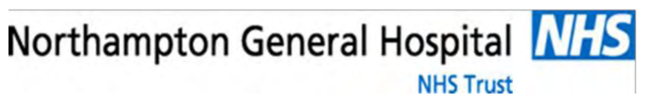
Public Trust Board

Thursday 29 September 2016

09:30

Board Room
Northampton General Hospital



A G E N D A

PUBLIC TRUST BOARD

Thursday 29 September 2016
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 28 July 2016	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Infection Prevention Annual Report	Assurance	Ms C Fox	**F.**
10:25	**OPERATIONAL ASSURANCE**				
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:50	**STRATEGY**				
	13.	STP and Clinical Collaboration Update	Assurance	Mr C Pallot	**I.**
	14.	Communications & Engagement Strategy Update	Assurance	Mrs S Watts	**J.**
	15.	Equality and Diversity Strategy Update	Assurance	Mrs J Brennan	**K.**
	16.	Sustainable Development Strategy	Assurance	Mr C Abolins	**L.**
11:15	**GOVERNANCE**				
	17.	Corporate Governance Report	Assurance	Ms C Thorne	**M.**
11:25	**FOR INFORMATION**				

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Integrated Performance Report	Assurance	Mrs D Needham	**N.**
11:35	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Q.**
	22.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**R.**
12:00	**23.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

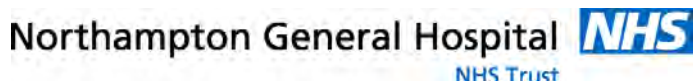
DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 24 November 2016 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).



Minutes of the Public Trust Board

Thursday 28 July 2016 at 10:00 in the Board Room
at Northampton General Hospital

Present

Mr P Farenden	Chairman (Chair)
Mr P Zeidler	Non-Executive Director
Dr M Cusack	Medical Director
Ms C Fox	Director of Nursing, Midwifery & Patient Services
Mr G Kershaw	Non-Executive Director
Mrs L Searle	Non-Executive Director
Mrs D Needham	Chief Operating Officer and Deputy Chief Executive Officer
Mrs J Brennan	Director of Workforce and Transformation
Ms O Clymer	Non-Executive Director

In Attendance

Ms K Palmer	Executive Board Secretary
Ms C Thorne	Director of Corporate Development Governance & Assurance
Mr C Pallot	Director of Strategy and Partnerships
Mr C Abolins	Director of Facilities and Capital Development
Mr A Foster	Deputy Director of Finance
Mrs S Watts	Head of Communications

Apologies

Dr S Swart	Chief Executive Officer
Mr S Lazarus	Director of Finance
Mr D Noble	Non-Executive Director

TB 16/17 025 Introductions and Apologies

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

Apologies for absence were recorded from Dr S Swart, Mr S Lazarus and Mr D Noble.

TB 16/17 026 Declarations of Interest

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

TB 16/17 027 Minutes of the meeting 26 May 2016

The minutes of the Trust Board meeting held on 26 May 2016 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 26 May 2016 as a true and accurate record of proceedings subject to two typographical errors.

TB 16/17 028 Matters Arising and Action Log 26 May 2016

The Matters Arising and Action Log from the 26 May 2016 were considered.

Action Log Item 53:
Dr Cusack advised that action log item 53 would be discussed at August's Board of Directors.

The Board **NOTED** the Action Log and Matters Arising from the 26 May 2016.

TB 16/17 029 Patient Story

Ms Fox presented the Patient Story.

Ms Fox shared with the Board a poem written by a patient who was undergoing

DRAFT

Cancer treatment.

Mr Farenden commented that the poem was powerful with a strong message about not being complacent in life.

Mr Kershaw queried whether the poem would be published. Ms Fox stated that it may be included in a future Director of Nursing blog.

The Board **NOTED** the Patient Story.

TB 16/17 030 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden advised that he had attended a meeting with fellow Chairmen and Non-Executive Directors to discuss the STP. Mr Farenden noted the frustration from the attendees on how the STP is progressing.

Mr Farenden reported that he had attended a Provider Chair Meeting with Dr Swart where Jim Mackay presented the RESET paper.

Mr Farenden stated that he was involved in a Health and Wellbeing Day where Multi-Speciality Community Providers were present. Mr Farenden commented that the GP Federation were the main attendees, with discussions based primarily on the challenges the GP's encounter. Mr Farenden advised that he had a 1:1 with the new chair of the Health and Wellbeing Board on how the Trust could bring the health economy together.

Mr Farenden reported that he had recently helped with the judging of the Best Possible Care Award nominees and was struck by the vast array of staff who had been nominated. Mr Farenden noted that he is looking forward to the event on 30 September 2016.

Mr Farenden commented that he had completed his 'Beat the Bug' rounds. Mr Farenden stated the rounds had presented the usual challenges and issues he had seen previously.

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

TB 16/17 031 **Chief Executive's Report**

Mrs Needham presented the Chief Executive's Report on behalf of Dr Swart.

Mrs Needham advised that the Trust welcomed Mr Ron Daniels, the NHS Institute Safer Care Faculty Chair who delivered a session on surviving Sepsis. Mr Daniels was very impressed by the patient outcome work and the continual focus on Sepsis that the Trust delivers.

Mrs Needham reported that NGH has been asked on behalf of the East Midlands Academic Health Science Network Patient Safety Collaborative (PSC) to develop and lead a system-wide improvement plan to reduce avoidable harm. Mrs Needham noted that NGH will be working with 8 other acute Trusts within the East Midlands and that the partnership will help raise the profile of NGH.

Mrs Needham commented that as the NHS moves into 'RESET' mode, it is important to continue the Trusts Quality journey. Mrs Needham stated the Trusts needs to continue to invest time and energy into our staff to ensure that they are equipped with the correct skills to further develop our services, make changes and provide the best possible care.

Mrs Needham advised that the Trust is working closely with the University of Northampton to deliver a Patient Safety and Quality Improvement accredited course at NGH. Mrs Needham stated that this is due to commence in 2017.

Mrs Needham reported that the STP had been submitted on 30 June 16 and was discussed at a national challenge meeting with Simon Stevens as well as other key leaders. Mrs Needham noted that early feedback received was that the plan was sensible and pragmatic. Mrs Needham shared with the Board that the key priorities in the plan are urgent care, development of the workforce, development of the IT infrastructure, development of primary and community care, and estate. Mrs Needham advised that the Trust has been asked to refine the plan and resubmit in 2 months. Mrs Needham commented that work on implementation has commenced with CEO leads and SROs for each work stream has been identified.

Mrs Needham stated that as Workforce is a large part of the STP, the Board are to note that Dr Swart has noted her appreciation to all staff in her weekly blog and also via a separate letter to all staff regarding Brexit. Mrs Needham advised that an early indication from other NHS providers is that turnover has started to increased but NGH does not appear to be seeing the same pattern. Mrs Needham commented that the communication was to ensure all staff feel highly valued including international staff.

Mrs Needham shared with the Board that she encourages board members to attend the Best Possible Care Awards held on 30 September 16.

Mrs Searle echoed Mrs Needham's comments on commitment to Quality. Mr Farenden stated that it is fundamental that the Trust delivers safe and high quality care.

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

TB 16/17 032 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack drew the Board to page 23 of the Board pack which highlights the continued improvement in the HSMR. Dr Cusack noted that the Trust has been below the line for the last 5 months and commented that next month the Trust will fall within the 'better than expected' range.

Dr Cusack advised that he had met with CHKS this week following the Trust being shortlisted for a National Safety Award. Dr Cusack stated that out of the 160 Hospitals nominated, NGH ranked in the top 5 in safety parameters and the top quartile for 13/15 of the parameters.

Dr Cusack commented that on page 20 of the Board pack there is a table that notes the number of Serious Incidents and Never Events by year since 2010. Dr Cusack noted that that Never Event reported on 07 April 16 is close to being submitted to the CCG.

Dr Cusack reported that since the last report to the Board, during the reporting period 1/5/2016 – 30/6/2016 4 new Serious Incidents have been reported, with a total now of 7 Serious Incidents in 2016/17. Dr Cusack advised that during the reporting period there were five serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure, one of which relates to a Never Event. Dr Cusack stated that the remaining four are listed on page 22 of the Board pack.

Dr Cusack advised that the SI Group commonly reviews incidents where there has been both moderate and severe harm therefore the title of the meeting was

potentially misleading. Dr Cusack noted that group name as a result has been changed to better reflect the group's function and is now been renamed as 'Review of Harm Group'. Dr Cusack commented that the terms of reference and agenda have also been amended accordingly. Mr Farenden queried whether the changes to the group will generate more structured learning. Dr Cusack believes that it will help people understand why certain incidents are not classified as a 'SI' but still requiring discussion within this forum. Dr Cusack noted that some incidents do not need as lengthy investigation and can be done in a more concise way.

Ms Fox commented that the changes to the group are proactive and will encourage staff to report incidents. Ms Fox stated that the group will now meet weekly which will enable the group to look at clusters of incidents that occur in a short time frame.

Ms Clymer commented that this is fantastic and is impressed by the use of best practice.

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

TB 16/17 033 Director of Nursing and Midwifery Care Report

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

Ms Fox advised the Board that the Nursing and Midwifery Care report had been discussed at all relevant sub-committees. Ms Fox stated that the report did not include the nursing staff numbers and gave the Board a verbal update on this. Ms Fox reported that the nurse fill rate continued to improve. Ms Fox advised that the 'Care Hours Per Patient Per Day' figures were being collected and Ms Fox awaits further information on this.

Ms Fox shared with the Board that the National Quality Document applies to all clinical staff rather than predominantly nursing.

Ms Fox reported that in June 2016 NGH achieved 98.2% harm free care (new harms).

Ms Fox drew the Board to page 28 of the Board pack which includes a graph demonstrating pressure ulcers/100 bed days in relation to hospital acquired pressure ulcers. Ms Fox noted that there are three key points plotted on the graph which was when pressure ulcer collaboratives took place. Ms Fox stated that a strong focus in the pressure ulcer collaboratives had been given to leadership, steering groups, cultural analysis and a review of training in TNA.

Ms Fox discussed that there had been progress made in all health care acquired infections. Ms Fox noted that this was positive and that it could be linked to increased activity as well as great work from the clinical teams.

Ms Fox advised that in relation to Falls Prevention, there is a review of best practice underway. Ms Fox commented that the Quality Assurance & Improvement matron has undertaken a 'gap analysis' of the recent Falls NICE guidance, the Trusts current Falls care plan, Bed rail assessment and care plan to objectively consider if further improvements can be made. Ms Fox stated that the outcome will be discussed by the Falls Team and Patient Nursing Services.

Ms Fox reported that the ADN's would be completing a cluster review on moderate to severe harm falls.

Ms Fox drew the Board to page 35 of the report which details the progress on the Friends & Family Test. Ms Fox commented that although the Trust is below the national average, the Trust is making significant progress with a performance rating

of 91.7% in June 16.

Ms Fox shared with the Board that the Trust had achieved its Dementia CQUIN for Q1. Ms Fox stated that the Trust had also achieved the Anti-Microbial CQUIN for Q1 and gave her extended thanks to the Audit & Governance team for their hard work on helping to achieve this.

Mr Farenden commented that it was encouraging to hear about the progress made in infection prevention control. Mr Farenden remarked that on recent visits to 2 wards he had noted complacency on hand hygiene and queried whether a reminder could go out to all staff stressing the importance of this. Ms Fox clarified that there will be a question in the 'Real Time, Right Time' survey about staff washing their hands and will be able to use this data to drive to the front line teams.

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

TB 16/17 034 Same Sex Accommodation Board Statement of Compliance

Ms Fox presented the Same Sex Accommodation Board Statement of Compliance.

Ms Fox advised that the report was for information only.

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

TB 16/17 035 24 Hour Survey in A&E – Summary Report

Mrs Needham presented the 24 Hour Survey in A&E – Summary Report.

Mrs Needham advised that on 22 March 16 a survey was undertaken by Healthwatch in A&E. Mrs Needham stated that the survey was requested following an increase in activity and the survey would give an subjective opinion as to why patients were coming to A&E.

Mrs Needham reported that a paper survey was handed out to 144 patients over a 24 hour period.

Mrs Needham commented that the results of the survey were highlighted on page 51 of the report pack and summarised the key findings to the Board. Mrs Needham advised that patients are speaking to a GP, a receptionist in Primary Care or ringing 111 prior to attending A&E. Mrs Needham noted that the majority of patients were advised to come to A&E and the patient believed that they were in the right place. Mrs Needham reported that 37% of the patients could have been seen by a GP and did not require care in A&E.

Mrs Needham stated that key comments made by the patients were the lack of access to GP surgeries and the inability to get an appointment. Mrs Needham noted that there is a challenge to access a GP for some patients in the county. Mrs Needham reported that that the report has been shared with the CCG Mrs Needham commented that a response is yet to be received; however the Urgent Care workstream in the STP will address the concerns.

Mr Farenden suggested that an action plan needs to be devised. Mrs Needham listed the 3 Urgent Care groups for the Board as the Urgent Care Network (Provider led), Urgent Care Programme (part of the STP) and the Urgent Care Working Group (which GP Federations do not attend). Mr Pallot commented that the issue is a system problem and not a sector problem.

Mrs Needham advised that there was the possibility of writing to the Practice Managers at the individual surgeries listed on page 64 of the Board pack. Ms Fox stated that the Lead GP from the CCG attends CQRN and Ms Fox suggested that

the issue could become a standing agenda item at this meeting. Mr Farenden confirmed that this would the right environment to raise the issue. Ms Fox advised that she would take this to CQRM.

Action: Ms Fox

Mr Zeidler commented that it was brilliant initiative to request an independent survey and queried whether it could be done on a more regular basis to obtain a trend. Ms Fox clarified that she would speak to the Healthwatch Manager and also the Head of Patient Experience & Engagement about future surveys.

Mrs Searle remarked that the report was very useful and if the survey was repeated the larger number of results collected would able the Trust to further identify practices that are referring the highest number of patients to A&E.

as primary care contracting is the responsibility of the CCG and the Trust is unsighted on the contents of those agreements
The Board **NOTED** the 24 Hour Survey in A&E – Summary Report.

TB 16/17 036 **Equality and Diversity Report**

Mrs Brennan presented the Equality and Diversity Report.

Mrs Brennan advised the report contained the Equality and Human Rights Workforce Annual Report 2015/2016, the Equality & Human Rights Workforce Monitoring Report 2015/2016 and the Equality Objectives July 2016. Mrs Brennan stated that the Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities.

Annual report

Mrs Brennan in drawing attention to progress against the annual staff survey results noted that the percentage of staff stating they had experienced discrimination at work in the last 12 months had significantly improved since the 2014 survey results and is above average (better than) when compared to acute Trusts. Mrs Brennan advised that there has been a slight improvement in relation to the second key finding which relates to the percentage of staff who believes that the organisation provides equal opportunities for career progression and/or promotion. Mrs Brennan noted that notwithstanding the improvement work is still needed on this indicator.

Mrs Brennan advised that the Trust has recruited over 100 overseas nurses and noted that she has future concerns on EU recruitment following on from the Brexit result.

Mrs Brennan reported that the in February 2016 the Trust was presented with an Employer of the Year award for its support of apprentices from South Leicestershire College.

Monitoring report

Mrs Brennan explained that the purpose of this analysis was to enable the trust to review its workforce profile against that of the local population, identifying consistencies and apparent inconsistences. For example Mrs Brennan stated that the Trust has a greater proportion of BME staff employed than the proportion of the BME population within the local community.

Mrs Brennan also explained that the analysis included an internal review against key performance indicators by protected characteristics, for example she drew attention to the fact that younger people tended to have greater levels of sickness absence than older staff.

Mrs Brennan drew the Board's attention to page 148 of the Board pack which details the Equality Objectives Four Year Plan 2016 – 2020. Mrs Brennan explained that the Equality objectives had been updated to incorporate objectives arising from the WRES analysis to support the four year plan and recommended this to the Board for approval following endorsement by the Workforce Committee.

Mr Farenden asked for clarification on the areas of vulnerability within the report for the Trust. Mrs Brennan confirmed that the percentage of BME Senior Managers is lower than the BME population within the local community. Mrs Brennan commented that there is refresher training planned for appointing officer staff and that the Equality & Diversity Staff Group will continue to monitor this.

Mrs Brennan advised that executive appointments had been administered by the recruitment agencies and therefore no data was available for that group.

The Board **NOTED** the Equality and Diversity Report and **APPROVED** the Equality Objectives Four Year Plan 2016 – 2020.

TB 16/17 037 **Finance Report**

Mr Foster presented the Finance Report.

Mr Foster advised that in terms of the key numbers the overall I&E position is a deficit of £3.003m which is £43k favourable to the year to date plan. Mr Foster noted that this position is measured against the revised I&E control total agreed with NHSI for FY16-17 and includes Sustainability Funding of £2.4m at Q1.

Mr Foster reported that the Trust had Strongly advised not to miss Q1 financial position by NHSI. Mr Foster stated that a number of non-recurrent measures were applied to the underlying Q1 position to ensure delivery of this important target. Mr Foster noted that the adjustments at Q1 included a review of aged Agency staff and non-pay accruals £160k, accrual for approved non-recurrent VAT claims £83k, release of CCG SLA provisions £150k and release of deferred income £100k. Mr Foster advised that the application of these measures whilst low risk give rise to a reduced level of flexibility in managing financial pressures likely to be experienced later in the financial year.

Mr Foster commented that Pay expenditure gives cause for concern at Q1 and is £2.496m (5%) adverse to plan for the year to date driven by high costs of agency medical staff and agency HCAs. Mr Foster shared with the Board that a number of actions have been put in place to review and control medical & HCA agency in the last two weeks and management haver responded well to this challenge. Mr Foster advised that the medical divisions have been asked to review their medical agency staff and that the Senior Nursing Team are addressing the high HCA enhanced care costs.

Mr Foster stated that Agency expenditure is currently exceeding the authorised cap set at £13.04m (£13.04m is equivalent to a 26% reduction year-on-year across all staff groups) by £0.95m driven by a spike in Medical staffing costs in June. Mr Foster reported that NHSI are taking a very close interest in management of the cap and may look to audit our procedures and controls in the near future.

Mr Foster commented that the CCG are raising significant and increased levels of contractual data challenges in Q1. Mr Foster noted that there remains some risk in the delivery of certain CQUIN schemes. Mr Foster was encouraged by the positive news received from Ms Fox of the achievement of the Anti-Microbial CQUIN.

Mr Foster advised that cash flow is being managed effectively with the risk previously associated with this dissipated.

Mr Foster shared with the Board that following the Finance Investment and Performance Committee a formal forecast exercise to be undertaken in August 16 to assess the impact of the current run rate against the revised plan and to overly known changes (e.g. private sector Bed expansion plans).

Mr Foster noted that there will be a financial focus on non-medical and non-nursing agency staffs which Mrs Needham has already commenced work on.

Mr Foster advised that clinical pay, back office and Pathology issues will also be addressed.

Mr Farenden urged the Non-Executive Directors to read the RESET documentation issued by the NHSI.

The Board **NOTED** the Finance Report.

TB 16/17 038 **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the Substantive Workforce Capacity increased slightly in June 16. Mrs Brennan stated that annual Trust turnover decreased by a further 0.17 to 9.97% in June 16 which is above the Trust target of 8%.

Mrs Brennan reported that sickness absence increased by 0.30% to 4.26% which is above the Trust target of 3.8%.

Mrs Brennan drew the Board to page 170 of the Board pack which details the Appraisals, Mandatory Training and Role Specific Essential Training compliance rates. Mrs Brennan noted that Mandatory Training compliance has increased for the 3rd consecutive month and congratulated staff for attending despite internal pressures.

Mrs Brennan shared her concern that the Role Specific Essential Training compliance rates could be criticised by the CQC. Mrs Brennan advised that a deep-dive will be completed. Mrs Brennan confirmed that she has also asked the Divisions to look at in further detail at their Divisional Performance meetings and for the Divisions to devise action plans. Mrs Brennan stated that she would bring the action plans to Octobers Board of Directors.

Action: Mrs Brennan

Mrs Searle queried the Annual Turnover (Permanent Staff) table on page 173 of the Board pack and asked for clarification as what staff were categorised under 'Other Clinical Support' within the CSS Division. Mrs Brennan advised she would investigate and bring back to next month's Board of Directors (August).

Action: Mrs Brennan

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

TB 16/17 039 **Clinical Collaboration Update**

Mr Pallot presented the Board with a Clinical Collaboration Update.

Mr Pallot advised that feedback following the first submission of the STP was that the Trust's STP was categorised as 'amber'. Mr Pallot noted that a revised plan would be submitted at the end of September 16. Mr Pallot stated the STP document needed more granularity and this was to be incorporated in the project brief for each workstream as well the project initiation document for each workstream.

Mr Pallot drew the Board to page 182 of the Board pack which details the proposed structure for delivery the STP. Mr Pallot advised that he would be working on the Scheduled Care Programme element of the structure with KGH's Chief Executive (Mr David Sissling) as the lead. Mr Pallot stated that he had met with Mr Sissling to discuss the Scheduled Care Programme and to set out their expectations to the CCG. Mr Pallot noted that in principle the Trust can only deliver 3 of the 10 work-streams due to current resources. Discussions are ongoing with the CCG to have a number of their staff allocated to the workstream to ensure delivery.

Mr Pallot advised that he has met with Capsticks LLP to discuss a contractual agreement with KGH (Federation) and an update on this discussion will be given at Augusts Board of Directors.

Action: Mr Pallot

Mr Farenden commented that it was good to see the proposed structure for delivery of the STP.

Ms Clymer queried whether it was likely that Mr Pallot will receive the additional resources he has requested. Mr Pallot stated that he has asked for additional human resource and financial support.

The Board **NOTED** the Clinical Collaboration Update.

TB 16/17 040 Annual Fire Safety Report 2015/16 including the Annual Statement of Fire Safety Compliance

Mr Abolins presented the Annual Fire Safety Report 2015/16 including the Annual Statement of Fire Safety Compliance

Mr Abolins advised that the report highlights the risk assessments taken by the fire office across the Trust and findings from these assessments have been used to prioritise fire safety works within the rolling annual capital programme.

Mr Abolins drew the Board to page 191 of the Board pack which lists the building works incorporating Fire Safety completed during 2015/16. Mr Abolins summarised that these included completion of alterations to form new Ambulatory Care Centre and Clinical Observation area, including improved fire barriers, fire alarm and automatic fire detection system, emergency lighting system and extension of the automatic fire suppression system; Completion of works to Gosset Ward including new fire alarm and automatic fire detection system and new emergency lighting system; Completion of alterations to form a new Blood Taking Unit including extension to the existing fire alarm and automatic fire detection system and new emergency lighting system.

Mr Abolins noted that a phased programme of improvement was underway on the Trust's fire alarm and automatic fire detection system.

Mr Abolins reported that annual training attendance had improved with 78.3% compliance at the end of April 2016.

Mr Abolins stated that fire drills have continued during 2015/16 with 64 areas completing one.

Mr Abolins advised that 6 fire incidents occurred on site (5 - 2014/15), 5 resulted in the activation of the fire alarm system. Mr Abolins noted 2 of concern, firstly when a patient accidently set fire to bed clothes. Mr Abolins confirmed that patients should not be allowed access to fire making materials. Mr Abolins advised that second incident was when an e-cigarette battery overheated in a staff member's pocket,

which then fell on the carpet and caused a minor fire.

Mr Abolins reported that since 1 April 2015 there have been 35 activations of the fire alarm system between 0800h and 2000h which would previously have had an FRS response but which were successfully dealt with by the Trust's Fire Response Team. Mr Abolins stated that the FRS did attend on 7 occasions during this time. There were 33 actuations of the fire alarm between 2000 and 0800h resulting in 26 attendances of the FRS.

Mr Abolins commented that moving forward work is still be done on the action plan that followed the external audit in the Trust's fire safety management for compliance with HTM 05-01 which was completed in 14/15.

Mrs Searle queried whether there was a trend noted in the reasons behind the increase in fire activations. Mr Abolins clarified that as the fire alarms get older, the alarms are likely to encounter more problems.

Mrs Needham queried whether action is needed in light of the incident involving an e-cigarette battery. Mr Abolins confirmed that a risk assessment and audit would be completed. Mr Abolins stated he would bring the report to a future Executive Team meeting.

Action: Mr Abolins

The Board **NOTED** the Annual Fire Safety Report 2015/16 including the Annual Statement of Fire Safety Compliance.

TB 16/17 041 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that the Integrated Performance Report had been discussed at all relevant sub-committees.

Mrs Needham reported that the Trust had performed at 94.6% for the AE 4hr target in June and that the good performance had continued into July. Mrs Needham shared with the Board that the Trust was performing above trajectory in both Cancer and A&E.

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

TB 16/17 042 Highlight Report from Finance Investment and Performance Committee

Mr Farenden presented the Report from the Finance Investment and Performance Committee.

The Board were provided a verbal update on activities undertaken during the month of June and what had been discussed at the Finance Investment and Performance Committee meeting held on 20 July 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Farenden advised of the key points –

- The Changing Care @NGH programme was discussed in detail.
- Medicine and Surgery are due to enter a formal recovery process.
- The agency cap in line with medical staff was discussed in detail.
- The positive performance in A&E.
- The improvement of ambulance handover times.
- Angela Grace Business Case was recommended for approval to the Board from the Finance Committee.

- Extension of the Vascular Service Business Case was recommended for approval to the Board from the Finance Committee.

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

TB 16/17 043 **Highlight Report from Quality Governance Committee**

Ms Searle presented the Report from the Quality Governance Committee.

The Board were provided a verbal update on activities undertaken during the month of June and what had been discussed at the Quality Governance Committee meeting held on 22 July 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mrs Searle advised of the key points –
- The Medicine Optimisation Plan was discussed with a further update requested.
- A QI update was received.
- An update was given on QuEST/ECLIPPs work on the End of Life Pathway.
- The Theatre Safety Report was present by Dr Frerk with a further update requested.
- The CQC monthly update report was received by the Committee.
- The Committee approved the Heatwave Plan.
- The Committee continue to commit to Quality throughout the Trust.

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

TB 16/17 044 **Highlight Report from Workforce Committee**

Mr Kershaw presented the report from the Workforce Committee.

The Board were provided a verbal update on activities undertaken during the month of June and what had been discussed at the Workforce Committee meeting held on 20 July 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Kershaw advised of the key points –
- The OD plan was discussed.
- Recruitment and retention plan were discussed and action plans noted.
- A joint presentation on Nursing Initiatives from both a HR and Nursing perspective.
- The impact Brexit could have on international recruitment.
- The impact tuition fees could have on recruitment.
- Associate Nurse Role.

Mr Kershaw advised he had attended a Freedom to Speak Up workshop and noted that NGH appears to be taking a good approach to delivering this responsibility.

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

TB 16/17 045 **Highlight Report from Hospital Management Team**

Mrs Needham presented the report from the Hospital Management Team (HMT).

Mrs Needham advised that the gap in trainee doctors in Anaesthetics was discussed.

Mrs Needham stated that the Division has developed action plans to mitigate this risk.

Mrs Needham commented that a presentation was given on the acute assessment hub.

Mrs Needham reported that the HMT had reviewed the Angela Grace and extension of Vascular Services Business Cases and had recommended approval to the Finance Committee.

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

TB 16/17 046 **Any Other Business**

Mrs Brennan advised that the Trust had appointed an ENT Consultant to the Junior Doctor Guardian role.

Date of next meeting: Thursday 29 September 2016 at 09:30 in the Board Room at Northampton General Hospital.

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

Public Trust Board Action Log

Last update 02/09/2016

Ref	Date of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
NONE								
Actions - Current meeting								
63	Jul-16	TB 16/17 035	24 Hour Survey in A&E – Summary Report	Mrs Needham advised that there was the possibility of writing to the Practice Managers at the individual surgeries listed on page 64 of the Board pack. Ms Fox stated that the Lead GP from the CCG attends CQRN and Ms Fox suggested that the issue could become a standing agenda item at this meeting. Mr Farenden confirmed that this would the right environment to raise the issue. Ms Fox advised that she would take this to CQRM.	Ms Foc	Sep-16	On agenda	Update to be given in Matters Arising
Actions - Future meetings								
59	Jul-16	TB 16/17 038	Workforce Performance Report	Mrs Brennan shared her concern that the Role Specific Essential Training compliance rates could be criticised by the CQC. Mrs Brennan advised that a deep-dive will be completed. Mrs Brennan confirmed that she has also asked the Divisions to look at in further detail at their Divisional Performance meetings and for the Divisions to devise action plans. Mrs Brennan stated that she would bring the action plans to Octobers Board of Directors.	Mrs Brennan	Oct-16	On Track	To be discussed at **Octobers** BoD

Report To	**Public Trust Board**
Date of Meeting	**29 September 2016**

Title of the Report	**Chief Executive's Report**
Agenda item	**7**
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Public Trust Board
29 September 2016

Chief Executive's Report

1. **Staff Health and Wellbeing**
   There is an increasingly obvious and critical need to improve the health and well-being of the NHS workforce. As pressure on the NHS increases there is a real danger that the workforce is unable to cope with the demands that are made resulting in demoralisation and poor retention and recruitment of staff at all levels. There are a number of strands of work over recent years that have been supported in order to address the various issues. These include the Trust's focus on Quality Improvement, the Staff Engagement Strategy and our Communication Strategy and a variety of initiatives that support the development of the workforce. The Health and Well Being Strategy was launched last April and is being supported through the Health and Well Being Steering Group led by executive directors and enthusiastically promoted by emerging leaders at NGH and the communications team. It was fantastic to receive such excellent feedback at a recent Healthy Workplace Conference at Northampton University where the presentation on 'The Northampton General Hospital Journey to a Trust Wide Programme' delivered by Sarah Ash and Anne-Marie Dunkley was described as conveying ' infectious enthusiasm' for an impressive programme of work. This is such a critical part of delivering improvements for the workforce that it is important that the Board to be aware of the improvements underway and that key programmes are acknowledged, supported and extended where possible. It is particularly important to note that the current steering group has a membership that extends to partners across health and social care and confirms the ambition to move towards the concept of NGH as a Health and Well Being campus. The promotion of a healthy and resilient workforce is a key component of high quality patient care

2. **Cross-Party Commission on the Future of Health and Social Care**
   In early August I was interested to receive a letter from some senior politicians and an independent charity asking for support for setting up a cross-party commission on the future of the NHS and Social Care. Norman Lamb, Stephen Dorrell, Liz Kendall and Janet Morrison all express their concern at the very serious impact of the current chronic under-funding of the NHS and Social Care. I hope to be able to contribute to contribute to these discussions.

   The board will be aware of Northamptonshire County Council's proposed cuts to the adult social care budget which will inevitably impact on this hospital. For this reason it is essential that we do all we can to improve those areas which are within our control. As we plan for our new 60 bed facility we have an opportunity to really think about new models of care and use that to lever improvements in care throughout the hospital. We also need to ensure that our new emerging models of care both now and for the future use every opportunity to move towards more coordination across the health and social care system. The impact of cuts in social care needs to be mitigated in ways that change these conversations so that they are more productive and less blame focussed.

   More recently Chris Hopson, CEO of NHS Providers, has warned the government that it will face 'unpalatable choices' if the service is to remain within the existing budget. This warning was delivered days after the NHS posted its worst set of performance figures for services such as A&E, planned operations and ambulance response times.

   Hopson blames the 'full-blown crisis in social care, created by cuts to town hall budgets' for causing 'major problems for the NHS'. His message is also echoed by Chris Ham, the King's Fund chief executive, who said 'The clear message from NHS leaders, doctors and nurses I've spoken to is that they are increasingly unable to cope with rising demand for services, maintain standards of care and stay within their budgets.'

This frank and open discussion in the media about the NHS by such eminent figures is something that I welcome. We recently had an exceptionally difficult week in terms of emergency pressures and had to resort to all the measures we usually use in the height of winter, including the cancellation of elective procedures. But no matter how well everyone at team NGH pulls together to cope with the crisis, we continue to be concerned about we can continue to sustain services.

It is important that we remember that despite the increased pressure we have managed to do reasonably well on most mandated quality measures. We can certainly show improvements in mortality measures and many harm measures, as well as in improved systems and safety awareness across the hospital over the last few years.

This is something we must not lose sight of and is something which has only been possible because of the exceptional commitment of so many of our staff. The more pressures that we face as a hospital and in the NHS generally, the more important it is that we continue to focus on what matters most which is the experience of our patients and our staff.

3. Sustainable Transformation Plan (STP)

We continue to work with our colleagues in health and social care, community services and the voluntary sector on the Northamptonshire STP to develop programmes that will improve care and reduce cost.

So far a series of programmes have been agreed. The Board will be aware that here at NGH we are focusing specifically on working more collaboratively with Kettering General Hospital for a range of specialities and contributing to the many discussions about programmes of work that are set out to improve the care out of hospital so we have fewer admissions and better discharge arrangements. We have also formally committed to improving the coordination of care across the system and to supporting the prevention agenda. There is also an agreement that that we need to work collaboratively to ensure that all providers can be more efficient both individually and collectively.

Whilst we have agreed the broad programmes of work, we have not yet agreed the full detail of the implementation plan that needs to sit underneath the broad ambition. Work is also still under way to understand exactly how the reductions in cost will be realised. This is true for our STP and for many others across the country.

NHS Improvement and NHS England continue to oversee progress and are pushing the STPs nationally to develop and deliver schemes that result in a reduction in the cost of services. It is these 44 plans across the country that have the task of delivering savings to reduce the NHS deficit. These plans will need to be built into our routine contracts and in to business planning each year. It is for this reason that we are actively encouraging our clinical staff to get involved in those areas that affect them as the plans are clarified and become part of our normal planning and operating model in the years to come

4. Patient Safety

I continue to be impressed by the efforts that go on every day to keep our patients safe across the hospital site. Balancing the needs of patients at every stage is not an easy task with the continual pressure on our bed base 24 hours a day, every day. The emphasis on safety continues for the site team, the on-call teams and for all the clinical teams.

Whilst A&E is often the barometer for pressure in the hospital and there is no doubt that this pressure is increasing, it is also an area where we have a particularly successful focus on patient safety. Walking around our A & E department in recent weeks I am really impressed at the positive atmosphere despite the pressures and can see a huge difference compared to a few years ago. There are many reasons for this but I was particularly impressed with the enthusiasm shown with respect to the East Midlands safety culture work that our teams have been part of. I was really proud that the results of our baseline safety questionnaire in A& E were so good with such a positive view of safety culture in the department. This will spur us on to share best practice across the 8 East Midlands Trusts that are part of this initiative and also spur us on to look at those parts of safety culture that need more focus. We know that in order to ensure better and safer care we do need to improve internal flow and that will be our focus over the coming weeks as we work towards embedding the SAFER bundle and ensure everyone is focussed on minimising

unnecessary waits for tests and decisions. By improving this just a little we would certainly improve crowding in A & E, but we would also reduce our length of stay and therefore not need to use the escalation areas the way we do at the moment . If these were freed we would be able to deliver the care our elective patients need.

5. **Junior Doctors' Strike Action**
We were very relieved that the September junior doctors' strike action was cancelled but of course we remain worried about how we will cope with the planned action in the months up to Christmas.

I am confident that the team at NGH will work together and find creative solutions to minimise harm to patients. At the same time, however, I am conscious that we must not place an intolerable burden on our workforce.

We place great value on our doctors in training and want to support them to realise their full potential, as well as deliver great care to our patients. In my conversations with them they have indicated that they do feel supported here, and we must continue that focus.

Our plans for dealing with the impact of the strike action are being developed in the usual way, with meetings at every level of the hospital. The focus for the Board will be to seek assurance that we are doing the very best to keep our patients safe, mitigate the effects of delays, communicate with patients and staff and, importantly, involve our partners in the health and social care system.

6. **Annual General Meeting**
Our Annual General Meeting on Saturday September 16th was framed around the perspective of our patients and our staff. To assist us in this we used the voice of a patient to frame the picture of the activity increases and pressures we face and the voice of our staff describing the million cups of tea that underpin the more formal reporting statistics. The theme of the meeting was around the need to focus on what really matters most which is the way that patients and staff feel about the care that is delivered, the need to consider how to spend every pound wisely for the benefit of patients, staff and the taxpayer, the need to work in partnership, the need to value and reward our workforce and the overriding need to focus on quality of care and improvement in quality of care delivered by team NGH and team NHS. The patient's description of 'random acts of kindness delivered with effortless grace' led well into the staff accounts of the value of 'a cup of tea'.

7. **HSJ Awards**
This year our organisation has been shortlisted for an HSJ Award in the Staff Engagement category for the work undertaken to recruit staff to our nurse bank. Members of the communications team will be presenting to the judging panel in early October and the winner will be announced at the Awards ceremony in November. We will be supporting the awards event and have also committed to making sure that more people are aware of all the award opportunities that arise during the year.

Dr Sonia Swart
Chief Executive

Report To	PUBLIC TRUST BOARD
Date of Meeting	

Title of the Report	Medical Director's Report
Agenda item	8
Sponsoring Director	Dr Michael Cusack, Medical Director
Author(s) of Report	Dr Michael Cusack, Medical Director
Purpose	Assurance

Executive summary

There were no incidents in July or August '16 that met the criteria of a Never Event. Five new Serious Incidents have been reported onto STEIS during the reporting period 1/7/2016 – 31/8/2016. Following initial investigation, two of these incidents have been de-escalated as they did not then meet the SI reporting criteria. Where appropriate immediate actions have been agreed at the SI Group to mitigate the risk recurrence.

Seven serious incidents remain open and under investigation. Three Serious Incident reports have been submitted to the CCG for closure during the reporting period – one of which relates to a Never Event.

Dr Foster data showed overall mortality expressed as the HSMR and SHMI remains within the 'as expected' range. The Trust remains within expected compared to hospital Trusts nationally for the two patient safety indicators related to mortality. There is no evidence of a 'weekend effect' in relation to mortality.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and Assurance	Risks to patient safety if the Trust does not robustly investigate and identify any remedial actions required in the event of a Significant Incident or mortality alert.
Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)

Enclosure D

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

The Board is asked to note the contents of this report, details of clinical risks, mortality and the serious incidents declared and identify areas for which further assurance is sought.

Public Trust Board
September 2016
Medical Director's Report

1. Summary Serious Incident Profile

Shown in the table are the numbers of Serious Incidents and Never Events which have been reported on the Strategic Executive Information System (StEIS) by year since 2010:

	10/11	11/12	12/13	13/14	14/15	15/16	16/17
Serious Incidents	27	55	78	115	93	11	8
Never Events	2	2	1	0	1	3	1

2. Never Events in 2016/17

There were no incidents in July or August that met the criteria of a Never Event.

One Never Event report was submitted to the CCG for closure and the learning from the report is detailed below:

STEIS number	Directorate
2016/9477 W-61968	Women's
Brief Description of Incident	
Retention of a foreign object	
Recommendations and Actions	
• All inserted bungs (intended for removal at the end of surgery) must be recorded on the swabs and instruments board and be included in the "count" within the PACKS category. • The theatre standard operating procedure to include the swabs within the bung within the overall swab count. • Development of a local policy for managing swabs, sharps, instruments and other foreign bodies used during surgery that is applicable across all Trust operating theatres. • Progression of Theatre Safety Group work plan focussing on revision of WHO checklist, mandatory training, Learning from Error, safety behaviour and team function/dynamics.	

The CCG are currently undertaking a series of quality visits within the areas that the Never Events have occurred in. These visits are specifically reviewing the learning and the changes in practice that have been implemented as a result of the Never Events.

3. New Serious Incidents

Since the last report to the Board, during the reporting period 1/7/2016 – 31/8/2016 5 new Serious Incidents have been reported onto STEIS. Following initial investigation, two of

incidents were de-escalated as they did not then meet the SI reporting criteria. The three that remain active and under investigation are:

2016/22390 – Error with blood sample analysis
2016/18007 – Behavioural concern
2016/18031 – Baby born with low APGARS

A Root Cause Analysis (RCA) is being undertaken into each of these incidents. The Trust has a contractual agreement with the CCG to submit all RCA reports to them within a 60 working day timeframe; provide evidence to support the Duty of Candour requirement; and provide evidence to support the completion of RCA action plans via the Serious Incident Assurance Meetings (SIAM).

Within **2016/17**, 9 Serious Incidents have been reported under the following categories:

- Surgical/invasive procedure
- Sub-optimal care
- Delay in treatment/referral to specialist team
- Falls
- Complication during surgery
- Diagnostic incident
- Behavioural concern
- Maternity/Obstetric incident

4. Open Serious Incidents

The serious incidents at 31st August 2016 which remain **open** and under investigation are listed below:

STEIS/Datix Ref.	Date Reported on STEIS	STEIS Criteria / SI Brief Detail	Directorate	Submission date
2016-9316 W-61695	06 Apr 2016	Surgical Error/Nephrectomy	General & Specialist Surgery	29 Jul 2016
2016/12689 & W-62695	10 May 2016	Ophthalmology - Delay in Appointment	Surgery Division	03 Aug 2016
2016/15015 W-63558	02 Jun 2016	Sub-Optimal Care of Deteriorating Patient	Urgent Care	25 Aug 2016
2016/15999 W-56836 & W-58943	13 Jun 2016	2 x falls with fractures	General & Specialist Surgery	06 Sep 2016
2016/16728 W-63014	21 Jun 2016	EVAR Stent insertion - complications during procedure	General & Specialist Surgery	13 Sep 2016
2016/ 18007 W-64484	05 Jul 2016	Behavioural Concern	Urgent Care	28 Sep 2016

W-64534				
2016/18031 W-64367	05 Jul 2016	Baby born with low APGARS	Obstetrics	28 Sep 2016

5. Serious Incidents Submitted for Closure

During the reporting period there were three serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure, one of which relates to a Never Event (described above). The learning identified from the two other serious incidents is:

2016/12689 Ophthalmology-delay in appointment

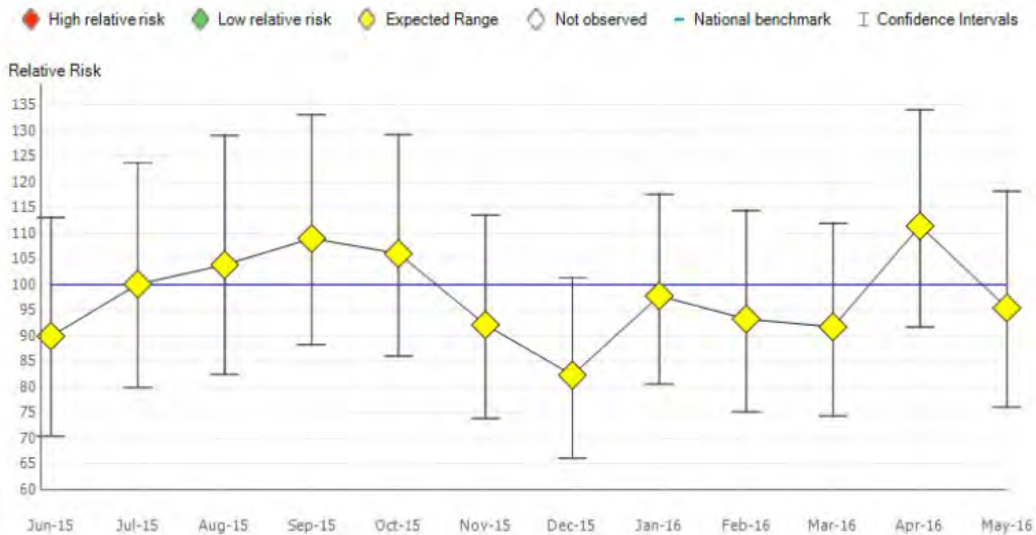
- Audit to determine whether patients with an up-coming appointment have been booked appropriately according to the clinical grading
- The SOP for Age related macular degeneration to be reviewed
- Ensure incident is fully shared at Governance Meetings

2016-8981 Failure to Escalate a Deteriorating Patient

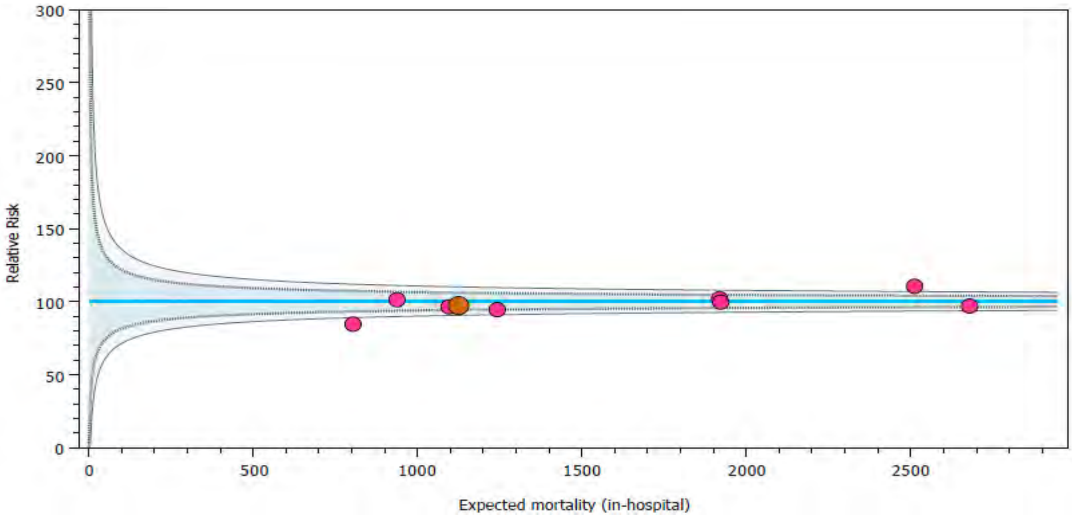
- Strict adherence to the early warning score escalation policy and SAP sticker placement.
- Further training for ward teams regarding escalation of clinical concerns.
- Completion of a Treatment Escalation Plan in all cases where it is appropriate to do so.
- Review of the night handover meeting and adherence to format proposed by the Divisional Director for Medicine .
- Completion of the new Non-Invasive Ventilation protocol (Quality Improvement Program) and embedding into clinical practice.
- Updated Protocol to be on Trust Intranet.
- Review of the process for recording attendance at the night team handover

6. Mortality Monitoring

The HSMR for the year to May 2016 remains with the 'as expected' range at **97.5**. The overall 12 month trend is shown. As was the case in 2015, a 'spike' again seen in SMR during the month of April which is being investigated further:



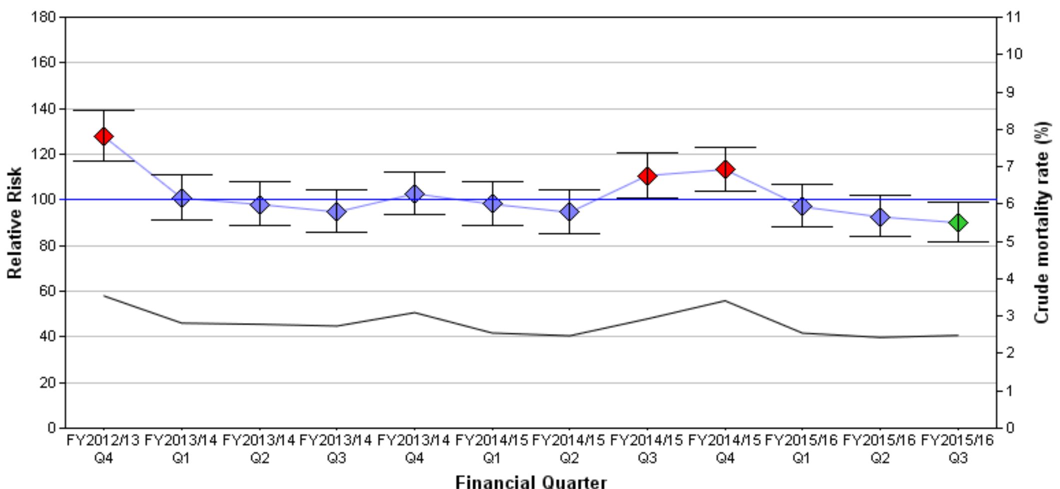
The crude (unadjusted) mortality for the HSMR group of diagnoses was 3.26% (peer group mean was 3.60%). The NGH HSMR and that of our peer group is shown in the funnel plot below:



The SMR for the All Diagnoses Metric for the rolling year to May 2016 has continued to track the HSMR closely and also remained within the 'as expected' range [SMR=**97.48**]. This approximates more closely than HSMR to the SHMI and suggests that this metric will also remain within 'as expected' range.

The NGH crude (unadjusted) mortality within the All Diagnoses group was 1.23% (Midlands & East Peer group rate was 1.46%).

The revised SHMI for the period April 2015 to March 2016 was released on 22/9/16 and has remained within the 'as expected' range at **94**. The SHMI trend is shown below:



7. Patient Safety Indicators

Two of the patient safety indicators are related to mortality:

- deaths in low risk diagnosis groups – RR=**76.5**
- deaths after surgery – RR=**98.3**

For both mortality indicators, the Trust is currently within the 'as expected' range when compared to hospital trusts nationally.

8. Weekend Effects

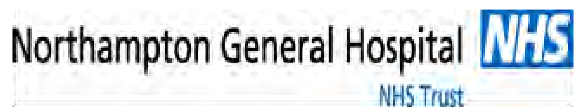
For the rolling year ending to May 2016 there was no statistical difference between the standardised mortality rates for weekend (**95.7**) and weekday admissions (**98.0**).

9. Next Steps

The Review of Harm Group will meet on a weekly basis as described in the report to expedite the agreement & external notification of Serious Incidents.

Mortality within the Trust is closely monitored and reported through the Quality Governance Committee. The Mortality Surveillance Group model has been adopted in accordance with NHSE recommendations and will provide assurance to Trust Board.

This Board is asked to seek clarification where necessary and assurance regarding the information contained within this report.



Report To	PUBLIC TRUST BOARD
Date of Meeting	September 2016

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

Executive summary

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

Key points from this report:

- Safety Thermometer – The Trust achieved 99.2% harm free care (new harms).
- Pressure ulcers incidence - 14 patients were harmed with a total of 18 pressure ulcers. This shows 36% decrease in the number of patients harmed on the previous month.
- Infection prevention- there were 3 patients identified with *Clostridium difficile* infection, 0 MRSA bacteraemia and 3 MSSA bacteraemia.
- Falls- 1 in-patient fell that caused severe harm and this is currently under investigation.
- Friends and Family Test (FFT) showed Inpatients 90.7%, Out Patient Department (OPD) 92.8%, Emergency Department 86.4% and Maternity 97.5% ‘would’ recommend our services.
- There is an update from Midwifery Services, Complaints Services, End of Life Care and the Nursing and Midwifery Dashboard.
- The overall Safe Staffing fill rate in August was 105%

Enclosure E

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

Actions required by the 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.

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

Trust Board
September 2016
Director of Nursing & Midwifery Report

1. Introduction

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

2. Midwifery Update

This report provides an update within the maternity unit:

- Sign-up to Safety
- Launch of Newborn Early Warning Track and Trigger on postnatal wards

Sign Up to Safety

The Maternity service Sign up to Safety improvement plan aims to reduce the number stillbirths and undiagnosed small-for-gestational age babies by 50% by March 2018. Smoking in pregnancy can lead to miscarriage, stillbirth, premature birth and low birth weight. The improvement plan specifically focuses on identifying women who smoke during pregnancy and implementing an innovative midwife led pathway which includes increased antenatal surveillance. Use of Carbon Monoxide monitors during routine antenatal care has been implemented. Referral to the Smoking Cessation team has improved as women take up the offer of support to stop smoking.

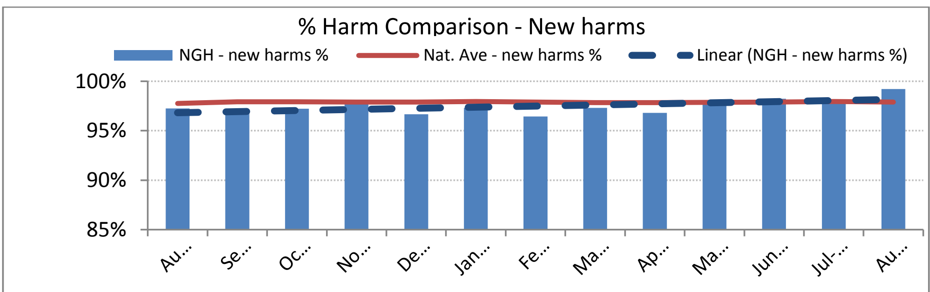
Implementation of the proposed pathway will increase the number of women requiring serial ultrasound measurements in pregnancy. We have a team of midwives trained in ultrasonography and an additional ultrasound machine has been ordered to allow full implementation of the proposed pathway by Q3.

New Early Warning Trigger & Track (NEWTT) in Maternity Wards

In September the service will launch the NEWTT on the maternity wards. Newborn early warning scores are used to detect early deterioration in seemingly healthy babies who have identified risk factors that prompt closer observation, whilst remaining with their mother on the postnatal ward. Within our population there are an undetermined number of infants who are at a higher risk of developing problems following birth who are being cared for in a low risk environment. NEWTT allows for early identification and appropriate escalation of any signs of deterioration, prompting early intervention.

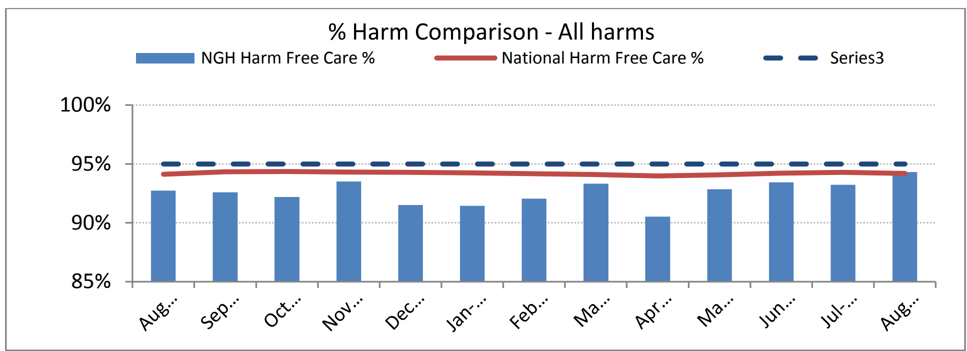
3. Safety Thermometer

The graph below shows the percentage of all new harms attributed to the Trust. In August 2016 NGH achieved 99.2% harm free care (new harms). This is an improvement to the previous month.



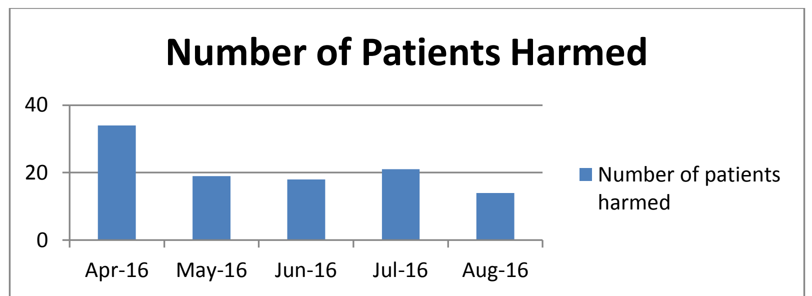
Enclosure E

The graph below illustrates the Trust has achieved 94.31% of harm free care in August. Broken down into the four categories this equated to: 0 falls with harm, 0 VTE, 1 CRUTI and 4 'new' pressure ulcers.

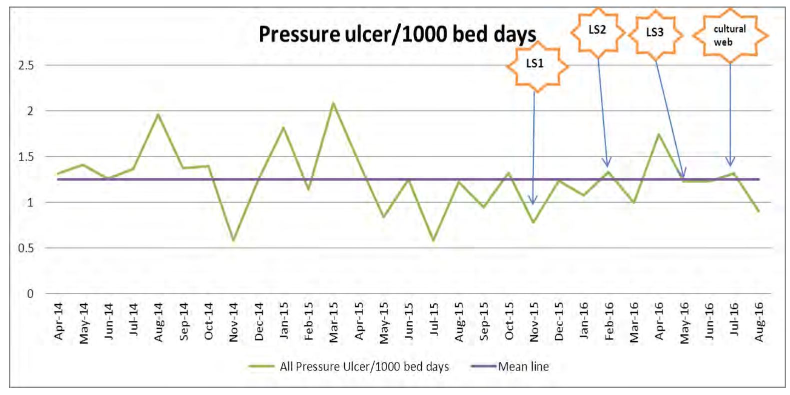


4. Pressure Ulcer Incidence

In August 2016, a total of 14 patients were harmed whilst in the care of Northampton General Hospital, resulting in 18 pressure ulcers, illustrated in the graph below. This represents a 36% decrease in the number of patients harmed from the previous month (July 2016).



The graph below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure damage. The graph is annotated with the dates of the pressure ulcer collaborative meetings. These started in October 2015 with the expert group meeting followed by Learning Session 1 (LS1) in November 2015, Learning Session 2 (LS2) in February 2016 and Learning Session 3 (LS3) in May 2016. LS4 is planned for September 2016. In addition to the collaborative an extraordinary session was held in July 2016 to enable senior nurses to examine the culture within the organisation, this was led by Director of Nursing.



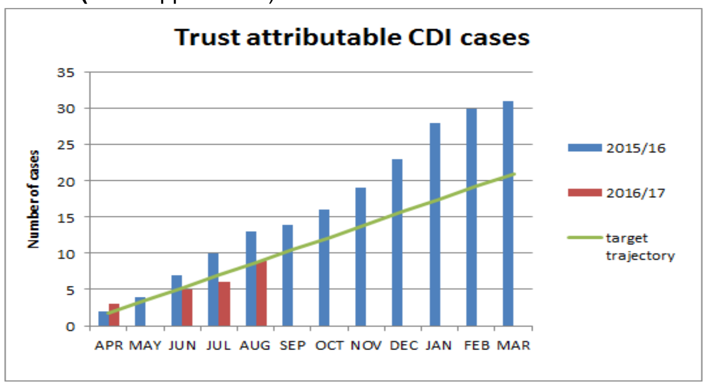
Other changes within the Trust by the Tissue Viability Team to reduce pressure ulcer incidence include;

- Tissue Viability team commenced Saturday working (3 month Trial) from August 2016. 39 patients were assessed over 4 Saturday mornings.
- Share & Learn meetings changed from monthly to weekly from August 2016, with the aim of reviewing all incidences within 10 days of validation of severity (grade of pressure ulcer) of harm.
- Training needs analysis completed in collaboration with Quality Assurance Matron, Head of Professional and Practice Development and Tissue Viability Lead Nurse. Plans include future additional targeted training and drop in sessions.
- Evaluation of Parafricta Garments, designed to offer protection of fragile skin from friction and associated shear damage, commenced on 4 wards, Collingtree, Talbot Butler, Holcot and Creaton.
- A review of processes within the Tissue Viability Team to ensure that resources are targeted at effective pressure ulcer prevention.

5. Infection Prevention and Control NHS Improvement Programme

The following provides an update up until the 1st September 2016 on the Trust's position in respect of Health Care Acquired Infections (HCAI's).

***Clostridium difficile* Infection (**Trust apportioned)

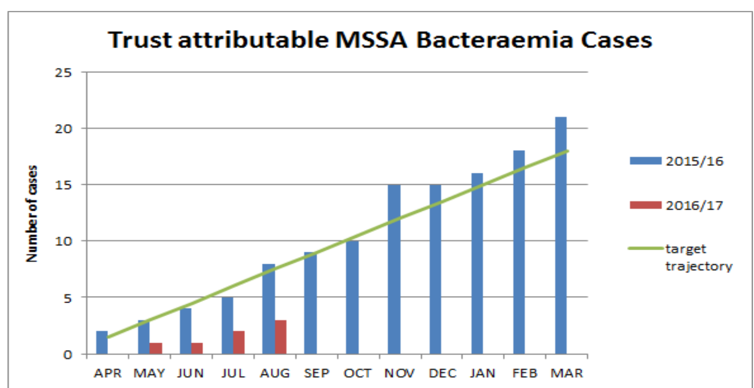


The graph above shows to date there have been 9 cases of *Clostridium difficile* infection apportioned to the Trust. 3 patients were identified in August 2016.

MRSA bacteraemia

For August there has been 0 Trust attributable MRSA bacteraemia

MSSA Bacteraemia



Enclosure E

There is no national target set for MSSA bacteraemia. Due to updated guidance from Public Health England (PHE) and a change in formula, the outturn for MSSA bacteraemia for 2015/2016 is at 24. The Infection Prevention forward plan will now set a revised ambition of no more than 18 cases for 2016/2017. For August 2016 up until 1st September there were 3 Trust attributable cases.

Hand Hygiene

Infection Prevention Team (IPT) have been doing focused work on hand hygiene, highlighting its importance to all staff groups. There were 20 wards that did not achieve the required standard of 90% compliance. On re-auditing, there was an improvement in the results with 10 wards achieving 100% compliance, 4 wards scored between 90-99%, however, 6 wards scored below 89%. The IPT will be discussing the results at the Infection Prevention Operational Group with the Matrons. The results of the audits have been fed back to the Divisional triumvirates. IPT will be auditing hand hygiene compliance 2 monthly for 2016-2017, the Divisional Matrons will be auditing hand hygiene compliance as a part of Saving Lives and the Quality and Assurance Matrons will be ensuring compliance from the Ward Assessment & Accreditation programme.

Infection Prevention and Control NHS Improvement Programme

As reported in April 2016, the IPT is working with NHS Improvement on an Infection Prevention and Control Improvement Programme. Collingtree, Willow and Creaton (formerly Allebone) wards continue to increase their PDSA (Plan, Do, Study Act) cycles and test of change.

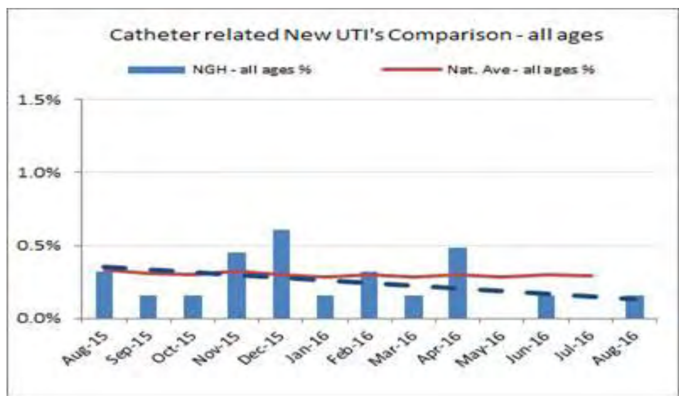
Benham Ward and the Emergency Admission Unit (EAU) have now joined the Infection Prevention Collaborative and a test of change is being undertaken with the admission checklist paperwork with these areas. The successful changes are also being rolled out to Rowan and Hawthorn wards. Following the meeting in July 2016 with NHS improvement, the collaborative work has identified an approach to “scale up and spread” across the Trust.

In collaboration with the Communication Team a presentation has been prepared for the summit event in Leeds. The change package was on the agenda for August Infection Prevention Steering Group (IPSG). This report will continue to update the group on the sustainability of this Quality Improvement Project.

Surgical Site Surveillance – August 2016

The Trust takes part in the national surveillance scheme for over 150 hospitals in England so that it can measure the rate of surgical site wound infection and be sure that patients are given the highest possible standard of care. A Root Cause Analysis (RCA) is instigated for all presumptive infections. Please note that surveillance in August is still ongoing as patients are monitored via a questionnaire or followed up 30 days after their operation date. However, Trauma and Orthopaedic patients where an implant has been inserted are monitored by the Orthopaedic Directorate for up to 1 year post operatively, as per PHE guidance The Trauma and Orthopaedic Directorate have taken ownership of the knee, hip and fractured neck of femur operations with support from the Infection Prevention Team. This is working very well and is beneficial to the patients and if the directorate has any infections or issues can be dealt with in a timely manner. To date the Orthopaedic directorate have identified 3 surgical site infections. RCA’s have been performed for all 3 cases and the cases are being reviewed at the Trauma and Orthopaedic morbidity and mortality meeting. The figures for August are not yet available and will be reported on in next month’s report

Catheter Related Urinary Tract Infections (CRUTI)

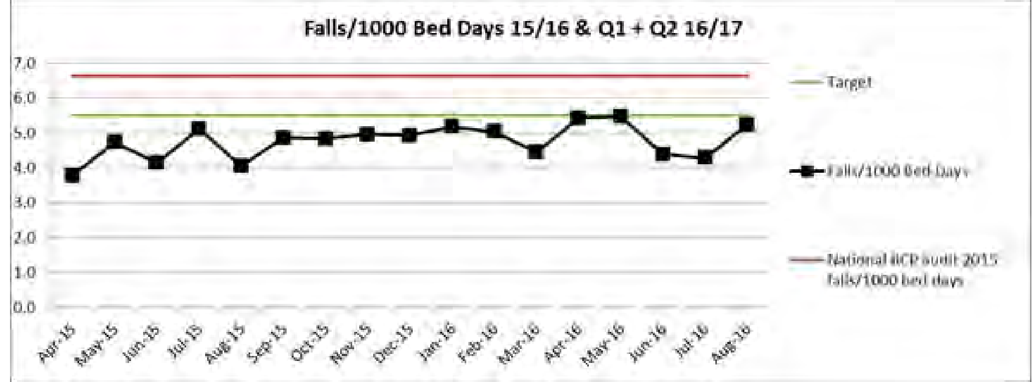


The graph above shows that for August 2016 there was 1 Trust attributable CRUTI, in accordance with the safety thermometer data. This was apportioned to Compton ward. A Root Cause Analysis (RCA) is in progress.

6. Falls Prevention

Falls/1000 bed days

The way in which we calculate our bed days has changed from 1st April 2016; we are no longer including bed days from maternity. This results in our bed days being lower and therefore may make our falls/1000 bed days appear higher, if compared with last year. Therefore as these figures are not comparable with previous years a Statistical Process Control (SPC) chart or run chart cannot reliably be generated. Last year's figures are shown in the graph below for information only.



The graph above illustrates that the Trust's Patient Falls/1000 bed days are below the national average, and the (internally set) annual target of 5.5 falls/1000 bed days. There has been an increase in the number of patient falls for the month of August.

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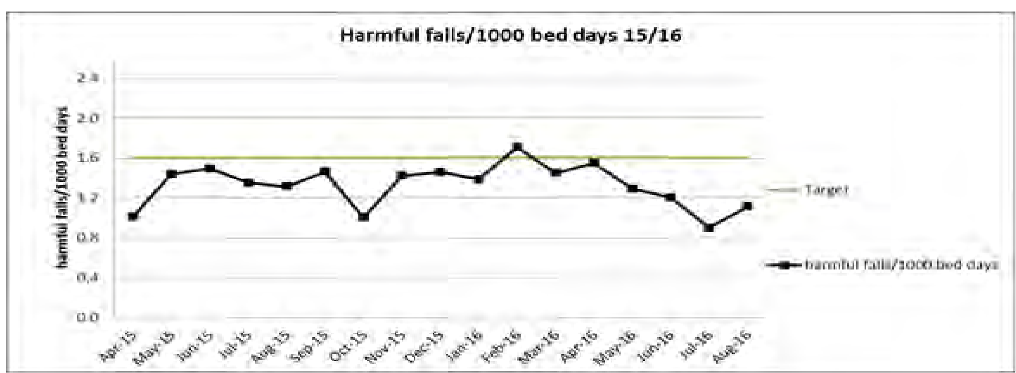


The graph above demonstrates that in August 2016 there was a slight increase in harmful falls/1000 bed days. In the month there were 2 moderate falls and 1 severe fall, all patient falls are under investigation by the Divisions. This is still below our internally set target.

Works underway to reduce the falls rate/improve post fall care:

- The falls team are finalising new amendments of the falls care plan.
- The falls team are raising awareness for the need of medication reviews.
- Lying and standing BP guidelines are being reviewed. To be sent to all ward areas by November 2016.
- There is continued focus work with Avery Healthcare associated with patient falls.
- A post falls head injury flow chart poster has been updated and distributed.

7. Nursing and Midwifery Dashboard

The Nursing and Midwifery Quality Dashboard provides triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process a review of the Quality Care Indicators (QCI) has taken place as planned. The proposal was to reduce the QCI dashboard as the Assessment & Accreditation programme was 'rolled-out' across the Trust. However due to the limited Quality Assurance Matron capacity it has been agreed by the senior nursing team that the QCI process should continue and be reviewed again in the New Year.

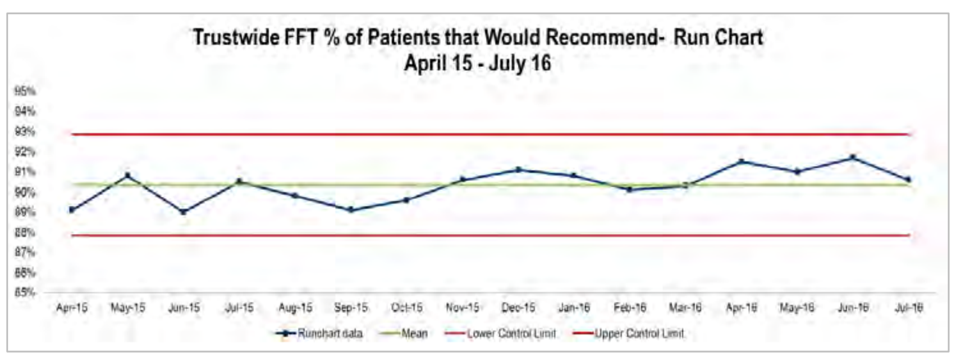
The Quality Care Indicators (QCI) for August 2016 shows the following:

- Privacy and Dignity section is the area of the month with most of the red and amber ratings. On further review of the audit information, this relates to patients not feeling as though they are up to date with treatment plans and involved in their care planning. Work is being undertaken and ongoing within the Divisions.
- Compliance with falls assessments and care planning has improved again this month to 90% compared to 88% in July. Ward areas continue to monitor compliance and implement suggestions from the Falls Group.
- Surgical Division - QCI were peer reviewed, Willow, Hawthorn, Head and Neck wards require improvement. Ward Sisters, Matrons and ADN's are aware and actions are in place to improve outcomes.
- Medical Division – Allebone and EAU require improvement, in patient observation and escalation and patient experience. Ward Sisters, Matrons and ADN's are aware and actions are in place to improve outcomes.
- Womens Children's and Oncology Division - Talbot Butler has been identified to require improvement. Ward Sisters, Matrons and ADN's are aware actions are in place to improve outcomes.
- First impressions and 15 steps, general wards are at 85%. Work is underway to improve the clutter and general appearances of the general wards, through the IPC, 'Going for Gold' Declutter initiative.
- There was 1 complaint for August for the general wards and 21 PAL's enquires

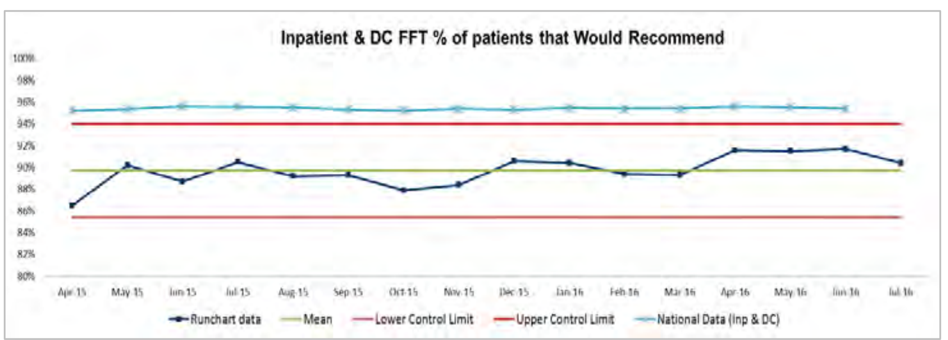
- Congratulations to Compton, Finedon, Dryden, Spencer, Cedar and Althorp as they have all shown compliance. (See appendix 1)

8. Friends & Family Test

FFT Overview- % Would Recommend Run Charts



Trust wide results for the amount of patients that would recommend reduced slightly in July; however results still remain above the mean line for the fourth month consecutively.



Interestingly, the Trust wide results correlate with the Inpatient/Day Case results which also saw a decline in July, but remained above the mean line.

9. Dementia CQUINS

Discharge Summaries

The 2016/17 dementia CQUIN, in contrast to previous years, includes patients admitted via the non-urgent pathway. Planning for the collection of this data was undertaken during Q1 and the subsequent split in compliance figure is reportable from Q2.

Owing to the work undertaken in this area in Q1, the segregated data is available in “shadow form” (June 2016) to illustrate compliance in advance of the reporting deadline. The overall compliance target remains at 90%, which has been achieved for each element of the CQUIN, as illustrated in the graphs below.

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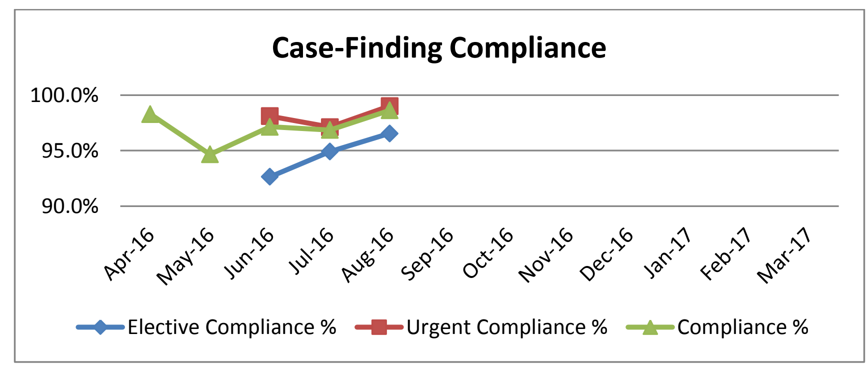
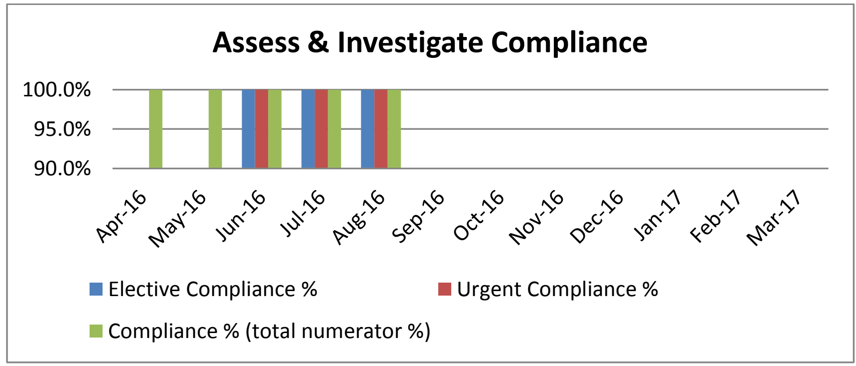
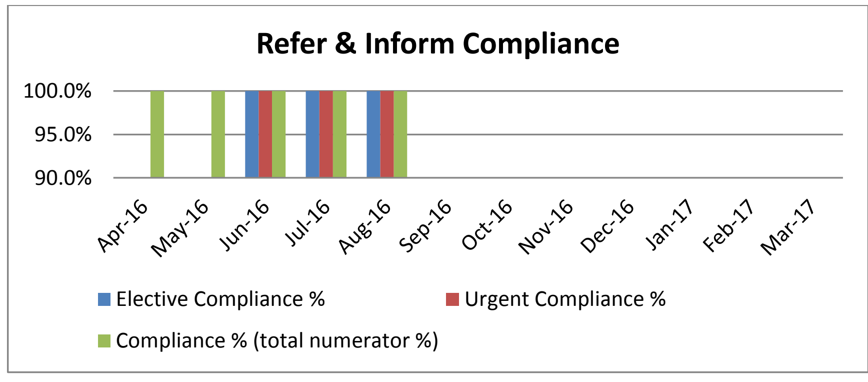






In addition to the inclusion of the elective pathway patients, the CQUIN also includes the requirement (from Q3) to identify those patients admitted with an *existing* diagnosis of dementia or delirium and provide a plan of care in line with that of the Find, Assess, Investigate, Refer and Inform (FAIRI). Significant work has been undertaken to achieve the successful identification of this cohort of patients, using the Electronic Discharge Notification (EDN) system and associated reporting. This is running in "shadow form" throughout Q2 in order to gain assurance as to the effectiveness of this system before formally reporting in Q3.

John's Campaign

A progress update on the John's Campaign CQUIN was discussed at the August Patient and Carer Experience and Engagement Group and the proposed statement of intent in relation to the project agreed and endorsed:

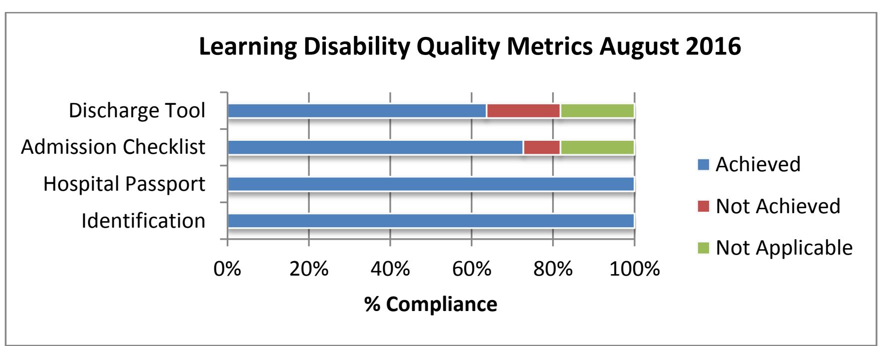
"John's campaign aims to give carers of people with dementia the same right to accompany them in hospital as parents of sick children. The campaign recognises that carers have a valuable role in

the reassurance and dignity of patients and strives to ensure that access is related to patient needs and carer availability, not visiting hours.

At Northampton General Hospital we believe that the involvement of carers is fundamental to the provision of the best possible care. Our intent is to welcome all carers of patients living with dementia to take an active and participative role in supporting their relative or friend, based on individual needs and not hospital processes and visiting restrictions".

The agreement of the statement of intent forms part of the CQUIN requirement for John's Campaign, in addition to the development of an implementation plan for roll out. The Campaign is currently in pilot on three ward areas with plans for roll out across the Trust in Q3 and Q4.

Learning Disability



The Learning Disability Quality Schedule is built around four key components:

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

The above graph shows the continuing improvement in the quality schedule metrics, with only one patient (n=11) not having the LD assessment within 24hrs of admission. Where 'not applicable' is recorded, this represents patients who decline a particular intervention, or with whom it was not clinically appropriate.

The Learning Disability Steering Group continues to focus on the quality schedule as an area for improvement and individual scenarios where the target is not achieved are reviewed by the learning disability service.

10. Learning from Complaints

As a Trust we see complaints as an important part of helping us to learn how to improve the quality of people's experience, improve safety, effectiveness and outcomes through the lessons learned from complaints. The complaints process previously in place was identified as requiring development; subsequently a more robust process has been developed to support the implementation and monitoring of the learning from complaints across the organisation. The success of the process is reliant upon the clinical divisions taking both accountability and responsibility for the learning that is identified and put into practice within their areas. This involves ensuring that evidence of completion / implementation is obtained and that Health Assure, which is used to monitor the process, is regularly updated to provide Trust assurance that learning is taken seriously and lessons are learned from the feedback we receive.

This will be monitored through quarterly reporting and a complaints dashboard which is currently in development.

11. End of Life Update

The Director of Nursing initiated an internal and external review of End of Life Care to provide an overview of the Trust compliance with national guidance. The internal review was undertaken by an Associate Director of Nursing, Head of Governance and End of Life Project Lead in June 2016. The external review was undertaken by a Specialist Palliative Care Nurse, Matron for Cancer Services and a Chaplain from Ipswich Hospital. The aim was to assess the provision of End of Life Care across the Trust, to ascertain the quality of care and its compliance with regulatory frameworks and national policy. Following both End of Life reviews we are awaiting the final report but an improvement plan is in progress.

In line with national directives, patients thought to be in the last few hours/days of life should have a personalised plan of care in place to identify and meet their individual needs. The Trust has made significant improvements in the number of patients who have a Dying Person's Care Plan in place reaching 72% of patients and it also demonstrates evidence of senior medical review and discussion with patients and/or family.

The Trust has a local CQuIN related to End of Life care for 2016/17 related to Preferred Place of Death, exploring whether patients achieve their documented preferred place of death, and the reasons why it is and is not achieved. Quarter 1 data identified a number of themes related to the non-achievement of preferred place of death, which includes poor prognostication resulting in unexpectedly rapid patient deterioration, lack of advance care planning and late referral to the Specialist Palliative Care Team. All areas identified are being addressed through training. Quarter 2 data has been collected ready for reporting in late September.

The Trust was non-compliant with one of the organisational questions in the National Care of the Dying Audit because it had not undertaken a recent survey of bereaved relatives/carers. Seeking the views of families following the death of a loved one is difficult and needs to be approached in a sensitive way. The team have worked with the Head of PALS and Bereavement to develop a process for capturing the experience of families when they collect the death certificate. This enables any concerns to be addressed in a timely manner reducing carer anxiety. The results will be presented to the End of Life Strategy group on a quarterly basis to share learning and agree appropriate actions to improve patient/family care.

12. Safe Staffing Update

A summary of the ward analysis for staffing is included at the end of the report. There is an update from the Divisions for each ward that is below 80% 'fill-rate' explaining the actions to maintain patient safety. In line with National Quality Board guidance (2016) the narrative from the Divisional teams includes all 'red flag events' that have been recorded through the incident system (Datix) against the wards relating to staffing. Please see appendix 2.

The overall fill rate for August 2016 was 105%, compared to 103% in July and 102% in June. The combined fill rate during the day was 107%, compared with 100% in July. The combined night fill rate was 101% for August compared with 107% in July. RN fill rate during the day was 109% and for the night 93%.

13. Recommendations

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

Appendix 1

Aug-2016	Medicine															Surgery								
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Knightley	Holcot	Victoria	Talbot Butler	Rowan	Willow	Head & Neck	Spencer	Abington	Cedar	Althorp	Hawthorn	General Wards
Falls/Safety Assessment	73.%	80.%	73.%	97.%	100.%	93.%	90.%	100.%	88.%	100.%	100.%	97.%	70.%	93.%	100.%	97.%	71.%	80.%	97.%	97.%	100.%	100.%	78.%	90.%
Pressure Prevention Assessment	82.%	87.%	94.%	95.%	100.%	91.%	90.%	100.%	95.%	85.%	98.%	98.%	80.%	100.%	88.%	100.%	79.%	75.%	97.%	93.%	100.%	100.%	67.%	91.%
Nutritional Assessment	83.%	98.%	90.%	95.%	100.%	100.%	95.%	100.%	80.%	88.%	100.%	100.%	85.%	97.%	75.%	100.%	85.%	78.%	92.%	100.%	97.%	100.%	100.%	93.%
Patient Observation and Escalations	77.%	96.%	100.%	96.%	96.%	100.%	96.%	100.%	79.%	96.%	100.%	100.%	96.%	100.%	96.%	100.%	69.%	92.%	96.%	100.%	96.%	100.%	100.%	96.%
Pain Management	97.%	100.%	100.%	100.%	100.%	100.%	90.%	100.%	100.%	87.%	100.%	100.%	83.%	95.%	93.%	90.%	97.%	97.%	100.%	100.%	97.%	97.%	100.%	97.%
Nursing & Midwifery Documentation - Quality of Entry	72.%	93.%	100.%	97.%	97.%	94.%	96.%	97.%	80.%	97.%	97.%	96.%	91.%	94.%	80.%	76.%	84.%	81.%	100.%	89.%	97.%	97.%	88.%	91.%
Medication Assessment	93.%	97.%	93.%	100.%	100.%	100.%	93.%	100.%	70.%	100.%	100.%	100.%	93.%	100.%	97.%	100.%	97.%	97.%	100.%	97.%	100.%	100.%	90.%	96.%
Patient Experience - Protected Mealtimes (PMT) Observations	50.%	100.%	75.%	100.%	100.%	100.%	100.%	100.%	88.%	88.%	100.%	100.%	100.%	88.%	100.%	88.%	71.%	88.%	100.%	100.%	88.%	88.%	88.%	92.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	82.%	100.%	100.%	100.%	100.%	40.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	71.%	95.%
Patient Experience - Environment	50.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	50.%	100.%	100.%	83.%	100.%	100.%	83.%	95.%
Patient Experience - Privacy and Dignity	66.%	89.%	68.%	89.%	83.%	94.%	90.%	97.%	68.%	87.%	98.%	95.%	83.%	95.%	73.%	85.%	83.%	94.%	97.%	91.%	95.%	99.%	85.%	88.%
Patient Safety and Quality	74.%	100.%	92.%	100.%	100.%	100.%	88.%	96.%	29.%	80.%	100.%	100.%	92.%	100.%	77.%	100.%	88.%	88.%	100.%	92.%	92.%	96.%	89.%	90.%
Leadership & Staffing observations	82.%	96.%	87.%	92.%	97.%	95.%	94.%	95.%	74.%	95.%	95.%	97.%	92.%	95.%	84.%	97.%	87.%	96.%	100.%	98.%	97.%	98.%	92.%	93.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	88.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	96.%	100.%	86.%	98.%
SOVA/LD/Cognitive Impairment	71.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	74.%	100.%	80.%	100.%	100.%	100.%	100.%	100.%	100.%	98.%
First Impressions/15 Steps	77.%	83.%	89.%	69.%	80.%	86.%	86.%	89.%	86.%	89.%	91.%	80.%	86.%	80.%	69.%	89.%	86.%	91.%	94.%	91.%	100.%	94.%	80.%	85.%
Safety Thermometer – Percentage of Harm Free Care	96.43%	84.62%	92.86%	81.48%	90.24%	77.78%	80.00%	100.00%	100.00%	91.67%	94.44%	95.45%	96.15%	94.44%	96.43%	100.00%	93.33%	92.86%	100.00%	100.00%	100.00%	100.00%	96.67%	90.00%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	1	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	3	0	0	7
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	3
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	1	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	4
Falls (Moderate, Major & Catastrophic)	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	3
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3
Patient Overdue Observations frequency - <7%	4.5%	7%	7%	6%	8%	8%	4%	5%	11%	6%	8%	13%	9%	11%	3%	8%	8%	5%	13%	5%	6%	6%	5%	18%
Caring																								
Complaints – Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Number of PALS concerns relating to nursing care on the wards	0	2	1	0	5	0	0	1	0	0	2	1	2	1	1	0	1	2	1	0	1	0	0	21
Friends Family Test % Recommended	100.0%	80.8%	91.2%	100.0%	70.6%	70.6%	94.9%	95.2%	83.1%	85.0%	69.2%	100.0%	80.0%	100.0%	95.5%	86.3%	89.5%	85.7%	80.0%	88.9%	92.6%	93.4%	84.1%	87.7%
Well Led																								
Staff Nurse Staffing - Registered Staff (day & night combined)	92%	91%	99%	105%	96%	100%																		
Staff Nurse Staffing - Support Worker (day & night combined)	136%	121%	183%	128%	148%	170%																		
Staffing related datix	0	1	0	0	1	0	0	0	0	0	0	1	0	2	0	3	0	0	0	0	0	0	1	9

Enclosure E

Northampton General Hospital NHS
NHS Trust

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — August 2016

Ward name	Day: Registered midwives/nurses — Total monthly planned staff hours	Day: Registered midwives/nurses — Total monthly actual staff hours	Day: Care Staff — Total monthly planned staff hours	Day: Care Staff — Total monthly actual staff hours	Night: Registered midwives/nurses — Total monthly planned staff hours	Night: Registered midwives/nurses — Total monthly actual staff hours	Night: Care Staff — Total monthly planned staff hours	Night: Care Staff — Total monthly actual staff hours	Day: Average fill rate - registered nurses /midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses / midwives (%)	Night: Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD): Registered midwives/ nurses	CHPPD: Care Staff	CHPPD: Overall	Actions/Comments	Red Flag
Abington	1601.75	1551.75	1426	1408.75	1104	1080.75	1066.75	1126	96.9%	98.8%	97.9%	105.6%	860	3.1	2.9	6.0		
Allebone	1620	1543.38	1063.75	1601.75	1322.5	1277	713	1393.23	95.3%	150.6%	96.6%	195.4%	868	1.8	1.6	3.4	Late staff sickness, work prioritised. No harms occurred Enhanced carer initially not covered, work prioritised extra staff allocated half way through shift	1 x Other Staffing Issue 1 x Shortfall of 25% or more planned RN on Shift.
Althorp	980.25	919	794	683	713	724.5	379.5	368	93.8%	86.0%	101.6%	97.0%	305	5.4	3.4	8.8		
Becket	2033.25	1763	1415.5	1766.33	1782.5	1678.25	713	1090.75	86.7%	124.8%	94.2%	153.0%	794	4.3	3.6	7.9		
Benham	1783.5	1680.42	889.5	1396.5	1424.25	1412.25	713	1457.25	94.2%	157.0%	99.2%	204.4%	703	4.4	4.1	8.5		
MATERNITY COMBINED UNIT: Sturtridge, MOW, Balmoral & Birth Centre	7136	6632.50	3712.4	3175.25	6750.5	6075.5	3144.7	2301.25	92.9%	85.5%	90.0%	73.2%	1160	11.0	4.7	15.7	The MSW night duty fill rate is affected by the sickness and maternity leave. Registered Midwifery staff is kept above 90% to ensure safe care.	none
Brampton	1403	1345.75	1044.5	1097.5	1069.5	1072.75	713	1138.25	95.9%	105.1%	100.3%	159.6%	864	2.8	2.6	5.4		
Cedar	1603.48	1591.42	1741	1720.75	1069.5	1069.5	1069.5	1138.5	99.2%	98.8%	100.0%	106.5%	891	3.0	3.2	6.2		
Collingtree	2377.25	2154.58	1767	2227.25	1781	1735.25	713	1153.93	90.6%	126.0%	97.4%	161.8%	1225	3.2	2.8	5.9	Enhanced carer not covered therefore patient absconding may have been avoided - patient returned safely x2 staff lower than planned, all work prioritised and escalated as required no harm to patients	1 x Other Staffing Issues. 1 x Delay or Omisson of regular checks - personal needs
Compton	1047.5	995.25	753.25	1080.25	713	713	356.5	712.5	95.0%	143.4%	100.0%	199.9%	551	3.1	3.3	6.4		
Creaton	1782.5	1614	1687.5	1791	1069.5	1071.5	713	1090.25	90.5%	106.1%	100.2%	152.9%	862	3.1	3.3	6.5		
CHILD HEALTH COMBINED: Disney, Gosset & Paddington	7442.1	6088.4	2793.75	2054.91	5405	4748.92	1414.5	1106.5	81.8%	73.6%	87.9%	78.2%	992	10.9	3.2	14.1	HCA vacancy - proactive recruitment continues. Safe staffing maintained and elective activity managed by prioritising HCA to day work and increased %registered nurses across the 24 hours.	None
Dryden	2103.2	1774.25	977.5	1003.75	1426	1442.5	713	979	84.4%	102.7%	101.2%	137.3%	793	4.1	2.5	6.6		
EAU	2135.75	1958	1069.5	1759.4	1782.5	1762.5	1058	1706	91.7%	164.5%	98.9%	161.2%	881	4.2	3.9	8.2		
Eleanor	1069.5	1056	705.75	769	701.5	713	713	793.5	98.7%	109.0%	101.6%	111.3%	335	5.3	4.7	9.9		
Finedon	2141.25	1908.5	488.75	444.25	1069.5	1069.5	353.5	352.75	89.1%	90.9%	100.0%	99.8%	492	6.1	1.6	7.7		
Hawthorn	1957	1968.58	1068.5	1110.23	1426	1425.25	974.92	1078.42	100.6%	103.9%	99.9%	110.6%	836	4.1	2.6	6.7	Patient fell however even though they were 1 staff member down the fall was not related to staffing	1 x Staffing Issue
Head & Neck	1059.5	1033.75	705.33	687.5	908.5	833	356.5	369.5	97.6%	97.5%	91.7%	103.6%	402	4.6	2.6	7.3		
Holcot	1405.75	1341.5	1411.5	1751.75	1081	1078	713	1688	95.4%	124.1%	99.7%	236.7%	860	2.8	4.0	6.8		
ITU	6002.08	5225.33	816.5	736.25	4577	4174.5	713	646.75	87.1%	90.2%	91.2%	90.7%	372	25.3	3.7	29.0		
Knightley	1069.5	993.75	886.5	1106.25	1069.5	999.25	356.5	735.25	92.9%	124.8%	93.4%	206.2%	648	3.1	2.8	5.9		
Rowan	1961.83	2025.67	1067	994.75	1782.5	1740.25	710.5	735.25	103.3%	93.2%	97.6%	103.5%	894	4.2	1.9	6.1	Late staff sickness caused lower staffing numbers. No patients came to harm, care was prioritised appropriately situation escalated to out of hours senior team for support when required. High dependency on the ward and 1 RN position not filled. No patients came to harm, care was prioritised appropriately situation escalated to out of hours senior team for support when required	1 x Staffing Issues 2 X Shortfall of 25% or more of planned RN on Shift
Spencer	977.5	977.17	564.17	632.92	713	716	356.5	460	100.0%	112.2%	100.4%	129.0%	396	2.5	1.6	4.1		
Talbot Butler	2574.5	2148.75	1409.75	1230.67	1425	1068.25	713	1127	83.5%	87.3%	75.0%	158.1%	869	3.7	2.7	6.4	The numbers of HCA increased on night duty increased to support patient care. RN ongoing recruitment, awaiting 5 WTE staff to start. Staffing monitored daily by the Matron and reallocation as required. Due to the red flag staffing issue no patient came to harm, care prioritised	1 x Staffing Issue
Victoria	1196.25	1158.25	704.75	1025.75	713	713	345	1023.5	96.8%	145.5%	100.0%	296.7%	557	3.4	3.7	7.0	Enhanced carer not filled therefore slip may not of occurred no harm resulted from the slip	1 x Staffing Issue
Willow	2317.25	2253.17	1069.5	1105.5	2139	1970	713	767	97.2%	103.4%	92.1%	107.6%	853	5.0	2.2	7.1		

Key:
- Below 80% Shift Fill Rate Target
- 80% and Above Shift Fill Rate Target

Report To	Public Trust Board
Date of Meeting	29 September 2016

Title of the Report	Infection Prevention Annual Report
Agenda item	10
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Authors of Report	Wendy Foster, Matron Infection Prevention Matron Garry Hunt – Decontamination Lead Claire Salt – Antimicrobial Pharmacist Claire Brown – Occupational Health
Purpose	Assurance
Executive summary This annual report provides a summary of the performance and developments related to Infection Prevention and Control (IPC) during 2015/2016 and a broad plan of work for 2016/17.	
Related strategic aim and corporate objective	Corporate Objective 1 – Focus on Quality & Safety
Risk and assurance	Provides assurance on risks
Related Board Assurance Framework entries	BAF – 1.1, 1.2, 1.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (NO) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (NO)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/

	policy will not promote equality of opportunity for all or promote good relations between different groups? (NO) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (NO)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? Yes, to provide assurance in relation to the Health Act 2008 (Updated Check) and Social Care Act.

Actions required by the Trust Board

The Board is asked to note the content of this annual report and to support the work plan moving forward.

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Enclosure F

1. Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2015/16 and the broad plan of work for 2016/17 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI.

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

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

2. Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's Infection Prevention and Control (IPC) activity in 2015/16. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

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

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

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

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

MRSA
The HCAI objective for MRSA bloodstream infections for 2015/16 was 0 avoidable MRSA bacteraemia cases.

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

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

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

During 2015/16 the Trust had 2 Trust apportioned MRSA bacteraemias.

***Clostridium difficile* Infections**

The HCAI national objective set for NGH trust apportioned cases of *Clostridium difficile* infections (CDI) for 2015/16 was no more than 21.

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

There were 31 patients with Trust-apportioned CDI in 2015/16. This is discussed further on in the report on page 13.

Meticillin Sensitive *Staphylococcus aureus* Bloodstream Infections

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

During 2015/16 there were 21 post 48 hour cases of MSSA bacteraemias.

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

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

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

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

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

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

The Board of Directors receive:

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

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

3. Governance and Monitoring

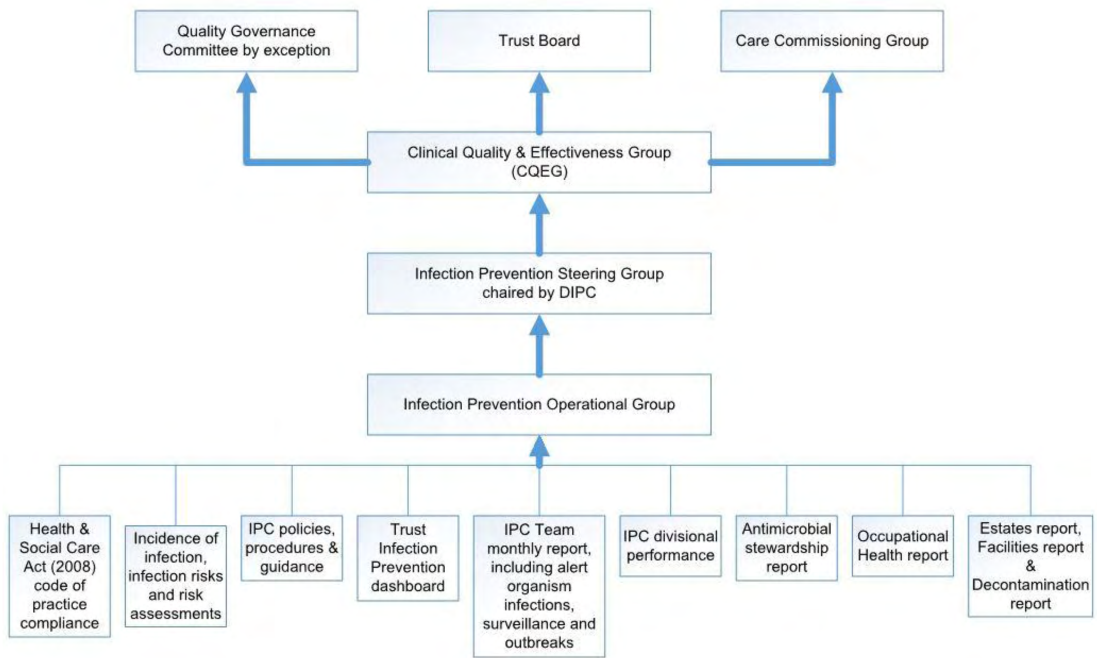
IPC Governance
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

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

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

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

Infection Prevention Steering Group Structure



In 2015/16 the Infection Prevention Committee was reviewed and divided into an Operational Group (IPOG) and a strategic steering group, titled Infection Prevention Steering Group (IPSG). The terms of reference for both groups were reviewed, rewritten and agreed through the Clinical Quality and Effectiveness Group (CQEG) see Appendix 2.

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

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

Quality Governance Committee (QGC)
The Quality Governance Committee is a sub-committee of the Trust Board and reviews areas of concern arising from the IPSG by exception.

Links to Clinical Governance and Patient Safety
The DIPC reports the Trust position in relation to infection prevention and control to CQEG on a monthly basis. The Divisions include their monthly infection prevention data within their own quarterly reports to CQEG. Learning from Post Infection Reviews (PIR) for MRSA bacteraemia and *Clostridium difficile* infections are shared by the wards at IPOG and at CQEG. Going forward for 2016/17 learning from MRSA bacteraemia may be presented through the' Dare to Share' forum.

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

Monitoring

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

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

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

Infection Control Standards and Assurance
In 2015/16 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control. This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust continues to undertake a number of interventions in relation to infection prevention and control as detailed within the HCAI Reduction Plan 2015/16. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Medical Director and Matron for Infection Prevention and Control.

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

4. Healthcare Associated Infection Statistics and Targets

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

Alert Organisms[3]

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

Alert Conditions

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

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

Identified Priorities for 2015/16
In 2015/16, the Trusts HCAI Reduction Delivery Plan set out to:

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

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

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

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

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

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

MSSA bacteraemia (Trust-apportioned and non-Trust apportioned cases)

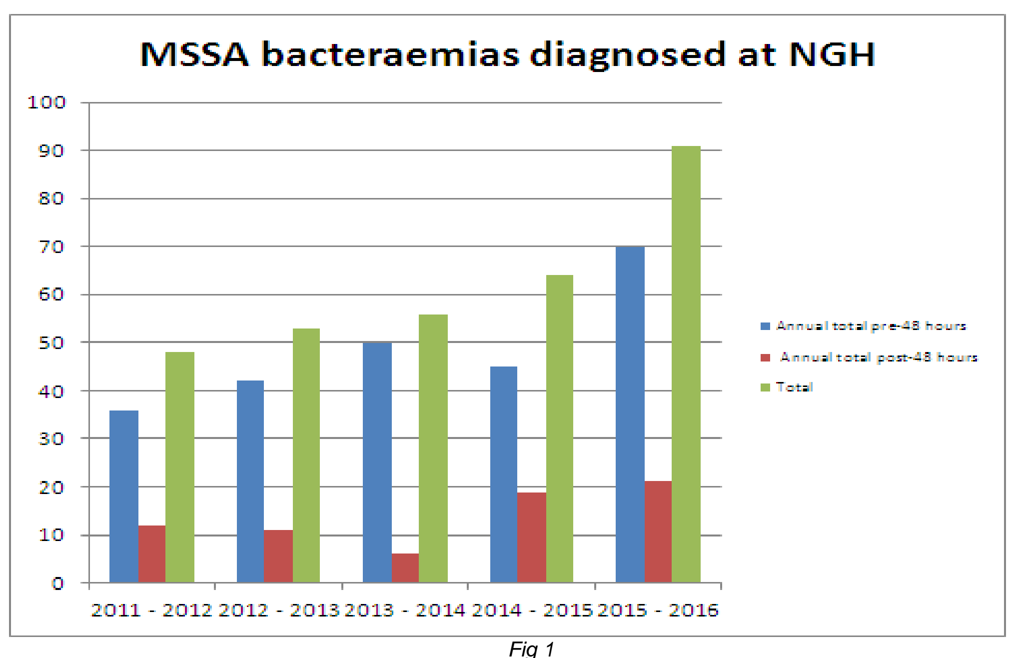


Fig 1

The number of MSSA bacteraemias increased by 16% from 19 in 2014/15 to 21 in 2015/16. The IPCT for 2016/17 have developed an MSSA action plan and this will be monitored through IPSG.

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

Enclosure F

2015/16 the trust was apportioned 2 MRSA bacteraemias

Patient number 1, Blenheim bacteraemia August 2015
The patient was an elderly patient with complex health needs, who had been an inpatient at Northampton General Hospital Trust from April to June 2015. Blenheim ward, Avery Care Home from June to July 2015. Turnfurlong, Specialist Care Centre for 2 days in July 2015 and NGH from July 2015 to the beginning of August 2015 before being transferred to Avery Care home (Blenheim) August 2015. During hospitalisation within the acute trust patient was treated for an *Escherichia coli* (*Ecoli)* urinary tract infection and pneumonia.

Patient was transferred back to the acute trust through Accident and Emergency at the beginning of August unwell with diarrhoea, vomiting and dehydration. A blood culture was taken and meticillin resistant *Staphylococcus aureus* (MRSA) was identified. The patient received treatment for the MRSA as per Trust policy. Learning identified that further blood culture training for medical and nursing staff in the Emergency Department was required. To include indications for taking a blood culture and documentation. Good practice identified that blood culture packs are utilised throughout the organisation which includes the process on the front of the pack and all equipment required for undertaking a blood culture. MRSA practice was improved as an outcome to ensure that patients must be screened before being transferred to Avery Care Home, Cliftonville and Blenheim wards.

In conclusion it was agreed by all including members from the CCG at the PIR meeting that this was a complex case and that the MRSA bacteraemia acquisition should be ranked as two sources.

1) MRSA from wounds
2) MRSA possible contaminated blood culture.

Patient number 2, Brampton Bacteraemia in March 2016
The patient was admitted and treated for a MRSA urinary tract infection (UTI) with Co-amoxiclav. He had a long term urinary catheter in situ on admission and had a history of MRSA colonisations and MRSA urine infections. Three weeks later he became confused and agitated, self-removed his long-term urinary catheter with the balloon still inflated and the next day became septic. The medical team reviewed the patient, took blood cultures, a CSU and commenced Tazocin. The blood cultures and the CSU both isolated MRSA. The source of the bacteraemia was most likely that the trauma caused by removing the catheter generated a portal of entry for MRSA from the urine to enter the bloodstream.

The two root causes identified were that the GP and the hospital antibiotic choices were inappropriate for a patient with MRSA and the MRSA decolonisation treatment should have been continued even after a negative MRSA screen as this patient was a high risk heavily colonised patient with an invasive device. Good practice included good compliance with MRSA decolonisation treatment and MRSA screening.

MRSA bacteraemia cases 2011–2016

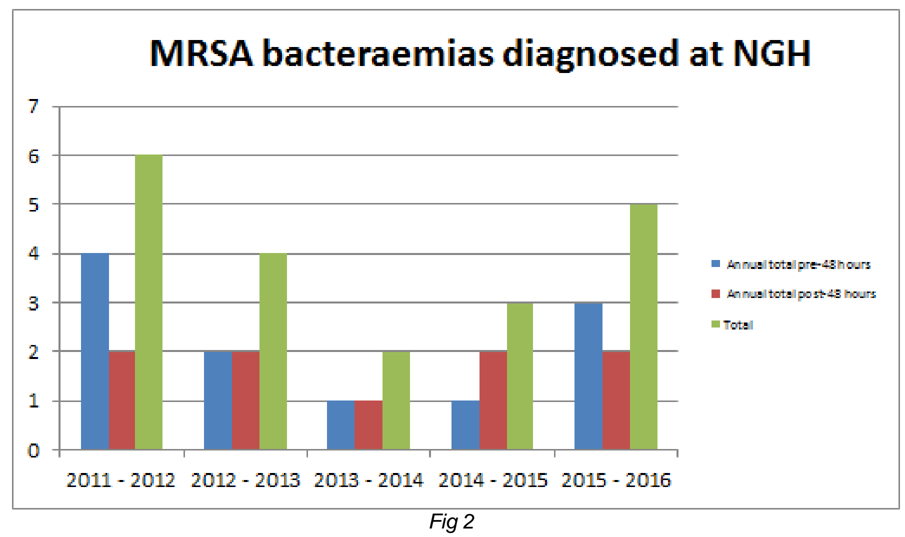


Fig 2

MRSA bacteraemia cases by month 2015-2016

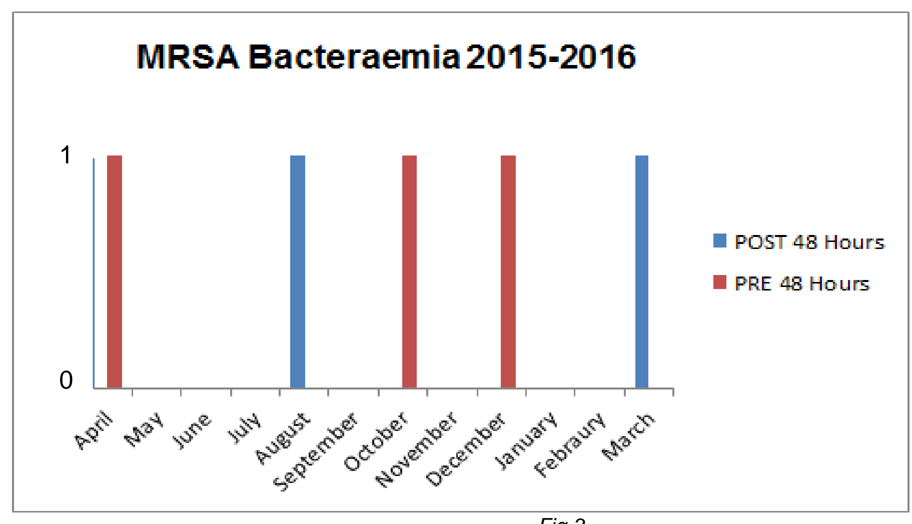


Fig 3

MRSA Colonisations
The graph below reflects the number of cases of MRSA colonisations attributed to the Trust per month during 2015/16

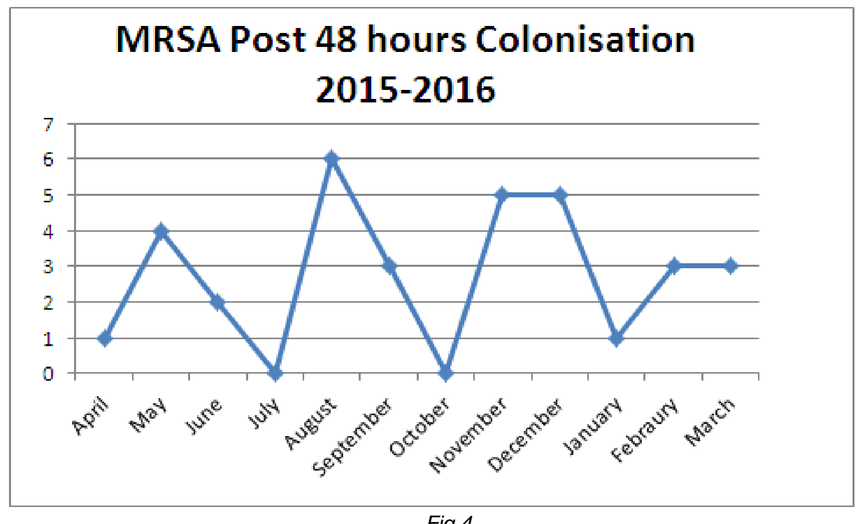


Fig 4

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

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

The IPCT identified a range of actions which were implemented on any ward that had 2 or more new cases in a 28 day period. For 2015/16.These wards were as follows Abington (September 2015) Willow (March 2016).

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

MRSA Screening by Patient Group:

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

Northampton General Hospital (NGH) achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall compliance for the year for electives 99.56% (patient specific verified data) and the overall compliance for non-electives was 95.85% Efforts continue to achieve greater compliance.

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

***Clostridium difficile* infection (CDI)**

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

The CDI NHS England target for the Trust for 2015/16 was no more than 21 cases. There were 31 patients with Trust-apportioned CDI in 2015/16 as shown in the graph below.

CDI –YTD against the end of year target

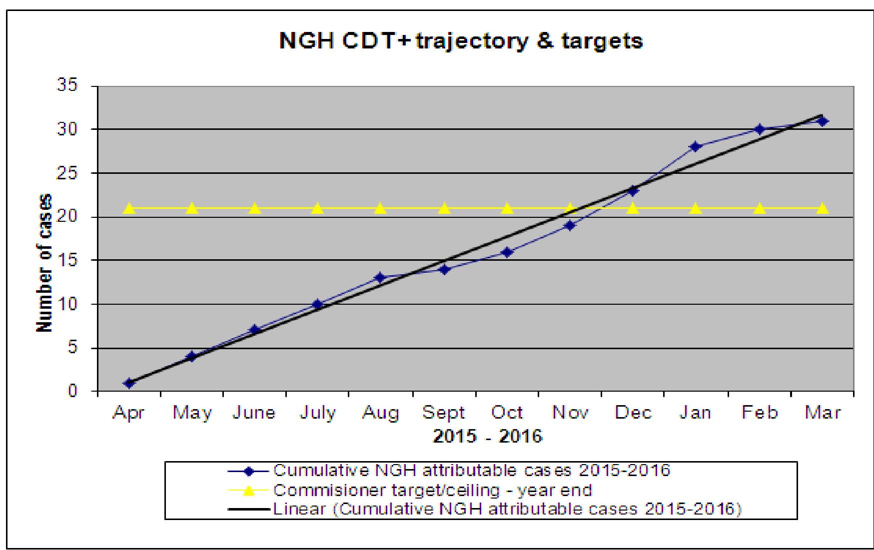


Fig 5

All CDI cases have been investigated by the clinical teams, the IPCT, the Consultant Microbiologist and the Antimicrobial Pharmacist utilising a Post Infection Review (PIR) process. Wards that have had trust attributable CDI are asked to feedback their findings from the Post Infection Review (PIR) process at the monthly IPOG meeting, where their learning can be shared with members of the group. Findings from the PIR are also presented through IPSG and CQEG. The Clinical Commissioning Group (CCG) in line with National Guidance review all trusts attributable CDI PIR's. Of the 31 cases there was 1 lapse in care appointed by the CCG. As the CDI trajectory was exceeded for 2015/16, a thorough retrospective review of all medical notes for the 31 patients with confirmed trust attributable CDI was conducted by the IPCT, Deputy Director of Quality and Governance and the Antimicrobial Pharmacist and a detailed thematic analysis was produced and presented at the Quality Governance Committee. This review and the themes identified have enabled the production of the *Clostridium difficile* Improvement Plan (2016/17).

Actions completed in 2015/16 to reduce the risk of CDI

- The PIR process was revised and improved (Appendix 3)
- A peer review visit was conducted that found good processes in place at NGH and made no recommendations
- A Situation Background Assessment Recommendations Tool (SBAR) was implemented for every patient that develops to ensure key actions are completed promptly
- Increased surveillance of ward areas by IPT to identify patients with diarrhoea promptly
- Patients with CDI are reviewed on a weekly basis by a Consultant Microbiologist, Consultant Gastroenterologist, Antimicrobial Pharmacist and Infection Prevention and Control Nurse, to ensure that they are being managed appropriately, responding to treatment and that other medications have been reviewed in a timely manner e.g. proton pump inhibitors
- Infection Prevention Committee was reviewed and divided in to an Operational Group (IPOG) and a strategic Steering Group (IPSG). With the support of the NGH Governance team the governance structure of this group was reviewed and the terms of reference were agreed at March's Clinical Quality and Effectiveness Group (CQEG) March 2016 meeting

The Environment

Actions completed in 2015/16

- Cleaning service centralisation
- Enhanced cleaning Standard Operating Procedure implemented following a patient developing CDI
- Estates, Domestic & Infection Prevention (EDI) inspections completed following a patient developing CDI
- PAS 5748 Cleaning Standards integrated into cleaning policy and schedules
- Environmental cleanliness audits conducted monthly and reported to IPOG

Education

Actions completed in 2015/16

- Implementation of *C.diff* grab pack for ward-based training following a case of CDI
- *C.diff* training embedded in induction and mandatory annual refresher training
- *C.diff* campaign held in January 2016 where the IPCT engaged with over 200 members of staff to reinforce key *C.diff* messages

Antimicrobial Stewardship

Actions completed in 2015/16

- The Antimicrobial Pharmacist conducted a retrospective review of all 2015/16 *C.diff* cases to determine antibiotic related themes
- The October 2015 antibiotic compliance audit found that 98.5% of antibiotic indications adhered to trust antibiotic guidelines
- Antimicrobial Stewardship Group have conducted a gap analysis to the NICE Antimicrobial Stewardship Guidelines
- The antibiotic guidelines made more accessible via a smartphone application
- Held an antibiotic awareness week to reinforce the importance of documenting and challenging indication, duration and review dates for antibiotics and also the key messages from the Start Smart - Then Focus guidance
- Collaborative work was undertaken with the CCG to help achieve the 2015/16 Quality Premium on improved antibiotic prescribing in primary and secondary care

The following figures are from PHE from the beginning of April 2015 to the end of March 2016 (Financial Year). These show Trust apportioned cases of CDI within our locality

Trust Apportioned cases for the Financial Year 2015-2016

	Trajectory	**Actual**
Northampton General Hospital	21	**31**
Kettering General Hospital	26	**26**
United Lincolnshire Hospitals	59	**58**
University Hospital Coventry and Warwick	42	**38**
Worcester Acute Hospital	32	**28**

Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-lactamase Producers)
ESBLs are a group of enzymes produced by bacteria. The enzymes break down antibiotics such as cephalosporins and penicillin's, but the bacteria are usually susceptible to and hence treatable with the carbapenem antibiotics.

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

ESBL Producing Bacteria (Clinical Isolates)

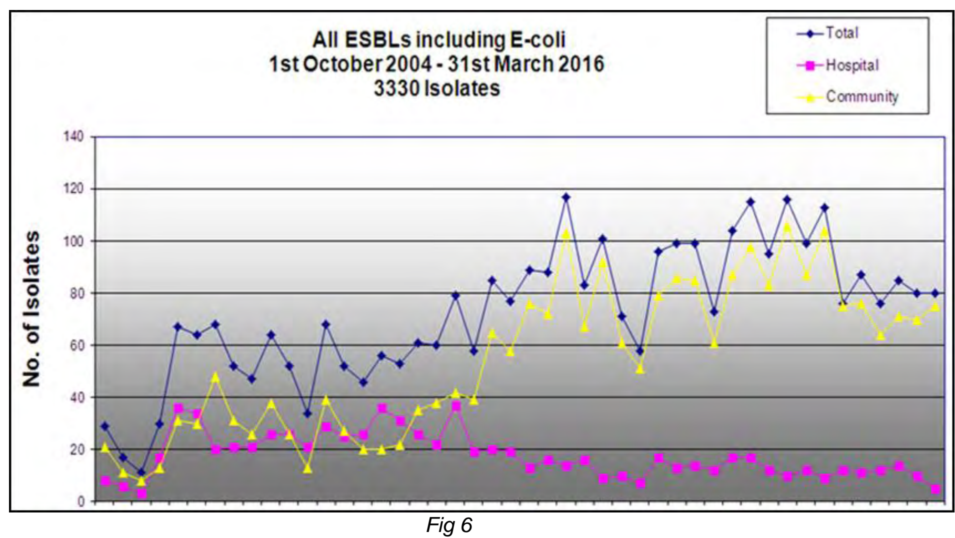


Fig 6

***Escherichia coli* (*E. coli*) bacteraemia**

In accordance with the Department of Health Guidelines the IPT commenced mandatory reporting of *E coli* bacteraemia in June 2011. National data is collated to include all positive results, they are not attributed to either acute of community responsibility.

All *E. coli* post 48 hour positive blood cultures have detailed data collated and internal RCA's are conducted to highlight any common trends and learn from this analysis. Currently NGH considers all episodes diagnosed after 48 hours as hospital attributed.

Antimicrobial Resistance: CPE (Carbapenemase Producing Enterobacteriaceae)
CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

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

- A Trustwide CPE Procedural Document

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

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

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

In 2015/16 IPCT continued their work on CPE and going forward as part of the forward plan for 2016/17. July 2016 is CPE month. A CPE Grab Pack (providing accurate information and education) is also available for all staff within the infection prevention department and the site office should this be required out of hours.

Mandatory Surveillance of Surgical Site Infections

NGH is participating in Surgical Site Infection Surveillance (SSIS) that is co-ordinated by Public Health England (PHE) in order to enhance the quality of patient care, where the rates of SSI's are compared with other hospitals that take part in surveillance. This system demonstrates significant reductions in rates of SSI in hospitals that participate in these benchmarking schemes. For the mandatory surveillance of SSI following orthopaedic surgery, all NHS Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures, during a financial year that runs from 1st April to 31st March.

Every patient included in the surveillance is actively and systematically followed up from the time of surgery. This includes monitoring during the post-operative hospital stay, on readmission or any return visit to the hospital e.g. outpatient clinic. SSI may also be reported by the patient in a post discharge wound healing questionnaire that is completed at 30 days post op.

- Patients with no implant insertion, the surveillance of SSI must be stopped on the 30th day after their surgery
- Patients where an implant was inserted: a deep incisional or organ/space SSI must be followed for up to 1 year after their surgery

In collaboration with the Trauma and Orthopaedic Directorate the IPCT undertake 5 different categories for SSIS each quarter. Total hip replacement and total knee replacement, fractured neck of femur are undertaken each quarter. The IPT then choose 2 other categories, which vary each quarter.

All data for a surveillance period must be submitted within 60 days of the end of the period to PHE, who generate a report on data. This report contains our own data together with aggregated data from other hospitals contributing data in the same surgical category, see table 1.

Table 1: Surgical Site Infection Surveillance

From 1st April 2015 to 31st March 2016 the IPCT undertook the following surgical site infection surveillance categories: Total Knee Replacement (TKR), Total Hip Replacement (THR), # Neck of Femur, Abdominal Hysterectomy, Small Bowel, Caesarean-section, Limb Amputation, Vascular Surgery and Large Bowel.

April 2015/March 2016	Total Knee Replacement	Total Hip Replacement	#NOF	Abdominal Hysterectomy	Small Bowel	C-section	Limb Amputation	Vascular Surgery	Large Bowel
Total no of procedures	233	292	333	57	14	324	63	33	39
No. of SSI inpatient/ readmission	1	4	5	0	2	2	0	2	1
No. of SSI post discharge confirmed by healthcare professional/ reported by midwife						8			
No. of SSI patient reported post discharge		1		3	1	23	1	3	3
Total infections	1	5	5	3	3	33	1	5	4

Quarterly SSI reports from 1st April 2015 to 31st March 2016 compared with results from all hospitals in this surgical category for the previous 5 years available.

April – June 2015/16

April – June 2015/2016	Total Knee Replacement	Results from all hospitals	Total Hip Replacement	Results from all hospitals	#NOF	Results from all hospitals	Abdominal Hysterectomy	Results from all hospitals	Small Bowel	Results from all hospitals
Total no of procedures	77	121041	87	119059	95	63957	57	1623	14	2104
No. of SSI inpatient/ readmission	1 1.3%	789 0.7%	2 2.3%	907 0.8%	2 2.1%	941 1.5%	0 0%	27 1.7%	2 14.3%	178 8.5%
No. of SSI post discharge confirmed by healthcare professional/ reported by midwife	0 0%	280 0.2%	0 0%	171 0.1%	0 0%	51 0.1%	0 0%	7 0.4%	0 0%	4 0.2%
No. of SSI patient reported post discharge	0 0%	No data	0 0%	No data	0 0%	No data	3 5.3%	No data	1 7.1%	No data
Total infections	1 1.3%	1069 0.9%	2 2.3%	1078 0.9%	2 2.1%	992 1.6%	3 5.3%	34 2.1%	3 21.4%	182 8.7%

Please note: One Total Knee Replacement patient, two total hip replacement, two #NOF and two small bowel patients developed wound infection post-surgery from April – June 2015/16, making the rate of surgical site infections for this patient group above the national average. Root cause analysis (RCA's) was completed for each of the seven patients and action plans set out and completed as below:

- With regards to small bowel surgery patients, the surgical Consultant confirmed that both infections were unavoidable due to the type and risks of surgery that were undertaken

- With regards to all orthopaedic surgeries, all patients were discussed at the Trauma and Orthopaedic (T and O) M&M meetings

- Education was provided by the IPCT to Abington Ward staff with regards to the correct use of decolonisation, commencement of decolonisation for each patient on admission and to ensure that all decolonisation prescriptions are correctly signed by clinicians

- The ward manager provided education to all staff on the rationale and process for prophylactic decolonisation by empowering healthcare professionals to take ownership of this

- The Surgical Site Infection (SSI) Care Bundle for #NOF patients was updated by the Orthopaedic Consultant

- A SSI presentation was presented at the trauma and orthopaedic M&M meeting by the Orthopaedic Consultant with regards to antibiotic practices and to provide an update on the SSI care bundle

July – September 2015/16

July - September 2015/2016	Total Knee Replacement	Results from all hospitals	Total Hip Replacement	Results from all hospitals	#NOF	Results from all hospitals	C-section	Results from all hospitals
Total no of procedures	52	257130	79	247589	80	90971	324	25043
No. of SSI inpatient/ readmission	0 0%	1362 0.5%	2 2.5%	1433 0.6%	2 2.5%	1183 1.3%	Total: 10 3.1%	927 3.7%
No. of SSI post discharge confirmed by healthcare professional/ reported by midwife	0 0%	856 0.3%	0 0%	502 0.2%	0 0%	90 0.1%		
No. of SSI patient reported post discharge	0 0%	1945 0.8%	1 1.3%	901 0.4%	0 0%	133 0.1%	23 7.1%	718 2.9%
Total infections	0 0%	4163 1.6%	3 3.8%	2836 1.1%	2 2.5%	1406 1.5%	33 10.2%	1645 6.6%

Please note: Two Total Hip Replacement and two # NOF patients developed wound infection post-surgery from July – September 2015/16, making our rate of surgical site infections for this patient group above the national average. RCA's were completed for each of the two patients and action plans set out and completed as below:

- SSI (Surgical Site Infection) Care Bundle for # NOF patients was updated by the Orthopaedic Consultant
- SSI presentation was given at M&M meeting by Mr Auld regards to antibiotics update, SSI bundle, decolonisation treatment, appropriate orthopaedic wards for patients and time in theatre
- Education was provided by the IPCT to Abington Ward staff with regards to correct use of decolonisation, commencement of decolonisation for each patient on admission and to ensure that all decolonisation prescriptions are correctly signed by clinicians
- The ward manager provided education to all staff on the rationale and process for prophylactic decolonisation by empowering healthcare professionals to take ownership of this
- The ward manager provided education on importance of swabbing all wounds on admission

Although the surgical site surveillance for C-section following reconciliation were below the national average.

- Recommendations were made to improve outcomes for mothers by developing a C-section leaflet, written and verbal reinforcement given to mothers on discharge and education regarding wound care on discharge
- The Maternity Safety Thermometer will monitor infections (point prevalence) both in hospital and following discharge for 10 days postnatal on a monthly basis

October – December 2015/16

October - December 2015/2016	Total Knee Replacement	Results from all hospitals		Total Hip Replacement	Results from all hospitals		#NOF	Results from all hospitals		Limb Amputation	Results from all hospitals		Vascular Surgery	Results from all hospitals
Total no of procedures	74	261342		85	251275		73	91642		35	1987		33	6206
No. of SSI inpatient/ readmission	0 0%%	1337 0.5%		0 0%	1415 0.6%		0 0%	1181 1.3%		0 0%	63 3.2%		2 6.1%	171 2.8%
No. of SSI post discharge confirmed by healthcare professional/ reported by midwife	0 0%	864 0.5%		0 0%	513 0.2%		0 0%	96 0.1%		0 0%	2 0.1%		0 0%	8 0.1%
No. of SSI patient reported post discharge	0 0%	1976 0.8%		0 0%	896 0.4%		0 0%	135 0.1%		1 2.9%	21 1.1%		3 9.1%	117 1.9%
Total infections	0 0%	4168 1.6%		0 0%	2824 1.1%		0 0%	1412 1.5%		1 2.9%	86 4.3%		5 15.2%	296 4.8%

Please note: Two Vascular patients developed wound infection post-surgery from October – December 2015/16, making our rate of surgical site infections for this patient group above the national average. Root cause analyses (RCA's) were completed for each of the two patients and action plans set out and completed as below:

- Education was delivered by ward sister to all healthcare professionals to ensure that decolonisation treatment is given correctly as per drug chart instruction and signed appropriately

- Education was delivered by ward sister to all healthcare professionals to limit unnecessary wound exposure

January – March 2015/16

January - March 2015/2016	Total Knee Replacement	Results from all hospitals	Total Hip Replacement	Results from all hospitals	#NOF	Results from all hospitals	Large Bowel	Results from all hospitals	Limb Amputation	Results from all hospitals
Total no of procedures	**30**	**271961**	**41**	**260797**	**85**	**92538**	**39**	**19826**	**28**	**2036**
No. of SSI inpatient/ readmission	**0 0%**	**1315 0.5%**	**0 0%**	**1399 0.5%**	**1 1.2%**	**1133 1.2%**	**1 2.6%**	**1926 9.7%**	**0 0%**	**60 2.9%**
No. of SSI post discharge confirmed by healthcare professional/ reported by midwife	**0 0%**	**850 0.5%**	**0 0%**	**557 0.2%**	**0 0%**	**85 0.1%**	**0 0%**	**180 0.9%**	**0 0%**	**2 0.1%**
No. of SSI patient reported post discharge	**0 0%**	**2021 0.7%**	**0 0%**	**889 0.3%**	**0 0%**	**133 0.1%**	**3 7.7%**	**306 1.5%**	**0 0%**	**22 1.1%**
Total infections	**0 0%**	**4186 1.5%**	**0 0%**	**2845 1.1%**	**1 1.2%**	**1351 1.5%**	**4 10.2%**	**2412 12.2%**	**0 0%**	**84 4.1%**

Please note: Although the surgical site surveillance for Large Bowel and #NOF following reconciliation were below the national average, the following recommendations were made:

One patient who underwent large bowel operation developed wound infection post-surgery in Quarter 4 January – March 2015/16. A RCA was completed for this patient and action plans set out and completed as below:

- Consultant colorectal surgeon confirmed that this was unavoidable infection due to the faecal spillage from the bowel and that the infection was inevitable due to rupture of the colon
- Education by ward sister was provided to all healthcare professionals to ensure that decolonisation treatment is given correctly as per drug chart instruction and signed appropriately

One #NOF patient developed a wound infection post-surgery in Quarter 4 January – March 2015/16. A RCA was completed for this patient and action plans set out and completed as below:

- The Orthopaedic Consultant who performed the operation confirmed that this was a very complicated and difficult procedure as it had taken three hours complete the operation.
- Education by the Orthopaedic Consultant will be provided at M&M meeting to all surgeons, to ensure that second dose of antibiotics will be given if procedure is too long
- Education by ward sister will be provided to all healthcare professionals to ensure that decolonisation treatment is given correctly as per drug chart instruction and signed appropriately

Untoward Incidents and Outbreaks
There were not any outbreaks for 2015/16.

Influenza
In 2015/16 there was a national epidemic of influenza. The epidemic was late this year. There was a rise in the number of patients admitted with respiratory symptoms and an increase in the confirmed number of cases with influenza. Northampton General Hospital (NGH) Pathology laboratory was able to process the diagnostic swabs sent from patients within 12 hours. Therefore, prompt influenza diagnosis of the patient's condition ensured that there was effective management of patients. There was a collaborative approach between the IPCT team and staff at NGH. Proper management of these patients was as follows:

- Prompt isolating of patients with suspected influenza within a side-room
- The wearing of correct Personal Protective Equipment (PPE)
- Correct signage in place on the isolation room doors
- All staff was made aware of what was required when caring for these patients. A grab pack was developed which was taken to the ward area where there was a suspected case. There was a flu kit developed and this remains in the Trust Operations room and the Infection Prevention and Control Department in the advent of an emergency situation

The prompt and correct management of these patients also enabled isolation of patients to discontinue if not required, in particular the discharge of paediatric patients. There was no evidence of secondary spread. Therefore there was not an outbreak of influenza within NGH.

The graph below shows how the number of patients admitted with confirmed influenza peaked in February 2016 and troughed from April onwards finishing at NGH in May 2016.

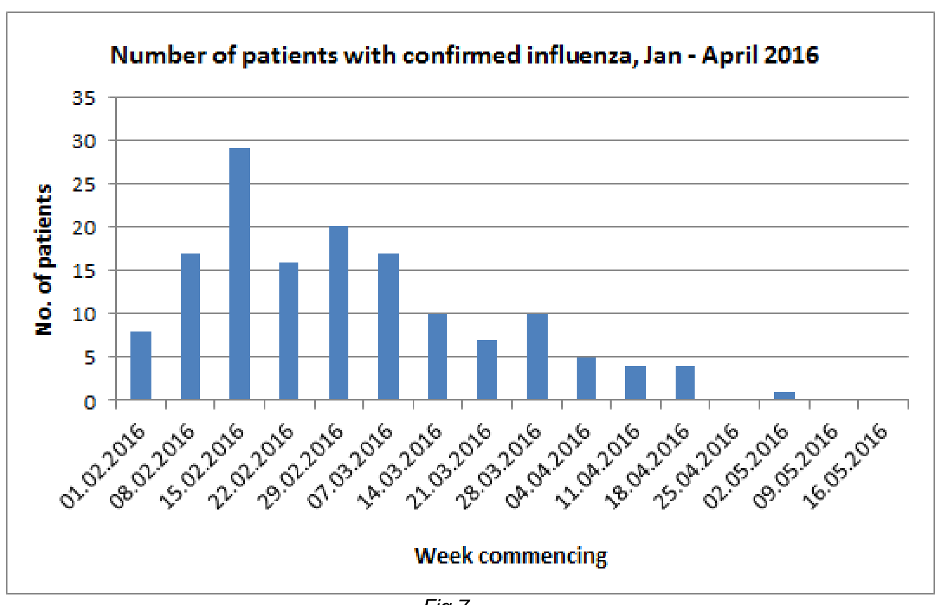


Fig 7

5. Infection Prevention Annual Audit Plan

Infection Prevention Audits April 2015 - March 2016
The IPT performed the audits in the table below. All audits are reported at the Clinical Quality and Effectiveness Group (CQEG), Infection Prevention and Control Operational Group (IPOG) and the Infection Prevention Steering Group (IPSG). Actions from the audits are monitored through the IPSG.

	Annual audits	6 Monthly / 3 Monthly	Monthly Audits
Apr 2015	Standard precautions MRSA decolonisation & PGD audit		*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits, HHOT and PPE peer review audits
May 2015	Handling & disposal of waste audit Enteral feeding	Commode audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits, HHOT and PPE peer review audits
Jun 2015	Handling & disposal of sharps audit – by smartsharp rep		*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits, HHOT and PPE peer review audits
Jul 2015	Handling & disposal of linen audit		*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits, HHOT and PPE peer review audits
Aug 2015	Blood culture audit	Catheter-related UTIs prevalence audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits, HHOT and PPE peer review audits
Sept 2015	CVAD related infections prevalence, insertion and continuing care & care plan audit	HHOT peer review audits	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits,
Oct 2015			*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits
Nov 2015	Isolation precautions audit	Commode audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits. Water outlet flushing audit.
Dec 2015	Environment audit	HHOT peer review audits Repeat commode audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits. Water outlet flushing audit.
Jan 2016	Blood Culture Audit		*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits. Water outlet flushing audit.
Feb 2016	PVC related infections prevalence & care plan audit	Catheter-related UTIs prevalence audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits.
Mar 2016	Aseptic non-touch technique audit Risk assessment / transfer checklist audit	Isolation facilities utilisation audit	*C.difficile* SIGHT compliance audit Safety thermometer audit validation for CAUTIs Beat the Bug audits. Water outlet flushing audit.

Further audits: *'Focus on infections'* audits (rapid improvement tools) audits when a ward has 2 or more MRSA or *C.difficile* cases in a 28-day period e.g. Isolations, Environment audits. Hand hygiene audits will be conducted periodically by Deb to the measure of frequency of use of soap in various dispensers.
Completed audits: will be colour coded GREEN as record of completion. Completed audit reports are saved in the Audit folder of the IP shared drive.

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

6. Hospital Cleaning

Devolved Cleaning and Food Delivery to a Centralised Service Nomination
During 2015 an in-depth and complex review of devolved cleaning and food services at ward level was undertaken. The project team for this review included the Deputy Director of Nursing, Infection Prevention Matron, Associate Directors of Nursing and the Hotel Services Manager.

This review identified various options for future delivery of these support services. These options included:

- Do nothing
- Maintain devolved services (i.e. Directorates continued to operationally manage these support staff)
- Maintain devolved services and management but increase level of centralised support (with recruitment, training for example)
- Centralise these support services

The Trust board agreed to the centralisation of these support services to be managed by the Trusts Hotel Services department (part of the Facilities Directorate). This process involved a change over from devolved directorate / division managed support staff to a centralised managed service.

Over a four month period between September and December 2015 Senior Housekeepers, Domestic, Host and Hostess staff were transferred (sensibly and sensitively) across to a centralised managed service ensuring all involved were fully communicated with and their individual concerns addressed.

It is a credit to the Management, supervisory team and staff that this transition has been successful and beneficial to our patients and clinical colleagues and service users.

The IPCT and the Domestic Manager integrated the PAS 5748 Cleaning Standards (BSI, 2014) into the Trust Site Cleaning Policy, which complement the National Specifications for Cleanliness in the NHS (NPSA, 2007) that the Trust currently uses. The PAS 5748 risk ratings have been applied to each ward and department and the roles and responsibilities for cleaning different elements of the environment have been allocated to the relevant staff group: nursing, domestics, estates and host/esses.

Compliance to the PAS and National Specifications for Cleanliness is audited on wards monthly and in out-patient departments quarterly by a Domestic Supervisor and the Ward or Department Manager through completion of the Environmental Cleanliness Audits (IPT, 2010)

These audit results are reported to the IPOG monthly via the Trusts Infection Prevention Dashboard where the Matrons provide assurance that actions have been addressed. Any recurring non-compliances are escalated to the IPSG via the highlight report.

Monthly Environmental cleaning audits are performed in all directorates with the table below providing an overall average at the end of the year:

Month	%
April	97.3%
May	95.5%
June	97.5%
July	93%
August	96.6%
September	96.4%
October	95.5%
November	86%
December	96.4%
January	96.7%
February	96.5%
March	96.4%
AVERAGE	**95%**

Patient-Led Assessments of the Care Environment (PLACE) took place during March 2016. The aim of PLACE (which took over from the long established PEAT programme) is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, cleanliness, the condition, appearance and maintenance of healthcare premises. The initial report submitted to the Department of Health reflected good scoring levels which will be confirmed during October – November 2016.

The IPCT always participates in these assessments and the Trust continues to achieve acceptable scores in the majority of the assessment process. The assessment which is carried out mainly by patient representatives and the results of the 2015 assessment were as follows:

- Cleanliness **99.78 %**(97.57%)
- Condition appearance and maintenance **90.30% (**88.49%)
- Privacy, dignity and wellbeing **92.73% (**86.03%)
- Food and hydration **93.62%** (90.11%)
- Dementia **79.79% (**74.51%)

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

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

7. Decontamination Arrangements

Sterile Service Department

The Sterile Service Department processed nearly 160,000 trays and procedure packs between April 2015 and March 2016. This is an increase of circa 15,000 items based upon the previous year. The department continues to provide fully compliant podiatry services to NHFT, and a full theatre tray service to BMI Three Shires, as well as Northampton General Hospital.

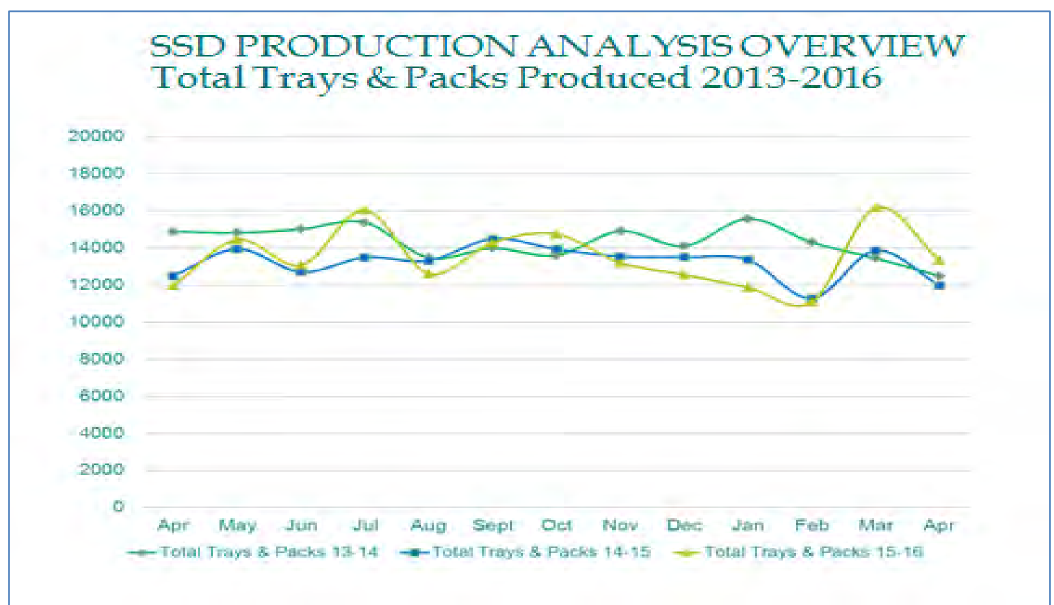


Fig 8

The Sterile Service Department has maintained its registration for compliance with European and British decontamination guidance during a three day external re-certification audit and have maintained its ISO9000/13485/Medical Device Directive 93/42/EEC accreditation for 2015/16. The department maintains monthly Key Performance Indicators (see *Fig 8*).

The “Institute of Decontamination Sciences Technician Certificate” continues, and we currently have seven technicians enrolled on this course who are working through the syllabus. Two students were successful in completing this course last year.

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

We continue to operate our machinery according to national guidance in the forms of the CFFP (Choice Framework for Local Policy) and HTM (Health Technical Memorandum), these documents include:

- CFPP 01-01:2013 - Management and decontamination of surgical instruments used in acute care (Soon to be updated to HTM-01-01).
- HTM-01-06:2016 - Management and decontamination of flexible endoscopes

The Sterile Services Department is currently upgrading its Washer-Disinfectors with new state of the art equipment. The project started in April 2016 with an estimated completion during August 2016.

Medical Equipment Library
The Medical Equipment Library (MEL) has continued to work in conjunction with Patient and Nursing Services to streamline the way the Trust orders ad-hoc rental mattresses. The entire

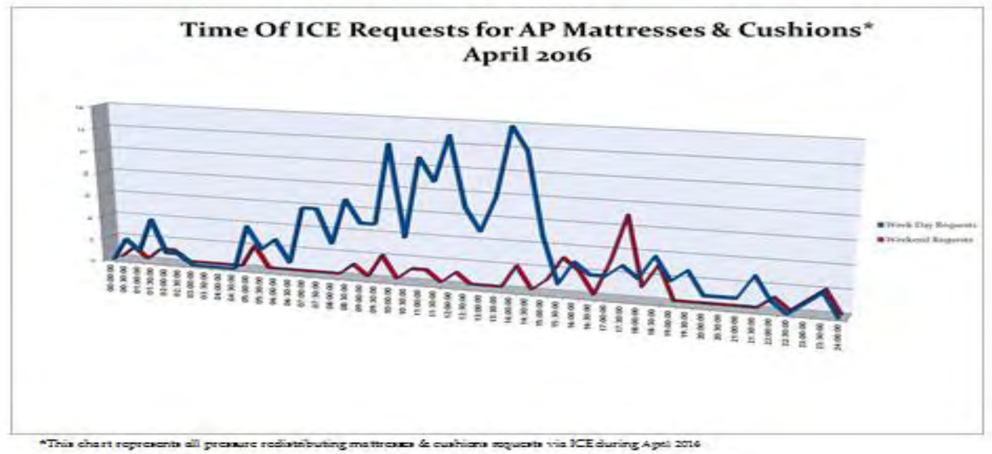


Fig 9

order process has been reviewed and Key Performance Indicators are now produced to evidence the availability of equipment (and requests) both in and out of working hours (see *Fig 9*).

The manual T Card system aids the library in the tracking of VAC therapy pumps, infusion and syringe pumps and the new T34 24hr syringe drivers is still operational, however a new improved system is required to track pumps such as the T34 McKinley pumps which are sent out with the patient to the community. Further work is still underway to investigate RFID (Radio Frequency Identification) to enable all items to be tracked within the Trust.

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

The MEL has expanded its remit with the inclusion of weighing scales, negative pressure wound therapy and falls alarms etc. The scope of the library is due to increase further in the coming year.

Endoscopy
The department is fully equipped with single sided Automated Endoscope Reprocessers (AERs), Drying Cabinets and Reverse Osmosis (RO) water systems. A scope transportation system is in use. The scope transportation system allows flexible endoscopes to be transported safely in a vacuum sealed plastic pouch between users and the endoscopy reprocessing room.

Further discussions are required during the coming year to establish the feasibility of placing storage cabinets in theatre.

Further discussions are required concerning the capacity of the existing Endoscopy Unit as this does not allow for any growth. If a new facility is proposed, then pass-through AER's will be specified.

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

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

Forward Plan 2016/17

- A review and business case is to be developed to replace the existing traceability system within Sterile Services.
- A business case has been submitted for RFID tracking of all devices from the Equipment Library.

Summary
The Trust Decontamination Lead continues to sit on the Infection Prevention Operational Group and Decontamination Group and provides a monthly report to the Infection Prevention Operational Group.

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

8. Information Provision

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

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

Infection Prevention information is also provided for services users via the Trust internet (external) and intranet (internal) sites the IPT internal website has been improved upon this year and will continue to improve for 2016/17.

The IPCT working in collaboration with the Trust communication team and have developed their own brand 'the bug stops here'. This is utilised on all communication across the trust.
Going forward for 2016-2017 the IPT have an annual communications plan, incorporating:-

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

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

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

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

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

9. Antimicrobial Stewardship

9.1 Compliance to Trust antibiotic policy

Point prevalence audits were performed by Clinical Pharmacists at the Trust over a one day period (April and October 2015). The aim was to audit antimicrobial prescribing at the Trust and compliance to the Trusts Antibiotic Policy. This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Criteria 9 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship, there should be an ongoing programme of audit, revision and update. The following table summarises the audit results:

April 2015:

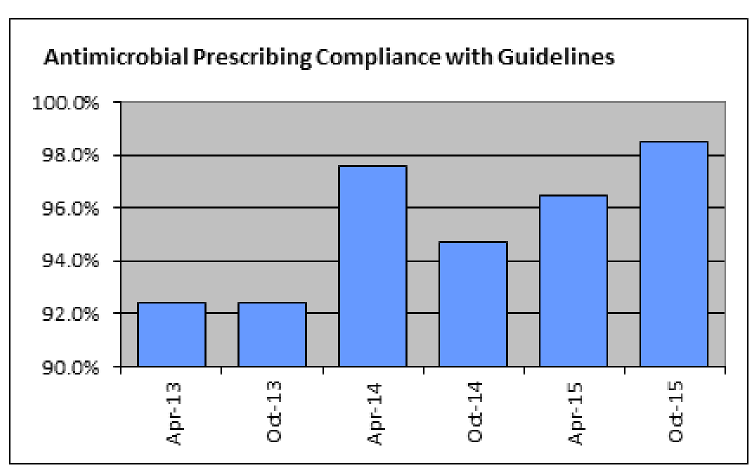
Descriptor	Number	Proportion	Comments
Total number of patients seen	**618**		This is the highest number ever covered. The Avery wards, Cliftonville and Blenheim were included for the first time.
Number of patients on antibiotics	**196**	**31.7%**	The proportion is lower than October 2014, 35.9% of patients were receiving antibiotics.
Total number of antibiotics prescribed	**256**	**1.3 per patient**	This is higher than October 2014 when 1.2 antimicrobials were prescribed per patient.
Number adhered to the policy	**215** **247 (including valid reasons for non-compliance)**	**84%** **96.5% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Micro approved = 16 • Based on culture and sensitivities = 3 • No guidelines for infection = 13 (see below for a list of infections) 9 prescriptions, 3.5% did not comply with NGH antimicrobial guidelines (see below for a list of infections).
Number of intravenous (IV) prescriptions	**136**	**53.1%**	This is lower than the previous audit in October 2014 (62%).

<table>
<tr><th>Descriptor</th><th>Number</th><th>Proportion</th><th colspan="2">Comments</th></tr>
<tr><td>Number of oral prescriptions</td><td>120</td><td>46.9%</td><td colspan="2">This is higher than the previous audit in October 2014 (38%).</td></tr>
<tr><td>Average duration of IV antibiotics</td><td>4.1 days</td><td rowspan="2"></td><td>This comparable to the average of 3.9 days in October 2014. (Lifelong and long term courses approved by microbiology were excluded)</td><td rowspan="2">As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.</td></tr>
<tr><td>Average duration of oral antibiotics</td><td>3.2 days</td><td>This comparable to the average of 3.2 days in October 2014. (Lifelong and long term courses approved by microbiology were excluded)</td></tr>
<tr><td>Duration of antibiotic administration stated on prescription chart</td><td>110</td><td>43%</td><td colspan="2">This has increased slightly from 41.6% from October 2014. More work needs to be done to ensure reviews are taking place and that all course lengths are documented.</td></tr>
<tr><td>Number of antimicrobial prescriptions with one or more omitted dose</td><td>25</td><td>9.8%</td><td colspan="2">9.8% of patients taking antibiotic courses have one or more dose omitted; this has increased from 7%. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses.</td></tr>
<tr><td>Number of prescriptions with indication stated by prescriber</td><td>75</td><td>29.3%</td><td colspan="2">There has been a slight decrease from 31.7% in October 2014. Start smart then focus states that the clinical indication for antimicrobials should be documented both in the medical notes and on the drug chart.</td></tr>
</table>

October 2015:

Descriptor	Number	Proportion	Comments
Total number of patients seen	**562**		Fewer patients were audited than previously, mainly due to the Avery wards not being included. They will be included in April 2016.
Number of patients on antibiotics	**207**	**36.8%**	The proportion is higher than April 2015 (31.7%) but comparable to October 2014 (35.9%).
Total number of antibiotics prescribed	**265**	**1.3 per patient**	This is same as April 2015.
Number adhered to the policy	**232** **261 (including valid reasons for non-compliance)**	**87.5%** **98.5% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Microbiology approved = 7 • Based on culture and sensitivities = 4 • No guidelines for infection = 18 (see below for a list of infections) 4 prescriptions, 1.5% did not comply with NGH antimicrobial guidelines (see below for a list of infections).
Number of	**148**	**55.8%**	This is higher than April 2015 (53.1%) but

<table>
<tr><th>Descriptor</th><th>Number</th><th>Proportion</th><th colspan="2">Comments</th></tr>
<tr><td>intravenous (IV) prescriptions</td><td></td><td></td><td colspan="2">lower than October 2014 (62%).</td></tr>
<tr><td>Number of oral prescriptions</td><td>117</td><td>44.2%</td><td colspan="2"></td></tr>
<tr><td>Average duration of IV antibiotics</td><td>4.9 days</td><td rowspan="2"></td><td>This higher than the average of 4.1 days (April 2015) and 3.9 days (October 2014)
(Lifelong and long term courses approved by microbiology were excluded)</td><td rowspan="2">As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.</td></tr>
<tr><td>Average duration of oral antibiotics</td><td>3.7 days</td><td>This comparable to the average of 3.2 days (April 2015 and October 2014).
(Lifelong and long term courses approved by microbiology were excluded)</td></tr>
<tr><td>Duration of antibiotic administration stated on prescription chart</td><td>123</td><td>46.4%</td><td colspan="2">This has increased again from 43% (April 2015). More work needs to be done to ensure reviews are taking place and that all course lengths are documented.</td></tr>
<tr><td>Number of antimicrobial prescriptions with one or more omitted dose</td><td>20</td><td>7.5%</td><td colspan="2">7.5% of patients taking antibiotic courses have one or more dose omitted; this has decreased from 9.8%. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses.</td></tr>
<tr><td>Number of prescriptions with indication stated by prescriber</td><td>92</td><td>34.7%</td><td colspan="2">This has increased from 29.3% (April 2015) but is still very low. Start smart then focus states that the clinical indication for antimicrobials should be documented both in the medical notes and on the drug chart.</td></tr>
</table>



The results are reported by the antimicrobial pharmacist to Antimicrobial Stewardship Group (ASG) and IPSG, by the divisional lead pharmacists to the divisional board meetings and by the microbiologist to CQEG. These biannual audits will be repeated and are scheduled for April and October 2016.

East Midlands Antimicrobial Stewardship Key Performance Indictors for 2015-16

This is the first time NGH has participated in this audit. It allows benchmarking between the Trusts. Reassuringly we have a high percentage of prescriptions judged to be clinically reasonable; this is consistent with our bi-annual point prevalence audits. Key areas for improvement at NGH are recording of indications, review dates/durations and the 3 day prescribing decision in medical notes. This audit is to be discussed at ASG and we are looking at how ePMA may be utilised to improve recording of indications. Please see below for key results.

Audit & Quality Indicators	NGH	Chesterfield Royal	Derby Hospital	KGH	Milton Keynes	NUH	Sherwood Forest	UHL
% of Antibiotic Prescriptions Clinically Reasonable	94	67	74	92	87	87	97	80
% of Antibiotic Prescriptions with an Indication Documented on the Chart	33	94	97	92.7	67	82	65	92
% of Antibiotic Prescriptions with a Stop / RV date / Duration on prescription	50	70	86	95	20	72	59	56
% of Antimicrobial Prescriptions >72 hrs with a Day 3 Prescribing Decision Documented in the notes	50	94	No Data	54	85	68	82	No Data

9.2 Training initiatives

Ad hoc antimicrobial stewardship induction sessions are given to new clinical pharmacists.

9.3 Antibiotic campaigns

European Antibiotic Awareness Day – 18th November 2015

This annual awareness day was marked at NGH by screensavers highlighting the issue of resistance and encouraging staff to make a pledge as Antibiotic Guardians.

Antibiotic Awareness Week – Monday 29th February 2016

During the week the IPT, trainee clinical scientist and antimicrobial pharmacist used promotional stands, quizzes and screensavers highlighting the issue of resistance and encouraging staff to make a pledge as Antibiotic Guardians.

9.4 Antimicrobial Stewardship Group

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

- Sep 2015 [6 attendees]
- Jan 2016 [5 attendees]
- May 2016 [9 attendees]

Developments in the last year have included;

- NICE Guideline on Antimicrobial Stewardship (NG15) - a gap analysis has been completed and an action plan for antimicrobial stewardship is being developed
- Carbapenem controls - an approval code for meropenem has been introduced
- Mandatory training in Antimicrobials and Antimicrobial Stewardship
- Improving 3 day review of empiric antibiotics
- Guideline Development and Monitoring of Use

9.5 Other Antimicrobial Developments

PHE Antibiotic Validation Protocol

2013/14 antibiotic consumption data was validated as per the ESPAUR validation protocol for NHS Acute Trusts and submitted to PHE in June 2015

Nitrofurantoin MR Switch

A switch has been made to nitrofurantoin MR, the potential annual saving is £4,800 plus improved patient compliance from twice daily dosing instead of four times daily.

Adult Renal Antibiotic Guidelines

Guideline for dosing of antibiotics for patients with impaired renal function has been updated to include all commonly used antibiotics in the Trust. It is now available on the intranet alongside the antimicrobial guidelines.

Formulary Committee Requests

- **Rifaximin (Xifaxanta®)**
  For small intestinal bowel bacterial overgrowth. Last line option, GI Consultant initiation only
- **Fosfomycin**
  Fosfomycin offers an oral option for drug resistant ESBL UTIs that currently require either an inpatient admission for Meropenem or Intermediate Care Team (ICT) referral for once daily Ertapenem. For Consultant Microbiologist initiation only
- **Pivmecillinam**
  Pivmecillinam is an alternative agent for UTIs to nitrofurantoin and trimethoprim. For Consultant Microbiologist initiation only

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

10. Staff Development and Training

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

Training was a key tool in improving staff knowledge on Infection Prevention practices in 2015/16. The IPCT delivered training across the entire spectrum of staff and for a wide range of purposes from generic Trust-wide sessions at induction to bespoke training on very specific issues.

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

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

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

Developments
On the 15th October 2015 the Infection Prevention Team celebrated their sixth annual study day.

Fifty healthcare professionals came together from across the Trust to learn more about different aspects of infection prevention and control. The event was sponsored by five companies whose infection prevention products we use.
The Deputy Director of Nursing for Patient & Nursing Services gave the welcoming address. There were varied presentations throughout the day ranging from a talk about the role of the patient representative, food and bacteria and estates and their role. The study day was evaluated well by all who attended and the next study day is IPCT study day is October 13th 2016.

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

11. Isolation

In March 2016 the IPCT performed an isolation room usage audit. The findings suggested that there are adequate numbers of side rooms within the trust.

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

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

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

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

12. Laboratory Services

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

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

13. Policies

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

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

14. Audit Programme

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

The dashboard supports continuous quality improvement, development and manages trends, providing safer care for our patients. The title of the dashboard has been changed to the Trusts Infection Prevention Dashboard and is monitored monthly through IPOG.

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

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

The Hygiene Code was revised in July 2015, and the NGH governance team who have updated Health Assure to reflect the revised code. IPCT continue to align and update supporting evidence to provide assurance with the Hygiene Code.

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

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

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

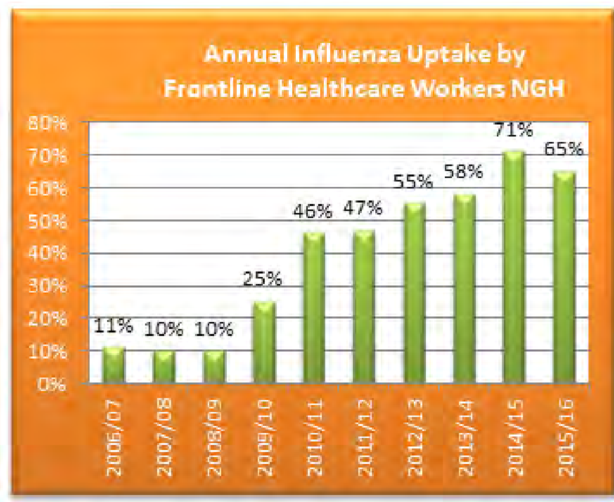
I4. Occupational Health
The Occupational Health Department provides services from Billing House. Total activity (measured in clinical events) for 2015/16 was 16,396 which is a 7% increase on the previous year. This includes new employment screening, vaccinations, blood tests, physiotherapy, nursing and medical consultations.

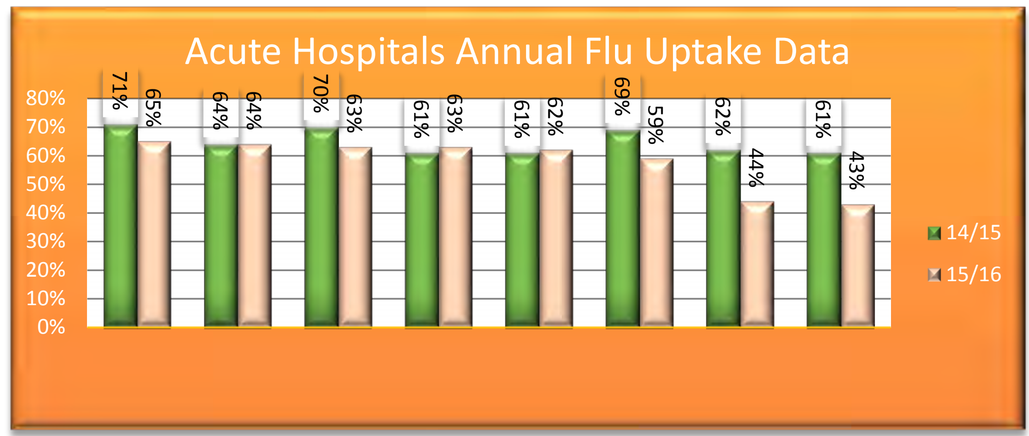
Activity 2015/16	
Blood tests	4373
Vaccinations	3188
Work health screening	2107
General clinic	1743
Nurse appointments	907
Other tests	1914
Management referrals	873
Physiotherapy	378
Physician	376
Health Surveillance	422
Contamination Injuries	115
Total Activity 2015/16	16396

In addition to the external contract work the department now provides services to private individuals and companies who may need ad hoc services. The target for 2015/16 was 150,000 and was exceeded the total figure for income being £216,579.

The department has improved its establishment levels and now has two OH Consultants giving 4pa's per week which is double the previous level of 2 pa's per week. The Consultants are working via collaborative working with Leicester UHL OH Department.

The flu campaign in 2015/16 was slightly lower than the previous year but this may have been to the previous year's adverse media coverage regarding the shift on flu strains. NGH come highest in uptake compared to our local acute Trusts, but it remains a challenging project.





Summary

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

However, a number of key risks and challenges exist and are covered in the plan of work for 2016/17, see Appendix 3.

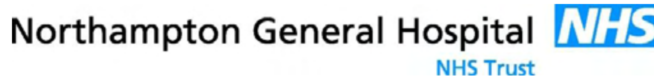
Author(S)	Wendy Foster – Lead Matron Garry Hunt – Decontamination Lead Claire Salt – Antimicrobial Pharmacist Claire Brown – Occupational Health
Owner	Carolyn Fox
Date	31st August 2016

Appendix 1

IPCT Structure 2015/16

Post	Post holder	WTE
Board Executive Lead (DIPC)	Mrs Carolyn Fox	Not defined
DIPC	Mrs Carolyn Fox	Not applicable
Chair of the Trust Infection Prevention and Control Group	Mrs Carolyn Fox	Not applicable
Consultant Medical Microbiologist	Dr Minas Minassian Dr Anthony Bentley Dr Maria Ntoumpanaki	Not defined
Band 8a IPC Matron	Mrs Wendy Foster	1 x 1.0
Band 7 IPC Nurse	Mrs H.Slyne Mrs R Pounds	1 x 1.0 1 x 1.0 (secondment)
Band 6 IP Support Nurses	Mrs J Hart Mrs T Arnold Mrs K. Baptiste Miss N .Clews	1 x 0.40 1 x 0.68 1 x 1.0 1 x 1.0
Band 4 Secretarial Administration and Surveillance	Mrs Karen Tiwary	1 x 1.0

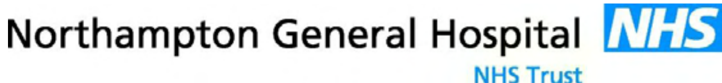
Appendix 2a



Infection Prevention Steering Group (IPSG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy • Matron for Infection Prevention & Control or nominated deputy • Consultant Microbiologist • Medical Director or nominated Deputy • Deputy Director of Quality & Governance • Associate Director of Nursing for Medicine • Associate Director of Nursing for Surgery • Associate Director of Midwifery • Associate Director of Nursing for Oncology • Head of Estates / Deputy Director of Facilities • Head of Hotel Services
Quorum	6 members
In Attendance	• Deputy Director of Nursing, Midwifery & Patient Services • Antimicrobial Pharmacist • Occupational Health Lead • Public Health England (PHE) representative • Patient representative • Minute taker
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the CQEG
Date of Approval by CQEG	• March 2016
Review Date	• March 2017



Infection Prevention Steering Group

Terms of Reference

1. Constitution

The Trust hereby resolves to establish a steering Group of the Clinical Quality and Effectiveness Group (CQEG) to be known as the Infection Prevention Steering Group.

2. Purpose

The purpose of the Steering Group is to provide strategic direction for the prevention and control of Healthcare acquired infections in Northampton General Hospital NHS Trust that minimises the risk of infection to patients, staff and visitors. The Steering Group will:

- Strengthen the performance management of Health Care Associated Infections (HCAI's) and cleanliness across the Trust
- Provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes
- Make recommendations as appropriate on Infection Prevention Control matters to the Board via CQEG
- Performance Manage the Trust against the Infection Prevention and control strategy
- Will ensure that there is a strategic response to relevant new legislation and national guidelines

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy
- Matron for Infection Prevention & Control or nominated Deputy
- Consultant Microbiologist
- Medical Director or nominated Deputy
- Deputy Director of Quality & Governance
- Associate Director of Nursing for Medicine
- Associate Director of Nursing for Surgery
- Associate Director of Midwifery
- Associate Director of Nursing for Oncology
- Head of Estates and Deputy Director of Facilities
- Head of Hotel Services

4. Quorum, Frequency of meetings and required frequency of attendance

- No business shall be transacted unless six members of the Steering Group are present, one of whom must be the Chair or their nominated Deputy
- The Steering Group will meet monthly.

- Members of the Steering Group are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the Chair.

5. In attendance

In addition to the core membership, other staff will be invited to attend by the Chair of the Steering Group.

Authority

The Steering Group is authorised by CQEG to investigate any activity within its terms of reference and to seek any information it requires to provide assurance to the Board. The Steering Group will seek external expert advice and invite attendance if considered appropriate.

6. Duties

- To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008)/ The Hygiene Code updated 2015.

- To fulfil the Trust's statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies.

- To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies are evidence based, reflect relevant legislation and published professional guidance. Recommend submission and approval to Procedural Document Group.

- To develop the annual infection prevention and control programme of activity and ensure that it is submitted to Quality Governance Committee (QGC) and approved by the Trust Board

- Monitor achievement of the objectives contained within the annual programme.

- To receive, review and endorse the annual Infection Prevention and Control Report.

- Management and investigation of outbreaks of infection.

- To receive a written Infection Prevention & Control report which includes:

  i. Outbreaks of infection
  ii. MRSA & Clostridium difficile data
  iii. Isolation deficits
  iv. Trust compliance with externally set targets
  v. Progress against the rolling infection prevention & control programme
  vi. Audit outcomes
  vii. Training and development plans/ compliance
  viii. Updates of relevant legislation / guidance/ best practice
  ix. Campaigns planned or delivered

- Receive a written highlight report and minutes from the Infection Prevention Operational Group and review the TOR annually.

- To receive written reports from the Trust operational IPC group to ensure that assurance is gained as to the implementation of Infection Prevention & Control practices & policies within the Trust. Providing assurance that all appropriate measures are being taken to assist the achievement of the national and local infection present ambition.

- Receive written reports from Deputy Director of Estates and Facilities in relation to water safety, decontamination compliance, structural/ building works that are planned within the Trust. To ensure that prevention and control of infection is considered as part of all service or building development activity, changes to HTM's or ACOP that may have infection control implications

- Receive written reports from the Head of Hotel services in relation to food hygiene, Environmental Health visits/ reports, PLACE outcome reports, cleaning compliance with standards and audits, domestic service training plans & compliance, and introduction of new cleaning products or systems of work.

- Receive written reports from the Occupational Health Manager which include needlestick injuries, flu vaccination programme compliance, outbreak issues affecting staff, any incidents of staff TB or BBV that have been or are currently under investigation or look back exercises for any infectious disease where an increased incidence has been reported nationally, to ensure that the staff and therefore the patients, are adequately protected where possible to do so.

- Receive written reports from the antimicrobial pharmacist which include an update from the Antimicrobial Stewardship Group.

- Receive written reports from the Associated Director of Nursing/Midwifery as requested by the Chair in relation to specific Infection Prevention and Control matters.

- To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

- To disseminate information and advice on prevention and control of infection to all appropriate Trust Division and their Directorates.

- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

7. Accountability and Reporting arrangements

The minutes of the Steering Group meetings shall be formally recorded by the Secretary/Surveillance Assistant **.**Copies of the minutes of the Steering Group meetings will be provided to all members of the Group and will be available to all Trust Board members.

The Steering Group Chair shall prepare a written summary report to CQEG after each meeting. The Chair of the Steering Group shall draw to the attention of CQEG any issues that require escalation to the Trust Board, require executive action or support.

Sub-committee and reporting arrangements

The Steering Group shall have the power to establish sub-groups for the purpose of addressing specific tasks. In accordance with the Trust's Standing Orders, the Steering Group may not delegate powers to a sub-group unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-group must be approved by the Steering Group and reviewed as stated below.

8. Administration

The Infection Prevention Steering Group shall be supported administratively by the Infection Prevention and Control Secretary /Surveillance Assistant

- Agreement of the agenda for Steering Group meetings with the Chair

  Requesting of reports from authors in a timely manner in accordance with the reporting schedule

- Collation of reports and papers for Steering Group meetings
- Circulate agenda and papers for the meetings 7 days in advance of the Meeting
- Ensuring that suitable minutes are taken, a record of matters arising and actions are accurately documented
- All reports will be submitted in writing with a front sheet

9. Requirement for review

These terms of reference will be formally reviewed by the Steering Group at least annually.

FOI Reminder
The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 2b

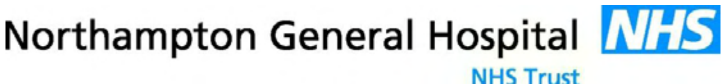
Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC • Deputy Director of Nursing • Infection Prevention Matron • Modern Matrons • Estates and Facilities • Hotel Services • Therapies or nominated representative • Domestic Team Leads/Supervisors
Quorum	Eight members that must include either: • Director of Nursing, Midwifery & Patient Services/DIPC or • Deputy Director of Nursing, Patient & Nursing Services • Member of the Infection Prevention Team as required • Modern Matrons (5)
In Attendance	• Director of Nursing Midwifery & Patient Services/DIPC & Director of Infection Prevention & Control • Deputy Director of Nursing • Matron for Infection Prevention or a member of the Infection Prevention Team • Modern Matrons • Lead within Estates • Lead within Facilities The Group would have the authority to co-opt any person necessary to assist in its deliberations
Frequency of Meetings	• Monthly
Accountability and Reporting	• The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members on request. • The Matron for Infection Prevention reports to Director of Nursing monthly operational infection prevention issues. • The Matron for Infection Prevention produces an Annual Report for the Care Quality & Effectiveness Group. • The DIPC (Director of Nursing) & Matron for Infection Prevention reports and participates in the Whole Health Economy Infection Control meeting. • The DIPC (Director of Nursing) or Deputy Director of Nursing will report from the Operational Group

	into the IP&C Steering Group.
Date of Approval by IPSC on behalf of Quality Governance Committee	May 2016
Review Date	• Annually



Infection Prevention Operational Group (IPOG)

Terms of Reference

1. Constitution

The Trust hereby establishes a group to be known as the Infection Prevention Operational Group (IPOG). The aim of the group is to ensure operationally:

1. The Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008), (the "Hygiene Code").

2. To receive reports on specific operational problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations to the IP Steering Group.

3. To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance, prior to approval by IP Steering Group.

4. To monitor divisional performance regarding adherence to infection control practice through the monitoring of the matrons dashboard Infection Prevention and Control audits and putting actions into place where required.

5. To discuss relevant issues presented by the Infection Prevention & Control Team (IPCT) and any other member of the committee.

6. To make recommendation to IP Steering Group and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

7. To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

8. To ensure that prevention and control of infection is considered as part of all service development activity.

9. To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.

10. To monitor the performance of the infection prevention and controls programme and make suggestions for improvement, including review of improvement plans from Divisions.

2. Purpose

The purpose of the IPOG is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust and making recommendations to the IP Steering Group and divisions.

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC
- Deputy Director of Nursing
- Infection Prevention Matron
- Modern Matrons
- Estates and Facilities
- Hotel Services
- Therapies or nominated representative
- Domestic Team Leads/Supervisors
- The group would have the authority to co-opt any person necessary to assist in its deliberations

4. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless eight members of the group are present. This must include not less than eight members that must include either:

- Director of Nursing, Midwifery & Patient Services/DIPC or
- Deputy Director of Nursing
- Member of the Infection Prevention Team
- Modern Matrons (5)

The group will meet monthly. Members of the group are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

5. In attendance

Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the group Chair and relevant members are entitled to be present at a meeting of the group, but others may attend by invitation of the Chair.

6. Authority

The group is authorised by the Trust to investigate any activity within its terms of reference and to seek any information and to make any recommendations through the Infection Prevention Steering Group (IPSG), through its chair that is deemed appropriate. Or any area within the terms of reference where action or improvement is required.

7. Duties

To attend meetings as required and report to the IPOG in an open and honest manner and address any issues.

8. Accountability and Reporting arrangements

The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members on request.

9. Sub-groups and reporting arrangements

The group shall have the power to establish sub groups for the purpose of addressing specific tasks or areas of responsibility. The terms of reference, including the reporting procedures of any sub groups must be approved by the group and regularly reviewed.

10. Administration

The group shall be supported administratively by the Administration/Surveillance person whose duties in this respect will include:

- Agreement of the agenda for group meetings with the Chair
- Collation of reports and papers for group meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried

11. Requirement for review

These terms of reference will be formally reviewed by the group at least annually.

12. FOI Reminder

The minutes (or sub-sections) of the Infection Prevention Operational Group unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 3

Healthcare Associated Infection Reduction Plan 2016-17

Priorities and key goals for 2016-17

- A reduction in the number of patients with CDI (<21 cases)
- Zero patients with MRSA bacteraemia
- A 25% reduction in the number of patients with MSSA bacteraemias (<18 cases)
- Sustain measurement of CRUTI prevalence through Safety Thermometer Strategic Group and action plan
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system
- To embed the CPE screening process
- To implement the 2016/17 IPC communications strategy

The plan is built upon the criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This set out ten criteria against which the trust is assessed on how it complies with registration requirements of infection prevention.

BRAG Key	
(blue)	**Complete**
(green)	**On-track**
(orange)	**Delivery issues**
(red)	**Unable to deliver**

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2016-17							
	Clinical teams to undertake case review using principles of RCA and PIR and present to IPSC: • All cases of MRSA bacteraemia • All cases of NGH attributed CDI • All cases of NGH attributed MSSA bacteraemia • All cases of NGH attributed E.coli bacteraemia							
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPC and CQEG.	Quarterly	Consultant microbiologist					
1 b Promote a culture of continuous quality improvement in IPC	Review and update IPSG terms of reference and IPOG terms of reference	January 2017	IP Matron					
	Provide monthly reports to IPSG	Monthly	IP Matron					
	Provide monthly reports to CQEG	Monthly	IP Matron					
	Reports monthly to the trust board	Monthly	DIPC					
	Present surveillance data regarding HCAIs to IPSG	Monthly	IP Matron & cons. micro					
	Monitor the progress of patients with *C.diff* infection at IPOG meetings	Monthly	IP Matron					
	Implement IP audit plan for 2016-17 and report monthly at IPOG and IPSG. *(For further information please refer to the IP annual audit plan).*	Monthly	IP Matron					
	Implement the IP surveillance plan for 2016-17 and report quarterly at IPSG and CQEG. *(For further information please refer to the IP surveillance plan).*	Monthly	IP Matron					

	IPT to conduct '*Beat the bug*' ward quality visits with members of the executive team	Monthly	IPT & exec team					
	IPT to work with the trust communication team to deliver a continuous year long campaign that focuses on keeping patients safe from infection	Ongoing	IPT & comms team					This commenced in Jan 2016 and will run until March 2017

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
2 a Maintenance of a clean, safe and appropriate environment which facilitates the prevention and control of HCAI	The Trust Hotel Services Manager and Domestic Manager will report key issues monthly to IPOG	Monthly	Hotel Services Manager & Domestic Manager					
	Review monthly cleaning audit scores at IPOG	Monthly	IP Matron & Matrons					
	IPT to embed enhanced cleaning standard operating procedure	June 2016	IPN					
	IPT and Facilities to launch cleaning roles and responsibilities	June 2016	IPN & Domestic Manager					Awaiting the Domestic team to launch the Electronic Cleaning Audit Tool (currently being trialled)
	IPT and Facilities to scope out a deep clean programme (ward of the week)	June 2016	IP Matron					This has been approved by the IPSG
	Introduce IP & Estates risk assessment to be completed prior to Estates work commencing. IPT to be involved in any Estates works from the project commencement	Ongoing	IP Matron & Estates Projects Lead					
	The Trust Estates Maintenance Manager will report key issues monthly to IPOG	Monthly	Estates Maintenance Manager					
	The Deputy Director of Facilities will provide a comprehensive report quarterly to IPSG	Quarterly	Deputy Director of Facilities					

2 b Decontamination standards are monitored and adhered to	The Trust Decontamination Lead will ensure that the Decontamination Group operates according to its terms of reference and reports monthly to the IPOG	Monthly	Decontamination Lead					
2 c Water safety requirements are monitored and adhered to	The Trust Water Safety Lead / Responsible Person will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPSG	Quarterly	Deputy Director of Facilities					
	The Trust Deputy Responsible Person will report and update any water safety issues to IPOG	Monthly	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
3 a To improve antimicrobial prescribing and stewardship	The Trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Pharmacist will report quarterly to the IPSG	Quarterly	Antimicrobial pharmacist					
	Antimicrobial audits will be presented to IPSG	Quarterly	Antimicrobial pharmacist					
	The Trust Antimicrobial pharmacist to undertake a GAP analysis of the NICE guidance baseline assessment tool for Antimicrobial stewardship (NG15).	Quarter 1	Antimicrobial pharmacist					Completed Q1
	The Trust Antimicrobial pharmacist from the GAP analysis to formulate an action plan	Quarter 2	Antimicrobial pharmacist					

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

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
4 a Provide useful information for staff on the prevention and control of infections	IPT to scope out the possibility of sharing Infection Prevention information in a novel way and to share this information at relevant meetings and across the Trust	Monthly	IPT					
	Produce screensavers or posters as required to clarify IP procedures and processes	Monthly	IP Matron					
	Send out information via email system to communicate updates on IP practices or polices as required e.g. during outbreaks	Q1, Q2, Q3, Q4	IP Matron					
	Produce a monthly IP infogram to share updates and key information on infections to be displayed on two notice boards in the hospital corridors	Monthly						
	To implement the IPC communication strategy and monthly focus on specific aspect of IPC	Monthly						
	To install lightboxes in prominent locations across the trust	Quarter 1						This has been purchased by the Communications Team and is on track
4 b Provide useful information for patients and visitors on the prevention and control of infections	To update the IPC page of the external website	Monthly	IPT					This is being reviewed corporately.
	Provide patient information leaflets on *C.diff.*, MRSA, ESBLs, surgical site infection prevention, urinary catheters and enteral feeding	Q1	IPT PDNs Nutritional support nurse					Completed
	To develop patient information leaflets for central venous access devices and peripheral venous cannulas	Quarter 2	IPT					Completed Q2
	Provide outbreak information to patients and visitors regarding ward closures and	Q3 & Q4						

	preventing the spread of infection							

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
5 a To improve CPE screening and care of suspected, presumptive or confirmed positive cases	To monitor numbers of screens and results and report positive cases to IPSG	Monthly	IPN					
	To scope out implementing the CPE screening process at Pre-Operative Assessment Clinic	Q3	IPT POAC Manager					
5 b To remain within the *C.diff* trajectory of 21 cases for 2016-17	To have *C.diff* trajectory on to the risk register and review quarterly	Quarterly	IP Matron					
	To continue to identify wards that require support for 1 case of *C.diff* or period of increased incidence (2 or more cases within 28 days), conduct PIR for all post admission *C.diff* cases and maintain the *C.diff* antigen positive surveillance	Q1, Q2, Q3 and Q4	IPT					
	To develop and commence a *C.diff* improvement plan for 2016/17 that implements the outcomes of the 2015/16 *C.diff* retrospective case review	Q1, Q2, Q3 and Q4	IPT					

5 c To minimise the risk of infection to patients by conducting MRSA screening and managing patients who are colonised or infected with MRSA effectively	To maintain MRSA screening processes according to trust MRSA policy, monitor elective and emergency screening compliance and conduct surveillance of previous MRSA positive inpatients.	Q1, Q2, Q3 and Q4	IPT					
5 d To minimise the risk of infection to patients by preventing MSSA bacteraemias	To develop a MSSA bacteraemia reduction plan for 2016/17	Q1	IPT					Completed Q1
	To action the MSSA bacteraemia reduction plan	Q1, Q2, Q3 and Q4	IPT					
5 e To minimise the risk of cross-infection for alert organisms	IPT to review all patients who acquire an alert organism infection and provide ongoing advice and support to medical and nursing staff	Q1, Q2, Q3 and Q4	IPT					
	IPT to conduct surveillance and management of outbreaks of infection	Q1, Q2, Q3 and Q4	IPT					There have not been any outbreaks for Q1 and 2
5 f To minimise the risk of infection to patients from catheter-related urinary tract infections	IPT to scope out developing an algorithm for managing a patient with a positive urine dipstick and suspected/confirmed urinary tract infection	Q2	IPT					
	IPT to undertake a retrospective review of the 2015/16 CRUTI cases to identify key themes	Q1	IPT					Completed Q1
	IPT to develop CRUTI action plan to address the themes identified from the retrospective case review	Q2	IPT					Competed Q2

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
6 a Staff receive appropriate IP training	IP is part of induction and mandatory training. IP mandatory training is to be monitored and reported to CQEG by the Infection Prevention Matron.	Monthly	IP matron					
	To scope out an ANTT refresher training forward plan	Q2	IPT, PDNs, Clinical Skills Trainer L&D manager					
	ANTT – to generate reports for the number of staff trained in ANTT by staff group	Q3	IPT, PDNs, Clinical Skills Trainer L&D manager					
6 b IP workforce and capability	Ensure that all IPT members are skilled, knowledgeable and have an appraisal process in place to ensure clear objectives and development needs	Q1, Q2, Q3 and Q4	IP matron					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
7 a To provide advice regarding appropriate isolation use	IPT to undertake daily review of the urgent care wards A&E, EAU and Benham to identify patients admitted that require isolation	Q1, Q2, Q3 and Q4	IPSNs					
	To attend the safety huddle twice daily to provide isolation and IP advice	Q1, Q2, Q3 and Q4	IPSNs / IPN / IP matron					
	IPT to undertake daily review of the Side Room	Q1, Q2, Q3	IPSNs					

	Monitor Tool and RAG rate each isolation room to facilitate the Site Management Team in effective patient placement	and Q4						
	To conduct an annual trustwide audit of isolation facilities as per the annual audit plan and report findings to IPSG the following month	Quarter 3	IPT					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory Andrea O'Connell					This is completed annually

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
9 a To ensure that evidence based IP policies and associated procedural documents are available	The IP policies and associated procedural documents are reviewed three yearly and in accordance with new guidance	Q1, Q2, Q3 and Q4	IPT					
	IP policies and procedural documents are audited as per the IP annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPT					

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
10 a To ensure that healthcare workers are protected from communicable diseases and from work exposures	Occupational health advice is available for staff	Q1, Q2, Q3 and Q4	Occupational Health Team					
	Occupational Health Team provide a quarterly report to IPC regarding key issues	Quarterly	Occupational Health Team					This is to be provided for August at IPSG
	Infection Prevention training is mandatory for all staff and reported monthly to CQEG via the IPT report	Monthly	Matron IPT					
	IPT to facilitate fit testing for paediatric staff, anaesthetic staff, ED staff and critical care staff and ensure relevant	Q1, Q2, Q3 and Q4	IPT					

Report To	TRUST BOARD
Date of Meeting	29th September, 2016
Title of the Report	Financial Position - August FY16-17
Agenda item	11
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Andrew Foster, Deputy DoF.
Purpose	To report the financial position for the period ended August 2016/17.

Executive summary

This report sets out the financial position of the Trust for the period ended 31st August. The overall I&E position is a deficit of £5.71m, £0.23m favourable to the year to date plan. This position is measured against the revised I&E control total agreed with NHSI for FY16-17.

- The Trust has performed favourably to plan in August and continues to assume STF funding of £4.0m for the year to date on the basis that it will maintain financial plan delivery and recover the agreed performance trajectories required by Q2 (see STF criteria and weighting below).
- Pay expenditure run rate continues to reduce month on month but remains significantly adverse (4%) to plan for the YTD.
- Agency expenditure is currently exceeding the authorised cap by £1.4m for the YTD.
- The Trust continues to manage operational cashflow and to meet all commitments as they fall due.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY16-17 signal another challenging financial year ahead and the requirement to develop a medium term financial strategy to deliver financial balance in the medium term.
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

Enclosure G

Actions required by the Committee
The Board is asked to note the financial position for the period ended August 2016/17 and to consider the actions required to ensure that the financial control total is delivered.

Financial Position

Month 5 (August)
FY 2016/17

Report to:

Trust Boardrs

September 2016

Enclosure G

1. Overview

	RAG	This Month Aug	Last Month Jul 16	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	Red	(35,202)	(33,914)	(1,287)
Achieving EFL (£000's)	Green	23,700	23,700	0
Capital Cost Absorption Duty (%)	Green	3.5%	3.5%	0
Achieving the Capital Resource Limit (£000's)	Green	17,398	17,398	0
Financial Sustainability Risk Rating	Red	2	1	1
I&E Position				
Actual in Month Position (£000's)	Red	(1,287)	(1,418)	130
Forecast in Month Position (£000's)	Red	(2,058)	(836)	(1,222)
Actual Year to Date Position (£000's)	Red	(5,710)	(4,422)	(1,287)
Forecast Year to Date Position (£000's)	Red	(5,710)	(4,422)	(1,287)
Forecast End of Year I&E Position (£000's)	Red	(15,129)	(15,129)	0
EBITDA %	Red	-0.2%	0.2%	-0.4%
Income				
MRET Penalty - YTD (£000's)	Red	(1,841)	(1,549)	(292)
Readmissions YTD - Gross (£000's)	Red	(1,421)	(1,143)	(278)
Contract Fines & Data Challenges (£000's)	Amber	(95)	(86)	(9)
Elective variance to plan (£000's)	Amber	(68)	(105)	37
Daycase variance to plan (£000's)	Green	50	(122)	172
Non-Elective variance to plan (£000's)	Green	2,333	1,914	419
Outpatients variance to plan (£000's)	Green	582	445	138
Operating Costs				
Pay Expenditure (£000's)	Amber	16,303	16,495	192
Agency Staff Costs (£000's)	Red	1,303	1,354	51
Agency Staff Cap (£000's)		1,087	1,087	0
Non-Pay - Clinical (£000's)	Amber	5,047	4,970	(77)
Non-Pay - Other (£000's)	Green	2,867	3,015	148
Cost Improvement Schemes				
Year to Date Actual (£000's)	Green	4,765	3,597	1,168
Year to Date Plan (£0o0's)		4,240	3,317	923
Forecast Delivery (£000's)	Red	10,646	10,313	333
Annual CIP Target (£'000s)		12,900	12,900	0
Capital				
Year to date expenditure (£'000s)		5,417	2,280	
% of annual plan Committed	Red	53%	44%	8%
Annual Capital Expenditure Plan (£000's)	Green	17,398	17,398	0
Cash				
In month movement (£000's)	Green	3,854	11	3,843
In Year movement (£000's)	Green	5,661	1,807	3,854
New PDC / Temporary borrowing (£000's)	Green	9,982	7,436	2,546
Debtors Balance > 90 days (£000's)	Red	1,273	1,227	(46)
Creditors % > 90 days	Green	0%	0%	0%
Cumulative BPPC - by volume (%)	Green	99.0%	98.9%	0.1%

Key issues for this report

This report sets out the financial position of the Trust for the period ended 31st August. The overall I&E position is a deficit of £5.71m, £0.23m favourable to the year to date plan. This position is measured against the revised I&E control total agreed with NHSI for FY16-17.

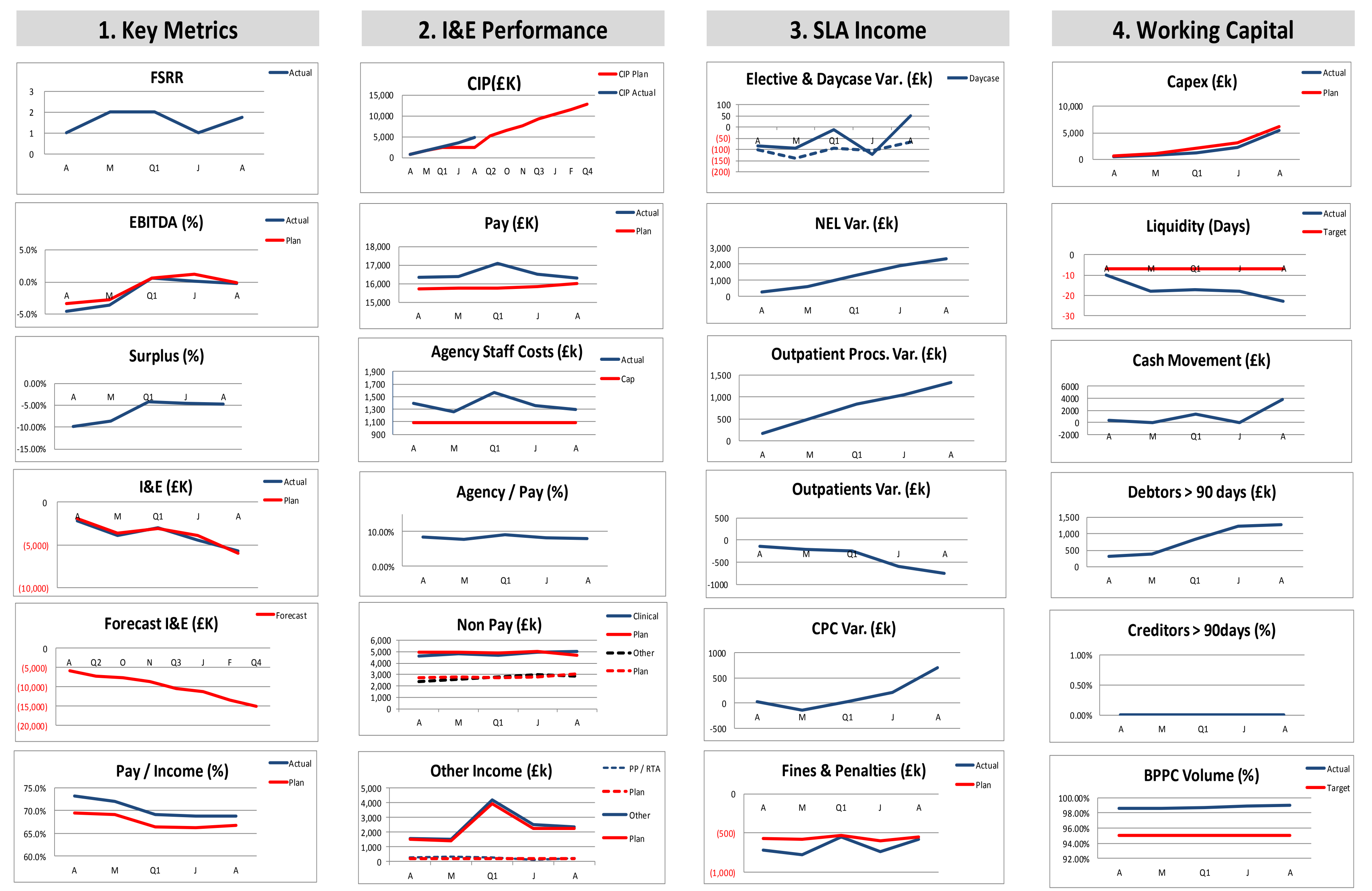
Key points:

- The Trust has performed favourably to plan in August and continues to assume STF funding of £4.0m for the year to date on the basis that it will maintain financial plan delivery and recover the agreed performance trajectories required by Q2 (see STF criteria and weighting below).
- Pay expenditure run rate continues to reduce month on month but remains significantly adverse (4%) to plan for the YTD.
- Income position continues to include provision for MRET and readmissions penalties but excludes access fines as a condition of meeting the STF criteria.
- The significant data challenge raised by the Host CCG in Q1 has now been resolved and the CCG have agreed to reimburse the Trust for the full value.
- Agency expenditure is currently exceeding the authorised cap by £1.4m for the YTD.
- The Trust continues to manage operational cashflow and to meet all commitments as they fall due.
- DH has now paid the STF funding of £4m to the Trust in August.
- The forecast exercise undertaken in July has been updated for M5 results and whilst this shows some improvement overall there remains a significant level of forward risk in delivering the financial control total which needs to be addressed (reported under separate cover).
- NHSI have issued a new "Single Oversight Framework." The related financial metrics will be included in the Q2 report.

STF criteria weighting

	Weight	Value £k
Finance	70.0%	6,790
RTT	12.5%	1,213
A&E	12.5%	1,213
Cancer	5.0%	485
Diagnostics	0.0%	-
Total	100.0%	9,700

2. KPI Trend Analysis



Enclosure G

3.0 Income and Expenditure Position

I&E Summary	Actual FY15-16	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Aug 16	Jul 16
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	246,152	256,346	106,178	106,772	594	21,242	21,576
Other Clinical Income	2,444	2,686	1,111	1,235	124	231	135
Other Income	20,872	27,562	11,379	12,118	739	2,344	2,498
Total Income	269,468	286,595	118,668	120,125	1,457	23,817	24,209
Pay Costs	(187,327)	(190,435)	(79,178)	(82,621)	(3,443)	(16,303)	(16,495)
Non-Pay Costs	(88,196)	(92,455)	(38,558)	(37,729)	829	(7,915)	(7,986)
CIPs		(0)	0	0	0	0	0
Reserves/ Non-Rec		(3,696)	(994)	0	994	0	0
Total Costs	(275,523)	(286,586)	(118,730)	(120,350)	(1,620)	(24,217)	(24,480)
EBITDA	(6,055)	9	(61)	(225)	(163)	(401)	(271)
Depreciation	(9,941)	(10,365)	(4,319)	(3,942)	377	(632)	(769)
Amortisation	(9)	(9)	(4)	(4)	0	(1)	(1)
Impairments	3,315	1,590	917	(1,808)	(2,725)	261	0
Net Interest	(355)	(1,239)	(275)	(225)	50	(57)	(52)
Dividend	(4,041)	(3,501)	(1,459)	(1,422)	37	(224)	(351)
Surplus / (Deficit)	(17,086)	(13,515)	(5,200)	(7,625)	(2,425)	(1,053)	(1,444)
NHS Breakeven duty adjs:							
Donated Assets	250	(24)	178	107	(71)	27	26
NCA Impairments	(3,315)	(1,590)	(917)	1,808	2,725	(261)	0
I&E Position (breakeven duty)	(20,151)	(15,129)	(5,939)	(5,710)	230	(1,287)	(1,418)

I&E Performance

- Financial performance for the period ended August 2016/17 is a normalised deficit of £5.710m, £230k adv. to the planned deficit of £5.940m.
- SLA income from Commissioners is £0.6m fav. to plan and now excludes provision for access fines in accordance with the conditions of the STF regime and standard contract.
- Other income above includes accrual for £4.024m of STF funding although the Trust has not met all of the performance conditions required to access the fund so far in September.
- Pay expenditure £3.443m (4%) adverse to plan driven by high costs of agency medical staff and agency nurses and HCAs.
- Non-Pay costs £0.829m favourable to plan but further increases predicted during the financial year (notably due to costs of PAS implementation, international nurse recruitment and building maintenance costs and contractual beds).
- Depreciation favourable to plan following completion of Q1 additions to the capital asset register and reassessment of in year phasing of charges.

Key Issues

SLA Income

- Underling position is £1.1 fav. to plan offset by requirement to make provision for potential fines and penalties of £3.356m for the YTD.
- Elective Inpatient income £0.07m : 1% (£0.1m adv.) adverse to plan .
- Daycase income £0.01m : 0% (£0.1m adv.) fav. to plan for the year to date.
- NEL income £2.56m (9%) fav. to plan for period to date giving rise to increased MRET penalty exposure.
- Reported income includes assessment of delivery of 87% of CQUIN targets.
- Reported position includes £0.4m of general provisions for data challenges and contract reconciliation issues.

Other Income

- Private Patient income £198k (£177k fav.) favourable to plan.
- RTA income £74k adv. (£62k adv.) to plan.
- Income / Other Generation £739k fav. (£662k fav.) to plan.

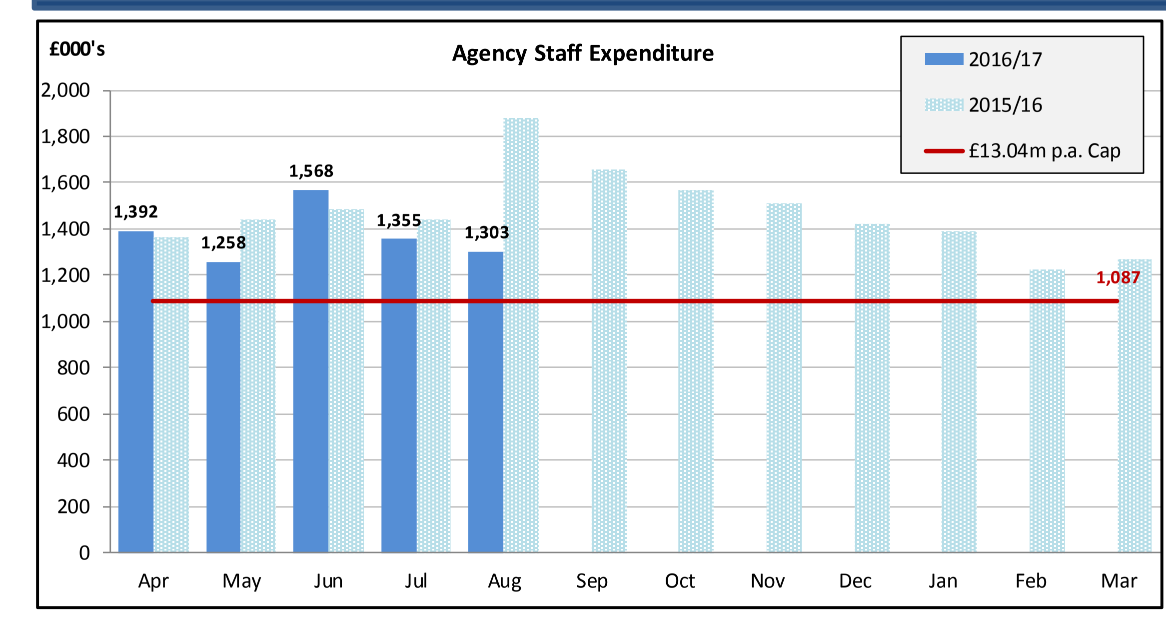
Pay

- Total agency staffing costs £1.303m (cap £1.087m) or 8.0% of the total pay bill for August. (NHSI agency cap for FY16/17 is £13.04m or c.6.6% of planned pay expenditure).
- Medical staffing £1.03m:4.5% adv. (£0.65m:4.4%) adverse to plan.
- Nursing pay expenditure £1.379m: 4.6% adv. (£1.031m: 4.3% adv.) to plan overall.

Non-Pay

- Drugs £362k (£240k) fav. to plan.
- Staff advertising £61k (£108k) fav. to plan.
- Prosthesis £146k (£109k) fav. to plan.
- Building and engineering £304k (£257k) fav. to plan .
- Energy costs £114k (£83k) fav. to plan.
- Computer maintenance / software £467k (£414k) fav. to plan.

3.1 Agency Staff Expenditure

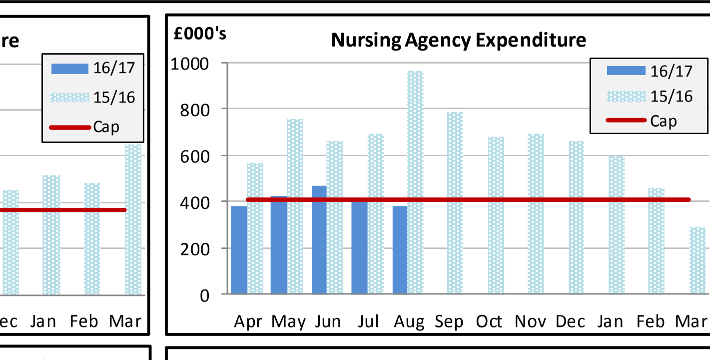


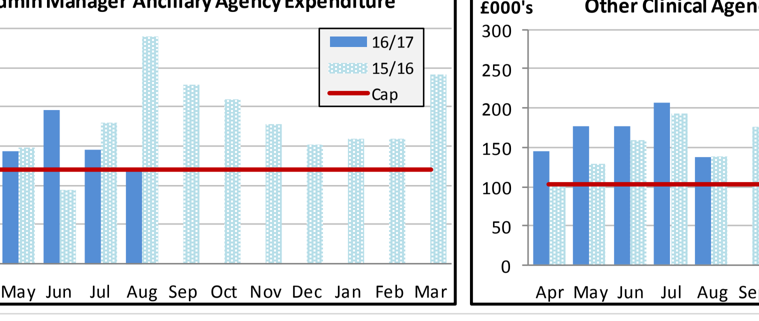
Medical Agency Expenditure

£000's

16/17 15/16 Cap

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar





Other Clinical Agency Expenditure

£000's

16/17 15/16 Cap

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Key Issues

- **The Trust total expenditure for agency staff in 2015/16 was £17.6m.**
- NHS Improvement issued a expenditure limit of £11.8m for the new financial year 2016/17.
- On appeal, this has been revised to £13.04m.
- £13.04m is equivalent to a 26% reduction year-on-year across all staff groups.
- Applying this annual limit equally across the year gives a £1.1m per month cap to keep within.
- At the end of August the Trust is £1.44m behind this cap.
- Agency Expenditure has reduced to £1.303m in month. But would need to average £881k for the remaining 7 months to meet the annual cap limit.
- Agency Medical Staff expenditure is currently 37% (£874k) higher than at this point last year. Urgent Care leading in expenditure.
- Agency Other Clinical Staff expenditure reduced this month, but there is still increasing pressure in Theatre Practitioner spend.
- Nursing agency spend fell below cap in August, which is often a pressured month for agency cover due to annual leave cover. Year-to-date this is now just £33k above cap year-to-date.
- Admin, Managers and Ancillary staff reduced to the cap level of £120k this month. This needs to average £97k per month in the remaining 7 months to meet the annual cap figure.

4.0 SLA Income by Point of Delivery

Point of Delivery		Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
AandE		49,857	48,752	(1,105)	5,811	5,658	(152)
Block / CPC		1,169,608	1,206,579	36,971	23,453	23,856	403
CQUIN		-	-		2,286	1,983	(303)
Day Cases		13,770	16,152	2,382	10,227	10,240	13
Elective		2,399	2,392	(7)	6,706	6,636	(70)
Elective XBDs		875	733	(142)	205	168	(36)
Excluded Devices		693	790	97	741	893	152
Excluded Medicines		-	173	173	9,103	9,006	(98)
Non-Elective		17,720	19,495	1,775	28,184	30,747	2,563
Non-Elective XBDs		15,125	14,092	(1,033)	3,298	3,066	(232)
Outpatient First		23,982	23,892	(90)	3,945	3,941	(4)
Outpatient Follow UP		83,324	75,376	(7,948)	7,644	7,105	(538)
Outpt Procedures		35,067	43,388	8,321	7,540	9,078	1,538
Other Central SLA Income					(193)	(2,250)	(2,057)
CIPs					61		(61)
Total SLA Income (before fines and penaties)					**109,011**	**110,128**	**1,117**
Fines & Penalties							
Contract Penalties	2WW				-	(3)	(3)
Contract Penalties	31 Day				-	(8)	(8)
Contract Penalties	62 Day				-	(33)	(33)
Contract Penalties	A&E				-	-	-
Contract Penalties	Cancelled Operations				-	(32)	(32)
Contract Penalties	CDIFF				-	-	-
Contract Penalties	MRSA				-	-	-
Contract Penalties	RTT - Incomplete				-	(20)	(20)
MRET	MRET				(1,685)	(1,841)	(156)
Readmissions	Readmissions				(1,148)	(1,421)	(272)
Sub-Total Fines & Penalties					**(2,834)**	**(3,356)**	**(522)**
Grand Total SLA Income					**106,178**	**106,772**	**594**

Key issues

Summary
£595k fav. to plan

SLA Income is £595k favourable to plan for the year to date and significantly better than predicted for the month of August.

CQUIN
£303k adverse to plan

CQUIN income recognises Q1 as achieved. Assumed 85% achievement across schemes in months 4 & 5.

Day Case and Elective Inpatients
£57k adverse to plan

Day cases have met the financial plan but above plan in activity due to zero-priced chemotherapy activity recorded in day case activity. Elective inpatients are below plan by 7 spells generating a marginal under-performance.

Non elective
£2,563k favourable to plan

Non elective activity is 9% above plan driven by A&E (Emergency Observation Area), Paediatrics, and General, Geriatric and Stroke medicine. There is a corresponding increase in MRET and Readmissions penalties which are adverse to plan.

Outpatients
£996k ahead of plan

The net position on outpatients is an over performance; Paediatrics, Ophthalmology, Respiratory Medicine, Cardiology, Oncology and Dermatology are over performing. This position is offset by a negative adjustment in relation to a coding and counting change which does not take effect until April 2017 (Ophthalmology).

A&E

A&E is £152k below plan.

Fines & Penalties
£522k adverse to plan

Adverse position driven by Non-elective activity and associated impact on MRET and Readmissions penalties.

4.1 SLA Income by Commissioner

Commissioner	Annual Plan	YTD Plan	Actual	Variance
	Finance £000's			
Nene CCG	202,873	84,092	84,159	67
Corby CCG	2,702	1,095	1,070	(25)
Bedfordshire CCG	673	280	249	(31)
East Leicestershire & Rutland CCG	626	255	315	60
Leicester City CCG	43	22	22	(0)
West Leicestershire CCG	91	28	29	0
Milton Keynes CCG	2,609	1,082	1,300	218
SCG	30,762	12,921	14,362	1,441
SCG Other (inc. Hep C)	1,134	375	404	29
Herts & South Midlands LAT	7,552	3,149	3,058	(91)
Cancer Drug Fund	3,131	1,312	841	(471)
NCA	3,624	1,547	1,437	(109)
Central	(100)	(42)	(473)	(431)
CIPs	2,481	61	-	(61)
Reserves / Contingency	(2,000)	-	-	-
Total SLA Income	**256,200**	**106,178**	**106,772**	**594**

Key issues

Nene Contract
£67k Over performance

Non-elective activity significantly above plan. Contractual Penalties, Readmissions and MRET fines are above planned levels by £737k mitigating the contractual over-performance.

CQUIN, critical care, elective and day case income continue behind plan.

Corby CCG
£25k adverse to plan

Non-elective income behind plan due to a lower than anticipated case-mix in clinical oncology, general surgery and vascular surgery and is being offset by over performance on excess bed days.

Specialised Commissioner
£1,470k favourable to plan

Over performance against the radiotherapy by 23% in activity terms, 33% in financial terms owing to a richer than expected case-mix. Excluded medicines are also over performing as expected due to pass through costs of HEP C medicines.

5. Statement of Financial Position

	Balance at 31-Mar-16	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	160,399	160,399	160,399		160,399	
IN YEAR REVALUATIONS		(6,643)	(5,817)	826	(4,225)	(4,225)
IN YEAR MOVEMENTS		2,680	5,817	3,137	18,222	18,222
LESS DEPRECIATION		(3,310)	(3,942)	(632)	(9,929)	(9,929)
NET BOOK VALUE	160,399	153,126	156,457	3,331	164,467	4,068
CURRENT ASSETS						
INVENTORIES	5,744	6,352	5,947	(405)	5,494	(250)
RECEIVABLES						
NHS RECEIVABLES	9,742	13,693	11,439	(2,254)	10,016	274
OTHER TRADE RECEIVABLES	1,250	1,087	1,221	134	1,300	50
RECEIVABLES IMPAIRMENTS PROVISION	(205)	(205)	(205)		(200)	5
CAPITAL RECEIVABLES	21					(21)
NON NHS OTHER RECEIVABLES	118	587	533	(54)	118	
COMPENSATION RECEIVABLES (RTA)	2,582	2,605	2,591	(14)	2,657	75
SALARY OVERPAYMENTS	546	477	463	(14)	475	(71)
SALARY SACRIFICE SCHEMES	468	515	435	(80)	500	32
OTHER RECEIVABLES	525	439	674	235	575	50
IRRECOVERABLE PROVISION	(629)	(629)	(601)	28	(579)	50
PREPAYMENTS	1,923	3,729	3,672	(57)	2,173	250
SUB TOTAL	16,341	22,298	20,222	(2,076)	17,035	694
NON CURRENT ASSETS FOR SALE	375					(375)
CASH	1,602	3,409	7,263	3,854	1,500	(102)
CURRENT ASSETS	24,062	32,059	33,432	1,373	24,029	(33)
CURRENT LIABILITIES						
NHS PAYABLES	978	2,540	3,199	659	1,478	500
TRADE PAYABLES REVENUE	2,390	2,665	3,409	744	3,554	1,164
TRADE PAYABLES FIXED ASSETS	5,192	4,383	6,424	2,041	2,656	(2,536)
TAX AND NI OWED	3,552	3,871	3,677	(194)	3,802	250
NHS PENSIONS AGENCY	2,347	2,331	2,262	(69)	2,497	150
OTHER PAYABLES	823	475	497	22	1,223	400
FINANCE LEASE PAYABLE under 1 year	121	121	121		124	3
SHORT TERM LOANS - DH (CAPITAL)	628	628	628		1,700	1,072
SHORT TERM LOANS - DH (REVENUE)		7,436	9,982	2,546		
SHORT TERM LOANS - NON DH	155	144	144		82	(73)
ACCRUALS	7,191	9,829	9,128	(701)	7,941	750
RECEIPTS IN ADVANCE	1,775	1,710	1,735	25	1,975	200
PDC DIVIDEND DUE	99	1,477	1,608	131		(99)
STAFF BENEFITS ACCRUAL	710	767	767		750	40
PROVISIONS	2,802	2,289	2,289		2,503	(299)
CURRENT LIABILITIES	28,763	40,666	45,870	5,204	30,285	1,522
NET CURRENT ASSETS / (LIABILITIES)	(4,701)	(8,607)	(12,438)	(3,831)	(6,256)	(1,555)
TOTAL ASSETS LESS CURRENT LIABILITIES	155,698	144,519	144,019	(500)	158,211	2,513
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,245	1,206	1,196	(10)	1,039	(206)
LOANS over 1 year DH (CAPITAL)	7,186	7,186	7,186		13,738	6,552
LOANS over 1 year DH (REVENUE)	18,851	18,851	18,851		33,980	15,129
LOANS over 1 year NON DH	166	166	166		84	(82)
PROVISIONS over 1 year	979	979	979		226	(753)
NON CURRENT LIABILITIES	28,427	28,388	28,378	(10)	49,067	20,640
TOTAL ASSETS EMPLOYED	127,271	116,131	115,641	(490)	109,144	(18,127)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258		119,258	
PDC TEMPORARY BORROWING						
REVALUATION RESERVE	41,435	36,860	37,425	565	38,437	(2,998)
I & E ACCOUNT BALANCE	(33,422)	(33,422)	(33,422)		(33,422)	
I & E CURRENT YEAR		(6,565)	(7,620)	(1,055)	(15,129)	(15,129)
FINANCING TOTAL	127,271	116,131	115,641	(490)	109,144	(18,127)

Key Movements

Non Current Assets

•Depreciation movement of £0.6m offset by capital expenditure additions of £3.1m & revaluations of £0.8m.

Current assets

•Reduction in Inventories of £405k (Pharmacy £146k, Pacing £285k, other £26k increase).

•Reduction in NHS receivables of £2.3m. Reduction in STF funding (£1,616k), Central Midlands SLA (£622k), Nene CCG 15/16 performance (£500k), Northants Healthcare (£271k). Increase in WIP (£371k).

•Increase in other Trade receivables of £0.1m.

•Decrease in Salary Sacrifice schemes of £0.1m.

•Increase in other receivables of £0.2m.

•Decrease in prepayments of £0.1m.

•Increase in cash of £3.9m. (£2.4m relating to STF funding)

Current Liabilities

•Increase in NHS payables of £0.7m.

•Increase in Trade Creditors of £0.7m.

•Increase in Trade Payables Fixed Assets £2.0m.

•Decrease in Tax and NI Owed of £0.2m.

•Increase in Short Term Revenue Loan of £2.5m.

•Decrease in accruals of £0.7m.

•Increase in PDC Dividends due of £0.1m.

Non Current Liabilities

•Negligible movement in non current liabilities.

Financing

•Increased deficit in month of £1.0m.

•Increase in Revaluation Reserve £0.6m.

6. Capital Expenditure

Capital Scheme	Plan 2016/17 £000's	M5 Plan £000's	M5 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Replacement Imaging Equipment (Loan - Tranche 1)	1,122	0	-8	-8	-1%	-6	-1%
Replacement Imaging Equipment (Loan - Tranche 2)	4,396	2,067	2,067	0	47%	2,067	47%
Additional Imaging Equipment (Loan)	2,200	683	683	0	31%	699	32%
Replacement NPfIT Systems	2,288	1,328	691	-637	31%	1,854	83%
Stock / Inventory System (Loan)	582	28	29	1	5%	0	0%
A&E / Orthopaedics	500	350	348	-2	70%	618	124%
Contingency	-681	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	938	177	92	-85	10%	116	12%
Estates Sub Committee	3,319	972	1,143	171	34%	2,194	66%
IT Sub Committee	3,101	1,042	771	-271	25%	1,774	57%
60 Bedded Ward	0	0	0	0	0%	0	0%
Other	458	0	0	0	0%	271	53%
Total - Capital Plan	**18,223**	**6,647**	**5,817**	**-830**	**32%**	**9,588**	**53%**
Less Charitable Fund Donations	-450	-25	-25	0	6%	-66	15%
Less NBV of Disposals	-375	-375	-375	0	100%	-375	25%
Total - CRL	**17,398**	**6,247**	**5,417**	**-830**	**31%**	**9,147**	**53%**

Funding Resources	£'000s
Internally Generated Depreciation	9,929
Finance Lease - 60 Bedded Ward	0
Capital Loans - Imaging Equipment (Approved)	1,122
Capital Loans - Replacement Imaging Equipment	4,396
Capital Loans - Additional Imaging Equipment	2,200
Capital Loans - Stock / Inventory System	600
Capital Loan - Repayment	-694
Other Loans - Repayment	-155
Total - Available CRL Resource	**17,398**
Uncommitted Plan	**0**

Key Issues

- The second linear accelerator has now been delivered and is operational.
- The third linear accelerator has been delivered and planned to be operational in December.
- As a result of the reduced level of capital loans availability nationally and funding the PAS business case internally the Trust is now planning to lease £1m of medical equipment replacements annually within the MESC plan from 2016/17.
- The A&E continues with completion of the fit stop area in August and waiting area / ambulance area in September.
- The initial full year depreciation forecast is currently £9,929k (M4 £9,929k).
- No finance lease costs will be committed in the current financial year in relation to the 60 bedded Ward facility although pre-lease costs are likely to be incurred by the preferred bidder. The project team are currently developing the OBC / FBC for approval by Trust Board and submission to NHSI. The main costs of the scheme are expected to slip into 2017/18.
- The sale of the Harborough Lodge property was completed in April 16.
- A plan has been agreed with Radiology to replace CT and MRI scanners, three x-ray rooms and undertake installation of additional CT scanner in an existing room and a MRI scanner in a new build. Further work is ongoing to determine timescales and expected completion dates to inform the draw down of the agreed capital loan funding . A CT scanner has been delivered in August and planned to be operational in September.
- The Inventory Management Project team have undertaken site visits and have chosen a preferred supplier, Genesis, and a further site visit is now being arranged.

7. Receivables, Payables and BPPC Compliance

	Total at August £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,221	390	131	133	567
Receivables NHS	10,003	8,927	284	85	706
Total Receivables	**11,224**	**9,317**	**415**	**218**	**1,273**
Payables Non NHS	(9,834)	(9,724)	(110)		
Payables NHS	(3,196)	(3,196)			
Total Payables	**(13,030)**	**(12,920)**	**(110)**		

Narrative	Total at July £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,087	191	248	164	484
Receivables NHS	12,258	10,762	152	601	743
Total Receivables	**13,344**	**10,953**	**399**	**765**	**1,227**
Payables Non NHS	(7,049)	(7,023)	(25)		
Payables NHS	(2,540)	(2,540)	(1)		
Total Payables	**(9,589)**	**(9,563)**	**(26)**		

Receivables and Payables

- Commissioner monthly invoices were paid on time, with the exception of West Leicester CCG & Leicester City CCG. Leicester City CCG is still in a credit balance position due to under performance relating to 2015/16.
- Continued focus on reducing age profile of non current debt.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £298k, of which £50k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover. Other significant balances include BMI Three Shires £185k and Alliance Medical £39k .
- NHS over 90 day debt predominantly relates to NCA's £309k (£249k), Central Midlands £405k and Kettering General £237k.
- With the exception of £110k, of which £109k relates to NHS Supply Chain for Capital Expenditure, all registered creditors are current (due within 30 days).

Narrative	April 2016	May 2016	June 2016	July 2016	Aug 2016	Cumulative 2016/17
NHS Creditors						
No.of Bills Paid Within Target	170	150	196	138	243	897
No.of Bills Paid Within Period	179	151	197	138	247	912
Percentage Paid Within Target	**94.97%**	**99.34%**	**99.49%**	**100.00%**	**98.38%**	**98.36%**
Value of Bills Paid Within Target (£000's)	1,405	2,065	1,761	1,759	2,030	9,020
Value of Bills Paid Within Period (£000's)	1,451	2,063	1,762	1,759	2,034	9,070
Percentage Paid Within Target	**96.79%**	**100.06%**	**99.98%**	**100.00%**	**99.79%**	**99.45%**
Non NHS Creditors						
No.of Bills Paid Within Target	6,235	7,879	8,782	7,361	7,873	38,130
No.of Bills Paid Within Period	6,318	7,984	8,883	7,409	7,926	38,520
Percentage Paid Within Target	**98.69%**	**98.68%**	**98.86%**	**99.35%**	**99.33%**	**98.99%**
Value of Bills Paid Within Target (£000's)	8,167	7,990	9,350	7,585	8,452	41,544
Value of Bills Paid Within Period (£000's)	8,211	8,202	9,405	7,612	8,484	41,914
Percentage Paid Within Target	**99.47%**	**97.41%**	**99.42%**	**99.65%**	**99.61%**	**99.12%**
Total						
No.of Bills Paid Within Target	6,405	8,029	8,978	7,499	8,116	39,027
No.of Bills Paid Within Period	6,497	8,135	9,080	7,547	8,173	39,432
Percentage Paid Within Target	**98.58%**	**98.70%**	**98.88%**	**99.36%**	**99.30%**	**98.97%**
Value of Bills Paid Within Target (£000's)	9,571	10,055	11,112	9,345	10,481	50,564
Value of Bills Paid Within Period (£000's)	9,662	10,266	11,167	9,371	10,518	50,984
Percentage Paid Within Target	**99.07%**	**97.94%**	**99.51%**	**99.72%**	**99.65%**	**99.18%**

Better Payment Practice Code

- The BPPC performance has been achieved for all targets in August and for cumulative position for year to date. £37k (57 invoices) were paid late including Estates £10k (4 invoices), Pathology £8k (5 invoices) and non-nurse bank £7k (16 invoices).

8. Cashflow

MONTHLY CASHFLOW	Annual	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
		ACTUAL					FORECAST						
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	246,973	19,343	21,547	20,808	19,889	21,204	20,632	20,592	20,592	20,592	20,592	20,592	20,592
STF Funding	9,700					2,425		2,425			2,425		2,425
SLA Performance/ Other CCG Investment													
Health Education Payments (SIFT etc)	9,863	798	785	858	821	828	845	821	821	821	821	821	821
Other NHS Income	15,575	1,419	652	2,850	914	1,679	1,226	1,477	1,072	1,072	1,072	1,072	1,072
PP / Other (Specific > £250k)	2,658	473		764	567	273	580						
PP / Other	12,048	1,046	691	711	817	783	800	1,200	1,200	1,200	1,200	1,200	1,200
Capital Loan	8,318							2,771	490		300	1,043	3,714
Revenue Support Loan	15,129												15,129
Revolving Working Capital Facility - deficit funding	0	2,038	1,554	2,120	1,724	-1,496	1,259	510	964	1,867	743	2,188	-13,469
Revolving Working Capital Facility - STF funding	9,700					4,042	808	808	808	808	808	808	808
Interest Receivable	38	3	4	5	2	3	3	3	3	3	3	3	3
Sale of Assets	585	585											
TOTAL RECEIPTS	**330,588**	**25,706**	**25,232**	**28,117**	**24,734**	**29,741**	**26,153**	**30,607**	**25,950**	**26,363**	**27,964**	**27,727**	**32,295**
PAYMENTS													
Salaries and wages	182,913	15,154	15,035	15,518	15,288	15,180	15,238	15,200	15,200	15,350	15,200	15,200	15,350
Trade Creditors	92,671	6,686	7,882	8,802	7,280	7,288	7,968	5,528	7,555	7,898	7,030	9,296	9,457
NHS Creditors	20,475	1,565	2,063	1,762	1,763	2,030	1,822	1,822	1,822	1,822	1,822	1,000	1,180
Capital Expenditure	19,811	1,864	300	620	404	1,215	2,034	5,611	1,373	1,293	1,487	2,042	1,568
PDC Dividend	3,472						1,856						1,616
Repayment of RWC Facility - STF funding	9,700						2,425	2,425			2,425		2,425
Repayment of Loans (Principal & Interest)	1,464					154	460					189	661
Repayment of Salix loan	155	12					85	21					38
TOTAL PAYMENTS	**330,661**	**25,280**	**25,281**	**26,702**	**24,735**	**25,867**	**31,889**	**30,607**	**25,950**	**26,363**	**27,964**	**27,727**	**32,295**
Actual month balance	-72	425	-49	1,415	-1	3,874	-5,736	0	0	0	0	0	0
Cash in transit & Cash in hand adjustment	-30	-24	14	15	12	-20	-27			1		-1	
Balance brought forward	1,602	1,602	2,003	1,968	3,398	3,409	7,263	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**2,003**	**1,968**	**3,398**	**3,409**	**7,263**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- Central Midlands Region SLA payments for July & August were both paid in August.
- STF funding for Quarter 1 was received from the Department of Health, on behalf of NHS England. Funding for Quarter 2 is anticipated to be received in October. This is reliant on the cumulative control total & access targets being achieved. Following the receipt of the Quarter 1 STF Funding, the respective borrowing will be repaid in September.
- Outstanding 2015/16 Final Over/Under-performance invoices/credit notes, issued in July, are anticipated to be settled & September and October.
- The Trust has drawn down a further £2.5m of Temporary Borrowing (3.5% Interim Revolving Working Capital Support Facility) in August. Further Temporary Borrowing (IRWCSF) of £2.1m has been approved for drawn down in Sept.
- Capital Expenditure increased in August. Capital Loan drawdowns are forecast for October & November in line with anticipated scheme expenditure.
- Interest payments for Revenue Support (£143k) & Replacement Imaging Equipment + Inventory System Capital Loan (£11k) were made in August. Repayment of Principal (£314k) & Interest (£46k) relating to the initial Capital Loan for Replacement Imaging Equipment will be made in September, along with the first interest payment for 16/17 Temporary Borrowing (£100k).

9. Risks to the Financial Position

Risk	Financial Drivers	Estimated Value FY16-17 £k	Mitigations	Impact on plan £K
Revenue Risks				
NHSI - Improved Control Total	NHSI has requested the Trust delivers an improved control total of £15.1m deficit (compared to the original planned £27.4m deficit).	2,600	Suspension of access fines. Reduction of to planned level of revenue reserves. Delivery of revised control total gives access to £9.7m of sustainability funding (avoids interest bearing loans).	Currently £0.2m fav. to revised plan.
Conditions to STF funding	The Trust is required to deliver both financial and performance trajectories to access the £9.7m STF funding. (Conditions assessed on a forecast basis). Weighting 70% Financial:30% Performance.	9,700	Routine forecasting and controls to be put in place to measure delivery against revised financial and performance trajectories.	£6.8m Financial £2.9m Performance
Non-elective Demand	Requirement to source additional contractual beds / open additional bed capacity on site due to high levels of urgent care demand and DTOCs. Limited additional capacity available in LHE.	1,200	£0.7m included in plan for additional contractual beds. Contract signed with AGE for additional 12 beds wef 1/7. Business case approved by Board in July for additional 38 beds on basis of additional NEL XBD income.	Up to £0.5m dependent on incremental income.
Cancellation of Elective activity	RTT pressures leading to lost elective income and requirement to outsource to Private sector. Income loss averaging £0.5m per month in Q4 FY15-16. Winter plan may require closure of T&O beds in Q4.	6,000	£3m included in plan to cover costs of outsourcing primarily for T&O, Ophthalmology and Endoscopy.	Up to further £3m based on Q4 FY15-16 run rate
New CQUINS	New national CQUINS may not be deliverable giving rise to loss of income. **100% CQUIN** delivery assumed in plan.	780	Impact assessment ongoing. Local variations submitted to NHSE refuted. Q1 delivery agreed with Commissioners.	390
Contractual Fines & Penalties	The Trust incurred fines (£1m) plus MRET (£3.8m) and Readmissions (£2.8m) penalties in FY15-16. Indications are that a similar level of penalties could be incurred in FY16-17.	7,600	The Trust has signed a contract in place with NENE CCG for FY16-17 which includes clauses for Fines and Penalties to be reinvested by the CCG through the agreement of Service Development Improvement Plans (SDIP). £1m provision in income plan for fines and penalties should be lifted under STF double jeopardy rule.	Dependent on SDIP process and delivery of STF conditions
Junior doctors new contract	Cost of new compliant rotas, pay protection, e-rostering and appointment of Guardian.	200-400	£800k pay reserve in plan but subject to ongoing national negotiations, review of new rotas and pay protection. Introduction of new contract will be staggered over 2 years.	Unknown but likely to be minimal in 16-17 due to phased implementation.
Vacancy Control	FY16-17 Plan includes requirement for Divisions to manage a (Trust wide) £2m vacancy factor based on known vacancies in March 16.	2,000	Level of current substantive vacancies sufficient to meet vacancy factor but temporary staff costs pushing pay bill significantly over budget at M5.	-
Pay Expenditure	Trust has incurred a £3.4m overspend at M5 and is currently exceeding the revised Agency Cap target. Indications that August rotation has resulted in additional shortfall in Junior Doctors rotas notably in Anaesthetics. Trust is identified as an outlier in terms of increased Pay expenditure by NHSI.	8,400	CIP workstream focused on reducing Medical Staff Agency usage and costs. Specific action being taken by Dons to reduce use of HCA Agency. Non-Pay underspend of £0.8m offsetting impact. Consultants covering out of hours in Anaesthetics.	5,000
CIP delivery	Delivery of CIP target will be challenging in year. £2.6m of CIPs rated as high risk. High level of non-recurrent CIP recorded. Latest risk adjusted forecast gives rise to £2.3m shortfall to plan.	2,254	Ongoing identification of new schemes and mitigating actions. Introduction of strict expenditure controls and delay planned developments.	2,254
NCC Proposed cuts	NCC have proposed a range of cuts to Adult Social Care Services which will adversely impact on the timely discharge of patients if fully implemented.	1,000	Limited mitigation pending consultation on proposed implementation plans. Likely to see increase in DTOCs giving rise to further beds pressures and Elective income loss. £103 per day fines being charged to NCC under provisions of CCA 2003 (wef 1/8).	500
Potential for abortive Fees (60 Bedded Case)	Trust has appointed Procure 21 partner to progress plans for new 60 bedded facility ahead of NHSI approval. The supplier will incur planning and feasibility costs which will need to be financed by the Trust if the FBC is not approved by NHSI.	440	Instruction issued to Procure 21 partner to limit fees to £440k pre FBC approval.	440
Non-Revenue Risks				
Capital Resources	Capital resources constrained due to reduced levels of deprecation and national loan restrictions.	2,000	Capital plan reduced and provision for up to £1m of operating leases in I&E plan. Option to finance 60 bedded ward facility included in plan as finance lease.	60 beds subject to FBC approval and CRL cover
Cashflow	Revised deficit of £15.18m requires access to IRWCSF and assumes £9.7m of STF Funding.	£24.8m gross defcit	Management of creditors. Improving I&E position ahead of plan. Delay capital expenditure. Advance payment of CCG mandate each month agreed with NENE CCG. DH approval to access to IRWCSF to cover planned deficit only. Receipt of £9.7m STF funding (subject to conditions). IRWCSF of £5.9m plus STF of £4.4m received up to August (STF pending Q2 delivery).	Provision for interest payments included in plan.

10. Conclusions and Recommendations

Conclusion:

- The Trust has performed favourably to both the financial plan and forecast for August. This result puts the Trust in a strong position to maintain delivery of the STF financial criteria for Q2.
- STF funding of £4m has been assumed in the YTD position despite some pressures on A&E and Cancer trajectories in September which have been assumed to recover and deliver by the end of Q2.
- The high level forecast exercise undertaken in July has been updated and is provided under separate cover. Despite the improvement in August, there remains a clear requirement to continue to develop an action plan to address current areas of risk and overspend in order that the Trust can continue to assume access the £9.7m STF funding and deliver the £15.1m deficit control total by the financial year end.
- Pay expenditure continues to exceed plan by £3.4m (4%) for the year to date with the earlier level of non-pay underspend reducing giving rise to an increased adverse variance overall for operating expenses.
- Agency costs remain £1.4m in excess of the required Agency cap trajectory. Actions to manage HCA nurse agency appear to have been successful in reducing the month on month cost of Nurse Agency despite the holiday period. This has been offset by pressures in Medical staffing where agency locum costs have increased by £80k month on month.
- CIP delivery is recorded as exceeding plan again in M5 although the position to date continues to be reliant on a significant element of non-recurrent delivery and with forward risk in terms of schemes yet to be delivered.
- The suspension of significant elements of access fines and penalties has helped deliver an improved income position and the overall position for SLA income is marginally favourable to plan when considering the latest estimates for MRET , Readmissions penalties and the risk of delivering all CQUIN schemes.
- NENE CCG have approved payment of £428k of income previously withheld in relation to the data challenge reported last month.
- There are a range of increasing risks to the financial position chief amongst which are the proposed cuts announced by NCC in August and elective income pressures.
- The Trust has implemented daily fines to NCC for Adult Social Care delayed transfers from 1st August.
- NENE CCG have signalled potential financial pressures which have emerged in August which may give rise to contractual risk later in the financial year.

Recommendations & actions

- Focus is maintained on managing the risks to the financial position and reducing the current level of Pay overspend through a formal action plan agreed by the Executive team.
- Divisions that are not meeting their financial targets continue to be subject to the approved performance management framework and develop action plans to improve financial performance for the remainder of the financial year.
- An assessment of the financial impact of the emerging Winter plan is prepared and agreed particularly in relation to the impact on the elective bed base and outsourcing of elective work to the private sector.
- NHSI have issued a “single oversight framework” in September and the Trust will need to establish how it likely to rate against this.

Report To	Trust Board
Date of Meeting	29 September 2016

Title of the Report	Workforce Performance Report
Agenda item	12
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services Sam Wright, Workforce Systems Manager
Purpose	This report provides an overview of key workforce issues
Executive summary • The key performance indicators show a decrease in contracted workforce employed by the Trust, and a decrease in sickness absence from July 2016. • Decrease in compliance rate for Mandatory Training and Role Specific Essential Training and an increase in compliance for Appraisals..	
Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 4.1, 4.2 and 4.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity

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	for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	No

Actions required by the Committee

The Committee is asked to Note the report.

Trust Board

29 September 2016

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from August 2016 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity decreased by 22.57 FTE in August 2016 to 4259.56 FTE. The Trust's substantive workforce is at 89.39% of the Budgeted Workforce Establishment of 4765.23 FTE. The decrease in capacity is attributed to a significant number of support workers from within Additional Clinical Services leaving the Trust. These leavers have not had an adverse effect on the Trusts turnover rate due to many of them remaining on the Bank.

Annual Trust turnover decreased for the sixth consecutive month by a further 0.23 to 9.60% in August which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 1.03% to 8.27%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in Allied Health Professionals, Healthcare Scientists and Medical & Dental. Additional Clinical Services, Estates and Ancillary and Admin and Clerical turnover increased.

Medical Division: turnover decreased by 1.12% to 9.58%

Surgical Division: turnover increased by 0.54% to 7.96%

Women, Children & Oncology Division: turnover decreased by 0.63% to 9.71%

Clinical Support Services Division: turnover increased by 0.48% to 8.37%

Support Services: turnover decreased by 0.25% to 12.71%

The vacancy rates for Additional Professional Scientific & Technical, Allied Health Professionals and Healthcare Scientists staff groups all decreased in August. 2016. Additional Clinical Services, Estates & Ancillary, Admin & Clerical and Medical & Dental staff groups had an increase in vacancy rate. The Registered Nursing & Midwifery vacancy rate also increased from 12.23% to 12.31%.

In month sickness absence decreased by 0.11% to 3.90% which is above the Trust target of 3.8%. Surgery Division was the only one below the trust target. In total 11 directorate level organisations were below the trust target rate.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for August 2016 is 81.46%; this is an increase of 1.11% from last month's figure of 80.35%.

Mandatory Training compliance decreased in August from 86.66% to 85.83% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance decreased in August to 76.44% from last month's figure of 77.06%.

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

Policies
During August 2016, minor changes have been made to the following Trust Policy:

Maternity, Adoption, Paternity & Shared Parental Leave Policy – minor amendments in relation to childcare vouchers

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

Recommendations/Resolutions Required
The Committee is asked to note the report.

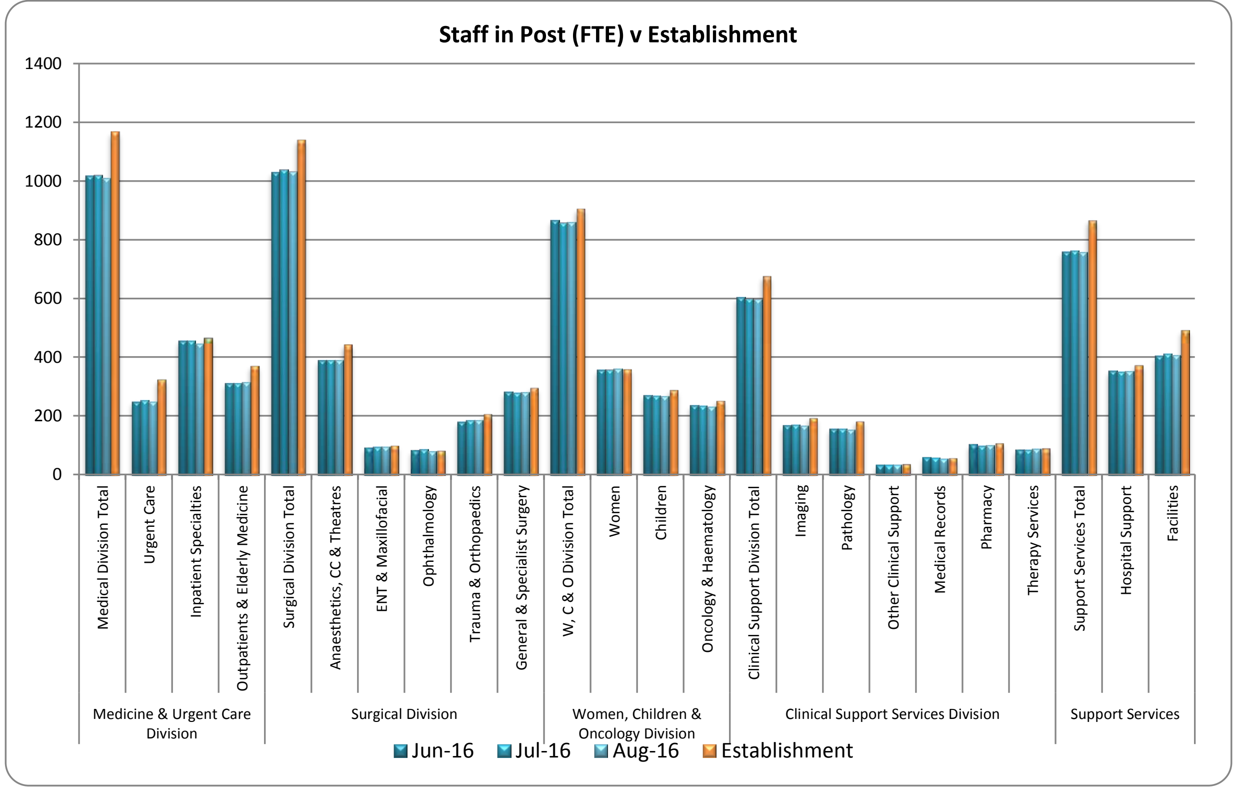
Next Steps
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Jun-16		Jul-16		Aug-16	Establishment	
Medicine & Urgent Care Division	**Medical Division Total**	1019.07	↑	1021.72	↓	1010.53	1168.70	86.47%
	Urgent Care	249.56	↑	253.59	↓	249.57	325.69	76.63%
	Inpatient Specialties	456.66	↓	455.96	↓	445.06	467.19	95.26%
	Outpatients & Elderly Medicine	311.85	↓	311.17	↑	314.90	372.82	84.46%
Surgical Division	**Surgical Division Total**	1031.27	↑	1039.17	↓	1033.22	1142.05	90.47%
	Anaesthetics, CC & Theatres	390.28	↓	389.66	↑	389.67	444.41	87.68%
	ENT & Maxillofacial	91.25	↑	94.08	↑	95.00	101.59	93.51%
	Ophthalmology	82.45	↑	87.03	↓	79.27	83.69	94.72%
	Trauma & Orthopaedics	180.43	↑	185.30	↓	184.53	209.01	88.29%
	General & Specialist Surgery	282.05	↓	278.31	↑	279.95	297.55	94.09%
Women, Children & Oncology Division	**W, C & O Division Total**	866.64	↓	859.42	↑	859.66	907.37	94.74%
	Women	357.92	↓	356.93	↑	360.38	360.93	99.85%
	Children	270.89	↓	267.60	↓	267.20	289.80	92.20%
	Oncology & Haematology	236.97	↓	234.04	↓	231.22	253.79	91.11%
Clinical Support Services Division	**Clinical Support Division Total**	604.03	↓	599.45	↓	597.67	677.44	88.22%
	Imaging	167.75	↑	169.95	↓	167.40	195.77	85.51%
	Pathology	156.25	↑	156.25	↓	153.25	184.35	83.13%
	Other Clinical Support	33.20	↑	33.60	↑	34.06	37.93	89.80%
	Medical Records	59.37	↓	57.31	↓	54.76	59.33	92.30%
	Pharmacy	102.73	↓	97.73	↑	100.91	108.72	92.82%
	Therapy Services	84.73	↓	84.62	↑	87.28	91.34	95.56%
Support Services	**Support Services Total**	759.72	↑	762.36	↓	758.48	868.12	87.37%
	Hospital Support	353.94	↓	351.26	↑	351.58	374.41	93.90%
	Facilities	405.78	↑	411.10	↓	406.90	493.71	82.42%
Trust Total		4280.72	↑	4282.13	↓	4259.56	4765.23	89.39%



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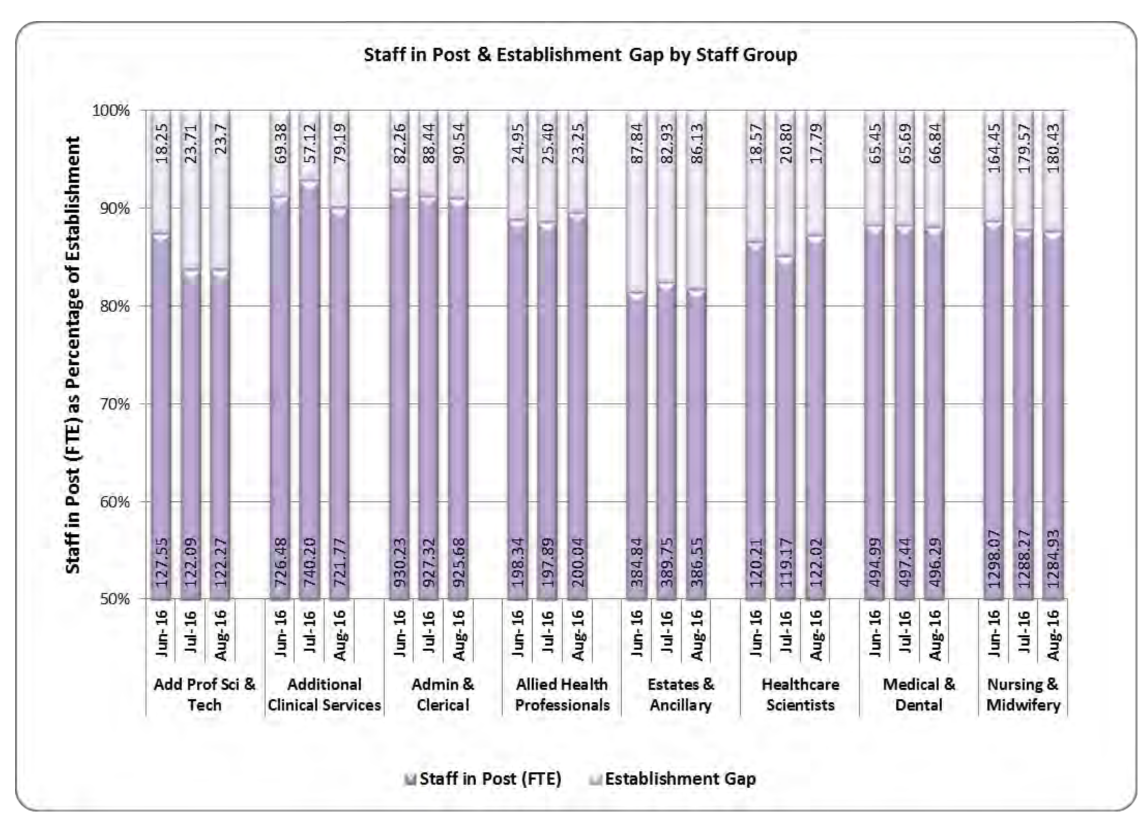
Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPACITY
Staff Group (FTE v Est)

Vacancy RAG Rates:	> 12%	7 - 12%	< 7%

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Jun-16	Jul-16	Aug-16
Add Prof Sci & Tech	12.51%	16.26%	16.23%
Additional Clinical Services	8.72%	7.16%	9.89%
Admin & Clerical	8.12%	8.71%	8.91%
Allied Health Professionals	11.17%	11.37%	10.41%
Estates & Ancillary	18.58%	17.55%	18.22%
Healthcare Scientists	13.38%	14.86%	12.72%
Medical & Dental	11.68%	11.67%	11.87%
Nursing & Midwifery	11.24%	12.23%	12.31%



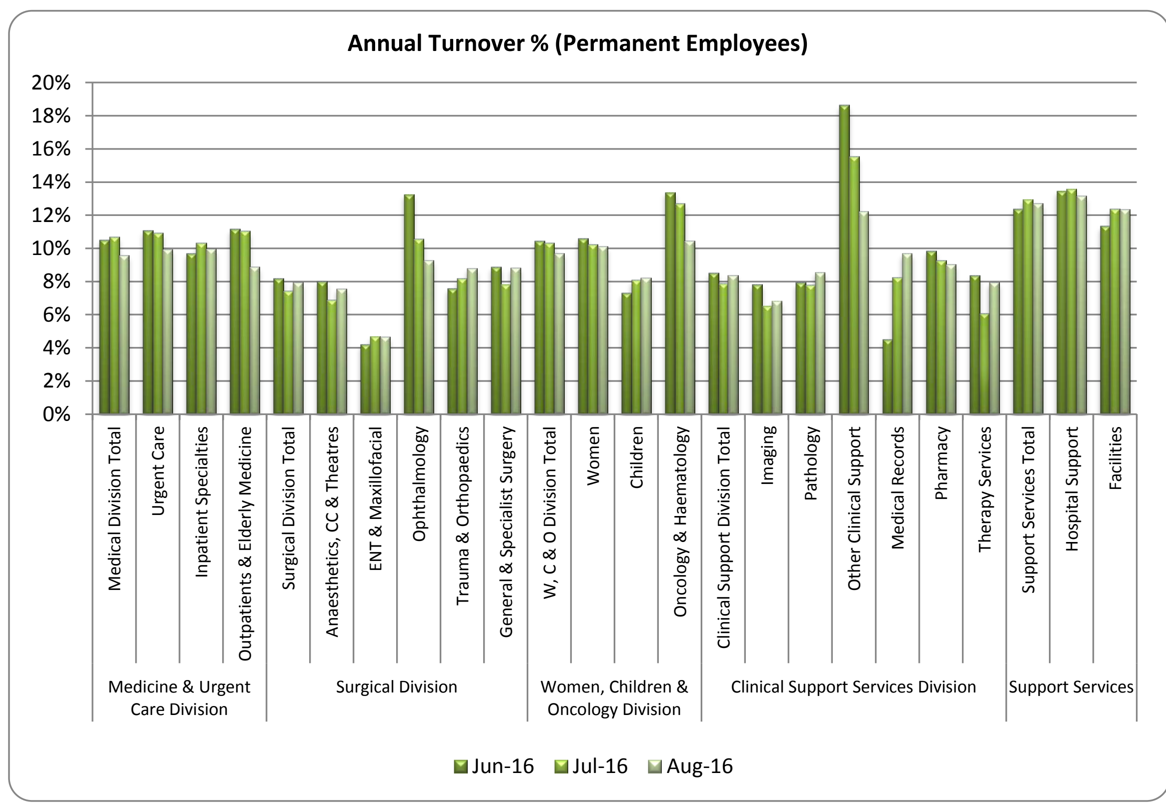
Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

Annual Turnover (Permanent Staff)		Jun-16		Jul-16		Aug-16
Medicine & Urgent Care Division	Medical Division Total	10.51%	↗	10.70%	↘	9.58%
	Urgent Care	11.09%	↘	10.94%	↘	9.93%
	Inpatient Specialties	9.71%	↗	10.34%	↘	9.96%
	Outpatients & Elderly Medicine	11.16%	↘	11.04%	↘	8.88%
Surgical Division	Surgical Division Total	8.19%	↘	7.42%	↗	7.96%
	Anaesthetics, CC & Theatres	8.01%	↘	6.89%	↗	7.55%
	ENT & Maxillofacial	4.22%	↗	4.68%	↘	4.65%
	Ophthalmology	13.25%	↘	10.57%	↘	9.28%
	Trauma & Orthopaedics	7.57%	↗	8.18%	↗	8.79%
	General & Specialist Surgery	8.88%	↘	7.83%	↗	8.82%
Women, Children & Oncology Division	W, C & O Division Total	10.44%	↘	10.34%	↘	9.71%
	Women	10.61%	↘	10.22%	↘	10.10%
	Children	7.30%	↗	8.08%	↗	8.20%
	Oncology & Haematology	13.38%	↘	12.70%	↘	10.45%
Clinical Support Services Division	Clinical Support Division Total	8.51%	↘	7.89%	↗	8.37%
	Imaging	7.82%	↘	6.52%	↗	6.82%
	Pathology	7.93%	↘	7.78%	↗	8.56%
	Other Clinical Support	18.64%		15.53%	↘	12.22%
	Medical Records	4.51%	↗	8.25%	↗	9.69%
	Pharmacy	9.84%	↘	9.28%	↘	9.03%
	Therapy Services	8.35%	↘	6.06%	↗	7.96%
Support Services	Support Services Total	12.37%	↗	12.96%	↘	12.71%
	Hospital Support	13.47%	↗	13.59%	↘	13.14%
	Facilities	11.34%	↗	12.38%	↘	12.34%
Trust Total		9.97%	↘	9.83%	↘	9.60%



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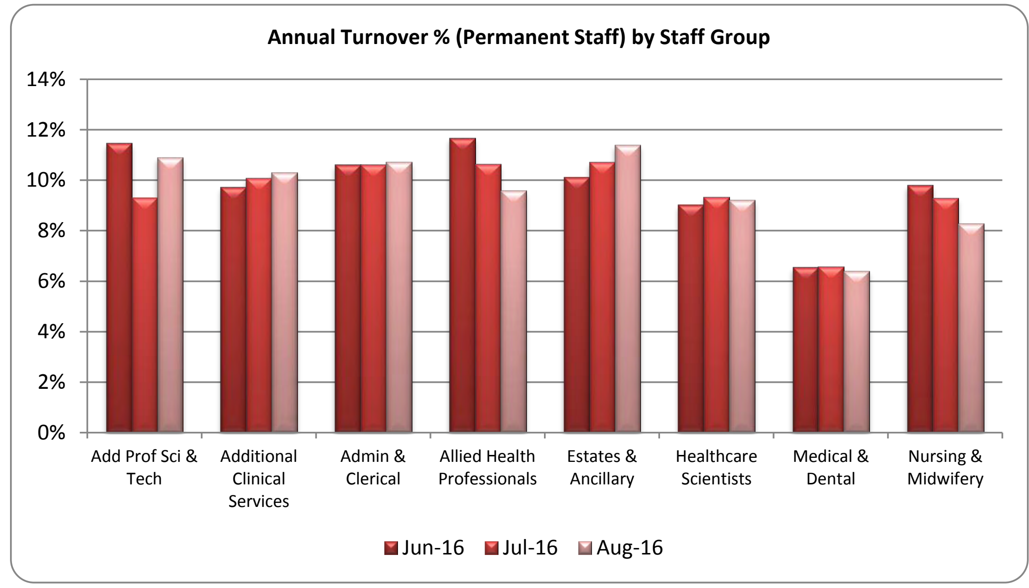
Workforce Committee: Capacity, Capability and Culture Report - August 2016

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

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

Staff Group	Jun-16		Jul-16		Aug-16
Add Prof Sci & Tech	11.47%	↘	9.32%	↗	10.90%
Additional Clinical Services	9.73%	↗	10.09%	↗	10.30%
Admin & Clerical	10.63%	↘	10.63%	↗	10.72%
Allied Health Professionals	11.67%	↘	10.64%	↘	9.58%
Estates & Ancillary	10.13%	↗	10.71%	↗	11.40%
Healthcare Scientists	9.03%	↗	9.34%	↘	9.22%
Medical & Dental	6.55%	↗	6.57%	↘	6.41%
Nursing & Midwifery	9.80%	↘	9.30%	↘	8.27%



Capacity: Substantive Workforce Capacity decreased by 22.57 FTE in August 2016 to 4259.56 FTE. The Trust's substantive workforce is at 89.39% of the Budgeted Workforce Establishment of 4765.23 FTE.

Staff Turnover: Annual Trust turnover decreased by a further 0.23 to 9.60% in August which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 1.03% to 8.27%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in Allied Health Professionals, Healthcare Scientists and Medical & Dental . Additional Clinical Services, Estates and Ancillary and Admin and Clerical turnover increased.

Medical Division: turnover decreased by 1.12% to 9.58%
Surgical Division: turnover increased by 0.54% to 7.96%
Women, Children & Oncology Division: turnover decreased by 0.63% to 9.71%
Clinical Support Services Division: turnover increased by 0.48% to 8.37%
Support Services: turnover decreased by 0.25% to 12.71%

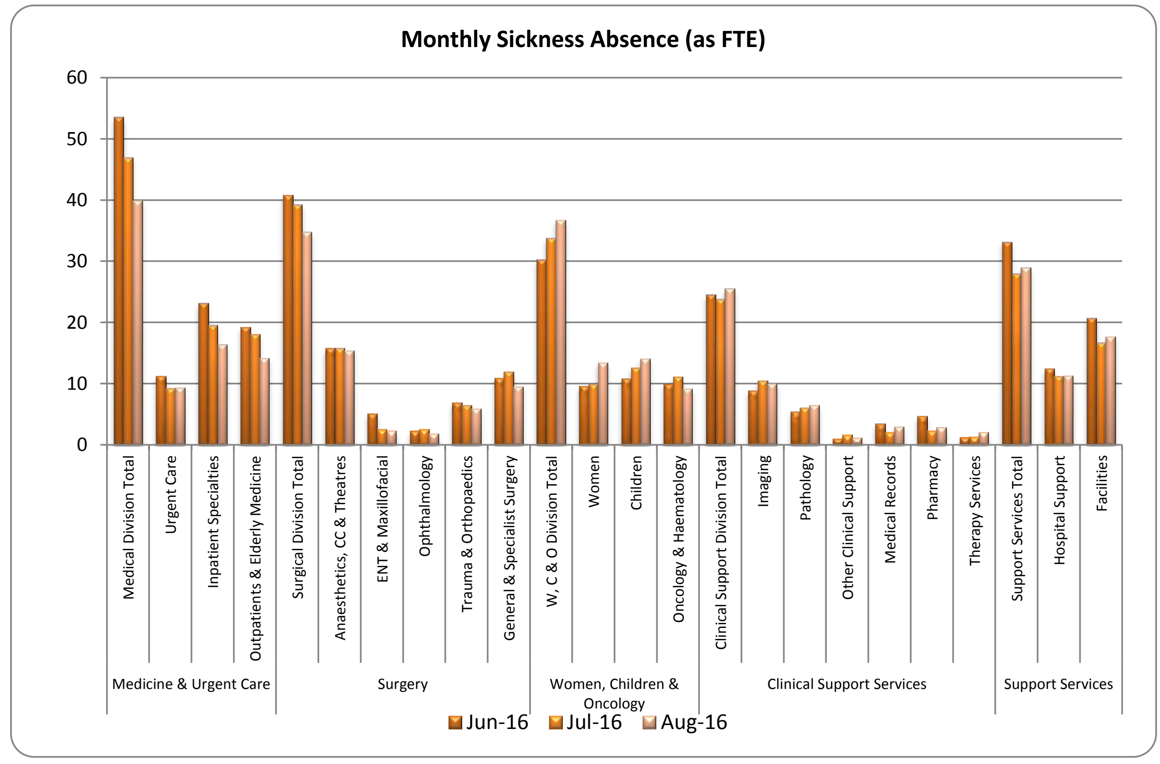
Staff Vacancies: The vacancy rates for Additional Professional Scientific & Technical, Allied Health Professionals and Healthcare Scientists staff groups all decreased in August. 2016. Additional Clinical Services, Estates & Ancillary, Admin & Clerical and Medical & Dental staff groups had an increase in vacancy rate. Registered Nursing & Midwifery vacancy rate also increased from 12.23% to 12.31%.

Sickness Absence: In month sickness absence decreased by 0.11% to 3.90% which is above the Trust target of 3.8%. Surgery Division was the only one below the trust target. In total 11 directorate level organisations were below the trust target rate.

Workforce Committee: Capacity, Capability and Culture Report - August 2016

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

Monthly Sickness (as FTE)		Jun-16	Jul-16	Aug-16	Aug-16	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	53.60	47.00	39.92	3.95%	2.43%	1.52%
	Urgent Care	11.26	9.26	9.28	3.72%	2.22%	1.50%
	Inpatient Specialties	23.11	19.61	16.38	3.68%	2.46%	1.23%
	Outpatients & Elderly Medicine	19.24	18.08	14.20	4.51%	2.55%	1.95%
Surgery	Surgical Division Total	40.84	39.28	34.82	3.37%	1.75%	1.62%
	Anaesthetics, CC & Theatres	15.77	15.78	15.39	3.95%	1.74%	2.22%
	ENT & Maxillofacial	5.09	2.54	2.29	2.41%	1.89%	0.52%
	Ophthalmology	2.26	2.53	1.84	2.32%	1.44%	0.88%
	Trauma & Orthopaedics	6.86	6.47	5.87	3.18%	1.53%	1.65%
	General & Specialist Surgery	10.89	11.94	9.55	3.41%	2.00%	1.41%
Women, Children & Oncology	W, C & O Division Total	30.25	33.78	36.71	4.27%	2.12%	2.15%
	Women	9.56	9.96	13.44	3.73%	2.05%	1.67%
	Children	10.78	12.63	14.11	5.28%	1.87%	3.41%
	Oncology & Haematology	9.91	11.16	9.16	3.96%	2.52%	1.45%
Clinical Support Services	Clinical Support Division Total	24.52	23.80	25.52	4.27%	2.10%	2.17%
	Imaging	8.82	10.49	9.99	5.97%	1.77%	4.20%
	Pathology	5.42	6.09	6.48	4.23%	2.08%	2.15%
	Other Clinical Support	1.00	1.62	1.14	3.35%	0.47%	2.89%
	Medical Records	3.40	2.07	2.97	5.42%	4.24%	1.19%
	Pharmacy	4.65	2.35	2.86	2.83%	1.84%	1.00%
	Therapy Services	1.22	1.27	2.07	2.37%	2.37%	0.00%
Support Services	Support Services Total	33.12	27.98	28.97	3.82%	1.92%	1.90%
	Hospital Support	12.42	11.24	11.29	3.21%	2.06%	1.15%
	Facilities	20.65	16.73	17.70	4.35%	1.80%	2.55%
Trust Total	*As FTE*	182.36	171.71	166.12			
	As percentage	4.26%	4.01%		3.90%	2.07%	1.83%



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Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPABILITY

Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Jun-16		Jul-16		Aug-16
Medicine & Urgent Care Division	Medical Division Total	82.04%	↓	81.99%	↓	80.12%
	Urgent Care	83.81%	↓	82.57%	↓	80.36%
	Inpatient Specialties	78.75%	↓	78.59%	↓	76.11%
	Outpatients & Elderly Medicine	85.28%	↑	86.33%	↓	85.36%
Surgical Division	Surgical Division Total	86.93%	↑	87.12%	↓	85.03%
	Anaesthetics, CC & Theatres	85.33%	↓	85.18%	↓	83.56%
	ENT & Maxillofacial	84.80%	↑	85.93%	↓	83.82%
	Ophthalmology	91.09%	↓	88.11%	↓	83.78%
	Trauma & Orthopaedics	86.63%	↑	88.08%	↓	84.80%
	General & Specialist Surgery	88.79%	↑	89.24%	↓	88.00%
Women, Children & Oncology Division	W, C & O Division Total	87.74%	↑	88.49%	↓	88.31%
	Women	85.41%	↑	86.18%	↓	85.58%
	Children	90.44%	↑	91.29%	↓	90.75%
	Oncology & Haematology	88.18%	↑	88.85%	↑	89.87%
Clinical Support Services Division	Clinical Support Division Total	89.34%	↑	90.13%	↓	90.07%
	Imaging	88.17%	↑	88.42%	↓	86.54%
	Pathology	87.27%	↑	88.76%	↑	89.48%
	Other Clinical Support	88.36%	↓	87.30%	↑	88.63%
	Medical Records	92.59%	↑	93.30%	↑	93.33%
	Pharmacy	93.35%	↑	94.79%	↑	95.22%
	Therapy Services	88.31%	↑	89.35%	↑	90.25%
Support Services	Support Services Total	86.57%	↑	87.24%	↑	88.01%
	Hospital Support	85.89%	↑	87.90%	↑	88.48%
	Facilities	87.10%	↓	86.74%	↑	87.66%
Trust Total		**86.25%**	↑	**86.66%**	↓	**85.83%**

Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Jun-16		Jul-16		Aug-16
Medicine & Urgent Care Division	Medical Division Total	73.27%	↑	73.36%	↓	72.62%
	Urgent Care	77.16%	↓	75.71%	↓	74.40%
	Inpatient Specialties	68.71%	↑	69.07%	↓	67.37%
	Outpatients & Elderly Medicine	76.22%	↑	77.41%	↑	78.35%
Surgical Division	Surgical Division Total	75.40%	↑	75.93%	↓	74.97%
	Anaesthetics, CC & Theatres	74.36%	↓	74.32%	↓	72.50%
	ENT & Maxillofacial	66.40%	↑	67.17%	↓	66.55%
	Ophthalmology	76.95%	↓	74.23%	↓	73.22%
	Trauma & Orthopaedics	79.51%	↑	80.96%	↓	78.71%
	General & Specialist Surgery	76.16%	↑	77.40%	↑	78.70%
Women, Children & Oncology Division	W, C & O Division Total	78.69%	↑	81.27%	↓	80.76%
	Women	73.58%	↑	76.47%	↓	76.13%
	Children	85.61%	↑	88.01%	↓	86.31%
	Oncology & Haematology	80.97%	↑	83.55%	↑	84.72%
Clinical Support Services Division	Clinical Support Division Total	83.54%	↓	83.35%	↓	83.19%
	Imaging	81.31%	↓	78.21%	↓	76.90%
	Pathology	77.88%	↓	77.64%	↑	80.62%
	Other Clinical Support	81.43%	↑	81.75%	↓	79.02%
	Medical Records	93.33%	↑	100.00%	↑	100.00%
	Pharmacy	87.71%	↑	89.71%	↑	90.75%
	Therapy Services	86.45%	↑	87.93%	↓	87.40%
Support Services	Support Services Total	70.49%	↑	71.94%	↓	71.83%
	Hospital Support	70.67%	↑	72.50%	↑	72.57%
	Facilities	70.27%	↑	71.28%	↓	70.95%
Trust Total		**76.14%**	↑	**77.06%**	↓	**76.44%**

Capability

Appraisals
The current rate of Appraisals recorded for August 2016 is 81.46%; this is an increase of 1.11% from last months figure of 80.35%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decreased in August from 86.66% to 85.83% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance decreased in August to 76.44% from last months's figure of 77.06%.

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

Workforce Committee: Capacity, Capability and Culture Report - August 2016

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Jun-16		Jul-16		Aug-16
Medicine & Urgent Care Division	Medical Division Total	76.16%	↓	73.87%	↑	75.41%
	Urgent Care	80.08%	↓	75.20%	↑	76.59%
	Inpatient Specialties	73.23%	↓	71.79%	↑	74.81%
	Outpatients & Elderly Medicine	76.92%	↓	75.62%	↓	75.46%
Surgical Division	Surgical Division Total	90.84%	↓	85.41%	↑	87.70%
	Anaesthetics, CC & Theatres	90.41%	↓	80.72%	↑	82.55%
	ENT & Maxillofacial	89.47%	↓	83.54%	↓	79.27%
	Ophthalmology	89.19%	↑	89.47%	↑	90.79%
	Trauma & Orthopaedics	90.06%	↓	85.14%	↑	90.70%
	General & Specialist Surgery	93.44%	↓	92.16%	↑	95.95%
Women, Children & Oncology Division	W, C & O Division Total	89.28%	↓	84.34%	↑	85.30%
	Women	88.00%	↓	84.46%	↓	82.75%
	Children	91.48%	↓	85.02%	↓	83.15%
	Oncology & Haematology	89.26%	↓	83.33%	↑	91.98%
Clinical Support Services Division	Clinical Support Division Total	82.83%	↓	80.12%	↑	81.82%
	Imaging	78.03%	↓	75.43%	↓	75.29%
	Pathology	85.89%	↓	82.93%	↓	81.48%
	Other Clinical Support	77.50%	↓	67.50%	↓	63.41%
	Medical Records	90.67%	↓	78.08%	↑	88.57%
	Pharmacy	88.03%	↑	90.09%	↑	90.35%
	Therapy Services	76.04%	↑	79.17%	↑	86.87%
Support Services	Support Services Total	78.52%	↓	78.13%	↓	77.25%
	Hospital Support	68.52%	↑	71.01%	↑	73.99%
	Facilities	86.06%	↓	83.37%	↓	79.64%
Trust Total		**83.57%**	↓	**80.35%**	↑	**81.46%**

Occupational Health Service
Billing House

Annual Report
2015/2016

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Report prepared by:
Claire Brown
Occupational Health Nurse Manager
August 2016

Enclosure H

Our vision - To provide the best possible care to all our patients

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Summary

Occupational Health is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs. (ILO/WHO1950).

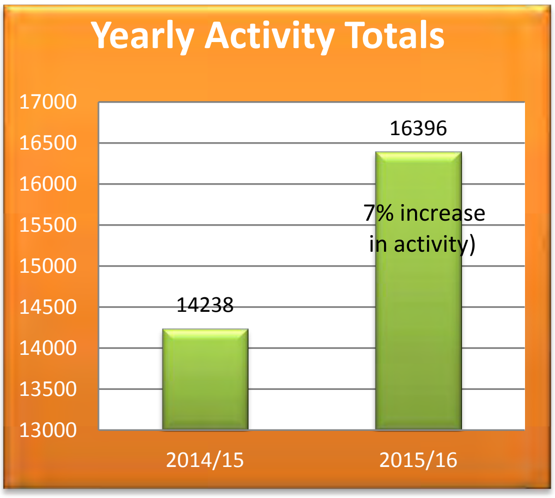
The Occupational Health (OH) Service is part of the Northampton General Hospital NHS Trust, providing services to the Trust (4500 staff) and other NHS/ non NHS organisations.

Total activity (measured in clinical events) for 2015/16 was 16,396 which was a 7% increase in activity from the previous year's figure of 14,238.

This includes new employment screening, vaccinations, blood tests, and physiotherapy, nursing and medical consultations.

In addition to the external contract work the department now provides services to private individuals and companies who may need ad hoc services. **The target for 2015/16 was exceeded and the total figure for income was £216,579 with a surplus of £66,579**

The department has been very busy during a period of establishment changes, implementation of new OH software and streamlining of internal processes.



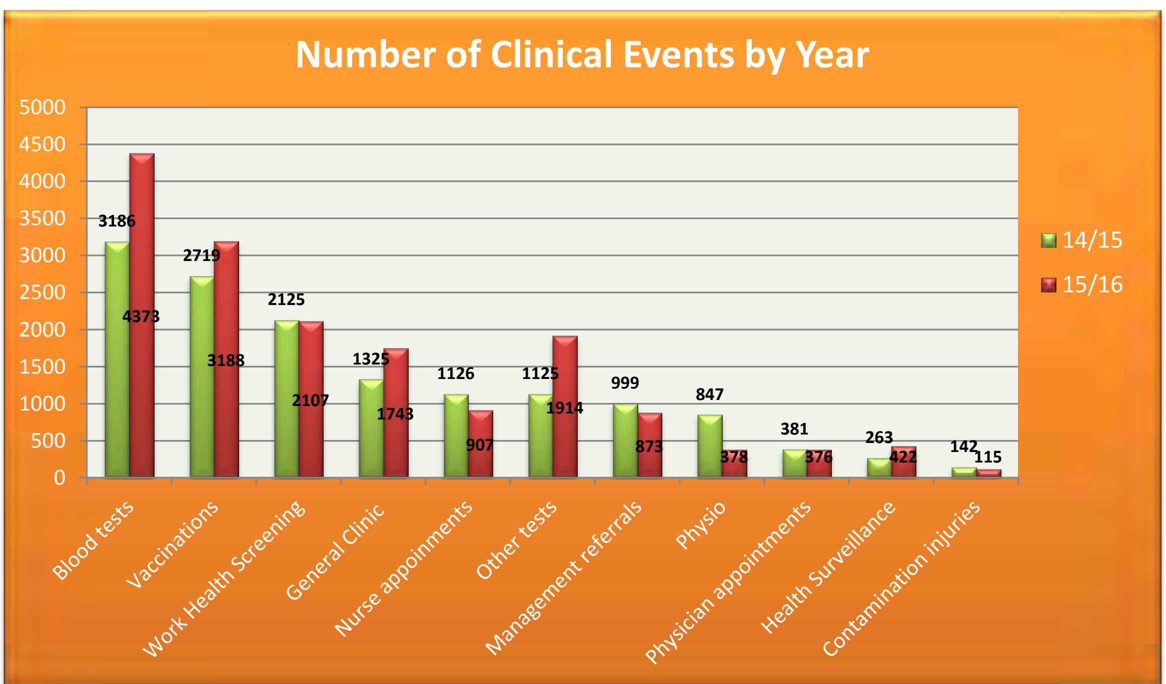
Enclosure H

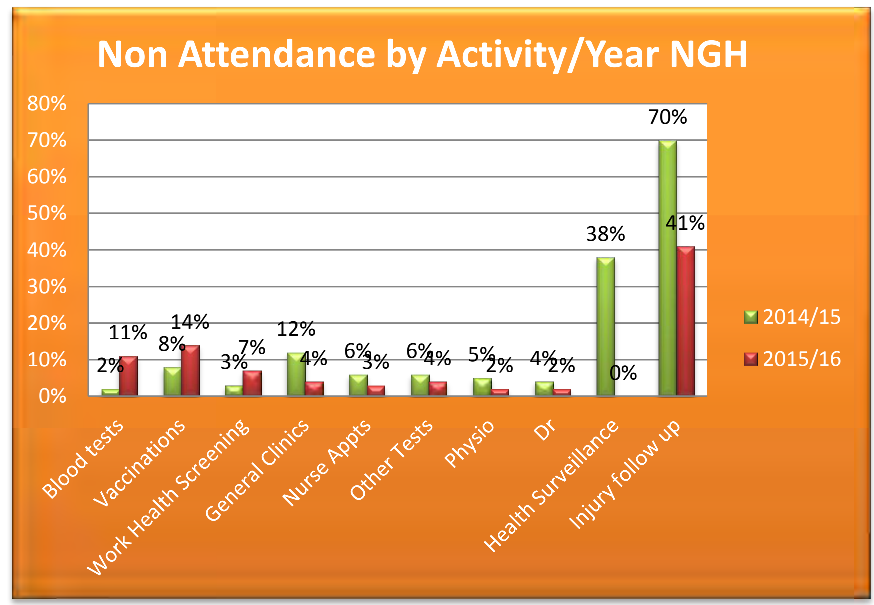
We put patient safety above all else

1.1 Activity Statistics

The aim of the clinical activity of the occupational health department is to look at the effects of health on work and work on health. In screening our staff on employment, a programme of vaccinations and tests can be planned to protect both the employee and the patients they care for as well as making sure that any health matters are supported.

This year's data shows an increase in blood tests and vaccinations with work health screening being comparative to last year's figure. The increase in blood tests and vaccinations (with no significant change in the amount of work health screenings) shows that there has been more staff without the required vaccinations and screenings being cleared for employment.
There has been a significant drop in the amount of physiotherapy appointments from 847 to 378; this is due to a change in work processes as more telephone advice and support being provided. The increase in health surveillance is due to a more comprehensive dermatology surveillance programme. The reduced number of management referrals in 15/16 is due to collaborative working between HR and OH to develop the quality of the referral and reduce the quantity, thereby making better use of resources.





Non-attendance for clinical appointments was 6.7% in 2014/15 and has increased in 15/16 to 9.6% the majority of which are external clients from the University and local dental practices. Full charges are invoiced for non-attendance to external clients.

A new system for non-attendance notification and rebooking of appointments has been developed and embedded into the appointment process; however, there are clients who repeatedly do not attend for their appointments, which is now dealt with by discharge after failure to attend after two occasions, which is documented in the system. Depending on the type of appointment the appropriate manager, Health & Safety or HR personnel may be informed.

There has been a change into the type of activity not attended where in 14/15 it was for the follow up appointments after contamination injury, in 2015/16 it was for blood tests; with significant improvements in 7 out of the 10 of the activity categories shown in the graph above.

For NGH staff, the following table shows that if the 433 hrs of nurse time that has been wasted by non-attendance had been used and sold externally at £93 per hour, it would have brought in **£40,269** in additional revenue

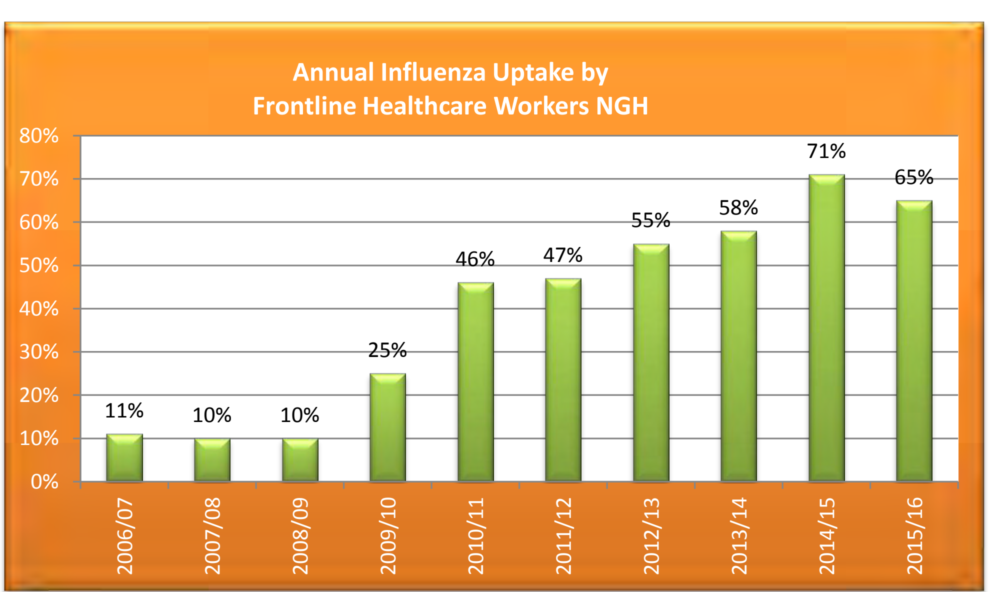
Total Hours lost for non-attended NGH appointments	433 hours
Costed at mid-point 6 for Nurse time	£6,711

1.2 Flu Vaccination Campaign

The flu campaign in 2015/16 showed a reduction in uptake to 65% compared to 2014/15 which was the most successful in the past nine years with a percentage uptake of 71%. The reduction in uptake was thought to be caused by negative media coverage of the change in flu strain part way through the programme.

There were many cases of patients with flu hospitalised at Northampton General Hospital from a wide range of ages; this increased the uptake of vaccine in January 2016 but did not impact significantly on the final uptake figures.

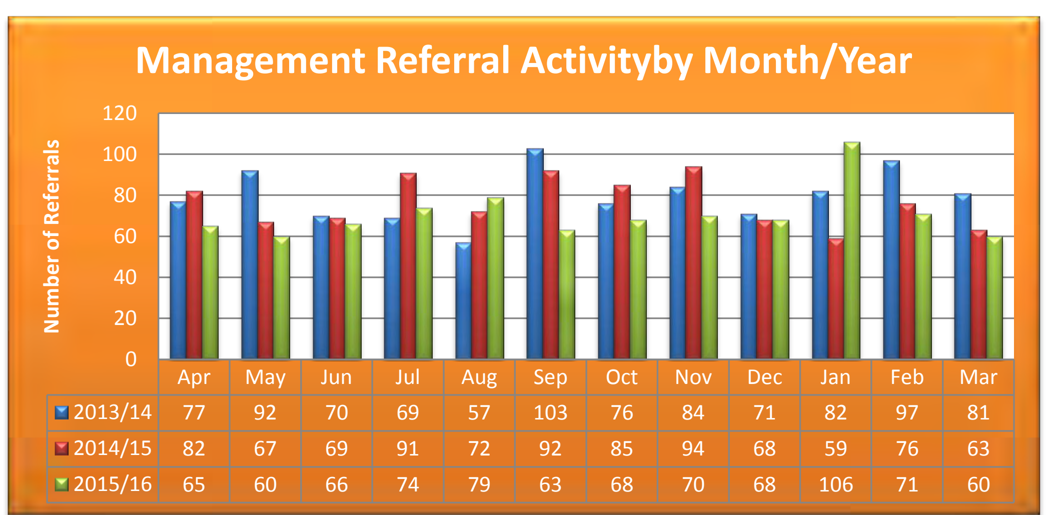
A national CQUIN target of 75% will be introduced for 16/17 with a financial incentive of £500,000.



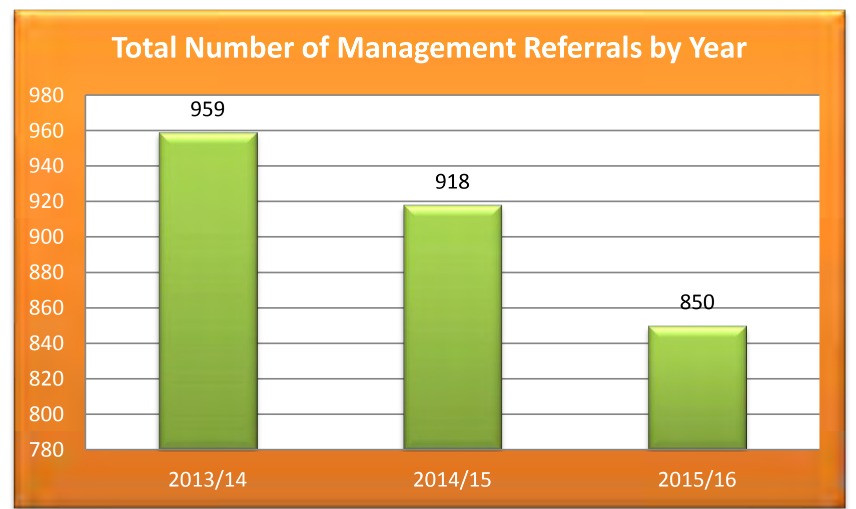
1.3 Management Referrals

The amount of management referrals received throughout the year does not show any significant patterns.

The total number of referrals continues to reduce 15/16 (850) is lower than 2014/15 (925) and 2012/13 (959), this is due to a more robust system of triage for better quality referrals and improved communication and education of managers on the sickness absence process.



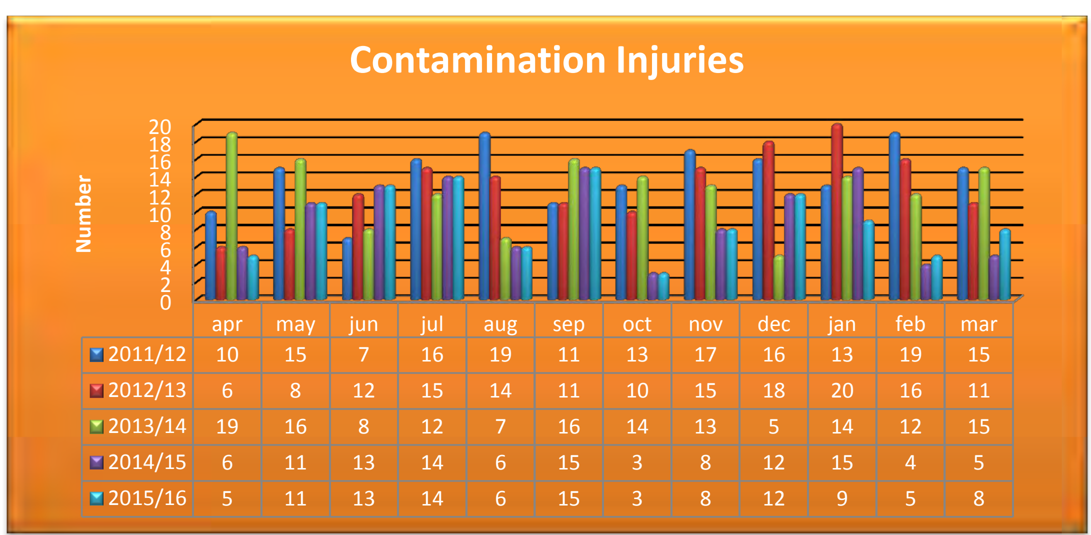
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14	77	92	70	69	57	103	76	84	71	82	97	81
2014/15	82	67	69	91	72	92	85	94	68	59	76	63
2015/16	65	60	66	74	79	63	68	70	68	106	71	60



The categorisation process for capturing of reasons for sickness absence is under development and details for this report are unavailable at this time.

Enclosure H

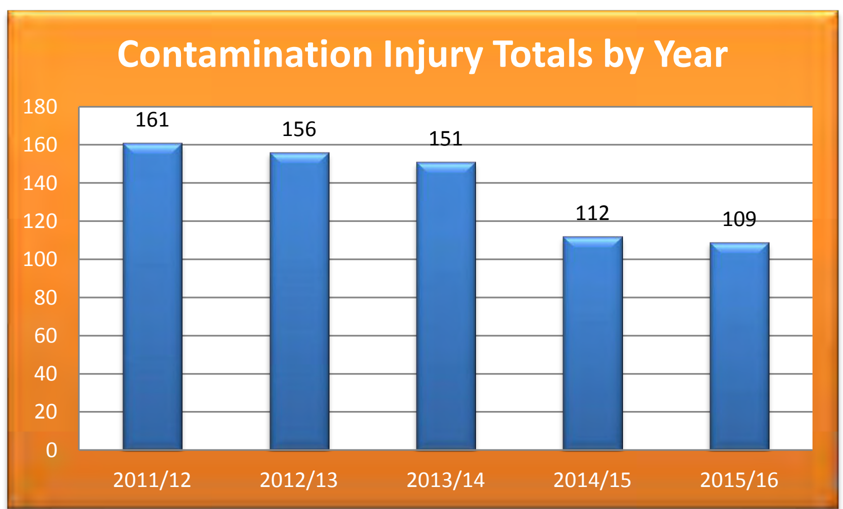
1.4 Contamination Injuries



	apr	may	jun	jul	aug	sep	oct	nov	dec	jan	feb	mar
2011/12	10	15	7	16	19	11	13	17	16	13	19	15
2012/13	6	8	12	15	14	11	10	15	18	20	16	11
2013/14	19	16	8	12	7	16	14	13	5	14	12	15
2014/15	6	11	13	14	6	15	3	8	12	15	4	5
2015/16	5	11	13	14	6	15	3	8	12	9	5	8

In looking at contamination injuries by numbers per month/year (above), it does not appear that there is much correlation between injuries and months. There are no definitive peaks or troughs comparing the five years data.

However in looking at total numbers of injuries by year (below) there is a continual downward trend since 2011. This will be due to the increased use of safer sharps devices cross the Trust, and more proactive communication regarding sharps prevention.



1.5 Physiotherapy

The Physiotherapy service continues to be valued by employees with many letters of thanks to the Specialist Physiotherapist.

Support to the clinician has been reviewed and there have been gaps highlighted in professional supervision and peer support measures. The solution to this has been to change the line of management for the clinician who now sits within the Therapies team. This has provided more direct support and better access to the physiotherapy team.

There have been further streamlining measures implemented with better use of resources with increased telephone triage and consultations.

For 2016/17 there is a new CQUIN for fast track access to physiotherapy which is being reviewed and developed under the remit of the Health and Wellbeing Steering Group

Physiotherapy activity has reduced from 847 to 378 due to changes in staffing in 14/15 (40 to 25 hours of physiotherapist time) change in types of referrals seen and better use of resources.

There have also been some changes within the manual handling team which has required OH and Physiotherapy input to ergonomic workplace assessments.

We aspire to excellence

2.0 East Midlands Streamlining

East Midlands Streamlining is a project championed by the regional Human Resource Directors to align the Recruitment, Medical Staffing, Occupational Health and Learning and Development speciality work streams for new employment across the region.
The occupational health work has been mostly involved with developing a solution for a single transferrable immunisation process for Drs to reduce the costs of repeating screening tests and immunisations.

The solution being planned utilises the current Electronic Staff Record (ESR) system. With a combination of ESR and local OH software products it may be possible to export from the OH systems into the ESR system; this would then enable the transfer of completed screening and immunisation tests nationally.
This project is ongoing.

2.1 Facilities

The OH department is sited over two floors which provide challenges for staff and clients as follows:

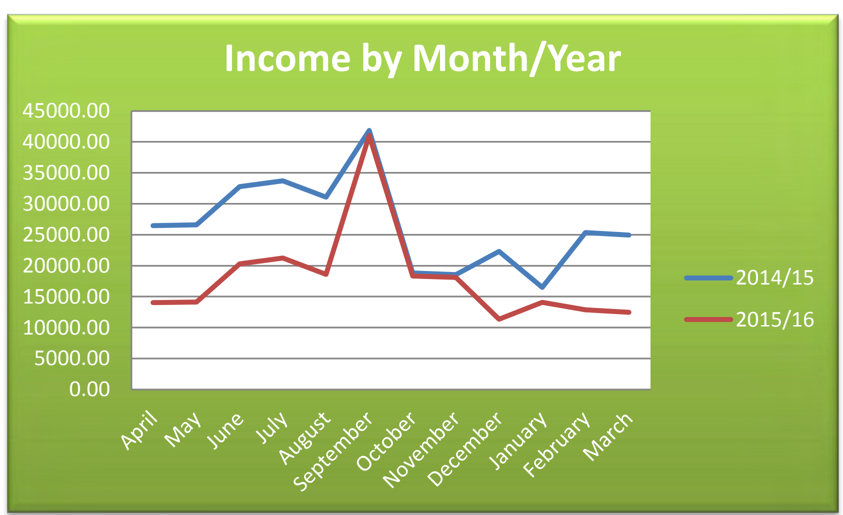
- Clinical activity on two floors - patient pathway not streamlined
- One reception area on the first floor so clients have to book in on the first floor and then return to lower ground floor to wait for physiotherapy
- Duplication of resources – clinical and administrative
- Administration of two areas with duplication of administrative activities

This has been discussed and solutions discussed as part of the back office co-location of services review for 14/15. The progress of the project has been slow due to a wider scoping exercise of additional office utilisation in Billing House.
The project is being reviewed by the Director of Facilities and will hopefully be progressed through 16/17.

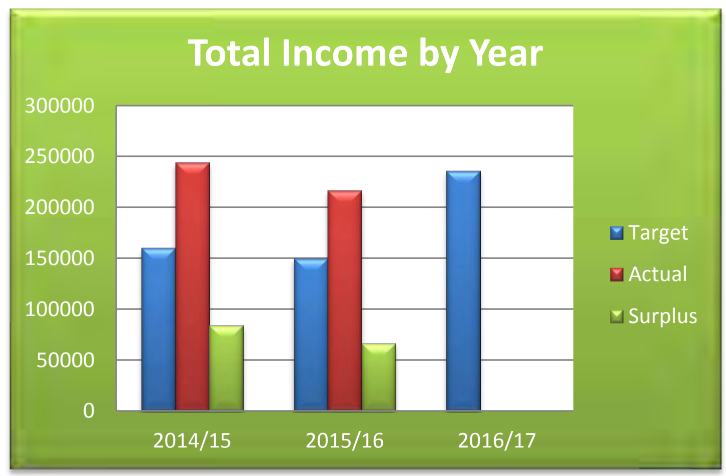
2.2 Income Generation

OH services continue to be provided to external clients. There continues to be new external clients requiring ad hoc services as well as work through contractual arrangements.

The yearly target of **£150,000** was exceeded and the total income for 2015/16 was **£216,579** exceeding the target by **£66,579**



The income target has been increased by **£86,000** for 2016/17 to **£236,000.**
The University of Northampton contract changed in 2015/16 and the annual contract price was reviewed to remove the retainer and only be set as per item of service costs; giving £30,000 reduction in income. The contract is to be renegotiated in 2017/18 when the national student funding process for healthcare students changes.



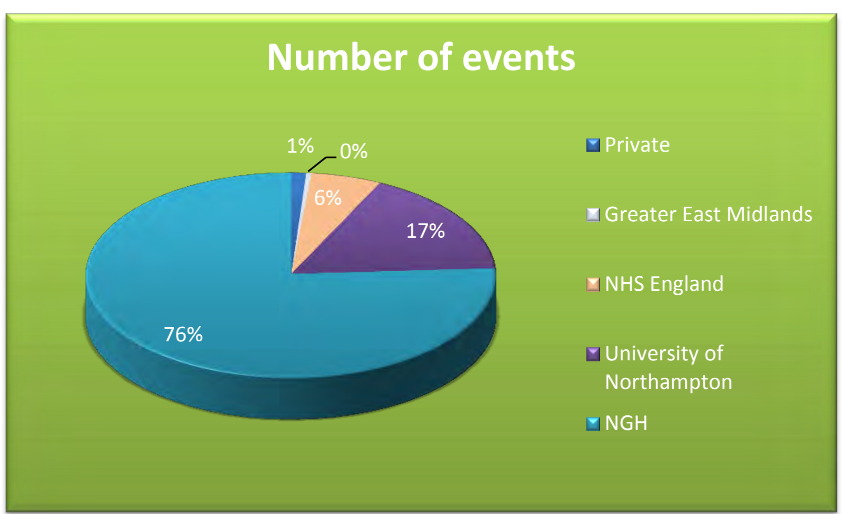
2.3 Customers

Enclosure H

The OH external client database consists of the following:

- University of Northampton
- Greater East Midlands /CCG
- 99 (29) Individual private clients /SME's
- 51 (39) Dental practices – paid for by NHS England
- 47 (36) GP practices – paid for by NHS England

(Figures for 14/15 in brackets)



2.4 Cost Improvements

There has been a change in the provision of Occupational Health Consultant provision which has realised a cost improvement. The previous service was sourced from an external provider which has now changed to an NHS contract arrangement via the University Hospitals of Leicester NHS Trust (UHL). The service has moved from one day a week of Consultant time to two days a week. The cost improvement is due to improved costs via an NHS contract rather than a private sessional Consultant.

Other cost improvements for 2015/16 were planned as part of the co-location of services which is ongoing. Changes to services late in 2015/16 due to the implementation of new electronic processes may provide cost improvements for the next financial year.

2.5 Internal Groups and Meetings

Occupational health team members participate in the following groups and meetings as part of the Trusts clinical and workforce activities, as well as internal OH departmental support activity.

- Health and Safety Committee
- Infection Prevention Committee
- Safer Sharps Committee
- HR Department meeting
- HR Managers meeting
- Core brief
- OH Clinical meetings
- OH Team meetings

3.0 Training

One of our nurses continued with her Occupational Health Specialist Nurse degree at London South Bank University in 2015/16 which is a two year course leading to Specialist Practitioner status. All staff have completed their mandatory and role specific training, with additional training in the use of the Audiometry equipment.

3.1 Electronic Records and OH Software System eOPAS

The system of progressing to a paper light service was realised in December 2015 with the introduction of the updated web based IT software system eOPAS (Occupational Practitioners Administration System and **'e'** being the most recent web based product). The software took 18 months of direct system configuration by the OH manager to provide a system that reflected the processes within the department.

Previously the OH team had two systems working in parallel with hard copy records and a software programme. This changed in 2015 to a paper light process where the records were scanned into a digital storage programme and all consultations and client services were detailed and recorded electronically.

This system also supports a portal where electronic questionnaires can be completed and submitted. This was configured to enable the NGH recruitment team to reduce their paperwork and processes by sending a link to new employees to complete a portal questionnaire rather than a hard copy. (Hard copy forms may still be used in circumstances where the new employee is unable to access the portal).
The roll out of this process has been very successful and has subsequently been implemented by the University of Northampton - Faculty of Health, for their healthcare student courses.

The portal has also been configured with the use of a specific questionnaire for TB health surveillance for areas exposed to TB in their work.

3.2 Professional Groups

The team are members of the following groups which supports collaborative working and streamlining of speciality activities.

- Trent Regional Occupational Health Nurse Group (OH Managers)
- Cambridgeshire Regional Occupational Health Managers Forum
- Northampton Occupational Health Nurses group
- NHS Health at Work Network

3.3 Service Improvements

Improvements for the OH Service

1. Investment in additional equipment for audiometry including an audio booth.
2. Investment in additional equipment for drug and alcohol screening
3. Development of a hospital internet page for Occupational health services for external clients.
4. OH team photo poster showing the whole team – for client identification of staff
5. Provision of free samples of hand care products for staff with skin issues

3.4 Annual Survey

This survey was carried out to gain customer feedback as part of work being undertaken to improve occupational health services to the Trust and other clients. 200 people were invited to take part in the survey of which 65 responded, giving a 32% response rate.

The survey was very positive about the current occupational health service with 82% of the respondents having their need fully met by the service, and 91% being likely or extremely likely to recommend OH services to a colleague.

The main services utilised were blood tests and immunisation at 37% followed by management referrals at 40%.

Enclosure H

In rating specific services, both access to the building and signage around the site remains an issue which remains on the facilities works programme.
Rating's for customer service, clinical consultations and the winter flu campaign continue to be favourable.
In looking at general support from Occupational Health for managers 51% agreed that they were provided with sufficient support (30% said this question was not applicable).
Occupational Health does provide services to external clients and contacts with other NHS organisations however 70% of respondents were not aware that this level of service was provided by Occupational Health.

3.5 Departmental Objectives 2015/16

The objectives for the next financial year can be found in **Appendix 1**

3.6 Clinical Capacity

Due to a high level of clinical activity local KPIs have not been met and the waiting times for appointments have on average been as follows

- Physiotherapist – average 2 – 3 weeks
- Nurse average 2 – 3 weeks (**KPI= 5 days**)
- OH Physician average 4 weeks (**KPI=10 days)**

Work has been done to review the length of time of the individual appointments which has freed up additional clinical capacity. This has included reviewing set appointment times with the clinical staff and reducing certain service times as follows:-

- 60 minutes to 45 minutes for specific medicals
- 30 minutes to 15 minutes for combined blood tests/vaccination appointments

3.7 Establishment

Work has been done to review the establishment each time there have been changes to the team. In 2015/16 there have been the following changes to the establishment

- Part time Consultant post 4 PA's per week provided through United Hospitals Leicester – this was previously filled by external contract provision
- Full time Band 7 Deputy Manager post – previously part time/term time contract
- Full time Band 5 Specialist Nurse training post (Band 6 on qualification) - previous vacant post
- Full time Band 3 Administration post - new post redesigned from budget available

The establishment is currently complete see OH organogram in **Appendix 2**

3.8 Complaints

No formal complaints were received by the Trust against the Occupational Health Department.

3.9 Fire Alarm Calls

No fire calls in 15/16.

3.10 Injuries to OH Staff

None to report

Enclosure H

We respect and support each other

4.1 Counselling

The counselling service provided by Cambridgeshire Consultancy in Counselling is provided on site (Tuesday and Wednesdays) within the OH department. There is one dedicated counsellor allocated to the department for continuity of care.
The service is also available for on-site post incident debriefing of which there have been two enquiries but not felt to be required.

4.2 OH Team Support and Working Life Enhancements

Even though this has been a busy year for the department there has been time to participate in other activities as follows:-

- Global Corporate Challenge – team walking activity
- Strictly Dancing event – won by our Physiotherapist
- Christmas office lunch
- Christmas evening event

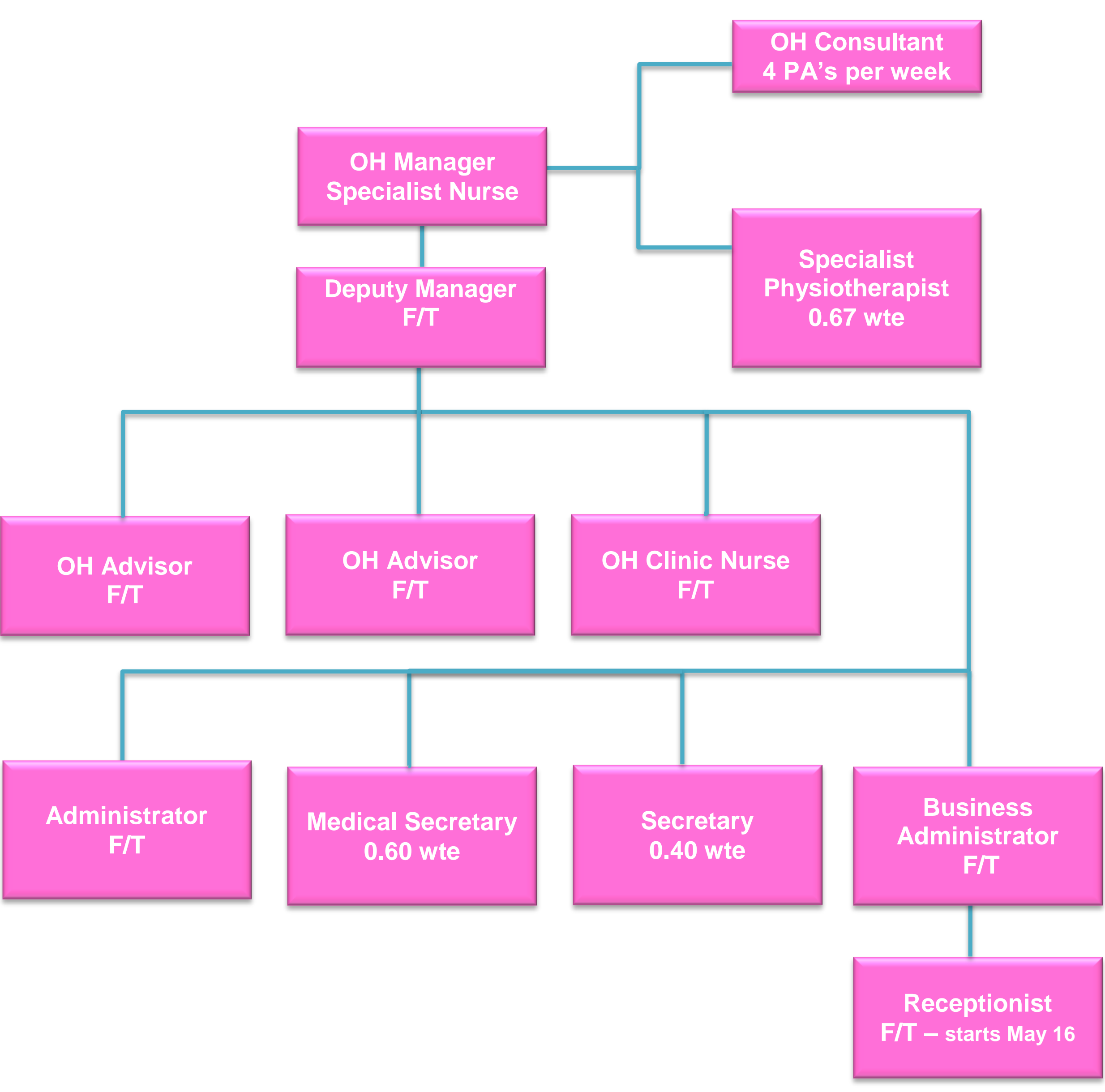
Occupational Health Departmental Objectives 2015/16

Appendix 1

1. 100% mandatory training for all OH staff
2. 100% appraisal completion for all OH staff
3. Completion of year 2 of OH degree for Specialist Nurse and commence year 1 for next candidate
4. Implementation of electronic questionnaire for medical staff recruitment
5. Co-location of services onto 1st Floor and improve disabled access
6. Continue to develop internal streamlining of recruitment process with HR to provide quality and timely services
7. Develop further innovation improvement and modernisation of the OH services with cost/resource efficiencies
8. Work with the Trusts Health & Wellbeing leads to provide additional support for stress related matters and improve mental wellbeing
9. Market new services of Drug and Alcohol Screening, and Fork Lift Truck Medicals
10. Review management referral process and streamline system working with the HR team and Trust Managers

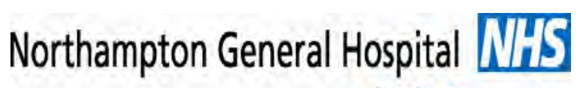
Appendix 2

Occupational Health Organisational Structure 2015/16



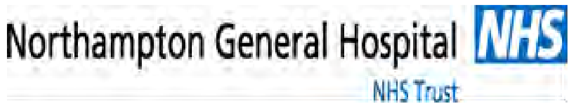
Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Sustainability and Transformation Plan Update
Agenda item	13
Sponsoring Director	Chris Pallot, Director of Strategy & Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy & Partnerships
Purpose	To provide an update on the STP programme in Northamptonshire.
Executive summary This report is presented to the Board to update on progress that is being made with the STP. The paper is that which was reported to the Health and Well-Being Board by NHS Nene Clinical Commissioning Group.	
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)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No



Actions required by the Trust Board/Committee

The Board is asked to note the update.



Public Trust Board
29th September 2016

Sustainability and Transformation Plan Update

1. Summary

This report is presented to the Board to update on progress that is being made with the STP. The paper is that which was reported to the Health and Wellbeing Board on 15 September and as such is the latest available. The paper is attached at appendix 1.

2. Recommendations/Resolutions Required

The Board is asked to note the update.

Northamptonshire Sustainability and Transformational Plan for the Health and Social Care System

15 September 2016

Health and Wellbeing Board update

Sponsor: John Wardell, Northamptonshire STP Lead

Presented by James Murray, STP Programme Director

1. STP update

Plan update

On the 30th June we submitted our draft STP plan to NHS England. We received feedback that good progress had been made to date and that we now need to develop the granular detail behind the plans that will form a key element of our final submission in October 2016.

From regional and national meetings, the overall feedback has been positive. The challenge now is to provide the level of detail and sequencing across all of our programmes of work and to develop a clear governance structure and process for delivery. We need to:

- Develop detailed and scheduled implementation plans for the first two years and high-level plans for the periods thereafter;
- Develop year on year financial profiles that will support system balance leading ultimately to organisational balance;
- Confirm details around identified new models of care and the impact they will have on the workforce and our Organisational Development plans;
- Develop our communications and engagement plans.

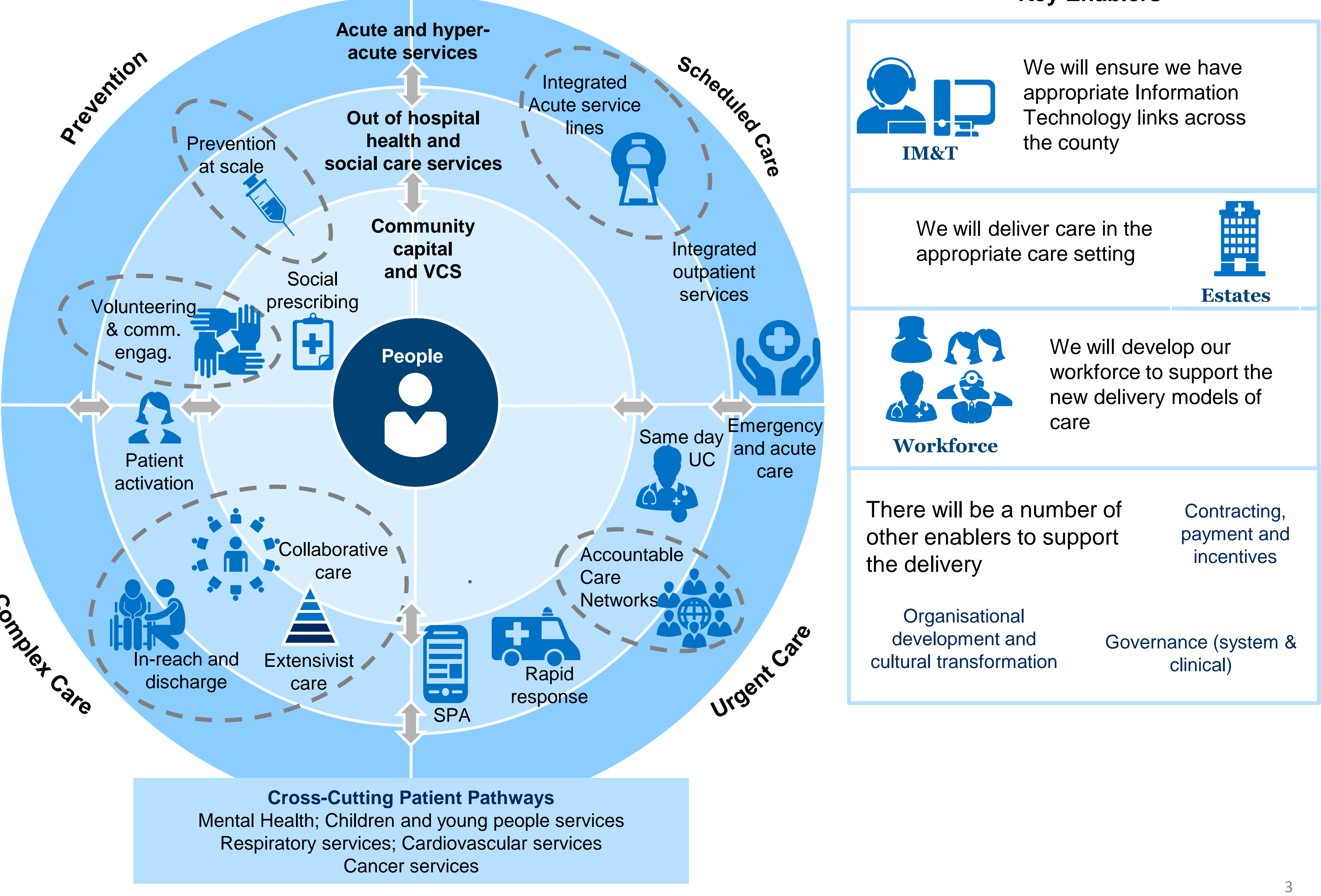
A modified governance structure has been created that will encompass our key programme areas with the following CEOs Sponsors and SRO Leads:

Programme	CEO Sponsors	SRO Leads
Prevention, Community Engagement and Patient Activation Programme	Carole Dehghani	Janet Doran
Scheduled Care	David Sissling	Chris Pallot
Complex Care/MCP	John Wardell	Lucy Dadge
Urgent Care	Angela Hillery	Jane Taylor /Giles West

Supporting enabling groups	Sponsors	SRO Leads
Workforce	Sonia Swart	Fiona Myers
IM&T	Paul Blantern	Akeem Ali
Finance & Activity Committee	James Murray	Finance Directors
Communications & Engagement	James Murray	Jennifer Morgan
Clinical Engagement	Matthew Davies/Miten Ruparelia	Medical/Nursing Directors

Supporting enabling groups have also been established. These will be critical to the success of the programme and will equally have a director lead and SRO support.

2. Our Programmes of work under the STP



Cross-Cutting Patient Pathways
Mental Health; Children and young people services
Respiratory services; Cardiovascular services
Cancer services

3. Progress Update (1/2)

Transformation Initiatives

- Programme Briefs have been produced for each of the key transformational areas
- Senior Responsible Officers (SROs) are now working with their teams to develop Project Implementation Documents, outlining the detailed next steps and milestone, and reaffirming the impact of the programmes on:
  - Closing the Health and Wellbeing gap
  - Closing the Care and Quality gap
  - Closing the Finance and Efficiency gap

Enabler Development

- Finance and Activity
  - Updated financial guidance was issued towards the end of August 2016.
  - Key issues arising from this are:
    - Update do nothing to fully include specialised services and primary car commissioning and cross refer to national assumptions
    - More explicit presentation of LA financial pressures
    - Clarity on certain aspect of allocations already within the CCG allocation particularly with regard to mental health and primary care
    - Confirm the expected 15-20% STF expected to go to primary care
    - Presentation of interventions in line with national categorisation
- Workforce:
  - First draft of an overarching workforce and OD strategy being developed for the multi-organisational programme of the STP
  - Robust governance and reporting processes being established between STP and LWAB, with key ‘engine room’ groups being established to support the workforce transformation
  - Each Programme area to develop high level narrative ‘on a page’ of the key workforce changes and risks to delivery for their projects

3. Progress Update (2/2)

- IM&T:

Local Digital Roadmap work started in Northampton before the STP process and has therefore been used as the basis of the informatics enabler for the STP.

  - The LDR was submitted to NHSE in July and formal feedback has now been received.
  - As part of the feedback NHSE asked for confirmation of LDR governance arrangements and these have now been agreed so that there is a formal LDR oversight board meeting monthly which has 5 workstreams reporting into it:
    - Infrastructure; Clinical Systems; Information Sharing; Business Intelligence; Informatics Workforce
  - All workstreams have started with a stocktake against the ambitions expressed in the LDR and will be formulating a workplan based on the stocktake findings

- Communications and Engagement:
  - Consultation is taking place with SROs to identify gaps, target audiences, challenges and opportunities. Once the key requirements for each area have been ascertained, they will then be incorporated into the form of communication required for each target audience.
  - As an STP region, we will also think practically about the forms of communication and marketing which have the most impact. Information messages and advertising do not encourage the level of engagement and involvement required to demonstrate full consultation, therefore we will need to develop a full programme of behavioural (social) marketing to achieve our objectives

4. Next Steps

Two-year NHS planning guidance, for 2017/18 and 2018/19, is due to be published during September. It will include the approach to future tranches of the Sustainability and Transformation Fund and the process for agreeing capital bids. The funding that has been used to support provider sustainability in 2016/17 will continue to be used in the same way for 2017/18 and 2018/19:

Key planning milestones are as follows:

- 16 September: finance submissions including more detail on capital, efficiency sources and investments for all STPs ;
- 20 September: publication of NHS planning guidance for 2017/18 and 2018/19 ;
- 21 October: full STP submissions including an updated finance template ;
- End-November: CCGs and NHS providers to share first drafts of operational plans for 2017/18 and 2018/19;
- End-December: CCGs and NHS providers to finalise two-year operational plans.

The work groups that have been established will enable the system to deliver to the above timeline.

In light of recent discussions on Local Authority financial sustainability, it will be necessary to build in an additional process to assess the impact on our previously calculated financial and health and care gaps, and the impact on the potential solutions so far proposed.

Report To	**Public Trust Board**
Date of Meeting	**29 September 2016**

Title of the Report	**Communications strategy update**
Agenda item	14
Presenter of the Report	Sally-Anne Watts, Head of Communications
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	All
Risk and assurance	N/A
Related Board Assurance Framework entries	1, 8, 14, 26
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	

Communications Strategy
2014 – 2017
Progress report

Enclosure J

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Progress against objectives

- Develop the NGH brand, promoting ownership and understanding of the trust's vision and strategy 4
- Strengthen staff communications 5
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Introduction and Context

Introduction

The communications strategy was approved by the board in September 2014.

This presentation provides an overview of progress to date since September 2015.

Whilst good progress has been made in many areas, we know that there is more to do, and this is reflected in our plans for 2016-2017.

The bigger picture

- We make and own our news – issues based communications rather than ad-hoc reactive communications
- Context setting – helping people understand how they can use the communication skills and tools we have to offer wisely
- Reputation management and stakeholder relations – as an organisation we need to be more strategic in our communications planning, using evidence-based communication tactics

1. Develop the trust brand and promote ownership and understanding of the trust's vision and values

We said we will do this by:

- **Developing a core script for the organisation to enable consistent use of key messages for all audiences**
- **Promoting a 'house style' for the trust**
- **Maximising our reputation, making us the hospital of choice**
- **Ensuring our audiences understand our role as a provider of specialist services**
- **Increasing the profile of specific services**
- **Consistently communicating the vision, values and strategic aims/objectives through communications with staff, stakeholders and the media**
- **Ensuring easy access to quality, safety and performance information to support informed patient choice**
- **Widely celebrating success to increase the positive profile of individuals, departments and the trust as a whole**

Progress

- During the year we continued to reinforce use of the strapline 'Best Possible Care' in all our media releases. Where possible and appropriate reference was also made to our core values in our media statements and social media postings. Our values are our core script.
- We have continued to use the NGH brand consistently in presentations, publications, posters and other print collateral
- We have worked with colleagues to minimise confusion and avoided an unnecessary proliferation of issue-specific brands and logos
- Continued to work with specialties to highlight their services
- Service improvements and performance highlighted in Insight, local media and via our social media channels
- Best Possible Care awards – September 2016 – reflecting our vision and values

Strengthen staff communication

3. Strengthen staff communication

We said we will do this by:

- **Sourcing and sharing good news stories from across the organisations that demonstrate the achievements of our staff**
- **Reviewing methods of staff communication, including their purpose and effectiveness, and developing an overall framework for staff communication, including an effective team briefing system with feedback mechanisms**
- **Promoting and reinforcing our vision and values and strategic aims/objectives in all communications to ensure staff ownership of our shared goals**
- **Showing support for cultural behaviours from the top by increasing the profile of senior staff living the trust values**

Progress

- Staff achievements regularly featured in Insight and the weekly bulletin; also on our Facebook and Twitter feeds
- Monthly core brief well attended. More work needed to monitor attendance and implement effective cascade/ feedback processes
- Core values reflected in weekly screensavers
- Our social media postings (Facebook and Twitter) use the hashtags #bestpossiblecare and, where appropriate, also signpost our other values #reflect/learn/improve; #patientsafety; #aspiretoexcellence; #respectandsupport. These are now being shared by members of staff who also use Twitter
- NGH staff feature in both internal and external communication – particularly successful in recruitment campaigns

Our challenges in 2016-17

- Enabling staff to access trust social media channels from within the workplace – Facebook at Work pilot site
- More work needed to bring our values to life and share learning – work being planned with IQE team
- Improving the core brief process by working with Divisions and departments to support them in developing a meaningful and effective cascade and feedback process
- Continue to find ways of ensuring the vision, values and strategic aims and objectives are shared and understood by our staff

4. Improve our communication with patients and the public

We said we will do this by:

- **Promoting and reinforcing the value the trust places on patient and public engagement and communication**
- **Recruiting and maintaining a vibrant and engaged membership**

Progress

- We have continued to grow the number of engaged followers on our social media channels, measured by the number of likes, shares, favourites and re-tweets
- Almost 8,000 followers (25% increase on last year) on Facebook (During August-September reached more than 100k people with more than 90% post engagement)
- 2,316 followers on Twitter (47% increase on last year)
- We regularly use video and filmed interviews with staff to 'tell the story' – radiology/Barratt birth centre/ volunteers/overseas nurse recruitment/ChitChat/FY1 recruitment/EAU recruitment/cup of tea
- All direct messages on Facebook and Twitter receive a response
- Member database now cleansed and automated system in place to enable regular communication
- Patient engagement events in rheumatology and dermatology held as part of clinical collaboration work
- 'What do our patients want' engagement event held in August 2016
- New lightboxes and information boards being installed during October 2016
- Infection prevention message being incorporated on lift doors October 2016
- Animation produced to support messages to patients/carers regarding discharge arrangements

Our challenges in 2016-17

- Develop and implement plan to engage membership through regular online communication and quarterly events
- Continue to push use of NGHPlus app to bring stories to life and add value to our communications by building context, relevance and efficiency of our messaging, and helping to build relationships
- Working with external stakeholders to ensure our staff, service users and the public are aware of and have opportunities to influence our strategy and service developments

5. Improve our communication with external stakeholders

We said we will do this by:

- **Developing effective relationships with key influencers, overseers and scrutineers, providing them with key points of contact and a formal briefing system**
- **Supporting partnership working**
- **Develop the ability to segment and target key stakeholders and record activity**

Progress

- Quarterly briefings with MPs now in place
- Information screens in outpatient waiting areas now operational in five areas and controlled by communications
- Executive meetings with key influencers locally, regionally and nationally
- Developing relationships with Healthwatch, Voluntary Impact Northamptonshire and Age Concern
- Developing relationships with University of Northampton – opportunities identified to work with third year media students
- Working with TwoFour production company on junior doctors' series with the aim of raising profile of training opportunities provided at NGH and encourage take-up of posts

Our challenges in 2016-17

- Re-launch NGH GP news
- Develop a stakeholder management database to bring structure to our stakeholder management, record activity and measure the impact

6. Develop our communications infrastructure and tools/techniques

We said we will do this by:

- **Developing and disseminating a toolkit of branded documentation templates and advice for staff to use in developing their own communications, and roll out media training to senior clinicians**
- **Continuing development that has already begun in using social media and explore further opportunities to use social media to enhance our communications and the patient experience**
- **Redeveloping the trust website and intranet and to better use our estate for communication**
- **Developing closer relations with the media and with communication functions within the local healthcare community so that we can better reflect the trust's views, as well as raise the profile of the trust**

Progress

- Targeted campaigns to support recruitment – Shortlisted for HSJ Award for staff engagement
- Media training provided as part of regional junior doctor training in NGH SIM Suite
- Social media guide produced for staff
- Website redesign underway
- Information screens in outpatient waiting areas now operational
- Quarterly briefings with local media
- Digital/social media apprentice recruited – due to start October 2016

Our challenges in 2016-17

- Develop and implement media training package for senior managers
- Ensure website is kept up to date, accessible and fit for purpose
- Introduce Facebook at Work to support internal communications and engagement

Communications in the future

The tables below summarise the steady progress we have made against the objectives set out in our three-year communications and engagement strategy.

Now

- Proactive, planned communications activity
- Over-reliance on one-way (push) staff communications throughout the organisation rather than two-way dialogue
- Strong brand and corporate image
- Publication of outcomes and performance data accessible but needs to be presented in a way that is more easily understood
- Ongoing patient engagement in relation to clinical collaboration; plans for member re-engagement
- Planned engagement with key stakeholders
- Proactive involvement in public health messaging – FMG, safe sleeping babies, flu, winter and seasonal messages
- Strong campaign planning where there is identified need

2017 target

- Proactive, planned communications activity
- Robust, systematic and effective two-way staff communication
- Strong brand and corporate image
- Transparency regarding all clinical outcomes which are published in a way that is easily understood
- Robust patient and public involvement/ engagement in service improvement and development
- Strong and effective relationships with stakeholders
- Proactive role in public health messaging
- Planned, targeted communications campaigns with measurable outcomes

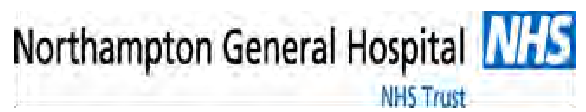
Our challenges and our priorities

Our challenges

- Website redevelopment
- Staff communication - Intranet/extranet or Facebook at work?
- Staff engagement – making connections and the CQC inspection
- Supporting IQE/patient safety messaging
- Winter/urgent care/strikes/morale/reputation
- Social media access
- Line manager/supervisor communication skills – training
- Brand Northamptonshire – recruitment and relationships
- GP communications
- Event management – Strictly NGH 2017, BPC Awards, long service
- #NGH275 celebrations in 2018
- Funding – securing a corporate communications budget
- Managing expectations – adding value and measuring what we do

Our priorities

- Reputation, reputation, reputation
- Website
- Engagement – making connections
- Stakeholder relations
- Upskilling



Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Equality and Diversity Strategy
Agenda item	15
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance that the equality agenda including the public sector duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust
Executive summary The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. The Trust Board is asked to approve the refreshed and reviewed Workforce Equality and Diversity Strategy 2016 to 2019. The Strategy details how the Trust will address its requirements of the Public Sector Equality Duty. It builds on the work already done and progress made on equality, diversity and human rights over the years and sets out our co-ordinated and integrated approach in relation to our workforce.	
Related strategic aim and corporate objective	Enable excellence through our people.
Risk and assurance	The Trusts equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the Four Year Action Plan and the WRES.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or

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	promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	NHS Constitution Public Sector Equality Duty Equality Act 2010 Equality Delivery System 2 (EDS2) Workforce Race Equality Standard (WRES)

Actions required by the Trust Board

The Board is asked to:

- Approve the Equality & Diversity Strategy 2016 – 2019

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WORKFORCE EQUALITY AND DIVERSITY STRATEGY 2016 – 2019

NGH-SY-814

Draft

Ratified By:	Trust Board
Date Ratified:	September 2016
Version No:	5
Supercedes Document No:	4
Previous versions ratified by (group & date):	Trust Board – April 2013
Date(s) Reviewed:	July 2016
Next Review Date:	September 2019
Responsibility for Review:	Director of Workforce & Transformation
Contributors:	HR Directorate

STRATEGY

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FOREWARD

The Workforce Equality and Diversity Strategy 2016 to 2019 for Northampton General Hospital NHS Trust details how the Trust will eliminate discrimination, advance equality and foster good relations between people who share certain characteristics and those who do not. It builds on the work already done and progress made on equality, diversity and human rights over the years and sets out our co-ordinated and integrated approach.

We aim to support our workforce in a responsive and appropriate way to meet the diverse needs of the different groups and individuals we employ.

To achieve these aims we want to ensure that employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work we do at the Trust.

Leadership and commitment at all levels of the organisation is central to the success of this Strategy. It is the duty of the Trust Board to implement the Strategy successfully. Trust staff will also have an important role to play with implementation and we welcome the opportunity to involve and work with all stakeholders to promote equality, diversity and human rights in order to improve the working environment we provide.

The Trust Board will receive regular feedback on the implementation and promotion of this Strategy and we will evaluate progress to ensure we are striving towards what we set out to achieve.

Equality for Staff

Our staff are our greatest resource. We actively promote a culture that encourages their richly diverse talents to lead services that deliver inclusive care.

This strategy promotes inclusive employment practices because well supported staff can deliver better care for our patients.

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1. NATIONAL EQUALITY AND DIVERSITY AGENDA

1.1 The NHS Constitution

The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

The key principles that guide the NHS in everything that is does are set out in the NHS Constitution which states:

- The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status
- Access to NHS services is based on clinical need, not an individual's ability to pay
- The NHS aspires to the highest standards of excellence and professionalism
- Patients will be at the heart of everything the NHS does
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients that it serves.

The principles are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public:

- Working Together for Patients
- Respect and Dignity
- Commitment to Quality of Care
- Compassion
- Improving Lives
- Everyone Counts.

These values serve to motivate and inspire us to deliver good quality care. They also are the values that through the NHS Constitution provide the public with guarantees about the services provided by the Trust. As such they can also be used to judge us, including by the government through formal inspection and review.

In addition to the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998 provide the framework for recognising the importance of equality and respecting diversity in all aspects of the work at Northampton General Hospital (NGH).

1.2 Equality and Human Right Commission

The Equality and Human Rights Commission (EHRC) has been given a mandate by Parliament to challenge discrimination, and to protect and promote human rights. It is their mission to be a catalyst for change and improvement on equality and human rights by being an outcomes-focused strategic regulator, a promoter of standards and good practice, an authoritative centre of intelligence and innovation and a trusted partner. The Equality and Human Rights Commission also has powers to investigate and launch legal proceedings.

1.3 The Equality Act 2010

The Equality Act 2010 covers everyone in Britain and protects people from discrimination, harassment and/or victimisation because of the protected characteristics that we all have. Under the Act, there are nine protected characteristics:

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- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership.

1.4 Public Sector Equality Duty - Our General Duties

This strategy contains actions that meet our obligations from the Public Sector Equality Duty (Section 149 of the Equality Act 2010). The Equality and Human Rights Commission technical guidance on the Public Sector Equality Duty was revised in August 2014 and this obliges that the Trust in the exercise of its functions, has due regard to the need to:

- Eliminate discrimination, harassment and other prohibited conduct
- Advance equality of opportunity
- Foster good relations.

The requirement in the Act to have due regard to the need to eliminate discrimination and other prohibited conduct means that the Trust needs to give advance consideration to issues of discrimination before making any policy decision that may be affected by them.

Having due regard to the 'need to advance equality of opportunity' includes the need for the Trust to:

- Remove or minimise disadvantage suffered by people who share a relevant protected characteristic that are connected to that characteristic
- Take steps to meet different needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
- Encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.

The Act specifies that 'the need to foster good relations' includes having due regard, in particular, to the need to tackle prejudice and promote understanding.

The disadvantages this strategy addresses are gaps between different people's work opportunities called 'inequalities'.

Disadvantage can sometimes amount to unlawful discrimination or abuses of people's rights and this strategy details the way people can hold us to account if these occur.

See section 3 for further information about the Trust's Delivery of Equality Duties.

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1.5 Public Sector Equality Duty - Our Specific Duties

To help deliver the general duty, there are also two specific duties which form the aims of this strategy:

Publication of Information
Publish equality information annually about employees to demonstrate compliance with the general equality duty.

Equality Objectives
Publish one or more specific and measurable objectives to deliver the general equality duty.

The specific duties also state the information must be published in a manner which is accessible to the public.

1.6 The Human Rights Act 1998

The Human Rights Act places all public authorities in the UK under a duty to respect the rights it contains in everything we do. We are under a duty not only to ensure that we do not commit human rights abuses but also we have a duty to take proactive steps in order to ensure that human rights are respected, protected and fulfilled.

These rights affect the rights of individuals:

- Human rights are about our basis needs as human beings
- Human rights belong to everyone, all of the time – not only certain groups at certain times
- They cannot be 'given' to us – only claimed or fulfilled
- They cannot be taken away from us, only limited or restricted in some circumstances
- They are about how public authorities, such as NHS organisations, must treat everyone as human beings.

In essence human rights are a set of universal minimum standards that must be met. They are not only about the protection of particular individuals and groups in society but are a practical framework to protect the rights of everyone.

Human rights values such as Fairness, Respect, Equality, Dignity and Autonomy (FREDA) underpin the public service ethos, the NHS Constitution and NHS Professional Codes of Conduct.

By putting human rights at the heart of health services we can not only comply with the law but also improve the quality of patient care.

As a Trust we have the responsibility to respect people's rights to ensure that everyone counts. For example employees having the right to be treated with dignity and respect such as ensuring that we do not discriminate.

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2 THE TRUST'S EQUALITY AND DIVERSITY STRATEGY

2.1 Commitment to Equality and Diversity

The Trust believes in the dignity of all people and their right to respect and equality of opportunity. The Trust values the strength that comes with difference and the positive contribution that diversity brings to the hospital. The Trust operates within a national framework of equality legislation, however, the Trust aims beyond simple compliance with the law. Equality is central to all that we do.

The Trust sees equality of opportunity and access as a vital part of its approach to become a model employer. It is committed to ensuring staff are recruited fairly and are provided with a positive and valuing work environment which supports them to achieve their maximum potential.

The Trust's commitment to equality and diversity also aims to continuously improve its working practices so that it creates an organisation which is recognised both internally and externally for embracing diversity and human rights and demonstrating equality in practice.

The Trust is committed to putting the principles of equality and diversity into practice for its workforce and the Trust pledges it will:

- Promote equality and diversity and human rights and work towards eliminating all forms of discrimination
- Develop a culture that values individuals and groups regardless of their backgrounds
- Forge partnerships with staff and stakeholders so they can influence the development and improvement of services.

2.2 The Equality Delivery System 2 (EDS2)

EDS2 was launched in November 2013. Its main purpose is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2 NHS organisations can also be helped to deliver on their Public Sector Equality Duty.

At the heart of the EDS2 is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership.

The EDS2 self –assessment has been undertaken and the outcomes have shaped and been mapped to form our equality objectives for the next 4 years.

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2.3 Workforce Race Equality Standard (WRES)

NHS England took the decision to introduce a national Workforce Race Equality Standard as a clause in the 2015/2016 contract alongside the mandating of the refreshed Equality Delivery System (EDS2). This decision was made following numerous reports that evidenced systematic discrimination against Black and Minority Ethnic (BME) staff in the NHS. The evidence from the reports highlighted that people from a BME background are less likely to be appointed once shortlisted, less likely to be selected for training and development programmes, more likely to experience harassment, bullying and abuse and more likely to be disciplined and dismissed.

The Standard is made up of nine indicators and these will highlight any differences between the experience and treatment of White staff and BME staff in the NHS with a view of encouraging and enabling NHS organisations to reduce the differences. The introduction of the Standard is intended to provide a real impetus, not just on race but equality in general and if successful the approach may be adapted for other protected characteristics.

The Standard will compliment and support EDS2 and our Public Sector Equality Duty. The initial baseline data exercise was undertaken in April 2015 and will be repeated annually to identify improvements, deteriorations or significant gaps between the treatment and experience of White and BME staff. This will then determine what actions we need to undertake to reduce any gaps between the treatment and experience of our BME staff.

2.4 The Trust's Workforce Equality Objectives

The Trust has agreed equality objectives for our workforce. The objectives set encourage an outcome focussed approach to setting challenging but measurable targets to improve the way we employ and support our staff.

The objectives address the biggest and most pressing issues facing the protected groups that we employ, prioritising the most significant issues for the protected characteristics, based on the outcomes of our EDS2 self-assessment and our annual WRES exercise.

Goal	Objective
1. Representative and supported workforce	We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing WRES and monitoring outcomes.
2. Inclusive leadership	We will improve our leadership and management capability.

The detailed Trust's equality objectives can be found at appendix 1. Progress on these are updated on a six monthly basis and the current version can be access via the Trust's internet. The link to this is:
http://www.northamptongeneral.nhs.uk/WorkforUs/Equality,DiversityHumanRights/Equality,DiversityHumanRights.aspx

2.5 Reporting Structure for Monitoring and Evaluating the Trust's Workforce Equality Objectives

The Trust has an Equality and Diversity Staff Group (EDSG) which is chaired by the Trust's Director of Workforce and Transformation. The multidisciplinary group meet quarterly and are committed to embedding a culture of equality, diversity and human rights into all aspects of everyday life at the hospital.

The purpose of the group is to champion and steer the work of Northampton General Hospital (NGH) so that the Trust is in full and positive compliance of equality, diversity and human rights legislation, regulations and codes of practice including NHS and DoH standards in relation to staff.

The EDSG reports to the Workforce Committee twice yearly and reports annually to the Trust Board by way of the Director of Workforce and Transformation.

3 THE TRUST'S DELIVERY OF THE EQUALITY DUTIES

3.1 Eliminating Discrimination, Harassment and Other Prohibited Conduct

The Trust proactively aims to eliminate discrimination, harassment and other prohibited conduct by carrying out Equality Analysis on all procedural documents and services. When incidents of discrimination do occur we have robust policies and practices in place to address this and these are monitored on a regular basis.

Staff Harassment and Discrimination Policies

Staff wishing to raise a complaint of harassment against a colleague or manager may do so through the Trust's Bullying, Harassment and Victimisation Policy and where allegations are founded these matters are dealt with through the Trust's Disciplinary Policy. The Grievance Procedure covers all other types of discrimination including failure to make reasonable adjustments.

In addition, the Trust has the Protecting Staff Against Violence, Aggression, Discrimination And Harassment from Patients and Public Policy as it believes that all staff have the right to work in an environment free from violence, aggression and harassment and where appropriate can take and support action to protect staff. The purpose of this policy is to provide managers and staff with a clear process for the prevention and management of violent aggressive and harassing incidents towards staff by patients and members of the public.

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Further advice on these policies is available from the Human Resources Department or Trade Union/Professional Organisations Representatives.

Training

Every employee of NGH must comply with equality law and the statutory equality duties, including the elimination of unlawful discrimination and the promotion of equality in employment and service provision.

Training for staff regarding these issues, as well as training regarding issues related to specific protected characteristics, will be provided in a variety of formats to ensure training regarding equality, diversity and human rights is available for all staff.

The promotion of equality, diversity and human rights in both service provision and employment requires the development of appropriate learning and development arrangements.

The Trust provides equality and diversity training for all staff including the Trust Board and it forms part of the Trust's mandatory training programme. Avoiding and tackling discrimination, harassment and other prohibited conduct is also a specific feature of the Trust's induction.

Further information regarding this is available from the Human Resources Department.

3.2 Advancing Equality of Opportunity

Vision and Values

The vision of the Trust is to provide the best possible care to all our patients and this vision is underpinned by our values:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each other.

Supporting the Trust to achieve these are a number of key strategies.

Making Improvements

In order to meet the general equality duty, as well as to demonstrate the outcomes in the specific duties, it will be necessary before decisions are taken, policies adopted or practices changes, to ensure that an Equality Analysis is undertaken to assess the equality impact of what is proposed. The outcomes of undertaking Equality Analysis and demonstrating due regard are:

- It ensures that activities and procedural documents do not discriminate.
- It helps to promote equal opportunities
- It helps to identify if certain groups are, or could be, disadvantaged by a procedural document or a change

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- It identifies where changes may be required to promote equality and eliminate discrimination.

Consideration will be given to:

- Effective processes and communication with staff
- Physical access
- Provision of information in a format which can be understood
- Cultural norms, preferences and practices of equality groups taken into account
- Available relevant data and staff feedback.

Trust and Directorate business plans will include reference to, and specific actions of, equality actions.

Through the equality analysis processes it will ensure that the Trust is able to:

- Remove or minimise disadvantage experienced by people connected to 'protected characteristics'
- Take steps to meet the needs of people who share a protected characteristic where these are different from people who do not share it
- Encourage people who share a protected characteristic to participate in work activities or any other activity where participation is disproportionately low.

3.3 Fostering Good Relations

An annual appraisal is undertaken by all staff each year and the appraisal is aligned to the Trust Values. In addition evidence of understanding and knowledge of equality and diversity issues needs to be provided by staff and discussed at their appraisals.

To tackle prejudice and promote understanding, this strategy includes actions to address the inclusion of diversity.

3.3.1 Engagement, Involvement and Consultation for Staff

Partnership Forum

The Trust has an active Partnership Forum and Operational Subgroup as well as a Local Negotiation Committee (LNC) that meet on a regular basis. Unions, Professional Organisations and management of the Trust attend both committees.

The hospital promotes partnership working and has jointly developed a Partnership Agreement. The Agreement is based on the Trust's vision, values and a set of shared principles.

Staff Involvement – Staff Survey

Our intention to become an Employer of Choice is based on developing an organisational culture whereby all staff can give their best and thrive. Our belief is that all staff should feel respected and valued and that individual commitment and dedication is recognised. Our actions in respect of this are translated into our

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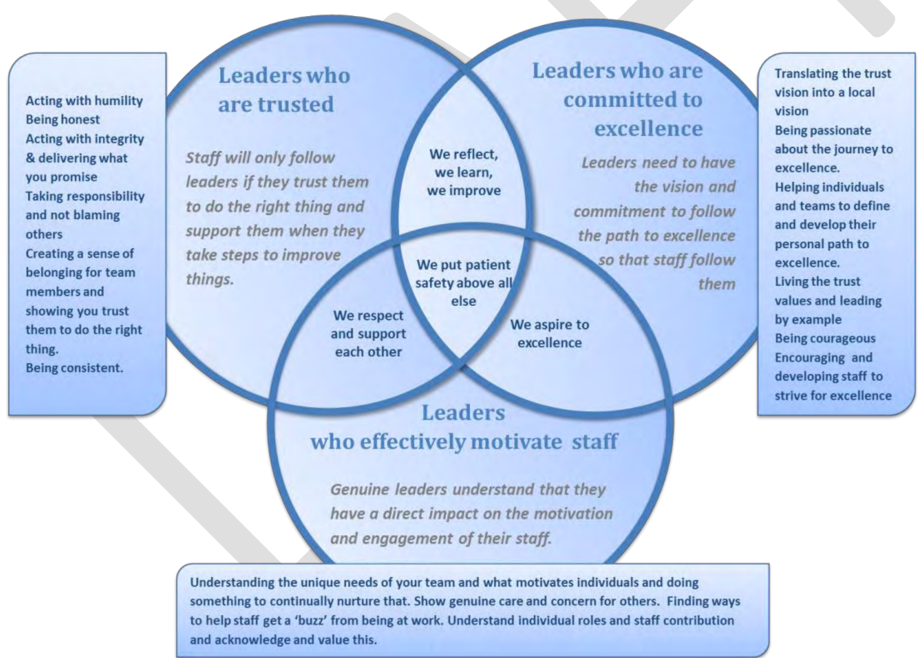
Organisational Effectiveness Strategy - Connecting for Quality, Committed to Excellence. This strategy underpins our work in developing the right culture, which is supported by our Staff Engagement Strategy and our leadership model.
The Trust endeavours to ensure that people find it easy to raise their concerns, including those from the "hard to reach" groups including through the following activities:

- Results from the Staff Family and Friends Tests
- Issues raised in via Trust policies
- Analysing the results of the equality and diversity monitoring exercises to staff experience
- Analysing the data collated as part of the WRES.

Trusts Leadership Model

The Francis Crick Programme is the vehicle for helping enable our clinical leadership model. The leadership skills development is based around the NGH Leadership model shown below:



In developing the Francis Crick Programme, it became clear that in order to equip our leaders with all the skills required to achieve our goal, integration with our managing for quality theme, was key to success. The Francis Crick Programme offers bespoke Leadership and Management development for our senior leadership community operating in an acute healthcare context.

- Leveraging commercial savviness for financial stability
- Driving sustainable quality and safety practise that delivers the best possible care

- Building trusted leadership that excels high organisational performance
- Stringent governance that delivers healthcare assurance and compliance.

The Programme is under consistent scrutiny to ensure that it is fit for purpose and maintains the flexibility to respond to the bespoke challenges our leadership community faces.

3.4 Monitoring and Publishing Information

Equalities monitoring data is the information the Trust collects about the demographics of our community and staff. We will utilise the information to understand those who are experiencing discrimination or barriers for those employed by the Trust.

Monitoring can be used to:

- Improve our knowledge and understand our staff and their requirements
- Find out what barriers exist for our employees or potential employees
- Understand what kind of improvements also improve satisfaction of staff within the Trust
- Identify whether we are treating people fairly, with dignity and respect
- Inform development and planning.

The Trust believes that monitoring is an important way of measuring the effects of policies in practice and is a vital part of any strategy to promote equality, diversity and human rights in the organisation. Without monitoring there is no reliable way of knowing whether discrimination might be taking place, how or why it takes place or whether the Trust's policies to prevent or tackle it are working.

Workforce data is collected and monitored relating to the protected characteristics as defined in the Equality Act 2010. Data analysis will influence the Trust on future activities and this information will also identify areas of under representation across the workforce whether this is in specific areas of work or in relation to salary bands.

In addition to the monitoring process the Trust will collect information by a range of different methods so that it is capable of assessing its performance and improving its services, these include:

- Keeping records of our workforce
- Satisfaction surveys, with results analysed by target groups
- Random or targeted personal interviews.

The Trust's Employee Staff Record (ESR) is used to collect employee data relating to the protected characteristics. The Trust will review the type and amount of information collected to ensure that adequate data is available to determine the effect its functions and policies have on minority groups.

Under the lead of the Human Resources Directorate, each Division and Directorate will ensure that there is fair recruitment and aim for a representative workforce so as to create a working environment that is safe, accessible for all, and free from harassment and discrimination.

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The Trust is required to publish sufficient information to demonstrate our compliance with the general duty across our functions.

3.5 Procurement and Commissioning

Many of the goods and services provided to the Trust are procured or commissioned from external suppliers/contractors. The NHS Purchasing and Supply Agency's procurement terms and conditions used by the Trust have specific clauses covering equality and diversity. Trust staff responsible for purchasing/commissioning will use these conditions as a minimum to ensure fair and proper practice is followed.

4 QUALITY AND COMPLIANCE – INSPECTION AND ENFORCEMENT

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) to deliver certain types of care to a wide range of standards: the 'Essential Standards of Quality and Safety'. The Trust participates in CQC reviews and inspections of our healthcare. These standards were introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 and the Care Quality Commission (Registration) Regulations 2009. The regulations include 28 outcomes grouped under the following headings:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management.

The activities contained within this strategy are harmonised with the relevant CQC outcomes because addressing equality is a marker of good quality.

The Care Quality Commission is the independent regulator of health and social care in England. The Care Quality Commission measures the quality of health care provided by the Trust and part of that includes equality.

Equality and Human Rights Commission

The Equality and Human Rights Commission (EHRC) is a statutory body independent of government. Its responsibilities include:

- Ensuring people are aware of their rights and how to use them
- Helping employers and service providers develop best practice
- Ensuring policymakers promote equality
- Using their powers to enforce the laws that are already in place:
    - Investigations

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- Agreements not to commit an unlawful act
- Judicial review and interventions
- Inquiries
- Injunctions
- Applications to restrain from unlawful advertising,
- Pressure to discriminate.

The Equality and Human Rights Commission have formal joint-working practices with the Care Quality Commission.

5 FURTHER INFORMATION

Further information regarding equality, diversity and human rights are available on the Trust's internet at

http://www.northamptongeneral.nhs.uk/WorkforUs/Equality,DiversityHumanRights/Equality,DiversityHumanRights.aspx.

All documents can be made available in a range of accessible formats and languages upon request.

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Appendix 1

Equality & Diversity Staff Group
Equality Objectives Four Year Plan 2016 – 2020

Equality Delivery System Goal	Narrative: The NHS is asked to……	Objective	Lead	Key Actions	Detailed Actions / Progress Report	Timescales	Completed/ Ongoing
1. Representative and supported workforce	The NHS should increase the diversity and quality of the working lives of the paid and unpaid workforce supporting all staff to better respond to patients' and communities' needs.	We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing WRES and monitoring outcomes.	Assistant Director of Organisational Development	Continue to implement the staff engagement strategy centered on the Trust's vision and values and the desired behaviors and performance of staff.	Organisational Development Team to continue to leading on staff engagement, culture, communication and behaviours.	Ongoing	
			HR Business Partners	To become health promoting trust that makes an active contribution to promoting and improving the wider health and wellbeing of our staff.	Implement the health and wellbeing strategy with the aim of improving the health of employees and to help to reduce inequalities.	Ongoing	
			Deputy Director of HR	On completion of the annual Workforce Race Equality Standard (WRES) baseline data exercise carry out a gap analysis against the previous year's data and take appropriate action in relation to the indicators that relate to the workforce and continue to monitor these.	Carry out an audit on the recruitment and shortlisting processes to previous senior posts to identify what actions are required.	June 2016	Ongoing
					Continue the recruitment training for managers which includes a session on equality awareness.	Ongoing	
					Align the staff survey and patient experience results through the Organisational Development department and based on any findings implement any required actions.	Ongoing	
					Programmed series of materials planned to help staff and colleagues recognise, address and report potential harassment and bullying.	Ongoing	
					Monitor and report on non-mandatory and	Ongoing	

STRATEGY

					CPD training by ethnicity.		
					Carry out a gap analysis of Trust equality and diversity activity against NHS Employers Equality & Diversity in Practice Top Ten Tips.	Commenced June 2016	Ongoing
			Assistant Director of Organisational Development	On receipt of the annual Staff Survey results carry out gap analysis and take appropriate action in relation to the key findings that relate to the workforce.	Analyse the full report provided by the Department of Health along with the survey administrators own electronic reporting toolkit to identify areas of concern and improvements.	Annually each February / March	

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Equality Delivery System Goal	Narrative: The NHS is asked to……	Objective	Lead	Key Actions	Detailed Actions / Progress Report	Timescales	Completed/ Ongoing
2. Inclusive leadership	NHS organisations should ensure that equality is everyone's business and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions.	We will improve our leadership and management capability.	Assistant Director of Organisational Development	Continue to implement the Trust values.	Organisational Development Team to continue to work across the Trust providing Rainbow Risk and other associated tools and embedding the Trust's values.	Ongoing	
			Deputy Director of HR	Empower each Division to set and be accountable for their own equality and diversity objectives through the clinically led structure with divisional links to the Equality and Diversity Staff Group.	Each Division to be provided with Equality and Diversity data for their areas and with the support of their HR Business Partner analyse the data to identify if there are any areas for improvement/objectives that can be set. Each Division to also have a nominated lead to represent them at the Trust's Equality and Diversity Staff Group.	Commences September 2016	
			Assistant Director of Organisational Development	Continue the leadership and management development programme including behaviours for the Trust.	The Leadership development programme (Francis Crick programme) to be delivered to the senior leaders in the new structure. The first co-hort of 50 to complete their programme in 2016/2017 and the second co-hort to commence in 2016/2017. 4 levels of Leadership Development programmes in progress. The Francis Crick programme, New Consultant Development and Band 6 & 7 Development. The Trust is looking to create a new programme for Team Leaders during 2016/17.	2016/2017	Ongoing
			Deputy Director of HR	On completion of the annual Workforce Race Equality Standard (WRES) baseline data exercise carry out a gap analysis against the previous year's data and take appropriate action in relation to the indicators that relate to	Actively encourage candidates to apply for senior management roles from BME backgrounds.	Ongoing	
					Roll out of further equality training for managers.	Ongoing	

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				leadership and continue to monitor these.			
			Assistant Director of Organisational Development	On receipt of the annual Staff Survey results carry out gap analysis and take appropriate action in relation to the indicators that relate to leadership.	Analyse the full report provided by the Department of Health along with the survey administrators own electronic reporting toolkit to identify areas of concern and improvements.	Annually each February / March	

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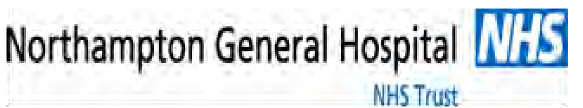

Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Sustainable Development Strategy
Agenda item	16
Presenter of Report	Charles Abolins, Director of Facilities and Capital Development
Author(s) of Report	Dr C Topping, Energy and Sustainability Manager
Purpose	For Information and approval
Executive summary The Sustainable Development Strategy 2016-2020 replaces the previous 2010-2015 strategy. The 2016-2020 strategy incorporates a section entitled our "Journey to date 2010-2016" and from this can be seen the significant improvements made over recent years. This new strategy is a statement of intent moving from predominantly energy and waste to more broad based sustainable healthcare, including; Procurement, Health and Wellbeing as well as implementing sustainable practices and technology for models of care. The first of a number of annual action plans is also included and progress will be reported through the Sustainable Development Committee and to the Board. As part of our commitment to a sustainable future for NGH it is proposed to sign a pledge to meet the 2020 Healthcare Challenge (briefing attached). The Sustainable Development Strategy 2016-2020 helps foster climate friendly healthcare and the trust Board are therefore requested to support this pledge.	
Related strategic aim and corporate objective	To ensure a sustainable future
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 3.1, 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or

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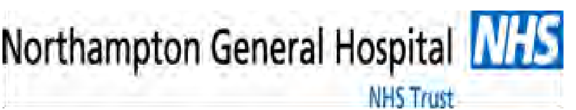
	promote good relations between different groups? (Y/N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	Yes. Compliance with environmental legislation

Actions required by the Trust Board

The Board is asked to: approve or endorse the 2016-2020 Sustainable Development Strategy



Public Trust Board
29 September 2016
Sustainable Development Strategy

- Replaces the 2010-2015 strategy

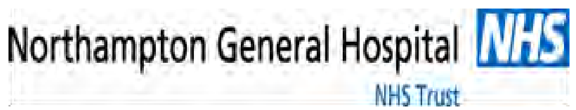
- Is a statement of intent – moving away from just energy and waste to sustainable healthcare
  - Procurement
  - Models of Care
  - Use of ICT
  - Promotion of Health and Wellbeing
  - Collaboration with local partners

- Is part of the requirement of the contract with the CCG:
  The long form of service condition SC18 currently states:
  - *18.1 In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment.*
  - *18.2 The Provider must maintain a sustainable development plan in line with NHS Sustainable Development Guidance. The Provider must demonstrate its progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans, and must provide a summary of that progress in its annual report*
  - *18.3 The Provider must, in performing its obligations under this Contract, give due regard to the impact of its expenditure on the community, over and above the direct purchase of goods and services, as envisaged by the Public Services (Social Value) Act 2012.*

- A new action plan will be created each year and reported through the SD Committee and to the Board.

- Aims to protect against risk from both climate change and future regulation changes and the challenges they pose to delivery of healthcare.

- Works with the principle that delivering healthcare in a more sustainable and less wasteful way can save money in both the short term and long term.



A Leadership Pledge by Hospitals, Health Centers and Health Systems from Across the Globe

Climate change, as The Lancet Commission put it in 2009, is “the biggest public health threat of the 21st Century.” Since then, the climate crisis has only deepened, and the science has become increasingly irrefutable, heightening the urgency for action.

We know that climate change is already exacerbating a wide range of health problems the world over. As the earth warms, infectious diseases like malaria and dengue are spreading to new locations, threatening to reverse hard won health gains in many parts of the planet. Heat waves are growing in intensity and number, killing tens of thousands outright and aggravating asthma, heart disease and heat stroke. Increasingly severe storms, droughts and floods, harm human health and put oft-overstretched and ill-prepared health systems at risk.

If greenhouse gas emissions remain unchecked, climate change will, within a matter of decades have severe pervasive and irreversible effects, undermining the food and water supply in many parts of the world, setting off mass migrations, and thereby triggering potentially unmanageable public health crises. While everyone will experience the scourge of climate change, the most vulnerable populations–the urban and rural poor, those who are least responsible for the problem—will suffer the greatest impacts.

Fossil fuel combustion—particularly burning coal–is the single greatest contributor to greenhouse gas emissions. Fossil fuels are also the source of significant local health problems. For instance, fossil fuels make a major contribution to air pollution, which, according to the World Health Organization, killed seven million people in 2012, causing twice as many deaths than AIDS, malaria and tuberculosis combined.

In order to protect local and global health from climate change and its sources, the world needs to move toward an economy based on clean, renewable, healthy energy. Indeed, a transition to a clean energy economy will benefit both the climate and public health.

As health care providers—hospitals, health systems and government health institutions—we recognize that we can play a leadership role in this transition.

We pledge to do our part to meet the challenge posed by climate change —a test perhaps as great as human civilization has ever known—by taking the following steps:

1. **Reducing Our Own Climate Footprint:** Our collective vision is to reduce our health care systems’ emissions, moving toward low carbon, and ultimately, carbon neutral health care. Many hospitals in most parts of the world are major energy consumers and can make large reductions in greenhouse gas emissions. Other hospitals and health systems are energy-starved, and can deploy renewable energy to foster better health outcomes. We pledge to lead the way toward low-carbon health care by setting greenhouse gas reduction and renewable energy targets for the year 2020 and increasing our ambition thereafter. We will work to implement energy efficiency measures and, when feasible, deploy clean renewable energy to power our buildings. We will measure and report on our progress, including financial savings related to these actions. We will also seek to identify our institutions’ other climate impacts, including transportation systems, purchasing policies, waste generation

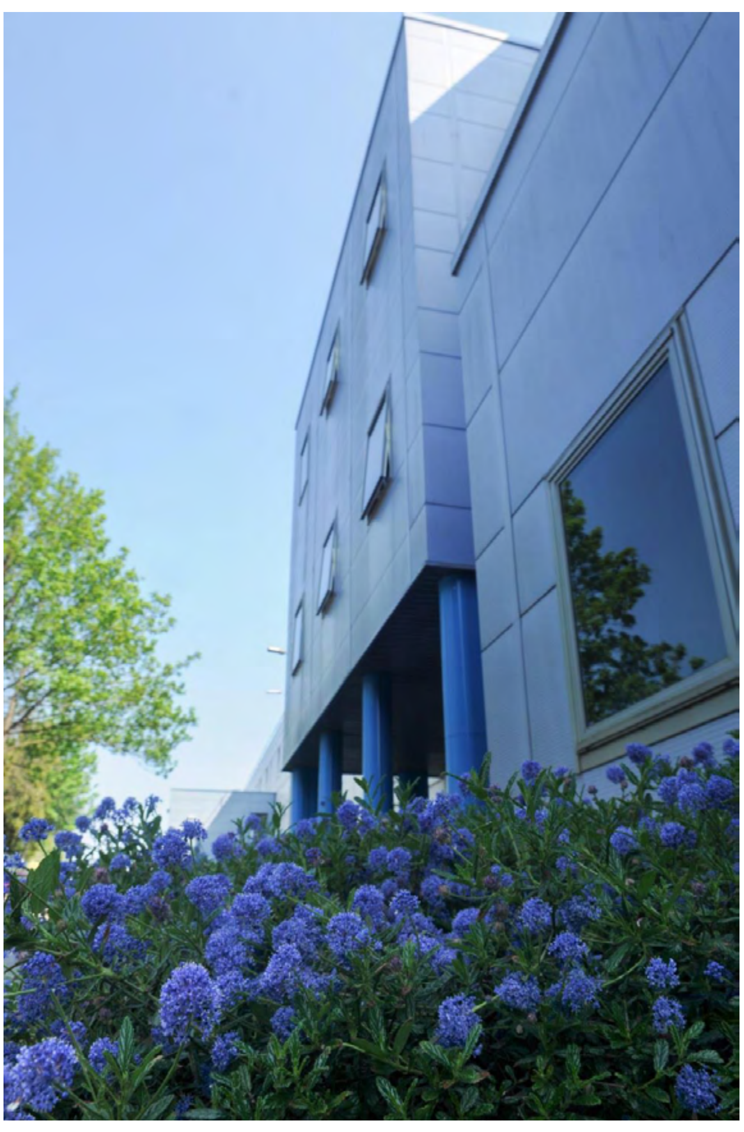
and disposal. We will begin to develop and implement plans to reduce these impacts as well.

2. **Preparing for Climate Impacts:** In order to serve our communities, hospitals and health centers need to remain operational during and after an extreme weather event. We need to understand, anticipate and be equipped to manage the health needs of our immediate community and prepare for shifting disease patterns. We pledge to prepare for the impacts of climate change by becoming more resilient to increasing incidents of extreme weather. We will work to implement a series of measures to assure that our physical infrastructure, staff, and communities are prepared for the immediate impact of extreme weather events, and the longer term impacts of changing patterns of disease, as well as other climate impacts, combining these efforts with low-carbon solutions whenever possible.
3. **Leading the Way to a Low-Carbon Future:** As health care providers respected by local communities, government and business, we commit to provide leadership in our societies for a healthy climate. We pledge to do so by educating health care professionals and hospital staff, as well as the communities in which we are located, on the challenges and solutions related to climate and health. We also pledge to encourage public policy, economic development and investment strategies that move our societies away from fossil fuel dependency and foster instead a healthy energy future, thereby protecting local and global health from climate change.

By moving toward low carbon health systems, health care can mitigate its own climate impact, save money and lead by example. By becoming more resilient, health care can help prepare for the growing impacts of climate change. And by providing societal leadership we can help forge a vision of a future with healthy hospitals and healthy people living on a healthy planet.

At this crucial juncture, the time to act to protect public health from climate change is now

Northampton General Hospital
NHS Trust



NORTHAMPTON GENERAL HOSPITAL NHS TRUST

CARING FOR THE FUTURE

Sustainability Strategy 2016-2020 | Clare Topping

Enclosure L

'Climate Change is the biggest opportunity for global health of the 21st Century.'

The Lancet 2015

Introduction

The 2015 update of The Lancet's 2009 report, warned once more that global climate change could undo 50 years of medical progress against health inequalities. But, they included good news; anything that we do to reduce climate change is likely to improve individual and global health outcomes.

In 2010 Northampton General Hospital published its first Sustainability Strategy, starting the process of embedding sustainability into the Trust's daily business. The goals were to establish governance structures, conserve energy and improve waste management. NGH has made substantial progress in all of these aims and is now pushing sustainability beyond its traditional home in the Estates Department. The intervening years have seen major changes: to the structure of the NHS, the available finance, the emphasis within sustainability and the available technologies. This new strategy builds on progress already made and outlines the NGH's response to addressing climate change, promoting resource efficiency and sustainable healthcare. Where appropriate, elements of the NHS Sustainable Development Unit's Sustainability Strategy from 2014/15 have been incorporated.

The Trust's commitment to sustainability is part of its board approved Clinical Services Strategy; one of the five strategic aims is to ensure a sustainable future. This sustainability strategy links with the complementary Travel Plan, Estates Strategy, Food Strategy and Procurement Strategy and ChangingCare@NGH program.

Success will result in a healthier workforce, working on a site that has minimal environmental impact, delivering care in the most efficient manner through achievement of objectives relating to six main themes:

- Direct environmental impact
- What we buy
- Changing behaviours both at work and in the community
- How we deliver our services
- How we will cope with the changing global and local situation
- Governance and reporting

Sustainable Healthcare and Northampton General Hospital

Sustainable healthcare means delivering health and social services in a way that is as effective and efficient as possible. The most sustainable system minimises unnecessary or ineffective use of resources (financial or natural) by delivering the right care, in the right place, at the right time – and by preventing care needs from arising at all. To achieve this will need changes to how, where and what care is delivered.

To deliver healthcare in financially and environmentally sustainable ways requires the same things: a focus on value, prevention of avoidable activity and cost-effectiveness. It is therefore a win-win situation; negative environmental impacts can be reduced whilst generating cost savings.

As the largest employer in the UK, the NHS is responsible for carbon emissions above that of many mid-sized countries. NGH, being the largest employer in the Northampton, has the opportunity to promote sustainable healthcare practices and set a leading example of a forward thinking healthcare institution.

'Wherever there is wasted expenditure, there is avoidable environmental damage as well'

Kings Fund 2012

Drivers for Change

We will need to adapt our healthcare delivery methods because of:

- *Finance*
  - Reduced finance from central government
  - Reduced Local Government funds for social care
  - Increasing utility costs
  - Resource scarcity driving higher food and raw material prices
  - Climate related taxes
- *Climate Change*
  - Warmer winters and hotter summers will change admission patterns
  - Increased cooling requirements will add to the environmental impact of buildings
  - Flooding will become a higher risk
  - Potential impacts on local infrastructure and supplies, particularly those imported, from increased frequency of severe weather events.
- *Demographics*
  - Aging population
  - Increased life expectancy
  - Rising levels of lifestyle related diseases such as diabetes and obesity
- *Expectations*
  - Staff, patients and visitors expect hospitals to proactively manage waste
  - An Ipsos MORI poll in 2011 found that 92% of respondents thought that the NHS should work in a more sustainable way, with 33% saying they should do this even if it costs money.
  - Increasing evidence links unsustainable practices and environmental damage with adverse health effects, e.g. diet, pollution
- *Legislation*
  - Carbon Reduction Commitment
  - Annual reporting requirements
  - Climate Change Act – requires a reduction in carbon emissions of 34% by 2020
  - Water, waste and air quality legislation
  - Planning permissions increasingly require organisations to proactively reduce travel related pollution.

Carbon Emissions reduced by 22%

Over 150 electricity submeters installed

Over 50% of domestic waste recycled

Health and Wellbeing Strategy in place

Over 50 Sustainability Champions

Investors in the Environment Green Accreditation

Bronze Food for Life Accreditation

Our Journey to date… 2010 to 2016

Northampton General Hospital started on its journey to a more environmentally conscious organisation in 2010 with its first Sustainability Strategy and the development of its first Carbon Management Plan. Since then we've made significant sustainability improvements, all of which are reported through the Sustainable Development Committee and in the Trust's annual report.

Reduced Carbon Emissions from Buildings

- 22% reduction to 11,215 tonnes in 2015/2016
- New energy centre - £3 million investment delivering 3,000 tonnes of $CO2_e$ saving and £500,000 net energy saving every year.
- Over £1.5million invested in energy efficiency measures through Salix funding

Improved reporting and metering

- Calculation of carbon footprint from anaesthetic gases, business mileage and staff commute and calculation of organisation carbon footprint using the Procuring 4 Carbon Reduction tool
- Installation of over 150 electricity submeters
- Establishment of a cross-functional Sustainable Development committee
- Inclusion of sustainability achievements in each Annual Report

Better waste management

- Trust-wide mixed recycling system with approximately 25% of recyclable waste segregated at source.
- Additional recycling of metal, pallets, inhalers and X-Rays.
- New waste contract with an emphasis on innovation
- Reuse platform implementation

Health and Wellbeing

- Cycle to Work scheme to reduce cost of bike ownership
- Additional bike storage facilities
- Regular Dr Bike sessions with over 75 bikes checked and serviced
- Regular health walks
- Health and Wellbeing steering group established

Engagement and education of staff

- Formation of a network of more than 50 sustainability champions
- Communication through a monthly sustainability newsletter
- Participation in national NHS Sustainability Day each year

External accreditation and awards

- Green accreditation through the Investors in the Environment scheme and Overall Achiever for 2015
- Bronze Food for Life accreditation achieved for patient meals
- New Energy efficient data centre, shortlisted for an environmental award
- Shortlisted in 2015 for the HSJ Awards for Improving Environmental and Social Sustainability

Reduce the Environmental Impact of NGH

Carbon Emissions

The carbon footprint from heating and lighting the NGH Estate has been measured since 2010. As part of the government's statutory targets we are tasked with reducing emissions by 34% by 2020 (the equivalent to 28% compared with 2013).

This will be achieved by:

- Utilising Salix funding to improve energy efficiency in buildings
- Including energy efficient technologies and whole life costing for new-build and refurbishment projects to determine the optimum technology
- Challenging contractors to produce energy efficient solutions and to quantify the savings
- Looking for innovative solutions to improve energy efficiency
- Ensure high maintenance standards are the norm for existing plant and equipment
- Incorporating renewable energy sources as the primary source of power for any new building projects
- Continuing the education and engagement of staff to ensure they understand their role in reducing energy consumption

Water

Water is a commodity that with increasing population and warmer summers is likely to become increasingly scarce and expensive, even in the East Midlands.

NGH will reduce its water consumption by:

- Working with its supplier and installing additional meters
- Installing water efficient technologies
- Fixing leaks in a timely manner

Waste and Recycling

As well as waste disposal being a significant financial cost, waste and resource efficiency is an area which has shown innovation and improvement in the last decade. It is also an area of the sustainability agenda that resonates with the majority of the population.

NGH will:

- Work with its waste management suppliers to find opportunities to extract maximum value from its waste stream.
- Introduce more robust processes for reuse within the Trust
- Improve employee and visitor engagement and education
- Increase recycling facilities
- Review process methodologies to determine where waste is produced.
- Continue to seek innovative technologies, particularly with respect to the closed loop and circular economies

Progress against these targets will be measured and reported annually, as a minimum, through the SD Committee and in the annual report.

By 2020 we will have:

Reduced:

carbon emissions by 28% compared to 2013

water usage by 2% each year

all waste from patients by 2% each year

Increased:

Recycling by 5% each year

The uptake of low carbon travel

Biodiversity

And:

Assessed and reduced carbon footprint from procurement

Integrated sustainable and ethical procurement practices

Enhanced our green spaces

Enclosure L

Increase the uptake of active and low carbon travel

Active travel reduces pollution and carbon emissions and improves the physical health of staff. Studies have shown that those who cycle, walk or use public transport to get to work are happier than those commuting by car; particularly if the car journey is more than 20 minutes long.

NGH carried out a staff survey to determine the level of active travel amongst staff and, along with information about business travel, calculated an approximate carbon footprint.

In the next five years NGH will:

- Create a new travel plan focussing on active and low carbon travel
- Work with the local university, council and other healthcare providers in the town to create a joined up approach to reduce the number of cars coming into Northampton.
- Work with potential suppliers to create viable alternatives to car use and reduce grey fleet emissions
- Utilise existing resources and technologies to provide more opportunities and information to reduce car use by staff and visitors.

This will be measured through annual surveys to determine any improvements made through ongoing provision of improved facilities, information, engagement and innovative solutions.

Enhance and improve access to green spaces and biodiversity on the NGH site.

NGH is unfortunately in a town centre location, where space is at a premium. However, studies have shown a direct link between the access patients have to nature and views of nature and reductions in lengths of stay, improvements in sleep and reductions in requirements for pain medication. In addition, the ability to go into green spaces has shown a calming effect for both staff and patients. The addition of shrubs, trees and green roofs has also been shown to reduce the urban heat island effect (the build-up of heat in concrete and built up areas) by several degrees.

As more and more areas are used for buildings, it is important to provide green refuges for insects, birds and animals.

NGH will:

- Include outdoor spaces in any refurbishment projects,
- Ensure that its grounds and gardens contracts are run with biodiversity in mind
- Improve and create access to the existing outdoor spaces.

Progress will be reported on a qualitative basis through the annual report.

What We Buy

The NHS calculated that the embedded carbon in the goods and services that are procured accounts for approximately 62% of the total carbon footprint. Acute hospitals are no exception to this.

Assess and Reduce the Carbon footprint from commissioning and procurement.

NGH started using the Defra Procuring 4 Carbon Reduction (P4CR) Framework as a first step to embedding sustainability in the procurement process and measure its progress. In the first year level one has been reached in all areas.

NGH will

- Continue to work through the P4CR Framework and use the tools within this to calculate an approximate annual carbon footprint. Where more accurate data is available it will be substituted into the calculation.
- Areas of high carbon emissions will be assessed for future project work.
- NGH will work with suppliers to help reduce the emissions from their operations.

The carbon footprint will be included in future annual reports.

Fully integrate sustainable and ethical procurement practices into procurement strategy, policy and processes for all goods and services including food and pharmaceuticals. Include a sustainability audit into all new initiatives.

Procurement practices, especially for an organisation the size of the NHS, can be used to drive innovation and sustainability through the supply chain. By improving the sustainability of its supply chain NGH can protect itself against reputational and business risk as well as lowering cost through reduced waste. As part of the drive to improve the sustainability of the procurement process.

NGH will:

- Introduce an inventory management system and standardise products to deliver reduced wastage and standardised processes, and achieve economies of scale.
- Include a sustainability assessment in all new initiatives and tenders
- Encourage SMEs to bid for work and maximise the social value act through its procurement processes
- Encourage the use of local suppliers and businesses.
- Work with suppliers to improve the sustainability of their products.
- Sign up to the Ethical Trading Initiative to ensure that labour standards are met within our supply chain as far as practicably possible.
- Take control of pharmaceutical use within NGH, through leveraging purchasing power in the manufacturing processes and improving wastage through stock management, incorrect use or overprescribing.
- Purchase food with consideration of food miles, seasonality, animal and worker welfare and removal of additives.
- Specify as a minimum that all food supply contracts must ensure that the Bronze Food for Life accreditation is maintained for all outlets and patient meals.

Progress will be reported through the Good Corporate Citizenship score, the number of tenders that include sustainability in the specifications, the value of goods purchased each year complying to Government Buying Standards, and the number of suppliers with environmental targets and commitments as well as Food for Life accreditation. A more quantitative outcome will be reported through reduced costs associated with the centralisation and standardisation of procurement and the inventory management system.

Build Healthy, Sustainable and Resilient Communities

Ensure staff, both present and future, have sufficient knowledge not only to make their actions and decisions as sustainable as possible, but also to promote sustainable actions to colleagues, patients and visitors.

Many of the reasons for lack of engagement in health sectors are cited as staff not having the correct knowledge or sufficient power to make changes, not understanding the financial and environmental costs of actions and ingrained habits.

These will be rectified through:

- Ongoing education of current staff; the education will be both general and directed towards specific job roles and departments.
- Provision of nursing education in conjunction with Northampton University
- Selecting for sustainable behaviours during the recruitment process
- Promoting sustainable behaviours through the appraisal process and reward programmes.
- Online learning
- Initiatives such as green theatres and healthy wards
- Awareness days such as NHS Sustainability Day
- Contributing to the development of services that enhance prevention, manage conditions in the community and identify when more specialist care is needed.
- Developing a communications plan to show the wider community our progress

Actively engage staff and wider communities in sustainable behaviours, particularly where improved health is the expected outcome (including the creation of a Health and Wellbeing Campus).

As part of its 5 year clinical strategy NGH committed to the creation of a Health and Wellbeing Campus in partnership with Public Health. The initial focus is on staff wellbeing. Through this the aim is to become an exemplar in staff, patient and visitor wellbeing through building strong local partnerships.

NGH will:

- Develop wellbeing programs for staff focusing on mental wellbeing, alcohol reduction, diet improvement, physical activity and smoking cessation.
- Broaden the program of work to encompass patients and visitors' wellbeing, with a purpose built facility at NGH to enable access to health interventions at the same time as the visit with a focus on prevention and direct support.
- Become a focus for the wellbeing agenda in the county.
- Promote investment to prevent illness discourage unhealthy lifestyles (for example consumption of too much meat)
- Promote the benefits of time spent with nature.

'The best thing that could be done for the environment, for quality of life and for the long-term viability of the NHS is to keep people healthy, stop people becoming patients in need of treatment. And you can do that in ways that are very environmentally friendly, by encouraging healthier lifestyles.'

Kings Fund 2012

NGH will:

Educate staff and patients about sustainability

Engage staff, patients and visitors in healthier, sustainable lifestyles

Prepare our Estate, people and services for the effects of Climate Change

And, ensure we are compliant with environmental legislation

How we cope with climate change

Assess risks relating to climate change and resource scarcity and mitigate these risks or adapt where mitigation is not possible – these include financial risks.

Climate change and resource scarcity, e.g. food, water, energy, could have an impact on the provision of services by NGH.

To manage these risks NGH will:

- Use the appropriate data and tools to assess the risks to infrastructure and Estates, as well as other soft FM and clinical services.
- Plan for the effects of climate change and the increased need for cooling in Estates decisions.
- Assess the risk of future shortages of key products critical to the delivery of core services and find more resilient alternatives if necessary
- Estimate the financial risk of climate change and resource scarcity to the Trust where possible
- Create and adaptation plan to ensure ongoing provision of services and, as appropriate, add risks to the local or corporate risk register

Ensure the Trust is compliant with environmental legislation and NHS sustainability reporting requirements.

In common with all other organisations, NGH is required to abide with environmental legislation, usually governed through the Environment Agency.

NGH will

- Maintain an up to date legislation register
- Perform regular audits on all aspects of legislation and ensure that actions are completed in a timely fashion.
- Report its environmental impact in line with SDU (Sustainable Development Unit) and HM Treasury guidelines
- Use the SDU's Good Corporate Citizenship tool to assess our progress and benchmark against other Trusts.
- Monitor and report progress annually

Ensure environmental management accreditation is maintained.

In 2014 and 2015 NGH achieved its Green Investors in the Environment accreditation. In 2014 we were also awarded Overall Achiever for its efforts to improve the environmental impact of the Trust.

NGH commits to maintaining this or a similar accreditation in order to provide external verification and validation of its progress.

Deliver our healthcare in the most sustainable way

Improvements in environmental sustainability also produce direct health benefits and can improve the quality of service for example by removing duplicate processes from care pathways and utilising advances in technology.

Implement innovative sustainable practices and technologies for both infrastructure and models of care.

NGH will:

- Continue to assess new technologies to reduce the environmental impact of our Estate.
- Use ICT to reduce travel of staff and patients taking advantage of advances in telehealth and telecare.
- Develop the care models offered through infrastructure and process improvements including remodelling of care pathways
- Expand its clinical trial and research project recruitment and enhance clinical networks for its delivery.
- Consider the environmental impact and toxicity of the materials and products used when delivering care.

Assess and adapt models of care to make them more sustainable through innovation but also by adopting best practice from other healthcare providers.

NGH recognises that for a sustainable future it needs to work in partnership to provide new approaches to care delivery. This aligns with the NHS SDU core aim of reducing hospital use to a minimum through prevention and care within communities and home settings.

NGH will:

- Learn from best practice and learn faster
- Evaluate financial and patient benefits from collaborative care models
- Integrate mental and physical health services around the service user.

NGH will collaborate with local hospitals and trusts, GP provider organisations, the CCG Northamptonshire County Council, and Northamptonshire Voluntary Impact to achieve these changes.

Over the next five years we will

Increase sustainability through innovation

Form partnerships and collaborations and share best practice

Develop metrics to show how environmental sustainability is interlinked with financial sustainability

Enclosure L

Collaborate with healthcare providers locally, nationally and internationally to share best practice and 'what works' in addition to local organisations and businesses.

NGH was a founding member of GGHH connect – an online collaboration platform for the Global Green and Healthy Hospitals network. This enables healthcare organisations around the world to share best practice and discuss barriers to improved sustainability.

NGH will

- continue to contribute to this platform as well as the other local networks that exist within the Northamptonshire, East and West Midlands region
- Learn from conferences and papers to find new ideas for improved care pathways as demonstrated by the implementation of Virtual Fracture Clinics
- Find best practice, develop joint sustainable service plans and collaborate on the use of assets.
- Work with charities, local providers, councils and businesses to share sustainability initiatives.

Develop metrics to show avoided costs (including avoided healthcare costs) and emissions from sustainability programs.

Reporting on the successes of sustainability initiatives is challenging as many of the benefits are difficult to determine quantitatively. As stated in the recent Lancet report, this is particularly true of avoided healthcare costs.

Until we can measure the costs and face decision makers with the true cost of the wider environmental impact, or costs deferred to following generations then there will be no buy-in to sustainable procurement and healthcare.

NGH will

- Start by measuring the easy stuff; reduced energy consumption, patient travel and waste avoided.
- Work with external organisations to develop metrics that reflect more of the benefits of a sustainable healthcare system
- Examine tools developed in other sectors to determine their suitability for adaptation by healthcare organisations.

Implementation, reporting and governance

This strategy has been agreed by the SD Committee and the Trust Board. Progress towards the objectives will be reported through the SD committee and in the annual report, through actions identified in an annually updated Sustainable Development Management Plan (SDMP). The SDMP will be presented to the board on an annual basis by the board lead for Sustainability; The Director of Facilities and Capital Development.

Additional reporting will be through the use of the Good Corporate Citizenship tool which can be used to benchmark progress as well as the annual report which will comply with Treasury guidelines for sustainability reporting for public sector bodies.

Next Steps

The detailed implementation of this strategy will be developed as a series of action plans in conjunction with the departments ultimately responsible for their delivery. The plans will include timelines and milestones and will be updated each year. Progress will be reported to the Sustainable Development Committee and through the Sustainability Newsletter with highlights included in the Annual Report.

Caring for the Future

Northampton General Hospital NHS Trust

Sustainable Development Action Plan 2016-2017

This year Northampton General Hospital has created a new strategy designed to build a more sustainable future, encompassing not just direct carbon emissions and waste, but also developing a strategy to deliver care in a more resilient, sustainable way. This Action Plan, being the first of five to span the years 2016-2020 is heavily biased towards the direct environmental impact of NGH. However, in future years, once this is business as usual, we will look at the impact of models of care from a sustainability perspective, delivering the right care, at the right time and in the right place.

Reduce Environmental Impact
Hotel Services Maintain Food for Life Status Patient Meals Achieve Food for Life Accreditation No 3 and Main Restaurants Encourage reduced meat consumption in staff restaurants Improve recycling within the Catering Department Create new travel plan focussed on active travel Determine potential costs and benefits for pool cars and lease cars to reduce emissions from grey fleet mileage Introduce new liftshare scheme Play an integral role in the Northamptonshire Total Travel Group Create shower facilities in the main building for cyclists and runners
Estates Improve submetering of water usage Create heat metering strategy Install heat meters to comply with heat network metering regulations Review potential for service line reporting Create strategy to deliver cooling across the Estate with the lowest environmental impact possible Replace calorifiers with plate heat exchangers Change peripheral theatre lighting to LED Review and optimise BMS system Determine additional sensors required to optimise VSDs Create specification to operate theatres on vsds by airflow thus utilising high efficiency filters Ensure BREEAM Excellent standard is achieved for new wards
Procurement Implement a robust process and procedure to ensure that items such as drip stands and lockers are refurbished Investigate how joining the Ethical Trading Initiative would impact on NGH Determine correct measures for annual reporting of impacts of sustainable procurement – and review annually Calculate Carbon Footprint using Defra P4CR tool Prioritise potential procurement streams for reducing carbon using DefraP4CR tool Determine which projects are suitable for whole life costing. Work with Supply Chain where appropriate Introduce an inventory management system to reduce wastage Ensure sustainability assessment is included in all tenders

Ensure new food contract includes specification of food for life accreditation
Ensure new food contract allows for a continually increasing level of sustainable food sourcing
Ensure Clinical Waste tender priorities sustainability and innovation
Waste
Review Baling options
Have robust refurbishment process
Implement Inhouse shredding
Set up waste group
Put standardised recycling into theatres
Complete legislation audit
Hold waste awareness day
Promote WarpIt platform across the Trust
Create resources for recycling education

Build Resilient Communities
Health and Wellbeing
Create Health and Wellbeing Action Plan
Create Health and Wellbeing Impact Wall to communicate initiatives to staff, patients and visitors
Enter teams into the Global Corporate Challenge
Offer GP Healthchecks to the over 40s
Carry out 3 month smoking cessation pilot with NHFT
Carry out annual health survey of staff
Open Althorp Garden for patient, staff and visitor use
Create outdoor space for discharge suite
Create at least one wildflower area
Increase Healthy Food options in Vending Machines
Serve a low calorie hot meal each day
Label sandwiches and salads with nutritional information
Governance and Climate Change
Create Sustainability Noticeboard to disseminate information about what NGH is doing and what staff can do to increase sustainable habits.
Assess major risks to NGH relating to Climate Change
Create Adaptation Policy to mitigate risks as far as reasonably practicable
Determine potential options for online learning about sustainability
Ensure Investors in the Environment Green Accreditation is maintained.

Deliver our Services in the Most Sustainable Way
Create Environmental Policy for Anaesthetics and Critical Care
Introduce recycling of single use metal instruments
Create plan for delivery of anti-coagulant service in community
Create business plan and process for delivery of virtual ward and medicine emergency response team
Assess options for delivering more sustainable healthcare through new and innovative IT systems

A Leadership Opportunity

2020 HEALTHCARE Climate Challenge

ABOUT THE CHALLENGE

As the climate crisis continues to accelerate Global Green and Healthy Hospitals (GGHH) is organizing the 2020 Health Care Climate Challenge (2020 Challenge) to mobilize health care around the world to protect public health from climate change.

The Challenge is based on three pillars:

Mitigation – Reducing health care's own carbon footprint and/or fostering low carbon health care.

Resilience – Preparing for the impacts of extreme weather and the shifting burden of disease.

Leadership – Educating staff and the public while promoting policies to protect public health from climate change.

The Challenge was launched in 2015 in a rolling series of events around the world, culminating in Paris at COP21, the UN Climate Conference, where leading health systems were recognized with awards. In 2016 thousands more hospitals and health systems are expected to participate in the 2020 Challenge.

WHO CAN PARTICIPATE?

Hospitals and health systems that sign the 2020 Challenge pledge on www.greenhospitals.net can participate.

Many of the initial participants have set ambitious mitigation targets of 30% or more carbon reduction by 2020. Yet all hospitals, health centers and health systems from everywhere in the world are encouraged to participate and help foster climate friendly health care.

HOW?

Each participant will:

Sign a pledge to reduce their carbon footprint, become more climate resilient and exert leadership for a healthy climate.

Establish carbon reduction targets for the year 2020 (or enter existing targets if they are already established).

Share data on progress over time.

Compete for Health Care Climate Awards which will recognize leaders globally, by region, and for each of the three pillars.

Receive an automatic membership in GGHH, and with it, access to tools and resources, including our online collaboration platform, GGHH Connect.

PARTICIPANTS

The 2020 Challenge currently has **80 participants, representing more than 9,000 hospitals and health centers in 23 countries**. As of July 2016, participants include (partial list):

Assistance Publique – Hôpitaux de Paris, **France**; British United Provident Association, **UK**; Buddhist Tzu Chi Medical Foundation, **Taiwan**; BUND Friends of the Earth Germany, **Germany**; Canadian Coalition for Green Health Care, **Canada**; Counties Manukau Health, **New Zealand**; Departamento de Salud de Xàtiva-Ontinyent, **Spain**; Dignity Health, **USA**; Gundersen Health System, **USA**; HackensackUMC, **USA**; Hospital Albert Einstein, **Brazil**; Hospital Clínica Bíblica, **Costa Rica**; Hospital León Becerra, **Ecuador**; Hospital San Luis de Buis-Paine, **Chile**; Hospital Sirio Libanes, **Brazil**; Hospital Zonal General de Agudos "Dr. Enrique F. Erill", **Argentina**; Kaiser Permanente, **USA**; Netcare Limited, **South Africa**; Pro Saúde, **Brazil**; Public Health Foundation of India, **India**; Secretaría Distrital de Salud de Bogotá D.C., **Colombia**; Siais Societá Italiana Dell'Architettura e Dell'ingegneria per la Sanitá, **Italy**; Sustainable Development Unit of NHS England and Public Health England, **UK**; St. Paul Hospital Cavite Inc., **Philippines**; Stockholm County Council, **Sweden**; Synergie Santé Environnement, **Canada**; The Mohammed VI University Hospital of Marrakesh, **Morocco**; University Health Network, **Canada**; Virginia Mason Medical Center, **USA**; Vivantes Hospital Neukölln, **Germany**; Western Cape Government Health, **South Africa**; Yonsei University Health System, **South Korea**.

For a complete list see: www.greenhospitals.net/2020-participants

GGHH is a project of Health Care Without Harm | www.noharm.org

Enclosure L

TOWARD LOW CARBON HEALTH CARE

Imagine hospitals around the world deploying onsite energy and super-efficient building design; sourcing sustainably grown food for their communities; minimizing waste generation; practicing water recycling.

Imagine the health sector as a beacon of and advocate for low-carbon development.

Imagine Global Green and Healthy Hospitals (GGHH).

ABOUT GGHH

GGHH is a worldwide network of hospitals, health systems and health organizations committed to reducing the health sector's environmental footprint and advocating for policies that promote environmental and public health.

Launched in late 2011, the Network has quickly grown to include more than 680 members from 38 countries representing the interests of more than 20.700 hospitals and health centers from every continent.

BENEFITS

GGHH Connect | An innovative, online platform, that connects leading hospitals, health systems, and experts from around the globe.

Case Studies | Sustainability successes from GGHH's membership on every continent.

GGHH Webinar Series | Experts and members share cutting-edge strategies for implementing sustainability in the health care sector.

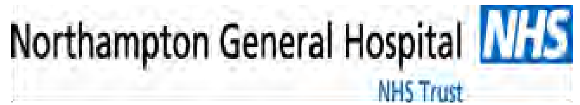
GGHH Guidance Documents | Comprehensive technical guides provide tools, actions and strategies for members to work on GGHH Goals such as Energy, Waste, Water, Buildings and Chemicals.

GGHH Agenda Goal Self-Assessments | These checklists help members analyze where their institution is strong and highlight potential focus areas for improvement.

THE 10 GOAL FRAMEWORK

- Leadership | Prioritize environmental health
- Chemicals | Substitute harmful chemicals with safer alternatives
- Waste | Reduce, treat and safely dispose of healthcare waste
- Energy | Implement energy efficiency and clean, renewable energy generation
- Water | Reduce hospital water consumption and supply potable water
- Transportation | Improve transportation strategies for patients and staff
- Food | Purchase and serve sustainably grown, healthy food
- Pharmaceuticals | Safely manage and dispose of pharmaceuticals
- Buildings | Support green and healthy hospital design and construction
- Purchasing | Buy safer and more sustainable products and materials

Acting Together for Environmental Health
www.greenhospitals.net



Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Corporate Governance Report
Agenda item	17
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**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)? (Y/**N**)

<table>
<tr><td>Legal implications / regulatory requirements</td><td>This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3</td></tr>
<tr><td colspan="2">Actions required by the Trust Board

The Trust Board is asked to:
To note the Use of the Seal, numbers of staff declarations and new declarations of interest by Trust Board members</td></tr>
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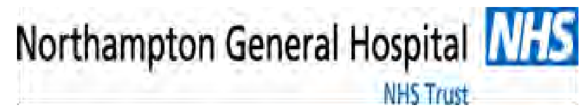


Public Trust Board

Corporate Governance Report
April – June 2016

Introduction

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

Use of the Trust Seal

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

The seal has been used on the following occasions during Quarter 1:

Lease – Northampton General Hospital & Alliance Medical Ltd – CT PET scanner

Collateral warranties x 3 - Northampton General Hospital & Alliance Medical Ltd & Interserve Construction Ltd (CT PET scanner)

Collateral warranties x 3 - Northampton General Hospital & Alliance Medical Ltd & Stride Treglown Ltd (CT PET scanner)

Collateral warranties x 3 - Northampton General Hospital & Alliance Medical Ltd & Ove Arup and Partners Ltd (CT PET scanner)

Collateral warranties x 3 - Northampton General Hospital & Alliance Medical Ltd & Lee Wakeman's Ltd (CT PET scanner)

Collateral warranties x 3 - Northampton General Hospital & Alliance Medical Ltd & Keystone Consulting Engineers Ltd (CT PET scanner)

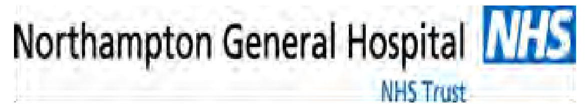
Declarations of Hospitality

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

- April – June 2016: 15 declarations received

Declarations of Interest

There were no new declarations of interest from Board members



Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Operational Performance Report
Agenda item	18
Presenter of Report	Deborah Needham Chief Operating Officer
Author(s) of Report	Lead Directors & Deputies
Purpose	For Information & Assurance
Executive summary The paper is presented to provide information and assurance to the committee on all national and local performance targets via the integrated scorecard. Each of the indicators which is red rated has an accompanying exception report	
Related strategic aim and corporate objective	Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks N Risk of not delivering performance standards Associated fines Patient experience Reputation
Related Board Assurance Framework entries	BAF – 1.2, 3.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)

Enclosure N

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (N)

Actions required by the Board

The Board is asked to:

- Note the performance report
- Seek areas for clarification
- Gain assurance on actions being taken to rectify adverse performance

Corporate Scorecard

Delivering for Patients:
2016/17 Accountability Framework for NHS Trust boards

August Performance

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

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

The arrows within this report are used to identify the changes within the last 3 months reported, with exception reports provided for underperforming measures.

1. Performance Summary

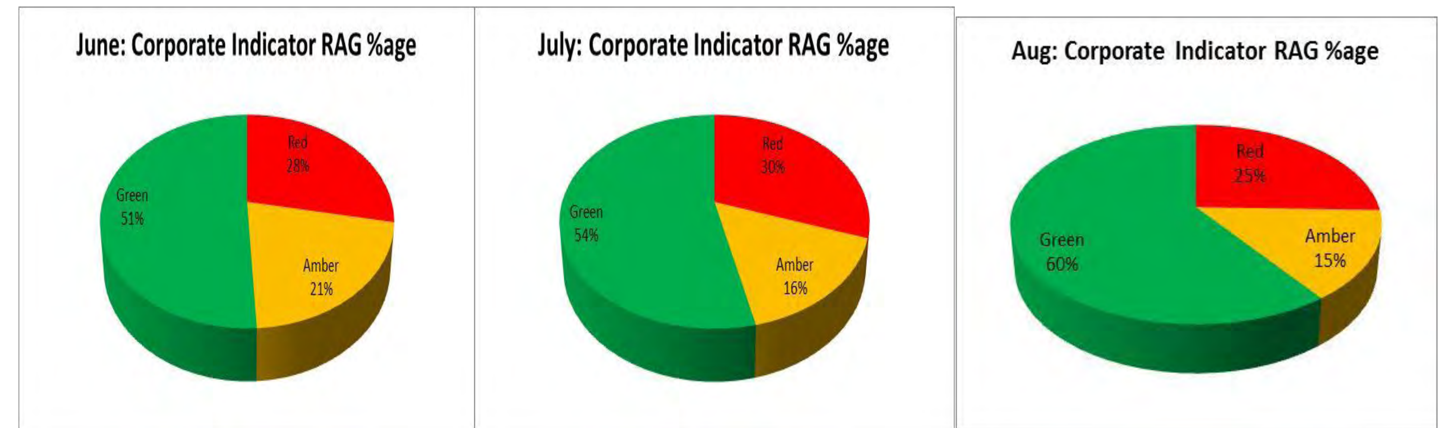
The table below provides an overview of the number of indicators in each domain by their August performance RAG status.

Note any indicators without a target and therefore RAG rating, have been excluded.

August Corporate Indicators: RAG Performance

	Number				Percentage		
Domain	**Red**	**Amber**	**Green**	**Total**	**Red**	**Amber**	**Green**
Caring	2	1	8	11	18%	9%	73%
Responsive	2	6	9	17	12%	35%	53%
Effective	3	0	6	9	33%	0%	67%
Well Led	5	1	1	7	71%	14%	14%
Safe	2	0	9	11	18%	0%	82%
Total	14	8	33	55	25%	15%	60%

The trend in RAG performance over the last 3 months shows an overall reduction in the percentage of red RAG rated indicators and an increase in green rated indicators:



2. STF Funding Performance Metrics

a. 2016/17 Trajectories

NHS Improvement have formally written to us confirming the trajectories we submitted for the key performance metrics which will be monitored against in order to access STF funding in 2016/17:

b. Performance Assessment

STF Funding Key Metrics: Performance Againts Trajectories

		Apr	May	June	Qtr1	July	Aug
A&E 4hr (95%)	Trajectory	88.5	84.0	85.0		87.0	86.0
	Actual	**88.5%**	**89.2%**	**94.6%**	**90.8%**	**91.1%**	**92.5%**
Diagnotiscs (99%)	Trajectory	99.9	99.1	99.1	99.1	99.1	99.1
	Actual	**99.9%**	**99.9%**	**99.0%**	**99.7%**	**99.9%**	**99.9%**
RTT (92%)	Trajectory	92.0	92.0	92.0	92.0	92.0	92.0
	Actual	**94.7%**	**94.5%**	**94.5%**	**94.5%**	**94.7%**	**94.0%**
RTT 52wks+ (0)	Trajectory	0	0	0	0	0	0
	Actual	**0**	**0**	**0**	**0**	**0**	**0**
Cancer 62 days (85%)	Trajectory	75.0	77.2	77.6		78.7	79.5
	Actual	**70.9%**	**76.5%**	**81.7%**	**76.5%**	**80.1%**	**72.1%**

Northampton General Hospital NHS Trust Corporate Scorecard 2016-17

Caring

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
C.2	Complaints responded to within agreed timescales	=>90%	↓	86.5%	88.6%	84.4%
C.3	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.4% (July 16)	↑	91.7%	90.5%	91.5%
C.4	Friends & Family Test % of patients who would recommend: A&E	85.4% (July 16)	→	86.4%	86.4%	86.4%
C.13	Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	94.9% (July 16)	↑	97.1%	100%	100%
C.14	Friends & Family Test % of patients who would recommend: Maternity - Birth	96.8% (July 16)	↑	98.3%	95.5%	98.9%
C.15	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	93.4% (July 16)	↓	96.8%	95.5%	94.8%
C.16	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	97.6% (July 16)	↑	98.3%	88.9%	99.5%
C.6	Friends & Family Test % of patients who would recommend: Outpatients	92.4 % (July 16)	↓	92.3%	91.6%	91.3%
C.7	Mixed Sex Accommodation	0	→	0	0	0
C.8	Total deaths where a care plan is in place	=>50%	↓	66.7%	71.6%	63.2%
C.9	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	=>98%	↑	98.4%	98.5%	100%

Footnote:

Friends and Family Test: Targets are now set against the latest national performance which is published two months retrospectively. The RAG rating is therefore only applied for the most recently published national performance.

Effective

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
E.1	Emergency re-admissions within 30 days (elective)	None	↑	3.6%	4.0%	2.7%
E.2	Emergency re-admissions within 30 days (non - elective)	None	↑	16.9%	15.9%	11.9%
E.3	Length of stay - All	=<4.2	↓	2.7	3.6	6.5
E.6	Maternity: C Section Rates - Total	<26.2%	↓	27.0% (106)	27.8% (125)	29.6% (124)
E.55	Crude Death Rates	Within expected range	↑	1.1%	1.2%	1.0%
E.11	Mortality: HSMR		→	97	97	97
E.10	Mortality: SHMI		→	98	98	98
E.18	# NoF - Fit patients operated on within 36 hours	=>80%	↑	85.7%	57.1%	88.5%
E.19	Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↑	70.0%	56.0%	86.0%
E.20	Suspected stroke patients given a CT within 1 hour of arrival	=>50%	↓	60.3%	67.2%	61.3%
E.54	% Daycase Rate	=>80%	↑	85.6%	88.0%	87.7%
E.58	Stranded NEL patients >75yrs (LOS > 7 DAYS)	=<45%	↑	51.7%	50.3%	50.0%

Safe

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
S.1	C-Diff	Ave. 1.75 per mth	↓	2	1	3
S.2	Dementia: Case finding	=>90%	↑	97.4%	96.9%	99.0%
S.3	Dementia: Initial diagnostic assessment	=>90%	→	100%	100%	100%
S.36	Falls per 1,000 occupied bed days	=<5.5	↓	4.4	4.2	5.2
S.6	Harm Free Care (Safety Thermometer)	94.2% (Aug 16)	↑	93.4%	93.2%	94.3%
S.12	MRSA	0	→	0	0	0
S.13	Never event incidence	0	↑	1	0	0
S.40	Pressure Ulcers (Hospital Acquired) - Grades 2-4	To be confirmed	↑	27	27	18
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↑	3	2	1
S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.3% (Aug 16)	↓	0.2%	0.0%	0.2%
S.20	VTE Risk Assessment	=>95%	↓	96.1%	95.1%	95.6%
S.21	Transfers: Patients transferred out of hours (between 10pm and 7am)	=<60	↑	61	67	44

Footnote:

S.6 & S.19 Safety Thermometer indicators: Targets are now set against the latest national performance. The RAG rating is therefore only applied for the most recently published national performance.

Responsive

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
R.1	A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	94.6%	91.1%	92.5%
R.2	A&E: 4hr SitRep reporting	=>95%	↓	94.6%	90.5%	92.2%
R.3	A&E: 12 hour trolley waits	0	→	0	0	0
R.41	Ambulance handovers that waited over 30 mins and less than 60 mins	None	↑	405	275	239
R.42	Ambulance handovers that waited over 60 mins	None	↑	130	47	15
R.24	Average Ambulance handover times	15 mins	↑	00:22	00:14	00:16
R.4	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	=>99%	↑	99.04%	99.96%	99.89%
R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	=>93%	↑	95.3%	96.3%	96.4%
R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	=>93%	↓	97.0%	91.8%	93.4%
R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	=>90%	↓	100%	93.3%	90.0%
R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↑	100%	77.7%	100.0%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↓	81.8%	80.0%	72.1%
R.11	Cancer: Percentage of patients treated within 31 days	=>96%	↓	95.9%	96.9%	92.3%
R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↓	89%	100%	75.0%
R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↓	100%	98.1%	96.3%
R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↓	93.1%	95.6%	88.0%
R.15	Operations: Urgent Operations cancelled for a second time	0	→	0	0	0
R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	2	0	2
R.19	RTT waiting times incomplete pathways	=>92%	↓	94.5%	94.7%	94.0%
R.20	RTT over 52 weeks	0	→	0	0	0
R.21	Delayed transfer of care	=<23	↓	80	59	83
R.43	DTOC as a % of Adult Bed Base (General & Acute)		↑	8.7%	9.7%	8.3%

Well Led

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	↑	65.7%	Not applic.	
W.2	Data quality of Trust returns to HSCIC (SUS)	=>90%	↑	93.3%	95.6%	Not avail
W.3	Turnover Rate	=<8%	↑	10.0%	9.8%	9.60%
W.4	Sickness rate	=<3.8%	↑	4.2%	4.0%	3.90%
W.5	Staff: Trust level vacancy rate - All	=<7%	↓	9.8%	11.1%	11.90%
W.5	Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	11.7%	11.6%	12.90%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↓	11.2%	12.2%	12.10%
W.5	Staff: Trust level vacancy rate - Other Staff	=<7%	↓	10.8%	10.6%	11.50%
W.9	Staff: Temporary costs & overtime as a % of total pay bill	None		15.3%	14.0%	14.0%
W.10	Percentage of staff with annual appraisal	=>85%	↓	83.0%	80.4%	81.40%
W.11	Percentage of all trust staff with mandatory training compliance	=>85%	↓	86.2%	86.6%	85.80%
W.12	Percentage of all trust staff with role specific training compliance	=>85%	↓	76.1%	77.0%	76.40%
W.15	Medical Job Planning	90%		To be reported from Sept		

Footnote:

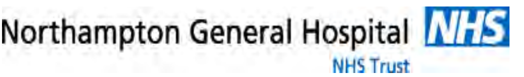
W.15 Medical Job Planning: Note, in the May 2016 Medical Divisional Performance Meeting it was agreed to change the target from 100% to 90%. This is effective from 2016-17. Compliance monitoring to commence from the Sept 2016 position.

Finance

	Indicator	Target	Trend	Jun-16	Jul-16	Aug-16
F.1	Surplus / Deficit (YTD variance at month end position)	0 Fav		67 Fav	(539) Adv	230 Fav
F.2	Income (YTD variance at month end position)	0 Fav		900 Fav	844 Fav	1,457 Fav
F.3	Pay (YTD variance at month end position)	0 Fav		(2,496) Adv	(3,147) Adv	(3,443) Adv
F.4	Non Pay (YTD variance at month end position)	0 Fav		1,177 Fav	980 Fav	829 Fav
F.6	CIP Performance (YTD variance at month end position)	0 Fav		213 Fav	280 Fav	Not avail
F.7	Waivers	0		3	2	5
F.8	Waivers which have breached	0		0	5	7

KEY	
↑	Improving performance over 3 month period (the latest month's performance is higher
↓	Reducing performance over 3 month period (the latest month's performance is lower
→	Stable performance delivery over 3 month period (the latest month's performance is

Enclosure N



Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2016/17 Accountability Framework for NHS trust boards

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

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

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

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Complaints responded to within agreed timescales	Externally mandated	Quality Governance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Complaints responded to within agreed timescales	=>90%	↓	98.0%	100.0%	84.2%	76.4%	78.6%	79.5%	82.9%	75.6%	67.0%	86.5%	88.6%	84.4%

Driver for underperformance:

- Reporting on June's figures now they have been validated
- 45 new complaints received in April
- 28 cases responded in agreed timescale
- 17 cases had timescale renegotiated
- 7 cases exceeded timescale
- Late or incomplete responses received from the Divisions + backlog of complaints built up in the Complaints dept.
- Therefore unable to meet internal and external timescales.

Actions to address the underperformance:

- Part time temporary complaints officer employed to help with backlog of work as of May 2016 (will now be covering vacant post as member of staff has since left).
- Service review undertaken (Making Quality Count) to identify areas for improvement (further work being undertaken in July). Outcome meeting with directorate's w/c 5th September 2016.
- Meeting arranged with Divisional colleagues during August and September 2016.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Friends and Family Test % - Inpatient/Daycase and Outpatients	Externally mandated	Quality Governance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.4% (July 16)	↑	89.3%	87.9%	88.4%	90.6%	90.4%	89.4%	89.3%	91.5%	91.5%	91.7%	90.5%	91.5%
Friends & Family Test % of patients who would recommend: Maternity - Birth	96.8% (July 16)	↑		94.4%	97.5%	96.4%	97.5%	94.7%	91.4%	97.8%	96.9%	98.3%	95.5%	98.9%
Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	97.6% (July 16)	↑	0.0%	100.0%	98.5%	100.0%	100.0%	97.6%	100.0%	99.1%	94.3%	98.3%	88.9%	99.5%
Friends & Family Test % of patients who would recommend: Outpatients	92.4 % (July 16)	↓	91.4%	89.8%	91.7%	92.0%	91.6%	91.7%	91.4%	92.1%	91.7%	92.3%	91.6%	91.3%

Driver for underperformance:

- The FFT continues to struggle to reach national averages for the % of patients that would recommend.
- It is evident that despite the underperformance there is a continued upward trajectory in all areas aside from Outpatients who saw a slight statistically insignificant decrease.
- When reviewing Inp/DC stats from November 2015, it is evident that the Trust continues to make progression.

Actions to address the underperformance:

- Many actions are being undertaken to address performance all of which are evidently having an effect.
- These include, providing information to the frontline teams to enable feedback to be used to make changes and providing the estates and facilities teams with comments relating to their areas.
- A further local survey is currently being initiated enabling wards to be able to identify specific areas where they are performing well and whether further improvements need to be made.

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

Enclosure N

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: Proportion of patients spending less than 4 hours in A&E / 4hr SitRep Reporting	Externally mandated	Finance, Investment & Performance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	90.7%	90.4%	87.3%	91.4%	80.4%	84.0%	81.0%	88.5%	89.2%	94.6%	91.1%	92.5%

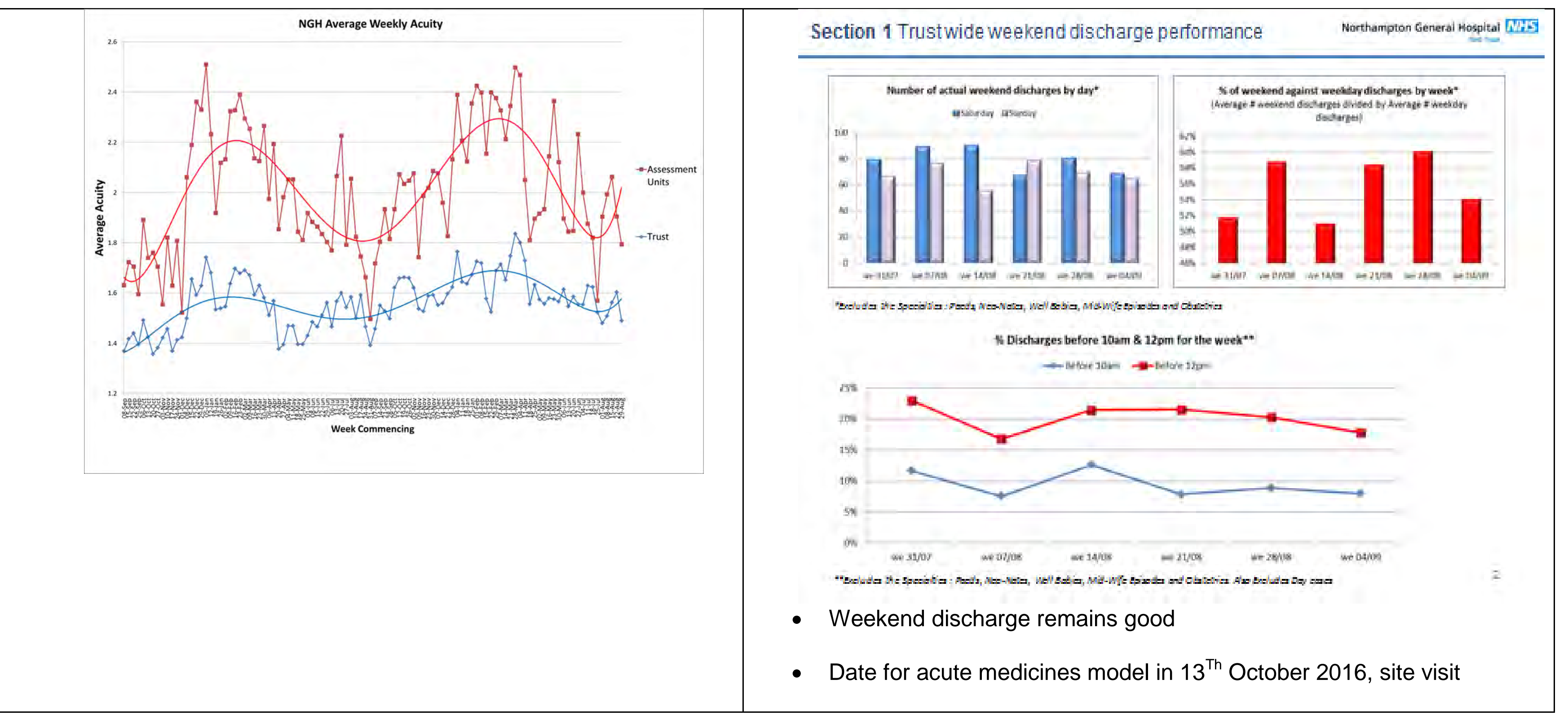
Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
A&E: 4hr SitRep reporting	=>95%	↓	91.0%	90.1%	88.1%	90.1%	82.1%	84.5%	80.6%	87.3%	90.0%	94.6%	90.5%	92.2%

Driver for underperformance:

- August achieved 92.5%: which is above agreed NHSI trajectory
- Work in progress in fit stop to improve but temporarily will reduce capacity until September when this will make a significant improvement
- Vacancies within medical staffing equating to 25 WTE across all of the grades
- Attendances: showed a 3.02 % increase in attendance numbers from April 16 – August, against the same period the year before.
- As shown below acuity is still well above baseline and in upper quartile):

Actions to address the underperformance:

- FIT Stop work commenced – to improve pressures in ED & patient flow
- IC24 contract performance meeting held – RAP action plan still not agreed by both parties: inability to fill GP shifts still noted
- A&E escalation policy completed and ratified
- Additional beds opened at Dickens Therapy unit: Angela grace unit
- Pull model implemented for speciality areas in medicine



- Weekend discharge remains good
- Date for acute medicines model in 13Th October 2016, site visit

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Ambulance Handover Times	Externally mandated	Finance, Performance & Investment Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Average Ambulance handover times	15 mins	↑	00:22	00:22	00:23	00:24	00:24	00:27	00:26	00:31	00:25	00:27	00:22	00:14	00:16

Driver for underperformance:

- A&E fit stop capacity
- Batching of ambulances
- Peak patient inflow to A&E
- More than one entry point through Fit Stop

IT & Handover Screens:

- Ambulances not appearing
- Crews not completing handover
- No Delay - Pick option removed
- No ability for Both NGH/EMAS to sign off for handover

Actions to address the underperformance:

- Overall reduction for ambulance handover time is significant
- Nurse put in place for ED for 10.00-22.00 shift
- Hatch built as part of Fit stop build completed
- New process implemented as of Friday 1st July 2016 : significant improvements noted in month (the trust currently has shortest average total turn around on that of any trust)
- Joint Audit carried out with EMAS: results awaited

Lead Clinician:	Lead Manager:	Lead Director:
Dr Jon Timperley	Sue McLeod	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↓	78.5%	80.6%	87.0%	80.6%	77.0%	69.4%	82.3%	79.4%	70.9%	76.5%	81.8%	80.0%	72.1%
Cancer: Percentage of patients treated within 31 days	=>96%	↓	97.2%	98.2%	94.8%	96.3%	100%	94.7%	94.9%	95.5%	93.7%	93.3%	95.9%	96.9%	92.3%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↓	100%	100%	85.7%	91.7%	100%	90.0%	92.3%	100%	88.9%	100%	88.9%	100.0%	75.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↓	100%	98.5%	100%	95.6%	98.2%	98.1%	98.5%	100%	100%	99%	100.0%	98.1%	96.3%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↓	96.4%	97.9%	98.9%	97.8%	100%	96.4%	95.2%	98.8%	96.2%	94.4%	93.1%	95.6%	88.0%

Driver for underperformance:

- Patient choice has had a significant impact on getting patients to OPA, Diagnostics or Treatments on time.
- A number of pathways are very complex therefore have delays in treatment planning, particularly when the treatments are shared across other Hospitals i.e Leicester.
- Late referrals particularly from KGH to the Trust after day 38.
- Capacity within the Trust and clinically lead ownership of the pathways.

Actions to address the underperformance:

CWT Overall

PTL: Development of revised PTL tracking and reporting is underway with a deep dive planned into patients passed 62 day with or without cancer. Particular focus will be done on patients passed 104 days with cancer with clinician input.

The substantive Cancer Manager and interim Trust Cancer Lead Manager are now both in post.

- Re-Introducing the cancer access policy and cancer

<table>
<tr><td colspan="2"></td><td>operational policy.
• Reviewing the cancer PTL and its processes
• Reviewing tracking methodology and coding of cancer waiting times patients.
• Introducing RAG rated local stretch targets
• Reviewing functionality of MDT's against best practice guidance
• Ongoing work with the CCG and SCN on clinically timed pathways
• Developing the existing and new members of the cancer services team to monitor and track patients effectively
• Securing clinician engagement via the Divisional Director for Oncology, Haematology & Radiotherapy with new systems and process.
Tripartite meetings with UHL and KGH Cancer Managers continue on a monthly basis to agree to the implementation and reporting of this these are well attend and also are ensuring the right focus is maintained to be able to work together to achieve the development of robust tertiary pathway monitoring.
• Pathology: Concerns regarding the availability of Histopathology remain; the pathology manager is working with outsourcing companies to support the Histopathology department until further recruitment of Histopathologists is made. However the average turn-round to report is 4 days (target 7 days) has been maintained but consistency of a clinician within the tumour site MDT mtg is an issue
• Radiology: The requirement is for patients on the 62 day pathway to be reported on in within 7 days CT and MRI scan requests. This is be reviewed weekly to ensure appropriate urgency is requested by consultants. The department continues to focus on this and plan to book appointments directly from clinics and or MDT's, a Cancer Coordinator is in post however ongoing learning and development is in progress with this role.</td></tr>
<tr><th>Lead Clinician:</th><th>Lead Manager:</th><th>Lead Director:</th></tr>
<tr><td>Clemens VonWidekind</td><td>Sandra Neale</td><td>Deborah Needham</td></tr>
</table>

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	1	1	1	2	3	11	2	6	4	2	0	2

Driver for underperformance:

- **General Surgery:**
  Constraints: Patient required a HDU bed. Patient was dated to come in on: 6th July 2016. Patient was cancelled on the day due to no HDU bed available. Required to bring patient in before 03.08.16. Patient was dated to come in on 28th July 2016. Patient was cancelled on the day due to no HDU bed available. Other than the CANHO code no further 28 day breach details noted on the admission sheets. Patient rebooked to come in on 5th August 2016.
- **Cardiology:**
  Two patients were booked on the complex CTO list and unfortunately the first one was more complicated than anticipated requiring that the second be rebooked. This procedure is not done regularly and is next scheduled for 20.9.16 due to annual leave in August.

Actions to address the underperformance:

- **General Surgery:**
  Patients should be clearly highlighted and booked within 28 days of their initial cancellation on the day. Details of the 28 day breach information need to be entered on to the waiting list entry on the day of cancellation, then highlighted further on the admission sheet. Any potential issue needs to be raised with the line manager and Directorate Manager. Assess the process for when patients are cancelled due to non-clinical reasons. Should there be a cover sheet to document any patient cancelled under this criteria?
- **Cardiology:**
  Patients should clearly be escalated as being unable to be listed within 28 days and alternative schedule to be done. In this case an additional list for this procedure should have been sought from the Consultant in order to ensure the patient did not wait longer than 28 days.

Lead Clinician:	Lead Manager:	Lead Director:
Mr Mike Wilkinson / Dr Warren Pickering	Fay Gordon / Sue McLeod	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	August 2016

Performance:

Indicator	Target	Trend	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Delayed transfer of care	=<23	↓	43	46	54	51.8	57.5	70	80	51	65	63	80	59	83

Driver for underperformance:

Key issues for discharge :

- Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit
- Reliance on beds; Insufficient capacity within the home support services
- Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS
- Confusion internally with regard to the major changes to the discharge process.
- Loss of a Mental Health bedded pathway for discharge.

Actions to address the underperformance:

- Outflow group is leading the programmes of work:
- Integrated discharge SPA – multi disciplinary team located together to facilitate discharge into home and bed based services, single tracking & reporting, clear escalation. 1.8WTE staff have been allocated to staff the SPA from the NGH discharge team. The SPA has been open for 3 weeks. We have seen a drop in referrals since opening. Analysis is required and a re-focus of the role of the discharge co-ordinator is required in simple discharges. .
- SAFER bundle is being implemented in the trust by October. Aims to ensure all patients have a senior review daily and also the Top 20 long stay patients are reviewed weekly by the senior team. There is now a plan to appoint from the site team by the beginning of October.
- Meeting with NORARCH (local care homes group) requested in order to agree some best practice guidelines.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Dione Rogers	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated	Quality Governance Committee.	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Maternity: C Section Rates - Total	<26.2%	↓	25.8% (113)	28.3% (110)	27.8% (110)	28.5% (107)	25.6% (94)	24.2% (90)	24.6% (97)	28.8% (121)	25.2% (98)	27.0% (106)	27.8% (125)	29.6% (124)

Driver for underperformance:

- Elective Caesarean section rate just under the national average 12.2% (national average 13.2%)
- Emergency Caesarean section rate higher this month – high activity during August 2016

Actions to address the underperformance:

- Continue monitoring
- Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making.
- Ongoing Elective Caesarean Section audits – good compliance
- Matron – Intrapartum Lead to work on labour ward to support normality and provide challenge and support in clinical decision making
- Continue with debriefs following all Caesarean Sections
- New appointment to Birth After Caesarean Clinic – working towards multidisciplinary clinic.

Lead Clinician:	Lead Manager:	Lead Director:
Owen Cooper	Rose McKee	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stranded NEL patients >75yrs (LOS > 7 DAYS)	Internally set	Finance, Investment and Performance Committee	August 2016

Performance:

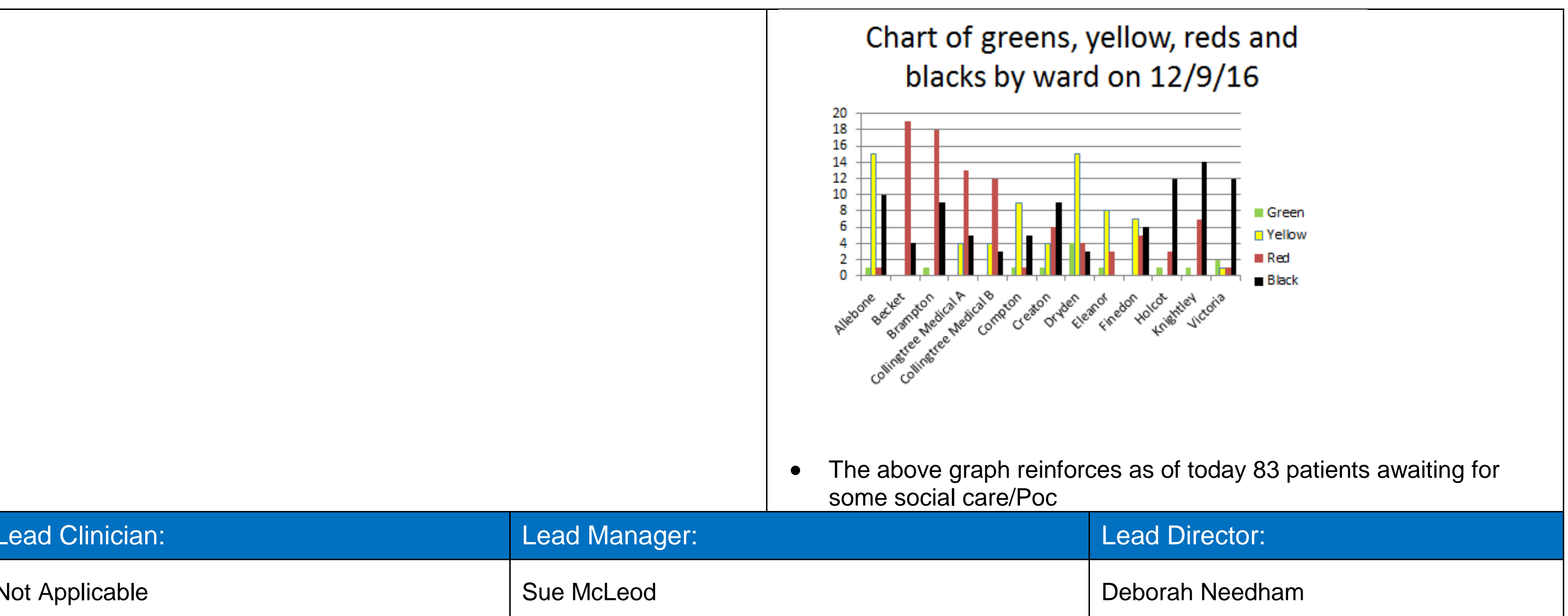
Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Stranded NEL patients >75yrs (LOS > 7 DAYS)	=<45%	↑	Not Avail	Not Avail	Not Avail	Not Avail	Not Avail	Not Avail	Not Avail	Not Avail	52.4%	51.7%	50.3%	50.0%

Driver for underperformance:

- Some improvement in month despite challenges as below
- DTOCs remains consistently High >
- HPT assessment waits remained high all month
- Discharge process delays
- Acuity remained above baseline
- Average LOS as a trust for august was 6.5 days as per previous 3.6 days

Actions to address the underperformance:

- Deep dive/ dragons den takes place weekly to challenge LOS > 7 days
- All patients reviewed and counter challenge provided if required
- Dickens therapy unit established: Occupancy now 93% and improving continuously with a buffer list being established
- SPA introduced to mitigate discharge processes issues: some teething issues
- EAU patterns of working embedded with morning and early afternoon, focus now on 16.45 handover



- The above graph reinforces as of today 83 patients awaiting for some social care/Poc

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Sue McLeod	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Turnover Rate	Internally set	Workforce Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Turnover Rate	=<8%	↑	11.5%	11.6%	11.5%	11.3%	11.5%	11.7%	11.7%	11.2%	10.8%	10.6%	10.1%	10.0%	9.8%	9.6%

Driver for underperformance:

- Lack of opportunities for progression
- Increase in numbers of staff retiring and returning
- Increased Trust activity and effect on areas used as escalation areas
- Staff survey indicates underlying cultural concerns i.e. bullying and harassment, lack of flexibility, support from line manager
- Management of change programs.

Actions to address the underperformance:

- Provision of an opportunity for any nurses that are contemplating leaving to discuss their reasons for doing so with the Nurse Retention Manager.
- Review of the exit interview questionnaire process.
- Development of an on-boarding questionnaire for new starters.
- OD undertaking work to improve the working environment
- Staffing being provided with employee voice / Friends and Family Tests
- Management Leadership programmes
- Introduction of Flexible Retirement policy

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Sickness Rate	Internally set	Workforce Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Sickness rate	=<3.8%	↑	4.0%	3.9%	4.0%	4.3%	4.1%	4.1%	4.3%	4.4%	4.0%	4.1%	4.0%	4.2%	4.0%	3.9%

Driver for underperformance:

- Short term absence – 2.07% and long term absence is 1.83%
- Short term absence remains the driver in August 2016 although there continues to be a downward trend on the % numbers of staff off sick as in April 2016 it was 2.42%
- The illnesses being reported are self-limiting which are all being managed in line with the Trust's trigger points
- The staff survey also highlighted that staff put themselves under pressure to attend work

Actions to address the underperformance:

- There has been a downward trend over the last two months with the % sickness rate at the lowest since August 2015
- Following an audit on sickness absence processes an audit checklist is being produced to advise managers on among other things the importance of return to work interviews
- The Health and Well Being Strategy is progressing well and a number of sessions have been set up to make staff aware of Mental Wellbeing such as Mindfulness
- Staff reaching the Trust's staff sickness absence policy triggers are being met with formally
- Trust wide Sickness Absence Management training sessions to be delivered by the third quarter
- A number of short term and long term dismissal meetings for ill health capability are taking place on a regular basis
- Monthly 1-1 meetings with Managers are taking place to support timely sickness management

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

Enclosure N

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Vacancy Rate	Internally set	Workforce Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Staff: Trust level vacancy rate - All	=<7%	↓	11.0%	10.9%	10.3%	9.7%	9.5%	9.5%	9.2%	7.4%	7.3%	10.0%	9.8%	9.8%	11.1%	11.9%
Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	9.8%	9.4%	10.1%	9.2%	9.9%	10.9%	10.9%	10.2%	10.9%	13.3%	11.8%	11.7%	11.6%	12.9%
Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↓	17.9%	18.1%	17.6%	14.8%	15.0%	13.4%	13.9%	11.1%	11.4%	11.6%	11.4%	11.2%	12.2%	12.1%
Staff: Trust level vacancy rate - Other Staff	=<7%	↓	12.5%	12.6%	11.7%	12.4%	12.0%	12.3%	11.5%	8.9%	8.4%	10.8%	10.6%	10.8%	10.6%	11.5%

Driver for underperformance:

- There is a national shortage of nursing staff along with a shortage within other professional allied specialities
- Change to the shift system (long days) decreases flexibility and therefore staff choose to join the bank
- A General Hospital is not as attractive as Teaching Hospitals

Actions to address the underperformance:

- Trust Open Days in difficult to recruit areas
- Forging links with local University to recruit Students
- Dedicated staff within HR for recruitment and retention
- More structured approach to Medical Staffing recruitment
- Recruitment timeline down to 9 weeks
- Monthly meetings with managers to support clearance processes developing enhanced working relationships
- Increase usage of apprenticeship schemes
- Overseas recruitment for nurses continues

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Percentage of staff with annual appraisal	=>85%	↓	70.3%	74.8%	76.7%	76.1%	80.4%	82.5%	83.3%	80.2%	81.9%	82.7%	83.0%	83.0%	80.4%	81.4%

Driver for underperformance:

- The Trust set a target of 85% compliance for appraisals in line with the CCG's expectation. The CQC requirement was for an improvement, which we have made with compliance ratings increasing from 41% in March 2014 to 83.57%.
- Whilst we have not achieved our target we have undoubtedly improved. There is no national target; the only benchmark data available is that contained within the national staff survey whereby the trust achieved 87% against a national average of 85%.

Actions to address the underperformance:

- Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested.
- All Divisional Directors and Divisional Managers will be reminded to have as one of their objectives that at least 85% of their staff must have an in-date Appraisal.
- An audit was carried out on wards in Medicine falling below 85% compliance. As a result of this, communication was sent out to remind managers on the process of new starters.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Percentage of all trust staff with role specific training compliance	=>85%	↓	70.1%	70.1%	70.5%	71.2%	71.3%	72.5%	73.0%	73.4%	74.0%	73.7%	75.2%	76.1%	77.0%	76.4%

Driver for underperformance:	Actions to address the underperformance:
• Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. • The target to be achieved by March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting. Further work is being carried out on Blood Training by reviewing the positions that require this. • Following 1:1 sessions with Ward Managers, the L&D Manager is providing further support through training them in understanding the reports to use them to monitor individual training and forecasting.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Clostridum difficile Infection Trust attributable (post 3 days)	Externally Mandated	Quality Governance Committee	August 2016

Performance:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
C-Diff	Ave. 1.75 per mth	↓	1	2	3	4	5	2	1	3	0	2	1	3

Driver for underperformance:	Actions to address the underperformance:
• Patient safety, to protect patients from acquiring a hospital acquired infection	• Post Infection Reviews (PIR's) are performed on all patients that develop Clostridium difficile infection post 3 days after their admission to Northampton General Hospital Trust. These PIR meetings include the ward Sister, the Consultant microbiologist, the Consultant or a member of the medical team for that specific patient, antimicrobial pharmacist and a member of the Infection Prevention team and the learning from the reviews are shared at the monthly Infection Prevention Operational Group meeting. • All completed PIRs are sent to the Clinical Commissioning Group for review to identify if there is a lapse in care. • The Trust continues to be involved with the NHS improvement Infection Prevention collaborative. The summit of the collaborative was on Thursday 8th September 2016 and the work around prompt sampling and isolation within 2 hours is now being scaled up and spread across other wards.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	Externally mandated	Quality Governance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↑	0	3	1	0	0	3	2	2	1	3	2	1

Driver for underperformance:

- Incorrect report issued on Hepatitis C antibody test.

Actions to address the underperformance:

- Incident brought to the attention of staff to raise awareness.
- SOP checked for accuracy – no issues raised.
- DATIX W-65949 completed.
- Early Management Report & Incident Assessment Form completed.
- Meeting arranged with Risk Management.
- Laboratory Information System – COGNOS - Results checked – no errors found.
- Laboratory Information System – APEX – interpretational rules enabled to reduce risk of misinterpretation.
- Declared as SI (Ref 2016/22390) – now being investigated under SI process.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minas Minassian	Julie Mason-Wright	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay - All	Internally set	Finance, Investment and Performance Committee	August 2016

Performance and Trajectory:

Indicator	Target	Trend	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Length of stay - All	=<4.2	↑	3.1	5.6	8.1	5.78	4.13	4.93	4.34	3.578	2.789	2.724	3.59	6.53

Driver for underperformance:

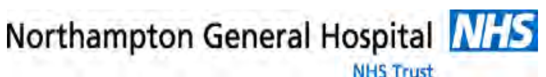
- Increasing numbers of Delayed Transfers of Care (DTOC) resulting in high numbers of 'stranded' patients
- Pathway for Dementia patients to Angela Grace beds is no longer in place. This cohort have very long LOS and there is no bedded solution at present.
- Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit
- Reliance on beds; Insufficient capacity within the home support services
- Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS
- Some unusually long LOS for some specialties e.g. Ophthalmology for patients with unusual presentations requiring prolonged inpatient stays

Actions to address the underperformance:

Outflow group is leading the programmes of work:
Discharge process re-design – stream lined process, early discharge planning, local empowerment and timely transfer of needs based information to the discharge SPA – due to open on the 22nd August.
Integrated discharge SPA – multi disciplinary team located together to facilitate and support discharge into home and bed based services, single tracking and reporting, clear escalation. 1.8WTE staff have been allocated to staff the SPA from the NGH discharge team. The SDPA has now been open for 3 weeks. We have seen a drop in referrals to the SPA since opening. Further analysis is required and a re-focus of the role of the discharge co-ordinator is required in simple discharges. .
SAFER bundle to be implemented within the trust by October. Aims to ensure all patients have a senior review daily and also the Top 20 long stay patients are reviewed weekly by the senior team. There is now a plan to appoint from the site team by the beginning of October.
Right Sizing Home Care Support – capacity modelling, reviewing integration options and increasing capacity
Deep dive reviews of all wards by senior manager and clinicians to scrutinise medical plans and ensure they are being followed up robustly.

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

Enclosure N



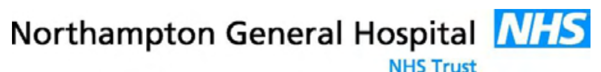
Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Report from the Finance Investment and Performance Committee
Agenda item	19
Presenter of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Author(s) of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Finance Investment and Performance Committee provides an update to the Trust Board on activities undertaken during the month of August.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 1.2, 5.1, 5.2 and 6.3
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**) 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**)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure O

Actions required by the Trust Board

The Trust Board is asked to note the report.



COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 29 September 2016

Title	**Finance Committee Exception Report**
Chair	**Phil Zeidler**
Author (s)	**Phil Zeidler**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *17th August 2016* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
• Pharmacy business case • Changing Care@NGH • Agency Cap • Operation Performance Report • Winter Planning • Ward Development (Outline business case)	

Key areas of discussion arising from items appearing on the agenda

- **Changing care programme still indicated as on track, combines carter initiatives, but still nothing included from the STP**
- **Agency Cap continues to be challenging,**
- **Continued improvement in A&E performance despite although activity was on the rise again in August.**
- **Winter planning begun, earlier than previously, but expected to be our biggest challenge**

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

- **Pharmacy increased weekend resource business case approved**
- **Recommend Board give delegated approval for the outline development case on the ward development**

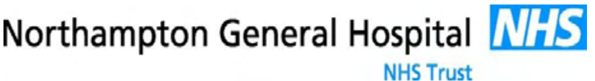
Any issues of risk or gap in control or assurance for escalation to the Board

- Winter Plan demonstrates the Trusts face significant capacity risks based on likely activity and restricted patient flow

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

Enclosure O

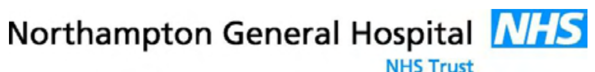


Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Report from the Quality Governance Committee
Agenda item	20
Presenter of Report	Graham Kershaw, Non-Executive Director and Chair of Quality Governance Committee
Author(s) of Report	Graham Kershsaw, Non-Executive Director and Chair of Quality Governance Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Quality Governance Committee (QGC) provides an update to the Trust Board on activities undertaken during the month of August.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 1.1, 1.3, 1.4, 1.6 and 2.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**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)? (Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Actions required by the Trust Board

The Trust Board is asked to note the report.



Enclosure P

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board – 29 September 2016

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

Executive Summary

The Committee met o*n 19/08/2016* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Corporate scorecard for quality Quality improvement scorecard CQC monthly update Nursing and Midwifery update Theatre Safety Ophthalmology update Hand washing and Doctors.	

Key areas of discussion arising from items appearing on the agenda

Ms Fox presented the Corporate Scorecard for Quality and advised that there had been a decrease in the number of complaints not answered within the required timeframe. Compliance is at 88.6% for July and Ms Fox anticipated that compliance would reach 90% for August. Concerns were expressed that Stroke patients spending at least 90 % of their time on the stroke unit had fallen to 56%.In response Mrs Needham confirmed that 2 stroke beds had been ring-fenced in August on Eleanor Ward. The Stroke Unit and Eleanor Ward will manage the ring-fenced beds themselves and Mrs Needham believed that this action was helping to mitigate the issue. Mrs Bradley advised that the Stroke care bundle was a Quality Priority and will be included in Septembers Quality Improvement Scorecard report. It was also noted that NoF compliance had dropped significantly. Dr Wilkinson stated that it was unclear as to why compliance had dropped. There were cancellations due health reasons and these were not linked to operational issues.

Mrs Bradley presented the Quality Improvement Scorecard and reported via exception and the committee raised questions on these as necessary. The committee queried how the Trust tests the LFE. Mrs Bradley stated that the learning experience is practical and all members of the team are involved. it was agreed that it would be useful to involve the University in helping measure the outcomes of the LFE simulation suite. Mrs Bradley agreed to liaise with colleagues at Northampton University regarding the opportunities available to evaluate learning via simulation.

Mrs Bradley informed the committee of e improved performance in out of hours transfers, There had been 67 Out Of Hours transfers during July, 98% had a patient risk assessment completed. Mrs Bradley also acknowledged a continued improvement from January 2016 regarding the number of operations cancelled on the day of surgery (all non-

clinical reasons) due to bed availability.

Mrs Wallace presented the CQC Monthly Update Report and advised that since the last report, work has progressed on updating CQCAssure with support from the supplier. The final iteration of CQCAssure was agreed last week with roll out expected in September. Preparations are on going for a Mock CQC inspection in October 2016.
It was requested that feedback from the October mock inspection is reported in the CQC monthly report to QGC.

The committee queried whether the QCQ is likely to look at the Trusts SI's. Mrs Wallace confirmed that the CQC has already gathered information on this and the Trusts learning from deaths. Mrs Wallace confirmed that the 'Never Event' action plan is in line with CQC standards.

The committee were informed that we had received a letter from the CQC regarding 'Never Events' and believed that the letter signals that there may an unexpected CQC inspection to Theatres. Dr Swart confirmed that the Medical Director would share the letters of response to the CQC from the Trust at August's Board of Directors.

Ms Fox delivered an update on Nursing and Midwifery and advised that in July 2016 NGH achieved 98% harm free care (new harms) with 93% for all other harms. Ms Fox then drew the Committees attention to the report on Pressure Ulcer Incidence and noted that Pressure Ulcer Prevention is reported in detail at CQEG. Ms Fox advised that a mini root cause analysis is carried out every time harm is reported. The Moving and Handling Audit explored the use of the correct equipment whilst moving a patient and also the staff's knowledge. This was done by observing the staff and asking patients. Ms Fox confirmed that the results of the audit will be presented at the Pressure Ulcer Prevention Group in September 16 and thereafter included in the QGC Nursing & Midwifery Report.

Ms Fox reported that there had been 7 cases of Clostridium difficile infection apportioned to the Trust for July 16. The CCG have reviewed these cases. The committee were also advised that the Trust is working with NHS Improvement on prevention of healthcare associated infections. The wards included have displayed enthusiasm and have adopted a unique approach to tackling patient harm. Ms Fox also advised that the nursing team have worked with Governance in relation to changing the approach to the post injury reviews for falls.

Dr Wilkinson reported in the absence of the Medical Director that as a result of the HSCIC publication timetable there has been a delay in the release of data to Dr Foster and therefore the July update on mortality is not yet available for review. Dr Wilkinson reported that there was no new Never Events reported in July.

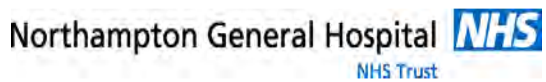
Dr Wilkinson advised that the Serious Incidents Group had been renamed at the Review of Harm Group (RoHG) and the changes to the group had been positive. The RoHG will consider other harm incidents to look for themes and trends, which included IP incidents, falls, medication errors and pressure ulcers. The Committee agreed on the significant importance of the RoHG and noted that the action plans agreed in the group need to be followed through.

Dr Wilkinson advised that an action plan had been developed which covers all areas of the work presented in July with key objectives noted and timelines agreed. A Safety Group has been organised and will meet 2 weekly to discuss the action plan. Dr Wilkinson stated that he and the Medical Director will oversee the group initially. The groups Terms of Reference have been agreed.

Dr Wilkinson reported on Theatre safety and that a training scheme will start in September and will include point of delivery simulation sessions in theatre. Training of complete teams is noted to be a key issue and the implementation of a rolling training programme should help to address this.

Enclosure P

The committee asked that to see the Theatre Team owning the action plan from the start. Dr Wilkinson agreed and commented that the Directorate will need to own their action plan with support from the Clinical Director and Governance Team. Dr Wilkinson stated that the aim is for each theatre to own its own quality metrics and analyse and improve its own performance. The committee requested that the action plan and results is brought to the Committee in detail as soon as possible . Dr Wilkinson confirmed that this would be presented in February 2017. The committee had a detailed update on Ophthalmology Update, which showed that the current backlog was nil. The committee noted the very detailed report and commented that the report now gave the Committee assurance that the problems in Ophthalmology had been successfully resolved. Dr Wilkinson brought to the committee's attention that there has been some concern about hand washing and Doctors. Ms Fox confirmed that a formal audit had been requested by the Infection Prevention Committee. The audit will look at hand hygiene guidance, as it can be confusing. Once the work has been done, the key message can be delivered to the staff. Ms Fox commented that the audit would apply to all staff.	
Any key actions agreed / decisions taken to be notified to the Board See key areas of discussion above.	
Any issues of risk or gap in control or assurance for escalation to the Board Non other than referred to above	
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 report	

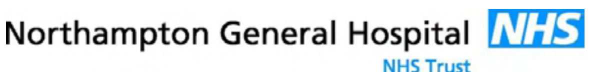


Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Report from the Workforce Committee
Agenda item	21
Presenter of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Author(s) of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Workforce Committee provides an update to the Trust Board on activities undertaken during the month of August.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 4.1, 4.2, 4.3
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) 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)

Enclosure Q

Legal implications / regulatory requirements	Statutory and governance duties
Actions required by the Trust Board The Trust Board is asked to note the report.	



COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board - 29 September 2016

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

<table>
<tr><td colspan="2"><u>Executive Summary</u>
The Committee met on 17/08/2016 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).</td></tr>
<tr><td><u>Key agenda items:</u>

Nursing Supply and Demand
Medical Education
Medical Revalidation and Appraisal annual report
Brand Northampton
Workforce performance
Safe nurse staffing</td><td>Board Assurance Framework entries
(also cross-referenced to CQC standards)</td></tr>
<tr><td colspan="2"><u>Key areas of discussion arising from items appearing on the agenda</u>.

Ms Fox presented the Nursing Supply and Demand NGH Report and advised that the report details the effect on the supply and demand for the Nursing and Midwifery Workforce. Ms Fox stated that a key focus of the report is the Nursing Associate (NA) role, which is a new role that will sit alongside existing nursing care support workers and fully qualified registered nurses. Ms Fox reported that the East Midlands have submitted an application for test bed status, which would see the region receive 300 AN trainees, with a total of 1000 allocated nationally. The result of the application will be known by September 16 and Ms Fox will update the Committee on the outcome.

Ms Fox stated that the Comprehensive Spending Review concluded that from August 2017, new students on pre-registration courses in England will have to take out maintenance and tuition loans in line with other university students rather than accessing a NHS bursary. This could have a negative impact upon people undertaking training .The committee were also advised that Health Education England will no longer inform the number of commissioned student places nationally. Universities can decide on the number of students they take and how many intakes they have each year. Ms Fox noted that due the potential increase, as the placement provider the Trust is reviewing their placement provision. The committee noted the challenges facing the Trust in this area and the impact it could have on nurse recruitment and staffing.

Dr Jeffrey presented the Medical Education Report – Oncology Update. Committee expressed strong concern at the continuing number of red outcomes. Dr Jeffrey noted that Cardiology is red for the 4th year in a row and Obstetrics and Gynaecology is also of great</td></tr>
</table>

Enclosure Q

concern. Mr Widekind stated that he is not surprised with the Obstetrics and Gynaecology results and to mitigate these concerns the directorate has put a plan in place.

The importance of acting before receipt of the GMC survey results was stressed to Dr Jeffrey and it was agreed that the Trust needs to look at itself internally and put plans in place to solve these on-going issues. The regularity of this also needs to be addressed. Dr Jeffrey advised that his proposed plan to the Medical Director is to ensure that a training forum runs within each department and changes to the training forum structure also need to be explored. Dr Jeffrey stated that special measure reports need to be completed monthly by a named consultant within the Directorate. The committee asked that a structured recovery plan be prepared and updated on at the next meeting of the committee.

Ms Fox presented the Safe Nurse Staffing Report and advised that areas of importance within the report were section 3: Carter Review Rostering Good Practice Guidance and section 5: National Quality Board Guidance, 2016.

On workforce performance discussion centred upon sickness absence and a further update to the committee once internal audit had completed their review of this area. Mrs Brennan advised that the Trust had been working with KGH, NHFT, St Andrews Hospital and the University of Northampton to promote working within healthcare in Northamptonshire and made a detailed presentation on this.

Dr Poyner presented the Medical Revalidation and Appraisal Qtly & Annual Report and advised that for the reporting period 1 April 2015 – 31 March 2016 Northampton General Hospital NHS Trust (NGH) had 306 doctors with a prescribed connection to the organisation. Dr Poyner also reported that the Associate Medical Director (AMD) for A&R is in the process of reviewing current draft Responding to Concerns Policy; liaising with HR to ensure Trust compliance; gaining ratification of the policy and once approved ensure it is cascaded as appropriate and uploaded to Trust intranet The committee agreed that it was extremely important to ensure a Responding to Concerns Policy is in place as it will ensure Doctors receive the right support early on. The Responding to Concerns Policy could also be linked to the Remediation Policy. It was also requested that that Responding to Concerns Policy is brought back to Octobers Workforce Committee.

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

See the detail contained within the above sections.

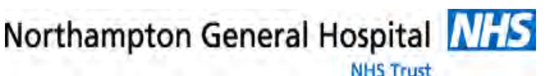
Any issues of risk or gap in control or assurance for escalation to the Board

Non other than referred to above

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

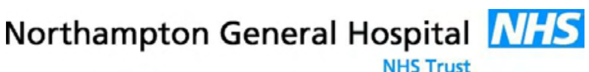
Note report



Report To	PUBLIC TRUST BOARD
Date of Meeting	29 September 2016

Title of the Report	Report from the Hospital Management Team Workshop Meeting held on 6 September 2016
Agenda item	22
Presenter of Report	Deborah Needham, Chief Operating Officer/Deputy CEO
Author(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO
Purpose	For Information & Assurance
Executive summary This report provides an update to the Trust Board on activities undertaken at the Hospital Management Team meeting held in September 2016.	
Related strategic aim and corporate objective	Strategic Aims - All
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 1.2, 1.5, 1.7, 2.1, 4.1, 4.2, 5.1,
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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	Statutory and governance duties
Actions required by the Trust Board The Trust Board is asked to note the report.	

Enclosure R



COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 29th September 2016

Title	**HMT Exception Report**
Chair	**Dr Sonia Swart**
Author (s)	**Mrs Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met as a workshop on 2nd September 2016 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. Divisional updates 2. Updates on: - Process for specialised commissioning MRET reinvestment - Annual planning process	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Divisional updates

Divisions presented their current concerns and actions being taken and any other divisional updates:

Medicine & Urgent care

a. Cardiology focus on diagnostics and backlog
b. Medical staffing & recruitment
c. Medical patients on surgical wards

Surgery

a. T/O plan for potential outsourcing
b. Anaesthetic staffing gaps and cover

Women's ,Childrens, Oncology, Haematology and Cancer

a. Cancer performance and recovery plan

Clinical Support services

a. EMRAD – the effect of deployment on turnaround times for reporting
b. Histopathology Recruitment and retention for medical staffing

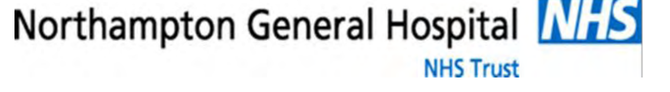
Process for specialised commissioning MRET

An update was provided on the process required for bidding against the specialised commissioning funds, a discussion about potential bids and associated timescales.

Annual planning process

A presentation was given by the Director of Strategy outlining the timescales, planning required for divisions, link to the STP and the ability to remove cost and the current health economy position.

Verbal report A summary briefing was provided by the CEO on: Urgent care and the new A&E development boards, social care proposals to cut services and remove cost and the effect this will likely have on NGH. The link with the STP and the predicted savings required and our role in working with KGH and further understanding what the community plans are and ensuring that we feed in to all the discussions. Emphasis on ensuring we remain focused on patients and the quality of care we provide, whilst helping and supporting our staff to make real sustainable change for example the 60 bedded assessment hub. **AOB** 1. An update was provided on the current A&E performance – below trajectory	
Any key actions agreed / decisions taken to be notified to the Board 1. A planning meeting to take place with the division of medicine to start planning recovery for the September A&E performance.	
Any issues of risk or gap in control or assurance for escalation to the Board All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board To note the contents of the report.	



A G E N D A

PUBLIC TRUST BOARD

Thursday 29 September 2016
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 28 July 2016	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Infection Prevention Annual Report	Assurance	Ms C Fox	**F.**
10:25	**OPERATIONAL ASSURANCE**				
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:50	**STRATEGY**				
	13.	STP and Clinical Collaboration Update	Assurance	Mr C Pallot	**I.**
	14.	Communications & Engagement Strategy Update	Assurance	Mrs S Watts	**J.**
	15.	Equality and Diversity Strategy Update	Assurance	Mrs J Brennan	**K.**
	16.	Sustainable Development Strategy	Assurance	Mr C Abolins	**L.**
11:15	**GOVERNANCE**				
	17.	Corporate Governance Report	Assurance	Ms C Thorne	**M.**
11:25	**FOR INFORMATION**				

Time		Agenda Item	Action	Presented by	Enclosure
	18.	Integrated Performance Report	Assurance	Mrs D Needham	**N.**
11:35	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Q.**
	22.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**R.**
12:00	**23.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 24 November 2016 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).