Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 28 March 2019

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 28 March 2019
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 A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 31 January 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Story	Receive	Mr C Pallot	**Verbal**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Mortality and Learning from Deaths Update	Assurance	Mr M Metcalfe	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**F.**
	11.	Bi-Annual Review of Nurse Staffing & Midwifery Staffing	Assurance	Ms S Oke	**G.**
	12.	Assessment & Accreditation Update – Qt3 Update	Assurance	Ms S Oke	**H.**
10:35	**OPERATIONAL ASSURANCE**				
	13.	M11 Finance Report	Assurance	Mr P Bradley	**I.**
	14.	Operational Performance Report	Assurance	Mr C Holland	**J.**
	15.	Workforce Performance Report	Assurance	Ms A Chown	**K.**
	16.	Electrical Power Outage Incident Debrief	Assurance	Mrs D Needham	**L.**
11:05	**FOR INFORMATION & GOVERNANCE**				
	17.	Emergency Preparedness Annual Report inc Winter Plan	Assurance	Mr C Holland	**M.**
	18.	Local Digital Roadmap Update	Assurance	Mr H Mathias	**N.**
11:25	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**Q.**
	22.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal.**
11:45	**23.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 30 May 2019 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 31 January 2019 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr A Burns	Chairman
	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 S Oke	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
	Dr E Heap	Associate Non-Executive Director
	Mr D Moore	Non-Executive Director
	Ms J Houghton	Non-Executive Director
In Attendance		
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Finn	Director of Facilities and Capital Development
	Mr C Holland	Acting Chief Operating Officer and Deputy Chief Operating Officer
	Ms K Palmer	Executive Board Secretary
	Mr C Pallot	Director of Strategy & Partnerships
	Ms C Campbell	Director of Corporate Development Governance & Assurance
	Ms S Watts	Associate Director of Communications
Apologies		
	Dr S Swart	Chief Executive Officer
	Mr D Noble	Non-Executive Director

TB 17/18 214 Introductions and Apologies

Mr Burns welcomed those present to the meeting of the January Public Trust Board. He remarked that he was pleased to be here.

Mr Burns advised that when NHSI had asked him to take on the role of Chairman at NGH he believed this would be positive in helping the collaboration with KGH which was an important part of both Trust's future. The collaboration would increase the influence from the acute sector within the STP.

Mr Burns stated the importance of the saying that no hospital can be an island and this phrase was strengthened by the NHS 10 year plan. He noted that this coming contracting and planning rounds may be challenging.

Mr Burns shared his belief that all Directors are equal. The inclusion of all the Directors would help make better decisions and the use of their skills make a better hospital.

Mr Burns informed the Board that at the February and April Boards there would be time spent looking how to add value to the Board and the sub-committees. The roles of the Board and the sub-committees must not be confused. The Board needed to focus on strategy whilst the sub-committees were required to establish how to best function.

Mr Burns welcomed all advice and thoughts on how the Board and sub-committees could work better.

Apologies for absence were recorded from those listed above.

TB 17/18 215 Declarations of Interest

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

TB 17/18 216 Minutes of meeting 29 November 2018

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

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 29 November 2018.

TB 17/18 217 Matters Arising and Action Log 29 November 2018

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

TB 17/18 218 Patient Story

Ms Oke presented Trust Board the patient story.

Ms Oke advised that a 71 year old had been admitted via ED 3 weeks prior due to severe pain they had been experiencing. The patient had an inflamed gall bladder however had a history of other illnesses therefore the family asked for the patients' diabetes to be reviewed by the surgical ward the patient was on.

The family had then expressed further concerns as no further diagnosis was made. The diabetes referral was made only at day 8 and placed on the sliding scale at day 9. The patient had experienced poor insulin management as an outcome of this. The family were not informed of the acute kidney injury the patient had experienced. The patient had been classed as a patient in decline.

The patient's records had been reviewed by the Governance Team and the incident did not meet the criteria to be declared as an SI. A full investigation was underway and the family had been provided an explanation.

Ms Oke commented on future mitigations and this had included the need for documentation to be robust, a diabetes link nurse had been introduced and the issues with communication would be further addressed. The communication aspect had been discussed with the whole MDT and the complaint had been shared with all involved.

The family had been offered a local resolution meeting however this was declined.

Dr Heap remarked that the patient being classed as an elderly patient in decline was surprising to her as she believed a patient of this age (71) should not be classed as this.

Mr Moore touched on the continued issue of communication problems within the Trust. He was of the opinion that communication was the most important element of the complaint to address. Ms Oke stated that communication needs differ between patients and this needed to be recognised.

Mr Archard-Jones queried whether the nurses would receive communication training. Ms Oke confirmed that communication training was part of the training pathways for clinical staff.

Mr Burns asked Ms Oke if she thought that the necessary changes had been implemented. Ms Oke noted that a large amount of work was still needed and the changing staff profile did make this difficult at times. Mr Metcalfe concurred and expanded to explain that the early diagnosis of patient was a key workstream in the Deteriorating Patient Board and GIRFT.

The Board **NOTED** the Patient Story.

TB 17/18 219 Chairman's Report

Mr Burns advised that had no further update to share with the Trust Board within his Chairman's report.

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

TB 17/18 220 Chief Executive's Report

Mrs Needham presented the Chief Executive's Report.

Mrs Needham discussed the Stroke National Audit with the Board. The Directorate had achieved a A rating. The Stroke Service had consistent achievement of this and believed credit should be given to all staff working within this area on behalf of the Board.

Mrs Needham advised that she had noted Brexit within her report and this would be discussed later on the agenda.

Mrs Needham reported on Cyber Security. The Trust continued to see daily activity attempting to gain access to the Trust's IT systems. On average 240 attempts were blocked daily. She remarked that staff are constantly reminded to not open strange emails or click on links that they did not know.

Mrs Needham stated that with the NHS' aim to become paperless this risk would only increase. Ms Gill commented that Audit Committee had suggested for the subject to be covered at inductions. Mrs Needham noted that it would be become part of mandatory training.

Mrs Needham informed the Board that performance for both flu vaccination and NHS Staff Survey completion exceeded last years performance

Mrs Needham advised that she had the pleasure of presenting the first 'Everyday Hero' award. She had found this heart-warming and was glad that this scheme had been implemented at the Trust. It had made her reflect on valuing the staff especially at this time of year when NGH and the NHS as a whole was under pressure with urgent care.

Mr Archard-Jones queried why 20% of staff declined the flu vaccination. Mrs Brennan explained that some staff cannot have the vaccination for medical reasons, some refused and some still believed the myths associated with the vaccination. Mrs Needham stated that a large amount of education on the flu vaccination had been done this year.

Mr Burns asked whether there was a cluster of staff refusing the vaccination that could create a safety risk. It was noted that there was previously clusters of staff however this had improved. Mrs Brennan commented that staffs in high risk areas are identified and the Clinical Director for the Directorate would carry out a risk assessment.

Mr Burns questioned Ms Oke as to whether she was concerned in regards to the staff that had declined the vaccination. Ms Oke believed that the Trust had done well in this area and the Trust was sitting 4th against its peers in Midlands & East.

Mrs Brennan highlighted that in previous years when Dryden Ward had a mass outbreak an education on Flu had been completed with the staff. Mr Metcalfe explained that following this incident a Dare to Share event had been held.

Mr Moore shared with the Board the worrying article he had read where only 50% of NHS organisations had invested finance into ensuring their organisation had up to date technology. He asked if NGH invested money into this area. Mrs Needham confirmed that the Trust did and had invested in staff, up to date software.

Ms Gill congratulated the Stroke Service on their achievement and asked in regards to collaboration work would learning from this be taken forward. Mr Pallot confirmed that it would. He believed a key element to the success was the single strong clinical leader involved who had been able to make a difference.

Mrs Needham delivered an update on the NHS 10 Year Plan.

Mrs Needham advised that her view of the plan was that it was ambitious however did have vision. She queried whether it was deliverable within the timescale set out. The plan asked for systems to develop plans by April 2019 for 1 year then by the Autumn for the next 5 years.

Mrs Needham stated that the plan had set out five areas to address the challenges faced by the NHS and these were; doing things differently, preventing illness, workforce, better use of data and technology and getting the most out of the money.

Mrs Needham reported that the plan majored on out of hospital care with hospital hubs in the Community. There would be increased care home support and increased support for mental health. It was noted that more of the spend would be directed towards mental health which would be beneficial for the Trust due to the numbers of patients who presented at A&E with low level mental health needs.

Mrs Needham commented that there would be incentives for Primary Care to keep patients out of hospital. There would be a big focus on Learning Disabilities, Cancer and Cardiovascular disease being delivered by Primary Care networks.

Mrs Needham advised that for in hospital care the aim would be to have less beds and new clinical standards. In regards to RTT 52 week, breaches would now be fined for. There would be increased support for staff and patient wellbeing. Mrs Needham noted that there would be increased focus on Ambulatory Care (ACC) which the Trust already did however would need to give ACC further focus.

Mrs Needham stated that prevention and public health would be key with patients managing their own health. This would be a challenge for this county as public health was limited and was currently aligned to the council. The Secretary of State would be visiting the Trust on the 07 February 2019.

Mrs Needham remarked that technology played a massive part in the plan. There would be funding available and the aim was to have a fully digitised NHS by 2024.This would provide major links across primary, secondary, tertiary and 3rd sector care. She believed this to be the correct thing to do.

Mrs Needham reported that Integrated Care with blended health and social care budgets would be in place. There would be learning from previous BCF issues.

She noted that Children and Maternity would receive additional funding and support for safety collaboratives and specialist clinics as well technology for children with cancer.

Mrs Needham discussed the major issues with the Board. She queried how this was affordable as well as how the Trust grows and changed the workforce. This would require working as a system however would be a big challenge to this County.

Mrs Needham commented that there would be more focus on working as a system to agree financially neutral changes to control totals. There was expectation of a reduction in non-clinical space by 5%, a reduction in agency costs which needed to involve new ways of working and reforms to the payment systems. Mrs Needham remarked that 2019/20 was a transitional year but the expectation was for providers to be in balance by 2020/21 with all NHS organisations to be balance by 2023/24.

Mrs Needham stated that capital remained unknown however this would be announced in the 2019 spending review workforce implementation plan this year. The plan would include the strengthening of leadership, incentives to train, more flexibility and a move to generalist training for doctors. There would be 500 additional nurses per annum, a focus on talent management alongside more support with retention and recruitment.

Mrs Needham advised that other elements of the plan included reducing mother and child deaths, supporting independent living and keeping people at home, more choice, better value for money and different ways of working.

Mrs Needham remarked that the challenge came when the Trust would start to receive more detail to enable more planning locally.

Mr Pallot believed that the plan provided a number of opportunities for the Trust to develop its own clinical strategy and should be welcomed.

Mrs Brennan commented that the workforce plan was under development and this was split into 5 workstreams. The plan would be shared in March with the detail received by the Autumn. An update would be brought to the Trust Board when circulated.

Action: Mrs Brennan

Mr Bradley stated that the financial challenge would be immense.

Mr Finn commented on access to capital. There would be access to capital through the STP and the Trust needed to make sure that this was used. It was noted that joint work with KGH on the Estates Strategy would be helpful.

Mr Burns remarked that once the individual Chair of the STP was recruited to that the plan moving forward should become much clearer. The Chair would be able to hold the Trust'w to account better than previously.

Ms Houghton queried whether there would be more Health & Well-being partnership involvement in the STP plans. Mrs Needham stated that the plan was to move to ICS'.

Ms Oke touched on the reality of the workforce plans given the timescales. It was a generational issue and the Trust needed to make itself attractive to work for. There needed to be a step change in the recruitment of international nurses.

Ms Gill asked if the system leaders would have performance objectives set. Mr Burns advised that there had been little in the way of objective setting within the STP for the leadership team however noted that the introduction of the new Chair may change this.

Mr Moore queried the timescales behind the plan. Mrs Needham clarified that by April 2019 the year one plan needed to be agreed and by the Autumn the five year system plan.

Mr Burns reminded the Board to look at the overall picture as one system. He believed the problem always linked back to the Workforce. Mr Burns was optimistic that the HR National Director would make a difference however noted the competitiveness of recruitment. There were no easy solutions and the Trust needed to do all it could.

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

TB 17/18 221 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe drew the Board to page 41 of the report pack CRR ID 1756. He believed the rating of 20 to be too high due to the staff that had now been recruited to the Nye Bevan Unit.

Mr Metcalfe discussed Consultant Job Planning which was included on page 43 of the report pack. He remarked that Consultant Job Planning had moved in the right direction and he anticipated that there would be zero consultants with a PA greater than 12 to be signed off by April 2019.

Mr Metcalfe advised that the Medical Model for Nye Bevan had been implemented 02 January 2019. He noted that there had been a positive impact in the continuity of care and fewer hand-offs.

Ms Gill stated that there appeared to have been an increased number of SI's. She asked whether this was due to a more transparent reporting culture or was this of concern. Mr Metcalfe explained that this was subjective. Since he had been in post as Medical Director he had started to Chair the Risk Of Harm Group which had strengthened and encouraged open dialogue.

Mr Moore drew the Board to page 41 of the report pack where the principle risks were listed and CRR ID 551. He had noted a positive paper on 24/7 working at a prior sub-committee and thought that this risk had reduced. Mr Metcalfe explained that the risk remained unchanged and that the paper that had previously been presented was based on an audit which the Trust had scored in the better quartile. As the risk owner Mr Metcalfe did not deem it appropriate to reduce this risk.

Mr Moore queried whether patients were as safe at the weekend as when admitted in the week. Mr Metcalfe clarified that this was regularly reviewed.

Ms Houghton referred back to 24/7 working. She commented that difficulties with 24/7 working did solely sit with the hospital as it can be difficult to get patients into care homes.

Mr Burns asked whether Mr Metcalfe was satisfied with the support he had received with job planning. Mr Metcalfe confirmed that he was. He had been glad to see it being brought in the right direction ensuring safety and continuity of service remained. He was grateful to the support he had received from the Chief Operating

Officer and Director of Finance at the Executive Consistency Committees.

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

TB 17/18 222 Mortality and Learning from Deaths Update

Mr Metcalfe presented the Mortality and Learning from Deaths Update.

Mr Metcalfe advised that this was the statuary quarterly report to the Trust Board. In quarter 2 the numbers had remained static and he believed that the next quarterly update would show significant improvement.

Mr Metcalfe stated that very few cases had gone through the Structured Judgement Tool as poor care and if so these had gone to the Risk of Harm Group for appropriate review.

The Board **NOTED** the Mortality and Learning from Deaths Update.

TB 17/18 223 Trust-Wide Mortality Case Note Review 12

Mr Metcalfe presented the Trust-Wide Mortality Case Note Review 12.

Mr Metcalfe advised that the report was being presented to the Trust Board following a request at the November Board for an update to the drift within the HSMR. The HSMR had now plateaued and the rise had been driven by the higher than expected mortality rate from April to May. He hoped the HSMR would now reduce due to the substantial reduction in crude mortality.

Mr Metcalfe drew the Committee to page 58 of the report pack which showed the peak in weekend mortality in April May time. This had been unexplained as there had been no change to the model of care, staffing and there had been no crisis. The only contributory factor had been the increased number of patients over the age of 90. Mr Metcalfe had discussed this with the Medical Director at the CCG to see if there had been a change in this cohort of patients care provision.

Mr Metcalfe reported that 24% of patients in the sample were aged 90 years or over and 57% were aged 80 years or over. A quarter of these patients had been in hospital for over a month.

Mr Metcalfe stated that the rise in HSMR is largely being driven by 2 diagnosis groups, Septicaemia (except in labour) and Secondary Malignancies. In regards to Septicaemia he believed a large number of these to be coding errors rather than a delivery of care issue on the basis of 6 audits which concurred with this belief.

Mr Metcalfe drew the Board to page 66 of the report pack and the Assessment of Problems in Healthcare graph. There was one case of definite harm and this had related to the failure to recognise that the patient was an end of life patient and appropriate support given.

Mr Pallot asked whether Mr Metcalfe required support from the Coding Team. Mr Metcalfe clarified that the coding team had been very helpful and had already been involved in this.

Dr Heap drew the Committee to page 51 of the report pack and the NGH Mortality Dashboard Q2 2018/19. She noted the overall number of adult inpatient deaths to be at 276. She challenged that only 2 of these were patients with a learning difficulty and only 2 were patients with a significant mental health diagnosis. Dr Heap remarked that these numbers were low and asked if the Trust was misidentifying the identification of patients with mental health. Mr Metcalfe confirmed he would review

these numbers.

Action: Mr Metcalfe

Mr Holland commented that he had completed an audit on patients admitted from a care home last month and large number had no care plan in place. He asked whether this impacted the Trust. Mr Metcalfe confirmed that the Deteriorating Patient Board had gathered the same information. Mr Holland informed the Board that the Trust completed Trust care plans for these patients.

Ms Houghton suggested the use of a face-track service for patients admitted from care homes. Mr Holland agreed it would be good to have this service at NGH.

Mrs Needham drew the Board back to page 66 of the report pack. She expressed concern on 'Delays in delivery of End of Life Care'. The previous CQC inspection had highlighted this and she queried whether the Trust was still an outlier in this area. Mr Metcalfe confirmed that this was correct and this area had been rated as 'required improvement' on the last CQC inspection. Since the CQC inspection and End of Life Nurse was in post. There was also a workstream set up within the Mortality Group to look at access to palliative care.

Ms Oke referred the Board to page 114 of the report pack which delivered an update on End of Life.

Mr Burns believed that the CQC would inspect End of Life care on their next inspection.

The Board **NOTED** the Trust-Wide Mortality Case Note Review 12.

TB 17/18 224 Director of Nursing and Midwifery Report

Ms Oke presented the Director of Nursing and Midwifery Report and advised that it had been discussed in detail at the Quality Governance Committee.

Ms Oke reported that work was underway to look at the Friends & Family Test (FFT) results and the quality of these results. The Patient Experience Team and the Volunteers had also been involved in collecting real time feedback.

Ms Oke informed the Board that during December there was 1 reported case of hospital onset C Diff, there have been 14 cases year to date and the Trust remained under trajectory against the 18/19 target of 20 cases.

Ms Oke stated that in regards to pressure ulcers the Trust had maintained a reduction in the number of pressure ulcers. In anticipation of the forthcoming NHSi (2019/20) requirement for the Trust to commence reporting all patients within the Trust with pressure ulcers, community acquired pressure ulcers had been incorporated into the report. Ms Oke advised that there would be a significant increase in the numbers of reported pressure ulcers due to this.

Ms Oke delivered a Safeguarding update to the Board. There was ongoing work with the CCG and KGH in relation monitoring safeguarding concerns within the community. Ms Oke felt more reassured on that there were improvements in safeguarding in the community. The Safeguarding Team would focus on the level 3 children's safeguarding with weekly training sessions in place.

Ms Oke reported that the opening of an additional 30 bedded escalation ward at the beginning of December has placed additional demands on staff availability. It was noted that despite this safe staffing levels had been maintained above 96% which was commendable.

Mrs Needham remarked on the Listening event which was due to be held in January 2019 for patients who attended the ED department in the previous 3 months. She asked if there was any feedback. Ms Oke confirmed it was scheduled for 31 January 2019. The patients who had been invited had attended the ED in November 2018. There had been 26 patients invited.

Ms Houghton drew the Board to page 111 of the report pack and the Maternity Safety Actions. She queried whether there were any financial implications if the Trust did not complete these actions. Mr Bradley clarified that there had been discussions on this and these equated to the value of £350k. The Trust had managed to hit these markers and Trust had agreed to invest to ensure that these markers would be met next year.

Ms Campbell questioned whether there were any other measures in house that could be used to triangulate the FFT results. Ms Oke explained that the Right Time Survey supported this and the feedback from these surveys is shared with the teams.

Mr Burns remarked that it would be good for the Non-Executive Directors to visit the Wards to gather feedback.

Mr Moore shared with the Board an article which he had read on infection control in other countries. This had included bed washes and staff screening for infections. He believed the staff screening for infections to be a scheme to look into. Mr Burns requested that a report on this to be shared at the Quality Governance Committee.

Action: Ms Oke

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

TB 17/18 225 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that the Month 9 financial pre – PSF position showed a year to date favourable positive position of £92k. However the Trust had not achieved the PSF of £827k relating to A&E performance in Quarter 3 and therefore was £735k adverse to the post-PSF plan.

Mr Bradley commented that delivering the pre-PSF plan year to date was an achievement for the Trust and was also recognised as such by the Trust regulators.

Mr Bradley stated that in month income underperformed, pay overspent, non-pay underspent and the monthly planned release of reserves led to the month end position.

Mr Bradley drew the Board to page128 of the report pack which detailed Income. The income and activity position was below plan in month only due to the lack of additional progress on the system gap funding. It was noted that non-elective activity in month was £768k above plan and was now £4,215k above plan year to date, however this was offset by loss on excess bed day income year to date of £3,085k. The Trust had not started to phase in the year end deal with Nene CCG.

Mr Bradley referred the Board to page 130 of the report pack which was the start of the Pay slides. It was reported that pay overspending was £3.16m ytd, £115k better than plan in month, after the removal of £4.9m of unplanned pay savings. The agency cap was exceeded in December by £108k mainly due to additional medical and nursing staff relating to winter plans and the escalation ward.

Mr Bradley discussed Non pay expenditure which was highlighted on page 132 of the report pack. It continued to help the bottom line and was £4.6m underspent year to date, £410k in month, of which £3,115k related to excluded drugs and medicines.

Mr Bradley drew the Board to page 133 of the report pack where the CIP summary had been detailed. In overall terms the Trust was ahead of plan and expected to meet the target; however Mr Bradley's main concern remained the delivery of recurrent CIPs, £5.9m year to date, which was an improvement of around £1m from the previous months position. There was continued work to seek recurrent schemes as the result of not delivering would mean a carry forward into 2019/20.

Mr Bradley reported on Capital on page 135 of the report pack. Mr Bradley and Mr Finn had met with NHSI in regards to the accommodation block. With regards to the ne w Main Entrance the Trust needed to look at legal advice before a paper is brought back. Mr Finn confirmed that the Board had agreed the initial planning stages for both schemes previously. Mr Bradley stated that timelines are appropriate.

Mr Burns noted that issues with non-recurrent CIPs flagged his attention. Mr Bradley advised that last year the Trust delivered£4.9m of recurrent CIPs, and therefore the achievement year to date in 2018/19 had exceeded this, however the importance of delivering the full plan recurrently was key to the Trust's finances going forward. It essential the message shared was that the non-recurrent CIPs needed to be met. It was noted that the achievement of CIPs were discussed in detail at the Changing Care meeting with opportunities also sought to find additional savings. The Changing Care Group looked at; outpatients and theatre efficiency, the model hospital and GIRFT and ideas from other hospitals.

Mr Burns remarked that the Trust appeared in a good place however non-recurrent CIPs was a growing problem.

Mrs Needham informed the Board that the Executive Team would be revisiting this, looking at model hospital and GIRFT to make decisions on services.

The Board **NOTED** the Finance Report.

TB 17/18 226 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity decreased in December 2018. The overall Trust vacancy percentage rate increased in December and the increased vacancy rate was partly attributable to an increased overall budgeted Establishment. Some of this is due to a lower amount of Non-Recurrent Pay CIP being applied as Divisions are now finding this year's CIP through other routes. The remainder constituted winter funding for the Benham Escalation ward.

Mrs Brennan reported that Sickness absence for December 2018 increased and was above Trust target. The trends noted were illnesses related to anxiety, stress and depression.

Mrs Brennan informed the Board that the Flu vaccination take-up percentage for the Trust is above target at 81.9% to date. The Trust had therefore achieved its CQUINN for the year.

Mrs Brennan stated that the current rate of Appraisals recorded for December 2018 had decreased. The HR BP's would be devising an action plan to address the poor performing areas.

Mrs Brennan advised that the Trust's confirmed final response to the staff survey rate was 43.6%. This was an improvement on 2017 when the Trust's final response percentage was 39%. There would be further detail available in February 2019.

Mrs Brennan reported that funding had been secured from LWAB for the STP to conduct a cultural insight deep dive assessment around Equality and Diversity. In addition two posts would be piloted as part of the associated initiative of 'Recruiting for Difference'.

Mr Finn asked if there were any themes coming out from the investigation into the drop in appraisal rates. Mrs Brennan believed it could be contributory to the number of new starters or that the appraisals had been done but had not loaded on to the system as completed.

Ms Houghton discussed the staff survey response being lower than the national average. She queried whether the results had identified increased stress and anxiety amongst staff. Mrs Brennan clarified that the take up rate was the issue as was the Directorates receiving the feedback on what had happened as a result of the staff survey results. There would be a programme next year to help with this.

Ms Campbell remarked that the relaunch of Freedom to Speak Up had seen an increased number of cases reported. She would work with Mrs Brennan on linking it in with the Respect and Support Campaign.

Mr Moore noted the turnover rate, vacancy rate and sickness absence rate reported and asked how the Trust compared with other hospitals. Mrs Brennan stated that the Trust vacancy rate was typical for an acute hospital and the Trust turnover was slow. Mrs Brennan confirmed she would gather benchmarking data and present to a future Workforce Committee.

Action: Mrs Brennan

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

TB 17/18 227 E&D Progress Report inc WRES update

Mrs Brennan presented the E&D Progress Report inc WRES update.

Mrs Brennan advised that there had been good progress on the Equality Objectives/Four Year Plan 2016 – 2020. In regards to the Divisional Objectives at the September 2018 Equality and Diversity Staff Group meeting, the Womens, Childrens, Oncology, Haematology and Cancer Services Division had reported on their Divisional objectives.

Mrs Brennan discussed the Workforce Race Equality Standards (WRES) data with the Board. The number of BME staff in the overall workforce, both in the clinical and non-clinical had increased. There was still concern on the number of BME staff at Board level.

Mr Burns commented that the report did not give him an indication of the level of the problem previously therefore requested in future that this information would be included.

The Board **NOTED** the E&D Progress Report inc WRES update.

TB 17/18 228 Gender Pay Gap Report

Mrs Brennan presented the Gender Pay Gap Report.

Mrs Brennan advised that there was no significant difference in the previous annual

report.

Mrs Brennan stated that the mean bonus gender pay gap had been discussed in detail at the Workforce Committee. The 2018 mean bonus gender pay gap for the Trust demonstrated that female staff were paid 83.20% less than male staff. This was likely due to Clinical Excellence Awards (CEA) and bonuses that were paid to workers on the Clinical Nurse Bank who completed 150 hours of bank work.

Mrs Brennan commented that the Workforce Committee had challenged whether the bonuses paid to Clinical Nurse Bank staff should be classed as bonuses. Mrs Brennan had explored this and the classification of a bonus payment had been correct because it was an incentive payment.

Mr Burns touched on CEA's and the gender split for applicants. Mr Metcalfe advised that the final meeting to evaluate the CEA evidence was 31 January 2019. The gap analysis had not been done however he believed there to be a fair spread between male and female applicants.

The Board **NOTED** the Gender Pay Gap Report.

TB 17/18 229 Operational Performance Report

Mr Holland presented the Integrated Performance Report taking it as read having already been discussed in detail at Finance, Investment & Performance Committee, Workforce committee and Quality Governance Committee.

Mr Holland advised that it had been a challenging month. The 4 hour target had performed at 83.38%. There had been an increased conversion rate after 4pm which is when the largest number of breaches had occurred.

Mr Holland reported that there was ongoing work on flow. The number of DTOC's had reduced. There was currently only 1 patient over 100 days when previously the numbers of patients had been over 20. The Board were reminded of the requirement from NHSI to reduce the target by 25% which the Trust had achieved however there had been a slight increase over the Christmas period.

Mr Holland stated that the Medical Model in Nye Bevan was now live and the time to be seen overnight had improved.

Mr Holland discussed RTT with the Board. The Trust had performed at 81.5% for RTT in December. It was reported that not all Directorate's had delivered therefore Mr Holland had requested action plans and also to look at their capacity gaps. He noted the ring-fencing of surgical beds had also gone well.

Mr Holland remarked that Cancer had remained challenging. For November the Trust had been at 76% for 62 days and December 80%. In December the Trust would be at 86% for 2ww referral and 95.7% for 31 days first treatment.

Mr Holland stated that Legacy patients are being discussed 4 times a week with the Directorates. There was also project manager in place for the lung and urology pathways.

Mr Archard-Jones noted the fluctuations in 2ww breast and 2ww referral performance. Mr Holland clarified that the 2ww breast symptoms compliance could be affected by the patient. The patient may not see the urgency of the referral and this can be a challenge. Mr Archard-Jones queried whether this should be included under cancer performance and he was informed that it was a national target.

Ms Houghton asked if there were any themes behind DTOC. Mr Holland confirmed he would collate this information.

Action: Mr Holland

Mrs Needham reminded the Board that there was a significant amount of patients ready for discharge however lack of capacity in the community prevented this.

Ms Gill noted the dip in the performance of ambulance handovers. Mr Holland stated that the Trust was still one of the best performing in the region. The Trust had met with EMAS as they did not agreed with the figures provided.

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

TB 17/18 230 Refreshing the Clinical Strategy 2019-2024

Mr Pallot presented the Refreshing the Clinical Strategy 2019-2024 update.

Mr Pallot advised that the paper proposed the process of engagement across the hospital in the refreshment of the clinical strategy. There had been consideration given on how to engage staff in a planned and structured way in how the Trust implemented the Clinical Strategy. This aligned the Trust to requirements laid out on the well-led framework.

Mrs Brennan noted that the roll out looked good. The People Strategy was due to be pushed out in February therefore it would be good to marry this up. Mr Pallot replied that this was possible albeit the strategy was not being rolled-out at this stage but an engagement on the contents of the new document

Mr Burns believed that it was important to see that the KLOEs had been included within the Clinical Strategy.

Mrs Needham remarked that due to the potential to engage staff across both NGH and KGH the use of similar paperwork needed to be considered.

Ms Gill asked whether there would be joint sessions with KGH on the strategy. Mr Pallot believed this to be unlikely as KGH had already circulated their clinical strategy however there was an intention to engage with a range of partners in the generation of the new strategy which would include KGH.

The Board **NOTED** the Refreshing the Clinical Strategy 2019-2024 update.

TB 17/18 231 HCP Partnership Update

Mr Pallot presented the HCP Partnership Update.

Mr Pallot advised that this was the latest update from the HCP. He drew the Board to page 192 of the report pack which was a good news story for the HCP.

Mrs Needham believed that the Trust needed to put forward their own good news story for inclusion within the monthly newsletter.

The Board **NOTED** the HCP Partnership Update.

TB 17/18 232 EU Exit Operational Readiness Guidance

Mrs Needham presented the EU Exit Operational Readiness Guidance Report.

Mrs Needham advised that the DHSC had written to Trusts in October 2018 asking that the Trust started to prepare for leaving the EU at the end of March 2019. The implication is not yet fully known for Health and some the guidance was confusing.

She reported that the Trusts had been asked that no stock piling takes place.

Mrs Needham stated that the Trust had been given a checklist which was outlined on page 200 of the report pack. There was the expectation that business continuity plans are up to date and tested. The Trust's Emergency Planning Core Standards had all been met and the Trust had been rated as fully compliant in their business continuity plans.

Mrs Needham confirmed she would update the Board when further guidance had been received.

The Board **NOTED** the EU Exit Operational Readiness Guidance Report.

TB 17/18 233 Highlight Report from Finance Investment and Performance Committee

Mr Moore advised that all areas to be noted from January's Finance Investment and Performance Committee had been discussed today at Trust Board.

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

TB 17/18 234 Highlight Report from Quality Governance Committee

Mr Archard-Jones advised that all areas to be noted from January's Quality Governance Committee had been discussed today at Trust Board. T

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

TB 17/18 235 Highlight Report from Workforce Committee

Ms Gill advised that all areas to be noted from January's Workforce Committee had been discussed today at Trust Board. These included –

- Freedom to Speak Up – the policy was to be updated and refreshed.
- Health & Wellbeing – a detailed update had been presented to the Committee.
- Schwartz rounds – the potential of using this training technique had been discussed.
- Medical Education Update – this had included an update from the Medicine Division on their GMC Trainee Survey results.

Mr Burns asked what the provision was for hot food on a Saturday and a Sunday. Mr Finn explained that the canteen was open to 6pm at the weekend. With the new main entrance there would be facilities that would be open till 8pm. Mr Metcalfe stated that the Junior Doctors got a free breakfast after a night shift.

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

TB 17/18 236 Highlight Report from Audit Committee

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

TB 17/18 237 Highlight Report from Hospital Management Team

Mrs Needham advised that all areas had been discussed at the sub-committees of the Board or previously at Board.

Mrs Needham stated that one area to highlight was on the workshop on Cancer. The action plans for the Divisions had been refreshed and with clear expectations on performance for quarter 4 noted.

Mrs Needham reported that the move to NHS.net mail from NGH mail was also

discussed. This would be taking place over the next 2 months. The planning for this was currently taking place. She hoped with training the disruption would be minimal.

Mr Burns noted that Business Case for an electronic management system for appointments. He asked if this had met any resistance and he was informed that the business case had not.

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

TB 17/18 238 Any Other Business

Secretary of State – Mrs Needham
Mrs Needham advised that the Secretary of State would be visiting the Trust on the 07 February 2019. A local MPs had asked for the visit. The Secretary of State was due to arrive at 2.30pm and there would be 30 minutes allocated for a Q&A session along with a visit to a ward area.

Date of next Public Board meeting: Thursday 28 March 2019 at 09:30 in the Board Room at Northampton General Hospital.

Mr A Burns called the meeting to a close at 12:05

Public Trust Board Action Log						Last update	18/03/2019
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
95	Jan-19	TB 17/18 223	Trust-Wide Mortality Case Note Review 12	Dr Heap drew the Committee to page 51 of the report pack and the NGH Mortality Dashboard Q2 2018/19. She noted the overall number of adult inpatient deaths to be at 276. She challenged that only 2 of these were patients with a learning difficulty and only 2 were patients with a significant mental health diagnosis. Dr Heap remarked that these numbers were low and asked if the Trust was misidentifying the identification of patients with mental health. Mr Metcalfe confirmed he would review these numbers.	Mr Metcalfe	Mar-19	On agenda	**Update in Matters Arising**
96	Jan-19	TB 17/18 224	Director of Nursing and Midwifery Report	Mr Moore shared with the Board an article which he had read on infection control in other countries. This had included bed washes and staff screening for infections. He believed the staff screening for infections to be a scheme to look into. Mr Burns requested that a report on this to be shared at the Quality Governance Committee	Ms Oke	Mar-19	On agenda	**Update in Matters Arising on progress to QGC**
97	Jan-19	TB 17/18 226	Workforce Performance Report	Mr Moore noted the turnover rate, vacancy rate and sickness absence rate reported and asked how the Trust compared with other hospitals. Mrs Brennan stated that the Trust vacancy rate was typical for an acute hospital and the Trust turnover was slow. Mrs Brennan confirmed she would gather benchmarking data and present to a future Workforce Committee.	Mrs Brennan	Mar-19	On agenda	**Update in Matters Arising on progress to Workforce**
98	Jan-19	TB 17/18 229	Operational Performance Report	Ms Houghton asked if there were any themes behind DTOC. Mr Holland confirmed he would collate this information.	Mr Holland	Mar-19	On agenda	**Update in Matters Arising**
Actions - Future meetings								
93	Nov-18	TB 17/18 206	Annual Fire Safety Report	Mr Finn reported that a Fire Specialist had been employed for a period of 2 months to check all mitigations were in place. There were also departmental surveys ongoing. Mr Finn suggested presenting an update to the May Board. The Board agreed.	Mr Finn	May-19	**On-Track**	
94	Jan-19	TB 17/18 220	Chief Executive's Report	Mrs Brennan commented that the workforce plan was under development and this was split into 5 workstreams. The plan would be shared in March with the detail received by the Autumn. An update would be brought to the Trust Board when circulated.	Mrs Brennan	TBC	**TBA**	

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	**Acting Chief Executive's Report**
Agenda item	***7***
Presenter of the Report	Deborah Needham, Acting Chief Executive
Author(s) of Report	Deborah Needham, Acting Chief Executive Sally-Anne Watts, Associate Director of Communications
Purpose	For information
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
28 March 2019

Acting Chief Executive's Report

1. Care Quality Commission

Work is already underway to ensure we are prepared for our CQC inspection later this year. Our Provider Information Response (PIR) was submitted to the CQC on 27 March 2019 and from that date we can expect to receive a minimum 12 weeks' notice of a formal inspection.

We have already been informed that our use of resources assessment, which is undertaken by NHS Improvement, will take place on 4 June 2019.

We have started to prepare staff for the inspection process, leading with one of our highly popular Question Time sessions. This will be followed up by other briefings for staff over the next few months.

A briefing document is being prepared for staff to assist them in being more prepared for the inspection. The document includes information about NGH, our structure and strategy, information about what to expect when the inspectors are on site, an explanation of each of the inspection domains of safe, caring, responsive, effective and well-led and a description of the ways in which each of our clinical divisions is addressing their challenges and what they're proud of. In addition we are producing 'The NGH Book of Best Practice' as we want to share progress and developments across the organisation, helping members of TeamNGH, and the wider public, be better informed and proud of what is happening in their hospital.

2. Baby-Friendly Accreditation

Our maternity services were recently accredited by UNICEF UK as being Baby Friendly for the second time. The award recognises how we care for mothers and babies, the information parents receive about breastfeeding and the support given to patients. Since being first accredited in 2016, NGH is one of just 64% of hospitals in the UK who have achieved Baby Friendly status.

Established in 1992 by the World Health Organisation and UNICEF, the Baby Friendly Initiative is a world-wide programme to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding. The inspection process combined tests and interviews about the knowledge levels of staff on a range of topics such as breastfeeding, skin to skin contact and the support offered to mothers throughout pregnancy and post-birth. During the visit mothers are also asked about their experience of the hospital and the support they have received.

3. Sustainability

The Sustainable Development Unit (SDU) for NHS England and Public Health England, together with the Healthcare Financial Management Association (HFMA) and NHS Improvement have awarded NGH with a certificate in recognition of Excellence in Sustainability Reporting.

The SDU conducted an analysis of all provider(s) and CCG('s) annual reports to evaluate sustainability content. Of the 432 organisations evaluated, 55 trusts and 42 CCGs (22%) were selected for recognition.

High quality reporting on sustainability is recognised as a fundamental way in which organisations can demonstrate their commitment to embedding environmental, social and financial sustainability and measuring, monitoring and reporting on sustainability through our annual report which in turn supports the assurance process for meeting legal, reputational and policy requirements.

4. Our staff

Work continues on our Respect and Support campaign with the opening of a new telephone hotline which is available from 10am to 4pm Monday to Friday. We are also running training sessions which consists of round table facilitators, and training on challenging bullying and inappropriate behaviour for team members and leading with respect for managers, supervisors and team leaders. In addition, we have set up a series of focus groups facilitated by Diversity by Design, who specialise in diversity in the workplace, to provide staff with opportunities to talk about diversity, equality and inclusion at NGH.

We have joined with Kettering General Hospital NHS Foundation Trust in a service level agreement with "Voice, a free, confidential support service for victims and witnesses of crime. Their services are available to anyone resident in Northamptonshire, whether a crime has been reported to the Police regardless of when or where it happened. Voice provides independent emotional support and practical assistance to help people cope, recover and thrive. We believe the service will benefit our staff, our patients and their relatives.

5. System planning for 2019/20

Partners within the Northamptonshire HCP continue to meet on a regular basis to agree a system financial framework as well as individual contract values for 2019/20. To date the negotiations have been extremely challenging mainly due to the construct of the national contracting ask and the requirement to balance budgets at both the organisational and system level.

6. Power outage 22/23 February 2019

During the late evening of 22 February 2019 the hospital lost power to approximately 75% of the site. An internal significant incident was declared and full command and control was put into place and led by the acting CEO throughout the night and the Director of Finance the following day. A full A&E divert was put into place which meant that A&E was fully closed for a period of time in the early hours of Saturday morning.

The staff who were involved and came in to help during the night and then throughout the weekend showed remarkable resilience and flexibility, for which I am extremely grateful. A full debrief has taken place with reflections and lessons learnt.

7. Winter pressures

March to date has been extremely busy, more so than January and February with urgent care pressures. The acuity of patients being admitted to our hospital has significantly increased with critical care being full on most days.

It never ceases to amaze me how in times of pressure team NGH shines and continues to provide outstanding care for our patients whilst balancing quality & performance, all whilst looking after each other. A great example of this was a chocolate bar delivered to 236 members of the oncology & haematology staff by their directorate management team, reminding staff to take a break.

The executive team also personally delivered 6,000 lunch vouchers to staff on 18 March as a thank you for being amazing through winter. This was kindly sponsored by our charity.

Deborah Needham
Acting Chief Executive

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	**Medical Directors Report**
Agenda item	**8**
Presenter of Report	Mr. M. Metcalfe, Medical Director
Author(s) of Report	Matthew Metcalfe, Medical Director
Purpose	The paper is presented to provide information to the board to form a discussion relating to medical quality and safety.

Executive summary

The paper is presented to provide information to the board to form a discussion relating to medical quality and safety.

Each of the indicators on the integrated scorecard (Appendix 1) for which the Medical Director is the executive lead and which are non-compliant have an accompanying exception report (Appendix 2) and these have been discussed in detail in the appropriate subcommittees. Within the body of the report are listed those corporate risks relating to the corporate medical portfolio. Where information is available benchmarking is included.

Within this month's report, the main areas of focus for discussion are:

a. Consultant Job Planning
b. Medical model in the Nye Bevan Building
c. Thrombosis
d. Deteriorating Patient

Related strategic aim and corporate objective	1
Risk and assurance	There is a potential risk to the organisation if risks are not identified in a timely manner and effective mitigation actions taken that the staff and patients in the organisation may experience foreseeable harm and the Trust could be exposed to reputational damage and prosecution.
Related Board Assurance Framework entries	BAF – ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	

Actions required by the Board

The board is asked to receive this report.

Medical Director's Report **28th March 2019**

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. This report should therefore be taken in conjunction with the director of nursing and midwifery report to the board. For ease of access the report is structured;

ii. in relation to the principle risks to delivery where these are rated "extreme" and pertain to the corporate medical portfolio (>14)
iii. review of harm, incidents and thematic
iv. mortality and the management of outlier alerts
v. related topics from the medical director's portfolio largely reflecting the reporting cycle of CQEG and QGC, this month;

a. management of actions arinsing from SI investigations
b. corporate medical structure
c. Venous thromboembolism prophylaxis

2. Risk

The principle risks to delivering high quality and timely patient care rated 15 and over are grouped below as follows. The mitigation of these is described in the corporate risk report register and associated reports, and discussed below in relevant sections.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk of reduced patient safety when demand exceeds capacity	20	15	Quality Governance
1757	Escalation areas budgeted for limited periods may remain open for extended periods	16	16	Quality Governance
1782	Venous Thromboembolism: compliance	16	16	Quality Governance
1955	Deteriorating Patient Care Lack of support / guidance in training to support staff in assessing and managing deteriorating patients across the Trust.	15	15	Quality Governance
1756	January 2019 new model commenced and has reduced medical waits. Admission waits remain the same despite being in the middle of winter which equates to a reduction that will be more evident in spring/ summer	20	15	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 under the current framework 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

	16/17	17/18	18/19
Serious Incidents	13	18	31
Never Events	1	3	1

3.ii New SI and moderate investigations

There were 9 serious incidents reported on STEIS during January and February 2019. These are on track to report by their deadlines. 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.

12 moderate harm incidents were identified, and these are subject to concise RCA investigations.

3.iii Thematic issues

No new themes have been identified from incidents since January. The previously recognised themes of delayed recognition of the deteriorating patient, with associated recurring issues around diabetic control, fluid management, safeguarding and escalation/end of life care continue to be addressed holistically through the deteriorating patient oerating group. The roll out through inpatient areas has been

confirmed. Issues relating to the failure to act upon investion results are being addressed through work led by the associate medical director for medicines and mortality.

4. Mortality

Further to the detailed mortality report presented to board in January 2019, the rolling 12 month HSMR to November 2019 for the trust has fallen to within the "expected" range at 105.7. It is anticipated that the downward trend will continue based on an unusually low crude mortality rate in more recent months. It is felt likely that changes in HSMR reflect changes in community health and social care provision. An update on the workstreams addressing areas of concern will be summarised to board in May. The statutory learning from deaths report is presented separately.

5. Management of actions arising out of SI investigations

Recognising that there has been significant reduction in overdue actions arising from recommendations of SI reports, the importance of mitigating identified risks as expediently as possible has been highlighted through discussion at QGC. In order to address this there is individual scrutiny of all overdue actions at CQEG, with clear plans for resolution agreed with the action owning divisions/directorates.

6. Corporate medical structure

The associate medical director positions have been reviewed and revised and new appointments made. The financial net effect has been cost releasing. The associate medical directors are now on a standard footing with time and remuneration equivalent to the clinical director positions.

7. Thrombosis

The upgrade to ePMA which will enforce VTE risk assessment is subject to further slippage on roll out. Testing has commenced in March 2019, with roll out now expected in April or May 2019. This is approximately a 3 month delay.

To date VTE assessment performance reports have not been resumed since the IT issues which interrupted them in November 2018.

Northampton General Hospital NHS
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Corporate Scorecard 2018/2019 FEB

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		➡		100.0%	92.7%	100.0%	83.3%	98.1%	98.1%	100.0%	97.4%	97.4%	98.0%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	⬇		84.2%	87.3%	86.4%	88.7%	88.3%	88.0%	87.3%	86.5%	88.2%	85.9%	85.1%	80.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	⬆		93.3%	92.1%	93.7%	92.0%	92.5%	91.4%	92.0%	92.5%	94.1%	92.6%	92.7%	93.5%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	⬇		100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	99.5%	98.7%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	⬆		93.9%	94.0%	97.9%	92.5%	92.8%	93.2%	92.8%	92.4%	93.8%	93.5%	93.5%	93.6%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	⬆		252	0	0	0	0	3	0	0	0	0	4	2
	Compliments	Sheran Oke	-	NGH										4,288	4,335	3,541	4,269	3,639
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	⬆		85.1%	88.9%	86.6%	93.9%	92.3%	91.5%	89.0%	86.8%	85.9%	83.3%	78.6%	80.9%
	Average Ambulance handover times	Debbie Needham	<=15 mins		⬇		00:13	00:14	00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		⬇		179	80	129	58	79	60	118	174	142	299	330	
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		⬇		23	11	5	2	1	3	15	17	19	30	49	
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		⬆		34	11	13	7	6	16	2	3	3	4	5	4
	Delayed transfer of care	Debbie Needham	=23	NGH	⬆		52	26	39	35	12	19	36	10	10	24	12	11
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	⬆		42	30	42	40	28	16	34	27	15	20	20	17
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	⬆		16	13	37	31	19	13	25	25	13	16	17	13
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	⬇		89.5%	77.6%	90.8%	70.0%	72.2%	70.8%	75.2%	94.0%	88.5%	86.1%	73.8%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	⬆		81.0%	72.8%	78.1%	23.3%	18.1%	31.1%	85.7%	91.1%	40.3%	35.4%	60.3%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	⬇		96.9%	98.8%	97.4%	92.7%	95.4%	97.5%	94.7%	97.5%	94.9%	96.6%	92.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	⬇		88.7%	100.0%	97.1%	100.0%	100.0%	98.8%	96.8%	100.0%	100.0%	100.0%	98.9%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	⬆		100.0%	97.3%	94.4%	96.1%	97.5%	97.6%	95.7%	95.8%	96.7%	94.9%	98.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	⬇		85.7%	90.0%	90.0%	78.6%	100.0%	100.0%	88.9%	86.7%	93.8%	93.8%	80.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	⬇		91.6%	81.1%	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	⬆		95.5%	100.0%	97.1%	68.4%	100.0%	93.8%	100.0%	83.9%	100.0%	81.8%	90.5%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	⬇		100.0%	97.7%	87.5%	90.0%	81.3%	78.7%	79.1%	85.7%	83.6%	89.1%	84.0%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	⬆		87.4%	88.8%	89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	⬇		0	1	0	0	0	0	0	0	0	0	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	⬆		99.9%	99.7%	99.5%	99.7%	99.5%	99.9%	100.0%	99.9%	99.9%	99.8%	100.0%	

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2018/2019 FEB

	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				74.6%	79.5%	96.5%	93.5%	93.0%	100.0%	92.7%	94.8%	95.7%	100.0%	79.7%	66.3%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				87.8%	90.7%	91.7%	87.8%	97.7%	93.3%	95.0%	98.0%	95.0%	95.3%	89.4%	82.5%
	Unappointed Follow Ups	Debbie Needham	=0	NGH													8,608	8,723
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			12.9%	11.7%	11.8%	12.2%	12.3%	12.5%	12.4%	12.5%	12.4%	12.3%	12.4%	12.4%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	3.8%	3.9%	4.4%	4.7%	4.5%	4.3%	4.0%	4.1%	4.5%	5.0%	4.7%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			10.8%	12.1%	11.8%	12.6%	13.3%	11.8%	11.1%	10.4%	10.4%	12.5%	11.8%	11.0%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.2%	12.8%	13.2%	14.3%	14.7%	9.4%	9.4%	8.8%	9.1%	10.0%	9.2%	2.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			8.5%	9.8%	9.5%	9.8%	10.5%	8.3%	7.5%	7.3%	7.6%	11.6%	11.3%	11.3%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			11.5%	13.2%	12.7%	13.7%	14.4%	14.1%	13.8%	12.9%	12.1%	13.6%	12.8%	12.5%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.9%	7.7%	7.5%	7.4%	8.9%	7.8%	7.9%	7.7%	7.8%	8.3%	8.2%	9.0%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.0%	88.6%	89.2%	89.5%	89.2%	88.8%	88.7%	87.9%	88.3%	88.5%	88.7%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH											81.9%	82.9%	82.0%	82.0%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.3%	84.6%	84.8%	85.0%	85.1%	83.8%	82.1%	82.0%	82.6%	83.0%	83.3%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			85.1%	85.4%	86.8%	86.8%	86.0%	85.1%	84.6%	83.1%	83.5%	81.7%	83.6%	84.6%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			75.8%	63.5%	63.6%	63.6%	58.3%	60.0%	12.5%	15.2%	27.5%	24.3%	28.6%	30.9%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			(3,436) Adv	148 Fav	288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			(12,070) Adv	615 Fav	1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(5,872) Adv	(539) Adv	(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			(3,864) Adv	283 Fav	555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			322	24	46	70	89	107	128	153	167	195	209	144
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			457.8	22.1	82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	322.1
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			(934) Adv	485 Fav	1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH												64.6%	66.0%	65.6%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH												39.2%	40.5%	41.0%
	Maverick Transactions	Phil Bradley	=0	NGH								27				15	21	21
	Waivers which have breached	Phil Bradley	=0	NGH			1	3	2	2		0				1	0	0
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH				60.2%	62.3%	56.6%	51.1%	55.1%	57.6%	54.2%	54.5%	54.8%	58.0%	57.1%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH				29.5%	31.3%	29.3%	22.1%	24.7%	26.2%	23.8%	23.1%	23.1%	23.9%	21.7%
	Length of stay - All	Debbie Needham	<=4.2	NGH			5.4	5.2	4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.8%	19.2%	19.0%	19.3%	18.9%	19.7%	17.9%	18.6%	17.5%	19.1%	18.4%	17.3%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.1%	3.7%	3.5%	3.5%	4.6%	3.3%	3.5%	3.1%	3.2%	4.7%	3.1%	2.4%

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2018/2019 FEB

	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.7%	13.3%	14.4%	15.8%	16.9%	17.1%	16.6%	14.4%	14.7%	17.5%	16.0%	12.4%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		96.0%	93.1%	88.9%	90.0%	87.5%	82.8%	77.1%	84.6%	82.8%	100.0%	86.5%	81.8%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.0%	28.4%	31.4%	34.1%	29.0%	29.9%	28.9%	31.5%	31.3%	32.2%	32.3%	27.3%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑			99	99	101	0	104	104	106	106	106	105	
	Mortality: SHMI	Matt Metcalfe	100	Nat	→			97	97	97	98	98	100	100	104	104	104	
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	↑		109	45	79	25	25	45	47	66	36	35	53	51
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	↓		96.3%	100.0%	94.9%	100.0%	100.0%	97.8%	95.7%	97.0%	97.2%	91.4%	98.1%	96.1%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	0	0	1	0	0	0	
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-				3	1	3	4	3	2	3	0	0	3	7	
	No of Comprehensive Investigations	Matt Metcalfe	=0	NGH														
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.6%	97.8%	97.9%	96.4%	96.5%	95.0%	95.7%	95.8%	95.4%	95.4%	95.6%	93.3%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	→		0	5	1	2	2	1	2	0	0	1	0	0
	MSSA	Sheran Oke	<=1.1	NGH	↓		0	2	1	0	2	0	0	2	1	0	1	2
	New Harms	Sheran Oke	<=2%	NGH	↑									2.11%	0.67%	0.99%	0.62%	0.15%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		5.1	4.4	4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→											85.6%	88.1%	88.1%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓											62.1%	59.8%	54.1%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	→											89.2%	89.2%	

Job plans progressed to stage 2 sign-off

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	90.0%	30.9%	↑	Matt Metcalfe

Performance vs Target

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
	75.8%	63.5%	63.6%	63.6%	58.3%	60.0%	12.5%	15.2%	27.5%	24.3%	28.6%	30.9%

What is driving underperformance?

- Data rebased in September to reflect compliance in all divisions to date.
- Compliance includes only job plans related to the current financial year
- Delays within Medicine Division has negatively impacted on other Divisions
- Complications within other Divisions delaying progress
- As the Divisions progress with Service planning, new job plans are entered, temporarily reducing compliance.
- New consultants also reducing compliance

Actions completed in the past month to achieve recovery

- Regular Executive Consistency Committee (ECC) meetings taking place with the Divisions for updates and challenge on progress
- Majority of Medicine now complete, with any outstanding going to mediation.
- Slower than anticipated progress with WCO&H however anticipate completion end of April
- ECC meetings continue with Surgery Division. Good engagement, however some issues are delaying progress.
- Clinical Support to complete next year with preliminary meeting being held in March

Exception report written by

Timeframe for recovery

Next steps

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	**NGH Mortality Dashboard**
Agenda item	**9**
Presenter of Report	Mr M Metcalfe Medical Director
Author(s) of Report	Dr L Jameson, Specialty Doctor
Purpose	In response to a publication from the National Quality Board March 2017 – National Guidance on Learning from Deaths

Executive summary

This paper includes the NGH Mortality Dashboard for Q3 2018/19

- Total number of in-patient deaths
- Number of deaths subjected to case record review
- Of the deaths reviewed, how many deaths were thought more likely than not to be due to a problem in care
- Learning identified from Mortality Case Note Review
- Updates to mortality processes

Screening rates have improved to 93% in Q3 and Trust wide Mortality Case Note Review 12 provided assurance of the high quality of care provided to 100 patients who died in May 2018.

Related strategic aim and corporate objective	Corporate Objective 1: Focus on Quality and Safety – We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF 1.4
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote

	good relations between different groups? No 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)?No 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

Actions required by the Trust Board

The Trust Board is asked to:

Discuss and where appropriate challenge the content of this report and to support the work moving forward

NGH Mortality Dashboard Q3 2018/19

Northampton General Hospital NHS Trust

	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to Dec 18	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings or Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q4 17/18	459	50	70%	94	13	3	2 CI / 1 NI
Q1 18/19	365	39	61%	128	11	1	1 NI
Q2 18/19	276	36	64%	54	6	2	2 NI
October	93	12	90%	23 of 24	4	0	0
November	108	10	94%	11 of 22	1	0	0
December	107	11	94%	10 of 23	1	1	1 CI
Total Q3 18/19	**308**	**33**	**93%**	**44 of 69**	**6**	**1**	1 CI

Vulnerable Adults

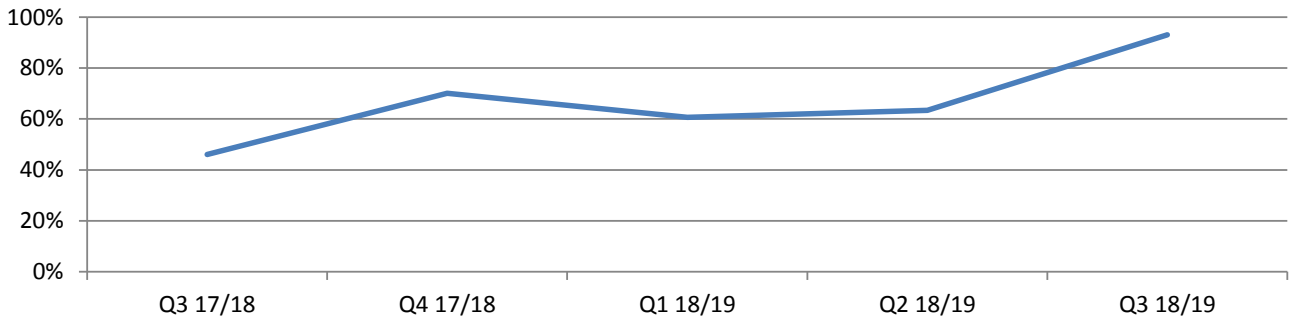
Patients with a learning disability

There were no deaths of patients with a learning disability during Q3 2018/19.

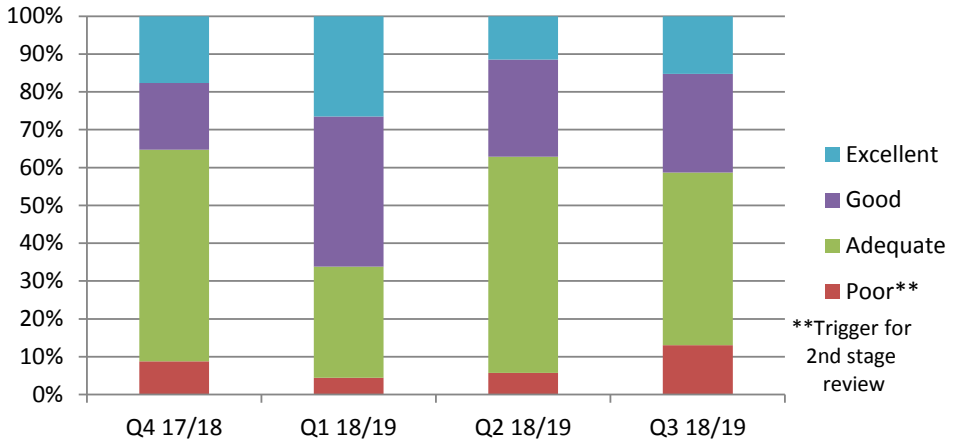
Patients with a severe mental illness

The care of 1 patient with a severe mental illness who died at NGH during Q3 2018/19 has been reviewed

Percentage of Deaths Screened by Mortality Screening Team



Distribution of Overall Care Scores from Structured Judgement Reviews



Learning from Screening, and Structured Judgement Reviews

Trust wide Mortality Case Note Review 12 looking at 100 consecutive deaths in May 2018 provided assurance of the quality of care provided to patients at this time. The sample group was very elderly with 24 patients aged 90 years or over. 25 patients were considered to have had excellent care and 65 good or adequate care. Only 3 patients were thought to have had poor care overall but these deaths were not judged to have been more likely than not to be due to a problem in care.

Learning from Review 12 and a deep dive into the Dr Foster data for Q1 2018 are being fed into the following workstreams:

Delivery of palliative care to patients with secondary malignancy
Sepsis
Clinical care/ documentation/ coding interface
Frailty

Screening Capacity

The screening rate has increased from 64% in Q2 to 93% in Q3 2018/19

Compliance with request for completion of Structured Judgement Review Tool was 64% in Q3 2018/19

A process for escalation of non-compliance was agreed in Jan 2019

Positive Feedback continues to be well received

In Q3 feedback was sent to doctors, nurses and other healthcare professionals from all areas of the Trust

The most commonly identified area of excellent care was communication with patients and their families

Introduction of the Medical Examiner Role

Members of the Working Group visited 2 local Trusts that are already running Medical Examiner services to see how the service works in practice to support the introduction at NGH

The Strategy for reducing mortality - learning from the screening and review of deaths was submitted to Procedural Documents Group

Response to Dr Foster data

Trustwide Mortality Case Note Review 12 was carried out during Q3 2018/19 looking at 100 consecutive deaths in May 2018

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	**Director of Nursing, Midwifery & Patient Services Report**
Agenda item	**10**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Natalie Green – Deputy Director of Nursing (Interim)
Purpose	Assurance & Information

Executive Summary

The paper references areas within the Trust scorecard relating to Caring and the nursing related aspects of the Safe domain:

- Patient Experience: The Trust wide results for the Friends and Family Test are 91.7% in February. 55 formal complaints and 3639 compliments were received
- Infection Prevention: 0 MRSA bacteraemia, 0 CDI, 2 MSSA and 1 CRUTI in February.
- Pressure Ulcer Prevention: **11** patients had acquired pressure damage - **7** had Category **2** pressure ulcers, 3 patients developed 3 Deep Tissue Injuries, these are being monitored in line with national guidance to ascertain whether they are to be classified as pressure ulcers. **1** patient developed an unstageable pressure ulcer
- Safety Thermometer: In February the Trust achieved 99.85% 'new harm free care'. Overall harm free care was 95.11% against a national picture of 93.91%.
- Maternity Safety Thermometer in February: the overall percentage of women and babies who received combined physical and psychological 'harm' free care was just below the national level of 78.5 % with the proportion of women receiving harm free care being 77.8.%
- Falls: There were 92 in-patient falls in total, 67 inpatient falls resulted in no harm to the patient, 21 were low harm and 4 were reported as moderate or above.
- Avery and Dickens Therapy Unit (DTU): Avery reported 5 falls in month; 4 low harm and 1 severe. There was no pressure ulcers reported.
  DTU had in total 3 falls; 2 no harm and 1 low harm. DTU reported zero pressure ulcers.
  - Overall fill rate for February was RN 93%, HCA 98% with a combined of 95%. CHPPD for adult wards was RN 4.0 and HCA 3.0 giving a combined CHPPD of 7.0.
- The report contains an update on Midwifery, Safeguarding, End of Life, Infection Prevention, Assessment and Accreditation and Nursing and Midwifery Quality care Indicator Dashboards.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks 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) 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

The Committee 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
March 2019

Nursing & Midwifery Care Report

1.0 Introduction

The Nursing & Midwifery (N&M) Care Report highlights key issues from the Divisions, audits and projects during the month of February. 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.

This report should be considered in conjunction with the report from the Medical Director aiming to provide assurance on the quality and safety of our services and the care provided.

2.0 Trust Scorecard – Summary

The Nursing and Midwifery care report relates to our patients and references the data that is presented in the Trust scorecard under the domains of Caring and those pertinent to Nursing and Midwifery in the Safe domain.

Key Areas

- Patient Experience - Acquired Pressure damage - Safeguarding - Infection rates
- Falls - Outcomes - Nursing & Midwifery Care Indicators - End of Life – Nurse Staffing

2.1 Quality of Care:

2.1.1 Complaints and Compliments

Patient care is at the centre of what we do as an organisation and we are committed to improving their experience. Whilst we receive a significant amount of positive feedback we also receive feedback when things have not gone so well. As a Trust we recognise that complaints and concerns are an opportunity to learn and improve.

February:
55 formal complaints received
100% response rate (compliance)
3639 compliments were received via FFT feedback

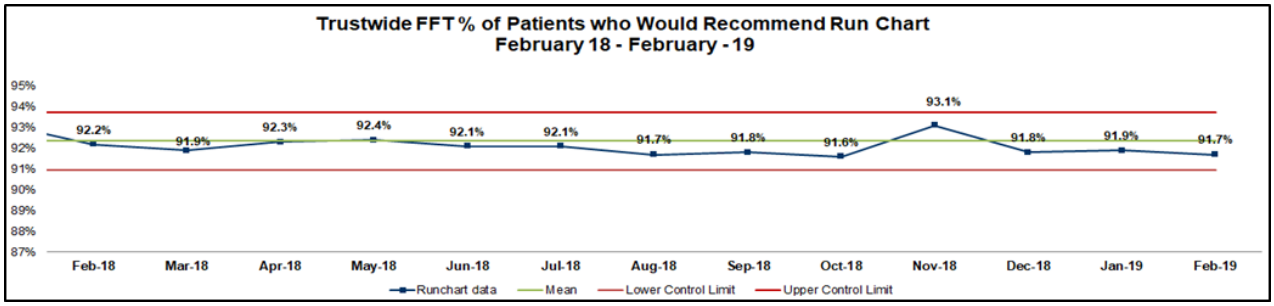
Themes:
The main categories are:

- Care x 18 (5 x medical / 5 x nursing / 8 x Allied Health Professionals)
- Communication x 15 (8 x medical / 2 x nursing / 5 x other)
- Cancellations/Delays x 11 (5 x treatment / 1 x operation / 1 x medication / 1 delay in diagnosis / 1 x scan / 2 x correspondence)

Work is taking place in the Divisions to address these themes at local level.

2.1.2 Friends and Family

The Trust wide recommendation rate is within the Trust's normal variance, it remains below the national average



From the work we have been doing throughout the Trust in December and January an improvement was seen for:

- Inpatient and Day Case recommendation rates in February to 93.5% compared with January at 92.7%
- The national target has dropped slightly from the fixed rate of 95.7% from October to January down to 95.6% in February
- The FFT response rates in Maternity have improved further from 32.7% in January to 35.1% in February overall, with a recommendation rate of 98.2%.

Emergency Department

The Emergency Department's recommendation results have seen a decrease since November, February saw a 5% drop from the previous month to 80.9%, with the national target only changing slightly by 0.2% in February. We can surmise that this is due to the activity and longer wait times, however a plan has been put in place to try to recover.

Improvement Plan:

- Patient Experience met with ED staff to go through patient responses for February and will be actioning all negative feedback going forward.
- Waiting Times - A new initiative is being put in place in the second week of March where waiting times should be reduced for the lower priority patients according to emergency needs.
- Patient experience will be providing extra volunteer support in collecting feedback.

Trust wide Improvement Plan - In order to increase our recommendation rates Trust wide, a number of initiatives have been introduced. These include:

- Screensavers for staff to remind them of FFT
- Reviewing the location of all collection points across the Trust and their visibility
- Higher level of patient engagement involving volunteers and staff from Patient Experience
- Working with Communications Team and IT to incorporate new means of collecting the data
- Staff in all areas making a proactive approach and imbedding FFT into weekly meetings
- Listening events

New - Family & Friends Test Responses Session – This session has been booked for 1st April for staff to attend that provides an overview of:

- FFT and the methods in which we collect data
- The comments portal and how to view and add actions
- Ways to promote FFT and increase response rates
- The new role of 'Staff Champion of Patient Experience'

- Experience of Care Week

These initiatives will be continuously reviewed and adapted accordingly.

2.2 Safe

2.2.1 Infection Prevention and Control

The Trust has an external target of no more than 20 patients with hospital onset *Clostridium difficile* infection (CDI) for 2018/19:

- 0 patient developed a hospital onset CDI in February 2019
- 14 patients have developed CDI to date, no lapses in care have been identified

The Trust has a Zero tolerance approach to patients with MRSA bacteraemia for 2018/19: There have been:

- 0 hospital onset MRSA bacteraemia for February 2019
- 0 hospital onset MRSA bacteraemia year to date

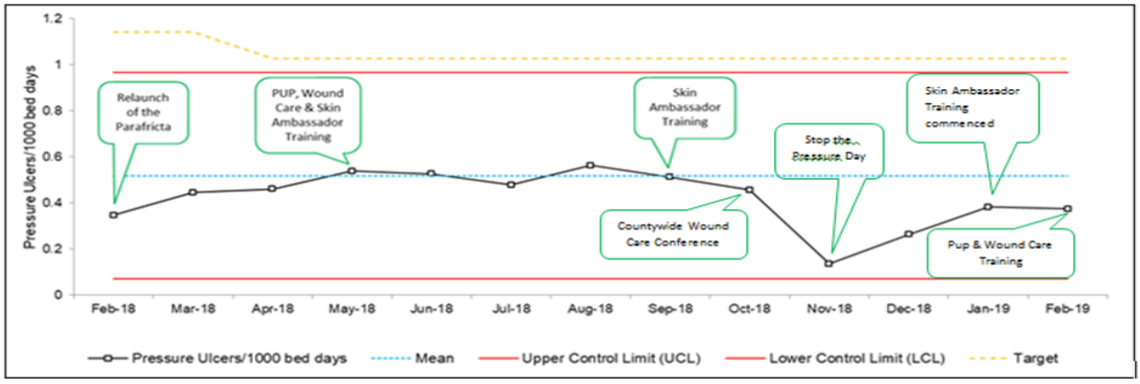
The Trust has an internal stretch target of no more than 13 patients with Trust apportioned MSSA bacteraemia for 2018/19: There have been:

- 2 hospital onset MSSA bacteraemia for February 2019
- 14 hospital onset MSSA year to date

The Incidence data for February 2019, 1 patient developed a hospital onset CRUTI

2.2.2 Pressure Ulcers

In February there were **394** datix reports submitted relating to tissue damage, following validation **34** patients were identified as having acquired Moisture Associated Skin Damage (MASD).
11 patients developed **11** pressure ulcers whilst in our care**. 7** patients developed **c**ategory 2 pressure ulcers**, 3** patients developed 3 Deep Tissue Injuries, and these are being monitored in line with national guidance to ascertain whether they are to be classified as pressure ulcers. **1** patient developed an unstageable pressure ulcer.



In anticipation of the forthcoming NHSi (2018/9) requirement for the Trust to commence reporting all patients within the Trust with pressure ulcers, community acquired pressure ulcers have been incorporated into this report (this includes care homes/patient own homes/other hospitals).

Patients admitted from Own Home/Care Home/Other Hospitals with skin breakdown	Number of Harms
Category 2	53
Category 3/Unstageable	15
Deep Tissue Injuries	20
MASD	57

The Tissue Viability Team is focusing their attention on the following areas:

- Implementing the new guidelines from NHSI which requires updating our documentation, the policy and changing the timeframe for acquired from 72 hours post admission to time of admission (this is being debated nationally)

- Improving accessibility of 'near time' out of hour's photographic recording of skin breakdown, this is currently being piloted on the Walter Tull assessment unit and will be evaluated after a month's trial. Two more cameras have been ordered for use on the assessment units.

- Pressure ulcer prevention and wound care training the team are undertaking a collaborative approach with IPC focusing on Wound care.

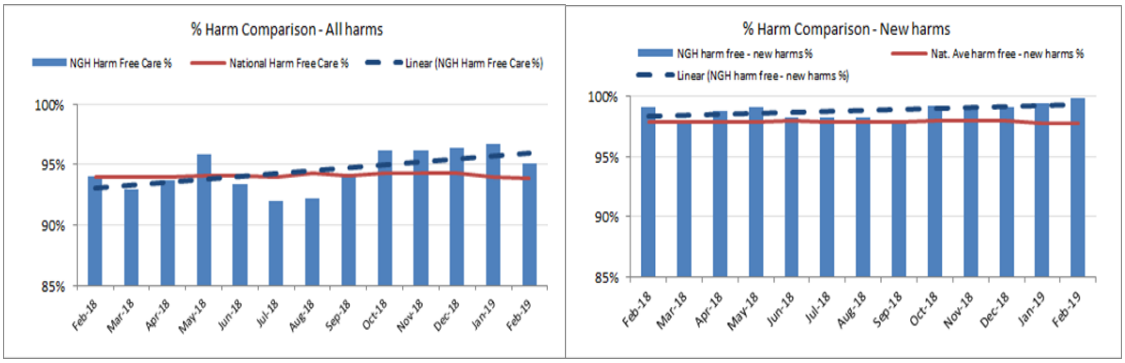
- The Team have developed a draft pressure ulcer prevention work book for all nursing staff and also currently creating a new staff intra net page.

- Working collaboratively with Kettering hospital and NHFT to bring together the 2nd Countywide Tissue Viability Conference in November 2019.

2.2.3 Harm Free Care (NHS Safety Thermometer)

The NHS Safety Thermometer is a monthly point prevalence audit. In February 99.85% of in-patients did not incur any new harm whilst in our care, which is above the national average comparison figures, the category of new harms are highlighted in the table below.

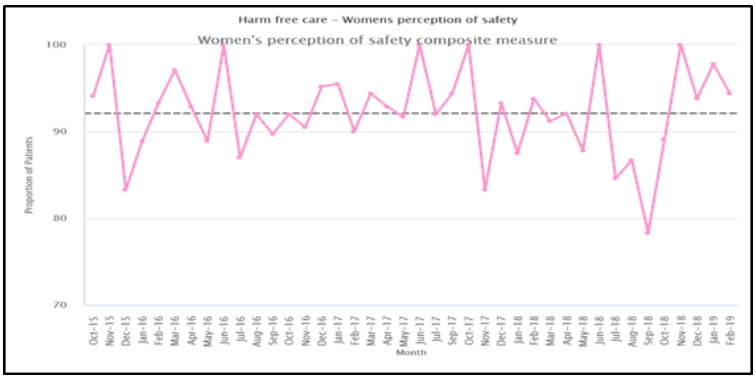
Overall harm free care was 95.11% which was also above the month's national average of 93.91%. (Appendix 1 provides the National Safety Thermometer Definition)



Maternity NHS Safety Thermometer

The maternity safety thermometer suggest that the overall combined harm free care was just below the national level of 78.5 % with the proportion of women receiving harm free care being 77.8.% as demonstrated in the graphs below.

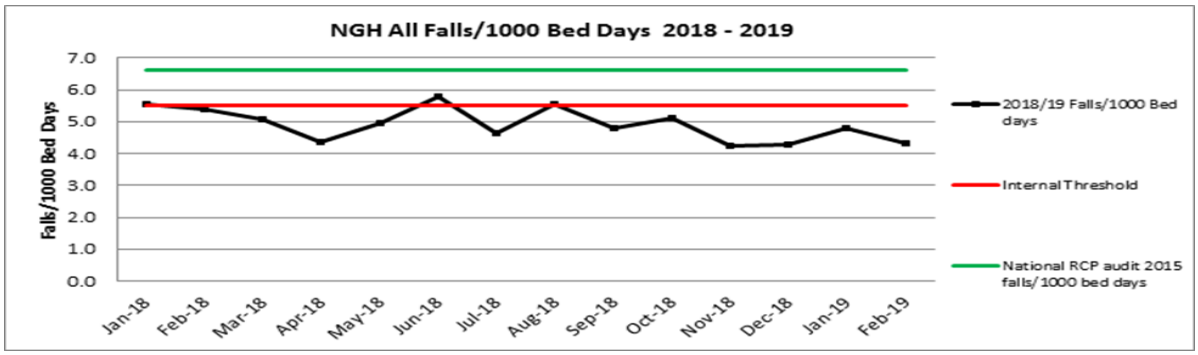
The percentage of women who received harm free physical care was 83.3% compared to 82.5% nationally. Out of the women surveyed for the February's Safety Thermometer none had 3rd/4th degree perineal trauma, however 15 women had a PPH of more than 1500mls and 4 babies had an Apgar of less than 7 at 5 minutes. The PPH quality improvement work and care bundle continues to be implemented and PPHs > 1500mls for February will be explored for any themes. All babies with low Apgar's at term are reviewed and all term babies admitted to Gossett ward have their care reviewed by both Obstetrics and Neonatology as part of the ATTAIN programme to reduce term admissions to special care.



Nationally the proportion of women who reported they were left alone at a time that worried them was 1.8% compared to 2.8% of the women surveyed locally. The proportion of women in the service who felt that their concerns about safety during labour and birth were not taken seriously was 2.8%, compared to a national figure of 3.8%.

2.4 Falls

There were 92 inpatient falls in total, 67 inpatient falls resulted in no harm to the patient. The rate per 1000 bed days is 4.30. In total there were 21 low harm falls and there were 4 moderate or severe patient incidents recorded.
All 4 incidents remain under investigation any learning will be shared with the teams and through the falls steering group.



3.0 Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards, Appendix 3, 4 and 5 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.

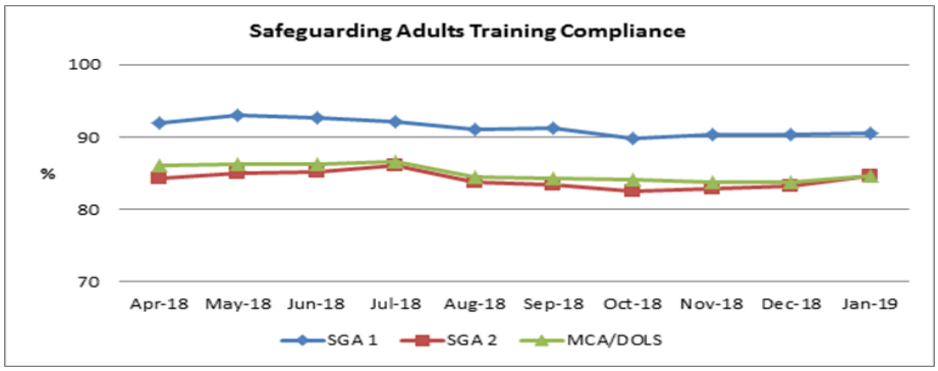
- In February there were 15 red domains, 49 amber the remaining are all green (281) in the Quality Care Indicator section

- The predominant red themes fall within the domains of Incomplete Documentation, Protected Mealtimes several assessments and rounds were continuing during the lunch period and the Environment areas had a general feel of being cluttered and general lack of tidiness.
- Victoria has 4 red domains, in the last month a change of leadership has been put in place which is expected to result in improvement
- This month has seen an improvement in the first impression standard with only 3 wards flagging as red
- In all instances the action planning from the dashboard is coordinated by the respective ADNS supported by the respective Matron and Ward Sister and discussed in the appropriate directorate Nursing/Midwifery forums

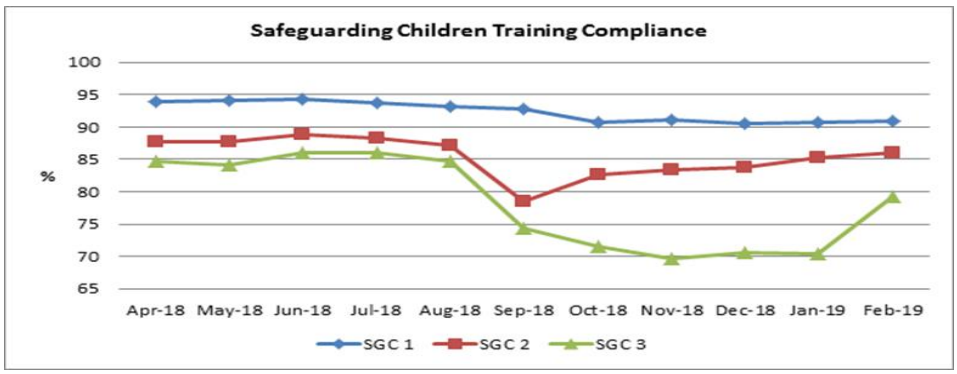
4.0 Safeguarding

4.1 Safeguarding Training Compliance

The training compliance rate of 85% is set as part of the quality schedule set by the Clinical Commissioning Group (CCG) for all safeguarding training. The graph below illustrates the compliance for Safeguarding Adults at the end of February:



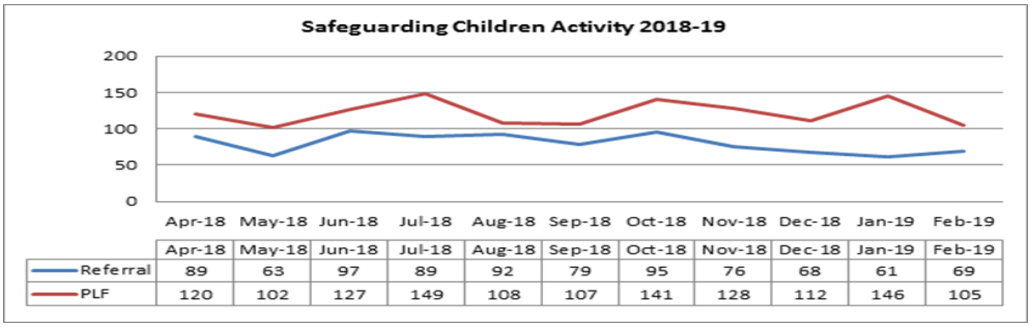
The graph below highlights the safeguarding children's training figures at the end of February.



Level 3 safeguarding children training compliance figures have increased from 69% to 79% following extensive remedial action by the safeguarding team. Weekly bespoke training sessions will be continued until compliance is at an acceptable continuum.

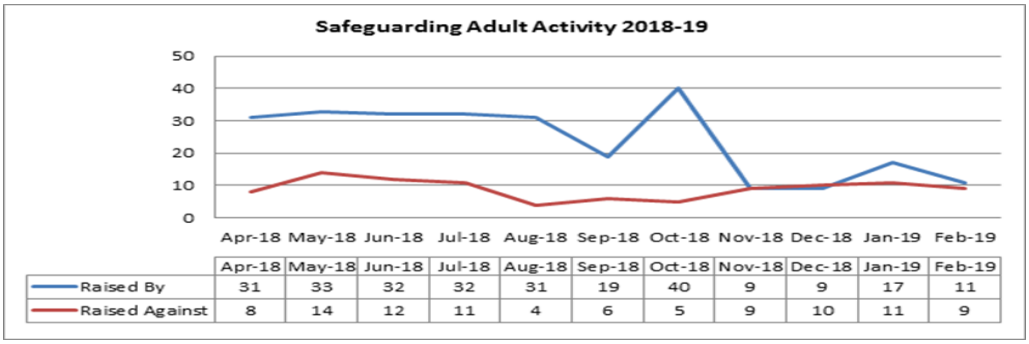
4.2 Safeguarding Children and Adult Referrals

The following charts demonstrate 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.



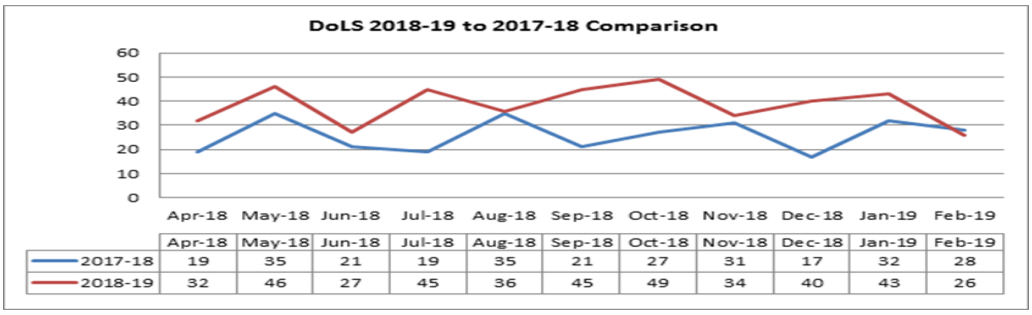
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Referral	89	63	97	89	92	79	95	76	68	61	69
PLF	120	102	127	149	108	107	141	128	112	146	105

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



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Raised By	31	33	32	32	31	19	40	9	9	17	11
Raised Against	8	14	12	11	4	6	5	9	10	11	9

The concerns with regards to the Local Authority continue, the Safeguarding team ensure that the CCG are aware of any discrepancies or potential omissions that they are made aware of.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
2017-18	19	35	21	19	35	21	27	31	17	32	28
2018-19	32	46	27	45	36	45	49	34	40	43	26

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have decreased during the reporting period. This provides assurance for the Trust that staff are considering restrictions that could infringe on patient's human rights.

4.3 Safeguarding Assurance Activity

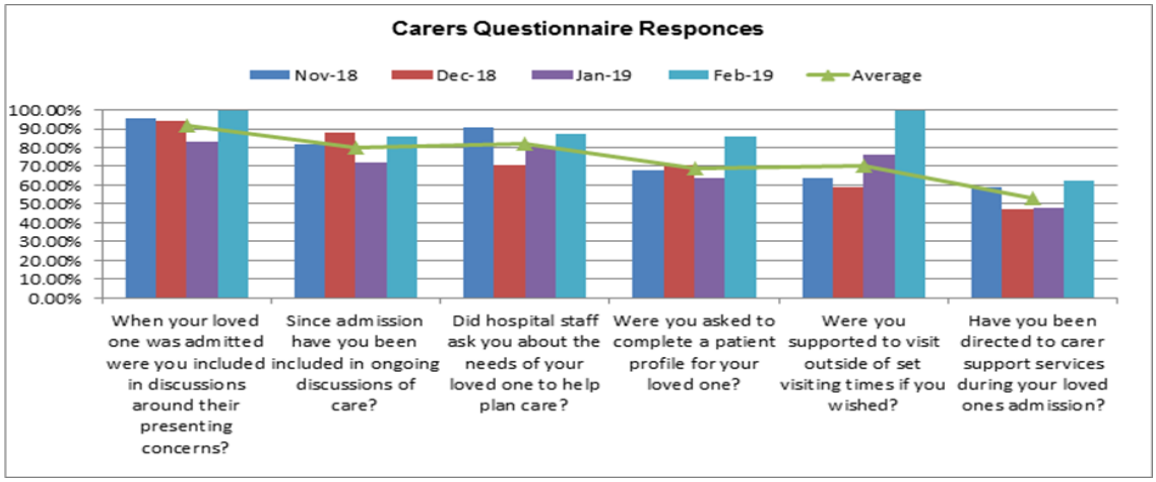
There are three children's Serious Case Reviews (SCR's) and two Safeguarding Adult Reviews (SAR's) in progress. All individuals (apart from one child) had contact with the Trust.

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.

4.4 Dementia Activity

Carer Feedback

The Dementia Liaison Nurse (DLN) receives monthly feedback from carers regarding the experience of their loved ones care.

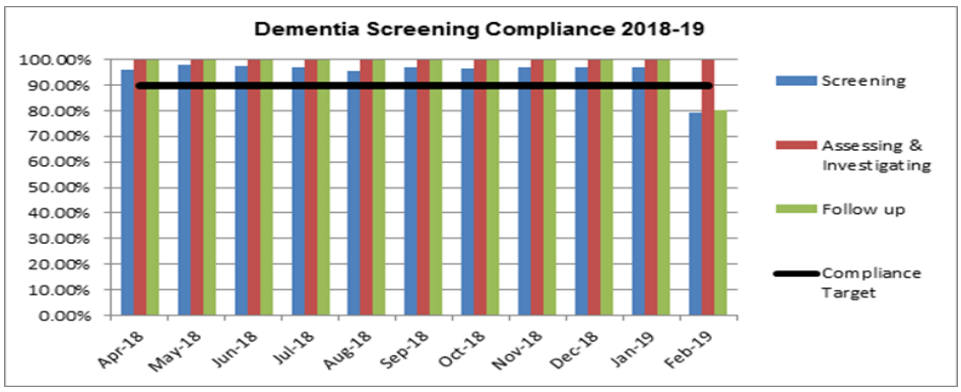


February has seen all question responses exceed the overall average response rate indicating a general improvement in all areas. This includes 100% of carers being involved in discussions at the point of admission as well as being aware of flexible visiting for dementia patients and an improvement in the number of carers being asked to complete the patient profile.

Following discussion with Northampton Carers changes have now been made to the dementia public internet site and staff intranet pages to include their details. Joint working will continue to occur to help ensure staff and visitors are aware of the service available

Dementia Screening Data

February data has shown the Trust to be non-compliant with the dementia screening and follow up for the first time as demonstrated below:



The reason for the decrease has been identified as a change from moving from hard copy clinical forms to an electronic basis from the Emergency Department to the Urgent Care Unit. This has taken away the prompt for medics to complete the dementia screening section previously identified within the non-elective admission proforma; this has been communicated to the Clinical Director of Urgent Care and the Medical Director.

5. Maternity Update

5.1 Maternity Transformation Programme Update

The provision of personalised individualised care for women, with the aim to have 'continuity of carer' throughout pregnancy and labour is a major component of the Maternity Transformation Programme, which seeks to achieve the vision set out in Better Births. The National Continuity of Carer targets are:

- 20% of women booked onto a Continuity of Carer model by April 2019
- 31% of women booked onto a Continuity of Carer model by 2020
- 51% of women booked onto a Continuity of Carer model by 2021

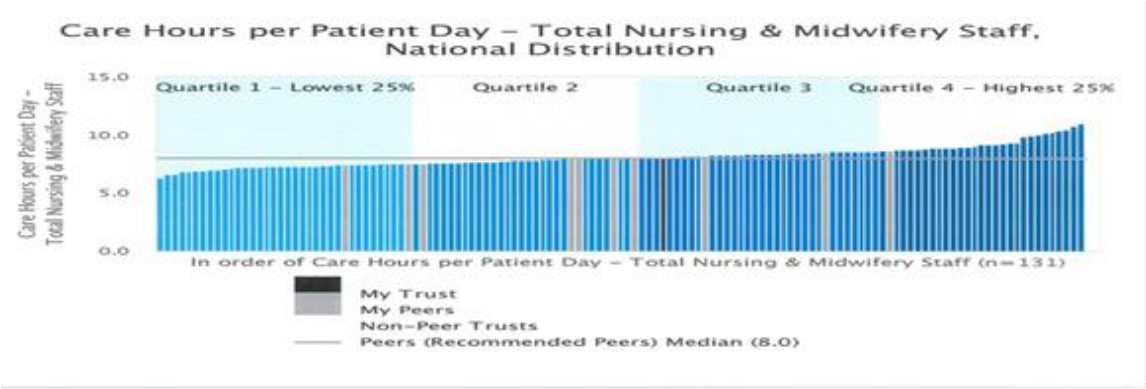
These changes will present a challenge for the maternity services, the largest being in attempting to implement a case loading team from escalation with the current felt vacancy rate of 20.83wte. It is not suggested good practice from what has been learnt from the Maternity Transformation Programme's early adopters and pioneers sites to implement a case loading team without full protection from escalation. Therefore until the felt vacancies are reduced and the Midwife to Birth ratio is 1:29 it will not be possible to release or protect the team from escalation, without it having a potential detrimental effect on other pathways of care. Other issues such as amendments to contract and on call payment agreements are being explored with HR. Currently there is no requirement to either have or monitor compliance across the whole pathway therefore we do not have a benchmark to go on, National work is continuing on how this data is going to be captured.

6.0 Safe Staffing

Overall fill rate for February was 95% the same as in January. Combined fill rate during the day was 92%, compared with 91% in January. The combined night fill rate was 100% compared with 101% in January. RN fill rate during the day was 91% and for the night 96%.

	Day	Night	Overall
RN	91%	96%	94%
HCA	92%	108%	99%
Overall	92%	100%	95%

Across the general adult wards Care Hours per Patient Day for the month of February was registered practitioner 4.0 and HCA 2.9 (which is the same for RN and a decrease in HCA from January); Trust wide inclusive of midwifery, paediatrics and critical care (which by nature are a higher care hours level) RN/M was 8.8 and HCA 3.2 (which is a decrease of 0.5 for HCA and a decrease of 0.2 for RN/M from January).
The two wards at Avery and the ward at Dickens Therapy Unit both reported 0 shifts unfilled during February and no staffing related harm to patients.

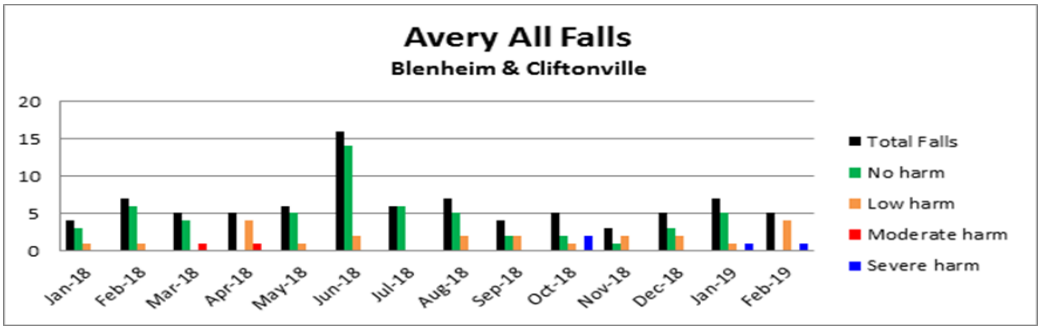


Of the 87 staffing Datix that were submitted and reviewed by the Associate Directors of Nursing & Midwifery 3 constituted a red flag, these have been reviewed by the Matron and Associate Director of Nursing for the Division involved. Delays occurred in all 3 cases with the timely provision of care, no actual harm occurred and duties were prioritised appropriately.

7.0 Avery and Dickens Therapy Unit

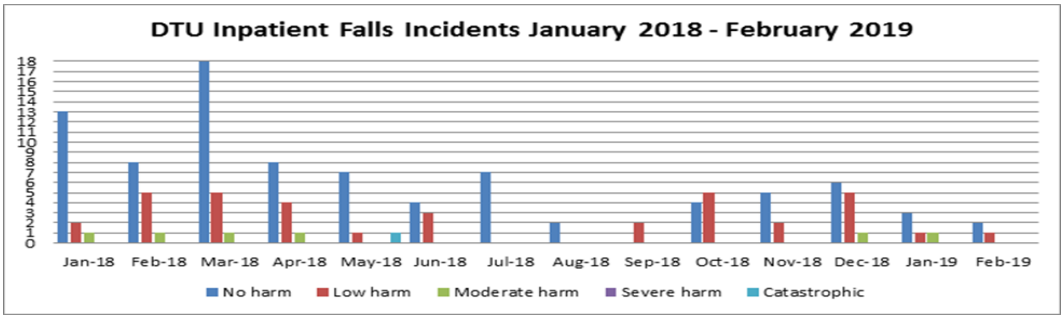
7.1 Avery

In February there were 5 inpatient falls, 4 low harm patient falls and 1 severe harm patient fall



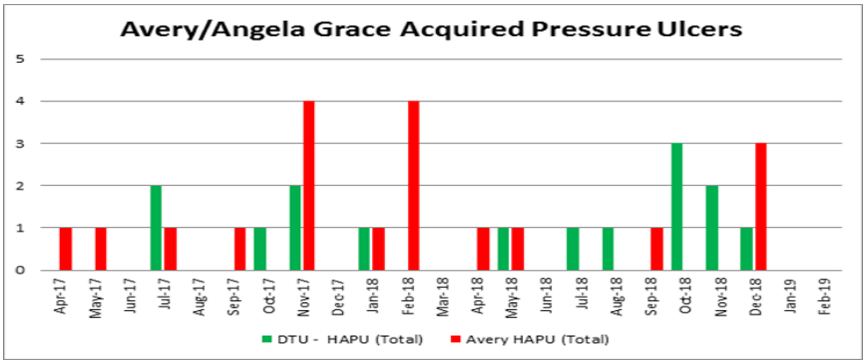
7.2 Dickens Therapy Unit

The below graph demonstrates the total number of falls incidents recorded at DTU and the harm that the patient sustained. There were 2 no harm patient falls and 1 low harm patient fall.



Avery/Angela Grace PU Incidence

The run chart below represents the number of pressure ulcer harms reported in 2017- 2019 to patients in Avery and Dickens Therapy Unit. The TVT continue to report and investigate these harms as per Trust protocol. There were no reported pressure ulcers at either establishment in February.



8.0 Assessment and Accreditation

During February two wards were assessed. One ward achieved a green rating and one ward achieved a red rating. The current status of all adult in-patient wards including Critical Care was, three blue wards, eleven green wards, eight amber wards and two red wards. Of the eleven green wards, four are awaiting panel to support blue ward status. The current status of outpatient departments is - three green departments and one amber department. Through the assessment process standard 5 (infection prevention) has been highlighted previously. Work is ongoing supported by the Practice Development Team and the Infection Prevention Team to improve care within this standard; further improvements have been noted in February.

9.0 End of Life

The Trust currently has an End of Life Strategy Group, End of Life Operational Group and a Link Nurses group – a review is taking place of all groups in terms of reference, purpose, duplication and requirements. Whilst this is under review projects and actions continue:

- Red Blankets: The team have sourced red blankets for use in catastrophic haemorrhage and are looking at funding for supplying each ward with a crisis box.
- EOL Operational Meeting: The last meeting was postponed due to the number of apologies and poor attendance. The team will be promoting attendance and possibly combining this with EOL link nurses in future. The team have recently met with the Shared Decision Making Facilitator with an aim of working with any of the Shared Decision Making Councils who wish to look at end of life initiatives.
- National Care of the Dying Audit: 2018 Round 1 outcomes have recently been released and will be discussed at the EOL strategy meeting, ratings in many areas were above national average; however there is work needed in relation to communication with and assessing the needs of families and carers.
- Tissue Donation: Work is ongoing with the pilot wards regarding the referral process, training of the staff and engagement. The team have asked the Quality Improvement Team to support tissue donation in the trust going forward looking at engagement and roll out.
- EOL Volunteers: Four new volunteers are due to undergo training. Further promotion of the service will take place once new volunteers in place.
- Monitoring of the action plan put in place to improve patient experience as reported in the 2018 survey

10.0 Recommendation

The 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 94.25%.

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.
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.
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. 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 (by asking women questions on women's perception of feelings around safety in labour. 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.

The Maternity Safety Thermometer enables a point prevalent calculation of the proportion of women and babies who received harm free care 'in month'. 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: perceptions of safety
- Mothers left alone at a time that worried them
- Concerns about safety during Labour and Birth not taken seriously

Appendix 2

Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

Appendix 3

Feb-2019	Medicine														WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Brampton	Collingtree	Compton	Dryden	Quinton	Eleanor	Esther White	Finedon	Holcot	Knightley	Victoria	Walter Tull	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp
Falls/Safety Assessment	86.%	90.%	100.%	93.%	83.%	93.%	85.%	100.%	100.%	100.%	96.%	90.%	67.%	100.%	93.%	100.%	100.%	100.%	83.%	100.%	80.%	93.%	97.%
Pressure Prevention Assessment	100.%	100.%	95.%	97.%	62.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	94.%	94.%	100.%	97.%	80.%	100.%	97.%	97.%	100.%
Nutritional Assessment	100.%	96.%	94.%	97.%	94.%	100.%	100.%	94.%	100.%	100.%	90.%	80.%	90.%	100.%	93.%	100.%	100.%	97.%	100.%	97.%	100.%	97.%	100.%
Patient Observation and Escalations	95.%	100.%	77.%	95.%	69.%	100.%	100.%	95.%	95.%	95.%	100.%	80.%	94.%	95.%	90.%	95.%	100.%	100.%	100.%	95.%	100.%	100.%	100.%
Pain Management	93.%	100.%	100.%	93.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	87.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	100.%	100.%	97.%	96.%	81.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	83.%	98.%	88.%	100.%	100.%	97.%	90.%	100.%	100.%	98.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	67.%	88.%	100.%	100.%	83.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	82.%	80.%	82.%	67.%	73.%
Patient Experience - Environment	100.%	80.%	100.%	100.%	100.%	100.%	75.%	88.%	100.%	100.%	100.%	100.%	60.%	80.%	80.%	100.%	80.%	80.%	80.%	100.%	100.%	100.%	100.%
Patient Experience - Privacy and Dignity	94.%	94.%	59.%	91.%	88.%	91.%	97.%	93.%	95.%	95.%	97.%	83.%	100.%	94.%	95.%	99.%	100.%	98.%	98.%	95.%	93.%	91.%	98.%
Patient Safety and Quality	80.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	87.%	92.%	100.%	100.%	100.%	100.%	90.%	95.%	100.%	100.%	100.%	100.%
Leadership & Staffing observations	93.%	96.%	91.%	95.%	100.%	92.%	93.%	93.%	88.%	100.%	77.%	83.%	65.%	100.%	98.%	100.%	100.%	100.%	96.%	94.%	92.%	92.%	100.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	100.%	94.%	100.%	69.%	83.%	89.%	80.%	86.%	86.%	91.%	80.%	83.%	66.%	97.%	83.%	91.%	83.%	80.%	80.%	86.%	77.%	80.%	100.%
Safety Thermometer – Percentage of Harm Free Care	100%	92%	100%	88%	94%	100%	90%	100%	97%	94%	86%	89%	94%	94%	100%	100%	100%	100%	90%	93%	100%	86%	100%
Pressure Ulcers – Category 2 incidence hosp acquired, (Previous Month)		1			1	1												1				1	
Pressure Ulcers – Category 3 incidence hosp acquired, (Previous Month)																							
Pressure Ulcers – Category 4 incidence hosp acquired, (Previous Month)																							
Pressure Ulcers -sDTI's incidence hosp acquired			1	1					1														
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caring																							
Complaints – Nursing and Midwifery	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0
Number of PALS concerns relating to nursing care on the wards	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	1	0	0
Friends Family Test % Recommended	100.0%	91.7%	90.9%	95.1%	33.3%	86.8%	80.0%	100.0%	90.1%	100.0%	100.0%	89.5%	83.3%	91.6%	82.8%	94.1%	90.0%	96.0%	92.9%	95.0%	100.0%	100.0%	95.7%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	94%	93%	92%	97%	93%	91%	100%	92%	93%	91%	94%	124%	91%	84%	99%	100%	99%	100%	93%	104%	97%	93%	97%
Staff Nurse Staffing - Support Worker (day & night combined)	102%	101%	90%	97%	90%	91%	123%	106%	95%	104%	98%	158%	107%	112%	93%	95%	107%	115%	114%	117%	107%	94%	89%
Staffing related datix	1	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	0

Appendix 4

Feb 19	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	92%	93%	88%
Pressure Prevention Assessment (Q)	66%	58%	92%
Child Observations [documentation] (Q)	100%	100%	97%
Safeguarding [documentation] (Q)	87%	94%	100%
Nutrition Assessment [documentation] (Q)	93%	100%	100%
Medication Assessment (Q)	100%	100%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Safety Thermometer – Percentage of Harm Free Care	100%	100%	100.00%
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Experience			
Friends Family Test % Recommended	95%	94%	100%
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	1	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Safety & Quality Environment Observations Observe patient records (Q)	100%	84%	100%
Privacy and Dignity (Q)	97%	96%	87%
Management			
Staffing related datix	0	2	0
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	95%	100%	92%

Appendix 5

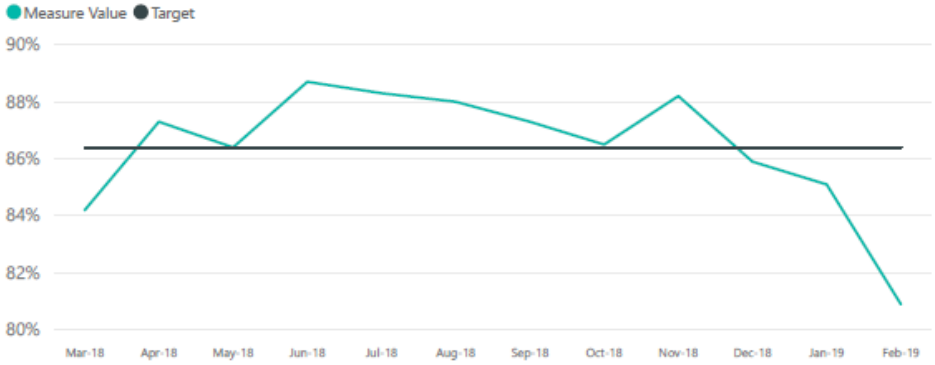
Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	93%	87%	100%	Nil
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	88%	100%	100%	100%
Medication Assessment (Q)	100%	100%	100%	92%
Environment Observations (Q)	100%	100%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	97%	97%	97%	100%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	83%	90%	97%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	100%	100%
Patient Experience (Q)	86%	83%	83%	98%
Patient Safety and Quality (Q)	93%	94%	96%	100%
Leadership & Staffing (Q)	100%	93%	100%	100%
Management				
Staffing related datix				
Monthly Ward meetings (Q)	100%	100%	100%	Nil
Saftey and Quality (Q)	92%	100%	100%	100%
Leadership & Staffing (Q)	100%	93%	100%	Nil

Friends & Family Test % of patients who would recommend: A&E

February 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
86.4%	80.9%	↓	Sheran Oke

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
84.2%	87.3%	86.4%	88.7%	88.3%	88.0%	87.3%	86.5%	88.2%	85.9%	85.1%	80.9%

What is driving underperformance?

- The results for A&E are 5.5% below the national average when comparing February with the most recent national data available (December).

Actions completed in the past month to achieve recovery

- A&E - Patient Experience met with ED staff to go through patient responses for February and will be actioning all negative feedback going forward. Waiting Times - A new initiative is being put in place in the second week of March where waiting times should be reduced for the lower priority patients according to emergency needs. Patient experience will be providing extra volunteer support in collecting feedback.

Exception report written by

Emma Wimpress / Sheran Oke

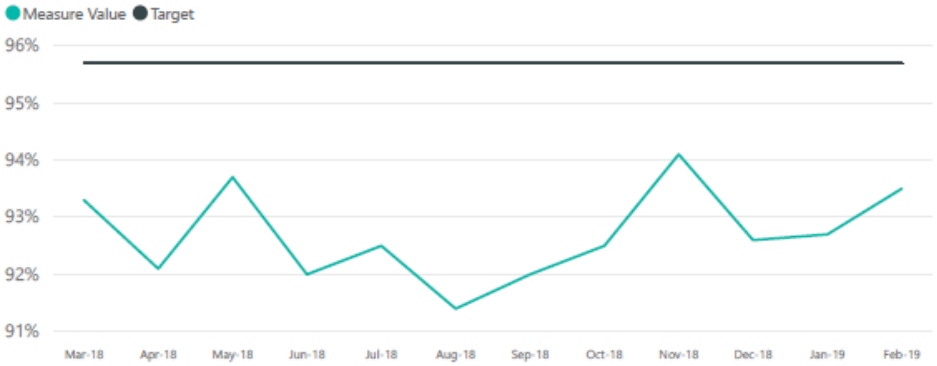
Timeframe for recovery

Next steps

Friends & Family Test % of patients who would recommend: Inpatient/Daycase

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	95.7%	93.5%	↑	Sheran Oke

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
93.3%	92.1%	93.7%	92.0%	92.5%	91.4%	92.0%	92.5%	94.1%	92.6%	92.7%	93.5%

What is driving underperformance?

- The result for Inpatient & Day Case continues to be stable with only small movements each month. The Inpatient & Day Case result is 2.1% below the national average for February which is a slight improvement from 3.0% in January.

Actions completed in the past month to achieve recovery

- The Right Time mini survey is continuing which enable the wards to identify specific areas where further improvements need to be made. Further analysis of the areas receiving low results is underway.

Exception report written by

Emma Wimpress / Sheran Oke

Timeframe for recovery

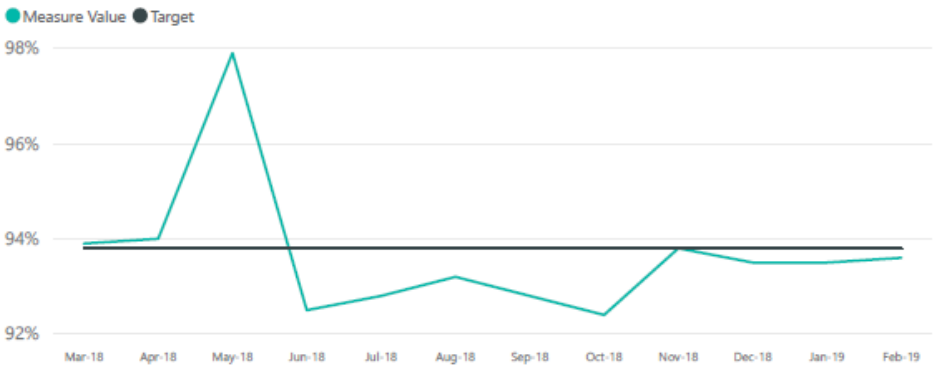
Next steps

Friends & Family Test % of patients who would recommend: Outpatients

February 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.8%	93.6%	↑	Sheran Oke

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
93.9%	94.0%	97.9%	92.5%	92.8%	93.2%	92.8%	92.4%	93.8%	93.5%	93.5%	93.6%

What is driving underperformance?

- The result for Outpatients in February remains the same as January at 0.4% below the national average.

Actions completed in the past month to achieve recovery

- The Patient Experience Department will continue to work on increasing recommendation rates as per the narrative in bullet points 1.

Exception report written by

Emma Wimpress / Sheran Oke

Timeframe for recovery

Next steps

Mixed Sex Accommodation

February 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	2	↑	Sheran Oke

Performance vs Target

Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
252	0	0	0	0	3	0	0	0	0	4	2

What is driving underperformance?

- Limited bed capacity across the organization
- Patient needing to step down from ITU and no suitable bed available
- 1 patient affected 27.2.19
- 1 patient affected 14.2.19

Actions completed in the past month to achieve recovery

- Root cause analysis completed by ITU matron for both patients
- Situation discussed with patients and apologies given
- Process reviewed in ITU to improve escalation of patients who may potentially breach.

Exception report written by

Timeframe for recovery

Next steps

Northampton General Hospital NHS Trust

Report To	**BOARD OF DIRECTORS**
Date of Meeting	**28 March 2019**

Title of the Report	**Bi-Annual Review of Nurse Staffing**
Agenda item	**11**
Presenter of the Report	Sheran Oke, Director of Nursing, Midwifery and Patient Service
Author(s) of Report	Sheran Oke, Director of Nursing, Midwifery and Patient Services Natalie Green, Interim Deputy Director of Nursing
Purpose	Approval

Executive summary

The purpose of this paper is to provide assurance on nurse staffing levels and staffing capacity to provide safe, high quality care across all wards and departments at Northampton General Hospital.

A separate paper providing an update on the Midwifery Staffing will be produced in light of the transformational changes being recommended national. The report will be prepared for April's Board meeting.

Related strategic aim and corporate objective	To be able to provide safe quality care to all our patients
Risk and assurance	The report aims to identify the current staffing position and assurance with regard to the progress and action taken to date.
Related Board Assurance Framework entries	BAF – 1.5 / 4.1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take collective responsibility for nursing, midwifery and care staffing capacity and capability.

Actions required by the Committee/Board

The Board is asked approve the paper.

Northampton General Hospital NHS Trust

Board of Directors
March 2019

Bi Annual Review of Nursing Staffing

1. Executive Summary

This paper will:

- Provide an update on nursing establishments; including ratios, skill mix, acuity and dependency measures, establishment uplift and compliance with National requirements
- Describe the Trust's compliance with NQB and Lord Carter guidance in relation to nurse staffing
- Present how the Trust's Care Hours per Patient Day (CHPPD) compares nationally, utilising Model Hospital
- Demonstrate compliance with the NHSImprovement October 2018 paper 'Developing Workforce Safeguards'
- Not provide an update on Midwifery Staffing as this will be presented as a separate paper to the Board in April.

2. Background

In 2013 The National Quality Board (NQB) issued guidance relating to the optimisation of staffing capacity and capability for Registered Nurses and Nursing Assistants. The Care Quality Commission and NHS England have subsequently produced additional guidance on the delivery of publishing staffing data as part of a 'Hard Truths Commitments' paper (March 2014)

In addition, the Department of Health and NHS England commissioned the National Institute of Health and Care Excellence (NICE) to develop evidence-based guidelines on safe staffing, with a particular focus on nurse staffing. The guidance was published in July 2014 and makes recommendations for safe staffing for nursing in adult inpatient wards in acute hospitals.

It was clear from these papers that Trust Boards are expected to take full responsibility for the quality of care provided to patients and, as a key determinant of quality; take full responsibility for nurse/midwife staffing capacity and capability.

In July 2016 the National Quality Board (NQB) published guidance that led on from the Carter report promoting an improvement in workforce efficiency that is beneficial for patient care. The NQB report focuses on 'right care, doing the right thing, first time; Minimising avoidable harm, a relentless focus on quality; and maximising the value of available resources, providing high quality care to everyone who uses healthcare'. The NQB framework provides guidance on delivering the right staff, with the right skill, in the right place at the right time. October 2018 NHS Improvement published 'Developing workforce safeguards' this document sets out to assist Trusts manage common workforce problems, makes recommendations and identifies best practice in the NHS.

National guidance states Trust Boards are required to:

- Manage nurse staffing capacity and capability by agreeing staffing establishments
- Ensure that three components are used when assessing annual staffing requirements – evidence-based tools, professional judgement and outcomes
- Consider the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitor staffing (nurse) capacity and capability through regular and frequent reports on the actual staff on duty versus planned staffing levels
- Examine trends in the context of key quality and outcome measures

- Ask about the recruitment, training, skills and experience, and management of nurses, and give to the Director of Nursing & Director of Organisational Development to oversee and report on this at Trust Board level

The Trust is compliant with the standards set out in the National documents up until the latest 'Developing workforce Safeguards' 2018. The additions in this document state that the Trust must:

- Include specific workforce statements in their annual governance statement confirming that the processes used are safe and sustainable
- The Medical Director and Director of Nursing must confirm in a statement to the Board they are satisfied with the outcome of the annual staffing assessment
- Assessment of the Trusts triangulation will be collected through the Single Oversight framework

3. Key Issues

National Quality Board (NQB) Guidance

The National Quality Board (NQB) publication Supporting NHS Providers to deliver the right staff, with the right skills, in the right place, at the right time: Safe, sustainable and productive staffing (2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

In January 2018 the NQB published a suite of resource documents focusing on safe, sustainable and productive staffing, one each for:

- Adult In-patients
- Urgent and Emergency care
- Maternity
- Learning Disability
- Mental Health
- District Nurse

Each document provides an improvement resource for each speciality. From this list of resource packs the 'adult-in patient' 'urgent care' staffing and the' Maternity' staffing are relevant to the Trust.
These documents focus specifically on nurse staffing on adult inpatient wards in acute hospitals and are aligned with Commitment 9 of *Leading changing, adding value*: "We will have the right staff in the right places and at the right time" (NHS England 2016).
The resource pack outlines a systematic approach for identifying the organisational, managerial and wards factors that support safe staffing. It makes recommendations for monitoring and taking action if not enough staff is available on the ward to meet patients' needs.

4. Northampton General Hospital (NGH) current nursing establishments

NICE guidance (2014) states that Trust Boards must agree nurse & midwifery staffing establishments and consider Registered Nurse: patient ratios, skill mix and allowances for planned and unplanned leave. A summary of NGH current nursing ratios and skill mix is included in appendix 1. The national guidance is for general wards to be at a minimum ratio of 1 registered nurse to 8 patients during the day shift, other areas have recommendations that are made in line with the acuity and/or dependency of the patient's i.e. Critical Care, Urgent Care and Care of the Elderly.

Those shifts that are below the 1:8 (i.e. more than 8 patients to one registered nurse) are highlighted in the aforementioned appendix. The rationale for this decision is described in the 'comments' column. There is no guidance to nurse:patient ratio during the night shift therefore if the staffing is below 1:8 this is due to reduced activity or increased dependency of patients who require a greater proportion of non-registered workforce. These levels of staffing have

been agreed by the Director of Nursing & Midwifery and Senior Nursing Team and are based on professional judgement.

In line with Developing Workforce Safeguards (2018) an annual establishment review must be undertaken, the Associate Directors of Nursing (ADN) have undertaken a detailed analysis of nurse staffing for all areas within their Division, the methodology that has been utilised is:

- National guidance for that specialty (if available)
- Analysis of a 2-month period from the SafeCare module in E-roster (see explanation in section 7)
- Quality outcome measures over the previous 6 months and any staffing red flags for the area
- Service changes
- Benchmarking via Model Hospital
- Professional judgement – Band 7, Matron, ADN and finally with Director of Nursing (Report Template appendix 2)

5. Safe Nurse Staffing

Following the publication of the NICE guidance in 2014 (Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals) the Trust has submitted the required data regarding the planned staffing against the actual staffing within a clinical area. This data is drawn from our E-roster system. This data set is known as 'Safe Staffing' and is collated monthly by the Trust and submitted to NHS England. The Safe Staffing data is presented as part of the Director of Nursing, Midwifery & Patient Nursing Services Workforce report at the Workforce Committee on a monthly basis. Links to this data is also included in the Open and Honest report that is available on the Trusts external website. The Trust consistently maintains the overall fill rate above 80% throughout the year.

Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts (NHS Improvement, June, 2018):

This publication by NHS Improvement stated that from September 2018 monthly CHPPD data will be published at a trust and ward level on 'My NHS & NHS Choices'. The publication of this data is in line with leading Change, Adding value (NHS England 2016) to 'have the right staff in the right places and at the right time' to achieve the triple aim of better outcomes, better patient and staff experiences plus better use of resources. The Trust is compliant with this data submission monthly.

National guidance is awaited for the separation between registered, unregistered and the newer role of Nurse Associates with the CHPPD dataset – currently the reporting combines all levels of nurse as one.

In the last year in accordance with national guidance the Trust has commenced and submitted its data of Care Hours per Patient Day (CHPPD), Appendix 3, 3.a and 3.b demonstrates our compliance with guidance, an explanation of CHPPD and a copy of January's submission. Performance has been reported to the Workforce Committee on a monthly basis and to the Trust Board bi-monthly.

6. Allowances for planned and unplanned leave

Key to establishing safe staffing levels is a comprehensive understanding of all ward/departments establishments and allowances for planned and unplanned leave. The current position with regard to establishment uplift is as follows:

- There is an overall 22.5% uplift. This is added to the budget of every ward/department covering the base establishment and including cover for annual, sick and study leave
- Of this, 15 % is allocated for Annual Leave, 7.5% is allocated for sickness and study leave.

Currently the uplift does not allow for maternity/paternity leave which can cause problems within areas that are predominantly made up of staff of child bearing age. The areas are able to apply for top up funds through their ADN and finance manager to cover a proportion of the backfill requirements.

7. Use of an evidence-based tool - SafeCare

For the generic wards the Trust has previously used a decision support toolkit endorsed by NICE to facilitate a systematic approach to determining nurse staff requirements based on the acuity and dependency of patients (Safer Nursing Care Tool – SNCT).

The Trust implemented 'SafeCare' in 2018 which is an electronic modular system that links directly with our E-roster system. SafeCare allows Senior Nurses to make evidence-based decisions on staffing, using real time information, allowing them to see whether wards and departments are staffed safely according to demand from patient numbers, patient acuity and dependency and care hours per patient day (CHPPD).

This will allow the Trust not only to fully ensure that it has the right staff with the right skills in the right place at the right time, but to clearly demonstrate that it is meeting the key criteria set out in the NQB expectations; using evidence-based tools to inform decisions on setting appropriate establishments as well as daily staffing levels on a shift by shift basis.

8. Establishment Review Programme 2019/20

As described in section 4 an annual establishment review takes place to support the alignment of establishment reviews with the annual budget setting process. A Standard Operating Procedure for Nursing & Midwifery is in place approved by the Workforce Committee and Finance & Performance Committee. The national references that were used by the ADNs include:

- Safe Staffing for nursing in adult inpatient wards in acute hospitals. NICE (2014)
- The Safer Nursing Care Tool. The Shelford Group (2014)
- Safer Staffing: A Guide to Care Contact Time. (NHS England 2015)
- RCN Policy Guidance 15/2006 Setting Appropriate Ward Nurse Staffing Levels in NHS Acute Trusts
- NHSI – developing workforce safeguards (October 2018)

In January each ADN undertook a comprehensive review of their Divisional areas their complete reports were reviewed and agreed by the Director of Nursing. A summary of those report recommendations is provided below:

Medicine & Urgent Care:
The ADN for Medicine used multiple references to undertake the review, the reason being that current establishment accuracy was difficult to judge due to the high vacancy factor and the effect this could have on the reliability of SafeCare data.

- RCN recommendations for Safe Staffing for Older people's wards (September 2012)
- The Use of Non-Invasive Ventilation in the Management of patients with COPD admitted to hospital with acute type ii respiratory failure (RCP and ICS 2008)
- Nurse Staffing in Stroke Services

The recommendations for this review from Medicine were (appendix 2a):

Brampton (Elderly) – Increase 1RN LD (from 4 to 5) and 1 RN N (from 3 to 4) to meet RCN recommendations of ratio of RNs to be 1:5 to 1:7 and to never exceed 1:7. An increase of 1HCA at night from 3 to 4 to assist with the high proportion of confused and frail patients who are at risk of falling
Triangulation with harms in last 6 months: Acquired Pressure damage – 3 (1 DTi and 2 category 2), Assessment & Accreditation - Amber, Harmful Falls 0, IPC – 0 concerns

Holcot (Elderly) **-** Increase 1RN LD (from 4 to 5) and 1 RN N (from 3 to 4) to meet RCN recommendations of ratio of RNs to be 1:5 to 1:7 and to never exceed 1:7. A decrease of 1HCA at night from 5 to 4 to reflect more RN cover and to reverse a previous trial of more HCA which did not meet the recommended ratio of 65:35
Triangulation with harms in last 6 months: – Acquired Pressure damage – 4 (all category 2)
Assessment & Accreditation - Amber, Harmful Falls 2, IPC – 0 concerns

The number and acuity and dependency of patients within medicine have changed over the last couple of years as we try to meet the needs of the population. Much of the work in Medicine and Urgent Care is unplanned and the service needs to have the correct numbers and skill to meet that demand and to recruit so that there is less reliance on temporary staff. Due to the current vacancy factor the recommendations mentioned above will be repeated in 6 months incorporating more of the data from SafeCare, an improved vacancy factor in order to validate the full recommendations made in the ADNs report.

Urgent Care

The Paediatric Registered Nurse establishment in the Emergency department is currently 7.46 wte, this does not meet the recommendations set out by RCPCH (2018) of at least 2 RSCNs per shift. Peak attendance is between the hours of 1600 and midnight, in order to safely triage, assess, implement and deliver care for all paediatric patients presenting to the ED, including resuscitation, an extra twilight RSCN shift is required. 12 wte RSCNs would be needed to meet this – an uplift of 4.5 wte.

The opening of the Nye Bevan unit changed not only the location and geography of the previous Benham and Creaton Wards but also their bed base, workload, and skill required from the nursing staff within those areas. The staffing on the Nye Bevan Unit has been reviewed a number of times in response to planned activity and acuity not meeting the actual situation when the wards function fully as assessment areas. The full functionality of the area is not fully embedded therefore no recommendations are included within this report, for the 2019 bi-annual staffing review Nye Bevan and the Emergency Department will have a full review completed.

The staffing in the Emergency Department (ED) has also been reviewed over the past year as the Directorate anticipated changes in demand following the opening of Springfield House for GP work, Ambulatory Care taking less acute patients out of ED and also the impact of the new model of working in Nye Bevan. We have had support from ECIST to try to remodel the staffing. However as initially the ability to run the medical model and more latterly winter pressures have meant that the Nye Bevan model for Nursing has not been able to be fully tested, the impact on ED has also not been realised. It is important to note that this is equally about skill and experience which is difficult to recruit to as it is about pure numbers of staff.

Surgery, Theatres & Critical Care:

Each of the services across the Division has had a review of their establishment, utilising National guidance and specialist guidance as detailed below.

- Guidelines for the Provision of Intensive Care Services, 2015
- Association for Perioperative Practice 2014 **Staffing for Patients in the Perioperative Setting**

The recommendations for this review from Surgery were:

Head & Neck ward - NGH run the H&N service for the county out of hours and at weekends the acute H&N patients from Milton Keynes and Kettering are transferred to NGH. At the time that the establishment was agreed this arrangement and the acuity of these transfer patients was not accounted for, particularly on the night shift for the Friday, Saturday and Sunday. The professional opinion supported by the data from SafeCare is that the registered workforce on nights for those 3 days needs to be increased by 1 RN.

Triangulation with harms in last 6 months: – Acquired Pressure damage – 2 (both category 2)
Assessment & Accreditation - Green, Harmful Falls 1, IPC – 0 concerns

Critical Care Unit - Critical Care establishment has been table top reviewed utilising ICS guidance and the 2017 CQC report. Year to date 2018/19 Critical Care's pay budget was under-spent, in part this was due to continual vacancies but also due to not all of the level 3 & 2 beds always being in use, which means the team can flex their staff requirements. There are no proposed changes to their establishment.

Gynae, Childrens, Oncology & Haematology
The wards and departments (day-case unit and outpatients) across this Division have all been reviewed.

- National Quality Board. Safe, sustainable and productive staffing: An improvement resource for neonatal care. London; 2018.
- BAPM Guidance on Cot Capacity and the use of Nurse Staffing, 2018

The only changes that have been recommended are:
Talbot Butler and specifically the Emergency Assessment Bay (8 trolleys) – currently this is staffed with 1 RN and 1 HCA day and night. In light of the acuity of these patients, the assessments required and the number that can be in the area at one time this establishment needs to reflect 2 RNs on shift with 1 HCA. The Division have recognised and support this recommendation which is being taken forward through the budget setting process.
Paediatrics are recommending slight skill mix changes, these will be done at local level as they are within current budgeted establishment.
From a professional perspective the changes to establishments have been discussed and approved however, the budgetary agreement and approval will be finalised by the Divisions.

9. Delivering Safe Care

The Nurse Staffing meeting meets monthly and is chaired by the Deputy Director of Nursing, which reports into the Nursing & Midwifery Board. The meeting reviews workforce metrics, recruitment and retention, use of bank and agency staffing and E-roster performance. Through this meeting the ADN/M raise key staffing concerns such as vacancies, sickness rates and changes in service needs that will have an impact on staffing.

The Assessment & Accreditation Framework and Director & Senior Team walk rounds also provides assurance to the Board that standards are being met in relation to the quality of clinical care and actions taken to improve where necessary.

On a day to day basis nurse staffing shortfalls are escalated, discussed and resolved at the morning Safety Huddle and Senior Nurse pm meeting in line with our 'Effective Nurse Staffing & Escalation' policy (NGH-PO-964). Through the policy the wards are RAG (Red, Amber, and Green) rated with regards to the skill mix ratio, patient acuity and dependency. At times wards may not be at their planned staffing levels but remain safe, conversely the ward may have increased acuity and dependency of patients and the full complement of planned staff are not able to provide safe care. Staff moves are made to address any such deficit/surplus. There may be times when a ward is on 'amber' due to a reduced number of planned staff which can be sustained for that shift, this is however not sustainable for long periods of time. Therefore, the professional judgement of the ward sister/charge nurse and matron is used to determine if a ward is rated Red, Amber or Green.

Due consideration is given to the following:

- Any immediate adverse implications from staffing shortfalls
- Enhanced Observation of Care (1:1 supervision or cohorting) of patients with specific nursing dependency needs
- The mitigation of risk using professional nursing judgement for wards where nurse staffing numbers fall below planned levels.
- Re-allocation of staff to ensure safety across the Trust, utilising professional judgement and data inputted onto SafeCare
- Out of hours (Nights and Weekends) this process is undertaken by the 'Sister On' and Clinical Site Manager. In addition, any adverse incidents relating to nurse staffing are reported through the existing Datix system.

10. Workforce

In recognition of the challenges faced by the Trust regarding the recruitment of registered nurses, which reflects the national picture, a dedicated Nurse Recruitment & Retention Team is in place to work alongside the senior nursing team to support and co-ordinate all recruitment activities.

Over the last 2 years there has been an overall reduction of vacancies for the core in-patient wards, however in quarter 3 of 2018/19 the number of vacancies has increased. The current vacancy (January 2019) for Nursing and Midwifery is 11.3%, with an annual turnover at 6.1%.

Early February saw our first Nurse Associates qualify and enter onto the NMC register – the Nurse Associate role was created to bridge the gap between registered and unregistered nurses which exists nationally and to create a further entry point into nurse training. Currently our Nurse Associates have been incorporated into areas of high vacancy with the ability to absorb into existing budget. NHSImprovement are working with the Chief Nurse of England to produce guidance on how this new role will fit into establishment reviews of the future – this is expected in Summer 2019.

The 'Model Hospital'
A recommendation from the Carter Report was to develop a 'Model Hospital' to enable Trusts to understand "what good looks like" and learn and adopt their best practice. Through the 'Model Hospital' work stream NHSImprovement is developing tools including a live dashboard which includes staffing information collected and presented in a standardised format. This will enable Trusts to compare staffing metrics including CHPPD, sickness rates, agency costs and local quality data with other trusts and identify areas where they need to improve. The Model Hospital data is provided to the Workforce Committee monthly to enable an overview of any chances that require consideration. Appendix 4

11. Next Steps

The following actions are to be progressed in the coming months across the Trust:

- Ongoing review of Model Hospital and CHPPD by senior nursing/midwifery colleagues
- Further embed use and knowledge of the SafeCare module across the Trust
- Await the outcome of the NHSImprovement guidance regarding Nurse Associates in establishment reviews

The Board is asked to note the work undertaken to date and approve the contents of this paper which ensures that our patients receive safe, Best Possible Care.

References and further reading:

The National Quality Board (2013) - How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time http://www.england.nhs.uk/.pdf

Hard Truths Commitments Regarding the Publishing of Staffing Data (2014) http://www.england.nhs.uk.pdf

National Institute for Health and Care Excellence (NICE 2014) - Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals http://www.nice.org.uk/guidance/sg1

The Shelford Group Safer Nursing Care Tool (2014) http://shelfordgroup.org/resource/chief-nurses/safety-nursing-care-tool

NHS Employers (2014) - NHS Qualified Nurse Supply and Demand Survey http://hee.nhs.uk/NHS qualified nurse supply and demand survey 2014.pdf

National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – July 2016

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (Carter report) – 2016

National Quality Board – resource pack (draft) January 2017

National Quality Board - Safe, Sustainable and Productive Staffing - An improvement resource for adult inpatient wards in acute hospitals, January 2018

National Quality Board - Safe, Sustainable and Productive Staffing - An improvement resource for maternity services January 2018

NHS Improvement - Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts, June, 2018

NHS Improvement – Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing October 2018

Appendix 1

Nursing & Midwifery Establishment (Mth 10 2019)

Ward	Budgeted Shift Pattern						Budgeted WTE - Finance - Mth		Skill mix	Variance to RN ratio Guidance + 6 month Harms Latest FFT
	Qualified			Unqualified			Qual.	Unqual. (Not Incl. Temp)	RN : HCA	
	E	L	N	E	L	N				
Abington	6	5	3	4	4	3	22.9	19.1	54 : 46	N – Agreed below 1:8 following review Harms – Falls :2 FFT 100%
Althorp	3	3	2	3	2	1	13.3	8.4	61 : 39	N - Predominantly elective service and rarely full to 18 beds Harms – zero FFT – 96%
Cedar	6	5	3	5	5	3	22.9	21.3	52 : 48	N – Agreed below 1:8 following review Harms – PU: 1, FFT 100% Falls rate higher no harms
Hawthorn	6	5	4	3	3	3	25.9	15.8	62 : 38	Harms – PU: 2, Falls: 1 FFT 92%
Head & Neck	3	3	3	1	1	1	15.6	7.9	66 : 34	Harms – PU: 1, FFT 95%
Rowan	6	5	5	3	3	2	28.5	13.5	68 : 32	Harms – PU: 0, FFT 90%
Willow	7	6	6	3	3	2	33.5	13.5	71 : 29	Harms – PU: 2, FFT 96%
7 Surgical Wards										
Esther White	6	6	5	5	5	5	28.7	26.1	54 : 46	Harms – PU: 3, Falls:1 FFT 90%
Walter Tull	8	8	7	5	5	5	41.5	24.7	66 34	Harms – PU: 1, FFT 92%
Becket	6	6	5	4	4	2	29.1	16.9	63 : 37	Harms – PU: 14, FFT 92%
Brampton	4	4	3	4	4	3	19.3	20.4	49 : 51	N – Agreed below 1:8 following review Harms – PU: 3, FFT 91% Falls rate higher no harms
Collingtree	7	7	5	6	6	4	32.7	27.0	55 : 45	Harms – PU: 3, FFT 95% Falls rate higher no harms
Compton	3	3	2	3	3	2	14.1	14.1	50 : 50	N – Agreed below 1:8 following review Harms – PU: 8, FFT 65% Falls rate higher no harms
Holcot	4	4	3	5	5	5	21.9	23.6	48 : 52	N – Agreed below 1:8 following review Harms – PU: 4, FFT 100% Falls rate higher no harms
Dryden	6	6	4	3	3	2	27.2	12.3	69 : 31	Harms – PU: 1, Falls 1 FFT 95%
Quinton	6	6	4	5	5	4	30.0	25.8	54 : 46	Harms – PU: 2, FFT 80% Falls rate higher thematic review
Eleanor	3	3	2	2	2	2	14.1	11.7	55 : 45	Harms – PU: 1, FFT 100%
Finedon	6	6	3	2	2	1	24.6	6.0	80 : 20	Harms – PU: 1, FFT 100%
Allebone Stroke	5	5	4	5	5	2	25.0	18.3	58 : 42	Harms – PU: 1, FFT 100%

Knightley		4	3	3	3	3	2		16.7	13.4	56 : 44	Harms – PU: 2, Falls 2 FFT 90%
Victoria		4	3	2	3	2	2		15.0	12.2	55 : 45	N – Agreed below 1:8 following review Harms – PU: 7, several low harm falls, 1 CRUTI, FFT 84%
14 Medical Wards												
Disney		*5*	*5*	*3*	*3*	*3*	*1*		23.3	8.7	73 : 27	
Paddington		*8*	*8*	*7*	*3*	*3*	*3*		38.0	12.2	76 : 24	
Gosset		*9*	*9*	*8*	*2*	*2*	*2*		47.0	7.5	86 : 14	
Talbot Butler		7	6	4	3	3	3		30.1	14.7	67 : 33	Harms – PU: 0, FFT 83% Falls rate higher no harms
Spencer		4	4	4	3	3	3		24.0	17.8	57 : 43	Harms – PU: 0, FFT 94%
5 WCHO Wards												
Critical Care		*14*	*14*	*14*	*2*	*2*	*2*		82.2	12.0	87 : 13	Harms – PU: 7
A&E		*16*	*20*	*14*	*5*	*6*	*4*		87.3	24.9	78 : 22	
Specialist Areas												

Qualified Shift Key:		
Above 1:8 or specialty guidance		
Equal 1:8 or specialty guidance		
Below 1:8 or specialty guidance		

Appendix 2
Professional Judgement Table

Nursing Establishment, Skill Mix, Nurse Indicators & Patient Ratios

Ward Speciality & No of Beds	Budgeted Shift Pattern **Budgeted**								Budgeted WTE		Skill Mix		Patient Ratio (RN)		Nurse Indicator 6 month incidents (PU, Falls, with Harm, IPC)	**Professional Judgement Complete? (Inc SNCT)**	
	Qualified				Unqualified				Qual	Un-Qual	LD	N	LD	N			
	E	LD	L	N	E	LD	L	N								Y/N	Vary
Eg:																	
Rowan +Lv 1 Surgical 30 Beds	*1*	*5*	*0*	*5*	*0*	*3*	*0*	*3*	*28.5*	*13.1*	*69*	*31*	*6:1*	*6:1*	*PU – O AA – Green Falls – 1 IPC – MRSA col*	*Y*	*N*

Black = current status
Red = Variance to be considered

Appendix 2a

Medical Division: Nursing Establishment, Skill Mix, Nurse Indicators & Patient Ratios

Ward Speciality & No of Beds	Budgeted Shift Pattern								Budgeted WTE		Skill Mix		Patient Ratio (RN)		Nurse Indicator 6 month incidents (PU, Falls, with Harm, IPC)	Professional Judgement Complete? (Inc SNCT)	
	Qualified				Unqualified				Qual	Un-Qual	RN	HCA	LD	N			
	E	LD	L	N	E	LD	L	N								Y/N	Vary
Allebone Stroke 28 beds		5		4		5		2	25	18.3	58	42	5.6:1	7:1	PU – 1 AA- Blue Falls IPC	*Y*	*N*
Brampton Medicine 27 (29 with day room)		4 5		3 4		4		3 4	19.3	20.4	49	51	7:1	9:1	PU – 3 AA- Green Falls IPC	*Y*	*Y*
Collingtree Gastro 41		7 6w/e		5		6		4	32.7	27	55	45	6:1	8:1	*6+6 W/end* *PU – 13* *A&A – Green* *Falls – high* *Pt and staff assaults*	*Y*	*N*
Compton Medical rehab (unwell pts) 18		3		2		3		2	14.1	14.1	50	50	6:1	9:1	*PU – 8* *A&A – Red* *Falls – high* *Pt Turnover increased*	*Y*	*N*
Holcot Medicine 27 (29 with day room beds)		4 5		3 4		5 4		5 4	21.9	23.5	48	52	7:1	9:1	PU – 4 AA- Amber Falls - yes IPC	*Y*	*Y*

Walter Tull 24 hour assessment area 25 beds (5 side rooms) 11 trolleys 10 assessment chairs		7 9		7 8		6 5		6 5	42.5	25.1	63	37			PU – AA- Falls IPC	*Y*	*Review in 6 months*
Esther White 48 hours assessment 30 beds (5 side rooms)		6		5 6		5		5	29.7	27.2	52	48			PU – AA- Red Falls - concern IPC – High number of mental health vulnerable	*Y*	*Review in 6 months*
ED	16		18	14 2 16.00 to 24.00	5		5	4 1 16.00 to 24.00	84.5 4.5 Rscn 5.4 RN	23.4	78	22	N/A		Staff assaults Medication error and omissions Increased attendance Increased Paediatrics attendance	*Y*	*Review RN in 6 months*

Black = current status
Red = Variance to be considered

Appendix 3

Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts – 2018

Gap analysis summary:

	Guidance recommendation	Trust status
a.	Do trusts have a clear process for Safe Staffing monthly returns to be quality assured as well as clinically validated within their organisation prior to submission? This will help ensure accuracy, completeness and robustness of reported CHPPD data.	Our Safe Staffing is reviewed by each Associate Director of Nursing/Midwifery prior to submission, in part to check that the 'red flags' are correct and provide a summary of actions associated with any red flags
b.	Are the ward and speciality names routinely checked for alignment across other national data returns?	This is checked by our Informatics Lead and the A.D.N/M
c.	Is there an active process for Model Hospital speciality and ward names alignment to be validated and updated with all changes alerted to NHSI?	This is checked by our Informatics Lead and the A.D.N/M
d.	Do trusts have an understanding as well as assurance to determine if the level of variation in their nationally reported CHPPD on Model Hospital is warranted or unwarranted?	The ADN/M & matrons have access to the Model Hospital data and as part of our cost improvement programme have reviewed their wards/departments against Model Hospital.
e.	Do trusts have an understanding of their reported CHPPD by ward compared to national averages and also with appropriate comparable wards at peer trust as part of their establishment setting and review process?	We review our CHPPD on a monthly basis which is reported to the Workforce Committee and benchmark ourselves against our 'peers' group. Bi –annual establishment review takes place using a multifactorial methodology.
f.	Are ward establishments set using NICE endorsed evidence based tools such as The Safer Nursing care Tool (SNCT) and Birthrate Plus and are these in line with NQB and underpinned by auditable clinical judgement?	We have used SNCT for many years across the trust to base our establishment upon, complimented by national guidance, RCN guidance ADN professional judgement. We have used the SafeCare data for the first time to give the same evidence-based tool.
g.	Are such tools used consistently and exactly as instructed in the implementation guidance in an auditable manner?	SafeCare is used for the adult in-patient wards we are capturing the data and now analysing on a regular basis and for the first time it has been used for the establishment review
h.	Is the set establishment as signed off at budget setting by Finance, Workforce, operational and clinical leads being expressed in terms of care hours (and could therefore be convertible to CHPPD) to enable comparisons and triangulation with nationally reported CHPPD?	Our current budgets & establishments are not 'measured' in CHPPD however moving forward this could be considered. The implementation of the SafeCare means this will be easier in the near future.

Appendix 3.a
Care Hours per patient Day (CHPPD)

'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (2016)

Lord Carter's report gave clear direction in regards to aspects of staffing across the hospital setting. The report focused on optimising resources and the development of new metrics to analysis staff deployment, to ensure right teams, right place, and right time thus delivering high quality efficient patient care.

Care Hours per patient day
The report details how to eliminate unwarranted variation in nursing & care staff deploys by the use of 'Care Hours per Patient Day (CHPPD) which is to be used as the single metric for nursing/care staffing.

CHPPD can be used to describe both the hours of care required and staff availability in relation to the number of patients.

CHPPD is calculated by adding the hours of registered nurses to the hours of care workers (healthcare assistance/maternity care workers) and dividing the total by every 24 hours of in-patient admission.

$$\text{Care Hours per Patient Day} = \frac{\text{Hours of registered nurse + Hours of care workers}}{\text{Total number of patients}}$$

The figure that is produced gives the number of hours of care that one patient within that ward / department is receiving in 24hour.
For example: If a surgical ward over a month has a CHPPD of 6.5 then this represents that in 24 hours of patient stay in that ward 6.5 hours of care is given.

It is proposed by Lord Carter that CHPPD can be used at different levels of the organisation from 'ward to board' and can be reported nationally. Last year NHS England collated data from over 1000 wards which demonstrated a significant variation in staffing levels of 144%, from 6.3CHPPD to 15.48 CHPPD. It is not clear within the report the variations, if any, in the types of wards in the pilot so it is difficult to draw comparisons with our wards/units.

In line with the national guidance our CHPPD data has been calculated as part of the 'Safe Staffing' metrics on the Trust monthly return to NHS England since April 2016 and is shared with the Workforce Committee.

Appendix 3.b
January 2019 – Safe Staffing Data /CHPPD

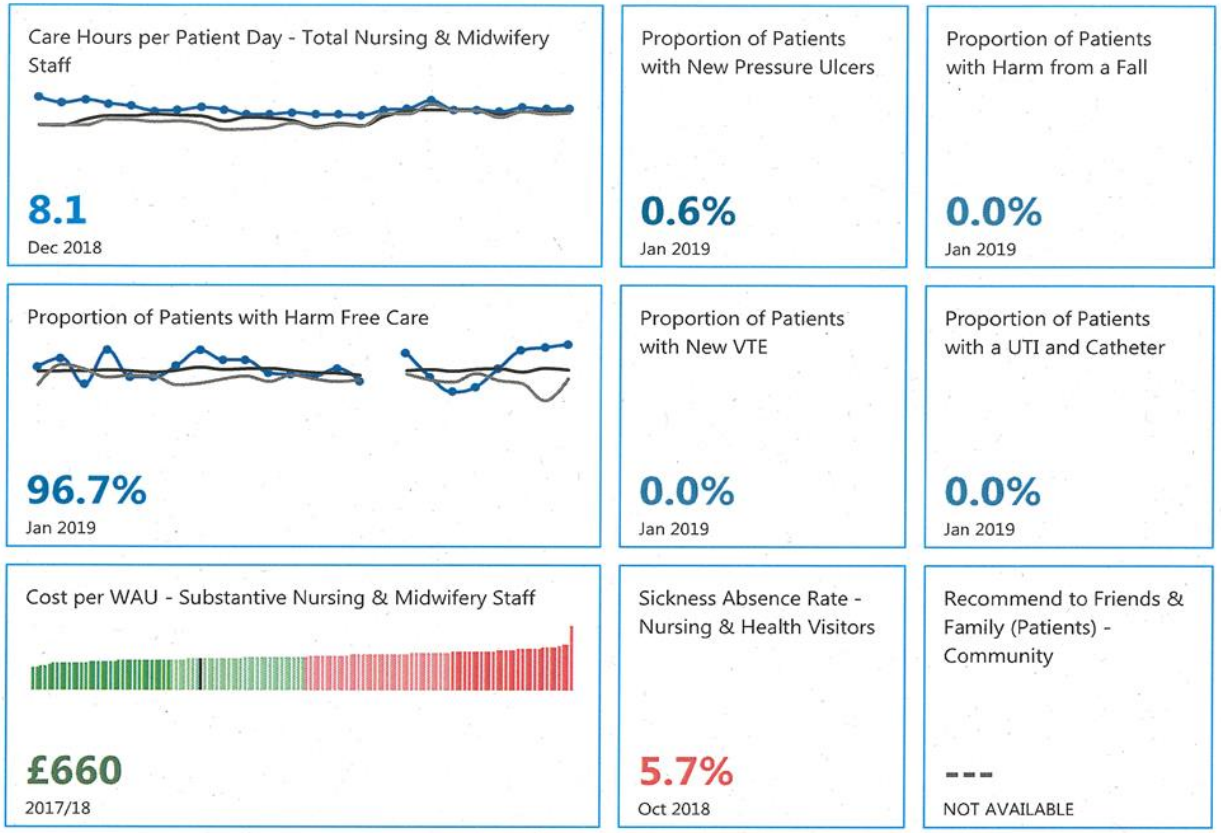
Northampton General Hospital NHS
NHS Trust

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — **January 2019**

Ward name	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)				Red Flag
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Red: Below 85% fill rate target; Amber: Between 85% and 95% fill rate target; Green: 95% and Above fill rate target								
Abington Ward (NCF)	1,857.75	1,704.25	1,488.05	1,300.55	1,060.50	1,071.50	1,060.50	1,395.50	91.7%	92.4%	100.2%	127.3%	857	3.2	3.1	6.3	
Allebone Ward (Stroke)	1,824.60	1,738.73	1,680.00	1,403.75	1,426.00	1,335.00	713.00	1,095.00	95.3%	84.8%	91.6%	151.8%	866	3.5	2.9	6.4	
Althorp (T&O)	937.25	859.50	772.50	487.50	713.00	703.50	506.00	368.00	100.5%	82.9%	100.4%	94.1%	259	6.2	3.3	9.5	
Becket Ward	2,029.75	1,933.00	1,413.50	1,195.25	1,782.50	1,759.25	713.00	724.50	95.2%	84.8%	100.9%	101.6%	798	4.7	2.4	7.1	
Brampton Ward	1,407.00	1,319.33	1,596.75	1,384.50	1,060.50	1,070.75	1,060.50	1,352.50	93.8%	86.7%	100.1%	126.5%	875	2.7	3.1	5.9	
Cedar Ward (TRAUMA)	1,900.50	1,702.08	1,765.55	1,513.00	1,060.50	1,087.50	1,060.50	1,296.50	89.6%	85.7%	101.7%	119.4%	914	3.1	3.1	6.1	
Collingtree Medical (40)	2,388.98	2,252.50	2,138.00	1,962.75	1,782.50	1,791.75	1,424.75	1,488.50	95.1%	91.8%	100.5%	102.2%	1248	3.2	2.7	6.0	
Compton Ward	1,040.48	855.75	1,187.00	1,026.00	713.00	713.00	713.00	711.25	82.2%	86.4%	100.0%	99.8%	557	2.8	3.1	5.9	
Dryden Ward	2,117.75	1,788.25	977.50	918.25	1,424.50	1,430.00	713.00	736.00	83.5%	93.9%	100.4%	103.2%	794	4.0	2.1	6.1	
Eleanor Ward	1,056.25	870.25	703.00	678.50	713.00	713.00	711.75	704.00	82.2%	96.5%	100.0%	111.8%	342	4.6	4.3	8.9	
Esther Wilde (Nye Bevan)	2,122.15	1,981.00	1,759.00	1,623.00	1,771.00	1,834.75	1,782.50	1,851.50	93.3%	92.3%	103.6%	93.7%	860	4.4	3.8	8.3	
Freedon Ward	2,129.50	1,845.33	310.50	437.00	1,060.50	1,060.50	345.00	368.00	86.7%	140.7%	100.0%	106.7%	506	5.8	1.6	7.4	
Hawthorn & SAU	1,959.50	1,881.83	1,061.00	1,379.17	1,424.75	1,418.50	977.50	1,161.75	96.0%	130.0%	99.6%	119.8%	923	3.6	2.8	6.3	
Head & Neck Ward	1,061.50	1,019.95	355.75	348.00	931.50	1,037.00	356.50	356.50	96.1%	97.3%	111.3%	100.0%	413	5.0	1.7	6.7	
Holcot Ward	1,405.15	1,140.42	1,770.75	1,585.50	1,060.00	1,060.00	1,771.00	1,775.00	81.1%	89.5%	100.0%	100.0%	830	2.7	4.0	6.7	
Knightley Ward	1,388.50	1,199.17	1,237.25	1,339.48	1,426.00	1,424.50	1,061.00	1,447.75	86.5%	108.3%	99.9%	133.4%	855	3.1	3.3	6.3	
Quinton Ward	1,746.15	1,686.58	1,684.50	1,685.50	1,426.00	1,415.08	713.00	1,481.50	108.0%	100.1%	99.2%	208.1%	931	3.5	3.6	7.0	
Raven (LSSU)	1,957.75	1,973.50	1,054.75	1,012.25	1,782.50	1,775.50	713.00	712.25	100.8%	96.0%	99.6%	99.9%	898	4.2	1.9	6.1	
Spencer Ward	1,428.00	1,358.75	1,054.50	959.00	1,058.00	1,063.50	1,060.50	1,168.00	95.2%	90.9%	102.4%	103.2%	660	3.7	3.1	6.8	
Talbot Butler Ward	2,583.00	2,417.67	1,427.25	1,324.50	1,426.00	1,752.25	1,060.50	1,228.25	93.6%	92.8%	122.9%	114.9%	725	5.8	3.5	9.3	red flag, workload prioritised due to unexpected acuity of patients. Delay of more than 30 minutes of routine medication for stay of patients - no harm to patients, apologies given Workload improved with the start of the night shift
Victoria Ward	1,162.00	939.92	924.50	851.75	711.50	723.00	713.00	813.25	80.9%	92.1%	101.6%	114.1%	544	3.1	3.1	6.1	
Walker 3d (Nye Bevan)	2,783.98	2,403.83	1,773.50	1,743.00	2,794.50	2,438.00	1,782.50	2,007.00	86.4%	98.3%	87.2%	112.3%	1075	4.5	3.5	8.0	
Willow Ward (+ Level 1)	2,315.25	2,312.17	1,064.25	1,048.50	2,139.00	2,021.25	713.00	819.25	99.9%	98.3%	94.5%	114.9%	855	5.1	2.2	7.2	red flag due to decrease in staff, bank and agency not covered, no patient harm occurred
									Total Average CHPPD					4.0	3.0	7.0	
ITU	5,106.75	4,667.75	847.87	663.42	4,722.25	4,347.42	678.50	644.00	87.5%	85.3%	92.1%	94.9%	374.0	23.6	3.5	27.1	
									Total Average CHPPD					23.6	3.5	27.1	
Barnell Birth Centre	1,773.40	1,717.75	724.50	627.75	1,426.00	1,260.50	713.00	588.25	96.9%	86.6%	88.4%	82.5%	119	25.0	10.2	35.2	
Robert Watson	1,073.25	1,195.00	1,035.00	1,035.00	1,060.50	1,048.42	1,060.25	896.75	111.3%	100.0%	97.8%	80.9%	474	4.7	4.0	8.7	
Sturridge Ward	4,320.25	4,079.92	1,929.75	1,547.50	4,286.70	3,894.00	1,252.00	1,198.75	94.4%	80.2%	90.8%	95.5%	475	18.8	5.6	22.4	
									Total Average CHPPD					18.8	5.6	22.4	
Darwin Ward	1676.75	1425.583	976.5	896	1069.5	991	356.5	348.75	85.1%	91.8%	92.7%	97.8%	302.0	8.0	4.1	12.1	
Grosvel Ward	2951	2748.417	694.25	606.5	2628.75	2552.75	423.25	400.25	93.1%	87.4%	96.0%	94.6%	553.0	9.6	1.8	11.4	Red Flag - all care prioritised no harm came to any babies, extra support gained from other ward and babies stepped down within 24 hours
Paddington Ward	2918	2569.75	1061	870.25	2408	1947.25	644	563	81.2%	82.0%	80.9%	87.4%	505.0	8.5	2.8	11.4	
									Total Average CHPPD					8.7	3.9	11.8	
								Total percentage	93.5%	92.0%	100.0%	102.7%	Total Average CHPPD	9.0	3.7	12.7	

Appendix 4

NHSI – Model Hospital – December 2018
Headlines Metric:



This screen shot provides a summary of the trust overall performance from Model Hospital December 2018. The next graphs depict the Trust position under the domains of the CQC key lines of enquiry and in relation to nurse staffing comparison.

Caring:

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Recommend to Friends & Family (Staff)	Q2 2018/19	84.7%	-	-		No variation available	
Recommend to Friends & Family (Patients) - Inpatient	Dec 2018	92.6%	-	-		No variation available	
Recommend to Friends & Family (Patients) - Outpatient	Dec 2018	93.5%	-	-		No variation available	
Recommend to Friends & Family (Patients) - Maternity Antenatal Care	Dec 2018	100.0%	-	-		No variation available	
Recommend to Friends & Family (Patients) - Maternity Birth Setting	Dec 2018	100.0%	-	-		No variation available	
Recommend to Friends & Family (Patients) - Maternity Postnatal Ward	Dec 2018	100.0%	-	-		No variation available	

100.0% is in quartile 3 - Mid-High 25% [blue]

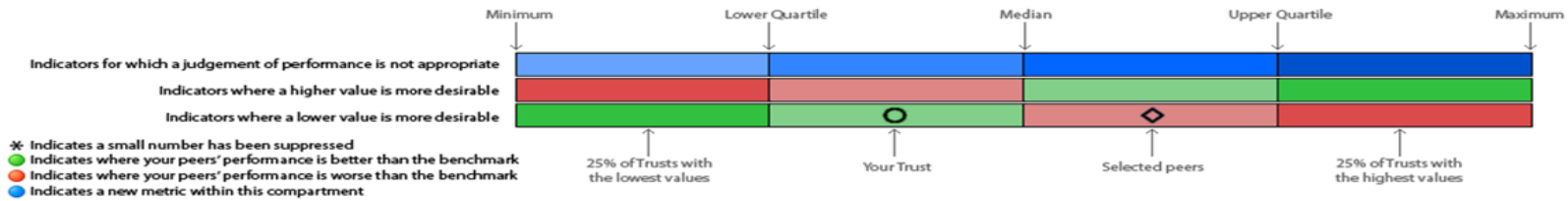
Money & Resources:

Money & Resources	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£660	£677	£710			No trendline available
Cost per WAU - Registered Substantive Nurses & Midwives	2017/18	£522	£534	£554			No trendline available
Cost per WAU - Healthcare Support Workers	2017/18	£138	£144	£155			No trendline available
Total Nursing & Midwifery FTE	2017/18	1,823.0	1,797.6	2,096.6			
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Dec 2018	8.1	8.0	8.0			
Care Hours per Patient Day - Registered Nurses & Midwives	Dec 2018	5.0	4.9	4.8			
Care Hours per Patient Day - Healthcare Support Workers	Dec 2018	3.1	3.1	3.2			
Cost per Care Hour - Total Nursing & Midwifery Staff	Nov 2018	£25.83	£27.16	£25.80			
Cost per Care Hour - Registered Nurses & Midwives	Nov 2018	£29.64	£31.71	£29.91			
Cost per Care Hour - Healthcare Support Workers	Nov 2018	£19.60	£19.36	£19.02			
Cost per Patient Day - Total Nursing & Midwifery Staff	Nov 2018	£210.74	£213.22	£207.32			
Cost per Patient Day - Registered Nurses & Midwives	Nov 2018	£150.10	£160.93	£144.81			
Cost per Patient Day - Healthcare Support Workers	Nov 2018	£60.64	£60.49	£61.06			
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£34,642	£34,065	£35,334			
Average Staff Cost - Registered Nursing & Midwifery Staff	2016/17	£41,246	£39,677	£41,419			
Average Staff Cost - Healthcare Support Workers	2016/17	£21,983	£22,552	£23,424			

People, Management & Culture: Well-led

People, Management & Culture: Well-led	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Sickness Absence Rate - Nursing & Health Visitors	Oct 2018	5.7%	3.8%	4.3%			
Sickness Absence Rate - Midwifery	Oct 2018	4.9%	4.1%	4.8%			
Sickness Absence Rate - Healthcare Support Workers	Oct 2018	6.0%	5.6%	6.4%			
Staff Retention Rate - Nursing & Health Visitors	Nov 2018	87.8%	86.2%	87.5%			
Staff Retention Rate - Midwifery	Nov 2018	87.9%	89.1%	88.9%			
Staff Retention Rate - Healthcare Support Workers	Nov 2018	78.6%	78.7%	83.5%			
Staff Survey (Nurses - Adult/General) - Recommend as place to work or receive tr...	2017	3.8	3.8	3.7			
Staff Survey (Nurses - Children) - Recommend as place to work or receive treatme...	2017	4.0	3.9	3.8			
Staff Survey (Nurses - Midwives) - Recommend as place to work or receive treatme...	2017	4.0	3.7	3.7			
Staff Survey (Nursing Assistants) - Recommend as place to work or receive treatm...	2017	3.7	3.9	3.9			
Recommend as a place to work (All Staff)	Q2 2018/19	73.4%	64.1%	-		No variation available	

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Proportion of Patients with Harm Free Care	Jan 2019	96.7%	93.2%	94.1%			
Proportion of Patients with Harm from a Fall	Jan 2019	0.0%	0.3%	0.3%			
Proportion of Patients with New VTE	Jan 2019	0.0%	0.3%	0.4%			
Proportion of Patients with New Pressure Ulcers	Jan 2019	0.6%	0.8%	0.8%			
Proportion of Patients with a UTI and Catheter	Jan 2019	0.0%	0.9%	0.7%			



Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	Assessment and Accreditation at Northampton General Hospital Q3 (2018-19)
Agenda item	12
Presenter of Report	Sheran Oke, Director of Nursing
Author(s) of Report	Carol Bradley - Nursing and Quality Matron
Purpose	For Information and Assurance

Executive Summary

This paper describes the progress made by the nursing teams using the 'Best Possible Care Assessment and Accreditation' framework during Quarter 3 (2018-19). The tool has 15 standards which are subdivided into elements of Environment, Care and Leadership and incorporate national and local performance indicators. All 23 adult inpatient wards have been formally assessed at least three times and this work continues.

Phase two of the roll out commenced in June 2018 and includes Outpatients, Critical Care and the Emergency Department. Paediatrics and Theatres are currently reviewing the tool using their expertise to advise changes in preparation for phase three roll-out in 2019-20.

Related strategic aim and corporate objective	Safety and Quality
Risk and assurance	Quality Care Standards
Related Board Assurance Framework entries	BAF – 3.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N Is there potential for or evidence that the proposed decision/policy will affect different population groups

	differently (including possibly discriminating against certain groups)? N
Legal implications / regulatory requirements	Ward and clinical areas requirements to comply with Trust Quality and Safety standards and Care Quality Commission (CQC) guidance

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

The Best Possible Care
Assessment and Accreditation Framework

1. Introduction

This paper aims to describe progress attained during Q3 (2018/2019) against the 'Best Possible Care' Assessment and Accreditation standards. The paper highlights the work that is currently being undertaken with adult inpatient areas in conjunction with the Nursing and Quality (N&Q) Matron. The paper also provides an update on the work commenced in Outpatients, Critical Care and the Emergency Department and the plans for phase three of the roll out.

This paper will:

- Provide assurance that the quality and safety of nursing care is being reviewed using the 'Best Possible Care' framework and that action plans are in place where standards are not being met
- Describe the Best Possible Care assessment results obtained from October to December 2018
- Provide an update on the outcomes of the second phase of the roll out commenced in June 2018 which includes Outpatient Departments, Emergency Department and Critical Care.
- Provide an update on the third phase of the roll out planned for Theatres, Paediatrics and Maternity.

2. Ward Assessment Results in Q3 (2018/19)

Activity in Q3

- 17 assessments were completed in Q3 (2018/19) 11 Green, 6 Amber, 0 Red
- Victoria Ward improved from Red to Amber status
- Dryden Ward improved from Amber to Green status
- Finedon Ward improved from Amber to Green status
- Collingtree Ward improved from Amber to Green status
- Critical Care improved from Amber to Green status
- Abington Ward deteriorated from Blue to Amber status on their annual assessment
- Spencer Ward and Rowan Ward achieved their third consecutive Green assessments and are in the process of applying for 'Best Possible Care' Blue Ward Status
- Allebone Ward were successful at panel in achieving 'Best Possible Care' status, which was approved by Trust Board in Q4 (2018/19)
- Head and Neck achieved a third consecutive green rating and are providing additional evidence prior to applying to panel for 'Best Possible care' status
- Wards continue to be actively engaged in, and supportive of, the assessment process
- Common themes from the assessment process are fed back to ward teams at the Nursing and Midwifery Professional Forum and the band 6 and 7 Professional Learning Communities

Please refer to:

- **Appendix 1** - Trust status per quarter/ month
- **Appendix 2** - Initial ward assessment results by standard
- **Appendix 3** - Adult Inpatient assessment results by standard Q3 (2018/19)
- **Appendix 4** – Out Patients Departments and Emergency Department results by standard Q3 (2018/19)

3. Non-progressing Wards

The definition of a non-progressing ward is a ward that has failed to obtain a green rating through the assessment and accreditation process after 4 consecutive assessments unless there are extenuating circumstances. The circumstances are discussed by the Quality Matron with the Director of Nursing and if warranted extenuating circumstances are granted/agreed.

The following wards have been identified and are being managed as non-progressing wards.

Knightley Ward – Medicine

Knightley ward achieved an amber rating in September 2018 following a red rating May 2018, an amber rating in January 2018, a red rating in November 2017 and 2 previous amber ratings in June 2017 and January 2017

As part of the actions there was a change in leadership on Knightley Ward in Q1 (2018/19)

Talbot Butler Ward- Oncology

Talbot Butler achieved an amber rating in November 2018, an amber rating in July 2018, a red rating in May 2018 and 3 previous amber ratings. Changes in senior leadership happened during Q2.

Victoria Ward- Elderly Medicine

Victoria Ward achieved an amber rating in October 2018, a red rating in July 2018 following 2 consecutive amber assessments and a red rating in January 2017.

There has been a reduction in the number of non-progressing wards from four to three in Q3 when compared to Q2

4. Outpatient Assessment and Accreditation

In Q3 2018-2019 the first assessment took place within the Medical Outpatient Department, they have been awarded a green rating and will be reassessed in approximately 9 months' time. To date the following Outpatient Departments have been assessed.

- Integrated Surgery
- Medical Outpatients Department
- Oncology
- Haematology

Results can be seen in **Appendix 4**

5. Focused work on Individual Standards

Standard 5 - Infection Prevention

Individual ward and department results against standard 5 (Infection prevention) have improved from 17 red areas in Q2 to 13 red areas in Q3 (**Appendix 3)**

Focused work on standard 5

- Thematic review undertaken to identify key elements of the standard that requires improvement
- Infection Prevention Team to monitor compliance and provide teaching in the key aspects of Standard 5 when visiting clinical areas
- The Infection Prevention Team providing additional training with a focus on key themes
- Education on Standard 5 to be included in band 6 and Band 7 Professional Learning Communities (PLC's) in Q4 (2018/19)
- Monitoring through Infection Prevention Steering Group

6. Phase Three

The remaining clinical areas to be included in the assessment and accreditation process are Theatres, Paediatrics and Maternity. These areas are planned for phase three of the roll out and the work involves;

- Working with the senior staff in these areas to make changes to the tool to meet the specific requirements of these specialist areas
- Piloting the new tools
- External validation
- Formal assessment

7. Recommendations

- The Trust Board are asked to note and support the content of this paper

Northampton General Hospital NHS
NHS Trust

Appendix 1 - Trust Status per Quarter (inclusive of Critical Care)

	Q1 2016 /17	Q2 2016 /17	Q3 2016 /17	Q4 2016 /17	Q1 2017 /18	Q2 2017 /18	Q3 2017 /18	Q4 2017 /18	Q1 2018 /19	Q2 2018 /19	Q3 2018 /19
Total number of Blue wards	0	0	0	0	0	1	2	3	3	3	2
Total number of Green wards	2	3	5	6	7	9	12	10	10	8	12
Total number of Amber wards	3	5	10	10	15	13	8	7	9	12	10
Total number of Red wards	1	2	0	3	1	0	1	3	2	1	0

Northampton General Hospital
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APPENDIX 2 - Initial Ward Assessment Results

Standard / Ward	Overall	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
EAU	June 2017															
Benham	Sep 2016															
Allebone	April 2017															
Becket	May 2017															
Brampton	June 2016															
Compton	Nov 2016															
Creaton	Oct 2016															
Collingtree	January 2017															
Dryden	May 2016															
Eleanor	Oct 2016															
Finedon	July 2016															
Holcot	July 2016															
Knightley	Feb 2017															
Victoria	Jan 2016															
Abington	Nov 2016															
Althorp	June 2016															
Cedar	June 2016															
Hawthorn	Nov 2016															
Head and Neck	May 2017															
Rowan	June 2016															
Willow	Sep 2016															
Spencer	June 2016															
Talbot Butler	March 2017															

Northampton General Hospital NHS Trust

APPENDIX 3 – Adult In-patient Assessment Results Q3 (2018/19) inclusive of Critical Care

Standard / Ward	Overall	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Esther White (Creaton)	April 2018															
Walter Tull (Benham)	Mar 2018															
Allebone	Sept 2018															
Becket	Oct 2018															
Brampton	Aug 2018															
Compton	Sept 2018															
Quinton (EAU)	Oct 2018															
Collingtree	Nov 2018															
Dryden	Oct 2018															
Eleanor	Aug 2018															
Finedon	Oct 2018															
Holcot	Dec 2018															
Knightley	Sept 2018															
Victoria	Oct 2018															
Abington	Dec 2018															
Althorp	Oct 2018															
Cedar	July 2018															
Hawthorn	Aug 2018															
Head & Neck	Nov 2018															
Rowan	Dec 2018															
Willow	Oct 2018															
Spencer	Dec 2018															
Talbot Butler	Nov 2018															
Critical Care	Nov 2018															
		5	**3**	**5**	**4**	**13**	**1**	**7**	**2**	**1**	**1**	**4**	**0**	**6**	**4**	**6**

Northampton General Hospital NHS Trust

APPENDIX 4

Outpatient Department Assessment Results Q3 (2018/19)

Standard / Department	Overall	1	2	3	4	5	6	7	8	9	10
Oncology	June 2018										
Haematology	June 2018										
Integrated Surgery	August 2018										
Medical Outpatient Department	October 2018										

Emergency Department Assessment Results Q3 (2018/19)

Standard	Overall	1	2	3	4	5	6	7	8	9	10	11	12
Emergency Department	November 2018												

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28th March 2019**

Title of the Report	Financial Position - Month 11 (FY2018-19)
Agenda item	13
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 month ended February 2019.

Executive summary

The Trust maintained a better than plan pre-PSF position, with a favourable balance of £364k, although this favourable position is likely to be offset in March by the unachieved STP related income which was phased quarterly in the plan.

The full finance-related Provider Sustainability Funding (PSF) of £5,683k has been earned to date, however only £965k of the available £2,435k A&E-related PSF has so far been earned, resulting in missed income of £1,470k.

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 month ended February 2019 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 11 (February 2018)
FY 2018/19

Report to:

Trust Board

March 2019

Content

1. Director of Finance Message

The Trust maintained a better than plan pre-PSF position, with a favourable balance of £364k.

The unachieved STP related income phased quarterly in the plan is likely to offset this favourable balance by the end of March.

The Trust continues to miss A&E trajectories and therefore has missed £1,470k income.

This report sets out the Trust's financial position for the month ended 28th February 2019. The results show a reported year-to-date pre-PSF deficit of £26,012k against a planned pre-PSF deficit of £26,376k, resulting in a favourable variance of £364k. This favourable variance is likely to be offset next month by the STP related income phased quarterly in the plan.

The full finance-related Provider Sustainability Funding (PSF) of £5,683k has been earned, however only £965k of the available £2,435k A&E-related PSF has so far been earned, resulting in missed income of £1,470k. It is likely that the A&E PSF for March will be missed, bringing the total unearned income to £1,792k.

The overall post-PSF position at the end of February is an adverse variance to plan of £1,106k.

Winter pressures continued with February being another busy month for the Trust. This was evident across most PODs except outpatients and elective activity which had some cancellations as a result of the operational pressures facing the Trust. Income was £130k better than plan in month.

Pay continued to be overspent, largely due to the continued use of agency medical staff in Medicine division as well as staffing of the escalation areas, in addition to use of agency to cover sickness and vacancies. This was in addition to back pay of additional PAs of around £70k. Overall, Pay was overspent by £287k, bringing the year-to-date pay variance to £3,901k. Agency spend is £946k with the key spends on medical and nursing agency staff.

Salary Overpayment continues to be an issue for the Trust and increased to £454k from £392k last month, with the largest overpayments recorded in the month arising from the Surgery Division (£51k recorded in February).

Other income is £3,175k better than plan year-to-date and improved by £526k in month mainly due to one-off external funding received in addition to continued increase of medicine sales, catering income, charitable donations and salary recharges income (matched by cost).

CIP delivery is £14,250k YTD which is £1,458k better than plan although around £5m of this is delivered through non-recurrent unplanned pay savings.

Capital is underspent against plan by £139k with a YTD spend of £17,606k. The capital team continues to work with the Services to ensure that the schemes can be delivered so that the Trust is able to meet its capital plan for the year.

The key risks to meeting the control total remain: loss of PSF, unachieved recurrent CIPs and ability to keep pay costs within planned budget.

Table 1: Income and Expenditure Summary

I&E Summary	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
		Plan	Actual	Variance	Plan	Actual	Variance	Jan-19	Dec-18
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	286,457	22,219	21,937	(282)	261,641	257,260	(4,381)	24,888	22,780
Other Clinical Income	11,898	1,298	891	(407)	10,600	8,549	(2,051)	960	760
Other Income	25,311	2,117	2,643	526	23,093	26,269	3,175	2,405	2,365
Total Income	323,666	25,634	25,471	(163)	295,334	292,077	(3,256)	28,253	25,905
Pay Costs	(219,759)	(18,772)	(19,060)	(287)	(201,010)	(204,912)	(3,901)	(19,294)	(18,903)
Non-Pay Costs	(108,976)	(8,724)	(8,580)	144	(99,734)	(94,503)	5,231	(8,947)	(8,481)
Unallocated CIPs	1,093	404		(404)	127		(127)		
Reserves/ Non-Rec	(1,269)	(293)		293	(992)		992		
Total Costs	(328,911)	(27,386)	(27,640)	(254)	(301,610)	(299,415)	2,195	(28,240)	(27,385)
EBITDA	(5,245)	(1,752)	(2,169)	(417)	(6,276)	(7,337)	(1,061)	13	(1,480)
Depreciation	(10,615)	(939)	(867)	72	(9,676)	(9,535)	141	(866)	(938)
Amortisation	(8)	(1)	(1)	(0)	(8)	(8)	(0)	(1)	(1)
Impairments	(1,826)	(0)		0	(0)		0		
Net Interest	(1,239)	(106)	(96)	10	(1,122)	(1,053)	68	(106)	(103)
Dividend	(1,529)	(127)	(93)	34	(1,402)	(1,312)	90	(75)	(127)
Surplus / (Deficit)	(20,462)	(2,924)	(3,226)	(301)	(18,483)	(19,246)	(762)	(1,035)	(2,649)
NHS Breakeven duty adjs:									
Donated Assets	122	25	13	(12)	225	(119)	(344)	21	13
NCA Impairments	1,826	0		(0)	0		(0)		
Surplus / (Deficit) - Normalised	(18,514)	(2,899)	(3,213)	(313)	(18,258)	(19,365)	(1,106)	(1,014)	(2,636)

Table 2: I&E Analysis (Pre & Post PSF)

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,705)	(26,376)	(26,012)	364
PSF: Finance	6,434	5,683	5,683	-
PSF: A&E	2,757	2,435	965	(1,470)
Post PSF	(18,514)	(18,258)	(19,365)	(1,106)

Table 3: Pre-PSF I&E Performance

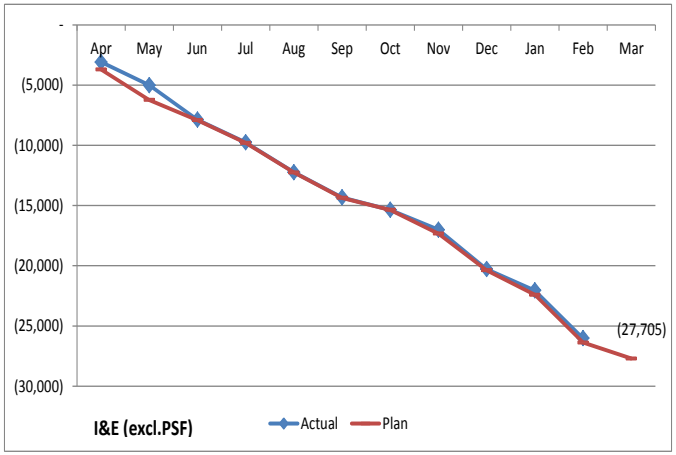
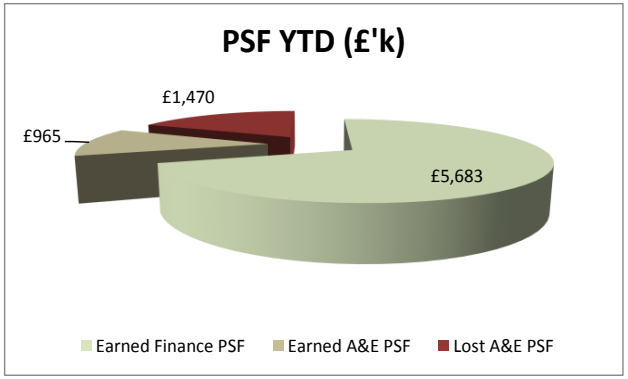


Table 4: PSF YTD Performance



2.1 Clinical Income (YTD)

Month 11 SLA Clinical Income is below plan, with a variance of -£354k (excluding pass-through medicines and devices). The YTD underlying underperformance has improved due to consistently high non-elective activity levels and A&E volumes.

- A&E activity is above plan by 3%, and also shows a casemix variance. An element is subject to coding & counting (£35k/mth), which is included within the challenge line.
- Cost per Case (CPC) is above plan due to Radiotherapy activity (£276k), Critical Care (£485k) and Direct Access volumes (£274k). This is offset by Maternity income now under plan by £172k.
- Day case performance is above plan by 0.7% on activity, and above plan financially (2.7%). Urology is above plan by £279k, with Vascular Surgery +£196k and Paediatrics +£178k. Pain Management (-£120k) and Plastic Surgery (-£120k) are under plan.
- Elective activity is reporting an improved position at 14% below the activity plan, 7.1% financially. The key under-performance remain in General Surgery, T&O and Urology. Planned activity overall is 1.1% below plan, with a financial position of 1.4% below. This is resulting in pressure to achieve RTT trajectories.
- NEL activity is now 2.4% above plan, with continuing positive casemix meaning a 6% favourable variance in income. General Surgery (30%), Cardiology (20%), T&O (9%) and Gen Med (3%) are the most significant areas above income plan. Stroke is the main beneficiary from casemix. XS bed day income offsets 68% of income over-performance on NEL.
- Outpatients are 4% below the activity plan (with Ophthalmology 9% below and Cardiology 63%), and under the income plan by 3.0%.
- OPROCS are 9% above activity plans, 8% above income plans.

Table 5: Key PoD Trend Analysis

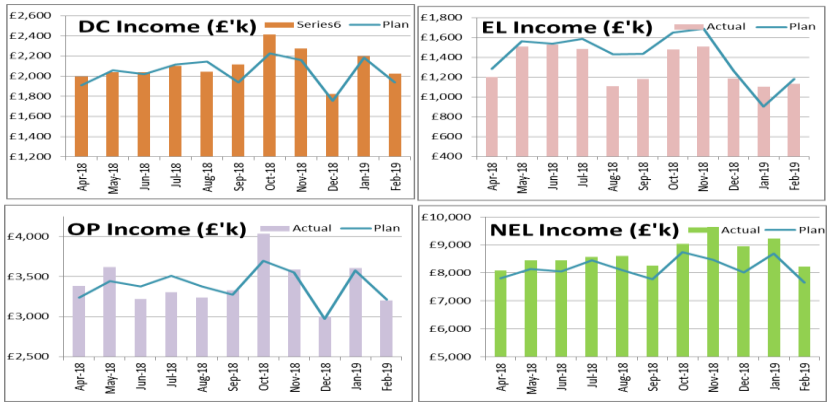


Table 6: SLA Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	117,510	121,453	3,943	15,053	16,088	1,035
Block	-	-	-	10,239	10,310	71
Cost per Case	2,721,562	2,896,199	174,637	34,294	35,288	993
CQUIN	-	-	-	4,587	4,723	136
Day Cases	37,343	37,612	269	22,454	23,071	616
Elective	4,817	4,140	(677)	15,515	14,411	(1,104)
Elective XBDs	1,135	1,343	208	303	360	57
Non-Elective	48,454	49,596	1,141	89,925	95,473	5,549
Non-Elective XBDs	30,222	16,720	(13,502)	7,494	3,707	(3,787)
Outpatient First	52,159	51,343	(816)	9,199	9,046	(154)
Outpatient Follow-up	192,783	184,224	(8,559)	15,362	14,732	(630)
Outpt Procedures	140,054	151,895	11,841	17,189	18,534	1,345
STP related income				3,450	1,350	(2,100)
CIP / Other				2,277	0	(2,277)
sub-total	**3,346,040**	**3,514,525**	**168,485**	**247,342**	**247,093**	**(249)**
Contract Penalties				(195)	(101)	94
Challenges				(1,650)	(1,849)	(199)
Readmissions				(2,928)	(2,928)	0
MRET				(5,425)	(5,425)	0
Fines & Penalties				**(10,198)**	**(10,302)**	**(104)**
Subtotal (excl. Excl Meds & Dev.)	**3,346,040**	**3,514,525**	**168,485**	**237,144**	**236,791**	**(354)**
Excluded Devices	4,202	2,932	(1,270)	1,891	1,339	(552)
Excluded Medicines	7,547	8,997	1,450	22,606	19,130	(3,475)
Total SLA Clinical Inc	**3,357,788**	**3,526,454**	**168,666**	**261,641**	**257,260**	**(4,381)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	1,050	659	(391)
Overseas Visitors	122	123	0
RTA / Personal Injury Income	1,309	1,120	(189)
PSF Funding	8,118	6,648	(1,470)
Total Other Clinical Income	**10,600**	**8,549**	**(2,051)**

2.2 Clinical Income By Commissioner (YTD)

Nene Contract - £1,756k over performance

The Month 11 position on the Nene contract is £1,756k over plan. This is from £1,573 over in Month 11. Month 11 has seen continued strong NEL activity, £265k over plan (incl XS bed day income).

Key impacts include:

- A&E activity above plan and favourable casemix, £129k above income plan 'in month' (£988k YTD). As mentioned previously there is a related Coding & Counting challenge which is c.£35k per month that reduces the Nene total.
- Planned activity for Nene, was above plan for DC and Elective IP in February, in income terms (+£52k). This is due to T&O & General Surgery exceeding plan, and therefore the higher value activity leading to an overall positive casemix.
- Current elective performance is resulting in pressure on RTT trajectories. Capacity is acknowledged as an issue, but options are being developed to address agreed RTT trajectories, including the ring-fencing of beds.
- OP activity is £198k over plan YTD due to Cardiology OPROC activity being transferred from Specialised Commissioners.
- In month OP (incl OPROC) activity for Nene was below plan by £21k in month.
- NEL is the most significant, £5.7m over plan due to favourable casemix and activity. This is partially offset by NEL XS bed day income below plan (£-3.3m).
- Income has been adjusted by £455k as a result of overperformance against the agreed year-end deal with Nene CCG.

Specialised Commissioner - £3,722k under performance

The under performance is attributable to excluded devices (-£578k), and excluded medicines (-£3.0m) which will have equivalent underspends (ie. there is no bottom-line impact). Hep C (-£1.5m) has been impacted by sick and maternity leave, in addition to a change in prescribing protocol and lower national contract prices. The HEP C service has now been resourced and plans are in place to re-establish activity. Rebates from Boots Pharmacy of over £400k and switching to bio-similars account for the remaining under-performance.

STP/Other - £2,400k under performance

£2,100k relates to the STP related income target, now with £1,350k (reported here outside of the Nene contract).

Within the NCA/Central/other plan is £1.8m relating to Productivity CIPs, offset by CQUIN provision and over-performing NCA's.

Table 7: SLA Clinical Income by Commissioner

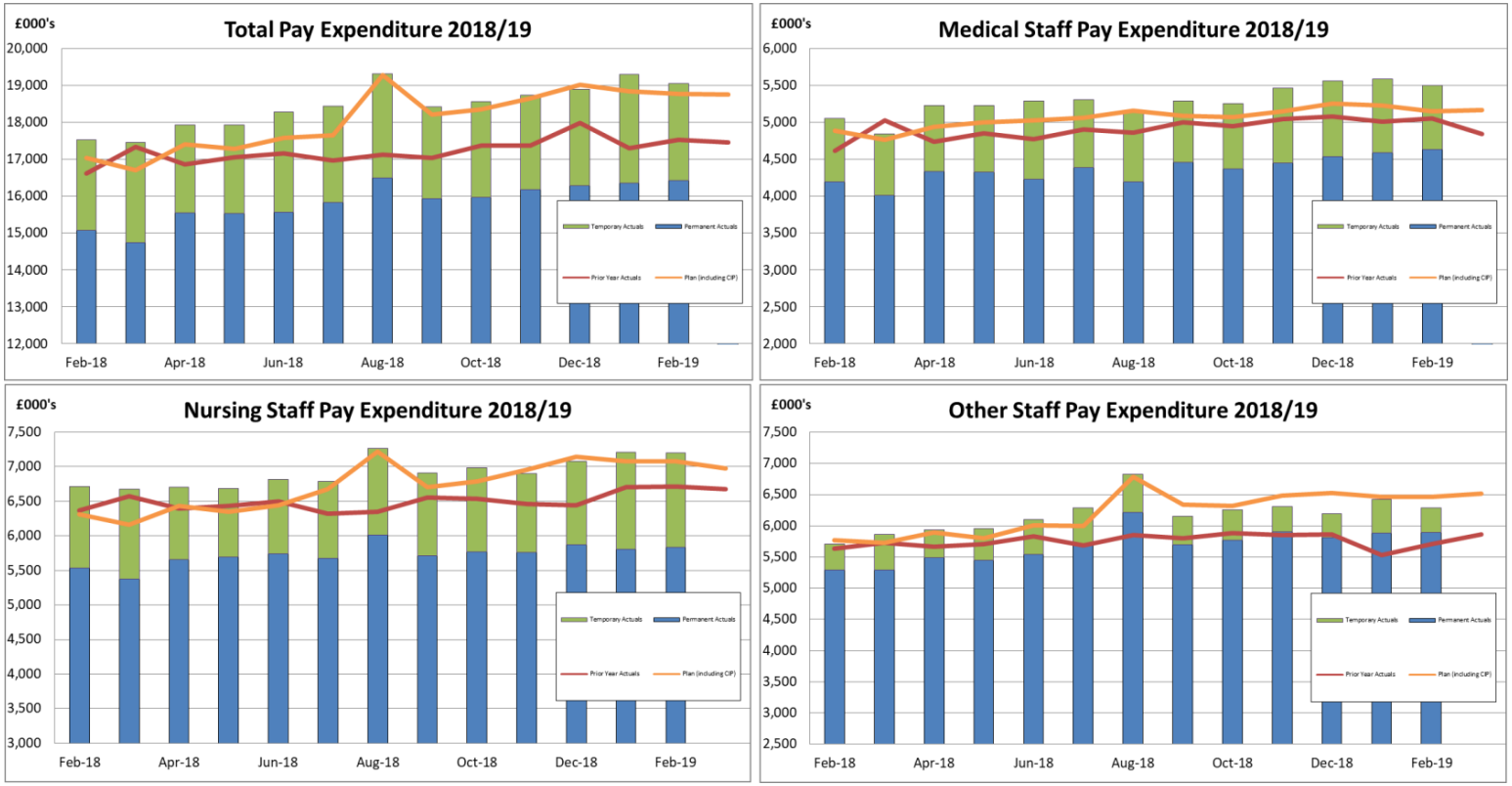
Commissioner	Finance £000's YTD Plan	Actual	Variance
Nene CCG	202,919	204,675	1,756
Corby CCG	2,601	2,692	91
Bedfordshire CCG	665	862	197
East Leicestershire & Rutland CCG	714	708	(7)
Leicester City CCG	47	109	62
West Leicestershire CCG	51	77	26
Milton Keynes CCG	2,771	2,288	(483)
Specialised Commissioning	38,318	34,595	(3,722)
Secondary Dental	6,037	6,137	99
STP related income	3,450	1,350	(2,100)
NCA / Central / Other	4,069	3,768	(300)
Total SLA Income	**261,641**	**257,260**	**(4,381)**

3. Pay Expenditure

In Month 11 Pay Expenditure was £19,060k against a plan of £18,772k; resulting in a £287k adverse variance in month.

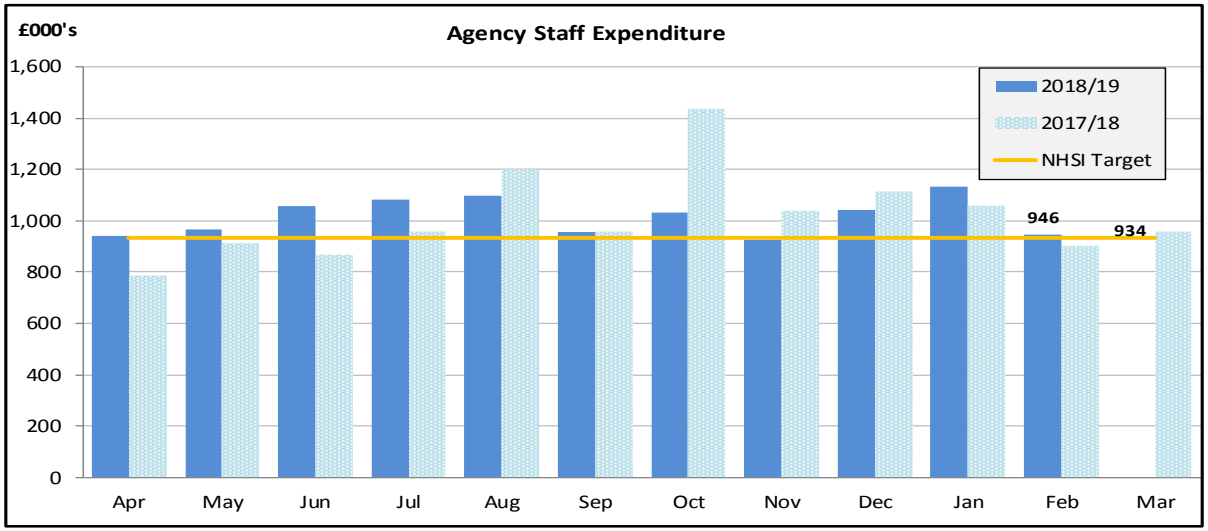
- The plan figure includes a CIP allocation of £146k being the amount of pay underspends across a number of cost centres within Medicine Division and Support Services applied as non-recurrent CIPs in month.
- The breakdown of the £287k adverse variance in month is mainly made up of:-
  - **Medical Staff £348k adverse** – further increase in permanent staff costs in Month 11 due to back-pay of additional PA's in Medicine and Surgical Division's (approx. £70k), and an increase in medical staff ADH payments for both Divisions. Continued overspend due to additional temporary staff being used above budgeted establishment in Medicine (mainly within acute medicine both consultants and juniors - Division £284k overspent in total on medical staff in month) and Women's, Children's and Oncology (mainly within Obs & Gynae and Oncology juniors).
  - **Nursing Staff £126k adverse –** nursing pay remains at a similar level to last month with a continued high expenditure on temporary staff across the Trust with 19% of total nursing pay costs. This is due to continued use of temporary staff to manage winter escalation areas. There are also continued areas of overspend within Medicine Division including A&E and the acute medical wards.

Table 12: Pay Expenditure

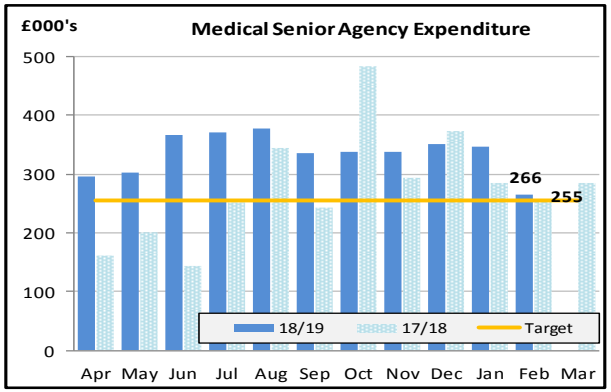


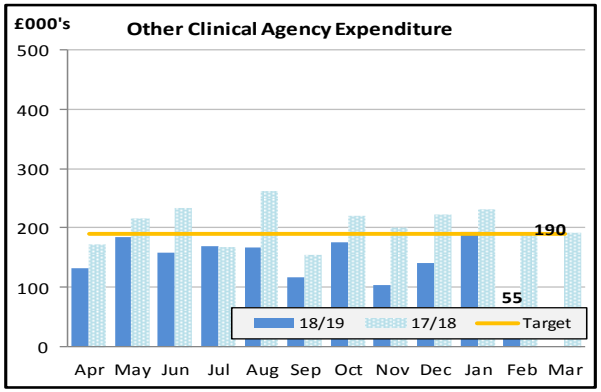
3.1. Pay : Agency Spend

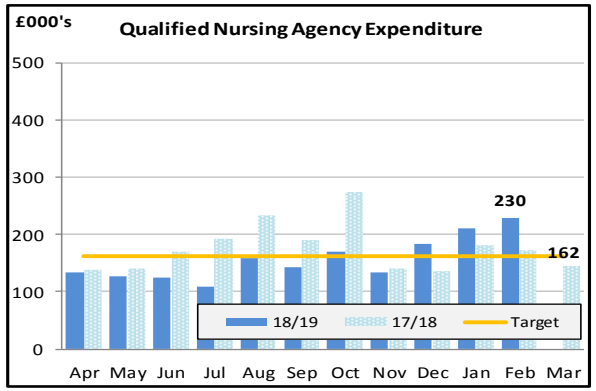
Table 8: Agency Analysis

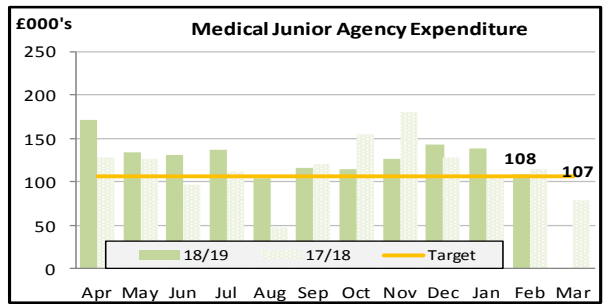


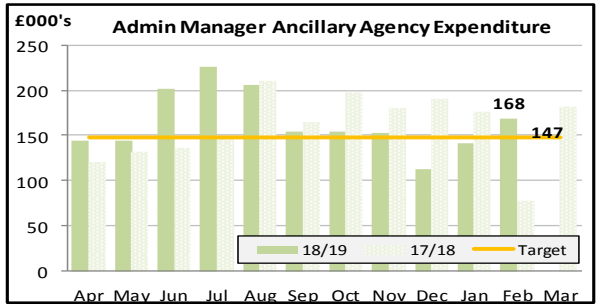
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Agency Senior Medical expenditure has reduced in M11 following a review of accruals. The numbers employed has remained around 14wte for the last few months. A similarly review in agency ODP (Other Clinical).
- With a year-to-date spend of £11.18m after 11 months, the Trust is in line to match the £12.2m spend of 17/18.

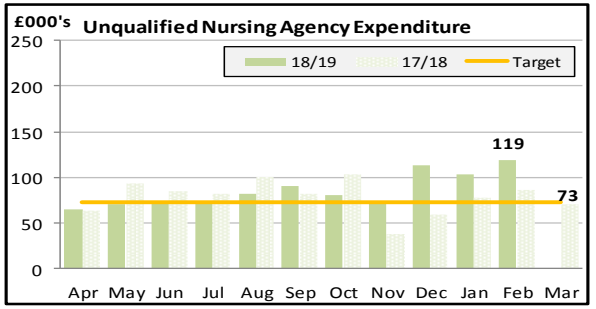












4. Non-Pay

Non Pay expenditure for month 11 is £1.2m favourable year to date (excluding Excluded drugs & devices); £0.3m adverse against plan in month.

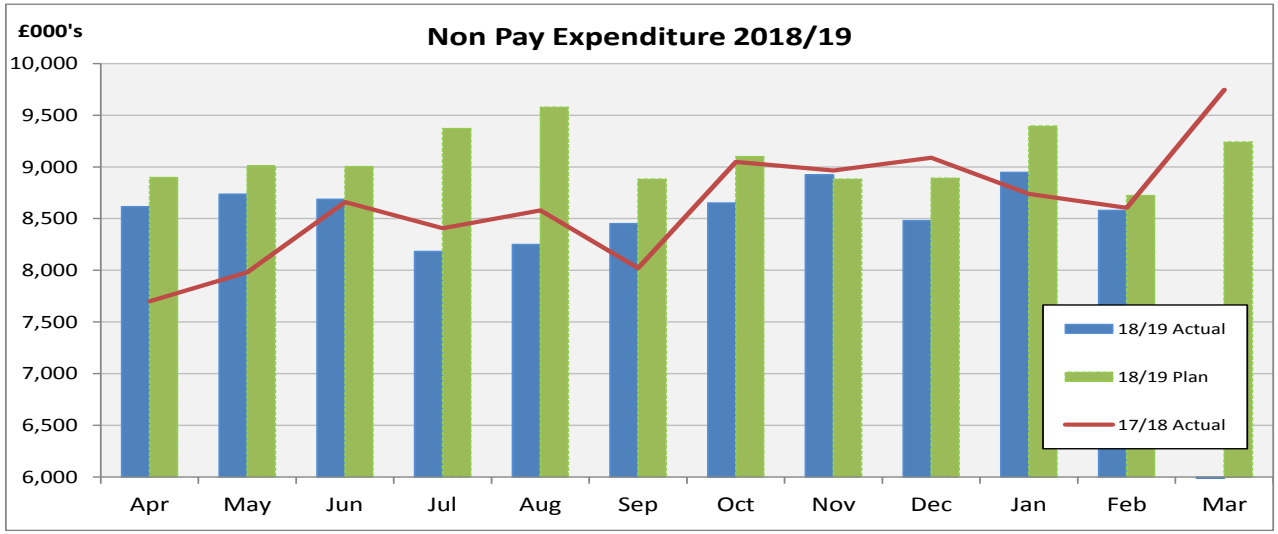
Key adverse variances include:

- £465k Medicines in-month adverse variance is due to reducing the budgets in Oncology by £500k to reflect the efficiency in expenditure across the whole year. This then highlights the existing runrate overspend in medicines which is due to more sales than planned and is matched by an over-performance in 'other income'.
- £143k Building & Engineering, is due to an anticipated £157k increase in the year-to-date Property Services rental charge for Danetre.
- £106k Training, includes £62k of courses paid by Charitable funds and reimbursed to the Trust through Other Income.

Favourable variances offsetting above adverse variances in month include:

- £352k Other Fees, due to the Trust not outsourcing large amounts of elective work compared to plan.
- £90k Computer Maintenance, is following a review and release of £35k of accruals on maintenance and digital dictation.

Table 9: Non-Pay Trend

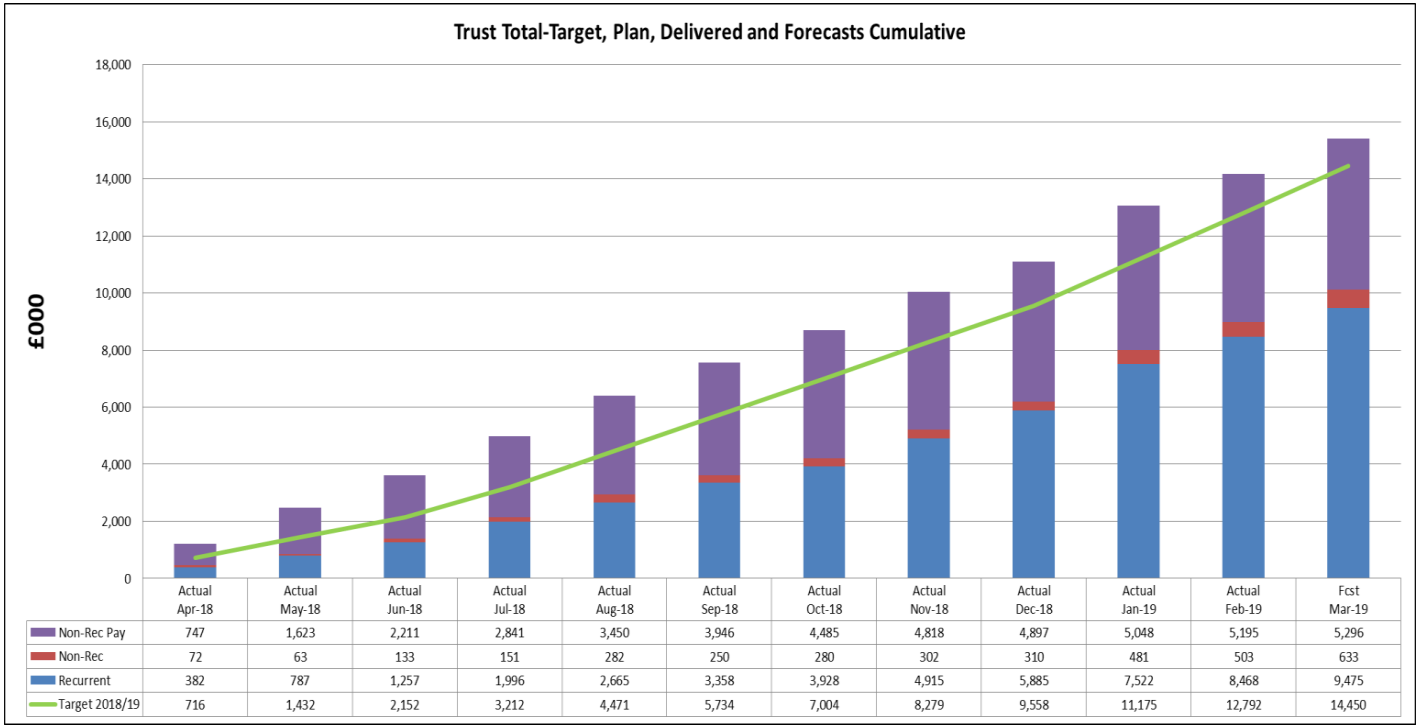


5. CIPs

Table 10: CIPS

Division	Plan	YTD Plan	YTD Rec	YTD Actual N/R	YTD Actual N/R Pay	Actual Total	Variance vs plan
SURGICAL DIVISION	3,894	3,447	2,099	121	1,067	3,287	-160
MEDICAL DIVISION	3,815	3,377	2,216	284	1,253	3,752	375
WCOH DIVISION	2,205	1,952	1,710	62	1,253	3,025	1,072
CSS DIVISION	1,734	1,535	1,240	39	663	1,942	407
HOSPITAL SUPPORT	1,118	989	159	70	959	1,188	199
FACILITIES	1,153	1,021	1,044	12	0	1,056	35
Expenditure Other (Held Centra	532	471	0	0	0	0	-471
Trust Total	**14,450**	**12,792**	**8,468**	**588**	**5,195**	**14,250**	**1,458**

Division	Plan	LTF Rec	LTF N/R	Actual N/R Pay	LTF Total	RAG Rated	Variance vs Risk Adjusted
SURGICAL DIVISION	3,894	2,464	135	1,067	3,666	3,608	-285
MEDICAL DIVISION	3,815	2,403	289	1,353	4,045	3,997	183
WCOH DIVISION	2,205	1,916	79	1,253	3,248	3,237	1,031
CSS DIVISION	1,734	1,382	42	663	2,087	2,071	337
HOSPITAL SUPPORT	1,118	173	70	959	1,203	1,203	85
FACILITIES	1,153	1,136	19	0	1,155	1,151	-3
Expenditure Other (Helc	532	0	0	0	0	0	-532
Trust Total	**14,450**	**9,475**	**633**	**5,296**	**15,404**	**15,266**	**816**



	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Actual Jan-19	Actual Feb-19	Fcst Mar-19
Non-Rec Pay	747	1,623	2,211	2,841	3,450	3,946	4,485	4,818	4,897	5,048	5,195	5,296
Non-Rec	72	63	133	151	282	250	280	302	310	481	503	633
Recurrent	382	787	1,257	1,996	2,665	3,358	3,928	4,915	5,885	7,522	8,468	9,475
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

The 2018/19 risk adjusted LTF is currently £15.266m against a target of £14.450m. This represents a positive variance of £816k.

Of the £15.404m forecasted delivery £5.929m (38%) of schemes are non-recurrent. This is predominantly £5.296m vacancies and pay underspend.

Cumulative delivery at month 11 totalled £14.250m against a year to date plan of £12.792m. This represents a favourable variance to plan of £1.458m, which is mainly due to £5.195m Non-Recurrent pay general underspend across all divisions.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M11 movements include the capital additions of £1.5m.
- Depreciation - £866k is net of £74k depreciation saving.

Current assets

• Inventories - £58k. Decreases in Pharmacy (£72k), Heart Centre (£74k) & Supplies Trading (£22k) stockholdings, are offset by an increase in Pathology (£107k).

•Trade & Other Receivables – £1,700k made up of : Decreases in NHS receivables (£591k), Trade receivables (£58k) & Prepayments , mainly phasing of CNST, (£1,162k). Increases in Income accruals (£37k), VAT reclaim (£28k), Salary Sacrifice Schemes (£39k) & Salary Overpayments (£21k).

•Cash – Increase of £1,849k.

Current Liabilities

• Trade & Other Payables - £2,195k made up of: Increases in Trade Payables & Other Payables (£941k), Capital Payables (£774k), Accruals (£588k), Receipts in Advance (£72k) & PDC Dividend (£94k). Decreases in NHS Payables (£176k), Tax, NI & Pension Creditor (£98k).

•Finance Lease Payable - Nye Bevan - £39k.

•Short Term Loans - £134k made up of decrease in Revenue Loan interest payable (£101k) & Capital Loan interest payables (£33k).

•Provisions - £82k made up of – Release of HR Compensation (£12k) & Legal Fees (£31k), 17/18 Agreement of NHS Balance s Estimates (£39k) of which £31k has bee n invoiced.

Non Current Liabilities

• Finance Lease Payable - £115k. Nye Bevan £105k, Car Park £10k.

• Drawdown of Revenue Loan - £2,698k.

• Repayment of Capital Loan - £537k.

Financed By

- I & E Account - £3,226k deficit in month.

Table 11: SOFP

TRUST SUMMARY BALANCE SHEET
MONTH 11 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	153,637	0
IN YEAR REVALUATIONS	0	510	510	0	(1,282)	(1,282)
IN YEAR MOVEMENTS	0	16,467	18,002	1,535	20,272	20,272
LESS DEPRECIATION	0	(8,669)	(9,535)	(866)	(10,402)	(10,402)
NET BOOK VALUE	153,637	161,943	162,612	669	162,225	8,588
CURRENT ASSETS						
INVENTORIES	6,272	5,638	5,580	(58)	6,372	100
TRADE & OTHER RECEIVABLES	16,479	22,391	20,691	(1,700)	17,068	589
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	2,755	4,604	1,849	1,500	(47)
TOTAL CURRENT ASSETS	24,298	30,784	30,875	91	24,940	642
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	24,781	26,976	2,195	19,499	(3,285)
FINANCE LEASE PAYABLE under 1 year	130	1,143	1,104	(39)	1,105	975
SHORT TERM LOANS	20,748	21,089	20,955	(134)	40,909	20,161
STAFF BENEFITS ACCRUAL	765	765	765	0	750	(15)
PROVISIONS under 1 year	2,744	1,418	1,336	(82)	1,200	(1,544)
TOTAL CURRENT LIABILITIES	47,171	49,196	51,136	1,940	63,463	16,292
NET CURRENT ASSETS / (LIABILITIES)	(22,873)	(18,412)	(20,261)	(1,849)	(38,523)	(15,650)
TOTAL ASSETS LESS CURRENT LIABILITIES	130,764	143,531	142,351	(1,180)	123,702	(7,063)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	10,899	10,784	(115)	10,772	9,779
LOANS over 1 year	52,394	70,637	72,798	2,161	55,591	3,197
PROVISIONS over 1 year	1,001	1,001	1,001	0	300	(701)
NON CURRENT LIABILITIES	54,388	82,537	84,583	2,046	66,663	12,275
TOTAL ASSETS EMPLOYED	76,376	60,994	57,768	(3,226)	57,039	(19,338)
FINANCED BY						
PDC CAPITAL	120,251	120,378	120,378	0	120,538	287
REVALUATION RESERVE	31,782	32,035	32,035	0	31,276	(506)
I & E ACCOUNT	(75,657)	(91,419)	(94,645)	(3,226)	(94,775)	(19,118)
FINANCING TOTAL	76,376	60,994	57,768	(3,226)	57,039	(19,338)

Table 12: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2018/19 £000s	ACTUAL 18/19 APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	FORECAST 18/19 MAR £000s	FORECAST 19/20 APR £000s	MAY £000s	JUN £000s
RECEIPTS																
SLA Base Payments	275,388	22,144	23,385	22,762	22,762	22,762	22,762	23,003	23,164	23,174	23,181	23,145	23,145	23,145	26,107	24,626
Provider Sustainability Funding (PSF)	5,797	0	0	0	2,580	0	1,379	0	0	1,838	0	0	0	0	1,930	2,253
Marginal Rate Emergency Tariff (MRET)	0	0	0	0	0	0	0	0	0	0	0	0	0	1,480	0	0
SLA Performance (relating to 17/18 activity)	-1,871	479	660	0	0	-112	-2,770	21	0	0	-232	11	70	0	0	0
SLA Performance (relating to 18/19 activity)	2,389	0	0	0	0	0	0	0	0	0	0	0	2,389	0	0	0
Health Education Payments	10,001	795	795	795	750	812	27	1,891	779	779	892	779	907	765	765	765
Other NHS Income	15,130	751	564	958	1,012	2,034	1,504	1,662	1,530	1,177	1,061	1,368	1,508	1,000	1,000	1,000
PP / Other (Specific > £250k)	5,254	0	970	316	531	428	708	325	505	349	403	345	373	325	325	325
PP / Other	12,380	1,194	908	1,057	1,001	1,251	601	1,112	1,304	775	1,119	1,057	1,000	1,200	1,200	1,200
Salix Capital Loan	515	0	0	0	0	0	0	0	0	0	0	0	515	0	0	0
PDC - Capital	287	0	0	0	0	0	0	0	0	127	0	0	160	0	0	0
Uncommitted Revenue Loan - deficit funding	18,514	4,439	3,143	-1,052	1,276	232	0	2,595	709	2,458	1,561	1,626	1,527	0	0	0
Uncommitted Revenue Loan - PSF funding	8,869	0	0	1,379	613	613	612	919	919	919	1,072	1,072	751	844	844	844
Interest Receivable	90	6	5	7	7	7	11	8	8	8	8	9	8	7	7	7
TOTAL RECEIPTS	**352,742**	**29,808**	**30,430**	**26,222**	**30,532**	**28,025**	**24,834**	**31,535**	**28,918**	**31,606**	**29,065**	**29,414**	**32,353**	**28,766**	**32,178**	**31,020**
PAYMENTS																
Salaries and wages	208,903	16,698	16,586	16,804	16,701	18,098	17,653	17,163	17,679	17,627	17,972	18,042	17,879	17,940	18,220	17,940
Trade Creditors	98,792	4,928	9,279	7,229	7,688	9,519	7,586	9,738	8,085	7,376	8,873	7,264	11,228	8,178	9,961	9,081
NHS Creditors	27,623	1,999	2,648	2,370	2,586	2,314	2,946	2,431	2,284	2,578	2,327	1,242	1,900	2,382	2,382	2,382
Capital Expenditure	8,791	1,493	414	1,004	459	739	310	520	785	572	478	270	1,748	126	723	723
PDC Dividend	900	0	0	0	0	0	200	0	0	0	0	0	700	0	0	0
Repayment of Revenue Loan - PSF funding	4,687	0	0	0	0	0	0	1,379	0	0	1,838	0	1,470	0	844	844
Repayment of Loans (Principal & Interest)	2,988	8	11	22	152	775	487	42	35	24	168	778	486	58	47	49
Repayment of Salix loan	62	29	0	0	0	0	3	29	0	0	0	0	0	81	0	0
TOTAL PAYMENTS	**352,746**	**25,156**	**28,938**	**27,429**	**27,585**	**31,445**	**29,184**	**31,302**	**28,868**	**28,177**	**31,656**	**27,595**	**35,412**	**28,765**	**32,177**	**31,020**
Actual month balance	-5	4,652	1,492	-1,207	2,947	-3,420	-4,350	233	50	3,429	-2,591	1,818	-3,059	0	0	0
Cash in transit & Cash in hand adjustment	-42	20	-1	-17	27	-32	18	-16	14	-10	-32	31	-45	0	0	0
Balance brought forward	1,547	1,547	6,219	7,710	6,486	9,460	6,009	1,677	1,894	1,958	5,377	2,755	4,604	1,500	1,500	1,500
Balance carried forward	**1,500**	**6,219**	**7,710**	**6,486**	**9,460**	**6,009**	**1,677**	**1,894**	**1,958**	**5,377**	**2,755**	**4,604**	**1,500**	**1,500**	**1,500**	**1,500**

- Closing cash balance at the end of February was £4,604k, which was £2,604k more than forecast, mainly due to a lower level of Trade creditor payments than anticipated.
- All SLA base payments for February were paid on time.
- £70k of 17/18 over-performance invoices issued to Milton Keynes CCG remain outstanding. Whilst this is forecast to be received in March, the Trust is currently in an under-performance position with the organisation which may delay payment into 19/20. The 18/19 settlement agreement invoices issued to Nene & Corby CCGs were paid on 1st March.
- Salix Loan Funding documentation is being finalised for a new non-interest bearing loan to be drawn down in March. PDC Capital has also been approved for 2 new schemes . £160k has been received in March.
- Uncommitted Revenue Loan of £2,698k has been drawn down in February. Further draw down of £808k has been approved in March. This is made up of new funding of £2,278k, less repayment of funding previously draw down in lieu of Qtr 3 & 4 PSF for A & E 4 hour wait targets.
- Interest payments on DHSC Revenue Loans of £194k were made in February, along with interest & principal repayments on Capital Loans (£584k). Further Loan interest & repayment of Capital Loan principal will be made in March.
- PDC dividend is due to be paid to DHSC in March, based on data submitted to NHSI at Month 9.
- Loan drawdown request for April 19 will be based on funding in lieu of PSF & FRF for Month 1 only (£844k).
- Marginal Rate Emergency Tariff (MRET) for Qtr 1 is due to be received in April (£1,480k).

Table 13: Cash forecast

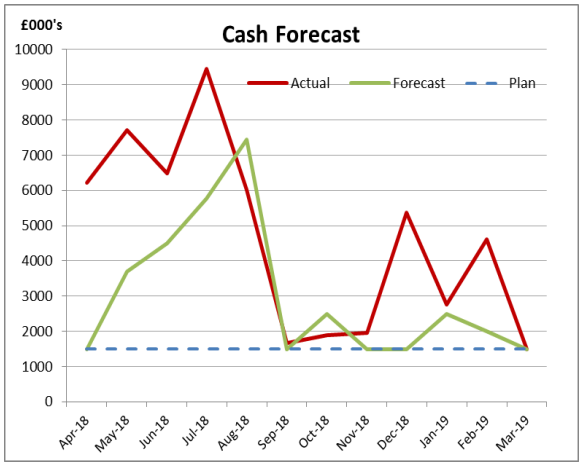


Table 14: Capital

Capital Scheme	Plan 2018/19 £000's	M11 Plan £000's	M11 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total M11 + Committed £000's	Uncommitted £000's	Plan O/S %
Medical Equipment - MESC Block	710	624	616	(9)	87%	707	(3)	0%
Medical Equipment - CF Specific Forecast	74	74	74	0	100%	74	0	0%
EAB Talbot Butler - CF Specific	343	329	329	(0)	96%	343	(0)	0%
Dexa Scanner - Enabling Costs (Lease)	0	0	0	0	0%	0	0	0%
CT Simulator Suite	37	37	37	0	101%	37	0	-1%
Information Technology - CaMIS	348	357	303	(54)	87%	306	(42)	12%
Information Technology	2,997	1,933	1,926	(7)	64%	2,391	**(607)**	20%
Estates - Backlog	1,720	1,394	1,380	(15)	80%	1,699	**(22)**	1%
Estates - Statutory	227	151	149	(3)	65%	189	**(38)**	17%
Estates - Non Maintenance	493	302	323	21	66%	430	**(64)**	13%
Estates - Ward Refurbishment	461	312	268	(44)	58%	419	**(42)**	9%
Nye Bevan - Setting Up Costs	328	325	328	3	100%	328	(0)	0%
Nye Bevan Assessment Unit (Finance Lease)	11,424	11,424	11,424	0	100%	11,424	(0)	0%
Inventory / Ledger Upgrade	32	32	28	(4)	89%	29	(3)	9%
MRI 1 Enabling Costs	212	217	210	(7)	99%	212	(0)	0%
Endoscopy Washers	251	0	0	0	0%	251	0	0%
Other - inc. Gamma Camera 2 & Breast Screening Mobile + Static	115	80	80	(0)	70%	99	(16)	14%
SALIX	515	557	535	(22)	104%	561	46	9%
Total - Capital Plan	**20,287**	**18,148**	**18,008**	**(139)**	**89%**	**19,497**	**(790)**	**4%**
Less Charitable Fund Donations	-417	-403	-403	0	97%	(417)	0	0%
Less NBV of Disposals	0	0	0	0	0%	0	0	0%
Total - CRL	**19,871**	**17,745**	**17,606**	**(139)**	**89%**	**19,080**	**(790)**	**4%**

Funding Resources		
Internally Generated Depreciation		10,402
Finance Lease - Assessment Unit		11,424
Salix		515
Public WIFI		127
Cancer Transformation Programme		148
Pharmacy Define		12
Capital Element - Finance Lease (Car Park Decking)	-	133
Capital Loan - Repayment	-	1,835
Capital Element - Finance Lease (Assessment Unit)	-	727
Other Loans - Repayment (SALIX)	-	62
Total - Available CRL Resource		**19,871**
Uncommitted Plan		**0**

Receivables and Payables

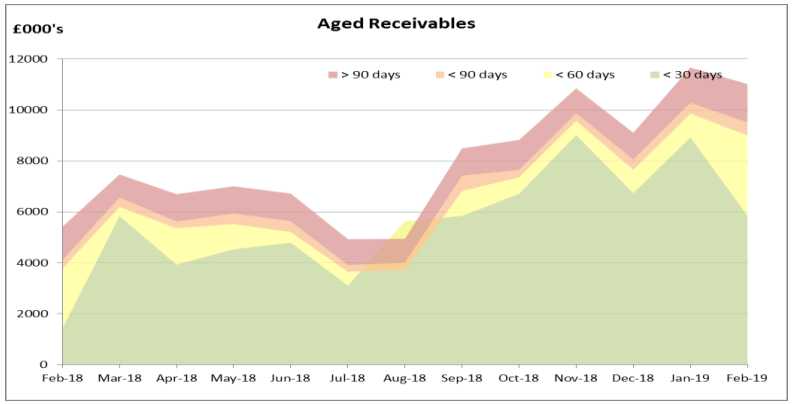
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £3,431k relates to PSF funding (Finance element only) for Months 7-11.
- NHS 31 to 60 days includes settlement agreement invoice raised to Nene CCG in January £2,384k. Payment was received on 1st March.
- NHS over 90 day debt include s University Hospitals of Leicester NHS Trust £30k, Kettering General Hospital NHS Foundation Trust £342k, NHS Property Services £40K, Milton Keynes CCG £71k and £340k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £413k ,of which £95k are paying in instalments & a further £330k have been referred to debt collection & private patients accounts of £65k.

Table 15: Receivables and Payables

Narrative	Total at February £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	1,619	528	276	119	696
Receivables NHS	9,402	5,321	2,880	393	808
Total Receivables	**11,022**	**5,849**	**3,157**	**512**	**1,504**
Payables Non NHS	(4,967)	(4,925)	(42)	0	0
Payables NHS	(1,280)	(1,280)	0	0	0
Total Payables	**(6,247)**	**(6,205)**	**(42)**	**0**	**0**

Narrative	Total at January £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	1,678	639	268	119	651
Receivables NHS	9,994	8,291	666	305	732
Total Receivables	**11,671**	**8,930**	**934**	**424**	**1,383**
Payables Non NHS	(3,268)	(3,268)	0	0	0
Payables NHS	(1,456)	(1,456)	0	0	0
Total Payables	**(4,724)**	**(4,724)**	**0**	**0**	**0**

Table 16: Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in February 2019

Table 17: BPPC

Better Payment Compliance Code - 2018/19

Narrative	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Cumulative 2018/19
NHS Creditors					
No.of Bills Paid Within Target	188	190	174	171	1,809
No.of Bills Paid Within Period	189	190	174	171	1,812
Percentage Paid Within Target	**99.47%**	**100.00%**	**100.00%**	**100.00%**	**99.83%**
Value of Bills Paid Within Target (£000's)	1,861	1,867	1,787	712	20,293
Value of Bills Paid Within Period (£000's)	1,861	1,867	1,787	712	20,308
Percentage Paid Within Target	**100%**	**100.00%**	**100.00%**	**100.00%**	**99.93%**
Non NHS Creditors					
No.of Bills Paid Within Target	7,097	6,351	6,614	6,099	67,071
No.of Bills Paid Within Period	7,127	6,363	6,639	6,105	67,345
Percentage Paid Within Target	**99.58%**	**99.81%**	**99.62%**	**99.90%**	**99.59%**
Value of Bills Paid Within Target (£000's)	9,217	8,288	9,923	8,061	97,433
Value of Bills Paid Within Period (£000's)	9,253	8,615	9,941	8,069	98,059
Percentage Paid Within Target	**99.61%**	**96.20%**	**99.82%**	**99.90%**	**99.36%**
Total					
No.of Bills Paid Within Target	7,285	6,541	6,788	6,270	68,880
No.of Bills Paid Within Period	7,316	6,553	6,813	6,276	69,157
Percentage Paid Within Target	**99.58%**	**99.82%**	**99.63%**	**99.90%**	**99.60%**
Value of Bills Paid Within Target (£000's)	11,078	10,155	11,710	8,772	117,726
Value of Bills Paid Within Period (£000's)	11,114	10,483	11,728	8,781	118,367
Percentage Paid Within Target	**99.67%**	**96.88%**	**99.84%**	**99.91%**	**99.46%**

7. Single Oversight Framework (SOF)

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

Table 18: SOF

Criteria	Score	Weight	Weighted Score
Capital Service capacity (times)	4	20.00%	0.80
Liquidity (days)	4	20.00%	0.80
I&E Margin	4	20.00%	0.80
Distance From Plan	2	20.00%	0.40
Agency spend (distance from cap)	2	20.00%	0.40
Overall Score			3.2

Finance and use of resources metrics

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

Note: brackets indicate negative numbers

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

8. Risks

Table 19

Risk	Description	Estimated Gross Impact £'m	RAG	Mitigations	Mitigated Impact £'m	Exec Lead
Revenue Risks						
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.	1.8		A&E operational trajectory unlikely to be recovered but the Trust may qualify for additional (bonus) PSF funding but is yet to be confirmed.	1.8	CH/LT
Winter pressures	Operational pressures as a result of patient acuity may require additional temporary staff than budgeted and lead to increased pay spend.	0.5		Effective implementation pf the winter plan; Management of agency spend through the Changing Care steering group.	0.2	CH/LT
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 Changing Care group. Regular meetings to challenge Divisions to find recurrent CIP schemes.	4.0	PB
Capital	Slippages in the Capital plan may mean that the Trust is unable to meet its allocated CRL (capital resource limit)	2.5		The Capital Committee is reviewing the IT and Estates plans to ensure that there are appropriate mitigations in place in order that the capital plan is met by the end of the year	0.1	PB

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 March 2019**

Title of the Report	**Operational Performance Report**
Agenda item	**14**
Presenter of Report	Mr C Holland (Acting COO)
Author(s) of Report	Mr C Holland (Acting COO) & Mrs D Needham (CEO)
Purpose	For information / discussion / assurance

Executive summary

The paper is presented to provide information to the board to form a discussion relating to national performance targets.

Each of the indicators on the integrated scorecard (Appendix 1) which are red rated have an accompanying exception report (Appendix 2) and these have been discussed in detail at Finance, Investment & Performance committee.

Where information is available benchmarking will be included.

Within this month's report, the main areas of focus for discussion are:

- Urgent care
- RTT
- Cancer

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks 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. Discuss the areas outlined as exceptions within the report

Operational Performance Report – March 2019

1. Introduction

The operational performance report is presented to provide information to the board to form discussion and actions relating to national performance targets.

The integrated scorecard can be found in appendix one. Areas rated as red have an accompanying exception report which has been provided by the manager and clinician responsible for delivery, the exceptions can be found in appendix two.

All exception reports are discussed at the subcommittees of the board, for operational performance this is Finance, Investment & Performance Committee (FIPC)

The main areas of focus in this report relating to national performance include Referral to Treatment Time (RTT), Cancer 62 days & the urgent care four hour standard.

2. Summary performance

The performance trajectories below were agreed as part of the operational plan for 2018/19 with NHSI. After the changeover of PAS a new trajectory for RTT was agreed.

Performance Trajectories 2018/19

A&E

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned performance	88.0%	86.3%	89.0%	89.0%	90.1%	90.3%	90.3%	90.3%	90.3%	90.3%	90.3%	95.0%
Actual performance	88.9%	86.5%	93.8%	92.3%	91.5%	88.9%	86.7%	85.9%	83.3%			

Cancer

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned performance	80.6%	85.4%	86.3%	85.8%	88.3%	89.1%	89.6%	85.8%	86.4%	87.1%	86.9%	88.5%
Actual performance	82.0%	81.0%	73.3%	78.5%	80.0%	81.5%	85.4%	76.0%				

RTT

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned performance	87.9%	88.6%	89.2%	89.8%	90.0%	90.8%	91.5%	92.1%	92.2%	92.6%	93.1%	93.3%
Actual performance	88.7%	89.0%	84.0%	81.0%	79.9%	80.3%	81.5%	82.1%				

Validated RTT results for December 2018 will not be available until 18th January 2018

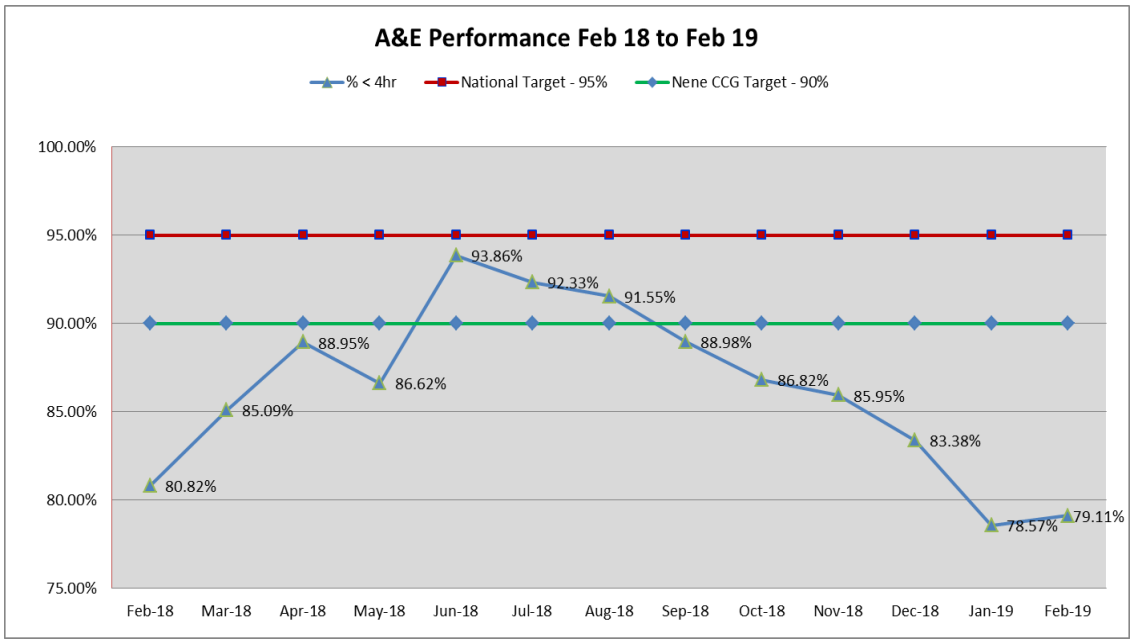
3. Key areas of performance

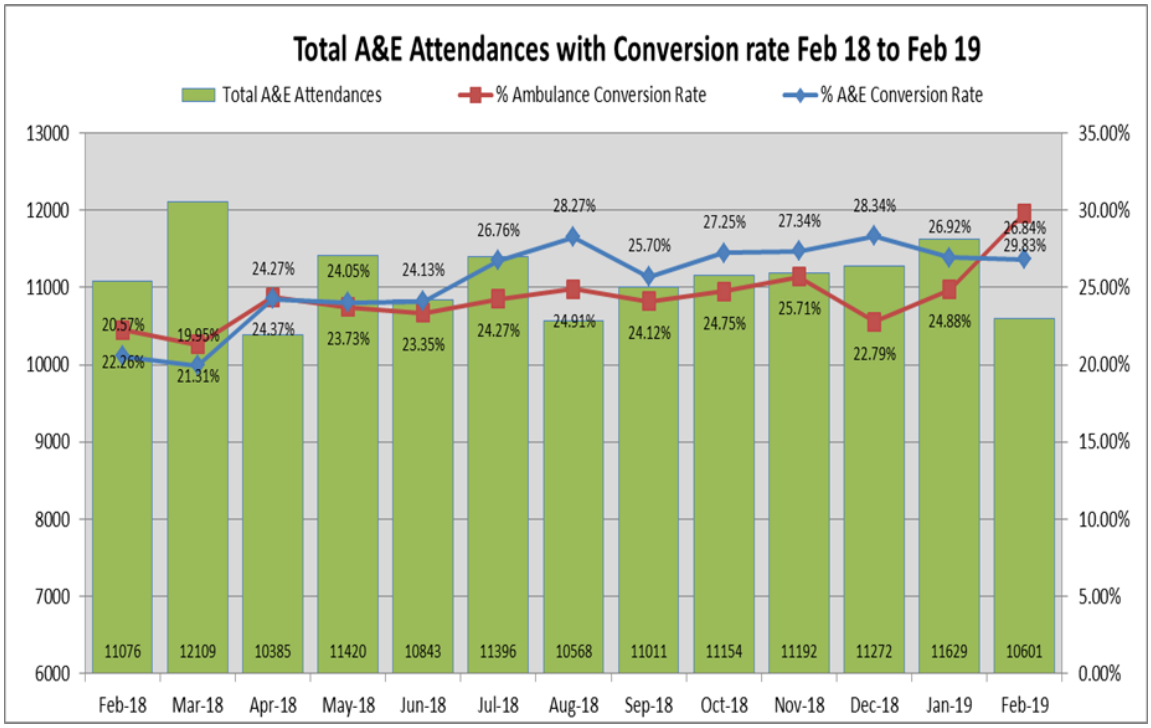
3.1 Urgent care - A&E & Delayed Transfer of care (DTOC)

The Trust achieved 79.11% against the 4 hour target for February 2019; an increase in performance on previous month of 0.54%. The trajectory target of 90.3% was not achieved by 11.19%. However this was based on a projection of 9,870 pts attending whereby we saw 10,601 pts (+731).

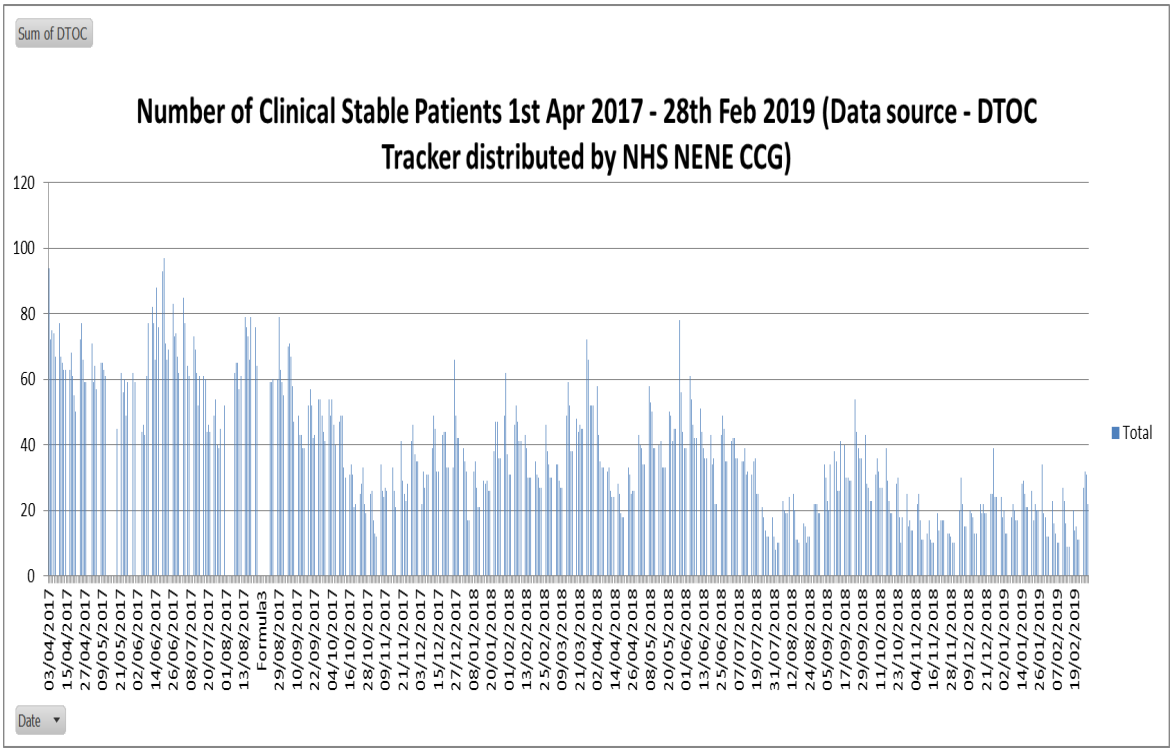
YTD is 86.7% compared to 2018 YTD of 85.7%.

- Attendance into ED was 10,601 patients, which is a decrease against the previous month by 1,028 pts. Compared to the same month in 2017 (graph 2) this is a decrease of 475 patients.
- Admission conversions have remained around the same 26.84% on the previous month.
- Acuity for the Trust remains at baseline however has increased on the Assessment areas and is slightly above that predicted.

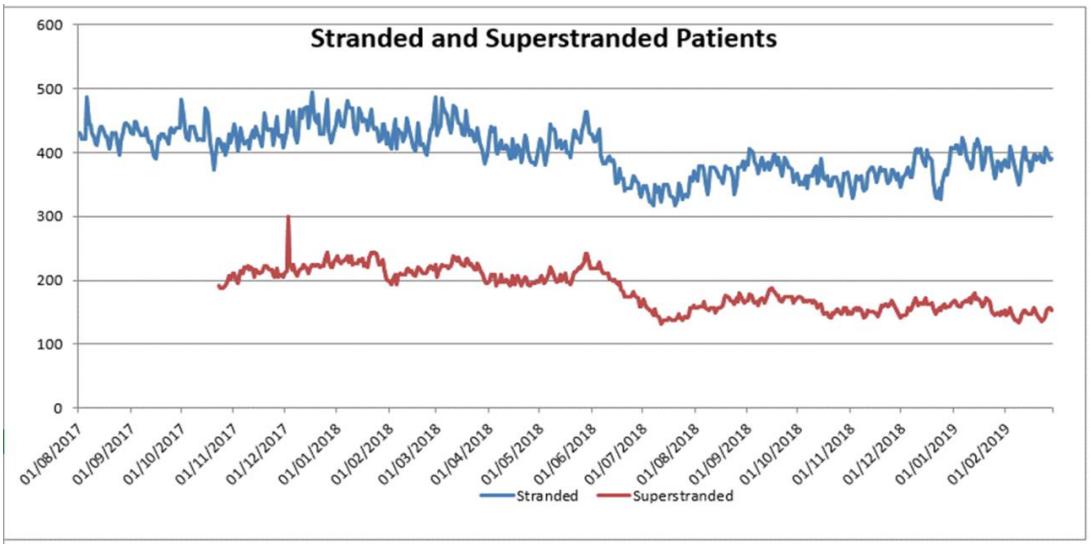




Throughout the first couple of months of 2019, the number of delayed transfers of care remained low but the total number of patients who required care on discharge remained static. The main issue being the complexity of the discharge plans for many patients, again this is a good indicator of acuity. The trust remains nervous that partners may begin to switch off winter schemes at the end of March which will see an increase in DTOC and Stranded figures. Assurances are being sought from all partners



Whilst DTOC remained low, the number of stranded (7 days plus) and super stranded (21 days plus) increased slightly in January but have since started to decrease from Febraury 2019. This month saw an increase in the number of Superstranded Patients >21 days LOS. As of Thursday 28th Feb there were 157 patients with a LOS>21days against a national target set by NHSI for NGH of 154



Actions being taken:

- Fixing flow programme revised to include two major work streams – Admission & Discharge with a steering group led by the CEO.
- Increased pathway 3 capacity in nursing homes has been procured which for NGH equates to 36 extra beds across the local community (delirium beds x6, dementia beds x4, Reablement beds x 15, High Level Residential beds, non-weight bearing beds)
- Length of stay reduction programme in the 3 community hospitals to enable rehab to be undertaken on the most appropriate place, plus increased flexibility on patients categories they will accept such as non-weight bearing patients and #NOF
- Additional beds open at NGH (Benham winter ward 28 beds)
- Full rapid roll out of SAFER & ibox
- New medical model implemented in Nye Bevan, A&E and ACC.
- Embedding three times a day board rounds on the Nye Bevan at 12 noon, 3pm and 7pm to increase churn and flow throughout the day.
- Focus on ensuring patients are moved to correct bed base on admission e.g. acute NOFs are not outliered with Abington required to identify patients to be stepped out of Abington to ensure acute patients to correct bed base
- Movement of staffing to accommodate late attendees to A&E (Capacity/Demand)
- Rehab community nurse to work on NGH site 3 times a week to 'pull' Orthopaedic patients into rehab facilities and home therapy
- Discharge Coordinators are supporting the wards by completing the PDNA's for the ward teams to improve the time between admissions to PDNA with the plan to reduce the time from admission to PDNA.
- Contracts have been signed for AGE-UK to support our elderly frail patients with their discharge from both A&E and the Discharge Suite on a trial 16 week starting in April
- Contract agreed for the local borough council to provide a homeless officer to support discharging patients who are ether homeless or cannot return to their homes. This has been successfully trialled in the north of the county and will now be rolled out here.
- A multiagency admission avoidance event is planned for the end of March to look at the patients attending ED on foot and by ambulance to analyses why they attend and what alternatives could have been provided
- An audit is underway of the GP expect patients presenting to ED with the CCG undertaking full review of every letter accompanying patient.

Risks

Infection - At the time of writing the number of patients who have been admitted to NGH and diagnosed with Flu has been minimal compared to the same period last year. Other local trusts have also had wards closed due to norovirus of which we have not had norovirus affect the operational running of the hospital for several years. We are seeing an increased footfall of adults and children with Respiratory Illnesses.

Middle Grade Doctor staffing in ED continues to be a risk with 10wte unfilled resulting in increased waits to be seen and increased conversion rates as patients are admitted by less experienced medical staff. Actions being undertaken are increased recruitment to fill the vacancies and to appoint Clinical fellows into these posts. Locums are being used to support the rota and SHO grades are being increased to provide more junior hands on support.

A longer term risk is the removal of additional pathway capacity in the community after March 2019. This is currently being discussed as part of the annual planning across the system.

Winter pressures

Whilst the performance has deteriorated compared to the same period last year, the flow within the hospital "feels better". Staff morale is generally good and the main focus continues to be on keeping our patients safe at all times. The daily safety huddle is in place 7 days a week, this gives our ward sisters and department heads the opportunity to share & learn but most importantly discuss and action together any issues.

However as we come to the end of a long winter period, staff in general are tired and the pressure has been relentless and we are concerned how we maintain our staff resilience despite a huge array of support in place

3.2 RTT

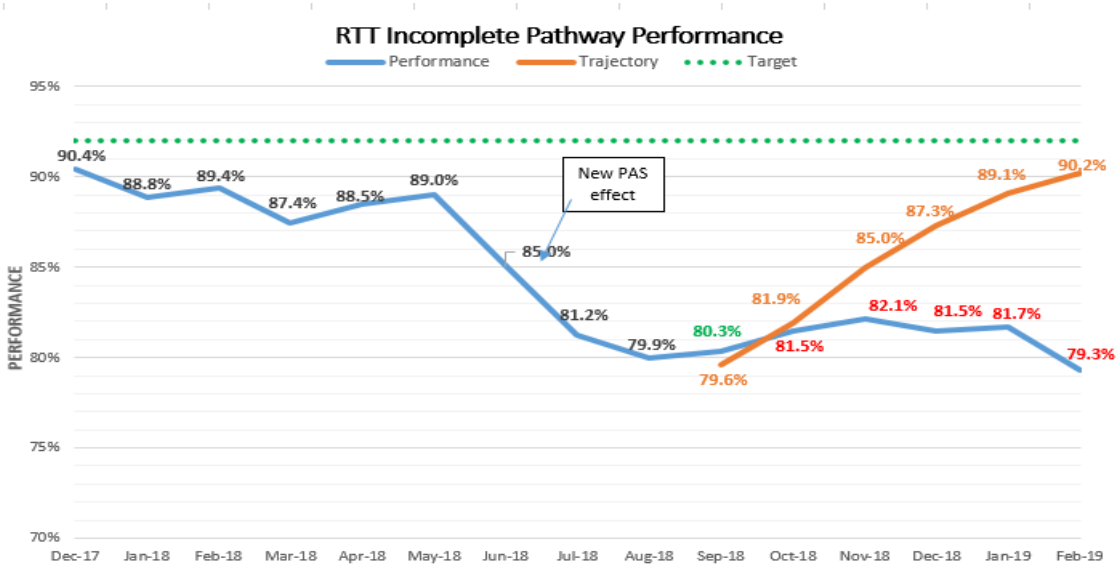
The Trust achieved 81.7% against the RTT target for January 2018; a slight increase of 0.2% on December's performance of 81.5%. The national target for RTT is 92%, but the trust was working to an agreed trajectory target of 89.1% for January.

The data for February has not yet been fully validated and currently sits at 79.3% but is expected to be circa 81% at close of validation

Graph 1 shows the performance of patients on incomplete pathways under 18 weeks.

Over the last 6 months every patient who was over 18 weeks has been reviewed by an external validation team and all patients over 35 weeks have been reviewed by the internal team, this was following the implementation of the new PAS to ensure our waiting list was accurate. There remains a few pockets of validation to be completed in key areas such as Cardiology and Ophthalmology which will further improve the RTT position once complete.

At present there is a mismatch between number of patients on the waiting list & the available capacity within some specialities. Teams have submitted their action plans to mitigate the capacity gaps.



Actions being taken:

- All specialities who are below target have an action plan to ensure ongoing validation & additional capacity (where available) is put into place.
- Validation is being targeted in the few areas now that have good numbers still to validate e.g. cardiology
- Actions now focused on creating more capacity, such as evening and weekend clinics, virtual triage clinics, recruitment of additional specialties doctors where necessary to meet the capacity gap. Capital expenditure e.g. Endoscopy washers and rooms to create reliable capacity. Increased use of Advice and Guidance and Consultant connect to reduce the referral rates (25% of Outpatient are discharged at first appointment)

Risks:

- Ability to recruit to locum and substantive medical posts
- Impact of the new medical model on availability of clinicians to see their outpatients
- Effect of winter e.g. flu and trauma stopping us doing elective work

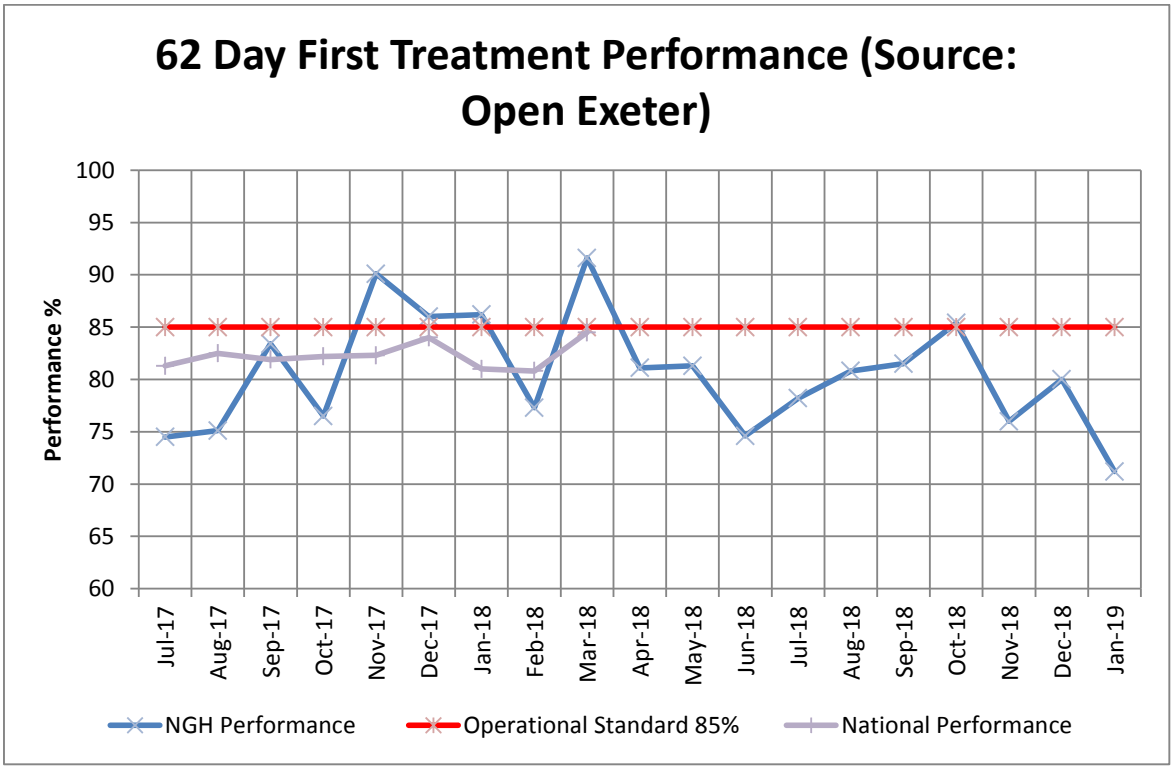
3.3 Cancer

Cancer performance has deteriorated for the 62 day pathway although has increased significantly from 30 to 60% for Breast and for March is currently at 80%. NGH reached 71.2% for the 62 day standard against the target of 85%. For the 62 day pathway, the main areas of poor performance are H&N and Lung although both haematology, Gynaecology & upper GI are below target.

The main causes for the underperformance are:

- The numbers of treatments are lower
- Patient initiated delays
- Late tertiary referrals
- No capacity at a tertiary provider
- Complex pathways
- Limited internal capacity

	Total Treatments	Number of Patients Within Target	Number of Patients Over Target	Performance	Operating Standard
2ww Referral	**1095**	**808**	**287**	**73.8%**	93%
2ww Breast Symptoms	**78**	**47**	**31**	**60.3%**	93%
31 Day First Treatment	**178**	**164**	**14**	**92.1%**	96%
62 Day combined with 31 Day Rare Treatments - Actual Total	**107.5**	**76.5**	**31**	**71.2%**	85%
Subsequent Surgery Treatments	**10**	**8**	**2**	**80.0%**	94%
Subsequent Drug Treatments	**95**	**94**	**1**	**98.9%**	98%
Subsequent Radiotherapy Treatments	**99**	**97**	**2**	**98.0%**	94%
62 Day Screening	**10.5**	**9.5**	**1**	**90.5%**	90%
62 Day upgrade	**25**	**21**	**4**	**84.0%**	85%



Actions being undertaken:

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
- Meeting held with head and neck MDT lead, Directorate Manager and Cancer Services to review current performance and identify areas for improvement which will be further supplemented by the pathway analyser work
- Revised Cancer performance meetings, new TOR and format to be rolled out from April to include Divisional and clinical attendance, chaired by the COO
- Ongoing issue to understand capacity and demand for initial OPA in order to recover 2ww and 2ww breast symptomatic standard, number of slot issues escalating.
- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway
- Straight to test for some colorectal patients ready for implementation, pending IT clinic finalisation and comms by CCG to GP's

-

Patients treated 104+ days

6 patients were treated in excess of 104+ days in January.

- 1 delayed as patient not fit-colorectal
- 2 patients transferred from head and neck to haematology both late, 1 treated within 23 days, one delayed due to further investigations and LRI input
- 1 patient was delayed due to patient being referred between oncology and surgeon and indecision by patient, this was father delayed due to a period of illness-Lung
- 1 patient delayed an investigation and had a further delay to Oncology OPA-Urology
- 1 patient delayed by tertiary provider-Urology
- 1 patient delayed due to OPA capacity-Urology

The breach panel continue to meet monthly, this is currently under review due to lack of clinical attendance and clinical harm review and identification of any learning at MDT is currently being discussed. No patients reviewed through the current process in the last month have been identified as harm caused due to delayed pathways.

4 Board recommendation:

The Board is asked to receive and discuss the report.

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2018/2019 FEB

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%				100.0%	92.7%	100.0%	83.3%	98.1%	98.1%	100.0%	97.4%	97.4%	98.0%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat			84.2%	87.3%	86.4%	88.7%	88.3%	88.0%	87.3%	86.5%	88.2%	85.9%	85.1%	80.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat			93.3%	92.1%	93.7%	92.0%	92.5%	91.4%	92.0%	92.5%	94.1%	92.6%	92.7%	93.5%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat			100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	99.5%	98.7%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat			93.9%	94.0%	97.9%	92.5%	92.8%	93.2%	92.8%	92.4%	93.8%	93.5%	93.5%	93.6%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat			252	0	0	0	0	3	0	0	0	0	4	2
	Compliments	Sheran Oke	-	NGH										4,288	4,335	3,541	4,269	3,639
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat			85.1%	88.9%	86.6%	93.9%	92.3%	91.5%	89.0%	86.8%	85.9%	83.3%	78.6%	80.9%
	Average Ambulance handover times	Debbie Needham	<=15 mins				00:13	00:14	00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25				179	80	129	58	79	60	118	174	142	299	330	
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10				23	11	5	2	1	3	15	17	19	30	49	
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0				34	11	13	7	6	16	2	3	3	4	5	4
	Delayed transfer of care	Debbie Needham	=23	NGH			52	26	39	35	12	19	36	10	10	24	12	11
	Average Monthly DTOCs	Debbie Needham	<=23	NGH			42	30	42	40	28	16	34	27	15	20	20	17
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH			16	13	37	31	19	13	25	25	13	16	17	13
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat			89.5%	77.6%	90.8%	70.0%	72.2%	70.8%	75.2%	94.0%	88.5%	86.1%	73.8%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat			81.0%	72.8%	78.1%	23.3%	18.1%	31.1%	85.7%	91.1%	40.3%	35.4%	60.3%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat			96.9%	98.8%	97.4%	92.7%	95.4%	97.5%	94.7%	97.5%	94.9%	96.6%	92.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat			88.7%	100.0%	97.1%	100.0%	100.0%	98.8%	96.8%	100.0%	100.0%	100.0%	98.9%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat			100.0%	97.3%	94.4%	96.1%	97.5%	97.6%	95.7%	95.8%	96.7%	94.9%	98.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat			85.7%	90.0%	90.0%	78.6%	100.0%	100.0%	88.9%	86.7%	93.8%	93.8%	80.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat			91.6%	81.1%	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat			95.5%	100.0%	97.1%	68.4%	100.0%	93.8%	100.0%	83.9%	100.0%	81.8%	90.5%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat			100.0%	97.7%	87.5%	90.0%	81.3%	78.7%	79.1%	85.7%	83.6%	89.1%	84.0%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat			87.4%	88.8%	89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	
	RTT over 52 weeks	Debbie Needham	=0	Nat			0	1	0	0	0	0	0	0	0	0	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat			99.9%	99.7%	99.5%	99.7%	99.5%	99.9%	100.0%	99.9%	99.9%	99.8%	100.0%	

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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				74.6%	79.5%	96.5%	93.5%	93.0%	100.0%	92.7%	94.8%	95.7%	100.0%	79.7%	66.3%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				87.8%	90.7%	91.7%	87.8%	97.7%	93.3%	95.0%	98.0%	95.0%	95.3%	89.4%	82.5%
	Unappointed Follow Ups	Debbie Needham	=0	NGH													8,608	8,723
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			12.9%	11.7%	11.8%	12.2%	12.3%	12.5%	12.4%	12.5%	12.4%	12.3%	12.4%	12.4%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	3.8%	3.9%	4.4%	4.7%	4.5%	4.3%	4.0%	4.1%	4.5%	5.0%	4.7%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			10.8%	12.1%	11.8%	12.6%	13.3%	11.8%	11.1%	10.4%	10.4%	12.5%	11.8%	11.0%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.2%	12.8%	13.2%	14.3%	14.7%	9.4%	9.4%	8.8%	9.1%	10.0%	9.2%	2.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			8.5%	9.8%	9.5%	9.8%	10.5%	8.3%	7.5%	7.3%	7.6%	11.6%	11.3%	11.3%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			11.5%	13.2%	12.7%	13.7%	14.4%	14.1%	13.8%	12.9%	12.1%	13.6%	12.8%	12.5%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.9%	7.7%	7.5%	7.4%	8.9%	7.8%	7.9%	7.7%	7.8%	8.3%	8.2%	9.0%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.0%	88.6%	89.2%	89.5%	89.2%	88.8%	88.7%	87.9%	88.3%	88.5%	88.7%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH											81.9%	82.9%	82.0%	82.0%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.3%	84.6%	84.8%	85.0%	85.1%	83.8%	82.1%	82.0%	82.6%	83.0%	83.3%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			85.1%	85.4%	86.8%	86.8%	86.0%	85.1%	84.6%	83.1%	83.5%	81.7%	83.6%	84.6%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			75.8%	63.5%	63.6%	63.6%	58.3%	60.0%	12.5%	15.2%	27.5%	24.3%	28.6%	30.9%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			(3,436) Adv	148 Fav	288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			(12,070) Adv	615 Fav	1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(5,872) Adv	(539) Adv	(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			(3,864) Adv	283 Fav	555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			322	24	46	70	89	107	128	153	167	195	209	144
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			457.8	22.1	82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	322.1
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			(934) Adv	485 Fav	1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH												64.6%	66.0%	65.6%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH												39.2%	40.5%	41.0%
	Maverick Transactions	Phil Bradley	=0	NGH								27				15	21	21
	Waivers which have breached	Phil Bradley	=0	NGH			1	3	2	2		0				1	0	0
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH				60.2%	62.3%	56.6%	51.1%	55.1%	57.6%	54.2%	54.5%	54.8%	58.0%	57.1%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH				29.5%	31.3%	29.3%	22.1%	24.7%	26.2%	23.8%	23.1%	23.1%	23.9%	21.7%
	Length of stay - All	Debbie Needham	<=4.2	NGH			5.4	5.2	4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.8%	19.2%	19.0%	19.3%	18.9%	19.7%	17.9%	18.6%	17.5%	19.1%	18.4%	17.3%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.1%	3.7%	3.5%	3.5%	4.6%	3.3%	3.5%	3.1%	3.2%	4.7%	3.1%	2.4%

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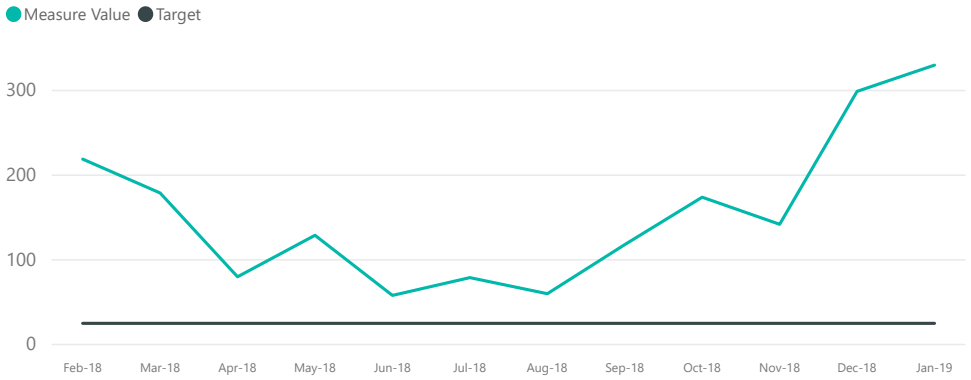
	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.7%	13.3%	14.4%	15.8%	16.9%	17.1%	16.6%	14.4%	14.7%	17.5%	16.0%	12.4%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		96.0%	93.1%	88.9%	90.0%	87.5%	82.8%	77.1%	84.6%	82.8%	100.0%	86.5%	81.8%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.0%	28.4%	31.4%	34.1%	29.0%	29.9%	28.9%	31.5%	31.3%	32.2%	32.3%	27.3%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑			99	99	101	0	104	104	106	106	106	105	
	Mortality: SHMI	Matt Metcalfe	100	Nat	→			97	97	97	98	98	100	100	104	104	104	
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	↑		109	45	79	25	25	45	47	66	36	35	53	51
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	↓		96.3%	100.0%	94.9%	100.0%	100.0%	97.8%	95.7%	97.0%	97.2%	91.4%	98.1%	96.1%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	0	0	1	0	0	0	
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-				3	1	3	4	3	2	3	0	0	3	7	
	No of Comprehensive Investigations	Matt Metcalfe	=0	NGH														
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.6%	97.8%	97.9%	96.4%	96.5%	95.0%	95.7%	95.8%	95.4%	95.4%	95.6%	93.3%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	→		0	5	1	2	2	1	2	0	0	1	0	0
	MSSA	Sheran Oke	<=1.1	NGH	↓		0	2	1	0	2	0	0	2	1	0	1	2
	New Harms	Sheran Oke	<=2%	NGH	↑									2.11%	0.67%	0.99%	0.62%	0.15%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		5.1	4.4	4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→											85.6%	88.1%	88.1%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓											62.1%	59.8%	54.1%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	→											89.2%	89.2%	

Ambulance handovers that waited over 30 mins and less than 60 mins

January 2019

Target	Actual	Direction of Travel	Accountable Executive
25	330	↓	Debbie Needham

Performance vs Target



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
219	179	80	129	58	79	60	118	174	142	299	330

What is driving underperformance?

- When the department is at maximum physical capacity, crews have been unable to offload and handover to ED team within set timeframes
- HALO support has been reduced
- Patients being held on trolleys when they are fit to sit in a chair
- Multiple ambulance arrivals within very short periods cause spikes in demand and our ability to deliver performance is comprised (e.g. 10 in 23mins)
- Paeds ED Corridor is very narrow and can create bottleneck with Pts queuing and prevent ambulance off-loading (on Risk Register)
- Fast Response Cars booking mobile to hospital and not calling clear at scene, thus showing as a delay when transporting resource has been cleared

Actions completed in the past month to achieve recovery

- Ambulance handover times over 60 mins remain invalidated by NGH Team and this is for review with EMAS Team
- EMAS have assigned representation to support Monthly meeting now and support with developing quality improvements to representation
- ED trackers continue to record any near misses and actual breaches, including registered crew numbers for validating with EMAS
- Inappropriate GP referrals being recorded and details being fed through to CCG lead for re-education

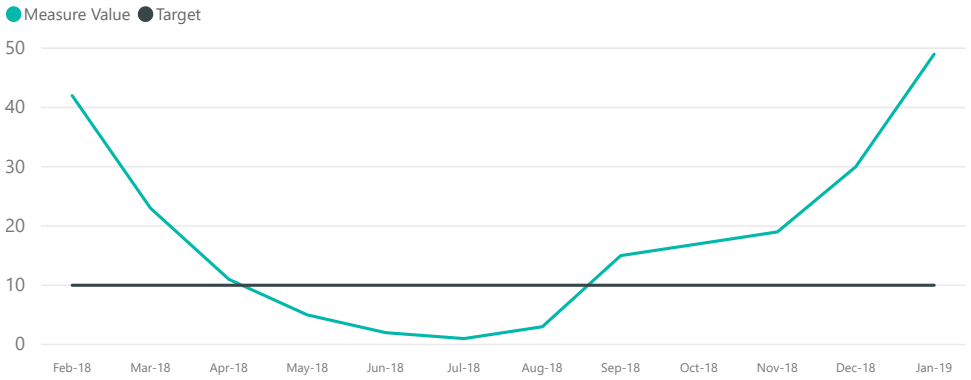
Exception report written by	Timeframe for recovery	Next steps
Fay Gordon		

Ambulance handovers that waited over 60 mins

January 2019

Target	Actual	Direction of Travel	Accountable Executive
10	49	↓	Debbie Needham

Performance vs Target



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
42	23	11	5	2	1	3	15	17	19	30	49

What is driving underperformance?

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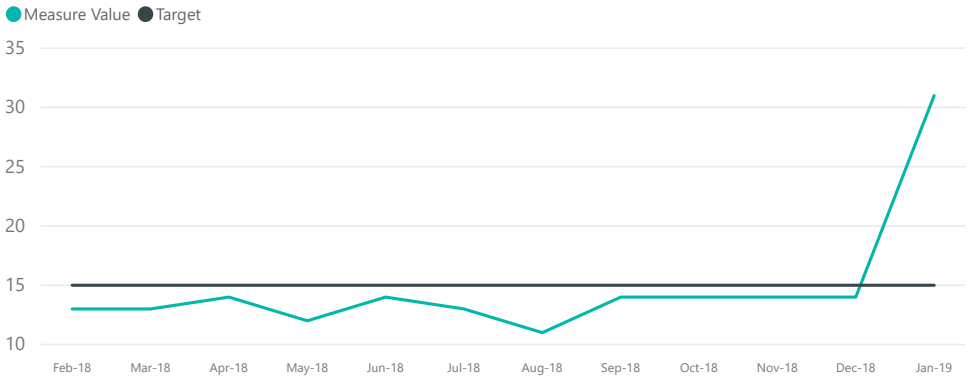
Exception report written by	Timeframe for recovery	Next steps
Fay Gordon		

Average Ambulance handover times

January 2019

Target	Actual	Direction of Travel	Accountable Executive
00:15	00:31	↓	Debbie Needham

Performance vs Target



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
00:13	00:13	00:14	00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31

What is driving underperformance?

- When the department is at maximum physical capacity, crews have been unable to offload and handover to ED team within set timeframes
- HALO support has been reduced
- Patients being held on trolleys when they are fit to sit in a chair
- Multiple ambulance arrivals within very short periods cause spikes in demand and our ability to deliver performance is comprised (e.g. 10 in 23mins)
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- Inappropriate GP referrals being recorded and details being fed through to CCG lead for re-education

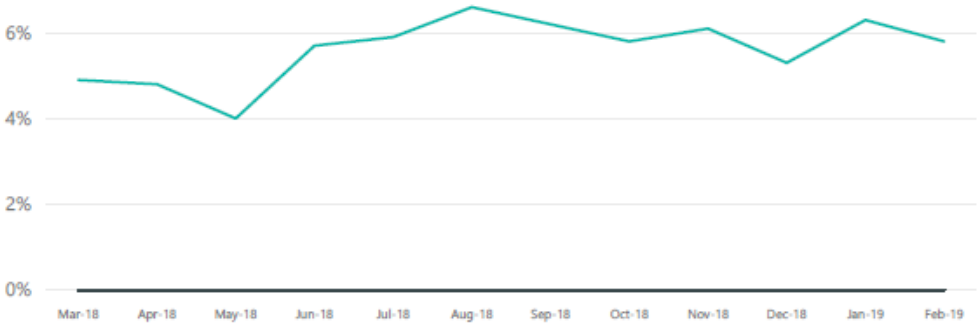
Exception report written by	Timeframe for recovery	Next steps
Fay Gordon		

Ward Moves > 2 as a % of all Ward Moves

February 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	0.0%	5.8%	↑	Debbie Needham

Performance vs Target

Measure Value Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

Timeframe for recovery

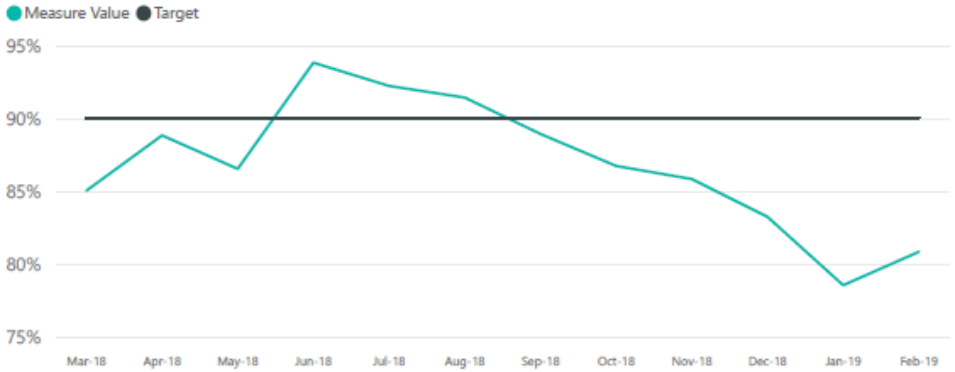
Next steps

A&E: Proportion of patients spending less than 4 hours in A&E

February 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
90.1%	80.9%	↑	Debbie Needham

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
85.1%	88.9%	86.6%	93.9%	92.3%	91.5%	89.0%	86.8%	85.9%	83.3%	78.6%	80.9%

What is driving underperformance?

- Bed availability has remained challenging within the Trust with all escalation areas being opened
- At times of maximum capacity the department has struggled to find adequate space to triage and review patients thus creating a backlog and an increase wait time
- When beds do become available transferring patients takes nursing resources away from the department, transfers can take a minimum of 30mins
- Nursing staffing remains challenged, and despite recruitment activity being successful onboarding is not instant

Actions completed in the past month to achieve recovery

- 'Majors Lite' now to become Business as Usual as of the 11th March 2019
- Leadership coaching for Middle Grades managing the shop floor to be developed by Consultants
- Leadership for all our Consultant Team to be developed by the Clinical Director for roll out

The ED holds a weekly Fixing the Flow (FTF) meeting which feeds into and receives direction from the Trust FTF meetings as a

Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.0%	60.3%	↑	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
95.3%	81.0%	72.8%	78.1%	23.3%	18.1%	31.1%	85.7%	91.1%	40.3%	35.4%	60.3%

What is driving underperformance?

2WW BREAST SYMPTOMATIC

The 2ww breast symptomatic standard has not been met for January reaching 60.3% against a standard of 93%. This is an improvement on December by 70%

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
- Meeting held with head and neck MDT lead, Directorate Manager and Cancer Services to review current performance and identify areas for improvement which will be further supplemented by the pathway analyser work
- Revised Cancer performance meetings, new TOR and format to be rolled out from April to include Divisional and clinical attendance, chaired by the COO
- Ongoing issue to understand capacity and demand for initial OPA in order to recover 2ww and 2ww breast symptomatic standard, number of slot issues escalating.
- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway

Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of 2 week GP referral to 1st outpatient appointment

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.0%	73.8%	↓	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
94.5%	89.5%	77.6%	90.8%	70.0%	72.2%	70.8%	75.2%	94.0%	88.5%	86.1%	73.8%

What is driving underperformance?

2WW

The Trust has not met the 2ww standard for January reaching 73.8% against the standard of 93%, only brain, Gynaecology, Upper GI and Sarcoma met the standard this month. A combination of inadequate capacity in the first instance and the volume requiring negotiation with each service area led to delays in the 2ww team being able to book patients in a timely manner. Slot issues have remained consistently above 100 a week, with the highest reaching 202 week of the 25/02, capacity and Demand and

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
- Meeting held with head and neck MDT lead, Directorate Manager and Cancer Services to review current performance and identify areas for improvement which will be further supplemented by the pathway analyser work
- Revised Cancer performance meetings, new TOR and format to be rolled out from April to include Divisional and clinical attendance, chaired by the COO
- Ongoing issue to understand capacity and demand for initial OPA in order to recover 2ww and 2ww breast symptomatic standard, number of slot issues escalating.
- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway

Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
94.0%	80.0%	↓	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
94.7%	85.7%	90.0%	90.0%	78.6%	100.0%	100.0%	88.9%	86.7%	93.8%	93.8%	80.0%

What is driving underperformance?

Subsequent Surgery

The Trust has not reached the standard for subsequent surgery for January reaching 80% against the 94% standard; this was due to 2 breaches, both due to capacity in skin and breast

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
- Meeting held with head and neck MDT lead, Directorate Manager and Cancer Services to review current performance and identify areas for improvement which will be further supplemented by the pathway analyser work
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- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway

Exception report written by

Timeframe for recovery

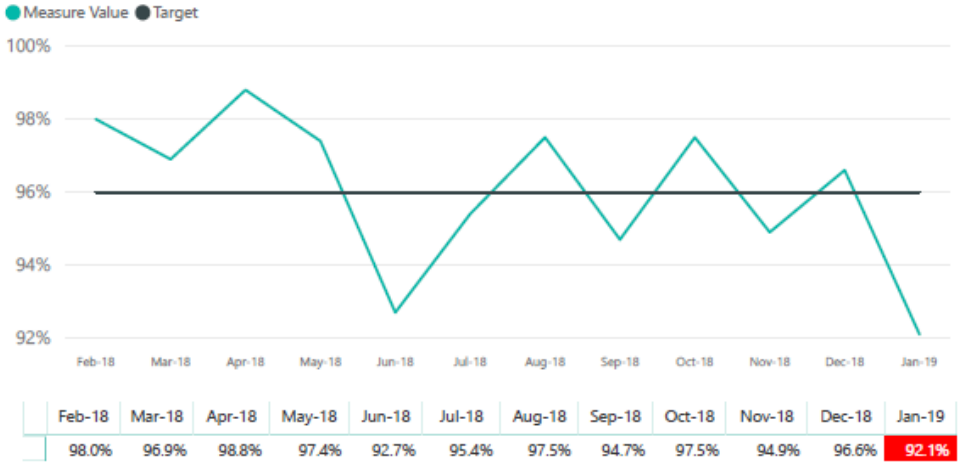
Next steps

Cancer: Percentage of patients treated within 31 days

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
96.0%	92.1%	↓	Debbie Needham

Performance vs Target



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
98.0%	96.9%	98.8%	97.4%	92.7%	95.4%	97.5%	94.7%	97.5%	94.9%	96.6%	92.1%

What is driving underperformance?

31 Day First Treatment

The Trust has not reached the 31 day standard, reaching 92.1% against the 96% standard. 14 breaches in total with 1 in breast due to capacity, 3 in head and neck all requiring further planning or dental review, 2 in colorectal due to fitness issues, 1 in sarcoma due to planning time, 6 in skin, all except one due to capacity and 1 in gynaecology as a further diagnostic and MDT discussion

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
- Meeting held with head and neck MDT lead, Directorate Manager and Cancer Services to review current performance and identify areas for improvement which will be further supplemented by the pathway analyser work
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- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway

Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of patients treated within 62 days of Consultant Upgrade

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0%	84.0%	↓	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
78.6%	100.0%	97.7%	87.5%	90.0%	81.3%	78.7%	79.1%	85.7%	83.6%	89.1%	84.0%

What is driving underperformance?

62 Day Consultant Upgrade

The Trust has not reached the 62 day consultant upgrade standard, reaching 84% against the local standard of 85% due to 4 breaches, 1 in Haem breached as transferred from head and neck, 1.5 in Lung, due to patient choice and fitness, 1 in Upper GI delayed due to a diagnostic delay and 1 in Urology delayed at UHL for treatment

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
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- Initial project management support secured for RAPID and NOLCP has not seen the traction expected to deliver these projects, re-think underway

Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers

January 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0%	71.2%	↓	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
77.3%	91.6%	81.1%	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%

What is driving underperformance?

3 of the 9 Cancer Waiting Times Standards have been met by the Trust for January 2019.

62 Day Standard
NGH reached 71.2% for the 62 day standard against the target of 85%. Under the Inter provider transfer rules the following applies, 3 lung patients were treated in time by the tertiary provider as well as 1 for Upper GI, 3 patients breached when treated by tertiary providers, 1 sarcoma patient was sent out by NGH in time, 2 urology patients were sent out after day 38, 1 of these was treated by the tertiary provider in time

Actions completed in the past month to achieve recovery

- Secure resource using transformation funds to utilise NHSi Pathway Analyser tool, across NGH and KGH all pathways, this will provide evidence of system bottlenecks in order to develop recovery plans
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Exception report written by

Timeframe for recovery

Next steps

Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
January 2019	85.0%	71.2%	↓	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
77.3%	91.6%	81.1%	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%

What is driving underperformance?

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Actions completed in the past month to achieve recovery

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Exception report written by

Timeframe for recovery

Next steps

RTT waiting times incomplete pathways

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
January 2019	92.0%	81.7%	↑	Debbie Needham

Performance vs Target

Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
89.4%	87.4%	88.8%	89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

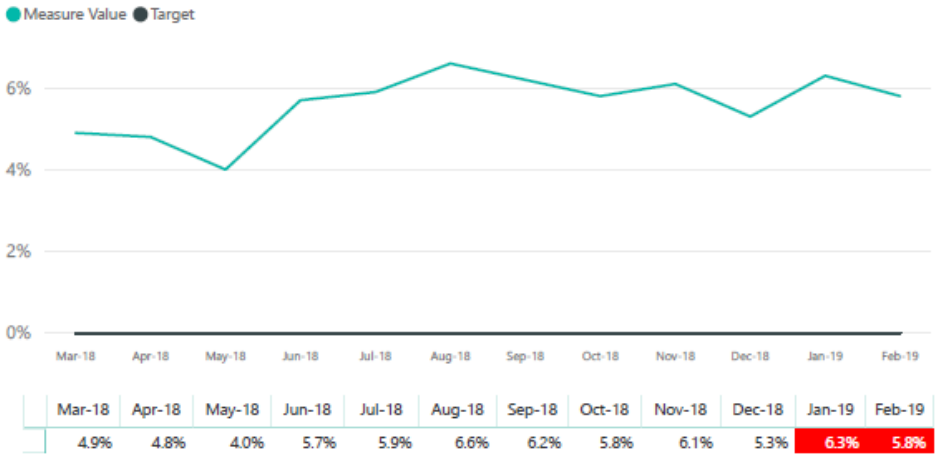
Timeframe for recovery

Next steps

Ward Moves > 2 as a % of all Ward Moves

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	0.0%	5.8%	↑	Debbie Needham

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

Timeframe for recovery

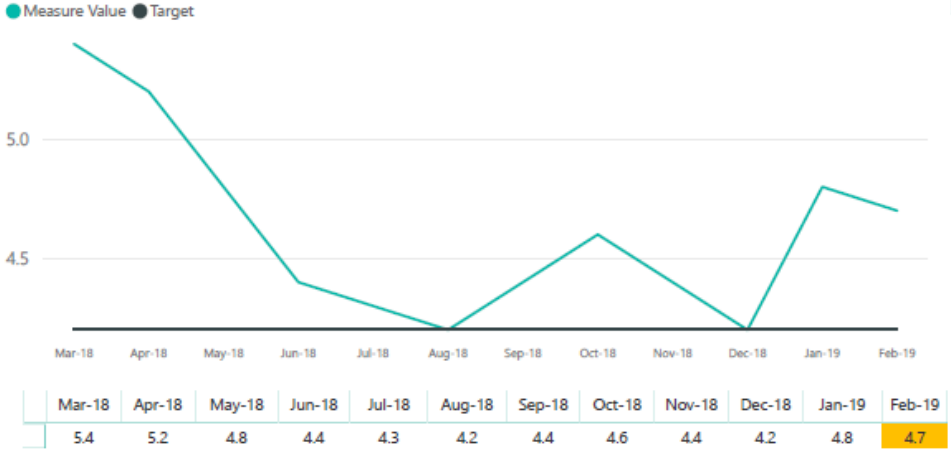
Next steps

Length of stay - All

February 2019

Target	Actual	Direction of Travel	Accountable Executive
4.2	4.7	↑	Debbie Needham

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
5.4	5.2	4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7

What is driving underperformance?

- INCREASE in LOS by 0.6 days during Jan and Feb but lower than same time last year
- 22 patients waiting for community rehab units (6 stroke) with long waits due to poor flow out of these units, patients often not suitable for single rooms
- PDNA referrals started too late in patients journey resulting in delays once medically fit
- PDNA's not updated in a timely fashion when there is a change in the patients situation
- Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit
- Overreliance on patients waiting for inpatient investigations and 'green card' referrals that could be done as outpatients
- Patients not deemed medically fit when community capacity is ready to take.

Actions completed in the past month to achieve recovery

- Weekly review with every ward of every patient with a LOS>7 days being carried out. This has reduced superstranded by >30% in 3 months (220 patients down to 132) This will be led by Therapies from mid Feb
- Discharge element of the recently relaunched of 'Fixing the Flow' initiative being led by Nursing Director
- 3 times a week tracking meeting face to face with Partners
- Discharge coordinators to support wards with completion of PDNA's to reduce delays from Feb
- Exec led top delays meeting to review the longest staying patients in the trust in place weekly (only 2 patients >100 days LOS, 20>200days when started)
- Robust use of the Choice Policy
- 'SAFER in 100 days' initiative spreading across the ward base

Exception report written by

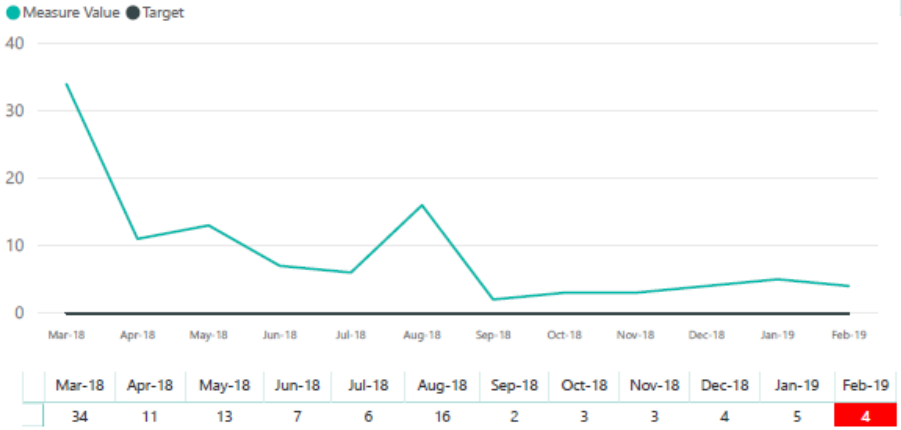
Timeframe for recovery

Next steps

Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons

February 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	4	↑	Debbie Needham

Performance vs Target



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
	34	11	13	7	6	16	2	3	3	4	5	4

What is driving underperformance?

Continued focus and challenge has led to a reduction. This will continue.

The * patients for February were:

- Eye list over-ran due to surgery complexity, 28 day patient cancelled without escalation. If escalated a diff patient would have been cancelled.
- 2 patients did not want to change surgeon, and with surgeons annual leave, there was no capacity to be treated within timescales. All surgeries have been undertaken now.

Actions completed in the past month to achieve recovery

- Reminder to eye team that all potential cancellations must be escalated prior to cancelling
- Further training has been initiated for the member of staff.

Exception report written by

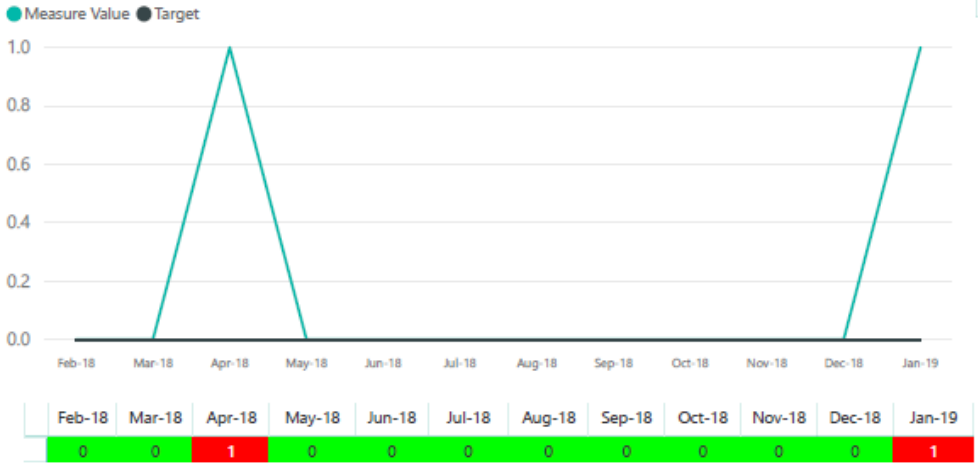
Timeframe for recovery

Next steps

RTT over 52 weeks

January 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	1	↓	Debbie Needham

Performance vs Target



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
0	0	1	0	0	0	0	0	0	0	0	1

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

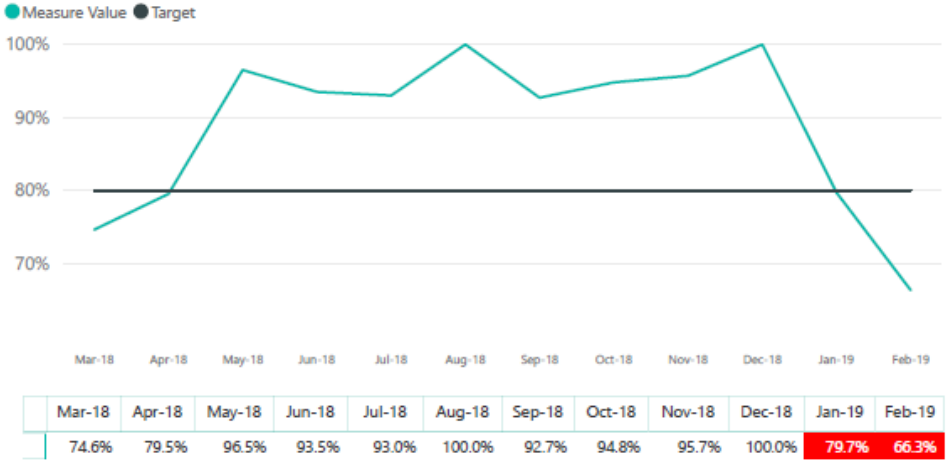
Timeframe for recovery

Next steps

Stroke patients spending at least 90% of their time on the stroke unit

February 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	80.0%	66.3%	↓	Debbie Needham

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
74.6%	79.5%	96.5%	93.5%	93.0%	100.0%	92.7%	94.8%	95.7%	100.0%	79.7%	66.3%

What is driving underperformance?

- February figures are worse than January a reflection of the increasing demand for stroke beds with a high admission rate and an ongoing difficulty in discharging those patients requiring complex care packages.
- Access to the Community Stroke beds remains challenging
- We have been unable to maintain ring fenced beds but this has been due to stroke demand, rather than medical patients being placed on the Stroke wards.
- We feel that the impact of the change in the Stroke Pathway is now being felt and that the bed modelling which suggested we would need 7 extra stroke beds to manage extra capacity is being realised

Actions completed in the past month to achieve recovery

Like January we had virtually no medical outliers during February and this is due to a good relationship with the Site Team. This is a real change in practice but even so we have been unable to maintain ring fenced beds and this illustrates the extra demand within the system caused by the change in pathway. Worryingly on one occasion, we had had to care for a thrombolysed patient outside the Stroke Unit.

We continue to try to improve the flow to the Community Stroke beds by ongoing discussion with NHFT managers and regular team meetings between the 2 sites.

I now think we need to look closely at the need for extra stroke beds within the Trust, as the situation remains as difficult in March.

Exception report written by

Fay Gordon / Matt Metcalf

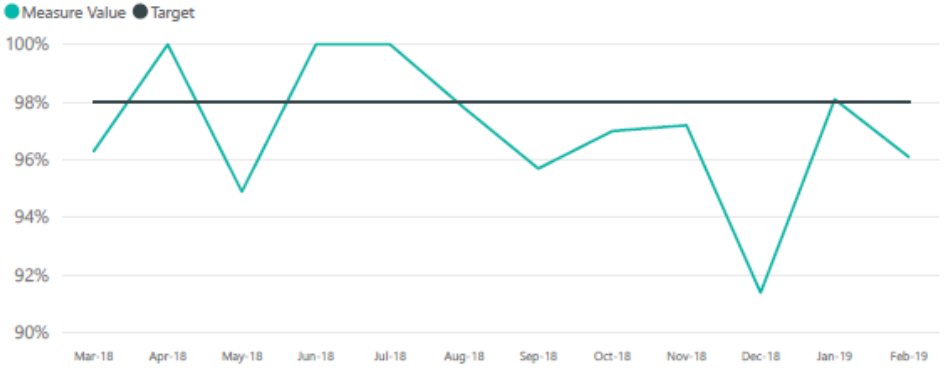
Timeframe for recovery

Next steps

Transfers: Patients moved between 10pm and 7am with a risk assessment completed

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	98.0%	96.1%	↓	Debbie Needham

Performance vs Target



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
	96.3%	100.0%	94.9%	100.0%	100.0%	97.8%	95.7%	97.0%	97.2%	91.4%	98.1%	96.1%

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

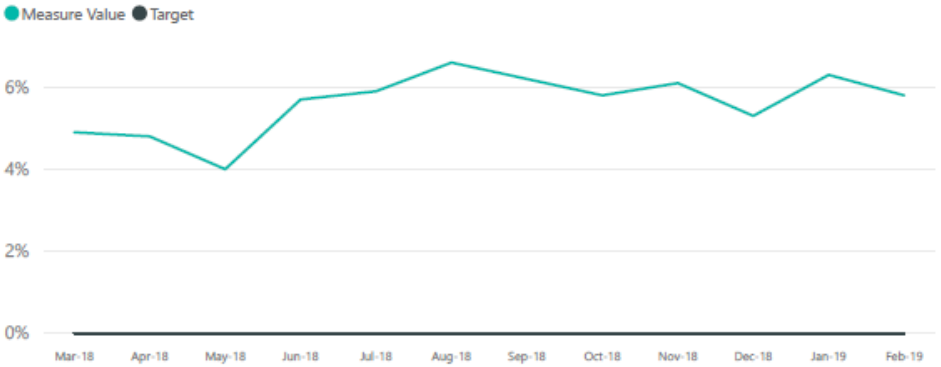
Timeframe for recovery

Next steps

Ward Moves > 2 as a % of all Ward Moves

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	0.0%	5.8%	↑	Debbie Needham

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

Timeframe for recovery

Next steps

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**Thursday 28 March 2019**

Title of the Report	**Workforce Performance Report**
Agenda item	**15**
Presenter of Report	Andrea Chown, Deputy Director of HR
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 January 2019.
- Decrease in compliance rate for Mandatory Training and an increase in compliance for Role Specific Essential Training and Appraisals.
- Exception Reports for Staff Role Specific Training, Staff Appraisals and Vacancy Rates.
- Update in respect of organisational development initiatives

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 28 MARCH 2019

WORKFORCE PERFORMANCE REPORT

1. Introduction

This report identifies the key themes emerging from February 2019 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 10.56 FTE in February 2019 to 4531.25 FTE. The Trust's substantive workforce is at 88.94% of the Budgeted Workforce Establishment of 5094.69 FTE.

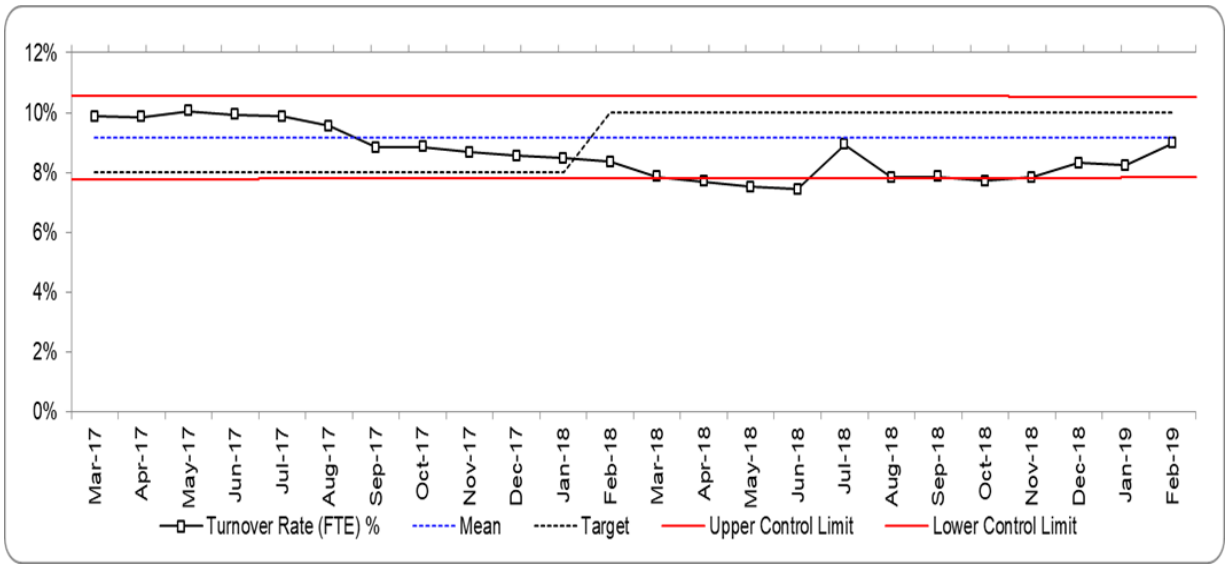
Trust Turnover

Annual Trust turnover for February 2019 increased by 0.74% to 8.97%, which is below the Trust target of 10.00%

Turnover by Division:

- Medical Division: turnover increased by 0.86% to 8.41%
- Surgical Division: turnover increased by 0.69% to 7.35%
- Women, Children & Oncology Division: turnover increased by 1.43% to 8.73%
- Clinical Support Services Division: turnover increased by 1.13% to 10.92%
- Support Services: turnover decreased by 0.34% to 10.32%

Trust Turnover 12 Month Trend



Vacancy Rates

The overall Trust vacancy percentage decreased by 0.75% to 11.06%

The largest decrease in vacancy rates was experienced by Healthcare Scientists, which decreased by 0.92% to 16.22%.

There has been an increase in vacancy rates for Allied Health Professionals, Add Prof Sci & Tech and Nursing & Midwifery staff groups.

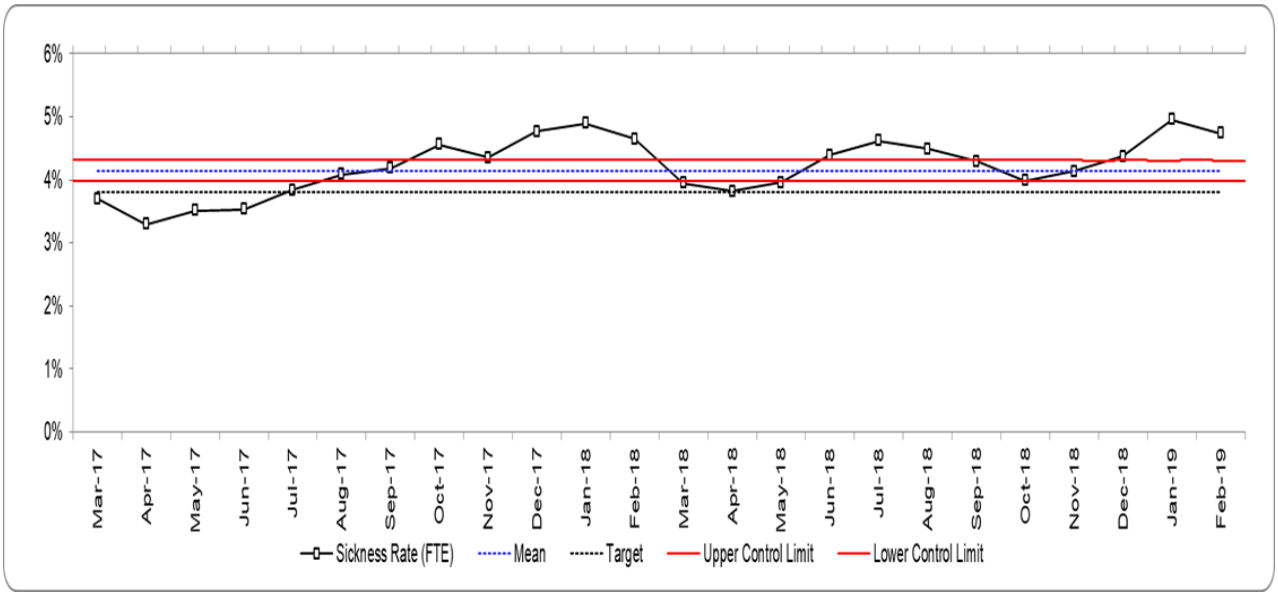
Sickness Absence

Sickness absence for February 2019 decreased from 4.96% to 4.74%, which is above the Trust target of 3.8%. All of the division's sickness absence rates were above the Trust target.

Sickness by Division:

- Medicine and Urgent Care at 4.67%
- Surgery Division at 4.27%
- Women, Children & Oncology at 4.45%
- Clinical Support Services at 4.22%
- Support Services at 6.10%

Trust Sickness Absence 12 month trend



2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for February 2019 is 84.57%; this is an increase of 0.95% from last month's figure of 83.62%.

Mandatory Training compliance decreased in February 2019 from 88.74% to 88.56%. This is a decrease of 0.18% from January 2019 and remains above the Trust target of 85%.

Role Specific Essential Training compliance increased in February 2019 to 83.76% from last January's figure of 83.28%, which is an overall increase of 0.48%.

2.3 Culture

Organisational Development update – Staff Engagement and Organisation Development Programmes

This update details the Trusts progress in relation to the Staff Engagement and Organisation Development initiatives in Quarter 3.

Staff Engagement

The Staff Engagement activity is an integral part of our current People Strategy. In quarter 3 the OD team delivered Staff Engagement Sessions e.g. Rainbow Risk, Living our Values Session and Boxes sessions to 321 staff across the Trust. We are currently reviewing the three pillars of staff engagement: Rainbow Risk, In your Box Session and designing a Good to Great Session. These team interventions will be adapted to promote our values '*We Respect and Support Each Other*' to underpin the Respect and Support campaign Specifically the three interventions are being revised to raise awareness at an individual level, tackle dysfunctionality at a team level and focus on application of thinking in practice at the service level.

Leadership and Management Development

James Stonhouse and Esther White Programmes

The James Stonhouse and the Esther White Management Programmes have been successfully running since March 2018. Both of these programmes have been created to support the development of staff with line management responsibilities across the Trust. The feedback from staff has identified that they have been able to apply their learning back into the workplace.

Consultant Masterclasses

Following a review of the Consultant Foundation Programme which includes feedback from consultant colleagues who completed the programme and feedback from colleagues who have attended the Consultant suppers, the Consultant programme has been revised to a series of bespoke masterclasses. The masterclasses aim is to provide consultants with a sense of the wider issues facing the NHS and NGH and introduce them to the management and leadership issues they will be required to perform effectively as a Consultant, including a session within the Simulation Suite specifically addressing how to manage behaviours.

Other Organisational Development interventions

The Organisational Development team continue to deliver a range of range of interventions such as coaching and team development Programmes. In quarter 3 a bespoke programme in Opthalmology began to shape the culture and build effective team work.

3.0 Assessment of Risk

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

4.0 Recommendations/Resolutions Required

The Trust Board is asked to note the report.

5.0 Next Steps

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

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2018/2019 FEB

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		→		100.0%	92.7%	100.0%	83.3%	98.1%	98.1%	100.0%	97.4%	97.4%	98.0%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		84.2%	87.3%	86.4%	88.7%	88.3%	88.0%	87.3%	86.5%	88.2%	85.9%	85.1%	80.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↑		93.3%	92.1%	93.7%	92.0%	92.5%	91.4%	92.0%	92.5%	94.1%	92.6%	92.7%	93.5%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↓		100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	99.5%	98.7%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		93.9%	94.0%	97.9%	92.5%	92.8%	93.2%	92.8%	92.4%	93.8%	93.5%	93.5%	93.6%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	↑		252	0	0	0	0	3	0	0	0	0	4	2
	Compliments	Sheran Oke	-	NGH										4,288	4,335	3,541	4,269	3,639
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↑		85.1%	88.9%	86.6%	93.9%	92.3%	91.5%	89.0%	86.8%	85.9%	83.3%	78.6%	80.9%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:13	00:14	00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↓		179	80	129	58	79	60	118	174	142	299	330	
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		23	11	5	2	1	3	15	17	19	30	49	
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↑		34	11	13	7	6	16	2	3	3	4	5	4
	Delayed transfer of care	Debbie Needham	=23	NGH	↑		52	26	39	35	12	19	36	10	10	24	12	11
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↑		42	30	42	40	28	16	34	27	15	20	20	17
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↑		16	13	37	31	19	13	25	25	13	16	17	13
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↓		89.5%	77.6%	90.8%	70.0%	72.2%	70.8%	75.2%	94.0%	88.5%	86.1%	73.8%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		81.0%	72.8%	78.1%	23.3%	18.1%	31.1%	85.7%	91.1%	40.3%	35.4%	60.3%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↓		96.9%	98.8%	97.4%	92.7%	95.4%	97.5%	94.7%	97.5%	94.9%	96.6%	92.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		88.7%	100.0%	97.1%	100.0%	100.0%	98.8%	96.8%	100.0%	100.0%	100.0%	98.9%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		100.0%	97.3%	94.4%	96.1%	97.5%	97.6%	95.7%	95.8%	96.7%	94.9%	98.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↓		85.7%	90.0%	90.0%	78.6%	100.0%	100.0%	88.9%	86.7%	93.8%	93.8%	80.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		91.6%	81.1%	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		95.5%	100.0%	97.1%	68.4%	100.0%	93.8%	100.0%	83.9%	100.0%	81.8%	90.5%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↓		100.0%	97.7%	87.5%	90.0%	81.3%	78.7%	79.1%	85.7%	83.6%	89.1%	84.0%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↑		87.4%	88.8%	89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	↓		0	1	0	0	0	0	0	0	0	0	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↑		99.9%	99.7%	99.5%	99.7%	99.5%	99.9%	100.0%	99.9%	99.9%	99.8%	100.0%	

Northampton General Hospital NHS
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Corporate Scorecard 2018/2019 FEB

	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				74.6%	79.5%	96.5%	93.5%	93.0%	100.0%	92.7%	94.8%	95.7%	100.0%	79.7%	66.3%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				87.8%	90.7%	91.7%	87.8%	97.7%	93.3%	95.0%	98.0%	95.0%	95.3%	89.4%	82.5%
	Unappointed Follow Ups	Debbie Needham	=0	NGH													8,608	8,723
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			12.9%	11.7%	11.8%	12.2%	12.3%	12.5%	12.4%	12.5%	12.4%	12.3%	12.4%	12.4%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	3.8%	3.9%	4.4%	4.7%	4.5%	4.3%	4.0%	4.1%	4.5%	5.0%	4.7%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			10.8%	12.1%	11.8%	12.6%	13.3%	11.8%	11.1%	10.4%	10.4%	12.5%	11.8%	11.0%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.2%	12.8%	13.2%	14.3%	14.7%	9.4%	9.4%	8.8%	9.1%	10.0%	9.2%	2.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			8.5%	9.8%	9.5%	9.8%	10.5%	8.3%	7.5%	7.3%	7.6%	11.6%	11.3%	11.3%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			11.5%	13.2%	12.7%	13.7%	14.4%	14.1%	13.8%	12.9%	12.1%	13.6%	12.8%	12.5%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.9%	7.7%	7.5%	7.4%	8.9%	7.8%	7.9%	7.7%	7.8%	8.3%	8.2%	9.0%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.0%	88.6%	89.2%	89.5%	89.2%	88.8%	88.7%	87.9%	88.3%	88.5%	88.7%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH											81.9%	82.9%	82.0%	82.0%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.3%	84.6%	84.8%	85.0%	85.1%	83.8%	82.1%	82.0%	82.6%	83.0%	83.3%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			85.1%	85.4%	86.8%	86.8%	86.0%	85.1%	84.6%	83.1%	83.5%	81.7%	83.6%	84.6%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			75.8%	63.5%	63.6%	63.6%	58.3%	60.0%	12.5%	15.2%	27.5%	24.3%	28.6%	30.9%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			(3,436) Adv	148 Fav	288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			(12,070) Adv	615 Fav	1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(5,872) Adv	(539) Adv	(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			(3,864) Adv	283 Fav	555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			322	24	46	70	89	107	128	153	167	195	209	144
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			457.8	22.1	82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	322.1
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			(934) Adv	485 Fav	1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH												64.6%	66.0%	65.6%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH												39.2%	40.5%	41.0%
	Maverick Transactions	Phil Bradley	=0	NGH								27				15	21	21
	Waivers which have breached	Phil Bradley	=0	NGH			1	3	2	2		0				1	0	0
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH				60.2%	62.3%	56.6%	51.1%	55.1%	57.6%	54.2%	54.5%	54.8%	58.0%	57.1%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH				29.5%	31.3%	29.3%	22.1%	24.7%	26.2%	23.8%	23.1%	23.1%	23.9%	21.7%
	Length of stay - All	Debbie Needham	<=4.2	NGH			5.4	5.2	4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.8%	19.2%	19.0%	19.3%	18.9%	19.7%	17.9%	18.6%	17.5%	19.1%	18.4%	17.3%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.1%	3.7%	3.5%	3.5%	4.6%	3.3%	3.5%	3.1%	3.2%	4.7%	3.1%	2.4%

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Corporate Scorecard 2018/2019 FEB

	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.7%	13.3%	14.4%	15.8%	16.9%	17.1%	16.6%	14.4%	14.7%	17.5%	16.0%	12.4%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		96.0%	93.1%	88.9%	90.0%	87.5%	82.8%	77.1%	84.6%	82.8%	100.0%	86.5%	81.8%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.0%	28.4%	31.4%	34.1%	29.0%	29.9%	28.9%	31.5%	31.3%	32.2%	32.3%	27.3%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑			99	99	101	0	104	104	106	106	106	105	
	Mortality: SHMI	Matt Metcalfe	100	Nat	→			97	97	97	98	98	100	100	104	104	104	
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	↑		109	45	79	25	25	45	47	66	36	35	53	51
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	↓		96.3%	100.0%	94.9%	100.0%	100.0%	97.8%	95.7%	97.0%	97.2%	91.4%	98.1%	96.1%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.9%	4.8%	4.0%	5.7%	5.9%	6.6%	6.2%	5.8%	6.1%	5.3%	6.3%	5.8%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	0	0	1	0	0	0	
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-				3	1	3	4	3	2	3	0	0	3	7	
	No of Comprehensive Investigations	Matt Metcalfe	=0	NGH														
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.6%	97.8%	97.9%	96.4%	96.5%	95.0%	95.7%	95.8%	95.4%	95.4%	95.6%	93.3%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	→		0	5	1	2	2	1	2	0	0	1	0	0
	MSSA	Sheran Oke	<=1.1	NGH	↓		0	2	1	0	2	0	0	2	1	0	1	2
	New Harms	Sheran Oke	<=2%	NGH	↑									2.11%	0.67%	0.99%	0.62%	0.15%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		5.1	4.4	4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→											85.6%	88.1%	88.1%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓											62.1%	59.8%	54.1%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	→											89.2%	89.2%	

Northampton General Hospital NHS
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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.

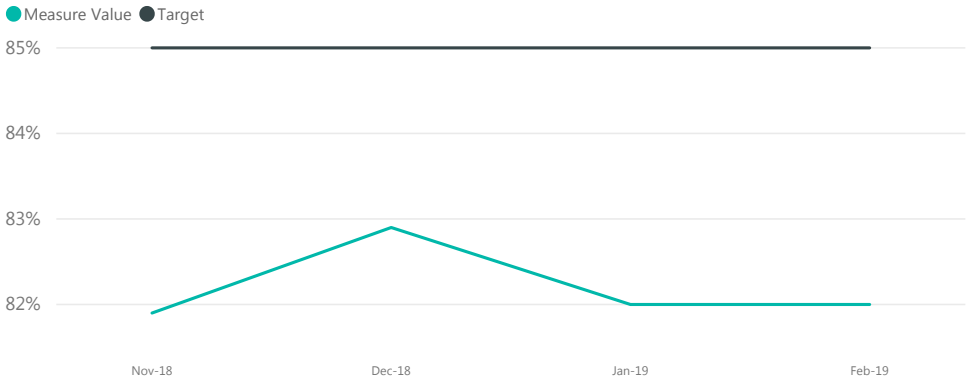
The domains identified within are: Caring, Responsiveness, Effective, Well Led, Safe and Finance, many items within each area were provided within the TDA Framework with a further number of in-house metrics identified from our previous quality scorecard which were considered important to continue monitoring.

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.

Percentage of all trust staff with mandatory refresher fire training compliance

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	85.0 %	82.0 %	↓	Janine Brennan

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19
81.9 %	82.9 %	82.0 %	82.0 %

What is driving underperformance?

Actions completed in the past month to achieve recovery

Exception report written by

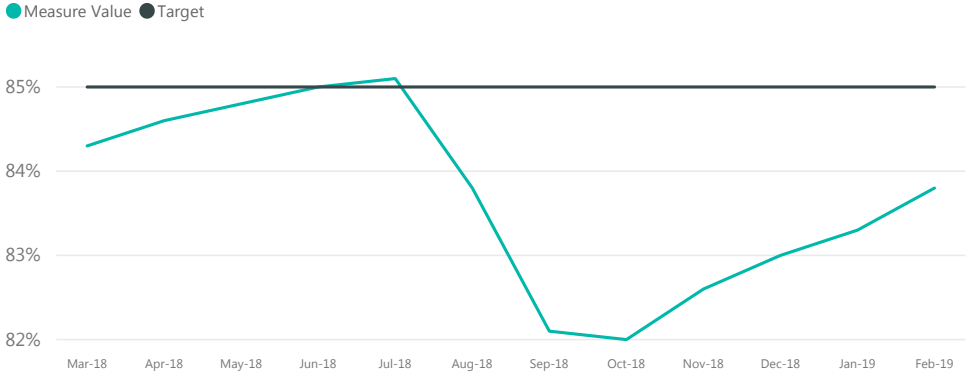
Timeframe for recovery

Next steps

Percentage of all trust staff with role specific training compliance

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
February 2019	85.0 %	83.8 %	↑	Janine Brennan

Performance vs Target



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
	84.3 %	84.6 %	84.8 %	85.0 %	85.1 %	83.8 %	82.1 %	82.0 %	82.6 %	83.0 %	83.3 %	83.8 %

What is driving underperformance?

Positions not being aligned to Role Specific Training subjects
• Inflexibility of the national OLM system means that the lowest dominator that training can be aligned to is position level not assignment level. There is no ability to change the current system.

Actions completed in the past month to achieve recovery

• 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.
• Promotion on the importance of RSET is included in the appraisal training.
• The Safeguarding Team continue to identify smaller numbers of positions as not requiring level 3 and work is currently being undertaken to remove the positions identified as not requiring the traning.
• L&D manager attended some DMB and DMT meetings to identify any issues with RSET and reiterated good practice

Exception report written by

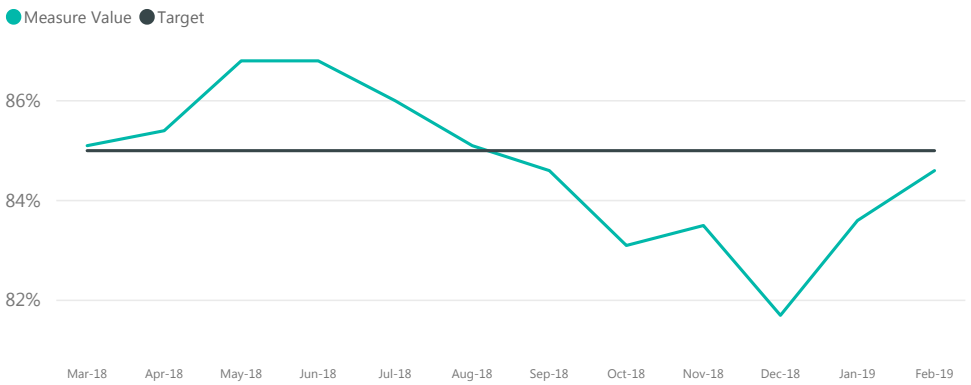
Timeframe for recovery

Next steps

Percentage of staff with annual appraisal

February 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0 %	84.6 %	↑	Janine Brennan

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
85.1 %	85.4 %	86.8 %	86.8 %	86.0 %	85.1 %	84.6 %	83.1 %	83.5 %	81.7 %	83.6 %	84.6 %

What is driving underperformance?

- The appraisal spreadsheet covers two months, so some areas have waited until the final cut-off date to notify L&D of the appraisal, even though the appraisal may have occurred during the first month meaning the member of staff is one month out of date.
- Appraisal information is being received after the submission deadline.
- The number of new starters within some depts. has affected the overall % compliance due to timing of start date and appraisal date

Actions completed in the past month to achieve recovery

- The HRBPs have created action plans for those areas with low compliance.
- The L&D manager has attend some DMB and DMT meetings to understand the reasons for low compliance and to reiterate processes. Main reasons for low compliance have been sickness and mat leave.
- Training for managers continues which covers the process of submission of data. 1:1's are also being conducted with managers

Exception report written by

Timeframe for recovery

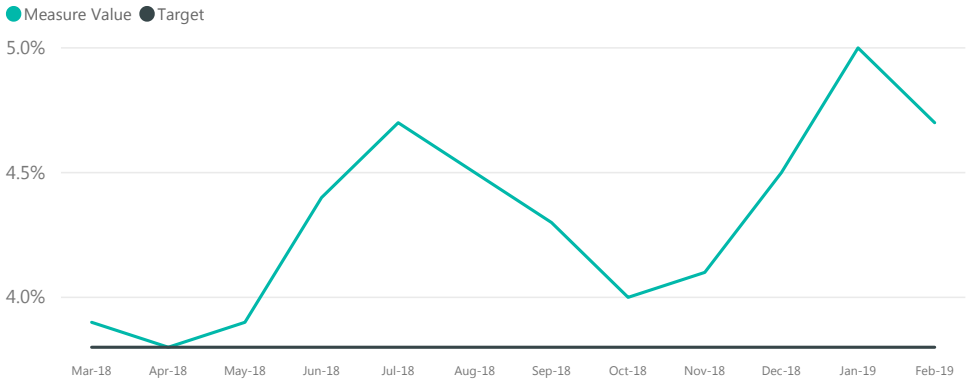
Next steps

Sickness Rate

February 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
3.8 %	4.7 %	↑	Janine Brennan

Performance vs Target



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
	3.9 %	3.8 %	3.9 %	4.4 %	4.7 %	4.5 %	4.3 %	4.0 %	4.1 %	4.5 %	5.0 %	4.7 %

What is driving underperformance?

There are high levels of seasonal illnesses with staffing levels having attributed to the increase in coughs/colds and flu
Anxiety and depression plus pregnancy related absences are also high
There are a high number of bullying and harassment cases across all divisions

Actions completed in the past month to achieve recovery

Robust sickness management continues.
There is a business case being put forward to the Workforce Committee to uplift WTE for maternity which if approved will alleviate pressure on existing staff.
HR input into recruitment with local team including clinicians looking at innovative ways to recruit and retain where there are staff shortages to alleviate pressure on existing staff.
The Respect and Support campaign is progressing with the Report for Support telephone line up and running which will support staff.

Exception report written by

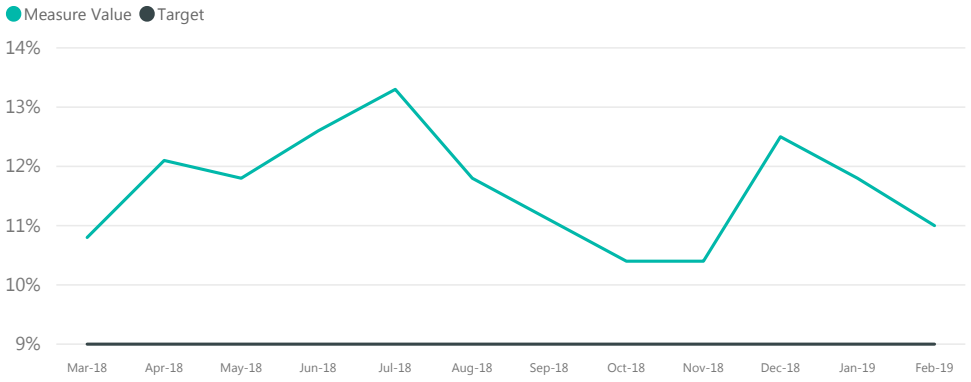
Timeframe for recovery

Next steps

Staff: Trust level vacancy rate - All

February 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	9.0 %	11.0 %	↑	Janine Brennan

Performance vs Target



Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
10.8 %	12.1 %	11.8 %	12.6 %	13.3 %	11.8 %	11.1 %	10.4 %	10.4 %	12.5 %	11.8 %	11.0 %

What is driving underperformance?

- There is a national shortage of nursing staff along with a shortage within other professional allied specialities & medical staff.

Actions completed in the past month to achieve recovery

- Trust Open Days in difficult to recruit areas.
- Nurse Recruitment KPIs are being redesigned.
- Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates.
- Overseas recruitment for nurses continues including direct overseas recruitment through existing overseas recruits.
- Medical Recruitment Strategy and Action Plan being implemented.
- Search Agency engaged to identify Medical Consultants
- New Recruitment system to improve and reduce recruitment timelines implemented due to be audited later in 2019.
- Engaged agency to place UK nurses with the Trust
- Employer Value Proposition project to differentiate between the Trust and other employers is being planned.

Exception report written by

Timeframe for recovery

Next steps

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28th March 2019**

Title of the Report	**Overview of the Electrical Power Outage Incident on 22 Feb 2019**
Agenda item	**16**
Presenter of the Report	Deborah Needham – Acting CEO
Author(s) of Report	Stuart Finn - Director of Estates and Facilities Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

This paper details an electrical power outage across the NGH site on Friday, 22nd February 2019. As a result of the outage, electrical power to parts of the site was lost for over 4 hours.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s) All BAF entries
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Group

The Group is asked to:

- Note the contents of this paper.
- Identify areas where additional assurance is required.

Northampton General Hospital NHS Trust

Electrical Power Outage
Friday, 22nd February 2019

1. Introduction

This paper details an electrical power outage across the NGH site on Friday, 22nd February 2019. As a result of the outage, electrical power to parts of the site was lost for over 4 hours.

2. Overview of the incident

At 23:15 on Friday, 22nd February the NGH site lost its main electrical supply. As a result, the emergency back-up generators were started and electrical power restored to some but not all areas of site.

Statements from staff involved, incident logs, and matters discussed at the debrief are currently being reviewed for inclusion within the formal debrief incident report. The following paper provides an overview of the incident, key timings and actions taken during the response.

Date/Time	Information/Comment
23:15 Friday, 22nd February	• All electrical power across site was lost. • The site generators started automatically and electrical supplies to some but not all of site was restored. • Power was not restored to areas supplied from switch room SB3 (A&E, Theatres) and Generators 6 & 7 (West end of site, including Spencer, Head & Neck, Holcot & Brampton) • The Estates on call manager was contacted and informed that power had been lost on site (if the generators start an alarm is activated at the main switchboard who will call out the Estates on call team).
23:40 Friday, 22nd February	• Site Manager phoned on-call manager advising power had gone off.
23.51 Friday, 22nd February	• On-call manager phone on-call Director.
00.02 Saturday, 23rd February	• Acting CEO contacted site manager. • On-call manager, Director and Acting CEO attended the Trust
00.45 Saturday, 23rd February	• Estates on call manager and electrician attended site and investigated. • On understanding the extent of the issue the on call manager called in another Estates manager and the site electrical AP (approved person). • On call manager also contacted Western Power the electrical supply provider, who confirmed there were no external supply issues and agreed to attend site
00.45 Saturday,	• Internal Significant Incident called.

23rd February	
00.55 Saturday 23 Feb	• ED Closed. • Although ED continued to have power, it was agreed to divert patients to neighboring Trust's as theatres, pathology & radiology were without power, and during the early stages of the incident, work was being undertaken to determine which areas were affected.
01.15 Saturday 23 Feb	• 2nd Estates manager and site electrical AP (approved person) arrived on site.
01.17 Saturday 23 Feb	• Command and Control was instigated as per the major incident plan in order to establish a command structure and allocation of roles to those involved with the response. As a result a Silver Command Meeting was held to provide an overview of the situation and allocation of actions to mitigate risks. • Updates were received from areas affected and the response team were able to make decisions based on the information provided • Business continuity plans were instigated to ensure patient safety was maintained.
01.45 Saturday 23 Feb	• Estates confirmed there was no generator feed to SB3(A&E, Theatres). • Estates isolated SB3 generator switch and reinstated supplies to SB3 by back feeding from SB4. • Supplies to SB3 were now reinstated
01.50 Saturday 23 Feb	• Western Power attended site and confirmed fault was not external and on NGH site • Estates attended the main HV (high voltage) incomer switch room and found that the HV switches feeding the site network had 'tripped'/opened. • The Trust HV specialist contractors, Freedom, were called out. • HV supply switches were reset by Estates but 'tripped' again.
01.54 Saturday 23 Feb	• Mortuary Fridge temperatures were OK and remained stable. • Local Coroners Undertaker was informed of the issues and requested not to bring deceased patients in until situation has been rectified.
01.55 Saturday 23 Feb	• Estates attended generator house 6 & 7 and found generators 6 & 7 running but, both control panels were in fault and would not reset • Mann Electrical was contacted by Estates and asked to attend site to support
02.00 Saturday 23 Feb	• Theatre staff remained in theatres as a contingency to be utilised for any ill patients who could be managed in recovery.
02.20 Saturday 23 Feb	• Mann Electrical arrived on site to support.
02.21 Saturday 23 Feb	• A further Silver Meeting was held. • The group reviewed any safety issues within each area. • Trust-wide staffing levels were reviewed to determine if there was any additional support that could be provided. • On call pharmacist was called in to ensure supply of medications. • Medical Consultant on-call was called in to support staff.

	• Consultant on-call surgeon was on-site • Additional staff were called in for the following day to provide support. • All Red Phones and the paging system were now working
03.30 Saturday 23 Feb	• Freedom arrived on site
03.30 Saturday 23 February	• A further Silver meeting was held. No new issues were raised. • The old part of Trust was still without power – Victoria, Compton, Althorp, Elderly Medicine, Brampton, and Holcot. • Discussions were held regarding patients attending on Saturday.
04.00 Saturday 23 February	• Estates continued investigating outage in areas supported by generator 6 & 7. • All panels on the LV ring from SB1 were disconnected and reinstated one at a time but the LV ring main switches at SB1 continued to trip. • Loose connection was found and repaired; all switches were reinstated and generator 6 & 7 reset. • Generator power was restored to all areas except Luke Building at 04.00
04.00 to 10.00 Saturday 23 February	• Freedom and Estates investigated and identified a fault on the HV ring between HV substation 1 and HV substation 8. • The HV ring open point was moved. HV supply switches in the main substation were reset and re energised restoring mains power to the HV network at 10am
04.00 to 10.00 Saturday 23 February	• Process of confirming security of all site supplies was carried out and mains power reinstate to areas step by step • Full mains power was restored and confirmed in all areas by 10am
05.00-05.30 Saturday 23 February	• Silver Meeting was held. • The group reviewed any safety issues within each area. • Acuity within the Trust was not high. • The decision was made for life or limb surgery only until a permanent power supply is restored. • A review of the days surgery patients was undertaken. • Estates advised that the Trust needs to remain on Generator power until the HV cable fault has been repaired • Paper charts have been printed off and distributed to areas. • The decision was taken to reopen ED however the trust remained on divert for Maternity Cases until electricity supply to the unit is sustainable.
05.30 Saturday 23 February	• The Trust re-opened with the exception of maternity which remained on divert as electricity supply was not yet sustained.
05.32 Saturday 23 February	• East Midlands Ambulance Service informed
05.35 Saturday 23	• Kettering General Hospital informed

February	
05.39 Saturday 23 February	• Nene and Corby Clinical Commissioning Group informed
05.41 Saturday 23 February	• NHS England informed
05.45 Saturday 23 February	• Milton Keynes Hospital informed
07.00 Saturday 23 February	• Silver Meeting was held. • Acting CEO gave a summary of the incident to the day team. • Spencer, Head & Neck, Holcot & Brampton remained without power. • There is temporary lighting on Holcot & Brampton. • No routine surgical procedures to take place today only those where there is a risk to life or limb as the Trust is currently running on generators until repairs can be made. • There were a few patients scheduled who have been informed to contact the Trust later. • All areas ensured that the emergency sockets were working • Pharmacy reviewed drug fridge contents as they may need to be quarantined. • Labour ward lighting is back on so a decision needs to be made as to when/ if they can reopen. • Trust to remain on internal significant incident. • All areas are on generator the problem appears to be in Luke Building
07.23 Saturday 23 February	• 111 Manager informed that the Trust has reopened.
07.47 Saturday 23 February	• Trust fully re-opened. • EMAS, CCG, NHSE, KGH & MK all informed that the Trust is fully reopened including Maternity
07.50 Saturday 23 February	• Acting CEO handed over and briefed Saturdays on-call Exec on the issues that had occurred overnight. • Next meeting planned for safety huddle @ 10:00 where Anaesthetists & Estates Dept were in attendance. The Medical Director was also in attendance.
10.00 Saturday 23 February	• Full mains power was restored and confirmed in all areas by 10am • Luke Building generator change over switch was isolated – building was on mains power but did not have generator back up
Monday 24 February	• Estates debrief meeting and action plan developed.
Tuesday 25 February	• Select Switching attended site to investigate Luke building faulty switch and controller.
07.00 Tuesday 25 February	• Generator test carried out on 'old site' – this covers the West end of site fed from Generators 6 & 7 • All generator power confirmed and proved operational

08.00 Wednesday 26 February to Thursday 4 March	• Freedom on site to identify location of faulty cable • Cable fault located and repaired Thursday 4 March and HV open point returned to original location
07.00 Tuesday 2 March	• Generator test carried out on 'new site' – this covers the East end of site • All generator power confirmed and proved operational
Saturday 6 March	• Faulty switch and controller in Luke building replaced • Generator test carried out on Luke building supplies • Generator power confirmed and proved operational
Wednesday 13 March	• Full debrief undertaken.

The above timeline provides an overview of the incident. The formal debrief took place on Wednesday 13th March and the chair acknowledged staff who worked tirelessly to ensure patient safety was maintained throughout.

3. Patient risk

Whilst awaiting for the full debrief report, it must be noted that no patients came to harm due to the power outage.

Throughout the incident the Silver commander was advised & very well briefed on patient safety by a consultant anaesthetist.

4. Recommendations

The Board is asked to note the contents of this report and gain assurance surrounding preparedness of the Trust to provide an effective response to a range of incidents and emergencies.

5. Next steps

The formal debrief report is currently being written and work is being undertaken with the Governance department to undertake a full review of the incident. Technical lessons identified will be incorporated into the Estates and Resilience departments work-plan for 2019.

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28th March 2019**

Title of the Report	**Emergency Preparedness, Resilience & Response Annual Report**
Agenda item	**17**
Presenter of the Report	Deborah Needham – Chief Operating Officer, Deputy Chief Executive
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

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

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

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1.8
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential for or evidence that the proposed decision/policy

	will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Group

The Group is asked to:

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

Northampton General Hospital NHS Trust

Emergency Preparedness, Resilience & Response – Annual Report March 2019

1. Introduction

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

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

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

Background

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

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

2. Overview of EPRR

Risk Assessment

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

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

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

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

Partnership Working

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

Debriefing from Live Events and Exercises

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

Communications

Communications is critical in dealing with any adverse incident. The Trust has recently purchased a dedicated web-based system to assist with the notification and call-out process during an incident. As part of the rollout of this system, the resilience team are linking with key areas within the Trust to provide training and ensure ongoing maintenance of contact details. Additionally, work has recently been undertaken to install contingency phones throughout the Trust in order to maintain communication during periods of potential IT/network outage. As part of the Trust's exercise programme, a series of communication cascade exercises will be held throughout the year in order to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7.

3. Governance

Resilience Planning Group

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

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

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

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

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

Planning Sector Reports

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

Corporate Major Incident Response Plan

This plan details the Trust's actions in the event of a major incident (e.g., a rail crash, floods, or a terrorist attack). Such an event will require the hospital to employ a different method of working in order to manage the situation. The plan contains unit-level plans that details the actions required of individual areas to ensure that a trust-wide response is achieved.

Version 2 of the Policy was released in July 2017. It is currently under review to incorporate recent changes within the Trust, primarily the addition of Nye Bevan.

Business Continuity Management Policy

Business Continuity Management is a management process that helps to manage the risks to the smooth running of the organisation or delivery of a service, ensuring that the Trust can continue in the event of a disruption. These risks can be from an external environment (e.g., power failures or severe weather) or from within the organisation (e.g., system failures or loss of key staff). A

business continuity event is any incident requiring the implementation of special arrangements in order to maintain or restore services.

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

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

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

- Adverse weather
- Heatwave
- Pandemic influenza

Version 4 of the Policy was released in April 2018. The policy aligns to British Standard ISO22301.

EU Exit Business Continuity Plan

The EU Exit Business Continuity Plan has recently been developed in consultation with the Brexit Planning Group with the intention of managing the Trust's response to the potential risks associated with the UK's departure from the EU at 23:00 on 29th March 2019. A separate EU Exit briefing note has been drafted to provide the Board with assurance surrounding the Trust's Brexit preparedness.

Adverse Weather Plan

Adverse weather covers conditions such as snow, ice, fog, floods, gales and high winds and heavy storms, which render journeys by road extremely hazardous. This plan details how the Trust would manage an adverse weather event which would result in staff requiring assistance to attend their place of work, and/or requiring overnight accommodation. The resilience team have recently acquired the services of 4x4 Response UK, an organisation who provide 4x4 vehicles, equipment and trained personnel to support the emergency services in adverse weather and poor road conditions where conventional plans cannot cope.

Additionally, the Trust has arrangements with Northampton Leisure Trust who operate the onsite Cripps Recreation Centre and will provide a 'Snow School' play scheme for 5-13 year olds to allow staff, who would otherwise be required to provide childcare, to work in the event of school closures.

Training

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

- Quarterly ED training days which focus on major incident and CBRN responses, including erection of the CBRN decontamination tent and donning the Powered Respiratory Protection suits.

- Monthly loggist training to ensure that NGH has sufficiently trained members of staff who can act as loggists during an incident.
- Attendance at the on-call manager's workshop focussed on resilience.
- A Major Incident training session was held as part of the Francis Crick Development Programme's Operational Management Day.
- Members of ED and Resilience attended the Critical Care Network mass casualty event which highlighted the impact of recent terror events on the health economy.
- The Divisional Director for Surgery attended the Major Incident Surgical Training & Teams (MISTT) Training Course and highlighted the benefit for surgical staff to attend the session focussed on cadaveric procedures for damage control.

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

Exercising

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

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

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

It is vital to ensure that internal exercises are run in a multi-departmental context in order to provide areas of the Trust with an increased understanding of any potential requirements and realistic expectations in the event of an incident.

ED undertook major incident table-top exercises on 23rd February 2018, 12th October 2018 and 6th February 2019. These exercises are open to all. The latter exercise was preceded by a call-out system test prior to a table-top exercise.

On the 12th February 2019 a major incident table-top was run for On-Call Managers, covering many different aspects of major incident management in order to provide an insight into major incident response and to ensure it was applicable to all areas of the Trust.

On the 22nd February 2019, the Emergency Department, Anaesthetics and Critical Care ran a table-top exercise to test the practicalities of collaborative working in the event of an influx of casualties following a major incident. This was well received by all in attendance.

Staff who have attended table-top exercises have found them to be enjoyable and informative with lots of new useful information discussed.

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

Exercise Tartar took place on 1st March 2018. Based around an active shooter and hostage situation in Northampton shopping centre, the aim of the exercise was to test the updated NHS

England Concept of Operations for managing Mass Casualties. All providers were based in their respective locations, with CCGs, NHS England and other players in a 'central' location.

Following the declaration of a mass casualty incident, the Trust's Incident Coordination Centre (ICC) was activated in the same way we would if it were a real incident. Simulated casualties were triaged by the Ambulance service at the scene and subsequent facilitation of the management and tracking of the simulated casualties become our responsibility for the duration of the exercise.

The session was well received and a number of learning points were identified for incorporation into the Trust's Corporate Major Incident plan.

Exercise Blue Peter took place on 18th October 2018. Based around an active shooter and hostage situations in Solihull and Peterborough, the aim of the exercise was to test the multi-agency management of mass casualty incidents. As per Exercise Tartar in March, the session was well received and further learning points were identified.

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

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

Live Incidents

During 2018, NGH experienced a number of extraordinary incidents. These are detailed below:

- 26th February – 3rd March 2018: "Beast From the East":

A number of adverse weather events took place in 2018. Most notably was the severe cold weather, icy conditions and heavy snowy associated with the 'Beast from the East'. Prior to this, the Trust made arrangements with the onsite Recreation Centre to provide a 'Snow School' play scheme for 5-13 year olds to allow staff, who would otherwise be required to provide childcare, to work in the event of school closures.

Additionally, it was agreed that Trust would purchase the services of 4x4 Response UK, an organisation who provide 4x4 vehicles, equipment and trained personnel to support the emergency services in adverse weather and poor road conditions where conventional plans cannot cope.

- 13th June 2018: Pharmacy Water Leak

A sewage leak to multiple areas of pharmacy required the implementation of the departmental business continuity plan due to the potential disruption to the service, damaged stock and risk to medicines supply service and pharmacy aseptic unit.

- 18th June 2018: Failure of site water softening plant.

On Monday 18th June, the site water softening plant failed. The plant feeds softened water to the Sterile Services reverse osmosis water plant for subsequent production of water used in the thermal disinfection stage of the SSD automated washer disinfectors.

As a result, SSD were unable to process any surgical equipment through the washers as the water quality being produced by the reverse osmosis plant was outside of the required upper limit of 30 micro-Siemens for water conductivity. The Business Continuity plan was activated, however the plan identified Coventry and Warwickshire University Hospitals to provide support, this has since been amended to utilise Kettering and Bedford General Hospitals.

- 3rd & 4th July 2018: IT Outage

At 15:47 on Tuesday 3rd July 2018, and 19:40 on Wednesday 4th July, whilst migrating the Trust's network from one pair of core switches to a new pair, a network loop was detected. The fibre optic links that connect the two pairs of core switches were shut down by automatic network loop prevention. The effect of this happening was that everything physically connected to the older pair of core switches (both Trust Datacentres) and everything connected to the new pair of core switches (all computers, phones and any other devices that plugs into a LAN wall socket) became disconnected from each other. This resulted in a complete loss of service for anything that relies on the Trust wired network or wireless network. The remedy was to change the configuration of these links to ensure that a loop cannot shut these down again. Additional protection for network loops has also been added to the Trust network to ensure that the noise of a loop shuts only the individual port and not the whole switch. In addition, work was undertaken to ensure key areas of the Trust have contingency phones and hard copies of key documentation.

- 23rd July 2018: Level 3 Heatwave

On Monday 23rd July, the Met Office issued a Level 3 heatwave warning as the threshold temperatures across the county were reached. As per the Trust's Heatwave Plan, upon notification of a local Level 3 event, the Trust ensure that risk assessments are undertaken from the perspective of patients and staff, and steps are taken to control the temperature and prevent it rising further.

- 10th August 2018: Suspicious Package

At approximately 17:40 on Friday 10th August a package, which was found on Hospital Street, was handed into the nursing staff on the Manfield Daycase Unit. The package was subsequently handed over to Security who carried it to the Site Management Office on the 2nd floor. The Site Manager examined the package and saw a tube with fluid, some wires and a battery pack. The Site Manager contacted the Police and described what she had seen. The Police attended the site with 6 officers and also contacted the Fire Service. The Police Sergeant on site took a photograph of the package and contacted the Explosive Ordinance Disposal (Bomb squad) (EOD). Based on the information provided, the EOD felt it appropriate to attend NGH to view the package and make safe if required. The EOD also instructed the Trust and the Police to put in a 100 metre cordon. The NILO arrived on site & advised that a 100m cordon was not required as the risk was minimal given that the device had already been transported through the hospital by several people. The corridor to Benham & Creaton wards was cordoned off and the corridor running horizontally to the wards was also cordoned off. The Fire Service National Inter-Agency Liaison Officer (NILO) was contacted by the Fire Service Control and made the decision to attend NGH.

The Chief Operating Officer commenced a review of wards and clinical areas within the potential exclusion zone in order to identify how many patients may require evacuation and where these could be transferred internally.

The Chief Operating Officer, Consultant in Charge of ED, and the NGH Director On-Call felt that it was appropriate to request a full ED divert to mitigate the risk of the package being a viable IED. The Chief Operating Officer informed the CCG On-Call Director & NHSI. The On-Call Director contacted Kettering General Hospital and Milton Keynes University Hospital who both accepted the request for mutual aid.

On hearing the description of the package and based on the fact that the package had been transported around the hospital, the Fire Service NILO felt that it was unlikely to be an IED and considered it to be a Vape device. The NILO entered the cordon and examined the package and was convinced that the device was a Vape device. He passed this information onto the EOD but was informed that the precautions must remain in place until the EOD had cleared the scene.

Those in attendance at the debrief were in agreement that the incident was managed appropriately and patient safety was maintained throughout the incident.

- 26th September 2018: Ward Evacuation

The activation of a fire alarm due to a strong smell of battery gas led to the evacuation of Spencer and Head & Neck wards. The ward teams worked well, moving patients to a place of safety as soon as possible. The Fire Response Team acted in accordance with their roles and responsibilities, setting up the inner cordon, preventing people entering the incident area and taking initial control. They carried out initial investigation into the cause of the alarm and escalated to the appropriate level by calling the Fire Service via Security's mobile telephone direct from the incident. Areas had evacuated on sounding of the alarm, in-patient areas had not but evacuated when informed to do so. Throughout the incident, patient and staff safety was the foremost priority.

- 22nd February 2018: Power Outage:

At 23:15 on Friday 22rd February 2019, the entire old site, with the exception of Cripps and Area K lost power, with no mains or generator feed. An internal significant incident was declared and command and control was instigated. Although ED continued to have power, it was agreed to divert patients to neighbouring Trust's as theatres were without power, and during the early stages of the incident, work was being undertaken to determine which areas were affected. Areas instigated their business continuity plans and regular meetings took place throughout the night to review the situation. At 05:30 the Trust re-opened with the exception of maternity cases who remain on divert as electricity supply was not yet sustained. The Trust fully reopened at 07:47.

A full debrief was undertaken on Wednesday 13th March. Estates colleagues are confident that all has been done to rectify the issues. Staff worked tirelessly to ensure patient safety was maintained throughout the incident. There was no reported harm as a result of the incident.

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

4. EPRR Core Standards Review 2017/18

NHS England requires providers of NHS funded care to provide assurance against the National Core Standards in relation to Emergency Preparedness, Resilience and Response (EPRR). Work to complete the annual EPRR Core Standards self-assessment took place to ensure tthat the

results provide a true reflection of the Trust's overall position against the NHS Core Standard 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 checklist. As such it is not possible to undertake a direct comparison against last year's submission.

Table1 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

NHS England and CCG colleagues attended the Trust on 16th August to undertake a site visit and a review of our policies, procedures and processes. Initial feedback was very complimentary. Following the submission, site visit and attendance at the EPRR assurance panel, NHS England were assured that NGH were, for the third year in succession, "fully compliant" with the requirements of the core standards. This included assurance of the programme of work to address any gaps.

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

Priorities for 2019, as identified by the Core Standards review.

- Progress plans for a whole-site evacuation exercise.
- Increase the number of trained loggists and provide opportunities for skills to be practiced.
- Ensure attendance at executive level at LHRP meetings, or provide a deputy with delegated decision making authority.
- Continue planning for the potential of a no-deal BREXIT.

5. Recommendations

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

6. Next steps

The past year has seen good developments in the Trust's resilience arrangements; however work is required to maintain full resilience. The priorities highlighted above will determine the Emergency Planning and Business Continuity work plan for 2019.

Appendix 1

Core Standards letter - NGH 291118.p

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28 March 2019**

Title of the Report	**Update on the NHCP Local Digital Roadmap (LDR)**
Agenda item	**18**
Presenter of Report	Deborah Needham (Acting CEO)
Author(s) of Report	Hugo Mathias (CIO)
Purpose	To provide an update on the LDR and assurance for the monies invested via the NHCP

Executive summary

The Local Digital Roadmap for the NHCP is delivering projects to bring a more joined-up care environment for the County.

The paper provides a breakdown of the projects and expands on the major project of the Northants Care Record (NCR) which is a bold project to bring a single care record across the county.

The paper describes the situation as at Feb 2019 which is when papers were last published.

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

For information.

Updates for the Northamptonshire Health & Care Partnership (NHCP) Local Digital Roadmap (LDR) at March 2019

Introduction

The NHCP LDR is a Digital transformation programme for the county and is currently funding a range of projects. Funding is through two sources:

- ETTF (Estates & Technology Transformation Fund). Primarily for Primary Care
- HSLI (Health System Led Investment). Only for Secondary Care

There were 5 workstreams set up to assist in the delivery of LDR

- Business Intelligence
- Clinical Services
- Information Sharing
- Infrastructure
- Integration

These workstreams quickly produced plans for projects. The projects identified were the 'low-hanging' fruit for the region where impact and value could be demonstrated. There is currently no unified strategic document to describe the Local Digital Roadmap from a Countywide perspective that maps to the individual stakeholder organisations. As such, the projects are those identified as impactful and deliverable within the funding envelope.

The projects currently funded are:

Project Name	Description	Funding Source
Shrewd	Real-time system-wide view of capacity for the STP footprint	ETTF
Online Consultations	Primary Care, Patient Self Triage software	ETTF
Wi-Fi (GovRoam)	County-wide (and London) wifi connectivity via GovRoam	ETTF
HSCN	Health & Social Care Network, replacing the N3 with faster access	ETTF
MiDOS	County-wide Directory of Services	ETTF
Northampton Care Record (NCR)	A countywide care record providing access to Primary care, secondary care and Social care information – See Appendix 1	Phase 1 =ETTF Phase 2 = HSLI
Northants Analystic Reporting Platform (NARP)	A next generation of business intelligence and analytics system that sits on top of the integrated information,	HSLI
Northampton Information Exchange (NIEx)	A single unified data environment for the shared care records and wider system intelligence and analytics	HSLI
Northampton Information Engine (NIE)	An integration engine for organisations that do not currently have a tool to manage the flow of data	HSLI
Northants Personal Health Record (NPHR)	Patient Portal (Next Year)	Not funded yet

Details of the funding for each project will be released at the end of March 2019. Currently there is no detailed information on funding or expenditure.

Current Finance Update

ETTF monies

Budget / Expenditure (provisional update @ 11th Feb 2019)				
Source	Budget	Actual	Forecast spend	Variance
ETTF (17/18)	£3,150,000	£2,522,723		£627,277
ETTF (18/19)	£574,000	£574,344*		(£344)
eConsultation (17/18)	£187,000	£0	£440,074	£0
eConsultation (18/19)	£253,074			

* The ETTF outturn is based on the following expenditure being processed (and invoiced to NHS England before 31st March 2019):

- NEL Procurement (for NCR)
- 3 month PM for BI work
- Project Manager for Online Consultations (with NEL)
- Field Engineer for HSCH (with NEL)
- Primal animation
- MiDOS (12 month licence and band 3 resources)
- SMS messages for Online Consultations (tbc)
- Information Sharing Gateway (extend licence)
- Comms / Engagement Lead (allocate underspend to NHFT, so resource resides with NHCP comms team)

Additional to the ETTF money is the HSLI money as an investment into PROVIDERS.

		HSLI Funding		
Project Name	Lead Provider	18/19	19/20	20/21
NCR	NHFT	£105,000	£100,000	£512,000
NHPR	NHFT	£	£410,000	£750,000
NARP	NHFT	£400,000	£100,000	£250,000
NIEx	NHFT	£500,000	£450,000	£650,000
NIE	NHFT	£300,000	£100,000	£550,000
		£1,305,000	£1,160,000	£2,712,000
		£5,177,000		

Current LDR Risks identified at Feb 2019

No.	Risk	Risk @ feb 2019	Mitigation plans
1	There is a risk that the LDR delivery is compromised as future ETTF funding is not approved.	A	• £966k secured • Opportunity to submit new digital initiatives for 2019/20 (£0.5m remaining)
2	There is a risk that a delay to appoint a SRO, CIO and GP IT lead will compromise engagement and delivery	A	• SRO identified, further engagement required • Proposing that key posts are funded for 2019/20
3	There is a risk that agreement on the Northants Care Record is not completed by 31st March 19	R	• New chair identified • Fund the NCR PM post • Confirm the new timeline (into Q1 2019/20)
4	There is a risk that the any potential delays to the rollout of the N3 replacement HSCN will impact on the delivery of other digital projects	A	• HSCN with providers on track (Green) • Additional resource funding for Primary Care HSCN being offered • Rebase the migration timetable to manage cost overruns (for the CCG)

5	There is a risk that due to a new framework (DOS3) that the PMO is unable to secure resources in a timely manner.	A	• Develop resource model where workforce is either secondment or working from fixed term contract • Only one external resource (in place till 31/03); future funding proposition to be developed • External resource not via NEL (another partner)

Work-Stream Updates

Project	Commentary	RAG Current
Screwd	Shrewd Resilience – stability work for KGH data feeds has been completed. A&E Board will be updated in late Feb on Waitless benefits and Transforming Sytems are supporting this work.	G (delivered)
HSCN	Both KGH and NGH have placed orders with Virgin Media via the NHS Digital led aggregated procurement. Both sites are now awaiting dates for installation and commissioning of circuits. NHFT and the County Council are both part of the Eastnet procurement and continue to progress their procurement and installations.	G
Wi-Fi (GovRoam)	A final proposal to build a proof of concept (POC) between NGH, NEL CSU - Albany House GP practice and a care home that is under the care of Albany house is being developed. This POC will provide seamless access between NGH, Albany House GP practice and will also provide GP's connectivity back to their home GP practice at a care home. Once the POC has been proven then a there will be a decision point around enrolling further organisations and sites.	A
Northants Care Record	The scope, specification and requirement documents have been written and circulated for review and approval from the steering group leads with a view to have a finalised procurement timeline.	A
Online Consultation	The Clinical Systems Lead presented at the GP Practice Managers day.	A
NARP / NIEx / NIE	A project initiation document was presented at the DTP Board in January. The frailty dashboard is currently being created. EoI exercise with Board for approval however no funding is currently secured to mobilise procurement and resources.	A
MiDOS	Proposal with N&C CCG approved. Mobilisation underway with plans for early publication in 2019	G

Timescales for completion of projects

Project Name	
Shrewd	Completed. Closure report being produced.
Online Consultations	'Doctorlink' or 'Engage-consult' are the two products for online consultation. The plan is to offer this service to 75% of practices by 2020. We are currently below 40%. Funding stops on the 31st March via the LDR. The CCG will need to provide funding after this point.
Wi-Fi (GovRoam)	June 2019
HSCN	June 2019
MiDOS	Ongoing CCG project
Northampton Care Record (NCR)	The ETTF element. Clinical Portal: We are ready to go to market with this procurement. Funding is still not guaranteed as need contractual obligation to spend the money for this to be drawn-down from NHSE. Once the HSLI element is approved, there will be enhanced features that will be around centralising the data storage and ability to provide patient portal.
Northants Analystic Reporting Platform (NARP)	Planned for 2020-21
Northampton Information Exchange (NIEx)	Planned for 2020-21
Northampton Information Engine (NIE)	Planned for 2019-20 as part of NCR initial phase
Northants Personal Health Record (NPHR)	In scope so that supplier can see what we desire to do, but funding is not secured until funding stream 2019/20 – we anticipate this being funded out of HSLI funding.

Impact & benefit for NGH

Project Name	Benefits	Impact
Shrewd	• Ability to see system-wide real-time capacity utilisation providing the ability to understand the bigger picture. • Accessible anywhere via Shrewd App. • Logins available for any NGH employee.	• Provides insight into KGH capacity for transfers when required. • Provides executives with insight into the capacity issues at the hospital when not onsite
Online Consultations	• Benefits to Primary Care settings. Reduced attendance at Springfield is possible	• Could reduce the demand on OP or emergency services
Wi-Fi (GovRoam)	• Ability to logon to networks anywhere within the County where there is a public sector wifi router. • Ability to logon in other parts of the country where GovRoam is used (London mostly) • Access to JISC for cyber protection insight and assistance (considered UK leaders in cyber protection)	• Quicker easier access for staff to have connectivity and do their jobs.
HSCN	• Faster access to information on the internet (anything off-site) • Faster upload and download of imaging • Faster connections for GP's and enables information exchange	• Faster service for large files (images etc)
MiDOS	• Ability for our staff to refer to other services that are easy to find • Accurate and up to date service directory	• Patient pathway management easier through use of accurate and up to date information
Northampton Care Record (NCR)	• Ability to see whole holistic patient record when patients present • Ability to share information quickly and effectively • Reduced errors from unknown medical issues	• Better treatment plans • Better planning of services • Informed medical professionals
Northants Analystic Reporting Platform (NARP)	• Saved cost of business intelligence solutions • Whole health record analysis providing better insight into demand and capacity planning	• Reduced waste for NHS services through improved planning
Northampton Information Exchange (NIEx)	• Ability for others to share information, benefits the trust by being able to see the information	• Whole healthcare picture for clinical staff
Northampton Information Engine (NIE)	• Ability for others to share information, benefits the trust by being able to see the information	• Whole healthcare picture for clinical staff
Northants Personal Health Record (NPHR)	• Reduced SARs demands and costs for delivering SARs • Informed patients	• Happier and informed patients and carers

Appendix 1:

Explaining the Northamptonshire Care Record

Due to the complexity and costs associated with the NCR, we have summarised the project below.

The degree of information sharing across the Health and Social care network in Northamptonshire varies. The deployment of the Medical Interoperability Gateway (MIG) has enabled the view of 10 discrete primary care data sets by:

- 111 service,
- GP Out-of-Hours services
- NGH acute hospital.

There are some movements of data through joined services between Kettering General Hospital NHS Trust and Northampton General Hospital NHS Trust.

The NCR is to address the availability of data for system-wide population heath management and service development to achieve NHCP's four key priorities:

There is data sharing in relation to safeguarding (adults and children) which exists across all partners in health and social care, although this is not digitally enabled. There are moves towards digital health records in the two acute Trusts, and the CareFirst system replacement option in Social Care (both Adults and Children) is being prepared.

The primary care systems in use are

- SystmOne (~80%)
- EMIS (~20%),

The community services and mental health provider (Northamptonshire Healthcare Foundation Trust) uses predominantly SystmOne.

The partners involved in the Northants Shared Care Record project are:

- 71 GP Practices in the County
- Northampton General Hospital NHS Trust
- Kettering General Hospital NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Northamptonshire County Council (NCC) (hosting adults and children's social services)
- East Midlands Ambulance Service NHS Trust
- 111 Service provider (Derbyshire Health United Healthcare)

- GP Out-of-Hours service provider (IC24)

Current set-up

In terms of electronic patient record/patient administration supplier solutions in use across the main providers, the list of current suppliers is relatively streamlined. This excludes any specialty or specific data systems in use in acute and community hospitals. We have illustrated the provider systems map in figure 1 below.

Fig.1 – Principal EPR/PAS systems map across main health and care providers in Northants as at February 2019

Approach

NHCP would like to see the creating of a single cloud based data environment that will act as the source data for the NCR and our secondary care system analytics. This approach will become the Northamptonshire Data Model.

There are three key elements to deliver the Northamptonshire Data Model in the following sections.

1) Northamptonshire Care Record (NCR) – System Care Record
2) Northamptonshire Information Exchange (NIEx) – single data environment
3) Northamptonshire Analytics and Reporting Platform (NARP) – Self-service for BI

The three elements of the model will be enabled through an integration engine for providers who do not already have one or have the capability to support open APIs. This element is the Northamptonshire Integration Engine (NIE), which will integrate relevant data where required and transfer into NIEx.

This is a multi-year transformational programme, each element contains a degree of phased

implementation. Suppliers are asked to consider these elements collectively and individually to enable procurement of parts.

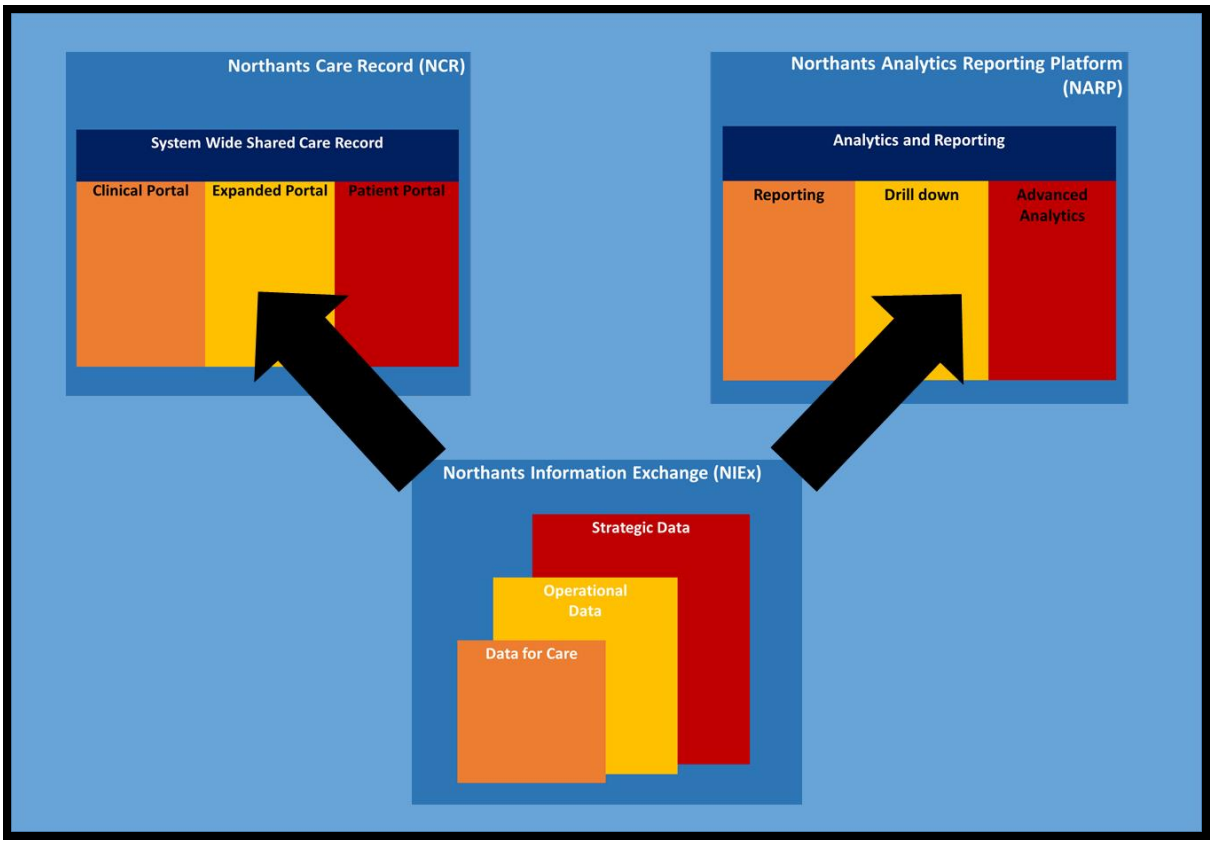


Fig. 2. Northamptonshire Data Model (Intended)

Northamptonshire Care Record (NCR) – System Care Record

The NCR is envisaged to commence as a project by delivery of the initial build of a clinical/care portal. Suppliers of the NCR will have their own solutions. We anticipate that integration engine technology (NIE) will be required to enable certain provider datasets to be utilised within the NCR.

As the local system matures we would expect to bring more data into scope of the NCR and also be aligning our data into the single data environment (NIEx described below). Alongside this we would expect to have a patient portal or access via the NHS App so patients can view and annotate their own data and information securely via mobile/personal devices. We have illustrated the intended delivery path in figure 3 below.

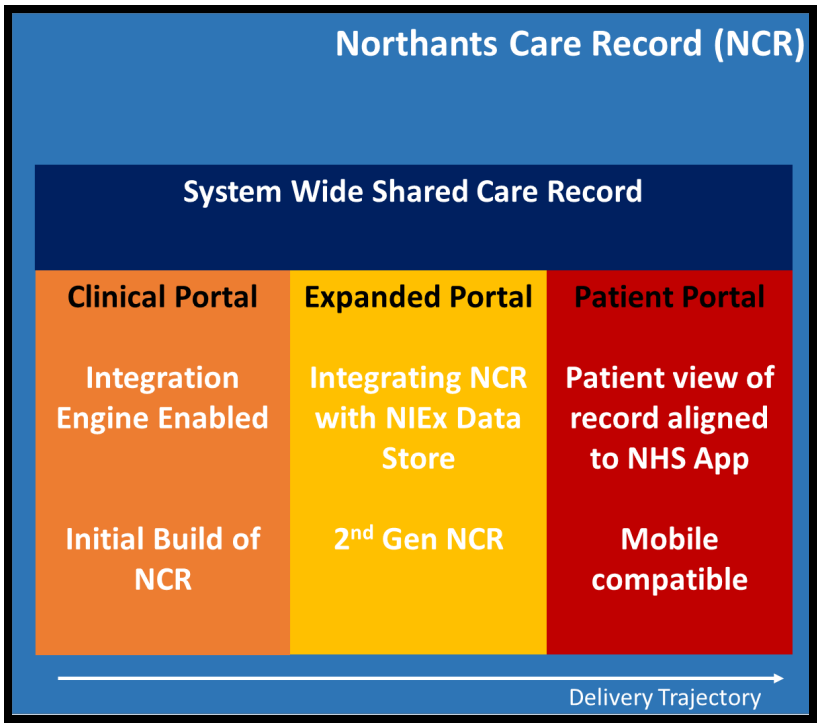


Fig. 3. Northamptonshire Care Record – Intended Approach and Trajectory

Northamptonshire Information Exchange (NIEx) – single data environment

It is our strategic intention to create a single unified data environment for shared care record and wider system intelligence and analytics. This is the NIEx or Northamptonshire Information Exchange. We would expect that local providers with current capability to flow data via HL7 FHIR messaging, API and FTP will be able to provide access to key elements of a base data set for provision of the NCR.

Our preferred direction of travel is to move from physical on premises data hosting and warehousing to a cloud based NIEx.

We expect the NIEx data environment to increase over time as more datasets are added into NIEx. We would expect datasets for the NCR to be identified first. Concurrent and on-going additional datasets for reporting and business intelligence/analytics would be sourced and imported including demographic data. After these core datasets are in situ, complex or additional internal datasets such as financial datasets or third party datasets will be added. This is set out in figure 4 below.

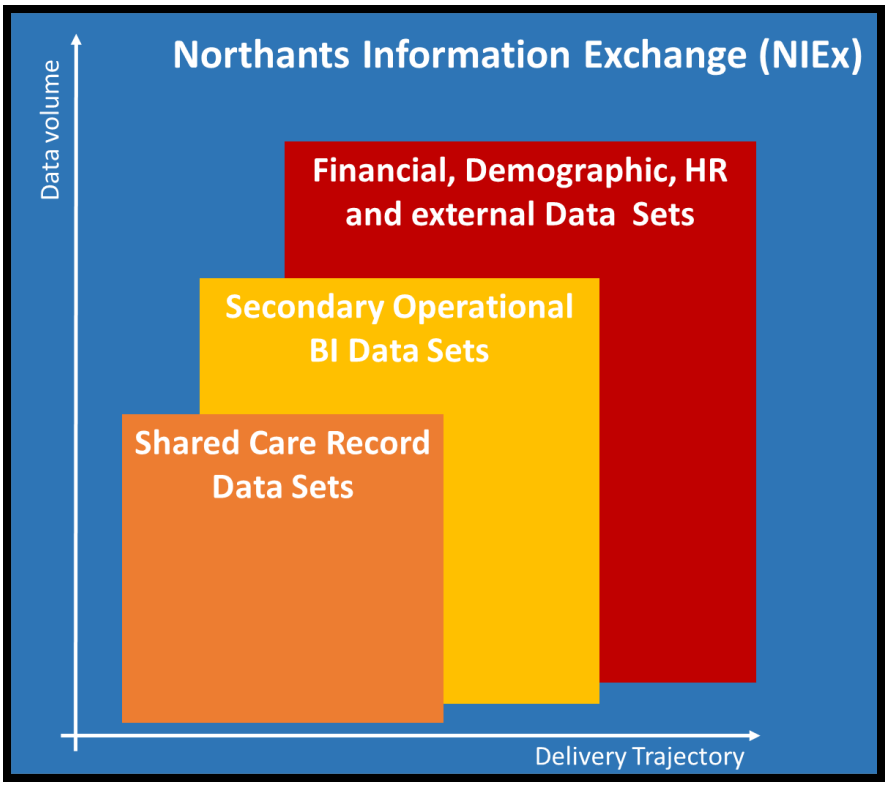


Figure 4. Northamptonshire Information Exchange – Intended Approach and Trajectory

Northamptonshire Analytics and Reporting Platform (NARP) – Self-service for BI

In order for the Northamptonshire Health and Care Partnership to deliver its key objectives, there is an essential requirement for robust up to date business intelligence integrated from multiple local organisations. To meet the increasing challenges for local services to achieve patient care targets, enable service transformation and identify financial savings, NHCP need to ensure they are intelligence-led.

We want to adopt the next generation of business intelligence and analytics systems through integrating information, so that the right intelligence is available to all stakeholders at the right time. This project will enable service transformation, assist in resolving the serious budget crisis that Northamptonshire NHS is facing, and, most importantly, improve patient outcomes.

The Northamptonshire Analytics & Reporting Platform (NARP) will support development of business intelligence capability that will provide the following:

- Visualisations for several specialties such as frailty, diabetes, cardiology and other key priority NHCP areas of focus.
- A data warehouse with pseudonymised data from multiple NHS and social care providers that can be used by providers for analysis to enable unmet need to be identified and services enhanced to meet the changing needs of patients across the region.
- Analytical tools that reference the data warehouse with sufficient capability to render reports in real-time via a dedicated business intelligence stack and software, along with a link to the Northamptonshire Information Exchange (NIEx).

- The potential for local and national submissions to be produced via the NARP to streamline the current process of multiple providers submitting separately.
- The foundations to reconfigure the model for delivering system-wide intelligence in the county over the longer term.

It is envisaged that implementation of NARP will require development of an interim data warehouse utilising a subset of health and social care data sets from local providers. Owing to demands for system-wide dashboards temporary data warehousing is required sooner, due to the anticipated timescales (greater than one year) for the implementation of the NCR and its associated data warehouse / integration architecture and reporting functionality. The intention is to use the NIEx as the single data store solution for the NARP once available as described above.

The provision of the NARP will enable a better understanding of risk stratification, the patient footprint, health condition prevalence, relationships with deprivation levels, population growth and other nationally available statistics, with forecasting built-in for the local (NHCP) health and care economy.

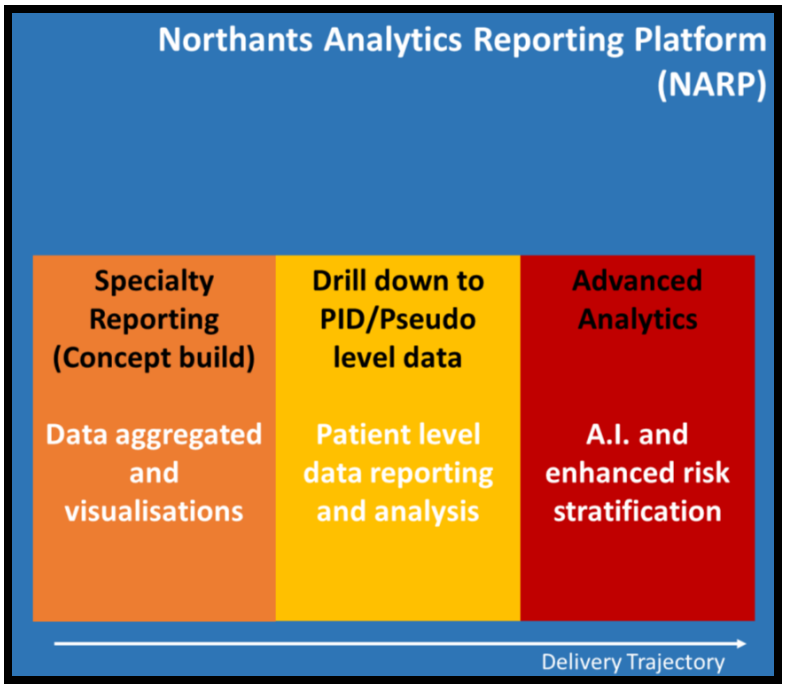


Figure 4. Northamptonshire Analytics Platform – Intended Approach and Trajectory

Financial context

There is funding available over the next 3 years that has been committed to the NCR.

The first phase will be for the care portal for sharing basic health and social care information. It is expected that this will be underpinned by integration engine and basic structure of NIEx digital information.

Simultaneously the development of the Northants Analytics Reporting Platform will be constructed alongside the development of NIEx.

Phase 2 will see the introduction of Personal Health Records and the work associated with 'patient activation' and the citizens of Northamptonshire taking greater ownership of their health and wellbeing; this should be aligned to NHS app roll-out. Aim to go to market for mobilisation in 2020/21. This phase will also see extensions to data sets that have not been included in phase 1.

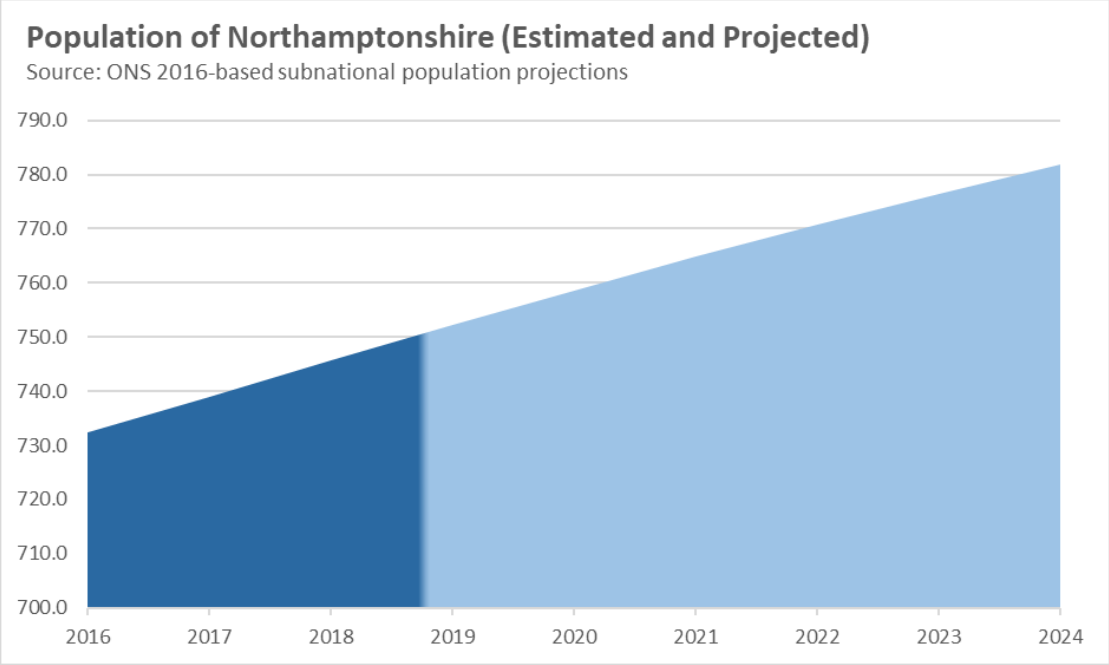
Phase 3 will see the transition of all the relevant components into a system-wide digital solution that will enable Northamptonshire to join the Local Health & Care Record (LHCR) programme with neighbouring STPs / ICS. This should see the NARP migrated across with all feeds being sourced by the NIEx.

There is a funding made available for the three phases of the project. The indicative fund range from £1.2m in the first year rising to circa £4m in the third year.

Demographic context

The county of Northamptonshire has an estimated resident population of 741,209 as per the 2017 ONS Mid-Year estimates. The population has grown by 7.1% since 2011, faster than the national average of 4.9%. The proportion that are children is 20% (0-15).

Given the estimated 5 year life of the project (from an IT product life perspective) the population estimate by 2024 is expected to rise to almost 782,000 residents.



COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: Thursday, March 28, 2019

Title	**Finance Committee Exception Report**
Chair	**David Moore**
Author (s)	**David Moore**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 20 February 2019 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:	**BAF References**
• **Finance Report for Month 10 and full year forecast;**	• ***5.1***
• **19/20 Budget Setting Update**	• ***5.1***
• **Changing Care @NGH Report**	• ***5.1***
• **Update on 19/20 Contract negotiation with CCG**	• ***5.1***
• **Operational Performance and Corporate Scorecard**	• ***1.1,1.2,1.4,1.5***
• **RTT Update**	• ***1.5***
• **Business Case Approvals**	• ***5.3***
• **Business Case Benefits realization**	• ***5.3***
• **Committee Effectiveness Review**	• ***1.1***
• **Terms of Reference**	• ***1.1***
• **IT Key Risks and Highlight Report**	• ***1.8***

Key areas of discussion arising from items appearing on the agenda

The Committee received the Month 10 Finance Report showing the Trust's pre-PSF position as £356K positive to plan on a year-to-date basis. Given the shortfall in PSF related to missing the Q3 A&E target, the Trust was £793K negative to plan on post-PSF basis. The Trust was now well placed to meet its full year control total of £27.7M, however there would be a further PSF shortfall given that the Trust would in all likelihood miss its Q4 A&E trajectory;

The Committee noted the fact that the only clinical service that operated at a surplus, and indeed was delivering above plan, was Ophthalmology which was also delivering on RTT. While it was acknowledged that the service had unique characteristics, it was questioned whether there were lessons that other services could learn from this performance;

The 19/20 Draft Plan had been submitted to NHSI with only minor calibrations to the high level numbers discussed at the January Board. Notwithstanding a report on the Plan presented to the Committee was reviewed in some detail. Concern was expressed by members about the adequacy of capital expenditure in future plans on estates (particularly maintenance backlogs), IT and medical devices. The Committee requested a paper be brought to a future Committee to give further assurance on prioritization and capital budgeting;

The fact that CIPs were at £14M+ in the 19/20 plan, similar to the current financial year, was scrutinized by the Committee who expressed concerns around delivery;

The Committee received an update on the situation with regard to contract negotiations and specifically the system gaps that could emerge as well as capacity issues;

Operational performance was reviewed and reports received on cancer, emergency medicine and RTT It was noted that only 4 out of 9 cancer targets had been met and that national targets for RTT and A&E had not been met. The Committee did receive reassurance from the Medical Director that the hospital was a safer place than a year ago;

The Committee reviewed the consolidated results received from members concerning the Committee's effectiveness. The results would be fed into the April Board meeting which would be looking at overall governance matters including Board Committees;

The Committee heard from the Director of IT that the number of incidents relating to confidentiality of patient data had risen.

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

The Committee gave final approval to two Business Cases that had been initially approved by the executive team. These were:

(1) Increase in Elective C-Section Staffing & Theatre Capacity
(2) Nursing Workforce Supply and Demand – Nursing Talent Academy 2019/20.

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

Continued concern around confidentiality of patient data subsequent to GDPR implementation where zero tolerance was the only option. This risk had been added to the Corporate Risk Register;

CIP's in the 19/20 plan were at the same levels as the current financial year of around 5%. Year on year. CIP targets at these levels posed a significant delivery risk.

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

Further scrutiny of the results of the Committee Effectiveness review.

Northampton General Hospital NHS
NHS Trust

COMMITTEEHIGHLIGHT REPORT

Report to the Trust Board: *28 March 2019*

Title	**Quality Governance Committee Exception Report**
Chair	**John Archard-Jones**
Author (s)	**John Archard-Jones**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *22 February 2019* 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: **Corporate score card** **QI Scorecard** **Nursing and Midwifery Report** **Medical Directors Report** **Deteriorating patients Board** **R&D annual report**	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)* ***1,2,3***

Key areas of discussion arising from items appearing on the agenda

Safety of patients during severe pressure of numbers
Continued work on 7 day services
Mortality rates
Risk management strategy
Patient experience

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

- **Thank you to staff for continued hard work.**
- **R&D Annual Report**
- **Approval of the BAF for 7 day services**
- **Approval of the Risk Management Strategy**
- **HSMR back within expected range**
- **Patient Experience – ongoing work to address communication issues**

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

None

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

Note thanks to staff for keeping patients safe.

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *28th March 2019*

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

Executive Summary

The Committee met on *20th February 2019* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries**
1. Medical Education	***3.3***
2. Medical Recruitment	***3.1***
3. Dementia Training	***3.2***

Key areas of discussion arising from items appearing on the agenda

1. **Medical Education –** making some progress. Integrated action plan covering issues from HEEM visit GP training survey, experience of junior doctors, to be presented at March meeting (MM)
2. **Medical Recruitment –** Divisional Heads to identify headcount required and gap analysis from which an action plan will be created to develop pipeline approach to recruitment of medical staff. Action plan to be presented at May committee (MM/JB)
3. **Dementia Training –** Proposal approved to provide role specific training for staff with direct contact with dementia patients, with voluntary option for all staff to join training (SO/JB)

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

Surgery action plan to be delivered at February committee – to be included in integrated plan **(MM)**
Medical recruitment pipeline – action plan due May committee **(MM/JB)**

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

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 28 March 2019
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 A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 31 January 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Story	Receive	Mr C Pallot	**Verbal**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Mortality and Learning from Deaths Update	Assurance	Mr M Metcalfe	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**F.**
	11.	Bi-Annual Review of Nurse Staffing & Midwifery Staffing	Assurance	Ms S Oke	**G.**
	12.	Assessment & Accreditation Update – Qt3 Update	Assurance	Ms S Oke	**H.**
10:35	**OPERATIONAL ASSURANCE**				
	13.	M11 Finance Report	Assurance	Mr P Bradley	**I.**
	14.	Operational Performance Report	Assurance	Mr C Holland	**J.**
	15.	Workforce Performance Report	Assurance	Ms A Chown	**K.**
	16.	Electrical Power Outage Incident Debrief	Assurance	Mrs D Needham	**L.**
11:05	**FOR INFORMATION & GOVERNANCE**				
	17.	Emergency Preparedness Annual Report inc Winter Plan	Assurance	Mr C Holland	**M.**
	18.	Local Digital Roadmap Update	Assurance	Mr H Mathias	**N.**
11:25	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**Q.**
	22.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal.**
11:45	**23.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 30 May 2019 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).