data pertinent to any ward based cardiac arrest. Each cardiac arrest is coded via the review responses and a final code of a preventable or non-preventable call is awarded.



When there has been an increase in the number of cardiac arrests coded as preventable we have undertaken a detailed review to determine the specific causes and identify learning.



We have not seen a decrease in the absolute number of preventable cardiac arrests that we sought to achieve. Between 2014 and 2016 there was a significant increase in the number of patients admitted non-electively and in the acuity which has had a direct effect on the numbers shown.

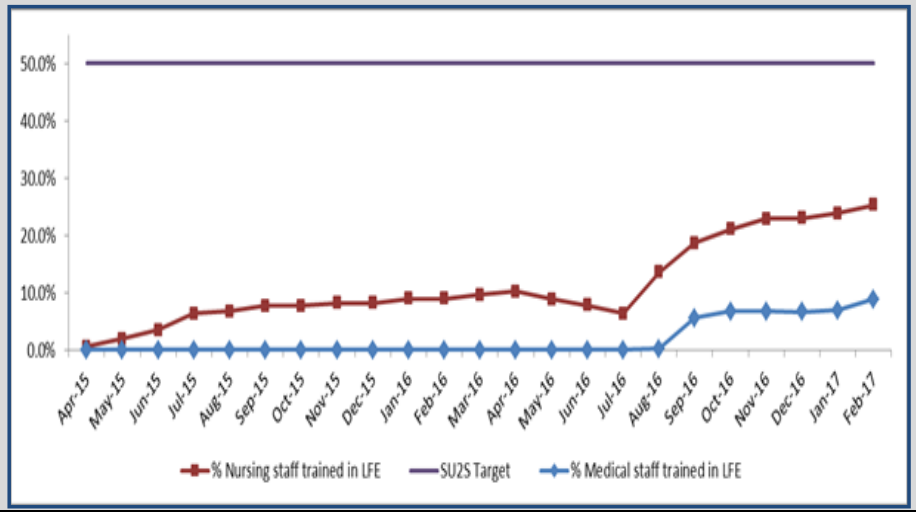
We continue to make a determined effort to reduce both the absolute and relative number of preventable cardiac arrests through our Resuscitation Group and the clinical Divisions.

We said we would:

Provide care that is safe by reducing harm through learning from errors within clinical teams.

What we achieved:

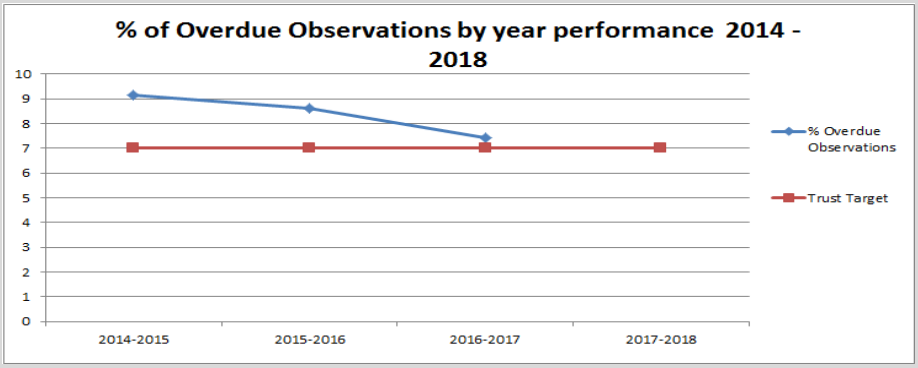
What:	The Chief Medical Officers report (CMO 2008) explained in detail how simulation in all its forms would be a vital part of building a safer healthcare system. Literature reviews frequently inform practice describing how well simulation training has worked in high risk organisations because it allow staff to practice

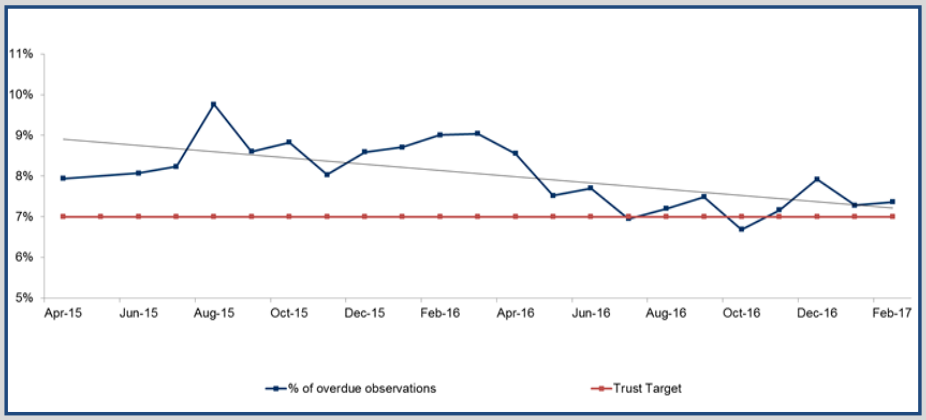
	difficult scenario's an learn technical and non-technical skills in relation to safety and team work, providing the safest environments for their workers and public. Whilst delivering simulation speciality training programmes since the Simulation Suite in NGH has opened it has become apparent there were common themes especially involving human factor skills. A programme has been developed working closely with the wards to create a bespoke session for each area that addressed human and system errors relating to their individual issues addressed through Datix incident reports and any serious incidents. The objectives of each session include communication, decision making, situational awareness, task focus, escalation and challenging behaviours.
How Much:	We will measure the amount of ward staff attending an annual learning from errors (LFE) session within the Simulation Suite. We aim for 50% of all ward teams to attend LFE by 2018. 2014-2015 Outturn – 5% of ward staff have attended an LFE session
When:	LFE was designed and implemented in April 2015. Attendance is collated quarterly and ward managers are informed of attendance levels.
Outcome:	The LFE sessions have now been running for nearly two years and showing a gradual increase in attendance, however medical staff attendance remains low. Point of care simulations were developed within Q2 of 2015-2016 with the aim of addressing the theory from LFE in the classroom to practice in the ward situation. These have been well received and the project has been further extended to a collaborative piece of work with Northampton University to assess the difference that LFE makes to practice. The aim by the end of 2018 is to undertake one Point of Care simulation each week. The 2014 – 2015 outturn was recorded as 5% of ward staff had attended LFE 2015 – 2016 - 33% of staff had attended LFE, which is a 28% increase from the baseline 2016 – 2017 - 43% of staff have attended LFE (excluding March 2017), which is a 43% increase above the baseline measurement. Staff are encouraged to attend annually and the below graph is refreshed each year to take this into account. 

We said we would:

Provide care that is safe by reducing harm through improving the quality & timeliness of patient observations.

What we achieved:

What:	Failure to take patients observations in accordance with their planned and prescribed care can lead to delayed identification of any potential deterioration and therefore potentially delayed treatment.
How Much:	We will measure all overdue observations data using VitalPac across all adult general wards. Vitalpac is an electronic system for recording observations and other clinical data. The system uses this clinical information to alert staff to changes in the condition of our patients. We will aim to improve overdue observation rate by 3% to achieve the Trust target of no greater than 7% overdue observations. 2014-2015 Out-turn – recorded as an average of 9.14%
When:	Monthly point prevalence audit data has been collected since 2014 and circulated to all adult general wards.
Outcome:	We have placed a threshold of acceptance at 7%. Any ward that is consistently above that target receives targeted support with additional lessons learnt from performing wards being utilised as good practice examples. There has been a gradual improvement year on year with targeted support to those wards demonstrating non-compliance including the use of additional IPod's to allow the ward co-ordinators to keep track of when patient observations are due and prompt the appropriate staff accordingly. A gradual roll out of bay tagging as a working principle has demonstrated an improvement towards the 7% trajectory being achieved. The 2014 – 2015 out-turn was recorded as an average of 9.14%. The mean for 2015 – 2016 was 8.61% demonstrating a 0.53% reduction from the baseline. The mean for 2016 – 2017 is 7.43% (excluding March 2017) demonstrating a 1.71% improvement from the baseline. 

	% Overdue Observations by month: 

We said we would:

Provide care that is safe by reducing harm through Improving Organisational Safety Culture.

What we achieved:

What:	In recent years there has been an increase in focus in the UK and internationally on approaches to improve safety and this has led to greater recognition of the importance of the culture of organisation and teams. NHS England launched the Patient Safety Collaborative in October 2014 following the publication of the Francis and Berwick Reports. Safety culture and leadership were identified as mandatory areas.
How Much:	The overall outcome measure for this project will be from the Pascal Survey – i.e. the operational staffs' perceptions of the safety culture in their work area. The survey will be repeated in 2018 and the following two years. **A&E** NGH received the highest favourable scores within the region. The Quality Improvement team have supported the A&E to identify three primary drivers to support the delivery of the above aim : • Improvement in the designated paediatric area to ensure 100% of children will receive a rapid assessment when clinically appropriate. (4 secondary drivers) • 100% of patients will attend A&E clinical observation area adhering to the Trust and departmental policy (3 secondary drivers) • 25% increase in the number of staff who have a favourable opinion of the work culture in A&E (6 primary drivers) **Maternity** The maternity team have identified two major work streams that will be led by community and hospital based midwives. The teams have identified the following areas for improvement : • An improved, transparent reporting culture (non-punitive response to errors)

	• Increased senior management visibility • Improved support and appreciate of staff • Improved internal communication There are also additional outcome measures for each primary driver, detailed below. **A&E** A&E Continuing Observation Area (COA) project (1): Average length of stay in the A&E COA A&E COA project (2): Compliance with the revised departmental policy on the clinical observation area. Rapid Assessment project: Time to triage paediatric 'minors' patients Rapid Assessment project: Average length of stay (LOS) for paediatric patients Staff Working culture project: Percentage of staff with a favourable opinion of the work culture. **Maternity** Non-punitive response to errors: % of staff who say there is a positive reporting culture Communication: % of staff who say there is effective communication within Maternity Senior Management: % of staff with a favourable opinion of senior managers Support: % of staff who feel appreciated and supported in their role We have also agreed all relevant process, balancing, financial and patient experience factors and measures with the project leads for each work area.
When:	The project aim for both work streams, is by 2020 there will be a 50% improvement from the 2016 baseline in the number of operational staff who have a favourable opinion of the safety culture in A&E and Maternity
Outcome:	The programme of culture assessment provides diagnostic and actionable insights into organisational and unit level cultures which enable the development of data driven training programmes to address areas of risk and opportunity. This includes a single culture survey using the safety attitudes questionnaire and a range of other surveys including for example engagement, burn out and resilience. **What are we trying to accomplish?** **Setting Aims: Safety Culture Measurement Programme using analytics devised by PASCAL Metrics which is a leader in this field** **Safety culture** is broadly defined as the norms and values and basic assumptions of the entire organisation. **Safety climate** is more specific and refers to the employees perceptions of particular aspects of the organisations culture.

The programme of culture assessment provides diagnostic and actionable insights into organisational and unit level cultures which enable the development of data driven training programmes to address areas of risk and opportunity. This includes a single culture survey using the safety attitudes questionnaire and a range of other surveys including for example engagement, burn out and resilience.

Across the East Midlands, all eight acute trusts participated in the survey and received responses from 1,384 staff. The overall survey response rate was 47%; whilst this was short of the 60% target, this level of response is seldom seen in any NHS internal survey.

A selection of NGH's very high level safety domain results from the survey is included within this report, broken down by subgroups. The subgroups were selected by the service leads for A&E and Maternity, in order to provide further insight into the perceptions of safety within the work areas.

The overall aim for both A&E and Maternity will be to improve the safety culture within their respective work areas.

Raw data has been obtained from East Midlands Academic Health Science Network for both A&E and Maternity. The data has been collated and the key areas for improvement have been identified.

For A&E the three primary work streams from this survey have been identified as:

- Improving the monitoring and care of patients in the clinical observation area (A&E COA)
- Introduction of rapid assessment for paediatric minors (Rapid Assessment)
- Improving the work culture within A&E (Work Culture)

For Maternity the four primary work streams from the survey have been identified as:

- Improving communication within Maternity (Communication)
- Improving the perception of the senior managers in Maternity (Senior Managers)
- Addressing the issue of 'blame culture' in Maternity (Blame)
- Providing more support to staff to address the issue of burnout (Support)

How will we know that a change is an improvement?

Establishing Measures:

A&E

The overall outcome measure for this project will be:

- The percentage of staff with a favourable opinion of the safety culture within A&E

This information will come from the Pascal Metrics survey, completed 2016, 2018, 2019 and 2020.

In order to further evidence the anticipated improvement in the safety culture in A&E, other measures have been established, related to the three work streams detailed above:

Workstream	Type of Measure	Measure
ED COA	Outcome	Length of stay in the COA
		Adverse events in the COA
	Process	% of continuative care sheets completed
		% of falls risk assessments completed
		% of A&E COA sheets completed
		Number of patients in COA, by acuity
	Balancing	Re-attenders to A&E
Rapid Assessment	Outcome	Time to triage
		Time to see a doctor
		Time to decision to admit
	Process	Number of staff upskilled
		No of patients who had rapid assessment, as a percentage of all paediatric minors
	Balancing	Re-attenders to A&E
Workstream	**Type of Measure**	**Measure**
Work culture	Outcome	% of staff with a favourable opinion of the senior managers
		% of staff who feel emotionally drained
		% of staff with a favourable opinion of the work culture
	Process	Number of simulation suite sessions carried out
		Number of point of care simulations carried out
		% approval rate for annual leave
	Balancing	Sickness rate
		Attrition rate
		Vacancy rate

Maternity

The overall outcome measure for this project will be:

- The percentage of staff with a favourable opinion of the safety culture within Maternity

This information will come from the Pascal Metrics survey, completed 2016, 2018, 2019 and 2020.

As for A&E, other measures have been determined in order to further evidence the anticipated improvement in the safety culture:
Please note that these measures will change as the projects develop. Unlike A&E the maternity projects are still in their initial stages.

Workstream	Type of Measure	Measure
Communication	Outcome	% staff who have a favourable opinion of the communication within Maternity
	Process	% staff who read Stork Talk (Maternity newsletter) every month
		Number of articles in Stork Talk
		Hit count on new Obs & Gynae intranet page
		Smartphone and Wi-Fi usage in the

		community
		Number of FAQ/mythbuster submissions to the intranet page
	Balancing	% staff who feel they are aware of the learning from Serious Incidents and adverse events in Maternity
Senior Managers	Outcome	% staff who have a favourable opinion of the senior managers in maternity
	Process	Number of job shadowings completed per quarter
Blame	Outcome	% staff who feel there is a positive reporting culture in Maternity
	Process	Attendance to the MIRF meetings
		Number of simulation sessions attended by maternity
	Balancing	Number of adverse events
Support	Outcome	% staff who feel appreciated and supported in their role
	Process	% staff who feel emotionally drained
	Balancing	Sickness rate
		Attrition rate
		Vacancy rate

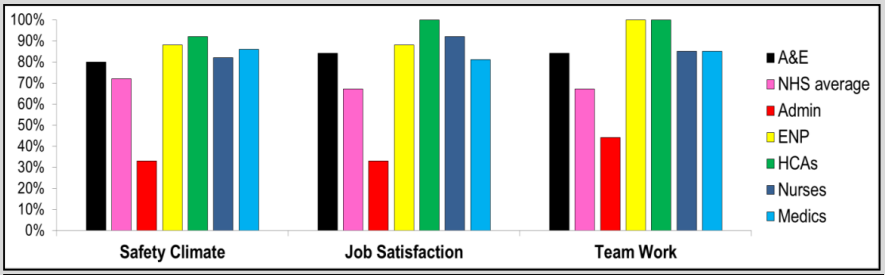
What changes can we make aimed at improvement?
PDSA
The interventions planned for both the A&E and Maternity projects are still in the discussion phase, whilst baseline data is being collected by the leads for the relevant workstreams.

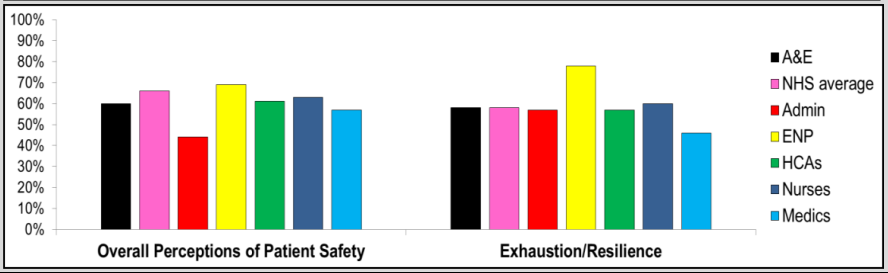
Quality Improvement Project Update:

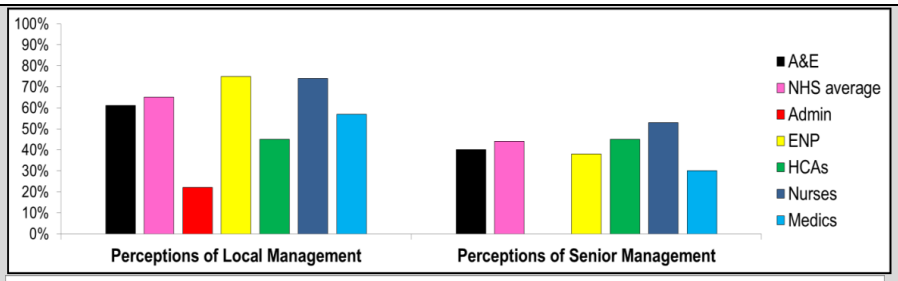
The granular data has been provided by East Midlands Academic Health Science Network, enabling the teams to identify key areas for improvement for both A&E and Maternity, which have been detailed above.

The data has been broken down by subgroup as is shown in the charts below.

A&E



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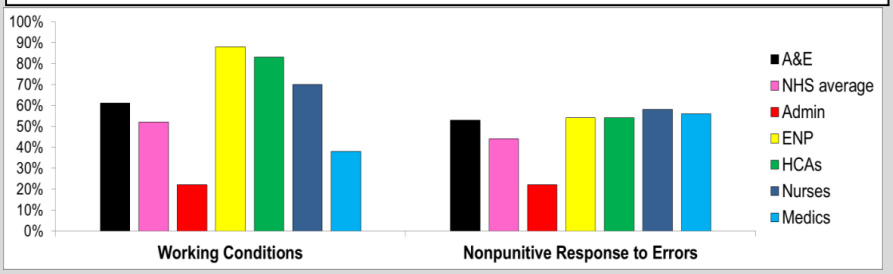
Perceptions of Senior Management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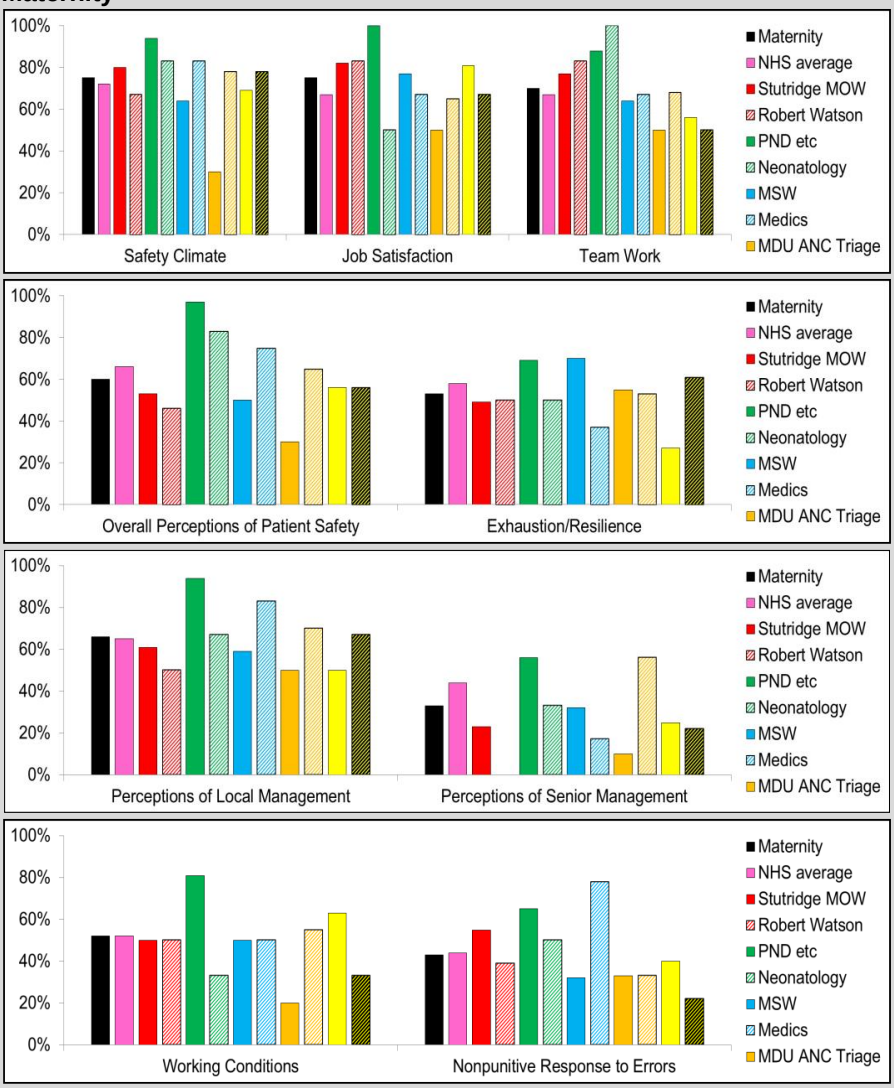
Nurses
Medics
Working Conditions
Nonpunitive Response to Errors

Maternity

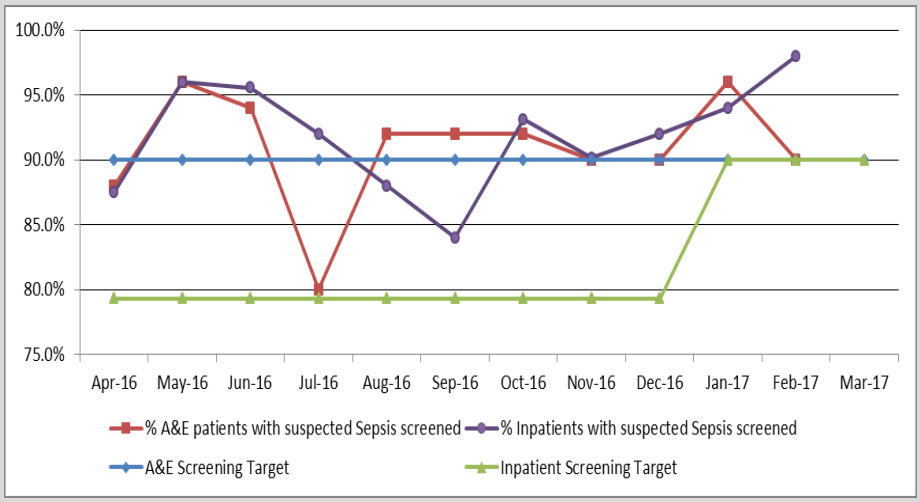


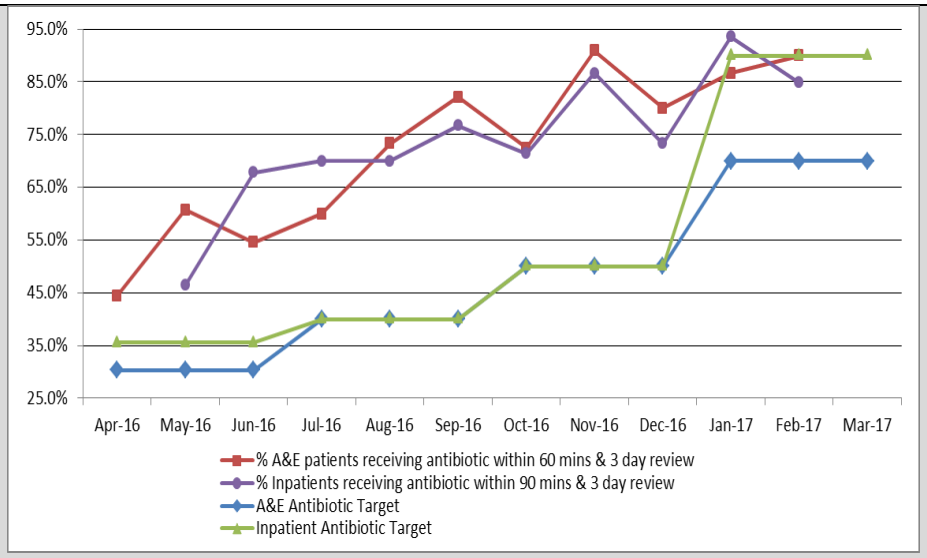
We said we would:

Provide care that is safe by reducing harm through eliminating delays in investigations and management for patients with sepsis

What we achieved:

What:	Failure to recognise symptoms of developing sepsis or red flag sepsis can lead to delayed antibiotic treatment, with a subsequent rise in morbidity / mortality and increased length of stay.
How Much:	We will eliminate delays in antibiotics administration to septic patients by ensuring that patients with deranged early warning scores (EWS) are screened for sepsis both on identification of EWS rise and at entry to the hospital. We also aim to increase antibiotic administration to 90% compliance within 60 mins (A&E) and 90 mins (inpatients), in line with national CQUIN targets, from

	diagnosis, for patients with red flag sepsis
When:	In 2016/17, we are measuring two groups of patients, those presenting to the Emergency Department and inpatients. For these groups, ie. A&E /inpatients , we are measuring performance against two sets of criteria: • The percentage of patients with EWS of 3 or higher, (a) on arrival in A&E, and (b) inpatients that are suspected of Sepsis that are screen for Sepsis. • The percentage of patients with red flag Sepsis (as set in UK Sepsis Trust / NICE guidelines) who are administered antibiotics within the appropriate timeframe (within 60 minutes / A&E and within 90 minutes / inpatients) **and** then had an antibiotic review within 72 hours.
Outcome:	Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with an estimated 106,000 people in the UK surviving sepsis and a further 44,000 deaths attributed to sepsis annually *(source UK Sepsis Trust)*. The Parliamentary and Health Service Ombudsman (PHSO) published *Time to Act* in 2013, which found that recurring shortcomings in relation to the sepsis management included: • Failure to recognise presenting symptoms and potential severity of the illness • Delays in administering first-line treatment • Inadequate first-line treatment with fluids and antibiotics • Delays in source control of infection • Delays in senior medical input 



Considerable progress has been made in the treatment of sepsis. We will continue to focus on this area so that we can consistently achieve the in-patient target and A&E targets to ensure that patients with sepsis receive potentially life-saving treatment as quickly as possible.

General Improvements in 2016/17

Quality Improvement

We have made Quality Improvement (QI) work a key point of focus to improve the care that we provide to our patients and have described this in our Quality Improvement Strategy.

To ensure that the learning can be captured and shared across the Trust, we developed a central repository that is supported by the QI team. This provides a library of projects & ideas that may benefit from further project work/development and will reduce areas of duplication & replication. This has been an important development for our organisation as it will particularly highlight work that is sustainable and can be transferred between teams to become business as usual.

During 2016/17 we had more than 40 projects across the Trust which were supported by our QI team some examples of which are listed below:

- Improving Nurse Knowledge of Acute Kidney Injury
- Improving early Discharge by earlier engagement with family/carers
- Reducing the amount of inappropriate cannula's
- Improving the accessibility of patient observations on admission unit ward rounds
- Doctor Toolbox
- Documentation of cardiac arrest management in out of hours cardiac arrest
- Standardisation of procedure specific equipment trays
- Improving Electronic Discharge Notification (eDN) completion in Urology.
- Effectiveness of the falls assessment form

- Improving access to gynaecology equipment for emergency assessment
- Improving accessibility to common guidelines
- Introducing a discharge system for medically fit for patients who requiring four times daily intravenous antibiotics
- Improving surgical handover
- Medical Emergency Team trial
- Improving the efficiency of giving medications by 25% on Holcot ward
- Night team handover
- Care of the patients on the stroke pathway who are 'nil by mouth'
- Improving the paging system
- Rapid tranquilisation
- Support of the Trust rollout of the SAFER bundle
- Improving accessibility of bedside sharps disposal
- Situation, Background, Assessment, Recommendation (SBAR) communication tool implementation
- Improving compliance with Venous Thromboembolism (VTE) risk assessment
- Improving medical weekend handover plans
- Introducing a daily '10 minute conversation' for the emergency team
- Improving access to emergency protocols
- A multidisciplinary approach to learning from error

Reflecting the high level of QI activity, the Trust submitted 17 projects for consideration by the Patient First conference. In all, we made 49 conference submissions this year, with 18 of these being shortlisted for presentation and the Trust received 4 QI awards.

We made 25 submissions of QI work carried out by our junior doctors which were accepted for the 2017 International Forum on Quality & Safety in Healthcare.

More recently we have had 12 submissions accepted for presentation at the Patient Safety Congress:

- Introducing a '10 Minute Conversation' – Improving Communication within the Adult Cardiac Arrest Team
- Improving Nursing Knowledge of Acute Kidney Injury
- Reducing the risks associated with blood transfusion: the experience of implementing patient blood management at Northampton General Hospital
- Easing the stress of rotation through the development of the Dr Toolbox mobile app and the introduction of a formal handover
- Improving Access to Emergency Protocols
- Improvement of Service Provision through the Introduction of Gynaecology Emergency Bags at Northampton General Hospital
- Improving intravenous Fluid Prescribing
- Learning from Errors - A Multi-disciplinary Approach within the Simulation Suite
- Improving the Efficiency of the Administration of Medication on an Acute Medical Ward
- Introducing Point of Care Simulations at Northampton General Hospital
- Improving the disposal of sharps
- Improving VTE re-assessment compliance

This work comes from across the multidisciplinary team and reflects the desire of all of our staff to seek innovative ways of improving the care we provide. Using this approach, we have improved the care for more elderly patients by making our Accident & Emergency Department “frail friendly” and improving the skills of our staff in Geriatric Emergency Medicine (GEM).

GEM in our A&E

We organised multidisciplinary GEM training on a bi-monthly basis and targeted teaching for specific groups e.g. our non-clinical staff.

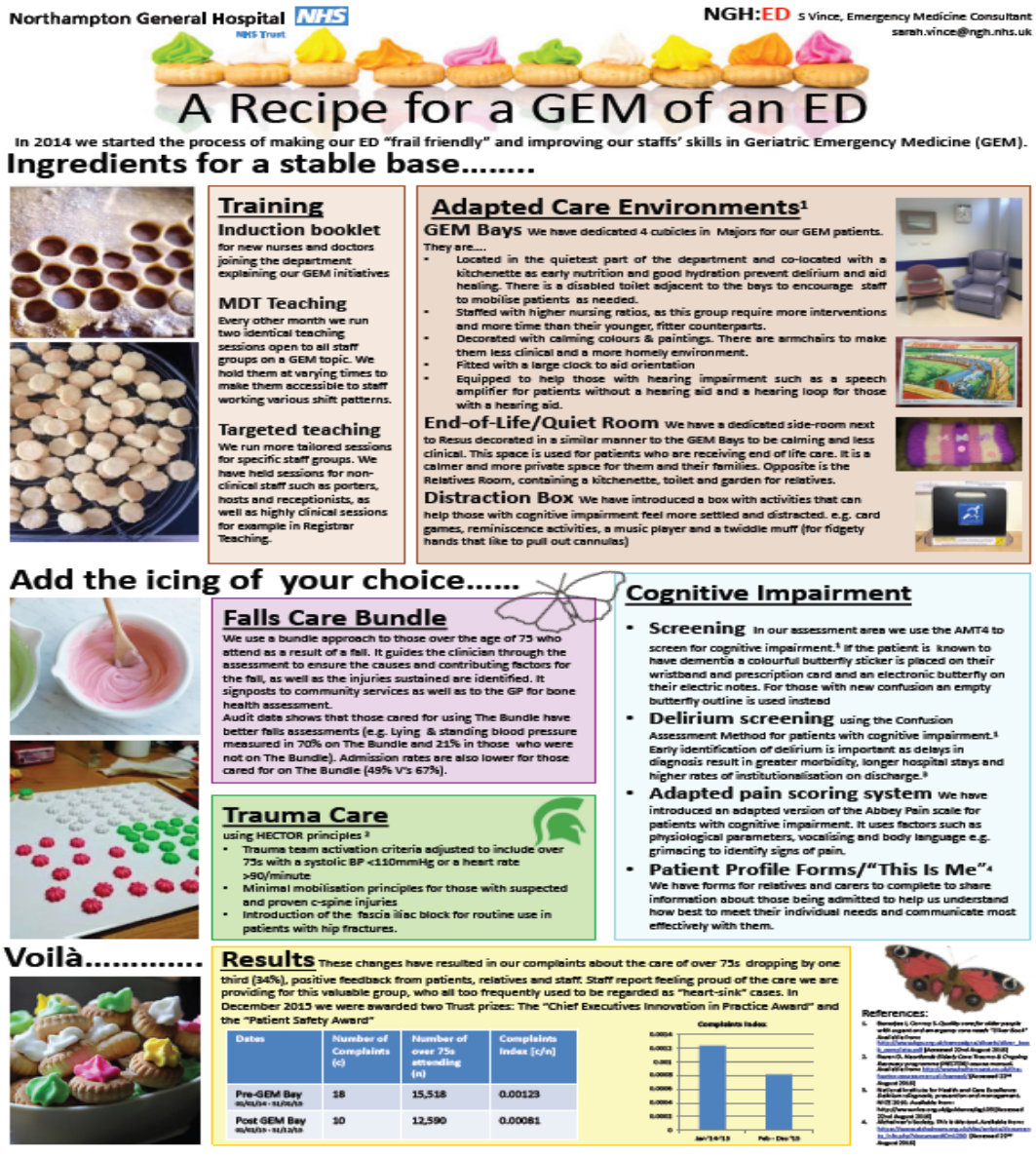
To make our clinical area more homely and calming we redecorated the four quietest bays and prioritised them for those with cognitive impairment and frailty with pastel colours. Specialised equipment such as speech amplifiers for those with hearing problems are also readily available. The nursing ratios are higher than for other Majors bays with 1 nurse and 1 healthcare assistant to 5 cubicles.

We have developed a number of specially designed care pathways for our GEM patients:

- Cognitive Impairment
- Falls Care Bundle
- Trauma Care

Since starting this programme our cognitive assessments have improved from 11-52% over 16 months. The Falls Bundle has improved the quality of falls assessments. In the year after the introduction of these changes, our complaints relating to the care of patients over 75 years of age fell by 34%.

With the right staff training, departmental processes and an adapted care environment we have been able to make our busy, A&E “frail friendly”.



Making Quality Count

Our flagship programme "Making Quality Count" is designed to engage our staff in a user-friendly and systematic method of improvement. Over a 3 month period we take teams through the programme, coaching them and training them to be able to lead and deliver change independent of our support.

Some examples of our work in Making Quality Count include the following areas

Supporting main theatres to change the way they work to start theatres on time to more effectively utilise all our theatre time.

- How: Empowered and coached our staff to gather data on late starts and supported them to analyse the root causes of starting late.

- What changed: Improved rostering of staff and skill mix, refocused the teams efforts and focus 1st thing in the morning to create more time and get ready for our 1st patient faster, built a new quality assurance framework to ensure patient safety and quality were guiding our actions
- The results: There was a 50% reduction in late starts and an 8% increase in theatre productivity which created 45 minutes extra preparation time per theatre through redesigning the morning huddle.

Reduced patient waiting by improved flow of patients attending the Diabetic Obstetric Outpatient Clinic to improve both patients and staff experience?

- How: Worked with staff and clinicians to understand the true demand and capacity of the clinic. Mapped the clinic flow and layout. Redesigned how clinicians worked together to take steps out of the patient pathway
- What changed: We worked with NHFT and changed when they delivered their sessions. We eliminated the queue at the start of the clinic. We created three pathways through the clinic and booked patients specifically these pathways. We agreed to deliver joint clinical Consultations, Additionally, we improved flow by putting patients in clinic rooms and clinicians went to them rather than clinicians waiting in a room.
- The results: Significant reduction in patient waiting time – average 47 minutes reduction, with more efficient use of clinical resources and happier patients – the reduced waiting and improved patient flow also resulted in happier staff.

Some of our other projects include:

- Reducing the time taken to respond to patient complaints
- Improving the theatre scheduling process for elective surgery
- A trial to reduce the demand on the pre-operative assessment unit by streaming ASA1 patients safely
- Improving the start of day and equipment requirement processes in day case surgery
- Supporting our nurses with service improvement methodology on the RCN leadership course

Electronic Prescribing and Medicines Administration

Across the Health Service there many instances where medication is given incorrectly or may be missed altogether. We recognised that medication safety could be improved by using and electronic prescribing system. In April 2015 we started to implement an e-prescribing and medicines administration system (EPMA). Since this time we have worked with the system developer (EMIS) to refine it and have gradually rolled it out across our Trust.

The EPMA system is now being used in our A&E and across all of our medical specialties. We have also made progress in using the system in our surgical areas including the operating theatres. During 2017 the EPMA will be rolled-out across the remainder of the Trust.

In those areas which are using the EPMA system we have seen a significant reduction in the number of incidents which are related to medication. As we develop the system further we expect this to improve quality and safety of services for our patients.

Our Nursing & Midwifery Strategy

We created a unique collaboration resulting in a truly shared vision for nursing and midwifery, by nurses and midwives. This strategy is the beginning of a three year journey which we embark on with the support of our Pathway to Excellence partners. The success of the journey is dependent on all the factors set out in our strategy.

Nursing & Midwifery Professional & Practice Development

We are supporting our nurses and midwives to develop degree and masters level education in partnership with our learning beyond registration academic partners. In addition, we are working on developing our nursing and midwifery workforce with specialist advanced practice.

Instrumental in the delivery of our Nursing & Midwifery Strategy the team support leadership through the delivery of preceptorship through to band 6 & 7 development programmes and the RCN Clinical Leadership Programme.

Supporting our nursing & midwifery workforce currently and for the future includes a comprehensive international preceptorship programme taking our new international colleagues through the required objective structured clinical examination (OSCE) assessment. We are currently in the top three Trusts nationally for our first time pass rate.

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Trainee Nursing Associates

The new nursing associate role is a key part of national plans to create a strong, sustainable nursing workforce for the future. The nursing associates will work alongside existing health care support workers and registered nurses to deliver hands-on care for patients.

The Trust is part of a wider East Midlands collaborative of NHS Trusts and universities and one of only 11 pilot sites in the UK training the first wave of nursing associates. 18 trainee nursing associate students have been recruited to this landmark pilot scheme, and the group began their 2 year programme in January 2017. The trainees were recruited from our existing healthcare assistant workforce, investing in our own staff for our future workforce.

NGH & the University of Northampton

Reflecting our desire to look for more ways to improve the quality of the services we provide to our patients we are collaborating with the University of Northampton to develop a number of areas where we can work together. Both organisations have a clear interest in biological, medical and health related research. Together are working towards a common goal of engaging in and delivering research for the benefit of the wider health economy population.

MSc– Patient Safety & Quality Improvement

Building on this collaborative model we are developing a Masters Degree programme in Quality Improvement & Patient Safety with the University of Northampton.

The course is aimed at healthcare professionals and managers who wish to develop a greater understanding and expertise in patient safety and quality improvement with a strong emphasis on practical application. This will be supported by developing the candidates' level of expertise by undertaking a project supported by both academic and clinical mentorship at NGH.

Collaboration with Health Education England (HEE)

Northampton General Hospital has been delivering a bespoke modular course for medical Registrar development since 2012 which aims to provide our doctors with a sense of the wider issues facing the NHS and the local issues related to hospital medicine.

As part of this course our registrars are asked to lead and deliver a patient safety, patient experience or clinical outcome based quality improvement project utilising the Institute for Healthcare improvement (IHI) approach "science of Improvement" which is a unique approach on improving quality, safety, and value in health care.

Building on our experience in this area we have been awarded funding to deliver the training across the county for Specialist trainees in both acute and general practice.

Dare to Share Learning Events

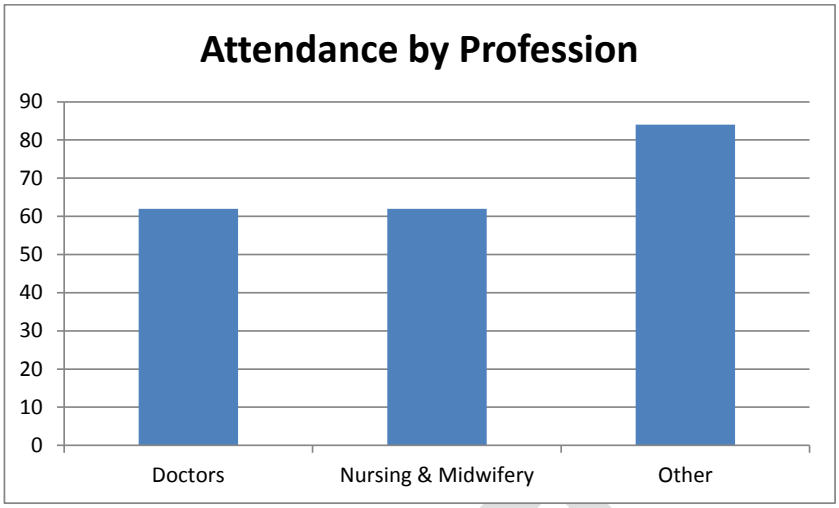
We have a number of methods for sharing learning following a clinical incident in order to keep our patients safe. This year we developed a new meeting to spread important safety information among a wide multidisciplinary audience.

There have been four of these 'Dare to Share' events held which have each focused on learning from adverse events which have occurred within the Trust, supporting us on our journey to deliver the best possible care. The staff involved in the incident share their own experiences and there has been an open dialogue about factors which contributed to the incident.

The events have been organised by our governance department and supported by the Medical Director. Each event consists of presentations and we have focused on a wide range of topics including:

- Unexpected admission to ITU
- Use of an alarm system for monitoring patients' heart rate
- Never Events
- Care of the patient treated with Non-Invasive Ventilation
- Safer sharps
- MRSA bactaermia
- Mental Capacity, Deprivation of Liberty and Medication

To date, the events have been attended by over 200 members of staff from a variety of disciplines:



During the meeting all attendees are encouraged to document the learning that they will take away and share with their colleagues. At the following meeting those who attend are asked to describe how they have change practice and what they have done differently as a result of the meeting.

Urgent Care

As with many Trusts we have experienced considerable pressure on our urgent care pathways. Patients are increasingly likely to present more acutely unwell with more complex medical problems. Right across the organisation our multidisciplinary teams have worked hard to improve the effectiveness of urgent care.

To support this work, we completed the final phase of improvement works within the A&E. This was part of a phased re-development programme which has taken place over the last four years, during which time the whole area has been brought up to the latest standards, capacity has been increased considerably, additional clinical facilities such as a new ambulatory care centre, state of the art resuscitation area and clinical observation unit have been developed, whilst at the same time maintaining 'business as usual'. Our patients can now benefit from new triage, general practitioner and resuscitation areas. We have also created a dedicated area for children in the A&E department where they can be seen and assessed by our staff.

Some of the key changes we have made in the last year are described in this section.

In-house Primary Care Streaming

We recognise that many patients will present to our A&E with problems that in the past would often have been reviewed by a General Practitioner. To ensure that patients are directed to see a General Practitioner when it is right to do so we have introduced a Primary Care Streaming service into our A&E. This builds upon our previous experience working in partnership with an independent GP service. The service ensures that patients who can be managed by a General Practitioner are seen in a timely way and avoid the main A&E.

Due to the success of this service we will extend it further in 2017/18. Our Primary Care Streaming service will be relocated to Springfield House once redevelopment work there has been completed.

This has been made possible as we have successfully bid for £858,000 of central funding which was announced in the Budget.

Consultant Connect

During 2016/17 we introduced the Consultant Connect system into the Trust. This allows GPs to quickly access our senior doctors for advice and guidance through a specialised phone system. Once rolled-out across the Trust the system has allowed patients to be directed toward appropriate investigations, clinics and other services avoiding the need for attendance at the A&E. This has undoubtedly improved the quality of the service we provide to our patients and made sure we continue to make the best possible use of our resources.

SAFER Bundle

To improve the care that we provide and minimise waiting and so help our patients to be discharge we have introduced the SAFER bundle in the Trust. This is a standardised way of managing patient flow through the hospital. It ensures that our patients are seen by a senior doctor as early as possible in their stay when clear treatment plans are made and discharge arrangements agreed.

We have a dedicated project team support the roll out of the SAFER bundle and have begun to see the benefit that it brings our patients.

Red2Green

The Red2Green approach is a visual system to assist in identifying any time that does not contribute to a patient's journey whilst they are in hospital. A 'green day is one where a patient has had treatment or an investigation which will move them along their treatment plan. A 'red' day is one where this has not happened and the time has not been used effectively. Our wards have adopted the Red2Green approach to ensure that time in hospital is used as effectively as possible and now make every effort to minimize 'red' days.

90 Day Discharge Collaborative

The aim of our 90 collaborative discharge work is to ensure that our ward processes are as efficient as possible. We are reviewing processes on a number of our wards and making targeted tests of change. In some of our clinical areas we have achieved a reduction in the length of stay for our patients by as much as 50%. Once we have demonstrated that a practice or process change is effective these are rolled out to other areas.

New Ways of Working

We are continuously seeking new or better ways of working. In the last year we have developed a new medical model to increase senior medical capacity in the acute assessment areas. We have also developed a 'consultant of the week' model in Oncology and Cardiology.

This has meant that our patients are seen more quickly be senior medical staff who are best placed to quickly decide on the treatment plan. For patients that do not need to remain in hospital we have been able to discharge them more quickly improving their experience of our services.

There have been changes to the way we work across the multidisciplinary team which ensure that we can quickly get the right professional to see each patient every time.

Staff Feedback & Communication

Feedback from our staff is vitally important in helping us to deliver the best possible care for our patients. We have a number of ways of getting feedback which includes the staff survey and the Board to Ward visits which are described elsewhere in this account. During 2016/17 we introduced several further meetings and engagement events to improve communication within the Trust and to ensure that the views of staff could be heard and acted upon.

Compass Check
Our compass check events were informal meetings where representatives from across our management team provided staff with a wide ranging update on the activity and progress within the Trust during the last year. These have been well received with highly positive feedback.

Listen & Learn
The feedback from these meetings identified that there were specific of areas where our staff would like to have more detailed information. In response we introduced Listen and Learn meetings which to date have focused on:

- Operations
- Human Resources
- Finance

Each of these meetings has been presented by the Director responsible for the area moving to a 'Question Time' style section chaired/hosted by the Chief Executive. These meetings have produced a lively discussion and very positive feedback with requests for further events.

CEO Engagement Events
Alongside these meetings we have established unscripted meetings with senior management team and our clinical divisions which are hosted by our Chief Executive. These informal meetings have provided opportunities for more informal conversations. Staff are invited to participate from across the Trust and the feedback has been very encouraging.

Channel 4 Documentary
This year we were pleased to allow the documentary maker Two Four Productions into the Trust to film our junior doctors. The documentary entitled 'Confessions of a Junior Doctor' followed doctors as they cared for and treated patients in the Trust. It has been widely praised for providing a very real insight into the work that juniors doctors do and the modern healthcare environment. Medical staff form part of a much wider team which provides care and the support which the multidisciplinary team provides to one another came through very strongly in the filming.

Team NGH
The ethos captured during the filming is part of a wider sense of staff being part of 'Team NGH' which we have seen developing in the Trust where we consistently help and support one another to provide the best possible care for our patients. We know that our staff far exceed expectations every day in striving to provide a level of care which we can be proud of. Described in the following sections are just a few examples of this.

Learning from our Patients Experience Feedback
Our patients' views are critically important to us and the Trust has worked hard across 2016/2017 to develop the ways in which patient feedback is captured and the ways in which it is shared with the organisation and used to inform change.

Over the past 12 months we have revolutionised the ways in which we actively collect patient feedback each month, taking on a three-pronged approach;

- The Real Time Survey
- The Friends & Family Test (FFT)
- The Right Time Survey

The Friends & Family Test
We have developed a suite of postcards bespoke to the organisation. The postcards compliment the six other ways that patients can answer the FFT including text messaging, online and via applications.

Two new surveys have been established within the hospital using the questions from the Inpatient Survey which the hospital routinely doesn't perform well in, along with additional questions identified as the most important aspects of patients' experience, by the patients themselves.

Quality Conversation- Patient Engagement Event
In January 2017 a patient engagement event was held entitled 'Quality Conversation- 'A Winter Warmer'. An invitation was sent out to over 1700 members of the hospital inviting them to attend the evening.

Presentations were followed by the opportunity to talk with the presenters and a number of other members of the senior team, and visit stands which were created especially for the event. The event was also attended by BBC Radio Northamptonshire. 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.

Patient Experience Network National Awards (PENNA)
The Trust was successful in the categories of 'Staff Experience' and 'the hospital doing the most to improve the experience of those with a disability' at the prestigious PENNA awards in March 2017.

In the Staff Experience category we had described our process for the Compliments Collation and the way in which we have focused on collecting and sharing compliments with staff. The second award was for the Maternity Chit-Chat group which was set up to support ladies with learning disabilities who are expecting, or have had, babies.

Volunteer Service
Our volunteer service aims to utilise volunteers to enhance and support staff to provide the best possible care to our patients. To date the volunteer service has recruited 160 volunteers which represents an increase of 75% since April 2016. In excess of 230 of our volunteers have undertaken mandatory training which is in line with the Lampard recommendations and the NHS standards. Additional bespoke training packages have been created for voluntary roles to ensure that our volunteers are fully trained.

We now have a volunteer presence on 23 wards which is ever increasing with the continuous recruitment of additional volunteers.

Following a successful campaign for the donation of books across Northampton, the new initiative of the 'Bedside Book Club' has been introduced. This service visits the wards twice weekly and allows patients to borrow books for the duration of their stay. The service has been well received and as well as the book offers additional companionship to our patients.

The volunteer service continues to work with some of Northampton's largest organisations. This has allowed the profile of the service to increase further, attracting more people to volunteer within the Trust.

The Best Possible Care Accreditation and Assessment Framework at Northampton General Hospital

Measuring the quality of nursing care delivered is not easy. We have developed a framework based on the Trusts 'Best Possible Care' approach to the delivery of care to our patients.
This process provides the Trust with assurance that the quality and safety of nursing care is being reviewed using the Best Possible Care framework and that action plans are in place where any fundamental standards are not being met.

The framework is designed around fifteen standards and aligns with the CQC essential standards. Each standard is subdivided into elements of Environment, Care and Leadership and also incorporates national performance indicators as well as local indicators developed from lessons learned arising from complaints, concerns, adverse and quality improvement work

The assessment process is undertaken by the Nursing and Quality Matrons who act as quasi external assessors. Each ward is assessed against the fifteen standards with each standard being Red Amber Green rated individually and when combined, an overall ward RAG rating produced. The re-assessment of the wards is dependent on the overall improvement and subsequent RAG as detailed in the table below.

Red	6 red standards
Amber	3-5 red standards
Green	2 red standards and 8 or more green standards Standard 15 must be green
Best Possible Care Ward	3 consecutive green assessments

At the end of the process the assessment result and feedback is provided to the ward sister/charge nurse and support is offered to the ward to implement their ward improvement plan by their matron and organisational development. The ward sister/charge nurse shares the result of the accreditation visit together with the improvement plan with their team.

The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole will provide the Board with comprehensive information regarding care delivery within the organisation.

When a ward's overall rating is 'Red' on two consecutive occasions and there is little or no evidence of improvement, the Matron, the divisional Associate Director of Nursing and the Director of Nursing, Midwifery and patient Experience will consider the actions that are required.

The Best Possible Care Assessment and Accreditation works at various levels:

- Patients -receive the 'best possible care'
- Ward teams – develops ownership and promotes healthy competition between wards
- Division – Can assess nursing care in their areas
- Trust Board – demonstrates the quality of nursing care across the Trust

Improving the Care of Patients with Dementia

Finger Food

The use of finger food was introduced to the Trust in July 2016 with a pilot first, followed by a Trust wide rollout. Finger food is an addition/alternative to the present hospital menu and can be of particular benefit to patients living with dementia. It was introduced as a meal option as it is has been shown to improve independence and increase self-esteem. Food can be eaten standing up or on the move, it can renew an interest in eating and it can provide more choice. Positive feedback has been received from families of patients who have used the option of finger food. Other areas have also benefited from the use including children's wards, maternity and post-op recovery.

Twiddle Muffs

A twiddle muff also known as a twiddle mitt / distraction mitt or muff is a unique multi-coloured knitted sleeve with buttons, bobbles, ribbons and other additions in and outside. This is for patients to put their hands into, to keep busy, distracted and to offer comfort. It may prevent patients picking or pulling at cannulas and dressings for example. Twiddle muffs are a single use item largely provided within the admission areas and remain with the patient throughout their hospital journey and can then be taken home when the patient is discharged. The twiddle muffs were launched in September at the Silver Link Conference. All wards and some departments are provided with twiddle muffs. Regular supplies of twiddle muffs are obtained from local knitting groups WI, staff members and volunteers.

Pressure Ulcer Collaborative

A pressure ulcer collaborative using a 'Breakthrough Series Model' began in October 2015 with representation from relevant clinical professional groups and most wards. A series of learning sessions were held through the year, culminating in a pressure ulcer prevention summit in the spring of 2017. A change package is being rolled out across the Trust that reflects the improvements that have been developed at ward level.

Health and Wellbeing

In recognition that the wellbeing of our staff is crucial in helping them to deliver the best possible care for patients we launched our Health and Wellbeing Strategy in April 2016. As part of this we developed an Annual Programme of Activities which took place throughout 2016/17 and 27% of our staff (1355) have now participated in a Health and Wellbeing initiative.

This work allowed us to achieve the 2016/17 Health and Wellbeing CQUINs. Our NHS staff survey results from 2016/17 indicate that our organisational focus on Health and Wellbeing has shown a statistically significant improvement.

Sustainability

In 2016 NGH was recognised by the NHS for Excellence in Sustainability Reporting. The Trust was awarded the Golden Apple Award for Healthcare Environmental Best Practice by the Green Organisation and we maintained our Investors in the Environment Green Accreditation, with the status of Best Green Champion (Large Organisations) being awarded for the second successive year.

We were also highly commended in the Healthcare Supply Association Awards Sustainability section.

The Catering team maintained Bronze Food for Life Accreditation from the Soil Association for patient meals and extended it to the food served to staff and visitors in the restaurant.

Priorities for Improvement in 2017/18

Our Quality Improvement Strategy aligns with our Quality Priorities and was developed with input from our staff and what quality means for them, through the lessons learnt from complaints and from serious incidents. It also takes into account the recommendations of the Francis Report and Berwick Review. The focus of the strategy is to ensure that patients and service users of NGH receive safe, effective services with a positive experience. We will aim demonstrate a year on year improvement against baseline, within all measurable benchmarks.

Our vision is to provide the best possible care to all of our patients. Our Quality Improvement Strategy (2016 – 2019) will help us to achieve further improvements in the quality of our clinical service over three years. We have aligned our quality priorities for the Year 2 of the Quality Improvement Strategy with the Sign Up to Safety Campaign that aims to make the NHS the safest health care system in the world.

The aim of each of the following six quality priorities is underpinned by a number of work streams that will enable us to deliver and measure successful outcomes:

Priority 1: Reducing Harm from Failures to Rescue

Rationale for the selection of this priority:

At NGH everyone endeavours to provide care which is of the very highest standard. Despite the extraordinary work of healthcare professionals, patients can be unintentionally harmed. One area where we recognise that this can occur is through failures to recognise or rescue patients who deteriorate while they are in hospital.

This priority will continue to focus us on how we can avoid patient deterioration and improve early interventions.

The projects that we will undertake are:

Project 1 – To improve the quality and timeliness of patient observations

Project 2 – To identify and manage the deteriorating patient

Project 3 – To eliminate delays in the investigation and management of patients with sepsis

What we will measure:

- The timeliness of observations
- Identification of the deteriorating patient
- Eliminating delays in investigations
- Use of the sepsis care bundle

Priority 2: Reduce Avoidable Harm from Failures in Care

Rationale for the selection of this priority:

This aligns with our first priority and will ensure that we provide our patients with care that is as safe as possible. To do so we will work on strengthening our learning systems and build capability in our staff to recognise and prevent harm in addition to undertaking specific work to address high priority areas.

The projects that we will undertake are:

Project 1 - Eliminate all pressure ulcers

Project 2 - Reduce harm from patient falls

Project 3 - Eliminate hospital acquired VTE

What we will measure:

- Pressure ulcers
- Falls with harm
- Hospital acquired Venous Thromboembolism
- Reduce omitted medicines

Priority 3: To Deliver Patient and Family Centred Care

Rationale for the selection of this priority:

Patient centred care is central to our core aim to provide the best possible care for patients, yet traditionally neither patients nor the public have had the power to shape the services they use and pay for, or define their value. As a result, many patients find services difficult to navigate, disempowering, burdensome, and seemingly designed to frustrate

Through working and listening to patients and families we can take into account the individual needs and preferences of our patients and carers which will drive our improvement focus and service design.

The projects that we will undertake are:

Project 1 – Communication deep dive to identify key issue areas within the patient journey

Project 2 – Initiate a set of Feedback Events with patients

Project 3 – Create a repository of patient stories

What we will measure:

- Friends and family test
- National patient surveys
- NHS Choices
- Dementia carers survey

Priority 4: To Lead and Promote a Reflective Culture of Safety and Improvement

Rationale for the selection of this priority:

In order to have the greatest impact, staff must be able to speak up about problems, errors, conflicts and misunderstandings in an environment where it is the shared goal to identify and discuss problems with curiosity and respect. The results of our safety culture questionnaire which we will benchmark with other regional hospitals and through regular board to ward discussion with staff will help us to achieve the excellence that we aspire to. We will use unwanted or unexpected outcomes and inefficiencies of practice as the basis for a learning and improvement process.

Our work to date has incorporated a key emphasis on learning from serious incidents and complaints as well as from case note review and previous analysis of lessons from the healthcare system. We have very much supported the concept of listening to staff and empowering them to understand their own role in leading and supporting change and speaking up when they see that improvements could be made.

The projects that we will undertake are:

Project 1 - Leadership training & development for staff

Project 2 - Board to ward leadership walk rounds

Project 3 – To improve organisational safety culture

Project 4 – Learning From Error for clinical teams

What we will measure:

- New appraisal process whereby each member of staff demonstrates they have delivered or contributed to a local QI project
- Staff survey results answering the question *"Am I supported to make changes"*
- Numbers of staff trained in QI
- Number of QI projects in place
- Number of QI projects submitted for external recognition and awards
- Staff survey results

- Safety culture questionnaire
- Qualitative feedback from Board to ward walk rounds
- Leadership and Development Programmes
- QI teaching and training
- Staff and patient satisfaction survey results

Priority 5: To Deliver Reliable and Effective care

We recognise that there are aspects of healthcare that do not perform as well as they should. To achieve best practice and outcomes for patients we will use care bundles to deliver high levels of reliable, efficient and effective care.

A care bundle is a structured way of improving the processes for care and with it, patient outcomes. At the same time as improving the consistency of care, bundles also improve efficiency ensuring that we make the best possible use of the resources available to us.

The projects that we will undertake are:

Project 1 – To develop/update care bundles where clinical appropriate

Project 2 – To introduce and increase consistent of use of relevant care bundle

What we will measure:

- Intentional rounding
- SSkin
- Stroke care
- Sepsis 6
- Heart Failure
- Ventilated acquired pneumonia

Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day. The delivery of our projects will be supported by promoting staff training on quality improvement knowledge and the skills to bring about change in practice to embed continuous improvement.

How progress will be measured and reported:

The metrics for our quality improvement priorities are agreed by the Trust Quality Governance Committee which is a sub-committee of the Board. Progress against these priorities will be reported to the Trust Quality Governance Committee through the Quality Improvement Scorecard in consultation with the clinical leads and Divisional Management teams.

Learning from Patient Feedback (Encompassing the Friends & Family Test, Complaints & PALS)

Complaints

We take learning from complaints very seriously. Any learning/action identified through the Complaints process is entered on to Health Assure, a system that enables the Trust to monitor each individual learning point. Additionally, the system also contains the details of the member of staff who has committed to take action, the timescales involved and the RAG rating assigned (i.e. green – complete, amber – on target, red – timescale exceeded). When the designated timescale has been reached, if evidence has not been received, then the RAG rating for each learning point will be revised to reflect this.

Detailed below are some examples of complaints and the action that has been taken as part of the learning process. It should be noted that this information relates to the top three themes for complaints for the financial year 2016/2017:

1. *Patient Care*

Complaint:
Patient raised a number of concerns regarding different aspects of care received relating to wound care whilst an inpatient. Issues referred to the wound being unchecked, the incorrect dressing used and infection prevention concerns were raised.

Outcome:
The complaint was addressed directly with the ward staff and the individual concerned during the investigation. Additional wound care training has been completed and standards of care and infection prevention guidelines were reiterated to the staff. An apology and explanation was provided along with reassurance of the learning taken forward.

Complaint:
Patient raised a number of concerns regarding a delay in the prescribing and administering of anticoagulant medication during his attendance.

Outcome:
The complaint was addressed directly with the individual concerned during the investigation in order to raise awareness and understanding of the need to ensure that this type of situation is acted upon in a timely manner. A memo instruction has also been sent to other clinicians within the department regarding patients who are awaiting inpatient specialty assessments. An apology and explanation was provided along with reassurance of the learning taken forward.

2. *Communication*

Complaint:
Patient raised concerns regarding the level of communication that was experienced in relation to an admission for a surgical procedure. The patient stated that they were not given advice as to how to escalate any concerns that they had postoperatively.

Outcome:
Through the course of the investigation it was identified that staff must ensure that patients are provided with the appropriate information verbally / in writing to ensure that they are aware of what to look for regarding postoperative complications. An apology and reassurance of the learning identified was expressed to the patient.

Complaint:
Patient raised concerns regarding the level of communication that was experienced in relation to an outpatient appointment. The patient was unable to leave a message as the telephone mailbox was full, and she was unable to make contact with anyone else as the relevant staff were on leave and messages were cleared. Additionally a letter confirming an appointment was not dispatched, as had been advised by a member of staff.

Outcome:
Through the course of the investigation it was identified that staff must access and action voicemail messages daily and that a 'buddy' system should be introduced when a member of staff is on leave to ensure that their calls are covered. Staff were also informed that they must ensure that actions agreed with patients must be followed up accordingly. Apology and reassurance of the learning identified expressed to the patient.

3. *Delays / Cancellations*

Complaint:
Relative raised concerns that the patient's appointment was cancelled as there was not a doctor available.

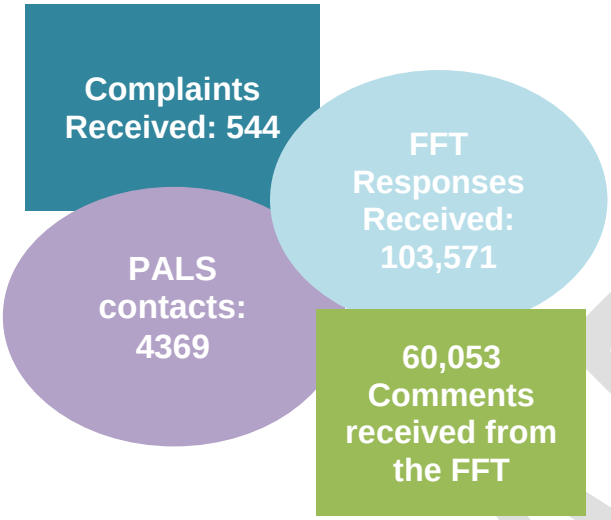
Outcome:
Through the course of the investigation it was identified that there this related to an administrative error whereby the clinic should have been closed on the system so that further patients could not be added. The Administration team was being restructured and the processes revised in light of this. An apology and explanation was provided to the patient. Reassurance was given of the learning identified and the action taken.

Complaint:
Patient raised concerns about the delay in her treatment when it was necessary to call for a more specialised member of staff from another area.

Outcome:
Through the course of the investigation it was identified that there needed to be more staff trained to use the equipment required to prevent delays in treatment being administrated. Training has since been undertaken, a grab box prepared to ensure treatment is administered promptly and a specific care plan is being set up for the patient as she has a relatively rare condition. An apology and explanation was provided to the patient. Reassurance was given of the learning identified and the action taken.

Northampton General Hospital NHS Trust

LEARNING FROM PATIENT FEEDBACK



Complaints Performance 2016/2017

100%	Percentage of complaints acknowledged within 3 working days
Ave 89%	Percentage of responses provided to complainant by agreed deadline

Complaints Performance 2015/2016

100%	Percentage of complaints acknowledged within 3 working days
Ave 87%	Percentage of responses provided to complainant by agreed deadline

What are our patient's main concerns?

The following Word Cloud has been produced from the Complaints and Friends & Family Test subjects most used throughout 2016/17 Q4.

Patient Experience

The Trust has worked hard across 2016/2017 to develop the ways in which patient feedback is collated, and the ways in which it is shared with the organisation and used to inform change.

It should be noted that there are 2 keys ways in which patients, families and carers give feedback to the organisation. As an organisation we refer to these within the Patient Experience & Engagement Strategy 2015-2018 as 'push' and 'pull' methods. Push methods are where we actively seek to gain feedback from our patients (Friends & Family Test, CQC National Surveys, in-house surveys, listening events), and others are pull methods – whereby we receive feedback from patients who have actively sought to contact the organisation (Patient Opinion, social media, NHS Choices, Complaints). We welcome all forms of contact from our patients and value all equally. It is through the breadth of these methods that we have developed a detailed and representative understanding of the experiences of our patients.

Over the past 12 months we have revolutionised the ways in which we actively collect patient feedback each month, taking on a three-pronged approach:

- The Friends & Family Test (FFT)
- The Real Time Survey
- The Right Time Survey

These will each be described in further detail below.

The Friends & Family Test

The FFT has been running successfully within the hospital for a number of years, however over the past year we have further developed the ways in which we collect responses to ensure we are providing patients with every opportunity possible to give their feedback. Previously the FFT was primarily collected using SMS text messaging and Interactive Voice Messaging (IVM), however it was acknowledged following the release of the FFT Guidance on Inclusivity in 2015 that more needed to be done. Following the guidance release a number of further methods were developed, this includes:

- Online Survey with over 50 languages available. Online survey link displayed throughout organisation in the 2 most popular languages after English, in Northampton.
- Children & Young People's online survey- included within text message to parents as an additional opportunity for the child or young person to give their feedback. Includes 3 different survey options depending on the age of the child.
- iPad set up within the Radiology department.

Most recently, the Trust has developed a suite of postcards bespoke to the organisation and the different services which collect FFT responses. Postcards also contain important demographic questions enabling the organisation to identify recommendation rates in line with protected characteristics and demographic groups.

The reporting for the FFT is extensive and varied. A great deal of focus has been placed on ensuring that the information reaches the right people at the right time to be able to make improvements based on areas of dissatisfaction.

CQC National Inpatient Survey Improvements

The CQC National Inpatient Survey is a mandatory survey undertaken each year by all hospitals nationwide that have Inpatient wards. The survey produces a series of reports detailing the hospitals performance and comparing results against the national average. The sample is typically drawn from July with results issued to the organisations the following May/June. Results from the National Survey are an overview of Trust wide performance and do not detail individual results for each of the wards. This makes it difficult to target improvement work, and for this reason it has been acknowledged that further work needs to be undertaken to understand the results at ward level in order to make the necessary improvements.

Therefore, 2 new surveys have been established within the hospital using the questions from the Inpatient Survey which the hospital routinely doesn't perform well in, along with additional questions identified as the most important aspects of patients' experience, by the patients themselves.

- The Real Time Survey: Introduced within the Organisation in October 2016, collecting 1:1 feedback from patients currently within inpatient wards and producing reports within 24 hours.
- The Right Time Survey: Started in November 2016 collecting feedback from patients following discharge from Adult Inpatient services and the Emergency Departments.

Further details on both of these surveys are provided below:

Real Time Survey

The survey, which has been devised is far more comprehensive than the Friends & Family Test and provides excellent information on the areas in which individual wards are doing well in and areas that they need to focus on. This measure is purely to enable frontline teams to understand better how patients are experiencing their ward.

The survey was introduced to obtain instant feedback from our patients and act upon it, whilst they are under our care on the wards. It is a 'here and now' survey to ensure that where possible positive improvements / changes take place whilst the patient is still in hospital. Initially 6 wards were chosen as a 'pilot' (phase 1) and this will be rolled out further in the next few months. The surveys are being undertaken by key clinical and non-clinical managers and the feedback is provided to the ward manager, matron and other members of the directorate senior team on the same day. Some of the improvements made to date are detailed below:

- Following patient feedback, lamps have been installed in all of the side rooms within Talbot Butler Ward as patients were stating that it was difficult to read.
- Creaton Ward had a number of comments relating to sleeping on the ward. They have held 2 team meetings where they have discussed this with staff and have increased the use of sleep well packs.
- Remote controls for some of the televisions on Talbot Butler were missing, these have now been replaced following this being highlighted by patients through the survey.

Right Time Survey

The premise of this survey is based around the 'Right Time to ask patients for their feedback' Identified as around 1-2 weeks' post discharge. As patients have left the organisation, they are issued with a survey by post. Responses are sent back to Patient Perspective who are undertaking the survey on the hospitals behalf. Patient Perspective have been contracted by the organisation since 2011 to undertaken the national surveys and the Right Time Survey will be conducted in much the same manner as the mandatory national surveys.

In summary, each month 600 questionnaires are sent out to patients that have attended as an adult inpatient and 600 questionnaires to patients that have attended A&E, to ask them for their feedback. Inpatient surveys commenced in November 2016 and A&E surveys commenced in January 2017. As with the Real Time Survey, the Right Time Survey uses a number of questions which have been taken from the National Inpatient Survey and the National A&E survey. Again this allows for the organisation to directly compare the results with the national results to see where progress is and isn't being made. Importantly, survey results will be available at department/ward level, as opposed to the national survey which gives an overarching Trust wide view.

In contrast to the Real Time survey, the Right Time Survey is able to include questions relating to Discharge. As the Real Time Survey is carried out whilst the patients are still on the ward it does not have the capability to capture satisfaction around the discharge process. It is important that this is included within this survey as it is one of the largest areas of dissatisfaction as stated by patients within the FFT, Complaints and PALS.

Side Effects Medication Poster

Within the National Inpatient Survey results patients are routinely stating that they do not receive explanations about their medication side effects before they leave hospital. For this reason a poster has been designed with an eye catching picture to prompt patients about their medication side effects.

The posters are in the process of being distributed throughout the wards. They are now visible within the Discharge Suite. Posters have also been displayed within the Boots pharmacy to show collaborative working and again to prompt patients to ask for advice if they are unsure.

4C's

COMMENTS, CONCERNS, COMPLAINTS, COMPLIMENTS

It is our aim to do everything possible to make sure that our patients receive the right treatment at the right time, to a high standard. We want to know what patients and relatives think of our services and how we can make their experiences count. We will listen to what patients and relatives have to say and then take action. If there is something that we can do straight away then we will aim to do it through front line staff and/or PALS. We aim to use the feedback that we receive to improve the quality of care and service provided to patients.

In the first instance anyone who raises any of the 4 C's should be advised to speak with a member of staff (i.e. nurse / midwife / manager) in that area as they are most often the person in the best

position to help and take immediate action. Where appropriate and in agreement with the person concerned the member of staff should complete a 4 C's form which are located on all wards and departments, noting the problem identified and the action taken. Completed forms should be sent to the Complaints Department and the relevant manager.

If the person feels that the issue has not been resolved by the member of staff contact should be made with the Head Nurse/Matron and a request made for them to speak with the patient/relative. Many problems can be quite easily resolved by talking things through with the right person at the right time. Misunderstandings can easily happen and are often very easy to put right.

Can anyone else help?
If the patient/relative does not wish to discuss their feelings with a member of staff then they should be advised to contact PALS who focus on the following:

- Provide on the spot advice and support to patients, their families and carers
- Provide information on NHS services
- Listen to concerns, suggestions and queries
- Help sort out problems on behalf of the patient or their representative

PALS will aim to respond to all concerns and complaints within 3 working days, or within a timescale agreed with the individual. If the person remains unhappy with the information and response received and they wish to make a complaint then they should be advised to contact the Complaints Department either in writing or by telephone.

Patients/relatives should be reassured that raising a complaint or concerns about their care will not affect their treatment or care. All complaints are treated seriously and in confidence.

Through a recent inpatient survey it was identified that members of the public were unclear how to raise concerns or make a complaint. In view of this the 4C's posters and leaflets have been reviewed and revised. The new information is more identifiable and visible and contains details advising members of the public how to raise concerns and complaints. A relaunch of the 4C's process will take place during 2017.

Patient Engagement

Listening Event – August 2016
The main theme of the first session was around Always Events, and therefore it was titled 'What patients Always want'- this is something which many organisations have rolled out successfully in the past and we believe that given the areas in which we need to improve on for our Inpatient Survey, having Always Events are likely to help to make improvements. Key members of staff attended to support and facilitate the event.

The Information Team extracted a random selection of 100 patients who had recently been inpatients within the hospital and these were each telephoned. 13 patients stated they would attend, accompanied by a relative or friend. On the day, 9 patients/relatives/friends attended the session. In addition to this around 12 members of staff and our patient rep attended to act as facilitators for the tables and workshops.

Feedback has been collated in a number of different ways. The 'Tell us about your Journey' sheets which were completed by both the patients and their carers/family/friends have been turned into 7

individual patient stories. Each sheet contained the attendees' experiences under the following headings.

- Reputation
- Arrival
- Contract of Care
- Stay
- Treatment
- After stay

Overall, the attendees voiced a positive experience. Some issues were identified, particularly around Waiting Times 'Appointments do not usually run on time, but always treated well and thoroughly' 'Pharmacy unreliable, waiting times need to be adjusted'. Further comments were given regarding the busyness of the wards 'Although they were far too busy and there should have been far more nurses' 'generally good, but shortage of nursing staff in general'. An attendee discussed their issues with communication 'Unfortunately there was a lack of communication on staff switch over, the night staff had no idea of my situation, lack of physio and exercise, pain killers, dressings or when I could go home'. The same patient went on to describe how they discharged themselves due to the lack of information given to them, and the issues this then led to with paperwork not being sent.

Interestingly, one patient stated that they had attempted to see their GP but had been advised to go to A&E as their surgery was fully booked. This was also the experience of a number of other patients during the A&E survey conducted between the hospital and Healthwatch earlier in the year.

The 4 always events which patients voted as the most important to them were:

- Teach Back will Always be used to ensure you understand information given at discharge
- You will Always be treated with Kindness, Respect & Dignity
- You will Always be Listened to
- Staff will Always do everything they can to control your pain

Quality Conversation- Patient Engagement Event (January 17)

In January 2017 a patient engagement event was held entitled 'Quality Conversation- 'A Winter Warmer'. An invitation was sent out to over 1700 members of the hospital inviting them to attend the evening. The evening was opened by the Director of Nursing and was followed with presentations by the hospital's Chief Executive, Deputy Director of Quality Improvement and the Matron for A&E. Presentations were followed by the opportunity to talk with the presenters and a number of other members of the senior team, and visit stands which 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, Healthwatch and First for Wellbeing. Hot Soup and rolls were provided for attendees alongside tea and coffee. The event was also attended by BBC Radio Northamptonshire.

Thirty people attended the event and feedback from the event has been 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.

Service Improvement – Complaints

Since the early part of 2016 the IQE team has been working in partnership with the Complaints team to look at ways in which our internal processes may be improved. This would support the Trust response rate which was RAG rated as amber for a number of months. A member of the IQE team was assigned to work with the Complaints team and as part of the work the following action has been undertaken:

- A random selection of 35 complaint files (from this financial year) have been independently reviewed, with 94% requiring extensions (when the initial timescale has been exceeded but the additional time is agreed with the complainant)
- Each file required on average 2 chases from the Complaints team to directorate staff as they exceeded the internal (and sometimes external) timescale
- The IQE advisor met with a number of directorate senior staff who are involved in the complaints process for their areas
- A solutions workshop was held on the 2nd November 2016, with representatives attending from some directorates and the Complaints team
- An update is being included (by the IQE team) in the Bi-Annual Quality Improvement & Efficiency Report

Shortlisted for the PENNA awards

Each year, the Patient Experience Network hold a National Awards ceremony where they invite NHS organisations to submit proposals based around a number of categories. For the 2017 awards NGH submitted 2 proposals and have been shortlisted for both of these. In addition to this, the second proposal was given a free additional entry into a further category- which it was also shortlisted for. The first proposal was for the Compliments Collation and the way in which NGH have focused on collecting and sharing compliments with staff. The second proposal was for the Maternity Chit-Chat group, set up to support ladies with learning disabilities who are expecting, or have had, babies. The awards ceremony will be held on the 21st of March.

Next steps:

To build upon the work we have already done we will be:

- Relaunching the 4 C's during 2017
- Continuing with the Right time and Real time surveys
- Launching of the Patient & Family Partners

NHS Staff Survey

We have continued to work on the development of a sustained, coherent and integrated approach to changing our culture and engaging staff in helping us to deliver long term sustainable change that results in best possible care. We have set ourselves the overall aim of introducing Best Possible Care and the Trust Values and bringing them to life over the years. A key priority from the

start was to align all efforts around the quality agenda in its broadest sense. This includes a relentless focus on patient safety and key quality outcome issues from all operational, clinical and managerial staff underpinned by key programmes of work. This work has been in progress for some time but some of the key initiatives have gained significant traction over the last 2 years.

This approach was originally captured in the Trust's Organisational Effectiveness Strategy: Connecting for Quality, Committed to Excellence. This led on from the Trust's focus on strategies for patient safety and quality improvement based but took this much further by focussing on the development of staff around Quality Improvement.

Our Employee Engagement strategy was designed to facilitate cultural transformation to deliver improved sustainable staff engagement for high performance working, building capability and commitment at all levels of the organisation. This has been underpinned by providing effective and supportive leadership and implementing a clinically led structure.

We are delighted to see that the combined efforts of the cultural work can be seen through the significant improvements in the results of our staff survey.

The 2016 annual National NHS Staff Survey took place during September to December 2016. A total of 4680 eligible staff had surveys sent directly to them and 1624 members of staff returned the survey.

Of the 32 key findings this year there has been improvement in 11, no deteriorations and 21 have stayed the same. These results support the continued positive trend of improvement at the Trust over the last 4 years. In addition the Trusts overall staff engagement score has also improve since the previous survey.

The Trust has had 12 statistically significant improvements since 2015, and these were for:

- Overall staff engagement
- Staff reporting good communication between senior management and staff
- Quality of non-mandatory training, learning or development
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Staff confidence and security in reporting unsafe clinical practice
- Organisation and management interest in and action on health and wellbeing
- Staff recommendation of the organisation as a place to work or receive treatment
- Staff satisfaction with level of responsibility and involvement
- Staff satisfaction with resourcing and support
- Recognition and value of staff by managers and the organisation
- Support from immediate managers
- Staff satisfaction with the quality of work and care they are able to deliver.

When compared against other acute trust, the Trust was in the top 20% for:

- Staff motivation at work
- Effective team working
- Percentage of staff appraised in last 12 months
- Quality of non-mandatory training, learning or development.

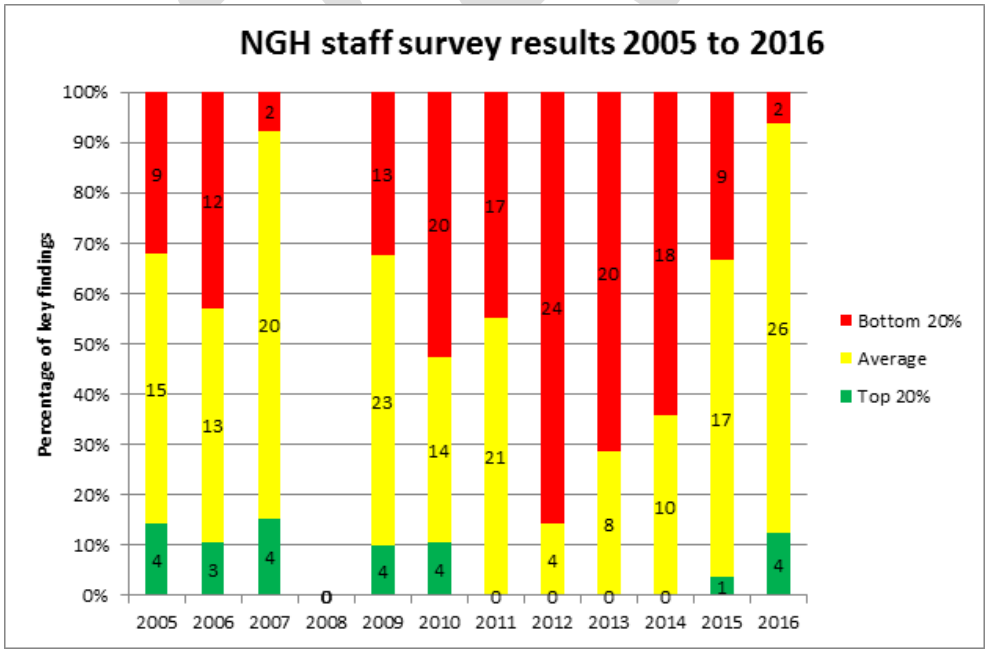
The Trust was benchmarked as above average when compared to other acute trusts for:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last 12 months
- Percentage of staff working extra hours
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff experiencing physical violence from staff in the last 12 months.

The Trust was benchmarked as average when compared to other acute trusts for:

- Quality of appraisals
- Percentage experiencing discrimination at work in the last 12 months
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Percentage attending work in last 3 months despite feeling unwell because they felt pressure
- Staff recommendation of the organisation as a place to work or receive treatment
- Staff satisfaction with the level of responsibility and involvement
- Staff satisfaction with resourcing and support
- Recognition and value of staff by managers and the organisation
- Percentage reporting good communication between senior management
- Support from immediate managers
- Staff satisfaction with the quality of work and care they are able to deliver
- Percentage agreeing that their role makes a difference to patients and service users
- Effective use of patient/service user feedback
- Percentage reporting the most recent experience of violence

The following graph shows the overall picture is now continuing towards an increasingly upward trend.



There have been improvements across all areas when you compare the Trust to the others as follows:

	Lowest (worst) 20%	Below average	Average	Above average	Top 20%
2015	9	15	5	2	1
2016	2	8	14	4	4
Percentage Improvement	78%	47%	180%	100%	300%

Overall we have been recognised as being in the top 5 most improved acute Trusts in the country.

The key areas for improvement, based on our rankings against other acute trusts include:

- Flexible working opportunities
- Staff experiencing harassment, bullying or abuse from other staff or patients/relatives/public
- Staff reporting most recent experience of harassment, bullying or abuse
- Physical violence from patients/relatives/public
- Equal opportunities for career progression
- Witnessing potentially harmful errors/near misses/incidents
- Confidence and security in reporting unsafe clinical practice
- Staff feeling unwell due to work related stress
- Organisation and management interest in and action on health and wellbeing.

We recognise that overall the survey shows a lot of improvement. However, given the results on bullying and harassment we will be focussing more effort on addressing this to support our trust value of *'we respect and support each other'*. We will approach this from two perspectives; firstly to support to staff by understanding their concerns through engaging directly with staff; developing our Mental Well-Being & Resilience policy and providing resilience training as part of our Health & Well-Being strategy and secondly to send clear communications and have robust policies that make it clear that any form of bullying or harassment is unacceptable and will be dealt with.

Statements of assurance from the Board

Review of services

During 2016/17 NGH provided and/or sub-contracted 72 NHS services.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2015/16.

Participation in National Clinical Audits and National Confidential Enquiries

This continues to be a high priority for the Trust. During 2016/17 Northampton General Hospital aimed to participate in all relevant projects included in the Quality Account list published by the HealthCare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The Quality Account list includes a variety of different topics and ways of collecting data. Some of the projects collect data for a short period of time (snapshot audits) and others collect data continually on the management of certain conditions. Some of the larger projects have developed to include several different work streams for example questions about the structure of the service provided (organisational questionnaires), questions about the process of individual patient care (case note reviews) and questions about the patient experience (patient questionnaires).

The following table gives details of all Quality Account audits and confidential enquiries to which Northampton General Hospital submitted data in 2016/17. Percentage participation is included for snapshot audits. For audits that collect data on a continual basis, the local percentage participation and data quality are reviewed when reports are published and plans made for improvement if needed.

Name of Audit	Participated Y/N	Percentage Participation
Perinatal Mortality (MBRRACE)	Y	Data collection ongoing
National Neonatal Audit Programme (NNAP)	Y	Data collection ongoing
Paediatric pneumonia (British Thoracic Society)	Y	Audit in progress
Diabetes (RCPH National Paediatric Diabetes Audit)	Y	Data collection ongoing
Adult Asthma	Y	100%
Chronic Obstructive Pulmonary Disease	N	no data entered
Chronic Obstructive Pulmonary Rehabilitation (British Thoracic Society)	Y	Audit in progress
Cardiac Arrest (National Cardiac Arrest Audit)	Y	Data collection ongoing
Adult Critical Care (Case Mix Programme)	Y	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Y	Year 3 – 100%
		Year 4 – Data collection ongoing
	Y/N	Core Audit – No data entered
		National Pregnancy in Diabetes - Data collection ongoing

Diabetes (National Adult Diabetes Audit)		Foot Care Audit – Year 3 data collection ongoing
		Inpatient Audit – 100%
IBD Registry	Y	Data collection ongoing
Hip, knee and ankle replacements (National Joint Registry)	Y	Data collection ongoing
Elective Surgery (National PROMS Programme)	Y	Data collection ongoing
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Data collection ongoing
National Vascular Registry	Y	Data collection ongoing
Asthma (paediatric and adult) CEM	Y	100%
Severe Sepsis and septic shock CEM	Y	100%
Acute Myocardial Infarction and other ACS (MINAP)	Y	Data collection ongoing
Heart Failure Audit	Y	Data collection ongoing
Stroke National Audit Programme (SSNAP)	Y	Data collection ongoing
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Y	Data collection ongoing
Renal Replacement Therapy (Renal Registry)	Y	Data collection ongoing
Lung Cancer (National Lung Cancer Audit)	Y	Data collection ongoing
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Data collection ongoing
Prostate Cancer Audit	Y	Data collection ongoing
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Data collection ongoing
Falls and Fragility Fracture Programme - National Hip Fracture Database	Y	Data collection ongoing
National Audit of Dementia	Y	100%
Severe Trauma	Y	100%
National Ophthalmology	N	No data entered
Renal Registry	Y	Data collection ongoing
Endocrine and Thyroid National Audit	Y	Data collection ongoing
Nephrectomy Audit	Y	Data collection ongoing
Percutaneous Nephrolithotomy	Y	Data collection ongoing

National Confidential Enquiries (NCEPOD)	Y	Young People's Mental Health – 100%
		Non-invasive Ventilation – 100%
		Chronic Neurodisability – Data collection ongoing
		Cancer in Children, Teens and Young Adults – Data collection ongoing
Re-audit of Patient Blood Management in Scheduled Surgery	Y	100%

National reports (including hospital specific and individual consultant specific results where appropriate) are published at varying intervals. Most audits will report annually but some provide more frequent updates or can be viewed on line. There were over 40 reports published relating to national clinical audit and NCEPOD between 1 April 2016 and 31 March 2017, the majority of which were relevant to acute hospitals. The clinical audit and effectiveness department monitors the publication of these reports and shares them with the clinical leads. The clinical leads are asked to review the report and recommendations, share the findings with their colleagues and assess the need for changes to their practice.

The recommendations made are wide ranging and some examples of changes that have been made following the review of national audit recommendations are given below. The results of many audits demonstrate good results compared with national figures and in these instances, no changes may be required.

Described below are some examples of some of the changes and learning we have identified following the publication of National Clinical Audit reports during 2016/17.

- Clinical Effectiveness
    - The Sentinel Stroke National Audit Programme measures the Key Indicators of the quality of a Stroke Service and NGH continues to perform very well. Over the course of 2016/17 rapid access to CT scanning although already good in Q1 has improved further and has been rated as “A” (the highest level possible) for the last 3 quarters.
    - The Cardiac Arrhythmia Audit shows that the use of pacemakers for Sick Sinus Syndrome at NGH has increased and is now in line with national figures. In addition more pacemakers are being inserted for primary prevention to manage problems before they arise.
    - The National Emergency Laparotomy Audit recommendations have been followed up locally by a review of pre-operative management of patients requiring emergency abdominal surgery to find the best way of ensuring that all patients receive the appropriate opinions, investigations and treatments without delaying surgery. Surgery for some patients brings a higher risk than others so this is assessed pre-operatively to identify those patients who will need a higher level of care such as Critical Care post operatively.
    - The Adult Cardiac Interventions Audit data (NICOR) continues to show that patients treated at NGH for a heart attack get the best recommended treatment available.
    - The Neonatal and Obstetric Teams continue to have joint meetings to share learning from the review of Perinatal Mortality (MBRRACE) data.

- Patient Safety
    - Using the results of the College of Emergency Medicine snapshot audits the Accident & Emergency Department is improving safety for patients receiving sedation by improving training for staff and developing “Sedation Champions” to help to spread the message. The audit has also helped highlight concerns about the use of the sedation across other areas and a Trust Sedation Committee is being established to address this. Safe discharge for children from the Emergency Department is also a priority and as a result of the Paediatric Vital Signs audit it is being enhanced by senior review before discharge where applicable.

- Unplanned admission to Critical Care in the 7 days after emergency abdominal surgery and unplanned return to return to theatre have been highlighted for review by the NGH team involved in The National Emergency Laparotomy Audit in order to learn and improve patient safety.

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- Patient Experience

  - Following publication of the National Neonatal Audit Programme the Neonatal Team continues to support breastfeeding by making DVD's and other resources available on the wards.
  - The End of Life Team has used the Care of the Dying Audit to launch a teaching programme to help staff feel more confident in supporting patients and their relatives/ carers. The care plan has been improved to make it easier to focus on and document the patient's wishes and the team have also started to routinely gather feedback from relatives/ carers after the death to help them improve the service they provide.
  - The National Hip Fracture data (part of the Falls and Fragility Fracture Audit Programme) recommended that more patients should be mobilised the day after surgery. This has been addressed locally by reviewing the way local anaesthetics are used at the end of the operation to see if a new approach will allow patients to mobilise earlier but still provide effective pain relief.

- Service Improvement

  - The Pulmonary Rehabilitation report (part of the COPD National Audit) showed that locally more patients should be referred for pulmonary rehabilitation and that some patients started the course but didn't finish it. In response the team have made changes to their referral processes to support the referral of the patients who will benefit the most.
  - Following the publication of the Care of the Dying Audit, the Specialist Palliative Care Team have expanded their service to be available seven days a week.
  - The Sentinel Stroke National Audit Programme Key Indicators are reviewed quarterly by the team to identify areas for improvement. For example, it is not always possible to admit a stroke patient to the Stroke Unit within 4 hours. Whilst recognising that pressure for beds remains very high efforts are being made to alleviate the concern. This includes actions to "ring fence" beds on the Stroke Unit, enhance the process for repatriating patients to their local hospital when appropriate and highlighting the knock on effect of delay in discharge caused by a lack of appropriate social care provision.

- Communication

  - The Accident & Emergency Department have reviewed the information that is shared with patients on discharge. Advice leaflets for those patients who required sedation during their stay and those with a plaster cast on their lower limb have been developed and are given to patients on discharge from the Emergency Department.
  - Having identified a lack of awareness of the role of Advance Care Plans the End of Life Care Team plan to highlight this during their Trust "Dying Matters" week.
  - National Neonatal Audit Project data continues to show how well the team at NGH respond to the needs of parents by communicating with them as soon as possible after a baby is admitted to the neonatal unit.

- For services that are shared between different healthcare providers, national audits can help providers come together to discuss the findings and improve care. For example the Cardiology Teams from NGH meet regularly with their colleagues from KGH to discuss Adult Cardiac Interventions Audit data (NICOR). The recommendations of a recently published Confidential Enquiry "Treat as One" which looks at the care of patients in general hospitals who also have a mental health diagnosis are being reviewed by a team made up of individuals from NGH, NHFT and the CCG.

- Data quality and Documentation

  - In order for audit reports to be useful the data entered must be as complete and accurate as possible and this partly relies on documentation in the notes being sufficiently detailed. One of the key actions for many of the clinical leads of the national audits is to continually review the quality of the data submitted and improve documentation to capture the relevant information if required.
  - An example of this during 2016/17 was the findings of the Paediatric Vital Signs Audit in the Emergency Department which showed that the current Paediatric Assessment Form didn't capture the data required for the audit and therefore the results did not reflect the actual standard of care provided. The form has been redesigned and re-audited to provide assurance of the care provided.
  - The National Audit of Oesophago-Gastric Cancer raised concerns at a national level that Trusts were not submitting data for a particular subset of patients. NGH reviewed this locally and was able to confirm that data for all patients has been submitted.

- Resources and staff recruitment

  - The National Audit of Inpatient Diabetes runs annually and in response to the latest report a business case for an additional diabetes nurse specialist and consultant has been developed.
  - The Pulmonary Rehabilitation team require further resources in order to be able to provide routine exercise assessment which is crucial for vigorous exercise prescription.
  - The Stroke Team have used learning from the national audit and a recent CQUIN to develop a service for delivering mood support to inpatients. A joint business case is being prepared with NHFT, KGH and Nene CCG to ensure the service will continue.

- National audit mortality and consultant level data

  - In 2016/17 there were 8 audits which published mortality data for NGH. This data could be specific to a service or to an individual consultant and is intended to signpost whether the service or the individual is performing "better than expected", "as expected" or "worse than expected". If a particular service or consultant is noted to be an "outlier" (data suggests they might be performing worse than expected) then this is investigated further.
  - The following audits published service level mortality data in 2016/17. Performance in all was at the "as expected" level.
    - National Emergency Laparotomy Audit (NELA)
    - National Hip Fracture Database (Part of the Falls and Fragility Fractures audit)
    - National Vascular Registry (NVR)
    - National Joint Registry (NJR)
    - British Association of Urological Surgeons (BAUS)

- Intensive Care National Audit and Research Centre (ICNARC)
- National Bowel Cancer Audit Project (NBOCAP)

- Data from the UK Perinatal Mortality Report (MBRRACE) was reviewed in further detail as published standardised and adjusted mortality rates suggested that NGH rates has previously been '10% higher than the average' when compared to similar sized units. It was noted that the sample size or number of patients was very small. All of these patients and the care they received has been reviewed in detail by the neonatal team to ensure that all possible learning has been identified and changes to practice made where necessary.
- The following audits published individual consultant level data in 2016/17. Performance in each case was "as expected".
  - National Vascular Registry (NVR)
  - National Joint Registry (NJR)
  - British Association of Urological Surgeons (BAUS) - Nephrectomy
  - National Bowel Cancer Audit Project (NBOCAP)

Local Clinical Audit

In 2016-17 we undertook 163 local clinical audits including 39 specifically against NICE guidance. Some examples are outlined below together with the resulting actions aimed at improving clinical quality, patient experience and patient safety.

All of the registered clinical audits were eligible for entry to the annual Trust Audit Presentation Day. The highlights from the Audit Day are described below.

Effective documentation or Continuation of care whilst in Emergency Department

There is an expectation that all A&E patients will have the following ongoing documented whilst they are in the Majors or Resuscitation areas:

- All patients with EWS >3 will have their vital signs documented after care intervention
- All pain scores should be repeated after initial assessment and pain management intervention (if pain score >1)
- All patients with a raised Anderson score will have pressure area care documented.
- Documentation of hygiene and elimination support should be clear in all patient notes
- Documentation of nutrition and hydration care intervention should also be clear in all patient notes.

Recommendations following the audit that were implemented – Use of a care plan continuation, introduction of a chart for efficient documentation of care interventions and as a prompt for e-documentation and repeating NEWS and pain scores.

Management of pain in patients with fractured neck of femur (NOF) in the Emergency Department

Due to increased assessment and monitoring of pain and increased use of Fascia Iliaca Block (FIB) technique more patients with moderate or severe pain are receiving analgesia within the first 60 minutes of arrival. On re-audit it was found that 37% of patients received a FIB and 46% of patients with severe pain received a FIB and these figures continue to improve.

Post-operative Blood Tests in Patients Undergoing Routine Urological Surgery

Post-operative blood tests in patients undergoing the majority of urological procedures have been found to be unnecessary. The changes implemented as a result have reduced the incidence of postoperative blood testing by 75%.

There were associated cost savings of at least £383,310 since the audit took place.

Use of CT Pulmonary Angiograms (CTPA) for patients with suspected Pulmonary Embolism

Many of the patients who have a CTPA scan to investigate for pulmonary embolism are found not to have this diagnosis. In some cases, 'rule-out' testing with a D-Dimer blood test were not performed at all before proceeding to the CTPA or Ventilation/Perfusion scans.

The audit found that the Wells deep vein thrombosis probability scoring system was rarely used for patients with a presumed pulmonary embolism. Most of the patients, who had a CTPA scan had presented with shortness of breath or chest pain due to Asthma or Chronic Obstructive Pulmonary Disease.

It was found that therapeutic Enoxaparin had not been started in some patients with a presumed pulmonary embolism.

Following the audit a pulmonary embolism treatment protocol has been designed which includes the use of the Wells Score and other clinical indicators to be assessed before referring for CTPA scan.

Consent in total hip and total knee replacement

The Trust undertook a joint clinical audit conducted University Hospitals Leicester NHS Trust to look at consent in lower limb joint surgery.

Recommendations from the audit included the use of the British Association of Anaesthetists approved consent forms or pre-printed stickers agreed by the orthopaedic surgeons. We are conducting a patient survey on the consent process and the use of different consent forms including electronic versions.

There has also been a trial of the use of patient workbooks to assess how well patients understand the patient information sheets for total hip replacement and total knee replacement to be conducted in patient joint school classes run in Physiotherapy.

Participation in clinical research

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2016 to March 2017 that were recruited during that period to participate in research approved by a research ethics committee was around 1200. To date 832 have recruited to 67 studies on the National Institute of Health Research portfolio within this financial year. This has shown an increase year on year of research activity resulting.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research contributes to successful patient outcomes.

We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in a wide range of clinical trials. This which is consistent with our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques to our patients.

Use of Commissioning for Quality and Innovation (CQUINs) payment framework

NHS Nene Commissioning Group is our main commissioner. We receive part of our income from them through an agreed CQUIN scheme where prior to the start of the financial year negotiations take place to agree specialist projects which bring about innovative quality improvement for our patients. Our CQUIN agreements with them are both local agreements and part of a national agenda.

In 2016/17 NGH agreed five local CQUINs and three themed national CQUINs equating to seven strands. NGH also holds a contract with commissioners known as Specialised Commissioners who are NHS England – Midlands and East. This contract is for specialised treatments that are commissioned on a regional or national basis. In 2016/176 NGH agreed three specialist CQUINs.

The CQUINs agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement. Each CQUIN is outlined below together with the RAG status of achievement.

KEY

No milestone
Milestones partially met

Milestones met
Milestones not met

TYPE	CQUIN INDICATOR NAME	Q1	Q2	Q3	Q4
LOCAL	1. End of Life Care Pathways				
	2. Dementia Discharge Summaries				
	3. Dementia Johns Campaign				
	4. Acute Kidney Injury				
	5. Delayed Transfer of Care				
NATIONAL	1a. Introduction of Health and Wellbeing Initiatives				
	1b. Healthy food for NHS staff, visitors and patients				
	1c. Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff				
	2a. Timely identification and treatment of Sepsis in emergency departments				
	2b. Timely identification and treatment of Sepsis in acute inpatient settings				
	4a. Reduction in antibiotic consumption per 1,000				

	admission				
	4b. Empiric review of antibiotic prescriptions				
SPECIALIST	WCa. Two year follow up assessment for very preterm babies				
	WCb. Pre-term Babies Hypothermia Prevention				
	IM3. Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance				

The CQUINs for 2017/18 have been agreed with our Commissioners and the Trust has two local CQUINs, six themed national CQUINs equating to 11 strands of work and three specialist CQUINs.

National CQUINs
1a. Improvement of staff health and wellbeing
1b. Healthy food for NHS staff, visitors and patients
1c. Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings
2b. Timely treatment of sepsis in emergency departments and acute inpatient settings
2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
2d. Reduction in antibiotic consumption per 1,000 admissions
4. Improving services for people with mental health needs who present to A&E.
6. Offering advice and Guidance (A&G)
7. NHS e-Referrals CQUIN
8. Supporting Proactive and Safe Discharge – Acute Providers
9. Preventing ill health by risky behaviours – alcohol and tobacco
Specialised CQUINs
IM3. Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance
GE3. Hospital Pharmacy Transformation and Medicines Optimisation
Public Health CQUIN
1. Clinical Engagement

Local quality requirements

The NHS Standard Contract contains quality requirements where NGH is required to report against certain indicators on a periodic basis. The quality requirements are set out in Schedule 4 of the NHS Contract and are collectively known as the Quality Schedule. They are split into six quality sections which include Operational Standards and National Quality Requirements. They also include Local Quality Requirements which are agreed locally with our commissioners and are derived from a variety of sources.

We report to our commissioners quarterly on all the relevant local quality requirements submitting evidence and demonstrating where we meet the requirements.

Quality Requirement for 2016/17
End of Life care
Patient Safety
Learning
Quality Care for Patients with a Learning Disability
Patient Experience
Nutrition and Hydration
World Health Organisation Surgical Checklist
National Early Warning Score
Safeguarding Children
Safeguarding Adults
Workforce
Venous Thromboembolism
Pressure Tissue Damage
Service Specifications
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)

Statements from the Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission under the Health and Social Care Act 2008. The CQC are the independent health and adult social care regulator. Their role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care. They do this by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety.

NGH currently has no conditions attached to registration and has not been required to take part in any special reviews or investigations under section 48 of the Health and Social Care Act 2008.

All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

The Trusts CQC grid below shows the outcome of the CQC inspections from 2014 where many areas were categorised as “Good”. Actions have now been completed to address those areas identified as “Requiring Improvement” or “Inadequate”.

A focused, short-notice announced CQC inspection of the trust took place on, 30 January and 7-9 February 2017. The inspection team focused on the four core services Medicine, Surgery, Urgent Care and End of Life Care. The first three were rated requires improvement and the latter inadequate at the inspection in 2014. There was also a review of the Well-Led domain at trust level. The final report has not yet been published but the trust received initial written feedback highlighting the following areas of good practice:-

- Positive, caring approach by staff to patients and their visitors.
- Clear focus on patient safety and patient-centred care.
- Positive and supportive staff culture across the hospital. The commitment and passion shown by staff to provide good patient care.
- The focus on patient safety in the emergency department despite the operational pressures.

- Use of escalation areas to manage bed capacity and demand.
- Medical outliers (patients cared for on a non-medical ward) were cared for effectively, with training in place to support surgical nursing staff to care for these patients.
- The maintenance of the hospital estate and levels of cleanliness; with plans in place to support refurbishment and address historical maintenance issues.

The CQC inspection team also gave feedback on some areas for improvement. These were:-

- Ensuring review of patient risk assessments for venous thromboembolism (VTE).
- The safer surgery checklist in plastic surgery to be reviewed to be compliant with the World Health Organisation (WHO) Five steps to safer surgery principles.
- Controlled drugs (from syringe drivers) were not being denatured (made inactive) before disposal in sharps bins.
- Confidential patient information displayed on whiteboards on wards was visible to patients and visitors.
- Medical records were not stored securely on all wards.
- Drug rounds for inpatients at the Heart Centre did not all take place at an appropriate time.
- Mental Capacity Act assessments were not consistently recorded to support do not attempt cardiopulmonary resuscitation decisions.
- Board sub committees following terms of reference, with regards frequency of review of the board assurance framework and risk registers.
- The review process for risks on the corporate risk register.
- Some trust policies found to be out of date for review.

A trust-wide action plan was developed by the executive team in response to the feedback given at the end of the inspection.

Care Quality Commission

Last rated
27 March 2014

Northampton General Hospital NHS Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

Are services

Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Good
Responsive?	Requires improvement
Well led?	Requires improvement

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RNS

We would like to hear about your experience of the care you have received, whether good or bad.

Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

Find out what we have changed since we received this rating from CQC:

NHS
Northampton General Hospital
NHS Trust

CareQuality Commission

Last rated
23 June 2015

Northampton General Hospital NHS Trust

Northampton General Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services (A&E)	Not rated	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Requires improvement	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Reference: medical not found	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Implementing Duty of Candour

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

As a Trust a significant amount of work has been undertaken to ensure we are compliant with the statutory and contractual requirements. Duty of candour training has been included in all the incident reporting/investigating and root cause analysis training given to staff.

The successful introduction of the Duty of Candour sticker was welcomed by the clinical staff and is widely used. The Governance Team has received positive feedback since the implementation, that the advice to staff is clear on what they need to deliver to be compliant with the statutory requirement.

The concept of a crib sticker for the staff has been shared at a Countywide Patient Safety Forum and has been utilised by another provider within the region.

Patients and/or their relevant person are encouraged to participate in the investigation and are offered being open meetings.

The Trust continues to demonstrate compliance with Duty of Candour to the Clinical Commissioning Group (CCG).

Hospital mortality monitoring

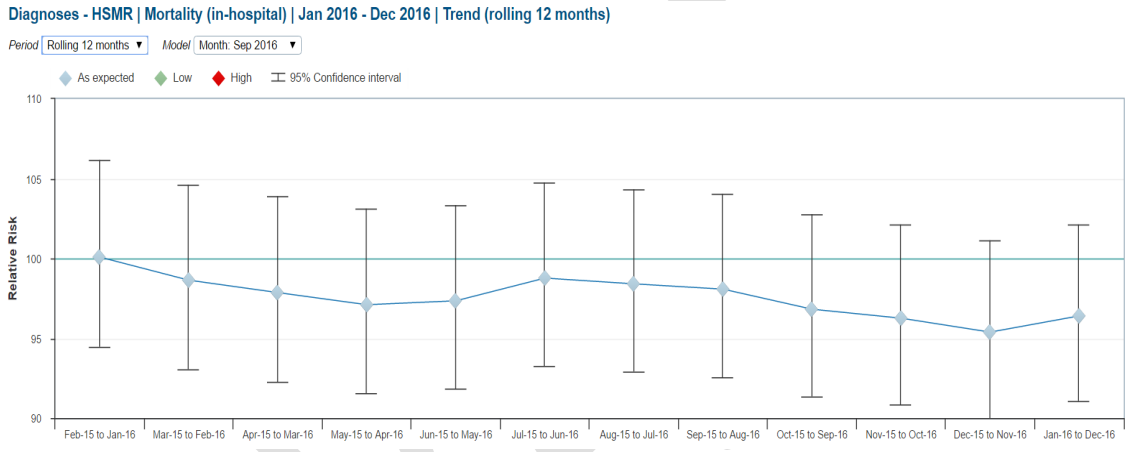
Northampton General Hospital uses three key mortality metrics which are benchmarked against all other hospitals in England and examine patient outcomes. These metrics are provided to the Trust by Dr Foster™ and the Health and Social Care Information Centre (HSCIC):

- The HSMR [Hospital Standardised Mortality Ratio] analyses mortality from the 56 most common and serious conditions which result in more than 80% of deaths which occur in hospital. The Standardised Mortality Ratio can be quoted as a percentage or ratio relative to the number of deaths that would have been expected to occur based on what is known about the patients that were admitted to hospital. A hospital that is performing 'as expected' would have an HSMR that is equal to 100. If the HSMR is higher than 100, then there is a higher reported mortality ratio. An HSMR that is less than 100 suggests that the mortality is low than would have been expected.
- The HSMR 100 looks at all hospital deaths. Both mortality indicators are case mix adjusted, taking into account the age of each patient and their general health before their admission to hospital.

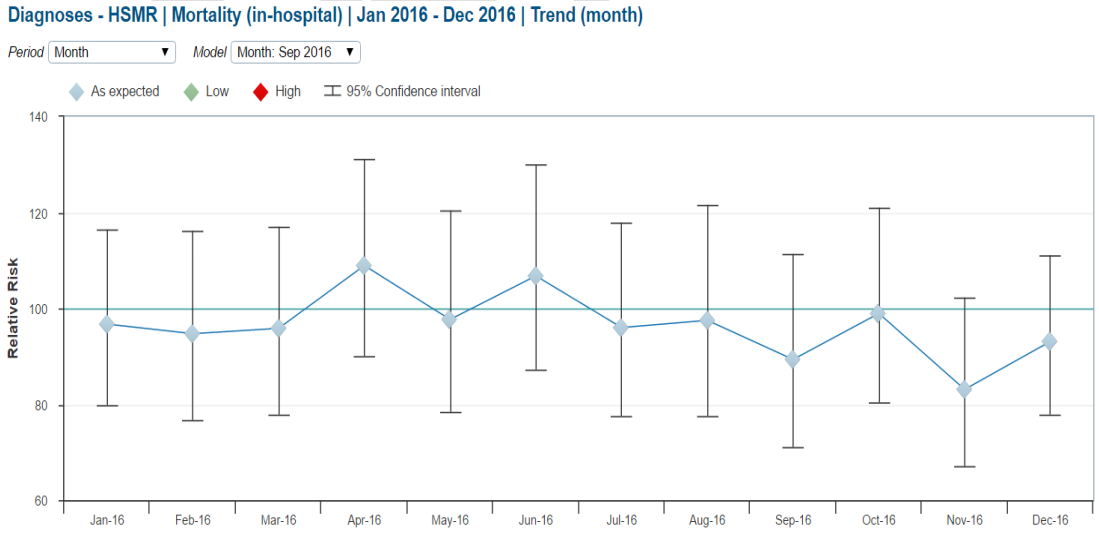
- The Standardised Hospital Mortality Index (SHMI) provides similar information to the MSHR but also includes patients who have recently been discharged from hospital (in the previous 30 days)

This information is under continuous review to identify areas of adverse performance which require further analysis and investigation. The analysis is presented to the Mortality Review Group each month and to the Clinical Quality and Effectiveness Group by the Associated Medical Director. The Medical Director reports to the Trust Board on mortality and planned actions in relation to any areas of concern through the Quality Governance Committee.

The HSMR is reported 3 months in arrears. During the year to December 2016 the HSMR has remained within the 'as expected' range: at 96.4:

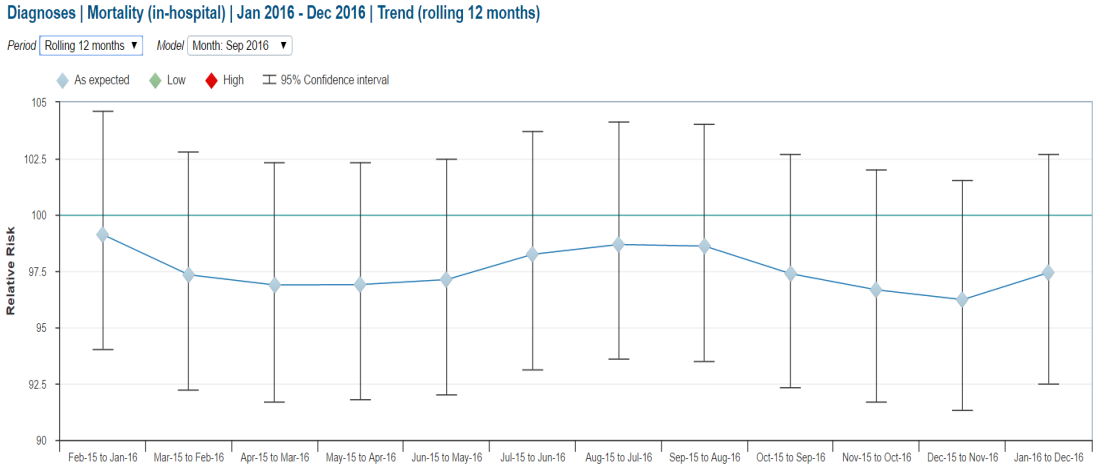


The monthly variation in the standardised mortality ratio over this 12 month period is shown below:

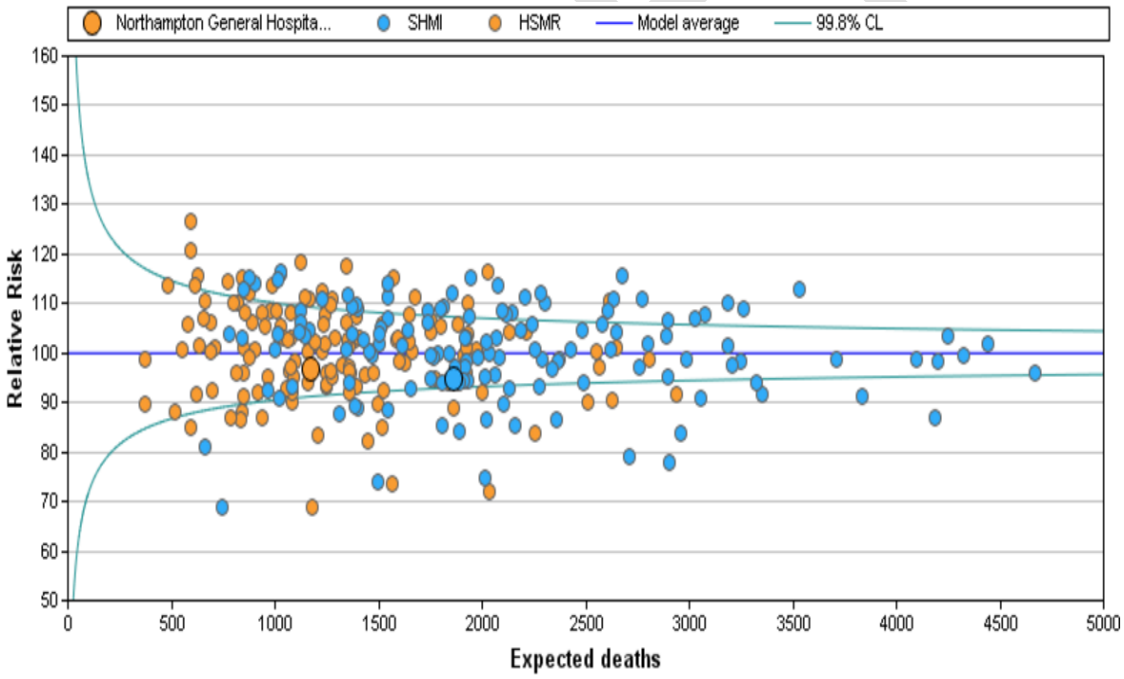


Due to the shorter monthly time frame there is more variation seen. The monthly Trust results have also remained in the as expected range.

The HSMR-100 metric which covers all diagnoses shows a similar pattern to that of the HSMR:



The Standardised Hospital Mortality Index (SHMI) has also remained in the 'as expected' range. The most recent update of the SHMI for the year from October 2015 to September 2016 was 94.7 and is shown in the graph below relative to our national peer group:



In December 2016 the CQC published a report "Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England". This review found that learning from deaths was not being given sufficient priority in some organisations and suggested that opportunities for improvements were being missed. It highlighted that Trusts could do more to engage families and carers and use their insights as a source of learning.

Following on from this the Secretary of state for Health delivered a parliamentary statement announcing his intentions that all NHS Trusts should collect and publish data on all deaths

occurring in hospital including an estimate of the number of deaths assessed as more than likely to have been due to problems in care (i.e. "avoidable" deaths), an assessment of potential causes of any variation from the national average, and evidence of learning and the actions taken.

In March 2017 the National Quality Board published the document "National Guidance on Learning from deaths – a framework for NHS Trusts and Foundation Trusts on Identifying, investigating and Learning from deaths in care".

In response to this the Trust has developed a policy for "Reviewing, investigating and learning from mortality". This policy describes how we learn and share this from reviewing the care of all patients who have died, and how we will engage with bereaved families and carers.

The majority of deaths are considered to be expected and unavoidable. It is recognised from available evidence that approximately 4% of deaths in hospital have an element of avoidability. We have developed a process to enable us to identify patients whose death may have been avoidable which will allow for an in-depth review of the case.

The outcome of these reviews will be provided to the Quality Governance Committee and the Trust Board by the Medical Director.

Data Quality

NHS Number and General Medical Practice Code Validity

The Trust submitted records between April 2015 and January 2016 to the Secondary Users Service for inclusion in the national Hospital Episode Statistics (HES) database which are included in the latest published data outlined below and compared to the previous year's results.

Period – April16 – Dec 16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.8%	99.9%
A&E	98.2%	99.5%

Period - Apr15 to Jan16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.9%	99.9%
A&E	98.1%	98.8%

Comparison	Valid NHS Number	Valid GMPC
Inpatients	0.0%	0.0%
Outpatients	-0.1%	-0.0%
A&E	+0.1%	-0.7%

Information Governance Toolkit attainment levels

The Information Governance Toolkit version 14 was completed and submitted on 29th March 2017 with an overall score of 81% and a return of 'Satisfactory'.

For the previous version (2015/16), the potential issue raised was the lack of a robust risk assessment processes embedded in our information risk management framework. The Information Governance team developed a risk assessment checklist to enable the Trust's Information Asset Owners (IAOs), carry out appropriate risk assessment for the different systems under their remit. This enabled the Trust to have adequate assurance not just on potential risk but increased the robustness of our information mapping (data flows) and our information asset register.

Version 14 emphasised the improvements made in-year by ensuring a robust Information Governance Management Framework process was followed with regular compliance reviews; however there remains 2 main areas which have seen significant improvement but have not attained the target set by the Trust at the start of the financial year. These are:

112 – Information Governance training

The toolkit target set by NHS Digital is for 95% of all staff to be trained in IG on an annual basis. This has not previously been achieved. The target was made compulsory in the version 14 release of the IG Toolkit.

Although compliance figures are higher this financial year, the Trust has been unable to achieve 95% training compliance and would have had to claim a level 1 assurance for this requirement. However as NHS Digital decommissioned their IG e-learning training tool in December 2016 (the core tool for IG training for NHS Organisations); NHS Digital have accepted that for Version 14, IG training figures can be reported over a 2 year period (April 2015 to March 2017).

Due to this directive, the Trust IG training compliance for April 2015 – February 2017 is 95.6% and therefore the Trust can claim a level 2 assurance for this requirement. This provision is only available currently for version 14 submission and may revert back to the annual compliance for version 15 which will be released in June 2017.

305 – Systems User Access

This element of the IG Toolkit requires the Trust to provide significant assurance that there is controlled access to Information Assets and systems by ensuring that system functionality is configured to support user access controls and by further ensuring that formal procedures are in place to control the allocation of access rights to local information systems and services.

These procedures are expected to cover all stages in the life-cycle of user access, from the initial registration of new users to the final de-registration of users who no longer require access to information systems and services. Robust procedures should be in place for the management of access rights which allow support staff to override system controls.

It was identified that although the Trust had formal procedures are in place to control the allocation of access rights to information systems and services, additional evidence was required to provide assurance that these procedures are operating effectively for all key business systems. The IG Team will be working with the IT team to ensure that there is a comprehensive monitoring process for key systems and inactive system accounts. Spot checks will be carried out to ensure the effectiveness of our processes.

An action plan, work schedule and a comprehensive confidentiality/information governance audit programme is being developed for a more proactive and robust approach to the Information

Governance Toolkit, with particular attention paid to the above areas. This will be monitored through the Information Governance Group chaired by the Director of Corporate Development Governance and Assurance (the Senior Information Risk Owner- SIRO) with regular reports to the Assurance, Risk and Compliance Group and the Quality Governance Committee as required.

Clinical coding error rate

Background

An audit was internally commissioned by Northampton General NHS Trust to fulfil the Information Governance (IG) Toolkit requirement 505 and the associated objectives are clearly defined to support this purpose. The toolkit requirement states that there should be established procedures in place for regular quality inspections of the coded clinical data using the Clinical Classifications Service (CCS) Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications OPCS-4 and ICD-10 and national clinical coding standards and the organisation's commitment to continual improvement of its coded data. The clinical coding audits are undertaken by a CCS approved clinical coding auditor.

In the audit, each of the 3 bed-holding clinical Divisions have been selected for audit which included all associated inpatient sub-specialties. This represents a snapshot of all inpatient coded data.

In addition to this yearly audit, there is a cycle of audit both random (individual coders quarterly) and targeted (monthly) undertaken by management staff which covers a minimum of 100 Consultant episodes each month.

NGH was not subject to an externally commissioned clinical coding audit at any time during the reporting period.

Objectives

- To assess Trust-wide inpatient coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505.
- To review the coded information for accuracy and adherence to national standards.
- To identify a baseline measure of accuracy for continuous improvement.
- To analyse the information provided to the coders at the time of the coding with the information contained in the case notes at the time of audit.
- To make recommendations where appropriate, to improve the quality of the coded clinical data.

Methodology

The individual episode data was selected at random across each of the Division's activity. The sample period was quarter 2 of 2016-17 and comprised 120 spells for each Division. A total of 5 excess notes were pulled per Division in case folders were unable to be audited.

The auditors carried out the audit strictly adhering to the Clinical Coding Audit Methodology Version 10.0 in order to satisfy the Information Governance requirement 505.

Results

The overall results for the 403 episodes (360 spells) audited reached IG level 2 requirements across all areas. In some areas, notably secondary coding, the percentages are above level 3 IG requirements.

The primary diagnosis and primary procedure scores were where the largest percentage of error was noted. Primary Diagnosis is the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem. The primary procedure is the main surgical operations in terms of complexity and use of resources.

Of the 38 primary diagnosis errors found, 12 were incorrect at 3rd character level, 11 at 4th character level and 7 were present but incorrectly sequenced in a secondary field. Of the 18 primary procedure errors found, 6 were due to the procedures not being coded, 5 were incorrect at 4th character level and 3 were incorrect at 3rd character level.

Financially, there was a 1.18% change in the value of the episodes following audit.

OVERALL	**% Accuracy Including All Error Sources**	**% Accuracy Excluding Non-Coder Error**
Primary Diagnosis	90.57%	91.07%
Secondary Diagnoses	91.54%	92.64%
Primary Procedure	92.41%	93.25%
Secondary Procedures	93.40%	93.64%
Divisional	***% Accuracy Including All Error Sources***	***% Accuracy Excluding Non-Coder Error***
Medicine & Urgent Care		
Primary Diagnosis	90.26%	90.26%
Secondary Diagnoses	90.15%	91.54%
Primary Procedure	90.48%	92.07%
Secondary Procedures	95.28%	95.28%
Surgery		
Primary Diagnosis	90.32%	90.32%
Secondary Diagnoses	90.31%	90.62%
Primary Procedure	91.09%	91.09%
Secondary Procedures	89.67%	90.14%
Womens, Childrens & Oncology		
Primary Diagnosis	91.20%	92.80%
Secondary Diagnoses	95.91%	97.17%
Primary Procedure	95.89%	97.26%
Secondary Procedures	100.00%	100.00%

	% Accuracy	**IG Level 2 Requirements**	**IG Level 3 Requirements**
Primary Diagnosis	90.57%	%	95.00%
Secondary Diagnoses	88.31%	80.00%	90.00%
Primary Procedure	92.05%	90.00%	95.00%
Secondary Procedures	90.99%	80.00%	90.00%

Themes of Good Practice Noted

- Standard of oncology chemotherapy coding was exceptional, both procedurally and diagnostically.
- Obstetric coding was of a high standard in the midst of some complex cases within the sample.
- Inpatient orthopaedic and general surgery was generally coded to a good standard.

Sources of error:

- Errors in the application of the primary diagnosis definition among a number of the coding team.
    - Driven by insufficient analysis of the full medical record where there is a conflicting main condition stated on the discharge letter.
- Errors in low complexity e.g. emergency medicine.
- Specific issues identified in coding for functional endoscopic sinus surgery (FESS) operations and the necessary code sequencing.
- Simple primary diagnosis errors noted within oral surgery.
- Histology reports not always referenced to update the coding.
- Some errors associated with non-recording of external cause codes.
- Evidence of coders not confining some diagnosis codes to the episode in which they were relevant.

Conclusions

The overall results met the required standard to reach IG level 2 across every Division which is positive. There were some particular areas identified where the coding was of a very good standard and this included the more complex activity within the sample. Errors were found within more low complexity, short stay spells.

The main priority for the department will be to highlight the importance of the primary diagnosis. This will also include reference to the discharge letter where there is a ‘main condition stated’ recorded by the clinician.

There were some specific training needs identified in relation to ENT surgery which will be addressed.

Work will be undertaken to ensure that multi-episode spells are extracted and coded at the same time within the coding office. This will assist with ensuring episodes are coded in isolation.

Actions undertaken

- Developed an intra-departmental project to place emphasis on improving primary diagnosis accuracy.
- Ensured that coders can view episode start/end times when extracting from notes on wards.
- Notes to be coded within the coding department for wards where multi-episode spells occur.
- Provided cross-departmental training on Head & Neck coding with a particular focus on FESS surgery.

Performance Against National Quality Indicators

In 2009, the Department of Health established the National Quality Board bringing the DH, the CQC, Monitor, the National Institute for Health and Clinical Excellence and the National Patients Safety Agency together to look at the risk and opportunities for quality and safety across the whole health system. The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework.

Performance data for NGH is included together with the NGH data from the 2014/15 Quality Account. Where available, data has been provided showing the national average as well as the highest and lowest performance for benchmarking purposes. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein.

For the following information data has been made available to the Trust by NHS Digital. Where this has not been available, other sources have been used and these sources have been stated for each indicator. Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

In accordance with the reporting toolkit the trust can confirm that it considers that the data contained in the tables below are as described, due to them having been verified by internal and external quality checking.

Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions

- *Summary Hospital-Level Mortality Indicator (SHMI)* – (value and banding of the SHMI)

Period	NGH Value	NGH Banding	National Average	National High	National Low
Oct 15 – Sep 16	95	2	100	116	69
Oct 14 – Sep 15	102	2	100	117	65
Oct 13 – Sep 14	98	2	100	119	59

*SHMI banding:
- SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than expected'
- SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected'
- SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'

The Trust has an 'as expected' SHMI at 95 for the period October 2015 to September 2016 as demonstrated in the table above. Unlike HSMR, the SHMI indicator does include deaths 30 days after discharge and therefore patients, including those on palliative care end of life pathways, who are appropriately discharged from the Trust.

NGH has taken the following actions to improve this rate and quality of its services; regularly analysing mortality data and undertaking regular morbidity and mortality meetings to share learning across the Trust and externally through countywide morbidity and mortality meetings.

- *Palliative Care Coding* – (percentage of patient deaths with palliative care coded at either diagnosis or specialty level)

Period	NGH	National Average	National High	National Low
Oct 15 – Sep 16	36.62%	29.74%	56.26%	0.39%

Oct 14 – Sep 15	25.9%	26.6%	53.5%	0.19%
Oct 13 – Sep 14	26.6%	25.32	49.4%	0.0%

NGH has taken the following actions to improve this rate and quality of its services; by prioritising end of life care and placing greater importance on palliative care

Domain 3 – Helping people to recover from episodes of ill health or following injury

- *Patient Reported Outcome Measures scores (PROMs)* - (adjusted average health gain)
  - Hip replacement surgery
  - Knee replacement surgery
  - Groin hernia surgery
  - Varicose vein surgery

	NGH Performance		National Performance		
	Reporting Period 2015/16	**NGH Quality Account 2014/15**	**Reporting Period Average**	**Reporting Period High**	**Reporting Period Low**
• Groin hernia surgery (EQ-5D™ Index)		0.103 (provisional Apr15 to Dec15)	0.089 (provisional Apr16 to Sep16)		
• Varicose vein surgery (EQ-5D™ Index)		N/A	0.09 (provisional Apr16 to Sep16)		
• Hip replacement surgery - primary (EQ-5D™ Index)		0.528 (provisional Apr15 to Dec15)	0.44 (provisional Apr16 to Sep16)		
• Hip replacement surgery - revision (EQ-5D™ Index)		N/A	0.28 (provisional Apr16 to Sep16)		
• Knee replacement surgery - primary (EQ-5D™ Index)		0.328 (provisional Apr15 to Dec15)	0.33 (provisional Apr16 to Sep16)		
• Knee replacement surgery - revision (EQ-5D™ Index)		N/A	0.288 (provisional Apr16 to Sep16)		

NGH has taken the following action to improve the rates, and the quality of its services by further developing the work undertaken in theatres.

- *Emergency re-admissions to hospital within 28 days of discharge* - percentage of patients readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust)

Period	**NGH**	**National Average**	**National High**	**National Low**
Patients aged 0-15				
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A

2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	13.15%	10.01%%	13.58%	5.10%

Period	NGH	National Average	National High	National Low
Patients aged 16 and over				
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	11.15%	11.45%	13.50%	8.96%

NGH has taken the following actions to improve the rates, and the quality of its services by improving discharge planning with an aim to reduce readmissions and working to improve the discharge process to ensure that early and effective planning for discharge is undertaken

Domain 4 – Ensuring that people have a positive experience of care

- *Responsiveness to the personal needs of patients*

Period	NGH	National Average	National High	National Low
2015/16	65.5%	69.6%	86.2%	58.9%
2014/15	68.9%	68.9%	86.1%	54.4%
2013/14	68.6%	68.7%	84.2%	54.4%

NGH continues to review patient experience and build on the work currently being undertaken across the Trust.

- *Staff who would recommend the trust to their family or friends – (*percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends)

Period	NGH	National Average	National High	National Low
Q2 - 2016/17	78%	80%	100%	44%

NGH is reviewing the scores in order to improve the rates, and so the quality of its services. The data is being fed through the trusts divisional structure with the aim to join it with patient experience. The trust aims to increase staff engagement and hope to develop a triangulation between performance, experience and engagement.

- *Friends and Family Test – Patient* - (percentage recommended)

Period	NGH	National Average	National High	National Low
Inpatient				
January 2017	94%	96%	100%	80%
March 2016	85.4%	67%	93%	38%

March 2015	86%	95%	100%	78%

Period	NGH	National Average	National High	National Low
Patients discharged from Accident and Emergency (types 1 and 2)				
January 2017	88%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	89%	87%	99%	58%

NGH has taken the following actions to improve the percentages, and the quality of its services by encouraging a culture of reporting throughout the Trust. Information on FFT has been covered in Section Four.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

- *Venous Thromboembolism* – (percentage of patients who were admitted to hospital and who were risk assessed, for venous thromboembolism)

Period	NGH	National Average	National High	National Low
Q1 16/17	95.67%	95.73%	100%	80.61%
Q4 15/16	95.2%	96%	100%	79.23%

NGH has taken action to improve the percentages and the quality of its services, by further developing systems to ensure risk assessments are reviewed and promoted. The aim is that all patients, who should have a VTE risk assessment carried out, have one 100% of the time.

- *Rate of Clostridium difficile (C.Diff) infection* - (rate per 100,000 bed days of cases of C.Diff infection, reported within the Trust amongst patients aged 2 or over)

Period	NGH	National Average	National High	National Low
2015/16	12.7	14.9	66	0
2014/15	12.2	41	114.4	0
2013/14	11.21	13.9	37.1	0

NGH has taken the following actions to improve the percentages, and the quality of its services by sending stool samples in a timely manner, prompt isolation of patient's with diarrhoea and improving antimicrobial stewardship.

- *Patient Safety*

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported within the trust - (Acute Non-Specialist)				
Oct 15 – Mar 15	3,538			
Apr 15 – Sep 15	3,722	4,647	12,080	1,559

Period	NGH	National Average	National High	National Low
The rate (per 1,000 bed days) of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Oct 15 – Mar 15	28.4	39	75.9	14.8
Apr 15 – Sep 15	31.1	39.3	74.7	18.1

Period	NGH	National Average	National High	National Low
The number of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Oct 15 – Mar 15	18	34.6	94	0
Apr 15 – Sep 15	6	19.9	89	2

Period	NGH	National Average	National High	National Low
The percentage of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Oct 15 – Mar 15	0.51%	0.40%	2.0%	0%
Apr 15 – Sep 15	0.16%	0.43%	0.74%	0.13%

The results show that the trust is below the national average for the level of harm. NGH has taken the following action to improve the percentages and rates, and so the quality of its services by further encouraging an open reporting culture. This is being done through regular engagement with staff via newsletters, through learning events such as Dare to Share and regular attendance at ward and department meetings.

Review of Activity 2016/17

The table below shows a snapshot of the Trusts performance activity up to 31 March 2017 with a comparison to the previous year's activity.

Activity	2015/16	2016/17	Difference	% Difference
Emergency inpatients	43,456	47,701	4,245	10%
Elective inpatients	5,824	5,634	-190	-3%
Elective day cases	39,610	42,393	2,783	7%
New outpatient attendances – consultant led	83,474	105,790	22,316	27%
Follow-up outpatient attendances – consultant led	155,562	208,420	52,858	34%
New outpatient attendances – nurse led	42,127	27,758	-14,369	-34%
Follow-up outpatient attendances – nurse led	154,412	101,938	-52,474	-34%
Total number of outpatient DNAs	34,770	36,708	1,938	6%

Patients seen in A&E	114,179	116,183	2,004	2%
Number of babies born	4,726	4,867	141	3%
Average length of stay (in days)	4.36	4.52	0.16	4%

Abbreviations

	#	Fracture
A	A&E	Accident and Emergency
	AKI	Acute Kidney Injury
	ACS	Ambulatory Care Service
	ASGBI	Association of Surgeons of Great Britain and Ireland
B	BP	Blood Pressure
C	CCG	Clinical Commissioning Group
	C.Diff	Clostridium Difficile
	CEM	College of Emergency Medicine
	CIA	Cartoid Interventions Audit
	CIP	Cost Improvement Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CNS	Cancer Nurse Specialist
	CT	Computed Tomography
	CQC	Care Quality Commission
	CQEG	Clinical Governance and Effectiveness Group
	CQUIN	Commissioning for Quality and Innovation
	C Section	Caesarean Section
D	DAHNO	Data for Head and Neck Oncology
	DH	Department of Health
	DNA	Did Not Attend
	DoOD	Do Organisational Development
	DTOC	Delayed Transfer of Care
E	EMRAN	East Midlands Rheumatology Area Network
	ePMA	electronic prescribing medicines administration
	ERAS	Electronic Residency Application Service
F	FFT	Friends and Family Test
	FY1	First Year 1
G	GMPC	General Medical Practice Code Validity
H	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
I	ICU	Intensive Care Unit
	IGT	Information Governance Toolkit
K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust
L	LFE	Learning from errors
M	MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
	MDT	Multi-Disciplinary Team
	MINAP	Myocardial Ischaemia National Audit Project
	MRI	Magnetic resonance imaging
	MRSA	Methicillin-Resistant Staphylococcus Aureusis
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NGH	Northampton General Hospital NHS Trust
	NICE	The National Institute for Health and Care Excellence
	NICOR	National Institute for Cardiovascular Outcomes Research
	NMET	Non-Medical Education and Training
	NNAP	National Neonatal Audit Programme
	NVD	National Vascular Database
P	PALS	Patient Advice and Liaison Service
	PCEEG	Patient & Carer Experience and Engagement Group
	PPEN	Patient & Public Engagement Network

	PROMs	Patient Reported Outcome Measures
Q	QCI	Quality Care Indicator
	QELCA	Quality End of Life Care for All
	QI	Quality Improvement
R	RCPH	Royal College of Paediatrics and Child Health
	R&D	Research and Development
	RTT	Referral to Treatment
S	SHMI	Summary Hospital-level Mortality Indicator
	SHO	Senior House Officer
	SIRO	Senior Information Risk Owner
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
	SSNAP	Sentinel Stroke National Audit Programme
T	TARN	Trauma Audit Research Network
	TTO	To Take Out
U	UTI	Urinary Tract Infection
V	VTE	Venous Thromboembolism
W	WHO	World Health Organisation
Y	YTD	Year to Date

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 May 2017**

Title of the Report	**Corporate Governance Report**
Agenda item	**15**
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	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
Related Board Assurance Framework entries	N/A
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**)

Enclosure K

Legal implications / regulatory requirements	This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3

Actions required by the Trust Board

The Trust Board is asked to:

- To note the Use of the Seal, numbers of staff declarations and new declarations of interest by Trust Board members

Northampton General Hospital NHS
NHS Trust

Public Trust Board

Corporate Governance Report
January – March 2017 (Q4)

Introduction

This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.

Use of the Trust Seal

The Trust's Standing Orders require that periodic reports are made to the Board detailing the use of the Trust's Seal. The Seal will generally be used for contracts in excess of the financial limits delegated to the Chief Executive under the Standing Financial Instructions, and for property matters, including disposals, acquisitions and leases.

The seal has been not been used during Quarter 4

Declarations of Hospitality

Staff within the Trust are required by the Standards of Business conduct Policy to declare any hospitality and/or gifts received.
Staff are given regular reminders through Trust communication mechanisms regarding their liabilities in respect to the requirements of this policy.

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- Jan – March 2017: 17 declarations received
  (this includes declarations from departments where lunch has been provided during an educational session and may involve a group of staff but is counted as a single declaration)

Declarations of Interest

John Archard-Jones	Consultant Director First for Wellbeing Director and Owner Africa Consulting Ltd. Trustee Northants Health Charity
Phil Zeidler	Director of Northampton Charitable Funds

Enclosure K

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 May 2017**

Title of the Report	**Self-Certification 2016/2017**
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	NHS Trusts are now required to self-certify that they are compliant with conditions equivalent to the provider licence with which Foundation Trusts are required to comply.

Executive summary

The Single Oversight Framework bases its oversight on the NHS provider licence and therefore Trusts are legally subject to the equivalent of certain provider licence conditions including G6 and FT4.

Providers need to self-certify the following after the financial year end:

NHS provider licence condition
The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
The provider has complied with required governance arrangements (Condition FT4(8))

The paper includes an explanatory pack in respect to the self-certification and subsequent process.

The completed self-certification templates for discussion and further Appendix outlining evidence the Board and its subcommittees have utilised throughout the year by which to gain assurance and to support sign off of the self-certification.

From July NHSI will contact a selection of Trusts to ask for evidence that they have self-certified. This can be through provision of templates or providing relevant Board minutes and papers recording

Enclosure L

sign off.	
Related strategic aim and corporate objective	ALL
Risk and assurance	The self-certification statements signed off by the Board must set out any risks and mitigation planned for each statement if applicable.
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)?(/N)
Legal implications / regulatory requirements	The Single Oversight Framework bases its oversight on the NHS provider licence and therefore Trusts are legally subject to the equivalent of certain provider licence conditions including G6 and FT4.

Actions required by the Trust Board

The Board is asked to:

- Consider and certify each Statement and if unable to do so agree what supporting commentary the Board wishes to submit.
- Approve the Corporate Governance statement for submission to NHSI
- Consider if there are any improvements to the work of the Board and its committees that might better support assurances concerning this annual declaration for the future and ensure the agendas and work of the committees is driven accordingly

Proposed Evidence for Self-Certification 2016/17

Corporate Governance section of Annual report
Annual Governance statement and auditors opinion
Board and sub committees review of effectiveness and Terms of Reference reviews
Board subcommittee focus on quality, performance (operational and financial), workforce, internal control and risk
Organisational Governance structure in place with clear reporting lines
Highlight reports from Groups reporting into Board sub committees
Highlight reports from Board sub committees to the Trust Board
Performance reports to Board and oversight of relevant sections in subcommittees
Board members appraisal (Executive and NED)
Board member training records
Standards of Business Conduct and corporate governance reports
Board Assurance Framework monitored by the Board
Board Assurance framework risks allocated to Board subcommittees
Board Annual cycle of Business
Board development
Patient stories at Board
Well Led framework gap analysis
Fit and Proper person tests

External audit opinion – annual report and quality indicators within Quality Account
External Audit opinion - use of resources
Internal Audit opinion
Internal Audit plan
Trust's Going Concern Status

Annual and business planning process
Budget setting process
Cost Improvement programme supported by Project Management Office (Changing Care@NGH) – monthly reporting
Monthly Finance reports
CQUIN reports

Risk management strategy approved
Risk register reviewed quarterly at Board and subcommittees
Risk and Compliance Group meets quarterly to oversee all clinical and corporate divisional risk registers

Divisional Performance meetings with Exec team
Executive team Monthly performance meetings with NHS Improvement
Clinical Quality meetings with Commissioners

Staff engagement strategy
Board to Ward
Beat the Bug Board visits
Mandatory and role specific training compliance monitoring
Appraisal rate monitoring
Recruitment pipeline – nursing
Raising Concerns Policy
Freedom to Speak Up Guardian reports
Staff survey results

Care Quality Commission reports and improvement plans
Information Governance toolkit self-certification and implementation work
Assessment and Accreditation scheme
Quality Improvement strategy and metrics
PLACE Audits
Friends and Family Test and Real Time survey results
Complaints reports
Incidents and Claims and litigation reports
Serious incident reports
Mortality reports
External partners and stakeholders meetings
Annual reports e.g. Safeguarding, Health and Safety, Clinical Audit, Risk management, Infection Control etc.

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 May 2017**

Title of the Report	**Approval of Annual Report and Annual Accounts 2016/17**
Agenda item	**17**
Presenter of Report	Simon Lazarus, Director of Finance
Author(s) of Report	**Annual Report** Eva Duffy, Communications **Annual Accounts** Derek Stewart, Finance
Purpose	For Approval
Executive summary The Annual Report and Annual Accounts 2016/17 are presented for approval.	
Related strategic aim and corporate objective	All
Risk and assurance	Assurance on the delivery of the trust's strategy, objectives and statutory duties
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? (**Y/**N)
Equality Impact Assessment	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)

Legal implications / regulatory requirements	Statutory duties to submit annual report and accounts

Actions required by the Trust Board

The Board is asked to:

The Board is asked to approve the Annual Report and Annual Accounts for 2016/17

Northampton General Hospital
NHS Trust

ANNUAL REPORT AND ACCOUNTS 2016/17

CONTENTS

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1st April 2016 and 31st March 2017.

The report is made up of three parts:

SECTION ONE:

PERFORMANCE REPORT

Chairman and Chief Executive's Overview

Welcome to our 2016/17 annual report. This report summarises some of our main achievements and challenges over the last year. It covers our finances and other important measures of our overall performance. We recommend reading this report alongside our Quality Account, which looks at the quality of our services over the same time period.

Our ongoing challenge is to deliver the best possible care for all our patients within our available resources. The recurring theme of the year was pressure on the urgent care system and its impact across the hospital. Against a national backdrop of unprecedented strain on NHS services, our emergency department treated more patients than ever before. The increasingly complex medical and nursing needs of our patients, particularly our older patients, meant we also admitted people in greater numbers than before for assessment or treatment.

There was a relentless focus through the hospital on ensuring our patients were safe and maintaining patient flow so that we could admit those patients in need of our care.

Our urgent care working group introduced significant changes during the year to strengthen our position. The group's main areas of focus during the year were:

- the introduction of the SAFER patient flow bundle – a set of simple rules to improve patient flow and prevent unnecessary waiting for patients
- the Red to Green initiative which sets out standards clarifying the expected time periods in which interventions and procedures should be performed.
- the development of the Dickens Therapy Unit, a therapy-led model of care for providing rehabilitation to help patients to go home, or move onto a suitable place of residence, as independently as possible

The impact of our urgent care pressures reverberated across the hospital, including our financial services. Thanks to the outstanding performance of our finance team, alongside our improving quality and efficiency (IQE) programme and a concerted drive across all departments, we finished the year well within the agreed financial targets. We achieved a year-end position £1.3million better than forecast.

Sustainability and transformation plan

Caring for higher numbers presents enormous challenges for a hospital in one of the UK's biggest population growth areas and one of our key priorities is to work with partners locally and the wider NHS economy to look for realistic and sustainable solutions.

During the year Northamptonshire's sustainability and transformation plan (STP) was published outlining how health and social care services in the county will be reshaped to focus on keeping people well – and giving them the right help as close to home as possible.

The STP is designed to ensure that services can meet the needs of local people in the future. To achieve this, there needs to be change. Without change, we will not be

able to deal with the significant challenges we are now facing. The plan is ambitious in scope and will require significant and fundamental changes to the way the health and social care system works.

National events

During the year we were affected by a number of national events and developments, the most significant being the outcome of a referendum in favour of a British withdrawal from the European Union. In the immediate aftermath of the result, we faced much uncertainty about the implications for our international employees. Just over a quarter of our staff were born outside the UK, spanning 91 separate countries or states. It is universally recognised that the entire NHS is dependent on the contribution of non-UK employees but it remains unclear at the time of producing this annual report what the impact of Brexit negotiations will be.

We also started the year with a continuation of the national dispute between junior doctors and the government about the imposition of a new employment contract. A mammoth effort involving teams across the hospital saw us develop plans for dealing with industrial action and we were proud to see that elements of our planning process were adopted as best practice nationally.

Our workforce

With the junior doctors contract dominating the national media agenda, we were approached by Two Four, an award-winning production company commissioned by Channel 4 to produce a documentary series celebrating the work of junior doctors. The four-part series, *Confessions of a Junior Doctor*, was filmed between August and December and when broadcast, it generated overwhelming support from our local community and the wider medical community in the UK.

One of our motivating factors for agreeing to take part in *Confessions of a Junior Doctor* was our pride in the support we give our junior doctors, academically, professionally and pastorally. We recognise that in responding to the sustained pressures across our services, all of our staff have given above and beyond the call of duty every day and so we took steps to bolster the support available to them.

In April 2016, we set a target that at least 10 per cent of our staff should have taken up some of the health and wellbeing initiatives on offer. By the end of the year, 27 per cent of staff had participated in a health and wellbeing initiative - approximately 1,355 staff.

As part of our health and wellbeing strategy, we identified that one of the key areas of employee support that we needed to focus on was mental wellbeing. This year, alongside our physical activity agenda, we will be doing more to tackle stigma and discrimination associated with mental health.

To this end, we have been working with Time to Change, a national campaign run by charities Mind and Rethink Mental Illness. In February, we joined the 473 other organisations which have signed the Time to Change Employer Pledge,

demonstrating our commitment to addressing stigma and discrimination in the workplace. Our pledge is to create a culture where our staff feel they can openly discuss and manage their mental wellbeing. We will raise awareness of the importance of mental health and wellbeing at work and provide the resources and tools our staff need to help them lead healthy lives, cope with the daily pressures, have positive relationships and achieve their full potential.

Our aim is not solely to be a hospital that responds to our patients' needs, but to be a health-promoting organisation making an active contribution to improving the wider health and wellbeing of our staff, our patients and those with whom we come into contact.

The launch of a new nursing and midwifery strategy was a defining moment for those professions at our hospital. Nearly 2,000 nurses, midwives and health care assistants were directly involved in the development of Our Journey to Pathway to Excellence.

It followed a three-month consultation period where nurses and midwives contributed their ideas and suggestions via suggestions boxes, consultation meetings and workshops.

The three-year strategy sets out the principles underpinning the delivery of nursing and midwifery services at the hospital:

- Excellence in patient care
- Building and strengthening leadership at all levels
- Recognising the work of nurses and midwives
- Protecting and promoting wellbeing in a positive practice environment
- Providing opportunities to develop skills and knowledge empowering nursing and midwifery teams to make decisions about clinical practice
- Establishing nursing and midwifery roles that are fit for the future

The strategy followed the announcement earlier this year that we are the first NHS hospital in the UK to sign up to an internationally-recognised programme for nursing and midwifery standards. The Pathway to Excellence programme recognises hospitals for the quality of patient care and professional satisfaction of the nurses and midwives who work in them. The programme is delivered by the American Nurses Credentialing Center (ANCC).

Achieving Pathway to Excellence accreditation mirrors what we're working to achieve here in Northampton, a culture where our nurses and midwives feel inspired and valued and where we aim to deliver the best possible care for our patients. It opens up exciting new opportunities to learn from a global community of healthcare settings, all sharing a common aim of achieving excellent standards of care.

During the year, we welcomed a group of history-making students who are leading the way in shaping the nursing workforce of the future. Thirty eight nursing associate students were recruited to a landmark pilot scheme, and the group began their studies at the University of Northampton in the Spring. The new nursing associate role is a key part of national plans to create a strong, sustainable nursing workforce

for the future. The nursing associates will work alongside existing health care support workers and registered nurses to deliver hands-on care for patients.

We introduced a new student placement model transforming the way student nurses are trained at the hospital following a successful pilot on two of our adult wards. Working with the University of Northampton we designed the programme, known as PL@N (Practice Learning at Northampton General Hospital). It incorporates the principles of supportive collaborative learning and coaching which means that the whole ward team is involved in our student nurses' development and training.

The strength of the support we give our student nurses means we were among the top-performing NHS employers in the country when it comes to mandatory accreditation of overseas nurses and midwives. Although the nurses we recruit from abroad are qualified in their home country, there is another layer of accreditation they have to undertake before they can register to practice here, to demonstrate they have the necessary clinical skills. We are one of only three NHS employers nationally to boast a 100 per cent pass rate among its overseas nurses who sit the OSCE examination, a test of competence that must be passed before a nurse from outside the EEA (European Economic Area) can practice in the UK.

Our patients

A significant amount of the feedback we receive from patients is not directly related to the medical or nursing treatment they received, it's about how we made them feel.

This year, we saw sustained improvement and achieved our highest ever score in the national Friends and Family Test (FFT), a survey recording the percentage of patients who would recommend to friends and family the hospital in which they had received treatment.

A development for 2016 was our inaugural patient listening event in which we posed the question to a group of former patients and their families: "*If you had a magic wand, what changes would you make to improve the experiences of care for other patients and families?"* A random selection of 26 patients who were inpatients in May were invited to attend the event with their families.

The listening event is just one way we used patient feedback to drive improvements. We started real-time patient surveys on our wards in a bid to ensure that feedback to our wards is timely and meaningful.

We're one of only six NHS organisations taking part in a research project to develop a national toolkit for using patient experience data to improve care. The collaborative research project will examine how frontline hospital staff use patient experience data to improve care. The project is led by the University of Oxford's Nuffield Department of Primary Care Health Sciences and Picker Institute Europe and funded by the National Institute for Health Research HS&DR Programme.

The aim of the project is to build an understanding of which types of data or quality improvement approaches are more or less likely to be useful with frontline teams in making health care more person-centred. The two-year project will result in the

production of a practical toolkit for the NHS on strategies for making patient experience data more convincing, credible and useful for frontline teams and Trusts.

During the year**,** we strengthened our support for patients at risk of domestic abuse with the creation of a new role of Independent Domestic Violence Advisor (IDVA) employed by Northamptonshire Sunflower Centre and based with us to offer advice and guidance to adults who have experienced domestic abuse and are at risk of injury, harm or homicide.

Based initially in the hospital's maternity offices, the role works alongside the hospital's safeguarding midwives. One in six pregnant women will experience domestic violence and around 30 per cent of domestic violence starts or worsens during pregnancy. This means our maternity team is uniquely positioned to identify women who are victims of domestic abuse and to offer support or make a child protection referral where appropriate.

However, we have lots of other departments providing treatment and care to domestic abuse victims, most obviously our various emergencies teams but by no means limited to those. We also know that our ward staff sometimes witness controlling or abusive behaviours towards an individual in-patient from a relative. Those situations can be very difficult for any member of staff to deal with; one of the aims of this new role is to give extra support to our staff in responding to situations where we have concerns that a patient is experiencing abuse.

A considerable amount was achieved during the year for the benefit of our patients who have dementia and their families. We launched *Do It For Dementia* as our primary fundraising campaign.

Over 7,000 people in Northamptonshire have dementia. The Department of Health estimates that only 59 per cent of people with dementia have a formal diagnosis. For patients with memory problems such as those with dementia, a hospital can feel like a chaotic and frightening environment.

With an initial target of £50,000, *Do it for Dementia* is raising money help create dementia-friendly spaces and to buy equipment and resources that will help to reduce confusion, anxiety and distress for patients who have dementia. It also supports our work around preventing depletion in life skills when patients come into hospital.

As part of the *Do It For Dementia* campaign, a 19-metre reminiscence mural of Abington Park was installed in the corridor to our elderly care wards. The spectacular image also triggers memories using the sense of smell and sound. Noises from the park are played through the corridor and the smell of cut grass can be pumped to transport patients away from the reality of the hospital environment to their memories of the park.

Other projects include the refurbishment of a kitchen and therapy area as well as plans for a redesign for dedicated garden area so patients with dementia can spend time outside in the fresh air. As well as those big ticket items, there are lots of resources that we'd like to see on wards across the hospital such as special clocks, memory boxes to encourage soothing reminiscences and calming activities and games.

During the year, nutrition, catering and nursing staff worked together to create a finger food menu for any patient who has difficulty eating a more conventional hot meal and has particular benefits for patients with dementia. The food boxes, providing a selection of finger foods, meet a calorie count of 400 across the required food groups.

Our patients with dementia can often have difficulty eating and drinking in hospital: it's an unsettling and confusing environment and the food we serve might not be familiar to them. As dementia progresses, people often find cutlery difficult to manage and they can lose the ability to identify their own thirst and hunger.

The food isn't wrapped, so it's easier for patients to pick the food up, and to eat when they want, not when we say it's time to eat. It gives them independence to make their own choices around when to eat. It empowers them. It's also good for our nurses because they can be confident that our patients are getting the right nutrition.

We further strengthened the support we give to patients with dementia and their loved ones with to the introduction of John's Campaign on our adult wards.

The aim of John's Campaign is to give relatives of patients with dementia more involvement in their care when they're admitted to hospital and this includes acknowledging the need for more flexible visiting times on wards.

Carers know all the little things about a patient that can make a big difference to the quality of their care. They know the patient best, they know their routines, what they like and dislike. When we involve carers, the patients are more likely to engage better with their treatment so it can reduce the length of stay. That's really good news for our patients because it means they can be back at home sooner.

Our local community

Two event in particular took place during the year that showcase the wonderful support we get from our local community:

- In autumn, we were inundated with donations when we called on local knitters and knitting groups to knit and donate twiddlemuffs to help reduce agitation and restlessness in patients with dementia. A twiddlemuff is a knitted handmuff with bits and bobs like zips and buttons added and incorporating different textures. Dementia can result in restless hands and agitation and twiddlemuffs can provide visual, tactile and sensory stimulation for people with dementia - as well as keeping hands cosy and warm.

- On World Book Day we launched our Bedside Book Club, a mobile library for our adult in-patients. It followed a town-wide campaign where we asked people living and working in Northampton to donate a copy of their favourite book. Thanks to the support of many Northampton businesses and employers, as well as individual donations, we collected an amazing 5,000 books. The library has been extremely well received on the wards taking part and we plan to roll it out to all adult wards before the end of the year.

Our volunteers

The volunteer service aims to support clinical staff to provide the best possible care to our patients.

In April, we appointed a volunteer services manager to oversee the service and increase the presence of volunteers across the hospital. In the course of the year, a new volunteer policy was ratified, confirming our commitment to a robust process ensuring that volunteers are recruited safely and are trained to ensure patient safety.

Following a number of recruitment events and promotions, we recruited an additional 160 volunteers, an increase of 75 per cent on the previous year. We ended the year with a volunteer presence in 23 wards and support services. In addition, 237 volunteers received mandatory training and various other bespoke training packages were created.

We introduced a new volunteer uniform to demonstrate that we value our volunteers as well as making it easier for colleagues, patients and visitors to recognise them.

Our buildings, facilities and IT infrastructure

We now boast the most advanced cancer centre in the UK thanks to a £5.5 million upgrade of our radiotherapy service. Patients receiving radiotherapy treatment now benefit from a greater range of therapies, better accuracy in targeting cancer cells and reduced side effects thanks to the purchase of three new linear accelerator (LINAC) machines, the most sophisticated cancer machines in the UK.

A linear accelerator (LINAC) is the device most commonly used for external beam radiation treatments for patients with cancer. The linear accelerator is used to treat all parts of the body by delivering high-energy x-rays to the region of the patient's tumour.

The upgrade has taken place in tandem with increased collaboration with University Hospitals of Leicester NHS Trust to develop a centre of regional excellence in oncology services for the East Midlands region.

Our partnership with Boots UK enjoyed a successful first year, with the outpatient pharmacy improving services and reducing waiting times for patients. During the first year of operation, over 35,000 patients visited Boots pharmacy. The turnaround on dispensing medicines since the partnership was established in June 2015 increased in speed, with 75 per cent of patients in the area receiving their prescriptions within 15 minutes compared to 29 per cent in 2015. We also saw a significant drop in the average wait time for patients in the same time period from 67 minutes to 41 minutes.

Despite the high levels of activity, we were able to make significant progress in planning, re-developing and improving our clinical areas including:

- The last phase of improvement works within our A&E department was completed. The phased re-development programme, taking place over the past four years, has seen the whole area brought up to latest standards,

capacity increased considerably, additional clinical facilities such as a new ambulatory care centre, a state-of-the-art resuscitation area and clinical observation unit developed – all while maintaining business as usual

- A much-needed expansion to the chemotherapy suite began following a highly successful fundraising campaign. We're seeing increasing numbers of patients receiving cancer treatment and that's largely because treatments are getting better, we have a greater range of options for treating patients and we have longer treatment cycles. That's really good news for our patients - but it means that we've outgrown the facilities for our day patients and we needed to invest in an upgrade of the chemotherapy suite to make their stay more comfortable and improve the working environment for the team.

- A new permanent CT scanning suite was installed, which means we no longer need to utilise a mobile unit which was previously brought to site for two or three days every week.

- During the year, we carried out extensive planning and design work for a new 60-bedded assessment hub. The new unit will will be sited on the car park at the front of the A&E department and construction work will commence in the summer of 2017.

- Plans were also developed to provide a GP led streaming unit at the Springfield building adjacent to the A&E department. Its co-location to our emergency department will ensure that patients in need of primary care services can receive these in the most appropriate setting and help alleviate pressure from the increasing attendances in at A&E.

We have continued throughout the year to replace essential services such as heating, ventilation, electrical and water pipework services across the site, as well as ensuring that our public spaces throughout the hospital are kept bright and fresh looking to provide a welcoming environment to our patients and visitors.

Throughout the year, we benefitted from our investment in a robust IT infrastructure, continuously developed to meet the increasing demands of our systems and services. Our previously built-in resilience has reaped huge dividends in zero network downtime and only scheduled server downtime over the course of the year, critical in giving clinicians confidence to move towards "paper-lite" working by 2020 in line with the National Information Board's vision for the NHS. Indeed our emergency department is already working in a paper-lite way. As we produce this annual report, we are in the final stages of procurement to refresh our wireless network, further enabling clinicians to access information on the move.

Excellent progress was made with our *best of breed* approach to electronic patient records:

- electronic prescribing and medicines management is now in use throughout medicine (including the emergency department) and trauma and orthopaedics

- all discharge summaries and clinical correspondence are sent electronically to primary care
- all vital signs and some nursing assessments are recorded electronically
- full electronic order communications for pathology, radiology and a significant number of other services has been in use for quite some time.

Our new core Emis patient administration system is due to go live in June and this will link our suite of Emis products, ED Symphony, Pharmacy, ePMA and PAS in the first instance through a health application portal improving our patient-centric view of clinical information.

As a member of the EMRAD Vanguard consortium since its inception, we worked to improve radiology systems and services across the East Midlands in collaboration with six other hospital trusts. This project made good progress over the year and is enabling sharing of images across the sites, moving towards cross site reporting for the benefit of our patients.

Priorities for the coming year include the PAS go-live and the potential for further integration and clinical noting. We will support greater use of our EMC vendor neutral archive for image storage and further digital records scanning and we will begin the process of replacing our laboratory information management system in collaboration with neighbouring NHS trusts.

Due to the increased focus of cyber-attacks on healthcare, security is paramount on our agenda. In May 2017, a global cyber attack infected many NHS organisations; we were not infected but we took precautionary measures to protect our systems. Thanks to our robust business contingency planning, there was no disruption to scheduled activity. While A&E saw an increase in activity as a result of GP surgeries being affected by the attack, our resilience plans ensured that patient safety remained our top priority.

Our awards

In a year in which we cared for more people than ever before, we had so much to celebrate and the nominations flooded in from members of the public, patients and staff for our 2016 Best Possible Care Awards - which made shortlisting the entries a very difficult task.

We hold these awards to recognise our employees and volunteers who make an exceptional contribution to patient care – and they took place last year thanks to funding from the Northamptonshire Health Charitable Fund and sponsorship from Johnson & Johnson, Avery Healthcare and the BGL Group.

In the midst of all the discussion around pressures on NHS services, our Best Possible Care Awards are an opportunity to take stock of and celebrate the competence and commitment, the professionalism and pride, the exuberance and enthusiasm that we see every day in every ward and every department.

As well as our own awards, we were delighted that a number of our employees were recognised on the national stage for their exceptional achievements:

- Our Chit Chat group was set up as a way of tailoring antenatal education, parenting advice and peer support to women with additional needs including learning disabilities or anxiety. The safeguarding midwives who set up the group won the Enhancing Patient Dignity category of the Nursing Times Awards as well as being finalists in the Royal College of Midwives awards and the Patient Experience Network awards.

- A successful campaign to recruit nurses onto our staff bank won a Public Services Communications gold award celebrating excellence in communications in the public sector. We were the only acute NHS Trust shortlisted for the awards and one of only four organisation nationally to achieve a gold award.

  The nurse bank campaign, entitled "*Join our bank and we'll invest in you*" was also shortlisted in the communications category of the HSJ Value in Healthcare Awards and the staff engagement category of the HSJ Awards.

- Three of our nursing staff were shortlisted for the East Midlands Leadership Academy award. Safeguarding midwife Emma Fathers, ward sister Stacey Cheney and pre-operative assessment sister Sharron Matthews were all finalists in recognition of their outstanding leadership qualities and commitment to improving patient care.

- We were recognised by the NHS for excellence in sustainability reporting, by the Green Organisation with their Golden Apple award for healthcare environmental best practice and we maintained our Investors in the Environment green accreditation, with Best Green Champion (Large Organisations) awarded for the second year.

- Our catering team maintained our bronze Food for Life accreditation for patient meals and extended it to the food served to staff and visitors in the restaurant.

- Our procurement team was highly commended in the sustainable procurement category at the Health Care Supply Association awards. The team have shown how refurbishing condemned furniture such as overbed tables and patient lockers can cut costs in half, which producing environmental and patient experience improvements.

- A quality improvement project which halved the length of time for an emergency gynaecological examination was shortlisted in the HSJ Value in Healthcare awards. Doctors introduced gynaecology emergency assessment bags into the emergency department so that the specialist equipment for a comprehensive gynaecological assessment would be immediately available. As a result, the length of time a patient waits in the department for an examination has been more than halved. It was very simple and inexpensive solution that's significantly reduced waiting times for our patients.

- We scooped a prestigious baby friendly award from children's rights organisation Unicef. The Baby Friendly Initiative, set up by Unicef (United

Nation's Children's Fund) 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.

In Northampton, just under 80 per cent of mothers choose to breastfeed their babies. We know that breastfeeding helps protect babies from a range of illnesses like gastroenteritis, chest infections, ear infections. The Baby Friendly award means we have best practice standards in place to strengthen mother-baby relationships and to support mothers who chose to breastfeed.

- We were shortlisted for the Northamptonshire Sports awards in the Active Workplace category. We were recognised for our activity programmes to improve staff health and wellbeing which include nutrition and fitness programme, taking part in local and national fitness challenges and lunchtime dance sessions.

- We won the staff engagement category of the Patient Experience Network Awards in recognition of our work in engaging with staff, collating feedback and using the intelligence gathered

- We won a Patient Experience Network Award for improving the experience of people with a disability. This came hot on the heels of receiving a Getting On Board award from the Northamptonshire Learning Disability Partnership Board in recognition of our work in supporting patients with a learning disability

It's heartening to see individuals, teams and departments across the full spectrum of our services being recognised for their outstanding contribution.

Inspection

As the end of the financial year approached, and still in the grip of our winter pressures, we were inspected by the Care Quality Commission. The inspection results have not been published at the time of producing this annual report but the informal feedback from inspectors was that care for patients was seen to be the priority, A&E felt calm despite the huge pressure we're under, and staff ware positive, confident and proud of their work.

We know we have improved in almost every way since the last inspection three years ago. Our hospital in many ways feels like a very different place and there's a tangible sense of pride in Team NGH.

Dr Sonia Swart
Chief Executive Officer

Paul Farenden
Chairman

AN INTRODUCTION TO NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Who We Are

Northampton General Hospital is an acute NHS hospital trust that offers a full range of hospital services from the main hospital site close to the centre of Northampton. We also provide day case and outpatient services at Danetre Hospital in Daventry.

We have formally pledged our commitment to continuous improvements in the quality of care we provide and patient safety by strengthening our focus on corporate accountability for clinical performance. We are committed to providing the best possible care for all our patients and this is central to our strategy for the future.

What We Do

We provide general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to 692,000 people living throughout the whole of Northamptonshire. We are an accredited cancer centre, providing services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. For one highly specialist urological treatment we serve an even wider catchment.

Our principal activity is the provision of free healthcare to eligible patients. We provide a full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

Our Vision and Values

Our vision is to provide the best possible care for all of our patients. This means we deliver safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our hospital sites or by our staff in the community.

Our values underpin all we do and were developed following discussion and consultation with our staff. They are:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each another

For patients this means they can expect to:

- Receive the right treatment at the right time and in the right place in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their individual needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision making about their care
- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

Our Strategic Aims
Our Trust Board sets our overall strategic direction, within the context of NHS priorities, and monitors our performance against objectives. It also provides financial stewardship, clinical governance and corporate governance to ensure that we continue to provide high quality care that offers value for money.

To support delivery of these organisational priorities we have developed five strategic aims that are also aligned to our vision and values:

1. To focus on quality and safety
We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety

2. To exceed our patients' expectations
We will continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients

3. To strengthen our local services
Provide a sustainable range of services delivered locally

4. To enable excellence through our people
We will develop, support and value our staff to provide our patients with quality care delivered by a highly trained and motivated workforce**.**

5. To ensure a sustainable future
To provide effective and commercially viable services for our patients, ensuring a sustainable future for NGH

The current healthcare environment remains very challenging and the constrained financial environment and difficulty in recruiting a substantive workforce are our main strategic risks. However we continually focus on

- transforming the way that our staff work and how we deliver key services to respond to changing patient needs, ensuring that we are able to respond to the demands placed on our services and the organisation;
- maximising efficiency and reducing cost so that we are a high value organisation;
- strengthening the way that we work with other organisations and partners, to establish partnerships and strategic alliances where this is mutually beneficial and improves the quality and efficiency of our services for patients;

Our Strategic Priorities
- Providing and strengthening our core hospital services through partnership working with other primary and secondary care providers
- Continuing to improve urgent care services
- Collaborating with other providers to provide care closer to home
- Developing partnerships with KGH in response to the challenged health economy workstream

- Become the hospital provider of choice for local GPs and patients
- Delivering excellence in patient care
- Developing health and wellbeing campus in partnership with Public Health

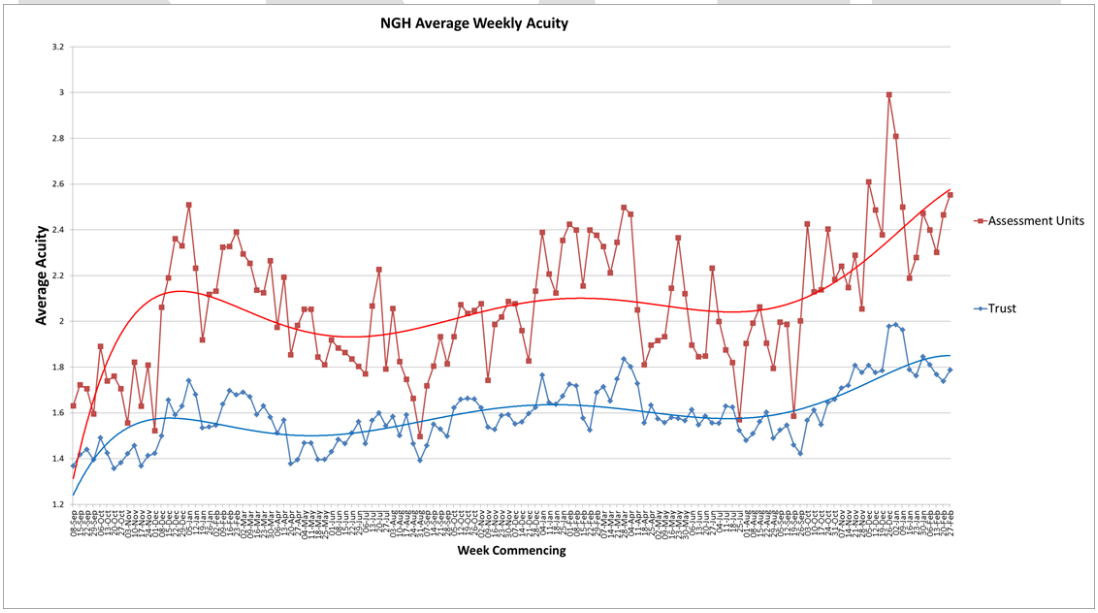
At the time of producing our annual report, our clinical strategy is under review.

PERFORMANCE ANALYSIS

Overview
The past year has seen increased collaborative working between us and other service providers within the county to ensure that patients are provided with the best quality care in the timeliest manner; quality of care always being at the heart of all service provision.

We experienced some operational challenges throughout 2016/17 with a 2 per cent increase in A&E attendances and a 10 per cent increase on the previous year for emergency admissions, further compounded by high acuity levels of patient presenting especially throughout the winter period. This resulted in increased time in hospital for some patients and in particular longer lengths of stay for those patients who require care or community services after discharge from hospital.

The acuity of our patients in the assessment areas and throughout the rest of the hospital can be seen below with a marked increase during winter.



A number of changes have been put in place over the year to ensure increased efficiency in all patient pathways with the aim of ensuring safety and quality of care along with a reduced length of hospital stay and safe discharge.

1) Perfect weeks – we ran site-wide 'perfect weeks' during the year and especially at Christmas with senior clinical and managerial staff supporting the wards to ensure discharges were optimised. Elective operating for more routine cases was reduced throughout these periods and key clinical staff asked to prioritise working on the ward areas.

2) Proactive management of elective work over the winter period: Winter always places a huge non elective medical demand on us and as such a plan to flex down elective work and to convert Althorp ward from elective orthopaedic surgery to medicine was agreed and planned. Althorp ward was converted to medicine in mid-January and the ward was handed back to orthopaedics during the first week of March. This clearly has had an impact on our elective performance for orthopaedics but during this period we asked other providers to help us with some cases who were clinically urgent while we focussed on day case work.

3) Improved support for frail patients being admitted via the Emergency Department via a dedicated frailty service ensuring patients have a CGA (Comprehensive Geriatric Assessment) within the 24 hours of admission. The frailty service is supported by two full time frailty nurses who work with A&E staff as well as the general wards - this has been and continues to be further developed into a non-bedded area where patients can be assessed with the aim of transfer home unless admission is urgently required.

4) A new rehab model of care utilising capacity at Angela Grace nursing home (Dickens Unit) By October 2017 we had 35 patients being supported with intensive physio and occupational therapy with the aim to ensure a speedy recovery and transition home without the requirement of ongoing care. The effect of this new model of care and therapy has proved successful with many patients now going straight home without the need for community care.

5) Expansion (FIT stop) within emergency department to ensure rapid see and treat. This service opened during the first week of September creating 9 assessment bays and freeing up A&E capacity to increase the footprint to 42 cubicles (including children's ED, resus, majors, minors and FIT stop) This service is consultant-led seven days a week and has been instrumental in ensuring we have the best ambulance handover figures in the region

6) Seven day working: during the year we extended our opening times in the ambulatory care centre. The service now operates across 7 days and into the evenings. The numbers of patients in the unit has continued to increase and is now exceeding the numbers it was originally designed for.

   The weekend discharge team has expanded during the year to include 2 additional senior doctors with the aim of ensuring patients who are ready to leave hospital are reviewed and discharged. At weekends both the on call manager and on call director are also based on site during the day to provide support to the clinical staff.

7) Development of a business case for a new assessment unit. Planning and design work has continued on this large development over the winter period.

8) Additional staff and new ways of working for the emergency department have been invaluable over the past year with the introduction of a social worker, GP, pharmacist and therapy staff based in the A&E to ensure patients are

receiving the most appropriate treatment, medication and can be rapidly seen and discharged home

9) Additional consultants in acute and general medicine were appointed to support the assessment areas and ensure medical teams could manage the increased numbers of medical patients admitted to our wards

10) S.A.F.E.R. patient flow principles were introduced by the end of October 2017 A daily SAFER dashboard is in place and now includes metrics on Red to Green which shows daily if patients' care plans are progressing, with the aim that every patient should be on a green day with something taking place to progress their care and discharge. The communications work on this programme has been recognised nationally and internationally with our SAFER posters being used as far away as New Zealand

11) We run a weekly senior review-and-challenge of all cases where patients are staying in hospital for long periods. At the start of the process we had 40 patients over 100 days stay and the meeting has supported the discharge of many of these patients yielding in excess of 10,000 beds days

12) The daily safety huddle was reviewed and refined jointly by the operational and nursing teams with a new daily 8.30am huddle that all wards and departments attend to update on patient safety, patient flow and any other concerns. This meeting has been hugely helpful over the winter in monitoring safety as well as galvanising the teams at times of immense pressure

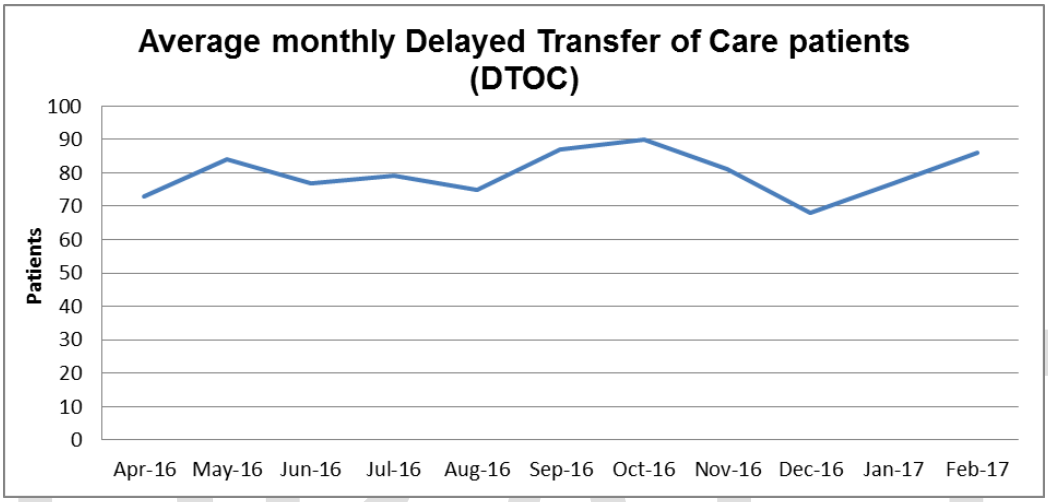
13) The Dementia and Delirium team from NHFT joined our discharge team over the winter period. This small team of therapists have been instrumental in supporting the discharge of some of our most vulnerable patients who can often have longer stays in hospital.

14) Advanced Primary care streaming: The medicine division led a robust plan to divert patients from the front door of ED into more appropriate services within the community as approximately 30 per cent of patients who attend A&E do not require our services. The GP triage staff rapidly assess patients and stream them to

- ambulatory care
- gynae assessment unit
- paediatric assessment unit
- oncology assessment (EAB)
- urgent care centre and GP out of hours off site
- booking them a rapid appointment with their own GP
- pharmacists
- home

Delayed Transfer of Care

Delayed transfers of care (DTOC) have been relatively static throughout the year. The figures below identify that, on average, 12 per cent of our bed base is utilised by patients recorded as being clinically fit for discharge but lacking facilities in the community/primary care to support their discharge.



ACTIVITY

The change in outpatient activity between consultant and nurse led is due to a change in the recoding of the activity; taking collectively, first outpatients has increased by 6.3 per cent with little change in the follow up figures.

Activity Comparison	2013-14	2014-15	2015-16	2016-17	Diff	% Diff
Emergency Inpatients	35,907	40,349	43,456	47,701	4,245	10%
Elective Inpatients	7,329	6,208	5,824	5,634	-190	-3%
Elective Daycases	38,052	38,346	39,610	42,393	2,783	7%
New outpatient attendances - Consultant led	77,973	80,037	83,474	105,790	22,316	27%
Follow-up outpatient attendances - Consultant led	152,425	149,977	155,562	208,420	52,858	34%
New outpatient attendances - Nurse led	39,775	38,571	42,127	27,758	-14,369	-34%
Follow-up outpatient attendances - Nurse led	81,535	114,953	154,412	101,938	-52,474	-34%
Total number of outpatient DNA's	26,525	30,350	34,770	36,708	1,938	6%
Patients seen in Accident & Emergency	107,786	109,305	114,179	116,183	2,004	2%
Number of babies born	4,573	4,685	4,726	4,867	141	3%
Average length of stay (in days)	4.60	3.55	4.36	4.52	0.16	4%

The reduction in elective inpatient activity is due to the increased need for emergency inpatients to access our beds which has meant we cancelled operations or on occasions where clinically appropriate we delayed operating in order that we care for those most in need of our services.

During the year we ran transformation programmes across surgery and outpatients with the aim of reducing the numbers of patients who do not attend (DNA), ensuring the numbers of patients in each clinic and on each list are adequate and that time is not wasted - ultimately improving the experience both of patients and our staff. The transformation projects are continuing during 2017/18.

National Performance Standards

Despite the pressures on both the organisation and the health economy in general, both locally and nationally, we fully achieved 9 of the 14 national targets throughout 2016-17 with a further 3 partially achieved, one of which was only missed in the first quarter of the year (cancer: percentage of patients treated within 31 days).

Performance Indicator	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
A&E: Proportion of patients spending less than 4 hours in A&E	95%	90.80%	90.90%	83.80%	82.40%
A&E: 12 hour trolley waits	0	0	0	0	0
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	> 99%	99.40%	99.80%	99.30%	99.60%
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	96.30%	96.60%	97.10%	96.90%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	97.40%	94.30%	95.10%	95.90%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	96.10%	97.60%	98.60%	94.00%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	85%	79.40%	78.60%	78.40%	91.90%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	76.50%	76.20%	83.20%	78.40%
Cancer: Percentage of patients treated within 31 days	96%	94.10%	96.70%	97.10%	98.15%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	94.60%	82.40%	95.30%	90.90%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	99.50%	98.40%	99.40%	97.04%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	94.50%	96.10%	98.30%	96.60%
RTT waiting times incomplete pathways	92%	94.50%	93.80%	92.30%	92.40%
RTT over 52 weeks	0	0	0	0	0

4hr A&E standard

2016/17 has been a challenging year for our urgent and emergency care services. Our emergency department has seen an additional 2,000 patients (two per cent increase) together with 4,000 more admissions than the previous financial year representing a 10 per cent increase.

During the first five months of the year performance exceeded the planned trajectory; however with the challenges of increased attendees to A&E and high acuity of our patients we were unable to sustain the performance throughout the remainder of the year.

A&E												
	A&E Attendance / 4 Hour Breach Performance											
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan 17	Feb 17
Total Patients Seen	9277	9895	10074	10129	10386	9655	9766	10138	9903	9652	9730	9602
> 4 Hour Waits	1823	1143	1612	1519	1350	1352	977	811	1188	1255	1216	1104
Trajectory	80.40%	88.45 %	84.00 %	85.00 %	87.00 %	86.00 %	90.00 %	92.00%	88.00 %	87.00 %	87.5%	88.5%
Actual performance		88.50 %	89.19 %	94.63 %	94.40 %	92.56	89.33 %	84.81 %	83.4%	83.2%	81.4%	78.3%

The external support required to reduce the number of patients who are delayed continues to be a challenge and the constraints within adult social care have impacted on performance within the hospital.

As we enter spring, a marked improvement in performance is identified in March which has continued for the first part of April with 8 of the first 18 days exceeding the 95 per cent target.

Diagnostic waiting times
The six week diagnostic waiting times have been maintained across the year. All specialities have responded well to the increase in activity and have been able to sustain the target by offering additional spaces for our patients.

Cancer waiting times
We had a challenging year with regards to meeting the cancer waiting times standards during 2016-17. This highlighted the need for an intense focus following concerns that the 31 day and 62 day standards in cancer care were not being delivered.

An interim cancer management specialist was recruited in August in order to support the new cancer services management team. A refreshed cancer recovery plan and tumour site action plans were produced with monthly oversight of these by the clinically-led cancer board, underpinned by a newly launched access and operational policy.

Performance prior to this intense focus saw us failing to meet the 62 day standard for 16 months, finally reaching target in December 16 at 86 per cent against the standard of 85 per cent. We sustained the performance against the 31 day standard meeting this each month from July 2016 onwards.

The number of patients exceeding the 62 day wait for a diagnosis/treatment in September 16 was 115, as at March 17 this stands at 48 and has seen a reduction of 58 per cent, however continued focus is required to ensure this is reduced to acceptable levels and does not rise again.

Pressures over the past year included access to medical records for weekly MDT meetings, ability for radiology to sustain access to investigations and reporting within seven days, staffing capacity in oncology and cancer services, availability of histopathology for MDT meetings and timely reporting and winter pressures.

Referral to Treatment
We have successfully maintained the achievement of RTT ongoing target, despite having to stop a significant proportion of elective work over the winter due to the urgent care pressures.

SUSTAINABILITY REPORT

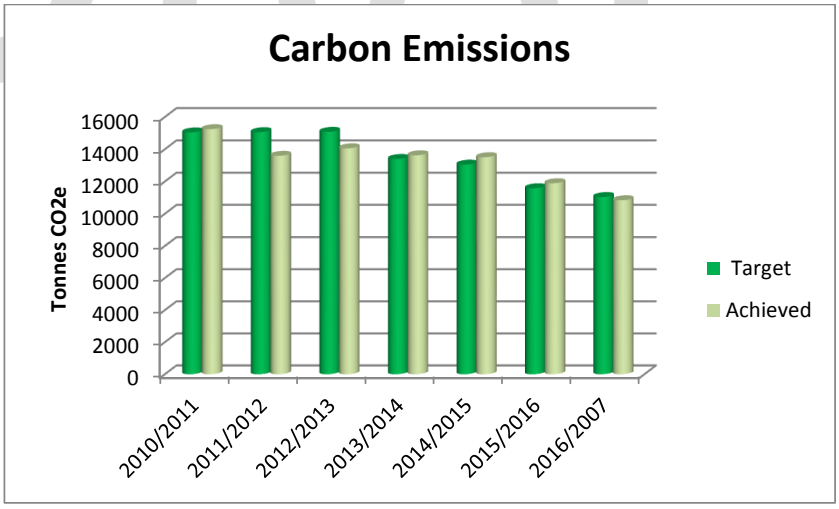
During the year we approved our new sustainability strategy, *Caring for the Future*. While emphasising the continued need to reduce our environmental impact, the strategy moves beyond the traditional areas of energy and waste to the wider sustainability aspects of healthcare delivery. It is aligned with both our clinical strategy and the NHS Sustainability Strategy and includes both quantitative and qualitative goals for the coming five years. All key performance indicators are on target, with the exception of water use.

Carbon Management Plan

We reached the end of the first contracted year of our energy strategy which achieved the guaranteed savings specified in the contract. Carbon emissions from heat and power were down by 11.5 per cent compared to the previous year.

Our biomass boiler became fully operational in December. Woodchip for the boiler is purchased from a local company that conducts tree clearances and tree surgery work around the local area, including our site. Carbon emissions from buildings have reduced by 31 per cent compared to 2010, which puts us close to requirements for the national 2020 target; a major achievement. This is with only a part year of the biomass operation.

Consumption of electricity continues to increase due to increased patient activity, increased data storage requirements and increased cooling requirements. Additional measures are therefore required to stay on target for 2020 and beyond. The potential options will be determined and reviewed in the coming year.



	2014/2015	2015/2016	2016/2017
Consumption Data			
Gas kWh	29,250,909	22,683,936	18,937,723
Electricity kWh	14,611,750	15,222,263	15,657,244
*Biomass			2,131,484
*Water m^3	127,781	136,464	151,982
Business Travel miles	977,976	943,475	894,928
Financial Data £			
Gas	1,148,238	1,276,017	1,189,156
Electricity	1,131,103	477,196	246,904
*Biomass			64,456
*Water	268,190	263,063	297,080
Business Mileage	431,790	395,717	364,465
Carbon Credits	214,397	191,202	171,965
*Renewable Heat Incentive			(73,343)

**approximate figures as full data not yet confirmed*

Investment
Further improvements have been made to our lighting. Inefficient lighting has now been replaced with LEDs in most stairwells, in staff restrooms and along corridors – additional daylight and motion sensors have been added. This work has been funded through an interest free Salix loan.

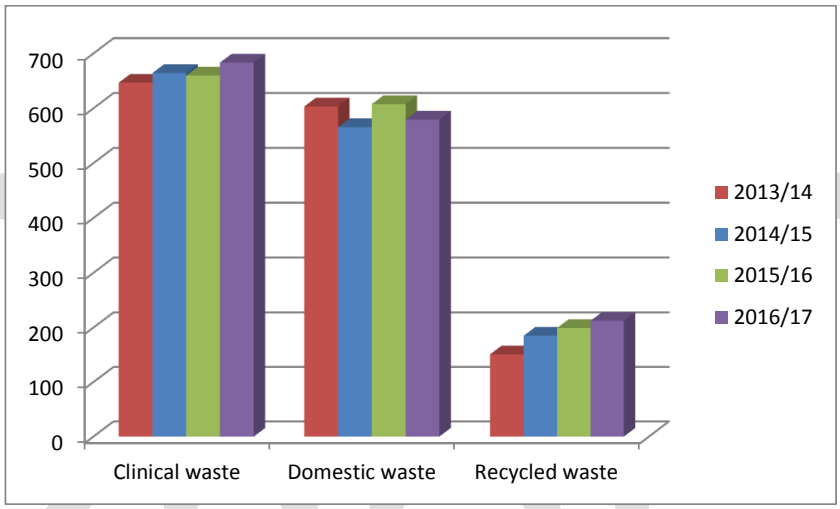
A review and some retuning of our building energy management system has been undertaken resulting in improved comfort levels and reduced energy spend. Following a successful change to the air handling unit in our pharmacy department, which has reduced spend by approximately £4,000 a year, similar schemes will be incorporated into the 2017 workplan.

Water Use
Water use increased significantly in the previous twelve months (11.4 per cent) due to two separate underground water leaks, the first in five years. These have now been repaired and water levels have returned to those of 2015. These water leaks have put us behind our target of a 2 per cent year-on-year decrease, but additional metering will be installed in the coming year to help target the installation of water saving technologies.

In conjunction with Anglian Water we also launched an awareness campaign to highlight the issue and cost of inappropriate items being flushed down toilets both within our hospital and in the wider Northamptonshire area.

Waste and Recycling
2016/17 saw a major push on waste. A multidisciplinary group now meets monthly to set the forward agenda for waste reduction and improved recycling. Joint meetings are held with Kettering General Hospital and our waste management contractor.

Regular waste audits are now conducted in conjunction with the infection prevention team with follow-up training given as appropriate



- Waste production on site has increased; this is a result of increased patient activity. Waste produced per patient decreased by 11.5 per cent compared with 2015/16.
- The level of recycling segregated on site increased by 6.6 per cent to 212 tonnes (almost 27 per cent of non-clinical waste). Additional revenue was also achieved through sale of wooden pallets, and the destruction of a further batch of archived X-Rays. These resulted in a further 97 tonnes of recycling.
- These figures do not include the furniture reused through two reuse initiatives. The WarpIt platform is an online site that allows staff to advertise items no longer required and to obtain items from other organisations. In addition, an innovative project undertaken with our procurement department to refurbish ward furniture has saved over £20,000 and prevented approximately 5 tonnes of waste going to landfill.
- In 2017 we will install a shredder baler which will reduce the confidential waste bill and result in a further revenue. We will continue our work with our waste management companies and improve recycling facilities aiming for a further 5 per cent increase in the amount of waste recycled.

Carbon footprint and procurement
The carbon footprint calculated using the Defra P4CR tool based on spend has been calculated at 80,288 tonnes $CO2_e$, a 6.6 per cent increase on the previous year. This reflects some additional spend categories included in the data set and increasing costs, particularly in construction materials, office equipment, and chemicals and gases.

We have also started to question suppliers about their own sustainability initiatives and have discovered a number of potential waste reduction schemes as a result.

The greenhouse gas emissions from anaesthetic gases are slightly higher than in previous years (2932 tonnes $CO2_e$). This is mainly due to increased use of Entonox, a gas used in A&E and maternity.

Other green initiatives
- Following the annual staff travel survey two further cycle shelters were installed at opposite sides of the site.
- Staff are now offered discounts if they take their own cup to our retail outlets rather than using a disposable cup.
- Over 9,000 Christmas cards were collected and taken to M&S who work with the Woodland Trust to plant more trees in the UK.
- And in more tree-related initiatives, both the emergency department and maternity department have introduced schemes to reduce the amount of paper they use. Between them they are saving around 50 trees a year.

Plans for next year
Next year will see the creation of a carbon management plan to ensure we stay on target to meet government legislation despite increasing energy demands on the site. Part of this will include investigation of further renewable energy schemes alongside the options to participate in capacity market mechanisms. These are schemes run by National Grid whereby high energy users are paid to change their consumption for short periods of time in high use periods, usually during Winter. These are designed to ensure that there is sufficient capacity on the grid reducing the potential of black outs.

We will also participate in Clean Air Day – highlighting the harmful effect of pollution on health, whilst promoting lower carbon forms of transport.

SECTION TWO

ACCOUNTABILITY REPORT

REPORT FROM THE DIRECTOR OF FINANCE

Economic Outlook and Impact on the Trust

The NHS continues to be under significant pressure both financially and operationally. Our response to this is to continue to focus on providing high quality care to our patients through our clinically-led structure. We maintained a stable and improving financial position in 2016/17 despite the at times extreme pressures on the hospital, particularly due to increasing demand for urgent care services.

The challenge going forward is only likely to get even greater as the funding levels for the NHS tighten still further and although we are well prepared to face what lies ahead with detailed plans in place that are agreed with service leaders and regulators, the pressure is continuing unabated so the risk of some non-delivery of targets including financial performance is high.

There is quite considerable uncertainty about future funding levels in the medium and long term but we are nevertheless working hard to establish sustainable plans for the future alongside our partners in the health and social care system.

Financial Performance

We planned for a deficit of £15.1 million in 2016/17. This compared favourably with the deficit of £20.1 million in 2015/16. The actual deficit of £13.8 million was better than plan by £1.3 million.

We met our other financial duties to manage its capital expenditure within its capital resource limit, its borrowing within its external finance limit and to pay its suppliers within 30 days for more than 95% of invoices paid.

Capital Expenditure

We invested £14.7 million in 2016/17 improving our estate, medical equipment and information technology (IT) assets. This included further substantial investment in radiotherapy treatment machines and high tech diagnostic imaging equipment. There are further plans in 2017/18 and beyond to ensure our estate, equipment and technology is updated to underpin the provision of high quality care for our patients. We are also planning to increase the capacity of the hospital to address the pressures we face through the provision of a new assessment hub; this development will go ahead with building commencing in 2017/18 and due for completion in spring 2018. The development will be financed through a lease with a capital value of approximately £12.4 million.

Charitable Funds

We are supported by the Northamptonshire Health Charitable Fund whose primary purpose is to support our work by providing grant funding, making use of the many generous donations and legacies they receive from the general public and from active fundraising.

During the year, the charity's governing arrangements were amended and the Trustees of the charity are now legally independent of our Trust Board with a brief that continues to ensure the charity contributes to enhancing patient experience.

To ensure local governance of funds, our senior nurses and managers are heavily involved as fund advisors actively, recommending the specific projects where funds should be spent.

During the financial year, the charity paid £1.1m as grants. Of specific note is the full funding of chemotherapy suite expansion and refurbishment. Other specific grants contributed towards:

- the acquisition of Springfield House as part of plans to improve urgent care services for our patients.
- provision of new equipment for our neo-natal intensive care unit Gosset ward
- Do It For Dementia (as discussed earlier in this section).
- improvements to patient and staff amenities
- creation of - and improvement to - family rooms
- sponsorship for staff undertaking extended professional development.

CORPORATE GOVERNANCE: THE TRUST BOARD

NHS Trust Boards are legally required to consist of more non-executive members than executive members. The current composition of the Trust's Board of Directors is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- One Associate Non- Executive Director
- Five executive directors with voting rights
- Four executive directors

The executive directors are full time employees of the Trust and non-executive directors were appointed by NHS Improvement.

Executive directors manage the day-to-day running of the Trust and, together with the Chair and non-executive directors are responsible for determining our strategic direction, agreeing our policy framework, monitoring our performance and systems of internal control and also shaping culture for the organisation.

The Trust Board discharges its responsibilities through bi-monthly public Board meetings and bi monthly Board of Director meetings, an annual public meeting and a framework of formal subcommittees. The supporting committee structure is designed to:

- Deliver the Board's collective responsibility for the exercise of the powers and performance of the Trust
- Assess and manage financial and quality risk
- Ensure compliance with Department of Health guidance, relevant statutory requirements such as the Care Quality Commission requirements and contractual obligations.

. The current composition of the Board is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- One Associate Non- Executive Director
- Five executive directors with voting rights
- Four executive directors

The directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business with Northampton General Hospital NHS Trust.

The directors are not aware of any relevant audit information of which our auditors are unaware and they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that our auditors are aware of that information.

Directors during 2016 /17
* denotes voting members of the Trust Board.

Job Title	Name	Comments
Chairman*	Paul Farenden	
Chief Executive Officer*	Sonia Swart	
Non-Executive Directors*	Phil Zeidler (vice Chair) Graham Kershaw Elizabeth Searle David Noble Olivia Clymer John Archard Jones Annette Gill (Associate)	 Stepped down October 2016 Commenced Nov-15 Commenced Jan-17 Commenced Jan-17
Chief Operating Officer*	Debbie Needham	
Medical Director*	Michael Cusack	
Director of Nursing*	Carolyn Fox	
Director of Finance*	Simon Lazarus	
Director of Facilities and Capital Development	Charles Abolins	
Director of Workforce and Transformation	Janine Brennan	
Director of Strategy and Partnerships	Chris Pallot	
Director of Corporate Development, Governance and Assurance	Catherine Thorne	

Board members

Paul Farenden, CIPFA, MBA
Chairman
Paul was appointed as Chairman on 1st March 2012. A local man, who was previously chief executive at the Dudley Group of Hospitals NHS Foundation Trust, Paul has some 40 years' experience in healthcare finance, management and leadership. A qualified accountant, Paul has been chief executive in three NHS Trusts over the last 20 years, where he has led large-scale organisational change. Paul's experience has provided him with an in-depth understanding of both the NHS and the wider healthcare system.

Phil Zeidler
Vice Chairman
Phil had a successful career as an entrepreneur in financial services, building a number of businesses, including the largest independent outsourced distributor of general insurance in the UK. Currently Chairman of two insurance businesses, a music fund and two strategy-of-change consultancies, his core skills lie in strategic planning, innovation and developing strategic relationships. He is married to a consultant paediatrician.

Graham Kershaw
Non-executive director
Graham holds a first class honours degree in business from Leeds Metropolitan University and an MBA. He is a fellow of both the Chartered Institute of Secretaries and Administrators and the Chartered Institute of Personnel and Development. Graham also holds a professional marketing qualification. Graham has been a main board director of a number of major UK retail companies including Lloyds Pharmacy, Capio UK and Joshua Tetley's. He is currently managing director of Cogniscence Ltd a business providing change management and business turnaround input mainly to the public sector.

David Noble
Non-executive director
David Noble's career has been in finance covering both the public and private sectors. Most recently David has spent nine years as Finance Director of the Equipment Procurement and Support sector of the Ministry of Defence, leading change programmes to improve the performance of the organisation. He chairs the audit committee.

Elizabeth Searle
Non-executive director
After qualifying as a nurse and working in cancer and palliative care, Liz Searle held posts in higher education developing palliative care courses, with Macmillan as Director of Education Development and Support, and at Sue Ryder Care as Head of Palliative Care working with their hospices.

Olivia Clymer
Non-executive director
Olivia's early career was spent with the Environment Agency, which subsequently led to roles in related areas in both the public and private sector. Her experience of the voluntary and community sector and local authority helped to develop her focus on regeneration and the challenges of social and economic disadvantage. Olivia has served as a member for the Consumer Council for Water and as a housing association board member for nine years. She is currently an associate non-executive director for Dudley and Walsall Mental Health Trust. Her experience in social care and systems transformation has informed her interest in the challenging area of sustainable healthcare provision.

John Archard Jones
Non-executive director
John has 30 years of commercial experience at senior levels in manufacturing, sales management, project management and major bids. He is a former managing director of the African region of ICL, a leading technology company. John now works in business consultancy and is an experienced non-executive director within both the public sector as well as private and listed companies in the UK and overseas. He is a former councillor with the London Borough of Barnet and is the founder and former member of a London-based charity for people with learning disabilities.

Anne Gill
Associate Non-Executive Director
Anne's experience includes a successful career as a senior human resources executive in consumer goods, retail and public sector organisations, with 10 years as HR Board Director for a multi-national fast-moving consumer goods (FMCG) organisation. She has also held leadership roles in supply chain and sales. She is currently a Board Trustee for the charity MedicAlert and works as an independent consultant specialising in leadership coaching and organisation development. She holds an MA in coaching and mentoring practice from Oxford Brookes University and is a Chartered Fellow of the Institute of Personnel and Development.

Dr Sonia Swart, MA, MB, BCh, MD, FRCP, FRCPath
Chief Executive
Sonia was appointed as Chief Executive on 20th September 2013, having been the Trust's Medical Director since September 2007 and acting Chief Executive since July 2013. Sonia qualified from the University of Cambridge and went on to train in general medicine and clinical haematology. She worked as a consultant haematologist in North Warwickshire before joining Northampton General Hospital in 1994. Prior to becoming Medical Director, Sonia combined an active clinical role with a number of managerial activities, including head of pathology, clinical director for diagnostics and clinical lead for the foundation trust application. Sonia has made a commitment to align the trust's aims, values, objectives and corporate governance to support a clinically-led quality agenda.

Deborah Needham
Chief Operating Officer
Deborah trained as a Registered General Nurse in Lancashire, where she held positions in both respiratory and emergency medicine units before moving to London in 1998 as a ward sister. After graduating as a nurse, Deborah gained a diploma in respiratory medicine and nursing care and a BA (Hons) in healthcare management

Simon Lazarus
Director of Finance
Simon joined the Trust in March 2014 from the Oxford University Hospitals NHS Trust where he was the Deputy Director of Finance. Simon has held a number of senior roles in NHS hospital finance since joining the NHS in 1993. He has a special interest in improving hospital finances, financial planning and major capital projects. Simon is a chartered accountant and has a degree in natural sciences from

Cambridge University. Simon started his career in the private sector working in London before joining the NHS.

Dr Michael Cusack
Medical Director
Dr. Michael Cusack, a consultant cardiologist, has joined our executive team from the end of September 2014. Mike was closely involved with reconfiguration of cardiac services across sites, led the Black Country Cardiovascular Network from 2008-2012 and has been involved in various aspects of pathway redesign. He has a longstanding interest in medical management and has been a clinical director and more recently a divisional medical director of a large surgical division at Royal Wolverhampton Hospital. His responsibility there included all surgical specialties, anaesthetics, theatres, support and maternity services in a medically led management model.

Carolyn Fox
Director of Nursing
Carolyn began her nursing career in Sheffield and qualified as a Registered Nurse in 1990. She held staff nurse positions and went on to become a Ward Manager in respiratory medicine. Carolyn worked in London as a Clinical Nurse Specialist before relocating to the North West. With an interest in quality, Carolyn worked as a National Programme Manager, NHS Quality Improvement Scotland and Assistant Director of Nursing, Salford Royal Foundation Trust before joining Aintree University Hospital as Deputy Director of Nursing.

Charles Abolins, FBIFM, MHCIMA
Director of Facilities and Capital Development (non-voting)
Responsible for the Trust's estates and facilities, procurement and capital development, purchasing and supply. After graduating in hospitality management from Birmingham College of Food and Tourism, Charles has held a number of facilities management posts in the NHS. Since joining NGH, Charles has been responsible for leading and implementing complex, major capital building programmes and managing a wide range of facilities support services. He is the Trust's lead for sustainability.

Janine Brennan
Director of Workforce and Transformation (non-voting)
Janine was appointed as Director of Workforce & Transformation on 2nd April 2013, having worked previously as Director of Workforce and Organisational Development at Royal Berkshire NHS Foundation Trust. She qualified in law and human resources management and has worked in a number of acute Trusts, as well as the public sector and not for profit
organisations. Janine's special interest is in developing staff commitment and engagement in ways that lead to improvements in the care we give to patients.

Chris Pallot MSc, BA (Hons), DipHSM, DipM
Director of Strategy and Partnerships (non-voting)
Chris has worked at the Trust since January 2010. He joined the NHS Management Training Scheme in 1995 after graduating from university and since then has gained a postgraduate Diploma in Marketing and an MSc in Management. During his

career, Chris has held previous positions at Kettering General Hospital, the NHS Modernisation Agency, Northamptonshire Heartlands PCT and NHS Northamptonshire. In previous roles he has been responsible for operational management, service improvement and commissioning & contracting. As Director of Strategy and Partnerships, he has responsibility for strategy development, contracting, market development and clinical coding services.

Catherine Thorne
Director of Corporate Development, Governance and Assurance (non-voting)
Catherine was appointed as Director of Corporate Development, Governance and Assurance in January 2015 having previously held the post of Director of Governance for London North West Healthcare NHS Trust. She started her career clinically within radiotherapy and oncology services, transitioning into a variety of senior NHS roles in quality assurance, service improvement and governance. Catherine acts as the Board Secretary in addition to responsibility for clinical governance, health and safety, and compliance, risk and legal services.

Table of Attendance 2016/17

A = Maximum number of meetings the Director could have attended

B = Number of meetings Director actually attended

	Trust Board / Board of Director Meetings		Audit Committee		Quality Governance Committee		Finance, Investment & Performance Committee		Workforce committee		Remuneration Committee	
Name	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Chairman	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Paul Farenden	12	10			12	8	12	9	12	6	1	0
Chief executive	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Dr Sonia Swart	12	11			12	8	12	10	12	9	1	1
Non-executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Graham Kershaw	12	10	4	3	12	3			12	11	1	0
David Noble	12	11	4	3			12	9			1	1
Elizabeth Searle	7	4	3	1	7	5					0	0
Phil Zeidler	12	11	4	3			12	9			1	1
Olivia Clymer	12	10	4	0	12	11	12	0	12	9	1	1
John Archard Jones	3	3	1	1	3	3	3	1	3	0	1	1
Anne Gill (Associate)	3	3	1	1	3	2	3	1	3	3	1	1
Executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Deborah Needham	12	11			12	9	12	11	12	11		
Simon Lazarus	12	11	4	4	12	7	12	11				
Carolyn Fox	12	11			12	11	12	10	12	11		
Dr Michael Cusack	12	11			12	11			12	11		
Chris Pallot	12	9			12	7	12	9				
Janine Brennan	12	10			12	10	12	10	12	11	1	1
Charles Abolins	12	11			12	9	12	9	12	8		
Catherine Thorne	12	12	4	3	12	10	12	10				

Board Meetings

The Board meets in public session every other month with a Board of Directors meeting in the intervening months. Where the Board meets in public this is also followed by a second session held in private. Information regarding Board meetings, including agenda and papers, is published on our website.

Audit committee

The Audit Committee meets around six times per year. Its purpose is to review the systems of integrated governance, risk management and internal control, to ensure that there is an effective internal audit function, to review the findings of the external auditor, to review the findings of other significant assurance functions and considers the draft annual report and financial statements before submission to the Board.

Finance Investment and Performance Committee
The Finance Investment and Performance Committee meets monthly. The committee's purpose is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust on behalf of the Board. In addition, this committee is responsible for ensuring the delivery of all key performance metrics.

Quality Governance Committee
The Quality Governance committee meets monthly. The purpose of the Committee is to ensure there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

Workforce Committee
The workforce committee meets monthly. The purpose of the committee is to provide assurance to the Trust Board on organisational development and workforce performance and on the achievement of associated key performance indicators and to make recommendations to the Trust board on key strategic organisational development and workforce initiatives.

Declarations of Interest

The Trust has a duty to ensure that all its dealings are conducted to the highest standards of integrity and probity. The statutory obligations are set out in the Code of Conduct and Accountability, published by the Department of Health and to this end we are obliged to compile and maintain a register of interest of directors, which may potentially influence their role.

The register is reviewed regularly and the Board receives a quarterly corporate governance report in which updates are reported. The current register of interest table is shown below.

Directors Interest Declarations:

Paul Farenden	Hon Treasurer of the retirement fellowship
David Noble -	Director, David C Noble Ltd
Phil Zeidler -	Chairman iGO4 Limited
	Chairman iGO4 Partners Limited
	Chairman iGO4 Solutions Limited
	Chairman Curium Solutions Limited
	Chairman Deadhappy Limites
	Non-Executive Director AssureOne Group
	Non-Executive Director Blue Badge Company
	Chairman of Ride High Limited
	Director of Northampton Charitable Funds
	Wife is consultant paediatrician at NGH

Olivia Clymer	Non-Executive Director for Dudley and Walsall Mental Health Trust
John Archard-Jones	Consultant Director First for Wellbeing
	Director and Owner Africa Consulting Ltd.
	Trustee Northants Health Charity
Janine Brennan -	Husband is an employee of Oxford University Hospitals – Director of Clinical Services
Chris Pallot -	Chairman, Voluntary Impact Northamptonshire

Statement of Chief Executive's Responsibilities as Accountable Officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Dr Sonia Swart

Chief Executive

Date

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Date Dr Sonia Swart

Chief Executive

Date Simon Lazarus

Finance Director

Annual Governance Statement 2016/2017

1. Scope of Responsibility

As Accountable Officer, I am responsible for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.
I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

I acknowledge my responsibilities as set out in the Accountable Officer Memorandum, including in relation to the production of statutory accounts, effective management systems and regularity and propriety of expenditure.

As Chief Executive I am accountable to the Trust Board. I am also responsible, via the NHS Accounting Officer, to Parliament for the stewardship of resources within the Trust

2. Governance framework of the organisation

The Trust's governance framework and system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives and
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

During 2016 the Trust Board has reviewed its governance arrangements and made some adjustments in reporting that align and embed improved systems of control and risk management to support the organisational operational structure.

In addition in April 2016 the Trust Board approved a three year risk management strategy and implementation plan to support improved risk management and assurance mechanisms across the organisation.

Trust Board and Committee structure

Northampton General Hospital NHS Trust has a Board of Directors (the Board) which compromises both Executive and Non-Executive Directors and has met monthly throughout the year.
Voting members comprise the Chair and five non-Executive Directors, one Associate non-Executive Director and five Executive Directors, including the Chief Executive along with four non-voting Directors.

The role of the Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure the Trust is providing safe, high quality patient – centred care.

The Board holds its meetings in public bi monthly and papers are available on the Trust website. The Board regularly reviews performance against national standards and regulatory requirements and a summary of performance against these priorities is available through the Trust's Annual report. The Board places a strong emphasis on quality and safety of patient care and in addition to performance reports, regularly hears directly from patients and carers, including patient stories and ward visits.

With reference to the requirements of the Trust's standing orders, the Director of Corporate Development, Governance and Assurance and Trust secretary has assessed the arrangements for the discharge of statutory functions. No irregularities or gaps in legal compliance have been identified.

The Trust Board approved the organisation's Quality Account in June 2016, further to review by the Quality Governance Committee. The accuracy of the Quality Account is assured through internal review and data checking processes as part of the Trust's data quality arrangements.

The Trust's External Auditors also undertook an audit of the 2016/17 Quality Account and their findings are being taken into account for the production of this year's Quality Account which is due to be agreed by the Board in June 2017.

During 2015/16 the Board reviewed its effectiveness against the Care Quality Commission's Well Led framework where a full gap analysis and action plan was agreed by the Trust Board. This was again reviewed in December 2016 and will be reviewed once again when information from the Care Quality Commission is made available following their latest consultation on their inspection regime.

The Board undertakes a bi-monthly programme of Board development activity. During 2016/17 this has largely centred on ensuring the Board understands the changing healthcare landscape and in particular the work in relation to Sustainability and Transformation programmes and how they link with organisational strategic aims related to ensuring safe and sustainable services via clinical collaboration.

Development activity also includes updates from the work undertaken in the previous year related to the organisational Quality Improvement (QI) agenda. This takes the form of updates and also front line staff presentations in respect to QI projects undertaken from various wards and departments across the organisation. In addition development sessions also include updates to Board member's statutory and mandatory training requirements throughout the year.

The principle committees of the Trust Board which support it in undertaking its responsibilities are:

Audit Committee
The Audit committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It is supported in this role by the Quality Governance committee.

Quality Governance Committee
The Quality Governance committee monitors, reviews and reports on the quality and safety of services provided by the Trust. This includes the review of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient centred care.

Finance Investment and Performance Committee
The Finance, Investment and Performance committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions.
Additionally it is responsible for overseeing the delivery of all key performance metrics for finance and operational delivery. The committee reviews the Trust's monthly financial and operational performance and identifies key issues and risks requiring discussion or decision by the Trust Board.

Workforce Committee
The Workforce committee monitors, reviews and reports on the organisational development and workforce performance of the Trust. This includes the achievement of associated key performance indicators and advising the Trust Board on key strategic organisational and workforce initiatives.

Remuneration and Appointments Committee
The Remuneration and Appointments committee has delegated authority from the Board to appoint and remove the Chief Executive and together with the Chief Executive to appoint and remove other Directors. In addition, it sets the remuneration, allowances and other terms and conditions of office for the Trust's Executive Directors.

Board and Subcommittee Attendance

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2016 to Mar 2017*	Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee
Paul Farenden	Non- Executive Director, Chair	1.3.12	10/12		x	x	x	x
Phil Zeidler	Non- Executive Director, Vice Chair	1.12.08	12/12	x		x		x
David Noble	Non- Executive Director	1.1.13	11/12	x	x	x		x
Elizabeth Searle*	Non- Executive Director	1.1.13	4/4	x	x			x
Graham Kershaw	Non- Executive Director	1.3.13	11/12	x	x		x	x
John Archard-Jones	Non- Executive Director	01.01.17	3/3	x	x			
Olivia Clymer	Non- Executive Director	2.11.15	10/12	x	x		x	x
Anette Gill	Non- Executive Director (Associate)	01.01.17	3/3	x			x	x
Sonia Swart	CEO	23.9.13	11/12		x	x	x	
Debbie Needham	Chief Operating Officer/ Deputy CEO	10.4.14	11/12		x	x	x	
Catherine Thorne	Director of Corporate Development Governance and Assurance	19.1.15	12/12	Attend	x	x		
Simon Lazarus	Director of Finance	11.3.14	11/12	Attend	x	x		
Janine Brennan	Director of Workforce and Transformation	2.4.13	10/12		x	x	x	
Charles Abolins	Director of Facilities	1991	11/12		x	x	x	
Chris Pallot	Director of Strategy and Partnerships	11.10.10	9/12		x	x		
Mike Cusack	Medical Director	26.9.14	11/12		x		x	
Carolyn Fox	Director of Nursing	20.7.15	11/12		x	x	x	

**Stepped down – 31/10/16*

3. The risk and control framework and risk assessment

As designated accountable Officer I have overall responsibility for risk management with specific responsibilities delegated to other Executive Directors and senior managers within the organisation.

Risk Management framework
The trust has a comprehensive Risk Management Strategy and Policy which has Board approval and is available to staff via the Trust's intranet pages.

These documents describe the Trust's overall risk management strategy, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk identification, evaluation and control system.

The leadership and governance framework for risk management is as follows:

- The Audit Committee meets 4-5 times annually and oversees the overall performance of the risk management system. Additionally the Trust's Board-level Quality Governance committee on a monthly basis and monitors reviews and reports on the quality of services provided by the Trust. It provides assurance to the Audit Committee and the Trust Board that effective governance, risk management and internal control systems are in place to ensure that the Trust's services deliver safe, high quality, patient-centred care. Key risks are highlighted to and reviewed by the Trust Board both as part of its regular monitoring of performance and in the context of specific issues that may arise.

- The Trust has an Assurance Compliance and Risk (ARC) Group which is chaired by the Director of Corporate Development, Governance and Assurance providing executive oversight of risk management issues. The group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust. All new risks with a proposed score of 15 and above ('Significant') are reviewed by a Risk Group who also undertakes a monthly review of corporate directorate and Divisional / Directorate risks with a score of 12 ('High') and above and those risks with high consequence but low likelihood.
  The Risk Group reports to the ARC group and reviews the Trust's corporate risk register on an ongoing basis and this is presented to the Trust Board and its sub committees on a quarterly basis.

- The Trust has a Governance team with a focus on integrated risk management – the team support the process of identification, assessment, analysis and management of risks and incidents at every level of the organisation and aggregation of results at a corporate level.

- The Director of Corporate Development, Governance and Assurance is the Trust's Senior Information Risk Owner (SIRO). Working closely with the Medical Director as Caldicott Guardian, the SIRO is responsible for taking ownership of information risk at Board level and advising the Chief Executive accordingly.

- For each of the Trust's Divisions a Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes within the Divisions, including management of the Divisional risk register supported by the Divisional manager. The Divisional management groups have responsibility for monitoring, managing and where necessary escalating risks on their

risk registers and significant risks are reviewed at monthly performance review meeting.

Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff are required to attend.

There is clear policy and guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at mandatory risk management training courses is monitored and fed-back to Divisions and corporate directorates via a central monitoring database with Human Resources which allows corrective action to be taken by management teams as required aimed to improve attendance rates throughout the year.

Board Assurance Framework (BAF)

Throughout 2016/17 the organisation continues to review processes for developing the BAF and risk management processes, with the Board approving a revised risk management strategy and implementation plan in 2016.

The BAF is based around the Trust's strategic objectives and is mapped to the Care Quality Commission's Fundamental Standards. It identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls.

It also details any gaps in control and assurance in relation to the risks, including strategic objectives related to service delivery, workforce, finance, service transformation, and infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partners.

The BAF is updated monthly by the Executive Director leads with a full review at the end of each quarter which is then presented to the Trust Board. In addition risks to objectives are reported to a Trust Board assurance committee for monitoring and oversight. It is also crossed referenced to the Corporate Risk Register.

The Trust has received a substantial assurance opinion from internal audit on the Board Assurance Framework.

The Trust's principal risks can be found listed in Appendix 1.

Internal Audit

The Trust's internal audit function is provided by TIAA who contribute to assurances available to me as Accountable Officer and to the Board in

underpinning the assessment of the effectiveness of the organisation's system of internal control.

TIAA have delivered the 2016/17 internal audit plan as Agreed at the start of the year through the Audit committee.

Counter Fraud

Northampton General Hospital NHS Trust Local Counter Fraud service ensures an annual plan of proactive work to minimise the risk of fraud within the Trust and is fully compliant with NHS Protect Counter Fraud Standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect.

The Trust is committed to promoting and maintaining an absolute standard of honesty and integrity, and to eliminating fraud and illegal acts committed within the Trust and detection exercises are undertaken where a known area is at high risk of fraud.

Fraud is deterred by publicising proven cases of NHS fraud and staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature throughout the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the Audit and Risk Committee and include details of reported suspicions of fraud in addition to actual fraud.

Stakeholder involvement in risk

Partners and stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including for example:

- **Patients and the public**
  - The work of the, the Patient Advice and Liaison Service and specific patient representative groups.
  - Patient membership of key Trust committees and groups.
  - The work of the local Health and Wellbeing Boards.
  - Meetings of the Trust Board held in public which include monthly Patient Stories.
  - An extensive volunteering programme across hospital departments including a new group of volunteers specifically dedicated to supporting the Trust's Friends and Family Test (FFT) agenda, handing out postcards for completion and collating data
  - Development of FFT infograms for each ward with a "You said…We did" focus
  - Representation on the Patient & Carer Experience and Engagement Group (PCEEG) from a Patient Representative and internal focus groups (such as BME, Dignity, end of life).

- Expert patient involvement in the redesign of dermatology and rheumatology programmes across Northampton and Kettering hospitals
- Plans for 2017/18 include development of a network of Patient and Family partners launched through a "Quality Conversation" event in early 2017.

- **Staff**
  - Strong focus on encouraging staff to raise concerns
  - Freedom to Speak Up Guardian appointed
  - Board to Ward and "Beat the Bug" visits by Executive and non-Executive Directors.
  - Monthly Core Brief to staff by Executive team.
  - Partnership forum with staff-side representation.
  - Staff Engagement Strategy that includes specific vehicle through which staff views are sought on key matters.
  - Expert patient involvement in the redesign of dermatology and rheumatology programmes across Northampton and Kettering hospitals

- **Partners**
  - Regular performance discussions with commissioners and NHS Improvement.
  - Executive meetings and discussion with Board Members at Kettering General Hospital NHS Foundation Trust and the establishment of a Federation agreement with them.
  - Weekly Operations Executive Meeting comprising the Chief Executive Officers of Health and Social Care partners across the Northamptonshire County.
  - Participation in the Sustainability and Transformation Programme for Northamptonshire.
  - System Resilience Group, A&E Boards, Sustainability and Transformation Board

Compliance matters

The Trust's Workforce Equality and Diversity Strategy was refreshed and reviewed in 2016. It builds on the work already done and progress made on equality and diversity over the years and sets out our co-ordinated and integrated approach in relation to our workforce.

Our Workforce Equality Objectives/Four Year Plan was also reviewed and refreshed in 2016. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce, with the key actions linked to the Workforce Race Equality Standard (WRES), health and wellbeing, staff survey results, divisional objectives and the leadership and management development programme. Alongside our Trust Equality Objectives/Four Year Plan each of our Divisions has been asked to produce 2-3 of their own equality objectives based on their specific equality monitoring data.

The Trust has undertaken and published the data required for 2016 in accordance with the NHS England Workforce Race Equality Standard (WRES) and our annual Workforce Equality and Diversity Report and Monitoring Report have also been published on our website along with other key equality and diversity documents.

The Trust has an Equality and Diversity Staff Group that meets on a quarterly basis and it reports into the Trust's Workforce Committee.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Northampton General Hospital maintains an Environmental Management System which is externally verified by and accredited to the Investors in the Environment Scheme (Green Level). The Trust has a Sustainability Strategy that has been approved by the Board with accompanying Sustainable Development Action Plans, progress against which is monitored through the Sustainable Development Committee. An adaptation policy is in preparation, following a review of the risks to the Trust arising from the changing climate. The Trust regularly reviews and publishes its Good Corporate Citizenship scores.

Progress in carbon reduction, climate change mitigation and adaptation along with other sustainable development initiatives are reported in the annual report and to the Board. Northampton General Hospital NHS Trust was one of only forty trusts recognised by the SDU, NHSI and HFMA for Excellence in its Reporting of Sustainability for the year 2015/16.

Details of compliance with the Care Quality Commission's Essential Standards of Quality and Safety can be found in Section 4 below.

Information Governance (IG)

Northampton General Hospital NHS Trust is committed to ensuring it manages all the information it holds and processes in an efficient, effective and secure manner through the application of robust IG policies and procedures to support the delivery of high quality patient care. The IG team also run a series of audits and checks across the organisation to ensure compliance.

The Trust has had one data security breach during the year which has been reported to the Information Commissioners Office and details are included within section 4.

Quality Account

The Trust produces an annual Quality Account report in respect to its quality priorities and the quality of services by an NHS healthcare provider. This Quality Account is an important way that the Trust reports and demonstrates improvements to the services delivered

In addition to a review of the quality of the services the Quality Account includes specific statements relating to assurance and the Trust's performance against national standards.

The indicators within this document are subject to external audit scrutiny and the auditors are required to provide an independent assurance opinion to the organisation. During 2016/17 the Trust received an unqualified limited assurance opinion for its Quality Account.

4. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
The Head of Internal Audit Opinion for 2016/17 concludes in summary that:

Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk

This is based on:

a) An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the first nine months of the financial year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. reliance being placed upon Third Party Assurances.

c) TIAA has carried out 21 assurance reviews to date, which were designed to ascertain the extent to which the internal controls are adequate and to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assurance assessment was provided. A summary is set out below:

Assurance Assessments	Number of Reviews
Substantial Assurance	3
Reasonable Assurance	8
Limited Assurance	10
No Assurance	0

TIAA has also undertaken two advisory reviews where an assurance opinion was not provided.

During the course of the period, ten limited/no assurance opinion reports have been issued. A summary of each is provided in the commentary below. Although the ten are a high proportion of the individual opinions for the year, this reflects the targeting of the internal audit plan on areas of risk and opportunity to further improve, and therefore the opinion reflects not just those individual audit results but a wider consideration of the organisational system of internal control

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Quality Governance Committee, Risk Management Group and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Corporate Performance Report and detailed financial and quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.
- The Audit and Risk Committee has overseen the effectiveness of the risk management arrangements.
- The Risk Management Group has reviewed the Trust's risk register and the Board Assurance Framework and monitored key clinical and non-clinical risks highlighted by Trust committees and individual managers.
- Executive Directors have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.

- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

The Trust has identified the following significant control issues and the actions which have been or are being taken to address them.

Compliance with Care Quality Commission (CQC) Essential Standards of Quality and safety

Northampton General Hospital NHS Trust is registered with the Care Quality Commission (CQC) and following the CQC Chief Inspector of Hospital's Inspection in January 2014 with a follow up inspection in September 2014 The Trust received an overall rating of 'Requires Improvement'.

The Trust underwent a further CQC inspection in February 2017 and at the time of writing this statement the final report and rating is awaited.

Data Security

The Trust reported one Information Governance incident to the Information Commissioner's Office in 2016/17

Details of the Incident

An anonymised data request was made by an ex-trust doctor for a report on their activity at NGH. A member of staff ran the report and anonymised the data by deleting the 5-6 columns of the report which contain personal identifiable information. This information was sent via an NGH email account to the unsecure email account of the requester.

It was later brought to the Trust's attention that the report was not anonymised but contained sensitive information including personal identifiable data (PID) of 6668 patients at the far right of the data columns within the spreadsheet. Both the member of staff's Line Manager and the Clinical Change Manager, who is the administrator for the IT system, confirmed that PID is usually only contained in the first 5-6 columns of the report. No explanation can be provided as to why the system generated further PID at the end of the report.

The IG serious incident procedure was initiated with a grading report to the Caldicott Guardian and the Senior Information Risk Owner. The incident was graded as a level 3 reportable incident. Based on this grade, the incident was escalated to the Information Commissioners' Office (ICO) via the Information Governance Incident reporting tool.

The ICO carried out their investigation and the information Governance Team fully cooperated with the ICO providing the necessary documentation and responses to provide assurance to the ICO.

The ICO closed this case and issued a decision notice on the 21st December 2016 of no further action is necessary at this stage. The ICO also stated that it was satisfied that the Trust had the appropriate policies and procedures in place to provide staff with the guidance required in handling such situations.

Lessons Learned

1. All future reports from that system must be sent to and from NHS mail email accounts
2. A procedure/policy will be developed with the specific scope of covering data extraction and sharing from that system.
3. An anonymised report will be programmed into the system for requests where PID is not required.
4. Staff must ensure all attachments or embedded document/reports are scrutinised for PID.
5. Teams or departments that send information out of the Trust regularly must have a process in place where a senior member staff or fellow colleague reviews the information before it is sent.
6. Care must be taken when physically transferring information or documents which contain PID from on location to another, onsite and offsite. All transfers must be carried out in line with Trust policies.

National Performance Standards
We have experienced significant challenges with our performance standards especially with the pressure on urgent care in quarters 3 and 4 of 2016/17. This also impacted on our RTT performance and in particualr some key elective specialties, although we achieved at a Trust level including diagnostics wait time expectations.

4hr A&E standard
2016/17 has been another challenging year for the Trust's urgent and emergency care pathways. Our emergency department has seen an additional 2,080 patients (1.8% increase), patients together with 2,000 more admissions than the previous financial year representing a 7% increase.

After a challenging start to the year, during June, July and August the acuity of patients decreased and performance was sustained above 90% standard however this deteriorated from September onwards with the Trust seeing an increase in both acuity and activity.

These issues contributed to a high bed occupancy rate throughout autumn and winter of 2016/17 and these issues remain challenging for the Trust with additional factors of high numbers of delayed discharges, with often in

excess of 10% of acute beds occupied with patients waiting for ongoing care and support outside of an acute hospital setting.

The external support required to reduce the number of patients who are delayed continues to be a challenge and the financial cuts in adult social care have impacted performance within the hospital, therefore along with increased collaborative working with partners in health and social care the plan to put in place a 60 bedded acute assessment hub with new model of care is an absolute necessity.

Cancer waiting times
The Trust had a challenging year with regards to meeting the Cancer Waiting Times Standards during 2016-17. This highlighted the need for an intense focus following concerns that the 31 day and 62 day standards in cancer care were not being delivered.

An interim Cancer management specialist was recruited in August in order to support the new Cancer Services management team. A refreshed Cancer Recovery Plan and tumour site action plans were produced with monthly oversight of these by the Cancer Board, underpinned by a newly launched Access and Operational Policy.

Performance prior to this intense focus saw the Trust failing to meet the 62 day standard for 16 months, finally reaching target in December 16 at 86% against the standard of 85%. The Trust has sustained its performance against the 31 day standard meeting this each month from July 16 onwards.

The number of patients exceeding the 62 day wait for a diagnosis/treatment in September 16 was 115, as at March 17 this stands at 48 and has seen a reduction of 58%, however continued focus is required to ensure this is reduced to acceptable levels and does not rise again.

Pressures over the past year have included access to medical records for weekly MDT meetings, ability for Radiology to sustain access to investigations and reporting within 7 days, staffing capacity in Oncology and Cancer Services, availability of histopathology for MDT meetings and timely reporting and winter pressures.

The Trust continue to attend bi-weekly meetings at the CCG in order to discuss their improvement programme, and provide assurance around patient breaches of the standard, this is now supported by the Trust cancer breach panel established in January 2017.

Improvements continue to be made on building relationships with our tertiary providers.
In order for the Trust to sustain its improvement journey clinicians, divisional management teams and Cancer Services need to continue to

work together in order to deliver the best possible care and in a timely manner to all patients on a cancer pathway.

RTT
We have maintained achievement at a trust level of RTT, however due to the urgent care pressures we stopped a significant proportion of elective work over the winter. We outsourced orthopaedic work and focussed on delivering day case activity in house. This led to a deterioration of performance in elective specialities and in particular within orthopaedics.

Re-allocating the specialist elective ward to orthopaedics and continuing with outsourcing will support improvement and attainment of the target during 2017/18.

Quality & accuracy of waiting list data & associated risks
The programme of work throughout 2016/17 has included audits against the accuracy and use of “clock stops” and RTT status codes, the reviewing of data accuracy for SUS returns against both local peers (peers as agreed under the Lord Carter programme) and nationally, as well as responses to internal audit reports as required.

The preparation for data migration to a new patient administration system (PAS) has now required a strong focus on all aspects of data beyond that of waiting lists and performance measurement to ensure that the data migrated is the most accurate it can be; the change in the move to the new PAS system has provided a greater opportunity to further investigate more aspects of data.

A programme of reviewing all national returns has been ongoing throughout the year with a focus on checking national guidance against the criteria used for the reports to generate the figures as well as checks with areas to ensure local criteria is correct; any requirements for change are presented at the Data Quality Steering Group (DQSG) for review and agreement to change with changes documented on the Information department’s reporting database.

This group will also ensure that any change to national guidance is identified and implemented in a timely manner with full documentation and sign-off maintained.

Our access policy has been reviewed in light of national recommendations and is currently out for consultation, and training on this and other aspects of data quality will form part of a new role specific mandatory training programme in 2107/18.

Current areas of risk include:

1. Non adherence to the access policy and timely input of data onto PAS. This is being mitigated by providing training to all key staff on the use of the access policy with more intensive training for individuals as identified

through the audit and validation work is, specifically around pathways for Referral to Treatment (RTT) and diagnostics. Mandatory role specific annual training is being developed to include data quality, patient pathways and the access policy for 2017/18.

2. Multiple systems being accessed to provide information both internally and externally, which could lead to discrepancies in the information being presented. This is being mitigated by a full assessment of internal and external data returns including information being processed through the data warehouse.

3. Data Migration to the new PAS may present a number of areas of data quality issues and the recording of pathways when the trust moves from a referral based system to a system more aligned with the capture of pathway activity. This is being mitigated by members of the data quality team be wholly engaged with the migration programme and seeking out possible areas of concern to correct and educate as necessary prior to migration and then time dedicated to the auditing post "go live".

Never events

There has been one Never Event incident reported by Northampton General Hospital during 2016/17.

The incident was reported onto STEIS (Strategic Executive Information System) in June 2016 and involved a retained foreign body ("bung") left in place after a laparoscopic hysterectomy.

A "bung", which had been made from sterile surgical theatre gloves filled with sterile swabs, was used on a patient undergoing a hysterectomy and was unintentionally left in situ at the end of the operation.
The patient was discharged home with the "bung" still in place.

The patient returned to the Trust several days later as planned whereby the "bung" was discovered; she was well and there were no complications (bleeding or infection) as a result of the incident. The patient continued to progress well and made an uncomplicated recovery from surgery.

Since the incident, changes in practice have been made which include the inclusion of all swabs used for the "bung" to be included within the swab count, which is checked throughout the procedure and documented.

The learning from the incident was shared both locally within the gynaecology governance and departmental meetings in addition to organisational learning through the Trust's quarterly Dare to Share Learning Event.

Financial Improvement Plan

Northampton General Hospital has an established programme for improving quality and efficiency. This is the Changing Care @ NGH

programme which consists of projects led by clinical leaders and executive directors. In 2016/17 the programme delivered £12.2 million of savings.

For 2016/17 the Trust started the year with a planned deficit of £15.1 million. The final deficit reported prior to audit of the accounts was £13.8 million.

The Trust is continuing to work with Health Economy Partners including commissioners, other healthcare providers and local government to identify a medium term sustainability and transformation plan aimed at returning the health system to a more sustainable financial position within five years. NGH does however like many NHS providers currently face a very challenging financial environment and is anticipating a deficit of £13.5 million in 2017/18 based on the latest available information at the time of writing.

Nurse Recruitment
The national shortage of trained nurses continues to pose a significant risk to the organisation. We continue with efforts to mitigate this risk and in addition to an overseas nurses recruitment programme the Trust has moved to a twelve hour shift standardisation within nursing which has seen an improvement in shift fill rates and improved continuity of care for our patients.

In addition a revised staff retention strategy is being implemented in order to support our existing staff and reduce turnover rates.

Trust Estate

During 2016/17 the Trust has undertaken a piece of work to better understand the nature of all risks related to the aging estate of Northampton General Hospital. This has allowed the organisation to prioritise its capital programme and escalate planned maintenance to support the building infrastructure. During the early part of 2017 a full risk assessment paper was resented to the Board and a further plan of mitigation and actions will be produced for 2017/18.

Conclusion
With the exception of the internal control issues that I have outlined in this statement, my review confirms that Northampton General Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Dr Sonia Swart
Chief Executive Officer
Northampton General Hospital NHS Trust

Appendix 1

Organisational Principal risks

1. Risk of suboptimal standards of care and patient experience related to difficulties in recruiting to substantive nursing posts across the organisation.

2. Risk of suboptimal standards of care and patient experience, in addition to a failure to meet national performance targets, due to high demand on emergency and urgent care services.

3. Risk of failing to meet emergency and urgent care demand and failing to meet national performance targets due to large numbers of delayed transfers of care leading to shortages in bed capacity.

4. Risk of systems failures related in relation to the Trusts' estate due to ageing infrastructure.

5. Risk of suboptimal standards of care and patient experience related to difficulties in recruiting to the medical workforce posts across the organisation.

6. Risk the Trust may not meet its statutory duties in relation to financial controls due to increased demand and activity, particularly related to emergency pathway pressures.

7. Risk of suboptimal standards of care and patient experience due to increased demand on cancer pathways together with late referrals.

8. Risk of not meeting cost improvement targets due to organisational pressure, poor organisational and stakeholder engagement causing slippage in programme schemes.

9. Risk of action by the ICO for failure of staff to comply with Trust systems and processes which ensure compliance with confidentiality of person identifiable information.

STAFF REPORT

Remuneration

A Remuneration & Appointments Committee meets at least annually and is comprised of non-executive directors. The duties of the Remuneration & Appointments Committee are set out in the Terms of Reference:

The primary role of the Remuneration and Appointments Committee is to establish a formal process for developing policy on executive remuneration and to oversee the appointment process for executive directors.

The Remuneration and Appointments Committee will determine the Remuneration and terms of service for the Chief Executive and executive directors, acting in accordance with the scheme of delegation and reservation of powers to the Board and approve any non-contractual benefits in relation to the termination of employment for executive directors.

The Remuneration & Appointments committee will oversee the process for the appointment of new members to the Trust board of directors ensuring that there is a formal, lawful procedure in place.

The Committee will also ensure that systems and processes are in place for the development of board members where appropriate.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2016/17 was £225-230k (2015/16, £225-230k). This was 10.48 times (2015/16, 10.49 times) the median remuneration of the workforce, which was £22k (2015/16, £22k).

In 2016/17 and 2015/16 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1k for part-time staff to £182k for the next highest paid director and £213k for the highest paid agency locum (full year effect) (2015/16 £1k - £180k)

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The ratio has decreased in 2016/17 by 0.01. Nursing staff represent the largest increase in Total Average Staff Numbers. The majority of staff on Agenda for Change terms and conditions received a 1% pay increase. This has contributed to the increase in the overall median remuneration of the workforce.

SALARY AND PENSION REPORT

Salary and pension entitlements of senior managers

Remuneration

Name and Title	2016-17					
	Salary	Expense payments (taxable) to nearest £100	Performance Pay and Bonuses	Long term Performance Pay and Bonuses	All Pension-related Benefits	Total - Salary & Benefits
	(bands of £5,000) £000	£00	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Paul Farenden - Chairman	20 - 25	19				20 - 25
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125 - 130				37.5 - 40	165 -170
Michael Cusack - Medical Director	185 - 190				47.5 - 50	235 - 240
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	110 - 115				105 - 107.5	215 - 220
Simon Lazarus - Director of Finance	120 - 125				32.5 - 35	155 - 160
Charles Abolins - Director of Facilities & Capital Development	85 - 90				0	85 - 90
Janine Brennan - Director of Workforce and Transformation	120 - 125				127.5 - 130	250 - 255
Chris Pallot - Director of Strategy & Partnerships	95 - 100				32.5 - 35	130 - 135
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				17.5 - 20	120 - 125
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	4				5 - 10
Graham Kershaw - Non-Executive Director	5 - 10	6				5 - 10
David Noble - Non-Executive Director	5 - 10	9				5 - 10
Elizabeth Searle - Non-Executive Director (to 31 October 16)	0 - 5					0 - 5
Olivia Clymer - Non-Executive Director	5 - 10	5				5 - 10
John Archard-Jones - Non-Executive Director (1 January 17 onwards)	0 - 5					0 - 5
Annette Gill - Associate Non-Executive Director (1 January 17 onwards)	0 - 5					0 - 5

Name and Title	2015-16					
	Salary	Expense payments (taxable) to nearest £100	Performance Pay and Bonuses	Long term Performance Pay and Bonuses	All Pension-related Benefits	Total - Salary & Benefits
	(bands of £5,000) £000	£00	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Paul Farenden - Chairman	20 - 25	25				20 - 25
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125 - 130				22.5 - 25	150 - 155
Michael Cusack - Medical Director	180 - 185				17.5 - 20	195 - 200
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	75 - 80				200 - 202.5	275 - 280
Simon Lazarus - Director of Finance	120 - 125				17.5 - 20	140 - 145
Charles Abolins - Director of Facilities & Capital Development	95 - 100				0	95 - 100
Janine Brennan - Director of Workforce and Transformation	120 - 125				5 - 7.5	130 - 135
Chris Pallot - Director of Strategy & Partnerships	95 - 100				15 - 17.5	115 - 120
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				0	100 - 105
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	6				5 - 10
Graham Kershaw - Non-Executive Director	5 - 10	14				5 - 10
David Noble - Non-Executive Director	5 - 10	7				5 - 10
Elizabeth Searle - Non-Executive Director (to 31 October 16)	5 - 10	5				5 - 10
Olivia Clymer - Non-Executive Director	0 - 5					0 - 5
John Archard-Jones - Non-Executive Director (1 January 17 onwards)						
Annette Gill - Associate Non-Executive Director (1 January 17 onwards)						

Salary Notes

Charles Abolin's 2016-17 salary represents 11 month's only
John Archard-Jones & Annette Gill were appointed to the Board in 2016-17. Therefore no salary values are reported for 2015-16

Carolyn Fox's 2015-16 salary represents a part year (July - March)
Olivia Clymer's 2015-16 salary represents a part year (November - March)
Elizabeth Searle's 2015-16 salary represents a full year

The benefits paid to Non-Executives and Chairman above relate to travel and subsistence between home & office

All pension related benefits represent the annual increase in total pension benefits entitlement. This represents the values payable at the beginning and end of the financial year, adjusted for inflation, irrespective of whether or not the position was held for full or part year and length of NHS service. Where this value is negative a nil balance is shown

Pension Benefits

Name & Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2017 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	2.5 - 5	0 - 2.5	40 - 45	110 - 115	538	42	580	0
Michael Cusack - Medical Director	2.5 - 5	0 - 2.5	45 - 50	120 - 125	711	90	801	0
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	5 - 7.5	15 - 17.5	30 - 35	100 - 105	453	98	551	0
Simon Lazarus - Director of Finance	2.5 - 5	0 - 2.5	35 - 40	90 - 95	545	46	592	0
Charles Abolins - Director of Facilities & Capital Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Janine Brennan - Director of Workforce and Transformation	5 - 7.5	17.5 - 20	50 - 55	155 - 160	859	144	1,003	0
Chris Pallot - Director of Strategy & Partnerships	0 - 2.5	0 - 2.5	25 - 30	75 - 80	377	55	432	0
Catherine Thorne - Director of Corporate Development, Governance & Assurance	0 - 2.5	2.5 - 5	35 - 40	110 - 115	644	69	712	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pensions Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

A rate of 0% Consumer Price Index (CPI) annual inflation has been used to calculate the real increases.

No lump sum is shown for senior managers who only have membership in the 2008 Section of the NHS Pension Scheme, unless they chose to move their 1995 Section benefits under Choice. No CETV is shown for pensioners, senior managers over 60 (1995 Section) or over 65 (2008 Section)

Off-Payroll Engagements Table 1

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months

Narrative	Number
Number of existing engagements as of 31 March 2017	**21**
Of which, the number that have existed:	
for less than one year at the time of reporting	**11**
for between 1 and 2 years at the time of reporting	**10**
for between 2 and 3 years at the time of reporting	**0**
for between 3 and 4 years at the time of reporting	**0**
for 4 or more years at the time of reporting	**0**

Confirmation that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Off-Payroll Engagements Table 2

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220

Narrative	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	**11**
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	**10**
Number for whom assurance has been requested	**1**
Of which:	
assurance has been received	**0**
assurance has not been received	**1**
engagements terminated as a result of assurance not being received	**0**

Off-Payroll Engagements Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	**0**
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	**10**

Expenditure on consultancy

Details of our expenditure on consultancy can be found at Note 8 on page X in the Annual Accounts

Exit packages

The Trust has no exit package costs in 2016/17

OUR STAFF

STAFF NUMBERS

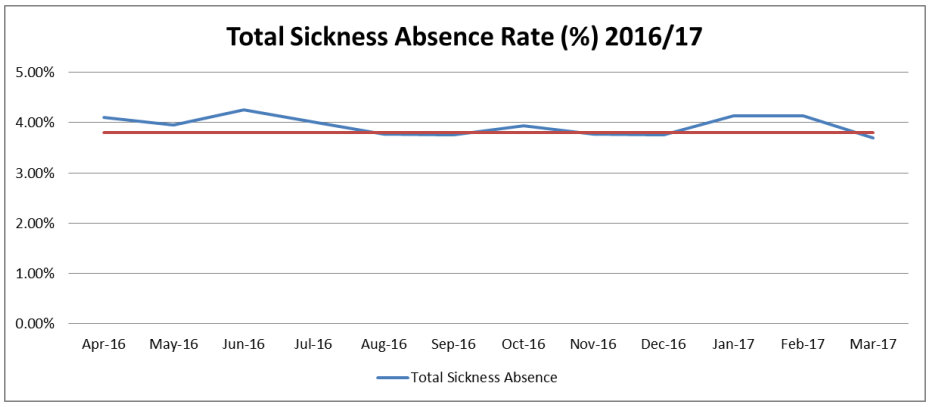
Staff Numbers							
	2016-17			2015-16			2014-15
Average Staff Numbers	**Total Number**	**Permanently Employed Number**	**Other Number**	**Total Number**	**Permanently Employed Number**	**Other Number**	**Total Number**
Medical and dental	558	504	54	529	494	36	534
Administration and Estates*	1036	952	84	983	910	73	984
Healthcare assistants and other support staff	1074	899	175	1065	875	190	1003
Nursing, midwifery and health visiting staff	1469	1303	166	1411	1268	143	1364
Nursing, midwifery and health visiting learners	1	0	1	0	0	0	0
Scientific, therapeutic and technical staff**	519	488	31	515	480	35	509
Healthcare Science Staff	150	150		148	148	0	152
Other	0	0	0	0	0	0	0
TOTAL	**4806**	**4296**	**510**	**4651**	**4174**	**477**	**4546**

* For 2016-7 figures composed of “Administrative & Clerical” and “Estates and Ancillary” staff groups

** For 2016-17 figures composed of “Add Prof Scientific and Technic” and “Allied Health Professionals” staff groups

SICKNESS ABSENCE

Sickness Absence %												
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Short Term Absence	2.42%	2.23%	2.37%	2.31%	2.04%	2.04%	2.56%	2.12%	2.40%	2.89%	2.73%	2.52%
Long Term Absence	1.69%	1.72%	1.89%	1.70%	1.73%	1.72%	1.37%	1.66%	1.35%	1.24%	1.41%	1.18%
Total Sickness Absence	4.11%	3.96%	4.26%	4.01%	3.78%	3.76%	3.93%	3.78%	3.75%	4.14%	4.14%	3.70%



Staff Sickness absence

	2016-17 Number	2015-16 Number
Total Days Lost	40,583	38,400
Total Staff Years	4,277	4,143
Average working Days Lost	9.49	9.27

ILL-HEALTH RETIREMENTS

Retirements due to ill-health

Not relevant for trust

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	2	4
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	241	135

Equality

During 2016/17 we refreshed and reviewed our Workforce Equality and Diversity Strategy. The updated strategy details how we will address requirements of the Public Sector Equality Duty. It builds on the work already done and progress made on equality and diversity over the years and sets out our co-ordinated and integrated approach in relation to our workforce.

Our equality objectives/four year plan was also reviewed and refreshed during 2016/17. The two main objectives link to the Equality Delivery System (EDS2) outcomes relating to the workforce, with the key actions linked to:

- Workforce Race Equality Standard (WRES),
- health and wellbeing,
- staff survey results,
- divisional objectives
- leadership and management development programme.

The objectives are:

EDS2 Goal	Objective
1. Representative and supported workforce	We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff by progressing WRES and monitoring outcomes.
2. Inclusive leadership	We will improve our leadership and management capability.

The detailed action plan can be accessed via our website:

http://www.northamptongeneral.nhs.uk/WorkforUs/Equality,DiversityHumanRights/Equality,DiversityHumanRights.aspx

2016 NHS Staff Survey Equality and Diversity Key Findings

The demographics of our workforce responding to the staff survey were broadly similar to our overall demographic profile were broadly similar with the exception of disabled staff - 15% of respondents were disabled compared to the 4% of our workforce - and ethnic background where 14% of the respondents were Black and Minority Ethnic compared to 79% of our workforce.

The percentage of staff reporting they had experienced discrimination at work in the last 12 months has not changed since the 2015 survey and we were benchmarked as average when compared to acute Trusts.

There was also no change in relation to the key finding which relates to the percentage of staff who believe that the organisation provides equal opportunities for career progression and/or promotion; we were benchmarked as below average when compared to other acute Trusts.

The survey has highlighted some areas of concern and the continuing work the organisational development and improving quality and efficiency teams will work to bring about a shift in culture, where everyone is focused on the values, positive behaviours, quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Workforce Race Equality Standards

Following the introduction of the National Workforce Race Equality Standard by NHS England, we produced baseline data for each of the nine indicators in April 2015 and these were published on our website.

We repeated the exercise in 2016 and compared these results to establish if there have been improvements in the experiences or the treatment of White staff and BME staff. Due to a change in two of the indicators in 2016 (1 and 9) no direct comparison could be made with the previous year's results, but of the remaining 7, there were 6 improvements and one deterioration. To address this work is underway to roll out equality training to managers. In addition work has commenced on strengthening the information and support available in relation to bullying and harassment across the organisation.

Gender Distribution of Staff

Directors and non-executive directors

Gender	Count	%
Female	7	43.75
Male	9	56.25
Grand Total	16	100

Senior managers (Band 8a and above) and senior medical staff

Gender	Count	%
Female	217	51.54
Male	204	48.46
Grand Total	421	100

Senior Managers (Band 8a and above)

Gender	Count	%
Female	144	71.29
Male	58	28.71
Grand Total	202	100

Breakdown by senior manager pay scales

Pay Scale	Count	Female	Male
XN08/XR08	129	99	30
XN09/XR09	43	27	16
XN10/XR10	12	7	5
XN11/XR11	5	5	0
WQ00	13	6	7
Total	202	144	58

Senior Medical Staff (Consultants)

Gender	Count	%
Female	73	33.33
Male	146	66.67
Grand Total	219	100

Breakdown by senior medical staff (consultant) pay scales

Pay Scale	Count	Female	Male
MD01	1		1
MC21	1	1	0
YC53	2	1	1
YC62	1	1	0
YC72	64	26	38
YC73	8	0	8
YM51	2	2	0
YM52	6	0	6
YM53	11	4	7
YM54	5	1	4
YM55	10	1	9
YM56	5	2	3
YM57	11	3	8
YM58	8	3	5
YM59	1	0	1
YM60	3	1	2
YM61	6	2	4
YM62	1	0	1
YM63	1	1	0
YM65	1	0	1
YM68	1	1	0
YM69	1	0	1
YM70	1	0	1
YM72	66	22	44
YM73	2	1	1
Total	219	73	146

All Employees

Gender	Count	%
Female	3909	79.19
Male	1027	20.81
Grand Total	4936	100

Disability Related Polices

We have three key policies relating to the recruitment and continuing employment of staff with a disability:

- recruitment, selection and retention policy
- employment of people with a disability policy
- management of sickness absence policy.

The purpose of the recruitment, selection and retention policy, together with the associated procedures, is to provide a framework which promotes a professional approach and the highest possible standards throughout the recruitment and selection process and to ensure a proactive and lawful approach to equality and diversity issues within the process, including the recruitment of people with a disability.

The purpose of the management of sickness absence policy is to provide managers with clear guidelines when managing either short term or long term sickness absence and other absence in connection with sickness. It is also designed to ensure compliance with the requirement of any relevant employment legislation including the Equality Act 2010.

Supporting both of these policies is the employment of people with a disability policy. The aim of this policy is:

- To raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of our commitment to people with a disability or someone's association with a person with a disability
- To ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities or someone associated with a person with a disability
- To ensure that staff and potential job applicants with a disability, or associated with a person with a disability, are treated fairly and receive the same opportunities as other staff to develop with appropriate and reasonable support.
- To take all reasonable steps to ensure that the working environment does not prevent people with a disability or those associated with a person with a disabled person from taking up positions for which they are suitably qualified.
- To assist staff who become disabled during their employment to adapt to the disability and to continue in post wherever possible, or, if this is not possible, to be redeployed or retrained, where this is practicable.

The policy provides guidance on the recruitment and ongoing employment of people with a disability. The policy focuses in particular on the responsibilities of all staff groups during the recruitment and selection process of an individual who has identified they have a disability or associate with a person who has a disability, in addition to the management of a current employee who develops or has an existing disability.

We have made a commitment to operate under the Government's Disability Confident Scheme (formally Positive about Disabled People 'Two Ticks' Scheme)

We have been certified as a Disability Confident Employer and as part of this commitment, we will:

1. Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to people

with disabilities who meet the minimum criteria for the job and making reasonable adjustments as required.

2. Keep and develop our staff - which includes supporting employees to manage their disabilities or health conditions.

This policy is underpinned by our workforce equality and diversity strategy.

SECTION THREE:

FINANCIAL STATEMENTS

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Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	10.1	**(203,764)**	(191,283)
Other operating costs	8	**(105,839)**	(94,833)
Revenue from patient care activities	5	**262,949**	248,771
Other operating revenue	6	**35,291**	24,791
Operating surplus/(deficit)		**(11,363)**	(12,554)
Investment revenue	12	**29**	32
Other gains and (losses)	13	**273**	(83)
Finance costs	14	**(813)**	(440)
Surplus/(deficit) for the financial year		**(11,874)**	(13,045)
Public dividend capital dividends payable		**(3,290)**	(4,041)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(15,164)**	(17,086)

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	16	**(3,815)**	5,906
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Other gain /(loss) (explain in footnote below)		**0**	0
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Other pension remeasurements		**0**	0
Reclassification adjustments			
On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**(18,979)**	(11,180)

Financial performance for the year

Retained surplus/(deficit) for the year	**(15,164)**	(17,086)
Prior period adjustment to correct errors and other performance	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**1,732**	(3,315)
Adjustments in respect of donated gov't grant asset reserve elimination	**(415)**	250
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(13,847)**	(20,151)

The increase in impairment of £1,732k relates in full to the quarterly BCIS net negative indices applied to the Buildings and is excluded from retained deficit and statutory breakeven in accordance with the DH Group Accounting Manual (GAM), note 16 refers.

Donated asset adjustment of £415k (consisting of £323k donated depreciation less £738k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	16	158,405	158,921
Intangible assets	17	1,204	1,270
Investment property	19	0	0
Other financial assets		0	0
Trade and other receivables	22.1	200	209
Total non-current assets		159,809	160,400
Current assets:			
Inventories	21	5,770	5,744
Trade and other receivables	22.1	23,887	16,340
Other financial assets	23	0	0
Other current assets	24	0	0
Cash and cash equivalents	25	1,621	1,602
Sub-total current assets		31,278	23,686
Non-current assets held for sale	26	0	375
Total current assets		31,278	24,061
Total assets		191,087	184,461
Current liabilities			
Trade and other payables	27	(24,109)	(24,345)
Other liabilities	28	(753)	(710)
Provisions	34	(4,808)	(2,802)
Borrowings	29	(208)	(276)
Other financial liabilities	30	0	0
DH revenue support loan	29	(18,851)	0
DH capital loan	29	(1,399)	(628)
Total current liabilities		(50,128)	(28,761)
Net current assets/(liabilities)		(18,850)	(4,700)
Total assets less current liabilities		140,959	155,700
Non-current liabilities			
Trade and other payables	27	0	0
Other liabilities	28	0	0
Provisions	34	(1,055)	(979)
Borrowings	29	(1,203)	(1,411)
Other financial liabilities	30	0	0
DH revenue support loan	29	(19,979)	(18,851)
DH capital loan	29	(10,428)	(7,186)
Total non-current liabilities		(32,665)	(28,427)
Total assets employed:		108,294	127,273
FINANCED BY:			
Public Dividend Capital		119,258	119,258
Retained earnings		(48,356)	(33,420)
Revaluation reserve		37,392	41,435
Other reserves		0	0
Total Taxpayers' Equity:		108,294	127,273

The notes on pages 85 to 101 form part of this account.

The financial statements on pages 80 to 84 were approved by the Board on 25 May 2017 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**119,258**	**(33,420)**	**41,435**	**0**	**127,273**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year	0	(15,164)	0	0	**(15,164)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	(3,815)	0	**(3,815)**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of available for sale	0	0	0	0	**0**
Impairments and reversals	0	0	0	0	**0**
Other gains/(loss) (provide details below)	0	0	0	0	**0**
Transfers between reserves	0	228	(228)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
Temporary and permanent PDC received - cash	0	0	0	0	**0**
Temporary and permanent PDC repaid in year	0	0	0	0	**0**
PDC written off	0	0	0	0	**0**
Transfer due to change of status from Trust to Foundatio	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension	0	0	0	0	**0**
Other pensions remeasurement	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**0**	**(14,936)**	**(4,043)**	**0**	**(18,979)**
Balance at 31 March 2017	**119,258**	**(48,356)**	**37,392**	**0**	**108,294**
Balance at 1 April 2015	**119,240**	**(16,684)**	**35,879**	**0**	**138,435**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year	0	(17,086)	0	0	(17,086)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	5,906	0	5,906
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Other gains / (loss)	0	0	0	0	0
Transfers between reserves	0	350	(350)	0	0
Reclassification Adjustments					
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under	0	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC received - cash	18	0	0	0	18
PDC repaid in year	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension	0	0	0	0	0
Other pension remeasurement	0	0	0	0	0
Net recognised revenue/(expense) for the year	**18**	**(16,736)**	**5,556**	**0**	**(11,162)**
Balance at 31 March 2016	**119,258**	**(33,420)**	**41,435**	**0**	**127,273**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 **Revaluation Reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		(11,363)	(12,554)
Depreciation and amortisation	8	9,703	9,941
Impairments and reversals	18	1,732	(3,315)
Other gains/(losses) on foreign exchange	13	0	0
Donated Assets received credited to revenue but non-cash	6	(738)	(7)
Government Granted Assets received credited to revenue but non-cash		0	0
Release of PFI/deferred credit		0	0
(Increase)/Decrease in inventories		(26)	217
(Increase)/Decrease in Trade and Other Receivables		(7,506)	(5,446)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		1,843	3,314
(Increase)/Decrease in Other Current Liabilities		43	(11)
Provisions utilised		(1,440)	(687)
Increase/(Decrease) in movement in non cash provisions		3,502	1,978
Net Cash Inflow/(Outflow) from Operating Activities		(4,250)	(6,570)
Cash Flows from Investing Activities			
Interest Received		29	32
(Payments) for Property, Plant and Equipment		(15,381)	(13,298)
(Payments) for Intangible Assets		(628)	(398)
(Payments) for Investments with DH		0	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		585	0
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Investment with DH		0	0
Proceeds from Disposal of Other Financial Assets		0	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		58	0
Net Cash Inflow/(Outflow) from Investing Activities		(15,337)	(13,664)
Net Cash Inform / (outflow) before Financing		(19,587)	(20,234)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		0	18
Gross Temporary and Permanent PDC Repaid		0	0
Loans received from DH - New Capital Investment Loans		4,707	6,651
Loans received from DH - New Revenue Support Loans		34,852	35,351
Other Loans Received		0	73
Loans repaid to DH - Capital Investment Loans Repayment of Principal		(694)	(427)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		(14,873)	(16,500)
Other Loans Repaid		(155)	(208)
Cash transferred to NHS Foundation Trusts or on dissolution		0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(121)	(44)
Interest paid		(723)	(381)
PDC Dividend (paid)/refunded		(3,387)	(3,811)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		0	0
Net Cash Inflow/(Outflow) from Financing Activities		19,606	20,722
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		19	488
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		1,602	1,114
Effect of exchange rate changes in the balance of cash held in foreign currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	25	1,621	1,602

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors has considered the Trust's overall financial position against the requirements of IAS1. The Board has also based its assessment on guidance from NHS Improvement about what is required to undertake a Trust's Going Concern assessment.

Continuity of service:

The Trust recorded a deficit of £13.8m which was £1.3m better than its planned deficit of £15.1m in 2016-17. This improved position included £1.1m of STP incentive and bonus. This was in addition to the core STF funding of £8.6m received as the Trust met most of its STF financial and operational trajectories. Further, the Trust delivered £12.2m of its challenging CIP programme.

The Board of Directors and NHS Improvement approved the Trust's two-year plan of £13.5m deficit in 2017/18 and £10.2m deficit in 2018/19. The income assumptions included in the plan are supported by signed contracts with Commissioners. The plan also recognises risks to its delivery such as bed capacity, appropriate demand management schemes as well as challenges to meeting the STF conditions. Non-recurrent STF funding of £8.7m is included in each of the two years. The plans include expected CIP programme delivery of £12.2m in 2017/18 and £10.7m in 2018/19.

The approved plans, supported by signed commissioner contracts constitute reasonable evidence that the NHS intends that the Trust will continue to provide healthcare services to the people of Northamptonshire.

Financing:

The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Trust has been reliant on cash support from the Department of Health in meeting its payment obligations and has drawn down a total of £39.559m at 31 March 2017; made up of £19.979m (revenue support loans), £14.873m (revolving working facility - fully repaid in March 2017) and £4.707m (capital loan).

Of the revenue support loans, £18.85m is repayable in February 2018 which will be less than 12 months from the reporting date. The Department of Health is yet to advise of refinancing arrangements regarding this loan however the uncertainty about the refinancing does not of itself affect the Trust's going concern basis.

The Board of Directors has therefore satisfied itself that on the basis that the Trust will continue to provide healthcare services and that its cash requirements will be supported by the Department of Health, it considers it appropriate that the accounts for the year ended 31 March 2017 should be prepared on a Going Concern basis.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust previously decided not to consolidate the charity on the basis of materiality. The Northamptonshire Health Charitable Fund is an independent body from 1 April 2016.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Ongoing status as a going concern;
- That no major service discontinuation is anticipated;
- Selection of indices for land and building valuations;
- All lease liabilities have been identified through a review of contract documentation.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Provisions - estimation provided to assess likelihood of possible financial obligations;
- Partially completed spells - estimation required regarding length of stay and case mix;
- Employee Benefits - estimate of levels of employee benefits not fully paid in year;
- Receivables - including injury cost recovery and other accounts receivable - estimation required to assess the level of where it is probable that the debt is irrecoverable

Further details of these estimations are given with each related note to the Accounts.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay using the financial year's case-mix and tariff rules.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements. This is calculated on a sample based estimation of accrued leave not taken and permitted to be carried forward into the following financial year.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS trust commits itself to the retirement, regardless of the method of payment.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at fair value, with the carrying value of existing assets written off over their remaining useful lives. The Trust only indexes equipment where the asset life is greater than 5 years, using the CHAZ index, which is RPI less housing costs.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets
Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

The trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Inventories
Drugs and consumables are valued at current replacement costs; this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Fuel Oil is valued at the lower of cost and net realisable value, recognising that it has limited commercial value.

1.17 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.18 Provisions
Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 34.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.24 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.25 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.26 Foreign currencies

The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 41 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.30 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The Trust has not identified any subsidiaries. Should any of these be identified in the future, further disclosures will be provided.

1.31 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

The Trust has not identified any associates. Should any of these be identified in the future, further disclosures will be provided.

1.32 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The Trust has not identified any joint operations. Should any of these be identified in the future, further disclosures will be provided.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has not identified any joint ventures. Should any of these be identified in the future, further disclosures will be provided.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Research and Development
Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.33 Accounting Standards that have been issued but have not yet been adopted
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.34 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2. Pooled budgets

The NHS Trust does not have any pooled budget arrangements.

3. Operating segments

The Trust Board considers all of its operations to be the provision of Healthcare operated as a single segment.

4. Income generation activities

The Trust has no formal registered income generation schemes.
For the purpose of reporting Catering and Non-staff car parking are treated as income generation activities.
The combined income and costs of these schemes are shown below.

Summary Table - aggregate of all schemes	**2016-17 £000s**	2015-16 £000s
Income	**2,700**	2,585
Full cost	**1,350**	1,239
Surplus/(deficit)	**1,350**	1,346

5. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**0**	0
NHS England	**44,975**	41,332
Clinical Commissioning Groups	**214,485**	204,058
Foundation Trusts	**1,009**	829
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**107**	107
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**0**	0
Private patients	**910**	792
Overseas patients (non-reciprocal)	**134**	185
Injury costs recovery	**1,329**	1,468
Other Non-NHS patient care income	**0**	0
Total Revenue from patient care activities	**262,949**	248,771

6. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**3,132**	3,021
Patient transport services	**0**	0
Education, training and research	**10,824**	11,306
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**399**	427
Receipt of charitable donations for capital acquisitions	**738**	177
Support from DH for mergers	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**1,481**	1,415
Sustainability & Transformation Fund Income	**10,739**	0
Income generation (Other fees and charges)	**2,700**	2,585
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**58**	45
Other revenue	**5,220**	5,815
Total Other Operating Revenue	**35,291**	24,791
Total operating revenue (note 5 + 6)	**298,240**	273,562

Other revenue includes :
Pharmacy Sales £417k (£1,810k)
Accommodation Charges £519k (£483k)
Provision of Services to private hospitals £719k (£482k)
Sustainability & Transformation Fund (STF) Income
- core STF £9,619k
- incentive STF £258k
- bonus STF £862k

7. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**134**	185
Cash payments received in-year (re receivables at 31 March 2016)	**33**	23
Cash payments received in-year (iro invoices issued 2016-17)	**79**	35
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**138**	11
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**29**	193
Amounts written off in-year (irrespective of year of recognition)	**338**	140

8. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	53	234
Services from CCGs/NHS England	0	0
Services from other NHS bodies	0	0
Services from NHS Foundation Trusts	1,349	1,260
Total Services from NHS bodies*	1,402	1,494
Purchase of healthcare from non-NHS bodies	2,759	2,901
Purchase of Social Care	0	0
Trust Chair and Non-executive Directors	56	54
Supplies and services - clinical	59,412	57,614
Supplies and services - general	3,514	3,401
Consultancy services	239	774
Establishment	3,399	2,998
Transport	205	139
Service charges - ON-SOFP PFIs and other service concession arrangements	0	0
Service charges - On-SOFP LIFT contracts	0	0
Total charges - Off-SOFP PFIs and other service concession arrangements	0	0
Total charges - Off-SOFP LIFT contracts	0	0
Business rates paid to local authorities	769	771
Premises	10,947	8,913
Hospitality	12	8
Insurance	219	215
Legal Fees	277	296
Impairments and Reversals of Receivables	517	790
Inventories write down	126	141
Depreciation	8,923	9,006
Amortisation	780	935
Impairments and reversals of property, plant and equipment	1,732	(3,315)
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	0
Internal Audit Fees	138	141
Audit fees	45	54
Other auditor's remuneration	40	46
Clinical negligence	8,005	5,718
Research and development (excluding staff costs)	0	0
Education and Training	838	757
Change in Discount Rate	15	13
Capital Grants in Kind	0	0
Other	1,470	969
Total Operating expenses (excluding employee benefits)	105,839	94,833

Supplies & services clinical includes value of drugs including gases of £27,698k (£27,757k)

Other auditors remuneration includes :
KPMG £40k (£46k)
- Expenses in relation to Salary Sacrifice Schemes £30k (£34k)
- Quality Accounts Audit Fee £10k (£12k)

Other expenditure includes :
Translation Services £87k (£91k)
Home Oxygen Service £123k (£126k)
Professional Subscriptions £229k (£171k)
Professional Fees £452k (£263k)

Employee Benefits		
Employee benefits excluding Board members	202,306	189,809
Board members	1,458	1,474
Total Employee Benefits	203,764	191,283
Total Operating Expenses	309,603	286,116

*Services from NHS bodies does not include expenditure which falls into a category below

9. Operating Leases

The Trust has a variety of operating leases, the majority of which when considered on an individual basis are of non material value. These include medical equipment, leased cars, photocopiers and pathology systems.

9.1. Northampton General Hospital NHS Trust as lessee

	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense			
Minimum lease payments		**675**	579
Contingent rents		**0**	0
Sub-lease payments		**0**	0
Total		**675**	579
Payable:			
No later than one year	702	**702**	533
Between one and five years	1,990	**1,990**	602
After five years	454	**454**	0
Total	3,146	**3,146**	1,135
Total future sublease payments expected to be received:		0	0

9.2. Northampton General Hospital NHS Trust as lessor

An optician's shop and Boot's chemist operate on the Trust's site under operating leases.

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	58	45
Contingent rents	0	0
Total	**58**	45
Receivable:		
No later than one year	58	45
Between one and five years	0	0
After five years	0	0
Total	**58**	45

A nursery is situated on the hospital site, the building being originally funded by the childcare provider, with the land being leased at a peppercorn rent. At the end of the lease the building has the potential to transfer to the Trust, this is currently assumed to have a zero fair value.

10. Employee benefits

10.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	171,329	163,187
Social security costs	15,385	11,754
Employer Contributions to NHS BSA - Pensions Division	17,045	16,333
Other pension costs	5	9
Termination benefits	0	0
Total employee benefits	203,764	191,283
Employee costs capitalised	0	0
Gross Employee Benefits excluding capitalised costs	203,764	191,283

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	2	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	241	135

10.3. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11. Better Payment Practice Code

11.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**93,148**	**111,972**	97,099	104,056
Total Non-NHS Trade Invoices Paid Within Target	**92,303**	**109,534**	96,360	103,534
Percentage of NHS Trade Invoices Paid Within Target	**99.09%**	**97.82%**	99.24%	99.50%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,127**	**20,938**	2,154	**19,783**
Total NHS Trade Invoices Paid Within Target	**2,085**	**20,858**	2,132	**19,746**
Percentage of NHS Trade Invoices Paid Within Target	**98.03%**	**99.62%**	98.98%	99.81%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust surpassed the 95% target.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	3
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	3

12. Investment Revenue

	2016-17 £000s	2015-16 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**16**	13
Other loans and receivables	**13**	19
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**29**	32
Total investment revenue	**29**	32

13. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**63**	**(83)**
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	**0**
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	**0**
Gain (Loss) on disposal of assets held for sale	**210**	**0**
Gain/(loss) on foreign exchange	**0**	**0**
Change in fair value of financial assets carried at fair value through the SoCI	**0**	**0**
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	**0**
Change in fair value of investment property	**0**	**0**
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	**0**
Total	**273**	(83)

14. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	749	387
Interest on obligations under finance leases	50	33
Interest on obligations under PFI contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	0	3
Total interest expense	799	423
Other finance costs	9	8
Provisions - unwinding of discount	5	9
Total	813	440

15. Auditor Disclosures

15.1. Other auditor remuneration

		2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:			
1. Audit of accounts of any associate of the trust		0	0
2. Audit-related assurance services	Quality A/cts	10	12
3. Taxation compliance services		0	0
4. All taxation advisory services not falling within item 3 above		0	0
5. Internal audit services		0	0
6. All assurance services not falling within items 1 to 5		0	0
7. Corporate finance transaction services not falling within items 1 to 6 above		0	0
8. Other non-audit services not falling within items 2 to 7 above	Salary Sacrifice	30	34
Total		40	46

N.B. These fees exclude VAT

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

16.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2016	13,200	122,755	576	3,433	39,329	68	19,075	175	198,611
Additions of Assets Under Construction	0	0	0	4,140	0	0	0	0	4,140
Additions Purchased	0	3,974	0	0	2,430	0	2,672	0	9,076
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	518	220	0	0	0	738
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(5,365)	4,581	0	784	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(4,149)	(10)	(98)	0	(4,257)
Revaluation	0	(3,885)	0	0	217	0	0	0	(3,668)
Impairments/reversals charged to operating expenses	0	(1,732)	0	0	0	0	0	0	(1,732)
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0
At 31 March 2017	13,200	121,112	576	2,726	42,628	58	22,433	175	202,908
Depreciation									
At 1 April 2016	0	1,134	21	0	26,397	51	11,943	144	39,690
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(4,149)	(10)	(98)	0	(4,257)
Revaluation	0	0	0	0	147	0	0	0	147
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	0
Charged During the Year	0	2,363	18	0	3,404	5	3,106	27	8,923
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0
At 31 March 2017	0	3,497	39	0	25,799	46	14,951	171	44,503
Net Book Value at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405
Asset financing:									
Owned - Purchased	13,200	109,486	537	2,203	16,267	12	7,470	4	149,179
Owned - Donated	0	6,895	0	523	562	0	12	0	7,992
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	1,234	0	0	0	0	0	0	1,234
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	13,200	117,615	537	2,726	16,829	12	7,482	4	158,405

Cost or Valuation: The negative Building Revaluation of £3,885k is the net effect of the BCIS negative indices applied quarterly.
Depreciation: The increase in Building Impairment £1,732k, consists of the net effect of the overall BCIS negative indices applied quarterly.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	4,456	36,506	0	0	472	1	0	0	41,435
Movements - indexation	0	(3,890)	0	0	(152)	0	0	0	(4,042)
At 31 March 2017	**4,456**	**32,616**	**0**	**0**	**320**	**1**	**0**	**0**	**37,393**

Additions to Assets Under Construction in 2016-17

Land	0
Buildings excl Dwellings	11
Dwellings	0
Plant, Machinery & Equipment (Including IT)	4,129
Balance as at YTD	**4,140**

16.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	19,930	101,205	576	2,786	39,083	63	16,867	175	180,685
Additions of Assets Under Construction	0	0	0	6,248	0	0	0	0	6,248
Additions Purchased	0	4,199	0	0	3,282	5	2,450	0	9,936
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	7	0	0	0	7
Additions - Purchases from Cash Donations & Government Grants	0	0	0	5	165	0	0	0	170
Additions Leased (including PFI/LIFT)	0	1,410	0	0	0	0	0	0	1,410
Reclassifications	0	2,598	0	(5,606)	2,346	0	662	0	0
Reclassifications as Held for Sale and Reversals	0	(382)	0	0	0	0	0	0	(382)
Disposals other than for sale	0	0	0	0	(5,596)	0	(904)	0	(6,500)
Revaluation	(6,730)	10,410	0	0	42	0	0	0	3,722
Impairment/reversals charged to reserves	0	3,315	0	0	0	0	0	0	3,315
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0
At 31 March 2016	**13,200**	**122,755**	**576**	**3,433**	**39,329**	**68**	**19,075**	**175**	**198,611**
Depreciation									
At 1 April 2015	0	0	0	0	28,666	47	10,435	115	39,263
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and Reversals	0	(7)	0	0	0	0	0	0	(7)
Disposals other than for sale	0	0	0	0	(5,484)	0	(904)	0	(6,388)
Revaluation	0	(2,215)	0	0	31	0	0	0	(2,184)
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	0
Charged During the Year	0	3,356	21	0	3,184	4	2,412	29	9,006
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0
At 31 March 2016	**0**	**1,134**	**21**	**0**	**26,397**	**51**	**11,943**	**144**	**39,690**
Net Book Value at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**
Asset financing:									
Owned - Purchased	13,200	112,892	555	3,428	12,418	17	7,112	7	149,629
Owned - Donated	0	7,354	0	5	514	0	20	24	7,917
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	1,375	0	0	0	0	0	0	1,375
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**

16.3. (cont). Property, plant and equipment

The Northamptonshire Health Charitable Fund has extended and refurbished the NGH Chemotherapy Suite, spending £518k in 2016/17, which is due to open end of April 2017. Also, £220k worth of equipment has been donated, including ultrasounds, incubators & ventilators.

BCIS (Building Cost Information Service) indices provided by Cushman & Wakefield have been applied to the Buildings on a quarterly basis. The next site revaluation exercise of NGH's Land & Buildings is due in April 2019.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Plant & Machinery	5 - 15 years
Transport	7 years
I.T.	5 years
Furniture & Fittings	5 years

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

The gross carrying amount of fully depreciated assets still in use is £25,820k (£23,311k)

17. Intangible non-current assets

17.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	399	8,082	0	0	0	0	8,481
Additions of Assets Under Construction	0	714	0	0	0	0	714
Additions Purchased	0	0	0	0	0	0	0
Additions Internally Generated	0	0	0	0	0	0	0
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0	0
Disposals other than by sale	0	(92)	0	0	0	0	(92)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	0
At 31 March 2017	399	8,704	0	0	0	0	9,103
Amortisation							
At 1 April 2016	280	6,931	0	0	0	0	7,211
Reclassifications	0	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0	0
Disposals other than by sale	0	(92)	0	0	0	0	(92)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairment/reversals charged to reserves	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0
Charged During the Year	2	778	0	0	0	0	780
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	0
At 31 March 2017	282	7,617	0	0	0	0	7,899
Net Book Value at 31 March 2017	117	1,087	0	0	0	0	1,204
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	117	1,087	0	0	0	0	1,204
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0	0
Total at 31 March 2017	117	1,087	0	0	0	0	1,204

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	0	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0	0
At 31 March 2017	0	0	0	0	0	0	0

17.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure - Internally Generated £000's	£000's	Total £000's
Cost or valuation:							
At 1 April 2015	399	7,966	0	0	0	0	**8,365**
Additions - purchased	0	377	0	0	0	0	**377**
Additions - internally generated	0	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(261)	0	0	0	0	**(261)**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	**0**
At 31 March 2016	399	8,082	0	0	0	0	8,481
Amortisation							
At 1 April 2015	262	6,275	0	0	0	0	**6,537**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(261)	0	0	0	0	**(261)**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Charged during the year	18	917	0	0	0	0	**935**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	**0**
At 31 March 2016	280	6,931	0	0	0	0	7,211
Net book value at 31 March 2016	119	1,151	0	0	0	0	**1,270**
Net book value at 31 March 2016 comprises:							
Purchased	119	1151	0	0	0	0	**1,270**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	0	**0**
Total at 31 March 2016	119	1,151	0	0	0	0	1,270

17.3. Intangible non-current assets

Intangible assets, software licenses and application software development are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

For the purpose of determining fair value historical cost is considered to be the most accurate basis considering the nature of software evolution and development.

Intangible Assets are depreciated on current cost evenly over the estimated life of the asset, which is determined on a case by case basis between 3 and 5 years.

The gross carrying amount of fully depreciated assets still in use is £6,017k (£5,129k)

18. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	1,732
Total charged to Annually Managed Expenditure	1,732
Total Impairments of Property, Plant and Equipment changed to SoCI	1,732
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Intangibles charged to SoCI	0
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Financial Assets charged to SoCI	0
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total impairments of non-current assets held for sale charged to SoCI	0
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	1,732
Overall Total Impairments	0
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total £000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	0
Over-specification of assets	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0
Loss as a result of catastrophe	0	0	0	0	0
Other	0	0	0	0	0
Changes in market price	1,732	0	0	0	1,732
Total charged to Annually Managed Expenditure	1,732	0	0	0	1,732
Total Impairments of Property, Plant and Equipment changed	1,732	0	0	0	1,732

Donated and Gov Granted Assets, included above	£000s
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

19. Investment property

	31 March 2017 £000s	31 March 2016 £000s
At fair value		
Balance at 1 April 2016	0	0
Additions Through Subsequent Expenditure	0	0
Other Acquisitions	0	0
Disposals	0	0
Property Reclassified as Held for Sale	0	0
Loss from Fair Value Adjustments - Impairments	0	0
Loss from Fair Value Adjustments - Reversal of Impairments	0	0
Gain from Fair Value Adjustments	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	0	0
Other Changes	0	0
Balance at 31 March 2017	0	0

20. Commitments

20.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	2,941	3,438
Intangible assets	0	65
Total	2,941	3,503

20.2. Other financial commitments

	31 March 2017 £000s	31 March 2016 £000s
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

21. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**1,904**	**3,794**	**0**	**46**	**0**	**0**	**5,744**	5,698
Additions	27,736	25,336	0	0	0	0	**53,072**	0
Inventories recognised as an expense in the period	(27,699)	(25,221)	0	0	0	0	**(52,920)**	0
Write-down of inventories (including losses)	(126)	0	0	0	0	0	**(126)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2017	**1,815**	**3,909**	**0**	**46**	**0**	**0**	**5,770**	**5,698**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**15,136**	9,742	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**1,668**	1,250	**0**	0
Non-NHS receivables - capital	**30**	21	**0**	0
Non-NHS prepayments and accrued income	**2,909**	1,923	**0**	0
PDC Dividend prepaid to DH	**37**	0	**0**	0
Provision for the impairment of receivables	**(752)**	(834)	**0**	0
VAT	**610**	473	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**9**	9	**200**	209
Operating lease receivables	**0**	0	**0**	0
Other receivables	**4,240**	3,756	**0**	0
Total	**23,887**	16,340	**200**	209
Total current and non current	**24,087**	16,549		
Included in NHS receivables are prepaid pension contributions:	**0**			

NHS receivables - revenue
- Estimated value of partially completed spells £2,625K (£1,436k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,653K (£2,582k)
- Salary overpayments/other recoverable pay £347K (£546k)

The great majority of trade is with Clinical Commissioning Groups as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**857**	676
By three to six months	**335**	121
By more than six months	**552**	45
Total	**1,744**	842

This includes £89k (£176k) relating to invoices raised to Clinical Commissioning Groups for Non Contracted Activity data.

22.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(834)**	(1,306)
Amount written off during the year	**599**	1,262
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(517)**	(790)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2017	**(752)**	(834)

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 60 days old from date of invoice unless known reason for payment delay.
17.41% (16.46 %) (local provision) of recognised Injury Cost Recovery claims are provided for.
All salary overpayments for which no recovery plan is in place, are provided for in full.

23. Other Financial Assets - Current

	31 March 2017 £000s	31 March 2016 £000s
Current part of loans repayable transferred from non-current assets	**0**	0
NLF deposits over 3 months	**0**	0
Closing balance 31 March	**0**	0

24. Other current assets

	31 March 2017 £000s	31 March 2016 £000s
EU Emissions Trading Scheme Allowance	0	0
Other Assets	0	0
Total	0	0

25. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	1,602	1,114
Net change in year	19	488
Closing balance	1,621	1,602
Made up of		
Cash with Government Banking Service	1,545	1,543
Commercial banks	61	50
Cash in hand	15	9
Liquid deposits with NLF	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	1,621	1,602
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	1,621	1,602
Third Party Assets - Bank balance (not included above)	0	0
Third Party Assets - Monies on deposit	0	0

26. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	0	375	0	0	0	0	0	0	0	0	375
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	0	(375)	0	0	0	0	0	0	0	0	(375)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	0	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2017	0	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	375	0	0	0	0	0	0	0	0	375
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	0	375	0	0	0	0	0	0	0	0	375
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	0

The Harborough Lodge Renal Unit located in Kingsthorpe, Northampton was sold in April 2016 for £585k, profit on sale was £210k.

27. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**855**	978	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,167**	1,000	**0**	0
Non-NHS payables - revenue	**2,961**	2,390	**0**	0
Non-NHS payables - capital	**3,113**	5,192	**0**	0
Non-NHS accruals and deferred income	**9,109**	7,966	**0**	0
Social security costs	**4,028**	3,551	**0**	0
PDC Dividend payable to DH	**0**	60	**0**	0
Accrued Interest on DH Loans	**75**	39	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**2,801**	3,169	**0**	0
Total	**24,109**	24,345	**0**	0
Total payables (current and non-current)	**24,109**	**24,345**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**2,380**	2,347		

28. Other liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Lease incentives	**0**	0	**0**	0
Other - Employee Benefits	**753**	710	**0**	0
Total	**753**	710	**0**	0
Total other liabilities (current and non-current)	**753**	**710**		

29. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Bank overdraft - Government Banking Service	0	0	0	0
Bank overdraft - commercial banks	0	0	0	0
Loans from Department of Health	20,250	628	30,407	26,037
Loans from other entities - SALIX	84	155	82	166
PFI liabilities - main liability	0	0	0	0
LIFT liabilities - main liability	0	0	0	0
Finance lease liabilities	124	121	1,121	1,245
Other	0	0	0	0
Total	20,458	904	31,610	27,448
Total other liabilities (current and non-current)	52,068	28,352		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	Other £000s	Total £000s
0-1 Years	20,250	206	**20,456**
1 - 2 Years	1,399	175	**1,574**
2 - 5 Years	24,175	459	**24,634**
Over 5 Years	4,833	571	**5,404**
TOTAL	50,657	1,411	**52,068**

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.
The Trust has agreed twelve schemes since 2012/13 of which six are fully repaid.
Each of these loans are subject to zero interest and are repayable over 4 years in equal instalments although these have been drawn on completion of each scheme.

An analysis of the DH loans held by the Trust is as follows:-

Loan Type	Agreement Date	Loan Facility Amount £000's	Interest Rate	Repayment Date	Analysis of Loan Balance - March 2017			
					Capital £000's	Deficit £000's	STF £000's	Total £000's
Capital	Mar-15	7,207	1.60%	10 year period	6,086			6,086
Capital	Mar-16	9,352	1.16%	10 year period	5,741			5,741
Revenue	Feb-16	18,851	1.50%	Feb-18		18,851		18,851
Revenue	Feb-17	14,515	1.50%	Jan-20		11,282	3,233	14,515
Revenue	Feb-17	2,995	1.50%	Feb-20		2,187	808	2,995
Revenue	Mar-17	2,469	1.50%	Mar-20		1,660	809	2,469
Total		55,389			11,827	33,980	4,850	50,657

30. Other financial liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Embedded derivatives at fair value through SoCI	0	0	0	0
Financial liabilities carried at fair value through profit and loss	0	0	0	0
Amortised cost	0	0	0	0
Total	0	0	0	0
Total other financial liabilities (current and non-current)	0	0		

31. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April 2016	**1,775**	1,777	**0**	0
Deferred revenue addition	**3,660**	849	**0**	0
Transfer of deferred revenue	**(2,889)**	(851)	**0**	0
Current deferred income at 31 March 2017	**2,546**	1,775	**0**	0
Total deferred income (current and non-current)	**2,546**	1,775		

32. Finance lease obligations as lessee

The Trust car park decking was completed under a Finance Lease arrangement.

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Within one year	**124**	121	**124**	121
Between one and five years	**550**	529	**550**	529
After five years	**571**	716	**571**	716
Less future finance charges	**0**	0	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**1,245**	1,366	**1,245**	1,366
Included in:				
Current borrowings			**124**	121
Non-current borrowings			**1,121**	1,245
			1,245	1,366

	31 March 2017 £000s	31 March 2016 £000s
Finance leases as lessee		
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

33. Finance lease receivables as lessor

Northamptonshire Healthcare NHS Foundation Trust occupies Battle House under a Finance Lease arrangement.

Amounts receivable under finance leases (buildings)	Gross investments in leases		Present value of minimum lease payments	
Of minimum lease payments	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Within one year	**9**	9	**9**	9
Between one and five years	**36**	36	**36**	36
After five years	**164**	173	**164**	173
Less future finance charges	**0**	0	**0**	0
Gross Investment in Leases / Present Value of Minimum Lease Payments	**209**	218	**209**	218
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**209**	218	**209**	218
Included in:				
Current finance lease receivables			**9**	9
Non-current finance lease receivables			**200**	209
			209	218

	31 March 2017	31 March 2016
Rental revenue	**0**	0
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue		

34. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**3,781**	0	0	0	0	0	3,781	0
Arising during the year	**4,056**	0	0	0	0	0	4,056	0
Utilised during the year	**(1,440)**	0	0	0	0	0	(1,440)	0
Reversed unused	**(554)**	0	0	0	0	0	(554)	0
Unwinding of discount	**5**	0	0	0	0	0	5	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**5,848**	0	0	0	0	0	**5,848**	0
Expected Timing of Cash Flows:								
No Later than One Year	**4,808**	0	0	0	0	0	4,808	0
Later than One Year and not later than Five Years	**938**	0	0	0	0	0	938	0
Later than Five Years	**117**	0	0	0	0	0	117	0

Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	95,245
As at 31 March 2016	95,588

Pension provisions are based on expected lives and current levels of payment.
Provisions arising in year relate to service level agreements, injury retirement, legal and associated employment claims.

35. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	0	0
Employment Tribunal and other employee related litigation	0	0
Redundancy	0	0
Other *[give details]*	0	0
Net value of contingent liabilities	0	0
Contingent assets		
Contingent assets *[give details]*	0	0
Net value of contingent assets	0	0

No contingency liabilities or assets have been identified.

The Trust is aware of recent legal rulings in relation to the calculation of overtime and holiday pay. At this stage it is not clear how this ruling may relate to the NHS and if so which staff groups may be affected. As such no financial value has been included in these accounts in relation to the rulings and the Trust will continue to monitor the situation pending legal advice and / or specific advice from NHS employers.

36. Financial Instruments

36.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Group are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust 's operating costs are incurred under contracts with primary care, Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

36.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	15,136	0	**15,136**
Receivables - non-NHS	0	8,141	0	**8,141**
Cash at bank and in hand	0	1,621	0	**1,621**
Other financial assets	0	209	0	**209**
Total at 31 March 2017	**0**	**25,107**	**0**	**25,107**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	9,742	0	9,742
Receivables - non-NHS	0	6,125	0	6,125
Cash at bank and in hand	0	1,602	0	1,602
Other financial assets	0	218	0	218
Total at 31 March 2016	0	17,687	0	17,687

36.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0	0	**0**
NHS payables	0	855	**855**
Non-NHS payables	0	19,226	**19,226**
Other borrowings	0	50,823	**50,823**
PFI & finance lease obligations	0	1,245	**1,245**
Other financial liabilities	0	753	**753**
Total at 31 March 2017	**0**	**72,902**	**72,902**
Embedded derivatives	0	0	0
NHS payables	0	978	978
Non-NHS payables	0	19,816	19,816
Other borrowings	0	26,986	26,986
PFI & finance lease obligations	0	1,366	1,366
Other financial liabilities	0	710	710
Total at 31 March 2016	0	49,856	49,856

37. Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2017 which effect the financial position.

38. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northampton General Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year Northampton General Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

Revenue Transactions
Health Education England £10.4m (£10.4m)
Nene Clinical Commissioning Group £203.7m (£194.7m)
Corby Clinical Commissioning Group £2.4m (£2.6m)
Milton Keynes Clinical Commissioning Group £2.9m (£2.5m)
East Midlands Specialised Commissioning Hub (previously Central Midlands Commissioning Hub) £37.5m (£32.9m)
Central Midlands Local Office **£8.0m** (£7.7m)
Northamptonshire Healthcare NHS Foundation Trust £1.3m (£1.3m)
Kettering General Hospital Foundation Trust £1.5m (£1.4m)
University Hospitals of Leicester NHS Trust £1.0m (£1.0m)

Expenditure Transactions
NHS Litigation Authority £8.2m (£5.9m) (NHS Resolution from April 2017)
Northamptonshire Healthcare NHS Foundation Trust £1.4m (£1.3m)
NHS Blood and Transplant £1.4m (£1.4m)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Northampton Borough Council (Business Rates £770k (£746k)), Northamptonshire County Council (Pathology Services £149k (£150k)) and HM Revenue & Customs (Employers National Insurance contribution £15.4m (£11.8m)), National Health Service Pension Fund Scheme £17.0m (£16.3m) and NHS Business Services Authority £10.4m (£7.6m)

The Trust has also received revenue and capital payments from Northamptonshire Health Charitable fund.

Grants totalling £341k (£372k), which were received from the Charity, have been treated in the Trust's Accounts as income and have primarily contributed towards staff and patients welfare. The Charity also funded £796k (£248k) of Building Works & Medical Equipment.

The Charitable Fund produces separate Trustees Report and Accounts which are available from the Finance Department of the Trust or on the Charity Commission website www.charity-commision.gov.uk. Should you wish to learn more about the Charitable Fund's activities and current initiatives visit www.nhcfgreenheart.co.uk or contact the Fundraising Team on 01604 545857 or E-mail greenheart@ngh.nhs.uk

39. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	451,533	857
Special payments	109,768	41
Gifts	0	0
Total losses and special payments and gifts	561,301	898

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	349,951	427
Special payments	53,686	55
Total losses and special payments	403,637	482

40. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

40.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	174,041	187,379	206,926	227,805	236,260	255,481	271,295	276,694	270,358	273,562	298,240
Retained surplus/(deficit) for the year	156	1,834	2,100	(4,958)	1,109	(1,917)	(764)	2,103	(20,111)	(17,086)	(15,164)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	729	7,039	0	3,453	899	(2,257)	3,338	(3,315)	1,732
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	(1,032)	264	351	248	250	(415)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	0	0
Absorption accounting adjustment							0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	156	1,834	2,829	2,081	1,109	504	399	197	(16,525)	(20,151)	(13,847)
Break-even cumulative position	(1,771)	63	2,892	4,973	6,082	6,586	6,985	7,182	(9,343)	(29,494)	(43,341)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.09	0.98	1.37	0.91	0.47	0.20	0.15	0.07	-6.11	-7.37	-4.64
Break-even cumulative position as a percentage of turnover	-1.02	0.03	1.40	2.18	2.57	2.58	2.57	2.59	-3.46	-10.78	-14.53

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

40.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

40.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	23,939	26,297
Cash flow financing	23,697	24,426
Finance leases taken out in the year	0	1,410
Other capital receipts	0	0
External financing requirement	**23,697**	25,836
Under/(over) spend against EFL	**242**	461

40.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	14,669	18,149
Less: book value of assets disposed of	(375)	(113)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(738)	(177)
Charge against the capital resource limit	**13,556**	17,859
Capital resource limit	13,561	17,877
(Over)/underspend against the capital resource limit	**5**	18

41. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	0	0

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *25th May 2017*

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

Executive Summary

The Committee met on *19nd April 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)*
• Finance report • Changing Care • Operational performance • Benefits realisation • Risk Register • BAF • IT Cyber Security	

Key areas of discussion arising from items appearing on the agenda

- **The Trust over performed against its Year End Financial Control Total by c £300k**
- **17/18 Changing Care programme is well developed but requires more schemes**
- **A&E continues to be challenged, with challenges to maintain motivation.**
- **It was noted that there are still no material Quipp schemes proposed from the CCGs/STP**
- **The Benefits realisation paper demonstrated the Trust needs to bring great focus on delivery of the benefits of approved projects as they are being implemented.**

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

- **17/18 Changing care plan to develop additional schemes to allow a 20% contingency**
- **The Committee Approved the STP Dermatology Business**

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

None that are not previously identified

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

Enclosure N

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 25th May 2017

Title	**HMT Exception Report**
Chair	**Dr Sonia Swart**
Author (s)	**Mrs Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 2nd May 2017 as a workshop 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. Divisional updates 3. Discussion on healthcare at home	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Divisional updates

Divisions presented their current concerns and actions being taken and any other divisional updates:

Medicine & Urgent Care
a. A&E performance
b. Recruitment of medical staff
c. Red 2 Green – *Not assured*

Surgery
a. RTT ongoing – Orthopaedics backlog and increasing trauma
b. Theatre utilisation – NHSi positive review
c. Issues after incident in theatre with associated learning & consent process
d. Step down from Critical care - delays and new process

Women's ,Childrens, Oncology, Haematology and Cancer
a. Cancer performance – 62 day target
b. Scorecards and governance review – *Not assured*
c. Additional beds on spencer ward – for Oncology

Clinical Support services
a. Radiology capacity increases
b. Histopathology – suspension of accreditation – awaiting outcome after submitting further evidence – *not assured*
c. Recruitment
d. Epma roll out

Enclosure O

Verbal report – information only

A summary briefing was provided by the CEO on:

a. CQC report progress
b. 60 bed assessment hub – case agreed
c. Junior doctors TV programme – positive feedback
d. Question comes to NGH, 2nd session on Culture
e. STP plans, clinical collaboration and urgent care

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

Bed review to be undertaken with a view to increasing capacity (virtual ward) over winter

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 25 May 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 30 March 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	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:05	**FOR INFORMATION**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Sustainability and Transformation Plan Update	Receive	Mr Pallot	**I.**
11:15	**GOVERNANCE**				
	14.	Approval of the Quality Account	Approval	Dr Cusack	**J.**
	15.	Corporate Governance Report	Receive	Mr C Thorne	**K.**
	16.	Self-certification	Receive	Mr C Thorne	**L.**
11:30	**ANNUAL REPORTS**				
	17.	Annual Report, Accounts and Annual Governance Statement and Auditors Letter of Representation	Receive	Mr Lazarus	**M.**
11:45	**COMMITTEE REPORTS**				

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**
	19.	Highlight Report from Quality Governance Committee	Assurance	Ms O Clymer	**Verbal.**
	20.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Verbal.**
	21.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**O.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 27 July 2017 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).