UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Friday 26 July 2019

09:30

Board Room
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Friday 26 July 2019
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 30 May 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	CCG Transition Programme	Receive	Mr T Sanders	**C.**
	6.	Patient Story	Receive	Executive Director	**Verbal.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report including • CQC Update	Receive	Dr S Swart	**D.**
10:15	**CLINICAL QUALITY AND SAFETY**				
	9.	Medical Director's Report including - • Learning from Deaths Update • GMC Survey Results	Assurance	Mr M Metcalfe	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**F.**
	11.	Maternity Bi-Annual Staffing Review	Assurance	Ms S Oke	**G.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Month 03 Finance Report	Assurance	Mr P Bradley	**H.**
	13.	Operational Performance Report	Assurance	Ms L Taylor	**I.**
	14.	Workforce Performance Report including – • People Strategy Update	Assurance	Mrs J Brennan	**J.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	15.	Equality & Diversity Workforce Annual Report 2018/2019	Assurance	Mrs J Brennan	**K.**
	16.	Equality & Diversity Workforce Monitoring Report 2018/2019	Assurance	Mrs J Brennan	**L.**
	17.	Equality & Diversity Workforce Progress Report for Staff	Assurance	Mrs J Brennan	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Board Assurance Framework	Assurance	Ms C Campbell	**N.**
	19.	Update Paper - Violence & Aggression Review Group (VARG)	Assurance	Ms S Oke	**O.**
11:40	**COMMITTEE REPORTS**				
	20.	Highlight Report from Finance and Performance Committee	Assurance	Mr D Moore	**P.**
	21.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Q.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**R.**
	23.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**S.**
	24.	Highlight Report from HMT	Assurance	Dr S Swart	**T.**
11:50	**25.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 26 September 2019 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Minutes of the Public Trust Board

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

Present		
	Mr A Burns	Chairman
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer & Deputy Chief Executive
	Mr P Bradley	Director of Finance
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Ms S Oke	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
	Mr D Moore	Non-Executive Director
	Ms J Houghton	Non-Executive Director
	Mr D Noble	Non-Executive Director
In Attendance		
	Mr C Pallot	Director of Strategy & Partnerships
	Mr S Finn	Director of Facilities and Capital Development
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mrs J Brennan	Director of Workforce and Transformation
	Miss K Palmer	Executive Board Secretary
	Ms S Watts	Associate Director of Communications
	Ms L Wightman	Director of Public Health (Agenda Item 5 only)
Apologies		
	Dr E Heap	Associate Non-Executive Director

TB 19/20 001 Introductions and Apologies

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

Apologies for absence were recorded from those listed above.

Mr Burns introduced Ms L Wightman (Director of Public Health) to the Trust Board. She would be delivering a presentation on the Director of Public Health Annual Report. The presentation would look at health from a County-wide perspective.

TB 19/20 002 Declarations of Interest

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

TB 19/20 003 Minutes of meeting 28 March 2019

The minutes of the Trust Board meeting held on 28 March 2019 were presented for approval subject to one amendment raised by Ms Houghton.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 28 March 2019.

TB 19/20 004 Matters Arising and Action Log 28 March 2019

Action Log Item 94

Mrs Brennan updated the Board and informed them that the National Workforce plan had still not been released. Once it had been she would update the Board.

The Board **NOTED** the Action Log and Matters Arising from the 28 March 2019.

TB 19/20 005 Director of Public Health – Annual Report

Ms Wightman introduced herself to the Board. She reported that it was a statutory requirement that an annual Director of Public Health report was produced. The report was available on the Northamptonshire County Council website.

Ms Wightman commented that it was her aim to make the annual report more accessible to enable the people of Northamptonshire to understand what the challenges were to Public Health.

Ms Wightman delivered a presentation on the annual report which was a summary of the annual report included within the Board papers.

Hospital Trust Board May2019.pptx

Mr Burns thanked Ms Wightman for her presentation. He remarked that this report was instead of the usual patient story that came to Public Trust Board.

Mr Pallot concurred with Mr Burns' thanks. He had found the annual report easy to digest. Mr Pallot believed that it would be positive to look at ways that the Trust's strategy could align with the Director of Public Health strategy. He noted that this could be quite powerful which Ms Wightman agreed with. She stated that there was importance on how to link up across the system.

Ms Houghton echoed Mr Pallot's remark. She asked that with the new model of local government, how could this be an opportunity to work differently. Ms Wightman responded that there was a big difference and the joining up of all the different services was a key element. There was an opportunity to provide complimentary services and this needed to be utilised.

Mr Metcalfe was struck by the number of west Northamptonshire patients that had died at NGH. He queried whether there was a national benchmark for this. Ms Wightman informed him that there was no national benchmark. She noted that there needed to be some educational pieces of work completed on whether people understood what it meant to die at home.

Mrs Needham commented that it was good to see emotional resilience documented within the annual report. The Trust saw a large number of patients presenting at A&E with low level physical health issues but also suffering from mental health conditions. It was reported that there was also a large number of attendees to A&E of an Eastern European background, presenting to A&E as they often have no primary care service in Eastern Europe.

Ms Wightman advised that work needed to be done on health literacy and this would be done by targeting specific population groups. Once a communication was developed this would be shared with the hospital.

Mr Noble queried vaccination rates. Ms Wightman clarified that vaccination rates were varied and in some areas below target. There were challenges in flu vaccination uptake and there were pockets of issues that sat with childhood vaccination. Mr Noble asked what the Trust's role was in this. Ms Wightman explained that there was work underway with the schools however since schools have become academies this had become harder.

Mr Moore remarked that it had been a very interesting presentation. He queried what Ms Wightman lost sleep over. Ms Wightman referred to Education. There was a need to give children the best start in life or the same problems would continue to happen.

Mr Moore queried what Ms Wightman felt to be her biggest success over the past year. Ms Wightman explained a programme that had been run in the winter that involved 24 organisations who had provided health checks for the public. A few examples of the positives from this had included a number of TB cases identified, vaccination issues highlighted and it got a number of people registered at GP's.

Ms Wightman believed that another key success had been the rebuilding of the relationship with Public Health England.

Dr Swart stated that she strongly supported the annual report and the reports strategic aim. She noted that there was cancer links to be made to the work detailed in the report. One in two people will get cancer and 45% of cancers are preventable. It would be good to deliver a joined up combined communication on this topic.

Ms Houghton referred Ms Wightman to her report and the reduction in her grant with the impact to workforce. The Trust workforce and the workforce of Northamptonshire were linked. Ms Wightman explained that there was a piece of work being done with midwifes in the growing challenge of obese pregnant ladies.

Mr Burns advised that this was a big opportunity to get providers across the county to think differently. The Trust staff are able to help and influence patient choices when it came to lifestyle.

The Board **NOTED** the Director of Public Health – Annual Report.

TB 19/20 006 Chairman's Report

Mr Burns delivered the Chairman's Report to the Board.

Mr Burns informed the Board that Ms A Hillery NHFT Lead Executive, would be stepping down from her lead role in the HCP. This would give the HCP the opportunity to refresh the model. The members of the HCP had all agreed that an interim independent Chair for the HCP was required who would then be able to complete a thorough diagnosis of what needed to be done.

Mr Burns reported that there was a new Non-Executive Director joining the Trust in July. This was Professor Tom Robinson who was an expert on Stoke and had a clinical background. This appointment will support the trusts journey towards obtaining teaching hospital status.

Mr Burns had attended a session in Derby on the NHS Long Term Plan. This had talked about opportunities for capital next year and the lack of it this year. At the event there had also be discussion on the Workforce Strategy. It was noted that workforce was a world-wide issue and this was a competitive world. The Trust needed to look how it could drive innovation and once the plan was published the Trust needed to act on these actions. Mr Burns reminded the Board that workforce was one of the Trust's top three priorities.

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

TB 19/20 007 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart welcomed CQC colleagues who were in attendance at the Public Trust Board. The Trust was due an unannounced CQC inspection in June/July 2019. There was a Use of Resources inspection planned on Tuesday 04 June and a well-led inspection on 24 and 25 July.

Dr Swart advised that urgent care pressures continued in May following the unexpected difficulties in both April and at the start of May. There was a large number of patient's delayed in hospital and this had increased again. There was a variety of cause behind this increase. Dr Swart stated that there were higher attendees into A&E and the pressures were being felt internally. She noted that a review was underway to look at the Trust's internal processes.

Dr Swart expressed her concern on the impact of this emergency pressure on all the Trust's other services.

Dr Swart believed that this strengthened the requirement to work with partners as discussed in the Director of Public Health presentation and the two unitary councils. She felt a real sense of positivity in respect of this.

Dr Swart remarked that one of the main difficulties sat with patient discharge. There would be discussion with the regulators to ensure there is capacity in place to enable improvements in discharge and it had been agreed that this would be the number one priority over winter.

Dr Swart reported that the Trust had been steadily making progress with the collaborative working with colleagues at KGH and there had recently been held the first Collaborative Steering Committee meeting. There are many models nationally for the ways hospitals work together and these were being reviewed. . The work so far had prioritised a joint approach to information, estates planning, some back office functions and a number of key clinical services that presented obvious opportunities for collaboration.

Dr Swart commented that following discussions with staff there needed to be an emphasis on thinking about the good things the Trust did as sometimes the focus could sometimes be on issues and problems that occur. When she had talked to patients the patients are always supportive of the workforce however the patients felt that there was a need for more clarity on how different services work together.

Dr Swart discussed recent successes at NGH. These included the Everyday Hero Awards, Best Possible Care Awards, National Nurses Day, International Day of the Midwife and Pathway to Excellence. These were all symbols of hope and are events that energise staff.

Dr Swart stated that the Trust had some finalists in the HSJ Patient Safety awards.

Dr Swart reported that Northampton General Hospital had been named a Veteran Aware Hospital in recognition of the Trust's commitment to improving NHS care for veterans, reservists, members of the armed forces and their families.

Dr Swart advised that Trust were recently made aware of a potential cyber-attack on NHS systems. The Trust IT teams initiated a rapid response and installed the emergency patches released by Microsoft with immediate effect to minimise the risk to the Trusts' systems.

Dr Swart informed the Board that there was a newly relaunched MSC in Quality Improvement and Safety.

Mr Archard-Jones noted the programme of work in ED on internal processes. He asked if any targets had been aligned to this piece of work. Dr Swart responded that referral to a service would be one target as well as the hoped noticeable reduction in overcrowding in ED. It would also be measured by the Length of Stay target. Dr Swart explained that it was a composite measure and an exact percentage could not be given due to the fluctuations in A&E. The Trust would ideally like to be the in the top quarter of Trusts for A&E performance.

Ms Gill remarked that programmes in the past had improved flow however these programmes had not been sustained. It was clarified that this would be discussed within the operational performance report to Board.

Mr Noble challenged how the Trust knew that the conversion rate was correct. Dr Swart believed that it was not necessarily the turn-around time of patients but the lengthy admissions of some patients (elderly/frail).

Mr Moore queried whether Dr Swart was happy with the progress of the collaboration work with KGH. Dr Swart confirmed that she was happy with this at the current time. There would be work looking at the strategic overlay. Mr Moore believed it would be good to develop mechanisms to oversee this. He was referred to the CSC Terms of Reference Terms of Reference paper later on the agenda.

Mr Burns has asked for there to be a joint conference in the Autumn to see what had been learnt to date from the new collaborative approach.

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

TB 19/20 008 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe drew the Committee to page 94 of the report pack and noted the increased risk related to the achievement of the CQUIN. This was due to the new CQUIN target being set higher than previous years and also the sheer volume of audit work required. This had been discussed at the CQUIN Review Group with mitigations in place to collect the data required. He would provide an update within his Medical Directors report at the next Trust Board.

Action: Mr Metcalfe

Mr Metcalfe delivered an update on new SI's and moderate investigations. There had been 2 cases of new-born babies that had required transfer to a tertiary centre for cooling which had been referred to HSIB. This was a new process, and the Trust's region was the penultimate for introduction of the process in the country. The Trust is in close communication with the HSIB team to manage the interface between normal investigation procedures and this approach whilst maintaining safety. Mr Metcalfe advised that the differences with HSIB investigations were that the investigation can often run for over 6 months. There was a joint meeting held between the Trust, the CCG and HSIB on this.

Mr Metcalfe reported that the rolling 12 month HSMR to January 2019 for the Trust remained within the "expected" range. However due to the figures for crude mortality this could increase but still remain in the "expected" range.

Mr Metcalfe commented that the Sepsis SMR was now within the expected range for the rolling year to January 2019.

Mr Metcalfe stated that there had been a concentrated effort on improving the

reporting culture at the Trust and this had showed promising early signs. It was noted that in some Directorates local resolution was being used as a substitute for incident reporting however Datix's should still be completed.

Mr Metcalfe advised that the upgrade to ePMA which will enforce VTE risk assessment was subject to further slippage on roll out. This was due to issues with testing which required the software to be re-patched with further testing this week. Mr Metcalfe would be meeting with the Medical Director of the product supplier.

Mr Archard-Jones asked what mitigations were in place whilst the issues were resolved with ePMA. Mr Metcalfe described the clot-busting campaign that was in place on the wards and also the additional teaching sessions for FY1's. There was information being collated daily at the safety huddles and support diverted to the areas where there was high non-compliance.

Ms Houghton noted the CQUIN risk and asked if this had both clinical quality issues and financial issues. Mr Metcalfe explained that the CQUIN was delivered from quality measures. Mr Bradley further expanded and stated that the CQUIN values were included in the Finance report to the Finance & Performance Committee.

Ms Gill queried whether Sepsis training was delivered to ancillary staff. Mr Metcalfe advised that this had been discussed at CQEG in the past. Whilst high awareness of Sepsis was beneficial for this staff cohort the responsibility on acting on suspected Sepsis was not deemed appropriate. All HCA staff are trained on Sepsis through their resus training who would then escalate to qualified staff.

Ms Campbell was pleased that incident reporting had increased, but noted there was further work to do to sustain this. The Trust currently used an older version of an electronic incident reporting system and moving forward there were discussions to look at the more current versions of systems That could further support an increase in incident reporting.

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

TB 19/20 009 Approval of the Quality Account

Mr Metcalfe presented Quality Account for Approval.

Mr Metcalfe informed the Board that the Quality Account presented for approval today was presented to the Quality Governance Committee in April 2019. The Trust was still awaiting final stakeholder feedback which was due 30 May 2019.

Mr Metcalfe stated that any amendments could be incorporated up until the 07 June and these needed to be sent to him.

Mr Burns commented that an inconsistent signature had been used for him in the Quality Account.

Ms Gill remarked that Quality Account showcased all the amazing work done at the Trust. There was so much that team NGH should be proud of.

Mr Moore advised that term Dementia had only been used twice in the report. He kindly asked for this to be reconsidered. The Board agreed that a future patient story would feature Dementia.

Ms Campbell informed the Board that from next year the format would be different. The Quality Account and the Annual Account would be amalgamated into one document. There would be further discussion on this at the Audit Committee. Mr

Burns believed that this was the correct way forward.

Mrs Needham reminded the Board that the staff had been engaged on the priorities included within the Quality Account.

Ms Gill asked what had been done to communicate the Quality Account to staff. Dr Swart clarified that once published staff would receive a summary of the document. She believed that it would be positive for the staff if the Executives delivered this message face to face with the departments.

The Board **APPROVED** the Quality Account.

TB 19/20 010 Director of Nursing and Midwifery Report

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

Ms Oke advised that the response rate for Friends & Family (FFT) had increased in inpatients and ED following a targeted campaign. There had been a successful effort in Births as well. She believed the use of volunteers had been key as they had provided face to face engagement with the patients.

Ms Oke remarked that one of the key themes reported to the volunteers had been noise at night. This had been mitigated by the introduction of a welcome back which had included an eye mask and ear plugs. There had also been the installation of an electronic ear which turned red when the ward reached a certain noise level.

Ms Oke drew the Board to page 216 of the report pack section 2.2. The new definitions for recording a hospital onset CDI have come into play from April 2019. These figures now included community onset CDI if the patient had a hospital admission in the four weeks prior. Ms Oke confirmed that this was being discussed with the CCG to see if there were any trends. In April there had been 3 CDI reported.

Ms Oke commented that there was 5 hospital onset MSSA bacteraemia in April. In 2 patients these were cannula related therefore the IPCT were undertaking a review of practice. The other 3 incidents were deemed as non-preventable.

Ms Oke reported that in April, the number of pressure ulcers per 1000 bed days was 1.0 and this was an increase from the previous month, due to the new reporting guidance of not using the 72hrs rule from NHSi which had commenced in April. It was noted that hospital acquired pressure ulcers was now counted as being 6 hours from admission.

Ms Oke informed the Board that in line with NHS Improvement guidance and the CCG quality requirement the Trust had commenced recording the number of patients admitted from the community (this includes care homes/patient own homes/other hospitals) with skin breakdown. This would be continually monitored.

Ms Oke advised that level 3 safeguarding children training compliance continued to improve and was now currently at 86%.

Ms Oke stated that the Trust was currently at 28% for Prevent training and the national target is 48%. There were mitigations in place to address this.

Ms Oke expressed her concern of safeguarding referral activity. In terms of safeguarding adults' referral activity, there had been a significant decrease in both the number of safeguarding allegations raised by the Trust and the number of safeguarding allegations against the Trust. Ms Oke has urged staff to raise a Datix in

addition to a referral to ensure action happened. The Trust was working with the CCG to report on this weekly and she has written to the new Director of Nursing at the CCG to raise the profile of this further.

Ms Oke drew the Board to section 6 safe staffing of the report. The overall fill rate for April was 98%. This is a national metric the Trust must report therefore Ms Oke wanted the Board to note that despite the good performance in this metric the Trust had 110wte nurse vacancies and 160wte HCA vacancies. Mrs Brennan stated that sickness and the manning of escalation wards also needed to factored into this. Ms Oke had encouraged her staff to report vacancies via Datix. The senior nursing team meets three times daily to ensure safe staffing. Mr Burns believed there needed to be an element of managing expectations of staff in relation to being moved around the wards to ensure safe staffing was maintained.

Ms Oke shared the positive news of the recent Pathway to Excellence conference which a team of nurses from NGH had attended. These were front facing staff. She commented that NGH was officially awarded Designation Status with a celebration recognising the Trust as the first ever UK organisation to gain this accolade.

Mrs Needham referred back to safe staffing. She reported that Benham which had been classed as a winter ward had suffered some issues with staff. Therefore the Executive Team had decided to staff this ward with 16 permanent members of staff. It was noted that Avery continued to be a worry therefore a senior nurse had been put in place to address this. The bed base for Avery had halved with the remaining beds to be removed later in the year. Ms Oke concurred with Mrs Needham's concerns in regard to Avery.

Mr Archard-Jones drew the Board to page 230 of the report pack and the performance of Paddington Ward. He had raised this concern at Quality Governance Committee however wished for this to be highlighted to the Board. Ms Oke explained that Paddington was a small ward with a small number of patients therefore compliance can appear to significantly drop if only one piece of paperwork is not completed. She was satisfied that there was no risk to patients on Paddington Ward.

Mr Archard-Jones asked how Pathway to Excellence could be used to improve recruitment. Ms Oke clarified that this needed to be marketed and she confirmed that unique selling points had been identified.

Ms Campbell congratulated Ms Oke on the improved response rates for FFT. She queried whether the good work done in maternity would be rolled out to other services. Ms Oke stated that the next focus would be on medicine.

Ms Gill noted the drop in the compliance (54.5%) with patients not being referred/highlighted via discharge letters by medical staff for the GP to refer onwards for review as described on page 222 of the report pack under dementia screening compliance. Ms Oke assured Ms Gill that this was being addressed.

Mr Moore remarked that Trust should be able to factor in an estimate for sickness and maternity leave for nurses therefore why this was not done so considering the high number of vacancies. Ms Oke explained that there was a percentage factored in for training, sickness and annual leave however none for maternity leave. Mr Moore believed that this should be something to consider.

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

TB 19/20 011 Month 01 Finance Report

Mr Bradley presented the Month 01 Finance Report.

Mr Bradley informed the Board the 2018-19 final audit had been closed.

Mr Bradley advised that the month 1 results had been very disappointing. The Trust had a pre - PSF overspend against plan of £635k and had potentially lost PSF and FRF of £844k, leaving the Trust's M1 position at £1,479k adverse.

Mr Bradley reported on the two main reasons. He drew the Board to page 247 which detailed pay costs. It was noted that once unplanned pay savings of £758k had been removed this was over £1m overspent. There are a number of reasons behind this including some backdated ADH and job plan costs without an accrual. The Trust was £257k above plan on senior medical locums and £165k on above establishment HCA costs. The agency spend in the month was £1.255m which was £321k above the monthly target. Mr Bradley remarked that a full explanation of these overspends was being worked through with the Divisions as this level of spend could not continue if the Trust was to meet our financial plan this year. Mr Bradley recognised the urgent care pressures the Trust experienced in April and the need to keep patients safe was also a contributory factor in the pay overspend. It was noted that fortunately non pay had been £407k underspent.

Mr Bradley referred the Board to page 245 of the report pack which included an update on income. It was reported that clinical activity was down by £367k with the biggest variances being on Outpatients £239k and electives £113k. It was down due to the level of cancellations in month due to poor flow of non-electives out of the hospital. The Trust at this time potentially lost £844k of PSF / FRF income, though this was recoverable.

Mr Bradley commented that the Trust has had poor financial start to 2019/20 and there needed to be a review on the financial governance of pay spend otherwise the Trust would go away from plan further very quickly. This would be picked up individually with the Clinical Directors and at the Divisional Performance Reviews.

Ms Houghton queried what could be done to fill vacancies quicker. Mrs Brennan clarified that there had been improvements in 2018. There would be a group this year to look at what could be done differently. There would be a visit to Derby to understand what is being done differently there due to their good performance in this. Ms Gill reminded the Board that the Medical Recruitment Strategy was to be presented to the July Workforce Committee.

Ms Houghton asked if there was any collaborative work being done with KGH on recruitment. Mrs Brennan stated that this was being done with nursing.

Dr Swart commented that Mr Metcalfe had done work with the Divisional Directors to look at Consultant gaps and what gaps could be substituted with doctors and nurses. The Trust still however needed to over recruit to Trust grade posts. The partnership with the University of Leicester should attract some clinical staff.

Mr Burns asked that the Finance & Performance Committee to focus on metrics that drove the measurement of the finances.

Action: Chair of Finance & Performance (Mr Moore)

The Board **NOTED** the Month 01 Finance Report.

TB 19/20 012 Operational Performance Report

Mrs Needham presented the Operational Performance Report.

Mrs Needham delivered an urgent care update to the Board. It was noted that A&E

performance dipped in April 2019 to 79%. She reminded the Board that quarter 4 had seen an overall dip in performance therefore the Trust had secured external help to understand the dip and to ensure that the right actions are in place to address this.

Mrs Needham referred the Board to page 260 of the report pack which outlined the reasons for the dip in performance. There had been a reduction in discharges in March/April 2019 and the increased number of super stranded patients. This could be a likely reason for the dip in A&E performance.

Mrs Needham clarified that there was an agreed action plan. Mrs Needham would take the lead for site management and real time issues, Ms Oke the lead for discharge processes and Mr Metcalfe the lead for ward, admission and assessment processes. There was also a big piece of cultural work that needed to be done. These actions would be developed with the staff. Mrs Needham confirmed she would further update the Board once the action plan was fully documented. The programme Board was meeting weekly and she expected to see an increase in performance over the next 2 months.

Mrs Needham reported that A&E performance to date for May was 83%. She would be sharing the output of this work with KGH.

Mrs Needham informed the Board that the main risk was with capacity in the community across social care mainly. The main issues lay with pathway 1 and pathway 3. There are weekly COO meetings to identify how capacity can be put in place.

Mrs Needham stated that 18 weeks RTT was at 79% despite a large amount of validation that had been done. There were capacity constraints in ENT, Cardiology, max-fax, Oral Surgery and Urology. Both max-fax and Oral surgery were both meeting their trajectories. She expressed that her main concern sat with Head & Neck and Cardiology. There has been additional capacity put in place however this still remained a challenge due to Workforce issues. There was a weekly performance meeting that was chaired by the Deputy COO and Mrs Needham would also now be chairing this meeting from June.

Mrs Needham advised that in April Endoscopy had lost 40 lists due to issues with the Endoscopy washers. This was approximately 300 patients. She hoped that the new washers installed would increase performance.

Mrs Needham updated the Board on Cancer performance.

Mrs Needham reported that there was improvement in breast and this was at 83.3% in April however this still remained a fragile service with workforce gaps. It was noted that 2ww overall had improved in May and was now over 90%. There were continued challenges for 62 day waits. Mrs Needham now chaired the daily PTL and any patient over 50 days would be micromanaged to prevent breaching. The areas of focus were Head & Neck, Lung, Urology and Colorectal.

Mrs Needham expressed concern for the Urology pathway with the University Hospital of Leicester having insufficient capacity for robotic surgery, however there were also worries over the internal processes. She also reported concerns with bloods and histology being sent away and taking a long time to receive results.

Mrs Needham was pleased to announce that a Clinical Lead has been appointed for Cancer and pathway changes were being made.

Mrs Needham advised that there was continued daily PTL’s to manage the legacy

patients. There were also harm reviews conducted for patients over 104 days. She expected that it would take several months to improve Trust performance due to the number of patients currently over 62 days.

Mr Burns noted the update on Cancer and asked Mr Archard-Jones for update from a Non-Executive perspective as he had become involved with some of the cancer work. Mr Archard-Jones remarked that he had attended the Cancer group. The Quality Governance Committee had also received a valuable presentation from Urology which had been done by the newly appointed cancer lead.

Dr Swart discussed the national cancer plan with the Board. There had been a delay in some projects due to funding and some projects were too early to see an impact. It was noted that the Medical Director chaired the Cancer HCP group.

Mr Noble shared his frustration that these concerns had been heard before. There appeared to be no progress with improving performance. Mr Metcalfe suggested breaking down the PTLs by tumour sites.

Mr Finn referred the Board back to the new washers installed in Endoscopy. There were 5 secured with 3 already installed and the remaining 2 to be installed in July.

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

TB 19/20 013 **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the overall Trust vacancy rate stood at 12.44% and this had been discussed in detail at the Workforce Committee. There was to be a large focus on medical and nursing recruitment.

Mrs Brennan stated that sickness had increased in month with the continued key themes to be Anxiety/stress/depression/other psychiatric illnesses therefore it was positive to hear about emotional resilience within the Director of Public Health annual report. She informed the Board that a Staff Health & Wellbeing Psychological Therapist was in the process of being recruited.

Mrs Brennan reported that the 'Trac' applicant management system had been implemented. She hoped that this would improve the recruitment process and turnaround time.

Mrs Brennan commented that a three month trial with a system that enabled medical bank shifts to be electronically advertised and doctors to book shifts was being undertaken.

Mrs Brennan remarked that the current rate of appraisals recorded for April 2019 decreased. This was being addressed by the HR Team.

Mrs Brennan delivered an update on the Respect & Support Campaign. It was noted that all training had been well received. The Respect & Support hotline since its launch has had a slow start therefore it had been promoted on the May payslips. The introduction of round table discussions had been successful.

Mrs Brennan stated that in conjunction with KGH and NHFT two equality and diversity projects were being run based on a recruitment pilot and a deep dive into understanding what it was like to work at NGH for staff with protected characteristics.

Mr Burns requested the information reported within the Workforce performance report was linked with the Trust Strategy and People Strategy so questions could be dealt with in that agenda item.

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

TB 19/20 014 Trust Vision and Aims

Mr Pallot delivered a presentation on the Trust Vision and Strategic Aims which summarised the paper in the board pack.

Please see below for further details.

NGH Strategy - FINAL Presentation - CP Publ

The Board discussed the strategic aims and vision as presented by Mr Pallot and some suggestions were agreed.

The Board endorsed the strategic aims and vision subject to amendments documented. .

The Board **APPROVED** the Trust Vision and Aims and AGREED proposed changes for use in the new strategy that will be presented to the Board on a later date.

TB 19/20 015 People Strategy

Mrs Brennan presented the People Strategy proposed framework.

Mrs Brennan advised that the People Strategy had been reviewed in light of the recent staff survey result. The framework had also been developed using intelligence from the consultation on the Trust Strategy, Freedom to Speak Up themes HR intelligence and key issues identified by the Chair of the Workforce Committee.

Mrs Brennan commented that a workshop had been held and these outputs had subsequently been presented in a Trust Board workshop. The framework had been framed round the feedback received at these sessions.

Mrs Brennan stated that there were five strategic imperatives and these were listed on page 318 of the report pack. Mrs Brennan reminded the Board that the People Strategy would be owned by the Trust Board.

Ms Gill queried whether the strategy reflected the capabilities needed to deliver the overall Trust strategy. Mr Moore questioned which part of the report was classed as the strategy. Mrs Brennan clarified that this was a strategic framework as opposed to a strategy.

Ms Houghton believed that this was a good start however was not sure whether it it could be more innovate.

Ms Campbell asked that under the Respect & Support section that Freedom to Speak Up was included.

Ms Gill asked whether external data had been taken into account as she was unsure whether there was enough included within the report that would respond to the external challenges.

Dr Swart remarked that a lot had come out of the workshop however intelligence from external information needed to be sought.

Mr Archard-Jones commented that there needed to be more to address staff capacity and that we needed some innovative recruitment solutions.

Mr Burns stated that there was no sense of excitement or detail on how to change things for the better. There needed energy and exciting ideas incorporated. He asked for another paper to be presented to the June Board of Directors taking on board the discussions held today.

Action: Mrs Brennan

The Board **NOTED** the People Strategy.

TB 19/20 016 Collaboration Steering Committee – Terms of Reference

Ms Campbell presented the Collaboration Steering Committee – Terms of Reference.

Ms Campbell advised that the paper presented the Terms of Reference for the Collaborative Steering Committee (CSC) as agreed by that Committee at its Inaugural Meeting on 20 May 2019.

Ms Campbell stated the Terms of Reference (ToR) would also be presented to the KGH Board. There had also been a review date of six months added to the ToR.

Mr Burns asked for clarity on point 9. It was explained that the CSC had no formal authority and decisions would come back to the two Boards for ratification.

Ms Houghton queried whether any Non-Executive input was needed. Mr Burns advised that it would best to keep the group how it currently was formed due to the complexity.

The Board **APPROVED** the Collaboration Steering Committee – Terms of Reference.

TB 19/20 017 Health and Safety Annual Report

Mr Finn presented the Health and Safety Annual Report

Mr Finn reported that there had not been a visit from the Health & Safety Executive or the Environment Agency to site during 2018/2019. The Trust was contacted by the Health & Safety Executive Principle Inspector in March 2019 regarding complaints from workers within the Trust relating to the lack of ventilation within Sterile Services and the increase in room temperature within the work area. Mr Finn commented that a response was returned within 24 hours, providing the risk assessment and remedial measures that had and were being undertaken. An e mail response from the Principle Inspector noted they were “content with the action taken”.

Mr Finn delivered an update on the Health & Safety Committee. There was work ongoing on how to simplify the reports presented to the Committee as well increasing the number of meetings but in doing so reducing the length of the meeting.

Mr Finn advised that there appeared to be an increase in the number of aggression towards staff from patients as reported via security and other reporting mechanisms. The Board understood the need for staff to be supported following involvement in one of these incidents. A sub group of the Health and Safety Committee was formed in January 19 to discuss and analyse incidents of aggression. The Deputy Director

of Nursing was now chairing the group, supported by nominated members of Clinical and Non-Clinical staff. It was proposed that an update from this group would be presented to CQEG rather than QGC.

Mr Finn delivered an update on Fire Safety. A weekly Fire Safety Task and Finish Group, chaired by the Trust Finance Director had been in place since May 19. It was reported that an external independent specialist review had also happened. The local fire service would be advised of any recommendations of the review.

Mr Burns referred the Board back the increased number of incidents of aggression towards staff from patients. He asked what can practically be done to address this. Mr Burns requested an update at the next Public Trust Board.

Action: Mr Finn

Mr Metcalfe commented that there appeared to be a normalisation of the tolerance of the aggression from patients. There had been rare occasions when patients had banned from the hospital unless they required emergency care.

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

TB 19/20 018 Freedom to Speak Up Annual Report

Ms Campbell presented the Freedom to Speak Up Annual Report.

Ms Campbell advised that following the relaunch of Freedom to Speak Up in January 2019 there had been an increase in caseload. The content of the majority of cases was firstly bullying and harassment, followed by patient safety issues.

Ms Campbell informed the Board that the value ambassador role had recently been launched. These roles would be to support and signpost staff for both Freedom to speak Up issues and Respect and support. There are 10 members of staff booked on two training sessions in June.

Ms Campbell stated that the Trust Board needed to revisit the Trusts self-Assessment and develop an overarching strategy in relation to Freedom to Speak Up.

Mr Burns remarked that Ms Campbell had been an excellent Freedom to Speak Up Guardian and welcomed the introduction of the value ambassador roles.

Dr Swart reported that it was critical that this work was rolled out with the OD Team to ensure it was communicated correctly to staff.

The Board **NOTED** the Freedom to Speak Up Annual Report.

TB 19/20 019 Self-Certification

Ms Campbell presented the Self-Certification Report.

Ms Campbell advised that this had been discussed at the Finance & Performance Committee. The Finance & Performance Committee had approved and was now presented to the Board for ratification.

The Board **RATIFIED** the contents of the Self-Certification Report.

TB 19/20 020 Highlight Report from Finance and Performance Committee

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

TB 19/20 021	**Highlight Report from Quality Governance Committee**

Ms Houghton asked for Board approval of the National Emergency Laparotomy Pathway.

The Board **APPROVED** the National Emergency Laparotomy Pathway and **NOTED** the Highlight Report from Quality Governance Committee.

TB 19/20 022	**Highlight Report from Workforce Committee**

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

TB 19/20 023	**Highlight Report from HMT**

The Board **NOTED** the Highlight Report from HMT.

TB 19/20 024	**Any Other Business**

There was no other business to discuss.

Date of next Public Board meeting: Thursday 25 July 2019 at 09:30 in the Board Room at Northampton General Hospital.

Mr A Burns called the meeting to a close at 12:40pm

Public Trust Board Action Log **Last update** **15/07/2019**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
106	May-19	TB 19/20 008	Medical Director's Report	Mr Metcalfe drew the Committee to page 94 of the report pack and noted the increased risk related to the achievement of the CQUIN. This was due to the new CQUIN target being set higher than previous years and also the sheer volume of audit work required. This had been discussed at the CQUIN Review Group with mitigations in place to collect the data required. He would provide an update within his Medical Directors report at the next Trust Board.	Mr Metcalfe	Jul-19	On Agenda	***Within Medical Directors Report**
107	May-19	TB 19/20 011	Finance Committee	Mr Burns asked that the Finance & Performance Committee to focus on metrics that drove the measurement of the finances.	Mr Moore	Jul-19	On Agenda	**Update Matters Arising**
108	May-19	TB 19/20 015	People Strategy	Mr Burns stated that there was no sense of excitement or detail on how to change things for the better. There needed energy and exciting ideas incorporated. He asked for another paper to be presented to the June Board of Directors taking on board the discussions held today.	Mrs Brennan	Jul-19	Gone to June BoD	**Confirmation given in Matters Arising addressed at BoD**
Actions - Future meetings								
94	Jan-19	TB 17/18 206	Chief Executive's Report	Mrs Brennan commented that the workforce plan was under development and this was split into 5 workstreams. The plan would be shared in March with the detail received by the Autumn. An update would be brought to the Trust Board when circulated.	Mrs Brennan	TBC	TBC	**Update from May Board - Mrs Brennan updated the Board and informed them that the National Workforce plan had still not been released. Once it had been she would update the Board.**
100	Mar-18	TB 18/19 246	Discharge Processes	Mr Burns queried what 3 metrics could determine if the project (discharge process) had been successful and time to discharge had reduced. He asked for an update at a future Board on what metrics would define this.	Mr Holland	TBC	TBC	
103	Mar-18	TB 18/19 249	Paediatric Nurse in Paediatric ED	Mr Burns asked for a future report on registered Paediatric Nurse in Paediatric ED.	Ms Oke	TBC	TBC	
109	May-19	TB 19/20 017	Health and Safety Annual Report	Mr Burns referred the Board back the increased number of incidents of aggression towards staff from patients. He asked what can practically be done to address this. Mr Burns requested an update at a Public Trust Board	Mr Finn	TBC	TBC	

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

The Northamptonshire CCGs Transition Programme

Toby Sanders, Joint CEO Northamptonshire CCGs

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Proposal

NHS Corby CCG

- 5 member practices
- Serving 80,000 people
- Annual commissioning budget of £117m.

NHS Nene CCG

- 66 member practices
- Serving 693,000 people
- Annual commissioning budget of £850m.

The proposal is to create a single new countywide CCG to drive required changes more efficiently and effectively – for front line workers and the people of Northamptonshire.

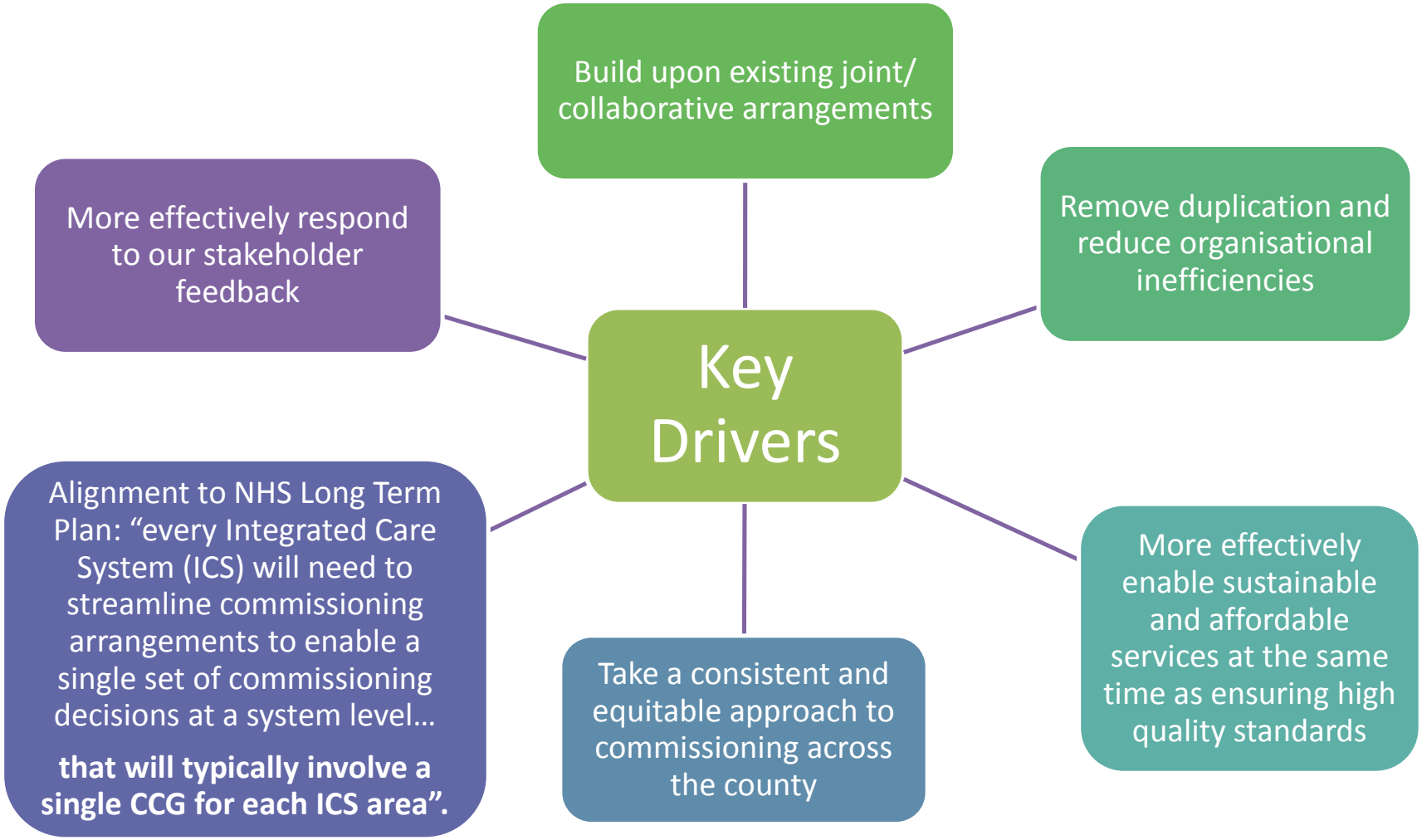
We want to hear your views

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Key Drivers for Change



'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

Potential Priorities

NHS Nene Clinical Commissioning Group

Priorities of the proposed new organisation:

- Remain a clinically led and managerially supported membership organisation
- Strengthen the delivery of improved quality of patient care and experience
- Enable the development of an Integrated Care System
- Improve the way we plan and commission services
- Reduce variation in services
- Reduce health inequalities

Are there any others you think we should add?

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Achieving the Priorities

The potential new organisation will achieve the priorities through:

- Speaking with a strong, consistent and credible voice amongst the NH&CP to strengthen the delivery of a positive lifetime of health, wellbeing and care in our community.
- Strengthening our organisational capability and leadership to become effective strategic commissioners.
- Ensuring patients, regardless of where they live, have equitable access to high quality services.
- Have a strong and effective relationship and engagement with our local population, members and partner organisations.
- Ensuring the best use of resources for the people of Northamptonshire
- Sharing best practice.

Are there any other ways we should achieve our agreed priorities?

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

Northamptonshire Health & Care Partnership

NHS Nene Clinical Commissioning Group

Through the Northamptonshire Health and Care Partnership (NH&CP) there is a:

"collective commitment to work together, with input from our community and staff, to transform the future care in our county."

The priorities of a potential single Northamptonshire CCG support the NH&CP priorities:

- We will work together with all local health and care partners to make sure our strategies are aligned.
- We will ensure our Partnership work is always aligned with ongoing national priorities, including the new GP Contract and NHS long Term Plan

And our shared transformation priorities:

- Care in your area (primary, community and social care).
- How we plan, buy and monitor services (strategic commissioning).
- Our hospitals working more closely together (unified acute model).
- Urgent and emergency care.

NHS Corby Clinical Commissioning Group

Clinically Led CCG

NHS Nene Clinical Commissioning Group

The proposed single Northamptonshire CCG would be clinically led through:

A single GP Chair elected from the membership.

Elected Member practice representation on the Governing Body and key decision making committees.

Agreement with the member practices, LMC, Federation leads and new PCN Accountable Clinical Directors on how CCG and GP Provider leadership can best be aligned once the new PCN landscape has been established starting in July 2019 and concluding in October 2019

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

360 Stakeholder Feedback

NHS Nene Clinical Commissioning Group

Feedback trends from **All Stakeholders**:

- Would like the CCG to actively listen to suggestions and ideas
- Would like to see strengthened and frequent engagement with patients and public
- Would like to see feedback from a more diverse population
- Would like to see an improved understanding of the needs of General Practice
- Would like to see more individual engagement with practices
- Would like to see clear deliverables in 2019/20 for improving the primary care offer
- Would like to see information more easily available and accessible to a wider audience, particularly committee papers
- Positive acknowledgement of new Joint CEO role
- Would like to see more transparency around the CCGs' financial position
- More involvement in planning service changes
- Would like a better understanding of the CCGs' top strategies
- Would like to see further targeted work on health inequalities

NHS Corby Clinical Commissioning Group

Northamptonshire CCGs Response

NHS Nene Clinical Commissioning Group

A single countywide CCG would:

- **Be more efficient** – there would be less duplication and resource would have more time to work closer with stakeholders
- **Have a dedicated Director of Primary Care Transformation** – enabling the CCG to understand the needs of General Practice and support shaping the future of Primary Care
- **Have clear deliverables for the County** – Giving stakeholders consistent and clear information to support the Primary Care offer

NHS Corby Clinical Commissioning Group

Learn From the Past

NHS Nene Clinical Commissioning Group

A single Northamptonshire CCG should take learning from the 2 existing CCGs, build on good practice and proactively develop the areas requiring improvement.

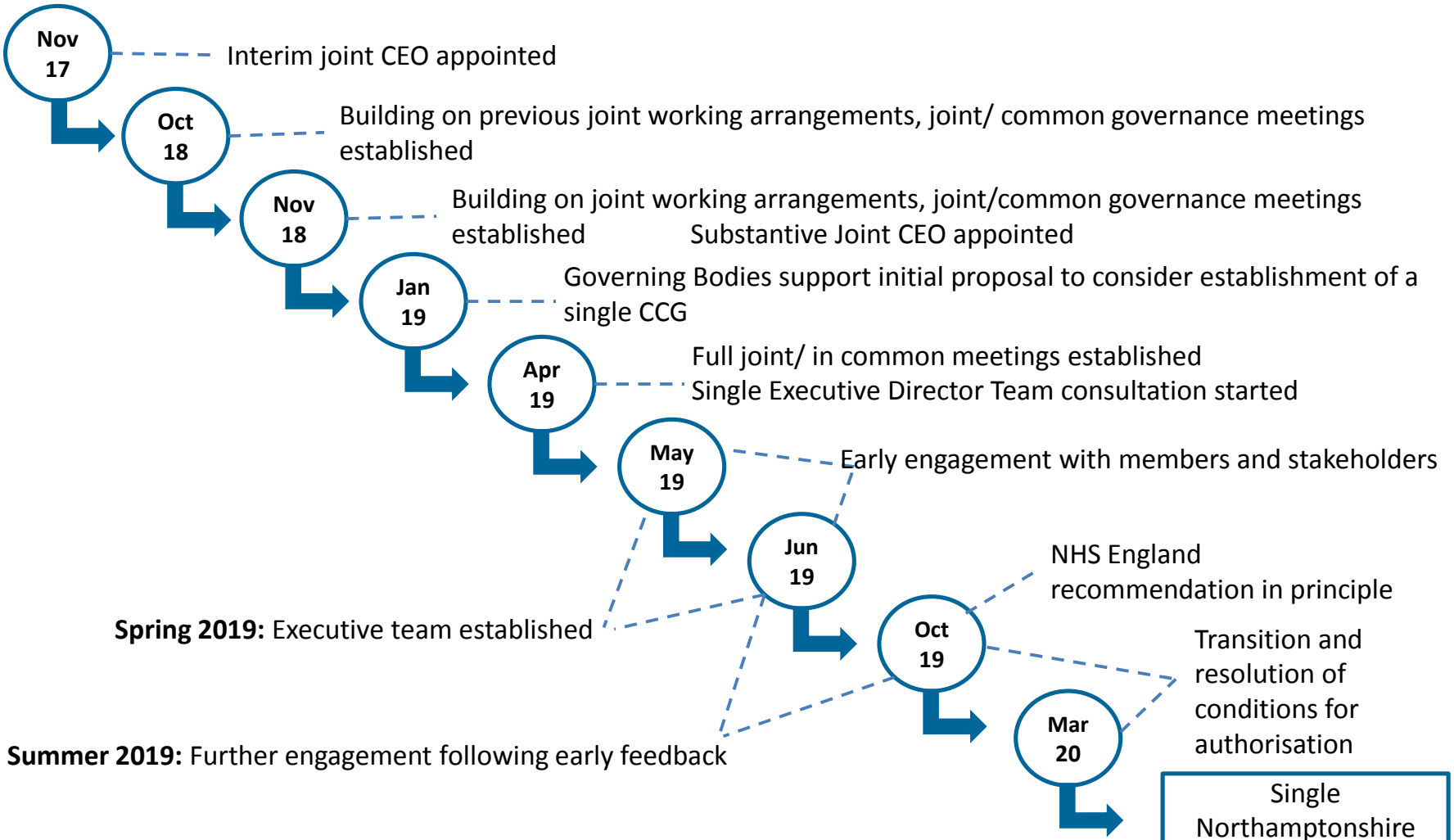
Learn from Good Practice	Opportunity to Improve
• Financial management	• Strategy and Planning
• Regulatory compliance	• Transformation
• Pockets of membership engagement	• Stakeholder engagement
• System collaboration	• Responding and acting upon feedback

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

Process and Outcome

NHS Nene Clinical Commissioning Group



'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

What Other Areas are Doing

NHS Nene Clinical Commissioning Group

CCGs in 14 health & care systems are looking to create single CCGs from April 2020 – including 5 in the Midlands:

- Northants
- Nottinghamshire
- Staffordshire
- Coventry and Warwick
- Hereford and Worcester

In 2021, a further 12 health & care systems are planned, including:

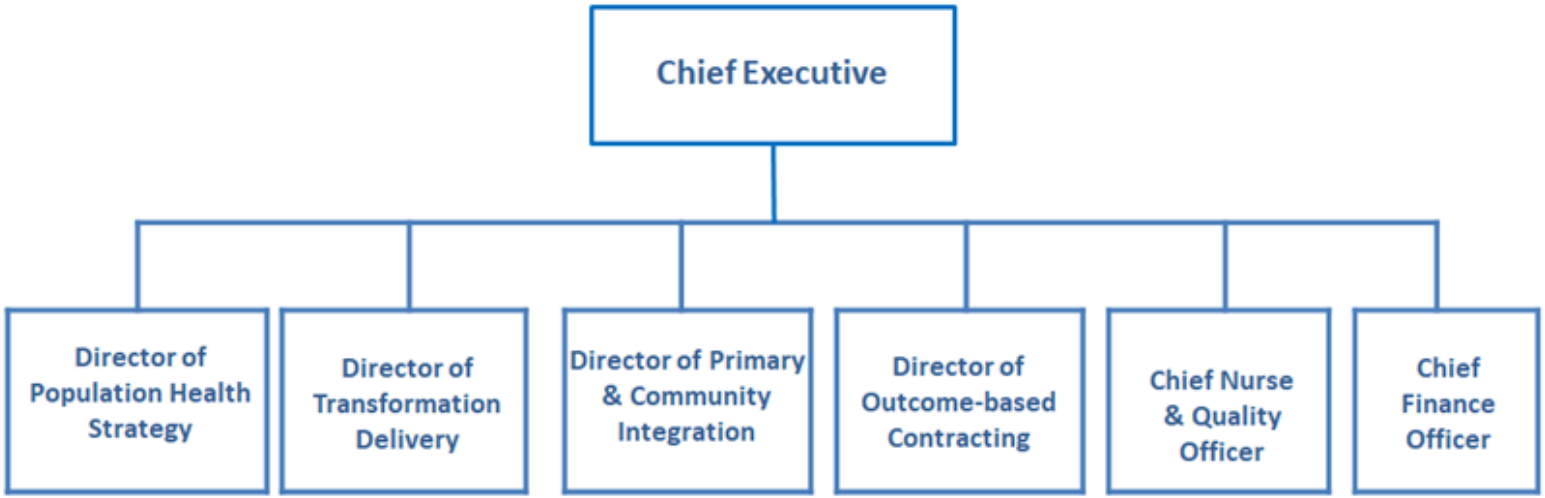
- Black Country
- Leicestershire
- Lincolnshire
- Shropshire
- Telford

'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

New Joint Management Team

NHS Nene Clinical Commissioning Group



'Corby and Nene CCGs working together for Northamptonshire'

NHS Corby Clinical Commissioning Group

Questions and Feedback

NHS Nene Clinical Commissioning Group

- Do you support the direction of travel?
- How do we develop this proposal further to benefit the county?
- Would you add any further priorities for a Northamptonshire CCG?
- Are there any other ways through which a Northamptonshire CCG should look to achieve the agreed priorities?

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**Chief Executive's Report**
Agenda item	***8***
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Deborah Needham, Deputy Chief Executive and Sally-Anne Watts, Associate Director of Communications
Purpose	For information
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board
26 July 2019

Chief Executive's Report

1. Care Quality Commission

Board members will be aware that our unannounced CQC inspection took place in mid-June and our well-led review is scheduled for 24 and 25 July.

The inspection team thanked us for receiving them so well and said they found NGH to be a friendly and welcoming organisation. They found that staff in all areas had care for patients as their main priority. High quality interactions between staff and patients were observed and care on the wards, as might be observed by walking on the wards, appeared good. Staff were seen to have a high priority to look after vulnerable people well whether this related to patients with learning disabilities, mental health issues or dementia.

The inspection team were impressed with the various initiatives to share learning from incidents and noted the efforts of the simulation team on wards and were also impressed with the engagement of staff in improvement initiatives such as our Shared Decision Making Councils and mention was made of well-being boxes.

It was noted that there was a good range of development opportunities for staff with various development and leadership offers. The inspection team also commented on the culture of embracing difference in terms of protected characteristics and had a good focus group session with some of our staff on this.

However, there were some concerns raised and we undertook to deal with these as a priority. These are not immediate must-do instructions, but it is important that we respond to and address these issues immediately and provide evidence of our actions:

- Medicines management
- Standards relating to COSH management
- Waste segregation
- Safety checks for interventional procedures in some areas
- Behaviour between staff groups

I was impressed by the real team feeling that has been generated throughout the CQC inspection process, in terms of preparation, during the inspection and readiness to respond to any concerns raised. Some of the concerns raised by the CQC can and will be dealt with very promptly whilst cultural issues will take longer and this is something which we are already actively working on.

2. Clinically-led review of NHS access standards

In 2018 Professor Stephen Powis, NHS National Medical Director, was asked to carry out a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use. An interim report of the review was published on 11 March which contained proposals to carefully test updates and upgrades to NHS access standards. NGH is one of 12 NHS trusts who will be taking part in the field testing of the proposed revised access standards for elective services from August 2019.

The aim of the review is determine whether updating and improving the targets currently in use could better support frontline staff to deliver the highest quality care for patients, taking into account advances in clinical practice and what patients say matters most to them.

The current standard is for 92% of those requiring routine hospital care to receive that care within 18 weeks of being referred. Whilst this standard has been associated with reductions in waiting times for routine care over the last 10 years, Professor Powis's review has identified a number of deficiencies with the current standard. These are:

- The target does not measure total waiting times and covers performance against the 18 week threshold and waits for patients who don't begin treatment within that threshold are not measured.
- Patients don't always understand what the target means for them, with many believing they will have to wait as long as 18 weeks for their treatment, whereas the majority will wait fewer than 8 weeks. Even when accounting for long-waiters, the average (mean) wait is fewer than 10 weeks.
- Patients don't understand their right to choose an alternative provider and it is felt that more could be done to help patients exercise that right, with more emphasis placed on providers and commissioners to help find and offer suitable alternatives that will deliver faster treatment.

Professor Powis's review has recommended testing the use of an average wait target for people on the waiting list, with the hypothesis that because every week counts for all patients in achieving an average, the focus is kept on patients at all stages of their pathway.

If ultimately adopted, this would be in addition to the existing six-week target for diagnostic tests, which is regularly met by NGH, and supported by the following additional measures to reduce long waits:

- 26 week patient choice offer – ensuring that patients who have not accessed treatment within the recommended timeframe are able to choose whether to access faster treatment elsewhere in a managed way
- 52 week treatment guarantee to further reduce 52 week waits with joint accountability for commissioners and providers.

Taken together, it is believed the improved measures have the potential to improve care and enhance patient safety and we will be keeping staff, patients, members of the public and other stakeholders up to date as appropriate during each stage.

Once testing is complete the NHS nationally will collate and analyse the data to track results, with the learning from NGH and elsewhere informing any final recommendations from the review later in the year.

3. People strategy

We are embarking on a trust-wide engagement exercise with our staff to develop our people strategy. The engagement sessions will be led by senior managers from across NGH, supported by a group of skilled facilitators and using a common methodology for which the leaders will receive training. The aim is to enable members of TeamNGH, whatever their role, to have an opportunity to contribute and put forward their views so that we can understand and clarify key issues under the three pillars of creating capacity, developing capability and shaping our culture.

The engagement sessions will take place between July and September, utilising existing meetings where possible. The iterative feedback will confirm and shape our priorities and commitments, and determine our short and medium-term objectives within our people strategy.

Feedback from staff who had the opportunity to be involved in discussions to shape and inform our revised strategy has been very positive and we believe there will be as much enthusiasm to become engaged in developing our people strategy. By developing and nurturing an open and honest culture, where we listen to and take account of the views of our staff we will make further progress towards becoming an organisation that is known for the respect and support shown to all colleagues.

The people strategy will be presented to the board for approval in October 2019.

4. Our staff

For the second year running our infection prevention and control team were shortlisted in the national HSJ Patient Safety Awards. Whilst the team did not achieve the ultimate accolade of winning the Award, it is well worth noting that they have been shortlisted on two separate occasions for different projects.

We are now awaiting the outcome of the Nursing Times Workforce Awards, which will be announced in September, and where NGH is shortlisted in three categories.

We recently welcomed Bonnie and Mark Barnes, the American creators of the DAISY foundation, to NGH for a second time to help us celebrate the achievements of our DAISY Award honourees. Now in its second year, the DAISY Award provides an opportunity for patients and their families to say thank you by sharing their story of how a nurse or midwife made a difference that they never forget.

To date 24 honourees have been recognised across NGH for their achievements in going above and beyond to provide memorable patient care. The DAISY Award is now complemented by our Everyday Hero Awards. Judging these awards is always a highlight as it helps us all to remember what a big difference a seemingly small gesture can make. So often when I present these awards the recipient tells me ‘I was just doing my job’. I am proud that we have so many members of TeamNGH who are prepared to go more than the extra mile for our patients and their colleagues and delighted that we are able to recognise, reward and share their commitment.

Another way we recognise the extraordinary achievements and commitment of TeamNGH are our annual Best Possible Care Awards. Judging for the 2019 Awards has recently taken place and the panel had a difficult task to select the winners in each category. The Awards Dinner, which takes place on 27 September, is a highlight of our NGH year.

Report To	**Public Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**Medical Directors Report**
Agenda item	**9**
Presenter of Report	Matt Metcalfe, Medical Director
Author(s) of Report	Matt Metcalfe, Medical Director
Purpose	The paper is presented to provide information to the board to form a discussion relating to medical quality and safety.

Executive summary

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

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

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

a. Patient Harm
b. Mortality
c. Thrombosis
d. Medical Gases
e. Action on CQC feedback

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

Actions required by the Board

The board is asked to receive this report.

Medical Director's Report July 2019

1. Introduction

The purpose of this report is to reflect faithfully upon the quality and safety of the clinical services afforded to our patients against our vision of delivering best possible care for all our patients. This report should therefore be taken in conjunction with the director of nursing and midwifery report to the board. For ease of access the report is structured;

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

a. thrombosis
b. medical gases
c. reposnse to CQC feedback in June 2019 relating to
    i. Medicines Management
    ii. LocSSIPS

2. Risk

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

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
966	Maintaining the safety and recognising vulnerable children & adults	6	20	Quality Governance Committee
1373	Restricted access to clinical areas - compliance risk	20	20	Quality Governance Committee
1665	Maintenance of Midwife to Birth Ratio	20	20	Workforce Committee
1850	Not able to undertake Autism Disorder assessments	20	20	Quality Governance Committee
1867	Maternity Safeguarding	20	20	Quality Governance Committee
1902	[CANCER - BRAIN] Compliance with NICE Guideline (NG99) on Neuro Rehabilitation	20	20	Quality Governance Committee

1967	[EAB] Emergency Assessment Bay Staffing and Competency Levels	15	20	Quality Governance Committee
1598	[TB WARD & Chemotherapy] risk to patient safety from lack of suitably experienced nurses resulting in sub optimal patient care	12	16	Quality Governance Committee
1782	Venous Thromboembolism: compliance. THe Trust is at risk of being unable to demonstrate full compliance with NICE guidelines.	16	16	Quality Governance Committee
1879	Patient safety/experience/reputational risk due to inability to provide dedicated triage area on/near Labour Ward	16	16	Quality Governance Committee
1911	Compliance with the Saving Babies Lives Care Bundle	20	16	Quality Governance Committee
1913	Provision of Transitional Care Facilities to support the implementation of ATAIN	16	16	Quality Governance Committee
1962	Maternity Activity and Capacity	20	16	Workforce Committee
2006	Acute Contract-Commissioned Activity	16	16	Finance & Performance Committee
2020	INFO & CLIN - Incorrectly closed RTT pathways impacting on patient treatment and potential breaches	16	16	Finance & Performance Committee
368	Risk of reduced patient safety when demand exceeds capacity	20	15	Quality Governance Committee
1411	Medical records not being received at the locations in a timely manner	9	15	Quality Governance Committee
1478	Assessment of Capacity for DNACPR	15	15	Quality Governance Committee
1682	Paediatric area understaffed with paed trained nurses	9	15	Workforce Committee
1844	[ONCOLOGY] Training Grade Oncology Doctor post removed without notice with possibility of more being removed	20	15	Workforce Committee
1955	Deteriorating Patient Care. The Trust is at risk of ineffectively managing deteriorating patients across the Trust	20	15	Quality Governance Committee
1984	CLIN and DQSP - Incomplete Medical Records from loose unfiled pages that should be in records impacting on patient care and GDPR	15	15	Finance & Performance Committee

New risk awaiting review and approval

ID	Risk Description and Consequences	Existing Controls	Risk Score (Current)
2001	Commissioning for Quality and Innovation (CQUIN) Risk of financial loss and compromised quality, inability to meet contractual/quality requirements due to a failure to deliver on the CQUIN indicators	CQUIN leads asked to risk assess CQUINs and draw action plans. Additional resources to be utilised from bank. Monthly CQUIN progress meetings including monthly reports and attendance by CQUIN Leads chaired by Medical Director. Meetings with Commissioners, Governance support for CQUIN Leads	20

No change in status (all risks have been reviewed in April):

ID	Description	Rating (Initial)	Current rating
368	Risk of reduced patient safety when demand exceeds capacity	20	15
1757	Escalation areas budgeted for limited periods may remain open for extended periods	16	16
1782	Venous Thromboembolism: compliance	16	16
1756	Ineffectiveness of the Nye Bevan unit due to ineffectiveness of the medical model, inability to recruit staff substantively, as well as impact of patient flow across the hospital.	20	15

Risk which has decreased in score and de-escalated from CRR to Departmental Risk Register

Having been assessed as having a risk score of below 15 following mitigating actions taken, the risk will continue to be managed and monitored via the Departments/Divisions/Directorates risk registers

ID	Risk Description and Consequences	Existing Controls	Risk Score (Current)
1886	Inconsistent process of Medical Team review of patients on the Nye Bevan unit and in the ED	Senior medical and nursing teams are regularly reviewing patient records and pathways to ensure that are receiving the care that they require.	12

		Regular Board Rounds to ensure that tasks are being completed. VTE assessments are reviewed throughout the day on the Ward and Board Rounds. Patients without an assessment are flagged to the relevant team in order for them to be completed. An IT solution is currently being developed to only allow prescribing once a VTE Assessment has been completed. Outstanding VTE Assessments are handed over at the daily huddles. Specialty teams inform the Nurse-in-charge if a patient requires review by another speciality so that CAmis and symphony are correct. New medical leadership (an Assistant Medical Director for the Transformation of Urgent Care) has been appointed to ensure new strategies and review tools are implemented.	

New Medical Director's office risk register risks rated 15 and above:

One newly approved risk

ID	Risk Description and Consequences	Existing Controls	Risk Score (Current)
1955	Deteriorating Patient Care Lack of support / guidance in training to support staff in assessing and managing deteriorating patients across the Trust.	Deteriorating patient board, deteriorating patient operational group, designated DP leads (medical and non-medical, Deteriorating care plan paperwork, collection of standards of care and contemporaneous feedback	15

Existing risk - rating increased and escalated to CRR

ID	Risk Description and Consequences	Existing Controls	Risk Score (Current)
1478	Non-compliance with documentation of mental capacity assessments when completing DNACPR orders. Ineffective patient care. Lack of compliance with the statutory code of practice for the MCA. Risk to continued regulatory and legislative compliance, reputational risk.	Regular training provision in relation to the MCA. Resources for medical staff written specific to the issue of MCA and DNACPR. MCA assessment documentation sticker housed with DNACPR forms. Review of compliance monitoring	15

3. Harm

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

i. The number of serious incidents (requiring STEIS escalation) and the number `of Never events in 2018/19, with previous years under the current framework for comparison.
ii. The number of new serious incidents requiring full root cause analysis (RCA) and moderate harm incidents requiring "concise" RCA since the last trust board. Summary information for new Serious Investigations initiated and submitted to the CCG are provided.
iii. Key thematic issues relating to avoidable patient harm.

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

	16/17	17/18	18/19	19/20
Serious Incidents	13	18	34	6

Never Events	1	3	1	0

3.ii New SI and moderate investigations

There were 6 serious incidents reported on STEIS during May and June 2019. These are on track to report by their deadlines. One SI report was submitted to the CCG for closure. The learning and actions arising have been shared through morbidity and mortality meetings, divisional governance meetings, CQEG and QGC.

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

3.iii Thematic issues

No new themes have been identified from incidents since January. The previously recognised themes of delayed recognition of the deteriorating patient, with associated recurring issues around diabetic control, fluid management, safeguarding and escalation/end of life care continue to be addressed holistically through the deteriorating patient oerating group. The roll out through inpatient areas has been confirmed. Issues relating to the failure to act upon investion results are being addressed through work led by the associate medical director for medicines and mortality. A recent cluster of diabetic management related incidents on the back of an ongoing theme has prompted the introduction of role specific training for clinical staff to support quality improvement for this.

4. Mortality

The rolling 12 month HSMR to January 2019 for the trust remains within the “expected” range at 105. Diagnosis and procedure specific outlying SMRs are investigated and managed in the usual process of trust reviews. The trust is currently screening 90% of inpatient deaths and engagement with structured judgement reviews required has improved substantially.

The trust has successfully recruited 8 medical examiners and of these 5 are doctors not currently employed by the trust (3 general practitioners, a palliative care consultant and a forensic pathologist). It is expected that the Medical examiner function will commence in September 2019.

5. Thrombosis

The upgrade to ePMA which will enforce VTE risk assessment is subject to further slippage on roll out. The product has repeatedly fallen over in testing and is not currently fit for purpose. The medical director, Chief Pharmacist and Chief

Information Officer and other colleagues from NGH have met with representatives of the supplier and explored the range of product issues and support experienced. The agreed action is that the supplier will return with appropriate representation to the trust and present their commitment to a work programme and governance structure. The Chief information Officer and Medical Director will bring a paper to the board in August with a recommendation as to whether to continue working with this supplier on this basis. VTE assessment within 14 hours was 76% in June 2019. This has improved through June 2019 driven through a number of measures including ward visits and support from the corporate medical team and the refresh and relaunch of the trust thrombosis intranet page.

6. Medical Gases

The revamped medical gases committee continues to drive a programme of improvement in medical gases governance. Specific areas of improvement relate to ratification of the medical gases policy and preparation of associated documents, progress with compliance with relevant HTM at audit by the external authorised engineer, and improvements in training and oxygen prescribing.

7. Response to CQC feedback

7.1 Medicines Management

The CQC highlighted opportunities to improve safe and secure medicines management on wards and in clinical areas. A executive led task and finish group has developed and delivered an education programme through the nursing and midwifery forum to support improvements. A programme of weekly ward led audits by the ward managers and supporting pharmacy led fortnightly audits will monitor and sustain improvements and identify areas where additional input may be helpful.

7.2 Adherence to LocSSIPS

The CQC found examples of excellent LocSSIPS documentation and areas of excellent practice. They also identified opportunities to reduce variation in application in practice and thereby further improve patient safety in interventional procedures. A working group has been established, reviewed the documents in use across the trust, made substantial progress in addressing gaps identified and agreed a work plan to relaunch and audit going forward.

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Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↑		92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	3	0	0	0	0	4	2	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↓					4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,560
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↑		92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.7%	85.5%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		79	60	118	174	142	299	330	400	420	343	203	69
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		1	3	15	17	19	30	49	33	22	13	11	15
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		6	16	2	3	3	4	5	4	4	11	1	4
	Delayed transfer of care	Debbie Needham	=23	NGH	↑		12	19	36	10	10	24	12	11	20	31	34	21
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↑		28	16	34	27	15	20	20	17	29	41	41	32
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↑		19	13	25	25	13	16	17	13	20	30	33	23
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↑		81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	No data submitted
	RTT over 52 weeks	Debbie Needham	=0	Nat	↓		0	0	0	0	0	0	1	3	1	0	1	No data submitted
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	No data submitted

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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%		↓		92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%		↑		97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%
	Unappointed Follow Ups	Debbie Needham	=0	NGH	↓								8,608	8,723	9,957	10,119	10,363	10,385
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH	↓		12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%
	Sickness Rate	Janine Brennan	<=3.8%	NGH	↓		4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH	↓		13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH	↓		14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH	↓		10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH	↑		14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%
	Turnover Rate	Janine Brennan	<=10%	NGH	→		8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH	→		89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH	↑						81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH	↑		85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH	↑		85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH	↓		58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH	↑		(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH	↓		72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH	↓		89	107	128	153	167	195	209	230	266	55	34	57
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH	↓		152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH	↑		1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH								64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH								39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH	↓			27	No data submitted	No data submitted	No data submitted	15	21	21	19	18	18	22
	Waivers which have breached	Phil Bradley	=0	NGH	↓			0	No data submitted	No data submitted	No data submitted	1	0	0	0	4	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH	↑		51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH	↑		22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH	↑		4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH	↓		18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%
	Emergency re-admissions within 30 days (elective) - Excludes ACC & COA	Matt Metcalfe	<=3.5%	NGH	↑		4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	ERROR	2.4%	ERROR	2.5%	3.1%	1.3%

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	Emergency re-admissions within 30 days (non-elective) - Excludes ACC & COA	Matt Metcalfe	<=12%	NGH	↑		16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	13.5%	13.2%	ERROR	13.6%	11.5%	8.8%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↓		0	104	104	106	106	106	105	106	104	103	104	105
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		98	98	100	100	104	104	104	104	104	104	100	100
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		25	45	47	66	36	35	53	51	35	35	35	No data submitted
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	No data submitted
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%	6.3%	3.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	1	0	0	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0		↓		3	2	3	0	0	3	7	1	0	0	2	3
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.1%	95.6%	93.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	HOHA (C-Diff > 2 Days)	Sheran Oke	<=1.75	Nat	↑		2	1	2	0	0	1	0	0	0	2	3	1
	Community Onset Healthcare Associated C-Diff infection (COHA)	Sheran Oke	<=3	CCG	↓											1	2	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH	↑		2	0	0	2	1	0	1	2	0	5	4	1
	New Harms	Sheran Oke	<=2%	NGH	↑					2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2	5.4	4.7
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→							85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓							62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓							89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%

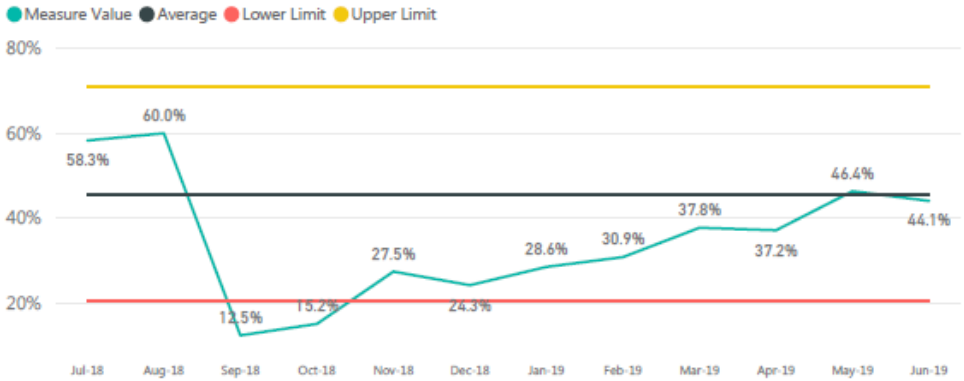
No data submitted — Data not provided

No data - pre KPI implementation

Job plans progressed to stage 2 sign-off

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.0 %	44.1 %	↓	Matt Metcalfe

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
58.3 %	60.0 %	12.5 %	15.2 %	27.5 %	24.3 %	28.6 %	30.9 %	37.8 %	37.2 %	46.4 %	44.1 %

What is driving under performance?

The data was rebased during September 2018 to reflect compliance in all divisions which includes job plans reviewed in the current financial year and progressed to second stage sign off. Delays within the Medicine Division has negatively impacted on other Divisions progress, however progress has been made with 69% of job plans within the division now at second sign off. As Divisions commence the job planning process the compliance declines as new job plans are entered (rolling year). New Consultants joining the Trust that require new job plans can also negatively impact on compliance. As we entered the 2019/20 Financial year, job plans that were reviewed early in the process are now out of date, therefore reducing the compliance. This relates to a small number of individuals (5).

Actions completed in the past month to achieve recovery

Regular Executive Consistency Committee (ECC) meetings continue to take place. Further improvement in Anaesthetics and Outpatients is acknowledged as new job plans are being agreed. Head & Neck and Ophthalmology have begun to enter new plans onto the system, reducing the overall compliance. Despite low compliance an ongoing improvement of job plans complying with 12 PAs or less continues (from 48 plans above 12PAs to 11 plans – a 77% improvement). Of the 11 outstanding, 6 job plans are currently in discussion, with the remaining 5 yet to be reviewed. New job plans have now been entered onto the system for 88% of Consultants and of these 56% have reached partial sign off.

Exception report written by

SmillieE

Timeframe for recovery

December 2019

Assurance Committee

Quality Governance Committee

Next steps

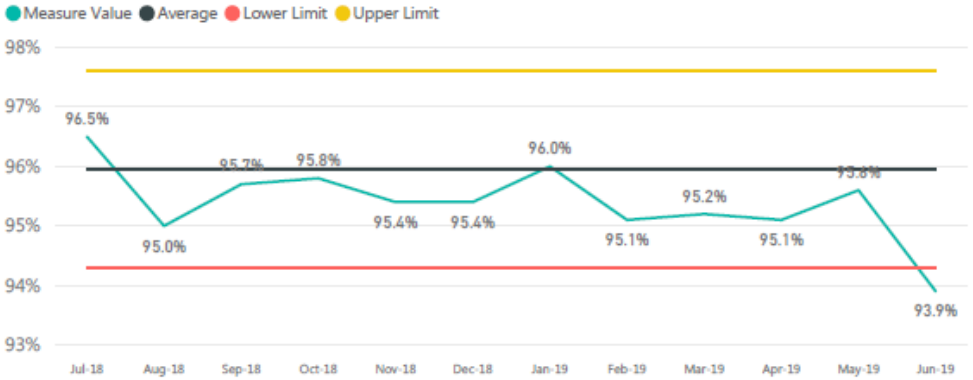
Executive Consistency Committee meetings will continue for the Divisions. Support continues from the QI team to ensure progress is maintained and that the changes to Job Plans are reflected in pay. Any job plans awaiting second stage sign off are being notified to the departments to ensure timely progression and expedited to the MD when necessary.

VTE Risk Assessment

June 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
95.0 %	93.9 %	↓	Matt Metcalfe

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
96.5 %	95.0 %	95.7 %	95.8 %	95.4 %	95.4 %	96.0 %	95.1 %	95.2 %	95.1 %	95.6 %	93.9 %

What is driving under performance?

VTE first risk assessment within 14 hours is currently 75% (including the low cohort assessment group)

Actions completed in the past month to achieve recovery

There has been a concerted effort supported by the Associate Medical Directors and QI to ensure risk assessments are done within 14h of admission and on a day to day basis the figures have improved in the last few weeks, particularly on Nye Bevan

Exception report written by

CrockettG

Timeframe for recovery

September 2019

Assurance Committee

Next steps

New initiatives on Nye Bevan include completing VTE risk assessments due before the start of the ward round (so they are prioritised and not "lost" within the other work that is generated by the ward round), and real time feedback to junior staff who have admitted a patient who has not had a risk assessment by the next ward round There have been ongoing difficulties in testing of ePMA 10.18 and roll out will be delayed beyond early August and the start date of new junior doctors

Report To	**Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**NGH Mortality Dashboard**
Agenda item	**19.1**
Presenter of Report	Mr M Metcalfe Medical Director
Author(s) of Report	Dr L Jameson, Specialty Doctor, Quality Improvement
Purpose	In response to a publication from the National Quality Board March 2017 – National Guidance on Learning from Deaths

Executive summary

This paper includes the NGH Mortality Dashboard for Q4 2018/19

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

Related strategic aim and corporate objective	Focus on quality and safety
Risk and assurance	The content of the Report identifies risks to the Trust for which assurance is provided
Related Board Assurance Framework entries	BAF – 1.1
Equality Analysis	There is no potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups?

	There is no potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)?
Legal implications / regulatory requirements	There are no legal/regulatory implications of the paper

Actions required by the Board

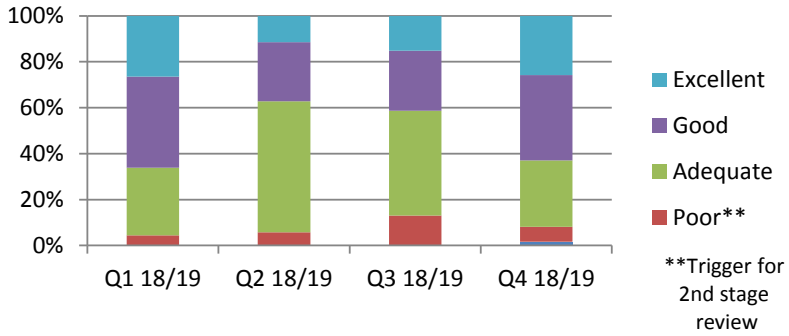
The Board is asked to:

Note and approve the content of the report

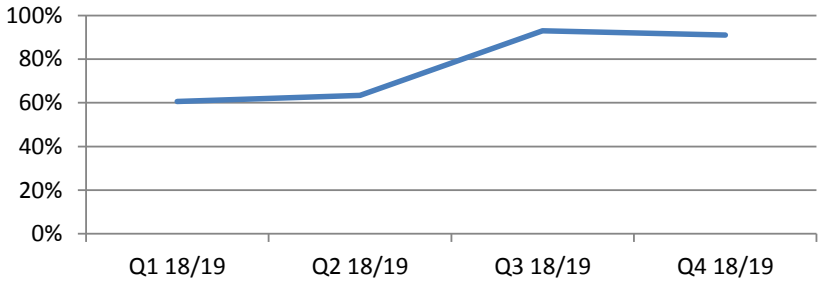
NGH Mortality Dashboard Q4 2018/19

	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to Dec 18	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings or Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q1 18/19	365	39	61%	136	11	1	1 NI
Q2 18/19	276	36	64%	74	7	1	1 NI
Q3 18/19	308	33	92%	65	9	2	1 CI / 1 NI
January	124	17	94%	24 of 26	4	1	1 CI
February	148	11	99%	28 of 33	0	0	0
March	112	9	94%	10 of 18	1	0	0
Total Q4 18/19	**384**	**37**	**91%**	**62 of 77**	**5**	**1**	1 CI

Distribution of Overall Care Scores from Structured Judgement Reviews



Percentage of Deaths Screened by Mortality Screening Team



In Q4 2018/19 there were no deaths of patients with a learning disability or severe mental illness

Learning from Screening, and Structured Judgement Reviews

In Q4 2018/19, Trust wide Mortality Case Note Review 12 was completed and 4 work streams launched in response to the findings.

Sepsis mortality started to fall during the quarter. Following Review 12 the sepsis team are looking closely at the importance of reviewing and challenging a suspected diagnosis of sepsis. If sepsis is confirmed then appropriate treatment can be prioritised but if the diagnosis is not confirmed efforts can be focused on alternative diagnoses and treatment. This improves clinical care, documentation and clinical coding.

Review 12 highlighted the large number of elderly patients and also the large number of **frail** patients who are admitted to NGH. The Elderly Medicine Frailty Team have started planning a Quality Improvement project to introduce frailty scoring across the Trust to quantify the number of frail patients and help plan and direct service provision in the future. The monthly morbidity and mortality meeting also plan to look in more detail at emergency readmissions and recurrent readmissions as well as reviewing their documentation to ensure that all co-morbidities are captured in each admission.

Patients with advanced cancer diagnoses did not appear to receive **palliative care** as often as other groups of patients and a working group was convened to look at the potential reasons for this. An initial action was to agree clinical coding rules for capturing delivery of palliative care from all those who deliver it. Further work will focus on acute oncology review , patients with obstructive jaundice and patients with malignant pleural effusions.

Clear documentation of a working diagnosis is vital to ensure accurate clinical coding and this will be explored through a working group looking at the **clinical care, documentation and coding interface** to increase the percentage of patients leaving the Nye Bevan Unit with a clearly documented working diagnosis. The clinical coding team established links with the Nye Bevan Unit Operational Group and visited the unit regularly to give advice about documentation and the impact on clinical coding. The next step is to explore how IT systems such as i-box can be used to quickly spread the message.

Compliance with request for completion of Structured Judgement Reviews increased from 64% in Q3 to 81% in Q4

Planning to introduce the Medical Examiner Sytem continued in Q4 with the agreement of job descriptions for Medical Examiners and Medical Examiner Officers

Validation of the screening and review process has been enhanced at directorate/ specialty and Trust wide level

Good correlation was seen between the findings of Trustwide Review 12 and the findings of screening and directorate/ specialty reviews

In addition, 2nd stage reviews for patients judged to have recieved excellent care is now carried out alongside cases of poor care where capacity allows

Dr Foster data for the management of patients with congestive heart failure began to show a higher than expected mortality rate in Q4

The cardiology lead will review this data in conjunction with data from mortality case note review, National Heart Failure Audit, National Confidential Enquiry into the management of Heart Failure, staffing levels and referral pathways

The bi-annual Countywide Morbidity and Mortality meeting was held at NGH in May 2019 and focused on the recent NCEPOD report "Common Themes" which summarised commonly occurring themes of 30 years of National Confidential Enquiries

Report By is equal to / is in **Post Specialty by Trust/Board**

and Indicator is equal to **Feedback** , **Clinical Supervision out of hours** , **Educational Governance** , **Overall Satisfaction** , **Local Teaching** , **Rota Design** , **Study Leave** , **Reporting systems** , **Handover** , **Induction** , **Supportive environment** , **Adequate Experience** , **Clinical Supervision** , **Curriculum Coverage** , **Educational Supervision** , **Work Load** , **Regional Teaching** , **Teamwork**

and Trust / Board is equal to **Northampton General Hospital NHS Trust**

and GEO Deanery/HEE local office is equal to **Health Education East Midlands**

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Acute Internal Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction					72.57	58.63	63.56	51.38
		Clinical Supervision					82.14	70.47	78.75	73.75
		Clinical Supervision out of hours					83.57	91.67	80.90	68.75
		Reporting systems					67.86	60.00	66.67	59.38
		Work Load					21.43	29.17	37.04	36.46
		Teamwork						58.34	65.74	58.33
		Handover					52.09	59.52	63.99	52.08
		Supportive environment					74.29	50.63	63.89	58.75
		Induction					82.14	65.11	63.33	48.75
		Adequate Experience					81.43	64.69	66.39	66.25
		Curriculum Coverage						58.33	66.67	63.54
		Educational Governance						56.25	64.82	59.38
		Educational Supervision					89.29	80.73	72.92	77.34
		Feedback					81.55	56.95	58.93	50.00
		Local Teaching					50.50	58.43	65.00	50.28
		Regional Teaching					58.69	66.57	65.24	55.14
		Study Leave					48.89	14.29	51.49	48.61
		Rota Design							36.81	47.66
Acute Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	74.50	68.00	74.22	70.33	69.33			
		Clinical Supervision	84.33	71.25	85.89	78.29	81.08			
		Clinical Supervision out of hours				83.38				
		Reporting systems					63.33			
		Work Load	36.33	31.77	39.12	34.72	20.14			
		Handover	83.59	75.00	75.00	67.19	68.06			
		Supportive environment				65.00	60.00			
		Induction	83.44	64.38	66.11	74.17	63.33			
		Adequate Experience	73.75	68.75	73.33	76.67	73.33			
		Educational Supervision	90.63	87.50	91.67	79.17	75.00			
		Feedback	58.65	67.26	74.48	75.70	59.72			
		Local Teaching	49.38	44.25	50.43	46.88	49.33			
		Regional Teaching	67.71		62.38	56.38	68.17			
		Study Leave	53.57	77.50	69.17	59.45	20.00			
Anaesthetics	Northampton General Hospital NHS Trust	Overall Satisfaction	89.50	89.23	90.46	90.67	83.75	86.29	82.38	83.32
		Clinical Supervision	91.86	94.13	92.46	90.80	87.81	90.74	92.14	95.20
		Clinical Supervision out of hours				94.00	91.33	93.67	93.75	95.10
		Reporting systems					67.86	79.4	80.4	74.17

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Anaesthetics	Northampton General Hospital NHS Trust							9	2	
		Work Load	50.65	57.21	53.20	60.14	45.83	64.09	57.64	53.73
		Teamwork						73.04	75.40	78.24
		Handover	50.00	65.91	66.67	63.39	78.41	74.36	71.46	70.98
		Supportive environment				88.33	80.00	78.82	76.19	73.42
		Induction	85.94	94.23	96.15	95.00	84.38	90.07	82.68	75.79
		Adequate Experience	91.88	88.46	92.31	92.00	85.00	87.21	82.26	84.34
		Curriculum Coverage						83.33	80.95	80.70
		Educational Governance						77.94	73.81	78.70
		Educational Supervision	92.19	94.23	92.31	93.33	92.19	88.97	86.01	80.59
		Feedback	76.95	81.09	83.01	80.45	67.22	77.08	73.33	74.02
		Local Teaching	71.81	71.08	78.45	73.57	65.21	77.64	77.17	79.79
		Regional Teaching	66.35	65.30	58.09	63.77	60.85	54.21	70.00	75.63
		Study Leave	62.62	73.33	59.83	60.00	55.38	70.67	47.37	52.34
		Rota Design							64.88	66.45
Cardiology	Northampton General Hospital NHS Trust	Overall Satisfaction	72.00	75.33	86.67	81.14	62.00	47.20	70.80	68.20
		Clinical Supervision	76.17	80.33	84.33	86.71	85.00	73.75	81.56	82.00
		Clinical Supervision out of hours				80.57	75.00	73.75	73.44	81.25
		Reporting systems					60.00	59.25	63.00	71.00
		Work Load	27.08	22.92	16.67	28.57	15.63	20.00	23.75	16.25
		Teamwork						50.00	49.17	55.00
		Handover	85.42	81.25	79.17	87.50	54.17	60.00	56.25	38.75
		Supportive environment				62.86	62.50	52.00	63.00	57.00
		Induction	79.17	75.00	95.00	80.00	56.25	56.25	46.00	68.00
		Adequate Experience	60.00	75.00	90.00	80.00	50.00	61.00	74.50	75.00
		Curriculum Coverage						60.00	64.17	71.67
		Educational Governance						58.33	70.00	60.00
		Educational Supervision	95.83	87.50	83.33	88.10	81.25	74.17	62.50	46.25
		Feedback	55.83	69.45	86.11	80.83	55.56	53.33	79.17	54.17
		Local Teaching	62.83	47.67	56.67	52.83	41.75	48.20	54.67	72.33
		Regional Teaching	62.44	74.08	60.17	58.75	54.67	63.55	76.00	60.00
		Study Leave	50.56	65.28	71.11	53.89	36.67	37.50	26.25	51.67
		Rota Design							31.25	45.00
Clinical oncology	Northampton General	Overall Satisfaction		61.71	78.00	62.00	81.33	74.75	58.00	21.25

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Clinical oncology	Northampton General Hospital NHS Trust	Clinical Supervision		65.71	79.50	85.25	64.00	70.00	73.96	41.67
		Clinical Supervision out of hours				88.75		73.33	86.11	45.14
		Reporting systems					68.33	73.33	75.00	38.75
		Work Load		45.83	53.65	46.88	25.00	28.13	41.67	31.77
		Teamwork						79.17	73.61	39.58
		Handover		35.00	16.67	43.75		72.22	62.15	14.58
		Supportive environment				63.75	68.33	75.00	66.67	12.50
		Induction		63.57	62.50	42.50	98.33	87.50	72.50	46.25
		Adequate Experience		67.14	80.00	67.50	90.00	70.00	71.67	26.88
		Curriculum Coverage						64.58	66.67	31.25
		Educational Governance						72.92	66.67	27.08
		Educational Supervision		78.57	62.50	81.25	83.33	91.67	47.92	57.81
		Feedback		71.67	83.34	66.67		76.39	40.28	37.50
		Local Teaching		45.40	37.00	36.25			41.33	
		Regional Teaching		65.13					79.33	
		Study Leave		52.22	41.67	37.78		58.33	43.75	53.47
		Rota Design							31.25	6.25
Clinical radiology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Community Child Health	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Community Child Health	Northampton General Hospital NHS Trust	Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Dermatology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Emergency Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	76.57	80.50	78.50	86.50	85.60	86.45	84.10	80.78
		Clinical Supervision	76.14	82.97	81.84	83.88	83.78	94.55	89.63	89.44
		Clinical Supervision out of hours				79.25	85.67	93.64	86.46	84.38
		Reporting systems					78.00	80.50	79.50	77.78
		Work Load	28.57	25.00	20.31	46.88	39.38	37.50	33.33	34.72
		Teamwork						76.52	76.67	65.74
		Handover	33.33	33.33	48.44	57.81	67.59	69.17	64.12	66.25
		Supportive environment				81.25	77.00	81.82	79.00	76.11
		Induction	78.57	88.75	83.75	85.63	97.50	90.34	88.50	85.00
		Adequate Experience	78.57	86.25	77.50	85.00	83.00	83.64	81.25	81.67
		Curriculum Coverage						84.09	82.50	81.48
		Educational Governance						82.58	79.17	70.37
		Educational Supervision	89.29	93.75	87.50	84.38	90.00	93.94	88.75	80.56
		Feedback	69.45	89.28	64.88	72.62	80.83	91.20	70.83	68.52
		Local Teaching	68.43	70.71	71.00	75.00	78.00	80.44	78.13	63.33
		Regional Teaching	69.94	70.50	53.94		71.78	71.78	81.04	67.02
		Study Leave	79.67	76.25	68.89	77.00	73.83	48.33	53.91	62.76
		Rota Design							65.00	57.64
Endocrinology and diabetes	Northampton General	Overall Satisfaction								

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Endocrinology and diabetes mellitus	Northampton General Hospital NHS Trust	Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Gastroenterology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
General (internal) medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	71.53	72.17	75.43	75.60	71.58	61.81	65.35	61.48
		Clinical Supervision	84.65	75.03	76.86	82.18	77.53	76.01	78.95	76.06
		Clinical Supervision out of hours				81.31	79.43	75.44	77.74	72.26
		Reporting systems					67.50	62.64	65.79	55.48
		Work Load	34.93	24.73	28.37	33.33	23.03	28.47	21.35	29.86
		Teamwork						62.90	62.92	51.98
		Handover	83.09	74.17	75.00	75.00	72.57	62.50	52.88	52.60
		Supportive environment				67.75	66.05	60.71	59.75	50.95
		Induction	74.90	63.19	74.68	81.75	81.32	71.03	60.94	66.19
		Adequate Experience	70.00	74.78	78.10	77.00	70.00	68.45	68.63	66.55
		Curriculum Coverage						63.89	63.75	63.10
		Educational Governance						59.92	57.50	55.56
		Educational Supervision	85.29	85.51	85.32	91.25	85.53	78.57	81.25	73.81

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
General (internal) medicine	Northampton General Hospital NHS Trust	Feedback	66.67	63.38	66.88	71.08	65.36	55.48	45.57	53.29
		Local Teaching	55.35	47.36	48.38	51.30	61.00	49.91	59.67	55.48
		Regional Teaching	66.02	69.83	69.40	68.88	80.67	62.09	46.75	53.47
		Study Leave	55.28	39.74	51.97	67.42	54.55	34.82	26.89	28.98
		Rota Design							27.50	42.26
General Practice	Northampton General Hospital NHS Trust	Overall Satisfaction	86.40	90.00	85.00					
		Clinical Supervision	89.25	90.50	84.25					
		Work Load	70.00	72.92	56.25					
		Supportive environment								
		Induction	98.00	96.25	96.25					
		Adequate Experience	80.00	90.00	82.50					
		Educational Supervision	85.00	100.00	100.00					
		Feedback	100.00	94.79	93.06					
		Local Teaching	63.00							
		Regional Teaching								
		Study Leave	82.78	42.50	57.22					
General psychiatry	Northampton General Hospital NHS Trust	Overall Satisfaction	68.00							
		Clinical Supervision	94.58							
		Work Load	39.58							
		Handover	25.00							
		Induction	78.33							
		Adequate Experience	56.67							
		Educational Supervision	75.00							
		Feedback								
		Local Teaching	71.00							
		Regional Teaching								
		Study Leave								
General surgery	Northampton General Hospital NHS Trust	Overall Satisfaction	73.89	80.00	76.42	82.40	79.00	67.38	67.87	68.07
		Clinical Supervision	87.63	88.62	89.63	87.53	91.00	82.58	81.79	88.67
		Clinical Supervision out of hours				86.88	90.25	82.08	83.06	85.69
		Reporting systems					75.91	65.27	66.43	58.08
		Work Load	40.79	41.96	38.38	37.92	45.70	32.03	32.92	36.67
		Teamwork						59.90	66.67	55.00
		Handover	63.82	70.45	68.75	75.00	58.80	66.07	65.97	42.97
		Supportive environment				73.33	76.88	62.50	59.00	62.00
		Induction	85.26	79.52	77.98	88.33	85.94	74.74	68.33	72.67
		Adequate Experience	76.32	83.81	77.89	85.33	79.38	66.88	63.67	69.33
		Curriculum Coverage						61.98	67.22	67.78
		Educational Governance						67.71	66.11	65.00
		Educational Supervision	89.47	82.94	85.53	85.00	90.63	84.37	86.67	84.17
		Feedback	70.54	73.68	69.68	59.72	75.30	67.31	75.70	72.76
		Local Teaching	53.95	52.09	53.70	50.00	46.33	45.0	57.5	53.33

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
General surgery	Northampton General Hospital NHS Trust							0	9	
		Regional Teaching	63.87	62.44	66.63	52.81		62.41	56.48	59.63
		Study Leave	74.82	72.17	62.59	74.29	69.58	66.41	46.30	55.09
		Rota Design							33.75	39.17
Genito-urinary medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Study Leave								
Geriatric medicine	Northampton General Hospital NHS Trust	Overall Satisfaction				76.00	88.00			
		Clinical Supervision				76.33	89.00			
		Clinical Supervision out of hours				78.00	90.67			
		Reporting systems					78.33			
		Work Load				31.25	22.22			
		Teamwork								
		Handover				79.17	69.44			
		Supportive environment				61.67	81.67			
		Induction				83.33	76.67			
		Adequate Experience				76.67	83.33			
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision				100.00	91.67			
		Feedback				80.56	88.89			
		Local Teaching				49.67	61.00			
		Regional Teaching				68.00	69.83			
		Study Leave				70.55				
		Rota Design								
Haematology	Northampton General Hospital NHS Trust	Overall Satisfaction	86.00	69.00	94.67		71.00	74.33	70.00	
		Clinical Supervision	94.25	80.25	98.33		90.25	83.33	93.33	
		Clinical Supervision out of hours					93.75	91.67	91.67	
		Reporting systems						81.67		
		Work Load	48.96	42.71	40.97		54.69	41.67	47.92	
		Teamwork						77.78	61.11	
		Handover	50.00				68.06	75.00	52.08	
		Supportive environment					71.25	68.33	71.67	
		Induction	93.75	80.00	95.00		78.75	68.75	73.33	
		Adequate Experience	95.00	75.00	96.67		80.00	74.1	69.1	

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Haematology	Northampton General Hospital NHS Trust							7	7	
		Curriculum Coverage						72.22	72.22	
		Educational Governance						77.78	63.89	
		Educational Supervision	100.00	87.50	100.00		93.75	79.17	91.67	
		Feedback	85.42	66.67	91.67		88.89	54.17		
		Local Teaching	73.50	60.67			50.00	62.33	63.89	
		Regional Teaching	75.13	79.67			63.83		81.67	
		Study Leave	66.67	58.89			69.44	77.08	40.28	
		Rota Design							52.08	
Histopathology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Intensive care medicine	Northampton General Hospital NHS Trust	Overall Satisfaction				88.00		90.33		
		Clinical Supervision				92.67		96.67		
		Clinical Supervision out of hours				92.67				
		Reporting systems						81.67		
		Work Load				64.58		61.81		
		Teamwork						66.67		
		Handover				75.00		63.89		
		Supportive environment				85.00		80.00		
		Induction				78.33		91.67		
		Adequate Experience				96.67		88.33		
		Curriculum Coverage						83.33		
		Educational Governance						66.67		
		Educational Supervision				83.33		91.67		
		Feedback				52.78				
		Local Teaching				66.00		67.33		
		Regional Teaching								
		Study Leave				73.33		54.86		
		Rota Design								
Neonatal Medicine	Northampton General	Overall Satisfaction								

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Neonatal Medicine	Northampton General Hospital NHS Trust	Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Neurology	Northampton General Hospital NHS Trust	Overall Satisfaction								58.33
		Clinical Supervision								
		Clinical Supervision out of hours								79.17
		Reporting systems								59.58
		Work Load								45.83
		Teamwork								55.55
		Handover								41.67
		Supportive environment								56.67
		Induction								56.67
		Adequate Experience								61.67
		Curriculum Coverage								61.11
		Educational Governance								47.22
		Educational Supervision								68.75
		Feedback								
		Local Teaching								48.33
		Regional Teaching								58.61
		Study Leave								68.05
		Rota Design								43.75
Obstetrics and gynaecology	Northampton General Hospital NHS Trust	Overall Satisfaction	76.29	81.00	82.77	80.00	66.46	73.58	69.83	59.41
		Clinical Supervision	90.93	93.50	88.23	85.29	79.77	86.98	82.73	86.09
		Clinical Supervision out of hours				85.42	83.09	89.09	80.68	83.06
		Reporting systems					67.73	71.36	71.67	69.41
		Work Load	44.20	54.17	45.03	41.96	41.19	36.81	28.99	31.49
		Teamwork						66.67	68.06	67.16
		Handover	84.62	82.14	90.91	91.67	73.33	70.42	59.17	40.42
		Supportive environment				71.79	55.77	68.33	65.00	53.53
		Induction	87.50	91.56	91.03	94.64	83.85	77.60	73.23	70.88
		Adequate Experience	74.29	77.50	84.62	82.86	65.38	72.29	70.21	58.38
		Curriculum Coverage						70.49	66.67	59.80
		Educational Governance						59.72	59.72	59.31
		Educational Supervision	83.93	93.75	88.46	82.14	88.46	84.03	75.00	81.25
		Feedback	71.53	83.63	75.64	78.47	67.71	68.1	76.2	61.46

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Obstetrics and gynaecology	Northampton General Hospital NHS Trust							8	5	
		Local Teaching	57.71	58.46	64.20	57.55	61.10	60.44	62.04	67.38
		Regional Teaching	69.91	65.65	67.28	61.38	58.25	65.13	60.65	60.71
		Study Leave	73.00	71.07	59.83	68.89	67.67	47.92	37.73	58.93
		Rota Design							44.79	33.20
Ophthalmology	Northampton General Hospital NHS Trust	Overall Satisfaction	70.00	66.00	74.40	83.00	94.00	69.40	90.50	80.75
		Clinical Supervision	90.75	82.13	94.60	91.13	97.75	90.00	97.50	93.75
		Clinical Supervision out of hours				93.00	95.67	86.56	91.67	
		Reporting systems					88.75	75.00	85.00	81.67
		Work Load	57.29	70.31	67.50	73.96	53.65	68.33	61.46	60.94
		Teamwork						66.67	79.17	75.00
		Handover						77.08	79.17	
		Supportive environment				82.50	93.75	70.00	82.50	80.00
		Induction	58.75	71.25	81.00	97.50	91.25	78.75	87.50	68.75
		Adequate Experience	65.00	72.50	74.00	85.00	97.50	71.00	86.25	80.63
		Curriculum Coverage						68.33	85.42	77.09
		Educational Governance						65.00	81.25	66.67
		Educational Supervision	75.00	75.00	95.00	100.00	91.67	90.63	93.75	89.06
		Feedback	40.28	61.46	71.67	87.50	90.63	84.72	87.50	93.06
		Local Teaching	62.75	71.00	63.00	60.33	60.00	68.75	78.89	82.78
		Regional Teaching	73.63		82.38	77.08	77.08	78.25	87.78	
		Study Leave		53.89	63.89	98.33		78.13	79.17	57.64
		Rota Design							78.13	56.94
Oral and maxillo-facial surgery	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Otolaryngology	Northampton General Hospital NHS Trust	Overall Satisfaction			86.67	92.00	69.33	70.00	66.75	72.50
		Clinical Supervision			81.00	92.67	81.67	86.67	86.25	72.19
		Clinical Supervision out of hours				92.67			87.50	84.38
		Reporting systems					61.67	75.00	73.75	68.33
		Work Load			54.17	64.58	50.00	50.00	40.11	51.56
		Teamwork						77.09	70.84	64.58
		Handover			50.00		81.94	77.08	54.69	71.36
		Supportive environment				86.67	75.00	68.75	67.50	67.50
		Induction			95.00	98.33	83.33	78.13	52.50	58.75
		Adequate Experience			93.33	100.00	70.00	77.50	71.88	77.50
		Curriculum Coverage						79.17	72.92	77.09
		Educational Governance						75.00	72.92	60.42
		Educational Supervision			100.00	100.00	100.00	82.29	87.50	85.94
		Feedback			75.00	94.44			66.67	52.09
		Local Teaching						56.33	57.78	5.56
		Regional Teaching						57.75	45.56	31.11
		Study Leave			53.89			47.92	41.15	39.58
		Rota Design							40.63	37.50
Paediatric Diabetes and Endocrinology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Paediatrics	Northampton General Hospital NHS Trust	Overall Satisfaction	76.92	77.26	76.24	77.74	84.19	69.86	81.13	84.44
		Clinical Supervision	87.98	91.58	92.12	90.49	93.57	88.48	92.92	94.84
		Clinical Supervision out of hours				93.03	94.81	86.25	91.03	92.19
		Reporting systems					76.84	71.79	73.67	76.42
		Work Load	36.54	41.12	43.38	46.20	36.31	31.25	45.42	45.31

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Paediatrics	Northampton General Hospital NHS Trust	Teamwork						65.48	71.67	77.60
		Handover	75.00	75.00	75.00	79.76	75.52	64.58	71.79	76.91
		Supportive environment				71.52	79.52	62.14	70.33	80.63
		Induction	88.85	86.58	91.47	86.74	91.43	81.25	77.33	84.06
		Adequate Experience	80.77	74.74	77.06	79.13	83.81	72.86	79.33	83.13
		Curriculum Coverage						69.64	76.67	79.69
		Educational Governance						61.31	69.44	73.89
		Educational Supervision	92.31	97.37	92.65	93.48	90.48	85.42	79.58	82.42
		Feedback	77.78	77.08	74.75	77.65	76.04	84.85	76.79	72.62
		Local Teaching	66.15	72.41	62.07	57.70	63.06	60.09	65.00	62.44
		Regional Teaching	63.81	64.39	57.23	63.40	63.33	64.33	66.60	57.05
		Study Leave	43.81	66.25	69.36	69.25	64.91	44.27	53.85	46.58
		Rota Design							51.67	60.16
Palliative medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Rehabilitation medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
		Local Teaching								
Renal medicine	Northampton General Hospital NHS Trust	Overall Satisfaction		75.00	81.60	81.33		63.00	76.33	
		Clinical Supervision		86.00	89.00	94.00		88.33	91.67	
		Clinical Supervision out of hours				95.67		80.83	81.25	
		Reporting systems						83.33	76.67	
		Work Load		28.13	50.00	60.42		29.17	42.36	

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Renal medicine	Northampton General Hospital NHS Trust	Teamwork						52.78	77.78	
		Handover		62.50	52.50			63.89	52.78	
		Supportive environment				83.33		70.00	73.33	
		Induction		86.25	95.00	86.67		50.00	70.00	
		Adequate Experience		80.00	84.00	93.33		74.17	81.67	
		Curriculum Coverage						63.89	61.11	
		Educational Governance						47.22	66.67	
		Educational Supervision		100.00	85.00	50.00		87.50	89.58	
		Feedback		76.04	80.83	50.00		72.22		
		Local Teaching		56.67	51.80	53.67		50.67	73.34	
		Regional Teaching			68.17	70.17			59.45	
		Study Leave		66.67	81.11	28.33		34.72	37.50	
		Rota Design							45.83	
Respiratory Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	76.00	64.00		70.00			76.00	68.00
		Clinical Supervision	83.50	77.00		70.25			88.33	88.33
		Clinical Supervision out of hours				76.00			89.58	79.17
		Reporting systems							56.25	
		Work Load	26.56	29.69		25.52			20.83	25.00
		Teamwork							58.33	63.89
		Handover	81.25	84.38		46.88			56.25	62.50
		Supportive environment				60.00			63.33	76.67
		Induction	57.50	65.00		56.25			78.33	78.33
		Adequate Experience	80.00	72.50		67.50			80.83	73.33
		Curriculum Coverage							69.44	69.44
		Educational Governance							55.56	75.00
		Educational Supervision	81.25	75.00		87.50			93.75	83.33
		Feedback	76.04			57.29				
		Local Teaching	59.50	42.25		43.00			55.00	58.33
		Regional Teaching	59.33	55.50					65.83	63.61
		Study Leave	42.78	71.25		38.89			68.75	41.67
		Rota Design							14.58	50.00
Rheumatology	Northampton General Hospital NHS Trust	Overall Satisfaction		82.67	77.33					
		Clinical Supervision		71.00	81.00					
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load		39.58	39.58					

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Rheumatology	Northampton General Hospital NHS Trust	Teamwork								
		Handover		79.17	66.67					
		Supportive environment								
		Induction		75.00	48.33					
		Adequate Experience		80.00	76.67					
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision		91.67	91.67					
		Feedback		91.67						
		Local Teaching		60.67	57.00					
		Regional Teaching								
		Study Leave		73.89						
		Rota Design								
Stroke Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Trauma and orthopaedic surgery	Northampton General Hospital NHS Trust	Overall Satisfaction	80.40	76.40	67.60	77.78	74.00	76.36	77.50	52.50
		Clinical Supervision	91.00	91.30	89.90	94.22	84.10	90.57	90.00	81.38
		Clinical Supervision out of hours				90.63	85.60	88.64	92.29	79.58
		Reporting systems					66.11	78.18	72.22	69.00
		Work Load	45.63	40.63	43.75	56.25	38.13	52.84	55.00	35.63
		Teamwork						71.97	65.83	58.33
		Handover	66.25	67.50	71.25	86.11	55.83	72.35	65.63	53.54
		Supportive environment				71.67	68.00	67.27	73.50	57.00
		Induction	88.33	95.50	70.56	88.89	83.89	78.98	72.38	62.75
		Adequate Experience	82.00	71.00	75.00	80.00	74.00	72.73	74.25	58.00
		Curriculum Coverage						73.48	74.17	57.50
		Educational Governance						73.48	67.50	64.17
		Educational Supervision	87.50	90.00	85.00	86.11	87.50	87.50	83.75	80.00
		Feedback	84.37	70.37	84.90	79.17	56.77	78.65	83.33	51.56
		Local Teaching	54.20	48.38	54.38	56.33	53.29	60.75	67.86	36.19
		Regional Teaching	82.56	75.75	82.57	90.13	85.21	86.9	84.0	71.55

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Trauma and orthopaedic surgery	Northampton General Hospital NHS Trust							6	5	
		Study Leave	72.92	66.67	75.55	69.17	54.63	52.27	55.09	44.91
		Rota Design							55.00	16.88
Urology	Northampton General Hospital NHS Trust	Overall Satisfaction	72.67	82.40	78.67	65.71	76.00	70.00	69.20	64.43
		Clinical Supervision	83.67	90.90	86.83	85.00	86.00	88.57	82.81	77.14
		Clinical Supervision out of hours				88.43	89.40	86.25	83.33	72.32
		Reporting systems					72.00	78.57	69.00	61.96
		Work Load	39.93	45.00	51.39	30.65	47.92	51.19	43.75	31.25
		Teamwork						75.00	70.00	64.29
		Handover	58.33	43.75	68.75	65.63		71.67	64.58	57.50
		Supportive environment				70.00	63.33	80.71	69.00	67.14
		Induction	83.33	70.33	81.67	85.71	73.33	76.49	75.00	74.29
		Adequate Experience	75.00	88.00	76.67	67.14	76.67	76.07	79.50	69.64
		Curriculum Coverage						76.19	70.00	64.28
		Educational Governance						73.81	66.67	50.00
		Educational Supervision	91.67	70.00	91.67	92.86	87.50	89.28	81.25	73.21
		Feedback	72.22	87.50	61.46	76.19	59.72	50.00	72.92	62.50
		Local Teaching	49.33	62.75		44.75	48.67	65.00		75.55
		Regional Teaching	68.88	78.06		65.75		74.08		66.67
		Study Leave	27.00	22.78	48.89	65.67	54.44	45.83	81.25	60.00
		Rota Design							50.00	33.04
Vascular surgery	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								

Report By is equal to / is in **Programme Group by Trust/Board**

and Indicator is equal to **Feedback** , **Clinical Supervision out of hours** , **Educational Governance** , **Overall Satisfaction** , **Local Teaching** , **Rota Design** , **Study Leave** , **Reporting systems** , **Handover** , **Induction** , **Supportive environment** , **Adequate Experience** , **Clinical Supervision** , **Curriculum Coverage** , **Educational Supervision** , **Work Load** , **Regional Teaching** , **Teamwork**

and Trust / Board is equal to **Northampton General Hospital NHS Trust**

and GEO Deanery/HEE local office is equal to **Health Education East Midlands**

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
ACCS	Northampton General Hospital NHS Trust	Overall Satisfaction	80.00	76.00	78.00	80.89	81.50	83.25	84.83	73.75
		Clinical Supervision	84.83	82.85	91.48	85.33	85.19	93.75	95.83	82.19
		Clinical Supervision out of hours				88.56	88.16	92.50	96.88	82.81
		Reporting systems					75.00	81.67	73.33	78.75
		Work Load	29.17	27.08	35.00	53.24	44.53	35.94	59.72	40.63
		Teamwork						62.50	76.39	60.42
		Handover	56.25	58.33	67.19	61.11	68.45	58.33	73.96	70.31
		Supportive environment				82.22	78.75	75.00	79.17	70.00
		Induction	74.17	92.00	83.50	79.44	85.00	90.63	84.17	66.25
		Adequate Experience	81.67	78.00	77.00	78.89	85.00	83.13	82.92	75.00
		Curriculum Coverage						81.25	79.17	77.08
		Educational Governance						64.58	75.00	64.58
		Educational Supervision	87.50	90.00	82.50	72.22	90.63	86.46	81.25	87.50
		Feedback	70.00	86.46	77.98	63.69	83.33	76.04	59.17	69.79
		Local Teaching	54.17	62.60	66.70	61.67	63.63	68.00	73.61	67.92
		Regional Teaching	68.44	56.58	61.63	56.05	59.29	54.58	78.61	55.00
		Study Leave	58.33	88.33	65.00	43.67	64.58	41.67	56.60	48.44
		Rota Design							68.75	56.25
Acute Internal Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Anaesthetics	Northampton General Hospital NHS Trust	Overall Satisfaction	85.50	89.00	85.71	88.50	82.86	85.00	79.00	77.90
		Clinical Supervision	93.75	94.25	89.43	90.63	87.57	90.63	95.45	93.38
		Clinical Supervision out of hours				93.88	92.14	95.63	95.63	93.54
		Reporting systems					82.50	80.16	82.61	74.50
		Work Load	46.09	55.47	49.11	60.68	38.39	62.50	55.68	46.88
		Teamwork						75.00	72.73	76.85
		Handover	50.00	65.63	64.29	62.50	78.47	75.00	71.02	66.41

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Anaesthetics	Northampton General Hospital NHS Trust	Supportive environment				86.25	80.71	80.63	73.64	70.00
		Induction	75.63	95.63	95.71	95.00	89.29	91.41	81.48	72.50
		Adequate Experience	88.75	88.75	88.57	92.50	81.43	85.94	80.45	78.25
		Curriculum Coverage						78.13	78.79	80.00
		Educational Governance						78.13	73.48	76.67
		Educational Supervision	90.63	93.75	89.29	96.88	96.43	86.46	84.66	76.88
		Feedback	75.60	80.73	74.41	76.79	61.81	73.21	73.81	75.93
		Local Teaching	69.25	68.13	77.14	74.50	64.86	82.25	74.24	79.17
		Regional Teaching	57.22	62.54	44.60	66.29	66.38	56.69	64.24	78.83
		Study Leave	59.05	70.63	62.62	62.14	71.67	82.55	46.67	54.38
		Rota Design							63.64	56.88
Anaesthetics F1	Northampton General Hospital NHS Trust	Overall Satisfaction						95.00		85.33
		Clinical Supervision						95.00		95.00
		Clinical Supervision out of hours						96.67		
		Reporting systems						88.33		
		Work Load						77.78		61.11
		Teamwork						75.00		75.00
		Handover								
		Supportive environment						85.00		73.33
		Induction						95.83		71.67
		Adequate Experience						92.50		80.83
		Curriculum Coverage						91.67		72.22
		Educational Governance						91.67		
		Educational Supervision						90.28		70.83
		Feedback								75.00
		Local Teaching								
		Rota Design								66.67
CMT	Northampton General Hospital NHS Trust	Overall Satisfaction	77.71	70.67	79.20	77.68	74.00	63.32	70.35	53.06
		Clinical Supervision	86.50	69.76	83.87	84.84	83.69	80.46	82.25	68.36
		Clinical Supervision out of hours				87.38	83.69	85.92	77.08	61.59
		Reporting systems					67.31	72.13	71.39	57.65
		Work Load	35.27	33.33	45.00	44.41	29.82	34.54	29.06	33.82
		Teamwork						67.11	67.92	51.47
		Handover	83.04	70.24	60.00	65.79	65.89	58.33	59.98	48.16
		Supportive environment				69.21	70.31	59.74	70.00	47.94
		Induction	73.81	75.48	64.67	78.68	78.44	70.18	71.44	61.47
		Adequate Experience	77.14	73.81	79.33	79.47	76.25	70.79	71.75	58.09
		Curriculum Coverage						60.09	65.00	58.33
		Educational Governance						58.33	67.50	49.02
		Educational Supervision	82.14	88.10	81.11	83.77	85.94	82.89	75.94	62.13
		Feedback	62.20	73.70	79.76	69.85	81.25	57.8	68.3	41.67

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
CMT	Northampton General Hospital NHS Trust							4	8	
		Local Teaching	55.36	50.43	52.00	50.00	48.06	54.42	66.50	57.55
		Regional Teaching	63.42	64.56	65.29	64.93	59.98	63.17	51.96	47.80
		Study Leave	49.50	55.32	49.81	44.69	40.56	30.15	44.08	34.93
		Rota Design							40.73	40.07
CST	Northampton General Hospital NHS Trust	Overall Satisfaction	73.33	70.86	65.14	57.33	61.14	72.00	60.50	59.71
		Clinical Supervision	83.83	91.57	92.86	90.00	78.71	88.33	93.75	85.71
		Clinical Supervision out of hours				94.33	81.29	91.67	98.44	85.71
		Reporting systems					59.17	72.50	60.00	68.75
		Work Load	34.38	32.14	39.29	50.00	20.54	42.71	46.88	31.25
		Teamwork						75.00	70.83	58.33
		Handover	56.25	67.86	66.07	75.00	40.48	85.83	65.63	58.93
		Supportive environment				66.67	59.29	76.67	71.25	60.71
		Induction	85.00	90.71	70.95	86.67	58.57	78.13	75.63	75.00
		Adequate Experience	68.33	62.86	67.14	56.67	57.14	65.00	55.00	56.79
		Curriculum Coverage						70.83	68.75	65.47
		Educational Governance						69.44	66.67	65.48
		Educational Supervision	87.50	92.86	100.00	100.00	89.29	89.58	89.06	81.25
		Feedback	78.13	68.45	79.17		41.67	82.50	88.89	67.86
		Local Teaching	54.50	44.43	55.00	56.33	34.57	46.33	49.58	31.67
		Regional Teaching	67.42	64.79	61.83	56.33		61.88	58.75	53.10
		Study Leave	64.17	39.33	65.48	77.78	40.00	42.01	43.75	57.44
		Rota Design							39.06	22.32
Cardiology	Northampton General Hospital NHS Trust	Overall Satisfaction	70.40	79.00	86.67	85.00	61.33	49.75	69.75	72.50
		Clinical Supervision	78.20	88.25	84.33	89.50	83.33	69.69	90.00	81.25
		Clinical Supervision out of hours				75.00	74.33	66.67	79.17	81.25
		Reporting systems					55.00	53.75	58.75	71.25
		Work Load	26.25	17.19	16.67	18.75	10.42	17.19	25.00	14.06
		Teamwork						47.92	40.63	60.42
		Handover	82.50	84.38	79.17	81.25	52.78	56.25	50.00	34.38
		Supportive environment				67.50	56.67	52.50	58.75	65.00
		Induction	76.00	85.00	95.00	90.00	51.67	57.81	43.75	72.50
		Adequate Experience	56.00	82.50	90.00	82.50	43.33	62.50	71.25	80.00
		Curriculum Coverage						62.50	63.54	72.92
		Educational Governance						58.33	64.59	68.75
		Educational Supervision	95.00	87.50	83.33	93.75	75.00	72.92	73.44	57.81
		Feedback	59.38	75.00	86.11	90.28		58.33		54.17
		Local Teaching	60.40	48.00	56.67	53.00	46.00	48.50	48.75	76.67
		Regional Teaching	61.33		60.17	55.31		62.81	73.75	68.75
		Study Leave	52.67	62.92	71.11	62.50		44.7	29.6	64.58

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Cardiology	Northampton General Hospital NHS Trust							9	9	
		Rota Design							21.88	45.31
Clinical oncology	Northampton General Hospital NHS Trust	Overall Satisfaction		68.00	70.67	56.00			61.25	
		Clinical Supervision		74.67	77.67	81.67			76.25	
		Clinical Supervision out of hours				86.33			92.19	
		Reporting systems							78.75	
		Work Load		62.50	60.42	43.75			54.69	
		Teamwork							77.09	
		Handover			16.67	33.33			65.11	
		Supportive environment				60.00			72.50	
		Induction		45.00	60.00	25.00			75.00	
		Adequate Experience		73.33	73.33	63.33			71.88	
		Curriculum Coverage							66.67	
		Educational Governance							75.00	
		Educational Supervision		75.00	58.33	75.00			32.81	
		Feedback		66.67	86.11	58.33			40.28	
		Local Teaching		48.67	37.00	32.67			37.09	
		Regional Teaching		66.58					82.08	
		Study Leave		62.22	41.67	37.78			65.28	
		Rota Design							37.50	
Clinical radiology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Core Anaesthetics	Northampton General Hospital NHS Trust	Overall Satisfaction	92.00	87.00		96.00		82.40	76.00	90.25
		Clinical Supervision	89.13	92.44		95.00		87.50	83.33	97.50
		Clinical Supervision out of hours				97.00		88.75	85.42	96.88
		Reporting systems						71.00	76.67	66.25
		Work Load	52.08	60.42		59.72		54.58	54.17	54.69
		Teamwork						65.00	69.45	81.25
		Handover	50.00	66.67		70.83		71.67	63.89	71.88
		Supportive environment				95.00		72.00	75.00	75.00
		Induction	97.50	91.25		96.67		82.50	70.00	81.25
		Adequate Experience	95.00	85.00		93.33		86.0	77.5	94.38

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Core Anaesthetics	Northampton General Hospital NHS Trust							0	0	
		Curriculum Coverage						86.67	77.78	85.42
		Educational Governance						71.67	63.89	87.50
		Educational Supervision	100.00	93.75		91.67		90.83	87.50	90.63
		Feedback	83.34	77.08		94.44		88.54	66.67	62.50
		Local Teaching	78.67	77.00		68.33		72.20	71.11	76.67
		Regional Teaching	77.50	70.13		64.58		43.10	66.67	59.59
		Study Leave	68.33	78.75				47.40	31.25	43.75
		Rota Design							54.17	78.13
Dermatology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Reporting systems								
		Work Load								
		Teamwork								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Emergency Medicine F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Rota Design								
Emergency Medicine F2	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Emergency medicine	Northampton General Hospital NHS Trust	Overall Satisfaction				86.67	74.29	78.38	72.57	70.00
		Clinical Supervision				79.67	81.43	83.59	85.89	86.88
		Clinical Supervision out of hours				72.00	80.40	95.0	83.8	78.75

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Emergency medicine	Northampton General Hospital NHS Trust							0	6	
		Reporting systems					65.00	74.29	77.86	73.75
		Work Load				56.25	32.74	40.36	47.02	41.93
		Teamwork						69.79	72.62	62.50
		Handover				54.17	75.00	71.87	55.36	66.96
		Supportive environment				83.33	67.14	68.13	74.29	71.25
		Induction				86.67	80.00	82.03	70.71	70.00
		Adequate Experience				93.33	71.43	81.56	70.00	77.50
		Curriculum Coverage						79.17	77.38	75.00
		Educational Governance						72.92	80.95	70.83
		Educational Supervision				91.67	85.71	89.58	84.82	75.00
		Feedback				69.44	73.81	71.53	75.00	58.33
		Local Teaching				81.33	65.43	71.50	75.24	53.96
		Regional Teaching					68.36	70.38	80.71	73.33
		Study Leave				58.89	43.10	35.94	48.21	55.21
		Rota Design							53.57	53.13
Endocrinology and diabetes mellitus	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
GP Prog - Emergency Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction		88.00	81.33	85.33	85.33	82.33	84.00	
		Clinical Supervision		84.50	74.33	84.00	86.17	95.00	88.33	
		Clinical Supervision out of hours				80.33		95.00	77.08	
		Reporting systems					66.67	65.00	83.33	
		Work Load		25.00	25.00	39.58	41.67	39.58	37.50	
		Teamwork						77.78	80.56	
		Handover		41.67	37.50	58.33	72.22	72.22	68.75	
		Supportive environment				73.33	75.00	76.67	75.00	
		Induction		83.33	83.33	95.00	96.67	95.83	90.00	
		Adequate Experience		96.67	76.67	83.33	90.00	77.50	85.00	
		Curriculum Coverage						75.00	77.78	
		Educational Governance						63.89	75.00	
		Educational Supervision		91.67	100.00	91.67	91.67	97.22	87.50	

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
GP Prog - Emergency Medicine	Northampton General Hospital NHS Trust	Feedback		94.44	50.00	83.33	70.83	97.22	86.11	
		Local Teaching		79.00	81.67	78.33	85.00	86.33	87.22	
		Regional Teaching					80.75		81.67	
		Study Leave					68.89	55.56		
		Rota Design							70.83	
GP Prog - Medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	75.33	62.00	72.00	69.60	82.67	57.80	70.20	
		Clinical Supervision	84.50	76.58	76.25	84.80	90.67	68.00	86.25	
		Clinical Supervision out of hours				84.80	92.67	72.50	87.08	
		Reporting systems					78.33	61.00	70.00	
		Work Load	34.38	19.79	15.63	32.50	27.08	32.50	27.50	
		Teamwork						62.50	66.67	
		Handover	77.08	81.25	93.75	72.50	83.33	70.00	53.75	
		Supportive environment				67.00	76.67	61.00	60.00	
		Induction	75.00	51.67	87.08	79.00	96.67	58.75	67.00	
		Adequate Experience	75.00	65.00	72.50	74.00	83.33	66.00	64.50	
		Curriculum Coverage						61.67	58.33	
		Educational Governance						58.33	50.00	
		Educational Supervision	79.17	83.33	93.75	90.00	100.00	80.00	78.75	
		Feedback		61.67	84.38	66.67	80.55	68.06	40.00	
		Local Teaching	58.50	47.17	42.75	53.40	72.33	51.60	60.00	
		Regional Teaching	68.25					70.31	53.83	
		Study Leave	62.67	41.67	76.67	80.56	70.55	40.00	29.17	
		Rota Design							36.25	
GP Prog - Obstetrics and Gynaecology	Northampton General Hospital NHS Trust	Overall Satisfaction				60.00	70.67			74.33
		Clinical Supervision				67.00	78.33			90.83
		Clinical Supervision out of hours				73.67	83.33			
		Reporting systems					71.67			71.67
		Work Load				31.25	50.00			31.25
		Teamwork								69.44
		Handover				91.67				39.58
		Supportive environment				43.33	66.67			66.67
		Induction				93.33	95.00			68.33
		Adequate Experience				70.00	73.33			77.50
		Curriculum Coverage								75.00
		Educational Governance								72.22
		Educational Supervision				83.33	100.00			93.75
		Feedback				48.61	83.33			
		Local Teaching				33.00	57.67			61.67
		Regional Teaching								60.83
		Study Leave				65.56				66.67
		Rota Design								58.33
GP Prog - Ophthalmology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
GP Prog - Ophthalmology	Northampton General Hospital NHS Trust	Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
GP Prog - Paediatrics and Child Health	Northampton General Hospital NHS Trust	Overall Satisfaction		80.00		86.67			65.00	77.67
		Clinical Supervision		90.75		89.08			85.00	93.33
		Clinical Supervision out of hours				92.92				93.75
		Reporting systems							56.67	77.08
		Work Load		34.38		52.08			27.08	37.50
		Teamwork							69.45	77.78
		Handover		75.00		79.17			64.58	72.92
		Supportive environment				61.67			43.33	75.00
		Induction		86.25		91.67			56.67	91.67
		Adequate Experience		82.50		86.67			70.83	85.00
		Curriculum Coverage							66.67	80.56
		Educational Governance							52.78	75.00
		Educational Supervision		100.00		100.00			58.33	72.92
		Feedback		73.96					50.00	65.28
		Local Teaching		81.50		77.33			48.33	55.00
		Regional Teaching							45.28	57.78
		Study Leave		65.42					36.11	19.44
		Rota Design							37.50	56.25
GP Prog - Psychiatry	Northampton General Hospital NHS Trust	Overall Satisfaction	68.00							
		Clinical Supervision	94.58							
		Work Load	39.58							
		Handover	25.00							
		Induction	78.33							
		Adequate Experience	56.67							
		Educational Supervision	75.00							
		Feedback								
		Local Teaching	71.00							
		Regional Teaching								
		Study Leave								
GP Prog - Surgery	Northampton General Hospital NHS Trust	Overall Satisfaction		78.67				68.75		
		Clinical Supervision		83.50				87.50		
		Clinical Supervision out of hours								
		Reporting systems						73.75		
		Work Load		54.86				67.19		
		Teamwork						79.17		
		Handover						72.92		
		Supportive environment						73.75		
		Induction		90.00				89.06		
		Adequate Experience		80.00				75.00		
		Curriculum Coverage						75.00		
		Educational Governance						77.0		

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
GP Prog - Surgery	Northampton General Hospital NHS Trust							8		
		Educational Supervision		91.67				84.37		
		Feedback		59.72						
		Local Teaching		52.00				63.25		
		Regional Teaching						59.92		
		Study Leave		56.11				51.56		
		Rota Design								
Gastroenterology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
General Practice F2	Northampton General Hospital NHS Trust	Overall Satisfaction	86.40	90.00	85.00					
		Clinical Supervision	89.25	90.50	84.25					
		Work Load	70.00	72.92	56.25					
		Supportive environment								
		Induction	98.00	96.25	96.25					
		Adequate Experience	80.00	90.00	82.50					
		Educational Supervision	85.00	100.00	100.00					
		Feedback	100.00	94.79	93.06					
		Local Teaching	63.00							
		Regional Teaching								
		Study Leave	82.78	42.50	57.22					
General surgery	Northampton General Hospital NHS Trust	Overall Satisfaction	82.00	80.89	78.50	89.71	84.00	89.00	70.88	79.20
		Clinical Supervision	96.88	93.22	92.75	95.29	97.40	98.75	93.13	95.00
		Clinical Supervision out of hours				95.71	98.40	97.50	92.97	92.50
		Reporting systems					73.75	68.44	75.71	59.00
		Work Load	56.25	51.39	33.59	47.32	52.50	46.88	46.09	42.50
		Teamwork						75.00	64.59	43.33
		Handover	73.44	67.19	70.31	75.00	66.67	60.42	64.84	43.75
		Supportive environment				83.57	78.00	85.00	60.63	68.00
		Induction	90.00	76.67	78.13	89.29	89.00	70.83	78.13	83.00
		Adequate Experience	82.50	84.44	77.50	88.57	84.00	88.75	63.75	77.50
		Curriculum Coverage						83.34	72.92	80.00
		Educational Governance						79.17	75.00	80.00
		Educational Supervision	90.63	83.33	78.13	82.14	85.00	86.46	92.97	92.50
		Feedback	70.83	77.60	73.44	77.08	85.42		96.67	87.50
		Local Teaching	60.25	52.33	49.25	50.43	45.80	43.75	59.79	61.67
		Regional Teaching	59.54		67.88	56.25		62.6	59.7	55.67

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
General surgery	Northampton General Hospital NHS Trust							3	9	
		Study Leave	78.06	77.62	76.67	76.67	73.33	76.56	50.00	55.42
		Rota Design							49.22	33.75
Geriatric medicine	Northampton General Hospital NHS Trust	Overall Satisfaction				76.00				
		Clinical Supervision				76.33				
		Clinical Supervision out of hours				78.00				
		Reporting systems								
		Work Load				31.25				
		Teamwork								
		Handover				79.17				
		Supportive environment				61.67				
		Induction				83.33				
		Adequate Experience				76.67				
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision				100.00				
		Feedback				80.56				
		Local Teaching				49.67				
		Regional Teaching				68.00				
		Study Leave				70.55				
		Rota Design								
Haematology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Histopathology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Reporting systems								
		Work Load								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Medicine F1	Northampton General Hospital NHS Trust	Overall Satisfaction	80.31	75.43	79.08	72.29	74.00	63.88	58.67	63.45
		Clinical Supervision	85.17	75.38	82.08	75.89	78.92	77.50	68.19	74.38
		Clinical Supervision out of hours				76.46	77.33	75.16	66.07	74.38
		Reporting systems					69.09	62.14	58.33	55.91
		Work Load	35.26	26.04	33.01	31.25	23.61	28.91	17.36	28.41
		Teamwork						61.46	64.82	51.51
		Handover	81.73							
		Supportive environment				64.29	67.08	60.00	53.33	50.45
		Induction	92.69	63.10	78.08	69.64	88.33	63.0	59.3	66.82

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Medicine F1	Northampton General Hospital NHS Trust							2	1	
		Adequate Experience	77.69	77.86	83.08	80.71	78.33	64.06	74.17	73.18
		Curriculum Coverage						57.29	71.30	73.48
		Educational Governance						64.58	50.93	49.24
		Educational Supervision	96.15	92.26	94.23	83.93	87.50	77.08	84.72	80.11
		Feedback	70.45	63.46	63.54	64.10	73.48	50.00	38.69	66.67
		Local Teaching	59.38							
		Regional Teaching	74.69							
		Rota Design							18.06	46.02
Medicine F2	Northampton General Hospital NHS Trust	Overall Satisfaction	58.40	75.33	76.57	90.40	72.00	71.25	66.67	63.80
		Clinical Supervision	83.60	72.67	83.29	90.40	76.83	81.88		84.00
		Clinical Supervision out of hours				89.00	80.33	73.33	81.25	79.69
		Reporting systems					63.50	62.50	70.00	49.00
		Work Load	50.42	35.42	45.24	30.00	34.03	38.54	36.11	25.42
		Teamwork						77.09	61.11	58.33
		Handover	82.50	68.75	72.92	77.50	68.06	68.75	50.00	55.00
		Supportive environment				72.00	63.33	76.25	60.00	58.00
		Induction	87.00	75.83	86.43	84.00	73.33	89.06	46.67	74.00
		Adequate Experience	60.00	75.00	81.43	86.00	68.33	71.88	74.17	72.50
		Curriculum Coverage						79.17	61.11	53.33
		Educational Governance						64.58	61.11	68.33
		Educational Supervision	95.00	83.33	82.14	85.00	79.17	81.25	66.67	80.00
		Feedback	62.50	58.33	69.64	85.00	57.29	56.25		50.83
		Local Teaching	52.80							
		Regional Teaching								
		Study Leave	55.00	49.44	35.83	57.00	55.83	43.75	18.06	37.50
		Rota Design							25.00	28.75
Neurology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Obstetrics and Gynaecology F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Obstetrics and Gynaecology F1	Northampton General Hospital NHS Trust	Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Rota Design								
Obstetrics and Gynaecology F2	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Study Leave								
		Rota Design								
Obstetrics and gynaecology	Northampton General Hospital NHS Trust	Overall Satisfaction	76.89	82.18	86.00	89.00	66.86	68.57	72.43	59.09
		Clinical Supervision	93.00	92.55	89.50	90.00	80.14	88.39	85.00	87.00
		Clinical Supervision out of hours				88.50	81.86	87.14	83.04	83.52
		Reporting systems					67.00	67.50	76.43	72.73
		Work Load	35.42	46.02	46.09	42.19	34.82	38.39	27.68	31.82
		Teamwork						67.86	67.86	67.42
		Handover	83.33	81.82	90.63	90.63	69.05	68.45	58.04	43.75
		Supportive environment				82.50	55.71	70.00	72.14	51.82
		Induction	91.67	89.55	92.29	93.75	85.00	73.21	69.82	74.09
		Adequate Experience	72.22	77.27	87.50	90.00	64.29	63.57	69.64	54.09
		Curriculum Coverage						67.86	69.05	56.06
		Educational Governance						55.95	61.91	56.82
		Educational Supervision	88.89	97.73	90.63	87.50	78.57	87.50	81.25	80.68
		Feedback	84.26	85.00	80.21	88.09	63.69	76.19	75.59	60.23
		Local Teaching	52.78	60.55	67.38	66.75	62.57	61.57	71.91	68.94
		Regional Teaching	69.91	65.65	67.28	61.38	56.71	63.25	62.86	60.68
		Study Leave	72.92	73.48	55.00	70.63	65.48	49.70	37.80	56.82
		Rota Design							43.75	27.27
Ophthalmology	Northampton General Hospital NHS Trust	Overall Satisfaction	65.33		78.67		92.00	77.67	93.67	
		Clinical Supervision	89.33		94.00		97.00	90.00	96.67	
		Clinical Supervision out of hours					95.67	88.33	91.67	
		Reporting systems					93.33	75.00		
		Work Load	54.17		54.17		52.08	58.33	62.50	
		Teamwork						72.2	80.5	

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Ophthalmology	Northampton General Hospital NHS Trust							2	6	
		Handover						77.78	79.17	
		Supportive environment					91.67	83.33	81.67	
		Induction	56.67		85.00		88.33	87.50	90.00	
		Adequate Experience	60.00		80.00		96.67	77.50	92.50	
		Curriculum Coverage						72.22	91.67	
		Educational Governance						75.00	83.33	
		Educational Supervision	66.67		100.00		100.00	93.06	95.83	
		Feedback	40.28		91.67		91.67		91.67	
		Local Teaching	64.00		67.00		60.00	69.67	78.89	
		Regional Teaching	75.17		86.83		77.08	78.50	87.78	
		Study Leave						84.72	79.17	
		Rota Design							77.08	
Ophthalmology F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Rota Design								
Oral and maxillo-facial surgery	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Otolaryngology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Otolaryngology	Northampton General Hospital NHS Trust	Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Paediatrics	Northampton General Hospital NHS Trust	Overall Satisfaction	80.40	73.71	74.00	73.88	82.82	72.08	83.15	83.91
		Clinical Supervision	91.60	90.86	93.57	91.06	93.71	92.60	93.85	94.77
		Clinical Supervision out of hours				93.76	94.82	89.90	91.32	92.61
		Reporting systems					76.00	72.69	77.31	76.00
		Work Load	38.13	40.63	40.18	43.75	34.56	34.62	46.63	40.34
		Teamwork						67.95	67.31	77.27
		Handover	75.00	75.00	75.00	80.15	74.70	67.95	73.08	74.07
		Supportive environment				70.29	81.18	65.77	71.54	80.45
		Induction	87.00	85.71	86.43	84.71	93.24	80.29	83.46	78.64
		Adequate Experience	82.00	70.00	74.29	76.47	83.53	73.46	78.65	81.59
		Curriculum Coverage						71.79	76.28	75.76
		Educational Governance						63.46	71.15	70.00
		Educational Supervision	97.50	96.43	92.86	95.59	94.12	88.14	89.42	81.25
		Feedback	80.83	78.21	72.92	79.17	76.30	82.50	83.98	67.19
		Local Teaching	62.90	68.57	56.93	54.24	62.59	57.46	65.13	63.18
		Regional Teaching	63.19	64.81	59.14	61.75	62.70	62.61	68.85	57.42
		Study Leave	39.05	67.78	68.47	67.94	67.81	44.71	56.41	56.44
		Rota Design							48.56	54.55
Paediatrics and Child Health F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Rota Design								
Paediatrics and Child Health F2	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Paediatrics and Child Health F2	Northampton General Hospital NHS Trust	Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Palliative medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
Pathology F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Work Load								
		Supportive environment								
		Induction								
		Adequate Experience								
		Educational Supervision								
		Feedback								
Radiology F1	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Reporting systems								
		Work Load								
		Teamwork								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Rota Design								
Radiology F2	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Study Leave								
		Rota Design								
Renal medicine	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Renal medicine	Northampton General Hospital NHS Trust	Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Respiratory medicine	Northampton General Hospital NHS Trust	Overall Satisfaction	80.00	58.67						69.67
		Clinical Supervision	84.33	79.00						93.33
		Clinical Supervision out of hours								85.42
		Reporting systems								
		Work Load	33.33	27.08						33.33
		Teamwork								63.89
		Handover	75.00	83.33						60.42
		Supportive environment								78.33
		Induction	65.00	55.00						78.33
		Adequate Experience	83.33	70.00						76.67
		Curriculum Coverage								69.44
		Educational Governance								72.22
		Educational Supervision	75.00	66.67						83.33
		Feedback	80.55							
		Local Teaching	61.00	39.33						56.11
		Regional Teaching	59.33							71.67
		Study Leave		86.11						47.92
		Rota Design								50.00
Rheumatology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Surgery F1	Northampton General Hospital NHS Trust	Overall Satisfaction	68.89	77.78	76.73	71.56	72.89	53.20	62.25	53.63
		Clinical Supervision	81.44	83.89	83.82	77.67	86.67	75.13	59.38	73.75
		Clinical Supervision out of hours				74.14	85.22	74.58	66.37	68.49
		Reporting systems					74.00	63.13	60.63	55.00
		Work Load	31.94	31.25	41.86	25.00	47.22	32.50	23.44	28.13
		Teamwork						52.50	69.79	60.42
		Handover	59.72							
		Supportive environment				61.11	71.11	52.50	55.63	50.63
		Induction	83.89	77.22	75.45	82.22	86.11	78.13	56.88	61.88
		Adequate Experience	75.56	83.33	80.00	78.89	78.89	57.00	65.31	59.69
		Curriculum Coverage						50.00	61.46	51.04
		Educational Governance						61.67	53.13	45.83
		Educational Supervision	91.67	79.63	86.36	86.11	91.67	80.00	76.56	71.88
		Feedback	69.17	70.83	60.98	50.00	61.57	45.42	61.46	50.70

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Surgery F1	Northampton General Hospital NHS Trust	Local Teaching	49.22							
		Regional Teaching	73.81							
		Rota Design							21.88	31.25
Surgery F2	Northampton General Hospital NHS Trust	Overall Satisfaction	68.80	87.20	64.80	76.67	72.80	74.33	73.20	41.50
		Clinical Supervision	77.60	81.40	82.20	86.50	80.40	81.25	83.00	66.46
		Clinical Supervision out of hours				90.00	81.56	76.00	91.25	69.10
		Reporting systems					68.00	77.00	77.00	65.00
		Work Load	42.50	45.00	45.00	41.32	48.75	40.63	53.33	37.50
		Teamwork						63.89	70.00	66.67
		Handover	52.50	75.00	67.50	81.25	62.50	63.89	67.50	53.47
		Supportive environment				75.83	69.00	60.83	77.00	60.83
		Induction	82.00	72.00	95.00	80.83	94.00	63.20	77.25	60.00
		Adequate Experience	74.00	86.00	66.00	83.33	74.00	77.50	80.00	56.25
		Curriculum Coverage						76.39	70.00	59.72
		Educational Governance						62.50	70.00	50.00
		Educational Supervision	100.00	100.00	95.00	95.83	95.00	87.50	87.50	85.42
		Feedback	69.44	89.59	72.22	79.17	62.50	54.17	50.00	32.64
		Local Teaching	46.20							
		Regional Teaching								
		Study Leave	24.45	68.75	27.92	37.33	50.55	30.83	48.75	35.00
		Rota Design							46.25	22.92
Trauma and orthopaedic surgery	Northampton General Hospital NHS Trust	Overall Satisfaction	94.40	80.00	85.00	87.20	86.40	80.00	87.60	79.00
		Clinical Supervision	100.00	94.00	93.25	98.40	93.40	97.00	96.00	98.00
		Clinical Supervision out of hours				91.20	91.80	94.00	90.83	90.00
		Reporting systems					71.25	81.00	73.75	71.00
		Work Load	56.25	58.33	54.69	59.17	47.50	50.00	50.00	40.00
		Teamwork						73.33	61.67	58.33
		Handover	77.50	79.17	75.00	90.00	68.33	74.17	62.50	61.67
		Supportive environment				75.00	77.00	70.00	74.00	67.00
		Induction	90.67	93.33	51.67	95.00	92.50	77.50	62.00	62.50
		Adequate Experience	96.00	86.67	92.50	92.00	86.00	75.50	82.00	82.00
		Curriculum Coverage						75.00	76.67	71.67
		Educational Governance						85.00	71.67	75.00
		Educational Supervision	80.00	75.00	75.00	80.00	85.00	90.83	78.75	72.50
		Feedback	85.83		90.28	90.28	80.56	95.83	86.11	81.94
		Local Teaching	56.20	60.00	65.25	53.40	62.80	69.20	74.67	35.33
		Regional Teaching	91.50	87.67	95.00	96.00	92.10	93.60	87.00	79.33
		Study Leave	89.58		74.58	86.67	68.00	70.83	66.15	56.77
		Rota Design							63.75	28.75
Urology	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								

Programme Group	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Urology	Northampton General Hospital NHS Trust	Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								
Vascular surgery	Northampton General Hospital NHS Trust	Overall Satisfaction								
		Clinical Supervision								
		Clinical Supervision out of hours								
		Reporting systems								
		Work Load								
		Teamwork								
		Handover								
		Supportive environment								
		Induction								
		Adequate Experience								
		Curriculum Coverage								
		Educational Governance								
		Educational Supervision								
		Feedback								
		Local Teaching								
		Regional Teaching								
		Study Leave								
		Rota Design								

Report To	**Trust Board**
Date of Meeting	**26 July 2019**

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

Executive Summary

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

- Complaints and Compliments: 32 formal complaints and 3559 compliments were received in June
- Friends and Family inpatient results are 93% and feedback from the National Inpatient Survey 2018
- Pressure Ulcer Prevention; 12 Category 2 pressure ulcers of which 1 was device related, 1 Deep Tissue Injury and 2 Unstageable pressure ulcers
- The report contains an update on Midwifery and the CNST incentive scheme, Safeguarding, Assessment and Accreditation, End of Life, and Nursing and Midwifery Quality Care Indicator Dashboards

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

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

The Board is asked to:

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

- Support the on-going publication of the Open & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data

Northampton General Hospital NHS Trust

Trust Board
July 2019

Nursing & Midwifery Care Report

1.0 Introduction

The Nursing & Midwifery (N&M) Care Report highlights key issues from the Divisions, audits and projects during the month of June 2019. 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. The report should be considered alongside the Trusts scorecard. 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. Notable inclusions in this month's report include a more detailed report on our maternity services and an interim report on the National Inpatient Survey 2018.

2.0 Trust Scorecard –Summary

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

2.1 Quality of Care:

2.1.1 Complaints and Compliments

Patient care is at the centre of what we do as an organisation and we are committed to improving their experience. Whilst we receive a significant amount of positive feedback we also receive feedback when things have not gone so well. As a Trust we recognise that complaints and concerns are an opportunity to learn and improve.
In June there were 32 formal complaints received, a 93% response rate (compliance) and 3559 compliments

Themes:

The main categories are:

- Care x 15 (12 x medical / 3 x nursing / 0 x other)
- Communication x 10 (3 x medical / 4 x other / 2 x nursing / 1 x midwife)
- Delays x 6 (1 x treatment / 1 x operation / 2 x tests / 1 x assessment / 1 x referral)

Our aim is that every complaint is responded to within the agreed timeframe and that any learning that comes from the findings is agreed and owned within the Directorate. These are logged through the Datix system, in the last few months another section has been added which means that evidence of that learning can also be logged and provided as evidence of a responsive and well led process.

2.1.2 Friends and Family Test

Inpatients

- Response rates remain above the national target of 30% at 34.5%
- Recommendation rates remain up from April's drop at 93%

Emergency Department

- Response rates have increased to 15.3% in June, a continued rise since February
- Recommendation rates for June remain above the national target at 86.1%

Action Plan to improve FFT

The Patient Experience team are undertaking the following to increase the *'would recommend'* rate

- Surveys - Bespoke surveys across the hospital and encouraging other areas to do the same.
- Listening Events – The Patient Experience Team are continuing to carry out listening events on the children's wards by speaking with the relatives/carers of the patients. These events have proved to provide some valuable feedback.
- Patient Experience Champions – This group currently has 23 members Trustwide and is continuing to expand. Each champion is helping to improve the patient experience and increase response and recommendation rates in their individual area and liaising regularly with their Shared Decision Making Councils.

2.1.3 In-patient 2018 Survey Highlights

To improve the quality of services that the NHS delivers, it is important to understand what people care and think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences. This national survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018. Each Trust receives a rating to the questions of 'Better', 'About the same' or 'Worse'.

Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients. Responses were received from 496 patients at Northampton General Hospital NHS Trust (42%). The overall inpatient experience scoring was 7.9/10. When reviewing the overall scores for the Emergency Department, the Trust scored 8.5. When compared with other Trusts, this was 'about the same'. Overall, 11 categories were scored as 'about the same' as other Trusts participating in the survey. There was no category in which the Trust was scored as 'worse than'

In three of the categories there was one question where we scored 'worse' than other Trusts:

1) Expectations after operation – Patients being told how they could expect to feel after operation or procedure
2) Doctors – Doctors not answering questions in a way that patients could understand
3) Hospital and Ward – Noise from other patients at night

We improved on 2 questions categorised as the 'worst than' from the 2017 survey previous year these were both in the nutrition section, one relating to being offered a choice of food and the other being offered assistance with eating when required.

A full and detailed report with recommendations will be prepared for the Patient & Carer Experience & Engagement Group.

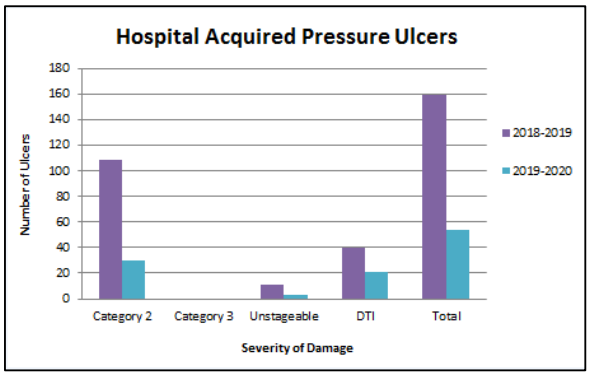
2.2 Safe

2.2.1 Pressure Ulcers

In June, following validation, there were 54 cases of Moisture Associated Skin Damage (MASD). 15 pressure ulcers developed whilst in our care, 12 were Category 2, 2 were Unstageable and 1 patient developed a Deep Tissue Injury which is being monitored in line with national guidance to ascertain whether this will be classified as a pressure ulcer.

The year on year reduction of hospital acquired pressure ulcers within the organisation continues.

Patients admitted from own home/care home/other hospitals	No of Harms	No of Patients



with skin breakdown		
Category 2	70	57
Category 3	13	11
Category 4	5	4
Unstageable	19	15
Deep Tissue Injuries	13	13
Moisture Associated Skin Damage	95	66

The Tissue Viability Team focus is currently on the following areas:

- Highlighting the increase in heel damage with the emphasis on correct use of aids and manual handling
- Pressure ulcer prevention and wound care training for the Trust
- Organising a new Trust wide, multidisciplinary wound collaborative. This will commence in September
- Leading the establishment of a countywide TVN forum involving KGH, NGH and NHFT.

3.0 Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards provide triangulated data utilising quality outcome measures, 15 steps methodology, patient experience and workforce informatics.

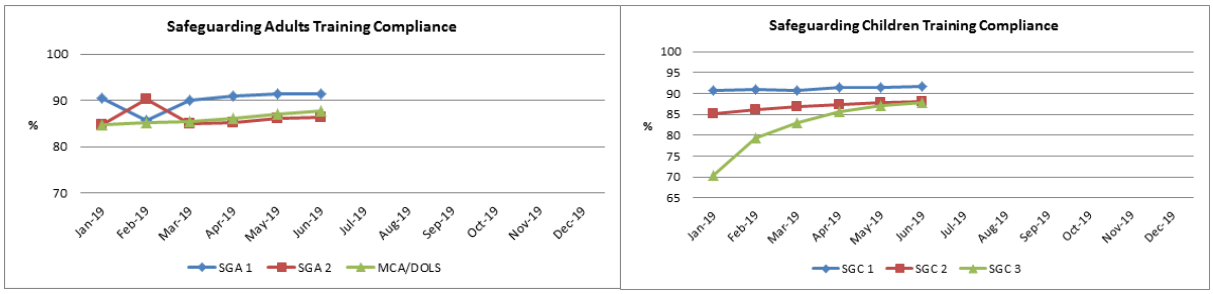
Exception Overview of the Nursing & Midwifery Dashboard

- In June there were 8 reds across the quality indicator questions, 5 in medicine, 2 in surgery and 1 in Children's
- One red was on Hawthorn due to incomplete care rounds, which the Matron dealt with at the time of audit and the second was on Head & Neck under first impressions which was due to being cluttered. The clutter is from necessary equipment and lack of storage space – conversations have been had with estates and the ward team as to how to try and improve.
- 2 reds were on Eleanor due to interruptions at meal time and increased clutter in first impressions – the band 7 has addressed both of these with the MDT
- 7 ambers were on Victoria, which has been an improvement, a seconded band 7 has recently been appointed who's objectives will include the QCI results
- 1 red and 4 ambers were on Holcot, the recent change in leadership has highlighted a couple of problems the Matron is working with the new band 7 regarding expectations and standard measures
- The paediatric domain which is red was with regards to the falls assessment and documentation, spot audits are in place and increased awareness which has had a positive effect as demonstrated in the improvements.
- The areas that are having an increased surveillance due to triangulation of QCI, outcome measures, patient experience and Assessment & Accreditation are: Victoria, Quinton, Benham, Holcot and Hawthorn – these areas recognised and monitored by the ADN's through to the Deputy and Director of Nursing and Midwifery.

4.0 Safeguarding

4.1.1 Safeguarding Training Compliance

The training compliance rate of 85% is set as part of the quality schedule; the Trust is meeting this requirement



The Trust has currently a remedial plan in place for Prevent training. With the introduction of an e-learning package the Trust is on track. Currently compliance is 78% (1955 staff members have received training out of 2510).

4.1.2 Safeguarding Children and Adult Referrals

Referral activity this month:

- Children – 83 referrals and 154 paediatric liaision forms
- Adults – 10 referrals raised by NGH and 10 raised against NGH
- DoLS – 40 applications made this month

Concerns continue regarding the reporting of safeguarding activity by Northamptonshire County Council, this continues to be escalated to the CCG.

The themes around allegations made about the Trust are regarding unsafe/poorly planned discharge with the lack of communication with families and external agencies. These are classified as omissions of care. Investigations are carried out by Ward Sisters/Department Heads rather than the safeguarding team to ensure that local learning is embedded into clinical practice. Overall learning for the Trust is disseminated via the monthly safeguarding bulletin, copied to wards, directorates and the Head of the Discharge Team.

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have slightly increased during the reporting period. There have been no further assessments undertaken by the local authority since the last report.

4.1.3 Safeguarding Assurance Activity

Clintonville/Avery - With the ongoing Section 42 enquiry being undertaken by the Local Authority, an increased senior nursing presence has been implemented. Daily feedback to the Director of Nursing is provided and further meetings have taken place with the investigating team and Avery management. No further concerns have been raised since the last Quality Governance Committee.

Four children's serious case reviews have been commissioned by the safeguarding children partnership. The Trust had contact with three of the families.

Two safeguarding adult reviews (SAR's) are reaching completion and the Trust had contact with both these adults. There is internal learning for the Trust around the application of the Mental Capacity Act. A full report and recommendations will be prepared when the review is completed.

There are three Domestic Homicide Reviews (DHR's) that are ongoing, which focus on the north of the county. Therefore there was no family contact with the Trust.

4.1.4 Dementia Quality Priorities

The use of the patient profile and dementia training compliance has been identified as quality priority for the coming year.

In order to capture the baseline data and formulate improvement, five medical wards will be audited monthly whilst all other adult wards will continue to be audited quarterly. The data will be evaluated and will form the basis of work to improve patient and carer experience.

Tier one dementia training is expected, and on track, to achieve 85% by the end of March 2020.

5.0 Maternity Update

5.1.1 Maternity Safety Highlight Report

The following tables show the progress made against two of the national drivers around maternity safety, the CNST Maternity Incentive Scheme (Maternity Safety Actions) and the Saving Babies Lives Care Bundle (SBLCB).

Maternity Safety Actions		
1	Perinatal Review Tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	Saving Babies Lives Care Bundle (SBLCB)	
7	Patient Feedback	
8	Multi-professional Training	
9	Safety Champions	
10	Early Notification Scheme (ENS)	

SBLCB V1		
1	Reducing Smoking in pregnancy	
2	Risk assessment and surveillance for fetal growth restriction	
3	Raising awareness of reduced fetal movement	
4	Effective fetal monitoring during labour	

SBLCB V2		
1	Reducing Smoking in pregnancy	
2	Risk assessment and surveillance for fetal growth restriction	
3	Raising awareness of reduced fetal movement	
4	Effective fetal monitoring during labour	
5	Reducing the number of preterm births	

Key	
Complete	The Trust has completed the activity within the specified timeframe
On Track	The Trust is currently on track to deliver within the specified timeframe
At Risk	The Trust is currently at risk of not being able to deliver within the specified timeframe
Will not be met	The Trust will not deliver within specified timeframe

5.1.2 CNST Incentive Scheme – Maternity Safety Actions

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The Trust sucessfully achieved this accreditation last year

Implementing these actions should deliver a qualitative difference in Trusts' performance on improving maternity safety and by doing this, trusts would be expected to reduce incidents of harm that lead to clinical negligence claims. The scheme will, therefore, reward those trusts who have implemented the 10 maternity safety actions.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by Thursday 15 August 2019.

Evidence is currently being collated demonstrating compliance with all standards and the Board Declaration report together with the evidence will be presented by the Director of Nursing & Midwifery to the Executive Team Meeting and CQEG by the stated deadline. The content of the Board Declaration report will then be shared and discussed at the Countywide Maternity Services Clinical Quality Review Meeting.

5.1.3 Saving Babies Lives (SBLCB)

In March 2019, all maternity units were asked to complete a Deep Dive audit around compliance with SBLCB version 1. The evidence was submitted to the Local Maternity System (LMS) and collated into a LMS wide response before being submitted to NHSE. Feedback was received by the Head of Quality at NHSE/I – Midlands in May/June 2019 and further evidence of compliance was requested. Suggestions were incorporated into the action plan and requested evidence was submitted. The Trust have now received email confirmation from the LMS and NHSE/I that there is no outstanding evidence for SBLCB version 1.

Version two of the SBLCB was released in March 2019 and has been produced to build on the acheivements of version one. The second version of the care bundle includes a greater emphasis on continous improvement with a focus on how processes and pathways can be developed and where improvements can be made.

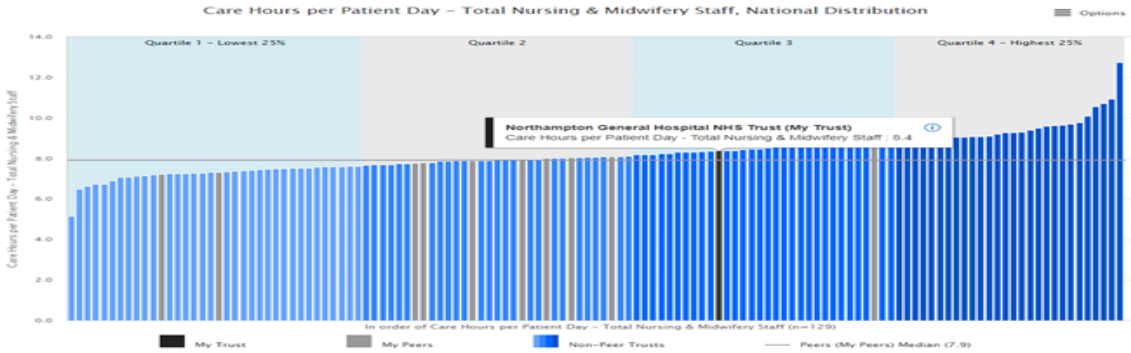
There are currently no concerns around the actions required to implement all the recommendations. The Fetal Surveillance Midwife commenced in April and the Healthy Lifestyle Midwife starts in July and both posts will lead on the elements of the care bundle. An initial gap analysis has been completed and baseline data is currently being collated as part of the quality improvement projects.

6.0 Safe Staffing

Overall fill rate for June was 97%, compared to 98% in May. Combined fill rate during the day was 92%, compared with 95% in May. The combined night fill rate remained the same at 102%. RN fill rate during the day was 89% and for the night 96%.
The average figures for the month demonstrate the responsiveness of our temporary staff to fill the gaps created by the current vacancies and extra open capacity and the ability of the senior staff to review and distribute staff safely across the organisation. Currently vacancies across the Divisions (Including Maternity) for the Inpatient areas are approximately 100wte with a 'felt' vacancy (which includes long term sick, vacancy and maternity leave) being nearer 180wte.
Acuity and Dependency of our patients and extra capacity remaining open has created extra pressure on resource and the requirement of increased temporary staff usage

	Day	Night	Overall
RN	89%	96%	92%
HCA	98%	113%	104%
Overall	92%	102%	97%

Across the general adult wards Care Hours per Patient Day for the month of June was Registered Practitioner 4.0 and HCA 3.3 (which is the same as May); Trust wide inclusive of midwifery, paediatrics and critical care (which by nature are a higher care hours level) RN/M was 9.8 and HCA 4.0 (which is an increase for RN/M by 0.4).



Of the 59 staffing Datix that were submitted and reviewed by the Associate Directors of Nursing & Midwifery 2 constituted a red flag, both of which were within maternity these have been reviewed by the Matron and Deputy Head of Midwifery. Neither of the red flags resulted in actual mother or baby harm

7.0 Assessment and Accreditation

There were no assessments undertaken in June. Three wards were discussed at Trust Board and received approval. In June the current status of all adult in-patient wards including Critical Care was six blue wards, seven green wards, twelve amber wards and no red wards. Of the seven green wards, one is awaiting panel to support blue ward status. The current status of outpatient departments is - three green departments and three amber departments. Interviews for the new Quality Assurance Matron have taken place with an interim cover plan for the vacated post to commence mid-July this will ensure continuity of the process and programme.

8.0 End of Life

The new countywide DNACPR form which includes an integral MCA assessment has been rolled out across the Trust. In the first month, MCA compliance has improved to 65% from 35%. Wards achieving 100% compliance have been acknowledged.

The Amber Care Bundle roll out continues with patients from ED being tracked to ensure appropriate review and continuation, alongside staff support.

The importance of learning from incidents is an important part of the team's role. Any themes and areas of improvement are highlighted and fed back to directorates. This month themes include:

- Clearer community referral pathways
- Clarity on which medications to discontinue or continue for doctors
- Revision of mortuary card for ease of completion

The revised End of Life Operational Policy is now available on Net Consent and includes deactivation of Internal Cardiac Defibrillators and clear Last Offices guidance.

9.0 Waste Segregation at Northampton General Hospital NHS Trust (CQC)

Following the CQC visit in June the visiting inspectors raised questions regarding the Trust's waste segregation policy and process. As such the Infection Prevention Team is reviewing the Policy against national guidance, our contractor's policies and our sustainability programme.

There is a three year forward plan for waste management and disposal audits and these audits are conducted weekly by the Energy & Sustainability Manager and Infection Prevention & Control Nurse, where issues are rectified at the time if possible, and findings are fedback to the Ward Manager or Ward Co-ordinator to action immediately. The results of the weekly audits are sent for review to the Director of Nursing and Midwifery and the Governance Team plus cascaded to the Divisions for dissemination.

Waste management and disposal has been included within the Infection Prevention Steering Group forward schedule from June and a quarterly waste management report will be compiled.

10.0 National Recognition

During the last two months there has been notable submissions made to national conferences and for national awards. In summary the following should be noted by the Board:

Three nominations were made to the Nursing Times Workforce Awards 2019, all have reached the shortlisting stage, the awards ceremony will be held on the 25th September 2019:

- Best employer for Staff recognition - Pathway to Excellence
- Best UK employer of the year –Pathway to Excellence
- Patient Safety Award - Surgical Practice Development Team

Two abstracts accepted for oral presentation at the annual Infection Prevention Society conference in Liverpool –September 22-23 2019

11.0 Recommendation

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

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 JUN

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↑		92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	3	0	0	0	0	4	2	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↓					4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,560
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↑		92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.7%	85.5%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		79	60	118	174	142	299	330	400	420	343	203	69
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		1	3	15	17	19	30	49	33	22	13	11	15
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		6	16	2	3	3	4	5	4	4	11	1	4
	Delayed transfer of care	Debbie Needham	=23	NGH	↑		12	19	36	10	10	24	12	11	20	31	34	21
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↑		28	16	34	27	15	20	20	17	29	41	41	32
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↑		19	13	25	25	13	16	17	13	20	30	33	23
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↑		81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	No data submitted
	RTT over 52 weeks	Debbie Needham	=0	Nat	↓		0	0	0	0	0	0	1	3	1	0	1	No data submitted
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	No data submitted

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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%		↓		92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%		↑		97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%
	Unappointed Follow Ups	Debbie Needham	=0	NGH	↓								8,608	8,723	9,957	10,119	10,363	10,385
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH	↓		12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%
	Sickness Rate	Janine Brennan	<=3.8%	NGH	↓		4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH	↓		13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH	↓		14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH	↓		10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH	↑		14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%
	Turnover Rate	Janine Brennan	<=10%	NGH	→		8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH	→		89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH	↑						81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH	↑		85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH	↑		85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH	↓		58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH	↑		(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH	↓		72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH	↓		89	107	128	153	167	195	209	230	266	55	34	57
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH	↓		152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH	↑		1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH								64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH								39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH	↓			27	No data submitted	No data submitted	No data submitted	15	21	21	19	18	18	22
	Waivers which have breached	Phil Bradley	=0	NGH	↓			0	No data submitted	No data submitted	No data submitted	1	0	0	0	4	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH	↑		51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH	↑		22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH	↑		4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH	↓		18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%
	Emergency re-admissions within 30 days (elective) - Excludes ACC & COA	Matt Metcalfe	<=3.5%	NGH	↑		4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	ERROR	2.4%	ERROR	2.5%	3.1%	1.3%

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	Emergency re-admissions within 30 days (non-elective) - Excludes ACC & COA	Matt Metcalfe	<=12%	NGH	↑		16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	13.5%	13.2%	ERROR	13.6%	11.5%	8.8%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↓		0	104	104	106	106	106	105	106	104	103	104	105
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		98	98	100	100	104	104	104	104	104	104	100	100
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		25	45	47	66	36	35	53	51	35	35	35	No data submitted
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	No data submitted
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%	6.3%	3.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	1	0	0	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0		↓		3	2	3	0	0	3	7	1	0	0	2	3
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.1%	95.6%	93.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	HOHA (C-Diff > 2 Days)	Sheran Oke	<=1.75	Nat	↑		2	1	2	0	0	1	0	0	0	2	3	1
	Community Onset Healthcare Associated C-Diff infection (COHA)	Sheran Oke	<=3	CCG	↓											1	2	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH	↑		2	0	0	2	1	0	1	2	0	5	4	1
	New Harms	Sheran Oke	<=2%	NGH	↑					2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2	5.4	4.7
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→							85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓							62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓							89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%

No data submitted — Data not provided

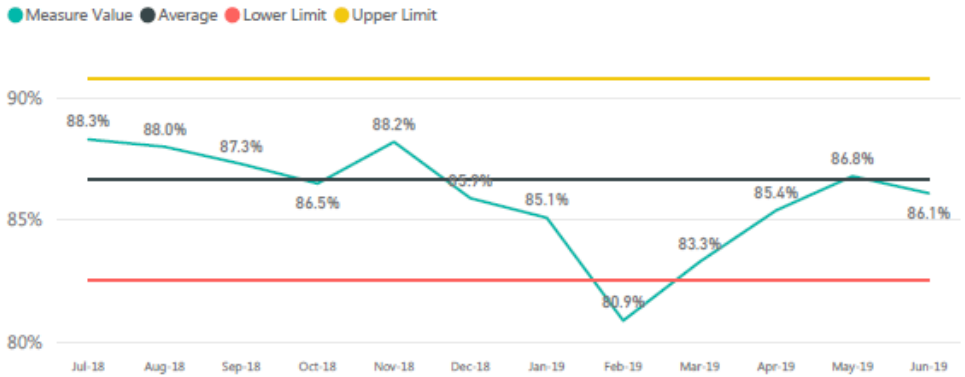
No data - pre KPI implementation

Appendix 3

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

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	86.4 %	86.1 %	↓	Sheran Oke

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
88.3 %	88.0 %	87.3 %	86.5 %	88.2 %	85.9 %	85.1 %	80.9 %	83.3 %	85.4 %	86.8 %	86.1 %

What is driving under performance?

The recommendation rate for A&E was 0.3% below the national average when comparing the result for June with the most recent national average data available (April 2019). This is slight decrease from the May result which was at 0.4% above the national average. The Emergency Department had a 9.8% text/interactive voice message failure rate during June which is an improvement compared 34% in April. This is due to IT improving processes so that the default number is the mobile telephone number which should help to rectify the problem and improve the response/recommendation rate.

Actions completed in the past month to achieve recovery

A&E continue with the initiative implemented at the beginning of the year to reduce waiting times for lower priority patients according the emergency needs.

Exception report written by

FrancisS1

Timeframe for recovery

July 2019

Assurance Committee

Quality Governance Committee

Next steps

Monitor the impact of the new initiative in A&E.

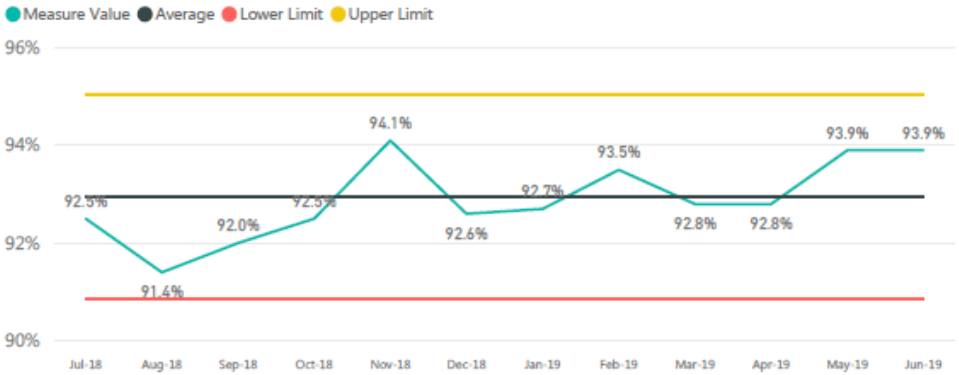
Increase communication through ‘FIT’ and ‘majors lite’ to patients on delays and accurate signposting

Appendix 3

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

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	95.7 %	93.9 %	↑	Sheran Oke

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
92.5 %	91.4 %	92.0 %	92.5 %	94.1 %	92.6 %	92.7 %	93.5 %	92.8 %	92.8 %	93.9 %	93.9 %

What is driving under performance?

The result for Inpatient and Day Case continues to be stable with only small movements each month. The Inpatient and Day Case result is 1.8% below the national average for June which was the same for May. When reviewing the ward recommendation rate there is wide variability, with results as high as 100% and as low as 81%. The focus over the next few months will be to understand this variability and how to reach a potential difficult cohort of patients.

Actions completed in the past month to achieve recovery

The Right Time survey continues alongside bespoke surveys which identify specific areas where further improvement is needed. Training and attendance at multidisciplinary meetings including forums, Councils and nurse development programmes during the month to raise awareness of patient experience.

Exception report written by

FrancisS1

Timeframe for recovery

July 2019

Assurance Committee

Quality Governance Committee

Next steps

Review variability in recommendations rates across wards. Continue with training and attendance at multidisciplinary meetings to raise awareness of patient experience.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
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Report To	**Trust Board**
Date of Meeting	**26th July 2019**

Title of the Report	Bi-annual Maternity Staffing Review
Agenda Item	**11**
Presenter of Report	**Sheran Oke, Director of Nursing and Midwifery**
Author(s) of Report	**Heather Gallagher, Associate Director of Midwifery (ADM)** **Christine Ainsworth, Deputy Head of Midwifery**
Purpose	For assurance

Executive summary

This bi-annual Maternity Staffing Review has been produced to inform the Trust Board of Midwifery staffing levels and that the Board receives assurance that safety is being maintained with regards to midwifery staffing numbers.

The review is required under the CNST Maternity Incentive Scheme V2 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The review has highlighted a deficit against the budgeted establishment of 9.82 wte midwives. A detailed action plan has been developed to provide mitigation and further actions required.

A business case will be developed to incorporate the deficit as well as the required staff to meet the requirements of the new continuity of carer models.

	Focus on Quality and Safety
Risk and assurance	As discussed in this paper
Related Board Assurance Framework entries	1.3 and 4.1
Equality Analysis	Is there potential for, or evidence that, the proposed

	decision/document will not promote equality of opportunity for all or promote good relations between different groups? No. Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No.
Legal implications / regulatory requirements	No
Actions required by the Group	

1 Introduction

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of this resource has been the overarching policy publication *Better Births* (2016) that highlighted the vision:

" ……..for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

Maternity staffing is central to delivering the triple aim of health and wellbeing, care and quality, and funding and efficiency, as described in *Five Year Forward View* and in Part 3 of the *Leading change, adding value* nursing framework. It is increasingly evident that personalised care leads to safer care and better outcomes. It is also well recognised that when staff work in well-led positive environments and are supported to take pride in their work, outcomes for women and babies improve. The current climate is challenging in many ways. Increasing acuity of births and the lack of availability of maternity staff reported by the Royal Colleges are significant issues for many units.

2 Background

The Trust has a duty to ensure that Midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013) and the Health and Social Care Act (2012). NICE (2015) states of the Trust board that it '*should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings'.*

This bi-annual Maternity Staffing Review has been produced to inform the Trust Board of Midwifery staffing levels and that the Board receives assurance that safety is being maintained with regards to midwifery staffing numbers.

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, for example:

- Reducing mortality & morbidity
- Reducing adverse incidents
- Reducing 30 day readmissions for both mothers and babies
- Improves the patient experience – continuity of carer throughout the pregnancy

National Quality Board (2018) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing.

The National Quality Board (2018) "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing", was published in January 2018. This is also aligned with commitment 9 of Leading change, Adding value: a framework for Nursing, Midwifery and Care Staff (2016). The safe staffing improvement resource provides an updated set of expectations for nursing and midwifery care staffing, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource.

The purpose of this resource is to help providers of NHS-commissioned services, boards and executive directors to support their head/director of midwifery and other lead professionals in implementing safe staffing for maternity settings. NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing. They hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources.

NQB Principles and Expectations

- Sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric;
- Offers guidance for local providers on using other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care;
- Identifies three updated NQB expectations that form a 'triangulated' approach to staffing decisions

<table>
<tr><th colspan="3">Safe, effective, caring, responsive and well–led care</th></tr>
<tr><td colspan="3">Measure and improve
– patient outcomes, people productivity and financial sustainability –
– report investigate and act on incidents (including red flags) –
– patient, carer and staff feedback –</td></tr>
<tr><td colspan="3">Implementing Better births maternity vision
– implement Birthrate Plus (BR+), Safer childbirth –
– develop local quality dashboard for safe sustainable staffing as part of the maternity dashboard –</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><th>Right staff</th><th>Right skills</th><th>Right place and time</th></tr>
<tr><td>1.1 Evidence-based workforce planning
1.2 Appropriate skill mix
1.3 Review staffing using the BR+ workforce planning tool annually and with a midpoint review</td><td>2.1 Multi-professional mandatory training, development and education
2.2 Working as a multi-professional team
2.3 Recruitment and retention</td><td>3.1 Productive working and eliminate waste
3.2 Efficient deployment and flexibility including robust escalation
3.3 Changes in working around Better births, including increased continuity and case-loading, and improvements in postnatal care and mental health initiatives</td></tr>
</table>

Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme was introduced in 2018/2019 and revised stretch criteria for the standards for 2019/2020.

"Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to

us in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. It is important to remember that trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care".

One of the ten required standards for the Trust is safe midwifery staffing:

CNST V2 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard and evidential requirement for the Safety Action 5 is:

- A systematic, evidence-based process to calculate midwifery staffing establishment has been done.
- The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service
- Women receive one-to-one care in labour (this is the minimum standard that Birthrate Plus is based on)
- A bi-annual report that covers staffing/safety issues is submitted to the Board.

A bi-annual maternity staffing review report that includes evidence of:

- A clear breakdown of Birthrate Plus or equivalent calculations to demonstrate how the required establishment has been calculated.
- Details of planned versus actual midwifery staffing levels.
- An action plan to address the findings from the full audit or table-top exercise of Birthrate Plus or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
- The midwife: birth ratio.
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birthrate Plus accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls.

Trusts should be evidencing the position by 15 August 2019.

NICE (2015) Safe Midwife Staffing in Maternity Settings; this report acknowledges that guidance, however the staffing tool to accompany the guidance has not been produced therefore the staffing formula via Birthrate Plus a nationally recognised midwifery staffing tool has been applied using same format as for the previous reviews but with recent data. In the NICE Guidance a minimum staffing ratio for women in established labour has been recommended, based on the evidence available and the Safe Staffing Advisory Committee's knowledge and experience. The Committee did not recommend staffing ratios for other areas of midwifery care. This was because of the local variation in how maternity services are configured and therefore variation in midwifery staffing requirements, and because of the lack of evidence to support setting.

NICE (2015) recommended the use of red flags. *A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.* The following are the recommended red flags, this data is collected and forms part of this staffing review report.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit.
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

High Quality Midwifery Care (RCM 2014) recognises the need that staffing levels are appropriate across the entire maternity pathway otherwise labour ward care is always prioritised at the expense of antenatal and postnatal care.

Staffing levels and skill mix within maternity services have been the focus of much debate in recent years. Maternity services nationally are constantly under pressure to utilise their manpower resources effectively and efficiently. A number of other factors have emerged, which include population demographics, national reports and guidelines along with an increase in public awareness and expectation especially in light of Morecambe Bay. In addition, diversity and complexity of patient needs continue to increase, and range from promoting health and well-being through the wider public health agenda to the high dependency care of sick women and babies.

National data published in July 2016 by the ONS stated that the rate of women having babies in their 40's is higher than that of under 20's for the first time since 1947, this increase in age profile comes with a recognized increase in complexities. The additional work associated with increased antenatal screening and the national Saving Babies Lives Care Bundle which includes the GAP/GROW programme of assessing fetal growth has been an additional pressure to the service.

3 Northampton Maternity Staffing Review

A review of recent national publications was undertaken prior to commencement of the staffing review in order to incorporate the latest evidence to inform the methodology and the recommendations.

It is an important factor to incorporate the professional judgment of the midwifery managers. Their views are then supported objectively by the use of the following information:

- Establishments were compared to 2018/2019
- Review of registered to unregistered midwives ratios
- The application of Birthrate Plus a nationally recognised tool which is the classification of case mix by categories I–V (table top)
- Booking & delivery statistics

The review process involved auditing the current staffing establishment against the Safer Childbirth (2007) RCOG standards for staffing levels in the maternity service to establish whether NGH were comparable via the nationally Birthrate Plus tool.

Self assessment against NQB (2018) Board recommendations in determining staffing requirements for maternity services.

No		R	A	G	Comments
1.	Boards are accountable for assuring themselves that appropriate tools (such as the NICE-recommended Birthrate Plus (BR+) tool for midwifery staffing) are used to assess multi professional staffing requirements				
2.	Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.				
3.	Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE guideline NG4.				
4.	Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources				Not compliant with RCOG or currently compliant with OAA staffing recommendations. Plan in place.
5.	Boards are accountable for assuring themselves that sufficient staff have attended required training and development, and are competent to deliver safe maternity care.				
6.	Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review				

7.	Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff				Agency midwives not used currently.
8.	Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.				
9.	Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.				
10.	Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.				
11.	Organisations must have mandatory training, development and education programmes for the multidisciplinary maternity team, and establishments must allow for staff to be released for training and development				Maternity safety training requirements have increased over last few years with no additional headroom allowance, despite this being over and above the usual training requirements for Nursing/AHP
12.	Organisations must take an evidence-based approach to supporting efficient and effective team working.				
13.	Services should regularly review red flag events and feedback from women, regarding them as an early warning system				
14	Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback				

Birthrate Plus Methodology

The Birthrate Plus Midwifery workforce planning system is based upon the principle of providing one to one care during labour and delivery to all women, with additional midwife hours for women in the higher clinical need categories. The full study assesses the midwifery workforce of a service based on the needs of women and records for a minimum period of 4 months on intrapartum care, hospital activity, and all other aspects of care provided by midwives from pregnancy till the mother and baby are discharged from postnatal care. The application of Birthrate Plus which is the classification of case mix by categories I–V. This classification for labour and delivery care has been used as a measurement of NGH current case mix and staffing levels alongside Birthrate Plus national averages for midwifery staffing.

Table Top exercise

The ratios below are based on the Birthrate Plus dataset, national standards with the Birthrate Plus methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth. These ratios were calculated following the Birthrate Plus Midwifery Services Full Establishment Review undertaken in May 2018.

Home births	34 births to 1 wte midwife
Delivery Suite births (all hospital care)	33 births to 1 wte midwife
Birth Centre births	55 births to 1 wte midwife
Antenatal & Postnatal Community care only	96 cases to 1 wte midwife
Overall ratio for **all** births	27 births to 1 wte midwife
9% is added to include the non-clinical midwifery roles as these are outside of the skill mix adjustment as above.	

Place of Birth	No of Births 2018/2019	wte Midwife required
Home	140	4.11
Hospital	4429	146.2
Community antenatal/ postnatal care only	228	2.37
Birth Centre	627	11.4
Additional 9%		14.8
		178.88

A staffing review of requirements for community is currently under review with the requirement to implement as part of the National Maternity Transformation 'Continuity of Carer' across the maternity pathway.

Midwifery Banding breakdown

Band	WTE
8c	1
8b	1
8a	4
7	28.9
5/6	134.16
Total	**169.06**

Nationally the ratio of senior midwives to midwives is 0.24%

Specialised Posts (9% Non-Clinical)

Specialist Posts (non-clinical contact)	9%: 14.8wte requirement
Clinical Effectiveness	0.6wte
Quality and Safety Midwife	1.0wte
Data Fail Safe Midwife	1.0wte
Matrons	4.0wte
Head of Midwifery and Deputy Head of Midwifery	2.0wte
Practice Development Midwives	2.0wte

Safeguarding Midwives (*removed Feb 2019)	2.0wte
Screening and Immunisation Infant Feeding Bereavement Clinical Change/IT (non-budgeted)	2.0wte
Total non-clinical contact	**14.6wte** **-0.2wte deficit**

Midwife to Birth Ratio – March 2019

153.86 wte	Number of wte clinical midwives in establishment
-16.37 wte	Number of wte on maternity leave
-5.53 wte	Number of wte long term sickness / absence
128.93 wte	Number of wte Substantive staff
13.6 wte	Number of wte in Bank Usage
142.53 wte	Total number of wte Midwives
4569 Births	Annualised delivery rate
1:32	Annualised Midwife to Birth Ratio for March

Midwife to Birth Ratio for 2018/19

Indicator	Q1	Q2	Q3	Q4
Midwife to Birth Ratio (Annualised delivery rate)	**1:31.9**	**1:31.6**	**1:34**	**1:32**

Guidance on midwifery staffing is based on Birthrate Plus calculations and Safe Midwifery Staffing for Maternity Settings – NICE (2015) which includes the need for professional midwifery judgement. The national safe midwifery staffing guidance suggests that the national accepted ratio of Midwife to birth is 1:28. For Northampton General Hospital the agreed Midwife to Birth ratio is 1:29. However, the Birthrate Plus establishment recommended a Midwife to Birth ratio of 1:27 due to the complexities of the population cared for.

- Projected maternity activity is monitored closely. In September our predicted Birth rate based on EDDs from bookings was 4928 which is over capacity in terms of midwifery establishments, Obstetric cover, theatre capacity and actual physical number of labour ward rooms. These figures do not include out of area women who book later in pregnancy to birth at NGH. The increase in maternity birth activity was 5.9%.
- Despite current financial pressures, a decision was made to reduce some maternity activity from outside the region, due to concerns regarding midwifery staffing levels. This is in conflict with the current National Maternity Transformation Programmes directive for more personalised care and choice of place of birth, however deemed appropriate due to safe staffing concerns.
- Bookings for January 2018 were in excess of 500.

- Due to the increase in activity and births meaning that the budgeted establishment for midwifery staffing maybe inadequate.
- The Escalation and Closure Policy was being used with increasing frequency due to increased activity.
- Trend of neonatal readmissions for breastfeeding babies with weight loss and jaundice which could be suggested to be possibly due to rapid discharge to create flow and capacity.

Current Midwifery Staffing

- Currently 6.31 WTE over budgeted establishment, as historically over recruited to cover for excessive amounts of maternity leave.
- 17.94 WTE Felt vacancies due to maternity leave and long term sickness, excluding short term sickness/other leave.
- Expected felt vacancies of 14.24 WTE by the end of March due to returners.
- MSW staffing deficit.

4 Review Findings

Planned interventions:
There have been a number of actions to proactively manage the reduction in staffing within the Service, all of which have been discussed and agreed by the Directorate. (see action plan)

Current position:
With the implementation of the 'short-term' actions the current Midwife to Birth ratio is currently 1:32 (this fluctuates). Progress against the medium term actions have commenced and advancement of the long term plans will be presented in the next bi-annual report. The Associate Director of Midwifery – Head of Midwifery continues to monitor the staffing levels across the Maternity Service and ensure that safety metrics, quality of care and maternity experience are not compromised. Agreement has been sort and agreed to recruit to cover the felt vacancies.

Midwifery Unit Closures

Part of the Maternity Escalation and Closure Policy contains a section regarding management of Maternity capacity. Within the Policy there is a comprehensive section upon the reasons why the Maternity Unit would temporarily close to admissions (one of which is staffing levels) and the processes surrounding the closure to ensure safety of women & babies and to support collaborative working with neighbouring Trusts.

Maternity services have seen peaks in service demand and activity, and increasing use of Maternity Escalation and Closure policy, at the same time there has been an increase in staff sickness and longer term absences (maternity leave and long term sickness). During the period 1st April 2018 to 31st March 2019 the maternity unit closed eight times for a total of 101 hours. This is the most occasions and the longest total duration the unit has ever needed to close for.

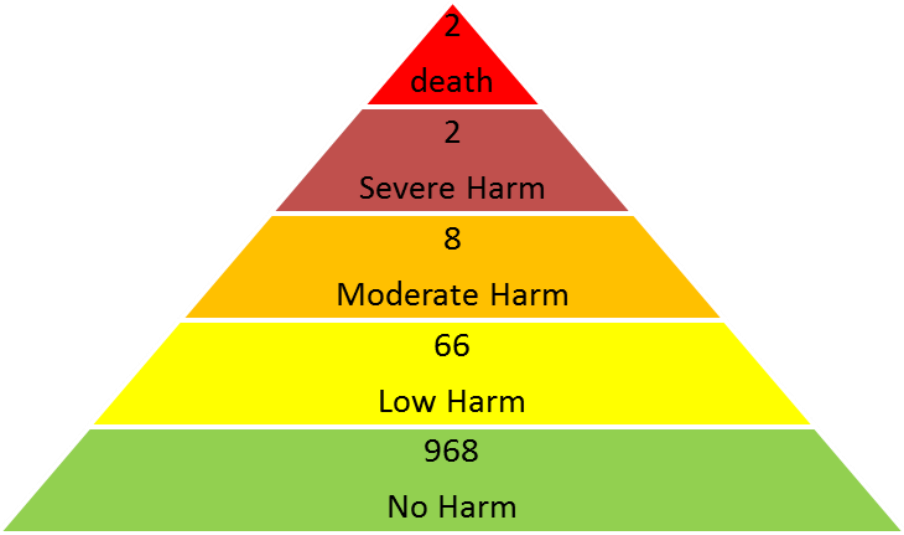
Indicator	Q1	Q2	Q3	Q4	Total
Number of Unit Closures	2	2	3	1	**8**
Hours Unit Closed for	24	17	56	3.5	**101**

Operational pressures are managed through the escalation policy, this often shows extreme troughs and peaks of activity with peak activity affecting the antenatal ward/postnatal; labour ward and postnatal ward often all at the same time, adding to the complexity of operationally managing the maternity service. These peaks and troughs are often seen system/region wide, resulting in neighbouring Trusts often declining to accept women even if a closure of the maternity unit is attempted, due to their own pressures. Maternity is similar to ED, in that the doors can never really be closed, and activity and demand are often difficult if not impossible to predict (NQB 2018).
A maternity Escalation and Closure Policy should be designed to ensure that there is sufficient midwifery staff to support activity during peaks in activity by "pulling in" staff from other parts of the service (particularly out of hours). However, we have currently a system with very little flex. The out of hour's availability of 'flex' midwives for periods of high activity needs to be further explored (NICE 2015, NQB 2018 & 2016) as currently it is reliant on the Home Birth Team.

Acuity tools have been implemented to allow for the robust assessment of real time staffing needs and appropriate response to shortages.

Datix Incidents overall

There were a total of 1046 incidents reported in obstetrics during the period of 1st April 2018 to 31st March 2019. The table below shows all incidents by actual harm:



Staffing Incidents

During the period of 1st April 2018 to 31st March 2019 there were 57 logged incidents in relation to staffing. Each Datix is reviewed in the context of the status of the maternity unit capacity, women's acuity and overall staffing levels. The table below shows the incidents by location and sub category:

	Increased Activity	Lack of suitably trained /skilled	Sickness	Total
Balmoral Ward	1	0	0	1
Barratt Birth Centre	2	0	0	2
Maternity Day Unit	0	1	0	1
Maternity Observation Ward	3	5	0	8
O & G	1	2	0	3
Robert Watson Ward	4	8	0	12
Sturtridge Labour Ward	22	6	2	30
Total	33	22	2	57

Under reporting on Datix staffing and activity/acuity concerns is suspected, as often the acuity tools have narrative describing red flags. Work is ongoing to embed the acuity tools further and allow robust triangulation with submitted Datix incidents related to Red Flags.

Midwifery Indicators (Red Flags)

Incidents by Incident date (Month and year) and Midwifery Red Flag Events

	Delayed or cancelled time critical activity	Missed or delayed care (e.g. delay of 60 minutes)	Delay of more than 30 minutes in providing pain relief	Delay of 30 minutes or more between presentation and triage	Delayed recognition of and action on abnormal vital signs	Midwife unavailable to provide cont 1-to-1 to woman in labour	Total
Apr 2018	1	1	0	0	0	0	2
May 2018	1	1	0	0	0	0	2
Jun 2018	1	3	0	0	0	0	4
Jul 2018	2	4	0	0	0	0	6
Aug 2018	1	3	0	2	0	0	6
Sep 2018	0	7	1	0	0	0	8
Oct 2018	1	3	0	1	0	0	5
Nov 2018	1	1	0	0	0	0	2
Dec 2018	0	3	0	1	0	0	4
Jan 2019	0	0	0	0	0	0	0
Feb 2019	0	8	0	0	0	0	8
Mar 2019	0	0	0	1	2	0	3
Total	8	33	1	5	2	0	53

Actual versus planned staffing (Fill Rates)

Actual versus planned staffing fill rates for registered and unregistered (MSW) staff is reported monthly via the Safer Staffing Report.

Fill rates for midwifery shifts are satisfactory and are maintained over 80% (high bank usage). A decision was made to offer enhanced bank rates to attempt to ensure adequate coverage of the shortfalls from the 1st February 2018. Fill rates for MSWs are poor due to the vacancy factor and consistently under 80%, particularly on nights. The service moves/redeploys staff to the areas of need, however it must be noted that the vacancy factor for MSWs is of concern as their establishment of MSWs will postnatal care should replace 10% of midwifery posts in postnatal areas.

Action Plan (Midwifery Staffing)

Directorate & Specialty: Maternity
Sign Off Forum: Divisional Governance Group

RAG Rating

Red	Not compliant / Overdue
Amber	On target
Green	Completed

	Recommendation	Services Assurance / Current Practice	Gaps / Required Actions	Due Date	RAG
1	Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources	Not compliant with RCOG or currently compliant with OAA staffing recommendations.	Not compliant with staffing recommendations. Recommendations not previously used in staffing reviews Business case submitted and supported by Executive Team	December 2019	
2	Organisations must have mandatory training, development and education programmes for the multidisciplinary maternity team, and establishments must allow for staff to be released for training and development	Maternity safety training requirements have increased over last few years with no additional headroom allowance, despite this being over and above the usual training requirements for Nursing/AHP	Head room insufficient to allow for staff to be released to attend all mandatory and role specific training. Full review of Training Needs Analysis Report to Workforce / Trust Board to request increase in headroom as per TNA findings	December 2019	

Action Plan (Midwifery Staffing)

	Recommendation	Services Assurance / Current Practice	Gaps / Required Actions	Due Date	RAG
3	Full staffing review to include the requirements of Better Births and Continuity of Carer models	Currently 9.82 wte deficit to provide care for existing models.	Development of business case to cover implementation of required models of care	September 2019	
4	Commencement of an On-call rota of Senior Midwifery Managers to provide 'out of hours' professional advice and clinical support	On call Senior Midwife rota in place			
5	Daily review of the staffing by the senior midwifery team incorporating a risk assessment of the activity against the staffing and proactively managing the risk across the Maternity Unit in accordance with Maternity Escalation Policy	Daily safety huddles introduced			

Action Plan (Midwifery Staffing)

	Recommendation	Services Assurance / Current Practice	Gaps / Required Actions	Due Date	RAG
6	Implementation of appropriate acuity tool to allow robust assessment of real time staffing needs and appropriate response to shortages	. Birthrate plus Acuity Tool – intrapartum introduced January 2019 and wards introduced June 2019.			
7	Implementation of 'enhanced' bank rates for our own midwifery staff to cover any shortfall within the off-duty	Enhanced bank rates introduced			
8	Monitor, record and investigate any 'red flags' events in accordance with NICE guidance (2015)	Midwifery red flags investigated and reported via the Midwifery Professional Leads Meeting			
9	Agreed recruitment into long term sickness and maternity leave within budget in progress	Agreement from ET to recruit into felt vacancies as long as we remain within budget		November 2019	
10	To stop out of area birth centre births referrals temporarily	Out of area referrals stopped. KGH women are referred at 36 weeks			

Action Plan (Midwifery Staffing)

	Recommendation	Services Assurance / Current Practice	Gaps / Required Actions	Due Date	RAG
11	Recruitment campaign for midwives and midwifery support workers (MSW) supported by HR Recruitment Manager	Recruitment event held in March 2019. Successful in recruiting MSWs but not for Midwives. Recruitment of 21wte Band 5 midwives – due to start October 2019.	Rolling advert for midwives	December 2019	
12	Consideration reduction in outside of area activity		Closely monitor projected deliveries – consider capping deliveries if activity/capacity concerns	March 2020	
13	Gap analysis of Maternity services against 'Safe, sustainable and productive staffing' NQB (2018)	Benchmarking in progress		August 2019	
14	Labour Ward Co-ordinator must be supernumery and have no caseload of their own during that shift.	Operational Manager rota Monday – Friday during the day to ensure LW co-ordinator supernumery. Report submitted to ET to request clinical backfill to extend Operational Manager role to 24/7	Agreed by ET – recruitment underway	October 2019	

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Trust Board**
Date of Meeting	**26h July 2019**

Title of the Report	Financial Position - Month 3 (FY2019-20)
Agenda item	12
Sponsoring Director	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the month ended June 2019.

Executive summary

This report sets out the Trust's financial position for the month ended 30 June 2019 and shows a pre-PSF & FRF deficit of £7,617k compared to plan deficit of £6,390k, resulting in an adverse variance to plan of £1,227k.

As the Trust's financial plan has not been achieved, we have not accrued for the finance-related PSF and FRF of £2,532k therefore the overall variance to plan is £3,759k. We can however recover the missed PSF/FRF later in the year when we hit plan.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY19-20 signals another challenging financial year and the requirement to maintain the financial discipline required to deliver the agreed control total.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board

The Board is asked to note the financial position for the month ended June 2019 and to review the performance against plan.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Financial Position

Month 3 (June 2019)
FY 2019/20

Report to:

Trust Board

July 2019

Content

1. Director of Finance Message

The Trust's financial position in month 3 improved with a reduction in the YTD deficit variance from £1,278k to £1,227k worse than plan, mainly due to Pay overspends.

No accrual is included for PSF and FRF funding as these are related to meeting the financial plan, therefore resulting in an overall adverse variance to plan of £3,759k.

This report sets out the Trust's financial position for the month ended 30 June 2019 and shows a pre-PSF & FRF deficit of £7,617k compared to plan deficit of £6,390k, resulting in an adverse variance to plan of £1,227k.

As the Trust's financial plan has not been achieved, we have not accrued for the finance-related PSF and FRF of £2,532k therefore the overall variance to plan is £3,759k. We can however recover the missed PSF/FRF later in the year when we hit plan.

Income is £529k above plan and has shown good improvement in month 3 as a result of increase in non-elective activity across the Trust. Elective and Outpatient activity continue to be below plan as the planned RTT backlog is yet to be met.

Operational pressures continue with the escalation wards still being open and funded from limited winter reserves. To date, £660k has been spent on winter and escalation ward, leaving only £565k for the rest of the financial year. This will likely create a cost pressure later in the year.

Pay is the key underlying reason for the adverse financial position and is £2,786k overspent at the end of month 3 due to a number of reasons including continued use of temporary medical and nursing staff to meet additional staff requirements as a result of operational pressures as well as vacancy and sickness cover. The Divisions are working on Financial Recovery Plans that include recruitment plans to bring down the level of temporary staff spend. Agency spend was £1,284k in the month, against a target of £934k.

CIP delivery is £3,197k in month 3 which is £632k better than plan although over 60% of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Capital spend is £659k at month 3 which is below plan of £725k. There has been a national requirement from NHSI for Trusts to reduce their capital plans across each STP. Following discussions with other Northamptonshire STP partners, as well as internal discussions at Capital Committee, it has been agreed a pragmatic approach would be to split the requirement in equal thirds between the two Providers and Community Trust. NGH's share is a reduction of £416k on the capital plan.

Cash continues to be a challenge but continues to be managed in a way that prioritises staff salaries. The Trust received an allocation of £421k additional PSF funding in relation to 2018/19, which will only have a cash impact in the current financial year.

Table 1: Income and Expenditure Summary

I&E Summary	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
		Plan	Actual	Variance	Plan	Actual	Variance	May-19	Apr-19
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	301,676	24,349	25,360	1,010	73,870	74,825	955	25,688	23,777
Other Clinical Income	24,986	1,520	1,058	(462)	4,559	2,402	(2,157)	685	659
Other Income	22,060	1,837	2,047	210	5,533	6,135	602	2,130	1,959
Total Income	348,722	27,707	28,465	758	83,962	83,362	(600)	28,503	26,394
Pay Costs	(236,740)	(19,391)	(20,199)	(808)	(58,029)	(60,815)	(2,786)	(20,319)	(20,298)
Non-Pay Costs	(103,262)	(8,547)	(8,954)	(407)	(26,155)	(26,088)	67	(8,772)	(8,362)
Unallocated CIPs	6,989	(309)		309	(411)		411		
Reserves / Non-Rec	(1,075)	188		(188)	372		(372)		
Total Costs	(334,087)	(28,059)	(29,153)	(1,094)	(84,223)	(86,903)	(2,680)	(29,091)	(28,659)
EBITDA	14,635	(352)	(688)	(336)	(261)	(3,541)	(3,280)	(588)	(2,265)
Depreciation	(12,355)	(1,015)	(1,015)	(0)	(3,045)	(3,045)	(0)	(1,015)	(1,015)
Amortisation	(7)	(1)	(1)	0	(2)	(2)	0	(1)	(1)
Impairments									
Net Interest	(1,356)	(107)	(108)	(1)	(316)	(322)	(6)	(110)	(104)
Dividend	(1,174)	(98)	(133)	(35)	(293)	(329)	(35)	(98)	(98)
Surplus / (Deficit)	(257)	(1,572)	(1,945)	(373)	(3,917)	(7,238)	(3,321)	(1,811)	(3,482)
NHS Breakeven duty adjs: Donated Assets NCA Impairments	257	30	(406)	(436)	59	(379)	(438)	15	27
Surplus / (Deficit) - Normalised	0	(1,542)	(2,351)	(809)	(3,858)	(7,617)	(3,759)	(1,796)	(3,455)

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

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF, FRF, MRET	(22,799)	(7,869)	(9,096)	(1,227)
PSF + FRF: Finance	16,881	2,532		(2,532)
MRET	5,918	1,479	1,479	
Post PSF + FRF	0	(3,858)	(7,617)	(3,759)

Table 3: Pre-PSF I&E Performance

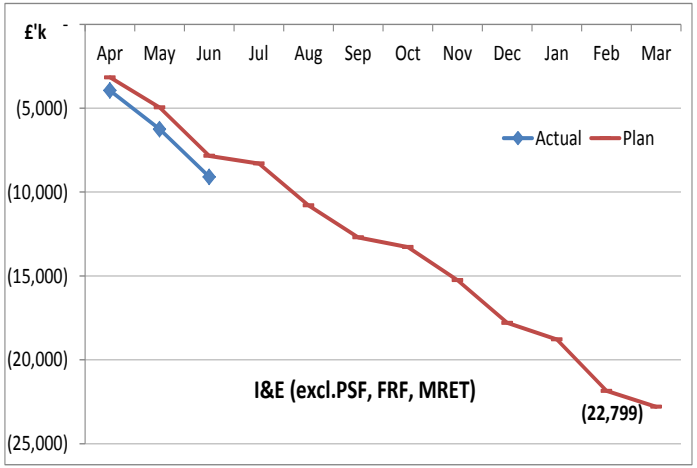
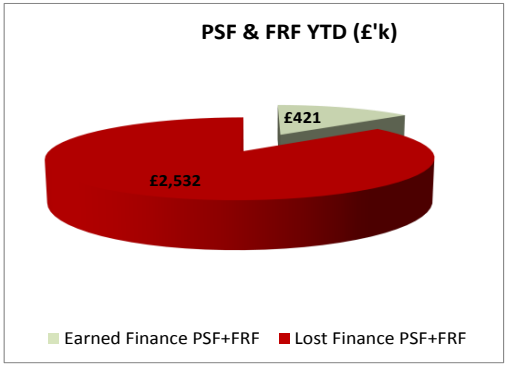


Table 4: PSF YTD Performance

£421k earned PSF relates to 2018/19 bonus PSF allocated to the Trust in current year.



2. Clinical Income By Commissioner (YTD)

Nene Contract - £924k under performance

The Month 3 position on the Nene contract is £924k over plan. The vast majority of this over-performance is NEL activity (£939k). Planned activity is also over (+£152k) but offset by Critical Care which is £356k under contract.

Key impacts In the underlying activity include:

- Planned activity (DC and EL) for Nene, is £152k over plan. This is all within Urology (£12k) and T&O (£189k), offset by Breast Surgery (-£67k). General Medicine activity is also £126k under plan which has been specifically affected in earlier months by problems with the Endoscopy washers leading to cancelled lists.
- Non-elective activity was above plan by £498k in June, £939k YTD. Over-performing YTD plan significantly in General Medicine (+£247k), and Cardiology (£178k), but generally across the Medicine Division.
- Outpatient activity has improved it's YTD position to £199k over plan. Late activity entered improved prior month income, with Respiratory below plan (-£52k) offset by Nephrology (+£35k) and Dermatology (£89k). There is an element of Coding & Counting challenges relating to newly coded OPROCs, but this is accounted for within the contract position.

Specialised Commissioning - £140k under performance

Excluded medicines are £161k over plan at the end of Month 3. This is offset by under-performance in Radiotherapy (-£193k) which should reduce when licence issues are resolved. Critical Care relating to Specialised patients was also £84k below plan.

Other - £194k over performance

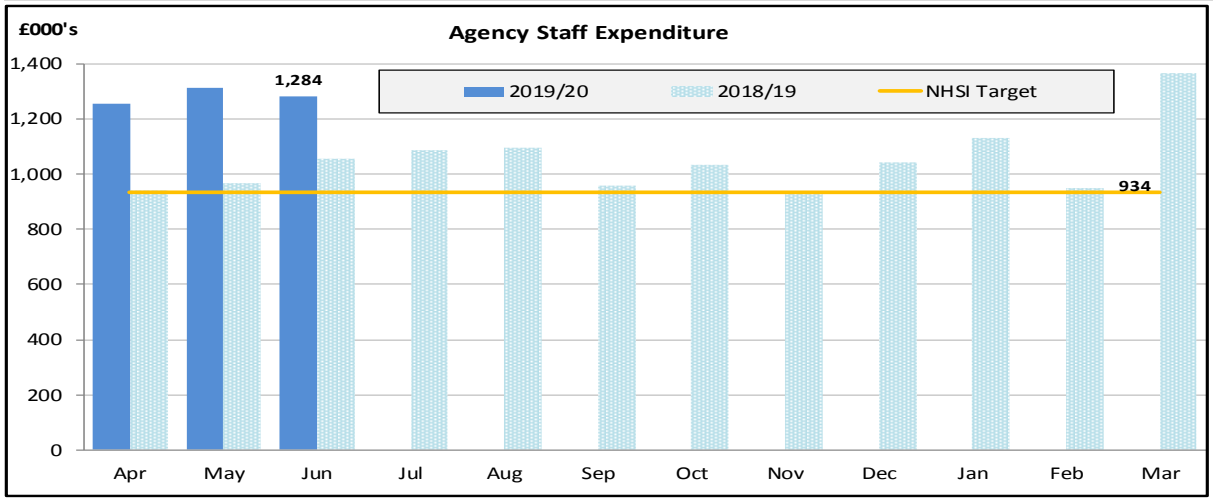
This is due to over performance on excluded medicines (CDF and Hep C).

Table 5: SLA Clinical Income by Commissioner

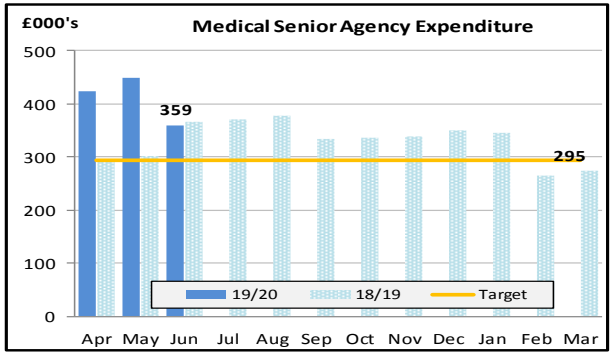
	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	58,828	59,752	924
Corby CCG	821	760	(61)
Bedfordshire CCG	229	183	(46)
East Leicestershire & Rutland CCG	197	249	52
Leicester City CCG	35	22	(13)
West Leicestershire CCG	20	18	(3)
Milton Keynes CCG	620	660	40
Specialised Commissioning	9,080	8,940	(140)
Secondary Dental	1,769	1,776	7
NCA / Central / Other	2,271	2,465	194
Total SLA Income	**73,870**	**74,825**	**955**

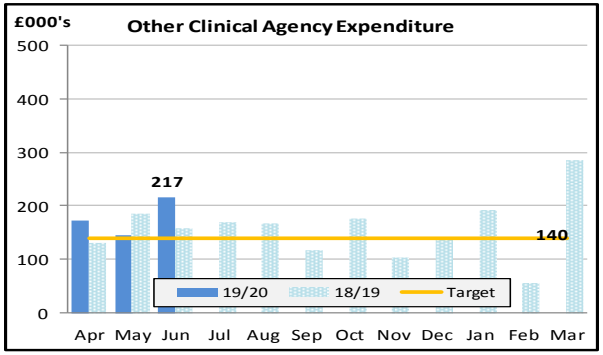
3. Pay

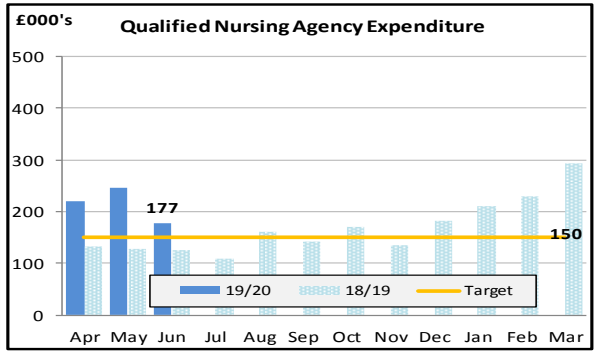
Table 6: Agency Spend

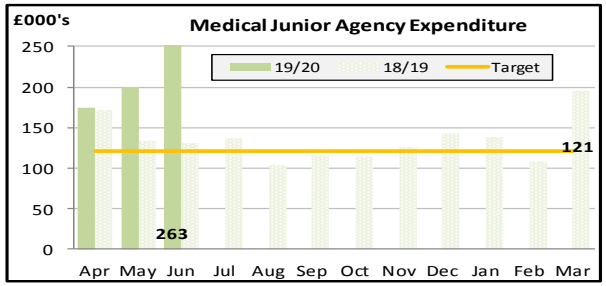


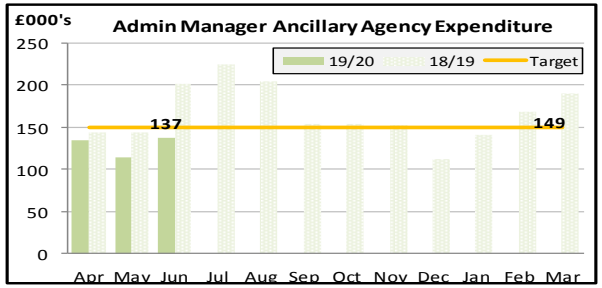
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2019/20.
- This £934k per month target is equivalent to an 10.6% improvement upon the 18/19 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Nursing agency expenditure reduced to the lowest monthly value since Dec-18.
- Junior Medical locums increased from 20wte to 25wte in June (to help manage the non-elective growth) driving the monthly spend to highest level seen.
- Other Clinical includes increased expenditure in Therapist and Theatre ODP cover due to vacancies.

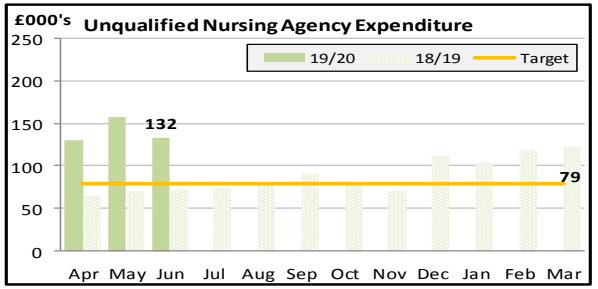












4. Non-Pay

Non Pay expenditure for month 3 is £0.4m adverse in month, but £0.1m favourable year to date.

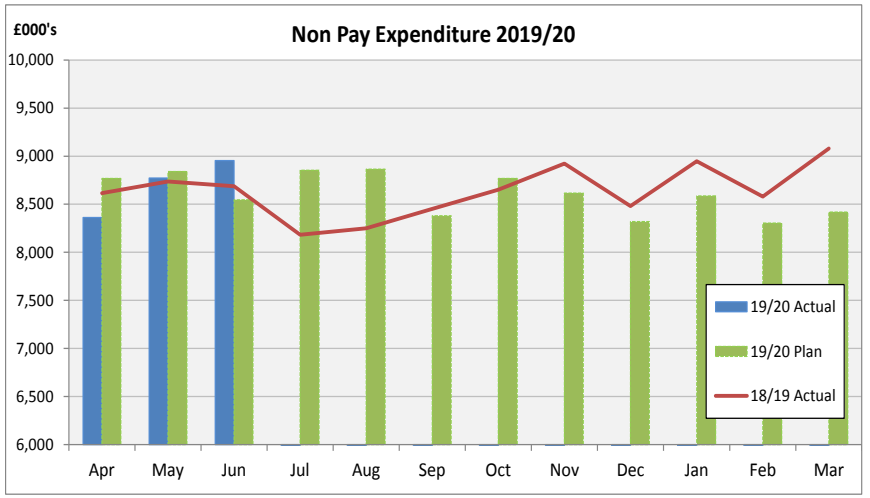
Excluding pass-through drugs and devices costs, the in month non-pay variance is £149k adverse to plan with key variances including:

- £289k Building, includes £395k of budget removed (for M1-M3) as a CIP achieved against the Angela Grace budget, and evens out in the YTD position.
- £149k Medical items is due to transferring £285k Non Pay inflationary reserve from this code to Other Fees to match corporate transformation expenditure in Q1.
- £104k Computer Equipment, includes £109k VAT due following a review of purchases in 18/19. Analysis to allocate specific expenditure is to be concluded in July, but early indicators are that this is mainly recent changes to IT expenditure rules.
- £56k Training, includes £33k of training costs which is offset by a favourable variance within Other income (Charitable Funding).

Favourable variances offsetting above adverse variances in month include:

- £258k Other Fees; includes £237k of budget set aside to match the RTT backlog in the income plan.
- £248k Medicines, is due in part to re-allocating a rebate earlier in the year from Other Income to Medicines expenditure category, to display net.

Table 7: Non-Pay Trend

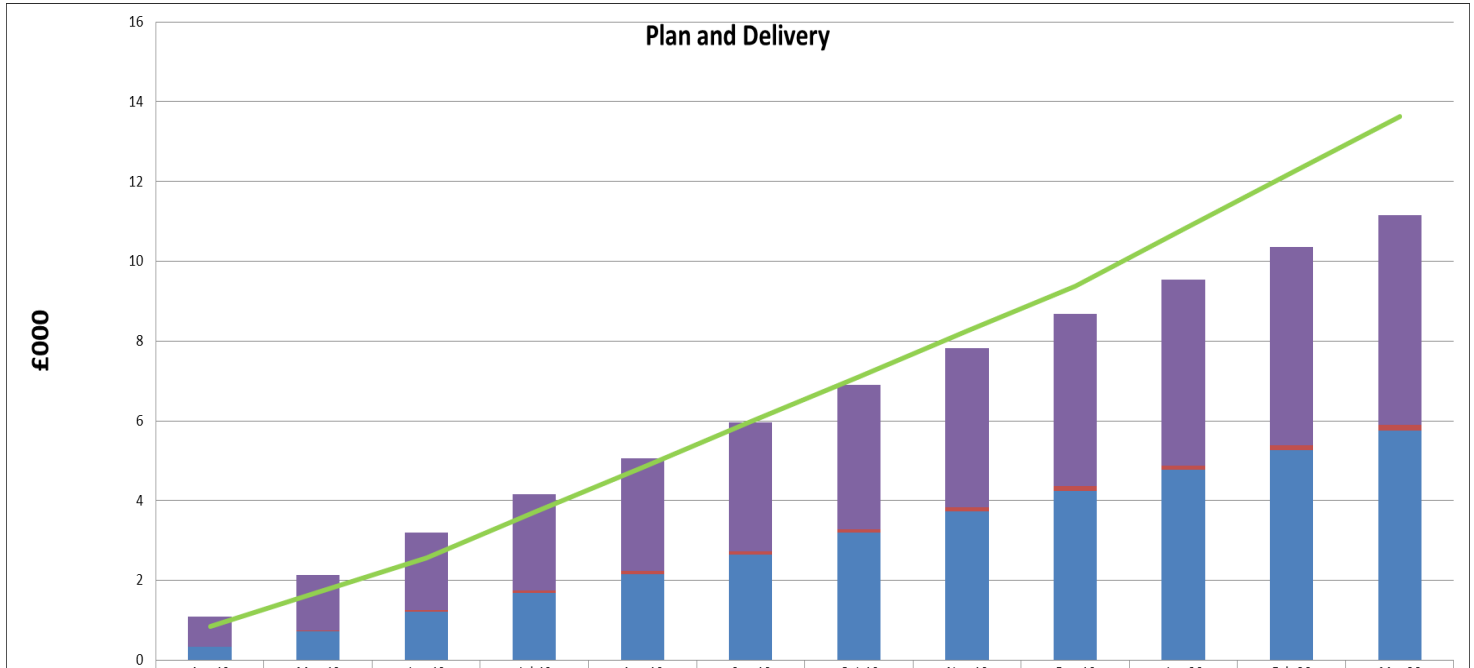


5. CIPs

Table 8: CIPs

YTD Delivery £000's						
Division	Plan	Rec	N/R	Pay Under	Actual Total	Variance vs plan
SURGICAL DIVISION	688	163	0	355	518	-170
MEDICAL DIVISION	698	688	17	348	1,052	354
WCOH DIVISION	428	32	12	277	321	-107
CSS DIVISION	397	111	6	548	665	268
HOSPITAL SUPPORT	200	90	7	349	447	246
FACILITIES	154	140	1	53	194	40
CENTRAL	0	0	0	0	0	0
Trust Total	**2,565**	**1,223**	**43**	**1,931**	**3,197**	**632**

Delivery £000's							
Division	Plan	Rec	N/R	Pay Under	Total	Risk Adj LTF	Variance
SURGICAL DIVISION	3,656	1,090	0	1,007	2,098	1,737	-1,919
MEDICAL DIVISION	3,711	2,687	66	1,106	3,860	3,827	116
WCOH DIVISION	2,275	516	12	995	1,522	1,313	-962
CSS DIVISION	2,108	507	25	1,563	2,095	1,990	-118
HOSPITAL SUPPORT	1,064	397	28	548	973	954	-110
FACILITIES	818	558	5	53	616	616	-201
CENTRAL	0	0	0	0	0	0	0
Trust Total	**13,632**	**5,756**	**135**	**5,272**	**11,163**	**10,438**	**-3,194**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Non-Rec Pay	758	1,389	1,931	2,406	2,839	3,242	3,618	3,986	4,326	4,653	4,968	5,272
Non-Rec Other	4	22	43	53	63	74	84	94	105	115	125	135
Recurrent	339	725	1,223	1,691	2,164	2,653	3,193	3,735	4,251	4,766	5,266	5,756
Target 2019/20	855	1,710	2,565	3,701	4,837	5,973	7,109	8,245	9,381	10,798	12,215	13,632

The month 3 2019/20 risk adjusted LTF is currently £10.438m against a target of £13.632m. This represents a negative variance of £3.194m.

Of the £11.163m forecast delivery £5.407m (48%) of schemes are non-recurrent. This is predominantly £5.272m vacancies and pay underspend. If this can become recurrent it will mitigate I&E risks otherwise it poses a risk to the 2020/21 financial position.

Cumulative delivery at month 3 totalled £3.197m against a year to date plan of £2.565m. This represents a favourable variance to plan of £632k, which is mainly due to £1.931m Non-Recurrent pay general underspend across all divisions.

All divisions meet on a regular basis to identify schemes.

Financial Escalation meetings are being held every fortnight to recover the financial position and to develop the Cost Improvement Programme.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M3 movements include the capital additions of £304k which includes £92k of PC's & Laptops.
- Depreciation charge is as planned £1,015k.

Current assets

- Inventories - £162k. Increases in Pathology (£87k), Heart Centre (£80k) & Pharmacy (£10k) stockholdings, are offset by £15k decrease in other areas.
- Trade & Other Receivables – £448k made up of : Increases in Income accruals (£851k), Trade Receivables (£115k), Other receivables (£10k) & Salary Overpayments (£41k) . Decreases in NHS Receivables (£172k), VAT reclaim (£49k), Salary Sacrifice (£53k), Compensation Recovery (RTC & PI Claims) (£10k) & Prepayments (£286k).
- Cash – Increase of £27k.

Current Liabilities

- Trade & Other Payables - £621k made up of: Decreases in NHS Payables (£196k), Trade Payables (£117k), Accruals (£274k) & Receipts in Advance (£543k). Increases in PDC Dividend (£133k). Capital Payables (£31k), Other Payables, which includes week 13 June salaries paid in July (£335k) Tax, NI & Pension Creditor (£11k) .
- Short Term Loans - £68k. Increases in Revenue Loan interest payable (£54k) & Capital Loan interest payables (£13k).

Non Current Liabilities

- Finance Lease Payable - £93k. Nye Bevan £82k, Car Park £11k.
- Loans over 1 year - £2512k. Drawdown of Revenue Loan £2,488k. Salix Loan received £25k.

Financed By

- I & E Account - £1,944k deficit in month.

Table 9: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 3 2019/20	Balance at 31-Mar-19 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	162,168	162,168	162,168	0	162,168	0
IN YEAR REVALUATIONS	0	465	465	0	553	553
IN YEAR MOVEMENTS	0	372	676	304	9,378	9,378
LESS DEPRECIATION	0	(2,030)	(3,045)	(1,015)	(12,355)	(12,355)
NET BOOK VALUE	162,168	160,975	160,264	(711)	159,744	(2,424)
CURRENT ASSETS						
INVENTORIES	5,338	5,100	5,262	162	5,238	(100)
TRADE & OTHER RECEIVABLES	23,892	24,858	25,306	448	27,319	3,427
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,553	1,414	1,441	27	1,500	(53)
TOTAL CURRENT ASSETS	30,783	31,372	32,009	637	34,057	3,274
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	23,806	27,559	26,938	(621)	21,055	(2,751)
FINANCE LEASE PAYABLE under 1 year	1,109	1,117	1,121	4	1,157	48
SHORT TERM LOANS	41,016	41,143	41,211	68	61,240	20,224
STAFF BENEFITS ACCRUAL	723	723	723	0	650	(73)
PROVISIONS under 1 year	731	681	681	0	350	(381)
TOTAL CURRENT LIABILITIES	67,385	71,223	70,674	(549)	84,452	17,067
NET CURRENT ASSETS / (LIABILITIES)	(36,602)	(39,851)	(38,665)	1,186	(50,395)	(13,793)
TOTAL ASSETS LESS CURRENT LIABILITIES	125,566	121,124	121,599	475	109,349	(16,217)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	10,686	10,493	10,400	(93)	9,529	(1,157)
LOANS over 1 year	53,693	54,273	56,785	2,512	38,124	(15,569)
PROVISIONS over 1 year	189	189	189	0	150	(39)
NON CURRENT LIABILITIES	64,568	64,955	67,374	2,419	47,803	(16,765)
TOTAL ASSETS EMPLOYED	60,998	56,169	54,225	(1,944)	61,546	548
FINANCED BY						
PDC CAPITAL	120,538	120,538	120,538	0	120,538	0
REVALUATION RESERVE	31,277	31,742	31,742	0	31,661	384
I & E ACCOUNT	(90,817)	(96,111)	(98,055)	(1,944)	(90,653)	164
FINANCING TOTAL	60,998	56,169	54,225	(1,944)	61,546	548

Table 10: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2019/20 £000s	ACTUAL 19/20 APR £000s	MAY £000s	JUN £000s	FORECAST 19/20 JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	292,993	24,288	23,924	24,994	24,724	24,383	24,383	24,383	24,383	24,383	24,383	24,383	24,383
Provider Sustainability Funding (PSF & FRF)	11,855	0	0	0	8,480	0	0	0	0	3,375	0	0	0
Marginal Rate Emergency Tariff (MRET)	5,918	1,480	0	0	1,480	0	0	1,480	0	0	1,478	0	0
SLA Performance (relating to 17/18 activity)	71	0	0	71	0	0	0	0	0	0	0	0	0
SLA Performance (relating to 18/19 activity)	-1,439	0	0	-1,439	0	0	0	0	0	0	0	0	0
Health Education Payments	8,931	775	775	767	737	655	655	683	777	777	777	777	777
Other NHS Income	12,526	1,025	790	1,711	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
PP / Other (Specific > £250k)	4,816	1,261	423	291	241	325	325	325	325	325	325	325	325
PP / Other	11,954	1,113	986	855	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Salix Capital Loan	25	0	0	25	0	0	0	0	0	0	0	0	0
PDC - Capital	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding 18/19 *	1,644	0	0	1,644	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding 19/20	4,800	1,695	0	0	976	0	1,164	0	0	360	0	605	0
Uncommitted Revenue Loan - PSF/FRF funding	14,455	844	0	844	1,125	0	1,125	1,688	1,688	0	3,657	1,969	1,515
Interest Receivable	90	10	8	8	7	7	7	7	7	7	7	7	7
TOTAL RECEIPTS	**368,638**	**32,491**	**26,907**	**29,770**	**39,770**	**27,370**	**29,659**	**30,565**	**29,180**	**31,227**	**32,627**	**30,066**	**29,007**
PAYMENTS													
Salaries and wages	225,558	18,633	18,786	18,820	18,705	19,030	18,705	19,030	18,705	18,705	19,030	18,705	18,705
Trade Creditors	92,455	6,068	8,154	8,764	9,384	9,390	9,024	4,975	6,598	9,279	6,484	8,095	6,240
NHS Creditors	22,349	2,160	2,105	1,767	2,102	2,102	2,102	2,102	2,102	2,102	2,102	800	800
Capital Expenditure	10,736	1,250	325	329	593	454	791	1,035	1,511	1,082	1,111	1,671	584
PDC Dividend	1,252	0	0	0	0	0	595	0	0	0	0	0	657
Repayment of Revenue Loan - Deficit funding	4,800	0	0	0	0	0	0	1,602	210	0	1,473	0	1,515
Repayment of Revenue Loan - PSF/FRF funding	8,120	1,930	0	0	0	2,252	0	1,688	0	0	2,250	0	0
Repayment of Loans (Principal & Interest)	3,273	58	47	49	171	796	502	64	53	56	176	795	505
Repayment of Salix loan	101	29	0	0	0	0	0	69	0	2	0	0	0
TOTAL PAYMENTS	**368,643**	**30,128**	**29,416**	**29,729**	**30,956**	**34,024**	**31,720**	**30,566**	**29,180**	**31,227**	**32,626**	**30,066**	**29,006**
Actual month balance	-5	2,363	-2,510	41	8,815	-6,654	-2,061	0	0	0	0	0	0
Cash in transit & Cash in hand adjustment	-48	29	-23	-13	-40	0	0	0	0	0	0	0	0
Balance brought forward	1,553	1,553	3,946	1,413	1,441	10,215	3,561	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**3,946**	**1,413**	**1,441**	**10,215**	**3,561**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

* NHSI identified that the Trust had some capacity to draw additional deficit support in respect of its reported 18/19 outturn position. £1,644k unfunded 18/19 deficit was drawn down. This is treated differently to the 19/20 deficit funding, which can only be drawn down up to the cumulative value of the Year to Date planned deficit.

- Closing cash balance at the end of June was £1,441k. This was slightly below the £1,500k expected minimum balance in order to facilitate payment of as many lower value creditors as possible.
- All June SLA base payments were invoiced at the 19/20 agreed contract values & paid on time.
- All previously issued over/under performance invoices & credit notes were settled in June. It is anticipated that invoices/credit notes relating to 18/19 performance will be issued late July/early August.
- Salix Loan was received in June. This is non-interest bearing & will be repaid in 10 instalments over 5 years.
- NHSI have advised that the Qtr 4 PSF & 18/19 Incentive Funding , which includes a further £421k, resulting from NHSI's Post Accounts Reallocation, will be paid in July. Upon receipt, the Revenue Loan PSF funding drawn down relating to Qtr 4 18/19, £2,252k , becomes repayable. This will be repaid to the DHSC in August. The repayment will be allocated to previous loan(s) drawn down & an updated repayment schedule issued.
- We expect to repay the loaned £1,688 relating to PSF/FRF funding for Q1 in October.
- The Trust can only drawdown deficit funding to the cumulative value of the deficit included in the NHSI plan. £1,602k of deficit funding is therefore forecast to be repaid in October as the Year to Date funding would otherwise exceed the plan.
- £2,488k Uncommitted Revenue Loan was drawn down in June and £2,101k has been approved for drawdown in July.
- We only recently received confirmation that the 2018/19 PSF funding will be paid later in July, hence the large forecast closing cash balance. Therefore there will be no need to drawdown any loan in August.

Table 11: Cash forecast

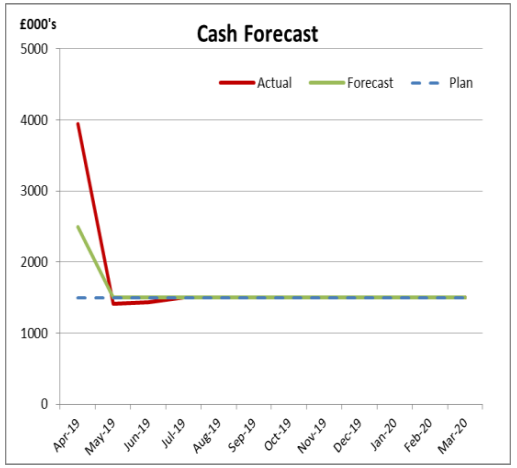


Table 12: Capital

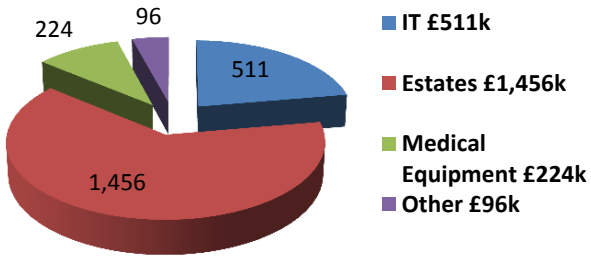
Capital Scheme	Plan 2019/20 £000's	M3 Plan £000's	Cum M3 Spend £000's	Under (-) / Over £000's	Plan Achieved %	M3 Commit + Spend £000's	Plan Achieved %
Medical Equipment - MESC Block	673	170	162	(8)	24%	209	31%
Medical Equipment - Charitable Funds	100	15	15	0	15%	15	15%
IT - iLab	1,000	0	3	3	0%	3	0%
Information Technology	2,150	287	218	(69)	10%	504	23%
Estates - Backlog	2,295	141	165	24	7%	861	38%
Estates - Statutory	167	40	(1)	(41)	(1%)	354	212%
Estates - Non Maintenance	817	20	33	13	4%	119	15%
Estates - Ward Refurbishment	1,750	0	5	5	0%	103	6%
Estates - Charitable Funds, Talbot Butler	0	0	3	3	0%	3	0%
Endoscopy Washers	61	47	71	24	117%	73	119%
Other - inc. Gamma Camera 2 & Breast Screening Mobile + Static	340	20	4	(16)	1%	24	7%
SALIX	25	0	0	0	0%	16	66%
Total - Capital Plan	**9,378**	**740**	**677**	**(63)**	**7%**	**2,283**	**24%**
Less Charitable Fund Donations	(100)	(15)	(18)	(3)	18%	(18)	18%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**9,278**	**725**	**659**	**(66)**	**7%**	**2,266**	**24%**

Funding Resources	
Internally Generated Depreciation	12,355
Salix	25
Capital Loan - Repayment	(1,835)
Capital Element - Finance Lease (Assessment Unit)	(978)
Capital Element of Finance Lease (Car Park)	(139)
Other Loans - Repayment (SALIX)	(150)
Total - Available CRL Resource	**9,278**
Uncommitted Plan	**0**

Key Points

- At M3 the initial CRL Limit has been confirmed by NHSI to be £9,278k. Salix Funding of £25k has been received for a 2018/19 theatre lighting scheme.
- The above figures are reported as at 30 June 2019. Since then, there has been a national directive from NHSI for STPs to reduce their capital plans by 20%. Fortunately for Northamptonshire STP, the requirement is only £1,249k (3.7%). Following discussions with other STP partners, as well as internal discussions at Capital Committee, it has been agreed a pragmatic approach would be to split the requirement in equal thirds between the two Providers and Community Trust. NGH's share is therefore a reduction of £416k on the capital plan, which the Capital Committee felt should be absorbable within the ward refurbishment programme, given the current delays being experienced with the project.

M3 Capital spend & commitments 2019/20



Receivables and Payables

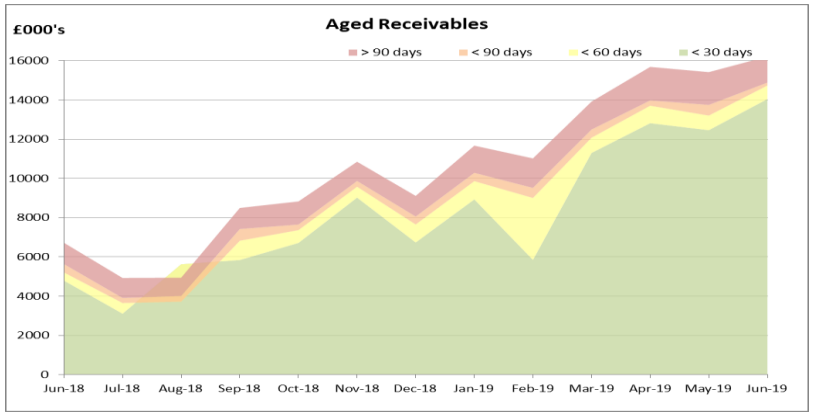
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. It includes £8,480k relating to PSF funding (Finance element only) for Qtr 4, 2018/19 Incentive Funding as well as the £421k PSF Post Accounts Reallocation.
- NHS over 90 day debt include s University Hospitals of Leicester NHS Trust £83k, NHS Property Services £81k, Central Midlands Region £51k and £172k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £571k, of which £175k are paying in instalments & a further £418k have been referred to debt collection & private patients accounts of £60k. Salary overpayments invoiced over 90 days are £191k.
- Contract Underperformance with Commissioners is included within the 0 to 30 Days Payables NHS balance.

Table 13: Receivables and Payables

Narrative	Total at Jun-19 £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	1,682	541	214	55	872
Receivables NHS	14,530	13,507	475	96	451
Total Receivables	**16,211**	**14,048**	**690**	**151**	**1,323**
Payables Non NHS	(4,735)	(4,733)	(2)	0	0
Payables NHS	(2,387)	(2,387)	0	0	0
Total Payables	**(7,123)**	**(7,120)**	**(2)**	**0**	**0**

Narrative	Total at May-19 £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	1,567	433	85	166	882
Receivables NHS	13,851	12,025	662	377	787
Total Receivables	**15,417**	**12,458**	**747**	**543**	**1,670**
Payables Non NHS	(4,822)	(4,580)	(241)	0	0
Payables NHS	(2,583)	(2,575)	(8)	0	0
Total Payables	**(7,404)**	**(7,156)**	**(249)**	**0**	**0**

Table 14: Aged Receivables



Better Payment Practice Code

- The BPPC target was missed in month 3 due to a number of reasons; including the late payment of NHS England SLA as reported in month 2, high pay cost in the preceding months and the consequence on limited cash, as well as a higher than forecast creditor balance due for payment.

Table 15: BPPC

Better Payment Compliance Code - 2019/20				
Narrative	**April 2019**	**May 2019**	**June 2019**	**Cumulative 2019/20**
NHS Creditors				
No.of Bills Paid Within Target	175	165	145	485
No.of Bills Paid Within Period	183	165	150	498
Percentage Paid Within Target	**95.63%**	**100.00%**	**96.67%**	**97.39%**
Value of Bills Paid Within Target (£000's)	1,919	2,082	1,643	5,644
Value of Bills Paid Within Period (£000's)	1,927	2,082	1,756	5,765
Percentage Paid Within Target	**99.58%**	**100.00%**	**93.57%**	**97.90%**
Non NHS Creditors				
No.of Bills Paid Within Target	5,046	7,430	6,513	18,989
No.of Bills Paid Within Period	5,065	7,475	6,642	19,182
Percentage Paid Within Target	**99.62%**	**99.40%**	**98.06%**	**98.99%**
Value of Bills Paid Within Target (£000's)	7,484	8,330	7,019	22,833
Value of Bills Paid Within Period (£000's)	7,490	8,430	9,006	24,926
Percentage Paid Within Target	**99.92%**	**98.82%**	**77.93%**	**91.60%**
Total				
No.of Bills Paid Within Target	5,221	7,595	6,658	19,474
No.of Bills Paid Within Period	5,248	7,640	6,792	19,680
Percentage Paid Within Target	**99.49%**	**99.41%**	**98.03%**	**98.95%**
Value of Bills Paid Within Target (£000's)	9,403	10,413	8,662	28,477
Value of Bills Paid Within Period (£000's)	9,417	10,512	10,762	30,691
Percentage Paid Within Target	**99.85%**	**99.05%**	**80.49%**	**92.79%**

7. Single Oversight Framework (SOF)

The Single oversight framework includes scoring for "finance and use of resources". The Trust score has deteriorated due to the performance in month 1 but can be recovered if the financial position improves.

Table 16: SOF

Criteria	Score	Weight	Weighted Score
Capital Service capacity (times)	4	20.00%	0.80
Liquidity (days)	4	20.00%	0.80
I&E Margin	4	20.00%	0.80
Distance From Plan	4	20.00%	0.80
Agency spend (distance from cap)	3	20.00%	0.60
Overall Score			3.8

Finance and use of resources metrics

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

Note: brackets indicate negative numbers

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

8. Risks

Table 17

Title		Risk	Risk score	Existing Controls	Mitigated Impact (£'m)	Exec Lead
I&E Risks						
Income	Income Mitigations	Nene CCG are proposing additional mitigations which would pose a risk to the Trust's financial position. In addition the new national requirement for certain procedures to have "Prior Approval" may impact on the Trust income	20	Continued discussions and negotiations with the STP partners; Improve processes to ensure approvals are maximised	0.4	DoS/DoF
	Unrealised Activity	Invest to save business cases may not deliver the full income assumptions	16	Continue to monitor via the Benefit Realisation report to FIPC and hold Divisional directors to account	0.6	Divisional Directors
	STP Partners	Cost pressures within the Northamptonshire STP may impact investments and result in operational pressure thereby impacting the ability to deliver planned activity. In addition closure of the Angela Grace / Avery beds may create further operational pressures	20	Working in close alignment with the STP partners Develop a robust operational plan for its implementation	1.1	DoS/DoF
Pay	Winter funding	Internal winter funded schemes may continue into Q1 2019/20 reducing the funds available for 2019/20 winter	16	COO & Deputy COO have oversight of the avaialble budget and approve spend	0.3	COO
	Cost Pressures	Unfunded existing cost pressures pose a risk to the financial position. For example, Nursing Bank premium, additional temporary medical staff used in the Medicine Division to cover A&E and Assessment wards	20	Monitoring through Perfromance meetings and FIPC Reporting	1.5	DoF/Execs
	Agency staffing	Risk of continued dependence on agency staffing due to workforce vacancies, sickness	16	Targeted recruitment drive and continued monitoring of usage via existing channels	0.8	DoHR
CIP	CIP Delivery	Trust's ability to deliver £13.6m CIP target recurrently	20	Should be achievable non-recurrently via Pay underspends, but would create a challenge for 2020-21; Monitoring via the PMO, Changing Care Steering Group and FIPC	4.0	DoF
Non-recurrent Funding	PSF,FRF funding	The Trust may not deliver the required conditions to access the financial PSF & FRF funding.	20	Management of operational and financial targets; Realistic plans set for Divisions.	16.9	DoF
Non-I&E Risks						
	Capital	The availability of funding to meet the Trust's capital requirements as well as the Trust's ability to fully maximise spend against the capital plan.	15	A realistic capital plan was set for 2019-20; Use of lease financing where possible; Management of slippage; Maximization of external funding, Charitable funds and ad-hoc bid processes.	0.5	DoF
	Cashflow	Cashflow difficulties may mean that the Trust is not able to meet its debt obligations as and when due	15	Continue to utilise DH's cash funding structures including regular cashflow submissions; management of debtors and creditors; receipt of non-recurrent funding	2.0	DoF
Overarching Risk						
	Financial planning for a Sustainable Future	Trust is unable to return to financial balance in the medium term and may not be able to meet the required control total set by Regulators for FY19-20.	20	Board approved realistic plan for 2019-20; To be monitored via FIPC monthly; Monthly financial assurance meetings with NHSI		DoF/Execs

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**Operational Performance Report**
Agenda item	**13**
Presenter of Report	Ms L Taylor (Deputy COO)
Author(s) of Report	Mrs D Needham (COO & DCEO)
Purpose	For information / discussion / assurance

Executive summary

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

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

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

- Urgent care
  Remains below the national standard but improved from previous month
- RTT
  Remains below the national standard
  FU backlog reducing and being managed through the weekly performance meeting
- Cancer
  3 of the standards remain below the national average with performance continuing to increase

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance only
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1, 1.2, 3.1, 3.2, 3.3

Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – No

Actions required by the Trust Board

The committee is asked to:

1. Note the report
2. Discuss the areas outlined as exceptions within the report

Operational Performance Report – July 2019

1. Introduction

The operational performance report is presented to provide information to the board to aid a discussion relating to the national operational performance targets.

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

All exception reports are discussed at the subcommittees of the board, for operational performance this is finance, investment & performance committee.

The main areas of focus in this report relating to national performance include RTT, Cancer & the urgent care four hour standard.

2. Summary performance

The performance trajectories below were agreed as part of the operational plan for 2019/20 with NHSI.

Rolling Year												
Accident & Emergency - Performance % (95% Standard)	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Planned Performance	89.0%	90.1%	90.3%	90.3%	90.3%	90.3%	90.3%	90.3%	95.0%	83.6%	84.6%	88.4%
Actual Performance	92.3%	91.5%	88.9%	86.8%	85.9%	83.4%	78.6%	79.1%	80.3%	79.0%	83.9%	85.6%
Cancer Waiting Times - 62 Day GP Referral	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Planned Performance	85.8%	88.3%	89.1%	89.6%	85.8%	86.4%	87.1%	86.9%	88.5%	79.2%	79.0%	78.8%
Actual Performance	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	74.0%	70.7%	70.0%	69.8%	
RTT Incompletes - Performance % (92% Standard)	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Planned Performance	89.8%	90.0%	90.8%	91.5%	92.1%	92.2%	92.6%	93.1%	93.3%	84.0%	84.3%	85.0%
Actual Performance	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	80.8%	80.0%	79.1%	80.7%	
Please note:												
Validated data for Cancer is not yet available for the reporting period												
The final RTT position for June 2019 is expected to be available on 17/07/2019												

3. Key areas of performance

3a. Urgent care - A&E

Four hour A&E performance increased in June 2019 to 85.55%, this is a 1.65 % increase from May 2019 and better than the regional average.

The national and midlands benchmarking:
Midlands – 83.4%
National – 86.4%

During June the number of DTOC decreased and whilst the number of stranded patients at month end appears high, the numbers of superstranded patients has now started to decrease.

During July, performance against the 4hr standard has decreased (to 15th July) but currently remains above the national average.

Actions being taken:

The transformation work being led by the DoN, MD and COO continues with 4 work streams now in place, being supported by transformation nous.

The HEAT programme has very specific operational dimensions and initiatives. However as implementation unfolds it is clear that it is more mindset and behaviour intensive than an SOP programme

Northampton General Hospital NHS Trust

Cultural change:

Behaviours:
- Discharge planning should be seen as a clinical priority
- Key staff to provide positive signaling & engagement to colleagues on the ground
- Reduce variation in joint ways of working between teams

Mindsets:
- Convincing teams that change is possible
- Reducing friction between teams
- Providing senior support to wards & site meeting where needed

Revamping the board rounds by developing:
- Implementing action driven multi disciplinary board rounds
- Implementing processes e.g. criteria led discharge

Resolving problems with the discharge process
- Implementing action driven multi disciplinary board rounds
- Implementing processes e.g. criteria led discharge
- Discharge Suite and Transport improvements
- Timely EDNs & TTOs

Real time management of the emergency pathway
- Refining the process of medical & surgical bed management
- Providing patient level discharge information
- Allocating the right patient to transfer to the right bed

Optimising front end processes
- Completing conversion rate analysis from whole A&E down to individual clinician level
- Improving ways of working between ED and AMU

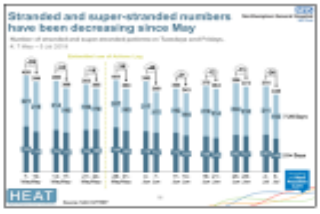
Supportive challenge to the nurses on the wards and at the bed meeting will drive the operational initiatives

The pace of change within each workstream is determined by how fast we can enact mindsets and behavioural change on the ground

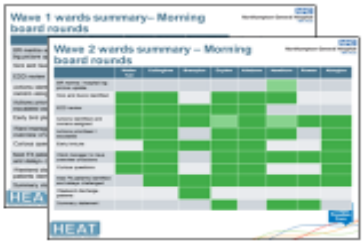
Providing the Best Possible Care

Initial positive impacts of the HEAT programme

Northampton General Hospital NHS Trust



Number of super stranded patients has reduced from ~200 on May 7th to <150 on June 5th



Wards in the first two focus waves have improved significantly against the framework of the board round SOP

HEAT

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Providing the Best Possible Care

Further expected impacts of the HEAT programme

Northampton General Hospital NHS Trust

Expected benefits over the next 12 weeks:

- 3-5% improvement in A&E
- Increase weekday discharges from ~82 to 90
- Fewer outliers across in-patient wards (currently record high of 38)
- Fewer DTAs at 0600, aim for <5 DTAs
- Reduced arrival to admission time in A&E. YTD prior to implementation phase = 6.67 hours
- Small reduction of 5-10% in patients staying over 7,14 & 21+ days ✓

Expected benefits of the cultural change within the organisation:

- Shift the narrative and prioritisation of the organisation and instil the belief that improvement in Emergency Care is possible
- Engage both clinical and operational leaders to change the hearts and minds of their colleagues across the entire hospital to achieve real change

HEAT

13

Risk

Reduced capacity for Complex discharge – resulting in longer lengths of stay, increased stranded & super stranded patients in acute beds. Potential for increased harm due to patients decompensating. At the time of writing the previously funded winter schemes have been funded although limited in some areas for ICT.

Internal actions as part of the TN support are taking longer than planned due to the culture change required rather than the process change. The cultural piece remains a significant concern across both nursing & consultants. Culture and change is being addressed through the urgent care transformation work.

3b. A&E attendance 2019 compared to 2018

Attendees during the first quarter of 2019 have increased above the same period last year, headlines are summarised as:

- Total attendances for the 3 month period (Apr – Jun) has increased by 4% when comparing 2018/19 vs 2019/20
- Attendances > 75 have seen the greatest % increase with the Age Band 86-90 yrs having an increase of 31% when comparing the data over the 3 month period (2018/19 vs 2019/20)
- NHS 111 Referrals has seen a 25% increase.
- Non Elective Admissions have increased by 3.2% but the conversion rate has remained consistent around the 19-20% mark for the same period when comparing the data
- No significant changes with attendances per GP Practice. However, the number of attendances from 'GP PRACTICE NOT KNOWN' did jump from 779 to 1223
- Arrivals by Ambulance also had significant increases for this year (Apr-Jun) – 13% Increase on last year

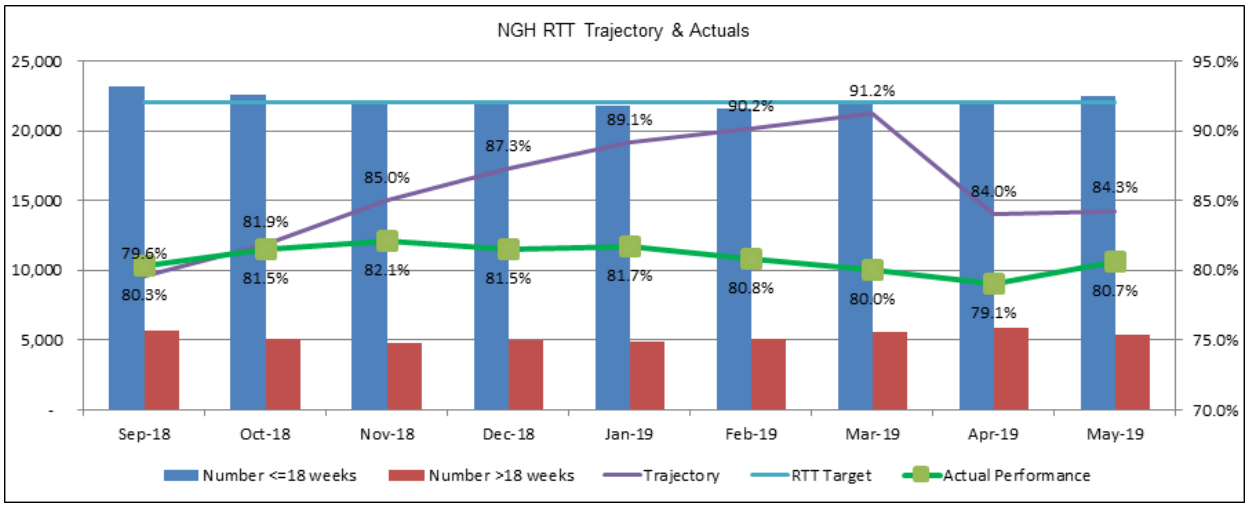
- For Referrals to Specialties – Urology saw the biggest increase over the 3 month period – 63 referrals for 2018/19 vs 314 for 2019/20. Also Cardiology saw an increase – 22% as did Medicine and Childrens.

Work is ongoing with partners to establish increased capacity in the community, reduce ALOS and increase throughput in the community hospitals and relaunch the IDTs.

The numbers of patients brought to A&E by the ambulance service continues to increase, engagament has been challenging and a need for improvement has been discussed with the services COO.

3c. RTT – 18 weeks

At the time of writing this report, the unvalidated RTT performance for June is currently 82.35% which is an improvement of 1.65% on Mays performance of 80.7% which was an increase from April 2019.



The national average for May 2019 increased to 86.9%, with performance in the midlands region of increasing slightly to 87.9%

Nationally there are 1,032 patients waiting over 52 weeks, with 25 of these being within the Midlands region.

There are no patients currently waiting over 52 weeks at NGH.

NHSI/E have asked that we join 12 other trusts in becoming a field test site for the new RTT reporting of average waits. We have attended 3 workshops on analysis & behaviour during July.

The target average wait (mean) is expected to be 8.5 weeks from referral. The current average at NGH is 11 weeks.

The field-testing of the Elective Care Clinical Review of Standards will begin on the 1st August 2019 and will run for an initial period of four months. During this time NGH will not be required to report compliance against the existing 18 Week RTT standard. In its place, field-test Trusts will report against an average wait standard. At the conclusion of the four-month field test period a decision will be required regarding the potential continuation of the field test throughout the winter.

3d. Unappointed follow up appointments

The number of outpatients waiting for a follow up appointment for greater than their planned date has started to decrease, specifically with H&N, cardiology & urology. Opthalmology remains a concern with the numbers increasing.

Each directorate has a recovery plan which is monitored at the weekly performance meeting.

Actions being taken:

- Action plans have been developed by specialties not achieving the RTT 92% standard, which includes additional clinics, Virtual clinics, weekend and evening activity, outsourcing and insourcing and the use of locums where possible
- Weekly performance meetings in place for all Directorates chaired by the Deputy COO where directorates will be held to account for their performance against trajectory.
- PTL meetings are in place in all Divisions weekly
- Harm reviews are in place

Risks:

The limiting factor for achievement is lack of capacity. Overtime is being offered and on occasion additional capacity in place. Virtual clinics are helping to reduce the backlog. The main risk being insufficient capacity to meet demand and staff burnout due to undertaking additional workload. Some consultant staff remain reluctant to undertake additional work at present due to the pension tax issues.

3e. Cancer

Cancer performance remains a challenge in May especially for 2ww Breast Symptoms, 2ww & 62 day pathway.

The main causes for the underperformance are:

- Patient initiated delays
- Late tertiary referrals
- No capacity at a tertiary provider mainly UHL for lung and urology
- Complex pathways
- Insufficient capacity within the first 2 weeks

There are currently 20 patients awaiting treatment from another provider who have all breached 62 days. 19 of which are with one specific tertiary provider.

May validated performance

	Total Treatments	Number of Patients Within Target	Number of Patients Over Target	Performance	Operating Standard
2ww Referral	**1159**	**1055**	**104**	**91.0%**	93%
2ww Breast Symptoms	**64**	**27**	**37**	**42.2%**	93%
31 Day First Treatment	**171**	**165**	**6**	**96.5%**	96%
62 Day combined with 31 Day Rare Treatments - Actual Total	**98**	**68.5**	**29.5**	**69.9%**	85%
Subsequent Surgery Treatments	**11**	**11**	**0**	**100.0%**	94%
Subsequent Drug Treatments	**106**	**105**	**1**	**99.1%**	98%
Subsequent Radiotherapy Treatments	**89**	**87**	**2**	**97.8%**	94%
62 Day Screening	**12**	**11.5**	**0.5**	**95.8%**	90%
62 Day Consultant Upgrade	**25.5**	**22.5**	**3**	**88.2%**	85%

May 2019 - National benchmarking

2ww – national 90.8%, Midlands – 88% (NGH – 91%)

2ww Breast – national 78.9%, Midlands 64% (NGH – 42.2%)

62 days – national 77.5%, Midlands – 74.3% (NGH – 69.9%)

All 3 areas of performance have improved again in June and July but still to be completed and validated.

Individual tumour site performance is shown below:

Cancer Site	Confirmed Total Treatments	Confirmed Total Breaches	Confirmed Performance
Breast	9.5	0	**100.0%**
Colorectal	9.5	3.5	**63.2%**
Gynaecology	9.5	3	**68.4%**
Haematology	10	5	**50.0%**
Head & Neck	5.5	2.5	**54.5%**
Lung	8.5	6	**29.4%**

Other	3.5	1	**71.4%**
Sarcoma	0.5	0	**100.0%**
Skin	18	2	**88.9%**
Upper GI	2	2	**0.0%**
Urology	21.5	4.5	**79.1%**
Total	**98**	**29.5**	**69.9%**

Patients waiting in excess of 62 days on their pathway as of the 09/07/19 is 43 showing a significant positive decrease on the previous month of 78 and has obviously accounted for the decrease in performance.

The daily PTL meetings chaired by the Chief Operating Officer continue and discuss all patients on a 62 day pathway including 2ww, screening and consultant upgrades from day 27 upwards on their pathway.

Tumour Site As at 05.06.2019	Without a Cancer Diagnosis	With a Cancer Diagnosis	Total number patients whose breach date has already passed	Tumour Site As at 09.07.2019	Without a Cancer Diagnosis	With a Cancer Diagnosis	Total number patients whose breach date has already passed
Brain	0	0	**0**	**Brain**	0	0	**0**
Breast	1	2	**3**	**Breast**	1	0	**1**
Colorectal	10	9	**19**	**Colorectal**	5	1	**6**
CUP	0	0	**0**	**CUP**	0	0	**0**
Gynaecology	3	1	**4**	**Gynaecology**	1	2	**3**
Haematology	5	1	**6**	**Haematology**	2	0	**2**
Head and Neck	0	4	**4**	**Head and Neck**	0	2	**2**
Lung	3	4	**7**	**Lung**	3	3	**6**
Other	0	0	**0**	**Other**	0	0	**0**
Paediatric	0	0	**0**	**Paediatric**	0	0	**0**
Sarcoma	1	0	**1**	**Sarcoma**	1	0	**1**
Skin	6	1	**7**	**Skin**	0	2	**2**
Upper GI	0	1	**1**	**Upper GI**	0	2	**2**
Urology	8	18	**26**	**Urology**	3	15	**18**
Grand Total	**37**	**41**	**78**	**Grand Total**	**16**	**27**	**43**

Actions being taken:

National Optimal Lung Cancer Pathway
The work towards implementing the NOLCP in June 2020 continues. Significant progress has been made when it comes to formalising the pathways, developing a straight to CT pathway, increasing EBUS capacity and the introduction of a pre-MDT each week.

Numerous challenges that need to be overcome in the next 12 months, from a respiratory service view the main limiting factor is the three consultant vacancies, limited diagnostic capacity owing to capacity in Endoscopy and limited space to increase cancer clinics owing to the current size of Chest clinic. The team continue to work closely with cancer services, the CCG and with KGH to overcome these challenges.

Gynaecology
Main area of concern is around late tertiary referrals, from KGH and MK, the service continue to work through MDT and service improvement discussions to streamline pathways, there will also be a more robust mechanism for challenging these through the breach panel.

Head & Neck
2ww slots have been increased within ENT and have been made directly bookable. A new pathway for dental OPG/assessment has been implemented as a review of recent breaches attributed to some of the reduced performance.

Urology
Radical prostatectomy waits are >13 weeks at UHL. The service have written to 8 patients (in legacy) to offer them the opportunity to have their treatment at UCLH.

Endoscopy
The Endoscopy service remains under significant pressure, mainly due to the decontamination equipment issues earlier this year, which led to lists being cancelled. To compound this issue the month on month routine, planned and 2WW requests have increased particularly since January 2019. During May there was a huge spike in 2WW referrals nearly doubling the expected demand. Whilst under these pressures the department have continued to try and maintain the service for 2WW and inpatients. The washer replacement programme is on track with the first three new machines in and live, with the final two scheduled to be live towards the end of July.

Oncology Service Update
Oncology and Haematology Clinical staffing remains challenging, due to the specialist nature of the service. The service is continuing to rely on bank/agency doctors to bridge gaps in the short-term until substantive posts are filled, Adverts have now closed for Consultant Clinical Oncologists, 3 consultants have been appointed in to the substantive role of Clinical Oncologist and have commenced in post. The service continues to have one trainee in post until August 2019. Gaps are currently being bridged by locum SPR level doctors to ensure no disruption to the service. 1 further consultant has been appointed as NHS locum for a 12 month fixed term contract which will further reduce the agency spend.

Patients treated 104+ days

8 patients were treated in excess of 104+ days in May

No patients were identified to have been caused harm by their delayed pathways; however two were referred to the review of harm group for further discussion.

4. Board recommendation:
The Board is asked to receive and discuss the report

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 JUN

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↑		92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	3	0	0	0	0	4	2	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↓					4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,560
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↑		92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.7%	85.5%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		79	60	118	174	142	299	330	400	420	343	203	69
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		1	3	15	17	19	30	49	33	22	13	11	15
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		6	16	2	3	3	4	5	4	4	11	1	4
	Delayed transfer of care	Debbie Needham	=23	NGH	↑		12	19	36	10	10	24	12	11	20	31	34	21
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↑		28	16	34	27	15	20	20	17	29	41	41	32
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↑		19	13	25	25	13	16	17	13	20	30	33	23
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↑		81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	No data submitted
	RTT over 52 weeks	Debbie Needham	=0	Nat	↓		0	0	0	0	0	0	1	3	1	0	1	No data submitted
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	No data submitted

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 JUN

	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%			92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%			97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%
	Unappointed Follow Ups	Debbie Needham	=0	NGH								8,608	8,723	9,957	10,119	10,363	10,385
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH		12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%
	Sickness Rate	Janine Brennan	<=3.8%	NGH		4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH		13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH		14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH		10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH		14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%
	Turnover Rate	Janine Brennan	<=10%	NGH		8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH		89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH						81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH		85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH		85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH		58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH		(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH		72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH		(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH		2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH		89	107	128	153	167	195	209	230	266	55	34	57
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH		152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH		1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH							64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH							39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH			27	No data submitted	No data submitted	No data submitted	15	21	21	19	18	18	22
	Waivers which have breached	Phil Bradley	=0	NGH			0	No data submitted	No data submitted	No data submitted	1	0	0	0	4	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH		51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH		22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH		4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH		18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%			87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 JUN

	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↓		0	104	104	106	106	106	105	106	104	103	104	105
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		98	98	100	100	104	104	104	104	104	104	100	100
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	↑		25	45	47	66	36	35	53	51	35	35	35	17
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	100.0%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	1	0	0	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0		↓		3	2	3	0	0	3	7	1	0	0	2	3
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.1%	95.6%	93.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	HOHA (C-Diff > 2 Days)	Sheran Oke	<=1.75	Nat	↑		2	1	2	0	0	1	0	0	0	2	3	1
	Community Onset Healthcare Associated C-Diff infection (COHA)	Sheran Oke	<=3	CCG	↓											1	2	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH	↑		2	0	0	2	1	0	1	2	0	5	4	1
	New Harms	Sheran Oke	<=2%	NGH	↑					2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2	5.4	4.7
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→							85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓							62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓							89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%

No data submitted — Data not provided

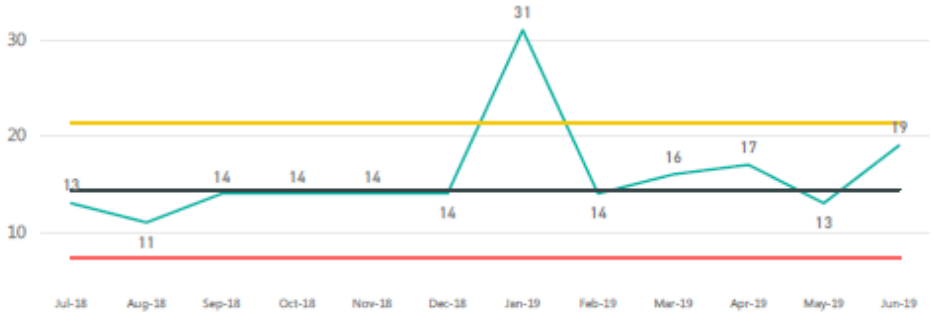
No data - pre KPI implementation

Average Ambulance handover times

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	00:15	00:19	↓	Debbie Needham

Performance vs Target

Measure Value · Average · Lower Limit · Upper Limit



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19

What is driving under performance?

Sustained reduction in overall number of Continued high ambulance conveyance from EMAS to NGH.

Actions completed in the past month to achieve recovery

High emphasis within department on achieving <30 minute target. Early escalation of constraints

Timeframe for recovery

August 2019

Exception report written by

LoasbyJ

Assurance Committee

Directorate Management Board

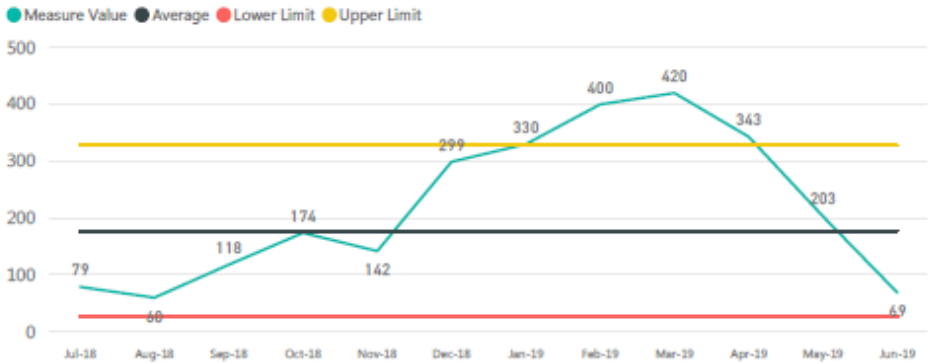
Next steps

IBOX dashboard to be completed during July to show day by day analysis of ambulance arrivals - this will then ensure that a retrospective visual analysis can be completed for challenge with EMAS. Joint meeting with KGH and NGH arranged for mid-July to optimise communication channels. Monthly meeting established with EMAS and NGH to understand pathways for development to avoid conveyance to ED.

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

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	25	69	↑	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
79	60	118	174	142	299	330	400	420	343	203	69

What is driving under performance?

Third consecutive month of overall reduction. Dramatic reduction this month alone.

Actions completed in the past month to achieve recovery

Continued progress with EMAS and CCG to work collaboratively in reducing Ambulance conveyances / access to alternative pathways.

Timeframe for recovery

August 2019

Next steps

Monthly meetings with EMAS and NGH. Collaboration meeting with KGH, NGH and EMAS to establish countywide reduction and wider learning set.

Exception report written by

LoasbyJ

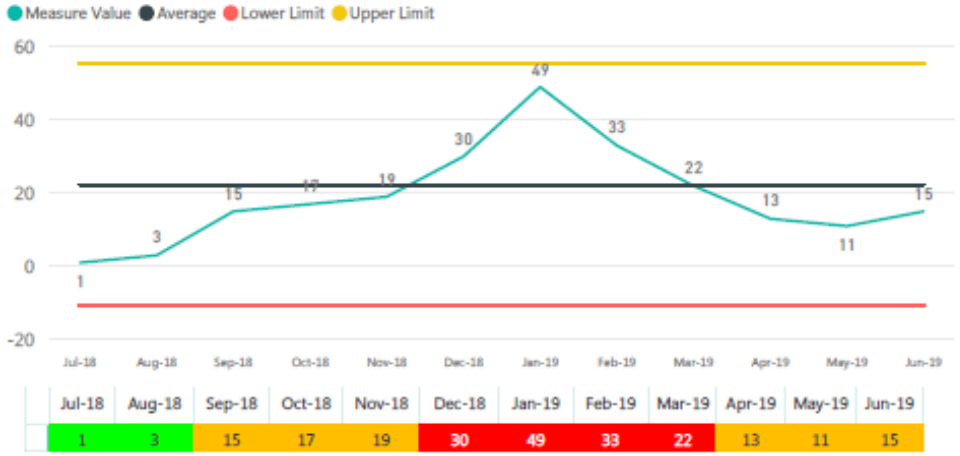
Assurance Committee

Directorate Management Board

Ambulance handovers that waited over 60 mins

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	10	15	↓	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
1	3	15	17	19	30	49	33	22	13	11	15

What is driving under performance?

Increased number of conveyances with periods of extreme surge and crowding in ED have contributed to delays in offloading ambulances. Internal flow has been constrained, multiple red calls resulted in an increase this month delayed off loads as clinical teams were diverted to the Resuscitation areas on multiple occasions. EMAS do not alter figures circulated despite immediate challenge. Actual number 14 Challenge at time of not signing off directly to EMAS.

Actions completed in the past month to achieve recovery

Developed an escalation of any ambulance delays of 30 mins or more to site to support handover. Process of supporting and facilitating handover agreed. Ongoing dialogue with EMAS re difference in numbers - regional issue due to EMAS IT system

Timeframe for recovery

August 2019

Next steps

Continue to embed the escalation process for ambulance delays, optimising communication with Site manager. IBOX dashboard will facilitate extended conversations with EMAS and CCG to understand regular peak patterns.

Exception report written by

LoasbyJ

Assurance Committee

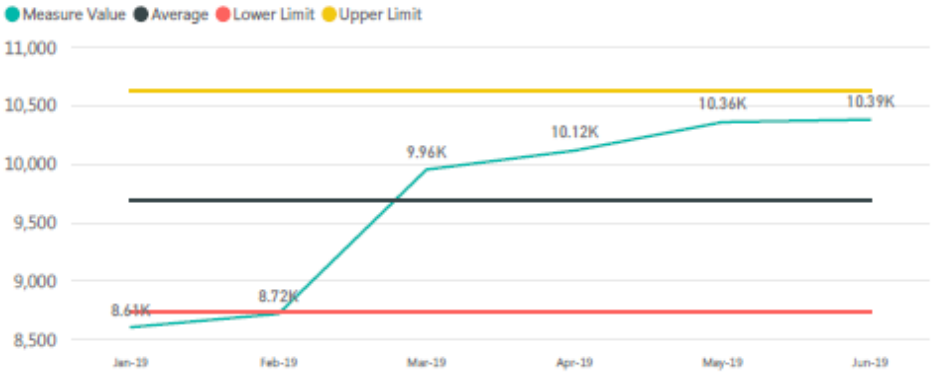
Directorate Management Board

Unappointed Follow Ups

June 2019

Target	Actual	Direction of Travel	Accountable Executive
0	10385	↓	Debbie Needham

Performance vs Target



Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
8608	8723	9957	10119	10363	10385

What is driving under performance?

•Cardiology, ENT, Ophthalmology & Urology have the largest issues with un-appointed follow ups •The weekly trust performance meeting monitors these patients, but accurate representation of the issue is reliant on areas recording an "appoint by" date. •Ophthalmology is a recognised national problem with issues of follow up capacity and this issues is being managed via the CCG for both NGH and KGH

Actions completed in the past month to achieve recovery

•All 4 above specialties have been asked for a rectification plan to resolve the issue and this will be presented to QGC in July •Ophthalmology patients all risk stratified to a standard protocol across Northamptonshire and additional capacity bought on line to have patients reviewed. Any evidence of harm identified from the appointment is captured and reported to the review of harm group and the CCG •All areas to continue to validate their waiting lists to remove data issues •Additional capacity including virtual clinics esp in ENT developed to support the process

Timeframe for recovery

October 2019

Next steps

As per above this is a big piece of work that will take 4 months to be resolved with extra admin and clinical support required during this time

Exception report written by

CrockettG

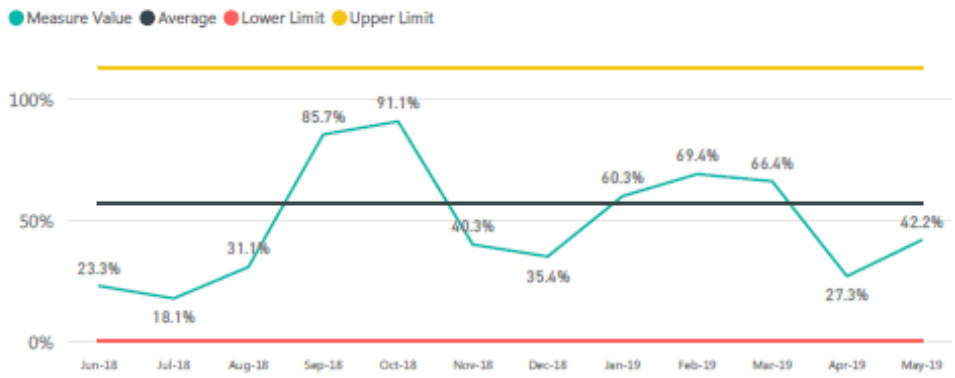
Assurance Committee

Finance Investment and Performance Committee

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

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
May 2019	93.0 %	42.2 %	↑	Debbie Needham

Performance vs Target



Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
23.3 %	18.1 %	31.1 %	85.7 %	91.1 %	40.3 %	35.4 %	60.3 %	69.4 %	66.4 %	27.3 %	42.2 %

What is driving under performance?

The 2ww breast symptomatic standard will not be met for May reaching 42.2% which is an improvement on last month against the standard of 93%.

Actions completed in the past month to achieve recovery

The breast service have continued to procure further capacity running additional bi-weekly clinics from April to June and in July and August every weekend.. They expect to achieve the standard in July and August

Exception report written by

BuckleyS

Next steps

continuation of additional capacity, exploration of collaborative working within the county

Timeframe for recovery

July 2019

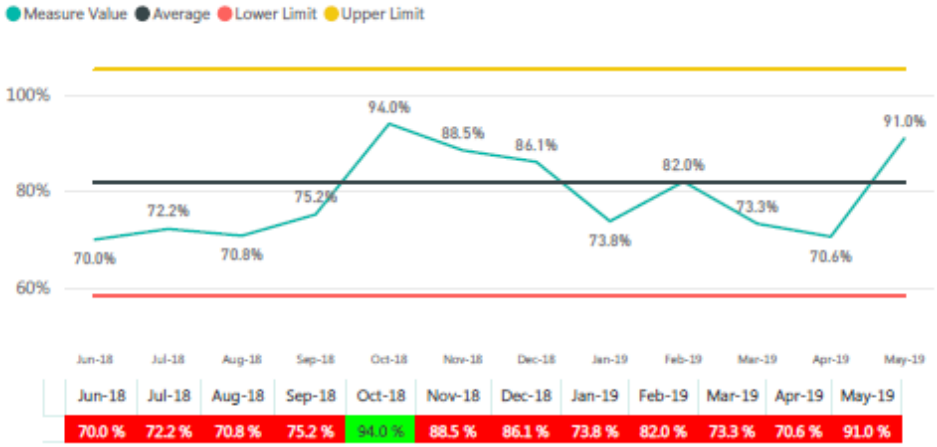
Assurance Committee

Finance Investment and Performance Committee

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

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
May 2019	93.0 %	91.0 %	↑	Debbie Needham

Performance vs Target



Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
70.0 %	72.2 %	70.8 %	75.2 %	94.0 %	88.5 %	86.1 %	73.8 %	82.0 %	73.3 %	70.6 %	91.0 %

What is driving under performance?

The Trust has only just failed to meet the 2ww standard for May reaching 91% against the standard of 93%, this is a 30% improvement on April performance. Brain, Gynaecology, Haematology, Lung, Sarcoma and Urology met the standard this month. Head and Neck were just under the standard. Skin has recovered reaching 99.5% which is fantastic

Actions completed in the past month to achieve recovery

Locum in place for dermatology which has recovered their position. The breast service have continued to procure further capacity running additional bi-weekly clinics from April to June and in July and August every weekend.

Exception report written by

BuckleyS

Timeframe for recovery

July 2019

Assurance Committee

Finance Investment and Performance Committee

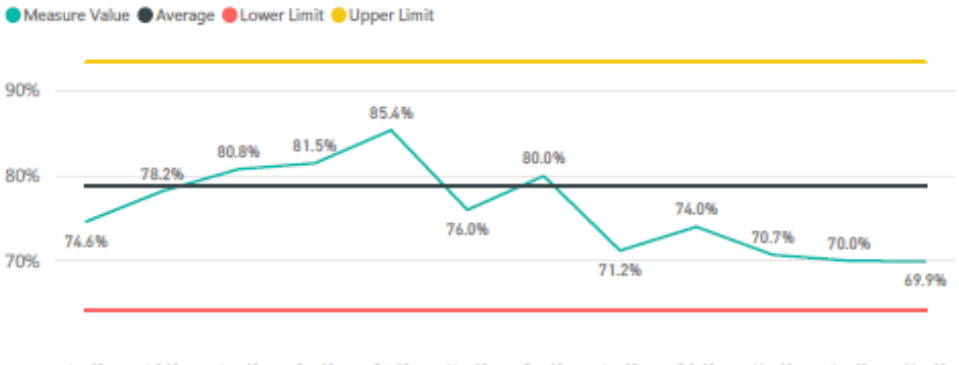
Next steps

Expected recovery of 2ww July at latest August due to extra capacity in breast and dermatology

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

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
May 2019	85.0 %	69.9 %	↓	Debbie Needham

Performance vs Target



Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
74.6 %	78.2 %	80.8 %	81.5 %	85.4 %	76.0 %	80.0 %	71.2 %	74.0 %	70.7 %	70.0 %	69.9 %

What is driving under performance?

The Trust has treated in May 98 patients which is in line with previous average treatments, however there have been 29.5 breaches reaching 69.9% against the 85% standard when the Inter Provider Transfer rules are applied now nationally. Breast, sarcoma and skin have achieved the 62 day standard.

Actions completed in the past month to achieve recovery

PTL Meetings Dally PTL meetings re-introduced, chaired by the Chief Operating Officer, attended by Radiology, Histopathology, Cancer Services, Oncology, Directorate and Divisional Managers by speciality to expedite patient pathways. Cancer Management Clinical Director for Cancer started to meet with Directorate Manager for Cancer and Lead Nurse to initially understand challenges within the Trust delivering Cancer and has already started to meet with MDT Leads. Directorate Managers have been asked to meet weekly with their MDT leads in order to secure proactive clinical input into their legacy patients moving forwards.

Exception report written by

BuckleyS

Timeframe for recovery

November 2019

Assurance Committee

Finance Investment and Performance Committee

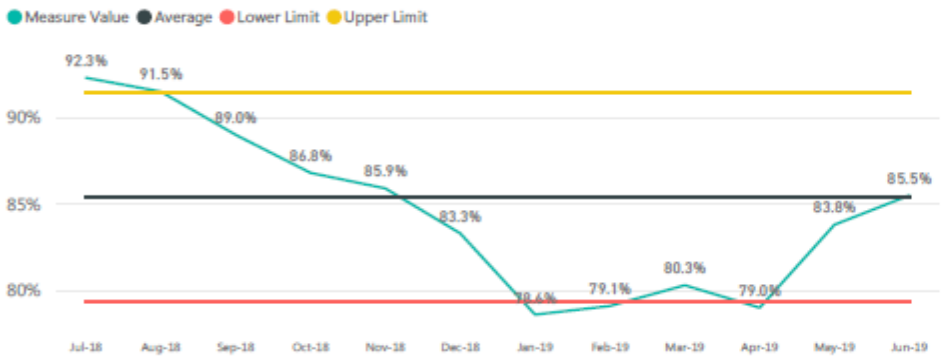
Next steps

Survey being conducted with MDT leads to secure their feedback on how they support cancer pathways. Revised Job description for tumour site leads to be launched at an event in September in order to improve clinical engagement Transformation funding agreed for Northamptonshire for 2019/20, meeting held with CCG, NGH and KGH to agree priorities aligned to 3 key pathway under review, Lung, Prostate and FIT being introduced in primary care later this month

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

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.1 %	85.5 %	↑	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
92.3 %	91.5 %	89.0 %	86.8 %	85.9 %	83.3 %	78.6 %	79.1 %	80.3 %	79.0 %	83.8 %	85.5 %

What is driving under performance?

Whilst overall attendance to A&E during the month of June saw a reduction of over 400 from may. A 1.39% increase in A&E conversion rate. Continued increase in Ambulance conveyance to NGH.

Actions completed in the past month to achieve recovery

June was the second consecutive month of improvement - 1.65% increase from May, achieving 85.55%, still some way from the required 95%.

Exception report written by

LoasbyJ

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

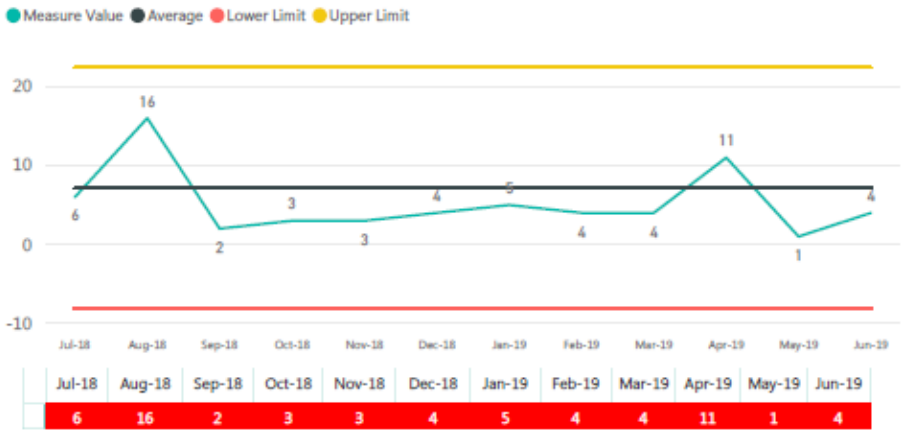
Next steps

Optimise Nye Bevan model and use of Assessment trolley areas to reduce footfall within ED, for GP and Surgical expected patients. Continue sustainment of <20 mins for Resus patients to be seen within 20 minutes of referral by ED - average time to triage

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

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	4	↓	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
6	16	2	3	3	4	5	4	4	11	1	4

What is driving under performance?

4 patients were not operated on within 28 days of their hopsital initiated operation date. 3 were in Maxial Facial services for dental extractions under general anaesthetic, cancelled due to lack of 1st assistant staffing. 1 was in general surgery, cancelled due to lack of beds. They were re-booked within 28 days but was cancelled again due to lack of operating time due to other over-running procedures

Actions completed in the past month to achieve recovery

Timeframe for recovery

July 2019

Next steps

Exception report written by

TuckerMR

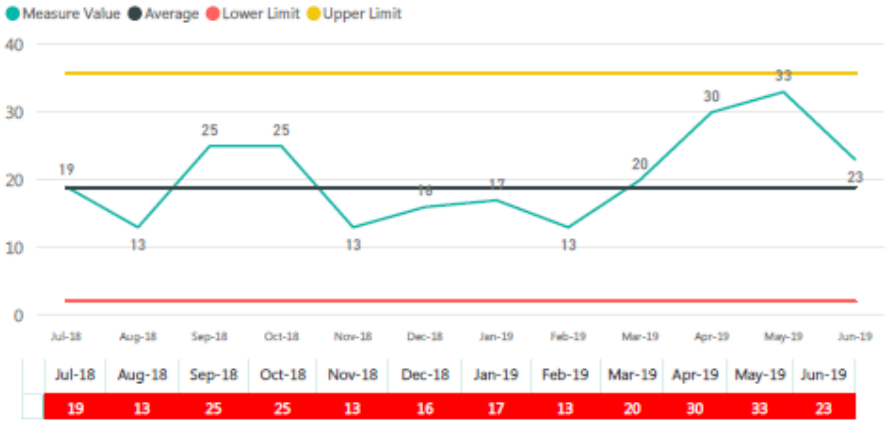
Assurance Committee

Finance Investment and Performance Committee

Average Monthly Health DTOCs

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	7	23	↑	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
19	13	25	25	13	16	17	13	20	30	33	23

What is driving under performance?

Improved to previous month ongoing micro managing of each health super stranded is occurring

Actions completed in the past month to achieve recovery

Super stranded process changed to ensure actions are mapped to completion within 24 hours. Matrons support and presence at each weekly super stranded meeting. Daily 'top 10 summit' whereby the 10 longest length of stayers are discussed each morning with specific actions around what the next step is required and fed through to DCOO. DCOO then engages with external stakeholders regarding any external delays

Timeframe for recovery

August 2019

Next steps

As above with increasing of daily summit to top 20

Exception report written by

TaylorLA

Assurance Committee

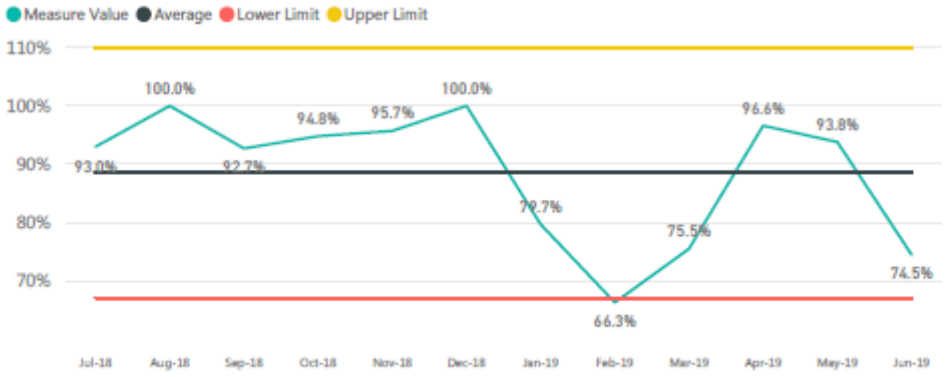
Finance Investment and Performance Committee

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

June 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
80.0 %	74.5 %	↓	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
93.0 %	100.0 %	92.7 %	94.8 %	95.7 %	100.0 %	79.7 %	66.3 %	75.5 %	96.6 %	93.8 %	74.5 %

What is driving under performance?

June's figures reflect the demand on the stroke service (85 confirmed strokes)and on the Trust as a whole. For the Stroke Pathway to function optimally within it's bed base (40 inpatient beds)we need to maintain a steady rate of discharges. Those patients requiring CHC decisions, complex care packages and community stroke beds at Isebrook continue to experience delays to discharge, despite robust engagement of the service MDT and discharge teams. We experienced 45 4 hour breeches to a stroke bed and only managed to maintain an empty ring fenced bed on Eleanor Ward on 10 days of June. This is despite carrying very few medical patients during this time.

Actions completed in the past month to achieve recovery

On going engagement with the Site Team to ensure that we try to maintain ring fenced beds. Effective daily board rounds with good staff engagement.

Exception report written by

BlakeM

Next steps

Further review of how we use the Community Stroke beds on the Isebrook Site.

Timeframe for recovery

August 2019

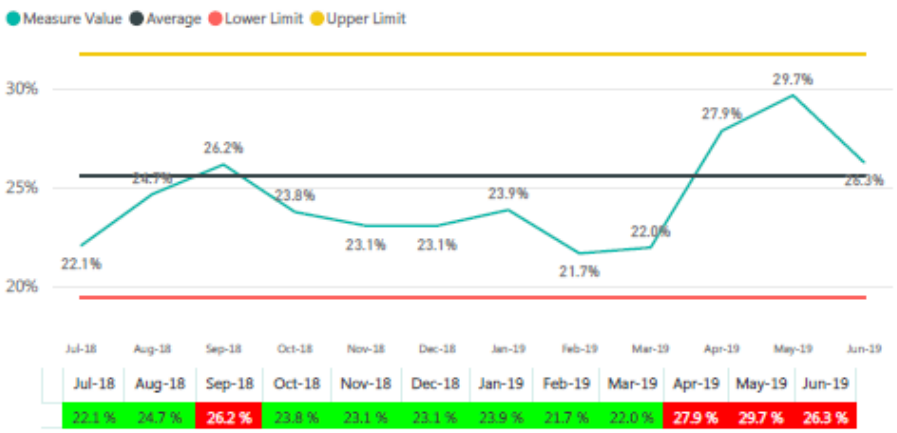
Assurance Committee

Quality Governance Committee

Super Stranded Patients (ave.) as % of bed base

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
June 2019	25.0 %	26.3 %	↑	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
22.1 %	24.7 %	26.2 %	23.8 %	23.1 %	23.1 %	23.9 %	21.7 %	22.0 %	27.9 %	29.7 %	26.3 %

What is driving under performance?

Increased numbers of stroke, NOF and high acuity will directly impact on the number of stranded patients and super stranded as they are dependent on community support for discharge

Actions completed in the past month to achieve recovery

Increased scrutiny around do patients have active treatment plan who is actioning it. Ward staff come directly to site and highlight any delays and issues, daily assurances sought that patients have had a senior decision maker review.

Exception report written by

CrockettG

Timeframe for recovery

October 2019

Assurance Committee

Finance Investment and Performance Committee

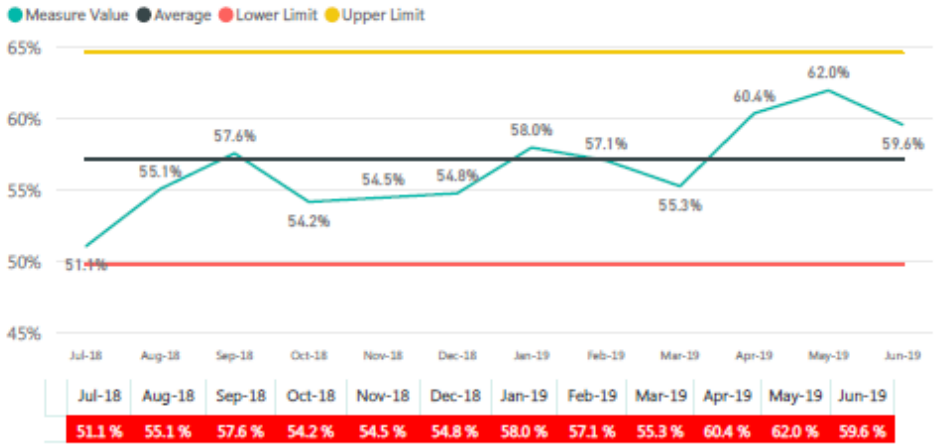
Next steps

As part of the HEAT programme the stranded has a specific focus and plan of work to reduce the number of patients between 7-20 days. also as per above - a trajectory to reduce this number is being set

Stranded Patients (ave.) as % of bed base

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	40.0 %	59.6 %	↑	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
51.1 %	55.1 %	57.6 %	54.2 %	54.5 %	54.8 %	58.0 %	57.1 %	55.3 %	60.4 %	62.0 %	59.6 %

What is driving under performance?

Increased numbers of stroke, NOF and high acuity will directly impact on the number of stranded patients and super stranded as they are dependent on community support for discharge

Actions completed in the past month to achieve recovery

Increased scrutiny around do patients have active treatment plan who is actioning it. Ward staff come directly to site and highlight any delays and issues, daily assurances sought that patients have had a senior decision maker review.

Exception report written by

TaylorLA

Timeframe for recovery

October 2019

Assurance Committee

Finance Investment and Performance Committee

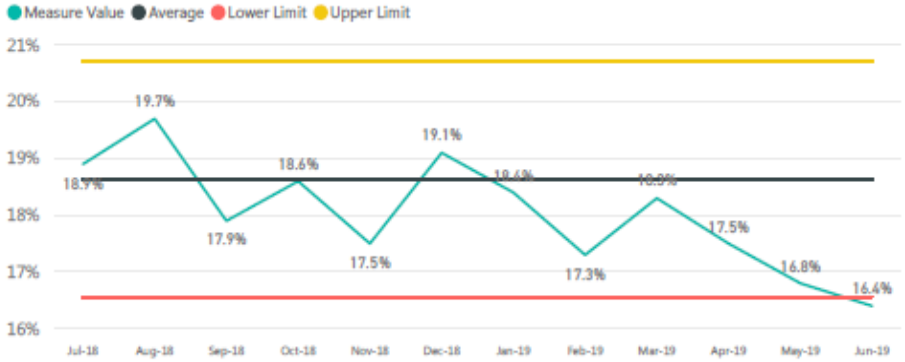
Next steps

As part of the HEAT programme the stranded has a specific focus and plan of work to reduce the number of patients between 7-20 days. also as per above - a trajectory to reduce this number is being set

Percentage of discharges before midday

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
June 2019	25.0 %	16.4 %	↓	Debbie Needham

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
18.9 %	19.7 %	17.9 %	18.6 %	17.5 %	19.1 %	18.4 %	17.3 %	18.3 %	17.5 %	16.8 %	16.4 %

What is driving under performance?

Achieving actual physical discharge from the trust is difficult to actually measure as patients may have physically vacated the bed but are not discharged from the hospital PAS system due to a variety of reasons such as ward clerks on break, batching of admissions, no weekend cover etc. In addition we have realised that the penultimate ward is not being coded as the time of day of discharge if a patient has gone to the DC suite this will skew the time of discharge and not reflect when the physical bed was in fact vacated and ready for the next patient. This is being rectified for July's scorecard. However we do recognise that our flow before noon continues to be challenging to achieve and was a key indicator of SAFER process.

Actions completed in the past month to achieve recovery

The HEAT transformation programme board have made this a key focus

Exception report written by

CrockettG

Timeframe for recovery

July 2019

Assurance Committee

Finance Investment and Performance Committee

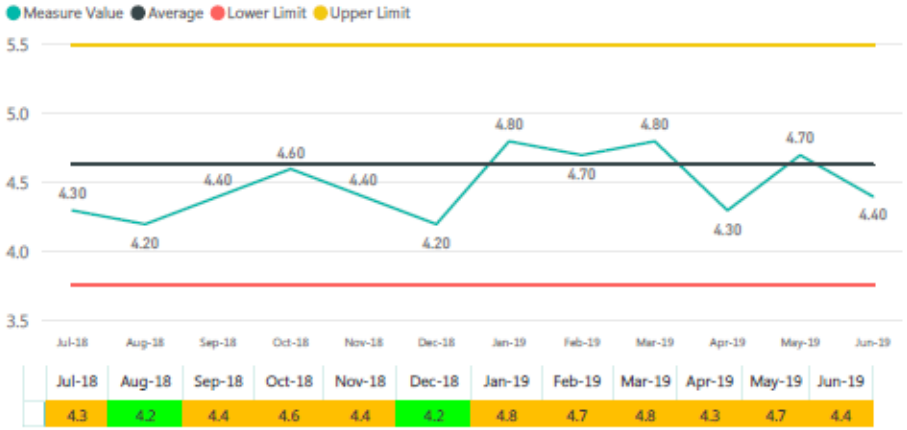
Next steps

The discharge and discharge planning process has been rebranded and relaunched with renewed vigour as part of our HEAT programme and is aligned with our board round work stream, EDDs and site process. Board rounds and ibox are being phased in across the trust July and August

Length of stay - All

June 2019	Target	Actual	Direction of Travel	Accountable Executive
	4.2	4.4	↑	Debbie Needham

Performance vs Target



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

What is driving under performance?

LOS for June has improved to the previous month however we are yet to achieve the target.

Actions completed in the past month to achieve recovery

The fact that it remains static at 4 days regardless of cohorts of patients shows that the patients that generate basic 'churn' and are the simple admissions and discharges are within range of what is required. However the number of stroke and NOFs patients in particular will skew our LOS adversely as they typically require supported discharges and extensive lengths of stays.

Timeframe for recovery

July 2019

Next steps

Review of NOF and stroke pathway to occur by September New process for July of looking at patients in the 7-20 day group with targeted actions.

Exception report written by

CrockettG

Assurance Committee

Finance Investment and Performance Committee

Report To	**Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**Workforce Performance Report**
Agenda item	**14**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues

Executive summary

The report covers the June 2019 performance and shows:

- The key performance indicators show an increase in contracted workforce employed by the Trust, and an increase in sickness absence from May 2019.
- Decrease in compliance rate for Mandatory Training and an increase in compliance for Role Specific Essential Training and Appraisals.
- Update in respect of organisational development initiatives

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 3.1, 3.2 and 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed

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

Actions required by the Board

The Board is asked to Note the report.

1. People Capacity

- *Vacancy rate (all staff groups) – 12.21%* ⬆
- *Nursing & Midwifery vacancy rate – 11.52%* ⬆
- *AHP vacancy rate – 14.14%* ⬆
- *Additional Clinical Services vacancy rate – 15.25%* ⬇
- *Medical vacancy rate – 7.58%* ⬆
- *Sickness absence in month – 4.54* ⬆

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People Capacity Highlight Page

Key Areas of Success

- Initial stages of implementation have commenced for a three month trial of an application which will enable us to increase the Trusts Medical bank and advertise shifts electronically. Internal Locum Centre processes have been mapped in conjunction with the software provider and a stakeholder meeting was held on Tuesday 11 June during which a demonstration of the benefits of the system was provided.
- Two mental health professionals have recently been appointed to work within the Occupational Health team to provide mental health support and training to NGH staff.
- Oncology medical candidates have been sourced to cover recently vacated posts thus enabling a continuation of Oncology staff maintaining near full establishment.

Key Areas of Concern

- Sickness absence continues to be above Trust target of 3.8% for a period in excess of 12 months.

- Recruitment timescales have been below target for 3 consecutive months.

Key Actions Taken

- Implementation of the TRAC Candidate management system has coincided with an increase in recruitment volume in particular HCA and volunteer recruitment. In order to recover recruitment timescales additional resource has therefore been temporarily provided to the HRSC through the utilization of vacancies elsewhere in the budget.

- Consultation meetings with users of the TRAC system have been set up to obtain feedback on the implementation of the system.

- To help assist in reducing sickness absence, two mental health professionals have recently been appointed to work within the Occupational Health team to provide mental health support and training to NGH staff, which it is hoped will help to address sickness absence attributed to mental health issues.

- Management and support of staff that are absent due to sickness continues in line with Trust sickness absence policy.

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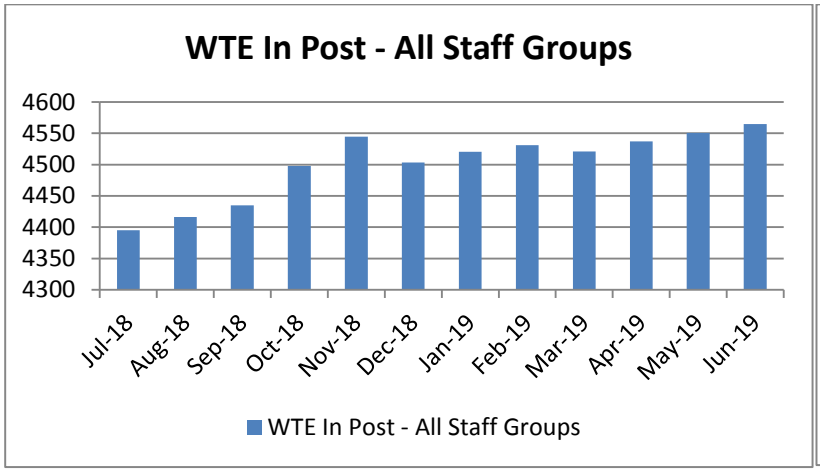
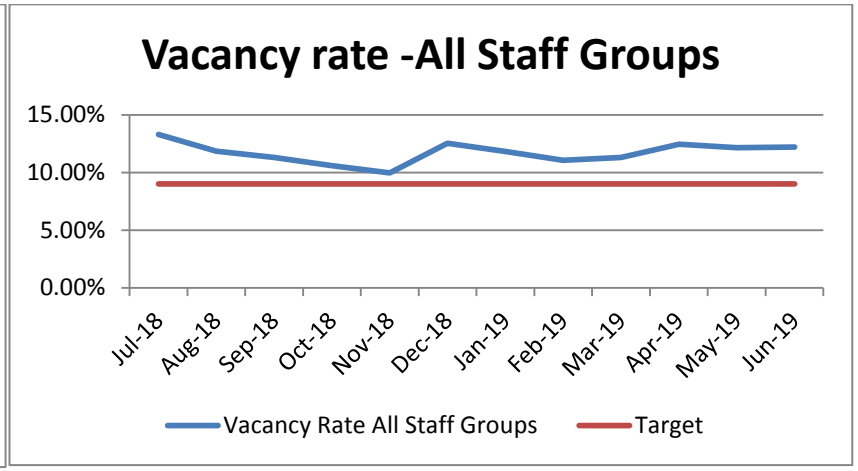
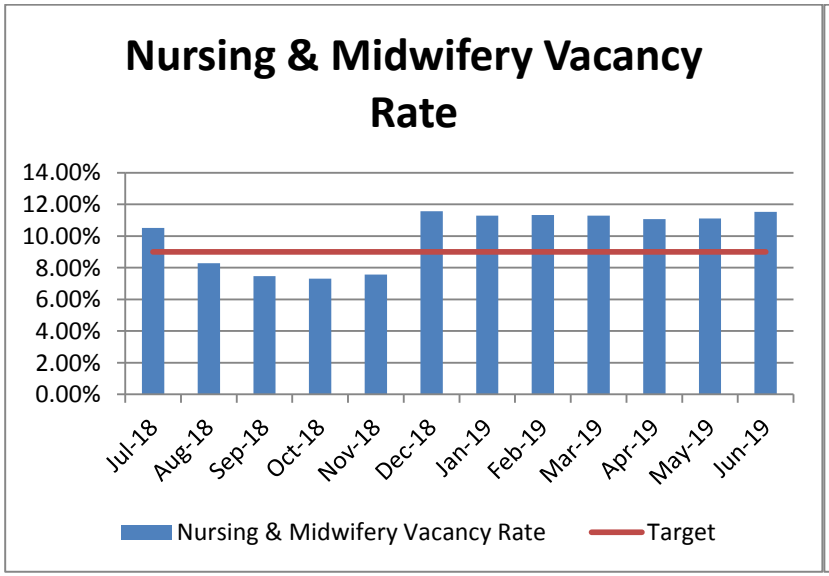
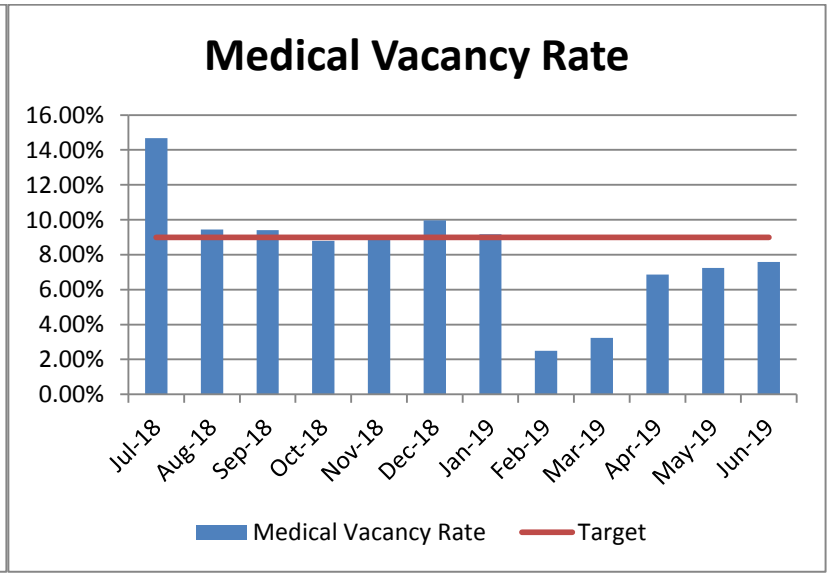
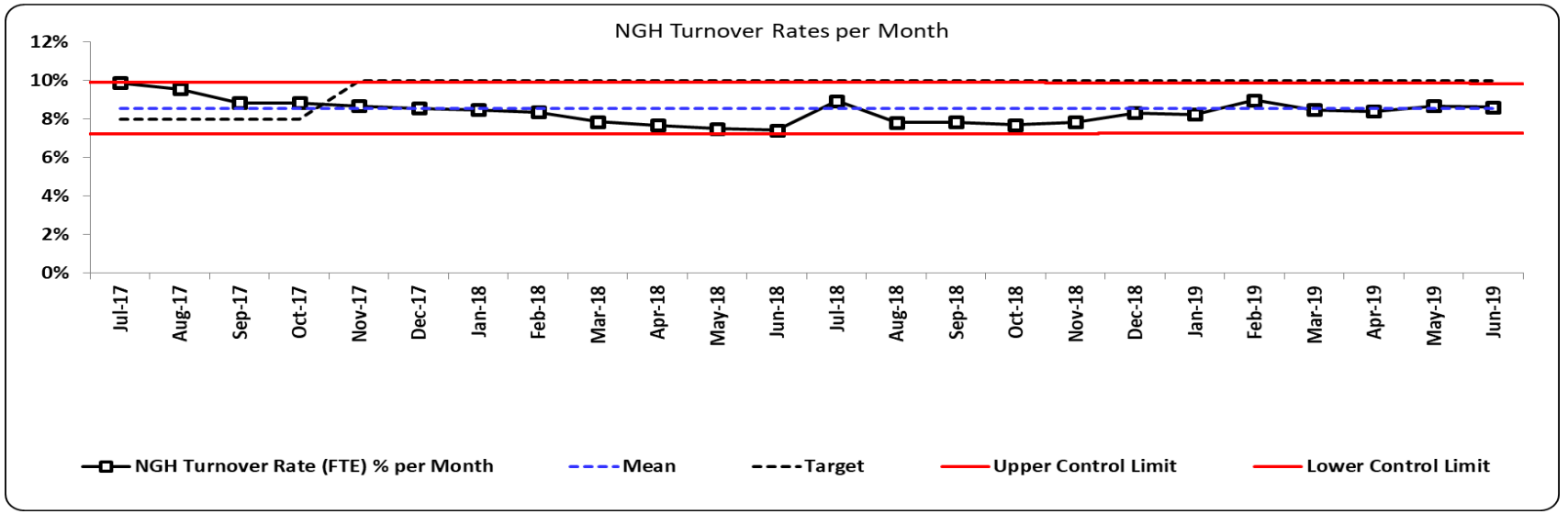
People Capacity











Trust-wide Reason for Resignation - June 2018 -May 2019	WTE
Voluntary Resignation - Relocation	82.69
Retirement Age	60.43
Voluntary Resignation - Work Life Balance	52.86
Voluntary Resignation - Promotion	38.12
Voluntary Resignation - Other/Not Known	37.46
Voluntary Resignation - Health	21.33
Voluntary Resignation - To undertake further education or training	14.75
Voluntary Resignation - Child Dependents	11.21
Voluntary Resignation - Better Reward Package	11.20
Voluntary Early Retirement - with Actuarial Reduction	10.04

In each of the top three categories for 'Reason for Resignation' detailed above, Nursing & Midwifery had the highest proportion of leavers citing these reasons for leaving.

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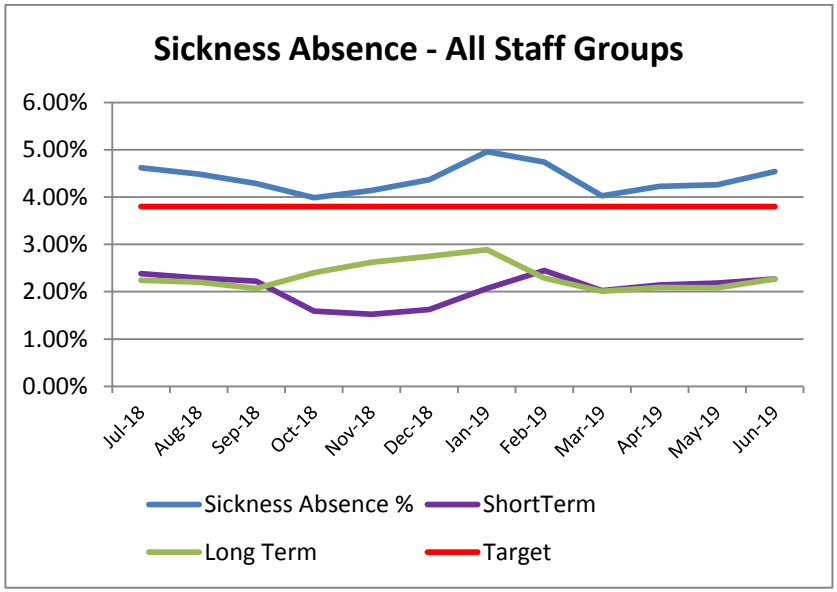
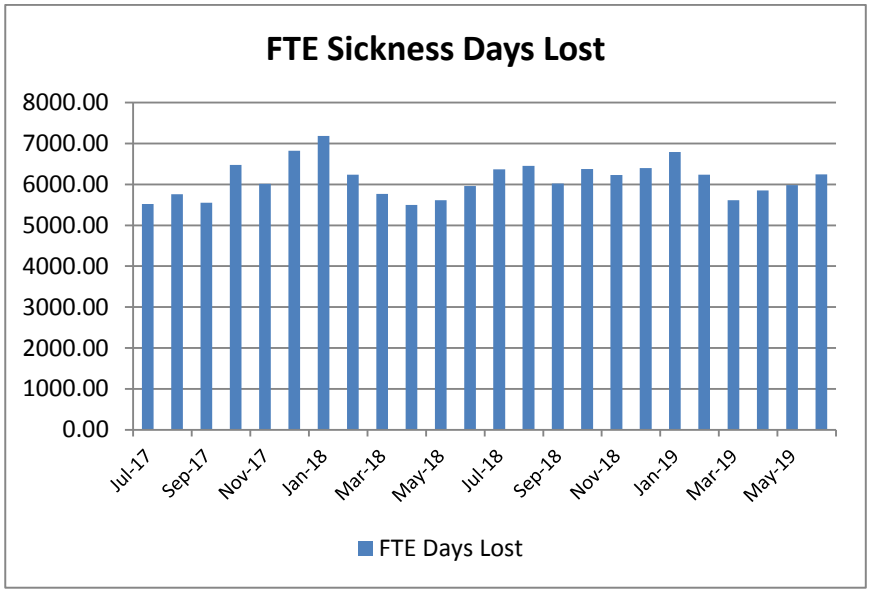
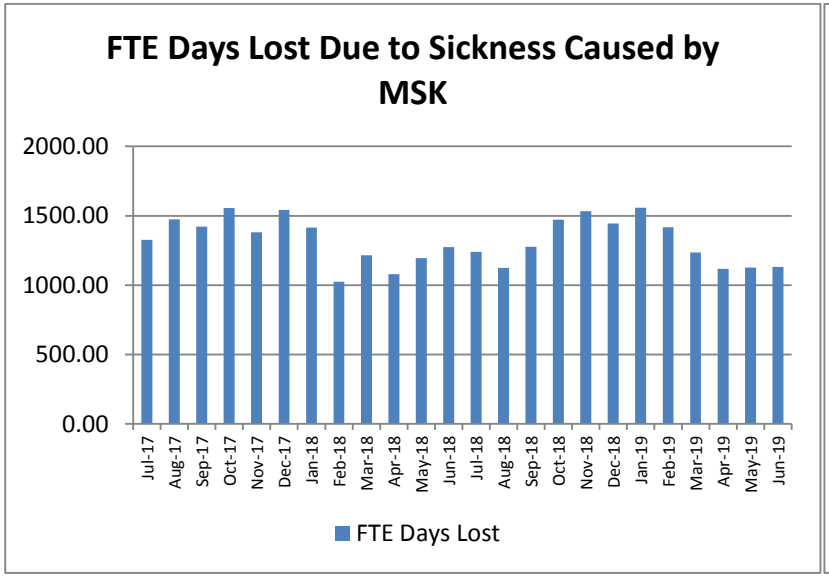
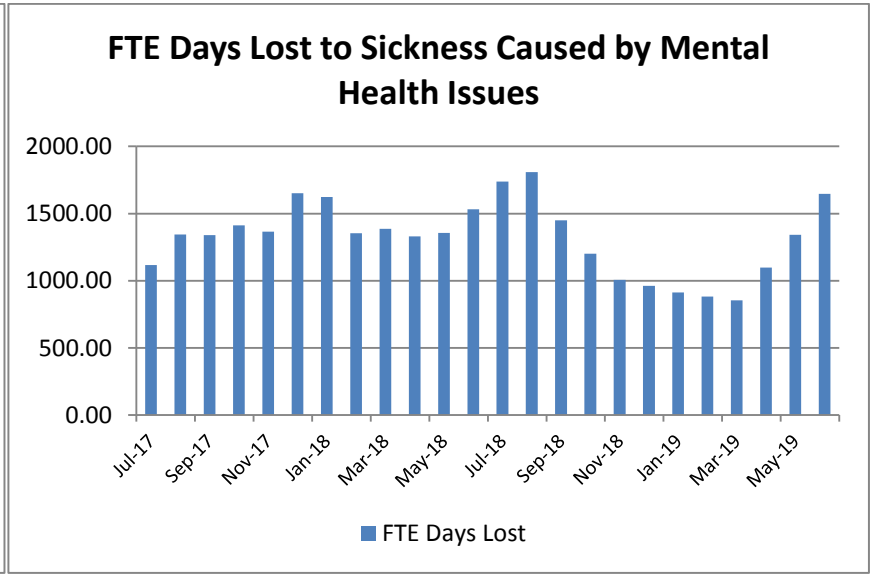
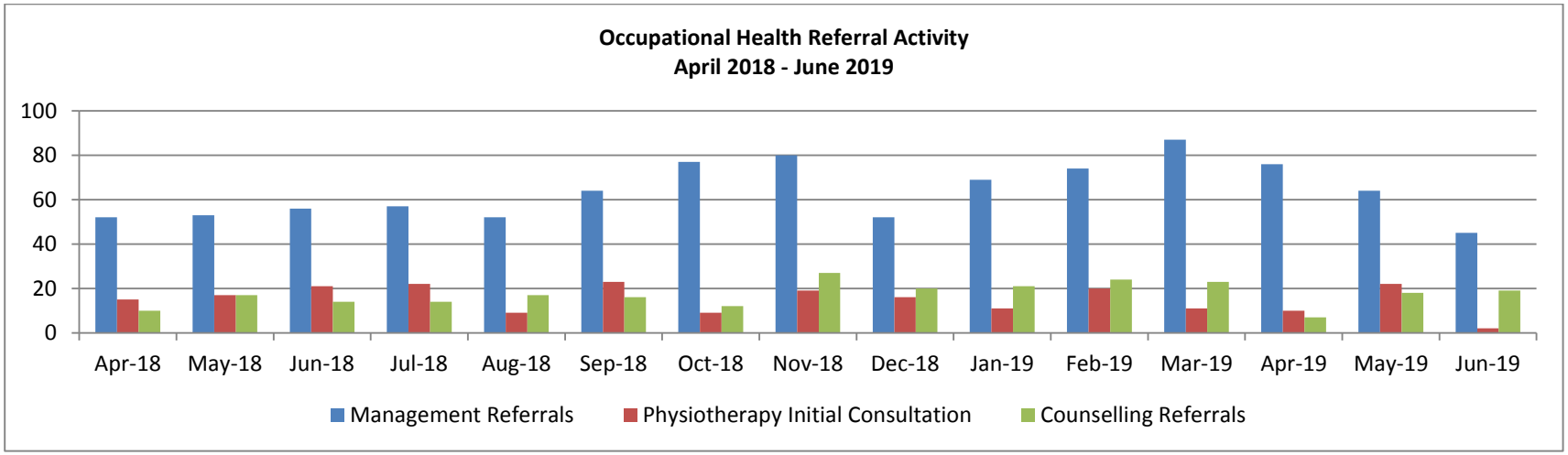


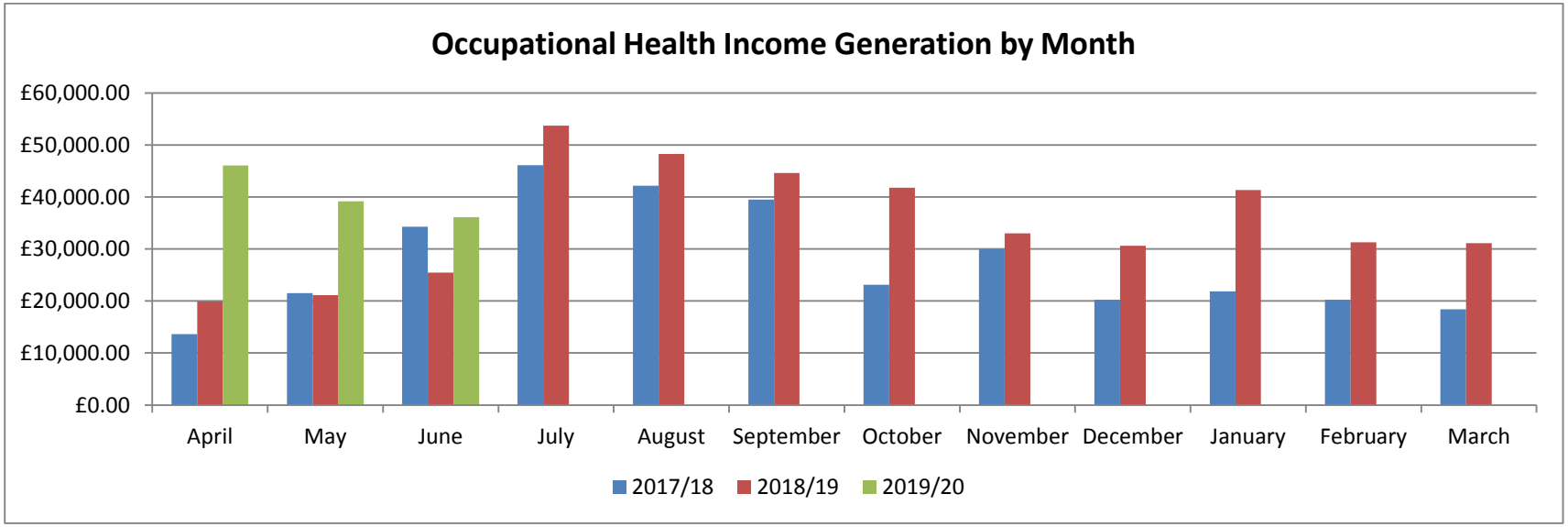






Occupational Health Activity





2. People Capability

- *Appraisal – 85.00%* 
- *Mandatory Training – 89.44%* 
- *Role Specific Training – 84. 54%* 

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People Capability Highlight Page

Key areas of success

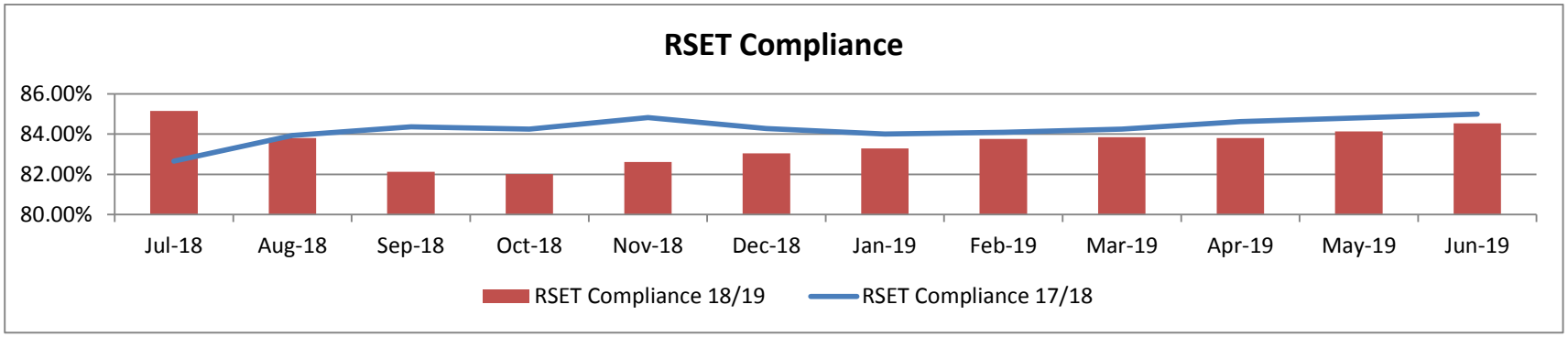
- One member of staff has commenced the Executive MBA level 7 at Aston University with another commencing in September through the apprenticeship levy funds.
- Contracts have finally been approved with a training provider to provide the Pharmacy level 2 qualification.
- After identifying a gap within the allocation of manual handling training, two levels of training have been introduced. The provisions of patient training and non-patient training will ensure that staff who move from one role to another who potentially need additional training will now be identified.
- All three areas; mandatory training, role specific training and appraisals all had an increase in compliance in May 2019
- Workforce Development funding has been allocated to enable AHPs to attend further training.

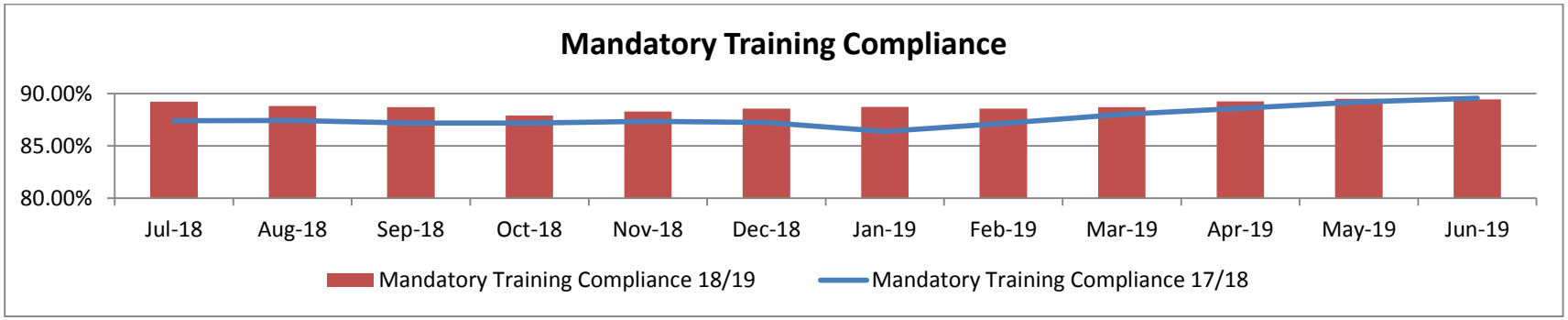
Key areas of concern

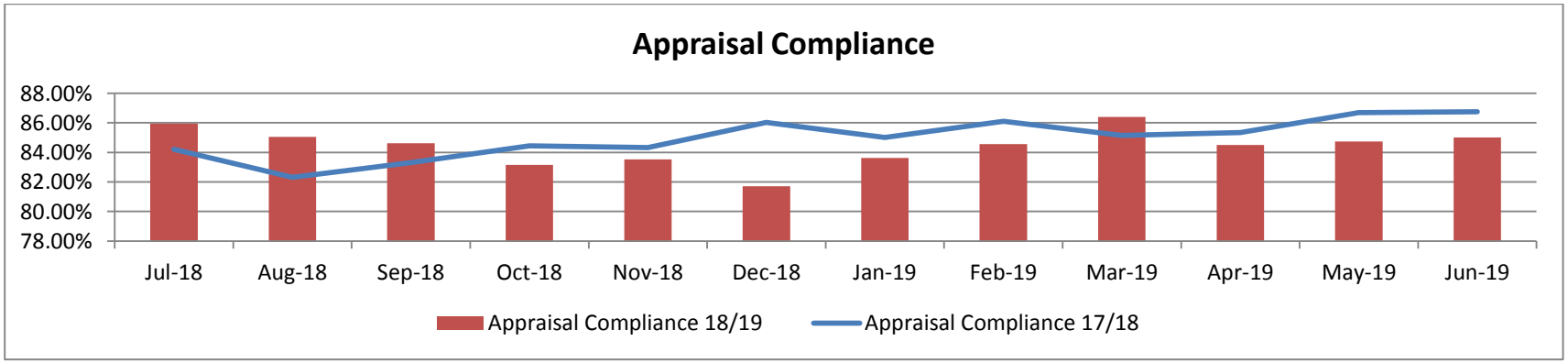
- The volume of work experience applications is mounting due to the time required to process them. In addition there is a lack of willingness in the Trust to take on placements.
- A potential delay in the commencement of the nurse degree apprenticeships has arisen due a dispute regarding the training provider's non acceptance of the Trust's contract and in doing so not complying with the funding rules.
- A number of training providers have recently gone into administration which has resulted in staff who have already been enrolled having to be put on a break in learning whilst we source alternative providers.
- Blood Training and BLS training are below 80% compliance
- Appraisals and RSET compliance is below 85%

Key actions taken

- Data cleansing is being undertaken within the OLM system for the roll out of Employee Self-Service
- Dementia has become RSET so work is being undertaken with the Dementia Liaison Nurse to make compliance reportable.
- Workforce Information is preparing guides and handouts for the launch of employee self-service.
- Support is being provided to named clinicians with the development for training for Diabetes/Insulin Safety.
- Work is being undertaken with Therapies on the OT/Physio Apprenticeship which is available from September 2019.
- Nurses have obtained LDA funding.
- A survey is being prepared to understand possible reservations from managers in respect of taking on work experience candidates with a view to seeking ways in which managers can be supported.


RSET Compliance
86.00%
84.00%
82.00%
80.00%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
RSET Compliance 18/19
RSET Compliance 17/18


Mandatory Training Compliance
90.00%
85.00%
80.00%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Mandatory Training Compliance 18/19
Mandatory Training Compliance 17/18


Appraisal Compliance
88.00%
86.00%
84.00%
82.00%
80.00%
78.00%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Appraisal Compliance 18/19
Appraisal Compliance 17/18

3. People Culture

People Culture Highlight Page

Key Areas of Success

- Courageous Conversations training has received positive feedback with participants recommending the training to others, and continues to receive interest

- Round Table Conversations has been successfully piloted and fully launched with the support of an NHS Elect expert to refine the process. There have been 10 requests for Round Table Conversations and 5 have been completed, successfully leading to mutually agreed outcomes.

Key Areas of Concern

- More work is required to increase engagement of clinical leaders and staff so that they recognise how behaviour impacts on patient treatment and care.

- More work is required to equip staff and managers with the skills and capability to communicate more effectively in order to avoid blame and judgmental approaches.

Key Actions Taken

- We have changed communications and messaging to embed the expectation of participation in training rather than offering it as an option, supported by quarterly reports to highlight attendance in different directorates to push our reach to staff across the Trust

- We recently embarked on a pilot programme with an external company, Momentum who have a successful track record on cultural change, building capability and performance improvements to provide senior leaders in the Trust with essential feedback capability to challenge and support development and address unacceptable behaviours. There is potential for similar training to be delivered internally in future to a wider audience of managers at lower levels

- A coaching skills programme for all colleagues is being piloted, with positive feedback received, and will be finalised ready for launch Sept 2019 to aid in developing the coaching supportive environment that promotes accountability and aids a culture of improvement.

- The Civility Saves Lives presentation took place on 19 July 2019 which is aimed at raising awareness of the impact people have on each other in healthcare.

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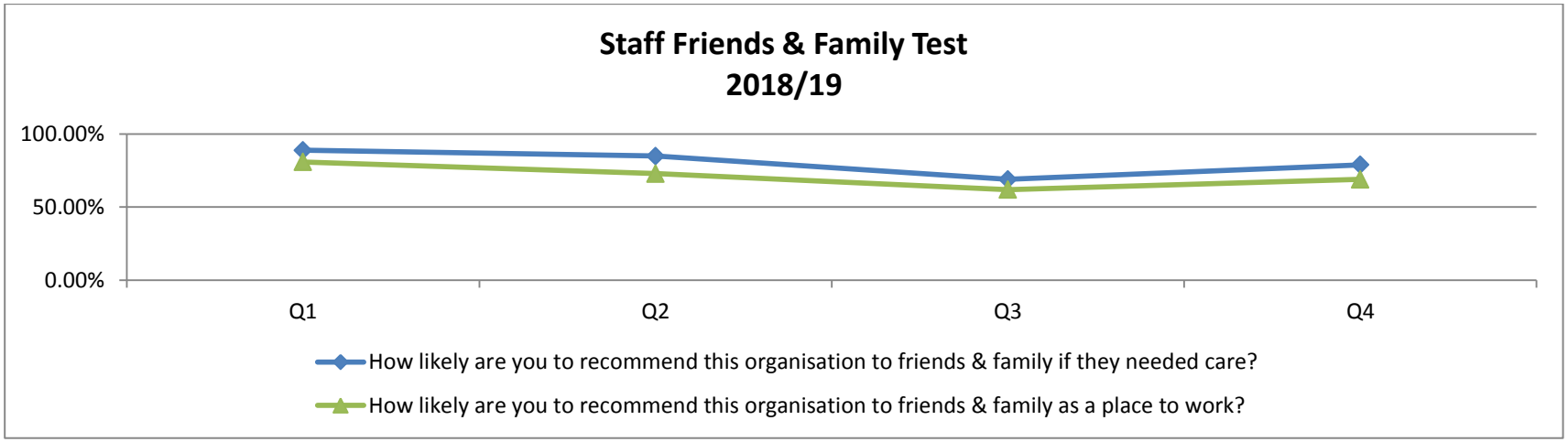
The total numbers in attendance for organisational development interventions

Quarter	Month	Respect and Support training			Total no. of staff	% of staff	Resilience	Courageous Conversations	Round Table Facilitation
		CB&IB for Staff	Leading with Respect for Managers	Grand Total					
	Jul-18	NA	NA	NA			25	NA	NA
	Aug-18	NA	NA	NA			30	NA	NA
	Sep-18	71	77	148			146	NA	NA
2018-19 Q2		71	77	148			201	NA	NA
	Oct-18	NA	NA	NA			63	NA	NA
	Nov-18	47	47	94			23	11	NA
	Dec-18	NA	NA	NA			41	NA	NA
2018-19 Q3		47	47	94			127	11	NA
	Jan-19	NA	NA	NA			8	NA	9
	Feb-19	NA	20	20			41	NA	NA
	Mar-19	32	NA	32			21	24	17
2018-19 Q4		32	20	52			70	24	26
	Apr-19	NA	28	28			8	NA	NA
	May-19	52	NA	52			14	9	NA
	Jun-19	NA	50 booked for 28/06/19	50			6	NA	NA
2019-20 Q1		52	Currently unable to report	52			28	9	NA
Total number		202	172	374	5182	7.2 (excl. June 2018)	426	44	26



The Q1 2019-2020 SFFT survey has recently closed and is in the process of being analysed.

Northampton General Hospital NHS
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Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↑		92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	3	0	0	0	0	4	2	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↓					4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,560
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↑		92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.7%	85.5%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		79	60	118	174	142	299	330	400	420	343	203	69
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		1	3	15	17	19	30	49	33	22	13	11	15
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		6	16	2	3	3	4	5	4	4	11	1	4
	Delayed transfer of care	Debbie Needham	=23	NGH	↑		12	19	36	10	10	24	12	11	20	31	34	21
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↑		28	16	34	27	15	20	20	17	29	41	41	32
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↑		19	13	25	25	13	16	17	13	20	30	33	23
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↑		81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	No data submitted
	RTT over 52 weeks	Debbie Needham	=0	Nat	↓		0	0	0	0	0	0	1	3	1	0	1	No data submitted
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	No data submitted

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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%
	Unappointed Follow Ups	Debbie Needham	=0	NGH									8,608	8,723	9,957	10,119	10,363	10,385
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%
	Turnover Rate	Janine Brennan	<=10%	NGH			8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH							81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			89	107	128	153	167	195	209	230	266	55	34	57
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH								64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH								39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH				27	No data submitted	No data submitted	No data submitted	15	21	21	19	18	18	22
	Waivers which have breached	Phil Bradley	=0	NGH				0	No data submitted	No data submitted	No data submitted	1	0	0	0	4	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%
	Emergency re-admissions within 30 days (elective) - Excludes ACC & COA	Matt Metcalfe	<=3.5%	NGH			4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	ERROR	2.4%	ERROR	2.5%	3.1%	1.3%

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	Emergency re-admissions within 30 days (non-elective) - Excludes ACC & COA	Matt Metcalfe	<=12%	NGH	↑		16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	13.5%	13.2%	ERROR	13.6%	11.5%	8.8%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↓		0	104	104	106	106	106	105	106	104	103	104	105
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		98	98	100	100	104	104	104	104	104	104	100	100
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		25	45	47	66	36	35	53	51	35	35	35	No data submitted
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	No data submitted
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%	6.3%	3.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	1	0	0	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0		↓		3	2	3	0	0	3	7	1	0	0	2	3
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.1%	95.6%	93.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	HOHA (C-Diff > 2 Days)	Sheran Oke	<=1.75	Nat	↑		2	1	2	0	0	1	0	0	0	2	3	1
	Community Onset Healthcare Associated C-Diff infection (COHA)	Sheran Oke	<=3	CCG	↓											1	2	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH	↑		2	0	0	2	1	0	1	2	0	5	4	1
	New Harms	Sheran Oke	<=2%	NGH	↑					2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↑		4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2	5.4	4.7
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→							85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓							62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓							89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%

No data submitted — Data not provided

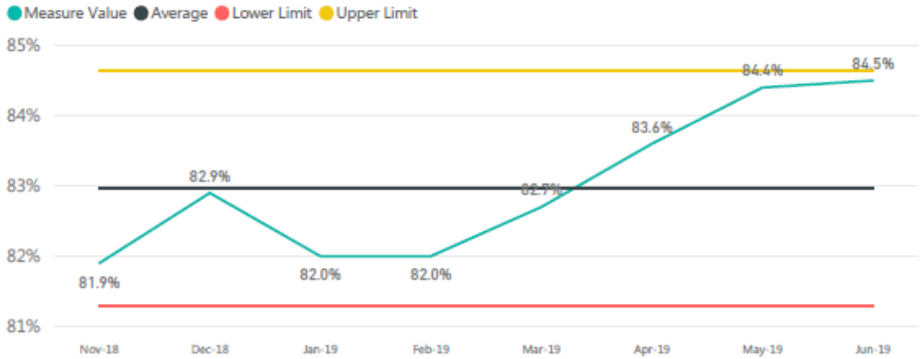
No data - pre KPI implementation

Percentage of all trust staff with mandatory refresher fire training compliance

June 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0 %	84.5 %	↑	Janine Brennan

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
81.9 %	82.9 %	82.0 %	82.0 %	82.7 %	83.6 %	84.4 %	84.5 %

What is driving under performance?

Trust is reviewing what training is required and how this will be delivered

Actions completed in the past month to achieve recovery

In June additional staff were recruited into the estates team to support fire safety compliance, including fire training. Monthly fire training compliance is provided to all departments on a monthly basis and is tracked through the divisional performance days and scorecards.

Exception report written by

CrockettG

Timeframe for recovery

July 2019

Assurance Committee

Workforce Committee

Next steps

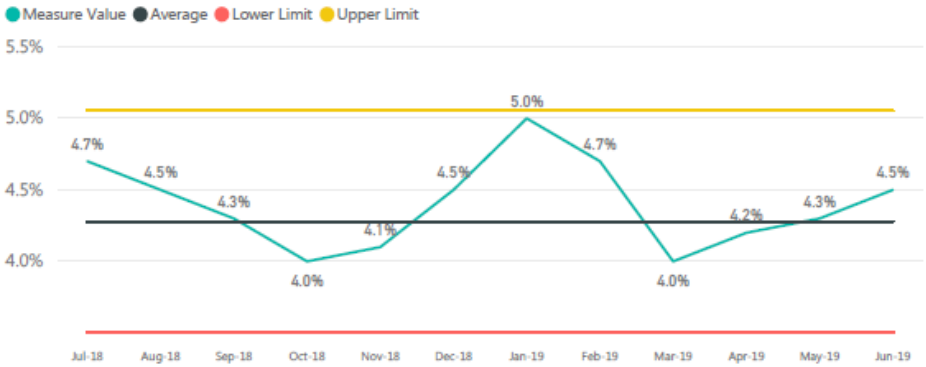
In addition to the above, the Trust is reviewing what training is required and how this will be delivered, it is currently ongoing and once we have a better understanding of the way forward we will provide an action plan.

Sickness Rate

June 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
3.8 %	4.5 %	↓	Janine Brennan

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
4.7 %	4.5 %	4.3 %	4.0 %	4.1 %	4.5 %	5.0 %	4.7 %	4.0 %	4.2 %	4.3 %	4.5 %

What is driving under performance?

Anxiety and depression plus pregnancy related absences are high. There are a high number of bullying and harassment cases across all divisions. Staff survey results suggests staff are experiencing an increase in MSK problems.

Actions completed in the past month to achieve recovery

Robust sickness management continues with support from the HR Business Partners and HR Advisors. The Respect and Support campaign is progressing with the Respect for Support telephone line up and running which will support staff.

Exception report written by

SansomB

Timeframe for recovery

April 2020

Assurance Committee

Workforce Committee

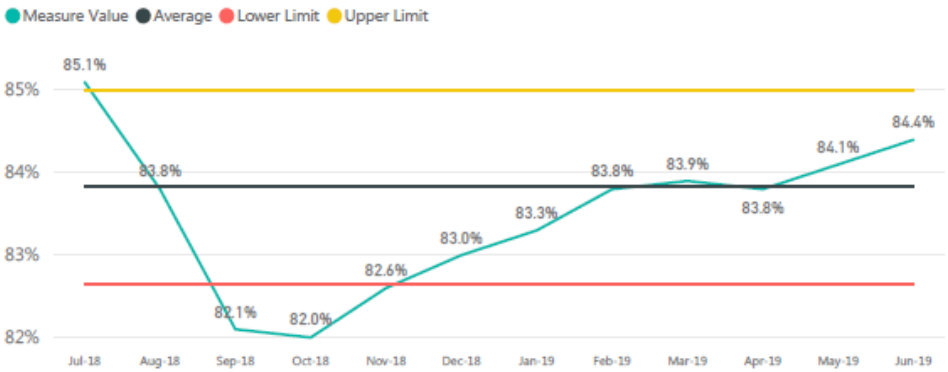
Next steps

Continue to manage sickness absence across all areas of the Trust. HR Business Partners to raise sickness as part of the divisional management meetings.

Percentage of all trust staff with role specific training compliance

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0 %	84.4 %	↑	Janine Brennan

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
85.1 %	83.8 %	82.1 %	82.0 %	82.6 %	83.0 %	83.3 %	83.8 %	83.9 %	83.8 %	84.1 %	84.4 %

What is driving under performance?

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

Actions completed in the past month to achieve recovery

Due to the number of positions being created each month, work continues on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely. Promotion on the importance of RSET is included in the appraisal training.

Exception report written by

SansomB

Timeframe for recovery

April 2020

Assurance Committee

Workforce Committee

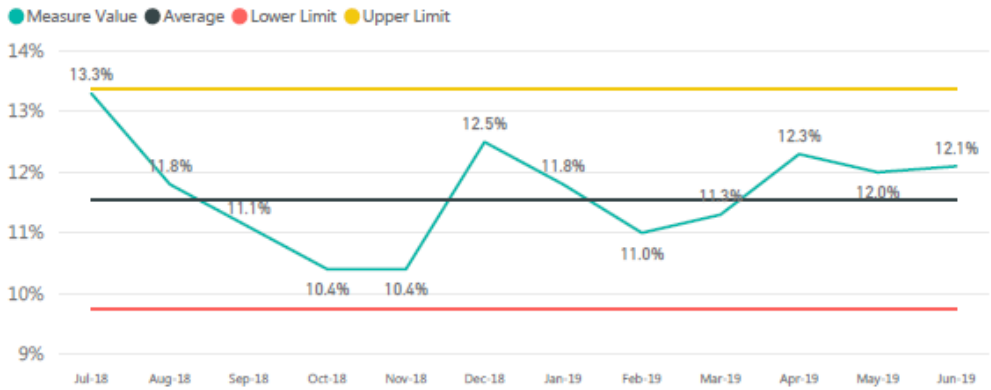
Next steps

HRBP's to raise importance of compliance at the DMT's Implementation by 2020 of employee self-service

Staff: Trust level vacancy rate - All

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	9.0 %	12.1 %	↓	Janine Brennan

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
13.3 %	11.8 %	11.1 %	10.4 %	10.4 %	12.5 %	11.8 %	11.0 %	11.3 %	12.3 %	12.0 %	12.1 %

What is driving under performance?

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

Actions completed in the past month to achieve recovery

Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

Next steps

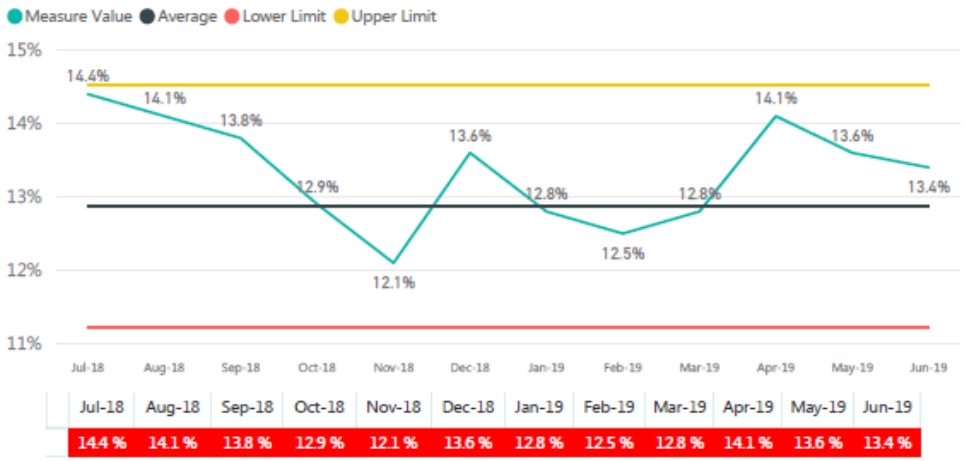
Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Staff: Trust level vacancy rate - Other Staff

June 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0 %	13.4 %	↑	Janine Brennan

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
14.4 %	14.1 %	13.8 %	12.9 %	12.1 %	13.6 %	12.8 %	12.5 %	12.8 %	14.1 %	13.6 %	13.4 %

What is driving under performance?

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

Actions completed in the past month to achieve recovery

Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

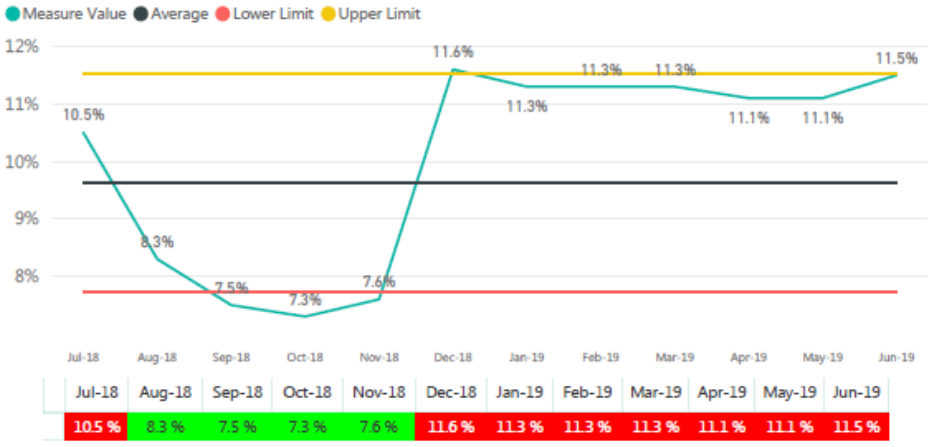
Next steps

Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Staff: Trust level vacancy rate - Registered Nursing Staff

June 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	9.0 %	11.5 %	↓	Janine Brennan

Performance vs Target



Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
10.5 %	8.3 %	7.5 %	7.3 %	7.6 %	11.6 %	11.3 %	11.3 %	11.3 %	11.1 %	11.1 %	11.5 %

What is driving under performance?

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

Actions completed in the past month to achieve recovery

Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

Next steps

Trust Open Days in difficult to recruit areas Nurses Recruitment KPIs are being redesigned Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits

Report To	**Trust Board**
Date of Meeting	**Friday 26th July 2019**

Title of the Report	**People and Organisational Development Strategy**
Agenda item	**14.1**
Presenter of Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Janine Brennan, Director of Workforce and Transformation
Purpose	To receive the updated overview of the developing People and Organisational Development Strategy. To consider whether an 'offer' of a money or monies worth benefit should be offered to staff as part of the engagement process and if so consider the financial value of this.

Executive summary

Following discussions at the June Board of Directors an updated overview, together with details on current interventions is attached in order to:

- Provide assurance on current activities and plans in place
- Outline future priorities, as previously developed
- Identify expected outcomes
- Identify dependencies.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 3.1, 3.2 and 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed

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

Actions required by the Board

The Board is invited to receive and comment upon the overview.

Trust Board Report
26th July 2019
People and Organisational Development Strategy 2019

1.0 Introduction

Following discussion at the Board of Directors on 27th May 2019, the strategic framework for the People and Organisational Development Strategy has been updated and details of current interventions and plans have been incorporated.

2.0 Overview

The purpose of the **people strategy** is to enable the creation **of a great place to work, learn, and care** where everyone:

- understands their role in delivering and improving care
- is trusted to do their job and is accountable and responsible for their work
- knows that caring for our people is as important as caring for our patients
- feels pride in what they do
- finds joy in working together.

Our current people strategy is built on 3 pillars:

- Building **capacity**: achieving the optimum workforce capacity to deliver the best possible care for our patients now and in the future
- Developing **capability**; developing the capabilities of our staff so they are able to deliver best possible care
- Shaping the **culture** to engage and energise our staff around best possible care.

The attached report sets out the agreed strategic imperatives against each pillar, a high level outline of current interventions and progress, an outline of future actions and anticipated high level outcomes, together with dependencies that will affect the ability to achieve the outlined priorities.

Further details of current initiatives are also given in more detail at appendix 1 which whilst not exhaustive, provides the board with more information on current interventions and rewards available to staff.

3.0 Staff Engagement

The plans for staff engagement have now commenced, with briefing session for Executives and senior leaders. Following discussions at the Board of Directors session a desire for some ‘offer’ of value be put to staff. This could comprise a range of options, but would be at cost, for example:

- Free car parking for staff cost circa £1m
- Freeday food-day (free lunch voucher every month) cost circa £250k.

The Board may therefore wish to consider if money or monies worth reward should be offered, and if so the potential value of funding that could be allocated. This would then be factored into the engagement process, seeking information from staff as to what would mean more to them.

4.0 Assessment of Risk

Staff engagement and motivation is a, if not the most, critical component for successful organisational performance and to achieve this requires effective leadership from the board down, investment in staff and the creation of a culture and climate where staff are able to give their best each and every day.

Failure to invest time, effort and resource to this end creates risks to delivery of organisational performance standards, patient safety and quality of service and financial fragility.

5.0 Recommendations/Resolutions Required

The Board is receive the report as set out above and determine if it wishes to consider the incorporation of extrinsic rewards as part of the engagement process and thereupon determine the financial amount to be allocated thereto.

6.0 Next Steps

The next steps will be to roll out the engagement process with staff, theme the outcomes from this and propose a final strategy to Trust board in October.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

People and Organisational Development Strategy 2020-2023 Overview
Best place to work, learn and care

Building Optimal **Capacity** to enable staff to deliver the best possible care

Strategic Priority	**Current Interventions and position**	**Future priorities**	**Expected Outcomes**	**Dependencies**
Reducing the number of trained nurse vacancies in core and specialist areas	Strategy: Local, National & International in place since 2015	Seek approval for investment to launch campaign to over-establish core and specialist trained nurses.	Zero to + 20 wte Elimination of agency cost Reduction in bank usage Reduced sickness absence Reduction in turnover.	Business case approval to pump prime up-front investment.
Develop & implement a proactive medical recruitment strategy	Plan in progress including establishment reviews to identify real gap, novel approaches such as conference sponsorship, early development of branding. Recruitment responsibility (non-training grades) currently devolved resulting in ad hoc, inconsistent approach, thus opportunity to improve.	Develop new CESR programmes together with a new Trust grade rotation programme with same benefits associated with doctors in training support & learning package based around the Derby model. Adopt a proactive and centrally managed approach to medical recruitment.	Significant reduction in medical staff vacancies. Reduction in agency cost. Centralisation of consultant and non-training grade posts recruitment bringing a planned and coordinated approach and greater visibility on progress and issues.	Funding to provide training & support package for CESR and rotations. Business case approval to centralise resources & provide a recruitment budget, and, if required, investment in additional posts to support rotational programmes.
Further develop our health and wellbeing initiatives to address staff	Comprehensive health and well-being strategy in place (see Appendix 2) covering physical and mental health programmes. Opportunities lie in expanding	Consult with services to target staff access to health and well-being interventions. Appointment of 2 Psychologists to support staff and develop	More staff accessing health & well-being interventions. Reduction in stress, anxiety, depression related	

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
sickness	the number of staff accessing the range of interventions. Main drivers of sickness are mental health and MSK. Counselling service and manual handling training in place. Purchased an electronic cognitive behavioural therapy (CBT) programme for staff.	greater awareness of self-management of mental health conditions and training managers to support staff with mental health conditions. Work with NHCP partners to maximise opportunities for sharing and promoting health and well-being.	sickness absence. Reduction in MSK associated sickness absence	
Improve staff retention	Retention plan in place for trained nursing staff. Recently introduced additional interventions e.g. careers clinics. Opportunity to develop a pro-active local retention programmes to target areas of high turnover.	Appointment of a HR people Solutions partner to focus on reducing turnover, particularly amongst nursing staff in core and specialist areas. This approach extends beyond the current retention approach in that the post holder will work within the wards and departments to identify key issues in a holistic way e.g. issues around staff engagement, leadership, ways of working and then work with local leaders to design, implement and measure local interventions. Adopt a broader reward strategy and Employer Value Proposition (EVP) based on feedback from	Reduced turnover in key areas. Improved staff engagement and morale. Improved 'attraction' for recruitment purposes (EVP)	Availability of resources for reward.

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
		staff engagement initiatives (see culture below). Develop and pilot flexible working options initially in nursing and then extending beyond.		

Develop staff **capability** to enable them to provide best possible care

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
Enriching the learning opportunities	A range of development in place for professional, technical, soft and personal skills supported by learning through doing programmes e.g. Making Quality Count (service improvement programme). Mandatory training programmes including stratification through a Mandatory and Role specific approach, utilising an innovative review of knowledge (ROK) model of delivery. Receive financial support from Health Education England to support training of professional staff, medical nursing, AHP etc.) plus non-professional staff groups e.g. band 2-4. New development programmes e.g. MSC in Quality Improvement.	Development of opportunities for staff to develop new roles/competencies to meet the health needs of tomorrows population. Developing comprehensive digital, AI and social media competencies to respond to evolution in the way health care will be delivered.	Best possible competent staff delivering best possible modern care.	Resources and skills to develop the workforce competencies of the future both professional and in support services and in new technology.
Develop and equip managers to meet core standards	Suite of Management development programmes in place internally and externally (mainly via NHS Elect and the	Develop new management standards and provide development to support this. Develop a new appraisal scheme	Improved performance (targets) and compliance with core standards. Improved staff survey.	May require further investment in management development or shift

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
	Leadership Academy). New feedback culture programme currently being rolled out for all managers. Staff survey results indicate concern with some aspects of management.	for managers to underpin the management standards, including a mandatory induction programme upon appointment to a management position.		of funding from other staff groups.
Developing a Talent Management strategy	Locally managed with good evidence of internal promotions, however no trust wide coordinated approach. Opportunity to implement strategic TM to enable NGH to tap into the potential skills of our current workforce and address future skills demand. Currently participating in the Leadership Academy Talent Management Diagnostic pilot. Future talent programmes in place e.g. Consultant Foundation programme and suite of external programmes accessed via NHS Elect.	Develop a Trust Talent Management strategy, pilot and roll out Trust wide. Develop a suite of programmes/development opportunities for those who are the talent of the future.	Identification of a Talent pool and succession plans in place. Improved retention of valuable, highly skilled staff.	Investment in funding to develop and retain those who are 'nearly ready'. Requires robust process of assessment to avoid exclusivity concerns, which requires competent, objective assessors of talent.
Enabling staff to access learning opportunities	Traditional on line (classroom based) and off line programmes supported by learning through doing programmes e.g. Making	Review current trends including 'lost tribes' and develop innovative approaches to development and utilise targeted	Key Performance indicators show access to development is across all staff groups, is relevant to	Likely to require investment in new technology and re-alignment of

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
	Quality Count (service improvement programme) Infrastructure in place to support professional development e.g. Director of Medical Education and Practice Development Team (Nursing and Midwifery) Concerns relating to access to training for some staff groups e.g. front line staff, junior doctors.	approach to key groups aligned to the Trust strategy and patient/organisational need.	their need and cost effective.	financial investment and trainers/development specialist support.

Creating a caring and inclusive **culture**

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
Leaders who's primary commitment is to enable their people to shine	Leadership Model in place with performance measured annually via the staff survey. Leadership model incorporated in management and leadership programmes. However, it has not been embraced across all managers and leaders, which provides an opportunity to achieve critical mass to signifcantly shift leadership competence across the whole trust, and extend beyond into our health care system. Staff survey results indicate concern with some aspects of leadership.	Take the current leadership model to the next level through: - Building trust through the concept of 'psychological contracts' - Identifying what motivates staff and what behaviours can disable their staff from giving their best - Engaging teams around developing annual team goals that set out a journey to what 'excellence' in that team looks like and feels like. Incorporating the leadership behaviours into the revised appraisal process for Managers (see developing capability). Leadership programme, based on outputs rolled out systematically.	Year on year improvement in perception of leadership behaviour measured via the staff survey. Improvement in leadership capability as measured through the appraisal process. Improved staff retention. Increased number and success of change. programmes both internally and as part of NGH contribution to change across the NHCP system.	Development of revised appraisal system for leaders/managers.
Creating a Working environment and climate where staff are enabled to give	Respect & support campaign launched 2018, recognised nationally as an innovative approach to addressing bullying & harassment, national toolkit	Next stage evolution of respect & support campaign to include targeted areas & address grade discrimination. Develop plans for addressing	Improvement in staff survey results, particularly in advocacy indicator (i.e. recommendation as a place to work).	Aligned financial and estates strategies and deliverables.

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
their best each and every day	based on NGH tools in graphic design stage for national roll out. Staff Equality and Diversity plan, monitoring and progress reports in place in line with our Equality duties. Training in place. Pilot on recruiting for difference in progress. Insights cultural deep dive for staff with protected characteristics in place, report being analysed. Estate infrastructure in place, new developments either in place e.g. Nye Bevan or underway i.e. new entrance project. Concerns relate to pressure of work due to vacancy rates (see Capacity), increasing volume and complexity of work, with limited financial resources, and in some areas physical space and lack of resources to deliver best possible care.	equality and diversity based on the outputs from the Recruiting for difference and cultural insights work. Create a working environment where motivation, satisfaction and engagement are understood and drive improvement, through a coaching and feedback culture(see developing capability) Enhance the reasons to stay (see capacity - Retention) Removing the barriers that get in the way of high performance (based on staff feedback from engagement interventions). Improving the 'offer' to staff in line with the National People plan but also in response to what staff tell us is important to them. Ensure that the Estate strategy incorporates capital and maintenance priorities that drive improvements for patients and provide an efficient & functional space for staff to deliver care, utilising Charitable		

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
		funds to support this, where appropriate. Ensure that the Trust, working with partners across the Northants Health system, receives appropriate activity and financial payment for the services it provides in order that the Trust is resourced to deliver this activity with the necessary staff, equipment and facilities to ensure that staff can deliver best possible care.		
Creating an inclusive engagement culture	Range of engagement interventions both regularly e.g. Core brief and ad hoc based on need e.g. focus groups on bullying and harassment. Staff Engagement strategy in place. Staff surveys in place. Concerns relate to engagement across the whole range of staff with some staff groups being hard to reach and/or not wishing to engage, therefore there is an opportunity to fundamentally change the culture by embracing	Roll out a summer of engagement whereby executives and senior leaders, together with experienced facilitators, reach out to all staff groups in their work environment to consult them on the shaping of the People strategy. Followed by a mirror image process to directly feedback to staff the details of the People strategy once developed. Introduction of Questback (technology led feedback process).	Improvement in staff engagement as measured through the staff survey. Awareness of and engagement with the new People strategy – staff are clear on our priorities and how we will implement and assess progress against those priorities.	Support of senior staff and investment in time to permit them to conduct engagement process.

Strategic Priority	Current Interventions and position	Future priorities	Expected Outcomes	Dependencies
	new methods of engagement.	Incorporate a system of staff engagement and feedback within revised management standards (see capability).		
Revolutionise our approach to key policies	A comprehensive suite of employment and other policies and processes in place, with some innovative/unique approaches e.g. SOSR employment, Probationary. However many of these are traditional, albeit designed around best practice and national codes of practice, and are thus designed to keep the trust 'safe' in terms of risk of litigation. In other words they are Trust focussed rather than employee focussed (benefit policies excepted).	Reviewing employment and other policies and processes using a 'through the looking glass' of our employees approach, and based on emerging evidence around behavioural neuro science, in a similar way to how we address serious incidents and safety breaches.	Improved perception of trust polices and the application thereof. Improvements in staff survey results. Improved retention of staff.	Support from Trade Unions (employment policies). Review of non-employment polices to ensure alignment and consistency of message.

Appendix 1

Development/reward/staff support currently in place		
Capacity	**Capability**	**Culture**
Health and well being	**Management/leadership Development**	**Respect & Support -Development**
Staff health checks	Francis Crick (band 8+)	Leading with respect
On site counselling service	James Stonhouse (team leader band 4-6)	Challenging bullying and harassment
Self referral physio service	Esther White (Band 7)	Courageous conversation
Lunch vouchers at flu time	NHS Elect Programmes	Resilience Training
Apprenticeships	Coaching skills	Team development e.g. Belbin
Workplace immunisations	Coach/mentor	**Respect & Support - Other Interventions**
Critical incident support service to access after traumatic individual or team cases	Influencing and negotiating	Round Table mediation
Weekly in-house slimming group Mission: SlimPOSSIBLE	Appraisal Training – performance conversations	Respect and Support hotline
Under 500 calorie healthy menus from our restaurants		Respect and Support reflection log
Weekly choir practice		Behavioural framework
Weekly lunch time and evening ballroom/Latin dance classes	**Quality Improvement**	Rainbow Risk/Arbingers Boxes
Menopause workshops	1 Making Quality Count -to learn and deliver quality improvement through lean methodology with an expert by your side to guide you and develop your learning	
Yoga sessions	2 Making Quality Count bitesize - As above but for staff that cannot commit to leaving the workplace for classroom time	**Other Interventions**
	3 MQC Clinic - A 4-week clinic/drop-in session to understand the pillars of our quality improvement methodology and to get expert	
Fast track physiotherapy service	help to make it successful	Values in Practice
Smoking cessation	Quality Improvement Training	Team charter development
Cycle to work scheme	Aspiring to Excellence - Medical Students	Team Analysis
Bike storage	Advanced Clinical leadership & management programme - registrars	Service diagnostic – 7S
Discounted membership to on-site gym		Performance prism – problem solving/change
Annual participation in Northamptonshire Sports Business Games	**Apprenticeship development**	Hawkins 5 C model for high performing teams
Fit in 50 seconds - to encourage desk bound staff to get moving	Business Administration Level 2 - mainly band 2 administration staff	Thomas Kilmann conflict styles
0-5k running group	Clinical Healthcare Support worker level 2 - HCAs brand new to post	Stakeholder mapping
Walking group	Senior Healthcare Support worker level 3	Appreciative Enquiry
Health and wellbeing newsletter	Healthcare Science Practitioner level 6 (degree)	
Health and wellbeing intranet pages	Nursing Associate level 5	
Health and wellbeing section in the weekly staff Bulletin	Operations Department Manager Level 5	
Stress management workshops	Pharmacy Services Level 2	
Sleep management workshops	Pharmacy Services Level 3	
Mindfulness workshops	Senior Leader level 7	
Nutrition and fitness programme	Registered Nurse level 6	
Pedometer challenges	Electrical engineering - level 3	
8 x picnic benches purchased to encourage staff to take a break outside	Plumbing & Heating level 2	
Promotion of National health campaigns and days (No Smoking day, Know Your Numbers week, Sun Awareness week, Stoptober, Dry January)		
Annual staff health and wellbeing event	**General development**	
Mental health awareness workshops for staff	Digital Academy	
Managing mental health in the workplace workshops for managers	Award submissions and presentations	
2-day Mental Health First Aid training courses	Communications	
Coming soon: Mental health champions launch	Consultant Foundation programme	
Coming soon: Drug and alcohol support workshop	Range of skills development ranging from developing strategy to assertiveness	
Coming soon: Suicide prevention workshop	Retirement workshops	
Coming soon: Loss and bereavement workshop	Maternity workshops	
Coming soon: Partnership with Northamptonshire Carers to introduce Carers passports	Change without migraines	

Development/reward/staff support currently in place		
Recruitment Relocation package Overseas nurses - flights, accommodation, fees e.g. OSCE Best of Both Worlds Introduce a friend Starting salary flexibility **Apprenticeships (see capability)** **Retention** Flexible working Special leave Study leave and professional leave careers clinics (nursing) Move them don't lose them (Nursing) Disability leave scheme Injury allowance 121 support for adoption and shared parental leave Pastoral Programme for Overseas Nurses and Doctors Payment of fees for overseas nurses e.g. OSCE **Roles/Experience** Work experience placements and career events Apprentices/Apprenticeship levy Ne roles e.g. Physicians Associates Nursing Associates **Reward & recognition** Pension including life insurance Child care voucher Financial loans Salary sacrifice - cars, home electronics, cycle to work, bikes, holiday scheme, nursery NHS benefits: discounts on shops, restaurants, holidays Bets possible Care awards Everyday hero awards daisy awards long service awards CEO thank you cards Christmas mince pie/fruit/drink voucher Winter hero's lunch voucher team NGH day Various engagement events Local initiatives e.g. ED golden Egg Boots discount (on site) Trilogy Gym discount Annual leave purchase Cavell star awards career days e/g/ ODP day, BMS day flexible working Clinical excellence Awards (Consultants)		

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**26 July 2019**

Title of the Report	**Equality and Diversity Workforce Annual Report 2018/2019**
Agenda item	15
Presenter of Report	Janine Brennan, Director of Workforce
Author(s) of Report	Sarah Kinsella, Corporate HR Officer
Purpose	Assurance that the equality agenda including the public sector equality duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Workforce Annual Report for 2018/2019 aims to demonstrate this compliance and provide assurance that the Trust is meeting its duty by reviewing the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2018 to 2019.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is monitored through the Equality and Diversity Staff Group with progress reports on the objectives.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? **No**

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 Equality Act 2010 (Gender Pay Gap Information Regulations 2017) NHS Constitution Equality Delivery Scheme (EDS2) Workforce Disability Equality Standard (WDES) Workforce Race Equality Standard (WRES)

Actions required by the Committee

The Workforce Committee is asked to endorse the content of the report.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Equality and Diversity

Workforce Annual Report April 2018 to March 2019

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Equality and Diversity

Workforce Annual Report

April 2018 to March 2019

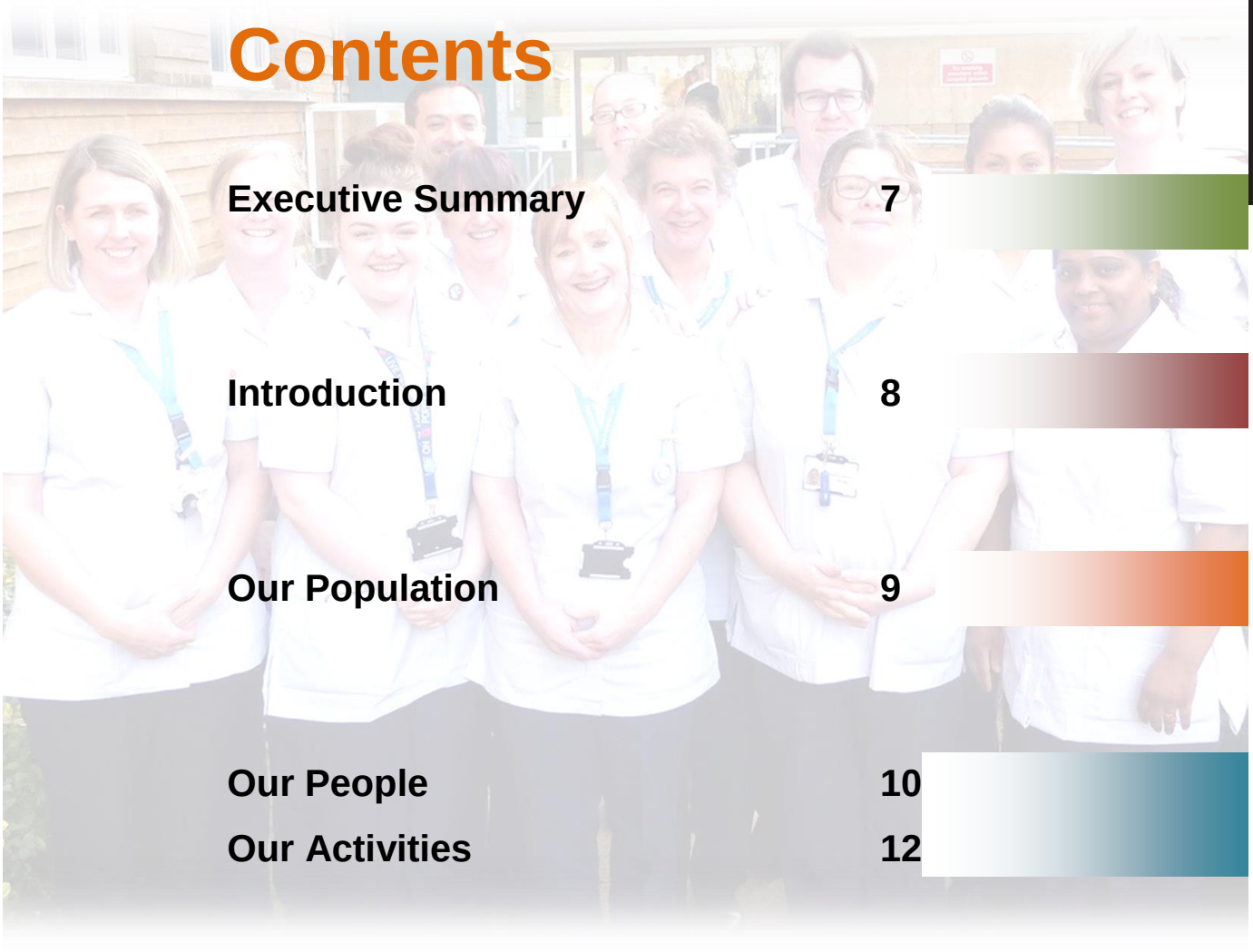
Our Vision and Values

Our vision is: To provide the best possible care for our patients

Our Values are:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect & support each other

Contents



Executive Summary

The Equality and Diversity Workforce Annual Report for 2018/2019 reviews the work Northampton General Hospital (NGH) has undertaken to promote equality and celebrate diversity within our workforce during April 2018 to March 2019. During the period that this report covers we continued to work to and review our progress against our Equality Objectives/4 Year Plan.

We have been undertaking a significant programme of work around our value of respecting and supporting each other with particular focus on behaviours such as bullying and harassment, which has strong ties to equality and diversity, as we recognise a respectful workplace is inclusive and values diversity. We are also piloting ways of building inclusivity into our recruitment processes.

In addition we undertook, for the second time, our Gender Pay Gap Report and published it in line with the 2017 legislation and compared the experiences of our BME staff to those of our White staff through the NHS Workforce Race Equality Standard. We will be looking at the results more closely during 2019/2020 to see what the Trust can do to make improvements.

We continued the implementation of our Health and Wellbeing Strategy, with a strong focus on mental health and wellbeing during 2018/2019, which included working closely with MIND.

There were some deteriorations in our 2018 National Staff Survey results for the elements of the survey that relate to equality and diversity. We shall be looking to establish where improvements can be made and our Equality Objectives/4 Year Plan will support this work. We are also refreshing and revising our people strategy to ensure that there is a stronger emphasis on inclusivity and the value that brings to the organisation and our board.

Dr Sonia Swart
Chief Executive

Alan Burns
Chairman

Introduction

Northampton General Hospital believes that Equality, Diversity and Inclusion is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential.

Diversity is about recognising and valuing difference and we aim to support our staff in a responsive and appropriate way to meet the diverse needs of the different groups and individuals we employ, because well supported staff can deliver better care for our patients. Our staff are our greatest resource and we work to actively promote a culture that encourages their richly diverse talents to lead services that deliver inclusive care.

To achieve this aim we want to ensure that our staff are not subject to any form of discrimination or unequal treatment. All staff can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work we do at the Trust, supported by our value of 'We Respect and Support Each Other'.

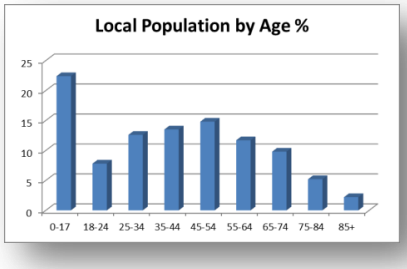
It is important to us that we do not discriminate unlawfully in the way we recruit, train and support our staff. We do not tolerate any forms of unlawful or unfair discrimination and recognise that all people have rights and entitlements by law.

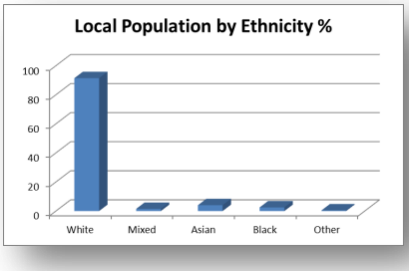
Further information regarding Equality and Diversity can be found on our website at
http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

Our Population

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 692,000. The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

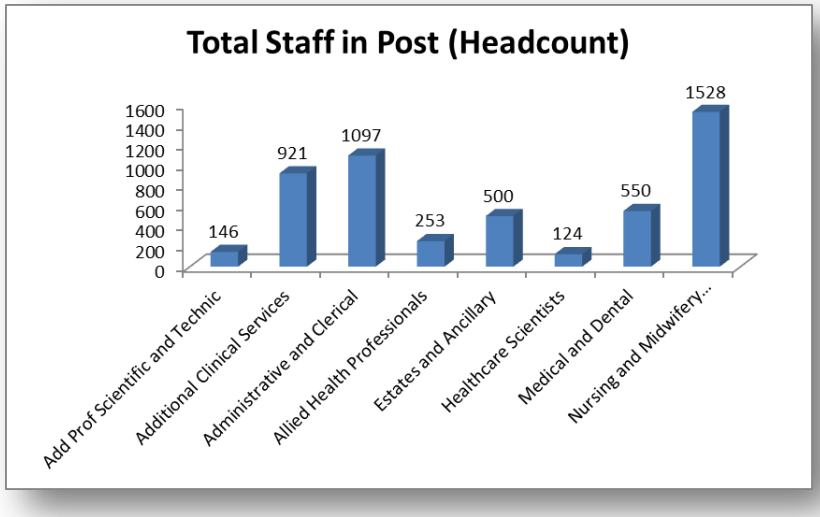
The principal activity of the Trust is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

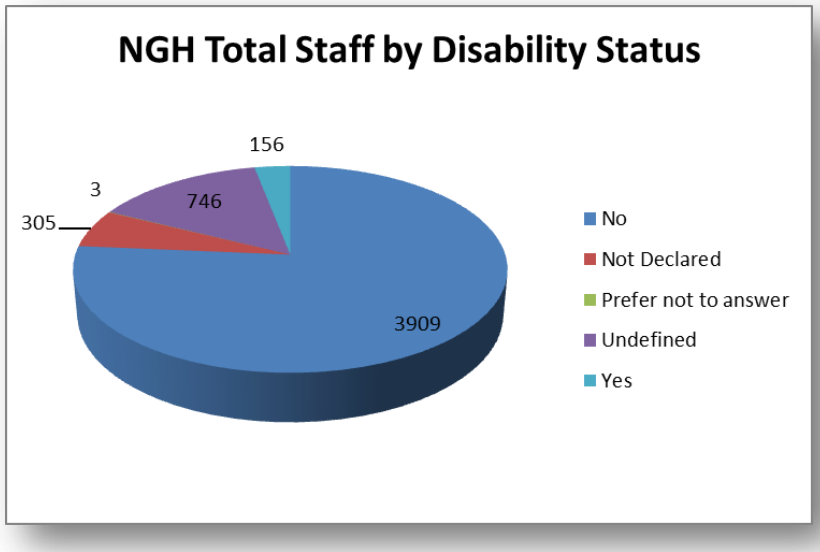




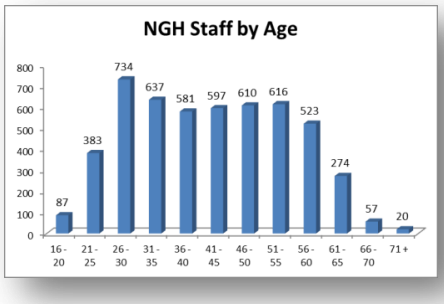
Our People

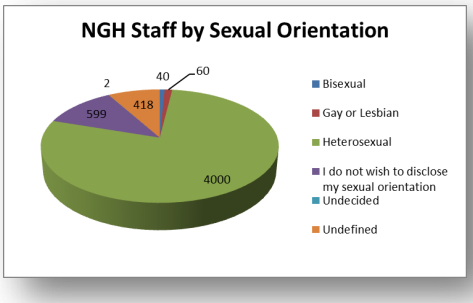
The Trust employs 4510.58 whole time equivalent (wte) members of staff, a headcount of 5119 people, (as at 31 March 2019).

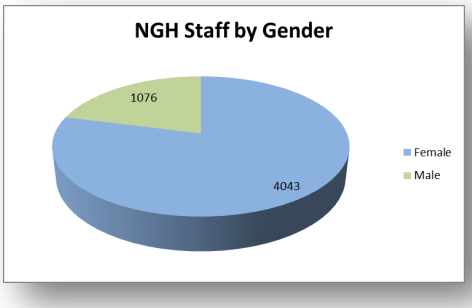


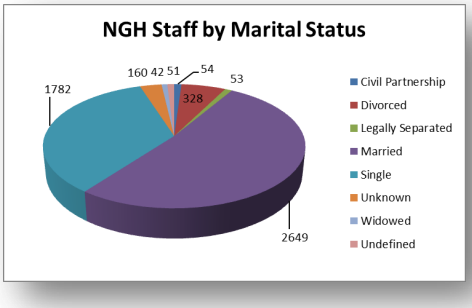


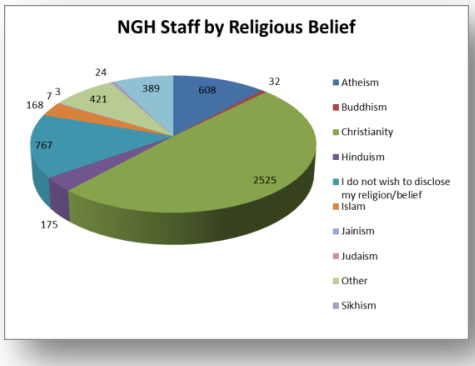
Chairman: Mr Alan Burn
Chief Executive: Dr Sonia Swart

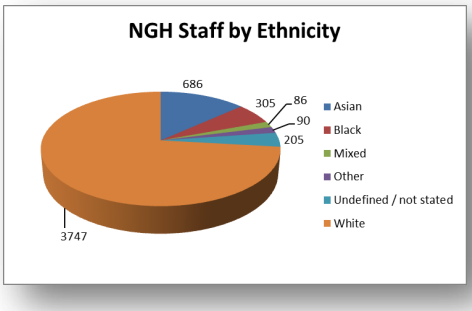












Chairman: Mr Alan Burn
Chief Executive: Dr Sonia Swart

Our Activities

NHS Equality, Diversity & Human Rights Week – 14 to 18 May 2018

The 14 – 18 May 2018 was the seventh NHS Equality, Diversity and Human Rights Week (#EQW2018).

Co-ordinated by NHS Employers, #EQW2018 is a national platform to highlight creating a fairer and more inclusive NHS for patients and staff.

The theme was once again **diverse, inclusive, together** to continue to reflect the move across the health and social care sector towards collaboration and integration. Working together makes the NHS stronger, we meet standards, enable change and collectively invest in the creation of a diverse and inclusive NHS workforce to deliver a more inclusive service and improved patient care.

Was asked our staff to think about how what they do on a day to day basis and how it can support us to be diverse, inclusive and together organisation.

Support for Staff becoming a Parent

During 2018/2019 we continued to provide support for staff becoming a parent to ensure that they are aware of their rights and entitlements. In addition to our Maternity, Paternity, Adoption and Shared Parental Leave Procedure we have a dedicated member of staff who can provide support and advice to individuals, who are applying for these types of leave, and their managers.

Workshops are run for staff who are pregnant to provide additional support and information. For other parenting leave such as adoption or shared parental leave individuals are seen on a one to one basis.

During the 12 month period that this report covers:

169 members of staff commenced maternity leave
31 members of staff commenced paternity leave
2 members of staff commenced shared parental leave.

Supporting Our Staff to Breastfeed

As a fully accredited Baby Friendly Hospital, we aim to help our staff to continue to breastfeed, if that is their wish, by promoting breastfeeding to our pregnant staff through our Maternity Workshops.

Breastfeeding has lots of benefits for a new mother and for their baby as well and we want staff to feel that they can continue breastfeeding when they return to work.

Support for Our Retiring Staff

Each year we run pre-retirement seminars for staff that are looking to retire within one to four years' time. The seminars help staff to prepare and plan for their retirement and covers aims and concerns, financial matters, inflation, taxation, investments, wills and equity release. In addition staff can also join the NHS Retirement Fellowship, which is a social, leisure, educational and welfare organisation for current and retired NHS and Social Care staff and their partners.

More than 16% of our workforce are over the age of 55, so these seminars prove useful for many of our staff.

Equality Analysis

We continued to undertake Equality Analyses to ensure that our services, plans, policies and procedures, continue to meet our public sector duties and give 'due regard' to ensure that everyone who works here or uses our services are treated fairly, equally and free from discrimination.

From April 2018 to March 2019 we completed 89 Equality Analyses.

We have also under taken a review of our Analysts over the last 12 months and organised for some further training to increase the number of staff that can review our procedural documents, together with ensuring that our business cases give greater consideration to equality.

Workforce Race Equality Standard (WRES)

We undertook our fourth WRES exercise in 2018 and it was submitted to NHS England and published on our website in September 2018.

There was improvement in some areas from 2017, such as an increase in the number of Black Minority Ethnic (BME) staff who work for us, along with a reduction in the likelihood that a BME member would be more likely to enter a formal disciplinary process than a White member of staff.

Deteriorations from the previous year were seen for BME staff reporting bullying, harassment or discrimination and a reduction in the number of BME staff who believe we provide equal opportunities for career progression or promotion.

The National WRES Report was released in January 2019 and when comparing our results to the national results we have more positive results for over half the indicators. The areas where our results are below that of the national results is for the same areas where we have deteriorated since 2017.

Our WRES Data Reports can be found on our Trust website.

Workforce Disability Equality Standard (WDES)

In the autumn of 2019 NHS England will be introducing the Workforce Disability Equality Standard (WDES). This is a set of key indicators which we will be measured against, from the data we hold for staff, to compare the experiences and treatment of our disabled staff compared to our non-disabled staff. We will then use the information to identify if there are any areas of concern that we need to investigate further to improve the experiences and treatment at work of our disabled staff.

During 2018/2019 we have been encouraging staff who have a disability to make us aware so we can ensure that they have the access to any support that they require, but to also enable us to make sure our records are correct so the outcomes of our analysis when we undertake the WDES for the first time give an accurate reflection of the experiences of our disabled staff.

Diversity by Design

In 2019 we commenced 'Diversity by Design'. In March 2019 a number of focus groups, for staff with protected characteristics, were run to get their views on working at the Trust. The information gathered from these groups will be analysed to see what improvements we can make for our staff to ensure that we are an inclusive workplace, for all staff regardless of their protected characteristics.

In addition we will be piloting alternative recruitment techniques to work towards removing unconscious bias during recruitment/interviews of applicants.

Equality & Diversity Group – Staff

Our Equality and Diversity Staff Group (EDSG) continues to meets on a quarterly basis. The purpose of the group is to champion and steer the work of the hospital so that we are in full and positive compliance of equality and human rights legislation, regulations and codes of practice including NHS and Department of Health standards.

The aim of the group is twofold, firstly to lead, advise and inform on all aspects of policy making, and employment including various engagements related to equality and inclusion legislation and policy direction. The second EDSG aim is to lead and monitor progress on the development of the Equality Objectives/Four Year Plan. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce:

A representative and supported workforce –

"We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing the Workforce Race Equality Standard (WRES) and monitoring outcomes."

Inclusive leadership -

"We will improve our leadership and management capability."

The key actions for each objective are linked to the Workforce Race Equality Standard (WRES), health and wellbeing, staff survey results, divisional objectives and the leadership and management development programme.

During 2019/2020 we will be reviewing our key actions to ensure that they are fit for purpose, meet the needs of the Trust, and continue to link to our analysis and findings from our most recent staff survey results and our findings from the annual WRES, WDES and Gender Pay Gap Reporting exercises.

Equality & Diversity Policies

Underpinning our Equality & Diversity Strategy and the objectives are a number of workforce policies and procedures that support our day to day work, some of which have specific connections to the Equality Act 2010, namely:

- Bullying, Harassment & Victimisation
- Employment of Staff with a Disability
- Flexible Working
- Maternity, Adoption, Paternity and Shared Parental Leave
- Recruitment, Selection & Retention
- Supporting and Managing Workforce Sickness Absence.

A number of these have been reviewed during 2018/2019 to ensure that they are up-to-date and in line with current legislation and best practice.

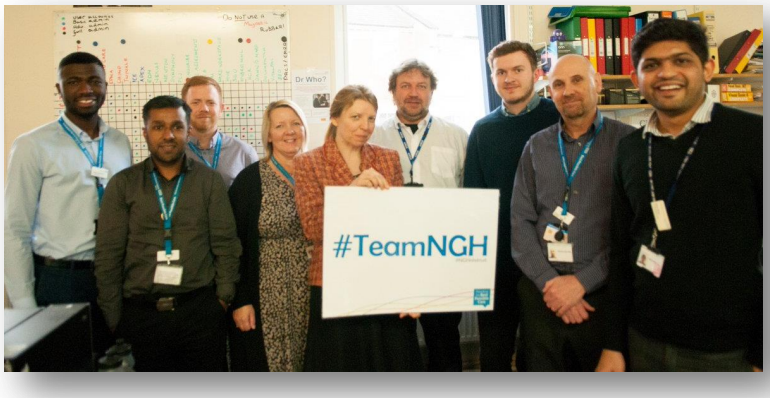
All our Human Resources procedural documents advise that our policies and procedures will be applied fairly and consistently to all employees regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation, whether working full or part-time or whether employed under a permanent, temporary or fixed-term contract.

Gender Pay Gap Reporting

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) we compiled our data for the second time, since the regulations came into effect. In December 2018 the approved report was published on our website and submitted to the Government in January 2019. Although we are not legally required to produce a written report it was agreed we would do this to give context to the data. The report can be found on our website

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

There has been a small improvement when comparing it to the results of the previous year and we will be looking at the results more closely during 2019/2020 to see what we can do to reduce the gap even further.



Disability Confident Scheme Certification

We are certified as a Disability Confident Employer (formally Positive about Disabled People 'Two Ticks' Scheme) and as a result of this we commit to:

- Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to disabled people who meet the minimum criteria for the job and making reasonable adjustments as required.

- Keep and develop our staff - which includes supporting our staff to manage their disabilities or health conditions.

Along with ensuring that our recruitment processes are accessible and fair, we also encouraged our existing staff, that have a disability, to make us aware so that we could meet with them and discuss what support could be provided, if required. Knowing which of our staff have a disability also enables us to record the number of disabled staff that we have and the nature of their disability, in line with the Data Protection Act.

During 2019/2020 we will be looking at working towards attaining the next level of certification, which is a Disability Confident Leader.

Our Value of Respect and Support

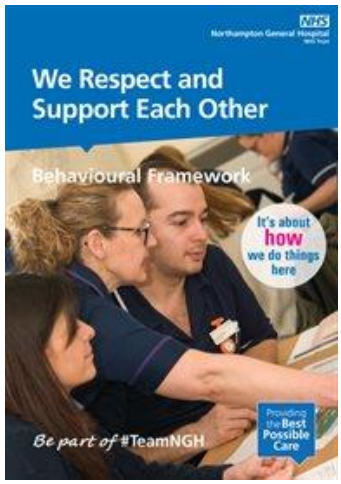
During 2018/2019 we have been undertaking lots of work around our value of respecting and supporting each other with particular focus on behaviours such as bullying and harassment, which has strong ties to equality and diversity, as we recognise a respectful workplace is inclusive and values diversity.

Work that has been undertaken includes:

- The development by more than 800 members of staff of a Behavioural Framework, which is a set of core behaviours based on our value of respect and support. They define 'how' we are expected to approach our work and sit alongside 'what' we do as outlined in each of our job descriptions.

- Training workshops, one for staff and one for managers, have been developed to address workplace bullying and inappropriate behaviours. Each of the workshops use a combination of classroom-based, interactive style training with Forum Theatre to cover how we address these behaviours, and set actions towards building a respectful and supportive environment. Two workshops are being offered, one for managers and one for staff.

- A redesign of part of our induction for new starters to ensure that there is a greater focus on equality and diversity and its link to the value of respecting and supporting each other along with what the role of staff is to ensure that everyone's behaviours are positive and inclusive.



This work will continue during 2019/2020.

National Inclusion Week 2018

During National Inclusion Week 2018, Leanna Denis, Deputy Team Lead / Highly Specialised Physiotherapist from the Community Stroke Team (in the centre of the picture) represented the Trust on a panel discussion, in partnership with St Andrews Healthcare.

Leanne said “I was honoured to be asked to be part of a panel discussion in conjunction with St. Andrews Healthcare for national inclusion week. National Inclusion week is an event created and run by Inclusive Employers and is an annual opportunity to raise awareness of inclusion in the workplace. The panel discussed their career highs and lows and gave advice for those trying to develop their career and future aspirations.”

“It was acknowledged that to develop your career when you are from a BAME background can be challenging but there are opportunities within and outside the Trust and mentors available to assist also. The opportunity to hear and share our stories was inspirational and the event will be held again for all staff in the near future.”

Our thanks to Leanna for representing Northampton General Hospital NHS Trust at this event and sharing her views and experiences with others to raise awareness.

Supporting our Staff who are Transgender

During 2018 we launched a Transgender Policy to support our transgender staff, patients and visitors. The policy gives guidance on the expectations and other considerations that may be necessary for our transgender staff and patients to ensure that they are treated with dignity and respect by all and what support we can offer staff if they are proposing to go through gender reassignment or to live as the opposite gender.

Faith and Belief

As one of the largest employers in Northampton our staff have many different religious beliefs, some of which have specific festival periods or Holy Days throughout the year.

Although there is no right that guarantees staff time off to attend religious services, we do recognise that it is good practice to accommodate requests where possible. To support with this we have been making our managers aware of key dates for religious observance and providing them with information to help them better understand the needs of our staff in relation to their religion or beliefs. Religious, spiritual and pastoral care is offered to patients, visitors and staff of all faiths and none and is a valued part of care within NGH.

The hospital has two chaplains and a team of 12 volunteer pastoral visitors. The chaplains regularly visit the wards and are always happy to offer support or a 'listening ear'. Hospital Chaplains have a duty of care not only for the patients, but also the whole for the whole hospital community, including staff, visitors and friends.

A Hospital Chaplain is always open for people of all faiths and none, to support them in their religious and spiritual journey. The Chapel is always open and can offer a refuge and sanctuary for prayer, reflection and meditation for staff, patients and visitors.

Staff Survey 2018 Equality & Diversity Results

The 2018 annual National NHS Staff Survey took place during October to December 2018 and 2,133 members of staff returned the survey. Of the 10 themes there was improvement in one and deterioration in six. Two stayed the same and one theme could not be compared.

The demographics of the staff that responded when compared to our workforce profile were broadly similar with the exception of disabled staff where 19% of the respondents identified they were disabled compared to the 3% of the our workforce recorded on the Electronic Staff Record (ESR).

Within the Staff Survey there are four specific questions about equality and diversity. The first question is in relation to the percentage of staff believing that we act fairly in relation to career progression and promotion. This result has deteriorated from 85.9% in 2017 to 83.4% in 2018. We are also slightly below average when compared to other acute trusts by 0.5%.

The question relating to personally experiencing discrimination at work in the last 12 months from patients/service users, their relatives or other members of the public has deteriorated from 6.2% to 8.4% in 2018. The national average when compared to other acute trusts is 6.1%.

The same question, but for managers, team leaders or other colleagues was 9.4% in 2017, but has risen to 10.2% for the 2018 survey. We are again above the national average which is 7.7%

Improvement was seen in the final question that asks if adequate adjustments have been made in order to enable staff to carry out their work. Our 2018 result was 76% up from 68.5 in 2017. We are also above the national average for acute trusts which is 72%.

The survey has highlighted some areas of concern and we will be working with our teams to analyse the results more deeply in order to continue our work in ensuring all our staff are focused on our values, by displaying positive behaviours, high quality care and striving for continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Health and Well Being for Staff

The working environment of an acute Trust is demanding and can be pressurised, therefore promoting a culture of health in our organisation has never been more important. Our staff are our biggest asset, they are committed to patient care and their physical and emotional wellbeing is central to good organisational performance.

As a Trust it is important that we ensure staff are resilient in terms of being engaged, valued and supported. There is lots of evidence around to show that happy engaged staff leads to improved patient care and the patient experience.

Over the past 12 months we have promoted a range of opportunities for staff to learn more about our plans to improve and invest in their health and wellbeing. We have provided practical options for staff to participate in, with the emphasis of providing them with visible and tangible initiatives to highlight the importance the hospital places on the wellbeing of our staff – some of which are:

Live Life... Live Well

- Mental health awareness workshops for staff and managers
- Resilience training
- Mindfulness, sleep and stress management workshops
- Occupational health service including counselling, health checks and workplace immunisations
- Critical incident support service to access after traumatic individual or team cases
- Dedicated Twitter page to promote health and wellbeing awareness and events
- Weekly in-house slimming group Mission: SlimPOSSIBLE which provides weight management advice and support for staff
- Health and wellbeing awareness events for staff
- Promotion of national awareness days including stop smoking day and world mental health day
- Health and wellbeing prize draws
- Under 500 calorie healthy menus in our restaurants
- Staff picnic benches
- Weekly choir practice
- Weekly lunch time and evening ballroom/Latin dance classes in partnership with Top dance
- Menopause workshop
- Yoga sessions
- Fast track physiotherapy service
- Stop smoking cessation for staff
- Cycle to work scheme
- Improved and additional bike storage facilities
- Discounted membership to on site Trilogy gym
- Participation in Northamptonshire Sports Business Games
- Participation in Workplace Challenge

Live Life... Live Well

Mental Health Awareness

Throughout 2018 MIND mental health awareness workshops have been held along with resilience training - delivered by Organisational Development. These workshops form part of an overall package, along with a range of initiatives to address the issues around inappropriate behaviour and bullying and makes up our Respect and Support campaign.

Over the past 12 months we have held 13 Managing Mental Health in the Workplace workshops, delivered by MIND to help managers learn how to recognise when a staff member is struggling, how they can support them and to equip managers with the skills they need to help them feel confident in having potentially difficult conversations with their staff.

To complement these workshops we have also held 7 Mental Health Awareness workshops for all staff delivered by MIND. The workshop aim is to raise awareness of mental health and to recognise the causes, symptoms and support options for a range of common and less-common mental health problems.

In total **240** staff members have attended a MIND Mental Health Awareness workshop and **185** managers have attended a MIND Managing Mental Health in the Workplace workshop during 2018.

In May *Wellbeing 4 You* drop in event for staff was held in the large hall of the post graduate medical centre to coincide with Mental Health Awareness week. The event included a free prize draw to win a spa day, health checks, Indian head massages, express mini facials, MIND advice and support, crystal healing, Solve It, Northants Police plus staff had an opportunity to make their own smoothie on a smoothie bike. **152** staff members attended. To complement the day 4 x 15 minute mindfulness sessions and a 1½hour resilience workshop were held.

Live Life... Live Well

Evaluation and Feedback

All health and wellbeing initiatives are subject to evaluation, using questionnaires and feedback forms at each event/initiative. The overall feedback from these evaluations has indicated a very positive response from staff. In addition we undertook a hospital-wide health and wellbeing survey during 2018.

Below is a snap shot of the 2018 health and wellbeing survey results compared to the first health and wellbeing survey from 2015.

91% of staff aware of positive action taken to promote health and wellbeing compared to 16% in 2015

40% of staff exercise 2-3 times a week compared to 32% in 2015

7% of staff drink alcohol 4 or more times a week compared with 11% in 2015

24% of staff never drink alcohol compared to 16% in 2015

7% of staff smoke compared to 13% in 2015

Live Life... Live Well

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Health and Wellbeing @ NGH

Quotes from staff using our health and wellbeing initiatives:

"The first mental health awareness workshop here at NGH was the start of me really realising I need to look after myself, I'm no good to others if I'm not managing myself"

"I just wanted to say what a good training session the mental health workshop was. I think it was the fact that the trainer was so passionate about the subject. It was really well presented and very thought provoking"

"The more we can raise awareness the easier it will be for people to admit they have issues"

"We all get stressed at work and find it hard to deal with but the resilience workshop gave us some ideas of things you can have in place to help you cope and bounce back more effectively.

"Feel really good about working for NGH with its commitment to our health and wellbeing, loads of support for exactly when you need it. Plus fun things to do to keep a fit body and mind!"

"The staff who attend Mission: SlimPOSSIBLE are really supportive, and it's great talking to people who have the same struggles, we can then all support and motivate each other".

"Dancing has been amazing, it gets me energised and motivated"

"I just wanted to say, the yoga session was amazing, it was fast, but I was guessing we would learn to speed up! I felt really euphoric afterwards, I'm sure the mediation at the end helped that!"


#TEAMNGH
#TeamNGH

Northampton General Hospital

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Report To	**TRUST BOARD**
Date of Meeting	**26 July 2019**

Title of the Report	**Equality and Diversity Workforce Monitoring Report 2018/2019**
Agenda item	16
Presenter of Report	Janine Brennan, Director of Workforce
Author(s) of Report	Sarah Kinsella, Corporate HR Officer, HR Business Partners, Head of HR Services, Learning & Development Manager
Purpose	Assurance that the equality agenda including the public sector equality duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Workforce Monitoring Report for 2017/2018 aims to demonstrate this compliance and provide assurance that the Trust is meeting its legal duty to monitor our workforce by the protected characteristics.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is monitored through the Equality and Diversity Staff Group with progress reports on the objectives.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for

	all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 Equality Act 2010 (Gender Pay Gap Information Regulations 2017) NHS Constitution Equality Delivery Scheme (EDS2) Workforce Disability Equality Standard (WDES) Workforce Race Equality Standard (WRES)

Actions required by the Committee

The Workforce Committee is asked to endorse the content of the report.

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Equality and Diversity Workforce Monitoring Report 2018/2019

CONTENTS

EXECUTIVE SUMMARY

The Equality and Diversity Workforce Monitoring Report for 2018/2019 provides analysis of the data that the Trust holds in relation to its workforce.

Northampton General Hospital (NGH) has a legal duty to promote equality of opportunity, foster good relations and eliminate harassment and unlawful discrimination. As part of our legal duty we must prepare and publish equality information annually comprising of an equality profile of our staff.

Our legal duty to monitor our workforce is addressed in this document. The report provides information for most of the protected characteristics in the following areas:

- Trust's Workforce Profile
- Recruitment Activity
- Employee Relations Caseload Activity
- Learning and Development Activity.

INTRODUCTION

Northampton General Hospital believes that Equality and Diversity is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential.

Diversity is about recognising and valuing difference and we aim to support our staff in a responsive and appropriate way to meet the diverse needs of the different groups and individuals we employ, because well supported staff can deliver better care for our patients. Our staff are our greatest resource and we work to actively promote a culture that encourages their richly diverse talents to lead services that deliver inclusive care.

To achieve this aim we want to ensure that our staff are not subject to any form of discrimination or unequal treatment. All staff can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work we do at the Trust, supported by our value of 'We Respect and Support Each Other'.

It is important to us that we do not discriminate unlawfully in the way we recruit, train and support our staff. We do not tolerate any forms of unlawful or unfair discrimination and recognise that all people have rights and entitlements by law.

Further information regarding Equality and Diversity can be found on our website at http://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx

OUR POPULATION

Northamptonshire has an estimated population of 741,000, with Northampton having an estimated population of 225,700, which in an increase of 10,527 from the 2011 census was 215,173.

The latest Health Profile for Northamptonshire (Public Health England, 3 July 2018) describes 32 indicators, most of which are related to health and lifestyle.

Northamptonshire is significantly worse than the England average for the following:

- Killed and seriously injured on roads
- Hospital stays for self-harm
- Hospital stays for alcohol related harm
- Physically active adults (aged 19+)
- Excess weight in adults (aged 18+)
- Smoking status at time of delivery of a child
- GCSE's achieved
- Violent Crime (Violent offences).

Northamptonshire Population (2011 Census)

Ethnic Group	Religion	Marital Status	Age Group	Gender
White 91.48%	Christian 59.9%	Single 29.2%	0-17 22.5%	Male 49.3%
Mixed 1.51%	Buddhist 0.3%	Married 41.4%	18-24 7.8%	Female 50.7%
Asian 4.04%	Hindu 1.2%	Civil Partnership 0.2%	25-34 12.6%	
Black 2.53%	Jewish 0.1%	Separated 5.3%	35-44 13.5%	
Other 0.43%	Muslim 1.7%	Divorced 14.3%	45-54 14.8%	
	Sikh 0.4%	Widowed 9.6%	55-64 11.7%	
	Other 0.4%		65-74 9.8%	
	No religion 29.2%		75-84 5.2%	
	Not stated 6.7%		85+ 2.2%	

EQUALITY ANALYSIS

Identifying and responding to the effect of the activities of the Trust on the different protected groups of staff remains of fundamental importance in the context of giving due regard in line with our Public Sector Equality Duties.

Equality Analysis remains a key component in delivering quality services and support to staff which meets the needs of all and ensures that employees are not excluded. The Trust continues to utilise its systems for Equality Analysis on policies, procedures, plans and programmes of change, to assess whether they have the potential to affect staff differently. This process identifies and addresses real or potential inequalities resulting from policy, practice or service development.

Where it is identified that a particular group or section of staff will be, or could be disadvantaged the Equality Analysis processes ensures that the Trust is able to:

- Remove or minimise disadvantage experienced by people connected to 'protected characteristics'
- Take steps to meet the needs of people who share a protected characteristic where these are different from people who do not share it
- Encourage people who share a protected characteristic to participate in work activities or any other activity where participation is disproportionately low.

From April 2018 to March 2019 the Trust completed 89 Equality Analyses.

During 2018 we also reviewed our processes around equality analysis to ensure that they are fit for purpose and continue to meet our responsibilities under the Equality Act 2010.

WORKFORCE PROFILE – APRIL 2018 to MARCH 2019

The following analysis contains quantitative information from the Electronic Staff Record (ESR) for the year ending 31 March 2019 relating to:

- Staff in Post by pay band/grade
- Sickness episodes by pay band/grade
- Leavers by pay band/grade.

Information relating to recruitment, employee relations caseloads and learning and development activity is provided separately within the monitoring report.

Where possible the information has been analysed against the following protected characteristics:

- Age
- Disability
- Ethnicity
- Religious Belief
- Sex
- Sexual Orientation
- Marital Status

Where possible our workforce demographic profile has been compared to that of the local population which we serve.

Workforce Profile by Pay Band / Grade

It is obviously important that the data we hold for employees relating to protected characteristics is as complete as possible in order to draw meaningful conclusions from any analysis.

In some areas the level of completeness of data is very high; over 96.03% of employees have declared their ethnic origin recorded, and a slightly smaller percentage (95.88%) have declared a marital status. Sex and age are recorded for all employees. Disability information has always been poorly recorded; 20.53% have not declared their disability status, which is an improvement on the reported figure in 2018 of 20.30%. Sexual Orientation and Religious Belief were not collected until relatively recently, and as a consequence employees who have been with the Trust for many years will often have nothing recorded against these criteria. This results in 19.67% of employees who have not declared their Sexual Orientation, together with 7.60% with no declaration of their Religious Belief.

N.B. For the purposes of the above if an individual has stated they would prefer not to declare, this has been counted as a declaration for the protected characteristics referred to.

Appendix 1 provides the data tables for detailed information regarding the workforce profile by protected characteristics for pay bands/grades.

Protected Group	Analysis
Age	When compared to the Northamptonshire population, the percentage of staff aged between 25 and 54 is significantly higher. However given that the Northamptonshire population covers children (0-17 – 22.5%) one would expect a higher proportion of staff to be aged between 22 and 54 than would be seen within the local population.
Disability	Only 2.96% of the NGH workforce has disclosed a disability. According to PANSI (Projecting Adult Needs & Service Information) the projection of Northamptonshire population aged between 18 and 64 likely to have either a moderate or serious disability is 7.9% and 2.4% respectively. However 23.3% of the workforce do not have a disability status recorded; if this data was complete the rate would probably increase but still be well below the local population estimated rate. In addition of the staff that complete the annual NHS staff survey approximately 20% of them indicate that they have a disability, so it is known that there is underreporting of disabilities on ESR (Electronic Staff Record). The physical nature of most work in the healthcare sector could help to explain the low representation of disabled people in the NGH workforce.
Sex	The NHS workforce is predominantly female, and at NGH the percentage is 79.02%. However the percentage of male employees is higher than the total for all staff, (20.98%) in the Agenda for Change band 8a – 9 group, at 35.46%, which is a small increase since reporting in 2016/2017. Within the medical & dental staff group 59% are male.
Ethnicity	According to the 2011 Census, the Northamptonshire population was 91.5% white, 8.5% Black & Minority Ethnic (BME), whereas the Trust employees (as at 31 March 2018) were 75.06% white (of which 67.8% were British or Irish), 21.36% BME. The overall percentage of BME employees is boosted by the high representation of this group (57.4%) in the Medical & Dental staff group. Although only 9.42% of staff in Agenda for Change bands 8a – 9 are in the BME group, 21.9% of bands 5 – 7 are BME, significantly higher than the average BME representation across all pay bands in the Trust.
Religion	The 2011 Census data indicated that 59.9% of the population of Northamptonshire were Christian, 1.7% Muslim, and 1.2% Hindu. Employee data showed 49.93% Christian. The percentage of the local population professing no religion was 29.2%; 7.84% of employee records had no religion defined, and a further 15.64% did not wish to state their religion or belief, while 11.30% professed to be Atheist. In total, 15.29% of employees are from a minority faith community.

Sexual Orientation	Sexual Orientation information is not collected as part of the National Census so a comparison cannot be made between Trust employees and the Northamptonshire population. However, 76.72% of employees are recorded as heterosexual. 13% did not wish to state their sexual orientation, and a further 8.48% had no data recorded. Bisexual, Gay or Lesbian employees made up 1.8% of the total.
Marital Status	Of the total number of employees, 51.91% were married compared with 41.4% of the local population; 34.37% of employees were single, 6.42% divorced, 0.90% in a civil partnership, 1.12% separated, and 0.78% widowed. The comparable figures in the local population were 29.2% single, 14.3% divorced, 0.2% civil partnership, 5.3% separated, and 9.6% widowed. The much higher percentage of widowed people in the population reflects the number in older age-groups no longer part of the working or economically active population.

Sickness Absence Analysis (number of episodes)

The number of separate episodes of sickness for the year ending 31 March 2019 was 7,901. Appendix 1 provides the data tables for detailed analysis of the information.

Employees' pay band or grade appears to have a relatively significant influence on the number of sickness episodes compared to other equality and diversity factors. Band 2 employees comprise 18.99% of the workforce, and are the second biggest staff group, but they were responsible for the single highest percentage of the sickness, equating to 25.28% of all episodes. The biggest staff group in pay band terms is Band 5, with 19.89% of the workforce, and they accounted for the second highest percentage of sickness episodes, at 24.25%. Staff in bands 7 and 8a-9 account for 8.89% and 4.02% of the workforce but only 6.81% and 2.96% of the sickness episodes.

Protected Group	Analysis
Age	The percentage of the total number of sickness episodes relating to each age group equates relatively to the proportionate size of each age group in terms of staff in post, indicating a fairly even spread of sickness across all age groups. The biggest age group numerically; 26-30 (13.58% of the workforce) had the highest group percentage of the total number of sickness episodes at 15.57%.
Disability	Employees who declare a disability comprise 2.96% of the workforce, although this figure would probably increase if the status of the 23.3% where no record is held was known. However, those employees who do declare a

	disability accounted for 4.08% of the sickness episodes, which is consistent with the figure recorded in 2016/2017 despite there being a small increase in the number of employees declaring a disability.
Sex	79.02% of employees are female and accounted for 84.48% of the sickness episodes. Conversely 20.98% of employees are male and account for 15.52% of the sickness episodes.
Ethnicity	In terms of ethnic groups as a percentage of the total number of employees, the percentage of sickness episodes in each group shows small variation. Asian staff comprise 12.78% of the number of employees but account for only 9.36% of sickness episodes. White employees comprise 75.06% of the workforce and account for 78.87% of sickness episodes.
Religion	Religious belief does not seem to play a significant part in an employee's likelihood of having episodes of sickness absence. The spread of sickness episodes across religious belief groupings is fairly consistent with the ratio of employees in each group, for example 50.97% of sickness episodes are within the Christianity group, which accounts for 49.93% of the workforce. However Islam is stated as the religion for 3.12% of the workforce but accounts for only 1.70% of sickness episodes, and similarly Hinduism applies to 3.02% of the workforce and only 1.43% of sickness episodes.
Sexual Orientation	As with religious belief, the percentage of staff within each category of sexual orientation as compared with the percentage of the total sickness episodes recorded does not show a significant variation, although those with no sexual orientation recorded or those not wishing to state their sexual orientation amount to 21.48% of the workforce and have 19.86% of sickness attributed to them. This represents a relatively large percentage of the workforce in total and may make meaningful analysis less likely. Nonetheless, 78.10% of sickness episodes occur in the heterosexual group, which in turn makes up 76.72% of the workforce. The Gay, Lesbian & Bisexual groups total 1.8% of the workforce and account for 2.05% of the sickness episodes.
Marital Status	There is some variation across the marital status groups between the percentage of employees in each one and the percentage of sickness episodes in each one. For example, married or civil partnership employees are slightly less likely to have sickness, with 52.81% of the workforce being in these groups but only taking 48.97% of

	the sickness episodes. By contrast divorced or legally separated employees make up 7.54% of the workforce and accounted for 8.32% of sickness episodes. Single employees are 34.37% of the workforce and they accumulated 37.88% of sickness episodes.

Leaving Employment

In total, 418 employees left the Trust in the year ending 31 March 2019. Appendix 1 provides the data tables for detailed information regarding the workforce profile by protected characteristics for leavers.

Band 5 employees (19.89% of the workforce) made up 22.96% of leavers and Band 2 employees, who form 18.99% of the permanent workforce, made up 22.49% of leavers.

Protected Group	Analysis
Age	A higher proportion of employees in the age groups from 16 to 25 left in the year than would be indicated by comparison with the percentage of the workforce that they represent. 19.15% of leavers came from this age group, which represents only 9.7% of the workforce in post. The number of leavers from this age group is consistent with last year. By contrast, the staff groups aged between 26 and 55 make up 73.84% of the workforce, but only 53.71% of the leavers which is a significant decrease since last year. People in these groups seem to become a stable part of the workforce, compared to those younger and probably earlier in their careers who are more inclined to change their employer. Employees aged over 55 made up 27.13% of the leavers but 16.48% of the workforce. This is expected given the numbers who would be retiring from this range.
Disability	Although the number of leavers in the group declaring a disability was small, they represented 3.72% of leavers, slightly higher than their representation rate among all employees, which was 2.96%. Employees positively declaring no disability (73.75% of the workforce) made up 72.34% of leavers, again in line with what might be expected.
Sex	Whilst 79.02% of the workforce is female, they made up 73.40% of the leavers. The male workforce (20.98%) provided 26.60% of leavers, so was over-represented.
Ethnicity	White employees made up only 75.79% of leavers,

	compared to 75.06% of the permanent workforce, so this group is slightly over-represented. Black employees are 6.02% of the workforce but 9.57% of leavers, so this group is over-represented. Asian employees 12.78% of all employees were only 6.91% of leavers, so therefore appear to be less likely to leave the Trust.
Religion	53.46% of leavers were recorded as Christian, a higher rate than the overall rate in the workforce. Among the minority religions, the percentage of leavers is 4.26% which unrepresentative of their proportion of the workforce (15.3%).
Sexual Orientation	A reasonably comparable percentage of Heterosexual permanent employees were leavers (75.27%) compared with the permanent workforce (76.72%). Those people not wishing to state their sexual orientation made up 16.22% of leavers compared with only 13% of the workforce. Gay, Lesbian or Bisexual employees are 1.8% of the workforce and 0.8% of the leavers.
Marital Status	Married employees were less likely to leave than their proportion of the workforce would suggest; 48.41% of leavers were married or in a civil partnership, compared to 52.81% in the workforce. Similarly, divorced and separated employees made up 7.54% of the workforce and 9.57% of leavers. Single employees comprise 34.37% of the workforce but 37.5% of leavers. This is likely to be linked to the age range of single employees, as they tend to fall into the younger age groups and are probably more likely to change employment before settling into a longer term career choice.

RECRUITMENT ACTIVITY – APRIL 2018 TO MARCH 2019

This section of the report is based on the recruitment activity information collected by the HR Service Centre between April 2018 and March 2019 and in relation to the protected characteristics of:

- The number of applicants
- Those shortlisted
- Staff appointed.

Equality and Diversity is addressed throughout the recruitment process, from advertisement of the job, to the appointment of the successful candidate, such as following the Trusts advertisement process, targeting a wide range of audiences.

Managers receive anonymous applications to ensure the selection process is equal and fair. Candidates shortlisted for interviews are based on their education, qualifications, experience and their personal specification. Managers are provided with Appointing Officer Training which includes equality and diversity and values based recruitment.

During the period that the report covers the Trust received 20,004 applications for vacancies. From which 5,041 people were shortlisted for interview and 1,151 were appointed. The overall number of applications received has increase from the previous year whereby 18,354 applications were received. The number of people shortlisted and appointed has decreased from 2017/2018 as 5,797 people were shortlisted and 1,400 people were appointed.

Recruitment – Ethnicity

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
WHITE - British	10,767	53.80%	3064	60.80%	739	64.20%
WHITE - Irish	97	0.50%	30	0.60%	6	0.50%
WHITE - Any other white background	1,949	9.70%	427	8.50%	105	9.10%
ASIAN or ASIAN BRITISH - Indian	1,698	8.50%	414	8.20%	77	6.70%
ASIAN or ASIAN BRITISH - Pakistani	629	3.10%	80	1.60%	14	1.20%
ASIAN or ASIAN BRITISH - Bangladeshi	338	1.70%	75	1.50%	10	0.90%
ASIAN or ASIAN BRITISH - Any other Asian background	465	2.30%	91	1.80%	18	1.60%
MIXED - White & Black Caribbean	251	1.30%	59	1.20%	12	1.00%
MIXED - White & Black African	191	1.00%	25	0.50%	4	0.30%
MIXED - White & Asian	85	0.40%	18	0.40%	2	0.20%
MIXED - any other mixed background	161	0.80%	41	0.80%	12	1.00%
BLACK or BLACK BRITISH - Caribbean	377	1.90%	98	1.90%	19	1.70%
BLACK or BLACK BRITISH - African	1,780	8.90%	364	7.20%	60	5.20%
BLACK or BLACK BRITISH - Any other black background	124	0.60%	28	0.60%	6	0.50%
OTHER ETHNIC GROUP - Chinese	94	0.50%	23	0.50%	7	0.60%
OTHER ETHNIC GROUP - Any other ethnic group	620	3.10%	104	2.10%	21	1.80%
Undisclosed	378	1.90%	100	2.00%	39	3.40%
Total	**20004**	**100%**	**5041**	**100%**	**1151**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by ethnicity.

It demonstrates that White – British has the highest amount of applications with 10,767 which equates to 53.80% of all applications. 3,064 were shortlisted and 739 were appointed to a position at the Trust.

White - Any other white background has the second highest amount of applications made with 1,949 or 9.70% of applications, which resulted in 427 of candidates being shortlisted of which 105 were successful in gaining a position with the hospital.

Black or Black British - African has the third highest amount of applications with 1,780 of which 364 were shortlisted and 60 were successful in gaining employment.

The most significant change has been in the other ethnic group category where there had been an increase of appointed candidates of 0.70%. This indicates that the advertising of vacancies are attracting more candidates from this category.

During 2018/2019 the Trust has continued focus recruitment on shortage occupations from overseas particularly for nursing and medical and dental.

Recruitment - Gender

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Male	5,014	25.10%	1077	21.40%	222	19.30%
Female	14,922	74.60%	3944	78.20%	921	80.00%
Undisclosed	68	0.30%	20	0.40%	8	0.70%
Total	**20004**	**100%**	**5041**	**100%**	**1151**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by sex.

The data shows that the Trust had a greater number of female applicants at 74.60% or 14,992, of which 3,944 were shortlisted and 921 were appointed.

Male applicants totalled 25.10% or 5,014 and of those 1,077 were shortlisted and 222 were appointed.

When compared to the previous year there is no significant change to the groups that have received the highest amount of applications. There have been some slight decreases in the number of applications received; however the numbers appointed have increased.

In addition during 2018/2019 the Trust has continued focus its recruitment activity on its nurse vacancies.

Recruitment – Disability

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Yes	822	4.10%	246	4.90%	46	4.00%
No	18,807	94.00%	4706	93.40%	1084	94.20%
Undisclosed	375	1.90%	89	1.80%	21	1.80%
Total	**20004**	**100%**	**5041**	**100%**	**1151**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by disability. There has been an increase in applications from this category resulting in an increase in shortlisted and appointed applicants

Disabled applicants totalled 4.10% or 822 and of those 246 were shortlisted and 46 were appointed. There has been an increase in the number of disabled applicants shortlisted and appointed.

During 2018/2019 the Trust has continued to be committed to supporting people with disabilities and through its certification as a Disability Confident Employer and is working towards accreditation for Disability Confident Leader.

Recruitment - Impairment

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Physical Impairment	190	19.30%	69	22.20%	14	24.60%
Sensory Impairment	47	4.80%	11	3.50%	0	0.00%
Mental Health Condition	164	16.60%	48	15.40%	9	15.80%
Learning Disability/Difficulty	136	13.80%	42	13.50%	12	21.10%
Long-Standing Illness	247	25.10%	83	26.70%	12	21.10%
Other	201	20.40%	58	18.60%	10	17.50%
Total	**985**	**100%**	**311**	**100%**	**57**	**100%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by impairment.

For the impairment category there had been a significant rise in applications being received.

The long standing illness category had the highest number of applications with 247 which equates to 25.10% of all applications. 83 were shortlisted and 12 were appointed to a position at the Trust.

The Other category had the second highest amount of applications made with 201 or 20.40% of applications, which resulted in 58 of candidates being shortlisted of which 10 were successful in gaining a position with the hospital.

Recruitment – Age

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Under 18	152	0.80%	62	1.20%	35	3.00%
18 to 19	552	2.80%	127	2.50%	60	5.20%
20 to 24	2,736	13.70%	624	12.40%	149	12.90%
25 to 29	3,834	19.20%	747	14.80%	174	15.10%
30 to 34	3,271	16.40%	713	14.10%	146	12.70%
35 to 39	2,637	13.20%	669	13.30%	132	11.50%
40 to 44	1,866	9.30%	512	10.20%	126	10.90%
45 to 49	1,870	9.30%	575	11.40%	114	9.90%
50 to 54	1,468	7.30%	460	9.10%	86	7.50%
55 to 59	995	5.00%	331	6.60%	74	6.40%
60 to 64	492	2.50%	156	3.10%	32	2.80%
65 to 69	93	0.50%	38	0.80%	11	1.00%
70 and over	28	0.10%	22	0.40%	10	0.90%
Undisclosed	10	0.00%	5	0.10%	2	0.20%

Total	**20,004**	**100.00%**	**5041**	**100.00%**	**1151**	**100.00%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by age.

In 2018/2019 the highest number of applications were received from the 25 to 29 age group with 19.20% or 3,834 applications. Of these 747 were shortlisted and 174 were appointed which has resulted in no significant change compared to last year.

The second highest number of applicants came from the age group of 30 to 34 year olds with 16.40% or 3,271 applications. From this 713 were shortlisted and 146 were appointed.

There has been an increase in appointment of the age ranges for 20-24. The trust has had a HCA recruitment campaign and this has attracted applications for this category. The information indicates that we continue to retain retirees over the age of 60.

The overall data assures the Trust that discrimination is not an issue and applicants are confident in disclosing their age.

Recruitment – Religious Belief

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Atheism	2,798	14.00%	797	15.80%	203	17.60%
Buddhism	125	0.60%	31	0.60%	10	0.90%
Christianity	9,772	48.90%	2517	49.90%	559	48.60%
Hinduism	947	4.70%	205	4.10%	34	3.00%
Islam	1,684	8.40%	275	5.50%	47	4.10%
Jainism	11	0.10%	4	0.10%	1	0.10%
Judaism	13	0.10%	3	0.10%	2	0.20%
Sikhism	84	0.40%	30	0.60%	5	0.40%
Other	2,381	11.90%	552	11.00%	128	11.10%
Undisclosed	2,189	10.90%	627	12.40%	162	14.10%
Total	**20,004**	**100.00%**	**5041**	**100.00%**	**1151**	**100.00%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by religious belief.

Christianity had the most number of applicants with 48.90% or 9,772. Of these 2517 were shortlisted and 559 were appointed. This shows that there has been a decrease in the number of Christians appointed when compared to 2017/2018.

Atheism continues to be second in the amount of applications received with 14.00% or 2,798. From this 797 were shortlisted and 203 were appointed.

There has been an increase in the Hinduism category compared to 2018/19. This is attributed to the international recruitment campaigns in India for clinical staff.

However, there has been an increase of 1% in the number of appointed candidates who did not disclose their religious belief.

Recruitment – Sexual Orientation

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Heterosexual	18,293	91.40%	4591	91.10%	1037	90.10%
Gay/ Lesbian	359	1.80%	98	1.90%	23	2.00%
Bisexual	334	1.70%	72	1.40%	13	1.10%
Other	64	0.30%	6	0.10%	0	0.00%
Undisclosed	25	0.10%	5	0.10%	3	0.30%
Total	**20,004**	**100.00%**	**5041**	**100.00%**	**1151**	**100.00%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by sexual orientation.

The groups have changed this year. Gay and Lesbian have been combined and an additional group called other has been introduced, as a result no analysis can be completed this year on the other groups.

Recruitment – Marital Status

Description	Applications		Shortlisted		Appointed	
	No.	%	No.	%	No.	%
Married	7,850	39.20%	2134	42.30%	451	39.20%
Single	9,731	48.60%	2240	44.40%	531	46.10%
Civil partnership	539	2.70%	109	2.20%	24	2.10%
Legally separated	201	1.00%	48	1.00%	9	0.80%
Divorced	914	4.60%	279	5.50%	59	5.10%
Widowed	177	0.90%	40	0.80%	8	0.70%
Undisclosed	592	3.00%	191	3.80%	69	6.00%
Total	**20,004**	**100.00%**	**5041**	**100.00%**	**1151**	**100.00%**

The table above show the number of applications that have been received, shortlisted and appointed between April 2018 and March 2019 by marital status.

The marital status of single had the most number of applicants with 48.60% or 9,731. Of these 2,240 were shortlisted and 531 were appointed.

Married had the second highest amount of applications with 39.20% or 7,850. From this 2,134 were shortlisted and 451 were appointed.

EMPLOYEE RELATIONS CASELOAD ACTIVITY – APRIL 2018 TO MARCH 2019

Background

This section of the report provides the equal opportunities breakdown for the formal Human Resources (HR) employee relations caseload activity across the Trust between the period of April 2018 and March 2019 for both open and closed formal cases.

The HR activity has been broken down into the following categories:

- Harassment and Bullying Cases
- Grievance Cases
- Disciplinary Cases (conduct)
- Performance Management Cases (capability).

In the year ending March 2019: there were 103 (89) formal cases; 22 (12) Harassment and Bullying cases, 17 (12) Grievance case, 56 (58) Disciplinary cases and 8 (7) Performance Management cases recorded on the HR database. (Previous year's cases in brackets).

Harassment and Bullying Cases

Age Group	No.	Comment
16 – 20	0	There are a lot more cases in age 51-55 compared to previous year. Also it is worth noting that the Trusts highest age ranges are between 26-30 and 31-35 but no B&H cases have been recorded in these age ranges The age groups where there are cases do fall into the top 5 age categories within the Trust.
21 – 25	2	
26 – 30	0	
31 – 35	0	
36 – 40	2	
41 – 45	4	
46 – 50	2	
51 – 55	7	
56 – 60	5	
61 – 65	0	
66 – 70	0	

Disability	No.	Comment
Yes	1	The case numbers do not suggest any trend towards disabled members of staff and the one case whereby the staff member was disabled the B&H case was not related to their disability It is important to note, however, that many allegations
No	15	
Not Declared	2	
Undefined	4	

		of harassment and bullying are dealt with at an informal level.

Sex	No.	Comment
Female	16	Given the small number of cases, it would be expected that there are a higher number of female cases based on the Trust demographic of 78.98% female and 21.02% male, however the number of male cases (37.5%) is higher than expected however this has reduced from last year when the split was 50%.
Male	6	

Ethnicity	No.	Comment
White	16	The case numbers appear consistent with the Trust profile and do not suggest a trend towards any one ethnic group. The Trusts highest ethnic group is white (73.20%) so these figures are in line with this ethnic group.
BME	2	
Asian	1	
Not stated	0	
Mixed white/ asian	1	
Mixed white /black	2	

Marital Status	No.	Comment
Civil Partnership	1	There appears to be an even spread of cases across nearly all status's which reflects the Trusts profile of staff and similar spread to last year's figure. The amount of Trust staff who are recorded as married is 51.75% so the amount of single staff who have B&H complaints is high in comparison to staff employed (34.81%) There is no data from the staff survey relating to this protected characteristic.
Divorced	2	
Legally separated	0	
Married	9	
Single	9	
Unknown	1	
Widowed	0	

Sexual Orientation	No.	Comment
Bisexual	0	The number of cases for Heterosexual staff appears to reflect the Trust's profile of 78.14% of staff declaring this as their sexual orientation. There is no data from the staff survey relating to this protected characteristic
Gay	0	
Heterosexual	13	
Does not wish to disclose	6	
Lesbian	0	
Undefined	3	

Religion	No.	Comment
Atheism	2	The distribution of cases appears to reflect the Trust's profile with 49.32% staff declaring Christianity as their religious belief. There is no data from the staff survey relating to this protected characteristic.
Buddhism	0	
Christianity	11	
Hinduism	1	
Does not wish to disclose	6	
Other	0	
Undefined	2	

Grievance Cases

Age Group	No.	Comment
16 - 20	0	There does not appear to be any trend in relation to age group and the amount of cases is fairly representative of the Trust profile. The highest proportion of staff are within the 26-30 age band (14.34%) in the Trust, however the highest number of cases fell within the 46-50 age band, with 11.92% of staff, the fourth largest within the Trust. There are 5 grievance cases in age range 46-50 but last year there were no cases in this age range. Further analysis may be required of each case and discussions with the Trust Equality and Diversity Staff Group. There is no data from the staff survey explicitly relating to grievances.
21 – 25	2	
26 - 30	3	
31 - 35	1	
36 - 40	1	
41 – 45	1	
46 – 50	5	
51 – 55	2	
56 – 60	2	
61 – 65	0	
66 - 70	0	

Disability	No.	Comment
Yes	4	The split of cases between individuals having a disability and not having a disability is not representative of the Trust's profile: 3% disabled, 76% not disabled, 6% not declared and 15% unspecified. There is no data from the staff survey explicitly relating to grievances.
No	8	
Not Declared	0	
Undefined	5	

Sex	No.	Comment
Female	10	Given the small number of cases, this split appears consistent against the 78.98% female and 21.02% male split in the Trust. There is no data from the staff survey explicitly relating to grievances.
Male	7	

Ethnicity	No.	Comment
White	13	The case numbers appear consistent with the Trust profile and do not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to grievances.
BME	0	
Mixed white & Asian	0	
Asian	2	
Unspecified	2	

Religion	No.	Comment
Atheism	2	The distribution of cases does not suggest any trend towards a religious belief and appears consistent against the 49.33% of staff who state their religious belief as Christianity There is no data from the staff survey explicitly relating to grievances.
Buddhism	0	
Christianity	10	
Hinduism	0	
Does not wish to disclose	1	
Other	0	
Undefined	3	
Islam	1	

Marital Status	No.	Comment
Civil Partnership	0	Given the small number of cases this split is reasonably representative of the 51.75% married and 34.81% single profile in the Trust. There is no data from the staff survey explicitly relating to grievances.
Divorced	0	
Legally separated	0	
Married	10	
Single	4	
Unknown	3	
Widowed	0	

Sexual Orientation	No.	Comment
Bisexual	0	The number of cases for Heterosexual staff appears to reflect the Trust's profile of 78.14% of staff declaring this as their sexual orientation. There is no data from the staff survey explicitly relating to grievances.
Gay	0	
Heterosexual	15	
Does not wish to disclose	0	
Lesbian	0	
Undefined	2	

Disciplinary Cases

Age Group	No.	Comment
16 – 20	1	The distribution of cases generally appears to correlate with the percentage of staff within those age groups. With less than 1% of staff within the 16-20 age group, 12% of staff at the Trust within 46-50 age groups, 10% in the 56-60 age group, then 11% within the 36-40 age group, 12% of staff within the 31-35 and 12% of staff in the 51-55 age group. There is no data from the staff survey explicitly relating to disciplinary.
21 – 25	2	
26 – 30	2	
31 – 35	7	
36 – 40	8	
41 – 45	4	
46 – 50	9	
51 – 55	7	
56 – 60	9	
61 - 65	6	
66 - 70	1	

Disability	No.	Comment
Yes	1	The case numbers do not suggest any trend towards disabled or non-disabled members of staff. The split is reasonably representative of the Trusts profile: 3% disabled, 76% not disabled, 6% not declared and 15% unspecified. There is no data from the staff survey explicitly relating to disciplinary.
No	41	
Not Declared	4	
Undefined	10	

Sex	No.	Comment
Female	32	The distribution of cases appears higher than expected for men against the 78.98% female and 21.02% male split in the Trust. Further analysis may be required of each case and discussions with the Trust Equality and Diversity Staff Group. There is no data from the staff survey explicitly relating to disciplinary.
Male	24	

Ethnicity	No.	Comment
White	39	The case numbers appear consistent with the Trust profile; for example 73% of staff have declared their ethnic group as White and Asian 13.40%. There does not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to disciplinary.
BME	2	
Not stated	1	
Asian	11	
Mixed white & Asian	3	

Marital Status	No.	Comment
Civil Partnership	0	The distribution of cases is reasonably representative of the Trust profile: 6% Divorced, 52% married, 3% unknown and less than 1% widowed. With the exception of singles where the split of cases remains higher than expected, as last year, based on the workforce profile for the Trust of 35% single. Further analysis may be required and discussions with the Trust Equality and Diversity Staff Group. There is no data from the staff survey explicitly relating to disciplinary.
Divorced	5	
Legally separated	1	
Married	29	
Single	16	
Unknown	5	
Widowed	0	

Sexual Orientation	No.	Comment
Bisexual	1	The distribution of cases appears to reflect the Trust's profile of less than 2% Gay, 78.1% Heterosexual, 12% not stated and 8% unspecified. The split of sexual orientation is not sufficiently disclosed to allow any meaningful analysis. There is no data from the staff survey explicitly relating to disciplinary.
Gay	1	
Heterosexual	42	
Does not wish to disclose	5	
Lesbian	0	
Undefined	7	

Religion	No.	Comment
Atheism	10	The distribution of cases appears to generally reflect the Trust's profile of 12% Atheism, 49.3% Christianity, 3% Hinduism, 3% Islam, 15% does not wish to disclose, 8% other and 5% undefined. The split of religious beliefs is not sufficiently disclosed to allow any meaningful analysis. There is no data from the staff survey explicitly relating to disciplinary.
Buddhism	0	
Christianity	21	
Hinduism	5	
Islam	1	
Does not wish to disclose	8	
Other	5	
Undefined	6	
Sikhism	0	

Performance Management Cases

Age Group	No.	Comment
16 – 20	0	Given the small number of cases this split is reasonably representative of the Trust profile except the Trust profile for age range 41-45 is 11.66% however 62.5% of our cases fell in this area and further analysis may be required? There is no data from the staff survey explicitly relating to performance management.
21 – 25	0	
26 - 30	0	
31 - 35	0	
36 - 40	0	
41 - 45	5	
46 - 50	0	
51 - 55	1	
56 - 60	1	
61 – 65	1	
66 - 70	0	

Disability	No.	Comment
Yes	0	Given the small number of cases, this does not suggest any trend towards disabled or not disabled staff. There is no data from the staff survey explicitly relating to performance management.
No	7	
Not Declared	0	
Undefined	1	

Sex	No.	Comment
Female	7	Given the small number of cases, this split appears consistent against the 78.98% female and 21.02% male split in the Trust. There is no data from the staff survey explicitly relating to performance management.
Male	1	

Ethnicity	No.	Comment
White	5	Give the small number of cases this appears consistent with the Trust profile and does not suggest a trend towards anyone ethnic group. There is no data from the staff survey explicitly relating to performance management.
BME	3	

Marital Status	No.	Comment
Civil Partnership	0	Given the small number of cases this split is reasonably representative although does suggest a trend towards Married staff. As the Trust profile is 6.41% Divorced, 51.75% married, 34.81% single. There is no data from the staff survey explicitly relating to performance management.
Divorced	0	
Legally separated	0	
Married	7	
Single	0	
Unknown	1	
Widowed	0	

Sexual Orientation	No.	Comment
Bisexual	0	Given the small number of cases, this appears to reflect the Trust's profile of 78.14% of staff declaring their sexual orientation as Heterosexual. There is no data from the staff survey explicitly relating to performance management.
Gay	0	
Heterosexual	6	
Does not wish to disclose	0	
Lesbian	0	
Undefined	2	

Religion	No.	Comment
Atheism	1	Given the small number of cases, the distribution does not suggest any trend towards a religious belief and is consistent with the Trust profile of staff where 49.33% of staff have declared their religious belief as Christianity. There is no data from the staff survey explicitly relating to performance management.
Buddhism	0	
Christianity	5	
Hinduism	0	
Does not wish to disclose	0	
Other	0	
Undefined	2	

LEARNING AND DEVELOPMENT – APRIL 2018 TO MARCH 2019

Background

The Trust has been using the centralised electronic Oracle Learning Management System, (OLM) to record training information since 2009. It has been used to record all staff's Mandatory Training and Role Specific Essential Training attendance which is then collated and reported via the Electronic Staff Record (ESR) system to the Trust's Workforce Committee.

The Trust, through the Practice Development Team, also provides and maintains records on clinical training such as Cannulation, Glucometer, Catheterisation, and Drug Calculation which are included in this section of the report.

Training is divided between mandatory training and role specific essential training (RSET). Mandatory means all staff need to attend, whilst RSET is specific to an individual's role. RSET is revised when there are changes such as in legislation and regulations and as a result there is a continuous process to update the OLM to ensure that RSET training is accurately set on the system against each role ensuring that staff only attend courses that are relevant to them.

To ensure that all staff achieve the required outcomes of the training, different learning styles have been utilised and sessions have been adapted to help staff within different roles understand what the training subject means to them.

The Trust's Induction continues to be offered twice a month, so staff can attend as close to their start date as possible. The Induction covers the Trust's values and behaviours as well as the 8 mandatory training subjects. All the Trainers who deliver the training on Induction have worked with both L&D and Organisational Development to review their training sessions to ensure that staff gain the knowledge and understanding of the specific subject matter in a meaningful way. They aim to make the session as learner friendly as possible, covering all learning styles which includes; group work, quizzes and case studies.

The Trust continues to recruitment International Nurses to the Trust and in order to provide additional support, bespoke preceptorship programmes and clinical skills have been provided including orientation to the Trust.

All mandatory training subjects have three methods of delivery; face to face, e-learning and workbooks/assessments. The workbooks are updated as changes are made to legislation or regulations and the assessment papers are changed within each refresher period.

Demand continues to be high for our Review of Knowledge sessions, and with more staff completing workbooks or e-learning this seems to be the preferred option of training than attending a traditional classroom lecture.

Staff have been encouraged to access on-going development across all levels; this includes Vocationally-Related Qualifications (VRQ's) & in-house

management programmes. Registered staff are also able to access modules at Degree & Masters level via the Workforce Development Fund (formally Learning Beyond Registration) held with Health Education East Midlands.

In addition the hospital continues to employ apprentices alongside offering apprenticeships to substantive staff. Collectively there have been 57 new starts during 2018/2019 covering; business administration, healthcare, scientist practitioners, nursing associates, operations manager, pharmacy and data analyst.

The Trust continues to offer functional skills in Maths and English. The Maths and English classes are available for all staff to attend with each one running over a 4 week period concluding with an exam and qualification. Please see table below detailing the number of staff accessing this training and the success rate:

NGH Summary
April 2018 to March 2019

Maths	
No. of Learners started	26
No. of passes	24
Achievement Rate %	**92.3%**

English	
No. of Learners started	32
No. of passes	30
Achievement Rate %	**93.7%**

Maths and English Total	
No. of Learners started	58
No. of passes	54
Achievement Rate %	**93.10%**

National Achievement Rate For Adult learners	**65%**

These achievement rates do not include learners who are booked onto blocks and have not taken their exams yet

The table below shows the analysis of the hospitals workforce using the Trust headcount by protected characteristics and the number of training courses attended. We currently collect data on 6 of the 9 protected characteristics, those not included are; gender reassignment, marriage and civil partnership and pregnancy and maternity.

It is important to note that the reports used for the analysis include the Trust's bank workers.

Training – Trust Headcount of 7,012	
Protected Group	**Analysis**
Sexual Orientation	The number of 'not stated' and the number of staff who do not wish to disclose their sexual orientation have both decreased from last year. There has been an increase in the number of staff disclosing that they are Gay or Lesbian and Heterosexual compared to last year. This year a new category of 'undecided' has been added. The report shows that all categories of sexual orientation are attending training and this correlates with the numbers of staff in post.
Religious Belief	The highest proportion of training was completed by the Christian religious group which correlates with the workforce profile. There has been a decrease in the number of staff who did not wish to disclose their religion/belief and the number of staff not stating their religion/belief. There has been an increase 7 of the 9 groups, although Buddhism and Jainism see a decrease. The training in these other categories is being completed proportionately.
Age Band	Training is offered to all age groups. There has been an increase in the number of staff within 5 groups; 26-30, 31-35, 56-60, 61-65 and 71+. The remainder 7 groups have seen a decrease. The number of staff in the 21-25 age band have seen the highest variance of attending training. The greater variance of non-attendance is within the 56-60 age band which may be attributable to this age group working more part-time.
Gender	There are more females attending training than males which correlate to the workforce profile. However, the report also identified that less males are completing training by proportion.

Disability	The number of 'undefined' has decreased from last year; the report also shows a decrease on the number of staff 'not declaring'. There has been an increase on the number disclosing a disability and a new category 'prefer not to answer' has been added. Training is accessible to disabled staff with all training rooms providing good access. There is an increase in the opportunity to access training by e-learning and workbooks so staff can complete their training in their usual workplace.
Ethnic Origin	The report details that training is provided to all staff and the Trust headcount and numbers of training courses attended by all staff reflects the Trust's ethnic population. For example the highest number of staff in the Trust is of white ethnicity with the second group being Asian and the third category from Black / Black British, which was the same last year. The highest variance in attendance is within the 'Asian or Asian British - Indian' and then 'Black or Black British – African'. Whilst the greatest variance in non-attendance is in the 'White – British', 'not stated' and 'undefined' groups. The number of 'undefined' saw an increase in the number of staff declaring this compared to last year, whilst the number of 'not stated' decreased.

In the tables below the variance column gives further information about which of our staff, by their protected characteristic, are accessing training by comparison against the Trust's headcount.

Gender	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
Female	5338	76.13	36912	80.18	4.05
Male	1674	23.87	9124	19.82	-4.05
Total	**7012**	**100**	**46036**	**100**	

Sexual Orientation	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
Bisexual	56	0.80	458	0.99	0.20
Gay or Lesbian	74	1.06	506	1.10	0.04
Heterosexual or Straight	5272	75.19	36651	79.61	4.43
Not stated (person asked but declined to provide a response)	994	14.18	5450	11.84	-2.34
Undecided	1	0.01	4	0.01	-0.01
Unspecified	615	8.77	2967	6.44	-2.33
Total	**7012**	**100**	**46036**	**100**	

Religious Belief	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
Atheism	841	11.99	5838	12.68	0.69
Buddhism	50	0.71	330	0.72	0.00
Christianity	3275	46.71	22478	48.83	2.12
Hinduism	242	3.45	1772	3.85	0.40
I do not wish to disclose my religion/belief	1215	17.33	6925	15.04	-2.28
Islam	241	3.44	1675	3.64	0.20
Jainism	8	0.11	63	0.14	0.02
Judaism	6	0.09	50	0.11	0.02
Other	516	7.36	3852	8.37	1.01
Sikhism	34	0.48	269	0.58	0.10
Unspecified	584	8.33	2784	6.05	-2.28
Total	**7012**	**100**	**46036**	**100**	

Age Band	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
<=20 Years	184	2.62	1410	3.06	0.44
21-25	641	9.14	5271	11.45	2.31
26-30	1045	14.90	7437	16.15	1.25
31-35	935	13.33	6162	13.39	0.05
36-40	803	11.45	5263	11.43	-0.02
41-45	770	10.98	5053	10.98	0.00
46-50	753	10.74	4797	10.42	-0.32
51-55	723	10.31	4841	10.52	0.20
56-60	615	8.77	3604	7.83	-0.94
61-65	354	5.05	1710	3.71	-1.33
66-70	116	1.65	392	0.85	-0.80
>=71 Years	73	1.04	96	0.21	-0.83
Grand Total	**7012**	**100**	**46036**	**100**	

Ethnicity	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
A White - British	4348	62.01	27783	60.35	-1.66
B White - Irish	64	0.91	391	0.85	-0.06
C White - Any other White background	438	6.25	3134	6.81	0.56
CA White English	3	0.04	30	0.07	0.02
CC White Welsh	2	0.03	10	0.02	-0.01
CF White Greek	2	0.03	14	0.03	0.00
CH White Turkish	1	0.01	14	0.03	0.02
CK White Italian	6	0.09	46	0.10	0.01
CN White Gypsy/Romany	3	0.04	26	0.06	0.01
CP White Polish	10	0.14	84	0.18	0.04
CQ White ex-USSR	1	0.01	0	0.00	-0.01
CS White Albanian	1	0.01	4	0.01	-0.01
CU White Croatian	0	0.00	18	0.04	0.04
CX White Mixed	1	0.01	0	0.00	-0.01
CY White Other European	19	0.27	116	0.25	-0.02
D Mixed - White & Black Caribbean	42	0.60	279	0.61	0.01
E Mixed - White & Black African	17	0.24	54	0.12	-0.13
F Mixed - White & Asian	33	0.47	204	0.44	-0.03
G Mixed - Any other mixed background	42	0.60	273	0.59	-0.01
GA Mixed - Black & Asian	1	0.01	0	0.00	-0.01
GC Mixed - Black & White	1	0.01	4	0.01	-0.01
GD Mixed - Chinese & White	3	0.04	16	0.03	-0.01
GE Mixed - Asian & Chinese	1	0.01	4	0.01	-0.01
GF Mixed - Other/Unspecified	4	0.06	17	0.04	-0.02
H Asian or Asian British - Indian	662	9.44	5335	11.59	2.15
J Asian or Asian British - Pakistani	90	1.28	647	1.41	0.12
K Asian or Asian British - Bangladeshi	38	0.54	239	0.52	-0.02
L Asian or Asian British - Any other Asian background	116	1.65	902	1.96	0.31
LA Asian Mixed	1	0.01	20	0.04	0.03
LE Asian Sri Lankan	6	0.09	28	0.06	-0.02
LF Asian Tamil	1	0.01	0	0.00	-0.01
LH Asian British	3	0.04	6	0.01	-0.03
LJ Asian Caribbean	0	0.00	4	0.01	0.01
LK Asian Unspecified	4	0.06	6	0.01	-0.04
M Black or Black British - Caribbean	76	1.08	466	1.01	-0.07
N Black or Black British - African	342	4.88	2414	5.24	0.37
P Black or Black British - Any other Black background	31	0.44	182	0.40	-0.05
PB Black Mixed	1	0.01	4	0.01	-0.01
PC Black Nigerian	4	0.06	30	0.07	0.01
PD Black British	7	0.10	38	0.08	-0.02
PE Black Unspecified	2	0.03	17	0.04	0.01
R Chinese	36	0.51	309	0.67	0.16
S Any Other Ethnic Group	69	0.98	497	1.08	0.10
SC Filipino	6	0.09	68	0.15	0.06
SD Malaysian	1	0.01	20	0.04	0.03
SE Other Specified	9	0.13	16	0.03	-0.09
Unspecified	160	2.28	824	1.79	-0.49
Z Not Stated	304	4.34	1443	3.13	-1.20
Total	**7012**	**100**	**46036**	**100**	

Disability	Trust Headcount	Trust Headcount %	Trained Headcount	Trained %	Variance %
No	5081	72.46	34946	75.91	3.45
Not Declared	551	7.86	2695	5.85	-2.00
Prefer Not To Answer	3	0.04	46	0.10	0.06
Unspecified	1180	16.83	7022	15.25	-1.58
Yes	197	2.81	1327	2.88	0.07
Total	**7012**	**100**	**46036**	**100**	

Equality & Diversity Training

Equality and diversity training remains mandatory for all staff and is included on the Trust's Induction for all new staff. All existing staff have to refresh their equality and diversity training every 3 years. To ensure staff are able to access this subject, we offer this training through e-learning and workbook/assessment.

All staff attending the equality and diversity training are given an awareness of the nine protected characteristics under the Equality Act 2010 and the adverse impact on clinical care if they are not respected.

Conclusion

In conclusion, this year we have seen a small increase in the overall number of staff attending training than previous years. This is presented in the overall % of compliance for both Mandatory Training and Role Specific Training which have also seen an increase. It is thought that the increase could be due to; more staff being aligned to role specific training, that there is a small increase in the number of staff attending the non-mandatory training sessions and that the recording requirements of training has been re-defined resulting in some training no longer being recorded in the way it has been historically.

Work continued on having a flexible approach to learning which removed barriers to access for groups with protected characteristics. Given that all mandatory training subjects can now be accessed through workbook/assessment sheets and e-learning, individuals have more opportunities to access it at any time during their working hours whether those hours are within the working hours of 9.00am to 5.00pm or during hours they work outside of these times.

The Trust has continued to explore innovative ways of delivering training and this has led to some courses being adapted for those staff groups such as within Domestic Services and the International Nurses that have been recruited to the Trust in the last year.

Learning and Development continues to communicate to staff the Trust's Mandatory Training Policy which was updated in 2017. This policy ensures that all staff are aware of the mandatory and role specific training they are required to undertake and for the Trust to be compliant against its' regulatory requirements.

Appendix 1

Equality and Diversity Workforce Data – 1 April 2018 – 31 March 2019

Staff in Post

Staff in Post by Age and Pay Group

Age Group/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
<=20 Years	2	31	48	4	2								87
21-25	1	24	98	43	25	129	29	6				28	383
26-30		21	138	33	64	177	137	41	4			119	734
31-35	1	38	107	46	46	163	100	37	26	4		69	637
36-40	1	36	101	46	34	117	89	61	24	25		47	581
41-45		21	86	46	37	124	90	82	28	53	2	28	597
46-50		41	93	66	52	94	86	73	38	52	7	8	610
51-55		36	119	65	56	84	75	73	45	49	8	6	616
56-60		58	96	59	50	84	57	48	26	32	4	9	523
61-65		34	68	27	22	38	26	28	15	14		2	274
66-70		8	14	8	11	7		5		3	1		57
>=71 Years		8	4	2	2	1		1				2	20
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Disability and Pay Group

Disabled/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
No	5	245	802	349	314	776	548	326	158	138	17	231	3909
Not Declared		31	18	12	11	96	19	24	8	29	2	55	305
Prefer Not To Answer		1		1		1							3
Unspecified		69	115	71	61	111	94	95	36	63	3	28	746
Yes		10	37	12	15	34	28	10	4	2		4	156
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Bisexual		3	12	1	3	16	4	1					40
Gay or Lesbian		3	13	7	4	10	6	8	4	2	1	2	60
Heterosexual or Straight	4	234	823	358	323	773	583	345	158	135	19	245	4000
Not stated (person asked but declined to provide a response)		72	67	44	40	168	55	42	25	41	1	44	599
Undecided	1				1								2
Unspecified		44	57	35	30	51	41	59	19	54	1	27	418
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Sex and Pay Group

Sex/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Female	3	232	822	368	352	892	603	383	156	73	14	145	4043
Male	2	124	150	77	49	126	86	72	50	159	8	173	1076
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Religious Belief and Pay Group

Religious Belief/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Atheism	2	35	142	44	60	108	106	49	24	14	1	23	608
Buddhism		4	1	3	1	3	3	1	1	4		11	32
Christianity	2	166	505	246	193	577	361	220	120	50	13	72	2525
Hinduism		1	17	5	10	27	9	10	3	46		47	175
I do not wish to disclose my religion/belief	1	76	122	55	65	165	96	68	25	42	3	49	767
Islam			18	8	4	19	10	12	4	16		77	168
Jainism					1			2	1	1		2	7
Judaism						1		1		1			3
Other		33	112	51	36	72	66	31	10	3	4	3	421
Sikhism		1	2	1	1	1	1	6	1	3		7	24
Unspecified		40	53	32	30	45	37	55	17	52	1	27	389
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Ethnic Origin and Pay Group

Ethnic Origin/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
A White - British	1	207	716	350	320	492	534	364	167	99	19	64	3333
B White - Irish	1	7	5	3	1	10	7	9	4	2			49
C White - Any other White background	1	66	78	27	11	75	34	10	7	12	1	13	335
CA White English		1	1			1							3
CC White Welsh				1									1
CF White Greek			1										1
CK White Italian			1				1		1				3
CN White Gypsy/Romany						3							3
CP White Polish		4	1			1	1	1					8
CS White Albanian						1							1
CY White Other European		1				5				1		3	10
D Mixed - White & Black Caribbean	1	1	8	4	2	4	5						25
E Mixed - White & Black African				1		4	1			2		1	9
F Mixed - White & Asian		3	1		2	4	2	1		3		3	19
G Mixed - Any other mixed background		2	5	6	1	6	2	2	1	3		1	29
GC Mixed - Black & White				1									1
GD Mixed - Chinese & White												1	1
GE Mixed - Asian & Chinese						1							1
GF Mixed - Other/Unspecified												1	1
H Asian or Asian British - Indian		11	47	14	38	200	34	27	7	70		64	512
J Asian or Asian British - Pakistani			5	2	2	3	2	5		6		31	56
K Asian or Asian British - Bangladeshi			7	2		2	3	3	1	1		7	26
L Asian or Asian British - Any other Asian background		5	18	5	2	21	4	3	3	11		15	87
LE Asian Sri Lankan												3	3
LH Asian British			1										1
LK Asian Unspecified		1											1
M Black or Black British - Caribbean		8	12	6	7	16	5	2	1			2	59
N Black or Black British - African	1	16	31	9	4	92	30	11	4	3	1	19	221

Ethnic Origin/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
P Black or Black British - Any other Black background		3	5	1	2	3	1	1		1		1	18
PB Black Mixed												1	1
PC Black Nigerian						2							2
PD Black British				1		1	1						3
PE Black Unspecified						1							1
R Chinese		1	2	1		3	4	3	2	4		7	27
S Any Other Ethnic Group			11	2	4	14	4	4	2	6	1	9	57
SC Filipino						5							5
SD Malaysian												1	1
SE Other Specified			1							1			2
Unspecified			5			1				3		53	62
Z Not Stated		19	10	9	5	47	14	9	6	4		18	141
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Staff in Post by Marital Status and Pay Group

Marital Status/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Civil Partnership		12	15	3	2	6	7	5	3			1	54
Divorced		24	60	47	41	46	40	40	15	9	2	4	328
Legally Separated		6	16	5	8	8	3	5		1		1	53
Married		133	443	231	203	507	380	290	137	175	16	134	2649
Single	5	147	394	146	132	407	237	98	41	17	3	155	1782
Unknown		21	22	6	10	22	19	11	8	25	1	15	160
Widowed		7	15	5	2	5	2	2	1	1		2	42
Unspecified		6	7	2	3	17	1	4	1	4		6	51
Grand Total	**5**	**356**	**972**	**445**	**401**	**1018**	**689**	**455**	**206**	**232**	**22**	**318**	**5119**

Sickness Absence Episodes

Sickness Episodes by Age and Pay Group

Age Group/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
<=20 Years	1	68	101		6								176
21-25		65	235	63	34	195	42	5				18	657
26-30		40	332	56	87	384	211	37	1			65	1213
31-35	4	55	218	98	55	353	135	57	32	1		20	1028
36-40		50	190	70	66	200	137	69	38	7		22	849
41-45		22	195	78	65	252	171	109	29	13		11	945
46-50		57	211	106	83	145	135	97	55	20	1	2	912
51-55		38	224	123	95	164	112	81	45	12		1	895
56-60		95	146	107	81	147	90	46	27	7		8	754
61-65		55	106	30	36	62	34	33	7				363
66-70		6	28	17	7	12		3		3			76
>=71 Years		9	11	1	9	2		1					33
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Disability and Pay Group

Disabled/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
No	5	393	1624	553	471	1425	783	375	183	29	1	123	5965
Not Declared		48	29	33	13	219	47	39	19	7		14	468
Prefer Not To Answer				3									3
Unspecified		88	242	122	91	175	177	114	28	27		9	1073
Yes		31	102	38	49	97	60	10	4			1	392
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Bisexual			17		4	30	5	2					58
Gay or Lesbian		8	32	21	2	21	23	11	10			3	131
Heterosexual or Straight	5	407	1675	604	498	1392	891	400	191	35	1	108	6207
Not stated (person asked - declined to provide a response)		88	139	78	65	383	92	62	20	9		25	961
Undecided					5								5
Unspecified		57	134	46	50	90	56	63	13	19		11	539
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Sex and Pay Group

Sex/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Female	1	336	1770	624	583	1738	920	471	174	20		77	6714
Male	4	224	227	125	41	178	147	67	60	43	1	70	1187
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Religious Belief and Pay Group

Religious Belief/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Atheism		63	273	68	102	166	163	64	37	1	1	10	948
Buddhism		5		7		5						5	22
Christianity	4	257	949	411	276	1082	535	255	145	12		32	3958
Hinduism		1	26	5	11	60	13	14	1	7		13	151
I do not wish to disclose my religion/belief	1	123	280	112	100	345	164	86	22	14		23	1270
Islam			33	7	9	23	26	15	7	3		45	168
Jainism					2				1	1			4
Judaism										1			1
Other		55	314	91	71	154	117	39	6			4	851
Sikhism		2	5	2	1	5		8	2	4		4	33
Unspecified		54	117	46	52	76	49	57	13	20		11	495
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Marital Status and Pay Group

Marital Status/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Civil Partnership		13	27	13	5	16	14	10	5				103
Divorced		58	125	81	72	67	88	62	32	1		4	590
Legally Separated		14	33	9	20	9	8	8					101
Married		178	838	384	291	1012	520	327	141	47		50	3788
Single	5	250	892	248	218	729	402	111	39	11		80	2985
Unknown		31	41	7	11	43	34	12	12	3	1	8	203
Widowed		8	25	6	5	4	1	4	1				54
Unspecified		8	16	1	2	36		4	4	1		5	77
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Sickness Episodes by Ethnic Origin and Pay Group

Ethnic Origin/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
A White - British		352	1587	613	536	880	836	444	202	31	1	29	5511
B White - Irish		6	6	6	1	20	14	9	3				65
C White - Any other White background	1	108	117	30	14	138	44	13	5			10	480
CA White English						2							2
CF White Greek			3										3
CK White Italian							3		1				4
CN White Gypsy/Romany						3							3
CP White Polish		5					6						11
CS White Albanian						5							5
CY White Other European						7						4	11
D Mixed - White & Black Caribbean		7	12	4	7	14	6						50
E Mixed - White & Black African						11	1			1			13
F Mixed - White & Asian		1	1		2	5	3	3					15
G Mixed - Any other mixed background		1	11	14	2	5	1	2					36
GC Mixed - Black & White				2									2
GE Mixed - Asian & Chinese						2							2

Ethnic Origin/ Pay Group	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
H Asian or Asian British - Indian		10	93	17	16	454	51	31	4	23		27	726
J Asian or Asian British - Pakistani			5	4	7	3	6	2		2		29	58
K Asian or Asian British - Bangladeshi			16	1		5	5	1	5			3	36
L Asian or Asian British - Any other Asian background		2	36	8	3	38	1	1	3	4		3	99
LE Asian Sri Lankan												3	3
LH Asian British			2										2
LK Asian Unspecified		1											1
M Black or Black British - Caribbean		10	19	9	7	27	12	1					85
N Black or Black British - African	4	18	39	22	9	153	35	10				9	299
P Black or Black British - Any other Black background		5	6		2	7	2	2					24
PB Black Mixed												2	2
PC Black Nigerian						4							4
PD Black British				3		1	2						6
PE Black Unspecified						1							1
R Chinese		1	1	1		7	2					4	16
S Any Other Ethnic Group			13	2	7	22	10	10				8	72
SC Filipino						8							8
SE Other Specified			4							1			5
Unspecified			2							1		5	8
Z Not Stated		33	24	13	11	94	27	9	11			11	233
Grand Total	**5**	**560**	**1997**	**749**	**624**	**1916**	**1067**	**538**	**234**	**63**	**1**	**147**	**7901**

Leaving Employment

Leavers by Age Band and Pay Group

Age Band/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
<=20 Years	7	8										15
21-25	5	15	2	2	9	2	1	1				37
26-30	4	17	6	4	24	9	2	1				67
31-35	2	5	3	2	19	9	3	2				45
36-40	3	8	5	2	5	5	4	5			2	39
41-45	2	6	1	2	5	4	5	1	1			27
46-50	1	9	4	1	12	3	3	1		2	2	38
51-55	1	9	8	3	7	6	7	5	1	1		48
56-60	5	10	4	3	6	5	10	1	3		1	48
61-65	2	6	6	3	5	5	4	3	1			35
66-70	2	1	2	2	3	1	4		1			16
>=71 Years				2	1							3
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Disability and Pay Group

Disabled/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
No	27	77	36	19	78	39	26	13	5	1	4	325
Not Declared	2	2		1	8	3	5	2		2		25
Unspecified	4	8	4	4	7	5	11	4	2		1	50
Yes	1	7	1	2	3	2	1	1				18
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Sexual Orientation and Pay Group

Sexual Orientation/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Bisexual		2			1	1						4
Gay or Lesbian	1	2	1		3							7
Heterosexual or Straight	28	79	37	18	77	40	31	17	5	1	3	336
Not stated (person asked but declined to provide a response)	2	8	2	7	12	6	5	2		2	1	47
Unspecified	3	3	1	1	3	2	7	1	2		1	24
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Sex and Pay Group

Sex/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Female	17	75	35	18	78	36	36	12	5	2	3	317
Male	17	19	6	8	18	13	7	8	2	1	2	101
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Religious Belief and Pay Group

Religious Belief/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Atheism	2	17	2	4	7	10	4	3				49
Buddhism		1	1		1		1					4
Christianity	17	42	24	13	58	24	21	8	4	1		212
Hinduism						2		1			1	4
I do not wish to disclose my religion/belief	6	12	7	6	14	9	5	5	1	2	1	68
Islam		3	2	2	5		1				2	15
Other	5	16	5		7	3	5	1				42
Sikhism	1				1			1				3
Unspecified	3	3		1	3	1	6	1	2		1	21
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Marital Status and Pay Group

Marital Status/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
Civil Partnership	2	1	1		1	2						7
Divorced	3	3	2	4	5	5	5	1		1		29
Legally Separated		2	1			1			1			5
Married	11	41	23	12	45	24	30	11	6	2	5	210
Single	15	46	12	8	43	15	8	8				155
Unknown	2		1	1	2							6
Widowed	1		1			1						3
(blank)		1		1		1						3
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Leavers by Ethnic Origin and Pay Group

Ethnic Origin/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
A White - British	21	78	33	18	54	35	30	16	4	2	1	292
B White - Irish		1	1		3	1	1					7
C White - Any other White background	6	7	1	2	6	6	1					29
CK White Italian					1							1
CN White Gypsy/Romany					1							1
CU White Croatian					1							1
CY White Other European					2							2
D Mixed - White & Black Caribbean					1	1						2
F Mixed - White & Asian									1			1
G Mixed - Any other mixed background		1	1	1	1		1					5
H Asian or Asian British - Indian	1	1			6	2		2			1	13
J Asian or Asian British - Pakistani		2			1		1				3	7
K Asian or Asian British - Bangladeshi		1	1	2								4
L Asian or Asian British - Any other Asian background	1	2	1		1		1					6
M Black or Black British - Caribbean				1	2		3		1			7
N Black or Black British - African	5	1			8	2	1					17

Ethnic Origin/ Pay Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Other	Other Medical	Grand Total
P Black or Black British - Any other Black background					2							2
PD Black British			1		1							2
R Chinese			1		1			1				3
S Any Other Ethnic Group			1				1		1			3
Z Not Stated				2	4	2	3	1		1		13
Grand Total	**34**	**94**	**41**	**26**	**96**	**49**	**43**	**20**	**7**	**3**	**5**	**418**

Report To	**TRUST BOARD**
Date of Meeting	**26 July 2019**

Title of the Report	**Equality and Diversity Progress Report for Staff**
Agenda item	17
Presenter of Report	Janine Brennan, Director of Workforce
Author(s) of Report	Sarah Kinsella, Corporate HR Officer
Purpose	Assurance that the workforce equality agenda is being implemented for staff across the Trust

Executive summary

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

- Workforce annual report and monitoring report
- Equality objectives/4 year plan
- Divisional objectives
- Workforce Race Equality Standard
- Gender Pay Gap Reporting
- BAME (Black, Asian and Minority Ethnic) Group
- Rainbow Badges

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the objectives.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed

	decision/document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 Equality Act 2010 (Gender Pay Gap Information Regulations 2017) NHS Constitution Equality Delivery Scheme (EDS2) Workforce Disability Equality Standard (WDES) Workforce Race Equality Standard (WRES)
Actions required by the Committee The Board is asked to approve the content of the report.	

Trust Board
25 July 2019

Equality and Diversity Staff Group – Progress Report

1. Introduction

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

This report provides the key highlights of actions taken:

- Annual Report and Monitoring Report 2018/2019
- Equality Objectives/4 Year Plan
- Gender Pay Gap Reporting
- Workforce Race Equality Standard and Workforce Disability Equality Standard
- 2018 NHS Staff Survey Equality and Diversity Key Findings
- BAME Group
- Rainbow Badges

2. Body of Report

The key actions from the March and June 2019 meetings are as follows:

Equality and Diversity Workforce Annual Report and Monitoring Report 2018/2019

The two reports were completed and approved by the Equality and Diversity Staff Group in June 2019, in preparation for endorsement by the Workforce Committee in July 2019. They will be published on the Trust's website, as part of its requirements under the Public Sector Equality Duty.

Equality Objectives/Four Year Plan 2016 – 2020

A progress report on the equality objectives/four year plan was presented to the Equality and Diversity Staff Group at the March and June 2019 meetings. Progress continues against the objectives including actions related to improving the mental wellbeing of staff and leadership management training. Progress also continues in relation to the Respect and Support Campaign.

Gender Pay Gap Reporting

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) the Trust submitted its 2018 data to the Government and published it on the Trust's website in February 2019.

Each year a mean and median average gap calculation is required. The results for the two years the reporting has taken place so far are:

Year	Mean Average Gap Gap for females being paid less than males at NGH	Medial Average Gap Gap for females being paid less than males at NGH
2017	30%	9.5%
2018	29.7%	8.9%

Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES)

Work is currently taking place on the annual WRES submission to NHS England. The data will be submitted in August 2019 for publication on our website in September 2019.

Likewise the first Workforce Disability Equality Standard (WDES) submission is also underway with the data also to be submitted in August 2019 for publication on our external website in September 2019.

2018 NHS Staff Survey Equality and Diversity Key Findings

The demographics of the staff that responded when compared to the Trust profile were broadly similar, with the exception of disabled staff where 19% of the survey respondents identified they has a disability compared to the 3% of our workforce recorded on ESR as having a disability.

This year the survey changed the way the results are calculated and the previous key findings have been replaced with 10 themes, each scored out of 10, one of which relates specifically to equality.

For the equality theme the Trust scored 8.9 out of 10, which is a 0.1 deterioration from 2017. The national average score was 9.1, with the best Trust scoring 9.6 and the worst Trust scoring 8.1.

Under this theme there are 4 questions from the survey that contribute to the overall theme result:

- Q14 - Organisation acts fairly with regard to career progression / promotion regardless of protected characteristic?
  There has been a deterioration of 2.5% and we are worse than the national average by -0.5%.

- Q15a - In the last 12 months experienced discrimination at work from patients / service users, relatives or public?
  There has been a deterioration of +2.2% and we are also worse than the national average by +2.3%.

- Q15b - In the last 12 months experienced discrimination at work from manager / team leader or other colleagues?
  There has been a deterioration of +0.8% and we are also worse than the national average by +2.5%.

- Q28b - Has adequate adjustments been made to enable you to carry out your work?
  There has been an improvement of +7.5% and we are also better than the national average by +4.0%.

The overall Trust staff engagement score was 7.1, with the national average being 7.0.

The table below shows the top and bottom groups of staff, for staff engagement, by protected characteristic, as recorded in the staff survey:

Top 5		Bottom 5	
1	Lesbian staff (7.7)	1	Gay staff (6.4) Prefer not to say – gender (6.4)
2	Buddhists (7.6)	2	Prefer not to say – religion (6.5)
3	Bisexual staff (7.5)	3	Hindhu staff (6.6)
4	Aged 66+ staff (7.3)	4	Disabled staff (6.7) Aged 16-20 staff (6.7)
5	Aged 41-50 staff (7.2) Non-Disabled staff (7.2) Female staff (7.2) Any other religion (7.2) Christian staff (7.2)	5	Male staff (6.8)

In relation to equality, the survey results have mostly indicated deteriorations for the Trust when compared to our 2017 results and the national average.

Work underway includes a pilot ‘recruiting for difference’ and a cultural deep dive to gain insight from staff who have a protected characteristic.

BAME (Black, Asian and Minority Ethnic) Group

During the course of 2019 we have been working with two enthusiastic members of staff to set up and launch a BAME Group. The aim of the group is to enhance and facilitate interdependent and collaborative working across core members to promote inclusion, equality, empowerment for staff who work at Northampton General Hospital and identify as BAME. The first meeting of the group is planned for 23 July 2019.

Rainbow Badges

The Rainbow Badge initiative, which originated at Evelina Childrens Hospital in London, is a way for NHS staff to demonstrate that they are aware of the issues that LGBT+ people can face when accessing healthcare.

The badge itself is intended to be a simple visual symbol identifying its wearer as someone who an LGBT+ person can feel comfortable talking to about issues relating to sexuality or gender identity. It shows that the wearer is there to listen without judgement and signpost to further support if needed.

By choosing to wear a badge our staff are sending a message that “you can speak to them”. They aren’t expected to resolve all issues and concerns but they are a friendly ear. Staff wearing a badge don’t have to identify as LGBT+ they just have to be willing to listen.

Rainbow Badges launches at the Trust on 15 July 2019, with an event at the Cyber Café and this will be supported by other types of ongoing promotion, for new and existing staff.

3. Recommendations

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

4. Next Steps

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

Report To	**Trust Board**
Date of Meeting	**26th July 2019**

Title of the Report	**Board Assurance Framework Q1 2019-20**
Agenda item	**18**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Purpose	To provide the Group with up to date information on the Board Assurance Framework (BAF) with respect to those risks scoring 15 and above. This report describes the Q1position in relation to the Board Assurance Framework and risks associated to delivery of corporate objectives described on the BAF

Executive summary

The purpose of the Board Assurance Framework is to provide the Trust Board of Directors with a simple but comprehensive method for the oversight of the effectiveness of the controls on the principal risks to meeting the Trust's objectives.

The BAF maps out both the key controls in place to manage the principal risks and also how sufficient assurance has been gained about the effectiveness of these controls.
It also provides a structure for various audit programmes and evidence to support the Annual Governance Statement.

The Audit committee is the principal assurance committee of the Trust Board and reviews the BAF register at each meeting

Each Principal risk has been assigned to one or more Board committees.

2. Assurance

The Trust Board is only properly able to fulfil responsibilities through an understanding of the principal risks facing the organisation. The Board, therefore, needs to determine the level of assurance that should be available to them with regard to those risks.

Principle Risks have been assigned to specific Board committees for discussion and challenge prior to presentation at Trust Board.

3. Population of the BAF

3.1 Executive Director Leads have reviewed and updated all sections of the previous BAF iteration in line with corporate objectives with a particular emphasis on any gaps in control, gaps in assurance, and the assurance position. The actions and milestones have been updated accordingly.

BAF Legend(Quick Guide)

The Assurance Framework has the following headings:

Principal risk	What could prevent the objective being achieved? Which area within the organisation does this risk primarily impact on clinical organisational or financial?
Key Controls in place	What controls/systems do we have in place to assist secure delivery of the objective? What is our mitigation for the risk?
Sources of Assurance on controls, including assurance level	Where can we gain evidence relating to the effectiveness of the controls/systems which we are relying on?
Gaps in control and/or gap in assurance	What does the evidence tell us in relation to the effectiveness of the controls/systems which are being relied upon? Are there any gaps in the effectiveness of controls / systems in place? What does the evidence tell us in relation to the assurance in respect to the controls/systems which are being relied upon? Where can we improve evidence about the effectiveness of one or more of the assurance / systems which we are relying on?
Action plan	Plans to address the gaps in control and/ or assurance and indicative completion dates

.

Changes to the BAF during Q1:

General changes made are as follows:

- Summary sheet provided for discussion purposes- potential additions include risk categories e.g.
  - Financial health and sustainability
  - Patient safety
  - Patient experience
  - Workforce capacity, capability and engagement
  - Systems, information and processes
  - Regulatory compliance and national targets
  - Equipment & estates
  - Strategy and system alignment
  - Reputation and brand

And Risk Appetite

- Initial Risk score dates have been updated to reflect the score at the end of Q4 2018/19.
- All references to Board sub committees have been changes to Board committees.
- All updates are presented in red ink for easy identification

The following updates have been made to the Principal Risks assigned to the Board committees:

1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services- Quality Governance Committee
- Sources of assurance, gaps in control and actions have been updated.

1.2 Risk of Failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties- Finance & Performance
- Key controls, gaps in assurance and actions updated

1.3 Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment- Quality Governance Committee
- Actions have been updated. Until Q1 completed baseline data will not be available for a significant proportion of CQUINS with a potential loss of 1.5% of contract value. Therefore the score has been increased from 8- 16

1.4 Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice- Quality Governance Committee
- Key controls, sources of assurance and actions updated.

1.5 Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on

patient safety and experience- Quality Governance Committee
- Principle Risk updated to include quality of care, key controls, sources of assurance and actions updated.

1.6 Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience- Quality Governance Committee/ Workforce Committee
- Actions updated.

1.7 Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failure- Quality Governance Committee/ Finance & Performance Committee
- Actions updated.

1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust- Finance & Performance
- Key Controls and actions updated

2.1 Risk that the Trust fails to promote a culture which puts patients first- Quality Governance Committee
- Key controls, gaps in controls and actions updated.

3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future- Workforce Committee
- Actions updated

3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- Workforce Committee
- Actions updated

3.3 Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture- Workforce Committee
- Actions updated

4.1 Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access- Finance & Performance
- Key controls, sources of assurance and actions updated.

5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2018/19 financial plan- Finance & Performance Committee
- Score increased from 8 to 20 due to the Q1 position being off plan. Actions updated.

5.2 Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH Programme- Finance & Performance Committee
- Score increased from 12 to 20 due to the recurrent savings challenge in year. Actions updated.

5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements Finance & Performance Committee
- Score increased from 10 to 15 due to NHSI/E request for a 20% cut in capital plans. Actions updated. Actions updated

Questions the Board may specifically want to ask in respect to the BAF:

- What does the evidence tell us in relation to the effectiveness of the controls/systems which are being relied upon?
- Are there any gaps in the effectiveness of controls / systems in place?
- What does the evidence tell us in relation to the assurance in respect to the controls/systems which are being relied upon?
- Where can we improve evidence about the effectiveness of one or more of the assurance / systems which we are relying on?

• **Related strategic aim and corporate objective**	ALL

Risk and assurance	The Board assurance framework describes key risks to the Trust's corporate objectives and informs the organisational Annual Governance Statement
Related Board Assurance Framework entries	ALL
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	The Board assurance framework is cross referenced to the Care Quality Commission Standards of Quality and Safety which the organisation has a statutory duty to meet.

Actions required

The Board is asked to:

- Note the changes made to the BAF
- Consider if the Board is gaining sufficient assurance that controls and actions in place are mitigating risks described

Northampton General Hospital NHS
NHS Trust

Board Assurance Framework 2019/20

Quarter 1

BAF RISK ID	CQC STANDARD (see Key)	PRINCIPAL RISK DESCRIPTION/FACTOR	MONITORING BOARD COMMITTEE	EXECUTIVE RISK OWNER	KEY CONTROLS	SOURCES OF ASSURANCE	GAP IN CONTROL OR ASSURANCE	INITIAL RISK SCORE AT End Q4 2018/19 C	L	RATING	CURRENT RISK SCORE C	L	RATING	ACTIONS & MILESTONES UPDATE	TARGET/ RESIDUAL RISK SCORE C	L	RATING	Risk Rating trend
CORPORATE OBJECTIVE 1 – FOCUS ON QUALITY AND SAFETY **We will protect patients from harm, provide best possible outcomes and make sure they have a good experience of care in a timely manner. We will empower our people to get things done and be constantly vigilant in keeping high quality standards ensuring that quality information is shared quickly with the people best placed to improve care. Where we can we will take opportunities to compare ourselves with, and learn from others to support our efforts for excellence. We will put patients at the heart of everything we do.**																		
PRINCIPAL RISK 1 – Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.																		
BAF 1.1	All Regulations	Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services CRR reference risks *1782, 1879, 1911, 366, 1867, 1902, 1611, 1303,*	Quality Governance committee	DoCDG & A	Clinical Governance structures and processes Clinical Audit strategy Board to Ward visits Quality metrics in Performance report to Board Divisional Quality Governance reports to Clinical Quality & Effectiveness (CQEG) committee Quality meetings with commissioners Quality Governance committee Clinical Quality & Effectiveness Group Patient and Carer experience Group ARC reports to QGC Ward Accreditation. CQC Relationship meetings.	Quality Governance committee report to Trust Board (L2) Trusts Quality Improvement scorecards (L1) Audit committee report to Board (L2) CQC inspection 2017 – rated GOOD (L3) Assessment and accreditation reports to Trust Board (L1) Divisional Quality Governance assurance reports to CQEG (L1) Compliance reports to QGC (L1) Peer review visits (L3) Screening QA visits (L3) Deanery visits (L3) Internal audit report- Operational Review of BAF & Risk Management – Stage I (November 18) (L3) ARC reports to QGC(L1) CQC Insight report (L3) CQC Engagement meetings (L3) JAG Accreditation (L3)	Trust has red flags related to Medical Trainee reports CQC Insight report indicates that due to the Trust's composite indicator score is similar to other trusts that are more likely to be rated requires improvement. Previous (2017) CQC Report highlighted EOL-Responsive Domain, which was rated RI for improvement. HSE Prohibition notice- Cat 3 Laboratory	5	2	10	5	2	10	**Quarter 2** A review of governance committee reporting structures has resulted in combining the risk and compliance meeting with ARC to become the key risk meeting at sub- board level and reduce repetition/ attendance requirements. The first engagement meeting has been held with the CQC and Trust staff. Further actions have been identified to improve staff engagement/ attendance in CQC processes and future events. A review and revision of Divisional Quality reports to CQEG is underway. **Quarter 3** A review of the Risk strategy is underway with an update to QGC planned in January 19. A review of Board papers has been undertaken with Executives to reduce repetition of information and ensure information presented to Board is more strategic. **Quarter 4** The Risk strategy has been reviewed and updated and was presented and ratified by QGC in February 19. A new Director of Medical Education is in post and an agreed joint governance review of a red flagged medical training specialty is underway supported by HEEM. Two other red flagged training areas have action plans in place with appropriate assurance provided. Work is ongoing to improve gaps in assurance for EOL – previous CQC Inspection rating of RI for Responsive Domain. DNACPR/ MCA spot audits are underway to provide assurance of appropriate practice. **Quarter 1** Use of Resources and CQC Core Services Inspection took place in June, the latter reviewing Medicine, ED and Maternity services. Well Led Inspection to take place 24th & 25th July. Deanery, HEE GMC and NHSI meeting held in May confirmed that clinical oncology training posts will remain unfilled until October 2019 by which time a number of actions and requirement must be in place to provide assurance prior to reinstatement of training posts. JAG Accreditation status gained for Endoscopy Services. Prohibition Notice issued by HSE on some activities in Cat 3 Laboratory following inspection in June. Task and finish Group underway to resolve issues urgently.	5	1	5	↔

								INITIAL RISK SCORE AT End Q4 2018/19			CURRENT RISK SCORE				TARGET/ RESIDUAL RISK SCORE			
BAF RISK ID	CQC STANDARD (see Key)	PRINCIPAL RISK DESCRIPTION/FACTOR	MONITORING BOARD COMMITTEE	EXECUTIVE RISK OWNER	KEY CONTROLS	SOURCES OF ASSURANCE	GAP IN CONTROL OR ASSURANCE	C	L	RATING	C	L	RATING	ACTIONS & MILESTONES UPDATE	C	L	RATING	Risk Rating trend
CORPORATE OBJECTIVE 1 – FOCUS ON QUALITY AND SAFETY **We will protect patients from harm, provide best possible outcomes and make sure they have a good experience of care in a timely manner. We will empower our people to get things done and be constantly vigilant in keeping high quality standards ensuring that quality information is shared quickly with the people best placed to improve care. Where we can we will take opportunities to compare ourselves with, and learn from others to support our efforts for excellence. We will put patients at the heart of everything we do.**																		
PRINCIPAL RISK 1 – Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.																		
BAF 1..2	Reg. 12	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties CRR reference risks 1196,1611,1303, 368, 1305,1782, 1911,1867, 1902	Finance, Investment and Performance committee	COO	Performance management framework policy Bi- Monthly performance reviews by Division Weekly Directorate performance meeting Daily Cancer times Patient time line performance meeting Bed meetings and safety huddle daily with escalation processes in place Symphony IT monitoring system in use for A&E NHSI review meetings monthly Changing Care @ NGH Programme Board - work-stream includes Inpatient Productivity Any 28day cancellations due to pressures can only be authorised by Chief Operating Officer A&E delivery Board Cancer Improvement Group meeting monthly Countywide COO group oversee schemes for A&E improvement County wide Cancer Board meets monthly Somerset reporting cancer Twice weekly tracking for DTOC Weekly review meeting for "stranded" patients Pathways meeting CCG fortnightly all organisations Elective Care Board CCG Monthly	Performance metrics at corporate, divisional and directorate level (L1) Finance, Investment and Performance committee to Trust Board (L2) Integrated performance report to Trust Board and committees (L1) Recovery trajectory for • A&E 4 hr target • Cancer targets • RTT (L1) Changing Care @ NGH programme to reduce LOS (L1) Outcome of NHSI accountability meetings (L3) Performance trajectories for • A&E • Cancer – 62days • RTT – incomplete • C Diff • MRSA Submitted to NHSI and CCG (L1) Good engagement with the intermediate care project across health & social care. (L2) A&E received rating of Good in CQC inspection 2017 with outstanding for well led. (L3) Benchmarking against other Trusts. (L3) Winter Plan. (L1)	Report to Board indicates under performance for: • Cancer targets (62 days) • A and E • RTT Limited assurance from Internal Audit on Admissions & discharges audit. Attendances, admissions, and acuity remain high Lack of capacity within endoscopy services causing outsourcing to private sector Outsourcing of elective activity to reduce backlog Social Care reductions may impact on attendance in A&E and flow in hospital Key posts in A&E remain difficult to recruit to. No lead Cancer clinician Poor Radiology attendance at MDT due to resource issues Key nursing and medical posts remain difficult to recruit to. Poor clinical attendance at Cancer Board Insourcing breast cancer capacity t meet demands Insourcing and Outsourcing Endoscopy activity to meet increasing demands	4	5	20	4	5	20	**Quarter 3** A&E performance remains below trajectory and the national target. The Nye Bevan Unit opened in October 2018 but due to lift failures to Esther White ward had to be closed during November with patients transferred to Benham Ward. From December 2018 additional doctors and capacity were put into place as part of the Winter Plan, Additional Intermediate Care capacity (Intermediate Care Business case) was put into place from October 2018 and during November and December additional Pathway 3 capacity has been put into place. The performance for 62 days and 2 week wait Breast continues to be a challenge. A daily PTL meeting is in place along with the clinically led Cancer Board. Breast capacity is constrained nationally due to a shortage of breast radiologists. Patient Choice remains problematic, with national rules not allowing for clock stops and limited robotic surgery capacity at UHL for the urology pathway. RTT performance remains below (original) trajectory and national target but post CaMIS implementation performance is on (revised) trajectory. Each speciality has an action place in place and trajectory. These are monitored through the weekly performance meetings. There are no patients waiting over 52 weeks. The Trust maintains its commitment to ensuring high standards of infection prevention and control. At the end of Q3 there remained 0 incidents of MRSA bacteraemia year to date and 13 cases of CDiff have been identified- all of which have been reviewed with no lapses in care identified. The monthly Safety Thermometer Prevalence Study continues with in excess of 97% of our patients receiving harm free care. **Quarter 4** A&E performance remains below trajectory for Q4. During January 2019 the new way of working with the medical consultants rota was implemented which reduced waiting times significantly for medically referred patients. The fixing the flow programme has been re launched with 2 workstreams. Front door led by the Medical Director and Backdoor led by the Director of Nursing. The programme is overseen by the DCEO. Cancer performance continues to be challenging for 2 week waits and 62 days. In Q4 challenged areas are breast, dermatology, Head and Neck and Urology. A new PTL weekly meeting led by the DCEO has been introduced. Additional capacity for dermatology and breast is being sourced. RTT is currently below target, this is mainly due to a mismatch between capacity and demand although performance is increasing slightly each month. Each speciality has an action plan and a trajectory and they report weekly to a performance meeting led by the DCEO. DTOC have increased in March 2019 despite additional pathway 3 capacity being put in place. Diagnostic target continues to be achieved. Each Division is held to account monthly on Quality, Performance and finance using the performance Management Framework.	4	2	8	↔

BAF RISK ID	CQC STANDARD (see Key)	PRINCIPAL RISK DESCRIPTION/FACTOR	MONITORING BOARD COMMITTEE	EXECUTIVE RISK OWNER	KEY CONTROLS	SOURCES OF ASSURANCE	GAP IN CONTROL OR ASSURANCE	INITIAL RISK SCORE AT End Q4 2018/19 C	L	RATING	CURRENT RISK SCORE C	L	RATING	ACTIONS & MILESTONES UPDATE	TARGET/ RESIDUAL RISK SCORE C	L	RATING	Risk Rating trend
CORPORATE OBJECTIVE 1 – FOCUS ON QUALITY AND SAFETY **We will protect patients from harm, provide best possible outcomes and make sure they have a good experience of care in a timely manner. We will empower our people to get things done and be constantly vigilant in keeping high quality standards ensuring that quality information is shared quickly with the people best placed to improve care. Where we can we will take opportunities to compare ourselves with, and learn from others to support our efforts for excellence. We will put patients at the heart of everything we do.**																		
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														Quarter 1 Cancer performance continues to be challenging for 2 week waits and 62 days. In Q1 challenged areas are breast, Head and Neck and Urology. Reorganisation of the 2 Dep COO roles in May 19 so that one post looks after urgent care and discharge and the other Elective care and cancer to provide dedicated support to the challenged areas A new PTL daily meeting led by the DCEO has been introduced. Additional capacity for dermatology has been sourced and is delivering the national standard but Breast continues to be a challenge across the entire county from a work force perspective. Currently insourcing extra clinics from a private provider every weekend to provide extra capacity. Merger of the entire breast service with KGH to create a county wide service is being pursued. RTT is currently below target, this is mainly due to a mismatch between capacity and demand although performance is increasing slightly each month. Each speciality has an action plan and a trajectory and they report weekly to a performance meeting led by the DCOO. Diagnostic target failed in April and May due to failures of the washers in Endoscopy and the subsequent capital replacement of the washers. This is coupled with increased referrals for scopes. Currently outsourcing activity to Ramsay Health (150 patients a month) and Insourcing with a private provider on site every weekend in our own unit. Not expected to achieve target till Q3 due to backlog Each Division is held to account monthly on Quality, Performance and finance using the performance Management Framework. The new medical model has increased trusts compliance with SAFER principals in that it ensures our acute medical patients have a consultant review 7 days a week with consultant attached to the NB from 0800-10pm and medical reg 24/7. The failure to meet the four hour standard is multifaceted and requires systemic changes across not just urgent care but base wards. ED have embedded the majors lite model which has increased our average daily none admitted performance to 96% and reduced crowding in the department significantly by ensuring that churn is constant of patients who are not requiring admission. Ambulatory has introduced additional pathways which have increased our ambulatory utilisation by a third and is in the process of sharing the pathways with local ambulance provider to allow direct access from ambulance conveyances. Work is being undertaken with primary care, CCG and EMAS specifically focusing on attendance avoidance with a system wide workstream underway following a MAAD event in May 2019. Internally we are in the process of launching electronic whiteboards and board round SOPs with real focus on matron and medical support, standardisation of board rounds and SAFER principals. Super stranded rates have decreased with the introduction of a daily 'top 10' summit with multi sector actions and escalations each day. Stranded continues to be problematic with the trust now placing focus on patients in the 7-20 day group and developing a robust tracking and escalation process. Site team meetings now have ward sisters attend with expectation of real time allocation of patients to beds, escalation of any delays and increased emphasis on ward staff knowing what the enxt steps are for their patients to expidite the recovery- this will take some time to embed but is expected to greatly assist with our stranded patient numbers. A review is underway of discharges during the weekend and we are in the initial phases of identifying what is required to ensure we have robust discharges 7 days a week from base medical wards.				

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BAF 1.3	Reg. 12	Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment	Quality Governance Committee	MD	Clinical Quality and Effectiveness Group Quality Governance Committee Contracting meetings with Commissioners Finance, Investment and Performance committee Regular contract meetings with CCG CQUINs oversight Group	Quarterly reports to commissioners (L3) Quarterly reports to Clinical Quality and Effectiveness Group (CQEG) (L1) Reports from CQEG to Quality Governance committee (L1) Quality Governance report to Trust Board (L2) Medical Director report monthly report to Board from Q3 onwards (L1) DON Monthly report to Board. (L1)	Contract with specialist commissioning not yet signed Until Q1 completed baseline data will not be available for a significant proportion of CQUINS Potential loss of 1.5% of contract value	4	2	8	4	4	16	**Quarter 2** The trust has achieved in excess of its forecast CQUIN performance in Q2 and remains on track. **Quarter 3** The trust has achieved in excess of its forecast CQUIN performance in Q2 and remains on track. **Quarter 4** Grip and scrutiny continued- contractual agreement resulted in 91% of CQUINs delivered. **Quarter 1** Awaiting availability of baseline data from Quarter 1 prior to any further action.	4	2	8	↑

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BAF 1.4	Reg. 12	Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice CRR reference risks *1879, 1782, 1955, 368, 1867,*	Quality Governance committee	MD/ DON	Monthly review of Dr Foster information and alerts Mortality Review Group Audit plan Incident and SI reporting policy Monthly Clinical Quality and Effectiveness Group Monthly Quality Governance committee Countywide Patient safety M&M meetings Review of Harm Group weekly Dare to Share alternate monthly Deteriorating Patient Board and Operational Groups FIT Group	Reports from Mortality review to CQEG and Quality Governance Committee (L1) CQEG reports to Quality Governance committee (L1) Medical and Nurse Director reports to Quality Governance and Trust Board (L1) Quality Governance reports to Trust Board (L2) Dr Foster data reports (L3) Results from Clinical audit (L1) Trusts Quality scorecard (L1) Patient Safety, Clinical Quality and Governance bi annual report (L1) Review of Harm Group monitoring implementation for SI action plans (L1) HSMR & SHMI data (L3) National Learning and reporting system data (L3) Incident report to Quality Governance committee (L1) Ward Assessment and Accreditation scheme (L2) Safety thermometer metrics via DoN report (L2) CQC inspection 2017- Rated Good (L3) Delivery of infection control trajectory requirements at end of 2019/20 (L1) Reports to FIT Group (L1)	Dr Foster data outlier re • Other perinatal conditions • Congestive cardiac failure • Respiratory failure • Secondary malignancies NICE-/ VTE compliance remains inconsistent Recurrent themes of harm identified requiring thematic approach to redress. Medical Examiner role requires an increase in resource required.	5	2	10	5	2	10	**Quarter 2** The Trust has successfully delivered on assigned trajectories for infection control e.g. C Diff and MRSA. Overall trend for Pressure ulcers remains on a downward trend. Compliance with VTE remains a challenge and the MD is now chairing the Thrombosis committee to provide leadership attention to improvements. Overall safety thermometer indicated overall harm free care as 93.51which is slightly below national average of 95% this quarter HSMR is just above the expected range. NGH is 1 of 5 Trusts within the peer group of 8 that sit within the 'above as expected' range There is no significant difference between the weekday and weekend HSMR for emergency admissions. Excision of the colon and or rectum alert: - The case series responsible for this alert will be reviewed through the mortality review group in the usual process and presented through CQEG A clot busting campaign has been instituted with significant increases in the rate of VTE recorded assessments pending the introduction of a forcing function to improve compliance through the trusts ePMA **Quarter 3** Significant improvement in VTE performance has been achieved on an interim basis through ha "clot buster" campaign and daily reporting of overdue assessments at the trust wide safety huddle. Some delay is expected to the introduction of the ePMA forcing solution but this is still expected to be introduced by the end of quarter 4. Delivered on assigned trajectory for Infection Control- CDiff/ MRSA (see objective 1). Overall trend for hospital acquired pressure ulcers continues on a downward trend. **Quarter 4** HSMR: Improved position- 104 (within expected range). Issues highlighted with electronic reporting of VTE assessments, spot audits to commence in new financial year. CCG review of VTE- action plan updated. Further delays in ePMA rollout due to issues identified in product testing- introduction delayed until the next quarter. Deteriorating patient care plan in progress for Trust roll out to identify patients earlier. Mortality review process for outliers as they occur continues- Trust process of learning from deaths well established, further discussions ongoing regarding management of increased resource requirements of the Medical Examiner role. Infection control: Year-end achieved target for CDiff, over trajectory for MSSA. **Quarter 1** MSSA above trajectory for month 2. Reset trajectory for CDiff (includes community and hospital onset). FIT group continues to undertake RCA's in response to falls with harm and pressure ulcers grade 2 and above- discussed regularly at share and learn events. HSMR remains within normal range. VTE assessment reporting back on-line. EPMA roll out next quarter.	5	1	5	↔

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BAF 1.5	Reg. 12	Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety, experience and quality of care CRR reference risks 1756, 1757, 368, 1280,	Quality Governance committee	MD/ DON	Reports to Clinical Quality and Effectiveness Group (CQEG) – 7 day services CQEG reports to QGC Work related to recruitment of all staff groups Work to revise medical rotas Job planning processes Review of clinical models in line with Trust 60 bedded unit Safe Staffing Report Quality Account Quality Improvement Strategy	Deputy Medical Director report to CQEG and HMT (L1) Quality Governance report to Trust Board (L2) Clinical Collaboration work to ensure robust services county wide across both acute Trusts (L1) Self-assessments undertaken biennially against 7 day services criteria (L1) Mortality review reports to QGC and Trust Board (L1) Safer staffing metrics (L1) CQC inspection 2017-rated Good (L3) Delivery of Quality Priorities (L1)	The area for continuing progress identified is "ongoing review" which relates predominantly to patients on medical base wards at weekends.	4	3	12	4	3	12	**Quarter 2** The Trust has made excellent progress against Core Standards 4, 5, 6 and 8 achieving 90, 87,100 and 90% compliances respectively in the April 2018 National audit. **Quarter 3** The trust is prepared for the transition to board assurance in place of national audits and focussing improvement action on ongoing review and early consultant review of non-elective patients. Safe Staffing levels reported monthly to Workforce Committee and the Board by the DON. Overall fill rate during Q3 was in excess of 94%. December fill rate 96%- (92% days/ 100% nights). "Real time" survey reporting in place supporting Friends and Family testing. This enables themes highlighted to be addressed e.g. noise at night. **Quarter 4** In the last National Audit for 7 day services the Trust was within the upper quartile of results for Midlands and East Region against 4 Core Standards, 7 Day services Self-Assessment- Board Assurance Framework presented to Trust Board in March 2019 prior to submission to NHSI. Further reviews of how to manage skills and capacity at weekends are ongoing. Fill rate for Safe Staffing continues to be over 95%. **Quarter 1** Safe staffing continues to be over 95% Additional pressure currently in the system due to continued use of escalation wards and increased use of agency nursing staff. Year 1 Quality Account implementation Plan in train with baseline KPI's to be confirmed. 7 Day Services: Board Assurance framework specific to 7 day services shows level of performance is being maintained.	4	2	8	↔

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BAF 1.6		Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience CRR reference risks 1455, 1280, 1188, 1756,1682	Quality Governance committee Workforce Committee	DoN	Nursing recruitment and retention plan including both UK and overseas recruitment programmes. Workforce committee Daily safety huddles x 3 Quality Governance committee Clinical Quality & Effectiveness Group Patient and Carer experience Group Safeguarding policies Safeguarding training Staffing escalation protocol Nurse Staffing Group Assessment and Accreditation Scheme reports to Board Nursing and Midwifery strategy	Nursing recruitment monthly recruitment pipeline tracker (L1) Monthly reports from Workforce committee to Trust Board (L2) Quarterly workforce report to workforce committee (L1) Quality Governance report to Trust Board (L2) Incident reporting (L1) Staff satisfaction survey (L3) Patient satisfaction survey (L3) CQC Inspection 2017 rated Good- (L3) Acuity and skill mix studies for nursing (L1) Hard Truths staffing report (L1) Open and Honest Care report (L1) Safety thermometer KPI's (L1) Falls data and benchmarking (L1) Nurse fill rate template (L1) Care hours per day per patient report (L1) Real time and Right Time surveys (L3)	Data in forward monthly recruitment pipeline tracker shows an ongoing shortfall in recruitment to nursing posts Trust turnover rate > 8% target Trust Sickness level > 3.8% target No uplift in pre-registration commissioning for nursing places. Unable to retain all graduating nurses who tend to relocate back to home base due to graduate nurse programme	5	5	20	5	5	20	**Quarter 2** In September new harm free care was 98.4%; overall harm free care as 92.2%. The Nursing & Midwifery staff fill rate continues to be monitored with an overall fill rate of 94% (RN) and 104% (HCA) reported for September. Twice daily staffing meetings led by the Director of Nursing ensure patient safety is maintained **Quarter 3** Overall for the quarter Harm Free Care was 96.4%- above the national score of 94.3%. "One stop" recruitment days now in place for HCA's. A demonstrable reduction in recruitment timeline noted- and will run monthly. Monthly RN recruitment in place supported by international recruitment pipeline. Safety Huddles increased to 3 x daily – additional huddle in the afternoon attended by Matrons and focus on clinical safety during following 24-48 hours. **Quarter 4** 99.38% of new harm free care in March 2019, overall 94.8%. 111 HCA's given job offers with 23 commenced in post. Recruitment days (Specialty and General) held in Q4. Current RN vacancy of 116 posts. 14 Nursing Associates appointed and in post. Pathway in place for 2-5 (Band) in place for alternative routes to Nurse Registration. Further work ongoing to increase oversea pipeline. Use of Social Media Networking to promote Trust. **Quarter 1** Harm Free care % continues above the national average. Proactive recruitment campaign continues. 53 HCA's in recruitment pipeline. Continue to support the establishment of nursing associate roles across the organisation, offering pathways into RN training via the Open University. Business case for internal nursing posts to be presented to July Workforce and Finance & Performance Committees.	5	2	10	↔

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BAF 1.7	Reg. 10 12 15	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures <u>CRR reference risks</u> 1701, 1738, 1783, 1174, 258, 1177, 1287, 1373, 1699, 1703, 1893, 1986, 1702	Quality Governance committee Finance, Investment and Performance committee	Do E&F	Health and Safety committee Fire safety committee Estates Compliance group Facilities Governance group Water safety group Resilience planning group Business continuity plan Training and scenario exercises undertaken Annual capital programme Medical Gas committee Ventilation group Asbestos group Fire Safety Task and Finish Group	H&S reports to Quality Governance committee (L1) Quality Governance committee reports to Trust Board (L2) Resilience planning group reports to Assurance, risk and compliance group (L1) Assurance, risk and compliance group reports to Quality Governance committee (L1) Regular reports to capital Group (L1) Capital Group reports to Finance, Investment and Performance committee (L1) Finance, Investment and Performance committee reports to Trust Board (L2) Annual Audit of high risk and statutory systems - Ventilation - Asbestos - Electrical - Gas PLACE audits (L3) H&S risk assessments (L1) Fire safety inspections (L3) HSE inspection(L3) ERIC self- assessment returns (L1) Premises Assurance model self- assessment (L1) External review audit of water hygiene annually (L3) Internal Audit report- Limited assurance opinion – Health and Safety (L3) Carter review paper (L1) CQC inspection 2017- rated Good (L3) Back log maintenance programme in place based on risk assessment (L1)	Large Backlog maintenance requiring is greater funding than is available Estates strategy currently being reviewed for alignment in light of revised Clinical Strategy and STP outputs. National context for finance has led to DH announcement that access to resource capital may be limited for – causing slippage of capital programme Full year depreciation forecast reduced requiring a review of commitments and financing options for capital plan in 2018/19 with likely impact for next 5 years Reduction in capital plan due to financial constraints Internal Audit report- Limited assurance opinion – Health and Safety. Access to clinical areas to carry out maintenance and compliance work is limited however decant plan in place.	5	4	20	5	4	20	**Quarter 2** Nye Bevan building handed over end of September. Creaton and Benham ward have been vacated to enable the decant programme. First stages of decant programme agreed as Knightley ward. Asbestos resurvey and remedial works continue and expect to complete in Dec 18. Site wide electrical testing continues and expects to complete in Dec 18. Fire compartmentation survey commissioned and due to start Nov 18. National PLACE results published; NGH have scored above all national benchmarks. 6 Facet survey currently underway. Estates have recruited a Compliance Manager. New Estates Compliance Group set up and receiving high risk subject reports/action plans. Divisional attendance at Trust H&S committee has improved. **Quarter 3** Asbestos survey will continue to Mar 19 due to access delays. All actions completed to date. 6 Facet survey has been completed a new 5 year Estates Capital plan has been developed based on the survey findings and risk assessment. The plan has been approved by the Estates Capital committee and presented to the Trust Capital Committee. The 18/19 Estates capital plan is on track to complete. A new decant plan has been approved by Exec team. Specifications and costs are being prepared. **Quarter 4** Asbestos survey will continue into April/May 2019 due to difficulties in accessing clinical areas. All high priority works have been completed. Internal review of asbestos management and the survey findings and plan has been completed; an external review of the findings has been commissioned. Water risk assessment nearing completion with report expected in May. Fire compartmentation survey reports completed and summary being developed. Expected recommendations are already included in the Estates Capital plan. External electrical infrastructure survey is being planned for May/June. Estates Compliance paper and action plan was presented to March private Board meeting. Additional estates management posts have been developed and will be advertised in April; interim posts are in place in the short term to support risk mitigations **Quarter 1** Asbestos survey completed and all high priority works completed. Asbestos Management plan (including procedures) have been revised and approved by external asbestos specialist. All Estates staff attended awareness training including procedures. Draft water risk assessment has been completed. Estates are currently reviewing the report. Update will be presented to water safety committee. Fire compartmentation survey works have been identified and a review of how these works can be procured and delivered is underway. A weekly Fire Safety task and finish group, chaired by DoF, is now running External electrical infrastructure survey is out to tender. A Ventilation group has been set up to monitor ventilation compliance: initial focus on theatre ventilation verification reports Estates compliance report is now presented monthly at the Finance committee. The last paper showed a move in fire safety assurance from 'No assurance' to 'Limited assurance' The paper sets out and monitors assurance progress over the next 5 years for all key estates infrastructure risks.	5	2	10	↔

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BAF 1.8	Reg. 17	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust <u>CRR reference risks</u> 1660, 1954, 1733, 1984, 1918	Finance Performance and Investment Committee	COO	IT Strategy IT steering group reporting to Finance and Performance committee Cyber security report to Finance committee IT subcommittee reporting to Capital committee Weekly performance meeting Elective access policy Staff training re CaMIS Data quality SOPs in place Clinical senate reporting into IT committee Microsoft Advanced Threat Detection (ATP) alerts – If Microsoft ATP detects any unusual patterns of activity that may indicate a virus or cyber threat on any of the Trust's workstations, we will receive an alert and we will investigate, then take any required action. Intrusion Prevention alerts – If the Trust's firewalls see an unusual traffic an alert will be generated. We will investigate, and take any required action. Sophos Anti-Virus – This is checked daily to ensure there are no issues with Trust devices updating their anti-virus software. Any viruses that are detected are reported here. We investigate these and disinfected the viruses from here. Microsoft Patching – All Trust workstations are patched every month with the latest Microsoft patches. Servers are patched every three months (unless an urgent patch is required).	Reports from IT to Finance and Performance committee (L1) Benefits realisation reports to Finance and Performance committee (L1) Minutes from IT subcommittee (L1) Application of additional Sophos updates(L2) IT strategy updated (L1) Data Quality Audits. (L1) Internal Audit- Replacement of PAS- Reasonable Assurance. (L3).	IT Team vacancies Ability for users to plug old equipment into network. Limited knowledge for staff regarding cyber security Potential for incorrect data input due to human error Low nursing numbers meaning data input could be delayed.	4	5	20	4	5	20	**Quarter 2.** CaMIS is now part of BAU. 6 weekly meetings in place with the admin teams. Work underway with local digital roadmap to facilitate information sharing. Clinical senate now in place reporting into IT committee Daily updates on specific projects to COO ADTs asked for via expectation letter within medicine. **Quarter 3** DSP Toolkit – Data Loss Protection (DLP) – Rollout of DLP to all Trust workstations. This software will flag if a user trying to send or save any Personal Identifiable Information (PII) or Patient Identifiable Information (PID). This should help reduce the amount of data breaches the Trust suffers. This needs to be complete by 29/03/19 DSP Toolkit – Annual Penetration Test – This is where a third party will test the Trust's network devices for any vulnerabilities. This needs to be complete by 29/03/19 DSP Toolkit – Survey of all out of support software used in the Trust – All out of support software is surveyed, an action plan is then put in place to remediate out of support software. This will typically be to uninstall it or update it. This needs to be complete by 29/03/19 **Quarter 4** Data Quality Group remains in place. Cyber training rolled out Trust wide. Further CAMIS training being planned. IT strategy updated. TIAA Audit completed following PAS change. DSP Toolkit completed- End of March 2019. Real time data input remains challenging for admissions, discharges and transfers. Monthly info to IT Committee on all areas of work within IT. **Quarter 1** New DSP Toolkit for 2019/20 released – there are 118 Mandatory Assertions to be met (51 Cyber/IT and 67 DSP). Forescout Network Access Control being deployed to give full visibility of all devices plugged into the Trust network. This will also block unauthorised devices. Tape backup of all Trust data now taking place weekly. Windows 10 migration is nearing 50% complete. In-built security for Windows 10 is much superior to Windows 7. Weekly CareCert meetings with KGH now taking place. A Data Quality Policy has been written, published and communicated via the intranet. A New Acceptable Use Policy has been written, published and will be made an enforced policy for all system users via NET Consent. A TIAA Cyber Awareness Training module has been released to all staff (awaiting feedback). An Internal Cyber Security Training Course will be offered to all IT staff, tbc. Automated Data Quality Alerts are in action and new alerts devised continuously. Data Quality Report is submitted to the Data Governance Group Monthly. Data Quality Dashboard in design to give clarity on metrics (to be in place Sept 2019) Data Quality Kitemark to be established (to be in place March 2020)	4	2	8	↔

								INITIAL RISK SCORE AT End Q4 2018/19			CURRENT RISK SCORE				TARGET/ RESIDUAL RISK SCORE			
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CORPORATE OBJECTIVE 1 – FOCUS ON QUALITY AND SAFETY **We will protect patients from harm, provide best possible outcomes and make sure they have a good experience of care in a timely manner. We will empower our people to get things done and be constantly vigilant in keeping high quality standards ensuring that quality information is shared quickly with the people best placed to improve care. Where we can we will take opportunities to compare ourselves with, and learn from others to support our efforts for excellence. We will put patients at the heart of everything we do.**																		
PRINCIPAL RISK 1 – Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.																		
					SPAM Emails – If SPAM email reaches a user and a ticket is opened on the service desk we then manually block the sender of this email. Weekly Care Cert meetings held with KGH to discuss new threats that have been published in the CareCert bulletin and share cyber knowledge. Forcepoint Web Filtering – This technology blocks malicious and non-Trust related web traffic. Sophos Anti-Ransomware protection. This software is installed on Trust Windows devices and watches for suspicious encryption behaviour. It will stop encryption and alert the IT team. Tape backups (off-line backups) – The Trust now backs up all data to tape once a week. This is the last line of defence for Ransomware as it is not able to be encrypted maliciously.															

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CORPORATE OBJECTIVE 2 –EXCEED PATIENT EXPECTATIONS **We will continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients** **We will ensure our patients have a good experience of care in a timely manner.** **We will put patients at the heart of everything we do.**																		
PRINCIPAL RISK 2 – Failure to deliver patient focussed care may lead to reputational risk and poor patient experience. this may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond.																		
BAF 2.1	All Regulations	Risk that the Trust fails to promote a culture which puts patients first <u>CRR reference risks</u> *1955, 366, 1305, 1867, 2003*	Quality Governance committee	DoN	Patient and Carer experience and engagement Group with the following reporting: • Dementia Group • End of Life Group • Patient Equality and Human rights group • Disability Partnership forum • Learning and Disability Group Nursing Director report to Quality Governance committee PALS and Complaints team Link with Health watch Regular performance reviews by Division including patient experience KPIs Patient Experience manager Consent Policy DNAR policy Safeguarding policies Safeguarding training Appointment of Head of Equality Diversity & Inclusion Guidelines that identify how we manage patients with protected characteristics .	Patient satisfaction survey (L3) Complaints report to Quality Governance committee (L1) Quality Governance reports to Trust Board (L2) NHS Choices feedback (L3) CQC inspection (L3) F&F tests (L3) Patient story to the Board (L1) Board to Ward visits (L1) National • Cancer survey • A&E survey • Inpatient survey • Neonatal survey • Outpatient survey (L3) PLACE audits above national average (L3) Assessment and Accreditation scheme reports to Board (L1) CQC inspection 2017 – rated GOOD (L3) Divisional Quality Governance reports to CQEG (L1) Do It for Dementia Campaign (L1) Equality and Diversity plan updates (L1) Pathway to Excellence (L3)	The trust performance in patient surveys for • Cancer survey • A&E survey • Inpatient survey • Outpatient survey Indicate areas for improvement Patient Involvement Strategy Volunteer Strategy	4	3	12	4	3	12	**Quarter 2** Learning Disability and Dementia Champions now in place on most wards. The results of the 2016 National Cancer Survey have been received. The Trust scored broadly on par with previous years, themes in the comments report focused on: communication; administration; continuity of care. **Quarter 3** Trust has been accredited with "Pathway to Excellence". First Trust in the UK and 166th globally. Complaints responded to 100% within 35 days- offering local resolution meetings where appropriate. Board to ward visits continue, focussing on infection control (Beat the Bug). **Quarter 4** Complaints continue to deliver 100% response rate. Trust is working with Healthwatch to ascertain what support can be offered to build a mutually beneficial relationship to put patients first. Patient Involvement Strategy development in train. **Quarter 1** EDI post out to advert. Patient involvement and volunteer strategy in consultation phase. Received results of inpatient survey 2018- action plan in development Complaints continue to deliver at 100% response rate	3	1	3	↔

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CORPORATE OBJECTIVE 3 ENABLING EXCELLENCE THROUGH OUR PEOPLE **We will recruit, retain and develop the staff we need to deliver best possible care and services in the best possible way. We will have an effective and supportive leadership throughout our organisation creating a high performance culture.** **Our employees will be engaged with the organisation and supported to reach their full potential and embrace change. We will support our employees' health and wellbeing. We will be an employee of choice.**																		
PRINCIPAL RISK 3 – – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.																		
AF 3.1	Reg. 12 18	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future <u>CRR reference risks</u> 1682, 1280, 1455	Workforce Committee	DoW&T	People Strategy 2015 -2020 Nurse Recruitment strategy Nurse Retention strategy Recruitment team within HR including dedicated Clinical Resourcing Manager Recruitment policies and procedures Annual business planning process includes workforce plan Workforce Plan submitted to LWAB IQE team and Making Quality Count Programme Changing Care programme – productivity initiatives Medical Workforce strategy Sickness Absence management policy Occupational Health Service Bank staff service E-rostering Apprenticeship scheme Regular skill mix reviews in Nursing Physicians Associate post Medical, Nursing and A & C banks in place Nursing Associate roles (pilot) Northamptonshire Branding Bi-weekly Agency meeting	Workforce report to workforce committee including: • Sickness rate KPIs • Appraisal KPIs • Training KPIs • Vacancy KPI (L1) Line managers receive compliance rates for appraisal (L1) Workforce committee reports to Trust Board (L2) Nurse Recruitment plan report to Workforce Committee (L1) Nurse Retention Report to Workforce Committee (L1) staffing data report to Workforce Committee and Quality Governance Committee (L1) Patient survey (L3) Staff survey (L3) Medical Trainee survey (L3) Internal Audit – Sickness Absence audit (L3) Changing Care@ NGH programme includes productivity review for medical, nursing admin and back office staffing (L1) Substantial assurance IA Maternity staffing report (L3) OH Annual Report (L1) CQC inspection 2017-rated GOOD (L3)	Difficulties in recruiting to medical and nursing vacancies due to national shortages Trust turnover rate > 8% target Trust has red flags related to Medical Trainee survey reports Opening of escalation areas dilutes capacity	5	2	10	5	2	10	**Quarter 2** Sickness Absence for quarter 2 stands at 4% against a Trust target of 3.8%. The overall Trust vacancy rate for September 2018 is 11.31% against a Trust target of 9%. Core & Specialist Nursing vacancy rate for is 10% against a Trust target of 9%. 105 vacancies remain in core & specialist areas. A total of 29 Specialty Registrars and Doctors were recruited between July & September 2018 together with a total of 7 Consultants. In addition to this 132 Junior Doctors commenced with the Trust via the Deanery. **Quarter 3** Sickness Absence for quarter 3 stands at 4.34% against a Trust target of 3.8%. The sickness absence audit for medical staff has been carried out and recommendations due to be completed by 31 December 2018 have now been actioned. These relate to training for the CDs by the HRBPs. The overall Trust vacancy rate for September 2018 is 12.52% against a Trust target of 9%. Core & Specialist Nursing vacancy rate for is 12.4% against a Trust target of 9%. 120 vacancies remain in core & specialist areas. Hep B Vaccine – delays in supply for 2019/20 alternative manufacturer providing limited supply. Flu Campaign 80% – CQUIN Target Achieved. OH Consultant post – continues to be supplied by Leicester although there are delays in clinic appointments due to increased demand **Quarter 4** Flu Campaign 81.5% – CQUIN Target Achieved and submitted to national data collection. Sickness absence for quarter 4 stands at 4.03% against a Trust target of 3.8%. It has come to light that one element of the sickness absence audit for junior doctors has not been completed by all divisions. This is the spot check on return to work interviews that Divisional Directors have been requested to carry out as part of the audit. HR Business Partners ae chasing Divisional Directors and evidence has been requested. Business Case for Psychological well-being Therapist approved. The overall vacancy rate for March 2019 is 11.3% against a Trust target of 9%. Turnover rate for march was 8.48% in March against target of 10%. Core & Specialist Nursing vacancy rate is 11.6% against a Trust target of 9%. 111 nurse vacancies in core & specialist areas. **Quarter 1** Flu campaign for 19/20 commenced - CQUIN target of 80% required Value of CQUIN for 19/20 £586,750. Mental Health business case recruited to – two mental health Psychologists appointed should commence in July. Sickness Absence for Quarter 1 stands at stands at 4.26% against a Trust target of 3.8%. The overall Trust vacancy rate for Quarter 1 is 12.14% against a Trust target of 9%. Core & Specialist Nursing vacancy rate for Quarter 1 is 11% against a Trust target of 9% which equates to 114.56 WTE vacancies as at May 2019. (June 2019 figures are not available at the time of writing). A total of 12 WTE overseas nurses have commenced in post within core and specialist areas since April 2019 and a total of 17.13 WTE equivalent nurses that were sourced locally have commenced in post within core and specialist areas. Over the same period, there were a total of 21.11 WTE nurse leavers from core and specialist areas. Trac candidate management system is fully implemented for recruitment, feedback is being obtained in respect of its implementation and overall performance with a view to making any adjustments that may enhance either the user experience or candidate experience. A positive meeting took place with HEE which resulted in an agreed plan to address junior doctor concerns in Oncology.	4	3	12	↔

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CORPORATE OBJECTIVE 3 ENABLING EXCELLENCE THROUGH OUR PEOPLE **We will recruit, retain and develop the staff we need to deliver best possible care and services in the best possible way. We will have an effective and supportive leadership throughout our organisation creating a high performance culture.** **Our employees will be engaged with the organisation and supported to reach their full potential and embrace change. We will support our employees' health and wellbeing. We will be an employee of choice.**																		
PRINCIPAL RISK 3 – – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.																		
BAF 3..2	Reg. 12 18	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future CRR reference risks *1305.*	Workforce committee	DoW&T	People strategy 2015-2020 Recruitment policies Study leave policy Appraisal policy Statutory and mandatory training policy Appraisal. performance and Mandatory Training linked with increment progression Annual business planning process includes workforce planning Francis Crick leadership and Management programme Leadership and Management development programmes for leaders Practice Development Team for Nursing staff Director of Medical Education for medical staff Consultant Foundation programme Continuing professional development and in house training programmes for staff. Nursing and Midwifery Committee	Workforce report to workforce committee includes: • Appraisal rate KPIs • Mandatory Training KPI • Role Specific Training KPI (L1) Workforce Committee reports relating to revalidation and Medical Education (L1) Workforce committee reports to Trust Board (L2) Line managers receive compliance rates for appraisal (L1) Staff survey results relating to training and development (L3) Medical Revalidation and Appraisal report (L1) Nursing revalidation report (L1) Divisional scorecards and Performance Review process (L1) CQC inspection 2017-rated GOOD (L3)	Underperformance against target on Role Specific Training Apprenticeship Levy is complex	4	2	8	4	2	8	**Quarter 2** During Q2 rate of Appraisals recorded was 83.1% against a target of 85%. Mandatory Training was 87.9% against a target of 85%. Role Specific Essential Training compliance was 81.9% against a target of 85%. **Quarter 3** Appraisals recorded were 81.71% against a target of 85%. Mandatory Training compliance is 88.56% against a Trust target of 85% Role Specific Essential Training compliance is 83.04% against a Trust target of 85%. 46 staff participated in the James Stonhouse Team leader 32 staff participated in the Esther White Leadership and management Training **Quarter 4** Mandatory Training compliance is 88.71% against a Trust target of 85% Role Specific Essential Training compliance is 83.84% against a Trust target of 85%. 44 staff participated in the James Stonhouse Team leader Programme 26 staff participated in the Esther White Leadership and management Training. **Quarter 1** During Q1 rate of Appraisals recorded was 84.73% against a target of 85%. Mandatory Training increased to 89.49% against a target of 85%. Role Specific Essential Training compliance also increased to 84.13% against a target of 85%. During Q1 28 staff attended the Esther White programme and 38 attended the James Stonhouse team leader programme IQE / Making Quality Count (MQC) MQC has been relaunched with two cohorts to commence in July 19 which is designed to develop staff in lean methodology and change management	4	2	8	↔

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CORPORATE OBJECTIVE 3 ENABLING EXCELLENCE THROUGH OUR PEOPLE **We will recruit, retain and develop the staff we need to deliver best possible care and services in the best possible way. We will have an effective and supportive leadership throughout our organisation creating a high performance culture.** **Our employees will be engaged with the organisation and supported to reach their full potential and embrace change. We will support our employees' health and wellbeing. We will be an employee of choice.**																		
PRINCIPAL RISK 3 – – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.																		
BAF 3.3	Reg. 12 13 18	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture <u>CRR reference risks</u> 2003	Workforce committee	DoW&T	Incident reporting Policy Employee Engagement Strategy Equality and Human Rights Group (staff) Workforce committee Trust leadership Model Freedom to Speak up gap analysis Raising concerns at Work policy Bullying and Harassment Policy Grievances at Work policy. Health and Wellbeing Strategy	Organisational Development updates to Workforce Committee, includes staff engagement and staff survey results(L1/ L3) Equality and Human Rights Group (staff) reports to Workforce Committee and Trust Board (L1/ L2) Web based incident reporting system available for staff (L1) Development of Health and wellbeing campus (L1) Staff survey (L3) Guardian of Junior doctors working hours report to Workforce Committee and annually to Trust board (L1) Freedom to Speak Up Guardian Report to Workforce Committee (L1) Workforce committee reports to Trust Board (L2) Staff Friends and Family Test (L3) Health & Wellbeing reports to workforce Committee (L1) Sickness rate (L1) Bullying & Harassment Gap Analysis (L1) CQC inspection 2017-rated GOOD (L3)	Trust results in staff survey relating to bullying and harassment require improvement	3	5	15	3	5	15	**Quarter 2** Bullying and Harassment cases remain high. It is anticipated with the introduction of the Report for Support telephone line in quarter 3 there will be drop in the numbers of staff raising the matters through the formal route. As part of the Respect and Support Campaign the following programmes are now available: Leading with Respect, Challenging bullying and inappropriate behaviour, Resilience Training. In Q2 the number of attendees are as follows: • Leading with Respect: 150 Managers • Challenging bullying and behaviour: 103 Staff • Resilience Training: 140 Staff and Managers • Courageous Conversations will be available in Q3 • Round Table informal mediation training will also be available in Q3 **Quarter 3** The Trust's confirmed final response rate is for the 2018 NHS Staff Survey 44 (2133 of staff responded). This is an improvement on 2017 when our final response percentage was 39%. Final report of the survey will be received by March 2019. The Respect and Support Campaign continued with: • 91 staff attended Challenging Bullying and Harassment Training • 51 Managers attended the Leading with Respect Training • 74 staff attended the Resilience Training **Quarter 4** The Staff Survey results show staff engagement remaining at the same level as in 2017; however in 6 of the 10 themes the trust is below average. Urgent work is underway to identify interventions to turn this around, as part f a refreshed People Strategy. The respect and support training continues including 27 staff and managers were trained in round table mediation. The Respect and Support hotline was launched. Work has commenced on an Equality & Diversity deep dive, together with a pilot on 'recruiting for difference' **Quarter 1** A revised people strategy is being developed which will reflect the 2018 staff survey and a comprehensive staff engagement programme has been developed, which will involve staff in the development of the strategy, and will take place during Q2. 4 round table conversations completed with successfully agreed outcomes from both parties in conflict. 12 staff contacted the respect and support hotline this quarter. 2 of the calls require further action from HR, the remainder of the calls have been closed due to successful outcomes. 72 Managers attended the Leading with respect training followed by 9 managers attending the Courageous Conversations training 49 staff attended the Challenging bullying and inappropriate behaviour training Increase in FTSU contacts in Q4 of last year have continued into Q1.	3	2	6	↔

								INITIAL RISK SCORE			CURRENT RISK SCORE				TARGET/ RESIDUAL RISK SCORE			
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CORPORATE OBJECTIVE 4 – TRANSFORM OUR SERVICES TO DELIVER BETTER CARE AND VALUE WITH LONG TERM SUSTAINABILITY **We will work creatively and collaboratively with our multiple partners to co-design sustainable services which deliver high quality care as part of a thriving health economy for the future.** **We will foster relationships built on mutual respect with our partners and co-produce innovative new service models that deliver aligned strategies providing better, sustainable care and improved value for the tax payer.** **We will work to support demonstrable benefits for our population and beyond by continually supporting the promotion and improvement of health and wellbeing**																		
PRINCIPAL RISK 3 – Failure to develop a sustainable future for Northampton General Hospital through delivery of high quality effective services in collaboration with partner organisations																		
BAF 4.1	Reg. 9 15	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access. CRR reference risks *1309*	Finance Performance and Investment committee	DoS&P	Board and Executive updated monthly on progress of the Health and Care Partnership (HCP/ STP) Operations executive oversight Collaboration Steering Board and associated governance frameworks with KGH Monthly updates to the Board via CEO report Non Exec Directors attend NED countywide and Chairs meetings Integrated Business Planning Group/ Strategic planning group County wide Finance Directors Group Unified Acute Model Board CEO is member of \HCP Board Director of S&P is senior responsible officer for the Unified Acute Model work stream and scheduled care work stream of HCP Significant partnerships described in Annual Plan Integrated Business Planning Framework Capacity and demand models for revised services with fully worked up service design Annual contract negotiation and service planning processes leading to a Board approved contract and annual plan Regulatory oversight of the annual planning process	Clinical strategy in place with aligned estates strategy in progress reports to Trust Board (L1) Estates strategy in-place with plans for Health and Well Being Campus being delivered alongside external partners (L1) Service line reports (SLR) (L1) Updates to Board via CEO report (L2) Medium term financial sustainability plan (L1) HCP Board in place update reports to Trust Board (L2) Plans delivered for collaboration with partners in respect to: • Rheumatology • Dermatology • Stroke Plans in development for • Plastics • Ophthalmology • Urology • Orthopaedics • MSK • ENT • Cardiology Reports on all collaboration schemes to Unified Acute Model Board (L2) Capacity and demand models for revised services with fully worked up service design (L1) Annual capacity and demand analysis and associated contract agreements Partnership in place with UHL NHS Trust for oncology services (L1)	Trust capacity issues have led to outsourcing and loss of market share Challenging relationships with local partners in context of health economy financial challenges Out of hospital work-streams fail to deliver reductions in activity Reduction in funding of adult social care leading to increased admissions Resistance to collaboration within some of clinical workforce due to capacity. Lack of Resource to support implementation of scheduled care programme is a risk	4	4	16	4	4	16	**Quarter 2** Stroke service redesign operationalised and complete. MSK redesign is awaiting confirmation from Commissioners re the framework through which it will be delivered. Programme for remaining specialities is constrained by lack of resource albeit PWC are supporting orthopaedics. Progress on the "form" work made which will clarify options for supporting collaboration between the Trusts which will support the clinical redesign of services. Overall, risk remains high due to the lack of schemes within the HCP that will help to deliver sustainability across the sector. **Quarter 3** Progress on the "form" of collaboration underway with Board to Board workshop in January Priority areas for clinical collaboration reviewed and agreed. MSK redesign still awaiting confirmation on approach from Commissioners PWC support to orthopaedics complete, commitment from both organisations for dedicated support to progress the programme Intermediate care business case implementation underway Still lack of schemes from the HCP to deliver system-wide transformation opportunities **Quarter 4** EY appointed to support collaboration with KGH. First wave of specialities are Cardiology, ENT and Breast. First wave of supporting functions for collaboration are; Contracting, Information and Informatics, Estates Dedicated support in place for implementing PWC recommendations in Orthopaedics. Agreed HCP transformation schemes for 2019/20 are; Urology, MSK, Frailty, Respiratory. PIDS have been developed, Director leads and PPM leads have been assigned. Plans to be developed in Q1&2 of 19/20 **Quarter 1** Collaboration Steering Board now established between the Trusts Work alongside EY has proceeded with proposals expected for ENT and breast in July MSK, Urology and Respiratory work-streams are commencing as part of the HCP First wave of supporting functions for collaboration are; Contracting, Information and Informatics, Estates with agreement between the Trusts on the preferred option for contracting . Revised MOU now being drafted that will form the over-arching agreement for all redesigned services	4	1	4	↔

								INITIAL RISK SCORE			CURRENT RISK SCORE				TARGET/ RESIDUAL RISK SCORE			
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CORPORATE OBJECTIVE 5 – ENSURE A FINANCIALLY SUSTAINABLE FUTURE **We will provide services that offer improved value for money within our financial budget.** **We will seek to deliver quality improvement programmes that support delivery of our financial sustainability.** **We will deliver a Capital programme which supports delivery of our Clinical and estates strategies as a driver for quality improvement and efficiency maintaining financial resource limits.** **We will develop and deliver a long term financial sustainability plan in conjunction with our partners.**																		
PRINCIPAL RISK 5 Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust																		
AF 5.1	Reg. 17	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan <u>CRR reference risks</u> 1748, 1204, 1196, 44, 1757, 1953, 697, 1750	Finance and Performance committee	DoF	Finance and Performance committee Changing Care @NGH programme Board Divisional performance reviews Trust has signed ETO compliant contract Regular contract review meetings Audit arrangements SFOs SFIs Policies and procedures Financial and accounting systems Counter Fraud plan NHSI review meetings Purchasing and Supplies Strategy Financial Assurance meetings with NHSI (bi-monthly)	Monthly report to Finance and Performance committee (L1) Finance and Performance committee Report to Board (L2) Finance KPIs (L1) Provision for potential fines against contract set aside in monthly position (L1) Audit committee reports to Trust Board (L2) Outcome of NHSI accountability meetings (L3) LCFS rated Green (L3) NHSI rating for Single Oversight Framework (L3) CQC inspection 2017-rated GOOD (L3)	Month 1 pay spend above plan and activity below plan Agency expenditure is currently above the set target for 19/20. Trust is scoring 4 against Finance and the Single Oversight Framework. CIP delivery to the value of £13.6m to be confirmed.	4	2	8	4	5	20	**Quarter 2** Q2 results show a reported year-to date pre-PSF deficit of £14,324k against a planned pre-PSF deficit of £14,367k, resulting in a favourable variance of £44k . The full Provider Sustainability Funding (PSF) of £3,217k year to date is included in the position. Agency staff expenditure Trust run-rate for 18/19 is £82k above the target. Monthly expenditure would need to drop to £852k per month, if the NHSI target was to be met by year end. **Quarter 3** Q3 results show a reported year to date pre-PSF deficit of £20,285k against a planned pre-PSF deficit of £20,377k, resulting in a £92k favourable variance. We have received the full PSF for finance totalling £4,182k year to date, but have not received A&E PSF in Q3 of £827k. This leaves the Trust with a £735k post –PSF year to date adverse position to plan. Agency staff run rate is running £77k per month above target. **Quarter 4** We expect to meet or slightly exceed the Trust pre-PSF deficit of £27,705k based on the draft position at the time of writing. We have earned the full PSF for finance totalling £6,434k for the full year, but have not received A&E PSF in Q3 & Q4 of £1,792k. Therefore the post PSF financial position is likely to be around £1.8m adverse to plan. NHSI have confirmed there is likely to be PSF bonus distributed however they are yet to confirm what the value may be. Agency staff cost was £12.5m against a target of £11.2m. **Quarter 1** At the end of Q1 the Trust has a pre-PSF deficit of £1.2m and a post PSF deficit of £3.8m. Months 1 and 2 showed deficits of c£0.65m per month, with a small surplus in M3. The three bedded Divisions are in fortnightly financial escalation and the regulators have requested a recovery plan which will be presented to the F&P Committee in July 2019.	4	2	8	↑

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CORPORATE OBJECTIVE 5 – ENSURE A FINANCIALLY SUSTAINABLE FUTURE **We will provide services that offer improved value for money within our financial budget.** **We will seek to deliver quality improvement programmes that support delivery of our financial sustainability.** **We will deliver a Capital programme which supports delivery of our Clinical and estates strategies as a driver for quality improvement and efficiency maintaining financial resource limits.** **We will develop and deliver a long term financial sustainability plan in conjunction with our partners.**																		
PRINCIPAL RISK 5 Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust																		
BAF 5.2	Reg. 17	Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme CRR reference risks 1747, 44	Finance and Performance committee	DoF	Changing Care @NGH programme Board Finance and Performance committee Schemes are clinically led with Exec sponsorship Divisional CIP requirement in addition to Changing Care @NGH schemes Divisional monitoring of delivery Purchasing and Supplies Strategy	PMO team engaged to oversee and manage cost improvement delivery (L1) Changing Care @NGH scheme delivery tracker (L1) Monthly FRP report to Finance and Performance committee (L1) Finance and Performance committee Report to Board (L2) Quality Impact assessment process for all schemes within CIP programme to ensure quality and safety not affected (L1) Use of Carter portal providing "model hospital" benchmark data. (L1) GIRFT opportunities pursued (L3)	The level of identified recurrent CIPs is currently c40%.	4	3	12	4	5	20	**Quarter 2** CIP delivery was £7,567k YTD which is £1,833k better than plan but over half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target. **Quarter 3** CIP delivery was £10,932k year to date which is £1,374k better than plan, however £4,897k is non recurrent in nature. Delivery of the full recurrent CIP target remains a risk going into 2019/20. **Quarter 4** CIP delivery was £15.9m for the year which is £1.4m better than plan, however £5.9m is non recurrent in nature. The undelivered recurrent CIP target has been rolled forward into the 2019/20 budget which has made the CIP challenge bigger. **Quarter 1** The savings challenge for 2019/20 is to deliver £13.6m of recurrent savings. At the end of Q1 the Trust has delivered £3.2m of savings against a £2.6m plan. Though this is a positive position unfortunately 62% is of a non recurrent nature. The fortnightly divisional escalation meetings include updates on progress in improving the recurrent / non recurrent split. Delivery of the full target recurrently will be a real challenge.	4	2	8	↑

BAF RISK ID	CQC STANDARD (see Key)	PRINCIPAL RISK DESCRIPTION/FACTOR	MONITORING BOARD COMMITTEE	EXECUTIVE RISK OWNER	KEY CONTROLS	SOURCES OF ASSURANCE	GAP IN CONTROL OR ASSURANCE	INITIAL RISK SCORE C	INITIAL RISK SCORE L	INITIAL RISK SCORE RATING	CURRENT RISK SCORE C	CURRENT RISK SCORE L	CURRENT RISK SCORE RATING	ACTIONS & MILESTONES UPDATE	TARGET/ RESIDUAL RISK SCORE C	TARGET/ RESIDUAL RISK SCORE L	TARGET/ RESIDUAL RISK SCORE RATING	Risk Rating trend
CORPORATE OBJECTIVE 5 – ENSURE A FINANCIALLY SUSTAINABLE FUTURE **We will provide services that offer improved value for money within our financial budget.** **We will seek to deliver quality improvement programmes that support delivery of our financial sustainability.** **We will deliver a Capital programme which supports delivery of our Clinical and estates strategies as a driver for quality improvement and efficiency maintaining financial resource limits.** **We will develop and deliver a long term financial sustainability plan in conjunction with our partners.**																		
PRINCIPAL RISK 5 Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust																		
BAF 5.3	Reg. 15 17	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements CRR reference risks 1605, 1749	Finance and Performance committee	DoF	Capital Committee Finance and Performance committee 5 year capital plan Purchasing and Supplies Strategy Leasing strategy in place Hospital Management Team Meetings	Finance report to Finance and Performance committee Includes progress on capital planning and expenditure plus forecast expenditure (L1) Finance and Performance committee Report to Board (L2) Internal audit (L3)	The Trust has a large backlog maintenance programme The estate of the Trust is ageing. National context for finance has led to DH announcement that access to resource capital may continue to be limited for 2019/20	5	2	10	5	3	15	**Quarter 2** Nye Bevan Assessment unit works have completed. The Trust's capital spend at month 6 was £14,842k in comparison to a planned YTD spend of £14,905k. Overall plan for the year is £21,519k. Total spend and committed amounts to £16,200k, which is 75% of the overall capital plan. The Capital Committee reviews and monitors the capital spend against plan regularly **Quarter 3** The Trust's capital expenditure at M9 was £15,785k, which is £359k below plan. The overall plan is now £19,902k following the receipt of final Nye Bevan invoices. Total spend committed is £17,359k leaving £2,545k (13% of the plan) to be committed and receipted by year end. **Quarter 4** The Trust's final capital plan budget was £19,871k and £19,869k was spent in year, a variance of £2k. **Quarter 1** The Trust's capital programme for 2019/20 totals £9.3m. However NHSI/E have requested that all capital plans be cut, by up to 20%, due to a lack of capital funds. Revised plans are required to be submitted on 15th July 2019. It is expected that the NGH reduction is likely to be around £420k. As at the end of Q1 the Trust has spent £659k against a £725k plan.	5	2	10	↑

Executive Leads

CEO	Chief Executive Officer
COO	Chief Operating Officer
MD	Medical Director
DoN	Director of Nursing
DoF	Director of Finance
DoW&T	Director of Workforce and Transformation
DoE&F	Director of Estates and Facilities
DoS&P	Director of Strategy and Partnerships
DoCD G&A	Director of Corporate Development, Governance and Assurance

CQC Fundamental standards

Regulation 8	General
Regulation 9	Person centred care
Regulation 10	Dignity and Respect
Regulation 11	Need for Consent
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 14	Meeting nutritional and hydration needs
Regulation 15	Premises and equipment
Regulation 16	Receiving and acting on complaints
Regulation 17	Good governance
Regulation 18	Staffing

Levels of Assurance	ASSURANCE LEVEL
Level 1 (L1)	Management or Operational Assurance e.g. Reports to Board and Board committees
Level 2 (L2)	Oversight functions e.g. reports from Audit committee / Clinical Performance committee to Board
Level 3 (L3)	Independent / external assurance e.g. CQC inspection / audits / external review

Consequence Score/Domain	Likelihood Score/Domain				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

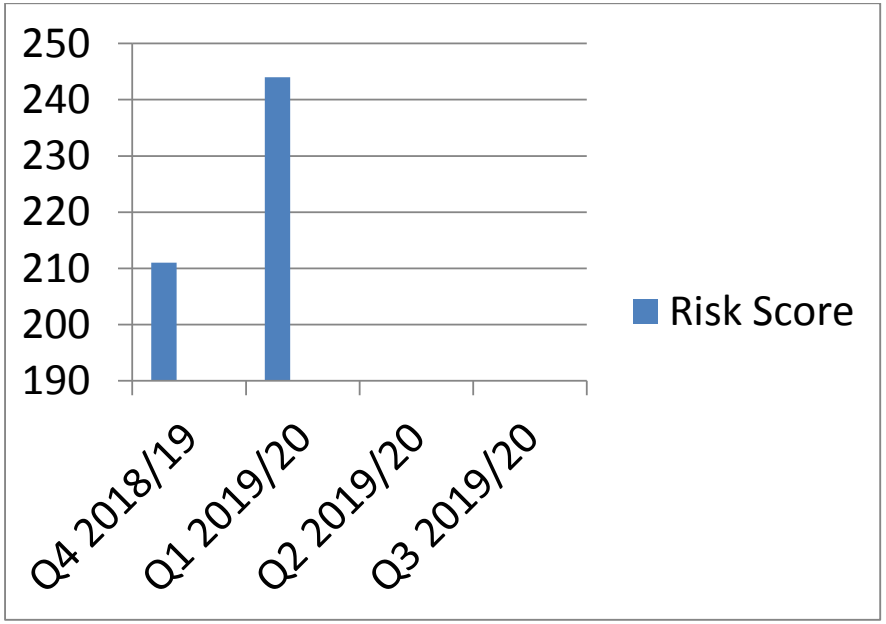
1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

APPENDIX 1 SUMMARY SHEET QUARTER 1 2019

Principal Risk 1 – Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
1.1	Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services	10
1.2	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties	20
1.3	Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment	16
1.4	Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice	10
1.5	Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety and experience	12
1.6	Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience	20
1.7	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	20
1.8	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust	20
Principal Risk 2 – Failure to deliver patient focussed care may lead to reputational risk and poor patient experience. This may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond.		
2.1	Risk that the Trust fails to promote a culture which puts patients first	12
Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	10
3.2	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future	8
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
Principal Risk 4 – Failure to develop a sustainable future for Northampton General Hospital through delivery of high quality effective services in collaboration with partner organisations		
4.1	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.	16
Principal Risk 5- Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust.		
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan	20
5.2	Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme	20
5.3	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	15

Movements on Board Assurance Framework (since previous Quarter)		
ADDITIONS	NONE	
INCREASES	1.3	Score increased from 8 to 16 due to the potential loss of 1.5% of contract value
	5.1	Score increased from 8 to 20 due to Q1 position being off plan
	5.2	Score increased from 12 to 20 due to the savings challenge in year
	5.3	Score increased from 10 to 15 due to 20% cut in Capital funding
DECREASES	NONE	
CLOSURES/ AMALGAMATED	NONE	

Graph shows risk score of 244 for 16 Principle Risks



UNIVERSITY OF LEICESTER
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Report To	**Trust Board**
Date of Meeting	**26 July 2019**

Title of the Report	**Update Paper - Violence & Aggression Review Group (VARG)**
Agenda item	**19**
Presenter of Report	Stuart Finn, Director of Estates and Facilities & Sheran Oke, Director of Nursing, Midwifery & Patient Services, DIPC
Author(s) of Report	Natalie Green, Deputy Director of Nursing (Interim)
Purpose	For Assurance

Executive summary

This report provides an overview of the projects and actions of the Violence and Aggression Review Group since its formation in May.

Related strategic aim and corporate objective	Enable excellence through our staff To be able to provide safe, quality care to all our patients
Risk and assurance	For assurance
Related Board Assurance Framework entries	BAF 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	None

Actions required by the Board

The Board is asked to note the report.

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Trust Board
July 2019

Update Paper on the Violence and Aggression Review Group (VARG)

Background
Violence and aggression towards our staff is a serious occurrence and is not taken lightly by the Trust, our staff are our most valuable asset and we strive to do everything possible to keep you safe and not to be afraid to come to work. Unfortunately in recent months the number of reported incidents and anecdotal reports has increased, which has put enormous stress and strain on our staff. Due to this a new group was formed in May – Violence & Aggression review Group (VARG).

From June 2018 – June 2019 1021 datix were reported in relation to violence and aggression which were categorised as 758 no harm, 250 low harm and 13 moderate harm; the top 3 themes were

- Aggression/agitation by the patient
- Assault (contact & attempted) by patient on staff
- Verbal abuse by patient to staff

The top 3 areas for these Datix were:

- Emergency Department
- Collingtree
- Nye Bevan

Duties
The members of VARG meet bi-weekly for the purpose of;

- Setting direction and providing guidance
- Assisting with the reduction of violence and aggression towards staff
- Improving safety and security at work for staff from violence and aggression

The group will achieve this through the following:

- Encouraging reporting to assure an accurate incidence profile
- Utilise co-production methods/pathways through working with external partners in the community
- Ensure correct expertise on the group
- Ensure clear reporting and categorisation of incidents
- Raise awareness of non-acceptable behaviours towards our staff
- Increase support and debrief sessions for staff
- Provide appropriate training for staff to enable de-escalation techniques, avoidance and appropriate restraint methodology.

Current Projects
VARG's purpose is to be proactive in its approach to dealing with violence & aggression towards our staff, we will utilise the expertise and support of our external partners whilst strengthening the Trusts culture to one of ZERO tolerance.

- Updating the Violence and Aggression Policy, poster production and campaign to increase awareness of non-acceptable behaviour
- Strengthening links with the Police, reinstating Hospital Watch and negotiating the presence of community support officers on site at agreed times during the week
- Personal alarms for staff working on Nye Bevan whilst an improved surveillance and alarm system is installed
- Improving and strengthening our current incident debriefing team – Improved training to enable appropriate debrief and support
- Increase awareness of the debrief team

- Planning a revamp of the debrief team – Supporting Our Staff (SOS) – with an ambition to respond to all incidents within 24hrs of reporting – this project is being undertaken with the QI team
- Improving drop down menu on Datix to reflect all types of incident
- Invited Substance to Solution to join the group monthly, working collaboratively with shared clients/patients increasing knowledge of community pathways
- Bespoke training session for the areas of highest incidents against staff – 22nd July Nye Bevan and Collingtree and arranging a MDT ED session
- Working on a robust categorisation of harm via Datix (not to normalise incidents) – working collaboratively countywide to have a standardised categorisation
- Continuation at each meeting to discuss specific incidents working through solutions and methods for future management – thus far this has provided a positive impact and appreciated by the teams involved.

Despite being a relatively new group the collaborative and collective working has already yielded positive results. Changes for the better have been made and the group are confident this will continue, every member is committed to making a difference for our staff

Summary

The Board are asked to review and note the content of the update paper.

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: Friday July 26, 2019

Title	**Finance Committee Highlight Report**
Chair	**David Moore**
Author (s)	**David Moore**
Purpose	**To advise the Board of the work of the Trust Board Committees**

Executive Summary

The Committee met on June 19, 2019 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	BAF References:
• Finance Report for Month 2;	• 5.1
• Changing Care @ NGH;	• 5.2
• Service Level Reporting and National Costing Collections;	• 5.2
• Operational Performance with a focus on A&E, Cancer, RTT and Unappointed Follow-ups;	• 1.1+2+4+5
• Update on the Outpatient Project;	• 1.2
• Estates Compliance Update;	• 1.7
• IT Committee Highlights Report;	• 1.8

Key areas of discussion arising from items appearing on the agenda

- The Chair requested an update on the Accommodation Block project and the New Front Entrance Project. The Committee was advised that while the former project was still in the process of review both by NHSi and Deloitte (who wanted to undertake a further 'value for money' review), the latter was progressing well and a Business Case was expected to be brought to September's Board for approval of the next phase of the project;

- The Committee received the M2 Finance Report and was disappointed to note that the in-month numbers continued to show a significant negative variance to plan of 1486K resulting in a full year variance of 2966K to plan. In view of these results NHSi was requiring a Financial Recovery Plan from the Trust. The most significant variance was on the Pay Costs line although income also had a 1358K negative variance to plan. The Committee also requested a presentation from the Surgical Division at the next meeting of the Committee to explain how its YTD variance of 1371K was going to be reeled in;

- The Changing Care @NGH report was received by the Committee with a degree of concern in view of (i) 65% of YTD CIP's were generated from non-recurrent items and that (ii) only 74% or 10.1M of the required 13.6M of saves had been identified so

- far. The Committee also requested a fuller review at its next meeting of benefits accruing from the deep dive into Vascular;

- A report was received on the work of the Service Level Reporting group. The group is working on the PLICs submission which is part of the NHSI Costing Transformation Programme (CTP). This is a process of implementing National Costing Standards e.g. standard Information feeds and methodologies across all Trusts. To provide assurance against this Programme, NHSI commissioned E&Y to undertake a number of Costing Assurance Reviews across a number of Trusts. NGH were selected as part of that process. The outcome of the E&Y review and an action plan to address issues raised was presented to the Committee. Issues identified were in line with those raised at other Trusts where similar reviews were undertaken although the Committee questioned whether resources were available to ensure corrective action would be taken in line with the Action Plan;

- Operational performance was reviewed and focused on A&E and Cancer were targets were not being met although significant effort was being placed on performance improvement – in the case of A&E with the help of consultants Transformation Nous. The Committee also heard that while there was slippage against RTT trajectories actions were being taken which should begin to gain traction; similarly it was understood that increasing Unappointed Follow-up numbers should now have plateaued.

- The Committee was pleased to note that the Estates Compliance Plan was tracking well.

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

- The Committee received the Procurement Strategy for 2019-2022 and noted favourably its focus on technology solutions, on collaboration both within and externally to the STP and on delivery of material savings to the Trust. The Committee was happy to give its approval to the document;

- A Business Case was received by the Committee for approval on an 'as done' basis. It was noted that strict NHS and Trust guidelines had not been followed in the context of the hiring of consultants or the amount (405K) involved. Concern was raised that payment under the project was not linked to performance. However, given the importance and the context of the project to changing the culture in emergency medicine, the Committee gave it's 'as done' approval while requesting a presentation from the consultants on progress at its next meeting.

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

- The Month 2 Finance Report shows a worrying trend, albeit only two months into the current financial year, which needs urgent reversal. A Financial Recovery Plan is being drawn up by the Trust to ensure a return to planned financial performance.

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

No further actions required of the Board.

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COMMITTEEHIGHLIGHT REPORT

Report to the Trust Board: 26th July *2019*

Title	**Quality Governance Committee Exception Report**
Chair	**John Archard-Jones**
Author (s)	**John Archard-Jones**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *21 June 2019* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries**
Corporate Scorecard for Quality Nursing & Midwifery Report Medical Director's Report Research & Development Governance Action Plan Compliance Report Cancer Urology Review Patient & Carer Experience and Engagement Annual Report	***BAF 1, 2, 3.***

Key areas of discussion arising from items appearing on the agenda

All reports noted.

Excellent presentation and discussion on Urology and their vision for the future

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

DON to identify Worry wards and to report on why, and a more detailed report on the Maternity Transformation Programme.

MD to review timeframe for Job Plans to be progressed to stage 2.

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

Safeguarding concerns in relation to the local authority

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

None

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *26 July 2019*

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

Executive Summary

The Committee met on *19 June 2019* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
• **People Strategy**	***3.1***
• **Medical Education Update**	***1.5, 3.1, 3.2, 3.3***
• **Workforce TOR**	***3.1***
• **Pension Update**	

Key areas of discussion arising from items appearing on the agend3.1a

- **People Strategy:** proposals for staff engagement in the people strategy development were shared with the committee for input and feedback. Engagement sessions would be held across wards and department throughout the summer, supported by the executive team and senior leaders. A blend of standard structured questions and opportunities for free thinking would be adopted. Divisional teams to provide details of areas to be involved and support available to HR by 24th June. **Action: Divisional Heads 24/6**
  The People Strategy would be aligned to the Interim NHS Workforce Plan that had been circulated to the committee. It was agreed that the Trust was already aligned to many of the proposals in the NHS Plan.

- **Medical Education Update:** HEEM to be invited to the September Workforce Committee where the Oncology action plan for addressing junior doctor issues would be presented. Following a committee discussion on how best to support the junior doctor induction process, it was agreed that there would be an appropriate reduction in activity. This would help to protect valuable training and induction time, leading to an improved experience for junior doctors. A progress update would be shared at the September committee. **Action: CL/Sept**

- **Workforce Terms of Reference:** Following a review by the committee, it was agreed that the Committee Chair would produce an annual report to the trust board. The Director of Governance would be added to the attendees, and a quorum of 4 Executive members with at least one Non Executive director (in addition to the Chair) was agreed. It was also recommended that the TOR should reflect decisions delegated by the trust board and cross committee decisions. **Action: CC/Sept**

- **Pensions:** Following concerns expressed at the committee about the large number of Band 2 and Band 5s opting out of the company pensions scheme, it was agreed that information sessions for all staff would be arranged. These sessions would share the benefits of the pension scheme so staff could make an informed decision. The feasibility of including these sessions in the induction programme for junior doctors, nurses, and all staff would be explored. A factsheet would also be produced and attached to payslips. **Action JB/SO/PB – July**

  A review of possible support/options to address pension contribution concerns eg finance issues, tax (including the tax implications of working additional hours for higher paid staff)– would be conducted. Possible options could include salary sacrifice, and information on organisations that could provide support.

  A fact sheet for doctors would be provided for to help them better understand impact of working extra hours on their pension. It was noted that this was a national issue that needed resolving. **Action: PB/July**

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

- **People strategy:** Divisional teams to provide details of areas to be involved and support available to HR by 24th June
- **Medical Education Update:** Oncology action plan due September. Update on improved induction process for junior doctors due at September committee **(CL)**
- **Pension:** Information sessions at induction to be explored. Fact sheets to be produced **(July JB/SO/PB).** Review of support options due September **(SS/PB Sept)**

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

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26th July 2019

Title	**Audit Committee Report**
Chair	**David Noble**
Author (s)	**David Noble**
Purpose	**To advise the Board of the work of the Audit Committee**

Executive Summary

The Committee met on 28th June 2019 to discuss items on its agenda drawn from its annual work plan and arising issues relevant to its terms of reference.

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Standing Orders and Schemes of Delegation Internal Audit Plan Counter Fraud Losses, Special payments, Waivers	

Key areas of discussion arising from items appearing on the agenda

The Committee received a progress report on the development of new Standing Orders, Standing Financial Instructions and the Scheme of Delegation. The Committee noted that the existing forms are out of date, too detailed and require a complete overhaul. The Committee agree with the proposal that the documents used by Nottingham University Hospitals NHS Trust should be taken as a template, adjusted to be appropriate for Northampton and presented for review at the next Audit Committee.

The Committee agreed the Internal Audit plan. There are nine audits planned for the year and these are aligned to the key risks facing the Trust.

The Committee noted the Counter Fraud Annual Report which concluded with a GREEN overall assessment, and approved the Counter Fraud workplan. The Committee were pleased to note that there was evidence that the Trust had learned from previous experience and that now procedures were being followed more rigorously in progressing suspected fraudulent activity.

The Committee continue to be frustrated by the level of salary overpayments in spite of the actions that have been taken over the last year, but are pleased to see that the rate of recovery of these overpayments is very high. This must continue to be monitored by the Finance Committee who will hold individual managers to account.

Any key actions agreed / decisions taken to be notified to the Board	
Any issues of risk or gap in control or assurance for escalation to the Board	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board	

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26 July 2019

Title	**HMT Exception Report**
Chair	**Dr Sonia Swart (CEO)**
Author (s)	**Ms Deborah Needham (Deputy CEO/COO)**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 2nd July 2019 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

1. CEO update
2. Divisional scorecards
3. Cancer performance
4. People strategy

Board Assurance Framework entries
1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

CEO update
An update was provided by the CEO detailing the summary verbal feedback from the recent CQC inspection across medicine, urgent care & maternity.
A brief update was also provided on the urgent care pressures and the transformation work being supported by transformation nous.

Divisional Scorecards
The divisional scorecards were highlighted for information and by exception:

Womens, Childrens, Oncology, Haematology & Cancer – Nursing workforce gaps & a decrease in salary overpayments.

Medicine – Urgent care pressures & the need to increase capacity in A&E.

Surgery – Challenges within the urology cancer 62 day pathway and achievement in orthopaedics for 18 weeks. .

Clinical Support services – An update was given on the recent HSE visit to the lab.

Cancer performance
An update was provided by Mr Cooper for the April cancer performance, including actions being taken for challenged pathways. Harm reviews in place with no harm noted for any patients waiting over 104 days.

People Strategy
Fiona Pittam (OD lead) presented the proposal for the development & engagement of the people strategy. Discussion and views were sought from the management team with several

ideas around dedicated engagement throughout the summer.	
Any key actions agreed / decisions taken to be notified to the Board None	
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.	

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PUBLIC TRUST BOARD

Friday 26 July 2019
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 30 May 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	CCG Transition Programme	Receive	Mr T Sanders	**C.**
	6.	Patient Story	Receive	Executive Director	**Verbal.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report including • CQC Update	Receive	Dr S Swart	**D.**
10:15	**CLINICAL QUALITY AND SAFETY**				
	9.	Medical Director's Report including - • Learning from Deaths Update • GMC Survey Results	Assurance	Mr M Metcalfe	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**F.**
	11.	Maternity Bi-Annual Staffing Review	Assurance	Ms S Oke	**G.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Month 03 Finance Report	Assurance	Mr P Bradley	**H.**
	13.	Operational Performance Report	Assurance	Ms L Taylor	**I.**
	14.	Workforce Performance Report including – • People Strategy Update	Assurance	Mrs J Brennan	**J.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	15.	Equality & Diversity Workforce Annual Report 2018/2019	Assurance	Mrs J Brennan	**K.**
	16.	Equality & Diversity Workforce Monitoring Report 2018/2019	Assurance	Mrs J Brennan	**L.**
	17.	Equality & Diversity Workforce Progress Report for Staff	Assurance	Mrs J Brennan	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Board Assurance Framework	Assurance	Ms C Campbell	**N.**
	19.	Update Paper - Violence & Aggression Review Group (VARG)	Assurance	Ms S Oke	**O.**
11:40	**COMMITTEE REPORTS**				
	20.	Highlight Report from Finance and Performance Committee	Assurance	Mr D Moore	**P.**
	21.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Q.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**R.**
	23.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**S.**
	24.	Highlight Report from HMT	Assurance	Dr S Swart	**T.**
11:50	**25.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 26 September 2019 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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