Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 26 July 2018

10:00

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 July 2018
10:00 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
10:00	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 May 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:30	**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.**
10:40	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Annual Health and Safety Report	Assurance	Mr S Finn	**J.**
	14.	Infection Prevention Control Annual Report	Assurance	Ms C Fox	**K.**
	15.	STP & Unified Model with KGH Update	Assurance	Mr C Pallot	**Verbal.**
	16.	Equality and Diversity – 1. E&D Workforce Annual Report 2016/2017 2. E&D Workforce Monitoring Report 2016/2017	Assurance	Mrs J Brennan	**L.**
11:40	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**N.**

Time	Agenda Item		Action	Presented by	Enclosure
	19.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**O.**
	20.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**P.**
12:10	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 27 September 2018 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 31 May 2018 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Farenden	Chairman
	Mr P Zeidler	Non-Executive Director and Vice Chairman
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy Chief Executive Officer
	Mr P Bradley	Interim Director of Finance
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Ms C Fox	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
	Ms J Houghton	Non-Executive Director
In Attendance		
	Ms C Corkerry	Deputy Director of Corporate Development Governance & Assurance
	Mrs K Spellman	Deputy Director of Strategy & Partnerships
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Finn	Interim Director of Facilities and Capital Development
	Ms K Palmer	Executive Board Secretary
	Mrs S Watts	Head of Communications
Apologies		
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Dr E Heap	Associate Non-Executive Director
	Mr C Pallot	Director of Strategy & Partnerships
	Mr D Noble	Non-Executive Director

TB 17/18 136 Introductions and Apologies

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

Mr Farenden introduced Ms J Houghton, new Non-Executive Director to the Trust Board.

Apologies for absence were recorded from those listed above.

TB 17/18 137 Declarations of Interest

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

TB 17/18 138 Minutes of the meeting 29 March 2018

The minutes of the Trust Board meeting held on 29 March 2018 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 29 March 2018.

TB 17/18 139 Matters Arising and Action Log 29 March 2018

Abington and Althorp Ward - Best Possible Care Status Presentation

Abington and Althorp Ward delivered a presentation on their respective wards.

Mr Farenden and Dr Swart presented the wards with their Best Possible Care Status plaques.

Ms Houghton asked Althorp Ward how they managed the challenging mix of surgical and medical patients. She was informed that practice development sessions are held to help learn how to manage this.

Mr Farenden queried how the enthusiasm could be rolled out across the Trust. Ms Fox stated Assessment & Accreditation had been running for 2 years. She was confident that the three wards who had achieve best possible care status would be able to sustain this status. The green and blue wards would be working with the wards identified for targeted support.

The Matters Arising and Action Log from the 29 March 2018 were considered.

Action Log Item 85
Mrs Spellman confirmed that the team would be resubmitting the business case.

The Board **NOTED** the Action Log and Matters Arising from the 29 March 2018.

TB 17/18 140 Patient Story

Ms Fox with the Trust Board the patient story.

Ms Fox advised that this was the story of a 94 year old patient who had died whilst admitted to NGH. The patient had hoped to be discharged home on the Friday afternoon to spend his final few days at home. Unfortunately the ward had been unable to get everything in place till after the weekend.

The patient's family were allowed to use a private room on the ward if required. The patient passed away surrounded by his family although they had wished he had been at home.

The family commented that they had found it difficult to ascertain who was in charge due to staff coming on and off duty. They believed that patient care should be looked at in a more holistic way.

The Board **NOTED** the Patient Story.

TB 17/18 141 Chairman's Report

Mr Farenden informed the Board that he had no update to present.

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

TB 17/18 142 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart commented on the NHS 70 celebrations. There are number of national NHS 70th anniversary events which included services at Westminster Abbey and York Minster on 5 July 2018. The Executive Team had invited staff to accompany them to these services.

Dr Swart stated that the Trust would celebrate NHS 70 at the AGM on the 6 July 2018. The AGM would look back at the past year and staff had been invited to attend.

Dr Swart advised that the Best Possible Care aware nominations had now opened. The Trust would try and build on other awards throughout the year. The Trust is now in the process of developing a corresponding set of Awards for both clinical and non-clinical staff.

Dr Swart reported that the Haematology had recently had an MP visit. It was noted

that the MP's had expressed concern about the long term plans for the NHS.

Dr Swart stated that in March 2018 the Prime Minister made a commitment to coming forward with a long term plan for the NHS. The Secretary of State is taking time to consult NHS Trust's across the country. Dr Swart stressed the need to make sure NGH are involved.

Dr Swart commented she and other members of TeamNGH were interviewed by the CQC who are preparing a good practice case study describing our journey from 'requires improvement' to 'good'.

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

TB 17/18 143 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe discussed the new alerts in relation to harm and mortality. There needed to be a unified approach to address these issues and get back to the route cause.

Mr Metcalfe stated that the early recognition and response to a deteriorating patient was high on the agenda. A Deteriorating Patient Board had been established with the Director of Nursing to deliver a coordinated response to this common cause. This would report through CQEG to QGC.

Mr Metcalfe advised that VTE and HAT reporting had changed due to updated NICE guidance. It would have an adverse impact on reporting compliance. There would be a change in the dominator excluding the low risk cohort of patients. The other change would be that first consultant review must occur within 14 hour and therefore future data would be collected to reflect this. The graphs would demonstrate first assessment within14 hours, greater than 14 hours and not assessed.

Mr Metcalfe noted that the impact of these changes would alter the Trust's reported compliance from circa 80% at present to circa 50% in future, subject to an improvement trajectory.

Mr Metcalfe confirmed that within his next Medical Directors report he would include both the old and new measures. It had been agreed at the Thrombosis Committee that IT would implement a forcing function within electronic prescribing precluding prescription of any medicines until the assessment had been completed for admitted patients. The Chief Information Officer had committed to take a paper with a work plan, a time line and associated costings for this to CQEG in June 2018.

Mr Metcalfe stated that the total number of consultant job plans paying over the maximum permitted in the job planning policy had dropped from 54 to 48 through Q3 and Q4 2017/18. This reduction had largely been achieved through a review of the job plans of the senior medical leadership, and a strict policy of authorising no further job plans over 12 PA either for new appointees or on annual review of existing plans (the maximum permitted in the policy).

Ms Houghton asked for further information on the Deteriorating Patient Board. She asked what the purpose was behind the Board and the timescales. Mr Metcalfe commented that when early opportunities to detect deterioration in a patient are missed the patient is likely to suffer a poorer outcome. He confirmed that he would bring a further update to Junes **Quality Governance Committee.**

Action: Mr Metcalfe

Mr Farenden referred to the narrative within the report 'It remains the intention that by close of 2018/19 there will be no consultant job plans over 12PA' and remarked

that this may be ambitious. Mr Metcalfe stated that he was confident that this could be achieved. The PA's needed to be delivered for the benefit of the organisation. Ms Gill commented that it was good to see a reduction in PA's.

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

TB 17/18 144 Director of Nursing and Midwifery Care Report

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

Ms Fox advised that in April 2018, the Trust achieved 98.03% harm free care (new harm).She noted that the maternity safety thermometer for the first time in a few months had seen deterioration. The maternity team are looking into this and an improvement plan would also be devised.

Ms Fox reported that the Trust was in a positive position in regards to pressure ulcers and falls.

Ms Fox stated that 6 patients had Trust attributable CDI to date. It was noted that 5 of these had been seen in surgery which is where the peak had happened last year. The work would be refreshed. Ms Fox had spoken to Public Health England who had noticed a national peak in cdiff incidents.

Ms Fox drew the Board to page 31 of the report pack. The Trust had a year on year improvement in the FFT results. She commented that on page 35 of the report pack there is the inclusion of medication safety which is the first time this information had featured within Nursing and Midwifery Report.

Ms Fox advised that PREVENT and WRAP training are above target.

Ms Fox stated that page 36 of the report pack updated the Board on Pathway to Excellence and nursing initiatives. She reported that the Director of Nursing Junior Fellows would come into place to work on developing projects that align to the Pathway to Excellence Standards.

Ms Fox reported that details on Avery and Dickens Therapy Unit were included on page 38 of the report pack. This section would develop over time.

Mr Zeidler queried the significant deterioration of the safety thermometer. Ms Fox reminded Mr Zeidler that the graph showing new harms focused on harms caused whilst a patient had been admitted to the Trust whereas all harms included harms that patient had been admitted with.

Ms Houghton commented that the report was good and balanced, with the pathway working fantastic. She drew the Board to page 27 of the report pack. She asked if there were any action plans to support these. Ms Fox commented that there was an overarching maternity plan that included neonatal work. A dedicated report on Post-Partum Haemorrhage came to a recent Quality Governance Committee (QGC).

Ms Houghton noted that the report indicated a good fill rate for nurses on page 38 of the report pack however page 45 of the report pack showed issues with maternity staffing. Ms Fox clarified that the findings from the Birth Rate Plus report are likely to suggest that an establishment review is needed. The Birth Rate Plus report would be presented to the Workforce Committee. There appeared to be enough registered midwives and the issue laid in the deficit of maternity support workers.

Mr Zeidler stated that the section on medication safety had been useful. He queried whether the Trust had significant issues compared to other Trusts. Ms Fox drew Mr Zeidler to page 36 of the report pack which showed where the Trust sat nationally.

The Pharmacy Team had expressed no concerns.

Mr Archard-Jones drew the Committee to page 44 of the report pack and asked if Ms Fox had any concerns regarding Robert Watson Ward. Ms Fox advised that further narrative on this had been included on page 33 of the report pack.

Mrs Corkerry asked whether there was a risk to Pathway to Excellence following the future change to senior leadership. Ms Fox informed the Board that the data pack would be submitted to the USA tomorrow (01 June 2018). The Trust is the only organisation in the UK to be using this. There needed to be a survey against 6 of the standards and a mock survey is underway. The mock survey needed to have 60% compliance and the Trust is currently sitting above this. The final survey is likely to be August/September time.

Mr Archard-Jones expressed his concern on the compliance scores on appendix 4. Ms Fox confirmed she would ask the Head of Midwifery to provide an update to the **June Quality Governance Committee.**

Action: Ms Fox

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

TB 17/18 145 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that M1 had delivered a favourable variance of £615k and that this was mainly from positive positions on other income, non-pay, reserves and CIP delivery.

Mr Bradley discussed the CIP delivery in month had delivered £1.2m versus £761k in the plan. Mr Bradley noted that £747k related to unplanned pay savings. This had highlighted a larger issue in overspending on cost centres already and this would follow the escalation process related to overspending cost centres.

Mr Bradley informed the Board that the CIPs had been phased by quarters at 15%, 25%, 25% and 35% rather than in twelfths. If phasing had remained at twelfths CIP delivery would had matched the plan in month 1.

Mr Bradley advised that only £373k of M1 CIP delivery had been recurrent and fortnightly meetings continued to review these.

Mr Bradley reported that as the Trust had achieved both the A&E and financial plans in month there is the inclusion of £460k Provider Sustainability Funds (PSF) into the position. PSF had been phased in quarters at 15%, 20%, 30% and 35%.

Mr Bradley stated that the £4.6m system gap had been phased in quarter ends rather than twelfths. If this had been phased monthly this would have moved the position by £383k.

Mr Bradley informed the Board that the Trust had ended the month with £4.6m more cash than plan. This was due to requesting funds some months in advance and the impact of the over £3m received in March for winter monies and CQUIN.

Mr Bradley discussed the system gap with the Board.

Mr Bradley advised that there had been a number of meetings trying to resolve the system financial gap of £22.2m. The Trust's own gap is £4.6m as discussed in last month's Board and a £4m income CIP gap.

Mr Bradley reported that at a meeting on the 09 May 2018 between the CEOs and DoFs the CCG committed to putting an additional £2m of MRET/Re-admissions funds into the pot. On the 21 May 2018 an email was distributed to the DoFs advising that the £2m of Corby UCC MRET monies was a double count and therefore should be removed. The solutions to bridge the gap had reduced from £12m to £10m. The CEOs had asked the DoFs to meet again and report back with further solutions / suggestions to bridge the gap.

The Board **NOTED** the Finance Report.

TB 17/18 146 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the Trust's substantive workforce is at 87.86% of the Budgeted Workforce Establishment. This percentage is slightly lower than in recent months due to an increase in budgeted establishment from 1 April 2018. Mrs Brennan investigated this and it was noted that the establishment had been increased overall to account for cost pressures, business case changes and some financial adjustments such as a reversal of the previous vacancy factors.

Mrs Brennan reported that Annual Trust turnover for April 2018 had decreased to 7.69%, which is below the Trust target of 10%.

Mrs Brennan stated that sickness absence for April 2018 decreased from 3.95% to 3.82% which is just above Trust target of 3.8%.

Mrs Brennan stated she had recently attended a LWAB workshop. The workshop looked at key areas on which the LWAB is to focus on and these areas to be aligned with the Northamptonshire Health Partnership.

Mrs Brennan commented that there had been a change on the in nurse recruitment with some emphasis now put on social media. The Best of Both Worlds initiative is positive and another bid had gone into Health Education England. As of March 2018 the Best of Both Worlds initiative had reached 4 million people through page impressions and readership circulation with advertising, articles and interviews.

Mrs Brennan advised that recruitment from the Armed Forces is being explored. It was noted that recruitment fairs had also been effective recently and the Trust would be attending more local open days.

Mrs Brennan discussed Nurse Retention with the Trust Board. An analysis over the last three years of the Trusts qualified nurse leaver's top reasons for leaving had been undertaken to enable the Trust to target reasons for this turnover. The highest reasons for leaving had been relocation and other/Not Known. The other/Not Known had now been removed from the form.

Mrs Brennan stated that work is underway to launch a new Exit Questionnaire process via a system due to be implemented shortly called 'Questback. The functionality of the system would also enable the Trust to contact leavers 6-12 month after their departure.

The Age Profile Analysis of Leavers showed the age range of late 20's and the 55 – 60 bracket to be high. The age range 41-45 was also high and the reason behind this had been unclear. The HR and Nursing Team are to meet to develop an action plan to address this.

Mrs Brennan advised that the Draft Health & Care Workforce Strategy for England to 2027 had been shared at the Workforce Committee. There would be feedback given

from LWAB and the East Midlands HR Directors on the strategy.

Mrs Brennan commented that an audit was conducted into Medical Staffing in September 2017, which was subsequently followed up with second audit conducted in December 2017 which provided limited assurance in respect of the improvements required. A further audit was conducted in April 2018 which demonstrated significant improvement therefore it had been removed from the risk register.

Mrs Brennan reported that the current rate of Appraisals recorded for April 2018 had increased, Mandatory Training compliance had increased and Role Specific Essential Training compliance had also increased.

Mrs Brennan stated that an action plan had been developed to support the Respect & Support campaign which would be launched in June 2018 supported by the Communication Team.

Mrs Needham noted that Women, Children & Oncology had consistently achieved their HR targets for 3 months in a row. Mr Zeidler queried whether this was impact of having a new Divisional Director in post. Mrs Needham believed that the new Divisional Director had been doing a good job however this was a whole team effort.

Mrs Brennan advised that the Trust is to sign an Armed Forces covenant in June 2018.

Ms Houghton highlighted the inclusion of agency staff within the report. It was clarified that this is a financial risk and goes through the Finance Investment and Performance Committee.

Ms Houghton noted that appraisal rate on page 76 of the report pack to be low and asked how this was being addressed. Mrs Brennan commented that HR Business Partners track appraisal rates and these are discussed at the Divisional performance meetings. The ward level scorecards also pick this up.

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

TB 17/18 147 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 reported that A&E performance for April was above trajectory and May is currently above at 86.33%.

Mrs Needham stated that Fixing the Flow remained a significant focus for Divisions and Directorates. There had been one workstream change to focus on the A&E process.

Mrs Needham advised there continued to be a low conversation rate of admissions from A&E.

Mrs Needham delivered a Cancer update to the Trust Board.

The Trust met the 62 day standard for March however failed the other 4 standards. The main area of concern is 2ww especially for Dermatology and Breast with plans in place to recover during June/July.

Mrs Needham advised that the Trust is above trajectory but below target for 62 days

in April.

Mrs Needham had started to chair the daily PTL meetings again. The legacy patients currently sit at 29 with the majority of these being diagnosed. She had briefed NHSI on the current performance, issues and actions.

Mrs Needham reported that the CQC system review on DTOC and the elderly had presented the outcome to those involved on 25 May 2018. The outcome had been fair and balanced.

Mr Farenden challenged whether the improvements in April to the 62 day standard only occurred due to Mrs Needham being involved in the daily PTL meetings again. Mrs Needham clarified that there is a clear escalation process in place which defined when her involvement is required. The area of concern laid in Urology as work done on changing the pathway had slipped back. She and Mr Metcalfe had discussions with the Consultant body.

Mrs Needham informed the Board that she is monitoring the challenges with Leicester on a daily basis.

Mrs Spellman stated that the collaboration teams had been working with KGH on Urology. There are transformations funds assigned to having one Urology pathway.

Ms Gill queried how the benefits from the MADE events are maximised. She was informed that the A&E delivery board would be picking the learning points up. Mrs Needham commented that the Newton Review had identified 4 key areas and that these would also be picked up.

In regards to the ASI Management Exception Report there were concerns in relation to the effectiveness of e-referral.

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

TB 17/18 148 Communication Strategy

Mrs Watts presented the Communication Strategy.

Mrs Watts stated that report sets out the Trust's 2018-2021 communications strategy.

Mrs Watts commented that there is a lot of excitement in regards to the TeamNGH staff portal. This would also be available as an app on mobile devices. The portal would allow online discussions in a live community setting.

Mrs Watts hoped that this would improve staff retention as it would include a post induction survey which HR can actively address the issues. The portal had a go live date of June 2018.

Mrs Watts reported that there would be the introduction of awards for non-nursing and midwifery staff.

Mrs Watts advised that the Trust had a strong staff following on social media channels. The Trust had 12k followers on Facebook and is one of the top Trust's in the country for followers.

Mrs Watts stated that the Trust had spoken to GP's to see how the GP's would best like to receive communications. It has agreed that short simple communication is the best way.

Mr Farenden praised Mrs Watts and her team for the positive transformation of the Communication Team. Mr Zeidler concurred with this and asked if there were any plans to include video clips on the portal. Mrs Watts believed that this would be looked at moving forward and that there were already plans to use video clips in the 'Respect & Support Campaign'.

The Board **NOTED** the Communication Strategy.

TB 17/18 149 Northamptonshire Health and Care Partnership Update

Mrs Spellman presented the Northamptonshire Health and Care Partnership Update.

Mrs Spellman advised that the update had come to Board for information. There had been a renewed focus on the workstreams and working together.

Mrs Spellman drew the Board's attention to Appendix 1 and that this would be discussed in further detail at the Private Board.

Mrs Needham noted the importance of pulling together all the urgent care worksteam actions.

Mr Farenden stated that there needs to be a shift from looking at the structure and process to progress.

The Board **NOTED** the Northamptonshire Health and Care Partnership Update.

TB 17/18 150 Quality Account

Mr Metcalfe apologised for the delay in distributing the Quality Account. This was due to the delay in receiving information from external stakeholder which had now been incorporated.

Mr Metcalfe confirmed that the Quality Account would be circulated electronically and asked for final feedback to be with him within 1 week.

The Board **NOTED** the Quality Account Update.

TB 17/18 151 Highlight Report from Finance Investment and Performance Committee

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

The Board were provided a verbal update on what had been discussed at the Finance Investment and Performance Committee meeting held on the 23 May 2018. 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 –

- Operational Performance had been discussed.
- Changing Care – the challenges and concerns in relation to non-recurrent CIPs becoming recurrent CIPs.
- Good review of the Springfield Urgent Care Centre had been received.
- Benefits Realisation Report had been presented.

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

TB 17/18 152 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 25 May 2018. 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 –

- QI team presentation on the recent conference the team had attended.
- All other key points had been included in both the Medical Director and Director of Nursing reports.

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

TB 17/18 150 Highlight Report from Workforce Committee

Ms Gill 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 23 May 2018. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Ms Gill advised of the key points –

- Action plan for Respect and Support Campaign.
- The implementation of A-EQUIP and Professional Midwifery Advocates update had been received.
- All other key points had been included in the Workforce Report.

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

TB 17/18 151 Highlight Report from Audit Committee

Mr Farenden presented the Highlight Report from Audit Committee.

The Board were provided a verbal update on what had been discussed at the Audit Committee meeting held on the 24 May 2018. 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.

The Board were advised of the key points –

- The Auditor report on the accounts had been encouraging.
- The Committee had recommended approval of the Annual Accounts.

The Board **NOTED** the verbal Highlight Report from Audit Committee.

TB 17/18 152 Highlight Report from Hospital Management Team

Dr Swart presented the Highlight Report from Hospital Management Team.

Dr Swart stated that there had been a discussion on Financial Management across the Trust and the system approach to the deficit.

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

TB 17/18 153 Any Other Business

Ms Fox advised that the single sex accommodation compliance level had now returned the levels previously seen.

Date of next Public Board meeting: Thursday 26 July 2018 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Farenden called the meeting to a close at 11:30

Public Trust Board Action Log						Last update	09/07/2018
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
86	May-18	TB 17/18 143	Medical Director's Report	Ms Houghton asked for further information on the Deteriorating Patient Board. She asked what the purpose was behind the Board and the timescales. Mr Metcalfe commented that when early opportunities to detect deterioration in a patient are missed the patient is likely to suffer a poorer outcome. He confirmed that he would bring a further update to Junes Quality Governance Committee.	Mr Metcalfe	Jun-18	On agenda	**update in Matters Arising that this had been presented at **Junes QGC****
87	May-18	TB 17/18 144	Director of Nursing and Midwifery Care Report	Mr Archard-Jones expressed his concern on the compliance scores on appendix 4. Ms Fox confirmed she would ask the Head of Midwifery to provide an update to the June Quality Governance Committee.	Ms Fox	Jun-18	On agenda	**update in Matters Arising that this had been presented at **Junes QGC****
Actions - Future meetings								
NONE								

Report To	**Public Trust Board**
Date of Meeting	**26 July 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 The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None

Actions required by the Trust Board

The Trust Board is asked to note the contents of the report

Northampton General Hospital NHS Trust

Public Trust Board
26 July 2018

Chief Executive's Report

1. Care Quality Commission – System Review

The report setting out the findings of the recent CQC system review was published on 12 July. The report is one of 20 targeted local system reviews looking specifically at how older people move through the health and social care system, with a focus on how services work together.

During the review, which was carried out in April, the CQC sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as service users, their families and carers.

The review found there was a system-wide commitment to serving the people of Northamptonshire, but that services had not always worked effectively together. A number of areas were highlighted where improvements are needed at a county-wide and organisation-specific level.

Here at NGH we are determined to play our part in the improvements needed in the health and care system. A key challenge for us is to improve our discharge processes and prioritise getting people home as soon as they are admitted. We are already making some good progress in this respect and, as a result, our bed availability for urgent admissions has much improved and fewer patients are waiting in our emergency department.

In terms of our wider response to the CQC's review findings, there will be a focus on our internal work but also on a number of programmes we are supporting, which include looking at true capacity and demand in the system, changes needed in commissioned services, support for frailty and advanced care planning.

Our aim is that next winter we will have fewer admissions for older people, especially when admitted predominantly for frailty, and shorter lengths of stay overall. This means that fewer older people will experience the inevitable deterioration that comes with long hospital stays and it also means that we can use our beds more effectively for the people who really need them.

We will be working with our partners across the health and care system to develop and agree an action plan and timescales and hope this will act as one of the important levers for the change we all know is needed.

2. Our systems

In early June we went live with our new CaMIS PAS. As with any major process change of this type there were a number of issues encountered in the early days which impacted on people's ability to work as normal. Some of the issues were quick and easy to fix and others took a little longer. However, those words do not reflect the huge amount of effort and commitment from everyone involved, no matter what their role or where they work.

The IT team worked round the clock to support staff, provide training, advice and support, including providing floor walkers to help staff with any issues throughout June.

On behalf of the board I want to offer our sincere thanks to all the teams for their extra effort and support put in before, during and post implementation. It is through their efforts and commitment that we have been able to still see patients and provide great care.

3. Our staff

NHS 70 celebrations

It was a huge privilege for me and Deborah Needham, our Chief Operating Officer/ Deputy CEO, to be able to attend separate services at Westminster Abbey and York Minster that commemorated 70 years of the NHS. We were each accompanied by two long-serving members of TeamNGH. At Westminster Abbey we enjoyed some amazing music, meaningful readings and a truly inspirational speech delivered by a 15 year old survivor of the Manchester bombings.

Both events were, in a sense, a spiritual celebration of the NHS at its best; an affirmation of the people's hopes for the NHS and the staff's commitment to it.

Whilst at the Abbey I thought back to our recent winter and realised that the thing that will stick in my mind most will not be the pressure or the difficulty of finding beds, but the incredible resilience, hope and hard work from TeamNGH - our winter heroes - whether recognised formally or just quietly getting on with it.

As part of the NHS70 celebrations the communications team posted more than 70 different job roles here at NGH in the lead up to 5 July. This was an excellent opportunity to showcase the many and varied faces and roles at TeamNGH.

On 4 July the Prime Minister hosted a reception at 10 Downing Street to thank NHS staff from around the country. Local MP, Michael Ellis, attended the reception and was accompanied by Dr John Trenfield from our A&E department.

Awards

Dr Sohaib Rufai, ophthalmology registrar at NGH, was recently selected as one of 85 international finalists for the Association for Research in Vision and Ophthalmology (ARVO) Members in Training (MIT) prize, awarded to the best presentation per category by world experts in the field. He went on to win the neuro-ophthalmology prize for his research into hand-held 3D eye imaging in infants with nystagmus or 'dancing eyes'.

Dr Rufai conducted his study in Leicester, the first centre in Europe to receive the handheld optical coherence tomography (OCT) scanner. Dr Rufai has led the world's first longitudinal study using handheld OCT to develop a grading system for underdevelopment of the retina in infants with nystagmus, to help prediction of future vision and management.

Celebrations

In early July we were delighted to welcome the founders of the DAISY Foundation, the Barnes family, for a celebration event to mark one year since the awards were launched at NGH.

Mark and Bonnie Barnes along with their granddaughter Riley, visited NGH to unveil a new display dedicated to past and present DAISY awards recipients.

Located on Hospital Street, the hall of fame celebrates those who have delivered exceptional care to their patients and their families. Following this the family were invited to an afternoon tea celebration with the DAISY honourees to mark their achievements and talk about the reasons behind the creation of the awards.

4. Our stakeholders

Our AGM on 6 July was well attended by many of our members, staff and key stakeholders including HealthWatch and local councillors. The event was very much in the spirit recognising the incredible efforts made and our aspirations for progress in the coming year.

Following feedback from previous AGMs we opted not to have an open Q&A session but instead board members were happy to discuss any issues or concerns with individuals after the AGM. This opportunity was well received as it meant there was more time available for personal discussion.

The event was a celebration not only of 70 years of the NHS but also what TeamNGH had achieved during the previous year. A number of services from both within NGH and elsewhere, including the NHS Retirement Fellowship and Maggie's Centre, provided information stands and displays and the catering team sourced some excellent NHS70 cupcakes which were much appreciated and, in a change from the usual, there was a barbecue to round off the proceedings and continue our NHS 70th birthday celebrations.

5. NGH in the news

In June NGH became the first organisation in the town to welcome an unusual new addition to the team, a virtual assistant who is on hand to greet and provide information to staff, patients and visitors.

The virtual assistant, funded by the Northamptonshire Charitable Health Fund, has been given the name Mia (messaging, information and advice), creates the illusion of a real person and speaks to people coming in to the hospital and can be moved to different locations around the site..

As well as providing a friendly face for people entering the hospital, Mia is an exciting alternative to traditional hospital signage. The content is tailored to address the most frequently asked questions from people coming to the hospital, with audio and visual content that can be changed and adapted to incorporate seasonal messages.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 July 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 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	
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) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	CQC Fundamental Standards – Safe External Review/Accreditation body : Nene and Corby Clinical Commissioning Group (CCG). Duty of Candour Requirements

Actions required by the Board

The Board is asked to note the contents of this report

Medical Director's Report

26th July 2018

1. Introduction

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

i. in relation to the principle risks to delivery where these are rated "extreme" (>14)
ii. review of harm, incidents and thematic
iii. mortality and the management of outlier alerts
iv. related topics from the medical director's portfolio on a rotational basis, this month;
a. Consultant Job Planning
b. Medical model in the Nye Bevan Building

2. Risk

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

2.1 Urgent Care

At the time of writing the urgent care pressures in the organisation remain largely in abeyance since the last medical director's report to board. In relation to planning for next winter, the actions required of other partners are coordinated through the urgent care delivery board.

Internally, the challenge to continuing to reduce these risks lies principally in delivering a more efficient medical model for urgent care before next winter whilst doing everything possible to engage our consultants in this priority.

Without the medical model changes and nursing establishment uplift the is a risk that the Nye Bevan will not deliver its full potential but rather end up in effect as additional ward capacity.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk of reduced patient safety when demand exceeds capacity resulting in a risk of non-achievement of Trust targets	20	15	Quality Governance

2.2 Clinical Staffing

Medical workforce gaps require re-distribution of relative clinical risk and absolute financial risk when responding to emergency pressures as a result of having to take down elective and outpatient activity to support safe emergency care. There is an associated risk to workforce morale. This remains a prominent concern amongst the consultant physician workforce in particular.

The deputy medical director for workforce and urgent care continues to lead an enhanced medical recruitment campaign to mitigate the key risks. The scope of this work has been broadened to incorporate high risk clinical areas outside medicine, for example oncology. Within medicine, there has been substantial progress in recruitment such that it is anticipated that 6 of the 8 WTE required to staff an enhanced urgent care medical model will have been appointed substantively and commenced in post by October 2018. The risks posed by medical workforce shortages have been further reduced by excellent junior doctor recruitment. Going forward the easing of visa restrictions for non-EU medical staff is anticipated to further facilitate recruitment. It is anticipated that this progress will be reflected in a reduction of the associated risk in the near term.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
551	Patients may receive suboptimal care at weekends due to reduced numbers of staff being available to provide full 7 day working.	16	16	Quality Governance
1518	The Trust has difficulty in recruiting to the establishment due to local and national shortages of medical staff and difficulties associated with overseas recruitment	16	16	Workforce
1155	Potentially unable to maintain appropriate staffing levels in theatre areas due to a large amount of staff vacancies	15	15	Quality Governance
1756	Ineffectiveness of the Nye Bevan unit due to ineffectiveness of the medical model, inability to recruit staff substantively, as well as impact of patient flow across the hospital.	20	20	Finance & Performance

3. Harm

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

i. The number of serious incidents (requiring STEIS escalation) and the number of Never events in 2018/19, with previous years for comparison.

ii. The number of new serious incidents requiring full root cause analysis (RCA) and moderate harm incidents requiring “concise” RCA since the last trust board. Summary information for new Serious Investigations initiated and submitted to the CCG are provided.
iii. Key thematic issues relating to avoidable patient harm.

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

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Serious Incidents	27	55	78	115	93	11	13	18	9
Never Events	2	2	1	0	1	3	1	3	0

Of note the SI framework has been updated in January 2018 and this has changed the thresholds slightly. This is unlikely to result in the same step change in numbers of SI reported as when the 2015 framework was introduced.

3.ii New SI and moderate investigations

There were 5 serious incidents reported on STEIS during May and June. These are on track to report by their deadlines and consist of;

i. Colorectal cancer patient lost to follow up with incurable recurrence
ii. Fall at Dickens therapy unit resulting in subdural haematoma
iii. Delay in surgical review of a patient with learning disability
iv. Maternal death
v. Complications of labour with still birth

There have been no further Never Events.

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

17 moderate harm incidents were detected during May and June, and these are subject to concise RCA investigations.

3.iii Thematic issues

No new themes have been identified through RoHG since the last board report. The issues previously identified relating to inadequate recognition and response to the

deteriorating patient have been triangulated with other sources including mortality outlier alerts and quality schedule compliance data. The inaugural meeting of the deteriorating patient board takes place on the 19th of July.

4. Mortality

4.1 Mortality summary data

All trust level indices for mortality rates, SMR, HSMR (overall, weekday and weekend) and SHMI continue to run below average and in the expected ranges.

Indicator	Month	Rolling year	Comments
HSMR	96	101	
Diagnoses-All	99	98	
HSMR weekend		103	
HSMR weekday		100	
SHMI		97	Oct16-Sep17
HSMR Palliative care coding		2.4%	National 2.4%
Charlson Comorbidity '0'		46.9%	National 49.0%

4.2 Mortality Alerts/Significant Variation under review

There is 1 new significant outlier since the last report

i. Respiratory failure, insufficiency , arrest (adult)

This was a CUSUM alert for March and June data. SMR remains raised at 177. The review of medical notes has now been completed (the ITU notes review was reported in May CQEG report).

This has identified the following areas of concern:

- Delayed administration of non invasive ventilation (NIV)
- Inappropriately administered CPAP
- Poor monitoring of NIV
- Lack of an escalation plan
- One patient had NIV removed and given to another patient.

These findings correlate with data available from the 2017 NCEPOD case review into NIV quality of care, and BTS annual audit into COPD exacerbations.

Actions identified include:

- Institute a respiratory consultant on call rota for NIV telephone advice, and alert all patients commenced on NIV to the respiratory team to allow review within 24hours
- Form a NIV prescription pack which would include a form for prescribing and monitoring NIV, information on monitoring and escalation
- Capillary blood gas machine on Becket and acute admissions ward to improve monitoring
- Appoint an NIV lead consultant (the last lead left 2 years ago and the role has been vacant since)
- Improve ratio of nursing to patient in dedicated areas providing NIV to bring NGH in line with national average

A business case is planned to address some of the above, not only highlighting the benefits in improved quality of patient care, but also reduced length of stay and reduction in admissions to ITU.

Alerts remain in the following diagnosis groups:

i.Regional enteritis and ulcerative colitis

There were 4 deaths vs 1 expected. One patient had already been referred to the Review of Harm group and one discussed at the learning disability M&M meeting. One patient had been screened in detail by the ITU M&M meeting. The final patient was sent to the specialty team for a structured judgement review and has also been referred to the Safeguarding team.

No further actions have been identified

ii. Acute and unspecified renal failure

The number of deaths remains significant for the rolling year but has improved over the last 2 months. Acute kidney Injury will be one of the work streams on the Deteriorating Patient Board which will meet for the first time in July.

iii. Sepsis

The number of deaths remains significant for the rolling year but has improved for the last 2 months. Sepsis will be included as one of the work streams for the Deteriorating Patient Board.

There are 2 new CUSUM alerts:

i. Respiratory failure, insufficiency , arrest (adult) – actions as above

ii. Procedural alert for Excision of colon and/or rectum. A case series review is currently being conducted by the governance lead for surgery.

5. Medical workforce

5.1 Consultant Job Planning

There have been some delays within Medicine Division in progressing job plans which were due to be completed or referred for mediation by the end of Q1 2018/19. This has in part been due to challenges in consultant engagement with the new model for Nye Bevan with the knock on effect that job plans cannot be finalised. There is also little familiarity with the sequence of service planning then team meetings with consultants followed by “best fit” job planning.

In order to support the division and ensure consistency of approach, the medical director, the chief operating officer and the director of finance have instituted fortnightly meetings with the clinical directors and divisional leadership to track progress and provide guidance on contended areas with consultants in specialities.

It is anticipated that the job planning meetings with consultants will have reached the point of agreement or referral for mediation by the end of August. This is sufficient to allow the commencement of the new medical model in the Nye Bevan building by October 2018 ahead of winter.

There are no services for which the clinical directors feel that more than 12 PAs are required to deliver the planned activity on a routine basis for any of their consultants.

5.2 Medical model for Nye Bevan

On the 22nd of June, with ECIP representatives in attendance, a meeting was held with consultants from medicine division to update them on progress with recruitment of physicians to support the new medical model. The physicians had earlier in the year expressed the clear view that whilst the need for change to the consultant leadership of urgent and emergency care was required, significant change required an increase in the number of consultants contributing to the rota from 16 to 24.

With 24 consultants on the rota, consultant colleagues themselves had proposed new rotas which would uplift the amount of time consultants spent supporting non-elective pathways by a factor of 2.5 (to an average of approximately 12 hours a week). This in turn allows for senior clinical decision makers to lead care from much earlier in patient pathways and for there to be fewer transfers of care from one consultant team to another whilst patients are in hospital.

The meeting with the consultants was constructive, and significant progress was made towards acceptance of the new model. Legitimate concerns remain in relation to the impact upon elective work due to the shift to emergency care. This is despite the recruitment of additional consultants, because whilst in theory they are able to back fill the elective sessions lost, they have not been recruited to the most pressured specialities evenly. Specifically there will be real pressure on gastroenterology and respiratory medicine.

There are plans to mitigate these pressures through a variety of different approaches. Over the coming weeks the medical director and the chief operating officer will join the divisional director in meeting with the consultants, speciality by speciality, to agree the mitigations required for each.

It is anticipated that the new medical model will be operated from the time that the Nye Bevan building is opened.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 July 2018**

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

Executive summary

A brief overview of the content of the paper

- **Safety Thermometer:** In June 2018 the Trust achieved 99.03% harm free care (new harm). Overall harm free care was 95.81% both an improvement from the previous month.
- **Maternity Safety Thermometer**: In June 2018 the proportion of women and babies who experienced harm free care (all) nationally was 88%, the Trust achieved better than the national rate at 100%.
- **Pressure Prevention**: 9 patients developed a total of 12 grade 2 pressure ulcers and there were No Unclassified Grade 3 pressure ulcer, validated during the reporting period of June 2018.
- **Infection Prevention**: In June 2018 there were:
  0 trust attributable MRSA bacteraemia
  0 trust attributable MSSA bacteraemia
  3 patient was identified with Trust attributable *E coli* bacteraemia
  2 patients were identified with Trust attributable Clostridium difficile infection (CDI).
- **Falls:** In June 2018 there was 1 moderate and 1 severe harm fall both are being investigated.
- **Friends and Family Test (FFT):** In June 2018 92.1% of patients said they would recommend the Trust.
- **Safeguarding**: The Trust has currently achieved 92% compliance in Basic **Prevent** Awareness Training and 94% compliance for **WRAP** training
- **Avery and Dickens Therapy Unit:** there were no infections or harmful falls at Avery or Dickens Unit in June 2018.
- There is an update on the Midwifery, Nursing and Midwifery Dashboards
- **Safe Staffing**: Overall fill rate is 102% for June 2018.

Related strategic aim and corporate objective	Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1.3 and 1.5
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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

The Board is asked to:

- Discuss and where appropriate challenge the content of this report and to support the work moving forward
- Support the on-going publication of the Open & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data

Northampton General Hospital NHS Trust

Trust Board
July 2018

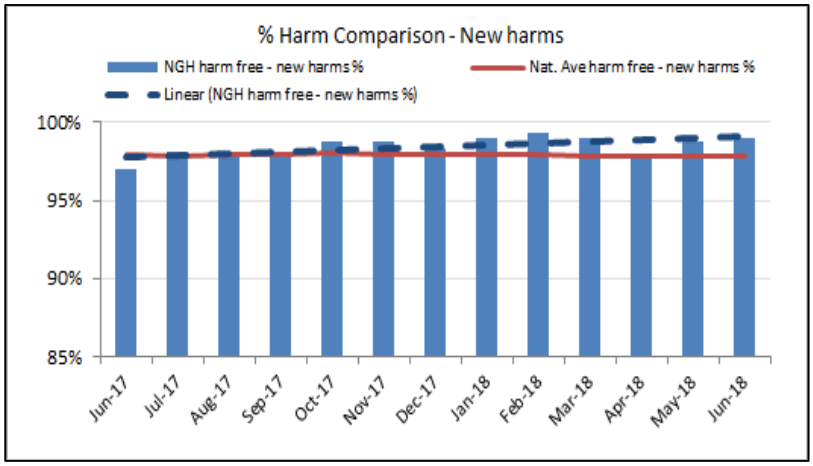
Director of Nursing, Midwifery & Patient Services Report

1. Introduction

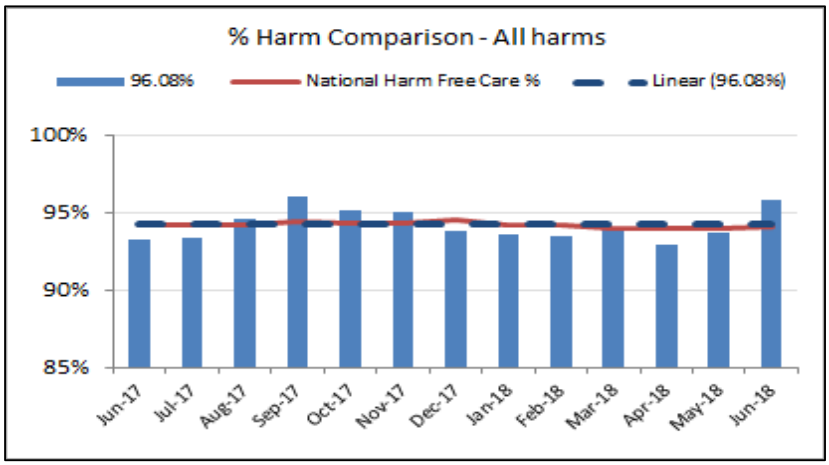
The Director of Nursing, Midwifery & Patient Services Report presents highlights from services, audits and projects during the month of June 2018. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This monthly report supports the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.

2. Safety Thermometer

The graph below shows the percentage of new harms attributed to an in-patient stay. In June 2018, the Trust achieved 99.03% harm free care (new harm); an increase from May 2018.



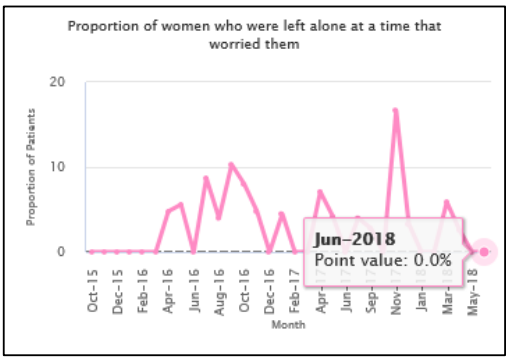
The graph below illustrates overall harm free care was 95.81% in June 2018, an increase from May 2018 all harm figures and above the national average. (Appendix 1 provides the National Safety Thermometer Definition)



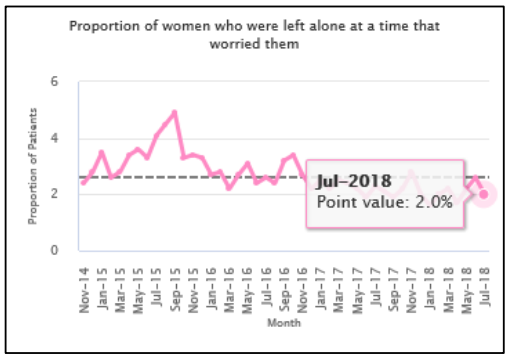
3. Maternity Safety Thermometer

The graphs below show the proportion of women who were left alone at a time that worried them for the month of June 2018 was 2.0% compared to a Trust rate of 0.5%.

NGH Women left alone

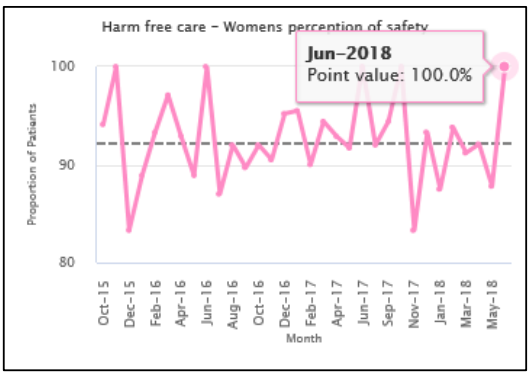


Nationally (Not all Trusts undertake the audit)

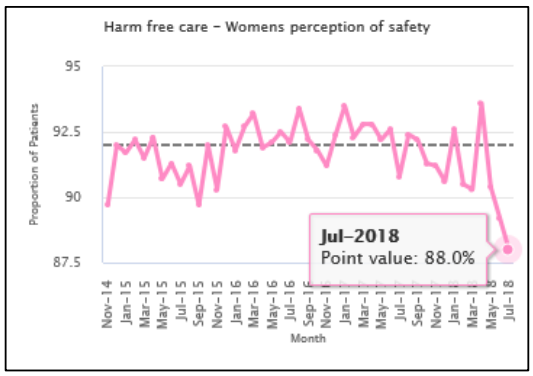


The graphs below show the harm free care for the month of June 2018. The proportion of women perception of safety nationally in June was 88.0% compared to a Trust rate of 0%.

NGH Perception of Safety

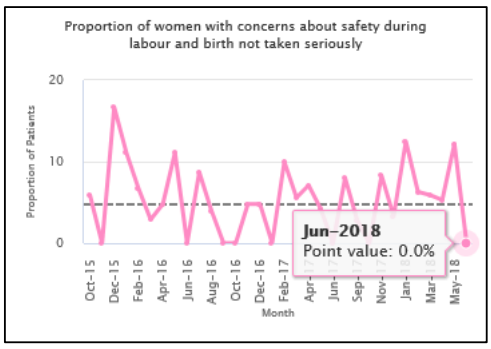


Nationally (Not all Trusts undertake**)**

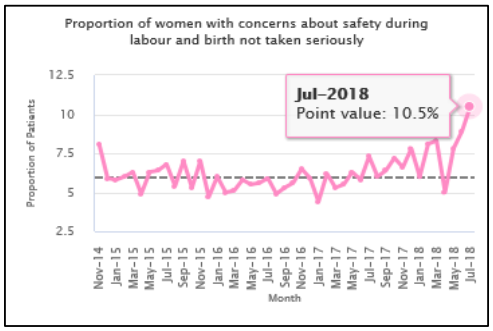


The graphs below demonstrates the proportion of women who felt their concerns were not taken seriously in labour nationally in July 2018 was 10.5% compared to a Trust rate of 0%.

NGH Concerns not taken seriously

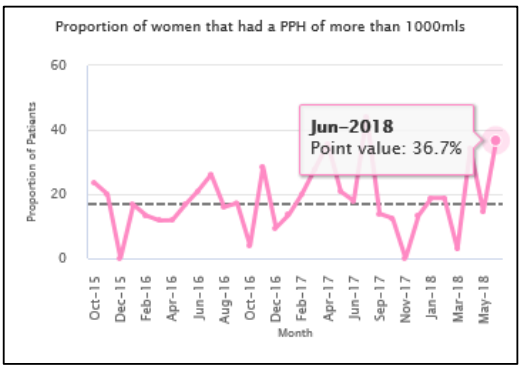


Nationally (Not all Trusts undertake)



The graphs below show the proportion of women who had a post postpartum haemorrhage (PPH) of more than 1000mls.

NGH PPH



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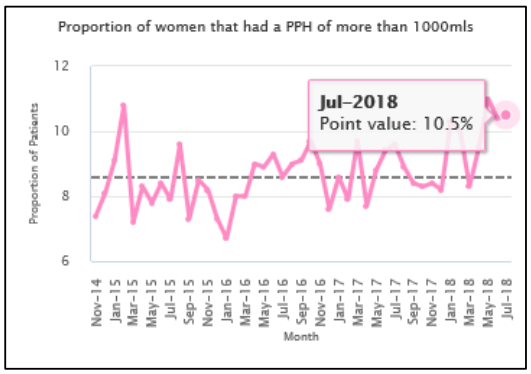
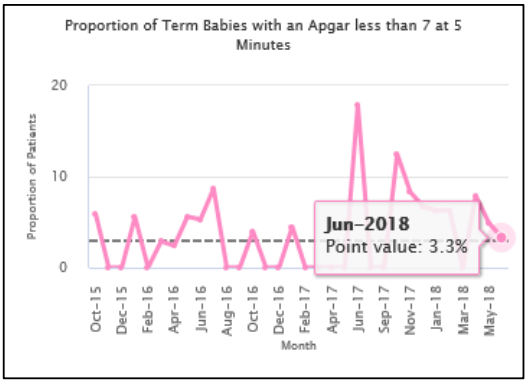


The proportion of women with a PPH over 1000mls nationally was 10.5% compared to the Trust rate of 36.7%. We monitor PPH over 1.5L as per RCOG guidelines. The data for severe PPHs over 1.5Litre: The implementation and evaluation of the PPH care bundle continues to show a steady improvement as demonstrated in the table below

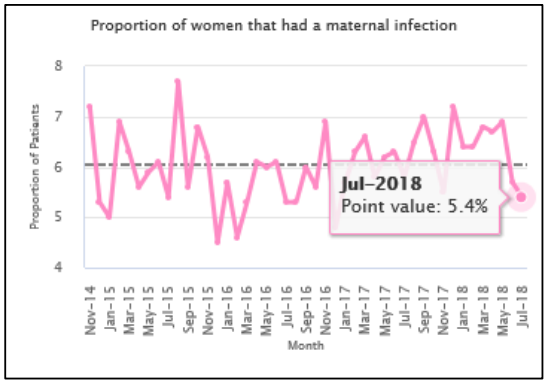
Severe PPHs over 1.5L	April	May	June
Number	13	16	7
Percentage (National benchmark <2.8%)	3.3%	3.9%	1.8%
Quarter	2.8		

The graphs below demonstrates the proportion of term babies with an Apgar of <7 at 5 minutes nationally was 5.4% compared to the Trust rate of 3.3% for July 2018.

NGH Term babies with an Apgar <less than 7 at 5 minutes



Nationally (Not all Trusts undertake)

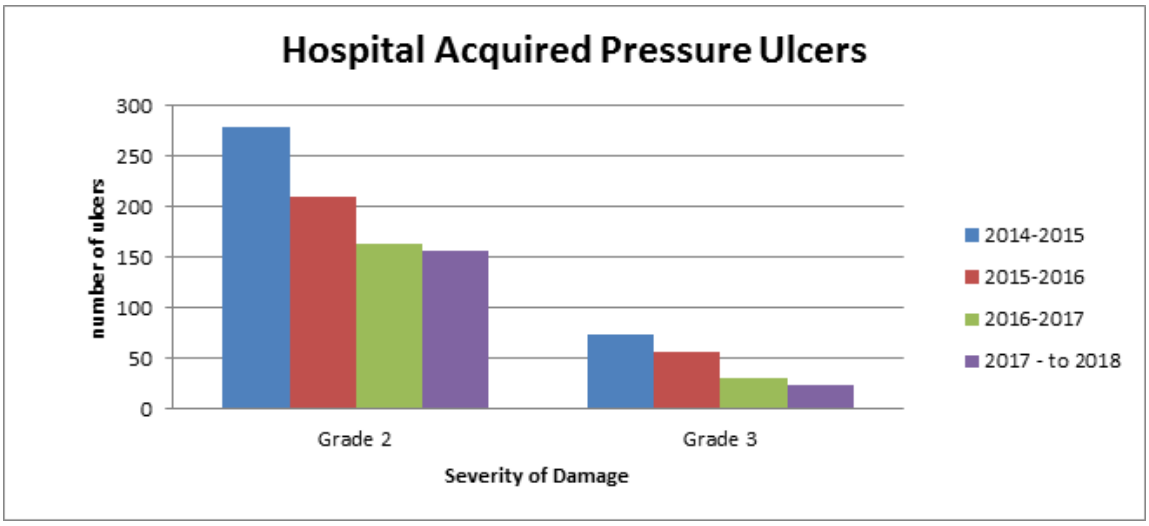


4. Pressure Ulcer Incidence

In June 2018, the Tissue Viability Team (TVT) received a total of 290 datix incident reports relating to pressure damage, which remains largely consistent with previous months. In June 2018, 22 were duplicated reports, 66 patients were not seen as they were either not admitted, or they were discharged within 48 hours of reporting pressure ulcer (PU) harm, or reported as grade 1 or moisture lesion. Of the remaining incidents reported, 202 were validated by the TVT on the wards or from photographs.

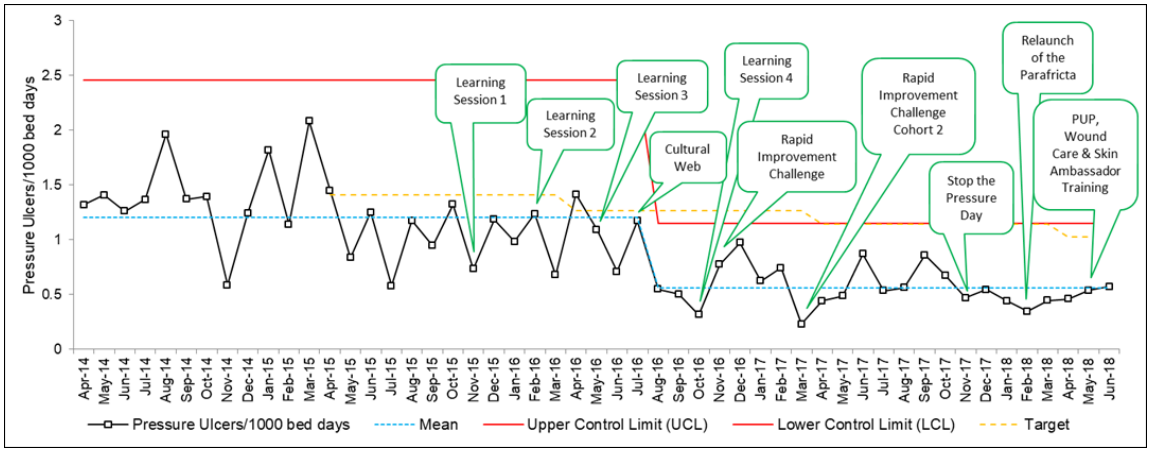
9 patients developed a total of 12 grade 2 pressure ulcers in June 2018. There were no Grade 3 harms validated during the reporting period. A total of 9 patients were harmed with pressure damage whilst in our care in June 2018.

The graph below demonstrates the continued downward trend in all hospital acquired Pressure Ulcer harms year on year.



Number of Pressure Ulcers per 1000 bed days

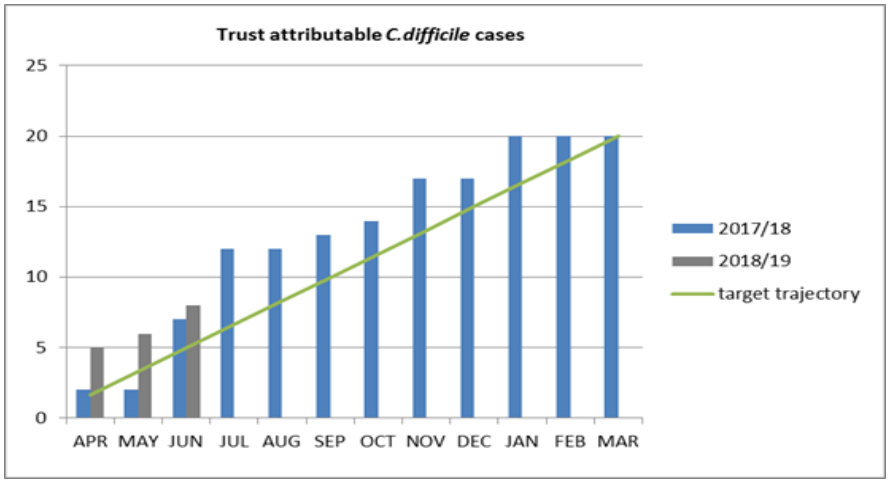
The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers. This is reported utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements.



5. Infection Prevention and Control

Clostridium difficile Infection (CDI)

In June 2018, 2 patients had Trust attributable CDI. The graph below shows the running total since April 2018 of patient with CDI. The trajectory for 2018/19 is 20. All Post Infection Reviews (PIRs) are reviewed by the Clinical Commissioning Group (CCG) and to date there have been no lapses in care.

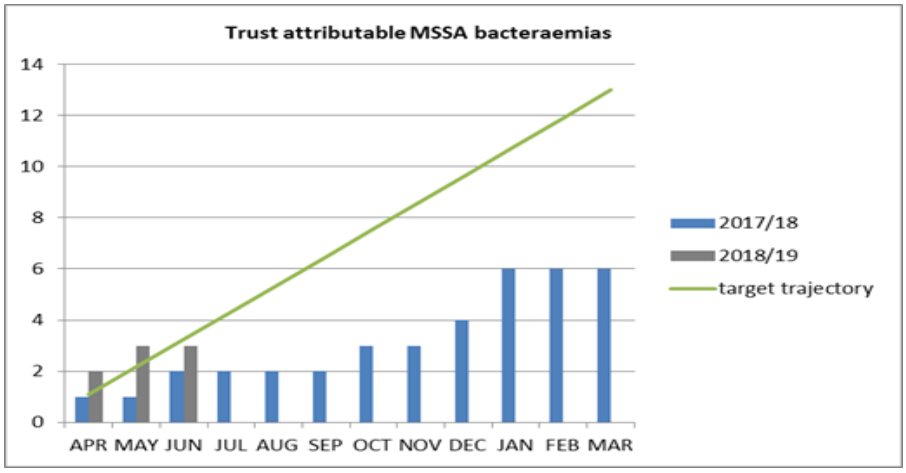


MRSA Bacteraemia and Colonisations

MRSA bacteraemia: 0 Trust attributable MRSA bacteraemia for June 2018.
MRSA colonisations: 2 Trust attributable MRSA colonisation for June 2018.

MSSA Bacteraemia

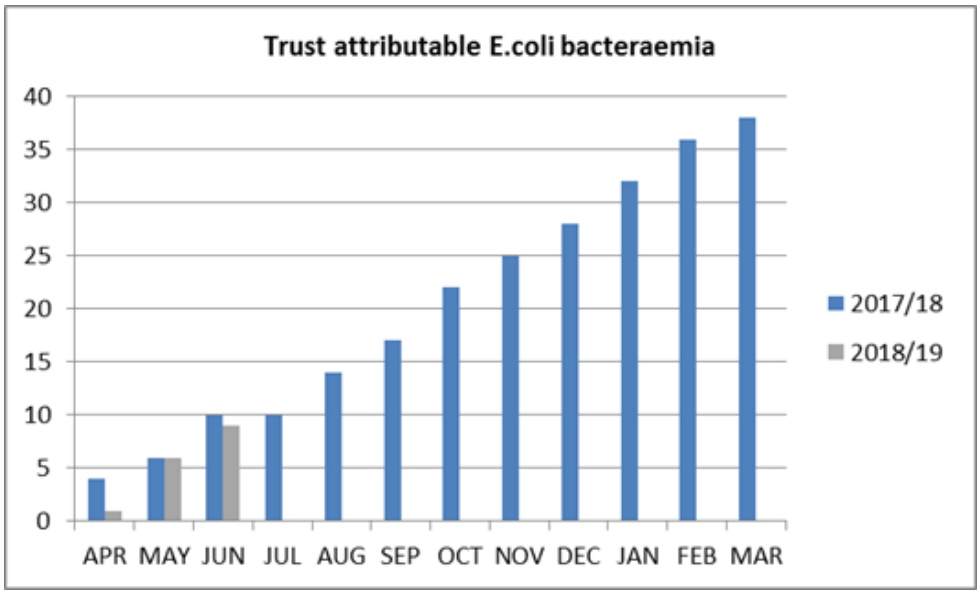
MSSA bacteraemia: 0 Trust attributable MSSA bacteraemias for June 2018. The graph below shows a cumulative total of MSSA bacteraemia for 2018/19. The Trust has set an internal trajectory of 13 MSSA bacteraemias for 2018/19.



Escherichia coli (*E.coli*) Bacteraemia

The local CCG ambition for 2018/19 is a 10% reduction across the whole health economy. Collaborative working will continue between Northampton General Hospital IPC Team, Public Health England, Kettering General Hospital IPC Team, the Community Lead IPC Nurse and the CCG to deliver the E.coli action plan that was commenced in 2017/18 and will continue to be reviewed at subsequent Whole Health Economy meetings that all of the above parties attend. Internally the 2018/19 Gram-negative forward plan was approved by Infection Prevention Steering Group (IPSG) in March 2018 had work has commenced by the IPCT in April 2018.

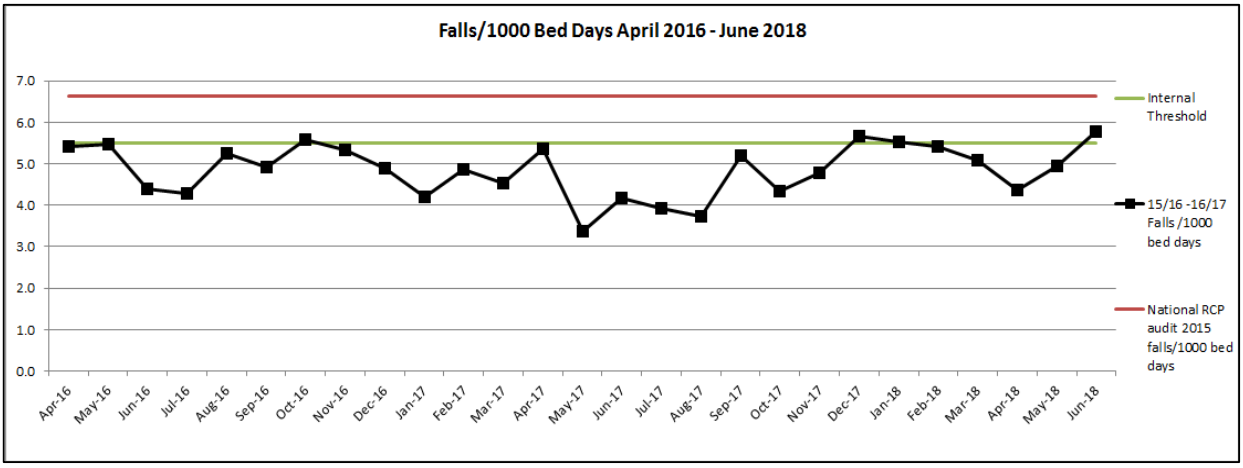
In June 2018, there were 3 Trust attributable E.coli bacteraemia. The graph below demonstrates the total since April 2018.



6. Falls

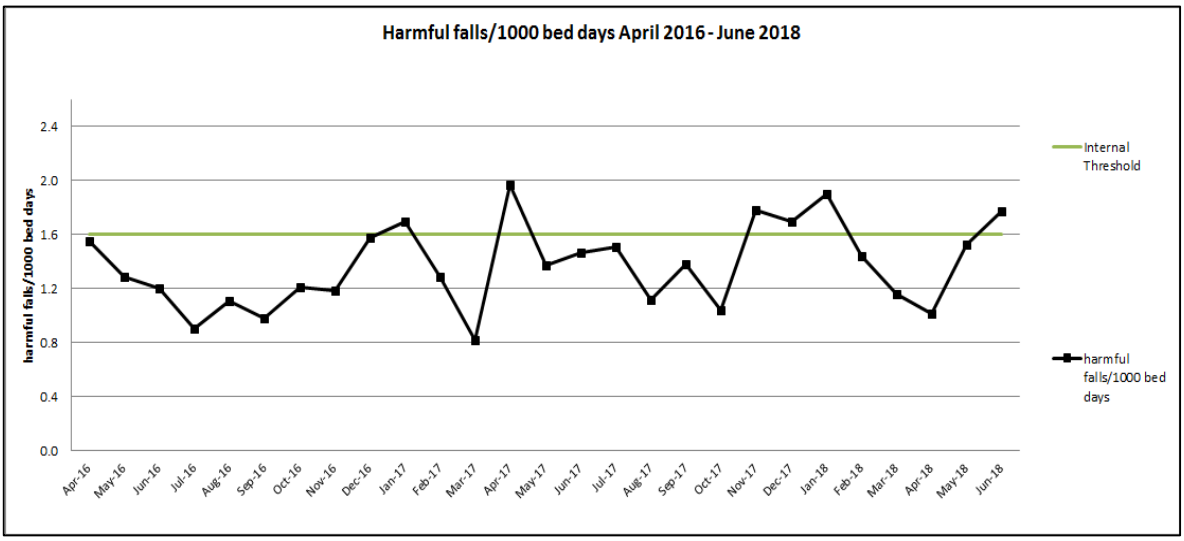
Falls/1000 bed days

The Trust's falls/1000 bed days are below the national average of 6.63/1000 bed days but above the Trusts internally set target of 5.5/1000 bed days. There was an increase in the number of falls/1000 bed days for June 2018 of 0.84 compared to the previous month of May 2018. In total there was 5.78 falls/1000 bed days recorded in the month of June.



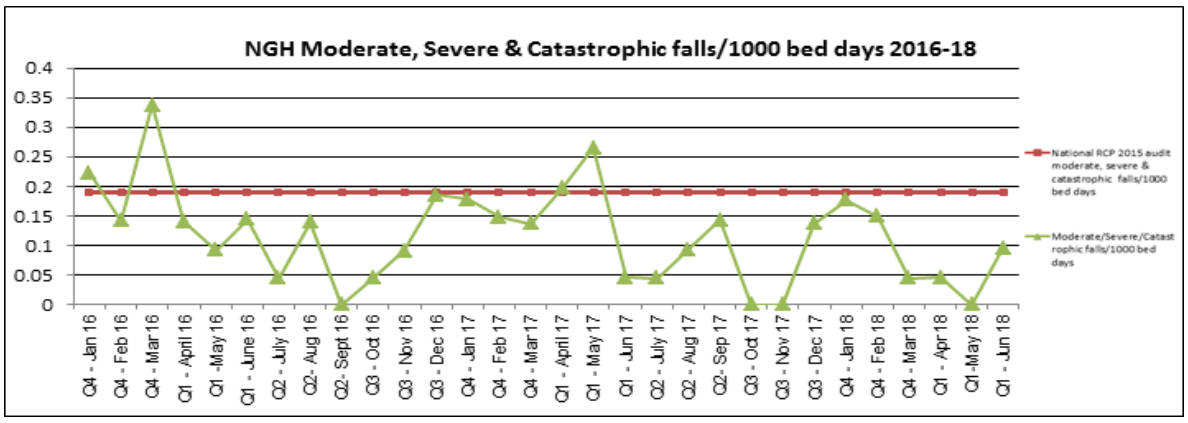
Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic

The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through June 2018 harmful falls/1000 bed days have increased by 0.24 compared to the previous month of May 2018. The rise in harmful falls is due to an increase in low harm falls and one moderate harm fall.



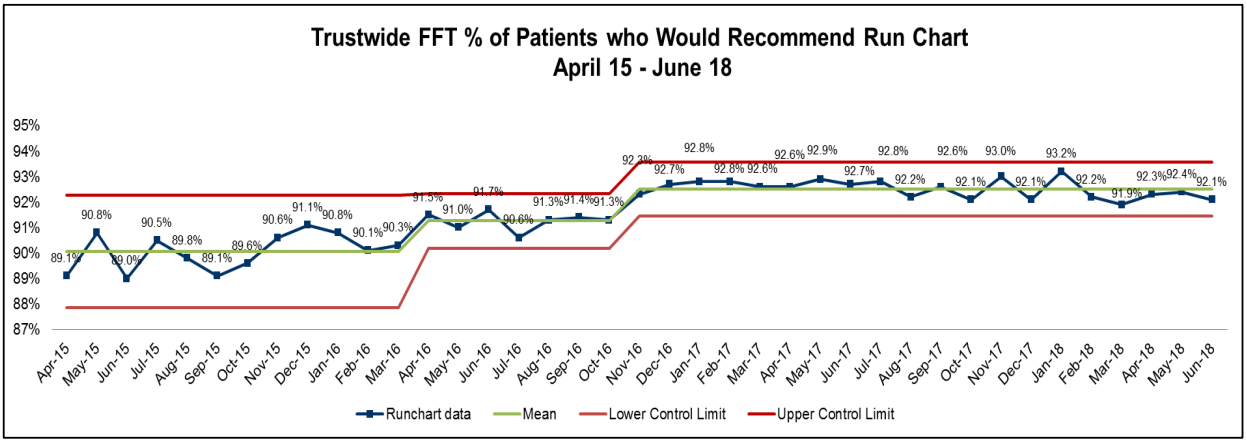
Falls Resulting in Moderate, Severe or Catastrophic Harm

The following graph below represents moderate, severe and catastrophic falls/1000 bed days. There was an increase in moderate severe or catastrophic falls in the month of June 2018. There was 1 moderate fall resulting in a fractured thumb and 1 severe fall resulting in fractured neck of femur.

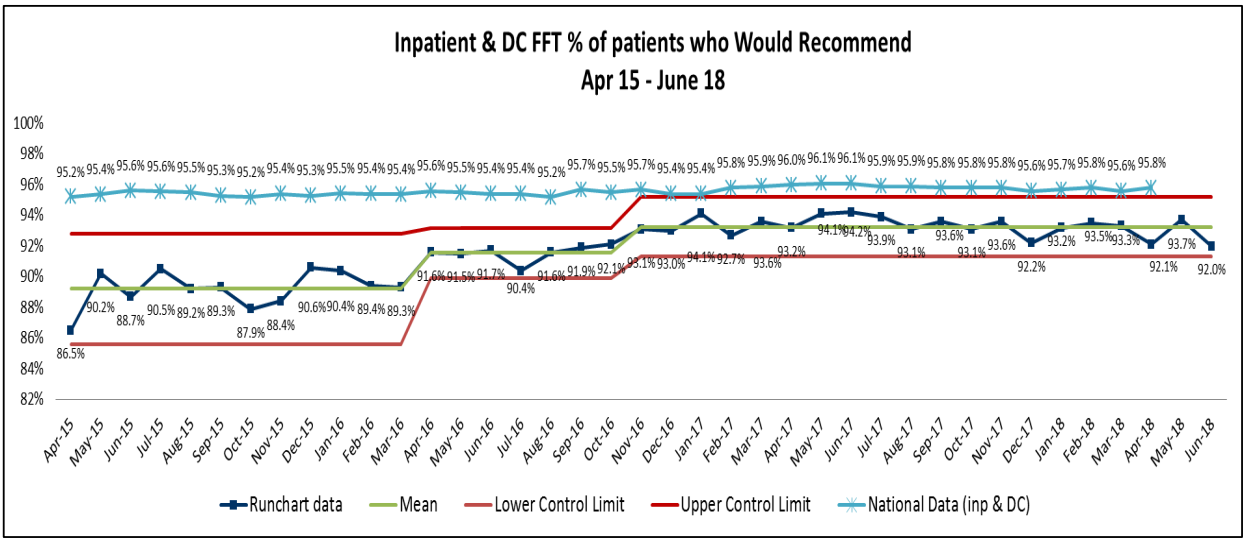


7. FFT Overview- % Would Recommend Run Charts – June 2018

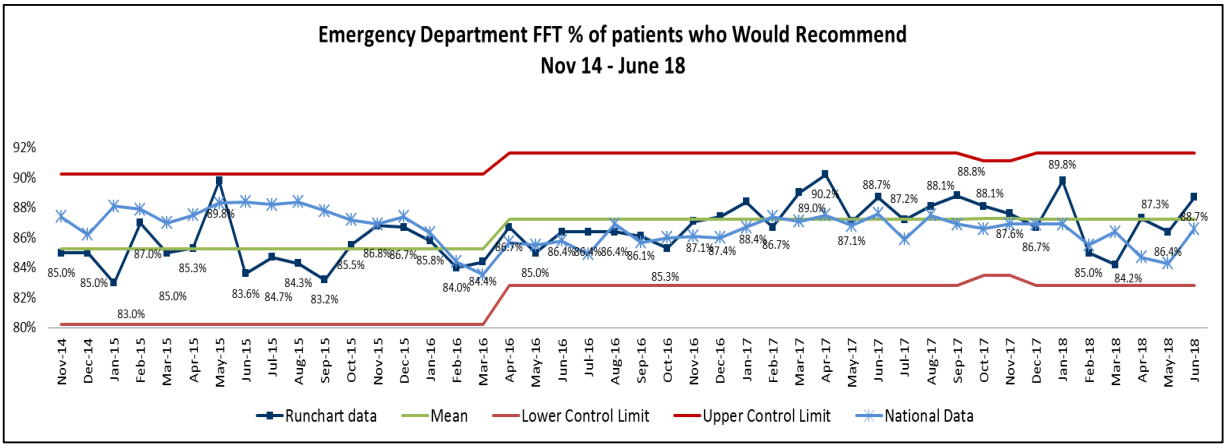
Trustwide data results decreased slightly in June 2018 with a recommendation rate of 92.1%; this is just slightly below mean line. Recommendation rates are still within normal variance.



Inpatient and Day Case results decreased in June 2018 with a recommendation rate of 92%. When comparing April's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 3.8% below the average. This is a decrease of 1.9% in May 2018.



The Emergency Department's recommendation result increased in June to 88.7%. When comparing April's (most recent data available) recommendation rate to the national average, NGH performed 2.1% above the national average (86.6%).



8. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards (appendix 2, 3 & 4) provide triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process, a review of the Quality Care Indicators (QCI) has taken place as planned with a reduction in the number of questions asked. The proposal is to further reduce the QCI dashboard once the Assessment & Accreditation Programme is fully established and 'rolled-out' across the Trust.

The QCI for June 2018 demonstrates the following:

Trust wide Overview of the Dashboard

- In June 2018 there were total of 16 red domains on the QCI dashboard for the general wards 15 in medicine and 1 in Surgery.

- Compliance with falls assessments and pressure prevention assessment has been high focus for the teams with improvement seen, the review continues in the 'collaboratives' and at the 'share and learn' meetings.
- Although First impressions is a subjective measure it remains an important factor and therefore continues to be a focus Trust wide due to the amounts of red and amber domains

Surgical Division

- The surgical division had 1 red domain on the QCI dashboard in June 2018 for the first time in 5 months. The surgical division had 9 amber domains, with focus required on first impressions
- Althorp Ward had the only red domain which was gaps in essential care rounds which is being been addressed and monitored.
- Abington Ward had a grey domain this is down to an inputting error which in turn led to an incomplete section. The matron has checked and this domain would have been green.
- The Ward Sister, Matron and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas for improvement.

Medical and Urgent Care Division

- The Medical Division has had 15 red domains in June 2018 on the dashboard a slight increase from the previous month.
- Knightley ward had no red domains and 2 amber domains. A marked improvement from last month's data. Additional support and training is being given by the QIA matrons, Practice Development Team.
- Becket, Collingtree and Dryden wards all had 1 red domain for first impression. At the time of the audit, the wards were very busy and there was equipment out in the open and not stored away. It was felt that the ward areas felt cluttered.
- Eleanor Ward had 4 red domains for incompletion of the care round documentation and incompletion of falls pressure prevention and nutritional assessment paperwork. Work is underway with the Ward Sister and the Eleanor team looking at ways of working for the whole team to ensure the completion of the documentation improves.
- Collingtree ward had 3 red domains and 3 ambers last month: in June they had 1 red domain and 3 ambers. The only red was for first impressions and the 3 ambers overdue observations and incomplete nursing assessments. The new overseeing matron has been in post for 2 months and she has a 15 week comprehensive action plan with the band 7 & 6's addressing care and quality issues – the QCI's will be used to focus and measure that action plan
- Finedon Ward had 3 red domains for protected mealtimes, privacy and dignity, leadership and staffing observations. The patient said they were disturbed by noise at night and bed side tables were cluttered, which is being addressed and monitored by the Ward Sister.
- EAU had 2 red domains for leadership and staffing observations and patient safety and quality. The escalation process for a deteriorating patient was discussed and the process reiterated. The uniform policy was not being adhered to by members of staff. The ward sister is aware of the results and monitoring the ongoing improvements
- Creaton Ward 2 red domains for leadership and staffing observations and patient safety and quality. The uniform policy was not being adhered to by members of staff.
- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve

Gynaecology Children's and Oncology Division

- Talbot Butler Ward had no red or amber domains in June 2018 which is an improvement from previous months, the matron and ward team are continually progressing their results whilst working on their assessment and accreditation action plan.
- Spencer had no red domains and 1 amber domain.
- Disney Ward is closed due refurbishment work and scored nil.
- Paddington Ward had 1 red domain for June 2018, for patient safety and quality. Documentation remains a challenge and this has prompted the Childrens Practise Development Nurse to undertake a programme of education and audits around this across all of our acute areas.
- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve.

Midwifery
In light of the recent months amber and red domains across the Midwifery service for the QCI indicators across the Midwifery Service, the following actions have been commenced:

- The matron has been working with the Ward Sisters to improve QCI data collection.
- Ward Sisters and Junior Sisters are now solely responsible for their wards/departments/areas completion of the QCI data. The task is not to be delegated to others.
- Data is being screened and cleaned, and verified by the Matron before uploading of the data by the admin staff.
- Ward Sisters and Matrons to use Performance and Accountability framework for their 121s monthly, for which will include responsibility and accountability for QCI audits and professional standards.
- The ADM will continue to monitor the results and highlight specific themes or areas to improve. Actions and audit improvement will be monitored via the ADM and Matrons 121 also using the Performance and Accountability framework
- Midwifery Professional Leads Group will continue to monitor the results monthly and leads will provide assurances reports and/or action plans, the ADM will oversee.
- Junior Sisters of MOW/Robert Watson to lead on amending and adapting the QCI audit for maternity and getting it electronic and not paper based.
- Assessment and Accreditation to be developed for maternity services to be implemented for inpatient areas to offer further assurances, as soon as the tool has been validated.

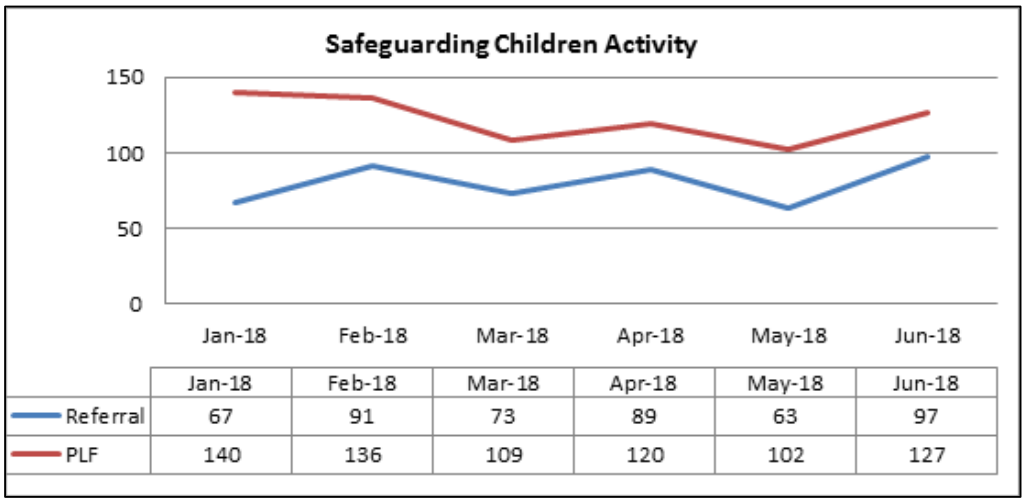
Improvements have been seen in QCI data quality and we expect to see further improvements once new process is fully embedded.

In June 2018 Summary: Following the implementation of the previous actions the QCI for the Midwifery service have started to improve.

- **Balmoral** had 1 amber domain for June in patient experience which is a data error (Nil submitted instead of N/A). Data cleaned but spreadsheet didn't re-calculate % prior to QCI dashboard development.
- **MOW**: had 1 amber domain for June in patient experience, this again is a data error as above.
- **Robert Watson**: 2 amber domains, one domain in patient experience due to noise from other patients. One amber domain in leadership and staffing due to a shift lead not wearing a red badge and a poorly stocked storeroom.
- **Sturtridge**: had 1 amber domain for June again in patient experience for noise from other patients. The nil for CD checking was 100% as this is entered under MOW by mistake (shared area).

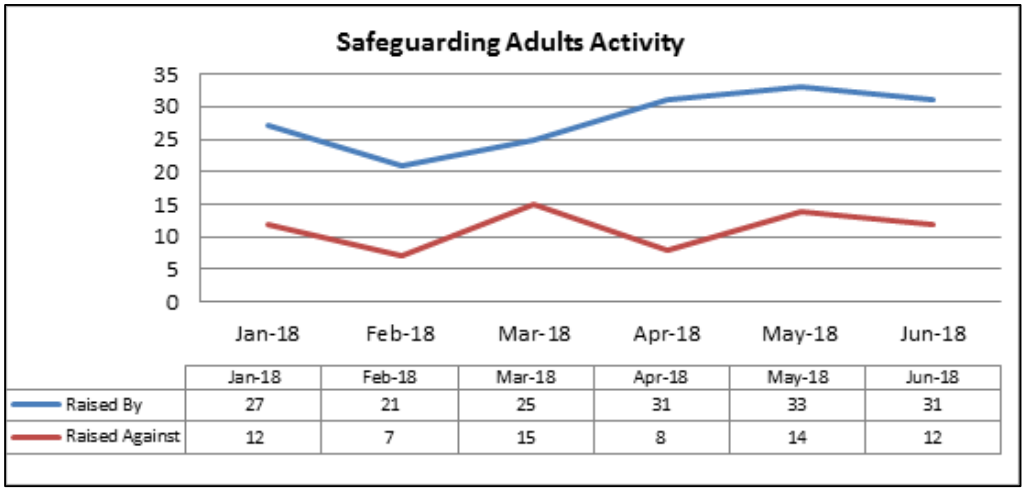
9. Safeguarding

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. There appears to have been a slight increase in the number of referrals made to the Multi-Agency Safeguarding Hub (MASH) and the number of PLF's completed in June 2018.



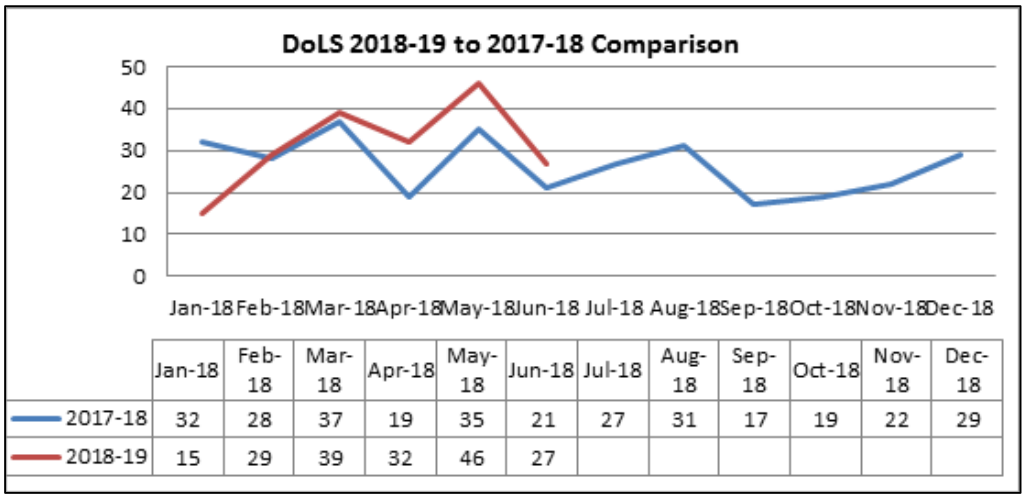
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Referral	67	91	73	89	63	97
PLF	140	136	109	120	102	127

In terms of safeguarding adults' referral activity, there has been a slight decrease in the number of safeguarding allegations raised by the Trust and a decrease in the number of safeguarding allegations against the Trust in June 2018. There are no identifiable trends regarding these figures.



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Raised By	27	21	25	31	33	31
Raised Against	12	7	15	8	14	12

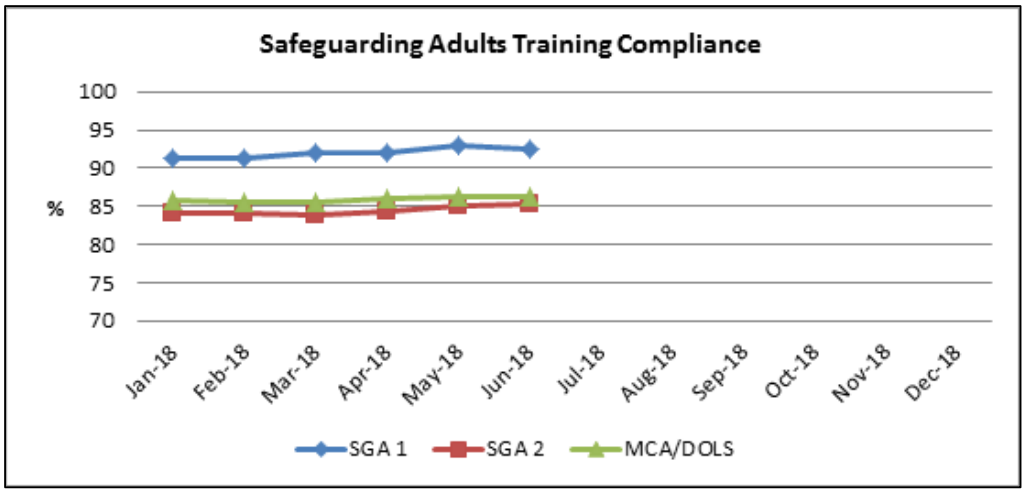
Deprivation of Liberty Safeguards (DoLS)



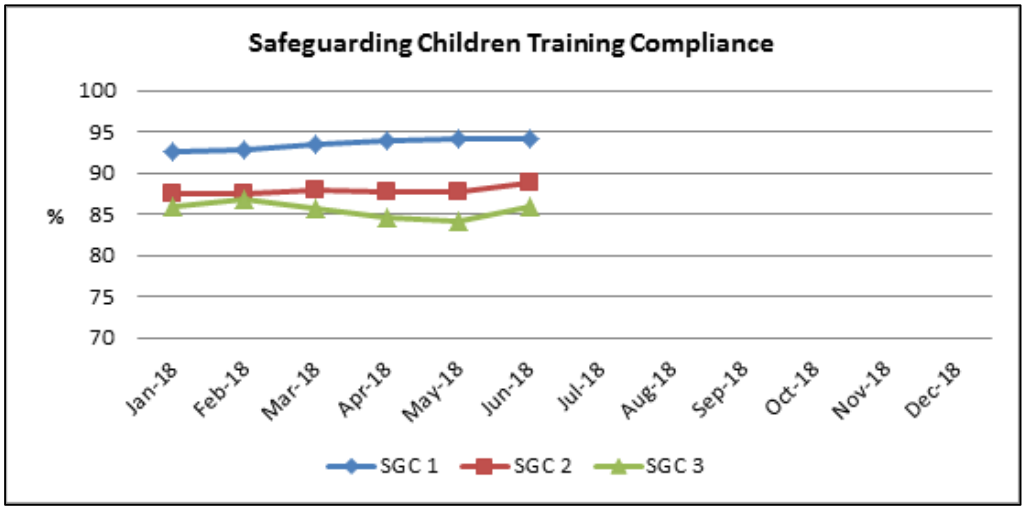
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
2017-18	32	28	37	19	35	21	27	31	17	19	22	29
2018-19	15	29	39	32	46	27						

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have significantly decreased during the reporting period. There is no identifiiable cause for this, but will be monitored closely by the adult Safeguarding Team.

Safeguarding Training Compliance
The two graphs illustrate the safeguarding training compliance for the Trust for June 2018: Compliance for level one safeguarding adults remains consistently compliant and there has been a slight increase in level two safeguarding adults to the expected compliance trajectory (85%). The safeguarding team are concentrating on obstetrics and gynaecology, oncology and urgent care as the areas that require training updates.



Safeguarding children level one and two training remain consistently compliant. Level three training has slightly increased to 86%, which has made all safeguarding training compliant for this reporting period.



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 92% compliance in Basic Prevent Awareness Training and 94% compliance (1114 staff members out of 1183) in WRAP training. The compliance trajectory is set as 85% and forms part of the quaterly report to NHS England and the Clinical Commissioning Group (CCG) as per the Prevent data assurance process.

10. Maternity Update

Local Maternity System (LMS) Transformational Plan

A Local Maternity System (LMS) Transformational Plan has been submitted (version 4). There is a detailed outline financial case for change (NHSE KLOE trajectories submission and informed the outline programme and work-stream plans for Continuity of Carer and Personalised Care Plan, Stillbirth and Neonatal deaths, Choice and Continuity of Carer).

Priority work streams identified for the next year (2018/2019) include;

- IT Digital
- Community Hubs
- Maternity Voices Partnership (MVPs)
- Continuity of carer
- Shared Learning

Clinical Negligence Scheme for Trusts (CNST)

Maternity Services have worked hard through the CNST incentive discount 10 criteria, in an attempt to access the 10% discount (£379,000). The CNST self-assessment was completed and the Maternity service was deemed to be complaint and the self-assessment was submitted. It is expected that the CNST monies will used to develop Maternity Safety work streams.

Maternity Improvement Plan

The Maternity Improvement Plan, The Best Possible Maternity Care every time: Journey to Outstanding, has been developed using the 5 CQC domains and with Maternity Transformation and National Maternity Safety initiatives. This will be launched together with the Midwifery Vision, overarching strategy and delivery plans 2018/2019 and 2019/2020 through Maternity Governance.

11. Safe Staffing

Overall fill rate for June 2018 was 102% compared to 104% in May and 102% in April. Combined fill rate during the day was 98% compared with 101% in May. The combined night fill rate was 107% compared with108% in May. RN fill rate during the day was 96% and for the night 97%. (Appendix 5)

Angela Grace (Dicken Therapy Unit):
There are two wards that form the Dickens Unit at Angela Grace where we commission beds for our patients to continue their clinical care.

Castle-Ashby ward & Althorp ward both have slightly different establishments & skill mix.

Castle-Ashby ward – 20 beds

Day shift	**Night shift**
1 Registered Nurse	1 Registered Nurse
1 team Leader (non-registered)	1 team Leader (non-registered)
3 HCA	1 HCA

Althorp ward – 16 beds

Day shift	**Night shift**
1 Registered Nurse	1 Registered Nurse
1 team Leader (non-registered)	1 team Leader (non-registered)
2 HCA	1 HCA

The establishment and skill mix is different to an acute hospital provider, such as ourselves, and is based on acuity & dependency of patients/clients in the rehabilitation phase of their care. To support the clinical staff there is a Clinical Lead who can work on the wards if there is a staff shortage and there is a Deputy Manager who can also work clinically if necessary.
During June 2018 there were 3 days shifts on Castle-Ashby when there was a reduction in one HCA. This was planned due to the low bed occupancy of 11 patients on the ward. No harm events occurred to patients during this time period.

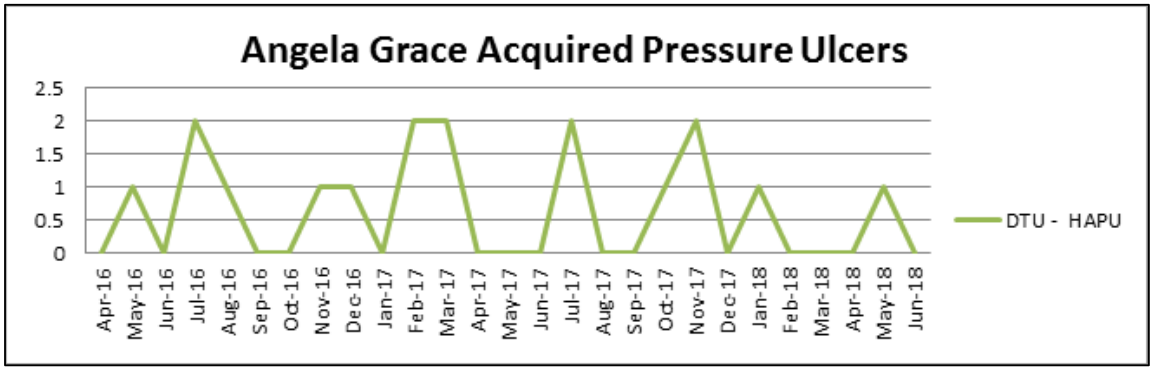
Avery:
We are currently in discussion with Avery to obtain an overview of the staffing data.

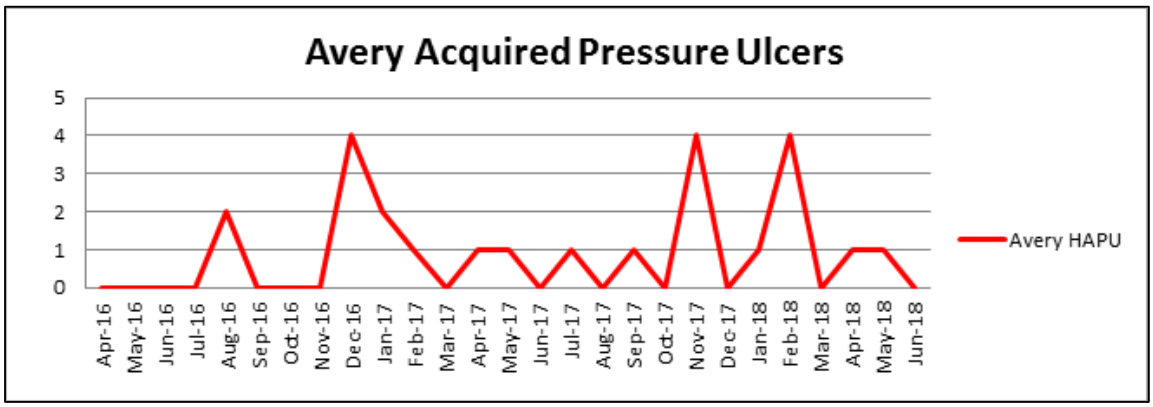
12. Avery and Dickens Therapy Unit

Avery/Angela Grace PU Incidence

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

There was no Pressure Ulcer reported on Avery (Blenheim and Cliftonville) or Dickens Therapy Unit (Angela Grace) during June 2018





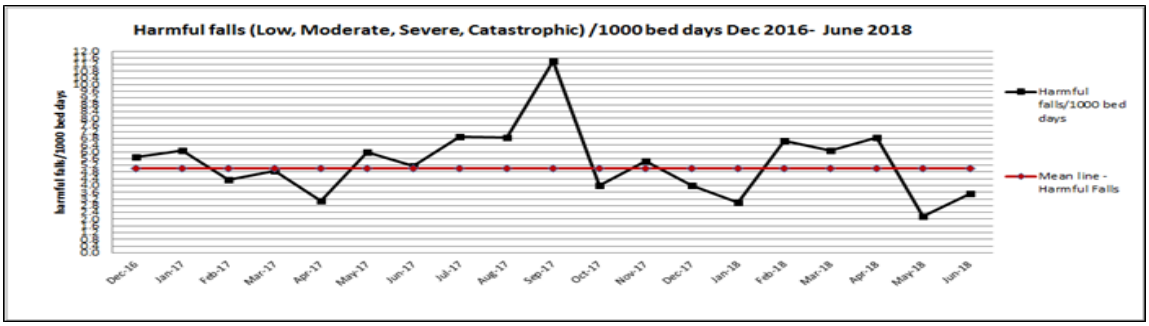
Infection Prevention

At Dickens and Avery in June 2018, there was 1 MRSA colonisation, with no MRSA bacteraemia, MSSA bacteraemias, *C.difficile* infections and E.coli bacteraemias

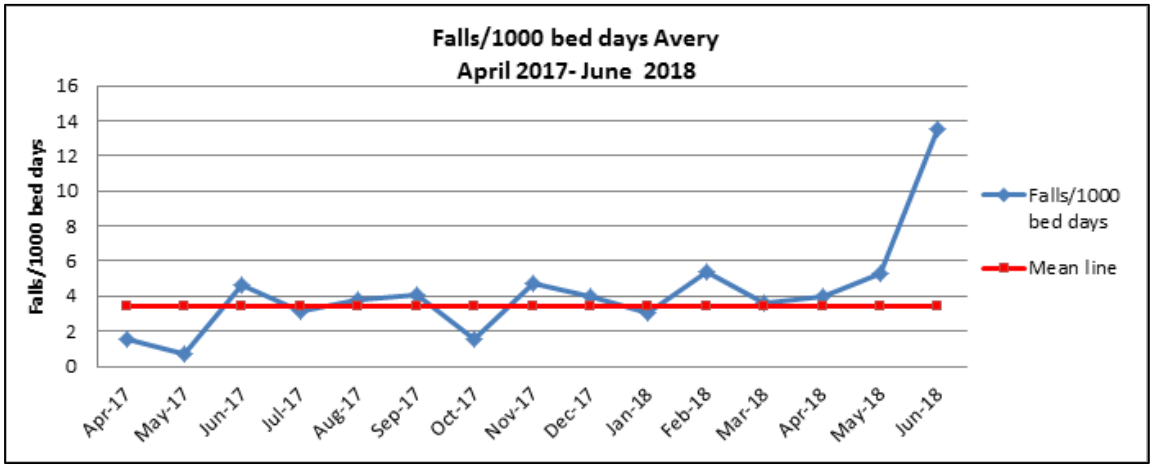
Dickens Therapy Unit

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

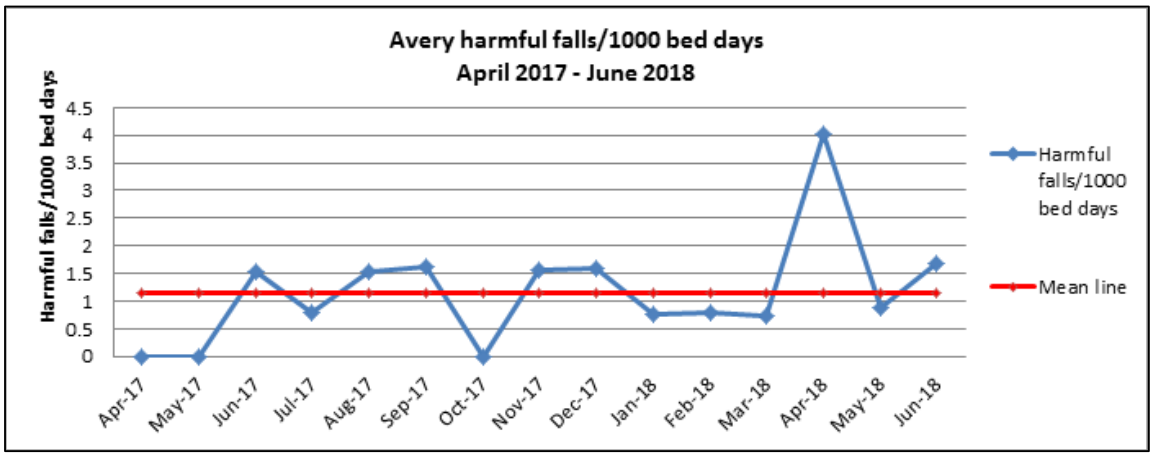
DTU Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in June 2018 by 1.37 when compared to May 2018. There were no moderate, severe or catastrophic harm patient falls in the month of June 2018.



Avery Falls Rates
There was an increase in the number of patient falls that were recorded at Avery during the month on June 2018. The graph below demonstrates incident data of the number of patient falls that have been recorded at Avery through June 2018. The biggest increase was at Blenheim where 12 patient falls were reported. Three patients had the 12 falls between them, in June 2018.
Following an increase in the number of falls at Avery in the month of June 2018 it has been agreed there will be a meeting to review Avery's policies, care plans and training. There has also been a meeting arranged to discuss the assessment process for Avery patients with the Site Management Team. An update on any actions will be provided in the July 2018 Director of Nursing Report.



Avery Data
The graph below demonstrates the total number of inpatient falls and the number of harmful inpatient falls (low, moderate, severe and catastrophic) at Avery between April 2017 and May 2018.



13. 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 and falls all harms are recorded on datix throughout the month (not just on this one day) reviews are undertaken to highlight any lapses in care, every area with an incident attends the Share and Learn forums to analyse further the incident and to develop plans for areas of improvement and future prevention.

Maternity Safety Thermometer

The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care. 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

Jun-2018	Medicine														WCO		Surgery							
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Holcot	Knightley	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp	General Wards
Falls/Safety Assessment	100.0%	97.1%	100.0%	100.0%	100.0%	97.1%	97.1%	100.0%	90.9%	57.1%	100.0%	100.0%	97.1%	80.0%	97.1%	93.3%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	96.4%
Pressure Prevention Assessment	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	94.4%	91.4%	51.4%	94.4%	89.4%	97.1%	94.4%	91.4%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	94.4%	94.4%	95.4%
Nutritional Assessment	97.1%	80.0%	100.0%	100.0%	87.1%	100.0%	100.0%	100.0%	97.1%	57.1%	100.0%	93.1%	100.0%	100.0%	100.0%	100.0%	93.1%	100.0%	97.1%	100.0%		93.1%	100.0%	91.1%
Patient Observation and Escalations	100.0%	100.0%	95.1%	95.1%	86.1%	100.0%	95.1%	100.0%	100.0%	100.0%		100.0%	100.0%	90.1%	95.1%	100.0%	95.1%	95.1%	95.1%	95.1%	100.0%	90.1%	100.0%	93.1%
Pain Management	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.1%	93.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.1%	87.1%	100.0%	99.1%
Nursing & Midwifery Documentation - Quality of Entry	100.0%	98.1%	100.0%	100.0%	97.1%	95.1%	98.1%	100.0%	87.1%	85.1%	100.0%	95.1%	93.1%	83.1%	90.1%	97.1%	93.1%	100.0%	96.1%	93.1%	93.1%	100.0%	100.0%	95.1%
Medication Assessment	100.0%	100.0%	100.0%	100.0%	100.0%	92.1%	100.0%	100.0%	100.0%	100.0%		100.0%	96.1%	100.0%	96.1%	100.0%	96.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.1%
Patient Experience - Protected Mealtimes (PMT) Observations	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.1%	100.0%	100.0%	67.1%	50.1%	100.0%	83.1%	100.0%	100.0%	83.1%	100.0%	100.0%	100.0%	100.0%	83.1%	100.0%	100.0%	89.1%
Patient Experience - Care Rounds Observe patient records	100.0%	100.0%	100.0%	100.0%	82.1%	100.0%	100.0%	100.0%	100.0%	82.1%	91.1%	80.1%	100.0%	100.0%	91.1%	100.0%	91.1%	82.1%	91.1%	100.0%	100.0%	82.1%	60.1%	89.1%
Patient Experience - Environment	100.0%	100.0%	100.0%	100.0%	100.0%	80.1%	100.0%	100.0%	100.0%	100.0%	80.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.1%	80.1%	100.0%	100.0%	100.0%	100.0%	92.1%
Patient Experience - Privacy and Dignity	87.1%	96.1%	95.1%	100.0%	100.0%	100.0%	92.1%	96.1%	88.1%	84.1%	75.1%	98.1%	99.1%	100.0%	98.1%	98.1%	95.1%	96.1%	95.1%	98.1%	99.1%	98.1%	100.0%	91.1%
Patient Safety and Quality	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	67.1%	95.1%	71.1%	100.0%	80.1%	100.0%	100.0%	86.1%	95.1%	86.1%	100.0%	90.1%	95.1%	100.0%	100.0%	93.1%	95.1%	89.1%
Leadership & Staffing observations	100.0%	100.0%	98.1%	100.0%	92.1%	98.1%	76.1%	94.1%	74.1%	92.1%	77.1%	100.0%	94.1%	92.1%	98.1%	98.1%	100.0%	98.1%	96.1%	100.0%	100.0%	100.0%	100.0%	90.1%
EOL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.1%
SOVA/LD/Cognitive Impairment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.1%	100.0%	100.0%	100.0%	96.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.1%
First Impressions/15 Steps	97.1%	77.1%	97.1%	80.1%	71.1%	89.1%	80.1%	77.1%	77.1%	97.1%	86.1%	86.1%	80.1%	80.1%	100.0%	91.1%	83.1%	83.1%	80.1%	100.0%	97.1%	91.1%	100.0%	83.1%
Safety Thermometer – Percentage of Harm Free Care	100.0%	92.3%	92.9%	100.0%	97.5%	83.3%	96.4%	100.0%	93.8%	100.0%	100.0%	86.2%	81.0%	94.4%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.7%	100.0%	95.8%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	3	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	10
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	3
Falls (Moderate, Major & Catastrophic)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	2
Patient Overdue Observations frequency - <7%	5.7%	7.1%	15.7%	7.5%	4.1%	9.1%	16.9%	3.8%	6.0%	6.5%	7.5%	5.4%	7.0%	13.5%	6.6%	8.3%	7.2%	5.6%	7.5%	7.2%	5.6%	6.3%	5.1%	7.6%
Caring																								
Complaints – Nursing and Midwifery	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	3
Number of PALS concerns relating to nursing care on the wards	0	0	0	0	1	0	0	1	2	0	0	0	2	2	0	1	0	0	1	0	0	0	0	10
Friends Family Test % Recommended	93.1%	97.5%	90.7%	74.3%	89.7%	100.0%	91.0%	94.7%	88.5%	91.3%	87.5%	78.9%	80.0%	75.0%	90.6%	73.4%	93.8%	83.9%	89.5%	97.8%	94.7%	95.7%	91.0%	90.5%
Well Led																								
Staff Nurse Staffing - Registered Staff (day & night combined)	91%	97%	95%	100%	105%	100%	90%	92%	121%	92%	92%	98%	96%	95%	92%	99%	101%	98%	100%	109%	102%	102%	93%	98%
Staff Nurse Staffing - Support Worker (day & night combined)	120%	107%	169%	181%	114%	155%	122%	96%	152%	106%	126%	166%	170%	158%	94%	102%	106%	101%	102%	128%	106%	110%	93%	125%
Staffing related datix	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3

Appendix 3

Jun 18	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	nil	90%	100%
Pressure Prevention Assessment (Q)	nil	100%	92%
Child Observations [documentation] (Q)	nil	98%	100%
Safeguarding [documentation] (Q)	nil	100%	81%
Nutrition Assessment [documentation] (Q)	nil	100%	97%
Medication Assessment (Q)	nil	95%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Safety Thermometer – Percentage of Harm Free Care			
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Overdue Observations frequency - <7%	0%	0%	0%
Patient Experience			
Friends Family Test % Recommended	100%	95%	100%
Complaints – Nursing and Midwifery			
Number of PALS concerns relating to nursing care on the wards			
Call Bells responses (Q)	nil	100%	nil
Patient Safety & Quality Environment Observations Observe patient records (Q)	nil	25%	100%
Privacy and Dignity (Q)	nil	100%	95%
Management			
Staffing related datix			1
Monthly Ward meetings (Q)	nil	100%	100%
Leadership & Staffing observations (Q)	nil	100%	94%

Appendix 4

Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	100%	96%	100%	100%
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	100%	94%	100%	100%
Medication Assessment (Q)	100%	100%	100%	100%
Environment Observations (Q)	100%	100%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	100%	100%	100%	100%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	100%	100%	100%	nil
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	100%	100%
Patient Experience (Q)	78%	82%	76%	85%
Patient Safety and Quality (Q)	100%	100%	100%	100%
Leadership & Staffing (Q)	100%	100%	100%	100%
Management				
Staffing related datix				1
Monthly Ward meetings (Q)	100%	100%	100%	100%
Saftey and Quality (Q)	100%	94%	100%	100%
Leadership & Staffing (Q)	100%	88%	100%	100%

Appendix 5

Northampton General Hospital NHS
NHS Trust

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — **June 2018**

Ward name	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)				Actions/Comments	Red Flag
	Registered midwives/ nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall		
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Key: Below 80% Shift Fill Rate Target / 80% and Above Shift Fill Rate Target									
Abington Ward (NOF)	1,808.75	1,862.00	1,362.00	1,253.75	1,035.00	1,035.25	1,023.50	1,263.25	102.9%	92.1%	100.0%	123.4%	803	3.6	3.1	6.7		
Allebone Ward (Stroke)	1,559.73	1,365.98	1,114.50	1,211.25	1,377.75	1,320.25	688.75	952.25	87.6%	108.7%	95.8%	138.3%	839	3.2	2.6	5.8		
Althorp (T&O)	935.25	824.50	577.75	536.50	690.00	692.75	322.00	299.00	88.2%	92.9%	100.4%	92.9%	195	7.8	4.3	12.1		
Becket Ward	1,966.50	1,854.15	1,352.25	1,402.50	1,725.00	1,714.75	690.00	790.50	94.3%	103.7%	99.4%	114.6%	770	4.6	2.8	7.5		
Benham (Assess Unit)	1,694.75	1,578.25	862.50	1,240.75	1,380.00	1,357.00	690.00	1,380.00	93.1%	143.9%	98.3%	200.0%	669	4.4	3.9	8.3		
Brampton Ward	1,374.25	1,368.00	1,031.00	1,484.50	1,025.75	1,023.67	690.00	1,628.50	99.5%	144.0%	99.8%	236.0%	850	2.8	3.7	6.5		
Cedar Ward (TRAUMA)	1,825.92	1,872.58	1,674.75	1,652.25	1,035.00	1,035.00	1,023.50	1,324.75	102.6%	98.7%	100.0%	129.4%	852	3.4	3.5	6.9		
Collingtree Medical (40)	2,308.50	2,516.92	1,714.00	1,640.42	1,725.00	1,715.00	690.00	1,089.75	109.0%	95.7%	99.4%	157.9%	1208	3.5	2.3	5.8		
Compton Ward	1,023.75	975.25	716.25	956.75	690.00	690.00	345.00	685.50	95.3%	133.6%	100.0%	198.7%	539	3.1	3.0	6.1		
Creaton SSU	2,019.25	1,671.00	1,033.00	1,165.50	1,375.25	1,375.00	1,035.00	1,355.50	82.8%	112.8%	100.0%	131.0%	637	4.8	4.0	8.7		
Dryden Ward	2,058.50	1,785.23	931.50	839.50	1,380.00	1,380.00	690.00	722.42	86.7%	90.1%	100.0%	104.7%	760	4.2	2.1	6.2		
EAU New	1,668.25	1,966.75	1,617.00	1,985.00	1,104.00	1,393.92	690.00	1,524.75	117.9%	122.8%	126.3%	221.0%	940	3.6	3.7	7.3		
Eleanor Ward	1,018.25	876.00	690.00	694.73	690.00	701.50	690.00	769.75	86.0%	100.7%	101.7%	111.6%	299	5.3	4.9	10.2		
Finedon Ward	2,070.00	1,822.75	354.02	416.52	1,035.00	1,035.25	356.50	480.50	88.1%	117.7%	100.0%	134.8%	472	6.1	1.9	8.0		
Hawthorn & SAU	1,888.25	1,870.58	1,030.25	1,024.00	1,380.00	1,389.75	931.00	970.25	99.1%	99.4%	100.7%	104.2%	834	3.9	2.4	6.3		
Head & Neck Ward	1,029.00	1,093.25	345.00	414.25	885.50	988.75	345.00	470.17	106.2%	120.1%	111.7%	136.3%	381	5.5	2.3	7.8		
Holcot Ward	1,343.75	1,299.17	1,354.75	1,722.75	1,035.00	1,035.00	690.00	1,677.75	96.7%	127.2%	100.0%	243.2%	841	2.8	4.0	6.8		
Knightley Ward (Medical)	1,031.25	956.50	861.50	1,211.25	1,035.00	1,035.00	342.25	834.00	92.8%	140.6%	100.0%	243.7%	624	3.2	3.3	6.5	Reviewed by Wd Sr & Matron. No harm to patients.	1 Red flag due to vacancy
Rowan (LSSD)	1,896.75	1,987.25	1,029.75	1,044.50	1,722.75	1,679.33	690.00	782.00	104.8%	101.4%	97.5%	113.3%	815	4.5	2.2	6.7		
Spencer Ward	1,381.00	1,354.75	1,020.75	995.00	1,035.00	1,039.58	1,035.00	1,108.25	98.1%	97.5%	100.4%	107.1%	564	4.2	3.7	8.0		
Talbot Butler Ward	2,465.25	2,169.92	1,337.67	1,188.17	1,380.00	1,380.00	690.00	724.50	88.0%	88.8%	100.0%	105.0%	754	4.7	2.5	7.2		
Victoria Ward	1,147.25	1,063.75	690.00	919.25	690.00	690.00	345.00	713.00	92.7%	133.2%	100.0%	206.7%	533	3.3	3.1	6.4		
Willow Ward (+ Level 1)	2,242.50	2,207.08	1,023.50	1,001.00	2,070.00	2,011.25	690.00	736.00	98.4%	97.8%	97.2%	106.7%	785	5.4	2.2	7.6		
													Total Average CHPPD	4.2	3.1	7.4		
ITU	4,845.25	4,264.58	752.50	613.00	4,473.50	4,123.83	690.00	609.50	88.0%	81.5%	92.2%	88.3%	318	26.4	3.8	30.2		
													Total Average CHPPD	26.4	3.8	30.2		
Barratt Birth Centre	1,752.30	1,533.50	686.00	435.00	1,380.00	1,271.25	685.83	394.33	87.5%	63.4%	92.1%	57.5%	127	22.1	6.5	28.6	Operational bleep holder re-assigned staff to ensure safe care. Rectruitment for MSWs in progress.	No red flags
Robert Watson	1,019.50	1,236.33	1,262.50	1,041.42	1,035.00	950.00	1,022.75	722.00	121.3%	82.5%	91.8%	70.6%	470	4.7	3.8	8.4	Recruitment for MSW on-going	
Sturtridge Ward	4,182.62	3,899.00	1,806.50	1,406.50	3,988.75	3,535.00	1,297.75	964.50	93.2%	77.9%	88.6%	74.3%	480	15.5	4.9	20.4	Operational bleep holder re-assigned staff to ensure safe care. Rectruitment for MSWs in progress.	No red flags
													Total Average CHPPD	14.1	5.1	19.1		
Disney Ward	1,654.75	1,612.67	925.50	808.75	1,035.00	1,048.25	345.00	345.00	97.5%	87.4%	101.3%	100.0%	118	22.6	9.8	32.3		
Gosset Ward	2,762.55	2,699.88	545.50	452.00	2,461.00	2,423.33	322.00	276.00	97.7%	82.9%	98.5%	85.7%	495	10.3	1.5	11.8		
Paddington Ward	2,152.50	2,064.50	929.75	792.75	1,972.25	1,679.25	425.50	424.00	95.9%	85.3%	85.1%	99.6%	416	9.0	2.9	11.9		
													Total Average CHPPD	14.0	4.7	18.7		
													Total Average CHPPD Trust wide	10.1	3.7	13.8		

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**26th July 2018**

Title of the Report	Financial Position - Quarter 1 (FY18-19)
Agenda item	10
Sponsoring Director	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the quarter ended June 2018.

Executive summary

This report sets out the Trust's financial position for the quarter ended 30th June 2018 and shows a reported post-PSF deficit of £6,520k against the planned post-PSF deficit of £6,555k, resulting in a favourable variance of £35k. In comparison to last month's results with a favourable position of £1,226k, the marked change highlights the profiling of the system-related income gap of £1,150k (FYE of £4,600k) phased quarterly in the plan.

CAMIS has been implemented successfully in month 3 and we are working through a few emerging issues to ensure that income and activity are fully captured and coded.

The full Provider Sustainability Funding (PSF) of £1,379k has been played into the position, although the A&E element of £414k could be at risk.

Non-pay spend was in line with plan overall.

Delivery of CIPs year to date is £3,608k against plan of £2,152k. The YTD delivery includes non-recurrent pay underspend of £2,211k

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY18-19 signals another challenging financial year and the requirement to maintain the financial discipline required to deliver the agreed control total.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board

The Board is asked to note the financial position for the quarter ended June 2018 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Quarter 1 (June 18)
FY 2018/19

Report to:

Trust Board

July 2018

Content

1. Director of Finance Message

The Trust financial position for Q1 was in line with plan, with the favourable variances built up in months 1&2, offset in month 3 by the system related income gap of £1,1150k (FYE of £4,600k).

CAMIS has been implemented successfully in month 3 and we are working through a few emerging issues to ensure that income and activity are fully captured and coded.

The full PSF of £1,379k has been played into the position, although the A&E element of £414k could be at risk.

This report sets out the Trust's financial position for the quarter ended 30th June 2018. The results show a reported post-PSF deficit of £6,520k against the planned post-PSF deficit of £6,555k, which is a favourable variance of £35k. In comparison to last month's results with a favourable position of £1,226k, the marked change highlights the profiling of the system-related income gap of £1,150k (FYE of £4,600k) phased quarterly in the plan. The full Provider Sustainability Funding (PSF) of £1,379k has been played into the position, although the A&E element of £414k could be at risk.

The in-month performance was an adverse variance £1,196k which is largely driven by Income and Pay adverse variances.

Income variance of £1,223k (plus excluded medicines variance of £344k) mainly relates to the income gap identified at planning stage which is expected to be met from schemes via the STP. Some of the schemes have now been identified however as at month 3, none of this has been played into the position. Should that have been the case, the position would have been better by £600k being the pro-rata of the schemes agreed to date, expected to be contractualised in July 2018.

CAMIS, the new patient administration system has been implemented successfully in June and we are working through a few emerging issues to ensure that income and activity are fully captured and coded. We have made reasonable estimates where there are concerns about the accuracy of data.

Pay variance was £698k adverse in month relating to: two bank holiday enhancement payments of £165k (paid one month in arrears), over establishment of medical staff including use of agency medical staff in Cardiology, Oncology, Surgery, as well as over-establishment of nursing staff due to escalation and supernumerary. The overspending cost centres will be held to account as part of the newly implemented 'Cost centre overspend' accountability mechanism.

Unplanned pay savings of £588k arising from pay underspends across a number of cost centres has been applied as non-recurrent CIPs in month 3.

Non-pay was on plan although buoyed by favourable variances from excluded medicines highlighted above.

Other income: The runrate favourable variance continued in month 3 with a £237k favourable variance relating to increased catering income, salary recharges and one-off charitable funds contribution towards expenditure.

Salary Overpayments identified in month 3 was £37k bringing the YTD position to £126k (M2: £89k). The Divisions are reminded of their responsibilities in this regard and will be performance managed on overspending cost centres. In addition, training and payroll workshops are being provided to support managers.

Agency ceiling: The Trust is exceeding the NHSI target of £934k by £121k in month 3. The overspend largely relates to medical staff and these are being monitored via the bi-weekly Agency management group.

CIPs: Year to date delivery of £3,608k against plan of £2,152k. The YTD delivery includes non-recurrent pay underspend of £2,211k.

Cash: Cash balance at the end of the month is £5,766k.

Capital: Capital spend to date at month 3 is £1,349k against a plan of £1,470k.

Single oversight framework: The Trust continues to score "3" against the "finance and use of resources" metric.

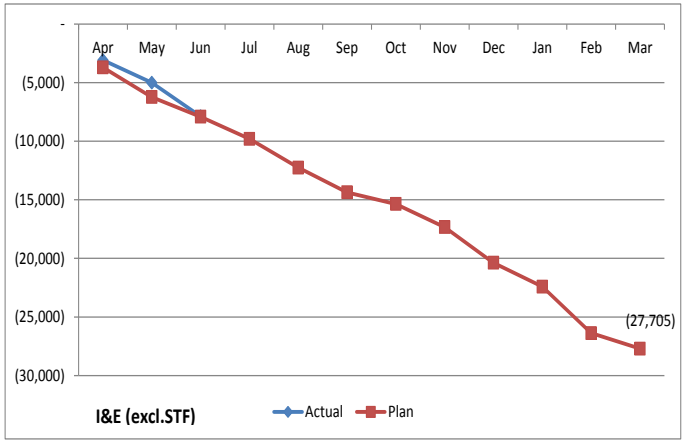
Income and Expenditure Summary

I&E Summary	Actual FY16-17	Actual FY17-18	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
				Plan	Actual	Variance	Plan	Actual	Variance	May 18	Apr 18
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	271,513	286,151	24,503	22,936	(1,567)	70,495	68,868	(1,627)	23,614	22,319
Other Clinical Income	2,373	5,837	11,898	685	637	(48)	2,056	1,868	(188)	579	652
Other Income	31,824	20,654	21,311	1,772	2,009	237	5,306	6,032	726	2,058	1,965
Total Income	294,525	298,004	319,360	26,960	25,582	(1,378)	77,857	76,768	(1,089)	26,250	24,935
Pay Costs	(199,813)	(207,233)	(218,165)	(17,577)	(18,275)	(698)	(52,251)	(54,150)	(1,900)	(17,938)	(17,937)
Non-Pay Costs	(94,406)	(103,550)	(109,854)	(9,002)	(8,687)	315	(26,909)	(26,039)	870	(8,737)	(8,615)
Unallocated CIPs		0	6,370	(356)		356	(1,499)		1,499		
Reserves/ Non-Rec		0	(2,955)	(207)		207	(649)		649		
Total Costs	(294,219)	(310,783)	(324,604)	(27,143)	(26,962)	181	(81,308)	(80,189)	1,118	(26,675)	(26,552)
EBITDA	306	(12,779)	(5,245)	(184)	(1,380)	(1,196)	(3,451)	(3,421)	29	(425)	(1,616)
Depreciation	(9,703)	(10,056)	(10,615)	(830)	(830)	(1)	(2,490)	(2,490)	(1)	(830)	(830)
Amortisation	(9)	(9)	(8)	(1)	(1)	(0)	(2)	(2)	(0)	(1)	(1)
Impairments	(1,732)	(4,085)	(1,826)	(0)		0	(0)		0		
Net Interest	(720)	(823)	(1,239)	(95)	(91)	5	(280)	(270)	10	(94)	(85)
Dividend	(3,307)	(2,411)	(1,529)	(127)	(126)	1	(382)	(381)	1	(127)	(127)
Surplus / (Deficit)	(15,165)	(30,164)	(20,462)	(1,237)	(2,428)	(1,191)	(6,605)	(6,565)	40	(1,477)	(2,660)
NHS Breakeven duty adjs:											
Donated Assets	(414)	138	122	25	26	1	75	71	(4)	20	25
NCA Impairments	1,732	4,085	1,826	0		(0)	0		(0)		
Surplus / (Deficit) - Normalisec	(13,847)	(25,940)	(18,514)	(1,212)	(2,402)	(1,190)	(6,530)	(6,494)	36	(1,457)	(2,635)

I&E Analysis (Pre & Post PSF)

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,705)	(7,934)	(7,899)	35
PSF	9,191	1,379	1,379	-
Post PSF	(18,514)	(6,555)	(6,520)	35

Pre-PSF I&E Performance

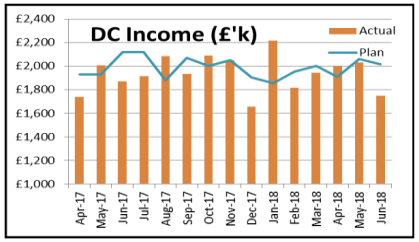


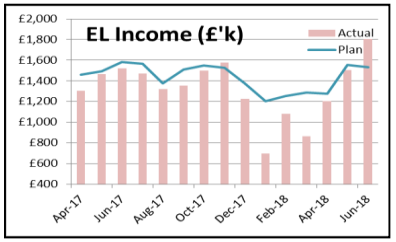
2.1 Clinical Income (YTD)

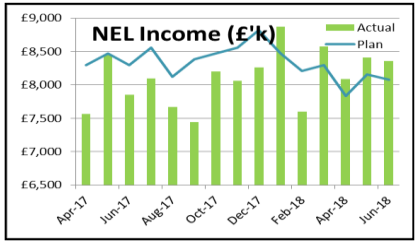
Month 3 SLA Clinical Income is below plan, with a variance of -£912k (excluding pass-through medicines and devices). The movement from a Month 2 position of +£310k is largely due to the income gap associated with the Northamptonshire STP which was phased quarterly into the plan. The impact on quarter 1 is £1,150k.

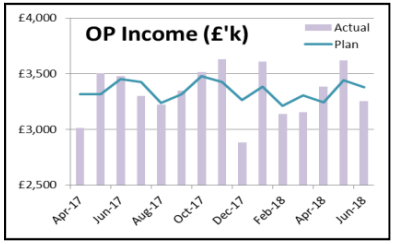
- A&E activity is above plan, and also shows a casemix variance. An element is subject to coding & counting challenge.
- Cost per Case (CPC) is above plan due to Radiotherapy activity and Direct Access volumes. This is offset by Maternity income under plan.
- Day case performance appears to have slowed in Month 3, now below plan by 1% on activity, 3% financially. General Surgery is under plan by £136k, with T&O under by £132k, partly offset by Vascular and Urology activity ahead of plan.
- Elective activity appears to have improved in Month 3, currently reporting 20% above the activity plan, 3% financially. However it appears that this may be one of the impacts of CaMIS, causing a swing between Elective and Daycase and is being investigated. Planned activity overall is 1.7% over plan, with casemix bringing the financial position to 0.6% below.
- NEL activity is 3.5% below plan, but positive casemix reports a 3% favourable variance in income. General Surgery (26%), Cardiology (15%) and T&O (6%) remain the most significant areas above income plan. Stroke is the main beneficiary from casemix. XS bed day income partly offsets this variance.
- Outpatients are below activity plan by 2%, particularly in Ophthalmology and Cardiology, although only 0.1% under the income plan. OPROCS are 5% above. Again an in-month issue has been identified regarding CAMIS and is expected to be resolved by month 4. In the meantime, a prudent estimate has been included in the numbers.

Table 5: Key PoD Trend Analysis









Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
AandE	32,053	32,661	608	4,106	4,287	182
Block	-	-	-	2,717	2,728	12
Cost per Case	734,821	776,707	41,886	9,261	9,372	111
CQUIN	-	-	-	1,251	1,251	0
Day Cases	9,936	9,840	(96)	5,986	5,777	(209)
Elective	1,346	1,638	292	4,363	4,513	151
Elective XBDs	313	318	5	84	107	23
Non-Elective	12,995	12,543	(451)	24,060	24,847	787
Non-Elective XBDs	8,055	5,802	(2,254)	1,997	1,367	(630)
Outpatient First	14,405	13,492	(913)	2,541	2,448	(93)
Outpatient Follow-up	51,806	51,462	(344)	4,130	4,215	85
Outpt Procedures	37,428	39,364	1,936	4,594	4,893	299
STP related income				1,150	0	(1,150)
CIP / Other				491	0	(491)
sub-total	**903,158**	**943,827**	**40,669**	**66,728**	**65,805**	**(923)**
Contract Penalties				(58)	(30)	28
Challenges				(450)	(467)	(17)
Readmissions				(799)	(799)	0
MRET				(1,480)	(1,480)	0
Fines & Penalties				**(2,786)**	**(2,775)**	**11**
Subtotal (excl. Excl Meds & Dev.)	**903,158**	**943,827**	**40,669**	**63,942**	**63,031**	**(912)**
Excluded Devices	1,123	817	(306)	510	375	(135)
Excluded Medicines	2,017	2,515	498	6,042	5,462	(580)
Total SLA Clinical Incom	**906,298**	**947,159**	**40,861**	**70,495**	**68,868**	**(1,627)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	286	176	(111)
Overseas Visitors	33	15	(18)
RTA / Personal Injury Income	357	266	(91)
PSF Funding	1,379	1,411	32
Total Other Clinical Income	**2,056**	**1,868**	**(188)**

2.2 Clinical Income By Commissioner (YTD)

Nene Contract - £602k over performance
The Month 3 position on the Nene contract is £602k over plan. This is from £763k in Month 2. The Month 3 position is likely to increase as the investigations into OP activity, and further IP coding are concluded enabling more activity to be verified against Commissioners.

Key impacts include:

- A&E activity above plan and favourable casemix. As mentioned previously there is a related Coding & Counting challenge which is not reported against the CCG at this stage.
- Critical Care. Following the discharge of a long term patient and continuing high occupancy this remains over plan.
- OPROC activity in Ophthalmology during May was a key driver of over-performance on this POD (+£165k)
- NEL is the most significant, £925k over plan due to favourable casemix. This is partially offset by NEL XS bed day income below plan (£-549k), and planned activity and casemix (-£209k).

Specialised Commissioner - £585k under performance
The under performance is attributable to excluded devices (-£138k), and excluded medicines (-£540k) which will have equivalent underspends. Hep C uptake has slowed dramatically in Q1, causing the majority of the variance.
Non-elective activity is also below plan, specifically in Paediatrics, Cardiology and General Medicine, although this is offset by planned activity, OP procedures and Radiotherapy income.

Secondary Dental - £61k over performance
Over-performance on Secondary Dental is in the MaxFax Specialty, £72k over in non-Elective activity and £18k in OP and OPROCs.

Other - £1,889k under performance
£1,150k relates to the STP related income target, and £490k relating to Productivity CIPs.

SLA Clinical Income by Commissioner

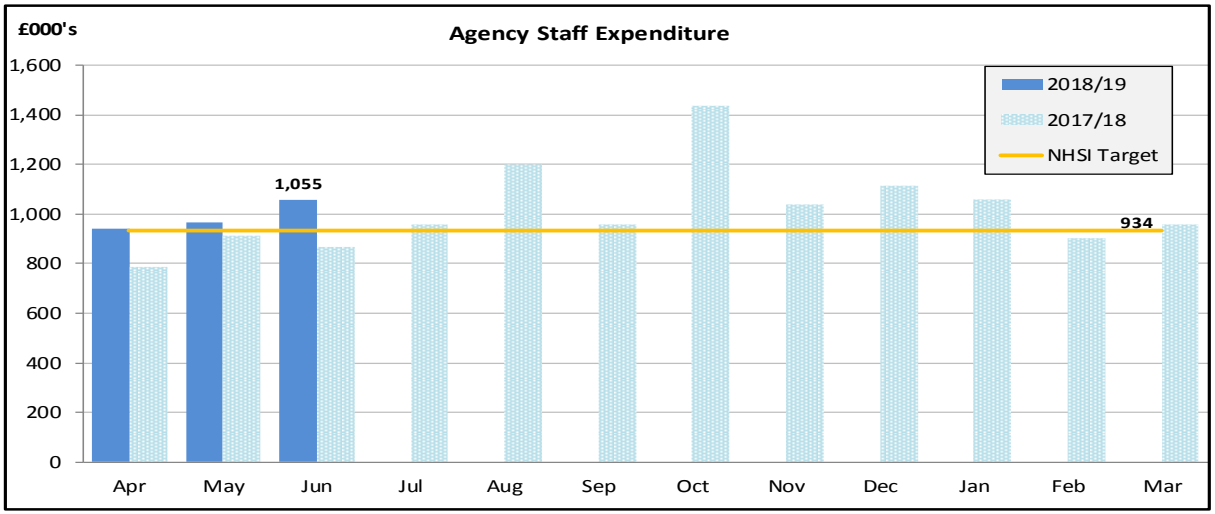
Commissioner	Finance £000's YTD Plan	Actual	Variance
Nene CCG	54,534	55,136	602
Corby CCG	657	781	123
Bedfordshire CCG	180	194	14
East Leicestershire & Rutland CCG	192	230	38
Leicester City CCG	13	22	10
West Leicestershire CCG	14	12	(1)
Milton Keynes CCG	-	-	-
Specialised Commissioning	10,294	9,709	(585)
Secondary Dental	1,632	1,694	61
NCA / Central / Other	2,979	1,090	(1,889)
Total SLA Income	**70,495**	**68,868**	**(1,627)**

2.3 STP Income Gap - Update

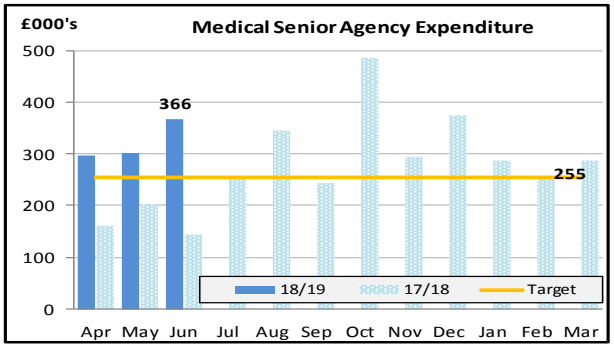
- The Northants healthcare system financial gap for 2018/19 has been estimated at £22.1m.
- The Directors of Finance have been able to find opportunities to cover £9.69m of this gap. This includes £4m of elective income repatriation for NGH which now needs plans to deliver in year. The table below shows the position by organisation.
- The governing bodies of the CCGs and the Board of NHFT will be discussing the identified items and gaining approval to transact the contract changes during June / July 2018 so that these can be applied by contact variations to our contract with Nene CCG by the end of July 2018.
- For NGH this would mean just over half of our £4.6m system gap will be covered but the balance currently has no resolution at this time and therefore remains a risk to meeting our control total.
- The agreed £2.3m is expected to be incorporated in the contracts in July. If this had been profiled evenly over the year, there would have been an improvement to the Q1 position of £600k.
- NHSE were written to by the system Chief Executives asking if they would bridge the £12.4m gap, mentioning that NHSI had improved control totals by £11m, and the response back was 'no'. Work now continues to look at opportunities to bridge this £12.41m system gap.

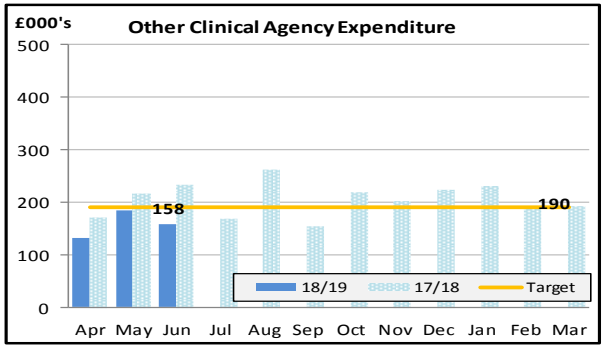
Solutions to bridge the systems gap	£m	KGH £m	NGH £m	NHFT £m	CCG £m
System Gap to Control Totals	**22.10**				
MRET assumptions KGH 16/17 v 18/19	***0.90***	0.90			
Fines split 50/50	***0.18***	0.08	0.10		
CQUIN fixed at 92% of opening contract values	***1.01***	0.31	0.60	0.10	
NHFT system contribution*	***1.00***	0.55	0.45		
NGH Income CIP	***4.00***		4.00		
MRET / Re-admissions*	***2.60***	1.43	1.17		
System sub total	**9.69**	**3.27**	**6.32**	**0.10**	**0.00**
Transactable in contract		3.27	2.32	0.10	0.00
System gap	**12.41**				

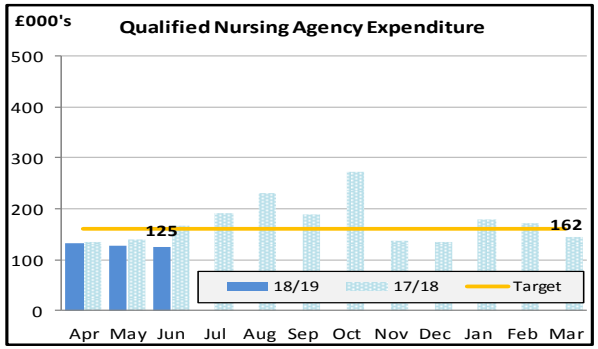
3. Pay: Agency Spend

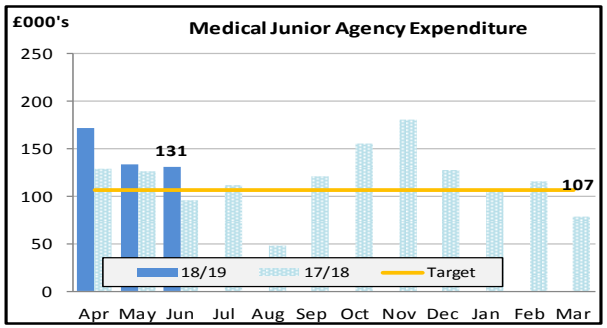


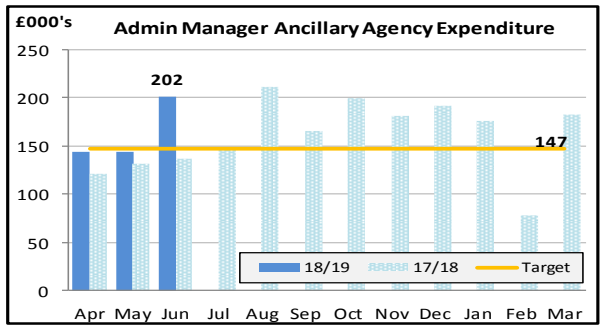
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Three new senior medical locums (2 surgical, 1 cardiology) this month have added to the already high level of agency cover in this staff group.

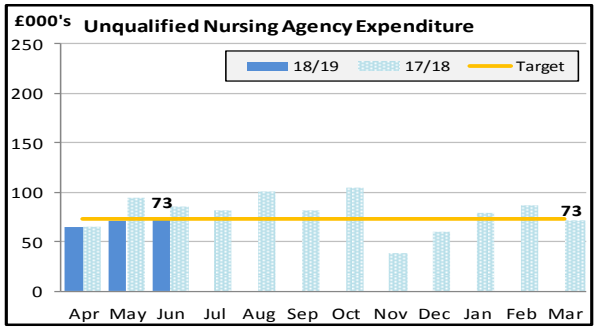












5. Trust wide CIP Programme update – M3

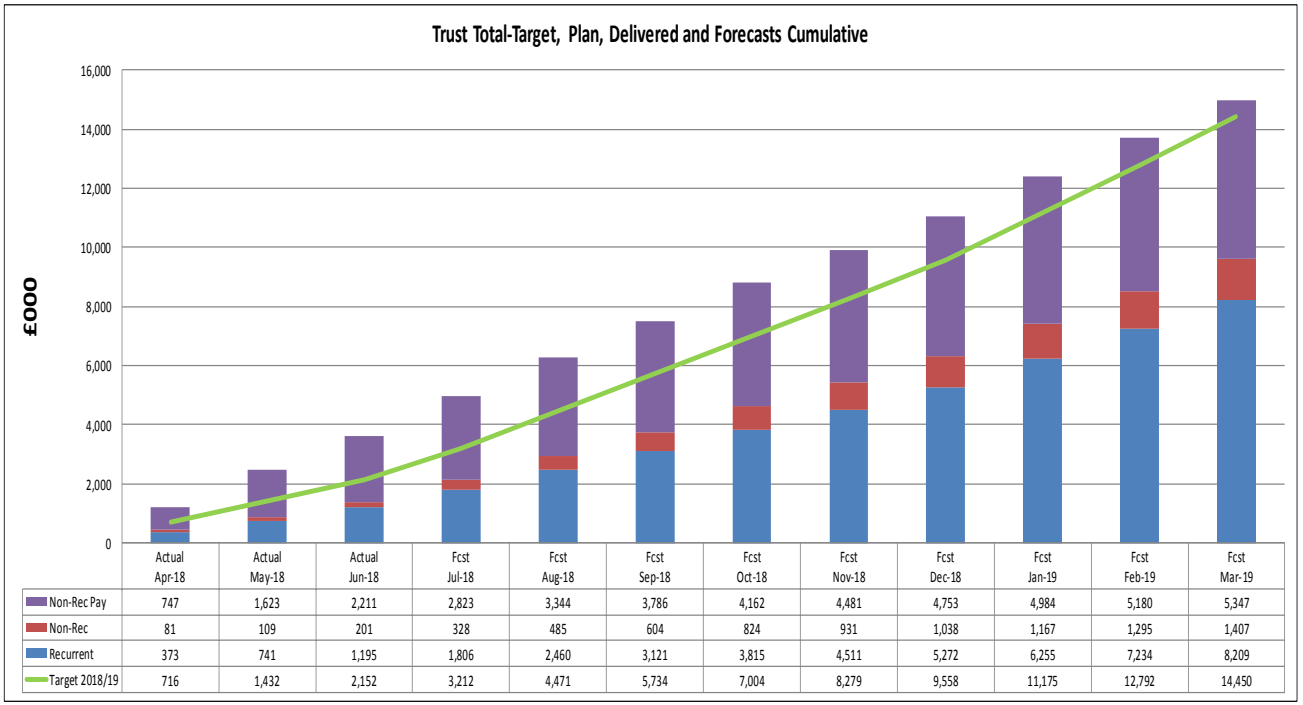
Overall Improvement Programme Update

YTD Delivery £000's

Division	Plan	YTD Plan	YTD Actual Rec	YTD Actual N/R	YTD Actual N/R Pay Underspend	Actual Total	Variance vs plan
SURGICAL DIVISION	3,894	580	277	66	477	820	240
MEDICAL DIVISION	3,815	568	296	32	325	654	86
WCOH DIVISION	2,205	328	262	14	394	670	342
CSS DIVISION	1,734	258	135	59	608	802	543
HOSPITAL SUPPORT	1,118	166	0	13	408	420	254
FACILITIES	1,153	172	225	17	0	243	71
Expenditure Other (Held Cer	532	79	0	0	0	0	-79
Trust Total	**14,450**	**2,152**	**1,195**	**201**	**2,211**	**3,608**	**1,456**

LTF £000's

Division	Plan	LTF Rec	LTF N/R	Actual N/R Pay Underspend	LTF Total	RAG Rated	Variance vs Risk Adjusted
SURGICAL DIVISION	3,894	2,243	357	1,148	3,748	3,038	-856
MEDICAL DIVISION	3,815	2,940	200	784	3,924	2,801	-1,013
WCOH DIVISION	2,205	1,273	94	949	2,316	1,870	-335
CSS DIVISION	1,734	751	203	1,464	2,418	1,806	72
HOSPITAL SUPPORT	1,118	0	67	1,002	1,069	778	-339
FACILITIES	1,153	907	48	0	955	792	-361
Expenditure Other (Held Centrally)	532	95	438	0	533	213	-318
Trust Total	**14,450**	**8,209**	**1,407**	**5,347**	**14,963**	**11,299**	**-3,151**



	Actual Apr-18	Actual May-18	Actual Jun-18	Fcst Jul-18	Fcst Aug-18	Fcst Sep-18	Fcst Oct-18	Fcst Nov-18	Fcst Dec-18	Fcst Jan-19	Fcst Feb-19	Fcst Mar-19
Non-Rec Pay	747	1,623	2,211	2,823	3,344	3,786	4,162	4,481	4,753	4,984	5,180	5,347
Non-Rec	81	109	201	328	485	604	824	931	1,038	1,167	1,295	1,407
Recurrent	373	741	1,195	1,806	2,460	3,121	3,815	4,511	5,272	6,255	7,234	8,209
Target 2018/19	716	1,432	2,152	3,212	4,471	5,734	7,004	8,279	9,558	11,175	12,792	14,450

Overview of progress, including risks and mitigation taken:

The 2018/19 risk adjusted LTF is currently £11.299m against a target of £14.45m. This represents a negative variance of £3.151m.

Of the £14.963m forecasted delivery £6.754m (45%) of schemes are non-recurrent. This is predominantly £5.347m vacancies and pay underspend. If this can become recurrent it will mitigate I&E risks otherwise it poses a risk to the 2019/20 financial position.

Delivery at month 3 totalled £3.608m against a year to date plan of £2.152m. This represents a favourable variance to plan of £1.456m, which is mainly due to £2.211m Non-Recurrent pay general underspend across all divisions.

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

Current scheme profiles are also being reviewed to see if savings could be released earlier than planned and move away for Q4 delivery if possible.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M3 movements include capital additions of £438k, of which £119k relates to MRI 1 spend and £120k Paediatric works .
- Depreciation - £830k in month as per 2018/19 plan.

Current assets

• Inventories - £89k Increase in Heart Centre (£222k) , Supplies Trading (£34k) & Pathology (£11k) is offset by decrease in Pharmacy stockholding (£184k).
• Trade & Other Receivables – £544k made up of: Decrease in Non-NHS Receivables (£266k), Increase in VAT reclaim (£215k), Increase in Prepayments: CNST & annual maintenance agreements (£498k), Increase in Salary Overpayments & release of Provision held (£53k).
• Cash – Decrease of £1,224k. Trade creditor payments were £2,360k less than forecast. NHS Creditors & Capital Expenditure were more than forecast (£700k). Drawdown of Uncommitted Loan YTD is in line with Plan.

Current Liabilities

• Trade & Other Payables - £1,674k made up of: Increase in NHS Trade Payables (£1,122k) & NHS Creditors (£565k), offset by decrease in Capital Payables (£471k). Increase in Accruals (£526k) & PDC Dividend (£202k), offset by decrease in Other Payables (£216k) & Receipts in Advance (£97k).
•Provisions - £546k. Release of Provision held for Property Services. Account now reconciled & invoices paid in July.

Non Current Liabilities

• Drawdown of Revenue Loan - £327k.

Financed By

- I & E Account -£2,428k deficit in month

SOFP

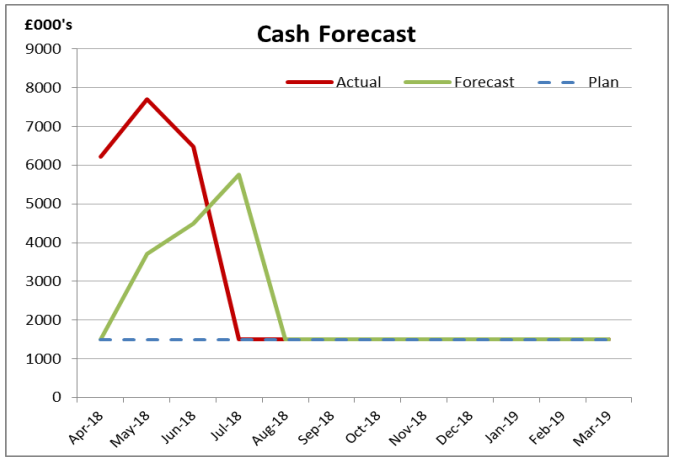
TRUST SUMMARY BALANCE SHEET MONTH 3 2018/19						
	Balance at 31-Mar-18	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	153,637	153,635	153,635	0	153,637	0
IN YEAR REVALUATIONS	0	510	510	0	510	510
IN YEAR MOVEMENTS	0	917	1,355	438	21,253	21,253
LESS DEPRECIATION	0	(1,660)	(2,490)	(830)	(10,623)	(10,623)
NET BOOK VALUE	153,637	153,402	153,010	(392)	164,777	11,140
CURRENT ASSETS						
INVENTORIES	6,272	6,234	6,323	89	6,372	100
TRADE & OTHER RECEIVABLES	16,479	16,594	17,138	544	16,988	509
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	7,710	6,486	(1,224)	1,500	(47)
TOTAL CURRENT ASSETS	24,298	30,538	29,947	(591)	24,860	562
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	24,896	26,570	1,674	19,272	(3,512)
FINANCE LEASE PAYABLE under 1 year	130	130	130	0	1,181	1,051
SHORT TERM LOANS	20,748	20,748	20,748	0	20,948	200
STAFF BENEFITS ACCRUAL	765	765	765	0	750	(15)
PROVISIONS under 1 year	2,744	2,734	2,188	(546)	1,997	(747)
TOTAL CURRENT LIABILITIES	47,171	49,273	50,401	1,128	44,148	(3,023)
NET CURRENT ASSETS / (LIABILITIES)	(22,873)	(18,735)	(20,454)	(1,719)	(19,288)	3,585
TOTAL ASSETS LESS CURRENT LIABILITIES	130,764	134,667	132,556	(2,111)	145,489	14,725
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	971	961	(10)	11,387	10,394
LOANS over 1 year	52,394	59,946	60,273	327	74,327	21,933
PROVISIONS over 1 year	1,001	1,001	1,001	0	1,001	0
NON CURRENT LIABILITIES	54,388	61,918	62,235	317	86,715	32,327
TOTAL ASSETS EMPLOYED	76,376	72,749	70,321	(2,428)	58,774	(17,602)
FINANCED BY						
PDC CAPITAL	120,251	120,251	120,251	0	120,378	127
REVALUATION RESERVE	31,782	32,292	32,292	0	32,768	986
I & E ACCOUNT	(75,657)	(79,794)	(82,222)	(2,428)	(94,372)	(18,715)
FINANCING TOTAL	76,376	72,749	70,321	(2,428)	58,774	(17,602)

Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2018/19 £000s	ACTUAL 18/19 APR £000s	MAY £000s	JUN £000s	FORECAST 18/19 JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	273,147	22,144	23,385	22,762	22,762	22,762	22,762	22,762	22,762	22,762	22,762	22,762	22,762
Provider Sustainability Funding (PSF)	8,554	0	0	0	2,580	0	0	1,379	0	1,838	0	0	2,757
SLA Performance (relating to 17/18 activity)	-2,024	479	660	0	-3,000	-163	0	0	0	0	0	0	0
Health Education Payments	9,539	795	795	795	795	795	795	795	795	795	795	795	795
Other NHS Income	17,271	750	564	957	1,000	1,000	4,000	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	4,217	0	970	316	531	300	300	300	300	300	300	300	300
PP / Other	12,361	1,195	908	1,058	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,200
Salix Capital Loan	860	0	0	0	0	0	50	0	120	690	0	0	0
PDC - Capital	127	0	0	0	0	0	127	0	0	0	0	0	0
Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	18,514	4,439	3,143	-1,052	1,276	232	0	896	1,053	0	2,955	1,140	4,432
Uncommitted Revenue Loan - PSF funding	9,191	0	0	1,379	613	613	612	919	919	919	1,072	1,072	1,073
Interest Receivable	72	6	5	7	6	6	6	6	6	6	6	6	6
TOTAL RECEIPTS	**351,829**	**29,808**	**30,430**	**26,222**	**27,563**	**26,545**	**29,652**	**29,557**	**28,455**	**29,810**	**30,390**	**28,575**	**34,825**
PAYMENTS													
Salaries and wages	208,103	16,698	16,586	16,804	17,315	18,975	17,315	17,315	17,575	17,315	17,575	17,315	17,315
Trade Creditors	99,146	4,928	9,279	7,229	7,960	7,969	8,630	8,174	8,236	8,665	8,574	8,441	11,061
NHS Creditors	23,853	1,999	2,648	2,370	2,138	2,138	2,138	1,938	1,868	2,138	2,138	920	1,420
Capital Expenditure	10,720	1,493	414	1,004	673	957	876	672	741	748	1,016	1,106	1,020
PDC Dividend	968	0	0	0	0	0	203	0	0	0	0	0	765
Repayment of Revenue Loan - PSF funding	5,974	0	0	0	0	0	0	1,379	0	919	919	0	2,757
Repayment of Loans (Principal & Interest)	3,001	8	11	22	152	772	487	42	35	25	168	793	487
Repayment of Salix loan	68	29	0	0	0	0	3	36	0	0	0	0	0
TOTAL PAYMENTS	**351,834**	**25,156**	**28,938**	**27,429**	**28,238**	**30,812**	**29,652**	**29,556**	**28,455**	**29,810**	**30,390**	**28,575**	**34,825**
Actual month balance	-5	4,652	1,492	-1,207	-675	-4,267	0	0	0	0	0	0	0
Cash in transit & Cash in hand adjustment	-42	20	-1	-17	-45	0	0	0	0	0	0	0	0
Balance brought forward	1,547	1,547	6,219	7,710	6,486	5,766	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**6,219**	**7,710**	**6,486**	**5,766**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- The Trust ended June with £6,486k cash balance, £1,986k more than planned. Trade Creditors payments are starting to come down to expected levels.
- SLA Base Payments from June are in line with 18/19 contracts.
- 17/18 Incentive STF (General Distribution) has been received from NHS England in July.
- Cash settlement of 17/18 Performance with Nene CCG of £3,000k is still forecast in July. Settlement by Milton Keynes CCG & Central Midlands is now forecast in August once final performance invoices have been issued.
- PP/Other (Specific >250k) represents VAT claim for June. This includes £102k recoverable VAT on Property Services Invoices.
- The Salaries and wages pay deal is forecast to be paid in July and arrears for April - June will be paid in August. The related funding is forecast to be received in September, though there could be a funding gap risk. The calculations will be updated when we have more information.
- Uncommitted Revenue Loan drawdown in June includes PSF funding for Qtr 1 & repayment of deficit funding drawn.

Cash forecast



Capital

Capital Scheme	Plan 2018/19 £000's	M3 Plan £000's	M3 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Medical Equipment - MESC Block	630	101	99	-1	16%	183	29%
Medical Equipment - CF Specific Forecast	100	7	7	0	7%	7	7%
Dexa Scanner - Enabling Costs (Lease)	30	0	0	0	0%	0	0%
CT Simulator Suite	27	27	26	-1	95%	26	95%
Information Technology - Replacement of NPfIT systems inc. CaMIS	622	200	165	-35	27%	182	29%
Information Technology	3,023	316	336	20	11%	501	17%
Estates - Backlog	1,615	438	364	-73	23%	967	60%
Estates - Statutory	360	34	19	-16	5%	65	18%
Estates - Non Maintenance	327	124	120	-4	37%	159	49%
Estates - Ward Refurbishment	725	0	0	0	0%	0	0%
Nye Bevan - Setting Up Costs	296	81	81	0	27%	150	51%
Nye Bevan Assessment Unit (Finance Lease)	12,329	0	0	0	0%	0	0%
Inventory / Ledger Upgrade	32	0	-4	-4	-13%	-1	-4%
MRI 1 Enabling Costs	277	143	143	0	52%	259	93%
SALIX	860	0	0	0	0%	0	0%
Total - Capital Plan	**21,254**	**1,470**	**1,355**	**-115**	**6%**	**2,498**	**12%**
Less Charitable Fund Donations	-100	0	-7	-7	7%	-7	7%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**21,154**	**1,470**	**1,349**	**-121**	**6%**	**2,491**	**10%**

Funding Resources	
Internally Generated Depreciation	10,623
Finance Lease - Assessment Unit	12,329
Salix	860
Public WIFI	127
Capital Element - Finance Lease (Car Park Decking)	- 130
Capital Loan - Repayment	- 1,835
Capital Element - Finance Lease (Assessment Unit)	- 752
Other Loans - Repayment (SALIX)	- 68
Total - Available CRL Resource	**21,154**
Uncommitted Plan	**0**

- The Trust's initial capital plan has been adjusted by PDC for Public WiFi of £127k to total £21,254k.
- There has been no further spend on Charitable Funds in M3.
- Cumulative spend (excluding charitable funds) to M3 is £1,355k, with further commitments of £1,143k. The commitments include £182k for IT, £592k for Estates and £84k for Medical Equipment.
- The Nye Bevan unit handover has slipped by two weeks with a tentative handing over scheduled for 13th July 2018, subject to final approval.
- MRI 1 has been commissioned and is now operational.

Receivables and Payables

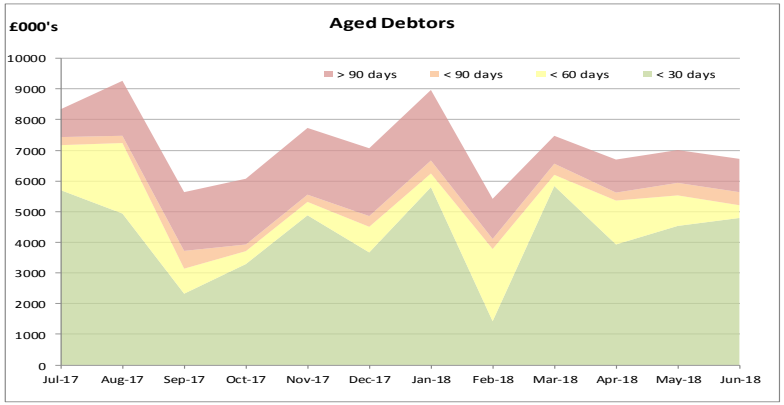
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance.
- Outstanding SLA performance invoices issued in March are included within the 61 to 90 days NHS Receivables Balance.
- NHS over 90 day debt include University Hospitals of Leicester NHS Trust £77k, Oxford University Hospital NHS Foundation Trust £20k, Kettering General Hospital NHS Foundation Trust £92k and NHS Property Services £157k (has now been paid in July) and £143k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £310k of which £154k are paying in instalments & a further £179k have been referred to debt collection, private patients accounts of £38k, BMI Three Shires £301k and Alliance Medical £35k.

Receivables and Payables

Narrative	Total at June £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	1,493	352	193	219	728
Receivables NHS	5,227	4,440	223	208	356
Total Receivables	**6,720**	**4,792**	**416**	**427**	**1,085**
Payables Non NHS	(4,218)	(4,193)	(24)	0	0
Payables NHS	(2,027)	(2,027)	0	0	0
Total Payables	**(6,245)**	**(6,221)**	**(24)**	**0**	**0**

Narrative	Total at May £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	1,827	413	409	460	546
Receivables NHS	5,180	4,120	587	(51)	524
Total Receivables	**7,007**	**4,533**	**995**	**409**	**1,070**
Payables Non NHS	(3,567)	(3,566)	0	(1)	0
Payables NHS	(1,462)	(1,462)	0	0	0
Total Payables	**(5,029)**	**(5,028)**	**0**	**(1)**	**0**

Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in June 2018.

BPPC

Narrative	April 2018	May 2018	June 2018	Cumulative 2018/19
NHS Creditors				
No.of Bills Paid Within Target	99	155	151	405
No.of Bills Paid Within Period	99	155	151	405
Percentage Paid Within Target	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Value of Bills Paid Within Target (£000's)	1,432	2,233	1,910	5,575
Value of Bills Paid Within Period (£000's)	1,432	2,233	1,910	5,575
Percentage Paid Within Target	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Non NHS Creditors				
No.of Bills Paid Within Target	3,887	7,280	5,731	16,898
No.of Bills Paid Within Period	3,953	7,319	5,748	17,020
Percentage Paid Within Target	**98.33%**	**99.47%**	**99.70%**	**99.28%**
Value of Bills Paid Within Target (£000's)	6,884	10,004	8,602	25,490
Value of Bills Paid Within Period (£000's)	6,954	10,029	8,615	25,598
Percentage Paid Within Target	**99.00%**	**99.75%**	**99.84%**	**99.58%**
Total				
No.of Bills Paid Within Target	3,986	7,435	5,882	17,303
No.of Bills Paid Within Period	4,052	7,474	5,899	17,425
Percentage Paid Within Target	**98.37%**	**99.48%**	**99.71%**	**99.30%**
Value of Bills Paid Within Target (£000's)	8,316	12,237	10,511	31,065
Value of Bills Paid Within Period (£000's)	8,386	12,262	10,525	31,173
Percentage Paid Within Target	**99.17%**	**99.80%**	**99.87%**	**99.65%**

7. Single Oversight Framework (SOF)

The Single oversight framework includes scoring for "finance and use of resources". The Trust continues to score "3" against this metric.

Criteria		Score	Weight	Weighted Score
Capital Service capacity (times)	-2	4	20.00%	0.80
Liquidity (days)	-31	4	20.00%	0.80
I&E Margin	-8%	4	20.00%	0.80
Distance From Plan	1%	1	20.00%	0.20
Agency spend (distance from cap)	-5%	2	20.00%	0.40
Overall Score				3.0

Finance and use of resources metrics

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Note: brackets indicate negative numbers

[1] Scoring a '4' on any metric will mean that the overall rating is at least a 3 (ie either a 3 or a 4), triggering a concern.

8. Risks

Risk	Description	Estimated Gross Impact £'m	RAG	Mitigations	Mitigated Impact £'m	Exec Lead
Revenue Risks						
Nye Bevan Unit	Efficacy of the new model for the 60 beds to ensure sufficient discharges to reduce length of stay and prevent escalation into elective wards; in addition to ability to recruit staff substantively for the new unit	2.5		Robust implementation through the working group. The COO has emphasised that the Unit will only open when there is satisfaction about the effectiveness of the new model.	2.5	DN
Nye Bevan Unit	Operational pressures may require the two vacated wards to be open all year leading to cost pressures. Under the new model for the Nye Bevan unit, one ward is assumed to be a decant ward and the other used as escalation ward but only for 4 months in the year.	2.8		Effective implementation of the transition to the Nye Bevan unit. Effectiveness of on-going discharge schemes (fixing the flow). Resilience to cope with winter pressures.	2.8	DN
Activity	Activity growth may be exaggerated as it is modelled on 2017-18 month 8 forecast outturn, which was higher than actual out-turn. In addition, the capacity to deliver the anticipated activity growth is limited, as the estimated bed gap is currently c.45 beds	4.0		Management of escalation areas, discharge schemes and schemes to lower LOS should help minimise this gap. Ring-fence elective wards for delivery of elective activity	4.0	DN
Activity	Challenges within the Northamptonshire county council and the impact of this on social care discharges in order to free up hospital beds. This was a major contributor to the strain on activity and income in 2017-18.	2.3		Leverage influence of NHSI and the newly formed DHSC to support better collaborative working. Plan assumed 1.6% demographic growth in comparison with national planning assumption of 2.3%	2.3	CP
Income	Risk that the income assumed to be deliverable via the STP does not materialise. In order to bridge the gap between the plan and the control total, £4.6m income has been assumed to be deliverable from activity from the STP schemes	4.6		Collaborative working with STP partners to support income gap delivery.	2.3	PB/CP/DN
Income	Stroke service transfer from KGH may not be fully supported by investment from Nene CCG. In addition, there is potential for losing income from existing non-elective activity.	1.0		To maintain planning funding discussions with Nene CCG to ensure the service can be implemented to current quality standards with limited or nil financial impact	1.0	CP
Income	Ability to invoice accurately for activity under PbR rules should there be issues with implementation of CAMIS.	3.0		Negotiations with the CCG, for example for block values in extreme circumstances or extended deadlines. Robust implementation testing before implementation.	1.0	DN
CQUIN	Risk of non-delivery against CQUINs	1.0		Early communication and focus on the delivery requirements. Appropriate resourcing where financially beneficial. CQUIN met in 2017-18, so organisational framework for delivery can be replicated.	0.5	CP
Challenges	Risk of increased challenges from NEL CSU which could be further heightened when CAMIS is implemented.	1.0		Improvements in Data Quality, training and education all help to reduce the number of challenges. Via the CAMIS project training should improve data input at source. Challenges provided in the plan at £1.5m	1.0	CP
CIP delivery	Delivery of £14.9m CIP target (5%) and possible high proportion delivered as non-recurrent CIPs.	5.1		Management of CIP plans and delivery through the revamped Changing Care model. Realistic plans set for Divisions. Focus on robust CIP delivery. Use of unplanned pay savings mechanism.	3.2	PB
PSF funding	Risk that the Trust may be unable to access all the allocated PSF if it fails to deliver all the financial and performance trajectories.	8.2		Management of operational and financial targets. Realistic plans set for Divisions. Focus of robust CIP delivery.	8.2	DN/PB

Report To	**Trust Board**
Date of Meeting	**Thursday 26 July 2018**

Title of the Report	**Workforce Performance Report**
Agenda item	**11**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues

Executive summary

- The key performance indicators show a decrease in contracted workforce employed by the Trust, and an increase in sickness absence since May 2018.
- A decrease in overall Trust staff turnover since May 2018.
- Nurse Recruitment Update.
- Nurse Recruitment and Retention Strategy refresh update.
- Increase in compliance rate for Mandatory Training, Role Specific Essential Training and for Appraisals.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.

Related Board Assurance Framework entries	BAF – 3.1, 3.2 and 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	No

Actions required by the Committee

The Committee is asked to Note the report.

Trust Board

Thursday 26 July 2018

Workforce Performance Report

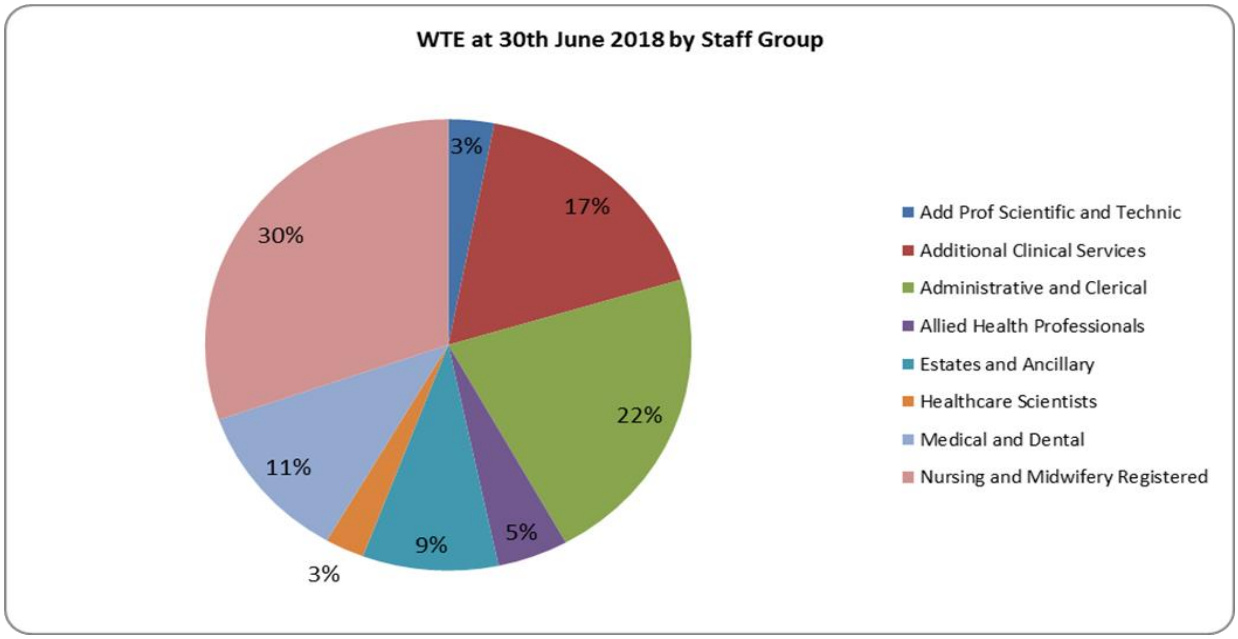
1. Introduction

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

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity decreased by 4.78FTE in June 2018 to 4408.54FTE. The Trust's substantive workforce is at 87.35% of the Budgeted Workforce Establishment of 5047.04 FTE. The decrease in capacity since May 2018 will have resulted from the establishment increasing from 5006.00 in May 2018 to 5047.04 in June 2018.



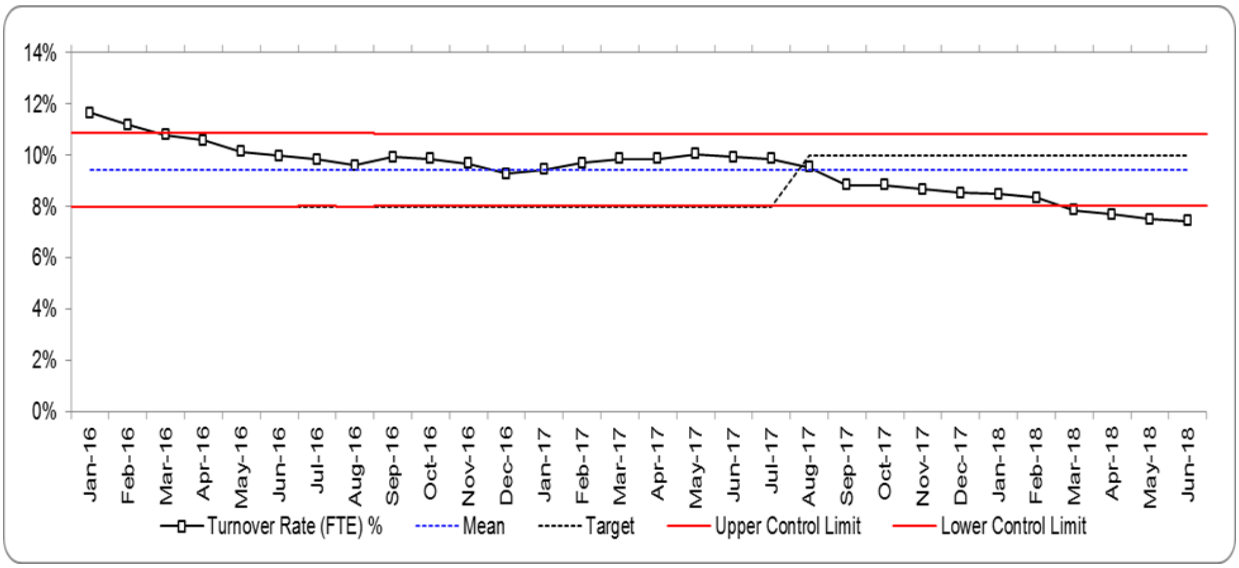
Trust Turnover

Annual Trust turnover for June 2018 decreased by 0.08% to 7.43%, which is below the Trust target of 10%

Turnover within Nursing & Midwifery decreased by 0.08% to 5.58%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the

Trust. Turnover also decreased for Additional Clinical Services by 0.54%; Allied Health Professionals by 0.68% and Estates & Ancillary by 0.66%.

Turnover increased for Add Prof Sci & Techn by 0.71%; Admin & Clerical by 0.33% and Healthcare Scientists by 1.09%. Medical & Dental turnover remained at 2.76%.



Turnover by Division:

- Medical Division: turnover decreased by 0.99% to 6.33%
- Surgical Division: turnover decreased by 0.13% to 6.37%
- Women, Children & Oncology Division: turnover increased by 0.77% to 6.65%
- Clinical Support Services Division: turnover increased by 0.37% to 8.88%
- Support Services: turnover decreased by 0.18% to 9.73%

Vacancy Rates

The overall Trust vacancy rate for June 2018 is 12.65% against a Trust target of 9%.

The vacancy % rate has decreased in June 2018 for Allied Health Professionals and Estates & Ancillary staff groups.

There has been an increase for Add Prof Sci & Tech; Additional Clinical Services; Admin & Clerical; Healthcare Scientists; Medical & Dental and Nursing & Midwifery staff groups

The largest decrease in vacancy rates was experienced by the Allied Health Professionals, staff group which saw a decrease of 3.48% from 15.65% to 12.17%.

Sickness Absence

Sickness absence for June 2018 increased from 3.96% to 4.39%, which is above the Trust target of 3.8%. Only the Clinical Support Services Division was under the Trust's target.

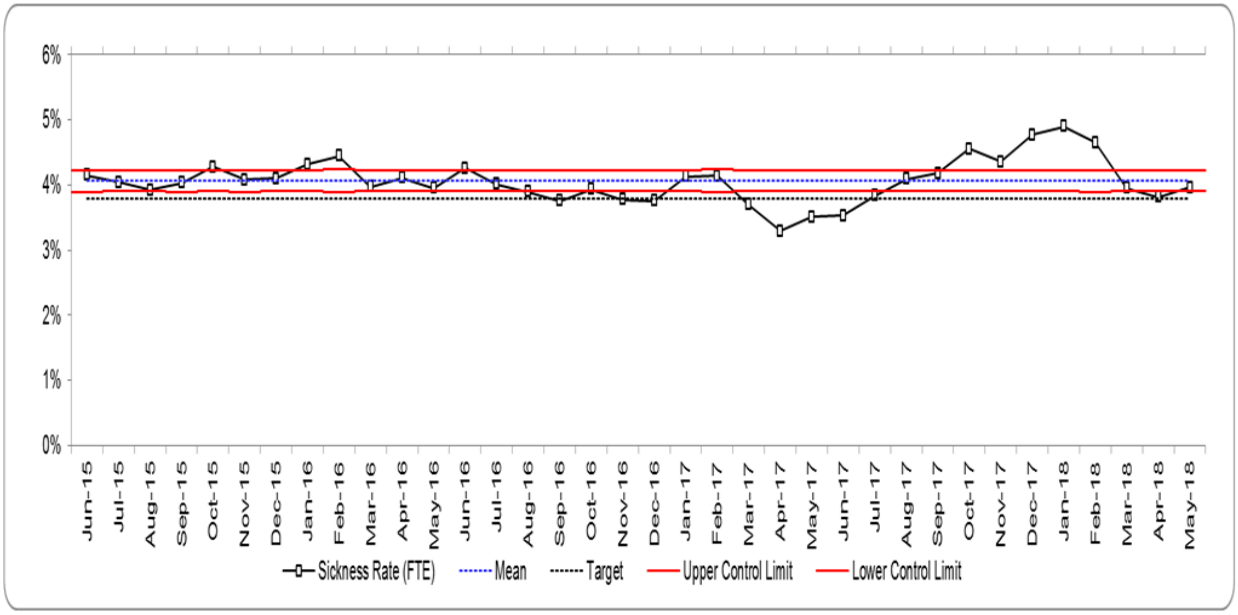
Sickness by Division:

- Medicine and Urgent Care at 4.55%
- Surgery at 4.04%
- Women, Children & Oncology at 4.53%
- Clinical Support Services at 3.27%
- Support Services at 5.36%.

Sickness absence increases were seen in medicine, surgery and support services.

The Facilities Directorate had the highest sickness rate of 6.43% amongst the directorates.

In total 6 directorate level organisations were below the trust target rate in June 2018 compared to 9 directorates in May 2018.



The top five reasons for sickness absence in terms of days lost are detailed as follows:

01st July 2017 - 30th June 2018				
Absence Reason	**Headcount**	**Abs Occurrences**	**FTE Days Lost**	**%**
S10 Anxiety/stress/depression/other psychiatric illnesses	415.00	578.00	19070.00	22.61
S98 Other know n causes - not elsew here classified	893.00	1174.00	12350.00	14.60
S28 Injury, fracture	244.00	285.00	6775.00	8.00
S25 Gastrointestinal problems	1325.00	1750.00	6304.00	7.50
S11 Back Problems	335.00	443.00	6224.00	7.40

Recruitment Progress Report

Overseas Nurse Recruitment Progress April to June 2018

- As at June 2018 there were 51 IELTS cleared Indian Nurses awaiting NMC decision letter in order to travel to the UK and commence work at the Trust. Between April and June 2018 a total of 21 offers were made to overseas nurses.
- 5 overseas recruits arrived from India between April and June 2018.
- It is anticipated that a further 15 overseas nurses will arrive during July to September 2018.

Local & National Recruitment Progress April 2018 to June 2018

- Between April 2018 and June 2018 a total of 16.89 WTE nurses started work in core and specialist areas with the Trust through recruitment via NHS Jobs.
- Between April 2018 and June 2018 a total of 8.80 students started work within core and specialist areas with the Trust.
- Between April 2018 and June 2018 nursing capacity was increased by 0.83 WTE as a result of existing nurses increasing their hours.

Overall Nurse Recruitment Progress between April 2018 and June 2018 (Including overseas recruits)

- Between April 2018 and June 2018 overall nursing capacity increased through new recruits and increases in hours by 31.52 WTE.
- Between April 2018 and June 2018 nursing capacity decreased through leavers and decreases in hours by 15.17 WTE.
- Between April 2018 and June 2018 nursing capacity therefore saw a net increase of 16.35 WTE.
- Of the 16.35 WTE net increase, 4.22 WTE were newly recruited nurses and 12.13 WTE were due to a decrease in establishment.

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

CORE AREAS	**71.72**
SPECIALIST AREAS	**37.07**
TOTAL	**108.79**

Nurse Recruitment Initiatives

Recruitment Fairs

A Trust wide recruitment day was held on 19th May 2018 and resulted in recruited 7 nurses being recruited.

The next recruitment open day for nursing has been scheduled for October 6th 2018.

Nurse Recruitment Social Media Update

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

- **LinkedIn :** total followers 2554 that's up 205 followers up since April 2018. The engagement rate on LinkedIn seems to be increasing as one post alone got 37 likes and 39 shares.

- **Twitter:** total followers 281 which is 48 followers up from April 2018 and as at week commencing Monday 9 July 2018, our tweets have earned 2367 impressions.

- **Instagram:** we now have 208 followers on Instagram 46 followers up from April 2018.

The increase in exposure on social media is a factor in the recent success at recruiting through Trust open days detailed above, as it enables greater exposure and reach to potential candidates wishing to attend the recruitment days.

Social media advertising of such events has enabled the Trust to reach approximately 17,000 people many of whom will work in the NHS, be a Nurse themselves or potentially have clinical friends or family.

Nurse Recruitment and Retention Strategy refresh

The HR and Nursing & Midwifery services teams recently participated in a strategy development session. This resulted in a number of actions designed to aid recruitment and retention.

Recruitment

In addition to maintaining our local, national and international approach the key areas of focus will be:

- Working with University of Northampton to agree numbers by out- turn

- Develop partnerships with St Andrews and a London Trust to develop rotational experiences ('Bright Lights and Back to the Country')

- Advertising campaign to attract male nurses

- Recruitment Pop Up Tour (battle bus)

- Review our advertising and marketing approaches.

Retention

Our approach to retention is structured around the themes of Best possible, start, career and retire.

Best Possible Start

- Revised induction to include cohorting, promotion of rewards and benefits
- Newly qualified decision making counsel
- On – boarding experience (18 months)

Best possible career

- Development journeys
- Internal transfer process – move them ,don't lose them
- New roles – DoN Nurse fellow
- Re-creating grades of clinical experts and clinical academic careers
- Revalidation support
- Career breaks
- Understanding and developing flexible careers
- Meaningful recognition – recognising the millennial effect.

Best Possible Retire

- Legacy opportunities
- Age 55 crystal ball prospectus.

Underlying these initiatives is further analysis of data such as leavers to bank etc. and implementation of new systems such as the recruitment system 'Trac'.

In addition a specific area of work was done around midwifery (for which recruitment and retention isn't currently an issue) focussed around internal rotations, succession planning, development, structure and new roles.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for June 2018 is 86.74%; this is an increase of 0.05% from last month's figure of 86.69%.

Mandatory Training compliance increased in June 2018 from 89.20% to 89.55% this is an increase of 0.35% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also increased in June 2018 to 84.99% from last month's figure of 84.81%.; that is an increase of 0.18%.

3.0 Assessment of Risk

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

4.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

5.0 Next Steps

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

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

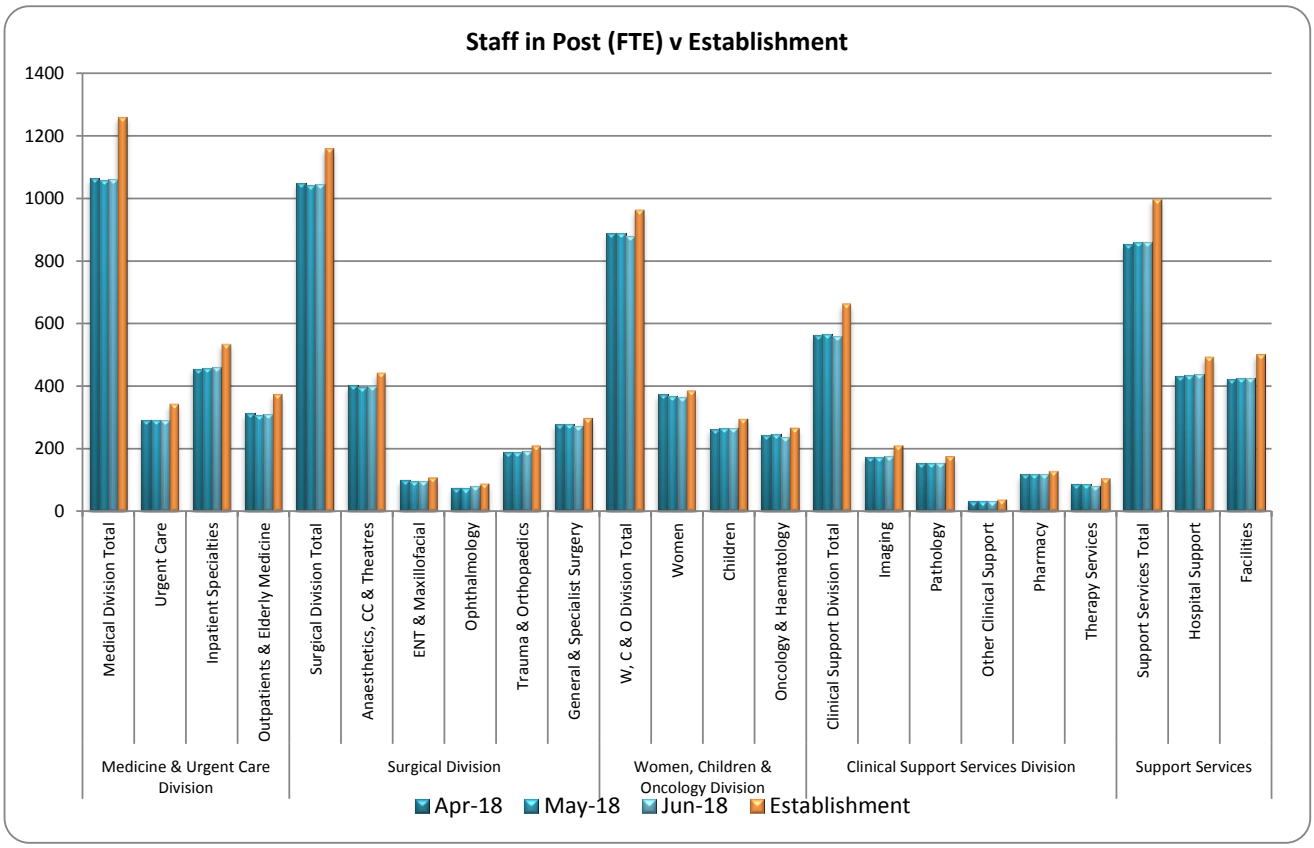
CAPACITY
Staff in Post

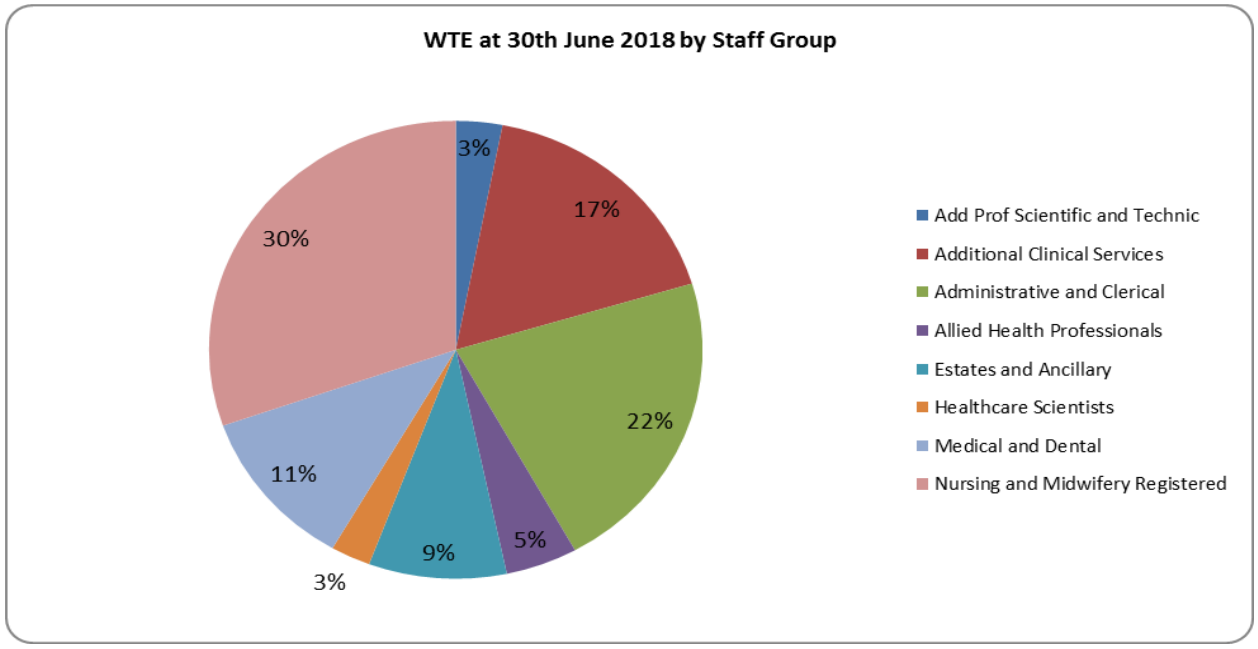
Establishment RAG Rates:	< 88%	88-93%	> 93%

Staff in Post (FTE)		Apr-18		May-18		Jun-18	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1063.91	↓	1057.31	↑	1060.29	1260.02	84.15%
	Urgent Care	292.52	↓	291.60	↓	289.87	344.92	84.04%
	Inpatient Specialties	455.80	↑	458.34	↑	459.62	536.47	85.67%
	Outpatients & Elderly Medicine	314.59	↓	306.37	↑	309.80	375.63	82.47%
Surgical Division	Surgical Division Total	1049.83	↓	1041.29	↑	1046.72	1160.67	90.18%
	Anaesthetics, CC & Theatres	402.44	↓	397.40	↑	401.00	444.70	90.17%
	ENT & Maxillofacial	98.88	↓	97.72	↓	96.32	108.66	88.64%
	Ophthalmology	73.57	↓	72.57	↑	80.95	90.46	89.49%
	Trauma & Orthopaedics	189.78	↓	188.28	↑	191.28	211.02	90.65%
	General & Specialist Surgery	279.35	↑	279.51	↓	271.37	299.03	90.75%
Women, Children & Oncology Division	W, C & O Division Total	888.01	↑	889.86	↓	879.81	963.82	91.28%
	Women	373.01	↓	368.61	↓	366.08	386.75	94.66%
	Children	262.85	↑	265.63	↑	266.01	297.42	89.44%
	Oncology & Haematology	241.75	↑	244.42	↓	237.31	267.52	88.71%
Clinical Support Services Division	Clinical Support Division Total	564.24	↑	565.47	↓	560.51	664.22	84.39%
	Imaging	172.21	↑	173.94	↑	175.18	211.53	82.82%
	Pathology	154.56	↑	155.56	↓	151.98	176.66	86.03%
	Other Clinical Support	32.18	↑	32.28	↑	32.72	39.12	83.64%
	Pharmacy	118.90	↑	118.90	↓	118.89	131.16	90.65%
	Therapy Services	86.38	↓	84.78	↓	81.74	105.75	77.30%
Support Services	Support Services Total	853.09	↑	859.40	↑	861.22	998.31	86.27%
	Hospital Support	430.66	↑	434.21	↑	436.29	495.05	88.13%
	Facilities	422.42	↑	425.18	↓	424.93	503.26	84.44%
Trust Total		4419.08	↓	4413.32	↓	4408.54	5047.04	87.35%

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

CAPACITY
Staff in Post





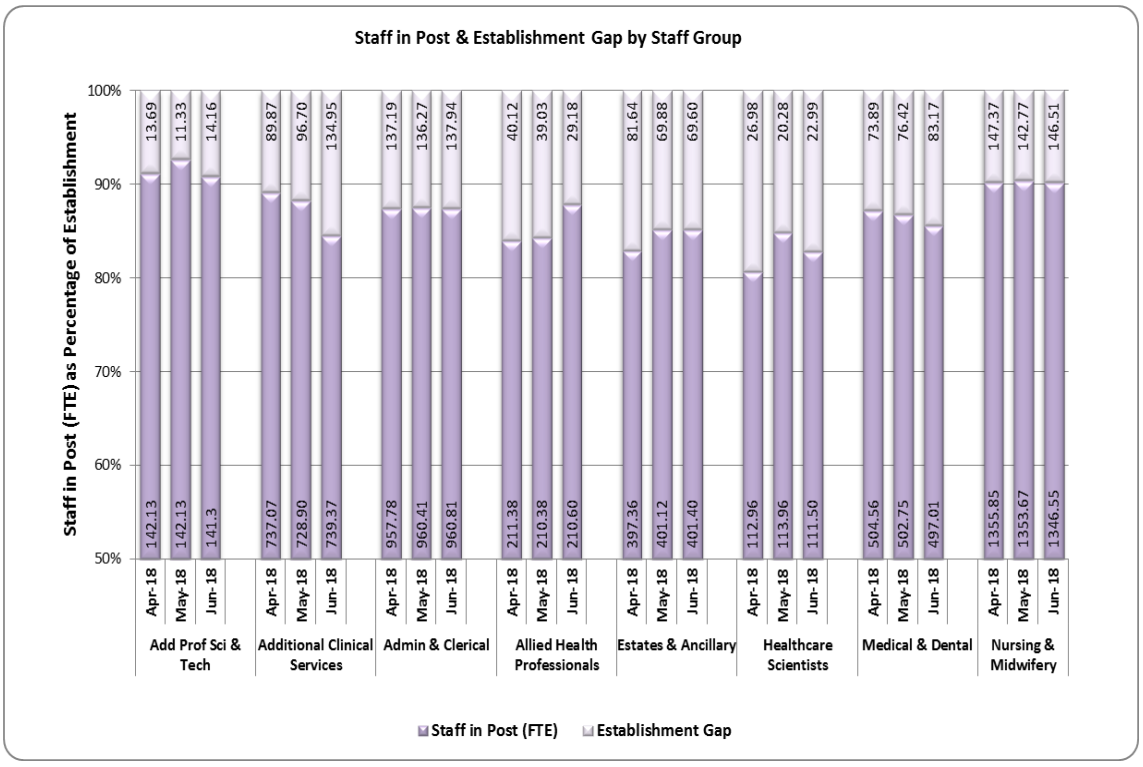
Workforce Committee: Capacity, Capability and Culture Report - June 2018

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Apr-18	May-18	Jun-18
Add Prof Sci & Tech	8.79%	7.38%	9.11%
Additional Clinical Services	10.87%	11.71%	15.44%
Admin & Clerical	12.53%	12.43%	12.55%
Allied Health Professionals	15.95%	15.65%	12.17%
Estates & Ancillary	17.04%	14.84%	14.78%
Healthcare Scientists	19.28%	15.11%	17.09%
Medical & Dental	12.77%	13.19%	14.34%
Nursing & Midwifery	9.80%	9.54%	9.81%



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

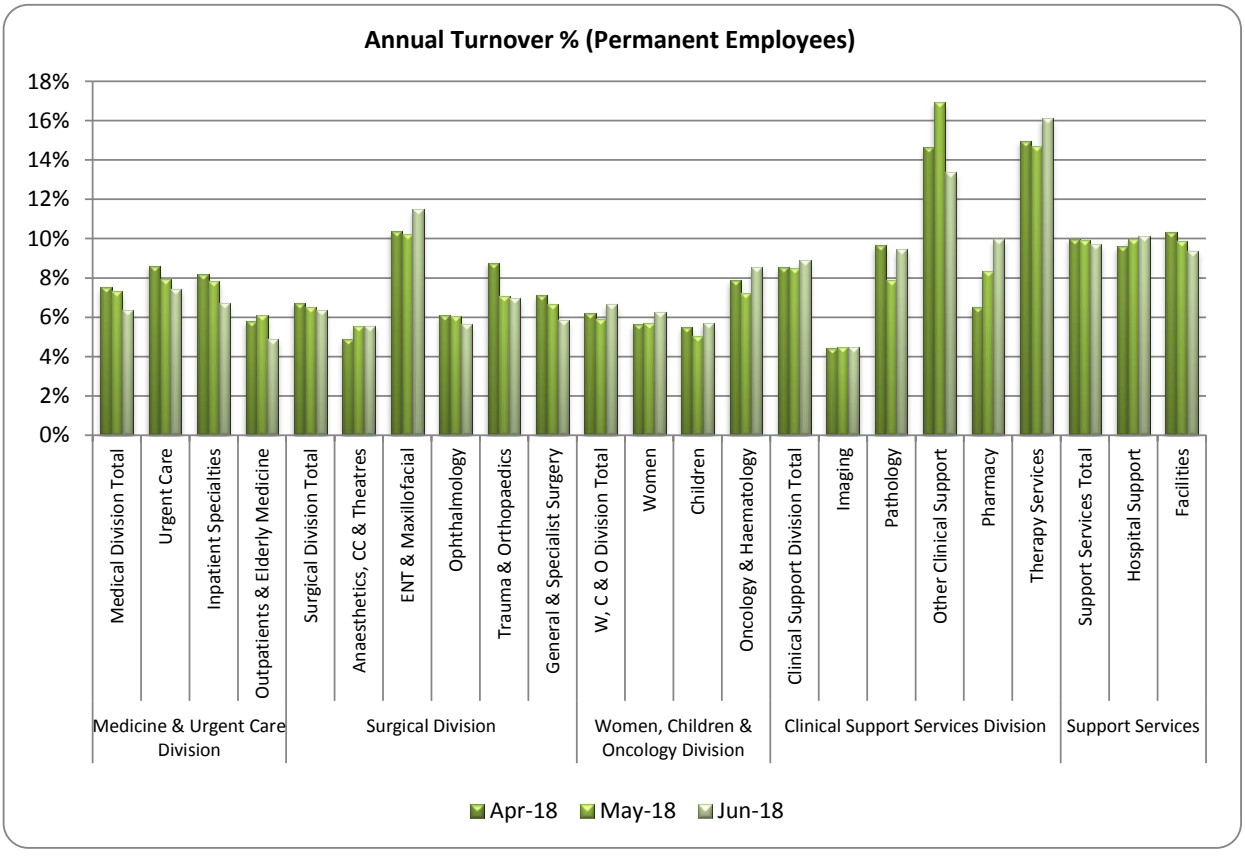
CAPACITY

Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Apr-18		May-18		Jun-18
Medicine & Urgent Care Division	Medical Division Total	7.53%	↘	7.32%	↘	6.33%
	Urgent Care	8.62%	↘	7.95%	↘	7.45%
	Inpatient Specialties	8.17%	↘	7.85%	↘	6.72%
	Outpatients & Elderly Medicine	5.81%	↗	6.10%	↘	4.87%
Surgical Division	Surgical Division Total	6.69%	↘	6.50%	↘	6.37%
	Anaesthetics, CC & Theatres	4.90%	↗	5.53%	↗	5.57%
	ENT & Maxillofacial	10.37%	↘	10.24%	↗	11.48%
	Ophthalmology	6.12%	↘	6.07%	↘	5.62%
	Trauma & Orthopaedics	8.77%	↘	7.06%	↘	6.98%
	General & Specialist Surgery	7.12%	↘	6.64%	↘	5.85%
Women, Children & Oncology Division	W, C & O Division Total	6.19%	↘	5.88%	↗	6.65%
	Women	5.66%	↗	5.71%	↗	6.25%
	Children	5.51%	↘	5.03%	↗	5.69%
	Oncology & Haematology	7.90%	↘	7.21%	↗	8.53%
Clinical Support Services Division	Clinical Support Division Total	8.54%	↘	8.51%	↗	8.88%
	Imaging	4.44%	↗	4.49%	↘	4.48%
	Pathology	9.65%	↘	7.86%	↗	9.46%
	Other Clinical Support	14.64%	↗	16.96%	↘	13.37%
	Pharmacy	6.53%	↗	8.35%	↗	9.95%
	Therapy Services	14.98%	↘	14.70%	↗	16.10%
Support Services	Support Services Total	9.99%	↘	9.91%	↘	9.73%
	Hospital Support	9.59%	↗	9.95%	↗	10.13%
	Facilities	10.32%	↘	9.87%	↘	9.39%
Trust Total		7.69%	↘	7.51%	↘	7.43%



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

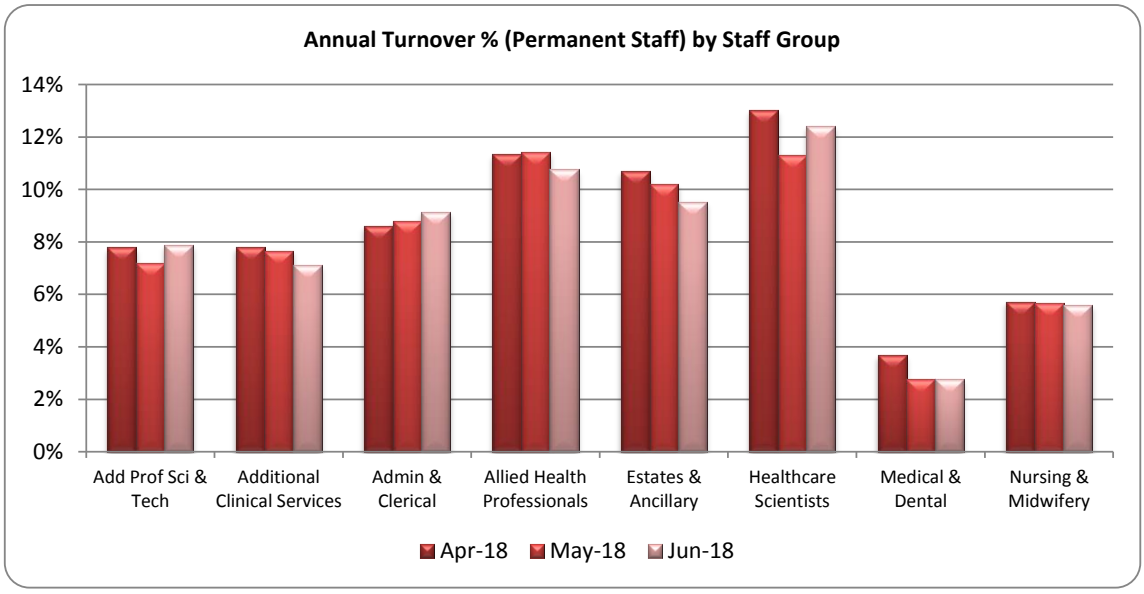
CAPACITY

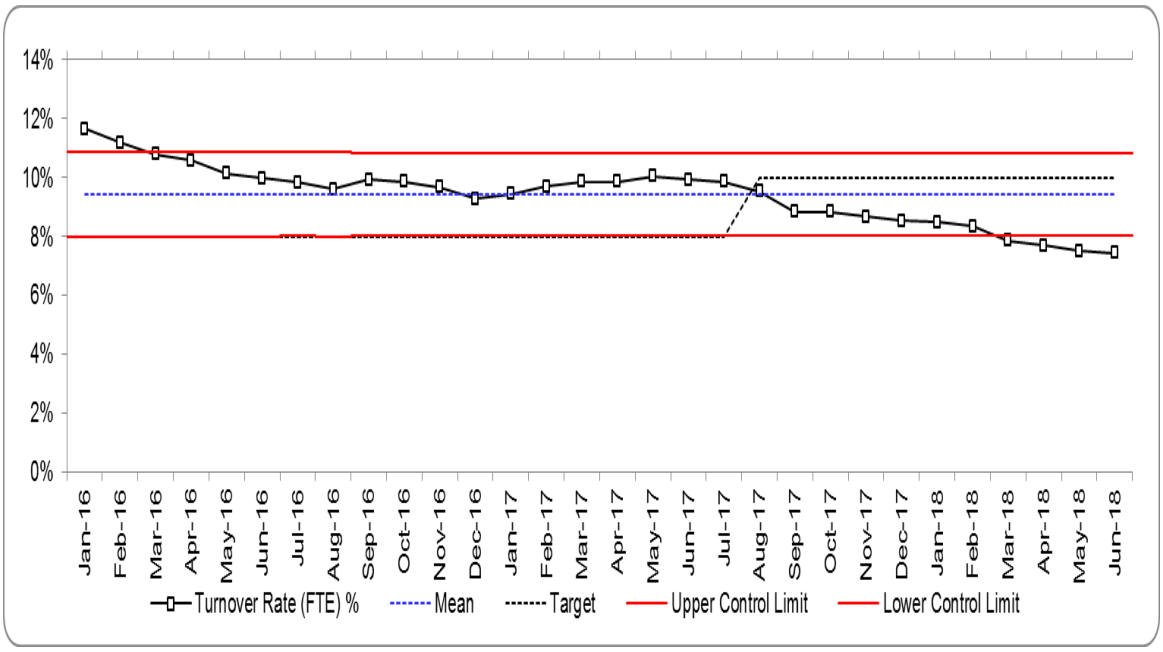
Turnover by Staff Group

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

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

Staff Group	Apr-18		May-18		Jun-18
Add Prof Sci & Tech	7.78%	↘	7.18%	↗	7.89%
Additional Clinical Services	7.81%	↘	7.66%	↘	7.12%
Admin & Clerical	8.60%	↗	8.80%	↗	9.13%
Allied Health Professionals	11.33%	↗	11.43%	↘	10.75%
Estates & Ancillary	10.69%	↘	10.19%	↘	9.53%
Healthcare Scientists	13.01%	↘	11.32%	↗	12.41%
Medical & Dental	3.69%	↘	2.76%	↘	2.76%
Nursing & Midwifery	5.72%	↘	5.66%	↘	5.58%





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

Capacity:
Substantive Workforce Capacity decreased by 4.78FTE in June 2018 to 4408.54FTE. The Trust's substantive workforce is at 87.35% of the Budgeted Workforce Establishment of 5047.04 FTE.

Staff Turnover:

Annual Trust turnover for June 2018 decreased by 0.08% to 7.43%, which is below the Trust target of 10%. Turnover within Nursing & Midwifery decreased by 0.08% to 5.58%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased for Additional Clinical Services by 0.54%; Allied Health Professionals by 0.68% and Estates & Ancillary by 0.66%.

Turnover increased for Add Prof Sci & Techn by 0.71%; Admin & Clerical by 0.33% and Healthcare Scientists by 1.09%. Medical & Dental turnover remained at 2.76%.

Turnover by Division:
Medical Division: turnover decreased by 0.99% to 6.33%
Surgical Division: turnover decreased by 0.13% to 6.37%
Women, Children & Oncology Division: turnover increased by 0.77% to 6.65%
Clinical Support Services Division: turnover increased by 0.37% to 8.88%
Support Services: turnover decreased by 0.18% to 9.73%

Staff Vacancies: The vacancy % rate has decreased in June 2018 for Allied Health Professionals and Estates & Ancillary staff groups.

There has been an increased for Add Prof Sci & Tech; Additional Clinical Services; Admin & Clerical; Healthcare Scientists; Medical & Dental and Nursing & Midwifery staff groups

Largest decrease experienced by Allied Health Professionals, decreasing 3.48% to 12.17%.

Sickness Absence:

Sickness absence for June 2018 increased from 3.96% to 4.39% which is above Trust target of 3.8%. Only Clinical Support Services Divisions was under the Trust's target

Sickness by Division:
Medicine and Urgent Care at 4.55%
Surgery Division at 4.04%
Women, Children & Oncology at 4.53%
Clinical Support Services at 3.27%
Support Services at 5.36%.

Facilities Directorate had the highest sickness rate of 6.43% amongst the directorates.

In total 6 directorate level organisations were below the trust target rate in June 2018 compared to 9 directorates in May 2018.

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

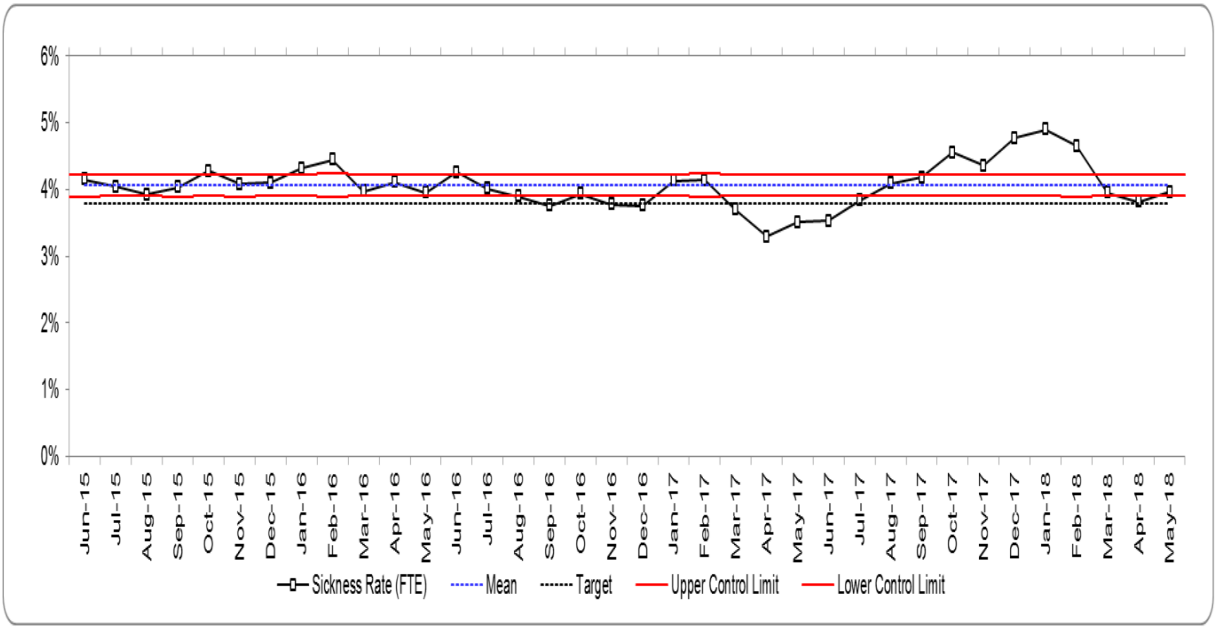
CAPACITY
In-Month Sickness

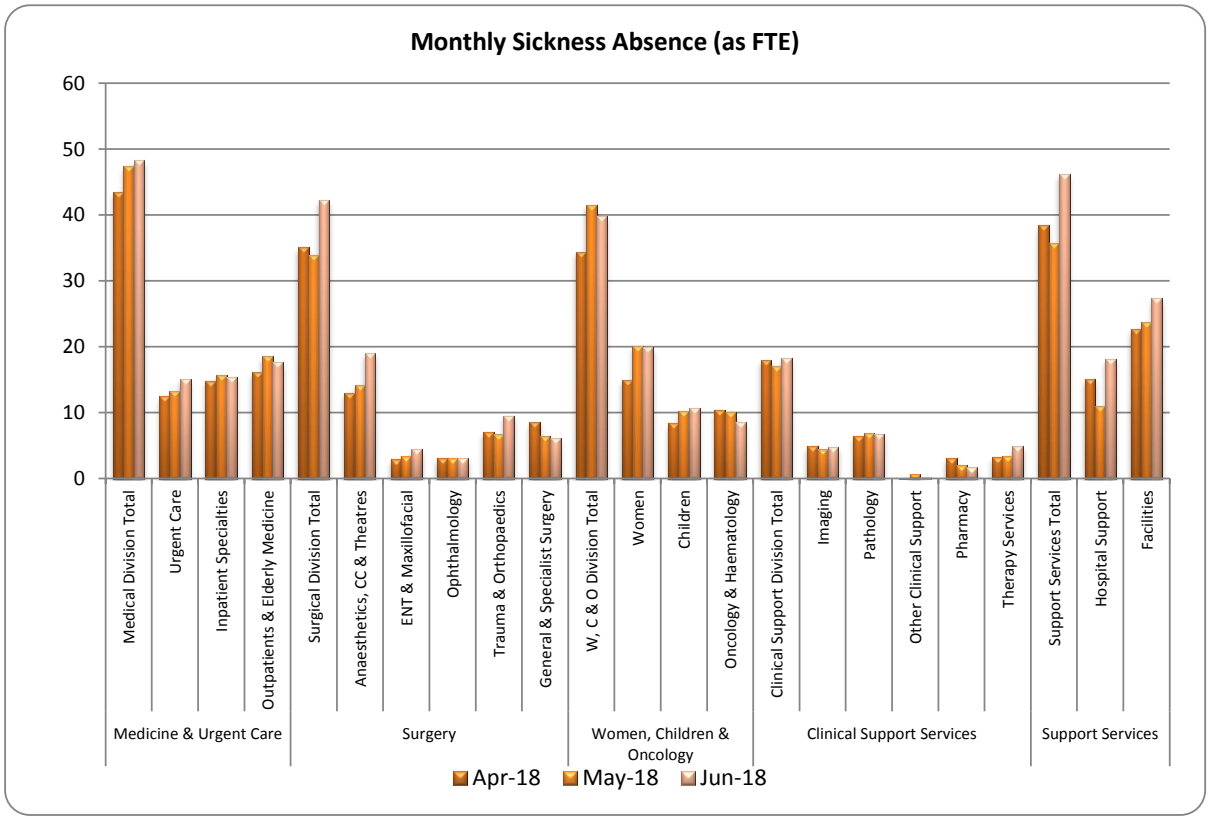
Sickness % RAG Rates:		
> 4.2%	3.8-4.2%	< 3.8%

Monthly Sickness (as FTE)		Apr-18	May-18	Jun-18	Jun-18	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	43.51	47.47	48.24	4.55%	2.96%	1.59%
	Urgent Care	12.55	13.30	15.07	5.20%	3.03%	2.17%
	Inpatient Specialties	14.86	15.63	15.44	3.36%	2.08%	1.28%
	Outpatients & Elderly Medicine	16.08	18.50	17.69	5.71%	4.21%	1.50%
Surgery	**Surgical Division Total**	35.06	33.84	42.29	4.04%	2.61%	1.43%
	Anaesthetics, CC & Theatres	12.96	14.11	19.01	4.74%	3.17%	1.58%
	ENT & Maxillofacial	2.96	3.35	4.47	4.64%	2.58%	2.06%
	Ophthalmology	3.10	3.11	3.10	3.83%	0.35%	3.48%
	Trauma & Orthopaedics	6.98	6.67	9.53	4.98%	4.12%	0.86%
	General & Specialist Surgery	8.60	6.46	6.11	2.25%	1.43%	0.82%
Women, Children & Oncology	**W, C & O Division Total**	34.37	41.47	39.86	4.53%	2.61%	1.92%
	Women	14.92	20.13	19.97	5.45%	3.06%	2.39%
	Children	8.44	10.28	10.72	4.03%	2.54%	1.49%
	Oncology & Haematology	10.30	10.07	8.57	3.61%	1.86%	1.75%
Clinical Support Services	**Clinical Support Division Total**	17.94	17.08	18.33	3.27%	1.74%	1.53%
	Imaging	4.93	4.51	4.82	2.75%	1.14%	1.60%
	Pathology	6.37	6.88	6.75	4.44%	2.26%	2.18%
	Other Clinical Support	0.05	0.72	0.18	0.55%	0.55%	0.00%
	Pharmacy	3.13	1.97	1.80	1.51%	1.07%	0.45%
	Therapy Services	3.31	3.36	4.90	5.99%	3.57%	2.42%
Support Services	**Support Services Total**	38.39	35.67	46.16	5.36%	2.92%	2.44%
	Hospital Support	15.12	10.94	18.15	4.16%	1.78%	2.38%
	Facilities	22.64	23.73	27.32	6.43%	3.94%	2.49%
Trust Total	***As FTE***	168.81	174.77	193.53			
	As percentage	3.82%	3.96%		4.39%	2.63%	1.76%

01st July 2017 - 30th June 2018				
Absence Reason	**Headcount**	**Abs Occurrences**	**FTE Days Lost**	**%**
S10 Anxiety/stress/depression/other psychiatric illnesses	415	578	19,070.00	22.61
S98 Other known causes - not elsewhere classified	893	1,174	12,350.00	14.60
S28 Injury, fracture	244	285	6,775.00	8.00
S25 Gastrointestinal problems	1325	1,750	6,304.00	7.50
S11 Back Problems	335	443	6,224.00	7.40

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





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

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Apr-18	May-18		Jun-18	
Medicine & Urgent Care Division	Medical Division Total	85.16%	↑	85.59%	↑	85.70%
	Urgent Care	86.26%	↑	87.27%	↓	86.61%
	Inpatient Specialties	81.92%	↑	82.43%	↑	83.40%
	Outpatients & Elderly Medicine	88.61%	↓	88.44%	↓	88.07%
Surgical Division	Surgical Division Total	86.07%	↑	87.28%	↑	88.30%
	Anaesthetics, CC & Theatres	87.37%	↑	89.01%	↓	88.96%
	ENT & Maxillofacial	85.45%	↑	86.39%	↓	83.13%
	Ophthalmology	91.64%	↓	89.49%	↑	92.03%
	Trauma & Orthopaedics	85.73%	↑	87.51%	↑	89.15%
	General & Specialist Surgery	83.02%	↑	84.43%	↑	87.38%
Women, Children & Oncology Division	W, C & O Division Total	89.87%	↓	89.73%	↑	90.25%
	Women	89.72%	↓	89.71%	↑	90.24%
	Children	91.67%	↓	91.42%	↓	91.13%
	Oncology & Haematology	87.73%	↓	87.55%	↑	89.09%
Clinical Support Services Division	Clinical Support Division Total	93.45%	↑	94.08%	↓	93.64%
	Imaging	92.82%	↑	93.09%	↓	92.43%
	Pathology	96.34%	↑	97.34%	↑	97.55%
	Other Clinical Support	95.11%	↑	96.20%	↓	94.85%
	Pharmacy	93.73%	↑	95.48%	↓	94.95%
	Therapy Services	88.66%	↓	87.64%	↓	87.04%
Support Services	Support Services Total	91.26%	↑	92.01%	↑	92.23%
	Hospital Support	91.64%	↓	91.14%	↑	91.73%
	Facilities	90.92%	↑	92.80%	↓	92.69%
Trust Total		**88.60%**	↑	**89.20%**	↑	**89.55%**

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Apr-18	May-18	Jun-18
Medicine & Urgent Care Division	Medical Division Total	82.05%	81.97%	82.94%
	Urgent Care	83.61%	82.59%	84.59%
	Inpatient Specialties	78.93%	79.22%	79.95%
	Outpatients & Elderly Medicine	84.92%	85.45%	85.50%
Surgical Division	Surgical Division Total	85.06%	85.18%	84.81%
	Anaesthetics, CC & Theatres	85.09%	85.11%	84.24%
	ENT & Maxillofacial	81.95%	81.87%	81.67%
	Ophthalmology	87.14%	85.68%	86.87%
	Trauma & Orthopaedics	87.57%	88.58%	88.11%
	General & Specialist Surgery	83.54%	83.60%	83.60%
Women, Children & Oncology Division	W, C & O Division Total	85.77%	85.99%	86.21%
	Women	84.23%	85.15%	85.22%
	Children	90.18%	89.02%	88.38%
	Oncology & Haematology	82.86%	83.41%	85.60%
Clinical Support Services Division	Clinical Support Division Total	88.19%	88.12%	87.20%
	Imaging	88.73%	88.34%	87.65%
	Pathology	90.37%	91.93%	92.48%
	Other Clinical Support	92.70%	93.43%	93.43%
	Pharmacy	83.86%	82.44%	80.16%
	Therapy Services	87.71%	87.89%	86.79%
Support Services	Support Services Total	84.73%	86.82%	87.27%
	Hospital Support	85.80%	87.25%	86.65%
	Facilities	83.36%	86.28%	88.07%
Trust Total		**84.62%**	**84.81%**	**84.99%**

Capability

Appraisals
The current rate of Appraisals recorded for June 2018 is 86.74%; this is an increase of 0.05% from last month's figure of 86.69%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in June 2018 from 89.20% to 89.55% this is an increase of 0.35% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also increased in June 2018 to 84.99% from last month's figure of 84.81%.; that is an increase of 0.18%.

The target compliance rates for Appraisals, Mandatory, and Role Specific Training have all been set at 85%, which should have been achieved by March 2015; this target was almost achieved this month, but work continues to achieve this level of compliance.

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

CAPABILITY

Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Apr-18	May-18		Jun-18	
Medicine & Urgent Care Division	Medical Division Total	81.88%	↑	82.97%	↑	83.53%
	Urgent Care	86.27%	↑	87.46%	↓	86.97%
	Inpatient Specialties	78.05%	↑	78.54%	↑	78.74%
	Outpatients & Elderly Medicine	82.86%	↑	84.64%	↑	86.80%
Surgical Division	Surgical Division Total	90.09%	↑	92.04%	↓	92.00%
	Anaesthetics, CC & Theatres	91.73%	↑	92.72%	↓	92.00%
	ENT & Maxillofacial	69.14%	↑	72.50%	↑	77.50%
	Ophthalmology	94.29%	↑	95.65%	↓	90.00%
	Trauma & Orthopaedics	94.38%	↑	96.05%	↑	96.11%
	General & Specialist Surgery	90.76%	↑	93.65%	↑	94.02%
Women, Children & Oncology Division	W, C & O Division Total	85.39%	↑	88.22%	↓	87.14%
	Women	86.09%	↑	90.78%	↑	91.29%
	Children	87.69%	↑	89.67%	↓	88.24%
	Oncology & Haematology	82.64%	↑	83.81%	↓	79.58%
Clinical Support Services Division	Clinical Support Division Total	89.31%	↓	87.89%	↑	88.29%
	Imaging	87.29%	↑	87.50%	↓	86.11%
	Pathology	91.52%	↓	88.55%	↑	90.80%
	Other Clinical Support	86.11%	↑	86.11%	↑	86.11%
	Pharmacy	91.41%	↓	89.06%	↓	87.20%
	Therapy Services	87.76%	↓	86.60%	↑	90.43%
Support Services	Support Services Total	81.74%	↑	83.08%	↑	83.55%
	Hospital Support	80.04%	↑	80.61%	↑	81.26%
	Facilities	83.24%	↑	85.25%	↑	85.58%
Trust Total		**85.35%**	↑	**86.69%**	↑	**86.74%**

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26th July 2018**

Title of the Report	**Operational Performance Report**
Agenda item	**12**
Presenter of Report	Mrs D Needham (COO/Deputy CEO)
Author(s) of Report	Directors & Deputy Directors
Purpose	For information / assurance

Executive summary

The paper is presented to provide information and assurance to the committee on all national and local performance targets via the integrated scorecard.

Each of the indicators which is red rated has an accompanying exception report

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

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety Enabling excellence through our people
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance only
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1, 1.2, 3.1, 3.2, 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned

	activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – No

Actions required by the Trust Board

The committee is asked to:

1. Note the report
2. Seek areas of clarification as required

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	APR-18	MAY-18	JUN-18
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	92.6%	100.0%	83.3%
	Friends & Family Test % of patients who would recommend: A&E	>=86.6%	87.2%	86.3%	88.6%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	92.1%	93.7%	91.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97.2%	97.9%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	93.9%	97.8%	92.4%
	Mixed Sex Accommodation	=0	0	0	0

	Indicator	Target	APR-18	MAY-18	JUN-18
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	88.8%	86.6%	93.8%
	Average Ambulance handover times	=15 mins	00:14	00:12	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	80	129	58
	Ambulance handovers that waited over 60 mins	<=10	11	5	2
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	11	13	
	Delayed transfer of care	=23	26	39	35
	Average Monthly DTOCs	<=23	30	42	40
	Average Monthly Health DTOCs	<=7	13	37	31
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	77.6%	90.8%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	72.8%	78.1%	
	Cancer: Percentage of patients treated within 31 days	>=96%	98.7%	97.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	97.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	97.3%	94.3%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	90.0%	90.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	81.1%	81.3%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	100.0%	97.1%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	97.7%	87.5%	
	RTT waiting times incomplete pathways	>=92%	88.7%	89.0%	
	RTT over 52 weeks	=0	1	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.7%	99.4%	
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	79.5%	96.4%	93.5%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	90.6%	91.6%	87.7%

	Indicator	Target	APR-18	MAY-18	JUN-18
Quality of Care: Effective	Length of stay - All	<=4.2	5.2	4.7	4.4
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.6%	3.4%	2.5%
	Emergency re-admissions within 30 days (non-elective)	<=12%	13.3%	14.0%	11.0%
	# NoF - Fit patients operated on within 36 hours	>=80%	93.1%	88.8%	90.0%
	Maternity: C Section Rates	<27.9%	28.4%	31.3%	34.1%
	Mortality: HSMR	100	99	99	101
	Mortality: SHMI	100	97	97	97

	Indicator	Target	APR-18	MAY-18	JUN-18
Finance and Use of Resources	Income YTD (£000's)	>=0	148 Fav	288 Fav	
	Surplus / Deficit YTD (£000's)	>=0	615 Fav	1,231 Fav	
	Pay YTD (£000's)	>=0	(539) Adv	(1,202) Adv	
	Non Pay YTD (£000's)	>=0	283 Fav	555 Fav	
	Bank & Agency / Pay %	<=7.5%	11.7%	11.7%	
	CIP Performance YTD (£000's)	>=0	485 Fav	1,041 Fav	1,456 Fav
	Salary Overpayments - Number YTD	=0	24	46	70
	Salary Overpayments - Value YTD (£000's)	=0	22.1	82	126
	Waivers	=0	12	9	
	Waivers which have breached	=0	3	2	

	Indicator	Target	APR-18	MAY-18	JUN-18
Quality of Care: Safe	Never event incidence	=0	0	0	0
	Number of Serious Incidents (SI's) declared during the period		1	3	4
	MRSA	=0	0	0	0
	C-Diff	<=1.75	5	1	2
	MSSA	<=1.1	2	1	0
	VTE Risk Assessment	>=95%	96.5%	95.9%	
	Harm Free Care (Safety Thermometer)	>=94%	92.9%	93.6%	95.8%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	4.3	4.9	5.7
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	45	79	25
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	94.9%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	=0%	4.8%	4.0%	5.6%

	Indicator	Target	APR-18	MAY-18	JUN-18
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	63.5%	63.5%	
	Sickness Rate	<=3.8%	3.7%	3.9%	4.4%
	Staff: Trust level vacancy rate - All	<=9%	12.1%	11.8%	12.6%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	12.7%	13.1%	14.3%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	9.8%	9.5%	9.8%
	Staff: Trust level vacancy rate - Other Staff	<=9%	13.2%	12.7%	13.7%
	Turnover Rate	<=10%	7.6%	7.5%	7.4%
	Percentage of all trust staff with mandatory training compliance	>=85%	88.5%	89.1%	89.5%
	Percentage of all trust staff with role specific training compliance	>=85%	84.6%	84.8%	84.9%
	Percentage of staff with annual appraisal	>=85%	85.3%	86.7%	86.7%

Run Date: 13/07/2018 15:08 Corporate Scorecard Run by: FrancisS

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2018/19 Accountability Framework for NHS trust boards

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

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

Each indicator which is highlighted as red 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:
Average Monthly Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Delayed transfer of care	<=23	66	3	59	44	22	25	29	39	27	52	26	39	35
Average monthly DTOC's	<=23	68	56	62	49	33	26	38	32	38	42	30	42	40
Average Monthly Health DTOC's	<=7	N/Avail	N/Avail	N/Avail	N/Avail	12	9	14	10	13	16	13	37	31

Driver for underperformance:

- Delays in social services assessment continue
- Lack of social workers in Trust and continuity
- Discharge to Assess (DTA) pathway not yet fully available
- Long delays due to community availability/resources
- Large delays in waiting time for medical rehabilitation beds/SCC beds and ability to take high level dependency patients
- Delays with patients awaiting brokerage for funding decision
- Delays in Wards sending accurate patient reflective PDNA's to SPA,
- Delays in SPA due to Systems and processes
- Tracker produced from SPA not supporting discharge,
- Internal delays with incomplete PDNA's being returned from SPA
- Ward Board Rounds
- Ensuring discharge plan for every patient
- Delays in completing TTO's and EDN's
- High Stranded patients
- Commencing discharge plans on admission

Actions to address the underperformance:

- Northampton Social Services currently under review
- Use of CHS brokerage for self-funding patients
- Use of Dickens therapy unit for reduce demand on care in community
- Overnight care model in place – further approval for increased capacity
- Recruiting 11 discharge co-ordinators, – 7 currently in post, 2 still to recruit,
- Allocating Discharge Coordinators, as and when trained, to medical Wards to assist in all discharge activities
- Three weekly tracking meetings to challenge and escalate discharges and delays, also to agree DTOC numbers
- PDNA Training being rolled out to all Wards
- Daily updates continue to be emailed to SPA for all patents on the Tracker
- DTOC coding to be re-reviewed
- Weekly Stranded patient reviews for all patients >7days LOS with Wards, supported by senior level engagement
- Twice weekly updates for all >7 days LOS from a Ward level from Discharge Team
- Identify potential patients for Avery beds earlier in admission pathway

• Delays with dementia and delirium team referrals • Long delays with homeless patients • Long delays awaiting provision for high levels of care, • Family/patient expectation	• Trusted Assessor Task and Finish group established to support the provision of a Trusted Assessment pathway and model • Monitor those waiting for medical rehabilitation beds and ensure they still require this pathway via daily tracking by discharge team and Therapy • Focus on weekend discharges and encourage recording of weekend plans within medical notes • Electronic version of PDNA to be introduced, currently sitting with WASP • New internal Tracker being reviewed • 'Safer in 100 Days' being rolled out on all Wards (promoting Board Rounds/Plans for every Patient) • Intermediate Care currently being redesigned to support admission and discharge

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Friends & Family Test	Externally mandated	Quality Governance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	94.1%	93.9%	93.1%	93.5%	93.1%	93.5%	92.1%	93.2%	93.4%	93.2%	92.1%	93.7%	91.9%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	92.8%	92.9%	92.3%	92.9%	92.2%	93.2%	93.5%	94.1%	93.7%	93.8%	93.9%	97.8%	92.4%

Driver for underperformance:

- It is evident when reviewing the data that the results for Inpatient & Day Cases have stabilised, with only small movements each month. Inpatient & Day Case areas are sitting 3.9% below the national average when comparing June with the most recent national data available.
- Outpatients performed 1.5% below the national average.

Actions to address the underperformance:

- It has also been identified through the Right Time that Discharge is a consistent theme of dissatisfaction within Inpatient areas. The project focussing on co-design with patients is continuing. It is expected that over the course of the project improvements should begin to be made within the FFT results.

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:
Staff Sickness Rate	Internally set	Workforce Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness Rate	<=3.8%	3.5%	3.8%	4.1%	4.0%	4.5%	4.2%	4.7%	4.8%	4.6%	3.8%	3.7%	3.9%	4.4%

Driver for underperformance:	Actions to address the underperformance:
• There is an overall trend that staff are less resilient due to pressures in the system • There is an increase of long term sickness absence due to stress and anxiety	• The sickness absence policy has been reviewed and changed to Supporting and Managing Workforce Sickness Absence to reflect a more supportive approach to staff health and wellbeing • Training has been provided on the changes to the policy • The Respect and Support Campaign was launched on 24 June 2018 and resilience training commences in July 2018 • Managers are being advised to continue to support staff through their 121 management meetings • The HR Business Partners and HR Advisors are supporting managers to carry out stress risk assessments when appropriate

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Percentage of all trust staff with role specific training compliance	>=85%	81.8%	82.6%	83.9%	84.3%	84.2%	84.8%	84.2%	83.9%	84.0%	84.2%	84.6%	84.8%	84.9%

Driver for under performance:	Actions to address the underperformance:
• Lack of insight into the importance of Role Specific Training due to not being called Mandatory • Positions not being aligned to Role Specific Training subjects • System (OLM) not flexible enough to report on staff requirements to undertake RSET and having the lowest dominator being set at position level not assignment level	• Due to the number of positions being created each month, work commences on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely. • We have completed all the Safeguarding templates to send to IBM to upload. However IBM is currently experiencing problems, so the files will not upload. As soon as this is rectified the templates will be sent. Upon completing the templates there are more positions that are required to complete level 2 and level 3. At the moment it is not known how this will affect the training compliance. • The Falls Prevention Lead has completed their analysis in reviewing the staff aligned to this training. However, due to the time this took, the Lead has requested a new list to work on, which was provided on 26 April 2018.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	91.9%	87.8%	86.8%	69.9%	78.7%	85.9%	93.2%	92.7%	94.5%	89.4%	77.6%	90.8%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	50.9%	63.0%	48.6%	12.1%	31.2%	79.1%	96.0%	94.2%	95.3%	80.9%	72.8%	78.1%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	94.1%	98.3%	97.0%	94.5%	98.8%	98.7%	98.4%	97.1%	100.0%	88.7%	100.0%	97.1%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	88.8%	81.8%	100.0%	90.0%	94.7%	100.0%	100.0%	91.6%	94.7%	85.7%	90.0%	90.0%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	74.5%	74.5%	75.1%	83.4%	76.5%	90.1%	86.0%	86.2%	77.2%	91.5%	81.1%	81.3%

Driver for underperformance:	Actions to address the underperformance:
Please refer to F&P report	

Lead Clinician:	Lead Manager:	Lead Director:
Mr O Cooper	Sandra Neale	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Complaints responded to within agreed timescales	Externally mandated	Quality Governance Committee	June 2018

Performance and Trajectory:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Complaints responded to within agreed timescales	=>90%	82.0%	84.9%	90.6%	90.2%	100.0%	93.1%	100.0%	93.4%	100.0%	100.0%	92.6%	100.0%	83.3%

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

Driver for underperformance:

For complaints received in April (responded to in June) the following should be noted:

- 36 complaints received
- 14 complaints agreed up to 20 days (lower complexity)
- 22 complaints agreed up to 30 days (high complexity)
- 0 complaints agreed up to 40 days (significant complexity)
- 18 extension requests issued (average number of extension requests in previous reporting year was 16 – this year to date average is 18)
- 6 holding letters sent (average number of holding letters in previous reporting year was 3 per month - only April's data available for this year to date)
- 0 complaints reopened

Reasons for underperformance:

- Increased number of new complaints received this year to date when compared to last year (LY – 127 / TY – 141). Each complaint requires a handling plan, identifying points & timescales, to be agreed via the complainant.
- 18 extension requests required due to divisional / directorate / other organisation's pressures
- 4 holding letters sent due to divisional / directorate pressures
- 2 holding letters sent due to delay in 3rd party responses

Actions to address the underperformance:

- Continue to utilise triage process in place to identify complaints that could be resolved earlier through local resolution
- Weekly complaints report is issued to highlight any complaints out of time
- New Complaints Officer commenced in post end of May 2018 – additional head currently in training
- Head of Complaints preparing response for significantly complex complaint
- Divisional Director (Medicine & Urgent Care) has requested to be made aware of any escalation emails sent to medical staff when their statements exceed the internal timeframe
- Review process where complaints involving other organisations are causing delays

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Lisa Cooper	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated	Quality Governance Committee.	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Maternity: C Section Rates - Total	<27.1%	28.3%	29.0%	29.5%	27.6%	21.8%	27.9%	28.6%	29.5%	27.9%	30.9%	28.4%	31.3%	34.1%

Driver for underperformance:	Actions to address the underperformance:
• Elective CS rates RED in May/June which puts overall rate RED. 31.3% for Q1	• Continue monitoring – discussed at Governance meeting, Consultant meeting and Midwifery Leads meeting. • Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making. • Continue with debriefs following all Caesarean Sections – this is now documented on Medway as part of the CS documentation. • Ongoing Elective Caesarean Section audits – good compliance • Birth After Caesarean Clinic – ongoing. • Anecdotal evidence noted in out of area for referrals specifically for Elective CS – data is currently being reviewed to assess whether this is an actual trend

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd	Not applicable	Dr Mathew Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay - All	Internally set	Finance, Investment and Performance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Length of stay - All	<=4.2	4.3	4.9	4.8	5.0	4.8	4.8	4.9	5.2	5.0	5.3	5.2	4.7	4.4

Driver for underperformance:

- **REDUCTION OF Av LOS BY 0.8 DAYS in 2 MONTHS**
- SPA processes continue to slow discharges and ward processes due to assessment times and brokerage
- High numbers of patients in the 21+ days LOS (220 patients)
- Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit
- Reliance on beds and almost no vacancies in care homes at present; Insufficient capacity within the home support services
- Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS
- 150 Live PDNA's in the SPA
- High DTOC rates in community beds leads to no flow from the acute to community

Actions to address the underperformance:

- Weekly review with every ward of every patient with a LOS>7 days being carried out. This has reduced our Stranded and Superstranded by >25% in 6 weeks
- Discharge element of 'Fixing the Flow' initiative being led by Nursing Director
- 3 times a week tracking meeting face to face with Partners
- New PDNA document in place (13 pages to 5 pages)
- Exec led top delays meeting to review the longest staying patients in the trust in place weekly
- Employed further 11 Discharge Coordinators to support Wards they are updating stranded patient process daily
- Robust use of the Choice Policy
- County wide review of Intermediate care underway (12 month project minimum)
- 'SAFER in 100 days' initiative spreading across the ward base

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:
Staff Vacancy Rate	Internally set	Workforce Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Staff: Trust level vacancy rate - All	<=9%	11.9%	12.5%	12.6%	11.6%	10.9%	10.8%	11.3%	10.1%	10.6%	10.8%	12.1%	11.8%	12.6%
Staff: Trust level vacancy rate - Medical Staff	<=9%	10.0%	13.9%	14.4%	16.1%	13.5%	11.8%	13.1%	13.2%	11.5%	13.1%	12.7%	13.1%	14.3%
Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	10.4%	10.7%	11.3%	9.9%	8.4%	7.9%	8.1%	8.7%	8.6%	8.7%	9.8%	9.5%	9.8%
Staff: Trust level vacancy rate - Other Staff	<=9%	13.6%	13.4%	13.2%	11.9%	11.9%	12.2%	12.7%	11.6%	11.5%	11.5%	13.2%	12.7%	13.7%

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 • Nurse recruitment action plan has been refreshed. • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Overseas recruitment for nurses continues • Medical Recruitment Strategy and Action Plan being implemented. • New Recruitment system to improve and reduce recruitment timelines in early stages of implementation.

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:
Number of Serious Incidents (SI's) declared during the period	Externally mandated	Quality Governance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Number of Serious Incidents (SI's) declared during the period	=0	1	0	2	2	6	3	1	1	4	3	1	3	4

Driver for underperformance:	Actions to address the underperformance:
• Complications of birth. • Maternal death • Delay in surgical review • Pathology	• Sturtridge of which the investigation is ongoing. • Sturtridge of which the investigation is ongoing. • Collingtree of which the investigation is ongoing • IG breach – 12 patient samples lost in transit to external organisation.

Lead Clinician:	Lead Manager:	Lead Director:
		Mr M Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Clostridum difficile Infection Trust attributable (post 3 days)	CDI Externally Mandated	Quality Governance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
C-Diff	<=1.75	5	5	0	1	1	3	0	3	0	0	5	1	2

Driver for underperformance:	Actions to address the underperformance:
• The driver for underperformance is the trust trajectory for Clostridium difficile infection (CDI) for 2018-2019 which is 20 trust attributable CDI	• Post Infection Reviews have been performed on all patients that have developed CDI • To continue to work within the CDI forward plan • The CDI change package continues to be reinforced and embedded across the Trust • A meeting will be held with the Consultant Microbiologist Antimicrobial Pharmacists and IPCT to identify a strategy for engaging medical staff in appropriate prescribing and prompt review of antibiotics

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Ward Moves > 2	Internally set	Finance, Investment and Performance Committee	June 2018

Performance:

Indicator	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Ward Moves (>2) as a % of all Ward Moves	=0%	3.9%	4.0%	4.1%	4.7%	4.2%	4.0%	4.1%	4.3%	4.9%	4.9%	4.8%	4.0%	5.6%

Driver for underperformance:	Actions to address the underperformance:
• Focus on right patient right bed. Patient move into appropriate specialty • Focus on creating assessment area beds to ensure bed capacity maintained at front door over a 24 hour period • Patients back flow into assessment areas when unable to support acuity • Late discharges • Overwhelmed ED resulting in increased admissions	• Work delivering reduced number of stranded patients to create right capacity at right time of day • All wards to have senior decision maker review patients daily and weekend plans for every patient confirmed to deliver capacity at right time of day • Medical team supporting acuity on base wards reducing number of patients transferring back on assessment areas • Focus on moving discharge profile to earlier in the day • Extra focus on managing ED first assessment times to maintain under 1 hour

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 July 2018**

Title of the Report	**Health and Safety Annual Report 2017/18**
Agenda item	**13**
Presenter of Report	Stuart Finn Interim Director of Estates and Facilities
Author(s) of Report	Fiona Potter, Health and Safety Manager
Purpose	Assurance

Executive summary

This report provides an analysis of the Trust's Health and Safety performance during the financial year 2017 – 2018 and highlights relevant issues pertaining to the Management of Health and Safety in the Trust.

The report concludes with a forward look, which gives an outline of the key Health and Safety priorities proposed for the financial year 2018/19.

Related strategic aim and corporate objective	• To be a provider of quality care for all patients • Provide appropriate care for our patients in the most effective way
Risk and assurance	The report highlights areas of risk and proposes measures to mitigate those risks
Related Board Assurance Framework entries	BAF 1.6 4.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Failure to meet statutory obligations under Health and Safety legislation

Actions required by the Trust Board

The Board is asked to consider the report and note the progress made during the year and the key issues highlighted.

Northampton General Hospital NHS
NHS Trust

Health & Safety Annual Report 2017-2018

Report Author: Fiona Potter, Health and Safety Manager.

Contributors:
Stephen Black - Manual Handling Lead
Francine Diffley - Clinical Specialist Physiotherapist, Occupational Health
Chris Wood-Radiation Protection Advisor
Ian Robinson- Interim Head of Estates
Linda Wiggins- Deputy Manager Occupational Health

Date: May 2018

Health & Safety Annual Report: 2017/18

1. Summary

The Health & Safety Departments work plan for 2017/18 was adapted to balance the operational challenges and investigations, against the strategic objectives. There have been positive developments, through;

- A reduction of the Control of Substances Hazardous to Health Risk from a corporate risk to a High risk.
- An average return of greater than 87% of all Health & Safety Inspections (3 areas achieved) 100%
- All Health & Safety Polices are in date
- Partnership working with professional colleagues, strengthening shared learning and opportunities to change and improve on health and safety practices.
- A three year Health & Safety Strategy, based on HSG 65 "Successful health and safety management" to ensure the Trust is able to build on health and safety systems currently in place, and proactively scan research quality initiatives and Trust models to continue to improve the health, safety and welfare provision for all.

Areas of continued monitoring relate to Risk Assessments, Estates and Facilities infrastructure, and incident occurrences relating to needlestick injuries and Workplace Aggression, Violence and challenging behaviour

2. Introduction

The purpose of this report is to provide the Trust Board with a summary of principal activities and outcomes relating to the promotion and management of health and safety within Northampton General Hospital (The Trust), supported by a review of health and safety performance during the financial year of 2017 – 2018.

The Health and Safety at Work etc., Act 1974 and associated regulations place duties on the Trust, to safeguard so far as is reasonably practicable the health, safety and welfare of employees and others who can be affected, such as patients, members of the public, volunteers and contractors by their undertaking.

The Trust monitors health and safety arrangements by various channels, including:

- Trust Health and Safety Committee (quarterly meetings)
- Specialist assurance reports
- Quality Governance Committee (quarterly)
- Risk and Compliance Group (Corporate risk rating 15 or above)
- Divisional and Directorate reports (6 monthly)
- Directorate/Corporate Quarterly health and safety inspections
- Internal and external audits
- Proactive site visits (face to face communication)

A number of process and systems are in place to ensure the effective health and safety management of the Trusts operations. These include; policies, procedures, safe systems of work, risk assessments, operational visits, training, health and safety newsletter, incident reporting, investigation and organisational learning.

The report concludes with a forward look, to outline of the Key Performance Indicators for the financial year 2018/19 based on key elements of the three year Strategic Health & Safety Management Strategy.

3. Regulation and Inspection visits

The Trust received a visit from the Environment Agency with regard to Radiation Protection. The inspection and compliance report did not raise any issues with regards to the Environmental Permitting Regulations 2010.

4. Update on Health & Safety Legislation and Guidance

The Ionising Radiation Regulation 2017(IIR 2017) came into force on 1st January 2018 and The Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER 2017) came into force on 6th February 2018. The Trust is proactively implementing regulatory changes that are monitored through the Radiation Protection Committee.

The HSE Sector Strategic Plans for Healthcare in 2017/18 focuses on the key message to "***Go Home Healthy*".** The plan topics are: Musculoskeletal Disorders, Stress, Depression or anxiety, and Workplace Violence and Aggression.

5. Health and Safety Governance

The Trusts Health and Safety Committee meet on a quarterly basis, and provide a quarterly summary report submitted to Quality Governance Committee.
Divisional reporting and attendance at the health and safety meeting has been variable due to pressures on the Trust, and a change of nominated health and safety representatives.

Attendance from Divisions at all future health and safety meetings will be monitored and reported to Divisional Directors and to QGC.

The following Committees provide assurance reports either on an annual basis or 6 monthly

- Radiation Protection (Annual)
- Safer Sharps (6 monthly)
- Estates/Facilities (Annual)
- Fire Safety (Annual)
- Security (Annual)
- Water Safety Group (Annual)
- Control of Substances Hazardous to Health (6 monthly)
- Manual Handling/Display screen equipment (Annual)
- Medical Gases (Annual)
- Occupational Health (Annual)

Recommendations and action points are tracked through the Health and Safety Committee action log or through specific committees. A summary of reports are outlined in Appendix 1

6. Health & Safety Audits

Health and safety specific compliance audits undertaken during the year covered;

- Management and the Control of Contractors
- Control of Substances Hazardous to Health
- Storage of medical gas cylinders on ward areas
- Health & Safety Inspection process

Action plans, are in place to address identified gaps in assurance, which are monitored and tracked through the Health and Safety Committee

The KPI was achieved for 2017/18

No	KPI 2017/18	Status	Details
1	At least 2 Compliance Audits Completed	KPI Achieved	4 compliance audits completed

7. Divisional Health & Safety Management Reporting

Each division is required to have their own local Health & Safety meeting to ensure health and safety issues are discussed managed and communicated locally. The Divisions are required to provide the Trust Health & Safety Committee with an assurance report, to evidence how they effectively manage Health & Safety and also to escalate any Health & Safety matters or concerns as deemed appropriate for the attention of the committee.

The management structure regarding local Health & Safety meetings, are different in each division. Regular meetings have not been taking place in some divisions due to staff relocating out of the division.

The quarterly H&S inspections cover:

- General housekeeping e.g. condition of floor covering, traffic routes
- Working environment e.g. Legionella water checks & waste management
- Work equipment, e.g. lifting equipment, hoists, electrical testing.
- Risk assessment/ COSHH/ DSE/lone working assessments
- Communication and Training
- Emergency Planning, fire table top, first aid provision
- Staff Consultation

The Divisional compliance for returning quarterly health and safety inspections are shown in Table 1. There has been an increase in the number of inspections returned across all areas, which evidences greater engagement across the Trust.

Table 1 Quarterly health and safety returns

Division/Area	Compliance level % (April 17)	Compliance Level% (July 17)	Compliance Level (October 17)	Compliance Level (January 18)
Medicine & Urgent Care	100	100	100	100
Clinical Support	71	80	80	67
Surgery	78	55	70	77
Women's Childrens Oncology, Haematology, cancer services	100	100	100	100
Facilities	74	83	100	100
Other corporate support areas	67	87	57	67

70%	
50-70%	
Under 50%	

No	KPI 2017/18	Status	Details
2	70 % compliance rate achieved for quarterly H&S inspections for each Division and area	KPI achieved	Medicine and Urgent Care, Women's Childrens Oncology, Haematology, cancer services and Facilities
2	70 % compliance rate achieved for quarterly H&S inspections for each Division and area	KPI not achieved across all Divisions	All areas had achieved above 50%, which is a significant improvement on the previous years. The H&S department will support Clinical support Services, and other corporate support areas to achieve a 70% compliance The overall % return average is 87%

The measurement of the Divisional reporting will be show in the divisional Compliance reports and will not be a Key Performance Indicator for the Health & Safety Department

8. Polices

Six policies/procedures have been written, reviewed or revised during the year by the Health & Safety Department and ratified by Procedural Documents Group:

- NGH-PO - 850 Safe Management of Sharps
- NGH- PO - 094 The Use of Display Screen Equipment (DSE).
- NGH- PO - 283 Transport Safety in the Workplace.
- NGH-PO - Slips, Trips & Falls (Staff and Visitors) Policy
- NGH-PO - 934 First Aid
- NGH- PO- 114 Risk Assessments for New and Expectant Mothers and Breastfeeding Mothers at Work

The Health & Safety Manager has given significant support and advice towards the Medical Gases Policy and the Laser Protection Policy.

No	KPI 2017/18	Status	Details
3	100 % H&S Policies in date	KPI Achieved	Of the 12 policies, all were in date at the end of the year 2017/18

The polices are available on the Trust intranet pages under Policies, Procedures and Guidelines

9. RIDDOR Incidents (Reporting of Injuries Diseases, and Dangerous Occurrences Regulations 2013)

The total number of RIDDOR reported incidents remain the same as for 2016/17 at 24.

Table 2: RIDDOR Reportable Incidents.

Year	2015/16	2016/17	2017/18
No of RIDDOR Reportable Incidents	**14**	**24**	**24**

A total of 21 staff incidents and 3 members of the public incidents were reported to the Health & Safety Executive under the above regulations

All incidents that are RIDDOR reportable are analysed through a health and safety initial assessment form and for sharps injuries a World Health Organisation Route Cause Analysis template. Incident analysis detailed in Appendix 2.

A number of new initiatives have been developed over the year to analyse the number of RIDDORs or incidents of moderate harm and above including

- Collaborative working with the Occupational Health Department, Manual Handling Lead and Trust Clinical Specialist Physiotherapist to review incidents of musculo skeletal injury and upper limb injury
- Collaborative working with safeguarding, security and with ward and clinical staff to review incidents of workplace aggression and violence.
- Collaborative working with the Dementia Liaison Nurse to review incidents of challenging behavior from patients who lack capacity.
- Review of training for security staff regarding clinical restraint/ non clinical restraint

8.1 Reporting incidents to the Health & Safety Executive

The RIDDOR regulations have strict criteria for reporting incidents (NGH-PC-801) During 2017/18 the number of reportable incidents to the Health & Safety Executive within the specified time criteria was 79% (19) a significant improvement on the 57% the previous year.

There were no specified injuries to patients reported under RIDDOR. There were three incidents relating to members of the public. Incident analysis detailed in Appendix 2.

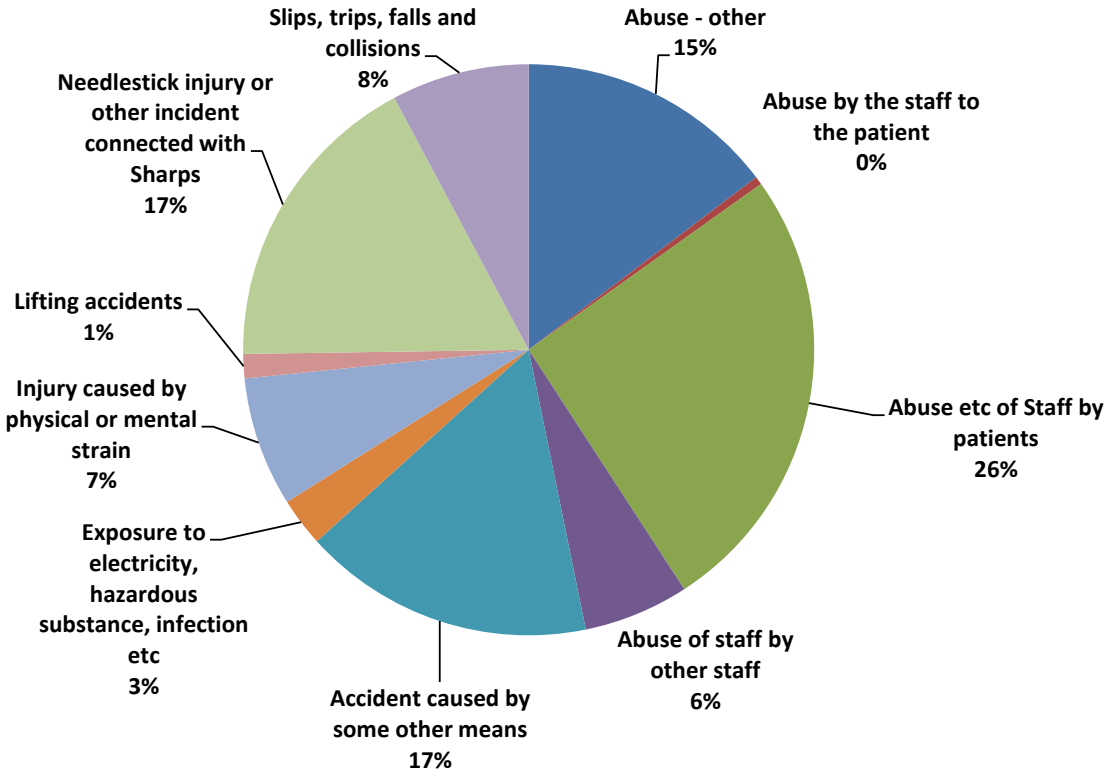
8.2 Total Incident rates (staff accident and injuries, specified incidents to patients)
Trust incidents are reported on Datix. For the period 1st April 2017 to 31st March 2018 a total of 901 incidents were recorded for staff and members of the public. A decrease of 0.5% on the previous year (See Table 3 and Figure 1)

Table 3 Incidents April 2017 to March 2018

Category	Total Number 901 (16/17 905)	Percentage of Total
Physical abuse, assault or violence, and unpredictable patient behaviour	423 (469)	47 (52)
*accident of some other type or cause**	153 (191)	17 (20)
injuries from contaminated sharps	152* (111)	17(12)
Manual handling/ musculoskeletal	76 (88)	8 (10)
Slips trips falls (excluding patient falls)	81 (47)	8 (3)
Contact with electricity, exposure to hazardous substances	16 (0)	3 (0)
Total	**901**	**100**

*include figures from incorrect disposal of sharps in waste

Figure 1: Total incidents April 2017– March 2018 (Total 901)



8.3 Sharps Incidents and review:

There was an increase in the number of low harm injuries from contaminated sharps and decrease in the number of moderate harm incidents. (See Figure 2)

The Sharps Safety Group review incident trends and follow up at ward or departmental level to raise awareness on the importance of using safer sharps devices and clinical practice.

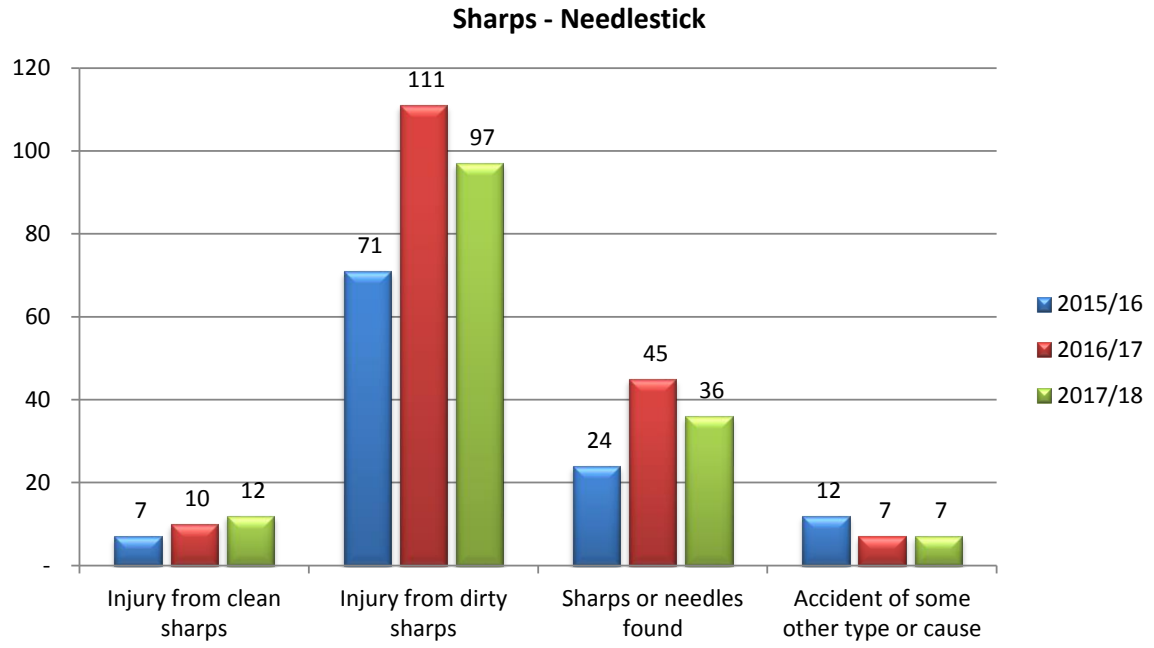


Figure 2 Total number of Sharp -needles stick incident and injuries

8.4 Manual Handling/ Musculoskeletal Incidents and review

The Trust workforce undertakes a significant number of manual handling operations. The current incident figures are shown in Table 4

Table 4: Manual Handling/Musculoskeletal incidents

Adverse event	2016/17	2017/8
Stretching or bending injury, other than lifting' incidents	19	25
Lifting in the course of moving loads	6	5
Lifting or moving a patient or other person	17	21
Lifting or moving an object other than a load	2	3
Other type of MSK incident	44	22
Total manual handling incidents with harm	88	76

There was an increase in the number of stretching bending injuries on the previous year and a decrease in the number of lifting or moving patients. The decrease may be as a result of the revised and refreshed manual handling training programme, and greater awareness of the use of slide sheets within the Trust

All Datix reported musculoskeletal incidents are offered triage by the Occupational Health Department and a “fast track” referral to the Physiotherapist to monitor the condition.

A total of 5 RIDDOR reportable incidents were reported to the HSE, due to musculoskeletal injuries. All were due to staff members not being able to work for 7 or more consecutive days (Appendix 2).

8.5 Incidents of Aggression, Violence and Challenging Behaviour and review
47% of all reported incidents relate to aggression, violence and challenging behaviour in the workplace. A breakdown of incidents by detail are shown in Figure 3.
A total of 5 RIDDOR reportable incidents were reported to the HSE relating to “over 7 days injury” from work

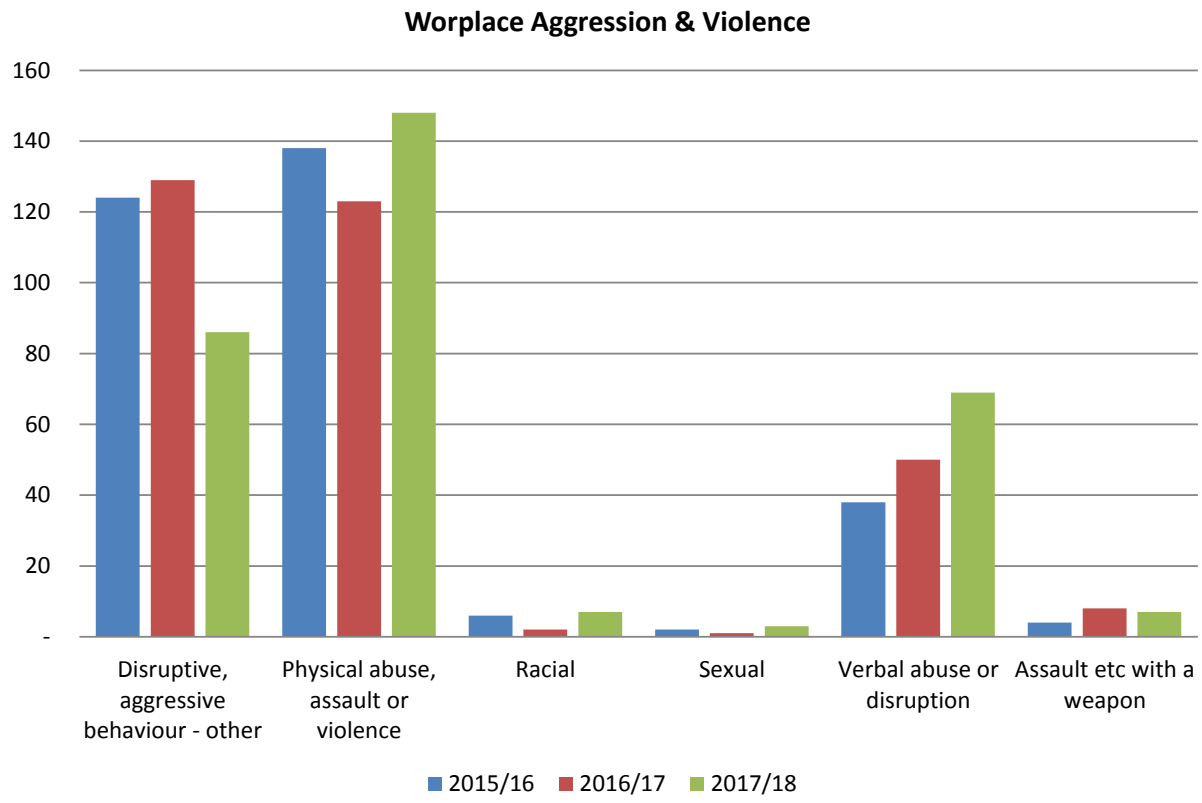


Figure 3 Total Incidents of aggression and violence to Trust Employees

The Trust continues to provide conflict resolution training, specialist disengagement training (break away training) for staff in areas most affected by aggression, violence and challenging behaviour. Conflict resolution training continues to increase from 67% to 83% Safeguarding, Security, Health and Safety and Practice Development are currently reviewing the training provision for all staff, to ensure it is fit for purpose.

10. Health &Safety Training

All employees are required to have Health and Safety awareness training as part of the Trust mandatory training program.

Table 6 Training information

Health & Safety Training	2015/2016	2016/17	2017/18
Health & Safety training, induction and refresher	84.7%	86.6%	84.8%

In addition to mandatory Health and Safety training, specific training courses were provided by the health and safety department to include: volunteer awareness, risk assessment, Board refresher training, and a program of COSHH assessment training.

No	KPI 2017/18	Status	Details
5	85% staff are up to date with their mandatory health and safety training in line Trust target.	KPI not achieved	Future focus to work with Training and Development to contact individuals who have not completed their health and safety training

The health and safety department will continue to monitor the requirement of health & safety training and communication

Communication

Health and Safety communication is provided though face to face contact, information via the intranet page on The Street, and updates to training.

The Health & Safety Calendar continues to promote health and safety topics through the newsletter and risk assessments

11. Health and Safety Plan for 2018/19 Forward look

The Key Performance indicators for the 2018/19 are:

No	KPI 2018/19	Status	Details
1	To implement an audit program to ensure 3 Compliance Audits Completed		
2	To ensure 100 % H&S Policies in date		
3	To maintain a level of 85% staff are up to date with their mandatory health and safety training		
4	To Develop and implement a health and safety training program for Senior Managers		
5	To Develop and implement a health and safety training program for health and safety leads		

In addition to the above, a key focus will be required on the Health and Safety Executive Work and Strategy Plan topics, of musculoskeletal disorders, work related stress and effective management control of identified risk.

Appendix 1 – H&S Committee Assurance Reports

Sub committee	Frequency of report	Chair
Control of Substances Hazardous to Health	6 monthly	Matron Medicine & Urgent Care
Estates/Facilities	6 monthly	Head of Estates
Fire Safety	Annual	Fire Safety Advisor
Manual Handling and ergonomics	Annual	Manual Handling lead/Trust Physiotherapists/Health & Safety Manager
Medical Gases	Quarterly	Divisional Director Medicine and Urgent Care
Occupational Health	Annual	Deputy Occupational Health Manager
Radiation Protection (incorporating laser safety)	Annual	Divisional Director of Clinical Support Services
Safer Sharps	6 monthly	Infection Prevention
Water Safety	6 monthly	Head of Estates
Security	Annual	Local Security Management Specialist
Water Safety Group	Annual	Head of Estates
New Sub Committee for 2018/9		
Asbestos management	6 monthly	Head of Estates
Contractor Management	6 monthly	Head of Estates

1. Radiation Protection (Annual)

The Radiation Protection Committee has monitored the changes in the new legislation, The Ionising Radiation Regulations 2017(IRR17) and The Ionising Radiation (Medical Exposure) Regulations 2017, along with the submission of information to the HSE web site.
All staff radiation doses were below statutory dose limits.

2. Safer Sharps (6 monthly)

The Safer Sharps Group meets on a quarterly basis to monitor incidences, of sharps/needle stick injuries, and the procurement of trials of new safe sharps models.

All non safer sharps risk assessments have been reviewed during 2018
The Group are looking to reduce the number of incidents for 2018/2019

3. Estates/ Facilities (Annual)

Specific Board report presented separately

4. Fire Safety (Annual)

Specific Board report presented separately

5. Security (Annual)

Specific Board report presented separately

6. Water Safety Group (Annual)

The water safety group monitor compliance with the safe management of water legislation across the Trust

7. Control of Substances Hazardous to Health (6 monthly)

The Corporate COSHH (474) risk has reduced to a High risk after an audit by members of the working group, during Q3 of 2017 and submission of a checklist.

The COSHH working group has moved from a monthly meeting to a quarterly meeting
All COSHH assessments have been reviewed and are available on the health and safety intranet page.

8. Manual Handling/ Display Screen Equipment (Annual)

Compliance rates for Manual handling training has increased from 83.9% to 85.4%
The Display Screen Equipment Policy was ratified and the eye sight test provider is Eye to Eye Opticians.

The highest numbers of referrals to the Trust physiotherapist are:

- Gradual onset/cumulative strain(work related)
- Injury at work
- Injury outside work affective work activities

A specific focus and support has been provided for the sonography department with ongoing monitoring of musculoskeletal conditions.

9. Medical Gases Committee (Annual)

The Medical Gases Committee meetings have been irregular during 2017; however have met more frequently during 2018.
An annual medical gas site audit undertaken by an independent Authorising Engineer during June 2017 and a detailed action plan has been drawn up by the Estates department.

A verbal report was provided by Dr Raghuraman Govindan, who has supported the committee as Chair, and has enabled progress on points of the audit.

The draft medical gases policy has been distributed for review and is due to be ratified in September 2018.

An audit of the number of medical gas cylinders on site has been undertaken with Pharmacy, the Portering department and BOC.

Practice development are in the process of implementing a training program for nurses and clinicians on monitoring the cylinder and regulator for the supply of medical gas.

10. Occupational Health

Specific Board report presented separately

Appendix 2: The total number of staff related reportable incidents were 21 a breakdown of the nature of the incidents are detailed below in Table 5 & 6
RIDDOR incidents (1st April 17 – 31st March 2018)

Type	Location	Causal factor
Slip stumble fall X 4	Willow ward	Tripped over equipment
	Holcot ward	Tripped over equipment
	Mansfield theatre	Misplaced footing off foot stool
	CSS	Slipped on item
Struck by object X 3	Robert Watson	Storage of item on locker. Access fan
	CSS	Struck by trolley
	CSS	Handling equipment
Lifting and handling	Abington ward	Mobilising patient
injury x 5	Main theatre	Mobilising patient
	Knightly	Patient fall on individual
	Abington ward	Mobilising patient
	CSS	Handling patient
Physical assault x 5	Compton	Administering medication
	Collingtree	Challenging behaviour
	ITU	Challenging behaviour.
	Abington	Grabbed by patient.
	Becket	Struck by patient using a walking stick
Dangerous Occurrences Exposure to biological agent		
Exposure to allergen X 1	Women & Children	Office Environment changes. COSHH assessment written
Hep C X 3	Finedon	Cascade training incident reporting
	Finedon	Difficult venepuncture
	Community	Blood taking, non safer sharp device used. Process changed

The total number members of the public reported incidents was 3

Type	Location	Causal factors
Slip, stumble, fall from height	Accident & Emergency	Fall in toilet & prior injury
	Outdoor area	Playing with child
Struck by object :	Integrated surgery outpatients	Speed of walking
		Struck by sliding door

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 July 2018**

Title of the Report	**Infection Prevention & Control 2017/18 Annual Report**
Agenda item	**14**
Presenter of Report	Carolyn Fox Director of Nursing, Midwifery & Patient Services and Director of Infection Prevention & Control
Author(s) of Report	Carolyn Fox - Director of Nursing, Midwifery & Patient Services and Director of Infection Prevention & Control Wendy Foster - Matron for Infection Prevention Holly Slyne - Infection Prevention & Control Clinical Nurse Specialist Steve Melville - Decontamination Lead Kiranjeet Dhillon - Antimicrobial Pharmacist Claire Brown - Occupational Health Manager
Purpose	Assurance

Executive summary

MRSA: During 2017/18 there were 0 Trust apportioned MRSA bloodstream infections against a target of 0. This is a sustained achievement from 0 MRSA bloodstream infections in 2016/17.

Clostridium difficile (CDI): During 2017/18 there were 20 Trust apportioned CDI against a trajectory of 21. This was a reduction from 21+1 in 2016/17. The change package that was scaled up and spread across the Trust from the Surgical CDI Collaborative in October 2017 has been shortlisted for a Health Service Journal Patient Safety Award within the IPC category.

MSSA: During 2017/18 there were 6 Trust apportioned MSSA bloodstream infections against an internal trajectory of 14. This was a 60% reduction from 15 in 2016/17. The quality improvement project undertaken to achieve this was presented at the International Forum for Quality & Safety in Healthcare in May 2018.

E.coli: For 2017/18 NHS England set a 10% reduction target across each whole health economy. The Trust achieved a 10.9% reduction from 46 cases in 2016 to 41 cases in 2017. As the Trust was one of 59 to achieve over a 10% reduction, Ruth May, Executive Director of Nursing, Deputy CNO & National

Director for Infection, Prevention and Control at NHS Improvement, wrote to the Director of Nursing and the Trust has shared a paper with NHS Improvement and presented at an NHS Improvement Collaborative Event on the work completed to protect patients from *E.coli* bacteraemia.

Influenza: From December 2017 to March 2018 a total of 355 patients were diagnosed with Influenza. There were peaks in both January and February 2018, but there were no outbreaks or ward closures due to Influenza.

Norovirus: The Trust had 3 patients with confirmed norovirus in March 2018. They were managed effectively and no ward closures were required.

There were no infection prevention and control related untoward incidents or outbreaks of infection during 2017/18.

Related strategic aim and corporate objective	Corporate Objective 1 – Focus on Quality & Safety
Risk and assurance	Provides assurance on risks
Related Board Assurance Framework entries	BAF – 1.1, 1.2, 1.3
Equality Analysis	There is no potential for, or evidence that, this document will not promote equality of opportunity for all or promote good relations between different groups. There is no potential, for or evidence that, this document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics).
Legal implications / regulatory requirements	To provide assurance in relation to The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015).

Actions required by the Trust Board

The Trust Board is asked to:

Note the content of this annual report and to support the Infection Prevention & Control work plan moving forward.

Northampton General Hospital NHS Trust

Contents

1 Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2017/18 and the broad plan of work for 2018/19 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in the year 2017/18 and the Trust's approach to reducing the risk of HCAI.

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

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

2 Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's performance for the prevention and control of infections in 2017/18. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The structure and headings of the report follow the ten criteria outlined in the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance[1].

2.1 Reportable Infections

The six infections that are now mandatory for reporting purposes are listed below.

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

MRSA bloodstream infections and *Clostridium difficile* infections are national contractual reduction objectives and there has been a continued focus on reducing both of these infection rates, but also on the reduction of MSSA and *E.coli* bloodstream infections.

2.2 MRSA

The HCAI objective for MRSA bloodstream infections for 2017/18 was 0 avoidable MRSA bacteraemia cases.

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

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

During 2017/18 there were 0 Trust apportioned MRSA bloodstream infections, which is a sustained achievement from 0 MRSA bloodstream infections in 2016/17.

2.3 *Clostridium difficile* Infections

The HCAI national objective set for NGH Trust apportioned cases of *Clostridium difficile* infections (CDI) for 2017/18 was no more than 21.

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

During 2017/18 there were 20 Trust apportioned CDI, which is a reduction from 21+1 in 2016/17.

2.4 Meticillin Sensitive *Staphylococcus aureus* Bloodstream Infections

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national targets. During 2017/18 there were 6 Trust apportioned MSSA bloodstream infections, which is a 60% reduction from 15 in 2016/17.

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

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections. For 2017/18 NHS England set a 10% reduction target across each whole health economy. The local whole health economy includes Northampton General Hospital NHS Trust, Kettering General Hospital NHS Trust, Northamptonshire Healthcare Foundation Trust and the Clinical Commissioning Group (CCG). The reduction target is held by the CCG.

The Trust achieved an internal 10.9% reduction from 46 cases in 2016 to 41 cases in 2017. As the Trust is one of 59 who have achieved a 10% or greater reduction in the hospital onset *Escherichia coli* bloodstream infections, Ruth May, Executive Director of Nursing, Deputy CNO & National Director for Infection, Prevention and Control at NHS Improvement, has written to the Director of Nursing and asked the Trust to share the work completed in the *E.coli* action plan to support other Trusts with key actions that will assist them on their improvement journey.

2.6 Klebsiella species and *Pseudomonas aeruginosa* bloodstream infections

These Gram-negative bloodstream infections have been required to be reported to PHE from April 2017. For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national targets. During 2017/18 there were 12 Trust apportioned Klebsiella species bloodstream infections and 4 Trust apportioned *Pseudomonas aeruginosa* bloodstream infections.

2.7 Director of Infection Prevention Control Reports to the Board of Directors

The Director of Infection Prevention & Control (DIPC) delivers an Annual Report to the Board of Directors.

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

The Board of Directors receive:

- IPC Report in the Director of Nursing Board Report (monthly)
- IPC Clinical Quality and Effectiveness Group (CQEG) Report (quarterly)

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

3 Governance and Monitoring

3.1 IPC Governance

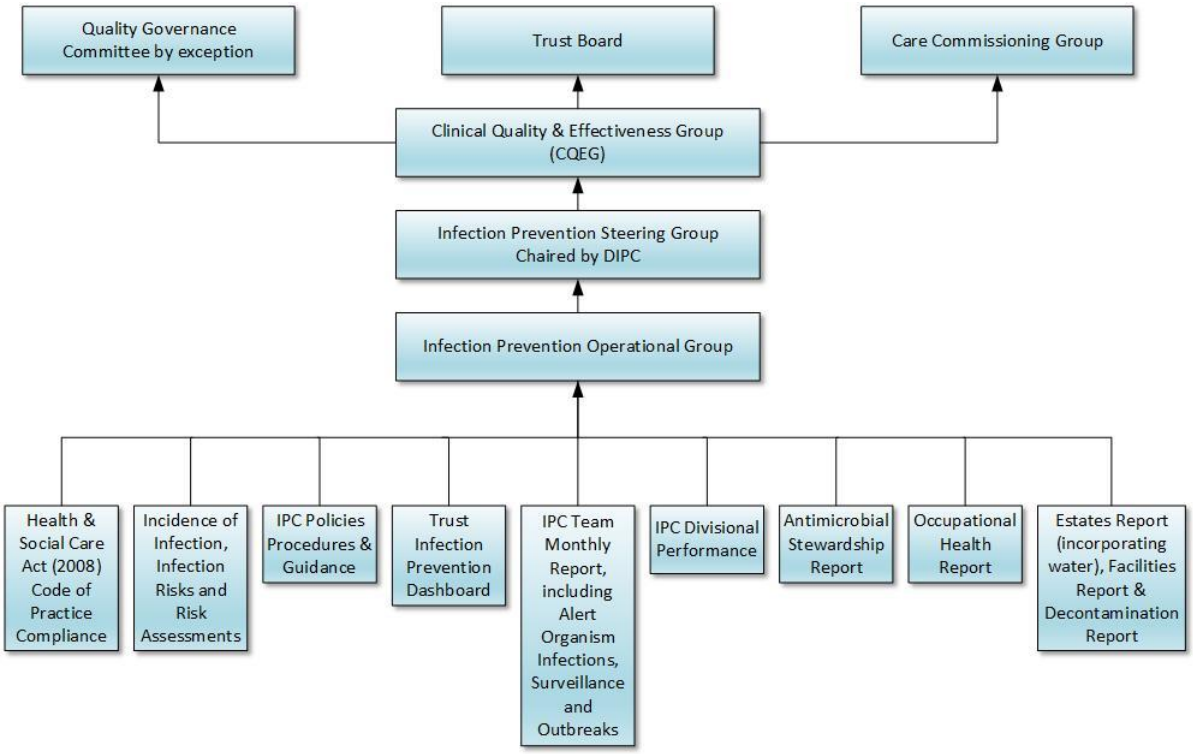
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

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

The DIPC is supported by the Medical Director, Consultant Microbiologist, Director of Estates and Facilities, the Matron for Infection Prevention & Control and the Trust Antimicrobial Pharmacist.

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

Infection Prevention Steering Group Structure



In 2017/18 the Infection Prevention Steering Group (IPSG) and the Infection Prevention Operational Group (IPOG) continue to be held on a monthly basis.

The purpose of the IPOG is to ensure that there is a managed environment within Northampton General Hospital (NGH) NHS Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing IPC advice at an operational level and makes recommendations to the IPSG and divisions. The Decontamination Lead and the Estates and Facilities Teams report to the IPOG.

The IPSG provides assurance that a zero-tolerance approach to avoidable HCAIs is delivered. The purpose of the IPSG is to provide strategic direction for the prevention and control of HCAIs within the Trust that minimises the risk to patients, staff and visitors. The DIPC provides a quarterly IPC report to CQEG from IPSG and IPC is also part of the Director of Nursing (DoN) report which reports monthly to the QGC and the Trust Board.

3.2 Quality Governance Committee

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

3.3 Links to Clinical Governance and Patient Safety

The DIPC reports the Trust IPC position to CQEG on a quarterly basis. Learning from Post Infection Reviews (PIR) for MRSA bacteraemia and *Clostridium difficile* infections are discussed at IPOG and emergent themes and learning are shared at IPSG and at CQEG.

3.4 Clinical Commissioning Group monitoring

NHS Nene & Corby Clinical Commissioning Group (CCG) is NGH's commissioning organisation. IPC is a key element of quality commissioning and forms part of a joint commissioning quality schedule. The IPCT prepare an assurance report every month for the CCG to monitor the Trust's rate of infection.

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

3.5 Northamptonshire Health Economy HCAI Group

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

3.6 Infection Prevention & Control Standards and Assurance

In 2017/18 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control. This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust undertakes interventions in relation to infection prevention and control as detailed within the HCAI Reduction Plan 2018/19 (Appendix 4). This work is led by the Director of Infection Prevention and Control and supported by the Consultant Microbiologist & Infection Control Doctor, Medical Director and Matron for Infection Prevention and Control.

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

4 Healthcare Associated Infection Statistics and Targets

4.1 Surveillance

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

4.2 Alert Organisms[3]

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

4.3 Alert Conditions

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

4.4 Current Actions to Improve Surveillance

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

4.5 Identified Priorities for 2017/18

In 2017/18, the Trust's HCAI Reduction Delivery Plan set out to:

- Reduce the number of patients with CDI and achieve the national targets and the Trusts' Quality Account
- Maintain the number of MRSA bacteraemia to achieve the national targets
- Reduce the number of patients with MSSA bacteraemia
- Support the Whole Health Economy to reduce the number of patients with *E.coli* bacteraemia

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

4.6 *Staphylococcus aureus* Bloodstream Infections

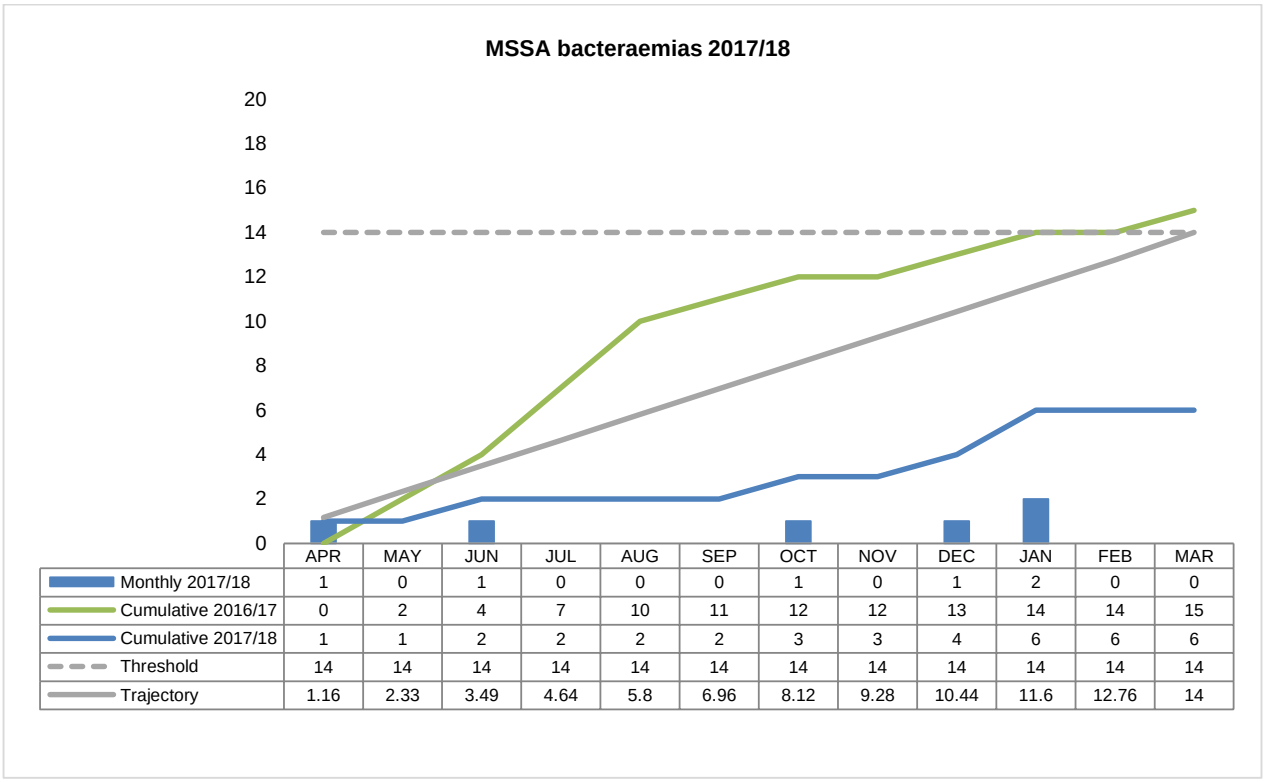
All *Staphylococcus aureus* bloodstream infections – sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA) – are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System. The Trust's incidence of MSSA and MRSA cases is reported on the PHE website. The incidence of these cases is reported publicly as acute Trust apportioned or otherwise. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

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

4.7 MSSA Bacteraemia

The outturn for MSSA bacteraemias for 2016/17 was at 15. The IPCT set a revised ambition of no more than 14 cases for 2017/18. This was met with a 60% reduction as 6 patients developed a Trust-apportioned MSSA bacteraemia in 2017/18, as displayed Figure 1. The IPCT have included a MSSA work stream in the 2018/19 HCAI reduction forward plan (Appendix 4) to sustain and reduce this further. Progress against this will be monitored through IPSG.

Figure 1



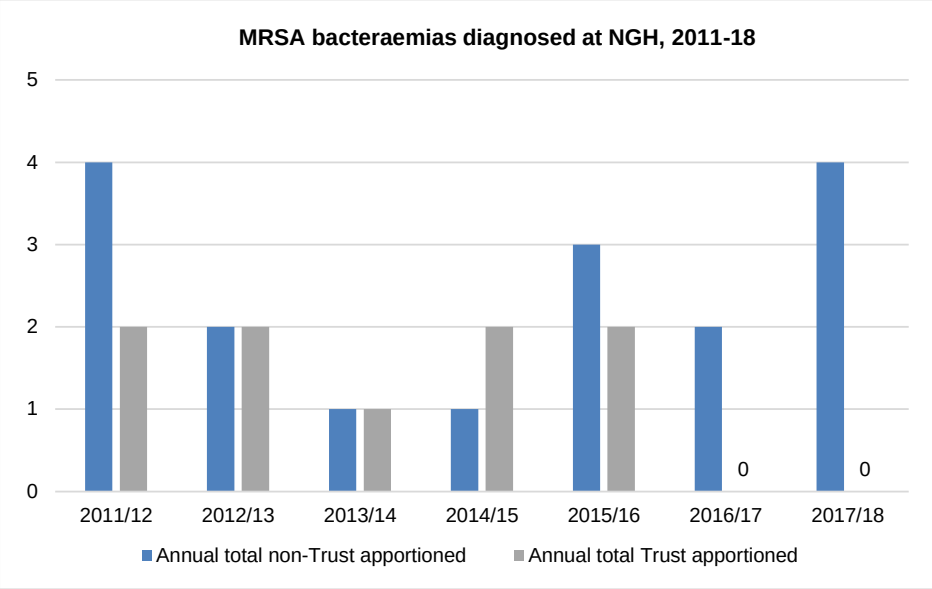
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Monthly 2017/18	1	0	1	0	0	0	1	0	1	2	0	0
Cumulative 2016/17	0	2	4	7	10	11	12	12	13	14	14	15
Cumulative 2017/18	1	1	2	2	2	2	3	3	4	6	6	6
Threshold	14	14	14	14	14	14	14	14	14	14	14	14
Trajectory	1.16	2.33	3.49	4.64	5.8	6.96	8.12	9.28	10.44	11.6	12.76	14

4.8 MRSA Bacteraemia

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

In 2017/18 there was 0 Trust-apportioned MRSA bacteraemias, this was a sustained achievement from 0 in 2016/17. Figure 2 presents the MRSA bacteraemia cases from 2011-2018 that were classified as either non-Trust apportioned or Trust apportioned.

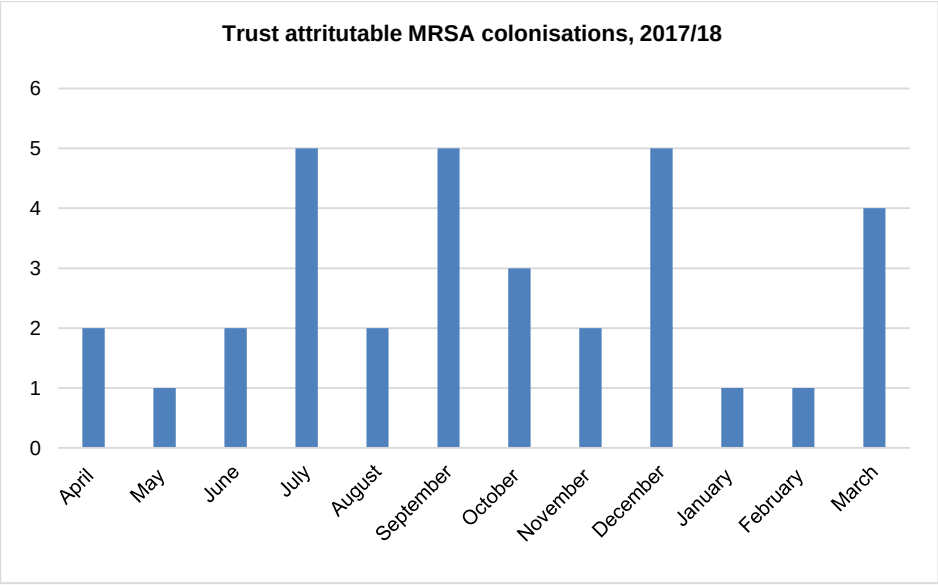
Figure 2



4.9 MRSA Colonisations

Figure 3 reflects the monthly cases of MRSA colonisations attributed to the Trust during 2017/18.

Figure 3



4.10 Period of Increased Incidence of MRSA Colonisation

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

The IPCT identified a range of actions which were implemented on any ward that had 2 or more new cases in a 28-day period. For 2017/18 there was one PII of MRSA on Knightley ward.

4.11 MRSA Screening by Patient Group

In line with the Department of Health 'MRSA Screening - Operational Guidance 2' the following patient groups are screened as indicated below in Table 1.

Table 1: MRSA Screening Criteria

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

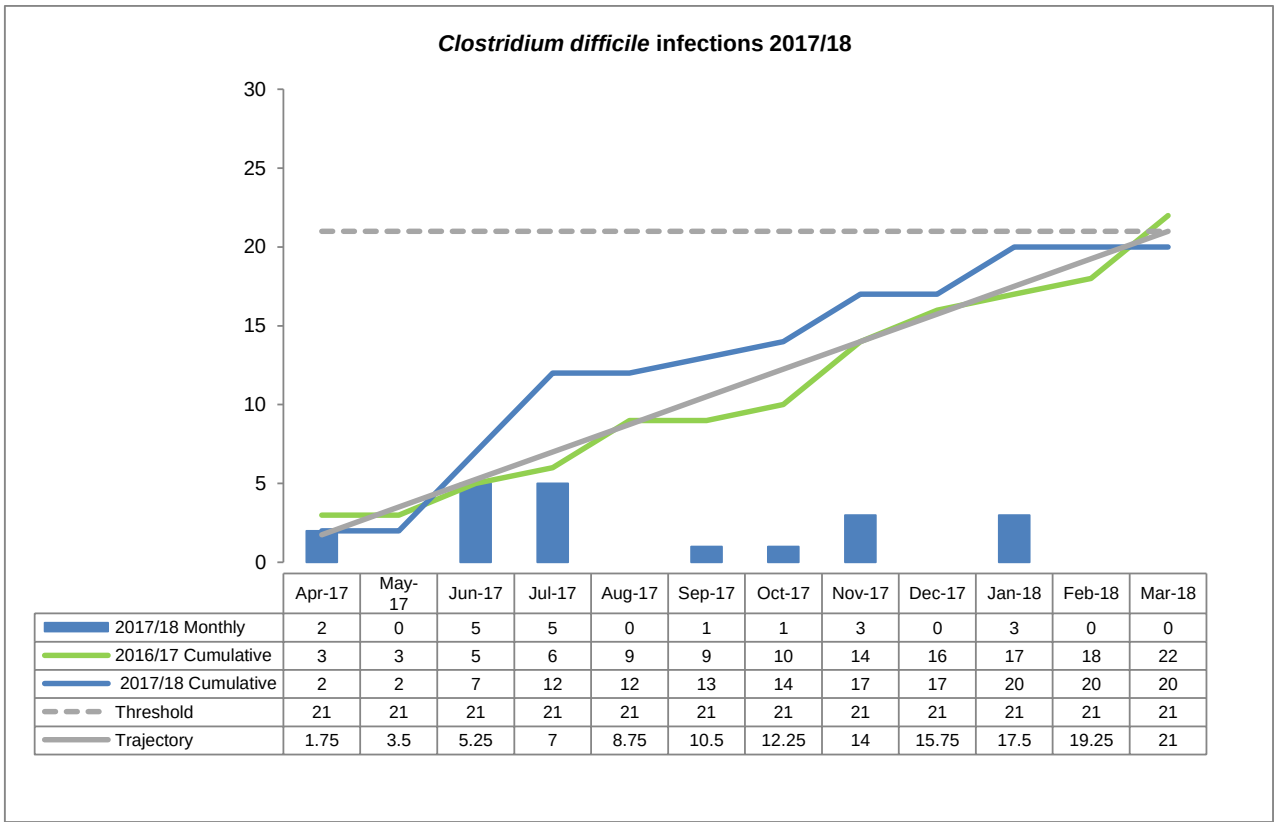
The Trust achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall MRSA screening compliance for the year for elective patients was 99.4% (patient specific verified data) and 96.7% for non-elective patients. Efforts continue to achieve greater compliance.

4.12 *Clostridium difficile* infection (CDI)

Since January 2004 it has been a mandatory surveillance requirement for the Trust to report cases of *Clostridium difficile* toxin positive stool.

The CDI NHS England target for the Trust for 2017/18 was 21 and at the outturn was 20 patients. In 2016/17 there were 21 +1 patients with CDI the +1 was potentially a false positive, giving a slight reduction on the previous year's outturn. This is presented in Figure 4.

Figure 4



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
2017/18 Monthly	2	0	5	5	0	1	1	3	0	3	0	0
2016/17 Cumulative	3	3	5	6	9	9	10	14	16	17	18	22
2017/18 Cumulative	2	2	7	12	12	13	14	17	17	20	20	20
Threshold	21	21	21	21	21	21	21	21	21	21	21	21
Trajectory	1.75	3.5	5.25	7	8.75	10.5	12.25	14	15.75	17.5	19.25	21

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

The Clinical Commissioning Group (CCG) review all Trust attributable CDI PIRs and of the 20 cases for 2017/18 there were 0 lapses in care appointed by the CCG. The CDI trajectory for 2018/19 is reduced to 20 Trust attributable cases. The IPCT have performed a thematic review of all 20 CDI cases and the findings from this review have enabled the production of the CDI Forward Plan for 2018.19. Progress against this work plan will be monitored quarterly at IPSG.

4.13 Actions completed in 2017/18 to reduce the risk of CDI

- Implementation of the 2017/18 HCAI reduction delivery plan which included a work stream on CDI reduction and was monitored by the IPSG quarterly. This included a sustained focus on prudent antibiotic prescribing and reviewing antibiotics and proton pump inhibitors in a timely manner to protect patients from CDI.

- Completion of the separate CDI forward plan that included additional specific operational initiatives to protect patients from CDI and was also been monitored quarterly through the IPSG.

- The Surgical Division CDI Collaborative utilised quality improvement methodology to refine different tests of change initiatives using Plan, Do, Study, Act cycles to implement changes that reduced the risk of CDI. The change package was scaled up and spread across the rest of the Trust in October and has been shortlisted for a Health Service Journal Patient Safety Award within the IPC caetegory.

- The weekly *C. difficile* round continues where patients with CDI are reviewed by the Consultant Gastroenterologist, Consultant Microbiologist, Antimicrobial Pharmacist and a member of the IPCT. This ensures that patients who have CDI acquisition have a multidisciplinary review and are on the correct course of treatment for their infection. As part of this there is advice and close monitoring of the antibiotics.

- The enhanced touchpoint cleaning procedure continues to be implemented when a ward has a patient develop CDI to minimise the risk of cross-infection.

- Estates, Domestic and Infection Prevention (EDI) reviews continue when a ward has a patient who has developed CDI to produce a thorough and a collaborative inspection of the ward from an IPC, cleanliness and environmental perspective.

- The IPCT have developed and implemented the Ward of the Week programme. In the absence of a decant ward and in order to remain proactive to any Estates or cleanliness issues on the wards, the IPCT have again collaborated with the Facilities and Estates Teams and have completed a Ward of the Week programmes on Sturtridge, Critical Care and Willow wards for 2017/18. During the designated week, the Estates, Domestic and IPC Teams work collaboratively to:
    - Complete an EDI review
    - Action and address any issues identified from the EDI
    - Implement the enhanced cleaning procedure
    - Provide any bespoke IPC training that the ward team may need for example hand hygiene, Aseptic Non - Touch Technique (ANTT)

  The aim is that this will ensure that patients are cared for in an environment where good infection prevention practices, cleanliness standards and the estate of the ward and are maintained.

4.14 Trust Apportioned CDI 2017/18

Table 2 presents the Trust apportioned cases of CDI for other Trusts within the locality of NGH to provide a benchmark for comparison against the Trust.

Table 2: Trust Apportioned CDI for 5 Trusts

2017/18	Trajectory	Actual
Northampton General Hospital	21	**20**
Kettering General Hospital	26	**21**
United Lincolnshire Hospitals	59	**69**
University Hospital Coventry and Warwick	42	**35**
Worcester Acute Hospital	32	**33**

4.15 Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-Lactamase Producers)

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

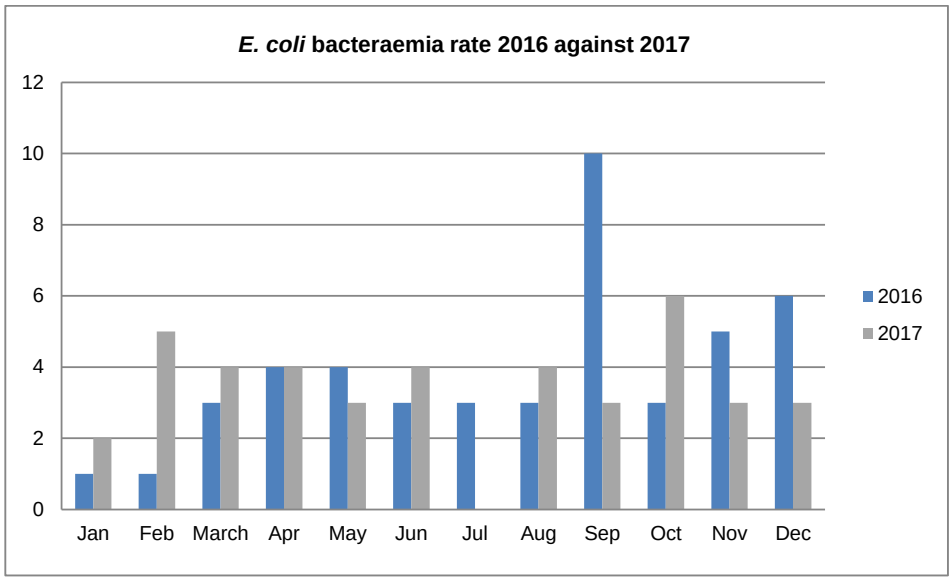
The epidemiology of these bacteria is not fully understood. The emergent nature of this field of microbiology is underlined by the absence of any national case definitions for community or hospital-acquired infections with ESBL producers, or recommendations on what constitutes an episode of infection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

4.17 Escherichia coli

In accordance with DH Guidance the IPCT commenced mandatory reporting of *Escherichia coli* (*E. coli)* bacteraemia in 2011.

All *E.coli* bloodstream infections are reported on a mandatory basis through the PHE Data Capture System. For 2017/18 NHS England set a 10% reduction target across each whole health economy for *E.coli* bacteraemias. The local whole economy includes Northampton General Hospital NHS Trust, Kettering General Hospital NHS Trust, Northamptonshire Healthcare Foundation Trust and the Clinical Commissioning Group (CCG). The reduction target is held by the CCG.

Figure 6



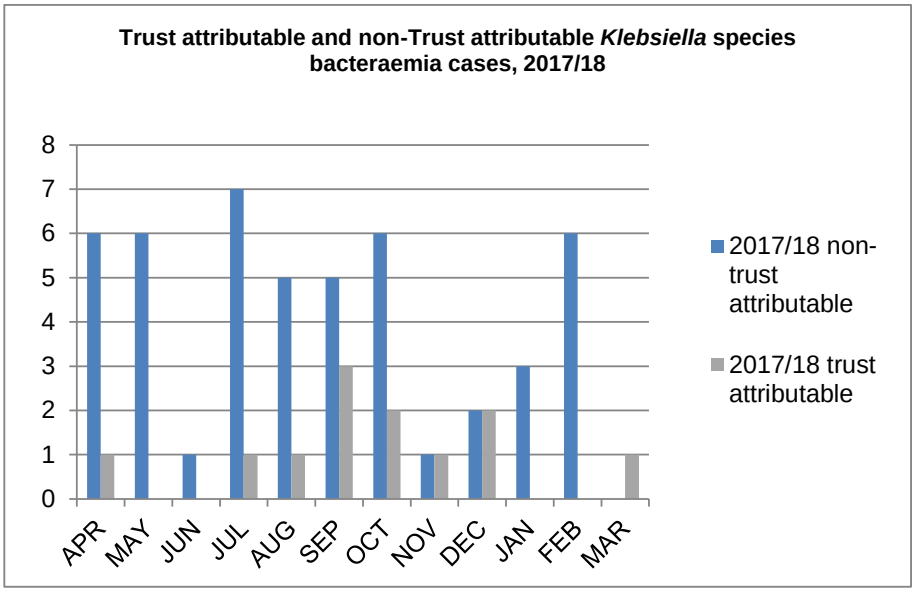
The Trust achieved an internal 10.9% reduction from 46 cases in 2016 to 41 cases in 2017. As the Trust is one of 59 who have achieved a 10% or greater reduction in the hospital onset Escherichia coli bloodstream infections, Ruth May, Executive Director of Nursing, Deputy CNO & National Director for Infection, Prevention and Control at NHS Improvement, has written to the Director of Nursing and asked the Trust to share the work completed in the E.coli action plan to support other Trusts with key actions that will assist them on their improvement journey.

4.18 Gram-Negative Bloodstream Infections

From April 2017 Gram-negative bloodstream infections surveillance has been commenced by the IPCT (*Klebsiella* species and *Pseudomonas aeruginosa),* which is also reported onto the PHE Data Capture System. This will enable PHE to identify trends at the end of the year which will then support Trusts to better understand these infections and also inform IPC practice to reduce the incidence of these bloodstream infections further. There are currently no national targets for these organisms.

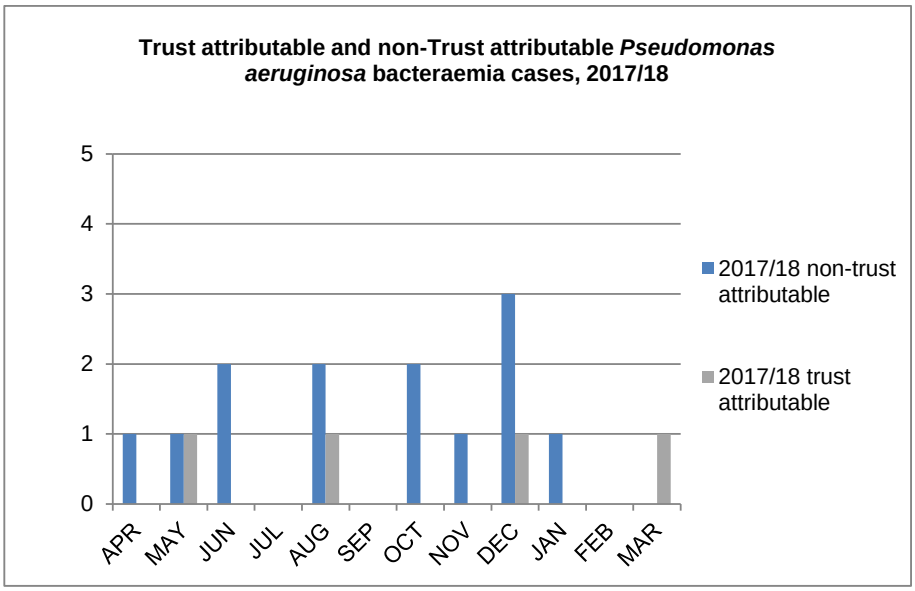
Figure 7 presents the Klebsiella species bloodstream infections that were Trust apportioned for 2017/18, there were 12 in total. There is no national target set for 2018/19 but mandatory reporting will continue.

Figure 7



The *Pseudomonas aeruginosa* bloodstream infections for 2017/18 are displayed in Figure 8. There were 4 Trust apportioned in total. There is no national target set for 2018/19 but mandatory reporting will continue.

Figure 8



For 2018/19 the IPCT has developed a Gram-negative bacteraemia forward plan which includes work streams to reduce the risk of *E.coli* and the other Gram-negative bacteraemia. This will be monitored quarterly through IPSG. The IPCT will also continue to work the Whole Health Economy and combine efforts to protect patients from Gram-negative bacteraemia.

4.19 Antimicrobial Resistance: Carbapenemase Producing Enterobacteriaceae (CPE)

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

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

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

Training on CPE is given at Trust Induction and in IPC mandatory training sessions and workbooks for clinical staff.

In 2017/18 there remained a focus on CPE in the Healthcare Associated Reduction Plan. The IPCT continued to monitor the number of CPE screens obtained and report positive cases to IPSG. The IPCT collaborated with the Site Management Team in June 2017 to identify patients that require CPE screening on admission or repatriation from high risk countries and hospitals. In November 2017 the IPCT implemented a CPE screening process for patients attending Pre-Operative Assessment Clinic to enable screening to be undertaken at the earliest opportunity. This work will continue into 2018/19 as detailed in the HCAI forward plan (Appendix 4).

4.20 Mandatory Surveillance of Surgical Site Infections

In collaboration with the Trauma and Orthopaedic Directorate and the Surgical Division, the IPCT undertake five different categories of Surgical Site Infection (SSI) surveillance each quarter. Total hip replacement, total knee replacement and repair of fractured neck of femur surgeries are surveyed every quarter. The IPCT conduct further surveillance on two additional categories of operation every quarter that survey patients undergoing general, vascular, obstetrics and gynaecology surgeries. All data for a surveillance period must be submitted within 90 days of the end of the quarter to PHE who collate and report on the data from all hospitals that have participated. The IPCT report SSI rates to IPOG, IPSG and CQEG quarterly for monitoring and assurance purposes.

4.21 SSI Surveillance Conducted by the IPCT

During 2017/18 the IPCT conducted quarterly SSI surveillance on a variety of operations as presented in Table 3. The Trust remained below the national average rate of SSI for all categories in which surveillance was completed.

Table 3: SSI Surveillance by Quarter 2017/18

Quarter	Category	Number of operations undertaken at NGH	NGH SSI rate	National average SSI rate
1	Abdominal hysterectomy	50	0%	1.3%
	Breast surgery	104	1%	0.8%
2	Caesarean sections	356	1.4%	9.3%
3	Limb amputations	28	3.6%	2.7%
	Vascular	53	1.9%	2.4%
4	Large bowel	44	0%	Not yet available
	Limb amputations	34	5.8%	Not yet available

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

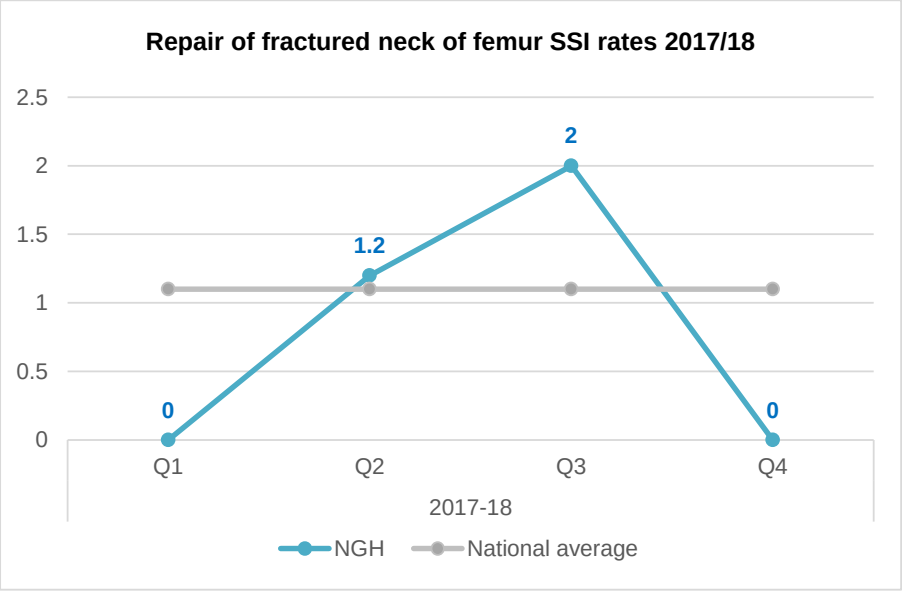
A Post Infection Review is conducted for all patients that develop a SSI and the infection is discussed with the patient's consultant to determine whether the infection was avoidable or not. SSI rates and learning from cases are reported back to the Surgical Division through the divisional governance structure for discussion and actioning as required. They are also reported to IPSG and CQEG quarterly.

The rate of SSI for patients undergoing limb amputation surgery was higher than the national average for quarter 3 with one patient out of 28 developing an infection. Given the small sample size a second quarter of surveillance was completed and the local rate remained above the national average in quarter 4. Post infection reviews are currently being undertaken and will then be discussed with the patient's consultant. Any learning identified will be shared with the Surgical Division.

4.22 SSI Surveillance Conducted by the Trauma and Orthopaedic Directorate

Figure 9 presents the quarterly SSI rate for the 329 patients that underwent repair of fractured neck of femur surgery in 2017/18.

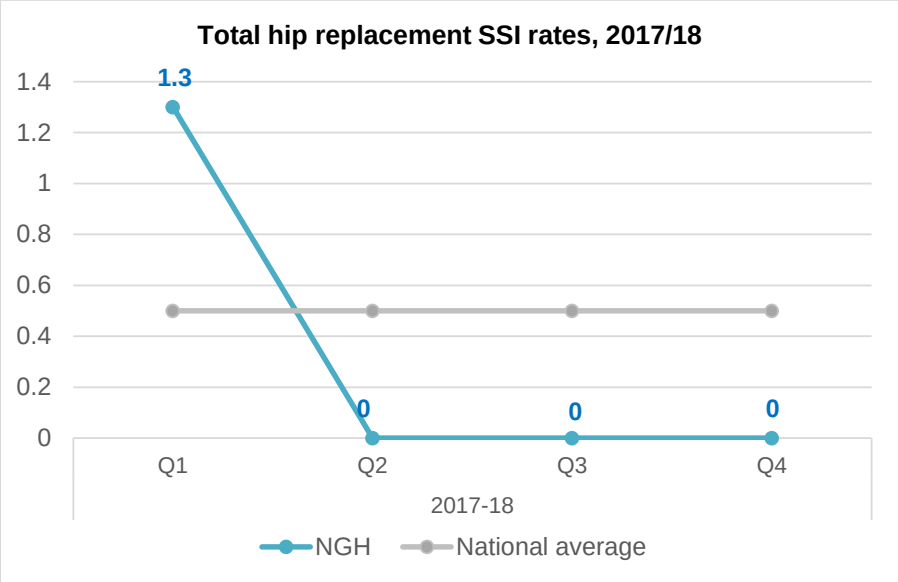
Figure 9



Following rates of SSI that were higher than the national average in quarter 2 and quarter 3, the IPCT have collaborated with the Matron for Trauma & Orthopaedics and the Practice Development Team and developed competence assessments for prophylactic decolonisation treatment for fractured neck of femur patients. This work is detailed in the 2018-19 HCAI reduction forward plan and will be rolled out on the Assessment Units in quarter 1 of 2018-19 as patients can go directly to theatre from these wards. In 2018/19 the IPCT will follow a patient along their journey from the ward to theatre and back to ensure that practices comply with IPC policies.

Figure 10 presents the quarterly SSI rate for 238 patients who underwent total hip replacement surgery in 2017/18.

Figure 10



Follow a SSI in Q1 of 2017/18, the Trauma and Orthopaedic Directorate commenced topical prophylactic decolonisation treatment for all patients undergoing total hip replacement surgery in July 2017. Since this intervention, no further SSIs have been detected.

Figure 11 displays the quarterly SSI rates for the 274 patients who underwent total knee replacement surgery in 2017/18.

Figure 11

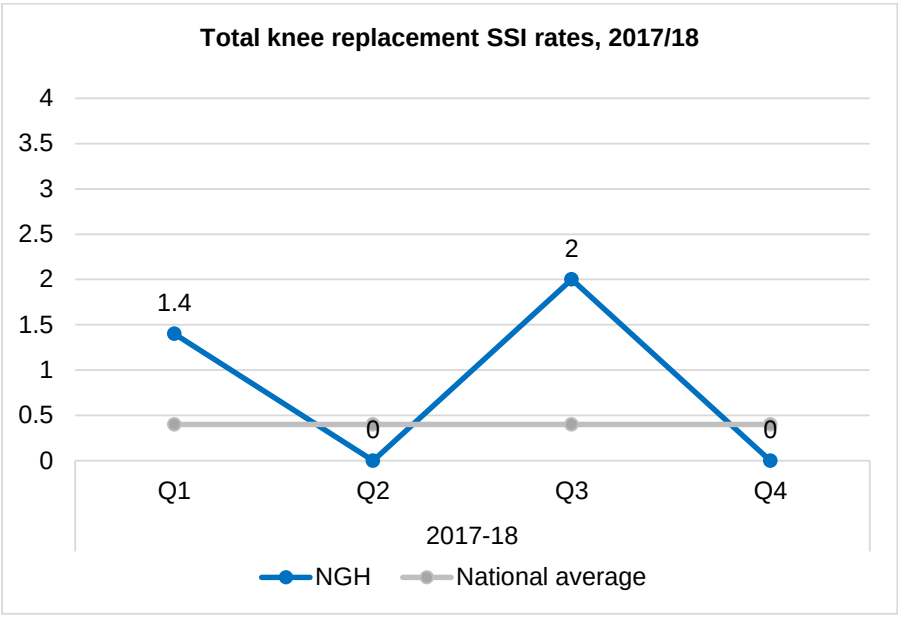


Figure 8 depicts high SSI rates in Q1 and Q3 for 2017/18 for total knee replacement surgeries. The SSI Lead for the Elective Orthopaedic patients presented the post infection reviews of these patients to the Orthopaedic Consultants for discussion. Following this, the Trauma and Orthopaedic Directorate commenced topical prophylactic decolonisation treatment for all patients undergoing total hip replacement surgery in July 2017 and improved practices around the single use patient equipment from October 2017.

SSI surveillance continues in 2018/19 as detailed in the SSI forward plan.

4.23 Untoward Incidents and Outbreaks

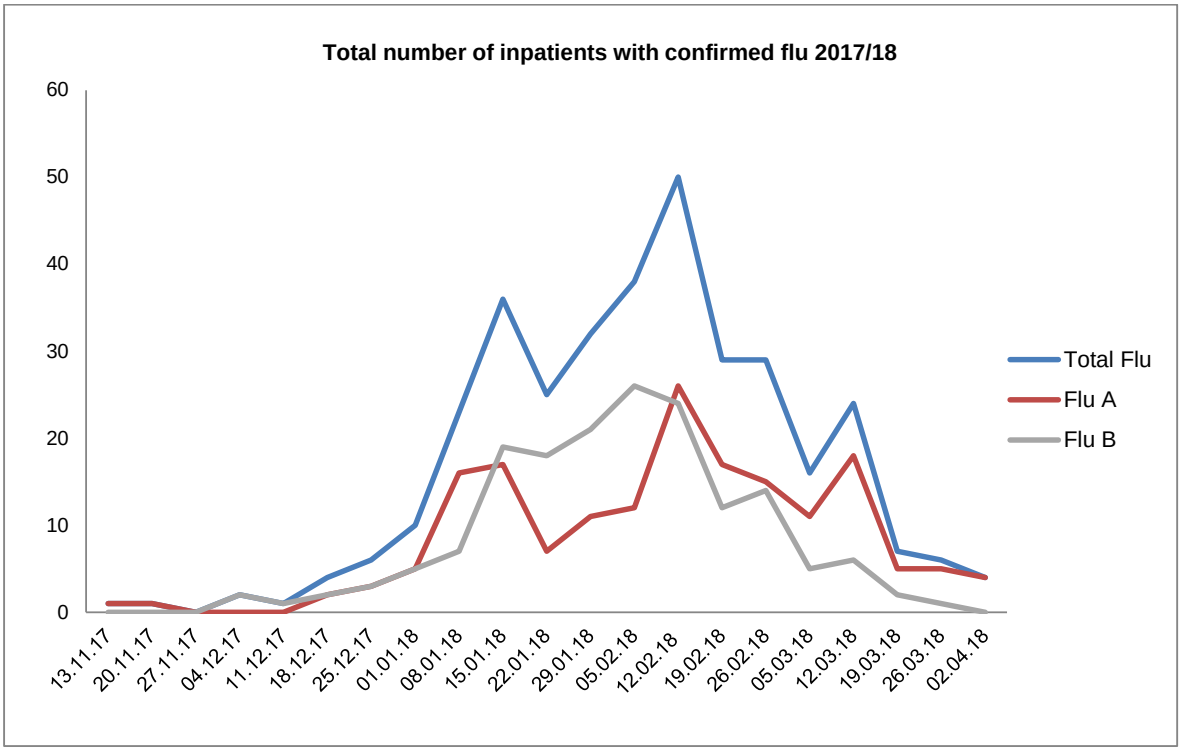
There were no untoward incidents or outbreaks of infection during 2017/18.

The Trust had 3 patients with confirmed norovirus in March 2018 and 4 patients with confirmed Norovirus in April 2018. They were managed effectively and no ward closures were required.

4.24 Influenza

From December 2017 to March 2018 a total of 355 patients were diagnosed with Influenza (Flu). Figure 12 shows the epidemiological pattern of Flu with the number of confirmed positive patients each week and that strains of both Flu A and Flu B were circulating. There were peaks in both January and February 2018, but there were no outbreaks or ward closures due to Flu.

Figure 12



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

5 Infection Prevention & Control Audit Plan 2017/18

The IPCT performed various audits throughout 2017/18 as illustrated in Table 4. All audits are reported at the Infection Prevention and Control Operational Group (IPOG) for discussion and actioning, at the Infection Prevention Steering Group (IPSG) for assurance purposes and the Clinical Quality and Effectiveness Group (CQEG).

Table 4: IPC 2017/18 Audit Plan

	Annual audits	6 Monthly	Quarterly	Monthly Audits
Apr 2017	Standard precautions		HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
May 2017	Handling & disposal of waste audit Mouth care audit	Commode cleanliness audit	Water outlet flushing audit PICC line related BSI audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits Safety thermometer audit validation for CRUTIs
Jun 2017	Handling & disposal of sharps audit Catheterisation in Maternity		MSSA & MRSA suppression compliance audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Jul 2017	Blood culture audit		HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Aug 2017	Cannula-related BSI and, central-line related BSI prevalence audits	Re-audit sharps compliance	Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Sept 2017		Catheter-related UTIs prevalence audit	MSSA & MRSA suppression compliance audit.	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Prompt sampling. Safety thermometer audit validation for CRUTIs
Oct 2017	Isolation precautions audit		HHOT peer review audits	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Prompt sampling. Safety thermometer audit validation for CRUTIs
Nov 2017	Risk assessment /transfer checklist audit	Commode cleanliness audit	Water outlet flushing audit PICC line related BSI audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Prompt sampling. Safety thermometer audit validation for CRUTIs
Dec 2017			MSSA & MRSA suppression compliance audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Prompt sampling. Safety thermometer audit validation for CRUTIs
Jan 2018			Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Prompt sampling. Safety thermometer audit validation for CRUTIs
Feb 2018			HHOT peer review audits Change package	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs
Mar 2018	Aseptic non-touch technique audit	Catheter-related UTIs prevalence audit	MSSA & MRSA suppression compliance audit PICC line related BSI audit	*C.difficile* SIGHT compliance audit. Beat the Bug audits. Safety thermometer audit validation for CRUTIs.

Further audits: will be conducted when a ward has 2 or more MRSA or *C.difficile* cases in a 28-day period e.g. Isolations, Environment audits.

Completed audits: will be colour coded GREEN as record of completion. Completed audit reports are reported to IPOG and IPSG monthly and CQEG quarterly.

Infection Prevention Team, V4, 31st March 2018.

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

6 Environmental Cleanliness 2017/18

In 2017/18 the Trust continued to complete monthly environmental cleanliness audits using an electronic audit tool that reflects the National Specifications for Cleanliness in the NHS (NPSA, 2007) and additionally the PAS 5748 Specifications for Cleanliness (BSI, 2014). The electronic audit tool enables the Domestic Supervisor to generate an action plan which is shard with the relevant Ward Manager and Matron. All cleanliness audits scores are reported monthly to IPOG and any concerns or good practice are escalated to IPSG.

The IPCT continue to work collaboratively with the Domestics, Catering and the Estates Teams to maintain a clean and safe environment for patients.

No Patient-Led Assessments of the Care Environment (PLACE) occurred during 2017/18, the next unannounced visit is scheduled for quarter 1 of 2018/19.

Monthly environmental cleanliness audits are performed in all directorates and the Trustwide average compliance score for each month of 2017/18 is presented in Table 5.

Table 5: 2017/18 Environmental Cleanliness Compliance

Month 2017/18	Trustwide environmental cleanliness compliance
April	96.8%
May	95.8%
June	96.0%
July	95.9%
August	97.2%
September	96.6%
October	96.5%
November	96.4%
December	96.7%
January	96.5%
February	96.7%
March	96.8%

7 Decontamination Review 2017/18

7.1 Sterile Service Department

The Sterile Service Department processed 16,7800 trays, procedure packs and supplementary instruments in 2017/18. The department continues to provide a fully compliant service to NHFT Podiatry and a full theatre tray service to BMI Three Shires, as well as Northampton General Hospital. The department has maintained its ISO 13485 /Medical Device Directive 93/42/EEC accreditation for 2017.

The Department has developed the following Vision ensure the team continues to focus on patient care and patient experience: *"We are committed to providing a top quality service to all customers whilst meeting clinical needs in a timely manner".* The team have also developed four key objectives to support the vision that are centred on quality, efficiency and collaborative working.

The Sterile Service Department (SSD) has its registration for compliance with European and British decontamination guidance during a three day external re-certification audit and subsequent Corrective Action Requests close out audit. This followed changes made to the standard BS EN ISO13485:2016 during early 2016 prior to the Trust's audit. The new standard ISO 13485:2016 has to be implemented by March 2019 and work is already underway to achieve this, including revision of the SSD procedural documents. The SSD will have a subsequent two day audit by the notifying body at the end of May 2018. Progress updates will continue to be reported to the IPOG.

The traceability system is due for further upgrades in the coming year to allow full reporting of the turnaround time from SSD. This will provide the department with the information to monitor its key performance indicators within the service level agreement. Machinery continues to be operated according to national Health Technical Memorandum (HTM) guidance, these documents include:

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

The SSD has been working collaboratively with Theatres and other customers to ensure that all requests are met and that no patients are delayed or cancelled due to unavailability of kit.

A review of knowledge questionnaire has been developed for all staff to ensure that they have the skills, knowledge and competencies to carry out decontamination of medical devices. Any training gaps are then identified and additional training arranged, this ensures that all staff are kept up to date with any changes to legislation or regulatory requirements.

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

8 Antimicrobial Stewardship

8.1 Compliance with Trust Antibiotic Policy

The clinical pharmacists performed a Trustwide antimicrobial point prevalence audit in April 2017. Areas that do not have a regular pharmacy visit were excluded (maternity, Emergency Department, Singlehurst). The aim was to audit antimicrobial prescribing and compliance to the Trust Antibiotic Policy.

This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, criteria 3 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship to optimise patient outcomes and there should be an ongoing programme of audit, revision and update.

Table 6 presents the results of the Trustwide antimicrobial point prevalence audit.

Table 6: Trustwide Antimicrobial Point Prevalence Audit Results

Descriptor	Number	Proportion	Comments	
Total number of patients seen	**584**			
Number of patients on antibiotics	**223**	**38.2%**	The proportion is slightly higher than April 2016 (37.8%).	
Total number of antibiotics prescribed	**288**	**1.3 per patient**	This is higher than April 2016 (1.1 per patient).	
Number adhered to the policy	**246** **260 (including valid reasons for non-compliance)**	**85.4%** **90.2% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Micro approved = 14 • Based on culture and sensitivities = 8 • No guidelines for infection = 6	
Number of intravenous (IV) prescriptions	**161**	**55.9%**	This is comparable to April 2016.	
Number of oral prescriptions	**128**	**44.4%**	This is comparable to April 2016.	
Average duration of IV antibiotics	**3.3 days (Previously) 2.7 days**		This is higher than previous years audit. *(Lifelong and long term courses approved by microbiology were excluded)*	As this is a point prevalence audit data is not available for the total course lengths actually given to each
Average duration of oral antibiotics	**2.4 days**		This is the same as the previous years audit. *(Lifelong and long term courses approved*	

		[redacted]	*by microbiology were excluded)*	individual patient.
Duration of antibiotic administration stated on prescription chart	**163**	**57%**	This has increased again from 51.8% (April 2016). The next release of ePMA will have a 48-hour review prompt for all IV antibiotics. All oral antibiotics as of March 2018 now have mandatory duration field.	
Number of antimicrobial prescriptions with one or more omitted dose	**28 (prev 19)**	**9.7% prev 7.7**	It is worrying that 9.7% of patients taking antibiotic courses have one or more dose omitted. Antibiotics are critical medicines and no doses should be omitted or delayed.	
Number of prescriptions with indication stated by prescriber	**193 (prev) 99**	**67%**	This has increased from 40% (April 2016). The next release of ePMA will have a mandatory indication field for all antibiotics and will be rolled out to all surgical wards. Mandatory indications for all prescriptions should be 100%.	

An overall compliance of 90.2% to the antibiotic guidelines was achieved. This is less than April 2016 (98%) and is partially explained by the national antimicrobial shortages experienced during April 2017 (see section 8.6). Guidance was published by the DH which temporarily superseded Trust guidance. The audit will be repeated in April 2018. Results are expected to improve as many of the shortages and restrictions that were in place have now been lifted.

8.2 Anti-Microbial Resistance: Commissioning for Quality and Innovation (CQUIN)

Antimicrobial resistance (AMR) has risen over the last 40 years and is linked to the inappropriate and overuse of antimicrobials. The Commissioning for Quality and Innovation (CQUIN) has been amended from 2016/17 to monitoring the review of antibiotics in patients diagnosed with sepsis. It was specified that the review must be undertaken be a senior clinician or microbiologist in order to fulfil the CQUIN criteria.

Goal: reviewing the use of broad-spectrum antibiotic consumption through effective antimicrobial review of septic patients within 72 hours

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

Empiric review data

Data was collected to cover a variety of specialities including admissions, elderly care, ITU, paediatrics, and surgery. 30 prescriptions (oral and intravenous) each quarter were retrospectively audited from patients coded with a diagnosis of sepsis. The results were submitted to Public Health England (PHE) on a quarterly basis as outlined in the submission criteria. Table 7 displays the results of the empiric review of antibiotics within 72 hours 2017/18.

Table 7: Review of Empiric Antibiotics at 72 Hours CQUIN Results

Quarter	Target	Result
Q1	25%	84.4%
Q2	50%	97%
Q3	75%	96.7%
Q4	90%	96.7%*

*Awaiting confirmation from PHE

Additional data was also collected on the outcome of the review, intravenous (IV) to oral switch, escalation to a broader spectrum antibiotic or narrow spectrum according to sensitivities/ microbiologist advice.

Overall, the trust has successfully achieved the CQUIN, which will continue into 2018/19. Table 8 outlines the decisions made at the point of review. This data shows that in many cases antibiotics were switched rather than stopped at 72 hours.

Table 8: Outcome of 72 Hour Review Audit Results

Quarter	Antibiotics stop, switch or IV to oral switch	Antibiotic stop decision
Q1	63%	0%
Q2	28%	9.4%
Q3	37.9%	0%
Q4	Results pending from PHE	

Consumption data

Baseline data for CQUIN achievement was compared against data submitted for 2016 and required:

- A reduction of 1% or more in total antibiotic consumption against the baseline (25%)
- A reduction of 2% or more in carbapenem against the baseline (25%)
- A reduction of 2% or more in piperacillin-tazobactam against the baseline (25%)

The following data is based on **quarters one, two and three only.**
At this point in time, the Trust is set to achieve the reduction in total piperacillin-tazobactam consumption due to the national antibiotic shortage experienced during 2017/18.

Carbapenem consumption and total antibiotic consumption remained consistently high throughout the first three quarters of the year due to the shortage of piperacillin-tazobactam. New initiatives from quarter 4 onwards has reduced the Trust's carbapenem consumption by 20% when compared to other quarters through the use of the electronic Prescribing and Medicines Administration (ePMA) reporting functions. This initiative will remain in place over the coming year.

This CQUIN remains for 2018/19 with slight amendments. Total antibiotic consumption and carbapenem reduction remains, reduction in piperacillin-tazobactam has been changed and switched to improving the use of certain antibiotics in the Aware category as defined by NHS Improvement.

8.3 Training initiatives

Training sessions have been provided to medical core trainees, junior doctors and clinical pharmacists. Key teaching themes emphasised effective stewardship, risks from resistance, developing their understanding of antibiotics and *C.difficile*. Three sessions have been made available for junior doctors training. This will be expanded over the coming year with the aim of reaching clinicians of all grades and physicians associates.

8.4 Antibiotic campaigns Antibiotic Awareness Week & European Antibiotic Awareness Day

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

- Promotion of antibiotic stickers
- Promotion of Microguide- antibiotic guide
- Visiting local school to provide education to children
- Junior Doctors training session
- Ward based competition using a PHE quiz
- Promote the correct checking and documentation of patients allergies

8.5 Antimicrobial Stewardship Group (ASG)

The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults and children admitted to hospital. Meetings were held in March, August and December 2017 and developments in the last year have included:

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

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

- Mandatory training in Antimicrobials and Antimicrobial Stewardship

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

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

- Patient Group Directive for paramedics to administer meropenem in patients suspected with sepsis

- Changes in guidelines to promote reduction in broad-spectrum antibiotics

8.6 National Shortage of Antibiotics

The shortage of piperacillin-tazobactam, a key antibiotic, during the financial year posed the biggest risk to antimicrobial stewardship. Scarcity occurred after an earthquake in China reduced the availability of key a manufacturing ingredient. This forced the NHS to purchase limited supplies of piperacillin-tazobactam at an extortionate price in comparison to previous years. This unfortunately had a consequent effect on the price and availability of alternative antibiotics such as co-amoxiclav, gentamicin and cephalosporins. A Trustwide switch occurred to cope with demand during peak times. This switch is expected to revert back in 2018 as supplies become available.

8.7 Other Antimicrobial Developments

Adult Renal Antibiotic Guidelines

Guideline for dosing of antibiotics for patients with impaired renal function was updated in March 2017 to include all commonly used antibiotics in the Trust.

Adult Antibiotic Guidelines

The Trust Adult Antibiotic Guidelines are currently being reviewed and will reflect the amendments in the CQUIN. Major changes have occurred in the treatment of infective endocarditis, urinary tract infections and respiratory infections. The use of broad-spectrum antibiotics is being removed and replaced with alternatives where appropriate to reduce the risk of antimicrobial resistance and healthcare associated infections.

Mandatory Antibiotic Durations

ePMA has now been fully implemented in all medical and surgical wards including theatres. In its first release, an indication when prescribing antibiotics was mandatory. This functionality has now been expanded; all oral antibiotics now also require a duration to be completed prior to prescribing. This will be

monitored over the following year and is expected to reduce the Trust's overall consumption of antibiotics and reduce the risk of unintentionally prolonged courses.

Antimicrobial Pharmacist Team

Within this financial year, two new 0.5 WTE antimicrobial pharmacists were recruited to substantive posts. They are now fully established and work alongside the diabetic foot team and IPC team.

8.8 Planned Developments for 2018/19

OPAT pathway

There has been an increased drive within the Trust to ensure medically fit patients requiring IV antibiotics are safely discharged home and complete the course with the community IV team. It has been identified that certain governance issues need to be strengthened to support the current service and expand to accommodate future capacity.

UTI guidance

Currently under review; use of broad-spectrum antibiotics is expected to be removed and replaced with narrow spectrum alternatives in line with the local resistance patterns to improve patient safety and reduce resistance.

Compliance Criterion	What the registered provider will need to demonstrate
4	Provide suitable accurate information on infections to service users, their visitor and any person concerned with providing further support or nursing/medical care in a timely fashion.

9 Provision of IPC Information

Information pertinent to IPC is provided to patients, visitors and staff in a variety of appropriate mediums and reflects seasonal trends in local and national infections.

9.1 Information for patients and visitors

The Trust provides patients, carers and visitors with information as required through patient information leaflets, the Trust internet site and signage across the organisation. The IPCT are always widely available to discuss specific infections with patients and their carers and answer any questions that they may have.

9.2 Information for staff

Information for staff is available in the IPC policies, procedures and clinical guidelines on the Trust intranet. Care pathways and care plans also provide condition specific information for staff. The IPC intranet page also hosts information sheets on a variety of infectious diseases, videos for aseptic non-touch technique, blood culture collection and the CDI change package, and information on how to access IPC mandatory training and contact the IPCT.

HCAI information for staff is documented on patient admission proformas, interdepartmental transfer forms, relevant care plans and also on discharge letters. The community healthcare providers are informed by the Trust IPCT when patients are discharged with HCAIs where care is required to be continued.

The IPCT brand 'The Bug Stops Here' is now recognisable and synonymous with the IPCT and is utilised across the Trust. As part of the IPC communications plan for 2017/18 the Trust has implemented the 'Stop Gel Go' signs at entrances to the hospital, wards and out-patient departments.

In 2018/19 the IPCT will continue with the IPC monthly campaigns that focus on a specific element of IPC practice each month. During the monthly focus, good news stories are published in the Trust insight magazine and e-bulletin, relevant screen savers are circulated, and the infection prevention information boards monthly reports to divisional governance meetings also encapsulate the focus of the month.

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

10 Identification of Patients with Infection

The IPCT ensure that patients with, or at risk of, infection are identified at the earliest opportunity and receive the appropriate treatment by:

- Visiting the Emergency Department and Admission Units daily to identify patients with suspected or confirmed infections on admission to the Trust
- Attending the daily Clinical Safety Huddles to provide specialist IPC advice to the Trust
- Co-ordinating the daily update of the Side Room Monitor Tool to identify side rooms for patients with, or at risk of, infection
- Co-ordinating the weekly CDI ward round
- Conducting surveillance and follow up of patients with MSSA and MRSA colonisations, *C.difficile* antigen carriers, patients with catheter-related urinary tract infection and surgical site infection, to work with the nursing, medical and pharmacy teams to ensure that they receive appropriate treatment and care to minimise the risk of cross-infection.

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

11 Staff IPC Training and Development

All staff roles include the relevant principles of infection prevention and control practice in the job description. How this is applied is outlined at the individual's local induction.

11.1 IPC Mandatory Training

Training was integral to developing staff knowledge of IPC practices and updates to policies in 2017/18. The IPCT delivered training across the entire spectrum of staff and for a wide range of purposes from generic Trustwide sessions at induction to bespoke training on very specific issues.

The IPCT fully support the Trust mandatory training programme, delivering sessions for all staff at mandatory training sessions. Attendance to these sessions is recorded on the Trust central training record database and compliance to IPC mandatory training is tracked within the IPC Reports. Table 9 presented the Trustwide 2017/18 IPC mandatory training compliance, which has consistently remained above the Trust target of 85%.

Table 9: IPC Mandatory Training Compliance

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Trained in Month	279	247	245	241	286	246	267	258	176	266	292	291
Percentage Compliance	86.2%	86.3%	86.5%	86.9%	86.8%	86.5%	86.1%	86.3%	86.3%	85.4%	85.9%	87.5%

From April 2017 aseptic non-touch technique assessment of competence has been included into annual IPC mandatory training for all staff who use this key IPC skill. Compliance has remained above 85%.

11.2 Developments

In October 2017 the IPCT hosted the seventh annual study day. The study day was well attended with sixty healthcare staff from across the Trust attending. Presentations were very well evaluated and included caring for patients with Tuberculosis, environmental antibiotic resistance and a patient story of living through meningitis.

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

12 Isolation

The IPCT audits the occupancy of isolation rooms annually and reports findings to the IPOG and IPSG. This was conducted in January 2018 and showed that the occupancy rate of side rooms for patients with suspected or confirmed infections was 59.5%. The findings of the audit suggest that there are adequate side rooms within the hospital to manage the isolation of patients with suspected or confirmed infections.

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

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

13 Laboratory Services

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

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

14 Policies

The Trust has IPC policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008; Code of Practice on the Prevention and Control of Infections and Related Guidance.

These documents are monitored utilising a variety of audit tools to measure staff compliance with guidance as detailed in section 5 of this report. Additionally, through induction and ad-hoc bespoke sessions, training for all staff types is undertaken to ensure they are kept informed of current policies and procedures as outlined in section 11 of this report.

14.1 Saving Lives

Saving Lives is a National compilation of High Impact Interventions (HII) utilising a "Care Bundle" approach based on evidence based practice. It was first published in 2005 and updated in 2010. It was delivered at NGH in 2007. It directly measures clinical processes and therefore in addition to the IPC Audit Plan, each clinical area completes monthly a self-assessment audit against the relevant High Impact Interventions for that clinical area. These results populate the Trust's Infection Prevention dashboard along with results from the monthly hand hygiene observational audits, cleaning audits, MRSA bacteraemia and *Clostridium difficile* infection figures. The IPCT updated these audit tools in April 2017 to reflect evidence-based best practice.

The Infection Prevention dashboard supports continuous quality improvement, development and there has been a strong focus on trend analysis and providing safer care for patients in 2017/18. The dashboard is presented and monitored monthly through the IPOG.

14.2 Hygiene Code Compliance

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

The IPCT continue to align and update supporting evidence to provide assurance of compliance with the Hygiene Code and report areas of non-compliance to IPSG for monitoring and assurance.

14.3 IPC Board Quality Visits

To support the ongoing HCAI agenda across the Trust, all Executive and Non-Executive Directors and the Trust Chairman continue to participate in the 'Beat the Bug' IPC Board Quality Visits on a monthly basis. These visits are facilitated by the IPCT and involve visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive and Non-Executive Directors visit two or three wards and audit the clinical area against set criteria. Findings are collated by the IPCT and reported monthly to the IPOG and IPSG, and quarterly to CQEG.

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

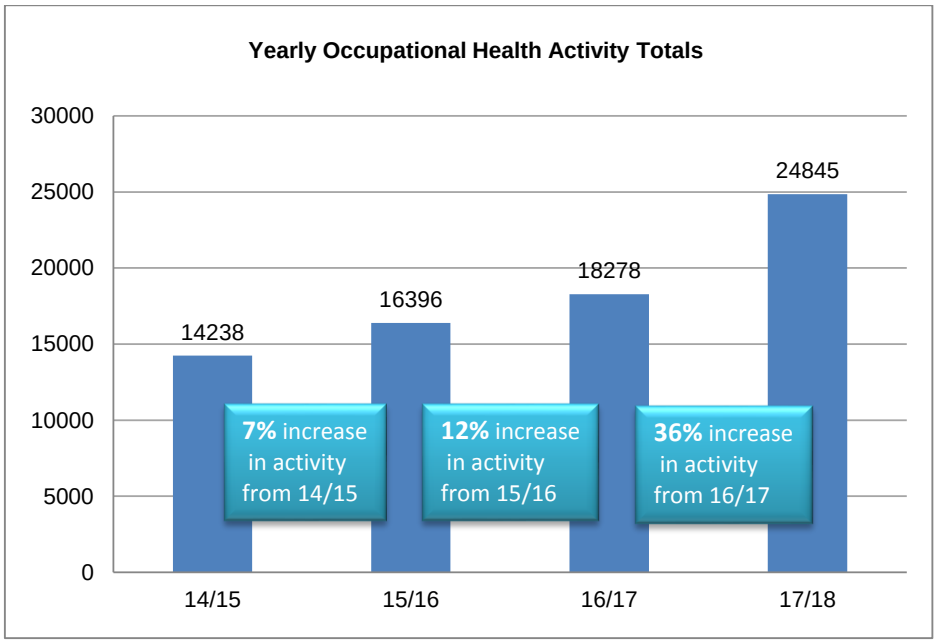
15 Occupational Health

Occupational Health has had a productive but challenging year. There have been service improvements with the addition of an extra clinic nurse and a new text reminder service to reduce non-attendance.

The main challenge has been the national shortages of vaccines (Hepatitis B, BCG, MMR). This forced a change to the screening processes to enable health clearances and safe working practices to be maintained. This was addressed and managed through a corporate risk assessment and updates were provided quarterly to IPSG.

Total activity, measured in clinical events and displayed in Figure 13, for 2017/18 was 24,845 which is a 36% increase on the previous year. This increase is due to the addition of the clinic nurse to the establishment.

Figure 13



In looking at Figure 13, the following should be noted:

- There has been an increase in blood tests for increased screening due to the national shortages of Hep B, BCG and MMR vaccine.
- The increase in activity is due to the additional clinic nurse time with faster throughput and reduced waiting times.

15.1 Activity Breakdown

Table 10 displays the various clinical events that comprised the overall Occupational Health Department activity.

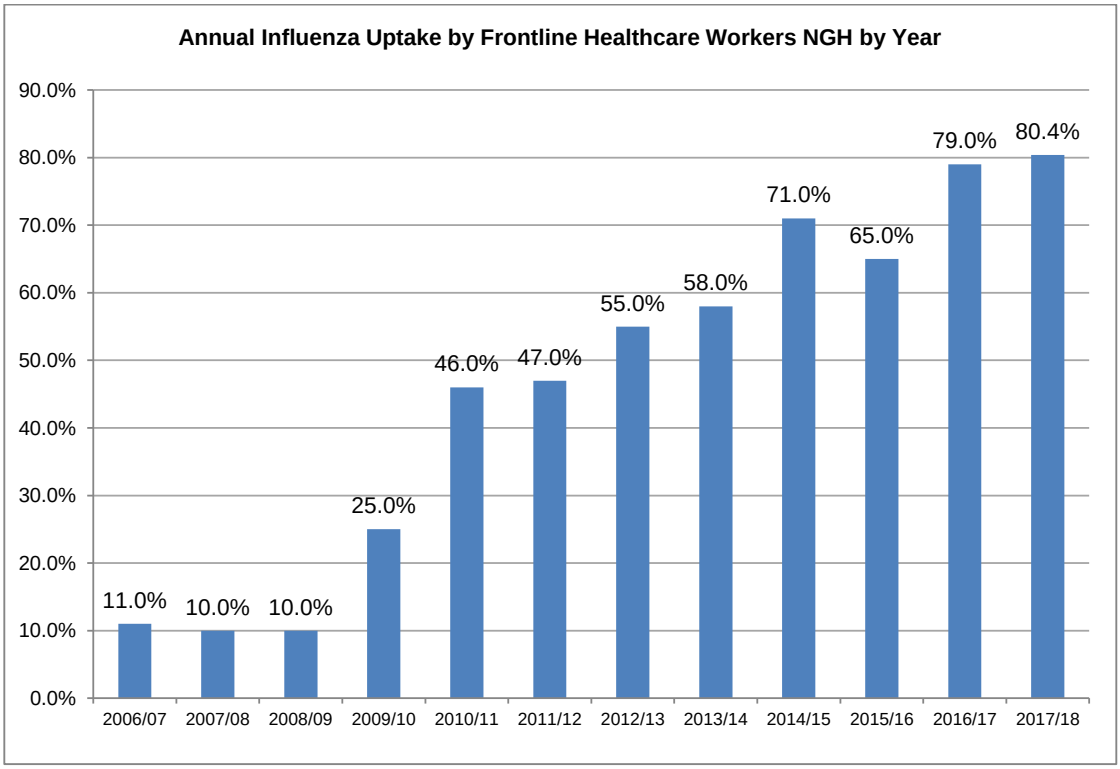
Table 10: Occupational Health Department Activity by Clinical Event

Activity	2015/16	2016/17	2017/18
Blood Tests	4373	7291	10477
Vaccinations	3188	2841	6697
Work Health Screening	2107	1907	2146
General Clinic	1743	1621	810
Nurse appointments	907	2354	2323
Other Tests	1914	187	257
Management Refs	873	736	858
Physio	378	876	217
Dr Appts	376	501	476
Health Surveillance	422	281	316
Contamination Injuries	115	230	268
Totals	**16,396**	**18,825**	**24,845**

15. 2 Influenza Vaccination

The Influenza campaign in 2017/18 achieved an uptake of 80.4%, as shown in Figure 14, which enabled the CQUIN target to be achieved. This There was a positive response from staff for the additional clinics and trolley visits in the evenings and weekends.

Figure 14



15.3 Measles

Public Health England (PHE) confirmed Measles outbreaks in five areas across the UK in January 2018. The OHD took a proactive approach to ensure staff and patient safety was maintained by auditing the approximately 900 staff that work in high risk areas to ensure that they were vaccinated against Measles. The OHD also ensure that at employment screening, staff that work in high risk areas have documented evidence of having had 2 MMR vaccinations or Measles and Rubella antibodies prior to commencing work.

16 Summary

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

However, a number of key risks and challenges exist and are covered in the HCAI forward plan of work for 2018/19, as detailed in Appendix 4.

Authors	Wendy Foster - Matron for Infection Prevention Holly Slyne - Infection Prevention & Control Clinical Nurse Specialist Steve Melville - Decontamination Lead Kiranjeet Dhillon - Antimicrobial Pharmacist Claire Brown - Occupational Health Manager
Owner	Carolyn Fox
Date	20th April 2018

17 Appendix 1 - IPCT Structure 2017/18

Post	Post holder	WTE
Board Executive Lead (DIPC)	Ms Carolyn Fox	Not defined
DIPC	Ms Carolyn Fox	Not applicable
Chair of the Trust Infection Prevention and Control Steering Group	Ms Carolyn Fox	Not applicable
Consultant Medical Microbiologist	Dr Minas Minassian Dr Basel Allouanti Dr Martha Kestler	Not defined Not defined
Band 8a IPC Matron	Mrs Wendy Foster	1 x 1.0
Band 7 IPC Clinical Nurse Specialists	Mrs H Slyne Mrs R Pounds	1 x 1.0 1 x 1.0
Band 6 IP Support Nurses	Mrs J Hart Mrs K. Draper Mrs K. Baptiste Miss N. Clews	1 x 0.40 1 x 0.68 1 x 1.0 1 x 1.0
Band 4 Secretarial Administration and Surveillance	Mrs Karen Tiwary	1 x 1.0

18 Appendix 2 - Terms of Reference for the Infection Prevention Steering Group

Northampton General Hospital NHS Trust

Infection Prevention Steering Group (IPSG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy • Matron for Infection Prevention & Control or nominated deputy • Consultant Microbiologist • Medical Director or nominated Deputy • Deputy Director of Quality & Governance • Associate Director of Nursing for Medicine • Associate Director of Nursing for Surgery • Associate Director of Midwifery • Associate Director of Nursing for Oncology • Head of Estates / Deputy Director of Facilities • Head of Hotel Services • Consultant Anaesthetist / Sepsis Lead • Head of Capacity and Flow • Antimicrobial Pharmacist
Quorum	6 members
In Attendance	• Deputy Director of Nursing, Midwifery & Patient Services • Occupational Health Lead • Public Health England (PHE) representative • Patient representative • Minute taker
Frequency of Meetings	Monthly
Accountability and Reporting	Accountable to the CQEG
Date of Approval by CQEG	February 2018
Review Date	February 2019

Northampton General Hospital NHS Trust

Infection Prevention Steering Group

Terms of Reference

1. Constitution

The Trust hereby resolves to establish a steering Group of the Clinical Quality and Effectiveness Group (CQEG) to be known as the Infection Prevention Steering Group.

2. Purpose

The purpose of the Steering Group is to provide strategic direction for the prevention and control of Healthcare acquired infections in Northampton General Hospital NHS Trust that minimises the risk of infection to patients, staff and visitors.

The Steering Group will:

- Strengthen the performance management of Health Care Associated Infections (HCAI's) and cleanliness across the Trust
- Provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes
- Make recommendations as appropriate on Infection Prevention Control matters to the Board via CQEG
- Performance Manage the Trust against the Infection Prevention and control strategy
- Ensure that there is a strategic response to relevant new legislation and national guidelines

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy
- Matron for Infection Prevention & Control or nominated Deputy
- Consultant Microbiologist
- Medical Director or nominated Deputy
- Deputy Director of Quality & Governance
- Associate Director of Nursing for Medicine*
- Associate Director of Nursing for Surgery*
- Associate Director of Midwifery*
- Associate Director of Nursing for Oncology*
- Head of Estates and Deputy Director of Facilities
- Head of Hotel Services
- Consultant Anaesthetist / Sepsis Lead
- Head of Capacity and Flow
- Antimicrobial Pharmacist

4. Quorum, Frequency of meetings and required frequency of attendance

- No business shall be transacted unless six members of the Steering Group are present, one of whom must be the Chair or their nominated Deputy and 2 clinical representatives from the Divisions (as indicated by * above).
- The Steering Group will meet monthly.
- Members of the Steering Group are required to attend a minimum of 9 meetings held each financial year.

5. In attendance

In addition to the core membership, other staff will be invited to attend by the Chair of the Steering Group.

6. Authority

The Steering Group is authorised by CQEG to investigate any activity within its terms of reference and to seek any information it requires to provide assurance to the Board. The Steering Group will seek external expert advice and invite attendance if considered appropriate.

7. Duties

- To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008)/ The Hygiene Code updated 2015.
- To fulfil the Trust's statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies.
- To review Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies are evidence based, reflect relevant legislation and published professional guidance. Recommend submission and approval to Procedural Document Group.
- To develop the annual infection prevention and control programme of activity and ensure that it is submitted to Quality Governance Committee (QGC) and approved by the Trust Board
- To monitor achievement of the objectives contained within the annual programme.
- To receive, review and endorse the annual Infection Prevention and Control Report.
- The management and investigation of outbreaks of infection.
- To receive a written Infection Prevention & Control report which includes**:**

    i. Outbreaks of infection
    ii. MRSA & Clostridium difficile data
    iii. Isolation deficits
    iv. Trust compliance with externally set targets
    v. Progress against the rolling infection prevention & control programme
    vi. Audit outcomes
    vii. Training and development plans/ compliance

viii. Updates of relevant legislation / guidance/ best practice
ix. Campaigns planned or delivered

- To receive a written highlight report and minutes from the Infection Prevention Operational Group and review the TOR annually.
- To receive written reports from the Trust operational IPC group to ensure that assurance is gained as to the implementation of Infection Prevention & Control practices & policies within the Trust. Providing assurance that all appropriate measures are being taken to assist the achievement of the national and local infection present ambition.
- To receive written reports from Deputy Director of Estates and Facilities in relation to water safety, decontamination compliance, structural/ building works that are planned within the Trust. To ensure that prevention and control of infection is considered as part of all service or building development activity, changes to HTM's or ACOP that may have infection control implications.
- To receive written reports from the Head of Hotel services in relation to food hygiene, Environmental Health visits/ reports, PLACE outcome reports, cleaning compliance with standards and audits, domestic service training plans & compliance, and introduction of new cleaning products or systems of work.
- To receive written reports from the Occupational Health Manager which include needlestick injuries, flu vaccination programme compliance, outbreak issues affecting staff, any incidents of staff TB or BBV that have been or are currently under investigation or look back exercises for any infectious disease where an increased incidence has been reported nationally, to ensure that the staff and therefore the patients, are adequately protected where possible to do so.
- To receive written reports from the antimicrobial pharmacist which include an update from the Antimicrobial Stewardship Group.
- To receive written reports from the Associated Director of Nursing/Midwifery as requested by the Chair in relation to specific Infection Prevention and Control matters.
- To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.
- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.
- To disseminate information and advice on prevention and control of infection to all appropriate Trust Division and their Directorates.
- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

8. Accountability and Reporting arrangements

The minutes of the Steering Group meetings shall be formally recorded by the Secretary/Surveillance Assistant**.** Copies of the minutes of the Steering Group meetings will be provided to all members of the Group and will be available to all Trust Board members.

The Steering Group Chair shall prepare a written summary report to CQEG after each meeting. The Chair of the Steering Group shall draw to the attention of CQEG any issues that require escalation to the Trust Board, require executive action or support.

9. Sub-committee and reporting arrangements

The Steering Group shall have the power to establish sub-groups for the purpose of addressing specific tasks. In accordance with the Trusts' Standing Orders, the Steering Group may not delegate powers to a sub-group unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-group must be approved by the Steering Group and reviewed as stated below.

10. Administration

The Infection Prevention Steering Group shall be supported administratively by the Infection Prevention and Control Secretary /Surveillance Assistant:

- Agreement of the agenda for Steering Group meetings with the Chair
- Requesting of reports from authors in a timely manner in accordance with the reporting schedule
- Collation of reports and papers for Steering Group meetings
- Circulate agenda and papers for the meetings 7 days in advance of the meeting
- Ensuring that suitable minutes are taken, a record of matters arising and actions are accurately documented
- All reports will be submitted in writing with a front sheet

11. Requirement for review

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

FOI Reminder

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

19 Appendix 3 - Terms of Reference for the Infection Prevention Operational Group

Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

Membership	• Deputy Director of Nursing (Chair) • Infection Prevention Matron • Modern Matrons (or nominated deputies) • Estates and Facilities representatives • Hotel Services • Therapies or nominated representative • Domestic Team Leads/Supervisors • Clinical Site Manager for Capacity and Flow • Decontamination Lead
Quorum	Seven members that must include: • Deputy Director of Nursing, Patient & Nursing Services (chair or nominated deputy) • Member of the Infection Prevention & Control Team • Modern Matrons (5 minimum)
In Attendance	• Director of Nursing Midwifery & Patient Services/DIPC & Director of Infection Prevention & Control • Admin support • Quality Matrons • Tissue Viability Nurses • Practice development Nurses The Group would have the authority to co-opt any person necessary to assist in its deliberations
Frequency of Meetings	Monthly
Accountability and Reporting	This group is accountable & reports into the Trusts Infection Prevention & Control Steering Group
Date of Approval by IPSG on behalf of Quality Governance Committee	April 2018
Review Date	April 2019

Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

1. Constitution

The Trust hereby establishes a group to be known as the Infection Prevention Operational Group (IPOG). The aim of the group is to ensure operationally:

1. The Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008), (the "Hygiene Code").

2. To receive reports on specific operational problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations to the IP Steering Group.

3. To review Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance, prior to approval by IP Steering Group.

4. To monitor Divisional performance regarding adherence to infection control practice through the monitoring of the matron's dashboard Infection Prevention and Control audits and putting actions into place where required.

5. To discuss relevant issues presented by the Infection Prevention & Control Team (IPCT) and any other member of the committee.

6. To report to and make recommendation to IP Steering Group and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

7. To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

8. To ensure that prevention and control of infection is considered as part of all service development activity.

9. To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.

10. To monitor the performance of the infection prevention and controls programme and make suggestions for improvement, including review of improvement plans from Divisions.

2. Purpose

The purpose of the IPOG is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust, sharing good practice and making recommendations to the IP Steering Group and Divisions.

3. Membership

- Deputy Director of Nursing (Chair)
- Infection Prevention Matron
- Modern Matrons
- Estates and Facilities
- Hotel Services
- Therapies or nominated representative
- Domestic Team Leads/Supervisors
- Clinical Site Manager for Capacity and Flow

The group have the authority to co-opt any person necessary to assist in its deliberations

4. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless seven members of the group are present. This must include:

- Deputy Director of Nursing (chair or nominated deputy)
- Member of the Infection Prevention Team
- Modern Matrons (minimum of 5)

The group will meet monthly. Members of the group are required to attend a minimum of 80% of the meetings held each financial year.

5. In attendance

Other Directors and officers of the Trust may be asked to attend at the request of the Chair. Only the group Chair and relevant members are entitled to be present at a meeting of the group, but others may attend by invitation of the Chair.

6. Authority

The group is authorised by the Trust to investigate any activity within its terms of reference and to seek any information and to make any recommendations through the Infection Prevention Steering Group (IPSG), through its Chair that is deemed appropriate, or any area within the terms of reference where action or improvement is required.

7. Duties

To attend meetings as required and report to the IPOG in an open and honest manner and address any issues.

8. Accountability and Reporting arrangements

The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members. The group will provide a monthly report on its work to the IPSG.

9. Sub-groups and reporting arrangements

The group shall have the power to establish sub groups for the purpose of addressing specific tasks or areas of responsibility. The terms of reference, including the reporting procedures of any sub groups must be approved by the group and regularly reviewed.

10. Administration

The group shall be supported administratively by the Administration/Surveillance person whose duties in this respect will include:

- Agreement of the agenda for group meetings with the Chair;
- Collation of reports and papers for group meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward

11. Requirement for review

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

12. FOI Reminder

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

20 Appendix 4 – DRAFT Healthcare Associated Infection Reduction Plan 2018/19

Priorities and key goals for 2018/19

- A reduction in the number of patients with CDI (<20 cases)
- Zero patients with MRSA bacteraemia
- A reduction in the number of patients with MSSA bacteraemia (<13 cases)
- Sustain measurement of *E. coli* bacteraemia within the Whole Health Economy
- Sustain measurement of CRUTI prevalence through Safety Thermometer Strategic Group and action plan
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system
- Sustain CPE and *Candida auris* screening procedures
- Implement the 2018/19 IPC communications strategy

The plan is built upon the ten criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This is the ten criteria against which the Trust is assessed on to determine how it complies with the registration requirements of infection prevention.

BRAG Key	
	Complete
	On-track
	Delivery issues
	Unable to deliver

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2018-19 as detailed above	Q1	IPC Matron					
	Clinical teams to undertake case review using principles of RCA and PIR on all cases of NGH attributable: • MRSA bacteraemia • CDI • MSSA bacteraemia • *E.coli* bacteraemia Within the recommended time frame for each microorganism	Q1, 2, 3 and 4	IPC Matron					
	To prepare a monthly IPC report, which is presented monthly at IPSG and IPOG and quarterly at CQEG, on all cases of NGH attributable: • MRSA bacteraemia • CDI • MSSA bacteraemia • *E.coli* bacteraemia • Klebsiella species bacteraemia • *Pseudomonas aeruginosa* bacteraemia	Monthly	IPC Matron					
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPSG and CQEG.	Quarterly	Consultant Microbiologist					
1 b Promote a culture of continuous quality improvement in IPC	To review and update IPSG terms of reference and IPOG terms of reference annually	February 2019	IPC Matron					
	To provide monthly Infection Prevention and Control report to IPSG giving assurance to the	Monthly	IPC Matron					

	group and escalating any concerns							
	To provide quarterly Infection Prevention and Control report to CQEG giving assurance to the group and raising any concerns	Quarterly	IPC Matron					
	To provide a monthly Infection Prevention and Control update for the Director of Nursing Report which is presented monthly at the Trust board	Monthly	IPC Matron					
	To present surveillance data regarding HCAIs to IPSG	Monthly	IPC Matron & cons. micro					
	To present the CDI PIRs monthly at IPOG, and share the learning to prevent further CDI acquisition	Monthly	Matrons and ward Managers					
	To implement the IPC audit plan for 2018-19 and report monthly at IPOG and IPSG. *(For further information please refer to the IPC annual audit plan).*	Monthly	IPC Matron					
	To implement the IPC surgical site surveillance plan for 2018-19 and report quarterly at IPSG and CQEG. *(For further information please refer to the IPC surgical site surveillance plan).*	Quarterly	IPC Matron					
	IPCT to conduct '*Beat the bug'* ward quality visits with members of the executive team and report findings to IPSG and IPOG through the monthly IPC report.	Monthly	IPCT & exec team					
	IPCT to work with the Trust communication team to deliver a continuous year long campaign that focuses on keeping patients safe from infection	Ongoing	IPCT & comms team					

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	

2 a Maintenance of a clean, safe and appropriate environment which facilitates the prevention and control of HCAI	The Trust Hotel Services Manager and Domestic Manager will report key issues monthly to IPOG as a standing agenda item	Monthly	Hotel Services Manager & Domestic Manager					
	Review and monitor monthly cleaning audit scores through the dashboard trend analysis at IPOG, as a standing agenda item. For areas of poor compliance, Matrons are challenged by the chair of the group	Monthly	IPC Matron & Matrons					
	IPCT and Domestic Team to sustain the enhanced cleaning standard operating procedure to deliver enhanced touch point cleaning when required	Monthly	IPCN & Domestic Manager					
	IPCT and Estates to complete a bi-monthly review of the Trust Estate and action any IPC issues	Bi-monthly	Matron for IPC & Estates Manager					
	IPCT, Estates and Domestic Team to complete a review of the ward (EDI inspection) following every case of CDI, periods of increased incidence or outbreaks of infection and report outstanding issues to IPOG as a standing agenda	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT, Estates and Domestic Team to complete EDI inspections for all Out-Patient Departments (OPD) annually as detailed in the EDI OPD forward schedule	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT and Facilities to sustain ward of the month	Monthly	IPC Matron					
	IPCT & Estates perform Airborne Fungal Spores and Contamination of Water Services risk assessments prior to Estates work commencing	Ongoing	IPC Matron & Estates Projects Lead					
	The Trust Estates Maintenance Manager will report key issues monthly to IPOG as an agenda item	Monthly	Estates Maintenance Manager					

	The Deputy Director of Facilities will provide a comprehensive report quarterly to IPSG as detailed on the Infection Prevention and Control forward plan	Quarterly	Deputy Director of Facilities					
2 b Decontamination standards are monitored and adhered to	The Trust Decontamination Lead will ensure that the Decontamination Group operates according to its terms of reference and reports monthly to the IPOG as an agenda item	Monthly	Decontamination Lead					
2 c Water safety requirements are monitored and adhered to	The Trust Water Safety Lead / Responsible Person will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPSG as detailed on the Infection Prevention and Control forward plan	Quarterly	Deputy Director of Facilities					
	The Trust Deputy Responsible Person will report and update any water safety issues to IPOG	Monthly	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
3 a To improve antimicrobial prescribing and stewardship	The Trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Pharmacists will provide an Antimicrobial report quarterly to the IPSG as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					
	Antimicrobial audits will be presented to IPSG as part of the antimicrobial report as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					

	The Trust Antimicrobial Pharmacists will deliver the actions from the NICE antimicrobial guidance gap analysis as part of the antimicrobial report as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					
	The Antimicrobial Pharmacists will continue to prompt Proton Pump Inhibitor (PPI) review for patients commencing antibiotics as detailed in the *C.diff* Forward Plan	Monthly	Antimicrobial pharmacists					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
4 a Provide useful information for staff on the prevention and control of infections	Produce Trust wide screensavers or posters as required to clarify IP procedures and processes	Monthly	IPCT					
	Send out information via email system to communicate updates on IPC practices or polices as required e.g. during outbreaks	Monthly	IPC Matron					
	To implement the IPC communication strategy and monthly focus on specific aspect of IPC	Monthly	IPCT					
4 b Provide useful information for patients and visitors on the prevention and control of infections	Provide patient information leaflets on C.difficile, MRSA, ESBLs, CPE, norovirus, influenza, surgical site infection prevention, central venous access devices, peripheral venous cannulas, urinary catheters, enteral feeding and using decolonisation treatment	Monthly	IPCT					
	To collaborate with the Tissue Viability Nurses and Falls Prevention Team to review the patient information quality boards at the ward entrances	Q1-Q2	IPCT TVNs Falls Prev. Team					
	Provide outbreak information to patients and	Q1,2,3,and 4	IPCT					

	visitors regarding ward closures and preventing the spread of infection with the support of the Trust communications team							
	To implement reversible ward closure signs with the Estates department and track progress through IPSG	Q2	IPC Matron					

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
5 a To minimise the risk of CPE through screening and care of suspected, presumptive or confirmed positive cases	To maintain CPE screening processes according to Trust CPE Policy, monitor the number of patients screened, the results and report positive cases to IPSG	Monthly	IPC Matron					
5 b To remain within the C.diff trajectory of 21 cases for 2018-19	To have C.diff trajectory on to the risk register and review quarterly with the Assistant Director of Nursing and Midwifery	Quarterly	IPC Matron					
	To continue to identify wards that require support for 1 case of C.diff or period of increased incidence (2 or more cases within 28 days), conduct PIR for all post admission C.diff cases and maintain the C.diff antigen positive surveillance	Q1, Q2, Q3 and Q4	IPCT					
	To develop and commence a C.diff reduction plan for 2018-19 that implements the outcomes of the 2017-18 C.diff aggregated review	Q1, Q2, Q3 and Q4	IPCT					

5 c To minimise the risk of infection to patients by conducting MRSA screening and managing patients who are colonised or infected with MRSA effectively	To maintain MRSA screening processes according to Trust MRSA policy, monitor elective and emergency screening compliance and conduct surveillance of previous MRSA positive inpatients.	Q1, Q2, Q3 and Q4	IPCT					
	To scope out using Octenilin wound gel for patients who have wounds colonised or infected with MRSA / MSSA	Q1-2	IPCT TVNs					
	To maintain prophylactic decolonisation processes according to the MRSA Policy, audit compliance quarterly and report to IPSG							
5 d To minimise the risk of infection to patients by preventing MSSA bacteraemias	To maintain MSSA surveillance and management of local MSSA infections according to the MSSA SOP	Q1, Q2, Q3 and Q4	IPCT					
5 e To minimise the risk of infection to patients by preventing *E.coli* bacteraemias	To collaborate across the Whole Health Economy to reduce the incidence of *E.coli* bacteraemias	Q1, Q2, Q3 and Q4	IPC Matron					
5 f To minimise the risk of infection to patients by prevention Gram-negative bacteraemias	To implement the 2018-19 Gram-negative bacteraemia forward plan that addresses the themes identified from the aggregated review of the 2017-18 *E.coli* bacteraemias	Q1, Q2, Q3 and Q4	IPCT					
5 g To minimise the risk of cross-infection for alert organisms	IPCT to review all patients who acquire an alert organism infection and provide ongoing advice and support to medical and nursing staff	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to conduct surveillance and management of outbreaks of infection	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to commence flagging patients with previous MRSA, C.diff, MSSA and CPE on CAMIS inpatient management system	Q2	Matron for IPCT					
5 h	IPCT to report CRUTI case reviews quarterly	Q1, Q2, Q3	IPCT					

To minimise the risk of infection to patients from catheter-related urinary tract infections	to IPOG and IPSG to identify key themes	and Q4						
	IPCT to deliver the CRUTI element of the Gram-negative bacteraemia forward plan to address the themes identified from the retrospective case reviews	Q1, Q2, Q3 and Q4	IPCT					
5 i To minimise the risk of infection to patients from influenza	IPCT to develop and implement a 2018-19 Flu Ready action plan in collaboration with Occupational Health Team to present at IPSG in Aug 2018	Q2	IPCT					
5 j To minimise the risk of infection to patients from ventilator-acquired pneumonia (VAP)	IPCT to collaborate with Critical Care and Microbiology Laboratory Manager to develop an SOP for specimen testing necessary to enable the Critical Care Team to commence VAP surveillance	Q1-2	Critical Care IPCT Microbiology Laboratory Manager					
	Critical Care Team to commence VAP surveillance	Q3	ITU Consultant IPCT					
5 k To minimise the risk of infection to patients from sepsis	To monitor the progress of the sepsis CQUIN through IPSG	Quarterly	Sepsis Lead					
5 l To minimise the risk of infection to patients from line-related infection	To set up an IV / Vessel Health forum to implement evidence-based practices to protect patients from line-related infection	Q1, Q2, Q3 and Q4	IPCT					
	To conduct PICC-line related bloodstream surveillance and report to IPOG and IPSG quarterly	Q1, Q2, Q3 and Q4	IPCT					
5 m To minimise the risk of infection to patients from MERS	To implement the MERS section of the Viral Respiratory Infections procedural document in the Emergency Department	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
	To reflect and learn from each patient with suspected MERS in the ED to improve practice and share at IPOG	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
5 n To minimise the risk	To scope out whether HAP surveillance could be implemented within the Trust	Q1-2	IPCT					

of infection to patients from hospital acquired infection (HAP)	To scope out implementation of a care bundle and audit tool to protect patients from HAP that will include as a minimum regular mouth care and sitting patients out for meals	Q3-Q4	IPCT					
5 o To minimise the risk of infection to patients from surgical site infection (SSI)	To conduct an audit of orthopaedic patients' core temperatures during their journey to and through theatre and report findings to IPOG and IPSG	Q1-2	IPCT Manfield theatre team Matron for theatres and Matron for T&O					
	To develop a prophylactic decolonisation treatment competency for the ward nursing teams caring for patients with fractured neck of femur patients prior to theatre	Q1-2	IPCT PDNs Matron for T&O					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
6 a Staff receive appropriate IPC training	IPC is part of induction and mandatory training. IPC mandatory training is to be monitored and reported to CQEG by the Infection Prevention Matron	Quarterly	IPC Matron					
	To continue to conduct ANTT assessments of competence as part of annual IPC training for clinical staff who require it	Q1, Q2, Q3 and Q4	IPCT					
	To commence annual ANTT wound assessments of competence in the Surgical Division	Q1	IPCT					
6 b IPC workforce and capability	To ensure that all IPCT members are skilled, knowledgeable and have an appraisal process in place to ensure clear objectives and development needs	Q1, Q2, Q3 and Q4	IPC Matron					
	To develop competencies for the IPC Team, IPC Superlinks and scope out Cleanliness	Q1-Q2	IPCT					

	Champions competencies							
6 c Hand hygiene	Relaunch the Hand Hygiene Code of Practice	Q1	IPC Matron					
	Celebrate Hand Hygiene Week	Q1	DIPC, ADNs IPCT Matrons					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
7 a To provide advice regarding appropriate isolation use	IPCT to undertake daily review of the urgent care wards A&E, EAU and Benham to identify patients admitted that require isolation	Q1, Q2, Q3 and Q4	IPSNs					
	To attend the safety huddle twice daily to provide isolation and IPC advice	Q1, Q2, Q3 and Q4	IPSNs / IPCN / IPC Matron					
	IPCT to undertake daily review of the Side Room Monitor Tool and RAG rate each isolation room to facilitate the Site Management Team in effective patient placement	Q1, Q2, Q3 and Q4	IPSNs					
	To conduct an annual trustwide audit of isolation facilities as per the annual audit plan and report findings to IPSG	Q3	IPCT					
	To provide adequate signage for Side Room numbers	Q1-Q2	IPCT & Estates Manager					
	To scope out the feasibility of having window wall art in the isolation rooms to enhance the patient experience of being in isolation	Q1-Q2	IPCT IPOG					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support					
Objective	**Programme of work (action)**	**Timeframe**	**Lead**	**BRAG**	**Progress and comments**

		and milestones		Q 1	Q 2	Q 3	Q 4	
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory Andrea O'Connell					

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
9 a To ensure that evidence based IPC policies and associated procedural documents are available	The IPC policies and associated procedural documents are reviewed three yearly and in accordance with new guidance	Q1, Q2, Q3 and Q4	IPCT					
	IPC policies and procedural documents are audited as per the IPC annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPCT					

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
10 a To ensure that healthcare workers are protected from communicable diseases and from work exposures	Occupational health advice is available for staff	Q1, Q2, Q3 and Q4	Occupational Health Team					
	IPC Matron and Occupational Health Lead meet bi-monthly to discuss operational issues	Bi-monthly	IPC Matron & OH Lead					
	Occupational Health Team provide a quarterly report to IPC regarding key issues	Quarterly	Occupational Health Team					
	IPC training is mandatory for all staff and reported quarterly to CQEG via the IPCT report	Quarterly	Matron IPC					
	IPCT to facilitate fit testing for FFP3 masks for	Q1, Q2, Q3	IPCT					

	paediatric staff, anaesthetic staff, Urgent Care staff and Critical Care staff	and Q4						

The 2018/19 IPC HCAI Reduction Plan will be reported quarterly to IPSG throughout 2018/19 for monitoring and assurance purposes.

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 July 2018**

Title of the Report	**Equality and Human Rights Workforce Annual Report 2017/2018**
Agenda item	16.1
Presenter of Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Andrea Chown, Deputy Director of Human Resources & Sarah Kinsella, Corporate HR Officer
Purpose	Assurance that the equality agenda including the public sector equality duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Workforce Annual Report for 2017/2018 aims to demonstrate this compliance and provide assurance that the Trust is meeting its duty by reviewing the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2017 to 2018.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trusts equality agenda for staff is being monitored through the equality and diversity group with progress reports on the Four Year Action Plan and the WRES.
Related Board Assurance Framework entries	BAF 2.1 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? **N** If yes please give details and describe the current or planned activities to address the impact. **N/A** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **N** If yes please give details and describe the current or planned activities to address the impact. **N/A**
Legal implications / regulatory requirements	NHS Constitution Public Sector Equality Duty Equality Act 2010 The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) Workforce Race Equality Standard (WRES)

Actions required by the Trust Board

The Workforce Committee is asked to endorse the content of the report.

Equality and Diversity

NHS
Northampton General Hospital
NHS Trust

Workforce Annual Report

April 2017 to March 2018

Providing the Best Possible Care

Front Cover: Angelika Mercado, Business Administration Apprentice. To find out more on Northamptonshire NHS & Partners First Apprenticeship Awards event see page 23

Northampton General Hospital
NHS Trust

Equality and Diversity

Workforce Annual Report

April 2017 to March 2018

Our Vision and Values

Our vision is: To provide the best possible care for our patients

Our Values are:

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

Contents

Chairman: Mr Paul Farenden
Chief Executive: Dr Sonia Swart

Executive Summary

The Equality and Diversity Annual Report for 2017/2018 reviews the work Northampton General Hospital (NGH) has made to promote equality and celebrate diversity within its workforce during April 2017 to March 2018.

During the period that this report covers we continued to work to and review our progress against our Equality Objectives/4 Year Plan along with comparing our Workforce Race Equality Standards data against our data from 2016.

In addition we undertook, for the first time, our Gender Pay Gap Report and published it in line with the new legislation. We will be looking at the results more closely during 2018/2019 to see what the Trust can do to make improvements to our gap.

We continued the implementation of our Health and Wellbeing Strategy, with a strong focus on mental health and wellbeing during 2017/2018, which included working closely with MIND.

The 2017 National Staff Survey results were unchanged from the previous year, for the elements of the survey that relate to equality and diversity. We shall be looking at these results in more details to establish where improvements can be made and our Equality Objectives/4 Year Plan will support this work.

Dr Sonia Swart
Chief Executive

Paul Farenden
Chairman

Introduction

Northampton General Hospital believes that Equality and Diversity is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential.

We aim to support our staff in a responsive and appropriate way to meet the diverse needs of the different groups and individuals we employ, because well supported staff can deliver better care for our patients. Our staff are our greatest resource and we work to actively promote a culture that encourages their richly diverse talents to lead services that deliver inclusive care.

To achieve this aim we want to ensure that our staff are not subject to any form of discrimination or unequal treatment. All staff can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work we do at the Trust, supported by our value of 'We Respect and Support Each Other'.

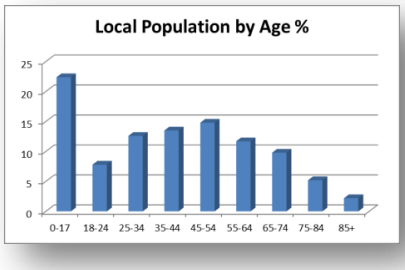
It is important to us that we do not discriminate unlawfully in the way we recruit, train and support our staff. We do not tolerate any forms of unlawful or unfair discrimination and recognise that all people have rights and entitlements by law.

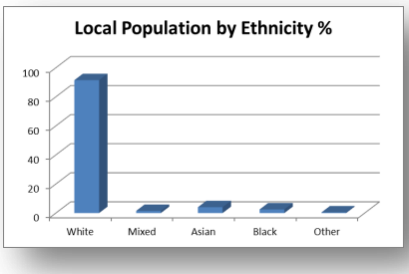
Further information regarding Equality and Diversity can be found on our website at
http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

Our Population

We provide general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to 692,000 people living throughout the whole of Northamptonshire. The Trust is also an accredited cancer centre, providing services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. For one highly specialist urological treatment we serve an even wider catchment.

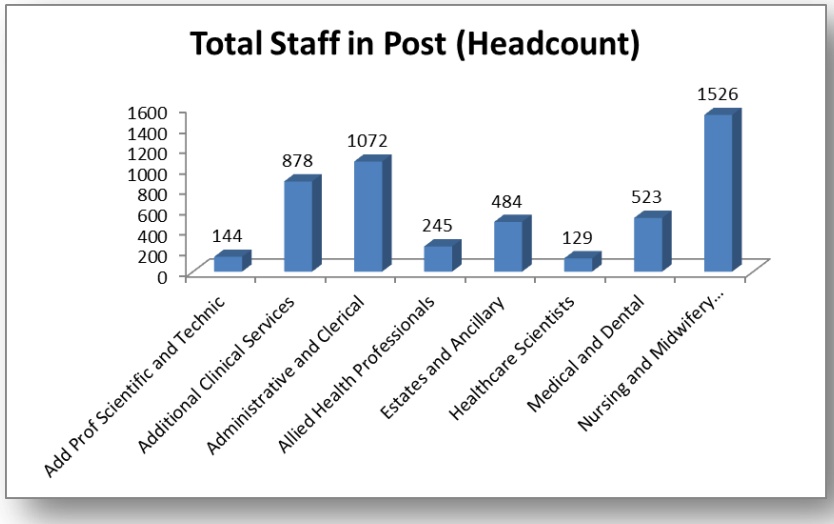
Our principal activity is the provision of free healthcare to eligible patients. We provide a full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals.

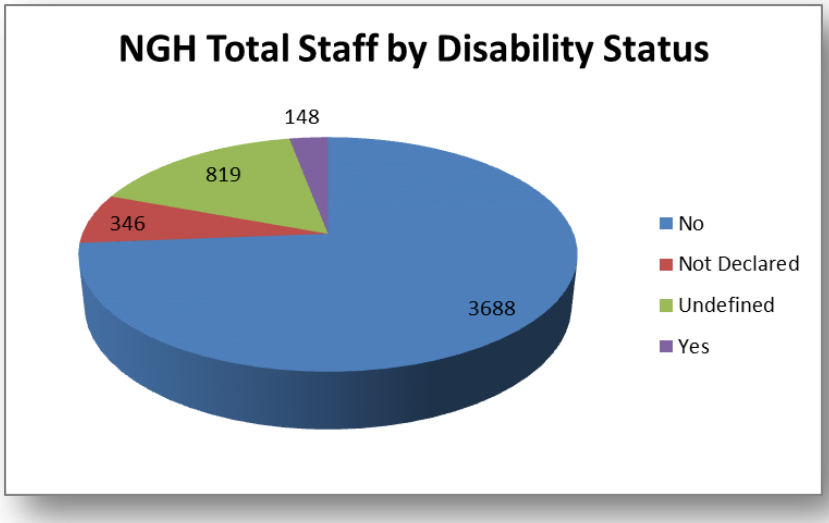




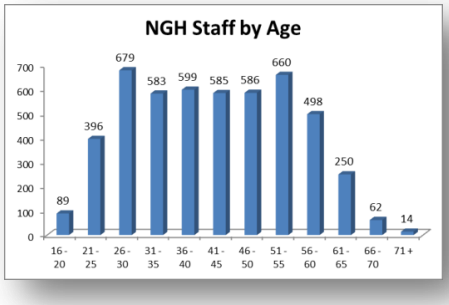
Our People

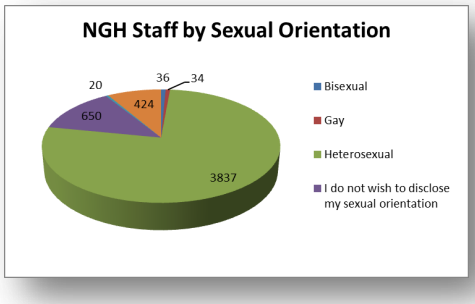
The Trust employs 4250.94 whole time equivalent (wte) members of staff, a headcount of 5001 people, (as at 31 March 2018).

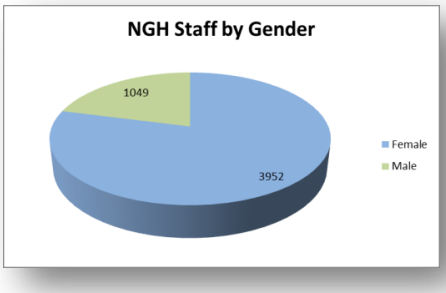


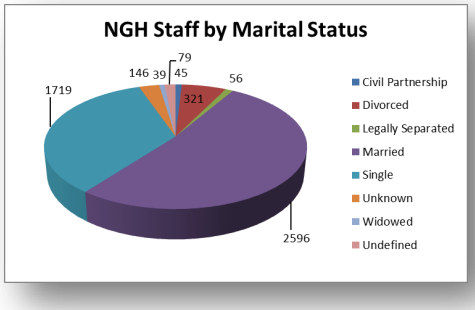


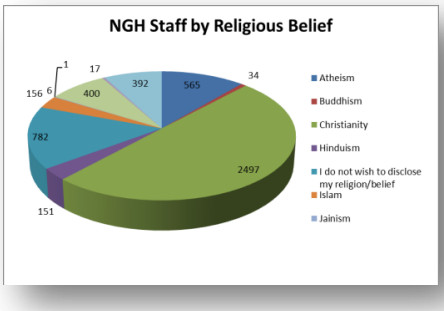
Chairman: Mr Paul Farenden
Chief Executive: Dr Sonia Swart

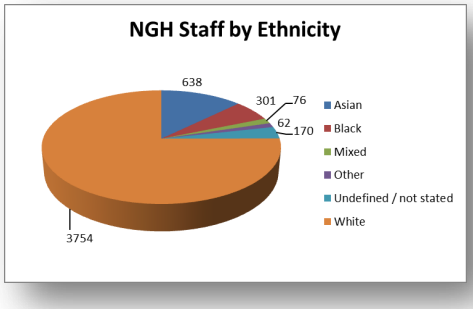












Our People

interesting articles

The 15–19 May 2017 was the sixth NHS Equality, Diversity and Human Rights Week (#EQW2017).

Co-ordinated by NHS Employers it is a national platform for NHS organisations to work to create a fairer, more inclusive NHS for patients and staff.

The theme for 2017 was diverse, inclusive, together, which was chosen to reflect the move across the health and social care sector towards collaboration and integration - as reflected in the Five Year Forward View and the Sustainability and Transformation Plans. It also focussed on working together to make the NHS stronger, meet standards, enable change and collectively invest in the creation of a diverse and inclusive NHS workforce to deliver a more inclusive service and improved patient care.

We asked our staff during Equality, Diversity and Human Rights Week to spare a few minutes to think about what they could do on a day to day basis to ensure that the we are a diverse and inclusive organisation and how Living Our Values Everyday, especially “We respect and support each other” is hugely important to achieving this.

Support for Staff becoming a Parent

During 2017/2018 we continued to provide support for staff becoming a parent to ensure that they are aware of their rights and entitlements. In addition to the Trust's Maternity, Paternity, Adoption and Shared Parental Leave Procedure we have a dedicated member of staff who can provide support and advice to individuals, who are applying for these types of leave, and their managers.

Workshops are run for staff who are pregnant to provide additional support and information. For other parenting leave such as adoption or shared parental leave individuals are seen on a one to one basis.

During the 12 month period that this report covers:

- 162 members of staff commenced maternity leave
- 15 members of staff commenced paternity leave
- 3 members of staff commenced shared parental leave.

In addition we also offered staff access to our employee childcare voucher scheme along with making staff aware of the nursery that is situated in the grounds of the hospital.

Supporting Our Staff to Breastfeed

As a fully accredited Baby Friendly Hospital, we aim to help our staff to continue to breastfeed, if that is their wish, and since 2017 we have been asking that managers support them to do this and promoting breastfeeding to our pregnant staff through our Maternity Workshops.

Breastfeeding has lots of benefits for a new mother and for their baby as well and we want staff to feel that they can continue breastfeeding when they return to work.

Support for Our Retiring Staff

Each year we run pre-retirement seminars for staff that are looking to retire within one to four years' time. The seminars help staff to prepare and plan for their retirement and covers aims and concerns, financial matters, inflation, taxation, investments, wills and equity release. In addition staff can also join the NHS Retirement Fellowship, which is a social, leisure, educational and welfare organisation for current and retired NHS and Social Care staff and their partners.

Approximately 16% of our workforce is over the age of 55, so these seminars prove useful for many of our staff.

Equality Analysis

We continued to undertake Equality Analyses to ensure that our services, plans, policies and procedures, continue to meet our public sector duties and give 'due regard' to ensure that everyone who works at the Trust or uses our services are treated fairly, equally and free from discrimination.

From April 2017 to March 2018 we completed 76 Equality Analyses.

Workforce Race Equality Standard (WRES)

We undertook our third WRES exercise in 2017 and it was submitted to NHS England and published on our website in September 2017.

In general there was improvement in the all the key indicators, with the exception of the percentage difference between the Black Minority Ethnic (BME) representation of the Board and the overall workforce, which has deteriorated. In addition it was noted that we do not have any Very Senior Managers (VSM) who are BME, as determined by the VSM criteria in the WRES Technical Guidance.

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

We are currently working on a campaign linked to our Value of Respect and Support each other and this will include training around equality and behaviours linked to bullying and harassment.

Our WRES Data Reports can be found on our Trust website.

Religious Festivals and Holy Days

As one of the largest employers in Northampton our staff have many different religious beliefs, some of which have specific festival periods or Holy Days throughout the year.

Although there is no right that guarantees staff time off to attend religious services, we do recognise that it is good practice to accommodate requests where possible. To support with this we have been making our managers aware of key dates for religious observance and providing them with information to help them better understand the needs of our staff in relation to their religion or beliefs.

Equality & Diversity Group – Staff

Our Equality and Diversity Staff Group (EDSG) continues to meets on a quarterly basis. The purpose of the group is to champion and steer the work of the hospital so that we are in full and positive compliance of equality and human rights legislation, regulations and codes of practice including NHS and Department of Health standards.

The aim of the group is twofold, to lead, advise and inform on all aspects of policy making, and employment including various engagements related to equality and inclusion legislation and policy direction. In addition, the EDSG aim is to lead and monitor progress on the development of the Equality Objectives/Four Year Plan. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce:

1. A representative and supported workforce –

   "We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing the Workforce Race Equality Standard (WRES) and monitoring outcomes."

1. Inclusive leadership -

   "We will improve our leadership and management capability."

The key actions for each objective link to the Workforce Race Equality Standard (WRES), health and wellbeing, staff survey results, divisional objectives and the leadership and management development programme.

During 2018/2019 we will be reviewing our key actions to ensure that they are fit for purpose and meet the needs of the Trust, especially linked to our analysis and findings from our most recent staff survey results and our findings from the 2017 WRES and Gender Pay Gap Reporting exercises.

Equality & Diversity Policies

Underpinning our Equality & Diversity Strategy and the objectives are a number of workforce policies and procedures that support our day to day work and some of these have specific connections to the Equality Act 2010, namely:

- Bullying, Harassment & Victimisation
- Employment of Staff with a Disability
- Flexible Working
- Maternity, Adoption, Paternity and Shared Parental Leave
- Recruitment, Selection & Retention
- Supporting and Managing Workforce Sickness Absence.

A number of these have been reviewed during 2017/2018 to ensure that they are up-to-date and in line with current legislation and best practice.

All our Human Resources procedural documents advise that our policies and procedures will be applied fairly and consistently to all employees regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation, whether working full or part-time or whether employed under a permanent, temporary or fixed-term contract.

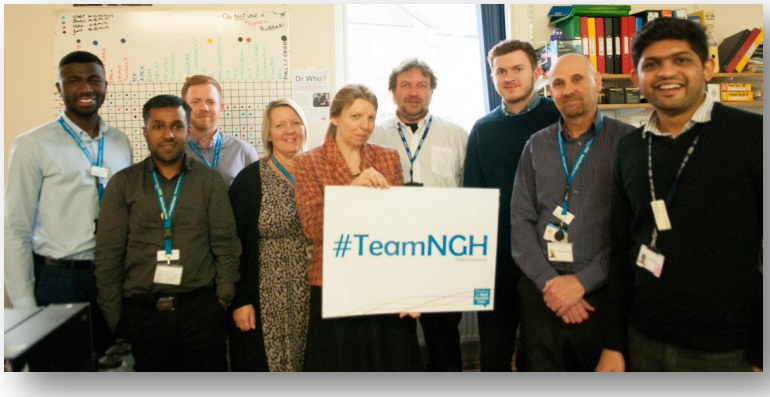
Gender Pay Gap Reporting 2017

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) we compiled our data in December 2017. Although we are not legally required to produce a written report it was agreed this should be done to give context to the 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 and Trust Board in January 2018. The approved report was published on our website and submitted to the Government by 31 March 2018, as part of the requirements under the Regulations.

We will be looking at the results more closely during 2018/2019 to see what we can do to reduce the gap that was identified.

You can see a copy of the report on here on our website:
http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx



Disability Confident Scheme Certification

The Trust is certified as a Disability Confident Employer (formally Positive about Disabled People 'Two Ticks' Scheme) and as a result of this we commit to:

- Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to disabled people who meet the minimum criteria for the job and making reasonable adjustments as required.

- Keep and develop our staff - which includes supporting our staff to manage their disabilities or health conditions.

Along with ensuring that our recruitment processes are accessible and fair, we also encouraged our existing staff, that have a disability, to make us aware so that we could meet with them and discuss what support could be provided, if required. Knowing which of our staff have a disability also enables us to record the number of disabled staff that we have and the nature of their disability, in line with the Data Protection Act.

During 2018/2019 we will be looking at working towards attaining the next level of certification, which is a Disability Confident Leader.

Learning & Development

During 2017/8 we continued to recruit apprentices into various roles. Apprentices apply through NHS jobs and after attending an assessment day are then put forward for interview. Upon successful interview they are offered an apprenticeship post which is for a minimum of 12 months. Anyone can apply for an apprenticeship and they range from those leaving school to older people who want to train in another area or have brought up their children and now want to get back into work, but chose an apprenticeship so that they can gain a qualification alongside learning the job.

With the introduction of the Apprenticeship Levy on 1st April 2017, it has opened up the opportunity for more staff to complete an apprenticeship whilst employed with us. The levy has meant changes to the funding rules and eligibility criteria meaning that those staff who have a degree can access this training and with the introduction of higher level apprenticeships, we can train staff from level 2 up to level 7, which are the senior roles within the Trust. The creation of apprenticeship standards means that there are more career pathways which helps us to 'build our own' and provide a career for anyone joining the Trust.

Our Learning and Development Department have also been organising a free four week course for all NHS staff to enable them to gain a functional skills qualification in Maths or English equivalent to a GCSE.

Northamptonshire NHS & Partners Apprenticeship Awards 2018

To celebrate National Apprenticeship Week 2018 (5 to 9 March) and the successes of our apprentices, Thursday 8 March saw the first award ceremony for county-wide apprentices across Northamptonshire NHS organisations and partner healthcare organisations.

The ceremony brought together our apprentices and their mentors together with those from Kettering General Hospital NHS Foundation Trust and Northamptonshire Healthcare NHS Foundation Trust as well as representatives from general practice and adult social care.

There were lots to celebrate on the evening from individual successes and heart-felt nominations, to the difference apprentices have made to the care patients, service users and carers have received across Northamptonshire.

The award categories recognised all apprentices working in many different job roles and settings across the partnership network including; Business Administration, Recruitment, Pharmacy Technician, Domestic Assistants and Healthcare Assistants.

There were 7 categories and NGH had winners in each category.

Staff Survey 2017 Equality & Diversity Results

The 2017 annual National NHS Staff Survey took place during September to December 2017 and 1871 members of staff returned the survey.

Of the 32 key findings there was improvement in 2, deterioration in 5 and 25 stayed the same. There were 2 results that showed statistically significant improvement and we were in the top 20% of acute trusts for staff engagement, staff motivation at work and the percentage of staff appraised in the last 12 months.

The demographics of the staff that responded when compared to the Trust profile were broadly similar with the exception of BME staff where 14% of respondents indicated they were from a BME background compared to 22% or our workforce and disabled staff where 19% of the respondents identified they were disabled compared to the 3% of the our workforce.

Within the Staff Survey there are two specific key findings about equality and diversity.

The first key finding is in relation to the percentage of staff experiencing discrimination at work in the last 12 months. This result has not changed since the 2016 results and we were ranked as below average when compared to other acute trusts.

There was also no change in relation to the second key finding which reports the percentage of staff who believe that the organisation provides equal opportunities for career progression and/or promotion and we were ranked as above average when compared to other acute trusts.

The survey has highlighted some areas of concern and we will be working with our teams to analyse the results more deeply in order to continue our work in ensuring all our staff are focused on the Trust's values, by displaying positive behaviours, high quality care and striving for continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Health and Wellbeing for Staff

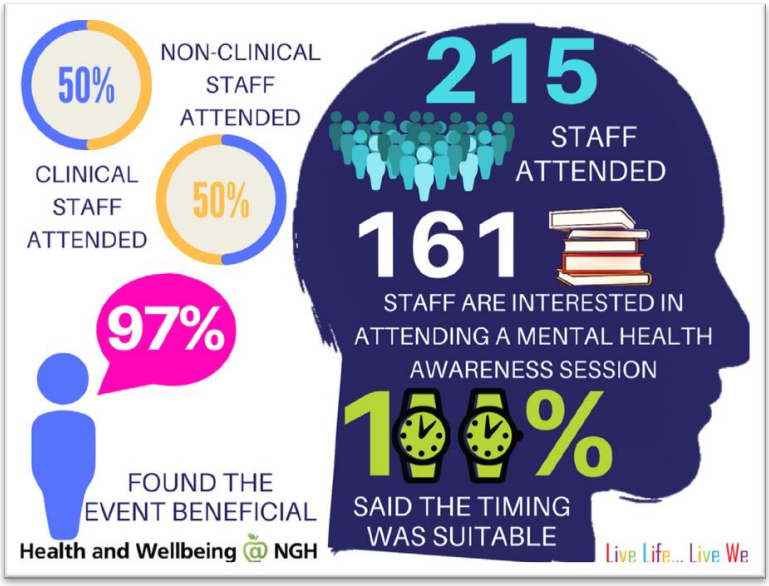
Throughout the year we have developed a campaign of initiatives that supports the introduction of our Health and Wellbeing Strategy. Our aim, through the strategy is to improve staff wellbeing and morale and to ultimately be recognised as a health promoting Trust. Our health and wellbeing initiatives have included:

- Staff Health Checks
- 12 week Nutrition and Fitness programme in partnership with Trilogy
- Weekly choir practice sessions
- Weekly Ballroom/Latin dance classes in partnership with Top Dance
- Introduction of Mission: SlimPOSSIBLE – in-house weekly slimming group for staff providing advice and support
- Improved bike storage facilities
- Participation in 100 Day Global Challenge
- Participation in Northamptonshire Sport Business Games
- Participation in Workplace Challenge
- Promotion of local and national awareness campaigns.

The focus during the year was on mental health awareness and ways we can do more to tackle stigma and discrimination.

Mental health awareness event 'Mind Your Head' took place on 10 October 2017 to coincide with World Mental Health Day. A drop in event was arranged for all staff, where a range of stands representing different areas that link with mental health and supporting information was available.

Below is a brief summary from the event:



Two mental health awareness workshops delivered by MIND took place. The workshops were open to all staff to help:

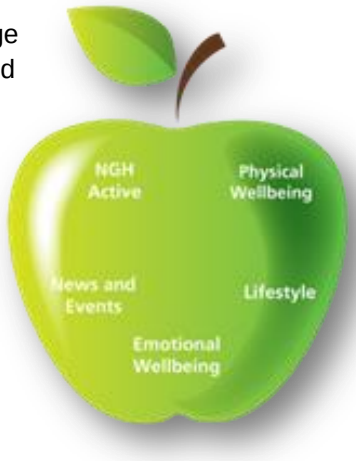
- Understand how mental health conditions are assessed, classified and diagnosed
- Identify the signs, symptoms, causes and treatment options for a range of mental health conditions
- Challenge common assumptions and prejudices associated with mental health.

Attendance and feedback from both sessions was extremely positive and further workshops will be organised.

Ten Managing Mental Health in the Workplace workshops for managers were organised and they helped support managers to identify:

- The signs and symptoms of stress, anxiety and depression
- The possible causes and impact of these conditions
-
- The range of reasonable adjustments to support someone with a mental health condition
- The management skills necessary to manage staff who are stressed, anxious and depressed

Time to Talk Day 2018 – Talking Therapy Sessions in partnership with Northampton MIND were organised. These were bookable 10 minute 1-1 talking therapy sessions for staff to talk about stress, anxiety, depression or mental health in general.



Care Quality Commission Visits 2017

Following a number of inspections by healthcare watchdogs the Care Quality Commission (CQC) we were official reclassified from Requires Improvement to Good in 2017.

The hospital was found to be good in all five categories inspected – safe, well led, caring, responsive and effective – with many outstanding features highlighted by the inspection team. The Trustwide focus on patient safety was noted.

Here are some of the things that the CQC said in their report specifically in relation to equality and diversity:

"The leadership teams were cohesive and inclusive."

"The Trust provided core elements in mandatory training to include fire, information governance, health and safety, safeguarding adults and children, manual handling, equality and diversity, infection prevention practice, safeguarding vulnerable adults, and trust induction."

"Staff told us they felt respected, valued and were treated fairly, with equal opportunities for training, development and career progression."

Everyone at the Trust is very proud of this achievement and Dr Sonia Swart, our Chief Executive said: "The inspection report paints a picture that everyone working here will recognise. The essence is that of a positive team spirit delivering care of a high standard in a clinically-led structure where staff are proud of what they do. I'm really pleased for everyone who's worked with determination over the past three years to get us to this point. The reports confirms that this was a whole team effort and that our direction of travel is the right one. It gives us renewed confidence that if we sustain our current improvements and continue our current approach, we will be able to move from Good to Outstanding."

Northampton General Hospital

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- Find us on facebook
- Follow us on twitter @nghnhstrust

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 July 2018**

Title of the Report	**Equality and Human Rights Workforce Monitoring Report 2017/2018**
Agenda item	16.2
Presenter of Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance that the equality agenda including the public sector duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Workforce Monitoring Report for 2017/2018 aims to demonstrate this compliance and provide assurance that the Trust is meeting its legal duty to monitor our workforce by the protected characteristics.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trusts equality agenda for staff is being monitored through the equality and diversity group with progress reports on the Four Year Action Plan and the WRES.
Related Board Assurance Framework entries	BAF 2.1 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? **N** If yes please give details and describe the current or planned activities to address the impact. **N/A** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **N** If yes please give details and describe the current or planned activities to address the impact. **N/A**
Legal implications / regulatory requirements	NHS Constitution Public Sector Equality Duty Equality Act 2010 The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) Workforce Race Equality Standard (WRES)

Actions required by the Trust Board

The Workforce Committee is asked to endorse the content of the report.

Northampton General Hospital
NHS Trust

Northampton General Hospital

Equality and Diversity Workforce Monitoring Report 2017/2018

CONTENTS

EXECUTIVE SUMMARY

The Equality and Diversity Workforce Monitoring Report for 2017/2018 provides analysis of the data that the Trust holds in relation to its workforce.

Northampton General Hospital (NGH) has a legal duty to promote equality of opportunity, foster good relations and eliminate harassment and unlawful discrimination. As part of our legal duty we must prepare and publish equality information annually comprising of an equality profile of our staff.

Our legal duty to monitor our workforce is addressed in this document. The report provides information for most of the protected characteristics in the following areas:

- Trust's Workforce Profile
- Recruitment Activity
- Employee Relations Caseload Activity
- Learning and Development Activity.

INTRODUCTION

Northampton General Hospital believes that Equality and Diversity (E&D) is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfill their potential.

The Trust aims to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of the different groups and individuals we serve and the staff we employ.

To achieve this aim, we want to ensure that service users and employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances.

It is important to us that we eliminate discrimination in the way we provide our services and the way we recruit, train and support our workforce. The Trust does not tolerate any forms of unlawful or unfair discrimination. In addition it recognises that all people have rights and entitlements.

OUR POPULATION

Northamptonshire has an estimated population of 732,452 people, as at 2016. Since 2011 there has been a population increase of 5.9%. It is estimated that the population of Northamptonshire will rise to approximately 754,000.

More than 20% of the population are in the least deprived quintile, and around 15% are in the most deprived quintile.

The latest Health Profile for Northamptonshire (Public Health England, 4 July 2017) describes 30 indicators, most of which are related to health and lifestyle.

Northamptonshire is significantly worse than the England average for the following:

- GCSE's achieved
- Violent Crime (Violent offences)
- Smoking status at time of delivery
- Excess weight in adults
- Hospital stays for self-harm
- Hospital stays for alcohol related harm
- Killed and seriously injured on roads.

Northamptonshire Population (2011 Census)

Ethnic Group	Religion	Marital Status	Age Group	Gender
White 91.48%	Christian 59.9%	Single 29.2%	0-17 22.5%	Male 49.3%
Mixed 1.51%	Buddhist 0.3%	Married 41.4%	18-24 7.8%	Female 50.7%
Asian 4.04%	Hindu 1.2%	Civil Partnership 0.2%	25-34 12.6%	
Black 2.53%	Jewish 0.1%	Separated 5.3%	35-44 13.5%	
Other 0.43%	Muslim 1.7%	Divorced 14.3%	45-54 14.8%	
	Sikh 0.4%	Widowed 9.6%	55-64 11.7%	
	Other 0.4%		65-74 9.8%	
	No religion 29.2%		75-84 5.2%	
	Not stated 6.7%		85+ 2.2%	

EQUALITY ANALYSIS

Identifying and responding to the effect of the activities of the Trust on the different protected groups of staff remains of fundamental importance in the context of giving due regard in line with our Public Sector Equality Duties.

Equality Analysis remains a key component in delivering quality services and support to staff which meets the needs of all and ensures that employees are not excluded. The Trust continues to utilise its systems for Equality Analysis on policies, procedures, plans and programmes of change, to assess whether they have the potential to affect staff differently. This process identifies and addresses real or potential inequalities resulting from policy, practice or service development.

Where it is identified that a particular group or section of staff will be, or could be disadvantaged the Equality Analysis processes ensures that the Trust is able to:

- Remove or minimise disadvantage experienced by people connected to 'protected characteristics'
- Take steps to meet the needs of people who share a protected characteristic where these are different from people who do not share it
- Encourage people who share a protected characteristic to participate in work activities or any other activity where participation is disproportionately low.

From April 2017 to March 2018 the Trust completed 76 Equality Analyses.

During 2018 we will be reviewing our processes around equality analysis to ensure that they are fit for purpose and continue to meet our responsibilities under the Equality Act 2010.

WORKFORCE PROFILE – APRIL 2017 to MARCH 2018

The following analysis contains quantitative information from the Electronic Staff Record (ESR) for the year ending 31 March 2018 relating to:

- Staff in Post by pay band/grade
- Sickness episodes by pay band/grade
- Leavers by pay band/grade

Information relating to Recruitment & Promotion and Disciplinary & Grievance Procedures is provided separately within the monitoring report.

Where possible the information has been analysed against the following protected characteristics:

- Age
- Disability
- Ethnicity
- Religious Belief
- Sex
- Sexual Orientation
- Marital Status

It is important to know and understand the demographic profile of our workforce, and to be able to compare this profile with that of the local population which we serve.

Workforce Profile by Pay Band / Grade

It is obviously important that the data we hold for employees relating to protected characteristics is as complete as possible in order to draw meaningful conclusions from any analysis.

In some areas the level of completeness of data is very high; over 96.60% of employees have their ethnic origin recorded, and a slightly smaller percentage (95.50%) has a record for marital status. Sex and age are recorded for all employees. Disability information has always been poorly recorded; 23.30% have no record relating to disability status, which is an increase on the reported figure in 2017 of 19%. Sexual Orientation and Religious Belief were not collected until relatively recently, and as a consequence employees who have been with the Trust for many years will often have nothing recorded against these criteria. This results in 21.48% of employees for whom the Trust has no record of Sexual Orientation, and 23.48% with no record of Religious Belief.

Appendix 1 provides the data tables for detailed information regarding the workforce profile by protected characteristics for pay bands/grades.

Protected Group	Analysis
Age	When compared to the Northamptonshire population, the percentage of staff aged between 25 and 54 is significantly higher. However given that the Northamptonshire population covers children (0-17 – 22.5%) one would expect a higher proportion of staff to be aged between 22 and 54 than would be seen within the local population.
Disability	Only 2.96% of the NGH workforce has disclosed a disability. According to PANSI (Projecting Adult Needs & Service Information) the projection of Northamptonshire population aged between 18 and 64 likely to have either a moderate or serious disability is 7.9% and 2.4% respectively. However 23.3% of the workforce do not have a disability status recorded; if this data was complete the rate would probably increase but still be well below the local population estimated rate. The physical nature of most work in the healthcare sector could help to explain the low representation of disabled people in the NGH workforce.
Sex	The NHS workforce is predominantly female, and at NGH the percentage is 79.02%. However the percentage of male employees is higher than the total for all staff, (20.98%) in the Agenda for Change band 8a – 9 group, at 35.46%, which is a small increase since reporting in 2016/2017. Within the medical & dental staff group 59% are male.
Ethnicity	According to the 2011 Census, the Northamptonshire population was 91.5% white, 8.5% Black & Minority Ethnic (BME), whereas the Trust employees (as at 31 March 2018) were 75.06% white (of which 67.8% were British or Irish), 21.36% BME. The overall percentage of BME employees is boosted by the high representation of this group (57.4%) in the Medical & Dental staff group. Although only 9.42% of staff in Agenda for Change bands 8a – 9 are in the BME group, 21.9% of bands 5 – 7 are BME, significantly higher than the average BME representation across all pay bands in the Trust.
Religion	The 2011 Census data indicated that 59.9% of the population of Northamptonshire were Christian, 1.7% Muslim, and 1.2% Hindu. Employee data showed 49.93% Christian. The percentage of the local population professing no religion was 29.2%; 7.84% of employee records had no religion defined, and a further 15.64% did not wish to state their religion or belief, while 11.30% professed to be Atheist. In total, 15.29% of employees are from a minority faith community.

Sexual Orientation	Sexual Orientation information is not collected as part of the National Census so a comparison cannot be made between Trust employees and the Northamptonshire population. However, 76.72% of employees are recorded as heterosexual. 13% did not wish to state their sexual orientation, and a further 8.48% had no data recorded. Bisexual, Gay or Lesbian employees made up 1.8% of the total.
Marital Status	Of the total number of employees, 51.91% were married compared with 41.4% of the local population; 34.37% of employees were single, 6.42% divorced, 0.90% in a civil partnership, 1.12% separated, and 0.78% widowed. The comparable figures in the local population were 29.2% single, 14.3% divorced, 0.2% civil partnership, 5.3% separated, and 9.6% widowed. The much higher percentage of widowed people in the population reflects the number in older age-groups no longer part of the working or economically active population.

Sickness Absence Analysis (number of episodes)

The number of separate episodes of sickness for the year ending 31 March 2018 was 9,045. Appendix 1 provides the data tables for detailed analysis of the information.

Employees' pay band or grade appears to have a relatively significant influence on the number of sickness episodes compared to other equality and diversity factors. Band 2 employees comprise 18.89% of the workforce, and are the second biggest staff group, but they were responsible for the single highest percentage of the sickness, equating to 27.09% of all episodes. The biggest staff group in pay band terms is Band 5, with 20.57% of the workforce, and they accounted for the second highest percentage of sickness episodes, at 25.82%. Staff in bands 7 and 8a-9 account for 9.11% and 3.81% of the workforce but only 6.57% and 2.34% of the sickness episodes.

Protected Group	Analysis
Age	The percentage of the total number of sickness episodes relating to each age group equates relatively to the proportionate size of each age group in terms of staff in post, indicating a fairly even spread of sickness across all age groups. The biggest age group numerically; 26-30 (13.58% of the workforce) had the highest group percentage of the total number of sickness episodes at 15.57%.
Disability	Employees who declare a disability comprise 2.96% of the workforce, although this figure would probably increase if the status of the 23.3% where no record is held was

	known. However, those employees who do declare a disability accounted for 4.08% of the sickness episodes, which is consistent with the figure recorded in 2016/2017 despite there being a small increase in the number of employees declaring a disability.
Sex	79.02% of employees are female and accounted for 84.48% of the sickness episodes. Conversely 20.98% of employees are male and account for 15.52% of the sickness episodes.
Ethnicity	In terms of ethnic groups as a percentage of the total number of employees, the percentage of sickness episodes in each group shows small variation. Asian staff comprise 12.78% of the number of employees but account for only 9.36% of sickness episodes. White employees comprise 75.06% of the workforce and account for 78.87% of sickness episodes.
Religion	Religious belief does not seem to play a significant part in an employee's likelihood of having episodes of sickness absence. The spread of sickness episodes across religious belief groupings is fairly consistent with the ratio of employees in each group, for example 50.97% of sickness episodes are within the Christianity group, which accounts for 49.93% of the workforce. However Islam is stated as the religion for 3.12% of the workforce but accounts for only 1.70% of sickness episodes, and similarly Hinduism applies to 3.02% of the workforce and only 1.43% of sickness episodes.
Sexual Orientation	As with religious belief, the percentage of staff within each category of sexual orientation as compared with the percentage of the total sickness episodes recorded does not show a significant variation, although those with no sexual orientation recorded or those not wishing to state their sexual orientation amount to 21.48% of the workforce and have 19.86% of sickness attributed to them. This represents a relatively large percentage of the workforce in total and may make meaningful analysis less likely. Nonetheless, 78.10% of sickness episodes occur in the heterosexual group, which in turn makes up 76.72% of the workforce. The Gay, Lesbian & Bisexual groups total 1.8% of the workforce and account for 2.05% of the sickness episodes.
Marital Status	There is some variation across the marital status groups between the percentage of employees in each one and the percentage of sickness episodes in each one. For example, married or civil partnership employees are slightly less likely to have sickness, with 52.81% of the

	workforce being in these groups but only taking 48.97% of the sickness episodes. By contrast divorced or legally separated employees make up 7.54% of the workforce and accounted for 8.32% of sickness episodes. Single employees are 34.37% of the workforce and they accumulated 37.88% of sickness episodes.

Leaving Employment

In total, 376 employees with permanent contracts left the Trust in the year ending 31 March 2018. Band 2 employees form 18.89% of the permanent workforce but 22.87% of leavers were from this group; band 5 employees (20.57% of the permanent workforce) made up 24.46% of leavers.

Appendix 1 provides the data tables for detailed information regarding the workforce profile by protected characteristics for leavers.

Protected Group	Analysis
Age	A higher proportion of employees in the age groups from 16 to 25 left in the year than would be indicated by comparison with the percentage of the workforce that they represent. 19.15% of leavers came from this age group, which represents only 9.7% of the workforce in post. The number of leavers from this age group is consistent with last year. By contrast, the staff groups aged between 26 and 55 make up 73.84% of the workforce, but only 53.71% of the leavers which is a significant decrease since last year. People in these groups seem to become a stable part of the workforce, compared to those younger and probably earlier in their careers who are more inclined to change their employer. Employees aged over 55 made up 27.13% of the leavers but 16.48% of the workforce. This is expected given the numbers who would be retiring from this range.
Disability	Although the number of leavers in the group declaring a disability was small, they represented 3.72% of leavers, slightly higher than their representation rate among all employees, which was 2.96%. Employees positively declaring no disability (73.75% of the workforce) made up 72.34% of leavers, again in line with what might be expected.
Sex	Whilst 79.02% of the workforce is female, they made up 73.40% of the leavers. The male workforce (20.98%) provided 26.60% of leavers, so was over-represented.

Ethnicity	White employees made up only 75.79% of leavers, compared to 75.06% of the permanent workforce, so this group is slightly over-represented. Black employees are 6.02% of the workforce but 9.57% of leavers, so this group is over-represented. Asian employees 12.78% of all employees were only 6.91% of leavers, so therefore appear to be less likely to leave the Trust.
Religion	53.46% of leavers were recorded as Christian, a higher rate than the overall rate in the workforce. Among the minority religions, the percentage of leavers is 4.26% which unrepresentative of their proportion of the workforce (15.3%).
Sexual Orientation	A reasonably comparable percentage of Heterosexual permanent employees were leavers (75.27%) compared with the permanent workforce (76.72%). Those people not wishing to state their sexual orientation made up 16.22% of leavers compared with only 13% of the workforce. Gay, Lesbian or Bisexual employees are 1.8% of the workforce and 0.8% of the leavers.
Marital Status	Married employees were less likely to leave than their proportion of the workforce would suggest; 48.41% of leavers were married or in a civil partnership, compared to 52.81% in the workforce. Similarly, divorced and separated employees made up 7.54% of the workforce and 9.57% of leavers. Single employees comprise 34.37% of the workforce but 37.5% of leavers. This is likely to be linked to the age range of single employees, as they tend to fall into the younger age groups and are probably more likely to change employment before settling into a longer term career choice.

RECRUITMENT ACTIVITY – APRIL 2017 TO MARCH 2018

This section of the report is based on the recruitment activity information collected by the HR Service Centre between April 2017 and March 2018 and in relation to the protected characteristics of:

- The number of applicants
- Those shortlisted
- Staff appointed.

Equality and Diversity is addressed throughout the recruitment process, from advertisement of the job, to the appointment of the successful candidate, such as following the Trusts advertisement process, targeting a wide range of audiences.

Managers receive anonymous applications to ensure the selection process is equal and fair. Candidates shortlisted for interviews are based on their education, qualifications, experience and their personal specification. Managers are provided with Appointing Officer Training which includes equality and diversity and values based recruitment.

During the period that the report covers the Trust received 18,354 applications for vacancies, 5,797 people were shortlisted for interview and 1,400 people were appointed. The overall number of applications received and people shortlisted has decreased from the previous year whereby 19,740 applications were received and 5,703 people were shortlisted, however the number of people appointed has increased even though the number of applicants has decreased.

Recruitment – Ethnicity

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
WHITE - British	10,449	56.90%	3563	61.50%	909	64.90%
WHITE - Irish	79	0.40%	37	0.60%	15	1.10%
WHITE - Any other white background	1,942	10.60%	454	7.80%	128	9.10%
ASIAN or ASIAN BRITISH - Indian	1,603	8.70%	519	9.00%	98	7.00%
ASIAN or ASIAN BRITISH - Pakistani	462	2.50%	123	2.10%	20	1.40%
ASIAN or ASIAN BRITISH - Bangladeshi	309	1.70%	72	1.20%	11	0.80%
ASIAN or ASIAN BRITISH - Any other Asian background	340	1.90%	94	1.60%	23	1.60%
MIXED - White & Black Caribbean	242	1.30%	66	1.10%	10	0.70%
MIXED - White & Black African	97	0.50%	26	0.40%	3	0.20%
MIXED - White & Asian	57	0.30%	16	0.30%	6	0.40%
MIXED - any other mixed background	131	0.70%	51	0.90%	11	0.80%
BLACK or BLACK BRITISH - Caribbean	404	2.20%	106	1.80%	20	1.40%
BLACK or BLACK BRITISH - African	1,445	7.90%	423	7.30%	84	6.00%
BLACK or BLACK BRITISH - Any other black background	108	0.60%	26	0.40%	5	0.40%
OTHER ETHNIC GROUP - Chinese	96	0.50%	29	0.50%	4	0.30%
OTHER ETHNIC GROUP - Any other ethnic group	317	1.70%	110	1.90%	16	1.10%
Undisclosed	273	1.50%	82	1.40%	37	2.60%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by ethnicity.

It demonstrate that White – British has the highest amount of applications with 10,449 which equates to 56.90% of all applications. 3,563 were shortlisted and 909 were appointed to a position at the Trust.

White - Any other white background has the second highest amount of applications made with 1,942 or 10.60% of applications, which resulted in 454 of candidates being shortlisted of which 128 were successful in gaining a position with the hospital.

Asian or Asian British - Indian has the third highest amount of applications with 1,603 of which 519 were shortlisted and 98 were successful in gaining employment.

When compared to the previous year there is no change to the ethnic groups that have received the highest amount of applications. There has been a decrease in the number of applications received; however there has been a slight increase in the number appointed.

The most significant change has been in the undisclosed category where candidates appointed has decreased by 2%. This indicates that more applicants are comfortable in disclosing their ethnicity.

When compared to the Northamptonshire Population 2011 Census information the percentage of Mixed, Asian, Black and other Ethnic groups appointed is higher than the local population and the percentage of White applicants appointed is lower than the local population.

During 2017/2018 the Trust has continued focus recruitment on shortage occupations from overseas; however there has been renewed focus on recruiting from the UK, especially to nursing positions.

Recruitment - Sex

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Male	4,112	22.40%	1197	20.60%	253	18.10%
Female	14,184	77.30%	4574	78.90%	1134	81.00%
Undisclosed	58	0.30%	26	0.40%	13	0.90%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by sex.

The data shows that the Trust had a greater number of female applicants at 77.30% or 14,184, of which 4,574 were shortlisted and 1,134 were appointed.

Male applicants totalled 22.40% or 4,112 and of those 1,197 were shortlisted and 253 were appointed.

When compared to the previous year there is no significant change to the groups that have received the highest amount of applications. There have been some slight decreases in the number of applications received; however the numbers appointed have increased. The undisclosed percentage of appointed candidates has risen by 0.6%.

When compared to the Northamptonshire Population 2011 Census information the percentage of females appointed is higher than the local population and the percentage of male applicants appointed is lower than the local population, but this is to be expected at an NHS Acute Trust whereby there is a high number of nursing staff who are predominantly female. In addition during 2017/2018 the Trust has continued focus its recruitment activity on its nurse vacancies.

Recruitment – Disability

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Yes	651	3.50%	233	4.00%	36	2.60%
No	17,352	94.50%	5436	93.80%	1337	95.50%
Undisclosed	351	1.90%	128	2.20%	27	1.90%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by disability.

The data shows that the greater number of applicants disclosed they did not have a disability at 94.5% or 17,352, of which 5,436 were shortlisted and 1,337 were appointed.

Disabled applicants totalled 3.50% or 651 and of those 233 were shortlisted and 36 were appointed. There has been a slight decrease in the number of disabled applicants shortlisted and appointed.

There is no data from the Northamptonshire Population 2011 Census about disability to compare to the Trust data.

During 2017/2018 the Trust has continued to be committed to supporting people with disabilities and through its certification as a Disability Confident Employer.

Recruitment - Impairment

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Physical Impairment	126	16.30%	52	17.70%	3	7.30%
Sensory Impairment	53	6.80%	28	9.60%	8	19.50%
Mental Health Condition	154	19.90%	52	17.70%	6	14.60%
Learning Disability/Difficulty	157	20.30%	62	21.20%	15	36.60%
Long-Standing Illness	188	24.30%	66	22.50%	6	14.60%
Other	97	12.50%	33	11.30%	3	7.30%
Total	**775**	**100%**	**293**	**100%**	**41**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by impairment.

This is a new category of report obtained from NHS Jobs. This report shows that applicants have disclosed their actual impairment. The results are shown above and as this is a new report this year no analysis can be made.

There is no data from the Northamptonshire Population 2011 Census about impairment to compare to the Trust data.

Recruitment – Age

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Under 18	126	0.70%	55	0.90%	32	2.30%
18 to 19	564	3.10%	148	2.60%	63	4.50%
20 to 24	3,028	16.50%	858	14.80%	276	19.70%
25 to 29	3,599	19.60%	968	16.70%	238	17.00%
30 to 34	2,454	13.40%	773	13.30%	166	11.90%
35 to 39	1,995	10.90%	651	11.20%	138	9.90%
40 to 44	1,687	9.20%	598	10.30%	129	9.20%
45 to 49	1,879	10.20%	645	11.10%	131	9.40%
50 to 54	1,523	8.30%	538	9.30%	104	7.40%
55 to 59	892	4.90%	338	5.80%	76	5.40%
60 to 64	529	2.90%	203	3.50%	42	3.00%
65 to 69	51	0.30%	14	0.20%	2	0.10%
70 and over	14	0.10%	4	0.10%	1	0.10%
Undisclosed	13	0.10%	4	0.10%	2	0.10%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by age.

In 2017/2018 the highest number of applications were received from the 25 to 29 age group with 19.60% or 3,599 applications. Of these 968 were shortlisted and 238 were appointed which has resulted in no significant change compared to last year.

The second highest number of applicants came from the age group of 20 to 24 year olds with 16.50% or 3,028 applications. From this 858 were shortlisted and 276 were appointed which is an increase of 4.5% compared 2016/2017.

There has been an increase in appointment of the age ranges, under 18, 18-19 and 60-64. These figures show that the Trust has been successful in recruiting apprentices and students. The information indicates that we have been able to retain retirees over the age of 60.

When compared to the Northamptonshire Population 2011 Census information the percentage of staff appointed aged between 18 and 54 is higher than the local population and the percentage of staff aged 55 and above is lower than the local population. This is to be expected in an NHS Acute Trust whereby many nursing and clinical staff can retire and take their pension aged 55.

The overall data assures the Trust that discrimination is not an issue and applicants are confident in disclosing their age.

Recruitment – Religious Belief

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Atheism	2,523	13.70%	842	14.50%	218	15.60%
Buddhism	111	0.60%	37	0.60%	7	0.50%
Christianity	9,274	50.50%	3024	52.20%	722	51.60%
Hinduism	791	4.30%	217	3.70%	38	2.70%
Islam	1,135	6.20%	297	5.10%	48	3.40%
Jainism	12	0.10%	6	0.10%	1	0.10%
Judaism	8	0.00%	5	0.10%	2	0.10%
Sikhism	120	0.70%	36	0.60%	8	0.60%
Other	2,256	12.30%	664	11.50%	173	12.40%
Undisclosed	2,124	11.60%	669	11.50%	183	13.10%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by religious belief.

Christianity had the most number of applicants with 50.50% or 9,274. Of these 3,024 were shortlisted and 722 were appointed. This shows that there has been a decrease in the number of Christians appointed when compared to 2016/2017.

Atheism had the second highest amount of applications with 13.70% or 2523. From this 842 were shortlisted and 218 were appointed. In comparison to 2016/2017, the number of staff appointed in the Atheism category has increased.

However, there has been a decrease of 1% in the number of appointed candidates who did not disclose their religious belief. This demonstrates that applicants feel comfortable in disclosing their religious belief.

Where comparisons can be made to the Northamptonshire Population 2011 Census information it is mostly comparable with the local population's religious beliefs.

Recruitment – Sexual Orientation

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Lesbian	97	0.50%	37	0.60%	10	0.70%
Gay	158	0.90%	51	0.90%	15	1.10%
Bisexual	341	1.90%	82	1.40%	16	1.10%
Heterosexual	16,472	89.70%	5260	90.70%	1273	90.90%
Undisclosed	1,286	7.00%	367	6.30%	86	6.10%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by sexual orientation.

The highest number of individuals applying for remains within the heterosexual group with 89.70% or 16,472 applicants. TheTrust shortlisted 5260 and 1273 were appointed, which is a decrease from the previous year.

There has been a 0.5 increase in the appointed percentage for the lesbian category which supports the decrease in the Hetrosexual category.

There is no data from the Northamptonshire Population 2011 Census about sexual orientation to compare to the Trust data.

Recruitment – Marital Status

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Married	7,064	38.50%	2367	40.80%	518	37.00%
Single	8,837	48.10%	2630	45.40%	697	49.80%
Civil partnership	567	3.10%	134	2.30%	25	1.80%
Legally separated	224	1.20%	97	1.70%	14	1.00%
Divorced	906	4.90%	309	5.30%	64	4.60%
Widowed	226	1.20%	75	1.30%	10	0.70%
Undisclosed	530	2.90%	185	3.20%	72	5.10%
Total	**18,354**	**100%**	**5,797**	**100%**	**1,400**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2017 and March 2018 by marital status.

The marital status of single had the most number of applicants with 48.10% or 8,837. Of these 2630 were shortlisted and 697 were appointed.

Married had the second highest amount of applications with 38.50% or 7,064. From this 2367 were shortlisted and 518 were appointed.

There has been a decrease of applicants who are single and a slight rise in percentage of applicants who are married or divorced.

When compared to the Northamptonshire Population 2011 Census information the percentage of staff appointed is lower than the local population for marital status, with the exception of those who are single or in a civil partnership which is higher than the local population.

EMPLOYEE RELATIONS CASELOAD ACTIVITY – APRIL 2017 TO MARCH 2018

Background

This section of the report provides the equal opportunities breakdown for the formal Human Resources (HR) employee relations caseload activity across the Trust between the period of April 2017 and March 2018 for both open and closed formal cases.

The HR activity has been broken down into the following categories:

- Harassment and Bullying Cases
- Grievance Cases
- Disciplinary Cases (conduct)
- Performance Management Cases (capability)

In the year ending March 2018 there were 89 formal cases; 12 Harassment and Bullying cases, 12 Grievance cases, 58 Disciplinary cases and 7 Performance Management cases recorded on the HR database.

Harassment and Bullying Cases

Age Group	No.	Comment
16 - 20		There appears to be a fairly even spread of cases between the age groups of 36-40 upwards and including 56-60 for harassment & bullying complaints. This is a shift from last year where the majority of the complaints were raised by employees within the 41-45 age range. The age groups where cases have been raised also have the highest proportion of staff within the Trust (60% combined)
21 - 25		
26 - 30	1	
31 - 35		
36 - 40	2	
41 - 45	2	
46 - 50	3	
51 - 55	1	
56 - 60	3	
61 – 65		
66 - 70		

Disability	No.	Comment
Yes	2	The case numbers do not suggest any trend towards disabled members of staff. The results from the staff survey do not correlate with the number of formal recorded cases, with a higher proportion of disabled staff stating they have experienced harassment, bullying or abuse from staff within the last 12 months. It is important to note, however, that many allegations of harassment and bullying are dealt with at an informal level.
No	6	
Not Declared		
Undefined	4	

Sex	No.	Comment
Female	8	Given the small number of cases, it would be expected that there are a higher number of female cases based on the Trust demographic of 79.02% female and 20.98% male, however the number of male cases is higher than expected.
Male	4	

Ethnicity	No.	Comment
White	7	The case numbers appear consistent with the Trust profile and do not suggest a trend towards any one ethnic group.
BME	1	
Asian	3	
Not stated	1	

Marital Status	No.	Comment
Civil Partnership		There appears to be an even spread of cases across nearly all status's which reflects the Trusts profile of staff. There is no data from the staff survey relating to this protected characteristic.
Divorced	2	
Legally separated	1	
Married	4	
Single	4	
Unknown	1	
Widowed		

Sexual Orientation	No.	Comment
Bisexual		There have been no cases raised related to the sexual orientation of the individual. The number of cases for Heterosexual staff appears to reflect the Trust's profile of 76.7% of staff declaring this as their sexual orientation. There is no data from the staff survey relating to this protected characteristic
Gay	1	
Heterosexual	8	
Does not wish to disclose	2	
Lesbian		
Undefined	1	

Religion	No.	Comment
Atheism		The distribution of cases appears to reflect the Trust's profile with 49.9% staff declaring Christianity as their religious belief. There is no data from the staff survey relating to this protected characteristic.
Buddhism		
Christianity	5	
Hinduism	2	
Does not wish to disclose	3	
Other	1	
Undefined	1	

Grievance Cases

Age Group	No.	Comment
16 - 20		There does not appear to be any trend in relation to age group and the amount of cases is representative of the Trust profile, with the highest number of cases falling where the highest proportion of staff are in the Trust. There is no data from the staff survey explicitly relating to grievances.
21 – 25		
26 - 30	1	
31 - 35	1	
36 - 40	1	
41 – 45	2	
46 – 50		
51 – 55	4	
56 – 60	3	
61 – 65		
66 - 70		

Disability	No.	Comment
Yes	3	The case numbers do not suggest any trend towards disabled or non-disabled members of staff. The split is reasonably representative of the Trusts profile: 3% disabled, 74% not disabled 7% not declared and 16% undefined. There is no data from the staff survey explicitly relating to grievances.
No	6	
Not Declared	1	
Undefined	2	

Sex	No.	Comment
Female	10	Given the small number of cases, this split appears consistent against the 79.02% female and 20.98% male split in the Trust. There is no data from the staff survey explicitly relating to grievances.
Male	2	

Ethnicity	No.	Comment
White	9	The case numbers appear consistent with the Trust profile and do not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to grievances.
BME	1	
Mixed white & Asian	1	
Asian	1	

Religion	No.	Comment
Atheism		Given the small number of cases, the distribution of cases appears does not suggest any trend towards a religious belief. There is no data from the staff survey explicitly relating to grievances.
Buddhism		
Christianity	4	
Hinduism		
Does not wish to disclose	3	
Other	1	
Undefined	3	
Hindu	1	

Marital Status	No.	Comment
Civil Partnership		Given the small number of cases this split is reasonably representative of the 52% married and 34% single profile in the Trust. There is no data from the staff survey explicitly relating to grievances.
Divorced		
Legally separated		
Married	9	
Single	3	
Unknown		
Widowed		

Sexual Orientation	No.	Comment
Bisexual		The number of cases for Heterosexual staff appears to reflect the Trust's profile of 76.7% of staff declaring this as their sexual orientation. There is no data from the staff survey explicitly relating to grievances.
Gay		
Heterosexual	9	
Does not wish to disclose		
Lesbian		
Undefined	3	

Disciplinary Cases

Age Group	No.	Comment
16 – 20		The distribution of cases generally appears to correlate with the percentage of staff within those age groups. With 13% of staff at the Trust within the 51-55 age group, 12% of staff within the 31-35 age group and 1% of staff in the 66-70 age group. There is no data from the staff survey explicitly relating to disciplinary.
21 – 25	3	
26 – 30	6	
31 – 35	10	
36 – 40	6	
41 – 45	7	
46 – 50	7	
51 – 55	10	
56 – 60	6	
61 - 65	2	
66 - 70	1	

Disability	No.	Comment
Yes	1	The case numbers do not suggest any trend towards disabled or non-disabled members of staff. The split is reasonably representative of the Trusts profile: 3% disabled, 74% not disabled 7% not declared and 16% undefined. There is no data from the staff survey explicitly relating to disciplinary.
No	39	
Not Declared	5	
Undefined	13	

Sex	No.	Comment
Female	35	The distribution of cases appears higher than expected for men (39%) against the 79.02% female and 20.98% male split in the Trust. Further analysis may be required of each case and discussions with the Trust Equality and Diversity Staff Group. There is no data from the staff survey explicitly relating to disciplinary.
Male	23	

Ethnicity	No.	Comment
White	41	The case numbers appear consistent with the Trust profile and do not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to disciplinary.
BME	5	
Not stated	6	
Asian	5	
Mixed white & Asian	1	

Marital Status	No.	Comment
Civil Partnership		The distribution of cases is reasonably representative of the Trust profile: 6% Divorced, 52% married, 3% unknown and less than 1% widowed. With the exception of singles where the split of cases remains higher than expected, as last year, based on the workforce profile for the Trust of 34% single. Further analysis may be required and discussions with the Trust Equality and Diversity Staff Group. There is no data from the staff survey explicitly relating to disciplinary.
Divorced	5	
Legally separated		
Married	26	
Single	20	
Unknown	6	
Widowed	1	

Sexual Orientation	No.	Comment
Bisexual		The distribution of cases appears to reflect the Trust's profile of less than 1% Gay, 76.7% Heterosexual, 13% do not wish to disclose and 8% undefined The split of sexual orientation is not sufficiently disclosed to allow any meaningful analysis. There is no data from the staff survey explicitly relating to disciplinary.
Gay	2	
Heterosexual	40	
Does not wish to disclose	10	
Lesbian		
Undefined	6	

Religion	No.	Comment
Atheism	3	The distribution of cases appears to generally reflect the Trust's profile of 11% Atheism, 49.9% Christianity, 3% Hinduism, 16% does not wish to disclose, 8% other, 2% undefined and less than 1% Sikhism. The split of religious beliefs is not sufficiently disclosed to allow any meaningful analysis. There is no data from the staff survey explicitly relating to disciplinary.
Buddhism		
Christianity	28	
Hinduism	1	
Islam		
Does not wish to disclose	14	
Other	5	
Undefined	6	
Sikhism	1	

Performance Management Cases

Age Group	No.	Comment
16 – 20		Given the small number of cases this split is reasonably representative of the Trust profile. There is no data from the staff survey explicitly relating to performance management.
21 – 25		
26 - 30	1	
31 - 35		
36 - 40	3	
41 - 45	2	
46 - 50		
51 - 55		
56 - 60		
61 – 65	1	
66 - 70		

Disability	No.	Comment
Yes		Given the small number of cases, this does not suggest any trend towards disabled or not disabled staff. There is no data from the staff survey explicitly relating to performance management.
No	6	
Not Declared	1	
Undefined		

Sex	No.	Comment
Female	6	Given the small number of cases, this split appears consistent against the 79.02% female and 20.98% male split in the Trust. There is no data from the staff survey explicitly relating to performance management.
Male	1	

Ethnicity	No.	Comment
White	5	Give the small number of cases this appears consistent with the Trust profile and does not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to performance management.
BME	2	

Marital Status	No.	Comment
Civil Partnership		Given the small number of cases this split is reasonably representative of the 6% Divorced, 52% married, 34% single profile in the Trust. There is no data from the staff survey explicitly relating to performance management.
Divorced	1	
Legally separated		
Married	4	
Single	2	
Unknown		
Widowed		

Sexual Orientation	No.	Comment
Bisexual		Given the small number of cases, this appears to reflect the Trust's profile of 76.7% of staff declaring their sexual orientation as Heterosexual. There is no data from the staff survey explicitly relating to performance management.
Gay		
Heterosexual	5	
Does not wish to disclose	1	
Lesbian		
Undefined	1	

Religion	No.	Comment
Atheism	1	Given the small number of cases, the distribution does not suggest any trend towards a religious belief and is consistent with the Trust profile of staff. There is no data from the staff survey explicitly relating to performance management.
Buddhism		
Christianity	4	
Hinduism		
Does not wish to disclose	1	
Other		
Undefined	1	

LEARNING AND DEVELOPMENT – APRIL 2017 TO MARCH 2018

Background

The Trust has been using the centralised electronic Oracle Learning Management System, (OLM) to record training information since 2009. It has been used to record all staff's Mandatory Training and Role Specific Essential Training attendance which is then collated and reported via the Electronic Staff Record (ESR) system to the Trust's Workforce Committee. This year saw ESR undergoing major improvements which has led to a more efficient OLM system enabling the L&D team to view training records more easily and streamline the booking and recording of attendance.

The Trust, through the Practice Development Team, also provides and maintains records on clinical training such as Cannulation, Glucometer, Catheterisation and Drug Calculation which are included in this section of the report.

Training is divided between mandatory training and role specific essential training (RSET). Mandatory means all staff need to attend, whilst RSET is specific to an individual's role. RSET is revised when there are changes such as in legislation and regulations and as a result there is a continuous process to update the OLM to ensure that RSET training is accurately set on the system against each role ensuring that staff only attend courses that are relevant to them.

To ensure that all staff achieve the required outcomes of the training, different learning styles have been utilised and sessions have been adapted to help staff within different roles understand what the training subject means to them.

The Trust's Induction continues to be offered twice a month, so staff can attend as close to their start date as possible. The Induction covers the Trust's values and behaviours as well as the 8 mandatory training subjects. All the Trainers who deliver the training on Induction have worked with both L&D and Organisational Development to review their training sessions to ensure that staff gain the knowledge and understanding of the specific subject matter in a meaningful way. They aim to make the session as learner friendly as possible, covering all learning styles which includes; group work, quizzes and case studies.

The Trust continues to recruitment International Nurses to the Trust and in order to provide additional support, bespoke preceptorship programmes and clinical skills have been provided including orientation to the Trust.

All mandatory training subjects have three methods of delivery; face to face, e-learning and workbooks/assessments. The workbooks are updated as changes are made to legislation or regulations and the assessment papers are changed within each refresher period.

Demand continues to be high for our Review of Knowledge sessions, and with more staff completing workbooks or e-learning this seems to be the preferred option of training than attending a traditional classroom lecture.

Staff have been encouraged to access on-going development across all levels; this includes Apprenticeship Frameworks, Vocationally-Related Qualifications (VRQ's) & in-house management programmes. Registered staff are also able to access modules at Degree & Masters level via the Learning Beyond Registration contract held with Health Education East Midlands.

The hospital continues to employ apprentices across the Divisions and in different roles. 10 new apprentices commenced their apprenticeship during 2017/2018 and of those 8 were offered full time employment by the Trust on completing their apprenticeship and 1 continued onto a higher apprenticeship.

The Trust continues to offer functional skills in Maths and English. The Maths and English classes are available for all staff to attend with each one running over a 4 week period concluding with an exam and qualification. Please see table below detailing the number of staff accessing this training and the success rate:

NGH Summary
April 2017 to March 2018

Maths	
No. of Learners started	29
No. of Passes	24
Achievement Rate %	**82.8%**

English	
No. of Learners started	22
No. of Passes	20
Achievement Rate %	**90.9%**

English and Maths Total	
No. of Learners started	51
No. of Passes	44
Achievement Rate %	**86.3%**

National Achievement Rate for Adult learners	**74%**

The table below shows the analysis of the hospitals workforce using the Trust headcount by protected characteristics and the number of training courses attended. We currently collect data on 6 of the 9 protected characteristics, those not included are; gender reassignment, marriage and civil partnership and pregnancy and maternity.

It is important to note that the reports used for the analysis include the Trust's bank workers.

Training – Trust Headcount of 6,957	
Protected Group	**Analysis**
Sexual Orientation	The number of 'not stated' has decreased from last year, but the number of staff who do not wish to disclose their sexual orientation has increased. There has however been an increase in the number of staff disclosing that they are Gay, Heterosexual and Lesbian compared to last year. The report shows that all categories of sexual orientation are attending training and this correlates with the numbers of staff in post.
Religious Belief	The highest proportion of training was completed by the Christian religious group which correlates with the workforce profile. There has been an increase in the number of staff who did not wish to disclose their religion/belief and the number of staff not stating their religion/belief. There has also been an increase 7 of the 9 groups, although Hinduism and Islam see a decrease. The training in these other categories is being completed proportionately.
Age Band	Training is offered to all age groups. There has been an increase in the number of staff within all groups apart from 26-30 and over 71. The number of staff in the 21-25 age band is the same as last year, although they have seen the highest variance of attending training. The greater variance of non-attendance is within the 56-60 age band which may be attributable to this age group working more part-time.

Sex	There are more females attending training than males which correlate to the workforce profile. However, the report also identified that less males are completing training by proportion.
Disability	The number of 'undefined' has decreased from last year. The report shows an increase on the number of staff 'not declaring' and an increase on the number disclosing a disability. Training is accessible to disabled staff with all training rooms providing good access. There is an increase in the opportunity to access training by e-learning and workbooks so staff can complete their training in their usual workplace.
Ethnic Origin	The report details that training is provided to all staff and the Trust headcount and numbers of training courses attended by all staff reflects the Trust's ethnic population. For example the highest number of staff in the Trust is of white ethnicity with the second group being Asian and the third category from Black / Black British, which was the same last year. The highest variance in attendance is within the 'Asian or Asian British - Indian' and then 'White British' group. Whilst the greatest variance in non-attendance is in the 'not stated' and 'undefined' groups which also saw an increase in the number of staff declaring these compared to last year.

In the tables below the variance column gives further information about which of our staff, by their protected characteristic, are accessing training by comparison against the Trust's headcount.

Sex	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
Female	5225	75.10	36285	80.57	5.46
Male	1732	24.90	8753	19.43	-5.46
Total:	**6957**	**100%**	**45038**	**100%**	

Sexual Orientation	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
Bisexual	49	0.70	407	0.90	0.20
Gay	45	0.65	341	0.76	0.11
Heterosexual	4984	71.64	35367	78.53	6.89
I do not wish to disclose my sexual orientation	1164	16.73	5764	12.80	-3.93
Lesbian	22	0.32	189	0.42	0.10
Not stated	693	9.96	2970	6.59	-3.37
Total:	**6957**	**100%**	**45038**	**100%**	

Religious Belief	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
Atheism	776	11.15	5197	11.54	0.38
Buddhism	51	0.73	292	0.65	-0.08
Christianity	3203	46.04	23305	51.75	5.71
Hinduism	210	3.02	1491	3.31	0.29
I do not wish to disclose my religion/belief	1325	19.05	6882	15.28	-3.77
Islam	203	2.92	1354	3.01	0.09
Jainism	9	0.13	54	0.12	-0.01
Judaism	4	0.06	21	0.05	-0.01
Other	487	7.00	3543	7.87	0.87
Sikhism	27	0.39	141	0.31	-0.08
Not stated	662	9.52	2758	6.12	-3.39
Total:	**6957**	**100%**	**45038**	**100%**	

Age Band	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
16 - 20	188	2.70	1299	2.88	0.18
21 - 25	652	9.37	5301	11.77	2.40
26 - 30	984	14.14	6542	14.53	0.38
31 - 35	876	12.59	5460	12.12	-0.47
36 - 40	846	12.16	5763	12.80	0.64
41 - 45	795	11.43	5145	11.42	0.00
46 - 50	729	10.48	4888	10.85	0.37
51 - 55	782	11.24	5295	11.76	0.52
56 - 60	598	8.60	3320	7.37	-1.22
61 - 65	320	4.60	1596	3.54	-1.06
66 - 70	125	1.80	376	0.83	-0.96
71 +	62	0.89	53	0.12	-0.77
Total:	**6957**	**100%**	**45038**	**100%**	

Ethnicity	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
White - British	4302	61.84	28420	63.10	1.27
White - Irish	71	1.02	478	1.06	0.04
White - Any other White background	419	6.02	2999	6.66	0.64
White Unspecified	2	0.03	10	0.02	-0.01
White English	3	0.04	19	0.04	0.00
White Welsh	2	0.03	11	0.02	0.00
White Greek	3	0.04	58	0.13	0.09
White Turkish	2	0.03	16	0.04	0.01
White Italian	8	0.11	52	0.12	0.00
White Gypsy/Romany	6	0.09	24	0.05	-0.03
White Polish	8	0.11	43	0.10	-0.02
White Albanian	1	0.01	3	0.01	-0.01
White Mixed	2	0.03	1	0.00	-0.03
White Other European	27	0.39	210	0.47	0.08
Mixed - White & Black Caribbean	38	0.55	235	0.52	-0.02
Mixed - White & Black African	16	0.23	71	0.16	-0.07
Mixed - White & Asian	25	0.36	108	0.24	-0.12
Mixed - Any other mixed background	43	0.62	289	0.64	0.02
Mixed - Black & White	1	0.01	4	0.01	-0.01
Mixed - Black & Asian	1	0.01	0	0.00	-0.01
Mixed - Chinese & White	2	0.03	7	0.02	-0.01
Mixed - Asian & Chinese	1	0.01	4	0.01	-0.01
Mixed - Other/Unspecified	2	0.03	0	0.00	-0.03
Asian or Asian British - Indian	565	8.12	4548	10.10	1.98
Asian or Asian British - Pakistani	80	1.15	525	1.17	0.02
Asian or Asian British - Bangladeshi	32	0.46	169	0.38	-0.08
Asian or Asian British - Any other Asian background	111	1.60	713	1.58	-0.01
Asian Mixed	1	0.01	8	0.02	0.00
Asian Sri Lankan	8	0.11	37	0.08	-0.03
Asian British	4	0.06	17	0.04	-0.02
Asian Unspecified	5	0.07	16	0.04	-0.03
Black or Black British - Caribbean	80	1.15	589	1.31	0.16
Black or Black British - African	331	4.76	2576	5.72	0.96
Black or Black British - Any other Black background	32	0.46	211	0.47	0.01
Black Nigerian	4	0.06	14	0.03	-0.03
Black British	8	0.11	41	0.09	-0.02
Black Unspecified	1	0.01	0	0.00	-0.01
Chinese	37	0.53	250	0.56	0.02
Any Other Ethnic Group	65	0.93	494	1.10	0.16
Filipino	6	0.09	45	0.10	0.01
Malaysian	0	0.00	10	0.02	0.02
Other Specified	14	0.20	72	0.16	-0.04
Undefined / Not Stated	588	8.45	1641	3.64	-4.81
Total:	**6957**	**100%**	**45038**	**100%**	

Disability	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance %
No	4725	67.92	33730	74.89	6.98
Not Declared	708	10.18	3247	7.21	-2.97
Undefined	1339	19.25	6701	14.88	-4.37
Yes	185	2.66	1360	3.02	0.36
Total:	**6957**	**100%**	**45038**	**100%**	

Equality & Diversity Training

Equality and diversity training remains mandatory for all staff and is included on the Trust's Induction for all new staff. All existing staff have to refresh their equality and diversity training every 3 years. To ensure staff are able to access this subject, we offer this training through e-learning and workbook/assessment.

All staff attending the equality and diversity training are given an awareness of the nine protected characteristics under the Equality Act 2010 and the adverse impact on clinical care if they are not respected.

Conclusion

In conclusion, this year we have seen a decrease in the overall number of staff attending training than previous years. However as the overall % of compliance for both Mandatory Training and Role Specific Training is increasing, it is thought that the decrease is due to; less staff being aligned to role specific training, that there is a reduction in the number of staff attending the non-mandatory training sessions and that the recording requirements of training has been re-defined resulting in some training no longer being recorded in the way it has been historically.

Work continued on having a flexible approach to learning which removed barriers to access for groups with protected characteristics. Given that all mandatory training subjects can now be accessed through workbook/assessment sheets and e-learning, individuals have more opportunities to access it at any time during their working hours whether those hours are within the working hours of 9.00am to 5.00pm or during hours they work outside of these times.

The Trust has continued to explore innovative ways of delivering training and this has led to some courses being adapted for those staff groups such as within Domestic Services and the International Nurses that have been recruited to the Trust in the last year.

Learning and Development continues to communicate to staff the Trust's Mandatory Training Policy which was updated in 2017. This policy ensures that all staff are aware of the mandatory and role specific training they are required to undertake and for the Trust to be compliant against its' regulatory requirements.

Appendix 1

Equality and Diversity Workforce Data – 1 April 2017 – 31 March 2018

Staff in Post

Staff in Post by Age and Pay Group

Age Group/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
< = 20 Years	5	35	45	3	1								89
21 - 25	1	21	99	45	25	127	41	4	1			32	396
26 - 30	2	32	112	41	50	203	110	30	3			96	679
31 - 35		32	105	42	34	142	92	38	19	1		78	583
36 - 40		32	94	46	43	119	95	72	30	24		44	599
41 - 45		22	84	44	36	129	98	73	21	52	4	22	585
46 - 50		35	105	62	41	99	66	70	33	54	9	12	586
51 - 55		46	130	69	55	88	85	86	45	43	7	6	660
56 - 60		53	95	50	45	77	56	53	25	32	3	9	498
61 - 65		30	57	27	24	35	23	25	14	11	2	2	250
66 - 70		8	16	8	9	9	2	5		3	2		62
> = 71 Years		6	3	1	1	1						2	14
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Disability and Pay Group

Disabled/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
No	6	240	755	331	272	746	513	307	138	126	18	236	3688
Not Declared		31	24	11	10	130	26	28	10	30	5	41	346
Undefined	1	71	132	83	68	122	102	115	39	62	4	20	819
Yes	1	10	34	13	14	31	27	6	4	2		6	148
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Bisexual		2	8	2	3	14	5	1				1	36
Gay		2	9	2	3	7	4	1	2	1	1	2	34
Heterosexual	7	237	789	353	282	743	549	335	146	127	19	250	3837
I do not wish to disclose my sexual orientation		64	74	44	46	204	60	52	22	39	6	39	650
Lesbian		1	4	2		5	4	3	1				20
Undefined	1	46	61	35	30	56	46	64	20	53	1	11	424
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Sex and Pay Group

Sex/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Female	7	226	793	363	317	900	585	392	141	74	14	140	3952
Male	1	126	152	75	47	129	83	64	50	146	13	163	1049
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Religious Belief and Pay Group

Religious Belief/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Atheism		32	138	39	50	94	100	49	24	13	3	23	565
Buddhism		4	2	3	1	2		3	1	4		14	34
Christianity	4	167	506	239	183	564	355	224	111	52	15	77	2497
Hinduism		1	13	6	6	17	13	7	3	41		44	151
I do not wish to disclose my religion/belief	1	69	111	56	61	196	95	69	23	40	7	54	782
Islam	1		10	11	4	25	9	6	3	13		74	156
Jainism					1			1	1	1		2	6
Judaism						1							1
Other	1	35	105	51	28	79	55	34	6	2	1	3	400
Sikhism		2	3	1		2		4	1	3		1	17
Undefined	1	42	57	32	30	49	41	59	18	51	1	11	392
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Ethnic Origin and Pay Group

Ethnic Origin/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Any Other Ethnic Group	1		9	5	2	11	6	4	2	6		7	53
Asian British			1									1	2
Asian Mixed												1	1
Asian or Asian British - Any other Asian background		4	20	3	1	21	2	3	3	10		18	85
Asian or Asian British - Bangladeshi	1		3	4	1	4	2	3		1		2	21
Asian or Asian British - Indian		12	46	17	17	157	34	16	7	63		58	427
Asian or Asian British - Pakistani			2	2	2	4	2	2		6		40	60
Asian Sri Lankan												4	4
Asian Unspecified		2											2
Black British				1		1	1					1	4
Black Nigerian						1						1	2
Black or Black British - African		17	29	9	4	92	28	12	3	3	1	19	217
Black or Black British - Any other Black background		3	4	1	2	4	1					1	16
Black or Black British - Caribbean		7	13	5	6	15	4	5	1	1		5	62
Chinese		1	1	1		6	4	2	2	4		10	31
Filipino						6							6
Mixed - Any other mixed background			5	6	2	3	1	3		3		3	26
Mixed - Asian & Chinese						1							1
Mixed - Black & White				1									1
Mixed - Chinese & White												1	1
Mixed - White & Asian		2	1		2	3	2	1		3		3	17
Mixed - White & Black African						3	1			1		2	7
Mixed - White & Black Caribbean		2	3	5	2	5	4					1	22
Not Stated		18	16	5	6	61	16	9	6	4	2	23	166
Other Specified			1							1		7	9
Undefined				1				1				2	4

White - Any other White background	1	69	69	22	7	86	26	11	3	11	1	16	322
White - British	5	205	710	344	309	511	519	375	159	99	23	68	3327
White - Irish		7	6	4	1	14	10	8	4	2		3	59
White Albanian						1							1
White English		1	1			1							3
White Greek			2			1							3
White Gypsy/Romany						6							6
White Italian			1			2	2		1				6
White Mixed												1	1
White Other European		1		1		8	2			1		4	17
White Polish		1	2			1	1	1					6
White Turkish										1			1
White Unspecified												1	1
White Welsh				1									1
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Staff in Post by Marital Status and Pay Group

Marital Status/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Civil Partnership	1	9	10	3	1	6	7	6	2				45
Divorced		27	62	44	39	43	39	42	11	7	3	4	321
Legally Separated		6	15	6	7	7	7	5	1	2			56
Married	1	129	437	230	171	513	365	299	128	170	20	133	2596
Single	6	145	381	143	136	407	229	88	42	15	3	124	1719
Unknown		23	15	6	7	20	16	9	6	20	1	23	146
Widowed		7	15	3	2	5	2	3		1		1	39
Undefined		6	10	3	1	28	3	4	1	5		18	79
Grand Total	**8**	**352**	**945**	**438**	**364**	**1029**	**668**	**456**	**191**	**220**	**27**	**303**	**5001**

Sickness Absence Episodes

Sickness Episodes by Age and Pay Group

Age Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
< = 20 Years	59	121	4		2							186
21 - 25	74	371	112	42	250	62	3				21	935
26 - 30	94	338	88	77	513	198	43	1			56	1408
31 - 35	55	258	76	46	278	150	48	22			24	957
36 - 40	51	255	98	94	330	152	68	30	1		17	1096
41 - 45	38	195	62	78	291	203	131	42	5		4	1049
46 - 50	63	269	130	55	232	95	93	40	5	4	4	990
51 - 55	61	293	130	96	177	142	101	37	1			1038
56 - 60	110	211	107	64	155	92	68	30	5			842
61 - 65	74	104	44	45	89	40	28	10	1			435
66 - 70	14	30	14	5	18	3	12					96
> = 71 Years	6	6			1							13
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Disability and Pay Group

Disabled/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
No	490	1987	635	406	1655	808	404	156	4	1	97	6643
Not Declared	62	30	28	35	322	55	28	19	6		27	612
Undefined	105	339	170	113	278	216	157	32	8	3		1421
Yes	42	95	32	48	81	58	6	5			2	369
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Bisexual	3	20	1		30	12						66
Gay		31	6	2	22	10	2		1			74
Heterosexual	513	2068	738	460	1678	917	408	171	8	1	102	7064
I do not wish to disclose my sexual orientation	124	157	58	98	494	109	57	29	3		24	1153
Lesbian	4	10	6		11	3	10	1				45
Undefined	55	165	56	42	101	86	118	11	6	3		643
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Sex and Pay Group

Sex/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Female	417	2112	745	545	2068	1000	516	162	5		71	7641
Male	282	339	120	57	268	137	79	50	13	4	55	1404
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Religious Belief and Pay Group

Religious Belief/ Pau Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Atheism	88	438	107	89	188	175	60	29			5	1179
Buddhism	8	6	3	3	4		2				4	30
Christianity	321	1195	457	281	1320	582	286	127	1	1	39	4610
Hinduism	4	24	6	3	41	19	11	5	1		15	129
I do not wish to disclose my religion/belief	149	284	96	120	480	157	82	29	3		33	1433
Islam		26	23	6	36	20	9		5		29	154
Jainism				1	1			3			1	6
Judaism					1							1
Other	81	321	123	50	171	104	34	5				889
Sikhism	2	6	1		5		4	3	2			23
Undefined	46	151	49	49	89	80	107	11	6	3		591
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Marital Status and Pay Group

Marital Status/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Civil Partnership	9	25	6	1	23	8	9	1				82
Divorced	56	163	74	73	86	93	61	21				627
Legally Separated	16	52	13	3	12	17	10	3				126
Married	241	1000	449	288	1195	602	379	136	12	4	42	4348
Single	322	1129	304	220	860	374	118	33	3		64	3427
Unknown	36	34	10	8	64	38	7	14	2		4	217
Widowed	13	24	8	1	10	2	8					66
Undefined	6	24	1	8	86	3	3	4	1		16	152
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Sickness Episodes by Ethnic Origin and Pay Group

Ethnic Origin/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Other Medical	Grand Total
Any Other Ethnic Group		14	13	3	23	7	26		2		2	90
Asian British											1	1
Asian or Asian British - other Asian	7	49	4	2	38	3	5		1		8	117
Asian or Asian British - Bangladeshi		4	2	5	11	9	5				3	39
Asian or Asian British – Indian	13	82	18	8	371	54	20	11	6		24	607
Asian or Asian British – Pakistani		2	13	3	8	2	2				20	50
Asian Unspecified	3											3
Black British			2		1	6						9
Black Nigerian					2						1	3
Black or Black British – African	33	63	7	14	186	35	17				11	366
Black or Black British - Any other Black	4	7	2		6	2					1	22
Black or Black British – Caribbean	18	21	6	11	30	4	8					98
Chinese		2	3		6	4	1		1		1	18
Filipino					12							12
Mixed - Any other mixed	3	23	8	2	11	8	8					63
Mixed - Asian & Chinese					1							1
Mixed - Black & White			2									2
Mixed - Chinese & White											3	3
Mixed - White & Asian	1	1		2	5	6	3				1	19
Mixed - White & Black African	1		1		12						1	15
Mixed - White & Black Caribbean	3	3	6	1	9	7						29
Not Stated	39	44	6	18	173	35	9	6	1		4	335
Other Specified		3									6	9
White - Any other White	97	145	33	8	208	20	14	3			15	543
White - British	460	1955	732	524	1162	922	461	184	7	4	18	6429
White – Irish	10	17	7	1	23	6	15	8			2	89
White Albanian					1							1
White English	1				1							2
White Greek		7			1							8
White Gypsy/Romany					11							11
White Italian					3	3						6
White Mixed		1									1	2
White Other European	2	2			17	1					3	25
White Polish	4	4			1	3	1					13
White Unspecified					3							3
White Welsh		2										2
Grand Total	**699**	**2451**	**865**	**602**	**2336**	**1137**	**595**	**212**	**18**	**4**	**126**	**9045**

Leaving Employment

Leavers by Age Band and Pay Group

Age Band/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
< = 20 Years	8	6			1						15
21 - 25	7	16	5	2	22	5					57
26 - 30	2	5	1	2	19	5	3	2			39
31 - 35	4	8	4	4	7	6	4	2			39
36 - 40	1	7		4	16		3				31
41 - 45	2	8	3	2	7		2	5	2		31
46 - 50		7	3	4	3	4		3	2	1	27
51 - 55	6	6	5	2	4	4	5	1	1	1	35
56 - 60	2	13	2	2	4	12	7	5	6	1	54
61 - 65	5	7	9	2	5	1	3	1	1	1	35
66 - 70	1	3	1		3	2			1		11
> = 71 Years					1		1				2
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Disability and Pay Group

Disabled/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
No	32	68	24	14	61	28	24	14	7		272
Not Declared	3	2	2	3	14	4		1	2	4	35
Undefined	3	11	6	6	11	7	4	3	4		55
Yes		5	1	1	6			1			14
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
Gay						1		1			2
Heterosexual	28	72	24	19	70	28	20	13	7	2	283
I do not wish to disclose my sexual orientation	9	11	7	2	14	4	5	3	4	2	61
Lesbian								1			1
Undefined	1	3	2	3	8	6	3	1	2		29
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Sex and Pay Group

Sex/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
Female	15	71	29	18	72	31	22	12	4	2	276
Male	23	15	4	6	20	8	6	7	9	2	100
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Religious Belief and Pay Group

Religious Belief/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
Atheism	4	12	1	3	10	4	1				35
Christianity	19	50	21	9	44	18	16	17	6	1	201
Hinduism					2	1			3		6
I do not wish to disclose my religion/belief	11	14	6	4	21	5	4	2	3	2	72
Islam			2	1	3	1	1		1		9
Other	4	9	2	4	5	4	3			1	32
Sikhism							1				1
Undefined		1	1	3	7	6	2				20
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Marital Status and Pay Group

Marital Status/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
Civil Partnership		2			2	1	1				6
Divorced	1	4	4	3	7	4	2	1			26
Legally Separated	1	3	1	1			1	3			10
Married	9	41	18	10	36	19	19	10	12	2	176
Single	24	34	10	8	42	13	4	5		1	141
Unknown				1	2	2			1		6
Widowed	1	1			1						3
Undefined	2	1		1	2		1			1	8
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

Leavers by Ethnic Origin and Pay Group

Ethnic Origin/Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A - 9	Consultant	Other	Grand Total
Any Other Ethnic Group					2						2
Asian or Asian British - Any other Asian background		1		1	2		1				5
Asian or Asian British - Bangladeshi					1						1
Asian or Asian British - Indian	2			2	4	1	2		5		16
Asian or Asian British - Pakistani			2	1	1						4
Black British						1					1
Black or Black British - African	2	6			8	4	2	1			23
Black or Black British - Any other Black background		1									1
Black or Black British - Caribbean	2	1			4	1	1				9
Filipino					2						2
Mixed - Any other mixed background		2			1						3
Mixed - White & Asian					1						1
Mixed - White & Black African	1				1						2
Mixed - White & Black Caribbean					1						1
Not Stated	4	3	2		6	2		1		2	20
White - Any other White background	7	3			8	4	1	1			24
White - British	20	66	29	20	44	26	21	15	8	2	251
White - Irish		2						1			3
White English					1						1
White Gypsy/Romany					2						2
White Italian					1						1
White Mixed		1									1
White Other European					2						2
Grand Total	**38**	**86**	**33**	**24**	**92**	**39**	**28**	**19**	**13**	**4**	**376**

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *26th July 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 *20th June 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- Finance report
- Changing Care
- Operational performance
- Winter Plan
- Procurement Report
- Salix loans

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

Key areas of discussion arising from items appearing on the agenda

- The Trust delivered a financial result £600k ahead of plan in the second month, £1.2m YTD There continues to be challenges on pay overspend in some areas. The executive are running a process of discovery and will report to the committee in August
- The Committee received the Changing Care programme report, it was noted the Trust still needs to find a considerable number of additional schemes to achieve the planned savings.
- The committee was not assured that sufficient progress was being made with closing the £22m 'system Gap' (NGH's part £4.6m) This will now be a separate standing agenda item to maintain the necessary level of scrutiny on progress.
- A&E performance achieved the trajectory albeit a slight dip from last month. Cancer targets remain challenging but broadly positive, missing 4 by a small margin. The committee was advised the path back to green would take a few months.
- The committee received information on the increased focus of the organisation on the rebooking of cancelled operations within the 28 day target, which have improved.
- The committee received the first draft of the 18/19 winter plan, which included evidence of significant learnings from last winter which will be applied.
- The quarterly procurement report shows continued progress, achieving targeted savings. Benchmarked performance shows the trust in the upper quartile for most categories on the Model Hospital procurement measures and nationally ranked again in the top 10 trusts for procurement.
- The Committee received a proposal for taking out further Salix Loans for energy saving initiatives and recommends them to the Board for approval. We committee requested that any significant investment proposals using Salix loans previously taken out be brought back to the committee under the 'benefits realisation' review.
- The committee received an update on the implementation of Camis system. There was significant issues with out patient clinics and a back log of work generated as staff got used to he new system, but overall it appears a very smooth transition for such a major project

Any key actions agreed / decisions taken to be notified to the Board	
Any issues of risk or gap in control or assurance for escalation to the Board •	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board The committee recommends to the Board that it approve all the proposed energy savings plans to be funded through interest free Salix loans (the meeting was not quorate for this item)	

Northampton General Hospital NHS
NHS Trust

COMMITTEEHIGHLIGHT REPORT

Report to the Trust Board: ***26 July 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 *22 June 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Corporate Scorecard for Quality Quality Improvement Scorecard Nursing & Midwifery Report Medical Director's Report QI Presentation Compliance Report Risk Management Annual Report Health and Safety Annual Report	

Key areas of discussion arising from items appearing on the agenda

VTE compliance workstream is a priority for the MD
AKI and Sepsis continued to be outliers. Update to July report.
A Pilot of a patient safety APP would be for 3-6 months across approx. 60 beds.
Concern Re the Amber metrics for Robert Watson ward to be reviewed.
Safeguarding adult's referrals showed a significant increase. Further details requested.
There was some concern at the reduction of incident reporting.

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

All Reports were for Noting only. Any actions agreed are in the action log.

Any issues of risk or gap in control or assurance for escalation to the Board
None

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board
None

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***26 July 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 *20 June 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- Workforce Performance
- Recruitment update
- Agenda for change pay award
- Respect & Support campaign
- People strategy
- Safe staffing

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

Key areas of discussion arising from items appearing on the agenda

- **Workforce performance -** annual turnover down to 7.51% v 10% target, lowest in many years. Mandatory training compliance increased to 89.20% from last month, above the Trust target of 85%. Great achievement, given the significant winter pressures.
- **Recruitment update:**
  - Tier 2 Visa Cap removal for Doctors & Nurses w.e.f. 6th July –a 'shopping list' for overseas medical recruitment now being developed including Radiology, Oncology and Medical Specialities
  - Assessment Hub – 11 nurses recruited for urgent care and a further 13 nurses recruited from recent open days, leaving only 2 vacant nursing posts. Work continuing on recruitment of Therapy staff, which was proving challenging. Good progress on medical recruitment.
- **Agenda for Change pay award –** 3 year pay deal, with some changes to pay structures, agreed, subject to final sign-off by unions. Trust will monitor funding to ensure changes are financed. Query as to whether bank staff were included in the funding. Those not on agenda for change would have their salaries reviewed.
- **Respect & Support campaign –** launch of campaign on Monday 25th in the Cripps Centre, funding still being explored. Total number of bullying and harassment cases had increased to 11 largely due to raising of awareness.
- **People Strategy -** will be refreshed and presented in October, with an annual progress review in May.
- **Safe Staffing –** Data now available from Angela Grace but not provided by Avery. This would be pursued through the contracting process.

Any key actions agreed / decisions taken to be notified to the Board	
Any issues of risk or gap in control or assurance for escalation to the Board	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Board of Directors: 10th July 2018

Title	**HMT Exception Report**
Chair	**Dr S Swart**
Author (s)	**Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met as a workshop on 10th July 2018 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries**
1. Highlight report 2. Stroke service expansion 3. CAMiS update 4. Outpatients strategy 5. Divisional scorecards 6. AOB	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Verbal report – information only

A summary briefing was provided by the CEO which included the CQC system review findings, NHS 70, new government funding, Collaboration with KGH, super stranded performance against trajectory & A/E performance.

Stroke Service expansion

Dr Boovalingam gave a presentation on the operational effect & patient pathway for the stroke service expansion which is due to go live in September.

CAMiS update

Mrs Needham gave an update on the CAMiS PAS go live weekend, operational impact during the go live weekend and subsequent issues relating to data quality & data migration within outpatients.

Outpatients strategy

Mr Tucker shared a paper on the out patients strategy & asked HMT to agree the formation of a directorate (within CSS) which will scope & deliver the outpatient transformation. A further business case will be presented to HMT with invest to save options.

Divisional scorecards:

Each division presented their scorecards & highlighted any immediate issues/areas to note.
Medicine & Urgent Care – New medical model & the appointment of seven new consultants. Cost control being a major priority for the division & job planning/service planning consolidation.
CSS – Review of therapies model currently taking place.
Surgery – Decreasing ALOS for NEL #NOF patients project in place, Divisional team working on maximising income & improved patient experience through lower cancelled operations. .

Womens, Children's, Oncology, Haematology, Cancer – Division are working on new maternity metrics. Further focus on CIP's and cost control. **Other business** None raised	
Any key actions agreed / decisions taken to be notified to the Board Agreed development of a directorate for outpatients within the CSS division	
Any issues of risk or gap in control or assurance for escalation to the Board All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register.	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board To note the contents of the report.	

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 July 2018
10:00 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
10:00	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 May 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:30	**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.**
10:40	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Annual Health and Safety Report	Assurance	Mr S Finn	**J.**
	14.	Infection Prevention Control Annual Report	Assurance	Ms C Fox	**K.**
	15.	STP & Unified Model with KGH Update	Assurance	Mr C Pallot	**Verbal.**
	16.	Equality and Diversity – 1. E&D Workforce Annual Report 2016/2017 2. E&D Workforce Monitoring Report 2016/2017	Assurance	Mrs J Brennan	**L.**
11:40	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**N.**

Time	Agenda Item		Action	Presented by	Enclosure
	19.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**O.**
	20.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**P.**
12:10	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 27 September 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).