Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 27 September 2018

09:30

Board Room
Northampton General Hospital

AGENDA

Northampton General Hospital NHS Trust

PUBLIC TRUST BOARD

Thursday 27 September 2018
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 26 July 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log • Avery Update	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.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:30	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	12.	Operational Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Corporate Governance Report	Assurance	Mrs C Corkerry	**I.**
	14.	Healthcare Partnership Update	Assurance	Mr C Pallot	**Verbal**
	15.	EPRR Core Standards & Assurance 2018/19	Assurance	Mrs D Needham	**J.**
11:40	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	17.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**L.**
	18.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**M.**
12:00	**19.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

Time	Agenda Item	Action	Presented by	Enclosure
DATE OF NEXT MEETING **The next meeting of the Public Trust Board will be held at 09:30 on Thursday 29 November 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 26 July 2018 at 10:00 in the Board Room at Northampton General Hospital

Present		
	Mr P Farenden	Chairman
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy Chief Executive Officer
	Mr P Bradley	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		
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Finn	Interim Director of Facilities and Capital Development
	Ms K Palmer	Executive Board Secretary
	Mr C Pallot	Director of Strategy & Partnerships
	Ms C Thorne	Director of Corporate Development Governance & Assurance
Apologies		
	Mr P Zeidler	Non-Executive Director and Vice Chairman
	Dr E Heap	Associate Non-Executive Director
	Mr D Noble	Non-Executive Director

TB 17/18 154 Introductions and Apologies

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

Apologies for absence were recorded from those listed above.

TB 17/18 155 Declarations of Interest

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

TB 17/18 156 Minutes of the meeting 31 May 2018

The minutes of the Trust Board meeting held on 31 May 2018 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 31 May 2018 subject to two amendments raised by the attendees.

TB 17/18 157 Matters Arising and Action Log 31 May 2018

Action Log Item 86 & 87

The Trust Board were informed that these had been presented at the Quality Governance Committee.

The Board **NOTED** the Action Log and Matters Arising from the 31 May 2018.

TB 17/18 158 Patient Story

Mrs Needham presented Trust Board the patient story.

Mrs Needham advised of patient who had previously suffered a brain injury following a road traffic accident which had caused mobility issues.

The patient had fallen in the shower and had broken two bones. The patient firstly needed a splint then following a Consultant appointment a displacement fracture had been identified and the patient would need a cast. The patient was distraught over this however the Consultant was noted to have been 'fantastic' with her.

The patient had arrived 2 hours early for her follow up appointment due to her nervousness of travelling on the road at peak times. A nurse saw her waiting and moved her up in the queue which had meant a lot to the patient. She needed another x-ray and cast. Again the doctor was noted to be calm and delivered fantastic patient care.

The patient's family noted that they had witnessed the best patient care and how the patient had not been disregarded at any time.

Mr Farenden thanked Mrs Needham for the patient story. He reminded the Board that all issues raised in the patient stories are acknowledged and improvements are made if required.

The Board **NOTED** the Patient Story.

TB 17/18 159 Chairman's Report

Mr Farenden presented the Chairman's report.

Mr Farenden advised that he had attended a Chair and CEO meeting ran by NHS Providers. This had been held the day after additional funding for NHS had been announced. It was of noted importance that the financing of the NHS had been acknowledged.

Mr Farenden commented that he had found the Nursing Conference he had attended to be uplifting. The room had been focused on learning and the day had been successful.

Mr Farenden attended the Daisy Awards and met the founders of the Daisy Awards. The afternoon tea sessions had gone well and it was a good occasion.

Mr Farenden remarked that the AGM he had attended had been his last but had been the best one he had attended. There had been a good balance of both formal presentations and the opportunity for people to talk to the Trust Board members.

Mr Farenden informed the Board that NHSi had failed to make an appointment to the Chair post. He had hoped the advert would have attracted a high quality Chair.

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

TB 17/18 160 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart advised that the CQC System Review was now out in the public domain. The report is one of 20 targeted local system reviews that looked specifically at how older people move through the health and social care system, with a focus on how services work together.

Dr Swart stated that the review found there was a system-wide commitment to serving the people of Northamptonshire, but that services had not always worked effectively together for older people. The review related to all parts of the patient journey including how difficult it was once a patient was in hospital to then be discharged home as quick as possible.

Dr Swart reported that an action plan is required within 20 days. She had feedback that there are 150 fewer patients currently in hospital then in the winter with ongoing work to improve the situation. It had been decided to delay the action plan until a system wide decision is formally made regarding the upcoming winter.

Dr Swart noted that it is important that system works together and sticks by any decisions with fortitude. The Trust would support all efforts to get all teams to work together. The CQC system review had been presented to the Lords Select Committee last week.

Dr Swart advised that the CAMIS implementation had gone as well as expected which was likely due to the extensive planning period. The implementation had happened without any major disruption. The Trust had been able to report on its key targets and there was no patient harm noted.

Dr Swart discussed the NHS 70 celebrations with the Board. She had attended a celebration at Westminster and Mrs Needham had attended one at York Minster. They both had felt very privileged to have been there. Dr Swart commented that there needed to be more celebration events.

Dr Swart stated that a number of junior doctors had started today and that it had been a pleasure to speak to them. They were given their white coats with 'Doctor' on the back. Mr Metcalfe had also attended. The Junior Doctor handover was scheduled for week commencing 30 July 2018 and she noted the incredible effort from staff involved for this to happen all in one day.

Dr Swart commented that she had met the founders of the DAISY Foundation. The staff had appreciated this event and Dr Swart had felt lucky to be part of it.

Dr Swart reported the AGM on the 06 July had been a success.

Dr Swart informed the Board of the Virtual Assistant based on the Billing Road front door. This would be used to promote public health messages and also support staff.

Dr Swart shared with the Board that the Director of Nursing post had been recruited to, a Ms S Oaks who would be starting on the 01 September 2018 to have a month handover with Ms Fox. The Director of Governance post had also been recruited to, a Ms C Campbell.

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

TB 17/18 161 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe noted the recent maternity death SI. This had involved a nurse who had worked at the hospital and this had been traumatic for the staff involved.

Mr Metcalfe drew the Board to page 27 of the report pack and Consultant Job Planning. There had 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 had been due to challenges in Consultant engagement with the new medical model for the Nye Bevan unit.

Mr Metcalfe noted that there needed to be job plans fit to support emergency care this winter. There had been a consistency committee set up to support the Division and this involved the Medical Director, the Chief Operating Officer and the Director Of Finance. He hoped all job plans would be locked down by the end of August 2018.

Mr Metcalfe advised that on the 22 June 2018 with ECIP representatives in attendance, a meeting was held with Consultants from the Medicine division to update them on progress with recruitment of physicians to support the new medical model.

Mr Metcalfe stated that 7.1wte of the 7.8wte Consultants required on the new rota had been filled. This was noted to be positive.

Ms Gill remarked that this had been good progress on the medical model.

Mrs Needham commented on the winter plan. The winter plan would be coordinated by the A&E delivery board however highlighted the risk to the Board that due to the second Section 114 issued by NCC may see a significant impact to Social Care. Mr Farenden asked for the implications of this. He was informed that a meeting is scheduled for the 01 August where further information may be given.

Dr Swart is not entirely sure that there would be no government intervention.

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

TB 17/18 162 Director of Nursing and Midwifery Care Report

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

Ms Fox advised that the information within the Director of Nursing and Midwifery Care Report had been discussed at both the Quality Governance and Workforce Committee.

Ms Fox stated that in June 2018 the Trust achieved 99.03% harm free care (new harm).

Ms Fox reported that the Trust had improved and sustained its positive pressure ulcer position.

Ms Fox commented on Clostridium difficile Infection (cdiff). There had been 10 cases year to date with the most recent reported again in Surgery. All Post Infection Reviews (PIRs) are reviewed by the Clinical Commissioning Group (CCG) and to date there have been no lapses in care. Ms Fox remarked that the national picture is also showing an increase in cdiff incidents.

Ms Fox confirmed that she would be bringing a paper to the Quality Governance Committee in August detailing the actions in place to address the increased cdiff incidents. Mr Farenden queried why it had become a national issue. Ms Fox stated that Public Health England had struggled to identify a reason. There is possibility it could be linked to the Tacozin shortage and the increased elderly population who require multiple antibiotics in the community.

Ms Fox advised that there is a ward based training programme in place as well as a very robust post infection review process. There are no environmental concerns and the Trust now needed to look at antimicrobial prescribing. If this continued there is a possibility that some clinical areas would need to be fogged and this could impact on patient flow.

Mr Metcalfe stated that anti-microbial stewardship would be looked at.

Ms Houghton suggested that the Trust invited the Infection Control lead at NHSI (Ms D Adams) to carry out an internal review. Ms Fox believed that this would take the Trust down the incorrect route. Ms Adams is aware of the situation and the actions

taken by the Trust.

Ms Houghton asked how close the CCG worked with the GPs in the community on this topic. Ms Fox stated that the CCG had been made aware of the prescribing issue in the community and would be reviewing proton pro-inhibitors. The GP lead is also well sighted.

Ms Fox noted the increase in falls of low harm. There is ongoing work to address this.

Ms Fox drew the Board to page 51 of the report pack. There is recruitment underway of maternity support workers.

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

TB 17/18 163 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that the month 3 financial position showed a year to date positive position of £35k. This is deterioration from the £1.2m ahead of plan seen in month 2. The main reasons for the variance are income c.£200k below recent trend, £1.2m due to the first quarters phasing of the £4.6m system financial gap and pay above trend by c£400k.

Mr Bradley stated that income is down by c£200k and pay is up by c£400k. The income issues had arisen following CaMIS implementation particularly in outpatients and issues around maternity data which are being addressed.

Mr Bradley reported that £9.7m of the options to address the system gap should be proceeding though the CCG and NHFT governance processes to ensure that £2.3m of the £4.6m gap can be contractualised by the end of the month. The remaining £2.3m would be a challenge and is back to the system providers to address.

Mr Bradley advised that pay overspend in month had been a concern. A total of £165k was related to bank holiday payments from May which had impacted more heavily due to the pay budgets phased in twelfths. Mr Bradley remarked that growing spend on medical locums is also worrisome as this had pushed agency spend by £121k above the agency cap.

Mr Bradley remarked that 29 cost centres had overspent by 10% or more for three consecutive months. There are meetings in place to address this with attendance from the COO, the Director of Finance and CEO. An update would be presented to the August Finance Investment and Performance Committee.

Mr Bradley expressed his concern that the delivery of recurrent CIPs in the first quarter had been £1.2m which is less than a tenth of the annual requirement. The current recurrent forecast is £8.2m which is still not a confirmed level of achievement and it is it is still £6.2m below the level required and therefore puts the 2019/2020 finances at risk. Mr Bradley had asked NHSI for some good examples of CIPs.

Mr Bradley advised that PSF funds for Q1 are included however there still remained a risk relating to the £414k for A&E. The Board were informed that Trust had now successfully appealed the £414k since the distribution of this report.

Mr Bradley stated that the Agenda for Change wage award funding notification had been received last week. There had been some issues with a few members of staff who had not noted that the Agenda for Change wage award would push them into a higher pension contribution banding.

Mr Bradley commented that the Doctors wage awards had been announced. He informed the Board that for each 1% the cost to the Trust was £600k and at this time only the base 1% uplift is funded The BMA want an equivalent incremental change as experienced through the Agenda for Change wage award.

Mrs Needham commented on the dip in clinical income in outpatients. This income is likely to improve as the Directorates are now working through their backlog of data input following the PAS changeover.

The Board **NOTED** the Finance Report.

TB 17/18 164 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the Trust's substantive workforce is at 87.35% of the Budgeted Workforce Establishment. It was noted that Annual Trust turnover for June 2018 decreased by 0.08% to 7.43%, which is below the Trust target of 10%. Mrs Brennan stated that the overall Trust vacancy rate for June 2018 is 12.65% against a Trust target of 9%.

Mrs Brennan commented that sickness absence for June 2018 increased from 3.96% to 4.39%, which is above the Trust target. It was noted that this level of sickness absence was unusual for this time of the year.

Mrs Brennan drew the Board to page 72 of the report pack. The top five reasons for sickness absence in terms of days lost are detailed within table. The top reason for sickness was 'Anxiety/stress/depression/other psychiatric illnesses' which caused Mrs Brennan concern. The Trust continued to work on supporting mental health & wellbeing.

Mrs Brennan stated that as at June 2018 there were 51 IELTS cleared Indian Nurses awaiting NMC decision letter. Between April and June 2018 a total of 21 offers were made to overseas nurses and 5 overseas recruits had arrived from India.

Mrs Brennan reported that between April 2018 and June 2018 a total of 16.89 WTE nurses started work in core and specialist areas. There had also been a total of 8.80 students start work in these areas.

Mrs Brennan informed the Board that between April 2018 and June 2018 nursing capacity saw a net increase of 16.35 WTE. Mrs Brennan noted that this was the first time she had seen a net increase and the vacancy factor to be this low.

Mrs Brennan discussed Nurse Recruitment initiatives with the Board. This included Trust-wide recruitment fairs and increased presence on social media.

Mrs Brennan advised that the HR and Nursing teams had come together to refresh the Recruitment and Retention Strategy. This included working with University of Northampton to agree numbers by out- turn, an advertising campaign to attract male nurses and a recruitment Pop Up Tour (battle bus).

Mrs Brennan reported that retention is structured around the themes of Best possible start, career and retire. These are listed on page 75 of the report pack.

Mrs Brennan commented that Appraisals, Mandatory Training and Role Specific Essential Training compliance recorded for June 2018 had increased. It was noted that Role Specific Essential Training had been just below the Trust target.

Ms Houghton remarked that the turnover figures were fantastic however noted her concern on sickness rates. She was surprised to see Estates & Facilities so high.

Mrs Brennan advised that this rate was not unexpected for thos occupational groups.

Ms Houghton asked for a further explanation on resilience training. Mrs Brennan stated that the Trust had signed the 'Time to Change' pledge last year. There had been mental health awareness workshops and managers had been given training to help support staff with mental health issues. There is also a funding request submitted to the charity for a psychological wellbeing therapist.

Dr Swart commented on the importance of getting the right support for staff. She is due to meet the new CEO of St Andrew's Healthcare on how services could be shared across the two providers. The Trust needed to invest in this somehow to help staff respond to individuals with mental health issues better.

Ms Gill queried that age profile of the staff of with stress related sickness. Mrs Brennan was unsure and confirmed she would look into this.

Action: Mrs Brennan

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

TB 17/18 165 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that A&E performance was above the trajectory that the Trust had submitted to NHSI. It is currently at 92.6% for July. She reported that July had started well however had recently slipped due to a difficult weekend in A&E with high first assessment & an increase in stranded patients.

Mrs Needham informed the Board that A&E performance year to date was at 90.3% with an increase of 8% in A&E attendees. This time last year performance was at 87.4%. It was noted that DTOC was still higher than the Trust would want.

Mrs Needham shared her concern on the 62 day standard and 2ww for cancer. This had been discussed at the Finance Investment and Performance Committee. It was noted that lack of recruitment to certain posts had affected these targets. There is slow support from tertiary providers and a significant lack of capacity internally for some specialities.

For 2ww Breast, Mrs Needham reported that there had been an increase in performance in May however this had declined in June. A consultant is on long term sickness and this post had been unable to be backfilled. The Trust would be looking at outsourcing some Breast work.

Mrs Needham stated that the deputy COO chaired the daily PTL. She advised that next week every patient from day 7 (previously day 30) would be discussed.

Mrs Needham commented that a new way of working is to be piloted in Urology. There is a one stop shop for the Prostate patients.

Ms Gill queried whether the recent maternity death had impacted on C-section performance on the scorecard. Mr Metcalfe stated that maternity death had not influenced C-section performance. The change in this performance is due to changes in the NICE guidance and an increase had been noticed nationally. This is managed in CQEG which feeds into the Quality Governance Committee.

Ms Gill asked if the number of ward moves in month had influence the increase in

patient falls. Ms Fox believed that this was not linked. The patients are encouraged to mobilise to prevent deconditioning. She would be concerned if the falls were over bed rails.

Mr Metcalfe delivered a further update on Cancer. The Cancer STP had submitted a refined and improved bid to the Cancer Alliance. This is to improve the diagnostic part of a complex patient's pathway and also looking at pathway management.

Dr Swart discussed the national programme of Cancer in the UK. The UK needed to do more to diagnose patients more quickly. This included ideas of more efficient testing and scanning.

Mr Pallot noted the comment on page 101 of the report pack which stated that Stranded and Super stranded numbers had reduced by >25% in 6 weeks. He asked how this matched the trajectory which the Trust had been set. Mrs Needham advised that the Trust had been the 4th worst performing in this area for super stranded patients. Since 2 weeks ago the Trust met the target and had made really good progress. It could now be a challenge to sustain this.

Mr Archard-Jones queried if there were metrics to measure whether a discharged patient is readmitted within a certain timeframe. Mrs Needham commented that the readmission rate had reduced in June.

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

TB 17/18 166 Annual Health and Safety Report

Mr Finn presented the Annual Health and Safety Report.

Mr Finn stated that compliance rate achieved for quarterly H&S inspections for each Division and area had failed to meet the 87% target. He commented that the H&S representatives had changed and hoped that this would drive increased compliance.

Mr Finn advised that of the 12 policies all were in date at the end of the year 2017/18.

Mr Finn noted that the 85% training target had just been missed and sat at 84.2%.

Mr Finn reported that the Corporate COSHH (474) risk had 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 had moved from a monthly meeting to a quarterly meeting.

Mr Finn commented that RIDDOR had remained static with no key themes identified.

Mr Finn advised that incident reporting had reduced by 0.5% on the previous year. It was noted that 'Physical abuse, assault or violence, and unpredictable patient behaviour' remained the highest reported category. He stated that Conflict resolution training continued to increase from 67% to 83%.

Mr Finn commented that the Medical Gases Committee had been chaired by the Deputy Medical Director and a new chair had now been found.

The Board **NOTED** the Annual Health and Safety Report.

TB 17/18 167 Infection Prevention Control Annual Report

Ms Fox presented the Infection Prevention Control Annual Report.

Ms Fox stated that there was a legal requirement to present this report to the Board.

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

TB 17/18 168 STP & Unified Model with KGH Update

Mr Pallot delivered a STP & Unified Model with KGH Update.

Mr Pallot advised that there was no recent paper from the Delivery Support Unit to be shared with the Trust Board on this occasion.

Mr Pallot reported that he and other colleagues from the Trust had attended a STP development day which had discussed the workstreams within the STP and confirmed that the Unified Acute Model, Primary, Community and Social Care and Urgent Care were the priority areas. A key element of the discussion had been the resource provided to supporting the workstreams and this was an area of concern for Mr Pallot. A paper is to be submitted to the DSU week commencing 30 July 2018 to confirm the resource request for the workstream.

Mr Pallot stated that there had been a positive clinical meeting with Leicester to discuss SEMOC. He hoped that this would be moving forward in the right direction.

Mr Farenden queried what had influenced the change of perspective with Leicester. Mr Pallot commented that the Oncologists were advised that they needed to lead and drive this. There would be a focus on honary contracts. The tumour sites would be looked at to see where the need for speciality skills is needed and it would provide an opportunity to standardise how Consultants work i.e. clinic templates would be the same.

The Board **NOTED** the STP & Unified Model with KGH Update.

TB 17/18 169 Equality and Diversity

Mrs Brennan presented the Equality and Diversity Reports.

<u>E&D Workforce Annual Report 2016/2017</u>

Mrs Brennan advised that if this report was endorsed by the Board it would be published on the Trust's website.

Mrs Brennan commented on the 'Supporting Our Staff to Breastfeed' campaign. She noted this included running workshops for pregnant members of staff.

Mrs Brennan reported on the Workforce Race Equality Standards (WRES). The areas highlighted to the Board were discrimination at work and the number of staff reporting harassment. The Respect & Support campaign would be addressing these.

Mrs Brennan stated that the Respect & Support campaign had been launched on the 25 June 2018. There had been good attendance at this event.

Mrs Brennan advised that the Gender Pay Gap information had been reviewed by the Workforce Committee and was consistent with other Trusts across the country.

Mrs Brennan drew the Board to page 104 of the report pack which detailed mental health. The 'Mind Your Head' event had taken place in October with over 250 attendees. There had also been a 'Time to Talk Day 2018'.

<u>E&D Workforce Monitoring Report 2016/2017</u>

Mrs Brennan drew the Board to page 219 of the report pack and the Sickness Absence Analysis. The biggest cohort of staff sickness sits within the 26 – 30 year

group.

Mrs Brennan commented that the distribution of disciplinary cases appeared higher than expected for men (39%) against the 79.02% female and 20.98% male split in the Trust. This would be monitored by HR Business Partners.

The Committee **NOTED** the Equality and Diversity Reports and **ENDORSED** the E&D Workforce Annual Report 2016/2017.

TB 17/18 170 Highlight Report from Finance Investment and Performance Committee

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

TB 17/18 171 Highlight Report from Quality Governance Committee

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

TB 17/18 172 Highlight Report from Workforce Committee

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

TB 17/18 173 Highlight Report from Hospital Management Team

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

TB 17/18 174 Any Other Business

Ms Fox advised that Ms Ruth May (Executive Director of Nursing for NHSI) had recently visited the Trust to gain an understanding of the work done at NGH. She spent 2 to 3 hours looking at a showcase of work. It was reported that she would be looking at potentially mandating similar schemes nationwide.

Date of next Public Board meeting: Thursday 27 September 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	08/08/2018
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
89	Jul-18	TB 17/18 164	Workforce Performance Report	Ms Gill queried that age profile of the staff of with stress related sickness. Mrs Brennan was unsure and confirmed she would look into this.	Mrs Brennan	Sep-18	On Agenda	
Actions - Future meetings								
NONE								

Report To	**Public Trust Board**
Date of Meeting	**27 September 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
27 September 2018

Chief Executive's Report

1. Associate Teaching Hospital

Following discussion with the College of Life Sciences at the University of Leicester it has been agreed that NGH will be designated as an Associate Teaching Hospital. Approval has been given to us using the Associate Teaching Hospital designation and University of Leicester logo.

It is not proposed that the University of Leicester Associate Teaching Hospital logo will appear on all trust signage and documentation. The first consideration should be where this will add value and secondly, where it is appropriate and will not lead to confusion. The affiliation with the University of Leicester does not change the name of the trust and trust signage will not be amended to incorporate the new logo. However, the new logo will be applied to our headed stationery, board reports, presentations, publications, websites and social media such as LinkedIn.

Existing stocks of stationery will be used up, and new orders will include the Associate Teaching Hospital logo where appropriate. Work is now underway to develop brand guidance and usage for staff prior to the new logo being widely used and available to trust staff from 1 November 2018.

Alongside this formal change in trust signage and documentation there is ongoing work to ensure that we work in partnership with the University of Leicester in order improve the focus on education and research and develop shared posts to signal these improvements in academic focus.

2. Local Health Economy Update

Through the Health and Care Partnership and with the support of system leaders there has been significant work to ensure that we go into this winter with a set of plans that ensure that our patients and staff will have a better experience of emergency care. This has involved our joint support for a system demand and capacity plan and our joint support for the implementation of a series of schemes to ensure that our hospitals run at more efficient occupancy levels and our patients are helped where possible to stay at home or to be discharged to community settings where this would be the best option. This will go alongside our own extensive internal focus on keeping patients safe and improving quality and efficiency of care. This work is very much an extension of work in place over successive years but the collaborative approach which is critical to its success does bear the hallmarks of much improved system working**.**

3. Our patients

During August our cardiology team treated the 4000th patient in our Heart Centre. The facility is highly regarded by our patients and staff and the story of our 4000th patient will feature in the next issue of Insight, our hospital magazine.

When someone has a stroke it is important they receive fast emergency treatment from expert staff in specialist facilities in order to get the best possible health outcome. For many years now all Northamptonshire patients suspected of having a stroke are brought to NGH for their emergency treatment. The majority of stroke patients went to receive their ongoing care at NGH, whilst a small number living in north of the county were transferred to Kettering General Hospital (KGH) if appropriate after receiving emergency care at NGH.

In order to ensure all patients living in Northamptonshire receive the same level of care from a hyper acute and acute stroke unit, from the end of August 2018 all stroke patients will receive care at NGH until they are ready to return home. In this way we can ensure they get the maximum benefit from the specialist facilities and highly-trained staff, thereby reducing death rates and long-term disability from strokes. At the same time there will be investment in community stroke services to support all patients when they are ready to go home.

Any stroke patient currently receiving outpatient services at Kettering General Hospital will continue to do so, although the KGH outpatient clinic is relocating to Fotheringhay Outpatients Unit in the main block.

KGH will also continue to provide outpatient follow-up care and treatment for Transient Ischemic Attack (very minor strokes).

4. Our staff

Respect and Support Campaign

We have recently been successful in securing funding from NHS Improvement, who are interested in showcasing our Respect and Support Campaign across the wider NHS. The funding will allow us to progress the programme in a timely manner as well as bring subject matter experts into NGH to support our initiatives.

Since the launch of the Building Resilience training in July, nearly 100 members of TeamNGH have attended the training. Feedback has been positive, with staff saying they have been provided with a range of skills and knowledge to help them cope better with their day-to-day pressures.

Around 100 managers and clinical leaders attended recent Leading with Respect training and approximately 100 staff are due to attend training in October on how to challenge bullying and inappropriate behaviour. Both training programmes include practical ways in which delegates can help promote our core values as well as support to address workplace bullying and harassment. More programmes have been arranged in November and January, which are already becoming booked up.

Everyday Hero Awards

Building on the success of our Winter Heroes Awards earlier this year and the DAISY Awards for nurses and midwives, we are launching our NGH Everyday Hero Awards for all clinical and non-clinical staff who are not nurses or midwives.

The Award is aligned to our core values underpins our vision of providing the Best Possible Care. We believe the Award will help to raise morale along with the profile of NGH as an organisation where staff are valued and their commitment is recognised and rewarded.

Twelve Awards will be presented each year, on a quarterly basis (three per quarter). All unsuccessful nominees will receive a certificate of nomination, a thank you card from the Chief Executive and a copy of their nomination.

NGH Everyday Hero Award recipients will receive:

- A surprise presentation, by a member of the selection committee, organised with the area manager
- The recipient will receive the Everyday Hero enamel badge, a certificate, a copy of the nomination, a basket of fruit and a gift experience
- Award recipients will be featured in internal communications, on the website and social media accounts

Everyday Hero Award recipients will feature on our NGH ‘wall of fame’ on the hospital street.

All Everyday Hero promotional and gift collateral will include the charitable fund logo to help raise awareness of the charity, which is helping to support our Awards. The Awards are also being funded through our communications budget, which will cover the cost of all print, copy and marketing collateral (signage, leaflets, certificates, wall of fame installation and photographs). Our health and wellbeing budget will fund provision of a basket of fruit for Award recipients.

Long Service Awards
December will see us celebrate and recognise those members of TeamNGH who have 25 years' continuous service at NGH. This year we are taking the opportunity of introducing new categories of long service, with commemorative pins being awarded to those staff who have achieved 30 and 35 years' continuous service at NGH and a 40 year pin for those who have achieved 40 years' NHS service.

Flu Vaccination
Our annual flu vaccination campaign starts in earnest on 8 October, with our flu clinics in the cybercafé. All staff being vaccinated will receive a voucher entitling them to a free lunch to the value of £4 in either the main restaurant or Cripps No3@Cripps, valid from 1 October 2018 until 28 February 2019.

NHS Improvement has announced that all frontline NHS staff are expected to get vaccinated to protect patients as part of a new plan for winter. We are aiming to build on the success of last year's campaign, which saw more than 76% of staff being vaccinated.

Health and Wellbeing
Members of Team NGH recently took part in the fifth annual Workplace Challenge Business Games. Organised by Northamptonshire Sport, the games saw Team NGH compete against 19 other businesses from across the County in a series of sporting activities including cycling, athletics, walking football, archery and a team challenge. Although they did not win the event helped break down barriers across professions, support the development of TeamNGH and generate a shared purpose.

A range of initiatives have been introduced to help staff improve their physical and mental health, including cervical smear tests, blood pressure checks, mindfulness training and mental health awareness and training workshops. The recent blood pressure checks were attended by more than 100 members of staff, 22 of whom were referred to their GP.

Our menopause workshop has proved to be one that has filled the quickest, and staff have expressed their appreciation of the work we are doing to support them. Staff attending the mental health first aid workshop will be issued with a green enamel pin badge which identifies them as someone whom colleagues can approach for help, advice and support.

To date 338 staff have taken part in mental health awareness training from MIND, 40 have taken part in a mindfulness taster session and 56 have attended our lunchtime yoga class. Demand for future, similar events is high and most are already fully booked.

5. Our stakeholders

Healthwatch
Young Healthwatch Northamptonshire is a local group for young people to have a say on health and social care issues. It allows them to have a say and make their voices count.

Following their relaunch in October 2017 Young Healthwatch Northamptonshire have been involved in a number of projects, including development of the NHS Go app, which provides free/confidential health advice and local services for young people.

Members of Young Healthwatch Northamptonshire have been involved in helping us improve our services to young people. In October 2017 they came to look at our children's wards from the perspective of a young person. The visit was a great success and their final report included recommendations for improvements and areas of good practice. To quote from their report *'Overall the children's wards in Northampton General Hospital were welcoming and safe. All the areas we visited were clean and well organised. Space on the wards was utilised well. They appeared to provide a good level of care and there were safety measures in place to safeguard the patients on the wards. The staff seemed happy and friendly. The patient and set of parents we talked to spoke well of their experience of the ward. The children's wards seem to listen to the patients and staff to make improvements for future patients.'*

6. NGH in the news

BBC Radio Northampton

Staff from NGH helped to support BBC Radio Northampton's Helen Blaby last week as part of Helen's Big Health Check - a series of events providing free health advice and checks from a range of different providers. A number of Team NGH departments and services were involved, including breast cancer screening, mouth cancer, abdominal aortic aneurysm screening and our pharmacy department, attending free events at Daventry, Rushden and Northampton.

Nye Bevan Building

The Nye Bevan Building has been the subject of significant media interest and we have worked with the media to explain to our local community the rationale and purpose of the new build, as well as communicating practical matters such as internal road closures and traffic diversions.

A media day has been organised to take place the week prior to the building accepting its first patients. This will provide a rare opportunity for media access to emergency facilities without the usual concerns around patient confidentiality and disruption to service delivery. The event takes the form of a guided tour with opportunities for interviews with senior leaders and representatives of the different professional groups who have worked together to develop new models of care, including nursing, medical and therapies.

Media attending include BBC Look East, Anglia News, BBC Radio Northampton and the Chronicle & Echo.

In addition to the media day the communications team have arranged for seven opportunities for staff to be shown around the Nye Bevan building before it opens. These events have been well received and most are fully booked.

Care Quality Commission

NGH features in the recent CQC report that explores how a number of high performing trusts have used a systematic approach to quality improvement to ensure better patient outcomes and performance. This report highlights what trusts have told the CQC about their experiences of using QI as a systematic approach to improving service quality, efficiency and morale. Using the words of hospital staff and case studies, including quotes from myself and Jane Bradley, the report identifies successful initiatives to share learning with other trusts and inspire those who may be considering adopting a QI approach.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 September 2018**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Presenter of Report	Mr Matt Metcalfe
Author(s) of Report	Mr Matt Metcalfe – Medical Director
Purpose	Assurance
Executive summary	
Related strategic aim and corporate objective	
Risk and assurance	
Related Board Assurance Framework entries	
Equality Analysis	
Equality Impact Assessment	
Legal implications / regulatory requirements	
Actions required by the Trust Board The Board is asked to note this report.	

Medical Director's Report

27th September 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

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.

There has been good progress with the clinical teams towards implementing a model with patient care delivered earlier by consultants with more continuity and less reliant on locum staff. In particular the time commitment and rota required to support the model are largely accepted, and the individual services are working though the detail of how to mitigate the gaps which would otherwise appear in the delivery of elective commitments including cancer.

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.

All 8 of the additional consultants required to support the Nye Bevan medical model have been recruited. Across the organisation over the last 12 months the work of the medical recruitment strategy led jointly by the medical and HR directors has begun to deliver meaningful improvements in consultant numbers of 8.5%.

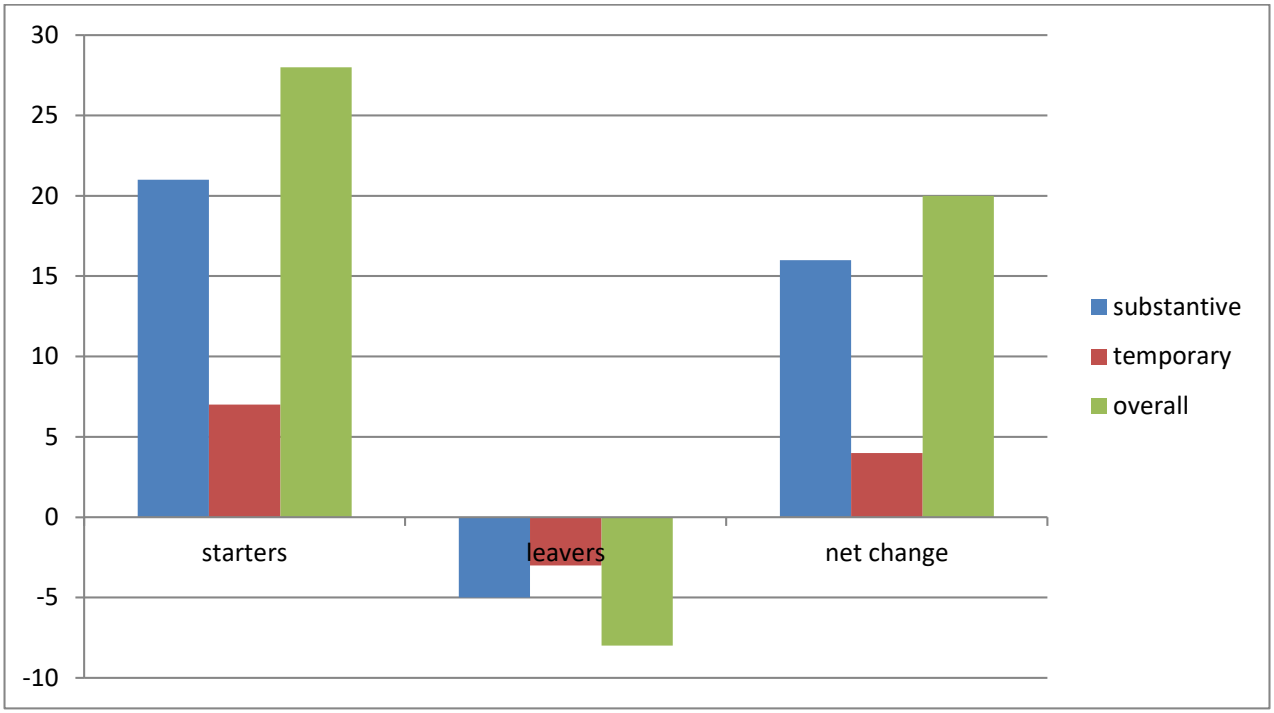


Figure 1. Change in number of consultants employed at NGH over last 12 months

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	14
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 July and August. These are on track to report by their deadlines and are summarised in the following table;

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Location	45 day completion date
W-88280	Acting on chest X-Ray result	ED	04/09/2018
2018/14152 W-90454	Decision making around surgery	Hawthorn	04/09/2018
2018/14552 Complaint 415	Testicular torsion	ED	25/09/2018

2018/19860 W-91868	Care prior to Peri-arrest	Rowan	17/10/2018
2018/20376 W-88776	Delay inserting PEG	Collingtree	30/10/2018

There have been no further Never Events.

During July and August 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.

10 moderate harm incidents were detected during July and August, and these are subject to concise RCA investigations. This is a significant reduction from the previous 2 months (17) and due to a new threshold for concise investigation being introduced. Specifically, a third test has been introduced to the original two. The tests are;

i. Was there moderate or severe harm to the patient?
ii. Was this potentially avoidable (ie due to lapses in care against defined standards)?
iii. (new) following preliminary gathering of the facts, is a formal concise RCA process likely to uncover more learning than already gleaned?

Alongside this change, it has been agreed by the Review of Harm Group that where moderate or severe harm is suffered by a vulnerable patient then the threshold will be lowered to, in essence only the second question, in order to address concerns regarding diagnostic overshadowing and compliance with the requirements of the mental capacity act.

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 response to these are taken forward through the deteriorating patient board, meeting next in October.

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 in the expected ranges. Although sepsis mortality remains raised, this demonstrates an improving trend. Acute and unspecified renal failure has improved such that it no longer triggers an outlier alert.

Indicator	Rolling year	Comments
HSMR	104	
Diagnoses-All	101	
HSMR weekend	103	
HSMR weekday	100	
SHMI	98	Jan 17 - Dec 17
Acute and unspecified renal failure	125	High risk diagnosis No longer raised
Acute cerebrovascular disease	82	High risk diagnosis
Acute Myocardial infarction	95	High risk diagnosis
Congestive heart failure	100	High risk diagnosis
#NOF	118	High risk diagnosis
Pneumonia	87	High risk diagnosis Significantly lower
Sepsis	133	High risk diagnosis Significantly raised
Low-risk groups	93	
HSMR Palliative care coding	2.3%	National 2.4%
Charlson Comorbidity '0'	46.9%	National 48.6%

4.2 New Mortality Alerts/Significant Variation under review

Urinary tract infection (UTI) has now triggered as an outlier alert. It is important to note that mortality is coded against the primary recorded diagnosis *on admission*. UTI is almost never a reason for admission, but is often documented as a medical reason for admission for the social admission of frail elderly patients. An admission diagnosis of UTI is therefore effectively a surrogate marker for frailty.

Alongside this, UTI is very rarely a true cause of death. However, mortality rates are reported against the recorded diagnosis on admission, not the true cause of death (as is more accurately recorded on the death certificate). Since UTI is rarely a cause

of death, in statistical terms the *expected* mortality among patients with UTI on admission so an increase in *observed* mortality cases coded as UTI triggers readily. The majority of deaths attributed to UTI have occurred in patients aged over 75 years.

4.3 Trust wide mortality review

Whilst the trust wide mortality indices remain within normal range, there has been a gradual drift towards increased mortality rates. Whilst not statistically significant the medical director's office will be coordinating a trust wide mortality review of 200 consecutive in hospital deaths, using a validated structured judgement review tool.

This will have two main purposes. Firstly to identify any themes which signpost opportunities to further improve the quality of care for patients. Secondly to identify issues relating to inappropriate coding which may artefactually adversely impact the trust's standardised mortality rates.

This is a significant and time-consuming undertaking and will likely report back to QGC in January 2019.

Medical workforce

4.4 Consultant Job Planning

There have been significant 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. These delays have been addressed through a series of meetings, service by service, between the consultants and the directorate management team. The meetings have been directly supported by the divisional leadership team, the chief operating officer and the medical director.

These meetings have been positive, with the following features in common;

i. Acceptance of the need for and time commitment for the new medical model in the Nye Bevan building.
ii. Legitimate concerns about the need to backfill the elective activity displaced by the need to commit more time to the emergency medical model.
iii. Constructive engagement and joint ownership of appraising options to address the concerns.

Executive consistency committee (ECC) meetings have been commenced with the WCOH division and their directorates to support timely progression of the process. The process, together with timeline for it in each division, have been shared with the clinical leadership teams and consultants via publication on the intranet. ECC Meetings with Surgery division will commence in October.

4.5 Medical model for Nye Bevan

The mew model with significantly increased consultant commitment to emergency medical care has been delayed to allow resolution of the issues listed above. No time limit has been set for this however it is anticipated, given the constructive engagement from consultant colleagues, that the new model can be run by the beginning of quarter 4.

In the meantime a detailed SOP for the new medical model has been completed, and point of care simulation sessions are running in the completed building with multidisciplinary teams to facilitate the transition.

5. Thrombosis

The recording first assessment for venous thromboembolism (VTE) within 14 hours remain low. It appears that this reflects primarily a recording issue rather than a care delivery problem, as a recent audit of inpatient wards found that of those patients without a recorded 1st assessment within 14 hours, 92% were in fact receiving prescribed thromboprophylaxis (preventative treatment to prevent clots forming). As there are always a small proportion of patients for whom prophylaxis is not appropriate (for example if they are in hospital due to a bleeding stomach ulcer).

Further assurance maybe derived from the observation that the rate of hospital acquired thrombosis (HAT) has not increased, nor has the rate at which HAT are deemed preventable upon root cause analysis (performed for all HAT).

Nevertheless further improvement work is necessary to improve compliance with NICE guidance relating to the recording of 1st assessment of VTE risk. The medial director's office is leading an enhanced programme to drive this, the key elements including patient and doctor communication, education, facilitation (IT) alongside an intensive support and intervention on inpatient wards. The long term strategy remains "forced" first assessment through the electronic prescribing system.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**September 2018**

Title of the Report	**Director of Nursing, Midwifery & Patient Services Report**
Agenda item	**9**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Natalie Green, Interim 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 August 2018 the Trust achieved 98.28% harm free care (new harm). Overall harm free care was 91.96%.
- **Maternity Safety Thermometer**: In August 2018 the proportion of women and babies who experienced harm free care (physical and Womens perception of safety) was 75.6%, which is slightly above the national aggregate of 73.3%
- **Pressure Prevention**: 9 patients developed a total of 11 category 2 pressure ulcers, no category 3 pressure ulcer, and 6 DTI validated during the reporting period of August 2018.
- **Infection Prevention**: Reported separately
- **Falls:** In August 2018 there were 2 moderate harm patient falls and 1 severe harm patient fall. All incidents have had Initial assessments completed and reviewed by the Review of Harm Group. No further level of investigation was required.
- **Friends and Family Test (FFT):** In August 2018, 91.7% of patients said they would recommend the Trust.
- **Avery and Dickens Therapy Unit (DTU):** There was 1 x grade 3 pressure ulcer reported at DTU and 1 low harmful. At Avery in August 2018 there were no pressure ulcers reported and 5 no harmful falls and 2 low harm falls.
- There is an update on the Midwifery, Nursing and Midwifery Dashboards
- **Safe Staffing**: Overall fill rate is 98%.

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
September 2018

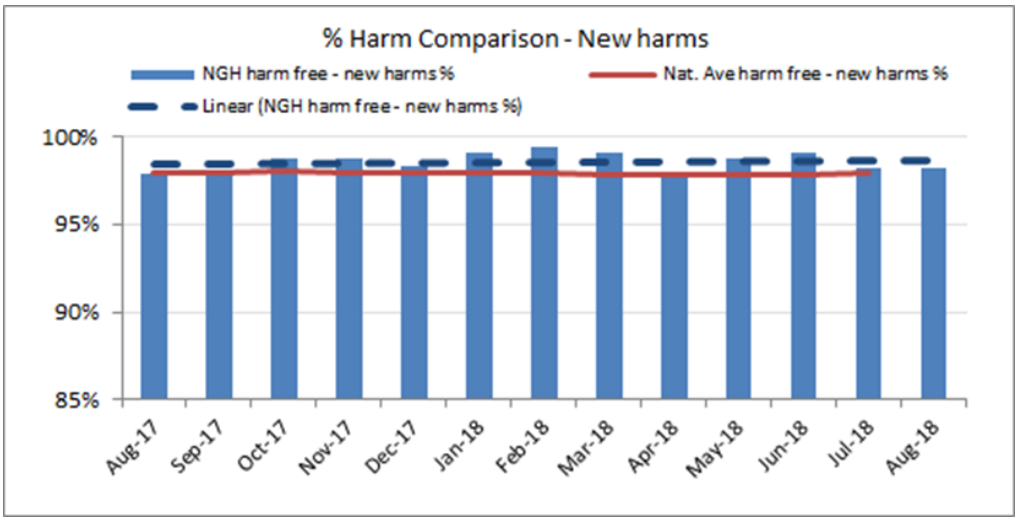
Director of Nursing, Midwifery & Patient Services Report

1. Introduction

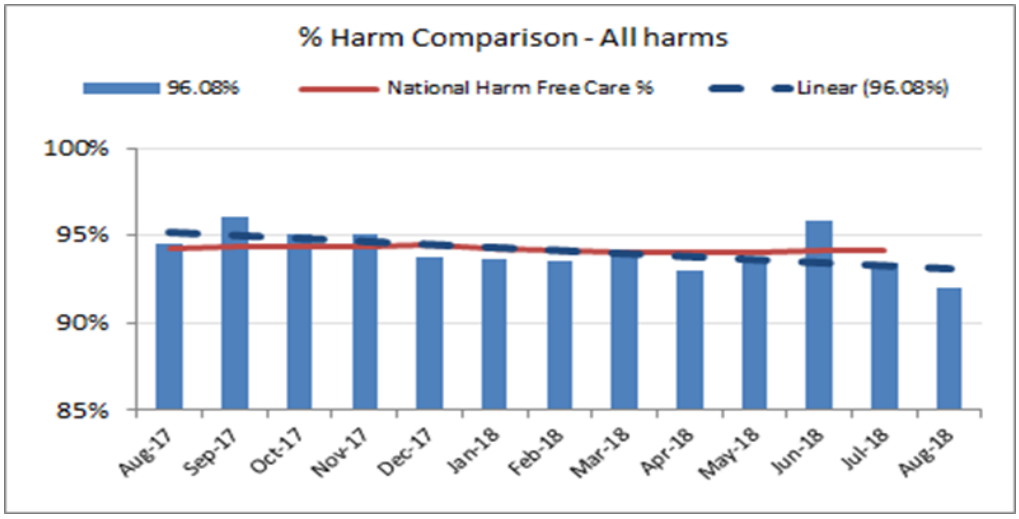
The Director of Nursing, Midwifery & Patient Services Report presents highlights from services, audits and projects during the month of August 2018. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' 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 August 2018, the Trust achieved 98.25% harm free care (new harm); a slight increase from July 2018.



The graph below illustrates overall harm free care was 91.96% in August 2018, a decrease from July 2018 all harm figures. (Appendix 1 provides the National Safety Thermometer Definition)



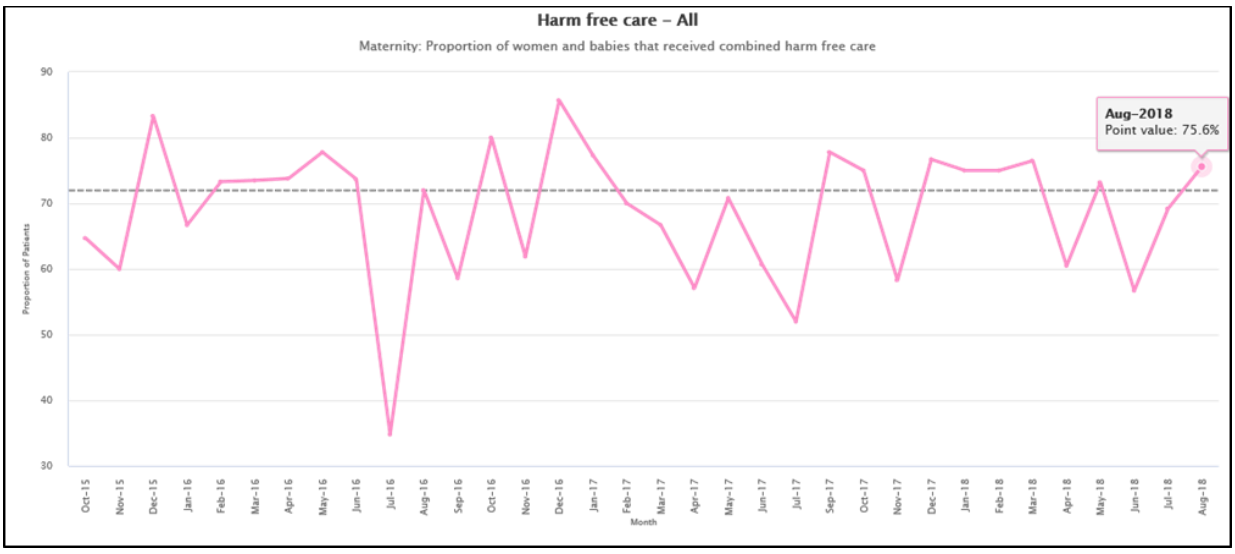
3. Maternity Safety Thermometer

The Maternity Safety Thermometer enables the calculation of the proportion of women and babies who received harm free care. The numerator is defined as the number of women in whom all of the following harms are absent:

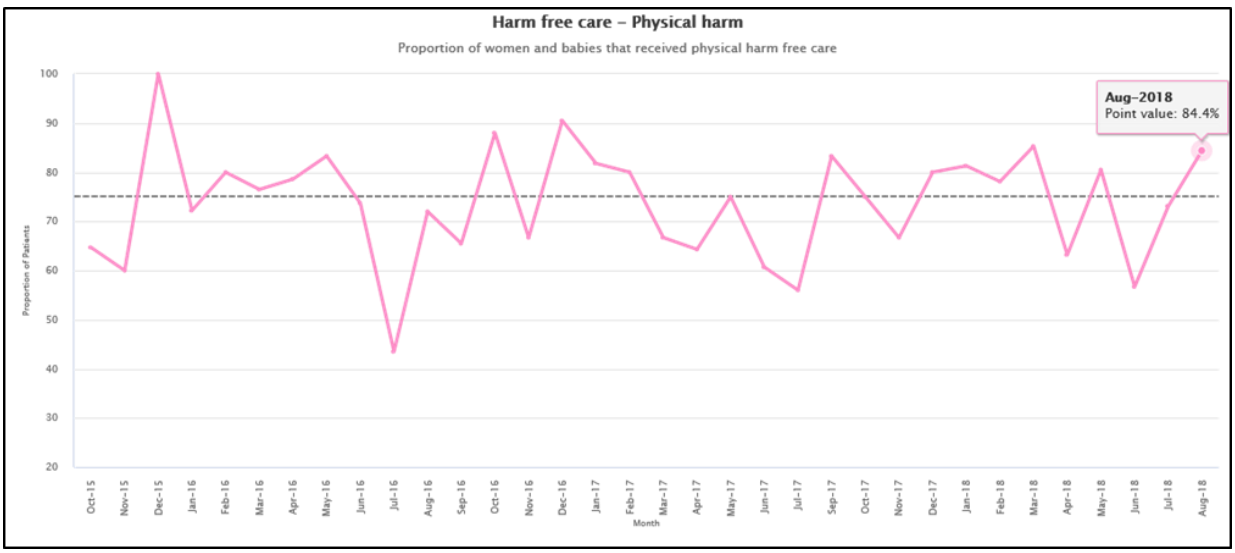
Physical 'harms':
- Maternal infection
- 3rd/4th degree perineal trauma
- PPH of more than 1000mls
- Babies with an Apgar less than 7 at 5 Minutes

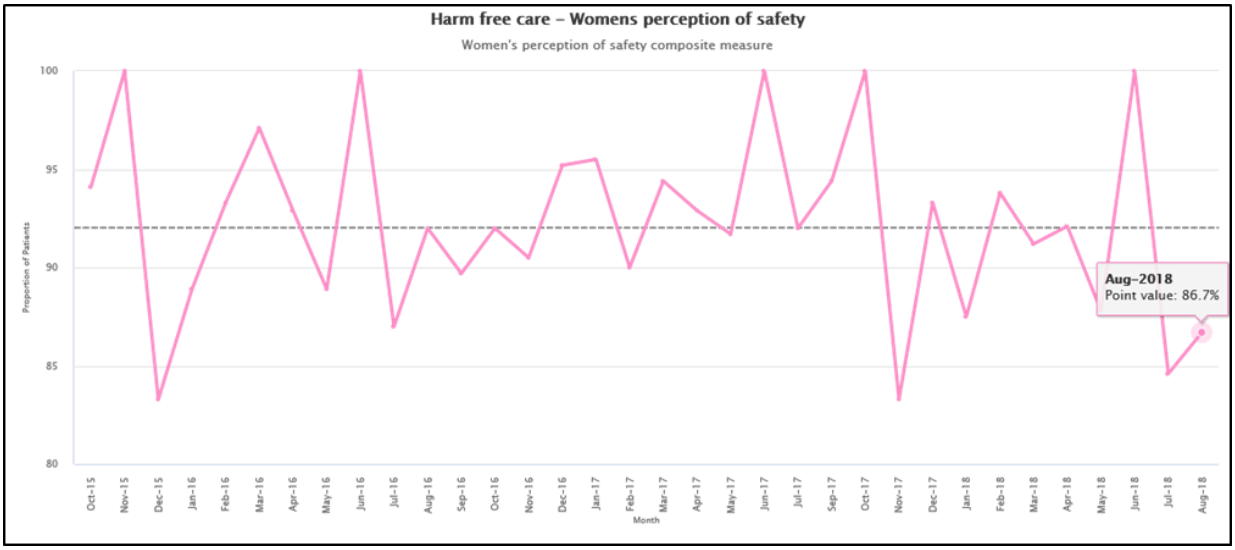
Psychosocial Questions:
- Mothers left alone at a time that worried them
- Concerns about safety during Labour and Birth not taken seriously

The following graph illustrates that the overall percentage of women and babies who received 'harm' free care in August 2018 was 75.6% which is slightly above the national aggregate of 73.3%.



The following 2 graphs show the percentage of harm free care associated with physical harm and psychosocial harm (women's perception of safety), both of which have demonstrated an increase in August 2018.





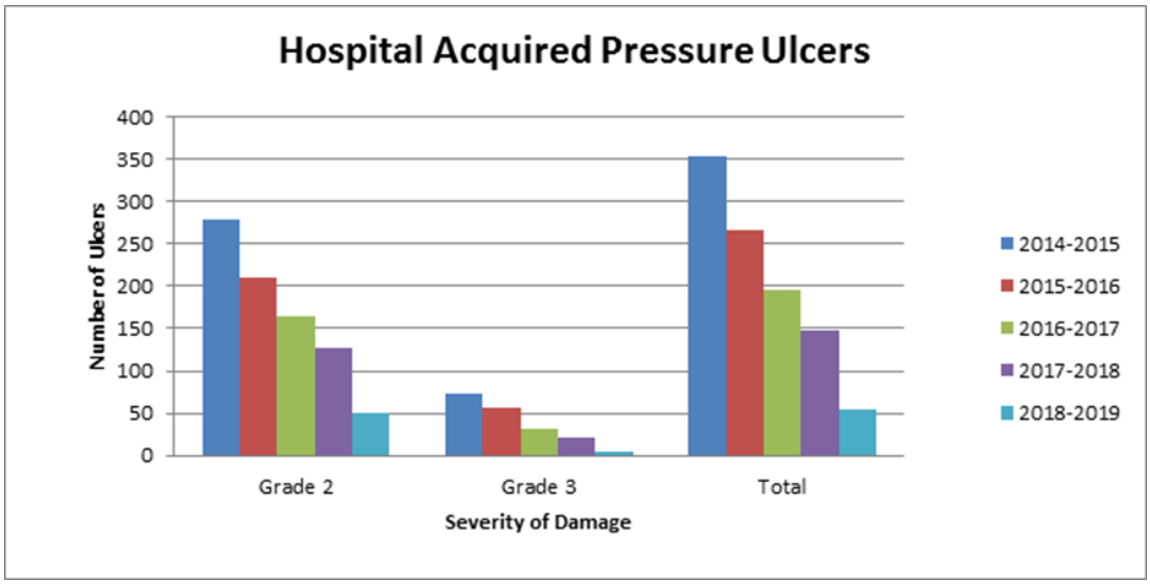
6.7% of women answered that they were left alone at a time that worried them and the same two women also answered that their concerns about safety during labour and birth were not taken seriously. Both women's concerns were in relation to the induction of labour (IOL) process and delays experienced due to the high activity. The Associate Director of Midwifery and Matrons are reviewing the processes and pathway of IOL to ensure a safe patient experience.

4. Pressure Ulcer Incidence

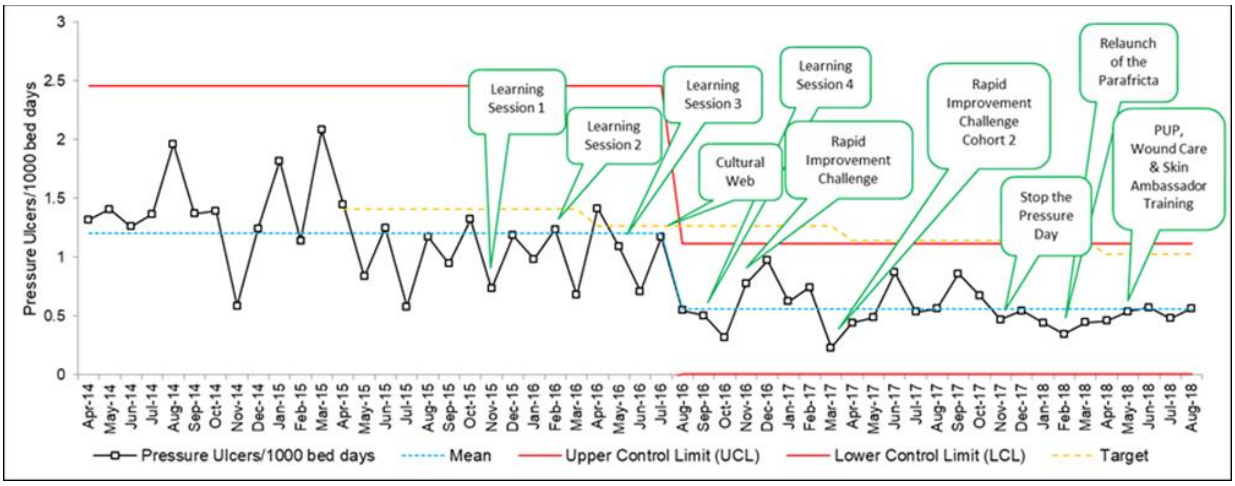
In August 2018, the Tissue Viability Team (TVT) received a total of 320 datix incident reports relating to pressure damage, which remains largely consistent with previous months.
In August 2018, 37 were duplicated reports, 52 patients were not seen as they were either not admitted, or they were discharged within 48 hours of reporting pressure ulcer (PU) harm, or reported as category 1 or moisture lesion. Of the remaining incidents reported, 231 were validated by the TVT on the wards or from photographs.

9 patients developed a total of 11 category 2 pressure ulcers in August 2018 and 6 deep tissue injuries (DTIs) validated during the reporting period. A total of 15 patients were harmed with pressure damage whilst in our care in August 2018.

The following graph demonstrates a slight increase in category 2 pressure ulcers, but a downward trend in category 3 in all hospital acquired Pressure Ulcer harms year on year

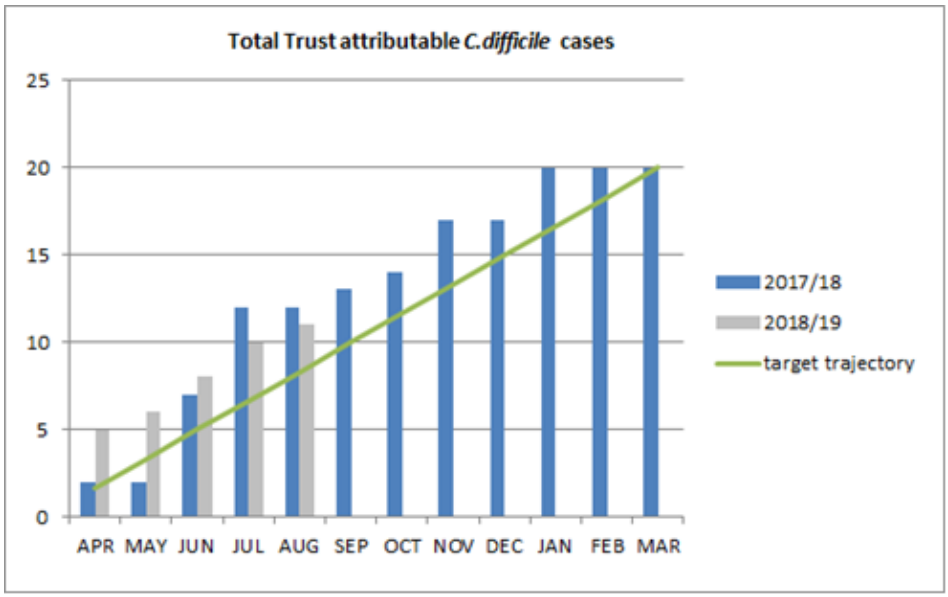


Number of Pressure Ulcers per 1000 bed days
The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers. This is reported utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements.

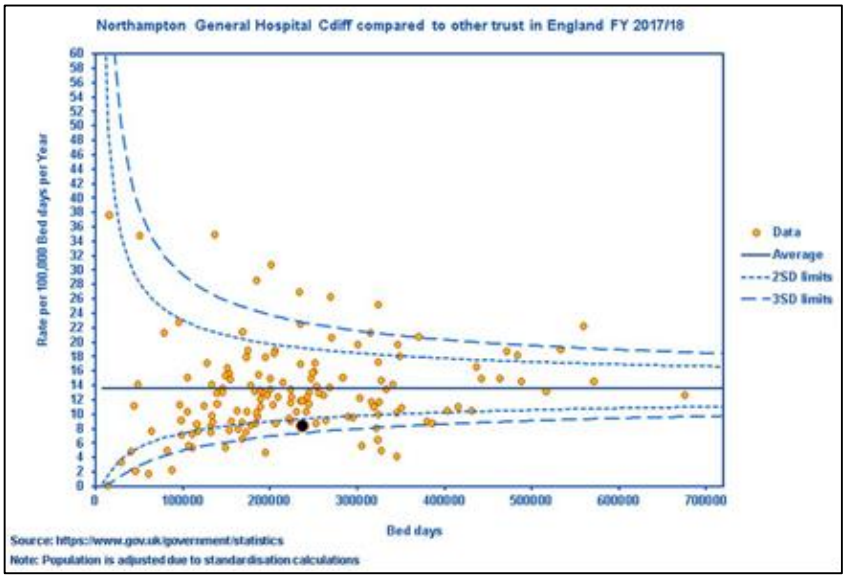


5. Infection Prevention and Control

***Clostridium difficile* Infection (CDI)**
For August 2018, one patient developed a Trust attributable CDI, against a trajectory of 20 for the year.

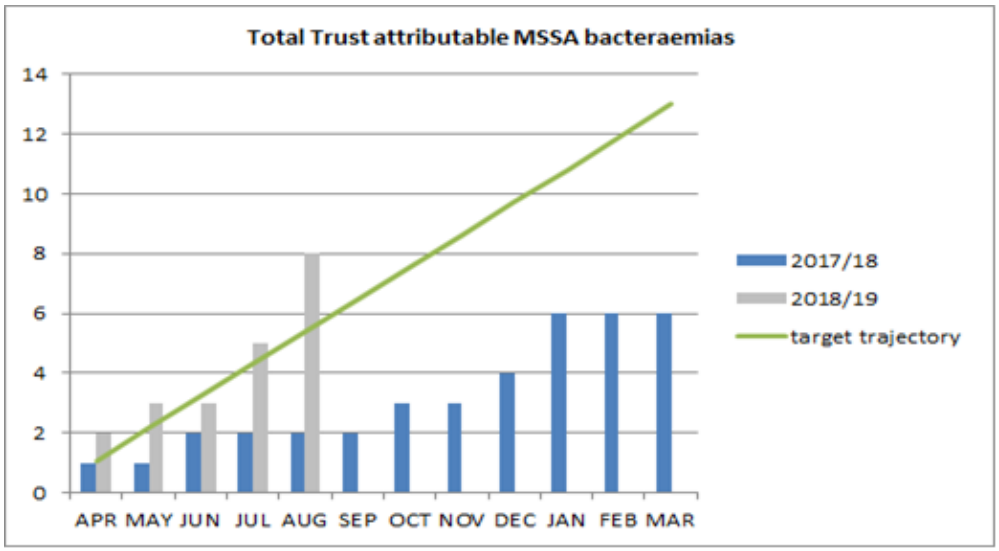


CDI national perspective
Nationally, the average CDI rate was approximately 14 per 100,000 bed days at the 2017/18 year end. Public Health England report that nationally CDI has increased in quarter one of 2018/19 and that for the year end 2017/18, NGH was over 2 standard deviations below the national average with a CDI rate of 8 per 100,000 bed days.

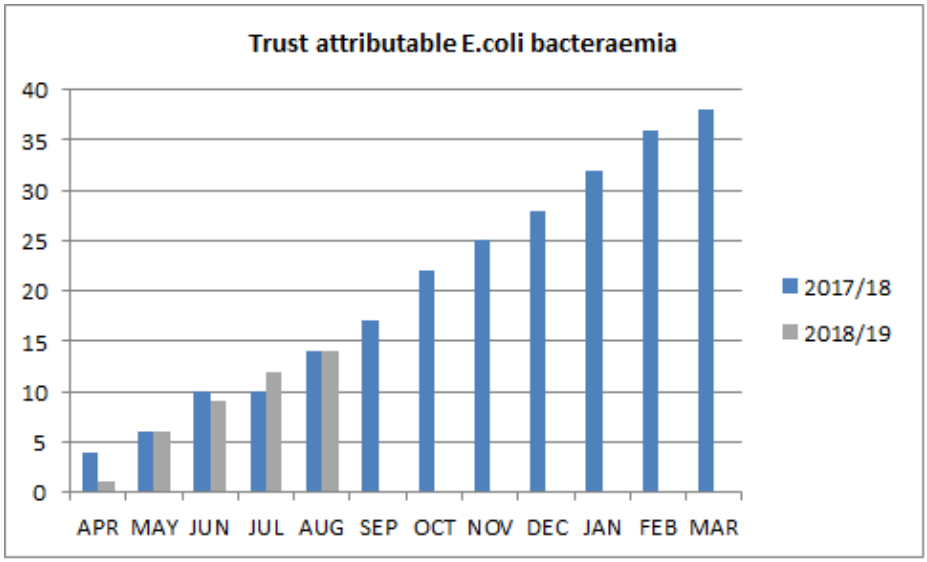


MRSA Bacteraemia and Colonisations
MRSA bacteraemia: 0 Trust attributable MRSA bacteraemia for August 2018 to date. MRSA colonisations: 1 Trust attributable MRSA colonisation for August 2018, the Trust has 12 Trust attributable MRSA colonisations to date.

MSSA Bacteraemia
MSSA bacteraemia: 3 Trust attributable MSSA bacteraemia for August 2018. The graph below shows a cumulative total of MSSA bacteraemia The Trust internal trajectory for 2018/19 is 13.



***Escherichia coli* (*E.coli*) Bacteraemia**
In August 2018 to date, there were 19 non-Trust attributable *E.coli* bacteraemia and 2 Trust attributable *E.coli* bacteraemia. This Trust attributable cumulative comparison to the previous year is shown in the following graph:

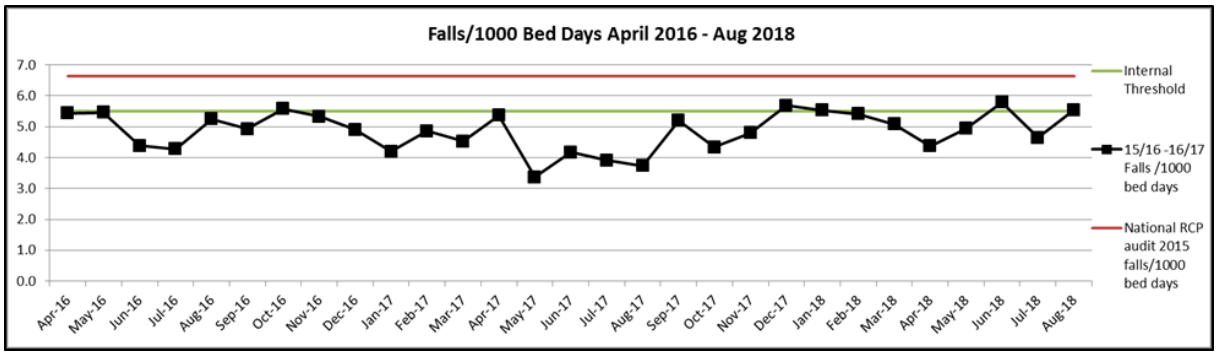


Healthcare Associated Gram- negative bloodstream infections
NHSI have also asked for a wider Gram - negative bloodstream infection reduction of 50% by March 2021. To support the halving of healthcare associated Gram negative bloodstream infection (GNBSI) mandatory reporting is to include Klebsiella species and Pseudomonas aeruginosa. The trust has been reporting on both of these GNBSI since April 2017 and will continue to do this, both of which are reported on in this report.

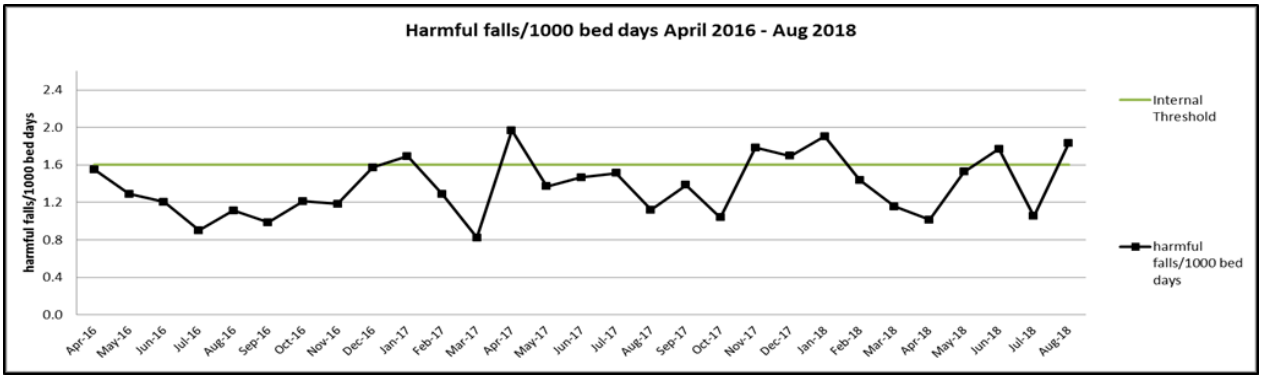
In August 2018, 1 patient developed a Trust attributable Klebsiella species bacteraemia.
In August 2018, 0 patients had a Trust attributable Pseudomonas aeruginosa bacteraemia

6. Falls

Falls/1000 bed days
The Trust's falls/1000 bed days are below the national average of 6.63/1000 bed days and equal to the Trusts internally set target of 5.5/1000 bed days. There was an increase in the number of falls/1000 bed days in August 2018 of 0.9 compared to the previous month of July 2018. In total there was 5.54 falls/1000 bed days recorded in the month of August.

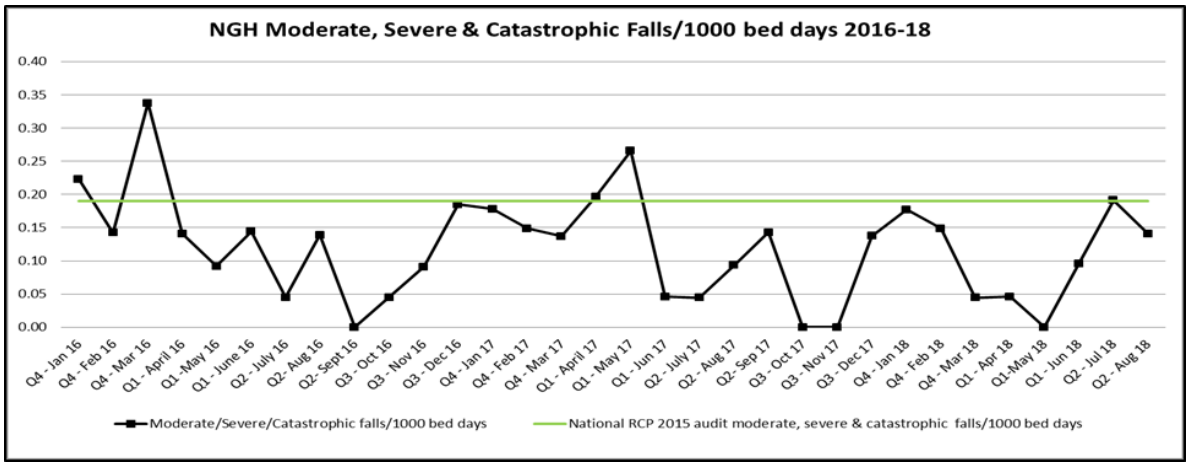


Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic
The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through August 2018 harmful falls/1000 bed days have increased by 0.78 compared to the previous month of July 2018. This is due to an increase in low harm falls. These are the least harmful patient falls that can occur, where a patient requires enhanced observations or first aid.



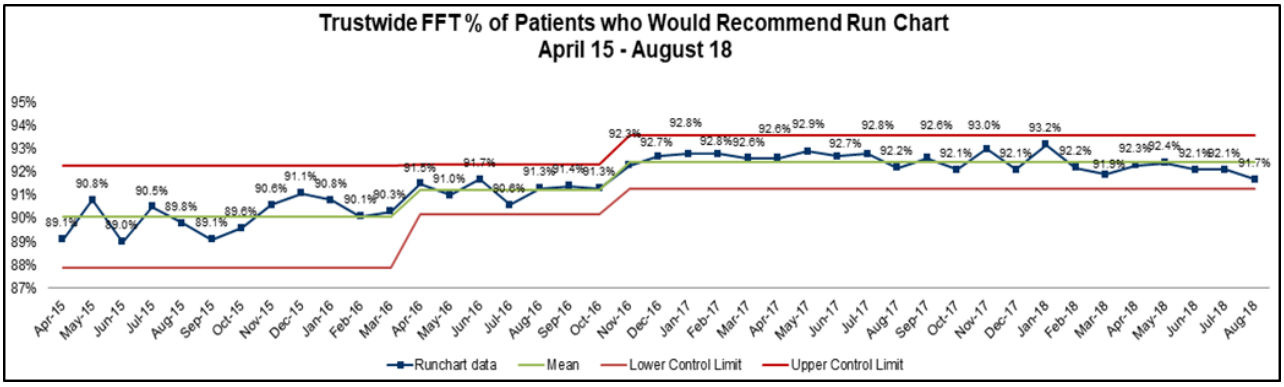
Falls Resulting in Moderate, Severe or Catastrophic Harm

The following graph below represents moderate, severe and catastrophic falls/1000 bed days. There was a decrease in moderate severe or catastrophic falls in the month of August 2018. 2 moderate harm patient falls resulted in; 1 patient sustaining a fractured wrist and a second patient requiring sutures to a head wound. 1 severe harm patient fall resulted in a patient sustaining a peri prosthetic hip fracture and requiring surgery. 1 preliminary investigation report has been submitted to the Review of Harm Group and no further level of investigation was required.

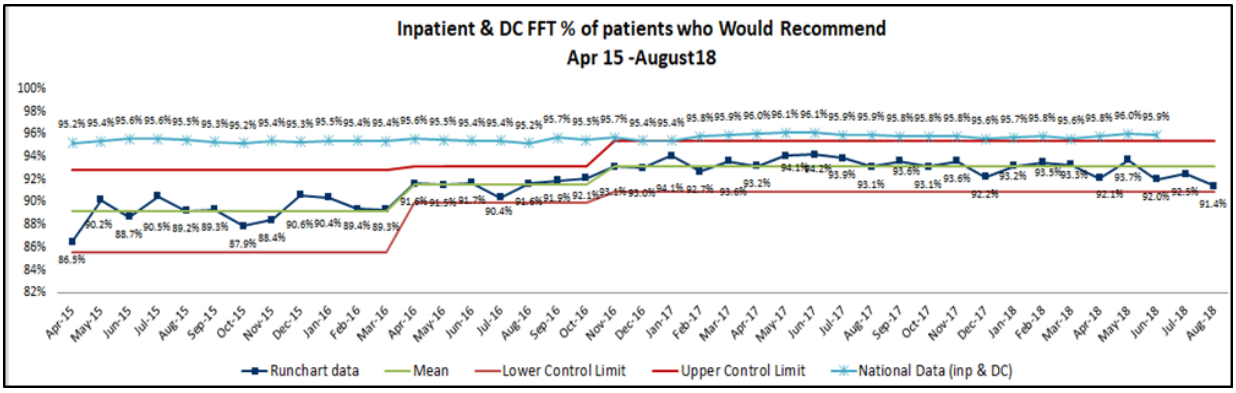


7. FFT Overview- % Would Recommend Run Charts – June 2018

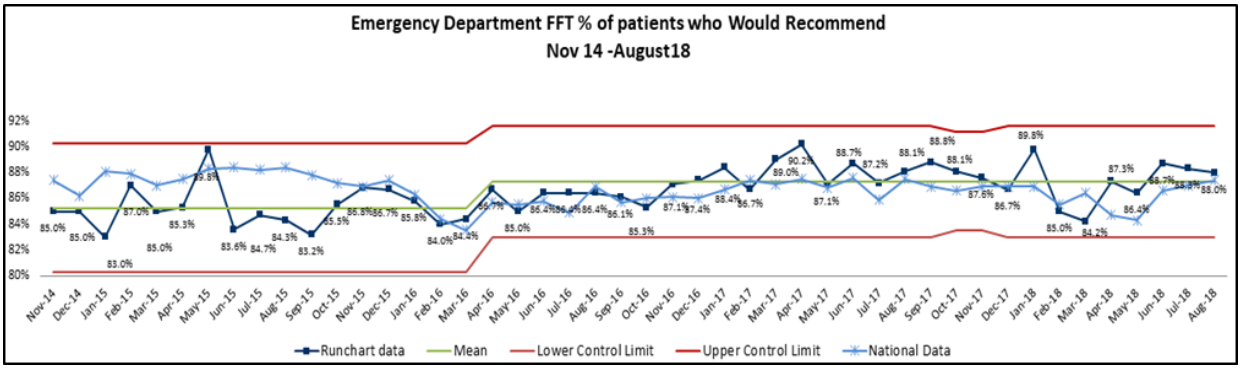
The Trust wide FFT result has decreased from July 2018 with a recommendation rate of 91.7%; this is below mean line and recommendation rates are still within normal variance



Inpatient and Day Case results have reduced slightly in August 2018 with a recommendation rate of 91.4%. When comparing June's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 4.5% below the average.



The Emergency Department's recommendation result decreased slightly in August 2018 to 88%. When comparing June's (most recent data available) recommendation rate to the national average, NGH performed 0.6% above the national average of 87.4%.



8. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards, Appendix 2 and 3 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.

Trust wide Overview of the Dashboard

- In August 2018 there were total of 6 red domains on the QCI dashboard for the general wards, 5 in medicine and 1 in WCO.
- Compliance with care round documentation and pressure prevention assessment has been 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 no red domains and 18 amber domains on the QCI dashboard in August 2018
- 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 had 5 red domains and 22 ambers in August 2018 on the dashboard, a decrease from the previous month.
- Knightley Ward QCI's results in totality have been removed from the dash board, due to technical difficulties which were unable to be resolved at the time of the report writing. The Matron and ward team are working with the hard copy to address any issues.

- Allebone Ward had 1 red domain for Nutritional Assessment; the reassessment documentation was not completed for a patient.
- Collingtree Ward had 1 red domain for incompletion of the nutritional assessment documentation. The Ward Sister is going to do spot checks on the documentation.
- Eleanor and Quinton (EAU) Wards had 1 red domain for first impression the entrances looked cluttered at the time of the audit. The Ward Sisters are monitoring the environment.
- Becket Ward had 1 red domain for patient safety and quality. A new member of staff had to be reminded on the use of the hover lift
- 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 1 red domain for first impression and 3 amber domains in August 2018. The Matron and ward team are continually reviewing and monitoring their results whilst working on their assessment and accreditation action plan.
- Spencer had no red or amber domains.
- Due to technical difficulties which were unable to be resolved at the time of the report writing the Children Wards QCI results in totality have been removed from the dash board. The matron and ward team are working with the hard copy to address any issues. The results from the hard copy show on Paddington ward show 67% for falls assessment and 50% for patient safety and quality. The two Children's wards were combined during this time. The falls assessment was not always completed and staff have been reminded of their responsibilities to complete admission documentation. The patient safety and quality sections showed that the daily checks were not inputted correctly and the result should read 75%.
- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve.

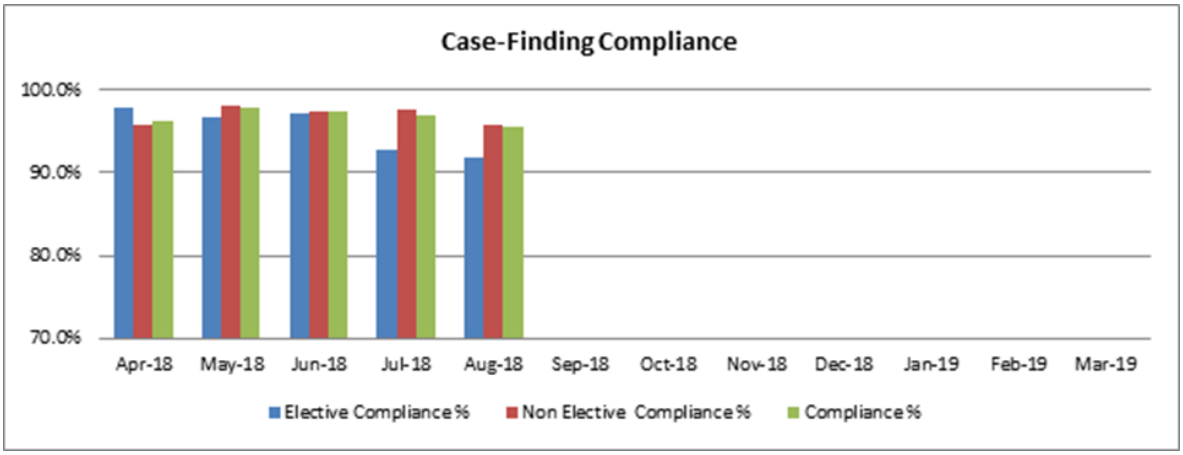
Midwifery

- Maternity had one red domain and no amber domains in August 2018
- The red domain was for Patient Safety and Quality and relates to the Maternity Observation Ward (MOW). This was for missed controlled drug checks on MOW and also missed checks on medical gas cylinders. Until recently MOW did not stock any controlled drugs and therefore staff have not been used to carrying out these checks. In July 2018, the decision was made to stock Oramorph. This is the second month that there have been concerns regarding the checking of equipment and controlled drugs. Actions taken in response – checks to be completed by LW staff as part of daily process. Assurance that checks have been completed to form part of daily handover.
- The Ward Sisters, Matrons and ADM/Deputy HoM, monitor the results monthly and highlight any specific themes or areas for improvement. These are discussed at the Midwifery Professional Leads Meeting

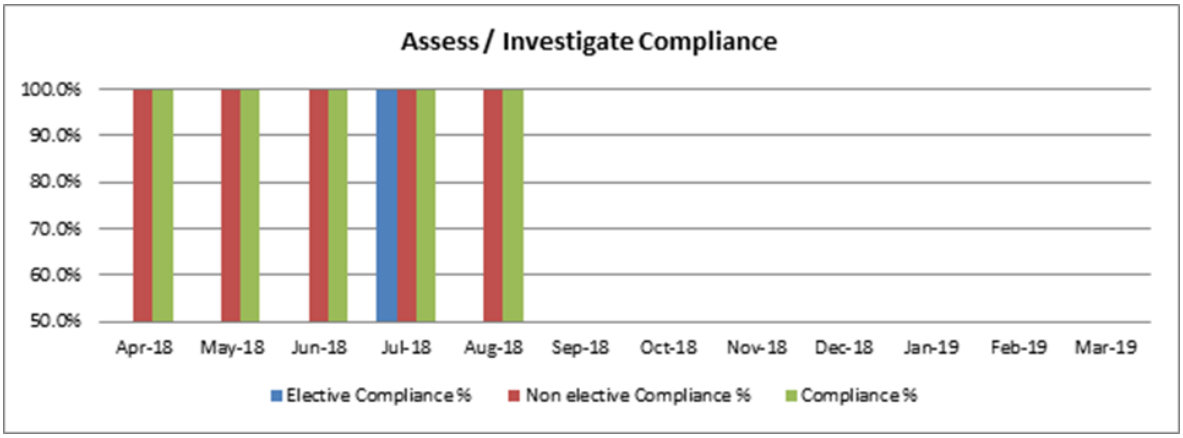
9. Safeguarding

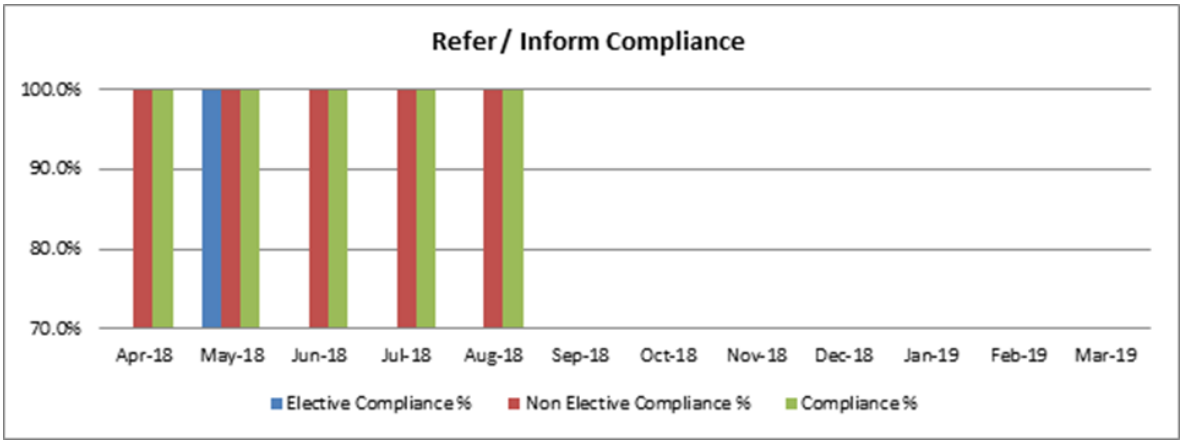
Dementia Activity

The figures for case-finding continue to be above the 90% compliance level for this reporting period as demonstrated in the following table:



In addition, as illustrated in the following two graphs, the compliance figures for assessment and referral continue to be above the compliance level of 85%.

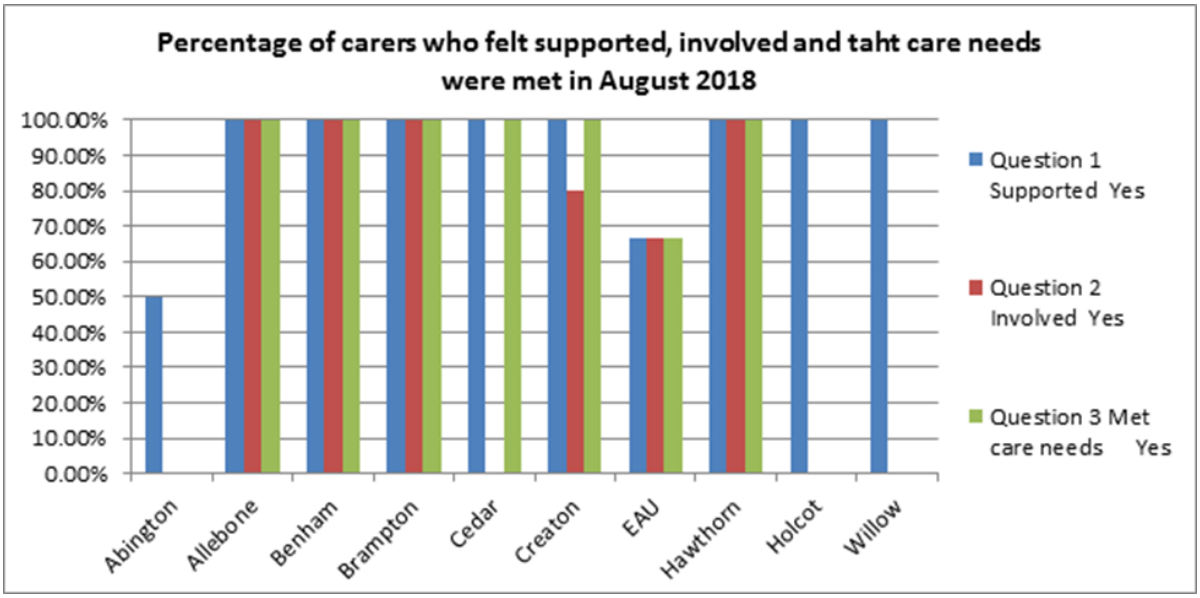




Carer Feedback

One hundred and nine people with dementia were identified within the data collection population during August with eighty five questionnaires being distributed. A return of 20% was achieved which falls slightly below the average return rates for surveys (30-40%). This decline is possibly due to the National Audit of Dementia currently taking place which includes a carer's questionnaire data collection.

The following chart highlights the responses received in August 2018. Please note that this only shows wards of which returns were received:



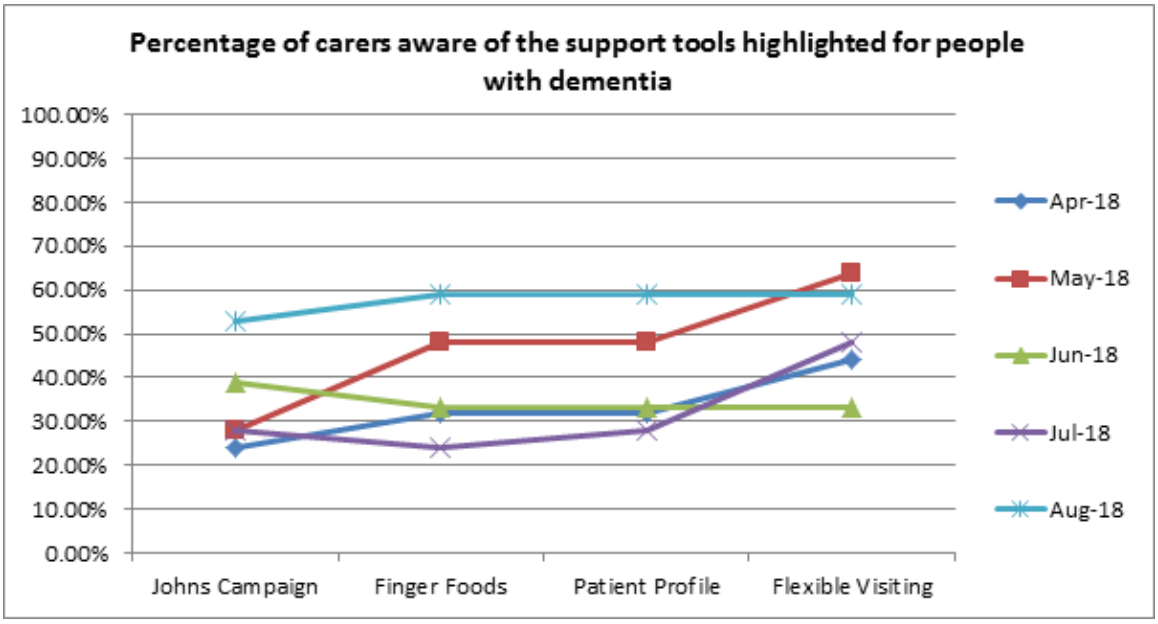
Positive feedback continues to focus on staff being kind and understanding and includes:

- “everyone was very kind”
- “the staff were very understanding of my Dad’s condition
- “Good communication re: Mum’s progress and her care plan going forward.”

In turn, communication remains the theme of what needs to be improved for patients and carers across the Trust. Comments include:

- “Explain to and involve the patient more"
- "Keep the carer better informed"
- "we have been told one thing by one nurse and something else by another"

The chart below highlights the carer’s awareness of specific projects implemented across the trust for patients with dementia during 2018/19:

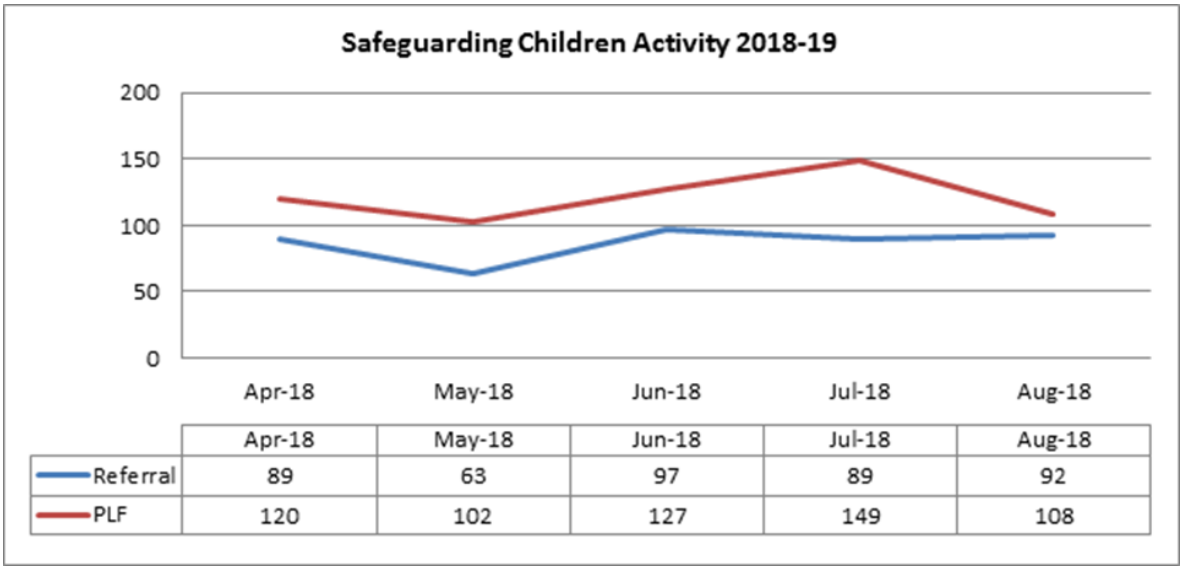


There has been a general increase by carers about the specific projects apart from flexible visiting. The revised patient profile has been re-launched across the Trust and an audit will take place at the end of September to find out which wards/departments are embedding this as part of everyday nursing care.

The dementia notice board has been well received by both staff and visitors which have led to an increase in carer contact with the Dementia Liaison Nurse. A further notice board is planned for by Holcot and Brampton Wards as requested by nursing staff.

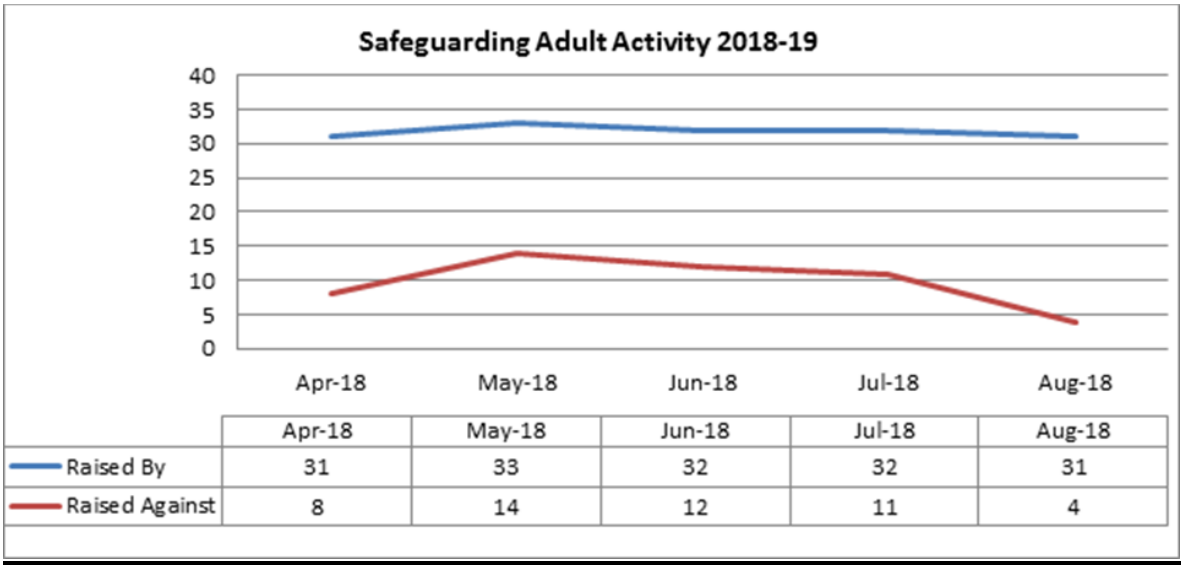
Safeguarding Children and Adult Referrals

The following 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 a slight decrease in the number of PLF's completed in August 2018, although this is not significant.



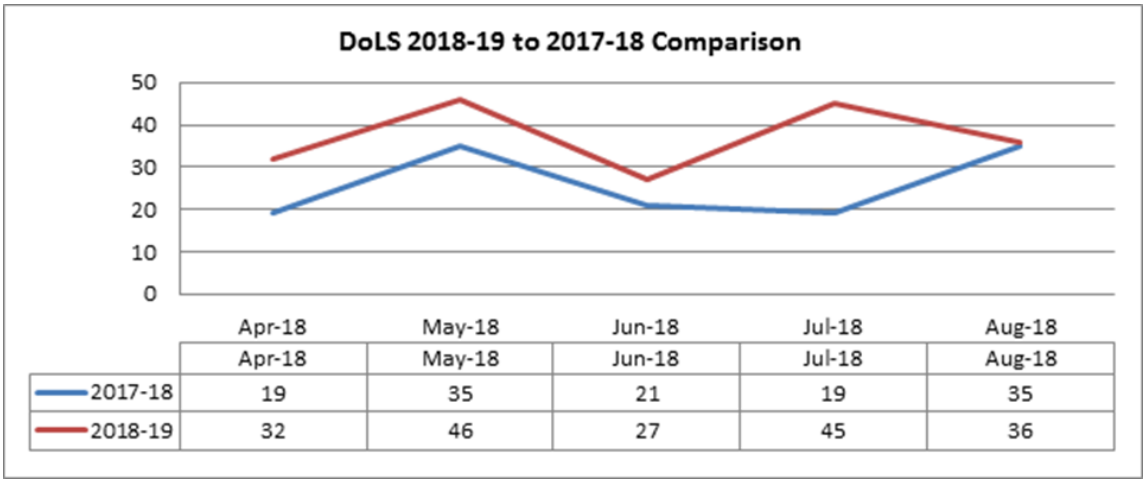
	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Referral	89	63	97	89	92
PLF	120	102	127	149	108

In terms of safeguarding adults' referral activity, there has been a minimal decrease in the number of safeguarding allegations raised by the Trust and at the same time a significant decrease in the number of safeguarding allegations against the Trust in August



	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Raised By	31	33	32	32	31
Raised Against	8	14	12	11	4

Deprivation of Liberty Safeguards (DoLS)

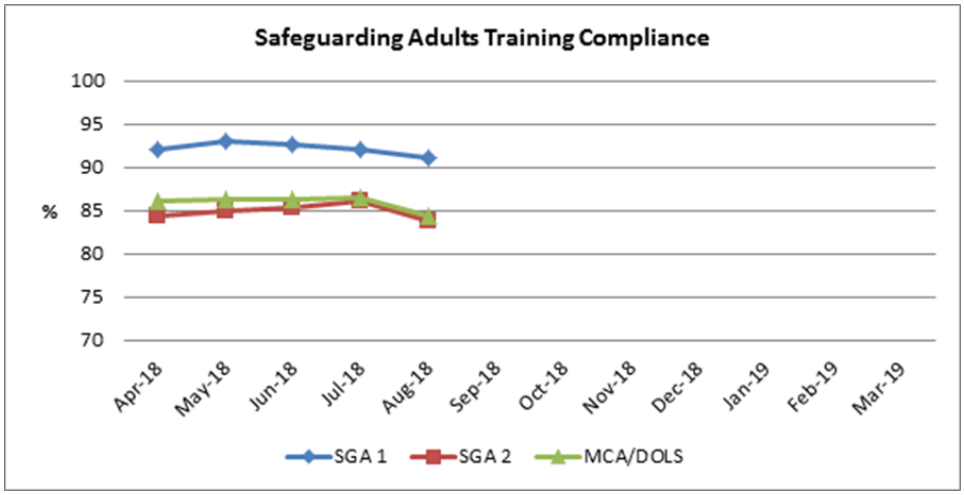


	Apr-18	May-18	Jun-18	Jul-18	Aug-18
	Apr-18	May-18	Jun-18	Jul-18	Aug-18
2017-18	19	35	21	19	35
2018-19	32	46	27	45	36

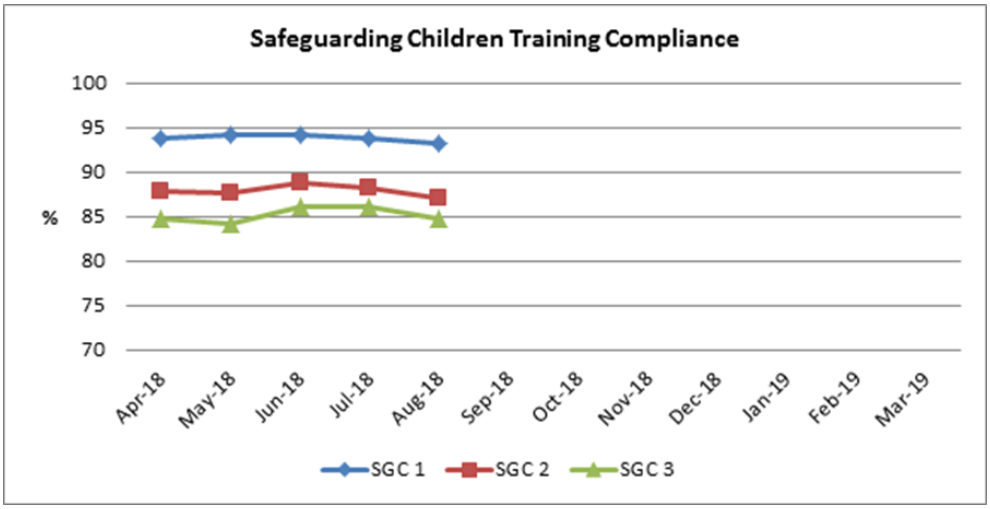
DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have significantly increased during the reporting period, which provides assurance that legislation is being adhered to by the organisation.

Safeguarding Training Compliance

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



Compliance for level one safeguarding adults remains consistent. However there has been a slight decrease in level two safeguarding adult's compliance to 84% in August 2018.



In addition level three safeguarding children training has slightly decreased to 85%, but remains compliant for the last three consecutive months.

The Trust has achieved 92% compliance in Basic Prevent Awareness Training and 95% compliance (1135 staff members out of 1196) in WRAP training. The compliance trajectory is set as 85% and forms part of the quarterly report to NHS England and the Clinical Commissioning Group (CCG) as per the Prevent data assurance process

Safeguarding Assurance Activity
There are two children's Serious Case Reviews (SCR's) and two Safeguarding Adult Reviews (SAR's) in progress. All individuals had contact with the Trust.

There are five ongoing Domestic Homicide Reviews (DHR's) that are ongoing in the county. Only one individual had contact with the Trust as the other four DHR's occurred in the north of the county.

Risk Register
There are currently three safeguarding risks present on the Patient and Nursing Services risk register:

966 – Vulnerable Children and Adults –Graded 12
1300 - Authorisation of Deprivation of Liberty Safeguards (DoLS) – Graded 9
1305 – Compliance with Safeguarding Training – Graded 12

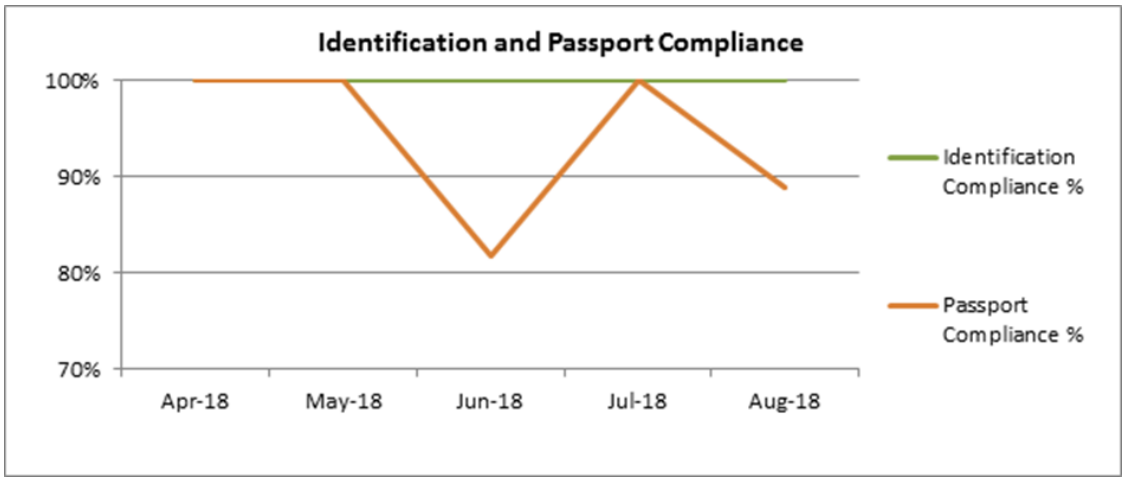
It is anticipated that the first two risks will be ongoing concerns due to continuing difficulties at the Local Authority and the delay in legislation review with DoLS.

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

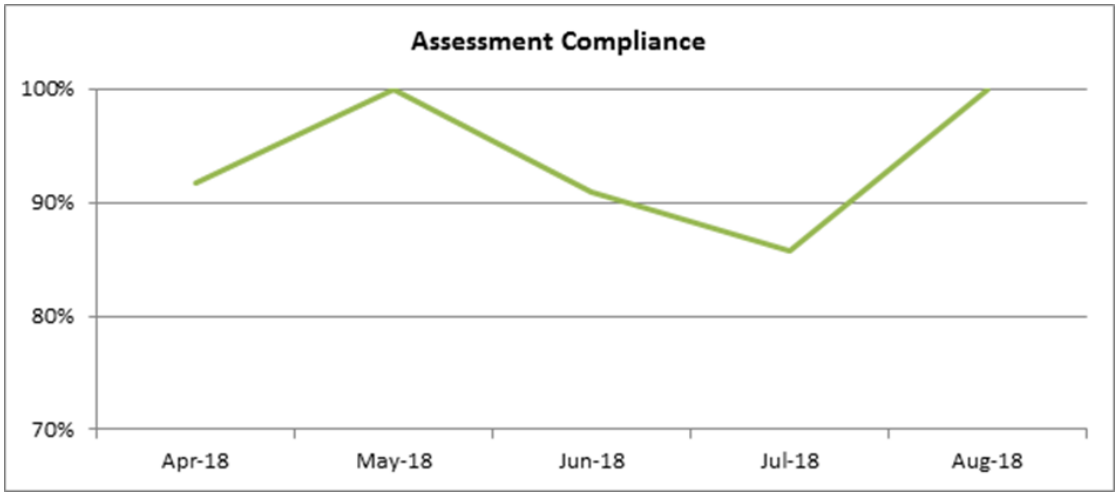
- The identification of people with a learning disability who are admitted to hospital; and of those:
- The use of the hospital passport;
- The use of a specific LD admission checklist;

A total of nine patients with a Learning Disability were admitted to the Trust in August.
100% of patients with a Learning Disability who were admitted to the Trust were identified and 89% of those who required a hospital passport received one within the first twenty-four hours of admission.

One individual did not have a completed hospital passport within the timescale due to safeguarding issues within the family. This information is illustrated in the graph below:



For August 2018 assessment compliance was 100% as demonstrated in the graph below:



In June 2018 NHS Improvement published the first 'Learning Disability Improvement Standards' for NHS Trusts. The standards are intended to help organisations measure the quality of service they provide to people with learning disabilities (LD) and/or autism.

There are four standards within the report which include:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Specialist learning disability services (not applicable to the Trust)

As part of this work a new national data collection will take place across all Trusts in England, which will take place from 17th September 2018 to 30th November 2018.

The Head of Safeguarding will be the point of contact for the data collection and coordination and updates will form part of this report as well as the Patient Carer Experience and Engagement Group (PCEEG).

10. Maternity Update

The Maternal and Neonatal Health Safety Collaborative is a three-year Quality Improvement programme supported by NHS Improvement. Following the first National learning set in May 2018 and completion of the diagnostic phase, a number of staff engagement sessions were held and a project plan has been agreed and developed. As well as improving the safety of the women, the objective of the project is to improve patient flow, prevent bottlenecks, improve the woman's journey and improve staff experience. Good progress continues to be made in all work streams:

Progress this month:

- Postnatal Pathway Work stream: Proposed revised pathways discussed and agreed in principle - further information regarding logistics needed before test of change.

- Recovery Work stream: Group have developed options for recovery area. Agreement on preferred option from all stakeholders.

- Learning from Excellence Work stream: Draft Reporting form and process agreed

- Postpartum Haemorrhage Work stream: change package implemented. Ongoing monitoring of implementation via the work stream group. Minor changes to risk assessment tool in relation to feedback. PPH score added to LW board

- Very successful staff engagement groups held in the form of Kitchen Tables - excellent engagement and ideas discussed

Further ideas that came from Kitchen Table events that will be implemented in September 2018:

- Implementation of a daily 11.00 Safety Huddle
- There is currently a daily multi-disciplinary ward round at 16.00 (obstetrician, anaesthetist and midwife) on the Maternity Observation Ward, this is to be extended to include Robert Watson
- Development of a discharge information DVD - this will ensure all women get the same information and will save on midwifery time

The second National Learning Set is due to take place in September 2018 and the NGH Quality Improvement Leads will be attending.

11. Safe Staffing

Overall fill rate for August 2018 was 98%, compared to 102% in July and 102% in June. Combined fill rate during the day was 94%, compared with 98% in July. The combined night fill rate was 104% compared with 106% in July. RN fill rate during the day was 93% and for the night 95%. (Appendix 4)

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 August 2018 there were zero shifts where the planned numbers were not achieved.

Avery:
Within Avery there are two wards (Blenheim & Cliftonville) where we commission beds for our patients to continue their clinical care. Avery has now agreed that on a monthly basis they will update the Quality Summary report, which the Trust receives, in regards to staffing levels. Avery will confirm whether there have been any instances when there has been a reduction in staffing from their 'planned' staffing numbers to their 'actual' staffing numbers and if any harm to patients has been caused by the reduction in staffing levels. In August there were no instances of reduction in planned staffing numbers.

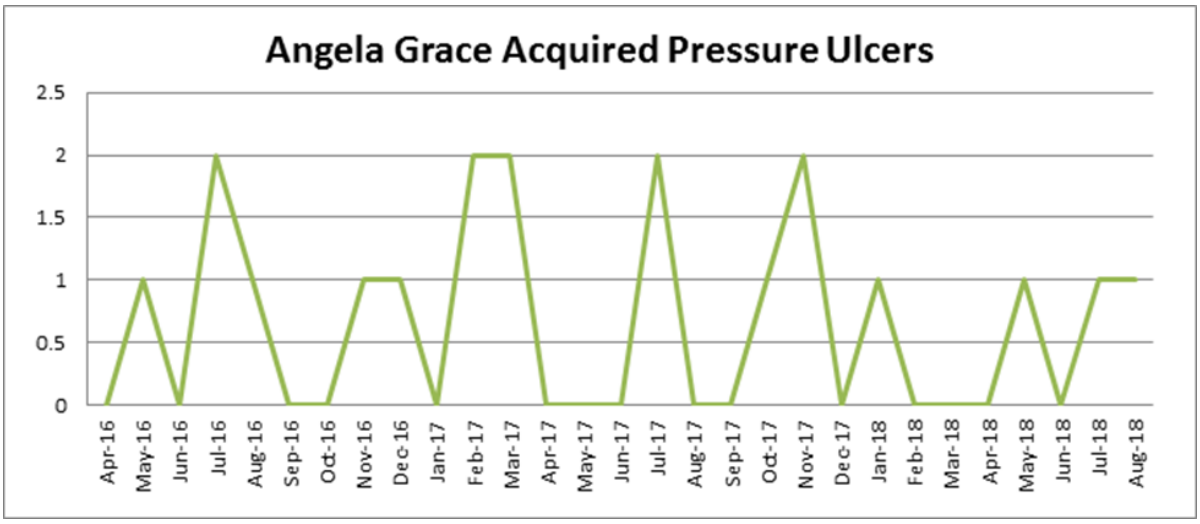
12. Avery and Dickens Therapy Unit

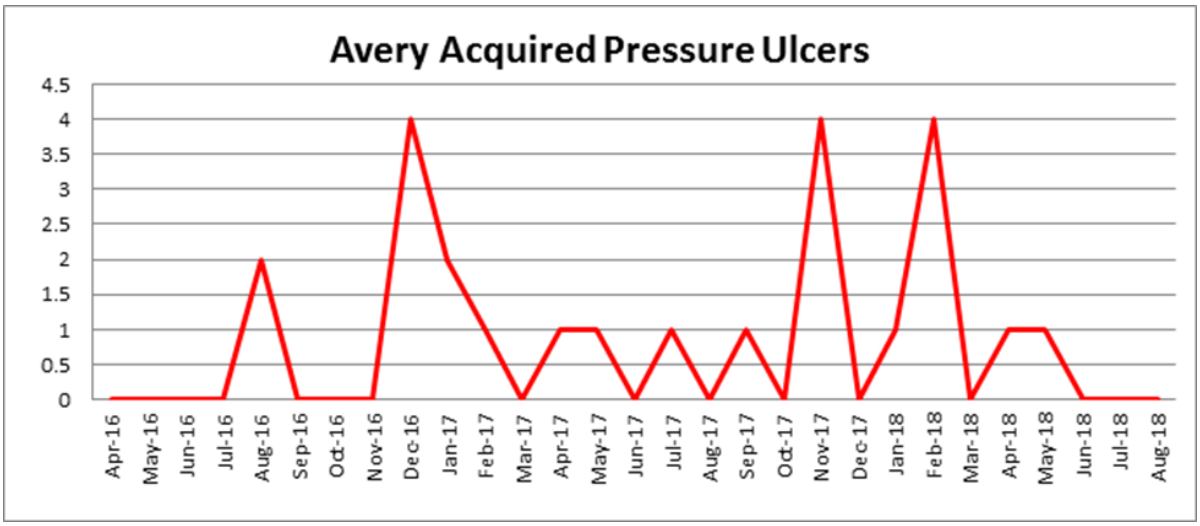
Avery/Angela Grace PU Incidence

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 1 x category 3 pressure ulcer reported on Dickens Therapy Unit (Angela Grace) during August 2018.

There was no pressure ulcers reported at Avery in August 2018





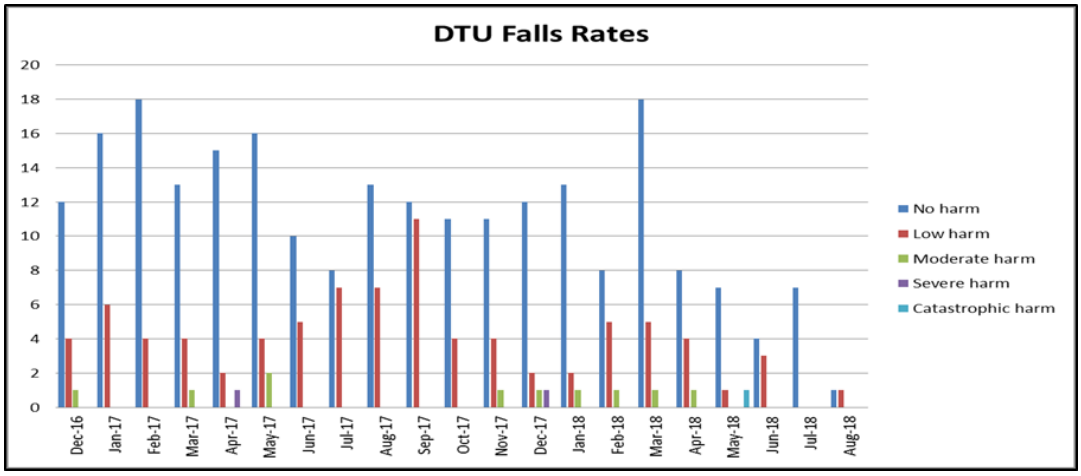
Infection Prevention

Zero cases of CDI at either establishment

2 patients during August at Avery had a positive MRSA colonisation report

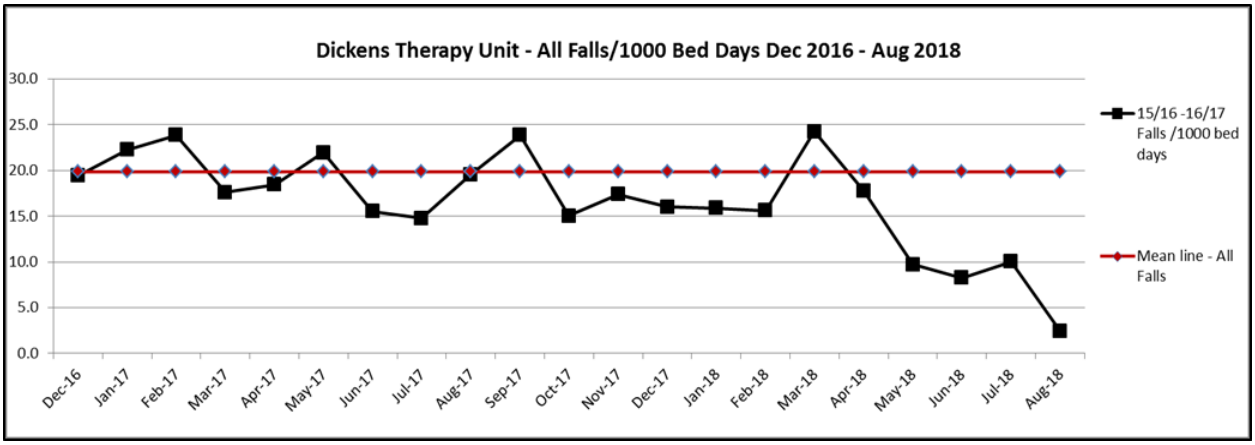
Dickens Therapy Unit

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. Please see the table below for a breakdown of falls incident data at DTU.



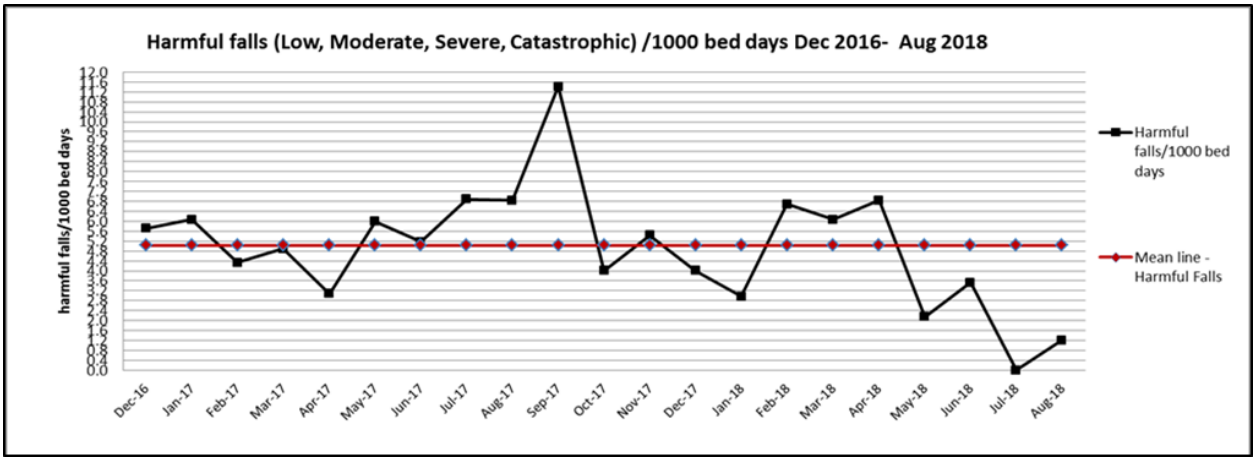
Falls/1000 Bed Days at Dickens Therapy Unit

The graph below demonstrates that the total number of patient falls/1000 bed days decreased in August 2018 by 7.61 compared to July 2018

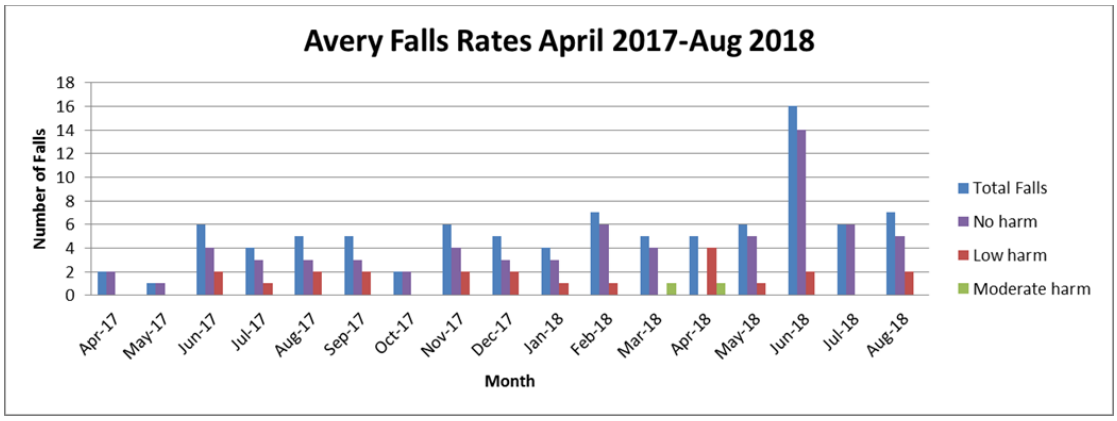


DTU Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic

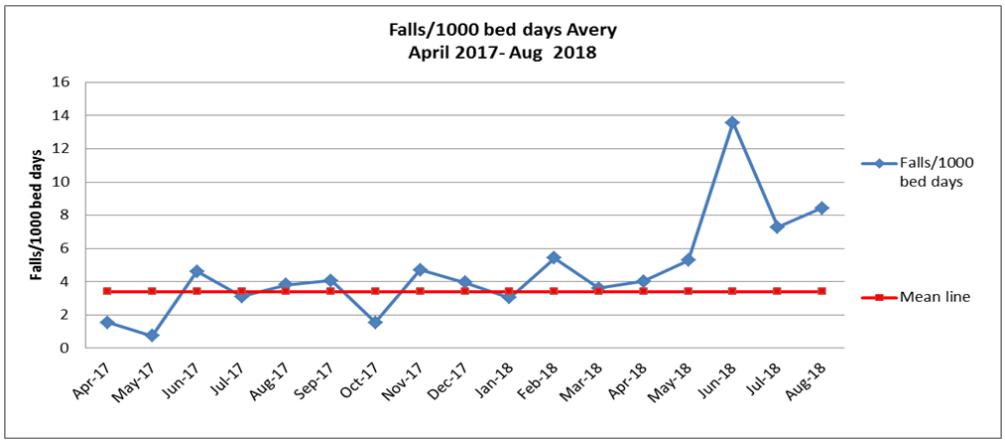
The graph below represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in August 2018 by 1.21 when compared to July 2018. This is due to one patient suffering a low harm fall. One patient sustained a subdural haematoma from a suspected fall but it is unclear when the patient's injury occurred. This incident is currently being investigated as a comprehensive investigation.



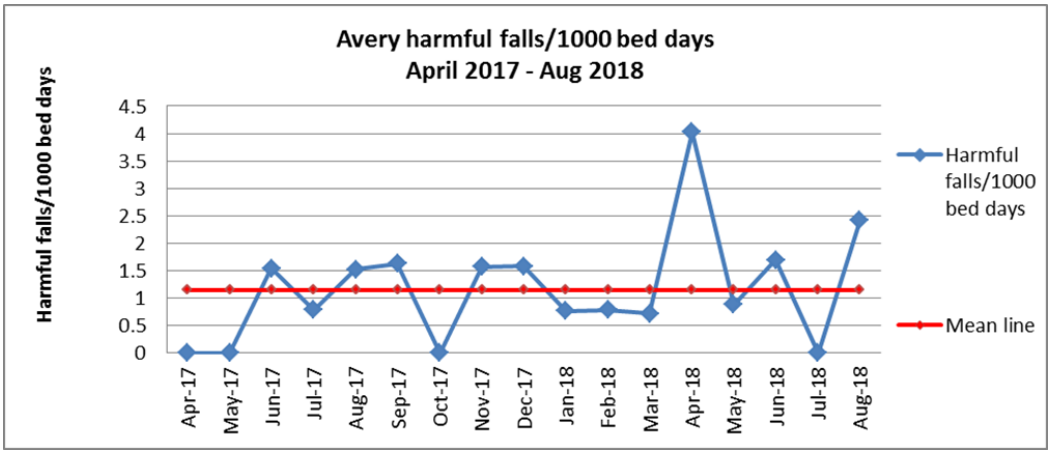
Avery Falls Rates
The graph below demonstrates the total number of inpatient falls and the number of harmful inpatient falls (low, moderate, severe and catastrophic) at Avery between April 2017 and August 2018.



Falls/1000 Bed Days at Avery
The following graph demonstrates the total number of falls/1000 bed days increased by 1.13 falls/100 bed days in the month of August 2018.



Avery Harmful Falls/1000 Bed Days Including Low, Moderate, Severe and Catastrophic
The following graph represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in August 2018 by 2.41 when compared to July 2018. This is due to two patients suffering a low harm fall.



13. Pathway to Excellence®

We have successfully passed our evidence submission for Pathway, putting us firmly on course to be the first UK hospital to have this international accreditation. The Nurse Survey was launched on the 11th September 2018 which lasts for 21 consecutive days.

14. Recommendations

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

Appendix 1

Nursing and Midwifery Safety Thermometer Definition

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

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

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

NGH has a rigorous process in place for Safety Thermometer data collection, validation and submission. Four sub-groups for each category exist and are led by the specialists in the area; they monitor their progress against any reduction trajectory and quality schedule target. For pressure damage 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

Aug-2018	Medicine													WCO		Surgery							
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU/Quinton	Eleanor	Finedon	Holcot	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp	General Wards
Falls/Safety Assessment	100.%	93.%	97.%	97.%	93.%	93.%	100.%	93.%	87.%	100.%	100.%	93.%	100.%	97.%	100.%	90.%	87.%	100.%	93.%	93.%	96.%	80.%	94.%
Pressure Prevention Assessment	100.%	94.%	97.%	100.%	89.%	100.%	100.%	91.%	85.%	100.%	100.%	94.%	100.%	97.%	100.%	100.%	94.%	89.%	94.%	94.%	100.%	94.%	96.%
Nutritional Assessment	76.%	90.%	97.%	100.%	67.%	97.%	97.%	97.%	87.%	97.%	100.%	97.%	100.%	93.%	100.%	87.%	87.%	93.%	90.%	90.%	100.%	100.%	92.%
Patient Observation and Escalations	100.%	90.%	95.%	95.%	100.%	100.%	95.%	100.%	95.%	100.%	100.%	95.%	100.%	100.%	100.%	100.%	95.%	95.%	95.%	95.%	100.%	95.%	97.%
Pain Management	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	97.%	93.%	100.%	97.%	97.%	95.%	100.%	100.%	90.%	100.%	98.%	95.%	98.%	88.%	98.%	100.%	88.%	100.%	97.%	92.%	100.%	90.%	96.%
Medication Assessment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	83.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	83.%	100.%	100.%	83.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	83.%	96.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%	91.%	82.%	91.%	91.%	100.%	82.%	100.%	82.%	100.%	100.%	96.%
Patient Experience - Environment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	98.%
Patient Experience - Privacy and Dignity	99.%	81.%	98.%	91.%	88.%	93.%	98.%	91.%	96.%	94.%	94.%	98.%	92.%	94.%	99.%	82.%	80.%	92.%	95.%	93.%	94.%	99.%	89.%
Patient Safety and Quality	100.%	76.%	100.%	100.%	100.%	100.%	100.%	86.%	95.%	100.%	100.%	100.%	95.%	100.%	100.%	100.%	100.%	81.%	100.%	100.%	100.%	90.%	92.%
Leadership & Staffing observations	100.%	82.%	98.%	100.%	100.%	88.%	94.%	98.%	98.%	88.%	100.%	100.%	96.%	98.%	100.%	100.%	98.%	96.%	94.%	100.%	96.%	96.%	92.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%
First Impressions/15 Steps	97.%	100.%	100.%	80.%	91.%	80.%	86.%	80.%	71.%	71.%	80.%	94.%	86.%	77.%	97.%	86.%	97.%	83.%	89.%	100.%	100.%	80.%	84.%
Safety Thermometer – Percentage of Harm Free Care	96%	100%	85%	96%	93%	67%	100%	96%	91%	100%	88%	79%	78%	92%	96%	97%	89%	90%	90%	96%	93%	100%	92%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	2	0	0	0	3	1	0	0	0	0	1	0	0	0	0	0	0	0	0	2	0	9
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
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	1	0	0	1	1	0	0	1	0	1	0	0	0	0	0	0	0	0	5
Falls (Moderate, Major & Catastrophic)	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	3
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Patient Overdue Observations frequency - <7%	5.5%	7.5%	15.3%	7.9%	4.1%	10.0%	16.7%	4.8%	6.4%	9.6%	8.4%	9.4%	17.9%	8.7%	8.0%	8.0%	6.2%	8.2%	7.8%	4.5%	6.1%	6.5%	8.7%
Caring																							
Complaints – Nursing and Midwifery	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	4
Number of PALS concerns relating to nursing care on the wards	1	2	1	0	1	1	0	1	0	0	0	3	1	1	2	0	0	3	0	1	4	1	27
Friends Family Test % Recommended	88.9%	84.8%	87.7%	84.6%	87.1%	80.0%	93.3%	91.3%	87.0%	91.7%	100.0%	83.3%	75.0%	80.0%	93.4%	89.5%	94.1%	93.3%	94.7%	90.6%	92.2%	95.8%	90.7%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	82%	91%	95%	94%	101%	102%	96%	87%	107%	93%	87%	96%	88%	88%	100%	99%	99%	99%	108%	102%	100%	94%	96%
Staff Nurse Staffing - Support Worker (day & night combined)	97%	97%	171%	135%	99%	106%	102%	92%	142%	93%	112%	164%	138%	99%	101%	112%	105%	98%	105%	106%	108%	85%	113%
Staffing related datix	0	0	0	1	0	0	1	0	2	1	0	1	0	0	0	2	0	0	1	0	0	0	9

Appendix 3

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%	90%	100%	100%
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	100%	100%	100%	100%
Medication Assessment (Q)	100%	100%	100%	100%
Environment Observations (Q)	100%	96%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	97%	94%	91%	100%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	Nil	100%	55%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	100%	100%
Patient Experience (Q)	100%	100%	100%	100%
Patient Safety and Quality (Q)	98%	97%	79%	99%
Leadership & Staffing (Q)	100%	100%	100%	100%
Management				
Staffing related datix	0	2	0	5
Monthly Ward meetings (Q)	100%	100%	100%	100%
Safety and Quality (Q)	100%	100%	100%	100%
Leadership & Staffing (Q)	100%	100%	100%	100%

Appendix 4

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

Ward name	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	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)	1,874.50	1,954.83	1,396.75	1,351.75	1,069.50	1,058.00	1,069.50	1,265.00	104.3%	96.8%	98.9%	118.3%	854	3.5	3.1	6.6
Allebone Ward (Stroke)	1,581.25	1,336.00	1,852.50	1,483.75	1,426.00	1,246.50	713.00	1,012.00	84.5%	80.1%	87.4%	141.9%	852	3.0	2.9	6.0
Althorp (T&O)	969.25	863.00	604.50	501.50	713.00	714.00	299.00	268.25	89.0%	83.0%	100.1%	89.7%	203	7.8	3.8	11.6
Becket Ward	2,031.75	1,832.55	1,415.50	1,278.75	1,774.75	1,636.75	701.50	782.00	90.2%	90.3%	92.2%	111.5%	797	4.4	2.6	6.9
Benham (Assess Unit)	1,767.75	1,617.00	891.25	1,328.00	1,426.00	1,426.00	713.00	1,410.50	91.5%	149.0%	100.0%	197.8%	782	3.9	3.5	7.4
Brampton Ward	1,389.00	1,263.25	1,266.50	1,348.00	1,069.00	1,054.25	713.00	1,331.50	90.9%	106.4%	98.6%	186.7%	869	2.7	3.1	5.8
Cedar Ward (TRAUMA)	1,878.08	1,891.50	1,752.25	1,739.75	1,069.50	1,069.50	1,069.50	1,298.75	100.7%	99.3%	100.0%	121.4%	891	3.3	3.4	6.7
Collingtree Medical (40)	2,410.25	2,490.17	2,104.75	1,903.20	1,782.50	1,752.00	1,311.00	1,475.75	103.3%	90.4%	98.3%	112.6%	1251	3.4	2.7	6.1
Compton Ward	1,069.50	1,109.50	1,086.75	1,077.25	713.00	714.25	586.50	701.50	103.7%	99.1%	100.2%	119.6%	552	3.3	3.2	6.5
Creaton SSU	1,774.50	1,644.33	1,753.25	1,403.25	1,419.25	1,419.25	1,069.50	1,485.25	92.7%	80.0%	100.0%	138.9%	762	4.0	3.8	7.8
Dryden Ward	2,139.00	1,714.50	963.25	799.25	1,426.00	1,403.75	713.00	736.00	80.2%	83.0%	98.4%	103.2%	791	3.9	1.9	5.9
EAU New	1,722.75	1,978.25	1,677.50	1,911.17	1,425.25	1,405.00	713.00	1,472.25	114.8%	113.9%	98.6%	206.5%	977	3.5	3.5	6.9
Eleanor Ward	1,064.25	950.50	696.75	656.50	713.00	704.00	713.00	655.50	89.3%	94.2%	98.7%	91.9%	312	5.3	4.2	9.5
Finedon Ward	2,123.25	1,699.25	348.25	430.50	1,069.50	1,069.50	356.50	356.50	80.0%	123.6%	100.0%	100.0%	504	5.5	1.6	7.1
Hawthorn & SAU	1,953.50	1,962.58	1,062.05	1,018.25	1,426.00	1,375.67	977.50	989.50	100.5%	95.9%	96.5%	101.2%	893	3.7	2.2	6.0
Head & Neck Ward	1,070.50	1,153.67	351.25	344.00	931.50	999.00	356.50	401.25	107.8%	97.9%	107.2%	112.6%	402	5.4	1.9	7.2
Holcot Ward	1,410.75	1,334.75	1,403.50	1,713.00	1,069.50	1,056.25	713.00	1,759.50	94.6%	122.1%	98.8%	246.8%	891	2.7	3.9	6.6
Knightley Ward (Medical)	1,065.00	990.00	891.75	1,001.75	1,069.50	1,069.50	612.25	826.25	93.0%	112.3%	100.0%	135.0%	644	3.2	2.8	6.0
Rowan (LSSD)	1,955.50	1,996.42	1,064.25	1,078.00	1,782.50	1,707.17	712.50	919.25	102.1%	101.3%	95.8%	129.0%	889	4.2	2.2	6.4
Spencer Ward	1,421.25	1,424.00	1,058.75	1,058.50	1,069.50	1,072.25	1,069.50	1,082.00	100.2%	100.0%	100.3%	101.2%	619	4.0	3.5	7.5
Talbot Butler Ward	2,576.25	2,124.35	1,405.50	1,240.67	1,426.00	1,380.00	713.00	862.00	82.5%	88.3%	96.8%	120.9%	738	4.7	2.8	7.6
Victoria Ward	1,182.00	953.75	711.25	890.75	713.00	713.00	575.00	885.50	80.7%	125.2%	100.0%	154.0%	547	3.0	3.2	6.3
Willow Ward (+ Level 1)	2,301.25	2,377.25	1,070.00	1,068.50	2,139.00	2,028.42	713.00	804.50	103.3%	99.9%	94.8%	112.8%	844	5.2	2.2	7.4
									Total Average CHPPD					4.1	3.0	7.0
ITU	5,045.00	4,212.08	787.50	705.25	4,634.50	4,112.50	724.50	764.50	83.5%	89.6%	88.7%	105.5%	372	22.4	4.0	26.3
									Total Average CHPPD					22.4	4.0	26.3
Barratt Birth Centre	1,793.35	1,625.07	610.80	513.50	1,426.00	1,277.42	615.25	448.00	90.6%	84.1%	89.6%	72.8%	132	22.0	7.3	29.3
Robert Watson	1,069.50	1,222.25	1,135.00	955.08	1,069.50	887.83	1,051.00	767.50	114.3%	84.1%	83.0%	73.0%	475	4.4	3.6	8.1
Sturtridge Ward	4,243.50	3,883.67	1,857.25	1,542.25	4,157.25	3,691.08	1,272.50	1,014.50	91.5%	83.0%	88.8%	79.7%	532	14.2	4.8	19.0
									Total Average CHPPD					40.7	15.7	56.4
Disney Ward	1,791.00	1,440.75	917.75	826.75	1,046.50	949.25	345.00	304.00	80.4%	90.1%	90.7%	88.1%	102	23.4	11.1	34.5
Gosset Ward	2,624.45	2,517.50	379.50	350.75	2,300.00	2,210.00	310.50	299.00	95.9%	92.4%	96.1%	96.3%	337	14.0	1.9	16.0
Paddington Ward	2,380.75	2,203.25	1,245.83	1,115.25	2,035.50	1,766.75	471.50	445.50	92.5%	89.5%	86.8%	94.5%	463	8.6	3.4	11.9
									Total Average CHPPD					15.3	5.5	20.8
									Total Average CHPPD Trust wide					11.1	4.3	15.4

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**27th September 2018**
Title of the Report	Financial Position - Month 5 (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

The forecast has been prepared on a high-level basis and will be refined on a monthly basis. The current forecast suggests a most likely outcome of £1.9m adverse to the pre-STF control total deficit of £27.7m. In a best case and worst case scenario, the variance to plan is expected to be within the range of £0.7m to £(4.0m).

The key factors to focus on to ensure the Trust is able to meet the control total remain:

- STP-related income: the ability of the Trust to get a final agreement on the identified £2.3m relating to the healthcare system.
- Improvement in the delivery of elective activity and daycases, which is currently below plan. Currently excess bed day income is below plan due to improved flow within the hospital but is yet to be offset by increased elective activity.
- Nye Bevan assessment unit: effective management of the new assessment unit in order to manage winter risks, improve patient flow in the hospital as well as manage associated costs of the unit and escalation ward.
- CIPs – delivery of identified schemes, particularly the large recurrent schemes scheduled to be delivered later in the year.
- Continued rigour and financial discipline in managing costs within budget.
- Deliver on the operational and financial trajectories in order to meet the PSF plan.

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 August 2018 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 5 (August 18)
FY 2018/19

Report to:

Trust Board

August 2018

Content

1. Director of Finance Message
2. Clinical Income (including update on the system financial gap)
3. Pay Expenditure
4. Cost Improvement Programme (CIP)
5. Statement of Financial Position
   - Cash Flow
   - Capital Expenditure
   - Aged Receivables
   - Better Payments Practice Code (BPPC) Performance
6. Single Oversight Framework
7. Risks

1. Director of Finance Message

The Trust delivered a small YTD favourable variance of £22k.

Income and activity are lower than expected and the Trust must now make full use of the capacity released as a result of the decline in 'excess bed days' in order to stay on plan by the end of quarter 2.

Full PSF is accrued for the period.

This report sets out the Trust's financial position for the month ended 31st August 2018. The results show a reported year-to-date pre-PSF deficit of £12,232k against a planned pre-PSF deficit of £12,254k, resulting in a favourable variance of £22k .

The full Provider Sustainability Funding (PSF) of £2,605k year to date is included in the position, including the A&E performance element.

The in-month financial performance is a small favourable variance of £22k, driven by non-pay favourable variance and reserves but offset by income underperformance and pay overspend.

The Trust has seen a reduction in stranded and super stranded patients (length of stay > 21 days) from previous levels of around 220 super stranded patients to a current level of around 150 (c. 30% reduction). This improvement in flow has translated to a reduction in income earned on "excess bed days" causing an adverse variance to plan of £1,800k YTD on that line. The reduction in excess bed days has not been matched with increased elective activity and therefore overall clinical income has deteriorated further in month 5 to an adverse variance of £2,222k YTD from £1,602k in month 4. The underperformance on activity is also mirrored in the use of medicines, medical and surgical items as well as outsourcing spend and is reflected in the growing favourable variance in non-pay spend at £962k in month 5. In addition, prior year provisions of £403k no longer required have been released, hence providing a non-recurrent benefit to the year-to-date position.

It is also worth noting that the financial gap attributed to the STP system at planning stage is due to kick in at the end of quarter 2. In order to meet the £1,150k of expected income requirement, runrate activity and income would have to be better by £1,150k to enable the Trust remain on plan. There is an opportunity within the system to repatriate elective activity, which should be feasible given the current bed status. The Trust now needs to step up elective activity in order to recover the position by the end of quarter 2.

Pay continues to be adverse to plan (£2,744k YTD) mainly because of use of temporary staffing including agency to cover vacancy, long term sickness. The overspending cost centre reviews are in place and will continue to be used to keep tighter control on costs.
Pay award is included in the position and fully funded for the AfC staff. The impact on non-AfC staff and medical staff will be assessed in future months.

Other income continues to do better than plan by £1,316k primarily due to increased catering income, charitable funds donation, car parking income and other one-off funding.

CIP delivery is £6,440k which is £1,969k better than plan but over half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Reserves of £745k have been transferred to fund year to date costs relating to agreed Trust strategic schemes such as unfunded elements of CAMIS implementation, STP contributions, escalation areas and ambulatory care centre. The transfers do not release any benefit to the Trust's bottom-line financial position.

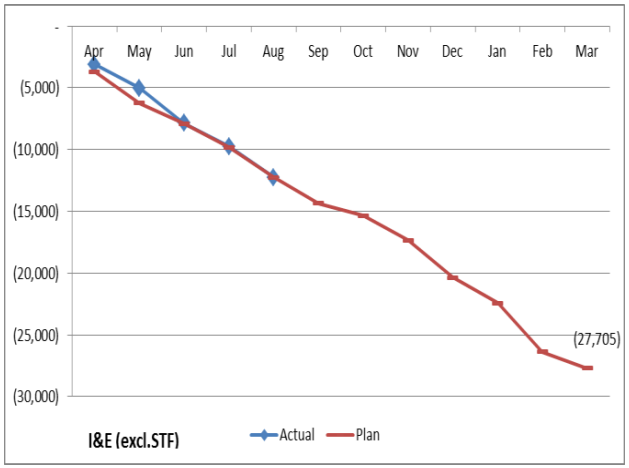
Income and Expenditure Summary

I&E Summary	Actual FY16-17	Actual FY17-18	Annual Plan	In-Month Plan	In-Month Actual	In-Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Recent Months: Actual Jul 18	Recent Months: Actual Jun 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	286,307	23,628	22,619	(1,010)	118,539	114,773	(3,767)	23,286	22,936
Other Clinical Income	2,373	5,837	8,307	2,035	2,143	109	5,228	5,116	(112)	1,136	637
Other Income	31,824	20,654	28,493	1,776	2,098	322	8,841	10,157	1,316	1,995	2,009
Total Income	294,525	298,004	323,107	27,439	26,860	(579)	132,608	130,045	(2,563)	26,418	25,582
Pay Costs	(199,813)	(207,233)	(220,634)	(19,276)	(19,318)	(43)	(89,172)	(91,917)	(2,744)	(18,448)	(18,275)
Non-Pay Costs	(94,406)	(103,550)	(109,737)	(9,577)	(8,249)	1,328	(45,858)	(42,470)	3,388	(8,182)	(8,687)
Unallocated CIPs		0	4,856	23		(23)	(1,661)		1,661		
Reserves/ Non-Rec		0	(2,836)	587		(587)	(412)		412		
Total Costs	(294,219)	(310,783)	(328,351)	(28,242)	(27,567)	675	(137,103)	(134,386)	2,717	(26,630)	(26,962)
EBITDA	306	(12,779)	(5,245)	(803)	(707)	96	(4,494)	(4,341)	153	(212)	(1,380)
Depreciation	(9,703)	(10,056)	(10,615)	(833)	(833)	(1)	(4,155)	(4,157)	(2)	(833)	(830)
Amortisation	(9)	(9)	(8)	(1)	(1)	(0)	(4)	(4)	(0)	(1)	(1)
Impairments	(1,732)	(4,085)	(1,826)	(0)		0	(0)		0		
Net Interest	(720)	(823)	(1,239)	(103)	(97)	6	(482)	(462)	20	(96)	(91)
Dividend	(3,307)	(2,411)	(1,529)	(127)	(127)	0	(637)	(635)	2	(127)	(126)
Surplus / (Deficit)	(15,165)	(30,164)	(20,462)	(1,867)	(1,765)	102	(9,773)	(9,599)	174	(1,269)	(2,428)
NHS Breakeven duty adjs:											
Donated Assets	(414)	138	122	24	(94)	(118)	124	(28)	(152)	(5)	26
NCA Impairments	1,732	4,085	1,826	0		(0)	0		(0)		
Surplus / (Deficit) - Normalisec	(13,847)	(25,940)	(18,514)	(1,843)	(1,859)	(16)	(9,649)	(9,627)	22	(1,274)	(2,402)

I&E Analysis (Pre & Post PSF)

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,705)	(12,254)	(12,232)	22
PSF	9,191	2,605	2,605	-
Post PSF	(18,514)	(9,649)	(9,627)	22

Pre-PSF I&E Performance

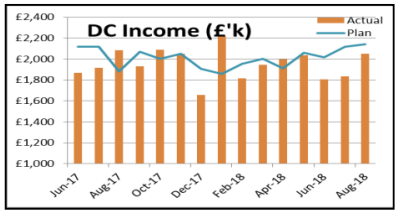


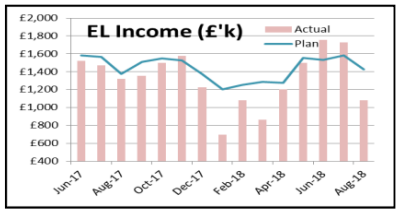
2. Clinical Income (YTD)

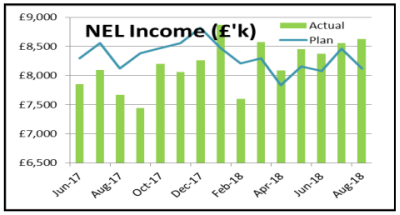
Month 5 SLA Clinical Income is below plan, with a variance of -£2,222k (excluding pass-through medicines and devices). The YTD underperformance includes significantly reduced XS bed days, without compensating activity in elective care and OP remains below plan.

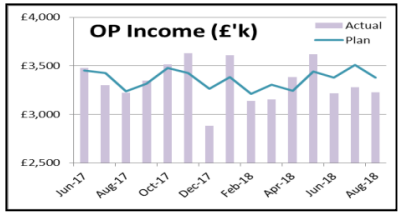
- A&E activity is above plan by 3%, and also shows a casemix variance. An element is subject to coding & counting challenge, which is within the challenge line. This is c.£35k per mth.
- Cost per Case (CPC) is above plan due to Radiotherapy activity (£197k), Critical Care (£153k) and Direct Access volumes (£103k). This is offset by Maternity income under plan by £128k.
- Day case performance is now reporting below plan by 1% on activity, 0.2% financially. General Surgery is under plan by £108k, with Oral Surgery under by £97k, partly offset by Vascular (+£95k) and Urology activity (+£68k) ahead of plan.
- Elective activity is reporting 12% below the activity plan, 8% financially. This includes adjustments to correct Elective Inpatients to Day Cases, as reported previously (further details on slide 2.2). Planned activity overall is 2.1% below plan, with the financial position 3.6% below.
- NEL activity is 1% below plan, but positive casemix reports a 4% favourable variance in income. General Surgery (30%), Cardiology (19%) and T&O (10%) remain the most significant areas above income plan. Stroke is the main beneficiary from casemix. Reduced XS bed day income more than offsets this variance.
- Outpatients are below activity plan, worsening to 5.4% (particularly in Ophthalmology (17%) and Cardiology (62%)), and under the income plan by 4%. OPROCS are 5% above. CaMIS migration has impacted OP activity (see slide 2.2).

Key PoD Trend Analysis









SLA Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	53,157	54,626	1,469	6,810	7,233	423
Block	-	-	-	4,528	4,547	20
Cost per Case	1,244,542	1,303,188	58,646	15,664	15,993	329
CQUIN	-	-	-	2,085	2,085	0
Day Cases	16,999	16,861	(138)	10,247	10,227	(20)
Elective	2,281	2,013	(267)	7,367	6,759	(608)
Elective XBDs	523	581	58	140	170	31
Non-Elective	21,775	21,565	(210)	40,644	42,184	1,540
Non-Elective XBDs	13,637	8,184	(5,453)	3,377	1,576	(1,800)
Outpatient First	23,768	22,341	(1,427)	4,192	3,969	(223)
Outpatient Follow-up	87,418	82,811	(4,607)	6,962	6,707	(256)
Outpt Procedures	63,990	66,389	2,399	7,854	8,285	432
STP related income				1,150	0	(1,150)
CIP / Other				964	0	(964)
sub-total	**1,528,089**	**1,578,559**	**50,470**	**111,982**	**109,736**	**(2,246)**
Contract Penalties				(96)	(40)	56
Challenges				(750)	(782)	(32)
Readmissions				(1,331)	(1,331)	0
MRET				(2,466)	(2,466)	0
Fines & Penalties				**(4,643)**	**(4,619)**	**24**
Subtotal (excl. Excl Meds & Dev.)	**1,528,089**	**1,578,559**	**50,470**	**107,339**	**105,117**	**(2,222)**
Excluded Devices	1,920	1,275	(645)	872	633	(239)
Excluded Medicines	3,448	4,131	683	10,328	9,023	(1,305)
Total SLA Clinical Inc	**1,533,456**	**1,583,965**	**50,508**	**118,539**	**114,773**	**(3,767)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	477	337	(141)
Overseas Visitors	56	179	123
RTA / Personal Injury Income	595	501	(94)
PSF Funding	4,100	4,100	0
Total Other Clinical Income	**5,228**	**5,116**	**(112)**

Clinical Income By Commissioner (YTD)

Nene Contract - £602k under performance

The Month 5 position on the Nene contract is £602k under plan. This is from £65k over in Month 4. The Month 5 position will improve slightly as further patient coding occurs, but the reduction against plan has been across most of the main points of delivery.

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. The is now c.£35k per month with the value within the main challenge provision, reported in 'Other'
- Critical Care. After an initial quarter of high occupancy levels were on plan during August.
- Planned activity, as reported earlier, was down against plan in August. This is significant against Nene, £388k below plan in the month and £794k YTD.
- OPROC activity in Ophthalmology during May was a key driver of over-performance on this POD, but this has been under plan since June.
- OP across all Specialties for Nene were below plan by 13%, a £183k impact on the contract in month (£626k year to date).
- NEL is the most significant, £1.75m over plan due to favourable casemix. This is partially offset by NEL XS bed day income below plan (£-1.3m).

Specialised Commissioner - £1,154k under performance

The under performance is attributable to excluded devices (-£238k), and excluded medicines (-£1,171k) which will have equivalent underspends. Hep C uptake has slowed dramatically, causing the majority of the variance.

Non-elective activity is also below plan, specifically in Paediatrics and General Medicine, although this is offset by planned activity, OP procedures (+£257k) and Radiotherapy income(+£203k).

Secondary Dental - £5k under performance

Over-performance on Secondary Dental is in the MaxFax Specialty, £97k over in non-Elective activity and £59k in Planned activity. This is offset by Oral Surgery, below plan on elective activity by £177k.

Other - £1,977k under performance

£1,150k relates to the STP related income target, and £742k relating to Productivity CIPs.

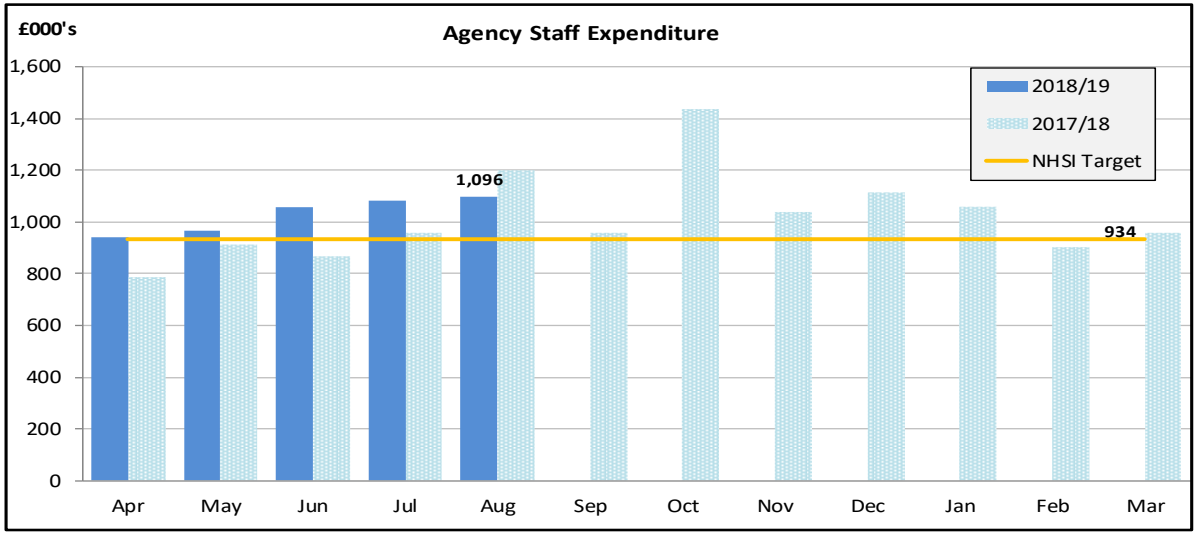
SLA Clinical Income by Commissioner

	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	92,170	91,568	(602)
Corby CCG	1,112	1,221	109
Bedfordshire CCG	304	340	36
East Leicestershire & Rutland CCG	325	330	4
Leicester City CCG	21	55	33
West Leicestershire CCG	23	35	12
Milton Keynes CCG	1,265	1,040	(225)
Specialised Commissioning	17,429	16,276	(1,154)
Secondary Dental	2,759	2,755	(5)
NCA / Central / Other	3,131	1,154	(1,977)
Total SLA Income	**118,539**	**114,773**	**(3,767)**

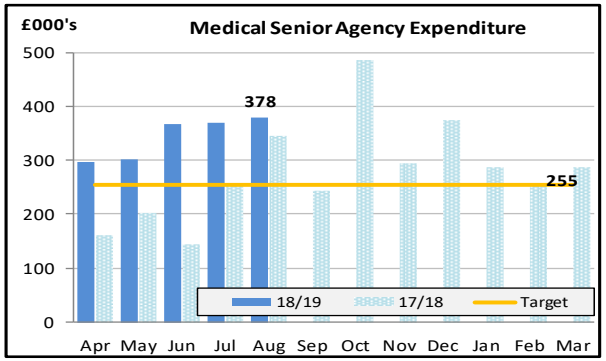
STP Income Gap - Update

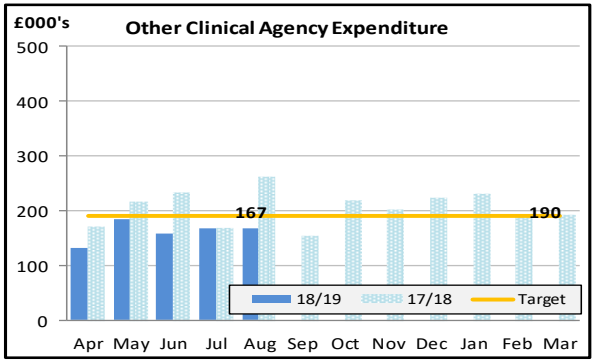
- The proposals to meet £2.3m of the £4.6m system gap have now gone through the Governing Body of both CCGs and the Board of NHFT.
- Despite promises that a contract variation (CV) would be issued by the end of July 2018, this is yet to be received.
- We remain unclear as to when CVs will be transacted.
- This has been escalated to NHSI
- At this time no financial benefit has been applied to the year to date financials.

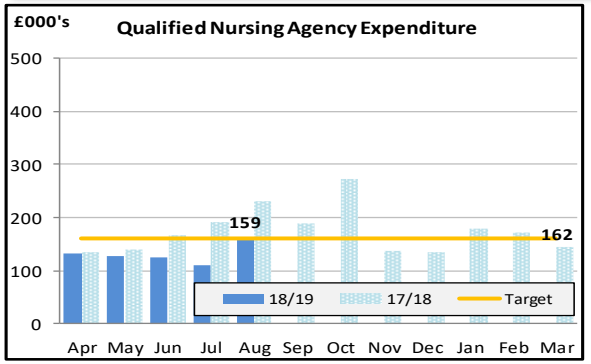
3. Pay: Agency Spend

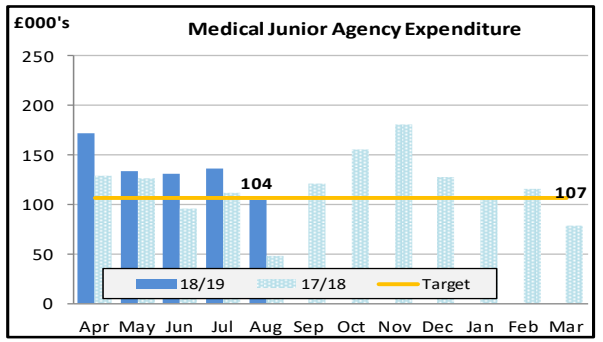


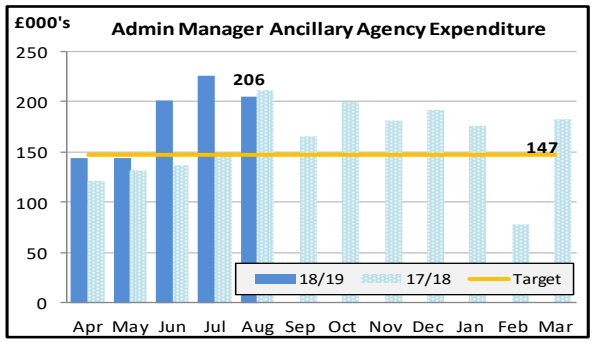
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Agency Management & Senior Medical Locum costs have been high since June with a number of key clinical and management posts requiring cover.
- The Trust run-rate for 18/19 is £94k above the target. This monthly expenditure needs to drop to £867k per month to meet the NHSI target at year end.

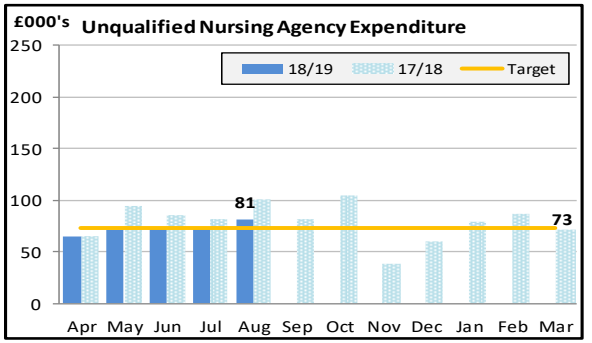












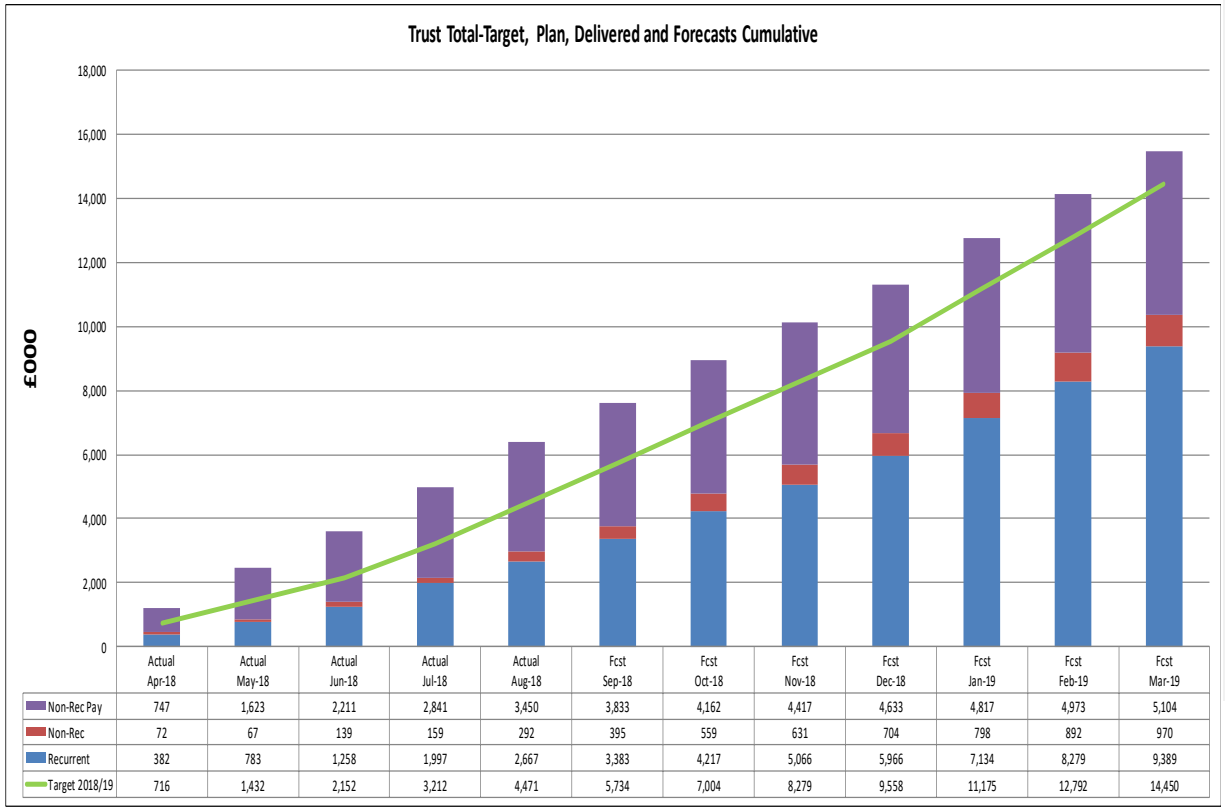
4. CIP

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	1,205	533	61	783	1,377	172
MEDICAL DIVISION	3,815	1,180	634	73	572	1,278	98
WCOH DIVISION	2,205	682	451	21	743	1,215	533
CSS DIVISION	1,734	536	556	39	663	1,258	722
HOSPITAL SUPPORT	1,118	346	0	70	689	759	413
FACILITIES	1,153	357	484	10	0	494	137
Expenditure Other (Held Ce	532	164	10	49	0	59	-106
Trust Total	**14,450**	**4,471**	**2,667**	**323**	**3,450**	**6,440**	**1,969**

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	2,438	148	1,199	3,785	3,087	-807
MEDICAL DIVISION	3,815	3,002	200	932	4,134	3,386	-428
WCOH DIVISION	2,205	1,249	86	1,178	2,514	2,020	-186
CSS DIVISION	1,734	1,476	60	663	2,199	1,831	97
HOSPITAL SUPPORT	1,118	0	70	1,132	1,203	877	-240
FACILITIES	1,153	1,138	15	0	1,153	1,120	-33
Expenditure Other (Held Centrally)	532	85	390	0	475	190	-342
Trust Total	**14,450**	**9,389**	**970**	**5,104**	**15,462**	**12,511**	**-1,939**



	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual 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	2,841	3,450	3,833	4,162	4,417	4,633	4,817	4,973	5,104
Non-Rec	72	67	139	159	292	395	559	631	704	798	892	970
Recurrent	382	783	1,258	1,997	2,667	3,383	4,217	5,066	5,966	7,134	8,279	9,389
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 £12.511m against a target of £14.45m. This represents a negative variance of £1.939m.

Of the £15.462m forecasted delivery £6.073m (39%) of schemes are non-recurrent. This is predominantly £5.104m 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 5 totalled £6.440m against a year to date plan of £4.471m. This represents a favourable variance to plan of £1.969m, which is mainly due to £3.450m Non-Recurrent pay general underspend across all divisions.

All 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.

The cross cutting transformation has now become part of the changing care steering group for the rest of the year to mitigate the potential shortfall in this years savings.

5. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M5 movements include capital additions of £12.5m, of which £11.8m relates to the Nye Bevan finance Lease.
- Depreciation - £833k in month as per 2018/19 plan.

Current assets

• Inventories - £92k Increase in Pharmacy (£188k) is offset by decrease in Pathology (31k), Heart Centre (£120k) & Supplies Trading (£128k) stockholdings .

• Trade & Other Receivables – £1,032k made up of: Increases in NHS receivables (£321k), Other receivables (£265k), VAT reclaim (£281k), Salary Overpayments (£27k) & Prepayments (£442k). Decrease in Trade receivables (£304k).

• Cash – Decrease of £3,451k. Deficit Funding drawdown £1,044k less than July. Increased level of Creditor payments following resolution of queries. Repayment of Capital Loan.

Current Liabilities

• Trade & Other Payables - £672k made up of: Increase in NHS Payables & Accruals (£414k), Trade Payables (£434k), Capital Payables (£42k), Tax, NI & Pension Creditor (£461k) & PDC Dividend (£127k). Decrease in Other Payables, which includes Net Pay (£354k), Accruals (£1,552k), Receipts in Advance (£113k) & Loan interest payable (£134k).

• Finance Lease Payable - £978k Nye Bevan repayments due within 12 months.

• Provisions - £403k. Released unutilised: Danetre Rental – VAT element confirmed as recoverable (£102k) & Winter Funding Expenditure (£300k). Quarterly payment made to NHS Pensions Agency for Injury Benefit Compensation.

Non Current Liabilities

• Finance Lease Payable - £10,714k. Nye Bevan element £10,724k

• Drawdown of Revenue Loan - £845k

• Repayment of Capital Loan - £536k

Financed By

- I & E Account - £1,765k deficit in month

SOFP

TRUST SUMMARY BALANCE SHEET
MONTH 5 2018/19

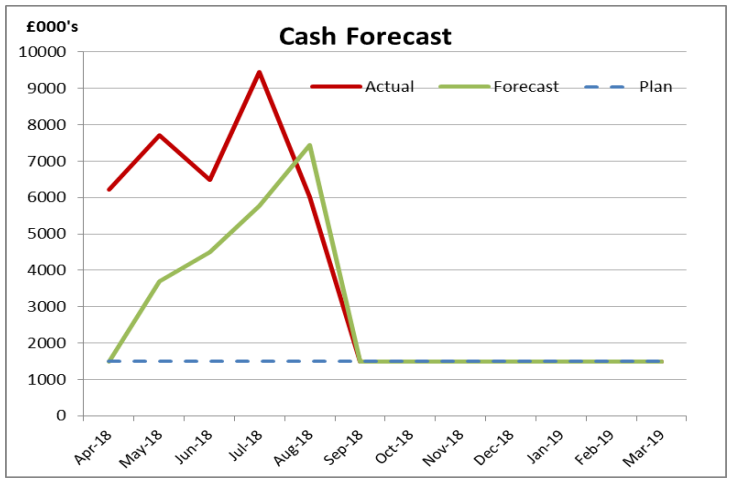
	Balance at 31-Mar-18 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	153,637	153,635	153,635	0	153,552	(85)
IN YEAR REVALUATIONS	0	510	510	0	510	510
IN YEAR MOVEMENTS	0	1,890	14,395	12,505	21,253	21,253
LESS DEPRECIATION	0	(3,324)	(4,157)	(833)	(10,623)	(10,623)
NET BOOK VALUE	**153,637**	**152,711**	**164,383**	**11,672**	**164,692**	**11,055**
CURRENT ASSETS						
INVENTORIES	6,272	6,242	6,150	(92)	6,372	100
TRADE & OTHER RECEIVABLES	16,479	15,250	16,282	1,032	16,988	509
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	9,460	6,009	(3,451)	1,500	(47)
TOTAL CURRENT ASSETS	**24,298**	**30,952**	**28,441**	**(2,511)**	**24,860**	**562**
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	26,845	26,173	(672)	19,272	(3,512)
FINANCE LEASE PAYABLE under 1 year	130	130	1,108	978	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	2,011	1,608	(403)	1,997	(747)
TOTAL CURRENT LIABILITIES	**47,171**	**50,499**	**50,402**	**(97)**	**44,148**	**(3,023)**
NET CURRENT ASSETS / (LIABILITIES)	**(22,873)**	**(19,547)**	**(21,961)**	**(2,414)**	**(19,288)**	**3,585**
TOTAL ASSETS LESS CURRENT LIABILITIES	**130,764**	**133,164**	**142,422**	**9,258**	**145,404**	**14,640**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	949	11,663	10,714	11,387	10,394
LOANS over 1 year	52,394	62,162	62,471	309	74,242	21,848
PROVISIONS over 1 year	1,001	1,001	1,001	0	1,001	0
NON CURRENT LIABILITIES	**54,388**	**64,112**	**75,135**	**11,023**	**86,630**	**32,242**
TOTAL ASSETS EMPLOYED	**76,376**	**69,052**	**67,287**	**(1,765)**	**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)	(83,491)	(85,256)	(1,765)	(94,372)	(18,715)
FINANCING TOTAL	**76,376**	**69,052**	**67,287**	**(1,765)**	**58,774**	**(17,602)**

Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2018/19 £000s	ACTUAL 18/19 APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	FORECAST 18/19 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	1,379	0	0	1,838	0	0	2,757
SLA Performance (relating to 17/18 activity)	-1,893	479	660	0	0	-112	-2,920	0	0	0	0	0	0
Health Education Payments	9,260	795	795	795	745	774	774	769	762	762	762	762	762
Other NHS Income	14,460	750	564	957	1,017	2,079	1,299	1,299	1,299	1,299	1,299	1,299	1,299
PP / Other (Specific > £250k)	4,753	0	970	316	531	428	708	300	300	300	300	300	300
PP / Other	12,612	1,195	908	1,058	1,001	1,250	1,000	1,000	1,000	1,000	1,000	1,000	1,200
Salix Capital Loan	775	0	0	0	0	0	0	0	0	0	775	0	0
PDC - Capital	127	0	0	0	0	0	0	0	127	0	0	0	0
Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	15,246	4,439	3,143	-1,052	1,276	232	0	2,595	1,044	1,119	671	95	1,684
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	73	6	5	7	7	7	6	6	6	6	6	6	6
TOTAL RECEIPTS	**346,305**	**29,808**	**30,430**	**26,222**	**30,532**	**28,032**	**25,620**	**29,650**	**28,219**	**30,005**	**28,647**	**27,296**	**31,843**
PAYMENTS													
Salaries and wages	205,328	16,698	16,586	16,804	16,701	18,098	17,480	17,020	17,300	17,300	17,300	17,020	17,020
Trade Creditors	96,056	4,928	9,279	7,229	7,688	9,519	8,793	7,584	7,709	7,669	8,116	8,052	9,490
NHS Creditors	25,066	1,999	2,648	2,370	2,586	2,321	2,750	2,138	2,138	2,138	2,138	920	920
Capital Expenditure	9,857	1,493	414	1,004	459	739	375	1,457	1,037	1,036	925	512	407
PDC Dividend	962	0	0	0	0	0	200	0	0	0	0	0	762
Repayment of Revenue Loan - PSF funding	5,974	0	0	0	0	0	0	1,379	0	1,838	0	0	2,757
Repayment of Loans (Principal & Interest)	3,004	8	11	22	152	775	487	42	35	25	168	793	487
Repayment of Salix loan	62	29	0	0	0	0	3	29	0	0	0	0	0
TOTAL PAYMENTS	**346,309**	**25,156**	**28,938**	**27,429**	**27,585**	**31,452**	**30,089**	**29,650**	**28,219**	**30,006**	**28,647**	**27,297**	**31,843**
Actual month balance	-4	4,652	1,492	-1,207	2,947	-3,420	-4,468	0	0	0	0	-1	0
Cash in transit & Cash in hand adjustment	-43	20	-1	-17	27	-32	-40	0	0	0	0	0	0
Balance brought forward	1,547	1,547	6,219	7,710	6,486	9,460	6,009	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**6,219**	**7,710**	**6,486**	**9,460**	**6,009**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- The Trust ended August with £6,009k cash balance, £1,434k less than forecast.
- Cash settlement of Final 17/18 Performance invoices/credit notes issued in July is forecast in September for the majority of Commissioners. The August SLA Performance entry relates to Milton Keynes CCG. Nene & Corby CCGs have taken credit notes in September.
- Other NHS Income includes funding of the Pay Award, 4 months funding (£1,196k) was received from DHSC in August to cover arrears.
- Pay Award Arrears were paid to staff on Agenda for Change contracts in August. Payments due to HMRC & Pensions in September include the additional associated deductions & contributions.
- The deficit funding element of the Uncommitted Revenue Loan drawdown in August was based on the expected cash requirement. A zero deficit drawdown has been approved for September.
- Repayment of Capital Loan Principal & Interest was made in August with further repayment due in September.

Cash forecast



Capital

Capital Scheme	Plan 2018/19 £000's	M5 Plan £000's	M5 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Medical Equipment - MESC Block	630	153	153	0	24%	201	32%
Medical Equipment - CF Specific Forecast	100	20	20	0	20%	20	20%
EAB Talbot Butler - CF Specific	350	136	136	0	39%	136	39%
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	230	177	-53	29%	182	29%
Information Technology	3,023	602	473	-129	16%	686	23%
Estates - Backlog	1,608	846	961	114	60%	1,357	84%
Estates - Statutory	373	61	67	6	18%	121	33%
Estates - Non Maintenance	322	102	119	18	37%	150	46%
Estates - Ward Refurbishment	725	0	0	0	0%	33	5%
Nye Bevan - Setting Up Costs	296	206	205	-1	69%	318	107%
Nye Bevan Assessment Unit (Finance Lease)	12,329	11,760	11,760	0	95%	11,760	95%
Inventory / Ledger Upgrade	32	32	24	-8	76%	25	79%
MRI 1 Enabling Costs	277	277	240	-37	87%	255	92%
SALIX	775	34	34	0	4%	539	70%
Total - Capital Plan	**21,519**	**14,487**	**14,397**	**-90**	**67%**	**15,809**	**73%**
Less Charitable Fund Donations	-450	-156	-156	0	35%	-156	35%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**21,069**	**14,331**	**14,240**	**-90**	**68%**	**15,653**	**74%**

Funding Resources	
Internally Generated Depreciation	10,623
Finance Lease - Assessment Unit	12,329
Salix	775
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	**21,069**
Uncommitted Plan	**0**

- The Trust's capital plan £21,169k at M5, has been adjusted to reflect the authorised Salix loan of £515k for calorifiers, leaving £260k of Salix loans still to be agreed.
- Cumulative spend (excluding Charitable funds) to M5 is £14,397k, this includes £11,760k for the Nye Bevan assessment unit Finance Lease, which is not actual cash spend but is a Capital Resource Limit funding source.
- It has been agreed with the Finance Lease provider – Shawbrook, because we have had partial handover we have entered in to the lease agreement ahead of the final handover. An adjustment will be made to the finance lease value once the water & heating works have been completed and the costs have been finalised.
- There are further commitments of £1,412k. The commitments include £505k for the salix calorifiers, £113k for Nye Bevan setting up equipment, £218k for IT, £500k for Estates and £48k for Medical Equipment – Manfield Theatre operating lights.
- There has been further Charitable Funds spend on the Emergency Assessment Bay in Talbot Butler of £136k.

Receivables and Payables

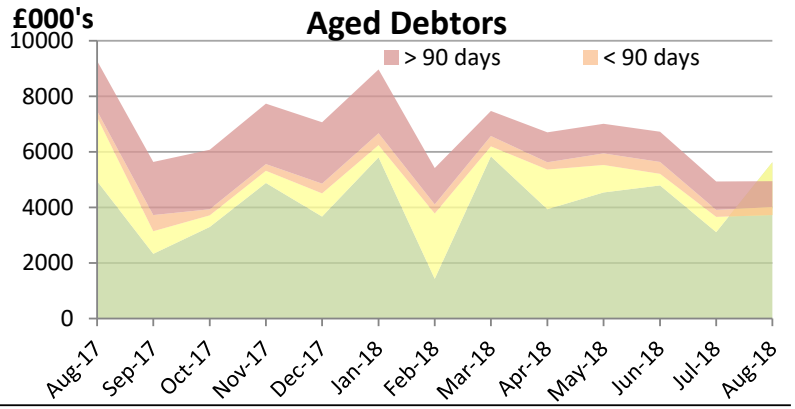
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £2,605k relates to PSF funding for M1-5.
- Balances are significantly lower than usual due to a credit note issued to Nene CCG for £3.5m for 17/18 under performance. This has been taken in month 6. 17/18 under/over performance invoices & credit notes issued in July are included in the 31 to 60 Days debt.
- NHS over 90 day debt include University Hospitals of Leicester NHS Trust £38k, Oxford University Hospital NHS Foundation Trust £131k, Kettering General Hospital NHS Foundation Trust £93k, Northamptonshire Healthcare Foundation Trust £40k, Milton Keynes CCG £64k and £218k NCA's, of which £48k is due from Oxford Univ Hospital.
- Non-NHS over 90 day debt includes overseas visitor accounts of £345k ,of which £152k are paying in instalments & a further £148k have been referred to debt collection & private patients accounts of £47k

Receivables and Payables

Narrative	Total at August £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,369	406	319	95	549
Receivables NHS	3,574	5,218	(2,221)	189	388
Total Receivables	**4,943**	**5,624**	**(1,902)**	**283**	**938**
Payables Non NHS	(5,144)	(5,127)	(6)	(11)	0
Payables NHS	(1,724)	(1,724)	0	0	0
Total Payables	**(6,867)**	**(6,851)**	**(6)**	**(11)**	**0**

Narrative	Total at July £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,673	695	195	106	677
Receivables NHS	3,254	2,410	345	152	346
Total Receivables	**4,927**	**3,105**	**540**	**258**	**1,024**
Payables Non NHS	(4,664)	(4,654)	(10)	(0)	0
Payables NHS	(1,310)	(1,296)	(11)	0	(2)
Total Payables	**(5,974)**	**(5,950)**	**(21)**	**(0)**	**(2)**

Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in August 2018

BPPC

Narrative	April 2018	May 2018	June 2018	July 2018	August 2018	Cumulative 2018/19
NHS Creditors						
No.of Bills Paid Within Target	99	155	151	151	161	717
No.of Bills Paid Within Period	99	155	151	152	161	718
Percentage Paid Within Target	**100.00%**	**100.00%**	**100.00%**	**99.34%**	**100.00%**	**99.86%**
Value of Bills Paid Within Target (£000's)	1,432	2,233	1,910	2,347	1,886	9,808
Value of Bills Paid Within Period (£000's)	1,432	2,233	1,910	2,361	1,886	9,822
Percentage Paid Within Target	**100.00%**	**100.00%**	**100.00%**	**99.39%**	**100.00%**	**99.85%**
Non NHS Creditors						
No.of Bills Paid Within Target	3,887	7,280	5,731	6,023	7,061	29,982
No.of Bills Paid Within Period	3,953	7,319	5,748	6,035	7,090	30,145
Percentage Paid Within Target	**98.33%**	**99.47%**	**99.70%**	**99.80%**	**99.59%**	**99.46%**
Value of Bills Paid Within Target (£000's)	6,884	10,004	8,602	8,163	10,640	44,292
Value of Bills Paid Within Period (£000's)	6,954	10,029	8,615	8,251	10,654	44,503
Percentage Paid Within Target	**99.00%**	**99.75%**	**99.84%**	**98.93%**	**99.86%**	**99.53%**
Total						
No.of Bills Paid Within Target	3,986	7,435	5,882	6,174	7,222	30,699
No.of Bills Paid Within Period	4,052	7,474	5,899	6,187	7,251	30,863
Percentage Paid Within Target	**98.37%**	**99.48%**	**99.71%**	**99.79%**	**99.60%**	**99.47%**
Value of Bills Paid Within Target (£000's)	8,316	12,237	10,511	10,510	12,526	54,100
Value of Bills Paid Within Period (£000's)	8,386	12,262	10,525	10,612	12,540	54,325
Percentage Paid Within Target	**99.17%**	**99.80%**	**99.87%**	**99.04%**	**99.88%**	**99.59%**

6. 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.

SOF

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	-7%	4	20.00%	0.80
Distance From Plan	0%	1	20.00%	0.20
Agency spend (distance from cap)	-8%	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.

7. Risks

Risk	Description	Estimated Gross Impact £'m	RAG	Mitigations	Mitigated Impact £'m	Exec Lead
Revenue Risks						
Activity	Slow pace at utilising the beds made available from the reduction in stranded and super-stranded patients, meaning that the loss in excess bed days income is not matched by elective income.	0.6		Utilise locums to fill current gaps where possible. Potential upside with non-pay costs associated with elective activity.	0.4	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	1.0		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	0.5	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.	1.5		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%	0.8	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. Financial position in line with plan YTD	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.	0.5		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	0.1	CP
Income	Ability to invoice accurately for activity under PbR rules following implementation of CAMIS.	1.0		Negotiations with the CCG, for example for block values in extreme circumstances or extended deadlines. Robust implementation testing before implementation.	0.5	DN
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.	1.5	DN
Escalation ward	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.	1.4	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.	0.3	CP
Challenges	Risk of increased challenges from NEL CSU which could be further heightened post CAMIS-implementation.	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	0.5	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.	2.3	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.	7.8		Management of operational and financial targets. Realistic plans set for Divisions. Focus of robust CIP delivery.	6.0	DN/PB

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**Thursday 27 September 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 an increase in contracted workforce employed by the Trust, and a decrease in sickness absence from August 2018.
- Decrease in compliance rate for Mandatory Training and Role Specific Essential Training and Appraisals.
- Carter Review Update
- Workforce Race Equality Standard (WRES) 2018 Reporting Update
- Organisational Development update – Respect and Support Campaign
- Exception Reports for Staff Role Specific Training, Staff Appraisals, Sickness Absence and Vacancy Rates.

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.

Northampton General Hospital NHS Trust

TRUST BOARD

THURSDAY 27 SEPTEMBER 2018

WORKFORCE PERFORMANCE REPORT

1. Introduction

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

2. Workforce Report

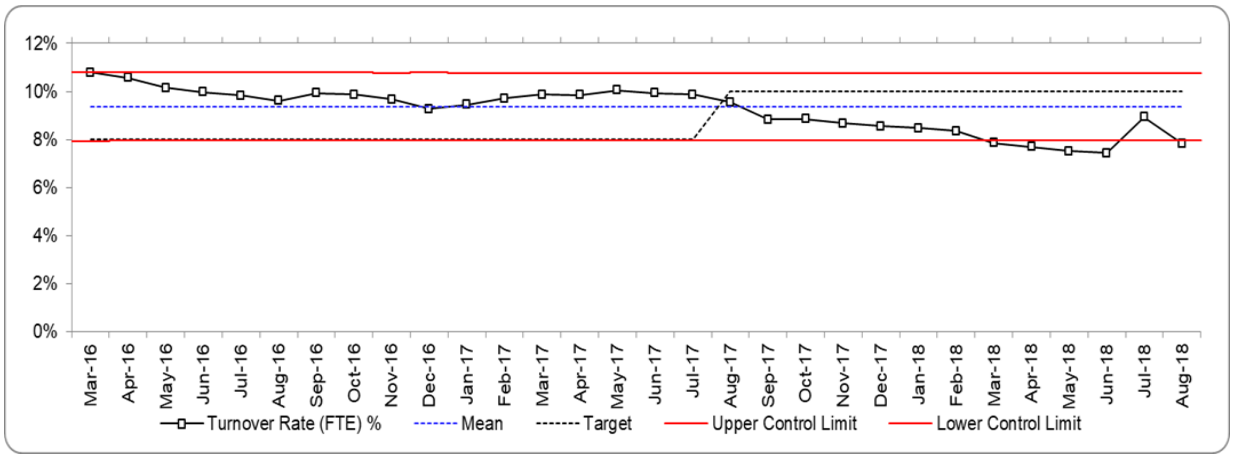
2.1 Capacity

Substantive Workforce Capacity increased by 20.99 FTE in August 2018 to 4416.23 FTE. The Trust's substantive workforce is at 88.16% of the Budgeted Workforce Establishment of 5009.41 FTE.

Trust Turnover

Annual Trust turnover for August 2018 decreased by 1.10% to 7.83%, which is below the Trust target of 10.00%

Turnover within Nursing & Midwifery decreased by 1.06% to 5.63%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.



Vacancy Rates

The overall Trust vacancy rate for August 2018 is 11.84% against a Trust target of 9%. The vacancy % rate has increased in August 2018 for Additional Clinical Services and Estates & Ancillary.

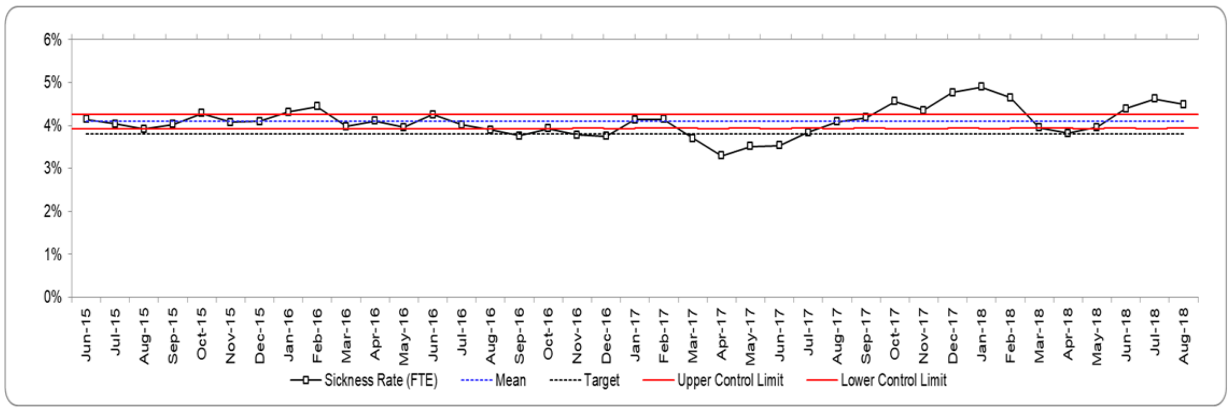
There has been a decrease for Add Prof Sci & Tech; Admin & Clerical; Allied Health Professionals; Healthcare Scientists; Medical & Dental and Nursing & Midwifery staff groups.

The largest vacancy rate decrease was experienced by Medical & Dental decreasing 5.23% from 14.67% to 9.44%.

Sickness Absence

Sickness absence for August 2018 decreased from 4.62% to 4.49%, which is above the Trust target of 3.8%. Only Clinical Support Services Divisions was under the Trust's target at 3.40%.

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



Carter Review

The HR directorate continue to progress the recommendations in relation to the Carter Report with regular meetings being held with the HR Corporate Officer who maintains a shared drive of all evidence relevant to each of the HR recommendations which include all or part of recommendation 1, and parts of 2 and 14. Appendix 1 provides a summary of the progress made.

The areas where most improvement has taken place within the last 6 months are in relation to the following:

- 'Staff Attrition – Recommendation 1c
- We Respect and Support Each Other' campaign – Recommendation 1e

Staff Attrition
The HR department has developed management practices to gain a better understanding of the reasons for high levels of staff attrition as the exit questionnaire has recently been revised and a software system utilised, which amongst other things, enables an electronic exit questionnaire to be automatically sent to any employee that is processed by payroll as a leaver on a monthly basis. The software will produce management information in the form of a dashboard at service level or Trust wide level to enable an analysis of the reasons why people are leaving.

We Respect and Support Each Other campaign
A full update in respect of the 'We Respect and Support Each Other' campaign can be found in section 2.3 of the report.

Current Gaps

Whilst there has been some development towards achieving the Carter recommendations there are number of gaps where further work is required and these are as follows:

Recommendation	Gap	Comments
1a) Implement a clear set of leadership capabilities used in the selection and performance management of leaders	Recruitment against the Trust's leadership model	The OD department have commenced the planning stage for introducing the leadership model as part of the selection process. It is envisaged the end to end process will take a minimum of 6 months to complete
14i) HR Director to introduce the nine management practices that strengthen organisational resilience, effectiveness and productivity	4 Leadership Strategy Talent management and succession planning	Talent management and succession planning is in the process of being designed. Business critical posts are currently being identified across the Trust in order to recognise individuals with high potential that will be provided with a range of support and development opportunities so they have the capabilities to apply for 'flight risk' posts when they become vacant. It is envisaged this process will take a minimum of a year to finalise
	7 Individual Performance Management System Quality of appraisals	Further work is required to improve the quality of staff appraisal and this is about to commence with the implementation of a quality review of the Trusts appraisal process. It is envisaged that the review together with implementation of the findings will take up to a year to complete as this will be linked to the talent management process

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for August 2018 is 85.04%; this is a decrease of 0.9% from last month's figure of 85.94%.

Mandatory Training compliance decrease in August 2018 from 89.22% to 88.81% this is a decrease of 0.41% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also decreased in August 2018 to 83.81% from last month's figure of 85.15%.; that is a decrease of 1.34%.

2.3 Culture

Workforce Race Equality Standard (WRES) 2018 Reporting

Baseline data for the National Workforce Race Equality Standard for 2018 has been produced and will be published on the Trusts website in September 2018. Data is collected each year against 9 indicators and year on year comparative analysis is undertaken to establish if there have been improvements in the experiences or the treatment of White staff and BME staff. A full copy of the report can be found at appendix 2.

Organisational Development update – Respect and Support Campaign

Introduction

This report provides an update on the Respect and Support Campaign since last reported in March.

Launch of the Respect and Support Campaign

The Respect and Support Campaign was launched in June 2018. Over 100 members of team NGH across the Trust attended. During the event there was an opportunity to hear more about the campaign and the range of interventions available for all staff. The event also included an introduction to Forum Theatre, a visual way of understanding and dealing with bullying and inappropriate behaviour at work. During the launch there were various stands highlighting the range of support available and examples of good practice around promoting our values 'We Respect and Support Each Other'.

Respect and Support Campaign

The information below provides a summary of the work undertaken to date.

- **Respect and Support Intranet Page**

A dedicated Respect and Support intranet page is available to all staff. The website includes links to a range of information to understand and address workplace bullying and inappropriate behaviour and there is a section on the support and training available for all staff to promote our values. A Respect and Support information booklet is currently being produced and will be circulated to all staff.

- **Behavioural Framework**

A Respect and Support Behavioural Framework has been developed which provided details of the behaviours staff are expected to display and this has been provided to all staff via a payroll attachment. All new starters will also receive the framework when they first join the Trust.

- **Self- Assessment Tool**

A Respect and Support self-assessment is also available for all staff. This is a self-reflection tool for individuals to identify their strengths and development areas based on the expected behaviours outlined in the Respect and Support behavioural framework.

- **Corporate Induction Programme**

The Respect and Support Behavioural Framework is included in our Living Our Values section of the Corporate Induction. Since the launch of the framework 200 new starters have received an introduction to behavioural framework.

- **Building Resilience Programme**

Since the launch of the Building Resilience training in July, nearly 100 staff across the Trust has attended the training. Feedback from delegates is positive and the evaluation shows it has given staff a range of skills and knowledge to be able to cope better with the day-to-day pressures they feel they have at work.

- **Leading with Respect and Challenging Bullying and Inappropriate Behaviour**

As part of the Respect and Support campaign there are two half day training programmes: '*Leading with Respect' is* for all managers/clinical leaders *and 'Challenging Bullying and Inappropriate Behaviour' is* for team members (non managers). Both training programmes include practical ways in which delegates can help to promote our core values 'We Respect and Support Each Other'. The training also includes the support available to address workplace bullying, harassment and inappropriate behaviour. Both programmes use a combination of classroom based training and Forum Theatre bespoke to the audience. The first programme, '*Leading with Respect'* commences on 13 September 2018 and approximately 100 managers/clinical leaders are booked to attend. '*Challenging Bullying and Inappropriate Behaviour'* for staff will start on 1 October 2018 and already approximately 100 staff have booked to attend. More programmes have been arranged in November and January.

- **Funding From NHS Improvement**

We have recently been successful in securing funding from NHS Improvement as they are interested in showcasing our Respect and Support Campaign across the wider NHS. This will allow us to progress the programme in a timely manner as well as bring subject matter experts into the Trust to support on the initiatives.

3.0 Policies

The procedural documents that were ratified in and uploaded to the intranet in August 2018 were as follows:

- Bullying, Harassment & Victimisation Policy – full review
- Disciplinary Policy – minor amendments
- Grievance Procedure – full review
- Job Banding Policy – minor amendments
- Managing Industrial Action Policy – full review
- Manual Handling Policy – full review
- Recruitment, Selection & Retention Policy – minor amendments
- Special Leave Policy – minor amendments
- Supporting and Managing Workforce Sickness Policy – minor amendments

4.0 Assessment of Risk

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

5.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

6.0 Next Steps

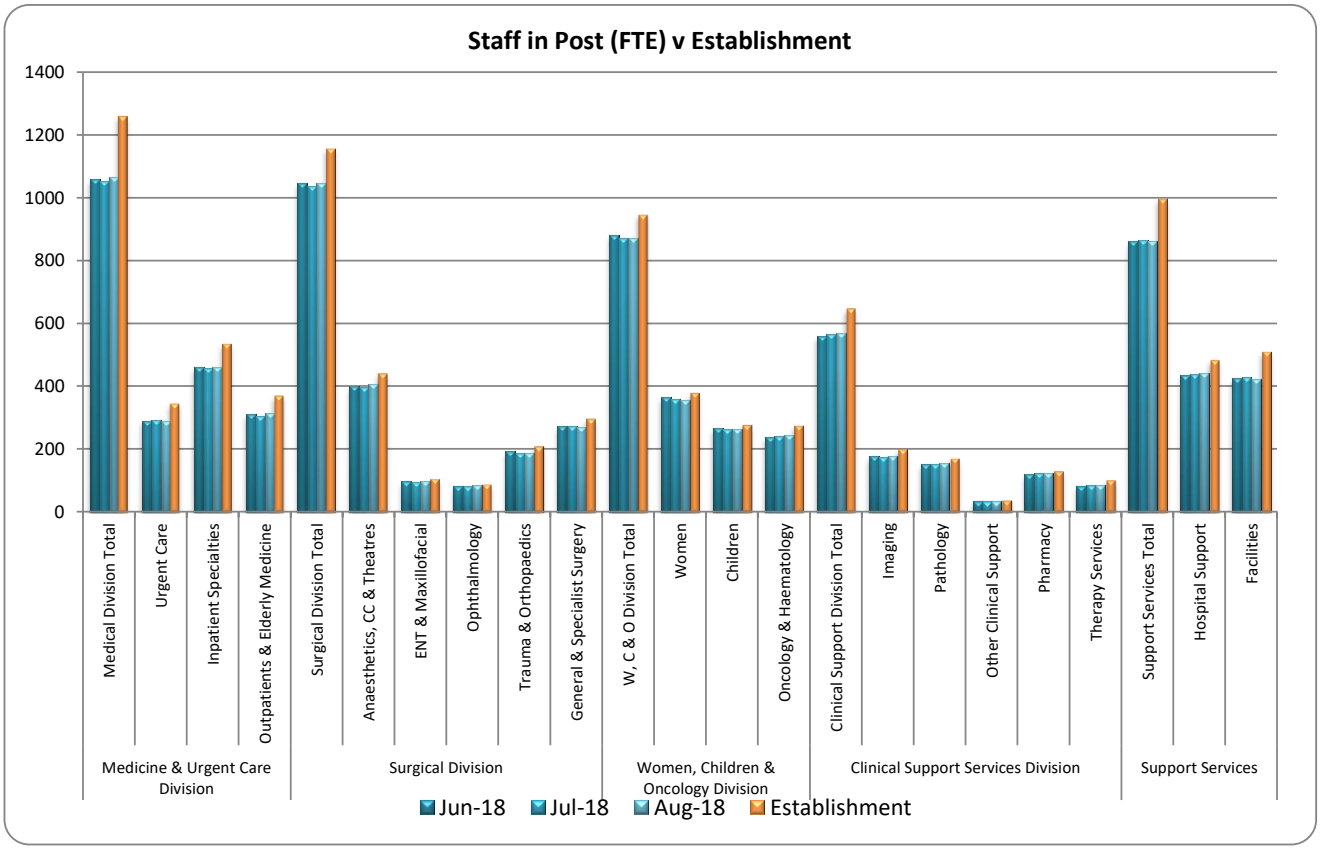
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as and when required.

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Jun-18	Jul-18		Aug-18		Establishment	
Medicine & Urgent Care Division	Medical Division Total	1060.29	↓	1053.45	↑	1067.28	1259.41	84.74%
	Urgent Care	289.87	↑	290.79	↓	289.88	347.49	83.42%
	Inpatient Specialties	459.62	↓	456.55	↑	461.44	537.02	85.93%
	Outpatients & Elderly Medicine	309.80	↓	305.11	↑	312.96	371.90	84.15%
Surgical Division	Surgical Division Total	1046.72	↓	1037.64	↑	1046.00	1157.01	90.41%
	Anaesthetics, CC & Theatres	401.00	↓	395.02	↑	405.74	442.83	91.62%
	ENT & Maxillofacial	96.32	↓	95.32	↑	96.56	107.80	89.57%
	Ophthalmology	80.95	↑	81.95	↑	83.49	90.46	92.29%
	Trauma & Orthopaedics	191.28	↓	187.92	↓	185.97	211.04	88.12%
	General & Specialist Surgery	271.37	↑	271.63	↓	268.53	298.08	90.09%
Women, Children & Oncology Division	W, C & O Division Total	879.81	↓	872.54	↓	871.41	947.51	91.97%
	Women	366.08	↓	358.54	↓	356.68	380.75	93.68%
	Children	266.01	↓	263.49	↓	262.42	278.25	94.31%
	Oncology & Haematology	237.31	↑	240.11	↑	242.11	276.38	87.60%
Clinical Support Services Division	Clinical Support Division Total	560.51	↑	565.67	↑	568.63	649.22	87.59%
	Imaging	175.18	↓	173.74	↑	175.98	201.95	87.14%
	Pathology	151.98	↑	153.26	↑	153.87	173.10	88.89%
	Other Clinical Support	32.72	↑	32.88	↑	33.02	39.12	84.41%
	Pharmacy	118.89	↑	121.49	↓	121.46	131.65	92.26%
	Therapy Services	81.74	↑	84.30	↑	84.30	103.40	81.53%
Support Services	Support Services Total	861.22	↑	865.95	↓	862.81	997.32	86.51%
	Hospital Support	436.29	↑	438.67	↑	441.27	485.06	90.97%
	Facilities	424.93	↑	427.28	↓	421.54	512.26	82.29%
Trust Total		4408.54	↓	4395.24	↑	4416.23	5009.41	88.16%



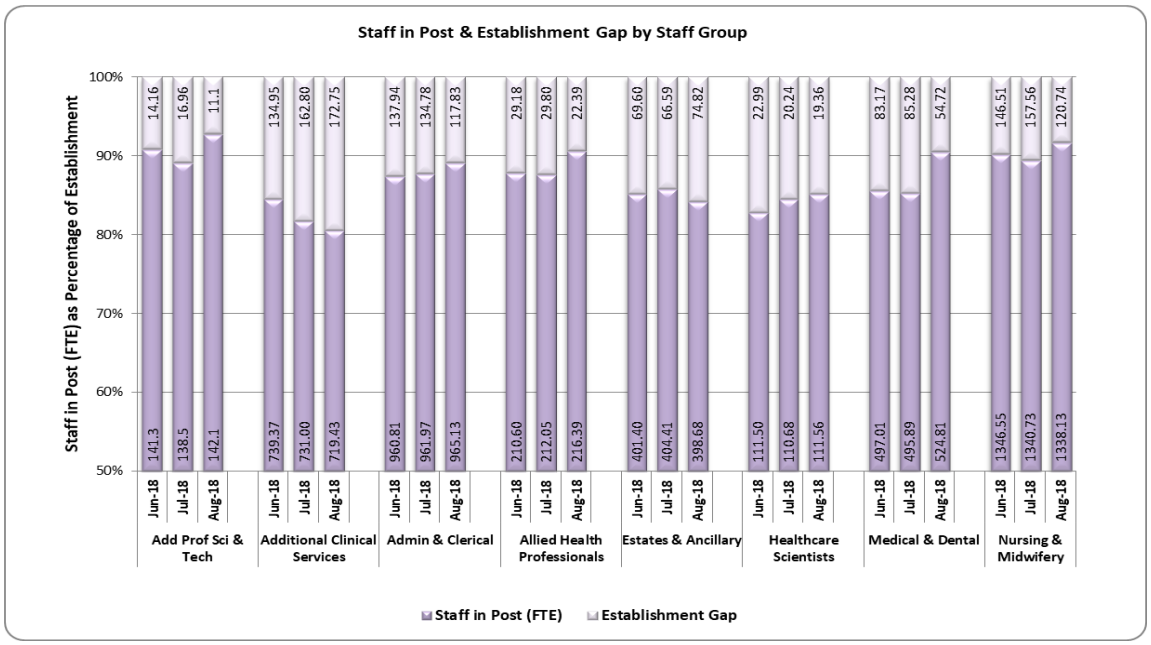
Workforce Committee: Capacity, Capability and Culture Report - August 2018

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Jun-18	Jul-18	Aug-18
Add Prof Sci & Tech	9.11%	10.91%	7.24%
Additional Clinical Services	15.44%	18.21%	19.36%
Admin & Clerical	12.55%	12.29%	10.88%
Allied Health Professionals	12.17%	12.32%	9.38%
Estates & Ancillary	14.78%	14.14%	15.80%
Healthcare Scientists	17.09%	15.46%	14.79%
Medical & Dental	14.34%	14.67%	9.44%
Nursing & Midwifery	9.81%	10.52%	8.28%



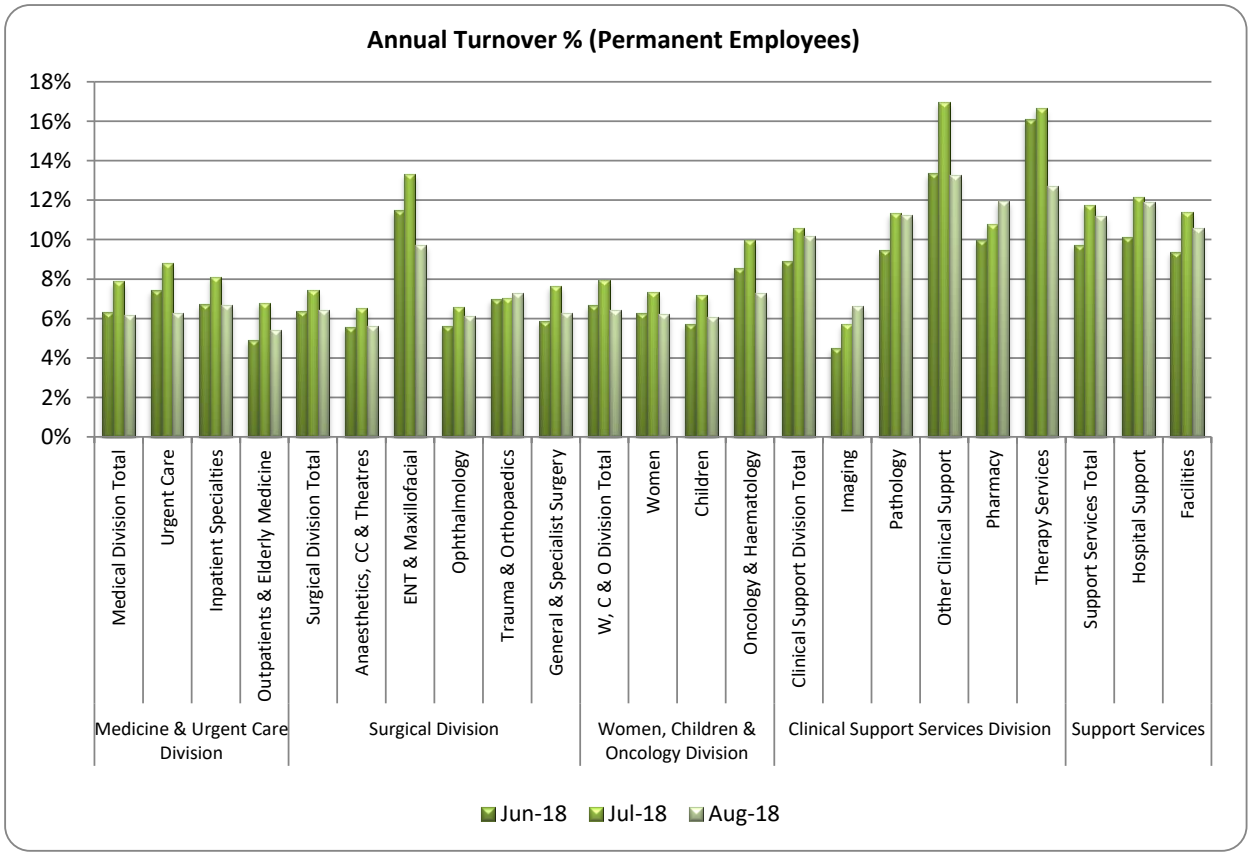
Workforce Committee: Capacity, Capability and Culture Report - August 2018

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Jun-18	Jul-18	Aug-18
Medicine & Urgent Care Division	Medical Division Total	6.33%	7.86%	6.15%
	Urgent Care	7.45%	8.83%	6.24%
	Inpatient Specialties	6.72%	8.09%	6.69%
	Outpatients & Elderly Medicine	4.87%	6.75%	5.40%
Surgical Division	Surgical Division Total	6.37%	7.42%	6.42%
	Anaesthetics, CC & Theatres	5.57%	6.51%	5.59%
	ENT & Maxillofacial	11.48%	13.31%	9.70%
	Ophthalmology	5.62%	6.57%	6.09%
	Trauma & Orthopaedics	6.98%	7.03%	7.28%
	General & Specialist Surgery	5.85%	7.64%	6.27%
Women, Children & Oncology Division	W, C & O Division Total	6.65%	7.96%	6.41%
	Women	6.25%	7.35%	6.21%
	Children	5.69%	7.18%	6.04%
	Oncology & Haematology	8.53%	9.99%	7.26%
Clinical Support Services Division	Clinical Support Division Total	8.88%	10.58%	10.16%
	Imaging	4.48%	5.72%	6.60%
	Pathology	9.46%	11.32%	11.24%
	Other Clinical Support	13.37%	16.95%	13.28%
	Pharmacy	9.95%	10.79%	11.95%
	Therapy Services	16.10%	16.65%	12.71%
Support Services	Support Services Total	9.73%	11.73%	11.19%
	Hospital Support	10.13%	12.17%	11.91%
	Facilities	9.39%	11.38%	10.59%
Trust Total		7.43%	8.93%	7.83%



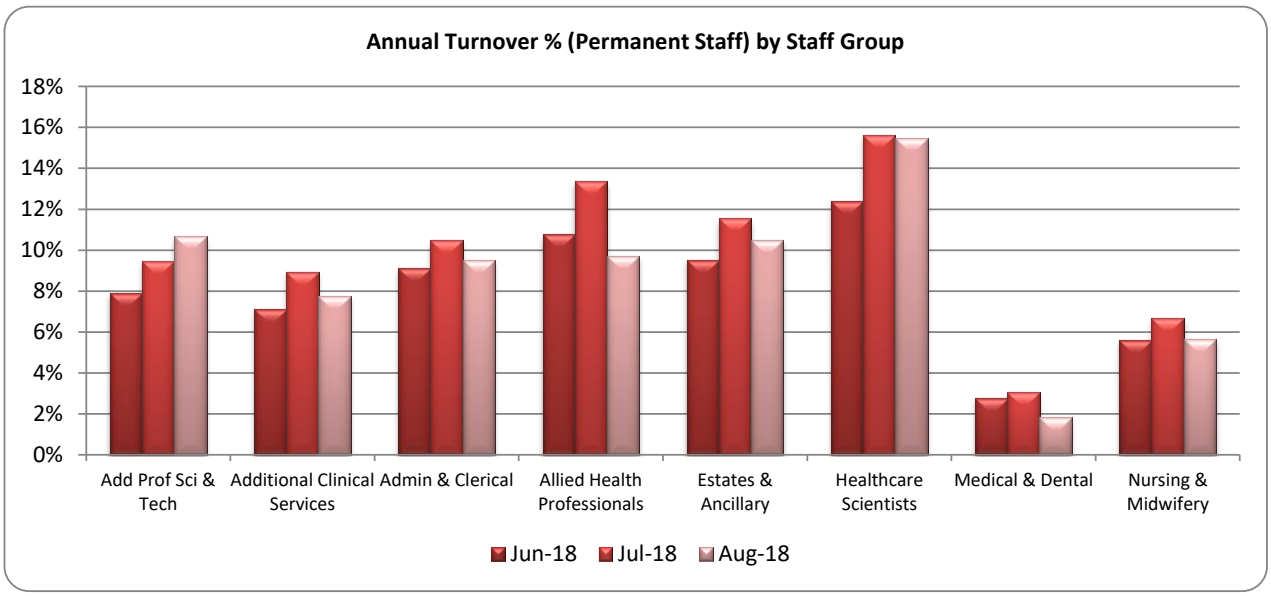
Workforce Committee: Capacity, Capability and Culture Report - August 2018

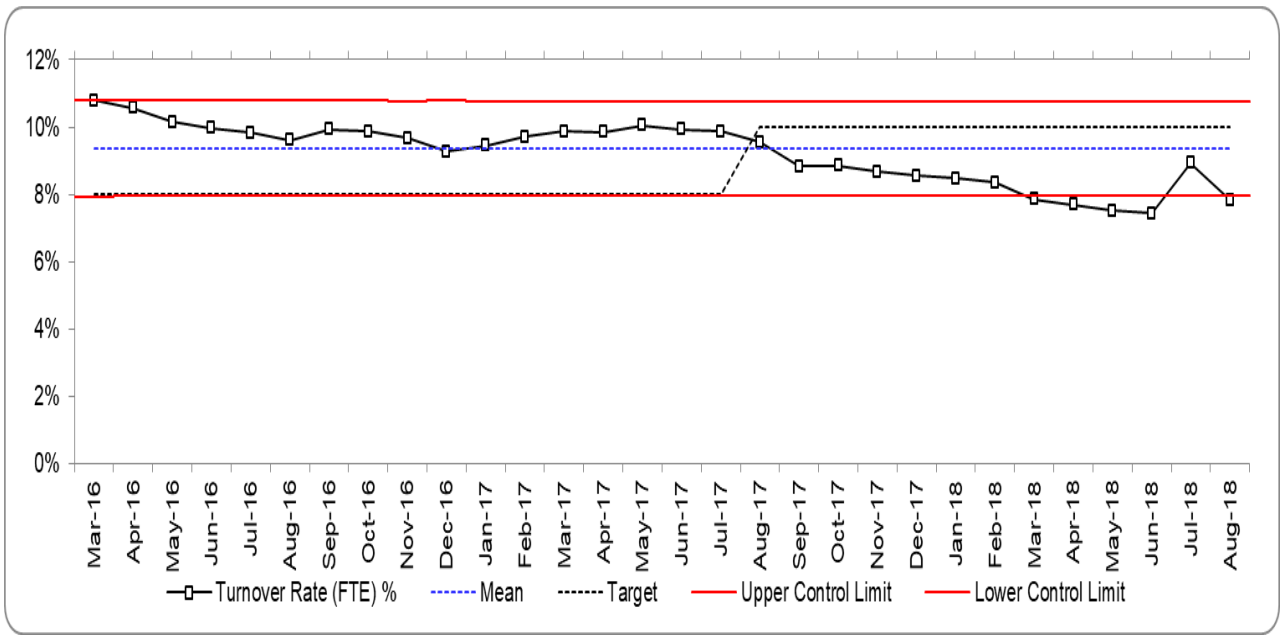
CAPACITY
Turnover by Staff Group

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	Jun-18		Jul-18		Aug-18
Add Prof Sci & Tech	7.89%	↗	9.48%	↗	10.69%
Additional Clinical Services	7.12%	↗	8.95%	↘	7.77%
Admin & Clerical	9.13%	↗	10.49%	↘	9.53%
Allied Health Professionals	10.75%	↗	13.38%	↘	9.70%
Estates & Ancillary	9.53%	↗	11.53%	↘	10.46%
Healthcare Scientists	12.41%	↗	15.59%	↘	15.44%
Medical & Dental	2.76%	↗	3.04%	↘	1.83%
Nursing & Midwifery	5.58%	↗	6.69%	↘	5.63%





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

Capacity:

Substantive Workforce Capacity increased by 20.99 FTE in August 2018 to 4416.23 FTE. The Trust's substantive workforce is at 88.16% of the Budgeted Workforce Establishment of 5009.41 FTE.

Staff Turnover:

Annual Trust turnover for August 2018 decreased by 1.10% to 7.83%, which is below the Trust target of 10.00%.

Turnover within Nursing & Midwifery decreased by 1.06% to 5.63%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.

Turnover also decreased for the following staff groups:

Additional Clinical Services decreased by 1.18%
Admin & Clerical decreased by 0.96%
Allied Health Professionals decreased by 3.68%
Estates & Ancillary decreased by 1.07%
Healthcare Scientists decreased by 0.15%
Medical & Dental decreased by 1.21%

Increasing only for Add Prof Sci & Tech by 1.21%

Turnover by Division:

Medical Division: turnover decreased by 1.71% to 6.15%
Surgical Division: turnover decreased by 1.00% to 6.42%
Women, Children & Oncology Division: turnover decreased by 1.55% to 6.41%
Clinical Support Services Division: turnover decreased by 0.42% to 10.16%
Support Services: turnover decreased by 0.54% to 11.19%

Staff Vacancies:

The vacancy % rate has increased in August 2018 for Additional Clinical Services and Estates & Ancillary.

There has been a decrease for Add Prof Sci & Tech; Admin & Clerical; Allied Health Professionals ; Healthcare Scientists; Medical & Dental and Nursing & Midwifery staff groups.

Largest decrease experienced by Medical & Dental decreasing 5.23% to 9.44%.

Sickness Absence:

Sickness absence for August 2018 decreased from 4.62% to 4.49% which is above Trust target of 3.8%. Only Clinical Support Services Divisions was under the Trust's target at 3.40%

Sickness by Division:

Medicine and Urgent Care at 4.36%
Surgery Division at 4.73%
Women, Children & Oncology at 4.32%
Clinical Support Services at 3.40%
Support Services at 5.42%

Ophthalmology Directorate had the highest sickness rate of 9.94% amongst the directorates.

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

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

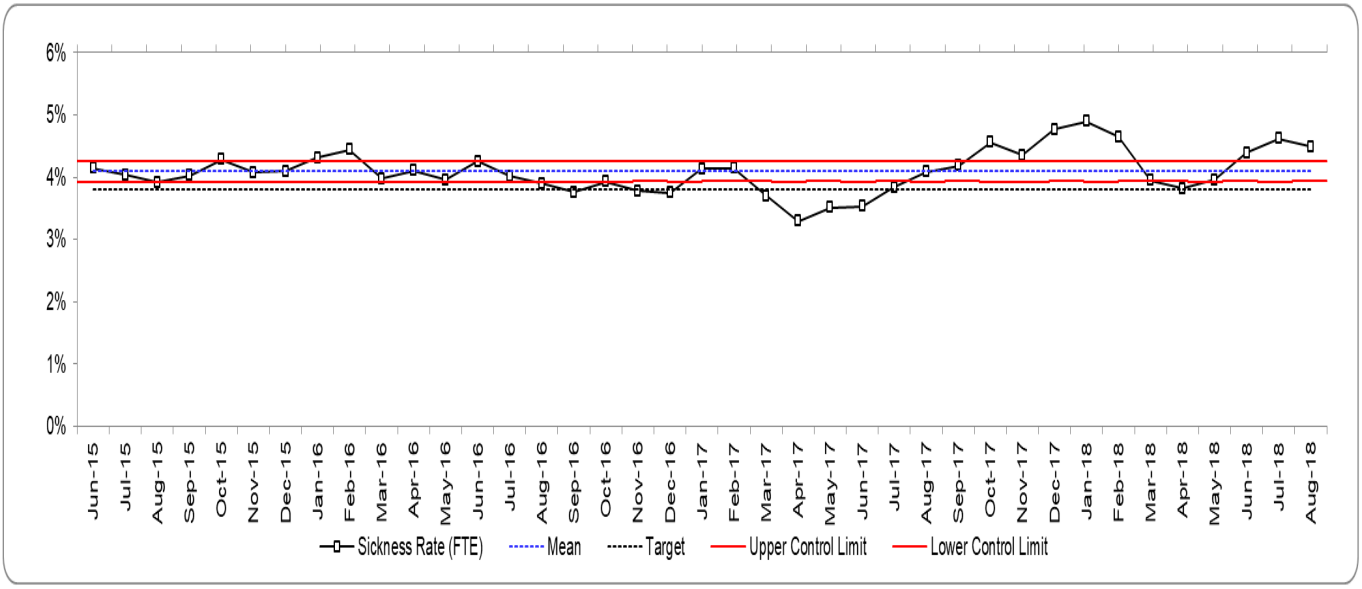
CAPACITY
In-Month Sickness

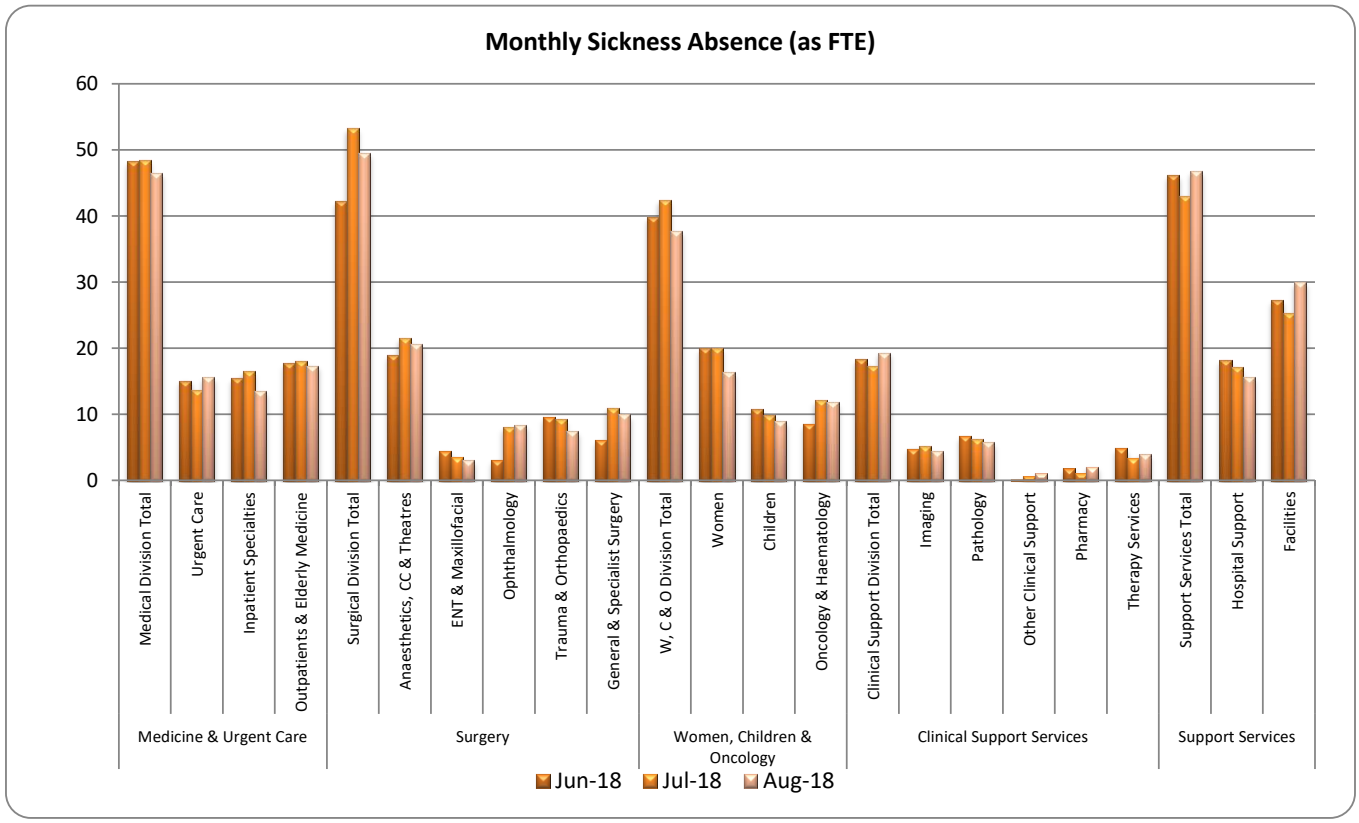
Sickness % RAG Rates:		
> 4.2%	3.8-4.2%	< 3.8%

Monthly Sickness (as FTE)		Jun-18	Jul-18	Aug-18	Aug-18	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	48.24	48.35	46.53	4.36%	2.44%	1.92%
	Urgent Care	15.07	13.64	15.57	5.37%	2.39%	2.98%
	Inpatient Specialties	15.44	16.57	13.52	2.93%	2.13%	0.80%
	Outpatients & Elderly Medicine	17.69	18.12	17.37	5.55%	2.95%	2.60%
Surgery	**Surgical Division Total**	42.29	53.33	49.48	4.73%	2.17%	2.56%
	Anaesthetics, CC & Theatres	19.01	21.53	20.65	5.09%	2.14%	2.95%
	ENT & Maxillofacial	4.47	3.49	3.06	3.17%	2.13%	1.04%
	Ophthalmology	3.10	8.05	8.30	9.94%	3.96%	5.98%
	Trauma & Orthopaedics	9.53	9.30	7.46	4.01%	2.00%	2.01%
	General & Specialist Surgery	6.11	11.00	9.94	3.70%	1.83%	1.87%
Women, Children & Oncology	**W, C & O Division Total**	39.86	42.41	37.64	4.32%	2.08%	2.24%
	Women	19.97	20.04	16.34	4.58%	2.13%	2.45%
	Children	10.72	9.83	8.95	3.41%	1.82%	1.59%
	Oncology & Haematology	8.57	12.10	11.81	4.88%	2.16%	2.72%
Clinical Support Services	**Clinical Support Division Total**	18.33	17.25	19.33	3.40%	2.50%	0.90%
	Imaging	4.82	5.23	4.38	2.49%	1.92%	0.57%
	Pathology	6.75	6.27	5.82	3.78%	1.92%	1.86%
	Other Clinical Support	0.18	0.71	1.06	3.20%	3.20%	0.00%
	Pharmacy	1.80	1.07	2.08	1.71%	1.71%	0.00%
	Therapy Services	4.90	3.35	3.95	4.68%	4.68%	0.00%
Support Services	**Support Services Total**	46.16	43.04	46.76	5.42%	2.35%	3.07%
	Hospital Support	18.15	17.11	15.67	3.55%	2.08%	1.47%
	Facilities	27.32	25.25	29.93	7.10%	2.58%	4.52%
Trust Total	***As FTE***	193.53	203.06	198.29			
	As percentage	4.39%	4.62%		4.49%	2.29%	2.20%

01st September 2017 - 31st August 2018				
Absence Reason	**Headcount**	**Abs Occurrences**	**FTE Days Lost**	**%**
S10 Anxiety/stress/depression/other psychiatric illnesses	439	604	17,748.96	24.1
S98 Other known causes - not elsewhere classified	896	1, 193	10,640.01	14.4
S28 Injury, fracture	237	275	5,674.61	7.7
S25 Gastrointestinal problems	1367	1, 794	5,497.82	7.5
S11 Back Problems	315	419	5,089.34	6.9

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





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

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Jun-18	Jul-18	Aug-18
Medicine & Urgent Care Division	Medical Division Total	85.70%	85.56%	84.37%
	Urgent Care	86.61%	85.95%	84.55%
	Inpatient Specialties	83.40%	83.55%	83.03%
	Outpatients & Elderly Medicine	88.07%	87.99%	85.98%
Surgical Division	Surgical Division Total	88.30%	88.77%	88.19%
	Anaesthetics, CC & Theatres	88.96%	88.84%	89.38%
	ENT & Maxillofacial	83.13%	85.32%	85.29%
	Ophthalmology	92.03%	89.01%	86.20%
	Trauma & Orthopaedics	89.15%	90.11%	89.37%
	General & Specialist Surgery	87.38%	88.75%	87.19%
Women, Children & Oncology Division	W, C & O Division Total	90.25%	89.30%	89.05%
	Women	90.24%	90.52%	89.78%
	Children	91.13%	89.66%	89.00%
	Oncology & Haematology	89.09%	86.65%	87.59%
Clinical Support Services Division	Clinical Support Division Total	93.64%	92.52%	93.23%
	Imaging	92.43%	91.50%	93.01%
	Pathology	97.55%	96.19%	96.47%
	Other Clinical Support	94.85%	94.29%	94.57%
	Pharmacy	94.95%	93.78%	93.82%
	Therapy Services	87.04%	85.65%	86.57%
Support Services	Support Services Total	92.23%	91.82%	91.71%
	Hospital Support	91.73%	91.48%	90.88%
	Facilities	92.69%	92.13%	92.48%
Trust Total		89.55%	89.22%	88.81%

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Jun-18	Jul-18	Aug-18
Medicine & Urgent Care Division	Medical Division Total	82.94%	82.89%	81.09%
	Urgent Care	84.59%	83.71%	81.59%
	Inpatient Specialties	79.95%	80.81%	79.24%
	Outpatients & Elderly Medicine	85.50%	85.07%	83.29%
Surgical Division	Surgical Division Total	84.81%	85.06%	83.68%
	Anaesthetics, CC & Theatres	84.24%	83.56%	83.22%
	ENT & Maxillofacial	81.67%	82.68%	79.30%
	Ophthalmology	86.87%	84.92%	81.17%
	Trauma & Orthopaedics	88.11%	90.23%	87.65%
	General & Specialist Surgery	83.60%	84.14%	83.22%
Women, Children & Oncology Division	W, C & O Division Total	86.21%	86.33%	85.03%
	Women	85.22%	85.29%	84.36%
	Children	88.38%	88.35%	86.92%
	Oncology & Haematology	85.60%	85.93%	83.95%
Clinical Support Services Division	Clinical Support Division Total	87.20%	88.20%	87.70%
	Imaging	87.65%	89.35%	90.47%
	Pathology	92.48%	88.29%	86.39%
	Other Clinical Support	93.43%	91.24%	88.11%
	Pharmacy	80.16%	87.08%	85.50%
	Therapy Services	86.79%	86.48%	85.53%
Support Services	Support Services Total	87.27%	86.70%	86.41%
	Hospital Support	86.65%	85.01%	84.01%
	Facilities	88.07%	88.86%	89.57%
Trust Total		**84.99%**	**85.15%**	**83.81%**

Capability

Appraisals
The current rate of Appraisals recorded for August 2018 is 85.04%; this is a decrease of 0.9% from last month's figure of 85.94%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decrease in August 2018 from 89.22% to 88.81% this is a decrease of 0.41% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also decreased in August 2018 to 83.81% from last month's figure of 85.15%.; that is a decrease of 1.34%.

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 not achieved this month, but work continues to improve current figures.

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

CAPABILITY

Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Jun-18	Jul-18	Aug-18
Medicine & Urgent Care Division	Medical Division Total	83.53%	83.73%	83.85%
	Urgent Care	86.97%	84.32%	84.04%
	Inpatient Specialties	78.74%	81.02%	82.47%
	Outpatients & Elderly Medicine	86.80%	87.13%	85.67%
Surgical Division	Surgical Division Total	92.00%	90.77%	87.51%
	Anaesthetics, CC & Theatres	92.00%	89.92%	85.18%
	ENT & Maxillofacial	77.50%	74.36%	71.60%
	Ophthalmology	90.00%	90.14%	84.29%
	Trauma & Orthopaedics	96.11%	97.77%	93.75%
	General & Specialist Surgery	94.02%	92.06%	92.37%
Women, Children & Oncology Division	W, C & O Division Total	87.14%	85.98%	86.97%
	Women	91.29%	90.02%	87.97%
	Children	88.24%	87.04%	88.76%
	Oncology & Haematology	79.58%	78.78%	83.61%
Clinical Support Services Division	Clinical Support Division Total	88.29%	87.99%	85.88%
	Imaging	86.11%	85.79%	88.65%
	Pathology	90.80%	91.46%	87.88%
	Other Clinical Support	86.11%	81.08%	81.08%
	Pharmacy	87.20%	86.82%	85.04%
	Therapy Services	90.43%	90.53%	80.00%
Support Services	Support Services Total	83.55%	82.26%	81.54%
	Hospital Support	81.26%	79.70%	78.04%
	Facilities	85.58%	84.54%	84.72%
Trust Total		86.74%	85.94%	85.04%

CARTER REVIEW

Areas/ Responsibility	Key actions to recommendations to be delivered by Trust	NGH Status	Comments	Management Lead(s)	Exec Lead(s)	Monitoring Group(s)
Human Resources	1a) Implement a clear set of leadership capabilities used in the selection and performance management of leaders;	Partially In Place	The Trust has adopted a leadership model. The HR department has evidence of developing leadership capabilities through Leadership programmes provided such as Francis Crick programme for senior managers, the James Stonhouse programme for Bands 4 to 6 and the Esther White programme for Band 7 and above. In addition there is a vocational related qualification for aspiring team leaders which is open to all staff. Recruitment against the Trust leadership model needs to be developed.	Fiona Pittam	Janine Brennan	Workforce Committee
	1b) Regular performance reviews ensuring that a culture of continuous improvement is developed;	In Place	Written evidence is kept up to date on a regular basis on the shared drive and our appraisal process includes annual performance reviews including personal development plans aligned to the Trust's values including 'we aspire to excellence'. The trust is in the top 20-% of trusts for its staff appraisal rate. The trust is 'above average' on the staff survey response in relation to staff's 'ability to contribute towards improvements at work'. The Trust has a structured and robust approach to developing a culture of continuous improvement.	Adam Cragg	Janine Brennan	Workforce Committee
	1c) develop management practices to gain a better understanding of the reasons for high levels of	Partially In Place	Written evidence demonstrates turnover is reported on a monthly basis. Turnover consistently runs below the Trust target. The exit questionnaire has recently been revised and a software system utilised, which amongst other things, enables an electronic exit questionnaire to	Adam Cragg	Janine Brennan	Workforce Committee

	staff attrition;		be automatically sent to any employee that is processed by payroll as a leaver on a monthly basis. In addition the software will produce management information in the form of a dashboard at service level or Trust wide level to enable an analysis of the reasons why people are leaving. In addition to this, the Trusts Retention and Reward Specialist is routinely notified of leavers within identified 'business critical staff groups', and a 'stay discussion' is held with each member of staff. This enables an exploration of the reasons why someone has decided to leave and also whether there is anything that could be facilitated to enable their continued employment at the Trust.			
	1d) improve sickness absence by adopting common definition, improving data collection and manage as part of the operational management scorecard and process;	In Place	Written evidence demonstrates data collection and reporting of sickness absence is in place through divisional management teams. The Trust has a policy with clear definitions for sickness absence. A gap analysis against best practice was undertaken in 2018, with limited changes to existing practice required.	Andrea Chown	Janine Brennan	Workforce Committee
	1e) CEO to lead a sustained campaign towards the reduction of bullying and harassment	In Place	The Respect and Support campaign has been developed to address bullying and harassment. Significant progress has been made following a presentation at the February Workforce Committee. A trust wide presentation has taken place at a 'Question Time' event and the 'We Respect and Support Each Other' campaign was launched at the end of June. A behavioural	Fiona Pittam Janine Brennan	CEO	Workforce Committee

			framework has been developed, approved by Staff Side and the relevant committees and has been circulated to all staff via payslips. Leading with respect training for clinical and non-clinical leaders, managers and supervisors is in place and challenging bullying and inappropriate behaviour training for all non-management staff is also being delivered. The programme is currently delivering its targets in line with the 'We respect and support each other' project plan.			
	1f) Create an environment that is fair and transparent; review polices, practices and agreements to ensure that they are clear, simple and swift to operate	In Place	Written evidence is kept up to date on a regular basis. All HR policies are reviewed regularly and currently all are in date. All HR policies are consulted on with staff side colleagues to ensure transparency	Andrea Chown	Janine Brennan	Workforce Committee
	1g) Mandatory use of Trust and national level succession planning processes and demonstrate use of NHS Executive Search to shortlist executive candidates before external recruitment consultancies are considered	See Comments	Currently the Trust does not utilise NHS Executive search on a mandatory basis prior to external recruitment as the Trust has a best value for money and multi-agency approach. A Talent management process is under development.	Fiona Pittam	Janine Brennan	Workforce Committee
	2d) develop medical staff bank to manage	In Place	There is a local medical staff bank with internal rates of pay. Rates of pay have been agreed with our local trust	Adam Cragg	Janine Brennan	Workforce

	vacancies in shortage specialties across a geographical region.		but the Trust has not agreed to regional bank rates due to that potentially increasing cost to the Trust. The trust has signalled its agreement to a regional agency MOU.			Committee
	2e) Implement NHSI good practice guidance to rely on NHS staff knowledge rather than external consultancies.	See Comments	The Trust would co-operate but there are no initiatives in place currently	N/A	N/A	N/A
	2i) Align with activities of national bodies with coordinated and proactive approach to managing the supply of staff, including overseas recruitment.	In Place	The Trust would co-operate but there are no initiatives in place currently	N/A	N/A	N/A
	2j) Adhere to the agency rules set out by NHS Improvement.	In Place	NHSI weekly returns, adhering to price cap/ ceiling and Framework operator rules.	Tony Maher	Phil Bradley	Finance & Performance
	14i) HR Director to introduce the nine management practices that strengthen organisational resilience, effectiveness and productivity.	Partially In Place	1 Values based behavioural framework The Trust has a clear set of values determining the behaviours expected for all occupational groups of staff and roles and tracks progress against these as part of the annual staff survey using bespoke questions. The Trust's Behavioural Framework agreed with Staff Side colleagues has been rolled out to all staff across the Trust and a self-assessment tool has been developed for all staff to access to assess themselves against the Trust's Behavioural Framework.	Fiona Pittam	Janine Brennan	Workforce Committee

			2 Patient Centred Organisation Fixing the Flow including Safer in a 100 days quality improvement programmes are patient centred as the workflow and resource allocation is designed around the patient through each stage of their hospital journey. Service planning has a bottom up approach and the Nye Bevan Unit has been designed with a medical model which also puts the patient at the centre of the process. Furthermore the different ways of working in A&E mirror a patient centred approach.	Steve Bryden Jane Bradley	Matt Metcalfe Sheran Oke Debbie Needham	Finance & Performance
		In place	3 Structural Improvement The Trust has a clinically-led structure which defines clear individual accountabilities and decision making responsibilities	Janine Brennan	CEO	N/A
		Partially in place	4 Leadership Strategy The Trust has a clear defined leadership model with a number of development activities such as the Francis Crick, James Stonhouse and Esther White leadership programmes. The leadership model together with the staff engagement strategy underpins the approach being taken. Talent management and succession planning is in the process of being designed. Business critical posts are currently being identified across the Trust.	Fiona Pittam	Janine Brennan	Workforce Committee
		In place	5 Operational Management processes The Trust has a Performance Management Framework which is reviewed annually. Weekly performance meetings take place and at these the divisions are held to account. Board to Ward rounds take place via the	Debbie Needham	CEO	Janine Brennan

			Trust Board on a monthly basis with both Non-Executives and Executive members visiting departments in a structured way. Changing Care meetings are held regularly whereby cost reduction and increased efficiency across the divisions is discussed and monitored.			
		In place	6 Dashboards The Corporate, Division and Directorate Operational dashboards are taken from the NHSI framework and provide a balanced view of patient, people, quality and financial performance. The financial operational performance dashboards also link with the Performance Management Framework.	Director of Corporate Development, Governance and Assurance	CEO	Various TB sub committees
		Partially in Place	7 Individual Performance Management System The Trust has a robust appraisal system in place and overall the Trust meets its target of 85% compliance. The staff survey results show the Trust in the top 20% nationally in relation to staff having an annual appraisal. Further work is required to improve the quality of staff appraisal and training has been undertaken to drive this improvement.	Fiona Pittam	Janine Brennan	Workforce Committee
		In Place	8 Engagement The Trust has a staff engagement strategy and approach across all staff groups in particular clinical engagement with the clinically-led structure	Fiona Pittam	Janine Brennan	Workforce Committee
		In Place	9 Colleague Opinion Survey The Trust carries out a number of survey monkeys on a regular basis which targets specific subjects such as health and wellbeing. However, the Trust does not use	Fiona Pittam	Janine Brennan	Workforce Committee

			the outcomes as a key metric in all managers performance appraisals due to the variety of measures used. The Trust includes bespoke questions around the Trust values and the Trust leadership model and these results are fed into Divisional management teams for consideration and action as appropriate.			

Northampton General Hospital NHS Trust

Appendix 2

Workforce Race Equality Standard (WRES) 2018 Reporting

1. Name of organisation

Northampton General Hospital NHS Trust

2. Date of report

August 2018

3. Name and title of Board lead for the Workforce Race Equality Standard

Janine Brennan, Director of Workforce & Transformation

4. Name and contact details of lead manager compiling this report

Sarah Kinsella, Corporate HR Officer, sarah.kinsella@ngh.nhs.uk

5. Names of commissioners this report has been sent to

NHS Nene Clinical Commissioning Group & NHS Corby Clinical Commissioning Group

6. Name and contact details of coordinating commissioner this report has been sent to

CCGs Quality Teams

7. Unique URL link on which this Report and associated Action Plan will be found

http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

8. This report has been signed off by on behalf of the board on

Date: 19 September 2018

Name: Janine Brennan, Director of Workforce & Transformation

Background narrative

9. Any issues of completeness of data

The Trust collects ethnic data through the completion of job applications by candidates via NHS Jobs2 which, for successful candidates, is then uploaded to ESR. The Trust is therefore reliant on applicants completing these elements of the application form.

The data for the period that this report covers shows that 3.38% of Trust employees have not stated/given their ethnicity or have a null entry on ESR.

10. Any matters relating to reliability of comparisons with previous years

There has been a decrease of 1.59% in the percentage of staff that have not stated/given their ethnicity or have a null entry on ESR since the WRES data exercise was undertaken in 2017.

11. Total number of staff employed within this organisation at the date of the report

4976

12. Proportion of BME staff employed within this organisation at the date of the report?

21.60%

13. The proportion of total staff who have self–reported their ethnicity?

96.62%

14. Have any steps been taken in the last reporting period to improve the level of self reporting by ethnicity?

The Trust's Workforce Information Team have not undertaken any large scale data cleansing exercises since the last reporting period, however they do undertake further investigations regarding individual employee records, where possible, to prevent any null entries on ESR. If the Trust is provided with information regarding errors on ESR they are also investigated and rectified.

15. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity?

In addition to the above, the Trust's Workforce Information Team is starting to implement basic self-service across the organisation and this will enable staff to update their own personal details on ESR. This will enable staff to view their ethnicity and we will be encouraging staff to be proactive in contacting Workforce Information to organise for the correct data to be entered if their record is showing a null or not stated entry.

Workforce data

16. What period does the organisation's workforce data refer to?

1 April 2017 to 31 March 2018

Workforce Race Equality Indicators

For each of these workforce indicators, compare the data for White and BME staff.

17. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

Data for reporting year:

Overall Workforce (4976)

- White 75.02% (3733)
- BME 21.60% (1075)
- Not Stated 3.38% (168)

	Overall Workforce 4976 staff			Non-Clinical Workforce 29.18% (1452) of Trust Workforce			Clinical Workforce 70.82% (3524) of Trust Workforce		
	White	BME	Not Stated	White	BME	Not Stated	White	BME	Not Stated
Under Band 1	0.12%	0.04%	0.00%	0.10%	0.02%	0.00%	0.02%	0.02%	0.00%
Band 1	5.71%	1.00%	0.36%	5.49%	1.00%	0.36%	0.22%	0.00%	0.00%
Band 2	15.88%	2.77%	0.32%	5.20%	0.54%	0.16%	10.67%	2.23%	0.16%
Band 3	7.48%	1.19%	0.12%	4.62%	0.62%	0.04%	2.85%	0.56%	0.08%
Band 4	6.39%	0.82%	0.14%	4.72%	0.42%	0.10%	1.67%	0.40%	0.04%
Band 5	12.68%	6.79%	1.21%	1.77%	0.34%	0.08%	10.91%	6.45%	1.13%
Band 6	11.25%	1.85%	0.32%	0.58%	0.08%	0.04%	10.67%	1.77%	0.28%
Band 7	7.92%	1.02%	0.20%	1.25%	0.16%	0.00%	6.67%	0.86%	0.20%
Band 8a	2.25%	0.30%	0.08%	0.84%	0.04%	0.02%	1.41%	0.26%	0.06%
Band 8b	0.72%	0.04%	0.04%	0.34%	0.02%	0.04%	0.38%	0.02%	0.00%
Band 8c	0.30%	0.02%	0.00%	0.06%	0.02%	0.00%	0.24%	0.00%	0.00%
Band 8d	0.08%	0.00%	0.00%	0.02%	0.00%	0.00%	0.06%	0.00%	0.00%
Band 9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
VSM	0.10%	0.00%	0.00%	0.06%	0.00%	0.00%	0.04%	0.00%	0.00%
Consultants	2.63%	2.55%	0.14%				2.63%	2.55%	0.14%
Career Grade Doctors	0.40%	1.19%	0.26%				0.40%	1.19%	0.26%
Junior Doctors	0.40%	0.64%	0.04%				0.40%	0.64%	0.04%
Other Medical Staff	0.70%	1.37%	0.14%				0.70%	1.37%	0.14%
Total	**75.02%**	**21.60%**	**3.38%**	**25.06%**	**3.28%**	**0.84%**	**49.96%**	**18.33%**	**2.53%**

Data for previous year:

Overall Workforce

- White 75.03%
- BME 20%
- Not Stated 4.97%

	Overall Workforce 4905 staff			Non-Clinical Workforce 28.66% of Trust Workforce			Clinical Workforce 71.34% of Trust Workforce		
	White	BME	Not Stated	White	BME	Not Stated	White	BME	Not Stated
Under Band 1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Band 1	5.44%	1.02%	0.53%	5.04%	0.96%	0.53%	0.41%	0.06%	0.00%
Band 2	16.23%	2.71%	0.37%	5.44%	0.43%	0.20%	10.78%	2.28%	0.16%
Band 3	7.03%	1.04%	0.14%	4.46%	0.51%	0.04%	2.57%	0.53%	0.10%
Band 4	6.77%	0.88%	0.12%	4.89%	0.41%	0.08%	1.88%	0.47%	0.04%
Band 5	12.84%	6.16%	1.55%	1.65%	0.27%	0.10%	11.19%	5.89%	1.45%
Band 6	11.25%	1.69%	0.41%	0.63%	0.04%	0.04%	10.62%	1.65%	0.37%
Band 7	7.83%	0.96%	0.20%	1.28%	0.16%	0.02%	6.54%	0.80%	0.18%
Band 8a	2.28%	0.27%	0.10%	0.84%	0.02%	0.04%	1.45%	0.24%	0.06%
Band 8b	0.75%	0.08%	0.04%	0.27%	0.02%	0.04%	0.49%	0.06%	0.00%
Band 8c	0.22%	0.02%	0.00%	0.08%	0.02%	0.00%	0.14%	0.00%	0.00%
Band 8d	0.10%	0.00%	0.00%	0.02%	0.00%	0.00%	0.08%	0.00%	0.00%
Band 9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
VSM	0.14%	0.00%	0.02%	0.10%	0.00%	0.25%	0.04%	0.00%	0.00%
Consultants	2.39%	1.92%	0.16%	n/a	n/a	n/a	2.39%	1.92%	0.16%
Career Grade Doctors	0.47%	1.12%	0.45%	n/a	n/a	n/a	0.47%	1.12%	0.45%
Junior Doctors	0.98%	1.71%	0.82%	n/a	n/a	n/a	0.98%	1.71%	0.82%
Other Doctors	0.29%	0.43%	0.06%	n/a	n/a	n/a	0.29%	0.43%	0.06%
Total	**75.03%**	**20.00%**	**4.97%**	**24.71%**	**2.83%**	**1.12%**	**50.32%**	**17.17%**	**3.85%**

The implications of the data and any additional background explanatory narrative

3.38 % of the overall workforce have a null or not stated entry for their ethnicity on ESR (Electronic Staff Record).

The 2011 Northamptonshire Census reported 8.50% of the population were BME.

There has been an increase of BME staff in the overall workforce, for the second year in a row and has increased by 1.60% since 2017. The overall BME clinical workforce has also increased for the second consecutive year and is now 18.33%. After a slight decrease the previous year the non-clinical workforce has now increased to 3.28%.

Within the clinical workforce, Band 5 has the highest number of BME staff at 6.45%, followed by Consultants at 2.55%. The Trust employs very few staff in bands 8c, 8d and 9 and Very Senior Managers and at the time of the report has no BME staff in these bands/grades in the clinical workforce.

Within the non-clinical workforce, Band 1 has the highest number of BME staff at 1.00%, followed by Band 3 at 0.62%. The Trust employs very few staff in bands 8d and 9 or Very Senior Managers and at the time of the report has no BME staff in these bands/grades in the non-clinical workforce.

There has again been an increase in BME Consultants of 0.63% and one of these holds a senior medical manager position (as defined by the WRES Technical Guidance 2017), of which there are three in the Trust. In addition the Trust does follow a clinically led structure and each of our 4 Clinical Divisions is led by a Divisional Director and has a one or more Clinical Directors. These are all Senior Medical and Dental staff, who report directly to the Trust's Chief Operating Officer. Of these 15 members of staff, 5 are BME, which is an increase since 2017.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust has been working on its recruitment processes to actively encourage candidates from all protected characteristics to apply for vacant posts. The Trust has also carried out some analysis of internal promotion for White staff compared to BME staff. In addition the Trust will carry out some further analysis for the percentage breakdown of White staff and BME staff within the individual bands by Division to identify if there are any areas of concern in line with the Trust's equality objective of, a representative and supported workforce and inclusive leadership.

18. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year:

1.39 relative likelihood of White staff being appointed from shortlisting compared to BME staff

Data for previous year:

1.18 relative likelihood of White staff being appointed from shortlisting compared to BME staff

The implications of the data and any additional background explanatory narrative

For the first time since commencing WRES reporting there has been a slight deterioration in this area. Of the individuals shortlisted 82 did not disclose their ethnicity. Of the individuals appointed 37 did not disclose their ethnicity.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

As previously referred to, the Trust has been working on its recruitment processes to actively encourage candidates from all protected characteristics to apply for vacant posts. Recruitment training for managers, which includes a session on equality awareness, protected characteristics and values based recruitment, has continued during 2017/2018 in line with the Trust's equality objective of, a representative and supported workforce.

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

Data for reporting year:

0.47 relative likelihood of BME staff entering the formal disciplinary process compared with White staff.

Data for previous year:

0.61 relative likelihood of BME staff entering the formal disciplinary process compared with White staff.

The implications of the data and any additional background explanatory narrative

For the third year running improvement has been seen in this area. Of the individuals entering a formal disciplinary process 11 did not disclose their ethnicity.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust regularly monitors equality data in relation to disciplinary activity to ensure there is fairness and equity regardless of ethnic background and this is provided to the Trusts Equality and Diversity Staff Group in line with the Trust's equality objective of, a representative and supported workforce.

20. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year: 1.03 relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff

Data for previous year: 0.54 relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff

The implications of the data and any additional background explanatory narrative

For the first time since commencing WRES reporting there has been a deterioration in this area. Of the individuals who had places offered and accepted on courses 94 did not disclose their ethnicity.

It should be noted, that this only relates to non-mandatory training and CPD that is organised through the Learning and Development Department. There is no facility to formally record other types of non-mandatory/CPD training that takes place elsewhere in the Trust as there is no method of recording this training centrally, so caution should be taken over the above data.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust will continue to monitor this on an ongoing basis in line with the Trust's equality objective of a representative and supported workforce.

National NHS Staff Survey indicators (or equivalent).

For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff

21. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Data for reporting year:

White 26.10%

BME 26.82%

Data for previous year:

White 28.94%

BME 26.39%

The implications of the data and any additional background explanatory narrative

There has been a slight increase of 0.43% in the number of BME staff who have experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months. In addition, this year a greater number of BME staff reported experiencing it, which is a shift from the previous year when White staff experiences were was higher than BME staff.

There was a slight improvement in the overall Staff Survey results and the Trust was ranked as average when compared to other Acute Trusts, which is an improvement from the previous year's survey.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust has launched a 'Respect and Support Campaign' which, although is primarily aimed at workplace behaviours, will equip staff with the skills and knowledge to recognise and challenge inappropriate behaviours from patients, relatives or the public supported by the Trust's Protecting Staff Against Violence, Aggression, Discrimination and Harassment Policy. This is in line with the Trust's equality objective of, a representative and supported workforce.

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Data for reporting year:

White 29.69%

BME 25.34%

Data for previous year:

White 26.95%

BME 23.15%

The implications of the data and any additional background explanatory narrative

There has been an increase in both the percentage of White staff and BME staff experiencing harassment, bullying or abuse from staff in last 12 months and 2.19% more BME staff experienced it when compared to the previous year, however the survey showed that 4.35% more of our White staff experienced it when compared to our BME staff.

There was also a deterioration in the overall Staff Survey results and the Trust was ranked in the bottom 20% when compared to other Acute Trusts, which is also a deterioration from the previous year's survey, however this was expected due to the work that has been taking place as part of the preparation and planning for the launch of the Respect and Support Campaign, which has raised the awareness of bullying and harassment to staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust has launched a 'Respect and Support Campaign' which will equip staff with the skills and knowledge to recognise and challenge inappropriate behaviours from staff supported by the Trust's Bullying, Harassment and Victimisation Policy. This is in line with the Trust's equality objective of, a representative and supported workforce.

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Data for reporting year:

White 88.34%

BME 66.45%

Data for previous year:

White 87.94%

BME 72.09%

The implications of the data and any additional background explanatory narrative

There has been a deterioration for this key finding as the percentage of BME staff who do not believe the Trust provides equal opportunities for career progression or promotion has dropped by 5.64% to 66.45% from the previous year. In addition the gap between the views of BME staff and White staff has also not improved and is now 21.89%, which is an increase of 6.04% from the previous year.

There was no change in the overall Staff Survey results, however the Trust is ranked as above average when compared to other Acute Trusts, which is an improvement from the previous year's survey.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust has undertaken some analysis on the numbers of BME staff promoted compared to White staff along with a comparison to the Trust's profile and the findings are being shared with key members of the HR Team so that they can consider ways to reduce the gap between the belief of BME and White staff. This is in line with the Trust's equality objective of a representative and supported workforce and inclusive leadership.

24. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Data for reporting year:

White 7.94%

BME 18.30%

Data for previous year:

White 6.50%

BME 12.09%

The implications of the data and any additional background explanatory narrative

There has been a deterioration in this area for both BME and White staff. For BME staff there has been an increase of 6.21% for BME staff and 1.44% increase for White staff. The survey also shows that 10.36% more BME staff than White staff feel they have been discriminated against which is a deterioration from the previous year where the gap was significantly smaller at 5.59%.

There was no change in the overall Staff Survey results, however the Trust is ranked as below average when compared to other Acute Trusts, which is also a deterioration from the previous year's survey.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The Trust has launched a 'Respect and Support Campaign' which will equip staff with the skills and knowledge to recognise and challenge inappropriate behaviours from staff supported by the Trust's Workforce Equality Strategy. In addition the Trust equality and diversity induction presentation has recently been reviewed and refreshed. This is in line with the Trust's equality objectives of, a representative and supported workforce and inclusive leadership.

Board representation indicator

For this indicator, compare the difference for White and BME staff.

25. Percentage difference between the organisations' Board voting membership and its overall workforce

Data for reporting year:

White 11.6%

BME -21.6%

Data for previous year:

White 10.7%

BME -24.1%

The implications of the data and any additional background explanatory narrative:

There has been an improvement of 2.50%, from the previous year for comparison of our BME workforce against the Trust's Board voting membership. However the BME percentage is still very high at -21.6% which shows that the voting members of the Trust Board does not represent the ethnicity of the overall workforce.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

For Executive Director recruitment the Trust uses recruitment agencies to source candidates. Previously the Trust has requested an analysis of the ethnicity of applicants and those who have been shortlisted, however the agencies advised that no candidates completed the equal opportunities form. The Trust has asked that all candidates are encouraged to complete this so that a proper analysis of the candidate pool can be undertaken. Additionally the Trust will actively encourage candidates from BME backgrounds in line with the Trust's equality objective of inclusive leadership.

26. Are there any other factors or data which should be taken into consideration in assessing progress?

The Trust has an Equality and Diversity Strategy (2016-2019) together with an Equality and Diversity Staff Group. Through the groups Terms of Reference there is an nominated equality representative for each division and the understanding of the role of the Divisional Representative has developed further during 2017/2018. Each Division is provided with equality and diversity data for their areas to analyse and identify any areas for improvement and supporting objectives to be set, at a Divisional level. These objectives are reviewed on an annual basis.

27. Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with

milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

The Trust has incorporated its WRES actions into its Equality Objectives Four Year Plan for 2016 – 2020, which was approved by the Trust Board in 2016 and reviewed in 2018. A copy of this can be found in the Equality and Diversity section of the Trusts website via:

http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

Progress reports against the objectives are provided to the Trust's Equality and Diversity Staff Group on a quarterly basis and general equality and diversity reports/updates are provided to the Trust's Workforce Committee, which is a subgroup of the Trust Board, on a 6 monthly basis.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27th September 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	JUN-18	JUL-18	AUG-18
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	83.3%	98.0%	98.1%
	Friends & Family Test % of patients who would recommend: A&E	>=87.4%	88.6%	88.3%	87.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.9%	91.9%	92.5%	91.4%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.8%	100.0%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.6%	92.4%	92.7%	93.1%
	Mixed Sex Accommodation	=0	0	0	3

	Indicator	Target	JUN-18	JUL-18	AUG-18
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	93.8%	92.3%	91.5%
	Average Ambulance handover times	=15 mins	00:14	00:13	00:11
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	58	79	60
	Ambulance handovers that waited over 60 mins	<=10	2	1	3
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	7	6	16
	Delayed transfer of care	=23	35	12	19
	Average Monthly DTOCs	<=23	40	28	16
	Average Monthly Health DTOCs	<=7	31	19	13
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	69.9%	72.1%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	23.3%	18.0%	
	Cancer: Percentage of patients treated within 31 days	>=96%	92.6%	95.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.1%	97.5%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	78.5%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	74.6%	78.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	68.4%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	90.0%	81.2%	
	RTT waiting times incomplete pathways	>=92%	84.7%	81.1%	
	RTT over 52 weeks	=0	0	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%	93.5%	92.9%	100.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	87.7%	97.7%	93.3%

	Indicator	Target	JUN-18	JUL-18	AUG-18
Quality of Care: Effective	Stranded Patients (ave.) as % of bed base	<=40%	56.5%	51.1%	55.0%
	Super Stranded Patients (ave.) as % of bed base	<=25%	29.3%	22.0%	24.6%
	Length of stay - All	<=4.2	4.4	4.2	4.2
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.3%	4.5%	2.9%
	Emergency re-admissions within 30 days (non-elective)	<=12%	15.4%	15.9%	14.0%
	# NoF - Fit patients operated on within 36 hours	>=80%	90.0%	87.5%	82.7%
	Maternity: C Section Rates	<27.9%	34.1%	28.9%	29.8%
	Mortality: HSMR	100	101	0	104
	Mortality: SHMI	100	97	98	98

	Indicator	Target	JUN-18	JUL-18	AUG-18
Finance and Use of Resources	Income YTD (£000's)	>=0	(1,089) Adv	(1,984) Adv	(2,563) Adv
	Surplus / Deficit YTD (£000's)	>=0	40 Fav	72 Fav	174 Fav
	Pay YTD (£000's)	>=0	(1,900) Adv	(2,702) Adv	(2,744) Adv
	Non Pay YTD (£000's)	>=0	870 Fav	2,060 Fav	3,388 Fav
	Bank & Agency / Pay %	<=7.5%	12.1%	12.3%	12.4%
	CIP Performance YTD (£000's)	>=0	1,456 Fav	1,785 Fav	1,969 Fav
	Salary Overpayments - Number YTD	=0	70	89	107
	Salary Overpayments - Value YTD (£000's)	=0	126	152.2	228.7
	Maverick Transactions	=0			27
	Waivers which have breached	=0	2		0

	Indicator	Target	JUN-18	JUL-18	AUG-18
Quality of Care: Safe	Never event incidence	=0	0	0	0
	Number of Serious Incidents (SI's) declared during the period		4	3	2
	MRSA	=0	0	0	0
	C-Diff	<=1.75	2	2	1
	MSSA	<=1.1	0	2	3
	VTE Risk Assessment	>=95%	96.4%	94.3%	91.3%
	Harm Free Care (Safety Thermometer)	>=94%	95.8%	93.3%	91.8%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.7	4.6	5.5
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	25	25	45
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	100.0%	97.7%
	Ward Moves > 2 as a % of all Ward Moves	=0%	5.6%	5.8%	6.6%

	Indicator	Target	JUN-18	JUL-18	AUG-18
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	63.5%	58.3%	60.0%
	Sickness Rate	<=3.8%	4.4%	4.6%	4.5%
	Staff: Trust level vacancy rate - All	<=9%	12.6%	13.2%	11.8%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	14.3%	14.6%	9.4%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	9.8%	10.5%	8.2%
	Staff: Trust level vacancy rate - Other Staff	<=9%	13.7%	14.4%	14.0%
	Turnover Rate	<=10%	7.4%	8.9%	7.8%
	Percentage of all trust staff with mandatory training compliance	>=85%	89.5%	89.2%	88.7%
	Percentage of all trust staff with role specific training compliance	>=85%	84.9%	85.1%	83.8%
	Percentage of staff with annual appraisal	>=85%	86.7%	85.9%	85.0%

Run Date: 12/09/2018 15:57 Corporate Scorecard Run by: CrockettG

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 or amber 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 Ambulance Handover Times	Externally mandated	Finance, Investment & performance committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	68	90	107	139	228	244	219	179	80	129	58	79	60

Driver for underperformance:

- At times of increased departmental capacity crews are unable to offload and handover within set timeframes.
- Multiple ambulance arrivals within a short periods cause spikes in demand and our ability to deliver performance is comprised.
- Fast Response Cars booking mobile to hospital and not calling clear at scene, thus showing as a delay when transporting resource has been cleared. Multiple occasions in July.
- Ambulance Turnaround screen has not been recognising some crews pins, thus showing as delays. This remains an ongoing problem, although reducing.
- Trolley shortage in ED towards the end of August slowing the handover time into FIT

Actions to address the underperformance:

- Early escalation to EMAS silver to request HALO should the need arise.- Daily escalation in place
- Black Breaches information requested daily from EMAS so they can be validated Monthly validation of report 3 in August are currently being disputed
- Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews, and to make aware of Trust pressures. Daily escalation in place when OPEL level increases or during spikes of high demand
- Trackers to escalate all ambulance delays approaching 25 minutes. Action is ongoing and monitored daily.
- Escalation to EMAS/Ops room if multiple ambulance arrivals in quick succession (10 or more per hour).
- Ambulance arrival screen now live in resus area and Fit area this allows for early planning of critically unwell patients and also nurses are able to handover crews without leaving resus area.
- Some breaches still occurring on PAU/Maternity when crews not logging out or coming to ED then transferring to PAU and not logging out.
- Trolleys have been repaired and Porters searched the Trust for stray trolleys.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	87.8%	86.8%	69.9%	78.7%	85.9%	93.2%	92.7%	94.5%	89.4%	77.6%	90.8%	69.9%	72.1%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	63.0%	48.6%	12.1%	31.2%	79.1%	96.0%	94.2%	95.3%	80.9%	72.8%	78.1%	23.3%	18.0%
Cancer: Percentage of patients treated within 31 days	>=96%	96.2%	97.6%	97.5%	96.1%	96.5%	97.9%	97.6%	97.9%	96.9%	97.3%	97.4%	92.6%	95.4%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	74.5%	75.1%	83.4%	76.5%	90.1%	86.0%	86.2%	77.2%	91.5%	81.1%	81.3%	74.6%	78.2%
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	80.0%	80.0%	66.6%	100.0%	100.0%	92.3%	79.1%	78.5%	100.0%	97.7%	87.5%	90.0%	81.2%

Driver for underperformance:	Actions to address the underperformance:
Please see finance & performance report, please note discrepancies against the national reporting due to rounding up/down 2ww referral 72.2% 2ww breast symptomatic 18.1% 62 day Consultant upgrade 81.3%	

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Monthly Health Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Average Monthly Health DTOC's	<=7	N/Avail	N/Avail	12	9	14	10	13	16	13	37	31	19	13

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
- Inaccurate information on Tracker from SPA
- Tracker produced from SPA not supporting discharge,
- Internal delays with incomplete PDNA's being returned from SPA
- Ensuring discharge plan for every patient
- Commencing discharge plans on admission
- Delays in completing TTO's and EDN's
- High Stranded patients
- Delays with dementia and delirium team referrals
- Long delays with homeless patients
- Long delays awaiting provision for high levels of care,
- Family/patient expectation

Actions to address the underperformance:

- Northampton Social Services currently under review
- NASS currently recruiting to support IDT (Integrated Discharge Team) approach directly on Wards, this will create continuity and speed up decision making process,
- Further integration with Health and Social providing a DTA process and Trusted Assessor pathway
- New Stroke re-hab pathway is in process involving Ward to Ward handover preventing unnecessary delays
- SCC currently under review, looking at utilising more of SCC beds for interim via Trusted Assessor route, still ongoing,
- Further training for Ward staff on PDNA's to commence September
- October will see a new MDT discharge decision process from Wards, this will no longer sit with SPA, referral will go directly to services required to support patients' needs and discharge, this should prevent SPA delays
- New process, as above should prevent inaccuracies on Tracker
- New IDT approach to discharge will support Wards
- SPA will not be responsible for returning PDNA's as the ownership from Oct will sit with Wards
- Recruiting 11 discharge co-ordinators, – all vacancies recruited awaiting HR process for 5 new recruits, when fully established this will support Wards in providing a plan for every patient
- Three weekly tracking meetings to challenge and escalate discharges and delays, also to agree DTOC numbers
- Daily updates continue to be emailed to SPA for all patents on the Tracker
- Allocating Discharge Coordinators, as and when trained, to medical Wards to assist in all discharge activities, escalating if TTO/EDN not complete

	• 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 • New shorter PDNA in place to Tracker Dementia and Delirium patients, • Identify potential patients for Avery beds earlier in admission pathway • Trusted Assessor Task and Finish group established to support the provision of a Trusted Assessment pathway and model to be rolled out from 29th October 2018 • 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 • Safer in 100 Days continuing on Wards promoting Board Rounds/Plans for every Patient • Intermediate Care currently being redesigned to support admission and discharge • Use of CHS brokerage for self-funding patients • Overnight care model in place • New Expectation Leaflet currently being developed, to be placed on every patients locker • New Preparing to Leave Hospital Patient document under development

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Jane Ajeto	Deborah Needham

Scorecard - Exception Report

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

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.9%	93.1%	93.5%	93.1%	93.5%	92.1%	93.2%	93.4%	93.2%	92.1%	93.7%	91.9%	92.5%	91.4%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.6%	92.3%	92.9%	92.2%	93.2%	93.5%	94.1%	93.7%	93.8%	93.9%	97.8%	92.4%	92.7%	93.1

Driver for underperformance:

- The result for Inpatient & Day Case continues to be stable with only small movements each month. The Inpatient & Day Case result is 4.5% below the national average when comparing August with the most recent national data available.
- The result for Outpatients is 0.5% below the national average when comparing August with the most recent national data available.

Actions to address the underperformance:

- The Right Time mini survey and Real-Time surveys are continuing which enable the wards to identify specific areas where further improvements need to be made.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Maternity: C Section Rates - Total	<27.1%	29.5%	27.6%	21.8%	27.9%	28.6%	29.5%	27.9%	30.9%	28.4%	31.3%	34.1%	28.9%	29.8%

Driver for underperformance:	Actions to address the underperformance:
• Month to month variation in both the emergency and elective caesarean rates influences the overall caesarean section rate • Last month there was a slight increase in emergency caesarean section rate and a decline in elective caesarean rate. • This month decrease in emergency caesarean section (below national average). Slight increase in elective caesarean section rate which puts overall rate at AMBER.	• 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.

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd	N/A	Dr Matt Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Mixed Sex Accommodation	Externally Mandated	Finance, Investment and Performance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Mixed Sex Accommodation	0	0	0	0	0	4	60	234	252	0	0	0	0	3

Driver for underperformance:	Actions to address the underperformance:
• Limited bed capacity across the organization • No agreement within organization to keep Stroke beds not ring fenced • Available capacity included in overall bed stock for both stroke and medical patients	• Stroke unit hyper acute beds are ring fenced from August 28/8/18 • Stroke unit beds are not included as medical capacity • Stoke beds availability discussed as an independent unit 4 x daily at bed meetings

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Fiona Wade	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
MSSA	Internally set	Quality Governance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
MSSA	<=1.1	0	0	1	1	1	2	0	0	2	1	0	2	3

Driver for underperformance:	Actions to address the underperformance:
• Three patients have developed an MSSA bacteraemia whilst under our care in August 2018; these were on Eleanor, Rowan and Benham wards. • The driver for underperformance is an internally set trajectory for Meticillin Sensitive *Staphylococcus aureus* (MSSA) of no more than 13 patients develop MSSA for 2018/2019	• Octenilin wound irrigation can now be prescribed • Post infection reviews have been undertaken for patients to understand the learning • The MSSA work stream of the HCAI reduction plan continues to be implemented across the Trust and includes surveillance and treatment of patients with a local MSSA infection

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:
Harm Free Care (Safety Thermometer)	Externally mandated	Quality Governance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Harm Free Care (Safety Thermometer)	>=94.4%	94.5%	96.0%	95.0%	95.0%	93.7%	93.6%	93.5%	94.0%	92.9%	93.6%	95.8%	93.3%	91.8%

Driver for underperformance:	Actions to address the underperformance:
• 8 patients developed pressure ulcers during our care. • 2 patients fell during the reporting period. • 1 patient developed a catheter related UTI.	• Clinical experts to review trends with incidence data in comparison to 'point prevalence' data • Continue with the root cause analysis process that will enable learning from the harm caused to our patients. • A.D.N. to review the collection methodology • 'New harms' remain at the national average at 98.25%

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Sickness Rate	Internally set	Workforce Committee	August 2018

Performance:

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

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 sickness absence related to stress and anxiety	Training has been provided on the changes to the Supporting and Managing Workforce Sickness Absence policy and it now reflects a more supportive approach to staff health and wellbeing Resilience training is now in place through the OD team and there has been a good uptake on the workshops 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:
VTE Risk Assessment	Externally mandated	Finance, Investment and Performance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
VTE Risk Assessment	>=95%	97.0%	96.7%	95.4%	96.2%	96.1%	96.8%	96.3%	96.5%	96.5%	97.8%	96.4%	94.3%	91.3%

Driver for underperformance:	Actions to address the underperformance:
• Select wards less compliant • Doctor change over period • Urgent care 'restructure' • Consultant knowledge not up to date with (re)assessment review guidance	• Junior doctors induction program amended to include patient story • Contribute VTE learning to core trainee education programme • Urgent care areas having focussed board rounds • Patient information leaflet amended and rolled out to ward areas • Trust screen saver rolled out to illustrate requirements • Planning on forced VTE RA through electronic prescribing system

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Carl Holland	Matt Metcalfe

Scorecard - Exception Report

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

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Percentage of all trust staff with role specific training compliance	>=85%	83.9%	84.3%	84.2%	84.8%	84.2%	83.9%	84.0%	84.2%	84.6%	84.8%	84.9%	85.1%	83.8%

Driver for under performance:

- 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
- The new intake of Junior Doctors has potentially caused a drop in the % of compliance

Actions to address the underperformance:

- Due to the number of positions being created each month, work continues on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely.
- Templates for Safeguarding Children level 2 and level 3 have been actioned by IBM. This has generated an error report which is currently being working through. The data in October should report accurately the positions that are required to complete level 2 and level 3.
- L&D are currently working through the training certificates that a number of Junior Doctors have emailed to us.

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:
Staff Vacancy Rate	Internally set	Workforce Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Staff: Trust level vacancy rate - All	<=9%	12.6%	11.6%	10.9%	10.8%	11.3%	10.1%	10.6%	10.8%	12.1%	11.8%	12.6%	13.2%	11.8%
Staff: Trust level vacancy rate - Medical Staff	<=9%	14.4%	16.1%	13.5%	11.8%	13.1%	13.2%	11.5%	13.1%	12.7%	13.1%	14.3%	14.6%	9.4%
Staff: Trust level vacancy rate - Other Staff	<=9%	13.2%	11.9%	11.9%	12.2%	12.7%	11.6%	11.5%	11.5%	13.2%	12.7%	13.7%	14.4%	14.0%

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. • Search Agency engaged to identify Medical Consultants • 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:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	August 2018

Performance and Trajectory:

	Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Operational Performance	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	2	2	1	1	12	17	9	34	11	13	7	6	16

Driver for underperformance:

- ENT 5 Patients
  2 patients were cancelled due to emergency cases
  2 patients were not breaches and should have been excluded from the report
  1 patient was cancelled due to an over run in theatre

- ORAL & Max fax SURGERY 7 Patients
  All with the exception of one patient were cancelled on the day because of Surgeon sickness.

  One patient however was cancelled due to an over run in theatres

  All patients had been dated with 28 days.

- GENERAL SURGERY 4 Patients
  All patients were cancelled due to an overrun in theatres

  All patients were allocated a new TCI within 28 days

Actions to address the underperformance:

The process for escalation of all 28 day patients at risk of cancellation on the day has been re-enforced to the theatre teams.

The admin teams have also been asked to highlight these patients at the morning huddle.

Where appropriate the admin teams have been asked to ensure 28 day breach patients are first on the list and that this is highlighted to the surgeon

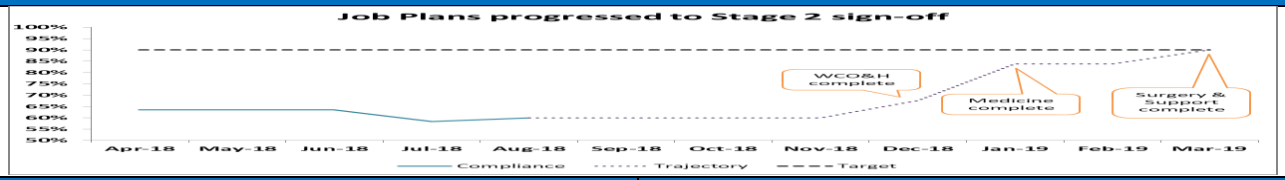
All services have been reminded of the escalation process for patients who are unable to be dated with 28 days

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Job plans progressed to stage 2 sign-off	Internally set	Quality Governance committee	August 2018

Performance and Trajectory:



Driver for underperformance:	Actions to address the underperformance:
• Medicine Division zero based from April as target date for completion has passed • WCO&H will be zero based after target completion date of September • Delays with Medicine and the level of support required has led to delays getting started with WCO&H • Medicine Job Planning paused as agreed at fixing the flow meeting until Quarter 4 • Regular Executive Consistency Committee meetings taking place with the Divisions for updates and challenge on progress	• New team leading on Service/Job Planning as of 1st June 2018 • Processes reviewed, refined and communicated to Consultant body • Webpage updated to provide better information • Lessons learnt being taken forward and good progress being made with WCO&H service planning • Anticipate WCO&H completion by end of December 2018 • Remaining Divisions to be completed by the end of the financial year

Lead Clinician:	Lead Manager:	Lead Director:
Dr W Zaw	Liz Smillie	Matt Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Mixed Sex Accommodation	Externally Mandated	Finance, Investment and Performance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Mixed Sex Accommodation	0	0	0	0	0	4	60	234	252	0	0	0	0	3

Driver for underperformance:	Actions to address the underperformance:
• Limited bed capacity across the organization • No agreement within the organization to maintain ring fence Stroke beds. • No beds ring fenced in step down areas to allow timely transfers of patients from mix sexed hyper acute unit • General medical patients routinely placed into beds on hyper acute unit • Stroke unit did not have authority to manage own bed stock.	• Stroke unit hyper acute beds ring fenced from August 28/8/18 for stroke patients only. • Stroke unit has step down beds ring fenced beds to allow hyper acute patients to step following hyper acute episode removing risk of same sex breach. • Stroke unit actively manages own bed stock. • If trust escalation status indicate a requirement to use stroke unit beds to alleviate operational pressures. An agreed designated area/bay on hyper acute unit is identified to be able to receive non stroke pts removing risk of same sex breach.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Internally set	Finance, Investment and Performance Committee	August 2018

Performance:

Indicator	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	96.3%	100.0%	94.9%	100.0%	100.0%	97.7%

Driver for underperformance:	Actions to address the underperformance:
• Significant challenges for August in relation to capacity and overnight admissions. • The late evening outliers are predominately due to demand from ED over anticipated and the late availability of surgical beds meaning patients from medical areas are outlied once the surgical bed is available.	• Continued focus, monitoring and embedding of site practitioners to create assessment unit capacity between the hours of 6pm and 8pm to prevent late in the day outlier. • Patients to be identified between 6pm and 8pm with risk assessment completed to ensure safe outlier practice. • Letter of expectation regarding requirement to complete risk assessments prior to outlier for all site team will be written in September. • Spot audits to occur daily to monitor.

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Lee Taylor	Debbie Needham

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 September 2018**

Title of the Report	**Corporate Governance Report Q42017/18 and Q1 2018/19**
Agenda item	**13**
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Information

Executive summary

This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.

Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (/**N**)

Legal implications / regulatory requirements	This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3

Actions required by the Trust Board

The Trust Board is asked to:

- To note the Use of the Seal, numbers of staff declarations and new declarations of interest by Trust Board members

Northampton General Hospital NHS
NHS Trust

Public Trust Board

Corporate Governance Report
Jan – March 2018 (Q4 – 2017/18) and April – June 2018 (Q1 – 2018/19)

Introduction

This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.

Use of the Trust Seal

The Trust's Standing Orders require that periodic reports are made to the Board detailing the use of the Trust's Seal. The Seal will generally be used for contracts in excess of the financial limits delegated to the Chief Executive under the Standing Financial Instructions, and for property matters, including disposals, acquisitions and leases.

The seal has been not been used during Quarter4 2017/18 or Q1 2018/19

Declarations of Hospitality and Interest

Staff within the Trust are required by the Standards of Business conduct Policy to declare any hospitality and/or gifts received.
Staff are given regular reminders through Trust communication mechanisms regarding their liabilities in respect to the requirements of this policy.

During Q4 a letter, previously circulated as part of the annual governance processes requiring Consultant and senior Trust staff to make return in respect to conflicts of interest (Appendix 1), was recirculated and at the end of Q1 2018/19 any staff not sending a response were written to with a personal letter requesting compliance.

- Jan – March 2018: 126 declarations received
- April – June 2018 : 34 declarations received
  (This includes declarations from departments where lunch has been provided during an educational session and may involve a group of staff but is counted as a single declaration)

Previous numbers

Time period	Number of declarations (gifts and hospitality)	Declarations of Interest (Positive return)	Declarations of Interest (Nil return)	Total
Q4 2017/18	13	32	81	126
Q1 2018/19	15	9	10	34

Jill Houghton, non-Executive Director of the Board has declared interests as an employee of J Houghton Consultants Ltd & lead on maternity improvement work hosted by Eastern Academic Health Science Network.

Appendix 1

Northampton General Hospital NHS
NHS Trust

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

Cliftonville
Northampton
NN1 5BD
Switchboard: 01604 634700

November 2017

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

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

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

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

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

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

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

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

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

Yours sincerely

Catherine Thorne

Catherine Thorne
Director of Corporate Development Governance and Assurance

Declarations of Interests Form

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

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

In particular, do you

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

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

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

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

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

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

   ……

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

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

OR

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

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

Job title: …… Contact details: ……

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

Title of the Report	**EPRR Self-Assessment Assurance Report**
Agenda item	**15**
Presenter of Report	**Deborah Needham** Chief Operating Officer/Deputy CEO
Author(s) of Report	**Jeremy Meadows** Head of Resilience & Business Continuity
Purpose	For information/awareness.

Executive summary

To provide an update of the EPRR self-assessment undertaken in August 2018 and progress against the NHS England Core Standards.

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

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

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

Related strategic aim and corporate objective	**Strategic aim 1 – focus on quality and safety**
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	**BAF 1.6**

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Committee

The Committee is asked to:

- To note the contents of this paper.
- Approve the proposed overall assessment of Fully Compliant.

Trust Board
27th September 2018
EPRR Self-Assessment Assurance Report

1. Introduction

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

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

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

2. Criteria for assessment of Core standards

The past 12 months have resulted in continued improvement in the implementation and development of emergency planning within the Trust. Key areas of improvement for 2018 have been the increase in number of ratified departmental Business Continuity response plans, and the recent ratification of the Corporate Business Continuity Plan.

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

The core standards are subject to annual review. Minor changes for 2018/19 include an expanded focus on Business Continuity, revised formatting and the removal of the CBRN (decontamination) equipment list.

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

- Fully Compliant
- Partially Compliant
- Non-Compliant

Table 1 below provides an overview of the Trust's position against the Core Standards which is described through a series of 64 criteria.

Table 1: NGH Core Standards Review 2018.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

The topic of this year's 'Deep Dive' element is Command and Control. It is deemed that the Trust is fully compliant with the eight core standards as a result of:

- A robust and dedicated on-call mechanism being in place to receive notifications relating to EPRR 24 hours a day, 7 days a week, and provide the ability to respond or escalate notifications to executive level.
- Personnel performing the on call function being appropriately trained in major incident response.

The EPRR self-assessment tool is attached for awareness. **APPENDIX 1**

Following sign-off by the Trust Board, the self-assessment will be for formally assessed by NHS England at the Assurance Panel on the 5h October.

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

Compliance level	Definition
Not compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

3. Summary

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

A number of moderate business continuity incidents have highlighted the Trust's ability to perform in accordance with the Command and Control structure, maintaining a focus on patient safety and providing the best possible care.

The emergency planning cycle will continue to determine the emergency planning and business continuity work plan for 2018-19. The key areas that will be prioritised within the next 12 months will continue to be Major Incident and Business Continuity planning and training & exercising, with an ongoing review of plans and close working with external stakeholders.

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

4. Recommendation

The Board is asked to note the contents of the report and approve the proposed overall assessment of Fully Compliant.

APPENDIX 1

NGH Core Standards self assessment tool

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments (including organisational evidence)
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Fully compliant				Deborah Needham, Chief Operating Officer and Deuputy Chief Executive is the Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR).
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant				Emergency Preparedness and Resilience Policy NGH-PO-389 advises of resources, funding and implementation and training requirements.
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Fully compliant				Annual EPRR report is submitted toTrust Board
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant				As per Emergency Preparedness and Resilience Policy, the Resilience Planning Group is the forum for reviewing the EPRR work programme following a review of lessons identified from incidents & exercises, risks and assurance processes. The core standards work programme forms the basis of the annual work programme.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant				The Board are satisfied that the Trust has appropriate resources to fulfill it's EPRR requirements.
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant	As a standing item on the Resilience Planning Group agenda, capturing of leaning from incidents to be expicitly added within the EPRR Policy.	Head of Resilience	1st October 2018	Incident response plans advise of the requirement for review following activation and consideration of lessons identified.
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Fully compliant				Corporate, Resilience and Divisional risk registers are in place and are regularly reviewed at governance meetings. Resilience specific risk register is reviewed at Resilience Planning Group meetings and is reported to the monthly Risk Group. Risks scoring 15 and above are escalated to the Corporate Risk Register.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant				EPRR Risks are reviewed at the monthly Trust Risk Group.
Domain 3 - Duty to maintain plans										
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Fully compliant				Partners are consulted as part of the planning process.
	Duty to maintain plans	Planning arrangements	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:							
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	Situation, Background, Assessment, Recommendation (SBAR) template to be added to the Incident Directors Action Card and Site Management Office.	Head of Resilience	1st October 2018	An internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation's ability to deliver safe patient care, the decalaraion of a Critical Incident is detailed within the Corporate Major Incident Plan.
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Trustwide Major Incident Plan is in place.
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	The Heatwave plan is currently upto date, however, following Summer 2018's prolonged hot weather, the plan is due to be updated following a review at the Resilience Planning Group.	Head of Resilience	1st October 2018	Trustwide Heatwave Plan is in place.
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Trustwide Adverse Weather Plan is in place.

15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Trustwide Pandemic Influenza Plan in place.
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Trustwide Infection Prevention and Control Policy is in place.
17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				An LRF Plan in place, however the scale of the response will be dependant on the incident and requested at such time. The Trust will envoke it's Business Continuity Procedures to ensure critical services are maintained wherever possible.
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Trust Capacity Management, Escalation and Patient Moves Plan.
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				In the event of a major incident, the Trust will activate the Majax element of the patient tracking system, Symphony. Each patient presenting during this time is assigned a unique reference number until discharge.
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	Awaiting confirmation from NCC of updated reception centres and traffic management. To be added to Trust Evacuation Plan following reciept.	Head of Resilience	1st November 2018	Lockdown and Evacuation plans in place to shelter or evacuation patients, staff and visitors.
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Updated to incorporate partial lockdown and progressive restriction of access / egress.
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage "protected individuals"; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Joint plan in place with Northants Police regarding the management of high profile patients.
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				Covered by LRF Excess Deaths Plan. Internal surge plan also exists with links between MKH and KGH and formal arrangements with local undertakers.
Domain 4 - Command and control										
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Fully compliant				Tried-and-tested dual tier on-call manager and director system in place consisting of suitably trained on-call staff. External partners are familiar with our out-of-hours contact details in the event of an incident. Head of Resilience contactable by numerous means out-of-hours.
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant				EPRR policy advises: Ensure all staff who participates in the Trust on-call system are trained in emergency and contingency response, including JESIP. Role specific Action Cards are contained within the Major Incident Plan. Centrally stored on-call shared drive repository of key resources for on-call staff.
Domain 5 - Training and exercising										
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant				Processes covered in on-call training above. Training needs analysis undertaken and training records are kept to demonstrate attendance.

27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant				A training and exercising needs analysis and schedule is in place to in order to test and validate plans as per the requirements of the CCA. Post exercising debriefs are undertaken in order to identify, capture and act upon areas for improvement.
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Fully compliant				Certificates issued to attendees following training sessions undertaken in accordance with the National Occupational Standards.
Domain 6 - Response										
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Fully compliant				The Trust has a predetermined Incident Co-ordination Centre and back up location. The primary location is the Site Management Office to ensure familiarity. The backup location is Training Room 2 and is used during exercises that require an ICC to be established. The Trust Major Incident Coordination Centre procedure details access, activation and equipment setup.
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Fully compliant	Work to ensure each ward has an up-to-date battle-box containing relevant contact lists, plans, action cards, and BCP's.	Associate Resilience Manager	1st December 2018	Electronic copies are available on the Trust Intranet and shared folders. Hard copies of key EPRR plans and procedures are located in key areas across the site.
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans	Fully compliant				Trustwide and local BCP's detail the management of business continuity incidents.
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records	Fully compliant	Ongoing training to ensure increased uptake of loggists.	Associate Resilience Manager	Ongoing	The Trust has a suite of loggists to be called upon in the event of an incident and are contactable via the major incident call-out system. In the event that a loggist is unavailable, particularly during the initial stages of an incident out of hours, decision makers are advised to keep cotemporaneous notes.
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Fully compliant				This is undertaken by the on-call executive and is detailed with the Major Incident Plan. On-call staff have access to Resilience Direct and have the ability to access any SitReps uploaded to the incident page.
35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				A&E have access to electronic and hard copies of the East of England clinical guidelines which was published in 2012. Awaiting reciept of an updated version.
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				A&E staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.
Domain 7 - Warning and informing										
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Fully compliant				Corporate communications team have detailed media handling policy in place and have recent experience of advising the public to choose well. Colleagues are aware of the importance of providing information in a timely manner. Major Incident Plan details how to communicate with stakeholders. Experience of producing a joined up media strategies with partner agencies via the SCG. Awaiting ratification of the Social Media Policy.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Fully compliant				Corporate communications team have detailed media handling policy in place and have recent experience of advising the public to choose well. A&E have an information leaflet for patients in the department which is distributed in the event of a major incident.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Fully compliant				Processes are in place to nominate a spokeperson in the event of local media enquiries. Communications team distribute messages to the public via social media and the Trust website.
Domain 8 - Cooperation										
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings	Fully compliant				AEO/Deputy attendance at LHRP meetings.
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant				CCG representation at the LRF.
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant				LRF mutual aid arrangements are in place and are referenced within appropriate plans.
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Fully compliant				The Trust co-operates and shares information with other local responders to enhance co-ordination and efficiency in line with the CCA. The Trust is signed up to the LRF data sharing protocol.
Domain 9 - Business Continuity										
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant				Corporate Business Continuity Plan outlines the requirement to undertake BC planning.

48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Fully compliant				The BCMS details relevant responsibilities, objectives, and resource requirements.
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Fully compliant				The BIA is reviewed annually. More frequently if lessons learned following an incident are to be included.
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Fully compliant				GDPR action plan in place, toolkit achieved.
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Fully compliant				Trust BCP's contains consideration for responding, recovering and managing its services during disruptions to people, information and data, premesis, suppliers & contractors and IT & infrastructure as per the requirements of ISO22301:2012.
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Fully compliant				Depertmental BCRP's are completed in line with Key Performance Indicators. Reports of any exercises are reported via Assurance, Risk and Compliance to the Board.
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Fully compliant				Internal audits frequently undertaken to ensure best practice. Reports to the Board via the Assurance, Risk and Compliance Group.
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Fully compliant				There is a process to review BCRPs following an incident, restructure or change of supplier/provider.
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Fully compliant				Departments assess the business continuity plans of providers and suppliers in order to receive assurance of arrangements in the event of a business continuity incident.
Domain 10: CBRN										
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant				Detailed within the CBRN/Hazmat Plan. The decontamination file includes details for TOXBASE and PHE (CRCE & NPIS).
57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully compliant				Trust specific CBRN/Hazmat Plan is alligned to national IOR guidance. It includes: • Identification of a CBRN incident and details the process for activating the plan • Steps 1-2-3 • Dry decontamination and wet decontamination • Contact details • Management of hazardous waste • Stand-down procedure, recovery and return to normal • Appendix 6 details access to national stocks of prophylaxis and Pods. Requests for access to stockpiles are to be made by the on-call exec after discussion with the 1st Consultant in ED.
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant				Risk assessments have been completed and appropriate training is in place: • Procedures to follow are listed in ED • Only appropriately trained staff undertake decontamination procedures • No contact by clinical staff until fully protected with appropriate PPE, assessment of whether wet or dry decontamination is appropriate (caustic chemical or not) • 1 day decontamination specific training takes place quarterly for ED staff • ED staff induction includes decontamination and major incidents.
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Fully compliant				There are sufficient numbers of decontamination-trained nursing staff with ED to ensure cover 24/7. A list of suitably trained staff is available to call-in if additional assistance should be required.
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Fully compliant				CBRN store contains response box and appropriate decontamination equipment as per the inventory list to ensure safe decontamination of patients and protection of staff. Any equipment used is replenished in a timely manner. (See Decontamination Equipment Checklist for specific details)
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Fully compliant				The Trust holds 16 replacements PRPS suits as per the Decontamination Equipment Checklist.
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Fully compliant				All equipment is serviced within required timescales. • Suits tested by Respirex annually. Currently in the process of receiving replacement suits. • Tent manufacturer is no longer in business, however the Trust's primary means of decontamination is the internal shower room. The tent is in addition to this should the anticipated number of patients exceed the throughput of the internal shower room. In this case, mass decontamination is expected to take place at the scene. Visual check of tent is undertaken during training sessions. • RAM GENES are tested by Medical Physics. This is staggered (October and December) to ensure 1x RAM GENE is always within the department. • Internal shower is flushed by housekeeping staff on a regular basis.

63	CBRN	Equipment PPM	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Fully compliant				As above.
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Fully compliant				Arrangements are in place for the disposal of PPE as per guidance of 1st April 2015.
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Y	Maintenance of CPD records	Fully compliant				Rhiannon Baker (ED Sister & CBRN Training Lead) has received EMAS HART train the trainer training: • Acute CBRNe/Initial Operational Response (IOR) Train the Trainer Course (Day 1) 31st May 2016 & (Day 2) 24th October 2016 • EMAS PRPS/Decontamination Train the Trainer Course 10th April 2018.
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant				Rhiannon Baker is the designated training lead for CBRN. Training days cover: • How to deal with contaminated patients • Donning and doffing VHF PPE (including FIT testing) • Donning and doffing PRPS suits • Wet and dry decontamination • IOR • Erection of the tent • RAM GENEs.
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Fully compliant				In addition to the ED Decontamination training lead, there are 4x further collegues who are EMAS approved HAZMAT / CBRN trained trainers.
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant				ED receptionists are aware of the requirement to inform self presenters to leave the building and await further instruction. Clinical staff to get appropriate PPE or PRPS suits. Staff to assist contaminated patients to undertake IOR dry decontamination or advise to enter the decontamination room, if required.
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Y		Fully compliant				All staff who are likely to come into contact with confirmed infectious respiratory viruses have been FIT tested and have 24/7 access to FFP3 masks.

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Fully compliant				The guidance document is currently awaiting formal publication through NHS England's Gateway process however the Trust is currently compliant with current best practice by working to ensure resiliant communications are maintained. IT and telephone systems have built in resilience. The Trust has digital VoIP and analogue systems, including emergency 'red' phones, mobile phones, radios, bleeps and pagers. The Head of Resilience holds a SIM enabled iPad in order to instigate the call out system in the event of N3 outage. A number of departments also use WattsApp as a means of communication.
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Fully compliant				The ICC is located in the Site Management office in order to maintain an element of familiarity, it is therefore staffed and in a state of readiness 24/7.
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Fully compliant				As above.
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				Detailed within the Major Incidet Control Room Procedure and Command, Control and Coordination Policy.
Domain: Command structures										
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				Clear and well versed command and control structure. Out of hours commander roles are aligned with the on-call structure.
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Fully compliant				Action Cards contained within the Major Incident Plan advises of multi-agency command and requirements to contact external stakeholders.
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				Colleagues with roles in the command and control structure have received JESIP decision making training.
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				The Major Incident Plan contains details of the post-incident recorvery planning arrangements.

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *27th September 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 *22nd August* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
• Finance report • Changing Care • Operational performance • Fixing the Flow • Winter Plan	

Key areas of discussion arising from items appearing on the agenda

- The Trust delivered a beak even financial performance in the fourth month, and remains on plan YTD. There continues to be challenges on pay overspend in some areas totalling £2.7m.
- The committee continues to be concerned around the lack of progress to close the £22m 'system Gap' (NGH's part £4.6m)
- The Committee received the Changing Care programme report, it was agreed the reporting of divisional CIPS would be moved out of this report so it can focus on transformational schemes as originally intended. There remains considerable gap in schemes to deliver the financial performance, and the Trust will be revisiting the opportunities under GIRFT.
- The executive scrutiny on divisional pay and cost centres is having some impact on pay overspend, but there is still more to be done.
- A&E performance exceeded the trajectory again despite a significant increase in admissions. A focus on the 'stranded' and 'super stranded' patients has been successful in reducing the number of long stay patients.
- Cancer targets remain challenging, with only 3 of the 9 standards met. Issues in resourcing the Breast cancer service are a particular concern.
- The committee received a second report on the18/19 winter plan. Whilst plans in the trust are well advanced, there remains no evidence of the broader health systems plans to prepare. This is a key risk for the trust.
- The committee received an update on the fixing the flow programme. The Nye Bevan unit is on track for commissioning in October, a key element of programme. Good progress was evidenced in recruitment and development of the medical model.
- The committee received an update on the implementation of Camis. There continues to be issues around training to use the system.

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 • The committee would highlight the increasing risk regarding the lack of transparent plans in the broader health system to prepare for Winter.	
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

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***27 September 2018***

Title	**Quality Governance Committee Exception Report**
Chair	**Paul Farenden**
Author (s)	**Paul Farenden**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *24 August 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:

- Quality Improvement Scorecard
- Nursing and Midwifery Report
- Complaint Report
- VTE/HAT Paper

Board Assurance Framework entries *(also cross-referenced to CQC standards)*

Key areas of discussion arising from items appearing on the agenda

- Attendance and membership of the safety huddle and increased DNA rates.
- Incidents of Cdiff in the surgical division and increase in falls.
- Implications of low level VTE assessments.
- Increase in concerns registered with PALs in particular the telephone service in ENT.

Any key actions agreed / decisions taken to be notified to the Board

- Senior doctor to attend safety huddle.
- CQEG to receive a further report on Cdiff.
- Deep dive learning to be instilled following complaints.

Any issues of risk or gap in control or assurance for escalation to the Board

n/a

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

n/a

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *27 September 2018*

Title	**Workforce Committee Exception Report**
Chair	**Paul Farenden**
Author (s)	**Paul Farenden**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *22 August 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 Report
- GMC Training Survey
- Medical Recruitment Strategy
- Talent Academy
- Occupational Health Annual Report

Board Assurance Framework entries *(also cross-referenced to CQC standards)*

Key areas of discussion arising from items appearing on the agenda

- Deterioration in key performance indicators and concerns surrounding 'soft' intelligence.
- Red flag analysis and action plan for improvement.
- Update on Talent Academy, seen as a key initiative for sustainable nursing workforce.
- Noted continued and sustainable future for Occupational Health service.

Any key actions agreed / decisions taken to be notified to the Board

- Develop understanding around 'soft' intelligence on performance matrix.
- Progress report required regarding actions on GMC training survey.
- Signed of HCA Apprenticeship proposal.

Any issues of risk or gap in control or assurance for escalation to the Board

Assurance required surrounding delivery of GMC training survey actions.

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

AGENDA

Northampton General Hospital NHS Trust

PUBLIC TRUST BOARD

Thursday 27 September 2018
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 26 July 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log • Avery Update	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.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:30	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	12.	Operational Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Corporate Governance Report	Assurance	Mrs C Corkerry	**I.**
	14.	Healthcare Partnership Update	Assurance	Mr C Pallot	**Verbal**
	15.	EPRR Core Standards & Assurance 2018/19	Assurance	Mrs D Needham	**J.**
11:40	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	17.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**L.**
	18.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**M.**
12:00	**19.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

Time	Agenda Item	Action	Presented by	Enclosure
DATE OF NEXT MEETING **The next meeting of the Public Trust Board will be held at 09:30 on Thursday 29 November 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).				