UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 30 May 2019

09:30

Board Room
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
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A G E N D A

PUBLIC TRUST BOARD

Thursday 30 May 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 28 March 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Director of Public Health – Annual Report	Receive	Ms L Wightman	**To Follow/C.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**D.**
10:05	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**E.**
	9.	Approval of the Quality Account	Assurance	Mr M Metcalfe	**F.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**G.**
10:45	**OPERATIONAL ASSURANCE**				
	11.	Month 01 Finance Report	Assurance	Mr P Bradley	**H.**
	12.	Operational Performance Report	Assurance	Mrs D Needham	**I.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**J.**
11:00	**STRATEGY**				
	14.	Trust Vision and Aims	Assurance	Mr C Pallot	**K.**
	15.	People Strategy	Discussion	Mrs J Brennan	**L.**
11:25	**FOR INFORMATION & GOVERNANCE**				
	16.	Collaboration Steering Committee – Terms of Reference	Assurance	Ms C Campbell	**M.**
	17.	Health and Safety Annual Report	Assurance	Mr S Finn	**N.**
	18.	Freedom to Speak Up Annual Report	Assurance	Ms C Campbell	**O.**
	19.	Self-Certification	Assurance	Ms C Campbell	**P**
11:55	**COMMITTEE REPORTS**				

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**Q.**
	21.	Highlight Report from Quality Governance Committee	Assurance	Ms J Houghton	**R.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**S.**
	23.	Highlight Report from HMT	Assurance	Dr S Swart	**T.**
12:05	**24.**	**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 Friday 26 July 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

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Minutes of the Public Trust Board

Thursday 28 March 2019 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr A Burns	Chairman
	Mrs D Needham	Acting Chief Executive Officer
	Mr P Bradley	Director of Finance
	Dr E Heap	Associate Non-Executive Director
	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	Associate Non-Executive Director
	Mr D Noble	Non-Executive Director
In Attendance		
	Mr C Pallot	Director of Strategy & Partnerships
	Mr C Holland	Acting Chief Operating Officer
	Mr S Finn	Director of Facilities and Capital Development
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Ms A Chown	Deputy Director of Human Resources
	Miss K Palmer	Executive Board Secretary
	Ms S Watts	Associate Director of Communications
Apologies		
	Dr S Swart	Chief Executive Officer
	Mrs J Brennan	Director of Workforce and Transformation

TB 18/19 239 Introductions and Apologies

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

Apologies for absence were recorded from those listed above.

TB 18/19 240 Declarations of Interest

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

TB 18/19 241 Minutes of meeting 31 January 2019

The minutes of the Trust Board meeting held on 31 January 2019 were presented for approval.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 31 January 2019.

TB 18/19 242 Matters Arising and Action Log 31 January 2019

The Board **NOTED** the Action Log and Matters Arising from the 31 January 2019.

TB 18/19 243 Patient Story

Mr Pallot presented the patient story.

Mr Pallot advised of a patient who had been admitted from 13 October 2018 to 09 January 2019. The patient was 92 years old and had a variety of physical health

problems. The patient had needed support of carers for a large variety of things.

Over the patients admission the patient had been moved several times and on each move the patient had lost one of their belongings. These items had included her shoes, her glasses and her teeth. Mr Pallot reported that the patient had been discharged with no teeth. This had been a failed discharge and had arrived back in A&E on the same day. This experience had been negative and had left the patient feeling depressed.

Mr Pallot commented that the patient's teeth appeared impossible to be replaced despite attempts to do so. After time the ward sister sent of an application for new teeth however these were never received.

The patient was not offered a soft food diet until the patient had been admitted to Holcot Ward. This was weeks after her teeth had gone missing and she had lost weight by this point. The patient was not encouraged to eat or drink.

Mr Pallot remarked that the patient's family had raised concerns that this had all happened despite regular visits from the family. The family queried what could have happened to a patient who did not have the regular family support. The family noted that the patient often complained of feeling thirsty however the ward remarked that the patient was dehydrated.

On the 11 January 2019 the patient died. The family asked what stage the Trust had been at in regards to her teeth and why the patient had not been prioritised considering the amount of weight that had been lost

Ms Oke commented that this was a very sad patient story and was going through the investigative process.

Mr Pallot noted that this clearly needed focus on and this theme been discussed many times at Board.

Mr Archard-Jones advised that the financial aspect of replacing patient belongings was regularly reported to the Audit Committee. Mr Noble concurred and believed that it had been also discussed by the Quality Governance Committee. Mr Archard-Jones confirmed that it had been flagged at the Quality Governance Committee and the previous Director of Nursing was to investigate this.

Mr Moore noted the underlying issue of dementia.

Mr Metcalfe reported that this was a complex patient however he had been struck that being fed was a human right. This had been raised as Serious Incident and had been raised to the Quality Governance Committee. There had been a recent Dare to Share on this topic. There had been a request that patient nutritional information was gathered at the daily safety huddles.

Ms Houghton shared with the Board that difficulties noted with protected meal times had been highlighted at a recent Quality Governance Committee.

Mr Holland informed the Board that the Trust had signed a contract with Age UK which could help mitigate some of these concerns.

Ms Oke stated that a Nutrition Nurse had been appointed and the Nutrition Group had been restarted.

Mr Metcalfe advised that the Dietetic Service provided by NHFT was 1.5wte. He believed that the Trust had a limited Dietetic Service and that it was inadequate for a

Trust this size. Mr Moore asked what similar Trusts had. He was informed that most Trust's employed their own and had more input than 1.5wte.

Mrs Needham expressed her sadness that it was the basic nursing care of the patient which had been neglected.

Mrs Watts noted that the more times a patient moved the more chance there was for an item to be lost. She suggested the creation of a checklist for when a patient moved wards. Mrs Needham commented that with the closure of Angela Grace and Avery this should help minimise the number of ward moves.

Mr Burns queried what else the Board could do. It should look at what else could be done in relation to Dieticians and also the volunteers. He asked for a report to go to the **Quality Governance Committee** in **April** and a report to the **May Trust Board**.

Action: Ms Oke

The Board **NOTED** the Patient Story.

TB 18/19 244 Chairman's Report

Mr Burns advised that there had been many discussions had on the contract. This had been a long process and would be discussed within Private Trust Board.

Mr Burns reported that he had conversions with the staff involved in the power outage and there was a report on this within the Public Trust Board agenda.

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

TB 18/19 245 Chief Executive's Report

Mrs Needham presented the Chief Executive's Report.

Mrs Needham advised that in regards to the upcoming CQC inspection which was due mid-June, the PIR had been submitted the previous evening. The Use of Resources assessment had been scheduled for the 04 June 2019. The Trust had been busy preparing briefing sessions and this had started with the Question Time session a few weeks ago.

Mrs Needham shared the positive news with the Board that for the second time the Trust had been accredited as baby friendly by UNICEF UK. The Trust had also recently received a certificate for excellence in sustainability reporting.

Mrs Needham commented that in relation to workforce, March had been very challenging with urgent care pressures. She remarked that the Trust staff continued to amaze her daily with their resilience and drive to deliver excellent care.

Mrs Needham stated that the Respect & Support Campaign continued with some new training for staff which had included a hotline for staff and focus groups.

Mrs Needham reported that the Trust had also joined with KGH to partner with Voice which was a service that offered a confidential support service for victims or witnesses of crime.

Mrs Needham advised that the majority of her time over the last few weeks had been taken up working with the Director of Strategy, the Director of Finance and system partners to agree the income from the CCG for 2019-20. Unfortunately at present the Trust was not in a position to agree the CCG offer. She noted that negotiations had been long and at times challenging. The gap across the system was small and she had found it frustrating that agreement had not been reached to close this.

Mrs Needham commented that at the last Board of Directors she had delivered a verbal update on the power outage which had occurred on the 22 February 2019, where approximately 75% of the site was without power for a period of time. It was noted that A&E had been closed and full command and control had been in place.

Mrs Needham shared her sincere thanks to everyone involved especially to those who came in during the night and into the Saturday.

Mr Noble asked that both KGH and Milton Keynes were formally thanked for being on standby when the Trust's A&E was closed. It was reported that KGH had accepted 7 ambulances.

Ms Gill also thanked the leadership from the Executive Team in the power outage.

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

TB 18/19 246 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe delivered an update on the IT in relation to VTE and HAT performance compliance. An upgrade had been completed in November 2018 and since then the Trust had been unable to report compliance with VTE assessment. A definitive IT system was needed to provide compliance with NICE guidance. Mr Metcalfe had been informed that the IT system needed further work and would be completed June 2019. He was grateful for Mrs Needham's push to get this resolved.

Mr Metcalfe commented that the rolling 12 month HSMR to November 2019 for the Trust had fallen to within the "expected" range. He hoped this would continue. Mr Noble referred to the narrative 'It is felt likely that changes in HSMR reflect changes in community health and social care provision'. He asked for further clarity on this. Mr Metcalfe explained that with the HSMR there was a lag time of 3 months and the challenges faced as a system were better this year than last year.

Ms Houghton remarked that she sat on the Mortality Committee and this Committee had still raised levels of concern as there had not been one key theme as to why the HSMR had reduced. The Trust would be conducting a peer view on a better performing Trust.

Mrs Needham asked Mr Holland to deliver an update on risk noted on page 25 of the report pack of escalation areas being open. Mr Holland reported that March had been a challenging month. There was one escalation ward left open and this was Benham Ward which currently had 5 patients on. There had been 26 patients originally. The staff would be released back to their base wards. It was noted that Angela Grace was also due to close.

Mr Moore referred to risk ID1756 in relation to the new medical model in Nye Bevan. He asked how this changed how the hospital operated. Mr Metcalfe explained that there had been step changes with the new medical model which was implemented on the 02 January 2019. There was a substantive consultant rostered there 13 hours a day. There had been a significant beneficial effect with the wait to be seen by a senior consultant reduced. Mr Metcalfe commented that there was going to be a rapid assessment bay however this was now bedded bays. The rapid assessment bay had been discussed by the Executive Team and would be implemented incrementally till June 2019 with it being introduced week commencing 01 April 2019.

Mr Archard-Jones stated that VTE compliance had been raised as an area of concern at the Quality Governance Committee. Mr Metcalfe believed that going back to a paper based system would be a retrograde step. The mitigation put in place was

spot audits of the system. Mrs Needham confirmed that if she had asked IT for a solution from week commencing 01 April 2019.

Mr Burns noted the update on the new Medical Model in Nye Bevan with work ongoing over the summer to have it fully implemented. He remarked that discharge was still an issue and what could be done to address this.

Ms Oke informed the Board that she and Mr Holland were leading a project team that was meeting weekly to look at the discharge process. The QI Team were supporting this and were developing project workstreams to make discharge effective. Mr Holland confirmed that they had allocated 6 mini projects to members of the larger project group.

Mr Holland stated that the conversion rate from ED had increased from 18% to 26%.compared to the same period last year

Mr Burns queried what 3 metrics could determine if the project had been successful and time to discharge had reduced. He asked for an update at a future Board on what metrics would define this.

Action: Mr Holland

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

TB 18/19 247 Mortality and Learning from Deaths Update

Mr Metcalfe presented the Mortality and Learning from Deaths Update.

Mr Metcalfe advised that screening rates have improved to 93% in Q3.

Mr Metcalfe referred to **action log item 95**. He confirmed that the numbers reported to the January Board in regards to mental health within the Mortality and Learning from Deaths Update Report had been correct.

Mr Metcalfe commented on the Structured Judgement Reviews. An escalation process was in place and it was followed through by a line manager led structure who would if appropriate then fed up to the Medical Director.

Mr Burns informed the Board that the Learning from Deaths process had been scrutinised at KGH in their recent CQC inspection.

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

TB 18/19 248 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 drew the Board to page 39 of the report pack and the Friends and Family Test update. The Emergency Department's recommendation results continued to decrease. This had been discussed and there was no clear answer to this. It was noted that the challenging waiting times could be affecting this. There was a Trust-wide improvement plan in place. Ms Oke reported that a Family & Friends Test Responses Session had been organised for the 01 April 2019.

Ms Oke advised that the level 3 safeguarding children training compliance figures had increased from 69% to 79% following extensive remedial action by the safeguarding team. Ms Oke was confident that this would reach 85% by the end of the May.

Ms Oke commended how well the staff had coped under the increased pressures,

being moved around the wards and with the escalation beds being open.

Ms Oke informed the Board that the Quality Governance Committee had received an End of Life presentation which had highlighted the challenges the Consultant had faced leading the End of Life workstream and the work which had followed the last CQC inspection.

Mr Noble drew the Board to Friends & Family Test (FFT) graph on page 39 of the report pack. The Trust continuously reported below the mean and was also below the national average. Ms Oke confirmed that there was focus on this performance as to understand the drivers. The Trust did also use the Real Time and Right Time survey's to gather valid feedback.

Ms Houghton commented on the narrative on page 42 of the report pack which stated that 'The PPH quality improvement work and care bundle continues to be implemented and PPHs > 1500mls for February will be explored for any themes'. Ms Houghton asked for an update on the PPH work to be included in Ms Oke's report to the **Quality Governance Committee.**

Action: Ms Oke

Mr Archard-Jones advised that at the Quality Governance Committee the End of Life presentation had highlighted that End of Life had not been included in the Clinical Strategy. Mr Pallot took this on board and would ensure that team is involved in one of the engagement sessions for the new strategy.

Action: Mr Pallot

Mr Burns remarked on the FFT results and how it linked it to a net effect of more unhappy patients, more patients on trolleys in ED and potential lack of a rapid assessment bay.

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

TB 18/19 249 Bi-Annual Review of Nurse Staffing & Midwifery Staffing

Ms Oke presented the Bi-Annual Review of Nurse Staffing & Midwifery Staffing Report.

Ms Oke advised that the report was to provide assurance on nurse staffing levels and staffing capacity to provide safe, high quality care across all wards and departments at Northampton General Hospital.

Ms Oke stated that a bi-annual staffing review had not been completed on Nye Bevan and the Emergency Department given the fact there had been investment in the establishment when the unit opened. The new ways of working were still being embedded. A maternity bi-annual staffing review would be presented to the **May Trust Board.**

Ms Oke commented that the Trust was compliant this year with the Developing Workforce Safeguards.

Ms Oke remarked that the Associate Nurse Directors had reviewed their establishments and updates from the Divisions were included on page 62 to 64 of the report pack. Ms Oke stressed that the Trust could not underestimate the number of nurse vacancies.

Mrs Needham asked when the Nye Bevan nurse staffing update would come to the Board. Ms Oke advised that this review would come to the **June Board.**

Ms Houghton noted that this was a comprehensive paper however noted that she

was uncomfortable approving the paper as requested within the report. Ms Oke asked the Board to note the recommendations and any feedback would be presented to the Workforce Committee.

Ms Oke commented that the Trust needed to have a registered Paediatric Nurse in Paediatric ED. She had been working with Paediatrics and ED to look at creating a rotational post.

Mr Moore asked to what extent the Safe Care Tool and the CHPPD Tool had on Ms Oke's decision making. Ms Oke explained that the Safe Care Tool could be used in conjunction with Allocate on the eRoster system.

Mrs Needham expressed that she had some concerns in relation to Midwifery staffing. Ms Oke clarified that this had been discussed at the Quality Governance Committee. There were a large number of midwives on maternity leave and the Trust did not use agency midwives to cover these gaps. There would be a future paper on the possibility to over-recruit on midwives.

Mr Burns asked for the Board to be informed if there were any failures when the Divisions looked at implementing the recommendations suggested by the Associate Nurse Directors.

Mr Burns asked for a future report on registered Paediatric Nurse in Paediatric ED.

Action: Ms Oke

The Board **NOTED** the Bi-Annual Review of Nurse Staffing & Midwifery Staffing Report.

TB 18/19 250 Assessment & Accreditation Update – Qt3 Update

Ms Oke presented the Assessment & Accreditation Update – Qt3 Update.

Ms Oke advised that the report described the progress made by the nursing teams using the 'Best Possible Care Assessment and Accreditation' framework during Quarter 3. There were 17 assessments completed in the quarter. This was reported as 11 Green, 6 Amber and 0 Red.

Ms Oke stated that Spencer Ward and Rowan Ward had achieved their third consecutive Green assessments and were in the process of applying for 'Best Possible Care' Blue Ward Status. It was noted that Allebone Ward had been successful at panel in achieving 'Best Possible Care' status, which was approved by Trust Board in Q4.

Ms Oke reported that there were 3 wards managed as non-progressing wards. These were Knightley, Talbot Butler and Victoria.

Ms Oke commented that in Q3 2018-2019 the first assessment took place within the Medical Outpatient Department. The department had been awarded a green rating and would be reassessed in approximately 9 months' time.

Mr Noble noted that Abington Ward had moved from blue to amber and asked the reasons behind this. Ms Oke clarified that there had been changes in senior leadership. The new ward manager would be establishing how to get back blue status.

The Board **NOTED** the Assessment & Accreditation Update – Qt3 Update.

TB 18/19 252 M11 Finance Report

Mr Bradley presented the M11 Finance Report.

Mr Bradley advised that the month 11 financial pre-PSF position showed a year to date favourable position of £364k. It was noted however that the Trust had not achieved the PSF of £1,470k related to A&E performance in quarter 3 and the first two months of 2019. Therefore the Trust was £1.1m adverse to the post-PSF plan.

Mr Bradley reported that continued delivery of the pre-PSF plan year to date was an achievement for the Trust and this had also been recognised by the regulators.

Mr Bradley remarked that in month income over-performed, pay over-spent, non-pay overspent and the monthly planned release of reserves led to the month end position.

Mr Bradley drew the Board to page 96 of the report pack which discussed income. The income and activity position was above plan in month. This continued the recent trend. The Trust had capped the CCG income to the levels agreed as part of the year end deal.

Mr Bradley noted that page 98 of the report pack was the start of the pay slides . It was noted that pay had overspend £287k in month, down from the £450k overspend in January 2019. The causes are the continued use of agency medics and nurses. It was reported that pay overspending was £3.9m year to date after the removal of the £5.2m of unplanned pay savings. Mr Bradley stated that the agency cap was exceeded in February 2019 by £12k mainly due to the additional medical and nursing staff related to winter plans and the escalation ward.

Mr Bradley remarked that on page 100 of the report pack non-pay expenditure continued to help the bottom line and was £1.2m underspent year to date. This did not include excluded drugs and devices).

Mr Bradley advised that in regards to CIPs in overall terms the Trust was ahead of plan and was expected to meet the target. In month the value of recurrent savings had increased by £946k.

Mr Bradley stated that the capital plan was included on page 104 of the report pack and capital should be fully spent up by the end of the month. There was daily monitoring of this throughout March.

Mr Bradley commented that in overall terms, via a few non-recurrent means, the Trust was slightly better than plan and the Trust hoped to meet the pre-PSF deficit of £27.7m at year end. This would be a huge achievement for the Trust.

The Board **NOTED** the M11 Finance Report.

Mr Bradley circulated the **Financial Plan – 2019-20.** This had been presented and discussed at the Finance & Performance Committee. The most recent contract offer was within £700k of what was detailed within the plan. Mr Bradley asked the Board to approve the recommended budget within the report.

The Board **APPROVED** the Financial Plan – 2019-20.

TB 18/19 253 Operational Performance Report

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

Mr Holland advised that A&E performance was at 79.1% which had been an

improvement on January 2019. The admission to conversion rate had remained the same at 26.9% and a large number of these patients were over the age of 75. Conversion rate for the over 75's was at 70%

Mr Holland reported that DTOC remained low however the number of stranded (7 days plus) and super stranded (21 days plus) increased slightly in January but had since decreased from February 2019.

Mr Holland commented that the Fixing flow programme continued. It had been revised and now included Admission & Discharge with a steering group led by the CEO. The new medical model was now implemented in Nye Bevan, A&E and ACC.

Mr Holland remarked that contracts had been signed for AGE-UK to support the Trust's elderly frail patients with their discharge from both A&E and the Discharge Suite on a trial for 16 weeks starting in April 2019. Another contract agreed was with the local borough council to provide a homeless officer to support discharging patients who are ether homeless or cannot return to their homes.

Mr Holland stated that a multiagency admission avoidance event had been planned for the end of March 2019. It was noted that this had been put back a month as the CCG had not been able to secure GP's to attend.

Mr Holland discussed operation Benham with the Board. This had included deep-dives by the Matrons and Ward Managers on patient waits. Benham ward was close to closure and the Trust had also closed Angela Grace this week.

Mr Holland delivered a cancer update to the Board. The 2ww wait was at 82%, 2ww breast symptoms were at 70%, 31 days was at 94.2% and 62 days was at 74.7%. Mr Holland noted that the number of treatments had been low in February 75 as opposed to 100 on average.

Mr Holland remarked that though the 2ww had improved there were still concerns with Dermatology. There had been work done to look at outsourcing some Dermatology work. This Directorate had the biggest number of patients on a Cancer pathway. Mr Holland stated that all cancer pathways had an action plan.

Mr Holland informed the Board that 6 patients were treated in excess of 104+ days in January. It was noted that 1 patient had been delayed by late referral by the tertiary provider.

Mr Holland advised that RTT had achieved 80.8% for February 2019 and 78.5% for March against a national target of 92%. There were action plans in place for all the Directorates. There had been one 52 week breach due to a patient being found who had been miscoded. This patient was then treated in month. Mr Holland commented that there was some new IT software that may flag up other patients who had experienced this miscoding.

Mrs Needham queried why the number of treatments had been low in February. Mr Holland clarified that this had been due to a reduction in the number of referrals.

Mr Archard-Jones asked if there was an update on the metric 'Stroke patients spending at least 90% of their time on the Stroke Unit'. Mr Holland explained that the flow at Isebrook was slow and this was the main reason to delaying of transfers. This was not appropriate for the patients as the patient was being kept in hospital too long. Ms Gill mentioned the discussions that had happened on the withdrawing of Stroke schemes. Mr Holland expressed his nervousness at this.

Ms Houghton remarked on the late tertiary referrals referenced in the report and

asked whether these pathways needed to be reviewed. Mr Holland had contacted other providers however these providers did not have the capacity. The issues with capacity at Leicester were patients waiting to use the da vinci technology. Mr Metcalfe commented that there was little clinical evidence that suggested the da vinci technology was better than surgery.

Mr Burns asked what the Board could do to support the reported issues with Cancer. Mr Holland believed the initial challenge sat with the 2ww and the capacity at the Trust. The running of additional clinics was a challenge and these clinics needed to be made more attractive for staff to run without exhausting the staff. In the short-term locums were being used where possible and he noted that insourcing would become expensive.

Mr Metcalfe remarked that with patient experience timeliness was important. The Trust needed to look at what it was doing internally to support patient experience in Cancer. A cancer user group would be useful.

Ms Gill stated that at a recent Quality Governance Committee a presentation had been shared on the leaflet given to Prostate patients and she asked if this could be replicated.

Mrs Needham advised that previously the Cancer PTL had to be micromanaged. She believed that inclusion of the Non-Executive Directors in supporting improvements to the Cancer Directorate would be beneficial and this included links across the HCP. The Non-Executive Directors were supportive of this.

Ms Houghton stated that the inclusion of the Non-Executive Directors to be a good suggestion however she had attended a HCP meeting and was unsure of how she would have been able to influence the meeting.

Mrs Needham informed the Board that there was no clinical lead for Cancer at the Trust at present but the role was being undertaken by the divisional director.

Mr Moore asked whether the HCP could address the high number of referrals sent by the GP's. He was informed that the HCP looked at the strategic approach rather than individual cases. Mr Metcalfe stressed the importance of not discouraging GP referrals.

Mr Archard-Jones believed there to be pathway issues with many patients going to the GP to be referred to a consultant to then being referred for the treatment the GP had recommended.

Ms Houghton queried whether the Trust would look to recruit the Clinical Lead for cancer again. She was informed that this would be revisited.

Mrs Needham requested that any Non-Executive Directors who wished to be involved in the Cancer work alongside herself and Mr Holland to contact her.

Action: Non-Executive Directors

Mr Burns asked for the discussion to be taken to one of the sub-committees of the Board for a further review. This was agreed to be at a **Quality Governance Committee** then at the following **Trust Board.**

Action: Mrs Needham

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

TB 18/19 254 Workforce Performance Report

Mrs Chown presented the Workforce Performance Report.

Mrs Chown advised that Annual Trust turnover for February 2019 increased. It was noted that the overall Trust vacancy percentage also decreased however vacancy rates in Nursing & Midwifery staff had increased.

Mrs Chown reported that Sickness absence for February 2019 decreased 4.74% and was above the Trust target. As a comparison Mrs Chown advised the national average for acute trusts is 4.26% and the average sickness rate in the East Midlands was 4.69%.

Mrs Chown stated that the current rate of Appraisals recorded for February 2019 increased, Mandatory Training compliance decreased and Role Specific Essential Training compliance increased.

Mrs Chown commented that within the culture section of the Workforce Performance Report there was a detailed update on Organisational Development. It was noted that Staff Engagement was an integral part of the People Strategy and that this would be presented to the **May Board.**

Ms Houghton queried whether Ms Chown had a job planning update. Mr Metcalfe referred Ms Houghton to the Medical Directors Report. There was an upward trend in compliance however was still below trajectory. There was work underway with aligning the job plans to the service plans.

Mr Burns asked for the fill target as it had not been included within the report. Mrs Chown clarified that she would be able to obtain this information if needed. Mr Burns believed that it was important for the Workforce Committee to look at what could be done different and look at this question from an imagination perspective.

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

TB 18/19 255 Electrical Power Outage Incident Debrief

Mrs Needham presented the Electrical Power Outage Incident Debrief.

Mrs Needham advised that the paper detailed the chronology of the electrical power outage across the NGH site at 11.15pm on 22 February 2019.

Mrs Needham stated that there was full command and control in place. This was led by herself through the night and the Director of Finance during the Saturday supported by the Medical Director.

Mrs Needham informed the Board that a full debrief had taken place on 13 March 2019. The early lessons indicated resilience of on-call teams (Estates, Management and IT), a checklist of all agencies to contact to advise of closure and a formal stand down procedure.

Mr Burns noted that it was text book how the Trust had responded and thanked the good management skills.

The Board **NOTED** the Electrical Power Outage Incident Debrief.

TB 18/19 256 Emergency Preparedness Annual Report

Mr Holland presented the Emergency Preparedness Annual Report

Mr Holland advised that the report detailed how the Trust met the requirements set out by the Civil Contingencies Act (CCA, 2004) and NHS England's Emergency

Preparedness, Resilience and Response (EPRR) Framework 2015.

Mr Holland stated that the Trust was a category one responder.

Mr Holland highlighted areas to note within the report. He commented that the Trust had recently purchased a dedicated web-based system to assist with the notification and call-out process during an incident. There had also been work recently undertaken to install contingency phones throughout the Trust in order to maintain communication during periods of potential IT/network outage.

Mr Holland remarked that the Corporate Major Incident Response Plan had been updated. The Business Continuity Management Policy was also in place which included a corporate-level policy supported by service-level plans.

Mr Holland stated that an EU Exit Business Continuity Plan had recently been developed in consultation with the Brexit Planning Group. There are updates received daily.

Mr Holland advised that training is in place for staff to ensure that they are appropriately trained to implement the required response. There was quarterly ED training days.

Mr Holland informed the Board of Exercise Tartar which had taken place on 1 March 2018. This was based around an active shooter and hostage situation in Northampton shopping centre.

Mr Holland reported that NHS England and CCG colleagues had attended the Trust on 16 August to undertake a site visit and a review of our policies, procedures and processes. It was noted that NHS England were assured that NGH were, for the third year in succession, “fully compliant” with the requirements of the core standards.

Mr Holland commented that plans for 2019 included a whole-site evacuation exercise and continued planning for the potential of a no-deal BREXIT.

Mr Moore queried whether the Trust involved KGH in incident planning and he was confirmed that NGH did.

Mr Burns remarked that there was no protocol for sharing of staff between KGH and NGH. This may be way forward for resilience planning for the future.

Mr Burns noted that four of the major incidents had involved problems with the estates infrastructure and questioned whether enough attention had been paid to this.

The Board **NOTED** the Emergency Preparedness Annual Report

TB 18/19 257 Local Digital Roadmap Update

Mr Mathias presented the Local Digital Roadmap (LDR) Update.

Mr Mathias advised of the 5 workstreams within the LDR. These were; Business Intelligence, Clinical Services, Information Sharing, Infrastructure and Integration. The projects currently funded were listed on page 177 of the report pack. The details of the funding for each project would be released at the end of March 2019. The funding sources were from ETTF (Estates & Technology Transformation Fund) or HSLI (Health System Led Investment).

Mr Mathias discussed the Current LDR Risks identified at February 2019 and these were included on page 178 of the report pack.

Mr Mathias drew the Board to appendix 1- Explaining the Northamptonshire Care Record. The Trust was looking at other providers to draw learning points in relation to this.

Mr Archard-Jones noted that the LDR was good move in the right direction however queried the omission of cyber security from the report. Mr Mathias clarified that cyber security was part of this. The Trust would be working closely with LGSS and KGH to ensure this would not be breached. Mr Archard-Jones expressed concerns with the GP's systems. Mr Mathias confirmed that these were monitored by LGSS.

Mr Noble remarked that the multi-year programme looked similar to a selection of mini projects. There was no SRO, no unified approach and no management. This concerned him. He believed this would not work unless managed as a transformational programme. Mrs Needham concurred and informed Mr Noble that a SRO had now been appointed. Mr Mathias also concurred and stated that the lack of a unified strategy to be frustrating. There needed to be a strategic view from the patch. He did not get to attend the Board monitoring the LDR and expressed concerns that his views were not voiced. Mrs Needham has escalated this up the HCP.

The Board **NOTED** the Local Digital Roadmap Update.

TB 18/19 258 Highlight Report from Finance and Performance Committee

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

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

TB 18/19 259 Highlight Report from Quality Governance Committee

Mr Archard-Jones advised that all areas to be noted from March's Quality Governance Committee had been discussed today at Trust Board.

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

TB 18/19 260 Highlight Report from Workforce Committee

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

- An update from Surgery in regards to the GMC trainee results and additional HEEM surveys to be presented to the **June** Committee. Mr Burns challenged the timescale of this and he was informed by Mr Metcalfe that this was appropriate due to the large amount of work to be done.

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

TB 18/19 261 Highlight Report from Audit Committee

Mr Noble circulated the highlight report from Audit Committee on the 27 March 2019.

Audit March Highlight Report.docx

Ms Campbell also highlighted that the Audit Committee had **recommended** approval of the Draft Conflict of Interest Policy.

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

TB 18/19 262 Any Other Business

Mr Burns thanked Mrs Needham for her work whilst acting up as CEO in Dr Swart's absence. This period had included difficult contracting rounds, winter pressures and the work with KGH.

Mr Burns commented that Mrs Needham had done an excellent job. He also thanked other members of the Board who had stepped up in this time. The Trust Board concurred with Mr Burns.

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

Mr A Burns called the meeting to a close at 12:10pm

Public Trust Board Action Log **Last update** **20/05/2019**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
93	Nov-18	TB 17/18 206	Annual Fire Safety Report	Mr Finn reported that a Fire Specialist had been employed for a period of 2 months to check all mitigations were in place. There were also departmental surveys ongoing. Mr Finn suggested presenting an update to the May Board. The Board agreed.	Mr Finn	May-19	On Agenda	**To be included in Health & Safety Annual Report**
99	Mar-19	TB 18/19 243	Patient Story	Mr Burns queried what else the Board could do. It should look at what else could be done in relation to Dieticians and also the volunteers. He asked for a report to go to the Quality Governance Committee in April and a report to the May Trust Board.	Ms Oke	May-19	On Agenda	**Update in DoN Report**
101	Mar-19	TB 18/19 248	Director of Nursing Report	Ms Houghton commented on the narrative on page 42 of the report pack which stated that 'The PPH quality improvement work and care bundle continues to be implemented and PPHs > 1500mls for February will be explored for any themes'. Ms Houghton asked for an update on the PPH work to be included in Ms Oke's report to the Quality Governance Committee.	Ms Oke	May-19	Gone to QGC	**confirmation given in Matters Arising addressed at QGC**
102	Mar-19	TB 18/19 248	Clinical Strategy	Mr Archard-Jones advised that at the Quality Governance Committee the End of Life presentation had highlighted that End of Life had not been included in the Clinical Strategy. Mr Pallot took this on board and would ensure that team is involved in one of the engagement sessions for the new strategy	Mr Pallot	May-19	On Agenda	**Update given at April Board of Directors - A specific session has been included in the process to re-write the strategy**
104	Mar-19	TB 18/19 253	Operational Performance Report	Mrs Needham requested that any Non-Executive Directors who wished to be involved in the Cancer work alongside herself and Mr Holland to contact her.	Non-Execs	May-19	On Agenda	**Update in Matters Arising**
105	Mar-19	TB 18/19 253	Operational Performance Report	Mr Burns asked for the discussion (Cancer deep-dive) to be taken to one of the sub-committees of the Board for a further review. This was agreed to be at a Quality Governance Committee then at the following Trust Board.	Mrs Needham	May-19	Gone to QGC	**confirmation given in Matters Arising addressed at QGC**
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	
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	

Director of Public Health Annual Report 2019

Northamptonshire

Northamptonshire County Council

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Introduction by the Director of Public Health Northamptonshire

I am pleased to present my first full year annual report, which is one of my statutory duties as Director of Public Health. I have independently set out my professional view of the health and wellbeing of our communities in Northamptonshire and have focused this year on health inequalities i.e. the differences in health status between individuals or groups. These inequalities are measured using life expectancy, mortality or disease rates across different population groups or geographic areas. The report explores how varying factors impact on the health of individuals and how differences in lifestyles (and therefore health outcomes) can vary considerably in various parts of the county.

Public health in Northamptonshire is currently working against a backdrop of local government restructure, with proposals to develop two new unitary local authorities being considered by central government. This potential transformation offers an opportunity to create new organisational visions and cultures focused on partnership working to improve education, skills, employment, environment, housing and community safety - the factors that affect the health behaviours and outcomes of Northamptonshire residents. For my team, this is an ideal time to achieve improvements in health at a local level with real involvement of individuals, families and communities.

For the people who live and work in Northamptonshire, health is improving overall and people continue to live longer; however these improvements are not distributed equally across the county and a longer life does not necessarily mean a healthier life. Individuals living in the poorest areas of Northamptonshire are still at higher risk of many health conditions and have a shorter life expectancy than those in wealthier areas. This report examines these differences both within and between the two proposed unitary local authority areas as well as providing a county-wide picture.

We can all agree that inequalities in health are avoidable and unfair and so in this report you will find insight and recommendations that aim to reduce health inequalities and give everyone the same opportunity to lead a healthy life, no matter who they are or where they live.

Lucy Wightman
Director of Public Health
Northamptonshire County Council

1. Background to health inequalities

Inequality - Inequality is the difference in social status, wealth, or opportunity between people or groups

Inequity - something that is not fair or equal

Health inequities are avoidable differences in health status or in the distribution of health outcomes between groups of people. Examples of such differences include life expectancy, teenage pregnancy rates and hospital admission rates following a fall. These inequities arise from inequalities within and between communities.

Health inequalities can exist across the whole of the life cycle. They can begin well before a baby is born, with factors such as the mother's access to healthcare or lifestyle factors that affect how healthy a baby is at birth such as her diet or whether she smokes. Inequalities can continue in childhood and children growing up in more deprived areas often suffer disadvantages throughout their lives, from educational attainment through to employment prospects, which in turn affects their physical and mental wellbeing. Throughout adulthood there can be differences in health status and outcomes such as having high blood pressure and lifestyle factors (e.g. smoking and being obese or overweight). An older person who is living in poverty is more likely to have ill health and frailty at an earlier age compared to someone the same age from a more affluent background. They are also more likely to die earlier from preventable conditions such as heart disease, stroke, and cancer that may have been caused by lifestyle factors or living conditions.

The Marmot report published in 2010 stated: "Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unjust."[1]

Professor Michael Marmot identified six goals to start to tackle inequalities:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure a healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill-health prevention**

These goals remain as relevant now in 2019 as they were in 2010 and local authorities, together with their partners including health, the voluntary and community sector and employers are ideally placed to take action to achieve these goals as their roles touch all these aspects.

Social determinants are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources and have a considerable influence and impact on health and wellbeing of individuals, families and communities. They have a greater impact than health and social care services in determining health. The determinants, as shown in figure 1, are a diverse range of social, economic and environmental factors.

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Figure 1

PEOPLE

The social determinants of health are all interconnected - how old you are, whether you're male or female, what kind of house you live in, how well you did at school, if you have a job and what kind of job it is, how active you are and the quality of the environment around you.

LIFESTYLE

Libraries, leisure centre, social services, sheltered housing, licensing, sports development

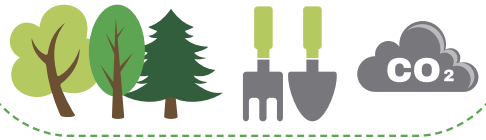
THE GLOBAL ENVIRONMENT

Waste disposal, recycling, planning and development control, climate change straegies

COMMUNITY

Social cohesion, area committees, community centres, youth groups, community development

THE NATURAL ENVIRONMENT

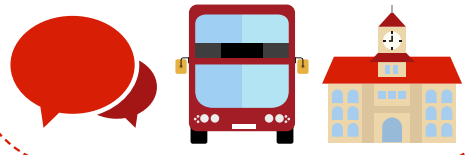


Air quality, parks, open spaces, sustainable development, allotments, agriculture

LOCAL ECONOMY

Local government jobs, commissioning services, regeneration, trading standards, economic development, business grants, tourism, marketing, consumer advice

ACTIVITIES



Training schemes, benefits advice, bus passes, health and safety, adult community learning, schools, physical activities, play provision, day centres

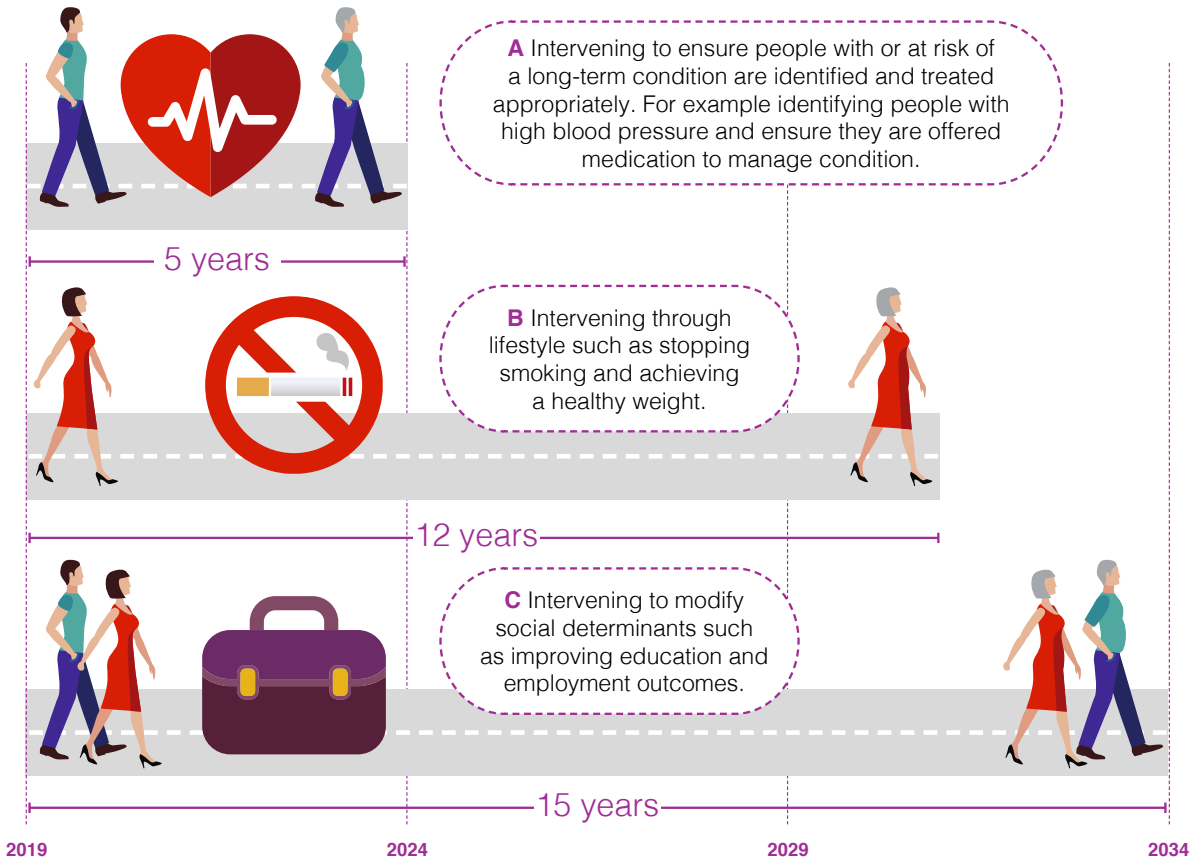
THE BUILT ENVIRONMENT

Housing, building control, environmental health, highways, speed limits, street lighting, play spaces, cycle routes, pedestrian zones, CCTV, car parks

There are a range of interventions that can impact on reducing health inequalities. Figure 2 shows the type of interventions can be divided up according to whether outcomes will be seen in the short, medium or long term. The quick wins are those in 'A' for example intervening to reduce mortality risk in those with established disease such as coronary heart disease (CHD), cancer or diabetes. People with risk factors for a long-term condition (for example, high cholesterol or high blood pressure) can benefit via medication and lifestyle change which can have a rapid impact at lowering their risk. A combination of interventions that cover all three impact times are essential if we are to reduce health inequalities in Northamptonshire.

People with risk factors for a long-term condition can benefit via medication and lifestyle change

Figure 2
Different Impact Times for Interventions (Adapted from Department of Health: Health Inequalities National Support Team 2010)



2. What are the health inequalities across Northamptonshire

It is proposed that the county and seven District Local Authorities in Northamptonshire may become two unitary local authorities. North Northamptonshire will include the districts of Corby, East Northamptonshire, Kettering and Wellingborough. West Northamptonshire will include the districts of Daventry, Northampton and South Northamptonshire. Figure 3 provides a snapshot of health and wellbeing outcomes across a person's life in both proposed unitary areas. The county and individual district versions are available as part of Northamptonshire's Joint Strategic Needs Assessment (JSNA).

Demographics

In 2017 the population in Northamptonshire was estimated to be 741,209. The graphic below presents the demographic differences between the two proposed unitary areas.

Although the West Northamptonshire area has the larger population due to the Northampton district which accounts for more than a third of the population of the county and has a higher average wage, **the overall health outcomes for the proposed unitary authorities are similar**. Changes in population are expected to be slightly higher in North Northamptonshire compared to West Northamptonshire, mainly due to increases predicted in Corby (15.7% from 2016-2026) which is much higher than all other districts (ranging from 6% to 9%). More information can be found in the Demography JSNA.

Generally, people are living longer and the percentage change in older people in Northamptonshire is expected to increase over time. The greatest increase in population is expected in the older age groups as shown in figure 4.

Life expectancy

Where you are born in Northamptonshire makes a difference to how long you will likely live. A male in Northamptonshire can expect to live an average of 80 years and a female an average of 83 years, similar to the national average. Figure 5 highlights differences between the two proposed unitary authorities, however it is of note that the greatest differences exist within the proposed unitary footprints, not between.

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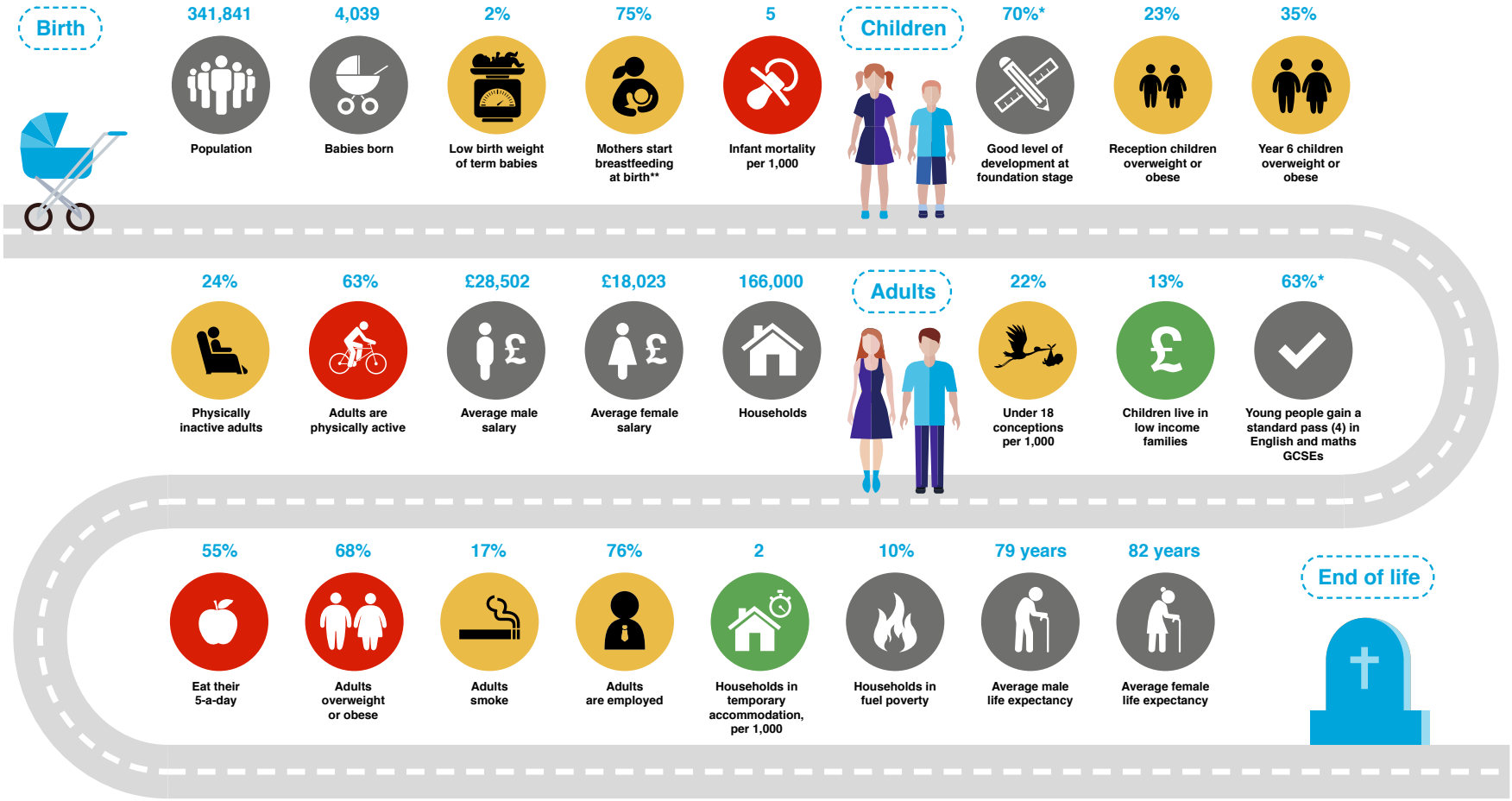
Figure 3a
Health and Wellbeing in Two Unitary Authorities, January 2019
North Northamptonshire



Source: Fingertips; Northamptonshire Analysis; ONS; NHS Digital; GOV.UK, Northamptonshire County Council; Please note data displayed is based on what is publicly available for Districts/Boroughs in November 2018 where possible, any local data is highlighted.

* Local Data, no comparators. BETTER SIMILAR WORSE NOT COMPARED

**This represents initiation only and not prevalence of breastfeeding. Please refer to figure 12 for more information and to show the prevalence at 6-8 weeks at a count level (47%)

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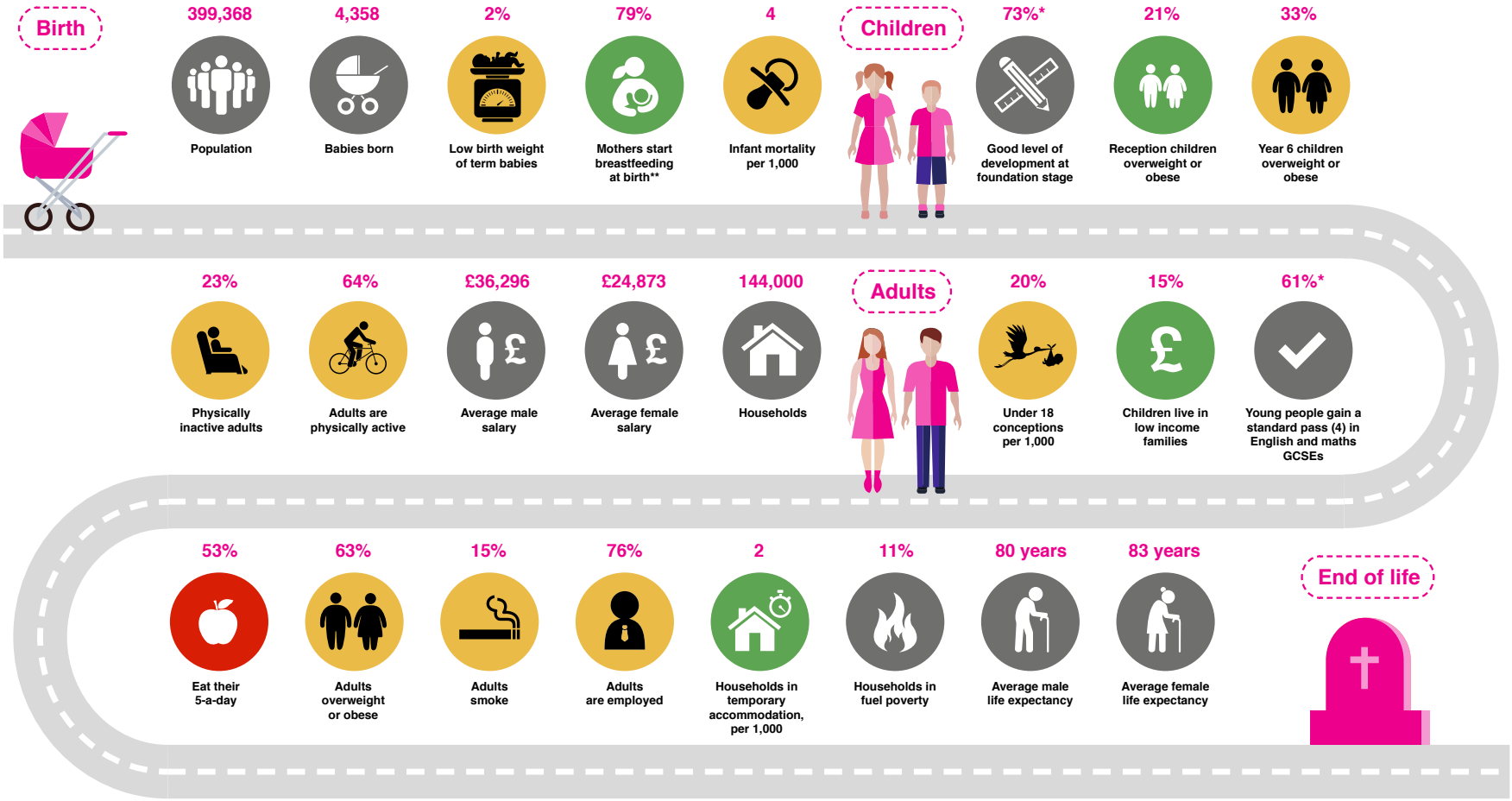
Figure 3b
Health and Wellbeing in Two Unitary Authorities, January 2019
West Northamptonshire



Source: Fingertips; Northamptonshire Analysis; ONS; NHS Digital; GOV.UK, Northamptonshire County Council; Please note data displayed is based on what is publicly available for Districts/Boroughs in November 2018 where possible, any local data is highlighted.

* Local Data, no comparators. BETTER SIMILAR WORSE NOT COMPARED

**This represents initiation only and not prevalence of breastfeeding. Please refer to figure 12 for more information and to show the prevalence at 6-8 weeks at a count level (47%)

Figure 4
Demographics in North and West Northamptonshire Unitary Authorities
Source: Census, ONS

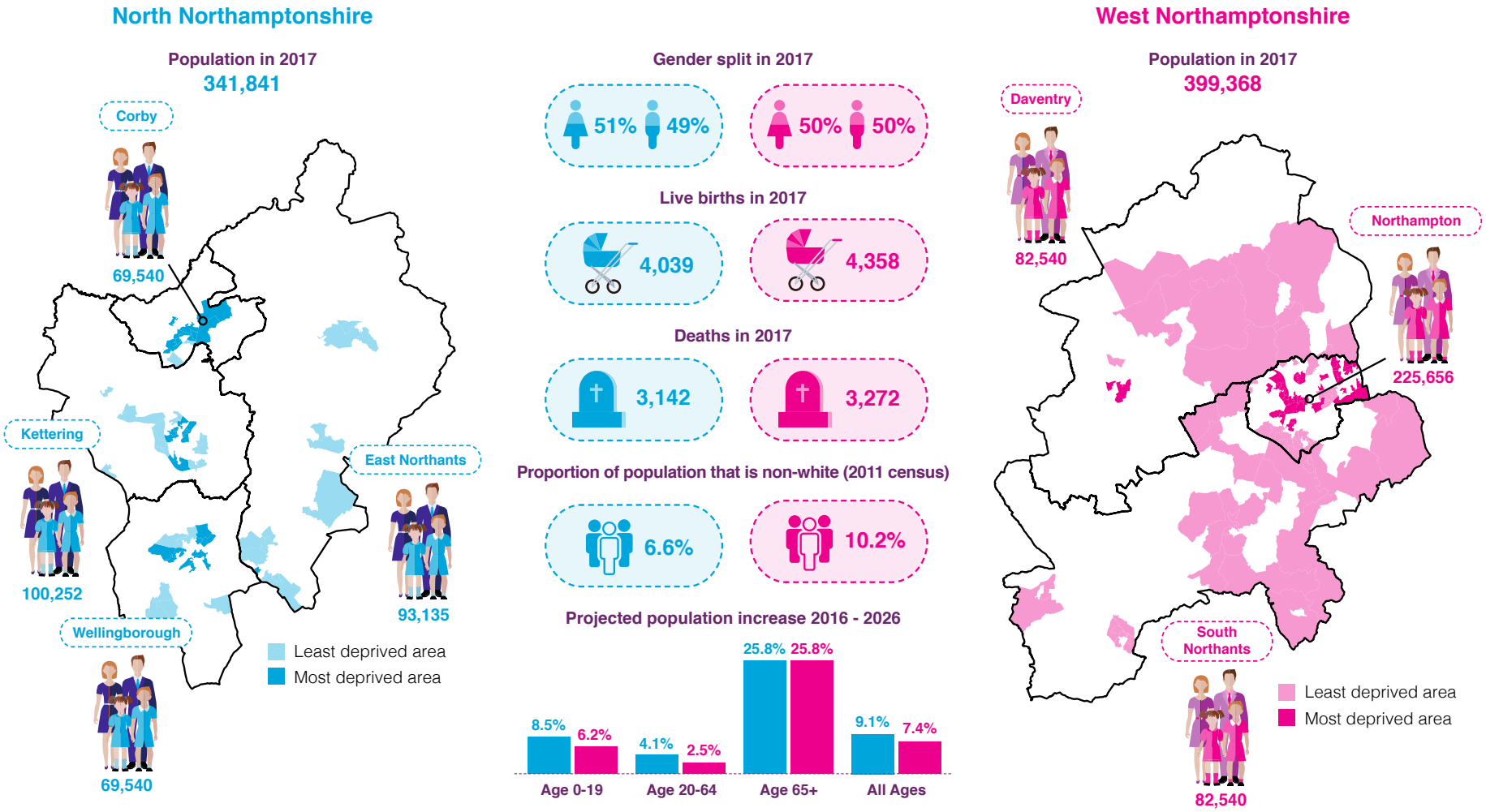


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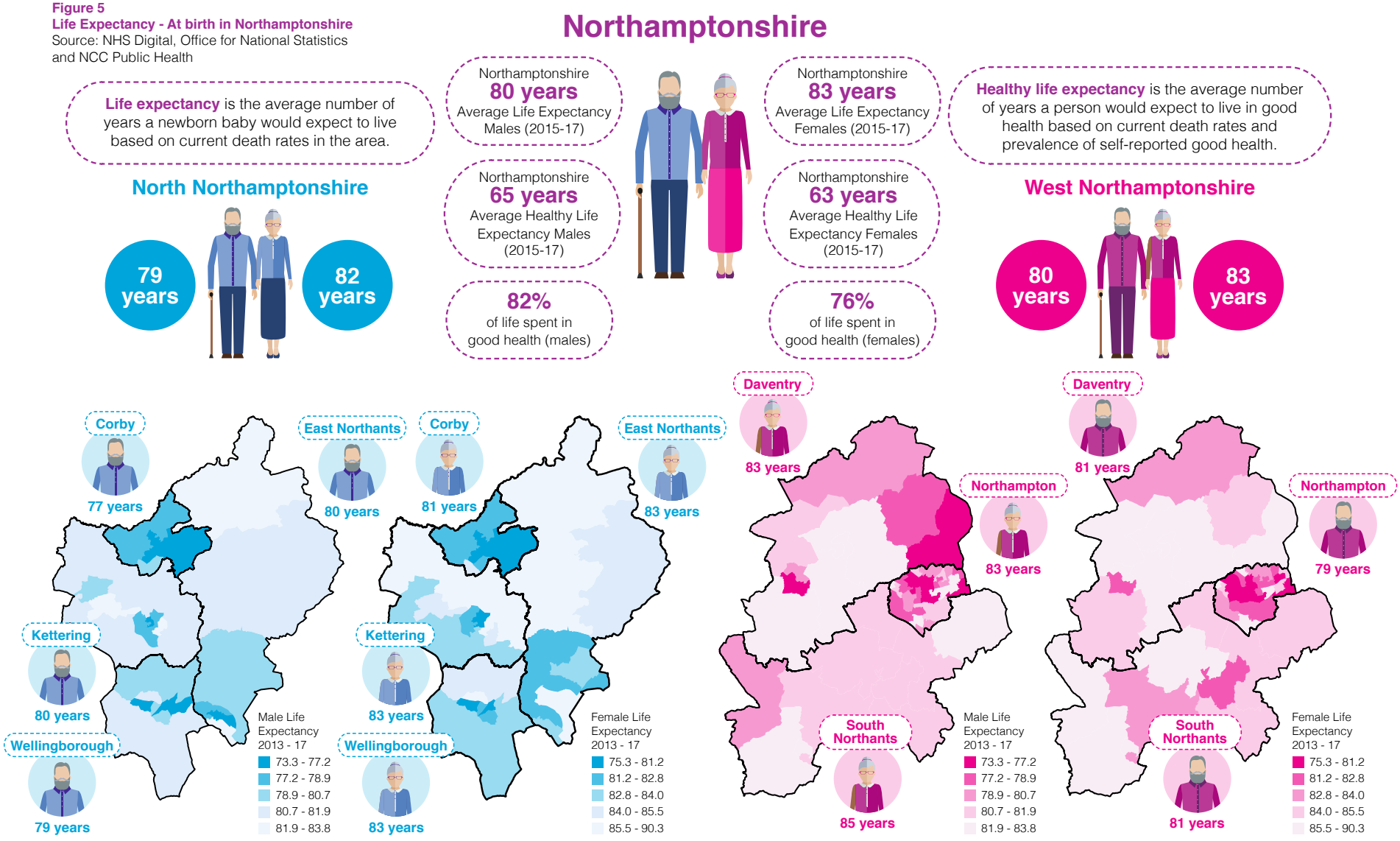
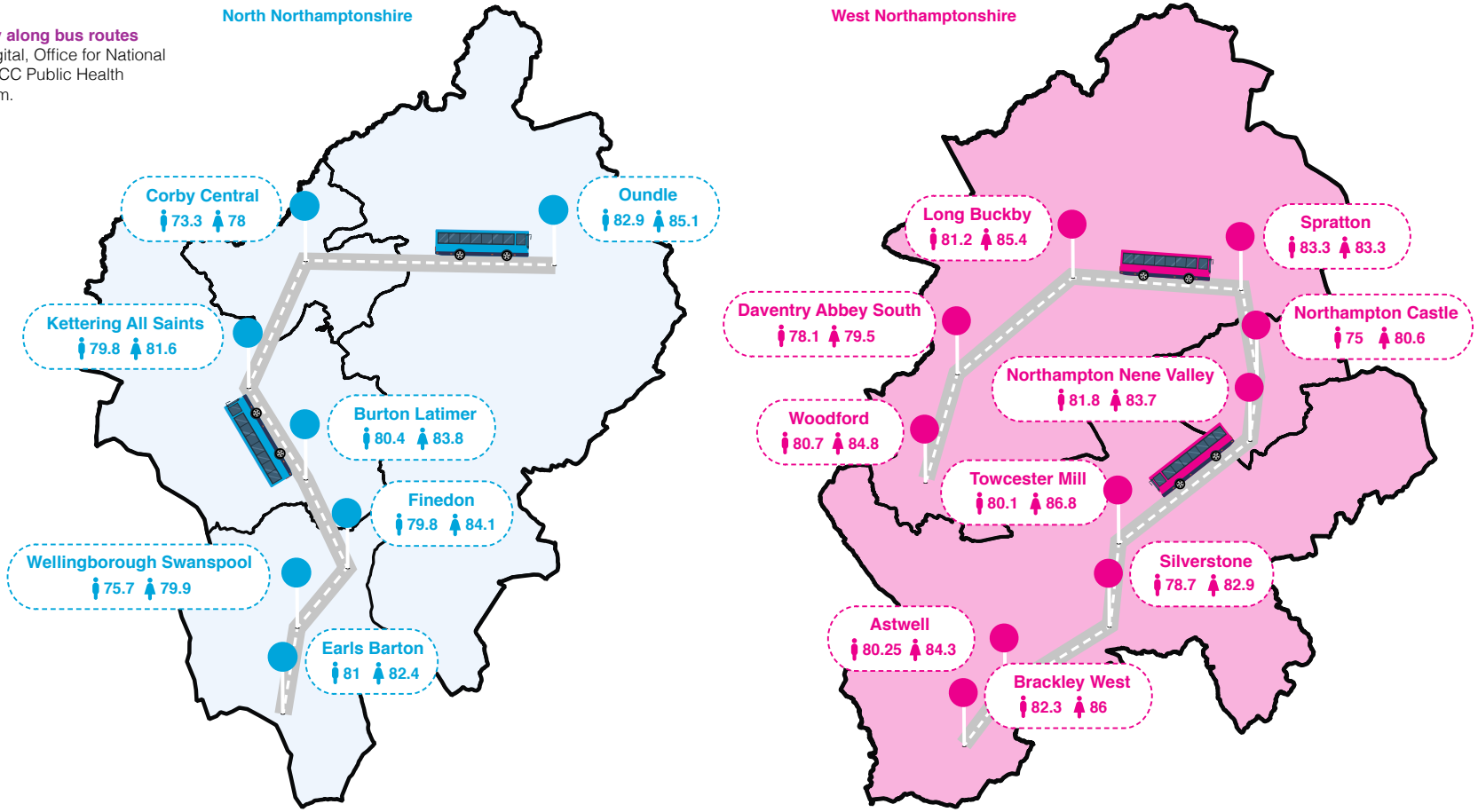
Figure 5
Life Expectancy - At birth in Northamptonshire
Source: NHS Digital, Office for National Statistics and NCC Public Health



The graphic below highlights these inequalities further across each unitary following a 'bus route' in each unitary, showing how communities that only live a few miles apart can have stark differences in life expectancy.

Figure 6
Life expectancy along bus routes
Source: NHS Digital, Office for National Statistics, and NCC Public Health Intelligence Team.



Deprivation

There is a strong connection between deprivation and population health. Populations which experience more deprivation will generally have poorer health. The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas in England. It uses a range of data sources to calculate an overall measure taking account of;

- **Income**
- **Employment**
- **Health deprivation and disability**
- **Education skills and training**
- **Barriers to housing and services**
- **Crime**
- **Living environment**

Generally, the most deprived parts of the county are in urban areas, particularly parts of Northampton, Corby, Wellingborough and Kettering. The least deprived areas are predominantly rural, although most of the towns will also contain some areas in this category with the exception of South Northamptonshire District which has no areas in the top 20% of deprived areas nationally.

Table 1 shows the number of areas that fall within the most and least deprived quintiles nationally. Between the two unitary areas, West Northamptonshire has a slightly higher proportion of its population experiencing more pronounced or reduced deprivation, which highlights the vast inequalities in the area. For example, in Northampton, 28% of population live in the most deprived areas where as in South Northamptonshire, more than 58% of the population live in the most affluent areas, with none living in areas of high deprivation.

Table 1
Population within the most and least deprived areas of Northamptonshire

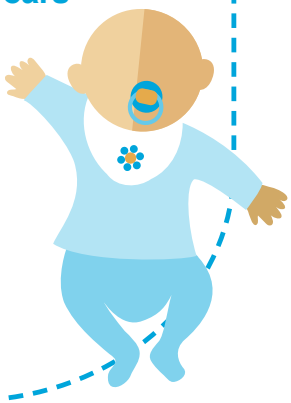
Area	20% most deprived nationally		20% least deprived nationally	
	Count of smaller areas	Population	Count of smaller areas*	Population
North Northamptonshire (UA)	31	52,830 (15.5%)	39	67,899 (19.9%)
Corby	12	18,359 (26.4%)	2	3,433 (4.9%)
East Northants	1	1,793 (1.9%)	15	29,603 (31.8%)
Kettering	7	14,097 (14.1%)	13	20,459 (20.4%)
Wellingborough	11	18,581 (23.5%)	9	14,404 (18.3%)
West Northamptonshire (UA)	38	67,509 (16.9%)	66	115,177 (28.8%)
Daventry	2	3,822 (4.6%)	14	26,251 (31.8%)
Northampton	36	63,687 (28.2%)	22	35,746 (15.8%)
South Northants	0	0	30	53,180 (58.4%)

Almost half of the gap in life expectancy between the most and least deprived areas of the county is due to excess deaths from heart disease, stroke and cancer.

Figure 7

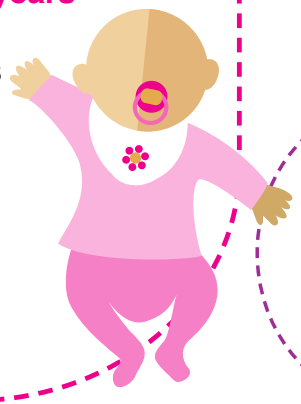
In **North Northamptonshire** area:

- in the **most** deprived areas a baby boy will expect to live to **75 years** and a baby girl to **79 years**
- in the **least** deprived areas a baby boy will expect to live to **82 years** and a baby girl to **85 years**.
- Resulting in an absolute difference of **7 years** for boys and **6 years** for girls between the most and least deprived areas.



In **West Northamptonshire** area:

- in the **most** deprived areas a baby boy will expect to live to **75 years** and a baby girl to **79 years**
- in the **least** deprived areas a baby boy will expect to live to **82 years** and a baby girl to **84 years**.
- Resulting in an absolute difference of **7 years** for boys and **5 years** for girls between the most and least deprived areas.



Almost half of the gap in life expectancy between the most and least deprived areas of the county is due to excess deaths from heart disease, stroke and cancer, much of which is caused by individual lifestyle choices. These are also the diseases that make up a large proportion of the burden of premature death in the county and England.

In Northamptonshire the main risk factors contributing to the burden of disease and death are tobacco smoking, diet, obesity, raised blood pressure and cholesterol and alcohol and drugs. Many of these lifestyle factors are linked with income, education or deprivation and tend to cluster in the population.

A summary of the differences between the most and least deprived areas in each proposed unitary can be seen in figures 8a and 8b.

In Northamptonshire the main risk factors contributing to the burden of disease and death are tobacco smoking, diet, obesity, raised blood pressure and cholesterol and alcohol and drugs.

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Figure 8a
Health and wellbeing by deprivation within and between the proposed unitary authorities, January 2019
Source: Fingertips; Northamptonshire Analysis; ONS; NHS Digital; GOV.UK, Northamptonshire County Council; Please note data displayed is based on what is publicly available for Districts/Boroughs in November 2018 where possible, any local data is highlighted.

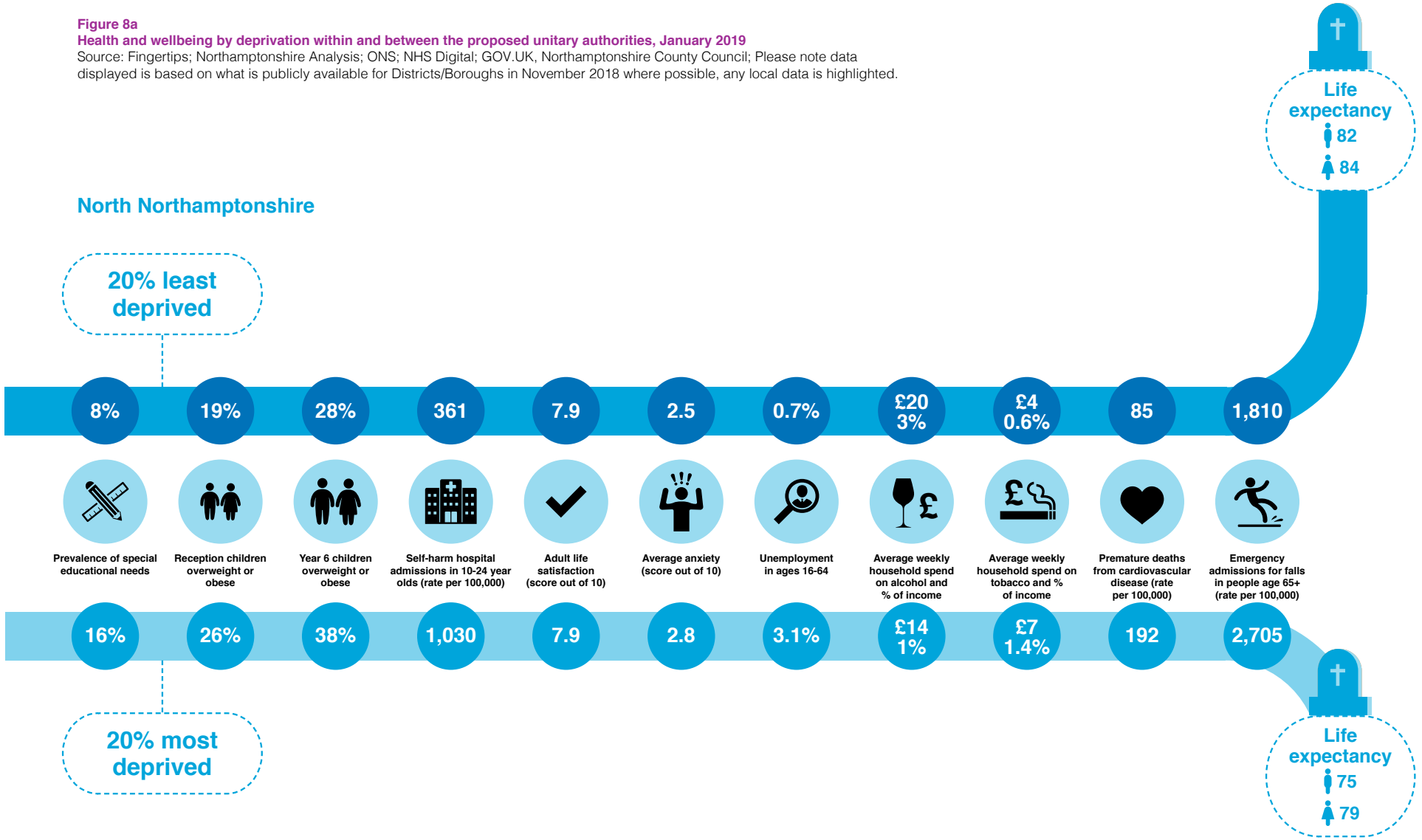
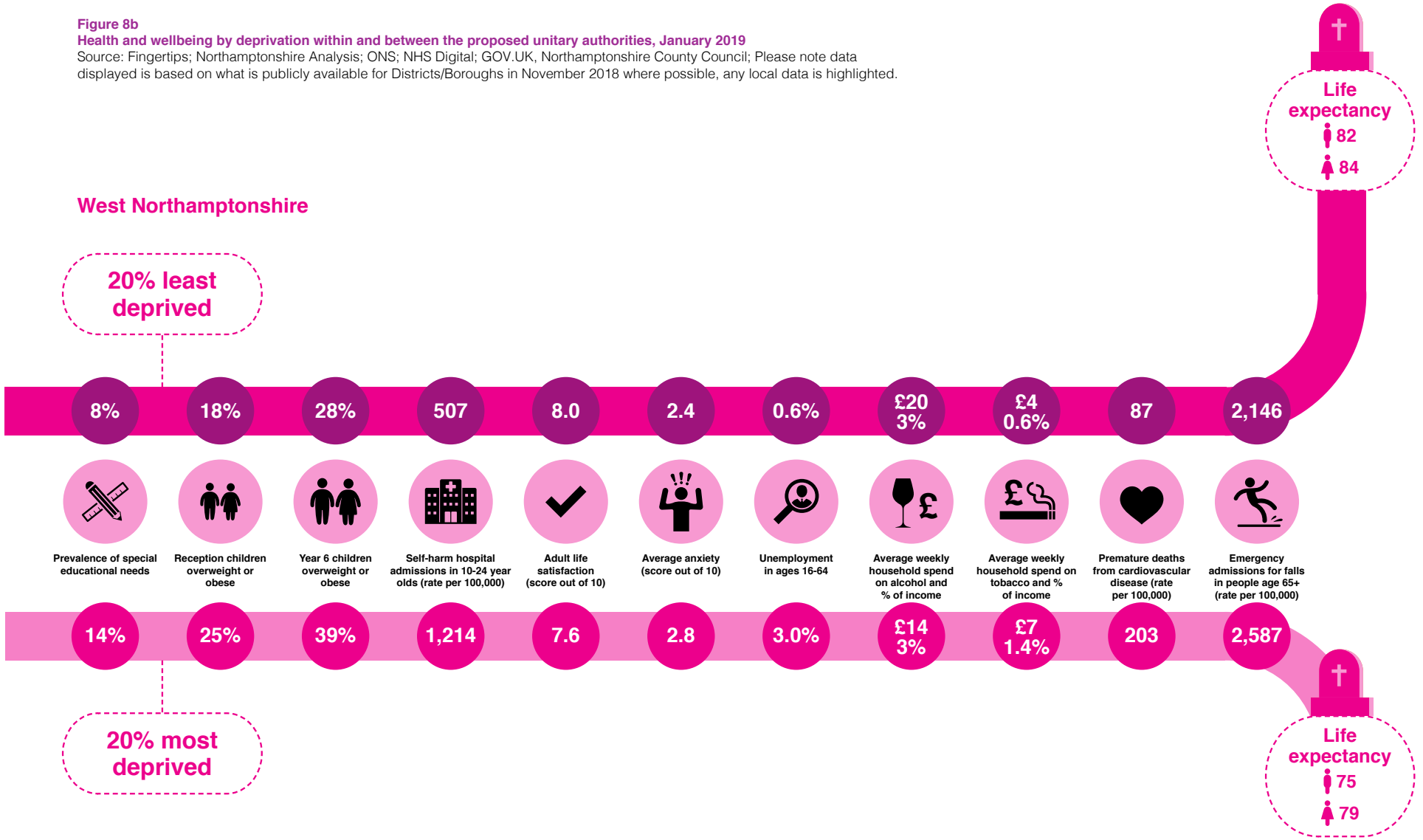


Figure 8b
Health and wellbeing by deprivation within and between the proposed unitary authorities, January 2019
Source: Fingertips; Northamptonshire Analysis; ONS; NHS Digital; GOV.UK, Northamptonshire County Council; Please note data displayed is based on what is publicly available for Districts/Boroughs in November 2018 where possible, any local data is highlighted.



3. Maternal health inequalities

There can be as much as seven years difference in life expectancy between two babies born on the same day, one from the least deprived area and the other from the most deprived of Northamptonshire for both unitary areas (figure 7). This inequality that relates to deprivation is avoidable.

Inequalities can begin well before a baby is born. We know that the health, lifestyle and ability of the mother to parent can and does have an effect on the development and health of the child.

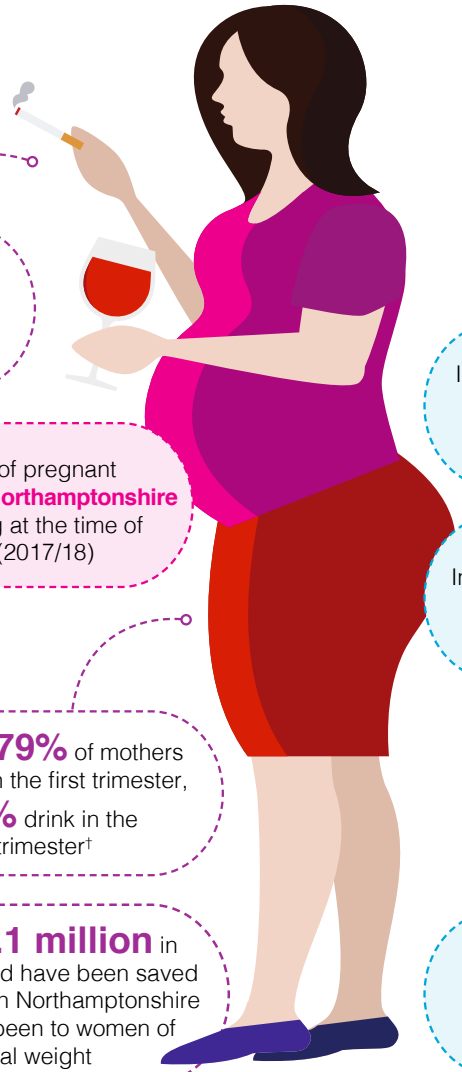
Although the focus here is the health of the mother, it is recognised that the role of the father, and/or wider family support is important, particularly to provide stability, resilience and support for a child.

There are many known avoidable maternal lifestyle risks that can have a life-long impact on a child's health, that lead to inequality from birth, increased risk of stillbirth, preterm birth and infant mortality.

The five main risks are maternal mental health, obesity, smoking in pregnancy and after birth, misuse of drugs and alcohol and teenage pregnancy.

It is recognised that the role of the father, and/or wider family support is important, particularly to provide stability, resilience and support for a child

Figure 9
Maternal Health - Risk Factors
Source: from Public Health England unless stated otherwise, Unitary Authority figures have been aggregated from district level data.



An estimated **10-15%** of deliveries are affected by depressive illness and anxiety*

13.7% of pregnant women in **North Northamptonshire** were smoking at the time of delivery (2017/18)

Corby had a rate of smoking at time of delivery in England **(17.3%)** in the highest 10% in the country

In 2018, **22%** of women who attended maternity bookings in the two hospitals were recorded as obese.^

12.7% of pregnant women in **West Northamptonshire** were smoking at the time of delivery (2017/18)

An estimated **79%** of mothers drink alcohol in the first trimester, and **49%** drink in the third trimester†

Roughly **£4.1 million** in NHS costs could have been saved if all deliveries in Northamptonshire in 2016 had been to women of normal weight

Impacts of poor maternal health include:
Miscarriage
Stillbirth
Low birth weight
Impaired growth and development
Birth defects
Behavioural issues in childhood

In 2015-17, infant mortality was **5 per 1,000** in **North Northamptonshire**

In 2015-17, infant mortality was **4 per 1,000** in **West Northamptonshire**

In 2016, **2.5%** of term babies in **North Northamptonshire** were low birth weight

In 2016, **2.4%** of term babies in **West Northamptonshire** were low birth weight

Teenage conceptions are at increased risk of premature delivery, low birthweight, and young mothers are more likely to smoke in pregnancy

In 2016, the teenage pregnancy rate was **20 per 1,000** in **North Northamptonshire**

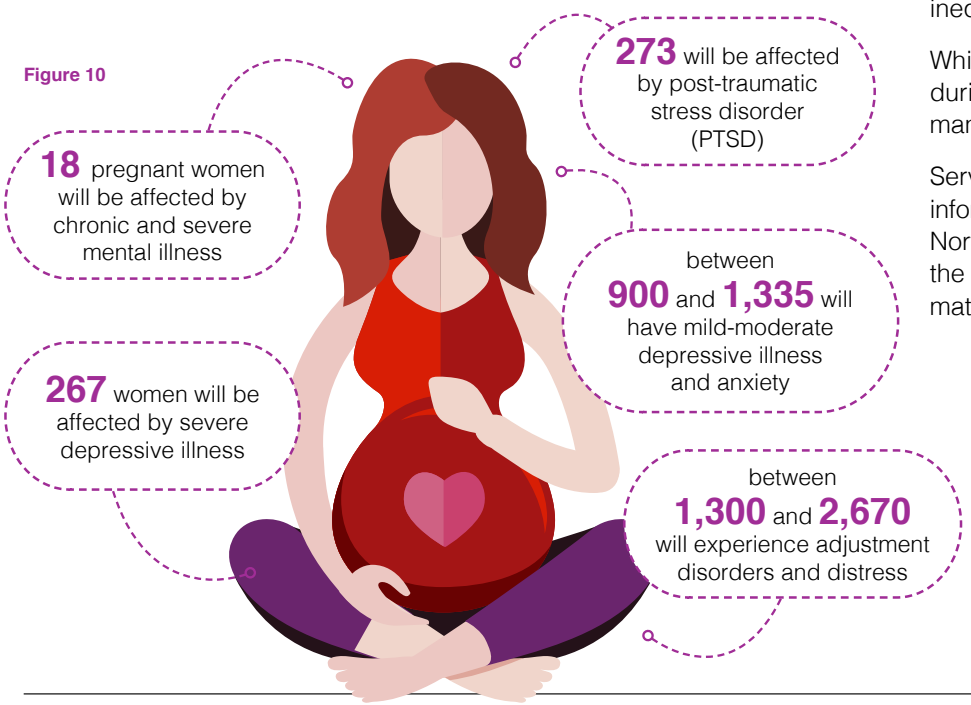
In 2016, the teenage pregnancy rate was **22 per 1,000** in **West Northamptonshire**

* Joint Commissioning Panel for Mental Health.
† Maternal alcohol intake prior to and during pregnancy and risk of adverse birth outcomes: evidence from a British cohort, C Nykjaer et al. ^Local maternity services data; Icons by Freepik-www.flaticon.com

Maternal mental health

Mental ill-health in pregnancy affects an estimated 1 in 4 women and is more common in women who live in more deprived areas. Mental ill-health can be the result of a pre-existing mental health condition or a condition such as stress, anxiety and depression, or a psychotic condition[2]. The negative impact on a child's development can have a lifelong impact affecting the child's resilience[3] and behaviour which can result in the need for specialist intervention. Public Health England modelled estimates applied to the number of women who give birth each year in Northamptonshire and suggested that approximately:

Figure 10



Maternal obesity

In 2018 an estimated 22% of women in Northamptonshire who booked for pregnancy services were recorded as obese, 20.8% in Northampton General Hospital (situated in West Northamptonshire) and 24% in Kettering General Hospital (situated in North Northamptonshire). Women who are overweight and obese at the start of their pregnancy are more likely to have complications in pregnancy such as gestational diabetes, pre-eclampsia, and birth outcomes, leading to increased risk of stillbirth and infant death than women who are a healthy weight[4]. Maternal obesity increases with social disadvantage and can contribute to an increase in health inequalities across generations.[5]

Whilst it is not recommended that women actively diet for weight loss during pregnancy, they should be encouraged towards healthy weight management with a healthy diet.

Service provision for overweight and obese women focuses on providing information and guidance with policies for clinical management at delivery. Northamptonshire is not an outlier for adverse birth outcomes, however the importance of healthy weight management and exercise supports maternal mental health and a healthy future lifestyle.

Mental ill health in pregnancy affects an estimated 1 in 4 women and is more common in women who live in more deprived areas.

Smoking during pregnancy and after birth

Smoking is one of the most important modifiable risk factors for improving an infant's health. There is a large variation in the rates of women smoking during pregnancy across Northamptonshire; the highest in deprived populations, amongst mothers under 20 years of age; national evidence states that mothers under the age of 20 are six times more likely than mothers aged over 34 to smoke whilst pregnant.[6]

Smoking during pregnancy has similar risks to obesity, affects child growth and development, increasing the risk of low birthweight, sudden infant death, respiratory problems, congenital abnormalities and child obesity. Passive smoking, defined as exposure to the smoke of others, is likely to have similar adverse effects on the child's growth and development, although to a lesser extent.

Northamptonshire's rates of smoking in pregnancy have reduced similar to the national trend. However, the rate remains significantly higher (worse) than the national average. In 2017/18 13.1% of pregnant women locally were smoking during their pregnancy compared to 10.8% in England; the areas proposed for inclusion in North Northamptonshire have a higher proportion of women smoking at the time of delivery at 13.7% (Corby 17.3%) than the areas proposed to be included in West Northamptonshire (12.7%). **Reducing the numbers of women who are smoking in pregnancy and after birth is a priority.**

Evidence shows that female smokers are more likely to quit or reduced, during pregnancy than at any other time of their life. By stopping smoking before or during pregnancy the risk of poor health outcomes for the child and mother decreases and while quitting early brings the greatest benefits for the child, quitting at any time yields health improvements.

Substance misuse: Drugs and alcohol

Maternal drug and alcohol use during pregnancy can have significant and damaging effects on an unborn infant, such as lower birth weight, increased risk of miscarriage and preterm birth, and can cause childhood mental health issues. In severe cases excessive alcohol intake when pregnant results in foetal alcohol syndrome (FAS) or foetal alcohol spectrum disorders (FASD), which have a variety of physical health issues, learning difficulties and behavioural problems. The number of women disclosing substance misuse during pregnancy is low and even fewer are have been referred to substance misuse services. In 2017/18, thirteen pregnant women started structured treatment for alcohol and/or drug misuse at Northamptonshire's substance misuse treatment services.

A small number of service providers are supporting mothers who are substance misusers in treatment and providing training on the dangers of substance misuse during pregnancy. Closer working between maternity units and addiction treatment services are needed, particularly around case management to help identify and manage risk.

Smoking during pregnancy affects child growth and development, increasing the risk of low birthweight, sudden infant death, respiratory problems, congenital abnormalities and child obesity.

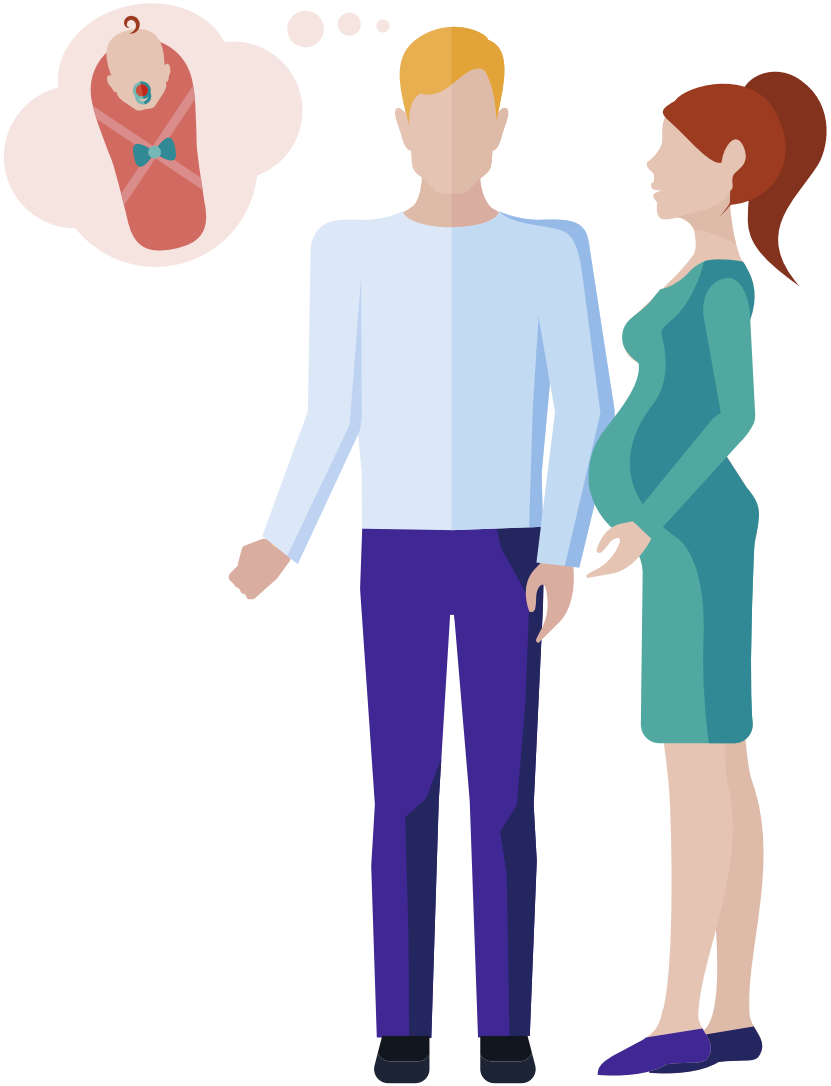
Teenage pregnancy

Teenage pregnancy is defined as under 18 conceptions and has a strong association with deprivation. Nationally the number of teenage pregnancies has been steadily reducing and it is recognised that not all teenage parents have vulnerabilities other than age and are well supported by families and services. However, the majority of local authorities are describing a current position of increasing vulnerabilities within their young parent population as a result of reducing local support services.

Compared to their peers in more affluent areas of the county, young women in the most deprived areas of Northamptonshire are more likely to become pregnant aged under 18 years. Reducing unintended teenage pregnancy and supporting teenage parents who choose to continue with their pregnancy are areas where there is focus, investment and the need for sustained effort to improve the long term outcomes of young people and their children.

Teenage conception rates are slightly higher in the areas proposed for West Northamptonshire compared to those proposed in North Northamptonshire. This is due to significantly higher than England rates in Northampton. Other districts (Corby, Wellingborough and Kettering) have high rates but they are not significantly different to the England average. South Northamptonshire is the only area that has statistically lower rates.

Teenage parents are offered access to the Family Nurse Partnership (FNP) programme, an evidence based bespoke programme for teenage mothers providing intensive support from early pregnancy until a child is two years old. For those young parents who choose not to access this programme, support is provided as part of the universal health visitor service.



4. Health inequalities in children

This chapter is divided into two parts, birth & pre-school children and school age children. For both groups the universal Healthy Child Programme is the delivery vehicle for universal child development and health surveillance as a measure of child wellbeing.

The State of Children's Health Report[7] states that 'across every indicator children from deprived backgrounds have much worse health and wellbeing than other children and young people. Children living in our wealthiest areas have health outcomes that match the best in the world. But the gaps between the rich and the poor are stark, and some of the outcomes amongst our deprived groups are amongst the worst in the developed world. It should not be this way. It must not be this way'.

Considerable investment needs to be made to address deprivation if positive impact to children long term ability to be healthy and achieve is to be realised.

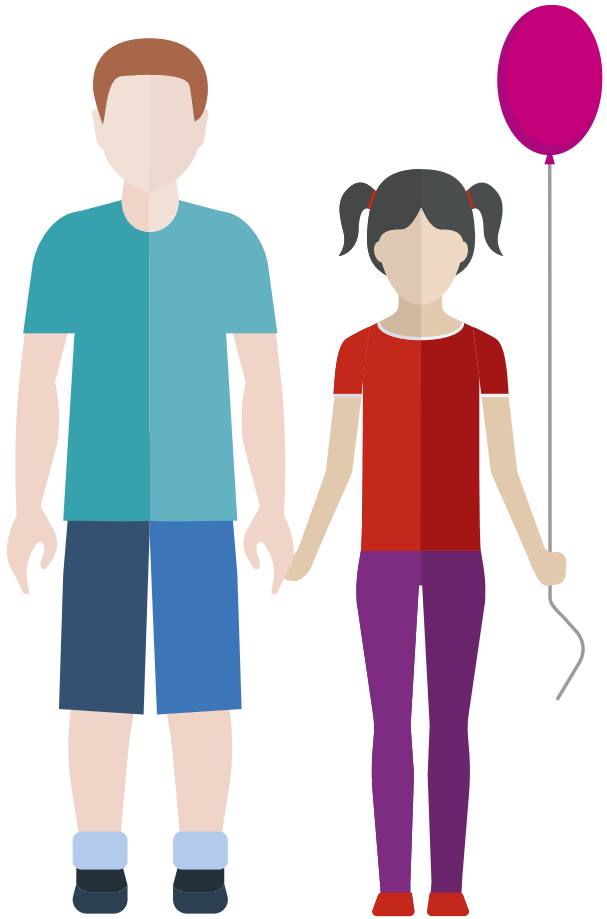


Figure 11
Map of Northamptonshire LSOAs by deprivation domain quintile - Income deprivation affecting children index

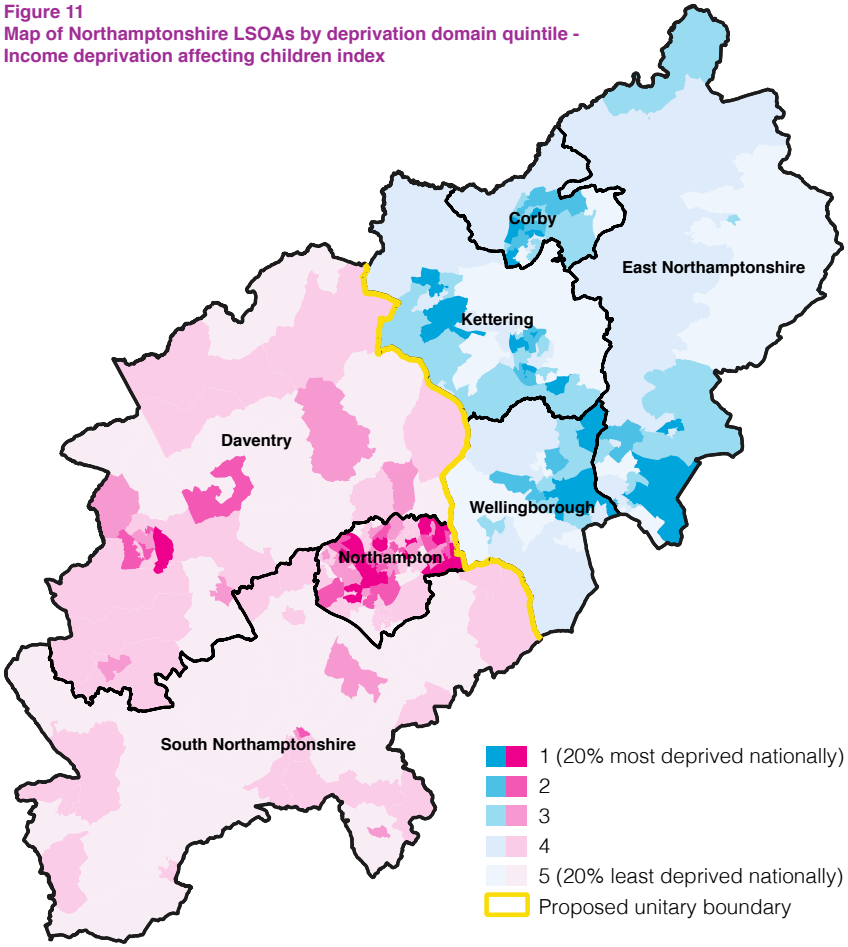
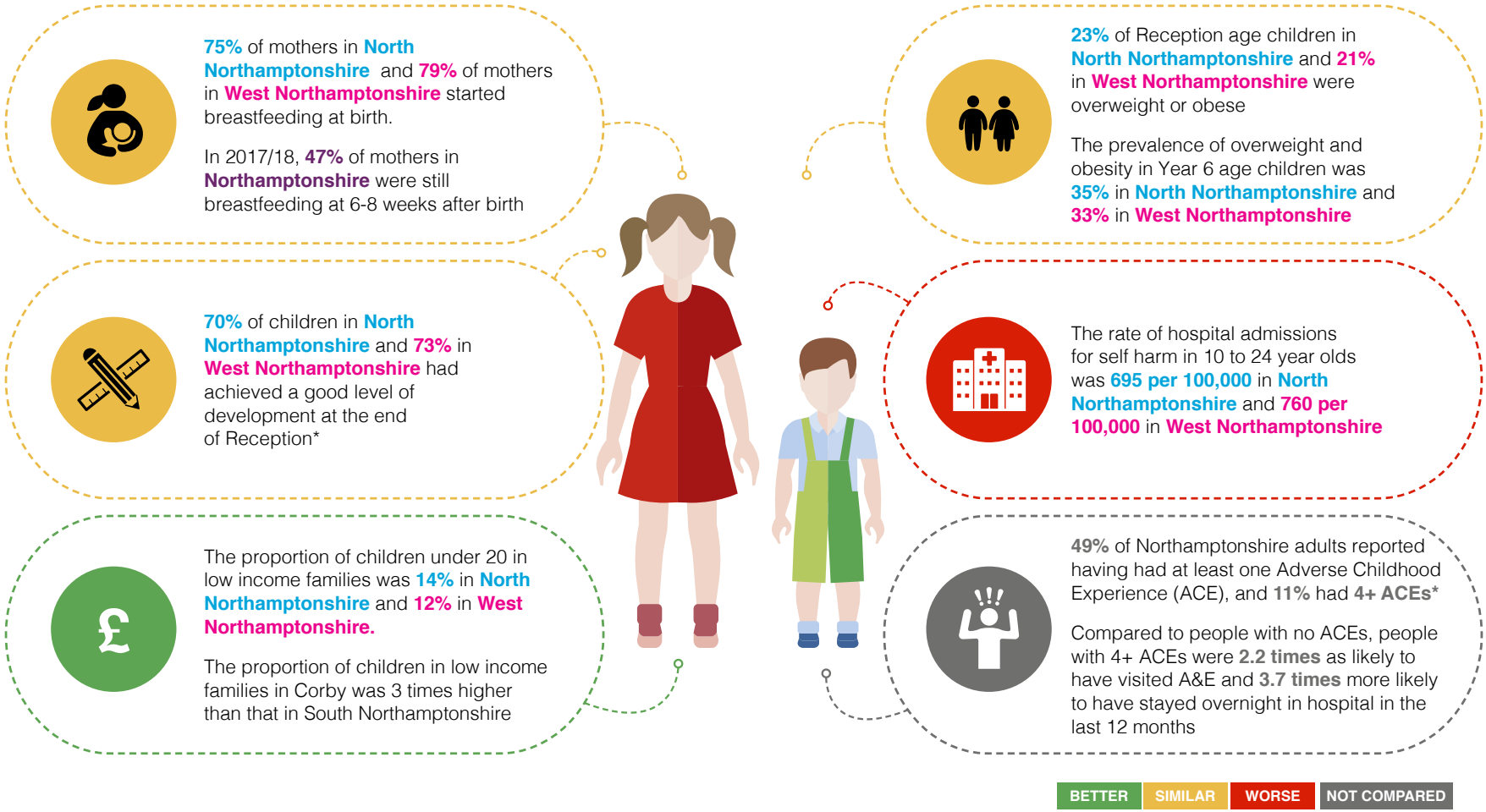


Figure 12
Child health across the proposed unitary authority areas
All data sourced from Public Health England unless stated otherwise and relate to 2016/17, Unitary Authority figures have been aggregated from district level data. * Local data from Northamptonshire County Council; ^2014/15 to 2016/17 - PHE; +2012/13 to 2016/17 - HES



Part 1: Birth and pre-school children aged 0-5 years

Birth and early years is a period of significant child development that can have lifelong impact. The social circumstances a child is born into and experiences during early years is often the root of many child health problems which can extend into adult life.[6] The Marmot Review[1] and the Kennedy Review[8] state that "the single most important cultural shift that is needed… is to invest in the development of children from minus 9 months to 2 or 3 years old. These early years are absolutely central to the developmental fate of a child."

The impact of deprivation and inequalities using school readiness as a proxy indicator of early year development, shows that children living in poverty do not have the same opportunities and life chances as their more affluent peers. The phrase 'child health inequalities' describes this difference in positive outcomes between babies born with every chance of a healthy life, and babies whose life chances have already been reduced during their mother's pregnancy or are altered by their parents' socio-economic circumstances and decisions in their early years. Factors such as income, housing, family size, employment, age, ethnicity, education, mental health, parenting skills, access to services and availability of social support impact the quality of children's early years.

Children from poorer backgrounds are more likely to experience:

- **Poor performance at school leading to fewer academic qualifications**
- **An increased likelihood of poor health in adult life**
- **Less opportunity to secure good employment**
- **Increased risk of offending**
- **Limited access to cultural and leisure opportunities**
- **Increased risk of being taken into care**

In Northamptonshire there are fewer children living in poverty compared to the England average, however, this masks significant variation within the county; we know that Corby, Wellingborough and Northampton have the highest proportion of children living in poverty.

Infant mortality

The infant mortality rate (IMR), is an indicator defined as the number of deaths of children aged under one year, per 1000 live births, per year. This is a population health indicator used to measure quality of health care. This measure of health reflects the relationship between causes of infant mortality and upstream determinants of health such as economic, social and environmental conditions. The risk factors for infant mortality include:

- **Maternal age**
- **Parents who are closely related to each other – genetic risk**
- **Smoking or maternal substance misuse**
- **Poor maternal nutrition or obesity**
- **Domestic abuse**
- **Social class and income deprivation**
- **Medical factors; maternal mental ill-health, pre-existing medical condition, history of problematic pregnancies, exposure to environmental pollutants and low birth weight.**

There is a slightly higher infant mortality rate in the proposed North Northamptonshire areas (5.1 per 1000 live births) compared with the West Northamptonshire areas (4.0 per 1,000 live births), although differences are not significant. The higher rate in North Northamptonshire is due to a significantly higher than England average (3.9 per 1,000 live births) rate in Wellingborough (6.9 per 1,000 live births).

Evidence shows that a quarter of deaths under the age of 1 could be avoided if there were no health inequalities.

Low birthweight

Low birth weight is defined as a birth weight of less than 2.5 kg (5.5lbs) and is associated with an increased risk of infant mortality, developmental problems in childhood and poorer health in later life[9]. There is a strong association between low birthweight and deprivation. A high proportion can be linked to the maternal risk factors mentioned in the previous section as well as possible issues in maternal services.

The proportion of term births recorded as low birthweight are similar in the two proposed unitary areas (2.5% in North Northamptonshire and 2.4% in West Northamptonshire).

Social and emotional skills and cognitive development

The early years are a key period for developing essential social and emotional skills such as empathy, trust, application and self-control. One important factor affecting the development of these skills is the mother's mental health. Cognitive development begins before birth and the first year of life is critical for the developing brain. By the age of three, children from the poorest backgrounds are less likely to be read to every day and are likely to have a much smaller vocabulary than children from the most affluent backgrounds.

By the age of three, children from the poorest backgrounds are less likely to be read to every day and are likely to have a much smaller vocabulary than children from the most affluent backgrounds.

Breastfeeding and infant nutrition

Breastfeeding is the safest and healthiest food for an infant, the World Health Organisation standard is that exclusive breastfeeding should be encouraged until a child is six months of age. Breast milk provides optimal infant nutrition and contains antibodies that reduce the risk of infection. Breastfeeding is a key way to reduce inequalities, contributing to mental, cognitive and physical development. For mothers, the breastfeeding benefits include weight management and reduced risks of osteoporosis, breast and ovarian cancer[10].

Mothers who are living in deprivation based on their socio-economic status are less likely to breastfeed their child; there is a ten-fold difference between the most deprived and most affluent mothers in breastfeeding initiation[11]. The decision to breastfeed is often generational within families and dependent on what is considered the 'norm' and can be influenced through education that sets out clearly the benefit from professionals during pregnancy care.

In Northamptonshire breastfeeding initiation rates are similar in all districts to the England average, with the exception of South Northamptonshire where the rate is higher. Between the proposed unitary authorities, three quarters (75%) of mothers initiate breastfeeding in North Northamptonshire compared to 79% in West Northamptonshire. These figures drop to just under half (47%) of mothers still breastfeeding at 6-8 weeks following birth.

In order to make an impact on sustained breastfeeding it is important to understand the factors which influence a mother's infant feeding decision in order to develop effective strategies to encourage more women to breastfeed.

School readiness

School readiness is a measure of how prepared a child is to succeed in school academically, socially and emotionally and is an indicator of the environment a child is born into and develops within, their parenting and support from birth. In households where there is greater economic disadvantage, parents are likely to be dealing with a range of insoluble problems that can impact on the child's school readiness.

There is variation across the county of children achieving a good level of development. Data shows that school readiness scores are generally lower in more deprived urban parts of Northamptonshire, and are lower in North Northamptonshire (69.9%) compared to West Northamptonshire (72.6%). Due to higher rates (75%) in South Northamptonshire and Daventry in West Northamptonshire and lower rates in Corby (70%) and Wellingborough (66%) in North Northamptonshire.[12]

Breast milk provides optimal infant nutrition and contains antibodies that reduce the risk of infection.

Part 2: School aged children and young people aged 5–19 years

The health and wellbeing needs of school aged children and young people has in the past, been given a lower priority than the pre-school population by policy makers. Consequently nationally we do not invest enough in prevention and early intervention for this group, especially for adolescents.

This age is a life stage of significant development which represents one of the critical transitions in the life span, characterised by a significant increase in growth and change in an individual, second only to infancy. Behaviour patterns established during this period especially between the ages of 10-19 can have a lasting effect on future health and wellbeing. Therefore embedding health and healthy behaviours for young people of this age, and better preparing and protecting them from health risks is critical to prevent adult life health problems.

Children and young people depend on their families, friends, communities, schools and health services to learn the important life skills they need to transition from child to adult and adjust to their increasing independence. Based on extensive evidence regarding health and education co-dependency it is essential that health and lifestyle services for physical, mental and emotional health work in partnership with schools to maximise achievement; this can have a life-long benefit for children.

For vulnerable children and young people who experience greater inequalities in health, for example children in care, children with disabilities and children who are carers for parents or siblings, the extent of health challenges are often greater because of their past and current experience; for example almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs which can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

Childhood obesity

Child obesity is a public health crisis in the UK. Obesity in childhood is the foundation for adult obesity and its health consequences are laid in the earliest years of life[13]. An obese child is highly likely to become an obese adult and being overweight or obese both influences and reinforces health inequalities. In Northamptonshire, nearly 1 in 4 children (22%) is overweight or obese by the age of 5 years old when they are measured as part of the National Child Measurement Programme, and national evidence shows only 1 in 20 children who are obese at Reception will return to a healthy weight by Year 6. Conversely, children who are healthy weight at age 5 are likely to remain so at age 11 and beyond. Studies show that obesity in teenagers overwhelmingly tracks into adulthood. In the county, South Northamptonshire is the only district to have levels of excess weight lower than the England average, resulting in lower rates overall for the proposed West Northamptonshire area compared to North Northamptonshire, as shown in figure 12.

Socially these children are more likely to experience bullying, low-esteem and a lower quality of life and as obese adults are at increased risk of cancer, heart and liver disease. They are also more likely to be from low-income households, living in deprived urban areas and those from black and minority ethnic families.

Local service provision is fragmented and not sufficiently resourced to deliver interventions at scale given the number of children and young people who require information, guidance and action. In 2019/20 a priority for NCC Public Health is to work with partners in the NHS, NSport, schools and the community to develop a pathway of interventions for healthy weight management.

Self-harm

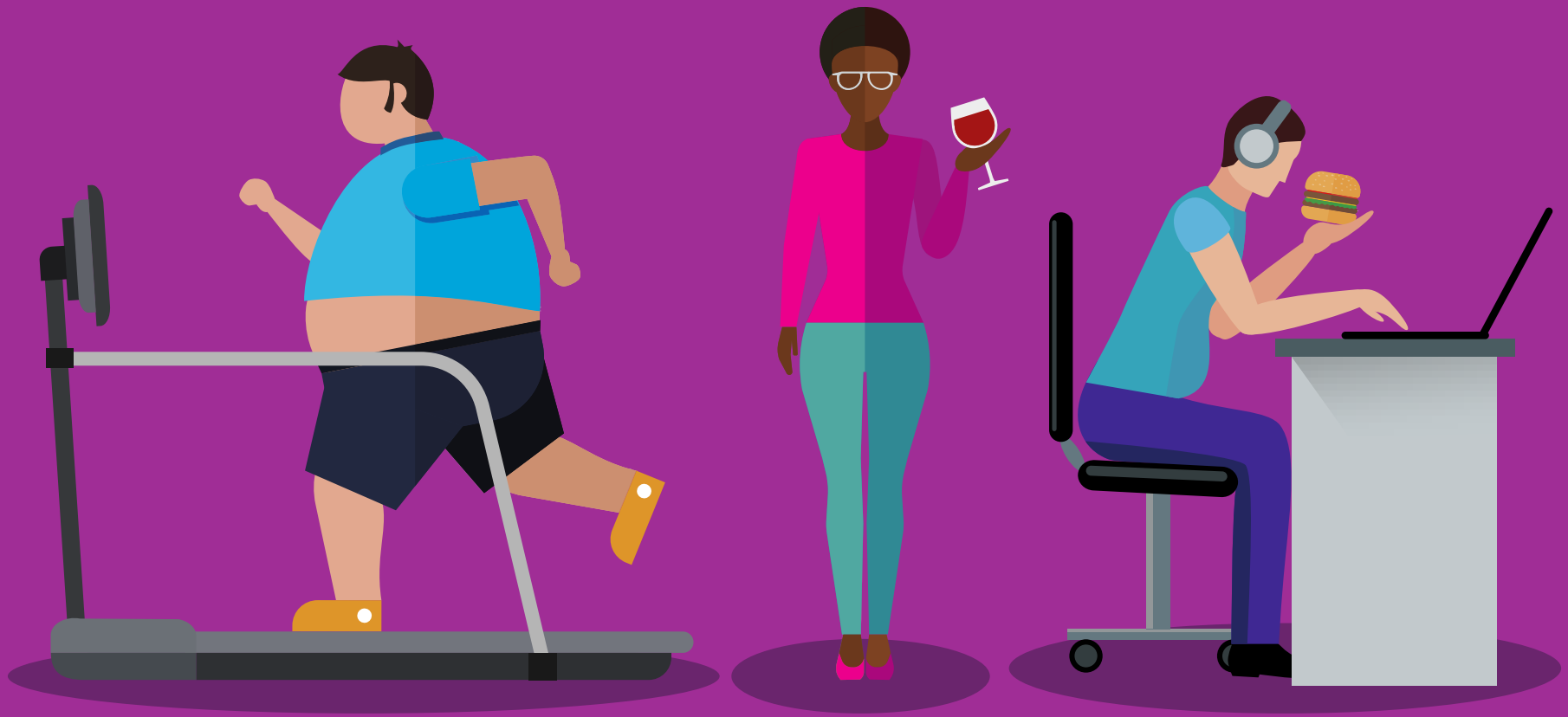
Self-harm is a major public health challenge and rates tend to peak in adolescence. Although most is not fatal it is signal of distress and increased risk of suicide. As mentioned previously adolescence is a life stage of significant change therefore an important life stage for intervention with huge potential for development of new skills and capabilities.

Locally rates of self-harm admissions are increasing in all ages and in Northamptonshire it is significantly higher than the England average, increasing at a faster rate than England and therefore widening inequalities.

Local analysis has shown the rate of hospital admissions as a result of self-harm in those aged 10 to 24 years in the proposed North and West Northamptonshire areas are not significantly different from one another (695 per 100,000 population in North Northamptonshire and 760 per 100,000 population in West Northamptonshire). However this masks inequalities within each area; those living in the most deprived areas of Northamptonshire are 3.9 times more likely to be admitted to hospital from self-harm than those in the least deprived areas. Indeed if the most deprived 20% of the population had the same rate of hospital admissions for self-harm as the least deprived areas there would be approximately 163 less admissions a year in the most deprived areas.

In Northamptonshire, nearly 1 in 4 children are overweight or obese by the age of 5 years old when they are measured as part of the National Child Measurement Programme.

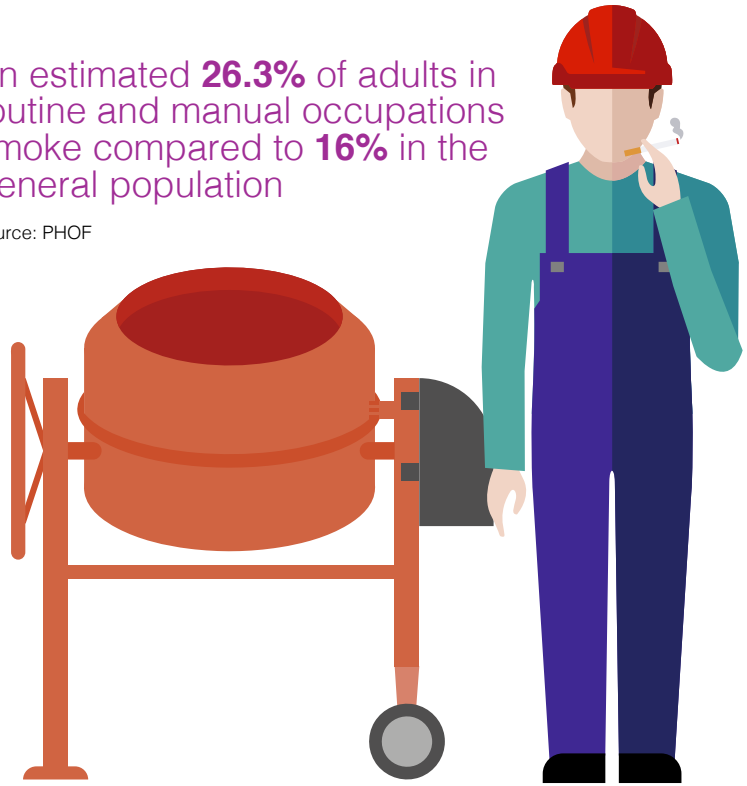
5. Lifestyle



Lifestyle can have a major impact on a person's health. Unhealthy lifestyle choices such as smoking, excess alcohol intake, poor diet leading to obesity or malnutrition, lack of physical exercise and problems resulting from drug taking all contribute to poor long term health outcomes.

An estimated **26.3%** of adults in routine and manual occupations smoke compared to **16%** in the general population

Source: PHOF



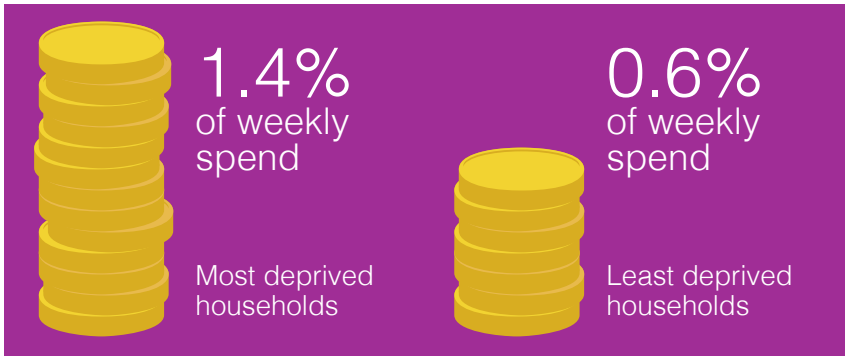
Smoking

Prevalence of smoking is reducing, however the decline in smoking rates is not seen equally across populations. Prevalence remains higher for men than women and people living in more deprived areas are more likely to smoke than those living in the least deprived areas. Furthermore, those in routine and manual jobs, never worked or in long term unemployment have higher smoking rates than the rest of the population.

As smoking rates increase with deprivation, the increased money spent on tobacco products causes a higher cost on low income households compared to higher income households. Those on low incomes spend a higher proportion of their income on tobacco (figure 13).

Action on Smoking and Health (ASH) estimates if smokers below the poverty line were to quit then there is a potential for nearly 5,000 households in Northamptonshire to be lifted out of poverty, potentially over 14,000 people, if the cost of smoking was returned to the household.[14]

Figure 13
Tobacco spend



Smoking is the biggest cause of preventable death in England, accounting for many deaths from cancer, respiratory and circulatory disease as well as contributing to the years people live in poor health. Smoking is related to more than 1000 deaths each year in Northamptonshire.[15] Evidence suggests that one in two smokers will die from a smoking-related disease, often prematurely[16]. Smoking related deaths have shown an increase in recent years locally. Prevalence is highest in the borough of Northampton which has the highest rate in the East Midlands and tenth highest in England.

Service level data shows overall for the county 35.5% of quit attempts result in a successful quit at 4 weeks. This varies across the proposed areas with 33% successfully quitting at 4 weeks in West Northamptonshire and 38% in North Northamptonshire.

The table below highlights the number of quitters and those had successfully quit after four weeks in different towns across the county.

In 2019/20 NCC Public Health will increasingly focus in reducing smoking prevalence among populations where the impact is of the greatest risk for example pregnant women, children and within hospital services.

Smoking is related to more than 1000 deaths each year in Northamptonshire.

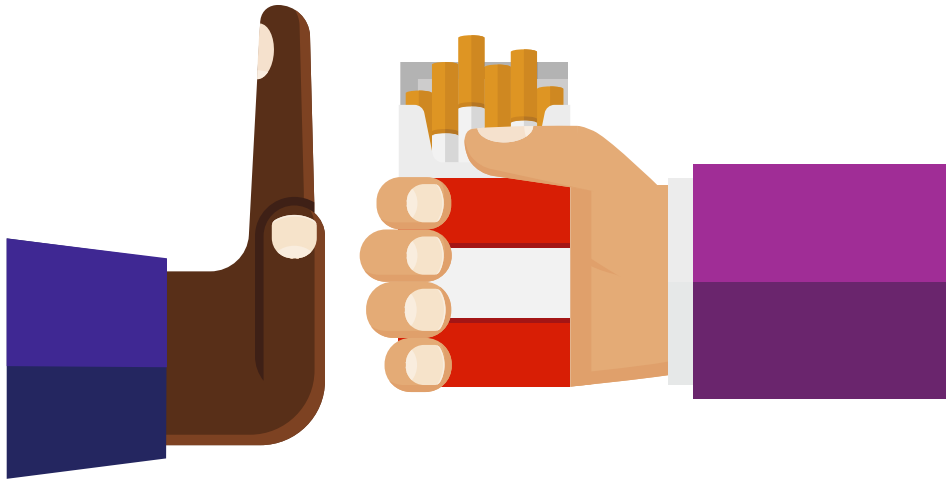


Table 2
Quit data 17/18 by town
Source: Quit Manager

Area	Quit date set	Successful 4 week quit	Conversion
Rushden	241	133	55%
Corby	487	219	44%
Kettering	439	236	54%
Wellingborough	699	322	46%
Daventry	316	110	35%
Northampton	1832	749	40%
South (Towcester and Brackley)	140	61	43%
Total	**4154**	**1830**	**44%**

Healthy weight and diet

Excess weight can have significant health issues for adults throughout their lives into old age.[17] Being overweight or obese is a common risk factor for diabetes, heart disease, stroke, liver disease, many cancers, arthritis and depression, causing death and injury and posing a high burden to health and social care (figure 14).

Obesity in turn can lead to lower employment rates, discrimination and stigmatisation, increased risk of hospitalisation and therefore impacting on life expectancy, reducing it by, on average, 3 years for excess weight and 8-9 years for those with severe obesity.[15]

The rising trend of overweight and obesity has been acknowledged as one of the most serious public health problems in the UK and by 2050 obesity is predicted to affect 50% of adult women, 60% of adult men and 25% of children. It is also more common among those living in more deprived areas, older age groups, some black and minority ethnic groups and people with disabilities.[18]

Poor diet is linked to 1 in 7 deaths in Northamptonshire, with high blood glucose and high body mass index (BMI) also is in the top ten leading risk factors for poor health and death locally.[19] Evidence also shows rates of excess weight are highest in more deprived areas (67.3%) compared to the most affluent areas (56.7%).[14]

In Northamptonshire, two thirds (66%) of the adult population are estimated to be overweight or obese, with more than a third of children (34.2%) classified as overweight or obese by the time they reach year 6 (age 10 to 11 years).[17]

Figure 14
Obesity harms health
Source: Adapted from Public Health England

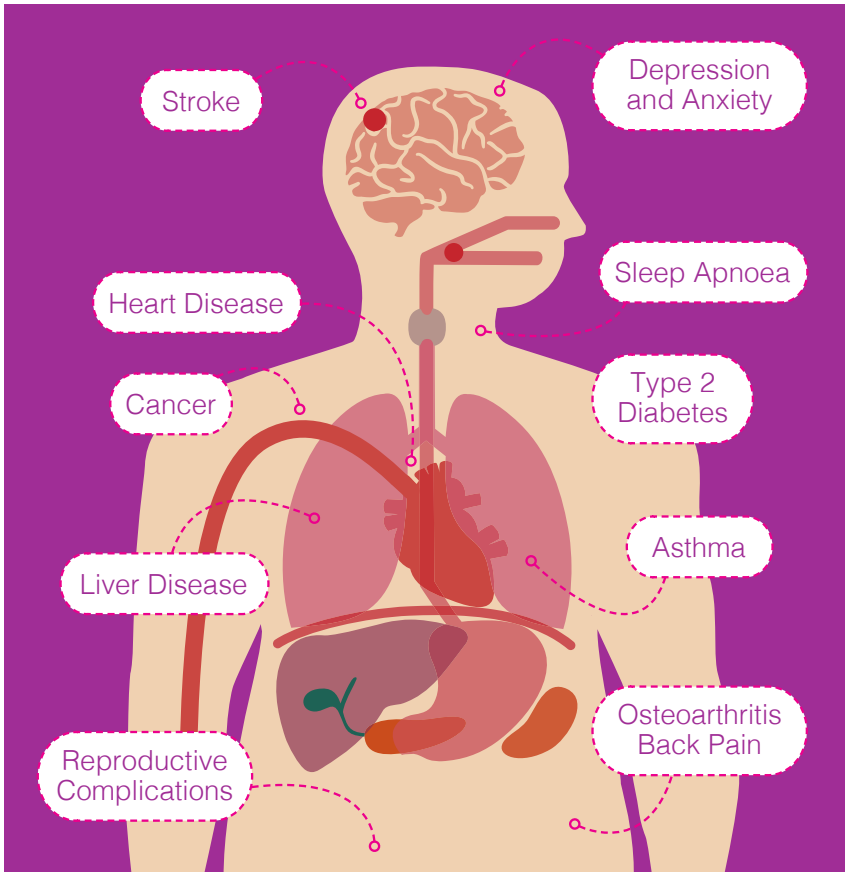


Figure 15 shows the variation between the districts and boroughs in the proposed North and West areas of the county, with significantly higher rates of excess weight in four of the seven districts (Kettering, Corby, East Northamptonshire and Northampton), the majority falling within North Northamptonshire.

The environment people live in can encourage unhealthy food and drink choices whereby they are often the easiest to access.

In Northamptonshire, just over half the population eat the recommended 5 fruit or vegetables on a usual day. This is similar for the two proposed unitary areas but masks the variation seen across districts. South Northamptonshire, East Northamptonshire and Daventry districts have a significantly higher proportion of the population consuming the '5 a day' compared to the England average whereas Corby and Northampton are significantly below the England average (figure 16).

Figure 15
Excess weight in adults, % 2016/17
Source: PHE fingertips profiles, Public Health, NCC

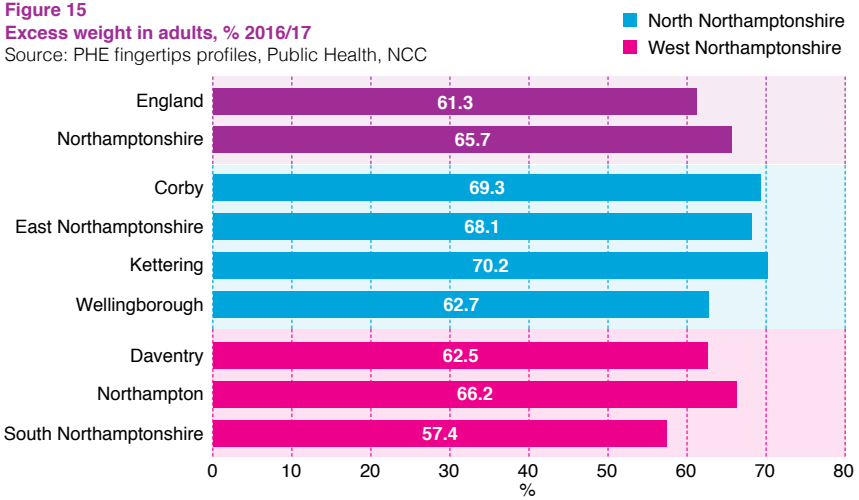


Figure 16
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)
Source: Public Health Outcomes Framework

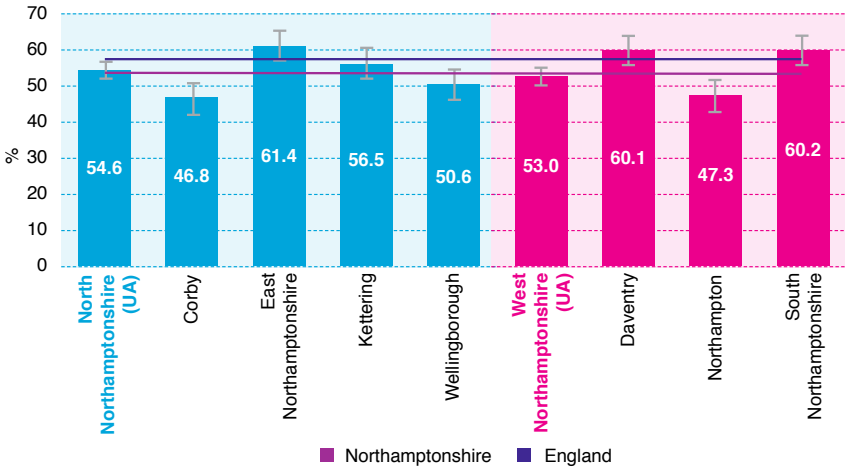


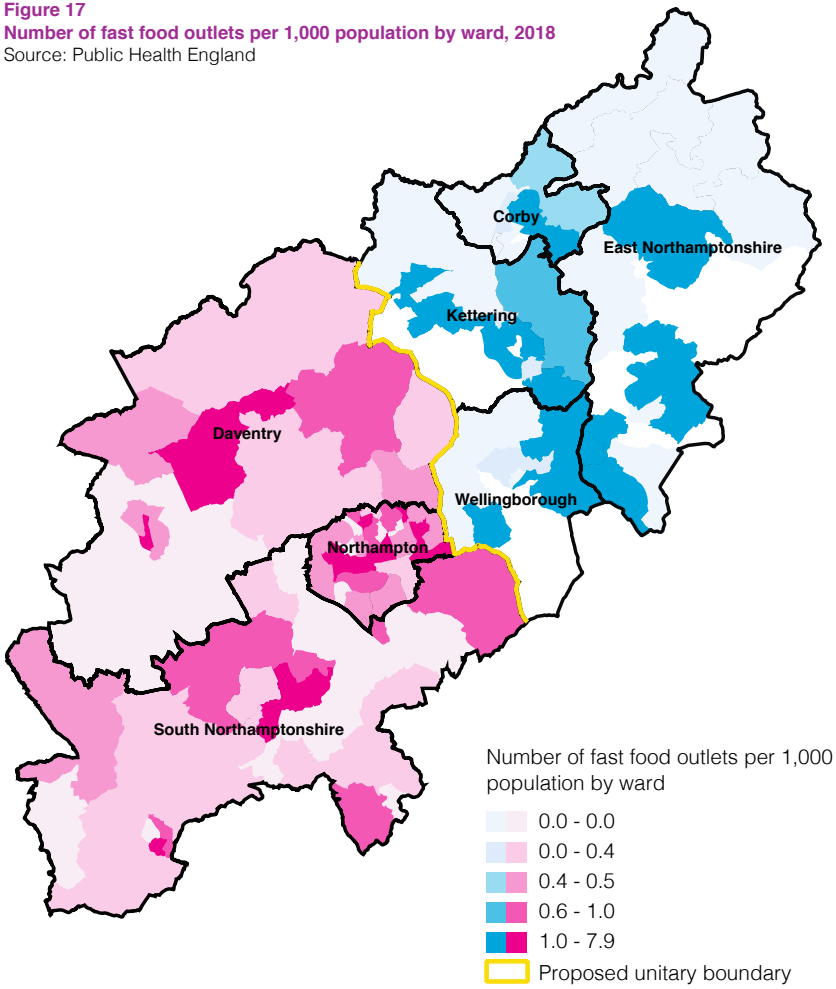
Figure 17 shows the concentration of fast food outlets per 100 people in each ward across Northamptonshire.

People may find it more difficult to make healthier choices when exposed to so many fast food options. Action is needed by the proposed new unitary authorities to tackle the growth of new fast food outlets, particularly in areas where there is a higher proportion of the population with excess weight and a high concentration of fast food outlets.

The opportunity to work with take away businesses should be explored to help families and children choose healthier options. This could include establishments introducing a healthier menu and employees being trained to signpost customers to healthier choices.

Excess weight can have significant health issues for adults throughout their lives into old age. Being overweight or obese is a common risk factor for diabetes, heart disease, stroke, liver disease, many cancers, arthritis and depression, causing death and injury and posing a high burden to health and social care.

Figure 17
Number of fast food outlets per 1,000 population by ward, 2018
Source: Public Health England



Physical activity

There are considerable health benefits from being physically active. Small increases in activity can protect against chronic diseases and improve quality of life.

Physical activity has been proven to help and manage over 20 chronic conditions and diseases and persuading those who are inactive to become active could prevent one in six deaths.[20] Physical activity has been identified as the fourth leading behavioural risk factor for deaths locally, associated with nearly 150 deaths a year in Northamptonshire.[18]

In the areas proposed for inclusion in North Northamptonshire, inactivity levels are highest in Wellingborough (28%) and Corby (27%). In areas that would be included in West Northamptonshire, inactivity levels are highest in Northampton (26%).

A worsening trend is shown in many districts and boroughs, in particular inactivity levels are increasing in Daventry, East Northamptonshire and Wellingborough. There is variation across both North and West Northamptonshire (figure 19), but generally the population in urban areas are less active than those in rural areas.

Figure 18
Physical activity in Northamptonshire
Source: PH Call to Action

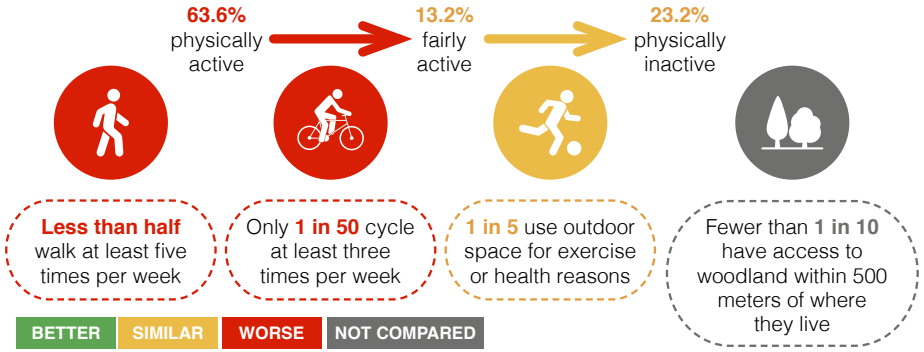
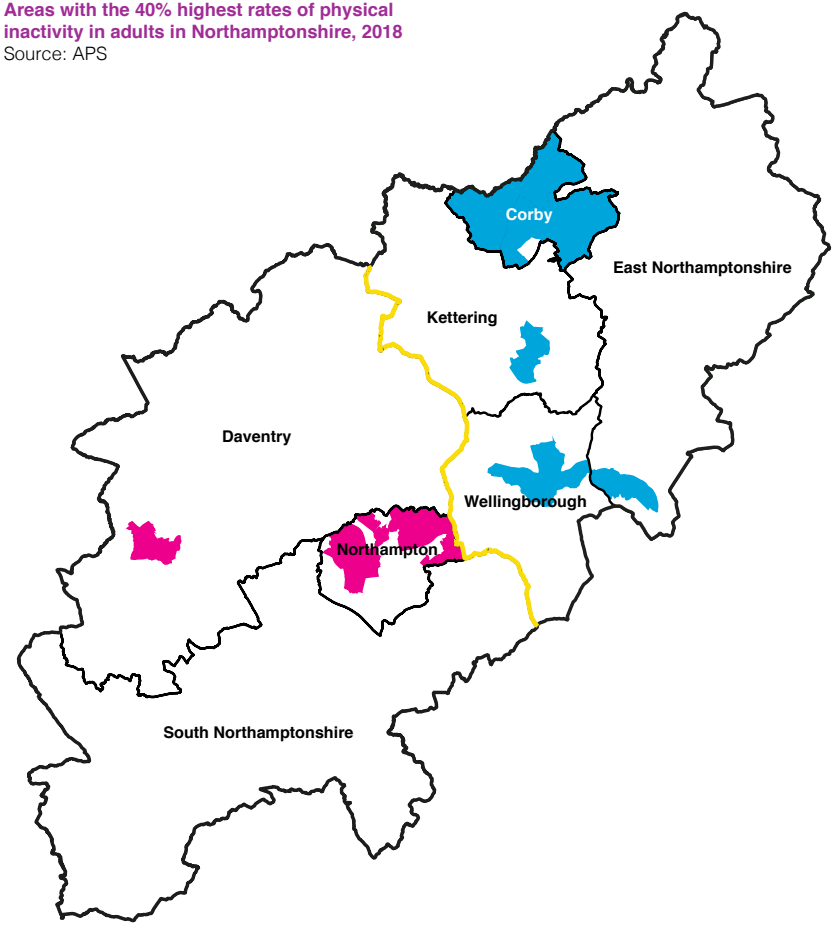


Figure 19
Areas with the 40% highest rates of physical inactivity in adults in Northamptonshire, 2018
Source: APS



Alcohol

Alcohol use can have a devastating impact on people's health, not just as a direct result of the substance on the body[21].

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population. An increase in alcohol harm in Northamptonshire has been observed over the last decade, with significant increases in the last few years.

Northampton, Corby, Kettering, and Wellingborough all had an admission rate for alcohol related conditions significantly higher than the England average in 2017/18.

Spending on alcohol per household is highest in the more affluent areas. This could be due to expensive alcohol products being purchased by households with higher levels of income. However, when you take this spend per week as a proportion of the household weekly spend, it shows a different picture with the highest proportion of weekly spend on alcohol in areas of higher deprivation (figure 21b).

The alcohol licensing regime is an important element of managing the impacts of alcohol on the population. NCC Public Health have agreed an approach to guide its input into alcohol licensing applications, consultations and decision making processes. This is in the context of my role as Director of Public Health and my statutory responsibility as a 'responsible authority'. This involves using data in relation to a range of alcohol harm indicators to identify geographical areas of high relative alcohol harm, however there is a need to develop a county-wide multi-agency partnership and strategy for alcohol that will focus on reducing alcohol related harm.

Improving knowledge across the population on safe alcohol is important across all parts of the county, but the proposed unitary authorities should prioritise the areas that have the greatest need which can be found from the alcohol related hospital admissions highlighted in figure 20.

Figure 20
Admission episodes for alcohol related conditions
Source: Public Health Outcomes Framework

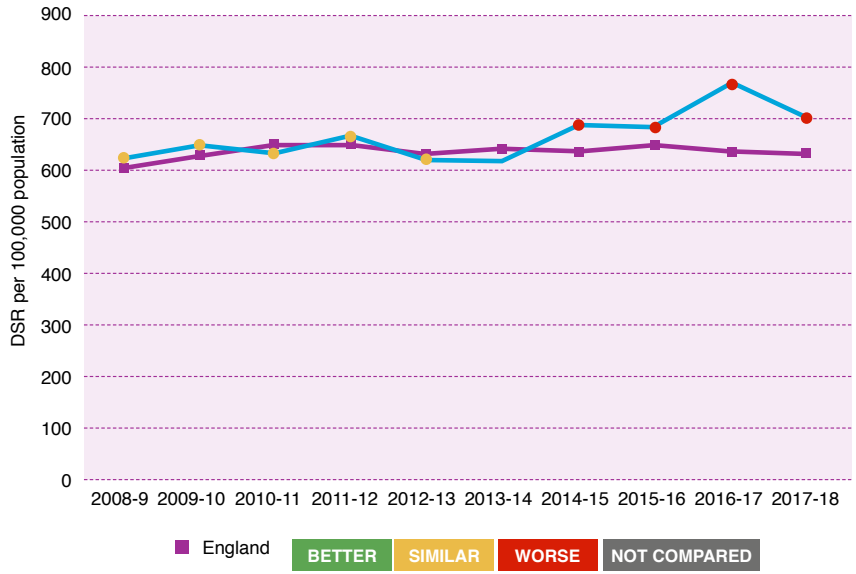


Figure 21a
Weekly spend on alcohol per household by LSOA based on living costs and food (LCF) survey

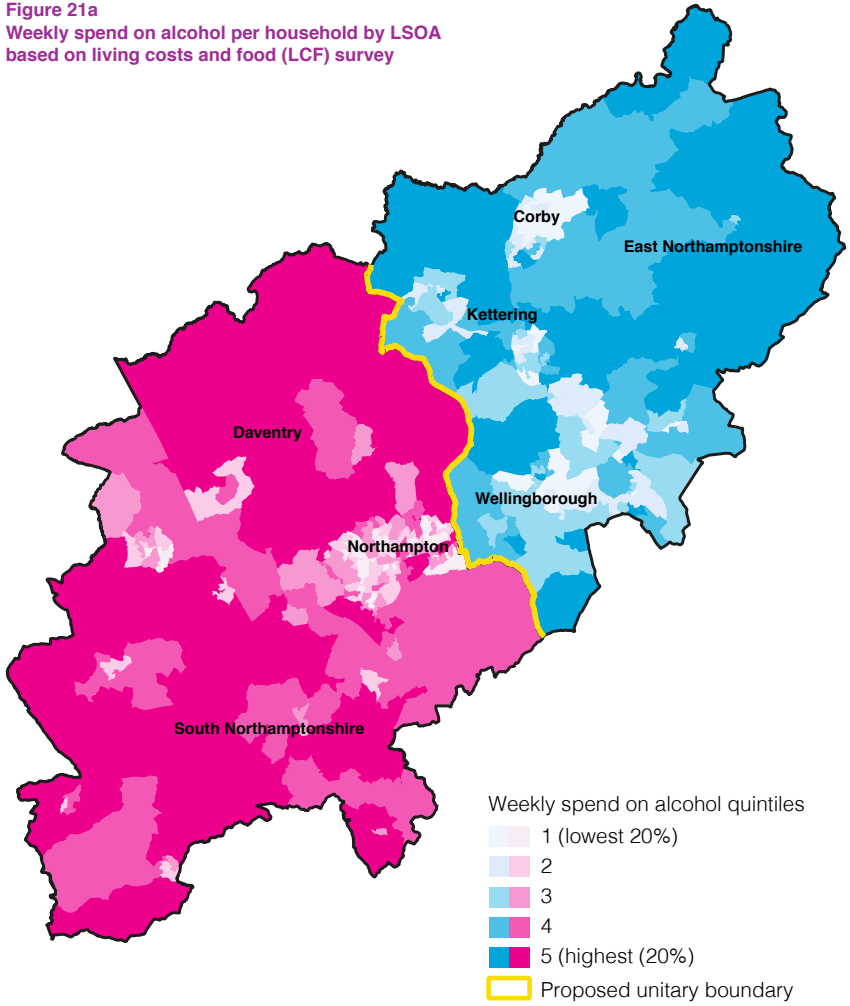
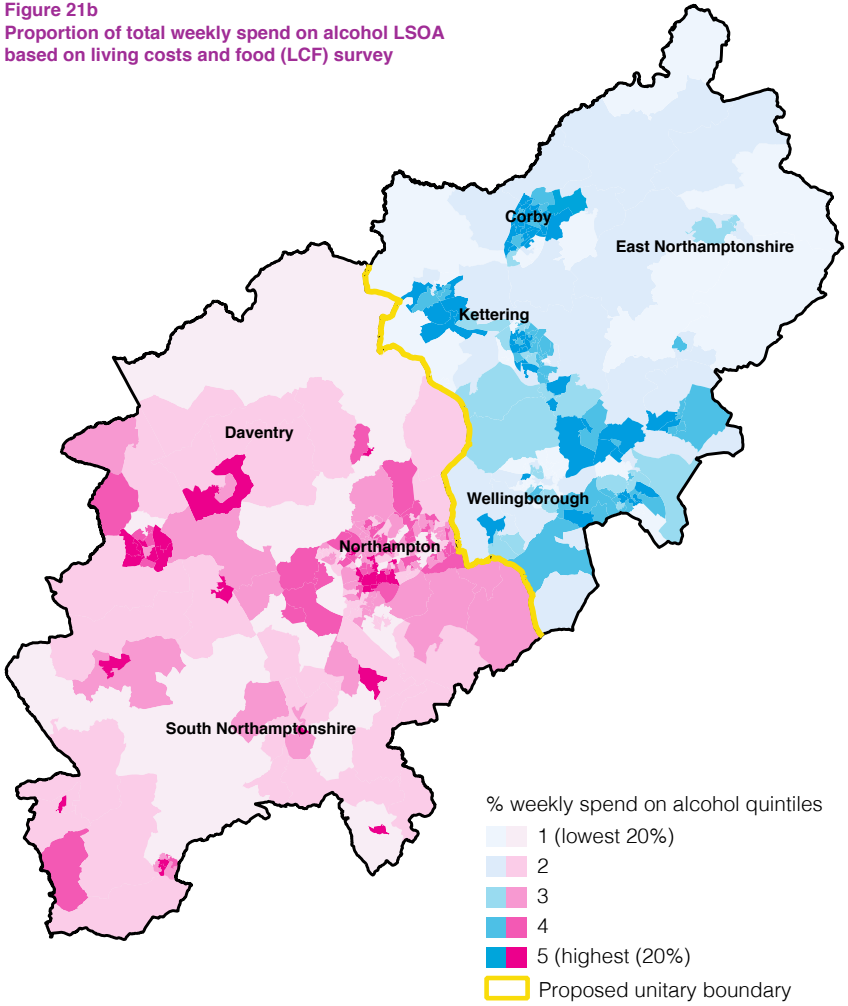


Figure 21b
Proportion of total weekly spend on alcohol LSOA based on living costs and food (LCF) survey



6. Wider determinants

Air quality

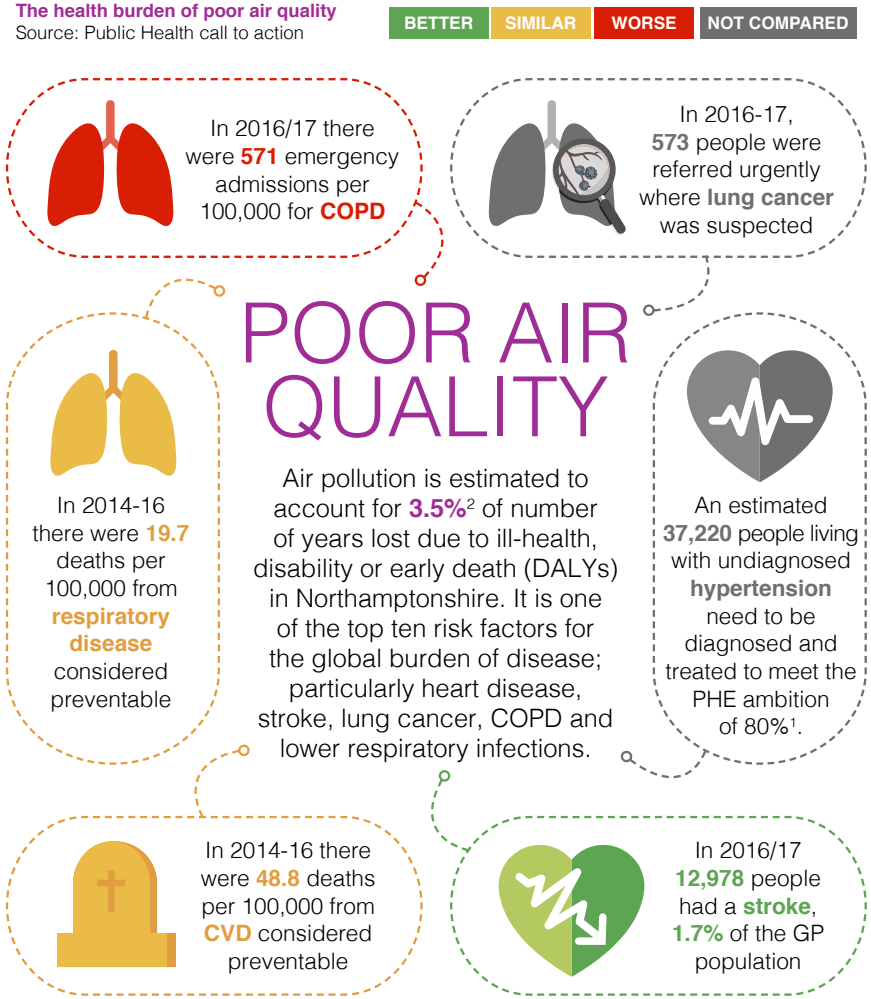
Elevated levels and/or long term exposure to air pollution can lead to conditions affecting human health. This mainly affects the respiratory and inflammatory response systems, but can also lead to more serious conditions such as heart disease and cancer.[22] People with lung or heart conditions may be more susceptible to the effects of air pollution. Poor air quality can drive health inequalities and increase early deaths from heart and respiratory diseases. The main pollutants of concern in Northamptonshire, as in most areas of the UK, are associated with road traffic, in particular Nitrogen Dioxide (NO_2) and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. Vehicle emissions are the main contributing factor, particularly diesel exhausts. There are eight declared 'Air Quality Management Areas' in Northamptonshire and all are in the West Northamptonshire proposed unitary authority. Seven are in Northampton and one is on the A5 in Towcester, all concern high levels of NO_2.

In North Northamptonshire, early deaths associated with poor air quality locally are estimated to be highest in Kettering and Wellingborough. In West Northamptonshire, they are estimated to be highest in Northampton.

Local authorities can help address health impacts and improve air quality by promoting active travel and sustainable transport to residents and businesses within the local authority area.

People with lung or heart conditions may be more susceptible to the effects of air pollution.

Figure 22
The health burden of poor air quality
Source: Public Health call to action

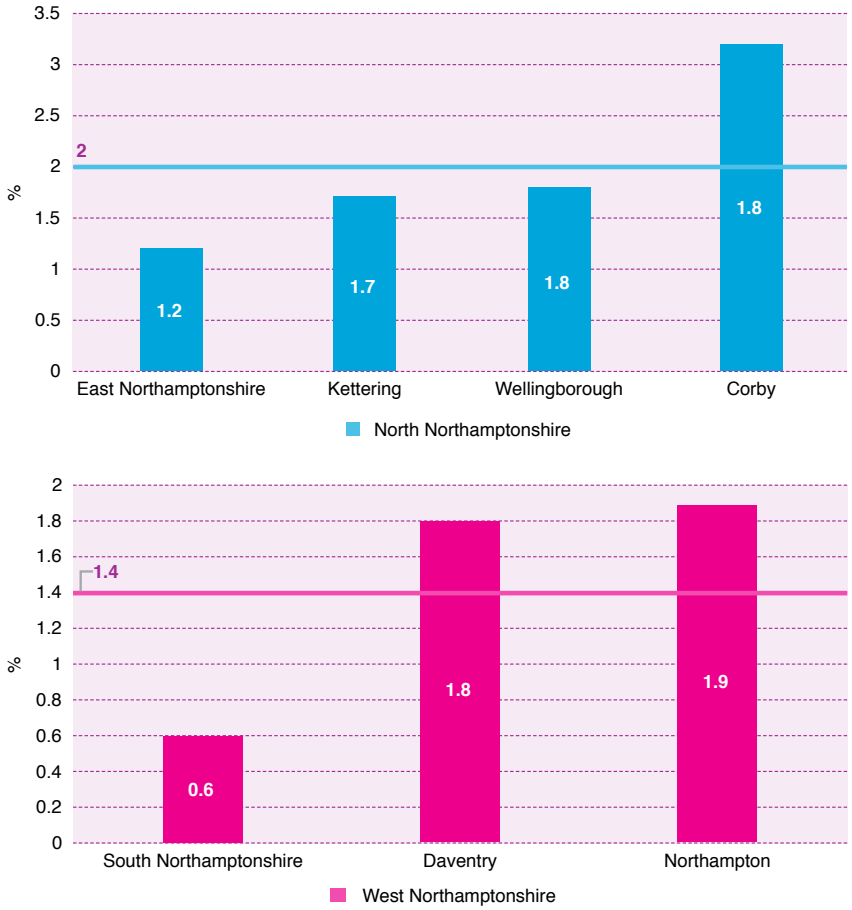


Employment

Employment is one of the most important determinants of physical and mental health[23]; the long-term unemployed have a lower life expectancy and worse health than those who work. The effect of unemployment does not just affect individuals. Children growing up in workless households are almost twice as likely to fail at all stages of education compared with children growing up in working families.

In West Northamptonshire 1.4% of the working age population were claiming unemployment related benefits in November 2018 compared to 2% in North Northamptonshire, the variation across the proposed unitaries is shown in figure 23.

Figure 23
Proportion of working population claiming unemployment related benefits
Source: NOMIS Nov 2018



Housing

Housing and neighbourhood conditions are widely acknowledged to be important social determinants of health, through internal housing conditions, tenure and neighbourhood characteristics. The impact on physical health can include damp surroundings that increase the risk of lung diseases or a broken stairwell can lead to trips and falls. Poor housing can also impact on mental health and wellbeing, particularly cold homes that can increase the risk of death in winter, unsuitable homes and overcrowded homes[24].

In 2011 there were 155,095 households in the proposed West Northamptonshire area. Northampton district has 11,319 households rented from the council, which is the highest number for any district or borough in West Northamptonshire. Furthermore, the borough of Northampton had 3,794 households of other types of social renting, which is the highest number for any area in West Northamptonshire. There were 132,635 households in the proposed North Northamptonshire area. The borough of Corby had 4,463 households rented from the council and Wellingborough has 3,956 households of other types of social renting. These were the highest numbers in terms of tenure for the areas in North Northamptonshire.

It is important that NCC Public Health work with the local housing organisations and housing departments in the new unitary councils, to enable them to better understand the health and wellbeing needs of their tenants and put in place a Making Every Contact Count approach. It is also important we, as a team, work with planning teams to design healthier spaces and places making use of tools such as Health Impact Assessments.

Homelessness

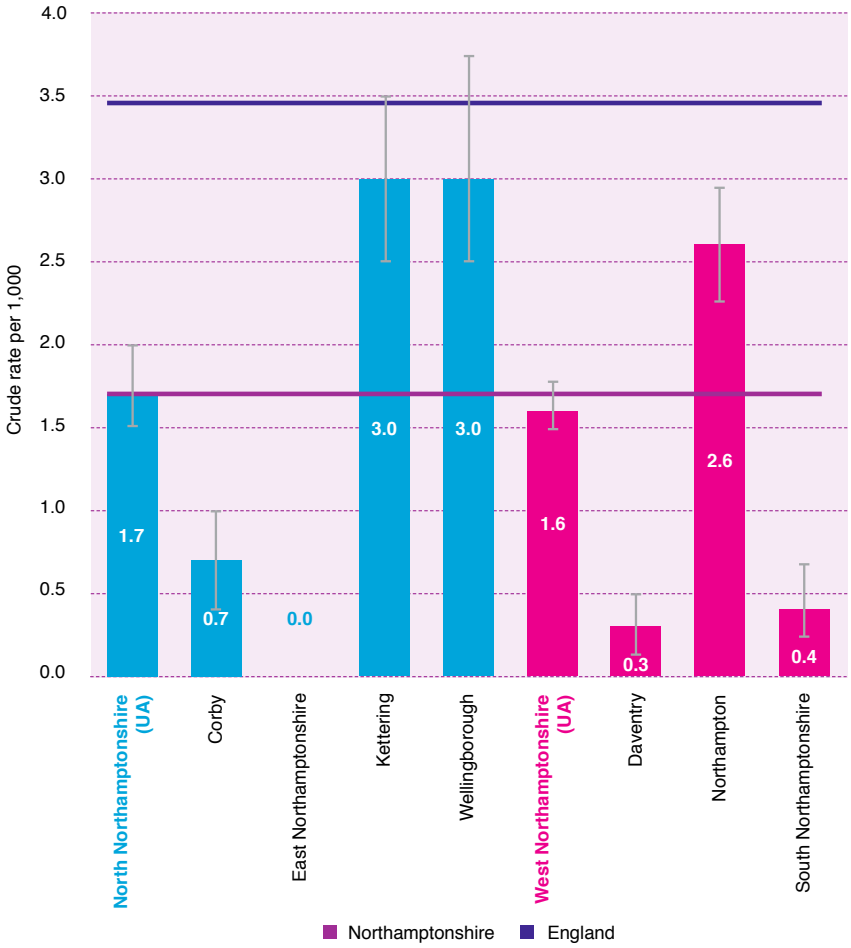
A range of factors such as relationship breakdown, debt, drug and alcohol addiction, underlying mental health and unemployment can all result in homelessness. Homelessness can have a considerably negative impact or be caused by a range of health factors. A national audit found that 41% of homeless people reported a long term physical health problem and 45% had a diagnosed mental health problem, compared with 28% and 25%, respectively, in the general population[25].

Data in figure 24 shows the statutory homelessness figures for the proposed unitary authorities and at district/borough level. There are no areas in Northamptonshire that have a statutory recorded homeless rate above the England average and all areas except Kettering and Wellingborough have a recorded rate below the national average. Both proposed unitary authorities have similar rates. The recorded rates in Corby, East Northamptonshire, Daventry and South Northamptonshire are particularly low and are also below the Northamptonshire average.

It is important that people with lived experience of homelessness are being heard in the design, commissioning and improvement of local services.

There is a need to ensure that we have more comprehensive data in relation to the needs of homeless people in Northamptonshire. This should be taken account through the Joint Strategic Needs Assessment in 2019.

Figure 24
Statutory homelessness - households in temporary accommodation
Source: 2017/18 PHOF, PHE, 2019



Mental health

Physical and mental health are intrinsically linked. Preventing and treating physical health conditions requires improving mental wellbeing just as much as preventing and treating mental health conditions requires improving physical health. Poor physical health, such as long term conditions like diabetes, are risk factors for poor mental health such as depression and anxiety. Mental health problems are common, experienced by a quarter of the population and start early in life. Half of all mental health problems are established by the age of 14 and three quarters by the age of 24 years.[26] In 2017, mental health problems were the fifth leading cause of morbidity and early death in Northamptonshire.

In addition the life expectancy of someone suffering with mental health problems can be up to 20 years less than the general population. Associated risks include unhealthy lifestyles such as substance misuse, poor diet and smoking and social determinants of health linked to no or poor employment and housing as well as access to services. The additional stigma and discrimination also negatively impact people's likelihood of seeking the help they need.

There is a strong association between deprivation and poor mental health[27]. Data from the Northamptonshire Mental Wellbeing Survey[28] is shown in the figures 25a and b. The survey was a large scale and face-to-face survey out by M·E·L Research across the county. It measured life satisfaction, whether life is worthwhile, happiness and reported happiness. The variation across the county can be seen in the maps below highlighting the 20% of the population with the lowest scores.

The Mental Health Prevention Concordat Partnership is a formal subgroup of the Northamptonshire Health and Wellbeing Board. There is a clear action plan outlining the future direction to prevent mental ill health. This includes development of a high impact campaign for suicide prevention, training around suicide prevention, training to increase awareness of general mental wellbeing and training in workplaces with an organisational approach to creating a mentally healthy workplace - including resilience training, mental health first aid training.

Mental health is an issue for the populations across Northamptonshire. There is an association between poor mental health and deprivation and people reporting higher levels of life satisfaction tends to be higher in the rural parts of the county. The areas of Northampton, Daventry, Corby, Kettering, Raunds, Rushden and Wellingborough are where the need is the greatest for mental health prevention and intervention to stop ill-health escalating.

Poor physical health, such as long term conditions like diabetes, are risk factors for poor mental health such as depression and anxiety.

Figure 25a
Life Satisfaction (based on ONS Mental Wellbeing question) by MSOA

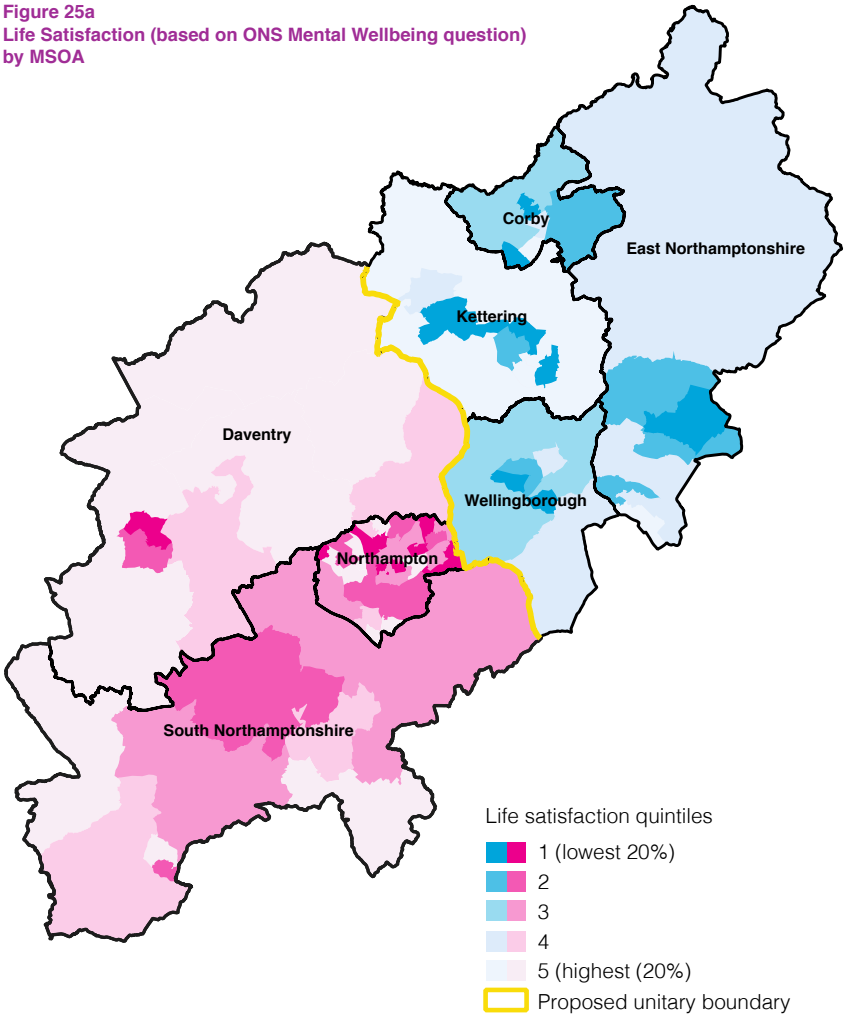


Figure 25b
Life Worthwhile (based on ONS Mental Wellbeing question) by MSOA

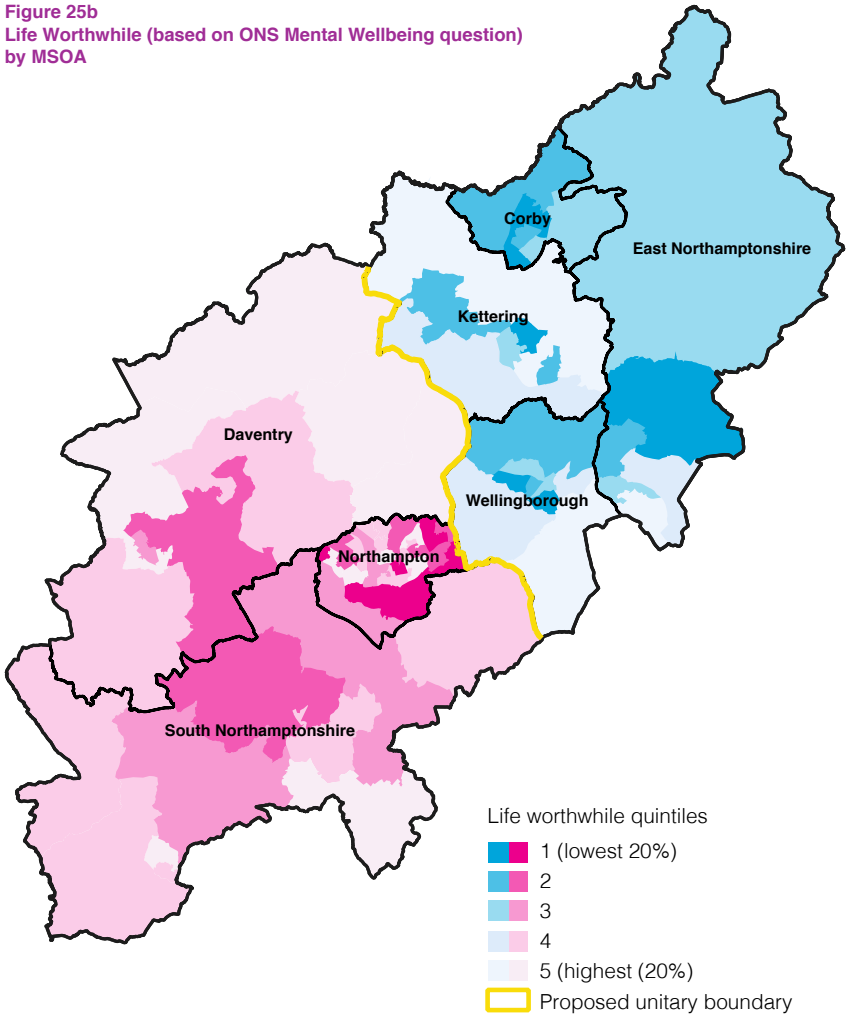


Figure 26a
Anxious Yesterday (based on ONS Mental Wellbeing question) by MSOA

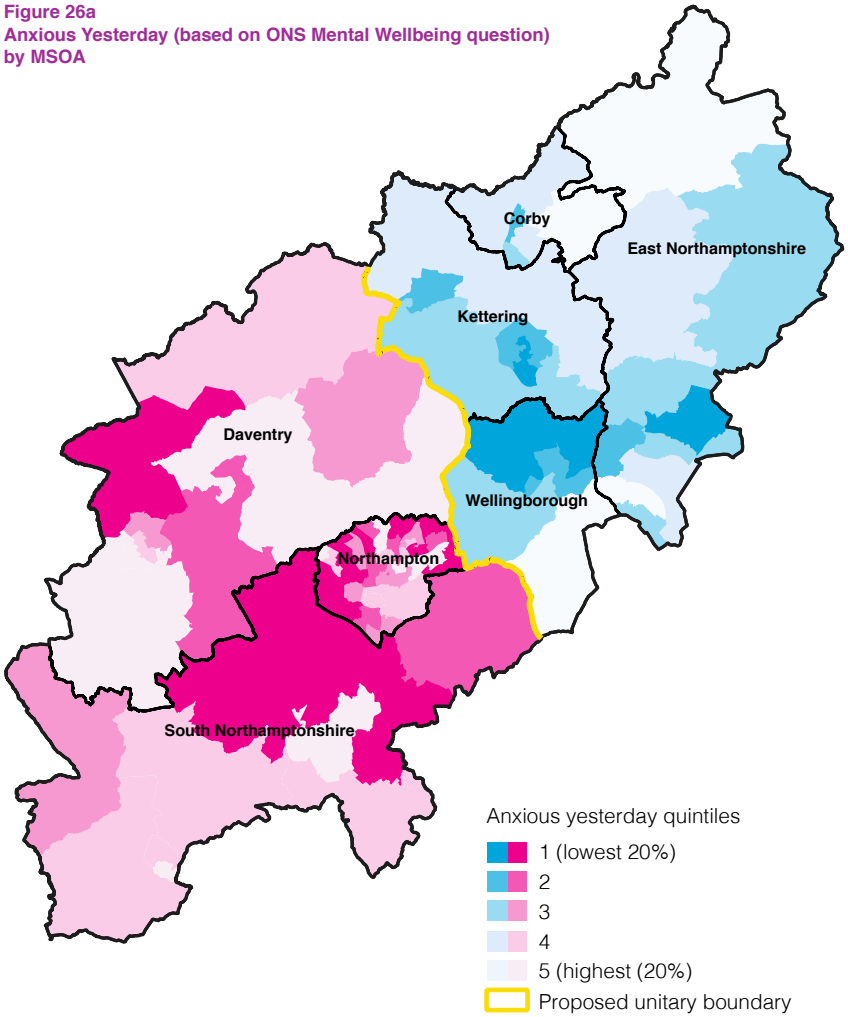
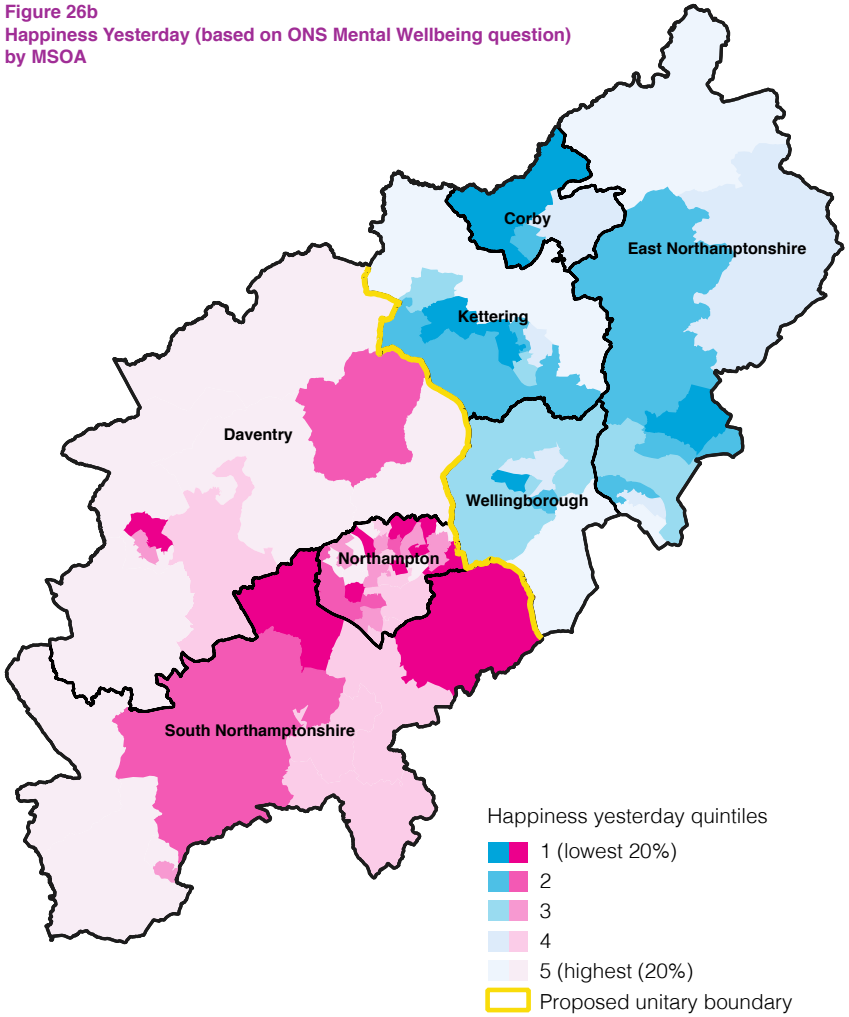


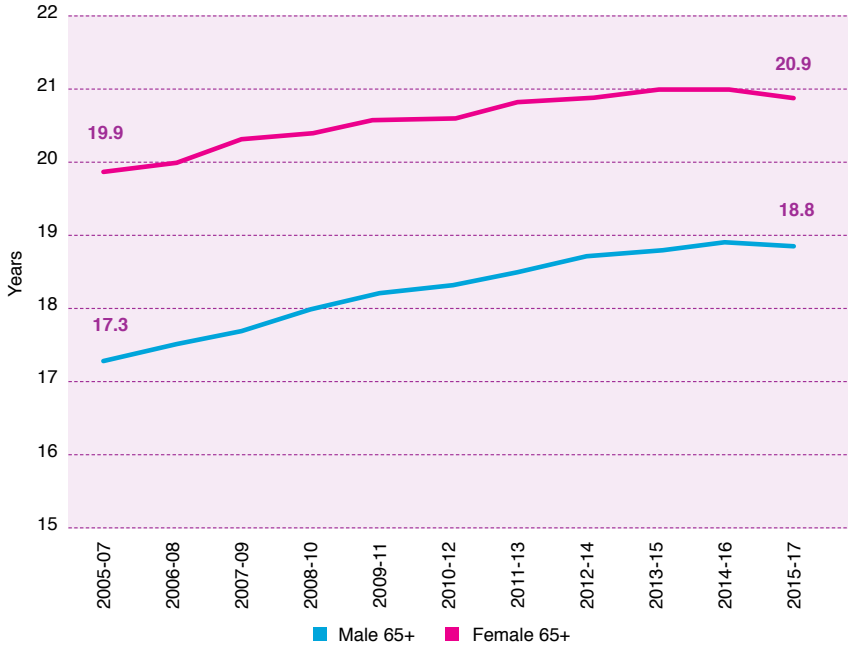
Figure 26b
Happiness Yesterday (based on ONS Mental Wellbeing question) by MSOA



7. Ageing

Life expectancy has been rising in Northamptonshire. The number of years a person is expected to live past 65 years has increased by 1 year for women and 1.5 years for men over the last 10 years.

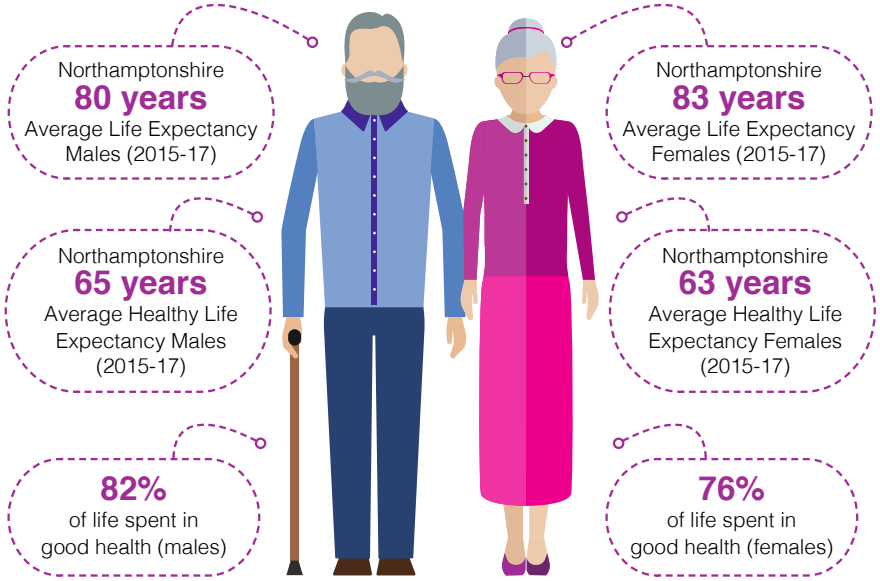
Figure 28
Life expectancy at age 65
Source: PHE profiles, NHS Digital, NCC PHI



Unfortunately we are spending many of these added years of life in ill-health, around 15 years for men and 19 years for women across their life span and 11 years for men and 10 years for women past 65 years of age.

An ageing population that is struggling with poor health, aside from the direct impact on the individual, also impacts on families, workplaces and increases pressures on health and social care services. It is a public health priority to help people stay well for longer by improving lifestyle choices as well as looking at the social determinants that affect a person's health such as housing, education, employment, food environment, isolation and mobility.

Figure 29
Northamptonshire average life expectancy for females and males



Long Term Conditions

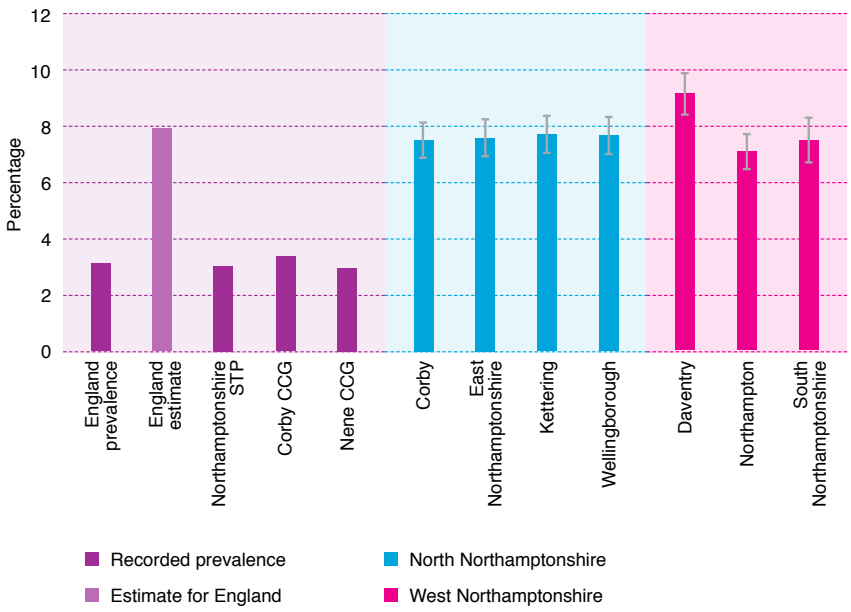
Long term conditions are conditions for which there is currently no cure but are managed with drugs and other treatment. Examples include diabetes, chronic obstructive pulmonary disease, depression and hypertension.[29] Identifying whether a person has or is at risk of developing a long term condition and ensuring they are treated appropriately can significantly improve their health. Furthermore to identifying people at risk, it is also important to ensure diagnosis of long term conditions early so they can be managed well. There is a relationship between high level of deprivation and a low diagnosis rate as well as higher mortality rates for the same conditions in the most deprived populations. In addition, those from more deprived populations are also more likely to have multiple long term conditions and therefore management of multiple conditions is important.[28]

The number of people diagnosed with a long term condition in Northamptonshire is lower than expected, with variation shown across different conditions. Figure 30 shows the recorded (on GP practice registers) and estimated prevalence for a number of conditions. Although not directly comparable as presented at differing geographies, it does show, when presented together, the potential extent of undiagnosed prevalence in the population.

For example, it is estimated that 59% of expected hypertension in the population is diagnosed. To achieve 80%, which is the ambition set by Public Health England, an additional 37,000 people in Northamptonshire would need to be diagnosed. Those undiagnosed and unknown implies the potential for unmet needs in the population and unnecessary negative outcomes for people such as early death and suffering.

Figure 30a
Estimated prevalence of Coronary Heart Disease (CHD) in 55-79 year olds based on 2015 data compared with Quality and Outcome Framework (QOF)[31] recorded prevalence in all ages 2017/18
Source: PHE Estimated Prevelance from PHE https://fingertips.phe.org.uk/profile/prevalence and QOF prevelance from NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2017-18

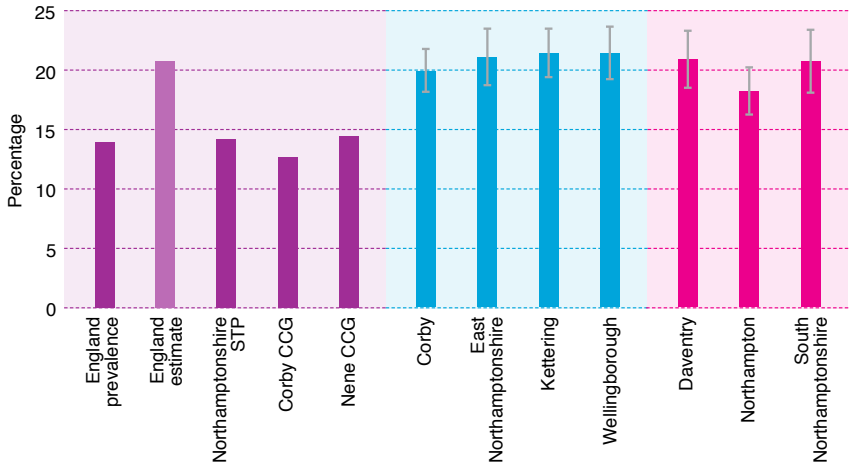
QOF CHD prevalence in 2017/18 (purple) and modelled estimates 2015 (with border)



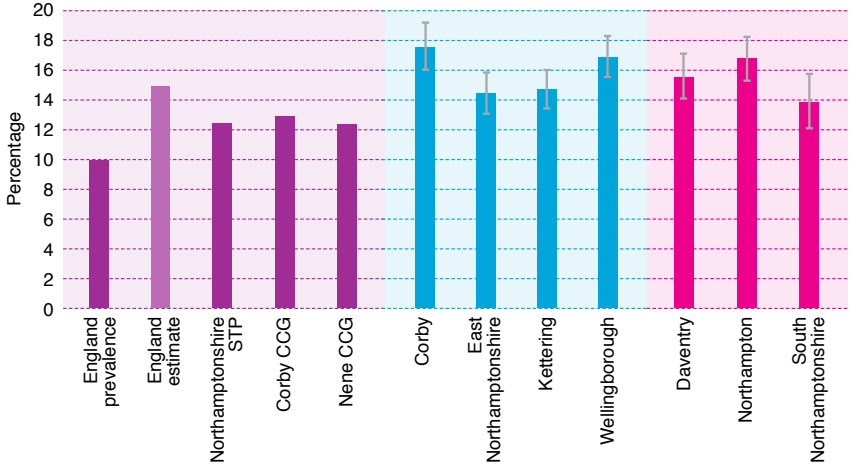
Enclosure C

Figure 30b
Estimated prevalence of CHD in 55-79 year olds based on 2015 data compared with QOF recorded prevalence in all ages 2017/18
Source: PHE Estimated Prevelance from PHE https://fingertips.phe.org.uk/profile/prevalence and QOF prevelance from NHS Digital
https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2017-18

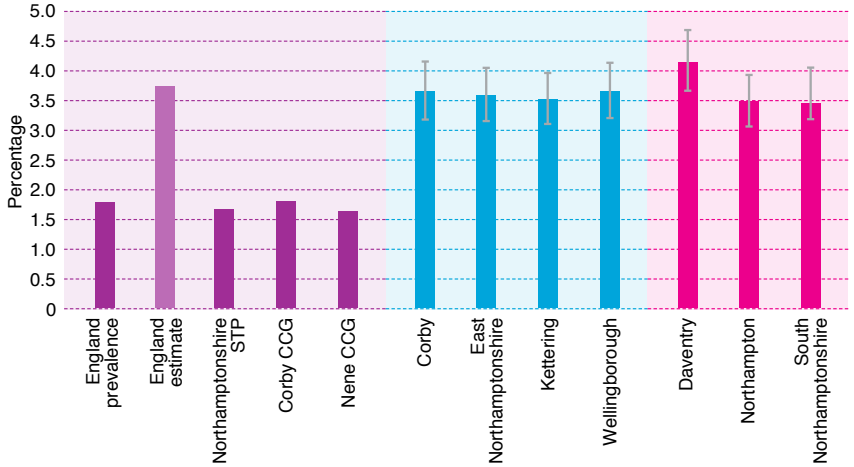
QOF hypertension prevalence in 2017/18 (purple) and modelled estimates 2015 (with border)



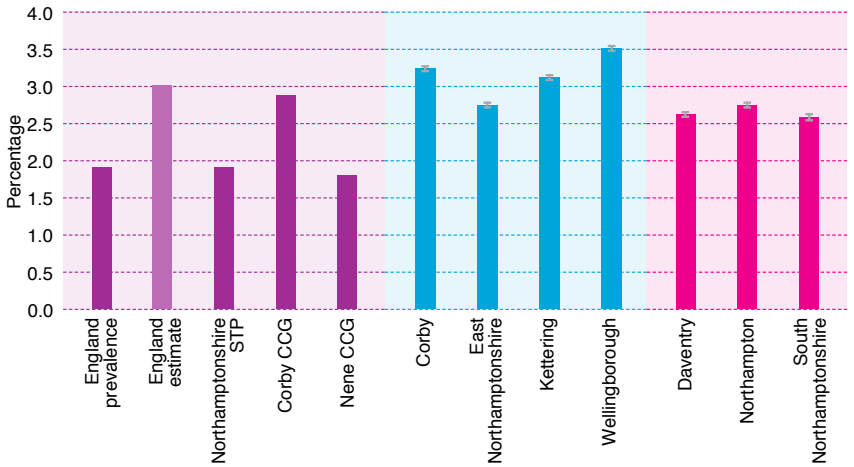
QOF Depression prevalence in 2017/18 (purple) and modelled estimates 2015 (with border)



QOF Stroke and Transient Ischemic Attack (TIA) prevalence in 2017/18 (purple) and modelled estimates 2015 (with border)



QOF Chronic Obstructive Pulmonary Disease (COPD) prevalence in 2017/18 (purple) and modelled estimates 2015 (with border)



Recorded prevalence | Estimate for England | North Northamptonshire | West Northamptonshire

The NHS Health Check programme targets people between the ages of 40-74 years old. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.

This programme is currently offered across Northamptonshire, in GP practices. It can help tackle health inequalities, through detection of long term conditions and addressing the burden of early death. A new model of delivery is currently being developed in Northamptonshire to improve uptake, especially in the most deprived areas, signposting to support for those who have had a health check and provision of quality support for partner organisations on opportunistic checks and pathways to treatment.

It is important to work with both Nene and Corby CCGs and Primary Care services to improve disease rate prevalence detection and provide preventative interventions to avoid disease. There will be GP practices in both proposed unitary areas that will benefit from enhanced support. In order to identify the practices that should be prioritised, further data analytical work should be undertaken.

An ageing population that is struggling with poor health, aside from the direct impact on the individual, also impacts on families, workplaces and increases pressures on health and social care services.

Frailty

Although people can be frail at any age, it is primarily related to ageing. It describes how our bodies change and deteriorate, leaving a person vulnerable to dramatic, sudden changes in health triggered by smaller events such as a minor infection or a change in medication or environment. It defines a group of people who are at highest risk of outcomes such as falls, disability, admission to hospital, or the need for long term care. The number of people over 65 for each district and borough that are classified as fit, mild, moderate or severely frail are estimated in table 3.

Table 3
Number of people living in Northamptonshire by frailty score
Source: https://www.northamptonshireanalysis.co.uk/dataviews/view?viewId=151 based on ONS mid year estimates 2012 – 2016 and Kent Integrated Database

	Total 065s	Fit (n)	Mild (n)	Moderate (n)	Severe (n)
Northamptonshire Total	128,629	67,200	41,549	15,621	4,204
North Northamptonshire	60,877	31,812	19,664	7,389	1,987
Corby	9,613	5,045	3,109	1,151	303
East Northants	18,422	9,643	5,942	2,230	600
Kettering	18,065	9,403	5,838	2,215	602
Wellingborough	14,777	7,721	4,775	1,793	482
West Northamptonshire	67,753	35,389	21,886	8,233	2,216
Daventry	16,423	8,680	5,279	1,943	514
Northampton	33,134	17,162	10,743	4,099	1,115
South Northants	18,196	9,547	5,864	2,191	587

Falls account for more than 50% of injury-related hospital admissions among people over 65 years and older. A person who is frail is more likely to experience a fall compared to someone who is fit.

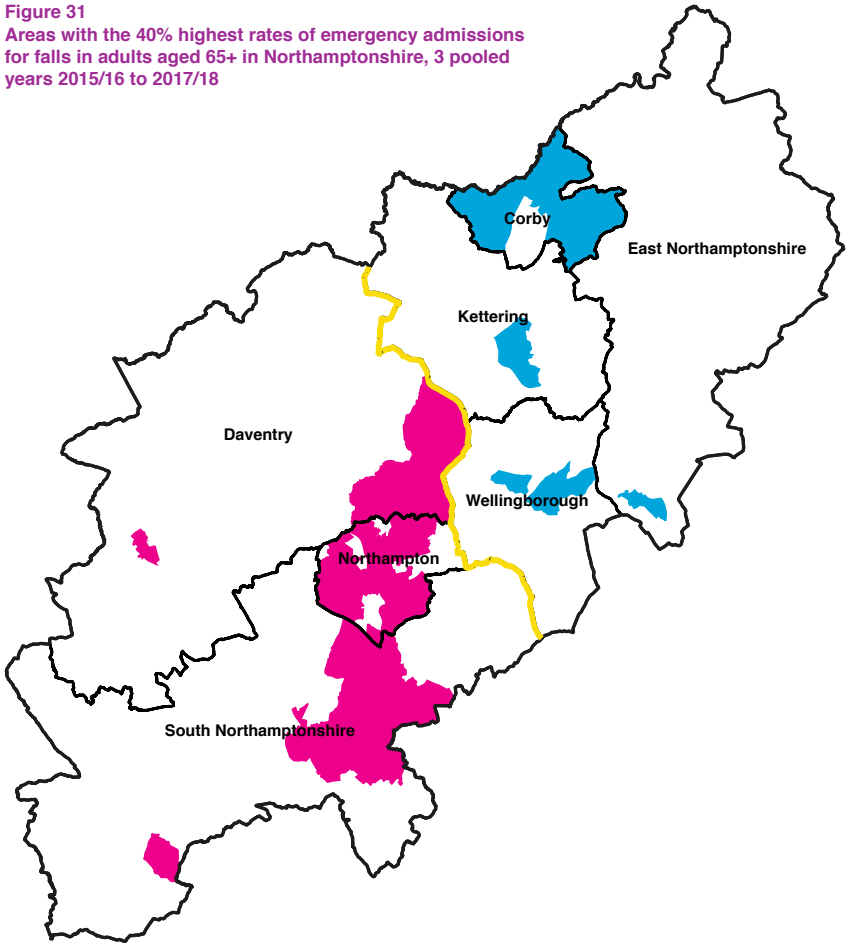
The proposed West Northamptonshire area had significantly higher rates of emergency admissions for falls compared to the England average for the over 65s females. The proposed North Northamptonshire area's rates were not significantly different to England average.

Figure 31 highlights the hotspots across the county and two proposed areas where falls admissions are highest.

NCC Public Health have transformed the local health and wellbeing advisor service to ensure that it has an emphasis on supporting mild frailty. The new offer is called the 'Supporting Independence Programme' and is aimed at promoting self-care and independence in people living with mild frailty.

Identifying whether a person has or is at risk of developing a long term condition and ensuring they are treated appropriately can significantly improve their health.

Figure 31
Areas with the 40% highest rates of emergency admissions for falls in adults aged 65+ in Northamptonshire, 3 pooled years 2015/16 to 2017/18



8. Key recommendations

Improving the health of the population of Northamptonshire is the responsibility of us all, whether we are statutory or voluntary, health and care organisations, local authorities, emergency services, education services, employers, community groups, families, parents or individuals.

As we move towards the proposed two new unitary authorities we must maintain focus on addressing the health inequalities that exist between and within each proposed new authority area. These health inequalities are complex and challenging and to tackle them we need the combined efforts of society working together to narrow the gap that exists mainly as a result of deprivation.

This report makes eight recommendations that require joint working to achieve the best outcomes for Northamptonshire residents:

1. Local leaders and organisations need to work with new shadow unitary authorities (subject to government agreement) to ensure that public health principles and practice to improve population health and reduce health inequalities are embedded in order to shape services to best meet need. Public health expertise will be available if and when the new councils emerge to understand and respond to health needs in communities.

2. There should be greater focus on improving health and promoting a healthy lifestyle for pregnant women and new parents. This will require an improvement in health literacy and understanding of what a healthy pregnancy means and how it can be achieved. In order to support the delivery of such, healthy lifestyle services will need to be developed to increase the chance that a child gets the best start in life.

3. The unhealthy weight of our children and young people has been referred to as a generation time bomb that can have lifelong health implications. We must get to the root cause to tackle this complex, multi-factored problem by working with and educating communities, schools and families to take a lead role in preventing our children becoming overweight and addressing the issue early if it arises.

4. To reduce the number of people who experience mental ill health we need to improve the effectiveness of prevention services for mental wellbeing. By developing emotional resilience in our communities, from the youngest to the oldest, through the effective implementation of the mental health concordat actions across Northamptonshire health, social care and education partners, we can raise awareness and promote positive mental health for all.

5. We know that nationally and locally the use of tobacco has reduced significantly, yet there continue to be groups of people who smoke and are at increased risk of adverse health outcomes and premature death. Services need to work together so that fewer women are smoking in pregnancy, more people waiting for planned operations 'stop before the op' and there is bedside support for in-patients, particularly those experiencing ill health due to respiratory or cardiac conditions.

6. Tackling unhealthy lifestyles and improving health are a means to prevent avoidable communicable and non-communicable disease, many of which are long term conditions that are preventable or could have been identified earlier and treated successfully. Primary, community and hospital services all have a role in fewer people experiencing avoidable ill-health and disease, by increasing uptake of vaccination, screening programmes; cancer, non-cancer and health checks and directing people to healthy lifestyle services.

7. As a community we want our older people to experience healthy aging which allows them greater autonomy and independence for longer and increases their healthy life expectancy. We know that for some older people this is not achievable, however for many more, if services can work with them at the first sign of frailty, we can halt or slow ill-health and maximise their wellbeing. We can achieve this by optimising use of the NCC Public Health 'Supporting Independence Programme' for people living with mild frailty.

8. Improving health, preventing ill health, supporting people to make healthy choices, having the skills to be responsible for their own health and that of their family and when required, accessing the right care at the right time in the right place, health does not happen without access to good information communicated effectively. NCC Public Health will develop a comprehensive communication and engagement strategy, linked to partners, that will reach into communities to educate, inform and support positive behaviour change.

Appendix A – Recommendations update 2017/18

Recommendation	Update
Topic: Protection from infectious disease	
Recommendation 1: During 2018/19, undertake a comprehensive review of services for the prevention, detection and treatment of Tuberculosis in order to present detailed recommendations for potential future improvements to the Northamptonshire Health Protection Committee.	A comprehensive review of the Tuberculosis (TB) service is ongoing. The commissioning arrangements for Northamptonshire are being benchmarked against others within the East Midlands TB Network and TB service providers have been engaged to ensure gaps in services are identified at this stage and so can be addressed. Latent TB screening has been implemented in nine general practices to date. A Screening programme for rough sleepers was carried out in November–December 2018 to identify cases of TB. This programme also addressed the infectious disease screening among homeless and substance misuse service users. We are seeing now increased early detection and timely treatment of TB.
Recommendation 2: Investigate the causes and contributing factors to Northamptonshire's relatively poor outcomes in relation to Hepatitis C and take corrective action as appropriate.	A review of premature deaths due to Hepatitis C related complications in Northampton and Kettering General Hospital has been conducted. Local hepatology specialists are reviewing the number of deaths and are working with the regional Hepatitis C network and the county's Coroner Services to identify the causes of those deaths. This year's rough sleeper Screening programme enabled further early detection and treatment preventing complications.
Recommendation 3: Consider additional Hepatitis C screening programme(s) for high risk population and new registrant migrants from high risk countries.	During the rough sleeper Screening programme over one third of those seen were of non-UK origin. In conjunction with the regional Hepatitis C Network, the Northamptonshire's Health Protection Committee is proposing screening in A&E to further increase early detection to the high risk populations.
Recommendation 4: Develop local proactive, multi-agency interventions aimed at improving Sexually Transmitted Infection service access for women, their children and sexual partners in communities that have low rates of GP registrations.	Northamptonshire's Health Protection principal is working with HIV consultants and D&A services to address early detection. The county's new Sexual Health Service procurement has been completed and the service will be mobilised in April 2019. An outreach programme which is designed to reach high risk groups will have sexually transmitted infection screening built into the service as routine care.

Recommendation	Update
Topic: Protection from infectious disease	
Recommendation 5: By March 2019, review local outbreak management arrangements, in relation to outbreaks of Sexually Transmitted Infections, to ensure that timely and proportionate responses are able to be implemented as soon as an outbreak is detected.	The local outbreak management agreement has been reviewed and an updated plan is now in place. This includes clear roles and responsibilities for all the agencies involved and will facilitate a timely response to outbreaks including sexually transmitted infections.
Recommendation 6: Develop communications plan for higher risk groups to reduce stigma and encourage take-up of HIV testing in order to reduce late diagnosis and help prevent spread by those unaware of their HIV status.	NCC Public Health continues to work with regional and local health partners to address health inequalities and deliver a health education sessions that promote benefits of testing and reduce stigma. A particular example of this work has been accomplished by CGL (commissioned by NCC to provide substance misuse treatment services).They are educating and offering screening and tests to all its new clients, who are otherwise hard to reach.
Recommendation 7: Consider routine HIV testing in high prevalence areas for all general medical admissions as well as new registrants in primary care.	CGL are now providing routine HIV testing to new clients. A further high risk group has also been engaged via the Homeless Screening Programme. In addition there are currently ongoing discussions with Northampton and Kettering General Hospitals to roll out to testing in A&E
Recommendation 8: Implement annual programme of local health promotion and educational campaigns focusing on reducing differences in immunisation uptake and helping individuals to assess the risks of vaccines and the risks of diseases. Communications should be tailored to the needs of specific audiences such as local parents; adolescents, and 'hard to reach' communities.	NCC has completed a comprehensive seasonal flu vaccination campaign. 103 frontline staff were vaccinated in house across the county and community outreach health education session held to engage with BAME groups. Reviews of this programme will inform an improved offer for winter 2019/20. NCC Public Health continue to work with East Midlands PHE regional team to address vaccine reluctance in active anti-vax groups.
Recommendation 9: Develop one-to-one or small group-based interventions that seek to reduce differences in the uptake of specific immunisations or completion of the immunisation schedule, such as involving health visitors and other community nurses.	NCC public health has worked with local community groups and voluntary organisations to raise awareness in hard to reach groups through public engagement sessions. In babies, we have seen improved uptake of MMR vaccinations through working with the working with NHSE vaccination team. School Health nursing teams are working with children to educate and promote the benefits of immunisations and have maintained national target of adolescent and childhood immunisation This year has also seen improved uptake of the seasonal flu immunisation – we anticipate positive outcomes due to this to be seen later in the year.

Recommendation	Update
Topic: Protection from infectious disease	
Recommendation 10: Continue to work with local health and social care partners, as well as the Health Protection Unit of Public Health England (PHE) to support, coordinate and improve the sharing of guidance and good practice for infection prevention and control.	NCC Public Health is working with the whole health economy infection control committee and its members. Monthly meetings are in place to review infectious disease incidents, policy and procedures of member organisations, chronic infectious diseases' issues and action plans as well as developing an action plan for local priorities as well as national.
Recommendation 11: Coordinate a review of the local Antimicrobial Resistance (AMR) strategy with a view to identifying opportunities for improvement which can be considered by the Northamptonshire Health Protection Committee and other appropriate local boards.	This is an annually scheduled and ongoing work stream with PHE in East Midlands, the medicine management team of Nene & Kettering CCGs and the WHE Infection control group. The national AMR strategy has been reviewed and monthly reviews of local antibiotic prescribing and incidence of infections acquired in health care settings are ongoing.
Topic: Environmental Hazards	
Recommendation 12: Engage with local partners to ensure that health and wellbeing issues, such as air quality are adequately considered at all stages in the creation and review of local development plans and policies.	NCC Public Health has responded to local planning authorities' (district councils) consultations on their local plans in order to address health and wellbeing issues in planning policies. This is both through informal dialogue and formal representations. Some of the district councils have incorporated health and wellbeing policies into their draft local plans. NCC has supported the creation of a joint planning in health post to ensure that health considerations are properly incorporated into local development plans and that appropriate money is secured from developers.
Recommendation 13: Continue to support Northampton Borough Council in working to improve air quality in Northampton Town Centre and delivery of the Northampton Low Emissions Strategy.	Northampton Borough Council (NBC) continues, with support from NCC Public Health, to develop its strategy for improving air quality in the town. NBC has consulted on proposals to amalgamate existing Air Quality Management Areas (AQMA) in the town into one larger AQMA to assist efforts to improve air quality.
Recommendation 14: In preparation for the 2018/19 winter season, partners should continue to work together to plan for and respond effectively to severe weather events in the county, taking account of lessons learned during winter 2017/18. This work should include recognising the more vulnerable sections of the community and addressing their needs.	In preparation for winter 2019/20, Northamptonshire County Council, in conjunction with the Local Resilience Forum, undertook the following preparedness activity: • Updated LRF arrangement for severe weather • Updated NCC procedures for responding to amber snow forecasts • Reduced service disruption during periods of heavy snow • Updated arrangements for managing peak demand on mortuary services • Reduced delays in mortuary system

Recommendation	Update
Topic: Environmental Hazards	
Recommendation 15: Organisations involved in creating and managing the built environment should consider severe weather and seek to design local places in such a way that protects the community from severe weather. This could include for example: • Initiatives to ensure people's homes are well insulated and that they can afford to maintain them at a reasonable temperature. • Designing new developments with features that help residents deal with periods of hot weather, such as appropriate building design and the inclusion of suitable shade in public spaces, such as tree coverage.	A new project, being overseen by NCC Public Health, to support energy efficiency and fuel poverty in the county has been introduced – Northamptonshire Energy Savings Service supports people to access support to enable them to keep their homes warm. We continue to work with planning teams to develop planning policy to address wellbeing.
Recommendation 16: To continue to work with communities to raise awareness of flood risk and promote personal resilience.	NCC Flood and Water Management Team and Emergency Planning are continuing to engage with communities throughout the county to raise awareness of flood risk and promote community and personal resilience through the Pathfinder 2 initiative. Communities throughout Northampton have also recently been engaged following the May 2018 flooding.
Recommendation 17: Continue to roll out the Community Flood Resilience Pathfinder Project to support communities to help themselves, including the continual uptake of new flood wardens.	Pathfinder 2 has engaged 30 communities since April 2017, whilst continuing to support the original 15 communities from Pathfinder 1. Funding has been secured for Pathfinder 3 for two further years from April 2019, which will work with 30 more communities to improve their resilience to flooding. In total over 100 flood wardens are now active in the county.
Recommendation 18: Ensure that every major planning application where the development site is affected by flood risk is accompanied by an appropriate flood risk management plan – including ensuring adequate emergency access and egress.	Applications continue to be assessed to ensure they meet our Local Standards for Surface Water Drainage in Northamptonshire. On average 70 major applications are received each month to ensure appropriate flood risk management plans and Sustainable Drainage Systems are incorporated.
Recommendation 19: Continue to support delivery of the actions set out in the Northamptonshire Local Flood Risk Management Strategy Action Plan.	The Northamptonshire Local Flood Risk Management Strategy Action Plan is continually monitored through quarterly Local Flood Risk Operational Group Meetings. The Flood and Water Management Team and Risk Management Authorities are continuing to work in partnership to ensure delivery of the actions.

Recommendation	Update
Topic: Societal Risks	
Recommendation 23: Commission and complete by March 2019 a comprehensive assessment of the health, social and economic impact of Domestic Abuse within Northamptonshire, identifying opportunities where coordinated multi-agency action could improve outcomes for victims and potential victims.	NCC Public Health has now recruited a Communities Officer with lead responsibility for domestic abuse. Working in conjunction with local partners and in particular the Office of Police Crime Commissioner (OPCC), the following work is currently underway and will be presented to a domestic abuse workshop in spring 2019: • Review and assessment of current evidence base for domestic abuse interventions. • Whole cost economic assessment for the impact of domestic abuse across Northamptonshire • Development of resources and information campaigns to support victims of domestic abuse to report to the police. • Develop operational plans to reduce the levels of rape in Northamptonshire. • (Police & Crime Plan)
Recommendation 24: Engage with education establishments to review and promote programmes which promote healthy relationships and challenge the prevalence and acceptance of sexual harassment and other sexual offences.	NCC has supported the continued work of the Online Safety Officer, based within children's safeguarding, to promote a better understanding of healthy relationships directly to students, parents and teaching staff. In addition work is continuing to develop a resource bank of information and guidance for schools to address these issues. Further development of a Healthy Schools Programme will support this work and a Public Health Officer has been recruited to lead on the delivery of this.
Recommendation 25: Engage with local partners to coordinate a network of support services for victims of hate crime and other forms of harassment.	NCC Public Health has supported the review of arrangements for a county-wide Community Safety Partnership (CSP) to bring together the good practice from the seven existing local CSPs. The Northamptonshire CSP has agreed the following priority areas: • Domestic Abuse • Serious and Organised Crime • Hate Crime • Anti-social behaviour

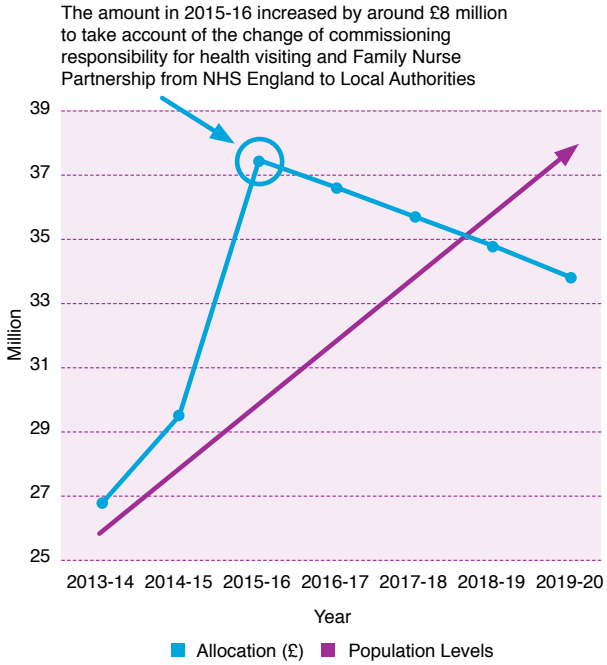
Recommendation	Update
Topic: Societal Risks	
Recommendation 26: Review and coordinate delivery of the PREVENT strategy for Northamptonshire as part of delivery of the national Counter Terrorism Strategy (CONTEST).	The Home Office launched its new interactive PREVENT training programme in November 2018, which has been adopted by Northamptonshire's PREVENT partner organisations. Coupled with further training courses aimed at professionals working with children and their families to raise awareness and understanding their responsibilities in tackling radicalisation and extremism. PREVENT training is now mandatory and forms part of the induction programme ensuring all new members of staff are aware of their duty. Additionally all staff are expected to renew their training every two years to account for changes in legislation and practice.
Recommendation 27: Review and actively promote training and education in relation to online safety and online behaviour in order to encourage both resilience and responsibility amongst internet users.	Online safety is being promoted via schools bulletin, conferences and a growing reputation within NCC. Our Online Safety Officer, working in Children's First, provides sessions delivered directly to schools to young people of all ages. Additionally sessions delivered to schools staff, parents and carers and partner organisations are available. These sessions cover: • How children use the internet and technology • The risks children take online • Harmful content online • Online radicalisation and extremism • Sharing and sexting • Sexual offending against children online • Bullying online • Supporting parents and carers • Supporting children and young people • How to make organisations safer places for children to go online.
Recommendation 28: Support delivery of the Targeted Mental Health in Schools (TaMHS) Conference on 9th October 2018	This conference, aimed at teachers and professionals, to address capacity in schools, meet children's mental health and behavioural needs across Northamptonshire was held in Kettering in October 2018. Improving mental wellbeing amongst young people is an ongoing workstream for Northamptonshire's Mental Health Transformation Board.

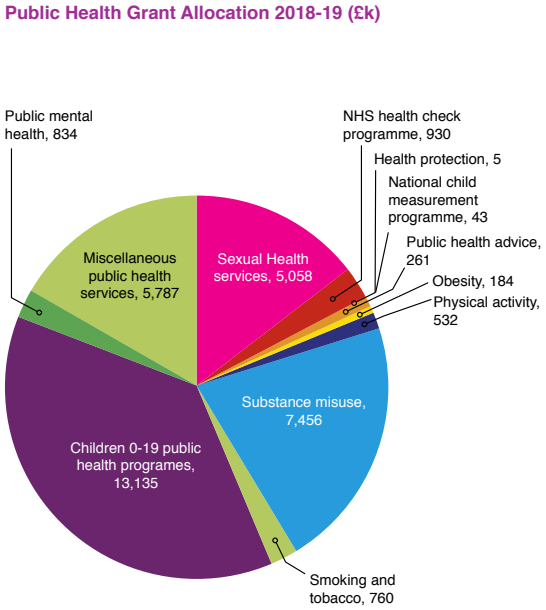
Appendix B – Public health finance

The NCC Public Health grant allocation for 2019/20 will be £33,866,000. This is a £918,000k reduction on the 2018/19 grant allocation of £34,784,000, despite the Northamptonshire population growing by an estimated 6.5k people.

The graph below shows the historic grant allocation and spend per head (The amount in 2015-16 increased by around £8 million to take account of the change of commissioning responsibility for health visiting and Family Nurse Partnership from NHS England to Local Authorities)

Current allocation is not aligned with need so in 2019/20 we will focus on realigning spend to need while ensuring mandatory duties continue.





Appendix C – Acknowledgements

Thank you:

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Caroline Thickens
Colin Thompson
Annette Walker
Nikita Wiseman

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Feedback

Thank you for choosing to complete our short questionnaire about this year's annual report. Your comments and feedback will help us to make decisions about improvements for future reports. Please note all responses are confidential. All responses should be sent to nwiseman@northamptonshire.gov.uk

1. Which sector do you currently work for?

☐ Private ☐ Voluntary/Community

☐ Public ☐ N/A – I do not work for any organisation

☐ Other (please specify)

2. If you work in the public sector, which organisation do you work for?

☐ Clinical Commissioning Group ☐ NHS Trust

☐ County Council ☐ Police

☐ District/Borough Council ☐ Fire and Rescue

☐ Other (Please specify)

3. Did you find the report:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree Strongly	Disagree
Interesting	☐	☐	☐	☐	☐
Easy to read	☐	☐	☐	☐	☐
Useful	☐	☐	☐	☐	☐
Appropriate in length	☐	☐	☐	☐	☐

4. After reading the annual report, do you have a better understanding of the health inequalities issues in Northamptonshire?

☐ Yes ☐ No ☐ Don't know

5. After reading the annual report, do you have a better understanding of how your organisation can contribute to reduce health inequalities?

☐ Yes ☐ No ☐ Don't know

6. If relevant to you/your organisation, do you intend on following any of the recommendations?

☐ Yes ☐ No ☐ Don't know

7. If yes, which recommendation/s will you act on?

8. How do you prefer to receive the annual report?

☐ Printed copy ☐ Online ☐ Other (please specify)

9. Please provide any additional comments regarding the annual report.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

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

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board
30 May 2019

Chief Executive's Report

1. Care Quality Commission

Board members will be aware that work is underway to ensure we are prepared for our CQC inspection in June/July.

We have now been informed by the CQC that they will carry out a provider level inspection of 'well led' on 24 and 25 July. A list of people required for interview has been provided which includes executive and non-executive board members.

We have also been invited to give a presentation to the well-led inspection team at the start of the well-led on-site inspection. This will provide us with an opportunity to present our vision and strategy for NGH, an overview of our performance and plans, and also to share our self-assessment of leadership capacity and capability.

At some point prior to the well-led inspection the CQC will also carry out an unannounced inspection of at least one core service. We have been advised that we should expect a phone call approximately 30 minutes before the inspection team arrives.

2. Local Healthcare System Pressures

We are now seeing record numbers of patients who are delayed in hospital whilst at the same time there is an increase in the number of people attending our emergency department. Currently the percentage of patients over 7, 14 and 21 days is the highest in the Midlands and East.

Patients who are deemed to be medically fit and awaiting discharge do not do well in an acute hospital setting and longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation, which can affect their health after they've been discharged and increase their chances of readmission to hospital. Any patient who stays too long in hospital therefore presents a risk to patient safety for those who are awaiting admission and is also at increased risk themselves. It is important, therefore, that we work closely with our partners in the local healthcare economy to address the reasons for these delays and it is also important to work with partners to ensure that patient in the community have access to services in a timely way so that they avoid admission to hospital where this is possible

We are undertaking a total review of our internal processes and have developed a plan to tackle a number of internal issues. However, it is clear that we do need significant support from our partners if we are to achieve any sustainable improvement. Since last year the pressure at the 'front door' has only increased the imperative to improve better use of care in the community but the last few weeks have seen an overload on the services available.

A great deal of effort has been put into seeing people who attend A and E more quickly and into better assessment in our wards here at NGH, and that proved effective in many ways. We were able to manage to keep waiting times in the emergency department within reasonable levels until recently when the number of patients delayed in hospital started to rise. Our staff are clearly struggling after a winter of pressure and I am concerned about the impact on an already over-stretched workforce. As we consider how best to support our staff it is increasingly important to emphasise the clear linkage between the wellbeing of staff and the care we give to patients both within the hospital and across the wider health and social care economy.

I am concerned also in relation to the impact of this emergency pressure on all our other services and part of the reason for our current internal process review and improvement plan is

to ensure that our managerial and clinical teams have the capacity to focus on other areas of pressure such as the treatment of elective patients and managing the diagnosis and treatment of cancer patients. Our teams also need to be able to help us redesign services for the future as part of our own improvement work and the work in place with partners and the time and space to do this is currently compromised by the extreme pressures on services.

3. Local Authority Update

A plan for two unitary authorities to replace Northamptonshire County Council has been approved by the government. The new authorities will be set up in 2020 during a transition period and will be in operation on 1 April 2021. As well as the two new unitary councils, a children's trust will also be established to deliver services on behalf of the new authorities.

The creation of the two new authorities and a children's trust will provide us with opportunities to work differently and more closely with our partners for the benefit of the community we serve. We already have representatives working with local government colleagues in the area of estates planning and it is likely this aspect of our work with become increasingly important as the unitary authorities are set up and as we consider how to wrap services around the needs of our population at a more local level. Our patients have often told us that they want services to be more joined up from the aspect of primary , secondary and social care and there are now some clear opportunities to make progress in this area. These important considerations will form part of the work that takes place in the Northamptonshire Health and Care Partnership as the system determines how best to implement the local response to the NHS 10 year plan and can link with and support the changes in local government.

4. Collaborative working with KGH

We are steadily making progress with our collaborative working with colleagues at KGH and recently held our first shared governance meeting. There are many models nationally for the ways hospitals work together ranging from loose collaborations to group models and mergers.

We hope to make pragmatic progress in this area and to form a collaboration which clearly provides benefits for patients, stabilises services that are otherwise not sustainable particularly form a workforce perspective and maximises the efficiency of the resources we manage. The work so far has prioritised a joint approach to information, estates planning, some back office functions and a number of key clinical services that present obvious opportunities for collaboration. The positive aspect of this work to date is the obvious appetite for positive change coming from the teams in both hospitals.

5. Our vision and values

Our vision and values were developed with our staff and underpin all we do. Our overall vision of providing the best possible care has served us well as it is simple to understand and has a deal meaning of providing the best possible care anywhere in some instances (such as NGH being the first UK hospital to have the most up-to-date radiotherapy equipment or achieving Pathway to Excellence accreditation) or to providing the best possible care when our emergency department is overcrowded and bed occupancy is over 100%, yet we continue to do all we can to keep patients safe and provide them with the best possible care.

The values that underpin this are that we put *patient safety first*, so we do all we can to avoid harm in the healthcare we provide; we *aspire to excellence* and to do this we must *reflect, learn and improve*, and we know we can only do any of that when we work in a culture of *respect and support for each other* and for our patients.

We are aware that although these values were developed with staff some years ago now, some of our staff are not fully cognisant of our vision and values in terms of understanding what they mean. In order to help raise awareness and complement the existing opportunities to

view them, our values are now on the homepage of our intranet, included on our presentation templates and soon will also be featured in various locations around the hospital as wall art. Staff around the hospital have also said they would value a simple linkage of the values in a narrative statement and the chance to discuss them when they work on their plans each year.

Our clinical strategy is aligned to our vision and values and members of the strategy and partnerships team have been using the staff engagement events to help raise awareness of how our strategic priorities, aims and values come together to form our corporate objectives, which they are helping to develop. This work will lead to a revised strategy for the hospital and a refresh of our strategic aims and overall vision.

The overall purpose of Best Possible Care has been generally understood in recent years and, until this last year, we had seen year on year improvement in the staff survey and in our staff engagement scores. This year, however, we did not do so well in the staff survey and there are other signs of pressure in the organisation such as increasing sickness levels and negative perceptions of management. We are therefore revisiting our People Strategy and the way we manage talent so that NGH can be a place where staff are proud to work, where people and teams are trusted to do their jobs and are accountable and responsible for their work, a place where everyone understands their role in delivering and improving care to align to the overall purpose of Best Possible Care, a place where people recognise the joy of working together to make things better and a place where everyone sees that caring for our people is as important as caring for our patients.

The work to redefine our aims and ambitions in this area is ongoing and we will ensure that our staff have opportunities to be involved. Our collective ability to understand the narrative around what our strategies and plans are now and how we plan to improve is critical. We are aiming to develop a refreshed People Strategy which emphasises the value of inclusion, equality and diversity and will be moving further with our respect and support campaign to ensure it is meaningful to all of our workforce and sets out a series of ambitions that confirm our commitment to the values that we promote in terms of supporting, developing and valuing our workforce.

6. Our staff

I recently helped to judge the second round of our Everyday Hero Awards and am looking forward to presenting the recipients with their superhero capes and awards. Many of the nominations came from our patients and their families and it was humbling to read about the dedication and commitment shown by our staff, despite the pressures they face in their everyday working lives. I also had the honour of presenting a long-serving member of staff with her 40 year badge and have now heard of another who is due to complete 50 years' continuous service with NGH later this year.

Our annual Best Possible Care Awards are highly valued by our staff and nominations are now being sought for this year's Awards, which will be presented at a glittering award ceremony on 27 September 2019. This is always a very special evening which is very much enjoyed by all who attend and I know from the feedback we receive that the awards are highly valued.

There have been a number of events over recent weeks when we have been able to celebrate our staff. There was National Nurses' Day on 12 May and International Day of the Midwife on 5 May, both of which were celebrated at separate events at NGH. With the support of the Cavell Trust, who gave us six tickets, twenty nurses and midwives were able to attend the annual ceremony in honour of Florence Nightingale at Westminster Abbey on 15 May.

On 14 May we held a Health and Wellbeing event where staff were able to find out more about ways to improve their mental and physical health and overall wellbeing. We were supported by a number of local businesses offering free head, neck, shoulder and arm massages and

partner organisations providing advice and information on topics as varied as mental health advice and support, home safety and managing your finances.

7. National and international recognition

A team from NGH were present at the Pathway Conference in America to receive our Accreditation award, where we were celebrated as being the first hospital in the UK to achieve this accolade. Nick Adams, Anisha Kochitty, Lesley Smith and Catherine Dartnell were chosen from our frontline teams to attend as they had provided evidence against each of the six Pathway standards and received a passport stamp. They were excellent ambassadors for NGH and their profession.

Our sustainability lead, Clare Topping, has been instrumental in ensuring that we retained our Investors in the Environment Green Award at the recent Investors in the Environment Awards, when her work was also recognised with a Best Green Champion Award

Holly Slyne and other members of our infection prevention and control team are finalists in the Infection Prevention and Control Initiative of the Year category at the HSJ Patient Safety Awards for the work they have done on protecting patients from infection through improving tropical prophylaxis compliance in surgery. Winners will be announced on 2 July at the ceremony in Manchester.

We have also been successful in being shortlisted in two categories for this year's Nursing Times Workforce Awards, the first is for Best Employer for Recognition and the second is for Best Employer for Learning and Development.

8. Veterans Aware Hospital

Northampton General Hospital has been named a Veteran Aware hospital in recognition of our commitment to improving NHS care for veterans, reservists, members of the armed forces and their families.

The accreditation, from the Veterans Covenant Hospital Alliance (VCHA), acknowledges the hospital's commitment to a number of key pledges, including:

- Ensuring that the armed forces community is never disadvantaged compared to other patients, in line with the NHS's commitment to the Armed Forces Covenant;
- Training relevant staff on veteran specific culture or needs;
- Making veterans, reservists and service families aware of appropriate charities or NHS services beneficial to them, such as mental health services or support with financial and/or benefit claims;
- Supporting the armed forces as an employer.

Ruth Smith, our armed forces project lead, accepted the accreditation on behalf of NGH from Major Paul Shipley MBE RA and Professor Tim Briggs, NHS National Director of Clinical Improvement and Co-Chair of the Veterans Covenant Hospital Alliance.

NGH is now one of 33 members of the VCHA and is part of only the second wave of hospitals to be accredited. The VCHA is a group of NHS acute hospitals which have volunteered to be exemplars of the best care for veterans and help to drive improvements in HS care for people who serve or have served in the UK armed forces and their families. In addition to their work for veterans and forces families as patients, Veterans Aware hospitals also work with the existing initiatives Step Into Health and the Employer Recognition Scheme to ensure that NHS organisations are 'forces' friendly' employers.

9. Cyber Security

We were recently made aware of a potential cyber-attack on NHS systems. I am pleased to report that our IT teams initiated a rapid response and installed the emergency patches released by Microsoft with immediate effect to minimise the risk to our systems.

10. Quality Improvement

We have supported quality improvement as a unifying theme for TeamNGH for a number of years. The newly relaunched MSC in Quality Improvement and Safety is a testament to this and there are many examples of innovative work throughout the hospital. Our transformation programmes under the umbrella of the Changing Care at NGH programme are also based on the principle that improving the quality of services in a iterative and scientific way will reduce waste in resources and we also have a team who are set up to work with teams to train them in service improvement methodology .

Sometimes, however, we need to consider how to realign our efforts around a pressing problem. In the context of the current pressures we face in the urgent care pathway we are bringing together a number of teams to realign our urgent care programme and to clarify the quality improvement offer.

We know we need to ensure that we re-energise our staff to improve the quality of care throughout the urgent care patient pathway within the hospital and at the referral to other services. We are just coming to the end of a 4 week programme to set out what a programme of transformation will look like for the next 3 months. This will build on the excellent work done already in many areas and on the concept that improvements in healthcare require a constant process of learning and reflecting in order to improve.

We have been listening to staff on the ground, working alongside experts in this area and will formally launch the new programme in the next couple of weeks. This will be led by key members of the executive team. We know there are many services in the hospital that are impacted by urgent care pressures and we need to ensure that we balance the needs of all the patients who need these services alongside the needs of those patients accessing urgent care. In view of the current pressures it is clear that benefits of improving the urgent care pathway for both patients and staff will extend to all services that NGH provides.

Dr Sonia Swart
Chief Executive

Report To	**Public Trust Board**
Date of Meeting	**30 May 2019**

Title of the Report	**Medical Directors Report**
Agenda item	**8**
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. Consultant job plans
d. Thrombosis
e. Incident reporting
f. Resuscitation and mental capacity assessment

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 Mayt 2019

1. Introduction

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

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

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

2. Risk

The principle risks to delivering high quality and timely patient care rated 15 and over are 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
368	Risk of reduced patient safety when demand exceeds capacity	20	15	Quality Governance
1757	Escalation areas budgeted for limited periods may remain open for extended periods	16	16	Quality Governance
1782	Venous Thromboembolism: compliance	16	16	Quality Governance
1955	Deteriorating Patient Care Lack of support / guidance in training to support staff in assessing and managing deteriorating patients across the Trust.	15	15	Quality Governance
1756	January 2019 new model commenced and has reduced medical waits. Admission waits remain the same despite being in the middle of winter which equates to a reduction that will be more evident in spring/ summer	20	15	Finance & Performance
2001	Commissioning for Quality and Innovation (CQUIN)	20	20	Quality Governance

	Risk of financial loss and compromised quality, inability to meet contractual/quality requirements due to a failure to deliver on the CQUIN indicators			
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.	15	15	Quality Governance

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	0
Never Events	1	3	1	0

3.ii New SI and moderate investigations

There were 3 serious incidents reported on STEIS during March and April 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 divisional governance meetings, CQEG and QGC.

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

2 cases of newborn babies requiring transfer to a tertiary centre for cooling have been referred to HSIB. This is a new process, and our region is the penultimate for introduction in the country. The trust is in close communication with the HSIB team to manage the interface between normal investigation procedures and this approach safely and effectively. An example of the differences is that HSIB investigations often run for over 6 months.

3.iii Thematic issues

No new themes have been identified from incidents since January. The previously recognised themes of delayed recognition of the deteriorating patient, with associated recurring issues around diabetic control, fluid management, safeguarding and escalation/end of life care continue to be addressed holistically through the deteriorating patient oerating group. The roll out through inpatient areas has been confirmed. Issues relating to the failure to act upon investion results are being addressed through work led by the associate medical director for medicines and mortality.

4. Mortality

The rolling 12 month HSMR to January 2019 for the trust remains within the “expected” range at 102.9. As requested at public board in January, an update against the key themes identified in trust wide mortality review 12 is presented here.

4.i Palliative care coding in secondary malignancy

SMR for patients with a primary diagnosis of secondary malignancy started to rise for the rolling year to May 2018 is still higher than expected 158.6 for the rolling year to Jan 2019. Following the publication of the May data, a deep dive of Dr Foster data highlighted that at NGH patients with secondary malignancy had less palliative care coded than the national picture for all spells.

Aim: Use the Dr Foster investigation pyramid to look at patients with a primary code of secondary malignancy by:

- Agreeing a local standard to record and code palliative care delivered by CNS teams in addition to Specialist Palliative Care Teams - completed
- Reviewing the case mix in detail – completed, not a contributing factor

- Considering structure of care in the acute and community setting – completed, a lack of available hospice beds remains an issue as is reduced community social care provision. An agreed OP pathway for patients with a new diagnosis of cancer started in March 2019 and it is hoped this will improve the pathway for patients with a poor prognosis by signposting directly to community palliative care services.
- Process of care – SACT data for NGH is within expected limits. A delay to oncology review within 24 hours has been highlighted and this has been addressed by the introduction of ICE referrals (started March 2019). The 2 largest groups within this basket are patients with obstructive jaundice and pleural effusions. The pathway for obstructive jaundice has been reviewed and a recommendation made to increase access to ERCP lists – this action has been passed to the appropriate clinical lead. An audit of the pleural effusion pathway is underway.

The project lead provides a written report to MRG bi-monthly (next due June 2019).

4.ii Sepsis

SMR for sepsis is currently as expected for the rolling year to Jan 2019. The sepsis work stream has been in place at NGH since the profile was raised nationally and to fulfil the requirements for the national CQUIN. It is also considered as part of the Deteriorating Patient work stream and as part of a Trust wide Mortality Case Note Review in 2017. The changes to clinical coding rules have been considered alongside the assessment of the quality of clinical care.

Aim: To improve the documentation of sepsis in the clinical record to enable accurate clinical coding by

- Regular review of cases of sepsis (sepsis lead and senior clinical coding staff) to understand more about the evolution of the sepsis diagnosis throughout an admission
- Local agreement that the sepsis nurse can make a statement in the notes to request the clinical staff to review the diagnosis of sepsis if it appears that the diagnosis may be incorrect

The project lead provides a written report to MRG bi-monthly (next due July 2019).

4.iii Clinical care/ documentation/ coding interface

A short first consultant episode of care, as often happens with the model of care at NGH can have a knock on effect on the quality of clinical coding and subsequently HSMR (as Dr Foster data is based on the admitting primary diagnosis).

Aim: To increase the percentage of patients leaving the Nye Bevan Unit with a clearly documented working diagnosis by

- adding an additional field to i-box – went live week commencing 29.04.19
- communicating change and promoting knowledge of the addition to i–box (on-going including local communications, NGH bulletin, Core Brief and visits to the wards)
- Auditing progress – early anecdotal evidence suggests that the addition is welcomed and an initial informal spot audit reported that over 90% of patients on EW ward had a working diagnosis recorded (approx. 60% on WT ward).
- Developing good practice guidance – in progress.

The project group provide a written report to MRG bi-monthly (next due June 2019).

4.iv Frailty

Deep dive Dr Foster data for the rolling year to May 2018 demonstrated that all age ranges showed a rise in relative risk over the previous 6 months but the most marked rise was in those aged over 65 years. The 75-84yrs group were attracting statistically significantly higher deaths than expected given the case-mix of patients (this has now returned to be within the as expected range). In addition the sample of the first 100 consecutive deaths in May 2018 reviewed as part of Trust wide Mortality Case Note Review 12 showed that 24% of the sample were aged 90 years or over.

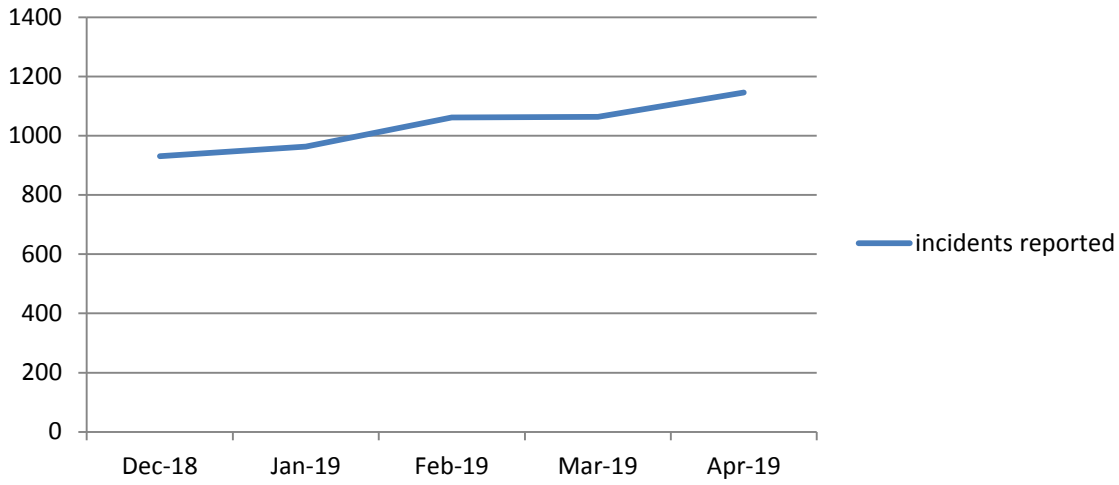
Aim: To explore the impact of patients with a co-morbidity of frailty by

- Identifying themes from Care of the Elderly M&M – themes picked up were failure to escalate (addressed by DPP) and failure to use Amber Care Pathway (addressed by EOL group)
- Further analysis of data for frail elderly patients – readmissions/ multiple admissions in last year of life (underway). Use the data to increase the scope of M&M meetings to include readmissions and patients with multiple admissions - ongoing
- QI project to introduce frailty scoring on admission across the Trust using the Rockwood Score to support identification of patients with frailty, service planning and future communication with community teams - ongoing

The project lead provides a written report to MRG bi-monthly (next due July 2019).

5. Incident reporting

The trust has been a lower quartile incident reported for some time. Since January 2019 there has been a drive coordinated through CQEG to increase incident reporting in a meaningful way. The reporting rates have changes as follows.



Whilst this is an encouraging trend it will be kept under close monitoring.

6. Job plans

The rate of completed consultant job plans signed off within policy continues to rise as the new job planning process embeds.

7. Thrombosis

The upgrade to ePMA which will enforce VTE risk assessment is subject to further slippage on roll out. Testing was commenced in March 2019, identifying significant bugs. Supplier has now applied patch and back in testing. Subject to successful performance in testing roll out by July 2019.

VTE assessment performance reports have resumed following the IT issues which interrupted them in November 2018. There has been no change in performance.

Northampton General Hospital NHS
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Corporate Scorecard 2019/2020 APR

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	83.3%	98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↑		86.3%	88.6%	88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		93.7%	91.9%	92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	→		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	→		97.8%	92.4%	92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	3	0	0	0	0	4	2	0	0
	Compliments	Sheran Oke	-	NGH								4,288	4,335	3,541	4,269	3,639	4,007	3,647
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		86.6%	93.8%	92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		129	58	79	60	118	174	142	299	330	400	420	343
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↑		5	2	1	3	15	17	19	30	49	33	22	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		13	7	6	16	2	3	3	4	5	4	4	11
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		39	35	12	19	36	10	10	24	12	11	20	31
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		42	40	28	16	34	27	15	20	20	17	29	41
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		37	31	19	13	25	25	13	16	17	13	20	30
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↓		90.8%	69.9%	72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↓		78.1%	23.3%	18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		97.4%	92.6%	95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		97.1%	100.0%	100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↓		94.3%	96.1%	97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↓		90.0%	78.5%	100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.3%	74.6%	78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	→		97.1%	68.4%	100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		87.5%	90.0%	81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↓		89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	↑		0	0	0	0	0	0	0	0	1	3	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.7%	99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	

Northampton General Hospital NHS
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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				96.4%	93.5%	92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	76.4%	96.6%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				91.6%	87.7%	97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%
	Unappointed Follow Ups	Debbie Needham	=0	NGH											8,608	8,723	9,957	10,119
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			11.7%	12.1%	12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	4.4%	4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			11.8%	12.6%	13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.1%	14.3%	14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			9.5%	9.8%	10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			12.7%	13.7%	14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.5%	7.4%	8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			89.1%	89.5%	89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%
	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%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.8%	84.9%	85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			86.7%	86.7%	85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			63.5%	63.5%	58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			46	70	89	107	128	153	167	195	209	230	266	20
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	74
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH										64.5%	65.9%	65.5%	69.0%	39.0%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH										39.1%	40.4%	41.0%	41.0%	42.8%
	Maverick Transactions	Phil Bradley	=0	NGH						27				15	21	21	19	
	Waivers which have breached	Phil Bradley	=0	NGH			2	2		0				1	0	0	0	
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			62.3%	56.5%	51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			31.3%	29.3%	22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.9%	19.2%	18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.5%	3.4%	4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	3.0%	3.3%	3.6%	2.9%

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.3%	15.7%	16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	16.5%	15.9%	16.8%	13.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		88.8%	90.0%	87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.3%	34.1%	28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑		99	101	0	104	104	106	106	106	105	106	104	103
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		97	97	98	98	100	100	104	104	104	104	104	104
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		79	25	25	45	47	66	36	35	53	51	35	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		94.9%	100.0%	100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.0%	5.6%	5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	1	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-		→		3	4	3	2	3	0	0	3	7	1	0	0
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		97.8%	96.4%	96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	94.1%	93.1%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	↓		1	2	2	1	2	0	0	1	0	0	0	2
	MSSA	Sheran Oke	<=1.1	NGH	↓		1	0	2	0	0	2	1	0	1	2	0	5
	New Harms	Sheran Oke	<=2%	NGH	↑							2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↓		4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→									85.6%	88.1%	90.7%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓									62.0%	59.7%	56.7%	57.2%	53.0%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓									89.2%	89.2%	67.5%	72.6%	70.6%

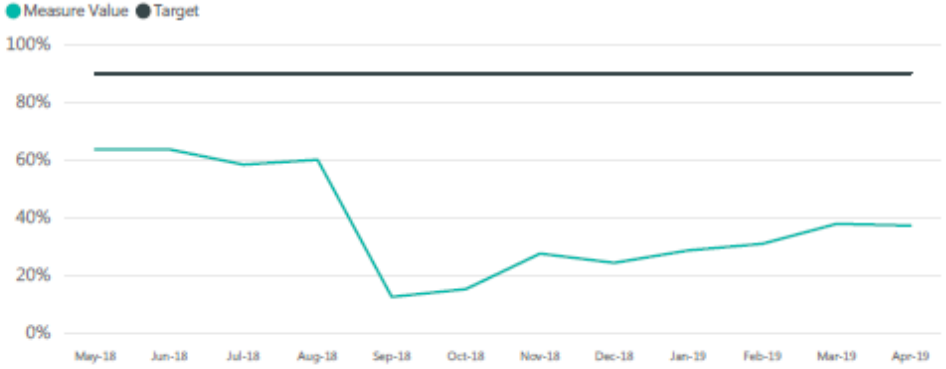
Data not provided

No data - pre KPI implementation

Job plans progressed to stage 2 sign-off

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
April 2019	90.0 %	37.2 %	↓	Matt Metcalfe

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
63.6 %	63.6 %	58.3 %	60.0 %	12.5 %	15.2 %	27.5 %	24.3 %	28.6 %	30.9 %	37.8 %	37.2 %

What is driving under performance?

The data was rebased in September 2018to reflect compliance in all divisions to date, of 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. 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 enter the new Financial year, job plans that were reviewed early in the process are now out of date again, reducing the compliance in month. This relates to a small number of individuals.

Actions completed in the past month to achieve recovery

Within April 2019 regular Executive Consistency Committee (ECC) meetings continue to take place. Further improvement in WCO&H is acknowledged as new job plans are being agreed. There is further reduction in compliance within the Surgical Division as new plans are added. Despite low compliance an ongoing improvement of job plans complying with 12 PAs or less continues (from 48 plans above 12PAs to 17 plans – a 65% improvement). Of the 17 outstanding, 10 job plans are currently in discussion. New job plans have now been entered onto the system for 85% of Consultants and of these 58% have reached partial sign off.

Exception report written by

SmillieE

Timeframe for recovery

July 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 within quarter one 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.

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Associate Teaching Hospital

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Report To	**Public Trust Board**
Date of Meeting	**30 May 2019**

Title of the Report	**Draft Quality Account 2018/19**
Agenda item	**9**
Presenter of Report	Mr. Matthew Metcalfe, Medical Director
Author(s) of Report	Mrs Jane Bradley Deputy Director Patient Safety & Quality
Purpose	• To provide an overview and update of 2018/19 Quality Account • Request Delegated authority to upload the final version of the Quality Account to NHS Choices by 30 June 2019

Executive summary

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. Quality Accounts are both retrospective and prospective. They reflect on the previous year's information regarding quality of services and look forward, explaining the Trusts priorities for quality improvement over the coming year.

Appendix 1 contains a first draft of the Quality Account 2018/19. This report details the sections contained therein and the information that is required.

The inclusion of graphics and final production format have been agreed and will be included in the final version when the narrative is completed and approved and external stakeholder feedback has been received and considered.
The following are time specific milestones and actions to be achieved.

- External Audit limited assurance report
- Stakeholder feedback – to be received 30 May 2019
- Consideration of external stakeholder feedback and refinement of Quality Account 07 June 2019
- Final graphics to be updated 14 June 2019
- Upload the final version of the Quality Account to NHS Choices by 30 June 2019

Related strategic aim and corporate objective	All
Risk and assurance	Provides assurance that the statutory requirement to produce a Quality Account with mandated content by the due deadline will be met.
Related Board Assurance Framework entries	BAF – please enter BAF number(s)
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)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	The Health Act 2009 requires all NHS providers of healthcare services in England to provide a Quality Account each year

Actions required by the Trust Board

The Trust Board are asked to:

- Note the draft 2018/19 Quality Account
- Provide delegated authority to upload the final version of the Quality Account to NHS Choices by 30 June 2019

Northampton General Hospital NHS Trust

Public Trust Board
May 2019
Quality Account 2018/19

1. Introduction

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. It also identifies areas for quality improvement in the coming year which should focus on all the domains of quality;

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Quality Accounts are both retrospective and prospective. They look back on the previous year's information regarding quality or services and look forward, explaining the Trusts priorities for quality improvement over the coming year.

2. The Quality Account must be uploaded to the NHS Choices website by 30 June 2019; but prior to this will be required to be signed off by Trust Board, Audit Committee and our external auditors. The Quality Account should be sent for engagement with patients, staff, shadow governors and it must also be submitted for review and comment by local partners/ stakeholders, including:

- NHS Nene and Corby Clinical Commissioning Group
- Healthwatch Northamptonshire
- Northamptonshire County Council Health Social Care Overview and Scrutiny

Quality Account 2018/19

In preparing the 2018/19 Quality Account attention is given to a number of documents:

- The Quality Accounts toolkit (Toolkit)
- NHS England letter dated 17 December 2018 on Reporting Arrangements 2018/19 (NHSE)
- Guidance for NHS Trusts on arrangements for external assurance 2014/15 (External)
- Quality Accounts: a guide for Local Involvement Networks (LINks); Quality Accounts: a guide for Overview and Scrutiny Committees;
- Other NHS Trusts Quality Accounts (Others (Stakeholders)
- Health Act 2009, NHS (Quality Accounts) Amendment Regulations 2010, NHS (Quality Accounts) Amendment Regulations 2011, NHS (Quality Accounts) Amendment Regulations 2012 and NHS (Quality Accounts) Amendment Regulations 2017 (HA Reg)
- Previous NGH Quality Accounts including comments from external stakeholders in previous Quality Accounts (Previous)

Recommendations

The Trust Board is asked to:

- Note the draft 2018/19 Quality Account
- Provide delegated authority to upload the final version of the Quality Account to NHS Choices by 30 June 2019

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QUALITY REPORT
2018/2019

northamptongeneral.nhs.uk

Providing the Best Possible Care

QUALITY ACCOUNTS 2018/2019

1 PART ONE INTRODUCTION

The purpose of this quality report is to illustrate to our patients, their families and carers, staff, members of local communities and our health and social care partners, the quality of services we provide.

The report is published each year. We measure the quality of services we provide by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

Part One of this report opens with a statement on quality from our Chief Executive, Dr Sonia Swart, Medical Director Mr. Matt Metcalfe and Director of Nursing and Midwifery Ms Sheran Oke.

In Part Two, we have provided details of our priorities for quality improvement that we intend to deliver during 2019/21 and details of a number of Statements of Assurance regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of NHS Improvement.

Part Three describes how we performed against the quality priorities set for 2018/19, together with performance against key national priorities in line with NHS Improvement Risk Assessment Framework.

The closing section outlines feedback from our key stakeholders.

Thank you for taking the time to read our quality report. If you would like to comment on any aspect of this document, we would welcome your feedback.
You can contact us at: pals@ngh.nhs.uk

1 STATEMENT OF QUALITY

Dr Sonia Swart
Chief Executive

Matt Metcalfe
Medical Director

Sheran Oke
Director of Nursing, Midwifery and Patient Services

Dear All

Welcome to the Quality Account of Northampton General Hospital NHS trust for 2018/19. We present updates on our progress against our quality priorities for the year in review alongside our priorities for the year ahead, which will be reflected in the Quality Improvement Strategy for 2019-2021. Beyond these, we are delighted to share some of our key achievements during the year, the highlights of which we touch upon here. These illustrate our commitment to providing the best possible care for patients which remains our overall aim. Our efforts and improvements are framed against our key values.

Patient safety above all else

There have been two major developments for our stroke service. Firstly it has been expanded to receive and care for all acute strokes in the county rather than just the hyperacute cases. Secondly the trust has led some of the first mechanical thrombectomy treatments in the country for stroke working in partnership with Oxford University Hospitals. Through all this the service has retained its SSNAP A rating.

Safe and effective emergency flows are important for all our patients and during the year the 60 bedded Nye Bevan emergency assessment building was completed to transform the way we deliver care for our urgent patients. Recognising the national shortfall in acute physicians the medical model has been delivered through the use of consultants of many medical specialities with

accreditation and experience of acute care and on a roster which facilitates early consultant review and continuity of care.

We continue to actively work on reducing patient harms and have seen reductions in our falls with harm, incidence of hospital acquired pressure ulcers and infection control metric including the rate of Clostridium Difficile.

We have also actively engaged in the maternity modernisation agenda aiming to ensure that the continuity of care model is in place by 2021

We aspire to excellence

The trust is the first UK hospital to achieve accreditation as a Pathway to Excellence hospital by the American Nurses Credentialing Centre and also continues to progress the Nursing and Midwifery ward and department accreditation and accreditation with increasing numbers of wards receiving the much valued 'Best Possible Care' ward status. The promotion of this work at national and international level has resulted in 12 national and international awards and a number of poster presentations at this level. These programmes are designed to drive improvements in core quality standards and to motivate the clinical workforce to be proud of these achievements.

The trust continues progress on the pathway towards university teaching hospital status with the medical college at the University of Leicester. Posts have been advertised for senior lecturers with honorary NHS contracts at NGH. A candidate for the associate non-executive director role from the university, with excellent research and educational credentials, has been nominated to sit on the trust board and the appointment is in process.

For the third consecutive year NGH have been recognised as the most successful NHS Trust at the world's largest patient safety conference, the International Forum on Quality & Safety in Healthcare.

In 2019 NGH colleagues presented sixteen posters at the conference on behalf of the hospital – the largest number of QI projects presented of any NHS Trust in England.

Likewise collaboration with the university of Northampton continues at pace, with a Master's Degree in quality improvement acknowledged as a flagship collaboration project. This programme is offered to health and social care professionals who wish to develop a greater understanding and expertise in quality improvement and patient safety. The dissertation for this Master's degree is an extended improvement project. Graduates of this MSc will be the leaders of tomorrow, equipped with the skillset and knowledge to lead and deliver the complex change the NHS will be required to deliver.

We reflect, we learn, we improve

The trust has developed a comprehensive care plan to support our clinical teams in recognising and responding to deteriorating patients in timely and holistic manner. This has been piloted and is being rolled out trust wide.

Closer working between the quality improvement and governance teams is allowing us to deploy our improvement resource where it is most needed responsively. In addition to the example of the deteriorating patient work described above there has been excellent work together on the "clot busting" campaign promoting awareness among staff and patients of the importance of thromboprophylaxis and patient empowerment.

Inter-speciality referrals for inpatients are now made electronically, which allows for more timely review and audit of referrals and outcomes.

We have further developed our partnership with the University of Northampton to enable us to grow our nursing and midwifery workforce and were a pilot site for the new Nursing Associate role with 14 Nurse Associates deployed within the organisation. This is part of a programme to address shortfalls in our healthcare workforce which includes imaginative ways of recruitment to challenging areas and the utilisation of apprenticeships.

We respect and support each other

Sustainable excellence in care is underpinned by a resilient workforce, and this is a key priority for the trust. For example, over the year we have seen an 8.5% increase in consultant numbers. Alongside recruitment drives, we have strengthened staff development opportunities with development masterclasses delivered for multiple staff groups by the quality improvement and organisational development teams.

For our clinical leadership teams, we have built on the previous in house leadership programmes with a new partnership with Momentum workshops to support leadership of effective change and working across boundaries.

We continue to develop our staff recognition schemes including further development of the DAISY scheme to celebrate the compassionate care our nurses and midwives give with nominations coming from patients and families and have used the same methodology to reward other staff groups for exceptional care through our Everyday Heroes awards.

We remain a key partner in the Cavell Nurses' Trust membership programme which provides support for UK nurses, midwives and healthcare assistance when suffering a range of distressing circumstances.

There has been continued work on health and wellbeing for staff bringing support for mental health issues and a sign up to the 'Time to Change' pledge to signal this. Our campaign on respect and support continues to develop and will require further work in the coming year.

Despite our commitment to Best Possible Care and the values that drive this we know there is more to do on many fronts. The challenging environment provided by increasing emergency pressures has stretched our staff and resources and unfortunately we were not able to provide emergency care as quickly as we would like and we continue to focus on this during 18/19. There has also been an impact on waiting times in other areas and again were are determined to improve this and improve the experience of cancer patients some of whom who wait too long to commence their treatment. We also know that we have more work to do to improve the experience of our patients and our staff.

Looking forward to 2019/20 and after wide consultation with staff and stakeholders we have developed Quality Priorities that we hope will address some of our key issues. Some of these will be extended from previous work and some will be new. These include:

Patient Safety above all else

- Improve Freedom to Speak up engagement
- Improve the safety focus of huddles
- Reduce further falls, C difficile ,pressure ulcers
- Improved care of the deteriorating patient
- Better outcomes in Maternity

We Aspire to Excellence

- Improvement in 7 day services
- Improved cancer patient experience
- More effective care for patients with Urological and Orthopaedic conditions through GIRFT

We reflect we learn we improve

- Increase reporting of incidents in order to support a learning organisation
- Comprehensive programme of mortality reduction through reviewing deaths

We respect and Support each other

- Increased focus on staff health and wellbeing
- Better communication for staff and patients

We hope this quality account provides a clear picture of the importance of quality and patient safety at Northampton General Hospital and that you find it informative.

To the best of our knowledge we confirm that the information provided in our Quality Account is accurate.


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athway
Proud
TeamNGH

1

STATEMENT OF DIRECTORS RESPONSIBILITIES

Alan Burns
Chairman

Alan Burns

Dr Sonia Swart
Chief Executive

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality Account, directors have taken steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

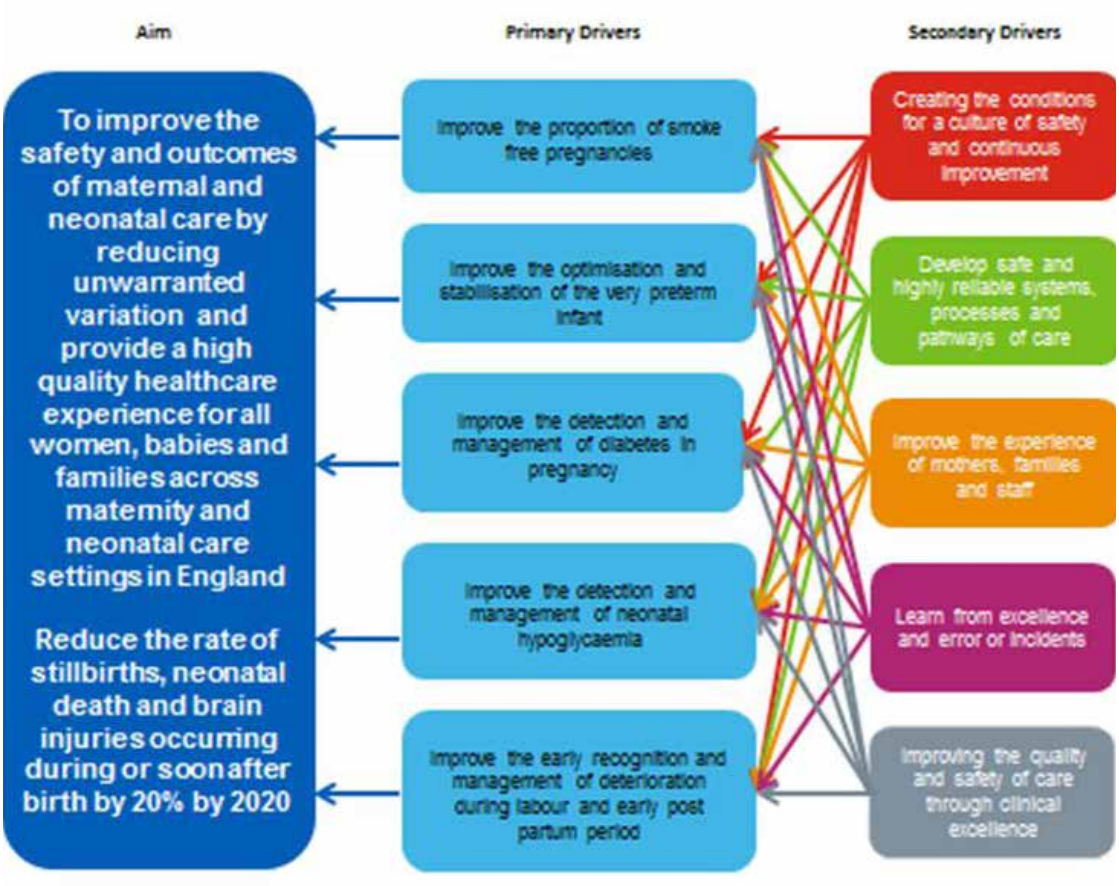
By order of the board

1 OUR PLAN AND ACTIONS FOR 2018/19

GOOD NEWS STORIES FROM THIS YEAR

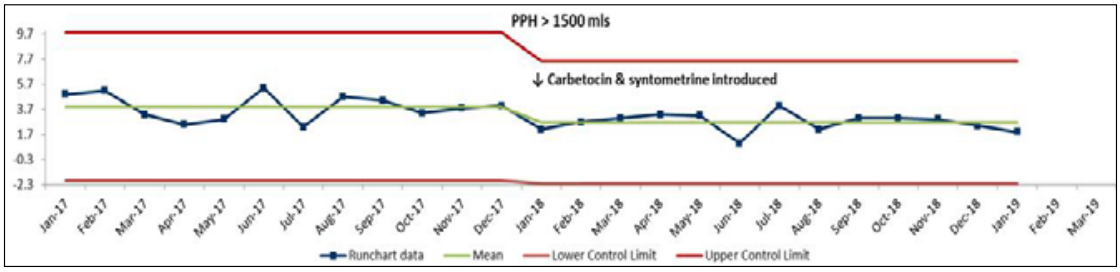
National Maternal and Neonatal Health Safety Collaborative (MatNeo)

The collaborative was announced by the Department of Health and supports the aims of the NHS England's Better births maternity review and the maternity transformation programme



The Maternal and Neonatal Health Safety Collaborative is a three-year quality improvement programme, supported by NHS Improvement. Northampton General Hospital are in Wave 2 of the programme which commenced in May 2018.

- Introduction of Maternity Safety Huddles
- Introduction of 10 @ 10
- Learning from Excellence
- Collaborative working between anaesthetists, obstetricians, midwives and theatre staff to agree and revised postnatal pathway, supported by a successful business case
- A reduction in the percentage of women having a postpartum haemorrhage of > 1500mls from a mean of 3.9% to 2.7%



Staff Engagement - Kitchen Table events

Receiving MatNeo Certificate from Phil Duncan – Programme Director of NHS Improvement

CNST Maternity Incentive Scheme

The CNST Maternity Incentive Scheme was launched by NHS Resolution in 2018 to incentivise Trust Boards to fund safety initiatives in support of the Government's ambition. 10 maternity safety actions were agreed by the National Maternity Champions and Trusts that were able to demonstrate the required progress against all of the following 10 actions were awarded a Maternity Incentive Scheme payment.

- Use of national Perinatal Mortality Review Tool to review all perinatal deaths
- Submission of the Maternity Services Data Set
- Transitional care facilities and implementation of the Avoiding Term Admission programme
- Effective system of medical workforce planning
- Effective system of midwifery workforce planning
- 100% Compliance with all 4 elements of the Saving Babies' Lives care bundle
- Use of patient feedback mechanisms and actions taken in response
- 90% of each staff group attendance at multi-professional maternity emergencies training in the last year
- Trust safety champions (obstetrician and midwife) meet bi-monthly with Board level champions to escalate identified issues
- 100% of qualifying incidents reported under NHS Resolution's Early Notification scheme

Northampton General Hospital was the only maternity service in the East Midlands who were successful in demonstrating compliance against all 10 maternity safety actions.

Better Births

Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives.

Following a number of stage engagement sessions and in conjunction with the Local Maternity Services Board (LMS), the following continuity models will be implemented in 2019/20

- Horizon Team – caseloading team to care for women who have had a previous stillbirth, neonatal death or recurrent miscarriage
- Phoenix Team – hybrid continuity team caring for women who are socially vulnerable

Maternity Quality Priorities for 2019/20

Building on the work streams started in 2018/19

Avoiding Term Admissions into Neonatal Units (ATAIN)

NHS Improvement have identified that over 20% of admissions of full term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together we can reduce the harm caused by separation.

The maternity and neonatal services at NGH hold a monthly Avoiding Term Admissions into the Neonatal Unit (ATAIN) review meetings. Whilst some transitional care services are provided on the postnatal ward, the reviews demonstrate that many babies who are suitable for transitional care are having to be separated from their mothers and either admitted to the neonatal unit or attend the neonatal unit for the administration of IV antibiotics.

An action plan is in place and a dedicated Neonatal Transitional Care Unit will be developed in early 2019/20.

Aim: To reduce the separation of mothers and babies when babies require transitional care (need to identify baseline and improvement)

Maternity Triage

As part of the Trusts learning from incidents and claims (Darnley v. Croydon Health Services NHS Trust the maternity services have reviewed the provision of maternity triage and an action plan has been developed to introduce a more formalised approach to maternity triage. This will be based on the Birmingham Symptom-specific Obstetric Triage System (BSOTS).

Each Baby Counts

The Each Baby Counts report demonstrates the complex nature of maternity care and likens it to the aviation industry. The report highlights the need to focus much more on human factions and situational awareness, which is something the aviation industry has done very well for some time.

We currently have 72 members of staff who have undertaken human factors training facilitated by Global Air Training for Health and a further two training courses are planned for 2019/20.

During 2019/20, human factors and situational awareness processes will be implemented on the labour ward and will be incorporated into all obstetric skills drills training.

Saving Babies Lives Care Bundle:

Version two of the Saving Babies' Lives Care Bundle was released in March 2019 and has been produced to build on the achievements version one. The second version brings together five elements of care aimed at improving the safety of women and babies.

- Reducing Smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement
- Effective fetal monitoring in labour
- Reducing preterm birth

Quality Improvement projects will be developed around all five elements of the care bundle.

Quality Improvement training

To support all staff with their ideas for improvement, the QI team in NGH deliver and support numerous academic and professional programmes. Participants on each of these programmes are supported with the delivery of a QI project within their work area. These programmes are:

- **Registrar Leadership & Management Programme** – In 2018/19, we delivered the largest programme to date. This is a 12 week advanced leadership programme for Specialty Registrars in the East Midlands region, which aims to improve leadership capability and capacity for our Consultants of Tomorrow. There were 30 participants in the most recent programme, double that of previous years.
- **Aspiring to Excellence SSC** – A 2 week student-selected component (SSC) offered to 5th year medical students from Leicester Medical School. This programme teaches the fundamentals of patient safety & quality improvement, enabling them to deliver a small improvement project in their area of interest.
- **Junior Doctors' Safety Board (JDSB)** – This programme coincides with the intake of junior doctors each August. Juniors are offered support to lead their own improvement project.
- **Trust Grade Development Programme** – Commencing in 2019, this new programme has been tailor-made for Trust Grade doctors in the East Midlands, following the success of the Registrar Leadership & Management Programme. The programme offers specialist sessions on Returning to Training/CESR programme, Navigating the NHS, Building Personal Resilience and Managing Change in the NHS. All participant are supported with to deliver a QI project.

- **Esther White and James Stonhouse programmes** – Delivered by Organisational Development, these programmes have a bespoke QI component delivered by the QI team.
- **Shared Decision Making** – As part of the Pathway to Excellence programme, Shared Decision Making Councils are supported to deliver QI projects in their work area. Each council receives QI training from the team.
- **Stroke Journey** – A longstanding programme delivered by the Community Stroke Team. In 2019, NGH QI team were invited to support the delivery of this programme, supporting participants to deliver QI projects as part of the programme. There were 15 participants in 2019, with 6 projects in total.
- **Creating Excellence SSC** – Commencing in 2019, NGH have been invited to lead a new student-selected component with Leicester Medical School. This SSC will be offered to all 3rd year medical students and runs over a 4 week period.
- **Medical Student Patient Safety & Quality Improvement teaching** – Commencing in 2019, NGH have been invited to co-deliver a bespoke patient safety and quality improvement curriculum for 1st year students, alongside University Hospitals Leicester and the Medical School. This programme will be delivered to ca 300 students.
- **RCN Leadership Programme** – A longstanding programmed facilitated by Practice & Professional Development, the NGH QI team have been invited to support the quality, service improvement and redesign projects delivered as part of this programme.
- **Band 5 Programme** – The NGH QI team deliver bespoke training to Band 5 nurses on this programme. The session covers the fundamentals of patient safety.
- Foundation Year 2 Patient Safety teaching – As part of the FY2 curriculum, the QI team in NGH facilitate the delivery of bespoke patient safety teaching.

We encourage staff of all disciplines to join the programmes on offer; however we recognise that some staff may not be able to fulfil the time commitments required to complete these programmes. Therefore, in autumn 2018 the QI team commenced with a new monthly teaching slot for QI, opened to staff of all disciplines. Between October 2018 and March 2019 we have trained 335 staff in Quality Improvement Fundamentals (QI methodology, QI project management and Measuring for Improvement).

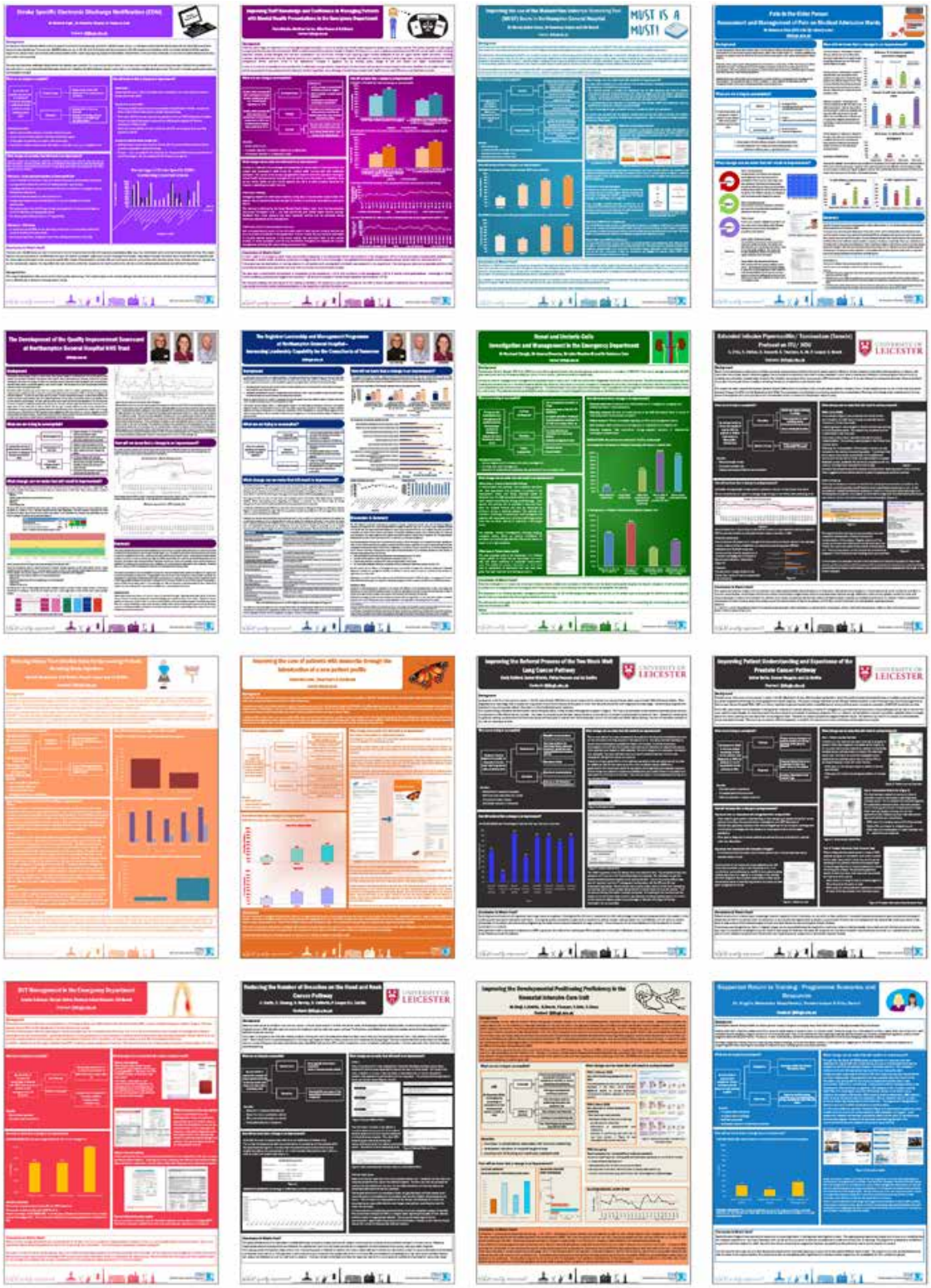
Conference success

For the third consecutive year NGH have been recognised as the **most successful** NHS Trust at the world's largest patient safety conference, the International Forum on Quality & Safety in Healthcare. In 2019 NGH colleagues presented sixteen posters at the conference on behalf of the hospital – the largest number of QI projects presented of any NHS Trust in England. The next largest number of posters presented was 12 – presented by the Royal Free Hospital.

The 16 posters presented at the International Forum on Quality & Safety in Healthcare 2019 (Glasgow, UK)

These sixteen posters reflect a small proportion of the large amount of ongoing improvement work supported by the NGH QI team. In March 2019 there were 81 ongoing QI projects recorded in the QI project repository. All 81 projects are aligned to corporate objectives and aim to improve the quality of care we deliver.
In Summer 2018 NGH were also recognised as the most successful organisation at the Patient Safety Congress. Fourteen QI project posters were presented at this conference – the largest number of any organisation in attendance.

With our continued success on the national and international platform, NGH has become renowned as a centre for excellence for quality improvement. Several large NHS organisations, including teaching hospitals, have sought advice from our expert QI team on how to embed local quality improvement work within their organisations.



1

MSc Quality Improvement & Patient Safety

Commencing in October 2019, NGH will deliver a new MSc Quality Improvement & Patient Safety, in collaboration with the University of Northampton.

This programme is offered to health and social care professionals who wish to develop a greater understanding and expertise in quality improvement and patient safety. The dissertation for this Master's degree is an extended improvement project.

The programme is offered on a part time basis over a 3 year period. Our mantra is that a strong understanding of QI and its application in healthcare is a fundamental requirement for any current or future leader in the modern NHS. Graduates of this MSc will be the leaders of tomorrow, equipped with the skillset and knowledge to lead and deliver the complex change the NHS will be required to deliver.

The programme will be offered to 20 students per year. Since commencing advertisement of the programme in January 2019 we have received 15 strong applications for the programme and look forward to a full cohort of 20 for October 2019.

Consultant Engagement

For the purposes of the quality account, good clinical engagement is defined as a relationship between the consultant body and the trust senior leadership based upon trust, open channels of communication with shared ownership of services and transparency of decision-making.

The fundamental aims of good clinical engagement are sustainable optimisation of the quality and efficiency of patient care. Inherent in the sustainability is a clinical workforce with a manageable and enjoyable workload.

The imperative to transform the way NGH works in the face of increasing pressures on the NHS acute sector, including emergency pressures and austere financial climate, requires strong consultant engagement.

Whilst at trust level the consultant staffing levels are comparable with regional trusts there are some significant shortfalls in some specialities. Also the number of non-consultant grade doctors is lower regionally than the national average and can negatively impact on a DGH compared to regional teaching hospitals.

Relentless winter pressures for bed holding consultants in particular have resulted in frequent urgent requests for additional clinical activity over and above job plans which when sustained over many months and combined with workforce gaps result in significant fatigue.

Workforce gaps inherently necessitate a constant balance of risk approach to clinical priorities. For example, any increase in consultant resource moved to support emergency patient pathways (a key priority for the trust and the NHS nationally) creates or exacerbates capacity gaps in the delivery of planned elective activity.

During 2017/18 there has been a clear willingness of the consultant body to respond to patient safety challenges as evidenced by the extraordinary efforts made by many through the winter of 2017/18.

This willingness of the consultant medical workforce to continue to be agile and adaptive will continue to be developed and harnessed as a priority for Trust Board executives, who will work with the energy and commitment of the consultant body in such a way that NGH patients and staff benefit from their clinical expertise in driving improvements in quality and efficiency.

Consultant Development Programme

Having received feedback from consultant colleagues who recently joined NGH and completed the consultant foundation programme including feedback from colleagues who have attended the Consultant suppers, during 2018/ 19 the Medical Director has refreshed the Consultant induction programme and updated the content to address the core requisites of a broader consultant leadership programme reflecting the dynamic changes in the NHS and NGH, making the content of the masterclasses relevant for all consultant staff regardless of their leadership position or experience.

The rolling programme will be delivered via internal and external subject matter experts as a bespoke 12 month modular masterclass course.

The aim of the programme is to provide jobbing consultants with a sense of the wider issues facing the NHS and NGH and introduce them to the management and leadership issues they will require to perform effectively as a Consultant, including a session within the Simulation Suite specifically addressing how to manage behaviours.

Professional training has traditionally, and not unreasonably, focused on the specific clinical skills and knowledge of medicine, rather than knowledge of how to work on the system in which it is practised. Therefore I am hopeful that the masterclass content will help equip Consultant colleagues to respond to such challenges and provide a broader understanding of the rapidly changing landscape in which we work.

Shared Decision Making:

Shared Decision Making (SDM), or shared governance, is a management process that empowers frontline staff and all members of the healthcare workforce to have a voice
The principles are: **Responsibility** – Staff are given the responsibility to manage Nursing & Midwifery decisions and to contribute to the Trust's vision and objectives at local level **Authority** – Staff are given the authority to act and this is recognised and supported throughout the trust **Accountability** – Staff are accountable for their decisions in terms of delivering patient care, developing the profession and initiating change **Equity** – Staff have an equal voice and no role is more important than another.

At NGH we use a councillor model, a few representatives from each area form a council they have dedicated time each month to hold meetings. Discuss department and trust wide issues that affect patients and the environment and they are empowered to make changes to improve patient care, safety and the environment. SDM started in 2017 with 6 pilot councils and has grown across the Trust, it is multi-disciplinary and without hierarchy to date NGH has 23 active councils working to improve care and or work life, with the support from the Charity some of the bigger projects have come to fruition. Projects have included giving children the variety they wanted

for drinks, offering de-caffeinated drinks to our maternity ladies, creating a quiet 'breaking bad news' room from a store cupboard, creating a dementia room on our fractured neck of femur ward, red zimmer frames for our high risk of falls patients and progressing a garden area for paediatrics and one in maternity.

Assessment & Accreditation:

The BPC Ward Assessment framework is aligns with; The Trust's vision and values, The 6 C's Practice values and The Chief Inspector of Hospitals Key Lines of Enquiry. Ward assessed against the 15 standards that describe essential elements of safe, high quality nursing care. Each standard is subdivided into elements of Environment, Care and Leadership.

Results and report are discussed with Wards Sister/ Charge Nurse by the Quality Assurance Matron who undertook the assessment. A ward Improvement Plan and support (Matrons, OD team, PDN, Specialist Nurses, and Buddies) is put in place. Reassessment timing is according to results/ grading, 3 Consecutive 'Green' assessments gains a recommendation for 'Best Possible Care Ward which is decided at panel following a presentation and portfolio submission by the ward. Currently NGH has 4 'best possible care' wards, 3 triple green wards, 6 green wards & 3 green outpatient areas.

DAISY Award:

The DAISY Award was introduced to honour and recognise the work nurses do for patients and families every day. The DAISY (Diseases Attacking the Immune System) Foundation was established in 1999 in the USA in memory of J. Patrick Barnes who died aged 33yrs from complications of Idiopathic Thrombocytopenic Purpura. The DAISY award provides on-going recognition of the clinical skill and especially the compassion nurses/midwives provide to patients and families all year long.

Since we launched DAISY at NGH in 2017 we have had 18 honourees and over 200 nominations, we launched our first annual Team award last year and awarded 3 student awards. This year we plan to introduce the DAISY leader award who will be nominated by either the patients/ families or staff.

FIT (Falls,Infection,Tissue Viabilty Council) Improvements:

NGH had its first Pressure Ulcer collaborative in 2016/17 which showcased multi-disciplinary working to achieve reductions in the amount of harm through pressure ulcers that was occurring. The success of this collaborative and changes in practice through raising awareness has been dramatic.

In 2016/17 Category 2 = 160 & Category 3 = 30, In 2017/18 Category 2 = 120 & Category 3 = 18, In 2018/19 Category 2 = 96 & Category 3 = 10

Reaching within trajectory targets set for Clostridium Difficile, set by NHS England:

In 2015/2016 rates = 31 In 2016/2017 rates = 22 In 2017/2018 rates = 20 In 2018/2019 rates = 14

Our falls rates within NGH have consistently been below national average per 100 bed days for both the number of falls and those that sustain harm. As part of the FIT SDM council our falls lead

shares and adapts ideas for improvement, collaborative forums have been run and we have been involved in the 90 day improvement collaborative.

Pathway to Excellence®

Pathway to Excellence® is an international accreditation system that acknowledges hospitals that put their nursing workforce at the forefront. This system understands that in order to deliver excellence in patient care you must first have a workforce that is enabled to deliver that. The American Nurses Credentialing Centre (ANCC) is the body who govern the process and have 6 standards that embody their values. We have become the first hospital in the UK to receive the Pathway® designated status. We have been internationally recognised as somewhere that supports and develops nurses and the teams around them to provide excellent care. To attain Pathway® designation evidence is submitted against the 6 standards – Shared Decision Making, Leadership, Safety, Quality, Wellbeing and Professional Development following acceptance of that evidence all registered staff are sent a survey to confirm the standards are in place. 81% of our registered nurses responded and 26/28 questions were responded to as strongly agree or agree – confirming that NGH is an organisation that recognises its staff and provides a positive practice environment.

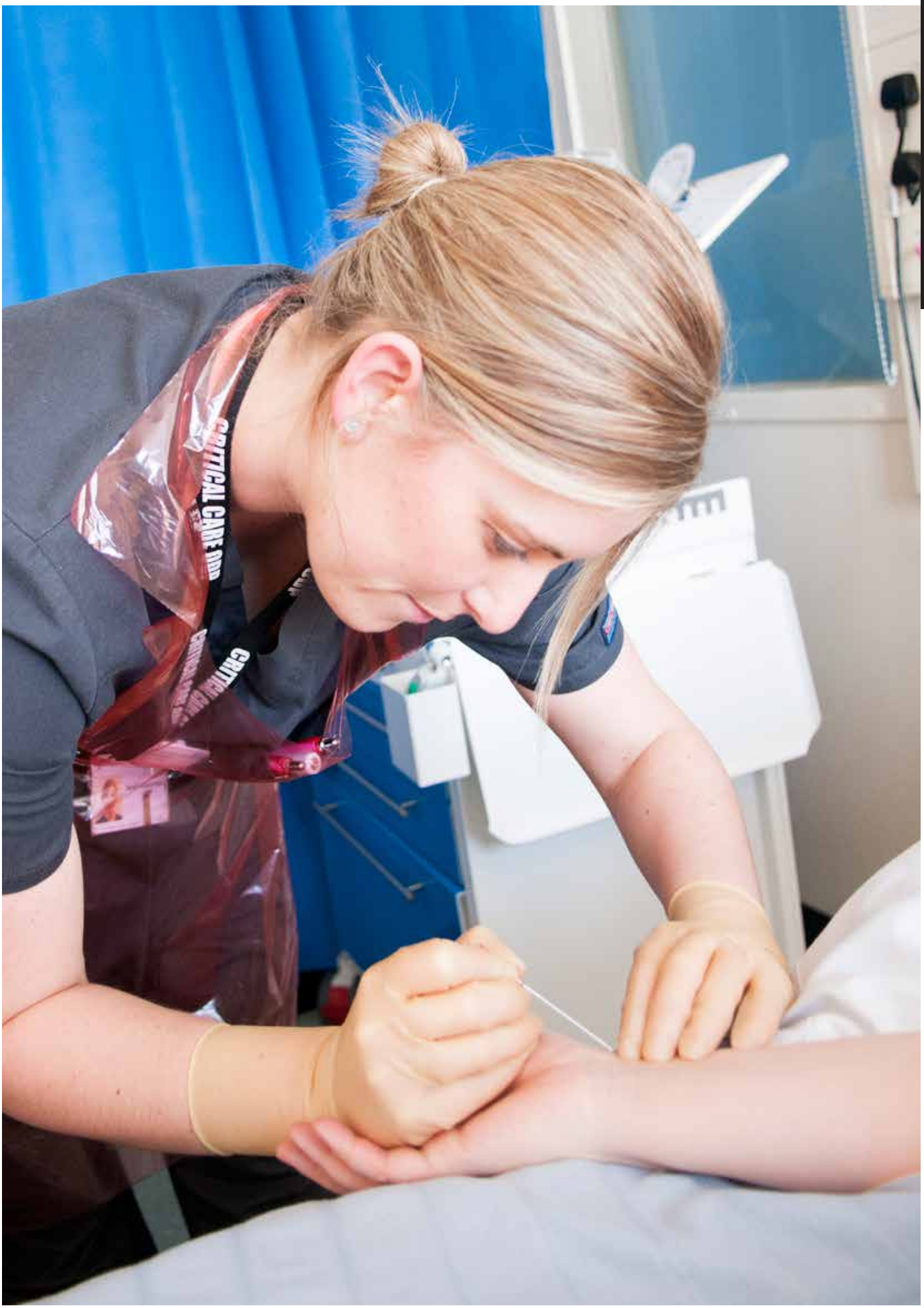
"Pathway to Excellence® has enabled me to put into words a lot about what I believe makes Northampton General Hospital the best choice for staff and service users.

Hand in hand with the Visions and Values of NGH, the Standards set out within Pathway to Excellence are things which I see carried out on a daily basis. Staff DO feel recognised, hard work IS rewarded, we ARE encouraged to grow and develop professionally and personally. We, as Nursing and Midwifery staff, Do have a voice and we can, and do, work together to drive and to ensure that the Best Possible Care is achieved".

RN Main Theatres

External Recognition:

Through our success with Pathway®, Shared Decision Making, Assessment & Accreditation and being a pilot for Nurse Associates the teams have presented national and internationally (Moya Flaherty, Michelle Coe, Holly Slyne, Tara Pauley, Carol Bradley & Natalie Green) published in journals (Gill Ashworth, Sarah Coiffait, Tara Pauley, Natalie Green, Emma-Mae Green, Holly Slyne) and we have 2 staff on scholarships, Emily Lambert for the Bronze Reseach programme and Sarah Coiffait is undertaking the Florence Nightingale Travel award.


CRITICAL CARE

2 PART TWO PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

OUR 2019/20 PRIORITIES

2

PRIORITIES FOR IMPROVEMENT

The traditional domains of quality include safe, effective, patient centred care and our quality priorities use these domains as a basis but take this further by focussing on continual improvement and aims to ensure that all our staff strive for excellence in all that they do and believe and support the organisational focus on delivering the "Best Possible Care".

Our quality priorities are focused on improving the safety, efficiency and effectiveness of the care we provide, as well as improving our patient experience. The Quality Priorities for 2019/21 will be year one of a three year phased programme were we deliver an accelerated and focussed 12 months project which can be revised and expanded on an annual basis.
The four key workstreams for our quality priorities are:

- Improving the safety culture at NGH
- Reduce the number of preventable harm events by 10% from 2018 baseline
- Efficient and effective outcome that will eliminate preventable early patient deaths
- Improve patient experience of care by 15% from 2018 baseline

AIM
Provide the Best Possible Care 2019 – 2022
Quality Priorities
Key Success factors
Improve the safety culture at NGH by 10% from baseline
Reduce the number of preventable harm events by 10% from 2018 baseline
Efficient and effective outcomes
Eliminate preventable early patient deaths by 10% from baseline
Improve patient experience of care by 15% from 2018 baseline
Improve the safety outcomes of maternal and neonatal care.
Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from xxx baseline by 2020
KEY
COM = COMMENCE
= CONTINUE
Enables & Measures
2019 YR 1
2020 YR 2
2021 YR 3
incidents reported - +/- categories
medical vacancies
nursing vacancies
Staff speaking up, disclosure – "speak up champion"
Staff health and well being
Safety huddles (content meaningful), code red status reporting & VPac data
Staff survey elements of safety culture
Board to Ward visits – relaunch
Hospital at night
7 day hospital services (4 core standards)
VTE risk assessment compliance NICE compliance
Reduction in c-diff
Reduction in pressure ulcers
Reduction in falls +/- with harm
SOC scores
HSMR data (As expected or below range)
SMR – Congestive Cardiac Failure
Deteriorating patient care plan use/activity
Specialist palliative care team referrals (nurse and doctor)
MECC – smoking cessation
MECC – alcohol dependence interventions?
Cancer experience Improve from baseline 2018
Patient communication
Staff communication
Improve from baseline 2018
Out patient appointment cancellations / changes
Cancelled operations
Staff – FFT
GIRFT – completion of Action Plans for Urology & Orthopeadics
Reducing Smoking in pregnancy
Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
Raising awareness of reduced foetal movement
Effective foetal monitoring in labour
Reducing preterm birth

STATEMENTS OF ASSURANCE FROM THE BOARD

2

A REVIEW OF OUR SERVICES

During 2018-19, Northampton General Hospital NHS Trust provided and/ or sub-contracted NHS services with 13 relevant Health service providers.

During 2018-19, Northampton General Hospital NHS Trust held two key contracts with NHS commissioners to provide services.

- The Trust's lead commissioner is NHS Nene Clinical Commissioning Group who also commissions on behalf of NHS Corby CCG, NHS Milton Keynes CCG, NHS Bedfordshire CCG, NHS Leicester City CCG, NHS East Leicester and Rutland CCG and NHS West Leicester CCG. This contract constitutes a range of acute hospital services including elective, non-elective, day case and outpatients.
- The Trust holds a contract with NHS England for Prescribed Specialised Services.

The Trust also provides a variety of services to other NHS organisations, public sector organisations and private sector companies. Key contracts are held with:

- Alliance Medical Limited
- Avery Healthcare
- Kettering General Hospital Foundation Trust
- Northamptonshire NHS Foundation Trust
- Backlogs Ltd
- Blatchford Group and
- Boots UK Ltd

The Northampton General Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services represents 92% per cent of the total income generated by the Northampton General Hospital NHS Trust for 2018/19.

NATIONAL CLINICAL AUDITS

Participation in National Clinical Audits and National Confidential Enquiries Northampton General Hospital (NGH) is committed to providing Best Possible Care in all its services and fully supports the use of clinical audit as part of our broad effort to consistently maintain and improve what we do.

During the 2018/19, 54 national clinical audits and 7 national confidential enquiries covered NHS services that Northampton General Hospital provides.

During that period Northampton General Hospital participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northampton General Hospital was eligible to participate in during 2018/19 are as follows:

MEDICINE DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Major Trauma (TARN)	Y	Continuous data collection
Feverish Children (RCEM)	Y	100%
Vital signs in Adults (RCEM)	Y	100%
VTE risk in lower limb immobilisation (RCEM)	Y	100%
COPD Pulmonary rehabilitation	Y	Snapshot Dec18-March19
COPD secondary care	Y	Continuous data collection
National Asthma audit (NACAP)	Y	Continuous data collection Starts Nov18
Adult Community Acquired Pneumonia	Y	Snapshot Dec18-March19
Non-Invasive Ventilation (BTS)	Y	Snapshot Feb-March19
National Lung Cancer Audit	Y	Continuous data collection
National Heart Failure Audit	Y	Continuous data collection
Acute Myocardial Infarction and other ACS (MINAP)	Y	Continuous data collection
Cardiac Rhythm Management	Y	Continuous data collection
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Continuous data collection
National Audit of Cardiac Rehabilitation	Y	Continuous data collection
IBD Registry	Y	Continuous data collection
Stroke National Audit Programme (SSNAP)	Y	Continuous data collection
FFFAP Inpatient Falls	Y	Continuous data collection
UK Parkinson's Audit	Y	100%
Diabetes Core Audit	Y	Continuous data collection
Diabetes Inpatient - HARMS	Y	Retrospectively entered
Diabetes Foot care	Y	Continuous data collection
National Audit of Dementia	Y	100%
Rheumatoid and Early Inflammatory Arthritis	Y	Continuous data collection

SURGICAL DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Adult Critical Care (Case Mix Programme)	Y	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Y	Continuous data collection
Hip, knee and ankle replacements (National Joint Registry)	Y	Continuous data collection
Elective Surgery (National PROMS Programme)	Y	Continuous data collection
National Vascular Registry	Y	Continuous data collection
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Continuous data collection
Prostate Cancer Audit	Y	Continuous data collection
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Continuous data collection
National Audit of Breast Cancer in Older Patients	Y	Continuous data collection
Falls and Fragility Fracture Programme - National Hip Fracture Database	Y	Continuous data collection
National Ophthalmology	Y	Continuous data collection
Nephrectomy Audit	Y	Continuous data collection
Percutaneous Nephrolithotomy	Y	Continuous data collection

WCOHCS DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Female Stress Urinary Incontinence Audit	Y	Continuous data collection
Perinatal Mortality (MBRRACE)	Y	Continuous data collection
National Maternity and Perinatal Audit	Y	Continuous data collection
National Pregnancy in Diabetes	Y	Continuous data collection
National Neonatal Audit Programme	Y	Continuous data collection
Paediatric Diabetes (NPDA)	Y	Continuous data collection
IBD Paediatric Audit of Biologic Therapies	Y	Continuous data collection
UK Cystic Fibrosis Registry	Y	Continuous data collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Snapshot ending April '19

CSS DIVISION AND TRUSTWIDE		
Name of Audit	Participated Y/N	Percentage Participation
National Comparative Audit of the Management of Major Haemorrhage	Y	100%
Audit of The Management of Maternal Anaemia	Y	Snapshot, Data collection current (March '19)
National Cardiac Arrest (ICNARC)	Y	Continuous Data collection.
Fracture Liason Service Database	N	No service at NGH
Learning Disability Mortality review	Y	Continuous Data collection.
Seven day hospital services survey	Y	100%

National Confidential Enquiries - NCEPOD		
Name of Audit	Participated Y/N	Percentage Participation
Pulmonary Embolism	Y	100%
Long term ventilation	Y	100%
Perioperative Diabetes	Y	100%
Bowel Obstruction	Y	100%
Young People's Mental Health	Y	100%
Cancer in Children, Teens & Young Adults	Y	100%
Acute Heart Failure	Y	100%

The Provider is a member of the following:	Screening Programmes
East Midland Children's Cancer Network	Breast Screening Programme
Haemoglobinopathy Clinical Network	Downs Syndrome Screening Programme
East Midlands Children's and Young People Cancer Network	New Born Hearing Screening Programme
GOSH led Congenital Heart Disease Network	Bowel Cancer Screening Programme
Thalassaemia and Sickle Cell Antenatal Screening Work	Cervical Cancer Screening Programme
Central Newborn Network for Neonatology (East Midlands Newborn Network)	Chlamydia Screening Programme
The East Midlands Critical Care Network	Retinal Screening Programme
East Midlands Cardiac & Stroke Network	Cervical Cytology Screening Programme
East Midlands Cancer Network	Thalassaemia & Sickle Cell Screening Programme
Leicestershire Northamptonshire Rutland Cancer Network as part of the EM Cancer Network	Infectious Diseases in Pregnancy Screening Programme
Leicester Renal Network	Blood Grouping and Antibody Testing in Pregnancy
TARN (trauma audit research network)	Foetal Anomaly Screening
East Midlands Major Trauma Network	New Born Blood Spot Screening
Midlands Critical Care and Trauma Network	New Born and Infant Physical Examination
Central England Trauma Network (part of Midlands Critical Care and Trauma Network)	Diabetic Retinopathy
	Abdominal Aorta Aneurysm Screening

ACTIONS TO IMPROVE HEALTHCARE AS A RESULT

All completed audits provide valuable information on our compliance with the area being looked at. The new Clinical Audit Strategy outlines the inclusion of more public and patient involvement in the process and also aims to make the reports available to the public.

Each year we hold an Audit Presentation Day where audit work has led to the improvement of patient care. The applications are shortlisted by clinicians and judged by previous winners, Board Chair and Senior Clinical Staff. The top prize went to a Student Nurse (see below)

Diabetic patients stand to benefit from nursing student's 'foot assessment' work

Patients with diabetes in Northampton will benefit from enhanced patient care in hospital, thanks to the work of a University of Northampton student.

The audit was an internal review of foot assessments for diabetic patients admitted to Northampton General Hospital.

As a direct consequence of the findings, funding has now been allocated to create a post within NGH to increase the number of assessments completed.

Dr Sonia Swart, Chief Executive of Northampton General Hospital, added: "At Northampton General Hospital we believe we all have two jobs: to deliver care and to improve care. Our hospital has been recognised on an international platform for the quality improvement initiatives our employees have delivered.
Other achievements through national and local audit include:

- Two-year mortality following colorectal major resection has fallen over the last 2 years to 11.1% compared with the national average of 18.9%.
- Our Stroke National Audit consistently receives a "level A" score and the clinical lead did an interview to the media praising our stroke service
- There have been no mortality outliers at unit or consultant level for surgical audits included in the Consultant Outcomes Programme
- End of Life Care (NICE and National Audit) – a huge amount of work has been done by the department to improve the quality of their service and deliver care fully compliant with NICE Guidance and participation with the NACEL National Audit
- Good compliance with most aspects of diagnosing and managing bronchiolitis in children and reduced unnecessary investigations and treatments but could improve further

A recent review (Jan 2019) of the clinical audit service is helping to plan increased awareness and related skills in auditing.

RESEARCH

Participation in clinical research

Northampton General Hospital NHS Trust is a research-active hospital which is striving to support the vision of providing the "Best Possible Care" and to meet its statutory duty for 'promoting research, innovation and the use of research evidence' (Health and Social Care Act, 2012). We are proud of our research history which is well established and embedded in the Trust with a history that stretches back to the 1980s.

Research is an integral part of our mission to constantly improve and be able to offer better care for patients. We see research as fundamental to everything we do which is embedded in the delivery of care.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in a wide range of clinical trials. This is consistent with our commitment to transparency and desire to improve patient

outcomes and experience across the NHS. Our engagement with clinical research also demonstrates our commitment to testing and offering the latest medical treatments and techniques to our patients.

The number of patients receiving NHS services provided by Northampton General Hospital in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1320 into 56 trials registered on the National Institute of Health Research portfolio. This demonstrates a significant achievement this year as the number of patients recruited to trials has increased by 79% compared to the same time last year.

The R&D department actively promotes both non-externally funded and commercial research which will ultimately improve patient care and enhance our national profile as a high-performing district general hospital. As evidenced by the Department of Health Strategy 'Best Research for Best Health', research is part of the core business of the NHS. The quality of care depends on research-based evidence, and anyone using the NHS can expect to be offered opportunities to take part in studies relevant to their needs.

We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way. Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our hospital for the benefit of our patients and staff.

Our aspiration is that every clinical area will be engaged in high quality research and every patient and member of staff should have the opportunity to be part of a research study.

ACCREDITATION SCHEMES

The following services have undertaken the following accreditation schemes during 2018/19. Participation in these schemes demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

2

SCHEME	SERVICE	ACCREDITATION STATUS
Medicines and Healthcare products Regulatory Agency (MHRA)	Aseptic Services Unit	Manufacturer's Specials Licence
MHRA	Pharmacy Stores & Distribution	Wholesaler Dealer's Licence
ANCC Pathway to Excellence Award	Nursing (Trust wide)	Designated 2018
Baby friendly initiative	Obstetrics	Full
ISO9001:2015 for Chemotherapy, Radiotherapy & Radiotherapy Physics	Oncology & Haematology	Full
JACIE for HPC Transplant	Oncology & Haematology	Autologus and allogeneic Transplantation in Adult Patients, Collection of HPC, Apheresis, Cell Processing – Minimally Manipulated
HTA for HPC Transplant	Oncology & Haematology	procurement, processing, testing, storage and distribution of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application)
GMP for Radiotherapy	Oncology & Haematology	Full
CQC for Radiotherapy	Oncology & Haematology	Full
ManA for Radiotherapy	Oncology & Haematology	Full
IR[ME]R	Oncology & Haematology	Full
Clinical Pathology Accreditation	Pathology	Blood Sciences, Immunology, Microbiology

COMMISSIONING FOR QUALITY AND INNOVATION INCOME

A proportion of the Trust's income in 2018/19 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework.

The CQUINs agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement. Each CQUIN is outlined below together with the RAG status of achievement.

TYPE	CQUIN INDICATOR NAME	Q1	Q2	Q3	Q4
LOCAL	1. STP				
NATIONAL	1a. Improving staff health and wellbeing: Improvement of health and wellbeing of NHS staff				
	1b. Improving staff health and wellbeing: Healthy food for NHS staff, visitors and				
	1c. Improving staff health and wellbeing: Improving the uptake of flu vaccinations for front line staff within Providers				
	2a. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings				
	2b. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment of sepsis in emergency departments and acute inpatient settings				
	2c. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review				
	2d. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions				
	4. Improving services for people with mental health needs who present to A&E				
	6. Offering advice and guidance				
	9 - Preventing Ill Health 9a - Tobacco Screening 9b - Tobacco Brief Advice 9c - Tobacco Referral & Medication Offer 9d - Alcohol Screening 9e - Alcohol Brief Advice or Referral				
SPECIALIST	Medicines Optimisation				
	Multi-system auto-immune rheumatic MDT				
	Clinical Engagement				

Key: No milestone; Milestones partially met; Awaiting results; Milestones met; Milestones not met

Local Quality Requirements

The quality requirements are set out in Schedule 4 of the 2017-19 NHS Contract and are collectively known as the Quality Schedule. They are split into six quality sections which include Operational Standards and National Quality Requirements. They also include Local Quality Requirements which are agreed locally with our CCG commissioners.

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We provide assurance to our commissioners quarterly on local quality requirements by submitting evidence and demonstrating where we meet the requirements.

Quality Requirement	Threshold 17-19
End of Life Care	To help deliver person-centred End of Life Care through integration within and between providers of healthcare along the pathway.
Patient Safety	1) National Information
	2) Incidents
	3) Policy
	4) Discharge Information
	5) Outpatient Letters
	6) Mortality & Morbidity
	7) Cancer Patients with a long waiting time
Learning	1) The provider will demonstrate a learning culture from ward to board.
	2) Review action taken towards implementation of NICE technical appraisal guidance, within three months of publication. Review action taken towards implementation of all other NICE guidance and Quality Standards that are judged to be appropriate to the Trust as a provider of acute care
	3) Evidence of learning from concerns about patient care raised by GPs and/or trust
Quality care for Patients with a Learning Disability	Implementation of actions from the Learning Disability 'Better Healthcare Plan'
Patient Experience	1)Evidence that patient experience is of equal importance as clinical quality and patient safety
	2) Evidence of learning from complaints and PALs enquiries
	3) Evidence of learning from National and regional surveys
Nutrition and Hydration	1) 95% of patients have completed MUST score within 24 hours
WHO surgical checklist	All patients undergoing a surgical procedure to have all stages of the WHO checklist completed

National Early Warning Score (NEWS)	Report on the percentage of patients that have NEWS under-taken within required time period and percentage of patients whose NEWS triggers need for review who are
Safeguarding Children	Implementation of Early Help Assessment (EHA), Section 11 Au- dit /Audits and Agreed Assurance Framework, Learning Supervision
Safeguarding Adults	Safeguarding Alerts Dashboard, Quality Monitoring Visits, SAAF, Safeguarding Alerts Dashboard, Quality Monitoring Visits, Learning, Supervision, Appropriate use of Mental Capacity Act (2005), Assessments and Deprivation of Liberty Safeguards, Training
Workforce	a) Assurance provided that 85% of all staff (including Drs & AHP) have received appraisals, mandatory and essential to role training b) Provider is compliant with the expectations in relation to nursing and midwifery and care staffing and capability as laid out in 'How to ensure the right People with the right skills are in the right place at the right time'.
VTE	As per Service Condition 22 the following will be required and monitored: 1. All patients receive VTE prevention in line with the NICE Quality standards. 2. Root cause analysis will be undertaken on all cases of hospital associated thrombosis.
Pressure Tissue Damage	2016/17 data to be used to set baseline of numbers of hospital acquired grade 2/3/4. Trust to agree ongoing improvement for the year in April 2017 (to be repeated for 2017/18) To continue to participate in countywide work to prevent pressure tissue damage.
Service Specifications	Assurance that all service specifications included in the 2017/19 contract are being implemented.
Quality Assurance regarding any trust sub- contracted services (list of services to be provided by the trust)	Assurance that all services sub-contracted by the trust have been fully quality monitored with any areas of concern investigated

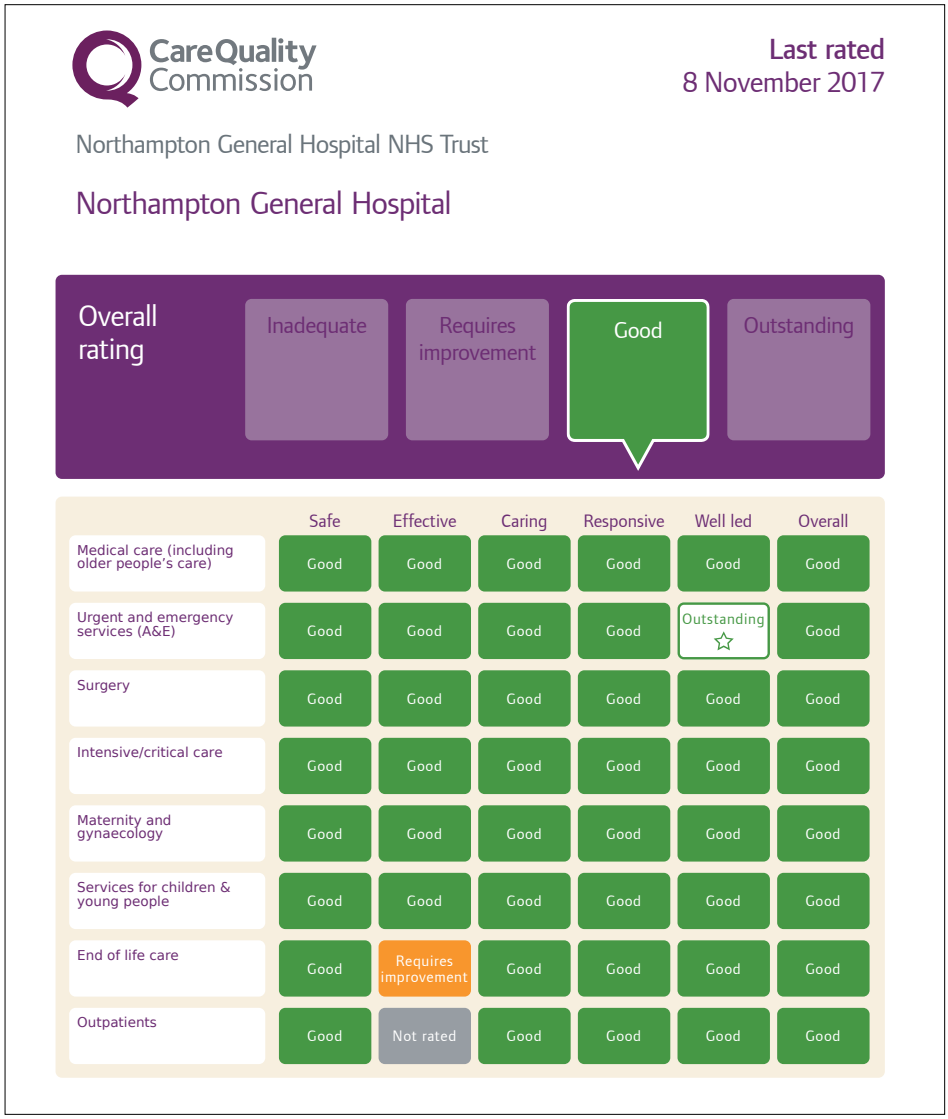
CARE QUALITY COMMISSION

NGH is registered with the CQC under the Health and Social Care Act 2008 and currently has no conditions attached to registration under section 48 of the Health and Social Care Act 2008.

The CQC has not taken any enforcement action against the Trust during 2018/19. The Trust has not participated in any special reviews or been investigated by the CQC during the reporting period.

The Care Quality Commission (CQC) did not inspect NGH during 2018/19, therefore the ratings for the Trust remain as per the report published in November 2017. Each of the eight core services was rated as good, along with an overall good rating for each of the five domains (safe, effective, caring, responsive and well-led) and for the Trust overall. The full report can be found on the CQC website https://www.cqc.org.uk/provider/RNS.

The Trust anticipates a CQC visit during 2019/20, both a use of resources (led by NHS Improvement (NHSI) and a quality inspection (led by CQC). Following these visits, the Trust will be issued updated ratings. The Trust is cited on any compliance concerns through the Assurance, Risk and Compliance Group and Quality Governance Committee.



SECONDARY USES SERVICE

NHS Number and General Medical Practice Code Validity

The Trust submitted records between April 2017 and January 2018 to the Secondary Users Service for inclusion in the national Hospital Episode Statistics (HES) database which are included in the latest published data outlined below and compared to the previous year's results.

Period - Apr 17 to Dec 17	Valid NHS Number	Valid GMPC
Inpatients	99.70%	100%
Outpatients	99.90%	99.90%
A&E	98.40%	99.80%

Period - Apr 18 to Dec 19	Valid NHS Number	Valid GMPC
Inpatients	99.75%	100%
Outpatients	99.90%	99.98%
A&E	98.64%	95.84%

Period - Apr 18 to Dec 19	Valid NHS Number	Valid GMPC
Inpatients	99.75%	100%
Outpatients	99.90%	99.98%
A&E	98.64%	95.84%

INFORMATION GOVERNANCE TOOLKIT

DATA SECURITY AND PROTECTION TOOLKIT ATTAINMENT LEVELS

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

The Data Security and Protection Toolkit is the successor framework to the IG Toolkit.

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this by the publication of annual assessments.

The toolkit enables The Trust to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

By assessing itself against the standard, and implementing actions to address shortcomings identified though use of the toolkit, organisations will be able to reduce the risk of a data breach.

Data Security and Protection Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Providing evidence and judging

2

whether the Trust meets the assertions, will demonstrate that the Trust is meeting the NDG standards. The NDG data security standards are;

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

Progress

Progress dashboard and reports

100 of 100 mandatory evidence items provided

33 0f 40 assertions confirmed

Your assessment status (if you were to publish now)

Standards Met

There are 40 areas of focus called 'Assertions' each of these has questions requiring evidence that are either mandatory or optional. 32 of these are Mandatory for the 31st March deadline.

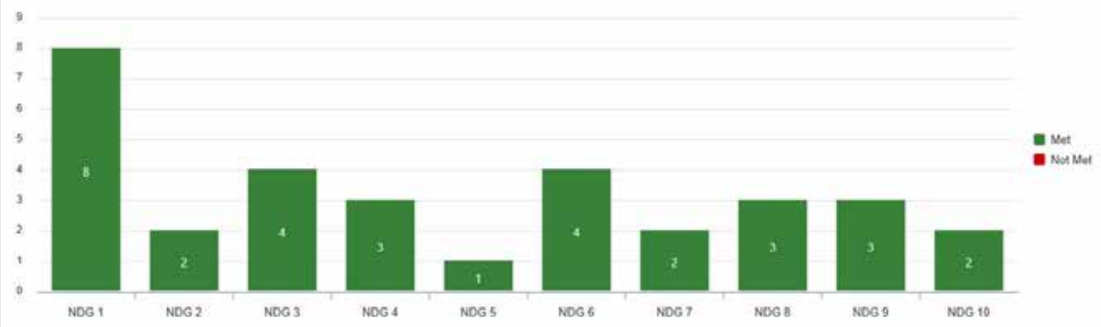
There are currently 100 mandatory evidence requirements across the DSP toolkit. On the 31st March 2019 the Trust completed all 100 of the Mandatory requirements and confirmed all 32 Mandatory Assertions (plus one non-mandatory).

The Trust's internal auditors (TIAA) have provided us with recommendations from the previous IG Toolkit assertion with a detailed action plan.

We took TIAA recommendations and produced an Action Plan which has taken into account the new General Data Protection Regulations (GDPR) as well as the 2018 submission. The DPO who is also the Head of Data Quality, Security and Protection, is making consistent developments and long term improvements to ensure all the recommendations are actioned. We recognise that the culture of the organisation needs to align with the need for good Information Governance and have plans for education, reporting, tools to ensure compliance and controlled phishing campaigns which redirect to educational materials as ways to embed this cultural change.

During 2018/19, the Chief Information Officer was appointed to the role of Senior Information Risk Owner and the

DSP Toolkit Dashboard



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

Medical Director continued as our Caldicott Guardian. The Trust reported nine Information Governance incidents to the Information Commissioner's Office in 2018/19.

CLINICAL CODING ERROR RATE

Clinical Coding Audit

Clinical coding audit is fundamental to the quality assurance process by rigorously reviewing how coding standards are being applied and how consistently. It allows retrospective amendments of incomplete or inaccurate data but more crucially, provides a learning and feedback tool whereby individuals can embed outcomes within their own practice. It can also be used to identify inconsistencies across a department that do not necessarily amount to an error but improve the quality of information produced. Furthermore, clinical coding audit findings often identify recommendations that benefit the Trust as a whole e.g. improved clinical record keeping or data quality errors.

The minimum requirement as specified under Data Security & Protection (DSP) requirements is a 200 patient episode audit per financial year. At NGH, there is a rolling quarterly audit program undertaken whereby approximately 300 episodes are formally audited each quarter in accordance with the latest national audit methodology by an approved national clinical coding auditor (internal).

However, there are varying mechanisms of audit and a variety is important to provide a comprehensive approach that suits the needs of the department and the Trust. As such, the reality is that a far larger number of episodes are audited in an informal manner.

Each quarter is audited once it is complete so at the time of writing there are two completed quarters for 2018-19 and the results below meet the mandatory requirements outlined in the DSP guidance.

Q1 2018-19	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	92.43%	92.83%
Secondary Diagnoses	91.84%	92.31%
Primary Procedure	96.03%	96.03%
Secondary Procedures	93.97%	93.97%

Q1 2018-19	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	93.03%	93.03%
Secondary Diagnoses	91.08%	91.08%
Primary Procedure	94.20%	94.20%
Secondary Procedures	91.15%	91.15%

LEARNING FROM DEATHS

The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure. 27.1	During April 2018 – March 2019 1203 of Northampton General Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 410 in the first quarter; 312 in the second quarter; 341 in the third quarter; 133 in the fourth quarter

Northampton General Hospital Screening data	In December 2017 The Trust introduced a process for screening of adult deaths to select cases for review (using the SJR tool) and identification of learning. During April 2018 – March 2019 the notes of 904 (75%) deaths were screened. 254 (62%) in the first quarter; 201 (65%) in the second quarter; 316 (93%) in the third quarter; 133 (95%)in the fourth quarter
The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure. 27.2	By 5th March 2018, 226 case record reviews and 1 investigation has been carried out in relation to 226 of the deaths included in item 27.1. In 1 case a death was subjected to both a case record review and a Comprehensive Investigation. There were no Serious Incidents. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 128 in the first quarter; 53 in the second quarter; 42 in the third quarter; 3 in the fourth quarter A Trust wide review of 100 consecutive deaths in May 2018 was carried out in response to a higher than expected HSMR – hence the number of reviews completed for Q1 is higher than other quarters.
An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this. 27.3	4 representing 1.8% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 1 representing 0.8% for the first quarter; 2 representing 3.8% for the second quarter; 1 representing 2.4% for the third quarter; 0 representing 0% for the fourth quarter. Following this judgement, deaths are referred to the Review of Harm Group for consideration for investigation. Of the 4 cases referred 1 was subject to a Comprehensive Investigation. The remaining 3 cases were discussed at Review of Harm These numbers have been estimated using the Avoidability of Death Judgement Score Score 1 Definitely avoidable Score 2 Strong evidence of avoidability Score 3 Probably avoidable (more than 50:50)

	Score 4 Possibly avoidable but not very likely (less than 50:50) Score 5 Slight evidence of avoidability Score 6 Definitely not avoidable These cases are discussed at a Trustwide Mortality Review Group bimonthly and a consensus decision reached. If Avoidability of Death Score is Grade 1,2 or 3, the death is judged more likely than not to have been due to problems in the care provided to the patient. These cases are referred to RoHG.
Neonatal deaths and Stillbirths	During April 2018 – March 2019 there were 6 neonatal deaths after 22 weeks and 20 stillbirths delivered from 24 weeks All qualifying deaths have been reviewed using the Perinatal Mortality Review Tool 2 deaths were investigated as serious incidents 0 deaths reviewed using the Perinatal Mortality Review Tool scored a Grade D (deaths judged more likely than not to be due to a problem in care
Patients with a learning disability or Severe Mental Illness (SMI)	During April 2018 – March 2019 (and included in the figures for 27.1) there were 5 deaths of patients with a learning disability 6 deaths of patients with a severe mental illness (SMI) All vulnerable adults are referred for SJR and are discussed at the bimonthly Vulnerable Adult Mortality Group meeting. In addition to local review processes, all patients with a learning disability are referred to the national mortality case note review process (LeDeR). SMI is defined at NGH at NGH as a patient admitted to NGH from a Mental Health Trust or a
A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. 27.4	See Appendix 1
The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period. 27.7	82 case record reviews, 2 Comprehensive Investigations and 2 Serious Incident investigations were completed after 01.04.18 which related to deaths which took place before the start of the reporting period.

An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this. 27.8	4 representing 4.9% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the same method detailed in section 27.3. Following this judgement, deaths are referred to the Review of Harm Group for consideration for investigation. Of the 4 cases referred, 2 were subject to Serious Incident Investigation and 2 to
A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8 27.9	8/308 representing 2.6% of the patient deaths reviewed during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Appendix 1

Learning, Actions and Impact of Mortality Case Note Review in 2018/19

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
Acute and unspecified renal failure (AKI)	Dr Foster data and Trust wide mortality case note review 10	Deteriorating Patient Board	• Focus on fluid balance and medication review
Sepsis	Dr Foster data and Trust wide mortality case note review 10	Sepsis/ Deteriorating Patient Board CQC response December 2018	• Appointment of a Sepsis Nurse • Monitor compliance with Sepsis CQUIN standards • Review of clinical documentation and the effect this has on the clinical coding
Validation of screening process	30 deaths chosen randomly from December 2018 and March 2019	Led by Mortality Review Group	• Improvements made to screening tool • Developed a "what good care looks like" document for sharing with screeners and reviewers

Respiratory failure, insufficiency and arrest	Dr Foster data and directorate mortality case note review	Led by Respiratory Team	• Increased availability for specialist advice for patients on Non-invasive ventilation • Review of guidelines related to respiratory failure • Review of nurse to patient ratios in dedicated areas providing non-invasive ventilation • Submit a business case for blood gas machines in admission wards and on Becket Ward.
Excision of colon and/ or rectum (procedural alert)	Dr Foster data and directorate mortality case note review	Led by Colorectal team	• Ensure all Serious Incident Investigation reports are discussed at directorate Morbidity and Mortality meetings
High HSMR May 2018	Dr Foster data (including deep dive data) and Trust wide mortality case note Review 12 (100 consecutive deaths in May 2018)	Frailty	• Shared work stream to look specifically at frailty - in development discussed with Nene CCG
		Secondary Malignancy – delivery of palliative care Secondary Malignancy – delivery of palliative care	• Agreement with clinical coding to ensure parameters for coding palliative care are agreed and consistently applied • Audits are planned to look at specific groups of patients who may be receiving palliative care ○ Patients with obstructive jaundice secondary to malignancy ○ Patients with a malignant pleural effusion
		Clinical care/ documentation/ coding interface	• Using iBox to highlight the working diagnosis for each patient daily to support accurate documentation that reflects the course of the admission and therefore the clinical coding
Other perinatal conditions (stillbirth)	Dr Foster data and comparison with data from Perinatal Mortality Review Tool	Led by Obstetric and neonatal teams	• Continue to review all qualifying cases using the Perinatal Mortality Review Tool

Congestive Heart Failure	Dr Foster data	Led by Heart Failure Team	• Initial review of clinical documentation and coding • Review of data in conjunction with data from the Heart Failure National Audit and National Confidential Enquiry looking at the management of patients with acute heart failure • Review of bedside Clinical Guideline for use at NGH
Acute and unspecified renal failure (AKI)	Dr Foster data and Trust wide mortality case note review 10	Deteriorating Patient Board	• Focus on fluid balance and medication review
Sepsis	Dr Foster data and Trust wide mortality case note review 10	Sepsis/ Deteriorating Patient Board CQC response December 2018	• Appointment of a Sepsis Nurse • Monitor compliance with Sepsis CQUIN standards • Review of clinical documentation and the effect this has on the clinical coding
Validation of screening process	30 deaths chosen randomly from December 2018 and March 2019	Led by Mortality Review Group	• Improvements made to screening tool • Developed a "what good care looks like" document for sharing with screeners and reviewers
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Excision of colon and/ or rectum (procedural alert)	Dr Foster data and directorate mortality case note review	Led by Colorectal team	• Ensure all Serious Incident Investigation reports are discussed at directorate Morbidity and Mortality meetings
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		Secondary Malignancy – delivery of palliative care	• Agreement with clinical coding to ensure parameters for coding palliative care are agreed and consistently applied • Audits are planned to look at specific groups of patients who may be receiving palliative care ○ Patients with obstructive jaundice secondary to malignancy ○ Patients with a malignant pleural effusion
		Clinical care/ documentation/ coding interface	• Using iBox to highlight the working diagnosis for each patient daily to support accurate documentation that reflects the course of the admission and therefore the clinical coding
Other perinatal conditions (stillbirth)	Dr Foster data and comparison with data from Perinatal Mortality Review Tool	Led by Obstetric and neonatal teams	• Continue to review all qualifying cases using the Perinatal Mortality Review Tool
Congestive Heart Failure	Dr Foster data	Led by Heart Failure Team	• Initial review of clinical documentation and coding • Review of data in conjunction with data from the Heart Failure National Audit and National Confidential Enquiry looking at the management of patients with acute heart failure • Review of bedside Clinical Guideline for use at NGH
			• Recruitment of 3 new Mortality Screeners to increase capacity. • The Medical Examiner Working Group has been set up to support delivery of a full Medical Examiner Service which includes recruitment and training of Medical Examiners, improved communication with bereaved families and carers and engagement with junior doctors and the coroner's office. • Processes for improving compliance with completion of mortality case note review have been improved. • Increase in the number of directorate/ specialty M&Ms • Mortality Strategy • Process for external sharing of SJRs in development • Agreement secured from Clinical IT Senate to build a local IT solution for completion of SJRs

DUTY OF CANDOUR

Implementing Duty of Candour

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

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To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

The Trust has worked with the Clinical Commissioning Group (CCG) and other healthcare providers within the region to produce a patient/relative Duty of Candour information leaflet. The providers were unable to reach an agreement on a leaflet that met all of their and our requirements therefore it was agreed that Northampton General Hospital would develop their own. This has been drafted and will be shared with the Review of Harm Group for feedback.

The Trust will implement the use of the leaflet in 2019/20.

Duty of candour training continues to be included in all the incident reporting/ investigating and root cause analysis training given to multi-disciplinary staff across the Trust.

Staff continue to utilise the Duty of Candour sticker which acts as a crib sheet to ensure staff correctly convey the appropriate information to any patients harmed during an incident.

Patients and/or their relevant person are encouraged to participate in any investigations that the Trust's 'Review of Harm Group' deems require a comprehensive Root Cause Analysis investigation. The patient/relevant person(s) are then offered the opportunity to meet with members of the investigation team to review the findings of the investigation and ask any questions they may have.

The Trust continues to demonstrate compliance with Duty of Candour to the CCG.

MANAGEMENT OF COMPLAINTS

Compliments, Comments, Complaints, Concerns (4Cs) and suggestions from patients, carers and the public are encouraged and welcomed. Should patients, carers or members of the public be dissatisfied with the care provided by this Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. The Trust welcomes all forms of feedback and information which is used to improve the service that is provided to the local community.

The 4Cs process is about patient choice and the Trust's wish to ensure that where possible any of the 4Cs raised are responded to swiftly and locally by staff. If the individual is dissatisfied with the outcome then they must be offered one of the following options:

- Speak to a senior member of staff (i.e. Matron, Manager)
- Contact PALS for on the spot support, advice and information

- Make a complaint through the NHS Complaints Regulations

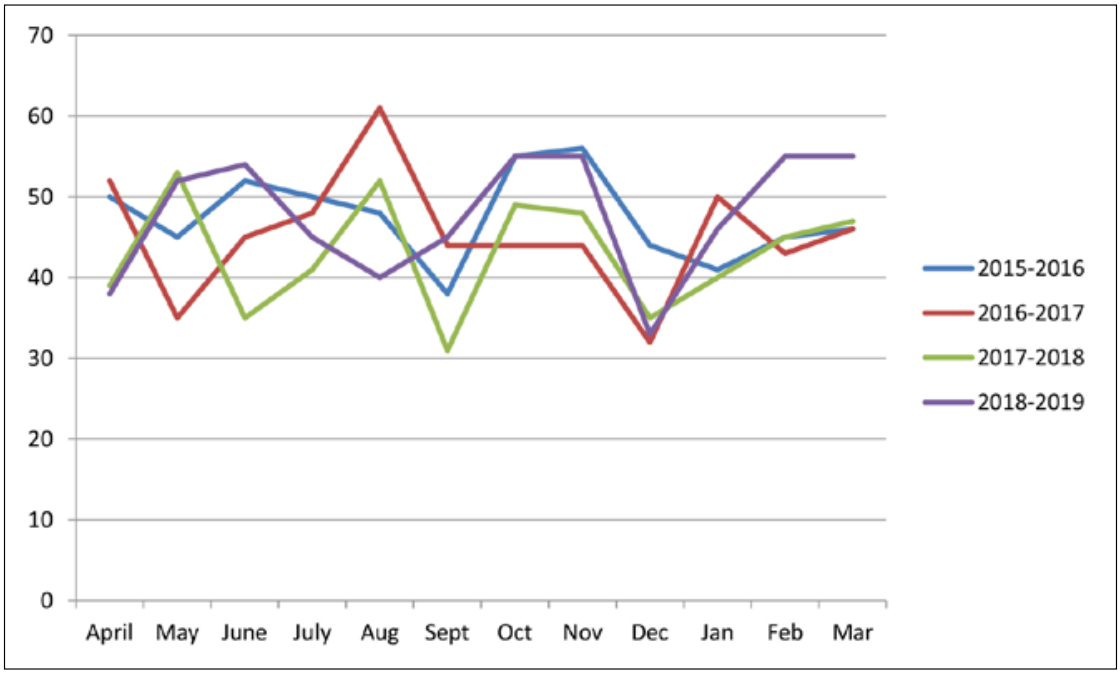
The aim is always to achieve local resolution where possible and the above should be used as an escalation process where appropriate and with the agreement of the individual. The Trust recognises that the information derived from complaints and concerns provides an important source of data to help make improvements in hospital services. Complaints and concerns can act as an early warning of failings in systems and processes which need to be addressed.

The Trust received a total of 573 written complaints that were investigated through the NHS Complaints Procedure from 1st April 2018 to 31st March 2019, which compares with 515 complaints received the previous financial year.

Total no of complaints for the year (Increase of 10%)	573
(Versus 2017/2018)	(515)
Average response rate	*97%
Total no of complaints that exceeded the renegotiated timescale	*12
Complaints that were still open at the time that the information was prepared (3rd April 2019)	*55
Total patient contacts/episodes	701,469
Percentage of complaints versus number of patient contacts/episodes	0.08%

**These figures were the current status at the time that the report was prepared 3rd April 2019. The final figures will not be complete until the end of May 2019 due to the timescales involved.*

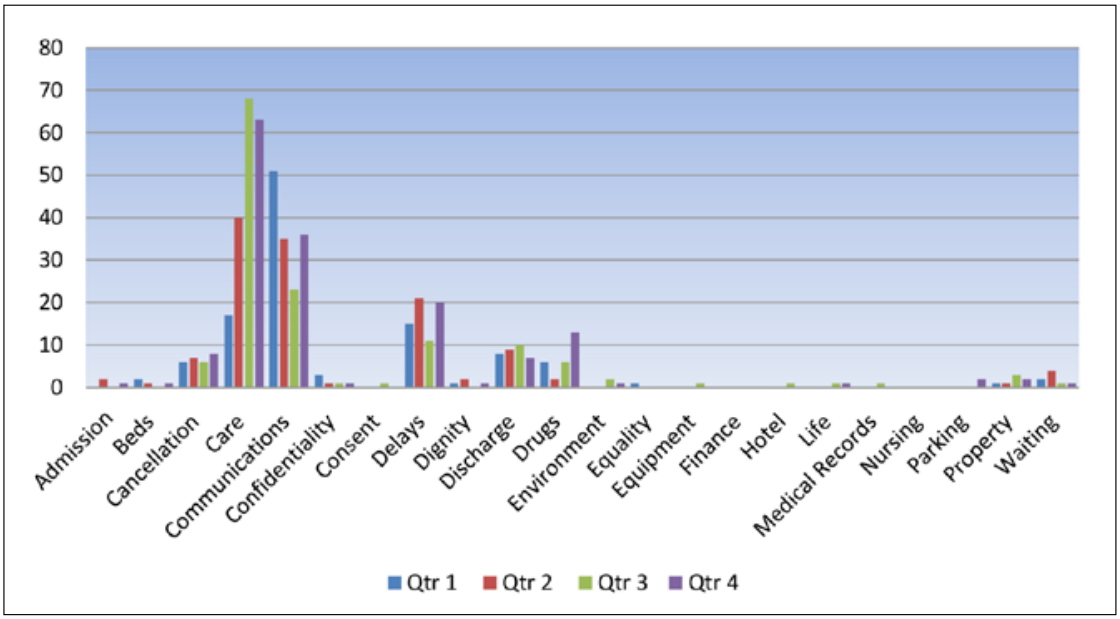
Number of complaints



Trend Analysis

The following chart provides the themes emerging from complaints:

Complaints (Primary) Subject Comparison 2018 - 2019



What we achieved in 2018/19 to improve complaints management

- Improved compliance with our performance targets in responding to formal complaints
- Aligned the Complaints Officers with the clinical divisions and compliance co-ordinators
- Attendance at Directorate and Divisional Governance meetings
- Developed a Complaints Review Panel process to be implemented in the next financial year
- Delivered bespoke training sessions to staff
- More local resolution meetings are being offered
- Recording all local resolution meetings where there is agreement
- Distribution of the new learning report to highlight learning and evidence of improvements from complaints
- Introduced electronic file processes to increase efficiency
- Working with Young Healthwatch to develop processes for younger people who access the organisation and wish to raise a complaint

FREEDOM TO SPEAK UP

Staff at Northampton General Hospital are able to speak up through their line managers or if unable to do so are able to make direct contact with the Trusts Freedom to Speak Up Guardian by telephone, personal approach or email. The Freedom to Speak Up Guardian will support staff to raise concerns and will maintain their anonymity if requested. Staff can also report concerns anonymously via the DATIX reporting system.

Feedback is provided directly to staff raising concerns as to progress with their case but also the outcome when any investigation is completed. Feedback is provided face to face. If the concern is raised anonymously, other methodologies can be utilised e.g. patient safety messages to update all Trust staff of a revised process or to reiterate appropriate processes.

The Trust Guardian will ensure any reports of detriment are dealt with robustly with staff supported accordingly.

The Freedom to Speak Up Guardian is happy to hear any concerns over quality of care, patient safety or bullying and harassment and will signpost staff appropriately to the Respect and Support helpline as required or any other HR process.

The Respect and Support Information Hotline is accessible for all staff in the Trust as part of the ongoing work that is available through the Respect and Support Campaign. The purpose of the hotline is to signpost a member of staff to the different interventions available in the Trust. These interventions have been developed through the campaign to provide support when the member of staff has concerns about an individual's behaviour or has relationship difficulties with others they work with. The hotline is a way of giving the member of staff an opportunity to talk through their issues with a trained individual and it is intended to provide the member of staff with options other than a formal process.

SEVEN DAY SERVICES

NHS England has committed to providing a 7 day service (7DS) across the NHS by 2020. The expectation is that all in-patients admitted through Non Elective routes, have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

The rationale for this intention is to improve safety, quality and efficiency of care, so that senior decision makers are available to provide the same level of assessment, diagnosis, treatment and intervention every day of the week. Then senior staff will be more available to provide information to patients, relatives and supervise junior staff.

To enable providers to track their progress in achieving the four priority 7DS clinical standards, a national self-assessment survey through internal audit process was developed. This is an online tool that allows providers to input data taken from patient case notes to measure achievement of standards 2 and 8, alongside an assessment of the availability of key diagnostics **(5)** and interventions **(6)**.

The four priority standards are:

- All patients admitted as an emergency to be reviewed by an appropriate Consultant within 14 hours of admission **(CS2)**
- Seven day access to Consultant directed and reported diagnostics **(CS5)**
- 24 hr access to Consultant directed intervention e.g. endoscopy, emergency surgery **(CS6)**
- Following initial assessment all patients to be reviewed daily by a Consultant or designated senior with those meeting level 2 and 3 ICU criteria to be seen twice daily. **(CS8)**

There have been changes to this over 2018-19, specifically the project has moved from a national survey based assessment to a Board Assurance Framework tool.

Acute services providers are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework.

The Data for spring 2018 was as follows.

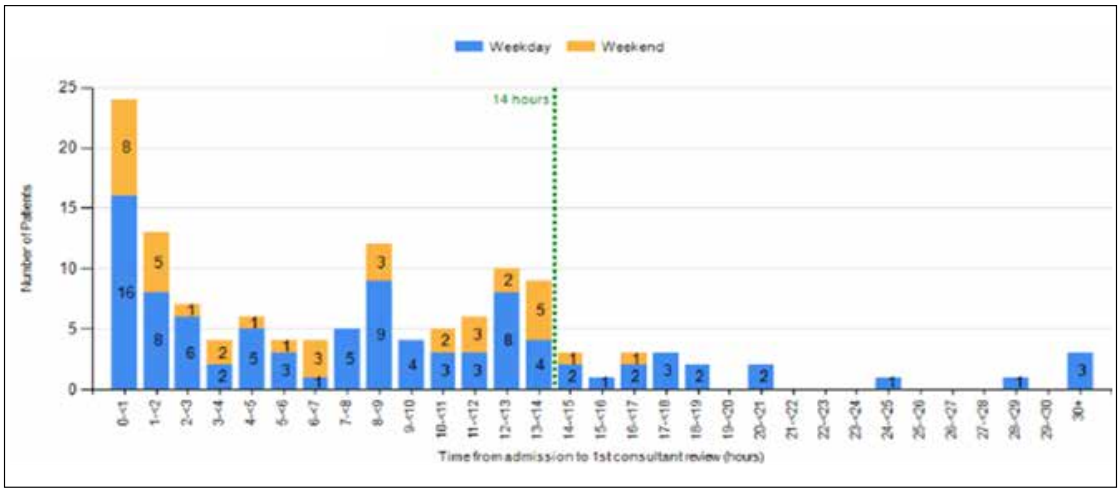
Results:
7DS Clinical Standard 2

	Day of admission									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	23	26	18	20	28	24	26	115	50	165
Number of patients reviewed by a consultant outside of 14 hours	2	4	5	3	3	2		17	2	19
Total	25	30	23	23	31	26	26	132	52	184
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	92%	87%	`78%	87%	90%	92%	100%	87%	96%	90%

2

Reasons why patients were not reviewed within 14 hours:	Number of patients
Consultant review not documented	10 patients
The patient was reviewed by a consultant but after 14 hours from admission had elapsed.	9 patients
Patient excluded from need for 1st consultant review to be by consultant as all exclusion criteria met	12

CS2 Hours between admission and 1st consultant review



7DS Clinical Standard 5
Provision of consultant directed diagnostic tests

Responses to the question:
'Ae the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs. In the appropriate timescales?

	Weekday	Weekend
Services	**Spring 2018**	**Spring 2019**
CT	Yes	Yes
Echocardiograph	Yes	Yes
Microbiology	Yes	Yes
MRI	Yes	No
Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

It was established that high standard MRI diagnostic was available to our patients over the weekend but not as prescribed standard.

7DS Clinical Standard 6

Comparison between provision of consltant directed interventions between surveys

Services	Weekday Spring 2018	Weekend Spring 2019
Critical Care	Yes - on site	Yes - on site
Primary Percutaneous Coronary intervention	Yes - on site	Yes - on site
Cardiac Pacing	Yes - on site	Yes - on site
Thrombolysis	Yes - on site	Yes - on site
Emergency General surgery	Yes - on site	Yes - on site
Interventional Radiology	Mix of on and off site (all by formal arragement)	Mix of on and off site (all by formal arragement)
Renal Replacement	Yes - on site	Yes - on site
Urgent Radiotherapy	Yes - on site	Yes - on site

7DS Clinical Standard 8

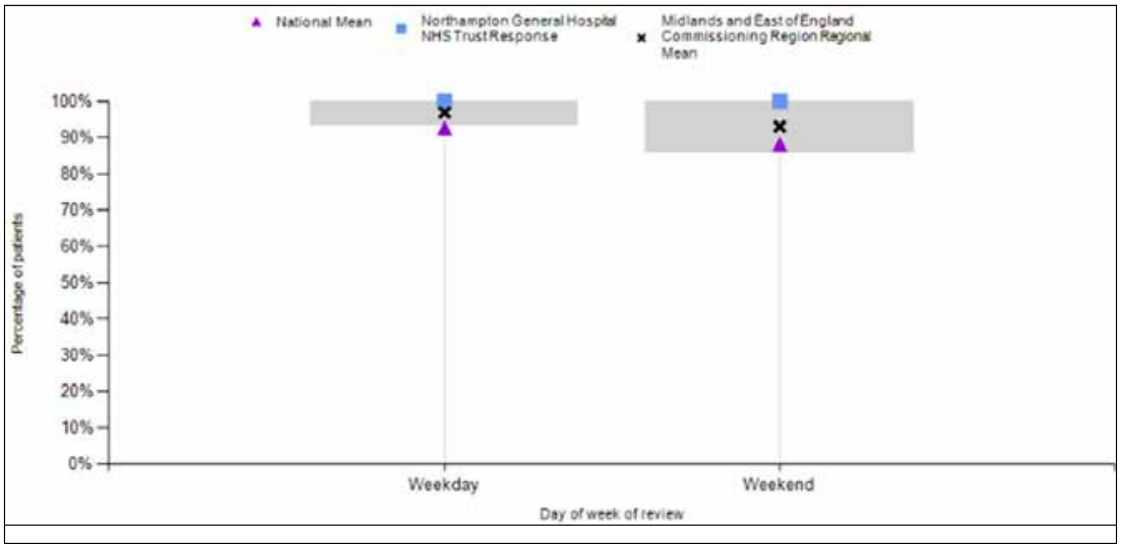
Patients who required twice daily consultant reviews and were reviewed twice by a consultant

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Twice daily reviews required & received	5	2	1			3	5	8	8	16
Twice daily reviews required & not received										
Excluded from the analysis										
Total number of daily reviews	5	2	1			3	5	8	8	16
Percentage - Receiving required once daily reviews	100%	100%	100%			100%	100%	100%	100%	100%

Patients who required once daily consultant reviews and were reviewed twice by a consultant

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Once daily reviews required & received	92	84	95	86	82	62	59	439	121	560
Once daily reviews required & not received	1	5	3	2	5	27	31	16	58	74
Excluded from the analysis	2		1	3	1	2	2	7	4	11
Total number of daily reviews	95	89	99	91	88	91	92	462	183	645
Percentage - Receiving required once daily reviews	99%	94%	97%	98%	94%	70%	66%	96%	68%	88%

National and regional benchmarking: Proportion of Twice daily consultant directed reviews



The Board Assurance Framework was presented to The Quality Governance Committee (22nd February 2019) as required by NHS Improvement. It was accepted as the way future assurance would be provided but, as directed by NHSI, it contained no new data.

This work is on our 2019-20 Clinical Audit Forward Programme. Specifically patients admitted through non-elective paths over the first two weeks of April (2019) will be audited against CS2 & CS8 by 'Real-time' data collection on the wards and obtaining notes after discharge if necessary. In addition a retrospective notes audit of patients admitted to specialist services (stroke and vascular) will be carried out.

Further information will be collected to audit compliance with against CS5 & CS6 in the same period. To supplement this, a review of mortality, complaints, incidents and patient feedback related to 7 day service provision will be carried out. This information will be presented through the Board Assurance Framework to the NGH Quality Governance Committee in time for the completed framework and the subsequent documented board assurance. This will be reviewed for lessons and improvements and amended as required for our second Bi-annual 7DS review and submission.

Submissions are due end of June and November 2019.

STATEMENTS OF ASSURANCE FOR SELECTED CORE INDICATORS

Performance Against National Quality Indicators

The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework. Where available, data has been provided showing the national average as well as the highest and lowest performance for benchmarking purposes. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein. For the following information data has been made available to the Trust by NHS Digital. Where this has not been available, other sources have been used and these sources have been stated for each indicator. In accordance with the reporting toolkit the trust can confirm that it considers that the data contained in the tables below are as described, due to them having been verified by internal and external quality checking

Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions

Summary Hospital-Level Mortality Indicator (SHMI) – (value and banding of the SHMI)

Period	NGH Value	NGH Banding	National Average	National High	National Low
Oct 17 – Sep18	104	2	100	127	69
Oct 16 – Sep 17	97	2	100	125	73
Oct 15 – Sep 16	95	2	100	116	69
Oct 14 – Sep 15	102	2	100	117	65
Oct 13 – Sep 14	98	2	100	119	59

*SHMI banding:

SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than expected'
SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected'
SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'

The Trust has an 'as expected' SHMI at 104 for the period October 2017 to September 2018 as demonstrated in the table above. Unlike HSMR, the SHMI indicator does include deaths 30 days after discharge and therefore patients, including those on palliative care end of life pathways, who are appropriately discharged from the Trust.

NGH has taken the following actions to improve this rate and quality of its services; regularly analysing mortality data and undertaking regular morbidity and mortality meetings to share learning across the Trust and externally through countywide morbidity and mortality meetings.

- Palliative Care Coding – (percentage of patient deaths with palliative care coded at either diagnosis or specialty level)

Period	NGH	National Average	National High	National Low
Oct 17 – Sep18	40.8%	31.1%	64.0%	10.7%
Oct 16 – Sep 17	41.1%	36.61%	59.8%	11.5%
Oct 15 – Sep 16	36.62%	29.74%	56.26%	0.39%
Oct 14 – Sep 15	25.9%	26.6%	53.5%	0.19%
Oct 13 – Sep 14	26.6%	25.32%	49.4%	0.0%

NGH has taken the following actions to improve this rate and quality of its services; by prioritising end of life care and placing greater importance on palliative care

Domain 3 – Helping people to recover from episodes of ill health or following injury

- Patient Reported Outcome Measures scores (PROMs) - (adjusted average health gain)
  - Hip replacement surgery
  - Knee replacement surgery
  - Groin hernia surgery
  - Varicose vein surgery

	NGH Performance		National Performance		
	Reporting Period 2018/19	Quality Account 2017/18	2017/18 Average	2017/18 High	2017/18 Low
• Groin hernia surgery (EQ-5DTM Index)	No longer collected	0.091 (final Apr17 to Sep17)	0.089 (final Apr17 to Sep17)	0.137 (final Apr17 to Sep17)	0.029 (final Apr17 to Sep17)
• Varicose vein surgery (EQ-5DTM Index)	No longer collected	* (final Apr17 to Sep17)	0.096 (final Apr17 to Sep17)	0.134 (final Apr17 to Sep17)	0.035 (final Apr17 to Sep17)
• Hip replacement surgery - primary (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	0.482 (final Apr17 to Mar18)	0.468 (final Apr17 to Mar18)	0.566 (final Apr17 to Mar18)	0.376 (final Apr17 to Mar18)
• Hip replacement surgery– revision • (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	* (final Apr17 to Mar18)	0.289 (final Apr17 to Mar18)	0.322 (final Apr17 to Mar18)	0.142 (final Apr17 to Mar18)
• Knee replacement surgery - primary (EQ-5DTM Index)	0.401 (provisional Apr18 to Sep18)	0.343 (final Apr17 to Mar18)	0.338 (final Apr17 to Mar18)	0.417 (final Apr17 to Mar18)	0.234 (final Apr17 to Mar18)
• Knee replacement surgery - revision (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	* (final Apr17 to Mar18)	0.292 (final Apr17 to Mar18)	0.328 (final Apr17 to Mar18)	0.196 (final Apr17 to Mar18)

- No scores available for fewer than 30 records.

NGH has taken the following action to improve the rates, and the quality of its services by further developing the work undertaken in theatres.

- Emergency re-admissions to hospital within 28 days of discharge - percentage of patients readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust)

Period	NGH	National Average	National High	National Low
Patients aged 0-15				
2018/19	N/A	N/A	N/A	N/A
2017/18	N/A	N/A	N/A	N/A
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	13.15%	10.01%	13.58%	5.10%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

Period	NGH	National Average	National High	National Low
Patients aged 16 and over				
2018/19	N/A	N/A	N/A	N/A
2017/18	N/A	N/A	N/A	N/A
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	11.15%	11.45%	13.50%	8.96%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

NHS Digital has confirmed that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

Domain 4 – Ensuring that people have a positive experience of care

- Responsiveness to the personal needs of patients

Period	NGH	National Average	National High	National Low
2017/18 (Hospital stay: 01/07/2017 to 31/07/2018; Survey collected 01/08/2017 to 31/01/2018)	65.1%	68.6%	85%	60.5%
2016/17 (Hospital stay: 01/07/2016 to 31/07/2016; Survey collected 01/08/2016 to 31/01/2017)	61.1%	68.1%	85.2%	60.0%
2016/17 2015/16 (Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016)	65.5%	69.6%	86.2%	58.9%
2014/15 (Hospital stay: 01/06/2014 to 31/08/2014; Survey collected 01/09/2014 to 31/01/2015)	66.5%	68.9%	86.1%	59.1%
2013/14 (Hospital stay: 01/06/2013 to 31/08/2013; Survey collected 01/09/2013 to 31/01/2014)	68.6%	68.7%	84.2%	54.4%

NGH continues to review patient experience and build on the work currently being undertaken across the Trust.

- Staff who would recommend the trust to their family or friends – (percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends)

Period	NGH	National Average	National High	National Low
2018	68.6%	71.3% (Acute Trusts)	87.3% (Acute Trusts)	39.8% (Acute Trusts)
2017	69%	70% (Acute Trusts)	86% (Acute Trusts)	47% (Acute Trusts)
2016	68%	69% (Acute Trusts)	85% (Acute Trusts)	49% (Acute Trusts)
2015	52%	69%	85%	46%

NGH is reviewing the scores in order to improve the rates, and so the quality of its services. The data is being fed through the trusts divisional structure with the aim to join it with patient experience. The trust aims to increase staff engagement and hope to develop a triangulation between performance, experience and engagement.

- Friends and Family Test – Patient - (percentage recommended)

Period	NGH	National Average	National High	National Low
Inpatient				
2018/19	N/A	N/A	N/A	N/A
2017/18	93%	96%	100%	75%
2016/17	91.1%	96%	100%	80%
March 2016	85.4%	67%	93%	38%
March 2015	78%	95%	100%	78%

Period	NGH	National Average	National High	National Low
Patients discharged from Accident and Emergency (types 1 and 2)				
2018/19	N/A	N/A	N/A	N/A
2017/18	88%	88%	100%	66%
2016/17	86.7%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	85%	87%	99%	58%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

NGH has taken the following actions to improve the percentages, and the quality of its services by encouraging a culture of reporting throughout the Trust.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

- Venous Thromboembolism – (percentage of patients who were admitted to hospital and who were risk assessed, for venous thromboembolism)

Period	NGH	National Average	National High	National Low
Q3 18/19	95.45%	95.65%	100%	54.86%
Q2 18/19	94.95%	95.49%	100%	68.67%
Q1 18/19	90.98%	95.63%	100%	75.84%
Q4 17/18	96.61%	95.23%	100%	67.04%
Q3 17/18	95.92%	95.36%	100%	76.08%
Q2 17/18	94.84%	95.25%	100%	71.88%
Q1 17/18	95.56%	95.20%	100%	51.38%
Q4 16/17	95.90%	95.46%	100%	63.02%
Q3 16/17	95.87%	95.57%	100%	76.48%
Q2 16/17	95.25%	95.45%	100%	72.14%
Q1 16/17	94.10%	95.74%	100%	80.61%
Q4 15/16	95.2%	96%	100%	79.23%

NGH has taken action to improve the percentages and the quality of its services, by further developing systems to ensure risk assessments are reviewed and promoted. The aim is that all patients, who should have a VTE risk assessment carried out, have one 100% of the time.

- Rate of Clostridium difficile (C.Diff) infection - (rate per 100,000 bed days of cases of C.Diff infection, reported within the Trust amongst patients aged 2 or over)

Period	NGH	National Average	National High	National Low
2018/19	N/A	N/A	N/A	N/A
2017/18	7.5	14	91	0
2016/17	8.7	12.9	82.7	0
2015/16	12.7	14.9	67.2	0
2014/15	11.8	14.6	62.6	0
2013/14	10.2	14.0	37.1	0

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

NGH has taken the following actions to improve the percentages, and the quality of its services by sending stool samples in a timely manner, prompt isolation of patient's with diarrhea and improving antimicrobial stewardship.

- Patient Safety incidents as per the NRLS data

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported to the NRLS within the trust - (Acute Non-Specialist)				
Oct 17 – Mar 18	3,800	5,175	19,897	1,311
Apr 17 – Sep 17	3,085	4,975	15,228	1,133
Oct 16 – Mar 17	4,335	6,707	14,506	1,301
Apr 16 – Sep 16	3,830	6,575	13,485	1,485
Oct 15 – Mar 16	3,538	4,335	11,998	1,499
Apr 15 – Sep 15	3,722	4,647	12,080	1,559

Period	NGH	National Average	National High	National Low
The rate (per 1,000 bed days) of patient safety incidents reported to the NRLS within the trust - (Acute Non- Specialist)				
Oct 17 – Mar 18	28.76	42.5	124	24.9
Apr 17 – Sept 17	23.47	42.8	111.69	23.47
Oct 16 – Mar 17	33.3	64.3	69.0	23.1
Apr 16 – Sep 16	30.8	40.9	71.8	21.1
Oct 15 – Mar 16	28.4	39	75.9	14.8
Apr 15 – Sep 15	31.1	39.3	74.7	18.1

Period	NGH	National Average	National High	National Low
The number of such patient safety incidents reported to NRLS, that resulted in severe harm or death - (Acute Non- Specialist)				
Oct 17 – Mar 18	33	18.8	78	0
Apr 17 – Sept 17	19	18.3	92	0
Oct 16 – Mar 17	13	34.7	92	1
Apr 16 – Sep 16	13	33.6	98	1
Oct 15 – Mar 16	18	34.6	94	0
Apr 15 – Sep 15	6	19.9	89	2

Period	NGH	National Average	National High	National Low
The percentage of such patient safety incidents that resulted in severe harm or death - (Acute Non- Specialist)				
Oct 17 – Mar 18	0.87%	0.37%	1.56%	0.00%
Apr 17 – Sept 17	0.62%	0.37%	1.55%	0.00%
Oct 16 – Mar 17	0.10%	0.36%	0.53%	0.01%
Apr 16 – Sep 16	0.33%	0.51%	1.73%	0.02%
Oct 15 – Mar 16	0.51%	0.40%	2.0%	0%
Apr 15 – Sep 15	0.16%	0.43%	0.74%	0.13%

NGH has taken action to increase the number of patient safety incidents reported and continues to encourage a positive reporting culture.

3 PART THREE PROGRESS AGAINST OUR PRIORITIES FOR 18/19 SET IN 17/18 QUALITY ACCOUNTS

This section shows our local improvement planning and progress made against our priorities set in the 2017/18 Quality Report, since its publication. These indicators are not covered by a national definition unless indicated otherwise.

Project Name: (1) Improving the Quality & Timeliness of Patient Observations

What are we trying to accomplish?

Setting Aims:

Aim – Improve overdue observation rate to achieve the Trust target of no greater than 7%.			
Goal Statement	**Measure**	**2014-2015 Outturn**	**Target Performance**
Improve the quality & timeliness of patient observations	Overdue observations data via VitalPac across all adult general wards	Recorded as an average of 9.14%	Improve overdue observation rate by 3% to achieve the Trust target of no greater than 7%

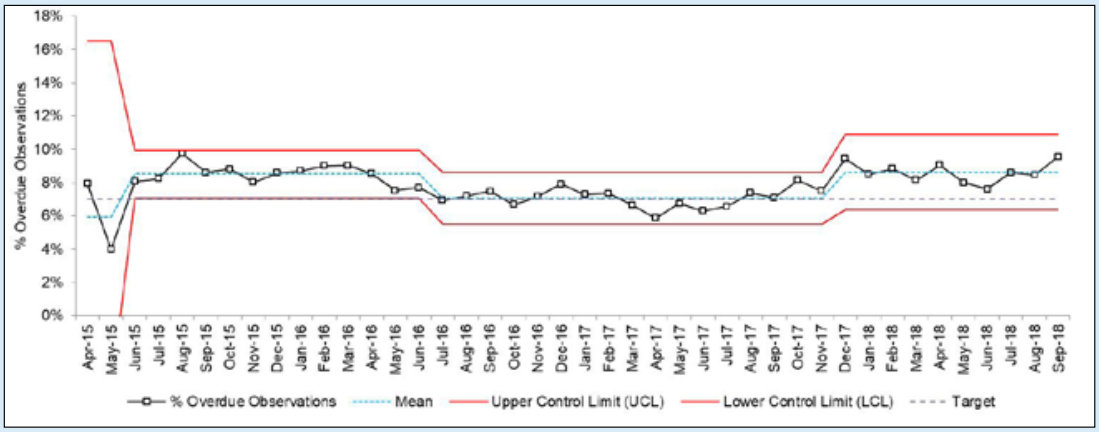
How will we know that a change is an improvement?
Establishing Measures:
VitalPac data for each ward is extracted monthly and circulated to wards. Targeted support is then offered to wards that are consistently are above the trust 7% target.

What changes can we make aimed at improvement?
PDSA

- Circulate late observation data to all adult wards monthly
- All wards non-compliant are expected to have an action plan in place.

Quality Improvement Project Update:

2018 data for late observations



Historically, late observation data was captured as part of a point prevalence audit and aligned to the 'bay working' project (this has since been superseded). as the data added little value.

Late observation data is now collected via VitalPac performance and reported and circulated to all senior nurses, matrons and ward sisters From Q2, the distribution has been distributed directly from IT colleagues. Historically NGH has placed a threshold of acceptance at 7%. Any ward that is consistently above that level is required to have an action plan in place through the senior nursing team.

During Q3 there has been some IT transitional difficulties extracting data from VitalPac and thus no data available for analysis on a monthly basis. This information is visible in VitalPac performance and reporting on a daily basis.

Project Name: (2) Improving the Early Identification & Management of the Deteriorating Patient

What are we trying to accomplish?

Setting Aims:

Aim – To improve early identification & management of the deteriorating patient			
Goal Statement	**Measure**	**2014-2015 Outturn**	**Target Performance**
Improve early identification & management of the deteriorating patient	1. Data evidencing critical risk patients 2. Reduction in preventable Cardiac arrest calls	38 coded preventable cardiac arrest calls following full review	Reduce preventable cardiac arrest calls by 15% by 2018/19 resulting in <32 preventable calls per year.

It has been reported that up to a third of hospital cardiac arrests could be preventable. Some of these could be prevented with better recognition of deteriorating patients and the correct escalation and management of these patients.

How will we know that a change is an improvement?

Establishing Measures:
- We will monitor critical risk >7 EWS patients
- We will monitor the % of these patients with a management plan in place
- We will monitor the number of cardiac arrest calls

What changes can we make aimed at improvement?

PDSA
- Monthly point prevalence EWS audit
- Resuscitation Committee standard agenda item
- Presentation of all preventable cardiac arrest call cases to CQEG monthly
- Learning to be shared across Trust
- Thematic data collected and analysed

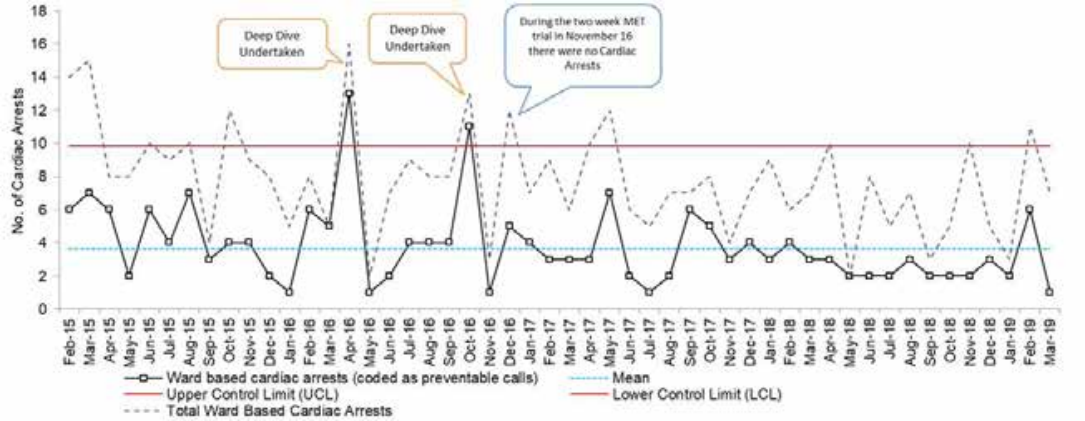
A monthly point prevalence audit reviewing critical risk >7 EWS patients each month and whether they have an appropriate plan in place. If no patients at time of audit are scoring within the critical risk category any patients scoring in the high risk >5 category will be reviewed instead. The required plan would include, Code Red, review to the appropriate level doctor, sufficient documentation to support the plan, TEP and DNACPR.

All ward based cardiac arrests will be fully reviewed by all clinicians on the Resuscitation Committee and the Resuscitation Officer responsible for the case and deemed as preventable or unpreventable. A brief review report of the case is then sent to the appropriate directorate for discussion at mortality and morbidity meetings.

UPDATE, from Q3 2018/19
A review of the data collected, the resource required, the impact and the value it offers took place and it appears the EWS audit data for patients scoring (>7 or >5, code red patients , TEP in place) proved to be of little value. A more strategic approach is suggested, which aligns to the deteriorating patient work stream and will allow the collection of more comprehensive and meaningful data, which will be of greater value. The deteriorating patient work stream leads have developed a care plan to assist in the safe and effective management of high risk patients in the Trust, which will be rolled out between February and August 2019. This will enable the identification of critical and high risk patients, whilst establishing the interventions, escalation and management plan for these patients. It is hoped that a standard of care (SOC) score will be calculated from each high/critical risk / deteriorating episode.

Preventable cardiac arrest calls

There have been 18 preventable cardiac arrest calls to date. The target of reducing preventable cardiac arrest calls by 15% is likely to be met. The main reason of missed opportunities to prevent cardiac arrest calls is a lack of anticipatory decision making relating to do not attempt cardio pulmonary resuscitation (DNACPR) orders. The deteriorating patient work stream oversees a work stream that has a focus on improving care in this area.



Project Name: (3) Eliminating delays in investigations and management for patients who are septic

What are we trying to accomplish?

Setting Aims:

Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting, resulting in organ dysfunction and death.

The Parliamentary and Health Service Ombudsman (PHSO) published Time to Act in 2013, which found that recurring shortcomings in relation to the sepsis management included:

- Failure to recognise presenting symptoms and potential severity of the illness
- Delays in administering first-line treatment
- Inadequate first-line treatment with fluids and antibiotics
- Delays in source control of infection
- Delays in senior medical input

At NGH we aim to eliminate delays in antibiotics administration to septic patients by ensuring that patients with deranged early warning scores (EWS) are screened for sepsis both on identification of EWS rise and at entry to the hospital . We also aim to increase antibiotic administration to 90% compliance within 60 mins from diagnosis for patients with red flag sepsis, for both ED and inpatients in line with national 2017/18 CQUIN targets.

How will we know that a change is an improvement?

Establishing Measures:
In 2017/18, we have continued to audit random samples of patients presenting to both the Emergency Department and inpatient wards. We are measuring performance against two sets of criteria (samples are audited monthly):

- Total number of patients presenting to emergency departments and other units that directly admit emergencies, and acute inpatients services who met the criteria of the local protocol on Early Warning Scores (from Q4: NEWS 2 greater than or equal to 5) and were screened for sepsis. Evidence is gathered from ED FIT forms' screening tool and inpatient screening data from Vitalpac, ePMA with reference to specific monthly reports from Blood Cultures and Coding.

- Total number of patients found to have sepsis in emergency departments and acute inpatient services in sample 2a who received IV antibiotics within 1 hour of the diagnosis of sepsis.
  Evidence is gathered from Vitalpac and ePMA with some reference to patient notes.

What changes can we make aimed at improvement?

PLAN:
The sepsis challenge continues into 2018/19:
Before national attention focused on the condition, patients dying of sepsis secondary to infection were often coded to the infection only, masking the prevalence and deadly potential of sepsis. During 18/19, acute and emergency units are expected to be transitioning to use the National Early Warning Score (NEWS 2) to screen patients. By Q4 of 2018/19, payment will only be made if over 90% of screened cases have been screened using NEWS 2. **NEWS 2 was established within all departments from December 2018. With the exception of Maternity departments and paediatrics departments, Both continue to utilise specific screening tools for their areas.**

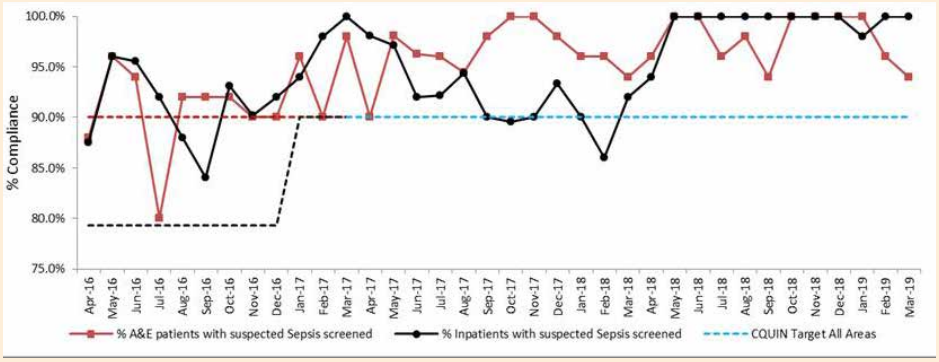
EARLY RECOGNITION:
Consistent, early recognition of sepsis presents a particular challenge and more needs to be done to educate clinical staff on early stage sepsis presentation. BLS and SIM training include a brief overview on sepsis/sepsis scenarios and Vitalpac functionality supports sepsis recognition but staff on adult inpatient ward, need to be vigilant and understand the implications of the body's dysregulated response to infection.

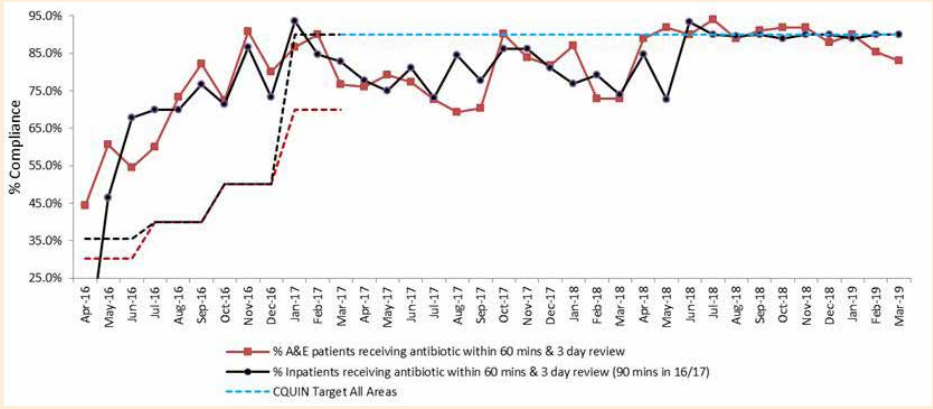
EARLY TREATMENT:
Consistent treatment with broad spectrum antibiotics < 60 minutes of diagnosis is equally challenging. 60 minutes is an aggressive target to initially assess / screen and consider, take blood cultures, prescribe/request and give ABX stat dose. Particular challenges include patients deteriorating OOH and contacting doctors when they are off ward. Where possible education of both Nurses and Doctors has highlighted, communication as a key to reducing the delay in Antibiotic treatment once prescribed.

CQUIN 2018-19:
Screening & treatment targets will continue to sit at 90% for ED and inpatients. Vitalpac auto-screening alerts facilitate, News 2 high screening compliance ; however, staff need to be educated to respond to the screening questions properly and to have a low level of suspicion if patients start to deteriorate. The 60 minute ABX target will be highlighted by the system but again, human factors such as inability to contact doctors within the hour will limit treatment compliance.

CQUIN SUPPORT:
The newly appointed Sepsis Nurse will proactively review deteriorating patients, visit wards to assess & discuss, challenge and educate staff both on the ward and in specific training sessions to build on best practice as well as audit, promote, report and so on.

2018/19 CQUIN audit results – target = 90%





Quarter 4 - CQUIN targets:

DO:
See actions in project update, below.

STUDY:
Early recognition of sepsis presents a particular challenge, especially when patients present a-typically for example, with no fever or pallor. As part of her role the Sepsis Nurse, will educate and constructively challenge nursing staff and clinicians. The Sepsis nurse has embarked on a Quality improvement project to enhance nurse's knowledge and confidence within the trust on early recognition and treatment of sepsis. Initiating sepsis champions within the Trust providing sepsis workshops, shop floor teaching and also teaching new starters to the Trust.

Consistent early treatment with broad spectrum antibiotics administered < 60 minutes of diagnosis is equally challenging. 60 minutes is an aggressive target to initially assess / screen, consider and make a diagnosis then prescribe and draw up, take blood cultures then give a stat dose. Issues include clinician/nurse communication especially OOH and off ward, plus potential delays escalation as patients begin to deteriorate. Some clinicians are wary of prescribing broad spectrum antibiotics because of antibiotic resistance.

The sepsis nurse is now working to identifying then review deteriorating patients, visiting wards to assess, and advise on treatment, then discuss, challenge, action plan any issues of concern. Educate staff on a case by case basis to build on best practice and has as also promoted, those who had initiated best practice and administered Antibiotics within 60 minutes.

ACT:
The Vitalpac auto-screening and treatment function implemented on Vitalpac now facilitates high compliance with screening inpatients, using NEWS2 when EWS rises or there are signs of confusion. Treatment using Sepsis Six is flagged up when sepsis is identified by nurses responding to a set of simple questions. This should lead to clearer escalation/ treatment decisions made earlier when patients start to deteriorate.
The Sepsis Nurse role provides senior, proactive oversight, aiming to drive rapid and consistent quality improvement across the Trust.

Quality Improvement Project Update - ACTION:

FRONTLINE AWARENESS:
- Consultant sepsis lead - next FY1 teaching sessions scheduled.
- September – Sepsis Awareness Week event(s) for World Sepsis day by Sepsis Nurse
- Teaching sessions have been shaped, organised and adapted to reflect action from learning by Sepsis Nurse since July2018
- BLS sepsis overview has been included in sessions since Dec 17
- SIM Suite continuing to use sepsis scenarios including POC sessions
- Sepsis boxes now hold two stocks of Meropenem for sepsis use.

RESOURCING:
- Full time Sepsis Nurse in post from June 2018

SEPSIS GUIDELINES:
- Guidelines published on Trust intranet in May. Sepsis Nurse has dissimulated to each sepsis champions. A possible poster competition to be held to engage staff with regard to the Sepsis guidelines.
- Patient information leaflet to be dissimulated in the Emergency department. Sepsis wellbeing service to be set up in conjunction with the Psychology team at the University of Northamption.

AUTO SCREENING - VITALPAC:

- Vitalpac Nurse 3.5 upgrade with auto-screening for sepsis went live on May 2018. It is expected that there will be ongoing user-related queries and issues as the upgrade was implemented quickly with minimal change management/pre-training (it is a simple to use but additional task set on Vitalpac). Rapid implementation was due to previous IT delays and the need to have a robust screening tool in place for inpatients as adoption of manual tools had been inconsistent over the previous two years.

Management & Governance:

- Clinical Lead / PM / Sepsis Nurse or Lead Antimicrobial Pharmacist update CQUIN Progress Group, Antimicrobial Stewardship Group and Infection Prevention Steering Group & CQEG.
- Performance presented in planned Directorate QI Scorecards (work in progress)

Project Name: (4) Leadership Training & Development for staff

What are we trying to accomplish?

3

Setting Aims

We aim to develop a safety improvement culture as part of the roll out of the NGH Leadership model, producing leaders who are; Trusted, Motivate staff & Committed to excellence. We are trying to change behaviours to deal with issues and incidents and make improvements rather than ignore them.

It has been a busy year for the Organisational Development Team, particularly in terms of embedding our values 'We Respect and Support Each Other' across the Trust. An overview of the activities are summarised below:

1. Respect and Support Training

As part of the Respect and Support Campaign a range of training has been developed, which are available for staff. These are outlined below:

1.1 Leading with Respect

Leading for Respect is training for Team Leaders, Operational Managers and senior leaders in clinical and non-clinical roles. The training is in two parts: Forum Theatre and Classroom based training. The aim of this session is to ensure managers understand their responsibilities in addressing workplace bullying, harassment and inappropriate behaviours. It also aims to develop self- awareness around behaviours and enable managers to act as role models. The programme includes an overview of the interventions available to support all staff if they witness or experience bullying and inappropriate behaviour.

Since the launch in September 2018, 170 staff has attended this training.

1.2 Challenging Bullying and Inappropriate behaviour

Challenging Bullying and Inappropriate behaviour training is for staff that do not have line management/supervisory responsibility. Like Leading with Respect, this training includes Forum Theatre and classroom based training. The programme aims to raise awareness of bullying and inappropriate behaviours, what the behaviours look like in practice, the distinction between good management/leadership and bullying, and how to challenge these behaviours if staff experience or witness it. The programme also includes an overview of the interventions available to support all staff if they witness or experience bullying and inappropriate behaviour.

Since the launch of this programme in September 2018, 145 staff have attended the programme.

1.3 Courageous Conversations

This workshop is a follow on workshop to Leading with Respect for managers to enable them to handle difficult conversations calmly and successfully by providing feedback in a way that shapes rather than shames the person on the receiving end. The workshop helps individuals to understand the psychology behind conflict, know why and when they should have a courageous conversation and provide tools to address behaviour they are finding inappropriate.
This was piloted on 14 individuals and is being redesigned for launch in March. There are 11 on the waitlist to attend.

1.4 Resilience Training

Resilience training is a programme that has been developed to look at personal emotional resilience. It helps individuals to recognise what depletes and what restores personal resilience, and provides a range of strategies and tools to build resilience and promote health and well-being.

Since the launch of this programme in August 2018, 169 staff has attended the programme.

1.5 Respect and Support Information Hotline

The Respect and Support Information Hotline is about to launch February 2019. The helpline uses a triage approach to signpost staff to interventions if they experience or witnesses bullying, harassment or inappropriate behaviour. These interventions have been developed through the Respect and Support campaign to provide support when members of staff have concerns about an individual's behaviour or have relationship difficulties with others they work with. The hotline is a way of giving the member of staff an opportunity to talk through their issues with a trained individual and it is intended to provide the member of staff with options other than a formal process.
1.6 Round Table Conversations
Round Table Conversations is an offering currently being developed and will be available by April 2019. It involves facilitated conversations to help resolve issues of conflict between two people and reach resolutions in an informal way without the need for the formal Grievance process and potential negative impact for all. The principle of holding a round table is based upon mediation theory. The process involves two facilitators meeting with the separate parties in conflict before bringing the two parties together to facilitate understanding of different perspectives and movement towards resolution. What is shared between all parties remains confidential, allowing for greater honesty and disclosure.

2. Leadership and Management Programme.

2.1 Esther White

This leadership programme consisting of six modules is for those who are new to leadership/ management or are existing leaders/managers that would like to upskill (typically Band 7). It is developmental, experiential and practical, based on the latest leadership theory and evidence. In this programme, individuals will increase their knowledge of the core skills for managing a team, learn how to use coaching conversation skills to manage and lead and understand how to manage and successfully implement change, . Quality Improvement methodologies and training is also provided on this programme.
Since the launch in April 2018, 28 delegates have completed this programme and 31 are currently engaged in the programme.

2.2 James Stonhouse

This leadership programme consisting of six modules is for those who are in a supervisory role (typically Band 4-6) who would like to develop themselves and learn helpful material to lead and manage their teams effectively. It is developmental, experiential and practical, based on the latest leadership theory and evidence. In this programme individuals develop core management skills, coaching skills, and self and other-awareness and they acquire tools to help them lead and get the best out of their team, Quality Improvement methodologies and training is also provided on this programme.
Since the launch in April 2018, 27 delegates have completed this programme and 55 are currently engaged in/enrolled onto the programme.

3. Staff Engagement

3.1 Staff Friends and Family

The Staff Friends and Family test is a quarterly survey to gather feedback from staff on two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. In Q1 2018, 402 individuals responded, in Q2 489 individuals responded, in Q3, 2133 individuals responded to the National Survey and in Q4 2019 ongoing to 15th March 2019, there have been 118 replies to date.

3.2 Rainbow Risk

Rainbow Risk is a team intervention that provides insight into four personality types and different associated work styles. By exploring common and different traits, and the value each type bring to the organisation, individuals understand how to communicate more effectively with others including with staff and patients. In Q1 2018, 90 individuals participated, in Q2 2018, 37 individuals participated, and in Q3 2018, 15 individuals participated. There has been a decrease in delivery of this intervention with focus on the Respect and Support Campaign, however we are in the process of redesigning this to incorporate the Respect and Support values to relaunch and take teams across the Trust through this from March.

3.3. Boxes training

Out of the box training is a follow on team intervention for those who have completed Rainbow Risk. It explores how aspects of our work and life experiences can influence the way we think and feel about life, and lead us to become restricted in our view to be less objectively and rationally. In the session, individuals recognise attitudes they may develop and behaviours that can be displayed when 'in the box' which are not necessarily positive or beneficial.

In Q1 2018, 30 individuals have participated, in Q2 2018, 26 individuals have participated, in Q3 2018 41 individuals have participated and in Q4 2019, 11 individuals have participated to date.

Quality Account - IQET Update

2018 has been a very successful year for the IQE team. We successfully delivered our targets to the end of Quarter 4 in terms of participation and projects for the making quality count programme. We also delivered a new programme called SAFER 100 days across all 12 medical inpatient wards as part of the fixing the flow programme.

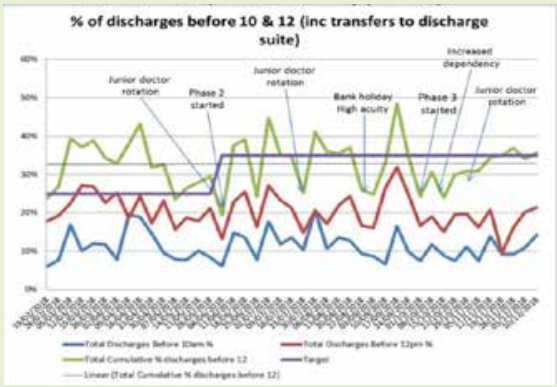
The safer in 100 days programme involved coaching our front line multi-disciplinary teams (MDT) in delivering a new method of patient planning through high quality board rounds, containing the following principles:-

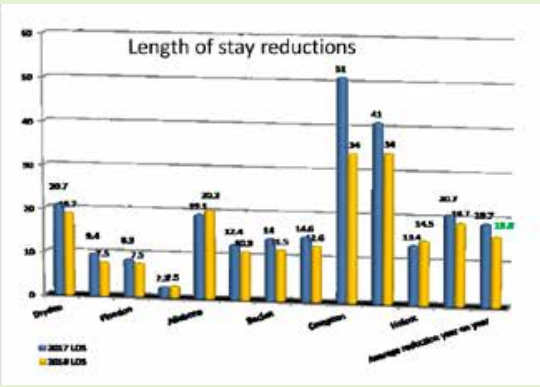
- Introducing a daily rhythm and set agenda to standardise the system.
- Implementing 'Fit 2 Sit' and 'End PJ Paralysis' , reducing the loss of muscle strength and deconditioning
- Twice daily board rounds Using "Red to Green" - ensuring each patient has a plan for the day and there is ownership of the actions with an afternoon update to ensure progress of the plan or delays/constraints have been escalated
- The main objective was to refocus the MDT on the patient's most valuable currency which is time.

Key elements of the system are to ensure we are working to the Safer daily rhythm, reinforce roles and responsibilities so everyone knows how they contribute to our patient care, log tasks and ownership and measure outcomes. This was trialled initially on four medical wards and is now being rolled out across the remaining medical division and urgent care with our on-going ambition for iBox and Safer to be Trust wide.

Our objective was to improve flow through the hospital much earlier in the day. Our headline metrics were:

- Patient flow before 12noon increase from 17% to 35%.
- Our peak of discharging patients moved from 6pm in 2017 to 3-4pm.
- LOS reduced from 18.7 days to 15.8 days.
- Stranded patients dropped by >25%





Throughout the programme we delivered a communication plan to keep the rest of the Trust aware of what's going on and our successes. We also created a "grab pack" with infographics and user guides for ongoing roll out to new team members to support sustainment.

IT supported us to build a scalable technology solution to sustain the Safer system via electronic white boards. This tool will help us to maintain the standards in the system.

The Quality Advisors continue to support other areas of the Trust with ongoing service improvement projects ranging from virtual clinics in Dermatology to support RTT Performance, Eye Casualty Triage, Domestic Services to improve isolation clean logistics and delivery, Outpatient Administration and Processes in Maxillo Facial and Urology and Paedaitric Cystic Fibrosis.

Project Name: (5) Board to Ward leadership Walk rounds

What are we trying to accomplish?

Setting Aims
Leaders need to interact with staff frequently, visiting their work place and asking for frank input. When all executives commit to regular visits (walkrounds), it can create a shared insight into the organisations safety issues.

How will we know that a change is an improvement?

Establishing Measures
A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical areas as part of monthly Trust Board Business.

- We will monitor the number of areas visited per month

- We will provide Divisional feedback identifying areas of good practice and improvement.
- We will demonstrate progress via improved staff surveys and safety climate results

What changes can we make that will result in improvement?

PDSA
The content of the board to ward guidance will continue to evolve, as regular reviews will be conducted to improve and update the process as initiatives and learning opportunities are developed and become available

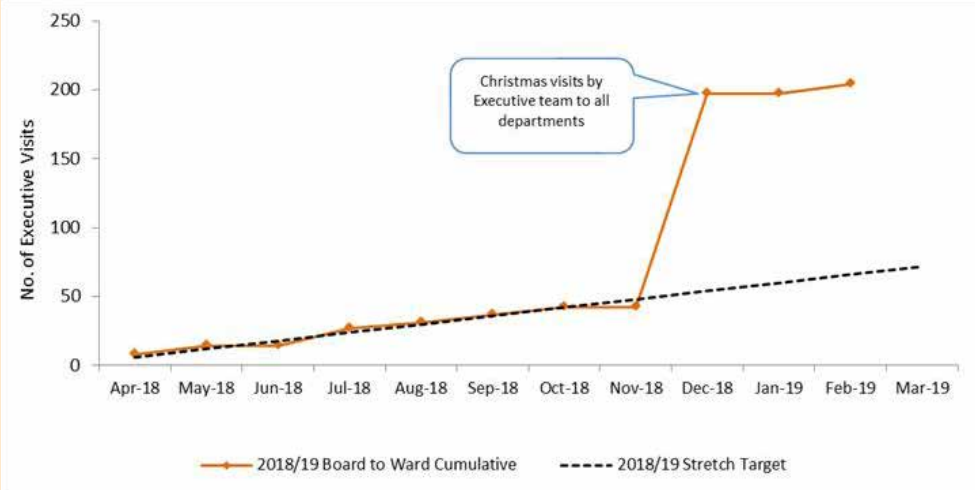
What are we trying to accomplish?

1. Setting Aims

Leaders need to interact with staff frequently, visiting their work place and asking for frank input. When all executives commit to regular visits (walkrounds), it can create a shared insight into the organisations safety issues.

2. Establishing Measures
A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical areas as part of monthly Trust Board Business.

- We will monitor the number of areas visited per month – presented monthly to QGC encompassed within the QI scorecard
- We will provide timely Divisional feedback if applicable, report all visits, themes and lessons learnt quarterly both internally and externally for patients and staff.
- We will demonstrate progress via improved staff surveys and safety climate results
- During 2018/19 – 197 executive safety rounds have taken place, this is above the internal stretch target of 72 visits a year, this is in addition to the "Beat the Bug" executive safety visits.



3. Themes identified
As this initiative becomes more embedded into practice, the discussion of areas of concern and the options for resolution becomes more dynamic. The purpose of the safety round is firstly to send a message of commitment and it also fuels a culture for change pertaining to patient safety.

The increase in issues raised is due to the increase in wards visited by the Executive Board members and the process of Board to Ward becoming embedded and accepted by clinical staff.

Project Name (6): To deliver training in QI methodology

What are we trying to accomplish?

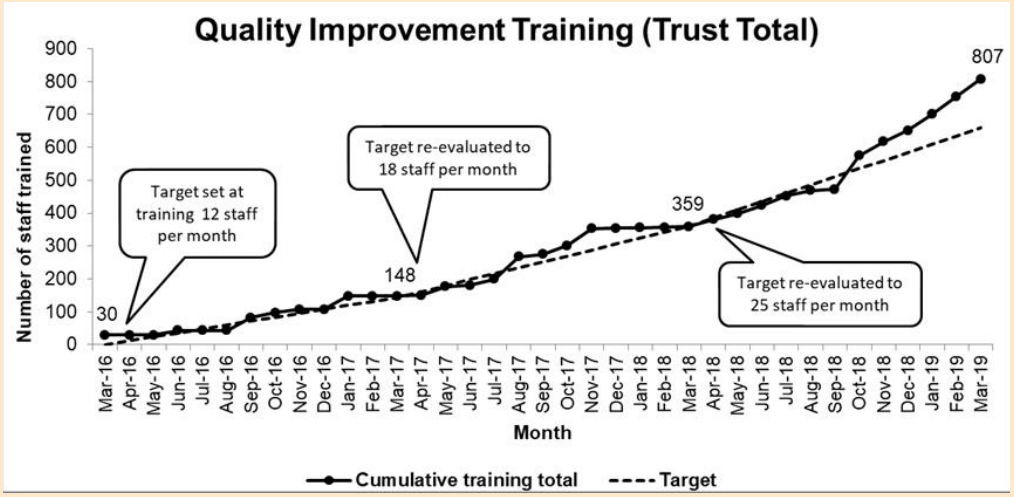
Setting Aims:
Initial aim set in March 2016:
By December 2018, train 400 staff in Quality Improvement methodology in Northampton General Hospital.

New smart aim set in March 2018:
By December 2018, train a minimum of 600 staff in Quality Improvement methodology (defined as the Model for Improvement using a standardised NGH QI project process) in Northampton General Hospital

How will we know that a change is an improvement?
Establishing Measures:

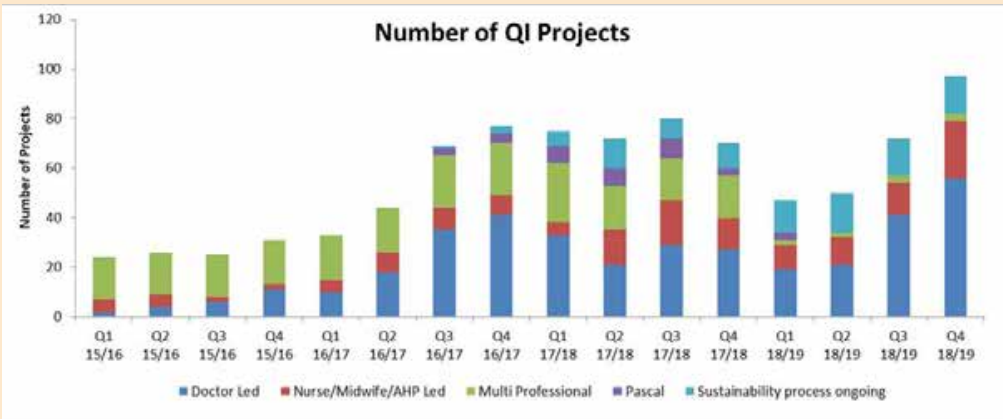
1. QI training
We will measure the number of staff we have trained in Quality Improvement methodology (IHI Model for Improvement and NGH QI project process) on a monthly basis. This data is stored in a database of all current NGH staff, enabling us to track progress by division and directorate.

The graph below shows the current training progress in a cumulative format.



We have achieved our aim – training a total of 660 staff between March 2016 and December 2018.

2. QI projects
We are also measuring the number of ongoing QI projects supported by the QI Hub. This is detailed in the graph below, also reported in the Quality Improvement Scorecard.



What changes can we make aimed at improvement?
The Quality Improvement team deliver various academic programmes to support the personal and professional development of our staff. Such programmes include:

- Junior Doctors' Safety Board
- Registrar Leadership & Management programme
- Trust Grade Development Programme
- Aspiring to Excellence Patient Safety programme
- Creating Excellence programme

We also deliver QI half-day sessions on programmes led by other teams including:

- Esther White and James Stonhouse programmes, led by Organisational Development
- Shared Decision Making Councils, led by Patient & Nursing Services
- The Stroke Journey, led by the Community Stroke team

The QI team also deliver monthly teaching sessions (previously quarterly until September 2018), which has seen 180 staff trained in 4 months.

We hope to train an additional 150 – 200 staff between January 2019 and March 2019.

Commencing in October 2019, NGH will also be delivering a new MSc Quality Improvement & Patient Safety in collaboration with the University of Northampton. This MSc will have 20 students per annum, with a large proportion expected to come from NGH each year.

Project Name (7): Safety Culture Assessment (Pascal Metrics)

What are we trying to accomplish?

Setting Aims: Safety Culture Measurement Programme (PASCAL Metrics)

Safety culture is broadly defined as the norms and values and basic assumptions of the entire organisation.
Safety climate is more specific and refers to the employees perceptions of particular aspects of the organisations culture.

In recent years there has been an increase in focus in the UK and internationally on approaches to improve safety and this has led to greater recognition of the importance of the culture of organisation and teams.

Safety culture and leadership were identified as mandatory areas for improvement from the Francis and Berwick report.

How will we know that a change is an improvement?

Establishing Measures:
Safety culture evaluation was completed using a 43-point questionnaire, developed by Pascal Metrics. The survey was completed by the two 'front door' services in the acute hospitals: Emergency Department and Maternity Department.

The safety culture survey has been broken down into 9 domains:
- Overall perceptions of patient safety
- Safety climate
- Job satisfaction
- Teamwork
- Working conditions
- Non-punitive response to error
- Perceptions of local management
- Perceptions of senior management
- Exhaustion / Resilience

What changes can we make aimed at improvement?
A baseline evaluation of the safety culture in both departments was completed in Summer 2016.

3

The NGH Emergency Department results for 2016 are shown below.

NGH ED had the highest scoring domains overall out of the 8 acute hospitals in the region.

The survey was repeated in Summer 2018, using the same key questions. The results are shown below.

We have seen an improvement in 4 domains (teamwork, safety climate, perceptions of local management and working conditions). Six of the nine domains remain on or above the industry median.

The Maternity Department results for 2016 are shown below.

The results for summer 2018 are shown below.

2018 is the final evaluation commissioned by the Patient Safety Collaborative. The findings have been collated for each department and shared with the departments for further analysis and investigation.

Project Name: (8) Point of Care (PoC, previously LFE) for Clinical teams

What are we trying to accomplish?

Setting Aims:

NHS Quality and Safety documents and reports state that cases of failure to recognise the deteriorating patient, and not calling for the correct help have become common themes during investigations, with the breakdown in team work and poor decision making as one of the main reasons, (Yu, Flott, Chainani, Fontana, & Darzi, 2016) (Dept of Health, 2015). Many cases of failure to recognise the deteriorating patient have been linked to difficulties in asking for advice and relaying information across professional and hierarchical boundaries.

During incident investigations staff raises issues such as the lack of awareness of time passing when dealing with problems, also systems and targets are challenging. They report that staffing levels are often insufficient, leadership is sometimes ineffective, and that there is still a blame culture in some areas. These all result in making working conditions difficult especially when dealing with deteriorating patients and communicating concerns to senior healthcare practitioners, (Dept of Health, 2015)(Yu et al., 2016)

During a Consultant core simulation faculty meeting chaired by the operational simulation and response lead within our Trust, the team discussed the national concerns and how we as a Trust could deliver educational programmes to support our staff. The core team discussed also how it had become apparent whilst delivering simulation speciality training programmes, there was a lack of understanding, especially around human factors skills. These Human Factor issues included a lack of situational awareness, communication, decision making, task focus and poor or inappropriate escalation to the correct member of staff. During debriefing of these sessions, the operational simulation and response lead found that the majority of staff were not aware of how human factors can either enhance or reduce performance in healthcare. (Reason J 1999).

Human factors science is concerned with interactions between humans using non-technical skills e.g. communication, situational awareness, assertiveness and task focus. In healthcare, staff having an understanding of how human factors science can improve efficiency, safety and effectiveness is fundamental to communication, leadership and patient safety (Flin, O'Connor, & Crichton, 2008)(Dept of Health, 2015)

The operational simulation and response lead discussed these findings with the risk management team to see if these themes were common in the Trust and how they could work collaboratively to develop a programme for teaching around human and system errors. To develop the learning from error (LFE) programme making it a fundamental part of the Trust educational journey, the operational simulation and response lead simulation worked closely with the Quality Improvement team, matrons, ward sisters and Director of Medical Education.

A programme was then designed for all wards and departments to have bespoke training using relevant scenarios based on real incidents from their ward/department as well as general incidents. Using Datix data from potential errors and common themes, the aim and objectives were based on communication, decision making, situational awareness, task focus, escalation and challenging behaviours. The operational simulation and response lead presented to the Trust executive team for approval before commenting with the educational programme.

Several literature reviews discuss how well simulation training has worked in high risk organisations, because it allows the staff to practice difficult situations and learn about technical and non-technical skills in relation to safety and teamwork, providing the safest environments for their workers, public and passengers. Simulation has been used in the forces and industry particularly in aviation since the 1st world war, focusing on human and system errors. However, it has only been in recent years embraced by the NHS, partly because of a focus on Patient Safety, Quality Improvement and litigation. Both the complexity of the NHS and patient safety innovative improvements have made it difficult for students and staff to gain opportunities in clinical placements and to explore how they would deal with real life emergencies and advanced clinical procedures. Often healthcare professionals have to recall classroom based learning to deal with emergencies or rare events for the 1st time on a patient. The Chief Medical Officers (CMO) Report explains in detail how simulation in all its forms will be a vital part of building a safer healthcare system. (CMO 2008)

How will we know that a change is an improvement?

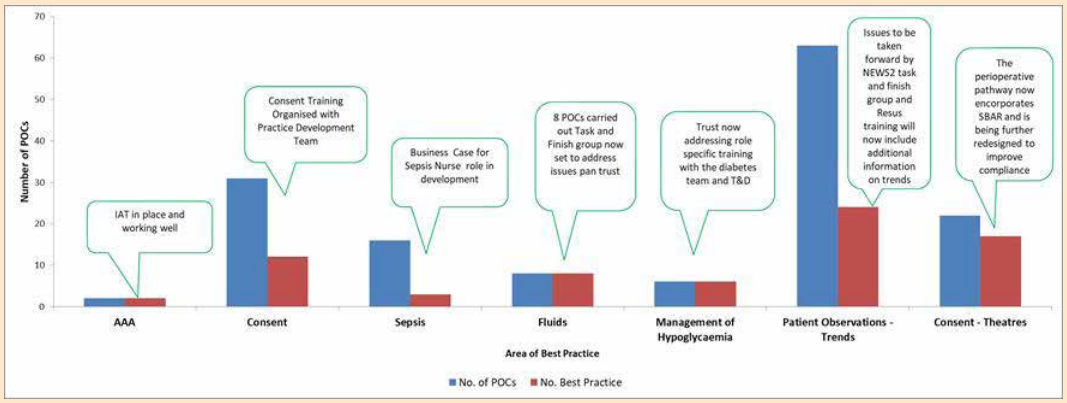
Establishing Measures
The aim was to have at least 50% of ward teams attending Learning from Error (LFE) sessions annually, by 2018. Over the year the programme achieved over 50% of nursing and allied health professional training but had minimal uptake from the medical teams. PDSA revealed the need to change the process. A pragmatic decision was made to stop running programmed LFE sessions within the Simulation Suite due in the main to lack of attendance, but this would be offered to teams if needed in the future. Learning from error training has now been built into all simulation training programmes both locally and regionally.

The Simulation and Resuscitation Service team have worked collaboratively to achieve Point of Care (PoC) simulations.
There are three arms to this piece of work:

Quality Improvement Project Update:
Phase 1

- **Annual plan** – the aim is that all wards will receive PoC during the year which addresses bespoke issues highlighted through datix reports.
- **Urgent care** – the urgent care project which is supporting staff on the two assessment wards to address reducing preventable cardiac arrests and increasing awareness of escalation of the deteriorating patient issues.
- **Reactive PoC's** – The Review of Harm group meets weekly and any major thematic concerns from the weeks agenda are formulated into PoC simulations, the report from which is accepted within the following weeks' agenda and escalated appropriately. These simulations are aimed at determining if staff are equipped to respond to a given clinical situation following National / local best practice.

Reactive PoC's



System improvements form the RoHG PoC simulation programme are as follows:

- Consent training for all ward staff which included, a new design of a perioperative care pathway to enable staff to make sure all patients are prepared correctly for surgical procedures before going to specialist clinics or theatres.
- Layout of our pain clinic to make sure all emergency equipment is accessible when needed
- Review of the diabetic treatment plans
- Escalation procedures including the use of SBAR DNACPR and MCA

2 x Identity Bracelets. One wrist, one alternate ankle, not operation site. ☐			
Details on identity band are correct	Yes ☐	No ☐	
Signed and dated Consent Form to planned operation present	Yes ☐	No ☐	
If Consent Form 4 required, a completed MCA Form is available	Yes ☐	No ☐	
Medicine Chart	Paper Chart present? ☐	On EPMA ☐	
Seen by surgeon to confirm need for surgery	Yes ☐	No ☐	
Relevant notes present	Yes ☐	No ☐	Anaes Questionnaire completed? Yes ☐ No ☐
Operation site marked	Yes ☐	N/A ☐	
IF ANY ITEMS WITHIN THIS BOX ARE NOT COMPLETED / CORRECT, THE PATIENT DOES NOT MOVE TO THEATRE			

- oUsing simulated patients the team tested the safety functions of the new Nye Bevan building before it opened to the public, including transferring of patients from the emergency department, ambulance to the new assessment building for urgent care and from urgent care building to areas of the trust, for example: CT, x-ray, wards, theatre and ITU. To make sure all the Trust systems worked effectively in line with patient safety initiatives.

Phase 2:

Priority proactive PoC simulation programme

- All wards received PoC training and this in situ training allowed for the team to work together with a deteriorated patient. All teams were prepped about the training but no told when the PoC would occur. The operational simulation and response lead, Safety leads and ward manager would decide on the day of the PoC that it was safe to proceed with the training. This occurred weekly and on a monthly basis the emergency cardiac /per arrest or trauma teams were also bleeped to attend.
- Expert core faulty observed the teams and a hot debrief after the simulation with the team. This allowed for a team discussion on clinical management and non-technical skills. This programme was very successful because of senior staff support within the Trust, and feedback from all staff who participated in PoC to say how safe and realistic the training was, the PoC programme became an integral part of education within our Trust. All teams received a written report of the PoC for their own learning, including learning from errors leaflet on human factors.

Current QI project : Urgent care division

- The urgent care wards needed to be clinically prepared for the new urgent care building which was due to open in October 2018. The operational simulation and response lead worked closely with the senior management team of the new build to
- Teach staff new skills for the assessment unit through simulation.
- Weekly PoC training programme within the new building to embed safe practices and support the teams with the new ways of working.

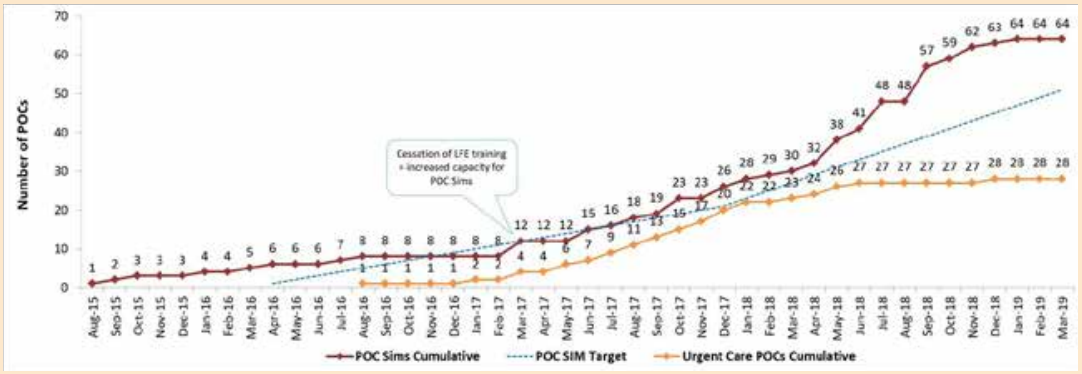
Reactive PoC simulations programme

- The RoHG PoC simulation programme now includes the deteriorating patients work stream.
- The aim of the deteriorating patient work stream is to improve patient safety across the Trust. Patients will be scored on the standard of care they receive, any lapses or omissions in care will be identified and an action learning plan established to improve care. The resuscitation and simulation team provide in terms of education, training, evaluation and sustaining good practice, through the PoC simulation training programme.

What changes can we make aimed at improvement?

- Collaborative working with the Governance, Safe Guarding and Quality Improvement Safety Leads
- The trust 2019 programme is divided into divisions enabling 3 months of PoC training for each division, capturing as many areas within the division as possible.

Annual PoC's



Examples from our staff Feedback: post PoC teaching

- Staff nurses feeling more confident managing difficult patients after the practice with POC
- Seniors want to have more practice at leading the POC to give them confident in leading the teams when doctors are busy with other acutely unwell patients and are delayed
- The practical sessions are realistic
- Faculty support in debriefs is non-judgemental and supportive
- 98% of the nursing staff agree this prepares them for dealing with real life emergency's
- They prefer the live actor where possible as it feels even more realistic
- The administration staff can see who helpful they are in an emergency
- Timings can be difficult with the management of the ward and flow of patients
- Understand the correct escalation process for patient who is scoring high on their EWS
- Understand the importance of the SBAR communication tool
- What the processes are if the doctor you call is too busy to attend
- Feedback is personalised and useful to our team
- It's realistic and safe
- Hands on practical and understating the knowledge behind the decision making process
- Its makes you nervous but found the learning helpful
- PM session were suggested to involve medical staff more
- The importance of effective communication

Best practice observed:

good recognition of the deteriorating patient
calling for help in less than 30 seconds
Prompt response and treatment for all medical emergency's with all teams
Good open and honest debriefs allowing for constructive safe learning
Good responses from the on call teams and participation
Good leadership from senior staff to junior staff
Minimal disruption to clinical teams working day

Improvements for 2019

Extensive work for all staff on escalation of the deteriorated patient and communication and use of SBAR for handovers
Through PoC simulation the team will focus all educational training on explicit communication using SBAR, decision making, situational awareness and teamwork when dealing with simulated clinical emergencies, followed by hot debriefs.

Project Name: (9) Eliminate Hospital Acquired Pressure Ulcers

What are we trying to accomplish?

Setting Aims:

Hospital acquired pressure damage continues to remain the biggest harm to our patients and the Trust continues to be an outlier for prevalence and incidence. Pressure ulcer prevention care at NGH is, for the most part, good with risk and skin assessments being completed almost comprehensively and the correct interventions are made for the majority of patients.

The Tissue Viability Team (TVT), with support from the Director of Nursing, Midwifery and Patient Services, and Senior Nursing Team, are committed to supporting the heightened level of activity across the Trust to sustain change and will continue to reduce the level of pressure harm that our patients experience whilst in our care.

How will we know that a change is an improvement?

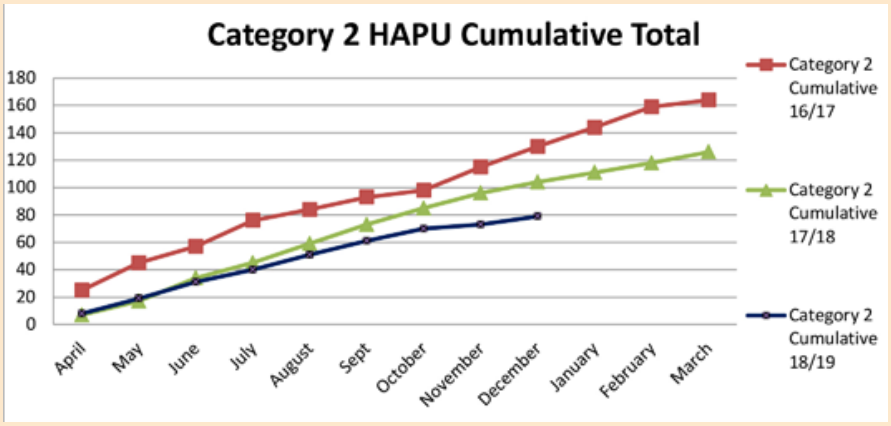
Establishing Measures:
We will measure the number of pressure ulcers of grade 2, 3 and 4. With a target to reduce grade 2 by 10% each year, grade 3 by 10% each year one and maintain grade 4 at 0%. We aim to reduce pressure ulcers by 50% overall by March 2019.

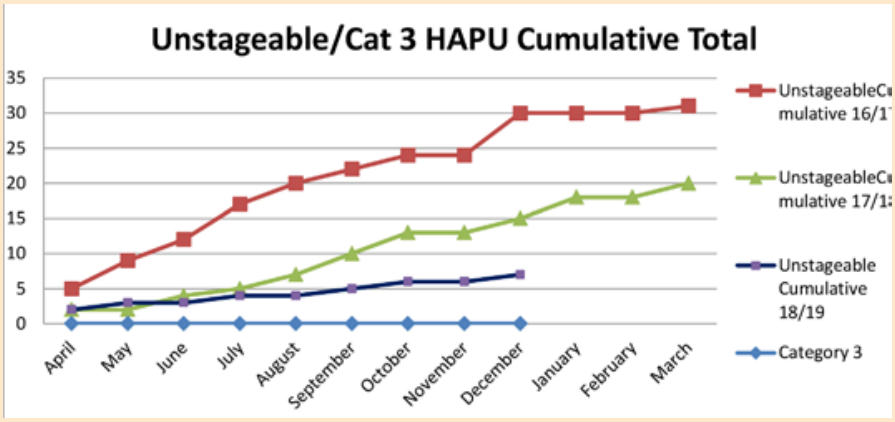
What changes can we make aimed at improvement?

PDSA:

- Collaborative working with Fall Prevention Team and IPC Team, which includes working together to reduce harms on the wards by carrying out post harm reviews together, redesigning new ward safety boards on wards.
- QI Projects to reduce harms and improve safety.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Category 2	8	11	11	9	11	10	9	3	6
Unstageable	2	1	0	1	0	0	1	1	0
Grade 4	0	0	0	0	0	0	0	0	0
Total HAPU (NGH) excluding sDTI's	10	12	8	9	11	12	16	3	6





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Countywide TV Forum

The aim of this forum is to enhance collaborative working across all trusts in Northants and improve communication. It will be used as a platform where new ideas and strategies can be shared as well as providing an opportunity to share patient stories and best practice.

October saw the launch of the **1st** Tissue Viability Conference with our partners from **NHFT, KGH, NGH and Three Shires Hospitals**. The day was really well attended by over 70 staff, with excellent presentations from our nurses and from Convatec, Biomonde and Smith & Nephew.

There were Q&A sessions and shared learning amongst all who attended.

SSKIN Audit

The priority for this audit is to establish the effectiveness of pressure ulcer prevention by measuring compliance with the SSKIN bundle on all general inpatient adult wards, excluding Critical Care. The "Skin ambassadors" were asked to undertake this audit and all of them found it a learning experience and were going to take it back and use it on their own wards.

From the audit results the Tissue Viability Team are working closely with the wards to improve on the issues identified, by providing more training on the ASSKING documentation, risk assessments and categorising of pressure ulcers.

An audit was undertaken on 20th August 2018, on the SSKIN documentation using a new revised audit tool to incorporate the new documentation that was implemented in April 2018, the results of this are below, another SSKIN audit was completed in December, results of which are still being reviewed.

Introduction of Training

- Training Dates for Pressure Ulcer Prevention and SKIN ambassadors have been arranged throughout 2019 as these sessions were well attended in 2018 and the team received excellent feedback.
- The Tissue Viability Team is also supporting the therapy teams with bespoke training.
- Trialling the use of Cameras on Assessment Wards for out of hours early photography of suspected damage.

Challenges to the Tissue Viability Team

- Implementing the New Guidelines from NHSi
- Gain Trust approval for Pressure Ulcer training to be Role Specific for frontline inpatient teams.

Other Actions

- Continue to work closely with ward areas that have a higher number of harms
- Communication across the hospital via screensavers and bi monthly newsletter.
- Manual Handling to visit wards to do spot checks of practice

Project Name: (10) To Reduce harm from (In-patient) Falls

What are we trying to accomplish?

Setting Aims:

Falls are the most commonly reported incident in all hospitals in the UK and can cause significant harm. At NGH we are implementing a 4 year programme to reduce harm from falls aiming for a 15% reduction by March 2019.

How will we know that a change is an improvement?

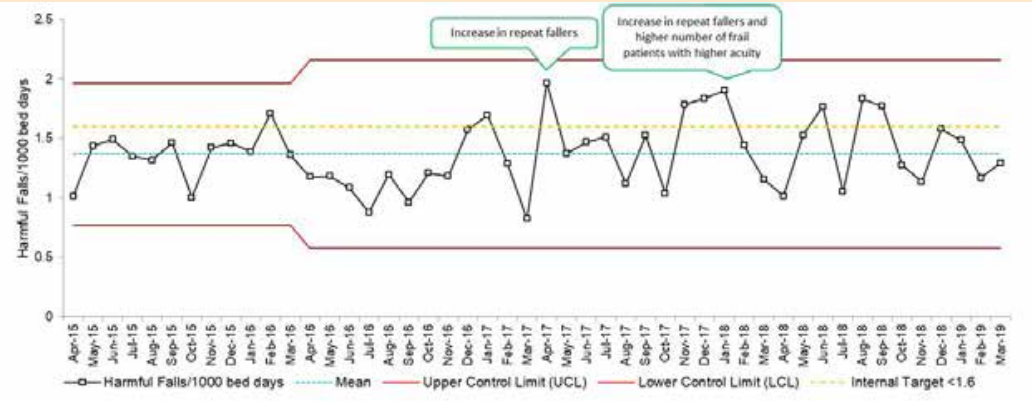
Establishing Measures:
We will monitor the number of harmful falls per 1000 bed days with a view to reducing them by 15%. Falls assessments will be completed within 12 hours of admission in 95% or more patients. Falls care plan will be completed within 12 hours of admission in 90% or more patients. 85% or more of staff to be trained.

What changes can we make aimed at improvement?

PDSA:

- Review current process for post falls review and make appropriate changes
- Develop a delirium policy to manage patients with confusion
- Introduce a process to review medication that may lead to increased falls

Quality Improvement Project Update:



The graph above demonstrates the harmful falls categorised as low, moderate, severe and catastrophic recorded at NGH between April 2015 and December 2018. The graph above demonstrates that the Trust remained below the internally set target of 1.6 harmful falls/1000 bed days during quarter 3.

Sign up to Safety 1 - Falls assessment will be completed within 12 hrs of admission in 95% or more patients.
In Quarter 3 2018/19 the mean average for completing Falls Risk Assessments was 98% - target achieved

Sign up to safety 2 - Falls care plan will be completed within 12 hours of admission in 90% or more patients
In quarter 3 2018/19 the mean average for completing falls care plans was 94% - target achieved

Sign up to safety 3 - Review current process for post falls review and make appropriate changes.
New post falls packs have been made available on all wards and the head injury flow chart updated.

Sign up to safety 4 - Develop a delirium policy to manage patients with confusion
Delirium Guidelines have been approved and are available on the Trust intranet.

Sign up to Safety 5 - Introduce a process to review medication that may lead to increased falls for patients admitted with a fall, **Sign up to safety 6** - Introduce a process to review medication that may lead to increased falls for patients at risk of a fall.
Work remains ongoing for auditing the number of medication reviews that are being completed.

Project Name: (11) Eliminate Hospital Acquired VTE

WHY:
Venous thromboembolism (VTE) has an estimated incidence of 1-2 per 1,000 of the population. Up to 60% of VTE cases occur during or within 90 days after hospitalisation, making VTE a leading preventable cause of death in hospital. However, research suggests that at least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and using appropriate preventative strategies (for example, early mobilisation following surgery, anti embolic stockings and anticoagulants in those most at risk).

What are we trying to accomplish?
Improve the percentage of VTE risk assessments undertaken at the time of admission.
Improve the timeliness of providing thromboprophylaxis to those patients deemed at risk of VTE.

Ensure that stockings provided as mechanical thromboprophylaxis are used appropriately
Reduce the number of Hospital Associated Thromboses (HATs) and increase learning from Root Cause Analysis (RCA).

Project Name: (12) To Reduce Omitted Medicines

What are we trying to accomplish?

Setting Aims
Omitted medication is the most regularly reported medication incident nationally, reported to the National Reporting & Learning System (NRLS). One of the highest reasons for omitted doses is doses which have not been documented.
The improvement project aims to reduce omitted doses (not documented) across the Trust.
The implementation of EPMA is anticipated to reduce omitted doses (not documented) further as the EPMA system at NGH highlights to nursing staff, doses that have not been documented as have being administered.

How will we know that a change is an improvement?

Establishing Measures
Following previous improvement work a baseline measure of all wards was undertaken in September 2014 which gave an average of 9% of patients, monitored 24 hours previously that had an omitted dose (not documented). The intention is to measure the percentage of omitted doses of medicines (not documented) with an aim to reduce by 10% in year 1 and 20% each year thereafter.

What changes can we make aimed at improvement?

PDSA:
The improvement tool is based on local feedback to nurses at the time of audit, and a feedback of the Trust results to Matrons for discussion at directorate level.

Planned changes undertaken:

- Implementation of EPMA across the Trust [Excl Paediatrics and Outpatient clinics].
- Project to improve availability of medication for patients using Green Bag Scheme with East Midlands Ambulance Service and highlighting to patients the importance of bring medication into

Quality Improvement Project Update:

The wards in the medical directorate had the greatest reduction in omitted doses 'not documented' which directly correlates with the introduction of electronic prescribing to these areas over this period of time.

Following improvements in 'omitted doses 'not documented'we have recently concentrated on 'omitted doses due to medication unavailable'.

Current work streams to improve this have been:

- Nurse ordering via EPMA button
- Priority ordering for Critical medication via EPMA
- Streamlining of ward stock lists
- Omnicells on wards for automatic ordering
- Campaign to improve patients own medication bought into hospital working with EMAS, and CCG and local radio
- Increase in digital lockers at bedside for patients own medication
- Technicians visits to wards to transfer medication not transferred with patient
- Dispensary liaison with urgent care wards for newly dispensed medication

The Medication Safety team implemented some work in August 2018 with the Communication team, Nene Commissioning and the East Midlands Ambulance Service to improve the availability of medications across the trust during 2018/19. This work hoped to increase the number of patients coming into hospital with their own medications to reduce the risk of patients missing doses due to unavailability at ward level.

In support of this a baseline audit for the month of April was conducted. This utilised data from the EPMA system which is now used across the trust (apart from Paediatrics).

During Q1 2018 – 2019 in addition to the above improvement work there is also a project within Urgent care to reduce omitted does due to medications not being prescribed.

We have been able to improve our reporting on omitted doses so that the report can be used as originally intended as an improvement and assurance tool which will be circulated on a monthly basis to ward sisters ,matrons and governance. The EPMA system has an option for documenting omitted doses marked as 'Other –Add note' . We have asked the provider of the EPMA system to remove this as an option but until this is done there is no assurance for the trust that this note is completed so the improvement will be to reduce the use of this reason ' Other –Add note' which can be easily used as a 'not documented' option.

Starting again using the EPMA report from January 2019:

Reason	Number of Omitted doses	%
Drug unavailable	140	11.4
Other (not documented)	316	25.8
Total omitted doses	1224	

Now that we have a more robust reporting system we can revert to our previous tool improvement tool based on local feedback to nurses at the time of audit, and a feedback of the Trust results to Matrons for discussion at directorate level.

Project Name (13): Effective Night Team Handover

What are we trying to accomplish?

Setting Aims:
Audit's completed on night handovers and patient transfers identified poor documentation and poor transfers/handover of care. The aim of this project is to ensure that patients requiring an internal transfer will have a documented transfer plan in place and appropriate staff escort. Patient transfers out of hours will be risk assessed.

How will we know that a change is an improvement?

Establishing Measures:
We will measure the number of attendances at night team handover, the aim being that all on call specialties will be represented and the number of patients transferred with a completed risk assessment in place . The aim is to get both of these measures to 100%.

What changes can we make aimed at improvement?

PDSA:
- Night team handover to be relaunched
- Roll out of patient transfer checklist.

Quality Improvement Project Update:

Ward moves risk assessed: inpatient move risk assessment completion rate kept above 97% in October and November 2018 and dipped to just under 97% in December.
OOH risk assessments: OOH risk assessment completion rate maintained around 97% until December, when it dipped to just over 91%.
The risk assessments are embedded practice, which includes monthly auditing to ensure standards are maintained.

Night time Handover :
This is now embedded. Data collection (hard copies) were started but were found to not add any value to the process. The register of attendance is now embedded and electronic works well.

Transfer Checklist :
The transfer checklist is being rolled out. ADNs asked to offer forward a programme of audit after one month of roll out. This is still to be completed

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Project Name: (14) Pain Management

What are we trying to accomplish?

Setting Aims:
The message that we are getting from comments on Friends & Family tests and as secondary comments on complaints is that some patients feel that their pain has not been well managed. Our aim is to increase the number of ward based nurses competent to complete a pain score and timely reassessment.

How will we know that a change is an improvement?

Establishing Measures:
We will measure:
1. Is pain evaluated and documented each shift
2. Are patients satisfied with their overall pain management during their admission

What changes can we make aimed at improvement?

PDSA:
- Ongoing pain score training for acute wards
- Acute Pain Team auditing accuracy of pain scores on patients that they review.

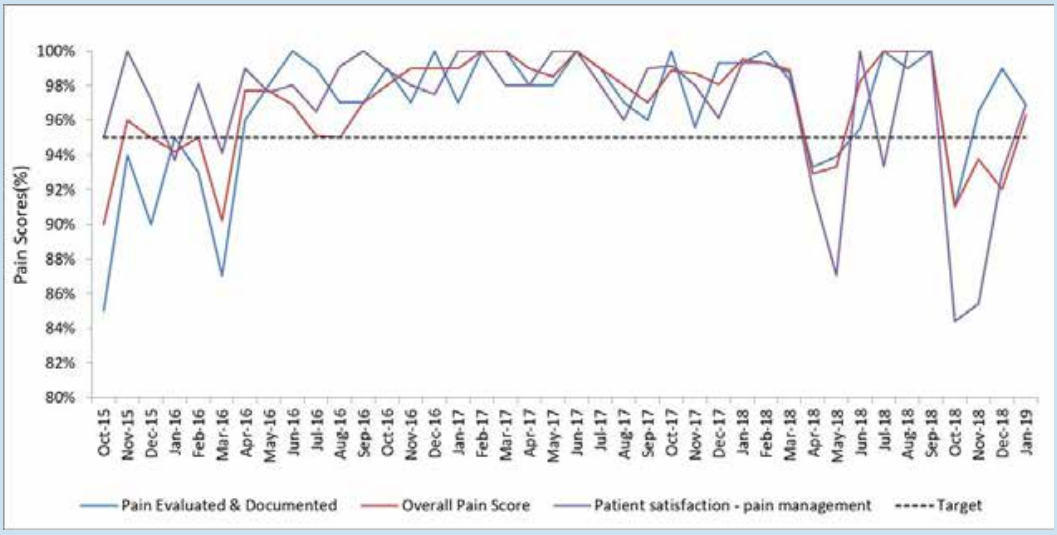
Quality Improvement Project Update:

1. Plan Training Schedule
Acute Pain Team members continue to deliver training requests and provide drop in sessions for departments if requested. Link Nurse meetings take place regularly. There continue to be monthly pain study days. No staffing issues which will affect the training schedule since full establishment achieved.

2. Monitor Pain Management QCI Data
Data continues to be collected on a monthly basis for all inpatient areas. The number of wards has increased in Q3 and there were inaccuracies in the QCI data recorded as a result. This has been corrected for this report. There is a sustained and significant improvement demonstrated through QCI's

3. Acute Pain Team to Audit accuracy of pain scores on patients they review
This audit is ongoing and reported monthly. Correlation between Ice referral scores and Pain Team demonstrate sustained improvement. HCA scores training continues. Acute Pain Team are now correlating the data so that there can be an increase in any specific learning gaps, and any common themes addressed

The project needs to be reviewed with Patient Experience lead to establish the number of complaints received regarding pain management as this project was a PDSA cycle



Project Name: (15) Time to Consultant Review

What are we trying to accomplish?

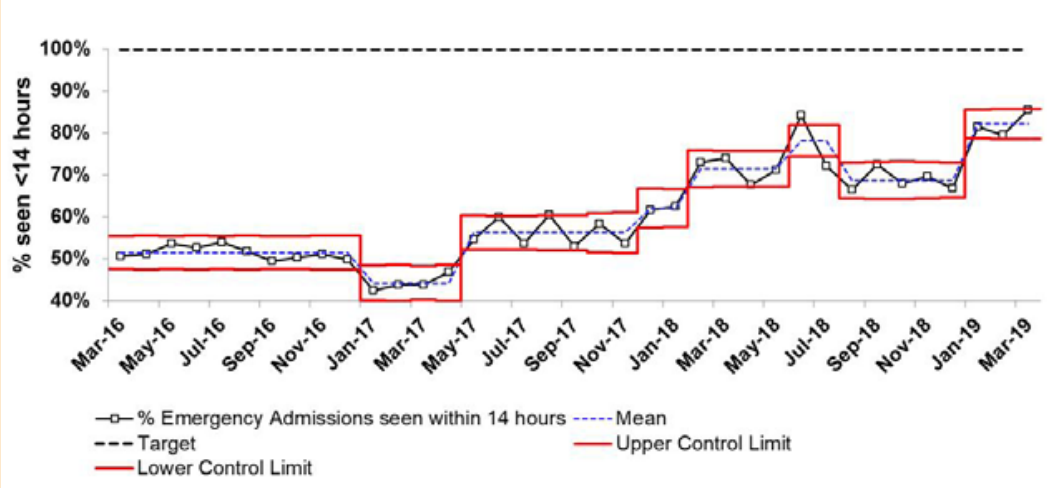
Setting Aims:
All patients should have Clinical review by a senior decision maker within 14 hours of admission irrespective of the day of the week. The new medical model implemented in Nye Bevan is expected to provide continuous presence of consultants for 13 hours (with 2 consultants) in the day for 7 days a week. The model also caters to consultant presence during peak hours of the day to avoid backlogs into the night. Hence it is expected to comply with set standards in Medicine. Also through review of other non elective services, including surgical specialties, oncology and haematology, this will further improve access to Consultants. This is already evident in the improvements in this area in the audit performed in Spring 2018.

How will we know that a change is an improvement?

Establishing Measures: Time to consultant review to be determined by biannual audit of clinical notes as recommended by national 7 day services sustainable improvement team. We currently have a plan endorsed by Quality and Governance Committee to assure Trust Board of the process of this service delivery.

What changes can we make aimed at improvement? The delivery of timeliness of review depends on how Consultant workforce are scheduled to facilitate this care and duration of the presence of consultants within the day to meet the demands placed on them.

	Autumn 2016	Spring 2017	Autumn 2017	Spring 2018
Clinical Standard 2: Time to 1st consultant review	71%	75%	72%	90%
Clinical Standard 5: Access to consultant directed diagnostics	N/A	89%	N/A	97%
Clinical Standard 6: Access to consultant directed interventions	N/A	89%	N/A	100%
Clinical Standard 8: Ongoing daily consultant directed review	Once daily 90% Twice daily 83%	90%	N/A	87%



Project Name: (16) WHO Safer Surgery Checklist

What are we trying to accomplish?

Setting Aims:
Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There are 5 Steps to Safer Surgery which are; Brief, Sign-In, Time-Out, Sign-Out and Debrief. The WHO Safer Surgery Checklist covers Sign-In, Time-Out and Sign-Out and should be used for every patient undergoing a procedure within theatres. The team meet for the Brief before the start of the operating list and discuss every patient on the list, identifying any issues. The Sign-In is a conversation between the anaesthetist and Anaesthetic Practitioner, as a minimum. The Time-Out and Sign-Out is a conversation between all members of the perioperative team. The Debrief is a conversation between all members of the team at the end of the operating list. We aim to improve staff engagement with these discussions, ensuring that all relevant issues are addressed and lessons are learnt.

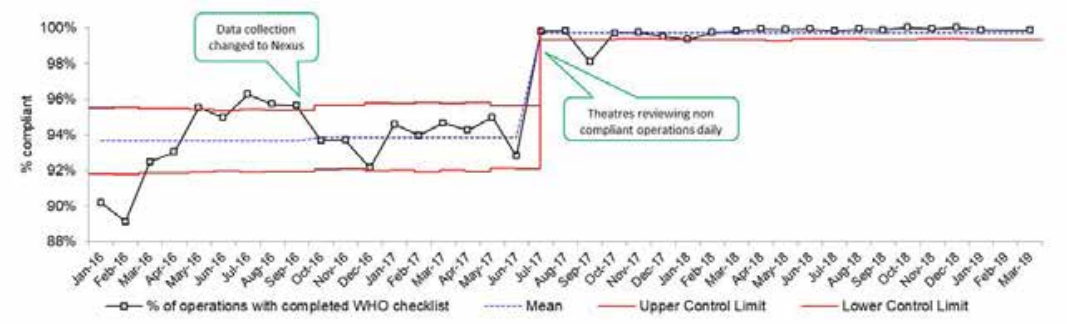
How will we know that a change is an improvement?

Establishing Measures:
We will measure the number of completed checklists versus the number of operations as a monthly spot-check, with the aim being that a checklist will be completed for 100% of operations. We will monitor the number of surgical never events with the aim being to eliminate them entirely. It is difficult to measure staff engagement in a conversation so we need to measure the impact of the increased staff engagement. This could be demonstrated through a reduction in issues arising during the list, which should be recorded on the Debrief Form.

Quality Improvement Project Update:

- Practice Educator for Theatres now in post
- MDT Human Factors training session Ophth in November 2018
- A NatSSIPs / WHO Policy is in the process of being written by Amanda Bisset.
- Installation of some of the Brief whiteboards is still outstanding within Obstetrics and DSU

WHO Compliance Data for December 2019



Project Name: (17) To Reduce the Number of Stillbirths and Undiagnosed Small for Gestational Age Babies

What are we trying to accomplish?

Setting Aims:

To increase antenatal detection of small for gestational age babies by 50% by March 2019

NGH use the Perinatal Institute Customised Growth protocol (GROW). The GROW software programme calculates a baby's 'term optimal weight' adjusted for maternal characteristics such as height, weight, ethnic group and parity and produces a chart to predict the optimal fetal growth curve for each pregnancy. The customised growth charts are used for serial plotting of fundal height and estimated fetal weight measurements by ultrasound scan. The fundal height should be measured at antenatal assessments after 25 weeks but not more frequently than every 2 weeks.

The use of GROW charts have been shown to increase antenatal detection of intrauterine growth problems

To increase the number of women who are screened for smoking by 50% by March 2018.

The Preventing Avoidable Harm in Maternity Care Capital Fund is part of the commitment by the Government, and NGH had a bid approved to buy 75 carbon monoxide monitors, one for every community midwife and supplies for Antenatal Clinic and the Maternity Day Unit. The monitors will identify women that smoke and those at risk of passive smoking and they will have increased surveillance in a midwife led ultrasound clinic. Smoking in pregnancy can lead to miscarriage, stillbirth, premature birth and low birth weight. It also increases the risk of sudden infant death syndrome. A further bid was made to Charitable funds for an ultrasound scanner and we are in the process of developing a new pathway for the detection, investigation and management of small for gestational age babies.

How will we know that a change is an improvement?
Establishing Measures:
We will monitor:

1) The number of women who have a carbon monoxide measurement recorded at their booking appointment. For women with a CO reading of over 11ppm we will monitor how many of these women have extra antenatal surveillance which will include serial growth scans. We are aiming for a 50% increase in both of these measures.

2) The number of small for gestational age babies detected during the antenatal period will be monitored via the Growth Assessment Protocol (GAP). We are aiming for a 50 % increase in this measure.

What changes can we make aimed at improvement?

- Carbon Monoxide readings to be taken at antenatal booking appointments
- Develop pathway for detection, investigation and management of small for gestational age babies
- Multi-disciplinary review of all stillbirths, and ensure lessons learnt are shared
- Implementation of the National Perinatal Mortality Review Tool (NPMRT)
- Establish a rolling audit programme to monitor performance through:
  - The SGA rate (proportion of babies born with a birthweight below the 10th customised centile)
  - The rate of antenatal referral for suspected SGA and antenatal detection/diagnosis of SGA

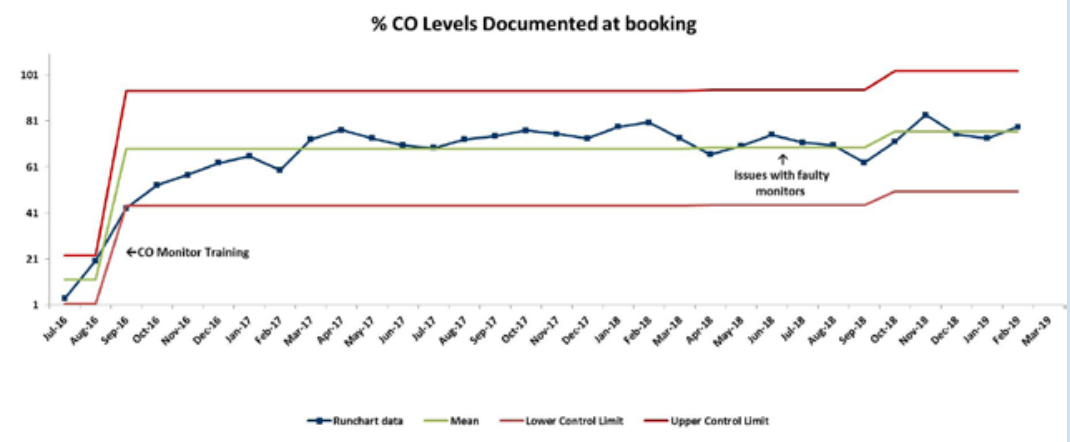
- Regular case-note audit of SGA/FGR cases that were not antenatally detected, and action plans on response to system failures
- Implementation of Stillbirth Care Bundle
- Implementation of Stillbirth Care Bundle

Quality Improvement Project Update:

1) To increase the number of women who are screened for smoking by 50% by March 2018

By March 2018 there was a 73.4% increase in the number of women who had a CO measurement taken at booking.

Women with a CO result of ≥ 4ppm are given a leaflet about the dangers to their unborn baby from smoking and will have an opt out referral to Northamptonshire Stop Smoking Service.

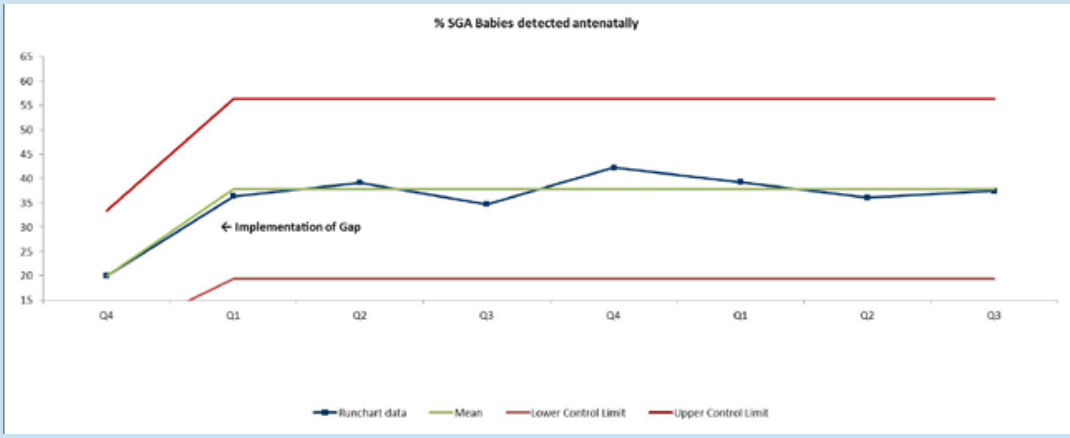


During 2018/19, CO measurements have continued to be taken at the booking appointment. There will always be some women who will decline to be screened. During the period April – September 2018 there were issues with faulty carbon monoxide monitors – these were returned to the manufacturers for replacement.

2) To increase antenatal detection of small for gestational age babies by 50% by March 2019

- Perinatal Institute's Growth Assessment Protocol (GAP) purchased and staff training undertaken as part of the annual skills drills training
- A random selection of records were audited on GAP from 2016/17 to establish a baseline of the number of babies with a birthweight below the 10th customised centile who were detected antenatally
- Review of the Management of Low Birthweight Babies guideline undertaken by Consultant Paediatrician to ensure correct neonatal observations are carried out when a baby birthweight plots below the 10th customised centile

The run chart below shows that the antenatal detection rates for SGA has increased from a baseline of 20% to a mean of 37.8% in Q3 2018/19 which demonstrates an increase of 89%



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Implementation of the Saving Babies Lives Care Bundle – Version 2:

Northampton General Hospital NHS Trust have implemented all four elements of the care bundle but further improvement could be made. Version 2 of the Care Bundle is due to be released in March 2019. In order to be able to continue the quality improvement work required to implement and monitor progress, the maternity services will be recruiting a Band 7 Fetal Surveillance Midwife. This post will be the lead for quality improvement and audit for all four elements of the Saving Babies Lives Care Bundle.

STAFF AND CULTURE

Our aim is to nurture the energy and commitment of our workforce so that they can deliver the best possible care for our patients. We do this by aligning staff around our desire to continuously improve the experience, care and safety of our patients. To support this staff can access a range of Quality Improvement development opportunities to enable them to improve the care they give and the service they provide. This aim is reinforced through our 4 values, which we measure each year as part of our annual staff survey.

Since the values were introduced we have seen year on year improvement in staff being aware of the values and saying that they experience the values being lived each day. Our staff engagement score, measured through the annual staff survey, has also seen year on year improvement, being maintained at 'above average' compared to the national average in the 2018 survey.

We have also worked hard, and continue to do so, to make this a great place to work for staff. This has included supporting staff health and well-being which includes initiatives such as free health checks, providing and promoting physical exercise and social activities such as the NGH Choir. We are one of the very few NHS organisations that has signed up to the national 'Time to change' pledge, aimed at removing the stigma associated with mental health conditions and providing support to staff during difficult times.

We have implemented a programme of work to support staff maintain their emotional and mental well-being has been rolled out across the trust with many staff participating in this programme.

Recognising the national shortage of staff in some areas for example nursing, we have introduced and supported new roles such as The Nurse Associate and have a proactive recruitment strategy that has seen significant reductions in nursing vacancies and medical vacancies.

We are pleased to have established a junior doctors forum and undertaken a range of initiatives such as providing doctors with breakfast after a night shift and other such actions designed to improve the working lives of our junior doctors.

We recently changed our trust appraisal process (designed around our values) and through this we encourage our staff to reflect, learn and improve. To support this we have a comprehensive range of education and development programmes ranging from personal and professional development to leadership and management development programmes. In the 2018 staff survey we saw a significant improvement in staff saying that the quality of our appraisals process had improved, rating as 'above average' compared nationally to other trusts.

Our challenge remains that we need to do more to support our staff who work in an increasingly challenging environment and to this end we are in the process of refreshing our People strategy to take us into 2019/20 and beyond.

AUDITED INDICATORS

Our auditors, KPMG audited performance indicators:

1. Percentage of patient safety incidents resulting in severe harm or death;
2. FFT patient element score

The information below summarises the findings of their draft report.

FINDINGS

RECOMMENDATIONS

AGREED ACTION

Responsible Person:
Target Date:

FINDINGS

RECOMMENDATIONS

AGREED ACTION

Responsible Person:
Target Date:

HOW OUR QUALITY ACCOUNT WAS PREPARED

Priorities for Improvement

The traditional domains of quality include safe, effective, patient centred care and our quality priorities use these domains as a basis but take this further by focussing on continual improvement and aims to ensure that all our staff strive for excellence in all that they do and believe and support the organisational focus on delivering the "Best Possible Care".

We have listened to what our staff have told us is important to them, we have acknowledged lessons learnt from serious incidents complaints and concerns and we understand that we need to identify quality priorities that will maintain the progress achieved to date.

We will further improve the progress and outcomes to eliminate avoidable harm whilst using different approaches to increase the health and wellbeing of our patients and staff, responding to our patients and carers on what they consider to be important.

The five key work streams for our quality priorities are:

- Improving the safety culture at NGH by 10% from baseline
- Reduce the number of preventable harm events by 10%from 2018 baseline
- Efficient and effective outcome that will eliminate preventable early patient deaths by 10% from baseline
- Improve patient experience of care by 15% from 2018 baseline
- Improve the safety outcomes for maternal and neonatal care Reducing the rate of still births, neonatal death and brain injuries occurring by 20% from 2019 baseline by 2021

ANNEX 1

STATEMENTS FROM STAKEHOLDERS

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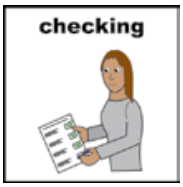
ANNEX 2

EASY READ PRIORITIES FOR 2019/20 ?

These are things we will do to make your care better next year.

We will make sure you are safe by:

Finding better ways to make sure people do not hurt themselves.



Making sure we always check how we do things.

Understanding why people may fall over and who might fall over. Then make plans to help them.

We will always check how patients are feeling by:

Creating courses that help people get better.

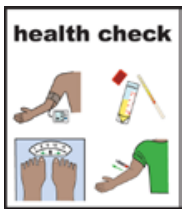
Getting more service users to help us decide who should work for us.

Finding more ways to help service users tell us what they think.

We will make sure your care is the best it can be by:

Sharing stories and information with our staff, to help us give better care.

Teaching our staff new ways to give you even better care.



Doing our best to always check your physical health.

ABBREVIATIONS

A	#	Fracture
	A&E	Accident and Emergency
	AKI	Acute Kidney Injury
	ACS	Ambulatory Care Service
	ASGBI	Association of Surgeons of Great Britain and Ireland
B	BP	Blood Pressure
C	CCG	Clinical Commissioning Group
	C.Diff	Clostridium Difficile
	CEM	College of Emergency Medicine
	CIA	Cartoid Interventions Audit
	CIP	Cost Improvement Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CNS	Cancer Nurse Specialist
	CT	Computed Tomography
	CQC	Care Quality Commission
	CQEG	Clinical Governance and Effectiveness Group
	CQUIN	Commissioning for Quality and Innovation
	C Section	Caesarean Section
D	DAHNO	Data for Head and Neck Oncology
	DH	Department of Health
	DNA	Did Not Attend
	DoOD	Do Organisational Development
	DTOC	Delayed Transfer of Care
E	EMRAN	East Midlands Rheumatology Area Network
	ePMA	electronic prescribing medicines administration
	ERAS	Electronic Residency Application Service
F	FFT	Friends and Family Test
	FY1	First Year 1
G	GMPC	General Medical Practice Code Validity
H	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
I	ICU	Intensive Care Unit
	IGT	Information Governance Toolkit
K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust
L	LFE	Learning from errors

M	MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
	MDT	Multi-Disciplinary Team
	MINAP	Myocardial Ischaemia National Audit Project
	MRI	Magnetic resonance imaging
	MRSA	Methicillin-Resistant Staphylococcus Aureusis
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NGH	Northampton General Hospital NHS Trust
	NICE	The National Institute for Health and Care Excellence
	NICOR	National Institute for Cardiovascular Outcomes Research
	NMET	Non-Medical Education and Training
	NNAP	National Neonatal Audit Programme
	NVD	National Vascular Database
P	PALS	Patient Advice and Liaison Service
	PCEEG	Patient & Carer Experience and Engagement Group
	PPEN	Patient & Public Engagement Network
	PROMs	Patient Reported Outcome Measures
Q	QCI	Quality Care Indicator
	QELCA	Quality End of Life Care for All
	QI	Quality Improvement
R	RCPH	Royal College of Paediatrics and Child Health
	R&D	Research and Development
	RTT	Referral to Treatment
S	SHMI	Summary Hospital-level Mortality Indicator
	SHO	Senior House Officer
	SIRO	Senior Information Risk Owner
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
	SSNAP	Sentinel Stroke National Audit Programme
T	TARN	Trauma Audit Research Network
	TTO	To Take Out
U	UTI	Urinary Tract Infection
V	VTE	Venous Thromboembolism
W	WHO	World Health Organisation
Y	YTD	Year to Date

Prepared by Quality Improvement

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April 2019

Report To	**Public Trust Board**
Date of Meeting	**30 May 2019**

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

Executive Summary

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

- Patient Experience: The inpatient results for the Friends and Family Test are 91% in April. 39 formal complaints 3647 compliments were received
- Pressure Ulcer Prevention; 9 Category 2 pressure ulcers, 12 Deep Tissue Injury, these are being monitored in line with national guidance to ascertain whether it is to be classified as pressure ulcers and 1 unstageable pressure ulcer were hospital acquired in April
- Maternity Safety Thermometer: the overall percentage of women and babies who received combined physical and psychological 'harm' free care was 83.3% which is above the national aggregate of 74.4%. Harm free physical care was 88.9% compared to 80.5% nationally and harm free care associated with psychosocial harm (women's perception of safety) was 94.4%, which is slightly above the national figure of 92.5%
- Falls: There were 114 in-patient falls in total, 81 inpatient falls resulted in no harm to the patient, 32 were low harm and 1 was reported as severe
- Avery reported 14 falls in month; 9 no harm and 5 low, there was 0 pressure ulcers reported.
- Overall fill rate for April was RN 94%, HCA 106% with a combined of 98%. CHPPD for adult wards was RN 4.0 and HCA 3.2 giving a combined CHPPD of 7.2
- The report contains an update on Midwifery, Safeguarding, End of Life, Infection Prevention, Assessment and Accreditation, Pathway to Excellence® and Nursing and Midwifery Quality care Indicator Dashboards.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1.3 and 1.5
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No

The Committee is asked to:

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

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Trust Board
May 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 May. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This monthly report supports the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.

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

2.0 Trust Scorecard – Summary

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

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

2.1 Quality of Care:

2.1.1 Complaints and Compliments

At the last Public Trust Board a patient story was recounted in which one aspect of concern was with regards to the timely assistance of the patient receiving their meals. Mr Burns asked whether the Trust volunteers could assist in these cases. The Head of Volunteers has provided an update, this is something the volunteers are working on to improve our existing service, currently there are over 70 volunteers trained to assist patients with feeding, these volunteers are attached to in-patient areas. The plan is that all ward buddy's will undertake this training, and we will refresh those volunteers who have not used the skill for a while, going forward all new ward buddy's will receive the training as standard. Where wards know patients need assistance and they or the family are unable to always help they contact the volunteer service and put in a request, this is then timetabled into the appropriately trained volunteers schedule where possible.

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.

April:
39 formal complaints
100% response rate (compliance)
3647 compliments

Themes:
The main categories are:

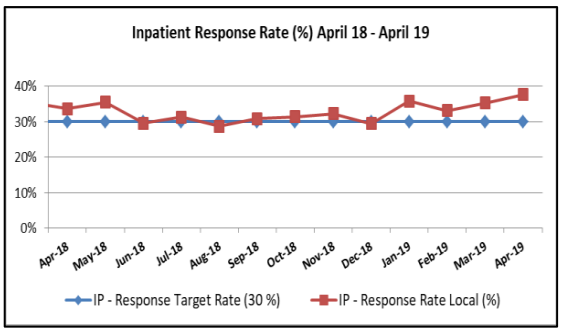
- Care x 13 (10 x medical / 2 x nursing / 1 x other)
- Communication x 10 (5 x medical / 3 x other / 2 x nursing)
- Delays x 6 (3 x treatment / 2 x operations / 1 x appointment)

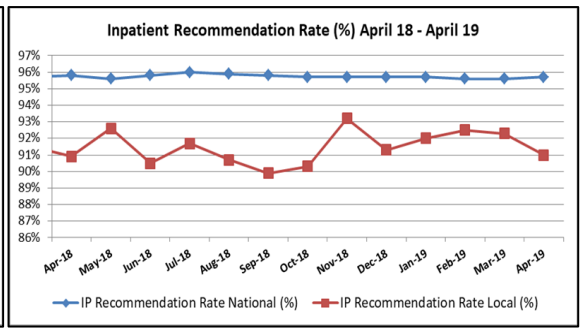
Our aim is that every complaint is responded to within the agreed timeframe and that any learning that comes from the findings is agreed and owned within the Directorate. These are logged through the Datix system; evidence of that learning can also be logged and provided as evidence of a responsive and well led process. This is monitored through the Divisional governance meetings and CQEG.

2.1.2 Friends and Family

Inpatients

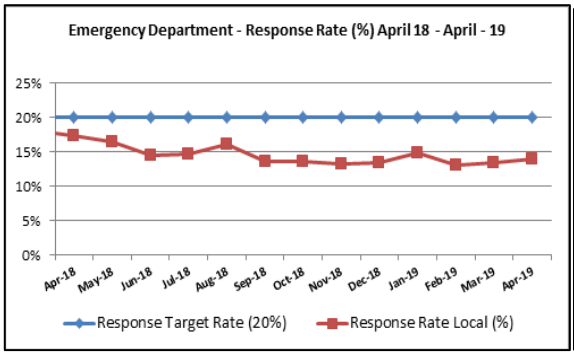
- Due to our targeted campaign response rates continue to rise and remain above target at **37.7%** compared with March at **35.3%**
- 10 ward areas received recommendation rates >90%, 8 >80% and 4 <80% - work with those areas is being taken forward to understand any comments or themes coming through the comments portal
- However the overall recommendation rates have dropped slightly from **92.3%** in March to **91.0%** which remains below the national target of **95.7%** - engagement from individual areas with FFT results has been higher in the last month and with the introduction of Champions we are hopeful that this percentage will now improve.

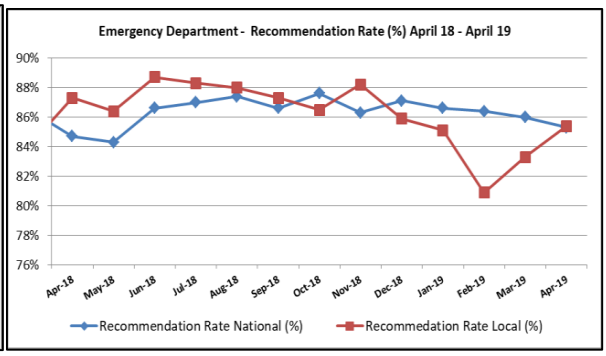




Emergency Department

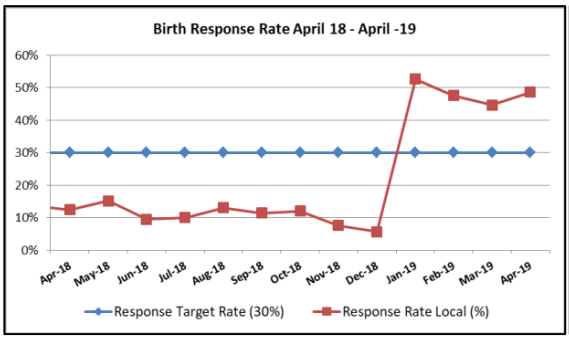
- Response rates have increased **13.5%** in March to **14.0%** in April.
- Recommendation rates have also increased from **83.3%** in March to **85.4%** with the national target dropping slightly to **85.3%** in April.
- It is slightly too early to say whether the improvements made have made this difference but the team are hopeful – A 'Majors Light' process has recently been put in place whereby the patients that would wait longer due to being lower acuity, are being seen quickly and directed to appropriate services away from the Emergency Department.

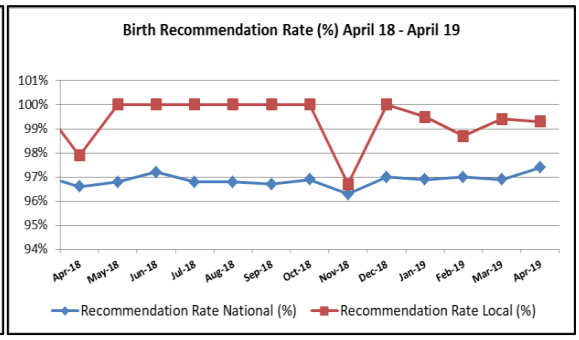




Birth

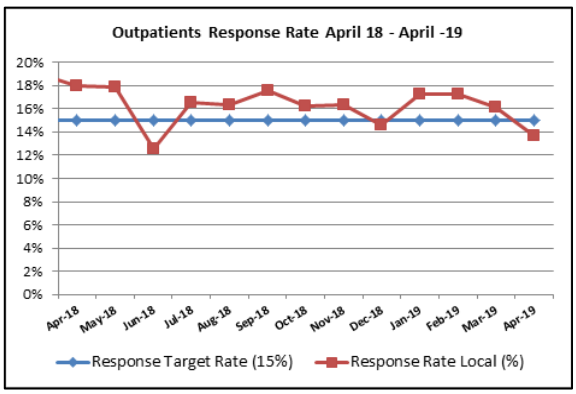
- April has seen another month where the response rate has increased from **44.7%** in March to **48.6%** and still remain above the target response rate of 30% set in January.
- Recommendation rates dipped slightly in April at **99.3%** compared with **99.4%** in March but still remain above the national target.

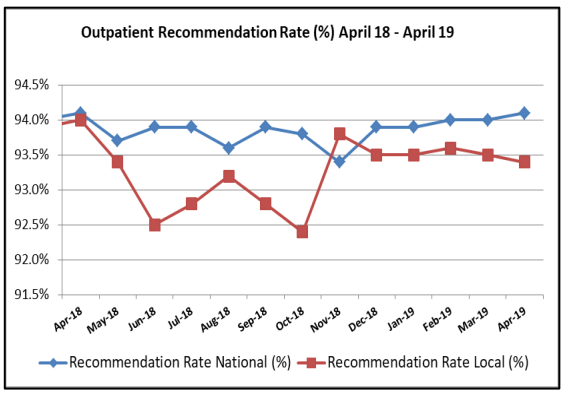




Outpatients

- Response rates dropped from **16.1%** in March to **13.7%** in April and were below the 15% target for the first time since December – the team will monitor this and increase the visibility and support if it is a continued trend
- Unsurprisingly with the drop in responses our recommendation rates dropped slightly from **93.5%** in March to **93.4%**





Overall Action Plan

Patient Experience are doing the following to increase the *'would recommend'*

- **Friends & Family Test Forum** - This encourages staff to take ownership, use the data captured and review the comments
- **Listening events** – Inviting patients who have attended the hospital to come and talk about their experience and how we can make improvements
- **Surveys** - Bespoke surveys across the hospital and encouraging other areas to do the same.
- **Introduction of Patient Experience Champions** – This will involve all areas Trustwide - not just clinical areas. The first meeting took place on Wednesday 15th May specifically looking at how the Divisions can access their data in real time and take control of plans to act upon the negative comments and themes

These initiatives will be continuously reviewed and adapted accordingly.

2.2 Safe

2.2.1 Infection Prevention and Control

The Trust has an external target of no more than 40 patients with hospital onset *Clostridium difficile* infection (CDI) for 2019/20:

- 3 patients developed a hospital onset CDI in April 2019; new definitions have come into play from April. Hospital onset, same as previous, and community based but have had a hospital admission in the past 4 weeks
- Health Economy discussions are taking place within the county regarding the action plan for the community based cases

The Trust has a Zero tolerance approach to patients with MRSA bacteraemia for 2019/20: There have been:

- 0 hospital onset MRSA bacteraemia for April 2019

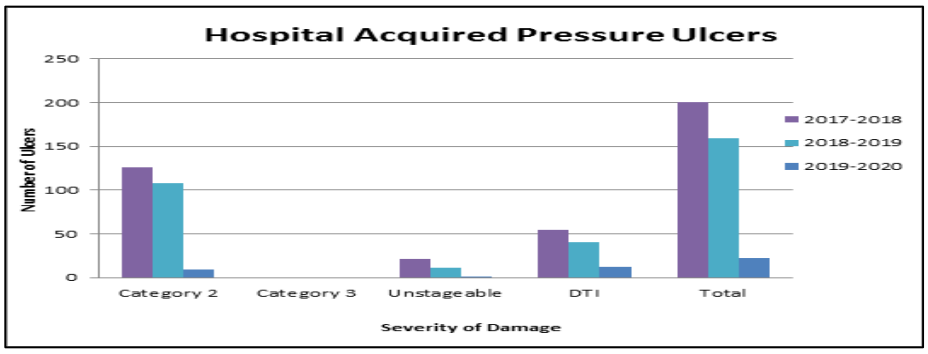
The Trust has an internal stretch target of no more than 13 patients with Trust apportioned MSSA bacteraemia for 2019/20: There have been:

- 5 hospital onset MSSA bacteraemia in April – in 2 patients these were cannula related therefore the IPCT are undertaking a review of practice

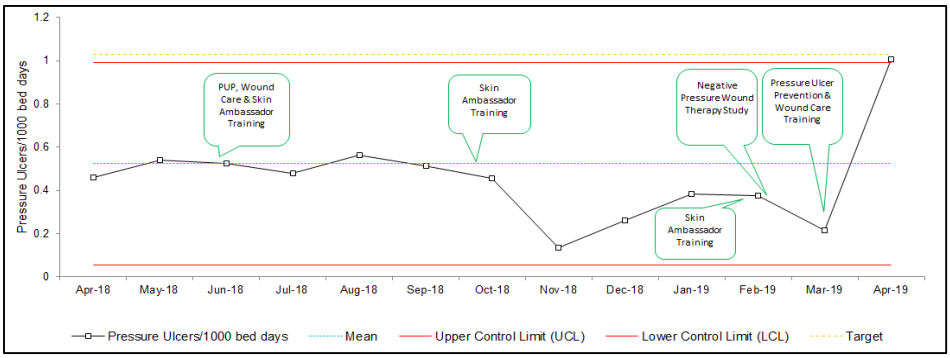
2.2.2 Pressure Ulcers

Following the monthly validation, 40 patients were identified as having acquired Moisture Associated Skin Damage (MASD). 9 category 2 pressure ulcers, 1 unstageable and 12 Deep Tissue Injuries which are being monitored in line with guidance.

The year on year reduction of hospital acquired pressure ulcers within the organisation continues as demonstrated below, this is encouraging as the improvements continue and against the new timeframe definitions set by the NHS Improvement guidance 2018/19.



In April, the number of pressure ulcers per 1000 bed days was 1.0; this is an increase from the previous month, due to the new reporting guidance of not using the 72hrs rule from NHSi which commenced in April, hospital acquired is now counted as being 6 hours from admission.



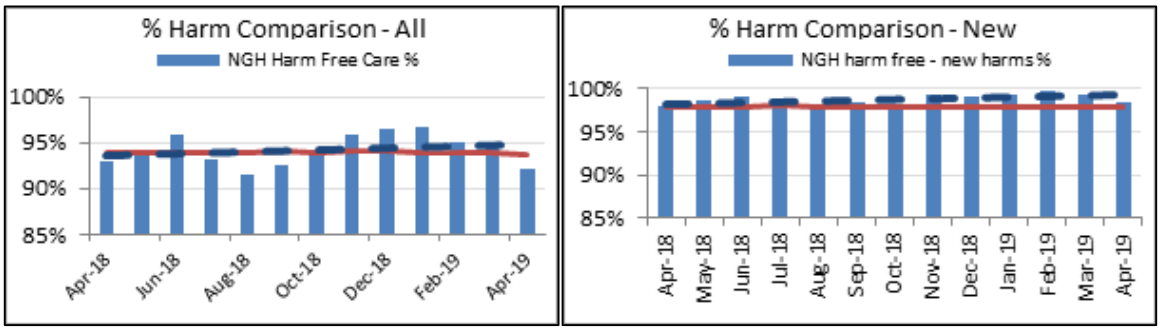
In line with NHS Improvement guidance and CCG quality requirement we have commenced recording the number of patients admitted from the community (this includes care homes/patient own homes/other hospitals) with skin breakdown, during April this was:

Patients admitted from Own Home/Care Home/Other Hospitals with skin breakdown	Number of Harms
Category 2	31
Category 3/Unstageable	20
Deep Tissue Injuries	10
Moisture Associated Skin Damage	48

2.2.3 Harm Free Care (NHS Safety Thermometer)

The NHS Safety Thermometer is a monthly point prevalence audit. In April 98.41% of in-patients did not incur any new harm whilst in our care, which is above the national average comparison figures, the category of new harms are highlighted in the table below. The category definitions for VTE have changed slightly to include a category of 'old other' – our anti-coagulation team are currently reviewing this definition and application as the change has affected our results. The number of VTE harms and diagnosis has not changed hence the request for the anti-coagulation team to review what is now being reported.

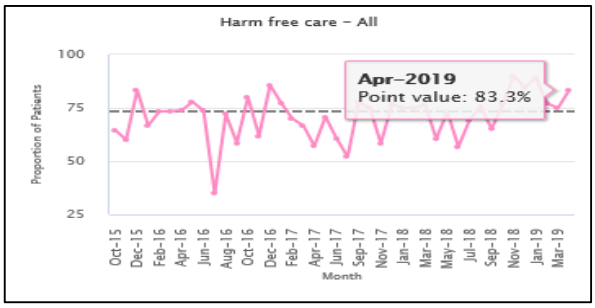
Overall harm free care was 92.05% which has dropped below the national average of 93.76% for the first time in several months which is due to the change in reporting of VTE as described above. (Appendix 1 provides the National Safety Thermometer Definition).

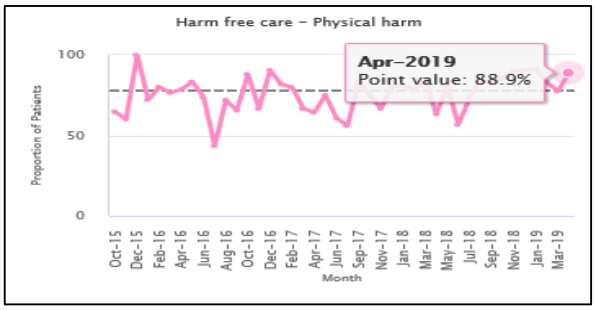


Maternity NHS Safety Thermometer

The Maternity Safety Thermometer enables a point prevalent calculation of the proportion of women and babies who received harm free care 'in month'.

The following graph illustrates that the overall percentage of women and babies who received overall 'harm' free care in April was 77.8% which is above the national aggregate of 74.4%.



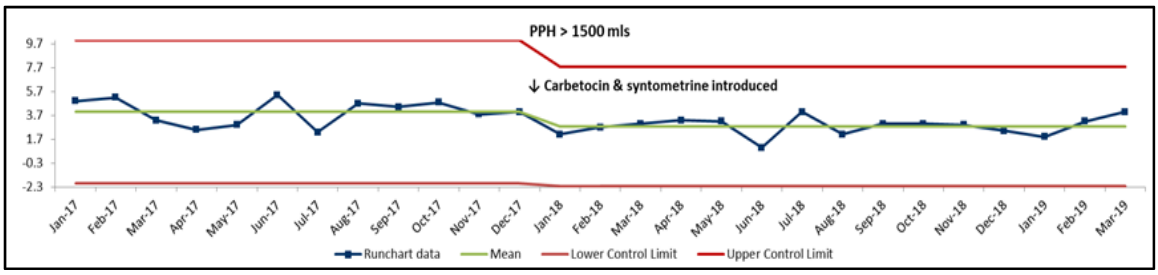


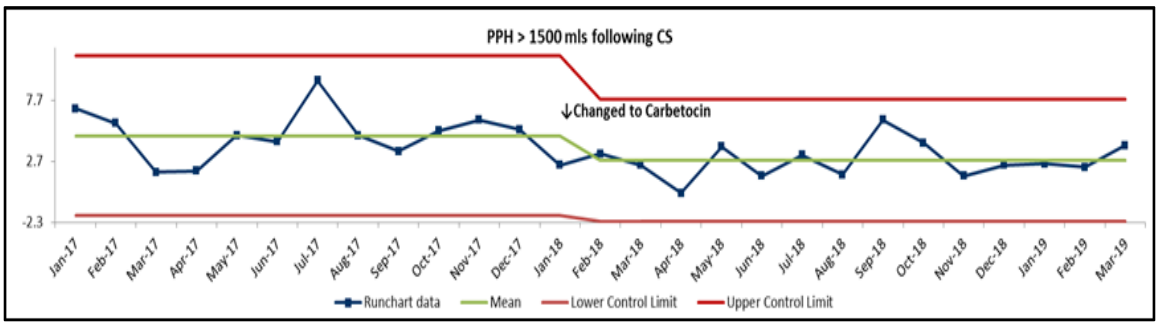
The percentage of women who received harm free physical care was 88.9% compared to 80.5% nationally. Out of the women surveyed for the April's Safety Thermometer 2 women had a 3rd degree tear and 2 women had a PPH of more than 1500mls. The percentage of harm free care associated with psychosocial harm (women's perception of safety). 94.4% of women surveyed said they felt safe compared to 92.5% nationally. None of the women surveyed locally reported that they were left alone at a time that worried them compared to 1.2% nationally. The proportion of women in the service who felt that their concerns about safety during labour and birth were not taken seriously was 5.6%, compared to a national figure of 6.6%.

Update on National Maternal and Neonatal Health Safety Collaborative

The NGH MatNeo Quality Improvement Leads were asked to present at the NHS Improvement National Learning Event held in Bristol in March. The year long MatNeo improvement work centred on improving the care of postnatal women, this included reducing postpartum haemorrhage (PPH). The PPH work looked at the prevention, recognition and response to the deteriorating patient through clinical excellence. A number of changes were implemented – a change in the pharmacological management of third stage, the introduction of PPH risks scoring and early identification and management of PPH and accurate measurement of blood loss for all deliveries.

The outcome was measured using Statistical Process Control charts. The overall PPH was reduced from a mean of 4% to 2.8% and the PPH rate following caesarean section was reduced from 4.8% to 2.8%

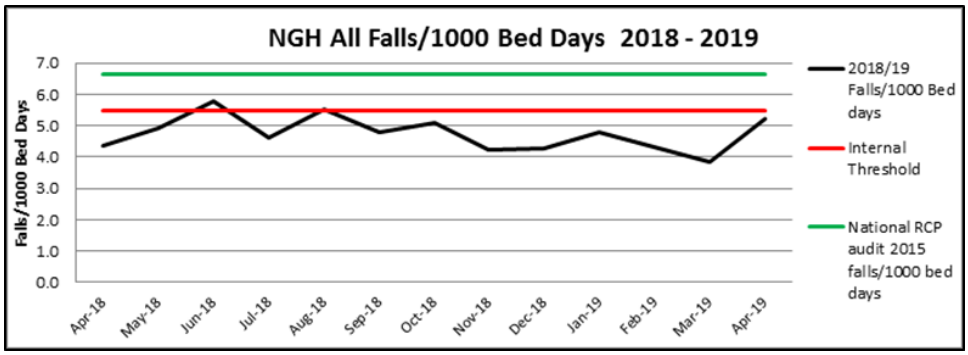




Further work is continuing around the accuracy of measuring blood loss, improving documentation and a focus on reducing traumatic PPH following vaginal delivery.

2.4 Falls

In April there were 114 inpatient falls in total, 81 inpatient falls resulted in no harm to the patient. The rate per 1000 bed days is 5.22. The harmful falls rate per 1000 bed days was 1.51; this is an increase of 0.22 from the previous month. In total there were 32 low harm falls. There was a decrease in moderate, severe and catastrophic falls during April of 0.05 falls/1000 bed days compared to March. In total there was 1 patient incident recorded as severe harm which was on Talbot Butler and is currently being investigated.



3.0 Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards, Appendix 3, 4 and 5 provide triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process, a review of the Quality Care Indicators (QCI) has taken place as planned with a reduction in the number of questions asked.

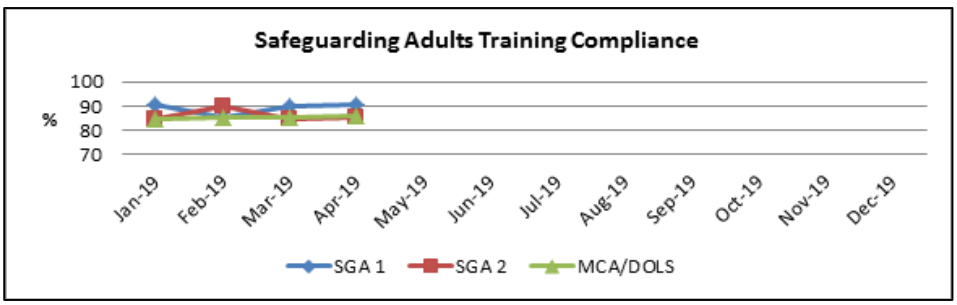
Trust wide Overview of the Dashboard

- In April there were 17 reds across the quality indicators questions
- 9 in medicine, 3 in surgery and 5 in Womens,Childrens, Oncology/Haematology
- The most improvement continues to be seen in the first impressions question
- Quinton has 2 red and 4 amber – The new matron for medicine is reviewing the QCI as part of her induction period and will pick this up with the ward Sister
- Of the ambers 6 are on Becket, 5 on Victoria with 1 red
- Paediatrics have 4 red areas - The paediatric domains which are red and amber are all within the assessment documentation – the ADN and Matrons are reviewing admission practice to evaluate any changes that have affected these results

4.0 Safeguarding

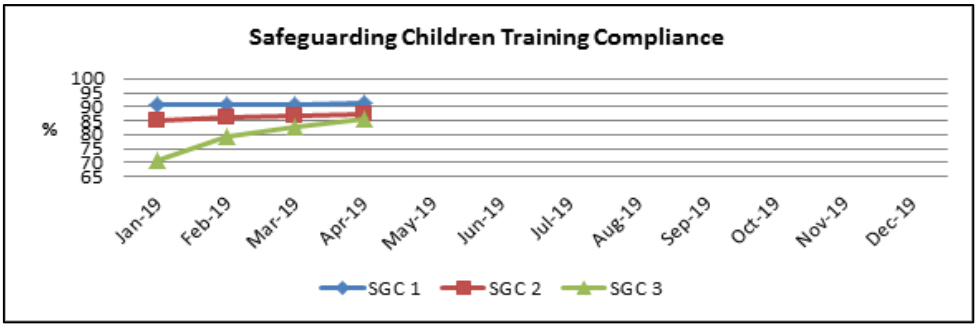
4.1 Safeguarding Training Compliance

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



Level 1 safeguarding adults and MCA are currently complaint either at 85% or above. Safeguarding level 2 has decreased by one percent to 84%.

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

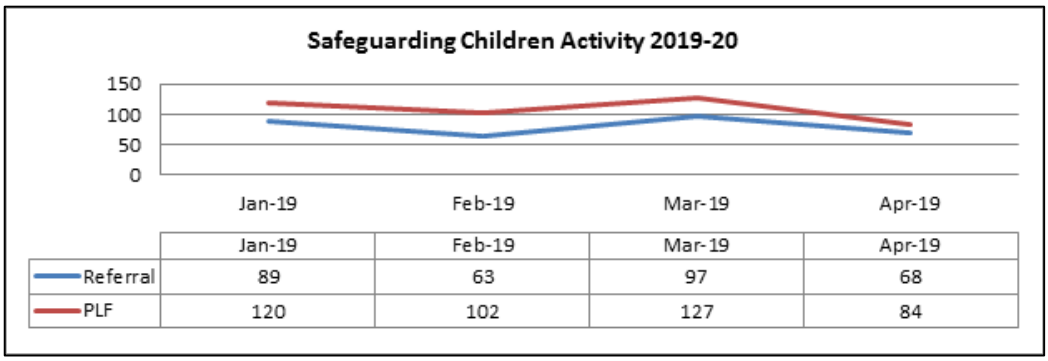


Level 3 safeguarding children training compliance continues to improve and remains marginally under compliance at 84%. A remedial action plan is still in place in terms of intensive monitoring and weekly bespoke training sessions, which will be continued until compliance is at an acceptable continuum.

The Trust has undertaken a further training needs analysis of WRAP (Workshop to Raise Awareness of Prevent) following feedback and challenge from the CCG and NHS England. The current compliance level is 28% with the national target of 48%, the safeguarding team are undertaking a targeted training programme to achieve compliance by quarter 3.
Basic Prevent awareness and competency level for Organisational Leads remains compliant for both levels (over 90%).

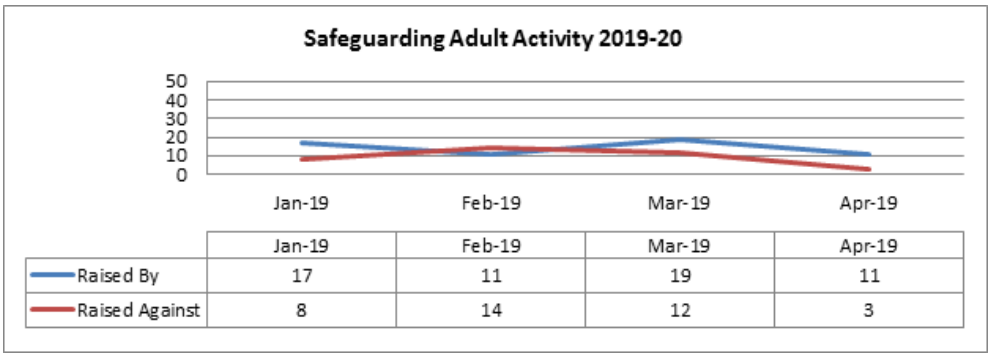
4.2 Safeguarding Children and Adult Referrals

The following charts below demonstrate the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of Paediatric Liaison Forms (PLF's) processed. April has seen a decrease in both Multi Agency Safeguarding Hub (MASH) referrals and PLF's during the reporting period, but there is no apparent reason for this.



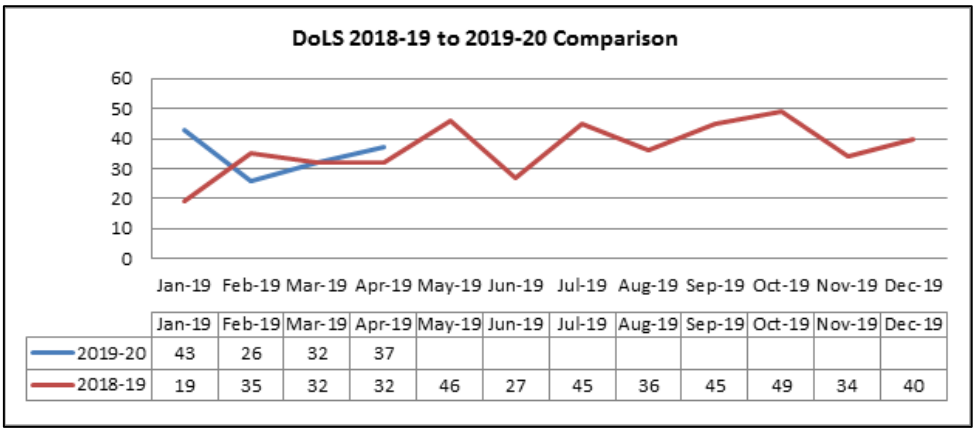
	Jan-19	Feb-19	Mar-19	Apr-19
Referral	89	63	97	68
PLF	120	102	127	84

In terms of safeguarding adults' referral activity, there has been a significant decrease in both the number of safeguarding allegations raised by the Trust and the number of safeguarding allegations against the Trust as illustrated in the graph below:



	Jan-19	Feb-19	Mar-19	Apr-19
Raised By	17	11	19	11
Raised Against	8	14	12	3

The information which the Local Authority provides the Trust around safeguarding activity continues to be a challenge and does not portray a totally accurate picture. Therefore our staff have been reminded to complete a Datix when they send a safeguarding referral to the Local Authority, so the Trust safeguarding team can monitor referrals more accurately.



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
2019-20	43	26	32	37								
2018-19	19	35	32	32	46	27	45	36	45	49	34	40

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have increased during the reporting period.

The Head of Safeguarding has received a response from the Head of the DoLS service at the Northamptonshire County Council In light of the recently published Local Governance and Social Care Ombudsman Investigation into a Complaint against Staffordshire County Council. The letter does not offer assurance that their capacity issues will be resolved therefore there will continue to be a backlog of requests for authorisations.
There has been one external assessment by the Local Authority during the reporting period.

4.3 Safeguarding Assurance Activity

The safeguarding team continue to experience gaps/ omissions in practice from the Local Authority. These concerns are captured on a weekly basis and shared with the CCG if required.

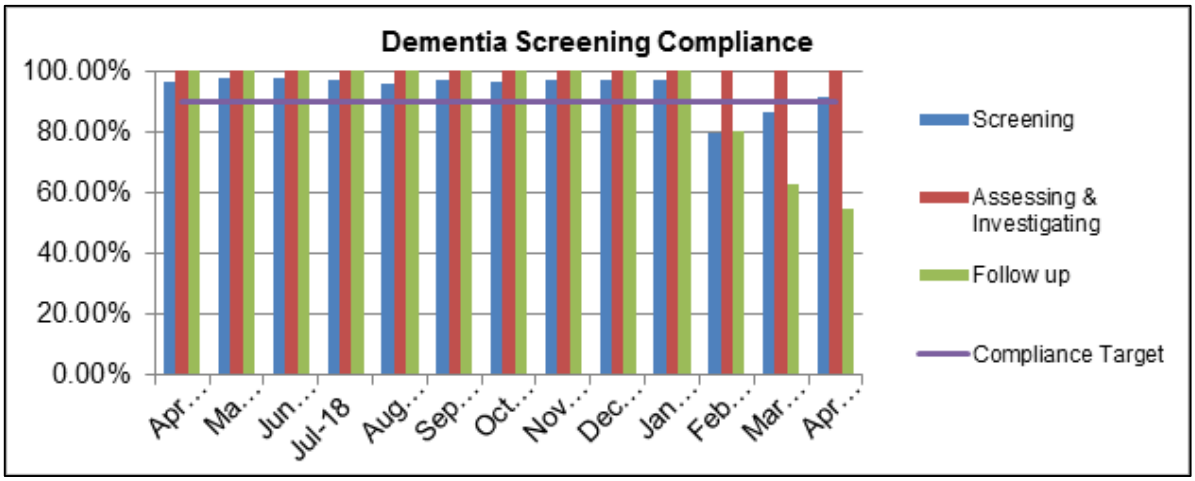
The Head of Safeguarding has observed a decline in pre-birth assessments during the last two weeks and has shared her concerns with the Deputy Director of Children's Services. We requested and have received an organisational structure chart for Children's Services with contact details for the different areas which our team are now using.

There are six children's Serious Case Reviews (SCR's) and two Safeguarding Adult Reviews (SAR's) in progress. All individuals (apart from one child) had contact with the Trust.
There are five ongoing Domestic Homicide Reviews (DHR's) that are ongoing in the county. Only one individual had contact with the Trust as the other four DHR's occurred in the north of the county.

4.4 Dementia and Carer

Carers are now asked to rate the care their loved one received whilst at NGH. This element of the feedback is shown as a cumulative total out of the 79 responses received to date. Positively, at this time the majority of care is being identified as very good overall. The dementia lead is monitoring all feedback and any negative themes are reviewed and actions discussed with the areas involved.

Compliance for the dementia screening (91.5%) and assessing and investigating (100%) has been achieved during this reporting period following a decrease over the previous months.



However there continues to be a 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. This has been highlighted to both the Medical Director and the lead Clinician for Dementia for investigation and action.

5. Maternity Update

Maternity Transformation Programme

The provision of personalised individualised care for women, with the aim to have 'continuity of carer' throughout pregnancy and labour is a major component of the Maternity Transformation Programme, which seeks to achieve the vision set out in Better Births. Better Births requires each LMS to ensure that by March 2019 at least 20% of women are booked on a continuity of carer pathway and that by March 2021; most women are booked on a continuity of carer pathway for maternity services.

Continuity of carer for the antenatal and postnatal periods is well established at NGH, the challenge is to meet the ambition for provision of continuity of carer for the intrapartum element of the woman's pregnancy. This requires extra resource and funding. Cost pressures for delivery of this model have been shared across the LMS and the additional staffing requirements were discussed during budget setting.

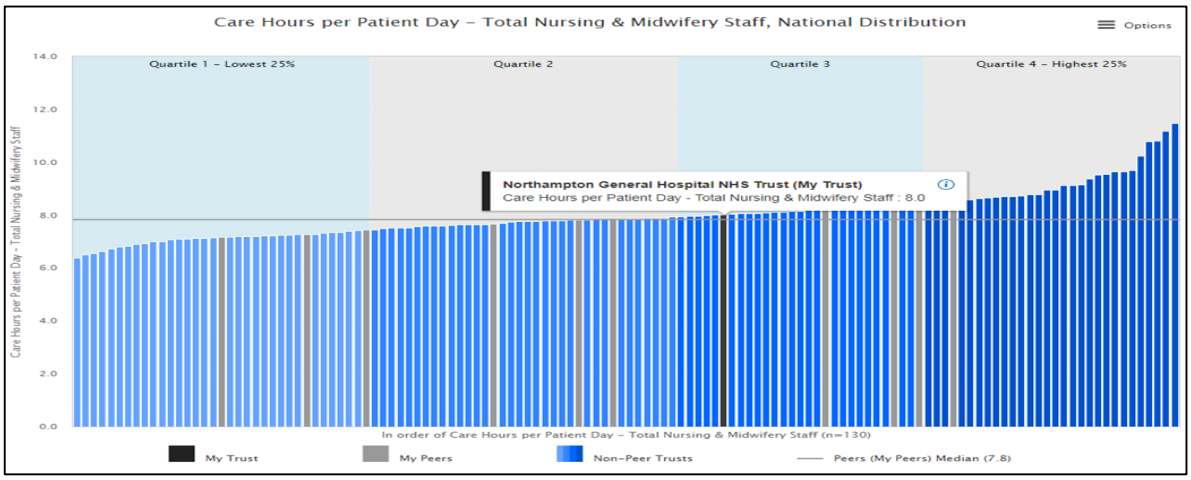
In addition, the current and projected activity within the maternity unit is presenting a challenge in taking forward the required changes in order to deliver the continuity of carer targets. A plan to reconfigure Sturtridge Labour Ward has been devised and agreed by the Divisional Management Team. A Justification Form has been submitted and the Division are awaiting approval to proceed with quotations and tenders.

6.0 Safe Staffing

Overall fill rate for April was 98%, compared to 96% in March. Combined fill rate during the day was 94%, compared with 91% in March. The combined night fill rate was 103% compared with 101% in March. RN fill rate during the day was 91% and for the night 97%. 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.

	Day	Night	Overall
RN	91%	97%	94%
HCA	98%	116%	106%
Overall	94%	103%	98%

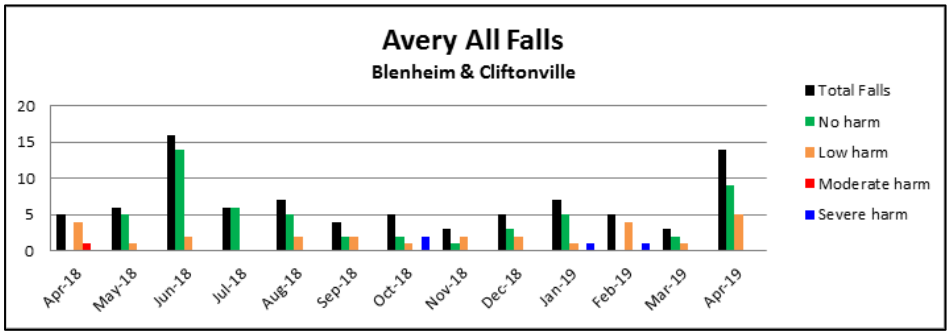
Across the general adult wards Care Hours per Patient Day for the month of April was Registered Practitioner 4.0 and HCA 3.2 (which is the same for RN and a slight increase in HCA from March); Trust wide inclusive of midwifery, paediatrics and critical care (which by nature are a higher care hours level) RN/M was 9.7 and HCA 4.2 (which is an increase for both from March).



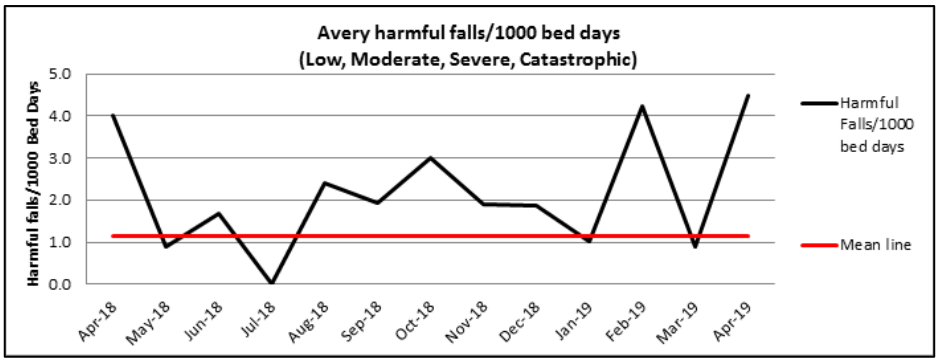
Of the 45 staffing Datix that were submitted and reviewed by the Associate Directors of Nursing & Midwifery 2 constituted a red flag, these have been reviewed by the Matron and Associate Director of Nursing for the Division involved. None of the 2 red flags resulted in actual patient harm. In accordance with the NHS Improvement document, Developing Workforce Safeguards 2018, the Nursing & Midwifery Quality Indicators dashboard are reviewed in correlation with any harms/concerns with staffing levels and reported in the safe staffing paper which is presented at Workforce Committee.

7.0 Avery

In April there were 14 inpatient falls, 9 no harm patient falls and 5 low harm patient falls.

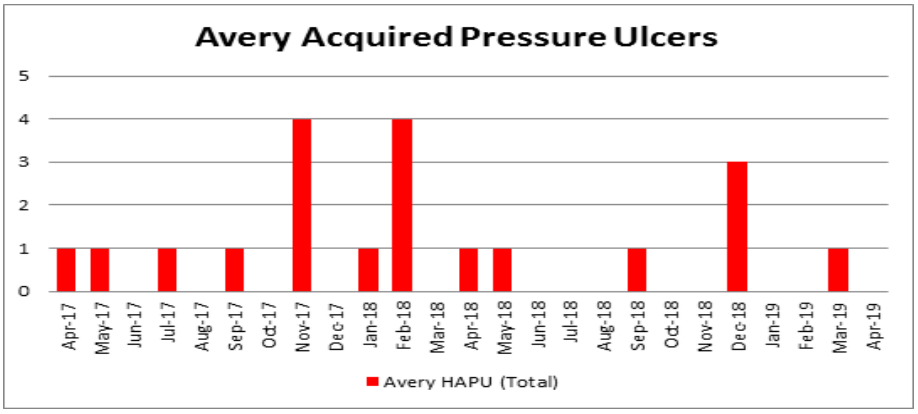


Avery Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in April by 3.6 when compared to March 2019. In total there was 5 low harm patient falls.



Avery PU Incidence

The chart below represents the number of pressure ulcer harms reported for patients in Avery. The TVT continue to report and investigate these harms as per Trust protocol.



There were no Pressure Ulcers reported on Avery during April.

8.0 Assessment and Accreditation

During April five wards were assessed two of which achieved green ratings and three who achieved amber ratings. One ward achieved green for the third consecutive occasion and is awaiting panel. In April, the current status of all adult in-patient wards including Critical Care was, four blue wards, nine green wards, eleven amber wards and no red ward. Of the nine green wards, four are awaiting panel to support blue ward status. The current status of outpatient departments is - three green departments and two amber departments. Through the assessment process standard 5 (infection prevention) has shown to be a challenge Trust wide. Work is ongoing supported by the Practice Development Team and the Infection Prevention Team to improve care within this standard with further improvements noted from the latest results.

9.0 End of Life

The Trust has agreed to adopt the new countywide DNACPR form which includes an integral MCA assessment from 1st June 2019. A working group will meet for the first time in May with the aim of streamlining existing audit and actions around MCA and DNACPR; this will include representation from End of Life, Resuscitation, Safeguarding and Learning Disability. A

countywide group are currently reviewing the role of senior nurses signing DNACPR forms; NGH is represented within this group.

On a weekly basis the Resus Officers audit all DNACPR forms. Findings are now accurate and indicate that DNACPR forms are consistently completed by the correct grade of doctor. The majority of DNACPR forms are accompanied by a Treatment Escalation Plan (TEP) across the Trust. The MCA continue to be consistently missed when a patient lacks capacity, the safeguarding Team and Resus Officers are addressing this at the time of the audit and at all safeguarding training.

Divisional directors informed monthly of all patients with a DNACPR which includes patients who lacked capacity and if they had the correct MCA documentation. Resus officers are now working closely with the palliative care, end of life and safeguarding / learning disability teams to ensure a robust system is in place for auditing and education.
Next steps: Bi-monthly MDT working group for this project to plan, implement and improve systems within our trust.

The National Audit of Care at End of Life (NACEL 2) audit remains on track and most bereaved relatives have given their consent to be contacted for the Quality Survey.

The Dying Person's Care Plan Steering Group is due to meet again in mid-May and will consider feedback from ward based staff that regularly use the document as well as care plans from other hospitals.

An End of Life Action Log for 2019-2020 has been created. This includes revision of the End of Life Strategy, setting out clear objectives for the service going forward as well as revision of the End of Life Operational Policy both of which have recently been ratified.

More End of Life Volunteer Champions has been recruited. For Dying Matters week the Specialist Palliative Care Team were at the Cyber Café, 13/14th May, talking with patients and staff about “starting a conversation”.

The End of Life Care Practice Educator held an Advance Care Planning stand at the Trust's recent Organ Donation Study Day and has facilitated an ACP information board for Compton ward. Specialist Palliative Care are supporting the assessment areas rolling education programme and working closely with RN and HCA staff on Talbot Butler and Creaton.

10.0 Pathway to Excellence

On April 24th -27th a team from NGH went to Orlando, USA to attend the Pathway conference. On the Thursday NGH was officially awarded Designation Status, with a lively celebration recognising us as the first ever UK organisation to gain this accolade. The team heard international speakers and spoke to a variety of nursing teams about their Pathway journeys and work within the six standards. A wealth of posters demonstrating examples of nursing excellence which has already got us all thinking about how we will embed work back at NGH.

Following the launch of ‘Challenge 500’ having worked with Northamptonshire Health Charitable Fund (our charity) Becket ward have raised over £800 toward their shared decision making council project the charity are willing to match the first £500 raised toward this innovation/improvement project. Five of the Becket team hiked to the top of Scafell Pike the highest mountain in England to fulfil the challenge.

Plans are in place to focus on the Pathway standard of ‘Wellbeing’ for Nurses day on May 10th with a variety of stands that reflect the theme of ‘cope and glory’ how we cope with working in day to day pressures faced within the NHS, build our resilience and proudly share the glory of the amazing work done across #teamNGH. Our nurses that went to Orlando will also be attending to share their learning experience.

The Terms of Reference for Pathway Steering Committee have been updated and presented to Nursing and Midwifery Board. Dates have been set for committee meeting throughout the year with a strategic plan for starting with the collating of evidence from June onward to support sustaining Pathway and 2022 re-designation.

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.

Appendix 1

Nursing and Midwifery Safety Thermometer Definition

The Department of Health introduced the NHS Safety Thermometer "Delivering the NHS Safety Thermometer 2012" the initiative was also initially a CQuIN in 2013/14 to ensure the launch was sustained throughout the nation. The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that needs be used alongside Trusts data that is prevalence based and triangulated with outcome measures and resource monitoring. The national aim is to achieve 95% or greater harm free care for all patients, which to date the national average is running at 94.25%.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, and urinary infection in patients with catheters and treatment for VTE. All inpatients (including those patients in theatres at the time but excluding paediatrics) are recorded by the wards and the data inputted onto the reporting system, on average NGH reports on 630+ patients each month.
The Safety Thermometer produces point prevalence data on all harms (which includes harms that did not necessarily occur in hospital) and 'new' harms which do occur whilst in hospital – in the case of falls, VTE and CRUTI the classification of 'new' means within the last 72 hours, this is slightly different for pressure damage as 'new' is categorised as development that occurred in our care post 72 hours of admission to hospital and is recorded throughout the patient stay on the Safety Thermometer.
NGH has a rigorous process in place for Safety Thermometer data collection, validation and submission; four sub-groups for each category exist and are led by the specialists in the area. For pressure damage and falls all harms are recorded on datix throughout the month (not just on this one day) reviews are undertaken to highlight any lapses in care, every area with an incident attends the Share and Learn forums to analyse further the incident and to develop plans for areas of improvement and future prevention.

Maternity Safety Thermometer
The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care (by asking women questions on women's perception of feelings around safety in labour. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women's homes and community postnatal clinics. The safety thermometer has only just been implemented in the community midwifery service.

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

Physical 'harms':

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

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

Appendix 2

Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

Appendix 3

Apr-2019	Medicine													WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Brampton	Collingtree	Compton	Dryden	Quinton	Eleanor	Esther White	Finedon	Holcot	Victoria	Walter Tull	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp
Falls/Safety Assessment	100.%	83.%	82.%	90.%	100.%	97.%	82.%	100.%	100.%	100.%	92.%	83.%	100.%	97.%	100.%	100.%	100.%	100.%	77.%	100.%	80.%	100.%
Pressure Prevention Assessment	100.%	100.%	90.%	100.%	79.%	100.%	100.%	100.%	100.%	100.%	86.%	96.%	100.%	83.%	100.%	97.%	100.%	100.%	80.%	97.%	86.%	100.%
Nutritional Assessment	100.%	87.%	100.%	93.%	87.%	73.%	76.%	100.%	100.%	100.%	100.%	92.%	97.%	100.%	100.%	100.%	100.%	93.%	93.%	97.%	93.%	100.%
Patient Observation and Escalations	95.%	100.%	92.%	95.%	100.%	100.%	87.%	100.%	100.%	100.%	100.%	88.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Pain Management	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	100.%	100.%	89.%	93.%	100.%	95.%	100.%	92.%	100.%	100.%	75.%	98.%	100.%	87.%	100.%	100.%	98.%	100.%	93.%	100.%	97.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	83.%	83.%	100.%	100.%	100.%	100.%	100.%	67.%	83.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	86.%	100.%	100.%	100.%	73.%	100.%	100.%	100.%	73.%	100.%	88.%	100.%	100.%	100.%	100.%	73.%	90.%	82.%	100.%
Patient Experience - Environment	100.%	80.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	80.%	80.%	83.%	100.%	80.%	100.%	80.%	100.%	80.%	80.%	100.%
Patient Experience - Privacy and Dignity	95.%	89.%	84.%	100.%	82.%	89.%	84.%	97.%	99.%	95.%	86.%	94.%	95.%	92.%	96.%	100.%	98.%	93.%	89.%	89.%	94.%	96.%
Patient Safety and Quality	84.%	95.%	100.%	100.%	100.%	100.%	90.%	87.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	90.%	100.%	95.%	85.%	100.%	90.%	95.%
Leadership & Staffing observations	89.%	96.%	100.%	90.%	100.%	100.%	73.%	94.%	90.%	96.%	100.%	82.%	88.%	84.%	98.%	100.%	98.%	98.%	94.%	94.%	83.%	96.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	100.%	86.%	91.%	86.%	86.%	89.%	80.%	94.%	89.%	80.%	86.%	80.%	100.%	82.%	77.%	83.%	97.%	80.%	66.%	80.%	80.%	100.%
Safety Thermometer – Percentage of Harm Free Care	97%	93%	97%	92%	85%	94%	88%	99%	96%	94%	87%	94%	96%	96%	96%	99%	91%	95%	95%	95%	95%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	1	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	3	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	1	0	1	0	0	1	0	0	0	1	0	0	0	0	1	0	0	3	0
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
HAI – MRSA Bact																						
HAI – C Diff			1														1					
Caring																						
Complaints – Nursing and Midwifery	1	1	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Number of PALS concerns relating to nursing care on the wards	3	0	1	1	1	0	0	0	0	0	1	1	0	0	0	0	1	1	0	0	1	0
Friends Family Test % Recommended	85.0%	76.9%	72.7%	84.6%	90.0%	96.4%	68.6%	89.3%	89.3%	96.7%	100.0%	75.0%	89.2%	95.5%	91.2%	85.5%	87.2%	87.3%	91.1%	97.0%	97.6%	96.9%
Well Led																						
Staff Nurse Staffing - Registered Staff (day & night combined)	87%	88%	102%	100%	94%	89%	102%	90%	95%	87%	98%	94%	81%	105%	99%	100%	97%	94%	112%	95%	93%	94%
Staff Nurse Staffing - Support Worker (day & night combined)	103%	94%	109%	93%	92%	100%	98%	105%	100%	151%	107%	139%	122%	123%	98%	106%	102%	118%	126%	103%	103%	72%
Staffing related datix	0	0	1	0	0	0	0	0	0	0	1	1	0	1	0	0	0	1	1	0	0	0

Appendix 4

Apr 19	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	75%	67%	100%
Pressure Prevention Assessment (Q)	87%	67%	na
Child Observations [documentation] (Q)	93%	75%	98%
Safeguarding [documentation] (Q)	87%	83%	100%
Nutrition Assessment [documentation] (Q)	89%	67%	94%
Medication Assessment (Q)	81%	100%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Experience			
Complaints – Nursing and Midwifery			
Number of PALS concerns relating to nursing care on the wards			
Call Bells responses (Q)	100%	100%	na
Patient Safety & Quality Environment Observations Observe patient records (Q)	100%	89%	100%
Privacy and Dignity (Q)	100%	98%	100%
Management			
Staffing related datix	1		
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	96%	96%	100%

Appendix 5

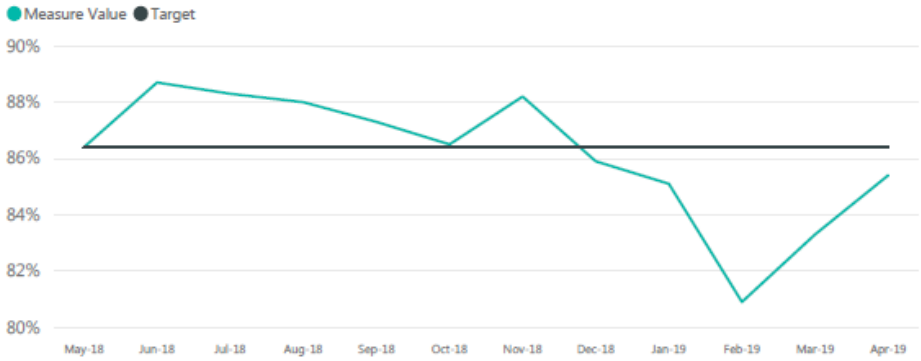
Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	100%	100%	100%	100%
SOVA/LD (Q)	na	na	na	na
Patient Observation Chart (Q)	100%	100%	100%	100%
Medication Assessment (Q)	88%	100%	100%	95%
Environment Observations (Q)	100%	92%	100%	93%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	100%	93%	100%	94%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	100%	100%	90%	91%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	1
Call Bells responses (Q)	100%	90%	100%	91%
Patient Experience (Q)	100%	100%	100%	100%
Patient Safety and Quality (Q)	100%	91%	88%	90%
Leadership & Staffing (Q)	100%	100%	100%	100%
Management				
Staffing related datix		1		
Monthly Ward meetings (Q)	100%	100%	100%	100%
Saftey and Quality (Q)	100%	100%	100%	100%
Leadership & Staffing (Q)	100%	100%	92%	98%

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

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
86.4 %	85.4 %	↑	Sheran Oke

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
86.4 %	88.7 %	88.3 %	88.0 %	87.3 %	86.5 %	88.2 %	85.9 %	85.1 %	80.9 %	83.3 %	85.4 %

What is driving under performance?

The recommendation rate for A&E was 1% below the national average when comparing the result for April with the most recent national average data available (February 2019). This is an improvement from the March result which was at 2.7% below the national average. Winter pressures continued to impact on the recommendation rate in A&E with highest levels of attendance ever seen with an 11% increase from same period last year and longer waiting times. The Emergency Department had a 34% text/interactive voice message failure rate during March but IT have reordered eCaMIS so the default is the mobile telephone number which will rectify the problem and should improve the response/recommendation rate.

Actions completed in the past month to achieve recovery

During the month A&E started an initiative to reduce waiting times for lower priority patients according the emergency needs. Patient Experience provided extra Volunteer support in collecting feedback to improve the response rate.

Exception report written by

FrancisS1

Timeframe for recovery

May 2019

Assurance Committee

Quality Governance Committee

Next steps

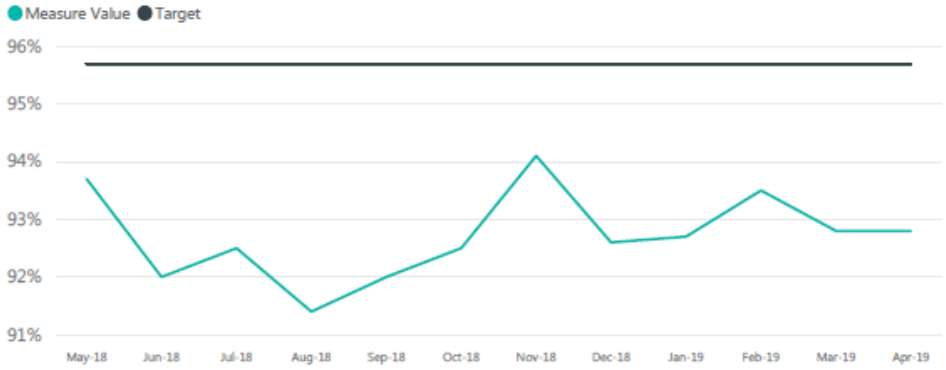
Monitor the impact of the new initiative in A&E, continue with the extra Volunteer support and review the failure rate of the text/interactive voice messages.

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

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
95.7 %	92.8 %	↓	Sheran Oke

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
93.7 %	92.0 %	92.5 %	91.4 %	92.0 %	92.5 %	94.1 %	92.6 %	92.7 %	93.5 %	92.8 %	92.8 %

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 2.9% below the national average for April which is a slight decrease from 2.8% in March. 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

May 2019

Assurance Committee

Quality Governance Committee

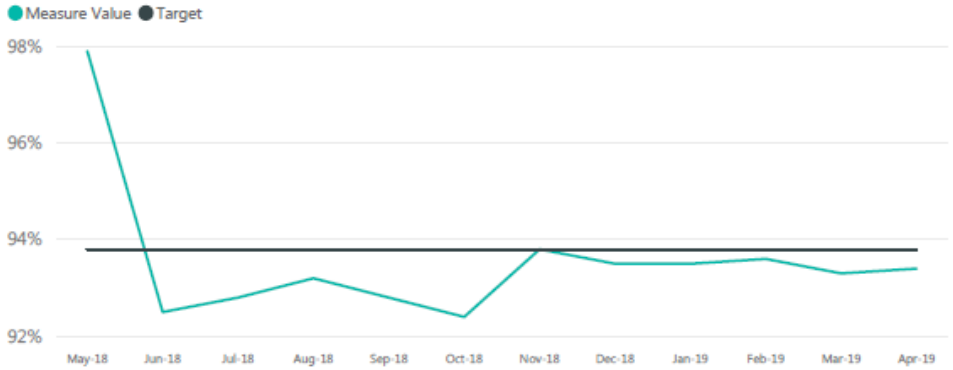
Next steps

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

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

April 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	93.8 %	93.4 %	↑	Sheran Oke

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
97.9 %	92.5 %	92.8 %	93.2 %	92.8 %	92.4 %	93.8 %	93.5 %	93.5 %	93.6 %	93.3 %	93.4 %

What is driving under performance?

The result for Outpatients in April remains static with March at 0.4% below the national average. Winter pressures impacted on outpatient appointments and waiting times but are now starting to improve.

Actions completed in the past month to achieve recovery

the Patient Experience Department continues to provide additional Volunteer support in collecting feedback to increase response rates. Patient Experience Champions are being recruited to raise awareness of the importance of patient experience and to disseminate this to their teams.

Exception report written by

FrancisS1

Timeframe for recovery

May 2019

Assurance Committee

Quality Governance Committee

Next steps

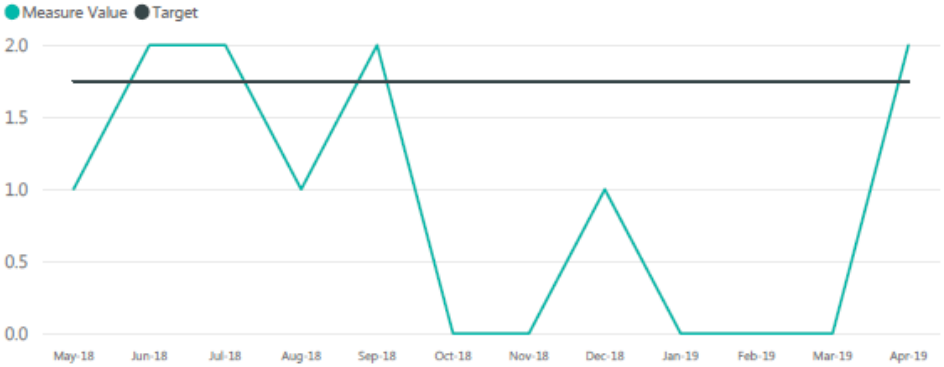
Finalise recruitment and training of Patient Experience Champions and continued Volunteer support in collecting patient feedback.

C-Diff

April 2019

Target	Actual	Direction of Travel	Accountable Executive
1.75	2	↓	Sheran Oke

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
1	2	2	1	2	0	0	1	0	0	0	2

What is driving under performance?

There are new descriptors for Clostridium difficile infection (CDI). The ceiling for 2019/20 is 40. The number allocated for the CDI for NGHT by the CCG for April is 3. For April 2019 NGHT had 3 patients attributed to the Trust under the new descriptors. 2 Hospital Onset Healthcare associated CDI (HOHA) and 1 Community Onset Healthcare Associated (COHA). The HOHA is a case that is detected 2 or more days after admission. The COHA is a case that occurred in the community, however the patient had been in the Trust reporting the case in the previous 4 weeks. There were no lapses in care identified.

Actions completed in the past month to achieve recovery

As per 2018/19 the IPCT have a Clostridium difficile infection plan of work for 2019/20 and this is on the May's agenda for the Infection Prevention Steering Group. The IPCT are working within the plan of work and this is reviewed at least quarterly.

Timeframe for recovery

June 2019

Exception report written by

FosterWE

Assurance Committee

Quality Governance Committee

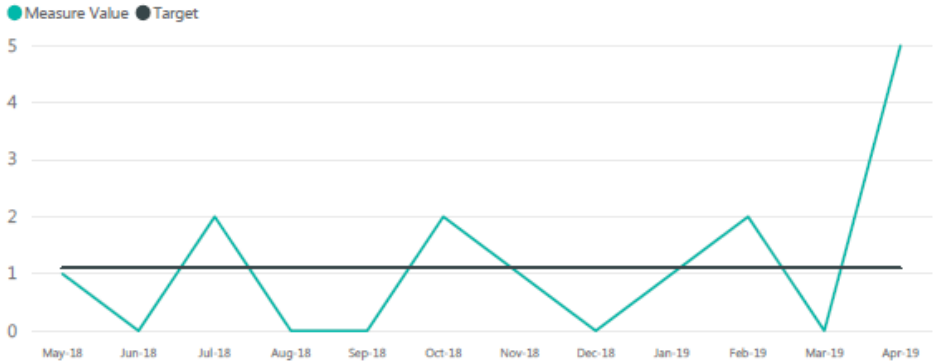
Next steps

Post Infection Reviews (PIR) are performed on all patients that are identified as a HOHA or COHA CDI. The latter is performed in collaboration with the Community Infection Control team. All PIR's go to the Clinical Commissioning Group (CCG) for review. They can also and will be discussed at the Whole Health Economy meeting which is held quarterly. The PIR are also presented at the Infection Prevention operational group and the learning is shared with all Matrons for the divisions who attend this group

MSSA

April 2019	Target	Actual	Direction of Travel	Accountable Executive
	1.1	5	↓	Sheran Oke

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
1	0	2	0	0	2	1	0	1	2	0	5

What is driving under performance?

This is an internal ceiling of 13 hospital onset MSSA bacteraemia, which has been set by NGHT. The sources that have been identified for the 5 patients that were identified in April 2019 are as follows: 2 patients the source of the MSSA bacteraemia was line related, 1 patient was chest sepsis and this was a patient who was at Cliftonville care home. 1 patient the source was a leg ulcer and the other cellulitis.

Actions completed in the past month to achieve recovery

IPCT complete Surveillance of the patients, Post Infection Reviews are in progress, action plans produced,and actioned. The learning is shared at the divisional governance meetings, at ward huddles and through the Infection Prevention Report at the Infection Prevention Operational Group and at the Infection Prevention Steering group

Timeframe for recovery

June 2019

Exception report written by

FosterWE

Assurance Committee

Quality Governance Committee

Next steps

As per 2018/19 the IPCT have a Healthcare Associated Infection Plan of work for 2019/20 and this is tracked through the Trusts Infection Prevention Steering group meeting which meets monthly it is reviewed at least quarterly. The IPCT are also going to review a new type of cannula dressing which enables less manipulation and scope out the use of non-ported cannulas.

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	83.3%	98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↑		86.3%	88.6%	88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		93.7%	91.9%	92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	→		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	→		97.8%	92.4%	92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	3	0	0	0	0	4	2	0	0
	Compliments	Sheran Oke	-	NGH								4,288	4,335	3,541	4,269	3,639	4,007	3,647
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		86.6%	93.8%	92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		129	58	79	60	118	174	142	299	330	400	420	343
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↑		5	2	1	3	15	17	19	30	49	33	22	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		13	7	6	16	2	3	3	4	5	4	4	11
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		39	35	12	19	36	10	10	24	12	11	20	31
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		42	40	28	16	34	27	15	20	20	17	29	41
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		37	31	19	13	25	25	13	16	17	13	20	30
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↓		90.8%	69.9%	72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↓		78.1%	23.3%	18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		97.4%	92.6%	95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		97.1%	100.0%	100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↓		94.3%	96.1%	97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↓		90.0%	78.5%	100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.3%	74.6%	78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	→		97.1%	68.4%	100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		87.5%	90.0%	81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↓		89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	↑		0	0	0	0	0	0	0	0	1	3	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.7%	99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				96.4%	93.5%	92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	76.4%	96.6%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				91.6%	87.7%	97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%
	Unappointed Follow Ups	Debbie Needham	=0	NGH											8,608	8,723	9,957	10,119
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			11.7%	12.1%	12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	4.4%	4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			11.8%	12.6%	13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.1%	14.3%	14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			9.5%	9.8%	10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			12.7%	13.7%	14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.5%	7.4%	8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			89.1%	89.5%	89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%
	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%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.8%	84.9%	85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			86.7%	86.7%	85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			63.5%	63.5%	58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			46	70	89	107	128	153	167	195	209	230	266	20
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	74
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH										64.5%	65.9%	65.5%	69.0%	39.0%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH										39.1%	40.4%	41.0%	41.0%	42.8%
	Maverick Transactions	Phil Bradley	=0	NGH						27				15	21	21	19	
	Waivers which have breached	Phil Bradley	=0	NGH			2	2		0				1	0	0	0	
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			62.3%	56.5%	51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			31.3%	29.3%	22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.9%	19.2%	18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.5%	3.4%	4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	3.0%	3.3%	3.6%	2.9%

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.3%	15.7%	16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	16.5%	15.9%	16.8%	13.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		88.8%	90.0%	87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.3%	34.1%	28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑		99	101	0	104	104	106	106	106	105	106	104	103
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		97	97	98	98	100	100	104	104	104	104	104	104
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		79	25	25	45	47	66	36	35	53	51	35	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		94.9%	100.0%	100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.0%	5.6%	5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	1	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-		→		3	4	3	2	3	0	0	3	7	1	0	0
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		97.8%	96.4%	96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	94.1%	93.1%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	↓		1	2	2	1	2	0	0	1	0	0	0	2
	MSSA	Sheran Oke	<=1.1	NGH	↓		1	0	2	0	0	2	1	0	1	2	0	5
	New Harms	Sheran Oke	<=2%	NGH	↑							2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↓		4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→									85.6%	88.1%	90.7%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓									62.0%	59.7%	56.7%	57.2%	53.0%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓									89.2%	89.2%	67.5%	72.6%	70.6%

Data not provided

No data - pre KPI implementation

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Report To	**Public Trust Board**
Date of Meeting	**30th May 2019**

Title of the Report	Financial Position - Month 1 (FY2019-20)
Agenda item	11
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 April 2019.

Executive summary

This report sets out the Trust's financial position for the month ended 30th April 2019 and shows a pre-PSF & FRF deficit of £3,455k compared to plan deficit of £2,820k, resulting in an adverse variance of £635k.

No accrual is included for PSF and FRF funding as these are related to meeting the financial plan, therefore the overall adverse variance to plan is £1,479k for month 1.

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 April 2019 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 1 (April 2019)
FY 2019/20

Report to:

Trust Board

May 2019

Content

The Trust ended month 1 with a financial position that is £635k 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 contributing to an overall adverse variance to plan of £1,479k.

1. Director of Finance Message

This report sets out the Trust's financial position for the month ended 30th April 2019 and shows a pre-PSF & FRF deficit of £3,455k compared to plan deficit of £2,820k, resulting in an adverse variance of £635k.

We have not accrued for the finance-related PSF and FRF of £844k therefore the overall variance to plan is £1,479k.

Income is £367k below plan mainly due to not achieving the RTT plan, however this is matched by unspent non-pay expenditure, so does not have an impact on the overall I&E position. The Trust however needs to consider the impact on patients having to wait longer for their treatments and how the backlog is managed. Operational pressures have been intense in April due to acuity and reduced social care funding resulting in less discharges ("stranded" and "super-stranded" patients increased to 390 and 181 respectively). These operational pressures have resulted in the opening of escalation areas (funded from reserves so depleting reserves for next winter) and resulted in several elective lists being cancelled with a knock-on effect on activity and income.

Pay is the main cause of the adverse financial performance this month with an adverse variance of £1,021k largely due to back-pay of additional PAs and ADHs (£282k) and the use of agency medical staff to cover vacancies (at a premium) and additional usage above establishment (£257k); in addition to significant use of unqualified nursing staff to cover A&E and assessment ward areas (£165k). The Trust needs to ensure that the governance and processes around use of additional staff above establishment, particularly during periods of extended operational pressure, is well understood across the Trust and that there is adherence to such processes to provide assurance that any overspends are properly authorised.

CIP delivery is £1,101k in month 1 which is £246k better than plan although about 70% 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 £94k at month 1 which is below plan of £274k, with slippages due to ward refurbishment schemes.

Cash – The Trust continued to manage cash effectively and paid creditors earlier than the 95% BPPC benchmark, whilst ending with a cash balance of £3,946k at month 1.

Conclusion

In order to recover the financial plan, the Trust needs to continue to work with Northamptonshire health care partners to address issues relating to patient flow across the hospital as well as get a tighter grip on pay costs, in order to be eligible for associated PSF and FRF funding which is £2,532 for quarter 1.

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	Mar-19	Feb-19
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	301,676	24,046	23,777	(269)	24,046	23,777	(269)	25,130	21,937
Other Clinical Income	24,986	1,519	659	(861)	1,519	659	(861)	944	891
Other Income	21,764	1,814	1,959	145	1,814	1,959	145	2,627	2,643
Total Income	348,426	27,379	26,394	(985)	27,379	26,394	(985)	28,701	25,471
Pay Costs	(237,820)	(19,277)	(20,298)	(1,021)	(19,277)	(20,298)	(1,021)	(19,449)	(19,060)
Non-Pay Costs	(105,129)	(8,769)	(8,362)	407	(8,769)	(8,362)	407	(9,079)	(8,580)
Unallocated CIPs	10,429	(62)		62	(62)		62		
Reserves / Non-Rec	(1,271)	(47)		47	(47)		47		
Total Costs	(333,791)	(28,155)	(28,659)	(504)	(28,155)	(28,659)	(504)	(28,528)	(27,640)
EBITDA	14,635	(776)	(2,265)	(1,488)	(776)	(2,265)	(1,488)	173	(2,169)
Depreciation	(12,355)	(1,030)	(1,015)	15	(1,030)	(1,015)	15	(867)	(867)
Amortisation	(7)	(1)	(1)	0	(1)	(1)	0	(1)	(1)
Impairments								(1,093)	
Net Interest	(1,356)	(101)	(104)	(3)	(101)	(104)	(3)	(108)	(96)
Dividend	(1,174)	(98)	(98)	0	(98)	(98)	0	(88)	(93)
Surplus / (Deficit)	(257)	(2,005)	(3,482)	(1,477)	(2,005)	(3,482)	(1,477)	(1,984)	(3,226)
NHS Breakeven duty adjs:									
Donated Assets	257	29	27	(2)	29	27	(2)	15	13
NCA Impairments								1,093	
Surplus / (Deficit) - Normalised	0	(1,976)	(3,455)	(1,479)	(1,976)	(3,455)	(1,479)	(875)	(3,213)

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

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF + FRF	(16,881)	(2,820)	(3,455)	(635)
PSF + FRF: Finance	16,881	844		(844)
Post PSF + FRF	0	(1,976)	(3,455)	(1,479)

Table 3: Pre-PSF I&E Performance

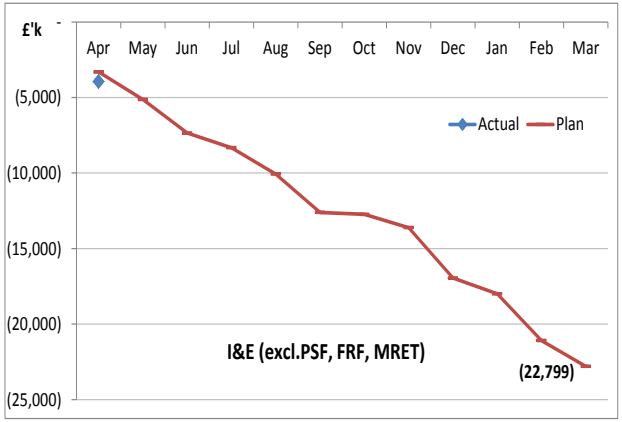
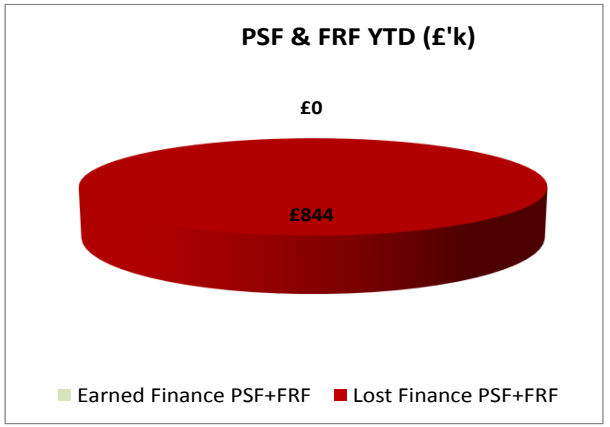


Table 4: PSF YTD Performance



2.1 Clinical Income (YTD)

Month 1 SLA Clinical Income is below plan, with a variance of £367k (excluding pass-through medicines and devices). This includes RTT income targets of £322k and a CIP target of £100k , impacting variances on Planned activity (£112k under plan) and OP activity (£238k under plan).

- A&E activity is below plan by 0.8%, and 1% below financial plan. This is split between main and Eye Casualty.
- Cost per Case (CPC) is broadly in line with plan. Strong ante-natal activity (+£59k) is offset by low Critical Care numbers (£64k below plan).
- Day case performance is below plan by 0.6% on activity, and by 1.6% financially. The £35k variance on income includes £50k CIP plan. MaxFax/Oral Surgery are 23% (£39k) above plan, with Plastic Surgery also under by £20k. Cardiology is over the activity plan by 13%,and £46k over on income.
- Elective activity is 5% below the income plan although significantly below the activity plan. The differential is due to the RTT recovery plan (see below). The under-performance in activity is aligned to Specialties with RTT plans. Activity has also dropped from 18/19 levels, impacted in April by NEL pressures.
- Non-electivity activity shows a minor variance above plan (0.8%) and is hitting the income plan (casemix is lower than plan in surgical areas in April). Emergency Medicine NEL is over plan (£61k), with the Surgery Directorate £46k under, reflecting the pressure on urgent care and discharge respectively.
- Outpatients are 4.2% below the activity plan and 6.8% below the income plan. As with Elective activity the variances for OP aligns with RTT plans, particularly in ENT, Gastro and Cardiology. Underlying this is increases in activity from March in Dermatology, Ophthalmology and Neurology.
- OPROCS are 5% below activity plans, 4% below income plans. Gynaecology and Ophthalmology are under plan.

Table 5: Key PoD Trend Analysis

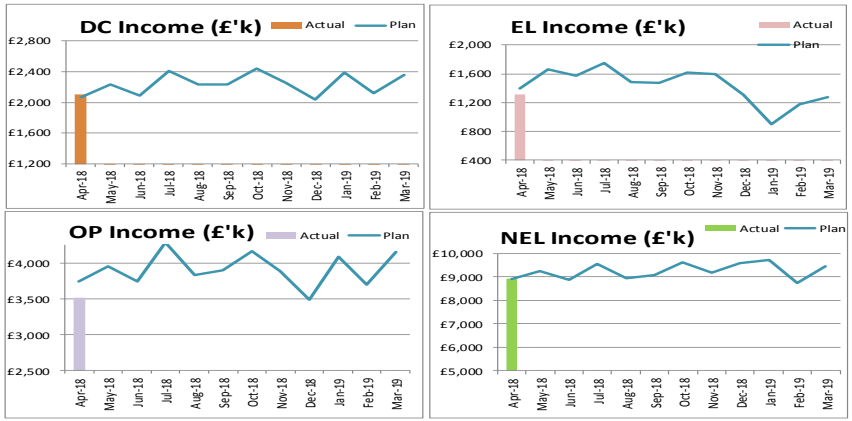


Table 6: SLA Clinical Income by PoD

SLA Clinical Income		Activity			Finance £000's	
Point of Delivery	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
AandE	11,170	11,081	(89)	1,698	1,678	(20)
Block	-	-	-	973	973	0
Cost per Case	262,825	247,868	(14,957)	3,171	3,151	(20)
CQUIN	-	-	-	228	228	0
Day Cases	3,315	3,284	(31)	2,118	2,083	(35)
Elective	480	315	(165)	1,395	1,317	(78)
Elective XBDs	129	114	(15)	39	39	0
Non-Elective	4,385	4,420	35	8,921	8,920	(1)
Non-Elective XBDs	1,755	1,416	(339)	477	492	15
Outpatient First	5,237	4,778	(459)	944	850	(94)
Outpatient Follow-up	16,753	16,280	(473)	1,491	1,420	(72)
Outpt Procedures	13,347	12,674	(673)	1,704	1,631	(73)
Other				0	0	0
sub-total	**319,396**	**302,230**	**(17,166)**	**23,159**	**22,782**	**(377)**
Challenges / Penalties				(150)	(140)	10
Readmissions				(265)	(265)	0
MRET				(493)	(493)	0
Fines & Penalties				**(908)**	**(898)**	**10**
Subtotal (excl. Excl Meds & Dev.)	**319,396**	**302,230**	**(17,166)**	**22,251**	**21,884**	**(367)**
Excluded Devices				103	95	(7)
Excluded Medicines				1,692	1,797	105
Total SLA Clinical Inc	**319,396**	**302,230**	**(17,166)**	**24,046**	**23,777**	**(269)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	72	59	(13)
Overseas Visitors	8	11	3
RTA / Personal Injury Income	102	96	(6)
PSF Funding	1,337	493	(844)
Total Other Clinical Income	**1,519**	**659**	**(861)**

CIP and RTT targets

- Productivity CIP targets are factored into Points of Delivery, in line with NHSI reporting. Month 1 includes £100k of CIP; £50k against DC activity and £50k OP.
- RTT Is also reported within points of delivery. In Month 1 this is a value of £322k; £142k in Elective, £180k in OP.
- Average prices used for the RTT plan were lower than Specialty Elective average to provide an element of casemix contingency.
- A cost response for RTT is also included in the plan, so under performance on these income targets should be reciprocated with an equivalent underspend.

2.2 Clinical Income By Commissioner (YTD)

Nene Contract - £378k under performance

The Month 1 position on the Nene contract is £378k under plan. The is largely linked to Obstetrics (births) at c. £170k under plan, with Critical Care also £86k below and Outpatients (incl OPROCS) £58k.

Key impacts In the underlying activity include:

- Planned activity (DC and EL) for Nene, was £35k below plan. Plastic Surgery accounted for £20k of this variance, with casemix in T&O leading to £18k under plan despite activity being over by 18 DC.
- Non-elective activity was below plan by £100k. A significant element due to births, which we will monitor with the service as we would not expect this to continue. Activity is also under in General Surgery and T&O. This was partially offset by activity Emergency Medicine.
- Outpatient activity is 2% below contract. Value, largely in Cardiology (-£54k) and Ophthalmology (-£82k). Dermatology and Paediatrics performance offset this.

Secondary Dental - £48k over performance

This over-performance is largely attributable to Day Case activity in Max Fax and Oral Surgery, as mentioned on Slide 2.1

NCA/Central/Other - £46k over performance

NCA activity is better than plan in Month 1. Also this line includes RTT and CIP targets which are offset by the movements in WIP as activity is not allocated to Commissioner until discharge.

Table 7: SLA Clinical Income by Commissioner

	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	19,200	18,822	(378)
Corby CCG	206	229	23
Bedfordshire CCG	75	44	(30)
East Leicestershire & Rutland CCG	65	86	21
Leicester City CCG	11	16	4
West Leicestershire CCG	6	4	(2)
Milton Keynes CCG	202	211	9
Specialised Commissioning	2,972	2,962	(10)
Secondary Dental	581	629	48
NCA / Central / Other	728	774	46
Total SLA Income	**24,046**	**23,777**	**(269)**

3. Pay Expenditure

In Month 1 Pay Expenditure was £20.3m against a plan of £19.3m; resulting in a £1.0m adverse variance in month.

- April 2019 substantive pay includes payment of new agenda for change pay rates from 1st April 2019 and increased pay for senior staff on spot salaries. Provision has also been taken for medical staff pay awards at 2% from 1st April in line with 2019/20 planning assumptions (actual pay award yet to be confirmed).
- The plan figure includes a CIP allocation of £758k being the amount of pay underspends across a number of cost centres within the Trust in Month 1. This has been applied as a non-recurrent CIP in month.

Main drivers of adverse variance to plan in month:-

- Back pay of additional PA's to consultants relating to 2018/19 - £87k additional cost pressure in month
- Over-establishment of middle grade and junior medical staff in general medicine by 17WTE (£121k above budget) mainly to support Nye Bevan and acute medicine model and gaps within the consultant establishment
- Increased numbers of agency and bank senior medical locums across the Trust at premium rates – 24.29WTE agency and bank consultants worked in month. Agency and budget only sufficient to cover approx. 12WTE temporary staff within budgeted establishment, additional staff cost pressure approx. £136k
- £195k overspend on medical ADH's across the Trust including a proportion of back pay for work done in 2018/19
- Adverse variance of £165k on unqualified nursing staff in month (36WTE above budget) with higher than establishment nursing numbers in areas under significant operational pressure including A&E , Nye Bevan and Talbot Butler (£60k overspend across three cost centres alone – remaining £105k adverse variance spread across other wards)

Table 8: Pay Expenditure

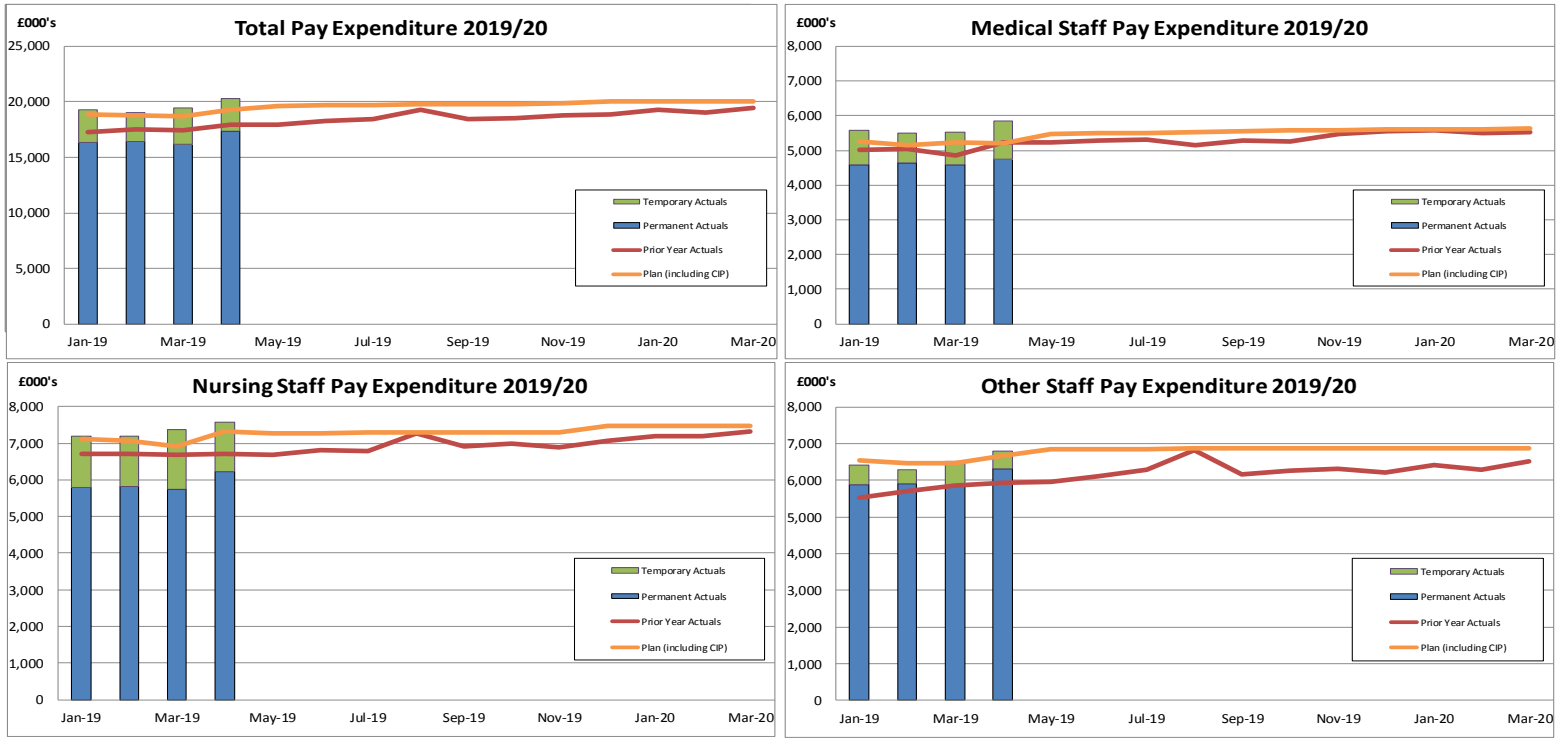
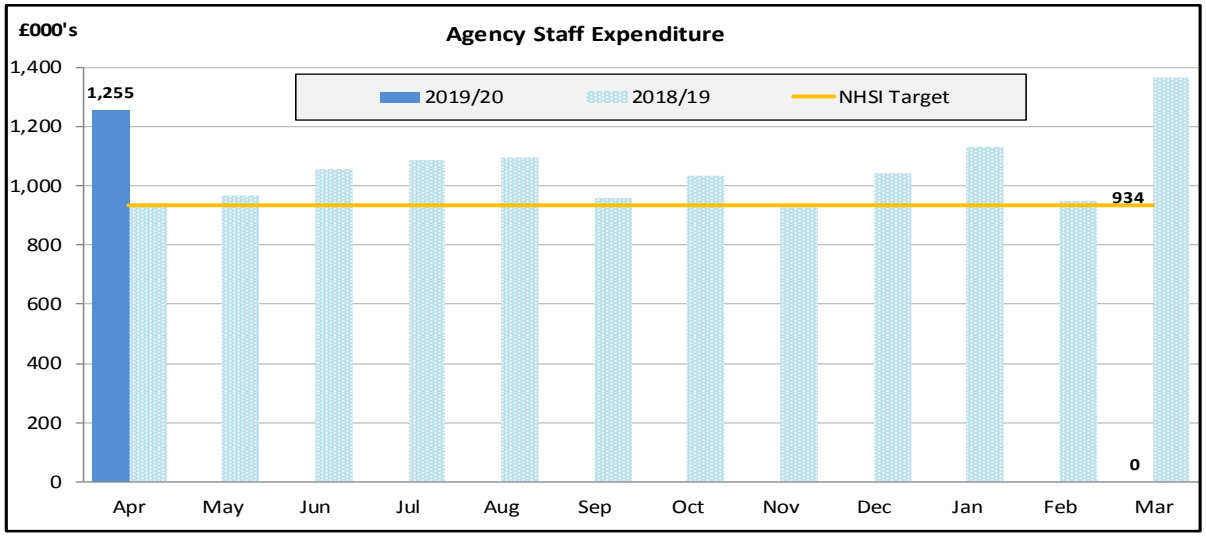
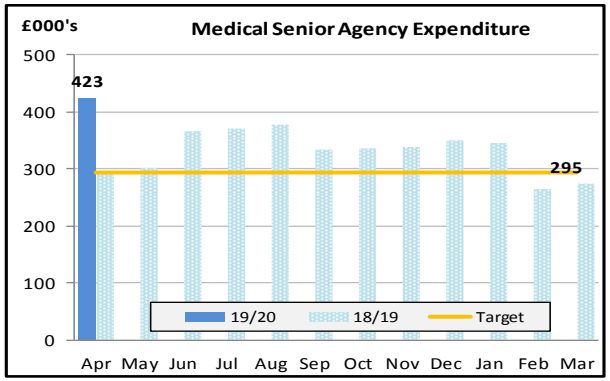
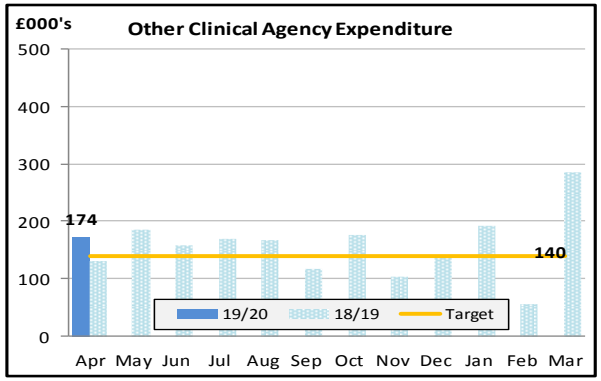


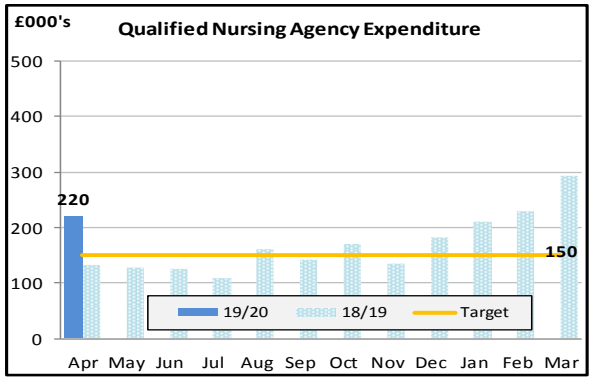
Table 9: Agency Spend

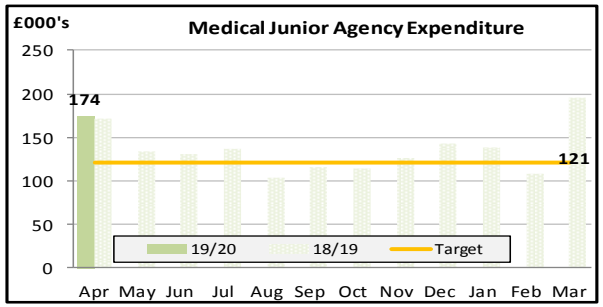


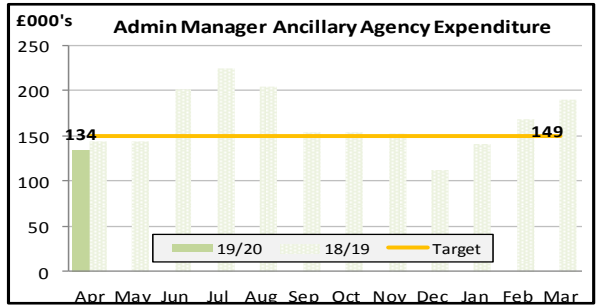
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2019/20.
- This £934k per month target is equivalent to an 10.6% improvement upon the 18/19 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Nursing continued the higher levels seen in the final quarter of 18/19, with staff employed in Theatres, and covering escalation areas still.
- Senior Medical agency recorded the highest monthly expenditure for 18 months. Mainly driven by Medical / Urgent Care, but also 3 surgical cover posts in Head & Neck and Breast pushing the recorded spend up in month 1.

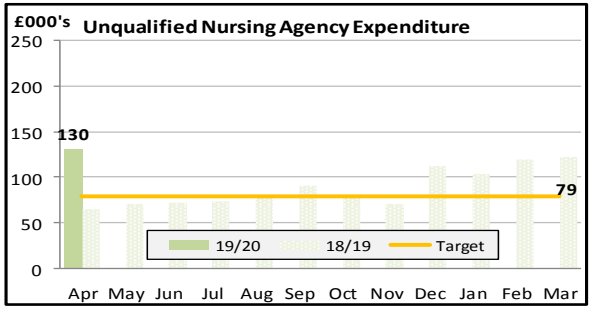












4. Non-Pay

Non Pay expenditure for month 1 is £0.4m favourable in month.

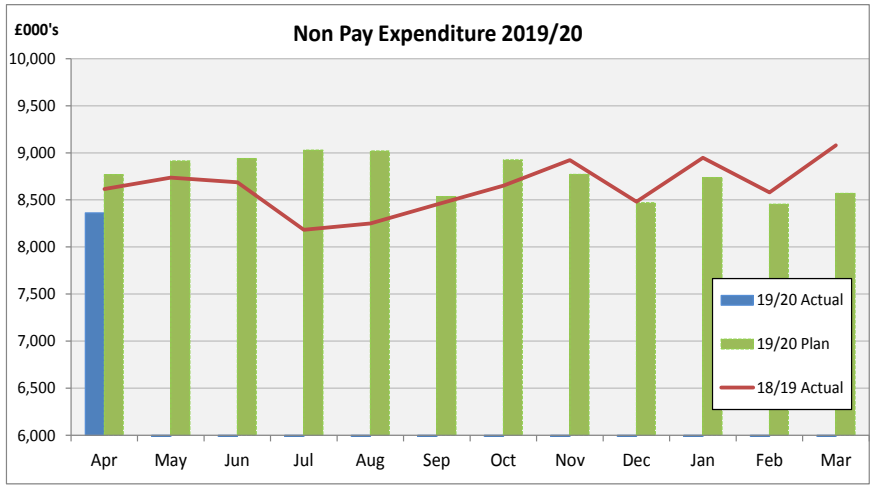
Excluding pass-through drugs and devices costs, the in month non-pay variance is £505k favourable to plan with key variances including:

- £286k Other Fees, £324k of which is due to budget set to mirror the planning assumption of clearing the RTT backlog within the first 5 months of 19/20.
- £199k Medical & Surgical Items, is in part due to £125k Non Pay inflation reserve set for all non pay. Plus a 10% underspend across the bed holding divisions.
- £73k Equipment Maintenance, is mainly due to bringing the managed medical equipment maintenance service back in house. This efficiency has been identified for potential CIP delivery, with budgets being reduced once an annual value has been confirmed.

Adverse variances offsetting above adverse variances in month include:

- £44k Prosthesis; an increased spend in Orthopaedic Theatre due to higher than plan complexity of elective work completed in April.
- £36k Equipment Hire, is also generated from orthopaedic complexity with spend over double the £16k per month budget.
- £34k Training; half of this variance is offset by LDA training income, reported under the Other Income category.

Table 10: Non-Pay Trend



	Annual Plan	Current Month - M1 Apr-19 Plan	Actual	Variance	Year to Date - M1 Apr-19 Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Non Pay - Fixed							
Equipment Hire	1,357	113	149	(36) Adv	113	149	(36) Adv
Equipment Maintenance	4,842	387	314	73 Fav	387	314	73 Fav
Clinical Non Pay - Fixed Total	**6,199**	**500**	**463**	**37 Fav**	**500**	**463**	**37 Fav**
Clinical Non Pay - Variable							
Prosthesis	2,116	156	200	(44) Adv	156	200	(44) Adv
Patient & Surgical Appliances	3,297	273	277	(4) Adv	273	277	(4) Adv
Patient Clothing & Travel	65	5	10	(5) Adv	5	10	(5) Adv
Lab Equipment Consumables	5,970	498	479	18 Fav	498	479	18 Fav
Blood	1,415	118	104	13 Fav	118	104	13 Fav
Medicines	5,954	479	513	(34) Adv	479	513	(34) Adv
Medical & Surgical Items	12,813	1,033	834	199 Fav	1,033	834	199 Fav
Dressings	880	71	58	13 Fav	71	58	13 Fav
Medical Gases	273	23	29	(7) Adv	23	29	(7) Adv
Clinical Non Pay - Variable Total	**32,784**	**2,655**	**2,505**	**150 Fav**	**2,655**	**2,505**	**150 Fav**
Clinical Non Pay - Total	**38,983**	**3,155**	**2,968**	**188 Fav**	**3,155**	**2,968**	**188 Fav**
Non Clinical Non Pay							
Building & Engineering Equipment	5,429	459	439	21 Fav	459	439	21 Fav
Cleaning Equipment	579	48	50	(2) Adv	48	50	(2) Adv
Energy & Utilities	2,584	215	255	(39) Adv	215	255	(39) Adv
Rates	1,091	91	94	(3) Adv	91	94	(3) Adv
Printing & Stationery	886	74	68	6 Fav	74	68	6 Fav
Computer Equipment & Maintenance	4,112	343	297	46 Fav	343	297	46 Fav
Communications	884	74	83	(10) Adv	74	83	(10) Adv
Office Equipment	107	11	15	(4) Adv	11	15	(4) Adv
Other Fee's	6,842	767	481	286 Fav	767	481	286 Fav
Losses & Compensations	772	64	69	(5) Adv	64	69	(5) Adv
CNST	12,044	1,004	1,002	2 Fav	1,004	1,002	2 Fav
Consultancy Fee's	537	45	38	7 Fav	45	38	7 Fav
Training	1,332	111	145	(34) Adv	111	145	(34) Adv
Travel & Benefits	1,317	110	69	41 Fav	110	69	41 Fav
Staff Advertising	619	52	41	11 Fav	52	41	11 Fav
Patient Provisions	1,554	129	144	(14) Adv	129	144	(14) Adv
Patient Linen	1,154	96	84	12 Fav	96	84	12 Fav
Non Clinical Non Pay	**41,844**	**3,693**	**3,373**	**320 Fav**	**3,693**	**3,373**	**320 Fav**
NHFT Expenditure SLA's	**1,505**	**125**	**128**	**(3) Adv**	**125**	**128**	**(3) Adv**
Sub-Total (Excl. Med./Dev.)	**82,332**	**6,974**	**6,469**	**505 Fav**	**6,974**	**6,469**	**505 Fav**
Excluded Medicines	21,494	1,692	1,797	(105) Adv	1,692	1,797	(105) Adv
Excluded Devices	1,302	103	95	7 Fav	103	95	7 Fav
Non Pay Expenditure	**105,129**	**8,769**	**8,362**	**407 Fav**	**8,769**	**8,362**	**407 Fav**

5. CIPs

Table 11: CIPs

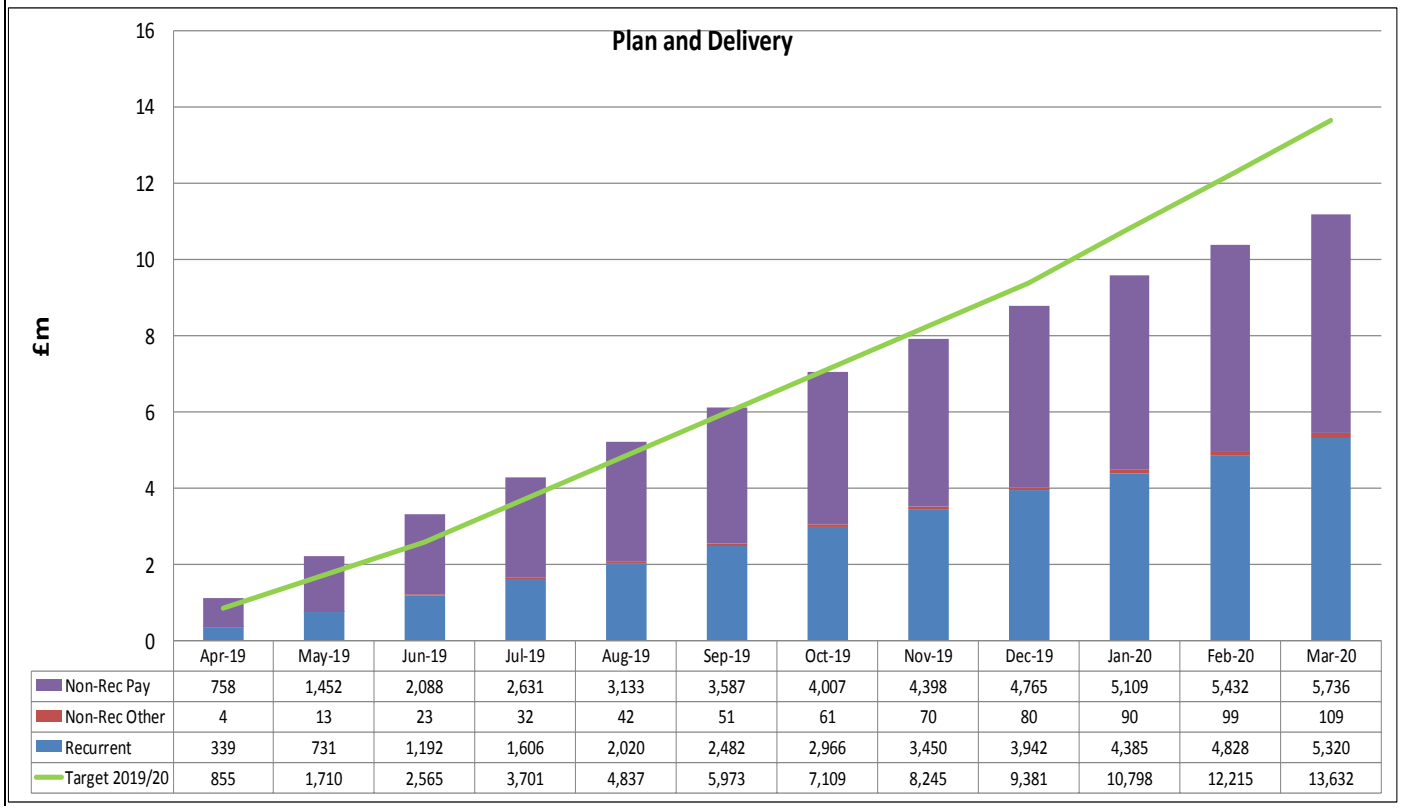
Overall Improvement Programme Update Month 1

YTD Delivery £000's

Division	Plan	Rec	N/R	Pay Under	Actual Total	Variance vs plan
SURGICAL DIVISION	229	45	0	167	212	-18
MEDICAL DIVISION	233	184	0	118	302	70
WCOH DIVISION	143	0	0	84	84	-59
CSS DIVISION	132	35	1	214	250	118
HOSPITAL SUPPORT	67	28	2	122	152	85
FACILITIES	51	47	0	53	100	49
CENTRAL	0	0	0	0	0	0
Trust Total	**855**	**339**	**4**	**758**	**1,101**	**246**

Delivery £000's

Division	Plan	Rec	N/R	Pay Under	Total	Risk Adj LTF	Variance
SURGICAL DIVISION	3,656	1,087	0	1,533	2,620	2,331	-1,325
MEDICAL DIVISION	3,711	2,593	66	933	3,592	3,077	-634
WCOH DIVISION	2,275	167	0	859	1,026	989	-1,286
CSS DIVISION	2,108	517	10	1,536	2,063	1,948	-160
HOSPITAL SUPPORT	1,064	397	28	456	882	860	-204
FACILITIES	818	559	5	419	983	470	-348
CENTRAL	0	0	0	0	0	0	0
Trust Total	**13,632**	**5,320**	**109**	**5,736**	**11,165**	**9,675**	**-3,957**



	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	1,452	2,088	2,631	3,133	3,587	4,007	4,398	4,765	5,109	5,432	5,736
Non-Rec Other	4	13	23	32	42	51	61	70	80	90	99	109
Recurrent	339	731	1,192	1,606	2,020	2,482	2,966	3,450	3,942	4,385	4,828	5,320
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

Overview of progress, including risks and mitigation taken:

The month 1 2019/20 risk adjusted LTF is currently £9.675m against a target of £13.632m. This represents a negative variance of £3.957m.

Of the £11.165m delivery £5.845m (52%) of schemes are non-recurrent. This is predominantly £5.736m 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 1 totalled £1.101m against a year to date plan of £855k. This represents a favourable variance to plan of £246k, which is mainly due to £758k Non- Recurrent pay general underspend across all divisions.

All divisions meet on a regular basis to identify schemes.

The Changing Care Steering Group is also exploring cross cutting transformation themes as a way to potentially mitigate any likely shortfall in this year's savings.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M1 movements include the capital additions of £96k and Depreciation charge of £1,015k.

Current assets

• Inventories - £87k. Decreases in Pharmacy (£43k) & Heart Centre (£220k) stockholdings, are offset by increases in Pathology (£121k) & Supplies Trading (£55k)

•Trade & Other Receivables – £856k made up of : Increases in Income accruals (£1,583k), Other receivables (£298k), Salary Overpayments (£27k) & Prepayments (£811k). Decreases in NHS receivables (£461k), Trade Receivables (£490k), VAT reclaim (£838k). The provision held for Salary Overpayments has increased by £66k following Payroll End of Year adjustments.

•Cash – Increase of £2,393k.

Current Liabilities

• Trade & Other Payables - £5,231k made up of: Increases in NHS Payables (£2,213k), Trade Payables (£2,234k), Accruals (£1,254k), Receipts in Advance (£881k) Tax, NI & Pension Creditor (£72k) & PDC Dividend (£36k). Decrease in Capital Payables (£1,482k).

•Short Term Loans - £56k. Increases in Revenue Loan interest payable (£43k) & Capital Loan interest payables (£13k).

•Provisions - £50k made up of – Release of HR Compensation (£28k) & Legal Fees (£18k), Reversal of 18/19 Agreement of NHS Balances relating to POP Accrual (£32k) & a new provision arising relating to Salary Recharges from UHL (£27k).

•Non Current Liabilities

• Finance Lease Payable - £96k. Nye Bevan £84k, Car Park £12k.

•Loans over 1 year - £580k. Drawdown of Revenue Loan £609k. Repayment of Salix Loan £29k.

Financed By

- I & E Account - £3,482k deficit in month.

Table 12: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 1 2019/20						
	Balance at 31-Mar-19	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	162,168	162,168	162,168	0	162,168	0
IN YEAR REVALUATIONS	0	0	0	0	553	553
IN YEAR MOVEMENTS	0	0	96	96	9,353	9,353
LESS DEPRECIATION	0	0	(1,015)	(1,015)	(12,355)	(12,355)
NET BOOK VALUE	162,168	162,168	161,249	(919)	159,719	(2,449)
CURRENT ASSETS						
INVENTORIES	5,338	5,338	5,251	(87)	5,238	(100)
TRADE & OTHER RECEIVABLES	23,892	23,892	24,748	856	27,319	3,427
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,553	1,553	3,946	2,393	1,500	(53)
TOTAL CURRENT ASSETS	30,783	30,783	33,945	3,162	34,057	3,274
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	23,806	23,806	29,037	5,231	21,473	(2,333)
FINANCE LEASE PAYABLE under 1 year	1,109	1,109	1,113	4	1,157	48
SHORT TERM LOANS	41,016	41,016	41,072	56	61,235	20,219
STAFF BENEFITS ACCRUAL	723	723	723	0	650	(73)
PROVISIONS under 1 year	731	731	681	(50)	350	(381)
TOTAL CURRENT LIABILITIES	67,385	67,385	72,626	5,241	84,865	17,480
NET CURRENT ASSETS / (LIABILITIES)	(36,602)	(36,602)	(38,681)	(2,079)	(50,808)	(14,206)
TOTAL ASSETS LESS CURRENT LIABILITIES	125,566	125,566	122,568	(2,998)	108,911	(16,655)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	10,686	10,686	10,590	(96)	9,529	(1,157)
LOANS over 1 year	53,693	53,693	54,273	580	38,107	(15,586)
PROVISIONS over 1 year	189	189	189	0	150	(39)
NON CURRENT LIABILITIES	64,568	64,568	65,052	484	47,786	(16,782)
TOTAL ASSETS EMPLOYED	60,998	60,998	57,516	(3,482)	61,125	127
FINANCED BY						
PDC CAPITAL	120,538	120,538	120,538	0	120,538	0
REVALUATION RESERVE	31,277	31,277	31,277	0	31,661	384
I & E ACCOUNT	(90,817)	(90,817)	(94,299)	(3,482)	(91,074)	(257)
FINANCING TOTAL	60,998	60,998	57,516	(3,482)	61,125	127

Table 13: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2019/20 £000s	ACTUAL 19/20 APR £000s	FORECAST 19/20 MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	292,275	24,288	24,757	24,323	24,323	24,323	24,323	24,323	24,323	24,323	24,323	24,323	24,323
Provider Sustainability Funding (PSF & FRF)	13,966	0	0	0	8,059	0	2,532	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)	0	0	0	0	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	9,200	775	775	765	765	765	765	765	765	765	765	765	765
Other NHS Income	12,025	1,025	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
PP / Other (Specific > £250k)	4,934	1,261	423	325	325	325	325	325	325	325	325	325	325
PP / Other	14,313	1,113	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan	0	0	0	0	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	6,042	1,695	0	1,644	0	0	0	642	0	1,157	273	631	0
Uncommitted Revenue Loan - PSF funding	13,673	844	0	844	1,248	0	0	2,565	1,305	0	3,657	1,969	1,241
Interest Receivable	87	10	7	7	7	7	7	7	7	7	7	7	7
TOTAL RECEIPTS	**370,995**	**32,491**	**28,162**	**28,669**	**38,407**	**27,620**	**30,152**	**32,307**	**28,925**	**32,152**	**33,028**	**30,220**	**28,861**
PAYMENTS													
Salaries and wages	222,838	18,633	18,755	18,455	18,455	18,755	18,455	18,755	18,455	18,455	18,755	18,455	18,455
Trade Creditors	94,080	6,068	8,497	7,414	9,355	9,774	7,478	6,336	5,259	10,357	7,877	8,356	7,309
NHS Creditors	25,382	2,160	2,402	2,402	2,402	2,402	2,402	2,402	2,402	2,402	2,402	800	800
Capital Expenditure	10,867	1,250	830	348	383	641	727	941	1,451	882	1,155	1,815	444
PDC Dividend	1,174	0	0	0	0	0	587	0	0	0	0	0	587
Repayment of Revenue Loan - PSF funding	13,288	1,930	0	0	640	2,252	0	3,739	1,305	0	2,662	0	760
Repayment of Loans (Principal & Interest)	3,273	58	47	49	171	796	502	64	53	56	176	795	505
Repayment of Salix loan	99	29	0	0	0	0	0	69	0	0	0	0	0
TOTAL PAYMENTS	**371,000**	**30,128**	**30,531**	**28,669**	**31,407**	**34,620**	**30,152**	**32,307**	**28,926**	**32,152**	**33,027**	**30,221**	**28,860**
Actual month balance	-5	2,363	-2,369	0	7,000	-7,000	0	0	-1	0	1	-1	1
Cash in transit & Cash in hand adjustment	-48	29	-77	0	0	0	0	0	1	0	-1	1	-1
Balance brought forward	1,553	1,553	3,946	1,500	1,500	8,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**3,946**	**1,500**	**1,500**	**8,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- Closing cash balance at the end of April was £3,946k.
- All SLA base payments , with the exception of £398k for Secondary Dental & £35k Cquin, were paid on time. These are forecast to be paid in May. 19/20 contract values have been invoiced to Nene & Corby CCGs. The remainder of Commissioners have been invoiced at the 18/19 rate.
- £70k of 17/18 over-performance invoices issued to Milton Keynes CCG remain outstanding. 18/19 Under-performance credit note & HEP C invoice have been issued to Central Midlands Commissioning Hub. It is anticipated that further performance invoices/credit notes will be issued following the reconciliation process at the end of Quarter 1.
- Qtr 1 MRET funding of £1,480k was received in April. Qtr 4 PSF & 18/19 Incentive Funding are forecast to be received in July.
- VAT return payments for March & April were received in April.
- Uncommitted Revenue Loan of £609k has been drawn down in April. This is made up of £1,695k deficit funding, £844k PSF & FRF & repayment of Qtr 3 PSF funding drawn down in lieu. The next drawdown will be June. Deficit funding can be drawn as required up to the year to date cumulative deficit position submitted in the plan.
- Creditor payments were £2,190k below forecast, mainly as a result of the high value payments made at the end of March. Salaries were £533k more than forecast.

Table 14: Cash forecast

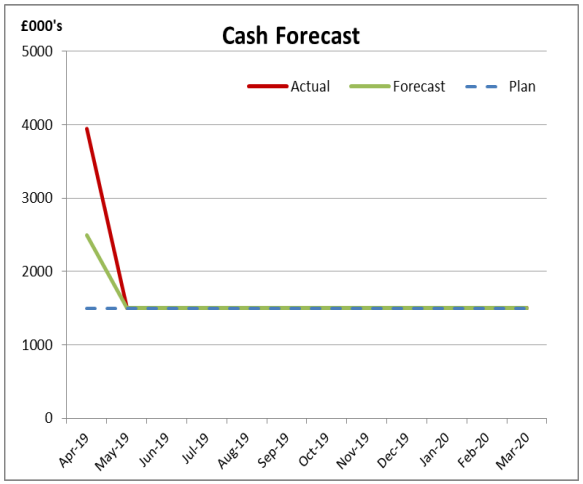


Table 15: Capital

Capital Scheme	Plan 2019/20 £000's	M1 Plan £000's	Cum M1 Spend £000's	Under (-) / Over £000's	Plan Achieved %	M1 Commit + Spend £000's	Plan Achieved %
Medical Equipment - MESC Block	793	9	9	0	1%	117	15%
Medical Equipment - Charitable Funds	100	0	0	0	0%	0	0%
IT - iLab	1,000	0	0	0	0%	0	0%
Information Technology	2,150	0	8	8	0%	192	9%
Estates - Backlog	2,008	15	24	9	1%	362	18%
Estates - Statutory	467	0	(9)	(9)	(2%)	6	1%
Estates - Non Maintenance	684	0	21	21	3%	110	16%
Estates - Ward Refurbishment	1,750	250	3	(247)	0%	89	5%
Inventory / Ledger Upgrade	0	0	0	0	0%	32	0%
Endoscopy Washers	61	0	40	40	66%	73	119%
Other - inc. Gamma Camera 2 & Breast Screening Mobile + Static	340	0	0	0	0%	20	6%
SALIX	0	0	0	0	0%	16	0%
Total - Capital Plan	**9,353**	**274**	**97**	**(177)**	**1%**	**1,016**	**11%**
Less Charitable Fund Donations	(100)	0	(3)	(3)	3%	(3)	3%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**9,253**	**274**	**94**	**(180)**	**1%**	**1,013**	**11%**

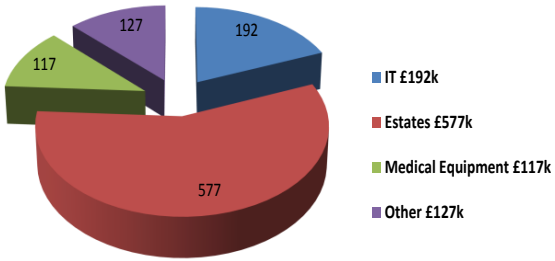
Table 16: Funding Resources

Funding Resources	
Internally Generated Depreciation	12,355
Salix	0
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	**9,253**
Uncommitted Plan	**0**

Key Points

- At M1 the available capital funding excluding Charitable Funds is £9.34m.
- The largest scheme allocations are Estates £1.75m for ward refurbishments & IT ILab £1m.
- Ward Refurbishment scheme has slipped due to Estates having difficulties gaining access to the wards.
- Charitable Fund spend includes £3k of fees for Talbot Butler – EAB.

M1 Capital spend & commitments 2019/20



Receivables and Payables

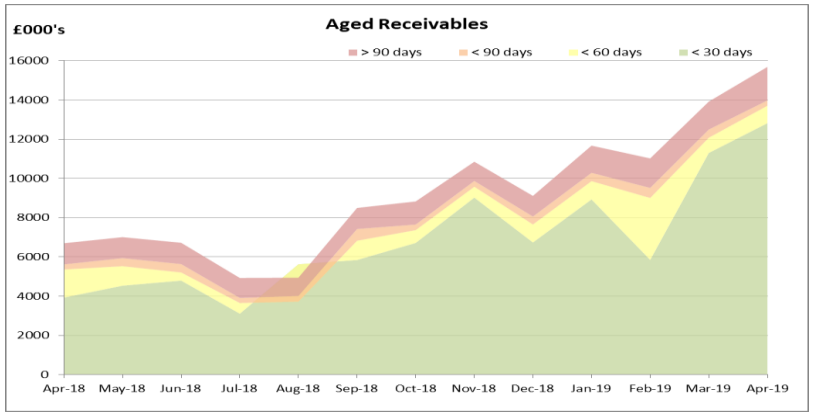
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £2,252k relates to PSF funding (Finance element only) for Qtr 4 & £5,807k to 18/19 Incentive Funding.
- NHS over 90 day debt include s University Hospitals of Leicester NHS Trust £53k, Kettering General Hospital NHS Foundation Trust £361k, mainly relating to Vascular Services, NHS Property Services £61k, Milton Keynes CCG £71k and £188k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £511k ,of which £116k are paying in instalments & a further £364k have been referred to debt collection & private patients accounts of £79k.
- Contract Underperformance with Commissioners is included within the 0 to 30 Days Payables NHS balance.

Table 17: Receivables and Payables

Narrative	Total at April £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	1,496	175	305	145	871
Receivables NHS	14,189	12,640	588	124	837
Total Receivables	**15,686**	**12,815**	**892**	**270**	**1,708**
Payables Non NHS	(4,769)	(4,759)	(10)	0	0
Payables NHS	(4,448)	(4,448)	0	0	0
Total Payables	**(9,218)**	**(9,207)**	**(10)**	**0**	**0**

Narrative	Total at March £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	1,986	838	276	127	746
Receivables NHS	11,930	10,460	503	289	677
Total Receivables	**13,916**	**11,298**	**779**	**416**	**1,423**
Payables Non NHS	(4,017)	(4,007)	(10)	0	0
Payables NHS	(1,087)	(1,087)	0	0	0
Total Payables	**(5,104)**	**(5,094)**	**(10)**	**0**	**0**

Table 18: Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in April.

Table 19: BPPC

Better Payment Compliance Code - 2019/20		
Narrative	**April 2019**	**Cumulative 2019/20**
NHS Creditors		
No.of Bills Paid Within Target	175	175
No.of Bills Paid Within Period	183	183
Percentage Paid Within Target	**95.63%**	**95.63%**
Value of Bills Paid Within Target (£000's)	1,919	1,919
Value of Bills Paid Within Period (£000's)	1,927	1,927
Percentage Paid Within Target	**99.58%**	**99.58%**
Non NHS Creditors		
No.of Bills Paid Within Target	5,046	5,046
No.of Bills Paid Within Period	5,065	5,065
Percentage Paid Within Target	**99.62%**	**99.62%**
Value of Bills Paid Within Target (£000's)	7,484	7,484
Value of Bills Paid Within Period (£000's)	7,490	7,490
Percentage Paid Within Target	**99.92%**	**99.92%**
Total		
No.of Bills Paid Within Target	5,221	5,221
No.of Bills Paid Within Period	5,248	5,248
Percentage Paid Within Target	**99.49%**	**99.49%**
Value of Bills Paid Within Target (£000's)	9,403	9,403
Value of Bills Paid Within Period (£000's)	9,417	9,417
Percentage Paid Within Target	**99.85%**	**99.85%**

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 20: 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

Risk Analysis - I&E Only	£'m
As below excluding CIPs and non-recurrent funding	6.2

Table 21

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	0.5	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	0.8	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	1.5	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	0.4	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	2.0	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	1.0	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	**30 May 2019**

Title of the Report	**Operational Performance Report**
Agenda item	**12**
Presenter of Report	Mrs D Needham (COO & DCEO)
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 and deteriorated in April 2019
- RTT
  Remains below the national standard and below the trajectory agreed with NHSI
- Cancer
  5 of the standards remain below the national average with performance starting 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 – May 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.

Agreed Trajectories for 2019/20

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Accident & Emergency - Performance % (95% Standard)	83.6%	84.6%	88.4%	89.0%	90.0%	90.5%	90.0%	89.0%	88.5%	88.0%	87.0%	87.2%
Cancer Waiting Times - 62 Day GP Referral	79.2%	79.0%	78.8%	79.4%	81.6%	82.3%	82.9%	85.2%	85.4%	85.4%	84.9%	85.0%
RTT Incompletes - Performance % (92% Standard)	84.0%	84.3%	85.0%	87.0%	90.4%	91.0%	91.5%	92.0%	92.0%	92.0%	92.0%	92.0%

Performance vs. trajectory for the rolling year period is as follows:

Accident & Emergency - Performance % (95% Standard)	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Planned Performance	86.3%	89.0%	89.0%	90.1%	90.3%	90.3%	90.3%	90.3%	90.3%	90.3%	95.0%	83.6%
Actual Performance	86.5%	93.8%	92.3%	91.5%	88.9%	86.8%	85.9%	83.4%	78.6%	79.1%	80.3%	79.0%
Cancer Waiting Times - 62 Day GP Referral	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Planned Performance	85.4%	86.3%	85.8%	88.3%	89.1%	89.6%	85.8%	86.4%	87.1%	86.9%	88.5%	79.2%
Actual Performance	81.3%	74.6%	78.2%	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	74.0%	70.7%	N/A
RTT Incompletes - Performance % (92% Standard)	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Planned Performance	88.6%	89.2%	89.8%	90.0%	90.8%	91.5%	92.1%	92.2%	92.6%	93.1%	93.3%	84.0%
Actual Performance	89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	80.8%	80.0%	79.1%

3. Key areas of performance

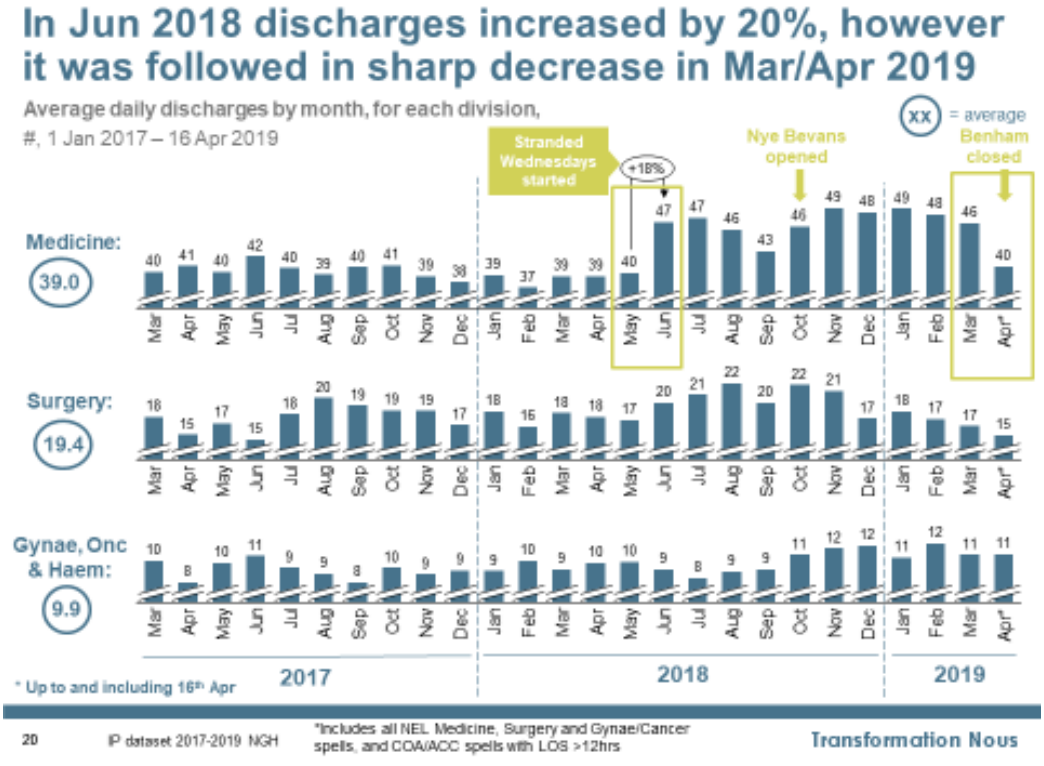
3a. Urgent care - A&E

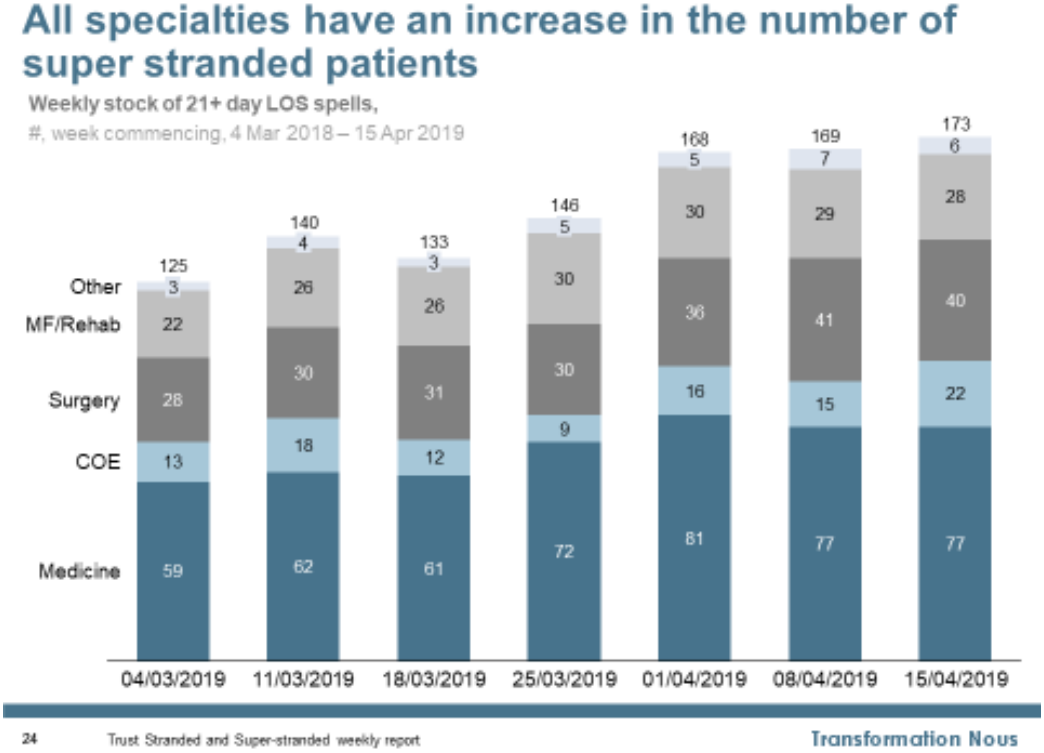
Four hour A&E performance decreased in April 2019 to 79.0%, this is a 10% decrease from April 2018. The national average also reduced in April 2019 to 85% with the average for the Midlands Trusts at 81.6%.

There are multiple reasons for the decrease in performance. There has been a significant decrease in the numbers of patients discharged within medicine & surgery and a subsequent decrease in the numbers of discharges on pathways 1 & 2 during April 2019. The spot purchase beds for pathway 3 have become blocked making discharge from both acute hospitals in the county challenging. As a direct result there has been an increase in the number of stranded and super stranded patients in April and May 2019. Across the month of April, the average number

of stranded and superstranded patients as a proportion of the bed base was 60.4% for stranded and 27.9% for superstranded. Both of these results show a marked increase on the performance for March at 55.3% and 22.0% respectively. As at 19/05, there were 383 stranded patients occupying Trust beds and 183 superstranded patients against a target for this year of 132.

The information below shows the decrease in discharges & increase in super stranded patients.

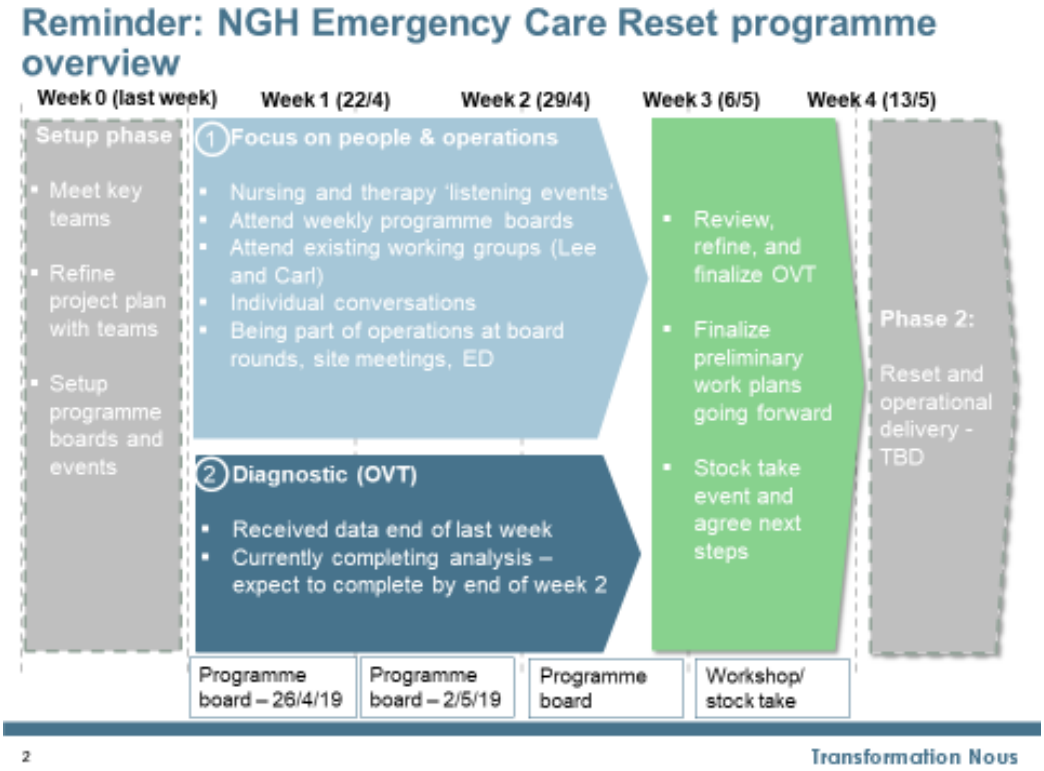




Actions being taken:

In April 2019 we enlisted some help with further identifying the issues for the decrease in performance and supporting the COO, MD and DoN to refine their action plans for transforming urgent care.

The diagram below shows the tasks undertaken over a 4 week engagement period.



The new plans are being produced at the time of writing this report but will broadly cover:

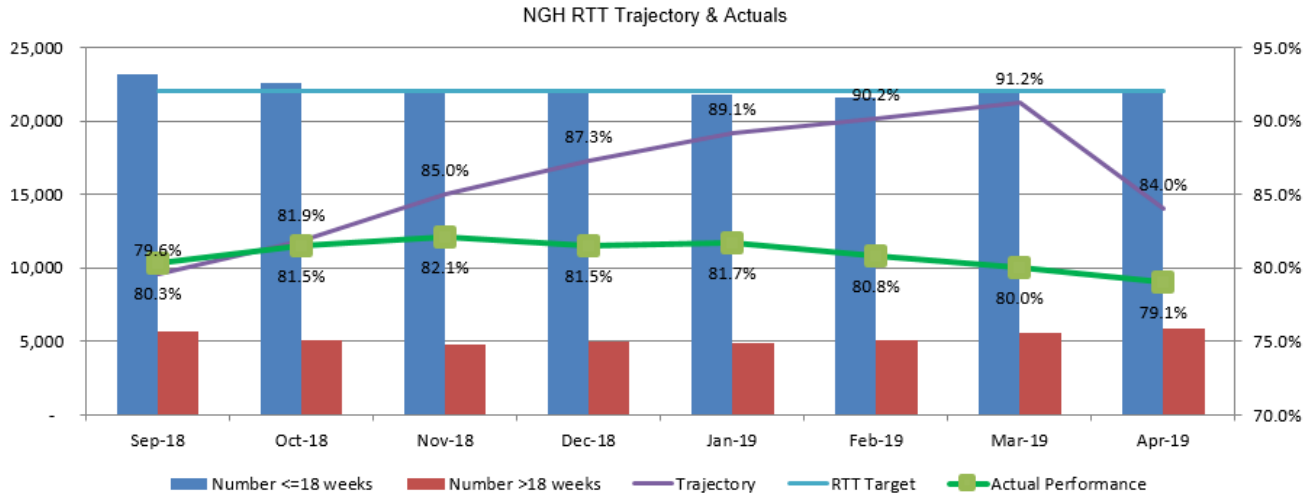
1. Ward processes – Board rounds, the use of Ibox (electronic white board) and SAFER principles.
2. Discharge processes – mainly for the complex discharge group, including PDNAs and the IDT.
3. Site management processes – including how the huddle and bed meetings work along with improved use of predictive information.

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 further discussions are ongoing with Nene CCG to ensure adequate numbers of care home beds and intermediate care is provided in the county.

3b. RTT – 18 weeks

The performance for April has decreased from the March performance of 80% to 79.1%.



The national average for March 2019 was 86.7%, with performance in the midlands region of 87.4%

The performance for April 2019 has not been published at time of writing.

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.
- A central tracking team has been established to support areas in the delivery of 18-week pathways with the aid of newly developed software, which will enable “smart” validation based on a set of rules as well as alerts for patients awaiting further investigation/activity.
- Interviews for a further 2 members of the team are at the end of May, this will help provide further assurance around the reporting and support focussed training across the trust
- Weekly performance meetings in place for all Directorates chaired by the Deputy COO
- PTL meetings in place in all Divisions weekly

Risks:

- Capacity is being reviewed by many areas across the trust; the opportunity to achieve national standard performance levels are currently restricted within current available resources.
- **NGH Endoscopy Washer and RO refurbishment.** The replacement of the RO and endoscopy washers at NGH will be a 4-5 month programme in partnership with Cantel. Together we have worked hard to limit the downtime affecting the department due to being unable to secure local support for decontamination of scopes and significant financial impact of hiring a decontamination unit into trust. The washers will be replaced in two phases.

During the two weekends in April the department was be unable to do any routine work, however main theatres were used to enable any emergency work to be undertaken as part of the on call bleed rota.

To mitigate the loss of lists we continue to increase out outsourcing to Ramsey Healthcare and have recently secured the use of Woodlands alongside Blakelands.

In March we outsourced 106 and in April 150.

In total for April 2018, we lost 40 lists for works/bank holidays and short notice leave. This will impact significantly on the diagnostic position for April, May and into June while we try and catch up on the backlog of patients.

3c. Cancer

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

For the 62 day pathway, the specialities which are achieving target are Gynaecology (an improvement from last month, breast & sarcoma.

The main causes for the underperformance are:

- Patient initiated delays
- Late tertiary referrals
- No capacity at a tertiary provider
- Complex pathways

There are currently 12 patients awaiting treatment from a tertiary provider who have all breached 62 days.

	Total Treatments	Number of Patients Within Target	Number of Patients Over Target	Performance	Operating Standard
2ww Referral	**1054**	**773**	**281**	**73.3%**	93%
2ww Breast Symptoms	**131**	**87**	**44**	**66.4%**	93%
31 Day First Treatment	**162**	**153**	**9**	**94.4%**	96%
62 Day combined with 31 Day Rare Treatments - Actual Total	**92**	**65**	**27**	**70.7%**	85%
Subsequent Surgery Treatments	**15**	**13**	**2**	**86.7%**	94%
Subsequent Drug Treatments	**56**	**53**	**3**	**94.6%**	98%
Subsequent Radiotherapy Treatments	**102**	**97**	**5**	**95.1%**	94%
62 Day Screening	**12.5**	**12.5**	**0**	**100.0%**	90%
62 Day Consultant Upgrade	**20**	**18.5**	**1.5**	**92.5%**	85%

National benchmarking

2ww – national 91.8%, Midlands – 90.3%

2ww Breast – national 78.5%, Midlands 74.2%

62 days – national 79.7%, Midlands – 76.8%

Cancer Site	Confirmed Total Treatments	Confirmed Total Breaches	Confirmed Performance
Breast	10	1	**90.0%**
Colorectal	11.5	2.5	**78.3%**
Gynaecology	7	0.5	**92.9%**
Haematology	5	3	**40.0%**
Head & Neck	7	4.5	**35.7%**
Lung	8.5	2.5	**70.6%**
Other	3.5	0.5	**85.7%**
Sarcoma	2.5	0	**100.0%**
Skin	6	1	**83.3%**
Upper GI	3.5	1	**71.4%**
Urology	27.5	10.5	**61.8%**
Total	**92**	**27**	**70.7%**

Actions being undertaken:

- **NHSi Pathway Analyser Work -** NHSi Pathway Analyser tool will be used for the head and neck pathway first, followed by all pathways; this work will be resourced by Cancer Services and the Information team initially, scoping has commenced, the analyser will evidence bottlenecks in the pathway, initial finding are anticipated by the end of June as largely manual data input process
- **Head & Neck Pathway -** Meeting between NGH, KGH and MK Head & Neck teams took place to agree minimum data set for transfer of patients in order to streamline pathways. Commenced.
- **PTL Meetings -** Corporate PTL meetings now in place, supported by a weekly patient focused ptl meeting from the 17th May 2019 to provide assurance of effective pathway management
- **National Optimal Lung Cancer Pathway -** NOLCP Project Plan now in place, The NOLCP is scheduled for implementation in June 2020, incorporating the 28 day faster diagnosis, with achievements so far
- **Rapid Access Prostate Imaging and Diagnosis pathway -** Urology team working towards implementing a one stop clinic for all urology patients including those suspected of cancer, this will ensure patients receive a diagnosis or ruling out of cancer by day 28, in line with the faster diagnosis standard, and improve our patient experience and outcome which will have a positive impact on our 62 day performance, timelines are planned for late summer 2019.
- **Breast 2ww -** Ongoing insourcing for breast to support initial 2ww clinic capacity, capacity and demand study under review again as increase in referrals is expected to exceed the demand insourcing has been based on

- **Skin 2ww -** Locum secured for dermatology
- **Endoscopy** - Significant delays in endoscopy due to the breakdown and issues with washers**.** Endoscopy insourcing under development, likely end of May early June
- **Oncology Service** – An additional 3 consultants have been appointed in to the substantive role of Clinical Oncologist and have commenced in post. Specific tumour sites continue to be a challenge - Lower GI and Brachy Therapy.

Patients treated 104+ days
12 patients were treated in excess of 104+ days in March with no harm currently noted.

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

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	83.3%	98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↑		86.3%	88.6%	88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		93.7%	91.9%	92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	→		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	→		97.8%	92.4%	92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	3	0	0	0	0	4	2	0	0
	Compliments	Sheran Oke	-	NGH								4,288	4,335	3,541	4,269	3,639	4,007	3,647
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		86.6%	93.8%	92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		129	58	79	60	118	174	142	299	330	400	420	343
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↑		5	2	1	3	15	17	19	30	49	33	22	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		13	7	6	16	2	3	3	4	5	4	4	11
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		39	35	12	19	36	10	10	24	12	11	20	31
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		42	40	28	16	34	27	15	20	20	17	29	41
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		37	31	19	13	25	25	13	16	17	13	20	30
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↓		90.8%	69.9%	72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↓		78.1%	23.3%	18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		97.4%	92.6%	95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		97.1%	100.0%	100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↓		94.3%	96.1%	97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↓		90.0%	78.5%	100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.3%	74.6%	78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	→		97.1%	68.4%	100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		87.5%	90.0%	81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↓		89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	↑		0	0	0	0	0	0	0	0	1	3	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.7%	99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	

Northampton General Hospital NHS
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	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%			96.4%	93.5%	92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	76.4%	96.6%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%			91.6%	87.7%	97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%
	Unappointed Follow Ups	Debbie Needham	=0	NGH										8,608	8,723	9,957	10,119
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH		11.7%	12.1%	12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%
	Sickness Rate	Janine Brennan	<=3.8%	NGH		3.9%	4.4%	4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH		11.8%	12.6%	13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH		13.1%	14.3%	14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH		9.5%	9.8%	10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH		12.7%	13.7%	14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%
	Turnover Rate	Janine Brennan	<=10%	NGH		7.5%	7.4%	8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH		89.1%	89.5%	89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%
	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%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH		84.8%	84.9%	85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH		86.7%	86.7%	85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH		63.5%	63.5%	58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH		288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH		1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH		(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH		555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH		46	70	89	107	128	153	167	195	209	230	266	20
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH		82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	74
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH		1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH									64.5%	65.9%	65.5%	69.0%	39.0%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH									39.1%	40.4%	41.0%	41.0%	42.8%
	Maverick Transactions	Phil Bradley	=0	NGH					27				15	21	21	19	
	Waivers which have breached	Phil Bradley	=0	NGH		2	2		0				1	0	0	0	
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH		62.3%	56.5%	51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH		31.3%	29.3%	22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%
	Length of stay - All	Debbie Needham	<=4.2	NGH		4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3
	Percentage of discharges before midday	Debbie Needham	>25%	NGH		18.9%	19.2%	18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH		3.5%	3.4%	4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	3.0%	3.3%	3.6%	2.9%

Northampton General Hospital NHS
NHS Trust

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	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.3%	15.7%	16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	16.5%	15.9%	16.8%	13.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		88.8%	90.0%	87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.3%	34.1%	28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑		99	101	0	104	104	106	106	106	105	106	104	103
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		97	97	98	98	100	100	104	104	104	104	104	104
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		79	25	25	45	47	66	36	35	53	51	35	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		94.9%	100.0%	100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.0%	5.6%	5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	1	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-		→		3	4	3	2	3	0	0	3	7	1	0	0
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		97.8%	96.4%	96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	94.1%	93.1%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	↓		1	2	2	1	2	0	0	1	0	0	0	2
	MSSA	Sheran Oke	<=1.1	NGH	↓		1	0	2	0	0	2	1	0	1	2	0	5
	New Harms	Sheran Oke	<=2%	NGH	↑							2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↓		4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→									85.6%	88.1%	90.7%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓									62.0%	59.7%	56.7%	57.2%	53.0%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓									89.2%	89.2%	67.5%	72.6%	70.6%

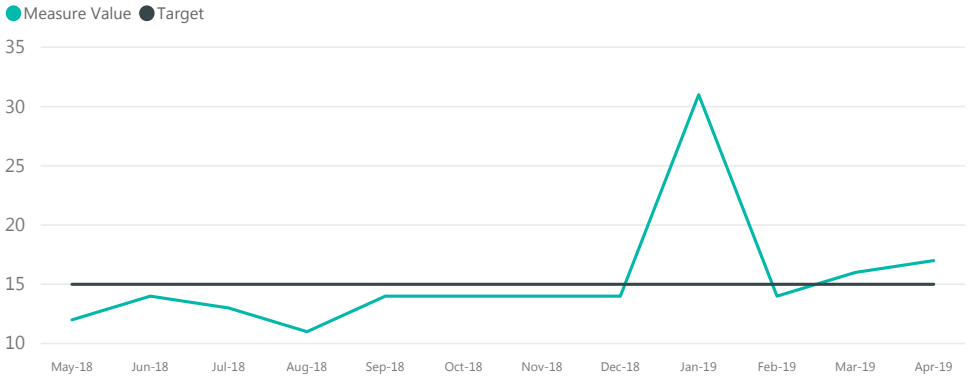
Data not provided

No data - pre KPI implementation

Average Ambulance handover times

April 2019	Target	Actual	Direction of Travel	Accountable Executive
	00:15	00:17	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17

What is driving under performance?

Ongoing issue with EMAs related to clustering of ambulances. This is a regional issue and system wide discussions are underway re this. EMAS have employed an additional 20 'crews', predominantly Agency or non-paramedic crew which has compounded our clustering and increase of conveyances. At times up to 16 ambulances received in less than an hour. Locum crews are not familiar with established pathways

Actions completed in the past month to achieve recovery

Developed ToR for a multi trust, EMAs and CCG bi-monthly meeting to collaboratively work together- sitting with CCG for sign off. Internal escalation process at 15 minute intervals to optimise timely off load

Timeframe for recovery

May 2019

Next steps

MAAD event to be held specifically looking at attendance avoidance, including Mental Health support. ACC continuing to develop pathways and have provided 3 pathways to EMAS. NB to commence GP expects Audit of Ambulance Arrival timings at NGH Site to ensure accurate reporting

Exception report written by

CrockettG

Assurance Committee

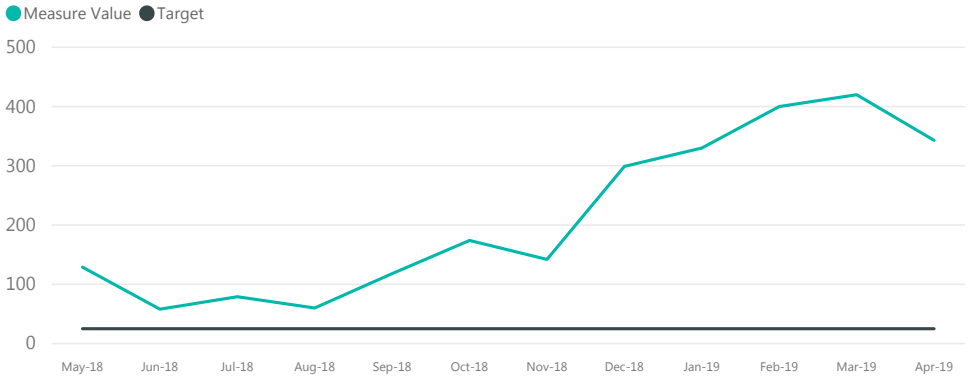
Directorate Management Board

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

April 2019

Target	Actual	Direction of Travel	Accountable Executive
25	343	↑	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
129	58	79	60	118	174	142	299	330	400	420	343

What is driving under performance?

Ongoing issue with EMAs related to clustering of ambulances. This is a regional issue and system wide discussions are underway re this. EMAS have employed an additional 20 'crews', predominantly Agency or non-paramedic crew which has compounded our clustering and increase of conveyances. At times up to 16 ambulances received in less than an hour. Locum crews are not familiar with established pathways

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Timeframe for recovery

May 2019

Next steps

MAAD even to be held specifically looking at attendance avoidance, including Mental Health support ACC continuing to develop pathways and have provided 3 pathways to EMAS. Nye Bevan to commence GP expects Audit of Ambulance Arrival timings at NGH Site to ensure accurate reporting Highlight with EMAS – 'Fit to Sit'

Exception report written by

CrockettG

Assurance Committee

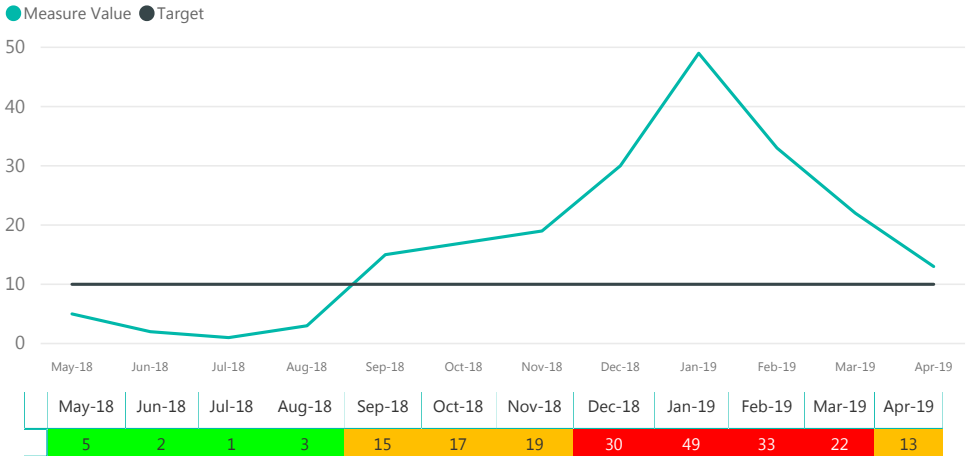
Directorate Management Board

Ambulance handovers that waited over 60 mins

April 2019

Target	Actual	Direction of Travel	Accountable Executive
10	13	↑	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
5	2	1	3	15	17	19	30	49	33	22	13

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 however there is dispute re number of ambulance delays related to EMAS It system. The trust confirms number with no feedback from 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

May 2019

Next steps

Continue to embed the escalation and actions undertaken when handover is challenged. Increased vigilance around crews 'signing off'. Documenting excessive clusters of ambulances and having direct dialogue with EMAS and CCG, to understand themes. Action from 160 and 161 Exception reports carry through

Exception report written by

CrockettG

Assurance Committee

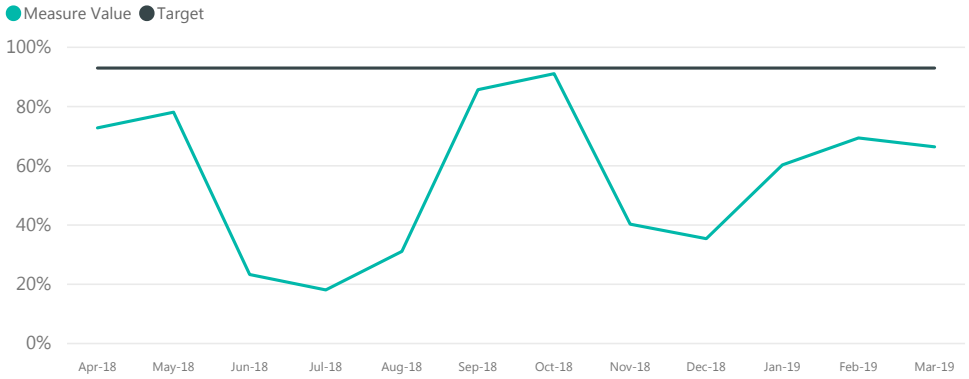
Directorate Management Board

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

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.0 %	66.4 %	↓	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
72.8 %	78.1 %	23.3 %	18.1 %	31.1 %	85.7 %	91.1 %	40.3 %	35.4 %	60.3 %	69.4 %	66.4 %

What is driving under performance?

The 2ww breast symptomatic standard has not been met for March reaching 66.4% against a standard of 93%. Of the 131 patients seen, 44 breached the standard, 10 due to patient choice

Actions completed in the past month to achieve recovery

Continued insourcing

Exception report written by

BuckleyS

Next steps

Revised corporate ptl meetings overseeing performance and holding teams to account for recovery

Timeframe for recovery

May 2019

Assurance Committee

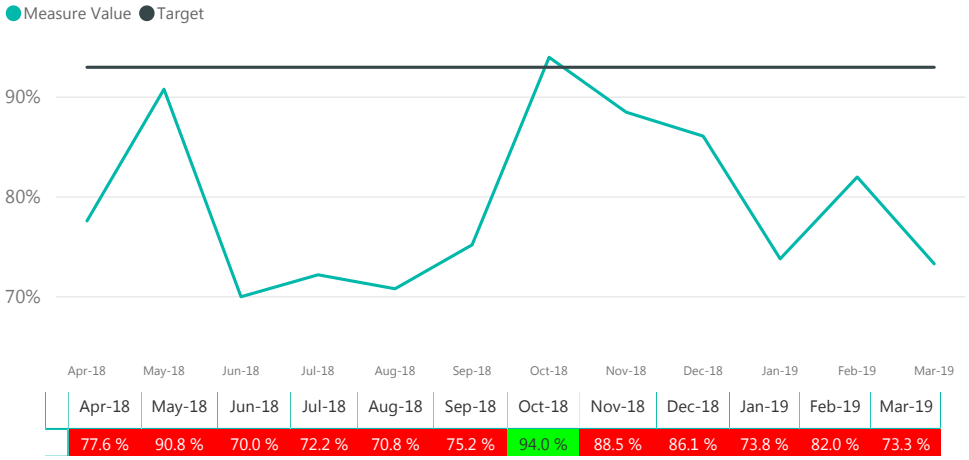
Finance Investment and Performance Committee

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

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.0 %	73.3 %	↓	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
77.6 %	90.8 %	70.0 %	72.2 %	70.8 %	75.2 %	94.0 %	88.5 %	86.1 %	73.8 %	82.0 %	73.3 %

What is driving under performance?

The Trust has not met the 2ww standard for March reaching 73.4% gynaecology, haematology, paediatrics, sarcoma and urology met the standard. The most challenged site was skin reaching 25.1%, locum support is now in place, and they are showing an improved position for April with ongoing improvements thereafter. Of the 1055 patients seen in March, 122 were in 7 days or less, 652 between 8-14 days, with 281 patients breaching the standard.

Actions completed in the past month to achieve recovery

Continued outsourcing in breast, locum support now in place for dermatology

Exception report written by

BuckleyS

Next steps

Revised format corporate ptl meeting overseeing performance, holding teams to account for recovery

Timeframe for recovery

May 2019

Assurance Committee

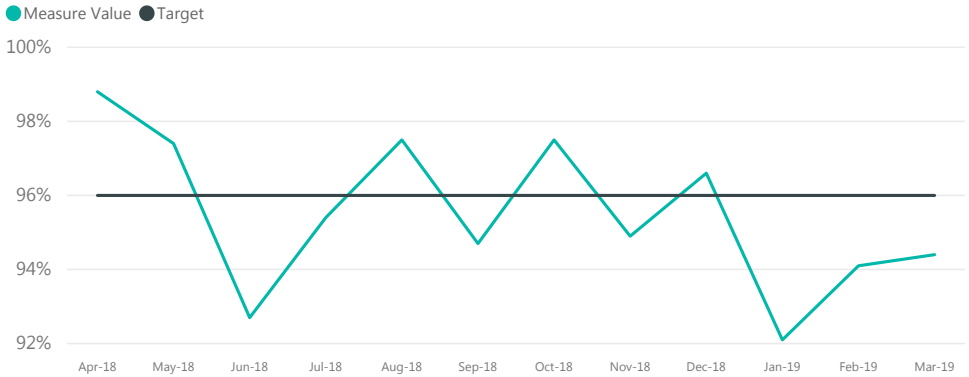
Finance Investment and Performance Committee

Cancer: Percentage of patients treated within 31 days

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
96.0 %	94.4 %	↑	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
98.8 %	97.4 %	92.7 %	95.4 %	97.5 %	94.7 %	97.5 %	94.9 %	96.6 %	92.1 %	94.1 %	94.4 %

What is driving under performance?

The Trust has not met the 31 day standard for March, reaching 94.3% against the 96% standard. 9 patients breached, 1 in gynaecology as the patient had a further tumour which required investigation to allow treatment of the Gynae cancer, 3 in head and neck all requiring dental assessment/extraction and healing time, 1 in lung, originally agreed to surgery but then opted for oncology treatment after pacemaker was moved, 3 in skin, two not upgraded and therefore tracked appropriately and in time, one due to clinic cancellation, 1 in urology requiring a joint procedure and delayed due to capacity by 1 day.

Actions completed in the past month to achieve recovery

Historically the trust has achieved this standard. Teams will be focusing on their current performance against this standard as a small number of breaches have resulted in this nit being met. Raised at corporate ptl meetings to ensure all teams have sight of issues

Exception report written by

BuckleyS

Next steps

All teams to focus on recovery, clinicians to be made aware of the standard and the requirements for reaching it.

Timeframe for recovery

May 2019

Assurance Committee

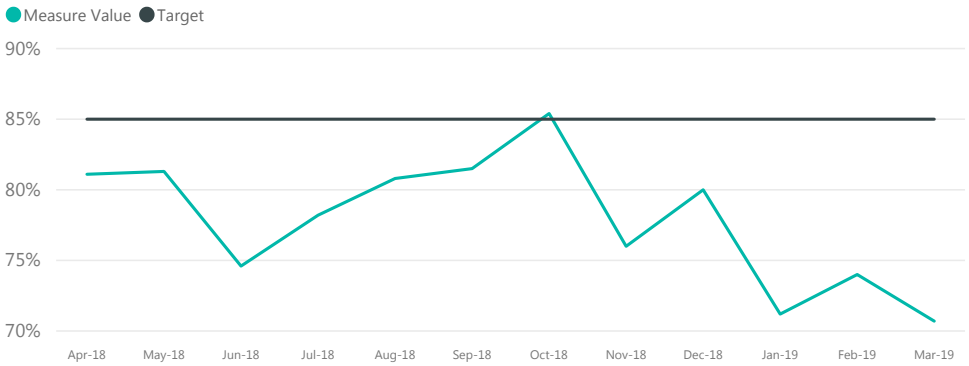
Finance Investment and Performance Committee

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

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0 %	70.7 %	↓	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
81.1 %	81.3 %	74.6 %	78.2 %	80.8 %	81.5 %	85.4 %	76.0 %	80.0 %	71.2 %	74.0 %	70.7 %

What is driving under performance?

NGH reached 70.2% for the 62 day standard against the standard of 85%. The Trust has treated in March 90.5 patients with 27 breaches; this is the lowest performance against this standard the Trust has achieved for 3 years. Breast, Gynaecology and Sarcoma met the standard. With IPT applied the Trust would have performed at 70.7%.The longest wait for a prostate patient at UHL for surgery was treated at day 163 on their pathway, referred from NGH at day 70.

Actions completed in the past month to achieve recovery

•NHSi Pathway Analyser tool will be used for the head and neck pathway first, followed by all pathways; this work will be resourced by Cancer Services and the Information team initially, scoping has commenced, the analyser will evidence bottlenecks in the pathway •Meeting between NGH, KGH and MK Head & Neck teams took place to agree minimum data set for transfer of patients in order to streamline pathways •Corporate PTL meetings now in place •NOLCP Project Plan now in place, ongoing internal project team meetings •RAPID Project Plan now in place, internal project team meeting needs establishing •Ongoing insourcing for breast to support initial 2ww clinic capacity •Locum secured for dermatology •Endoscopy insourcing under development

Exception report written by

BuckleyS

Timeframe for recovery

November 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

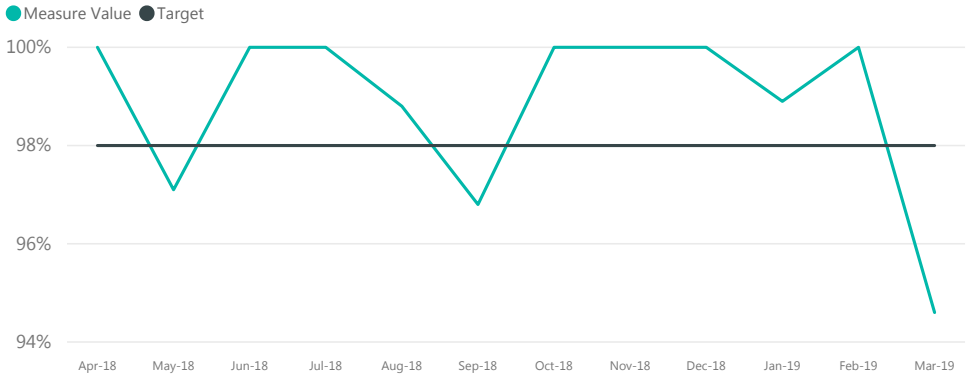
Update recovery plans from each service will continue to be reviewed at the monthly cancer board, these will also be discussed at the weekly corporate ptl meetings

Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
98.0 %	94.6 %	↓	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
100.0 %	97.1 %	100.0 %	100.0 %	98.8 %	96.8 %	100.0 %	100.0 %	100.0 %	98.9 %	100.0 %	94.6 %

What is driving under performance?

The Trust has not met the subsequent drug standard for March reaching 94.6% against the 98% standard; all 3 breaches were due to patient fitness. 56 patients were treated in March versus 73 in February and 96 in January; no specific reason has been identified for the drop in treatments.

Actions completed in the past month to achieve recovery

reduction in number of treatments led to standard not being met, no reason identified

Exception report written by

BuckleyS

Next steps

Increase in number of treatments in line with previous activity should recover position

Timeframe for recovery

May 2019

Assurance Committee

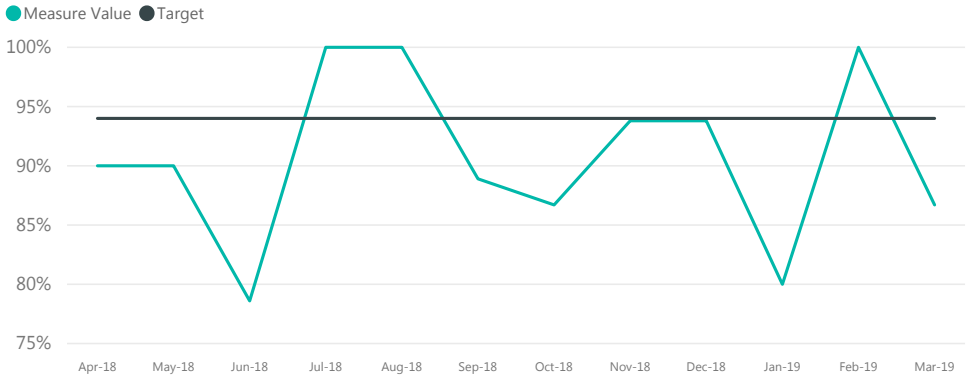
Finance Investment and Performance Committee

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

March 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
94.0 %	86.7 %	↓	Debbie Needham

Performance vs Target



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

What is driving under performance?

The Trust has not met the subsequent surgery standard for March reaching 87.5% against the 94% standard, both breaches in gynaecology, 1 due to capacity and 1 referred late by KGH.

Actions completed in the past month to achieve recovery

small cohort of patients makes reaching this standard very challenging, average 10 a month, trust to ensure all delays within their gift are resolved

Exception report written by

BuckleyS

Next steps

review of progress against the standard at the weekly ptl meetings

Timeframe for recovery

May 2019

Assurance Committee

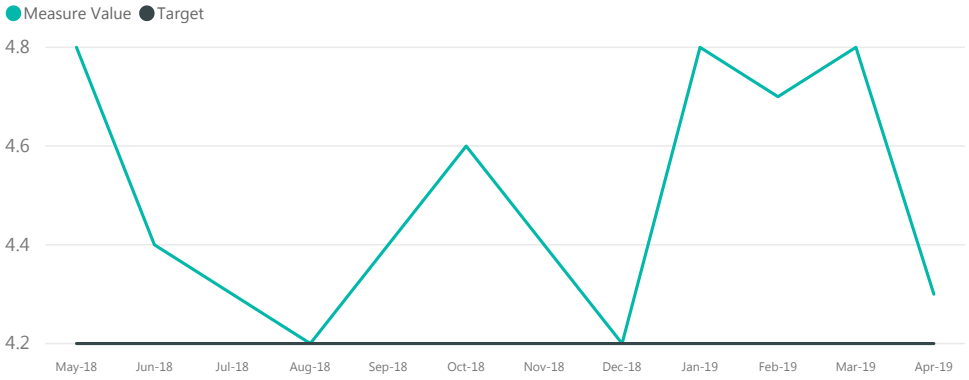
Finance Investment and Performance Committee

Length of stay - All

April 2019

Target	Actual	Direction of Travel	Accountable Executive
4.2	4.3	↑	Debbie Needham

Performance vs Target



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

What is driving under performance?

Reduction in Average LOS from March to April of 0.5 days from 4.8 to 4.3 days. However: • 195 live PDNA's on the system showing 195 patients who need a supported discharge (highest ever)with 70+ patients sitting with Social Care •PDNA referrals started too late in patients journey resulting in delays once medically fit •PDNA's not updated in a timely fashion when there is a change in the patients situation •Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit •Overreliance on patients waiting for inpatient investigations and internal referrals that could be done as outpatients •Patients not deemed medically fit when community capacity is ready to take.

Actions completed in the past month to achieve recovery

•Weekly review with every ward of every patient with a LOS>7 days being carried out. This now includes 3 teams each week •Discharge element of the recently relaunched of 'Fixing the Flow' initiative being led by Nursing Director •3 times a week tracking meeting face to face with Partners •Discharge coordinators to support wards with completion of PDNA's to reduce delays from Feb •Exec led top delays meeting to review the longest staying patients in the trust in place weekly (only 2 patients >100 days LOS, 20>200days when started) •Robust use of the Choice Policy •'SAFER in 100 days' initiative spreading across the ward base •Agreement to use rehab beds for non-weight bearing patients •ICT now on site 3 times a week to assess all NOF patients to pull early into community. . External support from Transformation Nous to help improve the non elective pathway

Timeframe for recovery

August 2019

Next steps

Project teams in place and meeting weekly to improve 6 key work streams . PDNA and Discharge Team . SAFER R2G . Doctor Cover EDN/ TTO . Mental Health . Discharge Suite / Transport . Criteria Led Discharge

Exception report written by

HollandC1

Assurance Committee

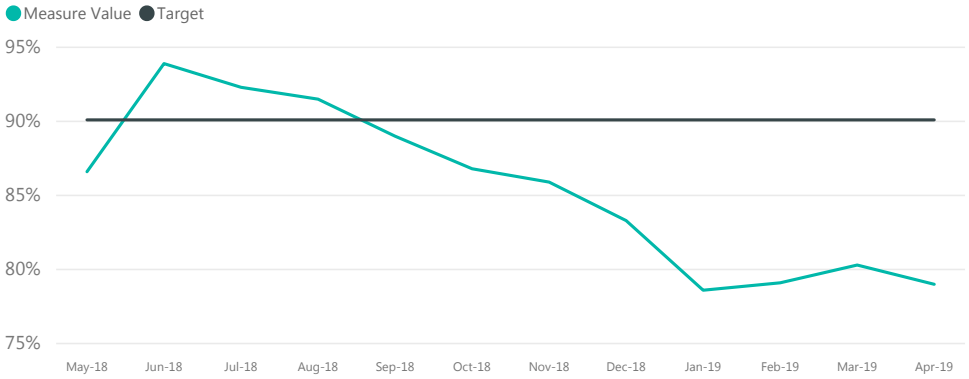
Finance Investment and Performance Committee

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

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
90.1 %	79.0 %	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
86.6 %	93.9 %	92.3 %	91.5 %	89.0 %	86.8 %	85.9 %	83.3 %	78.6 %	79.1 %	80.3 %	79.0 %

What is driving under performance?

Inability to achieve the 4hr standard is multi factorial with the main pressure point being the inability to transfer patients from the ED to the assessment wards or a base bed

Actions completed in the past month to achieve recovery

Reset of urgent care performance group with renewed project plan. There is particular focus on ACC, Nye Bevan assessment model and leadership. There is also a focused piece of work on the ED medical workforce who are currently carrying a number of middle grade vacancy's. This is being addressed through proactive recruitment. The rota is also being amended to enable the workforce to match peak times. It is anticipated that the new rota will be implemented in August 2019

Exception report written by

CrockettG

Timeframe for recovery

December 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

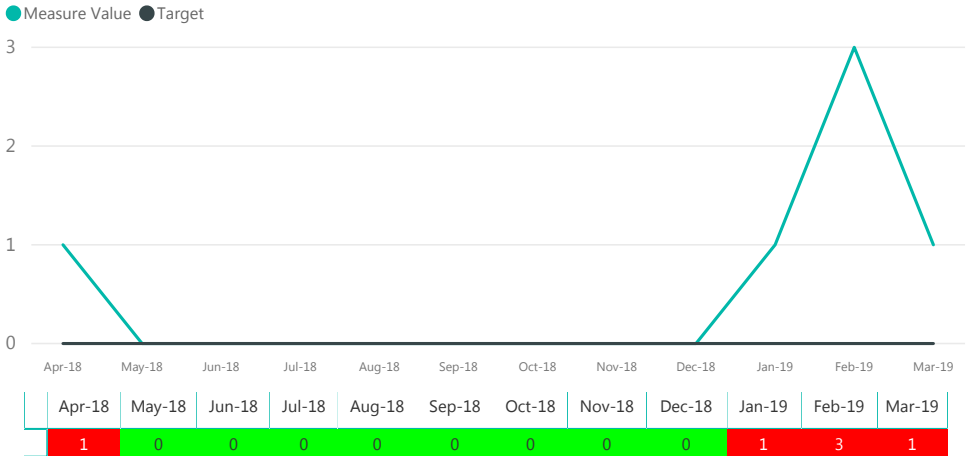
Aggressive recruitment to fill vacant middle grade posts in ED. Implement new middle grade rota in ED to match peaks in demand Major's lite model implemented to be embedded and become business as usual Nye Bevan assessment model, to be implemented and embedded

RTT over 52 weeks

March 2019

Target	Actual	Direction of Travel	Accountable Executive
0	1	↑	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
1	0	0	0	0	0	0	0	0	1	3	1

What is driving under performance?

•Central pathway validation team have been validating pathways around previously incorrectly closed pathways identified on CAMIS. This work has identified a small number of 52 week breaches which from April-19 will incur a fine for both the trust and the commissioners; £2,500 each per pathway and repeated in the following month if the patient is still not treated. •1 x 52 week breach identified in March 19 due to 'clock' being stopped inappropriately by admin staff following an MRI •Reliance on bank admin staff due to vacancy and sickness in admin roles •RTT code usually move from a 10 to a 20 to a 30 as the patient progresses on an RTT pathway but CAMIS allows any code to be submitted in this case a code 90 which removed the patient from the pathway

Actions completed in the past month to achieve recovery

•Urgent contact made with patient who was booked into first available clinic (patient had not contacted Trust to question the long delay) •Patient reviewed by consultant to ensure no harm has resulted from the prolonged wait (no Harm) •Patient offered surgery date within the month of the breach but patient refused date offered as wanted to wait a further 6 weeks •Patient underwent uneventful procedure the following month •Retraining provided to specialty admin team where breach was identified

Timeframe for recovery

May 2019

Exception report written by

CrockettG

Assurance Committee

Finance Investment and Performance Committee

Next steps

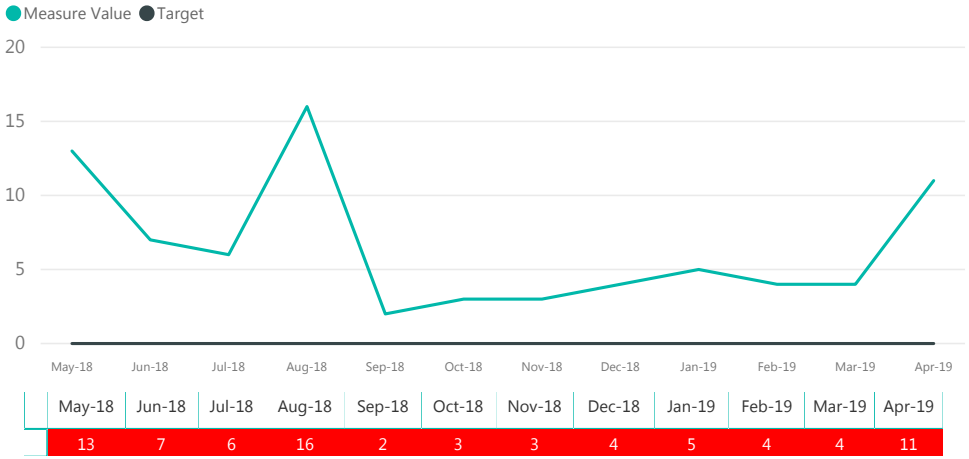
•Alfresco software to go live next month which will analyse all RTT pathways to ensure they follow an expected coding path. Any that don't fit the model will be flagged up via the detailed algorithm for detailed analysis. It is anticipated that this work will identify a few more potential 52 week breaches who will be treated in the same way as above to ensure we have caused no harm and their treatment is fast tracked within the month •Full retraining to be rolled out by the CAMIS team to all areas to ensure all staff fully conversant with the coding issues.

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

April 2019

Target	Actual	Direction of Travel	Accountable Executive
0	11	↓	Debbie Needham

Performance vs Target



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

What is driving under performance?

Performance deteriorated in April due to the requirements to cancel non-clinically urgent cases to support ED flow. This resulted in over 80 cancellations in the month which included patients whom has been previously cancelled.

Actions completed in the past month to achieve recovery

To minimise the impact of the additional cancellations in April we cancelled most patients the day before their surgical date

Timeframe for recovery

May 2019

Next steps

From 8th May we have stopped cancelling elective patients and therefore the main driver for Aprils performance drop will be mitigated

Exception report written by

TuckerMR

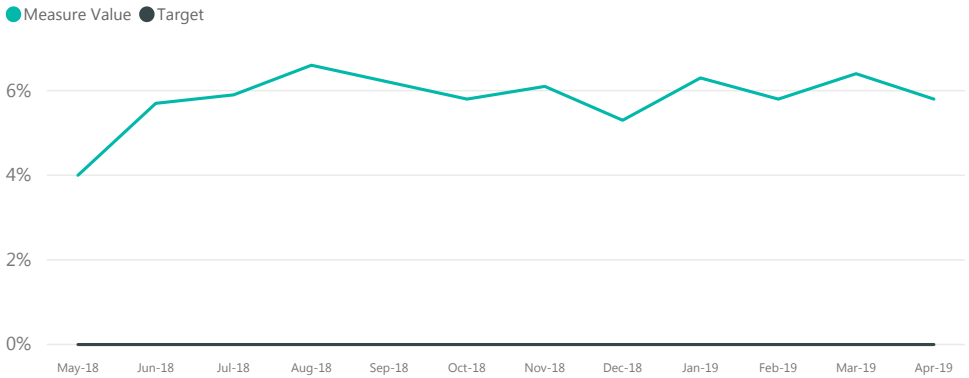
Assurance Committee

Finance Investment and Performance Committee

Ward Moves > 2 as a % of all Ward Moves

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

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
4.0 %	5.7 %	5.9 %	6.6 %	6.2 %	5.8 %	6.1 %	5.3 %	6.3 %	5.8 %	6.4 %	5.8 %

What is driving under performance?

NB has contributed to increased moves due to pts being streamed from there. In addition a number of pts have required speciality beds then step down from speciality beds - increased acuity pressure on speciality beds increases pt moves

Actions completed in the past month to achieve recovery

Focus on right patient right bed across the trust from ED. Discussions with IT re capturing and coding of pts move from NB into base wards

Exception report written by

CrockettG

Timeframe for recovery

December 2019

Assurance Committee

Finance Investment and Performance Committee

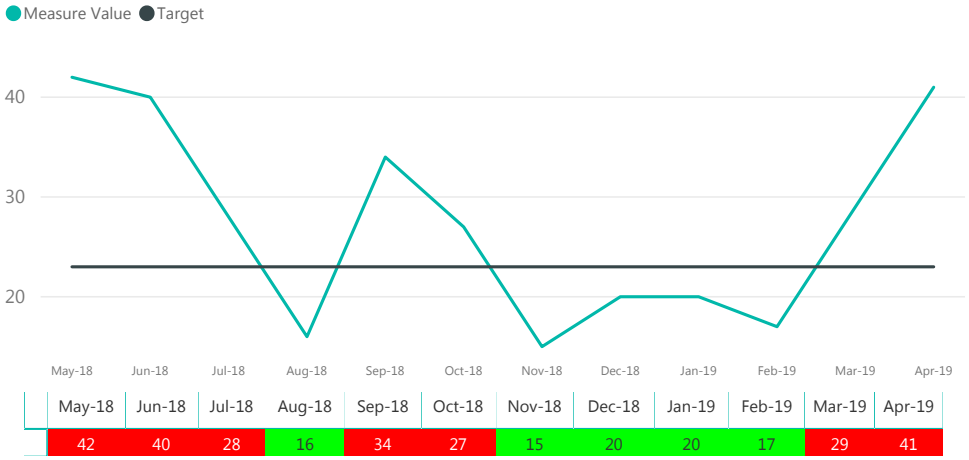
Next steps

Continued focus on ensuring right beds at onset of admission in particular during weekends. Agreement re coding of pts from NB. Focus on having a 'hot bed' for speciality wards Trust wide Transformation "Nous" on discharge process Trust wide development of direct access to base wards inclusion/exclusion criteria is required however this will be part of the overarching Transformation changes and require significant changes to current working models to achieve and also is dependent on 7 day working to achieve

Average Monthly DTOCs

April 2019	Target	Actual	Direction of Travel	Accountable Executive
	23	41	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
42	40	28	16	34	27	15	20	20	17	29	41

What is driving under performance?

Long delays with Social assessments High number of unallocated cases to Social, No interim placements meaning full Social assessment are being carried out in Trust Continued delays in early submission of PDNA's, PDNA's requiring checking before sending to SPA and Community Services as high percentage have been returned if not checked, Continued inaccuracies on Tracker from SPA meaning duplication of previous action, wrong DTOC coding recorded from SPA, Step down of Winter Community provision High numbers of patients waiting Discharge to Review, DTR, with the Crisis Response Team, CRT, Very few patients being discharged Specialist Care Centres, SCC, or Southfields Lack of urgency with supported discharges High numbers of Stranded patients More Discharge staff required

Actions completed in the past month to achieve recovery

Social are looking to provide further Interim placement to support social assessment outside of the acute setting, Further placements are being looked into Delays escalated to AD in Social, Meeting with HR to discuss competencies regarding upgrading Discharge Team staff to support completing PDNA' s Internal processes being reviewed to look at managing own SPA system, this is being considered through TEAM Project and Transformational Nous, Beginnings of IBOX being rolled out to provide an accurate DTOC recording system, Patients waiting DTR with CRT are being considered for SSC or Southfield's with both external managements Patient mapping improvement process commenced, awaiting next date with CCG to look at SPA and Service delays Low numbers of supported discharges have been raised with service managers, Community beds have completed MADE events to help support flow Stroke beds can be referred directly to Community Stroke Ward without PDNA, verbal handover from Ward to Ward is being trialled Stranded reviews are being revised, external partners are being invited to support, CCG and lead on Urgent Care are offering their support and attendance Further meeting to discuss commencement of New Housing Office Twice weekly Tracking Meetings to support flow and identify any delays

Timeframe for recovery

July 2019

Exception report written by

AjetoJ

Assurance Committee

Finance Investment and Performance Committee

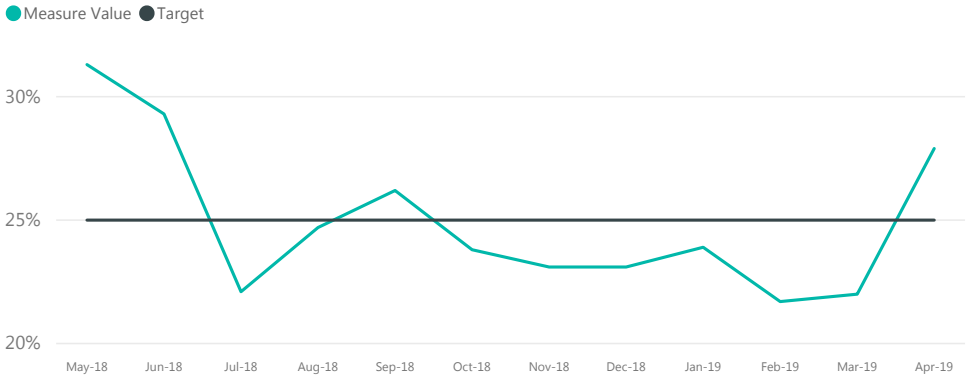
Next steps

Meeting with HR to support competencies for completion of PDNA's for Coordinators Further review of mapping process to look at SPA and Service delays External support form CCG/Urgent Care Further weekly TEAM Project meetings to develop improved discharge processes and systems ICT to help review patients on Rehab lists Discharge Coordinators Recruitment is underway; a further 5 are in HR process New Housing Officer to be appointed

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

April 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	25.0 %	27.9 %	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
31.3 %	29.3 %	22.1 %	24.7 %	26.2 %	23.8 %	23.1 %	23.1 %	23.9 %	21.7 %	22.0 %	27.9 %

What is driving under performance?

• Target set by NHSI of 134 patients >21days LOS (40% reduction) from a baseline of 220 • Last 12 months has seen an average 22% increase in Discharges across the Trust compared to previous year BUT at the end of March 19 and ongoing the numbers of discharges has dropped significantly and stranded numbers have increased have increased to 400 and superstranded to 180 patients • We have 195 PDNAs live in the system which equates to 195 patients needing a supported discharge from external partners. This is an unprecedented number with Social Services, Rehab and CRT seeing the longest delays • Increased delays in submitting PDNA's to the SPA due in the main to the staffing challenges on the ward where direct patient care takes precedent • Increased admissions from Urgent care (as we have empty beds are we more inclined to fill them!) • Over prescribing of care 'this patient will not cope at home' but 30% of care packages are cancelled within 72 hours as the patients don't want them

Actions completed in the past month to achieve recovery

• Discharge element of 'Fixing the Flow'(Trust wide Urgent Care Improvement project) initiative being led by Nursing Director with 6 project teams working on:PDNA & Discharge Team, SAFER & R2G, Dr Cover and EDN and TTO's, Mental Health, Discharge Suite and Criteria led discharge • Employed a further 6 Discharge Coordinators to support Wards (awaiting start dates); they are updating stranded patient process daily supporting wards with simple and complex discharges as well as supporting the wards to complete the PDNAs • Robust use of Choice Policy including legal framework around 'trespass' for our most difficult of cases • Multi Agency Admission Avoidance (MAAD) event run during April. To challenge the attendances in ED and where else they should and could have been treated

Exception report written by

CrockettG

Timeframe for recovery

October 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

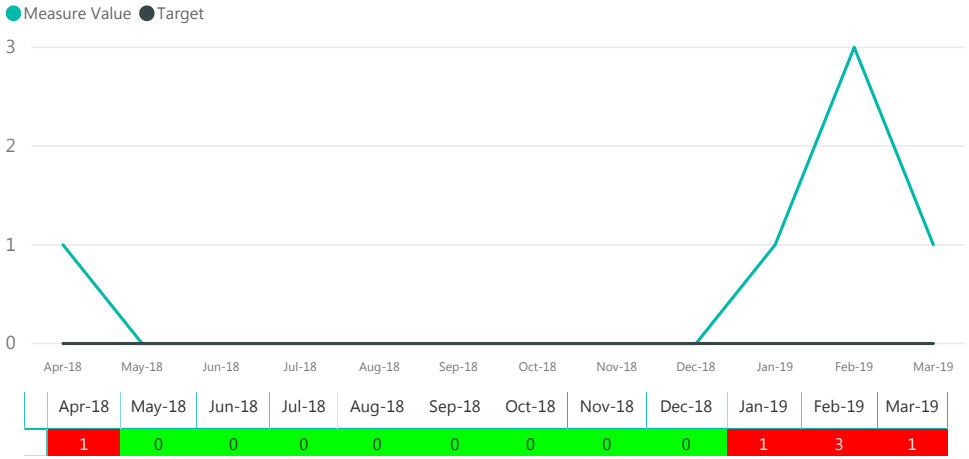
• Weekly senior review with every ward of every patient with a LOS>10 days being carried out by 3 teams led by Therapies • 3 times a week tracking meeting face to face with external Partners • Exec and Clinical lead top delays meeting to review the longest staying patients in the Trust in place weekly • Use of Southfields to house patients waiting for Domiciliary care packages

RTT over 52 weeks

March 2019

Target	Actual	Direction of Travel	Accountable Executive
0	1	↑	Debbie Needham

Performance vs Target



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
1	0	0	0	0	0	0	0	0	1	3	1

What is driving under performance?

•Central pathway validation team have been validating pathways around previously incorrectly closed pathways identified on CAMIS. This work has identified a small number of 52 week breaches which from April-19 will incur a fine for both the trust and the commissioners; £2,500 each per pathway and repeated in the following month if the patient is still not treated. •1 x 52 week breach identified in March 19 due to 'clock' being stopped inappropriately by admin staff following an MRI •Reliance on bank admin staff due to vacancy and sickness in admin roles •RTT code usually move from a 10 to a 20 to a 30 as the patient progresses on an RTT pathway but CAMIS allows any code to be submitted in this case a code 90 which removed the patient from the pathway

Actions completed in the past month to achieve recovery

•Urgent contact made with patient who was booked into first available clinic (patient had not contacted Trust to question the long delay) •Patient reviewed by consultant to ensure no harm has resulted from the prolonged wait (no Harm) •Patient offered surgery date within the month of the breach but patient refused date offered as wanted to wait a further 6 weeks •Patient underwent uneventful procedure the following month •Retraining provided to specialty admin team where breach was identified

Timeframe for recovery

May 2019

Exception report written by

CrockettG

Assurance Committee

Finance Investment and Performance Committee

Next steps

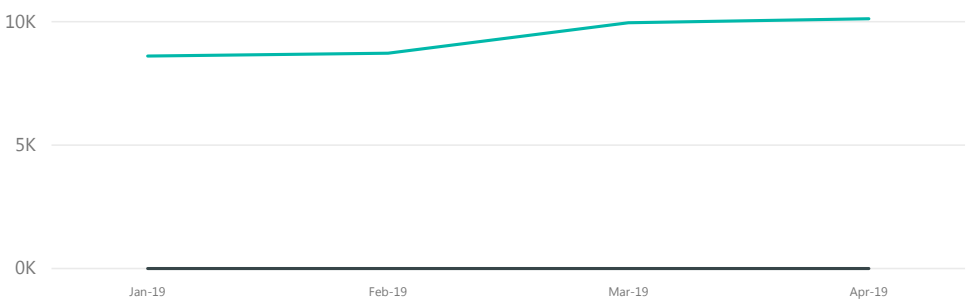
•Alfresco software to go live next month which will analyse all RTT pathways to ensure they follow an expected coding path. Any that don't fit the model will be flagged up via the detailed algorithm for detailed analysis. It is anticipated that this work will identify a few more potential 52 week breaches who will be treated in the same way as above to ensure we have caused no harm and their treatment is fast tracked within the month •Full retraining to be rolled out by the CAMIS team to all areas to ensure all staff fully conversant with the coding issues.

Unappointed Follow Ups

April 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	10119	↓	Debbie Needham

Performance vs Target

Measure Value Target



Jan-19	Feb-19	Mar-19	Apr-19
8608	8723	9957	10119

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

• Significant growth was noted in April, across all waits but most significant in the 19-20 week bracket. A review in one area identified that a large number of appointments had not been entered on the system due to a perceived failing of CaMIS to enable this recording. This was an incorrect perception and records have now been recorded appropriately and full training provided • 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

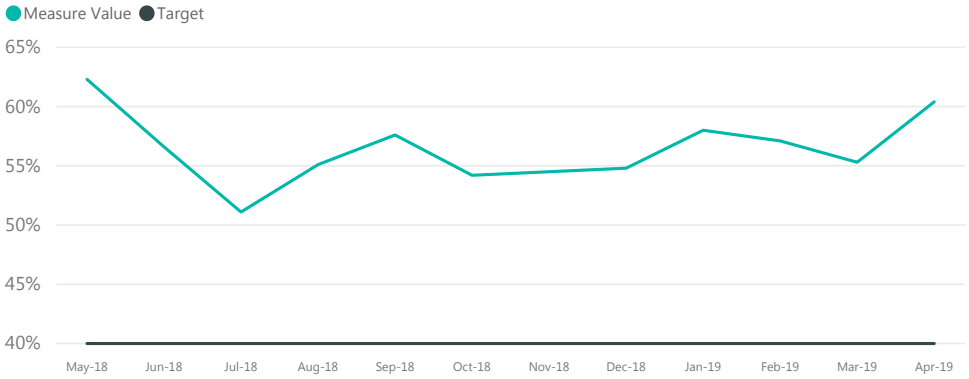
Finance Investment and Performance Committee

Stranded Patients (ave.) as % of bed base

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
40.0 %	60.4 %	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
62.3 %	56.6 %	51.1 %	55.1 %	57.6 %	54.2 %	54.5 %	54.8 %	58.0 %	57.1 %	55.3 %	60.4 %

What is driving under performance?

• Target set by NHSI of 134 patients >21days LOS (40% reduction) from a baseline of 220 • Last 12 months has seen an average 22% increase in Discharges across the Trust compared to previous year BUT at the end of March 19 and ongoing the numbers of discharges has dropped significantly and stranded numbers have increased have increased to 400 and superstranded to 180 patients • We have 195 PDNAs live in the system which equates to 195 patients needing a supported discharge from external partners. This is an unprecedented number with Social Services, Rehab and CRT seeing the longest delays • Increased delays in submitting PDNA's to the SPA due in the main to the staffing challenges on the ward where direct patient care takes precedent • Increased admissions from Urgent care (as we have empty beds are we more inclined to fill them!) • Over prescribing of care 'this patient will not cope at home' but 30% of care packages are cancelled within 72 hours as the patients don't want them

Actions completed in the past month to achieve recovery

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Exception report written by

CrockettG

Timeframe for recovery

October 2019

Assurance Committee

Finance Investment and Performance Committee

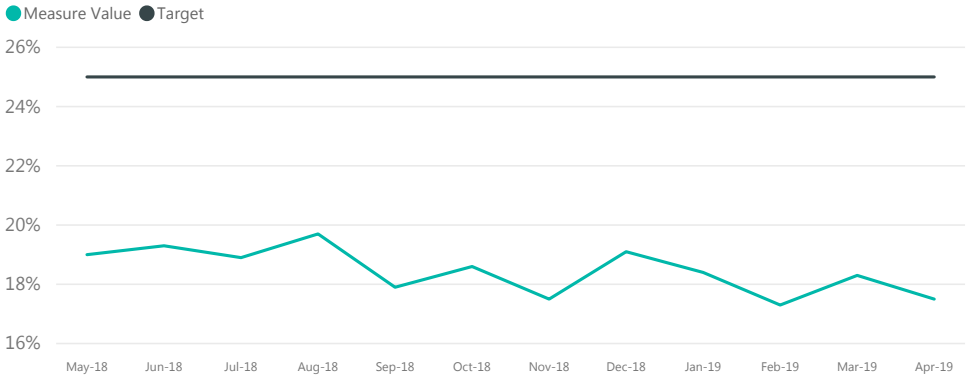
Next steps

• Weekly senior review with every ward of every patient with a LOS>10 days being carried out by 3 teams led by Therapies • 3 times a week tracking meeting face to face with external Partners • Exec and Clinical lead top delays meeting to review the longest staying patients in the Trust in place weekly • Use of Southfields to house patients waiting for Domiciliary care packages

Percentage of discharges before midday

April 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	25.0 %	17.5 %	↓	Debbie Needham

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
19.0 %	19.3 %	18.9 %	19.7 %	17.9 %	18.6 %	17.5 %	19.1 %	18.4 %	17.3 %	18.3 %	17.5 %

What is driving under performance?

• Current performance of 17.4% discharges against a target of 25% • Last 12 months has seen an average 22% increase in Discharges across the Trust compared to previous year BUT at the end of March 19 and ongoing the numbers of discharges has dropped significantly and stranded numbers have increased have increased to 400 and superstranded to 180 patients • Due to urgent care pressures elective activity has been stepped down for all but cancer and cat 1 surgery, as such only 'big' cases have been operated on and this impacts the discharge numbers and the support they need to go home • We have 195 PDNAs live in the system which equates to 195 patients needing a supported discharge from external partners. This is an unprecedented number with Social Services, Rehab and CRT seeing the longest delays • Increased delays in submitting PDNA's to the SPA due in the main to the staffing challenges on the ward where direct patient care takes precedent • Over prescribing of care 'this patient will not cope at home' but 30% of care packages are cancelled within 72 hours as the patients don't want them. • Junior doctor gaps delays the timely production of EDN's and TTO's • Ambulance provider (TASL) has a 2.5 hour window for collection if the transport is booked on the day • Many care packages and rehab community beds are notified to the trust on the day they become available so transport cannot be booked prior to the notification

Actions completed in the past month to achieve recovery

•Discharge element of 'Fixing the Flow' initiative being led by Nursing Director with 6 project teams working on:PDNA & Discharge Team, SAFER & R2G, Dr Cover and EDN and TTO's, Mental Health, Discharge Suite and Criteria led discharge •3 x a week track meeting with external Partners •Use of Choice Policy including legal framework around 'trespass' for difficult cases •Roll out 'i-box' electronic boards is advanced and has been embraced by the teams •Rehab beds in community used for Non weight bearing patients •Rehab community nurse to work on NGH site 3 times a week to 'pull' Orthopaedic patients into rehab and home therapy •Discharge Coordinators supporting wards by completing PDNA's for ward teams to improve time between admissions to PDNA with plan to reduce time from admission to PDNA. •Employed further 6 Discharge Coordinators to support Wards; they are updating stranded patient process supporting wards with all discharges as well as supporting wards to complete the PDNAs •Use of Southfields to house patients waiting for Domiciliary care packages •Private ambulance crews used to support discharges on day •Discharge booklet produced for all patients on arrival to clarify requirements by trust and patient regarding their day of discharge

Exception report written by

CrockettG

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

Actions to continue as per this month above but will include further development from the 'Dr Cover and EDN and TTO's project team' •Contracts have been signed for AGE-UK to support our elderly frail patients with discharge from both A&E and Discharge Suite on a trial 16 week starting in May •Contract agreed for local council to provide a homeless officer to support discharging patients who are homeless or cannot return to their homes. This has been successfully trialled in the north of the county and will now be rolled out here.

Report To	**Public Trust Board**
Date of Meeting	**30 May 2019**

Title of the Report	**Workforce Performance Report**
Agenda item	13
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 update in respect to the delivery of the People Strategy. In addition, it provides assurance of on-going monitoring and management of key workforce performance indicators and risks.

Executive summary

The report highlights Trust performance against the workforce Key Performance Indicators.

Highlights:

- Annual Trust turnover for April 2019 decreased to 8.40%, which is below the Trust target of 10.00%.
- NGH has been working with NHSI as part of our Respect and Support campaign. NHSI have developed a case study into the Trust's approach to tackling Bullying and Harassment.

Challenges:

- Sickness absence for April 2018 increased to 4.23% which is above Trust target of 3.8%.
- The overall Trust vacancy rate for April 2018 is 12.44% against a Trust target of 9%.
- Appraisal compliance decreased in April 2019 to 84.50% which is below the Trust target of 85%.
- Role Specific Essential training is below target at 83.81%.

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

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

Actions required by the Committee

The Board is asked to note the report.

WORKFORCE PERFORMANCE REPORT APRIL 2019

1. Introduction

This report provides an update in respect to the delivery of the priority workforce updates. In addition, it provides assurance of on-going monitoring and management of key workforce performance indicators and risks.

2. Summary

The key deliverables achieved since the last report include:

- Implementation of Applicant Management Systems (Trac) which will improve recruitment turnaround times.
- Work is underway to ensure we promote equality, diversity and inclusion.
- The Respect and Support campaign continues, with the Trust featuring as a national case study for NHS Improvement.

Key Performance Indicators tracking at or better than target include:

- Annual Trust turnover for April 2019 decreased by 0.08% to 8.40%, which is below the Trust target of 10.00%.
- Mandatory training compliance increased in April 2019 from 88.71% to 89.24% and remains above the Trust target of 85%.

There have however been challenges with the following targets:

- Contracted workforce increased by 12.73 FTE and the Trust's substantive workforce is at 87.56% of the Budgeted Workforce Establishment of 5181.24 FTE. However, despite the increase in contracted workforce, the overall contracted workforce has decreased slightly since last month from 88.7%, due to an increase in overall workforce budgeted establishment and is therefore below the Trust target of 93%.
- Sickness absence for April 2019 increased from 4.03% to 4.23% above Trust target of 3.8%.
- The rate of Appraisal compliance for April 2019 was recorded at 84.50% which constitutes a decrease of 1.90% since March 2019 and is below the Trust target of 85%.
- Role specific essential training compliance decreased in April 2019 from 83.84% in March 2019 to 83.81% and is below the Trust target of 85%.

Exception reports can be found at appendix 1.

3. Performance and Progress

3.1 People Strategy: Building Capacity

3.1.1 Staffing Establishment

The overall Trust vacancy rate stands at 12.44%, which is above the Trust target of 9%. However during the last three months the Trust has seen an overall net increase in contracted workforce of 16.21 FTE and the overall April 2019 figure is affected as a result of an increase in budgeted establishment.

An increased stability of the workforce enables a reduction in the reliance on temporary resources. Stable staffing is clearly linked with patient experience and quality outcomes. In this regard the key areas are Nursing & Midwifery and Medical & Dental staff vacancy rates.

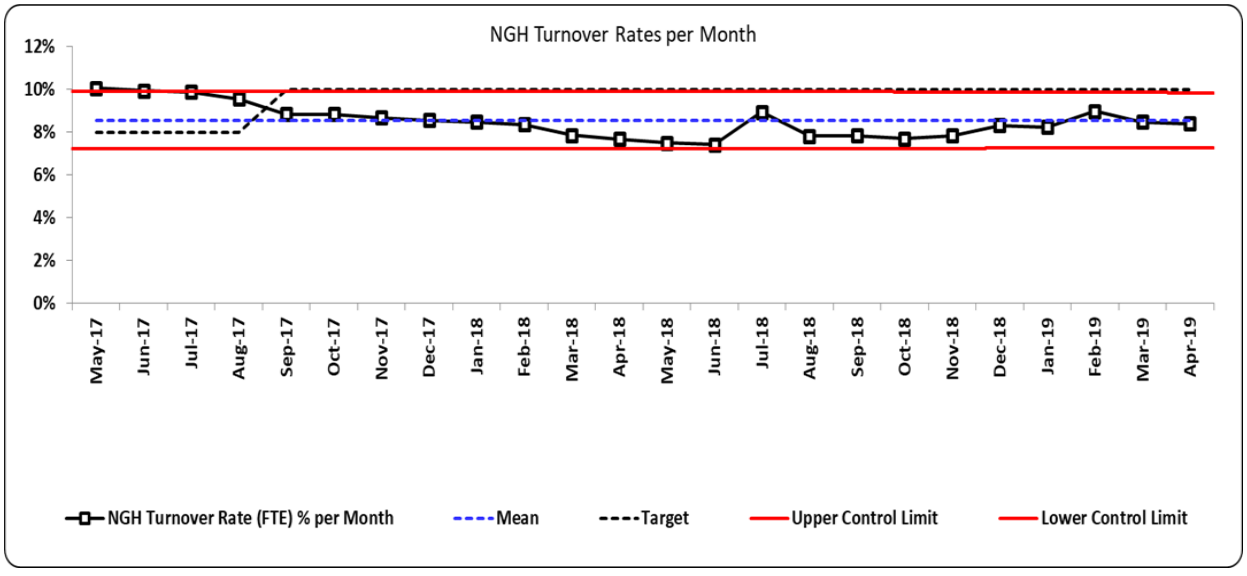
Nursing & Midwifery vacancy rate decreased from 11.28% in March 2019 to 11.08% in April 2019. The overall nursing vacancy factor is consistent with the national trend whereby nursing vacancies are running above one in ten posts being vacant. It is anticipated that challenges in respect of the balance of supply and demand will continue beyond the next five years and it will therefore be necessary for the Trust to address this in the short term through continuing overseas nurse recruitment and over the medium to long term through the Trusts continuing attempts to grow its own nurses through the development of the Talent Academy and the utilisation of the apprenticeship levy to support HCAs to become nursing associates and fully registered nurses.

There was an increase in the Medical & Dental vacancy rate from 3.23% in March 2019 to 6.87% in April 2019, however it remains below the Trust target of 9%. This increase corresponds with an increase in Medical and Dental turnover from 3.77% in March 2019 to 4.90% in April 2019. There was also an increase in budgeted establishment that contributed to an increase in vacancy factor. Medical recruitment activity is monitored to ensure that it is of sufficient volume to contain and reduce this vacancy factor and in this regard there are currently 70 doctors in clearance, which takes into account known and anticipated vacancies. In addition, 150 deanery doctors are in clearance as part of the August rotation.

3.1.2 Trust Turnover

The Trust annual turnover for April 2019 decreased by 0.08% to 8.40%, which is below the Trust target of 10.00%.

The graph below shows the overall turnover trend over a rolling 2 year period and indicates a general improvement, although there is a noticeable slowing down/levelling off during the last 6 months which may indicate that the turnover is stabilising at the rate of between 7% and 8%.



3.1.3 Sickness Absence

Sickness absence for April 2019 increased from 4.03% to 4.23% above Trust target of 3.8%.

Three particular wards are contributing to increases in sickness absence include high levels of both long and short term absence and it is notable that a number of absences are due to pregnancy related illness.

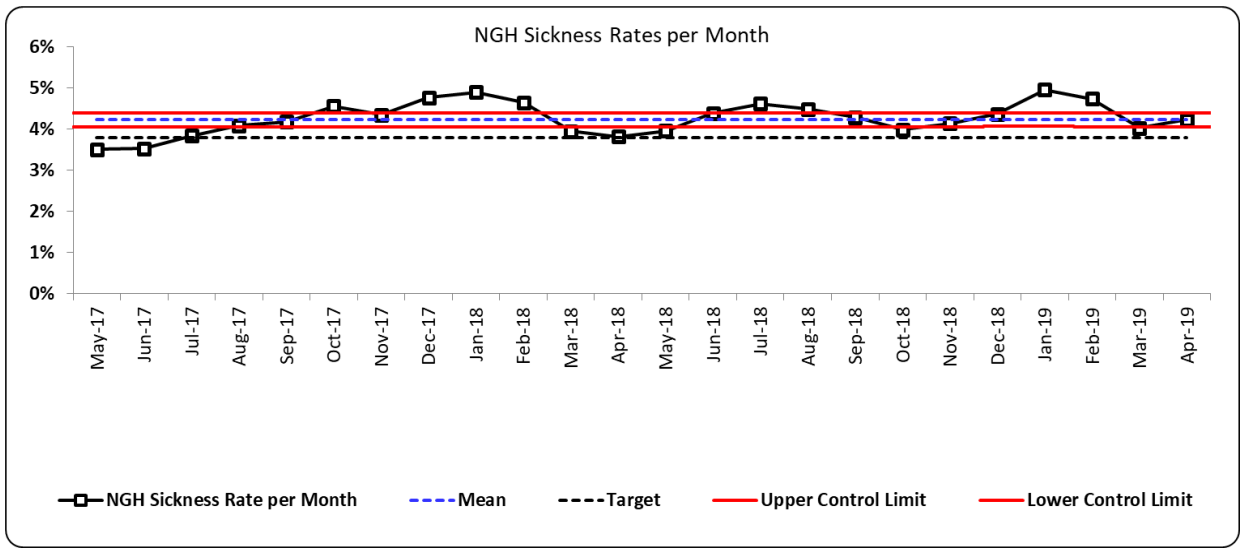
Facilities Directorate had the highest sickness rate of 6.60% amongst the directorates. Long term sickness is high however cases are being managed actively with a conclusion for these cases being sought. Short term sickness is usually under 3% however there has been a slight increase. Monitoring of this will occur to understand whether it is an ad-hoc increase or whether it becomes a more sustained pattern in which case, interventions will be explored.

The top reasons for sickness absence are as follows:

01st May 2018 - 30th April 2019				
Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	410	555	14,800.97	20.0
S98 Other known causes - not elsewhere classified	972	1,269	11,311.87	15.3
S12 Other musculoskeletal problems	311	396	5,907.73	8.0
S11 Back Problems	343	450	5,128.89	6.9
S28 Injury, fracture	219	242	4,699.25	6.4

A range of OD interventions are ongoing throughout the Trust which are anticipated will have a positive effect in reducing sickness absence attributable to anxiety/stress/depression/other psychiatric illnesses. The Trust Health and Wellbeing initiative is also designed to support staff in this regard together with the planned introduction of the role of a Staff Health & Wellbeing Psychological Therapist.

Overall Trust Sickness Absence Trend:



3.1.4 Applicant Management System (Trac)

The 'Trac' applicant management system, which now facilitates the Trusts recruitment process from posting a new vacancy, through to booking an applicant's induction course and start date has been implemented.

The use of the system enables the Trust to manage its adverts, candidates, pre-employment checks and workload more efficiently.

The system will deliver a number of benefits including significantly improved reporting functionality that will enable individual departments, divisions and the Trust as a whole to better monitor recruitment activity.

An audit was undertaken prior to implementation in order to measure the benefits realisation of the system and a further audit will be undertaken post implementation so that a comparative analysis can be undertaken.

3.1.5 Medical Bank

A three month trial with a system that enables medical bank shifts to be electronically advertised and doctors to book shifts is being undertaken.

The system has the potential to increase accessibility to bank doctors and the intention is that it will increase the Trusts bank fill rates and reduce agency spend as well as making the process smoother and easier for doctors to book shifts.

Baseline data is in the process of being collated so that an evaluation of benefits realisation can be undertaken at the end of the trial. Current processes are being mapped and a stakeholder engagement session is planned to take place mid-June and training will take place thereafter.

3.2 People Strategy: Developing Capability

3.2.1 Appraisals

The current rate of appraisals recorded for April 2019 is 84.50%, which is a decrease of 1.90% from last month's figure of 86.40% and is below the Trust target of 85%. Compliance is being reported and monitored through operational governance structures.

There are three notable areas that are reporting red in April 2019, Initial feedback is that this is attributable to vacancies and sickness absence, however the operational leads have been asked to provide an update on how this will be addressed.

3.2.2 Mandatory Training

Mandatory training compliance increased in April 2019 from 88.71% to 89.24% and remains above the Trust target of 85%.

3.2.3 Role Specific Essential Training

Role specific essential training compliance decreased in April 2019 to 83.81% from last month's figure of 83.84%, which is a decrease of 0.11% and is below the Trust target of 85%. Compliance is being reported and monitored through operational governance structures.

There are two notable areas that are reporting as red and the operational leads have been asked to provide an update on how this will be addressed.

3.3. People Strategy: Shaping Culture

3.3.1 Respect & Support Campaign

Training

As part of the Respect and Support campaign a range of training programmes have been developed and attendance is being tracked:

- **Leading with Respect**: Leading for Respect is for Team Leaders, Managers and people in positions of influence in clinical and non-clinical roles. The aim of this session is to ensure managers understand their responsibilities in addressing workplace bullying, harassment and inappropriate behaviours. Attendance since the launch in September 2018 is 164 staff.

- **Challenging Bullying and Inappropriate Behaviour:** This training is for staff that do not have line management/supervisory responsibility. The programme aims to raise awareness of bullying and inappropriate behaviours. Attendance since the launch in October 2018 stands at 223 staff.

- **Courageous Conversations:** This session is for delegates who may need the practical tools required to have a difficult conversation. Attendance since March 2019 stands at 38.

- **Resilience Training:** The resilience training is available for all staff across the Trust. It is a programme that has been developed to look at personal emotional resilience, taking time to recognise what depletes and what restores personal resilience. Attendance since the launch in July 2018 to 245 staff.

Respect & Support Hotline activity

Since the launch in February 2019 the Respect & Support hotline has taken 7 calls. Of the calls, some have resulted in staff feeling able to feedback to the individual themselves and 1 required escalation. The hotline continues to be publicised through the training and the workshops that are being undertaken together with posters and screen savers.

It is planned for information flyers to be attached to pay slips in May 2019 to promote use of the hotline.

Round Table Conversations

Round Table Conversations are facilitated informal conversations offered in order to resolve issues of conflict between two people.

There are already 28 facilitators trained and the Round Table Conversations offering will be communicated from May 2019 across the Trust. The OD Department are advertising for more Round Table Facilitators across the Trust to support this service.

Other Tools

The following have also been developed and are available for staff on the Respect and Support intranet page:

- Feelings log
- Behavioural framework
- Behavioural self-assessment tool

Respect and Support Case Study

The Trust has recently been the subject of a case study conducted by NHS Employers to promote best practice and document the way in which the Trust is tackling Bullying and Harassment. A full copy of the case study can be found at Appendix 2.

3.3.2 Equality, Diversity and Inclusion

The Trust is trialling a new recruitment process called 'Recruiting for Difference', which is designed to promote and encourage a diverse workforce through identifying underrepresented skills, experience and backgrounds and identifying a range of criteria against which applicants can be assessed with the aim of increasing workforce diversity. Two posts have been identified to pilot the process. The process involves using an objective evidence based assessment in a way that removes the possibility of unconscious bias occurring at shortlisting stage.

An independent organisation have run focus groups for staff with protected characteristics to identify how it feels for those staff to work at NGH. This will enable the Trust to ensure that we promote equality of opportunity and improve working conditions for staff with protected characteristics. A report on this is awaited.

4.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	83.3%	98.0%	98.1%	100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↑		86.3%	88.6%	88.3%	87.9%	87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		93.7%	91.9%	92.5%	91.4%	91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	→		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	→		97.8%	92.4%	92.7%	93.1%	92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	3	0	0	0	0	4	2	0	0
	Compliments	Sheran Oke	-	NGH								4,288	4,335	3,541	4,269	3,639	4,007	3,647
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		86.6%	93.8%	92.3%	91.5%	88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%
	Average Ambulance handover times	Debbie Needham	<=15 mins		↓		00:12	00:14	00:13	00:11	00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↑		129	58	79	60	118	174	142	299	330	400	420	343
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↑		5	2	1	3	15	17	19	30	49	33	22	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↓		13	7	6	16	2	3	3	4	5	4	4	11
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		39	35	12	19	36	10	10	24	12	11	20	31
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		42	40	28	16	34	27	15	20	20	17	29	41
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		37	31	19	13	25	25	13	16	17	13	20	30
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↓		90.8%	69.9%	72.1%	70.7%	75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↓		78.1%	23.3%	18.0%	31.0%	85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		97.4%	92.6%	95.4%	97.5%	94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↓		97.1%	100.0%	100.0%	98.7%	96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↓		94.3%	96.1%	97.5%	97.5%	95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↓		90.0%	78.5%	100.0%	100.0%	88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.3%	74.6%	78.2%	80.8%	81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	→		97.1%	68.4%	100.0%	93.7%	100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↑		87.5%	90.0%	81.2%	78.7%	79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	↓		89.0%	84.7%	81.1%	79.9%	80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	
	RTT over 52 weeks	Debbie Needham	=0	Nat	↑		0	0	0	0	0	0	0	0	1	3	1	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↓		99.4%	99.7%	99.4%	99.8%	99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				96.4%	93.5%	92.9%	100.0%	92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	76.4%	96.6%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				91.6%	87.7%	97.7%	93.3%	95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%
	Unappointed Follow Ups	Debbie Needham	=0	NGH											8,608	8,723	9,957	10,119
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			11.7%	12.1%	12.3%	12.4%	12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			3.9%	4.4%	4.6%	4.5%	4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			11.8%	12.6%	13.2%	11.8%	11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			13.1%	14.3%	14.6%	9.4%	9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			9.5%	9.8%	10.5%	8.2%	7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			12.7%	13.7%	14.4%	14.0%	13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.5%	7.4%	8.9%	7.8%	7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			89.1%	89.5%	89.2%	88.7%	88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%
	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%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			84.8%	84.9%	85.1%	83.8%	82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			86.7%	86.7%	85.9%	85.0%	84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			63.5%	63.5%	58.3%	60.0%	12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			288 Fav	(1,089) Adv	(1,984) Adv	(2,563) Adv	(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			1,231 Fav	40 Fav	72 Fav	174 Fav	392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(1,202) Adv	(1,900) Adv	(2,702) Adv	(2,744) Adv	(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			555 Fav	870 Fav	2,060 Fav	3,388 Fav	3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			46	70	89	107	128	153	167	195	209	230	266	20
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			82	126	152.2	228.7	260.9	313.1	340.9	371.9	392.3	454.4	509.2	74
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,041 Fav	1,456 Fav	1,785 Fav	1,969 Fav	1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav
	CIP Performance - Recurrent	Phil Bradley	-	NGH										64.5%	65.9%	65.5%	69.0%	39.0%
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH										39.1%	40.4%	41.0%	41.0%	42.8%
	Maverick Transactions	Phil Bradley	=0	NGH						27				15	21	21	19	
	Waivers which have breached	Phil Bradley	=0	NGH			2	2		0				1	0	0	0	
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			62.3%	56.5%	51.1%	55.0%	57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			31.3%	29.3%	22.0%	24.6%	26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.8	4.4	4.3	4.2	4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			18.9%	19.2%	18.9%	19.7%	17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%
	Emergency re-admissions within 30 days (elective)	Matt Metcalfe	<=3.5%	NGH			3.5%	3.4%	4.6%	3.2%	3.5%	3.0%	3.2%	4.7%	3.0%	3.3%	3.6%	2.9%

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 APR

	Emergency re-admissions within 30 days (non-elective)	Matt Metcalfe	<=12%	NGH	↑		14.3%	15.7%	16.8%	17.0%	16.6%	14.4%	14.6%	17.4%	16.5%	15.9%	16.8%	13.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		↓		88.8%	90.0%	87.5%	82.7%	77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%
	Maternity: C Section Rates	Matt Metcalfe	<29%		↑		31.3%	34.1%	28.9%	29.8%	28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%
	Mortality: HSMR	Matt Metcalfe	100	Nat	↑		99	101	0	104	104	106	106	106	105	106	104	103
	Mortality: SHMI	Matt Metcalfe	100	Nat	→		97	97	98	98	100	100	104	104	104	104	104	104
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	→		79	25	25	45	47	66	36	35	53	51	35	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	→		94.9%	100.0%	100.0%	97.7%	95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	Debbie Needham	=0%	NGH	↑		4.0%	5.6%	5.8%	6.6%	6.1%	5.8%	6.1%	5.2%	6.2%	5.8%	6.3%	5.7%
	Never event incidence	Matt Metcalfe	=0	NGH	→		0	0	0	0	0	1	0	0	0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	-		→		3	4	3	2	3	0	0	3	7	1	0	0
	VTE Risk Assessment	Matt Metcalfe	>=95%		↓		97.8%	96.4%	96.4%	95.0%	95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	94.1%	93.1%
	MRSA	Sheran Oke	=0	Nat	→		0	0	0	0	0	0	0	0	0	0	0	0
	C-Diff	Sheran Oke	<=1.75	Nat	↓		1	2	2	1	2	0	0	1	0	0	0	2
	MSSA	Sheran Oke	<=1.1	NGH	↓		1	0	2	0	0	2	1	0	1	2	0	5
	New Harms	Sheran Oke	<=2%	NGH	↑							2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%
	Number of falls (All harm levels) per 1000 bed days	Sheran Oke	<=5.5		↓		4.9	5.8	4.6	5.5	4.8	5.0	4.2	4.4	4.6	4.3	3.8	5.2
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat	→									85.6%	88.1%	90.7%	91.2%	91.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat	↓									62.0%	59.7%	56.7%	57.2%	53.0%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat	↓									89.2%	89.2%	67.5%	72.6%	70.6%

Data not provided

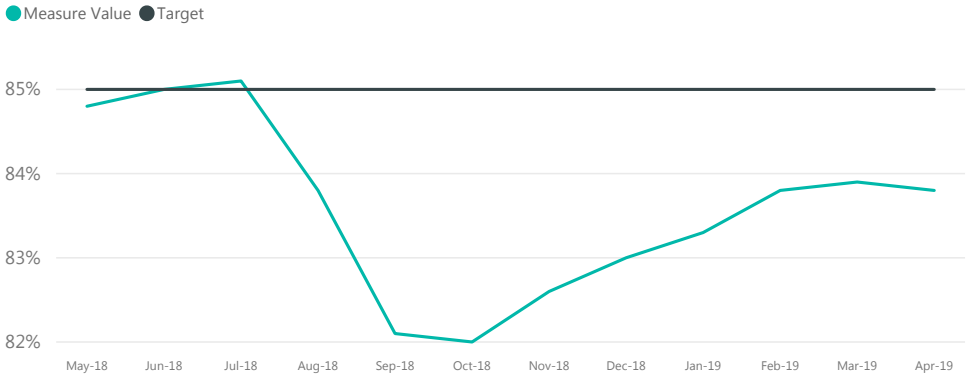
No data - pre KPI implementation

Percentage of all trust staff with role specific training compliance

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0 %	83.8 %	↓	Janine Brennan

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
84.8 %	85.0 %	85.1 %	83.8 %	82.1 %	82.0 %	82.6 %	83.0 %	83.3 %	83.8 %	83.9 %	83.8 %

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

Next steps

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

Timeframe for recovery

April 2020

Assurance Committee

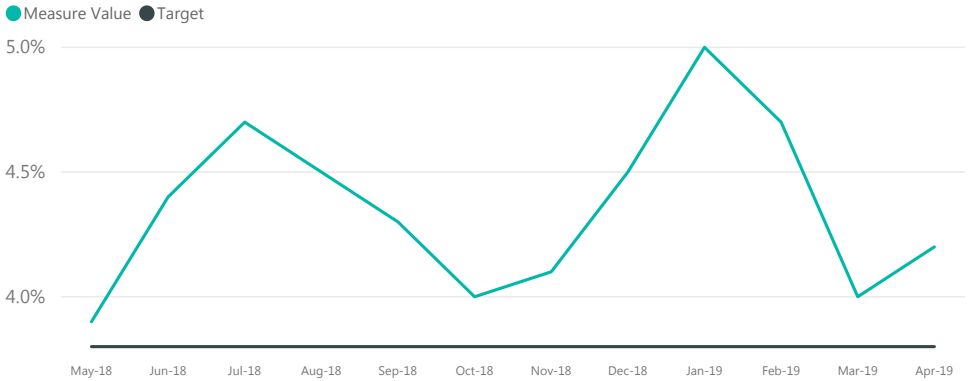
Workforce Committee

Sickness Rate

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
3.8 %	4.2 %	↓	Janine Brennan

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
3.9 %	4.4 %	4.7 %	4.5 %	4.3 %	4.0 %	4.1 %	4.5 %	5.0 %	4.7 %	4.0 %	4.2 %

What is driving under performance?

There is an increase in the number of individuals with long term conditions taking short term absences. Due to a number of nurses leaving in Occupational Health there are delays in getting appointments for staff who are absent from work. There have been pressures on substantive staff to undertake bank shifts.

Actions completed in the past month to achieve recovery

Robust sickness management continues with support from the HR Business Partners and HR Advisors. Occupational Health has actively been trying to recruit to the Occupational Health Nurse positions. The increase in bank workers is being regulated especially for individuals off sick.

Exception report written by

ChownA

Timeframe for recovery

May 2019

Assurance Committee

Workforce Committee

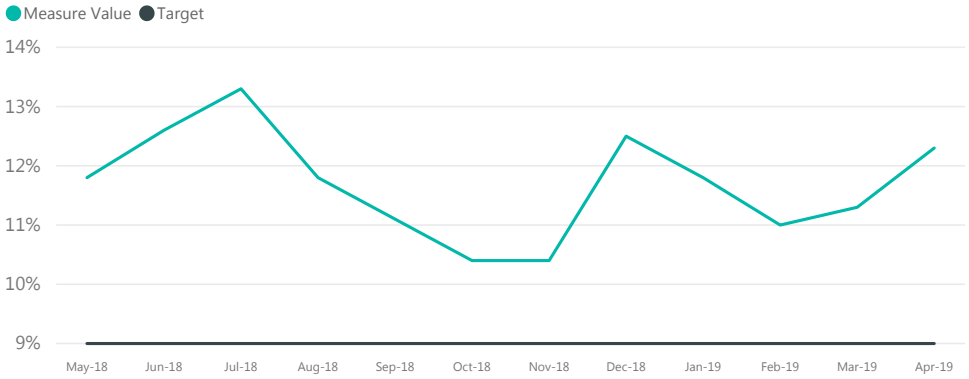
Next steps

Continue to manage sickness absence across all areas of the Trust. HR Business Partners to raise sickness as part of the divisional management meetings. The Occupational Health Manager is actively looking at innovative ways to increase the nursing time within the department. The Occupational Health Manager and HR Business Partners together are prioritising management referrals.

Staff: Trust level vacancy rate - All

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
April 2019	9.0 %	12.3 %	↓	Janine Brennan

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
11.8 %	12.6 %	13.3 %	11.8 %	11.1 %	10.4 %	10.4 %	12.5 %	11.8 %	11.0 %	11.3 %	12.3 %

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

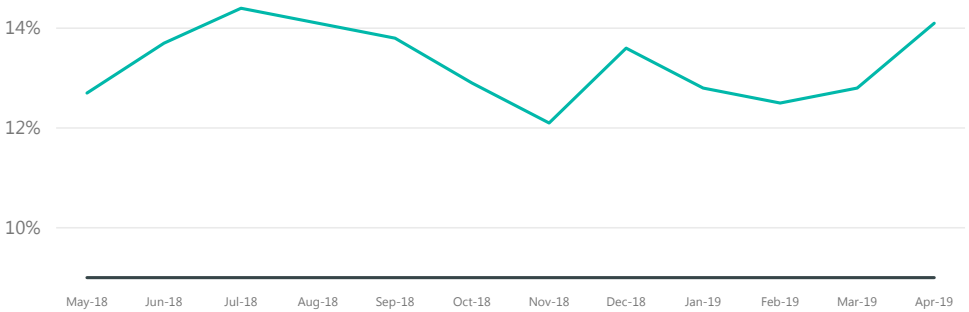
Staff: Trust level vacancy rate - Other Staff

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0 %	14.1 %	↓	Janine Brennan

Performance vs Target

Measure Value Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
12.7 %	13.7 %	14.4 %	14.1 %	13.8 %	12.9 %	12.1 %	13.6 %	12.8 %	12.5 %	12.8 %	14.1 %

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

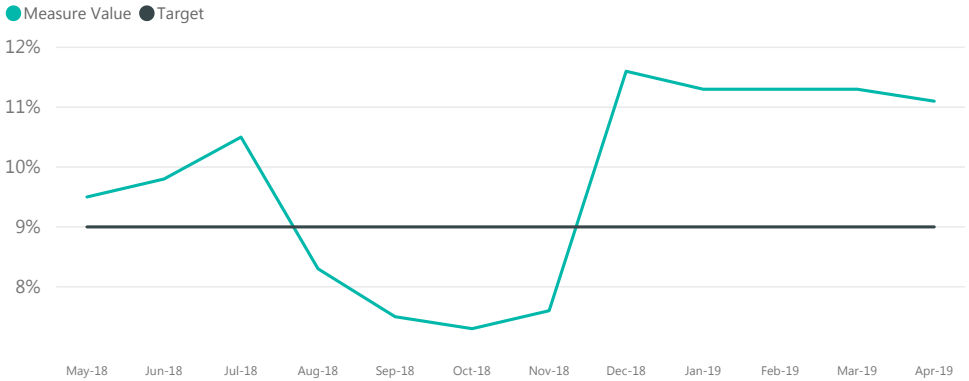
• Trust Open Days in difficult to recruit areas • Nurses Recruitment KPIs are being redesigned • Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates • Overseas recruitment for nurses continues including direct overseas recruitment through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

Staff: Trust level vacancy rate - Registered Nursing Staff

April 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0 %	11.1 %	↑	Janine Brennan

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
9.5 %	9.8 %	10.5 %	8.3 %	7.5 %	7.3 %	7.6 %	11.6 %	11.3 %	11.3 %	11.3 %	11.1 %

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

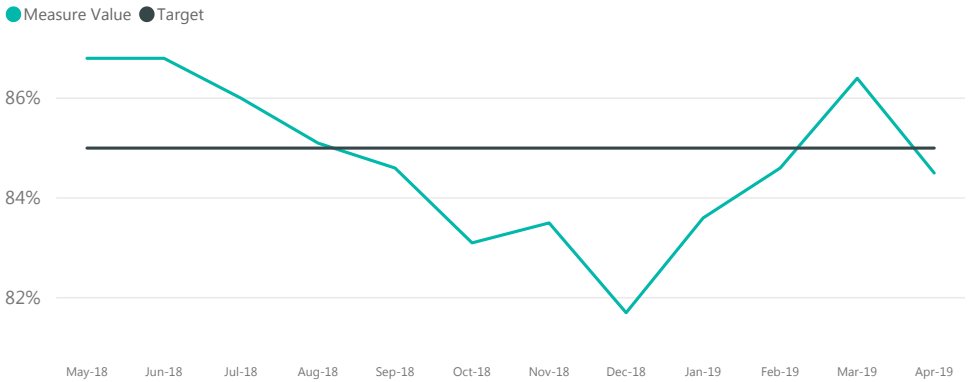
• Trust Open Days in difficult to recruit areas • Nurses Recruitment KPIs are being redesigned • Increased use of social networking & website development to maximise the exposure of the Trust to potential candidates • Overseas recruitment for nurses continues including direct overseas recruitment through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

Percentage of staff with annual appraisal

April 2019

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

Performance vs Target



May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
86.8 %	86.8 %	86.0 %	85.1 %	84.6 %	83.1 %	83.5 %	81.7 %	83.6 %	84.6 %	86.4 %	84.5 %

What is driving under performance?

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

Actions completed in the past month to achieve recovery

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

Exception report written by

SansomB

Timeframe for recovery

June 2019

Assurance Committee

Workforce Committee

Next steps

The HRBPs to address with those managers with low compliance and if necessary create action plans Those managers who have a discrepancy with the % of compliance have been asked to contact the L&D manager so an audit can be carried out.

Tackling bullying through cultural change: ‘Blame last, not first’

March 2019

A case study from Northampton General Hospital NHS Trust (NGH), a medium district general hospital, employing over 5100 staff and providing services to around 400,000 service users centred on Northampton and the surrounding areas.

What was the aim?

Following the publication of the 2016 national staff survey results, Northampton General Hospital NHS Trust was presented with a challenge. Although the results were generally positive across most areas, they showed that 26% of staff had experienced bullying and harassment by other staff in the previous 12 months.

The trust was concerned because the results did not reflect its organisational value: ‘We respect and support each other’ and because of potential impact on patient experience. It instigated a cultural change programme to address the issues by creating a more inclusive and supportive culture.

What was the solution?

NGH understood that how it handled the findings would say as much about culture as the results. This led to the overarching principle of ‘Blame last, not first’. From the outset this initiative was about understanding and changing behaviour, and not blame and punishment.

They involved as many staff as possible to understand and then address the cultural issues driving or at least enabling these inappropriate behaviours. Recognising the need for visible and meaningful board-level sponsorship, the Director of Workforce and Transformation led the change programme with high level engagement from the Chief Executive. They developed the comprehensive ‘Call it, Change it’ framework to address the challenges.

Understanding the issues

The research phase involved understanding the issue of inappropriate behaviour at both staff experience and psychological levels – what was happening and why it was happening:

- They ran a staff survey using bespoke questions to tease out what was actually happening with responses collected in a variety of formats including online, confidential inbox, individual consultations and phone conversations with the organisational development team. In total there were 799 responses, with over 50% saying they had experienced or witnessed bullying. Clear themes emerged including grade discrimination, staff reacting adversely under pressure, favouritism, micro-management, blame, etc. The primary reasons for bullying behaviour emerged as clash of personalities/styles and pressure at work.
- They followed this with staff focus groups to get more detail on the key themes. The 'Blame last, not first' principle was reinforced, and openness and honesty was encouraged.
- They investigated the psychology of human behaviour to give a richer understanding of why people behave as they do and why interpersonal relationship issues can arise. This also meant the response to the findings was robust and evidence based. It was clear that a 'one size fits all' response would not be effective.

These actions led the trust to the conclusion that any interventions needed to focus on changing behaviour through insight and support. For the small proportion of staff whose behaviour still required a zero-tolerance approach (such as cases of gross misconduct, repeated bullying, no personal insight), the formal disciplinary approach would be available.

The interventions

The trust developed a range of interventions broadly split between prevention and cure including:

- A behavioural framework, created in partnership with staff groups, which identified clear expectations and behavioural standards. It clearly articulated what it meant to show respect and support and was accessible, simple and meaningful.
- An innovative and creative engagement launch for the framework, using a forum theatre approach with professional actors. The approach involves playing out scenarios that come from feedback and giving the audience the chance to change the behaviours of the actors to demonstrate the impact of an intervention.
- Respect and support workshops for managers and staff to raise awareness of the framework, and what those behaviours look like in practice. The workshops also raised awareness of the options for action if staff experienced bullying behaviour.
- Team interventions, such as 'Values in practice' sessions, 'Rainbow risk' and 'In your box' – to help teams and individuals understand their own attitudes, beliefs and behaviours and how these impact on others through their communication styles and work preferences.

- Marketing and communications including: a poster campaign around ‘the faceless victim’ reinforcing the messages staff had shared about how they were made to feel.
- Self-help and wellbeing focused interventions such as courageous conversations, resilience training and reflection logs to support staff to capture and reflect on what is happening for them.
- Alternative conflict resolution approaches, including round-table discussions – an informal facilitated discussion approach for low level relationship issues that don’t require formal mediation. It involves two facilitators working with two individuals experiencing relationship difficulties. The process is based on the concept of restorative justice and aims to help to build understanding between the parties of each other’s perspectives in a non-adversarial way.
- Confidential information hotline staffed by HR and OD staff providing support by listening, exploring options and signposting.
- Values ambassadors – trained volunteers supporting the Freedom to Speak Up and the Respect and Support campaigns signposting staff to the support available, listening to issues and encouraging raising concerns at the earliest opportunity.

What were the challenges?

- Changing the mindset to a ‘Blame last, not first’ approach and avoiding the use of formal processes when not appropriate.
- Creating OD capacity to support development of the interventions.
- Engaging hard-to-reach groups.

What were the results?

- High number of staff are taking part in the programme
- Positive feedback from staff
- Reporting of bullying/inappropriate behaviour increased including a four-fold increase in the number of bullying complaints
- Anecdotal feedback suggests staff are more confident about speaking up
- Increased number of staff responding to 2018 national staff survey, which anecdotal feedback suggests is due to more confidence their feedback will be acted on.

What were the learning points?

- Understand the issues – the stories and experiences but also the underpinning drivers of human behaviour.
- Partnership working with colleagues is critical from the outset.
- Executive team leadership and meaningful buy-in are essential.
- Fast-track key interventions are needed to maintain momentum.

- Patience! It is not a quick fix. The 2018 staff survey showed an increase in staff reporting experiencing bullying and harassment from staff from 28% to 33%. However the percentage of people reporting their most recent experience of bullying increase from 63% to 65%. This is positive as the 'Call it, change it' framework has led to greater understanding of what constitutes bullying behaviour and willingness to report the issues. It is important to recognise that cultural change takes time and persistence and it will take time for the interventions that have been put in place to have an impact.

Next steps and sustainability

- Embed the 'Respect and support' behavioural framework through the whole employee lifecycle from recruitment to exit processes.
- Develop targeted interventions for hard-to-reach staff groups, such as bespoke interventions for medical staff.
- Develop follow-on communication campaigns to help build an understanding of the common purpose and individual staff contributions and help eliminate grade discrimination.
- Develop an evaluation and monitoring process to track progress and key metrics including the impact on retention, recruitment, sickness, staff engagement and the number of formal cases.
- Up-skill staff to feed back to individuals accused of bullying behaviour.
- Ensure all policies take the restorative approach of 'blame last, not first'

Want to know more?

Please contact:

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Fiona Pittam, Head of Organisational Development, Fiona.Pittam@ngh.nhs.uk

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

REPORT TO: Public Trust Board
30 May 2019

Title of the Report	**Trust Vision and Aims**
Agenda item	14
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy and Partnerships
Purpose	To seek agreement from the Board for the Trust vision and aims that will be central to the new Trust Strategy that is currently in production

Executive summary

This paper proposes a new vision and strategic aims for the Trust that will form the basis of our new strategy. It summarises the outputs of a previous board workshop and provides a rationale for why we need to have a clearer summary of our strategy.

It reaffirms that Providing the Best Possible care remains our overall mission and that our core values remain the same.

It also provides an update on the staff consultation that has taken place with regard to the priorities that should appear in the new strategy.

Finally, it proposes to the board that the vision and aims are approved.

Related strategic aim and corporate objective	This paper relates to all strategic aims; • Focus on quality and safety • Exceed patient expectations • Strengthen our local clinical services • Enable excellence through our people • Ensure a sustainable future
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: No
Related Board Assurance Framework entries	BAF 4.1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Trust Board/Committee

The Board is asked to discuss and approve the Trust vision and aims as listed in the paper.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board
30 May 2019

1. Introduction

The Trust is currently engaged in a process to rewrite its strategy, the process for which has been subject to board approval along with a workshop to agree the high level principles.

The Board has agreed that our mission statement "to provide the best possible care" along with our four core values do not need to alter. The values are:

- We put patient safety above all else
- We reflect, we learn, we improve
- We aspire to excellence
- We respect and support each other

However, it was clear that our overall vision, i.e. the description of where our organisation is heading along with our strategic aims to deliver it, needs to be clarified.

This paper proposes a vision statement for the Trust along with amended strategic aims. It also provides an update on the ongoing staff consultation for the new strategy.

This paper is an introduction only, to ensure Board members have the opportunity to read the draft vision and aims prior to the meeting where a presentation will take place.

2. Background

The workshop on 3 May 2019 engaged board members in the process to re-write our strategy and used the key lines of enquiry below to structure the debate.

Key Line of Enquiry: W2	Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?
WL2.1	Is there a clear vision and set of values, with quality and sustainability as the top priorities.
WL2.2	Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?
WL2.3	Have the vision, values and strategy been developed using a structures planning process in collaboration with staff, people who use services, and external partners?
WL2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?
WL2.5	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?
WL2.6	Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?

At the session a number of questions were posed to the Board with respect to the vision, values and strategic aims for the Trust and whether these should alter in the new document.

These are summarised below:

2.1 Question 1: Does the current strategy set a clear vision for what the organisation wants to be in the future?

The conclusion was that it doesn't and needs to be strengthened in the new version. This is a critical issue to be resolved in the new strategy inclusion of a new strategy and will provide a summary of what we wish to achieve. The debate that took place considered that the following areas should feature:

- Establishment of formal links with Kettering General Hospital NHS Foundation Trust and the alignment of services and functions where appropriate
- Leadership of the Integrated Care Partnerships across Northamptonshire alongside KGH and for NGH to lead in the in the west of the county
- Integration with primary care networks
- Partnership with the providers of community services for the west of the county
- Establishment of strong partnerships across health and social care county-wide

2.2 Question 2: Do we still align behind "To provide the Best Possible Care" as a mission statement?

The opinion of all present was that we do. This is embedded across the organisation and features in many aspects of our everyday business. It is known and understood by staff across the organisation and it is not felt necessary to change. But it is not a strategy – it is a description of what we hold dear as members of team NGH and hence the need for a compelling vision.

2.3 Question 3: Are our strategic aims still valid or need a change?

These are:

- A focus on quality and safety
- Exceed patient expectations
- Strengthen local clinical services
- Enable excellence through our people
- Ensure a sustainable future

The view was that these do satisfy the definition above but they also miss some of the critical elements and need further debate. The view was that there is nothing inherently wrong with the 5 strategic aims but they need to be refocused and enhanced.

The conclusion was that the new vision should also encapsulate our aims which would be refocussed to be more quantifiable. It was also acknowledged that our aspiration to become a University Hospital should be considered.

2.4 Question 4: Do our strategic priorities need to change?

These are:

- Providing resilient core DGH services at NGH
- Continuing to improve urgent care services
- Collaborate and integrate services with other providers
- Strengthen our specialist services
- Become the hospital of choice for local GPs and patients
- Delivering excellence in patient care
- Developing health and wellbeing campus in partnership with the University and local Council

We have already agreed that these need to change completely which is the point of the current staff consultation process.

2.5 Conclusion from the Workshop:

- Include a compelling and clear vision statement based as described above
- Retain Best Possible Care as a mission statement
- Add to our strategic aims
- Re-write our priorities with specific elements relating to our People Strategy

3.0 Proposed Vision

As a result of the board workshop the following is proposed as the vision for the new strategy. The aim is for a compelling summary of the strategic direction for the Trust that includes reference to our values and strategic aims:

Our commitment: To deliver the best possible care

*Our commitment means that we will strive to deliver the best possible care for our patients, every time. We will put quality and safety at the centre of everything we do. **Aspiring to excellence** for improved outcomes, reduced hospital acquired infections, increased patient and staff satisfaction. We will deliver compassionate and evidence based care by empowered staff who are supported to achieve their own personal ambitions for their careers.*

We will deliver year on year improvements in patient and staff feedback. We will ensure our patients experience the very best environment that we can provide, improving our current buildings and taking advantage of partnerships to build new facilities that are fit for the future. We will invest in our estate to ensure the hospital is a place our communities are proud of and which they can recommend as a place to receive excellent care. We will build a new hospital entrance, an off-site diagnostic facility, a new urology and endoscopy unit, an accommodation block for staff and continue to move away from the oldest parts of our site over the course of the next 5 years.

We will create a sustainable future. In five years time we will operate a very different organisation as more patients are treated outside of the hospital, closer to home. We will continue to deliver high quality clinical services and thereby financial sustainability. We will do this partnership with organisations across the county and in particular we will build a strong partnership with Kettering General Hospital NHS Foundation Trust. We will foster partnerships with Primary Care Networks and evaluate options for the provision of community services alongside the new Unitary Authorities to integrate care as much as possible.

*We will create a great place to work. An environment for our staff that **respects** the individual talents they each possess and **supports** them to deliver the best possible care. We will support our staff to **reflect, learn and improve** as they deliver care in an environment where a zero tolerance approach is taken towards violence and aggression.*

We will continue our journey to becoming a University Hospital alongside the University of Leicester and grow our range of research activities to enable our patients and staff to benefit from the opportunities that this brings.

*In five years time we will be different. But our values and our passion will stay the same. We are #TeamNGH and we will **deliver the best possible care** to everyone who needs it.*

The Board is asked to discuss and agree the vision for the new strategy.

4.0 Proposed Strategic Aims

The following are proposed as the strategic aims for the new strategy:

- We will put quality and safety at the centre of everything we do
- Deliver year on year improvements in patient and staff feedback
- Create a sustainable future
- Strengthen and integrate local clinical services particularly with Kettering General Hospital
- Create a great place to work to enable excellence through our people
- Become a University Hospital by 2020 and enhance the range of research and clinical trials we undertake

The Board is asked to discuss and agree the strategic aims for the new strategy.

5.0 Staff Engagement

The initial staff engagement process has completed. The strategy team have met with 456 colleagues in workshops around the Trust and spoken to many more whilst holding sessions in Hospital Street or visiting wards.

This has been a very positive experience with genuine enthusiasm from staff to get involved and own the process.

The process to evaluate the outcomes is ongoing with the following key priorities emerging:

- Ensuring patient and staff involvement and engagement
- Reduce readmissions by focussing on high quality care packages in community
- Maintain focus on safe and timely discharge
- Develop action plan to improve staff experience and reduce gaps in establishments
- Develop and embed a diverse and inclusive culture
- Deliver quality priorities and improve safety culture
- Delivery of high quality and timely cancer pathways
- Embed new roles to attract and retain staff
- Ensure clinical area compliance and develop sites of elective excellence
- Paper light notes/paperless back office
- Organisation wide thinking around equipment requirements
- To develop an action plan to improve patient experience

The next step will be to ask staff to vote on the range of suggestions made so that we can consolidate their views into a range of strategic priorities for the strategy.

We will now commence the process of external engagement along with patient and user groups as we further develop our priorities.

6.0 Communication

The process to re-write our strategy has been a very positive one with the engagement of staff from board level across the Trust. We will not stop there and continue to involve colleagues as the process continues.

We will not cease this communication once the strategy has been written. What has been clear is the real enthusiasm of colleagues to get involved in the strategic development of their organisation. The workshop based approach to this will continue with a rolling programme of sessions throughout the life of the strategy.

We also need to communication our strategy in an engaging manner, the process of engaging expertise in this area will now commence.

7.0 Recommendation

The Board is asked to discuss the vision and strategic aims. As a result the Board is asked to approve both items for inclusion in the new strategy.

Report To	**Public Trust Board**
Date of Meeting	**30 May 2019**

Title of the Report	**People and Organisational Development Strategy**
Agenda item	**15**
Presenter of Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Janine Brennan, Director of Workforce and Transformation
Purpose	For discussion in order to agree the strategic framework and direction of the Trust's People and Organisational Development strategy.
Executive summary Work has been underway to review our People strategy in light of the context in which we are operating and in order to respond to the 2018 staff survey results. This report sets out a proposed strategic framework (the purpose of our people strategy) underpinned by five strategic imperatives. The Board is invited to consider, discuss and agree a way forward.	
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 discuss the report, determine the strategic framework and agree the next steps.

Trust Board Report

30th May 2019

People and Organisational Development Strategy 2019

1.0 Introduction

The current Trust Clinical Strategy was agreed in 2014, and subsequently refreshed, and includes three supporting strategies which relate to people and organisational development

- Organisational Effectiveness strategy 2013/14: Connecting for Quality, Committed to Excellence
- Staff Engagement strategy 2014/15: Connecting for Quality
- People strategy 2016 -2020: Building Capacity, Developing Capability and shaping our Culture.

The effectiveness of these strategies is reviewed regularly. As part of this review, recognising the importance of workforce to service delivery and organisational performance, and in light of the 2018 staff survey results, we are taking the opportunity to reshape, refresh and align the strategy.

This revised strategy is intended to cover a 5 year timeframe and as a priority for our organisation, it will be appropriately resourced and supported.

2.0 Overview

Work has been underway to review the People Strategy (which built upon and further developed the two former strategies), in light of the ever demanding environment in which our staff work and the need to continually evolve what we do to support our staff. Our staff survey had shown year on year improvements, thus clearly evidencing the effectiveness of the approaches taken toward staff engagement over recent years, however this trajectory of improvement changed in the latest staff survey. It is imperative therefore that our strategy is shaped by what the staff have told us within the latest survey.

Our current people strategy is built on 3 pillars:

- Creating **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 energise and nurture our staff to deliver the best possible care.

Whilst this report focusses on the ‘Shaping culture’ aspect of our current People strategy, all three elements of our current strategy will ultimately be incorporated within the revised People and Organisational Development strategy.

2.1 Approach

Multi source data was collated. This came from HR intelligence (the core workforce dataset supplemented by less formalised data), staff survey results, clinical strategy and 'Respect and Support' focus groups, freedom to speak up themes and workforce committee intelligence together with input from Executives, Non-Executive Directors and Divisional leads. This data was synthesised to identify the key issues. Internal and external contextual influences were also identified.

The focus has been on the Trust wide response although organisational 'hotspots' were identified. The expectation is that any Trust wide activity is supplemented by local divisional and directorate plans.

An initial workshop was held where executive and non-executive directors, alongside senior clinicians and managers, reviewed the data, identified the imperatives, and started to suggest priorities and possible interventions. The workshop was facilitated by an external individual with both senior NHS and HR experience.

The outputs of this workshop were subsequently further explored and challenged at a meeting of Board members on 10th May 2018.

The Board acknowledged the work to date, committed to further debate and identified the key next steps, including the testing of proposals with staff and identification of measures.

2.2 Outputs

The proposed **strategic framework** is:

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.

The **strategic imperatives** were identified as

1. building a caring and inclusive culture
2. expecting leaders to role model
3. embedding talent management
4. developing managers and supervisors
5. creating a supportive working environment.

It is recognised that these may need further word crafting although they reflect the major areas for focus that were identified in the workshops.

The **priorities for action** underpinning the **imperatives** were identified as follows:

Building a caring and inclusive culture

To create a culture defined by trust and respect and which has inclusion at its heart by:

- positively seeking, giving, receiving and acting upon feedback – a feedback rich culture

- further developing our 'Respect and support' campaign
- using appropriate mechanisms in a timely and consistent way to respond to poor behaviour, using a restorative approach wherever appropriate
- recognising good behaviour
- embracing diversity and valuing the benefits that come from having diverse teams
- adopting the 'Just and learning culture' approach.

Leaders as role models

A trusted and respected leadership team who embody the Trust's values and behaviours and in leading by example create a caring and inclusive culture by:

- placing care for our teams at the forefront of what we do
- clarifying expectations
- building trust through clear, frequent and purposeful communications
- developing and implementing a structured visibility plan
- adopting a line of sight focus.

And to support this we will provide development and support and redesign our performance development process.

Embedding Talent Management

To create the capability and capacity to deliver the Trust's strategy by:

- providing learning and development opportunities for all
- realising the potential of our staff; mapping talent journeys and investing in talent management programmes (note the Trust is a pilot site for the Leadership Academy's Talent Management diagnostic)
- implementing innovative recruitment solutions
- improving staff retention.

Developing managers, supervisors and teams

Strengthen the clinically led structure by developing managers, supervisors and teams who:

- have clear roles and responsibilities
- set and uphold core standards
- provide feedback and support (see feedback culture above)
- embrace great team working.

Supportive working environment

Create a working environment where motivation, satisfaction and engagement are understood and used to drive improvement by:

- enhancing the reasons to join and stay
- removing the barriers and improving processes that get in the way of staff having a great day at work
- embedding the drivers of staff satisfaction
- undertaking HR policy reviews to ensure alignment with the strategy
- further developing our health and wellbeing initiatives
- reviewing our approach to flexible working.

2.3 Discussion

The Board is asked to

1. Challenge and confirm the framework
2. Explore the possible interventions
3. Set a direction for further work to be undertaken.

by exploring a set of questions. To support the discussion, set out at Appendix A, are a summary of our current interventions designed to support the development and engagement of staff.

2.4 Questions for the Board

i. Drawing on your own sources of **intelligence** is there anything to add to the data collection set out in 2.1 for further analysis?

ii. Based on your understanding of the data are the **imperatives** outlined above the right ones?

iii. Are the **priorities** that sit beneath the imperatives the right ones to focus on in order to deliver the people strategy?

iv. Following agreement of the overall direction, and engaging and obtaining feedback from staff on what's important to them, a plan will need to be developed. What are the high level initial thoughts on what we should do to develop these so that improvements are made and are meaningful to staff and what will the Board do to **lead** the strategy?

3.0 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.

This strategy will build upon what is already in place to mitigate the risks to the Trust strategy as set out in the Board Assurance Framework.

4.0 Recommendations/Resolutions Required

The Trust Board is asked to discuss and agree:

- The strategic framework
- The strategic imperatives
- The next steps.

5.0 Next Steps

The proposed next steps are:

1. clarify priority interventions
2. consult and validate with staff and other key stakeholders
3. identify measures of success
4. draw up an implementation plan with outcomes, milestones, and responsibilities and resource requirements
5. bring that plan back to the Board for approval.

Appendix A

Existing interventions underpinning our current strategy

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NHS
Northampton General Hospital
NHS Trust

Report To	**Trust Board**
Date of Meeting	**30th May 2019**

Title of the Report	KGH Collaborative working – Collaborative Steering Committee (CSC)Terms of Reference
Agenda item	**16**
Presenter of Report	Claire Campbell, Director of Corporate Development, Governance & Assurance & Richard Apps, Director of Governance Kettering General Hospital NHS Foundation Trust
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance & Assurance & Richard Apps, Director of Governance Kettering General Hospital NHS Foundation Trust
Purpose	To obtain Board approval at NGH and KGH of the Terms of Reference for the Collaborative Steering Committee.

Executive summary

The paper presents the Terms of Reference for the Collaborative Steering Committee (CSC) as agreed by that Committee at its Inaugural Meeting- Monday 20th May 2019.

Changes agreed to the draft Terms of Reference at that meeting are highlighted in Appendix 1.

- Revision of the wording of the Authority (Section 9).
- Membership expanded initially- for review at six months (Section 12).
- Monthly meetings to be held- rotating between organisations (Section 21).
- CSC support- amended to Directors of Governance (Section 26).
- Decision making- amended to formal approval by each Board (Section 27).
- Review date of six months added (Section 32).

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Corporate Objective 4: Transform our services to deliver better care and value with long term sustainability.
Risk and assurance	The development of the collaborative governance framework involved a structured planning process across both organisations. There is a risk that without a robust and properly resourced collaborative governance framework may result in stakeholders not fully supporting or understanding the collaboration and will likely result in non-achievement of the collaborations goals and the associated Trusts strategic objective. All risks associated with the project will sit on a joint Risk Register which will be considered by the Collaboration Steering Committee

	and escalated appropriately to individual organisations Corporate Risk Register and Trust Boards as required.
Related Board Assurance Framework entries	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? **(N)** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **(N)**
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No- in line with Trusts Standing Orders/ Constitution

Actions required by the Board

The Board is asked to:

- To approve the Terms of Reference of the Collaborative Steering Committee

Collaboration Steering Committee

Terms of Reference

Purpose

1. Both Trusts, Northampton General Hospital (NGH) and Kettering General Hospital (KGH) have agreed a series of collaborative working core principles and governance arrangements signed off by each Board in February 2019.
2. A Collaboration Steering Committee (CSC) has been established between the two organisations and will set the overall strategic intent for the collaboration, ensuring all proposals for future collaboration devised by the workstreams have appropriate strategic 'fit' prior to seeking approval from individual Boards.
3. The CSC will identify opportunities to improve outcomes for patients though innovative practice and partnerships.
4. The CSC will agree and confirm areas of common interest and priorities for joint work.

Context

5. There is an increased focus on hospitals to work with other health partners and local authorities to maximise their use of resources and clinical capacity to achieve the best clinical care and outcomes for patients and service users.
6. Both Trusts recognise the importance of collaboration in supporting the health and wellbeing of the wider community.
7. The Trusts recognise that to enable effective collaboration requires a joint decision-making forum to place the collaboration on a more formal and accountable framework.
8. The CSC builds on work already taken by the two trusts and the development work undertaken in the preceding six months by Boards and Directors to prepare for launch.

Authority

9. The CSC is a formal joint committee of both NGH & KGH and shall have the authority to make decisions in relation to those matters delegated to it as described in these Terms of Reference for each Trust Board to ratify.

10. Both Chief Executives will have the delegated authority to make collaboration decisions based on the current scope and delegation to them afforded by their partner organisations.

Roles and Duties

11. The duties of the CSC will include the following:

Strategy & Planning

- To discuss and agree the principles for collaboration.
- To manage the implementation plan for the collaboration work programme.
- To ensure wider alignment to the STP plans and objectives.

- Consider and ensure the right level of public engagement and that where necessary consultation is undertaken to ensure public and patient views on proposals.
- Agree the strategy for service enablers such as IMT, Estates.
- Considering interdependencies with other providers and specialist commissioned services.

Clinical & Corporate Model of Care

- The CSC will discuss and agree the core features of the collaboration clinical models including the underpinning workforce model. This will include oversight of the detailed clinical pathways and monitoring of the clinical outcomes and care standards for those patients receiving collaboration based clinical services.

Operating Model

- The CSC will discuss and agree the required operating model for each clinical and corporate collaboration area. This will describe the clinical and managerial leadership of each collaboration area. It will ensure oversight of the detail regarding the day to day running of services and interface with patients.

Policies

- Oversee the development of any required policies, standard operating procedures or guidelines that underpin the areas of collaboration.
- Ensure governance links to the policy framework of each organisation making clear the monitoring and audit of agreed policies.

Finance

- As a steering group, the group would discuss and test financial principles and would make recommendations to each Board in the following areas;
    - Agreeing the implementation of agreed financial principles to each clinical service as required – including, but not limited to, the budget, recharges and control total adjustments
    - Agreement of a commissioner management strategy relating to the collaborated service
    - Review and comment on the joint financial performance of each service – input into each Trust Board or Finance/Performance Committees
    - Agree financial benefits expected to be delivered by each service
    - Monitor and report on benefits realisation
    - Provide recommendations to each Trust on any investment requirements (Capital and Revenue)

Membership

12. The CSC is an internal group and shall consist of the following core members, with membership being balanced across each Trust. These roles will be represented for each Trust
    - Chief Executive (rotating Chair between the two CEO's)
    - Medical Director

- Director of Nursing
- Chief Operating Officer
- Director of Finance
- Director of Strategy & Planning
- Director of Governance
- Director of HR
- Director of Estates

Other individuals can attend by invitation, particularly when the Committee is discussing an agenda item that is the responsibility of that role.

Additional representation will be invited dependant on the topics requiring greater stakeholder insight and/or engagement, for example. Health Watch Representative

13. Each Trust shall provide a representative to fill one of the functions, ensuring that membership remains balanced. In the event of a representative being unable to attend, they may ask a counterpart from the partner Trust or from their own Trust to deputise for them. In this instance the membership will not be balanced numerically, though the deputy will be representing their function rather than their organisation.

14. Where a member cannot attend, they can send a suitably and duly nominated deputy to attend in their absence and be considered within the quorum.

Quoracy

15. For decision making purposes, a quorum shall be 8 members. The following roles must be represented for the meeting to be quorate: Chief Executive (or Deputy), Medical Director (or Deputy) and Director of Nursing (or Deputy), Chief Operating Officer (or Deputy)
16. Both KGH & NGH will commit to ensuring regular attendance from their senior representatives, with deputies attending only by exception.

Role of Members

17. Members of the CSC represent their organisations.
18. Members role is to consider the best use of resources to maximise the benefit to patients and the wider health community and partners in social care and education.
19. Both organisations have agreed a set of characteristics and principles that will support collaboration going forward, Appendix B.
20. Members are expected to develop and share a common purpose toward closer collaboration.

Conduct of Business

21. The CSC shall meet on a monthly basis, rotating sites between both organisations. Where an additional meeting is required outside of the established meeting pattern it shall be for the Chair to convene the meeting, with the agreement of leads from each Trust.

22. Papers will be circulated one week in advance, to enable organisations to consider the implications for their own organisations in advance of the meeting. Where this is not possible, any later circulation must be agreed with the Chair in advance.
23. The CSC is a private meeting of the Trusts.
24. Both parent Boards have agreed a common set of Collaboration Principles to set the tone and ways of working for the committee, Appendix A

25. Where any member of the CSC has concerns about the way in which the CSC is addressing a matter, or where he/she disagrees with a decision of the CSC, he/she may at any time refer that matter to the Board of the parent organisations at NGH & KGH. In such cases the CSC will refer to the dispute resolution procedure in the Memorandum of Understanding with the aim of resolving the matter.

26. The CSC shall be supported and administered by a secretary to the committee, jointly resourced through the CEO's of each Trust. The Directors of Governance shall advise the Chair of the CSC on the CSC's compliance with these terms of reference and with other relevant governance requirements and shall generally provide support to the CSC as required

27. Decision making

The CSG has the authority to implement and oversee progress of agreed policies and work programmes as identified and agreed by both Boards. The Partnership recognises that some decisions will need to be referred to the respective organisational Boards. The CSG also has the remit to contribute to development of new policy. The Partnership will provide an update to parent Boards through a standardised and agreed reporting format, See Appendix B.

When taking decisions members of the CSC will work constructively and pragmatically to reach a consensus position where all agree; voting arrangements will not apply to the decision making of the CSC.

Decision making member organisations shall ensure that their own constitutions and schemes of reservation and delegation provide members of CSC with sufficient authority to take decisions on matters presented to the CSC on behalf of their organisations. The authority to act will be primarily conducted through the authority delegated to each CEO and Executives nominated to the committee.

Where a recommendation has been made by the CSC, it shall be reported to the governing body of each of the Trust for formal approval.

Conflicts of Interest

28. Members are required to state for the record any interest relating to any matter to be considered at each meeting. These conflicts will be recorded in the minutes, and where necessary an individual may be asked to withdraw from the meeting for that part of the agenda.

29. Should the Chair of the meeting have a conflict of interest which necessitates his or her absence from the meeting, the role of Chair should be undertaken by one of the other core members present.

Accountability

30. The CSC does not usurp or replace any existing statutory accountabilities of member organisations. Individual member organisations retain their statutory accountabilities to their respective regulatory and oversight bodies.

31. The CSC will be accountable to both the governing bodies of its members and shall provide a report on its work following each meeting. This will include the appropriate identification and escalation of any collaboration risks and issues to parent Boards. The minutes of CSC shall be circulated to the governing bodies of both Trusts

Review Date

32. These terms of reference shall be formally reviewed in November 2019 and thereafter annually.

Appendix A – Collaboration Principles (agreed by NGH & KGH Board February 2019)

1. Patient Safety is paramount – All change proposed will be subject to robust Quality Impact Assessments.
2. The escalation of risks must be implicit – The process will include the management of risk through the collaboration steering group and to parent boards as per scheme of delegation.
3. Clinically led, managerially driven – Clinical leadership will be empowered and equally supported by robust managerial delivery.
4. Absolute clarity on delegated authority – Each structural element will be clear on its locus of control.
5. Clear roles & responsibility – Will be made explicit across structures, people and processes engaged with collaboration. Staff will fully understand any authority which has been delegated to them during the collaboration process.
6. Management of change and collaboration processes – there will be complete transparency of decision making within a clear governance framework for collaboration that has clear and standard documentation, with a clear audit trail of minutes that show what discussions took place, what risks were considered, and decisions made.
7. Clear benefits realisation plan – Progress will be consistently monitored with agreed KPI's that align to each organisations performance management framework.
8. Involvement of all employees – This will develop and grow capability of our workforce to collaborate as effective partners. This requires individuals to optimise their ability to take a broad range of views, to shape and agree a consensus view point and then take collective action on the decisions made. All views will be actively sought, recorded and conducted in an atmosphere of supportive challenge.
9. Transparency – openness, feedback and trust are essential informed by the right information.
10. Population Perspective- Each workstream will need to ensure this is constantly checked/ kept in mind.
11. Open Book- Both organisations will work to these principles, agreeing and defining what this means.
12. Capability assessments- Gaps in capability/ resources will be identified and either addressed to support workstreams and overall project or prioritised as require.
13. Communication- Clear messages will be agreed by both organisations for dissemination on the overall project, workstream outcomes and benefits to the local population. Celebrating successes to maintain momentum

Appendix B Example highlight report to KGH & NGH Boards from CSC

Collaboration Steering Committee Report		Date
Report to;	KGH Name of Committee Date	NGH Name of Committee Date
Item	Update	Action Required
1.		
2.		
3.		
4.		
Matters for Escalation	Update	Action Required
1.		
2.		
3.		
4.		
Risk and Issues	Risk Score	Mitigation
1.		
2.		
3.		
4.		

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Northampton General Hospital
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 May 2019**

Title of the Report	**Health and Safety Annual Report 2018/19**
Agenda item	**17**
Presenter of Report	Stuart Finn, Director of Estates and Facilities
Author(s) of Report	Fiona Potter, Health and Safety Manager
Purpose	Assurance

Executive summary

This report provides an analysis of the Trust's Health and Safety performance during the financial year 2018 – 2019 and highlights relevant issues pertaining to the Management of Health and Safety in the Trust.

The report concludes with a forward look, and outlines the key Health and Safety priorities proposed for the financial year 2019/20

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

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

Actions required by the Trust Board

The Board is asked to consider the report and note the progress made during the year and the key issues highlighted.
Note the poor attendance by Divisional Representatives at the Health and Safety Committee and recommendations to improve attendance through changes in the frequency of meetings and the reporting structure

Health & Safety Annual Report: 2018/19

1. Summary

The Health & Safety Departments work plan for 2018/19 was adapted to balance the operational challenges and investigations, against the strategic objectives. There have been positive developments, through;

- All Health & Safety Polices are in date
- Partnership working with professional colleagues, strengthening shared learning and opportunities to change and improve on health and safety practices.
- The continued monitoring and implementation of the Control of Substances Hazardous to Health Assessment process.
- The continued monitoring and implementation of Operational Risk Assessments within Clinical Areas
- The Health & Safety Committee have established a separate group, to review incidents of violence an aggression and restrictive physical intervention. The group going forward with be led by Patient and Nursing Services
- The Health & Safety work program follows HSG 65 "Successful health and safety management" to ensure the Trust is able to build on health and safety systems currently in place, and proactively scan quality initiatives and Trust models to continue to improve the health, safety and welfare provision for all.

The Health & Safety Committee seek to strengthen the position of Divisional assurance reporting and attendance for 2019/2020 by increasing the frequency of meetings, reformatting the Divisional reporting process in line with CEQEG reporting template and ensuring a nominated Deputy representative is established to attend

2. Introduction

Health and Safety at Work Act 1974 places duties on the Trust, to ensure that the health, safety and welfare of employees and those who are not employed but can be affected such as patients, visitors and contractors is safeguarded. Furthermore a number of other health and safety legislation place additional duties on the Trust to ensure Health & Safety risks that can cause harm are identified, assessed, mitigated and managed. The Trust aims to educate, support and enable staff to look after their own safety so far as is reasonably practicable to ensure the Trust fulfil its duties and responsibilities

The purpose of this report is to provide the Trust Board with a summary of principal activities and outcomes relating to the promotion and management of health and safety within Northampton General Hospital (The Trust), and an analysis of the health and safety performance during the financial year of 2018 – 2019.

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

- Trust Health and Safety Committee (Quarterly meetings – moved to monthly from May 2019)
- Annual Board report
- Quality Governance Committee (Quarterly reports)
- Assurance, Risk and Compliance Group (Corporate risk rating 15 or above)
- Divisional and Directorate reports (6 monthly)
- Directorate/Corporate Quarterly health and safety inspections
- Internal and external audits
- Proactive site visits (face to face communication)

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

This report concludes with a forward look, to outline of the Key Performance Indicators for the financial year 2019/20 based on key elements of theHealth & Safety Management System.

3. External Regulation and Inspection visits

There has 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. 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"

4. Update on Health & Safety Legislation and Guidance

Free For Intervention

The HSE Fee for Intervention is £154 per hour. The FFI is applied if any workplace is in a material breach of health and safety law

HSE Sector Strategic Plans

The HSE Sector Strategic Plans for Healthcare remains the same as the previous year with the key message to "***Go Home Healthy*****".** The plan topics are: Musculoskeletal Disorders, Stress, Depression or anxiety, and Workplace Violence and Aggression.

The Assaults on Emergency Workers (Offences) Act 2018 legislation came into force in October 2018, the aims of which would be:
To protect NHS workforce from deliberate violence & aggression.
Improve training for violent situations To include patients with dementia or mental illness
Promote partnership working between the NHS, Police and Crown Prosecution Service to prosecute offenders quickly
Care Quality Commission will scrutinise violence as part of its inspections (Well Led)

5. Health and Safety Governance

The Trusts Health and Safety Committee meet on a quarterly basis (this has moved to monthly from May 19), with a quarterly summary report provided to Quality Governance Committee.

The following Committees provide assurance reports to the Health and Safety Committee.

- Radiation Protection (Annual)
- Fire Safety (Annual)
- Security (Annual)
- Water Safety Group (Annual)
- Safer Sharps (6 monthly)
- Control of Substances Hazardous to Health (6 monthly)
- Estates (Per quarter)
- Manual Handling/Display Screen equipment (Annual)
- Medical Gases (From January 2019 a quarterly report is to be submitted to Clinical Quality Effectiveness Group)
- Occupational Health (Annual)

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

6. Health & Safety Audits

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

- Review of quarterly inspection checklist and action plans
- Health & Safety Management and the Control of Contractors
- Review of Risk and COSHH assessments within Clincial Areas

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

7. Divisional Health & Safety Management Reporting

The Divisions are required to provide the Trust Health & Safety Committee with a 6 monthly assurance report, to provide assurance regarding the monitoring and management within the Division and to escalate any Health & Safety matters or concerns as deemed appropriate for the attention of the committee.

Attendance at the Health and Safety Committee has been noted as being poor. As set out in Table 1 below. In order to address the matter the frequency of the Health and safety committee will be revised, and the Divisional reporting template is being re designed, to enable a more structured form of reporting.

Table 1 Attendance at the Health and Safety Committee April 18 – January 2019

	April 18	July 18	October 18	Jan 19
Surgery	Part meeting	Attendance	Apologies sent	Attendance
Medicine and Urgent Care	Part meeting	Apologies sent	No Attendance	Attendance
Women, Children, Oncology, Haematology & Cancer Services	No attendance	No attendance	Deputy in attendance	Deputy in attendance
Clinical support services	Apologies sent	Attendance	Attendance	Attendance

Each division is required to have their own local departmental Health & Safety meetings to ensure health and safety issues are discussed managed and items escalated as appropriate.

- The following information has been noted; Surgery has not had local health and safety meeting during the 12 month period.
- Medicine and Urgent care have had two meetings.
- Women, Children, Oncology, Haematology & Cancer Services review health and safety at Governance meetings.
- Clinical Support Services have separate meetings for Pharmacy and Pathology. Other areas of CSS do not have separate Health and Safety Committee meetings. The revised format of reporting will identify how health and safety is discussed within these areas

8. Health & Safety Inspections

Divisional compliance for returning quarterly health and safety inspections are shown in Table 2 and 3. There has been an overall decrease in the number of inspections returned across all areas, which evidences less engagement across the Trust than the previous year of 2017/18.

The results are a concern, as the health and safety inspection process is the method whereby Divisions provide assurance to the Trust that health and safety issues are being raised, managed and escalated at the appropriate Directorate level.

The quarterly H&S inspections cover:

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

Table 2 Health and Safety Inspection returns (Three years)

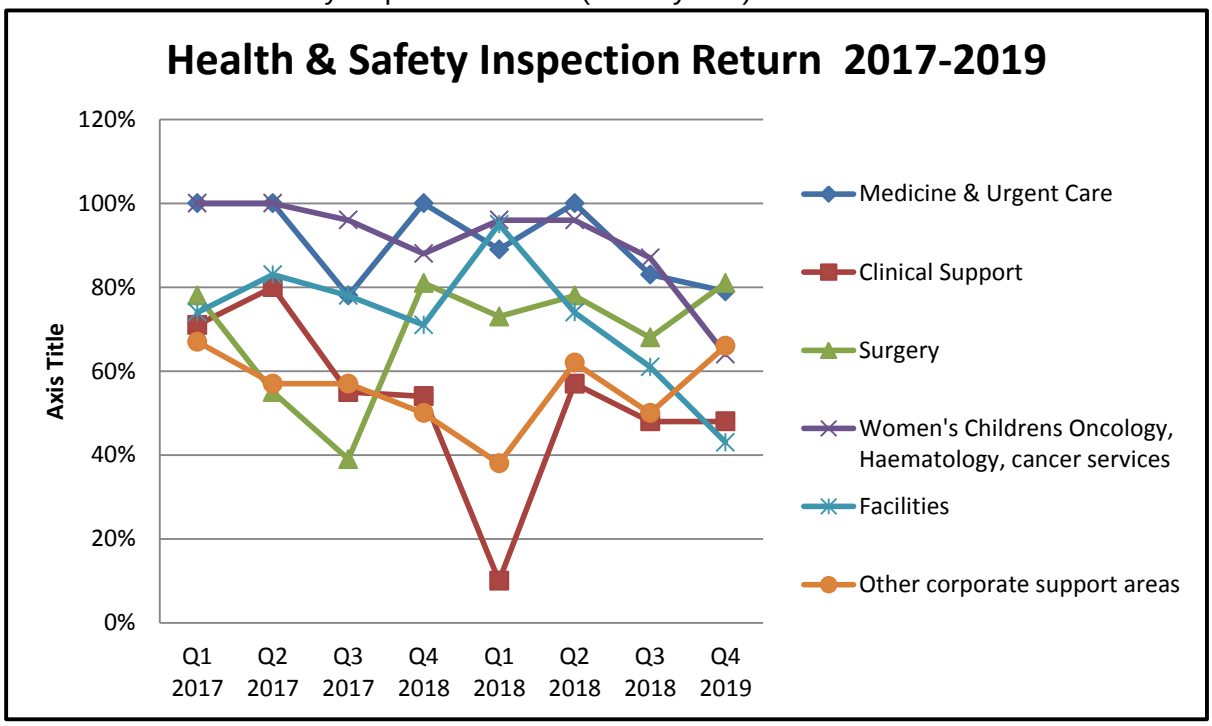


Table 3 Health and Safety Inspection by division April 18 – January 19

Division/Area	Compliance level % (April 18)	Compliance Level% (July 18)	Compliance Level (October 18)	Compliance Level (January 19)
Medicine & Urgent Care	89	100	83	79
Clinical Support	10	57	48	48
Surgery	73	78	68	81
Women's Childrens Oncology, Haematology, cancer services	96	96	87	64
Facilities	95	74	61	43
Other corporate support areas	38	62	50	66

70%	
50-70%	
Under 50%	

The key performance indicator of 70 % compliance rate was met by one Division Medicine and Urgent Care. The Key Performance Indicator was not met for all Quarters in the financial year

The subject has been discussed with the Chair of the Health and Safety Committee, the Health and Safety Manager and the Head of Governance. To improve reporting for 2019/2020 the Divisional reporting template submitted to the Health and Safety Committee is being updated/simplified and the inspection compliance rate is being increased to the figures shown Table 3. The Chair of the Health & Safety Committee has arranged meetings with the Divisional Directors to escalate the matter

9. Polices

Two health and safety policies/procedures have been reviewed and revised during the year by the Health & Safety Department and ratified by Procedural Documents Group:

- NGH-PO-246 Health and Safety Policy
- NGH-PC- 801Reproting of Injuries Diseases and Dangerous Occurrences (RIDDOR) has been updated to include the Memorandum of Understanding between the CQC and the HSE

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

The total number of RIDDOR reported incidents over a three year period have increased to 26. (Table 4)

Table 4: RIDDOR Reportable Incidents.

Year	2016/17	2017/18	2018/19
No of RIDDOR Reportable Incidents	**24**	**24**	**26**

A total of 24 staff incidents, 1 to a member of the public, and 1 Dangerous Occurrence incident were reported to the Health & Safety Executive under the above regulations. Incident analysis detailed in Appendix 2.

All incidents that are RIDDOR reportable are analysed through a health and safety initial assessment form and, for sharps injuries a World Health Organisation Route Cause Analysis template.

A new initiative has been developed to address the continued level of incidents of Violence, aggression and restrictive interventional practices. See section 9.3 for more detail.

Late reporting of Incidents to the Health & Safety Executive

The RIDDOR regulations have strict criteria for reporting incidents (NGH-PC-801)
During 2018/19 the number of reportable incidents to the Health & Safety Executive within the specified time criteria decreased from 79% (19) to 65% (17).

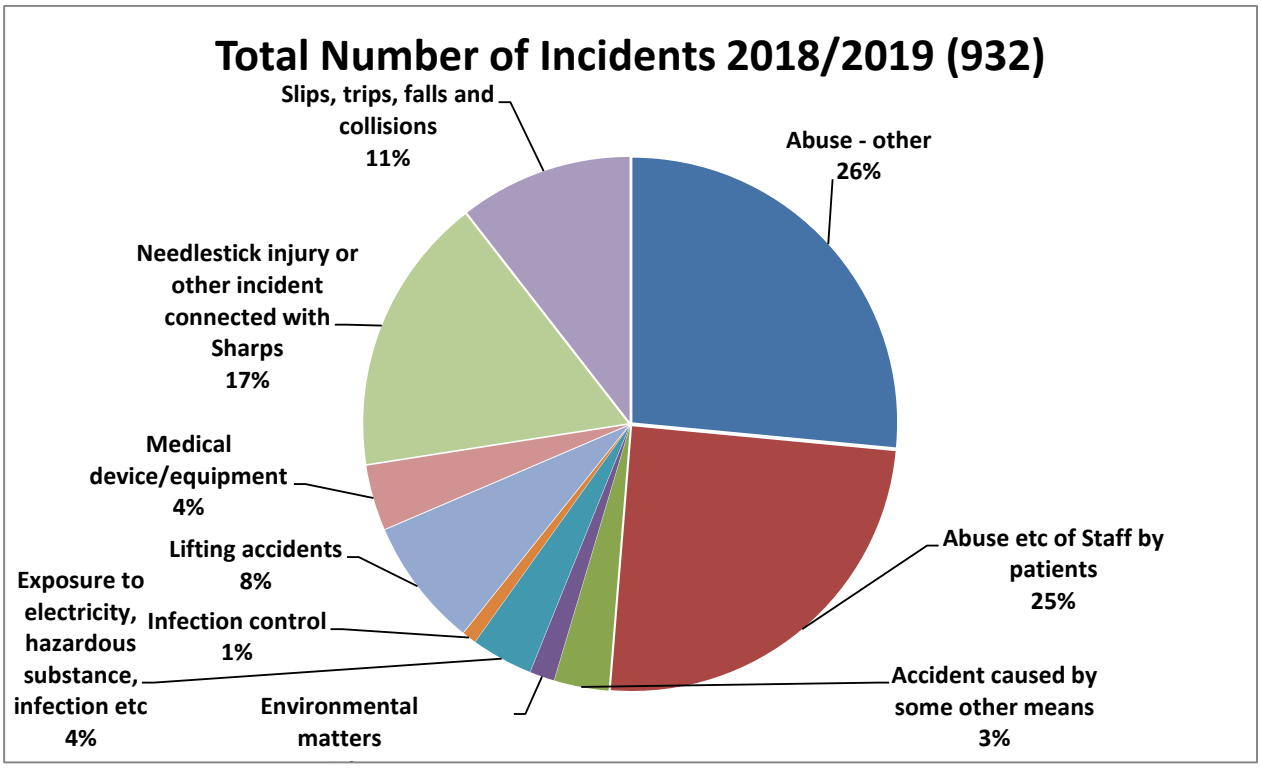
There are two reasons a) staff go off sick from work and do not inform their line managers until they return to work that they are off due to a work related injury. b) Datix forms are not completed when the injury/incident occurs

The Health and Safety Department continues to raise awareness of reporting through the newsletters, communications and Quality Street.

Total Incident rates (staff accident and injuries, specified incidents to patients)

For the period 1st April 2018 to 31st March 2019 a total of 932 incidents were recorded for staff and members of the public.
The figure is an increase on the previous year of 3% (See Figure 1 and Table 5)

Figure 1 total number of Incidents 2018/2019



Aggression Violence abuse remains at 52% of all incidents for the third year

A comparison of the top five incident categories does not indicate a significant increase overall across all categories, except for aggression and violence, and an increase in the level of harm from manual handling incidents.

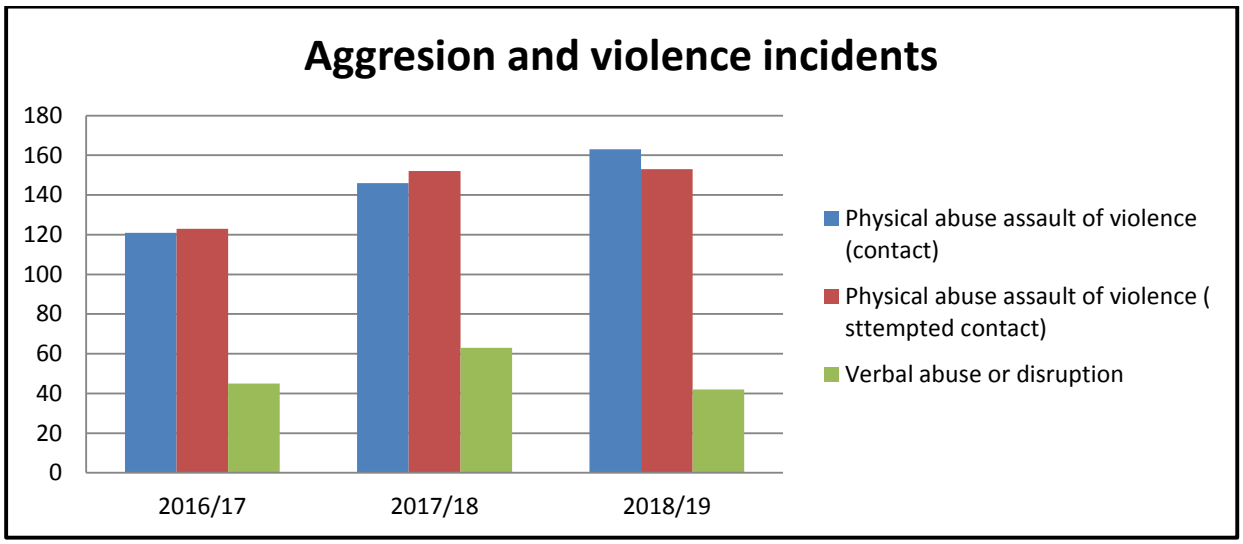
Table 5 Three year comparison of top 5 incident categories

Category	16/17 905	17/18 901	18/19 932
Physical abuse, assault or violence, and unpredictable patient behaviour	423 47%	469 52%	478 52%
Injuries from contaminated sharps	152 17%	111 12%	158 17%
Manual handling/ musculoskeletal	76 8%	88 10%	73 8%
Slips trips falls (excluding patient falls)	81 8%	47 3%	98 10%
Contact with electricity, exposure to hazardous substances	0 0%	16 4%	35 4%

Incidents of Aggression, Violence and Challenging Behaviour and review

Fifty two percent (478) of all reported incidents relate to aggression, violence and challenging behaviour in the workplace. Figure 2

Figure 2 Aggression and Violence incidents to Trust Employees three years



The number of incidents of aggression that resulted in a physical assault and contact made were 34% (163). Fourteen assaults are made by a visitor to staff, and 32% (152) incidents where there is no contact made.
The Trust is not made aware of prosecutions relating to members of the public.
There were 3 incidents of violence and aggression against Trust Security staff that resulted in prosecution.

There were 153 accounts of verbal abuse and aggressions account for the remaining number of incidents.

The members of staff who are most likely to be assaulted are Security Staff, Health Care Assistants and Nurses.
A sub group of the Health and Safety Committee was formed in January 19 to discuss and analyse incidents of aggression and where restrictive physical intervention was used.

The Deputy Director of Nursing is now chairing the group, supported by nominated members of Clinical and Non-Clinical staff. The Group will discuss themes surrounding aggression and violence, to review the patient pathways, education and training for staff and reviewing the provision of support and feedback to staff the group will report to CQEG and to the HSC for staff related incidents

Sharps Incidents and review
The Safer Sharps group continues to monitor trends in sharps/ needlestick injuries and incident reporting. And evaluate alternative safer devices that may reduce sharps related incidents

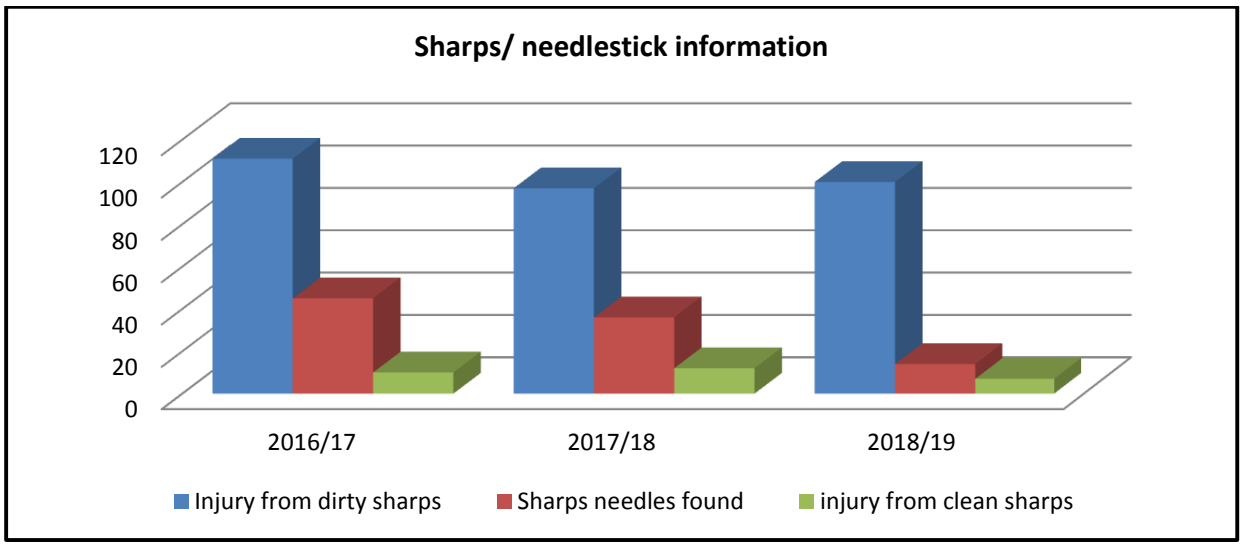
Incident reporting
The Sharps Safety Group review incident trends and follow up at ward or departmental level to raise awareness on the importance of using safer sharps devices and clinical practice. All sharp-related incidents have been presented on a monthly basis to the Infection Prevention Operational Group since September 2018 to share the learning and themes with the Matrons.
The number of RIDDOR reportable incidents has reduced from 6 to 4 over the last three years Figure 3

Incident Monitoring has resulted in

- 1-2-1 training for staff to reduce the risk of reoccurrence.
- The elimination of the number of incidents of sharps being found in public toilets within the Trust

The number of incidents relating to suturing remains the same as currently there is no viable safer sharps alternative to be used.

Figure 3 Sharps needle stick related incidents (three year)



Occupational Health provided information regarding nurses are the most likely group of staff to receive a sharps related injury, followed by Doctors and support services

Manual Handling/ Musculoskeletal Incidents and review

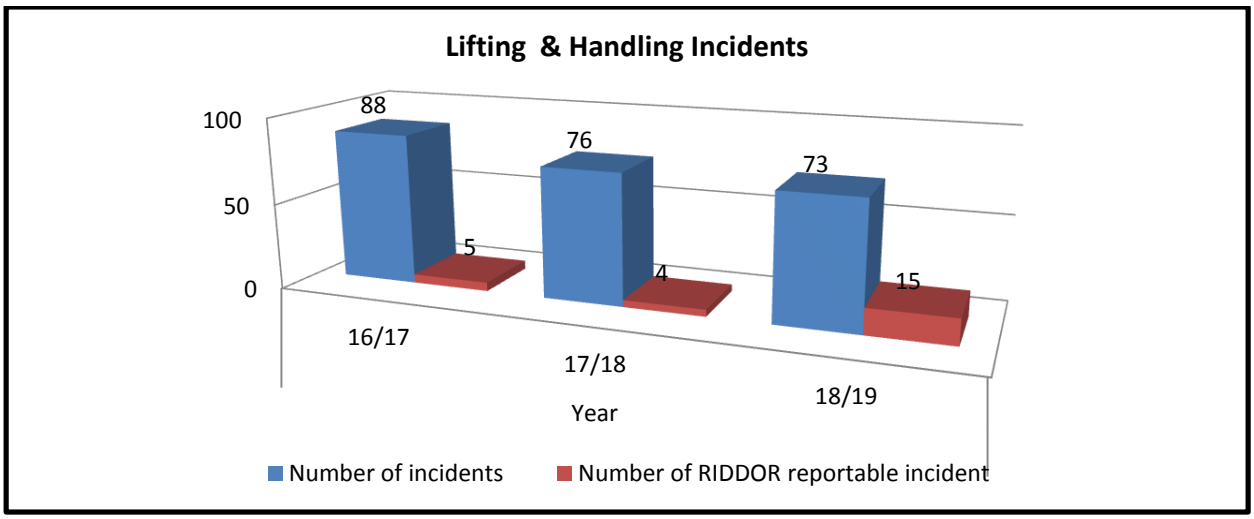
The Trust workforce undertakes a significant number of manual handling operations. The current incident figures are shown in Figure 4

A total of 73 incidents relating to manual handling which is a decrease in the overall numbers, however there was an increase in the number of RIDDOR reportable incidents from 4 to 15 due to musculoskeletal injuries.

The increase has due to:

- Patient Movement e.g. turning patient in bed
- Mobilising patients into the Nye Bevan unit,
- The use of equipment
-

Figure 4: Lifting and Handling/Musculoskeletal incidents 3 years



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

All injuries resulted in staff members not being able to work for 7 or more consecutive days. Three employees were not able to work for more than 3 months due to the nature of the injuries, and the nature of the work that was being undertaken. E.g. a shoulder injury for a nurse who works in a busy clinical setting

All departments have been asked to investigate the incidents and put in action plans to prevent a re occurrence.

Display Screen Equipment incidents
There has been a total of 6 Datix related to staff members falling off office chairs.

Trials were made looking at a variety of castors on office chairs including Brake Loaded, Brake Unloaded and Glides. In most cases wards/departments chose to change some or all of their office chairs to a more suitable castor type. Staff were advised on how to sit safely, avoiding dropping onto the chair without first checking the chair is in position.

11. Health &Safety Training

All employees are required to have Health and Safety Awareness training as part of the Trust mandatory training program. A health and safety refresher course is mandatory every three years

During the year a total of 1670 trust employees have completed some form of health and safety training providing an 88%completion rate (Table 6)

Table 6 Training information

Health & Safety Training	**2016/2017**	**2017/18**	**2018/19**
Health & Safety training, induction and refresher	86.6%	84.8%	88%
Manual handling	83%	85%	85%
Conflict resolution training* staff	77%	81%	83%

In addition to mandatory Health and Safety training, specific training courses were provided by the health and safety department to include:

- Annual Board health and safety training
- Volunteer awareness training
- COSHH assessment training

The health and safety department continues to offer face to face training within clinical areas, to monitor health and safety training requirements

12. Communication

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

The Health & Safety Calendar continues to promote health and safety topics through the newsletter and risk assessments for topics from the Health & Safety Calendar see Appendix 3.

13. KPI Performance

No	KPI 2018/19	Status	Details
1	At least 3 Compliance Audits Completed	KPI Achieved	3 compliance audits completed
2	70 % compliance rate achieved for quarterly H&S inspections for each Division and area	Not achieved	Not achieved in 3 of the 4 Divisions and the Corporate areas. Only achieved in Medicine and Urgent Care The template for the health and safety reporting schedule is being amended
3	100 % H&S Policies in date	KPI Achieved	Of the 12 policies, all were in date at the end of the year 2018/19
4	85% staff are up to date with their mandatory health and safety training in line Trust target.	KPI achieved	
5	To develop and implement a health and safety training program for Senior Managers	KPI partly achieved	The course has been developed and written. There is a power point presentation and work book the sessions can be face to face or by completion of the workbook. Dates to be issued shortly
6	To Develop and implement a health and safety training program for health and safety leads	KPI achieved	

14. Health and Safety Plan for 2019/20 Forward plan

The Key Performance indicators for the 2019/20 are:

No	KPI 2019/20	Status	Details
1	To implement an audit program to ensure 3 Compliance Audits Completed		
2	To ensure 100 % H&S Policies in date		
3	To maintain a level of 85% staff are up to date with their mandatory health and safety training		
4	To deliver a Health and Safety Training program for Senior Managers on roles responsibilities and accountabilities		
5	To improve Health & Safety inspection returns to >85%		
6	To improve attendance and 6 monthly reporting at Health & Safety committee to >85%		

Appendix 1 – H&S Committee Assurance Summary Reports

Sub committee	Frequency of report	Chair
Control of Substances Hazardous to Health	6 monthly	Matron Surgery
Estates/Facilities	Quarterly	Head of Estates & Compliance Manager
Fire Safety	Annual	Head of Estates
Manual Handling and ergonomics	Annual	Manual Handling lead/Trust Physiotherapists/Health & Safety Manager
Occupational Health	Annual	Deputy Occupational Health Manager
Radiation Protection	Annual	Radiation Protection Advisor
Safer Sharps	6 monthly	Infection Prevention
Water Safety	6 monthly	Head of Estates
Security (aggression, violence & restrictive intervention)	Annual	Local Security Management Specialist

1. Radiation Protection (Annual)

The Trust has registered work with x-ray generating equipment with the Health and Safety Executive in 2018 as required by the Ionising Radiations Regulations 2017.
The Trust sought consent from the HSE for its work with radioactive materials and operation of accelerators in 2018 as required by the Ionising Radiations Regulations 2017.

Departments throughout the Trust have undertaken a gap analysis exercise with respect to the updated Ionising Radiations Regulations. This has highlighted the need for:

- More radiation protection supervisors. Staff members who could undertake this role have been identified and a training course will be provided by imaging physics.
- The need to formally appoint radiation protection supervisors. Departmental managers have been made aware of this requirement.
- Additional radiation safety training. Training material has been supplied and radiation safety is now included at staff induction.

A new radiation policy has been drafted to clarify and consolidate a number of existing policies. This will be ratified by the radiation protection committee.
Staff doses for 2018 were below statutory dose limits.

Additional staff dose monitoring has been undertaken in order to further demonstrate compliance with the statutory dose limits, specifically:

- monitoring of vascular surgeons
- extremity monitoring of interventional radiologists
- eye monitoring of radiopharmacy technicians.

Audits of compliance with the Ionising Radiations Regulations 2017 have been undertaken with respect to:

- sealed radioactive sources
- external beam radiotherapy
- the Northampton Positron Emission Tomography centre

Radiation risk assessments and local rules have been updated throughout the Trust to reflect the changes in legislation.

2. Safer Sharps (6 monthly)

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

All non-safer sharps risk assessments have been reviewed during 2018
The Group select, review and trial any new safer sharps device
One to one training is provided in clinical areas if there is a trend identified in sharps incidents.

Specific training is due to be provided for maternity regarding the use of PPE to protect from blood splashes

Talbot Butler ward were provided with infection prevention training and waste disposable awareness after an increase in the number of waste disposal incidents.

3. Estates(Quarterly)

A number of the Estates health and safety Risks are monitored through the Assurance, Risk and Compliance Group. Reports are brought to the health and safety committee to update on progress against the action log.
Specific Estates Compliance Board report was presented separately

4. Fire Safety (Annual)

Specific Board report presented separately. Exception reporting is provided after a fire incident.
As separate weekly Fire Safety Task and Finish Group, chaired by the Trust Finance Director has ran since May 19.

5. Local Security Management Specialist, Security (Annual)

Specific Board report presented separately. The LSMS report presents statistical information on aggression, violence and assaults.
The 2018/19 report will include information on the number of physical interventions that the security staff undertake, to enable a holistic view of all incidents that occur in the trust.

6. Water Safety Group (Annual)

The water safety group monitor compliance with the safe management of water legislation across the Trust
The Health and Safety Committee monitors information Legionella assurance and compliance to the Approved Code of Practice L8.

The Trust currently has an external company undertaking a Legionella audit and Risk Assessment.
This group also reports into the Infection Prevention Steering Group.

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

The Trust's compliance to the Control of Substances Hazardous to Health (COSHH) regulations is coordinated and managed by the COSHH group to reduce the risk of harm and ill health to staff and patients so far as is reasonably practicable from exposure to Hazardous Substances.

The achievements of the Group this year have covered

Sixteen COSHH audits undertaken across the Trust, with 80% compliance to the completion of checklists

The generic COSHH assessments have been increased from 6 to 8. The new COSHH assessments are for latex and blood borne viruses. All COSHH assessments have been reviewed and are available on the health and safety intranet page.

A selection of COSHH assessments were shared with members of Health Safety and Wellbeing Partnership group of NHS Employers

All generic COSHH assessments are reviewed on an annual basis. Review of the new EH40/2005 Workplace Exposure Limits which came into force August 2018.

COSHH incidents are reviewed and learning shared with the group and the wider forum

8. Manual Handling/ Display Screen Equipment (Annual)

The Manual Handling Policy has been updated and ratified and the Manual handling risk assessments have been updated.

The manual handling team continue to:

- Promote the use of slide sheets when moving/turning patients and inserting/removing slings to reduce the risk of sheering, friction and/or pressure damage to patients

- Raise awareness of the Patient Handling Care Plan Risk Assessment paperwork to remind managers and staff about the importance of use and consequences of not keeping information up to date

- Monitor of the legal requirements of carrying out checks on hoists and slings, under Lifting Operations and Lifting Equipment Regulations 1998, and what to do if they does not meet the LOLER Regulations

- Monitor the movement and mobilising of the Bariatric patient, from admission through to discharge planning, techniques, equipment and staffing levels

Display Screen Equipment

A total of 14 complex assessments and 24 DSE assessments have been undertaken in the last 12 months
A total of 95 chair assessments have been undertaken
A total of 73 eye care vouchers have been issued

9. Medical Gases Committee (Annual)

A new Chair was appointed for the Medical Gases Committee and they have met regularly in 2019. The Terms of Reference were approved and all reports are now fed through Clinical Quality and Effectiveness.

10. Occupational Health

The Deputy Occupational Health manager provides updates to the committee. A specific Board report presented separately.

Appendix 2: RIDDOR reportable incidents
The total number of staff related reportable incidents were 26 a breakdown of the nature of the incidents are detailed below
RIDDOR incidents (1st April 18 – 31st March 2019)

Type	Location	Causal factor
Fall x 1	Pharmacy	Fell off chair
Struck by object x 1	Althorp	Struck door
Lifting and handling injury x 15	Sterile Services	Moving equipment
	Nye Bevan	Mobilising patient
	Ester white	Mobilising patient
	Nye Bevan	Lift Breakdown
	Common area	Mobilising patient
	Common area	Mobilising patient
	ITU	Moving equipment
	HDU	Moving patient
	IT	Moving equipment
	Finedon ward	Moving patient
	Creaton	Moving patient
	Knightly	Moving patient
	Day Surgery	Moving patient
	Child health	Moving patient
	Mansfield Theatre	Moving patient
Physical assault x 3	Cedar	Patient had dementia
	Collingtree	Deliberate assault
	Esther White	Deliberate assault
Dangerous Occurrences	Location	
Accidental release or escape of substances liable to cause harm	Estates	Asbestos Management Survey
Hep C X 1	Collingtree	Blade
HIV x 3 (low viral load)	Main Theatre	Suture
	Sturtridge	Blood splash
	Finedon	Dialysis
Members of the public	**Location**	**Causal factor**
Slip, stumble, fall x 1	Holcot	Tripped over equipment

Appendix 3 Health & Safety Calendar Topics for 2018/19

Month	Topic
April	First Aid & incident reporting including RIDDOR
May	Slips Trips and Falls Working at Height
June	Security Lone Working Aggression Violence & Unpredictable Challenging behaviour
July	Fire Safety
August	Waste management including sharps disposal
September	Manual Handing & Ergonomics'
October	Occupational health & Health & Wellbeing
November	Workstation Office Safety workplace health Safety & Welfare
December	Provision and Use of Work Equipment
January 19	Health & Safety roles, Responsibilities and Accountabilities
February	Risk Assessment & Risk Profiling
March	Medical Gas and Cylinder Safety

Northampton General Hospital NHS Trust

Finance & Performance Committee

Estates Compliance & Risk Monthly Update - April 2019

1. Purpose

This report provides the Committee a monthly update on the Estates Compliance & Risk report which was presented to the March 2019 Private Trust Board.

2. Introduction

This report highlights key themes and messages to help contextualise the risks and actions to move to a safe and compliant position. This report should be read in conjunction with the Estates Compliance & Risk report which was presented to the March 2019 Private Trust Board.

This month's report will focus mainly on progress and ongoing challenges for Managing Healthcare Fire safety. Unless explicitly stated the level of risk and assurance remains the same.

Potentially the greatest risk to this plan is the lack of the right people to fill the structure. A number of additional Estates management posts have been agreed and are in the process of being advertised. In the meantime additional support has been brought in through the use of agency staff.

3. Managing Healthcare Fire Safety

A fire compartmentation survey was commissioned in 2018, with the draft findings received May 2019. The reports will need validating, but the initial findings indicate that there are:

- £424k of new fire doors
- £33k of door repairs
- £143k of fire damper work
- £1.6million of major breaches

The Estates 5 year capital plan includes £3.98M expenditure for statutory fire safety. It is important to note that in addition to the above estimated costs there are further upgrade works included within that figure.

There is significant work required to reinstate fire compartments with the priority being 60 minute compartments in inpatient areas. Estates are working with nursing and operational staff to put in place additional operational mitigations. To manage the extent of the work summarised above will take a number of years to resolve and will require specialist fire engineering support and project management. Estates are reviewing how best to manage the reinstatement of the fire compartments.

The actions identified below will move fire safety to limited assurance; however it is unlikely to reduce risk due to the issues with the fire compartmentation, the fire alarm system and the fact that training will take time to embed.

At present there is one person managing these actions and fire overall, interviews are arranged to employ one or two additional staff off agency, alternatively a fire management consultancy will be commissioned.

Items 1 to 4 are linked to major issues with the fire alarm system across the site. The existing fire alarm maintainer are no longer used, and a new company in place as of April. These issues also link to poor commissioning and maintenance. New issues are being found on a regular basis, the latest issue is there are no working sounders in the Luke building. As issues are being found by the new maintenance provider they are being addressed as a priority.
The Estates team is also continuing their weekly fire system checks.

Item 5 is a key aspect of the Trust's fire safety plan. A recent activation of the fire alarm system resulted in areas being unnecessarily evacuated, this is due to insufficient understanding of fire management and roles and responsibilities.

Item 10 – The development of a prioritised plan to reinstate fire compartmentation across the site is complex and requires someone with the right expertise to manage this initially full time. Each fire compartment line will need to be certified. The Trust will be looking to employ a company to undertake this work off a framework. Fire compartmentation will be prioritised to address 60 minute fire compartments first where possible addressing inpatient areas first. A main challenge with this work is the disruptive nature of the work and the high level of asbestos across the site; this could well alter and delay reinstatement of the fire compartments. Where wards are decanted fire compartmentation will be addressed.

Managing Healthcare Fire Safety			
Risk	25	**Overall Assurance**	No assurance
Key Actions – ***Recommendation; by the end of June if the following actions are in place assurance may move from No assurance to Limited assurance, after which the risk should be reviewed to consider if it is right to move back to a risk rating of a 20.***			
	Actions to move to Limited Assurance	**Status**	**Update**
1	Identify Fire doors that don't close on activation of the fire alarms	Complete	This work was completed beginning of April
2	Identify fire doors that don't unlock on activation of fire and/or don't have alternative means of unlocking	Ongoing	Further update for end of May, as this is complex
3	Make temporary modifications to fire doors that don't close on activation of the fire alarm system	Complete	Where feasible this has been completed. There are areas where this has not been possible. c40% complete
4	Make temporary modifications to doors that don't unlock on activation of the fire alarm system	Ongoing	Alterations have been made but verification is required.
5	Ensure that fire response team is sufficient resourced at all times and trained	Started due to complete May	Meeting has taken place with the site team. Site are now starting to attend. Further changes to be made for Estates manager to attend fire response. Training requirements are to be put in place: Estates, Portering, and Security & Site team. To be completed mid May.
6	Tender fire door maintenance, appoint contractor to undertake maintenance to all fire doors	Appoint from framework – June 2019. Then 9 month risk based	Following the review of the fire maintenance issues, a contract has been agreed with a new Fire maintenance company which is now in place.

		rolling programme to complete, then annual programme	
7	Review and modify fire evacuation plans for all inpatient areas	Started due to complete end of June	Additional resources are being looked at either via agency or consultancy.
8	Provide training to all inpatient areas for fire evacuation, which is then cascaded throughout ward teams by lead person within each ward team	Started due to complete end of June	Additional resources are being looked at either via agency or consultancy.
9	Tender fire risk assessments/Inspections, appoint contractor to undertake fire risk assessments/inspections	Appoint from framework – June 2019. Then 6 month risk based rolling programme to complete. Thereafter annual inspections will be either carried out in-house or via a contractor.	Additional resources are being looked at either via agency or consultancy.
10	Develop a prioritised plan to address fire compartment breaches	June 2019	Initial high level review has been undertaken, but there are c4500 breaches
11	Appoint person to undertake face to face annual fire training until full review is undertaken as insufficient resources to do the above actions and deliver training	June 2019	Band 5 interviews 23/24th April
12	Appoint to the following posts; band 8a Business & Compliance Manager, band 7 Fire Officer and band 5 Trainee Fire Officer/Trainer	December 2019	Adverts due to go out 18th April, this has slipped and will go out in May. Agency interviews over the next two weeks for interim.

4. Other Updates

A weekly Fire Safety Task and Finish Group has been implemented from early May. The initial meeting was Chaired by the Trust CEO with subsequent meetings Chaired by the Director of Finance.

Appendix one shows the summary of risks and assurance for Estates and appendix two shows the summary of the number of actions which require completion. Movement on the

actions in appendix two require additional resources to address; adverts to fill additional posts will be advertised in the next two weeks.

Future reports to this committee will provide more detailed updates on other non fire action plans.

5. External Review

Recommendations within the Estates Compliance & Risk report presented to the March 2019 Private Trust Board include regular monitoring at the Finance Committee and an external peer review of the report, it's finding and actions.

An NHS Director of Estates and Facilities has been engaged and has attended site to begin the peer review. Additional maintenance and fire safety experts have been commissioned as part of that review and will be carrying out an in-depth specialist review during early May with a written report to follow.

Appendix 1 – Summary of Risk & Assurance

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Subject	Risk Score	Overall Assurance		Limited assurance	Reasonable assurance	Substantial assurance
Governance		Limited assurance		N/a	July 2020	2021
Managing Healthcare Fire Safety	25	No assurance		June 2019	July 2020	2022
Asbestos Management	20	*Historical*	*Current*	Current		
		No assurance	Reasonable Assurance	N/a	N/a	April 2020
Safe Water in Healthcare Premises	12 *(Currently being reviewed and likely to increase following Internal Audit Report)*	Limited assurance		N/a	December 2019	April 2020
Electrical Systems	20	Limited assurance		N/a	August	2021
Specialist Ventilation Systems for Healthcare Premises	15	Limited assurance		N/a	April 2020	2021
Medical Gas Pipeline Systems	20	Limited assurance		N/a	April 2020	2021
Control and Management of Contractors	Risk assessment required	*Trust*	*Estates*	Estates		
		Limited assurance	Limited assurance	N/a	April 2020	2021
Maintenance of Assets	Risk assessment required	No assurance		April 2020	August 2020	2021
Projects & Project Management	20	Limited assurance		N/a	April 2020	2021
Backlog & Functional Suitability of the Estate	20	*Backlog*	*Functional Suitability*	Backlog		
		Reasonable Assurance	Limited assurance	N/a	N/a	2021
Estate Structure & Staff	20	Limited assurance		N/a	April 2020	2021

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Appendix 2 – Summary of Actions (updated 7th May 2019)

	Indicator	Oct-18	Nov-18	Jan-19	Feb-19	Mar-19	Apr-19
HTM00 Policies and Principles of Healthcare Engineering (Kevin)	No. of actions open	51	51	51	51	51	51
	No. of actions due	8	27	37	41	50	50
	No. of actions over due	8	27	37	41	50	50
	No. of Actions over due by > 3 months	0	8	16	19	27	41
	No. of Complete Actions	0	0	0	0	0	0
HTM02 Medical Gases (Simon)	No. of actions open	92	91	91	91	91	83
	No. of actions due	73	91	91	91	91	37
	No. of actions over due	73	91	91	91	91	37
	No. of Actions over due by > 3 months	51	72	85	91	91	36
	No. of Complete Actions	0	1	1	1	1	9
HTM03 Ventilation (Paul)	No. of actions open	22	22	22	22	22	22
	No. of actions due	17	22	22	22	22	22
	No. of actions over due	17	22	22	22	22	22
	No. of Actions over due by > 3 months	14	17	22	22	22	22
	No. of Complete Actions	1	1	1	1	1	1
HTM04 Water (Paul)	No. of actions open	39	32	22	24	30	30
	No. of actions due	29	17	14	16	17	23
	No. of actions over due	29	17	14	16	17	21
	No. of Actions over due by > 3 months	10	3	8	8	9	16
	No. of Complete Actions	20	38	76	74	76	76
HTM05 Fire (James)	No. of actions open	92	87	87	87	88	88
	No. of actions due	54	68	68	68	78	80
	No. of actions over due	54	68	68	68	78	80
	No. of Actions over due by > 3 months	41	49	60	60	70	71
	No. of Complete Actions	9	14	14	14	13	13
HTM06 Electricity (Mark)	No. of actions open	23	13	10	10	10	10
	No. of actions due	23	13	10	10	10	6
	No. of actions over due	22	13	10	10	10	6
	No. of Actions over due by > 3 months	19	13	10	10	10	6
	No. of Complete Actions	2	12	2	2	2	0
Asbestos (Tony)	No. of actions open	37	37	37	35	38	38
	No. of actions due	26	36	36	34	25	26
	No. of actions over due	26	36	36	34	25	26
	No. of Actions over due by > 3 months	21	26	27	25	25	25
	No. of Complete Actions	17	17	17	19	29	29
Control of Contractors (Tony/Paul)	No. of actions open	0	0	0	0	22	22
	No. of actions due	0	0	0	0	0	3
	No. of actions over due	0	0	0	0	0	3
	No. of Actions over due by 3 months or more	0	0	0	0	0	0

	No. of Complete Actions	0	0	0	0	0	0
Risk Register (Kevin +all)	**In holding area, awaiting review**	2	5	5	5	3	3
	Being reviewed	7	7	9	9	8	7
	Awaiting final approval	2	4	2	2	2	4
	Being approved	1	2	2	2	1	1
	Open Final approval	34	33	33	34	33	34
	Overdue Review	18	19	21	23	17	14
	Closed in the last month	0	0	2	0	4	1
Incidents (Kevin +all)	**In holding area, awaiting review**	10	13		20	11	8
	Overdue	4	10		8	8	2
	Being reviewed	14	12		16	23	21
	Overdue	11	12		11	22	13
	Awaiting final approval	8	11		17	18	12
	Overdue	8	11		13	18	12
	Being approved	0	0		0	0	0
	Overdue	0	0		0	0	0
	Closed /Approved in the last month	18	20		22	15	16

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30th May 2019**

Title of the Report	**Freedom to Speak Up Annual Report and Quarter Q4 Report**
Agenda item	**18**
Presenter of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Author(s) of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Purpose	The report provides an update into the work of in respect to the Freedom to Speak Up requirements and on going work to support this agenda.
Executive summary The report provides the background to the introduction of Freedom to Speak Up and progress made to develop clear systems and process at Northampton General Hospital. It provides information on concerns raised in quarter 4, as well as 2018/19. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised. The report provides an overview of the Trust Guardians role since commencing in post. It outlines the development of the Values Ambassador roles and links, publications and work with the National Guardians' Office are also highlighted.	
Related strategic aim and corporate objective	Focus on Quality and Safety Enabling Excellence through our people
Risk and assurance	The report provides assurance that the Trust is meeting its legal duties with respect to Freedom to Speak Up.
Related Board Assurance Framework entries	BAF 1 BAF 2
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	There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.
Actions required by the Board The Board is asked to: • Note and comment on the content of the report, and accept this paper for information and assurance.	

FREEDOM TO SPEAK UP ANNUAL REPORT (INCORPORATING Q4 REPORT)

1. INTRODUCTION

In February 2015 the recommendations of "Freedom to Speak Up" (Chaired by Sir Robert Francis QC) were published. The review concluded that there was a serious issue in the NHS that required urgent attention if staff are to play their full part in maintaining safe and effective services for patients.

A number of recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns.

The agreed reporting route for Freedom to Speak up at the Trust is the Workforce Committee (quarterly) with a bi-annual report to Trust Board. The Freedom to Speak Up Guardian maintains a case log, to oversee the management and timeliness of investigations and outcomes and ensure the Trust policy is followed.

2. FREEDOM TO SPEAK UP CASES (JANUARY- MARCH 2019)

Within the quarter being reported, 16 Freedom to Speak Up cases were received. This is a huge increase on the previous quarter (1).

Content of cases reported:

- 5 cases identified issues with patient safety/ quality
- 2 cases identified issues with staff safety/ Training
- 9 cases identified issues with bullying and harassment
- 7 cases identified issues with systems, processes or policies
- 1 case identified issues with environment/ infrastructure
- 7 cases identified issues with workplace culture
- 5 cases identified issues with leadership
- 2 cases identified issues with use of resources

Cases reported by/ to:
14 cases were reported to the Guardian direct
1 case was received from the Director of Workforce & Transformation
1 case was received from the Acting CEO

Of the above cases;

- 6 remain open with ongoing investigations/ or report write up underway
- 4 referred to HR or within an HR process
- 2 referred to Fraud

1 case where the individual indicated they are suffering detriment as a result of speaking up.

Source of concerns raised by staff group:

- Doctor x1
- Nurse x 2
- Midwife x 3
- AHP's x 2
- Admin x 1
- Cleaning/ Catering/ Maintenance/ Ancillary staff x 2
- Corporate x 1
- Unknown x 4

12 individuals wish to remain anonymous.

3. FREEDOM TO SPEAK UP CASES (APRIL 2018 - MARCH 2019)

The numbers of cases reported via the Freedom to Speak Up policy for 2018/19 were 22. Cases reported each quarter were as follows:

Quarter 1- Three cases
Quarter 2- Two cases
Quarter 3- One case
Quarter 4- Sixteen cases

The increase in Quarter 4 directly correlates with the organisational relaunch of Freedom to Speak up.

In 2018/19 content of cases were:

- 9 cases identified issues with patient safety/ quality (41%)
- 2 cases identified issues with staff safety/ Training (9%)
- 12 cases identified issues with bullying and harassment (54%)
- 7 cases identified issues with systems, processes or policies (32%)
- 1 case identified issues with environment/ infrastructure (4%)
- 7 cases identified issues with workplace culture (32%)
- 5 cases identified issues with leadership (23%)
- 2 cases identified issues with use of resources (9%)

The data stored nationally does not enable the current Guardian to identify staff groups for Quarter one, therefore providing a full year's data – for the past three quarters the following staff groups reported concerns:

Source of concerns raised by staff group in last three quarters:

- Doctor x1
- Nurse x 3
- Midwife x 4
- AHP's x 2
- Admin x 1
- Cleaning/ Catering/ Maintenance/ Ancillary staff x 2
- Corporate x 1
- Unknown x 5

4. TRUST GUARDIAN ROLE- ACTIVITY IN PREVIOUS SIX MONTHS

- Identified reporting structure and presented quarterly reports
- Met with Lead Non-Executive Director for Freedom to Speak up
- Completed a review and revision of the FTSU Policy
- A re- Launch of Freedom to Speak up within the Trust commenced 16th January 2019 with communication team support
- All data submissions were made before the required deadline (Q2 onwards)
- Met with the Guardian of Safe Working to discuss how we support each other's guardian roles and identify solutions to the challenges faced at a local level
- Identified the need to develop a network of staff within the organisation to support Freedom to Speak up and met with Head of Organisation Development to progress the Values Ambassador role to support both Freedom to Speak up and Respect and Support initiatives
- Met with the GMC representative, and Medical Education Manager to discuss how to improve Junior doctor engagement with FTSU
- Trust Guardian made contact with the East Midlands network to build local relationships and attend future network meetings
- A draft training package prepared and tested on Governance team
- Update training delivered to Junior Doctors as part of induction and ongoing training sessions
- Training opportunities identified with Divisional Directors to increase staff awareness
- Launched the Values Ambassador role- 13 expressions of interest received.

5. NATIONAL GUARDIANS OFFICE

The Trust Guardian has highlighted key documents published by the National Guardians Office as follows:

5.1. Speaking up in the NHS in England

In September 2018 the National Guardians Office published a summary of the 2017/18 data which highlighted the following:

- Between 1 April 2017 and 31 March 2018: 7,087 cases were raised to Freedom to Speak Up (FTSU) Guardians in NHS trusts and foundation trusts.
- The number of cases raised each quarter over the year increased:
  - Q1 (April – June '17) 1,447
  - Q2 (July – Sept '17) 1,515
  - Q3 (Oct – Dec '17) 1,939
  - Q4 (Jan – Mar '18) 2,186
- More cases (2,223, 31% of the total) were raised by nurses than other professional groups.
- Content of cases reported
  - 3,206 (45%) cases included an element of bullying / harassment
  - 2,266 (32%) cases included an element of patient safety / quality
  - 1,254 (18%) cases were raised anonymously
  - 361 (5%) cases indicated that detriment as a result of speaking up may have been involved
  - 6 NHS trusts either did not make a return or reported that they received no cases through their Freedom to Speak Up Guardian in all four quarters.

The full report can be found at: https://www.cqc.org.uk/sites/default/files/20180919%20-%20Speaking%20up%20data%20report%202017%20-18.pdf

5.2 Freedom to Speak Up Guardian Survey 2018:

The National Guardians Office published the results of their most recent survey of Trust and Arm's Length Body Guardians in November 2018, which questioned progress with the implementation of the Freedom to Speak Up Guardian role and perceptions of Freedom to Speak Up Culture in the NHS in England. The survey indicated an apparent correlation between CQC ratings and perceptions of speaking up culture, including responses to the following statements:

- "Speaking Up is taken seriously in my organisation" – 90% of responses were positive in outstanding organisations, compared to 53% in organisations rated inadequate
- "Managers support staff to speak up" – 69% of responses were positive in outstanding organisations, compared to 11% in organisations rated inadequate
- "Senior leaders support staff to speak up" – 84% of responses were positive in outstanding organisations, compared to 47% in organisations rated inadequate.

It found that 42% of guardians responding to the survey indicated that they had no ring-fenced time to carry out their duties. Guardians with less ring-fenced time are less likely to carry out many of the basic functions of the role.

One of the more positive key findings from the survey is a reflection from those that responded that things are getting better, with 83% of Guardians saying the speaking up culture in the NHS had improved over the last 12 months.

Fieldwork for the 2018 Survey took place in June. Results are based on 361 responses (50% response rate) from Guardians. The full report can be found at: https://www.cqc.org.uk/sites/default/files/20181101_ngo_press_release-survey2018.pdf

5.3 National Guardians Annual Report

The report published in November 2018 highlights the progress that the office has made during Dr Hughes' second year and outlines future priorities. These include:

- Recommendations from the 2018 Freedom to Speak Up Guardian Survey to improve how the guardian role is being implemented, including an honest assessment of the time required by guardians to meet the needs of workers.

- Producing a universal guardian job description for organisations in the healthcare system, including independent providers of NHS services and arm's-length bodies, and developing an Education and Training Guide for guardians.
- Developing a post-pilot case review process that continues to support learning across healthcare.

The report also features several case studies highlighting the difference Freedom to Speak Up Guardians are making to the lives of NHS workers and patient safety, including:

- A guardian escalating a case to Barking and Dagenham Council resulting in an investigation into a modern slavery and trafficking ring.
- An NHS trust responding to concerns raised by healthcare workers in prison services to improve the prison's connection with the trust.
- Issues raised regarding the working environment of a surgical laboratory, which impacted on the safety of patients and workers.
- A worker speaking up about poor practice when cleaning spilt body fluids, resulting in a formal alert being raised across the organisation to ensure that all staff knew their responsibilities.

The full report can be found at:
https://www.cqc.org.uk/sites/default/files/CCS119_CCS0718215408-001_NGO%20Annual%20Report%202018_WEB_Accessible-2.pdf

5.4 Case Reviews

The National Guardians office published five case review reports which identified areas for improvement in speaking up processes, practices and culture at NHS Trusts.

All reports are reviewed by the Trust Guardian and (where appropriate) the Director of Workforce & Transformation to ascertain if there is any learning from the recommendations that would improve the speaking up processes and culture at Northampton General Hospital.

6. FURTHER WORK REQUIRED

The following areas of work have been prioritised to further the FTSU agenda at NGH:

- Review of the Trusts self- Assessment and implement areas for development which include the development of an overarching strategy and improvement plan and improved communications with respect to Freedom to Speak up.
- Identify training opportunities/programme within induction for all Trust staff to raise the profile of FTSU in the Trust

7. RECOMMENDATIONS

The Board is asked to note and comment on the content of the report, and accept this paper for information and assurance.

Report To	**TRUST BOARD**
Date of Meeting	**30th May 2019**

Title of the Report	**Self-Certification 2018/19**
Agenda item	**19**
Presenter of Report	Claire Campbell- Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell- Director of Corporate Development, Governance and Assurance
Purpose	NHS Trusts are required to self-certify that they are compliant with conditions equivalent to the provider licence with which Foundation Trusts are required to comply.

Executive summary

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

a) effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
b) complied with governance arrangements (condition FT4); and
c) for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7)- Not applicable

Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate. NHS trusts are therefore legally subject to the equivalent of provider licence conditions including conditions G6 and FT4 and must self-certify under these licence conditions. The CoS conditions do not apply to NHS trusts, and they are not required to self-certify under the CoS7 condition.

This paper provides the completed self-certification templates which, following discussion and debate, were approved by the Finance and Performance Committee (22nd May 2019) and are now presented to the Board for ratification.

The Trust is not required to submit provider licence self-certification declarations to NHSI; however NHSI will audit select providers.

The Trust is required to self-certify with Board sign off as well as publish the G6 self-certification declaration by 30th June 2019.

Related strategic aim and corporate objective	ALL
Risk and assurance	The self-certification statements signed off by the Board must set out any risks and mitigation planned for each statement if applicable.
Related Board Assurance Framework entries	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)
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 Single Oversight Framework bases its oversight on the NHS provider licence and therefore Trusts are legally subject to the equivalent of certain provider licence conditions including G6 and FT4.

Actions required by the Board
The Board is asked to:

- Consider each Statement and ratify the decision of Finance and Performance Committee.

1. INTRODUCTION

NHS Trusts are exempt from holding a provider licence, but they are required to comply with conditions equivalent to the licence that NHSI has deemed appropriate (Conditions G6 (3) and FT4 (8)).

The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are legally subject to the equivalent of certain provider licence conditions and must self- certify under these licence provisions.

NHS Trusts are required to self- certify annually that they can meet the obligations set out in the NHS provider licence (which includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

2. REQUIREMENTS

Providers must self- certify the following NHS provider licence conditions after the financial year end:

- The provider has taken all necessary precautions required to comply with the licence, NHS Acts and NHS constitution (Condition G6 (3)). Appendix 1.
- The provider has complied with required governance arrangements (Condition FT4 (8)). Appendix 2.

The aim of self- certification is for providers to carry out assurance that they are in compliance with the conditions. Any process should ensure that the Board clearly understands whether or not the provider can confirm compliance. Providers must state “confirmed” or “not confirmed” for each declaration explaining the rationale for the decision.

2.1. Condition G6 (3) requires NHS Trusts to have processes and systems that:

- Identify risks to compliance
- Take reasonable mitigating actions to prevent those risks and a failure from complying Occurring

2.2. Condition FT4 requires NHS Trusts to comply as follows:

- Providers should review whether governance systems achieve the objectives set out in the licence condition.
- There is no set approach to meeting these standards and objectives but it is expected that a compliant approach to involve effective Board and committee structures, reporting lines and performance and risk systems

2.3. Evidence of Attainment with above Conditions:

- The Board receives new guidance issued by regulators. Monthly delivery progress review meetings held with NHSI where requirements can be discussed.
- An Annual Governance Statement is in place and the Trust is compliant with the risk management and assurance framework requirements that support the statement pursuant to the most up to date guidance.
- The Trust has considered the Well Led Governance framework through a self-assessment process undertaken by the Board.
- The Trust has been rated as Good through the last CQC Inspection (2017/ 2018)
- The Trust Board meets monthly throughout the year in private and publically bi-monthly.
- The Trust has clear Standing Orders, Standing Financial Instructions and a Scheme of Delegation which determine the agreed framework for financial decision making.
- Systems of internal control are subject to regular audit annually by both internal and external audit.

- Relevant Board committees scrutinise key areas of performance including quality, workforce, finance and performance. Committees review such matters at each meeting and a highlight report from Chairs is provided highlighting key recommendations and areas of risk and potential lack of assurance to the Board.
- Each Board Committee has reviewed its own effectiveness in year with a number of recommendations made to improve effectiveness. Each Committee has also reviewed its Terms of Reference for Board approval.
- The Finance and Performance committee together with the Audit committee are the principal committees of oversight.
- The Quality Governance committee meets monthly and reviews performance in key areas of patient safety, patient experience and clinical outcomes. The committee receives a monthly CQC update report and an update against the Trust's own internal assessment and accreditation scheme.
- The Board has the correct personnel and considers its capacity and composition at key stages of recruitment.
- There are effective appraisal processes in place to support Board members.
- All Board members complete a "Fit and Proper persons" declaration annually.
- The Risk Management Strategy was approved by the Quality Governance Committee on behalf of the Board in February 2019 and will be reviewed annually.
- There are robust systems and processes to monitor and oversee our CIP programme; Changing Care@NGH.
- The Trust has a recent good track record of effective financial management.
- The Trust has an annual planning process that ensures business plans are developed and supported by appropriate engagement and approvals
- The board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.
- The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.
- The Trust has a number of new Board members both Executive and Non- Executive positions and needs to be cognisant of the need to ensure they gain knowledge of the systems and governance processes in place in the trust.
- The Trust currently carries a significant risk and challenge in respect to numbers of nursing and medical staff. The Trust has a range of approaches in place to ensure that short, medium and long-term workforce strategies and staffing systems are in place which assures the Board that staffing processes are safe, sustainable and effective; these are overseen on behalf of the Board by the Workforce committee.

For both Conditions set out above, NHSI will contact a select number of Trusts for their evidence of self- certification which will include completed templates, relevant Board papers and minutes recording the discussion and sign- off.

Providers must publish their self- certification within one month of the deadline for sign off. The deadline for Self- certification sign off for Condition G6 is 31st May 2019 and for FT4 the 30th June 2019. Publication of Condition G6 self- certification is required by the 30th June 2019.

Following board confirmation, compliance papers will be published on the Trust website.

3. RECOMMENDATION

The Board is asked to;

- Consider each Statement and ratify the decision of Finance and Performance Committee.

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2018/19 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sonia Swart	**Name**	Alan Burns
Capacity	Chief Executive	**Capacity**	Chairman
Date	14 May 2019	**Date**	14 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2018/19** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	An Annual Governance Statement is in place and the Trust is compliant with the risk management and assurance framework requirements that support the statement pursuant to the most up to date guidance.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board receives new guidance issued by regulators. Monthly delivery progress review meetings held with NHSI where requirements can be discussed. The Trust has considered the Well Led Governance framework through a self-assessment process undertaken by the Board.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Relevant Board committees scrutinise key areas of performance including quality, workforce, finance and performance. Committees review such matters at each meeting and a highlight report from Chairs is provided highlighting key recommendations and areas of risk and potential lack of assurance to the Board. Each Board Committee has reviewed its own effectiveness in year with a number of recommendations made to improve effectiveness. Each Committee has also reviewed its Terms of Reference for Board approval. The Finance and Performance committee together with the Audit committee are the principal committees of oversight.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust has been rated as Good through the last CQC Inspection (2017/ 2018) Systems of internal control are subject to regular audit annually by both internal and external audit. There are robust systems and processes to monitor and oversee our CIP programme; Changing Care@NGH. The Trust has a recent good track record of effective financial management. The Trust has an annual planning process that ensures business plans are developed and supported by appropriate engagement and approvals The board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Quality Governance Committee meets monthly and reviews performance in key areas of patient safety, patient experience and clinical outcomes. The committee receives a monthly CQC update report and an update against the Trust's own internal assessment and accreditation scheme.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	All board positions are filled, or plans are in place to fill any vacancies. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Sonia Swart **Name** Alan Burns

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | Please Respond

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: Thursday, May 30, 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 Sub committees**

Executive Summary

The Committee met on April 24th, 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
• Review of CRR and BAF;	• *ALL*
• Finance Report for M12;	• *5.1*
• Review of 19/20 Plan and Contract Update;	• *5.1*
• Quarterly Capital Update;	• *5.3*
• Changing Care @ NGH Update;	• *5.2*
• Presentation on Model Hospital and GIRFT;	• *5.2*
• National Costing Collections 18/19 Process	• *5.1*
• Operational Performance including National Targets;	• *1.1+2+4+5*
• Estates Compliance Update;	• *1.5*
• Private Patient Process;	• *1.7*
• IT Update.	• *1.8*

Key areas of discussion arising from items appearing on the agenda

Updates were received by the Committee under matters arising concerning progress on the Accommodation Block and the New Front Entrance. Both projects had forward momentum and a further report would be brought to the next Committee;

No major changes were made to the CRR. It was noted however that a full refresh would be taking place to account for the start of the new financial year and associated risks especially in relation to the 19/20 Financial Plan;

The Committee was pleased to receive the Director of Finance's report for M12 advising that the Trust had bettered its 18/19 Control total of 27.7M by 66K. The DoF further reported that subsequently a letter had been received from NHSi advising that a further 5.8M of PSF had been awarded resulting in a full year deficit of 14.4M which is 4.1K better than the post-PSF planned deficit of 18.5M. Discussion took place around lessons learnt from the year as well as key achievements;

The 19/20 Plan was reviewed on a month-by-month basis. The Committee also reviewed the currently identified risks to delivery and requested they be updated on the CRR;

The Quarterly Capital report indicated that the Trust had made full use of funds available for capital expenditures although concern was raised by the Chair of the limited resources available to a Trust of the size of NGH, with such an aging estate and the need to continually invest in technology and medical devises and equipment;

The Committee scrutinized the final CIP savings from the Changing Care @NGH programme. Recurrent savings totalled 9.97M with non-recurrent at 4.48M; while overall targets had been made, the downside was that the non-recurrent figure would be included in the new financial year's expectations. The target for 19/20 was 13.92M which the Committee agreed would require significant focus to achieve;

An excellent presentation was given to the Committee by Mr Maher (Changing Care Lead) and Mr Metcalfe (Medical Director) emphasising the importance of the Model Hospital as a tool for identifying CIP opportunities and GIRFT as a means of exploring unwarranted variations and building more efficient and effective processes;

Operational Performance was discussed with specific attention to Urgent Care and Cancer Standards and RTT. The Trust was not meeting the national standards in UC or RTT and was only meeting 4 of 9 Cancer Standards. Action plans were reviewed although concern was expressed regarding the fact that the change required to gain forward traction seemed hard to embed;

The Estates Compliance Plan was received from the Director of Estates. This report will now come to the Committee on a monthly basis. Assurance will be sought that the actions being taken to ensure compliance with the various Estates related areas identified are on track and sufficiently resourced to ensure patient and staff safety;

The IT Update was received by the Committee which included the IT Strategy. Given the pressures of time and the importance of this document to the future of the Trust it was agreed to receive a more detailed update at the next Committee meeting.

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

- Under Item 14 of the Agenda the Committee was provided with assurance around the processes of the National Costing Collections for 2018/19 and was ensured that sign off processes are consistent with National Cost Collection Guidance. Using powers delegated by the Board, the Committee approved the Collection process a required;

- A report was presented to the Committee relating to the Private Patients Service Pilot, previously approved by the Committee, giving an update on work to increase private patient income stream. Approval was sought to implement this process as business as usual. Included within this will be a permanent increase in resource in the Private Patient Office to co-ordinate the service. The Committee duly gave its approval.

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

- The Committee continues to express concern around the failure of the Trust to meet National Targets for RTT, UC and Cancer.

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 above items.

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***30 May 2019***

Title	**Quality Governance Committee Exception Report**
Chair	**John Archard-Jones**
Author (s)	**Jill Houghton**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *18 April 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)*
Corporate Scorecard	***BAF 1.1, 1.2, 3.1, 3.2, 3.3***
Quality Improvement Scorecard	***BAF 1.4***
Medical Director's Report	***BAF 1.4***
The National Emergency Laparotomy Pathway	***BAF 1.4***
The Draft Quality Account	

Key areas of discussion arising from items appearing on the agenda

The Committee noted the recent extraordinary pressures within the trust and the impact on the stroke metric and cancellation of outpatient clinics to release consultants to enhance patient flow across the Trust. The high levels of activity were managed by daily 'Gold' meetings to oversee safe staffing and patient safety.

The Committee noted that, although members were looking forward to more integrated way of reporting quality, commendation should be given to the excellent reports produced by the Quality Improvement Team who were currently supporting 88 projects and could demonstrate a financial impact of 604k in Quarter 4. Going forward Quality Improvement priorities will be reported in relevant Executive Directors Reports.

The Committee remained concerned about the lack of data on VTE risk assessment and HATS data. However, assurance was given that point prevalence audits would commence if the IT reporting issues were not resolved by April 25th 2019.

The Committee reviewed the National Emergency Laparotomy Pathway and recommended its ratification at the next Trust Board.

The Committee also noted the draft Quality Account and supported its ongoing development.

Any key actions agreed / decisions taken to be notified to the Board **N/A**	
Any issues of risk or gap in control or assurance for escalation to the Board **N/A**	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board **The Board is asked to approve the National Emergency Laparotomy Pathway.**	

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *30 May 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 *24 April 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:

- **Staff Engagement**
- **Nurse Retention & Recruitment Strategy**
- **Medical Education Quarterly Report**
- **Internal Promotions**
- **Freedom to Speak Up**
- **Board Assurance Framework**

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

3.1, 3.2, 3.3

Key areas of discussion arising from items appearing on the agenda

- **Staff Engagement Survey –** concern was expressed that although staff survey results had been getting better, the results had dipped in the latest survey. A workshop with the Board and Clinical Directors would be held on 7th May to review the staff survey, key issues and to develop ideas for action. An update on the output of this workshop, including staff involvement and communication, would be presented at the June Workforce Committee**.** **Action: JB June**
- **Nurse Retention & Recruitment Strategy –** overseas recruitment had resulted in 28 nurses joining the Trust. There had been a net increase of 10 wte in quarter 4 and the vacancy factor of 110.83 was the lowest in a number of years. However, there was an increasing trend of nurses leaving within the first 2 years post qualification and those leaving due to relocation and work life balance correlated with those leaving within the age brackets of 31-35 and 46-50. More analysis was needed to understand the reasons for nurses leaving, and the Trust needed to look at its response to work-life balance issues and demand for flexible working**.** **Action: JB, June**
- **Medical Education Quarterly Report –**A high level visit request had been received from HEEM in response to concerns regarding the quality of training for tor trainees in Oncology. The visit would take place in May, with representatives from HEEM, GMC, CQC and relevant senior leaders from Oncology with the new Head of Medical Education. There had been some progress on the Oncology improvement plan and Oncology had over-recruited to ensure sufficient cover if trainees were lost. A medical education strategy would be presented to the committee in July. **Action: MM/CL July**
- **Internal Promotions/Succession Planning** – a number of initiatives were presented from three Directorates (Clinical Support Services, Women's Children Oncology & Haematology, Medicine). These initiatives/ideas would be built into the talent management process that

was being developed. **Action: JB June TBC**

- **Freedom to Speak Up Annual Report (including 4th Quarter)** 16 incidents were reported in quarter 4. This was higher than the average for the Trust size, which was approx, 10 per quarter. There had been a high number from Midwifery and actions were being implemented to address issues in the Directorate, including a Values in Practice session. A Values Ambassador role had been launched with 16 people expressing an interest. A FTSPU strategy was being developed including the role out of further training opportunities for staff**. Action: CC, date for FTSU strategy to be confirmed.**
- **Board Assurance Framework -** 3 risks had decreased in score and 1 risk had increased in score. The consequence score of risk 3.3 was challenged and an increase in potential impact from 3 to 4 was agreed. **Action: CC, May**

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

Staff Engagement: Update on action June (JB)
Nurse retention/recruitment: Detailed analysis of leavers June (tbc) JB
Medical Education Strategy: to be presented in July (CS)
Internal Promotions/succession: Talent management update June (tbc) JB

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

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 30 May 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 7th May 2019 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries**
1. CEO update 2. Divisional scorecards 3. Cancer performance 4. HMT development	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 current urgent care pressures including the increase in stranded patient numbers. The issues faced across the system which have contributed to the increase in super stranded patients and the internal actions we are undertaking working alongside Transformation Nous.

An update was also provided on the response to the staff survey.

Divisional Scorecards

The divisional scorecards were highlighted for information and one area discussed by each division

Womens, Childrens, Oncology, Haematology & Cancer – Cancer performance and support required from each division to own the pathways.

Medicine – Urgent care pressures continue but work at the front door continues to prove successful with lower than normal waiting times for speciality review.

Surgery – Unappointed follow ups, in the head and neck directorate, causing some challenges especially in Opthalmology. Actions being taken to increase capacity.

Clinical Support services – An update was given on the outpatient strategy and work which is commencing on booking within the H&N directorate.

Cancer performance

An update was provided by Mr Cooper for the March cancer performance, support required from all divisions and changes being made to the cancer PTL meeting. Each divisional director gave an overview of their challenged areas and action being taken to improve

performance. **HMT development** Dr Swart led a discussion on the KLOE for the well led domain. The discussion led to three actions. Further development sessions on the clinical strategy, BAF & the outpatient strategy.
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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A G E N D A

PUBLIC TRUST BOARD

Thursday 30 May 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 28 March 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Director of Public Health – Annual Report	Receive	Ms L Wightman	**To Follow/C.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**D.**
10:05	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**E.**
	9.	Approval of the Quality Account	Assurance	Mr M Metcalfe	**F.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**G.**
10:45	**OPERATIONAL ASSURANCE**				
	11.	Month 01 Finance Report	Assurance	Mr P Bradley	**H.**
	12.	Operational Performance Report	Assurance	Mrs D Needham	**I.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**J.**
11:00	**STRATEGY**				
	14.	Trust Vision and Aims	Assurance	Mr C Pallot	**K.**
	15.	People Strategy	Discussion	Mrs J Brennan	**L.**
11:25	**FOR INFORMATION & GOVERNANCE**				
	16.	Collaboration Steering Committee – Terms of Reference	Assurance	Ms C Campbell	**M.**
	17.	Health and Safety Annual Report	Assurance	Mr S Finn	**N.**
	18.	Freedom to Speak Up Annual Report	Assurance	Ms C Campbell	**O.**
	19.	Self-Certification	Assurance	Ms C Campbell	**P**
11:55	**COMMITTEE REPORTS**				

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**Q.**
	21.	Highlight Report from Quality Governance Committee	Assurance	Ms J Houghton	**R.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**S.**
	23.	Highlight Report from HMT	Assurance	Dr S Swart	**T.**
12:05	**24.**	**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 Friday 26 July 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).