Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 28 September 2017

09:30

Board Room
Northampton General Hospital

Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 28 September 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 27 July 2017	Decision	Mr Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Nurse Recruitment and Retention Report	Assurance	Mrs J Brennan	**G.**
10:40	**FOR INFORMATION**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Sustainability and Transformation Plan Update	Receive	Mr C Pallot	**I.**
	14.	EPRR core-standards assessment	Receive	Mrs D Needham	**J.**
	15.	Best Possible Care Status	Receive	Ms C Fox	**K.**
11:00	**ANNUAL REPORTS**				
	16.	Corporate Governance Report	Receive	Ms C Thorne	**L.**
	17.	Infection Prevention Annual Report	Receive	Ms C Fox	**M.**
11:20	**COMMITTEE REPORTS**				
	18.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**

Time	Agenda Item		Action	Presented by	Enclosure
	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.**
11:30	**22**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 30 November 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 27 July 2017 at 10:00 in the Board Room at Northampton General Hospital

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

TB 17/18 023 **Introductions and Apologies**

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

Apologies for absence were recorded from Mr D Noble and Ms C Fox.

TB 17/18 024 **Declarations of Interest**

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

TB 17/18 025 **Minutes of the meeting 25 May 2017**

The minutes of the Trust Board meeting held on 25 May 2017 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 25 May 2017 as a true and accurate record of proceedings.

TB 17/18 026 **Matters Arising and Action Log 25 May 2017**

The Matters Arising and Action Log from the 25 May 2017 were considered.

Action Log Item 73
Ms Fox confirmed that the requested narrative was now included within her report.

The Board **NOTED** the Action Log and Matters Arising from the 25 May 2017.

TB 17/18 027 **Patient Story**

Mrs Needham introduced 'The last 1000 days' video to the Board. A poem was devised detailing patients last 1000 days and how the aim would be for the patient to spend these days at home.

Dr Swart shared with the Board the Patient Story which was a compliment letter from

Enclosure A

an ITU cancer patient. The letter commented on the dedicated busy staff. The patient admired the strength and composure of the staff involved in their care. Dr Swart stated that she was proud of the Critical Care team as they had gone out their way to help the patient and their family despite the pressures the team was under.

Mr Archard-Jones queried whether the compliment had been passed on to the staff involved. Dr Swart confirmed that it had.

The Board **NOTED** the Patient Story.

TB 17/18 028 Chairman's Report

Mr Farenden presented the Chairman's Report.

Mr Farenden commented on his recent Beat the Bug rounds and noted how it never ceased to amaze him the resilience of staff in the very challenging circumstances. It was attributable that staff have continued to demonstrate the Trust values.

Mr Farenden advised that he had a 1:1 with the Chair of NHFT. The topics of conversation were based around the STP, the STP's progress and the STP's leadership.

Mr Farenden also attended a meeting along with Ms Gill and Mr Archard-Jones with fellow Chairs and NEDs. The discussions were predominately on the STP and the challenges that it had encountered. Mr Farenden noted the commitment of the attendees in moving the STP forward in a positive direction. The meeting was honest and open about delivering the objectives set.

Mr Farenden reported that he had met with Mr Dale Bywater who is the NHSI Executive Regional Managing Director to discuss the Health Economy and how it could move forward. Mr Farenden stated that it was encouraging to see how Mr Bywater saw the Health Economy moving forward.

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

TB 17/18 029 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart commented on the Listen & Learn events at NGH and focused on 'Question Time' comes to NGH. This was an open forum and had worked well. It was noted that the Executive Team enjoyed these events. The Trust was starting to understand how it could work together and the correct culture to take forward.

Dr Swart stated that she had ran 'compass check' briefings targeted specifically at the Administration, Outpatient and Radiology teams. The administration staff have requested to have regular briefings and felt able to raise personal issues with Dr Swart.

Dr Swart discussed the recent NGH Dancing Stars. She stressed the importance of staff events to improve staff engagement.

Dr Swart reported that she was asked to speak at a recent NHSI conference on the challenge of creating improvement in a hospital under pressure. Dr Swart gave an honest account of the Trust's journey and how the Trust strived to help staff achieve their best.

Dr Swart stated that the Best Possible Care Awards were very positive for staff and feedback had been given that the staff found the event very motivational. Dr Swart went on to discuss that at this year's National Patient Safety Awards and NGH was

the only Trust to submit entries in twelve categories. The Trust was the most successful organisation in the UK for these Awards.

Dr Swart discussed the recent comments made in the media regarding the Friends of Northampton. Friends of Northampton were no longer able to provide their services to the Trust. The Trust's volunteer service staffs were energetic and enthusiastic with some members of the Friends of Northampton transferring to the hospital volunteer service. The Bedside Book Club initiative has been successful.

Mr Zeidler queried the Best Possible Care Awards and asked if it was to be of a similar size to last year. Mrs Watts commented that event number is similar to last year due the venue size constraints.

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

TB 17/18 030 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack reported that the key clinical risks were the pressures in the Urgent Care pathway and the discharge pathway which both had an impact on patients. The Trust had and continues to undertake substantial work in order to mitigate the risk to patients posed by the urgent care pressures. This was coordinated through the Urgent Care Working Group led by the Chief Operating Officer with representation from each of the clinical Divisions. The effects on staff are discussed at the Workforce Committee.

Dr Cusack stated that an extensive piece of culture work is underway on bringing together how the nurses and doctors work.

Dr Cusack noted the difficulties in securing sufficient nursing and medical staff. This was an issue at a national and international level. There is a continued focus on this and this concern is discussed at the Workforce Committee.

Dr Cusack discussed the serious incidents detailed in his report with the Board. 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.

Dr Cusack advised that that since the last report to the Board, during the reporting period 1/05/2017 – 30/06/2017, one new Serious Incident has been reported onto STEIS. To date within 2017/18, 2 Serious Incidents had been reported under invasive procedure – wrong site surgery (Never Event) and Sub-optimal care – unidentified fracture

Dr Cusack reported on the recent Never Event to confirm that the report had been finalised and submitted to the CCG in July. An Orthopaedic surgeon from Leicester and an external Governance Director had commended the investigation process. There has also been an additional external review of the safety culture in Theatres which will be reported to the Board via QGC. The review was positive and target areas identified which will be taken forward.

Dr Cusack stated that the HSMR for the year to March 2017 remains within the 'as expected' range. The crude mortality in the HSMR group of patients is 3.4% (Midlands & East peer group rate 3.7%). The variation in HSMR during the year to March 2017 is shown on the graph on page 22 of the report pack.

Dr Cusack commented that there were continued investigations into mortality outliers and the Trust continued to embed the recommendations in line with Trust policy.

Dr Cusack noted that the role of the Mortality Screeners had been developed and the recruitment process is underway.

Mr Farenden queried what has sped up in the investigation process of SI's across the Trust. Dr Cusack stated that Divisional teams have been cascading the information more efficiently. The Governance Team has also produced a newsletter and has run Dare to Share events.

Mrs Needham updated the Board further on the actions following the recent Never Event. The action plan is regularly audited and the recent Theatre Safety review was positive. The Divisional Director at the end of the session spoke to the staff on how proud he was of the team and how he would like to move leadership within Theatres into the Outstanding category

Mr Archard-Jones queried whether the SI reports recorded the number of near misses. Ms Thorne confirmed that this is captured on Datix and a quarterly incident report with this information is presented to QGC.

Mr Archard-Jones challenged what progress had been made by the Urgent Care working group. Mrs Needham advised that the key areas were Red to Green, Professional Standards, how to escalate to Doctors, timescales, 90 day collaborative work, how to move from black to red to green and how to manage frailty at the door.

Dr Swart stated that a cultural change was needed with firm commitment from all levels. Mrs Brennan commented that the OD is engaging everyone to work together and looking at how to change the culture.

Mr Archard-Jones queried when a difference would be seen. Mrs Needham clarified that an update will be brought the **September** Board.

Action: Mrs Needham

Mr Zeidler believed that there was a good reaction to mitigating the concerns from the recent Never Event however queried who and how was this audited. Ms Thorne confirmed that the Clinical Audit team would be responsible for this as well as the Quality Team.

Dr Cusack advised that in relation to the mortality review process the Trust has taken a lead in this. The structured judgement review tool was now in use in undertaking reviews of patient care. Initial experience with the tool has found it to be effective both in highlighting potential problems in care and as well as recording instances of notable care.

Ms Gill shared with the Board that the University of Bath had devised apps which can help with learning in relation to discussed information in the Medical Directors Report. Dr Cusack commented that he would explore this option.

Action: Dr Cusack

Mrs Brennan reported that to support overcoming difficulties in securing medical and nursing staff there was a nursing open day on the 15 July where 18 offers were made. Mrs Brennan stated that she will be bringing a report to the next month's Board.

Action: Mrs Brennan

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

TB 17/18 031 **Director of Nursing and Midwifery Care Report**

Mrs Barnes presented the Director of Nursing and Midwifery Care Report.

Mrs Barnes advised that the Nursing and Midwifery Care Report had been discussed in detail at QGC.

Mrs Barnes drew the Board to page 31 of the report pack to discuss Infection Prevention and Control. For June 2017 there were 5 patients that were Trust attributable cases of c.diff. A post incident review has been undertaken. There is a 90 day rapid improvement programme in place.

Mrs Barnes stated that the FFT results continued to show improvement. The focus will be on real time projects. This will involve non-clinical members of staff interviewing patients in key areas of concern and it is believed that this will help improve patient experience.

Mrs Barnes reported on level 3 Safeguarding training. The newly appointed Head of Safeguarding is running a task and finish group to undertake gap analysis against our training programme and intercollegiate guidance.

Mrs Barnes commented that the team who support patients with learning difficulties who go through Theatres have been nominated for a Nursing Times Award.

Mrs Barnes discussed the Safe Staffing update on page 42 of the report pack.

Mr Farenden noted that the reported cdiff for June was unusual for the Trust. Mrs Barnes concurred and stated that the cases were reported in surgical patients on surgical wards. A post incident review is being done to understand the themes.

Dr Swart queried whether there was any cross contamination in the hospital. Mrs Barnes confirmed that there was not.

Mr Kershaw challenged the reasons behind the increase in Pressure Ulcers on Holcot which has led to the 90 Day Pressure Ulcer Rapid Improvement Challenge being ran on the ward. Mrs Barnes believed that contributory to this was the use of stockings and a detailed review is being done to establish the cause. An update will be brought the **August** Committee.

Action: Mrs Barnes

Mr Archard-Jones queried appendix 6 and the 'nil' response. Mrs Barnes confirmed that this should be n/a not 'nil'.

Mr Pallot highlighted to the Board the possible financial impact from the c.diff incidents. Mrs Barnes stated that to date there had been no lapse in care has been found.

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

TB 17/18 032 **Same Sex Accommodation Board Statement of Compliance**

Mrs Barnes presented the Same Sex Accommodation Board Statement of Compliance.

Mrs Barnes advised that this was the annual report to the Board and asked for the Board support of the Same Sex Accommodation Board Statement of Compliance.

Ms Gill queried how transgender patients are treated. Mrs Barnes commented that the patient is asked and the clinical need will also be established. Mrs Needham

stated that there would also be a conversation with the patient to relay the fears of the other patients on the ward.

The Board **SUPPORTED** the Same Sex Accommodation Board Statement of Compliance.

TB 17/18 033 Finance Report

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that the I&E position YTD is a deficit of £4.2m, which is £180k adverse to plan. The Trust exceeded its pre-STF financial control total by £16k. However it did not achieve the A&E 4 hour target and therefore did not earn the associated STF of £196k.

Mr Lazarus reported that the Finance Team carried out a review of the income provisions on the balance sheet and identified £0.5m of income provision no longer required. This has been released this into the month 3 position.

Mr Lazarus highlighted his concerns to the Board. DC activity has dropped to 3% below activity plan, 7% below financial plan and elective income remains 6% below the financial plan.

Mr Lazarus stated that the Divisions are working hard on their recovery plans and are identifying actions to help recover their deficits. These actions would be included in the revised forecast report to Finance Committee in August.

Mr Lazarus commented that a more in-depth paper on financial activity was to be presented at Private Board.

Mr Farenden queried whether the Divisional plans will be time framed. Mr Lazarus confirmed the plans would be.

Mr Pallot advised that the contractual relationship with the CCG remains good. The CCG's commissioning support unit will be moving to London.

Mr Pallot stated that invoice validation will be starting in August which will involve increased scrutiny.

It was noted that DTOC is at 10% and acuity is higher than expected. Due to the bed gap the Trust has not been able to do the available elective activity.

Dr Swart queried what was different this year and that impact of income is likely to be bigger than before. Other organisations are having similar significant financial challenges.

The Board **NOTED** the Finance Report.

TB 17/18 034 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan noted that there was good performance against a large number of KPI's.

Mrs Brennan advised that the Turnover rate target has been adjusted to 10% as agreed at June's Workforce Committee.

Mrs Brennan commented that sickness absence was very good for the acute sector.

Mrs Brennan discussed the recruitment initiative 'Best of Both Worlds' with the Board. The initiative has launched and it has been received positively. The initiative has also got national recognition.

Mrs Brennan reported that the Trust would be working with MIND. Arrangements are underway for MIND to attend the Trust to provide manager training sessions to equip managers with the skills to spot the signs mental health issues, offer appropriate workplace support and signpost for professional help. Mrs Brennan stated that MIND would also be in the Trust on 15 August 2017 to provide a two hour mental health awareness session.

Mrs Brennan shared her concern in relation to the perceived stigma behind mental health issues and was delighted to report the good uptake for the awareness session.

Mrs Brennan stated that the Trust will be taking part in the Global Corporate Challenge and that the bid with Charitable funds was successful.

The Health & Wellbeing Lead has been appointed on a full-time basis to take forward the Health and Wellbeing agenda.

Mrs Brennan advised that the rate of appraisals, mandatory training and role specific essential training compliance had all increased in June.

Mrs Brennan discussed the Apprenticeship Levy with the Board. The Learning and Development team had secured additional funding from HEEM to design a course for mentors on supporting the apprentices. This training will be rolled out in October 17.

Mrs Brennan reported on the new values based appraisal system. She outlined the 3 courses which will be run. It will be the first time a training course for all staff has been designed.

Dr Swart noted that it is difficult to get QI aligned and appraisals will be a good way to do so.

Mr Archard-Jones queried what the appetite was for early retirement. Mrs Brennan stated that the nursing staff group had the higher rate of leavers. The other staff groups are quite variable.

Mrs Barnes advised that in relation to nurse retirement the nursing team had looked at a number of options to maintain the number of nurses. This ranges from a legacy nurse or midwife who would be a clinical expert in the role.

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

TB 17/18 035 **Equality and Human Rights Workforce Annual Report 2016/2017**

Mrs Brennan presented the Equality and Human Rights Workforce Annual Report 2016/2017.

Mrs Brennan highlighted the key points within the Equality and Human Rights Workforce Annual Report.

The WRES results from 2016 were compared with the 2015 results and it was noted that of the 7 that could be compared there were 6 improvements and 1 deterioration.

Mrs Brennan commented on the Staff Survey 2016 Equality & Diversity Results which raised concerns over bullying and harassment. A strategic group has been formed which will launch a 'Respect and support' campaign, taking an OD approach

to tackling this issue. Mrs Brennan stated that a further survey was in the process of being undertaken with and 600 responses had been received from staff.

There is to be a resilience training session for staff and managers. Work was also needed on how to build confidence in staff to challenge inappropriate behaviour.

Mr Farenden noted that there appeared to be a blurred line as to whether staffs see the behaviour as proper management or bullying. Mrs Brennan confirmed tah the purpose of the survey was to really understand and get beneath what is reported in the main staff survey results.

Mrs Brennan advised that the Equality and Diversity Staff Group (EDSG) meet on a quarterly basis. The group have adopted a revised approach to engaging the Divisions in becoming engaged with the equality Agenda.

There has also been bespoke training for domestic staff whose first language not English in relation to Information Governance is training.

Mrs Brennan shared with the Board that the Trust employs staff from 91 countries.

Ms Thorne commented that the Freedom 2 Speak Up Guardian will also work with the OD team and as a collective will run a joint learning session in September.

Mr Zeidler remarked that he found the Health & Wellbeing strategy on page 115 of the report to be fantastic however queried how the initiatives were being tracked. Mrs Brennan stated that questions in the staff survey will reflect this as well as feedback at the individual sessions. Mrs Brennan noted that the CQUIN also required evidence.

Mr Archard-Jones queried the amount of staff from EU countries within the 91 and whether Brexit had an impact. Mrs Brennan stated that no effect had been seen at current in terms of leavers and that international nurse recruits do receive a large amount of pastoral care. Her concern was more on the number of nurses who had failed the IELTS.

Dr Swart advised that a letter had gone out to staff immediately after EU vote outcome and Mr Farenden reported that a Board 2 Ward had also covered the issue.

The Board **NOTED** the Equality and Human Rights Workforce Annual Report 2016/2017.

TB 17/18 036 Equality and Human Rights Workforce Monitoring Report

Mrs Brennan presented the Equality and Human Rights Workforce Monitoring Report.

Mrs Brennan advised that the report is broken down by characteristics. The common theme she had noted was that the younger workforce was scoring higher on a large number of indicators than the older workforce, for example sickness is higher in the 16 – 20 age range.

Mrs Brennan stated that leavers were also higher in the younger workforce which is consistent with our data particularly on nursing staff that tend to leaving circa 2 years post qualification. There was some research called ‘Mind the Gap’ and ‘Narrow the Gap’ completed which looked at generational differences and further work would be undertaken on this once the Retention and Reward specialist had been appointed.

Dr Swart reported that at a recent nurse away day she attended it was noted that the younger nurses needed regular feedback. Mrs Barnes concurred with this and stated

that work is being done on how the younger generation of nursing staff could be given a structured approach for their career.

The Board **NOTED** the Equality and Human Rights Workforce Monitoring Report.

TB 17/18 037 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that the performance report had been discussed at the 3 sub-committees of the Board. Mrs Needham stated that on page 182 of the report pack it is detailed the changes that had been made to the scorecard as part of the annual review.

Mrs Needham reported on the ongoing achievement of the RTT target. It is a challenging target given the Trust's bed capacity gap. She noted that diagnostic performance remains positive also the stroke indicators.

Mrs Needham commented on the improving picture nin urgent care which had continued into July. The performance however still remains below the revised trajectory but is above the original trajectory. Daily challenges continued throughout July and performance is similar to June at current.

Mrs Needham shared her concern for quarter 2 A&E performance mainly due to the high acuity of patients. ITU and HDU are at full capacity the majority of the time. A CD from a well performing Trust was invited to spend two days in A&E and the assessment units. The CD was able to identify areas which the Trust could improve oio. The suggested areas of action would be brought to a future Finance & performance committee.

Mrs Needham stated that cancer performance remains below trajectory and is being performance managed daily by the Divisional manager. The number of legacy patients has decreased to 36 waiting over 62 days. The 62 day target was a risk and it is believed that this would be back on trajectory by November 17.

Mrs Needham advised that the 2ww still remains a challenge especially in breast due to Consultant gaps. The Trust has secured some additional capacity at Bedford hospital and Mrs Needham hoped the wait would reduce over the coming weeks.

Mrs Needham noted the support from NHSI in the form of weekly telephone calls, coaching and invitation to attend learning forums.

Mr Farenden queried whether Mrs Needham believed that A&E performance could get back on trajectory. Mrs Needham stated that she thought it could, but the DTOC number would need to reduce and the activity remain below plan.

Mr Archard-Jones questioned that job planning was 0 on the scorecard again. Dr Cusack commented that the target is phased across the year and job plans are not signed of till after quarter 1. Mr Archard-Jones wondered whether the holiday period had been taken into account. Dr Cusack stated that he hoped the clinicians would have organised their meetings prior to their annual leave and advised the Board that a job planning update was being delivered at the August Workforce Committee.

Mr Archard-Jones challenged whether the late signing of the job plans would impact on the services. Dr Swart suggested that Mr Archard-Jones was to meet with Dr Cusack to be given an overview of the job planning process.

The Board discussed the 60 bedded unit. Mrs Needham commented that it was important to test the changes to be implemented in the new unit prior to the go live

date. The changes will be tested using QI methodology.

Mr Zeidler queried whether Springfield House would be in place by October 17. Mrs Needham stated the importance of streaming patients to be the correct plan. The new model is what is currently in place in A&E with longer hours and more staff. The Board were advised that Springfield House should help increase capacity therefore improving the performance target.

Mr Abolins advised that the contractors for Springfield House are out to tender and it likely the go live date will be mid-November. The new model will be in place prior to the build completion and this will be in A&E.

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

TB 17/18 038 **Sustainability and Transformation Plan Update**

Mr Pallot presented the verbal Sustainability and Transformation Plan Update.

Mr Pallot commented that there was no paper from the CCG on the STP to share with the Board. Work continues to reboot the programme and nationally Northamptonshire is in the bottom 5 of 44 STPs.

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

TB 17/18 039 **Naylor Report NHS Property & Estates**

Mr Abolins presented the Naylor Report NHS Property & Estates.

Mr Abolins advised that the Naylor Report was an independent report released by the Government in March 2017. The report highlighted the importance of developing a modern fit for purpose estate releasing surplus NHS land, increasing efficiency and addressing backlog maintenance.

Mr Abolins drew the Board to page 209 of the report pack which detailed the STPs.

Mr Abolins stated that there is £10b required to cover the backlog of NHS maintenance issues.

Mr Abolins commented that the Government signal support in principle and the STP sub-group for Estates will stay close to these developments.

The Board **NOTED** the Naylor Report NHS Property & Estate.

TB 17/18 040 **Fire Safety Annual Report**

Mr Abolins presented the Fire Safety Annual Report.

Mr Abolins advised that Northamptonshire Fire and Rescue Service last completed a fire safety audit in 2014. The Trust's fire safety management arrangements were satisfactory. The Trust has made a request to be re-inspected and a date was to be agreed for later in the year.

Mr Abolins noted that all risk assessments for year 16/17 were reviewed and new risk assessments were added.

Mr Abolins stated that building works including fire safety during 2016/17 included completion of alterations to form new A and E FIT Stop, including improved fire barriers, fire alarm and automatic fire detection system, emergency lighting system and extension of the automatic fire suppression system. Completion of fire barriers to timber floors in Paddington and Disney undercroft was also completed.

Mr Abolins reported that there had been an increase in staff training to 5140 which is an increase of 454 from last year's attendance. At the end of March 2017 the Trust fire training figures for Whole Time Equivalents were 80.7% compliant.

Mr Abolins advised that 3 fire incidents occurred on site and none of them activated the fire alarm system.

Mr Abolins drew the Board to page 223 of the report pack which summarised the priorities for 17/18. One of the priorities was to ensure all areas to undertake an annual fire drill. There were 188 areas to cover and this to be highlighted on the Divisional scorecard from next month to make sure the Divisions will be held to account.

Mr Abolins discussed in detail the briefing on actions at NGH following the Grenfell Tower Fire which is included on page 224 of the report pack. The Trust has a significant amount of mitigation in place in the event of a similar fire. Mr Abolins confirmed to the Board that the Trust has none of the cladding in place of which Grenfell tower did.

The Board **NOTED** the Fire Safety Annual Report and **APPROVED** the Annual Statement of Fire Safety Compliance.

TB 17/18 041 **Highlight Report from Finance Investment and Performance Committee**

Mr Zeidler advised that the Highlight Report from the Finance Investment and Performance Committee on the 21 June 17 is included within the report pack.

Mr Farenden confirmed that he would produce a highlight report for August's Board of Directors which will draw out the key issues from the Committee on the 20 July 17.

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

TB 17/18 042 **Highlight Report from Quality Governance Committee**

Ms Clymer presented the Highlight Report from Quality Governance Committee.

The Board were provided a verbal update on what had been discussed at the Quality Governance Committee meeting held on the 22 July 17. 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 –

- Inpatient Survey – a dip in results
- WHO Checklist
- Cdiff – no cross contamination noted
- Sepsis boxes
- Security – an increase in conflict resolution training

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

TB 17/18 043 **Highlight Report from Workforce Committee**

Mr Kershaw 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 20 July 17. 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 Kershaw advised of the key points –

- Workforce performance was discussed in depth.
- Sickness absence was below target.
- Update given on the action plan to address Bullying & Harassment.
- Recruitment and retention of nursing – challenging to recruit oversea nurses, more focus to be given to local recruitment.
- Reviewed the CRR and the BAF.

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

TB 17/18 044 Highlight Report from Hospital Management Team

Mr Lazarus presented the Highlight Report from Hospital Management Team.

Mr Lazarus reported that there was a good briefing regarding Cancer and what is being done to reduce the backlog.

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

TB 17/18 045 Any Other Business

Mr Farenden noted that this was Mr Abolins last Public Board meeting and thanked him for his valued contribution. Mr Abolins has delivered not only professional opinion but sound steady advice. The Estate, despite its age is still in good condition both aesthetically and operationally. Mr Abolins was complimented on this.

Date of next Public Board meeting: Thursday 28 September 2017 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Farenden called the meeting to a close at 12.15 p.m.

Public Trust Board Action Log						Last update	15/08/2017
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
74	Jul-17	TB 17/18 030	Medical Director's Report	Mr Archard-Jones queried when a difference would be seen from actions noted in the Urgent Care Working Group. Mrs Needham clarified that an update will be brought the September Board	Mrs Needham	Sep-17	On agenda	
75	Jul-17	TB 17/18 030	Medical Director's Report	Ms Gill shared with the Board that the University of Bath had devised apps which can help with learning in relation to discussed information in the Medical Directors Report. Dr Cusack commented that he would explore this option.	Dr Cusack	Sep-17	On agenda	**Update to be given in matters arising**
76	Jul-17	TB 17/18 030	Medical Director's Report	Mrs Brennan reported that to support overcoming difficulties in securing medical and nursing staff there was a nursing open day on the 15 July where 18 offers were made. Mrs Brennan stated that she will be bringing a report to the next month's Board	Mrs Brennan	Aug-17	On agenda	**confirmation that the update was brought to August BoD**
77	Jul-17	TB 17/18 031	Director of Nursing and Midwifery Care Report	Mr Kershaw challenged the reasons behind the increase in Pressure Ulcers on Holcot which has led to the 90 Day Pressure Ulcer Rapid Improvement Challenge being ran on the ward. Mrs Barnes believed that contributory to this was the use of stockings and a detailed review is being done to establish the cause. An update will be brought the August Committee.	Mrs Barnes/Ms Fox	Aug-17	On agenda	**confirmation that the update was brought to August BoD**
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 September 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/ Dr Sonia Swart
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	

Public Trust Board
28 September 2017

Chief Executive's Report

1. Cancer Alliance

In 2016 following the publication of the National Cancer Plan 16 Cancer Alliances were set up and tasked with more local delivery of this plan. The East Midlands Cancer Alliance has been in place since December 2016. The original intention was that the Alliance should be able to drive transformation of cancer services to improve the experience and outcomes for patients with cancer. This intention remains valid and it is one which motivates the many clinicians in this field. There have however been a number of issues which have impaired the ability of the Alliance in the East Midlands to function in the way that was originally intended. These are now being resolved and the funding is coming through to set up the Alliance structures and hopefully to access transformation funding to assist the providers and commissioners and start to really improve care.

This is important for NGH for a number of reasons. Firstly, we have struggled to maintain the required standards for all the timings in the cancer pathways and as the demand for services increases it is important to look at ways of changing the way we do things. Secondly some of the proposed projects will release capacity in secondary care and allow existing capacity to be channelled more effective. Finally the focus on prevention of cancer and on much more involvement of the patient is critically important for the future and links well with the work that is necessary for successful STPs. A new cancer board has been set up which will span the Northamptonshire STP footprint, receive support from the Alliance , cover the operational , transformational and strategic agenda and report into the STP Board. There has been a very explicit instruction from the national team regarding mandatory links between the work of the Alliance and the 62 day performance target and this link will be maintained through the various projects.

I was asked to give oral evidence to the All Parliamentary Group on Cancer along with three other Alliance representatives from different parts of the country. There was considerable consistency in the views we expressed in relation to important issues facing those charged with delivering and improving cancer services and our hope was that the information that we provided and the views we had will be used next month when national teams are questioned. There were a number of important themes emphasising the urgent need for robust national workforce planning for cancer and indeed for the entire NHS workforce, the need for increasing clarity and transparency from all the key players and the importance of funding for transformation given in a timely way. The East Midlands Alliance currently has not received any transformation money but bids are in place for

projects that would pilot the implementation of the National Lung Pathway (reducing time to treatment to 50 days maximum), non-invasive testing to exclude bowel cancer (to reduce demand for colonoscopy and 2 week wait referrals for lower GI

cancer by up to 30% for a significant subset of patients) and a project to accelerate and improve the prostate cancer pathway. Further bids are being prepared to improve the way diagnostics support the cancer pathway and hopefully to streamline radiologist input and so release capacity for radiologists to concentrate on reporting.

This alliance work will support providers to continue to improve the delivery of the mandatory cancer access standards as well as in the important work to ensure that cancer patients are supported throughout their journey and following treatment in a more coordinated and less hospital focussed way.

From a NGH perspective we are struggling to meet all the cancer access standards at present and are developing a strong recovery plan to ensure pace and grip in this area but hope to help shape and lead the STP Cancer workstream in a way that ensures full clinical leadership for transformation.

2. Urgent Care

We have struggled to maintain our performance against the 4 hour urgent care transit target in recent months and despite a huge focus on this, the situation has deteriorate since the last Board meeting.

This has been the subject of considerable discussion and as a result the urgent care programme is currently being refocused and designed to be a hospital wide effort designed to re-engage the entire workforce. We plan to use a similar process to that adopted some years ago when supported by external consultancy and entitled 'Breaking the Cycle'. A key component will be to mandate and support clinical leadership and to have a robust weekly cycle of improvement work. To this end we intend to re-prioritise the current work programmes of all available Quality Improvement resources as well as members of the Changing Care team into a project managed prioritised portfolio of work led by our COO but with a triumvirate approach involved the MD and the DoN.

In summary we continue to have significant pressures in terms of demand for our services, we still have difficulty discharging patients quickly and effectively, we still have problems discharging complex patients and we do not have enough daily rhythm of flow of admission and discharge to give our patients the best care possible. In the last two months we have experienced very significant medical staffing issues as well as pressures on nurse staffing which have had a negative impact and we have also had some gaps in medical leadership at critical times.

This is a time therefore to refresh our plans and it will very much be an 'all hands on deck' approach with the clear aim of improving the care for patients but also ensuring we are using our resources more efficiently. In these efforts it will be important not to lose sight of the excellent improvement work already untaken in our A&E department and we should ensure we use the same methodology as we reinvigorate our efforts across the hospital

I was summoned to meet with Jeremy Hunt, Simon Stevens, Jim Mackey, Pauline Philips and others on 18 September when the CEO of around 60 Trusts were given a clear indication that in view of the expected pressures over this coming winter, we should ensure that I as CEO and the Board take a greater responsibility in overseeing progress in this important area. To this extent I will ensure that when the programme of work is launched, I give clear personal direction to the programme

and clear personal support to the people leading it. We will need to have a very strong and clear communication and engagement plan and make absolutely certain that we continue to embed our values and our open and honest approach into this.

3. **Best Possible Care Awards**
   More than 200 nominations were received for this year's Best Possible Care Awards and the judging panel was faced with the challenging task of whittling these down to six shortlisted nominees in each of the ten award categories. In a couple of cases this proved to be so difficult that two winners have been chosen. Winners will be announced at the Awards Dinner on Friday 29 September.

   This year we have been fortunate in securing both external sponsorship and support from the Northamptonshire Healthcare Charitable Fund for this very important event in the TeamNGH calendar, and we are grateful for all the support we receive from our community and the Charitable Fund.

4. **Annual General Meeting**
   Our AGM was held on Wednesday 20 September. Those who attended were interested to learn more about our developments, particularly the 60 bed assessment unit, GP-led urgent care hub and new MRI suite. There were also opportunities for people to find out more about what quality improvement means at NGH, how our simulation suite supports training and patient safety and what opportunities there are for them to improve their own health and wellbeing. The focus of the meeting was very much on an honest reflection of the progress made, the approach taken and the tasks still ahead of us and we were pleased to be able to bring things to life with the help of our communications team, ending with clips taken from the Channel 4 series 'Confessions of a Junior Doctor'.

5. **Awards**
   Our communications team's campaign to encourage people living and working in Northampton to donate a copy of their favourite book to our Bedside Book Club was awarded the Community Relations Campaign of the Year at the UK Public Sector Communications Awards. The Awards are for all public sector organisations across the UK and are strongly contested. NGH was one of the few NHS organisations to win one of the Awards this year. This award will I am sure ensure that our active volunteers are even more motivated to continue to work in partnership with our growing communications team to maximise the benefit of and the impact of volunteering at NGH.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28 September 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 Board, during the reporting period 1/07/2017 – 31/07/2017, two new Serious Incidents have been reported onto STEIS:

1. Delay in identifying septic shock — Emergency Department
2. Transfer of neonate for therapeutic cooling — Labour Ward

The investigation into the Never Event has been completed and the report submitted to the CCG. The Trust has responded to subsequent questions from the CCG. The key actions from the Never Event investigation are described in the report. No other investigations into Serious Incidents were closed during this period.

One Serious Incident currently remains open and is under investigation:

1. Missed Fractured Calcaneum — Fracture Clinic/ED

Dr Foster data showed overall mortality expressed as the HSMR remains within the 'as expected' range. The Trust position in relation to regional and national peer groups is described in the report.

An update is provided on recruitment of the mortality screening team as part of wider work to comply with The National Guidance for Learning from Deaths.

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.

Enclosure D

Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper
Actions required by the Trust Board The Board is asked to note the contents of this report, details of clinical risks, mortality and the serious incidents declared and identify areas for which further assurance is sought.	

Public Trust Board
September 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
1286	Frequent and prolonged loss of elective orthopaedic ward for escalation	20	20	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
464	Risk to stroke patients not receiving best practice care as unable to be consistently cared for within a stroke bed	20	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
1194	Delayed discharge on a near daily basis of Critical Care step down patients results in delay admitting new patients to the Unit	15	15	Quality Governance

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 roll out of the SAFER Bundle, 'Red to Green' and Primary Care Streaming. The development of Springfield as a designated Urgent Treatment Centre will increase capacity and improve patient flow. Work to develop on an 'acute floor' is being undertaken which will allow new models for delivery of urgent care to be introduced.

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
1348	High number of vacancies in Oncology/Haematology contributing to in-patient and out-patient delays	9	20	Workforce
979	Difficulty in recruitment and high turnover in nursing staff groups.	16	16	Workforce
1155	Potentially unable to maintain appropriate staffing levels in theatre areas due to staff vacancies	15	15	
81	Inability to maintain effective service levels due to reduced skilled nursing workforce for the existing bed base.	9	16	Workforce
92	Risk due to medical workforce issues including the high use of locums and loss of regionally funded posts	20	16	Workforce
1162	Vacant posts within Gen Med for CT, GP VTS and specialist posts as a result of lower fill rates in the East Midland South for training posts	16	16	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 range of measures have been adopted to increase staff recruitment and retention with some success.

Work continues 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. During September there have been significant gaps at junior doctor level which has impacted upon the delivery in the urgent care pathway. There has been some reliance on agency staff in the short-term to mitigate the effects of this with further focus on substantive 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	3
Never Events	2	2	1	0	1	3	1	1

2.2 Never Event(s) in 2017/18

There were no incidents in July/August 2017 that met the criteria of a Never Event. The investigation into the Never Event regarding wrong site surgery has been completed and the report has been finalised and submitted to the CCG (Clinical Commissioning Group) in July 2017. The Trust has responded to the queries raised by the CCG on the report.

2.3 New Serious Incidents

Since the last report to the Board, during the reporting period 1/07/2017 – 31/08/2017 two new Serious Incidents have been reported onto STEIS:

1. Delay in identifying septic shock — Emergency Department
2. Transfer of neonate for therapeutic cooling — Labour Ward

Each Serious Incident is investigated by a panel of individuals (with no conflict of interest) who are familiar with Root Cause Analysis techniques. The panel members have sufficient seniority in the organisation, that they can probe and ask questions of individuals and processes to establish the root cause of an incident, allowing them to make suggestions and recommendations for changes and actions which may be Trust wide.

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).

Since 1st April 2017 there have been four Serious Incidents which have been reported under the following categories:

1. Surgical/invasive procedure – wrong site surgery (Never Event)
2. Sub-optimal care – unidentified fracture
3. Delay in treatment – sepsis/post-partum haemorrhage

The systematic investigation of Serious Incidents results in important lessons being learned and improvements identified and implemented. These improvements support the embedding of an effective safety culture, thus allowing the delivery of high quality, safe patient care.

The lessons learned from serious incident investigations, are shared with clinical teams and staff through their local governance forums/groups. These are also shared with staff across the Trust where lessons apply more widely through the publication of safety alerts, bulletins and discussion at team meetings. A section on lessons learnt from Serious Incidents is included in the quarterly Governance newsletter, 'Quality Street'. Closed Serious Incidents are also discussed at the Directorate Governance Meetings as well as the Regional Patient Safety Learning Forum, hosted by the CCG.

The Governance Team also facilitate a Trust wide 'Dare to Share' Learning Event quarterly where learning from serious incidents is shared. The next Dare to Share meeting has been scheduled for the 27th October 2017.

Findings from Serious Incident reports are shared with the patient and/or family by the Governance Team in line with Trust's Duty of Candour.

2.4 Open Serious Incidents

There is one Serious Incident which currently remains open and is under investigation:

1. Missed Fractured Calcaneum Fracture Clinic ED

2.5 Serious Incidents Submitted for Closure

During the reporting period, the investigation into the Never Event in Orthopaedics was concluded and the submitted to Nene and Corby CCG:

1. Wrong site surgery Trauma & Orthopaedics

STEIS Number	Directorate
2017/10359	Trauma & Orthopaedics
Brief Description of Incident	
Wrong site surgery	
Actions	
1. Review and amendment of Trust Consent Policy. This will include the use of primary data source. 2. Agreement of a robust process for two-clinician consent to be undertaken on the ward before a patient lacking mental capacity is collected for theatre. 3. Further education of clinical staff in the application of the Mental Capacity Act/ Best Interest Assessment – particularly in relation to Consent.	

4. Production of a procedure document for the work flow for the Trauma co-ordination role in relation to the Trauma list.

5. Revision of the ward checklist to ensure that patients cannot leave the ward until site marking and consent has been completed.

6. Implementation of revised Falls Risk Assessment process across the Trust

7. Additional confirmation of review of available notes, imaging and physical examination

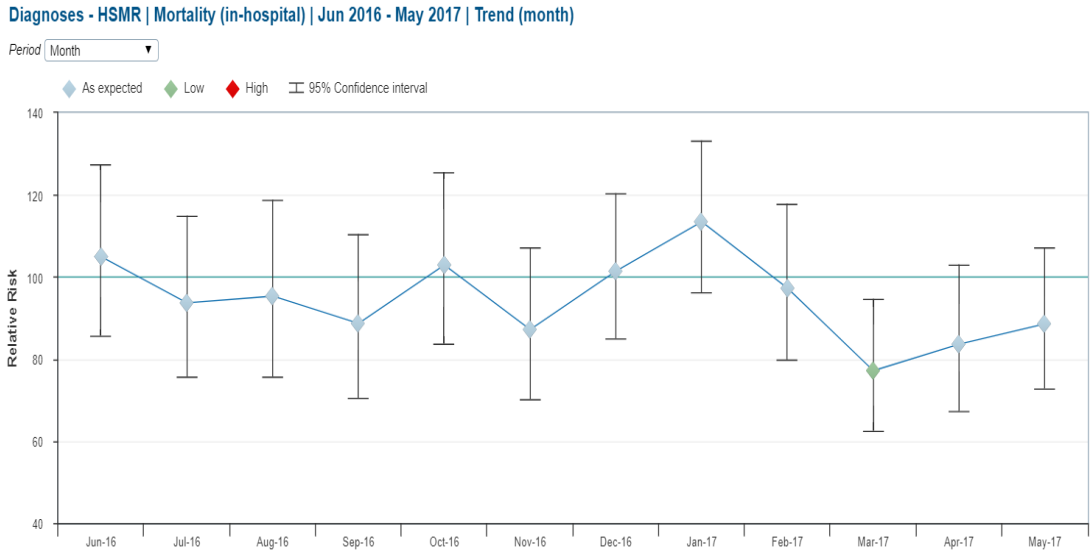
8. Distribution of the consent and Surgical Site Marking policy to all staff in theatre areas with confirmation of the requirement for marking and consent before leaving the ward

9. Trauma and Orthopaedic Directorate to develop counter checking procedure at the Trauma meeting

3. Mortality Monitoring

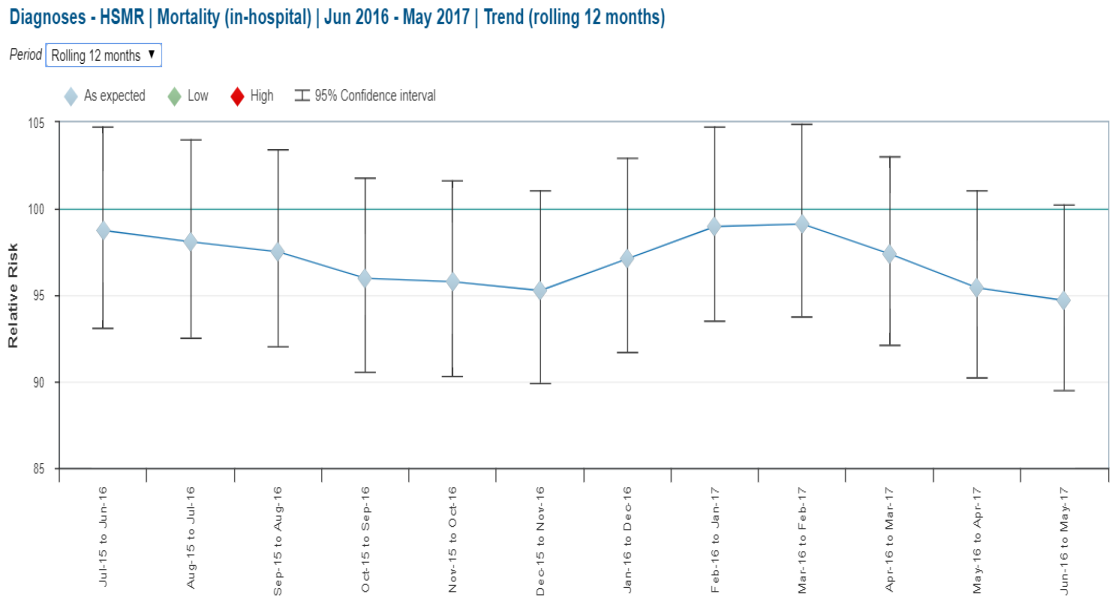
New Dr Foster information was not released in August while a national review by NHS Digital was completed in advance of closure of the data for 2016/17. This review period allows for any potential disputes over the 2016/17 data to be considered after which time it is fixed. There was minimal change in the principle mortality metrics as a result of this data review. The data for the first 2 months of 2017/18 has since been released and is presented here.

The HSMR for the year to May 2017 remains within the 'as expected' range at **94.7**. The variation in HSMR during the year to May 2017 is shown below:

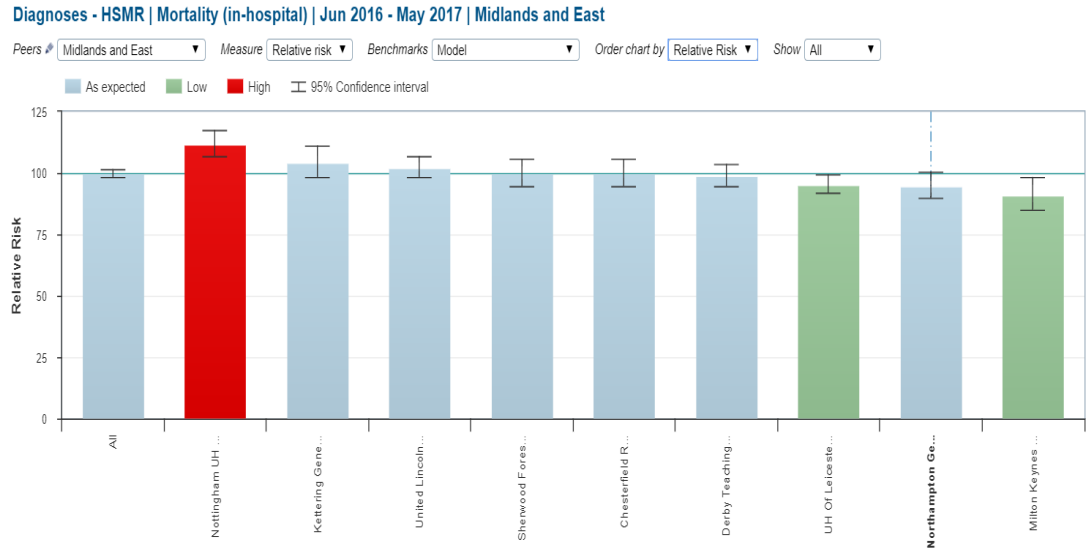


Each data point in the following graphic represents the value of the HSMR during the preceding 12-month period. The previous reduction observed in HSMR during February and March has been sustained through the following months:

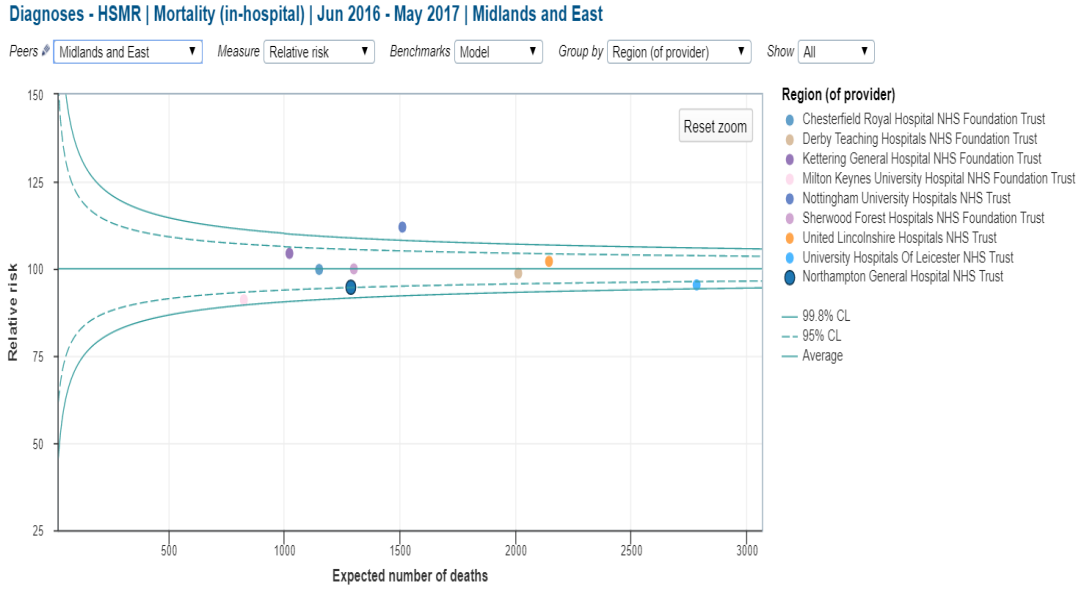
Enclosure D



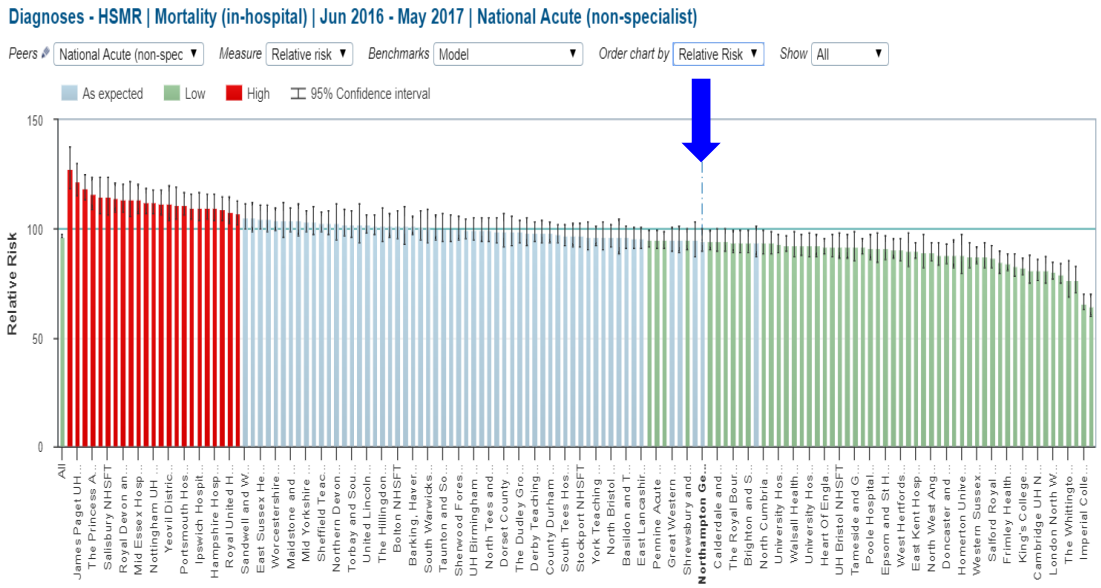
The majority of Trusts in the East Midlands are within the 'as expected' range for HSMR. The Trust remains in a stable position in respect to this parameter relative to the peer group shown below:



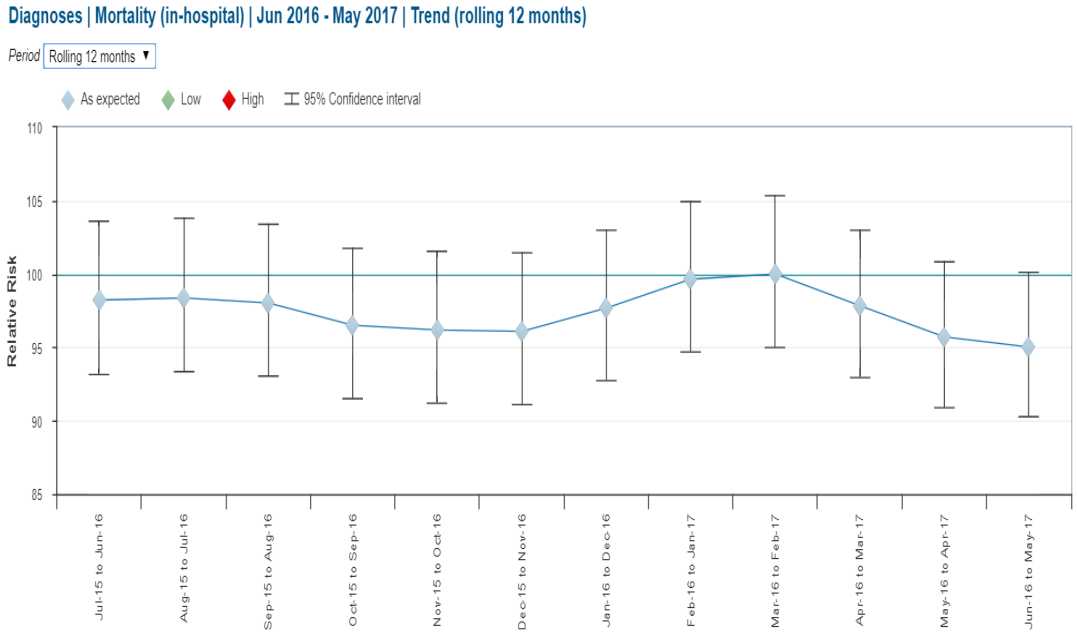
The Trust remains in a stable position in respect to this parameter relative to this regional peer group shown. This data is shown below in a funnel plot where the HSMR for NGH is shown to lie on the lower 95% confidence limit:



Performance against a national group of non-specialist acute Trusts is shown below. NGH is positioned among a number of Trusts with a statistically 'better than expected' HSMR:



The SMR for the All Diagnoses Metric also remains 'as expected' (SMR=**95.0**). The variation in the SMR for All Diagnoses mirrors that shown for HSMR and the rolling 12 month trend is shown below:

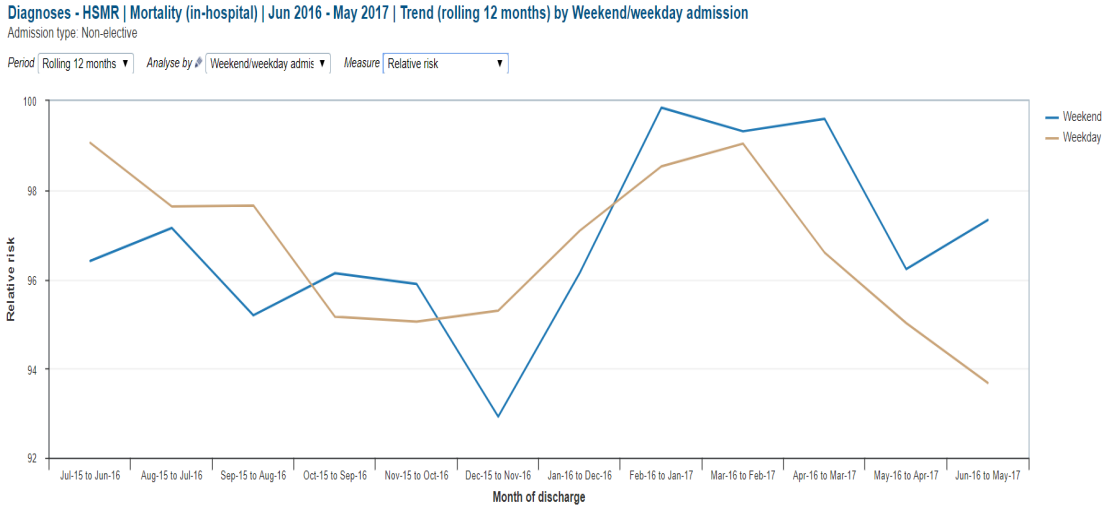


The Trust crude data shows that the mortality rate reduced further subsequently in the months of June to August:

2016				2017			
Month	Discharges	Deaths	Mortality rate (%)	Month	Discharges	Deaths	Mortality rate (%)
Jan-16	8419	126	1.5	Jan-17	9337	168	1.8
Feb-16	8773	102	1.2	Feb-17	8544	124	1.5
Mar-16	9065	114	1.3	Mar-17	9882	106	1.1
Apr-16	9080	141	1.5	Apr-17	8816	112	1.3
May-16	9359	109	1.2	May-17	9575	129	1.3
Jun-16	9726	114	1.2	Jun-17	9669	103	1.1
Jul-16	9681	118	1.2	Jul-17	9528	108	1.1
Aug-16	9181	102	1.1	Aug-17	9262	90	1.0
Sep-16	9190	92	1.0	Sep-17			
Oct-16	9392	113	1.2	Oct-17			
Nov-16	9637	107	1.1	Nov-17			
Dec-16	9215	150	1.6	Dec-17			

3.1 Weekend Effects

There is no significant difference for HSMR for patients admitted as an emergency on weekdays (**97.3**) compared with weekends (**93.7**). Both remain in the 'as expected' range:



3.1 New Alerts

There were no new alerts during April and May 2017.

3.2 Acute and Unspecified Renal Failure and Sepsis Review

Mortality Review 10 will focus on Acute and Unspecified Renal Failure and Sepsis. Both conditions have been the subject a recent mortality. A specific proforma for both groups of patients has been developed and training for new reviewers has taken place.

The challenge meetings will take place in September and October. The draft report will be presented to the Mortality Review Group in November and then shared with the clinical divisions. The divisions have been invited to a review meeting following this to agree key actions.

3.3 Mortality Review Process

Interviews for the Mortality Screeners have been scheduled in September. The mortality administrator has been advertised with expressions of interest.

In line with national requirements, the outcome of these reviews and the learning from them will be reported to the Board in the November.

NGH is a contributor to the Learning Difficulties Mortality Review and must now notify the LeDeR of all relevant deaths (as of 1st Sept 2017) that occur. The existing local processes for reviewing deaths among patients with learning difficulties will also continue while the national processes become embedded.

Three consultants from NGH have volunteered to be part of the Local Area Review Team that will carry out both the “light touch” and the “multidisciplinary reviews” as part of the LeDeR programme across all healthcare providers in the region.

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	**PUBLIC TRUST BOARD**
Date of Meeting	**28 September 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 Natalie Green, Associate Director of Nursing
Purpose	Assurance & Information

Executive Summary

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

Key points from this report:

- Safety Thermometer - In August 2017 the Trust achieved 97.85% harm free care (new harm)
- Pressure Prevention - 12 patients were harmed in August 2017 with 12 pressure ulcers, (11 Grade 2 pressure ulcers, and 1 unclassified pressure ulcer)
- Infection Prevention - There were no MRSA or MSSA in August 2017. There was 1 patient identified with Trust attributable Klebsiella, 1 with *Enterococcus* bacteraemia and 1 patient reported with Pseudomonas Aureginosa. 4 patients were identified with Trust attributable E coli bacteraemia. There were 0 patients identified with Clostridium Difficile Infection in August 2017 the Trust remains above the CDI trajectory for 2017/2018
- Falls - There were one moderate and one severe harm patient falls reported in August 2017, both of these cases are currently being reviewed by the team
- Friends and Family Test (FFT) - Trust wide results continued above the mean line in August at 92.2%. The past 10 months have all been static and above the mean of 92%
- There is an update on the Safeguarding and the Nursing and Midwifery Dashboard
- Safe staffing for August demonstrates that the overall fill rate was 102%.

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

Enclosure E

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
September 2017

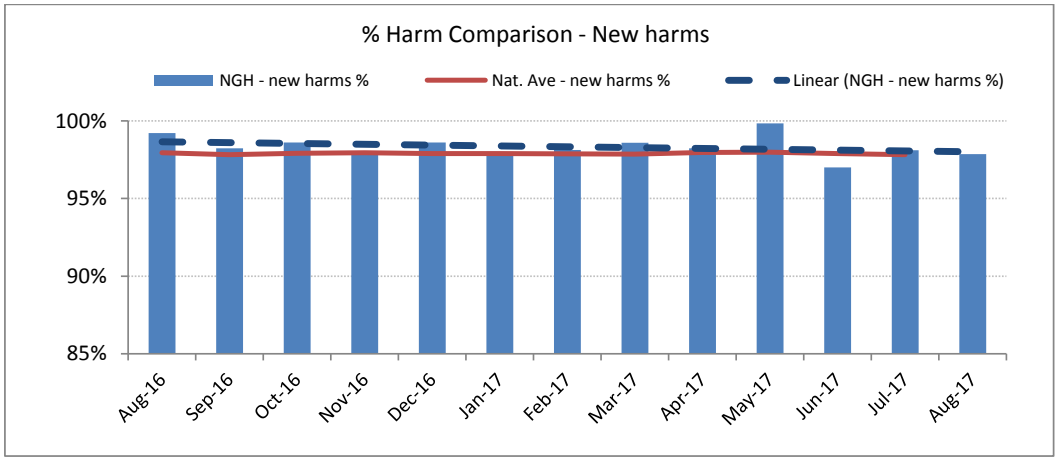
Director of Nursing & Midwifery Report

1. Introduction

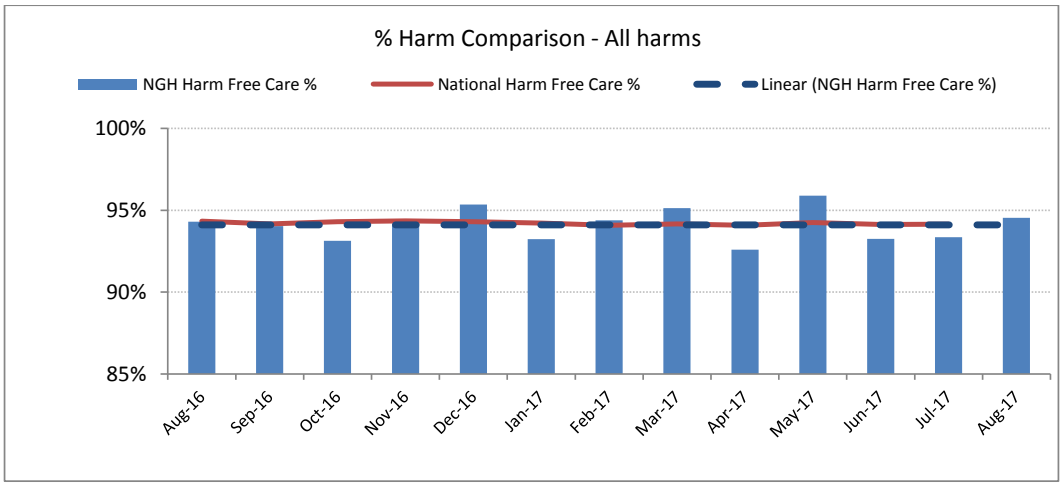
The Director of Nursing & Midwifery (N&M) Report presents highlights from services, audits and projects during the month of August 2017. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. 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 August 2017 the Trust achieved 97.85% harm free care (new harm); which is a slight decrease to last month's percentage.



The graph below illustrates overall harm free care was 94.54% in August; this is an increase to last month, remaining below the national aim of 95%. (Appendix 1 provides the National Safety Thermometer Definition).



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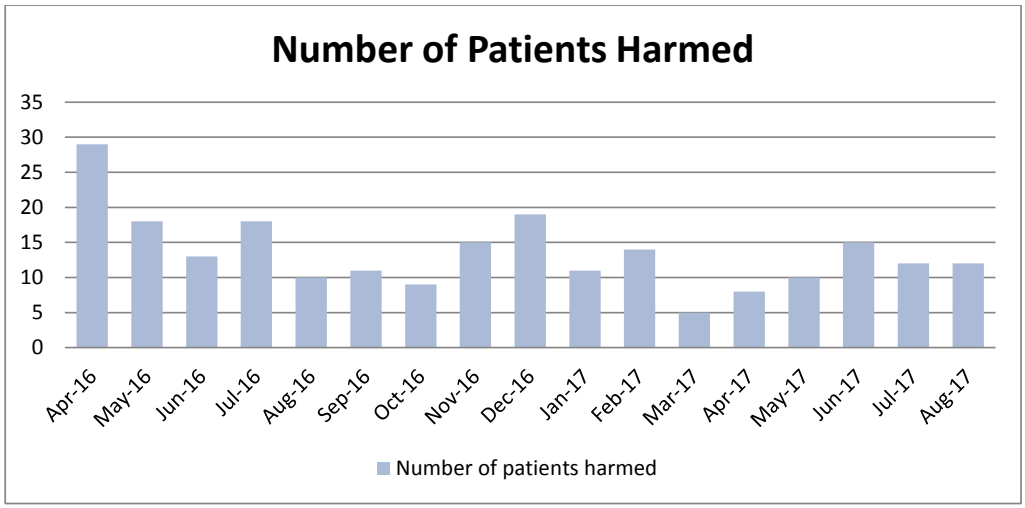
3. Pressure Ulcer Incidence

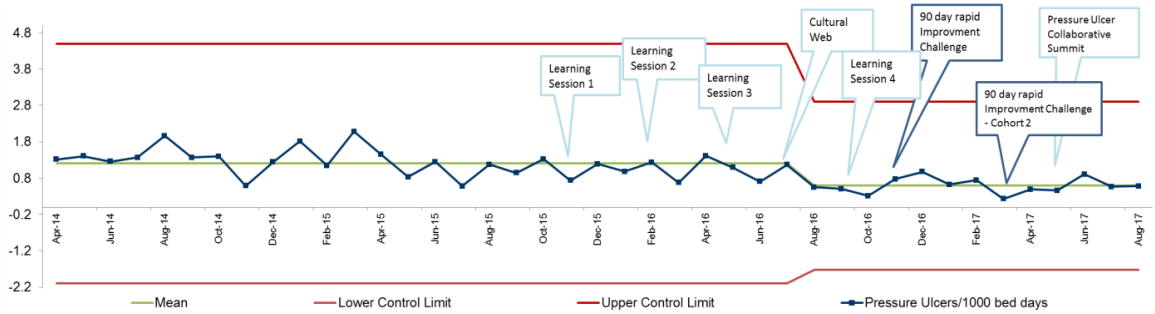
In August 2017 the Tissue Viability Team (TVT) received, a total of 317 incident reports relating to pressure damage. Of these 26 were duplicated reports, 28 patients were not seen as either not admitted or discharged within 24 hours of reporting pressure ulcer (PU) harm. Of the remaining incidents reported, 65% were validated by the TVT on the wards; the remainder were validated from photographs.

The graph below shows that 12 patients, with 12 PU's were harmed in August 2017 (11 Grade 2 pressure ulcers, 1 unclassified pressure ulcer).



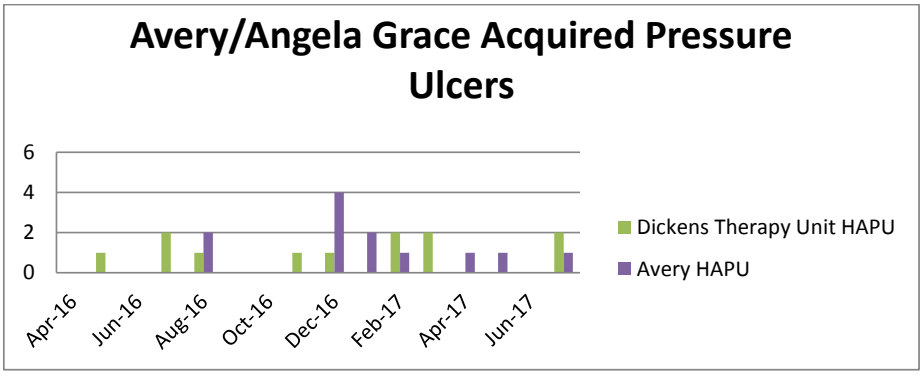
Number of Pressure Ulcers per 1000 bed days

The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers by Quality Improvement (QI) methodology, utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements that has been made since August 2016. The data illustrates 2 points below the mean line since June 2017.



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 were no acquired pressure ulcers (Grade 2-4) in August. One patient was readmitted to NGH with an sDTI at the end of the month which the TVT are monitoring.



Pressure Ulcer Prevention August Update
Althorp Ward: Has achieved 356 days (as of 7th September) without a pressure ulcer.

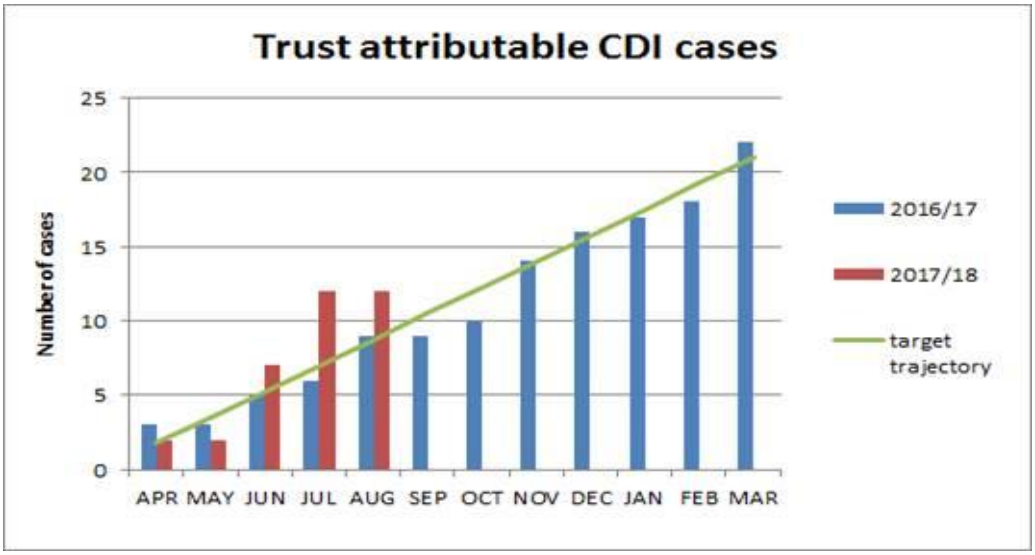
SSKIN Audit: The TVT carried out a second audit of compliance to the SSKIN Bundle in August; results will be disseminated following September's Pressure Ulcer Steering Group.

4. Infection Prevention and Control

This month there has been an update from Public Health England (PHE) regarding the Hepatitis B immunisation recommendations, which were developed in light of recent global shortages of the vaccine. These recommendations include dose sparing advice to preserve vaccine stock for those at highest immediate need. The Trust's Occupational Health Department have reviewed the Trusts protocol and undertaken a risk assessment, all contamination injuries will be seen promptly for a contamination injury risk assessment. In high risk incidents where Hepatitis B Immunoglobulin (HBIG) is indicated the Consultant Microbiologist will be contacted and A&E will arrange administration. IPCT and Occupational Health in collaboration with other colleagues are preparing a campaign across the Trust focusing on safer use of sharps.

Clostridium difficile Infection (CDI)

Clostridium difficile infection (Trust attributable)



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The above graph shows the number of patients with Trust attributable CDI. In August 2017 there were 0 patients with Trust attributable CDI, currently the Trust remains above the target trajectory.

CDI patients

The table below demonstrates the Trust apportioned cases to date that are awaiting review.

CDI Cases	CDI cases no lapse in care to date	CDI cases lapses in care	CDI cases awaiting review
12	9	0	3

All cases of CDI are given a severity score by the IPC Team utilising the national definition, which determines the appropriate treatment for the patient.

Clostridium difficile infection surveillance update

As previously reported in the future the way that the CDI data is categorised will be changing. All CDI data is reported on the HCAI Data Capture System (HCAI DCS) going forward this instruction will include additional data to facilitate the collection of information relating to any prior admission to the same hospital by the patient within two set periods of time (4 and 12 weeks).

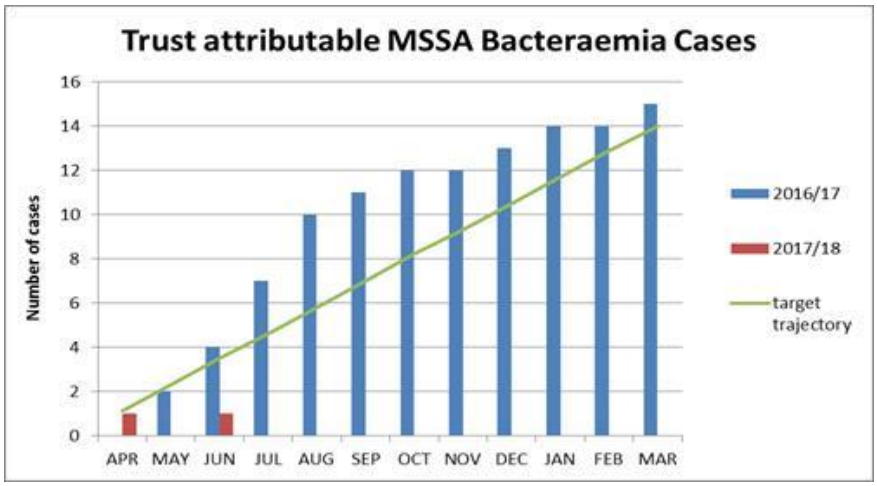
The current reporting year 2017/18 will continue with the existing categorisation in regards to our performance trajectory. (The new categorisations and DCS data flowchart are set out in Appendix 2).

MRSA Bacteraemia and Colonisations

MRSA bacteraemia: 0 Trust attributable MRSA bacteraemias in August 2017.

MSSA Bacteraemia

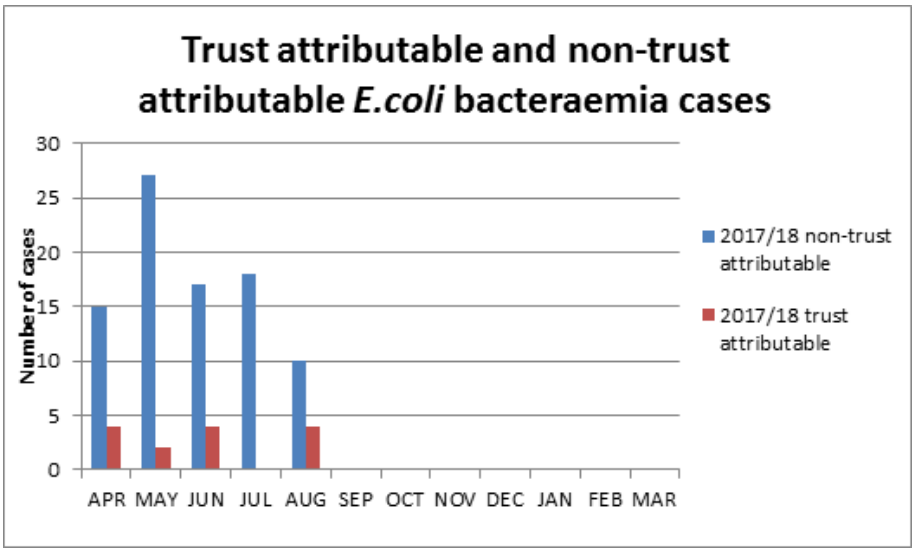
MSSA bacteraemia: 0 Trust attributable MSSA bacteraemias in August 2017.



Escherichia coli (*E.coli*) Bacteraemia

In April 2017 all Trusts was asked by NHSI to continue to collect baseline data for *E.coli* bacteraemia and commence additional data collection for other gram-negative bacteraemia. This was reviewed nationally in June 2017 and a decision taken to ask all Clinical Commissioning Groups (CCGs) to reduce *E.coli* bacteraemias by 10% in 2017/18.

The local CCG ambition is supported by the Quality Premium and will require a whole health economy approach. Therefore, working in collaboration with Northampton General Hospital IPC Team, Public Health England, Kettering General Hospital IPC Team and the Community Lead IPC Nurse, the CCG has produced a draft *E.coli* action plan which will be reviewed at subsequent whole health economy meetings, a summary of the action plan will be reported when it is finalised.



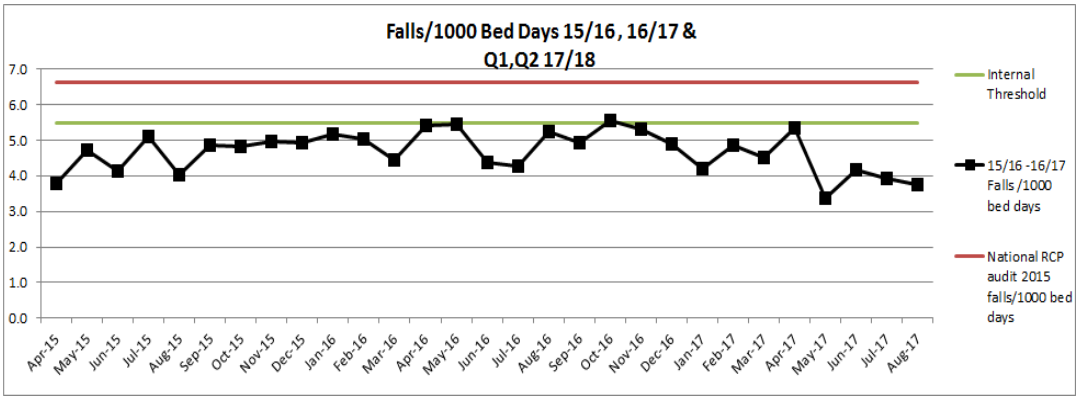
In August 2017 there were 10 non-trust attributable *E. coli* bacteraemia and 4 trust attributable bacteraemias.

Source of Infection August 2017	
Urine	1
Unknown	1
Intra-abdominal	1
Invasive device	1

5. Falls Prevention

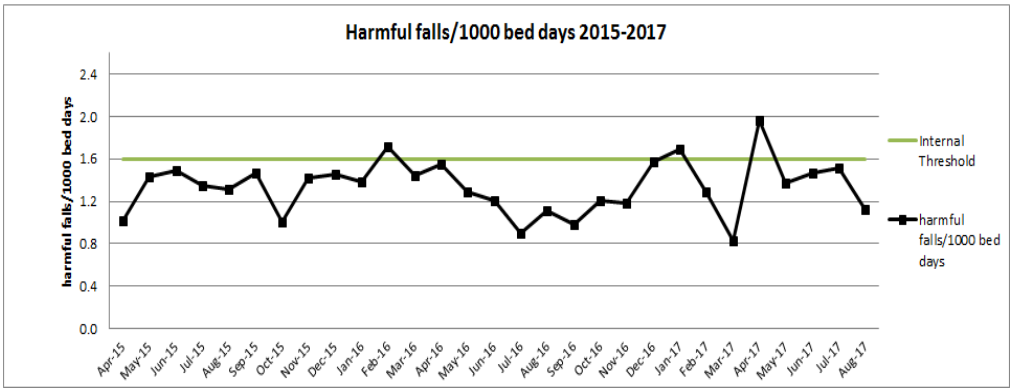
Falls/1000 bed days

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 a reduction in the number of falls/1000 bed days of 0.18 compared to the previous month of July 2017.



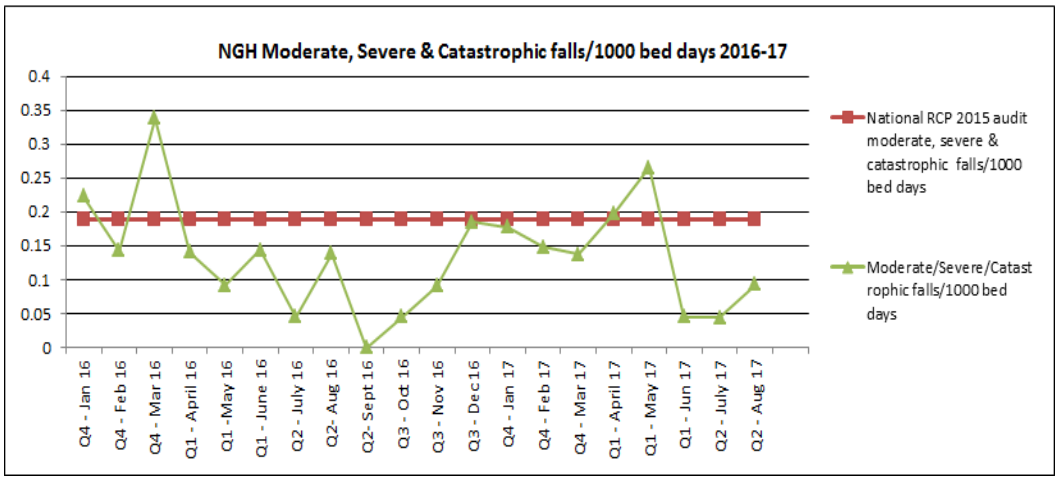
Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic

The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through August 2017 harmful falls/1000 bed days have decreased by 0.39, in total the Trust recorded 1.12 harmful falls/1000 bed days compared to 1.51 harmful falls/1000 bed days in July 2017. The Trust has an internally set target of 1.6 harmful falls/1000 bed days.



Falls resulting in moderate, severe or catastrophic harm

The following graph shows that moderate, severe and catastrophic falls/1000 bed days have increased in August 2017. In total 0.09 moderate /severe and catastrophic falls were recorded in August 2017, an increase of 0.05 when compared to July 2017. One moderate harm patient fall and one severe harm patient fall were reported in August 2017, compared to one severe harm fall in July 2017.



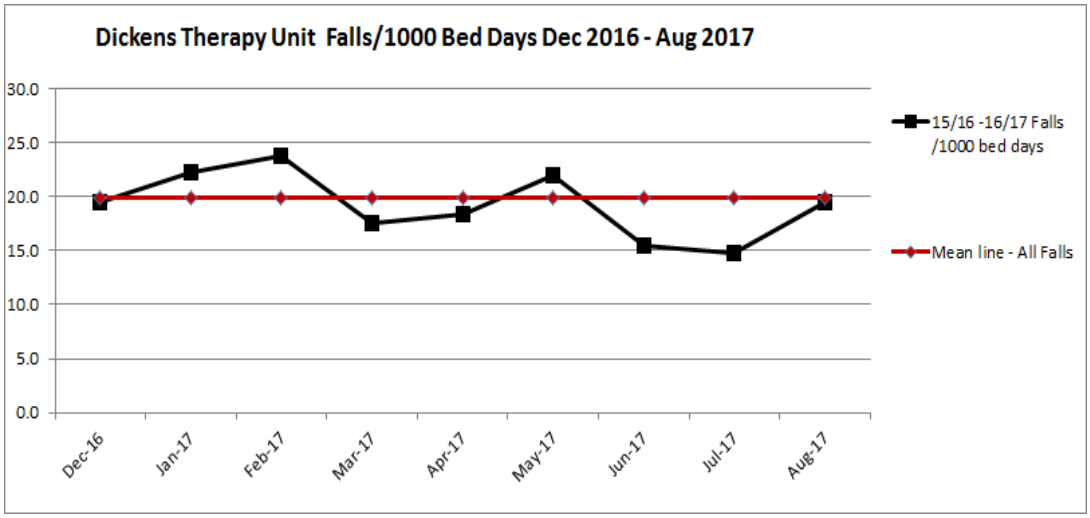
Dickens Therapy Unit
The bed days calculated for Dickens Therapy Unit (DTU) have not previously been counted in the existing bed day's data used to report the Trust's falls /1000 bed days.

Previously patient falls at DTU have been reported against the Trusts internal target of 5.5 falls/1000 bed days and The Royal College of Physician 2015 national average of 6.63 falls/1000 bed days. Within the National Audit the patient falls/1000 bed days that were declared were higher from community hospitals. These hospitals tend to have a more rehabilitation focus. The average for community hospitals was found to be 8.6 falls /1000 bed days. However, this was not used as a standalone target and the national figure is 6.63 falls/1000 bed days.

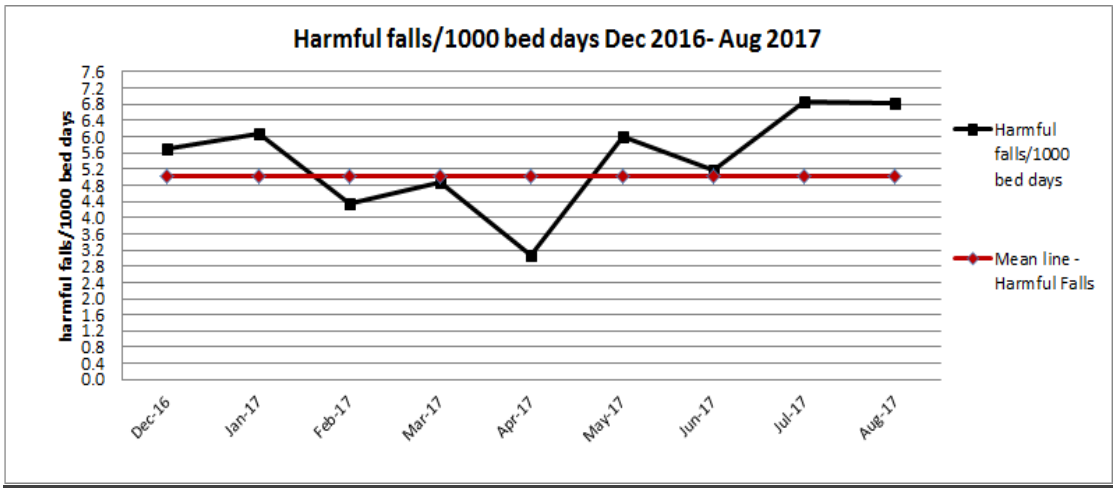
In order to bench mark the reported falls rates at DTU other units with a similar patient demographic and model were contacted to compare patient falls rates. One unit that was spoken to records data differently so it is not directly comparable; however some estimates have been made to compare falls/1000 bed days using occupancy data and falls rates that were provided. The data demonstrated that the falls rates were variable month by month at the unit. Some months falls rates were higher than those calculated at DTU and some months much lower. The data does demonstrate that higher than average falls/1000 bed days are not uncommon in such specialist units.

Actions undertaken at DTU include; staff training, a new monthly report to review patient falls rates, the standard operating procedure has been reviewed, Doctors training on admission criteria has been booked and a thematic review of harmful falls has been undertaken. Patient falls at DTU will continue to be measured and their performance monitored.

Falls/1000 bed days at Dickens Therapy Unit
The number of patient falls/1000 bed days increased in August 2017 by 4.8 compared to July 2017. The increase in falls/1000 bed days is due to an increase in patients who have had more than one fall in the month of August.



Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate and severe falls/1000 bed days. Harmful patient falls reduced in August 2017 by 0.04 when compared to July 2017. The total number of falls remains the same as July 2017 but bed occupancy was higher in August 2017 accounting for the reduction seen. There were no moderate or severe harm patient falls in the month of August 2017.



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 with a reduction in the number of questions asked. The proposal is to further reduce the QCI dashboard once the Assessment & Accreditation programme is fully established and 'rolled-out' across the Trust.

Please see (Appendix 3) for a definition of the Nursing Midwifery Dashboard, (Appendix 4) for the Nursing dashboard, (Appendix 5) for the Paediatric dashboard and (Appendix 6) for the Maternity dashboard. The specialist areas have all updated their QCI questions the IT

department are reviewing timeframes for the work to be completed by uploading onto the HIVE, theatres new QCI's are being uploaded currently and should be ready to use next month.

The QCI for August 2017 demonstrations the following:

Trust wide Overview of the Dashboard

- In August there were a total of 10 red domains on the QCI dashboard for the general wards, of which 4 were within the domain of first impression this is an increase from last month when there were 9 red domains. The first impression section is matching with the wards that are Amber or Red on the assessment and accreditation evaluation, work is taking place with the relevant band 7's to improve upon these results.
- Compliance with falls assessments and pressure prevention assessment has been high focus for the teams with improvement seen on this month's dashboard, review continues in the 'collaboratives' and at the 'share and learn' meetings. There is only 1 red for these two assessments this month and that was in the falls assessment category.

Surgical Division

- There were 2 red domains on the QCI dashboard in August 2017 for Surgery.
- Head and Neck Ward had 1 red domain for first impressions; the assessor felt the ward scored average on 3 questions, the level of coordination on the ward, the general ward environment and the leadership this section is being worked on through their work with assessment and accreditation.
- Willow ward had 1 red domain for patient safety and quality this was due to the fact that the emergency equipment and oxygen cylinders had not been checked on one day of the month
- The Ward Sister, Matron and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas for improvement.

Medical and Urgent Care Division

- Medicine had 6 red areas in August 2017 on the dashboard;
- Collingtree Ward had 1 red domain for falls assessment, which was due to 3/5 care plans being completed and 2/4 reassessments taking place on time. Collingtree also had a red domain for first impressions because the reviewer felt the ward scored average on 3 questions, the level of coordination and leadership on the ward, the general ward environment, however does acknowledge the ward was very busy at the time of the assessment.
- Holcot ward had 2 reds this month one in the domain of protected mealtime and the other for first impressions. Within the protected mealtime domain one question had not been completed which resulted in the lower % compliance
- EAU had a red domain for protected mealtime due to one question in the set not being completed; all other questions were 100%.
- The Ward Sisters, Matrons and the ADN monitor the results monthly and highlight any specific themes or areas to improve.

Gynaecology Children's and Oncology Division

- Talbot Butler and Gynaecology have 2 red domains in August 2017;
- Talbot Butler had 1 for the domain of documentation which was due to incomplete activities of daily living assessments which in turn led to incomplete nursing care plans
- Spencer had their red in the domain asking about the care rounds, the patients reported that the questions were not being asked of them on a regular basis.
- Paediatrics had no red domains which is now the third month in a row
- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to work on.

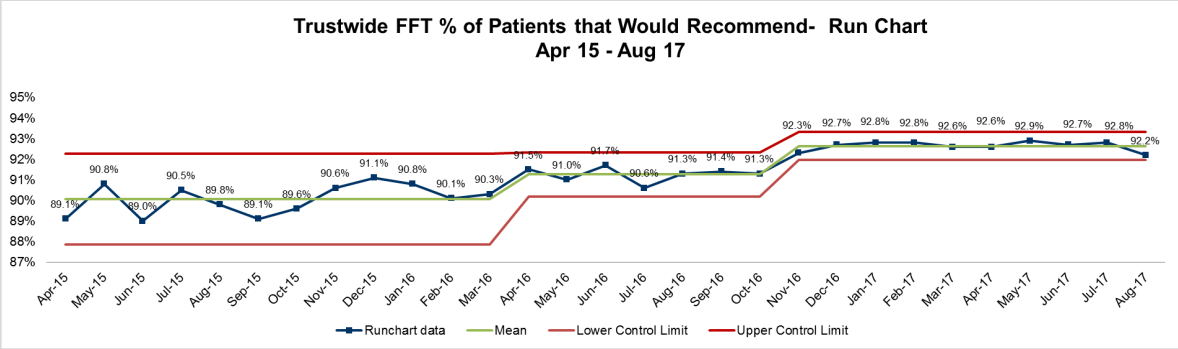
Maternity

- Robert Watson did not complete the QCI audit this month; a discussion has taken place with the band 7 and Matron regarding the importance of undertaking the audit. The ADM will be monitoring their audit completion in the coming months
- Emergency equipment daily checking compliance has been an issue, with checks not performed daily on MOW and therefore received 0%. An action plan is in place which is being monitored by the Matron.
- Maternity Observation Ward, scored 2 Ambers for patient experience (disturbance at night) which can be an issue with labouring women, the second Amber was due to failure to record resuscitation checks daily as previously identified in the Quality and Safety indicator domain.
- The new Associate Director of Midwifery (ADM) will be reviewing the questions and dashboard on going, to ensure the QCI questions relate to the dashboard and are completed appropriately, fully and in a timely manner.

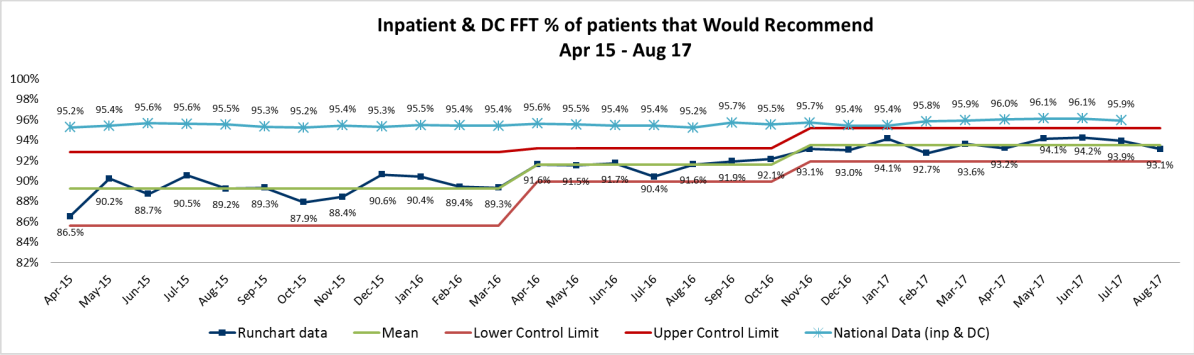
7. Friends & Family Test (FFT)

FFT Overview- % Would Recommend Run Charts

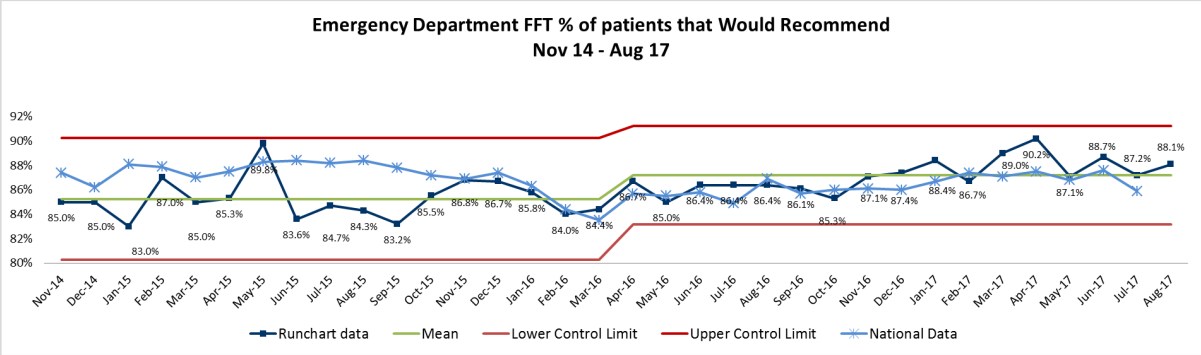
- The Trust wide results saw a slight decrease in August 17; this is likely due to the decrease seen in Inpatient and day case results. It should be noted that this did not move outside of the lower control limit and therefore would be considered normal variation within the data.



- The August results for Inpatient & Day Cases were 93.1% showing a slight decrease when compared with recent months. As with the Trust wide results, this does not move outside of the lower control limit. Given the pressures seen within the hospital for August, response rates fell within Inpatients and this is likely to have also had an impact on recommendation rates.



- The Emergency Department continues to see improved levels of satisfaction, with a number of consecutive months above the mean line, and also above the national average. August saw another improved month at 88.1% recommendation rate.



8. Safeguarding

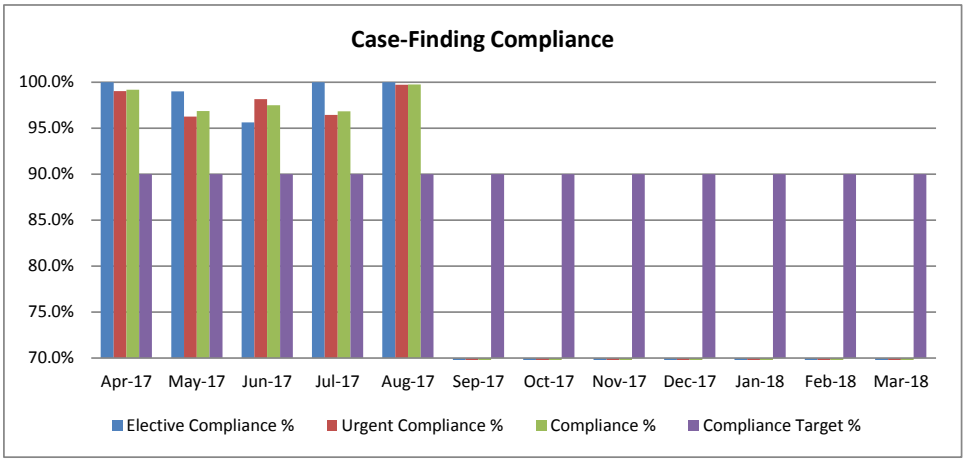
Dementia Activity

National Audit of Dementia Care in General Hospitals 2016-17

The above report was received by the Trust in August 2017 and was discussed at the Dementia Working Group. The Trust completed an organisational checklist, submitted a case note audit, staff and carer questionnaires. One hundred and ninety-nine hospitals took part in England and Wales and results were divided into seven areas. The area where the Trust was ranked highest was governance (84/199) and the lowest area ranked was discharge (177/195). The summary of the report and associated action plan will be discussed at the Patient and Carer Experience and Engagement Group in October 2017.

Discharge Summaries

The overall compliance target remains above 95%, 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 August is 100%.

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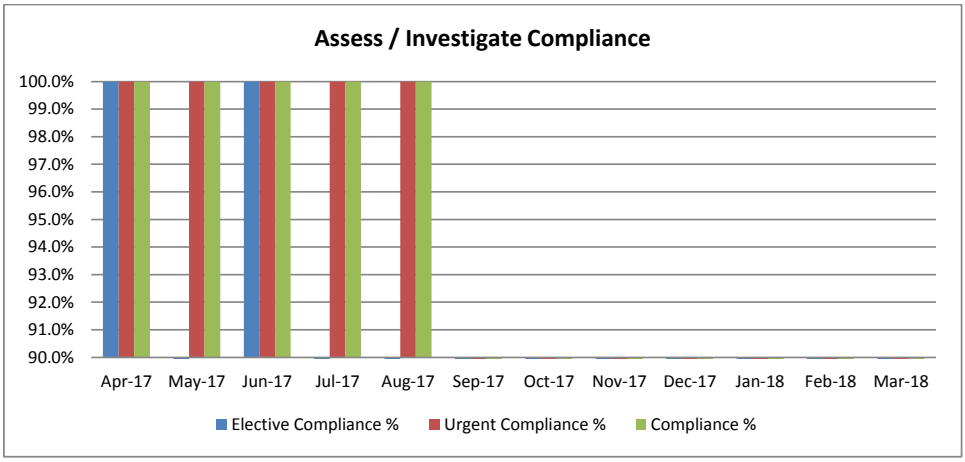
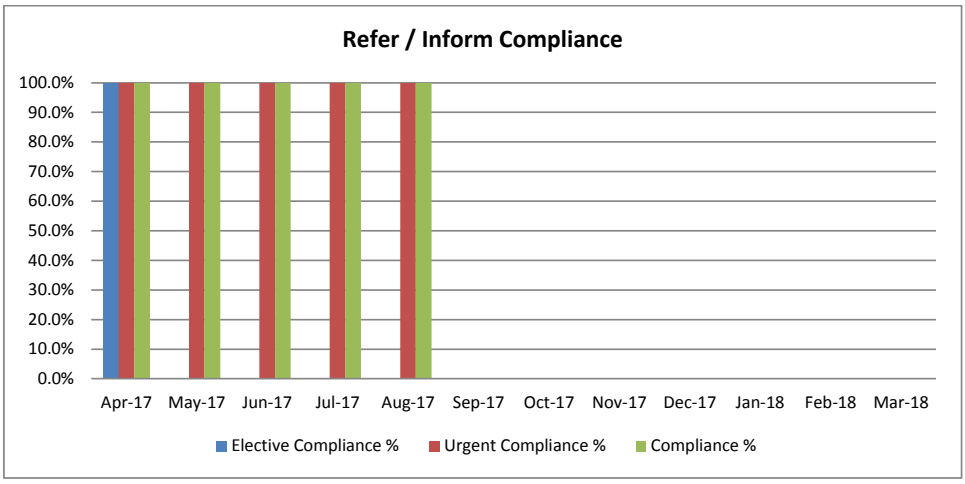


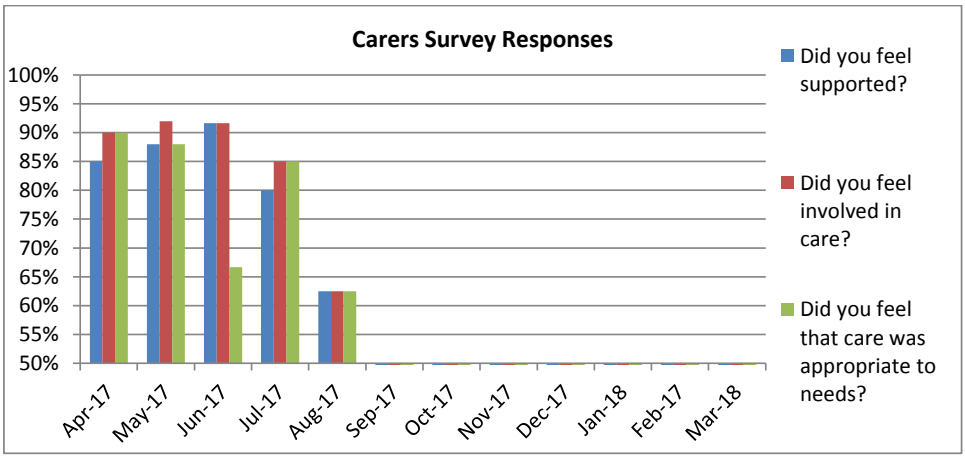


John's Campaign

The John's campaign has been successfully rolled out across all areas, in accordance with the delivery plan. A patient story regarding the benefits of flexible visiting times for families was presented at the 'Patient and Carer Experience and Engagement Group' meeting in August.

Carers Survey

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



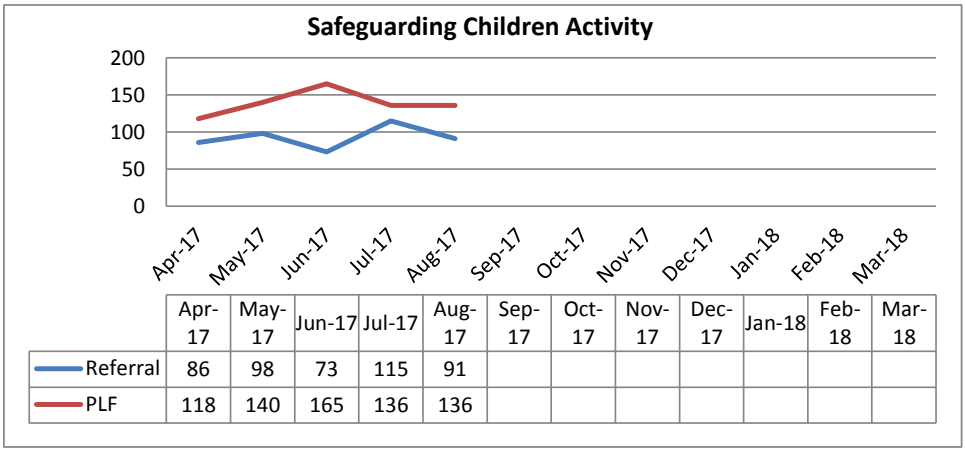
A reduction of carer questionnaires has been noted for August (only 8 written completed questionnaires received) which is a disappointing return and also highlights a general decrease in satisfaction from carers. The newly appointed dementia liaison nurse is reviewing the current process, and:

- the questionnaire format
- how carer's are approached as part of the patient's profile
- the number of questionnaires distributed
- working closely with the wards to ensure more responsive returns

This revised work is planned to be completed by the end of September.

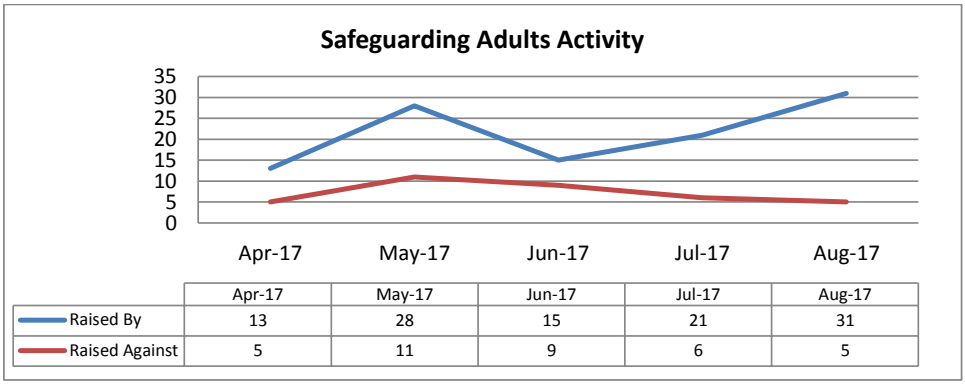
Safeguarding Children and Adult Referrals

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



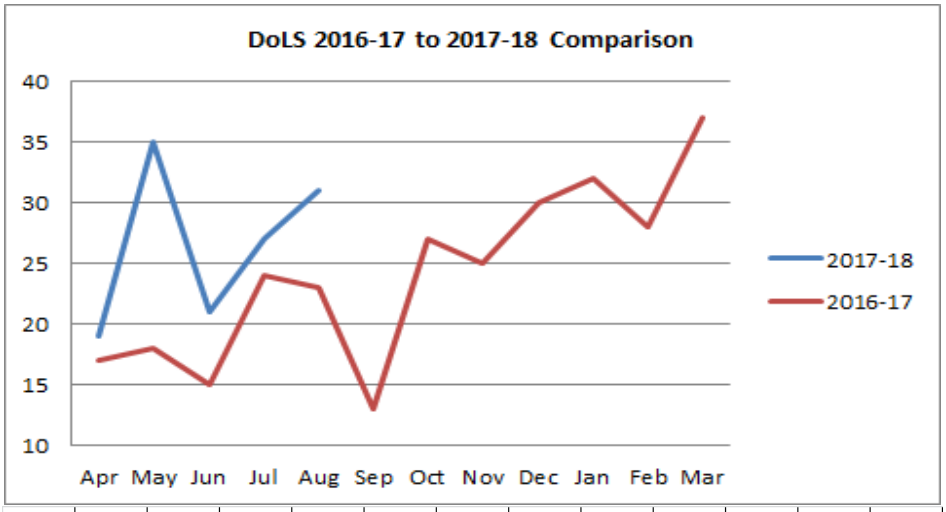
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Referral	86	98	73	115	91							
PLF	118	140	165	136	136							

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



	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Raised By	13	28	15	21	31
Raised Against	5	11	9	6	5

Deprivation of Liberty Safeguards (DoLS)

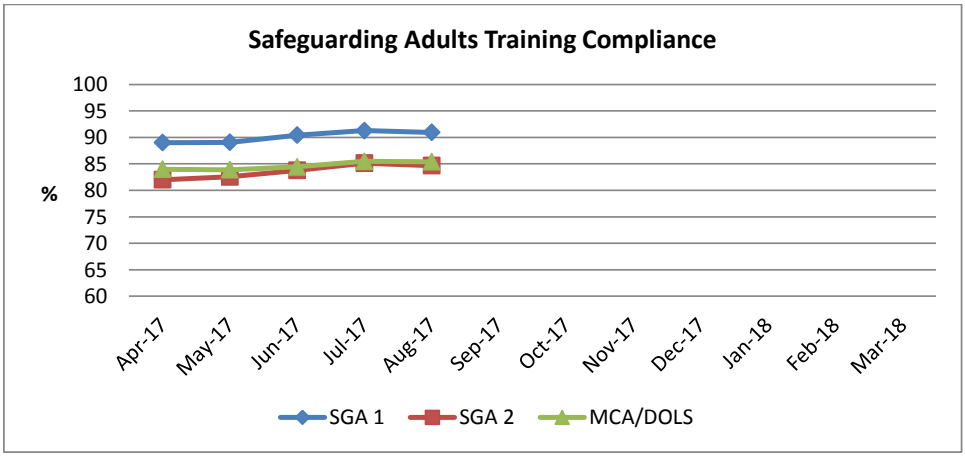


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	19	35	21	27	31							
2016-17	17	18	15	24	23	13	27	25	30	32	28	37

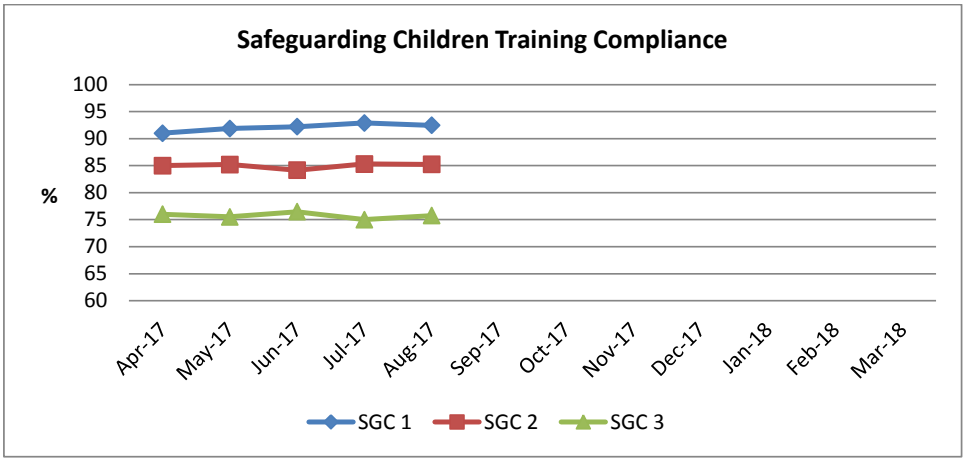
Applications for authorisations to Northamptonshire County Council (NCC) under the DoLS framework continue on an upward trend despite no competed authorisations by Best Interests Assessors (BIA). Internally all DoLS applications continue to be scrutinised on an individual basis by the safeguarding team to ensure that care is delivered in the least restrictive way possible.

Safeguarding Training Compliance

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



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

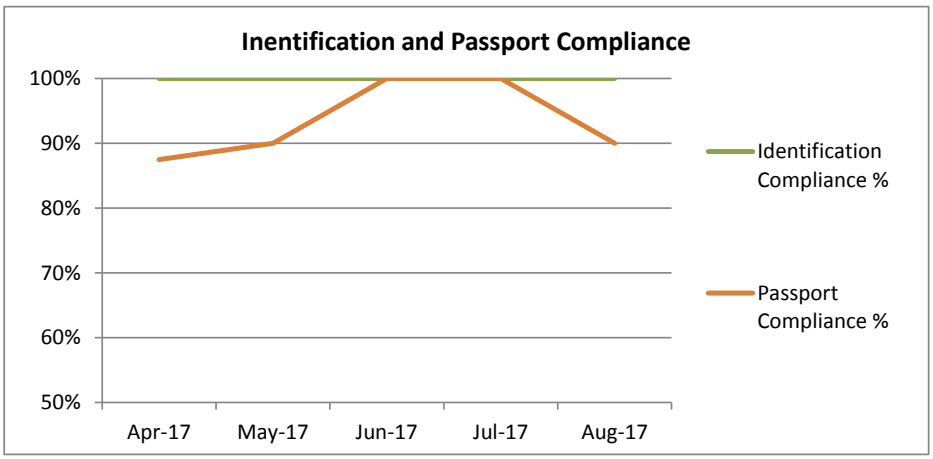


Compliance levels for Level 3 safeguarding children training continues to be a concern as under the required compliance level (85%). Training is being continued to be offered as both scheduled and bespoke. The safeguarding team are also looking at the roles and responsibilities of the staff who have been aligned to level three training to ensure that the appropriate competency level has been assigned.

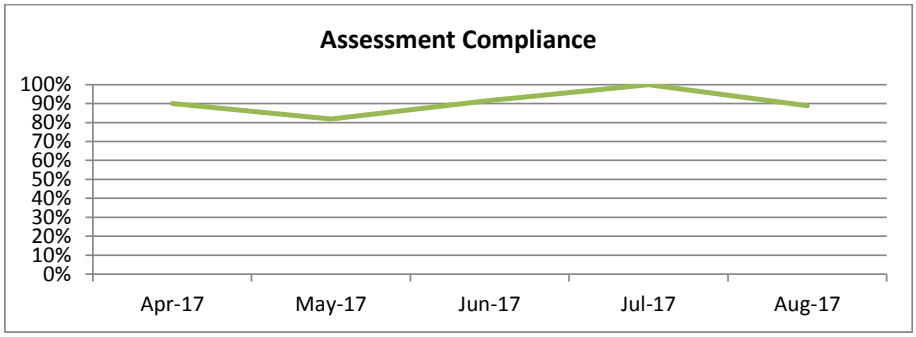
Learning Disability
The Learning Disability Quality schedule is built around three key components:

- 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 August 100% of patients with a Learning Disability who were admitted to the Trust were identified and 90% of those who required a hospital passport received one within the first twenty-four hours of admission as illustrated in the graph below:



For August assessment compliance was 89%. Again trends are illustrated in the graph below:



National Learning Disability Mortality Review (LeDeR)

From 1st September 2017 the Trust will be required to report all deaths of individuals with a Learning Disability to the LeDeR team at Bristol University. This was one of the recommendations of the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD). All deaths of people with a learning disability over the age of 4 and over will be reviewed irrespective of cause or place of death. Families and carers will be part of the review process.

9. Safe Staffing

The overall fill rate for August 2017 was 102%, compared to 104% in July and 104% in June. Combined fill rate during the day was 98%, compared with 100% in July. The combined night fill rate was 109% compared with 109% in July. RN fill rate during the day was 93% and for the night 95%. The Trust has not had a quarterly update in regards to the regional overview of the Safe Staffing data, therefore this will be presented when provided. (Appendix 7)

10. 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

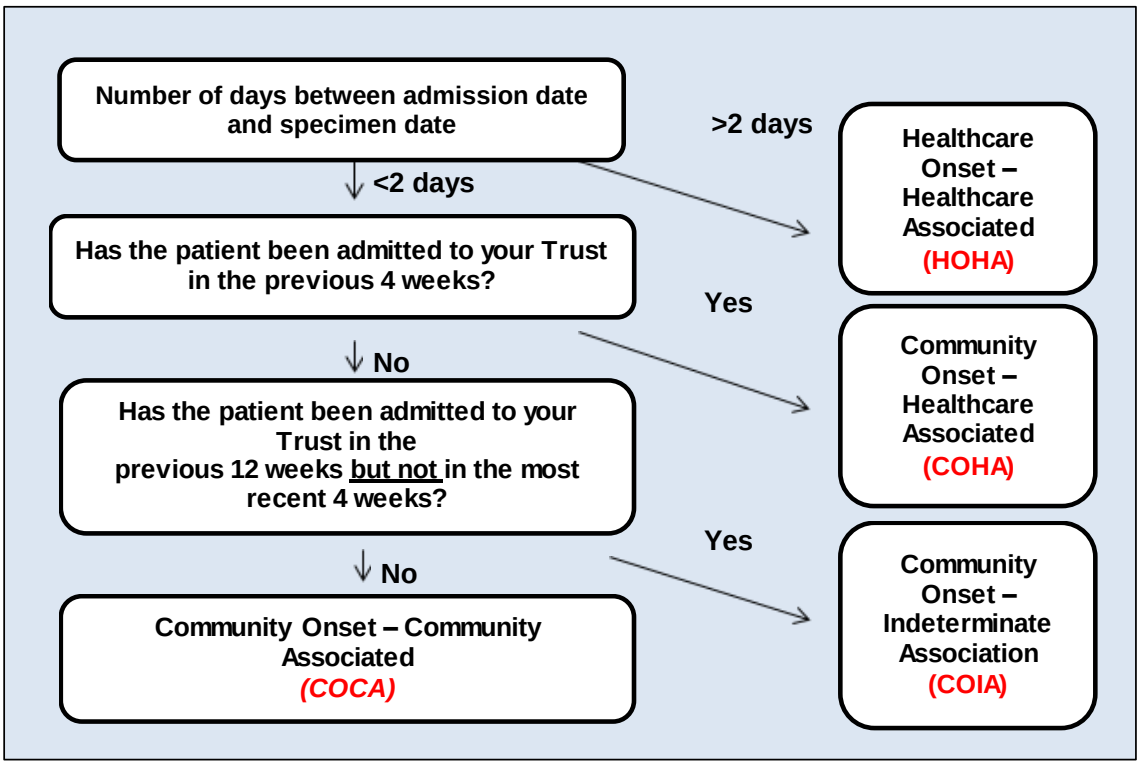
The Department of Health introduced the NHS Safety Thermometer *"Delivering the NHS Safety Thermometer 2012"* the initiative was also initially a CQuIN in 2013/14 to ensure the launch was sustained throughout the nation. The NHS Safety Thermometer is used nationally but is designed to be a local improvement 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



As an example the table below demonstrates what the current Trust data would look like if the new categorisations were applied now.

2017-2018	Current Pre CDI	Current Post CDI	COHA	COIA	COCA	HOHA
April	3	2	2	1	0	2
May	2	0	0	0	2	0
June	2	5	1	0	1	5
July	6	5	3	0	3	5
August	1	0	1	0	0	0
September						
TOTAL	**14**	**12**	**7**	**1**	**6**	**12**

Appendix 3

Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

Appendix 4

Aug-2017	Medicine														WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Holcot	Knightley	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp
Falls/Safety Assessment	100.%	80.%	90.%	90.%	77.%	93.%	100.%	93.%	83.%	100.%	100.%	90.%	90.%	87.%	90.%	90.%	96.%	100.%	88.%	90.%	90.%	100.%	97.%
Pressure Prevention Assessment	97.%	97.%	94.%	100.%	89.%	100.%	100.%	94.%	97.%	91.%	97.%	89.%	94.%	100.%	91.%	97.%	96.%	100.%	100.%	80.%	91.%	88.%	97.%
Nutritional Assessment	100.%	87.%	90.%	100.%	83.%	100.%	97.%	100.%	90.%	100.%	100.%	92.%	97.%	100.%	84.%	100.%	92.%	100.%	100.%	87.%	97.%	96.%	100.%
Patient Observation and Escalations	95.%	95.%	90.%	95.%	95.%	95.%	100.%	100.%	90.%	100.%	95.%	86.%	100.%	95.%	95.%	95.%	100.%	100.%	100.%	100.%	95.%	100.%	100.%
Pain Management	93.%	100.%	100.%	100.%	100.%	100.%	87.%	100.%	100.%	93.%	100.%	87.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	97.%	100.%	93.%	87.%	82.%	92.%	97.%	100.%	92.%	94.%	98.%	93.%	100.%	85.%	73.%	97.%	91.%	96.%	89.%	88.%	100.%	100.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	67.%	100.%	100.%	67.%	100.%	83.%	100.%	80.%	100.%	100.%	83.%	100.%	100.%	100.%	83.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	91.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	91.%	100.%	100.%	91.%	64.%	86.%	100.%	100.%	100.%	100.%	100.%	100.%
Patient Experience - Environment	100.%	80.%	100.%	80.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	80.%	80.%	100.%	100.%	100.%	80.%	80.%	80.%	100.%	100.%	80.%	100.%
Patient Experience - Privacy and Dignity	97.%	95.%	95.%	98.%	87.%	96.%	94.%	95.%	91.%	89.%	99.%	94.%	98.%	95.%	93.%	84.%	95.%	83.%	84.%	89.%	93.%	100.%	100.%
Patient Safety and Quality	100.%	90.%	100.%	95.%	86.%	95.%	95.%	100.%	100.%	100.%	100.%	86.%	100.%	100.%	81.%	95.%	100.%	73.%	93.%	95.%	86.%	95.%	100.%
Leadership & Staffing observations	100.%	94.%	100.%	98.%	84.%	100.%	98.%	98.%	98.%	100.%	100.%	98.%	98.%	100.%	88.%	98.%	100.%	86.%	97.%	98.%	96.%	100.%	100.%
EOL	100.%	100.%	92.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	80.%	83.%	83.%	74.%	66.%	86.%	97.%	80.%	86.%	80.%	86.%	63.%	83.%	86.%	86.%	83.%	86.%	86.%	80.%	74.%	94.%	97.%	100.%
Safety Thermometer – Percentage of Harm Free Care	96.3%	92.3%	89.3%	100.0%	90.5%	83.3%	85.7%	100.0%	100.0%	100.0%	93.8%	93.3%	85.7%	100.0%	92.9%	100.0%	100.0%	100.0%	85.2%	100.0%	100.0%	88.5%	100.0%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	2	0	0	3	1	0	1	0	0	0	0	2	0	0	0	0	1	0	1	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	1	0	1	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0
Falls (Moderate, Major & Catastrophic)	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Overdue Observations frequency - <7%	5.2%	7.1%	11.1%	7.9%	10.5%	8.0%	2.6%	4.4%	10.6%	6.4%	7.0%	3.6%	14.5%	6.6%	7.0%	10.3%	6.0%	7.4%	7.6%	7.4%	5.7%	7.0%	6.2%
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	0
Number of PALS concerns relating to nursing care on the wards	2	0	1	3	1	0	1	1	0	1	0	2	0	3	0	3	2	1	0	0	0	1	0
Friends Family Test % Recommended	94.1%	100.0%	90.9%	85.7%	84.2%	93.3%	80.0%	95.0%	84.7%	89.3%	84.0%	61.5%	100.0%	50.0%	100.0%	81.3%	87.8%	98.1%	91.0%	89.8%	93.3%	98.6%	96.8%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	97%	91%	94%	89%	99%	110%	90%	89%	90%	95%	96%	92%	95%	93%	86%	159%	96%	99%	96%	99%	97%	100%	94%
Staff Nurse Staffing - Support Worker (day & night combined)	131%	97%	165%	125%	139%	158%	123%	96%	160%	106%	162%	151%	102%	192%	111%	283%	115%	108%	130%	114%	131%	122%	86%
Staffing related datix	0	0	0	0	2	1	0	1	0	1	0	0	0	0	0	0	3	0	0	1	0	0	0

Appendix 5

Aug 17	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	100%	100%	100%
Pressure Prevention Assessment (Q)	100%	100%	100%
Child Observations [documentation] (Q)	100%	100%	97%
Safeguarding [documentation] (Q)	93%	100%	100%
Nutrition Assessment [documentation] (Q)	80%	100%	100%
Medication Assessment (Q)	95%	100%	76%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Experience			
Complaints – Nursing and Midwifery	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 Safety & Quality Environment Observations Observe patient records (Q)	100%	100%	100%
Privacy and Dignity (Q)	100%	100%	100%
Management			
Staffing related datix	0	0	0
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	100%	100%	100%

Appendix 6

Quality Care Indicators - Nurse & Midwifery	MATERNITY		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	MOW	Sturtridge
Quality & Safety			
Postnatal Safety Assessment (Q)	100%	100%	80%
Patient Observation Chart (Q)	100%	100%	100%
Medication Assessment (Q)	100%	100%	100%
Environment Observations (Q)	100%	100%	100%
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Emergency Equipment – Checked Daily (Q)	100%	0%	100%
Patient Quality Boards (Q)	100%	100%	100%
Controlled Drug Checked (Q)	NA	NA	100%
Patient Experience			
Complaints – Nursing and Midwifery	0	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Experience (Q)	88%	75%	88%
Patient Safety and Quality (Q)	100%	63%	100%
Leadership & Staffing (Q)	100%	100%	100%
Management			
Staffing related datix	0	0	1
Monthly Ward meetings (Q)	100%	100%	100%
Safety and Quality (Q)	100%	90%	100%
Leadership & Staffing (Q)	100%	100%	100%

Appendix 7

Northampton General Hospital NHS
NHS Trust

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

Ward name	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)				Red Flag	Actions/Comments
	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)	1,910.83	1,843.58	1,384.25	1,706.50	1,069.50	1,060.00	1,069.50	1,504.25	96.5%	123.3%	99.1%	140.6%	847	3.4	3.8	7.2	Red Flag due to one delay or omisson of regular checks	Unforeseen event, escalated appropriately. Care prioritised with no harm to any patients
Allebone Ward (Stroke)	1,610.00	1,323.00	1,142.50	1,169.30	1,414.50	1,276.50	713.00	998.75	82.2%	102.3%	90.2%	140.1%	861	3.0	2.5	5.5		
Althorp (T&O)	944.42	857.17	596.50	491.25	701.50	690.00	384.00	349.50	90.8%	82.4%	98.4%	91.0%	220	7.0	3.8	10.9		
Barratt Birth Centre	1,787.65	1,759.08	720.90	595.50	1,426.00	1,285.25	652.50	582.25	98.4%	82.6%	90.1%	89.2%	129	23.6	9.1	32.7		
Becket Ward	1,814.25	1,590.75	1,414.50	1,335.50	1,552.50	1,460.50	713.00	724.50	87.7%	94.4%	94.1%	101.6%	809	3.8	2.5	6.3		
Benham (Assess Unit)	1,780.25	1,584.75	897.00	1,262.75	1,414.50	1,405.00	713.00	1,392.50	89.0%	140.8%	99.3%	195.3%	746	4.0	3.6	7.6		
Brampton Ward	1,403.90	1,121.25	1,068.50	1,104.73	1,058.00	1,059.00	713.00	1,127.00	79.9%	103.4%	100.1%	158.1%	886	2.5	2.5	5.0	Red Flag due to three occasions for reduced staffing.	All care prioritised accordingly, escalated appropriately. No patient harm occurred due to reduced staffing
Cedar Ward (TRAUMA)	1,884.50	1,875.00	1,764.75	1,938.75	1,069.50	1,069.50	1,069.50	1,506.50	99.5%	109.9%	100.0%	140.9%	904	3.3	3.8	7.1		
Collingtree Medical (40)	2,383.50	2,383.50	1,766.50	1,943.25	1,784.75	1,759.33	713.00	1,505.00	100.0%	110.0%	98.6%	211.1%	1229	3.4	2.8	6.2		
Compton Ward	1,023.50	1,151.83	742.00	1,020.92	678.50	713.00	356.50	713.00	112.5%	137.6%	105.1%	200.0%	556	3.4	3.1	6.5		
Creaton SSU	1,715.75	1,445.15	1,687.25	1,750.25	1,069.50	1,070.75	713.00	1,209.00	84.2%	103.7%	100.1%	169.6%	859	2.9	3.4	6.4		
Disney Ward	2,014.25	1,660.83	962.00	792.08	1,069.50	984.00	356.50	332.75	82.5%	82.3%	92.0%	93.3%	201	13.2	5.6	18.8		
Dryden Ward	2,139.00	1,771.00	978.08	897.58	1,414.50	1,403.00	713.00	724.50	82.8%	91.8%	99.2%	101.6%	793	4.0	2.0	6.0		
EAU New	2,118.75	1,827.20	1,055.30	1,656.30	1,782.50	1,701.25	1,069.50	1,746.75	86.2%	157.0%	95.4%	163.3%	901	3.9	3.8	7.7		
Eleanor Ward	1,065.25	968.00	713.00	727.50	713.00	713.50	713.00	781.42	90.9%	102.0%	100.1%	109.6%	310	5.4	4.9	10.3		
Finedon Ward	2,164.75	2,048.50	367.00	483.00	1,069.50	1,069.50	356.50	690.00	94.6%	131.6%	100.0%	193.5%	496	6.3	2.4	8.7		
Gosset Ward	2,545.20	2,480.50	483.00	475.58	2,104.75	1,952.37	379.50	345.00	97.5%	98.5%	92.8%	90.9%	270	16.4	3.0	19.5		
Hawthorn & SAU	1,962.00	1,876.58	1,069.20	1,348.03	1,426.00	1,384.75	977.50	1,319.08	95.6%	126.1%	97.1%	134.9%	878	3.7	3.0	6.8		
Head & Neck Ward	1,067.00	1,064.25	704.25	716.75	943.00	919.75	356.50	494.50	99.7%	101.8%	97.5%	138.7%	400	5.0	3.0	8.0		
Holcot Ward	1,514.00	1,316.75	1,395.50	1,583.75	1,069.50	1,071.75	713.00	1,598.50	87.0%	113.5%	100.2%	224.2%	880	2.7	3.6	6.3	Red Flag due to one episode of reduced staffing on duty	Care prioritised & escalated, no actual patient harm occurred - internal review as to delays in response
ITU	5,008.75	4,193.50	743.75	614.25	4,565.50	4,094.75	713.00	646.75	83.7%	82.6%	89.7%	90.7%	338	24.5	3.7	28.3		
Knightley Ward (Medical)	706.25	709.33	895.50	829.08	1,058.00	960.75	356.50	446.25	100.4%	92.6%	90.8%	125.2%	655	2.5	1.9	4.5		
Paddington Ward	2,893.13	2,360.42	958.75	796.75	2,133.50	1,715.33	621.00	554.75	81.6%	83.1%	80.4%	89.3%	336	12.1	4.0	16.2		
Robert Watson	1,069.50	1,147.33	1,292.00	994.70	1,044.00	947.33	1,069.50	853.75	107.3%	77.0%	90.7%	79.8%	487	4.3	3.8	8.1		Reduction in MSW has been due to vacancies and long term sick. Interviews planned for mid September
Rowan (LSSD)	1,967.75	1,988.50	1,069.50	1,136.25	1,781.50	1,624.92	707.25	909.00	101.1%	106.2%	91.2%	128.5%	892	4.1	2.3	6.3	Red Flags - there were three occasions when the staffing was below planned off duty.	No harm to patients as reduced capacity of Level 1 patients. Appropriate Staffing levels for level 1 patients has been escalated to the site manager
Spencer Ward	920.00	1,530.13	442.75	1,069.00	713.00	1,063.75	356.50	1,195.25	166.3%	241.4%	149.2%	335.3%	640	4.1	3.5	7.6		
Sturtridge Ward	4,230.50	4,033.67	1,909.50	1,520.00	4,062.75	3,789.67	1,414.50	1,223.00	95.3%	79.6%	93.3%	86.5%	492	15.9	5.6	21.5		Reduction in MSW has been due to vacancies and long term sick. Interviews planned for mid September
Talbot Butler Ward	2,561.75	2,100.75	1,407.00	1,333.33	1,426.00	1,322.50	713.00	1,012.00	82.0%	94.8%	92.7%	141.9%	858	4.0	2.7	6.7		
Victoria Ward	1,190.25	1,048.50	713.00	1,144.50	713.00	724.50	356.50	907.75	88.1%	160.5%	101.6%	254.6%	555	3.2	3.7	6.9		
Willow Ward (+ Level 1)	2,310.50	2,385.83	1,060.50	1,105.50	2,136.75	2,025.33	701.50	793.50	103.3%	104.2%	94.8%	113.1%	861	5.1	2.2	7.3		

Enclosure E

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28th September 2017**

Title of the Report	Financial Position - August (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 August 2017/18.

Executive summary

This report sets out the financial position of the Trust for the period ended August 2017 which was a deficit of £6.3m (£1.5m adverse to plan). Excluding the effect of the missed STF relating to A&E performance, the YTD adverse variance was £1.1m (M4 - £0.847m).

The key issues for this report are:

- Income and activity continues to be the key focus and the identification of recovery actions that can be delivered in year to bring the position back on track would be critical to the Trust being able to deliver the agreed control total for the year.
- Pay position was an adverse variance of £1.0m YTD mainly due to underachievement of CIP and vacancy factor targets, consultants' backpay as well as increase in agency spend in August.
- Agency spend is still below target, £1.1m (YTD) but has increased in August largely due to increase in medical staffing as well as nursing.
- STF income of £2.1m is accounted for in the position, relating to the financial element of the STF and A&E streaming. The appeal for Q1 missed A&E STF was unsuccessful.

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

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Financial Position

Month 5 (August)
FY 2017/18

Report to:
Trust Board
September 2017

Enclosure F

Content

1. Overview

	RAG	This Month Aug	Last Month Jul	Change
I&E Position				
Actual in Month Position (£000's)		(2,092)	(1,502)	(590)
In-Month Position - Variance to Plan (£000's)	✗	(389)	(979)	590
Year to Date Position - Variance to Plan (£000's)	✗	(1,508)	(1,130)	(378)
Forecast End of Year I&E Position (£000's)		(13,546)	(13,546)	0
STF YTD Actual (£'000)		2,099	1,605	494
STF - Variance to Plan (£000's)	✗	(370)	(283)	(87)
EBITDA %	✗	-1.8%	-1.3%	-0.5%
Income				
Elective variance to plan (£000's)	✗	(423)	(397)	(27)
Daycase variance to plan (£000's)	✗	(414)	(583)	169
Non-Elective variance to plan (£000's)	✗	(1,250)	(904)	(346)
Outpatients variance to plan (£000's)	✗	(59)	(53)	(6)
MRET Penalty - YTD Variance to Plan (£000's)	✓	0	0	0
Readmissions - YTD Variance to Plan (£000's)	✓	0	0	0
Contract Fines & Penalties - Variance to Plan (£000's)	!	(18)	(18)	0
Operating Costs				
Pay - YTD variance to plan (£000's)	✗	(1,030)	(665)	(365)
Agency Staff Costs - YTD variance to Cap (£000's)	✓	1,081	1,163	(82)
Non-Pay - YTD variance to plan (£000's)	✗	(105)	38	(143)
Cost Improvement Schemes				
Year to Date Variance to Plan (£000's)	!	(177)	402	(579)
Forecast Delivery (£000's)	✗	9,519	9,739	(220)
Capital				
Year to date expenditure (£'000s)		2,051	1,271	780
% of annual plan Committed	✓	55%	52%	3%
Annual Capital Expenditure Plan (£000's)		13,205	13,175	30
Cash				
Closing Cash Balance (£000's)		1,388	5,600	(4,212)
New PDC / borrowing (£000's)		3,796	4,115	(319)
Debtors Balance > 90 days (£000's)	!	1,792	908	(884)
Creditors % > 90 days	✓	0%	0%	0%
Cumulative BPPC - by volume (%)	✓	99.4%	99.4%	0.0%

Key issues

This report sets out the financial position of the Trust for the period ended August 2017 – overall deficit of £6.3m which was £1.5m adverse to plan. The adverse variance includes missed STF of £0.4m, therefore the pre-STF adverse variance was £1.1m.

The key issues for this report are:

Income

- Income continues to be a key focus as activity remains below plan year to date. Increased length of stay, acuity and delayed transfers of care have contributed to this position. The Divisions are working on recovery action plans to improve the income position for the year.
- A forecast report has been prepared under separate cover and goes into more depth in estimating a potential I&E outcome for the Trust, as well as highlighting the recovery actions identified so far.

Pay

- Pay position was an adverse variance of £1.03m YTD (M4: £665k) which mainly related to unachieved CIP and vacancy factor in the budget, consultants back-pay, and increased spend on agency staff.
- Agency spend remains below the NHSI target by £1.1m (YTD) but has increased in August largely due to increase in medical staffing and nursing.

Non-pay & Reserves

- Non-pay was an adverse variance of £105k (M4:38k fav).
- Unspent reserves of £0.9m (M4: £0.7m) contributed to the I&E position.

Capital

- The Trust achieved a committed capital spend of 55% (M4: 52%) of its overall plan.

Liquidity

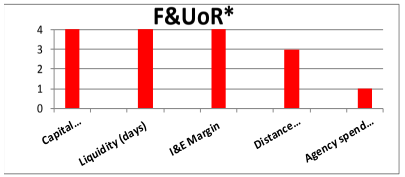
- The Trust continued to access deficit financing as planned.
- STF funding of £2.1m is included in the position.
- A strong rating of over 99% on BPPC performance was maintained.

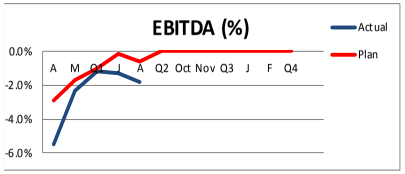
NHSI rating

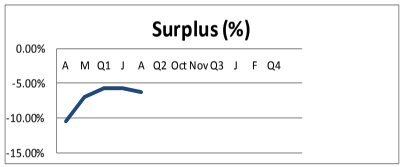
- The Trust continued to score "3" against the Finance and Use of Resources metrics.

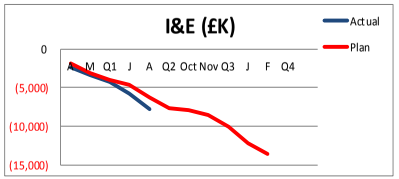
2. KPI & Trend Analysis

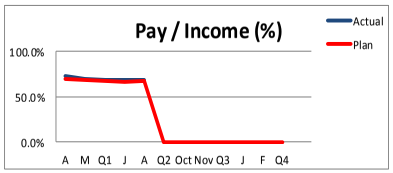
1. Key Metrics

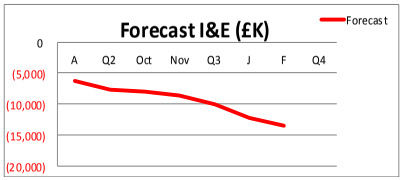




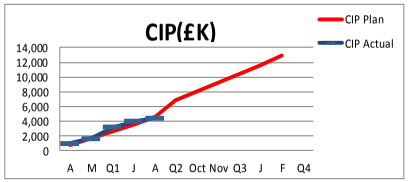


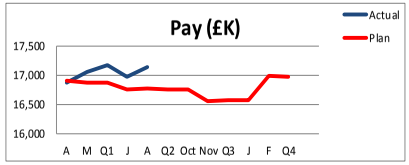


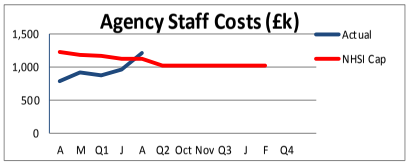


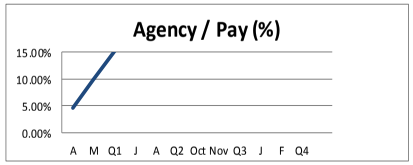


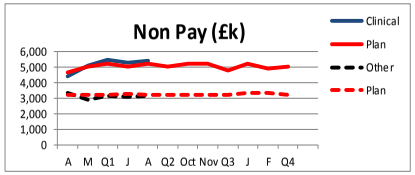
2. I&E Performance

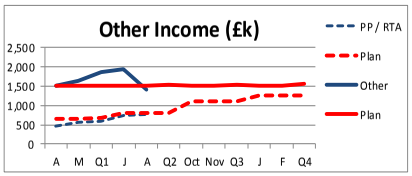




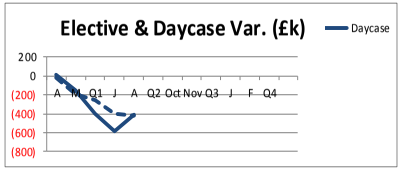


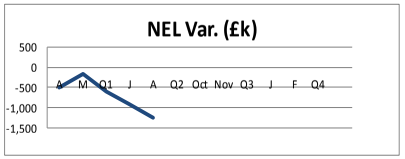


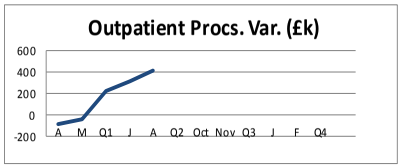


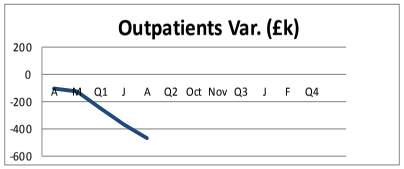


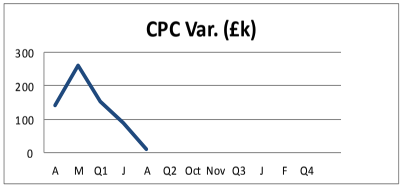
3. SLA Income

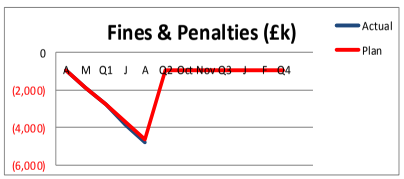




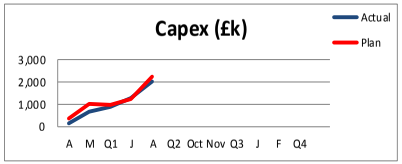


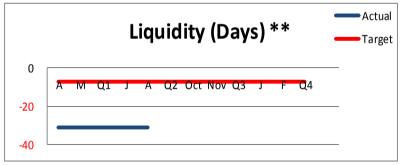


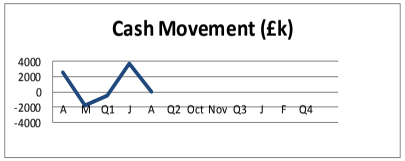


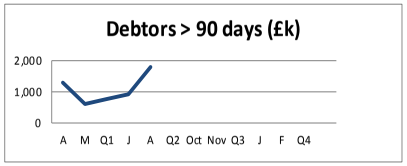


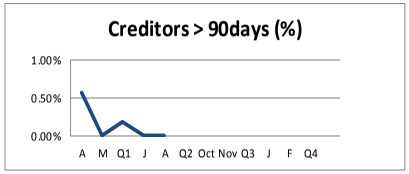
4. Working Capital

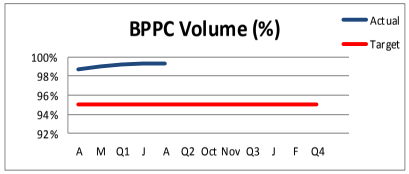












** F&UoP = Finance and Use of Resources metrics*

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

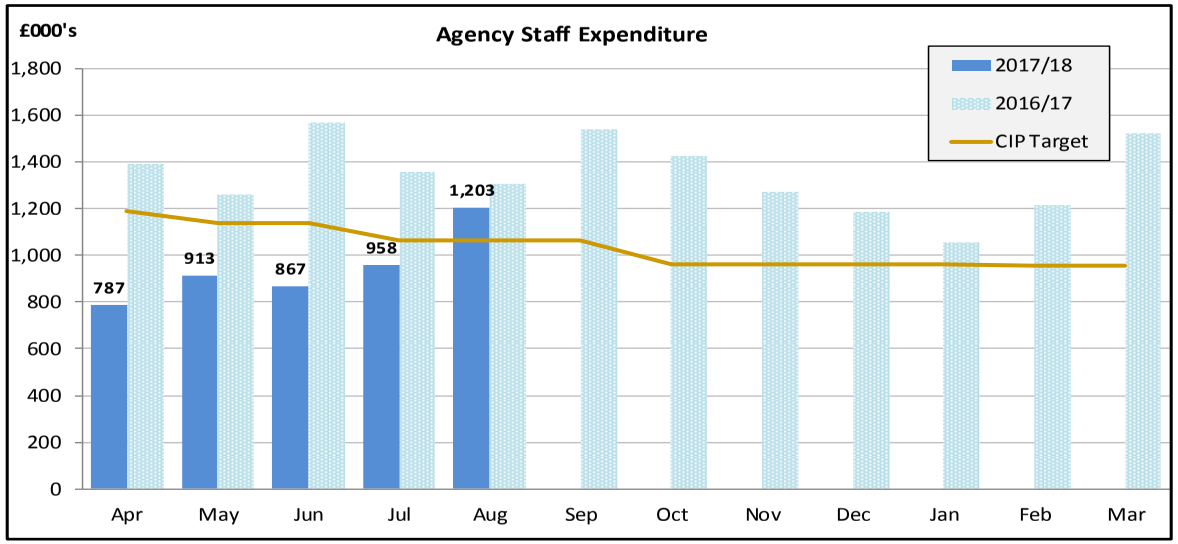
3.0 Income and Expenditure Position

I&E Summary	Actual FY16-17	Annual Plan	YTD plan	Actual FY17-18	Variance to Plan	Aug 17	Jul 17
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	274,325	114,342	112,790	(1,553)	22,582	22,328
Other Clinical Income	2,373	11,435	3,579	3,124	(455)	752	737
Other Income	31,824	18,282	7,576	8,350	775	1,406	1,939
Total Income	294,525	304,042	125,497	124,264	(1,233)	24,740	25,003
Pay Costs	(199,813)	(201,336)	(84,152)	(85,182)	(1,030)	(17,130)	(16,973)
Non-Pay Costs	(94,406)	(99,337)	(41,226)	(41,330)	(105)	(8,580)	(8,408)
Reserves/ Non-Rec		(3,365)	(883)	0	883	0	0
Total Costs	(294,219)	(304,037)	(126,260)	(126,512)	(252)	(25,711)	(25,381)
EBITDA	306	5	(763)	(2,248)	(1,485)	(971)	(378)
Depreciation	(9,703)	(10,205)	(4,116)	(4,116)	(0)	(837)	(837)
Amortisation	(9)	(9)	(4)	(4)	(0)	(1)	(1)
Impairments	(1,732)	(1,826)	(1,291)	(1,039)	252	0	(131)
Net Interest	(720)	(790)	(329)	(319)	10	(67)	(66)
Dividend	(3,307)	(2,669)	(1,112)	(1,118)	(6)	(224)	(210)
Surplus / (Deficit)	(15,165)	(15,494)	(7,615)	(8,844)	(1,229)	(2,099)	(1,623)
NHS Breakeven duty adjs:							
Donated Assets	(414)	122	35	7	(28)	7	(10)
NCA Impairments	1,732	1,826	1,291	1,039	(252)	0	131
I&E Position (breakeven duty)	(13,847)	(13,546)	(6,289)	(7,798)	(1,508)	(2,092)	(1,502)

Key Issues

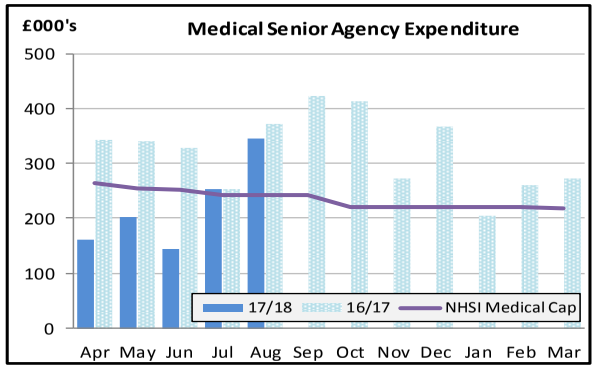
- Income continues to be the key driver behind the Trust's unfavourable financial position as activity year to date is yet to catch-up to the levels anticipated in the plan. The reasons for this are multi-faceted but the Divisions are working on recovery plan actions to improve the position.
- STF is the main reason for the adverse variance on 'Other clinical income' and includes the loss of £370k relating to missed STF for A&E 4 hour performance trajectory.
- Pay continues to average around £17.0m per month which is about £150k higher than plan. In addition, in August an increase in agency spend meant that the pay cost variance grew bigger.
- Non Pay costs is adverse to plan by £0.1m but includes excluded drugs adverse variance of £0.4m which has a corresponding favourable variance in income. Therefore excluding the effect of excluded drugs variance, non pay is a favourable variance to plan.

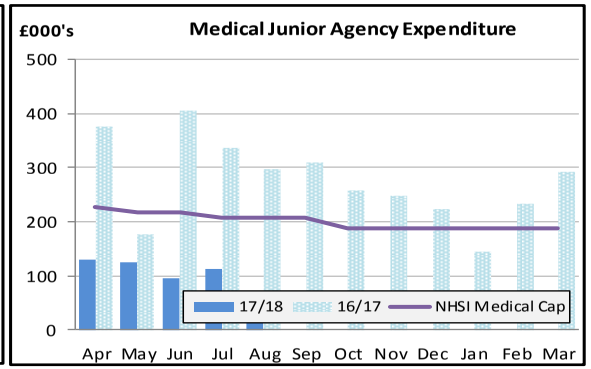
3.1 Agency Staff Expenditure

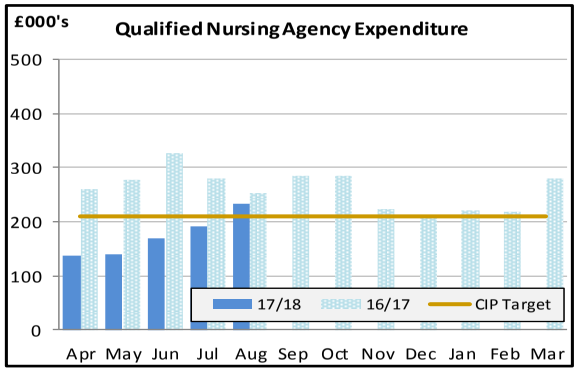


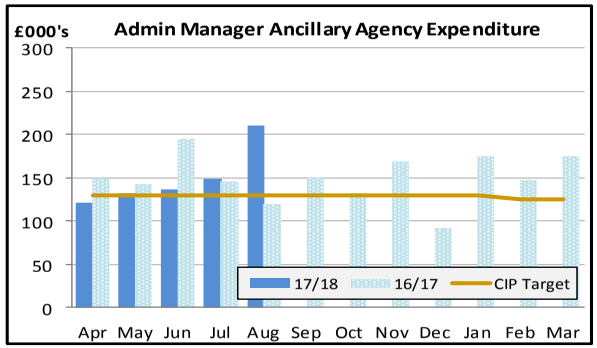
Key Issues

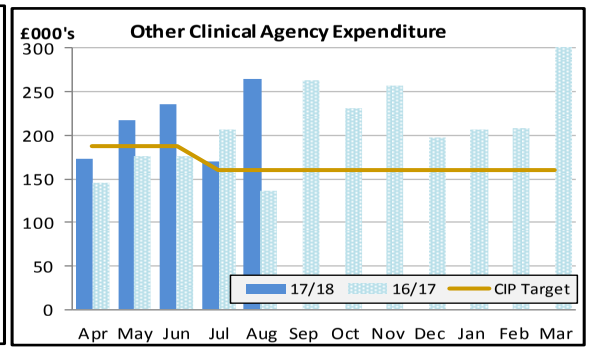
- **The Trust total expenditure for agency staff in 2016/17 was £16.1m.**
- NHS Improvement issued an expenditure limit of £13.04m for the financial year 2017/18, plus a £1.9125m reduction expected in Medical agency.
- The CIP targets by staff group have been developed to fulfil these NHSI targets throughout the year.
- At the end of Month 5 the Trust was £1.1m below the target of £5.8m year-to-date.
- Agency Expenditure has increased in Month 5, with Senior Medical up 80% on average and Other Clinical up 33% on average month this year.

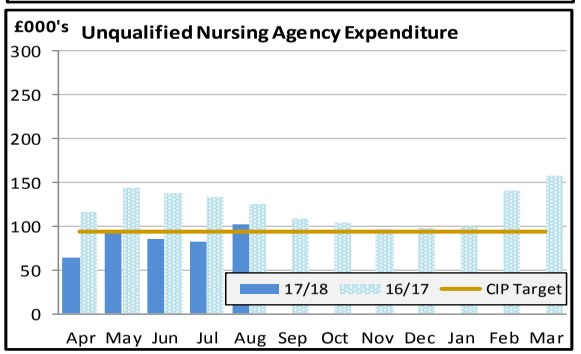












4.0 Clinical Income

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	50,793	50,316	(477)	6,467	6,297	(170)
Block	-	-	-	5,901	5,920	19
Cost per Case	1,186,632	1,203,091	16,459	13,409	13,420	10
CQUIN	-	-	-	2,032	2,219	186
Day Cases	17,110	16,648	(462)	10,232	9,818	(414)
Elective	2,623	2,209	(414)	7,475	7,039	(436)
Elective XBDs	473	492	19	119	131	12
Excluded Devices	-	-	-	870	978	108
Excluded Medicines	-	-	-	8,873	9,205	332
Non-Elective	22,936	21,296	(1,639)	41,725	39,475	(2,250)
Non-Elective XBDs	9,228	13,376	4,148	2,326	3,326	1,001
Outpatient First	26,123	23,703	(2,420)	4,585	4,145	(440)
Outpatient Follow UP	83,822	84,561	739	6,729	6,702	(28)
Outpt Procedures	60,712	61,724	1,012	7,124	7,533	409
CIP / Other				1,117	1,388	271
SLA Clinical Income	**1,460,451**	**1,477,416**	**16,966**	**118,983**	**117,594**	**(1,389)**
Contract Penalties				(94)	(113)	(18)
Challenges				(750)	(895)	(145)
Readmissions				(1,331)	(1,331)	0
MRET				(2,466)	(2,466)	0
Fines & Penalties				**(4,641)**	**(4,805)**	**(164)**
Total SLA Clinical Income	**1,460,451**	**1,477,416**	**16,966**	**114,342**	**112,790**	**(1,553)**

Other Clinical Income	Finance £000's		
	Plan	Actual	Variance
Private Patients	459	360	(99)
Overseas Visitors	56	147	91
RTA / Personal Injury Income	595	518	(77)
STF Funding	2,469	2,099	(370)
Total Other Clinical Income	**3,579**	**3,124**	**(455)**

SLA Clinical Income
£1,553k adv.

SLA Clinical Income was £1,553k adverse to plan year to date, with activity reported as below target in most areas, apart from excess bed days, excluded medicines and OP procedures. There has been a small improvement in activity in Month 5 on Daycases (£170k improvement).

Cost Per Case
£10k fav.

CPC remains above plan due to Direct Access over-performance.

CQUIN
£186k fav.

The CQUIN reported position includes the achievement of Q1 Rheumatology schemes that were previously estimated lower.

Planned activity
£837k adv.

DC activity was 6% above plan in Month 5, with most surgical areas contributing to this, including Gen Surgery increasing activity from Mth 4 by 13% (33), Oral Surgery 16% (40) and Gen Med 6% (39) improvement month on month.
Elective income remains 6% below the financial plan, with activity being 16% below plan. T&O accounts for £330k of the under performance.

Non-Elective
£1,250k adv.

NEL activity is 7% below plan at Mth 5 although excess bed days make some contribution towards reducing the adverse variance.

Fines & Penalties
On plan

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

Other Clinical Income
£455k adv.

STF adverse variance of £370k is the main contributor to this variance . Private patients and Overseas patients are broadly in line with plan overall.

4.1 High Level Commissioner Position

Commissioner	Finance £000's YTD Plan	Actual	Variance
Nene CCG	89,857	87,648	(2,209)
Corby CCG	1,202	1,110	(92)
Bedfordshire CCG	267	272	5
East Leicestershire & Rutland CCG	317	290	(27)
Leicester City CCG	24	37	12
West Leicestershire CCG	27	22	(5)
Milton Keynes CCG	1,255	1,188	(67)
Specialised Commissioning	15,666	16,804	1,138
Herts & South Midlands LAT	2,981	2,695	(286)
NCA / Central / Other	2,747	2,725	(21)
Total SLA Income	**114,342**	**112,790**	**(1,553)**

Nene Contract
£2,209k under performance

The reported under-performance on the Nene contract has slowed in Month 5, with the M5 position being a £2.209m variance (M4: £2.157m).
This is largely within the main POD's;

- DC £114k (M4: £337k)
- EL £573k (M4: £436k)
- NEL £1,380 (excl XS bed days) (M4: £1,179k)

The team will continue to focus on recovery plan actions as well as work with Commissioner to update the income forecast.

Specialised Commissioner
£1,138k over performance

Specialised is reporting an over-performance of £1,138k mainly due to excluded medicines (£943k), and Elective over-performance of £249k.

Herts & SM LAT (Secondary Dental)
£286k under performance

As with Nene this is largely across main POD's; DC (£69k), EL (£116k) and NEL (£82k).

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

4.2 STF Funding

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre STF	(22,261)	(8,758)	(9,896)	(1,138)
STF	8,715	2,469	2,099	(370)
Post STF	(13,546)	(6,289)	(7,797)	(1,508)

Key issues

- The Trust missed its pre-STF control total for M5 by £1.1m (M4: £847k) and also did not meet the 4hour A&E trajectory, therefore lost STF funding of £370k year to date.
- The appeal for the A&E 4 hour performance STF was unsuccessful therefore the loss to date of £370k has crystallised.
- Although the trust has not met its financial control total at M5, the accounts have been prepared on the assumption that the position would be recovered cumulatively by the end of the quarter and therefore the associated financial STF would have been earned. This means that should the Trust fail to meet the financial control total cumulatively at the end of the quarter, the position would further deteriorate by the STF amount. The amount at risk as at month 5 is £988k which is the value of the STF for months 4 & 5.

5. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET MONTH 5 2017/18	Balance at 31-Mar-17 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	159,809	159,809	159,809	0	159,809	0
IN YEAR REVALUATIONS	0	(2,597)	(2,597)	0	(5,434)	(5,434)
IN YEAR MOVEMENTS	0	1,377	2,162	785	13,175	13,175
LESS DEPRECIATION	0	(3,279)	(4,116)	(837)	(10,205)	(10,205)
NET BOOK VALUE	159,809	155,310	155,258	(52)	157,345	(2,464)
CURRENT ASSETS						
INVENTORIES	5,770	6,713	6,791	78	5,494	(276)
TRADE & OTHER RECEIVABLES	23,887	18,366	19,199	833	24,020	133
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,621	5,600	2,653	(2,947)	1,500	(121)
TOTAL CURRENT ASSETS	31,278	30,679	28,643	(2,036)	31,014	(264)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	24,112	25,532	25,873	341	27,314	3,202
FINANCE LEASE PAYABLE under 1 year	124	124	124	0	130	6
SHORT TERM LOANS	20,334	20,334	20,334	0	1,889	(18,445)
STAFF BENEFITS ACCRUAL	753	753	753	0	800	47
PROVISIONS	4,808	2,514	2,514	0	3,500	(1,308)
TOTAL CURRENT LIABILITIES	50,131	49,257	49,598	341	33,633	(16,498)
NET CURRENT ASSETS / (LIABILITIES)	(18,853)	(18,578)	(20,955)	(2,377)	(2,619)	16,234
TOTAL ASSETS LESS CURRENT LIABILITIES	140,956	136,732	134,303	(2,429)	154,726	13,770
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,121	1,081	1,070	(11)	991	(130)
LOANS over 1 year	30,489	34,604	34,285	(319)	63,006	32,517
PROVISIONS over 1 year	1,055	1,055	1,055	0	750	(305)
NON CURRENT LIABILITIES	32,665	36,740	36,410	(330)	64,747	32,082
TOTAL ASSETS EMPLOYED	108,291	99,992	97,893	(2,099)	89,979	(18,312)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258	0	120,116	858
REVALUATION RESERVE	37,392	35,838	35,838	0	33,716	(3,676)
I & E ACCOUNT	(48,359)	(55,104)	(57,203)	(2,099)	(63,853)	(15,494)
FINANCING TOTAL	108,291	99,992	97,893	(2,099)	89,979	(18,312)

Key Movements

The key movements from last month are:

Non Current Assets

- In Year M5 Movements include capital additions of £0.785m
- Depreciation - £0.8m in month as per 2017/18 plan.

Current assets

- Inventories - £78k. Increase in Pharmacy stock (£178k) offset by decrease in Heart Centre stockholding (£142k).
- Trade & Other Receivables – £0.8m. Increase in STF Accrual (£0.5m) & NHS Receivables accrual.
- Cash – decrease of £3.0m mainly due to loan repayment to DH (£2.8m).

Current Liabilities

- Trade & Other Payables - £0.3m movement includes increase of £0.7m in NHS & Capital Payables & £0.4m decrease in Accruals & Receipts in Advance.

Non Current Liabilities

- £0.3m - Repayment of Capital Loan Principal to DH.

Financed By

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

6. Capital Expenditure

Capital Scheme	Plan 2017/18 £000's	M5 Plan £000's	M5 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Refurbished MRI (Loan)	570	0	0	0	0%	641	113%
Imaging Replacement Rooms (Loan)	651	337	343	6	53%	648	99%
2nd MRI (Loan)	2,309	416	266	-150	12%	2,210	96%
Replacement Imaging Equipment Other Spend	0	0	26	26	0%	26	0%
Replacement NPfIT Systems	1,090	183	90	-94	8%	675	62%
Stock / Inventory System (Loan)	282	45	57	12	20%	96	34%
Chemo Appeal	100	100	91	-9	91%	102	102%
Contingency	332	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	756	205	205	0	27%	220	29%
Estates Sub Committee	3,252	685	591	-94	18%	1,989	61%
IT Sub Committee	2,363	318	453	135	19%	692	29%
Assessment Unit	755	0	0	0	0%	0	0%
A&E GP Streaming	858	0	0	0	0%	0	0%
Salix	87	87	41	-45	48%	47	54%
Total - Capital Plan	**13,405**	**2,376**	**2,162**	**-214**	**16%**	**7,346**	**55%**
Less Charitable Fund Donations	-200	-111	-111	0	56%	-122	61%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**13,205**	**2,265**	**2,051**	**-214**	**16%**	**7,223**	**55%**

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

Key Issues

- The Trust spend was £2.1m at M5.
- Actual spend plus the Commitments totalled £7.2m, therefore at M5 55% of the Capital Plan has been spent or committed.
- Commitments of £5.2m include the Radiology Imaging Equipment of £2.9m. The 2nd MRI works were delayed slightly but still forecast to complete by Christmas, and then followed by the refurbishment of the existing MRI during Q4. Room D is near completion, with installation of the equipment expected shortly. Room F is expected to begin early October & due to be completed late November.
- Replacement of PAS (NPfIT) the new CaMIS system has a target go live date of October 2017.
- The Assessment Unit has a planned handover date of May 2018. The £755k above represents the Trust's spend on IT & Equipment costs.
- The Trust is expecting planning permission for the A&E GP Streaming – Springfield on 19 September. Once this has been granted, the works will commence and the service is expected to be operational from 1 December 2017. £858k is the total for the whole scheme, awarded to the Trust as part of the Department of Health's easing A&E winter pressures.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at August £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	1,405	538	252	132	482
Receivables NHS	7,861	4,398	2,048	105	1,310
Total Receivables	**9,266**	**4,936**	**2,300**	**237**	**1,792**
Payables Non NHS	(4,628)	(4,607)	(20)	0	0
Payables NHS	(974)	(974)	0	0	0
Total Payables	**(5,601)**	**(5,581)**	**(20)**	**0**	**0**

Narrative	Total at July £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	1,339	577	170	102	491
Receivables NHS	7,000	5,122	1,299	162	418
Total Receivables	**8,339**	**5,699**	**1,468**	**264**	**908**
Payables Non NHS	(4,257)	(4,192)	(65)	0	0
Payables NHS	(650)	(650)	0	0	0
Total Payables	**(4,908)**	**(4,843)**	**(65)**	**0**	**0**

Receivables and Payables

- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £1.6m of 16/17 over-performance invoices, issued in July are included in the 31-60 days balance. £1.2m of these have been paid early September.
- NHS over 90 day debt increased to £1.3m. This includes £1.0m 2017/18 CQUIN Risk Reserve invoiced to Nene CCG, which remains in query. NHS Property Services £78k, which is part of an ongoing dispute, £47k Kettering General Hospital and £114k NCA's.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £372k, of which £124k are paying in instalments and over 43% of the balance passed to debt collection agency to recover. £19k relating to private patients, 69% of which is under contract query with insurance providers.

Better Payment Compliance Code - 2017/18

Narrative	April 2017	May 2017	June 2017	July 2017	August 2017	Cumulative 2017/18
NHS Creditors						
No.of Bills Paid Within Target	170	244	157	162	160	893
No.of Bills Paid Within Period	174	244	157	162	161	898
Percentage Paid Within Target	**97.70%**	**100.00%**	**100.00%**	**100.00%**	**99.38%**	**99.44%**
Value of Bills Paid Within Target (£000's)	2,073	2,547	1,378	2,458	1,840	10,297
Value of Bills Paid Within Period (£000's)	2,075	2,547	1,378	2,458	1,872	10,330
Percentage Paid Within Target	**99.90%**	**100.00%**	**100.00%**	**100.00%**	**98.31%**	**99.67%**
Non NHS Creditors						
No.of Bills Paid Within Target	5,005	6,087	7,329	6,186	7,201	31,808
No.of Bills Paid Within Period	5,068	6,130	7,369	6,201	7,246	32,014
Percentage Paid Within Target	**98.76%**	**99.30%**	**99.46%**	**99.76%**	**99.38%**	**99.36%**
Value of Bills Paid Within Target (£000's)	7,543	7,985	9,652	8,354	8,905	42,440
Value of Bills Paid Within Period (£000's)	7,589	8,008	9,679	8,362	9,155	42,792
Percentage Paid Within Target	**99.40%**	**99.71%**	**99.73%**	**99.91%**	**97.27%**	**99.18%**
Total						
No.of Bills Paid Within Target	5,175	6,331	7,486	6,348	7,361	32,701
No.of Bills Paid Within Period	5,242	6,374	7,526	6,363	7,407	32,912
Percentage Paid Within Target	**98.72%**	**99.33%**	**99.47%**	**99.76%**	**99.38%**	**99.36%**
Value of Bills Paid Within Target (£000's)	9,616	10,532	11,031	10,812	10,745	52,736
Value of Bills Paid Within Period (£000's)	9,664	10,555	11,057	10,820	11,027	53,122
Percentage Paid Within Target	**99.51%**	**99.78%**	**99.76%**	**99.93%**	**97.45%**	**99.27%**

Better Payment Practice Code

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

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	FORECAST SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	266,217	22,512	21,345	23,165	22,083	21,975	22,014	22,014	22,014	22,014	23,051	22,014	22,014
STF Funding	8,834	81	0	0	3,545	0	0	0	1,111	0	1,482	0	2,615
SLA Performance/ Other CCG Investment	3,492	873	-23	273	677	30	1,649	14	0	0	0	0	0
Health Education Payments	9,611	762	809	785	785	822	822	804	804	804	804	804	804
Other NHS Income	12,136	801	1,125	596	1,279	835	1,000	1,000	1,000	1,000	1,000	1,000	1,500
PP / Other (Specific > £250k)	2,094	610	273	313	346	327	225	0	0	0	0	0	0
PP / Other	13,660	1,044	1,258	1,072	1,276	835	975	1,200	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan	87	0	0	87	0	0	0	0	0	0	0	0	0
PDC - Capital	858	0	0	0	0	0	0	0	430	428	0	0	0
Capital Loan	3,611	0	0	0	0	0	1,047	0	0	2,014	0	0	550
Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	13,546	3,116	-32	979	523	1,703	1,076	286	301	606	1,488	2,201	1,299
Uncommitted Revenue Loan - STF funding	8,715	436	436	435	581	581	581	872	872	871	1,017	1,017	1,016
Interest Receivable	21	2	2	2	2	2	2	1	2	2	1	2	2
TOTAL RECEIPTS	**342,881**	**30,237**	**25,193**	**27,707**	**31,096**	**27,109**	**29,391**	**26,191**	**27,734**	**28,939**	**30,043**	**28,238**	**31,000**
PAYMENTS													
Salaries and wages	196,566	15,598	16,340	16,890	16,382	16,237	16,440	16,460	16,520	16,200	16,520	16,460	16,520
Trade Creditors	95,485	6,781	7,037	9,122	7,802	8,059	9,184	6,492	6,351	9,581	7,255	9,069	8,751
NHS Creditors	22,228	2,079	2,300	1,403	2,458	2,279	1,942	1,942	1,942	1,942	1,942	1,000	1,000
Capital Expenditure	13,413	843	1,243	810	643	663	1,027	1,260	1,612	1,206	2,465	1,028	614
PDC Dividend	2,646	0	0	0	0	0	1,305	0	0	0	0	0	1,342
Repayment of Revenue Loan - STF funding	10,215	2,425	0	0	0	2,284	141	0	1,173	134	1,743	0	2,315
Repayment of Loans (Principal & Interest)	2,332	0	0	0	92	513	448	8	3	11	118	682	456
Repayment of Salix loan	91	21	0	0	0	0	38	29	0	0	0	0	3
TOTAL PAYMENTS	**342,976**	**27,747**	**26,920**	**28,226**	**27,377**	**30,034**	**30,525**	**26,191**	**27,601**	**29,074**	**30,043**	**28,239**	**31,000**
Actual month balance	-95	2,490	-1,727	-519	3,719	-2,925	-1,133	0	133	-134	0	0	0
Cash in transit & Cash in hand adjustment	-26	32	-29	48	-34	-22	-20	-1	0	1	0	1	-1
Balance brought forward	1,621	1,621	4,143	2,387	1,915	5,600	2,653	1,500	1,500	1,634	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,143**	**2,387**	**1,915**	**5,600**	**2,653**	**1,500**	**1,500**	**1,634**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- All SLA payments were received on time.
- Final 16/17 Performance invoices/credit notes, issued in July, were paid in August. Payments from all other Commissioners are forecast to be received in September. Payment from Central Midlands Commissioning Hub (£1.2m) was received on 1 Sept.
- Little progress has been made with Nene CCG in respect of the £1.0m 2017/18 Cquin Risk Reserve. For this reason, payment is now not forecast to be received until January.
- Following receipt of Qtr 4 STF funding from NHS England in July, £2.3m of the corresponding borrowing was offset against the August Uncommitted Revenue Loan entitlement, resulting in a zero net cash draw down.
- DH has approved a further drawdown of £1.5m in September against the Uncommitted Interim Revenue Support Facility (ISUCL). This is a net drawdown to include repayment of the remaining borrowing in respect of the Qtr 4 STF funding.
- DH has also approved a Capital Loan draw down of £1.0m in September. This supports the expenditure incurred on the Replacement Imaging Equipment & Inventory System Schemes.
- Capital (principal & interest) & Revenue (interest only) Loan repayments have been made in August. Further repayments are due in September.

9. Conclusion

Key Points:

- The Trust did not meet its pre-STF financial control and also lost STF relating to A&E 4 hour wait. The combined effect was an adverse variance to plan of £1.5m.
- Activity and income remains the key area for the Trust's underperformance against plan. The Directorates and Divisions must continue to identify appropriate recovery actions needed to recover the Trust's financial position and deliver these actions in order to recover the Trust's financial position.
- STF income of £2.1m is accounted for in the position and an estimated £1.0m remains at risk (based on month 5), should the Trust not meet its quarter 2 financial control total.
- Agency spend continued to be below plan but has increased in month 5, bringing the year to date favourable variance to £1.1m.

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 September 2017**

Title of the Report	**Nurse Recruitment Strategy & Nurse Retention Update**
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 update on progress against the Nurse Recruitment Strategy and Nurse Retention
Executive summary This report sets out progress to date against Nurse Recruitment Strategy and Nurse Retention.	
Related strategic aim and corporate objective	Focus on Quality and Safety
Risk and assurance	Failure to recruit and retain sufficient nurses will create safety risks and risks to our ability to continue to provide services to patients.
Related Board Assurance Framework entries	BAF 2.1 / 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? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	All recruitment would be undertaken in accordance with statutory and regulatory requirements.

Enclosure G

Actions required by the Committee

The Committee is asked to note the report

Trust Board 28 September 2017

Nurse Recruitment & Retention Strategy Update

1. Introduction

This report sets out progress made between January 2017 and August 2017. The Board will recall that the Trust strategy for nurse recruitment is: ***Local, National and International.*** A significant emphasis was placed on international recruitment during 2015 and 2016 however for the reasons set out below the strategy is being re-balanced with a greater emphasis on local and national over international.

2. Recruitment Progress Report

2.1 Overseas Nurse Recruitment Progress January 2017 – August 2017

Key areas to note:

- The overseas recruitment campaign continues and between January 2017 and August 2017, 30 overseas recruits arrived from India and 2 from Romania totalling 32 recruits in total. However, the EU Market has effectively dried up.

- Between January 2017 and August 2017 a total of 20 offers were made to overseas nurses.

- There are currently 30 IELTS cleared Indian Nurses awaiting NMC decision letter to travel to the Trust and commence employment, 17 of which were offered positions since January 2017. It is anticipated that these nurses will begin to arrive during November 2017 to January 2018. The remaining 13 candidates were offered prior to January 2017 and are being queried as to their status with the agency that assisted in their recruitment due to the length of time it is taking them to arrive.

As a result of the increased cost of overseas recruitment brought about by the introduction of the Immigration Skills Charge from April 2017, it is necessary to ensure an ongoing review of the Trusts overseas recruitment to ensure that the appropriate standard and volume of nurses can be recruited in the most cost effective way possible.

With this in mind, a review of the current value of the agreement that the Trust has with its main international nursing agency is underway to ensure the best possible price for the talent recruited from overseas is achieved. This review has resulted in a recently resubmitted costing proposal, which includes proposals to source nurses from the domestic market as well as the overseas market. It is anticipated that balancing the Trusts overseas recruitment with the sourcing of domestic candidates will ensure that the required volume of nurse recruitment can be maintained in an affordable way.

A proportion of the nurses that are being sought domestically will be overseas nurses that have already worked in the UK. The utilisation of the 'Best of Both Worlds' microsite, which has been developed in conjunction with neighbouring Hospitals and the University of Northampton, which aims to attract health care professionals Northamptonshire will support the aim to attract recruits from the domestic national market.

In addition to this and in order to maximise the Trusts recruitment sources, discussions have also taken place with a number of permanent recruitment agencies including recruitment consultancies based on the continent who may be able to provide us with Dutch nurses who have relevant experience, although because of Brexit, it is unknown as to whether this will reap any benefits.

2.2 Local & National Recruitment Progress January 2017 and August 2017

Key areas to note:

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

2.3 Overall Nurse Recruitment Progress between January and August 2017 (Including overseas recruits)

Key areas to note:

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

As at August 2017, total nursing vacancies for core and specialist areas is 147.68 WTE.

A detailed Monthly Analysis of Recruitment, Attrition & Net gain/loss for months January 2017 to August 2017 can found at Appendix 1.

3. Nurse Recruitment Initiatives

3.1 Recruitment fairs

- We have been arranging physical recruitment events which will include 2 RCN events in Birmingham and Nottingham, and more recruitment open days here at NGH.

3.2 Brand Northamptonshire (Best of Both World's)

- Brand Northamptonshire has now launched with great media attention. The Trusts Director of Nursing, Midwifery and Patient Services has already given several interviews and the Communications team are fully engaged. There have also been clips on the radio describing the intent of the campaign.

3.3 Local Recruitment

- A recruitment consultancy has been engaged to establish if they are able to increase the number of specialist nurse CV's that are available to the Trust. Final feedback on the initial trial resulted in two candidates being submitted. There has been a second trial resulting in a further three candidates being put forward.
- The Clinical Resourcing & Planning Manager has been working with the Associate Directors of Nursing and certain wards, which has resulted in the identification of an opportunity to focus recruitment efforts on potential "feeder wards", where staff are incubated to more specialist wards. It will be important however to ensure that such areas are celebrated as being learning/development wards, where managers are proud that

they are developing the specialist workforce of the future rather than concerned that they are losing staff.

The initial example was of a historical strong link of people moving from Dryden to the Heart Centre. Joint open days and advertising are currently being arranged with a Cardiology open day on the 23rd September. By focussing on feeder departments, and through the enhancement of retention strategies, it is anticipated that progress will be possible with the recruitment issues of wards further along the career pathway.

- Open days are featuring high on the list of activities for the Trust. A Trust wide open day for Nursing took place on the 15th July 2017, which resulted in a total of 26 offers being made for nursing positions. Another is planned for October 2017 and also for the early New Year, 2018. In conjunction with nursing colleagues' consideration of smaller area specific recruitment open days for more specialist areas, such as one that took place for Ophthalmology in May 2017 is underway.

- A regular reporting mechanism that will detail all vacancies alongside recruitment activity and positions out to advert within core and specialist areas is being developed.

4. Retention Update

- In 2017, 3 overseas recruits had to be repatriated as a result of failing the OSCE examination.

- Turnover within the core and specialist areas stood at 88.39 wte plus a reduction in hours of 9.17 wte meant a net loss 97.56 wte between January and August

- Having been unable to successfully recruit to the vacant position of Nurse Retention Manager since December 2016, the role has been redesigned to encompass staff retention as a whole and also staff Reward. The redesign of this role has been undertaken in order to attract a specialist candidate of the relevant background and expertise. This approach did result in a stronger pool of candidates and the role has now been appointed to and the successful candidate is due to commence in November 2017. To support this broader role and the Clinical Resourcing & Planning role, a Recruitment and Retention Officer role has also been introduced and appointed to with the successful candidate due to commence in post in October 2017.

5. Assessment of Risk

As mentioned above, overseas recruitment is becoming more difficult and as a result of the immigration skills charge the costs of doing so are rising. This difficulty in recruiting from overseas is reflected in the recent report that there has been a 96% reduction in the numbers of EU nurses applying for registration with the NMC. As a result of these factors and in order to mitigate the risks associated with them, the work streams detailed in this report are being actively pursued.

The delay in recruiting a Retention specialist has impacted upon the ability to fulfil a necessary focus on staff retention.

5. Recommendations

The Committee is asked to note the report.

6. Next Steps

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

Detailed Monthly Analysis of Recruitment, Attrition & Net gain/loss - January - August 2017.

Year	2017								Total
Supply	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	
Vacancies advertised expected recruits	8.00	-	5.13	6.84	8.00	7.84	4.92	5.38	**46.11**
Open University Pre-registration Programme	-	-	-	-	-	-	-	-	**-**
EU Recruitment (Theatre Training Initiative)	1.00	1.00	-	-	-	-	-	-	**2.00**
International Recruitment	-	6.00	10.00	4.00	4.00	3.00	3.00	-	**30.00**
Student Nurse	-	3.00	2.00	2.00	-	-	2.00	2.00	**11.00**
New National Initiatives	-	-	-	-	-	-	-	-	**-**
Recruitment Fayres	-	-	-	-	-	-	-	-	**-**
NGH Recruitment Fayres	-	-	-	-	-	-	-	-	**-**
Increase in Hours	0.61	1.27	-	0.70	0.98	0.62	0.72	0.20	**5.10**
Targeted Social Media	-	-	-	-	-	-	-	-	**-**
HCA's Converting	-	-	-	-	-	-	-	-	**-**
Total Supply	9.61	11.27	17.13	13.54	12.98	11.46	10.64	7.58	**94.21**
	-	-	-	-	-	-	-	-	**-**
Revised Supply	**9.61**	**11.27**	**17.13**	**13.54**	**12.98**	**11.46**	**10.64**	**7.58**	**94.21**

Demand Increase	Jan	Feb	Mar	Apr	May	June	July	Aug	Total
Leavers	12.00	6.00	12.92	12.46	15.27	15.84	6.35	5.35	**86.19**
Retirees	1.00	-	0.72	-	-	0.48	-	-	**2.20**
Decrease in Hours	2.41	-	1.03	1.84	1.04	0.08	0.78	1.99	**9.17**
Uplift	-	-	-	-	-	-	6.86	-	**6.86**
Demand Increase Total	**15.41**	**6.00**	**14.67**	**14.30**	**16.31**	**16.40**	**13.99**	**7.34**	**104.42**

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 September 2017**

Title of the Report	**Operational 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 & 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 & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks N Risk of not delivering performance standards Associated fines Patient experience Reputation
Related Board Assurance Framework entries	BAF – 1.2, 3.1
Equality Analysis	Is there potential for, or evidence that, the proposed

Enclosure H

	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	JUN-17	JUL-17	AUG-17
Quality of Care: Caring	Mixed Sex Accommodation	=0	4	0	0
	Complaints responded to within agreed timescales	>=90%	82.0%	84.9%	90.6%
	Total deaths where a care plan is in place	>=50%	57.4%	59.5%	46.7%
	Friends & Family Test % of patients who would recommend: A&E	>=86%	88.7%	87.9%	88.1%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.9%	94.1%	93.9%	93.1%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.5%	95.5%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.7%	92.8%	92.9%	92.3%

	Indicator	Target	JUN-17	JUL-17	AUG-17
Operational Performance	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.3%	99.3%	99.9%
	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	88.7%	88.5%	88.5%
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	139	88	68
	Ambulance handovers that waited over 60 mins	<=10	19	7	2
	Average Ambulance handover times	=15 mins	00:13	00:12	00:13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	1	0	2
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	91.9%	87.8%	86.6%
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	50.9%	63.0%	47.3%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	94.1%	98.3%	95.1%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.0%	98.3%	96.6%
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	88.8%	81.8%	94.4%
	Cancer: Percentage of patients treated within 31 days	>=96%	95.5%	96.2%	98.6%
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	83.3%	80.0%	86.6%
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	100.0%	95.0%	91.6%
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	74.5%	74.5%	75.0%
	RTT over 52 weeks	=0	0	0	
	RTT waiting times incomplete pathways	>=92%	92.0%	92.1%	

	Indicator	Target	JUN-17	JUL-17	AUG-17
Quality of Care: Effective	Stranded patients >=75yrs (LOS > 7 DAYS)	<=45%	49.4%	49.7%	52.6%
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.5%	3.6%	3.2%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.0%	14.8%	13.1%
	Length of stay - All	<=4.2	4.3	4.9	4.8
	Maternity: C Section Rates - Total	<27.1%	28.3%	29.0%	29.5%
	Crude Death Rates	1	1.0%	1.1%	0.9%
	Mortality: HSMR	100	97	95	95
	Mortality: SHMI	100	96	96	96
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	95.8%	100.0%	97.7%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	96.2%	88.8%	90.1%
	# NoF - Fit patients operated on within 36 hours	>=80%	76.1%	82.7%	83.3%
	LOS > 7 Days	<=45%	9.8%	10.9%	10.5%

	Indicator	Target	JUN-17	JUL-17	AUG-17
Finance and Use of Resources	CIP Performance YTD (£000's)	>=0	436 Fav	251 Fav	
	Bank & Agency / Pay %	<=7.5%	12.3%	13.2%	
	Income (£000's)	>=0	562 Fav	(812) Adv	
	Non Pay (£000's)	>=0	(206) Adv	(156) Adv	
	Pay (£000's)	>=0	(298) Adv	(224) Adv	
	Surplus / Deficit (£000's)	>=0	101 Fav	(786) Adv	
	Salary Overpayments - Number	=0	65	107	140
	Salary Overpayments - Value YTD (£000's)	=0	68.6	117.4	178.9
	Waivers	=0	5	1	3
	Waivers which have breached	=0	0	0	1

	Indicator	Target	JUN-17	JUL-17	AUG-17
Quality of Care: Safe	Delayed transfer of care	=23	66	39	59
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	96.8%	100.0%
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	42	32	30
	Ward Moves (>2)	=0	132	144	139
	Ward Moves (>2) Context	=0%	3.9%	4.0%	4.1%
	Dementia: Case finding	>=90%	98.1%	96.4%	99.7%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	4.2	3.9	3.7
	C-Diff	<=1.75	5	5	0
	MRSA	=0	0	0	0
	MSSA	=0	1	0	0
	VTE Risk Assessment	>=95%	95.6%	95.8%	95.9%
	Never event incidence	=0	0	0	0
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	1	0	2
	Harm Free Care (Safety Thermometer)	>=94.1%	93.2%	93.3%	94.5%

	Indicator	Target	JUN-17	JUL-17	AUG-17
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	0%	47.9%	
	Percentage of all trust staff with mandatory training compliance	>=85%	86.5%	87.4%	87.4%
	Percentage of all trust staff with role specific training compliance	>=85%	81.8%	82.6%	83.9%
	Percentage of staff with annual appraisal	>=85%	85.0%	84.1%	82.3%
	Sickness Rate	<=3.8%	3.5%	3.8%	4.1%
	Staff: Trust level vacancy rate - All	<=9%	11.9%	12.5%	12.6%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	10.0%	13.9%	14.4%
	Staff: Trust level vacancy rate - Other Staff	<=9%	13.6%	13.4%	13.2%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	10.4%	10.7%	11.3%
	Turnover Rate	<=10%	9.9%	9.8%	9.5%

Run Date: 12/09/2017 16:04 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

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: A&E Performance	Externally mandated	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	89.1%	84.8%	83.3%	83.2%	81.3%	78.1%	86.7%	87.4%	85.3%	88.7%	88.5%	88.5%

Driver for underperformance:	Actions to address the underperformance:
• **Specialty waits** Adhering to professional standards still remains and issue in relation to A & E underperformance. Responsiveness of clinical teams to specialties is not consistent and embedded. • **Bed capacity** Bed capacity within Trust still remains a daily challenge. A major challenge is the availability of empty beds being aligned with a request for beds during our peak activity times. In addition, identifying patients for early discharge, particularly before 11am remains a concern within our assessment areas and medical wards. • **Vacancies within medical staffing equating to 11 WTE across all SHO and MG (3x SHO going through clearance)** Increased acuity Exit Block Increased complexity through >65 years age group	• Please see Urgent Care report

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	151	229	220	247	147	303	159	91	141	139	88	68

Driver for underperformance:

- Acuity still remains high across some specialties within the Trust. This has seen a marked increase in the last 4 weeks.
- Bed capacity within Trust still remains a daily challenge. A major challenge is the availability of empty beds being aligned with requests for beds during our peak activity times. In addition, identifying patients for early discharge, particularly before 11am remains a concern within our assessment areas and medical wards.
- Multiple ambulance arrivals within a short periods cause spikes in demand and our ability to deliver performance is comprised every day.
- Fast Response Cars booking mobile to hospital and not calling clear at scene
- Ambulance Turnaround screen has not been recognising some crews pins, thus showing as delays. This remains an ongoing problem

Actions to address the underperformance:

- In absence of HALO, crews to be requested to double up. This action is ongoing and is being monitored daily.
- Clinical guidance being written to support crews remotely with GP advice between 0800-2300hrs, awaiting access to System One escalated to CCG- On track to be delivered 31/10/17
- Early escalation to EMAS silver to request HALO should the need arise.- Daily escalation in place
- Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews, and to make aware of Trust pressures. Daily escalation in place when on OPEL4 or during increased demand
- Early escalation to EMAS/Ops room if multiple ambulance arrivals in quick succession (10 or more per hour). Daily escalation in place when on OPEL4 or during increased demand
- If Trust status BLACK corridor to be staffed to support ambulance turnaround. Daily escalation in place
- Ambulance arrival screen now live in resus area, this allows for early planning of critically unwell patients and also nurses are able to handover crews without leaving resus area.
- Trackers to escalate all ambulance delays approaching 25 minutes. Action is ongoing and monitored daily.
- Black Breaches information requested daily from EMAS so they can be validated Monthly validation of report
- Ambulance Handover to be implemented on PAU/Maternity On track started 15/08/17, implementation complete, reduction seen in PAU/Maternity ambulance delays

	• Ongoing work with EMAS on patients who are conveyed to NGH and subsequently discharged home (44%). On track to be delivered 20/9/17 (paper being written to explore pathways that may be of benefit) • Escalation flow chart implemented within ED – completed 25/7/17

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	50.8%	56.4%	51.4%	55.5%	55.6%	52.6%	56.2%	51.7%	49.3%	52.3%	49.4%	49.7%

Driver for underperformance:	Actions to address the underperformance:
• There still remains high numbers of delayed transfer of care (DTOC) within the trust. • The patients within the stranded group often have very complex discharge needs involving significant attention from both internal and external teams. • Small Dementia and Delirium team presently covering many complex patients. • In sufficient capacity in social care and CHC to safely discharge patients	• SPA, CCG and Discharge Team Manager jointly involved with trusted assessor training to all Ward Managers in discharge processes/detail. With this cascaded to their teams. (September 2017). • Advert has gone out for Discharge Co-ordinators. In post for Q4 • Dementia and Delirium team funding now confirmed to March 2018 • Social services reminder to attend the stranded meeting – raised by COO. • New schemes being agreed by COO's / CEO's

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay - All	Internally set	Finance, Investment and Performance Committee	August 2017

Performance:

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

Driver for underperformance:	Actions to address the underperformance:
• Improved position on previous Month. • Severe staffing issues during July and August with little take up from bank and agency for medics and nurses. • SPA not being updated on changes to patient pathways by wards. • Variable numbers of Delayed Transfers of Care (DTOC) due to changes in staffing at CCG. • High numbers of patients in the 21+ days LOS compared to other trusts outside of Northamptonshire. • Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit • Reliance on beds; Insufficient capacity within the home support services • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS.	• Outflow group is leading the programmes of work across Northamptonshire • New Trusted Assessor Route rolled out during August to improve PDNA process with SPA, expected to reduce ALOS once fully embedded • Trial of electronic referral of PDNA to begin in September with Abington as the pilot ward. • Employing further 11 Discharge Coordinators to support Wards, in post Q4. • Recruitment started to appoint two consultant teams dedicated to looking after the medical outliers and driving down the LOS. Will rely on agency in first instance to be up and running by end of September. • Review of community beds conducted with NHFT and NGH to identify blockages and move patients urgently in empty beds. Taking place in September. • New schemes added to the UCWG

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Ward Moves > 2	Internally set	Quality Governance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Ward Moves (>2)		Not applicable until Nov 2016		124	142	122	124	163	102	132	132	144	139
Ward Moves (>2) Context				3.8%	3.9%	3.7%	3.9%	4.5%	3.5%	3.7%	3.9%	4.0%	4.1%

Driver for underperformance:	Actions to address the underperformance:
• High bed occupancy driving the use of escalation areas. The use of escalation areas puts this figure higher however we are using these areas to keep patients safe. • Some patients moved to accommodate infection control precautions. • Medical specialty fracture NOF patients moved to ensure best practice received on specialist ward.	• Focus on review of medical outliers which numbers 32-55 patients, included in Trust 1430 Safe Flow Huddle (September 2017). • Group set up to produce Site manager and Capacity coordinators daily SOP to create a more consistent and robust operational daily rhythm and process of inpatient capacity management this subsequently reducing unnecessary patient moves with right bed first time. (September 2017). • Ward coordinators continue Pull model where specialty wards identify and “pull” their specialty patients from A&E admitting wards often following consultant priority patient lists. This usually means patients are seldom moved again. (Ongoing August 2017).

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Mrs Rebecca Conroy	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Friends and Family Test % - Inpatient/Daycase	Externally mandated	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.9%	91.8%	92.1%	93.0%	92.9%	94.0%	92.7%	93.6%	93.2%	94.1%	94.1%	93.9%	93.1%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.7%	91.8%	91.7%	92.6%	93.2%	93.0%	93.7%	92.7%	92.5%	93.5%	92.8%	92.9%	92.3%

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 less than 1% lower than the national average.
- August saw a decrease in recommendation rates for Inpatient/Day Case areas and Outpatients; however this was not outside of the parameters of normal variation. It should also be noted that for Inpatient and day case areas, compared with August 16 the recommendation has increased from 91.6% to 93.1%.

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. This includes a particular focus on communication around medication and discharge.
- Outpatient areas are now receiving monthly posters which can be displayed within waiting areas for staff and patients.
- A number of Consultants are receiving monthly data relating specifically to their own Outpatient clinics.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	96.8%	97.3%	96.4%	97.7%	96.1%	98.2%	96.5%	90.3%	85.9%	91.9%	87.8%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	100.0%	91.3%	96.0%	95.0%	95.5%	98.4%	94.1%	85.2%	72.8%	50.9%	63.0%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	83.3%	100.0%	81.8%	100.0%	88.2%	93.3%	100.0%	100.0%	90.9%	88.8%	81.8%
Cancer: Percentage of patients treated within 62 days of referral from Consultant Upgrade	>=85%	76.9%	77.7%	83.3%	100.0%	100.0%	70.0%	100.0%	84.6%	86.6%	83.3%	80.0%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	71.5%	81.6%	81.6%	85.9%	80.4%	79.6%	76.3%	80.2%	72.9%	74.5%	74.5%

Driver for underperformance:	Actions to address the underperformance:
Please see full exception report	

Lead Clinician:	Lead Manager:	Lead Director:
Mr C. Vonwidekind	Mrs Sandra Neale	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Percentage of all trust staff with role specific training compliance	>=85%	75.1%	76.5%	77.1%	78.1%	79.0%	79.7%	81.2%	81.0%	81.0%	81.8%	82.6%	83.9%

Driver for under performance:	Actions to address the underperformance:
• Lack of awareness of Role Specific subjects due to these being separated from the previous list of 23 Mandatory subjects. • Lack of insight into the importance of Role Specific Training due to not being called Mandatory • Positions not being aligned to Role Specific Training subjects • System (OLM) not flexible enough to report on staff requirements to undertake RSET and having the lowest dominator being set at position level not assignment level	• Increase awareness of the importance of undertaking RSET as well as mandatory training. • Work continues in aligning Role Specific subjects to new positions as they are created. • We have been informed that RSET cannot be set against assignment and has to be set against position. Additional work will need to be carried out to ascertain if there is another way.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Percentage of staff with annual appraisal	>=85%	83.5%	81.8%	80.8%	82.0%	85.3%	84.4%	84.2%	83.6%	85.0%	85.0%	84.1%	82.3%

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

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Vacancy Rate	Internally set	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Staff: Trust level vacancy rate - All	<=9%	11.1%	10.9%	10.6%	10.9%	10.7%	10.7%	10.6%	11.1%	11.4%	11.9%	12.5%	12.6%
Staff: Trust level vacancy rate - Medical Staff	<=9%	10.00%	10.3%	11.0%	9.9%	9.0%	9.7%	10.0%	10.7%	11.2%	10.0%	13.9%	14.4%
Staff: Trust level vacancy rate - Other Staff	<=9%	11.10%	11.3%	10.8%	11.0%	10.9%	11.0%	11.1%	13.8%	13.5%	13.6%	13.4%	13.2%
Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	11.50%	10.5%	10.1%	10.9%	11.1%	10.5%	10.0%	10.2%	10.3%	10.4%	10.7%	11.3%

Driver for underperformance:	Actions to address the underperformance:
• There is a national shortage of nursing staff along with a shortage within other professional allied specialities & medical staff.	• Trust Open Days in difficult to recruit areas • Practice Development continue to forge links with local University to recruit Students • Dedicated roles within HR for recruitment and retention • More structured approach to Medical Staffing recruitment • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Increase usage of apprenticeship schemes • Overseas recruitment for nurses continues • Attendance at job fayres to enhance Trust brand and maximise recruitment

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mr Adam Cragg	Mrs 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	August 2017

Performance and Trajectory:

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

Driver for underperformance:

- T&O Breach
- Upper limb Consultant off sick on day of patient TCI
- Complex combined upper and lower limb case that required a second lower limb Consultant to assist
- Case could not be undertaken by another Consultant
- Consultant not back at work within the 28 days

- ENT Day Breach
- TCI cancelled 04.07.17 as list over ran
- Second TCI given for 26.07.17. This was supposed to be cancelled the day before for a cancer case but wasn't cancelled correctly resulting in patient turning up for surgery on the 26th and being sent home.
- Third TCI given for 7th August, which went ahead. Patient breached 28-days on 1st August.

Actions to address the underperformance:

- Complexity of patient meant that it was not possible for another Consultant to undertake the case. It also required a second named Consultant to be present to assist.
- In view of this there was nothing that could have been done to prevent the breach.

- List over running was unexpected and therefore could not have been prevented.
- Staff to ensure TCI's are cancelled correctly, being mindful of all target dates
- All operating lists are closely monitored to ensure no further 28-day patients are missed

Lead Clinician:	Lead Manager:	Lead Director:
Dr Mike Wilkinson	Miss Fay Gordon	Mrs Deborah Needham

Scorecard - Exception Report

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

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Maternity: C Section Rates - Total	<27.1%	28.1%	26.3%	27.5%	28.4%	24.5%	25.0%	28.9%	28.2%	27.0%	28.3%	29.0%	29.5%

Driver for underperformance:	Actions to address the underperformance:
• Total CS rate amber	No change from previous exception reports • 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 which is now imminent. • Ongoing Elective Caesarean Section audits – good compliance • Birth After Caesarean Clinic – working towards multidisciplinary clinic

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

Scorecard - Exception Report

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

Performance and Trajectory:

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

Driver for underperformance:	Actions to address the underperformance:
• Serious incidents requiring investigation – 1 in June and 2 in August	• Serious incident investigations for August are still ongoing (postpartum hysterectomy following PPH and baby requiring cooling) • Serious incident for June (readmission with postnatal eclampsia) – awaiting report, due end Sept 2017 • At present there are no obvious clinical themes underlying these but this will be reviewed once all three reports are finalised

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd/Mr Owen Cooper	Mrs Sandra Neale	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	August 2017

Performance:

Indicator	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Delayed transfer of care	=23	90	75	67	45	50	46	92	59	90	66	39	59

Driver for underperformance:	Actions to address the underperformance:
• The system has seen a large rise in acutely unwell patients leading to a rise in patients requiring support • Delays in social services assessment • Large delays in waiting time for medical rehabilitation beds and ability to take high level dependency patients • Delay in sourcing Nursing Home and Residential Home placement due to lack of vacant beds • Lack of available capacity in social care	• Use of CHS brokerage for self-funding patients – Sept 17 • Recruitment commenced for 11 discharge co-ordinators on every ward – shortlisting complete and if successful to commence Q4 • Twice weekly tracking meetings to agree DTOC numbers on call. Memorandum of Understanding of DTOC agreed at Outflow 08/09/2017 • Identify potential patients for Avery beds earlier in admission pathway – criteria review Sept 17 • Trusted Assessor Pilot commenced 01/09/2017 for existing nursing home residents to return home without additional assessment by nursing home (10 homes in Northampton and South involved) • Monitor those waiting for medical rehabilitation beds and ensure they still require this pathway via daily tracking by discharge team • Focus on weekend discharges and encourage recording of weekend plans within medical notes • Pilot of email version of PDNA to commence 18/09/2017 to reduce lengthy phone call to SPA

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mrs Rebecca Conroy	Mrs Deborah Needham

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28 September 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 paper provides an update on progress with implementing the STP in Northamptonshire and is the same as that being presented to all organisations across the county. The paper was originally presented to the Health and Wellbeing Board in August 2017 which will explain references to that forum un the documents.	
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

Actions required by the Trust Board/Committee

The Board to note the update

STP Update Board Paper

August 2017

Date: August 2017	Item Number:

Title:
Northamptonshire Sustainability and Transformation Plan 2016-2021 for the Health and Social Care System

Report Author:
Mike Coupe – STP Programme Director

Presented by:

Purpose/Summary:

Purpose: To update the Health and Wellbeing Board on progress in the further development and implementation of the Northamptonshire Sustainability and Transformation Plan (STP).

Summary:

- An overview of the current status of the 16 STP projects is at Appendix 1. Good progress is being made in the development of detailed plans supporting each project
- Recruitment of specialist programme and change management support is about to commence. Total funding requirements in 2017/18 have been assessed at £1418k. Total funding currently available is £1029k. The Programme Director and the Finance Group are assessing priorities
- NHS England has assessed the performance of the Northamptonshire health and social care system as '4': 'needs most improvement'
- Angela Hillery has assumed responsibility as STP Lead
- The STP will now go through a 'reset'.

STP projects

The July update to the Board confirmed that the 16 projects currently comprising the STP had been grouped into four portfolios as follows:

Health & Wellbeing

- Building resilient communities through volunteering and social action
- Improving population mental health and wellbeing through social prescribing
- Systematic, personalised and proactive prevention at scale
- Clinical preventative services

Primary, Community & Social (PCS) Care

- Same day primary care
- Collaborative care teams
- Care homes
- Diabetes care package
- Intermediate care/ Community resilience/ Keeping you well at home

Acute & Secondary Care

- Escalation management and diversion
- Internal flow
- Effective discharges
- Rheumatology

- Dermatology
- Cardiology
- Orthopaedics
- Pathology
- Ophthalmology

System Development
- Accountable Care System
- Strategic commissioning
- Consolidation of back office functions

A RAG rated assessment of progress against plan and a brief commentary is at Appendix 1.

Where appropriate, business cases to support the roll out of projects are in preparation with a view to their feeding into the contracting, budgeting and business planning cycle for 2018/19.

Programme budget

The STP Finance Group submitted to the July STP Programme Board a paper which proposed a programme budget for 2017/18 and the two following financial years as follows:

2017/18	£1418k
2018/19	£1820k
2019/20	£1820k

Total funding identified for 2017/18 is £1029k. Recruitment of specialist programme and change management support is about to commence. The Programme Director and the Finance Group are currently assessing priorities.

NHS England STP Progress Assessment

NHS England has assessed the operational performance of the 44 health and social care systems within each STP footprint. The assessment rates each system against 9 domains:

- Emergency care – four hour standard
- Elective care – 18 week standard
- Safety – healthcare associated infections and special measures
- General practice – improving access
- Mental health – improving access
- Cancer – improving access
- Prevention – unnecessary hospital stays
- System wide leadership – partnership working
- Finance – system control totals.

The data for Northamptonshire is at Appendix 2. Data from other systems allowing a comparison of performance is not available.

Each system is placed in one of four bandings:

- 1 – outstanding
- 2 – advanced
- 3 – making progress
- 4 – needs most improvement.

Northamptonshire has been placed in band 4 ie needs most improvement.

STP management and development

Angela Hillery, CEO of Northamptonshire Healthcare Foundation Trust, has assumed responsibility as STP Lead.

Regulators require all STPs to provide the vehicle for delivering/ reporting progress on the national priorities identified in the 5YFW Next Steps report (primary care, urgent & emergency care, mental health, elective care and cancer).

It should be anticipated, therefore, that the STP will go through a 'reset'.

Further detail will be provided as and when it is available.

Lead Partners:

All Northamptonshire health and social care commissioners and providers.

Financial Implications:

Finance leads from partner organisations have completed the update of the 'do nothing' scenario deficit: the October 2016 submission identified a potential financial gap of £230m by 2020/21 assuming a do nothing scenario; the updated figure is £195m.

Risks:

As reported to the July Board, a formal risk and issues log will be developed as part of the mobilisation phase of the programme.

In the interim, the STP remains at risk from a common set of issues affecting all strategic change management programmes:

- Lack of project management and change management resources
- Varying levels of commitment across the programme
- Lack of staff engagement and ownership

The progress reported in this update has served to reduce some of these risks. The level of risk will be further reduced through the work on the reset.

Recommendations:

The Health and Wellbeing Board is asked to note the contents of this report.

STP progress dashboard - baseline view

July 2017

Data Sources

Indicators

Name	Description	Numerator	Denominator	Time period	Reference date	Source	Note
Overall performance	Overall STP assessment	N/A	N/A	N/A	N/A	N/A	The overall performance rating provides a summary categorisation for the STP based on a weighted sum of the indicators below. The transformation indicators are combined and given a weighting of 50%, with the combined remaining indicators also weighted 50%. Further detail on the methods applied is available in the supporting technical guidance.
A&E waiting times	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Total number of patients who have a total time in A&E within 4 hours from arrival to admission, transfer or discharge (all types of A&E)	Total number of A&E attendances (all types of A&E)	2016/17 year-end	Mar-17	Unify collection	
RTT waiting times	Patients waiting 18 weeks or less from referral to hospital treatment	Number of incomplete pathways within 18 weeks at the end of the reporting period	Total number of incomplete pathways at the end of the reporting period.	2016/17 year-end	Mar-17	Unify collection	
Provider Special Measures	NHS providers in special measures	N/A	N/A	Latest available	Jul-17	NHSI	Providers in special measures are attributed to the lead commissioner. The following Trusts were in special measures as at July 2017: Colchester University Hospitals NHSFT; Barts Health NHST; East Sussex Healthcare NHST; West Herts NHST; London Ambulance Service NHST; Walsall Healthcare NHST; Brighton and Sussex University Hospitals NHST; SE Coast Ambulance Service NHSFT; The Princess Alexandra NHST; St George's University Hospital NHSFT; Isle of Wight NHST; Northern Lincs and Goole NHSFT; United Lincs NHST; Kettering General NHSFT
Health Care Acquired infections - MRSA	Cases of MRSA per 100,000 acute trust bed days	Number of cases of each infection	Emergency bed days in acute trusts	Annual	2016/17	PHE's fingertips , AMR local indicators data for acute trusts in England	MRSA and Cdiff scores are averaged to provide a single HCAI score per STP
Health Care Acquired infections - Cdiff	Cases of c-difficile per 100,000 acute trust bed days	Number of cases of each infection	Emergency bed days in acute trusts	Annual	2016/17	PHE's fingertips , AMR local indicators data for acute trusts in England	MRSA and Cdiff scores are averaged to provide a single HCAI score per STP
Access to extended access appointments	Extended access to primary care services	The number of practices which meet the minimum access requirement	The total number of active GP practices in the STP at the time of collection.	Data from the most recent bi-annual publication	Mar-17	NHS England statistics (GP extended access)	
Patient satisfaction with opening times	Number of respondents satisfied with their GP practice opening times	Sum of patients very satisfied or fairly satisfied with opening times	Total responses (i.e. patients who did not complete this question were excluded from the denominator).	Annual	Jul-17	GP patient survey	Data used is in weighted form. For more information see https://gp-patient.co.uk/faq/weighted-data
IAPT recovery rate	Improving Access to Psychological Therapies recovery rate	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not). This is the following data field from the monthly / quarterly csv files Recovery	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment) This is calculated using the following data fields from the monthly / quarterly csv files FinishedCourseTreatment - Notcaseness	Rolling average for most recent financial quarter	Q4 2016/17	NHS Digital	
EIP two week wait	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	The number of people referred to the service experiencing first episode psychosis or at 'risk mental state' that start treatment within 2 weeks of referral in the last three months.	The number of people referred to the service experiencing first episode psychosis or at 'risk mental state' in the last 12 months	12 month rolling average due to small numbers	2016/17	Unify collection	
% of cancers diagnosed at stage 1 or 2	Cancers diagnosed at early stage	Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin	All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin	Data from the most recent annual publication	2015	Public Health England, data published 2017	
62-day waits	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	The number of people with an urgent GP referral for suspected cancer who received first treatment for cancer within 62 days in the reporting period	The total number of people with an urgent GP referral for suspected cancer who were treated in the reporting period	Rolling average for most recent financial quarter	Q4 2016/17	Unify collection	
Cancer Patient experience	Cancer patient experience	N/A because data is in the form of a score out of 10 (mean and 95% confidence intervals for each STP)	N/A see numerator	Data from the most recent annual publication	2015	Patient experience survey	The results are case-mix adjusted on cancer types taken from a 38-type categorisation. Cumbria CCG is split across two STPs but it was not possible to match 16 (approx. 2%) of its observations to either STP. Mapping for these postcodes was not possible so these observations were dropped from the estimation.
Emergency admissions	Total emergency spells per 10,000 population	Total emergency spells	Registered population	Annual figures	2016/17	SUS (tNR)	Directly standardised by age and sex to the England 2015 population
Emergency Bed days	Emergency bed days per 10,000 population	Emergency bed days	Registered population	Annual figures	2016/17	SUS (tNR)	Directly standardised by age and sex to the England 2015 population
DTOC	Delayed transfers of care (delayed days) for all reasons per 100,000 population	Number of delayed days (for all reasons)	Resident population	Rolling quarterly average	2016/17	NHSE statistics (DTOC)	
Leadership	Leadership status	N/A	N/A	ad hoc data collection	Jun-17	NHS England	System leadership assessments indicate the extent to which areas are working effectively to deliver system-level integration. They provide a holistic view of STP leadership performance and capacity, system-level planning, and engagement with communities, service users and staff. **Advanced** systems have the strongest system leadership, with organisations working well together at the system level and aligned behind a clear vision and plan. **Established** systems are working together at the system level, with organisations aware of the importance of effective system-level working and taking action to drive integration. **Developing** systems still work largely at the organisational level, but co-operate to achieve shared system level goals. **Early** systems may have a history of challenged relationships between organisations, and it may be too early to determine the impact of recent leadership changes.
CCG/Trust aggregated Total	STP financial performance against control total	Aggregate CCG and provider over/under performance against control total (£)	Aggregate CCG revenue resource limit (ie the amount of money available to provide healthcare for the population of the STP) (£)	2016/17 year-end position	Month 12 2016/17	NHS England	Positive % indicates that the CCG has outperformed the control total set by NHS England / Improvement, shown as a % of the total resource available. i.e they have achieved a higher surplus, or a lower deficit. Negative % indicates that the CCG has underperformed the control total set by NHS England / Improvement, shown as a % of the total resource available. i.e they have achieved a lower surplus, or a larger deficit.

		Hospital Performance					Patient Focused Change							Transformation					
		Emergency	Elective	Safety			General practice		Mental health		Cancer			Prevention			Leadership	Finance	
STP	Overall performance	A&E waiting time performance[1]	Referral to Treatment waiting time performance[2]	Providers in special measures[3]	Healthcare associated infections - MRSA[4]	Healthcare associated infections - c. difficile[5]	Extended access[6]	Patient satisfaction with opening times[7]	Improving Access to Psychological Therapies recovery rate[8]	Early Intervention in Psychosis 2-week waits[9]	% of cancers diagnosed at stage 1 or 2[10]	62-day waits[11]	Cancer patient experience score[12]	Emergency admissions rate[13]	Total bed days rate[14]	Delayed Transfers of Care rate[15]	System-wide leadership[16]	CCG/Trust performance vs. financial control total[17]	
		Mar-17	Mar-17	May-17	2016/17	2016/17	Mar-17	Jul-17	Q4 2016/17	2016/17	2015	Q4 2016/17	2015	2016/17	2016/17	2016/17	Jun-17	2016/17	
Northamptonshire	**Category 4 - needs most improvement**	84.1%	84.9%	Yes	0.0	8.9	0.0%	74.8%	39.9%	96.1%	56.8%	79.2%	8.5	112	589	12,063	4 - Early	-0.3%	

* indicates shadow Accountable Care System (ACS), or contains an ACS, or is a devolved system

Notes

1. Percentage of patients admitted, transferred or discharged from A&E within 4 hours
2. Patients waiting 18 weeks or less from referral to hospital treatment
3. NHS providers in special measures within the STP boundaries
4. Cases of MRSA per 100,000 acute trust bed days
5. Cases of c-difficile per 100,000 acute trust bed days
6. Percentage of general practices meeting minimum access requirements
7. Number of respondents satisfied with their GP practice opening times
8. Percentage of IAPT patients recovering following at least two treatment contacts
9. People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral
10. Percentage of cancers diagnosed at early stage
11. People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
12. Average cancer patient experience, case-mix adjusted
13. Total emergency spells per 10,000 population, age-sex standardised
14. Emergency bed days per 10,000 population, age-sex standardised
15. Delayed transfers of care (delayed days) for all reasons per 100,000 population
16. System leadership status
17. CCG/Trust combined surplus or deficit vs. total resource available (control total)

STP UPDATE: AUGUST 2017

PROGRAMME SUMMARY: The overall delivery status (process) is positive and significant progress has been made this month on programme planning.

Project Name	Update as at 11 August 2017	RAG
Health and Wellbeing		
Building resilient communities through volunteering and social action	VCSE Common Assurance Process - Project launch meeting held and PID drafting commenced Volunteer link - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval	
Improving population mental health and wellbeing though social prescribing	Social Prescribing Model - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval; Development of Social Impact Bond Expression of Interest to 'Life Chances Fund' commenced alongside stakeholder discussions; Socialisation approach around Social Prescribing policy statement for Northamptonshire drafted and stakeholder power and influence assessment being undertaken; Initial set of Social Prescribing presentation materials finalised	
Systematic personalised and proactive presentations at scales	County-wide prevention programmes & MECC - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval; initial discussions held with Districts and Boroughs representative around integrated approach to meeting citizens needs Sustainable Development Unit - Local Digital Roadmap liaison with NSDU mapped; web pages/micro site for Unit communications being explored Social Marketing - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval; Approach around hypertension under development Behaviour Change - No further work over the period, but will become element of social marketing approach	
Clinical preventative services	Optimising clinical care - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval Supporting new diagnoses of LTCs - Business Plan considered by STP Board and referred as test case for DoFs and Clinical Leaders review and approval	
Primary, Community and Social Care		
Same day primary care	The teams are currently rolling out across the GP federations. The team are supporting the development of the Business Case	
Collaborative care team	MDT arrangements have been agreed by the GP Federations.	
Care home	Initiative to be managed under the CCG governance arrangements. The team are supporting the development of the Business Case	

Diabetes care package	Transformation funding agree by NHS England for the project. The team are supporting the development of the Business Case	
Intermediate care	Project Initiative document developed further work continues to develop the case for change, agree clinical model and benefits realisation. The team are supporting the development of the Business Case	
Acute & Secondary Care		
Inflow	Project continues to develop work stream project documentation. Supprting development of Business Case	
Internal flow	Trusts continue to deliver on the work streams with the project. Supporting development of business case.	
Outflow	BCF alignment underway with outflow workstreams. Supporting development of Business Case	
Rheumatology	The teams have developed the referral protocols and will pilot these in order for them to form part of the MSK hub from December 2017.	
Dermatology	GPwSI training has been confirmed and an expression of interest document for GPs to sign up to be part of the integrated community dermatology service has been issued to all GPs.	
Cardiology	The business plan is being developed for the service and a series of business cases will be developed to support implementation. The first will be Cardiac MRI, Cardiac CT and heart failure.	
Orthopaedics	National guidance has been issued to the CCGs to establish and MSK service by December 2017. A PID has been completed and submitted to NHSE. Programme management arrangements have been confirmed and work is ongoing to complete a business case by the end of September based on the extensive work already carried out by the orthopaedic teams. Finance model to be confirmed by DoFs.	
Ophthalmology	A draft PID has been created and formed the basis of clinical discussion with CCG clinicians and acute teams in June 2017. The programme will consist of implementation of a series of pathways with the aim of easing pressure on acute services given year-on-year growth in activity and spend for the system. The programme will commence with 2017/18 planning for PEARS (Primary Eye Assessment and Referral Scheme) – known as MECS (minor eye conditions service elsewhere) where patients will be referred to a single point for minor eye conditions and where appropriate, directed to an accredited Optometrist for assessment and treatment in the community	
Pathology	The teams continue to work on the regional IT procurement and agreeing the model for Northamptonshire.	
System Development		

Accountable care system	Project is being redefined	N/A
Consolidation of back office functions	Work across NGH, KGH and NHFT being driven by Trust DoFs	

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28th September 2017**

Title of the Report	**EPRR Self-Assessment Assurance Report**
Agenda item	**14**
Presenter of Report	**Deborah Needham** Chief Operating Officer/Deputy CEO
Author(s) of Report	**Jeremy Meadows** Head of Resilience & Business Continuity
Purpose	For information/awareness.

Executive summary

To provide an update of the EPRR self-assessment undertaken in August 2017 and progress against the NHS England Core Standards.

As an acute provider of NHS Funded Care, the Trust is required to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This is referred to as 'emergency preparedness, resilience and response' (EPRR).

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The following is a summary of the Trust's self-assessment against these requirements and governs the work plan for the next 12 months.

Related strategic aim and corporate objective	**Strategic aim 1 – 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 (**Y**)
Related Board Assurance Framework entries	**BAF 1.6**

Enclosure J

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:

- To note the contents of this paper.

Trust Board
28th September 2017
EPRR Self-Assessment Assurance Report

1. Introduction

Emergency Preparedness, Resilience and Response (EPRR) is key to ensuring that the Trust is able to respond to a variety of incidents whilst continuing to provide its essential services. The Civil Contingencies Act (CCA, 2004) places a number of statutory duties on the Trust as a Category 1 Responder. These duties include:

- Risk assessments to inform contingency planning
- Emergency planning
- Business continuity planning
- Co-operation with other responders
- Information sharing with other responders
- Warning, informing and advising the public in the event of an emergency.

As an acute provider of NHS Funded Care, the Trust is required to carry out self-assessment against the NHS England Core Standards, and evidence appropriate planning and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act (2004) and NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework (2015).

2. Criteria for assessment of Core standards

The past 12 months have resulted in continued improvement in the implementation and development of emergency planning within the Trust. Key areas of improvement for 2017 have been the increase in number of staff that have undertaken training and exercising events in relation to incident response, and the recent ratification of the Corporate Major Incident Plan and Whole-site evacuation plan.

A robust and stringent process with Executive and Senior Management engagement has been followed to complete the self-assessment exercise to ensure that the results provide a true reflection of the Trust's overall position against the NHS Core Standard for Emergency Preparedness, Resilience and Response.

The Trust is required to benchmark each theme against the following compliance levels:

- Fully Compliant
- Partially Compliant
- Non-Compliant

The table below provides an overview of the Trust's position against the Core Standard which is described through a series of 46 criteria: (2016-17 comparison is shown in brackets)

Analysis shows a noteworthy improvement in the Trust's position compared to last year's assessment.

Table 1 below shows the current position of the Trust against the core standards. It shows that the Trust is compliant with 100% of the standards.

Table 1: NGH Core Standards Review 2017.

	All Standards		EPRR Standards		CBRN Standards		Governance Deep Dive	
	Total	**%**	Total	%	Total	%	Total	%
GREEN = Fully compliant with core standard.	**99**	**100%**	46	100%	47	100%	6	100%
AMBER = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	**0**	**0%**	0	0%	0	0%	0	0%
RED = Not compliant with core standard and not in the EPRR work plan within the next 12 months.	**0**	**0%**	0	0%	0	0%	0	0%

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
Governance	4	Fully	4	100% (100%)
		Partial	-	
		Non-Compliant	-	
Duty to assess risk	3	Fully	3	100% (100%)
		Partial	-	
		Non-Compliant	-	
Duty to maintain plans – emergency plans and business continuity plans	20	Fully	20	100% (75%)
		Partial	-	
		Non-Compliant	-	
Command and Control (C2)	7	Fully	7	100% (57%)
		Partial	-	
		Non-Compliant	-	
Duty to communicate with the public	2	Fully	2	100% (100%)
		Partial	-	
		Non-Compliant	-	
Information Sharing – mandatory requirements	1	Fully	1	100% (100%)
		Partial	-	
		Non-Compliant	-	
Co-operation	5	Fully	5	100% (100%)
		Partial	-	
		Non-Compliant	-	
Training and Exercising	4	Fully	4	100% (25%)
		Partial	-	
		Non-Compliant	-	

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
Governance	6	Fully	6	100%
		Partial	-	
		Non-Compliant	-	

The topic of this year's 'Deep Dive' element is Governance. It is deemed that the Trust is fully compliant with the six core standards as the result of:

- Publication of the results of the 2016/17 assurance process.
- Identification of a non-executive director who formally holds the EPRR portfolio.
- The Trust having an internal group that oversees and drives the internal work of the EPRR function.
- AEO attendance at the Local Health Resilience Partnership meetings

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
CBRN (Chemical, Biological, Radiological & Nuclear) Preparedness	5	Fully	5	100% (100%)
		Partial	-	
		Non-Compliant	-	
Decontamination Equipment	5	Fully	5	100% (60%)
		Partial	-	
		Non-Compliant	-	
Training	4	Fully	4	100% (100%)
		Partial	-	
		Non-Compliant	-	
Equipment	33	Fully	33	100% (100%)
		Partial	-	
		Non-Compliant	-	

Following sign-off by the Trust Board, the self-assessment will be for formally assessed by NHS England at the Assurance Panel on the 27th September.

On the basis of the Self-Assessment, the Trust will be declaring an overall rating of Fully Compliant, with 100% (up on 84% 2016-17) of all criteria being Fully Compliant. The definitions of full, substantial, partial and non-compliance are included below for awareness.

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Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

* Should an organisation be non-compliant the LHRP will regularly monitor progress throughout the year until it is has attained an agreed level of compliance.

The 3 main areas of improvement over the past 12 months, with a brief overview of each area, are listed below:

Duty to maintain plans – emergency plans and business continuity plans:
An area that has seen an improvement over the past 12 months is the ratification of a number of key plans. The Corporate Major Incident plan is the foundation of the Trust's incident response plans. This year it was updated as part of its annual review, in line with latest guidance and to reflect the latest reconfigurations within the Trust.

In extreme situations it may become necessary to evacuate parts of, or the whole of the hospital site to safeguard the health and wellbeing of patients, staff and visitors. Following work with Kettering General Hospital and Northamptonshire County Council, the Trust's evacuation plan has also been ratified, and details how we could evacuate and temporarily relocate a large number of patients, staff and visitors.

Work is ongoing to ensure that all policies and plans are aligned internally and externally with partner organisations though appropriate representation and involvement with multiagency groups including the Local Resilience Forum and Local Health Resilience Partnership. As part of the update requirements, plans are being reviewed and updated in accordance with current guidance. A number of plans remain under review; however, in line with the review schedule, the current plans remain fit for purpose in ensuring the Trust is able to respond to the appropriate scenario.

Training and Exercising:
Following the increase of the national threat level as a result of the London and Manchester terrorist attacks, daily major incident training sessions were held for Gold, Silver and Bronze commanders. These have subsequently been reduced to fortnightly sessions to ensure ongoing awareness and attendance.

The Head of Resilience is working with ED to deliver quarterly CBRN decontamination training sessions in order to support the response required to a potential incident.

To ensure that appropriate training and exercising of staff and procedures is undertaken, where appropriate, staff are encouraged to attend multi-agency training and exercising.

Command and Control (C2): A key area that has seen an improvement over the past 12 months is ensuring all staff fulfilling Incident Management roles have received appropriate training. Attendance at Local Resilience Forum (LRF) run strategic and tactical leadership training is encouraged for individuals expected to fulfil these roles. Presentation materials from these courses are used as a basis for in-house delivered training sessions.

A number of live incidents have seen the Trust instigate its Command and Control arrangements, meaning response staff have hands-on experience of their roles. A Training and Exercising plan has been developed to address any shortfalls not covered above, with training following a rolling 12 month cycle.

3. Summary

Based on the evidence above, the Trust should be assured that measures are in place to adequately respond to incidents. The Emergency Planning and Business Continuity function has observed a marked improvement over the past few years and this has seen an improvement in the Trust's capabilities to plan for and respond to a major incident or failure in business continuity.

The recent cyber-attack has highlighted the Trust's ability to perform in accordance with the Command and Control structure, maintaining a focus on patient safety and providing the best possible care.

The emergency planning cycle will continue to determine the emergency planning and business continuity work plan for 2017-18. The key areas that will be prioritised within the next 12 months will continue to be Major Incident and Business Continuity planning and training & exercising, with an ongoing review of plans and close working with external stakeholders. A multi-agency Live exercise is being planned for Spring 2018.

To provide further reassurance the Emergency Planning and Business Continuity Team will continue to engage with clinical and corporate teams to ensure the work programme is delivered to a high standard and timescale.

It is clearly visible that the current programme is maturing year-on-year. The Trust aims to maintain compliance against the EPRR Core Standard Framework within the next 12 months.

4. Recommendation

The Board is asked to note the contents of the report

Report To	Public Trust Board
Date of Meeting	28 September 2017

Title of the Report	Best Possible Care Status
Agenda item	15
Sponsoring Director	Carolyn Fox
Author(s) of Report	Carolyn Fox, Director of Nursing/Carol Bradley, Nursing & Quality Matron
Purpose	For Approval
Executive summary	
Related strategic aim and corporate objective	Safety and Quality
Risk and assurance	Quality Care Standards
Related Board Assurance Framework entries	BAF
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	Ward and clinical areas requirements to comply with Trust Quality and Safety standards and Care Quality Commission (CQC) guidance

Enclosure K

Actions required by the Trust Board

The Board is asked to note and approve the content of this report.

Best Possible Care Status

1. Introduction

The purpose of this paper is to recommend Cedar Ward for Best Possible Care status, following 3 successful, consecutive Assessment & Accreditation visits and a successful Best Possible Care Panel.

2. Background Information

The Assessment and Accreditation 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 lesson 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 RAG 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 (**Table 1**).

The Ward Sister/ Charge Nurse, Matron and Associate Director of Nursing (ADNS) are responsible for formulating a ward improvement plan, ensure that it is tracked and disseminated to all members of the ward team. The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole will provide the Trust Board with comprehensive information regarding care delivery within the organisation.

For a ward/area to be recommended for consideration to a panel for Best Possible Care they must have achieved Green Status on 3 consecutive occasions thus demonstration sustainability in delivering high standards of care. The ward/area will then formally apply for 'Best Possible Care' Status

Table 1: RAG Criteria

Red	6 red standards	Reassess in 2 months
Amber	3-5 red standards	Reassess in 4 months
Green	2 red standards and 8 or more green standards Standard 15 must be green	Reassess in 6 months
Best Possible Care Ward	3 consecutive green assessments	Reassess in 12 months

Enclosure K

3. Best Possible Care

When a ward/area has achieved green status on 3 consecutive occasions the ward/area will submit an application form and a portfolio of evidence to the Nursing and Quality Matrons within 6 weeks of their last assessment. Once the submission is accepted the panel will convene within 4 weeks.

The panel review will consist of the following elements:

- Examination of a portfolio of evidence submitted by the ward. Ward team presentation to panel with a focus on achievements and sustainability.
- Panel questions to ward team post presentation/at interview.
- Panel visit to ward

The panel will be chaired by the Director of Nursing and will include:

- Chief Executive
- Associate Directors of Nursing
- Non-Executive Directors
- Matrons (from other divisions than the ward applying for 'Best Possible Care' status)
- Representation from the University of Northampton (UCN)
- Representation from the CCG(Deputy Director of Quality) /NHSI/NHSE
- Representation from a Patient Family Partner

Panel decision options:

- To recommend the ward/area to the Trust Board for 'Best Possible Care' Status.
- To refuse to recommend the ward/area to the Trust Board for 'Best Possible Care' status.
- To defer the decision for a set timeframe

The final decision to grant 'Best Possible Care' status will be made by the Trust Board.

Wards that achieve Best Possible Care Status will be reassessed in 12 months.

Process Flow Chart (Appendix 1)

4. Cedar Ward

Cedar Ward were initially assessed in June 2016 and achieved a green rating. This was followed by further green assessments in December 2016 and July 2017 (Table 2 below).

Table 2

Standard	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
July 2017															
Dec 2016															
June 2016															

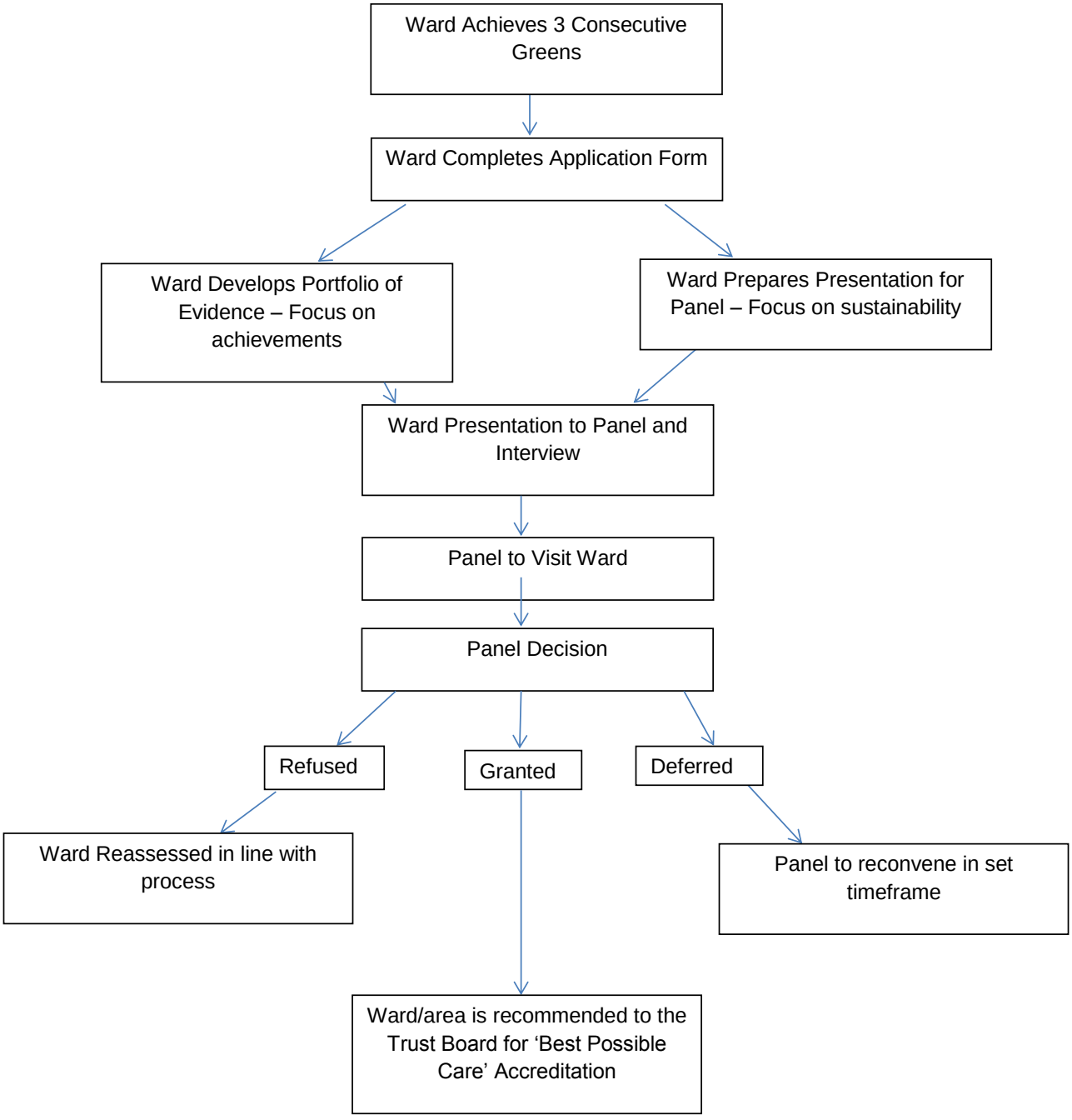
Cedar Ward applied for Best Possible Care status in August 2017 and a panel convened in September 2017. The Cedar ward team presented formally to the panel as to why they should receive Best Possible Care status and their plans for sustainability.

In addition the panel received an extensive portfolio of evidence developed around key performance indicators, detailed in Appendix 2. Cedar ward were asked a series of questions by the panel related to the process, portfolio and presentation. The panel visited the ward to see the improvements “in action”.

5. Recommendation

The panel would like to make a formal recommendation to the Trust Board to award Cedar ward Best Possible Care status.

Appendix 1 - BEST POSSIBLE CARE ACCREDITATION FLOW CHART



Appendix 2 **Essential Elements of Portfolio of Evidence**

Please provide supporting evidence within your portfolio. The evidence must cover a period no less than 12 months	**Panel Comments**
1. Structure and hierarchy of the team	
2. Patient Experience • FFT • Right time survey • Real time survey	
3. Complaints and PALS concerns numbers and themes	
4. Number of incidents (Datix) and themes	
5. Safeguarding • Numbers • Themes	
6. Serious Incidents – Numbers and themes	
7. Incidents of Pressure Ulcers and themes	
8. Infection Prevention • MRSA bacteraemias • MRSA acquisitions • Clostridium difficile • CRUTI • Other? • HHOT • HII • Environmental audits	
9. Falls with harms • Numbers • Themes	
10. Safety Thermometer data	
11. Nursing Quality Care Indicators and themes	
12. Training data • Mandatory • Role Specific	
13. Appraisal rates	
14. Patient length of stay	
15. Quality Improvement initiatives • Collaborative involvement	
16. Safety • Late Observations • Number of cardiac arrests • Number of peri arrests	
17. Ward testimonies • (1 patient,1 Consultant,1 AHP)	
18. Finance • Budget statements	
19. Roster Metrics • Sickness/absence rates • Use of temporary staffing	
20. Presentation • How the ward will sustain 'Best Possible Care' Status	

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28 September 2017**

Title of the Report	**Corporate Governance Report**
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	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**)

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
April – June 2017 (Q1)

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 1 2017/18

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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- 1st April – 30th June 2017: 16 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)

Previous numbers

Time period	Number of declarations
Q4 2016/17	17
Q3 2016/17	49
Q2 2016/17	30
Q1 2016/17	15

Declarations of Interest

No updates received

Report To	**Public Trust Board**
Date of Meeting	**28 September 2017**

Title of the Report	**Infection Prevention Annual Report**
Agenda item	**17**
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Authors of Report	Wendy Foster, Matron Infection Prevention Matron Mark Duggan- Acting Manager for Decontamination Kiranjeet Dhillon - Antimicrobial Pharmacist Claire Brown Occupational Health Manager/Specialist Community Public Health Nurse
Purpose	Assurance
Executive summary This annual report provides a summary of the performance and developments related to Infection Prevention and Control (IPC) during 2016/2017 and a broad plan of work for 2017/18.	
Related strategic aim and corporate objective	Corporate Objective 1 – Focus on Quality & Safety
Risk and assurance	Provides assurance on risks
Related Board Assurance Framework entries	BAF – 1.1, 1.2, 1.3
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? (NO) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (NO)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (NO)

	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (NO)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? Yes, to provide assurance in relation to the Health Act 2008 (Updated Check) and Social Care Act.
Group The Group is asked to note the content of this annual report and to support the work plan moving forward.	

1 Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2016/17 and the broad plan of work for 2017/18 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year 2016/17 and the Trusts' approach to reducing the risk of HCAI.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability.

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholders experience as well as helping to reduce the risk of infections. Additionally, the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements in particular NHS Nene & NHS Corby Clinical Commissioning Groups and Public Health England (PHE).

2 Executive Summary

The annual report for Infection Prevention and Control outlines the Trusts' Infection Prevention and Control (IPC) activity in 2016/17). In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The structure and headings of the report follow the ten criteria outlined in the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance[1].

2.1 Reportable Infections

The four infections that are now mandatory for reporting purposes are listed below. MRSA bloodstream infections and *Clostridium difficile* infections are national contractual reduction objectives.

- Meticillin[2] Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- *Clostridium difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- *Escherichia coli* (*E. coli*) bloodstream infections

There has been continuing focus on reducing both MRSA bacteraemia rates and *Clostridium difficile* rates, monitored by PHE.

2.2 MRSA

The HCAI objective for MRSA bloodstream infections for 2016/17 was 0 avoidable MRSA bacteraemia cases.

Cases are defined as non-Trust apportioned if blood cultures are collected on the day of admission or the day after; all other cases are apportioned to the Trust. It is the Trust-apportioned cases that are included as part of the national HCAI reduction targets.

There is now a standard national process for undertaking a Post- Infection Review (PIR) on all patients who have Trust or non-Trust apportioned MRSA. This involves a multiagency review of the patients care to determine if there have been any lapses of care which would have contributed to the infection.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf
[2] Meticillin has replaced Methicillin as the approved spelling

During 2016/17 the Trust had 0 Trust apportioned MRSA bacteraemias. This is a 100% reduction on 2015/2016.

2.3 *Clostridium difficile* Infections

The HCAI national objective set for NGH Trust apportioned cases of *Clostridium difficile* infections (CDI) for 2016/17 was no more than 21.

Cases are defined as Trust-apportioned CDI when the patients sample is taken on, or after, day 3. It is the Trust-apportioned cases that are included as part of the national HCAI reduction targets and the Trusts' quality goal.

There was 21 plus 1 patient with a Trust-apportioned CDI in 2016/17 that was on further investigation found to be a false positive.

2.4 Meticillin Sensitive *Staphylococcus aureus* Bloodstream Infections

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national targets.

2.5 *Escherichia coli* (*E. coli*) Bloodstream Infections

Although there is mandatory reporting of *E. coli* bloodstream infections, there are no targets and there is no recommendation to apportion cases to acute care or otherwise. This reflects the complexity of *E. coli* infections.

There was an increase in the number of all patients with *E. coli* bloodstream infections from 209 in 2014/15 to 241 for 2015/16 the majority of which were admitted with *E. coli* sepsis. In 2016/2017 this continues to rise to 264 patients with *E. coli* bacteraemias.

2.6 Director of Infection Prevention Control (DIPC) Reports to the Board of Directors

The DIPC delivers an Annual Report to the Board of Directors.

The Executive Team receive updates on patients with *Clostridium difficile* infections and MRSA bacteraemias.

The Board of Directors receive:

- Monthly IPC Board Report
- Clinical Quality and Effectiveness Group (CQEG) Monthly Report
- Patient Safety, Clinical Quality & Governance Progress Report (quarterly)

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

3 Governance and Monitoring

3.1 IPC Governance

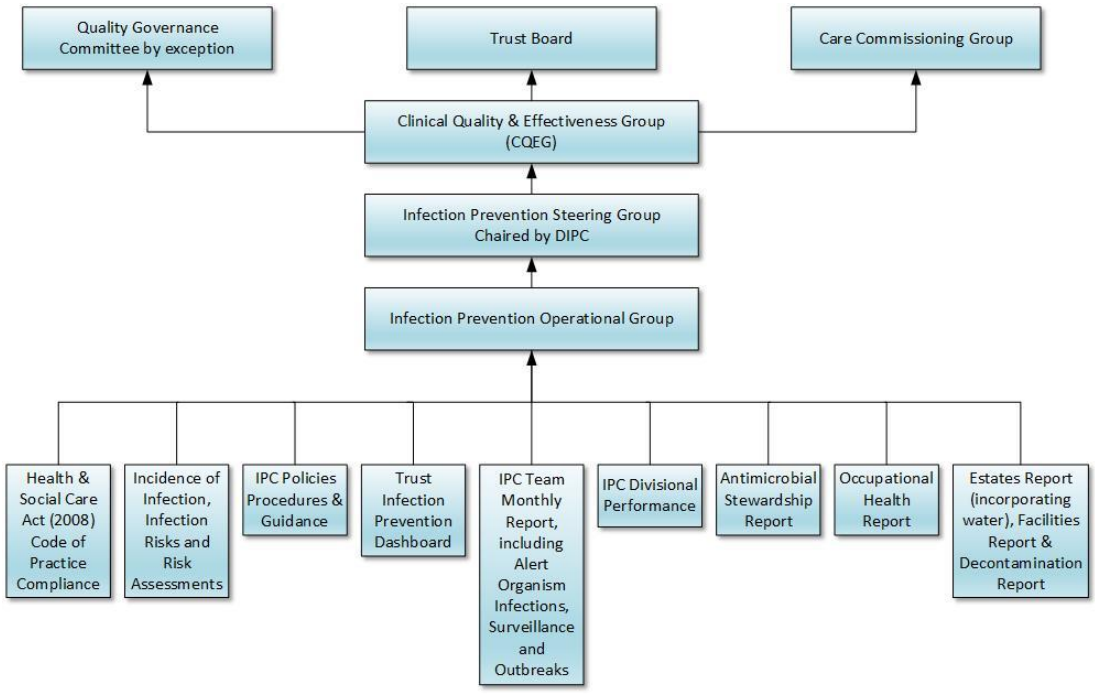
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Director of Nursing, Midwifery & Patient Services.

The DIPC is supported by the Medical Director, Consultant Microbiologist, Deputy Director of Nursing, the Matron for Infection Prevention and the Trust Antimicrobial Pharmacist.

The Infection Prevention and Control Team (IPCT) include microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, associate directors of nursing, divisional directors, divisional managers, divisional matrons, ward managers, infection prevention and control link staff and sterile services.

Infection Prevention Steering Group Structure



In 2016/2017 the Infection Prevention Committee and the Infection Prevention Operational Group (IPOG) continue to be held on a monthly basis.

The purpose of IPOG is to ensure that there is a managed environment within Northampton General Hospital (NGH) NHS Trust that minimises the risk of infection to patient's staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust and makes recommendations to the IPSG and divisions.

The purpose of the Steering Group is to provide strategic direction for the prevention and control of HCAIs in NGH NHS Trust that minimises the risk to patients, staff and visitors. Decontamination, Sterile Services reports through the IPOG. The Estates Department report both operationally and strategically. The DIPC also provides a monthly Infection Prevention report into CQEG.

3.2 Quality Governance Committee (QGC)

The Quality Governance Committee is a sub-committee of the Trust Board and reviews areas of concern and improvement arising from the IPSG.

3.3 Links to Clinical Governance and Patient Safety

The DIPC reports the Trust position in relation to infection prevention and control to CQEG on a monthly basis. Learning from Post Infection Reviews (PIR) for MRSA bacteraemia and *Clostridium difficile* infections are shared by the wards and departments at IPOG and at CQEG. There were 0 Trust attributed MRSA bacteraemia for 2016/2017. Learning from the Trusts' previous MRSA bacteraemias were presented at the Trusts' Dare to Share forum.

3.4 Infection Prevention Steering Group

The Trust Infection Prevention Steering Group provides a forum to support the delivery of a zero-tolerance approach to avoidable HCAIs. This Group reports into CQEG. Infection Prevention is part of the Director of Nursing (DoN) report which reports monthly to the QGC and the Trust Board.

3.5 Monitoring

3.6 Clinical Commissioning Group (CCG)

NHS Nene & Corby CCG is NGH's commissioning organisation. IPC is a key element of quality commissioning and forms part of a joint commissioning quality schedule.

The CCGs participate in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also oversee the cases of CDI, reviewing all cases and attributing any lapses in care.

3.7 Northamptonshire Health Economy HCAI Group

The Infection Prevention and Control Team (IPCT) are active members of the local whole health economy group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equally good quality.

3.8 Infection Control Standards and Assurance

In 2016/17 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control.
This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust continues to undertake a number of interventions in relation to infection prevention and control as detailed within the HCAI Reduction Plan 2016/17. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Medical Director and Matron for Infection Prevention and Control.

The IPCT continues to report numbers of MRSA/CDI to the Executive Team and to the Trust Board on a monthly basis and this is directly referenced in the Corporate Risk Register and Board Assurance Framework.

4 Healthcare Associated Infection Statistics and Targets

4.1 Surveillance

The Infection Prevention & Control Team (IPCT) undertakes continuous surveillance of alert organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

4.2 Alert Organisms[3]

- MRSA
- *Clostridium difficile*
- Group A *Streptococcus*
- *Salmonella* spp
- *Campylobacter* spp
- *Mycobacterium tuberculosis*
- Glycopeptide resistant *Enterococci*
- Multi - resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Influenza
- Neisseria meningitidis
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

4.3 Alert Conditions

- Scabies
- Chickenpox and shingles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

4.4 Current Actions to Improve Surveillance

On a weekly basis, a ward round of all patients with all CDI within the Trust is undertaken by the Consultant Microbiologist, Consultant Gastroenterologist, Antimicrobial Pharmacist and a member of the IPCT.

4.5 Identified Priorities for 2016/17

In 2016/17, the Trusts' HCAI Reduction Delivery Plan set out to:

[3] Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general infection prevention and control performance.

- Reduce the number of patients with CDI and achieve the national targets and the Trusts' Quality Account
- Reduce the number of MRSA bacteraemia to achieve the national targets
- Reduce the number of patients with MSSA bacteraemia

4.6 Staphylococcus aureus

All *Staphylococcus aureus* bacteraemias – sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA) – are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System (DCS). The Trusts' incidence of MSSA and MRSA cases is reported on the PHE website. The incidence of these cases is reported publicly as acute Trust apportioned or otherwise.

The reduction of **all** avoidable bloodstream infections including MSSA and MRSA continues to be an aim of the Trust.

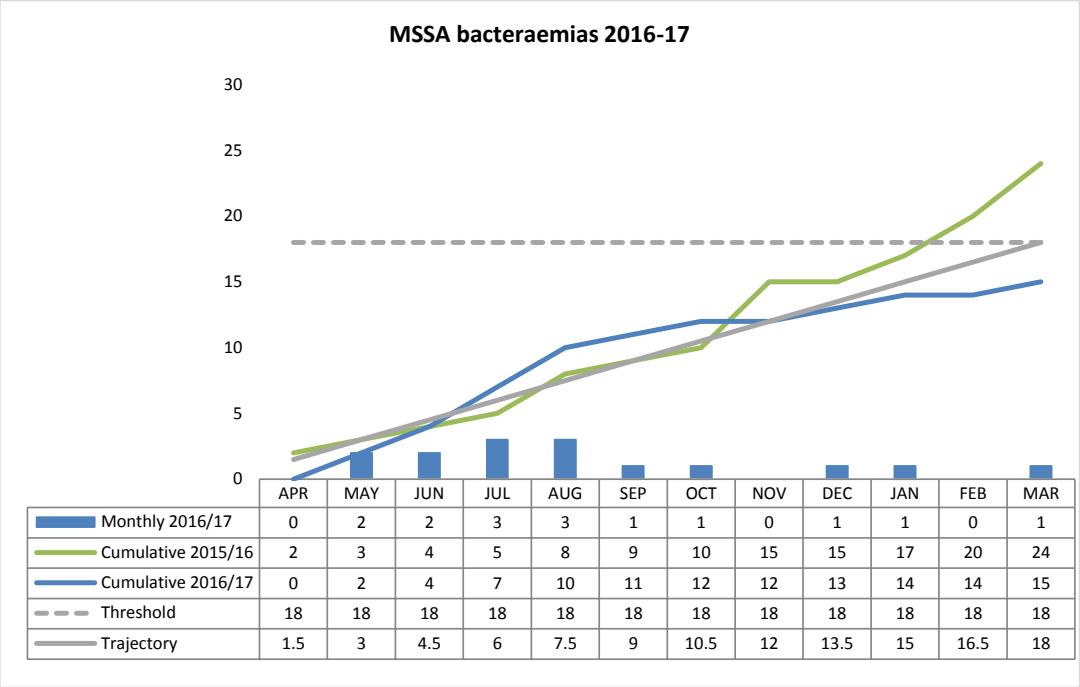
4.7 MSSA

There is a mandatory requirement for all NHS acute Trusts' to report MSSA bacteraemia since the 1st January 2011.This reflects the zero-tolerance approach that the Government has made clear that the National Health Service should adopt for all HCAI's, while recognising that not all MSSA bacteraemia are HCAIs. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The Trust records MSSA bacteraemia cases separately on the web-based system, as they do already for MRSA bacteraemia and the Chief Executive sign-off is on the 15th of the month.

4.8 MSSA bacteraemia (Trust-apportioned cases)

Fig 1



	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

Due to updated guidance from Public Health England (PHE) and a change in formula, the outturn for MSSA bacteraemias for 2015/2016 was at 24. IPCT set a revised ambition of no more than 18 cases for 2016/2017. This was met with a 38% reduction, 15 patients with Trust attributable MSSA bacteraemias. IPCT for 2017/18 a developed a further MSSA reduction plan and this will be monitored through IPSG.

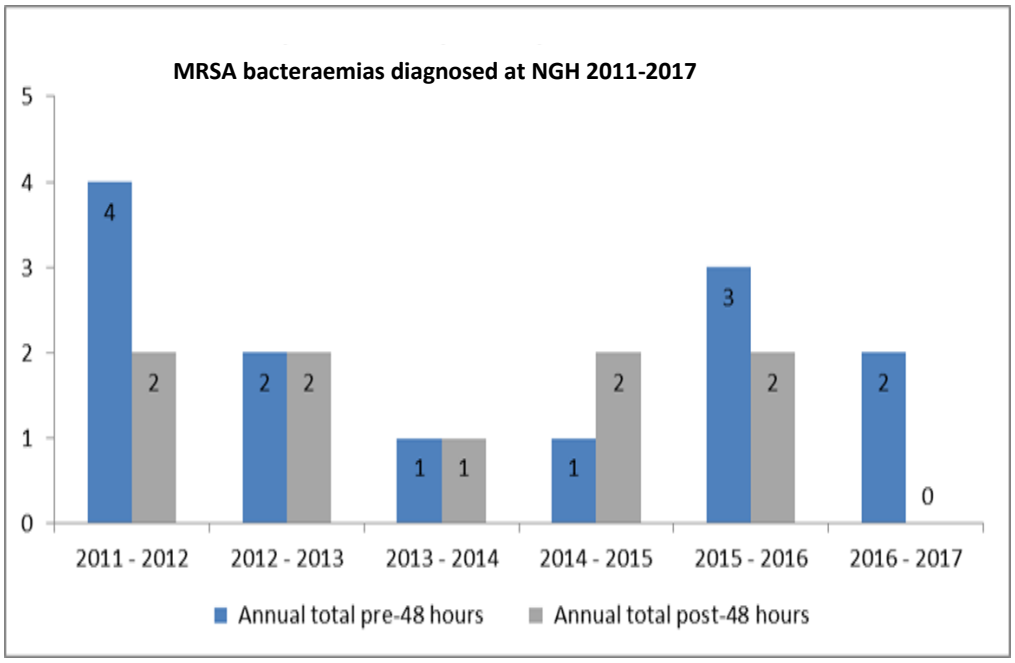
4.9 MRSA

The Trust investigates every MRSA bacteraemia as an incident and undertakes a post infection review (PIR). These investigations are fed back to a multi-disciplinary group including the DIPC and members of the Clinical Commissioning Group (CCG) and are accompanied by an action plan. These actions are monitored through the IPCT.

In 2015/16 the Trust was apportioned 2 MRSA bacteraemias. In 2016/2017 there was 0 Trust apportioned MRSA bacteraemias, this was a 100% reduction.

4.10 MRSA bacteraemia cases 2011–2017

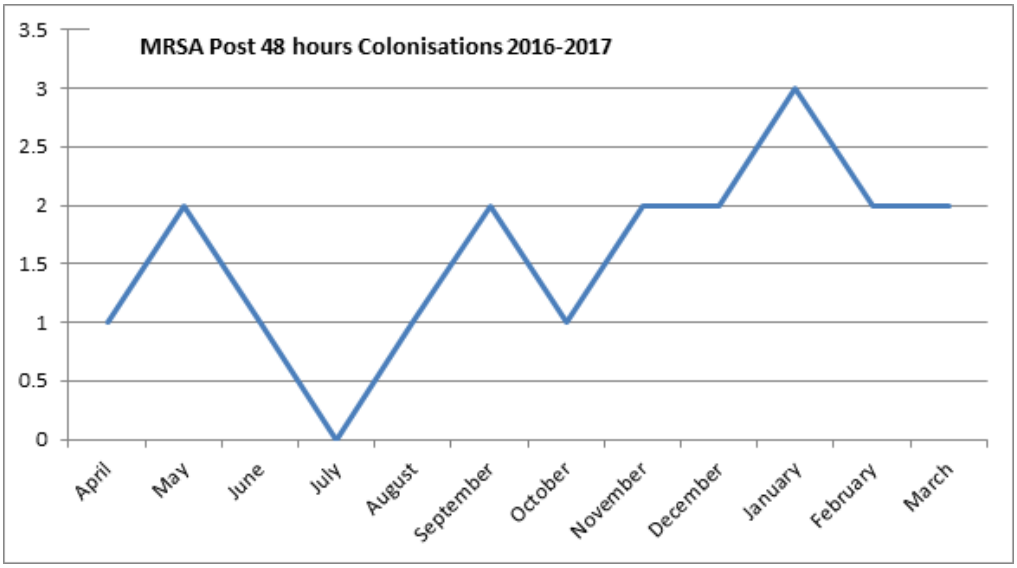
Fig 2



4.11 MRSA Colonisations

The graph below reflects the number of cases of MRSA colonisations attributed to the Trust per month during 2016/17

Fig3



The Trust continues to work with the CCG and the whole health economy in continuing to promote excellent HCAI policy and practice.

4.12 Period of Increased Incidence (PII) MRSA Colonisation

A PII is defined by Public Health England as 2 or more new cases of post admission MRSA colonisation on a ward in a 28-day period. Post admission is defined as any MRSA swab dated over 48 hours after admission.

The IPCT identified a range of actions which were implemented on any ward that had 2 or more new cases in a 28-day period. For 2016/17 the following wards Knightley and Becket had been on a Period of Increased Incidence (PII).

4.13 MRSA Screening by Patient Group

In line with the Department of Health 'MRSA Screening - Operational Guidance 2' the following patient groups are screened as indicated below:

Patient group / Admitted to	Screening
Elective admissions as described in DH letter and operational guidance (excludes some day cases)	Time of listing Eradication of MRSA attempted before admission
Critical Care patients	On admission to Critical Care and on a weekly basis
Renal dialysis patients	On admission and on a weekly basis
Surgical patients	On admission and on a weekly basis
All other patients including emergency admissions	On admission

Northampton General Hospital (NGH) achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall compliance for the year for electives 99.5% (patient specific verified data) and the overall compliance for non-electives was 97.12%. Efforts continue to achieve greater compliance.

4.14 Glycopeptide Resistant E*nterococci* (GRE)

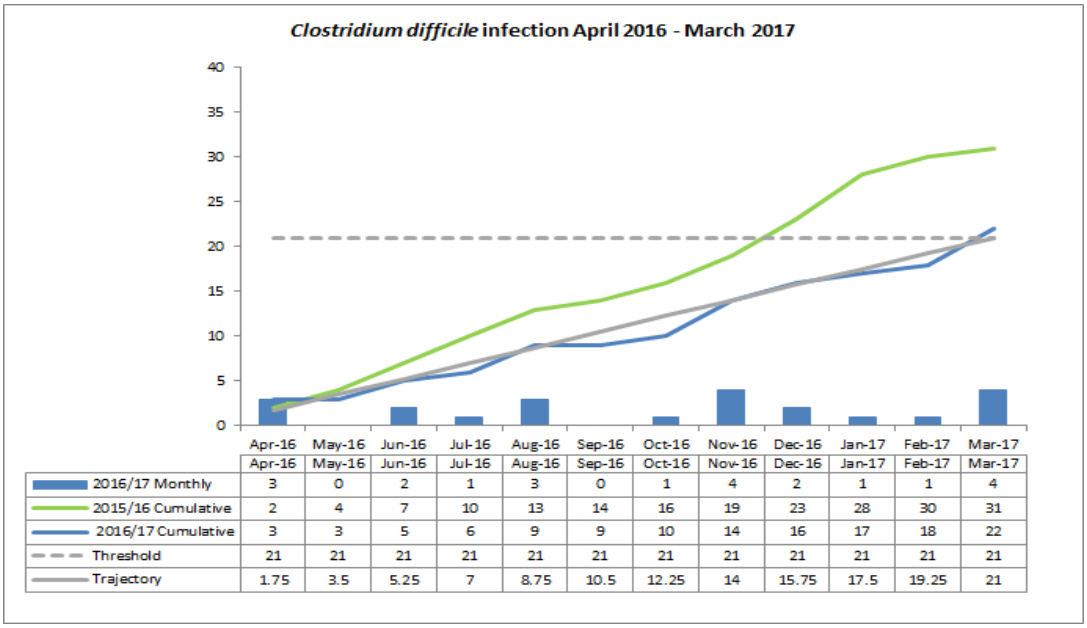
GRE are strains of *enterococci* resistant to the glycopeptide antibiotics (vancomycin and teicoplanin). *Enterococci* are bacteria normally found in the gut that may cause infections including bacteraemia. GRE bacteraemia is strongly associated with prolonged hospital stays and specialist areas such as renal units and intensive care units. GRE bacteraemias may be difficult to treat because only a few effective antibiotics are available. Rates per thousand bed days are not calculated owing to the small number of cases.

4.15 Clostridium difficile infection (CDI)

Since January 2004 it has been a mandatory surveillance requirement for the Trust to report cases of *Clostridium difficile* toxin positive stool. Non-inpatient cases detected in the Clinical Microbiology Laboratory must also be reported as part of the NGH data. *Clostridium difficile* cases are no longer subject to a separate target for patients aged 65 years and older, all cases in patients >2 years old are reportable.

The CDI NHS England target for the Trust for 2016/17 was no more than 21 cases. There were 31 patients with Trust-apportioned CDI in 2015/16. In 2016/17 there were 21 +1 patients with CDI the +1 was potentially a false positive. This is being reviewed by the Consultant Microbiologist. Therefore, there is a 32% reduction on the previous year's outturn.

Fig4



	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

All CDI cases have been investigated by the clinical teams, the IPCT, the Consultant Microbiologist and the Antimicrobial Pharmacist utilising a Post Infection Review (PIR) process. Wards that have had Trust attributable CDI are asked to feedback their findings from the Post Infection Review (PIR) process at the monthly IPOG meeting, where their learning can be shared with members of the group. Findings from the PIR are also presented through IPSG and CQEG.

In line with National Guidance, The Clinical Commissioning Group (CCG) review all Trusts' attributable CDI PIR's. Of the 21+1 cases, there were 0 lapses in care appointed by the CCG. The CDI trajectory for 2017/18 remains at 21 Trust attributable cases. The IPCT have performed a thematic review of all 21+1 CDI cases and the findings from this review have enabled the production of the *Clostridium difficile* Improvement Plan (2017/18).

4.16 Actions completed in 2016/17 to reduce the risk of CDI

- Implementation of the Annual Healthcare Acquired Infection reduction delivery plan which is monitored by the Infection Prevention Steering Group (IPSG), this included actions to reduce CDI and other healthcare associated infections.

- In addition, there has been a separate *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 Trust used quality improvement methodology to reduce CDI. The NGH collaborative group included the IPCT, ward staff and matrons from three wards, a domestic supervisor, antimicrobial pharmacist and a registrar. The group decided to focus on reducing *Clostridium difficile* (*C. diff*) infection as the trajectory was exceeded for 2015/16. The two main themes from the retrospective review of patients that developed *C. diff* in 2015/16 were delayed collection of faecal samples and delayed isolation of patients so the group concentrated on ways to improve practice surrounding these two processes.

- Using a quality improvement methodology, the IPCT supported Collingtree, Creaton and Willow ward teams to identify patients with *C. diff* more promptly by improving sampling process and also to isolate patients promptly to protect other patients from cross-infection. The ward managers used Plan, Do, Study, Act (PDSA) cycles to trial different tests of change initiatives and refine them each week. The teams also met every week with the IPT to share their experiences, PDSAs, tests of change and to improve and refine the products that have now formed the change package: the 'C the difference' toolkit. This has been rolled out across the Trust and will continue to underpin the IPCT work for 2017/2018.

- The weekly *C. diff* round continues where patients with *C. diff* acquisition are reviewed by the Consultant Gastroenterologist, Consultant Microbiologist, Antimicrobial Pharmacist, member of the IPT and now in addition our newly appointed Nutritional Nurse Specialist. This ensures that patients who have CDI acquisition have a multidisciplinary review and are on the correct course of treatment for their infection. As part of this there is advice and close monitoring of the antibiotics.

- In January 2016, IPT 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 of transfer of infection and protect other patients on the ward from infection.

- Estates, Domestic and Infection (EDI) Prevention review continues and therefore enabling a collaborative thorough review of a ward area that has a patient who has developed an infection for example CDI.

    - IPT have developed and implemented Ward of the Week. In the absence of a decant ward and in order to remain proactive to any Estates or cleanliness issues on the wards, IPT work with Facilities and have implemented a Ward of the Week programme. For one week each month the Estates, Domestic and Infection Prevention Teams work collaboratively to:
    - Complete an Estates, Domestic and Infection Prevention Inspection as above
    - Action and address any issues identified from the EDI
    - Implement the enhanced cleaning frequencies and schedules as described above
    - Provide any bespoke Infection Prevention training that the ward team may need for example hand hygiene, Aseptic Non - Touch Technique (ANTT) etc.
    - The aim is that this will ensure that patients are cared for in an environment where good infection prevention practices, cleanliness standards and the estate of the ward and are maintained.

The following figures are from PHE from the beginning of April 2016 to the end of March 2017 (Financial Year). These show Trust apportioned cases of CDI within our locality

4.17 Trust Apportioned cases for the Financial Year 2016-2017

	Trajectory	Actual
Northampton General Hospital	21	**21+1**
Kettering General Hospital	26	**21**
United Lincolnshire Hospitals	59	**57**
University Hospital Coventry and Warwick	42	**29**
Worcester Acute Hospital	32	**41**

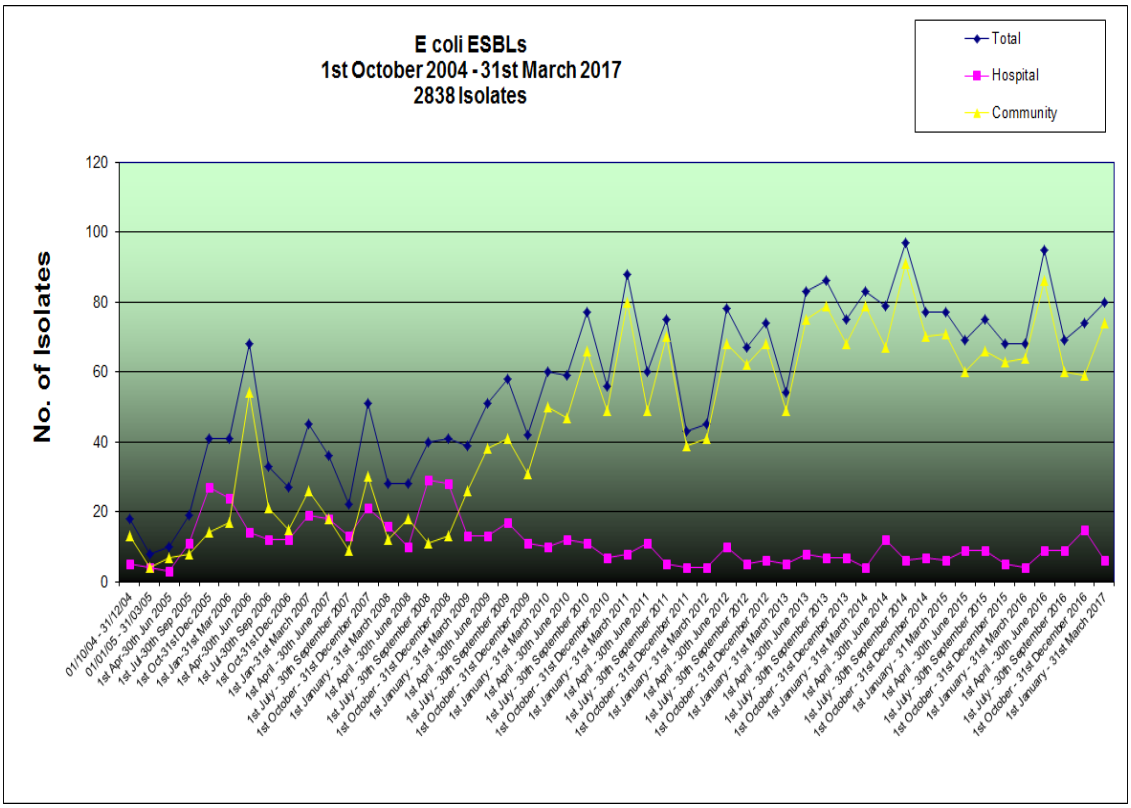
4.18 Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-lactamase Producers)

ESBLs are a group of enzymes produced by bacteria. The enzymes break down antibiotics such as cephalosporins and penicillin's, but the bacteria are usually susceptible to and hence treatable with the carbapenem antibiotics.

The epidemiology of these bacteria is not fully understood. The emergent nature of this field of microbiology is underlined by the absence of any national case definitions for community or hospital-acquired infections with ESBL producers, or recommendations on what constitutes an episode of infection with ESBL producing bacteria

4.19 ESBL Producing Bacteria (Clinical Isolates)

Fig 5



4.20 Escherichia coli (*E. coli*) bacteraemia

In accordance with the Department of Health Guidelines the IPCT commenced mandatory reporting of *E. coli* bacteraemia in June 2011.

All *E. coli* post 48-hour positive blood cultures have detailed data collated and internal RCA's are conducted to highlight any common trends and learn from this analysis. Currently NGH considers all episodes diagnosed after 48 hours as hospital attributed. There is currently no ceiling, however moving forward there is a national focus on reducing *E. coli* bacteraemia, and in line with guidance the Trust is also collecting data on other Gram –negative bacteraemias, *Klebsiella* species and *Pseudomonas aureginosa.* For 2017/2018 IPCT will continue to work with the Whole Health Economy and combine efforts to protect our patients from Gram –negative bacteraemia.

4.21 Antimicrobial Resistance Carbapenemase Producing Enterobacteriaceae (CPE)

CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

2014/15 the DH issued guidance in the form of a toolkit[4] and this predominantly concentrated on prevention: isolation of high-risk individuals and screening being of particular importance. Focus has been given to patients who have been an in-patient abroad in the past 12 months**.** In response to this, the IPCT collaborated with other local Trusts' and utilising the CPE toolkit has developed the following:

- A Trust Wide CPE Procedural Document
- A Patient Information Leaflet
- A Staff Information leaflet
- A Training package on CPE
- A CPE surveillance sheet
- A flowchart and "how to" screen patients who are suspected to have CPE

Training on CPE is given at Trust Induction, this is an annual update and supported through the clinical staff workbook.

In 2016/2017 IPCT continued to build upon the work that had already been undertaken to manage CPE. Continuing work identified in the Trusts' Healthcare Associated Reduction Plan. In July 2016, a 'CPE grab pack' was produced (providing accurate information and education) should this be required by staff out of hours. IPCT continue to monitor numbers of screens and results and report positive cases to IPSG. IPCT also implemented the CPE screening process with our Community midwife team. 2016/2017 IPCT scoped out implementing the CPE screening with Pre- operative assessment this work continues into 2017/18 and further work with the Site Management Team in quarter 2 to identify patients that require CPE screening on admission / repatriation from high risk countries / hospitals.

4.22 Mandatory Surveillance of Surgical Site Infections

In collaboration with the Trauma and Orthopaedic Directorate the IPCT undertake five different categories of SSI surveillance each quarter. Total hip replacement, total knee replacement and repair of fractured neck of femur surgeries are surveyed every quarter. The IPCT conduct further surveillance on two additional categories of operation every quarter that survey patients undergoing general, vascular, obstetrics and gynaecology surgeries. All data for a surveillance period must be submitted within 60 days of the end of the quarter to PHE who collate and report on the data from all hospitals that have participated. From 1st April 2016 to 31st March 2017 the IPCT and T&O directorate undertook surgical site surveillance on the following categories of operation: repair of fractured neck of femur, total knee replacement, total hip replacement, abdominal hysterectomy, Caesarean section, small bowel, breast, large bowel and vascular

[4] *Available* from here: http://www.hpa.org.uk/Publications/InfectiousDiseases/AntimicrobialAndHealthcareAssociatedInfections/1312Toolkitforcarbapenementero/

surgery. Table 1 presents the number of operations included in the surveillance and the number of SSIs identified.

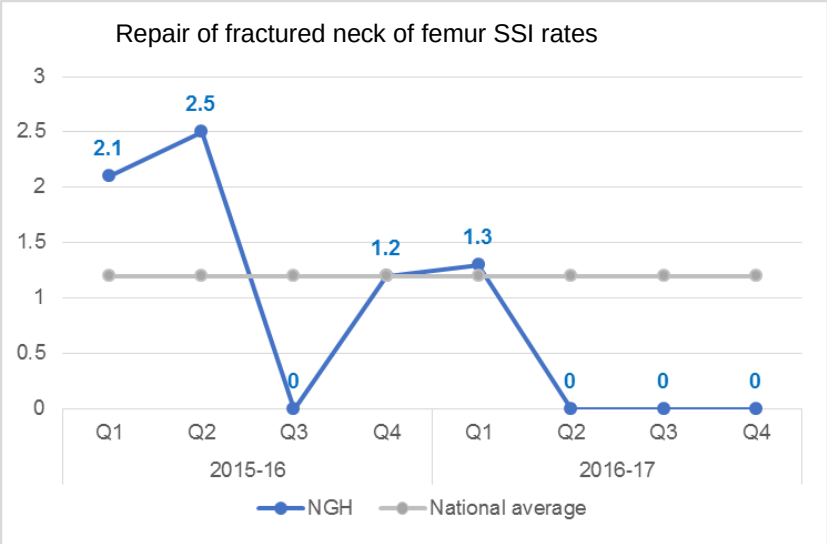
Table 1: SSI surveillance categories and SSIs detected 2016-17

2016/17	Repair of neck of femur	Total Knee Repl.	Total Hip Repl.	Abdominal hysterectomy	Caesarean section	Small bowel	Breast	Large bowel	Vascular
Total number of operations	353	263	244	42	358	22	108	62	64
No. of SSIs inpatient / readmissions	1	3	1	0	1	0	0	0	0
No. of SSIs post discharge confirmed by midwives					6				
No. of SSIs reported post discharge	0	2	1	0	0	0	0	0	0
TOTAL SSIs	1	5	2	0	7	0	0	0	0

4.23 Trauma and Orthopaedic continuous SSI surveillance 2016/17

Figure 6 presents the quarterly SSI rate for patients undergoing repair of fractured neck of femur surgery.

Figure 6: Repair of Neck of Femur quarterly SSI inpatient / readmission rate from April 2015 - March 2017



Following the high SSI rates in Q1 and Q2 of 2015-16, the T&O directorate completed an aggregated review and analysis and the ADN for the Surgical Division presented the recommendations to the Infection Prevention Steering Group in February 2016. The recommendations included:

- All patients requiring surgery for repair of neck of femur to receive topical decolonisation therapy prior to surgery
- Audits to be undertaken by the senior team on Abington ward to ensure that decolonisation therapy is prescribed and administered
- Review of the fractured neck of femur surgical site care bundle

- Quarterly discussion and sharing of learning from all patients who develop a SSI in this category of surgery at a T&O consultants meeting

Following the implementation of these recommendations, to date the NGH rate of SSI for this category of operation has consistently remained below the national average.

Figure 7 presents the quarterly SSI rate for patients undergoing total hip replacement surgery

Figure 7: Total hip replacements quarterly SSI inpatient / readmission rate from April 2015 - March 2017

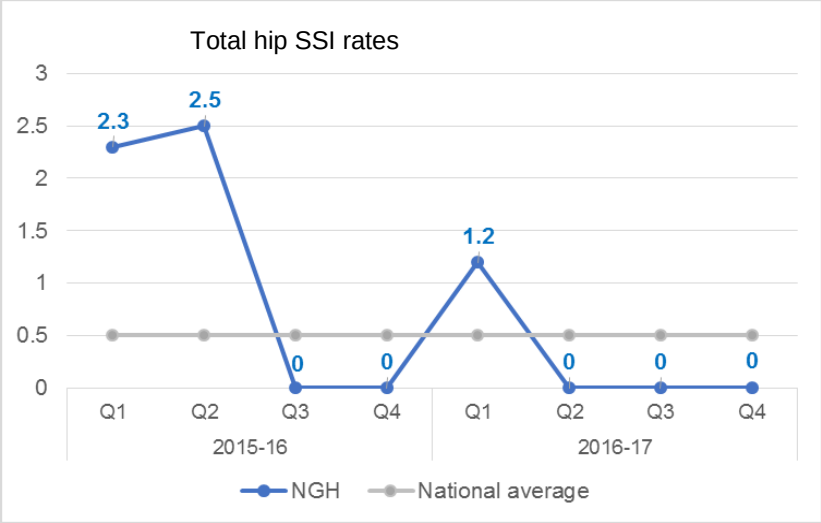


Figure 7 depicts high SSI rates in Q1 and Q2 of 2015-16 for hip replacements. Following this the T&O directorate completed an aggregated review and analysis and the ADN for the Surgical Division presented the recommendations to the Infection Prevention Steering Group in February 2016. Since then the rates have remained lower and are reported each quarter to the T&O directorate by the IPC Team.
Figure 8 displays the SSI rates for patients who have undergone total knee replacement surgery from April 2015 to March 2017.

Figure 8: Total knee replacements quarterly SSI inpatient / readmission rate from April 2015 - March 2017

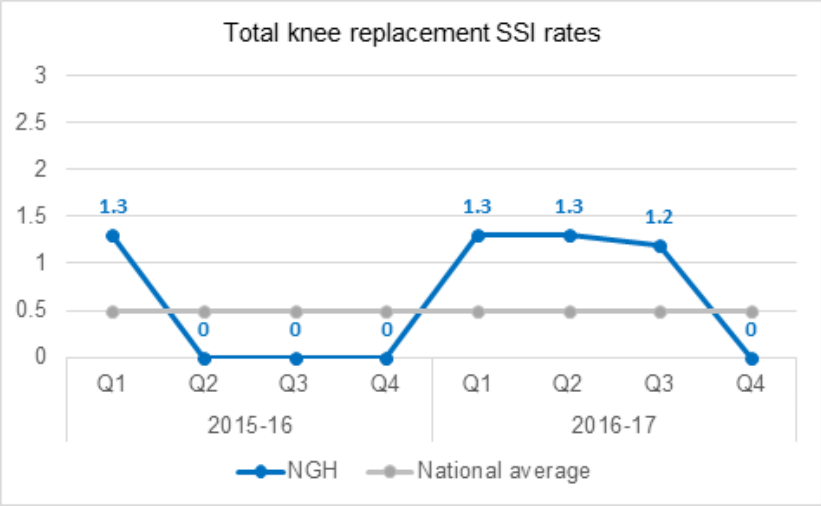


Figure 8 depicts high SSI rates in Q2 and Q3 for 2016-17 for knee replacements. The Matron for IPC presented these cases to the T&O consultants and the following actions have been implemented:

- Decolonisation treatment commenced in Pre-Operative Assessment Clinic for the elective orthopaedic patients
- Quarterly discussion and sharing of learning from all orthopaedic patients who develop a surgical site infection at quarterly T&O consultants' meetings
- Implementation of single patient use cuffs for delivering ice therapy to the knee to reduce post-operative swelling following this particular surgery
- The Matron for IPC to observe three total knee replacement operations in theatres and collate a report of findings

4.24 Further SSI surveillance conducted by the IPCT 2016/17

In addition to the T&O surveillance the IPCT also conduct quarterly surveillance on a variety of operations. For 2016/17 the Trust remained below the national average rate of infection for all categories surveyed, as presented in Table 2.

Table 2: Trust and national SSI rates 2016/17

Quarter	Category	Number of operations undertaken at NGH	NGH SSI rate (%)	National average SSI rate (%)
1	Abdominal hysterectomy	42	0%	1.2%
2	Caesarean sections	358	2%	3.4%
3	Small bowel	22	0%	6.6%
	Breast surgery	108	0%	0.8%
4	Large bowel	62	0%	Not yet available
	Vascular	64	0%	Not yet available

A Post Infection Review is conducted for all patients that develop a SSI and the infection is discussed with the patient's consultant to determine whether the infection was avoidable or not. SSI rates and learning from cases are then reported back to the surgical division through the divisional governance structure for discussion and actioning as required. In 2016-17 two patient information leaflets have been developed to provide patients with surgical wound care advice and information, one for patients who have undergone Caesarean section surgery and one for patients who have had general surgery.

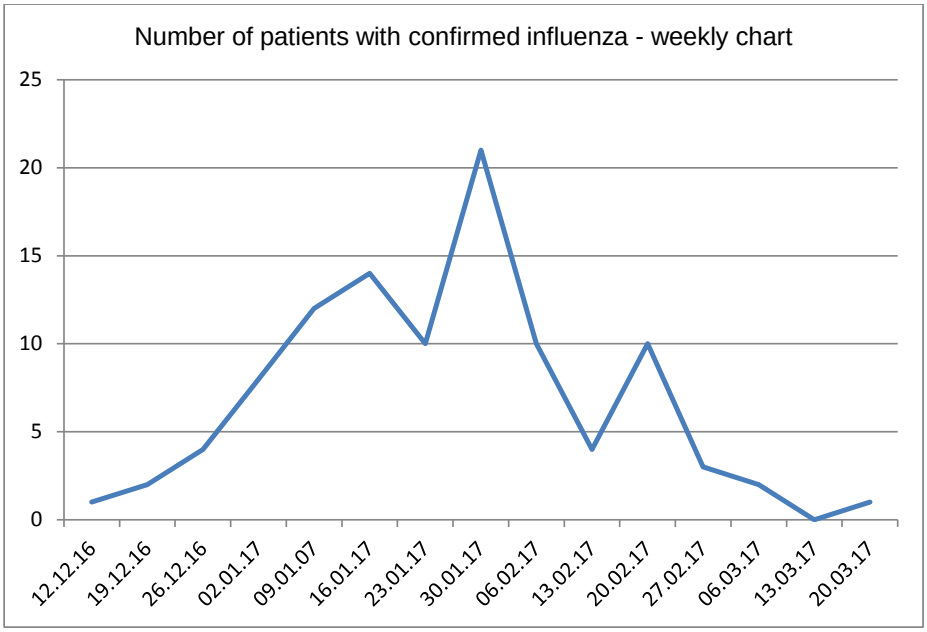
4.25 Untoward Incidents and Outbreaks

Influenza

In January 2017, an outbreak of influenza was declared on Dryden Cardiology ward at Northampton General Hospital. Outbreak meetings were convened in accordance with the IPC Major Outbreak Policy. The ward was closed to admissions and transfers, with an individual risk assessment approach for urgent cardiac patients. The outbreak was deemed to have affected a total of 6 patients during the outbreak on Dryden ward. The outbreak was declared as a Serious Incident in accordance with the Serious Incident framework (2015) and a comprehensive report was prepared and sent to the CCG. Daily meetings throughout the period of the outbreak ensured the situation was tightly managed and decisions were made promptly with the involvement of a multidisciplinary team at all stages. Therefore, maximising the safety of patients and staff. The outbreak was dealt with in a timely manner and normal working was resumed in a short time frame.

The graph below shows the number of patients admitted with confirmed influenza. The number of patients peaked at the beginning of January 2017, troughed slightly and peaked again later into January, finally troughed in March 2017.

Fig 9



The influenza activity within Northampton General Hospital reflected the epidemiological picture both within the East Midlands and nationally, which was reported on by PHE.

5 Infection Prevention Annual Audit Plan

5.1 Infection Prevention Audits April 2016 - March 2017

The IPT performed the audits in the table below. All audits are reported at the Clinical Quality and Effectiveness Group (CQEG), Infection Prevention and Control Operational Group (IPOG) and the Infection Prevention Steering Group (IPSG). Actions from the audits are monitored through the IPSG.

	Annual audits	6 Monthly	Quarterly and Monthly Audits
Apr 2016	Standard precautions		*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
May 2016	Handling & disposal of waste audit	Commode audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits Safety thermometer audit validation for CRUTIs Water outlet flushing audit.
Jun 2016	Handling & disposal of sharps audit		*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs MSSA & MRSA suppression compliance audit
Jul 2016		HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs Water outlet flushing audit.
Aug 2016		Commode audit HHOT repeat audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Sept 2016	HIS national point prevalence audit – includes cannula-related BSI, central-line related BSI and catheter-related UTI		*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs MSSA & MRSA suppression compliance audit. Water outlet flushing audit.
Oct 2016	Isolation precautions audit	HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Nov 2016	Risk assessment /transfer checklist audit	Commode audit HHOT repeat audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs Water outlet flushing audit.
Dec 2016		HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs MSSA & MRSA suppression compliance audit
Jan 2017	Isolation room usage audit	HHOT repeat audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs Water outlet flushing audit. **Change package audits**.
Feb 2017		Catheter-related UTIs prevalence audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Mar 2017	Aseptic non-touch technique audit Blood culture audit	HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs. Change package audits. MSSA & MRSA suppression compliance audit. Water outlet flushing audit.

Further audits: will be conducted when a ward has 2 or more MRSA or *C.difficile* cases in a 28-day period e.g. Isolations, Environment audits.
Completed audits: will be colour coded GREEN as record of completion. Completed audit reports are saved in the Audit folder of the IP shared drive.

Infection Prevention Team, V3 Feb 2017

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6 Hospital Cleaning

In 2016/2017 the Trust continued with monthly environmental cleanliness audits which were a paper based system. From December 2016, the Trust changed to an electronic audit tool. This system reflects the National Specifications for Cleanliness in the NHS (NPSA, 2007) and additionally the PAS 5748 Specifications for Cleanliness (BSI, 2014). The electronic audit tool enables the Domestic Supervisor to generate an action plan. All cleanliness audits scores are reported monthly to IPOG. Any concerns or good practice are escalated to IPSG.
The IPCT continue to work collaboratively with the Domestics and the Estates Team to maintain a clean and safe environment for our patients.

Monthly Environmental cleaning audits are performed in all directorates with the table below showing the monthly Trust percentage.

Month	%
April	96.8%
May	96.4%
June	97.0%
July	97.1%
August	96.5%
September	96.3%
October	97.0%
November	96.8%
December	96.6%
January	95.4%
February	96.1%
March	96.2%

Patient-Led Assessments of the Care Environment (PLACE) took place during March 2017. The aim of PLACE (which took over from the long-established PEAT programme) is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, cleanliness, the condition, appearance and maintenance of healthcare premises. The initial report submitted to the Department of Health reflected good scoring levels.

The IPCT always participates in these assessments and the Trust continues to achieve acceptable scores in the majority of the assessment process. The assessment which is carried out mainly by patient representatives and the results of the 2017 assessment were as follows:

- Cleanliness **99.66 %**(98.06%)
- Condition appearance and maintenance **97.45% (**93.37%)
- Privacy, dignity and wellbeing **89.98% (**84.16%)
- Food **87.71%%** (88.24%)
- Organisation Food **85.07%** (87.01%)
- Ward Food **88.37% (**88.96%)
- Dementia **82.29% (**75.28%)
- Disability **89.28% (**78.84%)

(The figures in bold are NGH's site score, the figures in brackets are the National Average scores)

Whilst this was a snapshot in time it is nevertheless a very good result and is used as evidence by the Care Quality Commission (CQC) in their reviews.

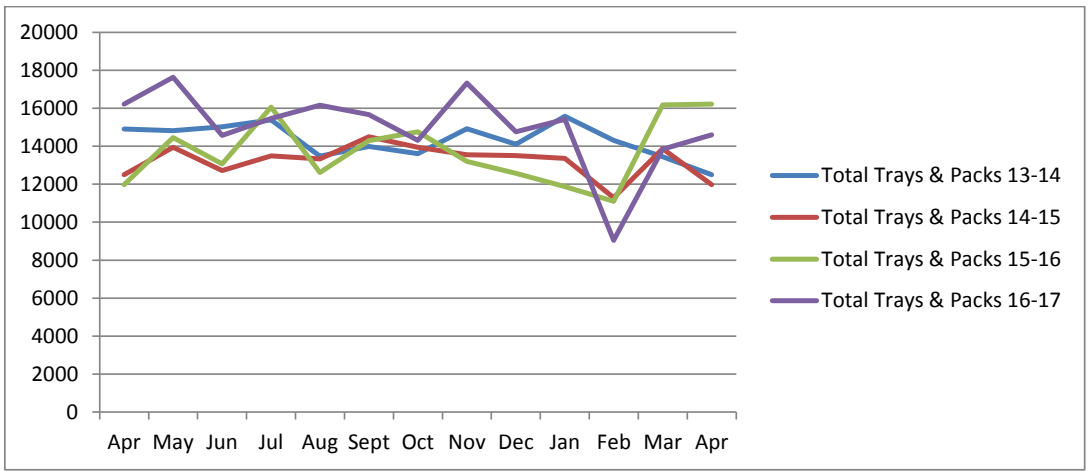
7 Decontamination Arrangements

7.1 Sterile Service Department

The Sterile Service Department processed 185,595 trays, procedure packs and supplementary instruments between April 2016 and March 2017. This is an increase of 12.5% increase items based upon the previous year. The department continues to provide a fully compliant service to NHFT Podiatry and a full theatre tray service to BMI Three Shires, as well as Northampton General Hospital.
The department has maintained its ISO9001/13485/Medical Device Directive 93/42/EEC accreditation for 2017 and maintains monthly Key Performance Indicators (see *Fig 10*).

SSD Production Analysis Overview Total Trays & Packs Produced 2013-2017

Fig 10



The Sterile Service Department (SSD) regained its registration for compliance with European and British decontamination guidance during a three day external re-certification audit and subsequent CAR close out audit following the changes that were made to the standard BS EN ISO13485:2016 during early 2016 prior to our audit.

Our Nexus traceability system is due for further upgrades in the coming year to allow full reporting of the turnaround time from SSD. This will provide the department with the information to monitor its key performance indicators within our service level agreement.

We continue to operate our machinery according to national guidance in the forms of the HTM (Health Technical Memorandum), these documents include:

- HTM 01-01:2016 - Management and decontamination of surgical instruments used in acute care.
- HTM-01-06:2016 - Management and decontamination of flexible endoscopes.

The Sterile Services Department had major upgrade works to its Washer-Disinfectors carried out with new state of the art equipment being installed. The project started in April 2016 and was completed in September 2016 giving the SSD five new washers with an increased capacity of 15 Deutschland International Norm (DIN) baskets compared to the previous capacity of the old machines which were 10 DIN.

The works took place over a period of 6 months in three planned phases with the SSD maintaining a service throughout the period of the works.

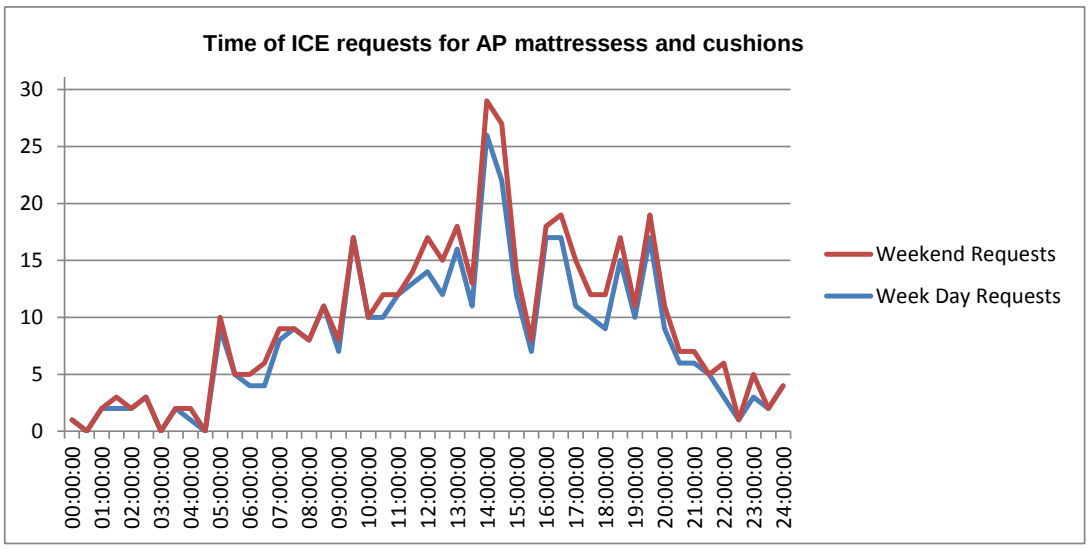
A photograph of the new Washers taken from within the SSD Clean Room can be seen below

Fig 11

7.2 Medical Equipment Library

The Medical Equipment Library (MEL) has continued to work in conjunction with Patient and Nursing Services and the Tissue Viability Team to streamline the way the Trust orders ad-hoc Bariatric rental mattresses. The chart below represents all pressure reducing mattress and cushion requests during April 2017 (Figure 12).

Fig 12



The entire order process has been reviewed and Key Performance Indicators are now produced to evidence the availability of equipment (and requests) both in and out of working hours.

The manual T Card system which aids the library in the tracking of Renasys negative pressure wound therapy pumps, infusion and syringe pumps and the new T34 24hr syringe drivers is still operational. Further work is still underway to investigate RFID (Radio Frequency Identification) to enable all items to be tracked within the Trust.

Staffing arrangements for the Medical Equipment Library (MEL) have been reviewed, with Staff from Sterile Services Department now rotating into this area to enable us to have a more robust staffing base. Any shortages of staff in the MEL can now be filled by SSD technicians.

The MEL has expanded its remit with the inclusion of weighing scales, negative pressure wound therapy and falls alarms etc. The scope of the library is due to increase further in the coming year 17/18 with the addition of all Bariatric equipment to enable tighter controls of the whereabouts of this equipment during use throughout the Trust along with a centralised storage area.

7.3 Endoscopy

The department is fully equipped with single sided Automated Endoscope Reprocessors (AERs), Drying Cabinets and Reverse Osmosis (RO) water systems. A vacuum sealed scope transportation system was in use, however due to a breakdown this is no longer in use, a suitable replacement for this system is being sourced. (The scope transportation system allows flexible endoscopes to be transported safely in a vacuum sealed plastic pouch between users and the endoscopy reprocessing room).

We continue to operate our machinery according to national guidance in the forms of the HTM (Health Technical Memorandum), these documents include:

- HTM 01-01:2016 - Management and decontamination of surgical instruments used in acute care.
- HTM-01-06:2016 - Management and decontamination of flexible endoscopes.

New scope storage cupboards have been fitted within the Endoscopy suite during April 2017.
Further discussions and work are planned for this year 17/18 concerning the capacity of the existing Endoscopy Unit as this does not allow for any growth. Also, the current AER's are now at the end of their working life and will need to be replaced next year 18/19. A number of options are currently being explored at the present time. If a new facility is proposed, then pass-through AER's may well be specified.

The Endoscopy Department are looking to provide a new service based out in the community at a local GP practice by carrying out diagnostic procedures in a procedure room setting.

The Authorised Person (Decontamination) continues to sign off test reports, and monitor the weekly tests in conjunction with the Endoscopy Manager.

7.4 Trust Wide

Work continues with departments that still have some local reprocessing of equipment. Assessments are maintained where necessary.

7.5 Forward Plan 2017/18

In 2017/18 there will be a planned upgrade to the existing Nexus traceability system within Sterile Services.

- A business case has been submitted by the Medical Devices manager for RFID tracking of all devices from the Equipment Library.
- Review current provision within the Endoscopy service.

7.6 Summary

The Trust Decontamination Lead continues to sit on the IPOG and Decontamination Group and provides a monthly report to IPOG.

Compliance Criterion	What the registered provider will need to demonstrate
3	Provide suitable accurate information on infections to service users and their visitors.

8 Information Provision

The Trust provides all service users with information as required. This includes information leaflets for patients, visitors and staff.

Staff are able to access Trust policies and clinical guidelines, care pathways and care plans to provide condition specific information.

Infection Prevention information is also provided for services users via the Trust internet (external) and intranet (internal) sites. In 2016/2017 the infection prevention internal website was updated. This includes new infection prevention training workbooks, the 'CDI' 'C the difference toolkit', factsheets on common infections and the new Infection prevention audits.

The IPCT brand the 'Bug Stops Here', is now recognisable and synonymous with the IPCT and is utilised Trust wide. As part of the communications campaign for 2016/2017 the Trust had new signage on the importance of hand hygiene for all, throughout the Trust inclusive of light boxes, on lift doors and more recently refreshing our signage with phase 1 of Stop Gel Go at the entrances to ward areas. Further phases are to be rolled out throughout 2017/18.

2017/2018 IPCT will continue Trust wide with:

- Monthly campaigns
- Good news stories within the Trust insight magazine and e bulletin
- Monthly screen savers
- A monthly infection prevention information board which provides accurate and timely performance information and updates on infection prevention for all patients, visitors and staff. These are displayed within two boards across the site.
- New posters have been developed informing all patients, visitors and staff of the importance of effective hand hygiene in helping to protect our patients from harm.
- A monthly report in the style of an infogram provides accurate information at our divisional governance meeting.

4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

The Trust provides condition specific information to support staff to provide safe care in a variety of ways:

- Condition specific care plans and care pathways
- Interdepartmental transfer forms
- Discharge information – community healthcare providers are informed by the Trust IPCT when patients are discharged as agreed.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

9 Antimicrobial Stewardship

9.1 Compliance to Trust antibiotic policy

April 2016:
This point prevalence audit of the compliance against the Trust antibiotic policy was performed by the clinical pharmacists on Tuesday 19th April 2016. Areas that do not have a regular pharmacy visit were excluded (Maternity, A&E and Singlehurst). The aim was to audit antimicrobial prescribing and compliance to the Trusts' antibiotic policy.

This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Criteria 9 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship, there should be an ongoing programme of audit, revision and update.

Trust Results

Descriptor	Number	Proportion	Comments	
Total number of patients seen	**588**			
Number of patients on antibiotics	**222**	**37.8%**	The proportion is slightly higher than October 2015 (36.8%).	
Total number of antibiotics prescribed	**247**	**1.1 per patient**	This is lower than October 2015 (1.3 per patient).	
Number adhered to the policy	**216** **242** (inc. valid reasons for non-compliance)	**87%** **98%** (inc. valid reasons for non-compliance)	Valid reasons for non-compliance • Micro approved = 10 • Based on culture and sensitivities = 7 • No guidelines for infection = 9 (see below for a list of infections) 5 prescriptions, 2% did not comply with NGH antimicrobial guidelines	
Number of intravenous (IV) prescriptions	**137**	**55.5%**	This is comparable to October 2015.	
Number of oral prescriptions	**110**	**44.2%**	This is comparable to October 2015.	
Average duration of IV antibiotics	**2.7 days**		This is lower than previous audits. *(Lifelong and long-term courses approved by microbiology were excluded)*	As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.
Average duration of oral antibiotics	**2.4 days**		This is lower than previous audits. *(Lifelong and long-term courses approved by microbiology were excluded)*	
Duration of antibiotic	**128**	**51.8%**	This has increased again from 46.4% (October 2015). The next release of ePMA will have a 48-hour review prompt for all IV	

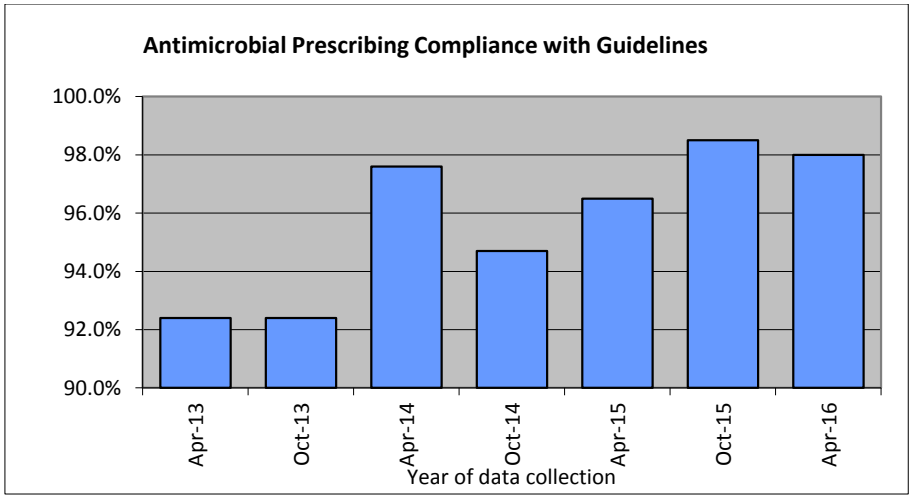
administration stated on prescription chart			antibiotics.
Number of antimicrobial prescriptions with one or more omitted dose	**19**	**7.7%**	It is worrying that 7.7% of patients taking antibiotic courses have one or more dose omitted. Antibiotics are critical medicines and no doses should be omitted or delayed. A joint pharmacy and nursing task and finish group has been set up to reduce omitted doses due to unavailable medicines.
Number of prescriptions with indication stated by prescriber	**99**	**40%**	This has increased from 34.7% (October 2015) but is still low. The next release of ePMA will have a mandatory indication field for all antibiotics.

Division Results

Descriptor	Medicine and Urgent Care		Surgery		Oncology (Talbot Butler)		Paediatrics	
	Number	Proportion	Number	Proportion	Number	Proportion	Number	Proportion
Total number of patients seen	**347**		**174**		**24**		**43**	
Number of patients on antibiotics	**131**	**38%**	**67**	**38.8%**	**13**	**54%**	**11**	**27.5%**
Total number of antibiotics prescribed	**132**	**1 per patient**	**82**	**1.2 per patient**	**18**	**1.4 per patient**	**15**	**1.9 per patient**
Number adhered to the policy	**123** **132**	**94%** **100%**	**62** **78**	**75.6%** **95%**	**16** **17**	**88.8%** **94.4%**	**15**	**100%**
	Numbers highlighted in red= valid reasons for non-compliance added							
Number of intravenous (IV) prescriptions	**60**	**45%**	**58**	**71%**	**10**	**55.6%**	**9**	**60%**
Number of oral prescriptions	**72**	**55%**	**24**	**29%**	**8**	**44.4%**	**6**	**40%**
Average duration of IV antibiotics	**2.9 days**		**2.6 days**		**4.4 days**		**1 day**	
Average duration of oral antibiotics	**2.1 days**		**3.4 days**		**1.9 days**		**1 day**	
Duration of antibiotic administration on chart	**66**	**50%**	**42**	**51%**	**9**	**50%**	**11**	**73%**
Number of prescriptions with one or more omitted dose	**12**	**9%**	**7**	**8.5%**	**0**	**0%**	**0**	**0%**
Number of prescriptions with indication stated by prescriber	**45**	**34.1%**	**36**	**44%**	**7**	**39%**	**11**	**73%**

Valid reasons for Non-compliance	Valid reasons for Non-compliance	Valid reasons for Non-compliance
Micro approved =5	Micro approved =5	Micro approved =0
Based on culture and sensitivities =4	Based on culture and sensitivities =3	Based on culture and sensitivities =0
No guidelines for infection =0	No guidelines for infection =8	No guidelines for infection =0
Non - compliance=0	Non -compliance=4	Non -compliance=1

Fig 13



Conclusion
Overall compliance with the antibiotic guidelines is 98%. This is comparable to October 2015 (98.5%) and to previous audits.

The audit will be repeated in April 2017. The audit was not conducted in October 2016 as the clinical pharmacists supported the data collection for the 2016 National Point Prevalence Survey on HCAI and AMU. (see below).

October 2016
Northampton General Hospital took part in the National Point Prevalence Survey on HCAI set out by Public Health England. The data is provisional as of February 2017. The antimicrobial usage data collected is below.

Table: Antimicrobial use: indications, route, reason in notes and appropriate review

Total	**248**	**100.0%**
Route of administration		
Parenteral	141	56.9%
Oral	107	43.1%
Other/unknown	0	0.0%
Reason in notes		
Yes	231	93.1%
No	14	5.6%
Unknown	3	1.2%
Antimicrobial changed		

No change	166	66.9%
Escalation	19	7.7%
De-escalation	9	3.6%
Switch IV to oral	36	14.5%
Adverse effects	1	0.4%
Other or unknown reason	17	6.9%

The above data on antimicrobial agent changed (no change=66.9%) is comparable to the data collected for the CQUIN quarter 4 2017, which reported that 60% of antibiotics had not been changed at 72 hours. This reported figure is higher as prescriptions may have only been initiated 24-48 hours prior to data collection at which point sensitivities may not have been reported by microbiology. Improving the appropriate review of antibiotics is an on-going part of the CQUIN 2017-18. Greater surveillance and teaching will be required to ensure appropriate reviews are conducted to reduce the risk of inappropriate prescribing and antimicrobial resistance.

Anti-Microbial Resistance: Commissioning for Quality and Innovation (CQUIN) 2016/17

Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The CQUIN aims to reduce antibiotic consumption and encourage a prescribing review within 72 hours of commencing an antibiotic.

Goal: Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours

Rationale: Reducing consumption of antibiotics and optimising prescribing practice by reducing the indiscriminate or inappropriate use of antibiotics which is a key driver in the spread of antibiotic resistance.

Empiric review data

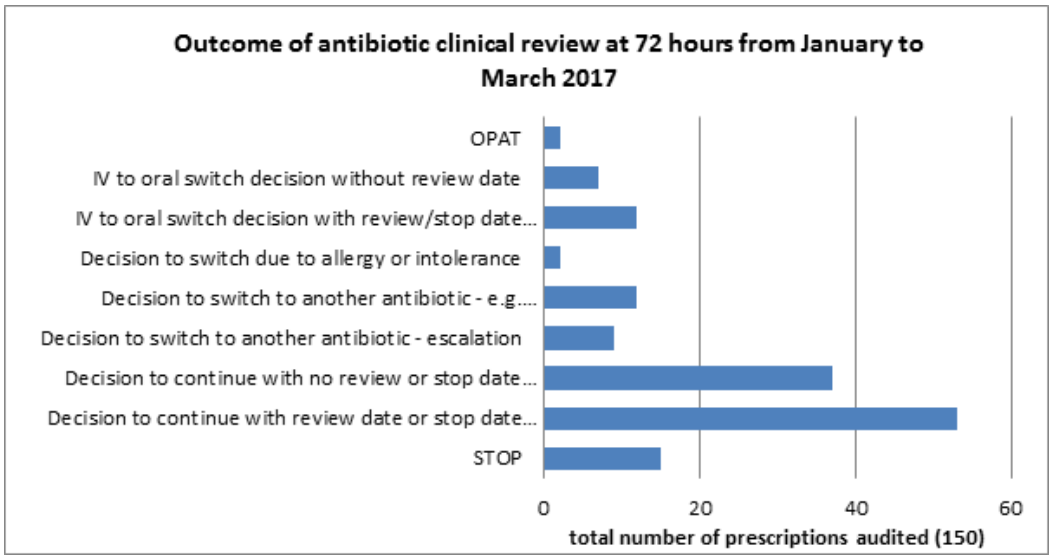
Data was collected by pharmacists in a variety of specialities including admissions, elderly care, ITU, paediatrics, and surgery. Data on 50 prescriptions (oral and intravenous) had been collected as a point prevalence survey each month. The results were submitted to Public Health England on a quarterly basis as outlined in the submission criteria.

Table: Empiric review of antibiotics within 72 hours 2016/2017

Quarter	Target	Result
Q1	25%	85%
Q2	50%	90%
Q3	75%	86%
Q4	90%	90%

Data from quarter 4 has been summarised in the graph below. Of the 150 antibiotic prescriptions audited, 101 were prescribed intravenously and 49 orally. 141 prescriptions had been clinically reviewed within 72 hours. The data shows that despite the review occurring within 72 hours, the significance of this was not clear. A total of 91 prescriptions continued with the empiric prescription. Of these, 54 had a defined stop/review date and 37 continued with empiric treatment with no stop/review date. This suggests that either de-escalation was not appropriate or we are using prolonged courses of intravenous antibiotics for patients. This element is now incorporated in CQUIN 2017/18.

Fig 14



(OPAT) outpatient antimicrobial therapy

Consumption data
Baseline data for CQUIN achievement is compared against data submitted for 2013/14. A partial payment is expected based on current data submitted.

Reduction of 1% or more in total antibiotic consumption against the baseline (25%)
Reduction of 1% or more in carbapenem against the baseline (25%)
Reduction of 1% or more in piperacillin-tazobactam against the baseline (25%)
25% to be paid for submission of consumption data to PHE for years: 2014/15 to 2016/17

The following data is based on **quarters one, two and three only.**
At this point in time, the Trust is set to achieve the reduction in total carbapenem consumption.

9.2 Training initiatives

Ad hoc antimicrobial stewardship induction sessions are given to new clinical pharmacists. Development of training has been included in the antimicrobial stewardship action plan for next year.

9.3 Antibiotic campaigns European Antibiotic Awareness Day – 18th November 2016

This annual awareness day was marked at NGH by encouraging staff to make a pledge as Antibiotic Guardians and using Public Health England resources (quizzes/crosswords) to promote appropriate antibiotic use. This was carried out in the cyber café and designed to target all hospital employees.

Antibiotic Awareness Week – Monday 14th November 2016
During the week the IPCT, trainee clinical scientist and antimicrobial pharmacist used promotional stands, quizzes and screensavers highlighting the issue of resistance and encouraging staff to make a pledge as Antibiotic Guardians. This also included daily visits to various wards to promote antibiotic awareness, antibiotic stewardship and promotion of appropriate review on day 3.

9.4 Antimicrobial Stewardship Group (ASG)

The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults and children admitted to hospital.

- May 2016 [9 attendees]
- August 2016 [6 attendees]
- November 2016 [8 attendees]
- March 2017 [6 attendees]

Developments in the last year have included:

- Active participation in Anti-Microbial Resistance CQUIN and submission of data
    - Empiric review of antibiotic prescriptions within 72 hours
    - Reduction in antibiotic consumption per 1000 admissions (facilitated by earlier development of meropenem code)

- Maintaining and updating an action plan for antimicrobial stewardship in line with NICE gap analysis

- Mandatory training in Antimicrobials and Antimicrobial Stewardship

- Guidance developed and disseminated to reduce Tazocin prescribing due to worldwide shortage

- Implementation of ePMA with built in 3 days review of antibiotics and indication for prescribing

9.5 Other Antimicrobial Developments

Adult Renal Antibiotic Guidelines
Guideline for dosing of antibiotics for patients with impaired renal function has been updated (March 2017) to include all commonly used antibiotics in the Trust. It is now available on the intranet alongside the antimicrobial guidelines.

Adult Antibiotic Guidelines
The Trust adult antibiotic guidelines require updating and have been given an extension until June 2017.

Compliance Criterion	What the registered provider will need to demonstrate
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

10 Staff Development and Training

All staff roles include Infection Prevention and Control in the job description. How this is applied is outlined at the individual's local induction when in post.

Training was a key tool in improving staff knowledge on Infection Prevention practices in 2016/17. The IPCT delivered training across the entire spectrum of staff and for a wide range of purposes from generic Trust-wide sessions at induction to bespoke training on very specific issues.

The IPCT participates in Trust Induction for all new starters. The IPCT also supports specific induction training to all grades of staff as requested by each service.

The IPCT fully support the Trust mandatory training programme, delivering sessions for all staff at mandatory training sessions. These sessions are recorded on the Trust central training records

Compliance with attendance at key infection prevention training (induction, annual mandatory and ANTT training) is tracked within the infection Prevention and Control Reports.

Table: IPC Training Compliance 2016/17

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Trained in Month	364	349	346	313	341	281	308	275	231	348	280	292
Percentage Compliance	70.0%	80.1%	79.6%	79.7%	79.1%	78.7%	80.4%	81.7%	83.0%	84.0%	84.7%	86.2%

10.1 Developments

On the 13th October 2016, the Infection Prevention Team celebrated their seventh annual study day at the Cripps Post Graduate Centre. The Medical Director gave the opening address. Sixty healthcare professionals attended. The study day evaluated well. Presentations included the *C. diff* collaborative and toolkit, meticillin sensitive *staphylococcus aureus*, influenza, including a patient's story from a Critical Care patient, this was well received. The group also split into interactive work stations to learn about ANTT, catheter care, PICC line care, identifying rashes and waste segregation.
The study day was sponsored by 5 representatives from companies whose products we use in the Trust.
The next IPCT study day is October 12th 2017.

Compliance Criterion	What the registered provider will need to demonstrate
7	Provide or secure adequate isolation facilities.

11 Isolation

In January 2017, the IPCT performed an isolation room usage audit. The occupancy of side rooms has risen from 97% in March 2016 to 99.2% in January 2017. This highlights how busy the Trust is and the pressure that there is for beds. The findings of the audit suggest that mostly there are adequate side rooms within the hospital. However, there is more pressure in the surgical division for side rooms due each surgical ward only having 2 side rooms

The target time for isolating patients with unexplained (and potentially infectious diarrhoea) is less than two hours. This is monitored by the IPCT and reported to the IPSG monthly.

Each ward has access to the Electronic Side Room Monitoring Tool. This identifies who is managed in a side room and the reason for their isolation and each ward identifies patients who can be transferred out of single rooms in the event that another patient requires isolation. This is checked daily by a member of the IPCT and the information is given daily to the Trust Site Management Team

For advice and support the IPCT team are available for advice 08:00-17:00 Monday – Friday and 9-12 midday Saturday. There is an on-call microbiology service for advice outside of these hours.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate.

12 Laboratory Services

Diagnostic microbiology is provided on site as part of NGH pathology services.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

13 Policies

The Trust has policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance.

These documents are monitored utilising a variety of audit tools to measure staff compliance with guidance. Additionally, through induction and ad-hoc bespoke sessions, training for all staff types is undertaken to ensure they are kept informed of current guidance.

13.1 Audit Programme

13.2 Saving Lives

Saving Lives is a National compilation of High Impact Interventions (HII) utilising a "Care Bundle" approach based on evidence based practice. It was first published in 2005 and updated in 2010. It was delivered at Northampton General Hospital in 2007. It directly measures clinical processes. Each clinical area is audited monthly against the High Impact Interventions which are pertinent to the care given in that particular setting. The High Impact Intervention results populate the Trusts' infection prevention dashboard along with results from the monthly hand hygiene observational audits, cleaning audits, MRSA bacteraemia and *Clostridium difficile* infection figures.

The dashboard supports continuous quality improvement, development and there has been a strong focus on trend analysis in 2016/17, providing safer care for our patients, this is presented and monitored monthly through IPOG. April 2017 has seen the launch of the Trusts' new Infection Prevention Audits and these audits are in line with Epic 3 guidance reflecting best practice, moving forward this should enable the audit process.

13.3 Health Assure

The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring healthcare associated infections by compliance with the Hygiene Code.

The Hygiene Code evidence has been uploaded onto the Health Assure platform which is an on-line corporate software that provides boards and management teams with assurance and information needed to plan, manage and report on key performance indicators.

IPCT continue to align and update supporting evidence to provide assurance with the Hygiene Code.

13.4 Beat the Bug, Board Quality Visit

To support the on-going HCAI agenda across the Trust, all Executive and Non-Executive Directors and the Trust Chairman continue to participate in these 'Quality Visits' on a monthly basis. These visits are facilitated by the IPT and they involve visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive and Non-Executive Directors visit 2/3 areas and audit the clinical area against set criteria. Findings from the visits is collated by the IPT reported monthly at CQEG and IPOG

The reviews are still being seen as very positive by staff on the wards, and the output from the reviews is beneficial, therefore it is important to maintain regular visits.

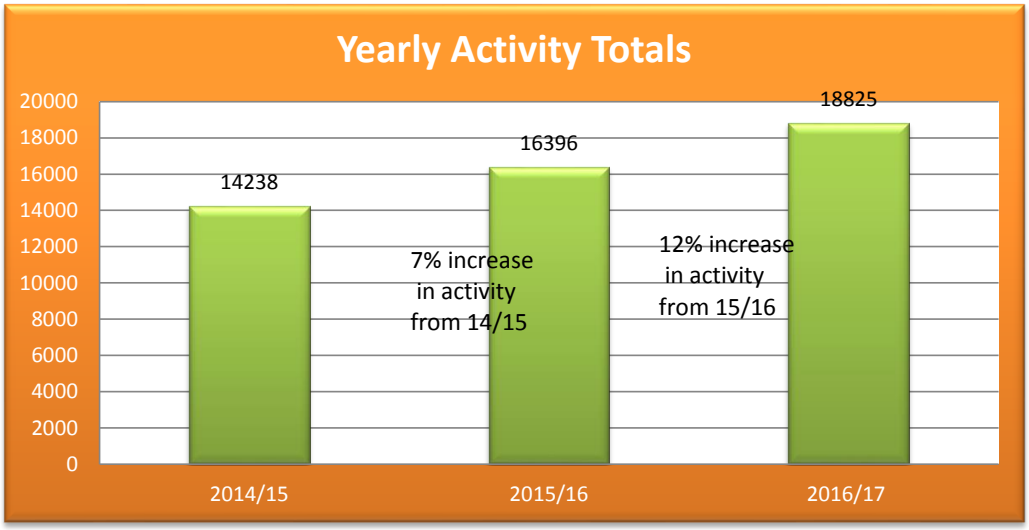
Compliance Criterion	What the registered provider will need to demonstrate
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

14 Occupational Health

Occupational Health has had a busy year with significant service improvements to streamline and improve services. Total activity (measured in clinical events) for 2016/17 was 18825 which is a 12% increase on the previous year. This includes new employment screening, vaccinations, blood tests, physiotherapy, nursing and medical consultations. There has been improved use of clinic time to facilitate an increase of external work especially from the healthcare students of the University of Northampton.

The use of the IT software programme eOPAS has enabled health surveillance to be carried out electronically this year via a portal questionnaire which has improved the collection of the data and a speedier system for TB surveillance and night workers assessment.

Fig 15



Activity Breakdown

Fig 16

	15/16	16/17
Blood Tests	4373	7291
Vaccinations	3188	2841
Work Health Screening	2107	1907
General Clinic	1743	1621
Nurse Appts	907	2354
Other Tests	1914	187
Management Refs	873	736
Physio	378	876
Dr Appts	376	501
Health Surveillance	422	281
Contamination Injuries	115	230
	16396	18825

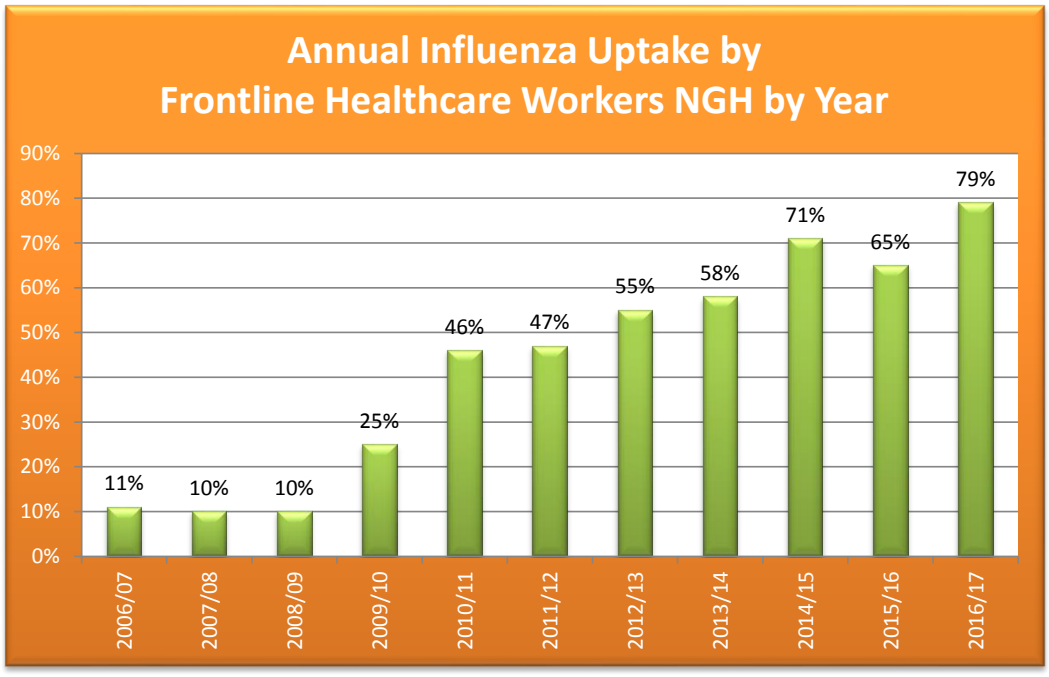
In looking at Fig 16 above the following should be noted: -

- There has been an increase in blood tests especially for latent TB testing, due to the national shortage of Mantoux serum and BCG vaccine.

- The electronic health questionnaire and portal system enabled staff to provide evidence of their previous vaccinations more easily which reduced the number of vaccinations required

The flu campaign in 2016/17 achieved an uptake of 79% see fig 16 which enabled the CQUIN target to be achieved. There was a positive response from staff for the additional clinics and trolley visits in the evening and weekend

Fig 17



15 Summary

Eliminating healthcare associated infections has remained a top priority for the public, patient and staff. The Infection Prevention team, through their plan of work, have implemented a programme of work which has been supported by colleagues at all levels through the organisation.

However, a number of key risks and challenges exist and are covered in the plan of work for 2017/18, see Appendix 3.

Authors	Wendy Foster – Matron for IPCT Mark Duggan- Acting Manager for Decontamination Kiranjeet Dhillon - Antimicrobial Pharmacist Claire Brown Occupational Health Manager/Specialist Community Public Health Nurse
Owner	Carolyn Fox
Date	31st May 2017

16 Appendix 1 - IPCT Structure 2016/17

Post	Post holder	WTE
Board Executive Lead (DIPC)	Mrs Carolyn Fox	Not defined
DIPC	Mrs Carolyn Fox	Not applicable
Chair of the Trust Infection Prevention and Control Group	Mrs Carolyn Fox	Not applicable
Consultant Medical Microbiologist	Dr Minas Minassian Dr Basel Allouanti	Not defined Not defined
Band 8a IPC Matron	Mrs Wendy Foster	1 x 1.0
Band 7 IPC Nurse	Mrs H.Slyne Mrs R Pounds	1 x 1.0 1 x 1.0
Band 6 IP Support Nurses	Mrs J Hart Mrs K. Draper (maternity cover) Mrs K. Baptiste Miss N. Clews Miss Fiona Fulthorpe (secondment)	1 x 0.40 1 x 0.68 1 x 1.0 1 x 1.0 1 x 1.0
Band 4 Secretarial Administration and Surveillance	Mrs Karen Tiwary	1 x 1.0

17 Appendix 2 - Terms of Reference for the Infection Prevention Steering Group

Northampton General Hospital NHS Trust

Infection Prevention Steering Group (IPSG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy • Matron for Infection Prevention & Control or nominated deputy • Consultant Microbiologist • Medical Director or nominated Deputy • Deputy Director of Quality & Governance • Associate Director of Nursing for Medicine • Associate Director of Nursing for Surgery • Associate Director of Midwifery • Associate Director of Nursing for Oncology • Head of Estates / Deputy Director of Facilities • Head of Hotel Services • Consultant Anaesthetist / Sepsis Lead • Head of Capacity and Flow
Quorum	6 members
In Attendance	• Deputy Director of Nursing, Midwifery & Patient Services • Antimicrobial Pharmacist • Occupational Health Lead • Public Health England (PHE) representative • Patient representative • Minute taker
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the CQEG
Date of Approval by CQEG	April 2017
Review Date	• April 2018

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Infection Prevention Steering Group

Terms of Reference

1. Constitution

The Trust hereby resolves to establish a steering Group of the Clinical Quality and Effectiveness Group (CQEG) to be known as the Infection Prevention Steering Group.

2. Purpose

The purpose of the Steering Group is to provide strategic direction for the prevention and control of Healthcare acquired infections in Northampton General Hospital NHS Trust that minimises the risk of infection to patients, staff and visitors.

The Steering Group will:

- Strengthen the performance management of Health Care Associated Infections (HCAI's) and cleanliness across the Trust
- Provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes
- Make recommendations as appropriate on Infection Prevention Control matters to the Board via CQEG
- Performance Manage the Trust against the Infection Prevention and control strategy
- Will ensure that there is a strategic response to relevant new legislation and national guidelines

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy
- Matron for Infection Prevention & Control or nominated Deputy
- Consultant Microbiologist
- Medical Director or nominated Deputy
- Deputy Director of Quality & Governance
- Associate Director of Nursing for Medicine*
- Associate Director of Nursing for Surgery*
- Associate Director of Midwifery*
- Associate Director of Nursing for Oncology*
- Head of Estates and Deputy Director of Facilities
- Head of Hotel Services
- Consultant Anaesthetist / Sepsis Lead
- Head of Capacity and Flow

4. Quorum, Frequency of meetings and required frequency of attendance

- No business shall be transacted unless six members of the Steering Group are present, one of whom must be the Chair or their nominated Deputy and 2 clinical representatives from the Divisions (as indicated by * above).
- The Steering Group will meet monthly.
- Members of the Steering Group are required to attend a minimum of 9 meetings held each financial year.

5. In attendance

In addition to the core membership, other staff will be invited to attend by the Chair of the Steering Group.

6. Authority

The Steering Group is authorised by CQEG to investigate any activity within its terms of reference and to seek any information it requires to provide assurance to the Board. The Steering Group will seek external expert advice and invite attendance if considered appropriate.

7. Duties

- To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008)/ The Hygiene Code updated 2015.

- To fulfil the Trust's statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies.

- To review Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies are evidence based, reflect relevant legislation and published professional guidance. Recommend submission and approval to Procedural Document Group.

- To develop the annual infection prevention and control programme of activity and ensure that it is submitted to Quality Governance Committee (QGC) and approved by the Trust Board

- Monitor achievement of the objectives contained within the annual programme.

- To receive, review and endorse the annual Infection Prevention and Control Report.

- Management and investigation of outbreaks of infection.

- To receive a written Infection Prevention & Control report which includes**:**

  i. Outbreaks of infection
  ii. MRSA & Clostridium difficile data

iii. Isolation deficits
iv. Trust compliance with externally set targets
v. Progress against the rolling infection prevention & control programme
vi. Audit outcomes
vii. Training and development plans/ compliance
viii. Updates of relevant legislation / guidance/ best practice
ix. Campaigns planned or delivered

- Receive a written highlight report and minutes from the Infection Prevention Operational Group and review the TOR annually.

- To receive written reports from the Trust operational IPC group to ensure that assurance is gained as to the implementation of Infection Prevention & Control practices & policies within the Trust. Providing assurance that all appropriate measures are being taken to assist the achievement of the national and local infection present ambition.

- Receive written reports from Deputy Director of Estates and Facilities in relation to water safety, decontamination compliance, structural/ building works that are planned within the Trust. To ensure that prevention and control of infection is considered as part of all service or building development activity, changes to HTM's or ACOP that may have infection control implications

- Receive written reports from the Head of Hotel services in relation to food hygiene, Environmental Health visits/ reports, PLACE outcome reports, cleaning compliance with standards and audits, domestic service training plans & compliance, and introduction of new cleaning products or systems of work.

- Receive written reports from the Occupational Health Manager which include needlestick injuries, flu vaccination programme compliance, outbreak issues affecting staff, any incidents of staff TB or BBV that have been or are currently under investigation or look back exercises for any infectious disease where an increased incidence has been reported nationally, to ensure that the staff and therefore the patients, are adequately protected where possible to do so.

- Receive written reports from the antimicrobial pharmacist which include an update from the Antimicrobial Stewardship Group.

- Receive written reports from the Associated Director of Nursing/Midwifery as requested by the Chair in relation to specific Infection Prevention and Control matters.

- To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

- To disseminate information and advice on prevention and control of infection to all appropriate Trust Division and their Directorates.

- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

8. Accountability and Reporting arrangements

The minutes of the Steering Group meetings shall be formally recorded by the Secretary/Surveillance Assistant**.** Copies of the minutes of the Steering Group meetings will be provided to all members of the Group and will be available to all Trust Board members.

The Steering Group Chair shall prepare a written summary report to CQEG after each meeting. The Chair of the Steering Group shall draw to the attention of CQEG any issues that require escalation to the Trust Board, require executive action or support.

Sub-committee and reporting arrangements

The Steering Group shall have the power to establish sub-groups for the purpose of addressing specific tasks. In accordance with the Trusts' Standing Orders, the Steering Group may not delegate powers to a sub-group unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-group must be approved by the Steering Group and reviewed as stated below.

9. Administration

The Infection Prevention Steering Group shall be supported administratively by the Infection Prevention and Control Secretary /Surveillance Assistant

- Agreement of the agenda for Steering Group meetings with the Chair

  Requesting of reports from authors in a timely manner in accordance with the reporting schedule
- Collation of reports and papers for Steering Group meetings
- Circulate agenda and papers for the meetings 7 days in advance of the Meeting
- Ensuring that suitable minutes are taken, a record of matters arising and actions are accurately documented
- All reports will be submitted in writing with a front sheet

10. Requirement for review

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

FOI Reminder

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

Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

Membership	• Deputy Director of Nursing • Infection Prevention Matron • Modern Matrons • Estates and Facilities • Hotel Services • Therapies or nominated representative • Domestic Team Leads/Supervisors • Clinical Site Manager for Capacity and Flow
Quorum	Seven members that must include either: • Deputy Director of Nursing, Patient & Nursing Services • Member of the Infection Prevention Team as required • Modern Matrons (5)
In Attendance	• Director of Nursing Midwifery & Patient Services/DIPC & Director of Infection Prevention & Control • Deputy Director of Nursing • Matron for Infection Prevention or a member of the Infection Prevention Team • Modern Matrons • Lead within Estates • Lead within Facilities The Group would have the authority to co-opt any person necessary to assist in its deliberations
Frequency of Meetings	• Monthly
Accountability and Reporting	• The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members on request. • The Matron for Infection Prevention reports to Director of Nursing monthly operational infection prevention issues. • The Matron for Infection Prevention produces an

	Annual Report for the Care Quality & Effectiveness Group. • The DIPC (Director of Nursing) & Matron for Infection Prevention reports and participates in the Whole Health Economy Infection Control meeting. • The DIPC (Director of Nursing) or Deputy Director of Nursing will report from the Operational Group into the IP&C Steering Group.
Date of Approval by IPSG on behalf of Quality Governance Committee	• May 2017
Review Date	• Annually

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

1. Constitution

The Trust hereby establishes a group to be known as the Infection Prevention Operational Group (IPOG). The aim of the group is to ensure operationally:

1. The Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008), (the "Hygiene Code").

2. To receive reports on specific operational problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations to the IP Steering Group.

3. To review Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance, prior to approval by IP Steering Group.

4. To monitor divisional performance regarding adherence to infection control practice through the monitoring of the matron's dashboard Infection Prevention and Control audits and putting actions into place where required.

5. To discuss relevant issues presented by the Infection Prevention & Control Team (IPCT) and any other member of the committee.

6. To make recommendation to IP Steering Group and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

7. To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

8. To ensure that prevention and control of infection is considered as part of all service development activity.

9. To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.

10. To monitor the performance of the infection prevention and controls programme and make suggestions for improvement, including review of improvement plans from Divisions.

2. Purpose

The purpose of the IPOG is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust, sharing good practice. and making recommendations to the IP Steering Group and divisions,

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC
- Deputy Director of Nursing
- Infection Prevention Matron
- Modern Matrons
- Estates and Facilities
- Hotel Services
- Therapies or nominated representative
- Domestic Team Leads/Supervisors
- Clinical Site Manager for Capacity and Flow
- The group would have the authority to co-opt any person necessary to assist in its deliberations

4. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless eight members of the group are present. This must include not less than eight members that must include either:

- Director of Nursing, Midwifery & Patient Services/DIPC or
- Deputy Director of Nursing
- Member of the Infection Prevention Team
- Modern Matrons (5)

The group will meet monthly. Members of the group are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

5. In attendance

Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the group Chair and relevant members are entitled to be present at a meeting of the group, but others may attend by invitation of the Chair.

6. Authority

The group is authorised by the Trust to investigate any activity within its terms of reference and to seek any information and to make any recommendations through the Infection Prevention Steering Group (IPSG), through its chair that is deemed appropriate. Or any area within the terms of reference where action or improvement is required.

7. Duties

To attend meetings as required and report to the IPOG in an open and honest manner and address any issues.

8. Accountability and Reporting arrangements

The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members on request.

9. Sub-groups and reporting arrangements

The group shall have the power to establish sub groups for the purpose of addressing specific tasks or areas of responsibility. The terms of reference, including the reporting procedures of any sub groups must be approved by the group and regularly reviewed.

10. Administration

The group shall be supported administratively by the Administration/Surveillance person whose duties in this respect will include:

- Agreement of the agenda for group meetings with the Chair;
- Collation of reports and papers for group meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried

11. Requirement for review

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

12. FOI Reminder

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

19. Appendix 4 - Healthcare Associated Infection Reduction Plan 2017-18

Priorities and key goals for 2017-18

- A reduction in the number of patients with CDI (<21 cases)
- Zero patients with MRSA bacteraemia
- A reduction in the number of patients with MSSA bacteraemias (<14 cases)
- Sustain measurement of *E. coli* bacteraemia within the Whole Health Economy
- Sustain measurement of CRUTI prevalence through Safety Thermometer Strategic Group and action plan
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system
- Sustain CPE screening process
- To implement the 2017/18 IPC communications strategy

The plan is built upon the criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This set out ten criteria against which the Trust is assessed on how it complies with registration requirements of infection prevention.

BRAG Key	
	Complete
	On-track
	Delivery issues
	Unable to deliver

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2017-18							
	Clinical teams to undertake case review using principles of RCA and PIR and present to IPSG: • All cases of MRSA bacteraemia • All cases of NGH attributed CDI • All cases of NGH attributed MSSA bacteraemia • All cases of NGH attributed *E. coli* bacteraemia							
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPC and CQEG.	Quarterly	Consultant microbiologist					
1 b Promote a culture of continuous quality improvement in IPC	Review and update IPSG terms of reference and IPOG terms of reference	February 2018	IPC Matron					
	Provide monthly reports to IPSG	Monthly	IPC Matron					
	Provide monthly reports to CQEG	Monthly	IPC Matron					
	Reports monthly to the Trust board	Monthly	DIPC					
	Present surveillance data regarding HCAIs to IPSG	Monthly	IPC Matron & cons. micro					
	Monitor the progress of patients with *C. diff* infection at IPOG meetings	Monthly	IPC Matron					
	Implement IPC audit plan for 2017-18 and report monthly at IPOG and IPSG. *(For further information please refer to the IPC annual audit plan).*	Monthly	IPC Matron					
	Implement the IPC surgical site surveillance plan for 2017-18 and report quarterly at IPSG and CQEG. *(For further information please refer to the IPC surgical site surveillance plan).*	Monthly & Quarterly	IPC Matron					

	IPCT to conduct '*Beat the bug'* ward quality visits with members of the executive team	Monthly	IPCT & exec team					
	IPCT to work with the Trust communication team to deliver a continuous year long campaign that focuses on keeping patients safe from infection	Ongoing	IPCT & comms team					

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
2 a Maintenance of a clean, safe and appropriate environment which facilitates the prevention and control of HCAI	The Trust Hotel Services Manager and Domestic Manager will report key issues monthly to IPOG	Monthly	Hotel Services Manager & Domestic Manager					
	Review monthly cleaning audit scores at IPOG	Monthly	IPC Matron & Matrons					
	IPCT and Domestic Team to sustain the cleaning standard operating procedure	Monthly	IPCN & Domestic Manager					
	IPCT and Estates to complete a bi-monthly review of the Trust Estate	Bi-monthly	Matron for IPC & Estates Manager					
	IPCT, Estates and Domestic Team to complete a review of the ward (EDI inspection) following every case of CDI, periods of increased incidence or outbreaks of infection	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT and Facilities to sustain ward of the month	Monthly	IPC Matron					
	Continue IPC & Estates risk assessments prior to Estates work commencing	Ongoing	IPC Matron & Estates Projects Lead					
	The Trust Estates Maintenance Manager will report key issues monthly to IPOG	Monthly	Estates Maintenance					

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			Manager					
	The Deputy Director of Facilities will provide a comprehensive report quarterly to IPSG	Quarterly	Deputy Director of Facilities					
2 b Decontamination standards are monitored and adhered to	The Trust Decontamination Lead will ensure that the Decontamination Group operates according to its terms of reference and reports monthly to the IPOG	Monthly	Decontamination Lead					
2 c Water safety requirements are monitored and adhered to	The Trust Water Safety Lead / Responsible Person will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPSG	Quarterly	Deputy Director of Facilities					
	The Trust Deputy Responsible Person will report and update any water safety issues to IPOG	Monthly	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
3 a To improve antimicrobial prescribing and stewardship	The Trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Pharmacist will report quarterly to the IPSG	Quarterly	Antimicrobial pharmacist					
	Antimicrobial audits will be presented to IPSG	Quarterly	Antimicrobial pharmacist					
	The Trust Antimicrobial Pharmacist will deliver the actions from the NICE antimicrobial guidance gap analysis	Quarterly	Antimicrobial pharmacist					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
4 a Provide useful information for staff on the prevention and control of infections	Produce screensavers or posters as required to clarify IP procedures and processes	Monthly	IPCT					
	Send out information via email system to communicate updates on IPC practices or polices as required e.g. during outbreaks	Monthly	IPC Matron					
	To implement the IPC communication strategy and monthly focus on specific aspect of IPC	Monthly						
4 b Provide useful information for patients and visitors on the prevention and control of infections	Provide patient information leaflets on *C. difficile*, MRSA, ESBLs, CPE, surgical site infection prevention, urinary catheters and enteral feeding, norovirus	Monthly	IPT					
	To develop patient information leaflets for central venous access devices and peripheral venous cannulas	Q1	IPT PDNs					
	Provide outbreak information to patients and visitors regarding ward closures and preventing the spread of infection	Quarter 2	IPT					
	To scope out possible implementation of reversible ward closure signs	Quarter 2						

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
5 a To improve CPE screening and care of suspected, presumptive or confirmed positive cases	To monitor numbers of screens and results and report positive cases to IPSG	Monthly	IPC Matron					
	To scope out implementing the CPE screening with Pre-Operative Assessment Clinic	Q2	IPCT & POAC Manager					
	To collaborate with the Site Management Team to identify patients that require CPE screening on admission / repatriation from high risk countries / hospitals	Q2						
5 b To remain within the *C. diff* trajectory of 21 cases for 2017-18	To have *C. diff* trajectory on to the risk register and review quarterly	Quarterly	IPC Matron					
	To continue to identify wards that require support for 1 case of *C. diff* or period of increased incidence (2 or more cases within 28 days), conduct PIR for all post admission *C. diff* cases and maintain the *C. diff* antigen positive surveillance	Q1, Q2, Q3 and Q4	IPCT					
	To develop and commence a *C. diff* reduction plan for 2017/18 that implements the outcomes of the 2016/17 *C. diff* retrospective case review	Q1, Q2, Q3 and Q4	IPCT					
5 c To minimise the risk of infection to patients by conducting MRSA screening and managing patients who are colonised or infected with MRSA	To maintain MRSA screening processes according to Trust MRSA policy, monitor elective and emergency screening compliance and conduct surveillance of previous MRSA positive inpatients.	Q1, Q2, Q3 and Q4	IPCT					
	To scope out how to continue using the MRSA decolonisation PGD on ePMA	Q2	IPCT					

effectively	To record the number of patients with newly acquired MRSA acquisition and include these numbers within the CQEG report	Q1, Q2, Q3 and Q4	Matron and IPCT					
	To evaluate the Prontoderm trial (conducted Q4 2016/17) at IPSG and scope out Trust wide rollout to replace Octenisan body wash	Q2	IPCT					
5 d To minimise the risk of infection to patients by preventing MSSA bacteraemias	To action the 2017/18 MSSA bacteraemia reduction plan	Q1, Q2, Q3 and Q4	IPCT					
5 e To minimise the risk of infection to patients by preventing *E. coli* bacteraemias	To complete an aggregated review of the *E. coli* bacteraemias for 2016/17 and present at IPSG	Q1	IPCT					
	To collaborate across the Whole Health Economy to reduce the incidence of *E. coli* bacteraemias	Q1, Q2, Q3 and Q4	IPC Matron					
5 f To minimise the risk of cross-infection for alert organisms	IPCT to review all patients who acquire an alert organism infection and provide ongoing advice and support to medical and nursing staff	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to conduct surveillance and management of outbreaks of infection	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to scope out flagging patients with previous MRSA, *C. diff*, MSSA and CPE on CAMIS inpatient management system	Q2	IPCT					
5 g To minimise the risk of infection to patients from catheter-related urinary tract infections	IPCT to report CRUTI case reviews quarterly to identify key themes	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to action the CRUTI action plan to address the themes identified from the retrospective case review	Q1, Q2, Q3 and Q4	IPCT					
5 h To minimise the risk of infection to patients from influenza	IPCT to develop and implement a 2017/18 Flu Ready action plan in collaboration with Occupational Health Team to present at IPSG in July 2017	Q2	IPCT					
5 i To minimise the risk of infection to patients	Critical Care to work with IPCT to clarify the definition of VAP and to ensure that practice is in line with National Guidance	Monthly	Critical Care Matron & IPC matron					

from ventilator-acquired pneumonia								
5 j To minimise the risk of infection to patients from sepsis	To monitor the progress of the sepsis CQUIN through IPSG	Quarterly	Sepsis Lead					
5 k To minimise the risk of infection to patients from line-related infection	To work through the intravascular access device section of the MSSA reduction plan, including conducting an annual CVAD audit	Q1, Q2, Q3 and Q4	IPCT					
5 l To minimise the risk of infection to patients from MERS	To implement the MERS section of the Viral Respiratory Infections procedural document in the Emergency Department	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
	To reflect and learn from each patient with suspected MERS in the ED to improve practice and share at IPOG	Q1, Q2, Q3 and Q4	IPCT & ED Matron					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
6 a Staff receive appropriate IPC training	IPC is part of induction and mandatory training. IPC mandatory training is to be monitored and reported to CQEG by the Infection Prevention Matron.	Monthly	IPC Matron					
	To embed ANTT assessments of competence into annual IPC training for clinical staff who require it	Q1, Q2, Q3 and Q4	IPCT					
6 b IPC workforce and capability	Ensure that all IPCT members are skilled, knowledgeable and have an appraisal process in place to ensure clear objectives and development needs	Q1, Q2, Q3 and Q4	IPC Matron					

6 c Hand hygiene	Relaunch the Hand Hygiene Code of Practice	Q1	IPC Matron					
	Update hand hygiene signs at ward entrances	Q1, Q2	IPC Matron & Estates Manager					
	Celebrate Hand Hygiene Week	Q1	DIPC, ADNs IPC Matron Matrons IPCT					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
7 a To provide advice regarding appropriate isolation use	IPCT to undertake daily review of the urgent care wards A&E, EAU and Benham to identify patients admitted that require isolation	Q1, Q2, Q3 and Q4	IPSNs					
	To attend the safety huddle twice daily to provide isolation and IPC advice	Q1, Q2, Q3 and Q4	IPSNs / IPCN / IPC Matron					
	IPCT to undertake daily review of the Side Room Monitor Tool and RAG rate each isolation room to facilitate the Site Management Team in effective patient placement	Q1, Q2, Q3 and Q4	IPSNs					
	To conduct an annual Trust wide audit of isolation facilities as per the annual audit plan and report findings to IPSG the following month	Quarter 3	IPCT					
	To launch reversible isolation signs	Q1	IPCT & Estates Manager					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory Andrea O'Connell					

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
9 a To ensure that evidence based IPC policies and associated procedural documents are available	The IPC policies and associated procedural documents are reviewed three yearly and in accordance with new guidance	Q1, Q2, Q3 and Q4	IPCT					
	IPC policies and procedural documents are audited as per the IPC annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPCT					
	To launch new IP audits across the Trust to replace Saving Lives audits	Q1	IPCN					

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
10 a To ensure that healthcare workers are protected from communicable diseases and from	Occupational health advice is available for staff	Q1, Q2, Q3 and Q4	Occupational Health Team					
	IPC Matron and Occupational Health Lead meet bi-monthly to discuss operational issues	Bi-monthly	IPC Matron & OH Lead					
	Occupational Health Team provide a quarterly report to IPC regarding key issues	Quarterly	Occupational Health Team					

work exposures	Infection Prevention training is mandatory for all staff and reported monthly to CQEG via the IPCT report	Monthly	Matron IPC					
	IPCT to facilitate fit testing for paediatric staff, anaesthetic staff, ED staff and critical care staff and ensure relevant	Q1, Q2, Q3 and Q4	IPCT					

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *28th September 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 *24th August* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- Finance report
- Formal Reforecast
- Changing Care
- Reference Costs
- Operational performance
- IT Committee highlight report

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

Key areas of discussion arising from items appearing on the agenda

- **The Trust is off plan by £1.1m, £850k of this is underperformance. £200k overspend on pay for last 3 months despite reducing agency, being investigated.**
- **All divisions are being challenged for remedial actions**
- **Changing Care programme is on plan but requires more schemes**
- **Maintaining agency caps increasingly challenging. Medical bank being developed.**
- **A&E performance has improved but remains under pressure. There is a DTOCs reset**
- **Significant challenges remain in achieving cancer targets, particularly Breast 2ww, committee received assurance the decline has been arrested**

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

- Reference cost process was approved
- Recommendations from cyber-attack review were accepted

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

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 28th September 2017

Title	**HMT Exception Report**
Chair	**Mrs Deborah Needham**
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 5th September 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. Cancer performance & plan update 3. Update on annual planning 4. Financial recovery workshop	1.1, 1.2, 2.2, 3.1, 3.2, 5.1, 5.2

Key areas of discussion arising from items appearing on the agenda

Verbal report – information only

A summary briefing was provided by the Deputy CEO on:

a. A&E performance & escalation with NHSI & NHSE
b. Cancer performance summary
c. Financial recovery summary

Cancer performance & plan update

A paper was presented which had been discussed at the August finance, performance & investment committee.

- Urology/Breast/Colorectal – all outside trajectory
- Surgical division asked to support pathway changes and escalation

Annual planning

A verbal update was given on the annual planning timescales and process.

AOB

A business case was presented by the W,C,O & H division as part of their recovery plan to invest in 2 additional HCA in order to free up nursing time to see increased numbers of patients in Gynaecology endoscopy. This was approved in principle.

Financial recovery Workshop

A presentation on the current activity gaps was provided and supported by the current financial position.

The Director of strategy & Deputy Director of Finance facilitated a workshop with the 4 divisions. The divisions presented the key actions being taken as part of the recovery plan. Each group were tasked to identify 3 further actions to improve the divisional position, identify any help required from external partners and challenge other divisions on their plans.

Any key actions agreed / decisions taken to be notified to the Board A further update on the workshops recovery actions will be presented as part of the finance update to trust board.	
Any issues of risk or gap in control or assurance for escalation to the Board All areas of risk regarding quality, Finance 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 28 September 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 27 July 2017	Decision	Mr Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Nurse Recruitment and Retention Report	Assurance	Mrs J Brennan	**G.**
10:40	**FOR INFORMATION**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Sustainability and Transformation Plan Update	Receive	Mr C Pallot	**I.**
	14.	EPRR core-standards assessment	Receive	Mrs D Needham	**J.**
	15.	Best Possible Care Status	Receive	Ms C Fox	**K.**
11:00	**ANNUAL REPORTS**				
	16.	Corporate Governance Report	Receive	Ms C Thorne	**L.**
	17.	Infection Prevention Annual Report	Receive	Ms C Fox	**M.**
11:20	**COMMITTEE REPORTS**				
	18.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**

Time	Agenda Item		Action	Presented by	Enclosure
	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.**
11:30	**22**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

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