Northampton General Hospital
NHS Trust

# Public Trust Board

**Thursday 25 January 2018**

**09:30**

**Board Room**
**Northampton General Hospital**

Northampton General Hospital
NHS Trust

# A G E N D A

## PUBLIC TRUST BOARD

**Thursday 25 January 2018**
**09:30 in the Board Room at Northampton General Hospital**

| Time | Agenda Item | | Action | Presented by | Enclosure |
|---|---|---|---|---|---|
| **09:30** | **INTRODUCTORY ITEMS** | | | | |
| | **1.** | Introduction and Apologies | Note | Mr Farenden | **Verbal** |
| | **2.** | Declarations of Interest | Note | Mr Farenden | **Verbal** |
| | **3.** | Minutes of meeting 30 November 2017 | Decision | Mr Farenden | **A.** |
| | **4.** | Matters Arising and Action Log | Note | Mr Farenden | **B.** |
| | **5.** | Patient Story | Receive | Executive Director | **Verbal** |
| | **6.** | Chairman's Report | Receive | Mr Farenden | **Verbal** |
| | **7.** | Chief Executive's Report | Receive | Dr S Swart | **C.** |
| **10:00** | **CLINICAL QUALITY AND SAFETY** | | | | |
| | **8.** | Medical Director's Report | Assurance | Mr M Metcalfe | **D.** |
| | **9.** | Director of Nursing and Midwifery Report | Assurance | Ms C Fox | **E.** |
| | **10.** | Mortality Update Report | Assurance | Mr M Metcalfe | **F.** |
| **10:20** | **OPERATIONAL ASSURANCE** | | | | |
| | **11.** | Finance Report | Assurance | Mr P Bradley | **G.** |
| | **12.** | Workforce Performance Report Including<br>• Equality and Diversity Progress Report for Staff<br>• Gender Pay Gap Report | Assurance | Mrs J Brennan | **H.** |
| **10:40** | **GOVERNANCE** | | | | |
| | **13.** | Corporate Governance Report | Assurance | Ms C Thorne | **I.** |
| **10:50** | **FOR INFORMATION** | | | | |
| | **14.** | Integrated Performance Report | Assurance | Mrs D Needham | **J.** |
| | **15.** | Emergency Preparedness Annual Report inc Winter Plan | Assurance | Mrs D Needham | **K.** |
| | **16.** | Estates Compliance Update | Assurance | Mr S Finn | **L.** |
| | **17.** | Fixing the Flow Update | Assurance | Mrs D Needham | **M.** |
| **11:10** | **COMMITTEE REPORTS** | | | | |
| | **18.** | Highlight Report from Finance Investment | Assurance | Mr P Zeidler | **N.** |

| Time | Agenda Item | | Action | Presented by | Enclosure |
|---|---|---|---|---|---|
| | | and Performance Committee | | | |
| | **19.** | Highlight Report from Quality Governance Committee | Assurance | Mr J Archard-Jones | **O.** |
| | **20.** | Highlight Report from Workforce Committee | Assurance | Ms A Gill | **P.** |
| | **21.** | Highlight Report from Audit Committee | Assurance | Mr D Noble | **Q.** |
| **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 29 March 2018 in the Board Room at Northampton General Hospital.**

**RESOLUTION – CONFIDENTIAL ISSUES:**

The Trust Board is invited to adopt the following:

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

Appendix A

Northampton General Hospital NHS
NHS Trust

# Minutes of the Public Trust Board

**Thursday 30 November 2017 at 09:30 in the Board Room at Northampton General Hospital**

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

**TB 17/18 068 Introductions and Apologies**

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

A presentation was delivered by Mrs S Cheney on Cedar Ward which had recently achieved the Best Possible Care Award status.

**TB 17/18 069 Declarations of Interest**

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

**TB 17/18 070 Minutes of the meeting 28 September 2017**

The minutes of the Trust Board meeting held on 28 September 2017 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 28 September 2017 subject to amendments passed to the Board Secretary.

**TB 17/18 071 Matters Arising and Action Log 28 September 2017**

The Matters Arising and Action Log from the 28 September 2017 were considered.

It was noted that all actions were picked up within reports on the agenda.

The Board **NOTED** the Action Log and Matters Arising from the 28 September 2017.

**TB 17/18 072 Patient Story**

Ms Fox shared with the Board a patient story which discussed the CAMHS service. There were delays in timely interventions as well as a lack of accessible care which had impacted the patient's physical and emotional wellbeing.

The Board **NOTED** the Patient Story.

**TB 17/18 073 Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden advised that he and Mr Zeidler had recently attended the QRM with the Executive Team. The team had been congratulated on the recent CQC rating.

Mr Farenden commented that the meeting had included appropriate constructive challenge from the regulators and the Executive Team had responded well. There had been a focus on finance, A&E and Cancer performance.

Mr Farenden shared with the Board the 2 recent NED appointments. One of these NED's was a substantive post and one would be an Associate NED.

Mr Farenden had attended a meeting of Chairs where discussion was had on the STP.

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

**TB 17/18 074 Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart discussed the CQC report and its positivity going into Winter. On 01 December there is to be a CQC celebration event thanking the workforce. This will involve displays, presentations and team NGH discussions.

Dr Swart commented that there had been positive feedback in relation to the CQC report from the media, partners and the public. There is a need to sustain the rating and how it can be transformed into a future 'Outstanding' CQC rating.

Dr Swart stated that the Trust had declared Opel 4 a number of times recently. The number of patients in ED waiting to be assessed and waiting for a bed is considerably higher than previous winters. It was noted that there is a need to be more externally focused in relation to securing additional funding.

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

**TB 17/18 075 Medical Director's Report**

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe informed the Board that he had changed the format of the Medical Director's Report and welcomed feedback.

Mr Metcalfe stated that in relation to risk, urgent care was the clinical priority for the Trust and this was being accelerated by the Fixing the Flow programme. This included Consultant engagement and ownership of actions within the programme.

Mr Metcalfe commented that there will be the introduction of senior medical leadership rota to support the organisation when in escalation which will help support the site team. When the Trust is on Opel 4 there will be a timetable of consultants who have SPA time available for the site team to call on when additional input is required on wards.

Mr Metcalfe delivered an update on Serious Incident's (SI) to the Trust board. There were 8 serious incidents reported on STEIS during September and October, 4 of these "outwith" local investigation processes. The Safeguarding Team at the Trust have confirmed the "outwith" cases present no current risk to patients or staff.

The 4 SI investigations opened during September and October are on track to report by their deadlines and consist of; Delayed diagnosis of an axillary nerve palsy, Preventable Hospital Acquired Thrombosis (HAT), Maternity cardiac arrest and Delay/failure to monitor cardiac patient.

Mr Metcalfe stated that Venous thromboembolism (VTE) and Hospital Acquired Thrombosis (HAT) needed improvement with NICE guidance. A new strategy had been put together and will be taken forward. Of the 19 HATs 5 of these were preventable, and 5 were fatal which were deemed unpreventable.

Mr Metcalfe discussed responsiveness to actions by senior medical staff with the Board. The Clinical and Divisional Directors have agreed that medical colleagues will respond to requests for statements/information in relation to incidents/complaints within 7 days. At 14 days the escalation will be to the medical director. The Director of nursing and Chief Operating Officer had agreed to the same timeframes for other staff groups. Mr Metcalfe confirmed to the Board that in future this would be presented in run rate form.

Mr Metcalfe advised that Consultant job plans would be aligned with Fixing The Flow and will be centred on the needs of the Trust. By Quarter 1 of 2018/19 the specialities and Directorates in Medicine division will have built service delivery models which specify the consultant resource required to support emergency flows.

Mr Noble thanked Mr Metcalfe for the report. He queried how the Board can gain assurance on the Governance of VTE compliance. Mr Metcalfe confirmed that this would be reported monthly at QGC via CQEG. The leadership of VTE and HATs compliance on night shift is the main priority.

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

**TB 17/18 076** **Director of Nursing and Midwifery Care Report**

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

Ms Fox advised that in October 2017 the Trust achieved 98.73% harm free care (new harm) and overall harm free care was 95.09%.

Ms Fox shared with the Board that pressure ulcers per 1000 bed days were now reporting back on the mean line. It was noted that there are a number of patients aged 75 plus who are predisposed to pressure ulcers and prevention work is ongoing to address this.

Ms Fox reported that the cdiff trajectory for the year is set at 21 and there had been 17 incidents of cdiff year to date. All of these had been reviewed by the CCG and there had been no lapse in care noted. Ms Fox confirmed that the Tazocin shortage is still a challenge.

There had been 5 incidents of cdiff on Willow Ward in surgical patients. This was noted to be unusual and Ms Fox informed the Board that there had been no lapse in care. The Board were made aware that this had been shared at the Infection Prevention Control (IPC) Committee that Public Health England had noticed an increase of cdiff in unusual patients nationally. Environmental work had been undertaken on Willow Ward to prevent further cases of cdiff.

Ms Fox stated that the Trust is in a positive position in relation to MSSA bacteraemia nationally and that an article is to be published on the Trust's Infection Prevent Control.

Ms Fox reported that the Gynaecology Children's and Oncology Division had seen

an increase in overdue observations. Ms Fox believed the investment of VitalPAC on all wards would help reduce this.

Ms Fox drew the Board to Appendix 9 which showed the Trust in the regional picture. The Trust had improved and was consistently achieving 96% plus fill rate. This included agency and bank staff.

Ms Fox shared with the Board that a report on Midwifery staffing would be presented to the Workforce Committee. The Head of Midwifery would be reviewing the midwife to patient ratio. The Trust currently sits at 1:31 ratio due to vacancies and a high number of maternity leave. To mitigate this risk the Trust had over-recruited to provide a safe service.

Mr Farenden queried whether the recent cdiff incidents had occurred in a condensed period of time. Ms Fox advised that the incidents did not and that environmental work was underway on the ward. Mr Finn stated that this included cleaning and redecorating the ward top to bottom.

Mr Zeidler challenged the number of red results for infection prevention in the table detailed in Appendix 7 Assessment and Accreditation Results considering the positive MSSA outlook. Mr Zeidler asked if there was anything the Non-Executive Directors could do to raise awareness of infection prevention.

Ms Fox clarified that the right time survey had highlighted the issue with Clinicians including Nurses not washing their hands correctly. She has asked the Infection Control Team to relaunch hand hygiene.

Dr Swart commented that hand hygiene needed to further embed as it is standard which should be owned jointly by the Doctors and Nurses.

Mr Archard-Jones drew the Board to the Executive Summary where he raised his concern that the narrative on safety thermometers may be misleading due to the different measures used for Womens & Paediatrics. Ms Fox confirmed she would explore different ways to phrase this narrative.

**Action: Ms Fox**

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

**TB 17/18 077** **Fixing the Flow Update**

Mrs Needham presented the Fixing the Flow Update.

Mrs Needham advised that the Fixing the Flow programme was launched on 30 October 2017 and will run over a period of 12 months. There are 3 workstreams which are led by the Medical Director, the Director of Nursing and herself. These are assessment, discharge and site management.

Mrs Needham drew the Board to page 57 of the report pack which detailed an example of a weekly report. The programme uses agile methodology which tests different ways of working and change using PDSA with support from Quality Improvement Team (QI), IQE and the Project Management Office (PMO).

Mrs Needham confirmed that the overall metrics and progress of the programme would be brought to the next Board meeting.

Mrs Needham discussed some of the changes which included how emergency flow would be managed which was with assessment units all being on the same floor level. There was criteria led discharge which had taken place as a pilot on Beckett Ward. It was noted that Springfield had opened and next week would see the

relocation of the Out of Hour services to onsite at NGH.

Mrs Needham commented that the areas which the Trust is judged on such as reducing admissions and average length of stay are difficult to measure weekly. Mrs Needham hoped to see an impact by the end of December on these.

Ms Fox reported on the criteria led discharge by a Nurse on a medical ward. This would be rolled out to other areas with the possibility of Therapist led discharges which would benefit the Trust. Ms Fox noted that in regards to the weekend discharge process there is engagement from an MDT perspective.

Mr Farenden queried the quantum of change in relation to criteria led discharge. Mrs Needham expected one patient per day from medical wards.

Mr Metcalfe stated that there had appeared to have been a poor awareness of who was on call therefore the rota had been disseminated again as well the information being inputted into an iPhone for the Doctors to use.

There had been a relaunch of the professional standards, monitoring of the senior medical rota and to work closer to the front door on the emergency floor to support admission avoidance.

Dr Swart commented that the regulators had carried out a mandatory assessment as the NGH is a category 3 Trust. A gap analysis has been undertaken and the key items had been picked out to include in Fixing the Flow. The assessment noted that there appeared to be a problem with the medical model and it had been agreed to work on this.

The Board **NOTED** the Fixing the Flow Update.

**TB 17/18 078** **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that the Trust had a pre-STF deficit of £13.9m which is £2.3m adverse to plan. STF trajectories had been met only in Q1 therefore this had resulted in missed STF income of £2.8m year to date.

In month there had been an improvement in activity and income which gave an early indication that the income actions in the Trust's financial recovery plan (FRP) are working.

Mr Lazarus drew the Board to page 79 of the report pack which showed an increase in senior medical agency staff. There will be increased central controls via Vacancy Control Panel's (VCP) and weekly reporting.

Mr Lazarus stated that Finance Committee it had been discussed the possibility of changing the forecast at the end of Quarter 3.

Mr Farenden commented that if would be better for the centre to know the forecast position as soon as possible.

Mr Archard-Jones queried that within plan C there had been the suggestion of a voluntary day of unpaid leave however the nurses he had spoken to were not aware of this. Mrs Brennan clarified that after discussions with the Union it had been decided to remove this option. Dr Swart stated that staff will be reminded of the salary sacrifice scheme in non-clinical areas.

The Board **NOTED** the Finance Report.

**TB 17/18 079** **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity increased in October 2017.

Mrs Brennan reported on vacancy rates.

Mrs Brennan commented that sickness absence was at its highest that she had seen. A deep dive had been completed and seasonal factors had doubled from September to October with additional working days lost.

Mrs Brennan shared with the Board that the flu vaccination was currently at 75.6%. It was noted that the 'Jab & Grab' campaign had been popular as well as the success of trolley rounds at the weekend and at night.

Mrs Brennan discussed the staff survey with the Board. There is currently a 31% response rate. Mrs Brennan had discussed this with the HRD's who had concurred they were experiencing the same issue.

Mr Noble queried the update for the flu vaccination county wide. Ms Fox confirmed she could locate this information and report back to the Board.

**Actions: Ms Fox**

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

**TB 17/18 080** **Integrated Performance Report**

Mrs Needham presented the Integrated Performance Report.

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

Mrs Needham advised that ambulance handover times continued to be one of the best in the East Midlands.

Mrs Needham stated that A&E performance decreased slightly in October and this decrease in performance had continued into November. It was noted that DTOC reduced in month and acuity peaked in October. The number of patients medically fit for discharge remained stable

Mrs Needham reported that work with partners in Health & Social Care continued with additional nursing home and domiciliary care capacity being put in place over the next month.

Mrs Needham commented that the Trust is still in escalation with the regulators and the Trust is having fortnightly meetings.

Mrs Needham highlighted her main concern to the Board. Her main concern was going into winter and the resilience of staff. So far the staff remained positive, upbeat, and are excited with regards to changes with Fixing The Flow, Springfield UCTC and the new Assessment hub.

Mrs Needham stated the number of stranded patients is increasing but of those over 20 days the majority are age 75 plus who generally stay longer.

Mrs Needham delivered a Cancer update to the Board.

Mrs Needham advised that 62 day target had decreased in October due to legacy patients being treated. It was noted that performance has increased in November to 91% against the 85% trajectory, this is not yet fully validated

Ms Needham stated that 2ww remained a challenge especially in breast. With additional capacity the Trust is improving and hoped to be back on track in January 2018.

Mrs Needham highlighted to the Board the issues surrounding non-emergency patient transport. The contract is held with the CCG who had changed the provider. The Board was informed that patients have had to be readmitted as they are waiting too long.

Ms Gill asked whether the volunteer service could be used. Mrs Needham confirmed it had been used for some patients however a large number of patients do need transport which holds stretchers.

Mr Pallot noted the unseen risk for outpatients not bringing there medication with them and then having a delay for transport.

Mrs Needham informed the Board of the new ASI CQUIN. The CQUIN is for the Trust to have less than 4% of patients being held on a list after being referred by their GP. If the Trust is at full capacity then patients will need to be held on a waiting list and this information would be included on future scorecards.

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

**TB 17/18 082** **Medical Recruitment Strategy**

Mrs Brennan presented the Medical Recruitment Strategy.

Mrs Brennan informed the Board that demand for medical recruitment is outstripping supply. A different strategy by grade has been developed.

Mrs Brennan advised that the supply of Junior Doctors to nationally recognised posts (i.e. those that attract a National Training Number (NTN) is provided through the Deanery). The Trust plan is to better predict the gap of Junior Doctors and over recruit for this grade.

Mrs Brennan commented on Trust grade and SAS grade Doctors. The supply of these positions is predominantly reliant upon the Trusts ability to attract those doctors from existing employers and/or overseas doctors.

Mrs Brennan stated that the supply of Consultants is reliant upon the Trusts ability to attract Junior Grade Doctors that are successful in obtaining their Certificate of Completion of Training (CCT). Mrs Brennan stated that the Trust may need to go overseas to recruit Consultants. The Divisional Director in Medicine will be focusing on this with HR.

Mrs Brennan advised that there is ongoing work at developing the Trust's medical brand and work is being done with the Divisions. The branding will be reflected differently in the specialities.

Mrs Brennan stated that work will be done jointly between HR and Medics to come up with plans for implementation.

Ms Gill queried whether this strategy would look at the recruitment process. Mrs Brennan confirmed that it would.

Dr Swart asked whether the Workforce Committee would have regular updates and Mrs Brennan confirmed that the Committee would together with a new working group monitoring the progress.

Mr Zeidler queried whether new Consultants are asked what they are looking for outside of the normal specifics of recruitment. Mrs Brennan stated that this would be done.

The Board **NOTED** the Medical Recruitment Strategy.

**TB 17/18 083 Sustainability and Transformation Plan Update**

Mr Pallot presented the Sustainability and Transformation Plan Update.

Mr Pallot stated that the report in the Board pack was from the PMO who had outlined the high level messages.

Mr Pallot informed the Board that due to the lack of project management resource the workstream progress with KHG had gone from green to red.

Dr Swart advised that she had received an update regarding additional resources and the Trust would need to explore how this would be defined practically.

The Board **SUPPOTED** that Sustainability and Transformation Plan Update.

**TB 17/18 084 Final CQC Report Outcome**

Ms Thorne presented the Final CQC Report Outcome.

Ms Thorne stated that the Trust had received formal notification of the 'Good' CQC rating. The CQC improvement plan would be reported to the Board via the Quality Governance Committee.

Ms Thorne advised that she chairs a Task and Finish Group which monitored the CQC improvement plan and this group will move on to become the 'Good to Outstanding' Group.

Dr Swart shared her concern that it may become difficult to maintain due to regular pressures the Trust faced. This highlighted the importance of the Fixing the Flow programme.

Ms Thorne stated that there were elements of the CQC Improvement Plan which were close to 'Outstanding' and other elements of the plan which were fragile.

Mr Farenden commented on the importance on the Trust not losing the 'Good' ratings and to focus on the fragile areas.

The Board **NOTED** the Final CQC Report Outcome.

**TB 17/18 085 Highlight Report from Finance Investment and Performance Committee**

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

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

Mr Zeidler advised of the key points –

- Changing Care was of plan in a number of areas including surgical productivity and mitigating actions were in place.
- Eurofins

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

**TB 17/18 086 Highlight Report from Quality Governance Committee**

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

The Board were provided a verbal update on what had been discussed at the Quality Governance Committee meeting held on the 24 November 2017. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Archard-Jones advised of the key points –

- Update on VTE compliance.
- EMRAD.
- Complementing the security staff on their good work despite the challenges they face.

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

**TB 17/18 087 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 the 22 November 2017. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Kershaw advised of the key points –

- Revalidation.
- Job planning.
- First update from the Health & Wellbeing Coordinator.
- Bullying and Harassment update – 700+ staff had responded to the Respect and Support survey. It had been noted that staff on lower bands can be treated differently at times.

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

**TB 17/18 088 Highlight Report from Hospital Management Team**

Mrs Needham presented the Highlight Report from Hospital Management Team.

Mrs Needham informed the Board that the HMT meet on 07 November 17. The topics covered were Finance and plan C.

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

**TB 17/18 090 Any Other Business**

There was no other business to discuss.

**Date of next Public Board meeting: Thursday 25 January 2018 at 09:30 in the Board Room at Northampton General Hospital.**

Mr P Farenden called the meeting to a close at 11:40.

Appendix B

| Public Trust Board Action Log | | | | | | | Last update | 15/01/2018 |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Date of meeting** | **Minute Number** | **Paper** | **Action Required** | **Responsible** | **Due date** | **Status** | **Updates** |
| **Actions - Slippage** | | | | | | | | |
| NONE | | | | | | | | |
| **Actions - Current meeting** | | | | | | | | |
| 80 | Nov-17 | TB 17/18 076 | Director of Nursing and Midwifery Care Report | Mr Archard-Jones drew the Board to the Executive Summary where he raised his concern that the narrative on safety thermometers may be misleading due to the different measures used for Womens & Paediatrics. Ms Fox confirmed she would explore different ways to phrase this narrative. | Ms Fox | Jan-18 | On agenda | |
| 81 | Nov-17 | TB 17/18 079 | Workforce Performance Report | Mr Noble queried the update for the flu vaccination county wide. Ms Fox confirmed she could locate this information and report back to the Board | Ms Fox | Jan-18 | On agenda | **update matters arising** |
| **Actions - Future meetings** | | | | | | | | |
| NONE | | | | | | | | |

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Chief Executive's Report** |
| **Agenda item** | ***7*** |
| **Presenter of the Report** | Dr Sonia Swart, Chief Executive |
| **Author(s) of Report** | Dr Sonia Swart, Chief Executive and Sally-Anne Watts, Head of Communications |
| **Purpose** | For information and assurance |
| **Executive summary**<br>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)<br><br>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**<br><br>The Trust Board is asked to note the contents of the report | |

Northampton General Hospital NHS Trust

# Public Trust Board
# 25 January 2018

## Chief Executive's Report

### 1. Winter pressures

We have experienced an extremely challenging start to 2018 with a particularly prolonged period of operating under sustained intense pressure. Early data analysis showed that we could expect the worst of the winter pressure to ease after January, and informed our decision to cancel all non-urgent elective activity for the remainder of the month. This comes on a background of a rise in pressure and acuity which started last September

Being able to provide our patients with notice of their cancellation avoided last-minute changes and the inconvenience this causes. We were also able to deploy some of our theatre staff's expertise in supporting our patients and colleagues in the emergency department and on the wards as appropriate.

We know that staying in hospital longer than necessary puts our patients at risk as well as impacting on our bed capacity. For this reason it was decided that we would use some of our allocation of the winter pressures funding to pay for placements in community care homes for those patients who are fit for discharge, but remain in hospital whilst awaiting a care package or a placement to be arranged by our partners.

At the same time as seeing an increase in the overall acuity of our patients, there is also a rise in the number of patients who are with us for more than seven days. This inevitably impacts on patient flow. The focus on the best and most efficient care for patients continues through our 'Fixing the Flow' programme. Part of this work has been to increase the focus of our matrons onto wards, where their role is to assist in addressing any blocks to patient flow and discharge, whatever the issue, clinical or non-clinical. We have also linked with partners from social care and health who have worked with us on site to help improve patient flow and outflow from rehabilitation, but we continue to see difficulties in obtaining the enough timely support from social care. This is having a significant impact.

With the support of the Emergency Care Improvement Programme from NHS Improvement we are planning a three day event on 22-24 January which will be attended by all our local health and social care partners. The aim of the event is for us all to work together to bring about a significant change in focus and ultimately improve patient flow and discharge.

This focus of this event will be useful also as preparation for the work we will need to do as a system as we prepare for the CQC review of the Northamptonshire Health and Social Care system which will take place in March and April. Ultimately this will test how well we are all working together for the best benefit for patients

**The money**

There has been a huge amount of media attention on the 'winter crisis'. Alongside this there is also an increasing realisation that cancelled operations and the high occupancy levels experienced by hospitals presents a number of challenges in addition to the immediate patients safety risks. This situation, which has been developing over the autumn, is challenging our financial position and will, therefore, require further emphasis in the months to come.

### 2. Our staff

It is a privilege to work alongside everyone in TeamNGH who always put patient safety and the patient experience at the heart of all they do. I have been overwhelmed by the response of staff across NGH, whatever their job role, and by their generosity in giving up their time. Many have stayed late or volunteered extra hours in the evenings or at weekends.

Medical colleagues have responded positively to requests for them to work very differently and non-clinical staff have gone to great lengths to support the hospital, our patients and their colleagues during this difficult time. Whilst many will tell you that they are 'just doing my job' I know that many have gone way above and beyond what might be expected. Whilst we have our annual Best Possible Care Awards, I believe it is also important that we recognise the commitment and dedication of our staff at other times. With this in mind we have introduced a Winter Heroes Board along the Hospital Street so that we can formally acknowledge and thank our colleagues who have gone above and beyond specifically in coping with the demands from winter pressures. When a nomination has been received and approved the individual or team receives a personal thank you card from me, which is delivered by a member of the executive team. A photo is taken of the individual/team with their card and that, together with a brief explanation of what they have done, appears on the Winter Heroes Board.

Before Christmas we submitted some information to NHS Providers regarding instances of where staff had gone above and beyond in relation to winter pressures and these were quoted by them.

## 3. Our stakeholders

I recently hosted an informal visit by Jon Ashworth MP, Shadow Secretary of State for Health, who was interested to understand more about the impact of winter pressures on hospital services and our staff, and the actions we were taking to improve our performance by ourselves and the wider health and social care community.

I have also issued a briefing to all our local MPs to update them on the actions we are taking to address the winter pressures to ensure that they are aware of the position and have up-to-date information available to them.

Our patients continue to provide us with positive feedback. Many have taken to social media to post their tributes and talk about their positive experience of the care we have provided. It is clear from the consistency of their messages that, whilst they can see for themselves the pressures we are working under, they also feel they are being cared for well, with dignity and compassion. This is important to them, and to us.

## 4. NHS70 and NGH 225

2018 marks an important milestone for both NGH and the NHS. The NHS celebrates 70 years since it was founded in 1948 and we at NGH celebrate being on our current site for 225 years.

The communications team is working with our archive volunteers to produce some visual displays to celebrate both events. The team is also looking at other ways in which we can celebrate and mark both occasions within existing resources.

A key event will be our AGM, which this year will take place on Thursday 5 July, which is the birthday of the NHS. We will host a 'SevenTea' event in the main hall at Cripps PGMC between 3pm and 5pm which will incorporate our AGM. There will be stands and displays depicting the history of NGH and the NHS.

**Dr Sonia Swart**
**Chief Executive**

Northampton General Hospital NHS
NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

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

**Executive summary**

**Risk**
The principle risks relating from emergency care pressures and medical workforce gaps are presented together with the related performance and financial risks.

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

i. Omissions in care following chemotherapy (death)
ii. Fall resulting in fractured neck of femur
iii. Delay in diagnosing lung cancer
iv. Baby – tertiary referral for cooling One SI report has been submitted to Nene CCG for closure.

There has been a **never event** in theatres, with no patient harm. The theme of incidents relating to theatre safety culture is discussed in the report.

**Mortality**
Dr Foster data showed overall mortality expressed as the HSMR remains within the 'as expected' range. Outlier alerts are being investigated in relation to respiratory disease and advanced malignancy. The AKI task and finish group have commenced pilots aimed at improving the mortality outlier alert

| | |
|---|---|
| against this.<br><br>**Consultant communication and engagement strategy** has been initiated and plans going forward have been described. | |
| **Related strategic aim and corporate objective** | Corporate Objective 1: Focus on Quality and Safety – We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety |
| **Risk and assurance** | For Assurance |
| **Related Board Assurance Framework entries** | BAF 14 |
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) |
| **Legal implications / regulatory requirements** | CQC Fundamental Standards – Safe<br>External Review/Accreditation body : Nene and Corby Clinical Commissioning Group ( CCG).<br>Duty of Candour Requirements |
| **Actions required by the Committee**<br><br>The Committee is asked to note the contents of this report | |

Northampton General Hospital NHS
NHS Trust

# Medical Director's Report

**25th Jan 2018**

## 1. Introduction

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

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

## 2. Risk

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

### 2.1 Urgent Care

Taken together these risks reflect the single greatest challenge to the trust in delivering safe high quality care. The trust response to this through the "fixing the flow" programme was described in the medical director's report to the November 2017 public board. The heightened emergency pressures experienced by the trust since Christmas 2017 coupled with central directives from the "winter room" of NHS England have resulted in the following additional measures;

i. Additional consultant physicians supporting the Emergency Department at peak hours.
ii. A supernumerary orthopaedic consultant based in the Emergency Department running virtual fracture clinic and seeing emergency musculoskeletal presentations upon arrival.
iii. A general surgery senior registrar or consultant based in ED during peak hours.
iv. "hot slots" in clinics available for admission avoidance.
v. Consultant physicians attending the morning safety huddles.
vi. Direct referral to sub-specialities during peak times to facilitate earlier optimal management.

These changes, whilst discussed in concept with the consultant body during a series of "calls to Arms" meetings before Christmas, have been, or are being, rushed into operation at significant pace. The main risk to this is that they lack the degree of oversight and coordination required to ensure that they deliver the best possible clinical value. Other risks include transferring risk from one area to another (e.g. outpatients to the front door) and the financial exposure of additional resource and/or loss of elective activity required to support the above. For example, the additional resource diverted from outpatient activity to the emergency department may be expected to have a

bigger impact upon performance against the 4 hour standard than it has. The recently appointed programme director of safer emergency care has commenced this month, and as a priority will be developing an oversight framework for the coordination and measurement of impact of interventions. Over 70% of the consultant body attended the “Call to Arms” meetings, and their constructive engagement has prompted and shaped some of the actions above.

As part of this framework, a review of pertinent risks on the corporate risk register will be required.

| CRR ID | Description | Rating (Initial) | Rating (Current) | Corporate Committee |
|---|---|---|---|---|
| 1286 | Frequent and prolonged loss of elective orthopaedic ward for escalation | 20 | 20 | Finance & Performance |
| 619 | Risk to patient safety and of deterioration in condition of the elective Heart Centre patients when they are cancelled due to the Heart centre being utilised as an escalation area | 25 | 16 | Quality Governance |
| 731 | Risk of not providing a safe and timely haemodialysis service for inpatient and outlier/emergency patients when emergency renal (Northamptonshire Kidney Centre) beds are utilised for outlying patients | 20 | 16 | Quality Governance |
| 1194 | Delayed discharge on a near daily basis of Critical Care step down patients results in delay admitting new patients to the Unit | 15 | 15 | Quality Governance |

### 2.2 Clinical Staffing

There are no further updates to be reported to board following the November report in relation to medical workforce strategy. The workforce gaps result in re-distribution of clinical risk and absolute financial risk when responding to emergency pressures as described above.

| CRR ID | Description | Rating (Initial) | Rating (Current) | Corporate Committee |
|---|---|---|---|---|
| 1348 | High number of vacancies in Oncology/Haematology contributing to in-patient and out-patient delays | 9 | 20 | Quality Governance |
| 551 | Patients may receive suboptimal care at weekends due to reduced numbers of staff being available to provide full 7 day working. | 16 | 16 | Quality Governance |
| 979 | Difficulty in recruiting to the establishment due to local and national shortages of nurses and difficulties associated with overseas recruitment. | 16 | 16 | Quality Governance |
| 1371 | 2/9 surgeons do not have adequate | 20 | 16 | Quality |

| | | | | |
|---|---|---|---|---|
| | theatre time (despite this being in their JD and jobplan) to deliver safe and effective care of their patients.<br><br>Specifically:<br>1)BCC skin tumours have now moved on to the 2WW and need timely excision and reconstruction - within 31 days of the decision to treat. excision and reconstruction is a 2 stage process and needs paired lists to achieve this<br>2)Glaucoma that is not controlled my medial means need urgent ie within 6 weeks surgery to control the eye pressure.<br><br>These operations need theatre time that is not currently available (theatre is available but not staffed - ie this is a staffing not infrastructure problem so readily addressed | | | Governance |
| 1389 | Lack of histopathologists will affect our MDTs as pathology results will be delayed. | 16 | 16 | Quality Governance |
| 1188 | Turnover within nursing from core and specialist areas is high. The net result of this is that despite the recruitment strategy there is little gain in nursing capacity in core and specialist areas. Poor retention in core and specialist areas leads to low staff morale and therefore this poses an even greater risk to staffing levels. Should the risk arise in that if recruitment comes more problematic our Trust turnover levels within core and specialist areas would result in a reduction in nursing capacity. This would come at a time when there is a requirement to increase capacity due to the 60 bedded unit. | 16 | 16 | Workforce |
| 1280 | Inability to maintain effective service levels due to reduced numbers of nursing workforce for the existing bed base within the Directorate which could result in a reduced standard of care and patient safety. This is consistent across the Medicine and Urgent Care division. | 9 | 16 | Quality Governance and Workforce |
| 1518 | The Trust has difficulty in recruiting to the establishment due to local and national shortages of medical staff and difficulties associated with overseas recruitment | 16 | 16 | Workforce |

| | | | | |
|---|---|---|---|---|
| 1199 | 30-70% of prescriptions on admission are unintentionally different from the medicines patients were taking before admission [NICE/NPSA/2007/PSG001].<br>• Inadequate capacity of pharmacy to review each admitted patient's prescriptions & correct anomalies.<br>• Inadequate capacity of pharmacy in admission areas to review each patient within 24 hours. | 15 | 15 | Quality Governance |
| 1155 | Potentially unable to maintain appropriate staffing levels in theatre areas due to a large amount of staff vacancies | 15 | 15 | Quality Governance |
| 1455 | Reduction in students/trainees coming into the profession and potentially not staying within the profession could reduce the number of registered nurses to work on the wards/departments. | 20 | 15 | Quality Governance |

### 2.3 Financial control

The adverse financial position is compounded by the loss of elective inpatient activity due to high non-elective occupancy. This is further exacerbated by the need to provide additional resources to support emergency demand. Some of this additional resource required is mitigated through redeployment of staff from cancelled elective activity.

The paucity of social care provision is a key driver for the high occupancy with non-elective patients which in turn results in poor financial control. The high threshold for accepting patients medically fit for discharge into appropriate community provision and the prolonged processes of assessment appear largely refractory to the patient safety impact of the local acute provider trusts' overcrowding.

High volumes of non-elective patients stretch the ability of the trust to consistently deliver high quality timely care, reflected in a risk to income from certain CQUINs, including those around the rapid identification and appropriate treatment of severe sepsis.

| CRR ID | Description | Rating (Initial) | Rating (Current) | Corporate Committee |
|---|---|---|---|---|
| 1531 | The Trust fails to deliver Financial and Performance Targets required to access £8.7m of STF funding. | 20 | 25 | Finance & Performance |
| 1343 | NCC Adult social Care cuts could severely impact discharges from Hospital and increase DTOCs giving riser to significant bed pressures and cancellation of elective activity. | 25 | 20 | Finance & Performance |
| 1527 | The Trust may fail to deliver on the agreed financial control total for 17-18 of £13.5m | 20 | 20 | Finance & Performance |

| | | | | |
|---|---|---|---|---|
| 1529 | CIP Schemes fail to deliver £12.9m target leading to risk of delivering I&E Control total. High proportion of CIP delivery is non-recurrent leading to increased recurrent deficits in future financial years. | 20 | 20 | Finance & Performance |
| 1012 | Due to national restrictions the Trust fails to secure capital loan financing to meet the proposed 5 year capital plan. | 12 | 16 | Finance & Performance |
| 1204 | The Trust fails to implement strict controls of Agency staff and Consultancy Services expenditure required by the DH and NHSI. Agency expenditure cap of £13.040m imposed by Regulators for FY17-18 and FY18-19. | 16 | 16 | Finance & Performance |
| 1581 | Risk of financial penalties and compromised quality. Inability to meet contractual/ quality requirements due to a failure to deliver on the CQUIN indicators | 16 | 16 | Quality Governance |
| 1528 | Risk that the development of the 60 bed hub is not completed in time to ease operational pressures and therefore have financial impact although that may be largely in respect of 2018/19. | 16 | 16 | Finance & Performance |
| 50 | Inability to recover key financial systems and processes in event of a disaster. | 4 | 15 | Finance & Performance |

**2.4 Performance**

The executive team have taken the decision that performance against the 18 week standard for elective care cannot be maintained in the face of non-elective pressures and the need to keep the hospital safe. This has facilitated the re-deployment of resource to support emergency pressures.

A work plan towards compliance with the NICE QS3 (VTE assessment) is in draft for consideration at the February Thrombosis Committee meeting, and the risk rating against 1476 will be reviewed regularly.

A review of incidents reported on Victoria ward has not revealed any patient harm resulting from lack of medical review, however the reported delays may be prolonging length of stay.

The medical director and Chief Information Officer are meeting to agree the key clinical priorities for developing IT interfaces to promote clinical safety and efficiency. Included in these are the need for EPMA and Vital Pac to interface to alert to the need for urgent drug administration (eg antibiotics in sepsis) and rationalisation of the IT systems supporting theatre scheduling to reduce errors on lists.

| CRR ID | Description | Rating (Initial) | Rating (Current) | Corporate Committee |
|---|---|---|---|---|
| 1611 | Skin cancer referrals to Dermatology are on the increase year on year. Demand for cancer referrals first appointments (and the subsequent demand for biopsies) is not being met by the current capacity. The STP for Dermatology (as a long term project) is not meeting addressing the current and immediate needs of the service, in not meeting demand | 20 | 20 | Finance & Performance and Quality Governance |
| 1453 | Two Consultant Urologists have resigned from post. One Consultant left in November 2016 and the other Consultant is due to leave January 2017. | 16 | 16 | Finance & Performance |
| 1476 | Inability to provide robust assurance of compliance of all aspects of NICE QS3 | 20 | 16 | Quality Governance |
| 1551 | Patients on Victoria ward are not seen on a regular basis by their medical team. No agreement on ward round/review frequency is in place. | 9 | 16 | Quality Governance |
| 1589 | IPM, ICE, Vital Pac and EPMA are all on different IT systems, thus you have to log out of one system and log into another. This poses as a clinical safety risk to patients as information to aid decision making may be lost. Also leads to inefficiencies and slows down the ward round. | 16 | 16 | Finance & Performance |

### 3. Harm

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

i. The number of serious incidents (requiring STEIS escalation) and the number of Never events in 2017/18 YTD, with previous years for comparison.
ii. The number of new serious incidents requiring full root cause analysis (RCA) and moderate harm incidents requiring “concise” RCA since the last trust board. Summary information for new Serious Investigations initiated and submitted to the CCG are provided.
iii. Key thematic issues relating to avoidable patient harm.

**3.i Run rate of SI and Never Event investigations**

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

**3.ii New SI and moderate investigations**

There were 4 serious incidents reported on STEIS during November and December. These are on track to report by their deadlines and consist of;

v. Omissions in care following chemotherapy (death)
vi. Fall resulting in fractured neck of femur
vii. Delay in diagnosing lung cancer
viii. Baby – tertiary referral for cooling

Three completed SI reports were submitted to Nene CCG. These pertained to a delay in delivering a baby with evidence of fetal distress, a delay in recognising and acting upon an axillary nerve palsy and a delay in recognising and treating sepsis in a patient transferred inappropriately from KGH to NGH. Further details and learning were shared at November and December QGC meetings.

There has been a further **never event** at the trust, with a wrong site local anaesthetic block being administered at the beginning of a surgical case in theatre. This is associated with a recent cluster of other theatre related incidents in which some of the principles of safer surgery have not been fully adhered to. A meeting with the relevant divisions and directorates is scheduled for the 16th of January and a verbal update will be available for the board.

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

**3.iii Thematic issues**

All 6 never events over the last 3 years at NGH have occurred in operating theatres. The medical director has indicated that the policies and principles which underpin safer surgery are a matter of professional accountability and will be initiating a programme of work aimed at embedding this firmly at NGH. Further details will be reported through QGC and to board in March 2018.

**Responsiveness actions**

The clinical and divisional directors have agreed that it is a reasonable expectation that medical colleagues will respond to requests for statements/information in relation to incidents/complaints within 7 days. Non-compliance will be escalated to the CD and DD concerned at that point. At 14 days the escalation will be to the medical director. There are currently no statements outstanding for more than 14 days, compared with 15 at the time of the November report to board.

## 1. Mortality

### Mortality rates

HSMR, SHMI and HSMR for weekend/weekdays are all as expected, although the SHMI at 96% is on the verge of “better than expected”.

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

Crude mortality was 1.2% for November and 1.7% for December

There are no specialty or consultant level mortality outliers in the National clinical audit data published in December 2017 (National Bowel Cancer Audit), with the 30 day and 2 year mortality rates reported within the “expected” range.

### Mortality alerts

Mortality alerts under review are;

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

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

The Acute Kidney Injury task and finish group has initiated 3 key workstreams around;

- Early identification of AKI
- Flagging of nephrotoxic drugs
- Improved fluid balance management

Progress against these work streams, which are currently at the pilot stage after baseline audits, will be monitored though CQEG and reported to QGC.

### Consultant Engagement

The series of mandatory “Call to Arms” meetings with the consultants were well attended and stimulated useful discussion and promoted engagement. In order to sustain the engagement the contributions made by the consultant body will be captured and reflected in the fixing the flow work programme. Feedback has been provided to the consultant body, including the following table;

| You said | What we are doing |
|---|---|
| **Replace Green Cards with an Internal Version of** | Appointing a medical lead to work alongside the |

| | |
|---|---|
| **Consultant Connect, and see internal referrals much sooner than within 72 hours** | deputy Chief Operating Officer to replace the green card system with a phone based system with a one working day review time limit |
| **Training our junior doctors needs to be enhanced by the changes we introduce so they come back** | We have asked the Director of Medical Education to attend or send a college tutor deputy to the weekly Fixing the Flow meetings |
| **Why not have specialities cover non-elective referrals/admissions during 0800-1800 so they get the best possible care as early as possible, with those admitted by "generalist" take out of hours reviewed by the relevant speciality the next working day?** | Medicine Division will incorporate this concept as far as possible into the new acute medical model. Further details on this will be shared as it emerges. It may be that a hybrid model of specialities and generalists will be required |
| **There ought to be a frailty take too, but recognised there are not enough consultants here at NGH to run this** | This will be considered in the new acute medical model, recognising the limitations posed by too few consultant geriatricians |
| **There ought to be "virtual" nursing home beds on our wards for patients who are medically fit for discharge with all paperwork done (eDN etc) so the medical teams can concentrate on seeing those who actually ought to be in hospital** | This will be incorporated into the new acute medical model, with clear criteria for escalating back to the medical team in the event that their medical condition deteriorates (as per Avery/Victoria ward patients) |
| **We could reduce the waiting times for coronary angiograms and thereby length of stay on the Emergency Floor wards (Benham and Creaton)** | Cardiology training staff and looking to pilot a new protocol week commencing 8th January 2018 |
| **Adopt a military model for specialities with high numbers of non-elective cases presenting through ED – specifically with cases allocated by presenting complaint directly to the consultant of the speciality who will undertake the initial assessment and management plan** | This will be piloted at peak times of attendance in ED during January 2018 for the General Medicine take and the Trauma and Orthopaedic take – recognising that this is "over and above" job plans as they are currently constituted the additional hours will be remunerated accordingly during the "test of change" – this will be refined and built into job plans the new acute medical model |
| **Earlier starts to consultant ward rounds in key specialities** | This is a workstream in the new acute medical model, of which more details as it emerges |
| **Junior doctors are more productive and happier when they are part of a "firm" – current contract and staffing levels have taken away their sense of belonging and responsibility** | This will be discussed at the January Clinical and Divisional Directors meeting – whilst the junior doctors contract and staffing levels preclude a re-introduction of a traditional "firm", a hybrid model restoring a team base is a realistic aim – updates to follow |

| | |
|---|---|
| **Instigate criteria led discharge for low risk patients to prevent delays and unnecessary medical review** | This is already being piloted in respiratory medicine, but thanks to your enthusiasm the roll out will be accelerated – next to cardiology then gastroenterology – anticipated starts in January 2018 |
| **"One stop" ward rounds – where the junior doctors and MDT action the consultant decisions in real time to reduce delays for patients** | These will be re-introduced in the Emergency Floor in January 2018 |

In order to build on this consultant engagement, the medical director has agreed with the divisional directors and clinical directors that a rolling programme of events will take place through 2018. Each quarter there will be a series of meetings analogous to the "Call to Arms" with the agenda set by the medical director and aligned with key organisational priorities. Also each quarter the consultant body will be invited to raise items for their own agenda through an internet based poll, and the top themes will be explored at workshops over working suppers.

| | |
|---|---|
| **Title of Meeting** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

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

**Executive Summary**

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

- **Safety Thermometer:** in December 2017 the Trust achieved overall harm free care of 93.76%.
- **Maternity Safety Thermometer:** the overall percentage of women and babies who received 'harm' free care in December 2017 was over 80.0% above the national aggregate of 71%.
- **Pressure Prevention:** 8 patients developed a total of 9 grade 2 pressure ulcers in December 2017. There were 2 Unclassified Grade 3 harms validated during the reporting period. A total of 10 patients were harmed with pressure damage whilst in the Trust in December 2017.
- **Infection Prevention:** in December 2017 there were:
  No Trust attributable MRSA bacteraemia
  1 Trust attributable MSSA bacteraemia
  3 patients were identified with Trust attributable E coli bacteraemia.
  No patients were identified with Trust attributable Clostridium difficile infection (CDI)
- **Falls:** in December 2017 there were; 2 patient falls with severe harm and 1 patient fall with moderate harm, all of these falls are being investigated.
- **Friends and Family Test (FFT):** Following the Trustwide data reaching the highest level to date at 93% overall for November there has been a depreciation in the results for December 2017 with the Trust wide results at 92.2%. This is lower than the average; however it does not fall outside of the levels of normal variation.
- **Safeguarding Adults & Children:** The report provides a summary of the Safeguarding for adults & children activity over the month.
- **Safe Staffing:** Overall fill rate for December 2017 was 101%, compared to 102% in November 2017.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Quality & Safety.<br>We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety |
| **Risk and assurance** | The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered |
| **Related Board Assurance Framework entries** | BAF 1.3 and 1.5 |
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) |
| **Legal implications / regulatory requirements** | Are there any legal/regulatory implications of the paper - No |

**Actions required by the Committee**

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

The Trust Board is asked to support the on-going publication of the Open & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data.

# Public Trust Board
# January 2018

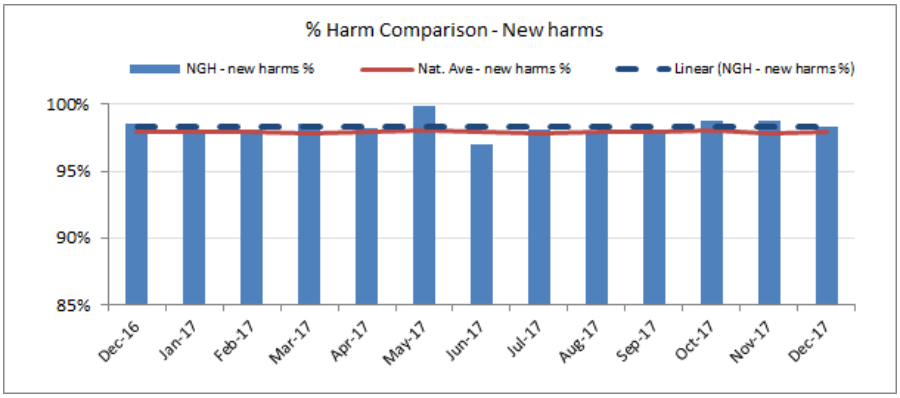
## Director of Nursing & Midwifery Report

### 1. Introduction

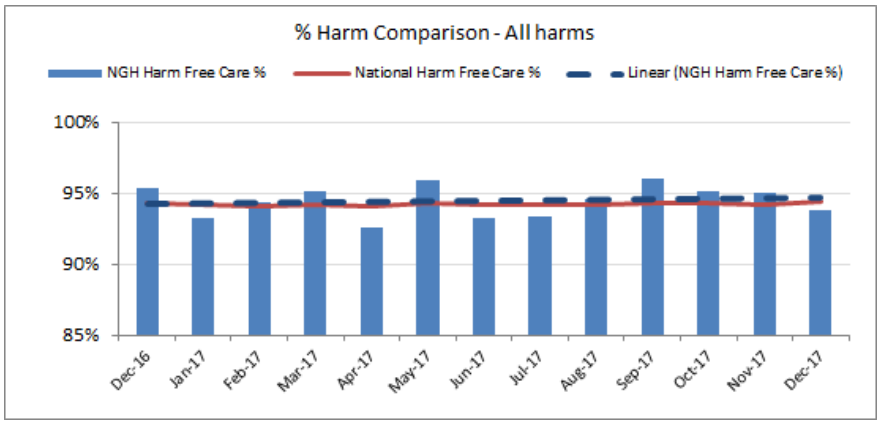
The Director of Nursing & Midwifery Report presents highlights from services, audits and projects during the month of December 2017. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This 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 shows the percentage of new harms attributed to an in-patient stay. In December 2017, the Trust achieved 97.94% harm free care (new harm); a slight decrease from last month.



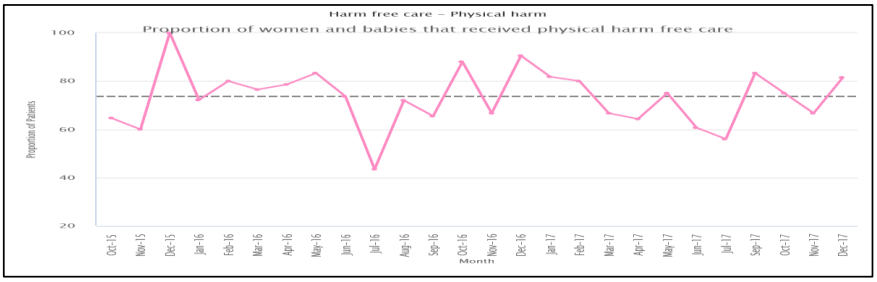

The graph below illustrates overall harm free care was 93.76% in December 2017, slightly below the national average of 95% for the first time since July 2017. (Appendix 1 provides the National Safety Thermometer Definition).



## 3. Maternity Safety Thermometer

The Maternity Safety Thermometer enables the calculation of the proportion of women and babies who received harm free care.

The following graphs illustrates that the overall percentage of women and babies who received combined and physical 'harm' free care in December 2017 were above the national aggregate of 71%.

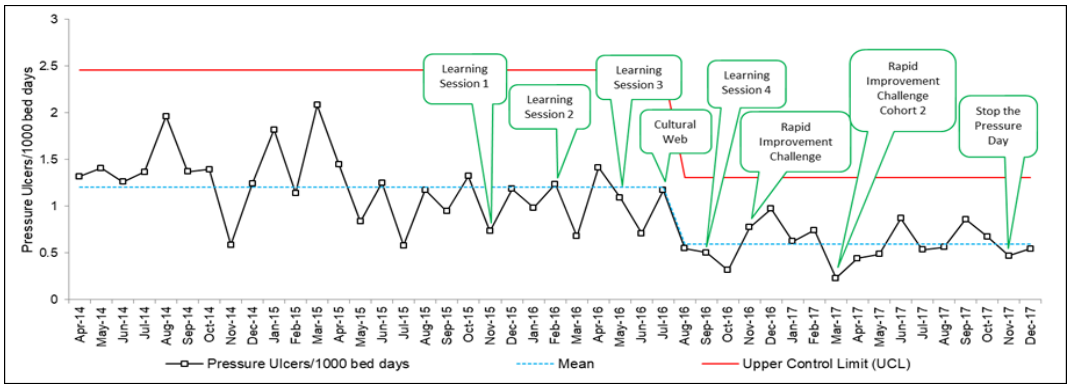




## 4. Pressure Ulcer Incidence

In December 2017, the Tissue Viability Team (TVT) received, a total of 392 datix incident reports relating to pressure damage. Of these 44 (11%) were duplicated reports. 30 patients were not seen as either not admitted or discharged within 48 hours of reporting pressure ulcer (PU) harm. Of the remaining incidents reported, 88% were validated by the TVT on the wards or from photographs. 8 patients developed a total of 9 grade 2 pressure ulcers in December 2017. There were 2 Unclassified Grade 3 harms validated during the reporting period. A total of 10 patients were harmed with pressure damage whilst in our care in December 2017.

**Number of Pressure Ulcers per 1000 bed days**

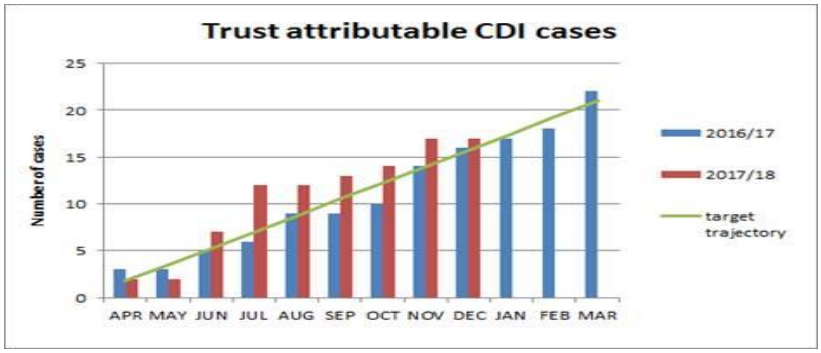
The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers. This is reported utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements.



## 5. Infection Prevention and Control

### *Clostridium difficile* Infection (CDI)

The graph below shows the number of patients with Trust attributable CDI. For December 2017, there were 0 patients with Trust attributable CDI. The CCGs are concerned about lapses in care that may have led to the infection or outbreaks – both indicating these were avoidable health care related infections. Of the 17 patients to date the external reviews by the CCG have identified no lapses in care.

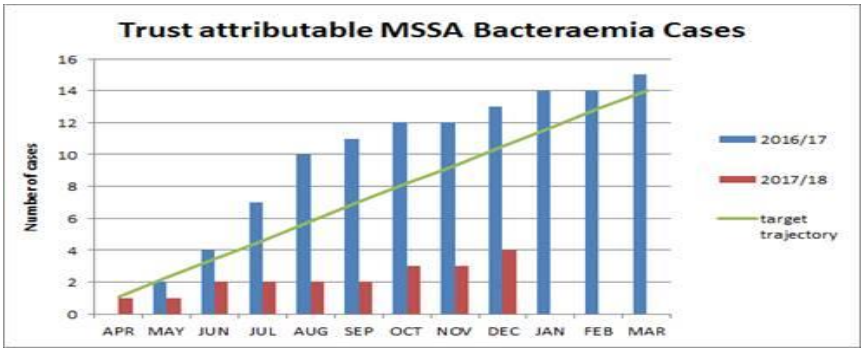



**MRSA Bacteraemia**

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

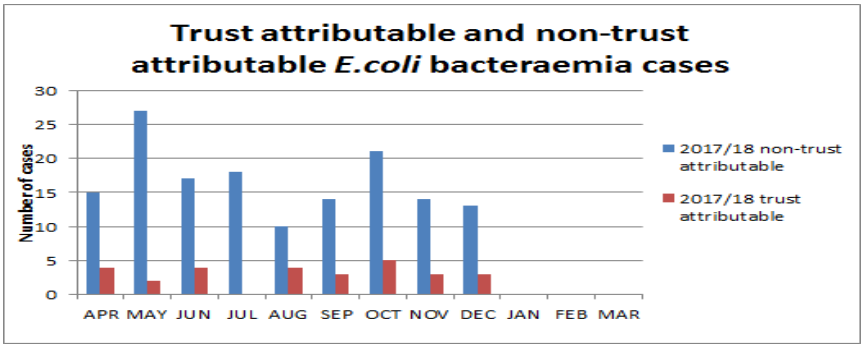
**MSSA Bacteraemia**

MSSA bacteraemia: there were 1 Trust attributable MSSA bacteraemia for December 2017. The Trust remains under its internal trajectory of 14, with 4 trust attributable MSSA bacteraemia to date.




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

In December 2017, there were 13 non- trust attributable *E.coli* bacteraemia and 3 Trust attributable *E.coli* bacteraemia. This is shown in the graph below: All 3 *E.coli* bacteraemia were of an unknown source.



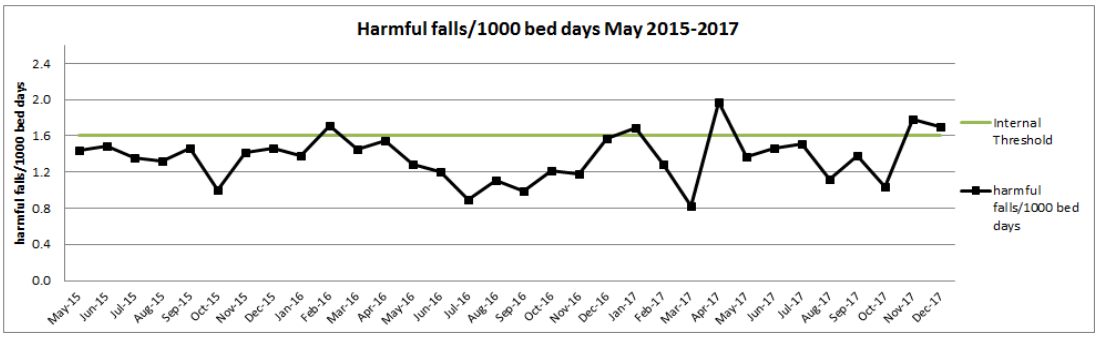

## 6. Falls Prevention

### Falls/1000 Bed Days

The Trust's falls/1000 bed days are below the national average of 6.63/1000 bed days, but above the internally set trust target of 5.5/1000 bed days. There was an increase in the number of falls/1000 bed days of 0.89 compared to the previous month of November 2017. This is the first time the Trust has been above the internally set target since September 2016. There have been a number of patients who have fallen more than once in the Trust during December 2017, acuity has been high and reporting mechanisms have changed. The reporting of falls will be monitored and reporting culture reviewed to ascertain if this has contributed to the increase in falls/1000 bed days.

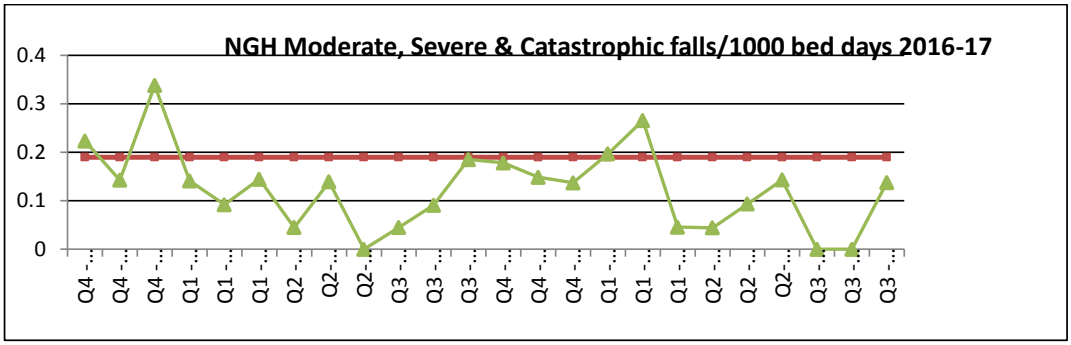
### Harmful Falls/1000 Bed Days Including Low, Moderate, Severe and Catastrophic

The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through December 2017 harmful falls/1000 bed days have decreased by 0.09, in total the Trust recorded 1.69 harmful falls/1000 bed days. This is above the Trusts internally set target of 1.6.



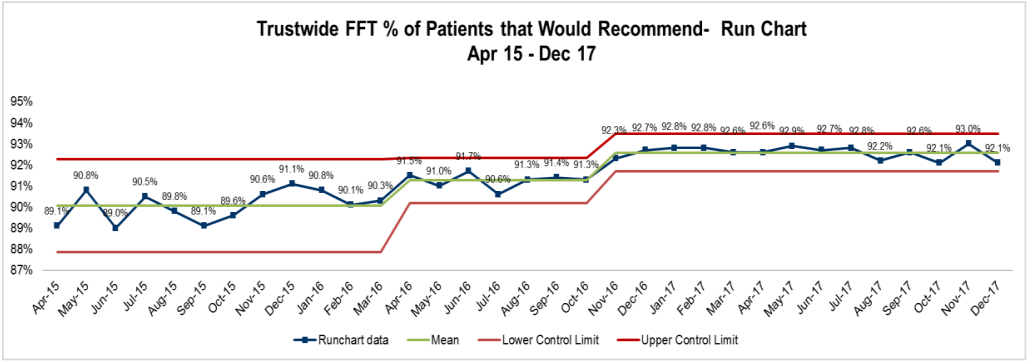

### Falls Resulting in Moderate, Severe or Catastrophic Harm

The following graph represents moderate, severe and catastrophic falls/1000 bed days. There has been an increase of 0.14 during December 2017 compared to the previous month. The Trust remains below the national threshold of 0.19. In total there were; 2 severe harm patient falls and 1 moderate harm patient fall.

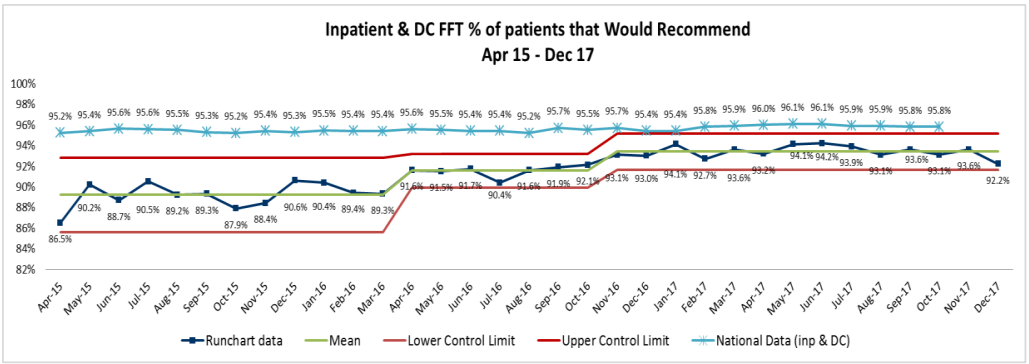



## 7. FFT Overview- % Would Recommend Run Charts

Following the Trustwide data reaching the highest level to date at 93% overall for November there has been a depreciation in the results for December with the Trustwide results at 92.2%. This is lower than the average; however it does not fall outside of the levels of normal variation.




December saw Inpatient & Day Case depreciate to 92.1% which is below the average which has been seen within these services since November 2016. Progress has stabilised within Inpatient and Day Case areas and although the results have not reached below the levels of normal variation, focus needs to be given to ensure this does not happen in the future.




**Patient Experience Network National Awards (PENNA) 2017**

The Trust has once again been shortlisted for the PEN National Awards. The three categories are:

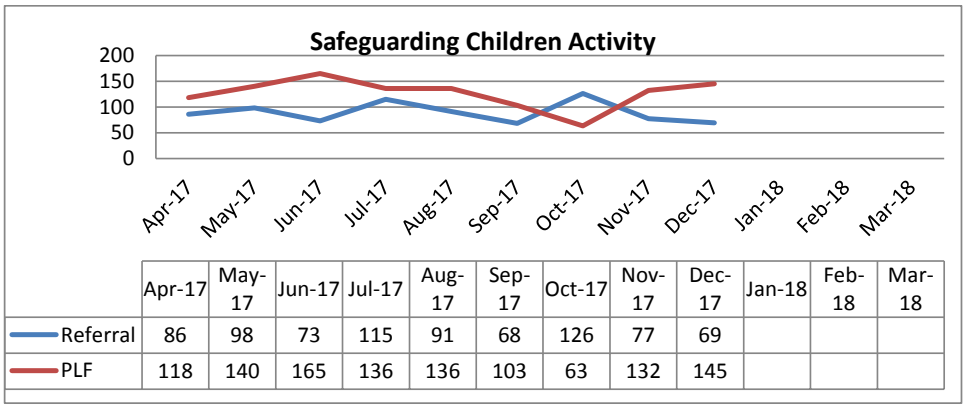
- Measuring, Reporting and Acting - "Keep Connected"- Engaging the Patient & Nursing Services Team in Collecting Patient & Carer Feedback
- FFT and Patient Insight for Improvement – Keep Connected
- Turning it Around When it Goes Wrong – Meet the Matron

**Keep Connected**
This entry is based around the way in which we collect real time feedback within the hospital through the senior corporate nursing team. The Keep Connected team have all received training in how to survey patients on a 1:1 basis. Each team member has a designated ward that they survey every month. We have been able to gain feedback from our elderly patients in ways that we would never have achieved otherwise. It has proved extremely valuable to have existing members of staff with their individual experiences and knowledge that they bring from their job roles. In times of financial constraint, finding new ways to work differently is essential and we have managed to do something which does not cost anything- but also doesn't compromise on quality!

**Meet the Matron**
Complaints in maternity have dropped significantly since the introduction of a Meet the Matron clinic within Maternity which focusses on 3 key areas, ensuring women have a choice in their care, they can raise concerns, and also gain closure on any potential traumatic incidences. From April 2016-March 2017 there were 18 complaints but from April 2017 to November 2017 only three. These figures reflect how not only a face to face meeting can help to resolve issues or concerns in a more satisfying way but also that less complaints are received as women are being placed at the centre of the care. Women who do want to make a complaint are given the option of sharing their concerns face to face with one of the Matrons. Following this it is explained that they still have the option of going through the formal complaints process if they would like to. However, to date none of them have chosen to proceed as they are happier with the outcome of having been listened to and had their feelings validated.

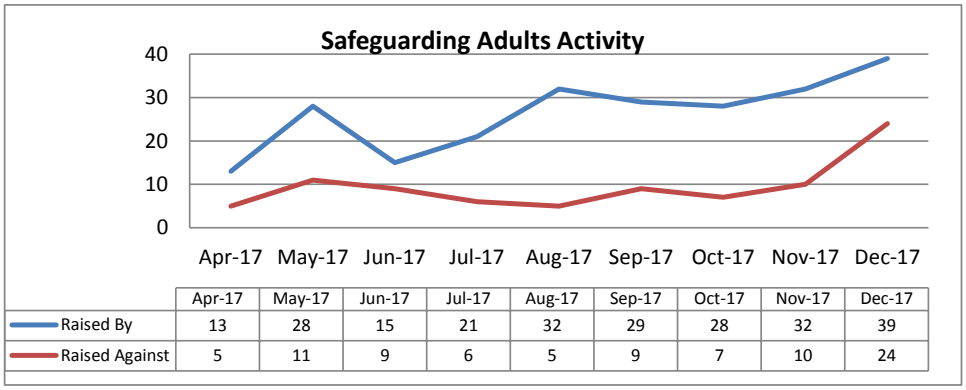
## 8. Safeguarding

**Safeguarding Children and Adult Referrals**
The graph below shows the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of Paediatric Liaison Forms (PLF's) processed. Both the number of referrals made to the Multi-Agency Safeguarding Hub (MASH) and the number of PLF's made remain at a constant level.



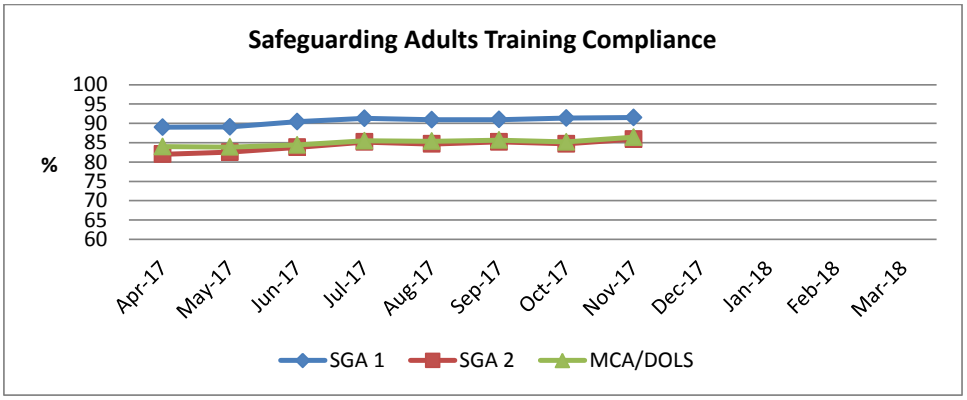

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral | 86 | 98 | 73 | 115 | 91 | 68 | 126 | 77 | 69 | | | |
| PLF | 118 | 140 | 165 | 136 | 136 | 103 | 63 | 132 | 145 | | | |

In terms of safeguarding adults' referral activity, there has been a very 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 has significantly increased during the reporting period. There is no apparent cause for this trend and the allegations raised are for a variety of incidents across the organisation.

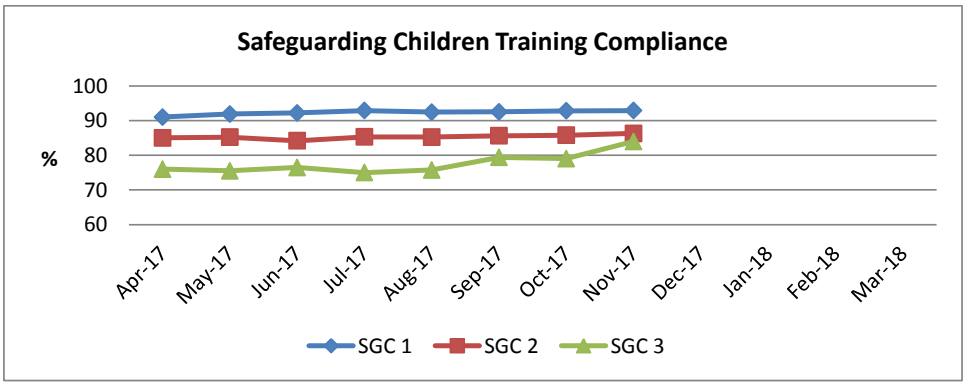



| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|
| Raised By | 13 | 28 | 15 | 21 | 32 | 29 | 28 | 32 | 39 |
| Raised Against | 5 | 11 | 9 | 6 | 5 | 9 | 7 | 10 | 24 |

**Safeguarding Training Compliance**
The following two graphs illustrate the safeguarding training compliance for the Trust for November 2017 (December's data was unavailable at time of reporting):




Compliance for the level one safeguarding adults, Level two safeguarding adults and MCA/DoLS training remain at a constant compliant trend as demonstrated in the grapg above.




Safeguarding children level one and two training compliance continues at a conistent level. There has been an increase in level 3 safeguarding training to 84% during November 2017. The Associate Directors of Nursing and the Head of Safeguarding have reviewed the safeguarding children competencies for all current roles within the Trust. This information will

be transferred to the Learning and Development team, so an up-to-date safeguarding training competency framework will be in place.This piece of work will be completed by January 2018.

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

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

The Trust has currently achieved 93% compliance in Basic Prevent Awareness Training and 67% compliance (534 staff members out of 795) in WRAP training. This information has been shared with both NHS England the CCG as per the recently introduced Prevent assurance data process.

## 9. Safe Staffing

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. This report provides an overview of the staffing levels in December 2017 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for the gaps that have been identified.

Overall fill rate for December 2017 was 101%, compared to 102% in November 2017. Combined fill rate during the day was 97% compared with 99% in November 2017. The combined night fill rate was 106% in December 2017 compared with 107% in November 2017. RN fill rate during the day was 94% in December 2017and for the night it was 95%. (Appendix 3)

## 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

### Nursing and Midwifery Safety Thermometer Definition

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

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

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

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

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

## Appendix 2

### Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

## Appendix 3

Northampton General Hospital NHS
NHS Trust

**Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff)** — **December 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) | 1,893.50 | 1,860.67 | 1,389.25 | 1,350.13 | 1,069.50 | 1,069.50 | 1,069.50 | 1,173.00 | 98.3% | 97.2% | 100.0% | 109.7% | 844 | 3.5 | 3.0 | 6.5 | | |
| Allebone Ward (Stroke) | 1,601.90 | 1,457.25 | 1,136.00 | 1,267.25 | 1,426.00 | 1,241.00 | 713.00 | 1,104.00 | 91.0% | 111.6% | 87.0% | 154.8% | 863 | 3.1 | 2.7 | 5.9 | | |
| Althorp (T&O) | 911.50 | 865.75 | 624.50 | 561.67 | 713.00 | 715.00 | 333.50 | 336.25 | 95.0% | 89.9% | 100.3% | 100.8% | 243 | 6.5 | 3.7 | 10.2 | | |
| Becket Ward | 2,014.50 | 1,934.25 | 1,417.00 | 1,148.75 | 1,782.50 | 1,724.00 | 713.00 | 777.25 | 96.0% | 81.1% | 96.7% | 109.0% | 799 | 4.6 | 2.4 | 7.0 | | |
| Benham (Assess Unit) | 1,758.25 | 1,682.50 | 890.75 | 1,325.25 | 1,414.50 | 1,404.00 | 713.00 | 1,395.17 | 95.7% | 148.8% | 99.3% | 195.7% | 796 | 3.9 | 3.4 | 7.3 | | |
| Brampton Ward | 1,404.75 | 1,278.00 | 1,059.25 | 1,310.25 | 1,069.50 | 1,058.00 | 713.00 | 1,529.50 | 91.0% | 123.7% | 98.9% | 214.5% | 889 | 2.6 | 3.2 | 5.8 | | |
| Cedar Ward (TRAUMA) | 1,864.50 | 1,886.58 | 1,757.75 | 1,668.00 | 1,069.50 | 1,069.50 | 1,069.50 | 1,104.00 | 101.2% | 94.9% | 100.0% | 103.2% | 893 | 3.3 | 3.1 | 6.4 | | |
| Collingtree Medical (40) | 2,360.92 | 2,399.83 | 1,764.25 | 1,853.00 | 1,782.50 | 1,775.25 | 713.00 | 1,035.00 | 101.6% | 105.0% | 99.6% | 145.2% | 1249 | 3.3 | 2.3 | 5.7 | | |
| Compton Ward | 1,046.50 | 1,091.25 | 722.25 | 953.17 | 713.00 | 690.00 | 356.50 | 713.00 | 104.3% | 132.0% | 96.8% | 200.0% | 557 | 3.2 | 3.0 | 6.2 | | |
| Creaton SSU | 1,980.25 | 1,813.08 | 980.00 | 1,375.75 | 1,666.75 | 1,544.25 | 989.00 | 1,552.50 | 91.6% | 140.4% | 92.7% | 157.0% | 810 | 4.1 | 3.6 | 7.8 | | |
| Disney Ward | 1,859.75 | 1,687.67 | 903.75 | 776.00 | 1,069.50 | 948.50 | 356.75 | 369.25 | 90.7% | 85.9% | 88.7% | 103.5% | 284 | 9.3 | 4.0 | 13.3 | | |
| Dryden Ward | 2,118.00 | 1,768.25 | 936.25 | 828.00 | 1,414.50 | 1,382.00 | 713.00 | 803.25 | 83.5% | 88.4% | 97.7% | 112.7% | 778 | 4.0 | 2.1 | 6.1 | | |
| EAU New | 1,676.65 | 1,720.50 | 1,664.25 | 1,887.00 | 1,069.50 | 1,402.75 | 713.00 | 1,345.50 | 102.6% | 113.4% | 131.2% | 188.7% | 951 | 3.3 | 3.4 | 6.7 | | |
| Eleanor Ward | 1,055.50 | 941.33 | 712.00 | 692.42 | 713.00 | 713.00 | 705.75 | 764.98 | 89.2% | 97.2% | 100.0% | 108.4% | 334 | 5.0 | 4.4 | 9.3 | | |
| Finedon Ward | 2,130.50 | 1,740.75 | 336.25 | 530.75 | 1,069.50 | 1,046.50 | 356.50 | 608.25 | 81.7% | 157.8% | 97.8% | 170.6% | 495 | 5.6 | 2.3 | 7.9 | | |
| Gosset Ward | 2,522.50 | 2,580.83 | 448.50 | 392.25 | 2,346.00 | 2,287.67 | 230.00 | 184.00 | 102.3% | 87.5% | 97.5% | 80.0% | 348 | 14.0 | 1.7 | 15.6 | | |
| Hawthorn & SAU | 2,171.25 | 1,929.00 | 1,299.50 | 1,139.50 | 1,667.50 | 1,400.00 | 1,184.50 | 1,158.25 | 88.8% | 87.7% | 84.0% | 97.8% | 887 | 3.8 | 2.6 | 6.3 | | |
| Head & Neck Ward | 1,071.50 | 1,135.75 | 681.75 | 562.50 | 910.25 | 1,015.00 | 356.50 | 483.00 | 106.0% | 82.5% | 111.5% | 135.5% | 412 | 5.2 | 2.5 | 7.8 | | |
| Holcot Ward | 1,401.50 | 1,271.00 | 1,421.23 | 1,937.73 | 1,069.50 | 1,049.50 | 713.00 | 1,841.00 | 90.7% | 136.3% | 98.1% | 258.2% | 877 | 2.6 | 4.3 | 7.0 | | |
| Knightley Ward (Medical) | 705.25 | 665.30 | 895.50 | 916.25 | 1,058.00 | 934.50 | 356.50 | 579.00 | 94.3% | 102.3% | 88.3% | 162.4% | 638 | 2.5 | 2.3 | 4.9 | | |
| Paddington Ward | 2,588.00 | 2,325.00 | 938.75 | 857.00 | 2,127.50 | 1,960.00 | 552.00 | 518.83 | 89.8% | 91.3% | 92.1% | 94.0% | 537 | 8.0 | 2.6 | 10.5 | | |
| Rowan (LSSD) | 1,958.48 | 1,991.07 | 1,052.75 | 1,080.58 | 1,782.50 | 1,694.00 | 713.00 | 1,006.83 | 101.7% | 102.6% | 95.0% | 141.2% | 862 | 4.3 | 2.4 | 6.7 | | |
| Spencer Ward | 1,392.75 | 1,454.17 | 989.75 | 1,198.25 | 1,069.50 | 1,068.00 | 1,069.50 | 1,196.00 | 104.4% | 121.1% | 99.9% | 111.8% | 613 | 4.1 | 3.9 | 8.0 | 1 red flag | Care delayed to patients, HCA moved to another ward. Staffing risk assessd across the Trust to ensure patient safety. No patient came to harm |
| Talbot Butler Ward | 2,584.25 | 2,213.45 | 1,391.50 | 1,178.75 | 1,403.00 | 1,305.75 | 713.00 | 870.00 | 85.7% | 84.7% | 93.1% | 122.0% | 831 | 4.2 | 2.5 | 6.7 | | |
| Victoria Ward | 1,172.98 | 1,074.98 | 705.75 | 979.75 | 713.00 | 714.50 | 356.50 | 890.25 | 91.6% | 138.8% | 100.2% | 249.7% | 553 | 3.2 | 3.4 | 6.6 | | |
| Willow Ward (+ Level 1) | 2,341.75 | 2,320.50 | 1,054.17 | 1,011.83 | 2,139.00 | 1,982.75 | 713.00 | 816.50 | 99.1% | 96.0% | 92.7% | 114.5% | 839 | 5.1 | 2.2 | 7.3 | | |
| | | | | | | | | | | | | | Total Average CHPPD | | | 7.7 | | |
| ITU | 5,061.75 | 4,694.32 | 718.75 | 666.25 | 4,692.50 | 4,396.88 | 694.75 | 614.25 | 92.7% | 92.7% | 93.7% | 88.4% | 387 | 23.5 | 3.3 | 26.8 | | |
| | | | | | | | | | | | | | Total Average CHPPD | | | 26.8 | | |
| Barratt Birth Centre | 1,837.75 | 1,723.25 | 720.50 | 495.50 | 1,414.50 | 1,207.25 | 688.25 | 436.08 | 93.8% | 68.8% | 85.3% | 63.4% | 141 | 20.8 | 6.6 | 27.4 | | MSWs rotated to areas of need during shifts to maintain women and babies safety. Additonal staff pulled from community settings. Programme of MSW recruitment on going |
| Robert Watson | 1,053.50 | 1,089.83 | 1,302.00 | 883.25 | 1,069.50 | 941.42 | 1,069.50 | 681.00 | 103.4% | 67.8% | 88.0% | 63.7% | 443 | 4.6 | 3.5 | 8.1 | | |
| Sturtridge Ward | 4,228.20 | 3,817.75 | 1,825.00 | 1,438.75 | 4,164.75 | 3,837.33 | 1,391.50 | 1,198.83 | 90.3% | 78.8% | 92.1% | 86.2% | 494 | 15.5 | 5.3 | 20.8 | | |
| | | | | | | | | | | | | | Total Average CHPPD | | | 18.8 | | |
| | | | | | | | | | | | | | Total Average CHPPD Trust wide | | | 9.4 | | |

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **PUBLIC TRUST BOARD** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **NGH Mortality Dashboard Q1 2017/18** |
| **Agenda item** | **10** |
| **Presenter of Report** | Mr M Metcalfe – Medical Director |
| **Author(s) of Report** | Dr A Bisset – Associate Medical Director (Clinical Governance)<br>Dr L Jameson – Specialty Doctor (Medical Director's Office) |
| **Purpose** | In response to the National Quality Board "National Guidance on Learning from Deaths". |

**Executive summary**

. The National Quality Board "National Guidance on Learning from Deaths" specifies that the following data must be published quarterly from Q3 2017/18 onwards:

- Total number of in-patient deaths, including Emergency Department deaths for acute Trusts.
- Total number of deaths that the Trust has reviewed.
- Of those deaths subjected to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care.

The NGH Mortality Dashboard has been designed to display the data and to give an overview of learning identified through mortality case note review and the planned steps to improve the process in the next quarter.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Which strategic aim and corporate objective does this paper relate to? |
| **Risk and assurance** | Does the content of the report present any risks to the Trust or consequently provide assurances on risks |
| **Related Board Assurance Framework entries** | BAF – please enter BAF number(s) |
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or |

| | |
|---|---|
| | promote good relations between different groups? (Y/N)<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) |
| **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)<br><br>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:

- To approve the NGH Mortality Dashboard

Northampton General Hospital NHS Trust

# Public Trust Board
# Date
# NGH Mortality Dashboard

## 1. Introduction

The National Quality Board "National Guidance on Learning from Deaths" specifies that the following data must be published quarterly from Q3 2017/18 onwards:

- Total number of in-patient deaths, including Emergency Department deaths for acute Trusts.
- Total number of deaths that the Trust has reviewed.
- Of those deaths subjected to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care.

The NGH Mortality Dashboard has been designed to display the data and to give an overview of learning identified through mortality case note review and the planned steps to improve the process in the next quarter.

## 2. Body of Report

**Background**

"National Guidance on Learning from Deaths" published by the National Quality Board in March 17 aims to introduce a standardised approach to enable Trusts to learn from deaths. This is an evolving process both locally and nationally.

By the end of Q2 2017/18, Trusts were required to publish a policy on responding to deaths. The NGH policy is available on the NGH intranet and on the NGH external website – Monitoring, Reviewing, Investigating and Learning from Mortality Policy.

http://srv-wap-001/IG_DocControl/HG_ViewDoc.aspx?HG_DocID=28e3dd83-4d48-4c42-86bf-b1df7a8b8640

By the end of Q3 2017/18, Trusts were required to publish the following data:

- Total number of in-patient deaths, including Emergency Department deaths for acute Trusts.
- Total number of deaths that the Trust has reviewed.
- Of those deaths subjected to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care.

**NGH Mortality Dashboard**

The attached NGH Mortality Dashboard shows the data relating to deaths in Q1 2017/18. The dashboard includes the trigger for 2nd Stage Review and referral to Review of Harm Group (based on the "Avoidability of Death Judgement Score"). It also includes learning identified from SJR review and planned steps for enhancing the process in the next quarter.

## 3. Assessment of Risk

The publication of the first dashboard for NGH has been delayed until January 2018 as there was no Public Trust Board meeting scheduled for December 2017.

## 4. Recommendations

Approve the NGH Mortality Dashboard.

## 5. Next Steps

In future the NGH Mortality Dashboard will be published quarterly and will reflect the changes in local processes such as the introduction of Mortality Screeners. It is also anticipated that national guidance will be updated and the dashboard will also reflect these changes as required.

# NGH Mortality Dashboard Q1 2017/18

SJR Structured Judgement Review
RoHG Review of Harm Group
RCP Royal College of Physicians

Northampton General Hospital NHS Trust

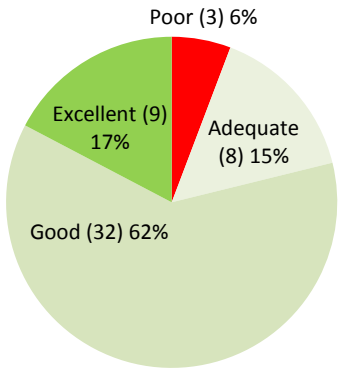
| 2017/18 | Monitoring & Screening | | | 1st Stage Review | | 2nd Stage Review | Investigation |
|---|---|---|---|---|---|---|---|
| | Total number of adult inpatient deaths | Total number of adult deaths in ED | Total Number of Deaths Screened* | Number reviewed using SJR Tool | Total number referred for second stage Review | Total Number of Avoidable Deaths (Grade 1,2 or 3) | Total Number of Deaths RoHG |
| **April** | 111 | 7 | 33 | 10 | 1 | 0 | 0 |
| **May** | 125 | 10 | 29 | 29 | 1 | 0 | 0 |
| **June** | 101 | 9 | 22 | 13 | 1 | 0 | 0 |
| **Total Q1** | **337** | **26** | **84** | **52** | **3** | **0** | **0** |

* using Medicine Screening Review Tool or ITU Screening

**Deaths of Patients with a Learning Disability**

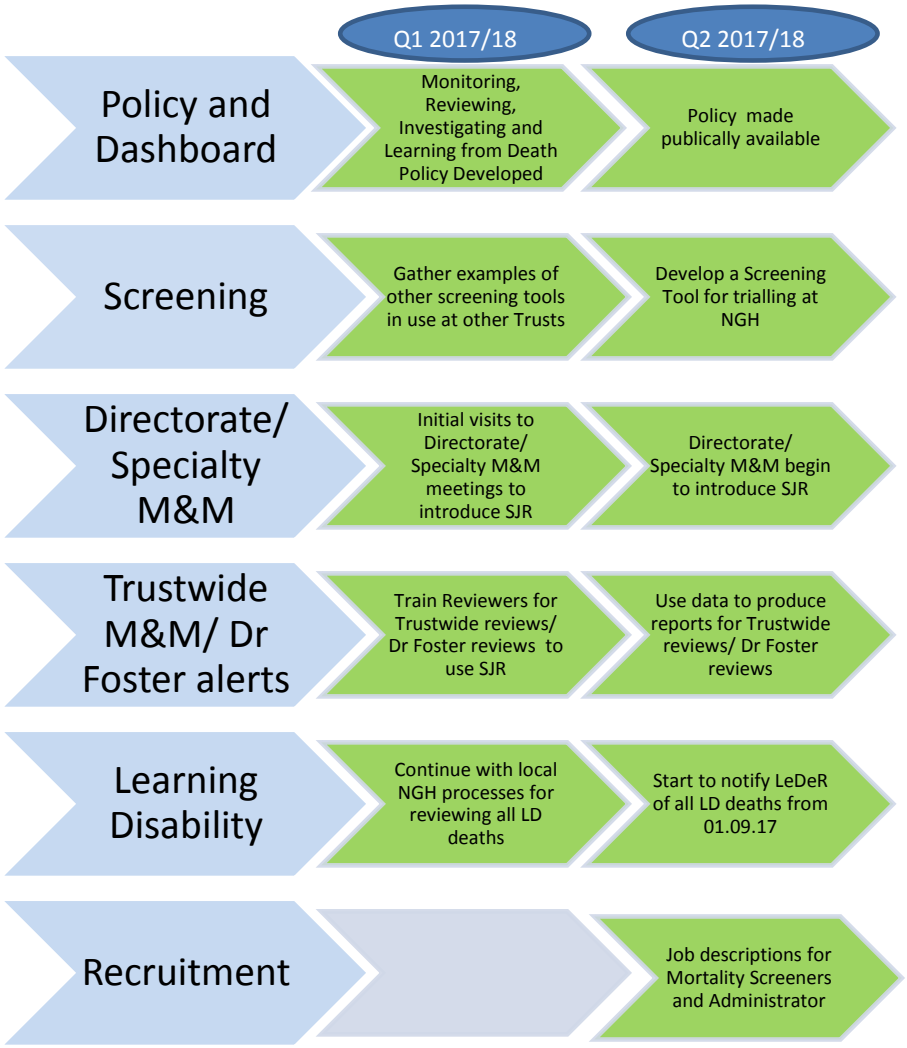
There were 4 deaths of patients with LD in the quarter. All deaths have been reviewed using the SJR tool and discussed at NGH LD Mortality Meeting.

**Overall Care Scores - 1st Structured Judgement Reviews**




**Overall Care Score**
1 - Very poor*
2 - Poor*
3 - Adequate
4 - Good
5 - Excellent
*** Trigger for 2nd SJR**

**Avoidability of Death Judgement Score (RCP SJR)**
1 - Definitely Avoidable*
2 - Strong evidence of avoidability*
3 - Probably Avoidable (more than 50:50)*
4- Possibly Avoidable but not very likely (less than 50:50)
5 - Slight Evidence of Avoidability
6 - Definitely Not Avoidable
*** Trigger for referral to RoHG**




**What did we learn from Explicit Judgements made in the Structured Judgement Reviews?**

**Admission and Initial Management**
Early Consultant Review and a clearly documented management plan are key to providing good care.

Plan for transfer of a patient from another Trust must be made consultant to consultant. This communication is important to ensure that the transfers are appropriate.

**On-going Care**
A deteriorating patient must be fully assessed and investigated and an open mind kept regarding the cause of the deterioration.

The Amber Care Bundle is very useful if recovery is uncertain and could be used more widely.

A Treatment Escalation Plan (TEP) must be completed with a Do not Resucitate order (DNAR).

**Care During a Procedure**
All procedures should be clearly documented and written consent obtained when appropriate.

**End of Life Care**
Good end of life care follows early recognition of the dying process and pro-active planning for end of life.

Examples of good documented communication with the patient and their next of kin demonstrate the high quality of end of life care

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **PUBLIC TRUST BOARD** |
| **Date of Meeting** | **25th January 2017** |

| | |
|---|---|
| **Title of the Report** | Financial Position - December (FY17-18) |
| **Agenda item** | 11 |
| **Sponsoring Director** | Phil Bradley, Interim DoF |
| **Author(s) of Report** | Bola Agboola, Deputy DoF |
| **Purpose** | To report the financial position for the nine months ended December 2017. |

**Executive summary**

This report sets out the financial position of the Trust for the period ended December 2017 – a pre-STF deficit of £20.3m which is £6.1m adverse to plan. The Trust missed the STF trajectories for the period and has therefore missed year to date STF of £4.5m, making the total adverse variance £10.6m year to date.

The key issues for this report are:

- There was a considerable drop in activity in December due to winter pressures being worse than anticipated, and this resulted in £1.0m in-month deterioration to the income position against plan. The YTD SLA income variance at the end of month 9 was £3.1m (M8: £2.1m). Some of this drop in activity was factored into the previous forecast and the forecast paper refresh exercise will pick up the latest trend.
- Pay: the YTD variance was £4.4m (M8: £2.8m) mainly due to one-off apprenticeship levy adjustment (£0.6m), unachieved budgetary CIP (£0.8m) and spend on temporary staffing over and above plan (£0.2m). With the exclusion of one-off adjustments, the pay position remains consistent with the pay spend in the last couple of months.
- Agency spend was within the cap and reported a £0.7m favourable position to the target.
- No STF income was assumed in this month's position; therefore the YTD total remains £1.1m.
- Cash continues to be a challenge and the Trust has been in discussion with NHSI about the protocols required to draw down additional cash in order to manage ongoing commitments.

| | |
|---|---|
| **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 nine month period ended December 2017 and to consider whether the forecast outturn should be revised.

Northampton General Hospital NHS
NHS Trust

Appendix G

# Financial Position

## Month 9 (December)
## FY 2017/18

Report to:
Trust Board
January 2018

## Content

# 1. Overview

| | RAG | This Month Dec | Last Month Nov | Change |
|---|---|---|---|---|
| **I&E Position** | | | | |
| Actual in Month Position (£000's) | | (4,365) | (1,900) | (2,466) |
| In-Month Position - Variance to Plan (£000's) | ✗ | (3,759) | (1,599) | (2,161) |
| Year to Date Position - Variance to Plan (£000's) | ✗ | (10,631) | (6,796) | (3,835) |
| Forecast End of Year I&E Position (£000's) | | (13,546) | (13,546) | 0 |
| STF YTD Actual (£'000) | | 1,111 | 1,111 | 0 |
| STF - Variance to Plan (£000's) | ✗ | (4,554) | (3,683) | (871) |
| EBITDA % | ✗ | -4.0% | -3.0% | -1.1% |
| **Income** | | | | |
| Elective YTD variance to plan (£000's) | ✗ | (669) | (532) | (136) |
| Daycase YTD variance to plan (£000's) | ✗ | (692) | (398) | (293) |
| Non-Elective YTD variance to plan (£000's) | ✗ | (2,822) | (2,404) | (419) |
| Outpatients YTD variance to plan (£000's) | ✓ | 129 | 472 | (343) |
| 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) | ✓ | 49 | (18) | 67 |
| **Operating Costs** | | | | |
| Pay - YTD variance to plan (£000's) | ✗ | (4,353) | (2,786) | (1,568) |
| Agency Staff Costs - YTD variance to Cap (£000's) | ✓ | 701 | 808 | (107) |
| Non-Pay - YTD variance to plan (£000's) | ✗ | (1,840) | (974) | (866) |
| **Cost Improvement Schemes** | | | | |
| Year to Date Variance to Plan (£000's) | ✗ | (287) | 106 | (393) |
| Forecast Delivery (£000's) | ✗ | 11,326 | 11,363 | (37) |
| **Capital** | | | | |
| Year to date expenditure (£'000s) | | 7,072 | 6,339 | 733 |
| % of annual plan Committed | ✓ | 78% | 74% | 4% |
| Annual Capital Expenditure Plan (£000's) | | 13,205 | 13,205 | 0 |
| **Cash** | | | | |
| Closing Cash Balance (£000's) | | 2,069 | 1,233 | 836 |
| New PDC / borrowing (£000's) | | 10,059 | 6,936 | 3,123 |
| Debtors Balance > 90 days (£000's) | ✓ | 2,212 | 2,176 | (36) |
| Creditors % > 90 days | ✓ | 0% | 0% | 0% |
| Cumulative BPPC - by volume (%) | ✓ | 98.9% | 98.9% | 0.0% |

## Key issues

**This report sets out the financial position of the Trust for the period ended December 2017 – a pre-STF deficit of £20.3m which is £6.1m adverse to plan. The Trust missed the STF trajectories for the period and has therefore missed year to date STF of £4.5m, making the total adverse variance £10.6m year to date.**

**Income**

- Activity and income experienced a marked dip in December mainly due to the challenges the Trust experienced due to winter. The income position was £1.0m worse than plan in-month, therefore bringing the YTD adverse variance to £3.1m.
- Excluding the effect of a favourable variance on excluded medicines (see non-pay below), the in-month variance was £1.3m adverse to plan.
- The decrease in activity is seen across all main PODs including Daycases, Electives and Outpatient procedures.
- The forecast paper (prepared under separate cover) already factored in some of the anticipated reduction in activity, but has been reassessed to reflect the latest trend.

**Pay**

- Pay was an adverse variance of £4.4m YTD (M8: £2.8m). The runrate over the past three months has been consistent and the adverse variance mainly consists of one-off in-month adjustment in relation to apprenticeship levy (£0.6m), unachieved budgetary CIP(£0.8m) in addition to temporary staffing costs above plan (£0.2m).
- Agency spend remained below the NHSI target with a favourable YTD variance of £0.7m .

**Non-pay & Reserves**

- Non-pay was adverse to plan by £1.8m (M8:£1.0m). The in-month movement was mainly due to excluded medicines (which is matched by favourable income variance of £0.3m) as well as an increase in outsourced histopathology and radiology work (due to vacancies) (£0.2m).
- Unspent reserves of £1.7m (M8: £1.4m) contributed to the I&E position.

**Capital**

- The Trust achieved a committed capital spend of 78% (M8: 74%) of its overall plan.

**Liquidity**

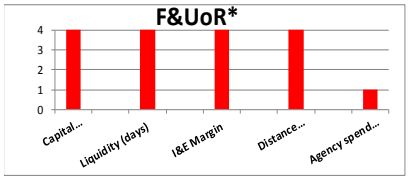
- The Trust continued to access deficit financing, however the adverse variance continued to impact cashflow . Restriction over supplier payments is in place.
- The first tranche of the winter funding (£449k) has been received and is included in the position.
- STF income of £1.1m (earned in Q1) is included in the YTD position.

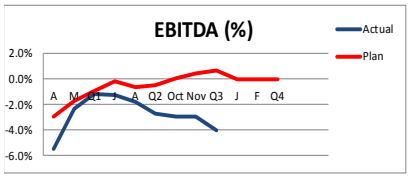
**NHSI rating**

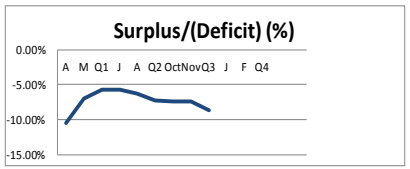
- The Trust continued to score "3" against the Finance and Use of Resources metrics.

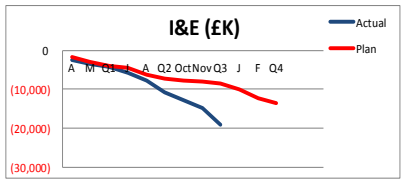
# 2. KPI & Trend Analysis

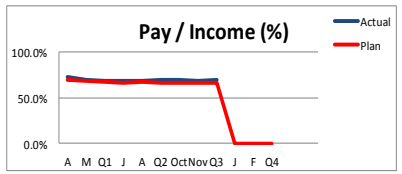
## 1. Key Metrics

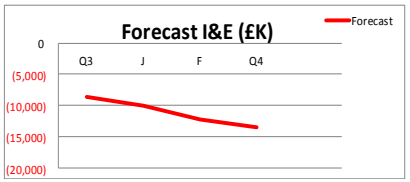


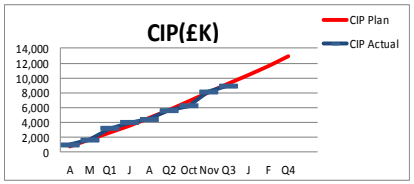



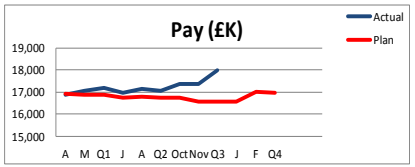



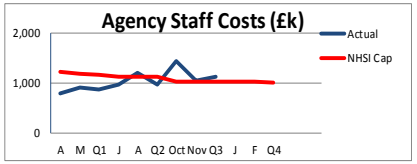



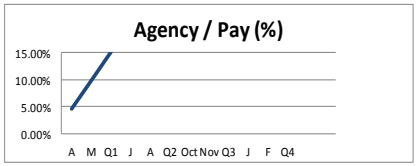



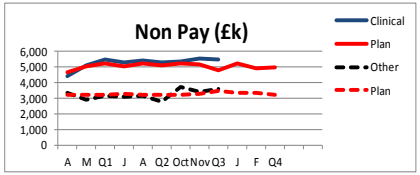

## 2. I&E Performance

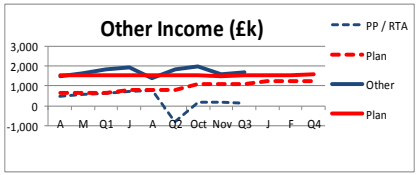


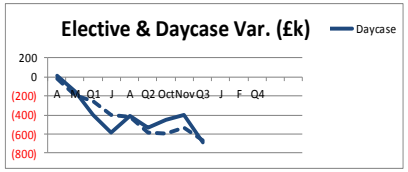



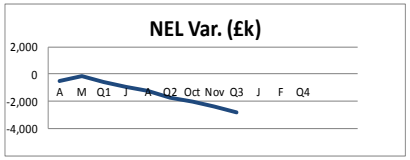



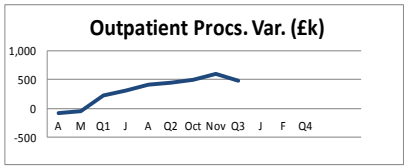



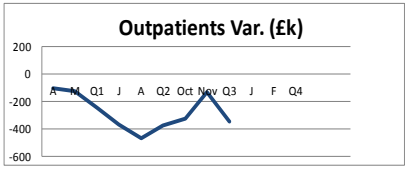



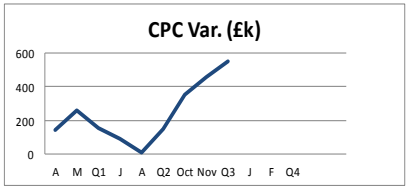

## 3. SLA Income

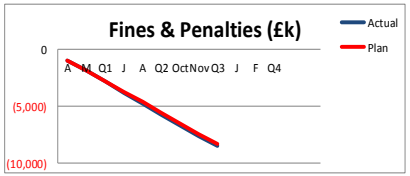


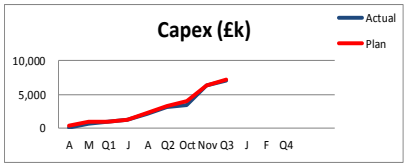



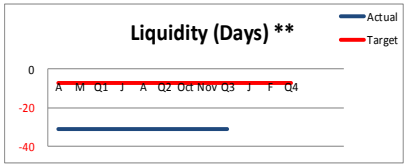



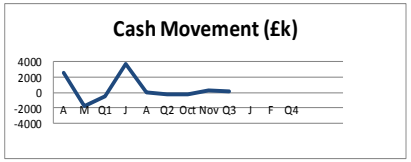



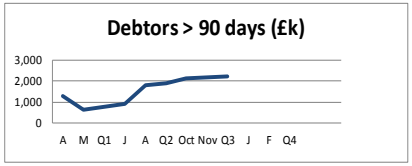



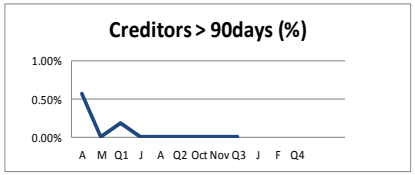

## 4. Working Capital

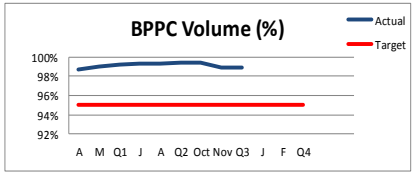



** F&UoP = Finance and Use of Resources metrics*

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

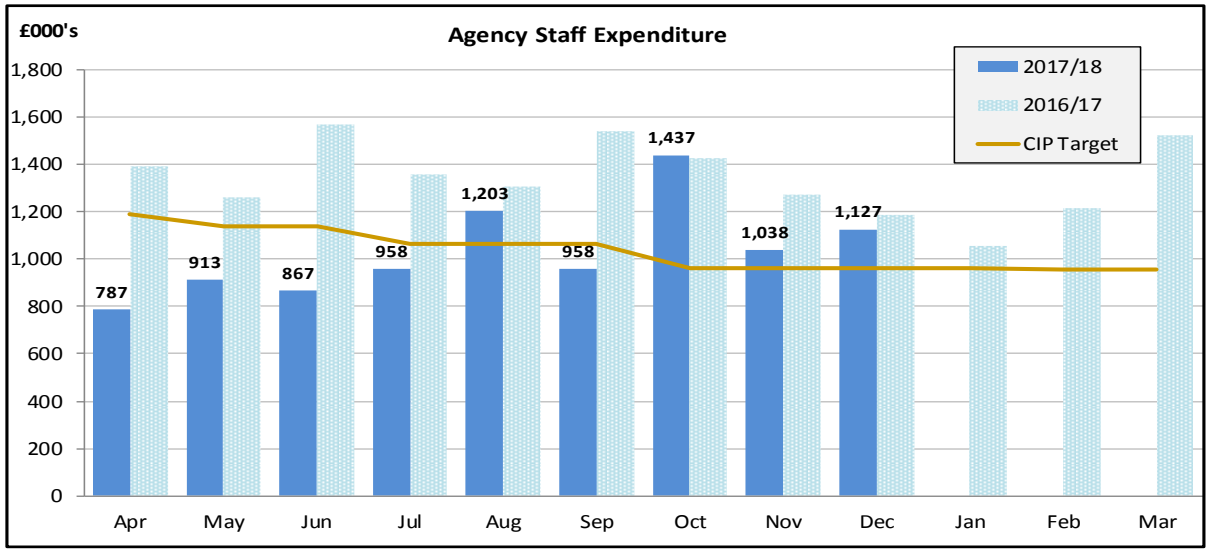
# 3.0 Income and Expenditure Position

| I&E Summary | Actual FY16-17 | Annual Plan | YTD plan | Actual FY17-18 | Variance to Plan | Dec 17 | Nov 17 |
|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| SLA Clinical Income | 260,328 | 274,325 | 206,973 | 203,828 | (3,145) | 22,258 | 23,698 |
| Other Clinical Income | 2,373 | 11,435 | 7,695 | 3,246 | (4,449) | 106 | 185 |
| Other Income | 31,824 | 18,259 | 13,670 | 15,397 | 1,728 | 1,666 | 1,604 |
| Total Income | 294,525 | 304,020 | 228,338 | 222,471 | (5,867) | 24,029 | 25,487 |
| Pay Costs | (199,813) | (201,278) | (150,584) | (154,937) | (4,353) | (17,991) | (17,362) |
| Non-Pay Costs | (94,406) | (99,610) | (74,615) | (76,455) | (1,840) | (9,089) | (8,966) |
| Reserves/ Non-Rec | | (3,127) | (1,703) | 0 | 1,703 | 0 | 0 |
| Total Costs | (294,219) | (304,015) | (226,902) | (231,392) | (4,490) | (27,080) | (26,329) |
| EBITDA | 306 | 5 | 1,436 | (8,921) | (10,357) | (3,050) | (842) |
| Depreciation | (9,703) | (10,205) | (7,482) | (7,482) | (0) | (843) | (843) |
| Amortisation | (9) | (9) | (6) | (6) | (0) | (1) | (1) |
| Impairments | (1,732) | (1,826) | (1,569) | 2,556 | 4,125 | 0 | 3,595 |
| Net Interest | (720) | (790) | (592) | (667) | (74) | (146) | (67) |
| Dividend | (3,307) | (2,669) | (2,002) | (2,215) | (213) | (426) | (224) |
| Surplus / (Deficit) | (15,165) | (15,494) | (10,216) | (16,735) | (6,520) | (4,466) | 1,619 |
| NHS Breakeven duty adjs: | | | | | | | |
| Donated Assets | (414) | 122 | 88 | 101 | 13 | 101 | 77 |
| NCA Impairments | 1,732 | 1,826 | 1,569 | (2,556) | (4,125) | 0 | (3,595) |
| I&E Position (breakeven duty) | (13,847) | (13,546) | (8,559) | (19,190) | (10,631) | (4,365) | (1,900) |

## Key Issues

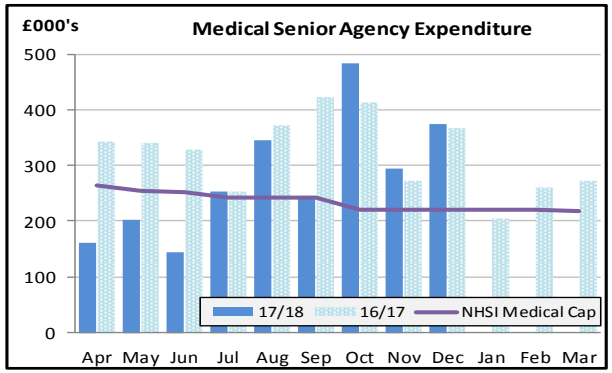
- SLA Clinical income is £3.1m adverse to plan, which is an in-month deterioration of £1.0m. Activity dropped more than planned and would suggest a reflection of the winter pressures on the Trust.
- Other clinical income includes £0.4m relating to the first tranche of the winter funding money. The adverse variance relates to missed STF of £4.5m due to operational and financial performance trajectories not met.
- Pay costs adverse variance of £4.4m (in-month deterioration of £1.6m) is a result of one-off adjustment re apprenticeship levy (£0.6m), unachieved budgetary CIP and vacancy factor (£0.8m) and temporary staffing costs above budget (£0.2m).
  The apprenticeship levy adjustment is as directed by the DH to account for the cost as an in-year charge rather than a prepayment. The effect of this was already factored into last month's forecast calculations, so the adjustment does not impact the forecast outturn.
- Non Pay costs: The increase in month is partly due to excluded medicines which is matched by favourable income variance, as well as increase in outsourced histopathology and radiology work (due to staff vacancies).
- Dividend accrual increased by £0.2m due to the impact of the revaluation of fixed asset.

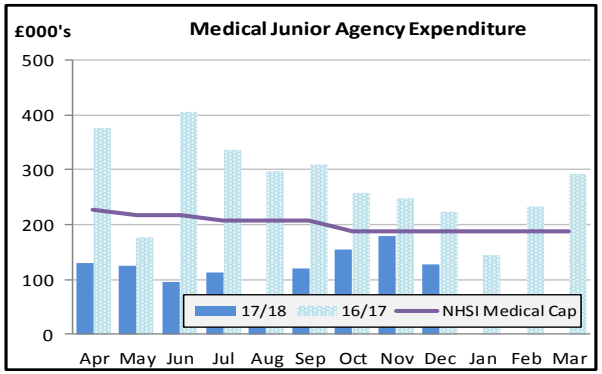
# 3.1 Agency Staff Expenditure

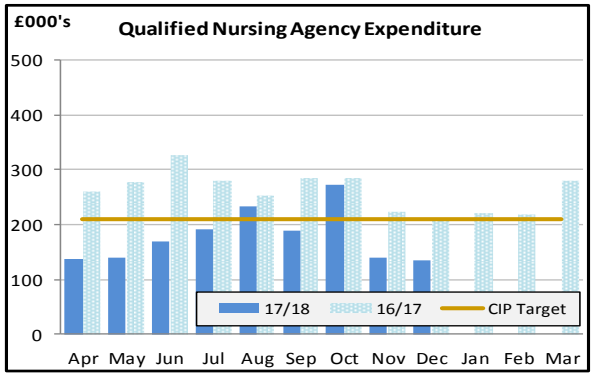


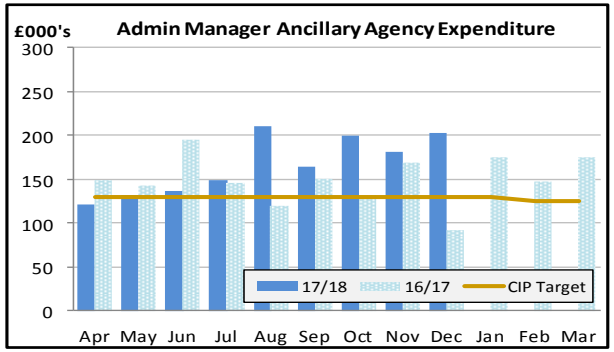

## Key Issues

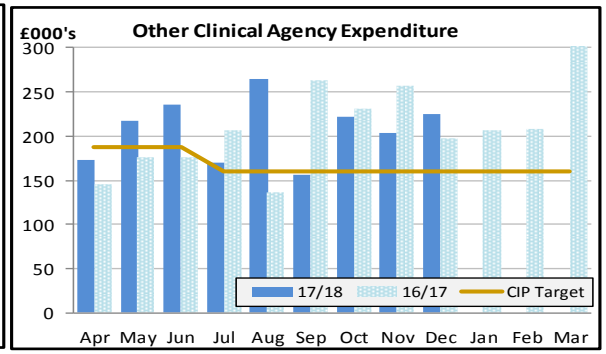
- The Trust full year target on agency spend is £13.04m (£10.0m YTD target).
- At the end of Month 8 the Trust agency spend was £0.7m below the target of £10.0m.
- Agency senior medical agency reported figures lower than 16/17 for every month Apr-Sep. In Q3, 17/18 has consistently recorded a higher figure than 16/17.
- Nursing agency expenditure has maintained significantly lower position in the last two months. Agency wte employed in November & December were 18% lower than the previous 12 months.

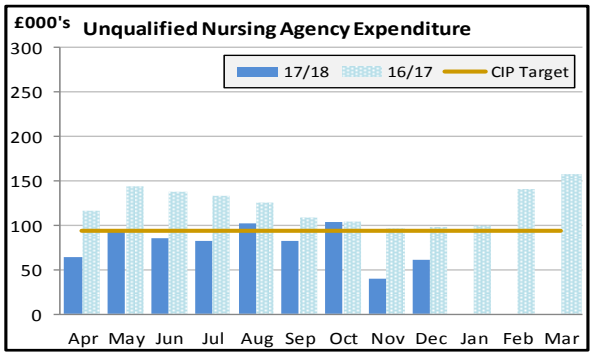


# 4.0 Clinical Income

| SLA Clinical Income | Activity | | | Finance £000's | | |
|---|---|---|---|---|---|---|
| Point of Delivery | Plan | Actual | Variance | Plan | Actual | Variance |
| AandE | 91,818 | 91,216 | (602) | 11,691 | 11,440 | (251) |
| Block | - | - | - | 10,621 | 10,676 | 55 |
| Cost per Case | 2,144,965 | 2,148,604 | 3,640 | 24,175 | 24,724 | 549 |
| CQUIN | - | - | - | 3,658 | 3,848 | 189 |
| Day Cases | 30,871 | 30,026 | (845) | 18,462 | 17,770 | (692) |
| Elective | 4,716 | 3,990 | (726) | 13,437 | 12,717 | (721) |
| Elective XBDs | 850 | 1,019 | 169 | 214 | 266 | 52 |
| Excluded Devices | - | 2,247 | 2,247 | 1,573 | 1,561 | (11) |
| Excluded Medicines | - | 658 | 658 | 16,041 | 17,272 | 1,231 |
| Non-Elective | 41,768 | 38,289 | (3,479) | 75,942 | 71,520 | (4,422) |
| Non-Elective XBDs | 16,816 | 23,522 | 6,706 | 4,237 | 5,836 | 1,599 |
| Outpatient First | 46,516 | 42,652 | (3,864) | 8,164 | 7,500 | (664) |
| Outpatient Follow UP | 149,314 | 154,265 | 4,951 | 11,984 | 12,300 | 317 |
| Outpt Procedures | 111,414 | 111,574 | 160 | 13,121 | 13,597 | 475 |
| CIP / Other | | | | 2,007 | 1,338 | (669) |
| **SLA Clinical Income** | **2,639,047** | **2,648,063** | **9,015** | **215,327** | **212,366** | **(2,961)** |
| Contract Penalties | | | | (170) | (121) | 49 |
| Challenges | | | | (1,350) | (1,582) | (232) |
| Readmissions | | | | (2,396) | (2,396) | 0 |
| MRET | | | | (4,439) | (4,439) | 0 |
| **Fines & Penalties** | | | | **(8,354)** | **(8,538)** | **(184)** |
| **Total SLA Clinical Incon** | **2,639,047** | **2,648,063** | **9,015** | **206,973** | **203,828** | **(3,145)** |

| Other Clinical Income | Finance £000's | | |
|---|---|---|---|
| | Plan | Actual | Variance |
| Private Patients | 859 | 591 | (269) |
| Overseas Visitors | 100 | 216 | 116 |
| RTA / Personal Injury Income | 1,071 | 880 | (191) |
| Winter Funding | - | 449 | 449 |
| STF Funding | 5,665 | 1,111 | (4,554) |
| **Total Other Clinical Income** | **7,695** | **3,246** | **(4,449)** |

**SLA Clinical Income**
£3,145k adv.

**SLA Clinical Income YTD adverse variance of £3.1m, in-month adverse variance of £1.0m. The month 9 result reflects the challenges the hospital faced in December with constant OPEL 4 alerts. This winter pressures effect is seen across most PODs including Elective, Non-elective, Daycases and Outpatient procedures.**

**Cost Per Case**
£549k fav.

CPC remains above plan due to Direct Access over-performance, with further improvements vs plan in chemo and radiotherapy income. Critical care activity was the main area improving vs plan in December (+£72k)

**CQUIN**
£189k fav.

CQUIN: The position includes the schemes achieved for Q1 and the accrual for the expected Q2 CQUIN. It also includes £0.7m YTD relating to 0.5% CQUIN risk reserve which was in dispute with the CCG. NHSI and NHSE have now resolved the dispute and we have received confirmation that CCGs should make payment soon.

**Daycases**
£692k adv.

The Month 9 position shows a worsening position against plan of £294k. Although plans are phased down in December (7% lower than Nov), the drop in activity was more significant at 15% (3,395 to 2,874).

**Elective**
£721k adv.

Elective income also worsened against plan by £127k. Similarly plans are phased down from November (10%) but actual activity dropped by 20%. 2016/17 saw elective activity maintained in December, potentially highlighting the increased difficulty of discharge this year.

**Non-Elective**
£2,822k adv.

NEL activity was 8% below activity plan, 6% below income plan at month 9; an in-month deterioration of £419k .
Activity levels dropped by 4% from November, with a high drop in Paediatric cases and Emergency Medicine NEL activity.

**Outpatients**
£129k fav.

Outpatients continued to outperform plan YTD, however a drop in activity in December reduced the over-performance by £343k this month.

**Fines & Penalties**
£184k adv.

Readmissions and MRET have been negotiated as blocks in 17/18, so will stay on plan. Challenges are under increased pressure and will be a key focus in Q4.

**Other Clinical Income**
£4,449k adv.

The adverse positon on Other clinical income was mainly driven by the loss of STF funding (£4.6m) as a result of missing the relevant trajectories. Private patients RTA income are also below plan. The Trust has received part of the tranche 1 winter funding (£449k).

# 4.1 High Level Commissioner Position

| Commissioner | Finance £000's YTD Plan | Actual | Variance |
|---|---|---|---|
| Nene CCG | 162,703 | 158,646 | (4,057) |
| Corby CCG | 2,177 | 1,910 | (267) |
| Bedfordshire CCG | 483 | 555 | 71 |
| East Leicestershire & Rutland CCG | 574 | 573 | (2) |
| Leicester City CCG | 44 | 64 | 20 |
| West Leicestershire CCG | 49 | 40 | (8) |
| Milton Keynes CCG | 2,274 | 2,278 | 4 |
| Specialised Commissioning | 28,457 | 30,083 | 1,626 |
| Herts & South Midlands LAT | 5,395 | 4,762 | (633) |
| NCA / Central / Other | 4,818 | 4,918 | 101 |
| **Total SLA Income** | **206,973** | **203,828** | **(3,145)** |

**Nene Contract -** £4,057k under performance
The position on the Nene contract worsened by £1.2m in Month 9 across all the core PODs. The activity drop in comparison to November was more stark than plan for DC and Elective, and NEL activity also saw a drop in discharge activity:

The adverse variance is largely within the main PODs;
- DC £15k favourable (M8: £233k favourable)
- EL £962k adverse (M8: £842k adverse)
- NEL £2,650k adverse (M7: £2,290k adverse). This is excluding XS bed days.

Day Case activity was over plan for two consecutive months up to December, but dropped by 15% in December, in comparison to the plan which was only phased down by 7%. Specialties particularly affected were T&O (42% down on November) and Ophthalmology (36%).
Elective activity for Nene reduced broadly in line with plan, but casemix value fell in the month. T&O showed a high drop in elective as well (47%) and General Surgery (28%).
NEL activity was lower than plan, with XS bed days also being on plan. Activity was broadly in line with November levels, other than a significant drop in Paediatric NEL non-emergency. This saw a reduction from average of c. 200 per month to only 105.

**Specialised Commissioner -** £1,656k over performance
An over-performance of £1.656m YTD was reported in December.
This is accounted for by excluded medicines expenditure (£2.1m). Elective over-performance of £628k is now being offset by under plan NEL activity (-£903k in General Medicine and Neo-nates) and DC (-£313k in Cardiology and Neurology). We are continuing discussions with the Commissioner on excluded medicines as they look to lower the spend.

**Herts & SM LAT (Secondary Dental) -** £633k under performance
As with Nene this is largely across main POD's; DC (£177k), EL (£200k) and NEL (£133k).

# 4.2 STF Funding

| I&E | Plan | YTD Plan | Actual YTD | Var |
|---|---|---|---|---|
| | £'k | £'k | £'k | £'k |
| Pre STF | (22,261) | (14,224) | (20,301) | (6,077) |
| STF | 8,715 | 5,665 | 1,111 | (4,554) |
| Post STF | (13,546) | (8,559) | (19,190) | (10,631) |

## Key issues

- The Trust did not achieve the eligibility criteria for both finance and operational elements of the STF in month 9. As a result, missed STF amounted to £4.5m YTD (M7: £3.7m).
- The STF guidance provides for the missed STF relating to the financial trajectories could be recovered cumulatively, subject to the Trust recovering the pre-STF financial position.

# 5. Statement of Financial Position

| TRUST SUMMARY BALANCE SHEET MONTH 9 2017/18 | Balance at 31-Mar-17 | Current Month | | | Forecast end of year | |
|---|---|---|---|---|---|---|
| | | Opening Balance | Closing Balance | Movement | Closing Balance | Movement |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **NON CURRENT ASSETS** | | | | | | |
| OPENING NET BOOK VALUE | 159,809 | 159,809 | 159,809 | 0 | 159,809 | 0 |
| IN YEAR REVALUATIONS | 0 | 9,164 | 9,164 | 0 | 11,658 | 11,658 |
| IN YEAR MOVEMENTS | 0 | 6,451 | 7,185 | 734 | 13,405 | 13,405 |
| LESS DEPRECIATION | 0 | (6,645) | (7,488) | (843) | (10,205) | (10,205) |
| **NET BOOK VALUE** | 159,809 | 168,779 | 168,670 | (109) | 174,667 | 14,858 |
| **CURRENT ASSETS** | | | | | | |
| INVENTORIES | 5,770 | 6,506 | 6,556 | 50 | 5,494 | (276) |
| TRADE & OTHER RECEIVABLES | 23,887 | 18,872 | 17,860 | (1,012) | 24,020 | 133 |
| NON CURRENT ASSETS FOR SALE | 0 | 0 | 0 | 0 | 0 | 0 |
| CASH | 1,621 | 1,233 | 2,069 | 836 | 1,500 | (121) |
| **TOTAL CURRENT ASSETS** | 31,278 | 26,611 | 26,485 | (126) | 31,014 | (264) |
| **CURRENT LIABILITIES** | | | | | | |
| TRADE & OTHER PAYABLES | 24,112 | 29,644 | 29,710 | 66 | 32,395 | 8,283 |
| FINANCE LEASE PAYABLE under 1 year | 124 | 124 | 124 | 0 | 130 | 6 |
| SHORT TERM LOANS | 20,334 | 20,334 | 20,702 | 368 | 1,889 | (18,445) |
| STAFF BENEFITS ACCRUAL | 753 | 753 | 753 | 0 | 800 | 47 |
| PROVISIONS under 1 year | 4,808 | 2,086 | 2,210 | 124 | 3,500 | (1,308) |
| **TOTAL CURRENT LIABILITIES** | 50,131 | 52,941 | 53,499 | 558 | 38,714 | (11,417) |
| **NET CURRENT ASSETS / (LIABILITIES)** | (18,853) | (26,330) | (27,014) | (684) | (7,700) | 11,153 |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | 140,956 | 142,449 | 141,656 | (793) | 166,967 | 26,011 |
| **NON CURRENT LIABILITIES** | | | | | | |
| FINANCE LEASE PAYABLE over 1 year | 1,121 | 1,040 | 1,030 | (10) | 991 | (130) |
| LOANS over 1 year | 30,489 | 37,425 | 40,548 | 3,123 | 63,006 | 32,517 |
| PROVISIONS over 1 year | 1,055 | 1,055 | 1,055 | 0 | 750 | (305) |
| **NON CURRENT LIABILITIES** | 32,665 | 39,520 | 42,633 | 3,113 | 64,747 | 32,082 |
| **TOTAL ASSETS EMPLOYED** | 108,291 | 102,929 | 99,023 | (3,906) | 102,220 | (6,071) |
| **FINANCED BY** | | | | | | |
| PDC CAPITAL | 119,258 | 119,556 | 120,116 | 560 | 120,116 | 858 |
| REVALUATION RESERVE | 37,392 | 44,001 | 44,001 | 0 | 45,957 | 8,565 |
| I & E ACCOUNT | (48,359) | (60,628) | (65,094) | (4,466) | (63,853) | (15,494) |
| **FINANCING TOTAL** | 108,291 | 102,929 | 99,023 | (3,906) | 102,220 | (6,071) |

## Key Movements

The key movements from last month are:

**Non Current Assets**

- In Year M9 movements include capital additions of £0.7m, of which £0.22m relates to MRI 2, Paediatrics Works £0.14m.
- Depreciation - £0.8m in month as per 2017/18 plan.

**Current assets**

• Inventories - £50k, Increase in Pharmacy (£80k) & Pathology (£67k) stockholdings to cover holiday period, offsets stock adjustment in Heart Centre (£100k)

• Trade & Other Receivables – £1.0m. Decrease in NHS SLA Performance Accruals (£1.0m). Increase in Other Receivables (£0.5m). Decrease in Prepayments (£0.6m) - Apprenticeship Levy no longer treated as prepayment.

• Cash – Increase of £0.8m. Receipt of Winter Pressures funding.

**Current Liabilities**

• Trade & Other Payables - £0.1m movement includes increase of £0.5m in Payables & £0.8m decrease in accruals. Increase in PDC Dividend accrual (£0.6m). Decrease in Receipts in Advance £0.2m

•Short Term Loans - £0.4m – Reclassification of Capital from Non-Current

•Provisions £0.1m – Property Services for Danetre Hospital. Balance disputed as part of Month 9 Agreement of Balances Exercise, so reclassified from Creditors

**Non Current Liabilities**

• £3.1m – Drawdown of Revenue Loan £1.5m. Draw down of Capital Loan £2.0m. Reclassification of Capital to Current £0.4m

**Financed By**

- PDC Capital - £0.6m drawdown for A & E GP Streaming
- I & E Account - £4.5m deficit in month

# 6. Capital Expenditure

| Capital Scheme | Plan 2017/18 £000's | M9 Plan £000's | M9 Spend £000's | Under (-) / Over £000's | Plan Achieved % | Total Actual & Committed £000's | Plan Achieved % |
|---|---|---|---|---|---|---|---|
| Refurbished MRI (Loan) | 678 | 0 | 0 | 0 | 0% | 641 | 95% |
| Imaging Replacement Rooms (Loan) | 610 | 610 | 610 | 0 | 100% | 610 | 100% |
| 2nd MRI (Loan) | 2,216 | 2,309 | 2,214 | -95 | 100% | 2,216 | 100% |
| Replacement Imaging Equipment Other Spend | 26 | 26 | 26 | 0 | 100% | 26 | 100% |
| Replacement NPfIT Systems | 1,090 | 268 | 261 | -7 | 24% | 650 | 60% |
| Stock / Inventory System (Loan) | 282 | 81 | 63 | -18 | 22% | 131 | 46% |
| Chemo Appeal | 100 | 100 | 91 | -9 | 91% | 99 | 99% |
| Contingency | 236 | 0 | 0 | 0 | 0% | 0 | 0% |
| Medical Equipment Sub Commiittee | 756 | 315 | 315 | 0 | 42% | 460 | 61% |
| Estates Sub Committee | 3,252 | 1,825 | 1,811 | -14 | 56% | 3,242 | 100% |
| IT Sub Committee | 2,363 | 861 | 860 | -1 | 36% | 1,111 | 47% |
| Assessment Unit | 755 | 0 | 54 | 54 | 7% | 184 | 24% |
| A&E GP Streaming | 858 | 858 | 837 | -21 | 98% | 863 | 101% |
| Other | 96 | 0 | 0 | 0 | 0% | 96 | 100% |
| Salix | 87 | 42 | 42 | 0 | 49% | 51 | 58% |
| **Total - Capital Plan** | **13,405** | **7,295** | **7,184** | **-111** | **54%** | **10,380** | **77%** |
| Less Charitable Fund Donations | -200 | -120 | -112 | 9 | 56% | -120 | 60% |
| Less NBV of Disposals | 0 | 0 | 0 | 0 | 0% | 0 | 0% |
| **Total - CRL** | **13,205** | **7,175** | **7,073** | **-102** | **54%** | **10,261** | **78%** |

| 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 on capital schemes at the end of month 9 was £7,073k, which is 54% of the overall Capital Plan.
- Actual spend plus the Commitments totals £10,261k, therefore at M9 78% of the Capital Plan has been spent or committed. Work is underway to ensure the remaining 22%, £2,944k is spent before year end.
- The MRI 2 has gone live, there is a small issue with the equipment (the intellispace portal) that is being resolved & snagging with the build.
- Commitments of £3,188k include the replacement of the magnet in the existing MRI. The refurbishment will need to replace the cage which is within the surrounding walls, this is scheduled to take place during Q4 2017/18. It is being funded from the remaining loan which has to be spent by year end.
- Upgrade works have started in Main Theatres 1 & 2. Works will continue in to 3 & 4 towards the end of January, including replacement of the theatre lights. Main Theatres 5 & 6 upgrade will be in the new financial year.
- A&E GP Streaming was handed over on 29th November and in operation the following day. External works on the roof & walls continue and the Charitable funds element of the works has started.
- The Assessment Unit plan of £755k above relates to setting up costs - IT & Equipment which will be partly spent in 2018/19, so will be managed within the slippage.
- The cost incurred on the Assessment unit build at the end of month 9 was £8,667k and will be recognised within the Trust's 2018/19 capital plan once the build is completed in June 2018.

# 7. Receivables, Payables and BPPC Compliance

| Narrative | Total at December £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 | 1,372 | 330 | 345 | 126 | 572 |
| Receivables NHS | 5,694 | 3,338 | 491 | 224 | 1,640 |
| **Total Receivables** | **7,066** | **3,668** | **836** | **350** | **2,212** |
| Payables Non NHS | (7,459) | (6,206) | (1,245) | (8) | 0 |
| Payables NHS | (1,399) | (1,383) | (15) | 0 | 0 |
| **Total Payables** | **(8,857)** | **(7,589)** | **(1,260)** | **(8)** | **0** |

| Narrative | Total at November £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 | 1,286 | 547 | 140 | 68 | 531 |
| Receivables NHS | 6,442 | 4,332 | 297 | 168 | 1,644 |
| **Total Receivables** | **7,728** | **4,879** | **437** | **236** | **2,176** |
| Payables Non NHS | (6,818) | (6,626) | (171) | (22) | 0 |
| Payables NHS | (1,952) | (1,870) | (82) | 0 | 0 |
| **Total Payables** | **(8,771)** | **(8,496)** | **(253)** | **(22)** | **0** |

**Better Payment Compliance Code - 2017/18**

| Narrative | Sept 2017 | Oct 2017 | Nov 2017 | Dec 2017 | Cumulative 2017/18 |
|---|---|---|---|---|---|
| **NHS Creditors** | | | | | |
| No.of Bills Paid Within Target | 142 | 134 | 137 | 210 | 1,516 |
| No.of Bills Paid Within Period | 143 | 134 | 145 | 263 | 1,583 |
| **Percentage Paid Within Target** | **99.30%** | **100.00%** | **94.48%** | **79.85%** | **95.77%** |
| Value of Bills Paid Within Target (£000's) | 1,688 | 1,589 | 1,434 | 2,115 | 17,123 |
| Value of Bills Paid Within Period (£000's) | 1,688 | 1,589 | 1,522 | 2,332 | 17,462 |
| **Percentage Paid Within Target** | **99.98%** | **100.00%** | **94.25%** | **90.70%** | **98.06%** |
| **Non NHS Creditors** | | | | | |
| No.of Bills Paid Within Target | 6,363 | 6,825 | 7,167 | 6,939 | 59,102 |
| No.of Bills Paid Within Period | 6,401 | 6,844 | 7,485 | 6,991 | 59,735 |
| **Percentage Paid Within Target** | **99.41%** | **99.72%** | **95.75%** | **99.26%** | **98.94%** |
| Value of Bills Paid Within Target (£000's) | 8,539 | 8,838 | 7,840 | 9,259 | 76,916 |
| Value of Bills Paid Within Period (£000's) | 8,593 | 8,847 | 9,077 | 9,683 | 78,992 |
| **Percentage Paid Within Target** | **99.37%** | **99.90%** | **86.38%** | **95.62%** | **97.37%** |
| **Total** | | | | | |
| No.of Bills Paid Within Target | 6,505 | 6,959 | 7,304 | 7,149 | 60,618 |
| No.of Bills Paid Within Period | 6,544 | 6,978 | 7,630 | 7,254 | 61,318 |
| **Percentage Paid Within Target** | **99.40%** | **99.73%** | **95.73%** | **98.55%** | **98.86%** |
| Value of Bills Paid Within Target (£000's) | 10,227 | 10,427 | 9,275 | 11,374 | 94,039 |
| Value of Bills Paid Within Period (£000's) | 10,282 | 10,436 | 10,598 | 12,015 | 96,453 |
| **Percentage Paid Within Target** | **99.47%** | **99.91%** | **87.51%** | **94.66%** | **97.50%** |

## Receivables and Payables

- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance.
- NHS over 90 day debt remains at £1.6m. This includes £1.0m 2017/18 CQUIN Risk Reserve invoiced to Nene CCG, which NHSI has now confirmed will be paid. NHS Property Services £78k, which is part of an ongoing dispute, £246k of 16/17 over-performance invoices and £107k NCA's.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £479k, of which £182k are paying in instalments and 81% of the balance passed to debt collection agency to recover. £28k relates to private patients, 78% of which is under contract query with insurance providers.
- The increase in outstanding Payables over 30 days is a result of restrictions to supplier payments due to cash constraints. Local protocols remain in place to manage the payments in the most efficient way practicable.

## Better Payment Practice Code

- Some BPPC performance targets in December were missed due to cash restrictions, with the number of invoices paid to other NHS organisations being affected the most.
- The cumulative target for 2017/18 remains compliant in all areas.

# 8. Cashflow

| MONTHLY CASHFLOW | Annual £000s | ACTUAL APR £000s | MAY £000s | JUN £000s | JUL £000s | AUG £000s | SEP £000s | OCT £000s | NOV £000s | DEC £000s | FORECAST JAN £000s | FEB £000s | MAR £000s | FORECAST 18/19 APR £000s | MAY £000s | JUN £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RECEIPTS** | | | | | | | | | | | | | | | | |
| SLA Base Payments | 266,217 | 22,512 | 21,345 | 23,165 | 22,083 | 21,975 | 22,014 | 22,015 | 22,014 | 22,014 | 22,014 | 22,014 | 23,051 | 21,998 | 21,998 | 21,998 |
| STF Funding | 4,737 | 81 | 0 | 0 | 3,545 | 0 | 1,111 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SLA Performance (relating to 16/17 activity) | 3,492 | 873 | -23 | 273 | 677 | 30 | 1,417 | 0 | 0 | 0 | 0 | 0 | 246 | 0 | 0 | 0 |
| Winter Pressures Funding | 2,641 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 449 | 449 | 1,744 | 0 | 0 | 0 | 0 |
| Health Education Payments | 9,594 | 762 | 809 | 785 | 785 | 822 | 822 | 808 | 800 | 798 | 787 | 808 | 808 | 810 | 810 | 810 |
| Other NHS Income | 11,654 | 801 | 1,125 | 596 | 1,279 | 835 | 593 | 1,002 | 1,040 | 884 | 1,000 | 1,000 | 1,500 | 1,000 | 1,000 | 1,000 |
| PP / Other (Specific > £250k) | 3,391 | 610 | 273 | 313 | 346 | 327 | 225 | 279 | 404 | 291 | 322 | 0 | 0 | 0 | 0 | 0 |
| PP / Other | 12,558 | 1,044 | 1,258 | 1,072 | 1,276 | 835 | 986 | 1,043 | 994 | 772 | 878 | 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 | 0 | 0 | 0 |
| PDC - Capital | 858 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 298 | 560 | 0 | 0 | 0 | 0 | 0 | 0 |
| Capital Loan | 3,611 | 0 | 0 | 0 | 0 | 0 | 1,047 | 0 | 0 | 2,014 | 0 | 0 | 550 | 0 | 0 | 0 |
| Exceptional Working Capital | 4,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,201 | 2,299 | 0 | 0 | 0 |
| Uncommitted Revenue Loan - deficit funding | 13,546 | 3,116 | -32 | 979 | 523 | 1,703 | 1,076 | 286 | 301 | 1,914 | 3,680 | 0 | 0 | 1,000 | 1,200 | 1,000 |
| Uncommitted Revenue Loan - STF funding | 7,844 | 436 | 436 | 435 | 581 | 581 | 581 | 872 | 872 | 0 | 1,017 | 1,017 | 1,016 | 436 | 436 | 435 |
| Interest Receivable | 23 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 4 | 1 | 2 | 2 | 2 | 2 | 2 |
| **TOTAL RECEIPTS** | **344,753** | **30,237** | **25,193** | **27,707** | **31,096** | **27,109** | **29,874** | **26,307** | **26,725** | **29,700** | **30,148** | **29,986** | **30,672** | **26,445** | **26,645** | **26,444** |
| **PAYMENTS** | | | | | | | | | | | | | | | | |
| Salaries and wages | 197,413 | 15,598 | 16,340 | 16,890 | 16,382 | 16,237 | 16,374 | 16,533 | 16,676 | 16,361 | 16,642 | 16,560 | 16,820 | 16,766 | 16,766 | 17,038 |
| Trade Creditors | 98,340 | 6,781 | 7,037 | 9,122 | 7,802 | 8,059 | 8,032 | 7,762 | 8,308 | 7,803 | 11,217 | 8,727 | 7,689 | 6,650 | 7,176 | 6,691 |
| NHS Creditors | 22,019 | 2,079 | 2,300 | 1,403 | 2,458 | 2,279 | 1,791 | 1,766 | 1,522 | 2,480 | 1,942 | 1,000 | 1,000 | 2,193 | 2,193 | 2,193 |
| Capital Expenditure | 13,370 | 843 | 1,243 | 810 | 643 | 663 | 575 | 944 | 798 | 1,758 | 757 | 1,245 | 3,092 | 800 | 500 | 500 |
| Creditors relating to Winter Pressures Funding | 1,744 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,744 | 0 | 0 | 0 | 0 |
| PDC Dividend | 2,916 | 0 | 0 | 0 | 0 | 0 | 1,305 | 0 | 0 | 0 | 0 | 0 | 1,611 | 0 | 0 | 0 |
| Repayment of Revenue Loan - STF funding | 6,594 | 2,425 | 0 | 0 | 0 | 2,284 | 141 | 1,158 | 149 | 437 | 0 | 0 | 0 | 0 | 0 | 0 |
| Repayment of Loans (Principal & Interest) | 2,361 | 0 | 0 | 0 | 92 | 513 | 448 | 8 | 3 | 11 | 118 | 711 | 456 | 8 | 11 | 22 |
| Repayment of Salix loan | 91 | 21 | 0 | 0 | 0 | 0 | 38 | 29 | 0 | 0 | 0 | 0 | 3 | 29 | 0 | 0 |
| **TOTAL PAYMENTS** | **344,848** | **27,747** | **26,920** | **28,226** | **27,377** | **30,034** | **28,703** | **28,201** | **27,456** | **28,850** | **30,676** | **29,987** | **30,671** | **26,446** | **26,645** | **26,444** |
| Actual month balance | -94 | 2,490 | -1,727 | -519 | 3,719 | -2,925 | 1,170 | -1,894 | -731 | 850 | -528 | -1 | 1 | -1 | 0 | 0 |
| Cash in transit & Cash in hand adjustment | -26 | 32 | -29 | 48 | -34 | -22 | 21 | 17 | -4 | -13 | -40 | 0 | 0 | 0 | 0 | 0 |
| Balance brought forward | 1,621 | 1,621 | 4,143 | 2,387 | 1,915 | 5,600 | 2,653 | 3,845 | 1,967 | 1,233 | 2,069 | 1,500 | 1,500 | 1,500 | 1,500 | 1,500 |
| **Balance carried forward** | **1,500** | **4,143** | **2,387** | **1,915** | **5,600** | **2,653** | **3,845** | **1,967** | **1,233** | **2,069** | **1,500** | **1,500** | **1,500** | **1,500** | **1,500** | **1,500** |

## Key Issues

- The Trust has applied further restrictions to supplier payments in December in order to manage its cashflow. Payments have been disallowed on a weekly basis since w/c 18th December
- Part of the tranche 1 Winter Pressures Funding was received on 29th December. Further funding is forecast to be received in January & February.
- As targets were not achieved to be eligible for Qtr 3 STF funding in December, only Deficit funding of £1.9m was received. Excess STF funding drawn to date was repaid £0.4m.
- DH has approved a further drawdown of £4.7m in January against the Uncommitted Interim Revenue Support Facility (ISUCL). This includes £1.0m STF Loan funding for Qtr 4, additional deficit funding of £2.2m as well as the in-month planned deficit of £1.5m to enable the Trust to pay overdue creditors. Once the January Drawdown has been received, the Trust will have reached its limit for 17/18 deficit funding of £13.5m. Any further funding, if approved, is likely to be drawn down as Exceptional Working Capital.
- Capital PDC draw down of £0.6m was received in December. This supports the expenditure incurred on the A & E GP Streaming.
- The Trust cashflow position has been exacerbated by the in-year adverse variance to plan and suggests that urgent action is required to sustain payment commitments. Discussions are in progress with NHSI in order to access additional funding required.

# 9. Conclusion

**Key Points:**

- The Trust did not meet its pre-STF financial control and has missed it by £6.1m year to date. In addition, missed operational and financial performance-related STF of £4.5m, brings the overall YTD adverse variance to £10.6m.
- Winter pressures have had a considerable impact on activity carried out in December and therefore the income position has worsened by more than £1m, bringing the YTD income adverse variance to £3.1m.
- A part of the first tranche of winter funding of £0.5m has been received and is included n the position.
- Pay was adverse to plan as a result of one-off adjustment re apprenticeship levy, unachieved budgetary CIP in addition to temporary staffing costs above plan. The Trust's centralised vacancy control panel is in full operation, with remit across all long term staff cover including agency, bank as well as substantive posts. Agency spend continues to be lower than the NHSI target YTD.
- The forecast recovery paper has been refreshed and will include the effect of winter pressures in order to assess a range of possible financial outcomes to assist the Board in making a decision about a realistic forecast outturn.

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Workforce Performance Report** |
| **Agenda item** | **12** |
| **Presenter of Report** | Janine Brennan, Director of Workforce & Transformation |
| **Author(s) of Report** | Adam Cragg, Head of Resourcing & Employment Services |
| **Purpose** | This report provides an overview of key workforce issues |

**Executive summary**

- The key performance indicators show a decrease in contracted workforce employed by the Trust and decrease in Trust Turnover.
- Decrease in compliance rate for Mandatory Training and Role Specific Essential Training and an increase in compliance for Appraisals.
- Health & Wellbeing/Sickness Absence Update
- National WRES Report Key Findings & NGH Comparison

| | |
|---|---|
| **Related strategic aim and corporate objective** | Enable excellence through our people |
| **Risk and assurance** | Workforce risks are identified and placed on the Risk register as appropriate. |
| **Related Board Assurance Framework entries** | BAF – 2.1, 2.2 and 2.3 |

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

**Actions required by the Committee**

The Committee is asked to Note the report.

# Workforce Committee

# Thursday 25 January 2018

# Workforce Performance Report

## 1. Introduction

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

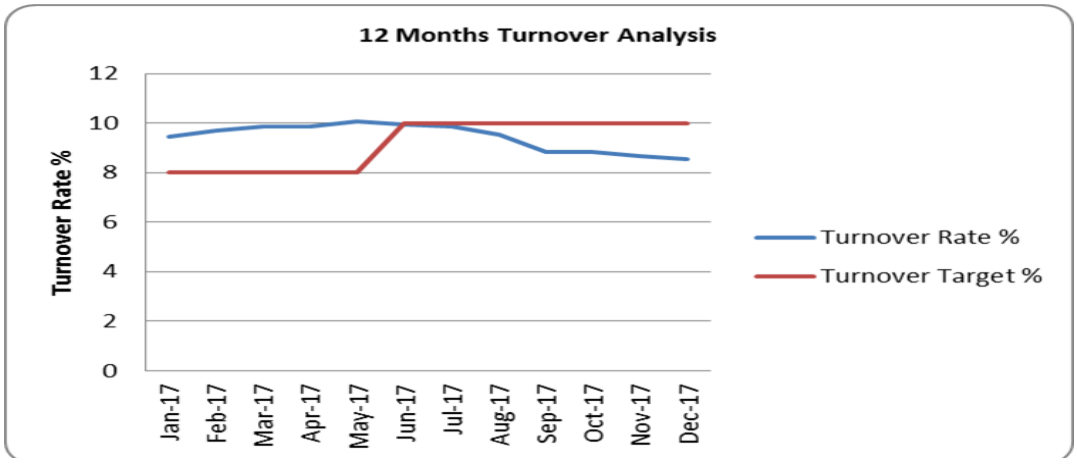
## 2. Workforce Report

### 2.1 Capacity

Substantive Workforce Capacity decreased by 11.34 FTE in December 2017 to 4377.96 FTE. The Trust's substantive workforce is at 89.50% of the Budgeted Workforce Establishment of 4891.78 FTE.

**Trust Turnover**

Annual Trust turnover for December 2017 decreased to 8.55%, which is below the Trust target of 10%.

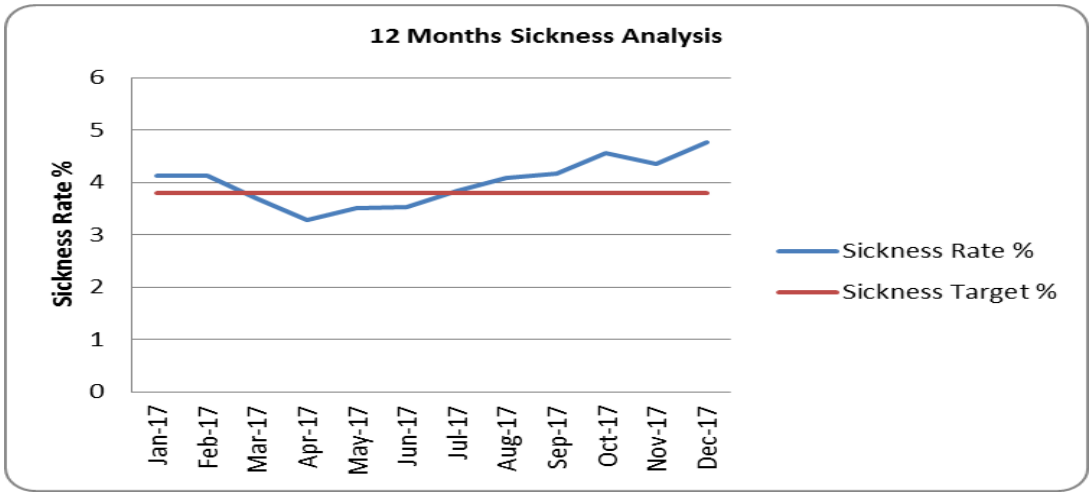



**Vacancy Rates**

The overall Trust vacancy rate for December 2017 is 10.5% against a Trust target of 9%. The vacancy % rate has increased in December for Add Prof Sci & Tech; Additional Clinical Services; Estates & Ancillary; Healthcare Scientists and Nursing & Midwifery.

**Sickness Absence**

Sickness absence for December 2017 increased from 4.35% to 4.77% which is above Trust target of 3.8%.




**Health and Wellbeing/Sickness Absence Update**

It is recognised that a successful health and wellbeing programme requires engagement, time and commitment and NHS Employers have identified the eight elements of workplace wellbeing that are critical to delivering a robust and effective health and wellbeing offer for staff.

The first four elements are key behaviours that need to be in place to ensure the other elements will be effective. The second four are the actions that have been identified. In summary, these are as follows:

| Key Behaviours | Actions |
|---|---|
| Leadership | Know your data |
| Shared Strategic Vision | Prevention |
| Engagement | Intervention |
| Communication | Evaluate and Act |

As part of an ongoing review of current best practice the draft analysis attached at ***appendix 1*** has been undertaken to identify any gaps between the main features of the eight elements against the current practice in the Trust. As a result recommendations have been developed where gaps have been recognised.

Some examples of the recommendations identified are as follows:

- Provide the top three reasons for sickness absence to the Health and Wellbeing Board on a six monthly basis to provide clear vison to the Board and influence future strategy
- Develop HR training for the managers following an extensive review of the current sickness absence policy
- Send corporate messages on wellbeing regularly through Core Brief

- Carry out a survey monkey regarding managers views on recording absence and request their views on the wellbeing agenda
- Occupational Health to provide free health checks for staff regardless of age in 2018.

The next step is for the Health and Wellbeing Steering group to discuss and agree the draft findings from the gap analysis and appropriately implement the recommendations.
For further information the link below provides details of the programme:
http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/the-way-to-health-and-wellbeing/eight-elements-of-workplace-wellbeing

## 2.2 Capability

**Appraisals, Mandatory Training and Role Specific Essential Training**

The current rate of Appraisals recorded for December 2017 is 86.03%; this is an increase of 1.71% from last month's figure of 84.32%.

Mandatory Training compliance decreased in December 2017 from 87.34%, to 87.24% this is a decrease of 0.10% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased in December 2017 to 84.28% from last month's figure of 84.82%.; that is a decrease of 0.54%.

## 2.3 Culture

**National Workforce Race Equality Standard (WRES) Report – NGH Comparison**

The table below summarises the key findings of the 2017 National WRES Report and the Trusts comparative position:

## 2017 Trust WRES Findings Compared to National NHS WRES Report

| 2017 National WRES Indicators | 2017 National WRES Report Key Findings | NGH Comparison to National Position | NGH Comparison Against Our Previous Years Results |
|---|---|---|---|
| Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board Members) compared with the percentage of staff in the overall workforce. | An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed again in 2017. This pattern has persisted since 2014. | 0.59% increase of BME clinical staff from 2016 to 2017. No change to the percentage of BME clinical staff in AfC Bands 6 to 9 between 2016 and 2017 | Improvement |
| | The number of very senior managers (VSMs) from BME backgrounds increased by 18% from 2016 to 2017 - from 212 to 250 in England. This is 7% of all VSMs, which remains significantly lower than BME representation in the overall NHS workforce (18%) and in the local communities served (12%). | 0% of VSMs are BME | No change |
| Relative likelihood of staff being appointed from shortlisting from shortlisting across all posts. | White shortlisted job applicants are 1.60 times more likely to be appointed from shortlisting than BME shortlisted applicants, who continue to remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands. | 1.18% | Improvement |
| Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation. | BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the 2016 figure of 1.56. | 0.61 | Improvement |
| Relative likelihood of staff accessing non mandatory training and CPD (Continuing Professional Development). | White staff were 1.22 times more likely to access non-mandatory and CPD training than BME Staff. This has increased since 2016 | 0.54 | Improvement |
| KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. | Similar proportions of white (28%) and BME (29%) staff are likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months. | White Staff = 28.94%<br>BME Staff = 26.39% | Improvement |
| KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. | The overall percentage of BME experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 27% to 26%. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other colleagues in the last 12 months. | White Staff = 26.95%<br>BME Staff = 23.15%<br>The National Report indicates that the Trust's data in this indicator suggests our practice may be better, because -<br>1. We have improved by at least 1% point in comparison to the previous year.<br>2. Our results have consistently improved from 2014 to 2016.<br>3. Our 2016 score is equal to or lower than the sector average for all BME staff. | Improvement |
| KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion. | BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. For white staff 88% believe their trust provides equal opportunities and for BME staff it is 76%. | White Staff Belief = 87.94%<br>BME Staff Belief = 72.09% | Improvement |
| Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues. | BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff at 14% and 6% respectively. | White Staff = 6.5%<br>BME Staff = 12.09%<br>The National Report indicates that the Trust's data in this indicator suggests our practice may be better, because -<br>1. We have improved by at least 1% point in comparison to the previous year.<br>2. Our results have consistently improved from 2014 to 2016.<br>3. Our 2016 score is equal to or lower than the sector average for all BME staff. | Improvement |
| Percentage difference between the organisations' Board voting membership and its overall workforce. | There has been a steady increase in the number of NHS Trusts that have more than one BME Board Member. There are now a total of 25 NHS Trusts with three or more BME members on the Board, an increase of 9 Trusts since 2016. | The Trust Board has no BME members. | Deterioration |

Overall the Trust reflects the position nationally.

The negative differences to note were that the Trust's increase in its overall BME workforce was less than the national increase, especially in 'Very Senior Manager' positions. In addition the Trust is very slightly below the national figure for the percentages of BME and White staff believing the Trust provides equal opportunities for career progression or promotion.

For the two following indicators the Trust was cited in the report as having *'data that suggests practice may be better'* (than the national standard)*:*

- In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues.

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

The reasons cited for this suggestion are as follows:

1. The Trust has improved by at least 1% point in comparison to the previous year.
2. The Trusts results have consistently improved from 2014 to 2016.
3. The Trusts 2016 score is equal to or lower than the sector average for all BME staff.

It should be noted, however that there is a caveat detailed in the report in respect of this, which states that; "C*aution should be exercised in assuming that trusts whose data is better are all engaged in better practice. Being on this list does not necessarily mean good practice is underway any more than not being on this list means there is no good practice underway at all."*

### 3. Policies

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

- Safe Working Hours Exception Reporting and Work Schedule Review (for Junior Doctors and Dentists) Procedure – Minor Changes
- Maternity, Adoption, Paternity & Shared Parental Leave Procedure – Full Review
- Agreement for Consultants Covering Absent Colleagues – Full Review
- Sabbatical Leave for Career Grade Medical Staff Policy – Full Review

### 4. Assessment of Risk

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

### 5. Recommendations/Resolutions Required

The Committee is asked to note the report.

### 6. Next Steps

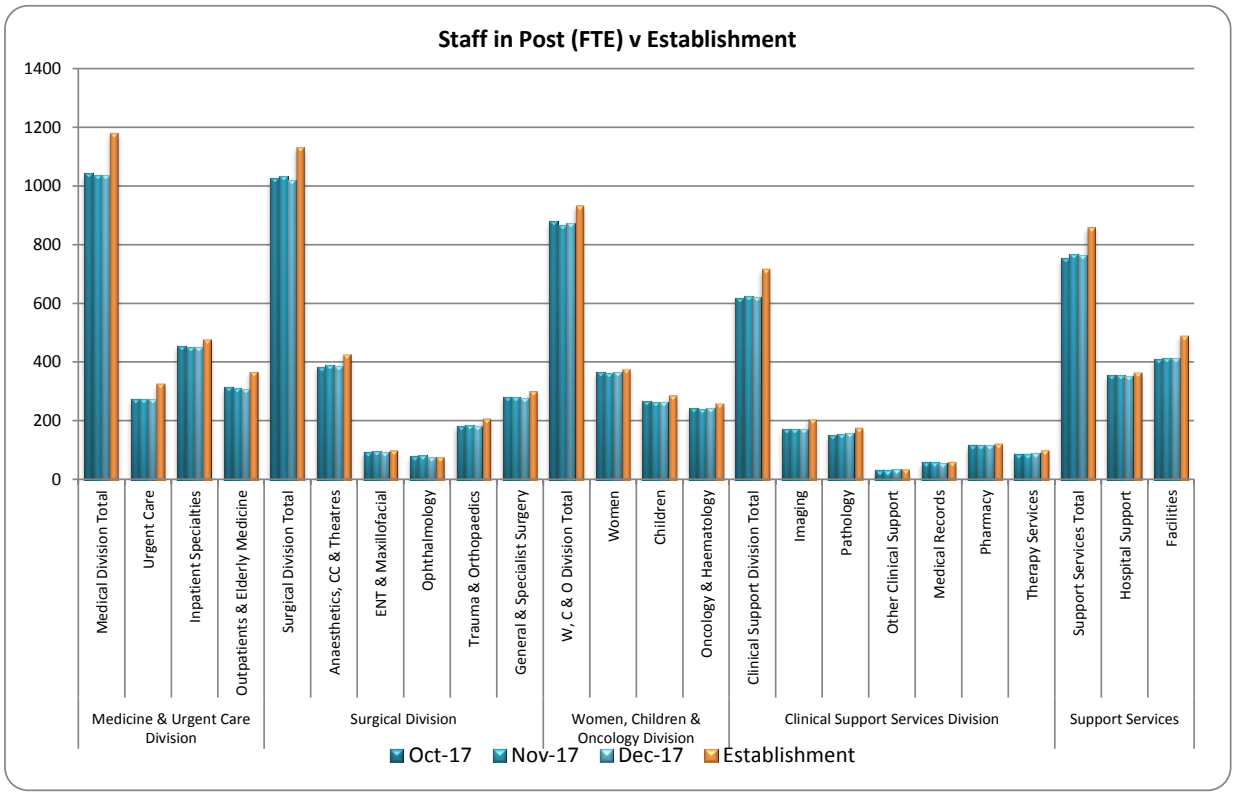
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as and when required.

# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPACITY**
**Staff in Post**

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

| Staff in Post (FTE) | | Oct-17 | | Nov-17 | | Dec-17 | Establishment | |
|---|---|---|---|---|---|---|---|---|
| Medicine & Urgent Care Division | Medical Division Total | 1042.13 | ↓ | 1036.22 | ↓ | 1036.01 | 1181.60 | 87.68% |
| | Urgent Care | 272.46 | ↓ | 272.42 | ↑ | 274.57 | 329.16 | 83.42% |
| | Inpatient Specialties | 455.24 | ↓ | 452.41 | ↓ | 451.41 | 479.33 | 94.18% |
| | Outpatients & Elderly Medicine | 313.43 | ↓ | 310.39 | ↓ | 309.02 | 370.11 | 83.49% |
| Surgical Division | Surgical Division Total | 1025.83 | ↑ | 1033.93 | ↓ | 1021.52 | 1133.89 | 90.09% |
| | Anaesthetics, CC & Theatres | 384.31 | ↑ | 388.81 | ↓ | 386.18 | 429.36 | 89.94% |
| | ENT & Maxillofacial | 93.66 | ↑ | 94.79 | ↓ | 91.56 | 103.20 | 88.72% |
| | Ophthalmology | 79.57 | ↑ | 80.57 | ↓ | 77.32 | 79.82 | 96.87% |
| | Trauma & Orthopaedics | 181.96 | ↑ | 183.96 | ↓ | 183.36 | 210.53 | 87.09% |
| | General & Specialist Surgery | 280.53 | ↓ | 280.00 | ↓ | 277.30 | 304.18 | 91.16% |
| Women, Children & Oncology Division | W, C & O Division Total | 878.87 | ↓ | 868.10 | ↑ | 874.43 | 935.15 | 93.51% |
| | Women | 366.81 | ↓ | 362.70 | ↑ | 365.57 | 380.07 | 96.18% |
| | Children | 267.00 | ↓ | 264.05 | ↓ | 263.96 | 289.76 | 91.10% |
| | Oncology & Haematology | 244.07 | ↓ | 240.35 | ↑ | 242.91 | 262.47 | 92.55% |
| Clinical Support Services Division | Clinical Support Division Total | 619.71 | ↑ | 624.24 | ↓ | 622.56 | 719.74 | 86.50% |
| | Imaging | 171.72 | ↑ | 172.93 | ↓ | 170.93 | 208.46 | 82.00% |
| | Pathology | 151.62 | ↑ | 155.62 | ↑ | 156.10 | 179.23 | 87.09% |
| | Other Clinical Support | 32.74 | ↑ | 32.74 | ↑ | 34.74 | 38.55 | 90.12% |
| | Medical Records | 58.88 | ↓ | 57.88 | ↓ | 56.35 | 64.03 | 88.01% |
| | Pharmacy | 116.66 | ↑ | 117.25 | ↓ | 116.25 | 125.48 | 92.64% |
| | Therapy Services | 88.09 | ↓ | 87.82 | ↑ | 88.20 | 103.99 | 84.82% |
| Support Services | Support Services Total | 753.74 | ↑ | 769.14 | ↓ | 765.77 | 861.45 | 88.89% |
| | Hospital Support | 354.79 | ↑ | 356.40 | ↓ | 353.35 | 368.54 | 95.88% |
| | Facilities | 408.95 | ↑ | 412.74 | ↓ | 412.42 | 492.91 | 83.67% |
| Trust Total | | 4388.36 | ↑ | 4389.30 | ↓ | 4377.96 | 4891.78 | 89.50% |



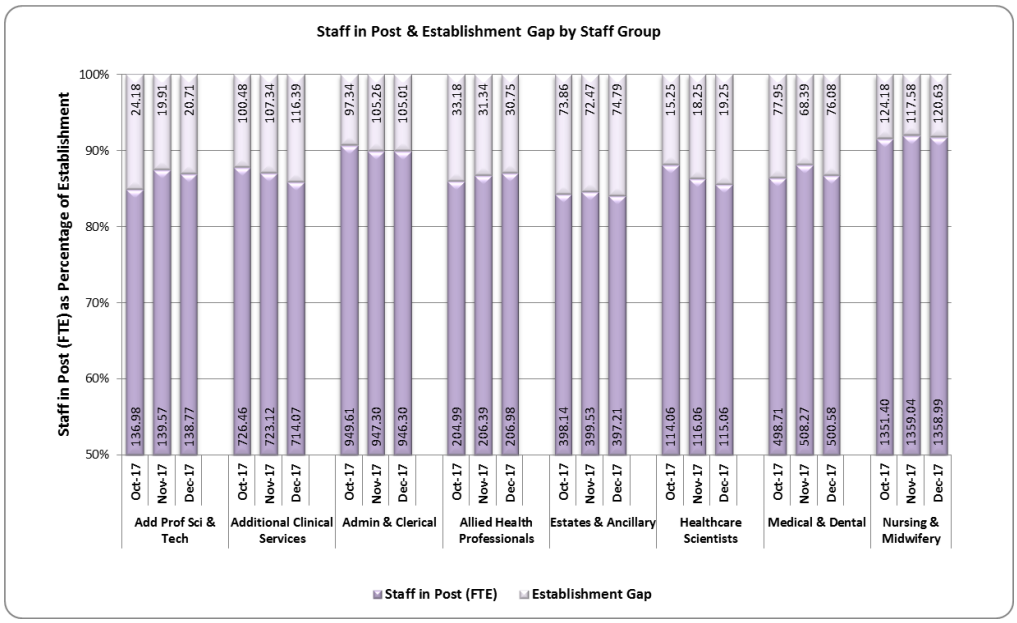
# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPACITY**
**Staff Group (FTE v Est)**

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

**Staff Group Vacancy Rate (Contracted FTE v Establishment)**

| Staff Group | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|
| Add Prof Sci & Tech | 15.00% | 12.48% | 12.99% |
| Additional Clinical Services | 12.15% | 12.92% | 14.02% |
| Admin & Clerical | 9.30% | 10.00% | 9.99% |
| Allied Health Professionals | 13.93% | 13.18% | 12.93% |
| Estates & Ancillary | 15.65% | 15.35% | 15.85% |
| Healthcare Scientists | 11.79% | 13.59% | 14.33% |
| Medical & Dental | 13.52% | 13.59% | 13.19% |
| Nursing & Midwifery | 8.42% | 7.96% | 8.15% |



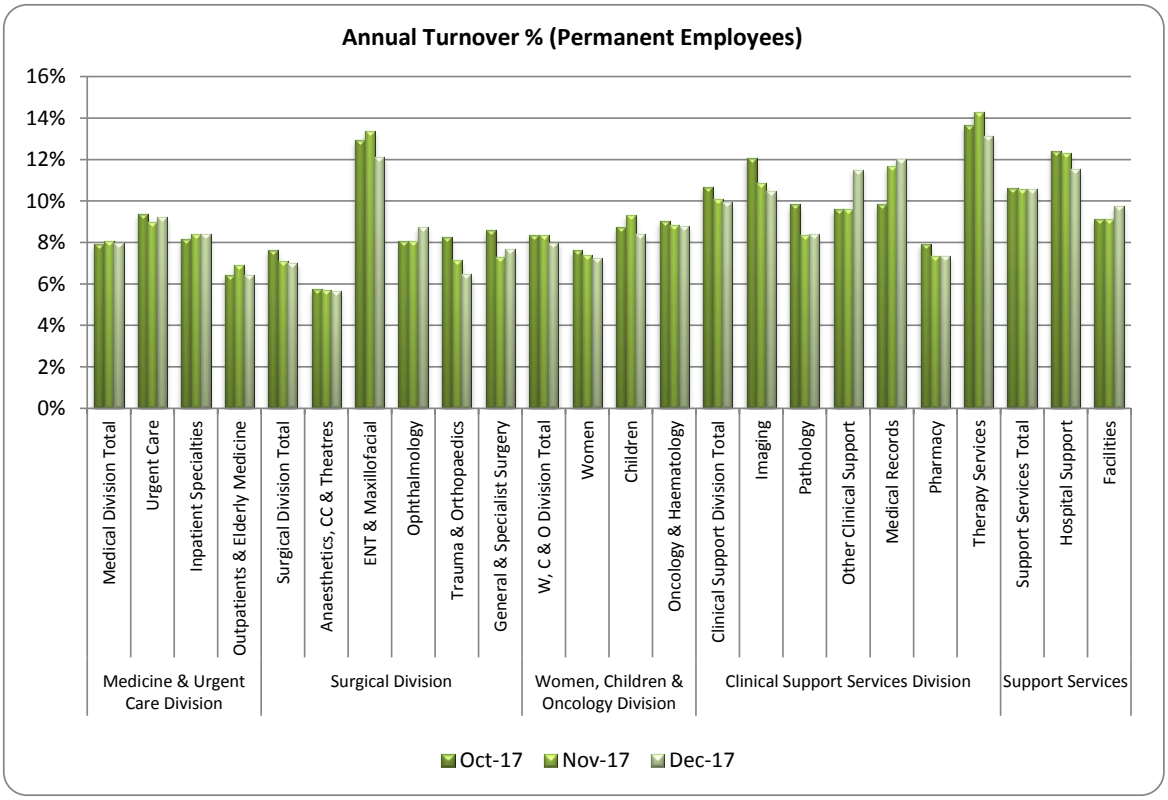
# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPACITY**
**Annual Turnover**

*Figures refer to the year ending in the month stated*

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

| Annual Turnover (Permanent Staff) | | Oct-17 | | Nov-17 | | Dec-17 |
|---|---|---|---|---|---|---|
| Medicine & Urgent Care Division | Medical Division Total | 7.91% | ↗ | 8.05% | ↘ | 7.97% |
| | Urgent Care | 9.37% | ↘ | 8.98% | ↗ | 9.22% |
| | Inpatient Specialties | 8.17% | ↗ | **8.39%** | ↗ | **8.42%** |
| | Outpatients & Elderly Medicine | 6.43% | ↗ | **6.90%** | ↘ | **6.40%** |
| Surgical Division | Surgical Division Total | 7.62% | ↘ | 7.10% | ↘ | 7.01% |
| | Anaesthetics, CC & Theatres | 5.72% | ↘ | 5.68% | ↘ | 5.67% |
| | ENT & Maxillofacial | 12.95% | ↗ | 13.37% | ↘ | 12.12% |
| | Ophthalmology | 8.05% | ↗ | 8.06% | ↗ | 8.76% |
| | Trauma & Orthopaedics | 8.24% | ↘ | 7.14% | ↘ | 6.47% |
| | General & Specialist Surgery | 8.57% | ↘ | 7.29% | ↗ | 7.66% |
| Women, Children & Oncology Division | W, C & O Division Total | 8.33% | ↗ | 8.33% | ↘ | 7.98% |
| | Women | 7.64% | ↘ | 7.36% | ↘ | 7.23% |
| | Children | 8.73% | ↗ | 9.33% | ↘ | 8.40% |
| | Oncology & Haematology | 9.02% | ↘ | 8.83% | ↘ | 8.77% |
| Clinical Support Services Division | Clinical Support Division Total | 10.65% | ↘ | 10.09% | ↘ | 9.96% |
| | Imaging | 12.07% | ↘ | 10.85% | ↘ | 10.47% |
| | Pathology | 9.82% | ↘ | 8.33% | ↗ | 8.39% |
| | Other Clinical Support | 9.58% | ↗ | 9.58% | ↗ | 11.48% |
| | Medical Records | 9.82% | ↗ | 11.70% | ↗ | 12.01% |
| | Pharmacy | 7.91% | ↘ | 7.32% | ↗ | 7.32% |
| | Therapy Services | 13.65% | ↗ | 14.28% | ↘ | 13.14% |
| Support Services | Support Services Total | 10.61% | ↘ | 10.58% | ↘ | 10.57% |
| | Hospital Support | 12.40% | ↘ | 12.31% | ↘ | 11.52% |
| | Facilities | 9.12% | ↗ | 9.12% | ↗ | 9.76% |
| Trust Total | | 8.84% | ↘ | 8.68% | ↘ | 8.55% |



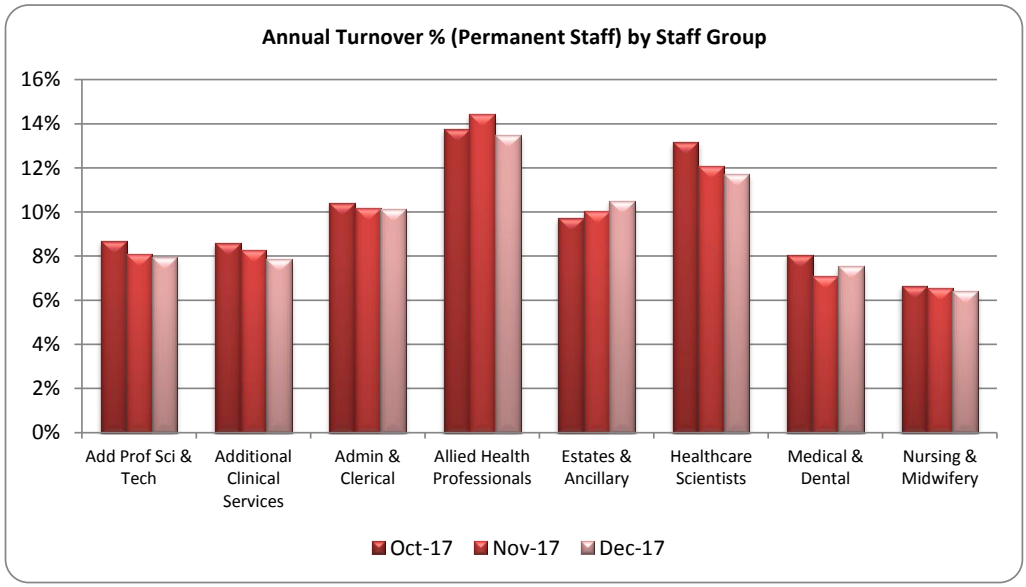
# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

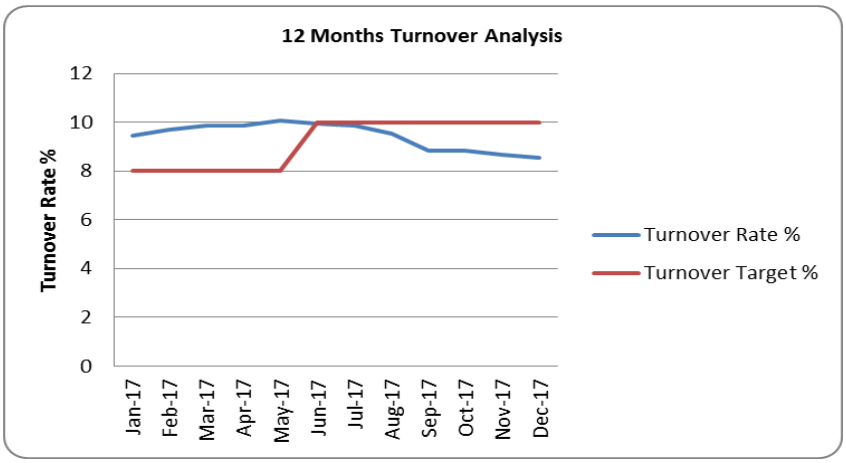
**CAPACITY**
**Turnover by Staff Group**

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

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

| Staff Group | Oct-17 | | Nov-17 | | Dec-17 |
|---|---|---|---|---|---|
| Add Prof Sci & Tech | 8.68% | ↘ | 8.07% | ↘ | 7.95% |
| Additional Clinical Services | 8.60% | ↘ | 8.29% | ↘ | 7.87% |
| Admin & Clerical | 10.40% | ↘ | 10.19% | ↘ | 10.15% |
| Allied Health Professionals | 13.77% | ↗ | 14.45% | ↘ | 13.50% |
| Estates & Ancillary | 9.73% | ↗ | 10.04% | ↗ | 10.50% |
| Healthcare Scientists | 13.15% | ↘ | 12.07% | ↘ | 11.70% |
| Medical & Dental | 8.05% | ↘ | 7.07% | ↗ | 7.52% |
| Nursing & Midwifery | 6.63% | ↘ | 6.55% | ↘ | 6.41% |



## Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**Capacity:**
Substantive Workforce Capacity decreased by 11.34 FTE in December 2017 to 4377.96 FTE. The Trust's substantive workforce is at 89.50% of the Budgeted Workforce Establishment of 4891.78 FTE.

**Staff Turnover:**

Annual Trust turnover for December 2017 decreased to 8.55%, which is below the Trust target of 10%. Turnover within Nursing & Midwifery decreased by 0.14% to 6.41%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased for Add Prof Sci & Tech by 0.12%; Additional Clinical Services by 0.42%; Admin & Clerical, by 0.04%; Allied Health Professionals by 0.95% and Healthcare Scientists by 0.37%.

Turnover increased for Estates and Ancillary by 0.46% and Medical & Dental by 0.45%.

Turnover by Division:
Medical Division: turnover decreased by 0.08% to 7.97%
Surgical Division: turnover decreased by 0.09% to 7.01%
Women, Children & Oncology Division: turnover decreased by 0.35% to 7.98%
Clinical Support Services Division: turnover decreased by 0.13% to 9.96%
Support Services: turnover decreased by 0.01% to 10.57%

**Staff Vacancies:** The vacancy % rate has increased in December for Add Prof Sci & Tech; Additional Clinical Services; Estates & Ancillary; Healthcare Scientists and Nursing & Midwifery.

There has been a decrease for Admin & Clerical; Allied Health Professionals and Medical & Dental staff groups; with the largest decrease experienced by Medical & Dental, decreasing by 0.40%.

**Sickness Absence:**

Sickness absence for December 2017 increased from 4.35% to 4.77% which is above Trust target of 3.8%. All divisions sickness rate were above target.

Sickness by Division:
Medicine and Urgent Care at 4.65%
Surgery Division at 4.5%
Women, Children & Oncology at 5.45%
Clinical Support Services at 4.13%
Support Services at 5.03%.

Facilities had the highest sickness rate of 6.86% amongst the directorates.

In total 7 directorate level organisations were below the trust target rate in December 2017 compared to 11 directorates in November 2017.

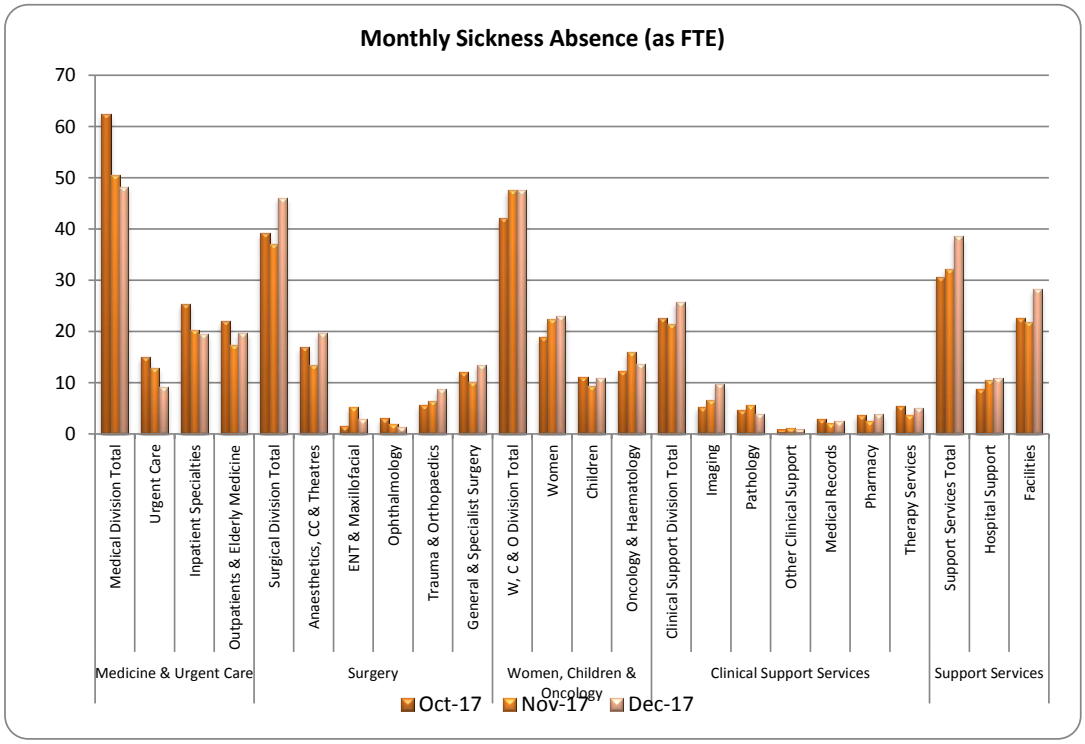
# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

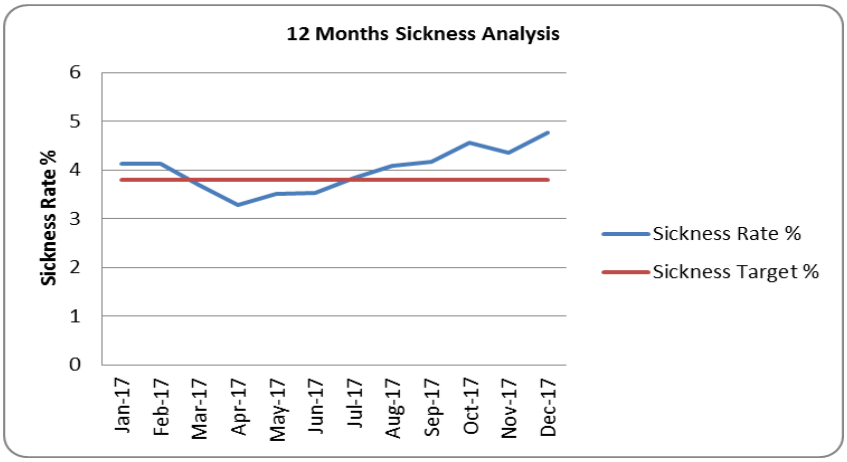
**CAPACITY**
**In-Month Sickness**

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

| Monthly Sickness (as FTE) | | Oct-17 | Nov-17 | Dec-17 | Dec-17 | Short Term | Long Term |
|---|---|---|---|---|---|---|---|
| Medicine & Urgent Care | Medical Division Total | 62.42 | 50.46 | 48.17 | 4.65% | 2.67% | 1.98% |
| | Urgent Care | 15.01 | 12.91 | 9.12 | 3.32% | 1.62% | 1.70% |
| | Inpatient Specialties | 25.36 | 20.27 | 19.46 | 4.31% | 2.32% | 1.98% |
| | Outpatients & Elderly Medicine | 21.97 | 17.32 | 19.65 | 6.36% | 4.13% | 2.23% |
| Surgery | Surgical Division Total | 39.29 | 37.01 | 45.97 | 4.50% | 2.34% | 2.16% |
| | Anaesthetics, CC & Theatres | 16.95 | 13.41 | 19.70 | 5.10% | 2.32% | 2.78% |
| | ENT & Maxillofacial | 1.58 | 5.19 | 2.93 | 3.20% | 1.31% | 1.89% |
| | Ophthalmology | 2.98 | 2.00 | 1.35 | 1.75% | 1.08% | 0.67% |
| | Trauma & Orthopaedics | 5.64 | 6.44 | 8.67 | 4.73% | 3.21% | 1.52% |
| | General & Specialist Surgery | 12.03 | 10.11 | 13.42 | 4.84% | 2.55% | 2.29% |
| Women, Children & Oncology | W, C & O Division Total | 42.19 | 47.57 | 47.66 | 5.45% | 2.89% | 2.56% |
| | Women | 18.85 | 22.31 | 23.07 | 6.31% | 3.03% | 3.28% |
| | Children | 11.08 | 9.32 | 10.95 | 4.15% | 2.43% | 1.71% |
| | Oncology & Haematology | 12.28 | 15.96 | 13.65 | 5.62% | 3.19% | 2.43% |
| Clinical Support Services | Clinical Support Division Total | 22.62 | 21.47 | 25.71 | 4.13% | 2.74% | 1.39% |
| | Imaging | 5.20 | 6.52 | 9.74 | 5.70% | 3.60% | 2.10% |
| | Pathology | 4.62 | 5.54 | 3.89 | 2.49% | 1.42% | 1.07% |
| | Other Clinical Support | 0.83 | 1.11 | 0.82 | 2.37% | 0.07% | 2.30% |
| | Medical Records | 2.90 | 2.04 | 2.43 | 4.31% | 2.56% | 1.76% |
| | Pharmacy | 3.60 | 2.59 | 3.84 | 3.30% | 2.44% | 0.86% |
| | Therapy Services | 5.45 | 3.71 | 5.03 | 5.70% | 5.03% | 0.68% |
| Support Services | Support Services Total | 30.68 | 32.15 | 38.52 | 5.03% | 2.11% | 2.92% |
| | Hospital Support | 8.76 | 10.55 | 10.78 | 3.05% | 1.63% | 1.42% |
| | Facilities | 22.57 | 21.83 | 28.29 | 6.86% | 2.56% | 4.30% |
| Trust Total | *As FTE* | 200.11 | 190.93 | 208.83 | | | |
| | *As percentage* | 4.56% | 4.35% | | 4.77% | 2.54% | 2.23% |

## Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017



# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPABILITY**
**Training & Appraisal Rates**

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

| Mandatory Training Compliance Rate | Directorate | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|
| Medicine & Urgent Care Division | Medical Division Total | 82.74% | 83.37% | 83.30% |
| | Urgent Care | 82.98% | 85.36% | 84.29% |
| | Inpatient Specialties | 79.65% | 79.90% | 80.19% |
| | Outpatients & Elderly Medicine | 86.77% | 86.41% | 86.74% |
| Surgical Division | Surgical Division Total | 85.34% | 85.50% | 85.36% |
| | Anaesthetics, CC & Theatres | 84.04% | 84.78% | 85.52% |
| | ENT & Maxillofacial | 84.61% | 83.44% | 83.44% |
| | Ophthalmology | 88.44% | 89.78% | 89.58% |
| | Trauma & Orthopaedics | 84.74% | 84.04% | 82.92% |
| | General & Specialist Surgery | 86.84% | 86.70% | 85.57% |
| Women, Children & Oncology Division | W, C & O Division Total | 88.49% | 89.42% | 88.65% |
| | Women | 88.74% | 89.77% | 88.34% |
| | Children | 90.85% | 91.32% | 90.08% |
| | Oncology & Haematology | 85.24% | 86.57% | 87.41% |
| Clinical Support Services Division | Clinical Support Division Total | 91.88% | 92.03% | 92.00% |
| | Imaging | 89.12% | 89.51% | 91.27% |
| | Pathology | 93.39% | 93.54% | 93.26% |
| | Other Clinical Support | 90.74% | 94.44% | 88.13% |
| | Medical Records | 93.67% | 92.96% | 96.62% |
| | Pharmacy | 93.90% | 94.95% | 93.72% |
| | Therapy Services | 91.22% | 88.89% | 87.57% |
| Support Services | Support Services Total | 90.10% | 88.80% | 89.39% |
| | Hospital Support | 90.02% | 89.19% | 90.63% |
| | Facilities | 90.16% | 88.48% | 88.37% |
| Trust Total | | 87.17% | 87.34% | 87.24% |

# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPABILITY**
**Training & Appraisal Rates**

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

| Role Specific Training Compliance Rate | Directorate | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|
| Medicine & Urgent Care Division | Medical Division Total | 81.87% | 82.50% | 81.93% |
| | Urgent Care | 81.69% | 83.09% | 82.72% |
| | Inpatient Specialties | 79.22% | 79.97% | 79.36% |
| | Outpatients & Elderly Medicine | 85.95% | 85.56% | 84.91% |
| Surgical Division | Surgical Division Total | 84.54% | 84.89% | 84.64% |
| | Anaesthetics, CC & Theatres | 85.66% | 85.95% | 85.34% |
| | ENT & Maxillofacial | 79.73% | 79.11% | 80.23% |
| | Ophthalmology | 82.68% | 82.60% | 81.22% |
| | Trauma & Orthopaedics | 87.14% | 86.63% | 86.56% |
| | General & Specialist Surgery | 83.10% | 84.07% | 84.03% |
| Women, Children & Oncology Division | W, C & O Division Total | 86.74% | 87.63% | 87.09% |
| | Women | 86.35% | 87.03% | 86.63% |
| | Children | 90.25% | 91.31% | 90.06% |
| | Oncology & Haematology | 82.17% | 83.32% | 83.61% |
| Clinical Support Services Division | Clinical Support Division Total | 85.28% | 85.42% | 85.39% |
| | Imaging | 86.55% | 86.80% | 87.01% |
| | Pathology | 91.00% | 88.79% | 88.99% |
| | Other Clinical Support | 88.15% | 85.93% | 79.73% |
| | Medical Records | 86.11% | 87.32% | 86.96% |
| | Pharmacy | 82.02% | 80.98% | 83.43% |
| | Therapy Services | 81.89% | 83.87% | 83.43% |
| Support Services | Support Services Total | 82.07% | 82.82% | 80.47% |
| | Hospital Support | 88.10% | 87.48% | 83.41% |
| | Facilities | 75.15% | 77.27% | 76.57% |
| Trust Total | | **84.25%** | **84.82%** | **84.28%** |

## Capability

**Appraisals**
The current rate of Appraisals recorded for December 2017 is 86.03%; this an increase of 1.71% from last month's figure of 84.32%.

**Mandatory Training and Role Specific Essential Training**
Mandatory Training compliance decreased in December 2017 from 87.34%, to 87.24% this is a decrease of 0.10% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased in December 2017 to 84.28% from last month's figure of 84.82%.; that is a decrease of 0.54%.

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

# Workforce Committee: Capacity, Capability and Culture Report - Decemberr 2017

**CAPABILITY**
**Training & Appraisal Rates**

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

| Appraisal Compliance Rate | Directorate | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|
| Medicine & Urgent Care Division | Medical Division Total | 82.61% | 81.25% | 80.60% |
| | Urgent Care | 87.64% | 87.59% | 84.00% |
| | Inpatient Specialties | 80.96% | 78.37% | 77.78% |
| | Outpatients & Elderly Medicine | 80.37% | 79.50% | 81.27% |
| Surgical Division | Surgical Division Total | 86.53% | 88.45% | 89.66% |
| | Anaesthetics, CC & Theatres | 82.93% | 84.43% | 87.27% |
| | ENT & Maxillofacial | 74.70% | 75.00% | 69.74% |
| | Ophthalmology | 85.14% | 88.00% | 92.96% |
| | Trauma & Orthopaedics | 93.60% | 95.40% | 95.40% |
| | General & Specialist Surgery | 91.53% | 94.33% | 95.08% |
| Women, Children & Oncology Division | W, C & O Division Total | 85.11% | 87.12% | 88.88% |
| | Women | 85.26% | 86.03% | 88.45% |
| | Children | 86.67% | 88.81% | 89.47% |
| | Oncology & Haematology | 83.82% | 87.45% | 89.67% |
| Clinical Support Services Division | Clinical Support Division Total | 83.89% | 84.67% | 87.65% |
| | Imaging | 74.16% | 76.67% | 85.31% |
| | Pathology | 84.66% | 87.35% | 87.43% |
| | Other Clinical Support | 70.27% | 71.79% | 76.92% |
| | Medical Records | 87.50% | 91.55% | 91.30% |
| | Pharmacy | 87.22% | 86.82% | 88.98% |
| | Therapy Services | 98.00% | 92.00% | 92.08% |
| Support Services | Support Services Total | 83.96% | 80.20% | 84.12% |
| | Hospital Support | 82.25% | 80.50% | 81.12% |
| | Facilities | 85.31% | 79.96% | 86.49% |
| Trust Total | | **84.44%** | **84.32%** | **86.03%** |

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Equality and Diversity Progress Report for Staff** |
| **Agenda item** | 12.2 |
| **Presenter of Report** | Janine Brennan, Director of Workforce |
| **Author(s) of Report** | Sarah Kinsella, Corporate HR Officer & Andrea Chown, Deputy Director of Human Resources |
| **Purpose** | Assurance that the workforce equality agenda is being implemented for staff across the Trust |

**Executive summary**

This paper provides a summary of the progress being made by the Equality and Diversity Staff Group, including developments in the following:

- Workforce annual report and monitoring report
- Equality objectives/4 year plan
- Divisional objectives
- Workforce Race Equality Standards
- Gender Pay Gap Reporting

| | |
|---|---|
| **Related strategic aim and corporate objective** | Enable excellence through our people |
| **Risk and assurance** | The Trust's workforce equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the objectives. |
| **Related Board Assurance Framework entries** | BAF 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? **No**<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No** |
| **Legal implications / regulatory requirements** | Public Sector Equality Duty<br>Equality Act 2010<br>Equality Act 2010 (Gender Pay Gap Information Regulations 2017)<br>NHS Constitution<br>Equality Delivery Scheme (EDS2)<br>Workforce Race Equality Standard (WRES) |

**Actions required by the Committee**

The Board is asked to approve the content of the report.

Northampton General Hospital
NHS Trust

# Public Trust Board
# January 2018

## Equality and Diversity Staff Group – Progress Report

### 1. Introduction

This report from the Equality and Diversity Staff Group provides an update on activities undertaken over the previous 6 months and also draws the committee's attention to any other issues of significance, interest and associated actions required.

This report provides the key highlights of actions:

- Annual Report and Monitoring Report
- Equality Objectives/4 Year Plan
- Divisional Objectives
- Workforce Race Equality Standards
- Gender Pay Gap Reporting

### 2. Body of Report

The key actions from the September and December meetings are as follows:

**Equality and Diversity Workforce Annual Report and Monitoring Report 2016/2017**

The two reports were completed in June 2017 and endorsed by the Workforce Committee in July 2017. These have been published on the Trust's website as part of its requirements under the Public Sector Equality Duty.

**Equality Objectives/Four Year Plan 2016 – 2020**

A progress report on the equality objectives/four year plan was presented to the Equality and Diversity Staff Group at the September and December 2017 meetings. Progress continues against all the objectives including the action to implement a programmed series of materials planned to help staff and colleagues recognise, address and report potential harassment and bullying (Respect and Support Campaign), which is linked to the Workforce Race Equality Standard (WRES) together with the 2016 Staff Survey results.

**Divisional Objectives**

At the most recent Equality and Diversity Staff Group meeting, the Clinical Support Services Division reported on the progress they had made against their Divisional objectives, which were set in December 2016. These were as follows:

1. Identify opportunities within the Directorates where staff in the 18-20 year age group can be employed to increase representation of younger workforce
2. Provide assurance that the Division is supporting disabled staff appropriately
3. Ensure all managers within the Division are equipped with the dates of all religious festivals that staff may request flexibility in working patterns to observe, for example fasting, prayer time.

The Division reported that they had not yet achieved their first objective, and on review of the 2017 equality data for the Division they have expanded the age range for this objective to 16-20 and 26-30 years of age, as these age ranges are both below the Trust figures. They are aware that

apprenticeships for some of the services provided by the Division will be available in the future, which will support the achievement of this objective. In relation to supporting disabled staff appropriately work is ongoing in this area and reasonable adjustments have been made when required. The Therapies Department have also put on dyslexia training for staff. Their third objective has been achieved and managers were informed about the dates of religious festivals so they were aware when staff may require adjustments to working hours to take into account fasting and prayers.

**Workforce Race Equality Standards (WRES)**

The Trust has submitted its WRES data to NHS England and it was published it on the Trust's website in the September 2017. In general there has been improvement in the all the key indicators, with the exception of the percentage difference between the BME representation of the Board and the overall workforce, which has deteriorated. In addition it was noted that the Trust does not have any Very Senior Managers (VSM) who are BME staff, as per the VSM criteria in the WRES Technical Guidance.

The National WRES Report was released in December 2017 and when comparing the Trust's results to the national results, for most of the indicators, the Trust's data reflects the national position. The differences to note were that the Trust's increase in its overall BME workforce was less than the national increase, especially in VSM positions and the percentages of BME and White staff believing the Trust provides equal opportunities for career progression or promotion was slightly below the national figure.

However for two of the indicators the Trust was cited in the report as having *'data that suggests practice may be better'* because:

1. We have improved by at least 1% point in comparison to the previous year
2. Our results have consistently improved from 2014 to 2016
3. Our 2016 score is equal to or lower than the sector average for all BME staff.

These two indicators were:

- In the last 12 months have you personally experienced discrimination at work from your manager/team leader or other colleagues
- The percentage of staff reporting experiencing harassment, bullying or abuse from staff in last 12 months.

**Gender Pay Gap Reporting**

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) the Trust compiled its data in December 2017. Although the Trust is not legally required to produce a written report it was agreed this should be done to give context to the raw data. The report was provided to the Equality and Diversity Staff Group in December 2017 for their approval prior to being presented to the Workforce Committee in January 2018. The Trust Board will receive the findings in February 2018. When the report has been approved by both committees it will be published on the Trust's website and submitted to the Government by 31 March 2018, as part of the requirements under the Regulations. The Trust will need to provide this information annually going forward.

## 3. Recommendations

The Committee is asked to approve the contents of this report.

## 4. Next Steps

Following the Committee, the Equality and Diversity Staff Group will continue to update the Equality Objectives/Four Year Plan on a regular basis and review/monitor the findings from the staff survey results and progress any areas of concern highlighted from either the WRES data, gender pay gap report, the staff survey or the annual monitoring report.

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Gender Pay Gap Report** |
| **Agenda item** | 12.3 |
| **Presenter of Report** | Janine Brennan, Director of Workforce |
| **Author(s) of Report** | Sarah Kinsella, Corporate HR Officer & Andrea Chown, Deputy Director of Human Resources |
| **Purpose** | Assurance that the Trust is complying with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) |

**Executive summary**

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires the Trust to publish on an annual basis the following information:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males receiving a bonus payment
- The proportion of females receiving a bonus payment
- The proportion of males and females in each quartile pay band

This paper provides the findings of the gender pay gap reporting for the Trust as at 31 March 2017.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Enable excellence through our people |
| **Risk and assurance** | The Trust's workforce equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the objectives. |
| **Related Board Assurance Framework entries** | BAF 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? **No**<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No** |
| **Legal implications / regulatory requirements** | Equality Act 2010 (Gender Pay Gap Information Regulations 2017) |

**Actions required by the Committee**

The Board is asked to approve the content of the report.

Northampton General Hospital NHS Trust

**Gender Pay Gap Report 2017**
**As at 31 March 2017**

## Introduction

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), Northampton General Hospital NHS Trust has undertaken gender pay gap reporting on the snapshot date of 31 March 2017.

The Trust has calculated the following for its employees and workers:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males receiving a bonus payment
- The proportion of females receiving a bonus payment
- The proportion of males and females in each quartile pay band

At the time the snapshot was taken the Trust had 5183 employees/workers, of which 4081 (78.74%) were female and 1102 (21.26%) were male.

The ratio of male to female staff that the Trust has is common place for an acute district general hospital such as Northampton. The greatest proportion of staff at the Trust are nurses/midwives and healthcare assistants.

The majority of these staff are female and this is supported by the number of registrants with the Nursing and Midwifery Council (NMC), who in their Equality and Diversity Report 2015-2016 reported that 89% of the registrants were female compared to 11% of males.

## NHS Pay Structure

The majority of staff at the Trust are on the national Agenda for Change Terms and Conditions of Service. The basic pay structure for these staff is across 9 pay bands and staff are assigned to one of these on the basis of job weight as measured by the NHS Job Evaluation Scheme. Within each band there are a number of incremental pay progression points.

Medical and Dental staff have different sets of Terms and Conditions of Service, depending on seniority. However, these too are set across a number of pay scales, for basic pay, which have varying numbers of thresholds within them.

There are separate arrangements for Very Senior Managers, such as Chief Executives and Directors.

As a public sector organisation, some of the services that are provided are on a 24/7 basis and therefore staff that work unsocial hours, participate in on-call rotas and work on general public holidays will also be in receipt of enhanced pay in addition to their basic pay. This mainly applies to clinical staff who work in ward areas along with non-clinical senior managers, who participate in the Senior Manager/Executive on-call rota and non-clinical staff who provide 24/7 services such as Estates staff.

The Trust does have a number of clinical departments that do not provide 24/7 such as clinics and outpatient areas and therefore these staff roles may not attract enhancements.

**Mean Gender Pay Gap**

The mean gender pay gap for the Trust is female staff are paid 30% less than male staff:

| Gender | Mean Hourly Rate |
|---|---|
| Male | £21.66 |
| Female | £15.17 |

The mean pay calculation indicates that there is a substantial difference between the average pay of the Trust's male and female staff.

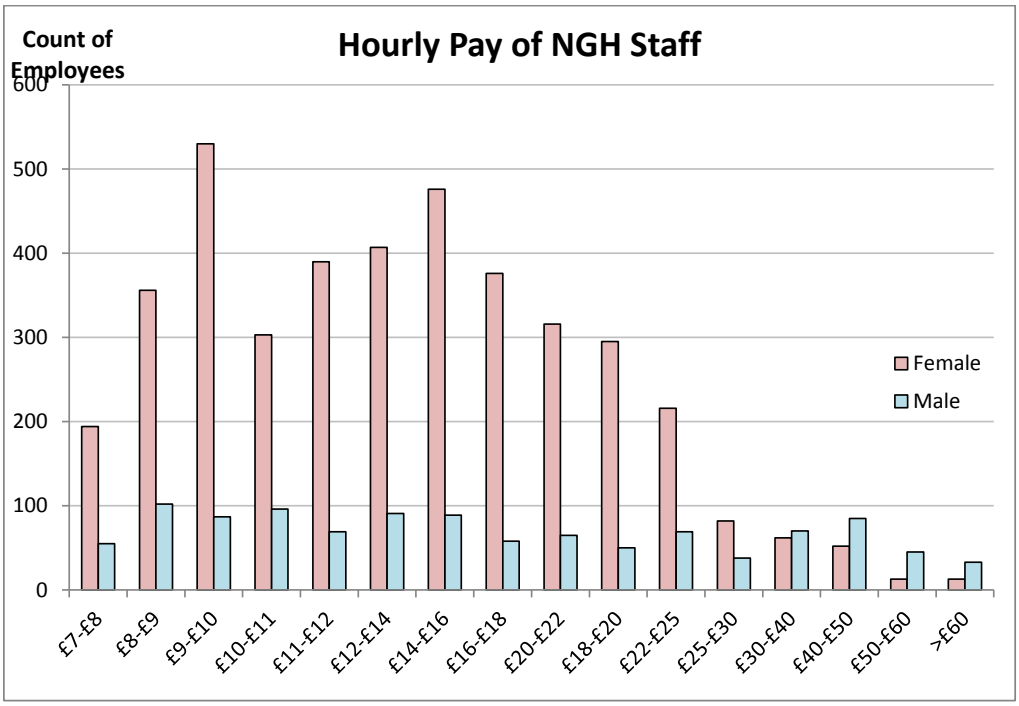
Our analysis shows that within the Trust there is a higher number of male staff in senior medical and dental positions. Of the senior medical and dental staff (Consultants) who are in the two highest basic pay thresholds, i.e. 14 years or more completed as a Consultant, 69% are male and 31% are female.

Some senior medical and dental staff also hold management positions such as Clinical Directors and Divisional Directors and are in receipt of responsibility payments in addition to their basic pay. Of these 7% are male and 4% are female.

In addition some senior medical and dental staff may be in receipt of Clinical Excellence Awards which are consolidated into basic pay. At the time of the snapshot, 44% of male Consultants were in receipt of a Clinical Excellence Award compared to 32% of our female Consultants.

All the payments referred to above are included in the mean hourly rate detailed above and impacts upon the mean gender pay gap calculation of 30%.

The graph below further demonstrates the Trust has a greater number of males on higher hourly rates of pay (£30 per hour and above) than female staff.



The Trust is mindful of the fact that because not all roles within the Trust attract enhancements this has also had an impact in distorting the mean hourly rate. In addition, flexible working opportunities are available for all staff to apply for, and some staff whose role would normally attract enhanced pay in addition to their basic pay may have requested to work set shifts, which do not attract the enhancements that their colleagues would be in receipt of and this again will have had an impact on the mean hourly rate.

As part of the reporting that the Trust undertook, comparisons were also made of the hourly rates of some specific posts, examples of which are below:

| Role | Number of Females | Average Hourly Rate | Number of Males | Average Hourly Rate |
|---|---|---|---|---|
| Senior Manager | 33 | £26.71 | 23 | £30.27 |
| Specialist Registrar | 76 | £25.77 | 62 | £26.02 |
| Modern Matron | 20 | £24.65 | 3 | £24.22 |
| Physiotherapist | 47 | £18.36 | 14 | £18.04 |
| Staff Nurse | 1031 | £16.90 | 101 | £16.87 |
| Healthcare Assistants | 592 | £10.59 | 99 | £10.92 |
| Receptionist | 162 | £9.62 | 19 | £9.43 |
| Housekeeper | 223 | £9.52 | 58 | £9.71 |

The Trust believes that this demonstrates, for some of its key roles, the gap is considerably less than 30%, in some cases and, as demonstrated above, the average hourly rate for females, in some roles, is greater than for male staff.

**Median Gender Pay Gap**

The median gender pay gap for the Trust is female staff are paid 9.5% less than male staff:

| Gender | Median Hourly Rate |
|---|---|
| Male | £14.77 |
| Female | £13.36 |

The median gender pay calculation indicates that there is a difference between the average pay of the Trust's male and female staff.

The Trust believes this figure is more representative of the gender pay gap, but acknowledges this still demonstrates there is a gap that needs to be addressed. However it should be noted that the points raised above in relation to the mean gender pay gap calculation are also contributing factors that impact upon the median gender pay gap calculation of 9.5%.

**Mean Bonus Gender Pay Gap**

The mean bonus gender pay gap for the Trust is female staff are paid 0% less than male staff:

| Gender | Mean Bonus Rate |
|---|---|
| Male | £395.45 |
| Female | £395.49 |

The mean bonus gender pay calculation indicates that there is no difference between the average bonus pay of the Trust's male and female staff.

During the period that this report covers bonuses were only paid to workers on the Clinical Nurse Bank who completed 150 hours of bank work. This is part of the Trust's bonus loyalty scheme to

increase the numbers of clinical bank workers and reduce the use of agency staff. Recipients of these bonuses are primarily band 5 nurses/midwives and band 2 healthcare assistants.

**Median Bonus Gender Pay Gap**

The median bonus gender pay gap for the Trust is female staff are paid 0% less than male staff:

| Gender | Median Bonus Rate |
|---|---|
| Male | £450.00 |
| Female | £450.00 |

The median bonus gender pay calculation indicates that there is no difference between the average bonus pay of the Trust's male and female staff.

The Trust is pleased to note that there has been no gender pay gap identified in relation to the bonuses paid as part of its Clinical Nurse Bank bonus loyalty scheme.

**Proportion of Males and Females Receiving a Bonus Payment**

| Gender | Proportion Receiving Bonus |
|---|---|
| Male | 1% |
| Female | 3.3% |

Of the total workforce, who are registered as workers on the Clinical Nurse Bank, 3.3% of females received bonuses compared to 1% of males.

As detailed above, recipients of these bonuses are primarily band 5 nurses/midwives and band 2 healthcare Assistants. As referred to earlier on in this report there is a greater number of qualified/trained females than males available to recruit to these posts.

**Proportion of Males and Females in Each Quartile Pay Band**

| Quartile | Gender | Number | Percentage |
|---|---|---|---|
| Lower | Male | 242 | 18.7% |
| | Female | 1053 | 81.3% |
| Lower Middle | Male | 246 | 19.0% |
| | Female | 1050 | 81.0% |
| Upper Middle | Male | 187 | 14.4% |
| | Female | 1109 | 85.6% |
| Upper | Male | 427 | 32.9% |
| | Female | 869 | 67.1% |

The lower quartile is made up of staff who are band 1 to mid-point of band 3 (based on basic pay), whose hourly rates are between £7.29 and £9.96

The lower middle quartile is made up of staff who are mid-point band 3 to mid-point band 5 (based on basic pay), whose hourly rates are between £9.96 and £13.61.

The upper middle quartile is made up of staff who are mid-point band 5 to mid-point band 7 (based on basic pay), whose hourly rates are between £13.61 and £19.04.

The upper quartile is made up of staff who are mid-point band 7 to doctor/consultants, senior/very senior managers pay grades (based on basic pay), whose hourly rates are between £19.04 and £117.20.

At the time the snapshot was taken the percentage of female staff was 78.74% and the percentage of male staff was 21.26%. As shown in the table above this percentage split is mostly mirrored in the lower and lower middle quartiles. There is a reduction in the percentage of male staff in the upper middle quartile, however the upper quartile demonstrates there is an increase in the percentage of male staff in the roles that attract the higher hourly rates of pay, as referred to earlier on in this report.

**Conclusion**

The Trust acknowledges that there could be greater female representation in its senior clinical roles, however the consultant workforce has a greater proportion of males to females across the NHS, which limits the pool of available applicants to these types of roles.

Over the past two years the Trust has been developing and implementing leadership development training to strengthen the skills of its existing staff to support career development within the organisation, which should assist with the career development of female staff into more senior clinical and also non-clinical management roles within the organisation.

Likewise the Trust acknowledges that there could be greater male representation in less senior roles, both clinical and non-clinical, however again there are some limitations due to the pool of available applicants and an example of this is male nurses/midwives.

The Trust has a robust recruitment process that has equality and diversity embedded into its processes along with values based recruitment. The Trust will continue to recruit in a non-gender biased manner to ensure that adverts and applicants are recruited in a fair, open and transparent manner.

The Trust hopes that over time, taking into account some of the issues highlighted in this report, the gender pay gap will reduce.

Report approved at Equality & Diversity Staff Group on 14 December 2017

Northampton General Hospital NHS
NHS Trust

| | |
|---|---|
| **Report To** | **PUBLIC TRUST BOARD** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Corporate Governance Report Q3** |
| **Agenda item** | **13** |
| **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**<br><br>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**)<br><br>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

Appendix I

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 3 2017/18

### Declarations of Hospitality and Interest

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.

During Q3 a letter has been circulated as part of the annual governance processes requiring Consultant and senior Trust staff to make return in respect to conflicts of interest (Appendix 1)

- Oct – Dec 2017 : 69 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 |
| Q2 2016/17 | 16 |
| Q3 2016/17 | 79 |
| Q4 | |

**Appendix 1**

Northampton General Hospital NHS
NHS Trust

From the office of Catherine Thorne
Director of Corporate Development, Governance and Assurance
e-mail: Catherine.Thorne@ngh.nhs.uk

Cliftonville
Northampton
NN1 5BD
Switchboard: 01604 634700

November 2017

Dear Colleague
I am writing to remind you of an annual requirement for senior staff and managers within the Trust to complete the attached Declarations of Interest form.

The reason for this is to improve the processes whereby we meet our legal obligations in respect to Corporate Governance. The Trust has a duty to ensure that all its dealings are conducted to the highest standards of integrity and probity and that its Staff, agents, contractors and others, when acting for the Trust in their official capacity, meet these standards.

Should you require further information both the Trust's Standards of Business Conduct Policy and the Standing Financial Instructions describe how we aim to ensure that individuals are aware that they must take decisions free from any potential or real situations of undue bias or influence in the decision-making of the Trust.

They set out the standards of conduct expected of all Staff where their private interests might conflict with their duties as an employee and the steps the Trust has taken to safeguard itself against potential conflicts of interest. Conflicts of interest may arise where an individual's personal, or a connected person's interests and/or loyalties conflict with those of the Trust.

The aim of this policy is to protect both the Trust and the individuals from any appearance of impropriety which may be a risk to its reputation or a breach of the Bribery Act 2010 and to support this all senior staff within the organisation are required to complete the attached form whether they have any interests to declare or not.

I would be grateful if you could kindly return the form by 31st December 2017 at the latest and this can be done in the following ways:

1) Print and complete the attached and return a scanned copy by email
2) Print and complete the attached and return via internal mail
3) Return an electronic copy with original signature

Completed form should be returned to
Kirsty Palmer, Committee Secretary, CEO offices; email via Kirsty.Palmer@ngh.nhs.uk

Should you have any queries please contact me on Catherine.thorne@ngh.nhs.uk and thank you in advance for your support in ensuring our legal compliance

Yours sincerely

Catherine Thorne

**Catherine Thorne**
**Director of Corporate Development Governance and Assurance**

## Declarations of Interests Form

Every member of staff is required to declare any personal, professional or business interest **which may conflict with their official duty or may be seen to compromise their personal** integrity in any way.

A Register of Interests is maintained by the Director of Corporate Development Governance and Assurance. The Register is submitted to the Audit committee and Trust Board
.
An express declaration as to whether or not you have any 'relevant and material interest(s)' is required from all members of staff.

In particular, do you

- Hold any Directorships, including Non-Executive Directorships in private companies or PLCs (with the exception of dormant companies);
- Own or part-own any private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Hold a majority or controlling share-holding in organisations likely or possibly seeking to do business with the NHS;
- Hold any position of Authority in a charity or voluntary organisation in the field of health and social care;
- Have any connection with a voluntary or other organisation contracting for NHS services;
- Receive any research funding or grant (as an individual, or on behalf of a department);
- Have any interest in pooled funds that are under separate management;
- Receive any royalties, licence fees or other similar payments, whether received as an individual or on behalf of a department.

**NB** This is not an exhaustive list. Please declare any other interest(s) which may be regarded as "relevant and material".

**Further advice should be sought from the Director of Corporate Development, Governance and Assurance**

**Declaration of Interests** ***Complete & submit to Kirsty.palmer@ngh.nhs.uk***

Please ***delete*** one of the following, ***as applicable***:

1. **I declare** the following relevant and material interest (*continue on another sheet as necessary)*
   ……

   Signature: …….. Name (printed) …… Date: …..…

   Job title: …… Contact details: ……...

**OR**

2. I understand the definition of relevant and material interests, and **I confirm** that I have **no interests** to declare

   Signature: …….. Name (printed) …… Date: ……..

Job title: …… Contact details: ……

Northampton General Hospital NHS
NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust board** |
| **Date of Meeting** | **24th January 2018** |

| | |
|---|---|
| **Title of the Report** | **Operational Performance Report** |
| **Agenda item** | **14** |
| **Presenter of Report** | Deborah Needham Chief Operating Officer / Deputy Chief Executive |
| **Author(s) of Report** | Lead Directors & Deputies<br>Cancer – Sandra Neale<br>Urgent Care – Paul Saunders<br>Fixing the Flow – James Avery |
| **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<br>Risk of not delivering performance standards<br>Associated fines<br>Patient experience<br>Reputation |
| **Related Board Assurance Framework entries** | BAF – 1.2, 3.1 |

| | |
|---|---|
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)<br><br>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 | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Quality of Care: Caring | Complaints responded to within agreed timescales | >=90% | 100.0% | 93.1% | 100.0% |
| | Friends & Family Test % of patients who would recommend: A&E | >=86.6% | 88.1% | 87.5% | 86.7% |
| | Friends & Family Test % of patients who would recommend: Inpatient/Daycase | >=95.8% | 93.1% | 93.5% | 92.1% |
| | Friends & Family Test % of patients who would recommend: Maternity - Birth | >=96.3% | 95.6% | 97.0% | 100.0% |
| | Friends & Family Test % of patients who would recommend: Outpatients | >=93.7% | 92.2% | 93.2% | 93.5% |
| | % deaths where a care plan is in place | >=50% | 62.1% | 71.2% | 63.9% |
| | Mixed Sex Accommodation | =0 | 0 | 0 | 4 |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Operational Performance | A&E: Proportion of patients spending less than 4 hours in A&E | >=95% | 86.5% | 82.6% | |
| | Number of ambulances (Total) | | 2,260 | 2,111 | 2,236 |
| | Average Ambulance handover times | =15 mins | 00:13 | 00:13 | 00:12 |
| | Ambulance handovers that waited over 30 mins and less than 60 mins | <=25 | 107 | 139 | 228 |
| | Ambulance handovers that waited over 60 mins | <=10 | 15 | 37 | 56 |
| | Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons | =0 | 1 | 3 | 5 |
| | Cancer: Percentage of 2 week GP referral to 1st outpatient appointment | >=93% | 78.7% | 85.9% | |
| | Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms | >=93% | 31.2% | 79.1% | |
| | Cancer: Percentage of patients treated within 31 days | >=96% | 96.1% | 96.5% | |
| | Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug | >=98% | 98.8% | 98.7% | |
| | Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy | >=94% | 96.0% | 96.6% | |
| | Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery | >=94% | 94.7% | 100.0% | |
| | Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers | >=85% | 76.5% | 90.1% | |
| | Cancer: Percentage of patients treated within 62 days of referral from screening | >=90% | 82.1% | 94.1% | |
| | Cancer: Percentage of patients treated within 62 days of Consultant Upgrade | >=85% | 100.0% | 100.0% | |
| | RTT waiting times incomplete pathways | >=92% | 92.1% | 92.0% | |
| | RTT over 52 weeks | =0 | 0 | 0 | |
| | Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test | >=99.1% | 99.6% | 99.5% | 99.9% |
| | ASI Management | <=4% | 32.0% | 25.2% | 24.1% |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Quality of Care: Effective | Stranded patients >=75yrs (LOS > 7 DAYS) | <=45% | 50.5% | 52.2% | 56.6% |
| | LOS > 7 Days | <=45% | 11.4% | 11.5% | 12.2% |
| | Length of stay - All | <=4.2 | 4.8 | 4.8 | 5.0 |
| | Emergency re-admissions within 30 days (elective) | <=3.5% | 3.1% | 3.2% | 2.7% |
| | Emergency re-admissions within 30 days (non-elective) | <=12% | 16.7% | 16.1% | 11.0% |
| | # NoF - Fit patients operated on within 36 hours | >=80% | 95.8% | 72.0% | |
| | Stroke patients spending at least 90% of their time on the stroke unit | >=80% | 98.2% | 83.0% | 91.9% |
| | Suspected stroke patients given a CT within 1 hour of arrival | >=50% | 91.3% | 93.4% | 94.6% |
| | Maternity: C Section Rates | <27.1% | 21.8% | 27.9% | 28.6% |
| | Mortality: HSMR | 100 | 96 | 96 | 97 |
| | Mortality: SHMI | 100 | 99 | 99 | 96 |
| | Crude Death Rates | 1 | 1.2% | 1.1% | 1.6% |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Finance and Use of Resources | Income YTD (£000's) | >=0 | (3,872) Adv | (4,405) Adv | |
| | Surplus / Deficit YTD (£000's) | >=0 | (4,606) Adv | (2,662) Adv | |
| | Pay YTD (£000's) | >=0 | (2,060) Adv | (2,786) Adv | |
| | Non Pay YTD (£000's) | >=0 | (435) Adv | (974) Adv | |
| | Bank & Agency / Pay % | <=7.5% | 12.9% | 12.9% | |
| | CIP Performance YTD (£000's) | >=0 | (668) Adv | (45) Adv | (286) Adv |
| | Salary Overpayments - Number YTD | =0 | 197 | 222 | 254 |
| | Salary Overpayments - Value YTD (£000's) | =0 | 236.2 | 280.9 | 329.9 |
| | Waivers | =0 | 0 | 3 | 3 |
| | Waivers which have breached | =0 | 0 | 0 | 1 |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Winter Pressures | Operations cancelled due to bed pressures | =0 | 9 | 31 | 40 |
| | Patients who need to be readmitted if transport arrives too late | =0 | 12 | 5 | 20 |
| | Delayed transfer of care | =23 | 22 | 25 | 29 |
| | Average Monthly DTOCs | <=23 | 33 | 26 | 38 |
| | Average Monthly Health DTOCs | <=7 | 12 | 9 | 14 |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Quality of Care: Safe | Never event incidence | =0 | 0 | 0 | 0 |
| | Number of Serious Incidents (SI's) declared during the period | =0 | 6 | 3 | 1 |
| | MRSA | =0 | 0 | 0 | 0 |
| | C-Diff | <=1.75 | 1 | 3 | 0 |
| | MSSA | =0 | 1 | 1 | 1 |
| | VTE Risk Assessment | >=95% | 95.3% | 96.2% | 96.1% |
| | Harm Free Care (Safety Thermometer) | >=94.22% | 95.0% | 95.0% | 93.7% |
| | Dementia: Case finding | >=90% | 100.0% | 100.0% | 84.5% |
| | Dementia: Initial diagnostic assessment | >=90% | 100.0% | 100.0% | 100.0% |
| | Number of falls (All harm levels) per 1000 bed days | <=5.5 | 4.3 | 4.7 | 5.7 |
| | Transfers: Patients transferred out of hours (between 10pm and 7am) | <=60 | 16 | 27 | 69 |
| | Transfers: Patients moved between 10pm and 7am with a risk assessment completed | >=98% | 100.0% | 100.0% | 100.0% |
| | Ward Moves (>2) Context | =0% | 4.2% | 4.0% | 4.1% |
| | Ward Moves (>2) | =0 | 151 | 147 | 146 |

| | Indicator | Target | OCT-17 | NOV-17 | DEC-17 |
|---|---|---|---|---|---|
| Leadership & Improvement Capability | Job plans progressed to stage 2 sign-off | >=90% | 41.1% | 54.5% | 63.9% |
| | Sickness Rate | <=3.8% | 4.5% | 4.2% | |
| | Staff: Trust level vacancy rate - All | <=9% | 10.9% | 10.8% | 11.3% |
| | Staff: Trust level vacancy rate - Medical Staff | <=9% | 13.5% | 11.8% | 13.1% |
| | Staff: Trust level vacancy rate - Registered Nursing Staff | <=9% | 8.4% | 7.9% | 8.1% |
| | Staff: Trust level vacancy rate - Other Staff | <=9% | 11.9% | 12.2% | 12.7% |
| | Turnover Rate | <=10% | 8.8% | 8.6% | |
| | Percentage of all trust staff with mandatory training compliance | >=85% | 87.1% | 87.3% | 87.2% |
| | Percentage of all trust staff with role specific training compliance | >=85% | 84.2% | 84.8% | 84.2% |
| | Percentage of staff with annual appraisal | >=85% | 84.4% | 84.3% | 86.0% |

Run Date: 10/01/2018 15:19 Corporate Scorecard Run by: FrancisS

Northampton General Hospital NHS
NHS Trust

# Northampton General Hospital NHS Trust

## Corporate Scorecard

### Delivering for patients:
### 2017/18 Accountability Framework for NHS trust boards

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

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

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

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

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E: Proportion of patients spending less than 4 hours in A&E | >=95% | 83.2% | 81.3% | 78.1% | 86.7% | 87.4% | 85.3% | 88.7% | 88.5% | 89.4% | 86.9% | 86.5% | 82.6% | 83.2% |

**Please note that the Dec 2017 performance is an estimate whilst awaiting final validated figure**

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| <u>Specialty waits</u><br>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.<br><br><u>Bed capacity</u><br>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.<br><br>• Vacancies within medical staffing equating to 8 WTE across all SHO, MG and Consultant (1x SHO going through clearance)<br>• Increasing acuity (4th highest episode on record)<br>• Exit Block<br>• Increased complexity through >65 years age group<br>• Increased ambulance conveyances that are subsequently discharged home. | • Please see Urgent Care report |

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

# Scorecard - Exception Report

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

## Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance handovers that waited over 30 mins and less than 60 mins | <=25 | 247 | 147 | 303 | 159 | 91 | 141 | 139 | 88 | 68 | 90 | 107 | 139 | 228 |
| Ambulance handovers that waited over 60 mins | <=10 | 36 | 35 | 61 | 23 | 12 | 12 | 19 | 7 | 2 | 11 | 15 | 37 | 56 |

## Driver for underperformance:

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

## Actions to address the underperformance:

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

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

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

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Medical Job Planning | Externally mandated | Quality Governance Committee. | December 2017 |

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Job plans progressed to stage 2 sign-off | >=90% | 51.5% | 66.3% | 74.3% | 76.5% | 0.0% | 0.0% | 0.0% | 0.0% | 47.9% | 56.3% | 41.1% | 54.5% | 63.9% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Job planning not performing against timeframe of Trust trajectory | • Directorate level assurance meetings continue to be progressed<br>• Follow up meetings to ensure actions completed.<br>• Reminders sent to 14% Trust-wide awaiting Dr agreement and sign off<br>• Reports distributed to Clinical Directors of those job plans still in discussion stage requesting timeframe for completion. |

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

## Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Patients who need to be readmitted if transport arrives too late | Internally set | Finance, Investment and Performance Committee | December 2017 |

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients who need to be readmitted if transport arrives too late | =0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 8 | 5 | 14 | 12 | 5 | 20 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • TASL new transport continues to under deliver the level of service expected.<br>• Significant delays for transport pick up in December.<br>• 3-4 hours = 61 patients affected<br>• 4-5 hours = 27 patients affected<br>• 5-6 hours = 7 patients affected<br>• 6+ hours = 10 patients affected | • CCG and TASL meetings are continuing to be held to address the underperformance.<br>• Transport issues continue to be escalated to the CCG through transport manager and Execs.<br>• 39 Private wheelchair taxis used to prevent delays in discharge and prevent re-bedding of patients.<br>• 65 patients moved by private ambulance provider. |

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

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ASI Management | < =4% | 30.1% | 26.6% | 30.0% | 34.8% | 33.3% | 30.7% | 39.0% | 37.1% | 34.3% | 32.4% | 32.0% | 25.2% | 24.1% |

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

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

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Operations: Operations cancelled due to bed pressures | Internally set | Finance, Investment and Performance Committee | December 2017 |

**Performance and Trajectory:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operations cancelled due to bed pressures | =0 | 27 | 28 | 38 | 19 | 27 | 31 | 12 | 1 | 2 | 10 | 9 | 31 | 40 |

| | Actions to address the underperformance: |
|---|---|
| **38 patients across all specialties were cancelled on the day in December as a result of winter pressures.** | • Fixing the flow project<br>• Day case and cancer activity only to be scheduled in January<br>• Proactive review of all theatre lists the day before to prevent on the day cancellation. |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Not Applicable | Fay Gordon | Deborah Needham |

# 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 | December 2017 |

## Performance and Trajectory:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons | =0 | 2 | 2 | 1 | 1 | 1 | 3 | 1 | 0 | 2 | 2 | 1 | 3 | 5 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • **General Surgery:** Patient listed for DSU. TCI 14/11/17. Pre-Op did not advise that not suitable for DSU. Listed for Main Theatres, TCI 30/11/17. Pre Op did not advise that an ITU bed was required. Patient cancelled again as no ITU bed available. Next TCI 28/12/17 but cancelled as Trust was on OPEL 4.New TCI 02/02/18 | • Pre Op Manager asked to investigate poor communication and prevent from occurring again. |
| • Two patients listed for surgery 06/11/17 and Consultant requested a third patient to be listed, but the Admissions Team were unable to contact this patient, therefore KT was added as ready for surgery. Patient listed 06/11/17 but was cancelled by Consultant as this was not his requested patient. Patient listed again 27/11/17 but Trust on OPEL 4 so cancelled as no bed available<br>Next TCI 28/12/17 but cancelled as Trust on OPEL 4.<br>New TCI 19/02/18 | • Admissions Team to inform Consultant if unable to contact patients and to liaise with Consultant regarding suitable alternative patients. |
| • **ENT :**Was cancelled on the day as a procedure preceding this patient took longer than anticipated which meant the Surgeon ran out of theatre time to perform the procedure on patient. | • These situations can occur in theatre whereby a procedure takes longer/is more complex than anticipated. Recommendation would be to monitor whether a pattern emerges that one Clinician is consistently overbooking their list and causing patients to be cancelled on the day. |
| • **ORAL Surgery:** Patient was listed for surgery but procedure could only be carried out by a Consultant or Senior staff grade, this was not indicated on the waiting list form and was subsequently booked into a junior theatre who on the day could not perform the procedure. | • All clinicians are to be reminded of the importance to note on the waiting list forms if a senior staff grade or above can only operate on a particular patient (this info would then be transferred onto the waiting list n IPM). New electronic booking form should also have a mandatory field that |

| | |
|---|---|
| • **Cardiology:** Patient booked in for procedure on the 30.11.17 – cancelled due to equipment failure.<br>• Patient was re- dated for 14.12.17 – cancelled due to lack of operating time in the Cath Lab.<br>• Patient was re-dated for the 21.12.17 – list cancelled sue to staff sickness.<br>• Patient was re-dated for 29.12.17 – procedure completed. | states appropriate grade to carry out procedure.<br><br>• To prioritise daily management of PTL's.<br>• Review 28 day breach report daily and ensure patients are dated within the target dates.<br>• Weekly 1:1's to go through outstanding TCI's. |

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

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer: Percentage of 2 week GP referral to 1st outpatient appointment | >=93% | 97.7% | 96.1% | 98.2% | 96.5% | 90.3% | 85.9% | 91.9% | 87.8% | 86.8% | 69.9% | 78.7% | 85.9% |
| Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms | >=93% | 95.0% | 95.5% | 98.4% | 94.1% | 85.2% | 72.8% | 50.9% | 63.0% | 48.6% | 12.1% | 31.2% | 79.1% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| Please see Finance & Performance paper, please note difference in performance due to rounding up/down<br><br>2ww standard- 86%<br>2ww breast symptomatic- 79.2% | |

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

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Dementia: Case Finding | Externally Mandated | Quality Governance Committee | December 2017 |

## Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dementia: Case finding | >=90% | 92.0% | 92.0% | 94.5% | 97.5% | 99.0% | 96.2% | 98.1% | 96.4% | 99.7% | 92.7% | 100.0% | 100.0% | 84.5.5% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Change in medical staffing, so new process for many.<br>• CQUIN nurse on leave for two weeks. Dementia Liaison Nurse covering role. Prompted medical staff when not completed, but did not have the capacity to continue to find the appropriate medic to complete the assessment | • Medical staff to be prompted via education and training, the importance of completing assessments for over 75<br>• Plans being developed for the process to be transferred to Vita Pac as part of general assessment of elderly people for medical staffing |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Matthew Metcalf | Tracy Keats | Debbie Needham |

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Number of falls (All harm levels) per 1000 bed days | Internally Set | Quality Governance Committee | December 2017 |

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls (All harm levels) per 1000 bed days | <=5.5 | 4.8 | 4.1 | 4.8 | 4.53 | 5.3 | 3.3 | 4.2 | 3.9 | 3.7 | 5.1 | 4.3 | 4.7 | 5.7 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| The reason for the underperformance in December 2017 is unclear and not attributable to one specific driver. Some drivers are not changeable for example;<br>Increased number of medical outliers, additional escalation beds opened to enhance capacity, the average age of patients was above 75 and the acuity of patients was high.<br><br>Other drivers which may have had an impact;<br><br>There were a number of patients who fell more than once<br><br>A number of patients suffering from confusion were seen within the number of patients falling<br><br>A change in datix reporting fields | • Review all in patient ward areas where an increase in falls was seen<br>• Review number of repeat falls v's ward area for trends<br>• Audit reporting culture for future comparisons<br>• Continue to work with appropriate Teams on managing patients with confusion<br>• An Internal Collaborative is currently running and once concluded a change package will be launched and added to the audit schedule |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Not applicable | Elizabeth Lomax-Enfield | Debbie Needham |

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Friends & Family Test | Externally mandated | Quality Governance Committee | December 2017 |

## Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family Test % of patients who would recommend: Inpatient/Daycase | >=95.8% | 92.9% | 94.0% | 92.7% | 93.6% | 93.2% | 94.1% | 94.1% | 93.9% | 93.1% | 93.5% | 93.1% | 93.5% | 92.1% |
| Friends & Family Test % of patients who would recommend: Outpatients | >=93.7% | 93.2% | 93.0% | 93.7% | 92.7% | 92.5% | 93.5% | 92.8% | 92.9% | 92.3% | 92.9% | 92.2% | 93.2% | 93.5% |

## Driver for underperformance:

- It is evident when reviewing the data that the results for Inpatient & Day Cases have stabilised and December has seen a decrease.
- Outpatient results were 0.2% below the national average for November.

## Actions to address the underperformance:

- A piece of analytical work into the main issues around communication has been undertaken. This will provide each of the Divisions and Directorates which specific targets for improving communication within their services. As this is one of the key areas of dissatisfaction it is expected that improvements will be seen within the FFT results within subsequent months. This work has now been circulated to each of the Divisions and Directorates and reports are due at PCEEG for what actions are being taken as a result of them.
- The second set of Right time mini-national survey results have been received and distributed to each ward which attained >50 results. For each of these, the ward will each identify where improvements need to be made within their individual areas.
- It has also been identified through the Right Time that Discharge is a consistent theme of dissatisfaction. A project focussing on co-design with patients is currently being formulated. It is expected that over the course of the project that improvements should begin to be made.

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

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity: C Section Rates - Total | <27.1% | 28.4% | 24.5% | 25.0% | 28.9% | 28.2% | 27.0% | 28.3% | 29.0% | 29.5% | 27.6% | 21.8% | 27.9% | 28.6% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Total CS rate amber | No significant change from previous exception reports.<br><br>• Continue monitoring – discussed at Governance meeting, Consultant meeting and Midwifery Leads meeting<br>• Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making.<br>• 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.<br>• Matron – Intrapartum Lead to work on labour ward to support normality and provide challenge and support in clinical decision making<br>• Continue with debriefs following all Caesarean Sections – this is now documented on Medway as part of the CS documentation.<br>• Ongoing Elective Caesarean Section audits – good compliance<br>• Birth After Caesarean Clinic |

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

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Mixed Sex Accommodation | Externally Mandated | Finance, Investment and Performance Committee | December 2017 |

## Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mixed Sex Accommodation | 0 | 0 | 0 | 0 | 6 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 4 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Winter pressures of high attendances and high acuity requiring acute patients to be outlied<br>• Pressures at KGH unable to accept stroke repats<br>• High medical intake and reduced elective surgery has meant patients being moved into outlier beds<br>• NHSI relaxation of mixed sex fines at end of December to manage the pressures<br>• No stroke rehab beds in community | • 1 medical patient placed in a bay of 3 stroke patients resulted in the 4 breaches<br>• NHSI relaxation of mixed sex fines at end of December to manage the pressures until end of January<br>• Enforce 1 repat a day with KGH (action site capacity manager)<br>• Ensure site team are fully sighted on potential breaches and they are escalated out of hours to on call managers (action site capacity manager) |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Not applicable | Carl Holland | Debbie Needham |

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Transfers: Patients transferred out of hours | Internally set | Finance, Investment and Performance Committee | Dec 2017 |

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Transfers: Patients transferred out of hours (between 10pm and 7am) | <=60 | 94 | 87 | 77 | 125 | 60 | 46 | 42 | 32 | 30 | 33 | 16 | 27 | 69 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Winter pressures of high attendances and high acuity requiring less acute patients to be outlied into surgery<br>• Numbers not as high as same period last year 69 vs 94<br>• High medical intake and reduced elective surgery has meant patients being moved into elective surgery beds with the Heart Centre and MDSU opened in the evenings.<br>• Discharge suite opened early on several days to create early flow and avoid 12 hours DTA's in ED | • Exec led 'fixing the flow' actions underway to reduce emergency pressures.<br>• All non-urgent elective work cancelled in January to create medical capacity.<br>• 'blended front door' created to get senior consultant decision makers to ED to manage patients there and not admit unless unavoidable<br>• 'SAFER start to 2018' trust wide initiative launched 8th Jan to decongest hospital |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Not applicable | CarlHolland/Stephan Natawidjaja. | Debbie Needham |

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm Free Care (Safety Thermometer) | >=94.1% | 95.3% | 93.2% | 94.3% | 95.1% | 92.9% | 95.9% | 93.2% | 93.3% | 94.5% | 96.0% | 95.0% | 95.0% | 93.7% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • The number of patients harmed by pressure ulcers above the national average on safety thermometer | • Following the completion of the Rapid Improvement Programme the 'change package' has been launched across the organisation to support trust wide changes. |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Not Applicable | Fiona Barnes | Carolyn Fox |

# Scorecard - Exception Report

| Metric underperformed: | Externally mandated or internally set: | Assurance Committee: | Report period: |
|---|---|---|---|
| Number of Serious Incidents (SI's) declared during the period | Externally mandated | Quality Governance Committee | Dec 2017 |

Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Serious Incidents (SI's) declared during the period | =0 | 1 | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | 2 | 6 | 3 | 1 |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Womens/Obstetrics - Baby - Tertiary referral for cooling (2017/30471) | • Identified following the Trust receiving a Clinical Negligence Claim – currently being investigated |

| Lead Clinician: | Lead Manager: | Lead Director: |
|---|---|---|
| Mr Owen Cooper | Sandra Neale | Debbie Needham |

# Scorecard - Exception Report

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

**Performance:**

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of all trust staff with role specific training compliance | >=85% | 78.1% | 79.0% | 79.7% | 81.2% | 81.0% | 81.0% | 81.8% | 82.6% | 83.9% | 84.3% | 84.2% | 84.8% | 84.2% |

| Driver for under performance: | Actions to address the underperformance: |
|---|---|
| • Lack of awareness of Role Specific subjects due to these being separated from the previous list of 23 Mandatory subjects.<br>• Lack of insight into the importance of Role Specific Training due to not being called Mandatory<br>• Positions not being aligned to Role Specific Training subjects<br>• System (OLM) not flexible enough to report on staff requirements to undertake RSET and having the lowest dominator being set at position level not assignment level | • Increase awareness of the importance of undertaking RSET as well as mandatory training through the appraisal training.<br>• Work continues in aligning Role Specific subjects to new positions as they are created.<br>• Work continues with the Safeguarding Children team who are reviewing their TNA. They are currently aligning the 3 levels to job positions in the Trust.<br>• Work continues with the Falls Prevention Lead in reviewing the staff aligned to this training. This has also led to the proposal of having two levels of training and looking at whether other training can be linked. |

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

# Scorecard - Exception Report

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

## Performance:

| Indicator | Target | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff: Trust level vacancy rate - All | <=9% | 10.9% | 10.7% | 10.7% | 10.6% | 11.1% | 11.4% | 11.9% | 12.5% | 12.6% | 11.6% | 10.9% | 10.8% | 11.3% |
| Staff: Trust level vacancy rate - Medical Staff | <=9% | 9.9% | 9.0% | 9.7% | 10.0% | 10.7% | 11.2% | 10.0% | 13.9% | 14.4% | 16.1% | 13.5% | 11.8% | 13.1% |
| Staff: Trust level vacancy rate - Other Staff | <=9% | 11.0% | 10.9% | 11.0% | 11.1% | 13.8% | 13.5% | 13.6% | 13.4% | 13.2% | 11.9% | 11.9% | 12.2% | 12.7% |

| 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<br>• Nurse recruitment action plan is being refreshed including a planned an overseas recruitment trip.<br>• Medical Overseas Recruitment Business Case being formulated.<br>• Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates.<br>• Overseas recruitment for nurses continues<br>• Attendance at job fayres to enhance Trust brand and maximise recruitment<br>• Business case for new Recruitment system to improve and reduce recruitment timelines submitted. |

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

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **PUBLIC TRUST BOARD** |
| **Date of Meeting** | **25th January 2018** |

| | |
|---|---|
| **Title of the Report** | **Emergency Preparedness, Resilience & Response Annual Report** |
| **Agenda item** | **15** |
| **Presenter of the Report** | Deborah Needham – Chief Operating Officer, Deputy Chief Executive |
| **Author(s) of Report** | Jeremy Meadows – Head of Resilience and Business Continuity |
| **Purpose** | For assurance/information/awareness. |

**Executive summary**

As an acute provider of NHS Funded Care, the Trust is required to 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 (CCA, 2004) and NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2015.

A robust and stringent process with Executive and Senior Management engagement has been followed to complete a review of the Trust's level of Emergency Preparedness to ensure that the results provide a true reflection of the Trust's overall position against the NHS EPRR Framework.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Which strategic aim and corporate objective does this paper relate to?<br><br>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 – please enter BAF number(s)<br><br>BAF 1 |
| **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**)<br><br>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 (**N**) |

**Actions required by the Group**

The Group is asked to:

- Note the contents of this paper.
- Discuss and appropriately challenge the contents of this report.
- Identify areas where additional assurance is required.

Northampton General Hospital
NHS Trust

# Emergency Preparedness, Resilience & Response – Annual Report January 2019

## 1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

The Trust has a suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with regional stakeholders to ensure cohesion with their plans.

The paper reports on the training and exercising programme, EPRR reporting programme, and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

### Background

The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

## 2. Overview of EPRR

### Risk Assessment

The Civil Contingencies Act (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken and response plans exist. Those risks currently identified on the Northamptonshire Local Resilience Forum Community Risk Register with a rating of high or very high include:

- Mass influx of evacuees
- Influenza type disease
- Fuel shortages
- Countywide loss of electricity
- Severe flooding

- Loss of significant telecommunications infrastructure in a localised incident such as a fire, flood or gas incident
- Major radiological contamination as result of an out of county nuclear reactor accident (inc. overseas)
- Local accident involving transport of hazardous materials

The emergency planning team works closely with other agencies as part of the Northamptonshire Local Resilience Forum to consider these risks to keep the county as safe as possible.

**Audits**

In July 2017, East Midlands Ambulance Service undertook an audit of the Trust's CBRN/HazMat (Chemical, Biological, Radiological and Nuclear/Hazardous Materials) incident preparedness. A formal response is yet to be received; however initial feedback to the Trust noted that the Trust was well-prepared to manage a CBRN/HazMat incident. The levels of equipment held, and the frequency of training and exercising undertaken for front-line staff within A&E was recognised.

The audit also acknowledged that Kettering General Hospital were unable to provide a CBRN/HAZMAT response during a 9 month period between July 2016 and March 2017. A Memorandum of Understanding between KGH and NGH was in place during this time to ensure there was a response capability in the county whilst KGH obtained the required equipment in order to undertake decontamination. During this time NGH provided its resources to conduct wet decontamination of persons presenting with, or where it was suspected that they have been caustically contaminated.

**Partnership Working**

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which with Trust is a member include the Northamptonshire Local Health Resilience Partnership and the Northamptonshire Health Resilience Working Group. The Trust is also represented at a number of sub groups of the Northamptonshire Local Resilience Forum. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England Central Midlands.

**Debriefing from Live Events and Exercises**

Following live events and exercises, debriefs are undertaken in order to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident and business continuity plans, and are shared with partner organisations.

**Communications**

Communications is critical in dealing with any adverse incident. As part of the Trust's exercise programme, a series of communications exercises was held in Northamptonshire over the past year. The unannounced exercise, named 'Exercise Clarion' took place on the 3rd July 2017 and simulated a major incident communications cascade. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They include testing telephone, e-mail, paging and other communications methods in use.

## 3. Governance

**Resilience Planning Group**

The Trust has a Resilience Planning Group that meets bi-monthly. All standing members of the group are required to attend 4 of the 6 meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

The group includes representation from all areas within the Trust and other Directors and Officers of the Trust may be asked to attend at the request of the Chair. External partner agencies will be invited if there are specific agenda items that require multi-health partner involvement.

The group is authorised by the Trust Board to investigate any activity within its terms of reference and to seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Group.

The Group has devolved responsibility from the Chief Operating Officer as the Accountable Emergency Officer for the following elements of the Resilience and Business Continuity workstreams:

- Ensuring that the Trust is compliant with the requirements of the Civil Contingencies Act (2004).
- Ensuring that the Trust can satisfy the requirements of external standards, legislation and statutory requirements.
- Ensuring that the Trust is engaged at a strategic, tactical and operational level with National, Regional and local health and multi-agency resilience agendas specifically: Local Health Resilience Partnership, Northamptonshire Local Resilience Forum and its sub-groups.
- Ensuring appropriate Trust input via Operational and Resilience routes into multi-agency plans, procedures and policies.
- Ensuring that the Trust has a robust and tested Major Incident Plan in place and that staff have been trained in their roles.
- Ensuring that the Trust has a range of emergency plans in place to respond to specific emergency situations such as Pandemic Influenza, Communicable Disease Outbreaks, Mass Casualty and CBRN.
- Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation.
- Ensuring that the Trust and all of its Directorates have robust Business Continuity Management plans in place which would enable the continued delivery of key services even whilst responding to an emergency.
- Ensuring that all Divisions are involved in the emergency planning and resilience agenda and that updates, potential risks and new initiatives are shared with respective management teams.
- To provide a forum to exchange information, and promote good practice in emergency planning across the Trust.

**Planning Sector Reports**

The following sections provide an area-by-area report on developments over the past year and planning for the next 12 months.

**Corporate Major Incident Response Plan**

This Plan details the Trust's actions in the event of an external major incident (E.g., a rail crash, floods, or a terrorist attack). Such an event will require the hospital to employ a different method of

working in order to manage the situation. The Plan contains unit-level plans that details the actions required of individual areas to ensure that a trust-wide response is achieved.

Version 2 of the Policy was released in July 2017.

**Business Continuity Management Policy**

Business Continuity Management is a management process that helps to manage the risks to the smooth running of the organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from an external environment (e.g., power failures or severe weather) or from within the organisation (e.g., system failures or loss of key staff). A business continuity event is any incident requiring the implementation of special arrangements in order to maintain or restore services.

The Policy comprises of a corporate-level policy supported by service-level plans. These service level-plans detail what would be required for the service to continue; which less-critical services or functions could be suspended and for how long in order to maintain critical services; which other services are required for that service to function; and which services rely on that service being operational.

All local plans have recently been reviewed and are currently being approved by the Resilience Planning Group.

The Policy has specific plans for the management of high likelihood incidents. These are:

- Adverse weather
- Heatwave
- Pandemic influenza

Version 2 of the Policy was released in November 2017. The policy aligns to British Standard ISO22301.

**Hospital Evacuation Policy**

This Policy details how the Trust would manage a scenario whereby it would need to evacuate a number of patients from the premises and potentially a whole block or site. Version 1 of the Policy was released in May 2017 and is due to be tested in spring 2018.

**Policy Review**

A summary of changes made to the documents is detailed below:

| | |
|---|---|
| **Major Incident Plan** | • Updated throughout in line with national guidance<br>• Update to A&E section following reconfiguration of the department<br>• Updated control room locations<br>• Updated action cards to reflect updated locations and responsibilities |
| **Business Continuity Management** | • Reviewed throughout in line with current guidance |

| Policy | |
|---|---|
| **Hospital Evacuation Policy** | • Adopted as a working document to develop procedures for the evacuation of the Trust |
| **Adverse Weather Plan** | • Updated to reflect change to non-emergency patient transport provider.<br>• Update to accommodation criteria<br>• Addition of Emergency Transport Information Leaflet for staff |

**Training**

A key part of any preparedness arrangements is to ensure that staff are appropriately trained to implement the required response. The Head of Resilience facilitates the delivery of monthly major incident training to staff, in addition to specific sessions as required, and has included;

- Quarterly A&E training days which focus on major incident and CBRN responses, including erection of the CBRN decontamination tent and donning the Powered Respiratory Protection suits.
- Loggist Training to ensure that NGH has sufficiently trained members of staff who can act as a loggist during an incident.
- Attendance at the on-call manager's workshop focussed on IT resilience.
- Monthly mandatory major incident training for all staff.
- Members of A&E and Resilience attended the Critical Care Network mass casualty event which highlighted the impact of recent terror events on the health economy.
- The Associate Resilience Manager attended a 3-day Emergo basic instructor course in order to allow the Trust to plan and facilitate Emergo training and simulation exercises.
- The A&E Resilience Lead attended the Major Incident Surgical Training & Teams (MISTT) Training Course and highlighted the benefit for surgical staff to attend the session focussed on cadaveric procedures for damage control.

As required by the EPRR Core Standards, all corporate-level training and exercising is based on and referenced to the National Occupational Standards for Civil Contingencies.

**Exercising**

The Trust has a rolling programme of live, table-top, command post and communications exercises that are designed to test and develop our plans. The Trust is required to undertake the following:

- Communications exercise – minimum frequency – every six months
- Table top exercise – minimum frequency – every 12 months
- Live exercise – minimum frequency – every three years

If the Trust activates its Incident Control Centre in response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.

Following the cyber-attack, and given the increased potential for a loss of IT, the Trust conducted a call-out exercise without the automated call-out system to test the Trust's ability to contact key staff during an IT outage.

Exercise Clarion is a Northamptonshire-wide major incident communications cascade exercise providing an opportunity for providers of NHS-funded care to test elements of their incident response arrangements. Exercises take place every six months and take the form of an unannounced call either in-hours or out-of-hours.

A&E undertook major incident table top exercises on 28th April, 21st July, and 17th November 2017. The latter exercise was preceded by a call-out system test prior to a table-top exercise.

The Trust participated in the Northamptonshire health economy winter preparedness exercise Stark 2. The aim of the exercise was to practice the health and social care response to severe winter pressures, including health command and control arrangements and business continuity.

Whenever possible, the Trust strives to ensure that testing is held in a multi-agency context in order to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide valuable insight into the operationalisation of our plans and important information regarding the areas of the plans that require further development.

Further exercises are planned for this year. These will include further communications cascade exercises and a table top exercise focussed on hospital evacuation.

**Live Incidents**

During 2017, NGH experienced a number of extraordinary incidents. These are detailed below:

- 12th May 2017: A significant incident was called internally with command and control put into place as a result of the global release of a ransomware virus and the potential for it to negatively impact on the Trust's ICT services. As a result of the threat, the Trust disconnected from the N3 network to prevent the risk of being infected. NGH was not affected directly as a result of the attack but more as a result in taking measures to protect the Trust from infestation. No evidence of ransomware was found at NGH. Staff worked tirelessly to ensure patient safety was maintained.
- July 2017: 5 patients attended the Trust following an acid attack in Northampton, decontamination was undertaken within A&E and patients were discharged once medically fit.
- August 2017: The Trust was put on standby as the result of a RTC on the M1 involving a minibus and two lorries. The incident required the Trust to enact parts of the major incident plan to ensure that services were ready to respond.
- November 2017: The Trust responded to a contaminated patient who presented at A&E after being exposed to a white powder in Northampton. A&E undertook dry decontamination followed by wet decontamination as per policy.

Debriefs were held after the incidents and action plans for plan development were produced. These incidents have helped the Trust and services to develop their plans to manage such incidents should they occur again in the future.

Nationally during 2017 there were a number of incidents, most notably the terrorist attacks at Westminster, Manchester and London which resulted in the national terrorist threat level being raised to Critical. The Trust implemented its plans for such eventuality and a number of major incident training sessions were arranged to ensure that staff were aware of the incidents and remained vigilant to potential security risks. The Trust has received findings from the debriefs

around those incidents and has begun to incorporate the learning into the Trust's incident response plans.

### 4. EPRR Core Standards Review 2017/18

NHS England requires providers of NHS funded care to provide assurance against the National Core Standards in relation to Emergency Preparedness, Resilience and Response (EPRR). As part of the review, NHS England has established that each year will include a 'deep dive' around specific issues. This year the deep dive has included arrangements on Governance. The other Core Standards have remained unchanged. Following the submission and attendance at the EPRR assurance panel, NHS England were assured that NGH were "fully compliant" with the requirements of the core standards. This included assurance of the programme of work to address any gaps.

The EPRR Core Standards confirmation letter is attached for awareness. **APPENDIX 1**

**Priorities for 2018**

- To further develop training and exercises to increase the number of staff involved.
- Further develop and test business continuity plans across the organisation to ensure continued delivery of its most critical services in the event of a business continuity disruption.
- Continued development and regular review of existing arrangements ensuring that they are embedded within the Trust, including; Pandemic Influenza, CBRN, Major Incidents.
- Develop new arrangements and systems for alerting staff of a major incident.
- Establish the number of Resilience Direct members within the on-call team and encourage registration / usage as appropriate.
- Continue to urge staff to commit to attending off-site training when it occurs.
- Ensure Loggists carry out regular refresher training and participate in exercises.
- Link in with the Northampton town evacuation plan to ensure alignment with the Trust Evacuation Plan and evacuation exercise.
- Continue to engage with departmental emergency planning leads.
- Continue to raise the profile of emergency preparedness within the organisation.

### 5. Recommendations

The Board is asked to receive this report as a statement of assurance of the preparedness of the Trust to provide an effective response to a range of incidents and emergencies.

### 6. Next steps

The past year has seen good developments in the Trust's resilience arrangements; however work is required to maintain full resilience, given the increased core standards assurance expected surrounding business continuity next year. The priorities highlighted above will determine the Emergency Planning and Business Continuity work plan for 2018.

**Appendix 1**

Core Standards Letter - NGH FINAL.p

Northampton General Hospital NHS Trust

| | |
|---|---|
| **Report To** | **PUBLIC TRUST BOARD** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Estates Compliance Update** |
| **Agenda item** | **16** |
| **Presenter of Report** | Mr S Finn, Interim Director Estates & Facilities |
| **Author(s) of Report** | Mr S Finn, Interim Director Estates & Facilities |
| **Purpose** | Assurance |
| **Executive summary**<br><br>Following the 'Estate Maintenance Risk and Compliance in clinical areas' paper that was presented to the Board in November 2016, with updates in February and July 2017; the following action plan and dashboard was requested by the Board. This paper presents the latest update as of 15th January 2018. | |
| **Related strategic aim and corporate objective** | Which strategic aim and corporate objective does this paper relate to? |
| **Risk and assurance** | Does the content of the report present any risks to the Trust or consequently provide assurances on risks |
| **Related Board Assurance Framework entries** | BAF – please enter BAF number(s) |
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N)<br><br>Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) |
| **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)<br><br>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:

- To note the Estate Compliance update

# Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

**Recap**

Following the 'Estate Maintenance Risk and Compliance in clinical areas' paper that was presented to the Board in November 2016, with updates in February and July 2017; the following action plan and dashboard was requested by the Board. This paper presents the latest update as of 15th January 2018.

The compliance risks and environmental issues detailed within November 2016's Board paper required a 3 to 4 week closure of each ward area to undertake the work effectively.

It was accepted as most unlikely that with operational pressures it would be possible to contemplate a ward closure.
However, it was agreed that the new assessment wards would support a programme of ward decants, although this would not be practical for at least 12 to 18 months.

The plan presented in February 17's update paper detailed additional measures that have been put in place (or were planned) to improve current compliance and extend mitigations for a further 18 months.
Delivery of the actions in the plan would ensure sufficient assurances are in place for the next 18 months.

**Current Position**

The action plans below have been updated with a quick reference dashboard added to each line to demonstrate the additional measures in place to provide compliance assurance.
A draft detailed ward decant programme has been developed to extend and improve those assurances and address the issues highlighted in the original paper.
The risk ratings for each key element below have not changed at this time but will continue to be reviewed monthly on the corporate risk register.

**Key items to note in this update:**

- A draft decant plan has been developed by Estates based on infrastructure risk. The draft plan is currently 2 to 3 years duration and will start when the assessment wards are opened in June 18. The draft plan has been based on Estates risks and has highlighted the wards with asbestos (Creaton and Benham) as a priority along with ITU and HDU.. The length of time each ward is closed varies; wards with asbestos could take 4 to 6 weeks whereas other wards can be done live to reduce time and cost.
  The draft plan will be discussed with Deputy Chief Operating Officer to ensure that it supports operational needs of the site. Following initial agreement of the draft plan a project team will be set up to finalise and implement the plans.
- Initial discussions have been held at Capital committee to highlight the additional cost of the works. The existing Estates capital plan will be diverted into the decant works but further funding of approximately £750K in year 1 has been estimated. Year 2 and 3 are to be confirmed but are expected to be similar cost.
- Phase 1 of the Electrical test and inspection programme completed in 2017. Additional distribution boards were identified and added to the 2018 programme which is due to complete in June 18.
- A number of ventilation systems in live wards were identified as requiring cleaning. These areas have been assessed and included in the decant plan. A trial is being planned in Willow ward (Feb 18) to clean in a live ward. If successful this will allow earlier completion of the duct work cleans.

## Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

- A number of remedial actions were highlighted in the water safety pipework audit and plans are in place to address; either through the decant programme or as part of planned works. There are mitigations in place and assurance of water safety is in place and independently verified.
- Fire compliance works are underway; fire damper maintenance is being arranged and is expected to complete April 18, remedial works to fire doors is currently out to tender, fire compartmentation surveyors are currently being sourced with the intention to commence compartmentation surveys prior to the decant plan in June/July 18.
- A 6 Facet Survey and update of backlog maintenance was due to be completed by February 18. A 'reset' of the Estates STP has identified the need for an STP standardised approach to 6 Facet surveys to ensure all organisations present data gathered to an agreed criteria. Information has been provided by NGH and as of 8th January 18 and we await the time scales for completion. At this time, this is not a risk to the Trust or our ability to deliver compliance.

Northampton General Hospital NHS
NHS Trust
Estates Department

# Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

**Key Estates Compliance Risks**

## 1. Electrical Safety

**Requirements**

- Frequency of electrical test and inspection in hospitals is 5 yearly (BS7671)
- It is at the Duty holder's judgement the level of testing required. It can be a sample of system tested but this depends upon previous tests, age and condition of the system, etc.

**Mitigation**

- As a short term measure Estates has commissioned non-intrusive testing which does not require isolation of any electrical supplies

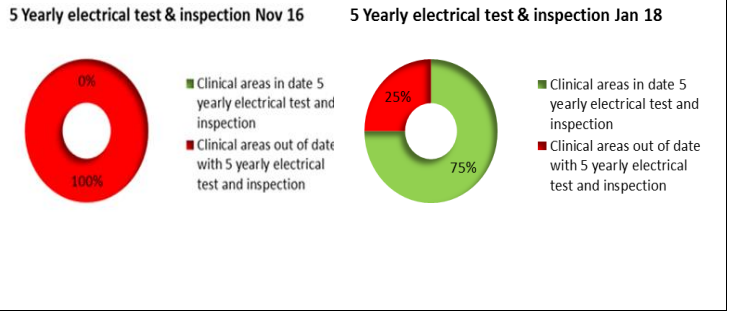
**Risk**

- Non-intrusive testing does not allow all the wiring and connections to be inspected.
- Considering the age of much of the site infrastructure non-intrusive testing should not be considered a long term strategy.
- Failure to meet statutory requirements

**Continuing/further mitigation works**

A strategy has been implemented which will see the whole site tested within 2 years.
This approach will involve thermographic inspections of circuits that cannot be isolated due to restricted access. These will be supported by all electrical testing that can be completed without risk of losing supplies.
The 2 year testing regime commenced in April 17 and has been very successful to the point that next year's testing plan has been brought forward.

| Action | Comment/update | Due date |
|---|---|---|
| Develop safe strategy/specification for testing all areas across site. To include risk rated areas eg occupied clinical, unoccupied clinical, age, etc. | Specialist provider was selected and provided a delivery plan. Testing for 2017 is nearing completion so the 2018 programme has been brought forward to start in October 17. | Complete |
| Procure electrical testing and inspection provider | Service procured with the support of Procurement team | Complete |
| Complete electrical test and inspection across the site | Testing for 2017 is completed as planned. 2018 programme was brought forward and started October 17. | 01/06/18 On track |
| Implement monthly visual inspections of all distribution rooms by Estates electricians | On track | Complete |
| Amend Capital Projects 'Preferred Solutions' document to ensure all capital refurbishment works include full electrical testing within the specification. | This has been added to the current Chemo Suite refurb and the Barratt kitchen works | Complete |
| Detail electrical upgrade programme for 17/18 capital plan | There is a current 2 year plan in place | Complete |



## Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

### 2. Non Specialist Ventilation Systems

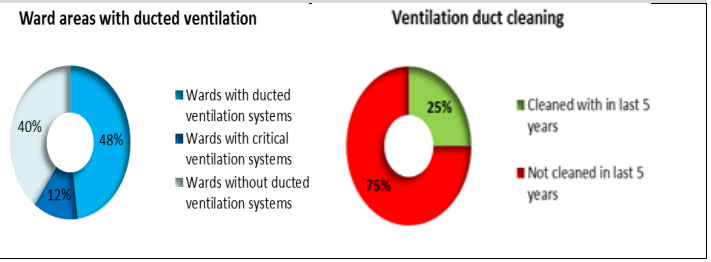
**Requirements**
- HSE guidance - Mechanical ventilation systems (including air-conditioning systems) should be regularly and adequately cleaned. They should also be properly tested and maintained to ensure that they are kept clean and free from anything which may contaminate the air

**Mitigation**
- Specialist ventilation systems across site are maintained and verified as per HTM
- Non specialist ventilation systems having a program of regular filter changing.

**Risk**
There is no record of non specialist ventilation system cleaning;
- Cleanliness of air supply duct work/air quality cannot be assured. There is no record of these systems ever being cleaned.
- No records of extract duct work cleaning.

**Continuing/further mitigation works**
A programme of sample 'dust deposit' testing has been completed (in line with TR19 the HVCA guide to cleanliness of ventilation systems recommendations).
This tested the cleanliness of all non critical ventilation by sampling at the start, middle and end/discharge of all non critical duct work without disruption to clinical services.
This report highlighted a number of ward ventilation systems that require cleaning.
These systems have been assessed and included in the decant plan.
A trial is being planned in Willow ward (Feb 18) to clean in a live ward. If successful this will allow earlier completion of the duct work cleans.

| Action | Comment/update | Due date |
|---|---|---|
| Identify all non specialist ventilation systems and source costs from specialist contractor to carry out sample 'dust deposit' testing of duct work | A programme of sample 'dust deposit' testing has been commissioned (in line with TR19 recommendations) and commenced 8th February 2017. | Complete |
| Carry out sample 'dust deposit' testing where access can be gained to determine extent of contamination risk | Commenced 8th February 2017 | Complete |
| Analyse results and develop plan for any remedial cleaning required cleans | A number of systems in live wards were identified for cleaning. These areas have been assessed and included in the decant plan but a trial is being planned in Willow ward to clean in a live ward. This will allow earlier completion of the duct work cleans. | Complete |




### 3. Water Safety

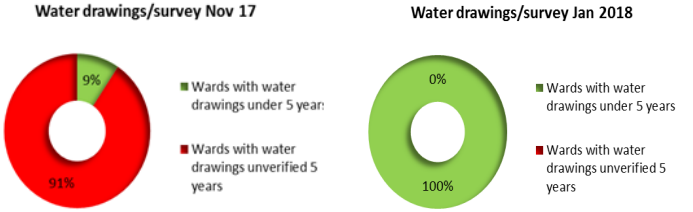
**Requirements**
- A full site water safety/legionella risk assessment (statutory).

**Mitigation**
- Water Safety Plans are in place & monitored at the Trust Water Safety Group.
- Additional supplementary water dosing system has been installed
- A site water safety/legionella risk review is completed annually by the Trust water safety advisor

**Risk**
- Failure to meet statutory requirements
- Risk of outbreak (legionella, pseudomonas, other water borne micro-organisms) in areas with our most vulnerable occupants ie wards

**Continuing/further mitigation works**
A full pipework survey to produce full water drawings across the entire site has been commissioned and started in January 2017. The survey includes a register of any significant issues found eg dead legs, flexible hoses, etc.

| Action | Comment/update | Due date |
|---|---|---|
| Complete full pipework survey to produce water drawings across the entire site | This survey work started in Jan 17 and has now completed. | Complete |
| Review drawings and develop plan for any remedial works required | A number of remedial actions have been highlighted and plans are in place to address; either through the decant programme or as part of planned works. | 31/03/18 On track |
| Amend Capital Projects 'Preferred Solutions' document to ensure all capital refurbishment works include full water survey and drawings within the specification. | | Complete |
| Detail water safety works programme for 17/18 capital plan | This plan has been developed but may change if the survey shows any high risk areas | Complete |



## Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

### 4. Fire Safety

**Requirements**

NHS Safety Alert DH/2014/003 says (by April 15);

- *'Systems should be implemented to ensure the integrity of fire stopping can be confirmed within the organisation's premises'*
- *'All installed fire and smoke dampers, and their associated actuating mechanisms and control systems, should be included in a formal maintenance programme to ensure that they are inspected and tested'*

**Mitigation**

- An inventory of all known/visible fire dampers has been collated and an external specialist has inspected and tested.
- Drawings have been produced to show where fire breaks should be. Where these fire breaks can be accessed they have been inspected.

**Risk**

*'Inadequate inspection, recording and documentation of fire stopping and damper maintenance may result in the organisation responsible for the building potentially being in contravention of Article 17 of the Regulatory Reform (Fire Safety) Order 2005 and thereby putting patients, visitors and staff at risk in the event of a fire.'*

**Continuing/further mitigation works**

A water pipework survey to produce full water drawings across the entire site was commissioned and the intention was to extend the survey to include inspection of fire barriers. Before the fire barrier survey could commence the first step needed to review and confirm the exact location of the where the barriers should be so as to avoid unnecessary inspections. The Trust Fire Safety Adviser has completed the identification of fire compartmentation and a surveyor is due on site 25th July to review and agree programme of inspections.

Completion of this survey work will be dependent on access to occupied areas but as with the water survey

| Action | | Comment/update | Due date |
|---|---|---|---|
| A | Complete survey to complete inspection of fire barriers | The Trust Fire Safety Adviser has completed the identification of fire compartmentation and a surveyor is due on site 25th July to review and agree programme of inspections. (This action initially had estimated 30% of the survey completed with the water drawing survey but on review the surveys did not include all the relevant information – there has been no cost to this work and it has not delayed the water survey programme) | 31/07/18 On track |
| B | Review survey results and plan any works required | Ongoing as survey results are received. This review will start April 18 | 31/08/18 On track |
| C | Amend Capital Projects 'Preferred Solutions' document to ensure all capital refurbishment works include fire barrier inspection within the specification. | | Complete |
| D | Detail fire safety works programme for 17/18 capital plan | This plan has been developed but may change if the survey shows any high risk areas | Complete |

### 5. Backlog and Environment Risk

The risks highlighted above have focused on the current estate compliance risks. Consideration has also been given to the ongoing challenge of maintaining and improving the existing environment and continuing to remove or mitigate future risks from ageing infrastructure.
Public and patient perception of how we deliver our services is significantly influenced by the environment.
It's reflected in patient satisfaction surveys, PLACE audits, CQC inspections, etc and any impression of a poor estate will be recognised and highlighted.

| Action | | Comment/update | Due date |
|---|---|---|---|
| A | Detail Backlog and Environment works programme for 17/18 capital plan | This plan has been developed but may change dependent on service needs, changes that would allow access to areas, audit results, changes in guidance, etc.<br>Many small redecorating works have been completed following the IPC EDI audits in preparation for the CQC inspection. A refurbishment tender for Medical Outpatients and Childrens Outpatients has been issued and will complete in financial year 17/18. | Complete |
| B | Continued Estates maintenance inspections and reactive works to maintain a safe and clean environment | Ongoing annual plan. As above - many small redecorating works have been completed following the IPC EDI audits in preparation for the CQC inspection. This inspection process is continuous and will be supported by Estates. | Complete |
| C | Complete a whole site 6 Facet survey and update current backlog information. | A 'reset' of the Estates STP has identified the need for an STP standardised approach to 6 Facet surveys to ensure all organisations present data gathered to an agreed criteria. Information has been provided by NGH and as of 8th January 18 and we await the time scales for completion. At this time, this is not a risk to the Trust or our ability to deliver compliance. | 3/12/17 Date to be confirmed |

## Estate Maintenance – Risk and Compliance in Clinical Areas (Board update paper January 2018)

**6. Decant ward plan**

The works detailed above will continue in line with the target dates and will significantly improve compliance over the next 18 months. This will provide extended mitigation until the new 60 bedded assessment unit is built and a programme of ward decants can begin.

| Action | | Comment/update | Due date |
|---|---|---|---|
| A | Following approval of 60 bedded assessment unit arrange meeting with COO and Deputy COO to agree outline ward decant plan. | A draft decant plan has been developed by Estates based on infrastructure risk. The draft plan is currently between 2 to 3 years but will not be able to start until the assessment wards are opened in June 18.<br>The draft plan has been based on Estates risks and has highlighted the wards with asbestos (Creaton and Benham)as a priority. The length of time each ward is closed varies; wards with asbestos could take 4 to 6 weeks whereas other wards can be done live to reduce time and cost.<br>The draft plan will be discussed with Deputy Chief Operating Officer to ensure that it supports operational needs of the site. Following agreement on the draft plan a project group will be set up to finalise and implement the plans. | 19/01/18<br>On track |
| B | Develop detailed plan of ward decants | This will follow the above meeting | 01/03/18 |
| C | Review progress of 60 bed scheme and update the actions in this plan | Scheme has been approved and will commence in July 17 and complete June 18. | Complete |
| D | Review potential locations on site for temporary ward | A location opposite the South entrance has been identified as the best option. This is no longer required with the new assessment wards providing capacity for decants. | Complete |
| E | Contract suppliers to discuss potential costs and location | Very high level indicative costs in the region of £2.2 million for 2 year hire and 3 year would be in the region of £2.7 million. These indicative figures include the one-off capital costs and the revenue costs for the building. | Complete |
| F | Develop temporary ward plan further | Following approval of the 60 bed assessment hub this is no longer required. | Complete |

Northampton General Hospital NHS
NHS Trust

| | |
|---|---|
| **Report To** | **Public Trust Board** |
| **Date of Meeting** | **25 January 2018** |

| | |
|---|---|
| **Title of the Report** | **Fixing the Flow** |
| **Agenda item** | **17** |
| **Presenter of Report** | Deborah Needham Chief Operating Officer / Deputy Chief Executive |
| **Author(s) of Report** | James Avery – Programme Director, Safer Emergency Care |
| **Purpose** | For Information & Assurance |
| **Executive summary** | |
| **Related strategic aim and corporate objective** | Focus on quality, safety and performance |
| **Risk and assurance** | Does the content of the report present any risks to the Trust or consequently provide assurances on risks N<br>Risk of not delivering performance standards<br>Associated fines<br>Patient experience<br>Reputation |
| **Related Board Assurance Framework entries** | BAF – 1.2, 3.1 |
| **Equality Analysis** | Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)<br><br>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 Committee**

The Committee is asked to:

- Note the performance report

Northampton General Hospital NHS Trust

**Fixing the Flow – Board report**

**January 2018**

1. Introduction

Fixing the Flow is our internal programme to improve patient flow across the hospital and address exit block from A&E. The programme was launched on 30th October 2017 and is split into 3 work streams

- **Assessment – ensuring effective patient pathways**
- **Discharge – delivering safe and efficient transfer of care processes for patients**
- **Site management – Responsive and proactive management of NGH clinical services and coordination of partners**

The expected outcomes of the programme are as follows:

- Standardisation across the hospital of operational practices for admissions, ward rounds and discharge processes
- Robust information to support effective management of our services
- Initiation of planning for discharge as soon as a patient is admitted
- Improved emergency access performance (A&E 4 hour target)
- Reduced bed occupancy; aiming for below 92% through reduced length of stay and admission numbers.
- Improved rates of safe patient discharge occurring each morning

Programme action and governance is maintained via work stream leads and a weekly full programme review chaired by an executive director.

The programme director for safe for emergency care, who will lead and coordinate the 'fixing the flow' project, has been in post from January 2nd. Actions to date include review of Work streams as part of induction and will result in full project plan focussed on delivering the

greatest impact. This work will initially involve close working with the Emergency Care support team to coordinate a Multi-Agency Discharge Event (MADE), a recognised methodology to address the significant number of patients with greater than 21 days length of stay. Senior leads from partner organisations will be required to attend NGH 22-25th January to action identified blocks to patient discharge.

**2. Work stream updates**

A: Assessment work stream update:

Smart Aim: By March 2018, to reduce the number of patients on Creaton/Benham by 10% from April 2017 baseline which remains on track.

Short Term Aim - 24th December 2017

The Short Term Aim predicted for 24 December 2017 to reduce the demand on MAU by 2.7% through the introduction of a 2 bedded functional SAU and RIF adult pathway was not achieved due to increasing Non-elective demand and the associated lack of capacity to operate a functional SAU on Hawthorn ward.

A trial is now being planned using best practice models of ambulatory surgical care as a template.

The longer term plan to introduce specialty medical staff basing themselves within ED and assessment units ( known as blended front door) was expedited and introduced on the 4th January 2018 due to increased None elective pressure and capacity demand. The support of senior medical colleagues was acknowledged and had a positive impact on ED attendance and admission conversion.

The Medical Director is supporting divisional teams to develop a revised senior rota to deliver a sustainable blended front door within ED to support early and safe discharge alongside prompt decision making

**Key achievements and actions in December:**

*(See (Appendix1) full action outline)*

1. Professional Standards defined and presented to consultant body with amendments following feedback. These standards show minimum time frames for patient review,

interspecialty review and support. Information team collating an indicator dashboard to mark weekly status

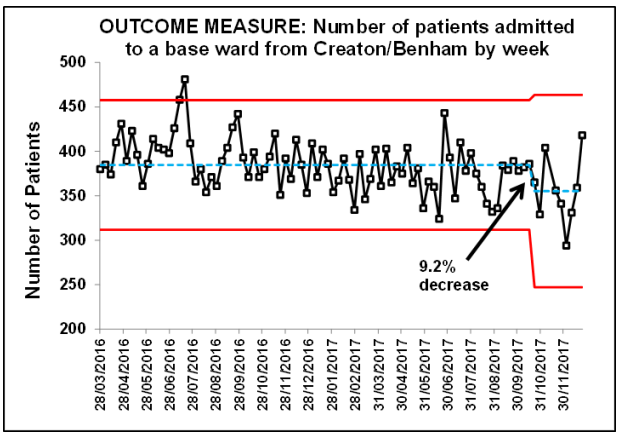
2. Discharge support Doctor role in place from Dec 14th and greatly supporting prompt prescription of discharge medication.
3. Following consultant meetings agreed to added front door support from specialties. This has been delivered in early January with good effect.
4. Trial of 'board 'rounds' commenced in Collingtree ward. These enable early morning prompt identification of patient in need of review and those who may be discharged.
5. Addition of frailty actions to the assessment work stream. This will provide support to the clinicians leading this work and prevent duplication.

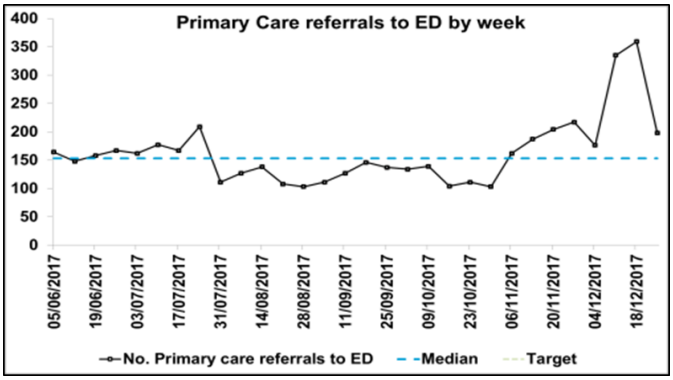
As of January 2018, the following improvement actions are complete and are now part of business. Each will receive ongoing monitoring on effectiveness.

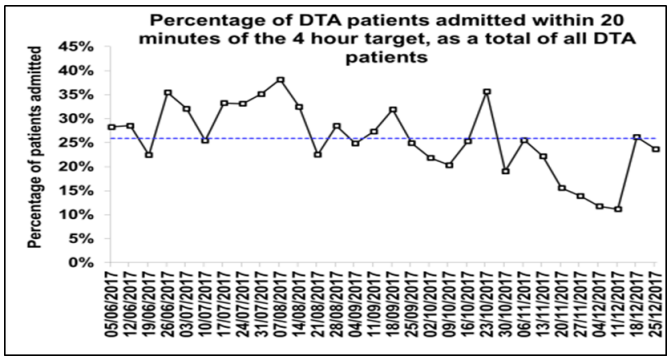
**Assessment work stream improvement initiatives now business as usual.**

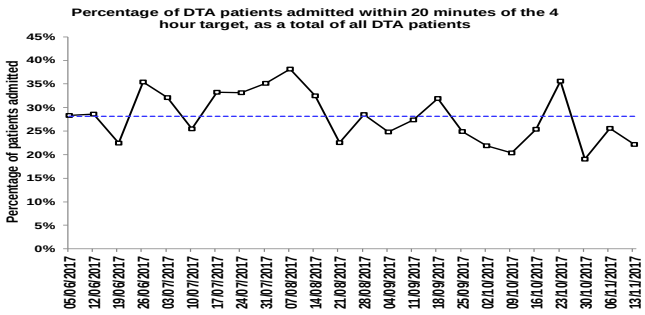
| |
|---|
| 0830hrs sign in sheet for medical staff on MAU |
| Medical staff daily contact information available for nursing staff on MAU |
| Rapid Transfer handover sheet |
| Ops Doc (Mon-Fri) |
| Communication on MAU (iPhones) |
| ACC functionality (new SOP) |
| Clinic overruns to ACC |
| Right Iliac Fossa Pain pathway |
| Postponed patients on the emergency list (Gen Surg) |
| Discharge Doctors |
| Training the urgent care floor |

## Work stream metrics



**B: Discharge work stream**

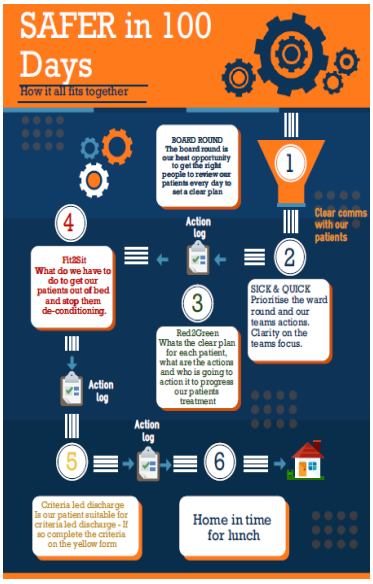
*(See (Appendix1) full action outline)*

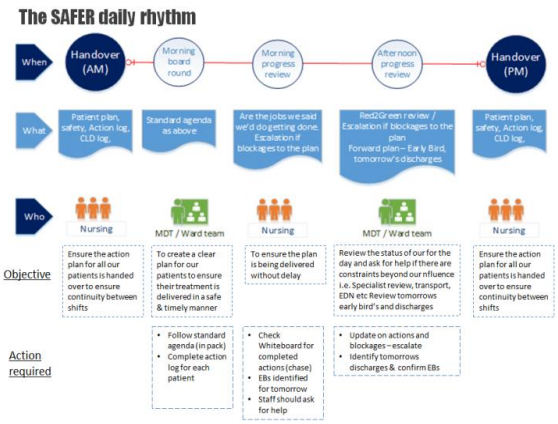
The work stream aims to achieve a greater level of safe patient discharge earlier in the day making use of criteria led discharge, effective board rounds and improvement tools such as ' Red 2 Green'

Having reviewed the programme delivery to date the team note a grasp of key concepts however this has not provided the impact required. Having trialled each element of the programme with nursing responsibility a 'SAFER' programme of teaching and on ward intensive support has been devised. This will encompass all programme aims. Delivery will begin before month end with a clear intention to deliver with pace and to establish sustainable change.

**Fig 1 SAFER' programme components**

Fig2. Describes the daily rhythm ward teams will adopt.



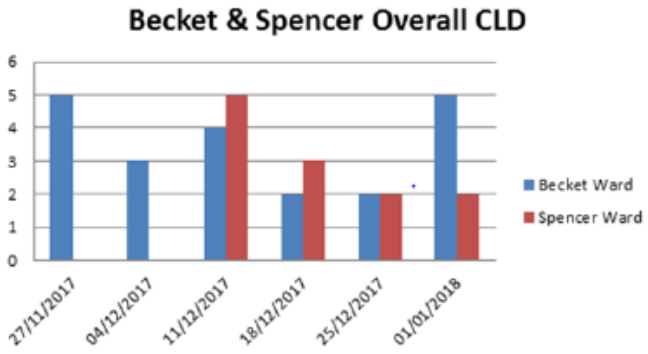




The roll out plan will be focused in 3 waves starting in medicine. Each wave will include 7 wards and last 2 weeks followed by sustainment auditing and further support if required. Each ward will have a full time coach assigned for the 2 weeks to support the ward adopt the new ways of working and help to solve problems as they arise.

**Treatment 1** - Criteria led discharge – Sponsor: Natalie Green

**Objective:** Design and Implement criteria led discharge to enable earlier discharge

**Update:** Week 6 saw an improved level of criteria led discharge. Support and training continues to these areas continue led by the senior nursing team.




**Treatment 2.** - Avery model review (HL) Sponsor: Jason King

**Objective:** Improve the model to facilitate weekend take to Avery, Improved clinical model to support reduced length of stay, Investigate contract renegotiation

**Update:** An updated criteria has been produced and action undertaken to enable a wider patient group to access this service. The proposed mapping exercise did not take place due to operational pressures.

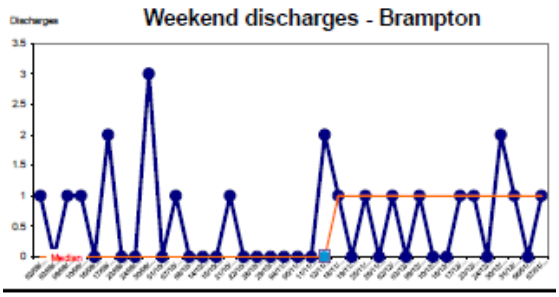
**Next steps:** Undertake postponed mapping exercise and pathway review

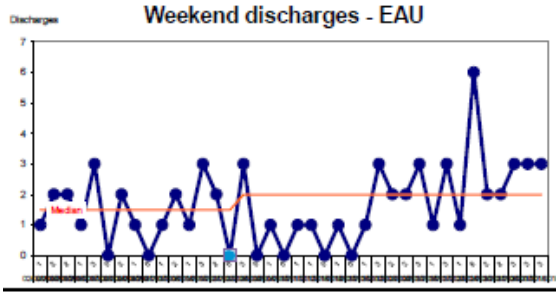
**Treatment 3.** - Weekend discharge Sponsor: Fiona Barnes

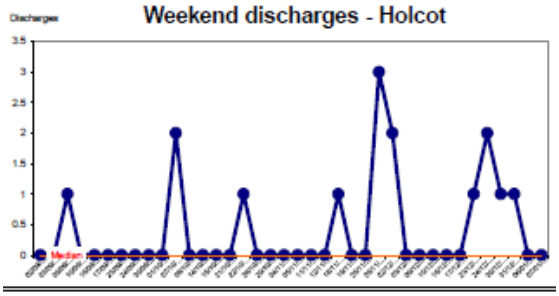
**Objective:** Improve weekend discharge processes and communications

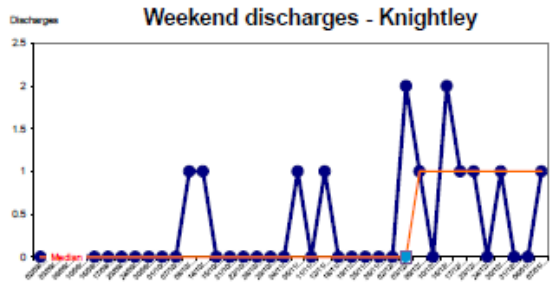
**Update:** Trial continues within 4 Ward teams (Becket, Holcot, Creaton, Brampton) Therapy and medical staff weekend plan stickers established to ensure consistency over weekend. Issues with compliance of medical staff checklist being addressed

Discharge Work stream metrics



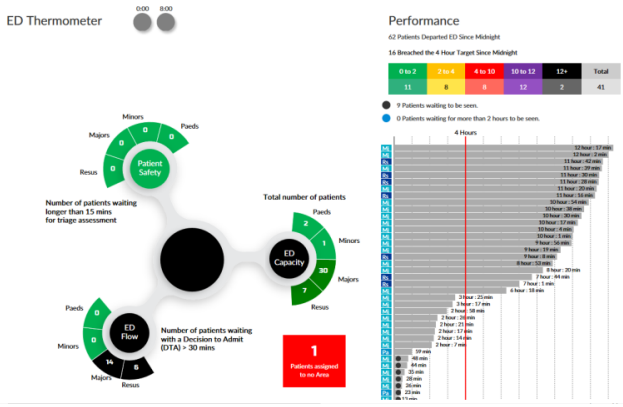



**C: Site Team**

This work stream aims to deliver effective site management over the 24hour 7 day period using dedicated staff to monitor and act to sustain patient flow.

The existing site team has benefited from a capacity manager secondment from the emergency care support team for three months. The delivery of an electronic discharge tracking and bed status report alongside Trust PC display of status and expected admissions has provided benefit to site operations with prompt escalation. This system is being further developed to include ward level required discharge levels alongside delivery of a live emergency care status dashboard: (fig1)

Fig 1 Live status ED Dashboard (Developed by CIO)




The improved level of information and proactive site management has supported the process of rapid transfer to wards from ED and prevention of patients returning to assessment units. Recruitment is under way to fully establish the site and capacity coordinator roles to provide a full 24/7 service.

**Conclusion**

Work stream updates demonstrate progress to understand and manage the organizations emergency pathway and expedite safe patient discharge. The acceleration of front door specialty clinician actions has provided support in a period of extreme challenge to the system.

The delivery of a multiagency event in January will provide further much needed support to expedite discharge and reduce occupancy rates which are providing a daily challenge to the organisation.

Revision of the delivery of key principles to support prompt safe discharge *(board rounds, Red to Green & safe discharge bundle, wider project planning)* will enable an improved impact and ability to sustain these changes to practice.

**Recommendations**

The board is asked to note this update

James Avery
Programme Director – Safer Emergency Flow

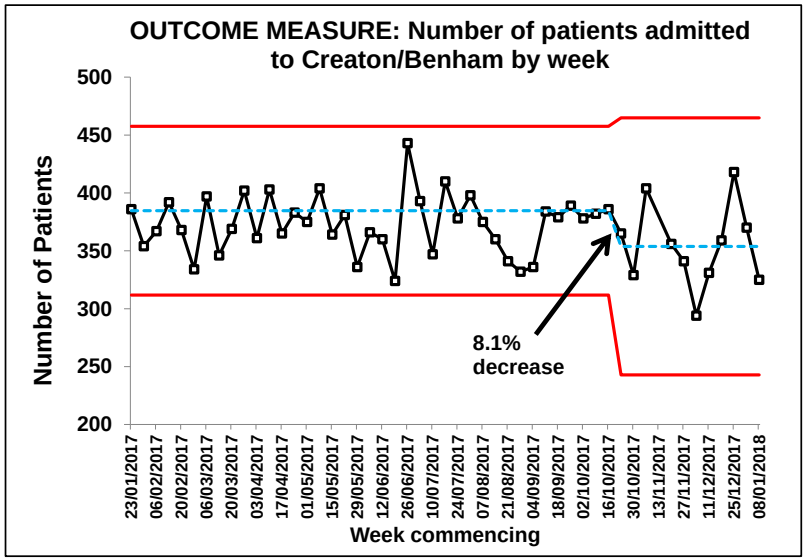
Northampton General Hospital
NHS Trust

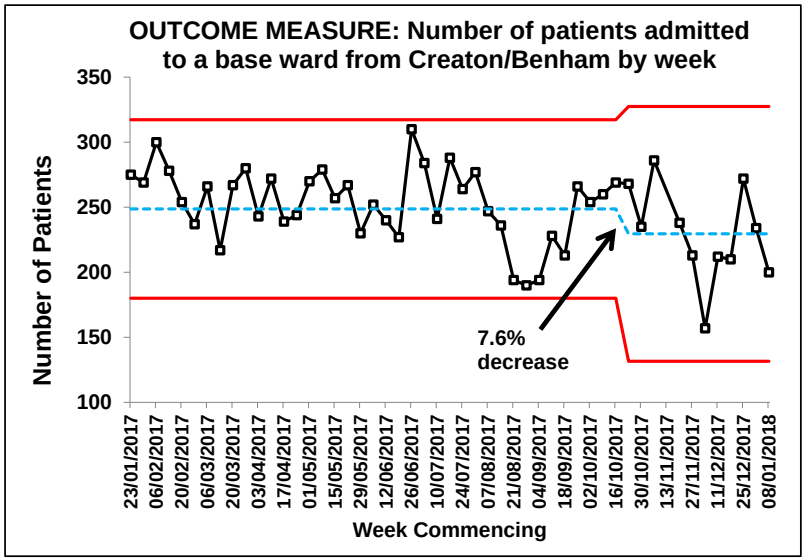
# Fixing the Flow

**16th January 2018**

**Assessment**

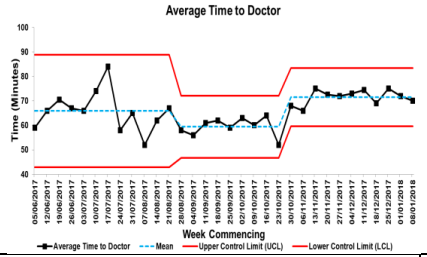
**SMART aim: By March 2018, to reduce the number of patients on EAU/Benham by 10% from the April 16-Sept 17 baseline.**



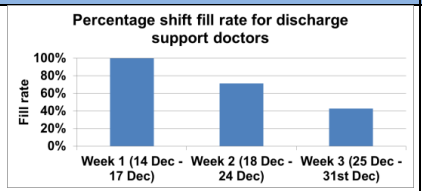
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| MEDICAL WORKFORCE: Professional Standards **SS** | Develop a monitoring tool for professional standards | Metric for three of the current 9 standards agreed | *An emergency department (ED) decisiosn making clinician will see new patients on arrival in ED*   | Refine professional standards: identify standards that are professional expectation and associated compliance tool where applicable.<br>Re-circulate professional standards |
| MEDICAL WORKFORCE: Medical r/v at the weekend **GR** | Increase senior medical review at the weekend and develop a SOP for the ED Acute Medical Consultant at the Front Door | review and redesign of the medical workforce, we have increased consultant led cover for the weekends and weekdays to support the demand in the interim. Also earlier commencement of ward rounds in assessment areas to identify early discharges have commenced from the 2nd of January. We have also commenced Regular Huddles with ED at 0800 and 1700. | Data TBC<br><br>Early discharges from assessment areas | Develop a sustainability plan<br><br>Confirm draft SOP for the ED Acute Medical Consultant at the Front Door is fit for purpose circulate to consultant workforce |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| MEDICAL WORKFORCE: Winter Discharge Doctors to improve flow **JB** | Further develop and embed process and hand over to Medical Staffing. | QI team developed and led discharge support doctor role and rota.<br><br>Rota commenced 14th Dec. |  | Handed over to medical division Tuesday 2nd Jan 2018.<br><br>Initiative to continue to March 2018 (NHSI Winter Funding)<br><br>Business as usual. Exceptions to be reported to FTF via DM for M&UC |
| MEDICAL WORKFORCE: Internal consultant communication **GR** | Replace green card referral with phone based system. | Appointed medical lead to work alongside deputy COO to replace a green card system with a phone based system. Dr. Kumaran to lead clinically on this project. Update and milestones to be submitted in 3 weeks. | Outcome measure = Average time from referral to review.<br><br>Base line date expected 6th February 2018 | PDSA commence February 2018<br><br>Full implementation April 2018<br><br>Evaluate impact of PDSA.<br><br>Confirm interconnectivity and transition with care flow module |
| MEDICAL WORKFORCE: Additional cover in the evenings in ED and Assessment Areas **GR** | New treatment | Developed a job card and SOP | Data to follow:<br>- 4 hr standard in evening.<br>- Attendance-to-admission conversion rate in evenings. | Volunteers to be identified.<br>Trial to commence 9th Jan 18.<br>Draft SOP to be confirmed and circulated |

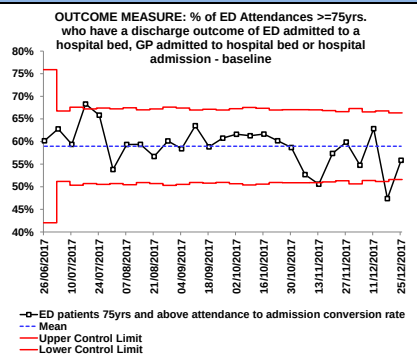
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| MEDICAL WORKFORCE: Medical workforce recruitment strategy **GR** | New treatment | Identify in the division in collaboration with finance and HR. identified approved suppliers to cover the existing gaps on long term placements. Awaiting a final plan on the appointment and deployment plans. | Data to follow:<br>- Attrition rate<br>- Vacancy rate<br>- Jobs in the pipeline | RG and AJ to collaborate with HR<br><br>Develop Draft SOP for locum workforce **(QI)** |
| ASSESSMENT BEST PRACTICE: Physician at the Front Door (blended front door) | Adopt a military model for specialties with high numbers of NEL attendances. | Discussed with consultant colleagues to adopt a military model for specialties with high numbers of NEL presenting to ED.<br><br>Agreed specialty to trial.<br><br>SOP to adopt Sick/Quick /Routine to manage overflowing demands. | Data to follow on peak times:<br><br>- Number of attendances to ED<br>- Number of patients referred to T&O for specialty review<br>- Percentage of T&O patients admitted. | PDSA at peak times of attendance in ED during January.<br><br>T&O first specialty to trial.<br><br>Test of change will be refined and built in to job plans as part of the new acute medical model. |

Northampton General Hospital NHS Trust

# Fixing the Flow

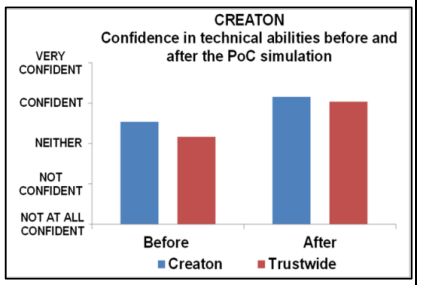
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| ASSESSMENT BEST PRACTICE: Frailty<br>Adopt a whole system perspective building upon a shared common vision/quality of care for older people across the whole patient pathway (acute and community settings).<br><br>**PS** | Previous work streams<br>1. Development of a Primary Care Coordinator/Collaborative Care Team Coordinator<br>2. Scoping of an alternative option to community beds which are not available<br>3. Confirmation and testing of an Assessment Model including initiation of CGA within 24hrs of admission<br>4. Exploration into the possible implementation of an advice line<br>5. Introduction of therapies at the front door (admission avoidance and optimisation of an average LOS) | Possibility of part time secondment from CCT to enable identification of patients and direct liaison with the appropriate CCT to expedite discharge explored. Confirmation of the role through sourcing of a job description from Leicester Hospital and discussed with the GP federation to identify resources OUTCOME: unsuccessful due to the GP Federation confirming there was no current capacity available and that coordinating resources from CCT would need to be funded from NGH. Alternative resources were explored and none were concluded as suitable or available OUTCOME: CEM Specialist Nurses proposed and put in a place a process to enable direct referrals from themselves to the CCT. CEM referrals are now live however opportunities are low as patients have either declined/not suitable therefore referral criteria needs to be reviewed. |  | Setting of clear expectations of the project for both acute and partner organisations, through the creation of measurable outcomes and milestones to demonstrate progress.<br><br>Identification of internal and external key stakeholders who will support the documenting and delivery of the rapid cycles of change and milestones outside of the FTF meetings.<br><br>Define pathway as part of Medical Model for new Assessment Hub. Develop frailty at the front door process.<br><br>Scope of possibility of virtual ward rounds with GPs and the use of Consultant Connect. |

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| | | The group received confirmation no community beds were available and therefore made the decision to await the patient outcomes of the Consultant Connect advice line to inform new patient pathways.<br><br>Baseline audit of CGA compliance within 24hrs measured and reported. Combined CGA document for use by the MDT to record assessment outcomes created, piloted, reviewed and implemented.<br><br>Consultant Connect implemented.<br><br>Model piloted, reviewed, temporarily funded with KPI reporting ongoing. Business case for permanent funding supported and awaiting approval. | | |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| ASSESSMENT BEST PRACTICE: Medical Model for new Assessment Hub **GR** | Develop transparent and efficient pathways to transferring best practice to new assessment hub | Strategic patient pathways for new Hub proposed | TBC - | Test pathways |
| ASSESSMENT BEST PRACTICE: Training the urgent floor team | Confirm numbers booked for urgent care training 21st Dec.<br><br>Monitor performance of further PoC sim on Creaton/Benham.<br><br>Identify best practice for medical assessment floor via PDSA. . | Evaluated feedback from Point of Care Simulation on Creaton and Benham 19/12/17 |  | PoC simulation in new assessment hub. Dates tbc<br><br>Business as usual. |
| ASSESSMENT BEST PRACTICE: Short Stay Assessment Bay (EAU 6 beds) | Trial planned 11/12/17 | Trial date currently delayed due to non-elective demand | Data to follow | Evaluate impact of assessment bay.<br><br>Obtain feedback on SOP. |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| ASSESSMENT BEST PRACTICE: Smart ward rounds **GR** | New treatment | Developed a SOP for Smart Ward Rounds, to increase flow earlier in the day SOP to adopt Sick/Quick /Routine to manage overflowing demands. | Trial commneced collingtree ward 8 janaury 2018 – first PDSA - Data to follow | PDSA - roll out plan to be developed |
| ASSESSMENT BEST PRACTICE: Urgent care One stop ward round **GR** | New treatment | Identified best practice during ward round. | Data to follow | PDSA on urgent floor. |
| ASSESSMENT BEST PRACTICE: Wait times for coronary angiograms on Benham/ Creaton **GR** | New treatment | Identified demand and agreed pilot. | Data to follow on average wait time for angiogram | Cardiology training staff. Pilot planned for new protocol w/c 8 Jan 2018. |
| SURGICAL ASSESSMENT Surgical Assessment Area **NG / FG** | Planned trial on 11/12/17 deferred due to operational pressures | Planned trial deferred due to operational pressures.<br><br>Version 7 of SOP circulated for approval. | Data to follow | Evaluate impact of SAA<br><br>Impact monitored by ADN Surgery. |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| SURGICAL ASSESSMENT Postponed patients on the Emergency list (Trauma) **FG** | Do today's work today for trauma patients | | 1st Jan – 7th Jan<br>No. on trauma list: 66<br>No. of Operations: 42<br>No. of Cancellations: 24<br>14 of 24 cancellations were due to lack of time. | Process developed to capture on-going data to be collected on trauma cancellations and overnight stays |

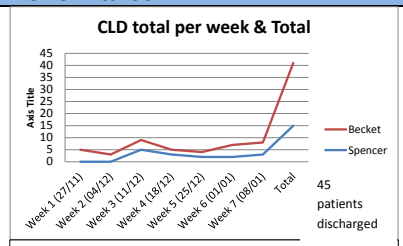
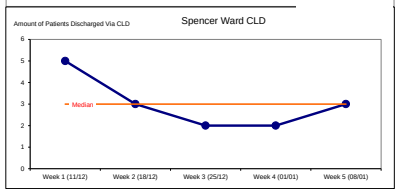
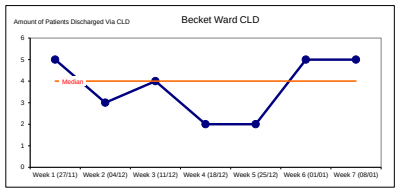
## Assessment: Processes embedded as part of Fixing The Flow

| | Treatment | Gatekeeper | Date |
|---|---|---|---|
| **1** | 0830hrs sign in sheet for medical staff on MAU | Medicine & Urgent Care ADN | 11/12/2017 |
| **2** | Medical staff daily contact information available for nursing staff on MAU | Medicine & Urgent Care ADN | 11/12/2017 |
| **3** | Rapid Transfer handover sheet | Medicine & Urgent Care ADN | 11/12/2017 |
| **4** | Ops Doc (Mon-Fri) | DD Clinical Support Services | 11/12/2017 |
| **5** | Communication on MAU (iPhones) | CIO | 11/12/2017 |
| **6** | ACC functionality (new SOP) | DD Medicine and Urgent Care and CD Urgent Care | 11/12/2017 |
| **7** | Clinic overruns to ACC | DD Medicine and Urgent Care and CD Urgent Care | 11/12/2017 |
| **8** | Right Iliac Fossa Pain pathway | DD Surgery | 11/12/2017 |
| **9** | Postponed patients on the emergency list (Gen Surg) | DM Surgery | 11/12/2017 |
| **10** | Discharge Doctors | DM Medicine | 02/01/2018 |
| **11** | Training the urgent care floor | DM Medicine | 09/01/2018 |

Northampton General Hospital NHS Trust

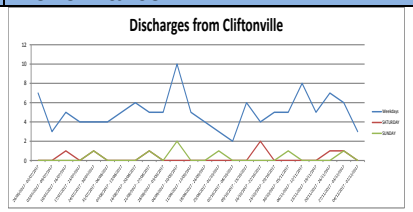
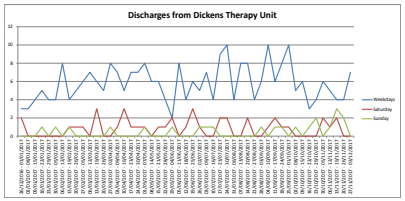
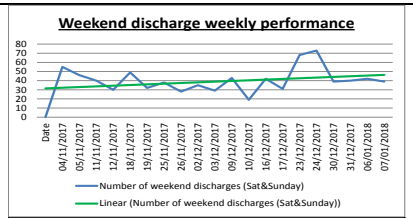
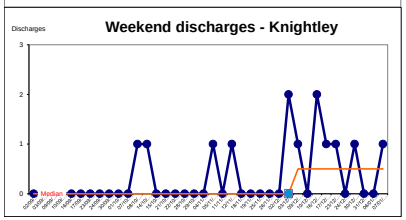
# Fixing the Flow

## Discharge

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| Criteria led discharge (NG) | Design and Implement criteria led discharge<br><br>Agree the AHP roles and process to support CLD | Continued trial Becket & Spencer<br><br>SI supported daily trial (process) on both wards<br><br>Attended the consultant meeting with interest from a number of doctors to be followed up, particularly Assessment wards<br><br>Excellent AHP engagement with CLD trial on both Becket and Spencer<br><br>Struggled with Consultant engagement on Spencer in Dr Kiyani's absence (escalated)<br><br>*As a result of the process the feedback from the teams is that even though the volume of patients going through CLD is small the quality of the patient plan has vastly improved* |  <br>  <br>  | Continue the trial and coaching on Becket ward and Spencer ward<br><br>Continue senior team visibility on both Becket and Spencer wards<br><br>Communicate reporting via EDN button with doctors<br><br>Gather ward staff feedback from Becket ward<br><br>Understand / escalate Spencer Ward consultant/junior changes<br><br>**Roll out to be part of the SAFER in 100 days programme** |

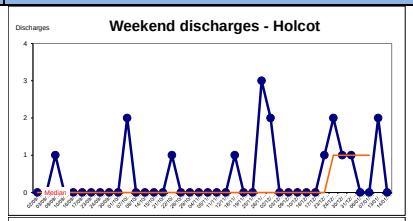
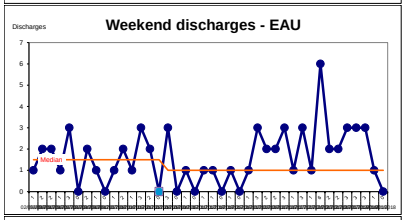
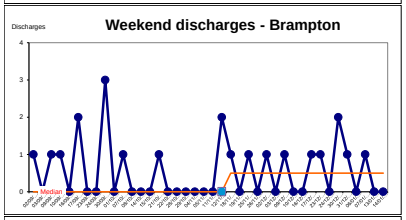
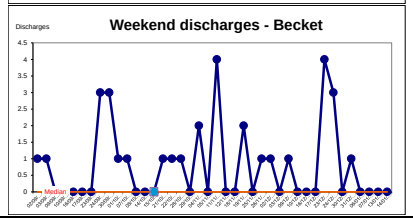
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| Avery model review (JK) | Review documentation<br><br>Commence trial 6/12<br><br>Contact team at Wolverhampton (details from AA) re processes/ ideas on implementing Red2Green | MDT on 15/12 was cancelled/postponed due to Trust position<br><br>Process mapping of MDT 20/12 cancelled – No NGH team attended |  <br>  | Reschedule cancelled sessions<br><br>Continue with trial on Brampton and EAU<br><br>Further work to be discussed on the processes, communication and the benefits of ward self-referral<br><br>Contact team at Wolverhampton (details from AA) re processes/ ideas on implementing Red2Green – has this been done? |
| Weekend discharge (FB) | Weekend discharges equates to 85% of the average weekly discharge rate<br><br>Weekend discharge team to be substantive and rostered | 100% compliance on the doctor handover checklist last weekend – Continue to monitor<br><br>90% compliance last weekend the quality and clarity of the weekend discharge planning stickers<br><br>Discuss with Carl - weekend manager on call checklist with the site work stream to lead the medical handover |  <br>  | Measure the quality of the discharge list – 26/1/18<br><br>Measure the quality and clarity of the weekend discharge planning stickers 90% compliance last weekend 26/1/18<br><br>Ward teams continue to add stickers into all notes on the 6 wards on Wednesday / Thursday night to document the weekend plan for each patient to support the weekend team. |

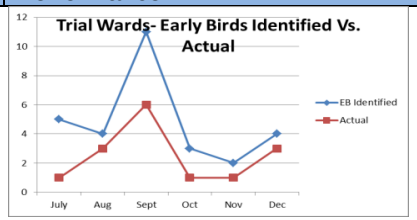
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| | | |  <br>  <br>  <br>  | Catch up with nursing team on Thursday – PDSA for next weekend<br><br>**Roll out to be part of the SAFER in 100 days programme** |

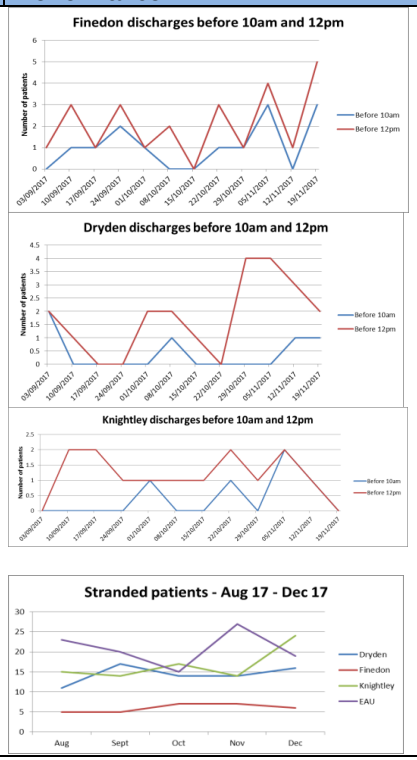
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| Early Bird Discharge Lounge (DS) | Agree the process for capturing the information to improve our volunteers early bird discharge rate | Strengthened comms at the huddle and on the wards this week |   | Continue to spread the word of the early bird using the huddle, ward visits and communications<br><br>Agree a clear definition of an early bird.<br><br>**Roll out to be part of the SAFER in 100 days programme** |

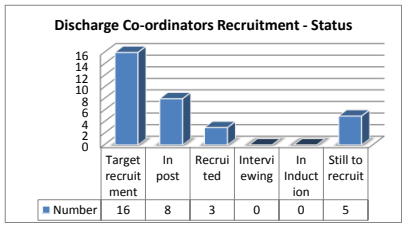
Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| **Supporting patients to leave hospital**<br><br>**Red to Green(DS)**<br><br>**+**<br><br>**SAFER (DS)**<br><br>Focus on F in this work stream<br><br>S - Senior Review.<br>A –Expected Discharge Date (EDD)<br>F - Flow by 10am<br>E – Early discharge.<br>R – Review. (MDT) | Circulate the implementation plan 5/12 and update the ward champions<br><br>Theme each day at safety huddle (Video / leaflet)<br><br>To realign Red2Green, PJP, Fit to Sit, SAFER, for next week.<br><br>S<br>A – R2G<br>F – Early bird / CLD / R2G<br>E – Early bird / R2G<br>R - | Further training and coaching on dashboard, with ward clerks and co-ordinators – dashboard had faults in so had to stop using<br><br>Newsletter to be drafted and given out at huddle and distributed across wards<br><br>Escalation process drafted<br><br>Pete Gordon ran an information session for Therapies 10th January |  | Meet with IT re dashboard integration<br><br>Further dashboard coaching<br><br>Andy Aldridge to visit each ward to talk through R2G with ward sisters (focus on EAU as KK was not here when started last time)<br><br>Complete scenario examples to make R2G clearer<br><br>Drafting compelling story with Eva and staff member<br><br>**Roll out to be part of the SAFER in 100 days programme** |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next steps |
|---|---|---|---|---|
| PJ Paralysis / Fit to Sit (DS) | To avoid our patients deconditioning by identifying those each morning that are able to get out of bed and get dressed | Designing a pop up banner to go outside wards to communicate to staff and families/carers – delayed due to Trust pressure<br>Compliance needs to be assessed | Data to be incorporated in the R2G dashboard | Ideas sent to Laurence Neale for creating pop ups<br>**Roll out to be part of the SAFER in 100 days programme** |
| LOS>20 Days Peer review (Raghu) | Peer review of long stay patients with >LOS of 20 days to ascertain the medically fit status | Meeting held on 8/1/18 to agree the scope and terms of the review. How to conduct the review and by who. | | |
| Discharge co-ordinators | Recruit to full establishment<br><br>Confirm roles and how the discharge co-ordinators interact and work with the ward/external teams | New job advert has been issued with an updated description<br><br>Team photograph has been sent to Andy Belcher to attach to the social media campaign. This will also include a link to the NHS jobs application.<br><br>SOP agreed<br>Screen saver created by Eva has been agreed to advertise to HCA population<br><br>Chased HR regarding 3 applicants awaiting start dates etc. |  | Send statement piece to Eva to include in the next Comms update describing the role of a discharge co-ordinator.<br><br>Andy Belcher social media campaigns to be released |

Northampton General Hospital NHS Trust

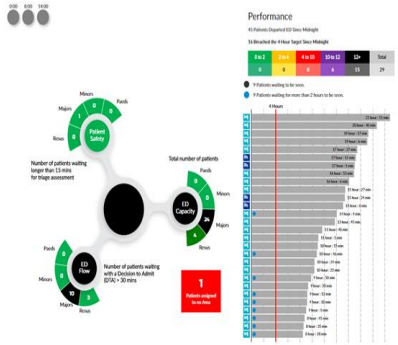
# Fixing the Flow

## Site

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| Test bed managers in assessment units **Owner CH** | Put senior site manager into the Assessment hub (EAU and Creaton) and one in site office | Risked assessed the capacity and ability of the current workforce to successfully implement the treatment. | • Transfers out each day from assessment areas.<br>• Improved discharges each day<br>• Increased rapid transfer within 30 mins to base wards<br>• Reduction in patients staying >48 hours<br>• No patients returning to assessment from base wards | Ongoing work in this area has had to stop due to gaps in rota for site team due to long term sickness. Will continue to work with assessment teams to prioritise actions from the initial report 18/12/2017 – This treatment is currently on hold – VCP panel has approved the recruitment to add to the team for an 8a and band 5 (two staff on long term sick) |
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
| Predictive information for the site team **Owner HM** | Start using daily discharges on white board | Bed managers updating white boards every 2hrs and LOS issues being challenged with wards | N/A | IT have tested one of the possible suppliers of touch screen white boards with the intention of purchasing and rolling out the implementation of the board onto all of the wards. Implementation date TBC. |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| Daily Information **Owner HM** | Go live with A&E dash board | A&E dashboard screen saver simplified and working.<br><br>There is an issue moving this to the wallpaper which we are currently working on – until then it will remain as a screensaver |  <br>  | |
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
| Test 2 site managers at night **Owner CH** | Trial additional site manager to improve flow process overnight | Suggested that once the ward move has taken place and settled to action the treatment for a trial period target would be end November | • Patients allocated to the right beds and the right time,<br>• % of overnight breaches of from 7pm to 7am<br>• Numbers of empty assessment spaces each morning | **This treatment is currently on hold due to the current sickness and vacancy levels within the team. Possible move towards moving x2 bed** |

Northampton General Hospital NHS Trust

# Fixing the Flow

| | | | | |
|---|---|---|---|---|
| | | | • No patients returning to assessment from base wards<br>• Reduction in patients staying >48 hours<br>• | **managers on to assessment floors Mon – Fri 09:00 to 18:00** |
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
| Site Team Review by ECIP<br>**Owner CH** | To identify best practice elsewhere and implement at NGH | Review with ECIP to begin 12.12.17 | | Interim Site capacity manager from ECIP in post and developing updated dash boards and processes to ensure continuity of service 24/7 |
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
| Escalation Process review<br>**Owner CH** | Review current triggers to create more action before hitting OPEL4 (Black) | Review criteria<br>Develop clear actions<br>Develop action card for all staff | Reduction in escalation to Level 4 | Best practice reviewed from other trusts and draft new escalation plan being drawn together. Expect first completed draft by 11.12.17 New structure for site 'drum beat' to be tested live W/B 18th Dec. Action card send out to all teams for review and are now due back. Currently working with partners to agree county wide triggers |

Northampton General Hospital NHS Trust

# Fixing the Flow

| Treatment | What we said we'd do | What we did | Performance | Next Steps |
|---|---|---|---|---|
| 'SAFER' start to 2018 | 'Breaking the cycle' type event to be run W/B 15th Jan 2018 | Multi-organisation input to improving patient flow post-Christmas being planned with support from ECIP | At beginning of week we started the days with a bed position of -100+ by Friday this was down to -50 | Ward Liason officers allocated to every ward all week to support process along with extra medics allocated to the 'blended front door' and base wards with ward rounds starting at 7am on assessment and consultant cover into the evening. Daily 3 hour tracking meetings and spot purchase beds added to the challenge to our partners. Site feels safer now but we now need to start working as normal and reduce the breaches |
| Treatment | What we said we'd do | What we did | Performance | Next Steps |
| Multi- Agency Discharge Event (MADE) | Trust are organising a multi-organisational event to take place on the 22nd Jan 2018 | Outcome to be reported after event |  MADE briefing Jan 2018 ver1.0.docx TCB | Hand out to be tabled. |

Northampton General Hospital NHS
NHS Trust

**COMMITTEE HIGHLIGHT REPORT**

| |
|---|
| **Report to the Trust Board: *25th January 2018*** |

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

**Executive Summary**

**The Committee met on *13th December* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).**

| **Key agenda items:** | **Board Assurance Framework entries** *(also cross-referenced to CQC standards)* |
|---|---|
| • Finance report<br>• Formal Recovery Plan<br>• Changing Care<br>• Operational performance<br>• IT Committee | |

**Key areas of discussion arising from items appearing on the agenda**

- **The Trust is off plan by £6.8m, £3.1m of this is underperformance and the remainder is lost STF funding due to the underperformance.**
- **£700k overspend on pay in month still not well understood.**
- **Financial recovery plan reviewed and committee challenged whether its feasible to get back to plan.**
- **Changing Care programme reported n plan but issues raised as to actual cash savings being delivered – being reviewed**
- **A&E performance remains under pressure, cancer is an improving picture.**
- **Commercial discussions on Diagnostics**
- **Issues with PAS implementation and dispute with Camis.**

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

- The committee recommends the Board considers formally revising our forecast year end outcome.
- Review of Changing Care deliverables to reflect actual Cash savings.

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

- The significant increase in pay was not fully explained and represents a gap in control and assurance, which should be explored by the Board.

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

**Action required by the Board**

Northampton General Hospital NHS
NHS Trust

**COMMITTEE HIGHLIGHT REPORT**

**Report to the Trust Board: *25th January 2018***

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

**Executive Summary**
**The Committee met on *17th January* 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 Recovery Plan
- Changing Care
- Operational performance
- Benefits Realisation
- Risk register and BAF
- IT Committee

**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 £10.6m YTD, £6.1m of this is underperformance and the remainder is lost STF funding due to the underperformance. This is a significant deterioration in month by £3.8m, coming from pay, non-pay and unachieved STF.
- The Committee recognised the continuing Winter pressures are a significant contributory factor to this financial deterioration as well as the performance on key targets such as A&E. Winter pressures started earlier than in previous years as demonstrated by increased acuity as far back as September and given the mandated cancellation of elective surgery in January the financial pressures are likely to get worse, although forecasting this impact is particularly challenging.
- In addition to the winter pressures, there continues to be under performance and a lack of understanding in some areas
- The Financial Recovery Plan illustrates that the Trust will almost certainly not achieve Plan, however the variation of outcomes is very wide (£1.5m to £9.5m adverse) and not currently well enough understood for the reasons referenced above.
- The committee recommended the Trust place itself in Internal Turnaround to address the situation
- The Committee recommends the Regulator is advised of the above in writing, but can not meet the requirements of the Protocol for Changes to an In-Year Financial Forecast at this stage until further work is completed under the Internal Turnaround programme.
- Changing Care programme reported just off plan but the issues raised last month as to actual cash savings being delivered and the evidence of conflicting reports around divisional CIPS led to a low level of confidence in the actual delivery of the financial savings.
- The Committee has requested the Changing Care report is reviewed and rewritten to ensure

it Reports the actual savings delivered to the Trust

- A&E performance remains under pressure, exacerbated by the winter pressures, cancer performance continues to improve.
- Benefits realisation Report there was a significant number of business cases that had not been delivered, and the committee requested greater clarity on the actions taken to stop the activity where the proposed investment has not delivered.
- Corporate Risks were reviewed and it was agreed the core financial risks would be increased in light of the current position
- Issues with PAS implementation are largely resolved.

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

- The Changing Care report is to be rewritten to reflect actual Divisional CIP delivery and cash savings to the trust.
-

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

- The significant increase in pay and non-pay became more explicit through the commentary in respect of the M9 finance report. This commentary brought the issues into sharper focus and this focus needs to be included in future written reportsThe committee concluded the Changing Care programme now requires a refresh in light of the current position and this includes the redefining the savings elements versus run rate reductions. This would give greater clarity to the Committee and the Board.
- The committee recommends the Board places itself in Internal Financial Turnaround
- The committee recommends the Board notifies our regulator in writing regarding our significant financial challenges and the work we are undertaking to understand the likely Financial Outturn for the current financial Year.

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

**Action required by the Board**

Northampton General Hospital NHS
NHS Trust

**COMMITTEE HIGHLIGHT REPORT**

| |
|---|
| **Report to the Trust Board: *25 January 2018*** |

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

**Executive Summary**

**The Committee met on *15 December 2017* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).**

| | |
|---|---|
| **Key agenda items:**<br><br>**Quality Improvement Scorecard**<br>**Nursing & Midwifery Report**<br>**Medical Directors Report**<br>**Annual Self-Assessment of Effectiveness**<br>**Patient Feedback Report**<br>**Communication Deep Dive**<br>**Research and Development Re[port** | **Board Assurance Framework entries** *(also cross-referenced to CQC standards)* |

**Key areas of discussion arising from items appearing on the agenda**

**Delay to the Maternity Governance report noted and this will be delivered to Jan. QGC**

**Imaging backlog had reduced from 2000 to a few hundred despite 50% vacancy rate in the directorate.**

**The Children's Services (NCC) discussion regarding risks, mitigations and actions.**

**Thanks to the Estates Team where recorded for their work during the snow and Ice.**

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

**Delay to the Maternity Governance report noted and this will be delivered to Jan. QGC**

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

Children's services (NCC) – Mitigation in place at NGH

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

**Action required by the Board**

Northampton General Hospital NHS
NHS Trust

**COMMITTEE HIGHLIGHT REPORT**

| |
|---|
| **Report to the Trust Board: *25 January 2018*** |

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

**Executive Summary**

**The Committee met on *13 December 2017* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).**

| **Key agenda items:** | **Board Assurance Framework entries** *(also cross-referenced to CQC standards)* |
|---|---|
| • Workforce performance<br>• Safe Nurse Staffing<br>• Engagement survey<br>• Annual self-assessment/TOR | |

**Key areas of discussion arising from items appearing on the agenda**

- Flu-Jab campaign - achieved CQUIN and positioned 3rd in the Region out of 55 Trusts. Success attributed to 'jab n grab' initiative, trolley rounds and communications.
- Engagement survey – initial response rate of 35%, below 2017 (32%) and below national average (40%). Next time, focus on paper based survey in clinical areas.
- Appraisals/Training – sustainable improvement over 2 years acknowledged
- TOR – feedback required on terms of reference

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

- Need to increase uptake of flu jabs in Maternity
- Feedback required on Terms of Reference (TOR) by end of January

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

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

**Action required by the Board**

Northampton General Hospital NHS
NHS Trust

**COMMITTEE HIGHLIGHT REPORT**

| |
|---|
| **Report to the Trust Board: *25 January 2018*** |

| | |
|---|---|
| **Title** | **Audit Committee Exception Report** |
| **Chair** | **David Noble** |
| **Author (s)** | **David Noble** |
| **Purpose** | **To advise the Board of the work of the Trust Board Sub committees** |

**Executive Summary**
**The Committee met on *15 December 2017* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).**

| **Key agenda items:** | **Board Assurance Framework entries** *(also cross-referenced to CQC standards)* |
|---|---|
| Review of BAF and Corporate Risk Register<br><br>Internal and External Audit Progress reports<br><br>Counter Fraud report<br><br>Registers of waivers, losses and special payments and salary overpayments | |

**Key areas of discussion arising from items appearing on the agenda**

See below

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

The committee were informed that the BAF risk rating for CAMIS/PAS had been increased. The committee endorsed this view.

The committee asked the Workforce Committee to review the risk of Junior Doctor retention.

TIAA will conduct an audit into pharmacy stock in February. In view of last years audit letter from KPMG this audit may require very rapid follow up.

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

Limited assurance reports were received from TIAA on Medical Staffing and Medical Records. The Committee actioned the Workforce Committee and Quality Committee to follow up these audits.

| | |
|---|---|
| **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**<br><br>To note | |

Northampton General Hospital
NHS Trust

# A G E N D A

## PUBLIC TRUST BOARD

**Thursday 25 January 2018**
**09:30 in the Board Room at Northampton General Hospital**

| Time | Agenda Item | | Action | Presented by | Enclosure |
|---|---|---|---|---|---|
| **09:30** | **INTRODUCTORY ITEMS** | | | | |
| | **1.** | Introduction and Apologies | Note | Mr Farenden | **Verbal** |
| | **2.** | Declarations of Interest | Note | Mr Farenden | **Verbal** |
| | **3.** | Minutes of meeting 30 November 2017 | Decision | Mr Farenden | **A.** |
| | **4.** | Matters Arising and Action Log | Note | Mr Farenden | **B.** |
| | **5.** | Patient Story | Receive | Executive Director | **Verbal** |
| | **6.** | Chairman's Report | Receive | Mr Farenden | **Verbal** |
| | **7.** | Chief Executive's Report | Receive | Dr S Swart | **C.** |
| **10:00** | **CLINICAL QUALITY AND SAFETY** | | | | |
| | **8.** | Medical Director's Report | Assurance | Mr M Metcalfe | **D.** |
| | **9.** | Director of Nursing and Midwifery Report | Assurance | Ms C Fox | **E.** |
| | **10.** | Mortality Update Report | Assurance | Mr M Metcalfe | **F.** |
| **10:20** | **OPERATIONAL ASSURANCE** | | | | |
| | **11.** | Finance Report | Assurance | Mr P Bradley | **G.** |
| | **12.** | Workforce Performance Report Including<br>• Equality and Diversity Progress Report for Staff<br>• Gender Pay Gap Report | Assurance | Mrs J Brennan | **H.** |
| **10:40** | **GOVERNANCE** | | | | |
| | **13.** | Corporate Governance Report | Assurance | Ms C Thorne | **I.** |
| **10:50** | **FOR INFORMATION** | | | | |
| | **14.** | Integrated Performance Report | Assurance | Mrs D Needham | **J.** |
| | **15.** | Emergency Preparedness Annual Report inc Winter Plan | Assurance | Mrs D Needham | **K.** |
| | **16.** | Estates Compliance Update | Assurance | Mr S Finn | **L.** |
| | **17.** | Fixing the Flow Update | Assurance | Mrs D Needham | **M.** |
| **11:10** | **COMMITTEE REPORTS** | | | | |
| | **18.** | Highlight Report from Finance Investment | Assurance | Mr P Zeidler | **N.** |

| Time | Agenda Item | | Action | Presented by | Enclosure |
|---|---|---|---|---|---|
| | | and Performance Committee | | | |
| | **19.** | Highlight Report from Quality Governance Committee | Assurance | Mr J Archard-Jones | **O.** |
| | **20.** | Highlight Report from Workforce Committee | Assurance | Ms A Gill | **P.** |
| | **21.** | Highlight Report from Audit Committee | Assurance | Mr D Noble | **Q.** |
| **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 29 March 2018 in the Board Room at Northampton General Hospital.**

**RESOLUTION – CONFIDENTIAL ISSUES:**

The Trust Board is invited to adopt the following:

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