Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 31 January 2019

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 January 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 29 November 2018	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Mortality and Learning from Deaths Update	Assurance	Mr M Metcalfe	**E.**
	10.	Trust-Wide Mortality Case Note Review 12	Assurance	Mr M Metcalfe	**F.**
	11.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**G.**
10:30	**OPERATIONAL ASSURANCE**				
	12.	Finance Report	Assurance	Mr P Bradley	**H.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**I.**
	14.	E&D Progress Report inc WRES update	Assurance	Mrs J Brennan	**J.**
	15.	Gender Pay Gap Report	Assurance	Mrs J Brennan	**K.**
	16.	Operational Performance Report	Assurance	Mr C Holland	**L.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	17.	Refreshing the Clinical Strategy 2019-2024	Assurance	Mr C Pallot	**M.**
	18.	HCP Partnership Update	Assurance	Mr C Pallot	**N.**
	19.	EU Exit Operational Readiness Guidance	Assurance	Mrs D Needham	**O.**
11:40	**COMMITTEE REPORTS**				
	20.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**P.**

Time	Agenda Item		Action	Presented by	Enclosure
	21.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Q.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**R.**
	23.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**S.**
	24.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**T.**
12:00	**25.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 28 March 2019 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 28 November 2018 at 09:30 in the Board Room at Northampton General Hospital

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

TB 17/18 194 Introductions and Apologies

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

Apologies for absence were recorded from those listed above.

TB 17/18 195 Declarations of Interest

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

TB 17/18 196 Minutes of meeting 26 July 2018

The minutes of the Trust Board meeting held on Minutes of meeting 27 September 2018 were presented for approval.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 27 September 2018 subject to one amendment to **TB 17/18 185.**

TB 17/18 197 Matters Arising and Action Log 27 September 2018

The Board **NOTED** the Action Log and Matters Arising from the 27 September 2018.

TB 17/18 198 Patient Story

Ms Oke presented Trust Board the patient story.

Ms Oke advised that in late August 2018 a Urology patient had been admitted to A&E to be catheterised. He was informed he would be contacted by the Urology department to arrange an appointment. Time passed and he heard nothing therefore

he contacted the hospital who reported that an appointment had not been made. He contacted the Urology department separately who clarified that an appointment had been scheduled the following week.

The patient commented that at his appointment the nurse had been kind, understanding and helpful. The patient had been disappointed when he had realised he needed to have the catheter back in however the nurse had made this procedure as painless as she could.

The patient was advised to visit their GP as they needed to be prescribed medication. The GP had initially refused to do this.

Ms Oke stated that that patient had found there to be variation between the standard of doctors who had treated him however noted all the nurses to be kind throughout his treatment.

Ms Oke clarified that an issue with answering the telephone had been reported and there was a workstream in place to address this. This included keeping the telephone directory up to date and for there to be a voice activated system in place. If a telephone call is not answered then the call would divert to another telephone.

Ms Oke confirmed that the patient would have a main point of contact and this included a nurse specialist being aligned to the patient. The Urology team would be reviewing nurse prescribers as well.

Dr Swart remarked that following this letter and other letters of a similar nature she had tested the Urology telephone number. She had her call answered and noted that there were further improvements put in place.

Mr Noble commented that it was good to see the evidence that issues within a patient story had been addressed.

The Board **NOTED** the Patient Story.

TB 17/18 199 Chairman's Report

Mr Zeidler presented the Chairman's report.

Mr Zeidler stated that he had no updates to share with the Board and that Trust was still awaiting a decision on the outcome of the new Chair.

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

TB 17/18 200 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart commented on the busy month for the Trust. She noted the importance of the achievement of the Pathway to Excellence Accreditation. The Trust had become the first hospital in the UK to be awarded this. Dr Swart thanked everyone involved in achieving this. She touched on the importance of the term 'excellence' within the accreditation and for this to be continued.

Dr Swart delivered a Health Economy update to the Board. The Trust was committed to delivering the health agenda. She believed there to be stronger partnership work going into this winter however noted the challenges at the County Council and with care homes going into administration.

Dr Swart remarked that the work with KGH was going well. This included a different

way of working which had been set up to make a difference.

Dr Swart advised that the Trust was a member of East Midlands Radiology Consortium (EMRAD) which had recently been announced as one the successful Wave 2 Testbeds launching an 18 month project on using Artificial Intelligence and Deep Learning to support breast screening. This was an exciting opportunity for the Trust. The first project involved exploring how computer assisted pattern recognition would perform the role of a Radiologist in interpreting mammography screening tests. Dr Swart confirmed she would keep the Board updated on any developments and importance of supporting these initiatives moving forward.

Dr Swart discussed the work with the CQC on producing a case study on driving improvement at NGH. This was a positive publication from the CQC. The Trust had met with the CQC recently and it had been discussed how to better share the Trust's QI journey.

Dr Swart reported that the she had met with the Chief Executive at St Andrew's to improve the Trust's work within the mental health arena.

Dr Swart noted the teething difficulties at Nye Bevan which was largely issues with the lift. She commented on the positive attitude of the staff within the unit. The patients and relatives were pleased with the new build and had remarked that they had liked the new ways of working, in particular the nurse bays. Dr Swart stated that it was important to build on the energy from the staff as further changes are still to be made.

Dr Swart remarked that a recent concert supported by the Trust Choir had been positive. There were a number of speakers and the event had been a success.

Mr Holland commented on Nye Bevan. The staff morale was much better than it had been in the previous unit.

Mr Moore asked when Nye Bevan would again be fully operational. He was informed that this would be 03 December 2018 and it was believed that the lift issues had now been resolved.

Mr Moore asked for clarity on the Trusts involvement in the CQC national urgent and emergency care survey 2018 as mentioned within the CEO report. He queried whether the results would be reported in 2019. He was informed that this was correct. He asked if the survey was patient driven which was clarified that it was.

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

TB 17/18 201 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe advised that as highlighted in recent board reports there had been a trend towards increasing mortality at NGH over recent months. The HSMR was now above average and he believed the accuracy of patients recorded diagnosis to be contributory to this. He informed the Board that a Trust Wide Mortality Review was underway and a report would be presented to the **January** Board detailing the results and governance of mortality outliers.

Mr Metcalfe stated that the Mortality review group meetings were now chaired by him. There had been workstreams identified to address the increased HSMR. These were; Clinical coding interface and the accuracy of diagnosis during primary episode, Frailty with the actions to be identified through mortality review 12; Access to

palliative care for secondary malignancy and coding; and Sepsis/UTI over diagnosis.

Mr Metcalfe reported that in addition the Deteriorating Patient Board was focussed on the quality of care the Trust gave to its sickest patients.

Mr Metcalfe commented that the new medical model would go live in the Nye Bevan unit on the 03 January 2019. This was an improved way of working and would be consultant directed earlier in the patient's admission to the Trust. To support the transition into the Nye Bevan building and then the introduction of a new working model within it an Associate Medical Director for emergency care transformation had been appointed.

Ms Gill noted that it was good to see the new medical model going live in January. Mr Metcalfe remarked that it was a huge team effort which had included the securing of 10 new substantive staff.

Mr Noble asked whether an update would be presented to the Quality Governance Committee (QGC) or the Trust Board. It was confirmed that a detailed update would be presented to QGC and a summary be included within the Medical Director Report to Trust Board.

Mr Moore asked for further information on to the extent the Trust was an outlier in mortality. Mr Metcalfe explained that the Trust had just tipped into the above average on the HSMR. In regional comparison 4 of out of the 8 providers were an outlier and the Trust was smallest outlier of the group.

Mr Metcalfe stated that the Trust's crude mortality was the same as the rest of the country.

The Board were informed that Ms Houghton was the Non-Executive Lead for mortality at the Trust.

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

TB 17/18 202 Director of Nursing and Midwifery Care Report

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

Ms Oke commented that she had reviewed the harm free care indicators and noted that it was good to see no large escalation with these indicators. In relation to safe staffing, due to the additional beds being open extra nursing staff had been required and on the whole these had been met.

Ms Oke reported that to strengthen Nurse staffing throughout the day an afternoon Matron's huddle was now in place to plan staffing cover for the next 24 hours. She was also working closely with her colleagues in recruitment.

Ms Oke discussed the Trust obtaining Pathway to Excellence Accreditation with the Board. She noted this to be a phenomenal achievement. There is a level of pride that now sits with the workforce and an increased amount of energy that she hoped would help with recruitment to reduce the vacancy factor.

Mr Noble commented on the downward trend of with Friends & Family results (FFT) and asked for an understanding of this. Ms Oke stated that she is currently at an information gathering stage. To provide ongoing feedback the Trust has volunteers conducting real time surveys on the wards which were providing live feedback to the nursing team. The most common theme reported was noise. In Maternity Services the Head of Midwifery would be undertaking a focused piece of work looking at how

to improve the number of response to the survey. Ms Oke noted that within ED there had been a link to long waiting times and the FFT results. Mr Noble remarked that most Trust's would also have a busy ED.

Mrs Brennan stated that over the same period staff sickness increased and a number of workforce metrics had also dipped.

Mr Holland expanded on the theme of noise and explained that there is cohort of patients with dementia and delirium that would typically create more noise at night.

Dr Swart advised that she had discussed the dip in FFT performance with Ms Oke. The volunteer aspect of conducting real time surveys was very important.

Mr Moore drew the Board to appendix 3 of the report and indicators under the 'caring' category. There were 50% of these marked as red and he queried whether there would be a triangulation exercise with this is data. Ms Oke clarified that this data does go through the Patient Experience Board. She expanded on the FFT results and informed the Board that the survey uses a likert scale of 1 to 5. The results only looked at the highly likely score on the scale which can make the data hard to compare.

Mr Archard-Jones noted appendix 5 of the report and praised the positive performance for the maternity wards. He commented that this was a great achievement.

Dr Heap congratulated the nursing team on the significant improvement in pressure ulcer performance.

Mr Zeidler highlighted the significant importance of achieving Pathway to Excellence and that it was richly deserved. On behalf of the Board he extended thanks to the nursing and midwifery team and all involved. He believed it would be good to see the future benefits of this accreditation most notably nursing retention and recruitment.

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

TB 17/18 203 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that the month 7 financial pre-PSF position showed a year to date positive position of £3k. This was £41k worse than the position a month 6. In essence a similar position to the last three months. Mr Bradley commented that the Trust had not achieved the PSF of £276k related to A&E performance and therefore was £273k adverse to the post-PSF plan.

Mr Bradley reported that as with the trend of recent month's income had underperformed, pay had overspent, non-pay had underspent and the month planned release of reserves led to the breakeven position.

Mr Bradley drew the Board to page 69 of the report pack. There had been a reduction in stranded and super-stranded patients. This had impacted on the Trust's excess bed day income to the tune of £2.4m year to date and this was a major contributor to the £2.5m adverse to position on income to plan. Mr Bradley commented that elective inpatient activity was below plan by £1m whilst non-elective was showing a positive position of £2.2m. There had been no further movement on the STP financial gap over the last month.

Mr Bradley referred the Board to page 71 of the report pack. This showed that the

agency cap had been again breached in August by £99k which was mainly by senior medical staff.

Mr Bradley commented that on page 72 of the report pack the CIP summary was included. In overall terms the Trust is ahead of plan and is expected to meet the target however he expressed his concern on the delivery of recurrent CIPs which is £3.9m year to date. Mr Bradley stated that there are plans to deliver over and above on elective activity in quarter 4 due to the opening of the escalation ward and the ring-fencing of elective beds. If the Trust failed to deliver this additional activity it would impact on the savings plan. There had been a number of additional identified savings which were discussed at the Changing Care meetings and these recurrent schemes would be included in the month 8 figures.

Mr Bradley advised that at the November Finance Investment and Performance Committee the forecast paper had been presented which had showed the best, most likely and worst case forecast scenarios. These ranged between £0.1m over achievement to £3.9m under achievement of plan with the most likely scenario £2.1m adverse to plan.

Mr Bradley remarked that he had been to a session where the processes for planning for next year had been agreed and he would bring this outcome to a future Board.

Action: Mr Bradley

Mr Bradley had met with the regional Finance Director and this had gone well. The Trust's plan appeared to be better in comparison to the Trust's peers.

Mr Bradley informed the Board that he had the monthly assurance meeting with NHSI on the 30 November 2018.

Mr Archard-Jones noted the increased agency staff expenditure and queried what this related to. Mr Bradley explained that due to staff sickness locums had been appointed. In Nye Bevan the locum in place would shortly change to substantive post and he believed that these agency cost would drop. Mr Metcalfe confirmed that a significant proportion of locum contracts came to an end at the end of February 2019.

Mr Pallot confirmed that the strategy team was working with finance to look at the future plans. There would be a joint paper on this topic which would include the national rules and how to articulate a county wide plan for the next year.

Dr Swart highlighted to the Board that the Trust had received a letter asking for a county wide plan.

The Board **NOTED** the Finance Report.

TB 17/18 204 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity increased in October 2018. It was noted that Annual Trust turnover for October 2018 decreased whilst the overall Trust vacancy rate for October 2018 was 10.59% against a Trust target of 9%.

Mrs Brennan stated that Sickness absence in October 2018 had decreased.

Mrs Brennan reported that flu vaccination uptake was at 70.45% and therefore at

current had achieved 50% payment of the CQUIN scheme.

Mrs Brennan updated the Board on the Applicant Management System (Trac). This would speed up the recruitment process and would be live in January 2019.

Mrs Brennan expressed her concern on the dip in performance on the capability KPI's. This was the second consecutive month therefore this would be monitored closely.

Mrs Brennan remarked that an update on the Respect & Support campaign was included in the report. The range of training was listed on page 83 of the report pack. The Respect and Support Helpline was currently being developed.
Mrs Brennan stated that the Round Table informal mediation service was currently being communicated across the Trust. The Trust was looking for Round Table Facilitators across the Trust to support this service. Other tools that had been developed included a feelings log, behavioural framework and a behaviour self-assessment tool.

Mrs Brennan informed the Board that she had presented at a national conference on the topic of Bullying & Harassment and this had been well received.

Mrs Brennan commented that the 2018 National NHS Staff Survey currently had a 35% response rate. There would be work done at looking how the Pathway to Excellence survey had achieved an 82% and what could be replicated. It appeared the potential gain from the results of the survey had been a factor in this. The national average response rate was 39%.

Dr Swart stressed the importance on staff making a link between the Staff Survey results and actions the Trust put in place.

Mr Moore asked what the response rate was for the previous year. Mrs Brennan confirmed she would provide this information to him.

Action: Mrs Brennan

Ms Campbell remarked that as part of the Freedom to Speak Up work she would be linking in with Mrs Brennan on how it could be aligned to the Respect & Support work. Ms Campbell would also be refreshing the Freedom to Speak Up policy with a relaunch planned in the New Year.

<u>Flu vaccination for Healthcare Workers</u>

Mrs Brennan advised that a letter dated 07 September 2018 had been received from NHS England with the ambition for 100% of all healthcare workers with direct patient contact to be vaccinated. She believed 100% to not be feasible due to underlying medical reasons that omitted some staff from having the vaccine.

Mrs Brennan drew the Board to page 97 of the report pack which showed the uptake of the flu vaccine at NGH over the past few years and how the uptake had increased significantly.

Mrs Brennan discussed this year's flu vaccine campaign. There had been clinics in the cyber café and trolley visits to wards/departments.

Mrs Brennan noted that the letter from NHS England detailed that for staff that declined to have their vaccine in high risk areas needed to inform their clinical director / head of nursing / head of therapy of this to allow a risk assessment to be carried out. A communication had been sent out to the staff affected.

Mr Archard-Jones remarked that this was a patient safety issued and needed to be taken seriously. Mrs Brennan agreed and commented that the clinicians needed to do the risk assessment and balance this risk.

Mrs Brennan drew the Board to pages 99 to 101 which documented the updated Self-Assessment Healthcare worker flu vaccination best practice management checklist. She expanded on action C1 - Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered. There had been discussions on this with the Occupational Health Manager who had advised that this had not worked well in the past and guidance had not been received in time to carry over training in any case. The action C3 Schedule for 24 hour mobile vaccinations to be agreed was believed to not be required as evening and weekend trolley round already took place.

Dr Swart informed the Board that there had been a large discussion at the A&E Board on the topic of the flu vaccine within elderly care homes.

Ms Gill queried whether when staff are recruited into these areas could having the flu vaccination be part of their contract. Dr Heap concurred with this. Mrs Brennan clarified it cannot be in their contract as it was a matter of 'consent' however this could set as an expectation.

Nurse Recruitment & Retention

Mrs Brennan advised that as at October 2018 there are 55 IELTS cleared Indian Nurses awaiting NMC decision letter. There had been 24 overseas recruits who had arrived from India in total between May and October 2018 with another cohort arriving 28 November 2018.

Mrs Brennan reported that between May and October 2018 overall nursing capacity increased through new recruits and increases in hours by 82.41 WTE. The overall capacity increase is believed to be linked to Nye Bevan. The overall net increase was 1.4 WTE, after turnover and increased establishment was taken into account.

Mrs Brennan stated that the vacancy factor was 115.39. She referred the Board to page 112 of the report pack to the March 2019 predicted vacancy factor figure of 89.14. This was very positive to see and had been the lowest this had been.

Mrs Brennan discussed the retention analysis with the Board. It was noted that between May and October 2018 there have been 67.64 nurse leavers from core and specialist areas. The key reasons appeared to be retirement or voluntary resignation due to relocation.

Ms Gill queried whether the relocation was to a higher banding job. Mrs Brennan advised that this information was not available.

Mr Archard-Jones asked whether exit interviews happened. He was informed the exit interviews occurred however discussions really needed to be held before a nurse handed in their notice and having a stay discussion, had been implemented recently. Mrs Brennan commented that 8 weeks after a nurse started employment at the Trust new starter questionnaire would be sent to them, once Questback had been introduced..

Mr Moore queried whether there was an update on the Apprenticeship Levy. It was confirmed that a paper would be presented to the December Workforce Committee. Ms Oke advised that a business case was being pulled together on how to use the

levy in regards to nursing.

Ms Oke commented that that since the removal of the bursary there had been a drop in student nurse applications. The Trust previously received 2 cohorts from Northampton University and now it was receiving one.

Mrs Watts remarked that the social media accounts from senior staff had an impact on recruitment.

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

TB 17/18 205 Integrated Performance Report

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

Mr Holland shared with the Board the positive news that the Trust's Stroke service had received a grade A rating from SSNAP. This was phenomenal considering the increased activity due to taking on the county wide service whilst maintaining the current bed base.

Mr Holland advised that there had been zero mixed sex breaches. The Trust had achieved the NHSE set target of 25% reduction for super-stranded patients (patients with a LOS >21days)

Mr Holland shared the positive news with the Board that the average length of stay had decreased by 1 day and the Board noted the significance of this.

Mr Holland updated the Board on performance in ED. The number of attendees had increased as had acuity with performance at 86.82%. The Trust were not to receive a visit from NHSI in regards to the Trust's winter plan as opposed to many other local trusts

Mr Holland reported that Knightly Ward would be moving to Creaton which provided an additional 7 beds. The Esther White Ward would be reopening on 03 December 2018 and Benham would become an escalation ward for Winter.

Mr Holland stated that surgical beds would been ring-fenced for winter starting in early December

Mr Holland delivered a Cancer update to the Board. He advised that October performance had improved. The 2ww was at 94%, breast symptomatic was at 91%, 31 days was at 97.9% and 62 days was at 84.2%.

Mr Holland commented that RTT was at 81.48% with the target trajectory set at 81.9% with all directorates having submitted RTT plans and trajectories

Mr Holland advised that Nye Bevan was due to re-open on 03 December 2018 with the new medical model going live in January 2019. He updated the Board as to where the additional beds for winter would be located. This would be 20 at Southfields, 6 at Angela Grace, 5 on Balmoral and 10 high level residential beds. Mr Holland believed that the Trust was in one of the strongest positions it had been in a long time going into winter.

Ms Gill asked whether the Trust had held any further MADE events. Mr Holland clarified that the Trust had supported MADE events at all three of the community rehab units which had resulted in significantly improved flow through those units over

recent weeks.

Mr Moore discussed the DTOC figures with the Board. He expressed his concern that the report suggested that DTOC was the biggest cause of the stranded and super-stranded patient numbers. He asked for more clarity on this in the next report.

Action: Mr Holland

Mr Bradley stated that £2.7m had gone to the council to provide extra capacity to the system to take patients out of the acute Trusts.

Mr Metcalfe touched on the achievement of the Stroke service who had received a grade A score and that this would benefit with recruitment. Mr Zeidler on behalf of the Board asked Mr Metcalfe to pass on their thanks on this accolade.

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

TB 17/18 206 Annual Fire Safety Report

Mr Finn presented the Annual Fire Safety Report.

Mr Finn advised that report covered the period of April 2017 to March 2018. Following on from the Grenfell Tower fire the Trust had received 2 inspections from the Fire & Rescue Service. The outcome of both of these had been satisfactory.

Mr Finn reported that there had been one reportable fire in the reporting period. This was a fire in Balmoral Ward and related to an oil filled radiator.

Mr Finn stated that fire training compliance was at 82%.

Mr Finn commented that there was limited assurance in relation to Fire Compartmentation. This is due to asbestos in some of the ceilings therefore the condition of the wall cannot be checked. An independent survey had been conducted and the results of this would feed into the decant plan.

Mr Finn remarked that another area of concern was that the Fire Dampers did not have a full inventory and were not part of a maintenance programme and tested.

Mr Finn noted that to update the fire doors this would cost the Trust £172k.

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.

Action: Mr Finn

Mr Noble drew the Board to page 135 of the report pack and raised concern on the lack of an associated plan in line with the preventative maintenance (PPM) scheme. Mr Finn clarified that this would be covered in the fire compartmentation work.

Dr Swart expressed her concern due to the age of the site. There was a need to update the long term plan.

Mr Noble noted that section 12 categorised the risk as an ‘Extreme Risk’. He asked where this conclusion had come from. He was informed that it was classified as an extreme risk due to the consequence rather than the likelihood.

The Board **NOTED** the Annual Fire Safety Report.

TB 17/18 207 Healthcare Partnership Update

Mr Pallot presented the Healthcare Partnership Update.

Mr Pallot informed the Board that within the report pack was the latest update produced by the Health and Care Partnership for dissemination across the county.

The Board NOTED the Healthcare Partnership Update.

TB 17/18 208 Highlight Report from Finance Investment and Performance Committee

Mr Zeidler advised that all areas to be noted from Novembers Finance Investment and Performance Committee had been discussed today at Trust Board.

- The business case for a new main entrance at the south entrance of the Hospital. The Committee had approved a small amount of spend for the pre-planning stage.

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

TB 17/18 209 Highlight Report from Quality Governance Committee

Mr Archard-Jones advised that all areas to be noted from Novembers Quality Governance Committee had been discussed today at Trust Board. These included –

- The positive Flu vaccination compliance which had now increased further since the Committee as presented to the Trust Board.
- A detailed discussion was had on mortality and further updates would come to the Committee.
- Excellent achievement of Pathway to Excellence.
- Safeguarding which would be discussed at the Private Board.
- QI Presentation which was based on personalised pathways for patients with prostate cancer.

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

TB 17/18 210 Highlight Report from Workforce Committee

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

- Respect & Support Campaign Update
- TRAC system to go live in January 2019.
- Freedom to Speak Up report was presented with this being refreshed going forward.
- Medical revalidation update within the papers.

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

TB 17/18 212 Highlight Report from Hospital Management Team

Mr Holland advised that all areas to be noted from Novembers HMT had been discussed today at Trust Board. These included –

- A workshop was held where the Divisions were tasked with developing metrics that could be used on their own divisional scorecard.
- Presentation from Surgery on their action plan following the staff survey results.
- Presentation on the Estates Strategy.

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

TB 17/18 213 Any Other Business

Dr Swart formally thanked Mr Zeidler. His input had been hugely valuable as had his common sense and support in hard times. The Trust was sad to see his departure.

Mr Zeidler noted that over the last ten years he had seen the hospital change unrecognisably. It was a safer place, more productive and relatively stable in regards to finances. He had experienced a change in culture and the hashtag #teamNGH had helped with this.

Date of next Public Board meeting: Thursday 31 January 2019 at 09:30 in the Board Room at Northampton General Hospital.

Mr Zeidler called the meeting to a close at 11:40

Public Trust Board Action Log						Last update	24/01/2019
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
91	Nov-18	TB 17/18 204	Workforce Performance Report	Mr Moore asked what the response rate was for the previous year. Mrs Brennan confirmed she would provide this information to him.	Mrs Brennan	Jan-19	On Agenda	**Update in Matters Arising**
92	Nov-18	TB 17/18 205	Integrated Performance Report	Mr Moore discussed the DTOC figures with the Board. He expressed his concern that the report suggested that DTOC was the biggest cause of the stranded and super-stranded patient numbers. He asked for more clarity on this in the next report.	Mr Holland	Jan-19	On Agenda	**Update in Matters Arising**
Actions - Future meetings								
90	Nov-18	TB 17/18 203	Finance Report	Mr Bradley remarked that he had been to a session where the processes for planning for next year had been agreed and he would bring this outcome to a future Board.	Mr Bradley	TBC	**TBA**	
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 Bradley	May-19	**On-Track**	

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Acting Chief Executive's Report**
Agenda item	***7***
Presenter of the Report	Deborah Needham, Acting Chief Executive
Author(s) of Report	Deborah Needham, Acting Chief Executive 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

Northampton General Hospital
NHS Trust

Public Trust Board
31 January 2019

Acting Chief Executive's Report

1. Stroke Sentinel National Audit Programme (SSNAP)

Board members will recall that during the summer of 2018 inpatient care for hyper-acute and acute stroke patients was centralised at NGH, so patients now receive the same quality and consistency of care in one location, wherever they live in the county. There is also increased rehabilitation support at NGH and at Isebrook Hospital in Wellingborough.

The most recent SSNAP audit covered the period during and after the centralisation and for the eighth time in the past nine audits NGH achieved the highest possible rating, placing the stroke service in the top 25% of stroke services in England. In addition to the overall A grade awarded to the service, NGH was awarded its first B grade for admissions to the Eleanor Stroke Unit in under four hours. No trust in the country achieved a higher grade in this category.

For patients these top scores show that they are receiving vital treatment much faster than the national average. On entering the hospital patients who are suspected of having a stroke, are assessed and receive a vital CT head scan on average 30 minutes after arrival, significantly quicker than the national average of 50 minutes. Alongside this, thrombolysis treatments are delivered to patients within an average of 35 minutes, with every patient who requires this treatment receiving it within the hour target.

I would like to thank all the teams who worked to help make the stroke transfer work whilst maintaining a consistently high standard of patient care. Stroke services at NGH are highly regarded and the centralisation of the service will lead to further development of specialist expertise, with additional investment identified for therapy and specialist psychology services.

2. NHS Long Term Plan

On 7 January 2019 NHS England published the NHS Long Term Plan, setting out its priorities for healthcare over the next ten years. A consultation and engagement period is now underway on the plan, which will run until the summer.

The plan includes a guarantee that, over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget, creating a ring-fenced local fund worth at least an additional £4.5bn a year in real terms by 2023/24. The series of improvements that are to be delivered are summarised in five key areas:

- Improving out of hospital care (primary and community services)
- Reducing pressure on emergency hospital services
- Delivering patient-centred care
- Digitally-enabled primary and outpatient care
- A focus on population health and local partnerships

The Northamptonshire Health and Care Partnership will now be building on the work we have already been doing to develop a strategy that takes forward the ambitions of the NHS Long Term Plan and working together to turn them into local action to improve services and the health and wellbeing of the community we serve.

Patients, staff and the public will be offered opportunities to help shape what the NHS Long Term Plan means for their local area, and how the services they use or work in need to change and improve.

To support wider engagement NHS England will be working with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

We have set up a separate area of our Intranet to host information and briefings in relation to the Plan for our staff and will continue to keep them informed via our existing communication channels, including our popular Question Time sessions.

3. Brexit

The UK is due to leave the European Union at 23:00 GMT on Friday 29 March 2019. The implications of the withdrawal agreement on the NHS are not yet known. In the meantime, however, the Department of Health and Social Care (DHSC) has made a number of Brexit-related announcements regarding preparations for a no deal Brexit scenario. At the time of preparing this paper the latest announcement is that NHS England director of acute care, Keith Willett, has been seconded to jointly lead a 200-strong team preparing the NHS for a no-deal Brexit alongside NHSE's national operations director, Matthew Swindells.

The trust has identified the Chief Operating Officer as the Senior Responsible Officer (SRO) to oversee the work to ensure continuity of supply of goods and services in the event of a no deal Brexit. Where categories of spend and suppliers are best engaged at a national level this is being managed centrally by the DHSC. All other categories and suppliers have been reviewed as part of a self-assessment methodology which has been submitted to the DHSC.

We have arrangements in place to prepare for a no deal Brexit and the Board will continue to be kept informed of any implications of the withdrawal agreement as further information is provided.

4. 2019/20 Business Case Prioritisation and Approval Process

Currently business cases are assessed through our divisional boards, strategic planning, group, executive team and hospital management team, with final approval required from the finance, investment and performance committee (FIPC). The process is documented in our integrated business planning framework which is updated annually.

To respond to the growing number of business cases that are submitted, last year each division was restricted to a maximum of three business cases. This led to concerns raised by divisions that this restricted their ability to propose service changes via this route.

Following discussion at the finance, investment and performance committee in December 2018, it was recommended that not all cases required approval at that level, and that the alternative forums already existing could approve certain cases as long as they had delegated authority to do so. This would be dependent on the content of the Standing Financial Instructions meaning that only cases over a set limit will be presented to FIPC for approval.

A paper setting out the proposed changes was considered by the FIPC in January and the outcome and recommendations will be reported to the Board.

5. Cyber Security

Criminal and state sponsored actors (hackers) continue to threaten the UK with malicious cyber activity. This Trust, along with all areas of the NHS, continues to see an increase in daily activity attempting to cause disruption and gain access to IT systems. The main issues for the Trust are:

a. Opportunistic and targeted attacks - These take the form of Phishing email campaigns in an attempt to fool Trust staff into clicking on a link that installs malware, such as a virus.
b. Exploitation of unpatched software – Ensuring that Trust's software is kept up-to-date with security patches is a priority as this is one of the most likely ways that an attack will be successful against the Trust.
c. Human resources for cyber security – With an ever growing estate of devices, applications and medical devices the IT team have a huge challenge to keep the Trust's patient and staff data safe.

6. Our staff

NGH Everyday Heroes

Our first three Everyday Heroes have now been chosen from more than 50 entries by our judging panel after a great deal of discussion and deliberation. All the Award recipients have demonstrated a clear willingness and commitment to go above and beyond to improve and enhance either a patient's experience or that of a colleague or team.

Everyday Heroes will receive a gift experience, pin badge, Everyday Hero cape and a basket of fruit to share with colleagues. At the time of preparing this report arrangements are being made to present the recipients one each for the months of October, November and December 2018, with their Award. Their photographs will then be displayed on our wall of fame, alongside the DAISY Award honourees on Hospital Street.

Flu vaccination

At the time of preparing this report 80.6% of staff have received the flu vaccination compared to 80.4% at the same time last year. Our CQUIN target has been met and, following discussion, it has been agreed that we will close off our national data collection system in February. We will continue to run clinics for new starters and go directly to teams to ensure all those wishing to be vaccinated have the opportunity to do so. We have already ordered the stocks of vaccine we will need for the 2019/20 to ensure we are prepared.

NHS Staff survey

The NHS staff survey closed on 30 November and our final completion rate was 44%, which is higher than the 39% achieved last year. We expect to receive and share the results with the Board and the wider organisation in March. The feedback we receive is vital to ensure we can continue to respond to the issues raised by staff. Our respect and support campaign and our focus on mental health and wellbeing for staff have been developed in direct response to feedback from previous staff surveys.

Deborah Needham
Acting Chief Executive

7 January 2019

on the day BRIEFING

NHS Providers

The NHS long term plan

The *NHS long term plan* has been published, following last June's announcement of a £20.5bn annual real terms uplift for the NHS by 2023/24. The *Plan* sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. A consultation and engagement period will now begin on the *Plan*, running until the summer.

This briefing summarises key content included in each chapter of the *Plan*: a new service model, action on prevention and health inequalities, progress on care quality and outcomes, the NHS workforce, digitally-enabled care, value for money and the next steps in implementing the plan. It also includes NHS Providers' view and press statement. For any questions on this briefing or our work in this area please contact Amber Jabbal, head of policy, amber.jabbal@nhsproviders.org.

Chapter 1: A new service model for the 21st century

The *Plan* includes a guarantee that over the next five years investment in primary medical and community services will grow faster than the overall NHS budget, creating a ring-fenced local fund worth at least an additional £4.5bn a year in real terms by 2023/24. It summarises a series of improvements to be delivered in the following five key areas:

1. Improving out-of-hospital care (primary and community services)
2. Reducing pressure on emergency hospital services
3. Delivering person-centred care
4. Digitally enabled primary and outpatient care (this is considered by Chapter 5)
5. A focus on population health and local partnerships through ICSs

Boosting out-of-hospital care and joining up primary and community services

Additional national investment, worth £4.5bn a year in real terms by 2023/24 will be invested in primary medical and community health services (and supplemented by further funding from CCGs and ICSs), to stem the pressure of high demand, expand the workforce and fund new services. Key measures include:

- **A new NHS offer of urgent community response and recovery support:** Within five years, all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver services within two hours of referral, in line with NICE guidelines, including delivering re-ablement care within two days of referral
- **Primary care networks of local GP practices and community teams:** Funding will cover expanded community multi disciplinary teams aligned with new "primary care networks" covering 30-50,000 people. From 2019, NHS111 will start booking patients directly into GP practices, as well

as referring to pharmacies. A shared savings scheme will be offered to primary care networks so they can benefit from their improvements

- Guaranteed NHS support for people living in care homes: There will be an upgrade in NHS support for care home residents with care homes supported by a team of healthcare professionals, including named GP support. The new primary care networks will work with emergency services while care home staff will have access to NHSmail to allow a greater of information to NHS staff
- Supporting people to age well: From 2020/21 the new primary care networks will assess local population risk and reduce hospital admissions through an increased use of preventative measures such as digital health records, population health management tools and new home-based or wearable monitoring equipment

Reducing pressure on emergency hospital services

The *Plan* aims to reduce the number of hospital admissions but importantly states that that the financial assumptions underpinning the *Plan* allow for hospital capacity to follow existing trends for the next three years. Key measures include:

- Pre-hospital urgent care: To support patients to choose the correct 'channel' of care, a single multidisciplinary Clinical Assessment Service as part of a fully integrated NHS 111 will be embedded. The Urgent Treatment Centre model will be fully implemented by autumn 2020, so all localities have a consistent offer for out-of-hospital urgent care. The plan is vague on how ambulance services form part of pre-hospital urgent care, but capital investment will target fleet upgrades and NHS England (NHSE) will set out a new national framework to overcome fragmentation in how services are locally commissioned
- Reforms to hospital emergency care – Same Day Emergency Care (SDEC): Every acute hospital with a type 1 A&E department will move to a comprehensive model of SDEC by 19/20 in both medical and surgical specialties, increasing acute admissions discharged on the day of attendance from a fifth to a third
- Cutting delays to discharge: An average delayed transfer of care figure of 4000 or fewer delays will be achieved through enhanced primary and community services as well as the introduction of an agreed clinical care plan within 14 hours of admission including an expected date of discharge, implementation of the SAFER patient flow bundle and MDT reviews on hospital wards.

Personalised care

The NHS will support and help train staff to help patients make the right decisions for them, increase support for people to manage their own health and roll out the NHS Personalised Care model. This will include social prescribing, personalised health budgets and targeted training to NHS staff to improve care planning for those in their last year of life.

A focus on population health via ICSs

Integrated Care Systems (ICSs) are central to the delivery of the LTP, with ICSs and expected to cover the country by April 2021:

- ICSs will have a key role in working with Local Authorities at place level
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health but CCGs will continue to make some decisions independently, for example in relation to procurement and contract award. There will be a single, leaner more strategic CCG for each ICS area
- Every ICS will have:
    - A partnership board drawn from commissioners, trusts, primary care networks, local authorities, voluntary and community sector and others
    - A non-executive chair locally appointed and approved by NHSE and NHSI
    - Full engagement with primary care through a named accountable clinical director of each primary care network
- All providers with an ICS will be required to contribute to ICS performance, underpinned by:
    - potential new licence conditions supporting providers to take responsibility with system partners, for wider objectives on resource use and population health
    - longer-term NHS contracts with all providers including care requirements to collaborate to achieve system objectives
    - Changes to align clinical leadership with ICSs including ensuring Cancer Alliances and Clinical Senates align with one or more ICS
- NHSI will take a more proactive role in supporting collaborative approaches between trusts, including supporting trusts to explore formal mergers
- A new Integrated Care Provider contract will be made available for use from 2019 to be held by public statutory providers
- A new ICS accountability and performance framework will provide a consistent and comparable set of performance measures, including a new 'integration index'
- ICSs will agree system wide objectives with the relevant NHSE/I regional director and be accountable for their performance against these objectives
- NHSE/I will support CCGs and local authorities to blend health and social care budgets.

Chapter 2: More NHS action on prevention and health inequalities

To address the growing demand for healthcare created by a growing and ageing population, the *Plan* sets out an aim to target the top five causes of premature death in England.

Priority areas

- Smoking: while smoking rates have fallen significantly, 6.1 million people in the UK still smoke, and nearly a quarter of women smoke during pregnancy. The *Plan* makes a commitment to offering all people admitted to hospital NHS-funded tobacco treatment services by 2023/24, with an adapted model for expectant mothers and their partners. A universal smoking cessation offer will be introduced for long-term users of specialist mental health and learning disability services.
- Obesity: nearly two thirds of adults in England, and a third of children leaving primary school, are overweight or obese. The government has pledged to halve childhood obesity. The existing

national diabetes prevention programme, which has benefited over 100,000 people, will be doubled over the next five years, with a new digital option. All trusts will be required to deliver against the standards set out by the next version of hospital food standards, including substantial restrictions on high fat, salt and sugar food. The *Plan* sets out an ambition to work with professional bodies to improve the quality of nutrition training within medical courses.

- Alcohol: over five years hospitals with the highest rates of alcohol-dependence related admissions will be supported to establish Alcohol Care Teams (ACTs) using the health inequalities funding supplement from their CCGs and in collaboration with local authorities and drug and alcohol services. Hospitals which have introduced ACTs have seen a significant reduction in A&E attendances, bed days, readmissions and ambulance call outs.
- Air pollution: almost a third of preventable deaths are due to causes related to air pollution. In 2017 3.5% of road travel was attributable to the NHS. The *Plan* sets out plans to ensure 90% of the NHS fleet will use low emissions engines by 2028, and heating from coal and oil fuel sources in NHS buildings will be fully phased out.
- Antimicrobial resistance: the *Plan* identifies a need for further progress on reductions in antimicrobial prescribing in primary care, and the health service will continue to support the delivery of the government's five year action plan on antimicrobial resistance, supporting system-wide improvement, surveillance, infection prevention and control, and antimicrobial stewardship, with resources for clinical expertise and senior leadership.

Stronger action on health inequalities

The *Plan* outlines some actions to tackle such health inequalities, including:

- Targeting a higher share of funding towards areas with high levels of health inequality than would be ordinarily allocated using the core needs formulae.
- The NHS will set out specific and measurable goals for narrowing inequalities through the service improvements outlined elsewhere in the *Long term plan*. All local health systems will be expected to set out in 2019 how they will reduce health inequalities by 2023/24 and 2028/29.
- The NHS will accelerate the Learning disabilities mortality review programme and do more to keep people with learning disabilities and autism to stay well with proactive care in the community.
- An investment of £30m to meet the needs of rough sleepers, ensuring that areas most affected by rough sleeping have access to specialist homelessness mental health support.
- Identifying and supporting unpaid carers to who are twice as likely to experience poor health, including quality marks for carer-friendly GP practices.
- Rolling out specialist clinics for people with serious gambling problems.

Chapter 3: Further progress on care quality and outcomes

For all major conditions, the quality of care and the outcomes for patients are now measurably better than a decade ago. However, the *Plan* looks at both physical and mental health and outlines a range of condition specific proposals.

A strong start in life for children and young people

Services for children and young people have seen some improvement in recent years, and the *Plan* outlines a push to build on these and broaden the focus of the NHS in this area in the next five and 10 years.

Maternity and neonatal services

- The NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally, following the launch of continuity of carer teams.
- The Saving Babies Lives Care Bundle (SBLCB) will be rolled out across every maternity unit in England, including a focus on preventing pre-term birth and the development of specialist pre-term birth clinics.
- Access to evidence-based care for women with moderate to severe perinatal
- Mental health difficulties and a personality disorder diagnosis will increase, to benefit an additional 24,000 women per year by 2023/24.

Children and young people's mental health services

- The Long term plan sets out a goal that over the coming decade 100% of children and young people who need specialist mental health care will be able to access it.
- Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.
- By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school/college-based MH Support Teams.
- Current service models will be extended to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults.

Learning disability and autism

- The NHS will tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- Uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability will be improved, so that at least 75% of those eligible have a health check each year.
- The STOMP-STAMP programmes will be expanded to stop the overmedication of people with a learning disability, autism or both.
- By March 2023/24, inpatient provision will have reduced to less than half of 2015 levels.

Children and young people with cancer

- The *Plan* identifies the need to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.
- From 2019, whole genome sequencing will be offered to all children with cancer, to enable more comprehensive and precise diagnosis, and access to more personalised treatments.
- From September 2019, all boys aged 12 and 13 to be offered vaccination against HPV-related diseases.
- Over the next five years NHSE will increase its contribution by match-funding clinical commissioning groups (CCGs) who commit to increase their investment in local children's palliative and end of life care services (this should more than double the NHS support, from £11m up to a combined total of £25m a year by 2023/24).

Redesigning other health services for children and young people

The *Plan* recognises that the needs of children are diverse and complex, and their profile should be raised at a national level.

- A children and young people's transformation programme will be created to oversee the delivery of the children and young people's commitments in the plan.
- Improvements in childhood immunisation will be prioritised.
- By 2028 the NHS will move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

Better care for major health conditions

The *Plan* focuses on tackling the top five causes of early death for the people of England: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.

Cancer

The *Plan* sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. The plan aims to increase awareness of symptoms, lower the threshold for referrals by GPs, improve screening, accelerate access to diagnosis and treatment, roll out personalised care plans, and expand screening of family members:

- Review the current cancer screening programmes and diagnostic capacity.
- Negotiate a capital settlement in the 2019 Spending Review, in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests.
- Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.
- Extend the use of molecular diagnostics and, over the next ten years, routinely offer genomic testing to cancer patients where clinically appropriate.

Milestones for cancer

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model will be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.

Cardiovascular disease

The *Plan* proposes improvement in early detection, the NHS Health Check, treatment, support of primary care multidisciplinary teams. Proposals include:

- Increase the identification of Familia Hypercholesterolaemia from 7% to 25% in the next five years through the genomics project.
- Create a national cardiovascular disease prevention audit for primary care.
- A national network of community first responders and defibrillators will help save up to 4,000 lives each year by 2028.

Milestones for cardiovascular disease

- Help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years.
- We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest.
- By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.

Stroke care

A specific aim of the plan is to modernise the stroke workforce with a focus on cross-specialty and in some cases cross-profession accreditation of particular competencies. The plan says further implementation and development of higher intensity care models for stroke rehabilitation are expected to show significant savings. The existing national stroke audit (SSNAP) will be updated to provide a comprehensive dataset.

Milestones for stroke care

- In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy.

- By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of the Plan
- By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke.
- By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.

Diabetes

The *Plan* proposes that the NHS will:

- Provide structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2.
- Ensure patients with type 1 diabetes benefit from life changing flash glucose monitors from April 2019.
- By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.
- Double the fund of the NHS Diabetes Prevention Programme over the next five years.

Respiratory disease

The *Plan* proposes to do more to detect and diagnose respiratory problems earlier, support the right use of medication, expand pulmonary rehabilitee and improve the response to pneumonia, particularly over winter. And from 2019, the existing NHS RightCare programme will be extended to reduce variation in the quality of spirometry testing across the country.

Adult mental health services

The long term plan builds on the *Mental health five year forward view*. The *Plan* proposes to increase the budget for mental health, in real terms, by a further £2.3 billion a year by 2023/24. Specific waiting times targets for emergency mental health services will take effect from 2020.

It sets out an expansion of talking therapies, new integrated primary care and community provision, a reduction in the average inpatient length of stay to 32 days and an upgrade of the physical environment for inpatient psychiatric care. Over the next 10 years, NHS 111 will be established as the single point of contact for those experiencing a mental health crisis. There will also be a new Mental Health Safety Improvement Programme, with a focus on suicide prevention.

Milestones for mental health services for adults

- New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.
- By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services.

- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post crisis support.
- By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.
- Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.

Short waits for planned care

Under the *Plan*, the local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list. The *Plan* reinforces that patients should have a wide choice of options for quick elective care, including making use of available Independent Sector capacity.

In relation to elective care the NHS National Medical Director's Clinical Standards Review will consider the 'stop the clock' rules. But meanwhile, there with be the reintroduction of the incentive system under which hospitals and CCGs will both be fined for any patient who breaches 12 months.

Research and innovation to drive future outcomes improvement

The *Plan* sets out the important role the NHS will plan in driving forwards research and innovation. It states that it will become easier to share innovation between organisations, innovation accelerated through a new Medtech funding mandate, and UK-led innovations that are proven as 'ready for spread', will be rolled out through Healthcare UK. We will also form an NHS Export Collaborative with Healthcare UK by 2021, working with selected trusts to export NHS innovations.

The *Plan* also states that the NHS will play a key role in genomics with the new NHS Genomic Medicine Service will sequence 500,000 whole genomes by 2023/24. During 2019, seriously ill children who are likely to have a rare genetic disorder, children with cancer, and adults suffering from certain rare conditions or specific cancers, will begin to be offered whole genome sequencing.

The NHS will also aim to increase the number of people registering to participate in health research to one million by 2023/24. Furthermore, to expand the NHS infrastructure for real world testing, there will be an expansion of the current NHSE 'test beds' through regional Test Bed Clusters from 2020/21.

Chapter 4: NHS staff will get the backing they need

The *Plan* does not obscure the scale of the challenges facing NHS trusts and staff with NHSE acknowledging that workforce growth "has not kept up with need" while staff have been inadequately

supported to meet the changing requirements of patients over the past decade. However while some tangible goals and new programmes have been outlined in the *Plan*, most of the requisite detail has been delayed until the publication of "the comprehensive workforce implementation plan", due to be published later in 2019. We expect this replaces the long awaited national workforce strategy.

Workforce implementation plan 2019

- The workforce implementation plan will be overseen by NHS Improvement (NHSI), with a national workforce group established by NHSI, NHSE and Health Education England (HEE) to ensure the delivery of its actions. The aim of the plan "is to ensure a sustainable overall balance between supply and demand across all staff groups"
- The national workforce group will include the new NHS Chief People Officer, the NHS National Medical Director, the Chief Nursing Officer; and other chief professions officers. It will also be made up of representation from staff side organisations, the Social Partnership Forum, Royal Colleges, The King's Fund, Health Foundation and Nuffield Trust.
- The *Plan* does not contain a complete list of priorities for the workforce implementation plan, but specifically notes a number of areas of focus, including:
    - shaping a modern, flexible and supportive employment culture within the NHS;
    - a "new deal" for staff to tackle bullying and harassment;
    - improving staff health and wellbeing, and ability to move between NHS employers;
    - options to improve the NHS leadership pipeline, building on the Kerr and Kark reviews; and
    - domestic recruitment and training.
- The NHS national nursing supply strategy will centre on increasing the number of undergraduate training places, with a pledge to fund an additional 5,000 places from 2019/20 (a 25% increase) and reduce the nursing vacancy rate to 5% by 2028.
- A new online nursing degree will be established, "linked to guaranteed placements at NHS trusts and primary care". The government hopes the degree will be launched in 2020 at a "substantially" lower cost than the £9,250-a-year for current students.
- The *Plan* points to an increased scrutiny on professional registration and entry standards, saying it is "paradoxical that many thousands of highly motivated and well-qualified applicants who want to join the health service are being turned away".
- The *Plan* also promises every nurse or midwife graduating a five-year NHS job guarantee every nurse or midwife graduating within the region they qualify.
- 4,000 more mental health and learning disability nurses will be in training by 2023/24, supported by enhanced 'earn and learn' measures, particularly earned at mature students lacking financial support.
- The *Plan* offers very little detail on medical education and training, leaving the specifics around the recruitment and retention of doctors to be established in the implementation plan. It does however emphasise its overarching strategy to shift the balance of training away from focusing on highly specialised skills to support the development of more balanced generalist roles.

International recruitment

- The *Plan* promised a "step change" in the recruitment of international nurses to work in the NHS. NHSE acknowledges the need to rely on migrant workers in the coming years given the lead time in training new domestic workforce entrants, saying that the NHS can expect national measures will "increase nurse supplies by several thousand each year."
- The workforce implementation plan will set out new national arrangements to support NHS organisations in recruiting overseas, recognising the difficulties faced by some trusts seeking to do this independently.
- Overall, the *Plan* gives very little new detail on how any "step change" will take place, noting that further discussions with the government will need to take place over new rules recently introduced in the immigration white paper.

Apprenticeships

- NHS trusts are asked to "take on the lead employer model" to improve the uptake of apprenticeships. The government also expects employers to offer all entry-level jobs as apprenticeships before considering other recruitment options.
- The *Plan* specifically promises a continuation of investment in nursing apprenticeships, saying that over 7,500 new nursing associates will begin employment in 2019: a 50% increase from 2018.
- The document point towards current difficulties with the apprenticeship system for NHS trusts, saying that the terms of the levy may have to change. The plan indicates that changes may not be fully considered until the government's review of the levy in 2020.

Staff experience and diversity

- NHSI will extend its retention collaborative to all trusts, as part of efforts to improve staff retention by at least 2% by 2025. This equates to a goal of retaining an additional 12,400 nurses.
- The *Plan* notes investment in current workforce development as a key priority saying it "expects HEE to increase investment in continue professional development over the next five years".
- Workforce diversity has been outlined as a key feature of the NHS long term plan, with the document outlining an additional £1 million to extend NHSE's work on the Workforce Race Equality Standard until 2025.
- Furthermore, the document says that each NHS organisation will set its own target for BAME representation across its leadership team and broader workforce by 2021/22.

Other key points

- The *Plan* underlines the government's commitment to national workforce planning in the NHS, saying it has been "disjointed at a national and local level" for too long. Annual recruitment

campaigns will be developed for roles facing the most acute shortages, in conjunction with royal colleges and trade unions.

- The government is pledging to create a "new compact with NHS leaders" to be enshrined in a new NHS leadership code setting out cultural values and leadership behaviours within the NHS.
- The document also underlines the need for greater flexibility in the workforce, and an improved use of technology: By 2021, NHSI will provide support to NHS trusts to deploy electronic rosters or e-job plans. A review of NHS workforce data will also be commissioned.
- The *Plan* re-introduces the potential for a professional registration scheme for senior NHS leaders to be introduces, while pledging to expand the NHS graduate training scheme.
- The *Plan* outlines a goal to double the number of NHS volunteers over the next three years, in part by committing an additional £2.3 million to the NHS Helpforce programme.

Chapter 5: Digitally-enabled care will go mainstream across the NHS

The *Plan* commits the NHS to be "digital first" in ten year's time. Particular attention has been given to digitally-enabled primary and outpatient care, primarily via a digital NHS front door in the form of the NHS App.

- Primary care: NHSE will create a new framework for digital suppliers to offer solutions to primary care networks, with the aim of offering every patient the right to switch to a new digital GP provider. By 2023/24 every patient will have access to a 'digital first' primary care provider.
- Outpatients: There will be push towards more non face-to-face outpatient care, with the intention to reduce face to face appointments by a third. This will remove around 30 million outpatient visits a year and will be driven by the increased use of telemedicine and mobile technologies. Where appropriate, every patient will be able to opt for a 'virtual' outpatient appointment.

The intention is that in 10 year's time, primary and outpatient care will be based on a model of tiered escalation depending on need. This new focus will also mean senior clinicians will be more reliant on digital technology, and less on junior staff and trainees, who will be freed up to learn and support services in other ways. This will also support the plan's other priorities, namely: supporting people to stay well, allowing patients to manage their own health, and allowing patients to stay at home.

In terms of digital health more broadly, the *Plan* describes four ways in which 'mainstreaming' digitally-enabled care will improve services:

- Improving patient experience: a number of benefits will be realised by empowering patients and carers. To support this, the NHS App will continue to be developed so that it becomes the 'standard online way' for people to access the NHS. There will also be a focus on improving interoperability and increasing the uptake of mobile monitoring devices. Personal health records will become more advanced, with patients and authorised carers being able to add information themselves

- Supporting the NHS workforce: new digital technology will also support staff working in trusts. For example, over the next three years there is an intention for all staff working in community services to have access to mobile digital services, including patients' care records and plans. Renewed focus will also be given to digital leadership in the NHS, including a new commitment for informatics representation on the board of every NHS organisation
- Quality clinical care: much of this work will also require the NHS to rethink the way patients interact with services. In addition to the changes to primary and outpatient services, all providers will be expected to advance to a 'core level of digitisation' by 2024. This will include accelerating the roll out of electronic patient records, improving IT hosting, storage and networks, and building resilient cyber security. The plan states central funding will be made available to trusts to help them achieve minimum standards
- Population health: NHSE will deploy population management solution to ICSs during 2019. This work will also involve the increased use of de-personalised data taken from local records.

The *Plan* recognises that this will only be achieved by creating the right environment and infrastructure. This will involve, among other things, creating a digitally literate workforce, making NHS solutions available as 'open source' to developers, and requiring NHS suppliers to comply with open standards and interoperability requirements.

Milestones for digitally-enabled care

- Introducing controls to ensure new systems procured by the NHS comply with new agreed standards
- By 2020, five geographies (to be confirmed) will deliver a longitudinal health and care record linking NHS and local authority organisations. Three more areas will follow in 2021
- By 2020/21, every patient will have access to their care plan on the NHS app, as well as communications from their carer professionals
- There will be 100% compliance with mandated cyber security standards by 2021.
- In 2021/22, every local NHS organisation will have a chief clinical information officer (CCIO) or chief information officer (CIO) on their board
- By 2024 there will be universal coverage of regional local health and care records.

Chapter 6: Taxpayers' investment will be used to maximum effect

The *Plan* outlines how the NHS will continue to become more efficient over the coming decade. It restates the following five tests set out by the government in the 2018 budget, and sets out how the NHS will meet them:

1. The NHS (including providers) will return to financial balance
2. The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care
3. The NHS will reduce the growth in demand for care through better integration and prevention

4. The NHS will reduce variation across the health system, improving providers' financial and operational performance
5. The NHS will make better use of capital investment and its existing assets to drive transformation.

Returning to financial balance

The *Plan* gives a revised timetable for the NHS to return to financial balance: the aggregate provider deficit should reduce each year, and the provider sector as a whole should balance by 2020/21. This is two years later than the aspiration set out in the 2018/19 planning guidance, for the sector to be back in the black by the end of the current financial year. Meanwhile, the number of trusts and commissioners in deficit should also decrease. The number of trusts reporting a deficit in 2019/20 is expected to halve, and all NHS organisations should be in balance by 2023/24.

Previously-trailed policy changes for 2019/20 are restated, with little additional detail. These include moving away from activity based payment systems, and aligning commissioner and provider financial incentives.

NHSI will introduce an "accelerated turnaround process" for the "30 worst financially performing trusts", whose combined shortfall is equal to the overall provider sector deficit. However no detail is given on what that process will involve, or how the trusts that will be subject to it have been identified.

Separately, a new Financial Recovery Fund (FRF) will be created to enable services to become sustainable. No details are given on the size of the fund or when it will begin. It will be accessible "for trusts where deficit control totals indicate a risk to financial sustainability and continuity of services". In return, trusts must draw up a multi-year financial recovery plan with NHSE and NHSI's joint regional team, and a rate of efficiency of at least 1.6% - 0.5% above the national minimum of 1.1%. The recovery plan will set out the actions needed to make services sustainable at both trust and system level, and the agreed responsibilities within the ICS or STP. It will be expected that trusts will implement national initiatives such as Getting It Right First Time and redesigning outpatient services. The *Plan* says the FRF will mean the end of the control total and Provider Sustainability Fund (PSF) regimes for trusts which deliver on their recovery plans. It does not say what the future of the PSF and control total regimes will be for trusts which are not eligible for the FRF.

Improving efficiency and reducing waste

The plan indicates there will be a "strengthened efficiency and productivity programme". Although it does not give detail on how the programme will run, it does set out ten familiar priority areas for efficiency and productivity:

1. Improving the availability and deployment of the clinical workforce using e-rostering
2. Saving money through standardising and scaling-up procurement of consumables
3. Developing pathology and imaging networks
4. Making community, mental health and primary care services more efficient, in line with recent reviews by Lord Carter

5. Improving value from medicines spend
6. Reducing administration costs. This includes a commitment to save £700m by 2023/24, of which £400m should come from providers. The plan does not state how those figures have calculated, where the reductions in spending will come from or whether they are recurrent or cumulative savings
7. Improving the way the NHS uses land, buildings and equipment, and will dispose of surplus assets to enable reinvestment
8. Reducing the use of less effective procedures
9. Improving patient safety
10. Continuing to tackle fraud.

Capital

The *Plan* says the NHS has invested less in recent years in infrastructure than it has done in the past, and at a lower rate than other western countries. It states that meeting its future aspirations will require digital capability and diagnostic equipment will be enhanced significantly.

The capital settlement for the *Plan* period will be set out in this year's Spending Review. At the same time, a number of reforms will be set out to the regime for accessing capital. These will "remove the existing fragmentation of funding sources, short-termism of capital decision making and uncertainty for local health economies".

Next steps

With 2019/20 positioned as a transition year, the next steps for implementing the *Plan* are:

- Local health systems receiving five-year indicative financial allocations for 2019/20 to 2023/24, and being asked to produce plans for implementing the *Plan's* commitments. Those local plans will then be brought together in a national implementation programme in the autumn
- The Clinical Standards Review and the national implementation framework being published in the spring, to be implemented in October following testing and evaluation of any new and revised standards
- The NHS Assembly being established in early 2019. The Assembly – its members comprising third sector stakeholders, the NHS arm's length bodies and frontline NHS and local authority leaders – will advise the boards of NHSE and NHSI and oversee progress on the *Plan*
- The spending review (expected in the autumn) setting out allocations for NHS capital, education and training as well as public health and adult social care

In support of these steps, the *Plan* commits to automating and standardising the generation and storage of data to reduce the burden on frontline services and reduce duplication. It also undertakes to set out a single list of "essential interventions" (including effective e-rostering and e-job planning and processes for standardising and aggregating procurement demand for products and services) to maximise value. The

national bodies will also work with the Health Foundation to increase the number of ICSs building their improvement capabilities.

National operating model

NHSE and NHSI will implement a new shared operating model, with shared regional teams accountable for managing local systems and the providers within them, and ensuring systems secure the best value from their combined resources. To deliver this, the *Plan* commits to:

- A move from relying on regulation and performance management to supporting service improvement and transformation
- Strong governance and accountability mechanisms in place for systems
- A reinforcement of accountability at board, governing body and local system ICS level for adopting standards of best practice and contributing to national improvement programmes, on a comply or explain basis
- Making better use and improving the quality of frontline data and information

Approach to local systems

The *Plan* commits to "balance[ing] national direction with local autonomy to secure the best outcomes for patients". As part of that approach, it sets out:

- An ambition for ICSs to cover England by April 2021. Local systems will be supported in producing and implementing development plans, including intensive support programme for the most challenged systems with peer support from more developed systems.
- The intention to support organisations to take on greater collaborative responsibility. As well as providing "high-quality care and financial stewardship from an institutional perspective", organisations will be expected to take on responsibility "for wider objectives in relation to the use of NHS resources and population health". System oversight will look at organisational and system objectives alongside organisational performance.
- Successful organisations will be asked to support their neighbours in developing capability and resilience, forming part of a 'duty to collaborate' for providers and CCGs.

Legislation

A "provisional list of potential legislative changes" which the national bodies would seek from government includes:

- Giving CCGs and providers **shared new duties** to promote the 'triple aim' of better health for everyone, better care for all patients, and local and national NHS sustainability
- Removing specific impediments to **'place-based' NHS commissioning**, including how CCGs can collaborate with NHSE and NHSE being able to integrate its public health functions within the Mandate
- Allowing trusts and CCGs to **exercise functions and make decisions jointly**. This would mean foundation trusts could create joint committees, and allow (with certain areas where there may be

a conflict reserved to one party) the creation of a joint commissioner/provider committee in every ICS, which could operate as a transparent and publicly accountable partnership board

- Supporting the creation of **NHS integrated care trusts**. This would better enable creation of new NHS integrated care providers (ICPs) and make organisational mergers easier to progress
- Removing the **Competition and Markets Authority's (CMA) duties** to intervene in NHS provider mergers, and its powers in relation to NHS pricing and NHS provider licence condition decisions. Monitor's 2012 Act competition roles would also be removed
- Allowing NHS commissioners to decide the circumstances in which they should use **procurement processes**, subject to a 'best value' test, and removing the wholesale NHS' inclusion in the Public Contract Regulations. Patient choice and control would be protected and strengthened
- Increasing flexibility in the **NHS pricing regime**, in order to move away from activity-based tariffs where appropriate, facilitate integration and reduce fragmentation in public health commissioning.
- Making it easier for **NHSE and NHSI** to work together, including being able to establish a joint committee and subcommittees, with corresponding streamlining of non-executive and executive functions.

NHS Providers view

A crucial next step will be the implementation of the plan which will require ruthless prioritisation of the key investment areas which will require continued engagement from trust leaders. In addition, the key interdependencies for the success of the *Plan* will be the national workforce implementation plan, along with training and education funding, capital investment, and a sustainable solution for social care funding. Some of these issues lie outside of NHSE/I's control and will be addressed in separate publications. In addition, the *Plan's* approach to addressing the wider determinants of health, will be heavily reliant on local authority support despite radical cuts to public health budgets in recent years.

Part 2 of the planning guidance is still due to be published later this week, which we expect will set out further detail on the operational and financial performance expectations for 2019/20. The trajectory to operational performance recovery against key constitutional targets is not included within the plan, however the clinical review of standards is expected to be published in spring 2019.

The importance of the local autonomy and the accountability of provider boards is mentioned within the *Plan*, although the role of the national bodies in ensuring consistency, value for money and support are equally at the forefront of the intended revised approach. The roll out of ICSs across the country by 2021, and the enhancements of the role of system working through the revised financial framework and in relation to commissioning structures, regulation and performance management are significant. We will be working closely with the national bodies, and providers, to unpack and help shape their implementation.

NHS Providers will continue to engage in the development of the detail underpinning the *Plan* and its implementation. We will also provide further analysis to members on what the *Plan* means for them and look forward to engaging members in our ongoing work in this area.

NHS Providers press statement

NHS long term plan - trusts are committed to creating world class services

Responding to the publication of the *NHS long term plan*, the chief executive of NHS Providers, Chris Hopson said:

"There will be strong support across the NHS for the vision and ambition set out in the document. Trusts and their staff are strongly committed to creating world class services and continuously improving patient outcomes. They also recognise the need to transform the way they provide care to reflect 21st century health and care needs.

"There is a huge amount to do across a wide range of areas. Successful delivery will depend on four key factors.

"First, ruthless prioritisation and effective implementation. To plan is to choose. We now need a detailed implementation plan that sets out exactly what will be delivered when. This must clearly match the priorities for each year to the available money and staff, ensuring that the trusts who have to deliver the plan are actually able to do so.

"Second, a rapid solution to current workforce shortages. This plan cannot be delivered whilst trusts still have 100,000 workforce vacancies. We need urgent action to solve what trust leaders current describe as their biggest problem. It's a major concern that we will have to wait longer to get the comprehensive plan that is needed here.

"Third, a clear path to recovering performance in areas like urgent and emergency care and routine surgery. Despite trusts working flat out, the NHS has fallen behind where it needs to be, missing all its key performance targets over the last four years. Whilst trusts are ready to look at updating these targets, we mustn't lose the enormous gains trusts made in cutting waiting lists and improving care in the early 2000s.

"Fourth, there are a range of other issues central to the success of the NHS that must be satisfactorily resolved through the spending review – social care, public health and NHS training budgets.

"The ambition and vision are welcome. But they need to be delivered.

"We welcome the commitment to an open and consultative process in developing a detailed implementation plan over the next few months. It is vital that the expertise and concerns of NHS trusts are central to those discussions. We look forward to making a full and positive contribution."

ENDS.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Presenter of Report	Mr M Metcalfe, Medical Director
Author(s) of Report	Matthew Metcalfe, Medical Director
Purpose	To ensure the Quality Governance Committee are aware of the risks on the Corporate Risk Register they have oversight of and provide assurance that risks are identified and managed through robust systems and processes implemented within the Trust

Executive Summary

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

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

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

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

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

Actions required by the Board

The Board is asked to receive this report.

Northampton General Hospital NHS Trust

Medical Director's Report

31st January 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;

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

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

2. Risk

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

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk of reduced patient safety when demand exceeds capacity	20	15	Quality Governance
1757	Escalation areas budgeted for limited periods may remain open for extended periods	16	16	Quality Governance
1782	Venous Thromboembolism: compliance	16	16	Quality Governance
551	Patients may receive suboptimal care at weekends due to reduced numbers of staff being available to provide full 7 day working.	16	16	Quality Governance
1518	The Trust has difficulty in recruiting to the establishment due to local and national shortages of medical staff and difficulties associated with overseas recruitment	16	16	Workforce
1756	Ineffectiveness of the Nye Bevan unit due to ineffectiveness of the medical model, inability to recruit staff substantively, as well as impact of patient flow across the hospital.	20	20	Finance & Performance

3. Harm

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

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

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

	16/17	17/18	18/19
Serious Incidents	13	18	22
Never Events	1	3	1

3.ii New SI and moderate investigations

There were 4 serious incidents reported on STEIS during December 2018 and January 2019. These are on track to report by their deadlines and are summarised in the following table;

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Location	45 day completion date
2018/30046 W-96198	Missed Lung Cancer	ED	25/02/2019
2018/30053 W-94446	Failure in Referral Process	Chest Clinic	25/02/2019
2018/30482 W-97725	Delay in Medical Review	Spencer	01/03/2019
2018/25155	Never Event Wrong site surgery – Breast cancer	Surgery	20/12/2018

During December and January six SI reports were submitted to the CCG for closure. The learning and actions arising have been shared through divisional governance meetings, CQEG and QGC.

13 moderate harm incidents were detected during December and January, and these are subject to concise RCA investigations.

3.iii Thematic Issues

No new themes have been identified from incidents in December and 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 operating group. Issues relating to the failure to act upon investion results are not directly covered by this group at the moment, and the Associate Medical Director for Clinical Governance is leading the development of a policy on this theme to support a trust wide response.

4. Mortality

There is a separate report to Trust Board this month setting out the findings of the trust wide mortality review 12, instigated when the HMSR appeared to be on a rising trend, exploring the care and records of patients from 100 consecutive in hospital deaths. There is also the statutory "Learning From Deaths" Report to the Board.

The trust level HMSR has fallen month on month for the last 3 months and the rolling HMSR may have peaked, at 106.1 in the year to September against 106.4 in the year to August. SMR and SHMI remain in the expected range, but as lag indicators may rise to follow the pattern of HMSR before falling again.

Crude mortality from October through to December has been lower than 2017, suggesting that the improvement may be sustained over coming months.

5. Medical Workforce

5.1 Consultant Job Planning

Oversight of medical job planning through executive consistency committee meetings continues to support improved compliance with the job planning policy. The number of job plans over 12 PA has reduced by 35%, at 33 in December 2018 compared with 51 in December 2017. The managed reduction in exceptions has ensured no impact to service delivery. Adherence to job planning policy has resulted in an increase in requests for mediation although to date no formal appeals have been lodged (over the last 12 months).

Medical recruitment over the last 12 months has seen a significant expansion in consultant medical staff, significantly facilitating job plan policy compliance.

5.2 Medical Model for Nye Bevan

The new rota for non-elective GIM provision commenced on the second of January 2019 to support an acute medical model with earlier consultant review by substantive consultant physicians and better continuity of care. To support the introduction of a new working model for medical assessment an associate medical director for emergency care transformation has been appointed.

There has been a positive impact on the waiting times for senior clinical review and overall medical waits to be seen, as monitored through the site reports. KPIs are being developed to continue to monitor the impact of the new model as it is implemented and improved.

6. Thrombosis

The upgrade to ePMA which will enforce VTE risk assessment is subject to some slippage on roll out. It is anticipated that testing will ocurr in February 2019, with roll out in March or April 2019 (subject to testing). This is a 1-2 month delay.

Following the “clot busting” campaign in October the overdue VTE assessments have been reported at the trust wide daily safety huddle. The initial impact has been positive, and the focus now is on maintaining this through a period of sustained winter pressure until the forcing function is introduced.

7. Deteriorating Patient

Development work on the Standard of Care score (which will be used as a KPI for the interventions to improve the care of deteriorating patients) and the deteriorating patient care plan is complete. This has been achieved through iterative improvements “road testing” the care plan against historical harm incidents and on 4 trial wards.

The roll out plan trust wide will be reported to CQEG in February and KPIs escalated as appropriate.

Appendix 1

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary Targets & RAG

	Indicator	Target	OCT-18	NOV-18	DEC-18
Caring	Complaints responded to within agreed timescales	>=90%	97.3%	97.4%	98.0%
	Friends & Family Test % of patients who would recommend: A&E	>=87.1%	88.4%	88.1%	86.8%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	92.4%	94.0%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97%	100.0%	96.6%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	92.3%	93.8%	93.5%
	Mixed Sex Accommodation	=0	0	0	0
	Compliments		4,288	4,336	3,641

	Indicator	Target	OCT-18	NOV-18	DEC-18
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	88.7%	86.9%	83.5%
	Average Ambulance handover times	<=15 mins	00:14	00:14	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	174	142	299
	Ambulance handovers that waited over 60 mins	<=10	17	19	30
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	3	3	4
	Delayed transfer of care	<23	10	10	24
	Average Monthly DTOCs	<=23	27	16	20
	Average Monthly Health DTOCs	<=7	25	13	18
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	94.0%	88.6%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	81.0%	40.2%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.5%	94.8%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.7%	96.8%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	88.8%	83.7%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	86.4%	78.0%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	83.8%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	86.7%	83.8%	
	RTT waiting times Incomplete pathways	>=92%	81.5%	82.1%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%	99.9%	
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	94.8%	96.8%	100.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	97.9%	96.0%	96.3%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Effective	Stranded Patients (ave.) as % of bed base	<=40%	54.1%	54.4%	54.7%
	Super Stranded Patients (ave.) as % of bed base	<=25%	23.7%	23.1%	23.1%
	Length of stay - All	<=4.2	4.5	4.4	4.1
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.4%	3.8%	3.3%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.1%	17.2%	11.8%
	# NoF - Fit patients operated on within 36 hours	>=80%	84.8%	82.7%	100.0%
	Maternity: C Section Rates	<29%	31.4%	31.3%	32.1%
	Mortality: HSMR	100	106	106	106
	Mortality: SHMI	100	100	104	102

	Indicator	Target	OCT-18	NOV-18	DEC-18
Safe	Never event incidence	=0	1	0	0
	Number of Serious Incidents (SI's) declared during the period		0	0	3
	MRSA	=0	0	0	0
	C-Diff	<=1.35	0	0	1
	MSSA	<=1.1	2	1	0
	VTE Risk Assessment	>=95%	95.7%	95.4%	93.6%
	New Harms	<=2%	2.11%	0.87%	0.96%
	Harm Free Care (Safety Thermometer)	>=94%	94.2%	96.1%	96.3%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.0	4.2	4.4
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=50	66	38	36
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=95%	98.9%	97.2%	91.4%
	Ward Moves > 2 as a % of all Ward Moves	<3%	5.8%	6.1%	6.2%
	Appointed Fire Wardens	>=85%			85.6%
	Fire Drill Compliance	>=85%			82.0%
	Fire Evacuation Plan	>=85%			89.2%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Well Led	Income YTD (£000's)	>=0	(3,337) Adv	(2,857) Adv	(3,650) Adv
	Surplus / Deficit YTD (£000's)	>=0	67 Fav	87 Fav	(432) Adv
	Pay YTD (£000's)	>=0	(3,221) Adv	(3,277) Adv	(3,166) Adv
	Non Pay YTD (£000's)	>=0	4,248 Fav	4,204 Fav	4,612 Fav
	Bank & Agency / Pay %	<=7.5%	12.4%	12.3%	12.3%
	Salary Overpayments - Number YTD	=0	163	167	186
	Salary Overpayments - Value YTD (£000's)	=0	313.1	340.9	371.9
	CIP Performance YTD (£000's)	>=0	1,704 Fav	1,821 Fav	1,554 Fav
	Maverick Transactions	=0			15
	Waivers which have breached	=0			1
	Job plans progressed to stage 2 sign-off	>=90%	15.1%	27.6%	24.2%
	Sickness Rate	<=3.8%	4.0%	4.0%	4.4%
	Staff: Trust level vacancy rate - All	<=9%	10.4%	10.3%	12.5%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	8.8%	9.0%	9.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	7.3%	7.6%	11.6%
	Staff: Trust level vacancy rate - Other Staff	<=9%	12.8%	12.1%	13.6%
	Turnover Rate	<=12%	7.7%	7.8%	8.3%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.8%	88.2%	88.6%
	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%		81.9%	82.8%
	Percentage of all trust staff with role specific training compliance	>=85%	81.9%	82.6%	83.0%
	Percentage of staff with annual appraisal	>=85%	83.1%	83.6%	81.6%

Appendix 2

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated – benchmarked against 2015/16 national statistics	Quality Governance Committee.	December 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Maternity: C Section Rates	<29%	**29.5%**	**27.9%**	**30.9%**	**28.4%**	**31.3%**	**34.1%**	**28.9%**	**29.8%**	**28.9%**	**31.4%**	**31.3%**	**32.1%**
Maternity: Number of C Section Procedures		124	90	122	110	127	126	122	124	114	118	126	121
Maternity: Number of Birthing Sessions		420	322	394	387	405	369	421	415	394	375	402	376

Driver for underperformance:

- Elective CS rate 15.4%, which is slightly, lower than November (16.9%), this month the Emergency CS rate, has risen from 14.4% to 16.7%.
- Quarterly CS rate for 2018/19:

Q1	Q2	Q3
31.3%	29.2%	31.6%

Actions to address the underperformance:

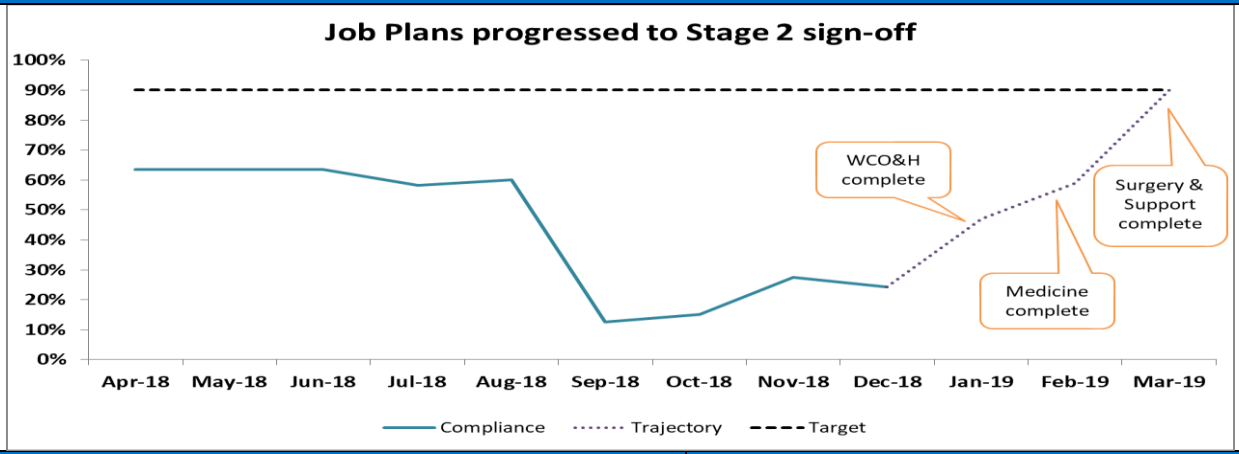
- Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making
- Continue with debriefs following all Caesarean Sections – this is now documented on Medway as part of the CS documentation
- Birth After Caesarean Clinic – ongoing

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd	Sandra Neale	Dr M Metcalfe

Scorecard - Exception Report

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

Performance:



Driver for underperformance:	Actions to address the underperformance:
• Data rebased in September to reflect compliance in all divisions to date. • Compliance includes only job plans related to the current financial year • Delays within Medicine Division has negatively impacted on other Divisions • Medicine Job Planning paused as agreed at fixing the flow meeting until Quarter 4 • As the Divisions progress with Service planning, new job plans are entered, temporarily reducing compliance.	• Regular Executive Consistency Committee (ECC) meetings taking place with the Divisions for updates and challenge on progress • Good progress being made with WCO&H and anticipate completion end of January • Process started with Surgery Division and second ECC meeting w/c 14th January. Good engagement, no issues anticipated with completion by the end of the financial year.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw	Elizabeth Smillie	Mr Matthew Metcalfe

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**31 January 2019**

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

Executive summary

Since Q3 2017/18 all Trusts have been required to publish the information included in the attached dashboard on a quarterly basis.

- Total number of in-patient deaths
- Number of deaths subjected to case record review
- Of the deaths reviewed, how many deaths were thought more likely than not to be due to a problem in care

This paper includes the following dashboard

- Q2 2018/19

The publication schedule for reports is as follows and allows reporting as promptly as possible whilst also allowing for the time taken to distribute cases and complete reviews:

- Q1 Sept meeting
- Q2 January meeting
- Q3 March meeting
- Q4 July meeting

Related strategic aim and corporate objective	1
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks

Related Board Assurance Framework entries	BAF – 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? (Y/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)? (Y/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

Actions required by the Board

The Board is asked to:

- Approve the NGH Mortality Dashboard

NGH Mortality Dashboard Q2 2018/19

Northampton General Hospital NHS Trust

	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to Sep 18	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings ot Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q3 17/18	383	47	46%	96	5	2	1 SI / 1 CI
Q4 17/18	459	50	70%	92	11	3	2 CI / 1 NI
Q1 18/19	365	39	61%	122*	8	1	1 NI
Jul-18	100	10	65%	12 of 19	1	0	
Aug-18	82	11	66%	14 of 20	2	1	1 CI
Sep-18	94	15	60%	15 of 19	2	0	
Total Q2 18/19	**276**	**36**	**63%**	**35 of 57**	**5**	**1**	1 CI

*May 2018 has a higher number of reviews because of the Trust wide Mortality Case Note Review 12 which included 100 deaths from that month

Vulnerable Adults

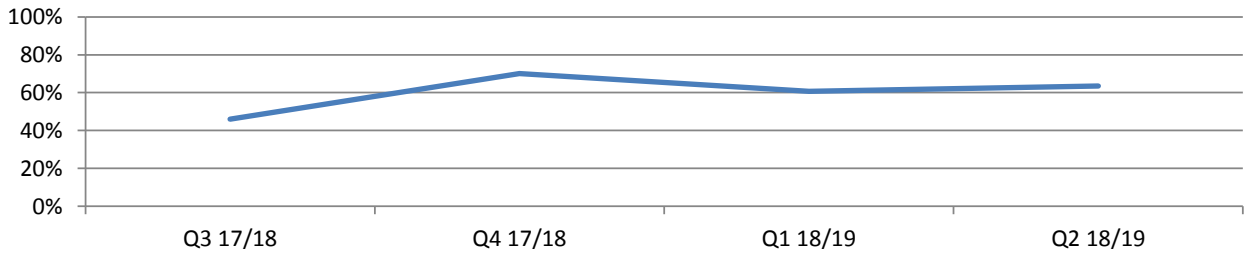
Patients with a learning disability

The care of 2 patients with a learning disability who died at NGH during Q2 18/19 has been reviewed. Both cases have been notified to the National Learning Disability Mortality Case Note Review (LeDeR).

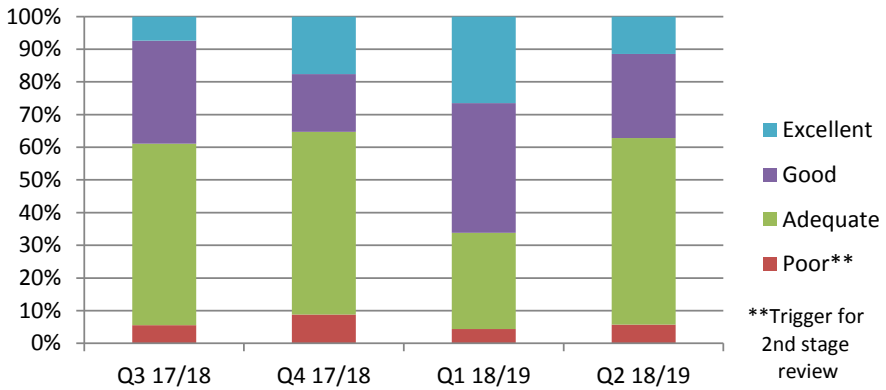
Patients with a significant mental health diagnosis

The care of 2 patients with a significant mental health diagnosis who died at NGH during Q2 18/19 has been reviewed.

Percentage of Deaths Screened by Mortality Screening Team



Distribution of Overall Care Scores from Structured Judgement Reviews



Learning from Screening, and Structured Judgement Reviews

The mortality screening and review process continues to provide assurance of the high quality of the care provided to the vast majority of patients who die at Northampton General Hospital.
Themes identified through the process are discussed at Mortality Review Group and either linked to existing work streams or fed back to clinical teams (for example The Deteriorating Patient Board and End of Life Care Morbidity and Mortality Meeting). A Strategy for reducing mortality - learning from the screening and review of deaths has been prepared and is currently out for consultation. The strategy outlines the different forums for sharing learning from the mortality process.
Validation of the process is addressed in several ways including comparison of screening and review outcomes, 2nd Structured Judgement Review meetings and Trust wide reviews. 2nd Structured Judgement Review meetings will be altered in Q4 2018/19 to include some cases where the care was judged to be excellent. This will help to validate the process and spread learning identified from excellent care.

Screening Capacity

2 new screeners started in post towards the end of Q3 so an increase in the screening rates will be seen in Q3 data (to be published Mar 2019)

Compliance with request for completion of Structured Judgement Review Tool

This is currently too low and a clear process for escalation of non-compliance will be agreed (Jan 2019)

Positive Feedback

Positive feedback from the mortality screening and review process is now well established for doctors, nurses and other healthcare professionals and is very well received

Information Governance Policy for Mortality processes

1st draft of this policy is completed and shared with the Information Governance Lead and will outline storage and sharing of information generated

Introduction of the Medical Examiner Role

A working Group has been established to address the introduction of this new role

Move to electronic process

The IT Clinical Senate has agreed to include electronic Structured Judgement Reviews as a future project (date for commencement tbc)

Response to Dr Foster data

A review of the Dr Foster basket "Excision of colon and/ or rectum" by the surgical team

1st Meeting of the Vulnerable Adult Mortality Meeting

This took place in June 2018 and included patients with a learning disability, significant mental health illness and acquired brain injury

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Trust Wide Mortality Case Note Review 12**
Agenda item	**10**
Presenter of Report	Mr M Metcalfe Medical Director
Author(s) of Report	Dr L Jameson, Specialty Doctor, Medical Director's Office
Purpose	To provide assurance of the quality of care provided to patients who died in May 2018 in response to data showing a high Hospitalised Standardised Mortality Ratio (HSMR)

Executive summary

- HSMR for Northampton General Hospital has been steadily rising in recent months and became significantly worse than expected for the rolling year to July 2018
- HSMR on a month by month basis shows that although several months have an HSMR of over 100, this is only statistically significant in May 2018
- The aim of Review 12 was to provide assurance of the quality of care received by patients who died at NGH in May 2018
- The first 100 deaths in May 2018 were selected for Structured Judgement Review
- The clinical coding was also reviewed (no changes to clinical coding were required)
- The sample included a high proportion of patients aged 90 years or over
- The vast majority of care was considered to be good or excellent
- 22% of patients were considered to have been medically fit for discharge at some stage during their admission
- It was considered that 13% of patients would have been better cared for outside an acute trust
- Outcomes from Review 12 correlated well with outcomes from routine mortality screening and review processes giving assurance of the validity of the process
- 3 cases considered to have overall poor care will progress to 2nd stage review
- This report will be discussed at MRG on 07.02.19 and the next steps for dissemination of learning will be agreed

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to?1
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – 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? (Y/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)? (Y/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

Actions required by the Board

The Board is asked to:

- Approve the report for Review 12

Northampton General Hospital
NHS Trust

Trust Wide Mortality Case Note Review 12

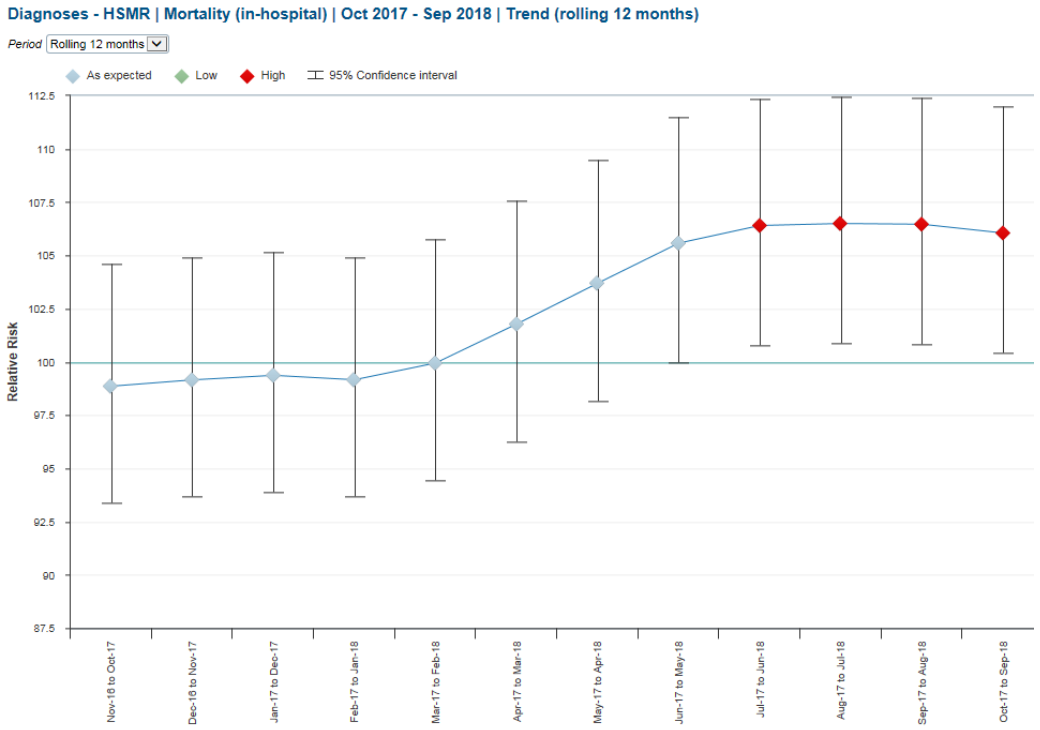
October 2018 – January 2019

1. Introduction

1.1 Hospital Standardised Mortality Ratio (HSMR)

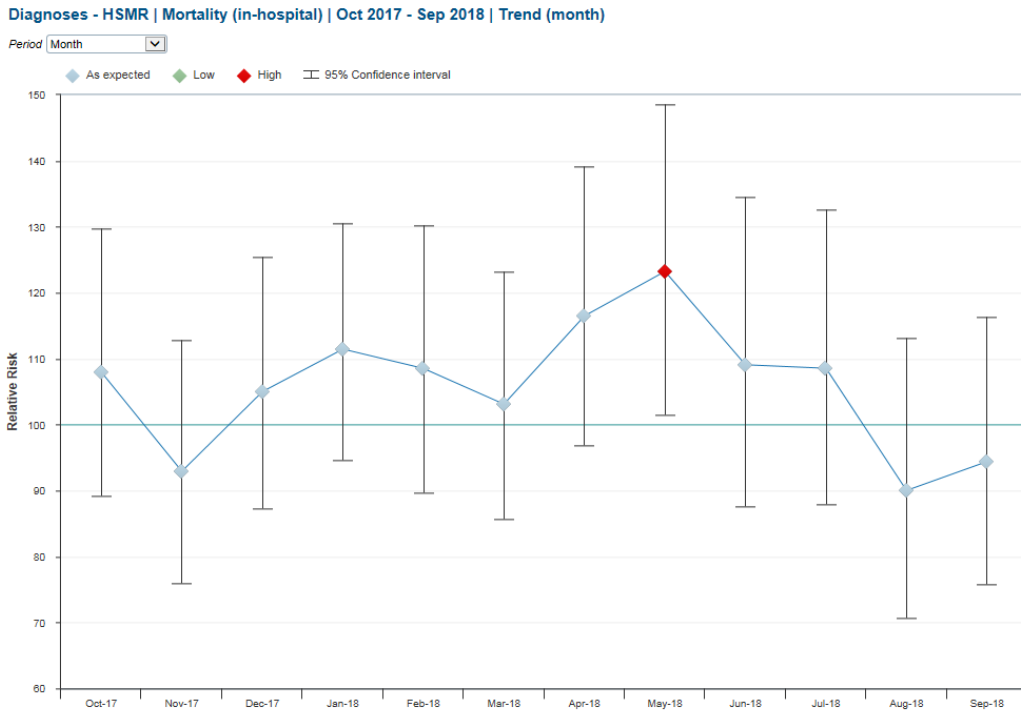
HSMR for Northampton General Hospital has been steadily rising in recent months and became significantly worse than expected for the rolling year to July 2018 (see graph 1). This high HSMR has persisted in the latest 4 months of published data up to and including the rolling year to September 2018.

Graph 1



Looking at the HSMR on a month by month basis shows that although several months have an HSMR of over 100, this is only statistically significant in May 2018 (see graph 2). Since May the HSMR for each individual month has been as expected and for August and September 2018 has been below 100.

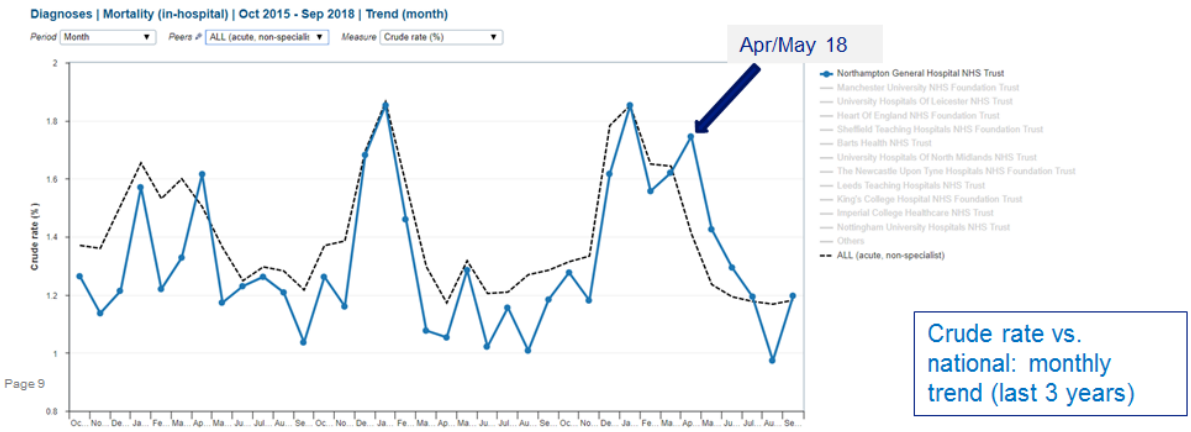
Graph 2



1.2 Crude Mortality

Graph 3 shows crude mortality for NGH vs the national rate monthly for the last 3 years and shows that NGH did not follow the National trend in May 2018 when crude Mortality remained high as nationally it started to fall.

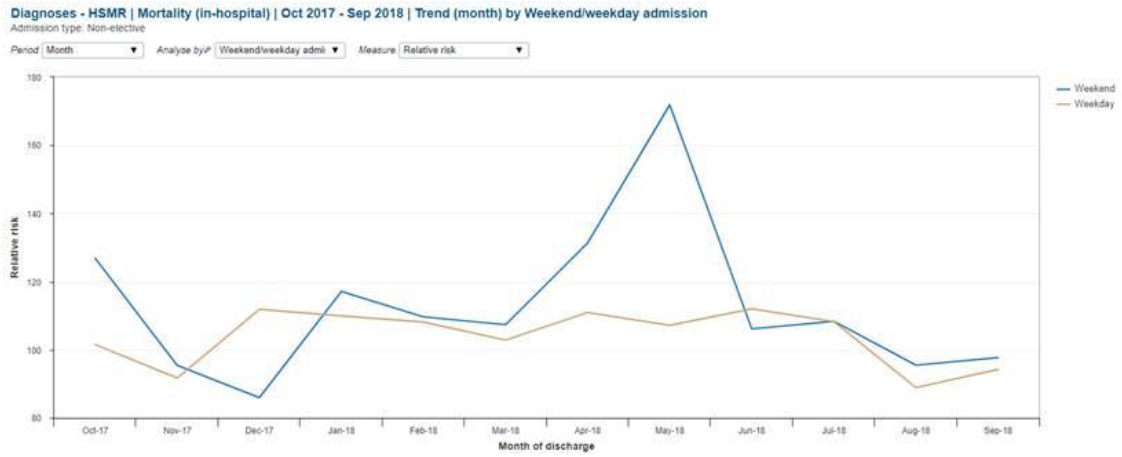
Graph 3



1.3 Weekend vs Weekday Mortality

HSMR for patients admitted at a weekend also became statistically significantly worse than expected in May 2018 (see graph 4).

Graph 4



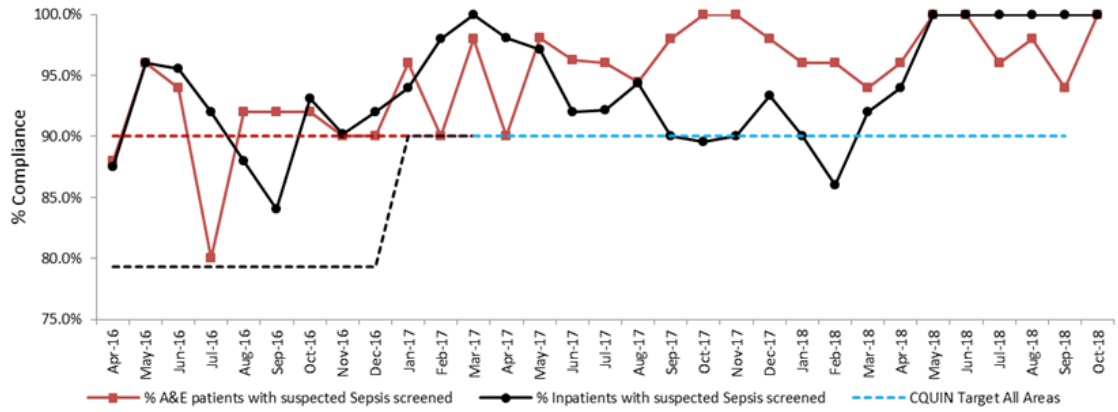
1.4 Outlying Diagnoses

The rise in HSMR is largely being driven by 2 diagnosis groups, Septicaemia (except in labour) and Secondary Malignancies. Both of these are diagnoses groups which have been investigated using mortality case note reviews in the last 18 months.

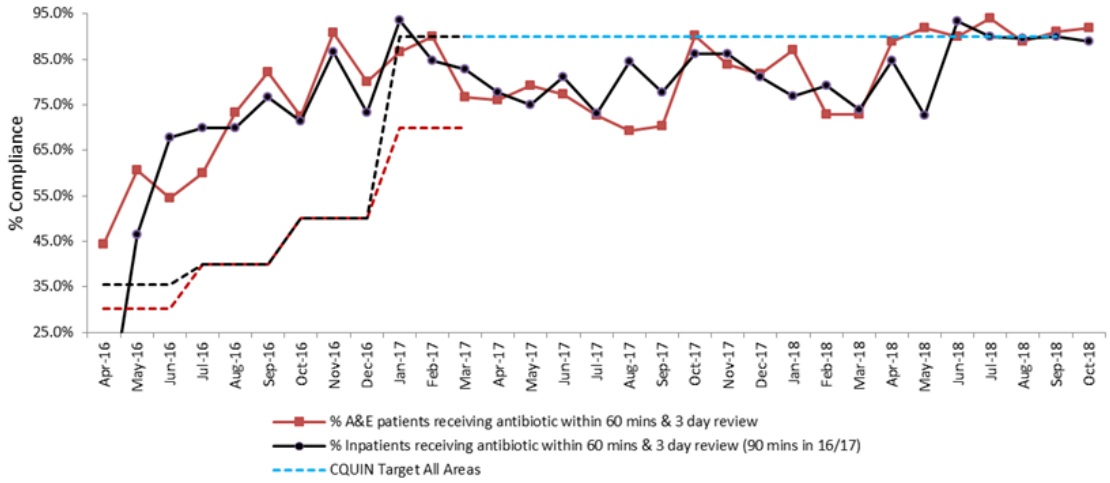
1.4.1 Sepsis

In December 2018 NGH received a letter from the Care Quality Commission asking for a detailed response in relation to the ongoing mortality alert for Sepsis. The response included details about Trust Wide Mortality Case Note Review 10 which looked at a group of 40 patients with sepsis and/ or AKI (whilst highlighting areas where care could be improved Review 10 did not pick up any deaths thought to be more likely than not to be due to a problem in care) and the National CQUIN (results of which are showing improvement in screening for sepsis and time to antibiotics both in A&E and on the wards (see graphs 5 and 6). There is concern that sepsis is over diagnosed and documented for many patients with high Early Warning Scores, particularly on admission. The national and local campaigns to improve the care of patients with sepsis in addition to the changes to clinical coding rules over the last 18 months are also considered to have had an effect on the number of cases identified. Sepsis continues to be monitored as a specific work stream through the Mortality Review Group at NGH.

Graph 5



Graph 6



1.4.2 Secondary malignancy

The care of 28 patients who died in Q4 17/18 with a primary diagnosis of secondary malignancy were reviewed in December 2017. Early recognition of the dying process to allow for a more dignified death and the appropriateness of place of death were 2 themes arising from this review but again deaths were not felt to be more likely than not to be due to a problem in healthcare. Recent Dr Foster data shows that NGH codes palliative care for patients with secondary malignancy less frequently compared with national data (4.8% compared with 7.2%) which may be a contributing factor to the SMR for secondary malignancies being higher than expected. Palliative Care Coding in Secondary Malignancy is monitored as a specific work stream through the Mortality Review Group at NGH.

1.5 Model of Care

The model of care at NGH, using admissions wards before transfer to a specialty ward has an influence on the primary diagnosis as recorded by the clinical coding team as transfer between consultants triggers the start of a new coding episode and therefore potentially a new primary diagnosis. The primary diagnosis is important because of the effect it has on the predicted risk of mortality. It is not uncommon for the definitive diagnosis to be made after the transfer of care has taken place and therefore this diagnosis is not reflected in the primary diagnosis for the first episode of care which is the important metric for Dr Foster. An example would be a patient admitted with a lower respiratory tract infection whose definitive diagnosis is revised to bronchopneumonia.

1.6 Documentation

In order for clinical coding to fully reflect the risk of mortality associated with an admission, documentation must be clear and working diagnoses must be updated during longer admissions if the situation changes. A work stream has been launched via Mortality Review Group which will attempt to look at models of care, documentation and clinical coding as a whole.

2 Aim of Review 12

To provide assurance of the quality of care received by patients who died at NGH in May 2018.

- To provide assurance of the quality and depth of clinical coding
- To use Trust Wide Mortality Case Note Review 12 looking at the first 100 deaths in May 2018 using the Structured Judgement Review Tool (SJR) to look at the quality of clinical care.
- To identify any deaths felt more likely than not to be due to a problem in care.
- To identify 50 new reviewers to increase training, knowledge and use of the SJR tool.
- To ask specific questions for Review 12 with relation to delayed discharge and appropriateness of place of care.
- To arrange themed challenge meetings to discuss learning identified from examples of excellent care and examples where care could be improved.
- To assure the quality of the mortality screening and review process where possible.

3 Method

3.1 Case Selection

The first 100 patients aged 18 years or over who died during an in-patient stay in May 2018 were included. Patients whose care had already undergone 2nd Structured Judgement Review (SJR) were excluded. The medical records for all 100 patients were available for review.

3.2 Structured Judgement Review Tool (SJR)

The standard SJR tool was used with additional sections added to include questions related to appropriateness of place of care, working diagnosis and safeguarding. The sections regarding the medical record and assessment of problems in healthcare were also enhanced to reflect local concerns. The challenge question posed following the publication of the first annual report of the National Mortality Case Record Review (What are you going to do at your healthcare organisation to try and improve the situation?) was also added to the front of the proforma. A copy of the SJR tool can be found in Appendix 1.

3.3 Recruitment of Reviewers

50 reviewers were recruited to review 2 cases each (40 consultants and 10 senior nurses). The consultants were chosen randomly from a list of consultants who had not taken part in any of the last 3 Trust Wide Mortality Case Note Reviews. Specialties with more consultants were allocated more review slots for random selection to even out the work load across specialties. The nursing staff were chosen randomly from a list of senior nurses who had received training to use the SJR tool. 3 reviewers were recruited after expressing an interest in being part of Review 12.

Reviewers were emailed initially, explaining that they had been selected to be part of Review 12 and giving them information about the rationale for carrying out Review 12. This was followed up by an email when their notes were delivered and included a deadline for the completion of the review. If the notes were not returned by the completion date a reminder email was sent and then repeated 1 week later. Non-compliance after this stage was escalated to Divisional Directors, Medical Director and Director of Nursing.

3.4 Training to use the SJR Tool

Most reviewers had already received training through their directorate/ specialty Morbidity and Mortality meeting (M&M). Reviewers were offered face-face training if they were not familiar with the SJR tool. In addition reviewers were provided with 2 locally written documents, a guide to using the SJR tool (see Appendix 2) and a list of examples of what good care looks like (see Appendix 3).

3.5 Data Validation

Outcomes of the mortality screening and review processes in place at NGH were compared with the outcomes from the completed SJRs in Review 12.

3.6 Administration

Administration for Review 12 was provided by the Mortality Administrator (Quality Improvement) and Specialty Doctor (Quality Improvement).

3.7 Data Analysis

Quantitative data from the completed SJR tools was analysed using an Excel spreadsheet. Qualitative data was grouped into themes for reporting.

Results

4.1 Clinical Coding Review (n=100)

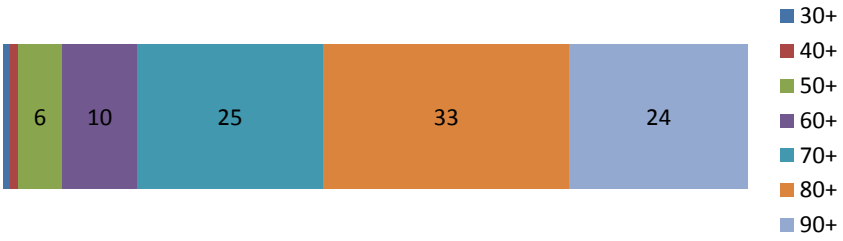
The primary codes for the sample were categorised by condition and a full list can be found in Appendix 4. The main findings of the coding review are as follows.

- No changes to primary codes.
- Documentation of bronchopneumonia could be improved and therefore more accurately reflect the mortality risk.
- The consistency of consultant transfer once a patient has been moved from the admissions ward needs to be improved to prevent patients presenting in the same way being coded differently.

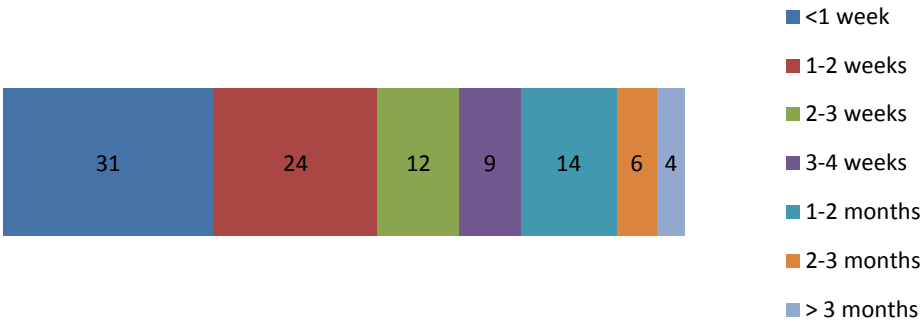
4.2 Demographic results for the sample (n=100)

The sample included 54 female patients and 46 male patients.

The age range was 39-100 years with an average age of 80 years (median 83). 57 patients were 80 years of age or over of which 24 were 90 years or older.

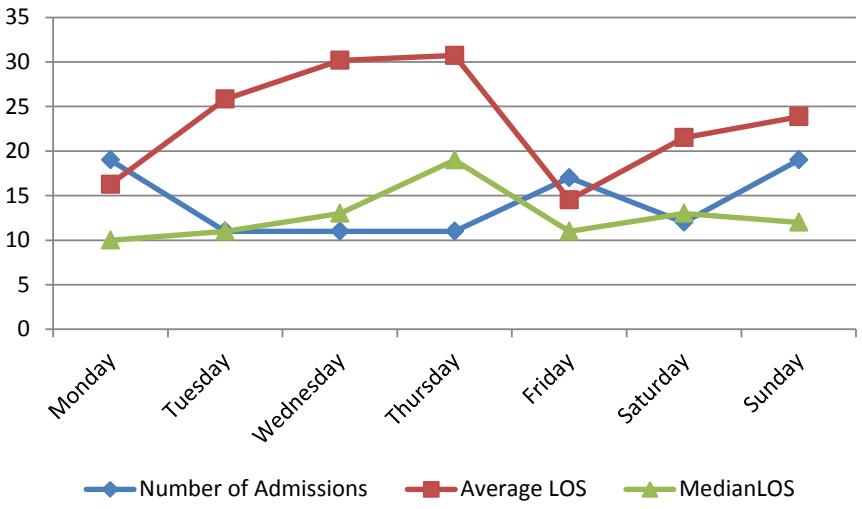


The range of length of stay was 1 -120 days with an average length of stay of 22 days (median 12). 24 patients stayed longer than 4 weeks of which 6 stayed more than 2 months and 4 more than 3 months.



The data has been further analysed by day of admission to look for patterns in numbers of admissions and length of stay. The highest numbers of admissions are seen on Sunday and Monday and the longest average length of stay is seen for patients admitted on Wednesdays and Thursdays (this effect is however less pronounced when looking at median length of stay). There does not appear to be correlation between weekend admissions and long lengths of stay (see graph 7).

Graph 7

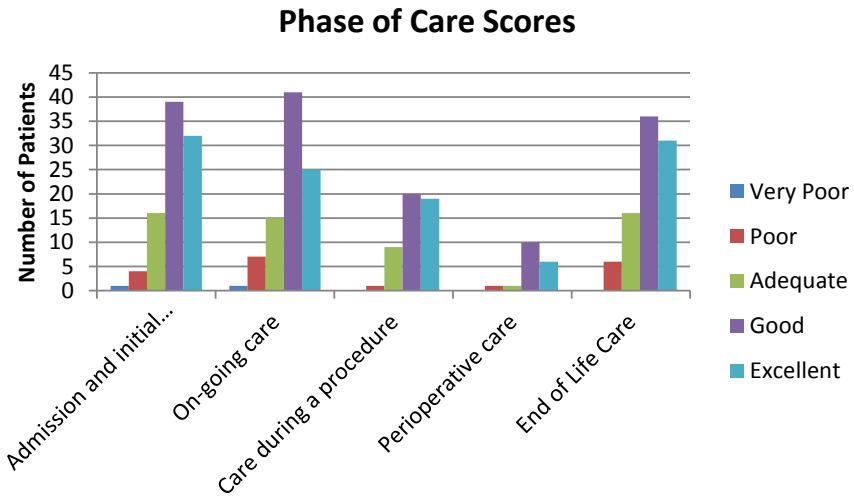


4.3 Quantitative Data n=93

93 completed SJRs have been returned and included in the analysis. The remaining 7 SJRs were not completed due to lack of capacity of the reviewers.

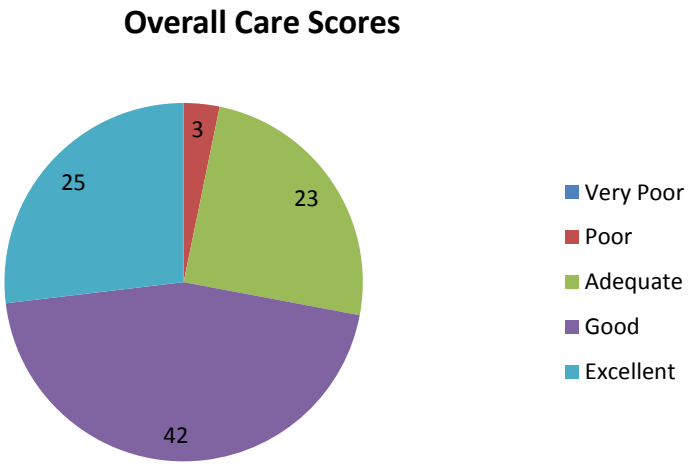
4.3.1 Phase of Care Scores

Graph 8



4.3.2 Overall Care Scores

Graph 9

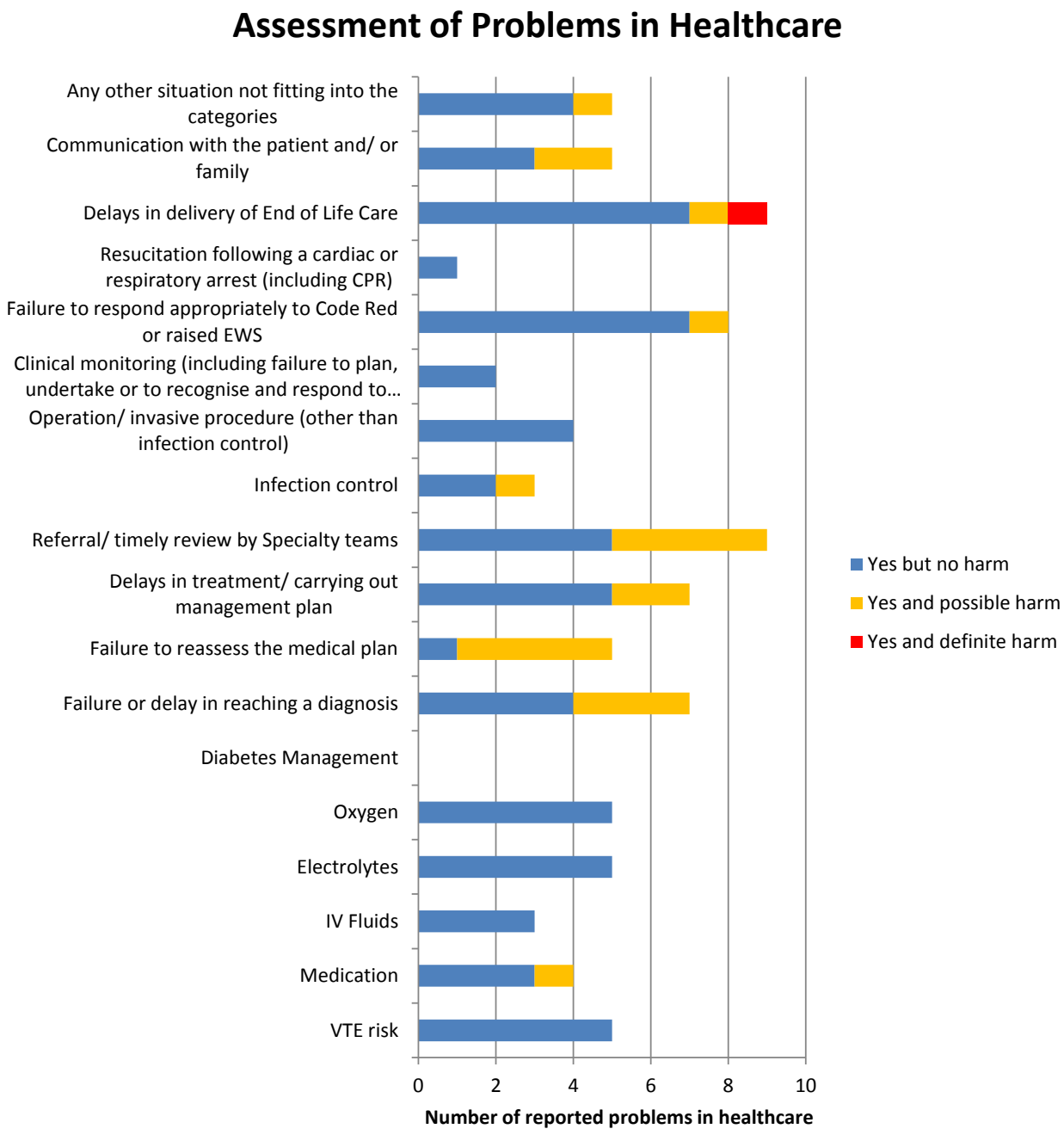


4.3.3 Review 12 Supplementary Questions

	Yes (percentage)
Was this an emergency readmission within 30 days of discharge?	28%
Was the patient medically fit for discharge at any point in the admission	22%
Was the working diagnosis on admission appropriate	95%
Would the patient have been better cared for outside of hospital	13%

4.3.4 Assessment of Problems in Healthcare

Graph 10

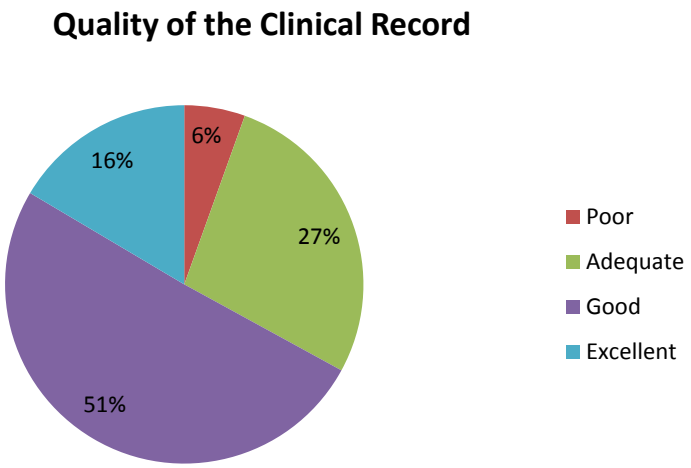


4.3.5 Safeguarding

	Yes (percentage)
Were there any safeguarding concerns?	4%
Was DOLS required?	4%
Was a MCA required?	19%
If yes, was it completed?	61%

4.3.5 Quality of the Clinical Record

Graph 11



In 92% of case records the reviewers felt that the notes told a story and that it was possible to follow the management plan and decision making.

4.4 Qualitative Data

4.4.1 Explicit Judgements

The explicit judgements made were of variable quality as is commonly seen and have been filtered to include only those notations that were true explicit judgements. As has been seen in previous reviews using the SJR tool approximately 2/3 of all explicit judgements are positive judgements outlining where care has gone well. Themes across the phases arising from the explicit judgements are highlighted below and a full list of explicit judgements by phase of care is included in Appendix 5 which also includes vignettes for 6 patients (3 who were judged to have received excellent care and 3 who were judged to have received poor care).

Areas for improvement	
Documentation	Poorly completed notes at all stages of the admission
Management plan	Delays to important investigations or failure to consider carrying out an important investigation
Senior review	Delayed or infrequent senior review or lack of overall consultant responsibility

4.4.2 Appropriateness of Place of Care

Reviewers were asked to comment on reasons for delayed discharge. The most common reason for delayed discharge was that the patient needed an increased level of care, either a package of care to enable them to get home or a nursing home placement. In 3 cases it was commented that the discharge was extremely complex either because of the level of care required, lack of engagement from the patient or unrealistic expectations of the family.

Reviewers were also asked to comment on whether they felt the patient would have been better cared for in another setting. Several reviewers commented that the preferred place of death was either not considered or not achieved and they felt this was sub optimal. Advanced care planning was mentioned as a possible mechanism for avoiding admissions at the end of life. Inappropriate initial admission was not a common feature but lack of more suitable placement after the initial problem had been treated was commented on.

4.4.3 What are you going to do at your organisation to try and improve the situation?

Reviewers were asked to consider the above question when they had completed their notes reviews. The comments have been grouped into themes and the most common are listed below.

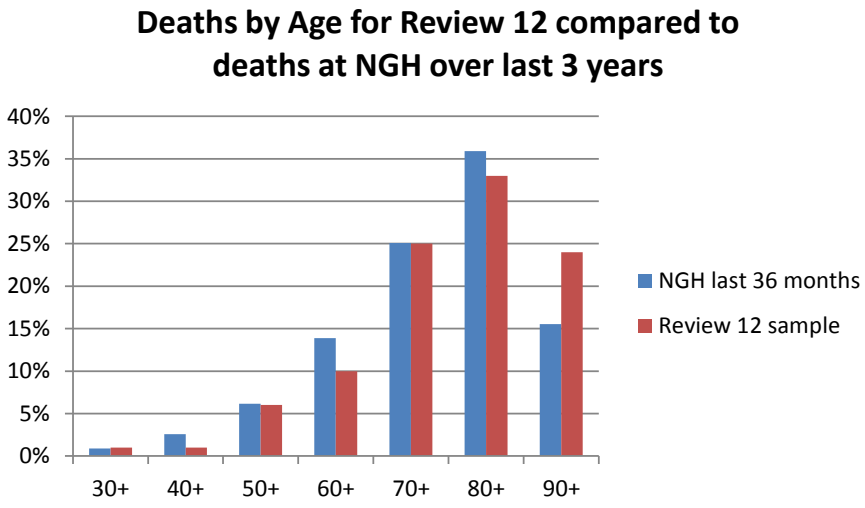
- Earlier discussion of DNAR/ TEP (11)
- Alternative location for EOL care (9)
- Escalate to more senior doctors (9)
- Better organised notes (9)

4.5 Analysis for Patients aged 90 years or over

4.5.1 Age distribution

24% of patients in this sample were aged 90 years or over. Graph 12 shows that there were 50% more deaths aged over 90 in the Review 12 sample compared to the distribution by age at NGH for the last 3 years.

Graph 12



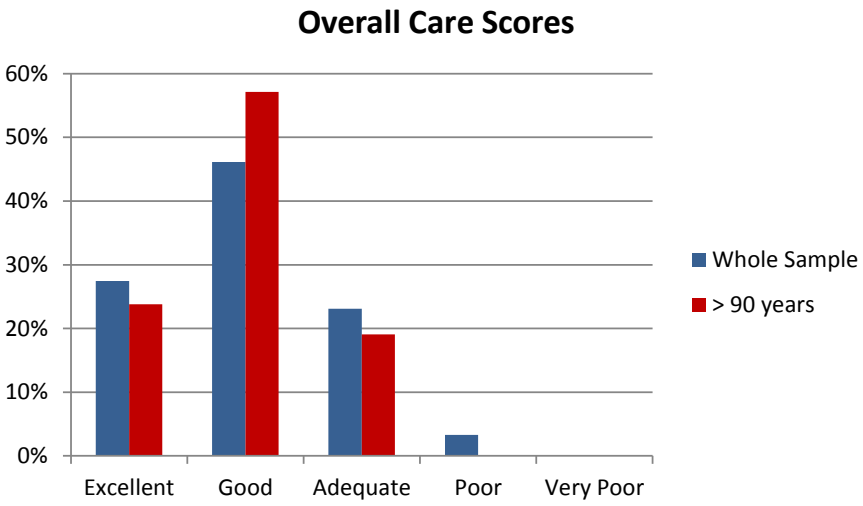
4.5.2 Risk of Mortality

The risk of mortality for all patients aged 90 years and over in the sample was extracted from Dr Foster data. The average risk of mortality was 38% (median 39%). The risk ranged from 3.5% to 78% with 4 patients having a mortality risk of less than 10%. The average risk of mortality for all deaths in May 2018 was 26%.

4.5.3 Comparison of Overall Care Scores

The overall care score for patients in this age group was adequate or above.

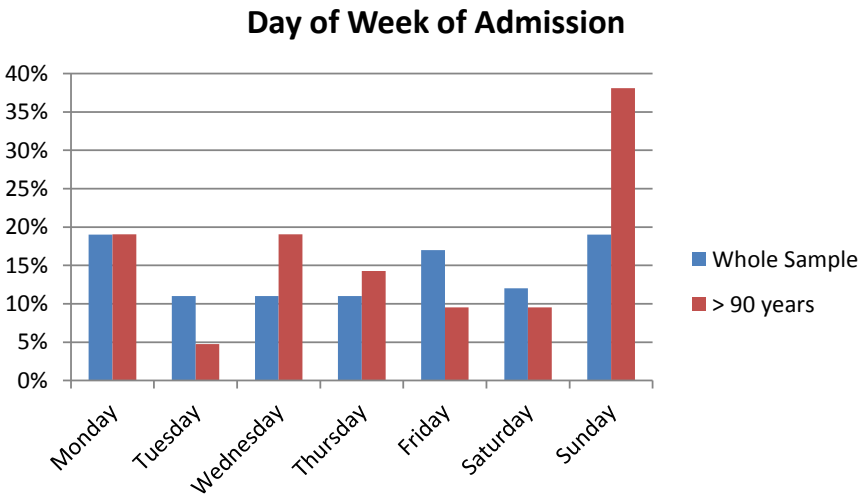
Graph 13



4.5.4 Comparison by Day of Week of Admission

Twice as many patients aged 90 years or over were admitted on a Sunday when compared to the whole sample.

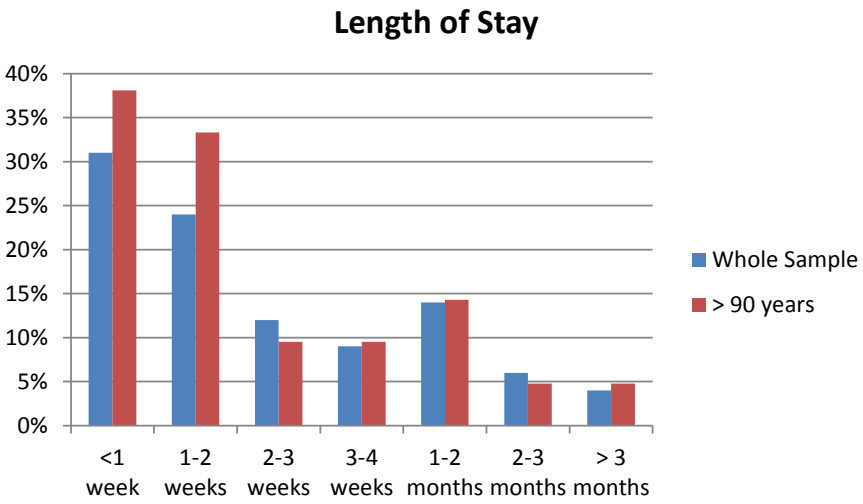
Graph 14



4.5.5 Comparison by Length of Stay

Distribution of length of stay was similar to the whole sample.

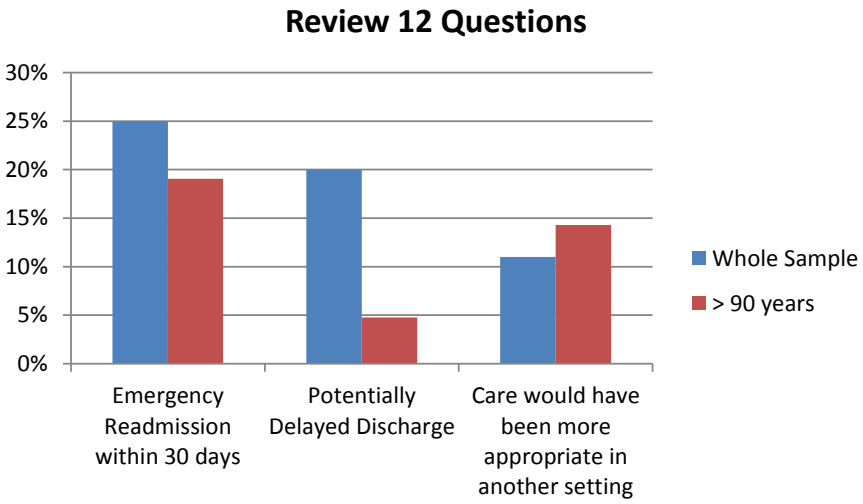
Graph 15



4.5.6 Review 12 Questions

Emergency readmission and potentially delayed discharge were slightly lower in those patients aged 90 years or over but it was slightly more likely that it would have been more appropriate to care for the patient in another setting.

Graph 16



4.6 Data Validation

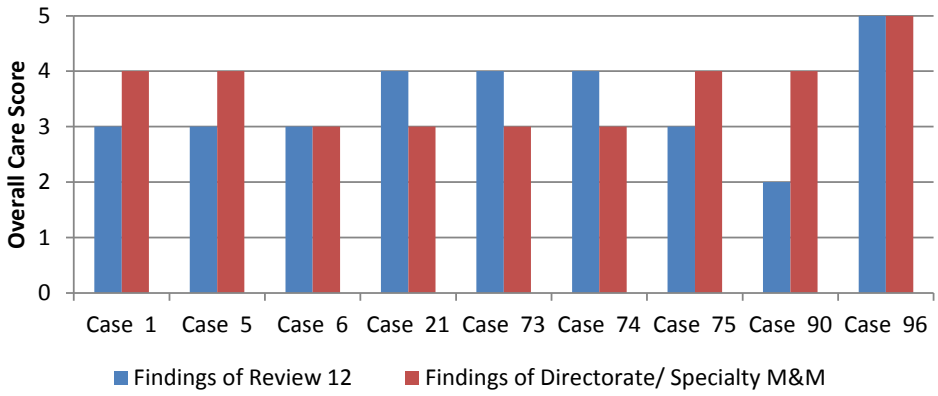
57 of the 100 cases in Review 12 had been screened by a member of the Mortality Screening team.

Those cases screened as not requiring further review all had an overall care score of adequate or above when reviewed as part of Review 12.

Structured Judgement Review was requested for 14 cases but only completed for 6. A further 3 SJRs were completed voluntarily by a directorate/ specialty M&M. For those cases that had a directorate/ specialty M&M the overall care scores have been compared with the outcome of Review 12. With the exception of Case 90 the correlation was good with no cases identified as requiring referral for 2nd stage review or investigation (see Graph 17) . Case 90 will be included in the 2nd SJR review meeting in February 2019.

3 cases in Review 12 have been judged to have had an overall care score of 2 (poor care). 2 were screened and selected for review by the Mortality Screening Process although neither review was completed.

Graph 17



5 Discussion

5.1 Significance of Dr Foster Data

Dr Foster data for HSMR and Weekend HSMR for the month of May 2018 shows a clear change which has now returned to "as expected" (although the effect of this is still being seen in the rolling year trend). Review 12 has not picked up a clear cause for this unusual data. The possibility that changes to the configuration of services and service delivery at NGH at this time has been considered and nothing specific has been identified.

- **Action: Contact primary and social care re changes to configuration of services.**

5.2 Limitations of methodology

Case note review is a subjective process. Attempts have been made to reduce variation by using a validated nationally recognised tool, training reviewers to use the tool and adding targeted questions to cover areas of concern. 4 reviewers who were unfamiliar with the tool took up the option of face-face training but it is hoped that the accompanying guide and instructions were a useful starting point for others.

Not all the case note reviews have been completed due to reviewers not having enough time however it is felt that a sufficient sample (>90%) has been returned to allow conclusions to be drawn.

Comparing the overall care scores for Review 12 with the outcome of the mortality screening and review processes shows good correlation of findings. Only 1 case from the 57 that have been through both processes has been referred for 2nd stage review after Review 12. However the data does highlight that compliance with request for 1st Structured Judgement Review is too low (6/14) and processes for following up non-compliance need to be improved in future.

A limitation of case note review as a method of assessing quality of care is the patient record. Although comments were made about the organisation, completeness and legibility of the records, all the case records were felt to be suitable for judgements about the care could be made.

- **Action: Review processes for follow up of non-compliance with request for SJR**

5.3 Clinical Coding

The primary codes were accurate based on the documentation in the notes. The documentation of bronchopneumonia when present rather than pneumonia is important

because the risk of death attributed to bronchopneumonia by Dr Foster in HSMR is higher. Dr Foster data to May 2018 shows that palliative care coding at NGH was comparable with national levels (2.3% vs 2.4%) as was Charlson Co-morbidity "O" scoring (46.9% vs 48.6%) providing further reassurance of the depth of the clinical coding.

As has been previously noted, the model of care at NGH which includes assessment units and consultant transfers also influences the clinical coding and this consultant transfer must be applied consistently.

Documentation in the notes of diagnoses, differential diagnoses and changes to the conditions being treated also has a large effect on what can be coded at different stages of the admission. For example, continuing to record sepsis after the sepsis has been treated or not revising a working diagnosis from sepsis to heart failure can both cause issues for clinical coders.

- **Action: Improve the rates of coding for bronchopneumonia**
- **Action: Improve the consistency of consultant transfers**

5.4 Quality of care

5.4.1 Quantitative data

The vast majority of care provided in each phase was judged to be good or excellent. A small number of examples of poor or very poor care (21 in total) were highlighted in 14 patients. This is reflected in the overall care scores where only 3 patients have been judged to have received poor care overall. A low overall care score at 1st SJR indicates that the care was considered to be poor or very poor but it does not indicate that the problem in care contributed to the death. This decision is subjective and often difficult to make and therefore another SJR is completed by a 2nd independent reviewer and presented to a Trust wide meeting. During this stage of the process a decision will be reached by the group as to whether any of the deaths were felt more likely than not to be due to a problem in care. The data regarding assessment of problems in healthcare also shows few instances identified, the most common being a delay in delivery of end of life care. When problems were judged to have occurred they were not associated with harm to the patient.

The quantitative data provides reassurance of the quality of care provided to the patients in Review 12.

- **Action: 3 cases to have 2nd SJR on 01.02.19**

5.4.2 Qualitative data

The explicit judgements confirm the findings of the quantitative data and highlight learning from examples of good and excellent care. The small number of negative explicit

judgements can be used to identify cases where further review (2nd SJR), discussion at a challenge meeting or feedback to an existing work stream may be of value.

Review 12 sought to identify patients whose discharge was delayed and patients where care would have been better provided elsewhere. These patients have been identified from both the specific Review 12 questions but also from the explicit judgements made when assessing the phases of care. Inappropriate initial admissions were not commonly noted however delays to discharging patients from hospital because of lack of capacity in the community was picked both for patients who were medically fit for discharge and for patients who could have had end of life care delivered in another setting.

The focus for what reviewers felt could be done differently to improve care was on the delivery of end of life care especially earlier recognition and appropriateness of place of death.

4.5 Patients aged 90 years and over

A higher proportion of the deaths in Review 12 (24%) were patients aged 90 years and over and this group were more frequently admitted on a Sunday although this does not appear to have any impact on length of stay. The risk adjustment for age will be clarified with Dr Foster as 4 patients in this group had a mortality risk of <10%. A summary of directorate/ specialty M&M for Care of the Elderly will also be compiled for the last 12 months and form part of the work stream for the Frail Elderly initiated by MRG.

- **Action: Contact Dr Foster re risk adjustment for age**
- **Action: Compile summary of Care of Elderly M&M**

4.6 Future Work Streams

The following work streams are already in place and will pick up a large amount of the themes from Review 12.

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

Once this report has been discussed at MRG on 07.02.19 challenge meetings will be arranged. Cases from review 12 will be specifically chosen to highlight certain themes, including cases where care was considered to be excellent. The possibility of including primary and social care in certain meetings will also be explored.

- **Action: Contact Medical Director for CCG to arrange combined challenge meeting**
- **Action: Share report with members of MRG and work stream leads**
- **Action: Agree topics for challenge meetings**

Action Log

Action	Comment	Responsibility	Due
3 cases to 2nd SJR meeting		LN/ LJ	01.02.19
Share copy of report with membership of MRG		LJ	21.01.19
Agree topics for Challenge Meetings		MRG	07.02.19
Contact Medical Director for CCG	• Changes to configuration of services in May 2019 • Challenge Meeting in conjunction with primary Care	LJ	18.02.19
Review process for follow up of non-compliance with 1st SJR		LN	07.02.19
Contact Dr Foster	Risk adjustment model for Age	LJ	Emailed 11.01.19
Clinical Coding	• Bronchopneumonia • Consultant Transfer	BG	Update 07.02.19
Summary of Care of Elderly M&M		LJ	Update 07.02.19

L Jameson
Specialty Doctor
Quality Improvement
15.01.19

Appendix 1

Trust Wide Mortality Case Note Review 12

You have been selected to be a case note reviewer for Review 12

Patient ID

Please complete the attached SJR form by **14.12.18**

When it is completed please email M&M@ngh.nhs.uk and the notes and completed SJR form will be collected from you.

If you need Vital Pac observations / investigation results / Post Mortem reports please email M&M@ngh.nhs.uk

As a reviewer you are challenged to think about why the same things are still happening despite us recognising the same themes repeatedly. **What are you going to do at your healthcare organisation to try and improve the situation?**

Having reviewed this set of notes, please make 1 recommendation of an action for you or for others that could make a difference.

The 1st Annual report from the National Mortality Case Record Review can be found by using this link:https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-annual-report-2018

Northampton General Hospital NHS Trust

Trust wide Review 12

Structured Judgement Review Tool

Review 12 ID:

Patient Identifier:		**Date of admission**		**Date of Death**	
Type of admission		**LOS**	days	**Age**	
Consultant Attribution:					
Ward Transfers:					
Specialty Transfers:					

Brief Summary of Admission:
Co-morbidities/ Past Medical History:

Phase of Care	Comments Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	Please rate the care during this phase 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent Care
Admission and initial management (approximately first 24 hours		
On-going care		
Phase of Care	**Comments** Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	**Please rate the care during this phase** **1. Very poor care** **2. Poor care** **3. Adequate care** **4. Good care** **5. Excellent Care**

Care during a procedure (excluding IV cannulation)		
Perioperative care		
Phase of Care	**Comments** Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	**Please rate the care during this phase** **1. Very poor care** **2. Poor care** **3. Adequate care** **4. Good care** **5. Excellent Care**

End of Life care		

Overall Quality of Care Score Taking into account the scores you have given to each individual phase of care and the explicit judgements you have made, please give your assessment of the overall quality of care by circling one of these 5 options. This score will be used to decide if further review is required	**1** **Very poor care**	**2** **Poor care**	**3** **Adequate care**	**4** **Good care**	**5** **Excellent care**

Review 12 supplementary questions

Was this an emergency readmission within 30 days of discharge	**Yes**	**No**
Was the patient medically fit for discharge at any point in the final episode?	**Yes**	**No**
If yes what was the reason for delayed discharge?		
Was the patient on an outlying ward at any point during their stay?	**Yes**	**No**
If yes, did this have an impact on the care they received (please give details)		
Was the working diagnosis on admission appropriate?	**Yes**	**No**
If no, please comment		
Would the patient have been better cared for outside of hospital?	**Yes**	**No**
If yes, please comment		

Assessment of problems in healthcare

Were there any problems with the care of the patient? If yes please complete the table below.

Was the problem related to:	**Did the problem occur? Yes/ No**	**Did the problem lead to harm? No/ Possibly/ Yes**
VTE risk		
Medication		
IV fluids		
Electrolytes		
Oxygen		
Diabetes management		
Failure or delay in reaching a diagnosis		
Failure to reassess the medical plan		
Delays in treatment / carrying out management plan		
Referral / timely review by Specialty teams		
Infection control		
Operation/ invasive procedure (other than infection control)		
Clinical monitoring (including failure to plan, undertake, or to recognise and respond to changes)		
Failure to respond appropriately to Code Red or raised EWS		
Resuscitation following a cardiac or respiratory arrest (including CPR)		
Delays in delivery of End of Life care		
Communication with patient and/or family		
Any other situation not fitting into the categories above		

Safeguarding

Were there any safeguarding concerns?	**Yes**	**No**	**N/A**
Was a DOLS required?	**Yes**	**No**	**N/A**
Was a MCA required?	**Yes**	**No**	**N/A**
If yes was it completed?	**Yes**	**No**	

Clinical Record

Please rate the quality of the patient record in enabling you to complete the review	1. Very poor 2. Poor 3. Adequate 4. Good 5. Excellent	
Could you follow the management plan and decision making from the notes? (Did they tell a story?)	**Yes**	**No**
If no, please comment		

Appendix 2

Mortality Case Note Reviewers Guide – the Structured Judgement Review tool

Background

This is a quick guide to help you use the Structured Judgement Review tool (SJR) as this tool differs in approach to previous notes reviews. The SJR is a nationally recommended and validated method of reviewing case notes – the result of collaboration between the Royal College of Physicians and the Academic Health Sciences network of York and Humber.

Reviewers are required to judge the safety and quality of care over different phases of an in-patient stay and record these judgements as explicit comments along with a score for each phase of care using a standard form. The objective is to highlight both good and bad care in order to learn as much as possible from both ends of the spectrum.

Using the tool

Demographics and reviewers notes (front page)

The details of the admission to be reviewed will be prepopulated for you on the front sheet and there is a blank space for you to make notes about the course of the admission.

Phases of Care and Explicit Judgements (pages 2,3 & 4)

Reviewers are asked to **explicitly** state their assessment of care and give a short justification for why they made that assessment rather than simply re-tell the events of the admission (implicit). Long sentences are not required. Explicit judgements allow another person who reads the review tool to understand the reviewer's real meaning. Examples of the difference between explicit and implicit judgements are:

Explicit Judgement	Implicit Statement
Escalation to critical care was too late	Critical care were called after 4 hours
Standards for note keeping were not met – GMC numbers not recorded	I couldn't tell who saw the patient
Very good care – rapid treatment of DKA	The patient's DKA was treated
Prompt review by consultant with a good management plan	The consultant saw the patient after admission and wrote a management plan
CT should have been done within 24 hours and failure to do this delayed making a diagnosis	CT scan was done the day after admission
High EWS was escalated promptly and appropriately – good care	EWS 10 – SpR reviewed the patient
Excellent documentation in nursing notes detailing communication with family	Family contacted by nursing staff

Judgement comments can be made on anything the reviewer thinks is important. If there has been good and bad care in a phase of care then both should be commented on. If it is not clear what has happened then this should also be included. Although there are 5 principle phases of care, not all phases will be applicable to each case reviewed: perioperative/procedural care may only be required in a few medical cases (for example lumbar puncture, chest drain, insertion of central line) and are more likely to be used in surgical cases.

Each phase of care should also receive a care score - one score per phase of care. Scores range from excellent (5) to very poor (1).This helps by providing a rounded judgement on the phase of care, particularly if there has been a mix of good and bad care.

The care should then be rated overall (page 4) – taking into account the scores for all the individual phases.

Safety of patient care also depends to some extent on good **record keeping (page 7)** therefore as part of the assessment the reviewer is asked to record their judgment on the quality and legibility of the records.

Using the tool – Assessment of Problems in Healthcare (page 6)

This section asks the reviewer to pick out specific areas of healthcare where a problem may have arisen and to decide if that problem led to harm. This is very helpful when analysing the data and looking for themes and in deciding which cases need further discussion or review.

Supplementary questions for Review 12 (page 5 & 7)

Supplementary questions have been added for Review 12 based on the findings of previous reviews and cover the following topics:

- Emergency readmission
- Delayed discharge
- Care of patients on outlying wards
- Admission Diagnosis
- Appropriate place of care
- Safeguarding

Help Available

If you would like further advice on any part of the process please contact the mortality team by email m&m@ngh.nhs.uk or phone Louise Nava/ Louisa Jameson on extension 4760.

Next Steps

Once all reviews are completed the data will be collated. Some notes may undergo a second review and we will ask you to present the notes you reviewed at a group meeting. Each group meeting will have a theme depending on the collated findings eg diabetes care, communication, escalation. It is anticipated that the final report will be available at the end of January and this will be circulated throughout the hospital.

Appendix 3

What Good Care looks like

Admission and initial management

Clearly documented clinical history and examination including systems enquiry with a working diagnosis and differential diagnosis if appropriate

Management plan

VTE risk assessment and appropriate prescription of thromboprophylaxis

Prompt completion of ePMA

Early consultant review – within 14 hours of admission

Admission to an appropriate ward

Clear communication with the patient and family regarding diagnosis and subsequent management plan

Prompt investigation and initial treatment as clinically indicated eg sepsis 6

Follow up and documentation of test results and action as required

On-going care

Clear management plan in notes including any ceilings of care, expected deviances from clinical observations

Regular senior review

Rapid referral to and assessment by specialist teams when required

Appropriate escalation in response to deterioration

Documentation of tests requested, results and action taken in response to results

Clear documentation of procedures and consent

Handover of necessary information between different professionals and between medical teams

Avoid confirmation bias – revisit original diagnosis if clinical course does not follow expected

No unnecessary ward moves

End of Life Care (EOLC)

Timely recognition of a dying patient

DNAR/TEP completed in good time

Documented communication with patient and relatives

Use of the EOLC pathway

No inappropriate active treatment

Appropriate specialist palliative care input

Discharge

Timely completion of accurate eDN and TTOs

Information given to patient regarding medication

Appendix 4

Group	Number	Findings
Respiratory	32	26/32 related to infections.
		18/32 coded to pneumonia (1 where bacterial cause coded).
		3 bronchopneumonia, 8 lobar pneumonia, 6 unspecified pneumonia.
		Bronchopneumonia - 2 specified by consultant, 1 from 'patchy consolidation' noted on x-ray.
		Lobar pneumonia - 4/8 noted to be bilateral pneumonia.
Cardiovascular	15	3 cerebral infarcts, 2 cerebral haemorrhages. Nothing of note related to coding.
Cancer	12	10 primary malignancies, 2 secondary malignancies. Nothing of note related to coding.
Sepsis	12	4/12 (33.33%) would not have been included in the sepsis basket had the first consultant episode not been a short one (<72 hrs).
		7/12 (58.33%) did not have a consultant transfer at all.
		Overall, there were 7 instances in the sample of 100 where transfers would impact the HSMR diagnosis (51 patients had no transfers at all).
Gastrointestinal	8	3 haemorrhages, 1 perforation, 1 ileus, 2 alcoholic liver disease. Nothing of note related to coding.
Urinary Tract Infections	5	Nothing of note.
Dementia, delirium, frailty	4	Nothing of note.
Acute Injuries	4	1 pneumothorax, 1 haemopneumothorax. Nothing of note related to coding.
Other	8	Nothing of note.

Scope for Improvement
Improve the rates of coding bronchopneumonia further…. The HSMR risk is greater than lobar or unspecified pneumonia. Repeat the work that was done a number of years ago……
Improve the consistency of consultant transfers once patients move out of assessment wards as patients in the same scenario are being recorded differently.

Appendix 5

Admission and Initial Management		
Theme	**Positive Explicit Judgements**	**Negative Explicit Judgements**
Quality of documentation on admission	Acceptable documentation of clinical history and initial assessment	Poor recording of date and time in clerking
	Documentation legible	Clerking not timed or signed
	Good documentation at every stage	No ED notes available - inadequate
	Good quality clerking	Nursing checklist not done
	Good level of history noted	VTE assessment late and incorrect
	Clearly documented clinical history and examination	Delay to VTE assessment
	Good concise clerking	VTE assessment not done
	Thorough clerking	Cursory history with minimal documentation of examination findings
	Timely and clearly documented clinical history and initial examination	VTE assessment and prescription not completed in line with expected standards
	Full and thorough assessment on admission	Inadequate clerking
	Prompt investigation and review soon after admission – good care	
Senior input	Evidence of early consultant review	Delay to specialty consultant review (> 24 hours)
	Good and prompt clerking, early review by registrar, consultant	Delay to consultant review (> 48 hours)
	Consultant ward round and planning – all very good	>5 hours between ED referral and medical review despite EWS 9 – poor care
	Consultant review – comprehensively done	Patient unhappy with 2 hour wait to see a doctor
	Assessed by consultant physician in A&E who clerked patient, good care	Delayed medical review up to 48 hours – poor review and poor planning
	Seen and clerked by consultant on the day of admission; good care	Delayed specialty opinion
	Good consultant plan and discussion with other specialties	
	Early escalation by nursing staff on ward and early consultant review – excellent care	
	Early escalation to SpR and early consultant review	
	Good consultant clerking	
	Early consultant review within 7 hours	
	Early consultant review within 14 hours	
	Excellent initial assessment by SpR	
	Early consultant review	
	Early review by SpR	
	Seen by consultant on day of admission	
	Seen by consultant shortly after admission – good care	

Making a diagnosis	Prompt diagnosis within 24 hours	No evidence of CXR acknowledgement
	Urgent investigations, good documentation	No evidence for diagnosis of UTI
	Comprehensive geriatric assessment	
	Sensible differential diagnosis and care plan	
	Reasonable plan and working diagnosis	
	Diagnosis considered at admission; good hierarchy of diagnostic making	
	Acute condition considered; good care	
	Social care issues identified early; good care	
	Efficient CT scanning confirmed diagnosis quickly	
	Follow up documentation of test results done in a timely manner and actions required specified	
	Clear working diagnosis and differential diagnosis	
	CT scan done immediately and appropriately	
	Appropriate and correct main differential diagnosis	
	Appropriate initial assessment	
	Care in ED resus was appropriate to clinical need	
	Very good initial assessment, diagnosis and management plan in ED	
Management plan	Appropriate antibiotics	Delay to specialist plan (4 days)
	Timely VTE assessment (within 30 mins)	Delay to initial investigations (7 days)
	Initial management as sepsis & AKI on CRF treated appropriately with IV fluids / IV antibiotics	Inappropriate admission to a surgical team
	Timely intervention and plans in place and communicated well	Inappropriate doses of sedation in a frail elderly patient
	Initially – sound management, early recognition of pneumothorax	Delay to specialist review (3 days)
	UTI diagnosed and antibiotics started appropriately	Delay in moving patient to a specialist bed (5 days)
	Fluid restriction and electrolytes maintained appropriately	The patient did not receive cardiology reviews within a timely manner and within professional standards
	Management plan clearly documented	
	Early documentation of escalation plan	
	Appropriate care for presenting problems	
	Appropriate referral for gastroenterology opinion	
	Clear plan of action	
	Promptly assessed, high EWS escalated promptly	
	Treated appropriately taking co-morbidities into account	
	Appropriate treatment for PE started	
	Timely administration of IV morphine	
	Working diagnosis and management plan explicit	
	Appropriately moved to an assessment ward	
	First dose of antibiotics given within 1 hour in line with sepsis treatment	

	Clear comprehensive management plan documented	
	Good management plan	
	Timely diagnosis made and relevant tests undertaken	
	Good medical plan documented	
	Excellent care by ED staff	
	Prompt SALT assessment	
	Clear plan	
	Initial pain problems addressed early	
	Clear comprehensive plan of care	
Communication	Family involved early	
	Clear discussion with patient's family regarding diagnosis and subsequent management	

Ongoing care		
Theme	**Positive Explicit Judgements**	**Negative Explicit Judgements**
Response to deterioration	Early diagnosis of cause of rapid drop in BP and falling Hb	Code Red documented appropriately but the response should have been from a more senior doctor
	Regular senior and specialty reviews	Documentation around an escalation plan could have been better, in particular ceiling of care
	Deterioration of sepsis picked up and outreach review sought with transfer to Critical Care	Delay in response to a patient with EWS 6
	Prompt CT scan when patient deteriorated	No escalation of a high EWS to a doctor and failure to follow EWS protocol
	Good early escalation to outreach and Critical Care when needed	No documented responses to code reds on multiple occasions
	Acute deteriorations dealt with appropriately	Lack of senior leadership through a very long admission
Communication	Clear communication with family regarding further management	Multiple ward changes – not in patient's best interests
	Excellent care – family involved at early stage	No evidence of discussion of the implications of test results with the patient – poor care
	Regular discussions with patient and family	Good input from anaesthetics with regard to risk assessment for surgery and clearly documented discussion with family
	Repeated updates to family documented	With hindsight the family expectations re discharge were unrealistic
	Excellent documentation of discussion with family	
	Exceptionally challenging and difficult diagnostic circumstances were relayed and documented to the patient and family regularly	
	Good SpR documentation for handover	
	Good documentation of communication with relatives	
	Family involved in discussions all along	
Management plan	IV antibiotics changed to Tazocin - appropriate	Inappropriate ward move
	Good MDT review	Failure to re-refer to specialty team when symptoms continued
	Appropriate specialist input sought	Delay in performing 24 hour ECG
	Management plan explained in the notes	Failure to consider repeat CT head
	Plan very clear with completed actions	Delay of almost 48 hours before CT scan done
	Regular MDT discussion	Treatment possible persisted too long
	Regular ward rounds – good care	Diagnostic label changed to infective exacerbation of COPD without any good evidence
	New problems identified quickly and appropriate referrals and decisions made – good care	Very clear assessment of multiple issues

	Investigations and results were requested and followed up promptly – good care	
	Regular review and ward rounds – good care	
	New problems identified early – good care	
	Addressed issues in a timely manner	
	Appropriate treatment following peri-arrest and diagnosis of pneumonia	
	Cared for under the correct specialty	
	Good plans and follow up	
	Good post- fall review	
	Good input from various teams including anticoag, pharmacy, PT, OT and SPCT – consistent, thorough and well documented	
Senior input	Daily consultant ward rounds noted - very good	Seen by 5 different consultants during the admission and it was unclear who was in charge or what the overall strategy was
	Prompt consultant review and senior decision making at point of arrest	No apparent consultant input for 6 days
	Clear documentation of senior decision makers on Critical Care	No medical review over a weekend
	Good communication between disciplines	
	Regular senior review including specialty team when appropriate	
	Senior review at the right time	
	Prompt review by vascular and anaesthetic consultants when patient deteriorated	
	Regular senior review – good care	
	Excellent consultant input and liaison with other HCP	
	Excellent input from many specialties	
	Excellent to have a cancer nurse specialist to support the patient even though the exact cancer diagnosis was not known	
	Prompt referral to neurology	
	Frequent consultant review	
Documentation	AMBER care bundle started, discussed with family by consultant on same day -treatment ceilings applied, all well documented.	Notes chronological erratic
	Documentation pretty good, easy to read and clearly signed and dated	Insufficient completion of fluid balance charts
		Poor completion of Sepsis 6 sticker

Care during a procedure and peri-operative care		
Theme	**Positive Explicit Judgements**	**Negative Explicit Judgements**
Management of procedure	Thrombolysis – all checks done	With hindsight, AKA may not have been appropriate
	Appropriate discussions, assessments and handovers during surgical procedures	
	Trained theatre staff appear to have met all standards	
	Clear documentation of rationale for Sengstaken tube insertion	
	ABG done – good care	
	Intubation – safety checklist completed fully	
	Correct procedure for ascetic tap documented	
	Bone Marrow Biopsy documented with no complications	
Timeliness of procedure	Prompt upper GI endoscopy	Long delay in getting CT guided biopsy due to resources
	Thrombolysis performed promptly	
Documentation/ Communication	Family fully informed	No documentation regarding surgical debridement although a request was made
	WHO documentation for endoscopy – good practice	No documentation of chest drain insertion
	Good record keeping during surgical procedures	
	Excellent documentation of care during Critical Care procedures with LOCSIPS	
	Procedure documentation appropriate	
	All procedures documented well	
	Good documentation in notes on Critical Care	
	Well documented discussion with patient and family	
Consent	Good documentation of consent	
	Consent for pacemaker and angiogram clear	

End of Life		
Theme	**Positive Explicit Judgements**	**Negative Explicit Judgements**
Recognition	DNAR/ TEP/ EOL care pathway early	Late recognition of a dying patient
	Early consideration of TEP and DNAR – excellent care	Only put on pathway on day of death – should have been earlier
	Care plan commenced in a timely way	Only instigated on day of death
	TEP done appropriately	DNAR/ TEP could have been in place prior to the cardiac arrest given that the prognosis was acknowledged
	Appropriate decision to palliation	Critical Care admission could have been avoided had EOL been recognised earlier
	Amber Care Pathway and EOL planning appropriate	No obvious planning for EOL
	Comprehensive documentation in Dying Persons Care Plan	TEP should have been discussed earlier
	Early referral to palliative care	Dying recognised too late despite the warning signs being present for some time
		Opportunities to complete DNAR/ TEP were missed
Management	This gentleman was taken gently through the last phase of his life. He accepted where he was through good care. He died peacefully.	Failure to use Amber Care Pathway
	Comfortable on EOL care pathway	Patient would have preferred to die at home
	Excellent discussion of likely prognosis with family	Treated with antibiotics for too long
	Good use of Amber Care Bundle	Focus throughout the notes was for diagnostics rather than a holistic approach – no end of life care identified
	Good communication with family	Medical notes at EOL did not reflect the nursing notes
		No MCA assessment for DNAR – poor practice
		Not all options for preferred place of death were explored
		No senior leadership
Documentation		EOL paperwork only partially complete
		Poor documentation in end of life paperwork (none for over 48 hours)

Case ID	Overall Care Score	Vignette
Audit ID 26	5 - Excellent Care	This frail elderly patient with a complex past medical history was admitted with a history of weight loss, urinary retention and acute kidney injury. Through appropriate investigations, a prompt diagnosis of malignancy was made which led to rapid decision making and a clear management plan. The patient was not fit for surgical treatment and end of life care was delivered in a timely manner.
Audit ID 28	5 - Excellent Care	This patient presented with a 3 week history of being non-specifically unwell, tired and breathless. The initial assessment was thorough and investigations were organised quickly based on a working diagnosis of sepsis. The seriousness of the patient's condition was recognised and escalated to Critical Care where full supportive care was provided. The Critical Care Consultant kept the patient's family updated throughout the admission and was fully involved in the discussion and decision to move to end of life care.
Audit ID 81	5 - Excellent Care	This patient was admitted with an acute catastrophic intracranial bleed which was promptly diagnosed. The severity of the event was recognised and a conversation about the prognosis was started immediately with the patient's family. End of life care was started very shortly after diagnosis and the patient died comfortably. Excellent Consultant led care.
Audit ID 17	2 – Poor Care	This patient was admitted with shortness of breath, decreased mobility and weight loss. The initial assessment and plan were very good but the team did not seem to recognise that the outcome for this patient was uncertain. The management plan was too focused on making a diagnosis and use of the Amber Care Pathway would have aided delivery of more holistic care.
Audit ID 58	2 – Poor Care	This patient presented with chest pain (diagnosed as Acute Coronary Syndrome) and a fall. There was a delay in obtaining cardiology review and transferring the patient to the cardiology ward. At one point during the admission there was a failure to appropriately escalate a raised Early Warning Score. The patient died unexpectedly after a 3 week stay.
Audit ID 90	2 – Poor Care	This patient had a mechanical fall at home and suffered an upper limb fracture which was managed surgically. Following a period of rehabilitation, physiotherapy and occupational therapy it was felt that the patient was not suitable to be discharged to their previous residence. Discharge planning was complex and slow leading to a very prolonged hospital admission during which the patient died. It was felt that the lack of senior input during the admission contributed to the difficulties in arranging a suitable discharge.

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Director of Nursing, Midwifery & Patient Services Report**
Agenda item	**11**
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: The report contains an update on Midwifery, Safeguarding, End of Life, Infection Prevention, Assessment and Accreditation and Nursing and Midwifery Quality care Indicator Dashboards.

A detailed discussion will have taken place within the Quality Governance Committee with the following being highlighted to the Board

- 28 formal complaints were received with 98% complaint responses sent within the agreed timeframes. 3930 compliments were received.
- Friends and Family Test (FFT): The Trust wide results have decreased from 93.1% in November to 91.8% in December.
- Pressure Prevention: 5 patients developed a total of 6 Category 2 pressure ulcers, and 2 patients developed 3 Deep Tissue Injuries during the reporting period of December 2018.
- Safety Thermometer: In December the Trust achieved 99% new harm free care. Overall harm free care was 96.39% against a national picture of 94.25%.
- Maternity Safety Thermometer: In December the overall percentage of women and babies who received combined physical and psychological 'harm' free care was 84.4% which is above the national aggregate of 75.2%.
- Falls: There were 98 in-patient falls in total, 62 inpatient falls resulted in no harm to the patient, 33 were low harm and 3 were reported as moderate or above.
- Avery and Dickens Therapy Unit (DTU): Avery reported 5 falls in month 3 no harm and 2 low harm, and 3 Pressure Ulcers, 2 category 2s and 1 unstageable.
- DTU had in total 12 falls 6 no harm and 5 low harm and 1 moderate harm. DTU also had 1 unstageable pressure ulcer reported.
- Overfill staffing rate in December was RN 93% and HCA 99%. The general adult wards Care Hours per Patient Day for the month of December was RN 4.1 and HCA 3.0

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1.3 and 1.5
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No

The Committee is asked to:

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

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

Northampton General Hospital NHS Trust

Trust Board
January 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 December. 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

As an organisation we aim to ensure that we deliver safe, high quality patient care, this is at the centre of what we do. Whilst we receive a significant amount of positive feedback we also receive feedback when things have not gone so well. As a Trust we recognise that complaints and concerns are an opportunity to learn and improve.

In December we received 28 formal complaints, the three main themes are:

- Care (n=14) (10 x medical / 2 x nursing / 2 x Allied Health Professionals) which equates to 50% of the total
- Communication (n=4) (3 x medical / 1 x AHP)
- Delays (N=3) (2 x appointments / 1 x referral)

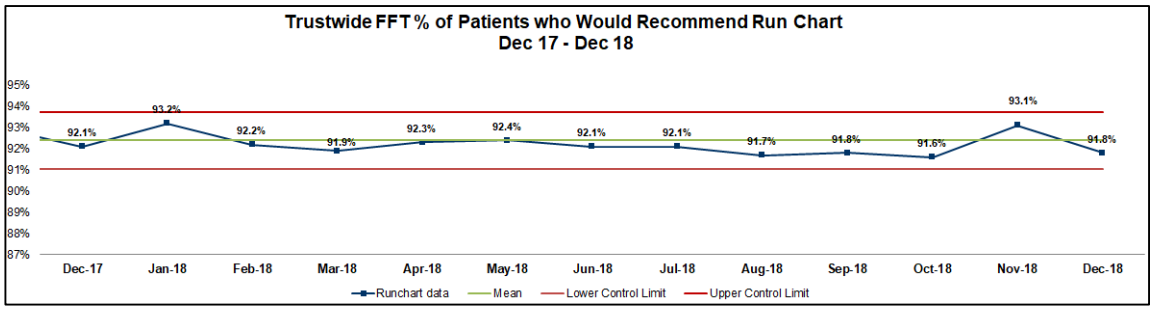
Our aim is that every complaint is responded to within the agreed timeframe and that any learning that comes from the findings is agreed and owned within the Directorate. These are logged through the Datix system, in the last few months another section has been added which means that evidence of that learning can also be logged and provided as evidence of a responsive and well led process. Our complaints response rate for the month was 98%.

We have logged receipt of 3930 compliments received Trust wide during the month of December

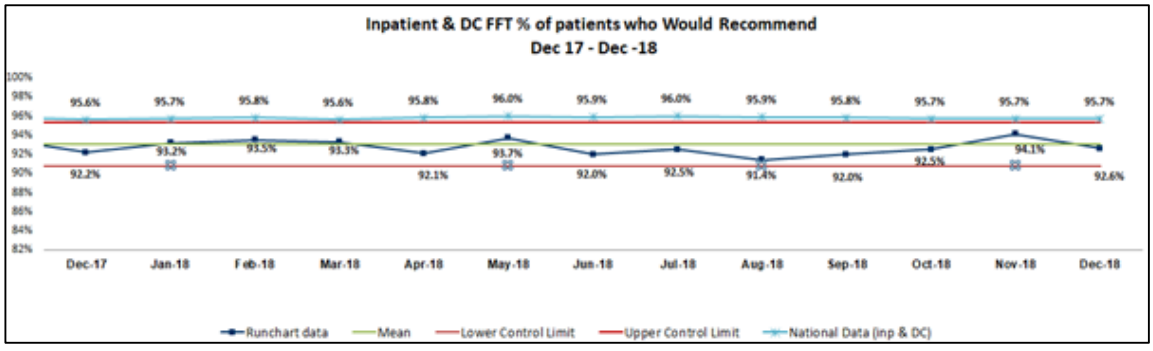
2.1.2 Friends and Family

The Trust wide recommendation rates remain within normal variance. However the results have decreased from 93.1% in November to 91.8% in December. Over the past 6 months, the results have remained at a similar level (91% - 93% recommend rate) Discussion has taken place at the PCEEG on how to improve both aspects.
The Patient Experience Department are relaunching FFT with a view to improving responses rates Trust wide. Actions include:

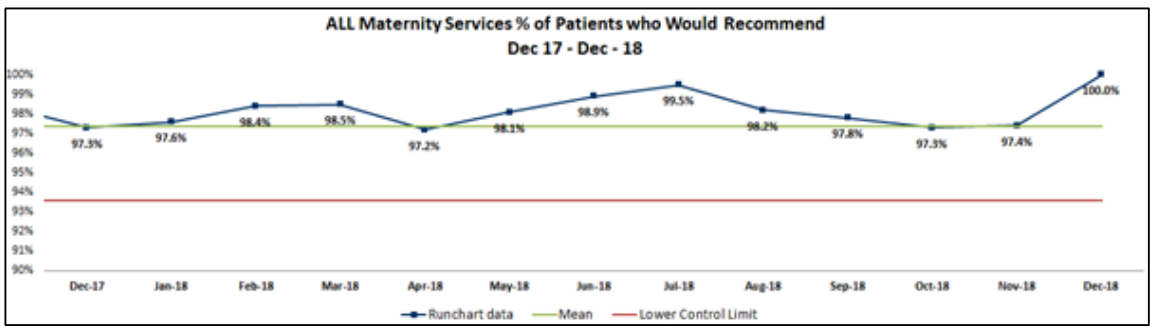
- Review positioning of collection boxes, particularly in outpatient areas
- Visit outpatient areas with a response rate of less than 10%
- Attend Sister/Matron Forum to remind about FFT
- Speak to patients about FFT cards
- Liaise with reception staff and encourage them to hand out FFT cards
- Attend the morning huddles for discharge information then a volunteer will go to the discharge suite and hand out the cards
- Action Plan for Birth



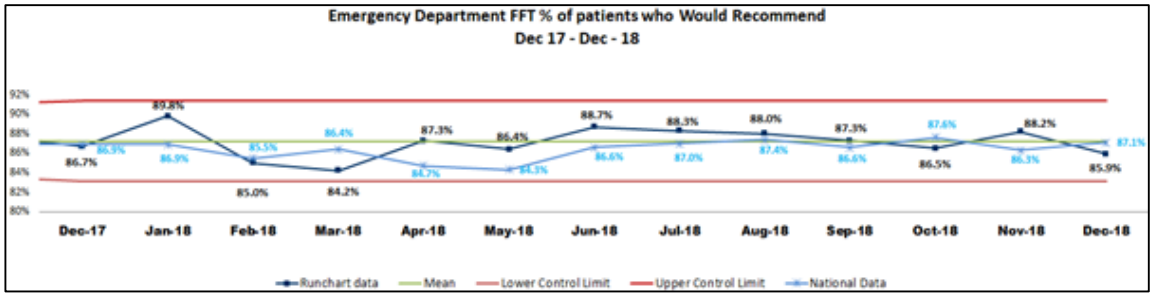
Inpatient and Day Case results have decreased slightly in December with a recommendation rate of 92.6% compared with November at 94.1%. When comparing October's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 3.1% below the average compared with 1.6% in November.



Maternity recommendation rates have increased greatly in December with a 2.6% increase to 100% compared with November at 97.4%.



The Emergency Department's recommendation result decreased in December to 85.9% from 88.2% in November. When comparing October's (most recent data available) recommendation rate to the national average, NGH performed 1.2% lower than the national average (87.1%).



NHS Improvement has created a FFT Headlines Tool to enables organisations to nationally compare response rates. The most recent data available (October 2018), NGH has achieved above the national average for response rates within ED and Inpatient and Day Cases and below the national average for births in maternity, a proactive campaign to address this has already commenced.

Service	NGH Response Rate Oct	Oct National Avg Response Rate
Inpatient & DC	27.1%	24.9%
ED	13.4%	12.2%
Births	5.6%	21.1%

Upcoming Actions

A full action plan is in place to increase responses for adult inpatient and maternity. (Full copy contained in the Highlight report from the Patient & Carer Experience & Engagement Group).

A Listening event is to be held in January 2019 for patients who attended the ED department in the previous 3 months, gaining valuable insight into their experience and how we can improve. The month after a similar event will be held for patients who have been an inpatient on Rowan ward – this is in response to their Right Time survey results.

2.2 Safe

2.2.1 Infection Prevention and Control

During December there was 1 reported case of hospital onset C Diff, there have been 14 cases year to date, the Trust remains under trajectory against the 18/19 target of 20 cases. Of the 13 cases which have so far been panel reviewed there have been no lapses in care identified.

There was 0 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA).

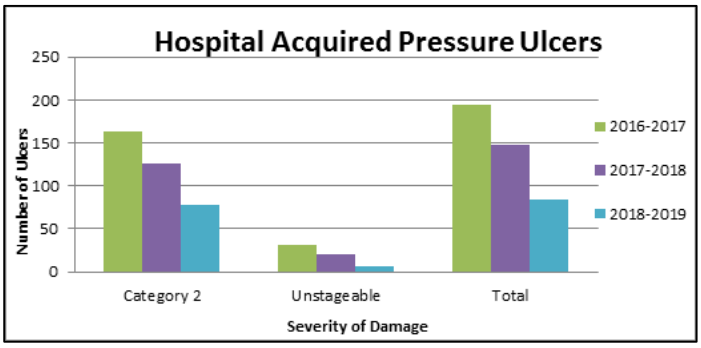
There have been no cases of hospital onset Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia year to date.

2.2.2 Pressure Ulcers

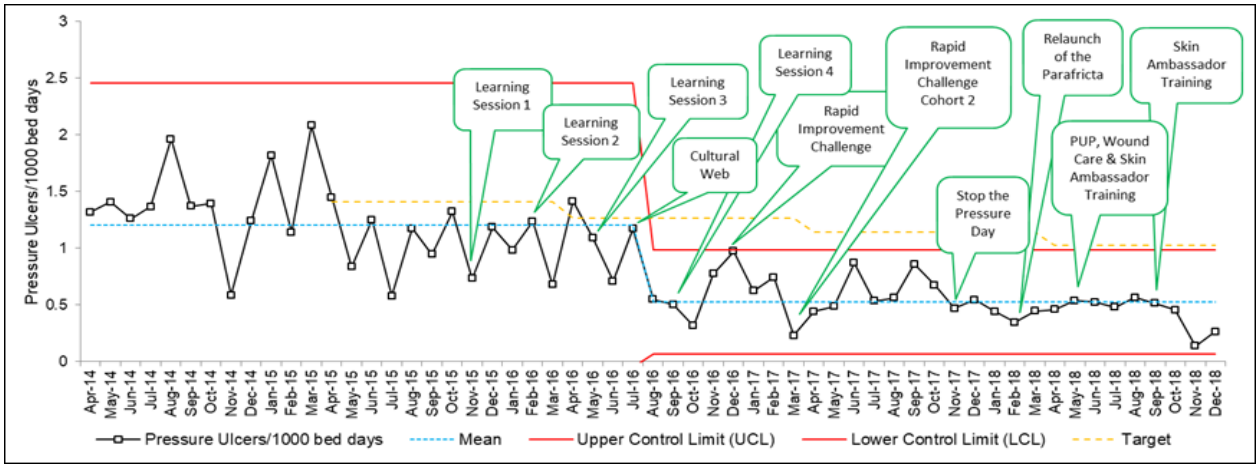
In December there were **286** datix reports submitted relating to tissue damage, following validation **42** patients were identified as having acquired Moisture Associated Skin Damage (MASD),

In total, **7** patients who developed **9** pressure ulcers whilst in our care, **5** patients developed **6** category 2 pressure ulcers, 2 patients developed **3** Deep Tissue Injuries, the latter are being monitored in line with national guidance to ascertain whether they are to be classified as pressure ulcers. Of the 9, 4 were device related, 1 developed on the patient's spine and one on the patient's heel.

There remains a year on year reduction in the incidence of hospital acquired pressure ulcers within the organisation demonstrated below are the category 2 and unstageable (the last hospital acquired category 3 was October 2018):



In December the number of pressure ulcers per 1000 bed days was 0.36; this is an increase from the previous month but remains less than the remainder of 2018. The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers demonstrating interventions which have been made which have resulted in statistically significant improvements.



There are four wards who have continued to maintain a high number of pressure free days; these are Althorp (679 days), Rowan (418 days), Talbot Butler (310 days) and Quinton Ward (83 days).

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

Patients admitted from Own Home/Care Home/Other Hospitals with skin breakdown	Number of Harms
Category 2	55
Category 3/Unstageable	11
Deep Tissue Injuries	11 (on 9 Patients)
MASD	72

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

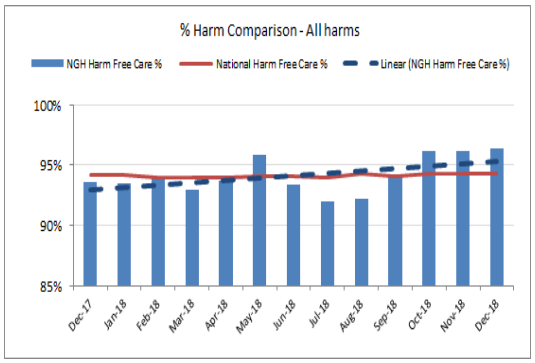
- Implementing the new guidelines from NHSi which requires updating our documentation, the policy and changing the timeframe for acquired from 72 hours post admission to time of admission (this is being debated nationally)
- Improving accessibility of 'near time' out of hour's photographic recording of skin breakdown, this is being piloted on the Assessment Units and will be evaluated after a month's trial.

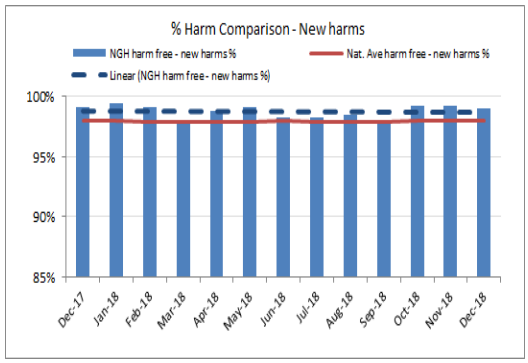
- Working closely with ward areas implementing and training staff on the ASSKING documentation (based on the SSKIN bundle), risk assessments and categorising of pressure ulcers

2.2.3 Harm Free Care (NHS Safety Thermometer)

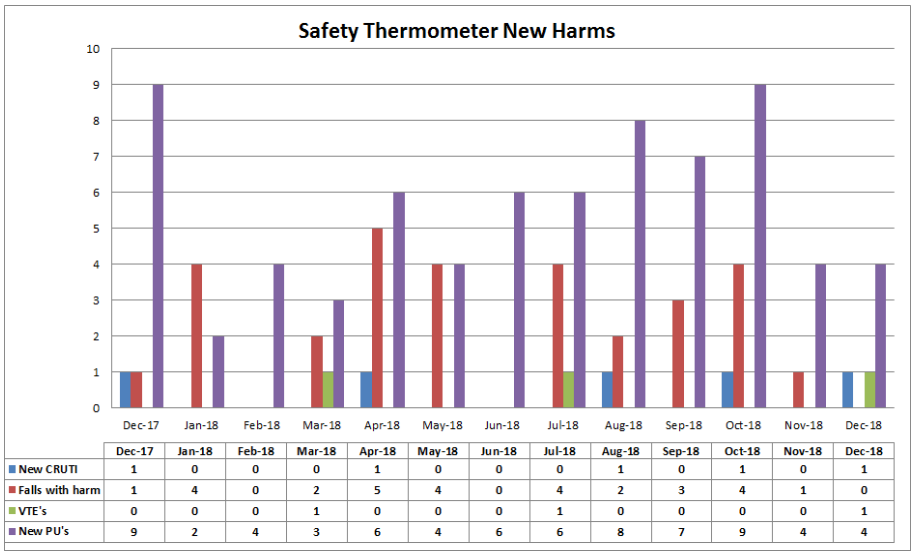
This monthly point prevalence audit showed that in December 99% of our in-patients did not incur any new harm whilst in our care, a similar result to November's and above the national average comparison figures, the new harms are highlighted in the table below.

Overall harm free care was 96.39% which was also above the month's national average of 94.25% this is our highest percentage in over a year and 3 months of results above the national target. (Appendix 1 provides the National Safety Thermometer Definition)





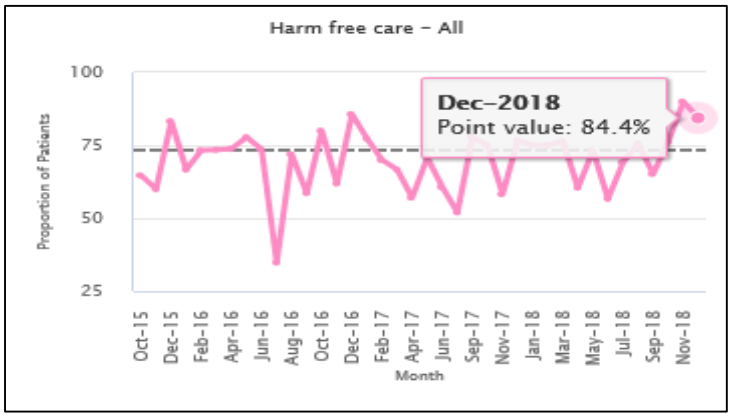
The new harms reported for December are illustrated in the graph below. The Matrons and Ward Sisters are aware of the point prevalence audit and review and monitor the results. The results are used in conjunction with the total monthly incidents and are discussed at monthly divisional meetings and included within the dashboard (Appendix 2 – 4).



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
New CRUTI	1	0	0	0	1	0	0	0	1	0	1	0	1
Falls with harm	1	4	0	2	5	4	0	4	2	3	4	1	0
VTE's	0	0	0	1	0	0	0	1	0	0	0	0	1
New PU's	9	2	4	3	6	4	6	6	8	7	9	4	4

Maternity NHS Safety Thermometer

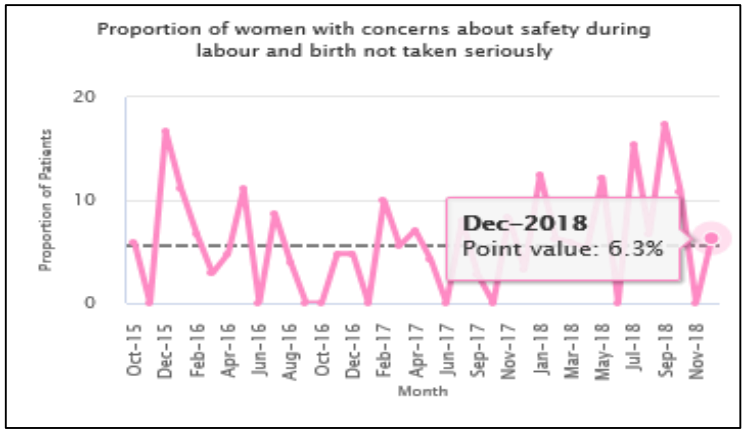
This is also a point prevalence study which aims to measure the overall percentage of women and babies who received combined physical and psychological 'harm' free care in December 2018, this was 84.4% which is above the national aggregate of 75.2%, as demonstrated in the graph below.



The percentage of women who received harm free physical care was 90.6% (80.4% nationally) and the percentage of women who perceived their care as being safe was 93.8% (93.5% nationally). No women surveyed for the December Safety Thermometer had a maternal infection, a 3rd/4th degree perineal trauma or a term baby with an Apgar score of less than 7 at 5 minutes. 9.4% of women had a PPH of more than 1000 mls.

The women's perception of safety has reduced from 100% in November 2018 to 93.8% in December 2018 (93.5% nationally).

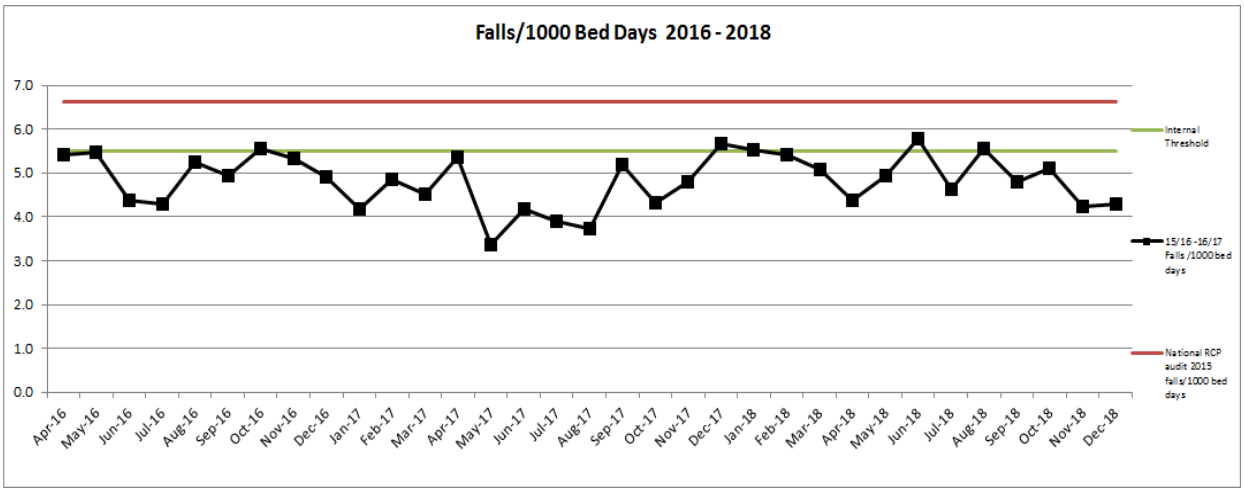
No women felt that they were not left alone at a time that worried them, which is below the national figure of 1.7% and is positive; however 6.3% women felt that their concerns about safety during labour and birth were not taken seriously compared to the national aggregate of 5.1%. This may be due to the fact that December was a period of high activity/acuity and staff shortages due to maternity leave and sickness which did put the service under pressure which could account for the findings this month. The maternity service will continue to correlate the impact of the activity / staffing on quality metrics such as the 'women's perception of safety'. If a negative trend is identified, a further piece of work will be led by the Head of Midwifery with the Matrons, to try to understand why women feel their concerns are not being taken seriously.



2.4 Falls

The falls rate per 1000 bed days is 4.29 compared to the national figure 6.8. There were 98 inpatient falls in total, 62 inpatient falls resulted in no harm to the patient, 33 were classified as low harm falls and 3 patients incurred moderate/severe harm, this is a slight increase from the previous month.

2 moderate harm patient falls resulted in; 1 patient fracturing their olecranon (elbow) and 1 patient sustaining a small subdural haematoma. 1 severe harm patient fall resulted in a patient fracturing their neck of femur. 2 falls were unwitnessed; all patients had multifactorial risk factors which had been identified prior to the patient falling. All 3 incidents remain under investigation any learning will be shared with the teams and through the falls steering group.



3.0 Nursing and Midwifery Dashboards

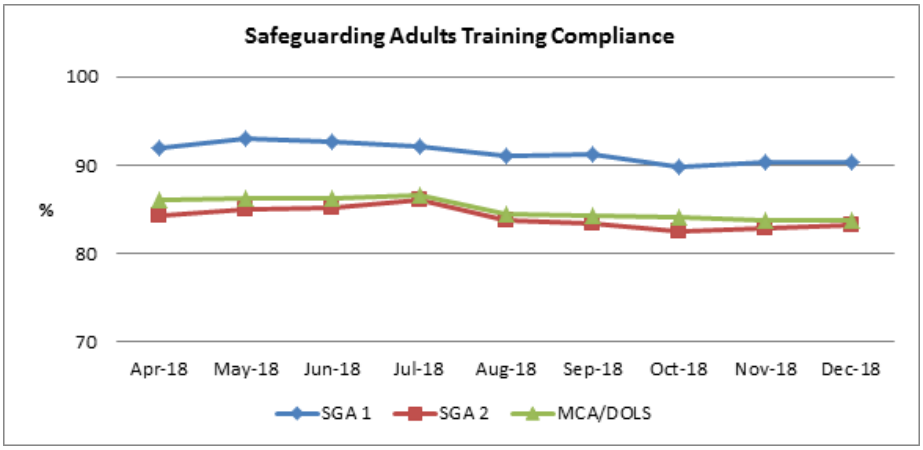
The Nursing and Midwifery Quality Dashboards, Appendix 3, 4 and 5 provide triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process, a review of the Quality Care Indicators (QCI) has taken place as planned with a reduction in the number of questions asked.

- In December there were 19 red domains, 49 amber the remaining are all green (281) in the Quality Care Indicator section
- The predominant red themes fall within the domains of First Impressions, mainly due to the high activity and lack of perceived co-ordination/time management, Protected Mealtimes several assessments and rounds were continuing during the lunch period and the Environment areas had a general feel of being cluttered and general lack of tidiness.
- The increase in the number of Protected Mealtime amber and red results has not been significant previously therefore this will be monitored during January and if the theme continues a programme of work and raising awareness will be taken forward by the ADNs and the Multi-disciplinary team.
- In all instances the action planning from the dashboard is coordinated by the respective ADNS supported by the respective Matron and Ward Sister and discussed in the appropriate directorate Nursing/Midwifery forums

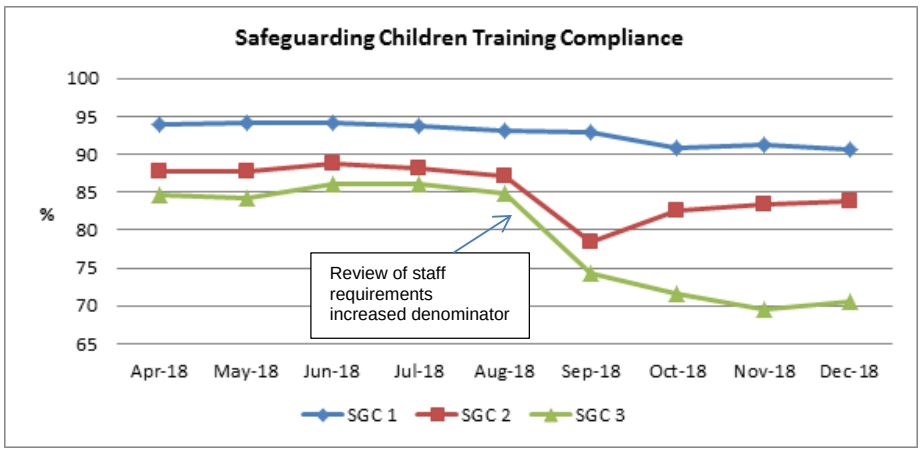
4.0 Safeguarding

4.1 Safeguarding Training Compliance

The training compliance rate of 85% is set as part of the quality schedule set by the Clinical Commissioning Group (CCG) for all safeguarding training. The graph below illustrates the compliance for Safeguarding Adults at the end of December. MCA and Level 2 safeguarding adults remain marginally under the compliance target (83%).



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



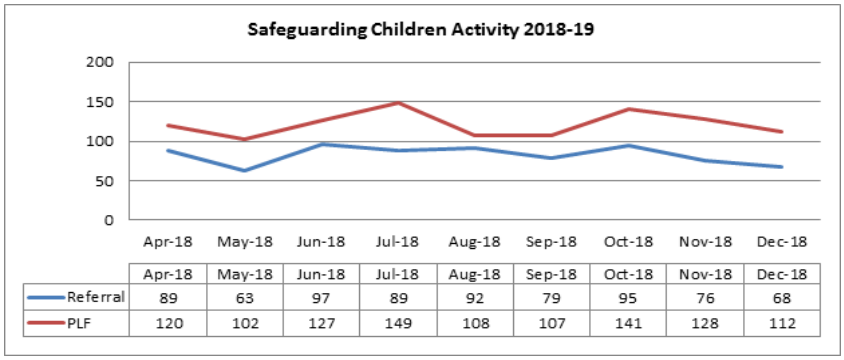
The Head of Safeguarding and Dementia, the Deputy Director of Nursing and the Learning and Development Manager have been working hard to resolve issues around correct roles and competencies across the organisation for level 3 training. Extensive communication regarding accessing training has been communicated to both the Associate Directors of Nursing and the Matrons to cascade across the organisation. A remedial plan has been instigated by the Director of Nursing which includes the Head of Safeguarding and the Learning and Development Manager reporting progress on a weekly basis.

The Trust has achieved 90% compliance in Basic Prevent Awareness Training and 97% compliance (1160 staff members out of 1201) in WRAP training. The compliance trajectory is set as 85% and forms part of the quarterly report to NHS England and the Clinical Commissioning Group (CCG) as per the Prevent data assurance process.

4.2 Safeguarding Children and Adult Referrals

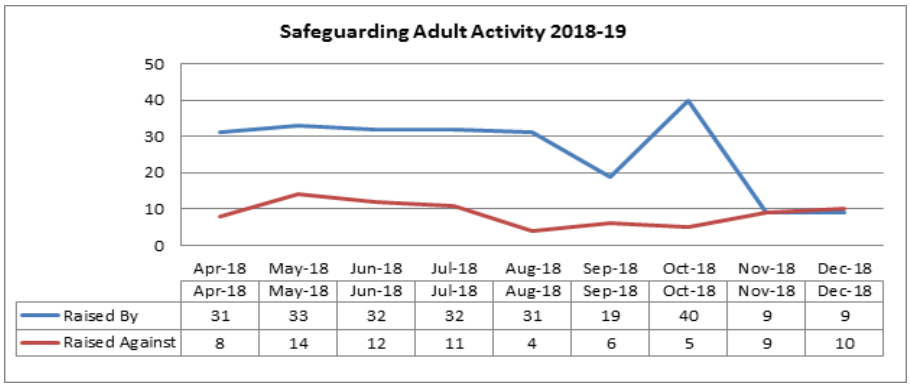
The following charts demonstrate the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of

Paediatric Liaison Forms (PLF's) processed. December has seen a slight drop in referrals but this is not statistically concerning.



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

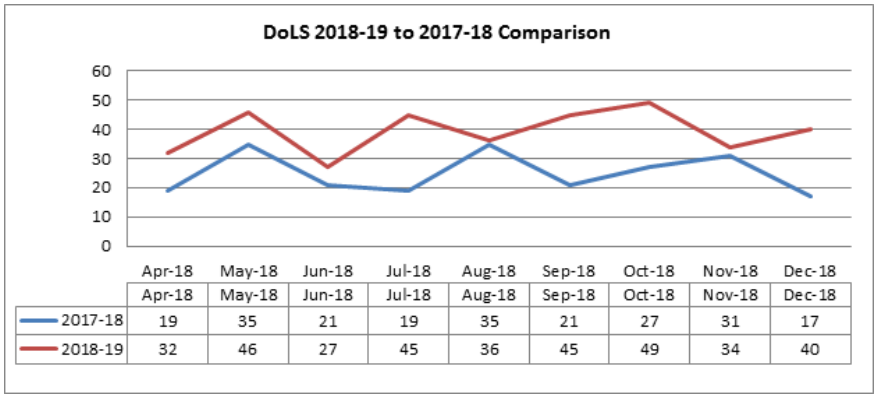
In terms of safeguarding adults' referral activity, there has been a significant decrease in the number of safeguarding allegations raised by the Trust, as recorded by the local authority, and at the same time a slight increase in the number of safeguarding allegations against the Trust in December as illustrated in the following graph.



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

However the figures which the Local Authority provide continue to raise grave concerns that significant information is not being collated and shared with the Trust as per local protocol. The decrease in the number of safeguarding referrals made by the Trust has not been at this level for several years. This issue has been raised with both the CCG and the Care Quality Commission. Immediate mitigation has been put in place within the Trust, Staff members completing safeguarding referrals have been requested to save copies and then send them to the safeguarding team which will address this concern.

4.3 Deprivation of Liberty Safeguards (DoLS)



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
2017-18	19	35	21	19	35	21	27	31	17
2018-19	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. This provides assurance for the Trust that staff are considering restrictions that could infringe on patient's human rights.

4.4 Safeguarding Assurance Activity

Concerns continue to be raised regarding Northamptonshire County Council and the impact this will have on children, young people and adults at risk. Areas identified by a recent focussed Ofsted Inspection were a request for workforce capacity to be reviewed, ensuring that allocated caseloads are manageable with robust oversight and that all referrals receive a timely allocation and assessment.

Updates/progress reports are discussed at both the Northamptonshire Safeguarding Adult and Children's Boards allowing open discussion to take place on the current position and challenges. The NGH safeguarding team continue to experience gaps/omissions in practice which have to be escalated to senior clinicians/managers. These concerns are captured on a weekly basis and shared with the CCG. It is recognised that there has been a reduction in the number of concerns raised in the latter half of December which may be due to the festive period.

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

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

4.5 Risk Register

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

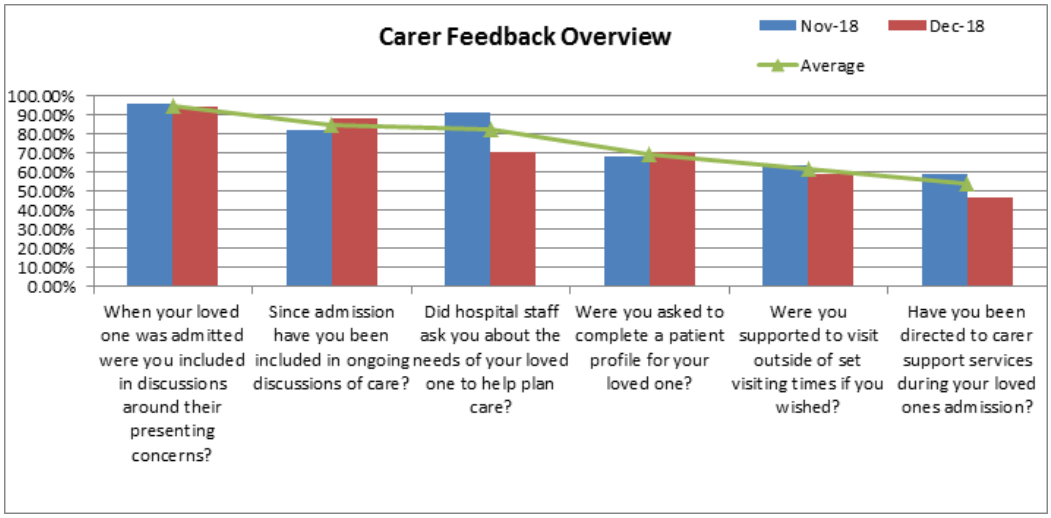
966 – Vulnerable Children and Adults –Graded 20
1300 - Authorisation of Deprivation of Liberty Safeguards (DoLS) – Graded 9
1305 – Compliance with Safeguarding Training – Graded 12

The risk associated with safeguarding children and adults (966) has been increased to an extreme risk rating to capture the continuing concerns about the adult and children's social care.

4.6 Dementia Activity

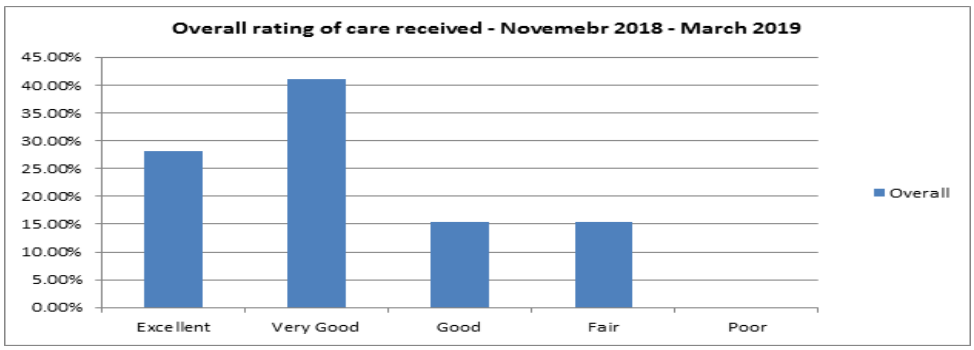
Carer Feedback

The Dementia Liaison Nurse (DLN) receives monthly feedback from carers regarding the experience of their loved ones care. A revised questionnaire was distributed from November with the aim of collating specific feedback to enable more focused actions.



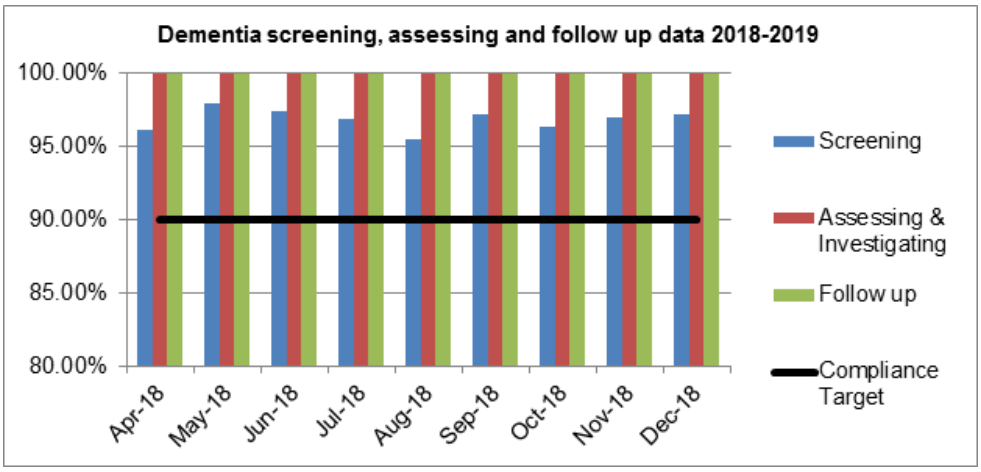
Feedback currently highlights that work needs to be focused on the patient profiles, John's Campaign and carer support which the DLN is addressing across the hospital and with support from Northamptonshire Carers who are based within the hospital.

Carers are now asked to rate the care of their loved one whilst being an in-patient at NGH. This is illustrated in the graph below following the receipt of thirty-nine carer questionnaires. This data can be broken down to month and ward area if requested, however this is not currently included within this report due to the small amount of data which is not providing any significant information to feedback at this time. Once any patterns are seen this will be shared and allow for specific actions to be formulated for improvement if required.



Dementia Screening Data

The Trust remains compliant with the dementia screening and follow up that is reported to NHS England on a monthly basis as highlighted in the graph below:



4.7 Learning Disability

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

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

A total of ten patients with a Learning Disability were admitted to the Trust in December.
100% of patients with a Learning Disability who were admitted to the Trust were identified and 100% of those who required a hospital passport received one within the first twenty-four hours of admission. For December assessment compliance was 90% due to one patient not receiving an appropriate assessment, staff have been reminded of the need for completion.

5. Maternity Update

5.1 Maternity Safety Actions

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.

The 10 Maternity Safety Actions (and the refinements for year two) have been agreed with the National Maternity Safety Champions in partnership with the Collaborative Advisory Group. Members of the group include: the Department of Health and Social Care, NHS Digital, NHS England, NHS Improvement, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, MBRRACE and the Care Quality Commission (CQC).

The National Maternity Safety Champions were appointed by the Department of Health as part of the government's ambition to help maternity services in England deliver better care to mothers and their babies. For this reason the majority of the Maternity Safety Actions are being recognised in other national drivers such as the draft 2019/20 NHS Standard Contract and the NHS Long Term Plan released 7th January 2019.

All the 10 Maternity Safety Actions dovetail with the work the Trust have been doing as part of NHS Improvement and the Maternal & Neonatal Health Safety Collaborative (MatNeo). The collaborative is a three-year quality improvement programme specifically aimed at improving the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and contributing to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths and brain injuries.

A gap analysis has been completed by the Maternity Divisional leadership team and key priority actions have been identified, some of which will require further funding. Business cases have been submitted and a paper is to be presented to the Executive Team. All actions will be monitored through the Divisional Governance Meeting.

5.2 PReCePT Programme

The PReCePT Programme is a quality improvement project designed to reduce the incidence of cerebral palsy through the administration of magnesium sulphate to eligible preterm mothers across England.

There was one woman admitted who met the eligibility criteria for administration of magnesium sulphate in December 2018 and this was administered. The Division are monitoring this programme through their divisional performance dashboard.

6.0 Safe Staffing

The overall fill rate for December 2018 was 96%, compared to 98% in November. Combined fill rate during the day was 92%, compared with 95% in November. The combined night fill rate was 100% compared with 101% in November.
RN fill rate during the day was 92% and for the night 95%. The opening of an additional 30 bedded escalation ward at the beginning of the month has placed additional demands on staff availability.

	Day	Night	Overall
RN	92%	95%	93%
HCA	93%	108%	99%
Overall	92%	100%	96%

Across the general adult wards Care Hours per Patient Day for the month of December was registered practitioner 4.1 and HCA 3.0 (which is a slight decrease compared to November); Trust wide inclusive of midwifery, paediatrics and critical care (which by nature are a higher care

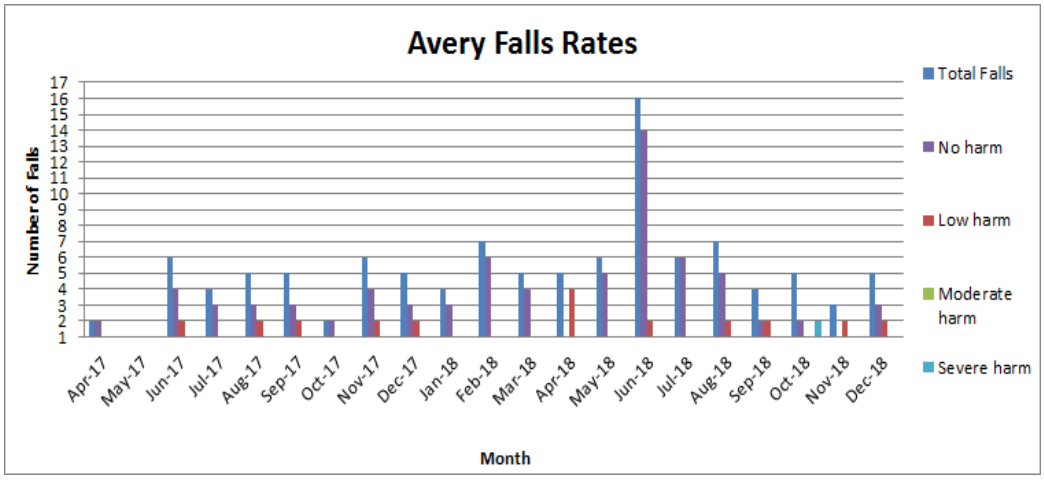
hours level) RN/M was 8.8 and HCA 3.8 (which is a slight increase for HCA and the same for RN/M in November).
The two wards at Avery and the ward at Dickens Therapy Unit both reported 0 shifts unfilled during December and no staffing related harm to patients.

Of the staffing datix that were submitted and reviewed by the Associate Directors of Nursing & Midwifery one constituted a red flag, this was reviewed by the Matron and Associate Director of Nursing for Medicine. There was a delay of over 30 minutes in the administration of a prescribed medication to a patient, it was not a time critical medication and the patient suffered no harm nor were there any ill effects from the delay – apologies given to the patient.

7.0 Avery and Dickens Therapy Unit

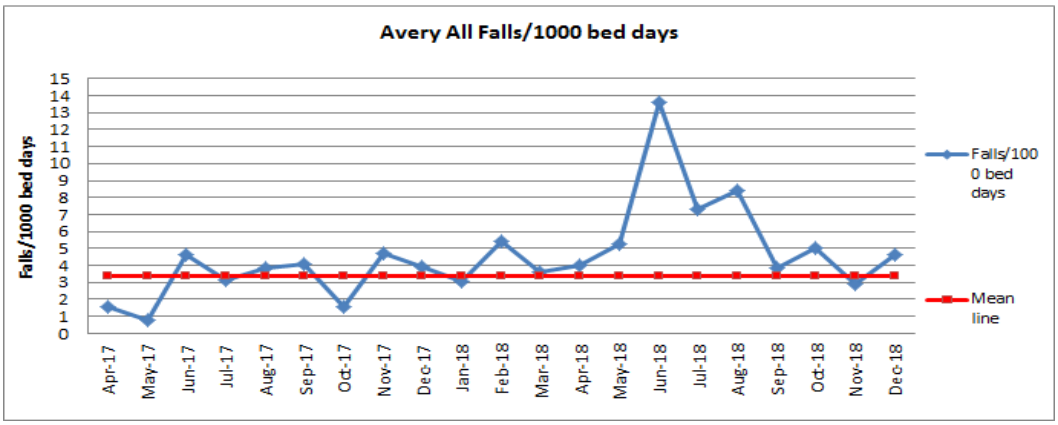
7.1 Avery

In December there were 5 inpatient falls, 3 no harm patient falls and 2 low harm patient falls.



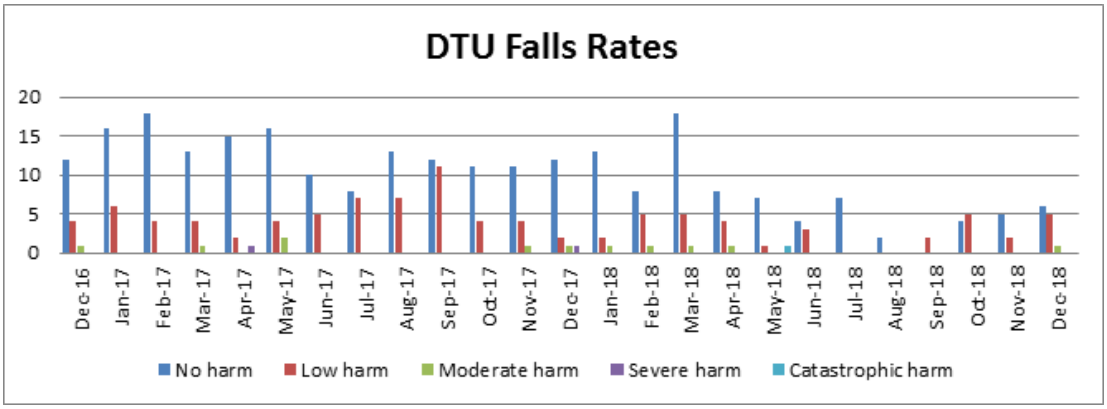
Falls/1000 bed days at Avery

The graph below demonstrates the total number of falls/1000 bed days increased by 1.78 falls/1000 bed days in the month of December.



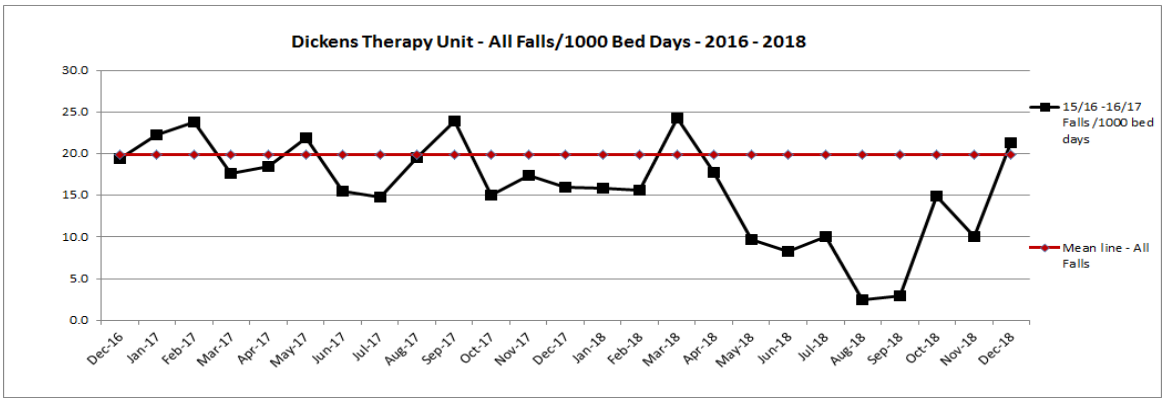
7.2 Dickens Therapy Unit

The following graph demonstrates the total number of falls incidents recorded at DTU and the harm that the patient sustained. There were 6 no harm patient falls, 5 low harm patient falls and 1 moderate harm patient fall, the patient sustained a fractured pubic rami.



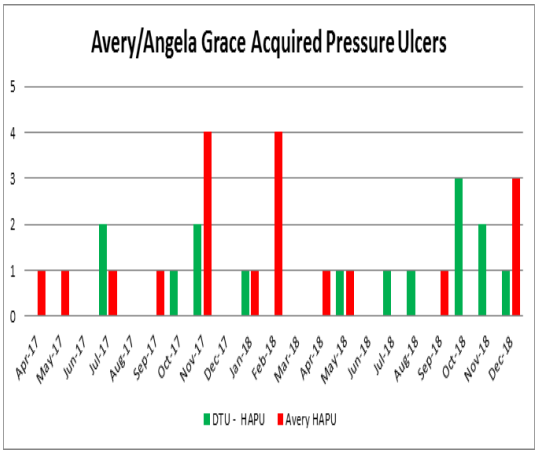
Falls/1000 Bed Days at Dickens Therapy Unit

The following graph demonstrates that the total number of patient falls/1000 bed days increased in December 2018 by 11.22 falls/1000 bed days.



Avery/Angela Grace PU Incidence

The run chart below represents the number of pressure ulcer harms reported in 2016-2018 to patients in Avery and Dickens Therapy Unit. The TVT continue to report and investigate these harms as per Trust protocol.



There was **1** Unstageable Pressure Ulcer reported by Dickens Therapy Unit (Angela Grace) during December 2018.
There were **2** Category 2 and **1** Unstageable pressure ulcers all on the same patient which was reported at Avery (Cliftonville) in the month of December 2018.
The TV Team have offered and continue to send training dates to the Staff at Avery and Angela Grace.

8.0 Assessment and Accreditation

During December four wards were assessed. Two wards achieved amber ratings and two wards achieved green ratings. In December, the current status of all adult in-patient wards including Critical Care was, two blue wards, twelve green wards, 10 amber wards and no red wards. Of the eleven green wards, one is awaiting Trust Board approval to be granted blue ward status, and 2 wards are awaiting panel. The current status of outpatient departments is - three green departments and 1 amber department. 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 improvements noted in December.

9.0 End of Life

Work progresses to develop our End of Life (EOL) and Specialist Palliative Care Services. Over the past few months key appointments have been made to the team to enable 7 day working. This is a welcomed addition to support inpatient areas.

Other initiatives which are taking place include: improving end of life care through the roll out of the Amber Care Bundle, the introduction of Careflow to improve the timeliness of referrals to the team and the piloting of a Tissue Donation project initially in 6 pilot wards aimed to increase the number of tissue donations where appropriate.

Improvements in EOL care is being monitored through the introduction of a balanced scorecard which will be reported in more detail in future reports.

The NGH team are involved in a countywide improvement project to increase the knowledge in the community and for community healthcare workers about palliative care. They will be working in conjunction with NHfT and KGH to prevent unnecessary and unwanted admissions when people are at the end of their life and increasing awareness of palliative care for people with learning difficulties.

10.0 Recommendation

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

Appendix 1

Nursing and Midwifery Safety Thermometer Definition

The Department of Health introduced the NHS Safety Thermometer "Delivering the NHS Safety Thermometer 2012" the initiative was also initially a CQuIN in 2013/14 to ensure the launch was sustained throughout the nation. The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that needs be used alongside Trusts data that is prevalence based and triangulated with outcome measures and resource monitoring. The national aim is to achieve 95% or greater harm free care for all patients, which to date the national average is running at 94.25%.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, and urinary infection in patients with catheters and treatment for VTE. All inpatients (including those patients in theatres at the time but excluding paediatrics) are recorded by the wards and the data inputted onto the reporting system, on average NGH reports on 630+ patients each month.
The Safety Thermometer produces point prevalence data on all harms (which includes harms that did not necessarily occur in hospital) and 'new' harms which do occur whilst in hospital – in the case of falls, VTE and CRUTI the classification of 'new' means within the last 72 hours, this is slightly different for pressure damage as 'new' is categorised as development that occurred in our care post 72 hours of admission to hospital and is recorded throughout the patient stay on the Safety Thermometer.
NGH has a rigorous process in place for Safety Thermometer data collection, validation and submission; four sub-groups for each category exist and are led by the specialists in the area. For pressure damage and falls all harms are recorded on datix throughout the month (not just on this one day) reviews are undertaken to highlight any lapses in care, every area with an incident attends the Share and Learn forums to analyse further the incident and to develop plans for areas of improvement and future prevention.

Maternity Safety Thermometer
The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care (by asking women questions on women's perception of feelings around safety in labour. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women's homes and community postnatal clinics. The safety thermometer has only just been implemented in the community midwifery service.

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

Physical 'harms':

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

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

Appendix 2

Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

Appendix 3

Dec-2018	Medicine														WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Brampton	Collingtree	Compton	(Knightley)Creaton	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.%	70.%	100.%	100.%	96.%	100.%	100.%	100.%	97.%	96.%	100.%	87.%	93.%	100.%	93.%	100.%	93.%	100.%	100.%	70.%	97.%	100.%	90.%
Pressure Prevention Assessment	100.%	94.%	100.%	100.%	81.%	79.%	97.%	90.%	100.%	100.%	100.%	100.%	94.%	100.%	77.%	100.%	100.%	100.%	100.%	66.%	94.%	97.%	100.%
Nutritional Assessment	97.%	83.%	92.%	88.%	75.%	92.%	100.%	97.%	93.%	93.%	100.%	97.%	93.%	97.%	90.%	100.%	100.%	100.%	100.%	77.%	90.%	97.%	100.%
Patient Observation and Escalations	84.%	86.%	90.%	100.%	82.%	90.%	100.%	100.%	90.%	86.%	95.%	95.%	95.%	95.%	95.%	95.%	100.%	95.%	95.%	86.%	95.%	95.%	90.%
Pain Management	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	98.%	100.%	93.%	98.%	90.%	97.%	95.%	97.%	98.%	97.%	100.%	95.%	98.%	95.%	92.%	100.%	100.%	100.%	100.%	93.%	98.%	98.%	98.%
Patient Experience - Protected Mealtimes (PMT) Observations	83.%	83.%	83.%	100.%	67.%	62.%	100.%	80.%	100.%	67.%	83.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	83.%	67.%	100.%	83.%
Patient Experience - Care Rounds Observe patient records	82.%	100.%	100.%	100.%	81.%	73.%	100.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	82.%	64.%	81.%	88.%
Patient Experience - Environment	100.%	100.%	100.%	100.%	80.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	80.%	80.%	100.%	80.%	80.%	100.%
Patient Experience - Privacy and Dignity	100.%	93.%	94.%	98.%	100.%	84.%	95.%	98.%	100.%	93.%	94.%	100.%	94.%	96.%	99.%	95.%	91.%	96.%	91.%	92.%	82.%	90.%	99.%
Patient Safety and Quality	100.%	90.%	100.%	100.%	89.%	92.%	100.%	100.%	100.%	81.%	100.%	100.%	100.%	90.%	100.%	100.%	100.%	100.%	95.%	100.%	92.%	90.%	95.%
Leadership & Staffing observations	95.%	86.%	100.%	95.%	85.%	96.%	100.%	98.%	100.%	86.%	92.%	100.%	95.%	90.%	96.%	96.%	96.%	98.%	98.%	100.%	92.%	96.%	98.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%
First Impressions/15 Steps	100.%	83.%	80.%	91.%	83.%	73.%	100.%	89.%	74.%	71.%	89.%	97.%	60.%	100.%	80.%	80.%	100.%	83.%	80.%	86.%	77.%	80.%	100.%
Safety Thermometer – Percentage of Harm Free Care	96%	96%	100%	85%	89%	100%	96%	90%	100%	100%	100%	96%	100%	97%	96%	100%	97%	97%	97%	100%	96%	96%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	1	0	1	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0	1	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Caring																							
Complaints – Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of PALS concerns relating to nursing care on the wards	0	0	1	2	0	0	1	0	0	0	1	1	1	0	0	1	0	1	1	2	0	0	0
Friends Family Test % Recommended	100.0%	97.1%	92.3%	95.2%	64.0%	80.0%	88.4%	83.3%	88.9%	92.1%	92.9%	75.0%	63.0%	90.8%	90.0%	89.6%	86.6%	90.7%	87.8%	93.5%	96.4%	88.9%	91.8%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	97%	99%	99%	103%	99%	91%	89%	110%	95%	90%	89%	94%	95%	91%	102%	101%	104%	101%	99%	104%	104%	102%	95%
Staff Nurse Staffing - Support Worker (day & night combined)	101%	90%	117%	94%	95%	108%	91%	113%	94%	84%	114%	97%	112%	108%	88%	96%	119%	98%	100%	107%	114%	98%	93%
Staffing related datix	0	0	0	0	0	3	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0

Appendix 4

Dec 18	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	78%	100%	100%
Pressure Prevention Assessment (Q)	84%	100%	96%
Child Observations [documentation] (Q)	100%	100%	100%
Safeguarding [documentation] (Q)	100%	100%	100%
Nutrition Assessment [documentation] (Q)	100%	100%	100%
Medication Assessment (Q)	100%	91%	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			
Friends Family Test % Recommended	91%	92%	100%
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	0	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Safety & Quality Environment Observations Observe patient records (Q)	98%	100%	75%
Privacy and Dignity (Q)	100%	100%	100%
Management			
Staffing related datix	0	0	0
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	100%	100%	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%	84%	100%	100%
SOVA/LD (Q)	Nil	Nil	Nil	nil
Patient Observation Chart (Q)	100%	93%	100%	100%
Medication Assessment (Q)	100%	100%	100%	100%
Environment Observations (Q)	100%	100%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	93%	100%	100%	93%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	97%	100%	97%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	100%	100%
Patient Experience (Q)	100%	100%	98%	100%
Patient Safety and Quality (Q)	96%	93%	96%	95%
Leadership & Staffing (Q)	100%	100%	100%	100%
Management				
Staffing related datix	0	1	0	1
Monthly Ward meetings (Q)	100%	100%	100%	100%
Saftey and Quality (Q)	100%	100%	100%	100%
Leadership & Staffing (Q)	100%	100%	100%	100%

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	OCT-18	NOV-18	DEC-18
Caring	Complaints responded to within agreed timescales	>=90%	97.3%	97.4%	98.0%
	Friends & Family Test % of patients who would recommend: A&E	>=87.1%	86.4%	88.1%	85.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	92.4%	94.0%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97%	100.0%	96.6%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	92.3%	93.8%	93.5%
	Mixed Sex Accommodation	=0	0	0	0
	Compliments		4,288	4,335	3,541

	Indicator	Target	OCT-18	NOV-18	DEC-18
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	86.7%	85.9%	83.3%
	Average Ambulance handover times	<=15 mins	00:14	00:14	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	174	142	299
	Ambulance handovers that waited over 60 mins	<=10	17	19	30
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	3	3	4
	Delayed transfer of care	=23	10	10	24
	Average Monthly DTOCs	<=23	27	15	20
	Average Monthly Health DTOCs	<=7	25	13	16
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	94.0%	88.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	91.0%	40.2%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.5%	94.8%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	95.7%	96.6%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	86.6%	93.7%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	85.4%	76.0%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	83.8%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	85.7%	83.6%	
	RTT waiting times incomplete pathways	>=92%	81.5%	82.1%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%	99.9%	
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	94.8%	95.6%	100.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	97.9%	95.0%	95.3%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Effective	Stranded Patients (ave.) as % of bed base	<=40%	54.1%	54.4%	54.7%
	Super Stranded Patients (ave.) as % of bed base	<=25%	23.7%	23.1%	23.1%
	Length of stay - All	<=4.2	4.5	4.4	4.1
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.4%	3.8%	3.3%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.1%	17.2%	11.8%
	# NoF - Fit patients operated on within 36 hours	>=80%	84.6%	82.7%	100.0%
	Maternity: C Section Rates	<29%	31.4%	31.3%	32.1%
	Mortality: HSMR	100	106	106	106
	Mortality: SHMI	100	100	104	102

	Indicator	Target	OCT-18	NOV-18	DEC-18
Safe	Never event incidence	=0	1	0	0
	Number of Serious Incidents (SI's) declared during the period		0	0	3
	MRSA	=0	0	0	0
	C-Diff	<=1.75	0	0	1
	MSSA	<=1.1	2	1	0
	VTE Risk Assessment	>=95%	95.7%	95.4%	93.5%
	New Harms	<=2%	2.11%	0.67%	0.99%
	Harm Free Care (Safety Thermometer)	>=94%	94.2%	96.1%	96.3%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.0	4.2	4.4
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	66	36	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	96.9%	97.2%	91.4%
	Ward Moves > 2 as a % of all Ward Moves	=0%	5.8%	6.1%	5.2%
	Appointed Fire Wardens	>=85%			85.6%
	Fire Drill Compliance	>=85%			62.0%
	Fire Evacuation Plan	>=85%			89.2%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Well Led	Income YTD (£000's)	>=0	(3,337) Adv	(2,957) Adv	(3,550) Adv
	Surplus / Deficit YTD (£000's)	>=0	57 Fav	97 Fav	(432) Adv
	Pay YTD (£000's)	>=0	(3,221) Adv	(3,277) Adv	(3,165) Adv
	Non Pay YTD (£000's)	>=0	4,246 Fav	4,204 Fav	4,612 Fav
	Bank & Agency / Pay %	<=7.5%	12.4%	12.3%	12.3%
	Salary Overpayments - Number YTD	=0	153	167	195
	Salary Overpayments - Value YTD (£000's)	=0	313.1	340.9	371.9
	CIP Performance YTD (£000's)	>=0	1,704 Fav	1,821 Fav	1,554 Fav
	Maverick Transactions	=0			15
	Waivers which have breached	=0			1
	Job plans progressed to stage 2 sign-off	>=90%	15.1%	27.5%	24.2%
	Sickness Rate	<=3.8%	4.0%	4.0%	4.4%
	Staff: Trust level vacancy rate - All	<=9%	10.4%	10.3%	12.5%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	8.8%	9.0%	9.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	7.3%	7.5%	11.5%
	Staff: Trust level vacancy rate - Other Staff	<=9%	12.8%	12.1%	13.5%
	Turnover Rate	<=10%	7.7%	7.8%	8.3%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.8%	88.2%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%		81.9%	82.8%
	Percentage of all trust staff with role specific training compliance	>=85%	81.9%	82.5%	83.0%
	Percentage of staff with annual appraisal	>=85%	83.1%	83.5%	81.6%

Run Date: 17/01/2019 14:43 Corporate Scorecard Run by: CrockettG

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Friends & Family Test % of patients who would recommend: A&E	>=87.1%	89.7%	85.0%	84.2%	87.2%	86.3%	88.6%	88.3%	87.9%	87.3%	86.4%	88.1%	85.9%
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	93.2%	93.4%	93.2%	92.1%	93.7%	91.9%	92.5%	91.4%	91.9%	92.4%	94.0%	92.6%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	94.1%	93.7%	93.8%	93.9%	97.8%	92.4%	92.7%	93.1%	92.7%	92.3%	93.8%	93.5%

Driver for underperformance:

- The result for Inpatient & Day Case continues to be stable with only small movements each month. The Inpatient & Day Case result is 3.7% below the national average when comparing December with the most recent national data available.
- The results for A&E are 1.2% below the national average when comparing December with the most recent national data available (October).

Actions to address the underperformance:

- The Right Time mini survey and Real-Time surveys are continuing which enable the wards to identify specific areas where further improvements need to be made.
- From January 2019, the Patient Experience Department is relaunching FFT with the hope in increasing recommendation rates.

Lead Clinician:	Lead Manager:	Lead Director:
N/A	Emma Wimpress	Sheran Oke

Northampton General Hospital NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**31st January 2019**

Title of the Report	Financial Position - Month 9 (FY2018-19)
Agenda item	12
Sponsoring Director	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the month ended December 2018.

Executive summary

This report sets out the Trust's financial position for the month ended 31st December 2018. The results show a reported year-to-date pre-PSF deficit of £20,285k against a planned pre-PSF deficit of £20,377k, resulting in a favourable variance of £92k.

The full finance-related PSF of £4,182k has been earned, however only £965k of the available £1,792k A&E-related PSF has been earned as the Trust missed the A&E trajectories for Quarter 3, resulting in missed income of £827k. Therefore the overall post-PSF position at the end of November is an adverse variance to plan of £735k.

Income and activity continued to show a strong performance. The Trust has managed to secure an agreed position with its main commissioners – Nene CCG and Corby CCG and this will help to provide some certainty around income.

Pay is overspent by £3,162k year-to-date and underspent against the December plan by £115k. Agency spend in December is £1,042k with the key spends on medical agency staff.

CIP delivery is £11,112k YTD which is £1,554k better than plan although about half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Capital is underspent against plan by £359k with a YTD spend of £15,785k.

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

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY18-19 signals another challenging financial year and the requirement to maintain the financial discipline required to deliver the agreed control total.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A

Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Committee

The Board is asked to note the financial position for the month ended December 2018 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 9 (December 2018)
FY 2018/19

Report to:

Trust Board

January 2019

Content

1. Director of Finance Message

The Trust delivered a better than plan pre-PSF position of £92k largely due to an improved overall income position.

However the loss of A&E related PSF brought the position down to an adverse variance to plan of £735k.

This report sets out the Trust's financial position for the month ended 31st December 2018. The results show a reported year-to-date pre-PSF deficit of £20,285k against a planned pre-PSF deficit of £20,377k, resulting in a favourable variance of £92k.

The full finance-related Provider Sustainability Funding (PSF) of £4,182k has been earned, however only £965k of the available £1,792k A&E-related PSF has been earned as the Trust missed the A&E trajectories for Quarter 3, resulting in missed income of £827k.

Therefore the overall post-PSF position at the end of November is an adverse variance to plan of £735k.

The Trust is planning to appeal the missed A&E PSF money, however there is no guarantee of a successful appeal. If the A&E trajectory for Q4 is missed it will put another £965k at risk and therefore mean the Trust may miss its control total by £1,792k, subject to the financial performance being maintained. A detailed forecast paper is provided under separate cover.

Income and activity performance, particularly non-elective activity, continued to show a strong performance in December and overall income was £343k worse than plan in December. However given that the plan included a quarterly phasing of the STP related income of £700k, the position in December was a good one. The Trust has now managed to secure an agreed position with its main commissioners – Nene CCG and Corby CCG and this will help to provide some certainty around income.

Pay is overspent by £3,162k year-to-date and underspent against the December plan by £115k. Agency spend in December is £1,042k with the key spends on medical agency staff.

Salary Overpayment continues to be an issue for the Trust and increased to £372k from £341k last month.

Other income is £2,362k better than plan year-to-date and improved by £195k in month mainly due to additional pay funding received from NHSI ,salary recharges, increased sale of medicines and catering income.

CIP delivery is £10,932k YTD which is £1,374k better than plan although about half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Capital is underspent against plan by £359k with a YTD spend of £15,785k. Reviews are ongoing to ensure that the schemes can be delivered or mitigations put in place to ensure that the Trust is able to meet its capital plan for the year.

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

Table 1: Income and Expenditure Summary

I&E Summary	Actual FY16-17	Actual FY17-18	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
				Plan	Actual	Variance	Plan	Actual	Variance	Nov-18	Oct-18
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	271,513	286,457	23,186	22,780	(406)	215,043	210,434	(4,609)	24,571	24,717
Other Clinical Income	2,373	5,837	11,898	1,145	760	(385)	8,004	6,699	(1,306)	829	826
Other Income	31,824	20,654	25,311	2,169	2,365	195	18,859	21,221	2,362	2,388	2,426
Total Income	294,525	298,004	323,666	26,500	25,905	(596)	241,906	238,354	(3,552)	27,789	27,968
Pay Costs	(199,813)	(207,233)	(219,917)	(19,018)	(18,903)	115	(163,396)	(166,558)	(3,162)	(18,745)	(18,565)
Non-Pay Costs	(94,406)	(103,550)	(109,461)	(8,892)	(8,481)	410	(81,613)	(76,977)	4,636	(8,922)	(8,651)
Unallocated CIPs		0	1,891	441		(441)	(1,134)		1,134		
Reserves/ Non-Rec		0	(1,424)	21		(21)	(485)		485		
Total Costs	(294,219)	(310,783)	(328,911)	(27,448)	(27,385)	64	(246,628)	(243,535)	3,093	(27,667)	(27,217)
EBITDA	306	(12,779)	(5,245)	(948)	(1,480)	(532)	(4,722)	(5,181)	(459)	122	752
Depreciation	(9,703)	(10,056)	(10,615)	(937)	(938)	(1)	(7,799)	(7,803)	(4)	(938)	(938)
Amortisation	(9)	(9)	(8)	(1)	(1)	(0)	(6)	(6)	(0)	(1)	(1)
Impairments	(1,732)	(4,085)	(1,826)	(0)		0	(0)		0		
Net Interest	(720)	(823)	(1,239)	(109)	(103)	6	(904)	(851)	53	(97)	(98)
Dividend	(3,307)	(2,411)	(1,529)	(127)	(127)	0	(1,147)	(1,143)	4	(127)	(127)
Surplus / (Deficit)	(15,165)	(30,164)	(20,462)	(2,123)	(2,649)	(526)	(14,578)	(14,985)	(407)	(1,040)	(412)
NHS Breakeven duty adjs:											
Donated Assets	(414)	138	122		13	13	175	(153)	(328)	42	20
NCA Impairments	1,732	4,085	1,826	0		(0)	0		(0)		
Surplus / (Deficit) - Normalisec	(13,847)	(25,940)	(18,514)	(2,123)	(2,636)	(513)	(14,403)	(15,138)	(735)	(998)	(392)

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

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,705)	(20,377)	(20,285)	92
PSF: Finance	6,434	4,182	4,182	-
PSF: A&E	2,757	1,792	965	(827)
Post PSF	(18,514)	(14,403)	(15,138)	(735)

Table 3: Pre-PSF I&E Performance

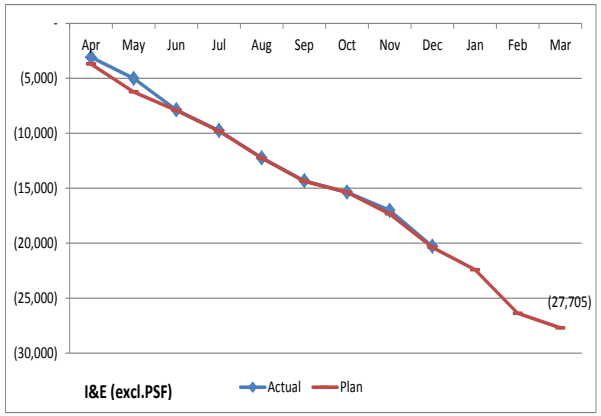
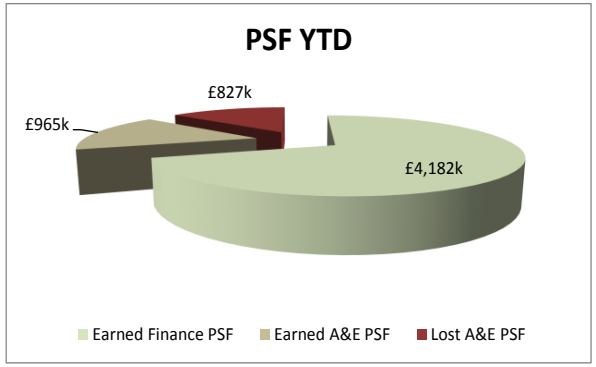


Table 4: PSF YTD Performance



2.1 Clinical Income (YTD)

Month 9 SLA Clinical Income is below plan, with a variance of -£1,493k (excluding pass-through medicines and devices). The YTD underlying underperformance has improved due to non-elective activity levels, and consistently high A&E volumes. However, the YTD position includes the Q3 STP related target, showing a YTD variance of £2.1m and CIP of £1.4m. NEL and NEL excess bed day income offset this by £1.1m, with A&E also £0.7m above plan.

- A&E activity is above plan by 2.6%, and also shows a casemix variance. An element is subject to coding & counting (£35k/mth), which is within the challenge line.
- Cost per Case (CPC) is above plan due to Radiotherapy activity (£242k), Critical Care (£293k) and Direct Access volumes (£228k). This is offset by Maternity income now under plan by £296k.
- Day case performance is above plan by 0.8% on activity, and above plan financially (2.8%). Urology is above plan by £230k, with Vascular Surgery +£161k and Paediatrics +£156k. Pain Management (-£124k) and Plastic Surgery (-£96k) are under plan.
- Elective activity is reporting 15% below the activity plan, 10% financially. The key under-performance is in General Surgery, T&O and Urology. Planned activity overall is 1.2% below plan, with a slightly improved financial position of 2.6% below. This is resulting in pressure to achieve RTT trajectories (see slide 2.2).
- NEL activity is now 1.9% above plan, and has been over-performing for 5 consecutive months. Positive casemix means a 6% favourable variance in income. General Surgery (32%), Cardiology (20%), T&O (8%) and Gen Med (3%) are the most significant areas above income plan. Stroke is the main beneficiary from casemix. XS bed day income largely offsets the income over-performance on NEL.
- Outpatients are now 4% below the activity plan, with in Ophthalmology (12%) and Cardiology (66%), and under the income plan by 3.0%. OPROCS are 8% above both activity and income plans.
- The challenge provision has been increased in Month 8 due to known over-charging on an OP procedure in Cardiology.

Table 5: Key PoD Trend Analysis

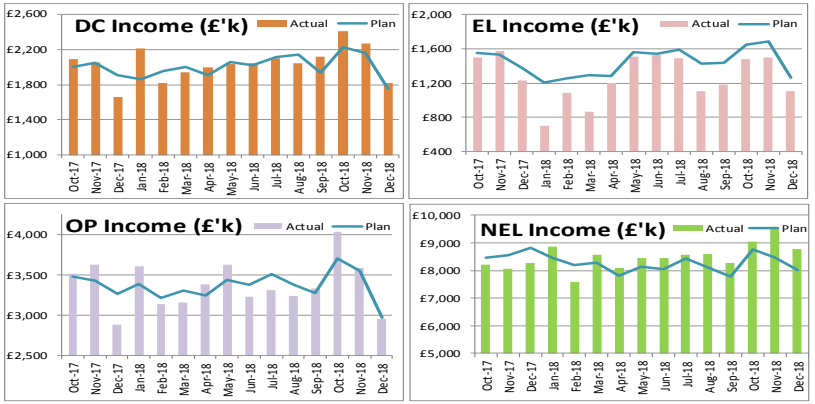


Table 6: SLA Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	96,664	99,202	2,538	12,383	13,131	748
Block	-	-	-	8,335	8,355	19
Cost per Case	2,216,315	2,349,531	133,216	28,095	28,648	553
CQUIN	-	-	-	3,753	3,778	25
Day Cases	30,493	30,728	235	18,331	18,839	508
Elective	4,134	3,490	(644)	13,431	12,088	(1,344)
Elective XBDs	945	1,124	179	252	295	43
Non-Elective	39,632	40,398	767	73,604	77,819	4,215
Non-Elective XBDs	24,634	13,907	(10,727)	6,116	3,032	(3,085)
Outpatient First	42,573	41,854	(719)	7,509	7,387	(122)
Outpatient Follow-up	157,546	150,359	(7,187)	12,552	12,051	(501)
Outpt Procedures	114,700	124,250	9,550	14,077	15,157	1,080
STP related income				3,450	1,350	(2,100)
CIP / Other				1,446	0	(1,446)
sub-total	**2,727,636**	**2,854,843**	**127,207**	**203,335**	**201,929**	**(1,406)**
Contract Penalties				(173)	(81)	92
Challenges				(1,350)	(1,530)	(180)
Readmissions				(2,396)	(2,396)	0
MRET				(4,439)	(4,439)	0
Fines & Penalties				**(8,357)**	**(8,445)**	**(87)**
Subtotal (excl. Excl Meds & Dev.)	**2,727,636**	**2,854,843**	**127,207**	**194,978**	**193,485**	**(1,493)**
Excluded Devices	3,441	2,461	(980)	1,551	1,166	(385)
Excluded Medicines	6,180	7,267	1,087	18,513	15,783	(2,730)
Total SLA Clinical Inc	**2,737,258**	**2,864,571**	**127,314**	**215,043**	**210,434**	**(4,609)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	859	564	(295)
Overseas Visitors	100	51	(49)
RTA / Personal Injury Income	1,071	901	(170)
PSF Funding	5,974	5,147	(827)
Total Other Clinical Income	**8,004**	**6,663**	**(1,342)**

2.2 Clinical Income By Commissioner (YTD)

Nene Contract - £677k overperformance

The Month 9 position on the Nene contract is £677k over plan; up from £380k over-performance last month. Month 9 has seen continued strong NEL activity, £645k over plan (offset by £374k XS bed day income below plan).

Key impacts include:

- A&E activity above plan and favourable casemix, £93k above income plan 'in month' (£709k YTD). As mentioned previously there is a related Coding & Counting challenge which is not reported against the CCG at this stage. The is now c.£35k per month with the value within the main challenge provision, reported in 'Other'
- Planned activity, as reported earlier, was above plan for DC and below for Elective IP in December. When looked at together, activity was slightly below plan (1%) and £77k below financially.
- OPROC activity is now £413k over plan YTD due to Cardiology activity being transferred from Specialised Commissioners.
- OP activity for Nene was below plan by £30k in month.
- NEL is the most significant, £4.2m over plan due to favourable casemix and activity. This is partially offset by NEL XS bed day income below plan (£-2.6m).

Specialised Commissioner - £3,190k under performance

The under performance is attributable to excluded devices (-£403k), and excluded medicines (-£2.5m) which will have equivalent underspends (ie. there is no bottom-line impact). Hep C uptake has slowed dramatically, causing the majority of the variance.

Non-elective activity remains below plan, specifically in Paediatrics (-£247k) and General Medicine (-£80k). Radiotherapy is at £260k over plan.

STP related income- £2,100k under performance

This reflects the underperformance on the planned income associated with the STP. However as we have now struck a year-end deal with our main Commissioners within the STP, the impact of a any underachievement is limited going forward.

Table 7: SLA Clinical Income by Commissioner

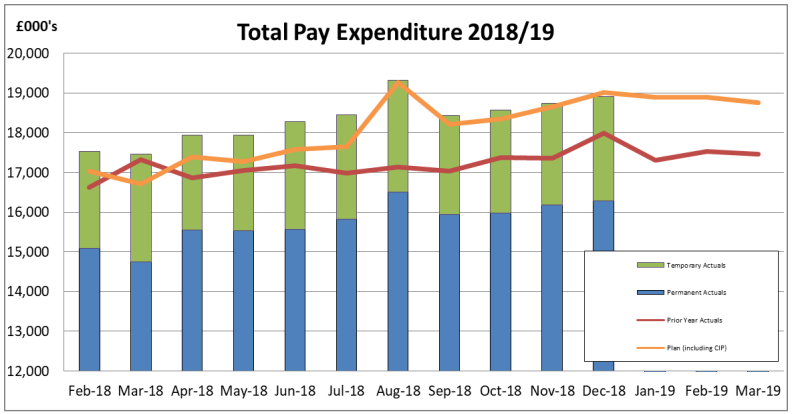
	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	166,514	167,191	677
Corby CCG	2,107	2,149	42
Bedfordshire CCG	547	678	131
East Leicestershire & Rutland CCG	585	585	(0)
Leicester City CCG	38	92	54
West Leicestershire CCG	42	56	14
Milton Keynes CCG	2,276	1,859	(417)
Specialised Commissioning	31,419	28,229	(3,190)
Secondary Dental	4,952	5,043	91
STP related income	3,450	1,350	(2,100)
NCA / Central / Other	3,112	3,201	89
Total SLA Income	**215,043**	**210,434**	**(4,609)**

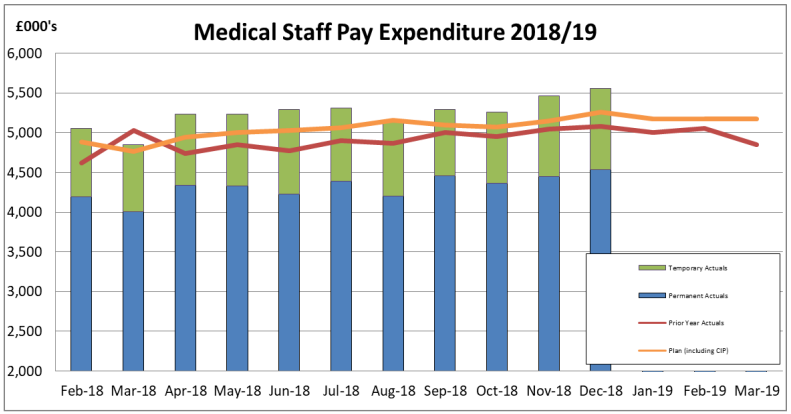
3. Pay Expenditure

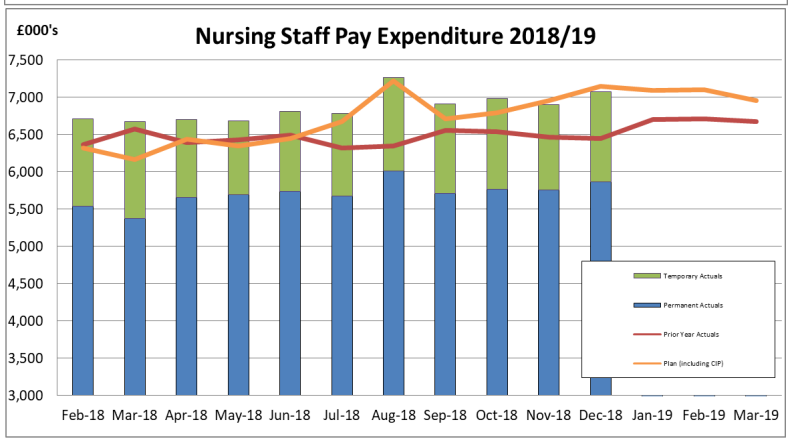
In Month 9 Pay Expenditure was £18,903k against a plan of £19,018k; resulting in a £115k favourable variance in month.

- The plan figure includes a CIP allocation of £86k being the amount of pay underspends across a number of cost centres applied as non-recurrent CIPs in month. This has significantly reduced from previous month following allocation of 2018/19 CIP targets across three of the Divisions.
- Pay expenditure continues to increase with increased worked WTE (32WTE increase month on month) including additional staff to cover winter pressures and the escalation ward (£240k additional pay expenditure incurred funded from designated reserves)
- The breakdown of the £115k adverse variance in month is as follows:-
- **Medical Staff £306k adverse –** further increased expenditure with an increase in permanent staff costs following further recruitment of senior medical staff and increased utilisation of temporary medical staff for winter escalation areas , urgent care and cover for oncology substantive consultant and middle grade gaps.
- **Other Staff (mainly Ancillary Staff) £135k favourable –** underspends against porters , senior domestic staff and escalation area budgets with a worked under-establishment of 28.5WTE in Month 9
- **Managerial and Admin Staff £107k favourable** - £47k underspend against senior management budgets in corporate areas and £76k underspend against admin and clerical budgets mainly due to unfilled vacancies across the Trust (worked under-establishment 61WTE across management and admin).

Table 8: Pay Expenditure







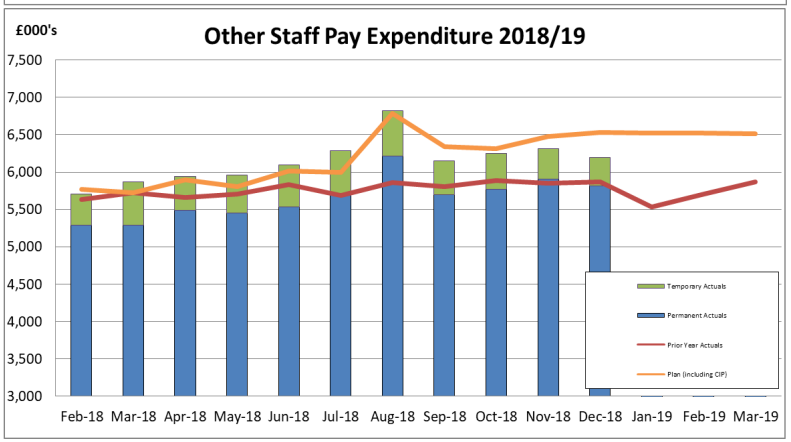
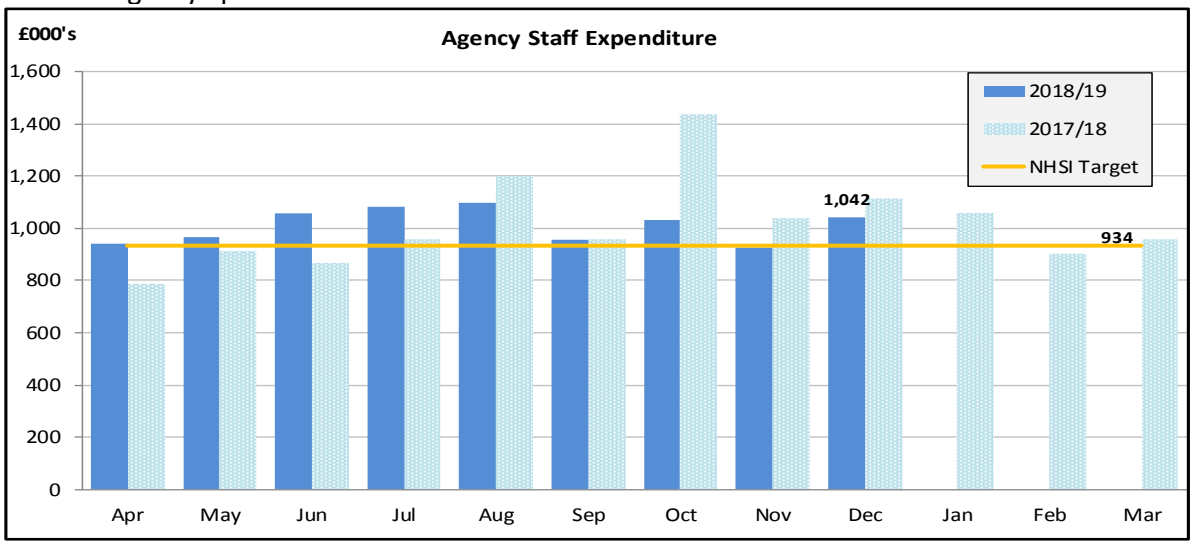
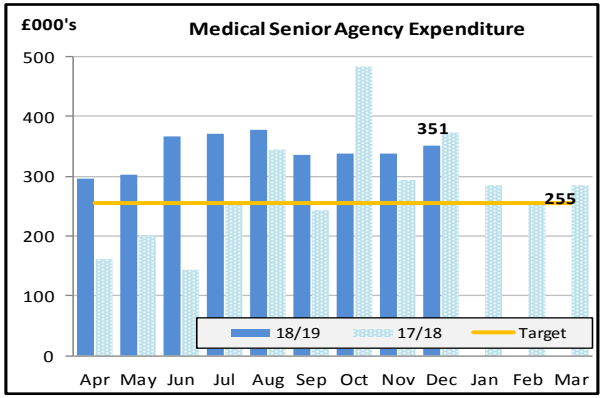
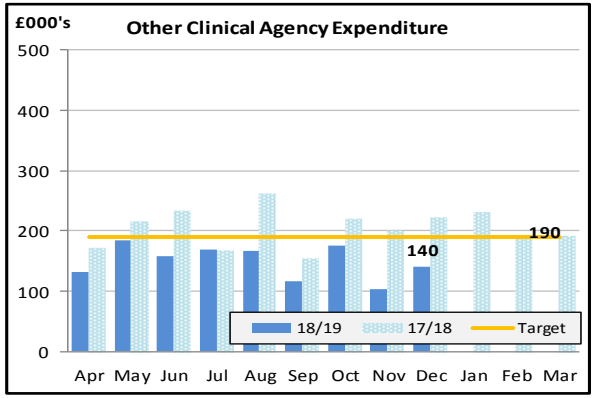


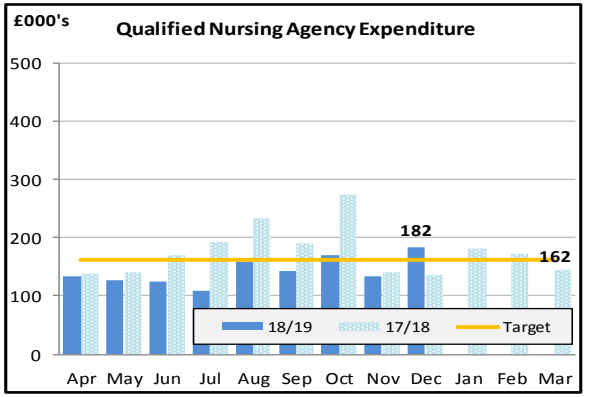
Table 9: Agency Spend

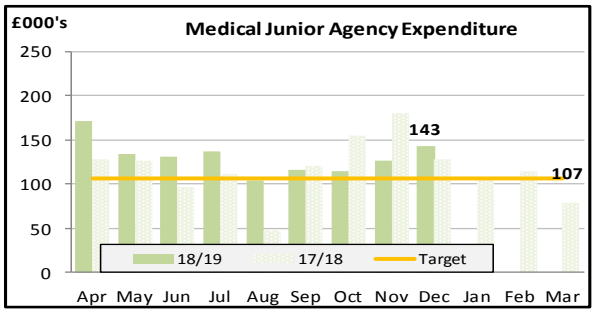


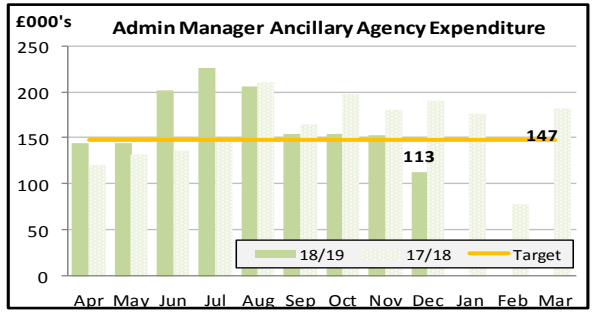
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- Opening the escalation ward placed a 32wte increase in Nursing demand. This has translated into 14wte increase in agency nursing.
- Most other staff groups held consistent with two previous autumn months.
- The Trust run-rate for 18/19 is £77k above the target. This monthly expenditure needs to drop to £703k per month, to meet the NHSI target at year end.

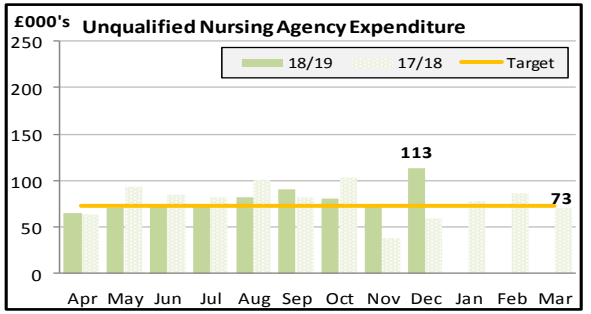












4. Non-Pay

Non Pay expenditure for month 9 is £4.6m favourable year to date; £0.4m favourable against plan in month.

Excluding pass-through drugs and devices costs, the in month non-pay variance is £87k favourable to plan with key variances including:

- £280k Other Fees, includes lower than budgeted levels of outsourcing (£64k), plus anticipated contribution toward STP joint-working consultancy fees now no longer required.
- £79k Computer Maintenance is actually an underspend against medical equipment maintenance, which (to date) is 20% down on the £1.1m per annum expenditure experienced in 2017/18.

Adverse variances offsetting above favourable variances in month include:

- £113k Building & Engineering Equipment, as Estates expenditure here is up £100k on the £270k average experienced in 17/18 and the first 8 months of 18/19.
- £86k Medicines, includes sales (chemo and aseptic service preparation) to BMI Three Shires and KGH totalling £30k.
- £53k Consultancy Fees, includes additional consultancy fees towards capacity planning
- £38k Staff Advertising, includes £49k of agency introduction fees for medical staff working in Urgent Care.

Table 10: Non-Pay Trend

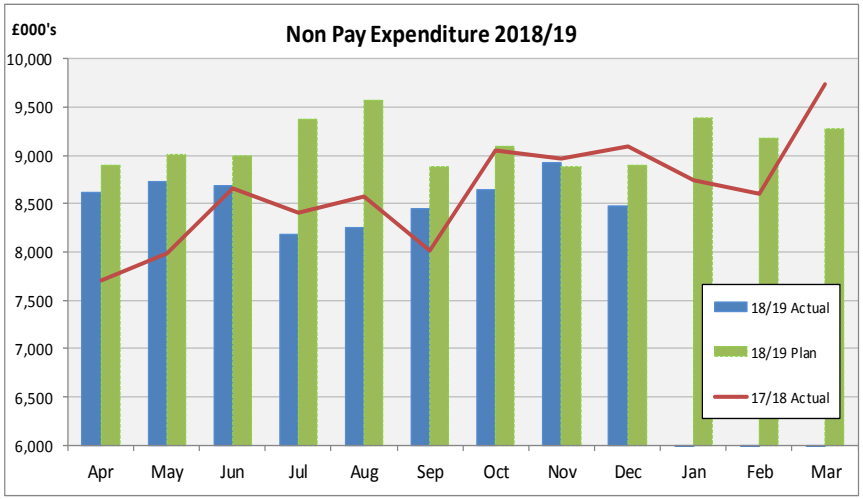


Table 11: Non-pay Analysis

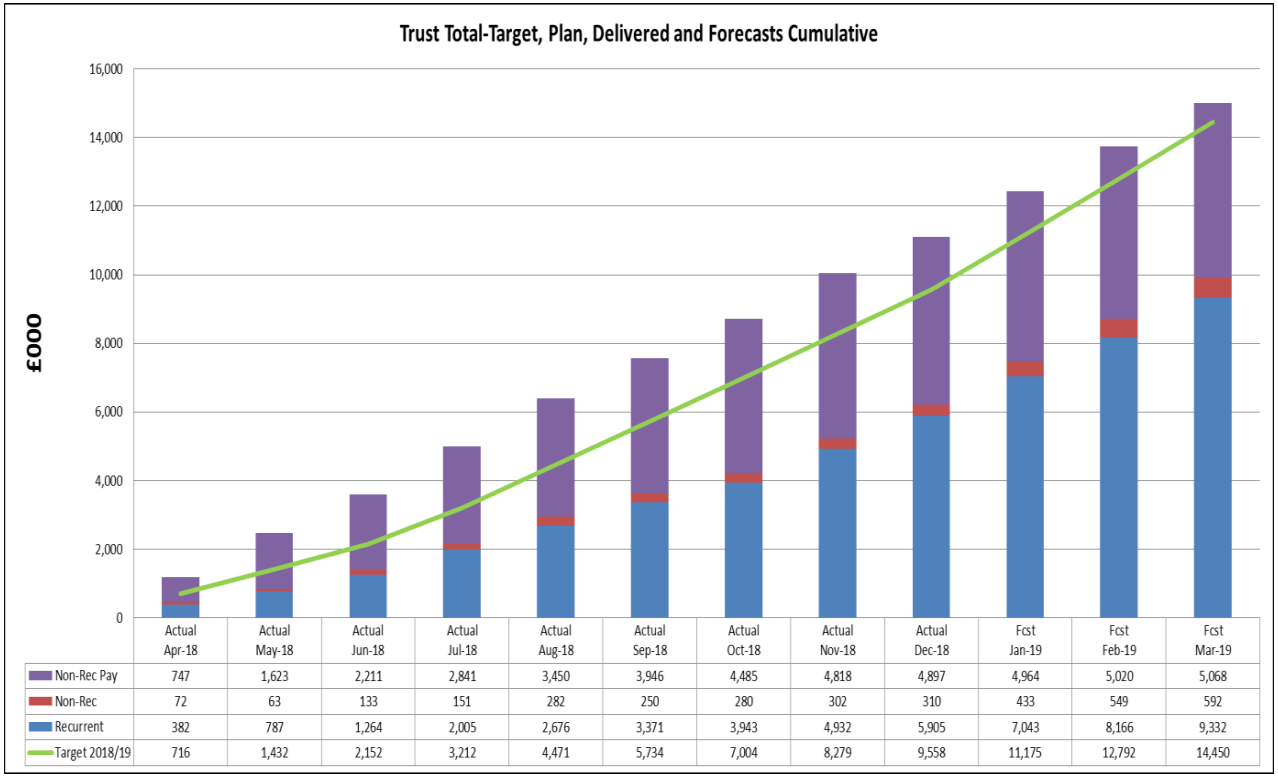
	Annual	Current Month - M9 Dec-18			Year to Date - M9 Dec-18		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Non Pay - Fixed							
Equipment Hire	1,306	109	136	(27) Adv	979	1,198	(219) Adv
Equipment Maintenance	5,261	433	414	19 Fav	3,961	3,530	431 Fav
Clinical Non Pay - Fixed Total	**6,566**	**542**	**550**	**(8) Adv**	**4,940**	**4,727**	**213 Fav**
Clinical Non Pay - Variable							
Prosthesis	2,127	177	147	30 Fav	1,597	1,485	112 Fav
Patient & Surgical Appliances	3,170	266	272	(6) Adv	2,372	2,617	(245) Adv
Patient Clothing & Travel	66	5	6	(0) Adv	49	75	(26) Adv
Lab Equipment Consumables	6,056	530	570	(41) Adv	4,469	4,916	(448) Adv
Blood	1,415	104	150	(46) Adv	1,103	1,034	69 Fav
Medicines	6,520	551	637	(86) Adv	4,876	4,919	(43) Adv
Medical & Surgical Items	11,492	968	947	21 Fav	8,596	8,096	500 Fav
Dressings	934	78	59	18 Fav	702	631	71 Fav
Medical Gases	274	23	25	(2) Adv	205	217	(12) Adv
X-Ray Consumables	1	0	0	0 Fav	0	0	0 Fav
Clinical Non Pay - Variable Total	**32,055**	**2,701**	**2,813**	**(112) Adv**	**23,969**	**23,991**	**(21) Adv**
Clinical Non Pay - Total	**38,621**	**3,243**	**3,363**	**(120) Adv**	**28,910**	**28,718**	**192 Fav**
Non Clinical Non Pay							
Building & Engineering Equipment	5,315	432	546	(113) Adv	4,018	4,258	(240) Adv
Cleaning Equipment	577	50	53	(3) Adv	434	489	(55) Adv
Energy & Utilities	2,653	222	269	(48) Adv	1,991	1,969	22 Fav
Rates	1,086	91	92	(1) Adv	818	824	(6) Adv
Printing & Stationery	917	76	65	11 Fav	688	666	22 Fav
Computer Equipment & Maintenance	3,871	326	248	79 Fav	2,892	2,637	255 Fav
Communications	971	86	60	26 Fav	714	700	15 Fav
Office Equipment	87	17	24	(6) Adv	68	151	(82) Adv
Non Pay CIP's	0	(0)	0	(0) Adv	(0)	0	(0) Adv
Other Fee's	7,270	578	298	280 Fav	4,920	4,321	598 Fav
Losses & Compensations	1,038	87	70	17 Fav	779	679	100 Fav
CNST	12,145	1,012	966	46 Fav	9,109	8,695	414 Fav
Consultancy Fee's	818	51	103	(53) Adv	699	760	(62) Adv
Training	1,184	99	86	13 Fav	887	922	(35) Adv
Travel & Benefits	1,390	108	94	14 Fav	1,029	780	249 Fav
Staff Advertising	631	53	91	(38) Adv	474	408	66 Fav
Patient Provisions	1,575	133	136	(3) Adv	1,185	1,190	(5) Adv
Patient Linen	1,161	96	84	12 Fav	873	776	98 Fav
Non Clinical Non Pay	**42,690**	**3,517**	**3,285**	**232 Fav**	**31,578**	**30,224**	**1,354 Fav**
NHFT Expenditure SLA's	**1,437**	**125**	**151**	**(25) Adv**	**1,061**	**1,084**	**(23) Adv**
Sub-Total (Excl. Med./Dev.)	**82,749**	**6,885**	**6,799**	**87 Fav**	**61,548**	**60,026**	**1,522 Fav**
Excluded Medicines	24,652	1,853	1,532	322 Fav	18,513	15,783	2,730 Fav
Excluded Devices	2,060	153	151	2 Fav	1,551	1,166	385 Fav
Non Pay Expenditure	**109,461**	**8,892**	**8,481**	**410 Fav**	**81,613**	**76,976**	**4,637 Fav**

5. CIPs

Table 12: CIPS

YTD Delivery £000's							
Division	Plan	YTD Plan	YTD Rec	YTD Actual N/R	YTD Actual N/R Pay Underspend	Actual Total	Variance vs plan
SURGICAL DIVISION	3,894	2,575	1,436	106	1,067	2,609	34
MEDICAL DIVISION	3,815	2,523	1,556	42	986	2,584	60
WCOH DIVISION	2,205	1,459	936	44	1,253	2,234	775
CSS DIVISION	1,734	1,147	985	36	663	1,684	537
HOSPITAL SUPPORT	1,118	739	130	70	928	1,128	389
FACILITIES	1,153	763	861	12	0	873	110
Expenditure Other (Held	532	352	0	0	0	0	-352
Trust Total	**14,450**	**9,558**	**5,905**	**310**	**4,897**	**11,112**	**1,554**

LTF £000's							
Division	Plan	LTF Rec	LTF N/R	Actual N/R Pay Underspend	LTF Total	RAG Rated	Variance vs Risk Adjusted
SURGICAL DIVISION	3,894	2,537	147	1,067	3,751	3,578	-316
MEDICAL DIVISION	3,815	2,595	219	1,146	3,960	3,651	-163
WCOH DIVISION	2,205	1,422	92	1,253	2,767	2,737	532
CSS DIVISION	1,734	1,469	45	663	2,177	2,127	393
HOSPITAL SUPPORT	1,118	173	70	939	1,183	1,180	62
FACILITIES	1,153	1,136	19	0	1,155	1,150	-3
Expenditure Other (Held	532	0	0	0	0	0	-532
Trust Total	**14,450**	**9,332**	**592**	**5,068**	**14,992**	**14,423**	**-27**



	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Fcst Jan-19	Fcst Feb-19	Fcst Mar-19
Non-Rec Pay	747	1,623	2,211	2,841	3,450	3,946	4,485	4,818	4,897	4,964	5,020	5,068
Non-Rec	72	63	133	151	282	250	280	302	310	433	549	592
Recurrent	382	787	1,264	2,005	2,676	3,371	3,943	4,932	5,905	7,043	8,166	9,332
Target 2018/19	716	1,432	2,152	3,212	4,471	5,734	7,004	8,279	9,558	11,175	12,792	14,450

Overview of progress, including risks and mitigation taken:

The 2018/19 risk adjusted LTF is currently £14.423m against a target of £14.45m. This represents a negative variance of £27k.

Of the £14.992m forecasted delivery £5.660m (38%) of schemes are non-recurrent. This is predominantly £5.068m vacancies and pay underspend. If this can become recurrent it will mitigate I&E risks otherwise it poses a risk to the 2019/20 financial position.

Cumulative delivery at month 9 totalled £11.112m against a year to date plan of £9.558m. This represents a favourable variance to plan of £1.554m, which is mainly due to £4.897m Non-Recurrent pay general underspend across all divisions.

All divisions are continuing to meet on a regular basis to identify plans to move non-recurrent schemes towards recurrent ones and to build contingency for potential slippage within the schemes.

The Changing Care steering group is also exploring cross cutting transformation themes although these are likely to be deliverable in the next financial year.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M9 movements include capital additions of £442k, which includes £197k IT spend, and £199k Estates spend.
- Depreciation - £939k in month as per 2018/19 plan.

Current assets

• Inventories - £145k. Increases in Pharmacy (£123k) & Pathology (£157k) are offset by decreases in Heart Centre (£112k), Gynae Endoscopy (£2k) & Supplies Trading (£21k) stockholdings.

• Trade & Other Receivables – £1,862k made up of: Decreases in NHS receivables (£1,848k), Income accruals (£294k), & Compensation Recovery (RTC & PI Claims) (£39k). Increases in Trade receivables (£106k) ,VAT reclaim (£53k), Prepayments (£97k),& Salary Sacrifice Schemes (£43k).

• Cash – Increase of £3,419k.

Current Liabilities

• Trade & Other Payables - £15k made up of: Increase in NHS Payables (£94k), Capital Payables (£46k), Accruals (£1,250k) & PDC Dividend (£127k) . Decrease in Trade Payables (£985k), Tax, NI & Pension Creditor (£115k) & Receipts in Advance (£77k).

•Interest Payable on Loans has been reclassified under IFRS 9. Accrued interest from Month 9 onwards is included as Short Terms Loans. This has resulted in a decrease in Trade & Other Payables of £342k.

•Finance Lease Payable - Nye Bevan - £4k.

•Short Term Loans £429k – Reclassification of Interest Payable £342k, In month increase in Interest Payable £87k - Revenue (£30k), Capital (£57k).

•Provisions - £1k HR Legal Fees provision released against invoice received.

Non Current Liabilities

• Finance Lease Payable - £97k. Nye Bevan £85k, Car Park £12k.

• Drawdown of Revenue Loan - £3,377k.

Financed By

- PDC Capital - £127k NHS WiFi.
- I& E Account - £2,649k deficit in month.

Table 13: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 9 2018/19						
	Balance at 31-Mar-18 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	153,637	153,635	153,635	0	153,637	0
IN YEAR REVALUATIONS	0	510	510	0	510	510
IN YEAR MOVEMENTS	0	16,059	16,501	442	21,259	21,259
LESS DEPRECIATION	0	(6,865)	(7,804)	(939)	(10,623)	(10,623)
NET BOOK VALUE	153,637	163,339	162,842	(497)	164,783	11,146
CURRENT ASSETS						
INVENTORIES	6,272	5,963	6,108	145	6,372	100
TRADE & OTHER RECEIVABLES	16,479	22,005	20,143	(1,862)	16,988	509
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	1,958	5,377	3,419	1,500	(47)
TOTAL CURRENT ASSETS	24,298	29,926	31,628	1,702	24,860	562
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	25,748	25,763	15	17,708	(5,076)
FINANCE LEASE PAYABLE under 1 year	130	1,123	1,127	4	1,181	1,051
SHORT TERM LOANS	20,748	20,715	21,144	429	21,199	451
STAFF BENEFITS ACCRUAL	765	765	765	0	750	(15)
PROVISIONS under 1 year	2,744	1,518	1,517	(1)	1,997	(747)
TOTAL CURRENT LIABILITIES	47,171	49,869	50,316	447	42,835	(4,336)
NET CURRENT ASSETS / (LIABILITIES)	(22,873)	(19,943)	(18,688)	1,255	(17,975)	4,898
TOTAL ASSETS LESS CURRENT LIABILITIES	130,764	143,396	144,154	758	146,808	16,044
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	11,379	11,282	(97)	11,387	10,394
LOANS over 1 year	52,394	66,465	69,842	3,377	75,295	22,901
PROVISIONS over 1 year	1,001	1,001	1,001	0	1,001	0
NON CURRENT LIABILITIES	54,388	78,845	82,125	3,280	87,683	33,295
TOTAL ASSETS EMPLOYED	76,376	64,551	62,029	(2,522)	59,125	(17,251)
FINANCED BY						
PDC CAPITAL	120,251	120,251	120,378	127	120,378	127
REVALUATION RESERVE	31,782	32,292	32,292	0	32,768	986
I & E ACCOUNT	(75,657)	(87,992)	(90,641)	(2,649)	(94,021)	(18,364)
FINANCING TOTAL	76,376	64,551	62,029	(2,522)	59,125	(17,251)

6.1 Capital

- The Trust's capital plan has been adjusted downwards by £905k to take account of the final costs of the Nye Bevan unit construction. Total capital plan now stands at £19,904k (including £450k of charitable funding).
- At the end of December, the Capital plan is underspent by £359k with a YTD spend of £15,785k.
- Commitments (orders placed but not receipted) at the end of December is £1,574k, bringing the total to £17,359k.
- In the last 3 months of the financial year there remains £2,545k (13% of the plan) left to commit & receipt. Estates & IT are tasked with continual review to ensure orders are placed & receipted before year end. Please see details on following slides for update.

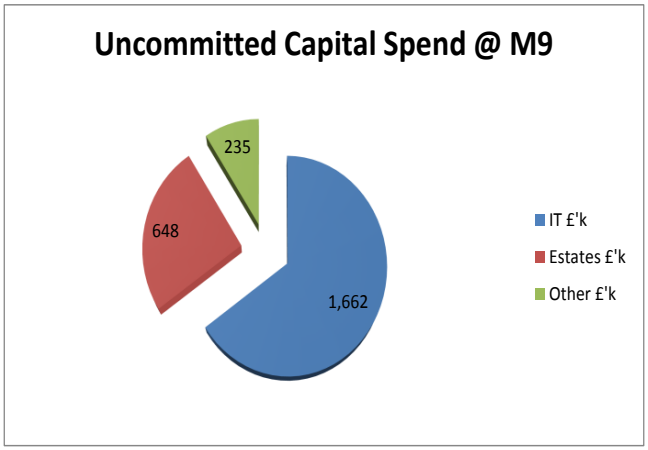


Table 14: Capital

Capital Scheme	Plan 2018/19 £000's	M9 Plan £000's	M9 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total M9 + Committed £000's	Uncommitted £000's	Plan O/S %
Medical Equipment - MESC Block	630	513	513	(0)	81%	624	(6)	1%
Medical Equipment - CF Specific Forecast	100	60	60	(0)	60%	60	(40)	40%
EAB Talbot Butler - CF Specific	350	325	325	0	93%	325	(25)	7%
Dexa Scanner - Enabling Costs (Lease)	0	0	0	0	0%	0	0	0%
CT Simulator Suite	27	27	26	(1)	95%	26	(1)	5%
Information Technology - CaMIS	362	362	313	(49)	86%	316	(46)	13%
Information Technology	3,023	1,110	1,037	(73)	34%	1,361	**(1,662)**	55%
Estates - Backlog	1,650	1,114	1,066	(49)	65%	1,580	**(69)**	4%
Estates - Statutory	229	84	49	(35)	21%	182	**(47)**	21%
Estates - Non Maintenance	522	238	229	(9)	44%	268	**(253)**	49%
Estates - Ward Refurbishment	657	85	52	(32)	8%	396	**(261)**	40%
Nye Bevan - Setting Up Costs	325	325	325	0	100%	325	(0)	0%
Nye Bevan Assessment Unit (Finance Lease)	11,424	11,424	11,424	0	100%	11,424	(0)	0%
Inventory / Ledger Upgrade	32	32	27	(5)	85%	28	(4)	12%
MRI 1 Enabling Costs	236	236	234	(2)	99%	236	(0)	0%
Other - inc. Gamma Camera 2 & Breast Screening Mobile + Static	273	55	55	(0)	20%	55	(218)	80%
SALIX	515	539	436	(103)	85%	539	24	5%
Total - Capital Plan	**20,354**	**16,528**	**16,169**	**(359)**	**79%**	**17,744**	**(2,610)**	**-13%**
Less Charitable Fund Donations	-450	-385	-384	0	85%	(384)	66	15%
Less NBV of Disposals	0	0	0	0	0%	0	0	0%
Total - CRL	**19,904**	**16,143**	**15,785**	**(359)**	**79%**	**17,359**	**(2,545)**	**13%**

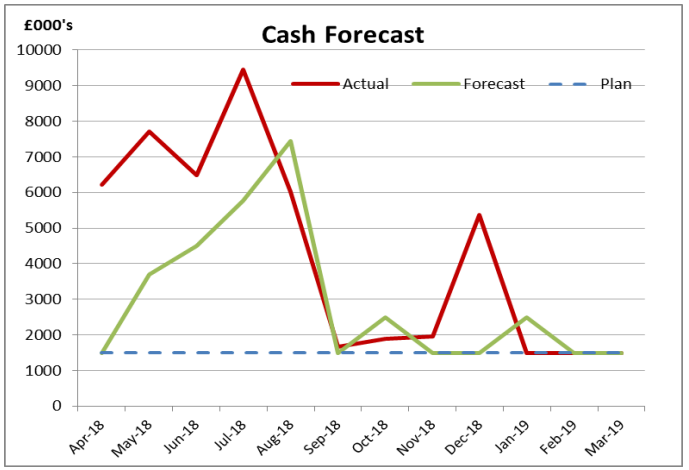
Funding Resources		
Internally Generated Depreciation		10,623
Finance Lease - Assessment Unit		11,424
Salix		515
Public WIFI		127
Capital Element - Finance Lease (Car Park Decking)	-	130
Capital Loan - Repayment	-	1,835
Capital Element - Finance Lease (Assessment Unit)	-	752
Other Loans - Repayment (SALIX)	-	68
Total - Available CRL Resource		**19,904**
Uncommitted Plan		**0**

Table 15: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2018/19 £000s	ACTUAL 18/19 APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	FORECAST 18/19 JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	275,388	22,144	23,385	22,762	22,762	22,762	22,762	23,003	23,164	23,174	23,181	23,145	23,145
Provider Sustainability Funding (PSF)	5,797	0	0	0	2,580	0	1,379	0	0	1,838	0	0	0
SLA Performance (relating to 17/18 activity)	-1,871	479	660	0	0	-112	-2,770	21	0	0	14	-164	0
Health Education Payments	9,874	795	795	795	750	812	27	1,891	779	779	892	779	779
Other NHS Income	15,289	751	564	958	1,012	2,034	1,504	1,662	1,530	1,177	1,299	1,299	1,499
PP / Other (Specific > £250k)	5,135	0	970	316	531	428	708	325	505	349	403	300	300
PP / Other	12,603	1,194	908	1,057	1,001	1,251	601	1,112	1,304	775	1,100	1,100	1,200
Salix Capital Loan	515	0	0	0	0	0	0	0	0	0	0	0	515
PDC - Capital	127	0	0	0	0	0	0	0	0	127	0	0	0
Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	18,514	4,439	3,143	-1,052	1,276	232	0	2,595	709	2,458	1,561	1,626	1,527
Uncommitted Revenue Loan - PSF funding	9,191	0	0	1,379	613	613	612	919	919	919	1,072	1,072	1,073
Interest Receivable	89	6	5	7	7	7	11	8	8	8	8	8	8
TOTAL RECEIPTS	**350,651**	**29,808**	**30,430**	**26,222**	**30,532**	**28,025**	**24,834**	**31,535**	**28,918**	**31,606**	**29,529**	**29,166**	**30,047**
PAYMENTS													
Salaries and wages	208,099	16,698	16,586	16,804	16,701	18,098	17,653	17,163	17,679	17,627	17,851	17,612	17,627
Trade Creditors	98,996	4,928	9,279	7,229	7,688	9,519	7,586	9,738	8,085	7,376	9,651	9,460	8,458
NHS Creditors	27,573	1,999	2,648	2,370	2,586	2,314	2,946	2,431	2,284	2,578	2,518	1,400	1,500
Capital Expenditure	8,759	1,493	414	1,004	459	739	310	520	785	572	334	916	1,214
PDC Dividend	962	0	0	0	0	0	200	0	0	0	0	0	762
Repayment of Revenue Loan - PSF funding	3,217	0	0	0	0	0	0	1,379	0	0	1,838	0	0
Repayment of Loans (Principal & Interest)	2,988	8	11	22	152	775	487	42	35	24	168	778	486
Repayment of Salix loan	62	29	0	0	0	0	3	29	0	0	0	0	0
TOTAL PAYMENTS	**350,656**	**25,156**	**28,938**	**27,429**	**27,585**	**31,445**	**29,184**	**31,302**	**28,868**	**28,177**	**32,360**	**30,166**	**30,047**
Actual month balance	-5	4,652	1,492	-1,207	2,947	-3,420	-4,350	233	50	3,429	-2,831	-1,000	0
Cash in transit & Cash in hand adjustment	-43	20	-1	-17	27	-32	18	-16	14	-10	-47	0	0
Balance brought forward	1,547	1,547	6,219	7,710	6,486	9,460	6,009	1,677	1,894	1,958	5,377	2,500	1,500
Balance carried forward	**1,500**	**6,219**	**7,710**	**6,486**	**9,460**	**6,009**	**1,677**	**1,894**	**1,958**	**5,377**	**2,500**	**1,500**	**1,500**

- Closing cash balance at the end of December was £5.377k, which was £3,877k more than forecast. This was largely due to receipt of Q2 PSF money previously expected in February 2019, as well as a lower than expected level of supplier payments.
- All SLA base payments for December were paid on time, with the exception of Central Midlands Commissioning Hub, £35k, which is forecast to be paid in January.
- Outstanding 17/18 Performance invoices/credit notes issued to Central Midlands Local Office (£245k credit) & Milton Keynes CCG (£82k) are now forecast to in February. Payment from Bedfordshire CCG (£14k) has been received in January.
- Payment for Quarter 2 PSF was received from NHS England in December. The corresponding Uncommitted Loan repayment will be repaid in January.
- Uncommitted Revenue Loan of £795k has been approved for drawdown in January. This is £2,633k of new funding ,less the repayment of funding received in lieu of Qtr 2 PSF (£1,838k).
- Trade Creditor & Salary payments were both significantly less than forecast. This was most likely due to the festive period & it is anticipated that these will catch up in January.
- £127k PDC Capital for Public WiFi has been drawn down in December.

Table 16: Cash forecast



Receivables and Payables

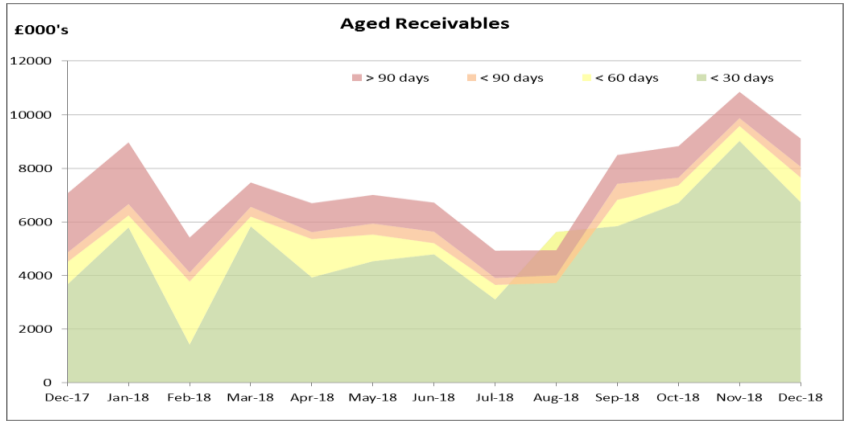
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £1,930k relates to PSF funding for Months 7-9.
- NHS over 90 day debt include s University Hospitals of Leicester NHS Trust £42k, Oxford University Hospital NHS Foundation Trust £86k, Kettering General Hospital NHS Foundation Trust £99k, NHS Property Services £40K, Milton Keynes CCG £82k and £194k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £432k ,of which £148k are paying in instalments & a further £298k have been referred to debt collection & private patients accounts of £62k.

Table 17: Receivables and Payables

Narrative	Total at December £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	1,711	415	502	77	717
Receivables NHS	7,398	6,322	417	326	334
Total Receivables	**9,109**	**6,737**	**919**	**403**	**1,051**
Payables Non NHS	(3,959)	(3,907)	(50)	(2)	0
Payables NHS	(1,368)	(1,368)	0	0	0
Total Payables	**(5,328)**	**(5,276)**	**(50)**	**(2)**	**0**

Narrative	Total at November £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	1,605	718	169	82	636
Receivables NHS	9,247	8,305	386	212	344
Total Receivables	**10,852**	**9,023**	**555**	**294**	**980**
Payables Non NHS	(4,898)	(4,898)	(0)	0	0
Payables NHS	(1,274)	(1,274)	(0)	0	0
Total Payables	**(6,172)**	**(6,172)**	**(0)**	**0**	**0**

Table 18: Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in December 2018

Table 19: BPPC

Better Payment Compliance Code - 2018/19

Narrative	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Cumulative 2018/19
NHS Creditors					
No.of Bills Paid Within Target	170	199	188	190	1,464
No.of Bills Paid Within Period	170	200	189	190	1,467
Percentage Paid Within Target	**100.00%**	**99.50%**	**99.47%**	**100.00%**	**99.80%**
Value of Bills Paid Within Target (£000's)	2,481	1,777	1,861	1,867	17,794
Value of Bills Paid Within Period (£000's)	2,481	1,777	1,861	1,867	17,809
Percentage Paid Within Target	**100.00%**	**100.00%**	**100%**	**100.00%**	**99.92%**
Non NHS Creditors					
No.of Bills Paid Within Target	5,546	5,382	7,097	6,351	54,358
No.of Bills Paid Within Period	5,567	5,399	7,127	6,363	54,601
Percentage Paid Within Target	**99.62%**	**99.69%**	**99.58%**	**99.81%**	**99.55%**
Value of Bills Paid Within Target (£000's)	8,327	9,326	9,217	8,288	79,450
Value of Bills Paid Within Period (£000's)	8,333	9,345	9,253	8,615	80,050
Percentage Paid Within Target	**99.92%**	**99.80%**	**99.61%**	**96.20%**	**99.25%**
Total					
No.of Bills Paid Within Target	5,716	5,581	7,285	6,541	55,822
No.of Bills Paid Within Period	5,737	5,599	7,316	6,553	56,068
Percentage Paid Within Target	**99.63%**	**99.68%**	**99.58%**	**99.82%**	**99.56%**
Value of Bills Paid Within Target (£000's)	10,808	11,103	11,078	10,155	97,244
Value of Bills Paid Within Period (£000's)	10,814	11,122	11,114	10,483	97,859
Percentage Paid Within Target	**99.94%**	**99.83%**	**99.67%**	**96.88%**	**99.37%**

7. Single Oversight Framework (SOF)

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

Table 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	2	20.00%	0.40
Agency spend (distance from cap)	2	20.00%	0.40
Overall Score			3.2

Finance and use of resources metrics

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

Note: brackets indicate negative numbers

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

8. Risks

Table 21

Risk	Description	Estimated Gross Impact £'m	RAG	Mitigations	Mitigated Impact £'m	Exec Lead
Revenue Risks						
PSF funding	Risk that the Trust may be unable to access all the allocated PSF if it fails to deliver all the financial and performance trajectories.	4.0		Management of operational and financial targets. The Trust is planning to appeal the missed A&E PSF funding	1.8	DN/PB
Nye Bevan Unit	Efficacy of the new model for the 60 beds to ensure sufficient discharges to reduce length of stay and prevent escalation into elective wards; in addition to ability to recruit staff substantively for the new unit	0.5		Robust implementation through the working group. The COO has emphasised that the Unit will only open when there is satisfaction about the effectiveness of the new model.	0.3	DN
Escalation ward	Operational pressures may require the escalation ward to be open for more than the 4 months it is budgeted for and may also impact the decant programme	0.4		Effective implementation of the transition to the Nye Bevan unit. Effectiveness of on-going discharge schemes (fixing the flow). Resilience to cope with winter pressures.	0.2	DN
CIP delivery	Delivery of £14.9m CIP target (5%) and possible high proportion delivered as non-recurrent CIPs.	5.1		Management of CIP plans and delivery through the Changing Care group. Regular meetings to challenge Divisions to find recurrent CIP schemes.	2.6	PB
Capital	Slippages in the Capital plan may mean that the Trust is unable to meet its allocated CRL (capital resource limit)	2.5		The Capital Committee is reviewing the IT and Estates plans to ensure that there are appropriate mitigations in place in order that the capital plan is met by the end of the year	0.5	PB

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**31 January 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 overview of key workforce issues

Executive summary

- The key performance indicators show a decrease in contracted workforce employed by the Trust, and an increase in sickness absence from December 2018.
- Increase in compliance rate for Mandatory Training and Role Specific Essential Training and a decrease in compliance for Appraisals.
- Briefing on Skills Advisory Panels
- Update in respect of Flu Campaign
- Update on Staff Survey
- Exception Reports for Staff Role Specific Training, Staff Appraisals and Vacancy Rates.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 3.1, 3.2 and 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or

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

Actions required by the Committee

The Committee is asked to Note the report.

Northampton General Hospital NHS Trust

TRUST BOARD

THURSDAY 31 JANUARY 2019

WORKFORCE PERFORMANCE REPORT

1. Introduction

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

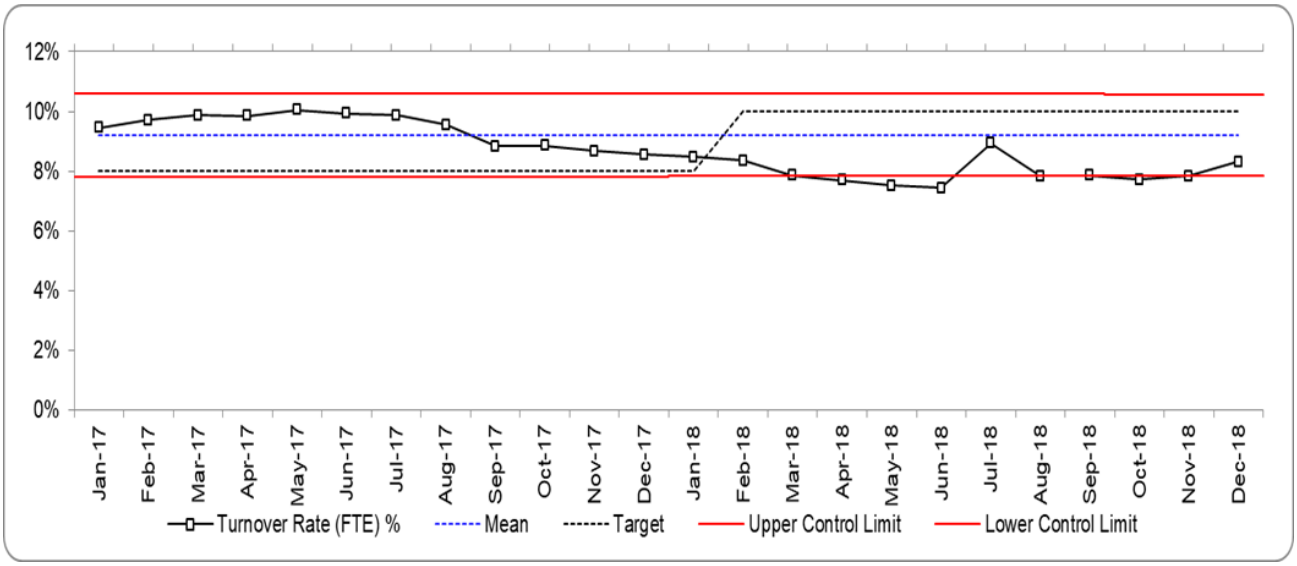
2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity decreased by 40.21 FTE in December 2018 to 4504.41 FTE. The Trust's substantive workforce is at 87.48% of the Budgeted Workforce Establishment of 5147.52 FTE. The Trusts overall budgeted establishment has also increased by 99.97 WTE, albeit a proportion of this is as a result of a temporary increase to establishment to reflect winter pressures since November 2018, together with a CIP adjustment (see below) which has driven the decrease in overall workforce capacity.

Trust Turnover

Annual Trust turnover for December 2018 increased by 0.48% to 8.32%, which is below the Trust target of 10.00%. This increase was across all divisions. The 12 Month Trust Turnover Trend is as follows:



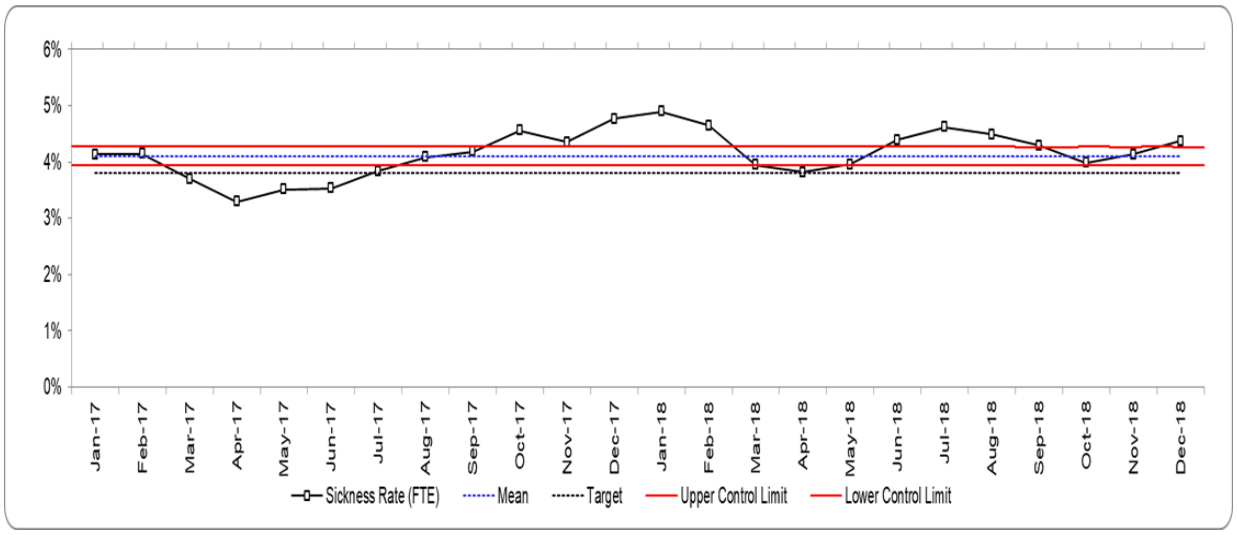
Vacancy Rates

The overall Trust vacancy percentage rate increased by 2.56% to 12.52%. This is against a Trust target of 9%. The increase in vacancy rate is partly attributable to an increase in overall budgeted establishment of 99.97 WTE. Of this approximately 48 WTE is due to a lower amount of Non Recurrent Pay CIP being applied as Divisions are now finding this year's CIP through other routes. The remainder constitutes winter funding of which 39.11 WTE is for the Benham Escalation ward.

Sickness Absence

Sickness absence for December 2018 increased from 4.14% to 4.37%, which is above the Trust target of 3.8%. The Division of Women, Children & Oncology was the only Division under the Trust's sickness absence target. The Support Services division had the highest sickness at 5.23%, with Facilities Directorate having the highest sickness rate of 6.24% amongst the directorates.

12 Month Trust Sickness Absence Trend



Flu Vaccination

The Flu vaccination take-up percentage for the Trust is above target at 80.6% to date. The Trust has therefore achieved its CQUINN for this year equating to £178,146.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for December 2018 is 81.71%; this is a decrease of 1.82% from last month's figure of 83.53% and is the lowest recorded rate for many years. As a result the HR Business Partners will be looking at areas with low appraisal rates and drafting action plans in order to address this.

Mandatory Training compliance increase in December 2018 from 88.29% to 88.56% this is an increase of 0.27% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also increased in December 2018 to 83.04% from last month's figure of 82.61%.; that is an increase of 0.43%.

2.3 Culture

Staff Survey

The Trust's confirmed final response rate is 43.6% (2133 responded). This is an improvement on 2017 when our final response percentage was 39%.

The response rate comparison against other Acute Trusts is as follows:

Staff Survey 2018 - Acute Trust	Worst performing trust: 34.8%	Best performing trust: 71.6%	Average response rate: 46.4%

The response rates, are listed below by Division:

Division	Eligible Sample	Respondents	Response Rate
Surgical Division	1151	440	38.2%
Medical Division	1159	427	36.8%
Women Children & Oncology Division	999	462	46.2%
Clinical Support Services Division	622	325	52.3%
Support Services	959	479	49.9%

Equality and Diversity

Funding has been secured from LWAB for the STP to conduct a cultural insight deep dive assessment around Equality and Diversity. In addition two posts will be piloted as part of the associated initiative of 'Recruiting for Difference'. Progress on this work will be reported to the Workforce Committee upon its completion.

3.0 Assessment of Risk

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

4.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

5.0 Next Steps

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

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	OCT-18	NOV-18	DEC-18
Caring	Complaints responded to within agreed timescales	>=90%	97.3%	97.4%	98.0%
	Friends & Family Test % of patients who would recommend: A&E	>=87.1%	86.4%	88.1%	85.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	92.4%	94.0%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97%	100.0%	96.6%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	92.3%	93.8%	93.5%
	Mixed Sex Accommodation	=0	0	0	0
	Compliments		4,288	4,335	3,541

	Indicator	Target	OCT-18	NOV-18	DEC-18
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	86.7%	85.9%	83.3%
	Average Ambulance handover times	<=15 mins	00:14	00:14	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	174	142	299
	Ambulance handovers that waited over 60 mins	<=10	17	19	30
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	3	3	4
	Delayed transfer of care	=23	10	10	24
	Average Monthly DTOCs	<=23	27	15	20
	Average Monthly Health DTOCs	<=7	25	13	16
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	94.0%	88.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	91.0%	40.2%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.5%	94.8%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	95.7%	96.6%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	86.6%	93.7%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	85.4%	76.0%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	83.8%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	85.7%	83.6%	
	RTT waiting times incomplete pathways	>=92%	81.5%	82.1%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%	99.9%	
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	94.8%	95.6%	100.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	97.9%	95.0%	95.3%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Effective	Stranded Patients (ave.) as % of bed base	<=40%	54.1%	54.4%	54.7%
	Super Stranded Patients (ave.) as % of bed base	<=25%	23.7%	23.1%	23.1%
	Length of stay - All	<=4.2	4.5	4.4	4.1
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.4%	3.8%	3.3%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.1%	17.2%	11.8%
	# NoF - Fit patients operated on within 36 hours	>=80%	84.6%	82.7%	100.0%
	Maternity: C Section Rates	<29%	31.4%	31.3%	32.1%
	Mortality: HSMR	100	106	106	106
	Mortality: SHMI	100	100	104	102

	Indicator	Target	OCT-18	NOV-18	DEC-18
Safe	Never event incidence	=0	1	0	0
	Number of Serious Incidents (SI's) declared during the period		0	0	3
	MRSA	=0	0	0	0
	C-Diff	<=1.75	0	0	1
	MSSA	<=1.1	2	1	0
	VTE Risk Assessment	>=95%	95.7%	95.4%	93.5%
	New Harms	<=2%	2.11%	0.67%	0.99%
	Harm Free Care (Safety Thermometer)	>=94%	94.2%	96.1%	96.3%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.0	4.2	4.4
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	66	36	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	96.9%	97.2%	91.4%
	Ward Moves > 2 as a % of all Ward Moves	=0%	5.8%	6.1%	5.2%
	Appointed Fire Wardens	>=85%			85.6%
	Fire Drill Compliance	>=85%			62.0%
	Fire Evacuation Plan	>=85%			89.2%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Well Led	Income YTD (£000's)	>=0	(3,337) Adv	(2,957) Adv	(3,550) Adv
	Surplus / Deficit YTD (£000's)	>=0	57 Fav	97 Fav	(432) Adv
	Pay YTD (£000's)	>=0	(3,221) Adv	(3,277) Adv	(3,165) Adv
	Non Pay YTD (£000's)	>=0	4,246 Fav	4,204 Fav	4,612 Fav
	Bank & Agency / Pay %	<=7.5%	12.4%	12.3%	12.3%
	Salary Overpayments - Number YTD	=0	153	167	195
	Salary Overpayments - Value YTD (£000's)	=0	313.1	340.9	371.9
	CIP Performance YTD (£000's)	>=0	1,704 Fav	1,821 Fav	1,554 Fav
	Maverick Transactions	=0			15
	Waivers which have breached	=0			1
	Job plans progressed to stage 2 sign-off	>=90%	15.1%	27.5%	24.2%
	Sickness Rate	<=3.8%	4.0%	4.0%	4.4%
	Staff: Trust level vacancy rate - All	<=9%	10.4%	10.3%	12.5%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	8.8%	9.0%	9.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	7.3%	7.5%	11.5%
	Staff: Trust level vacancy rate - Other Staff	<=9%	12.8%	12.1%	13.5%
	Turnover Rate	<=10%	7.7%	7.8%	8.3%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.8%	88.2%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%		81.9%	82.8%
	Percentage of all trust staff with role specific training compliance	>=85%	81.9%	82.5%	83.0%
	Percentage of staff with annual appraisal	>=85%	83.1%	83.5%	81.6%

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Sickness Rate	<=3.8%	**4.8%**	**4.6%**	**3.8%**	**3.7%**	**3.9%**	**4.4%**	**4.6%**	**4.5%**	**4.2%**	**4.0%**	**4.0%**	**4.4%**
Monthly Sickness Hours		7,284	6,298	5,807	5,409	5,814	6,363	6,961	6,787	6,193	6,049	6,161	6,995
Monthly Budgeted Hours		148,734	134,312	149,379	143,839	148,405	144,006	148,236	149,356	144,646	150,401	150,448	155,739

Driver for underperformance:	
Better recording and management of medical staff sickness absence There is an overall trend that staff are less resilient due to pressures in the system and the increase in the number of vacancies in some areas There are high levels of sickness absence related to stress and anxiety There are a high number of bullying and harassment cases across all divisions	The HR Business Partners have provided training to Clinical Directors in relation to sickness absence for medical staff and the Clinical Directors are proactively managing their cases Discussions are being held at some DMB and DMT meetings to develop strategies for reducing vacancies and therefore potentially reducing the pressures on staff's workload The Respect and Support Each Other campaign is progressing with the Report for Support telephone line due to be implemented at the end of January 2019 together with Roundtable discussions

Actions to address the underperformance:	
There is an overall trend that staff are less resilient due to pressures in the system. There are high levels of sickness absence related to stress and anxiety There are a high number of bullying and harassment cases across all divisions	The HR Business Partners have provided training to Clinical Directors in relation to sickness absence for medical staff The HR Corporate Officer together with the Locum Centre Manager have re-categorised some of the reasons for sickness absence so in the future it will be easier to identify work related stress as against personal stress The HR Business Partners have met with the Occupational Health Physiotherapist and discussed ways to improve the management of staff who have MSK conditions The Respect and Support Each Other campaign is gaining momentum with training for managers and staff Training is progressing for the HR staff in the delivery of the Report to Support telephone line

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Andrea Chown	Janine Brennan.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	December 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Percentage of staff with annual appraisal	>=85%	85.0%	86.1%	85.1%	85.30%	86.70%	86.70%	85.90%	85.00%	84.50%	83.10%	83.50%	81.60%
Number of Staff Who Received an Appraisal		3798	3785	3812	3825	3888	3866	3844	3789	3697	3728	3748	3713
Number of Staff Due for Appraisal		4468	4396	4477	4479	4481	4455	4471	4455	4370	4484	4488	4545

Driver for underperformance:	Actions to address the underperformance:
• Some areas have waited until the cut-off to notify L&D of the appraisal, even though it may have occurred two months earlier. • 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.	• Those areas with the greatest drop in % of compliance have been identified and has been escalated to be raised with the appropriate managers and HRBPs • Training for managers continues which covers the process of submission of data. 1:1's are also being conducted with managers.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Staff: Trust level vacancy rate - All	<=9%	10.1%	10.6%	10.8%	12.1%	11.8%	12.6%	13.2%	11.8%	11.1%	10.4%	10.3%	12.5%
Staff: Trust level vacancy rate - Medical Staff	<=9%	13.2%	11.5%	13.1%	12.7%	13.1%	14.3%	14.6%	9.4%	9.4%	8.8%	9.0%	9.9%
Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	8.7%	8.6%	8.4%	9.8%	9.5%	9.8%	10.5%	8.2%	7.4%	7.3%	7.5%	11.5%
Staff: Trust level vacancy rate - Other Staff	<=9%	11.6%	11.5%	11.5%	13.2%	12.7%	13.7%	14.4%	14.0%	13.7%	12.8%	12.1%	13.5%

Driver for underperformance:	Actions to address the underperformance:
• There is a national shortage of nursing staff along with a shortage within other professional allied specialities & medical staff.	• Trust Open Days in difficult to recruit areas • Nurse recruitment action plan has been refreshed. • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Overseas recruitment for nurses continues • Medical Recruitment Strategy and Action Plan being implemented. • Search Agency engaged to identify Medical Consultants • New Recruitment system to improve and reduce recruitment timelines in early stages of implementation. • Engaged agency to place UK nurses with the Trust • Commence early stages of Employer Value Proposition project to differentiate between the Trust and other employers. • Commenced work on establishing values based recruitment.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan.

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Percentage of all trust staff with role specific training compliance	>=85%	**83.9%**	**84.0%**	**84.2%**	**84.6%**	**84.8%**	**84.9%**	**85.1%**	**83.8%**	**82.1%**	**81.9%**	**82.5%**	**83.0%**
Percentage of all trust staff with role specific training compliance (Value 1)		20881	20903	20921	21066	21085	21299	21169	21001	21213	21135	21132	21096
Percentage of all trust staff with role specific training compliance (Value 2)		24859	24857	24831	24898	24863	25058	24861	25056	25831	25779	25587	25411

Driver for under performance:	Actions to address the underperformance:
• Lack of insight into the importance of Role Specific Training due to not being called Mandatory • Positions not being aligned to Role Specific Training subjects • System (OLM) not flexible enough to report on staff requirements to undertake RSET and having the lowest dominator being set at position level not assignment level	• 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. • Work continues of reviewing Safeguarding Children level 3 with further positions being identified as not requiring level 3 and this work is currently being undertaken.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Becky Sansom / Adam Cragg	Janine Brennan

Northampton General Hospital NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**31 January 2019**

Title of the Report	**Equality and Diversity Progress Report for Staff**
Agenda item	14
Presenter of Report	Janine Brennan, Director of Workforce
Author(s) of Report	Sarah Kinsella, Corporate HR Officer & Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance that the workforce equality agenda is being implemented for staff across the Trust

Executive summary

This paper provides a summary of the progress being made by the Equality and Diversity Staff Group, including developments in the following:

- Workforce annual report and monitoring report
- Equality objectives/4 year plan
- Divisional objectives
- Workforce Race Equality Standards
- Gender Pay Gap Reporting

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the objectives.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or

	promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 Equality Act 2010 (Gender Pay Gap Information Regulations 2017) NHS Constitution Equality Delivery Scheme (EDS2) Workforce Race Equality Standard (WRES)

Actions required by the Committee

The Board is asked to approve the content of the report.

Northampton General Hospital NHS Trust

Trust Board
31 January 2019

Equality and Diversity Staff Group – Progress Report

1. Introduction

This report from the Equality and Diversity Staff Group provides an update on activities undertaken over the previous 6 months and also draws the committee's attention to any other issues of significance, interest and associated actions required.

This report provides the key highlights of actions:

- Annual Report and Monitoring Report
- Equality Objectives/4 Year Plan
- Divisional Objectives
- Workforce Race Equality Standards
- Gender Pay Gap Reporting

2. Body of Report

The key actions from the September and December meetings are as follows:

Equality and Diversity Workforce Annual Report and Monitoring Report 2016/2017

The two reports were completed in June 2018 and endorsed by the Workforce Committee in July 2018. These have been published on the Trust's website as part of its requirements under the Public Sector Equality Duty.

Equality Objectives/Four Year Plan 2016 – 2020

A progress report on the equality objectives/four year plan was presented to the Equality and Diversity Staff Group at the September and December 2018 meetings. Progress continues against the objectives including actions related to improving staff engagement, improving the mental wellbeing of staff and the development of leadership management training. The key area of progress is linked to the development of the Respect and Support Campaign, which was launched in June 2018.

Divisional Objectives

At the September 2018 Equality and Diversity Staff Group meeting, the Womens, Childrens, Oncology, Haematology and Cancer Services Division reported on their Divisional objectives. These were as follows:

1. Increasing the representation of 18-20 year olds and post 56 year olds
2. Supporting of disabled staff
3. Awareness raising of religious festivals.

Workforce Race Equality Standards (WRES)

The Trust has submitted its WRES data to NHS England and it was published it on the Trust's website in the September 2018.

When compared to the 2017 data there has been improvement against the following key areas:

- The number of BME staff in the overall workforce, both in the clinical and non-clinical
- The relative likelihood of BME staff entering the formal disciplinary process compared with White staff
- The percentage of White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- The percentage of White Staff believing that trust provides equal opportunities for career progression or promotion
- Percentage difference between the organisations' Board voting membership and its overall workforce, however the BME percentage is still very high at -21.6% which shows that the voting members of the Trust Board does not represent the ethnicity of the overall workforce.

There have been deteriorations in the following areas:

- The relative likelihood of BME staff being appointed from shortlisting compared to White staff
- The relative likelihood of BME staff being appointed from shortlisting compared to White staff
- The percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- The percentage of BME and White staff staff experiencing harassment, bullying or abuse from staff in last 12 months
- The percentage of BME staff believing that trust provides equal opportunities for career progression or promotion
- The percentage of BME and White staff that in the last 12 months have personally experienced discrimination at work from either a manager, team leader or other colleagues

The WRES actions have been incorporated into the Equality Objectives Four Year Plan for 2016 – 2020 and work is taking place to further analysis career progression in the Trust by ethnicity, to establish if there is evidence to support staff's perception that the Trust does not provide equal opportunities for career progression and promotion for BME staff.

The published WRES report is embedded below:

WRES NGH
Response September

Gender Pay Gap Reporting

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) the Trust compiled its data in December 2018. Although the Trust is not legally required to produce a written report it was agreed this should be done to give context to the raw data. The report was provided to the Equality and Diversity Staff Group in December 2018 for their approval prior to being presented to the Workforce Committee in January 2019. The Trust Board will receive the findings in February 2019. When the report has been approved by both committees it will be published on the Trust's website and submitted to the Government by 31 March 2019, as part of the requirements under the Regulations. The Trust will need to provide this information annually going forward.

4. Recommendations

The Committee is asked to approve the contents of this report.

5. Next Steps

The Equality and Diversity Staff Group will continue to update the Equality Objectives/Four Year Plan on a regular basis and review/monitor the findings from the staff survey results and progress any areas of concern highlighted from the WRES data, gender pay gap report, the staff survey or the annual monitoring report.

Northampton General Hospital NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**31 January 2019**

Title of the Report	**Gender Pay Gap Report**
Agenda item	15
Presenter of Report	Janine Brennan, Director of Workforce
Author(s) of Report	Sarah Kinsella, Corporate HR Officer & Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance that the Trust is complying with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017)

Executive summary

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires the Trust to publish on an annual basis the following information:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males receiving a bonus payment
- The proportion of females receiving a bonus payment
- The proportion of males and females in each quartile pay band

This paper provides the findings of the gender pay gap reporting for the Trust as at 31 March 2018.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is being monitored through the Equality and Diversity Staff Group with progress reports on the objectives.
Related Board Assurance Framework entries	BAF 2.3

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Equality Act 2010 (Gender Pay Gap Information Regulations 2017)

Actions required by the Committee

The Board is asked to approve the content of the report.

Northampton General Hospital NHS Trust

Gender Pay Gap Report 2018
As at 31 March 2018

Introduction

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), Northampton General Hospital NHS Trust has undertaken gender pay gap reporting on the snapshot date of 31 March 2018.

The Trust has calculated the following for its employees and workers:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males receiving a bonus payment
- The proportion of females receiving a bonus payment
- The proportion of males and females in each quartile pay band

At the time the snapshot was taken the Trust had 5509 employees/workers, of which 4372 (79.36%) were female and 1137 (20.64%) were male.

Compared to the 2017 report there has been an overall increase in the workforce of 326. The female workforce has increased by 0.62% and the male workforce has decreased by the same percentage.

The ratio of male to female staff that the Trust has is common place for an acute district general hospital such as Northampton. The greatest proportion of staff at the Trust are Nurses, Midwives and Healthcare Assistants.

The majority of these staff are female and this is supported by the number of registrants with the Nursing and Midwifery Council (NMC), who in their Equality and Diversity Report 2016-2017 reported that 89% of the registrants were female compared to 11% of males.

NHS Pay Structure

The majority of staff at the Trust are on the national Agenda for Change Terms and Conditions of Service. The basic pay structure for these staff is across 8 pay bands and staff are assigned to one of these pay bands on the basis of job weight as measured by the NHS Job Evaluation Scheme. Within each band there are a number of incremental pay progression points.

Medical and Dental staff have different sets of Terms and Conditions of Service, depending on seniority. However, these too are set across a number of pay scales, for basic pay, which have varying numbers of thresholds within them.

There are separate arrangements for Very Senior Managers, such as Chief Executives, Directors and other senior managers who are not on an Agenda for Change Terms and Conditions of Service.

As a public sector organisation, some of the services that are provided are on a 24/7 basis and therefore staff that work unsocial hours, participate in on-call rotas and work on general public holidays will also be in receipt of enhanced pay in addition to their basic pay. This mainly applies to clinical staff who work in ward areas along with non-clinical senior managers, who

participate in the Senior Manager/Executive on-call rota and non-clinical staff who provide 24/7 services such as Estates and auxiliary staff.

The Trust does have a number of clinical departments that do not provide 24/7 such as clinics and outpatient areas and therefore these staff roles may not attract enhancements.

Mean Gender Pay Gap

The 2018 mean gender pay gap for the Trust demonstrates that female staff are paid 29.7% less than male staff:

Gender	Mean Hourly Rate
Male	£22.54
Female	£15.84

The 2017 mean gender pay gap for the Trust showed female staff were paid 30% less than male staff:

Gender	Mean Hourly Rate
Male	£21.66
Female	£15.17

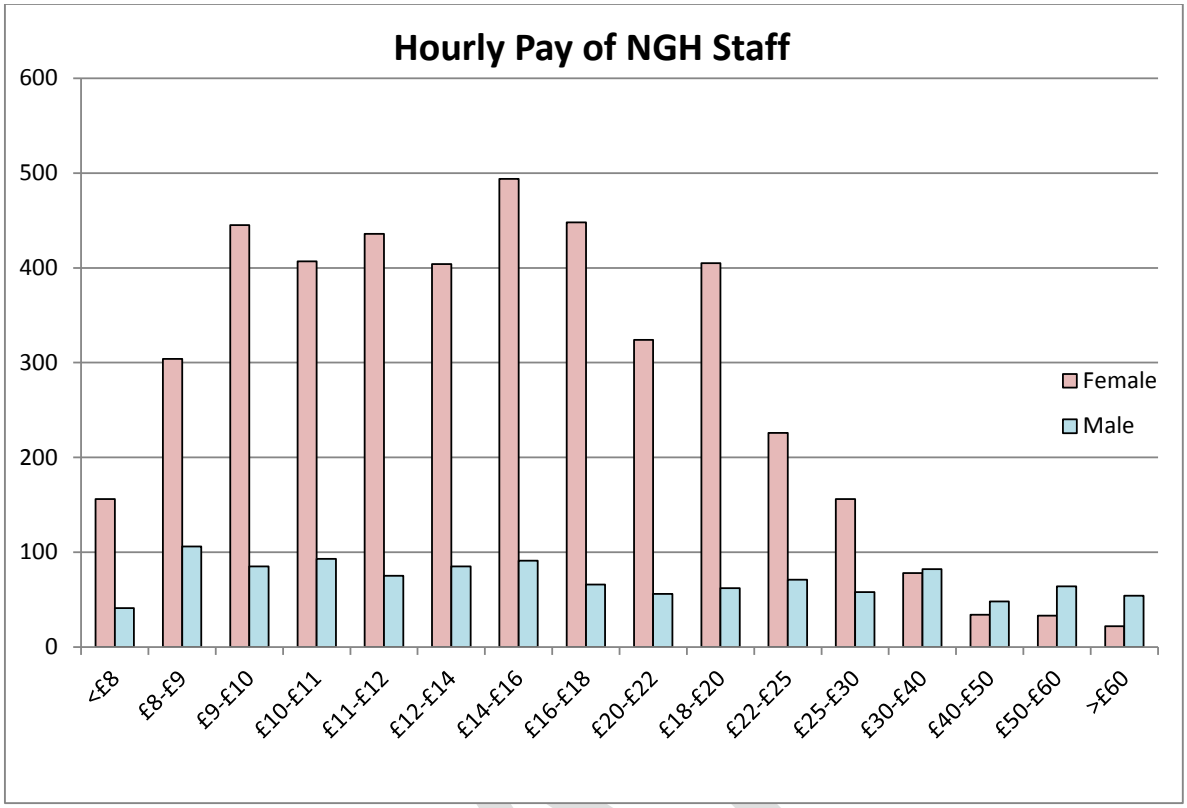
There has been a small reduction of 0.3% in the mean pay calculation, however it still indicates that there is a substantial difference between the average pay of the Trust's male and female staff.

Our analysis continues to show that within the Trust there is a higher number of male staff in senior medical and dental positions (Consultants). Of the Consultants, who are in the two highest basic pay thresholds, i.e. 14 years or more completed as a Consultant, 68% are male and 32% are female. This percentage split is largely unchanged from 2017.

Some senior medical and dental staff also hold management positions such as Clinical Directors and Divisional Directors and are in receipt of responsibility payments in addition to their basic pay. Of these that hold these positions 79% are male (7% of the total consultant workforce) and 21% are female (4% of the total consultant workforce). Again this percentage is largely unchanged from 2017.

The payments referred to above are included in the mean hourly rate detailed above and impact upon the mean gender pay gap calculation of 29.7%.

The graph below further demonstrates the Trust has a greater number of males on higher hourly rates of pay (£30 per hour and above) than female staff.



The Trust is mindful of the fact that because not all roles within the Trust attract enhancements this has also had an impact in distorting the mean hourly rate. In addition, flexible working opportunities are available for all staff to apply for, and some staff whose role would normally attract enhanced pay in addition to their basic pay may have requested to work set shifts, which do not attract the enhancements that their colleagues would be in receipt of and this again will have had an impact on the mean hourly rate.

As part of the reporting that the Trust undertook, comparisons were also made of the hourly rates of some specific posts, examples of which are below:

Role	Number of Females	Average Hourly Rate	Number of Males	Average Hourly Rate
Specialty Doctor	8	£35.11	8	£32.48
Modern Matron	26	£25.13	2	£26.52
Nurse Manager	18	£25.29	4	£22.95
Pharmacist	1053	£21.24	8	£17.32
Physiotherapist	46	£18.04	12	£17.66
Staff Nurse	1031	£17.79	95	£17.68
Healthcare Assistants	671	£11.67	87	£11.65
Receptionist	145	£9.55	14	£10.00
Housekeeper	243	£10.18	44	£10.69

The Trust believes that this demonstrates, for some of its key roles, the gap is considerably less than 29.7%, in some cases and, as demonstrated above, the average hourly rate for females, in some roles, is greater than for male staff.

Median Gender Pay Gap

The 2018 median gender pay gap for the Trust demonstrates that female staff are paid 8.9% less than male staff:

Gender	Median Hourly Rate
Male	£14.77
Female	£13.36

The 2017 median gender pay gap for the Trust showed female staff were paid 9.5% less than male staff:

Gender	Median Hourly Rate
Male	£14.77
Female	£13.36

There has been a small reduction of 0.6% in the median pay calculation, however it still indicates that there is a difference between the average pay of the Trust's male and female staff.

The Trust believes this figure is more representative of the gender pay gap, but acknowledges this still demonstrates there is a gap that needs to be addressed. However it should be noted that the points raised above in relation to the mean gender pay gap calculation are also contributing factors that impact upon the median gender pay gap calculation of 8.9%.

Mean Bonus Gender Pay Gap

The 2018 mean bonus gender pay gap for the Trust demonstrates that female staff are paid 83.20% less than male staff:

Gender	Mean Bonus Rate
Male	£6,323.21
Female	£1,060.49

The 2017 mean bonus gender pay gap for the Trust showed female staff were paid 82.4% less than male staff:

Gender	Mean Bonus Rate
Male	£6,312.13
Female	£1,110.93

There has been a slight increase of 0.8% between the 2018 and the 2017 calculation.

The calculations include the Clinical Excellence Aware (CEA) which accounts for the high percentage difference. At the time of the snapshot, 43% of male Consultants were in receipt of a CEA compared to 29% of our female Consultants. The percentage of female Consultants in receipt of a CEA has slightly reduced from 32% the previous year.

This calculation also includes the bonuses that were paid to workers on the Clinical Nurse Bank who completed 150 hours of bank work. This is part of the Trust's bonus loyalty scheme to increase the numbers of clinical bank workers and reduce the use of agency staff. Recipients of these bonuses are primarily Nurses, Midwives and Healthcare Assistants.

Median Bonus Gender Pay Gap

The 2018 median bonus gender pay gap for the Trust demonstrate that female staff are paid 85.1% less than male staff:

Gender	Median Bonus Rate
Male	£3,015.96
Female	£450.00

The 2017 median bonus gender pay gap for the Trust showed female staff were paid 81.3% less than male staff:

Gender	Median Bonus Rate
Male	£2,400.00
Female	£450.00

There has been an increase of 3.8% between the 2018 and the 2017 calculation.

The result of including the CEA within the bonuses for the 2018 calculation has resulted in a substantial difference between the average bonus pay of the Trust's male and female staff.

Proportion of Males and Females Receiving a Bonus Payment

Gender	Proportion Receiving Bonus
Male	11.5%
Female	15.1%

Of the total workforce, who are Consultants in receipt of CEA payments and those registered as workers on the Clinical Nurse Bank that are eligible for a bonus,15.1% of females received bonuses compared to 11.5% of males.

In 2017 the figures showed 12.1% of males (increase of 0.6% in 2018) and 15.4% of females (increase of 0.3% in 2018) received a bonus.

Proportion of Males and Females in Each Quartile Pay Band

Quartile	Gender	Number	Percentage
Lower	Male	281	20.4%
	Female	1096	79.6%
Lower Middle	Male	226	16.4%
	Female	1151	83.6%
Upper Middle	Male	187	13.6%
	Female	1190	86.4%
Upper	Male	443	32.1%
	Female	935	67.9%

The lower quartile is made up of staff whose hourly rates are up to £10.29

The lower middle quartile is made up of staff whose hourly rates are between £10.30 and £14.51.

The upper middle quartile is made up of staff whose hourly rates are between £14.52 and £19.57.

The upper quartile is made up of staff whose hourly rates are above between £19.57.

At the time the snapshot was taken the percentage of female staff was 79.36% and the percentage of male staff was 20.64%. As shown in the table above this percentage split is mostly mirrored in the lower and lower middle quartiles. There is a reduction in the percentage of male staff in the upper middle quartile, however the upper quartile demonstrates there is an increase in the percentage of male staff in the roles that attract the higher hourly rates of pay, as referred to earlier on in this report.

Conclusion

The Trust acknowledges that there could be greater female representation in its senior clinical roles, however the consultant workforce has a greater proportion of males to females across the NHS, which limits the pool of available applicants to these types of roles.

Over the past two years the Trust has been developing leadership development training to strengthen the skills of its existing staff to support career development within the organisation. During 2018 two key programmes have been launched, which should assist with the career development of female staff into more senior clinical and also non-clinical management roles within the organisation.

Likewise the Trust acknowledges that there could be greater male representation in less senior roles, both clinical and non-clinical, however again there are some limitations due to the pool of available applicants and an example of this is male Nurses and Midwives.

The Trust has a robust recruitment process that has equality and diversity embedded into its processes along with values based recruitment. The Trust will continue to recruit in a non-gender biased manner to ensure that adverts and applicants are recruited in a fair, open and transparent manner.

The Trust hopes that over time, taking into account some of the issues highlighted in this report, the gender pay gap will reduce.

Report approved at Equality & Diversity Staff Group on 13 December 2018

Report approved at Workforce Committee on 23 January 2019

Report approved at Trust Board on 31 January 2019

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31st January 2019**

Title of the Report	**Operational Performance Report**
Agenda item	**16**
Presenter of Report	Mr C Holland (Acting COO)
Author(s) of Report	Mr C Holland (Acting COO) & Mrs D Needham (CEO)
Purpose	For information / discussion / assurance

Executive summary

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

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

Where information is available benchmarking will be included.

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

- Urgent care
- RTT
- Cancer

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

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

Actions required by the Trust Board

The committee is asked to:

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

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	OCT-18	NOV-18	DEC-18
Caring	Complaints responded to within agreed timescales	>=90%	97.3%	97.4%	98.0%
	Friends & Family Test % of patients who would recommend: A&E	>=87.1%	86.4%	88.1%	85.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	92.4%	94.0%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=97%	100.0%	96.6%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	92.3%	93.8%	93.5%
	Mixed Sex Accommodation	=0	0	0	0
	Compliments		4,288	4,335	3,541

	Indicator	Target	OCT-18	NOV-18	DEC-18
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	86.7%	85.9%	83.3%
	Average Ambulance handover times	<=15 mins	00:14	00:14	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	174	142	299
	Ambulance handovers that waited over 60 mins	<=10	17	19	30
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	3	3	4
	Delayed transfer of care	=23	10	10	24
	Average Monthly DTOCs	<=23	27	15	20
	Average Monthly Health DTOCs	<=7	25	13	16
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	94.0%	88.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	91.0%	40.2%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.5%	94.8%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	95.7%	96.6%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	86.6%	93.7%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	85.4%	76.0%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	83.8%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	85.7%	83.6%	
	RTT waiting times incomplete pathways	>=92%	81.5%	82.1%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%	99.9%	
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	94.8%	95.6%	100.0%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	97.9%	95.0%	95.3%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Effective	Stranded Patients (ave.) as % of bed base	<=40%	54.1%	54.4%	54.7%
	Super Stranded Patients (ave.) as % of bed base	<=25%	23.7%	23.1%	23.1%
	Length of stay - All	<=4.2	4.5	4.4	4.1
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.4%	3.8%	3.3%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.1%	17.2%	11.8%
	# NoF - Fit patients operated on within 36 hours	>=80%	84.6%	82.7%	100.0%
	Maternity: C Section Rates	<29%	31.4%	31.3%	32.1%
	Mortality: HSMR	100	106	106	106
	Mortality: SHMI	100	100	104	102

	Indicator	Target	OCT-18	NOV-18	DEC-18
Safe	Never event incidence	=0	1	0	0
	Number of Serious Incidents (SI's) declared during the period		0	0	3
	MRSA	=0	0	0	0
	C-Diff	<=1.75	0	0	1
	MSSA	<=1.1	2	1	0
	VTE Risk Assessment	>=95%	95.7%	95.4%	93.5%
	New Harms	<=2%	2.11%	0.67%	0.99%
	Harm Free Care (Safety Thermometer)	>=94%	94.2%	96.1%	96.3%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.0	4.2	4.4
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	66	36	35
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	96.9%	97.2%	91.4%
	Ward Moves > 2 as a % of all Ward Moves	=0%	5.8%	6.1%	5.2%
	Appointed Fire Wardens	>=85%			85.6%
	Fire Drill Compliance	>=85%			62.0%
	Fire Evacuation Plan	>=85%			89.2%

	Indicator	Target	OCT-18	NOV-18	DEC-18
Well Led	Income YTD (£000's)	>=0	(3,337) Adv	(2,957) Adv	(3,550) Adv
	Surplus / Deficit YTD (£000's)	>=0	57 Fav	97 Fav	(432) Adv
	Pay YTD (£000's)	>=0	(3,221) Adv	(3,277) Adv	(3,165) Adv
	Non Pay YTD (£000's)	>=0	4,246 Fav	4,204 Fav	4,612 Fav
	Bank & Agency / Pay %	<=7.5%	12.4%	12.3%	12.3%
	Salary Overpayments - Number YTD	=0	153	167	195
	Salary Overpayments - Value YTD (£000's)	=0	313.1	340.9	371.9
	CIP Performance YTD (£000's)	>=0	1,704 Fav	1,821 Fav	1,554 Fav
	Maverick Transactions	=0			15
	Waivers which have breached	=0			1
	Job plans progressed to stage 2 sign-off	>=90%	15.1%	27.5%	24.2%
	Sickness Rate	<=3.8%	4.0%	4.0%	4.4%
	Staff: Trust level vacancy rate - All	<=9%	10.4%	10.3%	12.5%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	8.8%	9.0%	9.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	7.3%	7.5%	11.5%
	Staff: Trust level vacancy rate - Other Staff	<=9%	12.8%	12.1%	13.5%
	Turnover Rate	<=10%	7.7%	7.8%	8.3%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.8%	88.2%	88.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%		81.9%	82.8%
	Percentage of all trust staff with role specific training compliance	>=85%	81.9%	82.5%	83.0%
	Percentage of staff with annual appraisal	>=85%	83.1%	83.5%	81.6%

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2018/19 Accountability Framework for NHS trust boards

The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement and the CQC oversight measures used for identification and intervention.

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

Each indicator, which is highlighted as red or amber, has an accompanying exception report highlighting the reasons for underperformance, actions to improve performance and trajectory for the reminder of the year.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: Proportion of patients spending less than 4 hours in A&E	Externally mandated	Finance, Investment and Performance Committee	December 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	**82.8%**	**80.8%**	**85.0%**	**88.8%**	**86.6%**	**93.8%**	**92.3%**	**91.5%**	**88.9%**	**86.7%**	**85.9%**	**83.3%**
A&E: Proportion of patients spending less than 4 hours in A&E		8828	8946	10305	9241	9889	10177	10521	9673	9796	9684	9612	9390
A&E: Proportion of patients attending A&E		10650	11067	12110	10395	11418	10843	11394	10567	11009	11158	11186	11267

Driver for underperformance:

- We have seen a steady increase of attendances to the ED since September 2018 and we converted the highest amount to admissions this month
- Bed availability has remained challenging within the Trust
- The Nye Bevan Assessment areas have also been unable to run as an assessment area leaving patients waiting in ED longer
- At times of maximum capacity the department has struggled to find adequate space to triage and review patients thus creating a backlog and an increase wait time
- When beds become available transferring patients takes nursing resources away from the department, transfers can take a minimum of 30mins
- Available ward beds for patients tend to be available later in the day/evening, when staffing numbers have decreased reducing the capability of safe transfers
- Nursing staffing levels in December, especially over the Christmas period was especially challenging

Specialty waits

- Responsiveness of clinical teams to specialties is not consistent or embedded however had improved.

Actions to address the underperformance:

- Focussing ED on first assessment times instead of bed flow to support the Trust at the front door. Clinical Director developing action plan with support of Consultant Team
- Developing ‘Majors Lite’ to kick off in January, an early triaging process completed by senior nurse and Dr. Aim is to provide early treatment and/or signpost walk-in attenders at the front door
- On occasions where the 1st assessment had exceeded acceptable levels over the evening/night period; this has been addressed by ensuring there are two decision makers on every night shift and a command and control model for the lead of the department
- The ED holds a weekly Fixing the Flow (FTF) meeting, which feeds into and receives direction from the Trust FTF meetings as a work stream. These are attended by the senior team and have site team representation.

Lead Clinician:	Lead Manager:	Lead Director:
Dr T Dyer	Fay Gordon	Lee Taylor

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Ambulance Handover Times	Externally mandated	Finance, Investment & performance Committee	December 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	244	219	179	80	129	58	79	60	118	174	142	299
Ambulance handovers that waited over 60 mins	<=10	97	42	23	11	5	2	1	3	15	17	19	30

Driver for underperformance:	Actions to address the underperformance:
• December's performance has been recorded internally as only 4 ambulances over 60 mins • When the department is at maximum physical capacity, crews have been unable to offload and handover to ED team within set timeframes • Multiple ambulance arrivals within short periods cause spikes in demand and our ability to deliver performance is comprised • Paeds ED Corridor is very narrow and can create bottleneck with Pts queuing and prevent ambulance off-loading • Fast Response Cars booking mobile to hospital and not calling clear at scene, thus showing as a delay when transporting resource has been cleared	• ED trackers advised that they need to escalate as per the procedure at 30 and 45 mins to prevent this from happening • ED trackers recording any near misses and actual breaches, including registered crew numbers for validating with EMAS • System-wide meeting arranged as the EMAS data cannot be validated and other neighbouring Trusts also experiencing the same issues

Lead Clinician:	Lead Manager:	Lead Director:
Dr Tristan Dyer	Fay Gordon	Lee Taylor

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
RTT waiting times incomplete pathways	Externally mandated	Finance and Performance	November 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18
RTT waiting times incomplete pathways	>=92%	**90.3%**	**89.4%**	**87.4%**	**88.7%**	**89.0%**	**84.7%**	**81.1%**	**79.9%**	**80.3%**	**81.5%**	**82.1%**
RTT Waiting Times Incomplete Pathways		20002	20615	20135	20417	20929	21920	22609	22877	22979	22429	21892
RTT Waiting Times Pathways		22127	23059	23032	22996	23511	25867	27870	28616	28605	27519	26645

Driver for underperformance:

The current performance against RTT has decreased significantly this year for the following reasons:

- New way of counting within the new PAS system CAMIS
- A directive from NHSE to stop all elective work in January 18 due to the national urgent care pressures (NGH had delivered RTT to that point)
- lack of validation within some specialities as they become experienced with using CAMIS
- Capacity issues due to sickness or leaving of some key clinicians with challenges to recruit replacements
- Recovery of performance will be slow and the overall trust position will remain under national target for the remainder of 2018/19.

Actions to address the underperformance:

- Each speciality has a recovery plan in place and will be monitored against this at the weekly performance meetings.
- The divisional Managers in conjunction with the informatics team, using current activity positions & assumed capacity & resource throughout the remainder of the year, have developed the trajectories.
- All internal teams have now validated all patients >35 weeks
- An external team have validated patients <35 weeks (Cardiology, Neurology still have validation gains to be had)
- Weekly performance meeting in place with revised constitution
- RTT ‘housekeeping’ improved focus on OPCS codes, Missing outcomes and Un-appointed follow-ups.
- Locums and substantive recruitment in place to mitigate the workforce gaps
- Ring-fencing of surgical beds for winter to ensure elective work continues

Lead Clinician:	Lead Manager:	Lead Director:
Divisional Directors	Divisional Managers	Carl Holland

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	92.7%	94.5%	89.4%	77.6%	90.8%	69.9%	72.1%	70.7%	75.2%	94.0%	88.5%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	94.2%	95.3%	80.9%	72.8%	78.1%	23.3%	18.0%	31.0%	85.7%	91.0%	40.2%
Cancer: Percentage of patients treated within 31 days	>=96%	97.6%	97.9%	96.9%	98.7%	97.4%	92.6%	95.4%	97.5%	94.7%	97.5%	94.8%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	91.6%	94.7%	85.7%	90.0%	90.0%	78.5%	100.0%	100.0%	88.8%	86.6%	93.7%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	86.2%	77.2%	91.5%	81.1%	81.3%	74.6%	78.2%	80.8%	81.4%	85.4%	76.0%
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	79.1%	78.5%	100.0%	97.7%	87.5%	90.0%	81.2%	78.7%	79.0%	85.7%	83.6%

Driver for underperformance:

(Please note any variation of figures between the narrative and table above is due to rounding up/down on the system)

3 of the 9 Cancer Waiting Times Standards have been met by the Trust for November 2018.

62 DAY FIRST TREATMENT

National comparison figures for the 62-day standard for November are not yet available; however, for October NGH remained ranked 3rd out of 8 hospitals in the region for their 62-day performance.

NGH reached 76% for the 62 day standard against the target of 85%, with IPT applied The Trust would have 1.5 more breaches for Lung, 1 less for head and neck and 0.5 less for Upper GI giving no change to NGH performance.

The Trust has seen a reduction of 16%, undertaking 98 first treatments in November compared to 116.5 in October. This combined with the number of legacy patients treated has affected overall performance.

Actions to address the underperformance:

- Legacy patients being discussed 4 times a week in order to reduce numbers that had increased during the holiday period
- RAPID Project Manager in post, met with NGH and KGH clinical teams, walking the pathway for sample of patients in order to understand challenges and what works well as well as analysing data to support gap analysis
- NOLCP Project Manager recruited by KGH to work across both Trusts, awaiting start date
- Cancer Management Team meeting with senior managers to agree key strategic goals for 2019 in order to share at Cancer Board
- All teams required to refresh their improvement plans ensuring MDT work programmes captured and submitted to the Cancer Board on the 25/01

2WW

The 2ww standard has not been met reaching 88.5% against the standard of 93%. Of the 1073 patients seen 195 were in 7 days or less, 755 were seen between days 8-14 and 123 breached the standard. Breast, Colorectal, Skin and Upper GI did not meet the target with head and neck just failing. In order for the Trust to be able to meet their stretch target and national best practice of seeing patients within 7 days robust demand and capacity studies need to be undertaken by all sites.

2WW BREAST SYMPTOMATIC

The 2ww breast symptomatic standard has not been met for November reaching 40.3% against a standard of 93%. Of the 72 patients seen, 43 breached the standard, 2 of the breaches due to patient choice and the balance due to capacity

31 DAY FIRST TREATMENT
The Trust has not met the 31-day first treatment standard reaching 94.9% against the required 96% due to 9 breaches. 5 of the breaches were from head and neck, with 2 in Gynaecology, 1 in Lung and 1 in Urology. 6 of the breaches were due to further work up required on the patient after the decision to treat was reached resulting in the failure to treat within 31 days; clinical teams need to be made aware of this in order to review their practice.

Cancer Services will be sharing this at the weekly performance meeting and in the next newsletter in order to highlight the issue. 1 was due to patient fitness, 1 due to capacity and 1 due to patient initiated delay.

Subsequent Surgery
The Trust has not met the standard for subsequent surgery reaching 93.8% against the standard of 94%, failing by 1 patient as they could not proceed on the day and had their TCI re-schedule

62 Day Consultant Upgrade
The Trust has not met the 62-day consultant upgrade standard reaching 83.6% against the local standard of 85%, this is not reported nationally.

Lead Clinician:	Lead Manager:	Lead Director:
Mr O Cooper	Stephanie Buckley / Sandra Neale	Carl Holland

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Average Monthly Health DTOCs	<=7	10	13	16	13	37	31	19	13	25	25	13	16
Delayed Transfer of Care	=23	39	27	52	26	39	35	12	19	36	10	10	24

Driver for underperformance:

- Discharge to Assess (DTA) pathway not fully established for all Pathways
- Difficulties in accessing medical rehab beds due to community requests for medical intervention,
- High number of updated PDNA's being returned from SPA
- PDNA's not being submitted in a timely manner from Wards
- Missing information on PDNA's, still needing to be checked before sending
- Wards not fully engaging with discharge planning
- Lack of robust medical plans to support discharge
- Delays from medical teams due to treating unrelated medical problems
- SPA Tracker inaccurate not reflective of patients discharge pathway or plans
- High Stranded patients
- Not enough community beds to support delirium/dementia patients
- High returns for Crisis Response Team Discharge to Assess (CRT DTR)
- Family/patient expectation
- SCC beds full
- Lack of interim placements
- Extra funded beds full

Actions to address the underperformance:

- SOP and meeting to be arranged to developed a discharge pathway for medical rehab via a Trusted Assessor route (TA)
- Fortnightly Trusted Assessors meeting underway to support system
- Discharge Team informing Wards regarding requirements in updating PDNA's
- Discharge Nurses supporting Wards by checking PDNA's before submission
- Daily Tracking updates from Discharge Team combined with Tracking meetings supported by Social Services to ensure correct patient pathway
- Super Stranded/MADE event to be carried out on 16th January
- IDT increasing in numbers to supporting Ward discharges
- New Discharge booklet currently being developed
- Further Community D&D beds coming on line
- All returned CRT's being reviewed

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Jane Ajeto	Carl Holland

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	December 2018

Performance and Trajectory:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	**17**	**9**	**34**	**11**	**13**	**7**	**6**	**16**	**2**	**3**	**3**	**4**
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons (Value 1)		17	9	34	11	13	7	6	16	2	3	3	4

Driver for underperformance:

While we have not yet managed to achieve all patients being treated within 28 days of their cancellation, we have managed to maintain a low level.

In December, the 3 confirmed cases were not undertaken within 28 days.

All 3 were not able to be undertaken in the time period due to:

1) reduced theatre availability over Christmas and planned leave
2) other clinically urgent cancer patients requiring the theatre slots

1 case is being reviewed as they were initially booked on to a 'B' List (a list of patients with short notice availability that will be called if the main list patients are cancelled), and thus should not be classed as an 'on the day' theatre cancellation

Actions to address the underperformance:

- Continue with operational teams flexibly managing cancellation demand to ensure they are minimised
- Ensure TCI dates are booked within 28 days, and where not possible escalate the issue.
- Ensure 'on the day' the 28 day cancellations are identified to minimise risk of further cancellation

Lead Clinician:	Lead Manager:	Lead Director:
Mr Mike Wilkinson	Matt Tucker	Carl Holland

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Ward Moves >2	Internally set	Finance, Investment and Performance Committee	December 2018

Performance:

Indicator:	Target:	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18	NOV-18	DEC-18
Ward Moves > 2 as a % of all Ward Moves	=0%	4.3%	4.9%	4.9%	4.8%	4.0%	5.6%	5.8%	6.6%	6.1%	5.8%	6.1%	5.2%
Ward Moves > 2		158	165	185	167	145	221	241	280	237	254	265	217
Ward Moves		3,661	3,335	3,774	3,461	3,618	3,901	4,112	4,233	3,840	4,371	4,312	4,126

Driver for underperformance:	Actions to address the underperformance:
• Admissions were higher than discharges • Trend for ED arrivals is in high flow in and ambulance arrivals out of hours resulting in high numbers in ED increasing number of referrals • Winter flex Escalation areas currently open resulting in an increase in patients moves to ensure safe patient placement in areas that can meet pt needs	• • Senior Acute Medical Dr reviewing medical referrals in ED and screening patients for alternative pathways in and out of hours • Deep dive scheduled in all divisions weekly. Every ward assigned senior manager • Audit weekly ensuring all patients are receiving consult and reg reviews confirming medical plans

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Fiona Wade	Lee Taylor

Operational Performance Report – January 2019

1. Introduction

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

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

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

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

2. Summary performance

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

Performance Trajectories 2018/19

A&E

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

Cancer

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

RTT

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

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

3. Key areas of performance

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

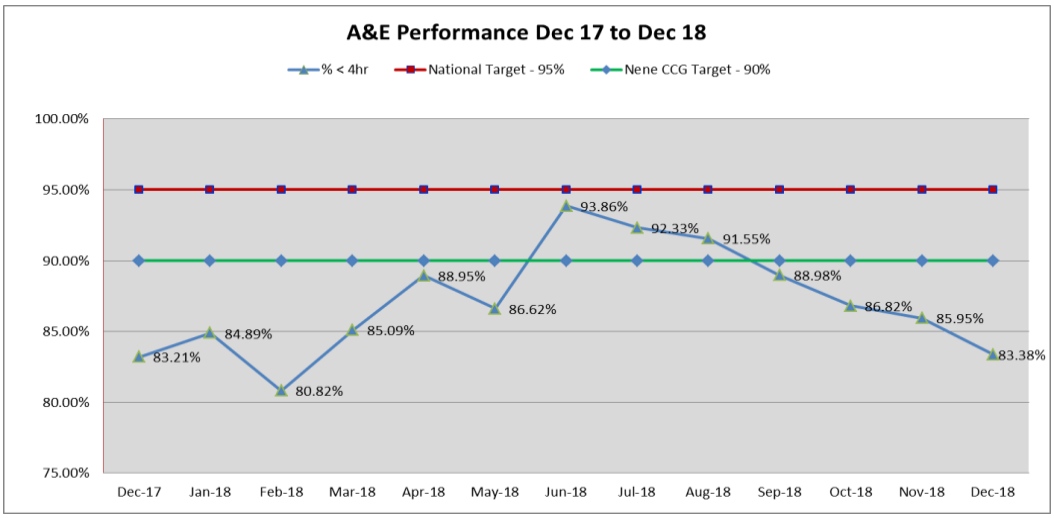
Four hour A&E performance decreased in December to 83.38%. December was the first month where the performance was less than the same month in 2017.

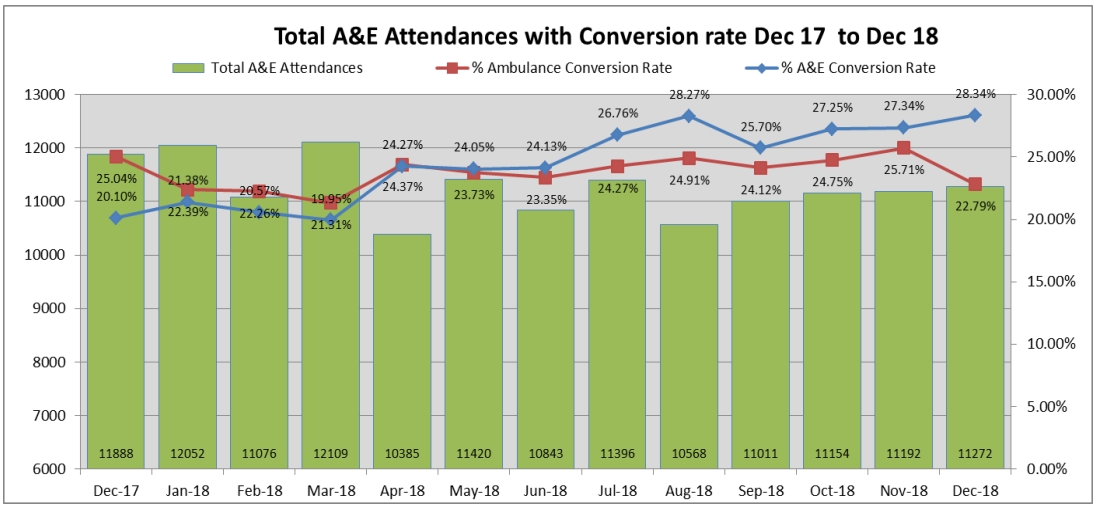
The underperformance was due to an increase in activity along with an increase in acuity of our patients who were admitted. The activity which presented via GP's or 111 remained stable but

the number of patients presenting directly to A&E who required admitting has increased and continues to increase in January.

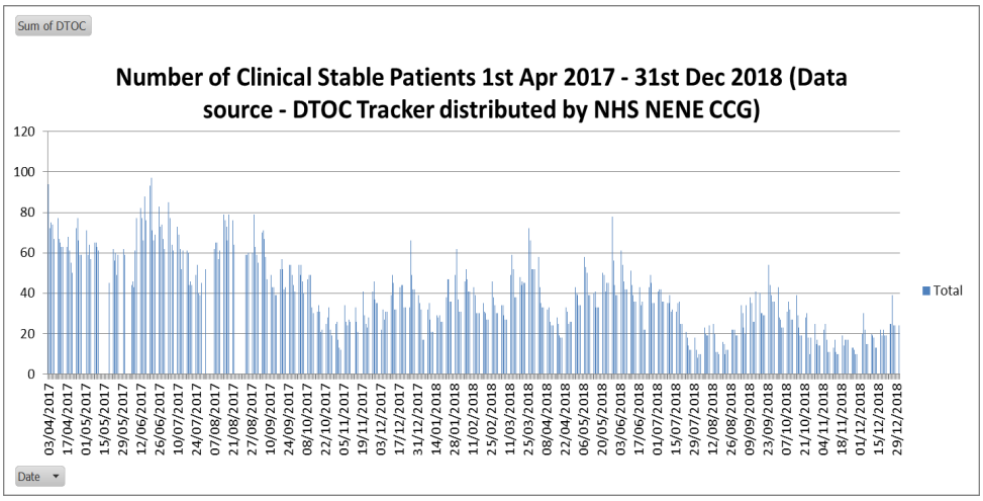
The conversion rate for patients attending A&E from 4pm and through the night increased in December and the same pattern is occurring into January. The influx of patients has on occasions been challenging to manage especially when multiple ambulances arrive together.

It is difficult to ascertain whether patients who present directly to A&E have become gradually unwell or whether they have sought primary care input at an early stage of their illness.

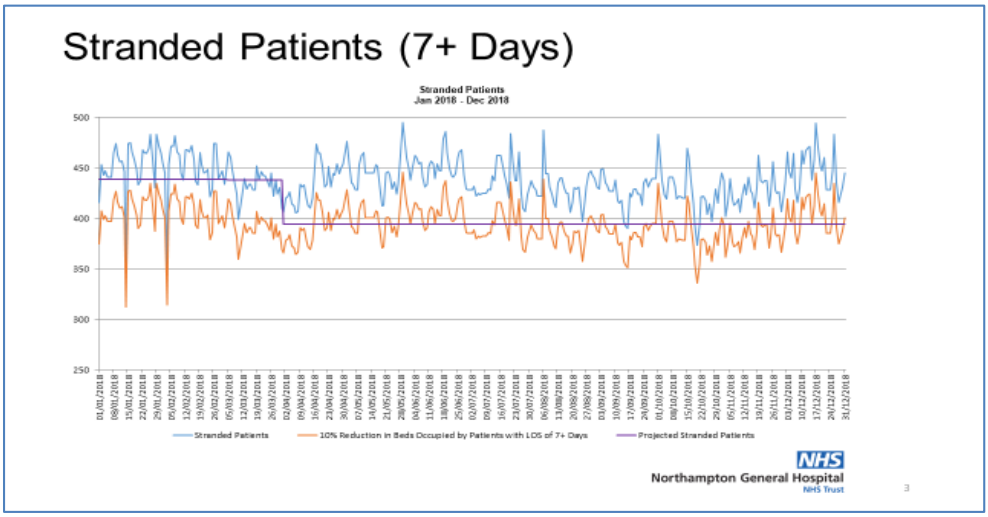


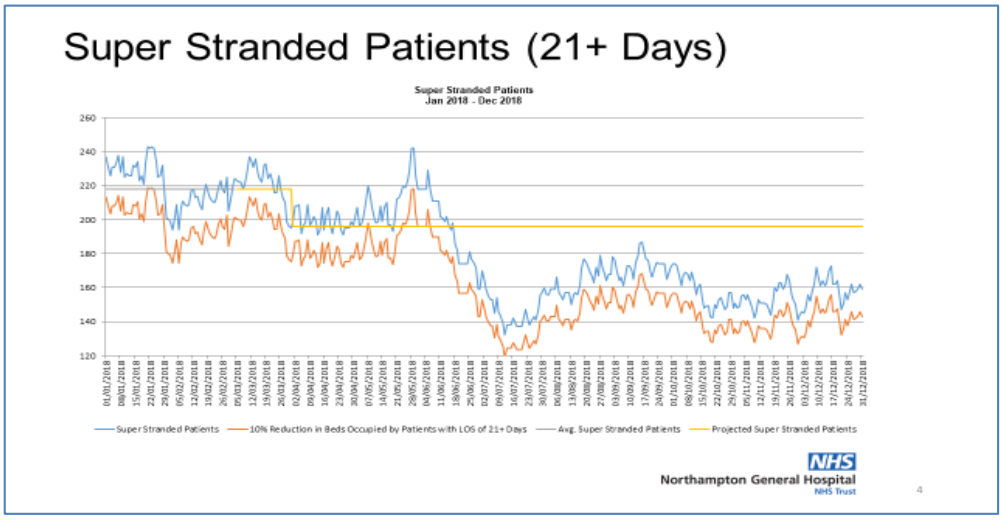


Throughout December 2018 & into January 2019, the number of delayed transfers of care remained low but the total number of patients who required care on discharge remained static. The main issue being the complexity of the discharge plans for many patients, again this is a good indicator of acuity.



Whilst DTOC remained low, the number of stranded (7 days plus) and super stranded (21 days plus) increased slightly in December but have since started to decrease mid-January 2019.





Actions being taken:

- Fixing flow programme revised to include two major work streams – Admission & Discharge with a steering group led by the CEO.

- Increased pathway 3 capacity in nursing homes has been procured which for NGH equates to 36 extra beds across the local community (delirium beds x6, dementia beds x4, Reablement beds x 15, High Level Residential beds, non-weight bearing beds)
- Length of stay reduction programme in the 3 community hospitals to enable rehab to be undertaken on the most appropriate place, plus increased flexibility on patients categories they will accept such as non-weight bearing patients and #NOF
- Additional beds open at NGH (Benham winter ward 28 beds)
- Full rapid roll out of SAFER & ibox
- New medical model implemented in Nye Bevan, A&E and ACC.
- Movement of staffing to accommodate late attendees to A&E (Capacity/Demand)

Risks

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

Cold weather – During December the number of patients being admitted with fractured neck of femur increased on average by 9 patients. This is likely to further increase as the weather becomes colder and the footpaths slippery with ice & snow.

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

Winter pressures

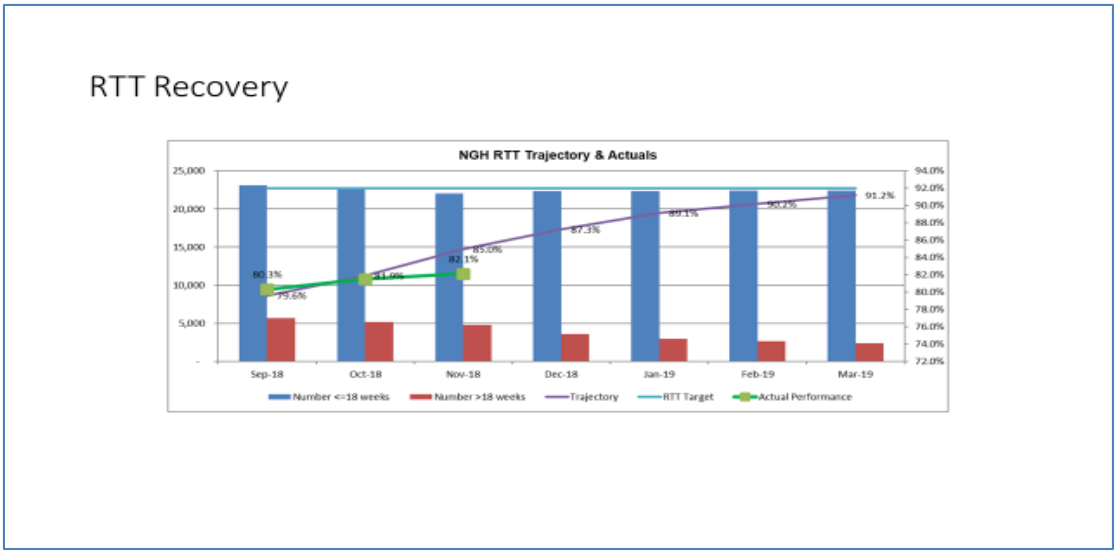
Whilst the performance has deteriorated compared to the same period last year, the flow within the hospital “feels better”. Staff morale is generally good and the main focus continues to be on keeping our patients safe at all times. The daily safety huddle is in place 7 days a week, this gives our ward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

3.2 RTT

The data for December has not yet been fully validated but is expected to be 81.48%

For November the performance was 82.1% which was a slight increase from October’s performance. Over the last 6 months every patient who was over 18 weeks has been reviewed by an external validation team and all patients over 35 weeks have been reviewed by the internal team, this was following the implementation of the new PAS to ensure our waiting list was accurate. All information has now been validated and the waiting list is a true reflection of the number of patients waiting.

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



Actions being taken:

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

Risks:

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

3.3 Cancer

Cancer performance has significantly deteriorated in November especially for 2ww Breast Symptoms & 62 day pathway.

For the 62 day pathway, the main areas of poor performance are H&N and Lung although both haematology, Gynaecology & upper GI are below target.

The main causes for the underperformance are:

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

Monthly Cancer Performance Figures

November 2018 (Validated)

	Total Treatments	Number of Patients Within Target	Number of Patients Over Target	Performance	Operating Standard
2ww Referral	1073	950	123	88.5%	93%
2ww Breast Symptoms	72	29	43	40.3%	93%
31 Day First Treatment	176	167	9	94.9%	96%
62 Day combined with 31 Day Rare Treatments - Actual Total	98	74.5	23.5	76.0%	85%
Subsequent Surgery Treatments	16	15	1	93.8%	94%
Subsequent Drug Treatments	78	78	0	100.0%	98%
Subsequent Radiotherapy Treatments	120	116	4	96.7%	94%
62 Day Screening	13	13	0	100.0%	90%
62 Day Consultant Upgrade	30.5	25.5	5	83.6%	85%

Actions being undertaken:

- Legacy patients being discussed 4 times a week with directorates
- RAPID Project Manager in post, met with NGH and KGH clinical teams
- NOLCP Project Manager recruited by KGH to work across both Trusts, awaiting start date
- Cancer Management Team meeting with senior managers to agree key strategic goals for 2019 in order to share at Cancer Board
- All teams required to refresh their improvement plans ensuring MDT work programmes captured and submitted to the Cancer Board on the 25/01. Commenced at the HMT in January.

Patients treated 104+ days

5 patients were treated during November who had been on their pathway over 104 days.

The breach panel met on the 14th December and reviewed breaches from October. No patients were identified to have been caused harm due to their delayed pathways.

4 Board recommendation:

The Board is asked to receive and discuss the report.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Clinical Strategy 2019-2024**
Agenda item	**17**
Presenter of Report	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy and Partnerships
Purpose	This paper is presented to the Trust Board to seek support for the process that will be undertaken to re-write the Clinical Strategy

Executive summary

The purpose of this paper is to propose a process by which the Trusts Clinical Strategy will be updated.

The strategy was originally published in 2014 and covered the period to 2020. In 2017 it was refreshed in recognition of the changing external environment with the decision taken that the overarching vision and values remained relevant.

This paper proposes a process of engagement across the hospital that will ensure divisions, directorates and departments have the opportunity to input into the short, medium and long term objectives that will construct the strategy.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? All
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks? No
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.2, 1.5, 1.6, 2.1, 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) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No

Actions required by the Board

The Trust Board is asked to approve the process that will be followed to refresh the Clinical Strategy and in particular the process to generate the short, medium and long term objectives that will form the basis of the document.

Northampton General Hospital NHS Trust

Public Trust Board
31 January 2019

Clinical Strategy 2019-2024

1. Purpose of Paper

The purpose of this paper is to propose a process by which the Trusts Clinical Strategy will be updated.

The strategy was originally published in 2014 and covered the period to 2020. In 2017 it was refreshed in recognition of the changing external environment with the decision taken that the overarching vision and values remained relevant.

Whilst there remains 12 months before the existing strategy needs to be presented to the Board it is proposed that this is undertaken early. This is because of the significantly changing environment in which the Trust is operating both locally and nationally.

This paper proposes a process of engagement across the hospital that will ensure divisions, directorates and departments have the opportunity to input into the short, medium and long term objectives that will construct the strategy. The engagement process will also include external engagement with our partners and patient groups to ensure they have an opportunity to be involved.

2. Background

Having an agreed and credible strategy that is easily recognised and supported by staff is critical for the overall management and direction of the Trust. Without this it will be impossible for the organisation to deliver its vision of delivering “Best Possible Care”.

A clear and coherent strategy will enable:

- The Board to be proactive and structured in how we work with our partners, maximising our ability to deliver safe care and be sustainable from operation and clinical perspectives
- Operationally it will set a clear sense of direction to guide planning activities and contribute to long term operational effectiveness
- Ensure divisions and directorates have clarity on expectations and assumptions on which to build their own planning activities. It will assist them to equip themselves and their teams for the years ahead

The national picture for the NHS is changing, the publication of the Long Term Plan necessitates a review of the Trust’s strategic direction as does the direction of the Health and Care Partnership and in particular our strengthening partnership with Kettering General Hospital NHS Foundation Trust (KGH).

Importantly, the CQCs Well-led key line of enquiry (KLOE 2) assesses whether an organisation has a clear vision and credible strategy.

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?

The CQC has not formally assessed our compliance with this requirement under their new regime although this will occur during our anticipated review in 2019.

For each of these reasons and because it is clear that time has passed since our strategy was updated, it would be appropriate to take this opportunity now to update the clinical strategy.

3. Process so Far

Colleagues are directed to **Appendix 1** where the current "strategy on a page" is enclosed for reference.

The process of updating our strategy has already commenced with the Board of Directors reaffirming the Trusts vision, "to provide the best possible care" and our values in October 2018:

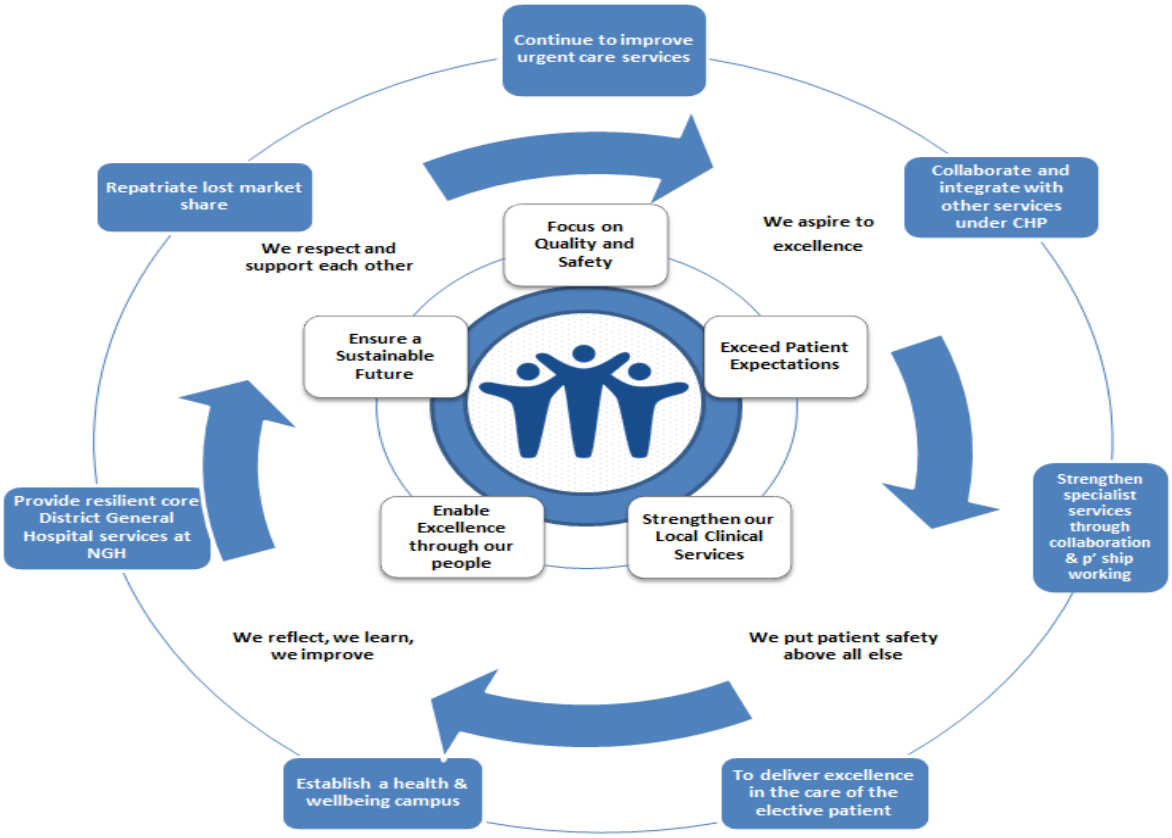
- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each other

We also considered our strategic aims that underpin these values and drive the overall direction of the organisation. We agreed that these remain relevant to the strategy:

- Focus on quality and safety
- Exceed patient expectations
- Strengthen our local clinical services
- Enable excellence through our people
- Ensure a sustainable future

This vision and our values and strategic aims form the basis for the remainder of our strategic planning and the direction given to the divisions when planning their services.

This has been represented as follows in the guidance issued to the divisions on the current planning process:



We have also commenced a revised planning approach with the divisions, initially aimed at producing their plans for 2019/20 but also with a focus on longer term development. So far the first of two workshops have been held with a second confirm and challenge workshop planned for the end of January and early February. The output of these sessions will assist not only with the planning process but also the generation of longer term aspirations and developments for the strategy.

The dates these sessions were held:

- Surgery – 1 November 2018
- Clinical Support Services – 5 November 2018
- Womens, Children, Oncology and Haematology – 30 October 2018
- Medicine - 30 November 2018

There are also more strategic pieces of work underway that will fundamentally affect not only the direction of the Trust but that of the Health and Care Partnership in the county. Central to this is the work underway with our colleagues at Kettering General Hospital NHS Foundation Trust to unify acute models of care and decide on the best future organisational form to promote service alignment.

4. The Approach

There are a number of distinct elements that will be followed from now to define our clinical strategy and ensure that colleagues from across the Trust and the broader health economy have the opportunity to be involved.

- Board workshop on 28 February 2019 to review the current approach, priorities and commitments in the strategy and to produce a long list of suggested revisions to be discussed during the engagement. These will include the priorities identified by the clinical divisions at the next series of business planning workshops held in early February
- Workshop with colleagues from Changing Care, Improving Quality and Excellence and Quality Improvement for the same purpose

From these sessions a long list of objectives that will form the basis of a review of “Our approach”, “Our Strategic Priorities” and “Our commitment” (see **Appendix 1**) will be produced. These objectives will form the short and medium term objectives for our revised strategy.

This long list will then be used in a series of wider engagement events across the four clinical divisions and support services which will take place in March and April as well as partner organisations and patient groups.

These events will ask the following questions in relation to the draft objectives:

- What is your overall feedback on the current vision, values and strategic aims of the Trust?
- What are the top four objectives, priorities and commitments from the list that you think are most important to the Trust?
- Which do you feel should be removed or amended?
- Are there any additional objectives that you would suggest and why?

The aim will be to retain the integrity of the previous overarching strategic direction for the duration of the strategy, and involve staff from across the organisation in developing the short/medium term objectives that will deliver it in the first 1-3 years to truly involve them in the process.

There are a range of processes that could be used to inform the engagement events. The proposal is that the structure listed in **Appendix 2** is used, this is similar to that employed recently at KGH and whilst the end product was different it was a helpful tool to engage staff.

The principle is that the diagram contains the elements that are pre-agreed by the Board (vision, values etc) and we add those that are identified after the wider engagement sessions with staff.

The output of this process will be reported to Trust Board in May 2019 for approval of the final objectives that will form the basis of our strategy. This will also provide sufficient time for other critical elements to be concluded:

- Work with KGH on the "form" of collaboration
- Finalisation of the 2019/20 planning round
- Inclusion of the NHS Long Term Plan priorities

5. Structure of the Outputs

The report back to the Board will include the results of the engagement with staff and a suggested graphical representation of the strategy that will be used in communications and posters around the organisations.

As mentioned, an initial draft of the graphical representation is listed at **Appendix 2**. The final product may not be comparable but it will give the strategy team a basis for the engagement events.

The final written Clinical Strategy will be presented to Board in July 2019.

Chris Pallot
January 2019

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 January 2019**

Title of the Report	**Health and Care Partnership Update**
Agenda item	**18**
Presenter of Report	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Health and Care Partnership Office
Purpose	This report is presented to the Board to provide an update on the progress of the Northamptonshire Health and Care Partnership
Executive summary This paper is the monthly newsletter produced by the Delivery Support Unit for the Health and Care Partnership. It represents the most recent information produced.	
Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strengthen our Local Clinical Services
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: Provides assurance on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 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) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned

	activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Board

The Board is asked to note the update

January 2019

Partnership Update

Northamptonshire
Health and Care Partnership

Happy New Year and welcome to the January 2019 edition of Partnership Update, bringing the latest news and developments from Northamptonshire Health and Care Partnership (NHCP) to our health and social care colleagues across the county.

As we move into 2019 we're pleased to be able to confirm that our new Partnership website is now up and running. This is the place to go to stay up to date on what we're doing, why we're doing it and how you can get involved.

Full details about the new website can be found on page 4, and if you have any feedback or suggestions we'd love to hear from you.

Elsewhere in this newsletter you can find out more about an exciting new local training programme to prepare nurses for careers in general practice. Northamptonshire is one of just three areas in the whole of England to run the pilot project and will be the first to launch it later this month, so this is a great example of how our county is leading the way in health and care partnership working.

There's also an update on our work to shape local health and care services around our communities, an example of some innovative joint working at one of our acute hospitals, details of how you can have your say on proposals to form two new unitary councils in Northamptonshire, and more.

We look forward to more successful partnership working with you in 2019!

Thank you
Northamptonshire Health and Care Partnership Board

Our transformation priorities – a quick reminder

- Care in your area (Primary, community and social care)
- How we plan, buy and monitor services (Strategic commissioning)
- Bringing care together across our hospitals (Unified acute model)
- Urgent and emergency care

NHCP has agreed to focus on four key areas of our health and care system where we can make the most difference together towards a positive lifetime of health, wellbeing and care in our community. This doesn't mean there aren't other areas where we are working together differently. But we are deliberately focusing on these priorities because we know this is where we can effect the most positive change by working collaboratively, rather than as individual organisations. You can read more about our transformation priorities and other areas of work here.

Care in your area

New nurse training scheme is a national first for Northamptonshire

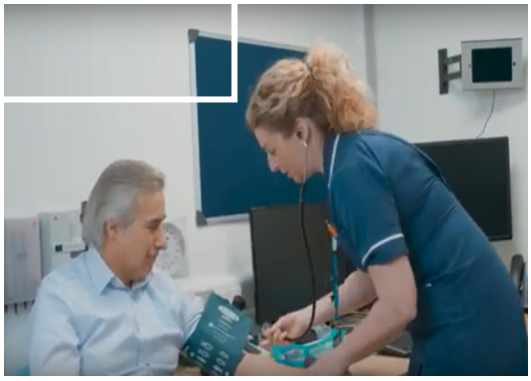
Northamptonshire is set to become the first area in England to begin a brand new training programme preparing nurses for careers in general practice.

The work-based education scheme is for registered nurses – including those who are newly qualified or looking to return to work – and is the latest innovative project from Northamptonshire Health and Care Partnership to support our county's GP practices.

Under the training programme, which starts at the end of January 2019, 10 successful recruits will be given paid roles at Northamptonshire practices run by Lakeside Healthcare and the 3Sixty Care Partnership GP federation.

There they will learn practical clinical skills while working under supervision and being mentored by experienced practice staff.

At the end of the programme they will receive a qualification covering core practice nursing skills – as well as being thoroughly prepared through practical experience to start their career as a general practice nurse.



Catherine Wills, primary care workforce programme manager for NHCP, said: "We're totally committed to helping our GP practices in Northamptonshire develop the workforce of the future, and it's hugely exciting for our county to be the drivers of such an exciting and innovative project. We hope our work will set a successful template for other areas to follow in the future."

The pilot training programme is being funded by NHS England and Health Education England.

The recruitment campaign, promoted through our joint Best of Both Worlds initiative, has been hugely successful with more than three applications received for each training post available. Shortlisted candidates attended a recruitment morning in December where they had the chance to demonstrate their knowledge and skills through speed interviews and team activities.

Due to the high levels of interest in the scheme, all candidates meeting essential criteria who have not gone forward to the training programme will be invited to a follow-up session to support them in applying for other general practice nurse vacancies. This will help to maximise the impact of the campaign and address some further gaps in the workforce across the county.

Shaping local health and care around our communities

One of the ambitions of Northamptonshire Health and Care Partnership is to create integrated local health and care services as close to home as possible. We also want to make sure our work engages with local communities and local community groups.

At the same time we recognise that Northamptonshire is a very diverse county, so a 'one size fits all' approach to local health and care will not work. The needs of people living in Daventry, for example, will be different to the needs of people in Corby.

In December we launched an opportunity for different areas of the county to come forward and develop plans to shape local services around their communities. Under this new initiative, local places are being invited to explore how GP practices, pharmacies, dental practices, community care services, the voluntary and community sector, social care and local councils can all work together more closely to improve the health and wellbeing of people living in their areas.

Applications from local collaborations are now being processed and we will announce up to four places that have been selected to take this project forward within the next few weeks.

Each area will then develop their plans locally before putting those plans into practice. Support for this work will be provided by the National Association of Primary Care – and it will then be used to help us shape our wider plans for integrated health and care services across the whole of Northamptonshire.

Urgent and emergency care

Case study: Age UK Northamptonshire launches support service for patients at KGH

As part of our work to improve our county's urgent and emergency care services, health and care organisations in Northamptonshire are working together to ensure those in need can acccess the right care in the right place at the right time – and so people in hospital are supported to return home as soon as they are well enough.

Just one of the many projects supporting this work around the county is a new service to improve older people's experience of being a patient at Kettering General Hospital – especially during busy times – which was launched in December.

The Age UK Northamptonshire Support Service is a team of paid support workers, and a co-ordinator, who will be working in the hospital's A&E department, main ward blocks and discharge lounge. The new service is one of the most comprehensive services provided by Age UK charities at a hospital anywhere in the country and will complement the work done by KGH's own volunteers.

The new Age UK Northamptonshire team at KGH

The Age UK Northamptonshire team will support the hospital by helping patients with a wide variety of non-clinical tasks ranging from getting cups of tea, filling in forms, and providing activities for dementia patients, to taking people home in Age UK Northamptonshire minibuses and checking they have everything they need.

Age UK Northamptonshire Business Development Director, Sue Watts, said: "The new service will improve the patient experience at KGH by having specially-trained staff available to support the particular needs of older people.

"Coming into hospital can be a traumatic and confusing experience for some older people. Our support workers will be able to give patients that extra bit of time and support that busy clinical staff sometimes cannot provide straight away. These sorts of things can help prevent unnecessary admissions to hospital and also help speed up the discharge process for more vulnerable patients."

Click here to read more. We will be highlighting more local projects supporting our Partnership work in future newsletters.

New A&E minors area opens at KGH

On Christmas Eve Kettering General Hospital opened its expanded A&E minors area for people with minor injuries and less serious medical problems.

The move is part of a £2.4m refurbishment and relocation programme to improve care for patients using the hospital's A&E services. The work has involved expanding the department into the adjacent Frank Radcliffe Fracture Clinic. It has improved the A&E minors service by creating:

- 10 extra A&E examination rooms
- 4 additional triage rooms
- A dedicated plaster room for A&E only (previously A&E shared a plaster room with the fracture clinic)
- A dedicated room for a GP

To enable this expansion KGH is also relocating its fracture clinic and dermatology department.

The hospital's dermatology department moved off site to improved facilities in Prospect House in Lower Street, Kettering (alongside the Weavers and Eskdaill GP practices and Rowlands Pharmacy) in November.

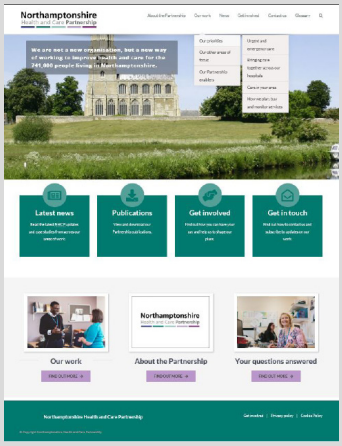
The plan is for the Frank Radcliffe Fracture Clinic to move into the area previously occupied by the dermatology department as soon as some estates matters are complete.

Visit the brand new NHCP website

The new Northamptonshire Health and Care Partnership website – www.northamptonshirehcp.co.uk – is now live for all the latest updates about our Partnership work.

The NHCP website includes:

- Background to the Partnership, including our mission, vision, values and ambitions
- Information about our transformation priorities and other areas of focus
- Latest news, updates and case studies on our Partnership work across Northamptonshire's health and care organisations
- Current and previous editions of our Partnership Update newsletters (to download or read online)
- Details of how you can get involved with our work or get in touch with us



Our website will continue to develop over the coming weeks with new pages and resources to be added, including NHCP publications, upcoming events and more.

In the meantime, we would love to hear your feedback about the site and suggestions for anything you'd like to see there in the future. You can get in touch via the website or by emailing nhcp.communications@nhs.net.

New chairman appointment at Northampton General Hospital to strengthen partnership working

NHS Improvement has appointed Alan Burns as the new chairman of Northampton General Hospital.

Alan is currently the chairman of Kettering General Hospital NHS Foundation Trust and has many years' experience as a chairman and chief executive. He has also been involved in national work on public sector reform and research and development, and was vice chairman of the NHS Confederation.


Alan Burns

On learning of his appointment Alan said he was looking forward to the challenge of working with the two acute hospitals in Northamptonshire to help create an outstanding acute sector that meets the needs of our local population and has the support of patients as well as Northamptonshire Health and Care Partnership.

Alan is keen to emphasise that his focus will be on improving services and partnership working across the two hospitals, saying: 'I am delighted to be given this opportunity of maximising the chances of success in both our hospitals and am looking forward to meeting the team at NGH and learning more about their services and areas of expertise.

"By working together we can make a greater contribution towards the health and care partnership and our shared work on health and wellbeing in the county. This is not about merger or acquisition but about creating high quality services where staff are proud to work and where patients can expect the highest of standards. I hope I will be able to offer something to help lead both trusts towards becoming outstanding in an excellent system.

"The people in Northamptonshire deserve to receive health services of a high standard, and my aim is to ensure staff feel suitably supported and valued, and for our patients to continue to receive the very best care possible.'

Alan's appointment, which is for two years, began on 20 December 2018 when he replaced Paul Farenden, who had extended his term of office until a new chairman could be appointed at NGH.

Paying tribute to Paul Farenden, NGH chief executive Dr Sonia Swart, said: "During Paul's tenure NGH has become a safer, more quality-driven and efficient organisation with a more collaborative culture as recognised by the Care Quality Commission and others.

"We are looking forward to working with Alan and our colleagues at Kettering General Hospital as we set out to strengthen the way we work together and improve services to patients but also ensure that both organisations can continue as viable independent hospitals committed to a journey of improvement."

Latest news

Supporting clinical staff through change

If our Partnership work is to succeed, it's important to ensure that clinicians at all levels across our health and care organisations are fully engaged in what we are doing.

In order to build clinical engagement across the Partnership, and as part of the workplan for the Strategic Clinical Group, Julie Shepherd (NHCP Nurse Lead) and Ganesh Baliah (NHCP Allied Health Professional Lead) organised and hosted a 'professional support' workshop in December for non-medical clinicians currently working within Partnership workstreams.

A diverse staff group attended the workshop, including pharmacists, physiotherapists, podiatrists, occupational therapists and nurses, representing a great cross-section of our clinical workforce.

The workshop, supported by EMLA Clinical Leadership funding, enabled colleagues to make suggestions and challenge in a constructive and engaging manner. Delegates were also encouraged make a commitment to engaging with the Partnership and to bring a colleague to a follow-up meeting in March 2019. Any queries about these workshops should be directed to ganesh.baliah@nhs.net.

Still time to have your say on unitary councils proposals

The Government consultation on proposals to replace Northamptonshire's existing county, district and borough councils with two unitary local authorities continues until Friday 25 January 2019 – so there is still time to have your say.

Anyone with an interest in the proposed restructure can take part in the consultation – particularly people who live and work in our county.

Click here for further information and to complete an online survey.

Meanwhile, the Secretary of State for Housing, Communities and Local Government, James Brokenshire, has now laid before Parliament an order under the Local Government Act 2000 to postpone district and parish elections in Northamptonshire due to be held in May 2019.

The decision comes after all eight councils in the county expressed concerns that district councillors elected in May 2019 would serve only one year before the proposed formation of the unitary authorities, and elections in such circumstances could risk confusing voters.

The order states that changes will come into effect on 14 January 2019 and councillors shall continue in their positions until the postponed elections in May 2020.

Staff: we want your views on Partnership working

Are you involved with a Northamptonshire Health and Care Partnership workstream, governance group or system enabler? If you are, the NHCP workforce team wants to know your views on how well the Partnership's principles, values and behaviours are embedded into what we do and how we work together.

By understanding where we are now, we can track and monitor our progress in working together and develop activity to support the wellbeing and engagement of our staff while supporting our collective mission to empower positive futures.

Please click here to complete a short online survey for whichever NHCP workstream, enabler or group you are involved with. If you are a member of more than one, it would be helpful if you could complete a survey for each individually via the unique link. Each survey should take no more than around five minutes to complete.

Your NHCP team

The Northamptonshire Health and Care Partnership brings together leaders from across our county's health and care system, each with a wealth of experience in a range of backgrounds and disciplines. Each transformation priority and workstream is led by an executive sponsor from one of our organisations, supported by a senior responsible officer (SRO).

Partnership and Delivery Support Unit (DSU)

- Angela Hillery (NHFT)
  Partnership Lead
- Dr Miten Ruparelia
  Clinical Lead
- Julie Shepherd (NHFT)
  Nurse Lead
- Mike Coupe*
  Programme Director
- Tim O'Donovan
  Assistant Programme Director

System Enabler Leads

- Mike Coupe (DSU)
  Estates
- Richard Wheeler (NHFT)
  Finance
- Nigel Brokenshire (NEL CSU)
  Digital Transformation
- Janine Brennan (NGH), Chris Oakes (NHFT and LWAB**)
  Workforce
- Dionne Mayhew (NHFT)
  Communications

Transformation Priority Leads

- **Strategic Commissioning**
  Sponsor: Toby Sanders (CCGs)
- **Unified Acute Model**
  Sponsors: Simon Weldon (KGH), Sonia Swart (NGH)
  SROs: Chris Pallot (NGH), Polly Grimmett (KGH)
- **Primary, Community and Social Care**
  SRO: David Williams (NHFT)
- **Urgent and Emergency Care**
  Sponsor: Simon Weldon (KGH)
  SRO: Eileen Doyle (KGH)

Workstream Leads

- **Cancer**
  Sponsor: Sonia Swart (NGH)
  SRO: Karen Spellman (NGH)
- **Children and Young People**
  SRO: Jean Knight (NHFT)
- **Health and Wellbeing**
  Sponsor: Lucy Wightman (NCC Public Health)
  SRO: Stuart Mallett (DSU)
- **Learning Disabilities**
  Sponsor: Anna Earnshaw (NCC)
- **Maternity**
  SRO: Emma Donnelly (CCGs)
- **Mental Health**
  Sponsor: Sandra Mellors (NHFT)
  SRO: Catherine O'Rourke (CCGs)

* Currently supporting PCS and Estates
** Local Workforce Advisory Board

Get in touch: nhcp.communications@nhs.net
Visit our website: www.northamptonshirehcp.co.uk

Northampton General Hospital NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**31st January 2019**

Title of the Report	**EU Exit Operational Readiness**
Agenda item	**19**
Presenter of the Report	Deborah Needham – Acting CEO (Chief Operating Officer/Deputy CEO)
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

This paper sets out the current status of Brexit negotiations, summarises implications for the NHS and our preparations to date for a 'no deal' Brexit.

The Trust has identified the Chief Operating Officer as the Senior Responsible Officer (SRO) to oversee the work to ensure continuity of supply of goods and services in the event of a No Deal Brexit. Some categories of spend and suppliers are best engaged at a national level and these are being managed centrally by the Department of Health and Social Care (DHSC). All other categories and suppliers were reviewed as part of a self-assessment methodology, submitted to the DHSC on 30th November 2018.

The Trust has arrangements in place to prepare for a No Deal Brexit and the SRO will keep the Board informed of any implications of the withdrawal agreement as further information is provided, if this is enacted.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s) NA
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/

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

Actions required by the Group

The Group is asked to:

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

Northampton General Hospital NHS Trust

EU Exit Operational Readiness, January 2019

1. Introduction

The UK is due to leave the European Union at 23:00 on Friday 29th March 2019. The UK and the EU have spent more than a year trying to agree on how Brexit will work in practice. This has now been agreed with the EU and backed by the cabinet. They have also agreed a rough outline of how future relations might work, known as the political declaration.

The implications of the withdrawal agreement on the NHS is not yet known. However, in the meantime, the Department of Health & Social Care (DHSC) has made a number of Brexit-related announcements in regards to preparations for a No Deal Brexit scenario. This paper sets out the current status of Brexit negotiations, summarises implications for the NHS and our preparations to date.

2. The NHS and No Deal Brexit

The political declaration does not cover health, care, public health or research, and security co-operation is not finalised, so the implications of this withdrawal agreement on the NHS is not yet known. However, in the meantime, the DHSC has made a number of Brexit-related announcements in regards to preparations for a No Deal Brexit scenario.

The Secretary of State for Health & Social Care wrote to all Chief Executives on 12th October 2018 to set out what the Trust needs to do to step up preparations to ensure continuity of supply of goods and services in the event of a No Deal exit from the EU. In his letter, Mr Hancock stated that, while a scenario in which the UK leaves the EU without agreement remains unlikely, he had asked his Department to put plans in place to ensure the continuity of supplies to the NHS. As part of this activity, the DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit.

In new guidance published on the 21st December 2018, the DHSC have requested a Board member undertake a role to oversee preparations for Brexit and ensure that Trusts have updated their business continuity plans to factor in all potential fallout from a No Deal exit.

Organisations are also expected to undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.

Providers have also been requested to review capacity and activity plans “as well as annual leave” around 29th March.

Continuity of Supply of Medicines

The Government has set out a scheme to ensure a sufficient and seamless supply of medicines in the UK in the event of a No Deal Brexit.

In the unlikely event we leave the EU without a deal in March 2019, based on the current cross-Government planning scenario, the DHSC will ensure the UK has an additional six weeks supply of medicines in case imports from the EU through certain routes are affected. This is the current planning assumption but will of course be subject to revision in light of future developments. Under the medicines scheme, pharmaceutical companies should ensure therefore they have an additional six weeks supply of medicines in the UK on top of their own normal stock levels.

The scheme also includes separate arrangements for the air freight of medicines with short shelf-lives, such as medical radioisotopes. The Government is working closely with companies who provide medicines in the UK to ensure patients continue to get the medicines they need.

The DHSC has given assurance that Hospitals, GPs and community pharmacies throughout the UK do not need to take any steps to stockpile additional medicines, beyond their business as usual stock levels. There is also no need for clinicians to write longer prescriptions. Local stockpiling is not necessary and any incidences involving the over ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly. Clinicians should advise patients that the Government has plans in place to ensure a continued supply of medicines to patients from the moment we leave the EU. Patients will not need to and should not seek to store additional medicines at home.

Workforce

Technical Notice on Recognition of Professional Qualifications

This notice states that, in the event of no deal, the Mutual Recognition of Professional Qualifications (MRPQ) Directive will no longer apply to the UK. The Government will develop a new recognition procedure for EEA professionals which will differ from existing arrangements (for example, automatic recognition and temporary access to regulated activities on the basis of a declaration will no longer be applicable). The Government will work with the devolved nations and the regulatory bodies to ensure a UK-wide system of recognition.

In terms of the Trust's Workforce, currently 8% of our staff are EU nationals. The Trust is supporting our EU staff to ensure they understand the opportunity to gain settled status through this scheme and the Trust will be reimbursing individual staff members the £65 application fee. This has been well-received.

Other Goods & Services

The Secretary of State has written to all Trust Chief Executives to advise of the requirements to ensure continuity of supply of goods and services in the event of a No Deal Brexit.

A pack of materials has been received by the Trust's Head of Procurement, including a self-assessment methodology to use to identify contracts that may be impacted by EU exit.

The pack also includes a list of categories and suppliers that are being managed by DHSC, such as the supply of medicines and these are out of scope of the self-assessment, unless otherwise stated. These include:

• Licenced Medicines and vaccines;

• Medical Devices and clinical consumables (a list of suppliers are out of scope of the self-assessment);

• Food;

• Nutritional Feeds;

• Pathology/in vitro diagnostic devices (a list of suppliers are out of scope of the self-assessment);

• Capital equipment and spare parts, and

• Hotel Services (a list of suppliers are out of scope of the self-assessment).

All categories and suppliers in scope of the self-assessment are currently being reviewed by the Trust's Procurement Department.

Business Continuity Plans

The DHSC has stated that any preparations for a March 2019 No Deal scenario should be part of the work that Trusts are already doing to update existing business continuity plans in line with the NHS England EPRR Core Standards and the NHS England EPRR Annual Assurance process.

EU Exit Operational Readiness Guidance

The EU Exit Operational Readiness Guidance, developed and agreed with NHS England and Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal. This will ensure organisations are prepared for, and can manage the risks in such a scenario.

The guidance is attached for information **APPENDIX 1.**

The following table provides an overview of the Trust's preparedness in line with the aforementioned local EU Exit readiness requirements.

Actions for providers: Local EU Exit readiness preparations

Risk assessment and business continuity planning	
Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to: • The seven key areas identified nationally and detailed below. • Potential increases in demand associated with wider impacts of a 'no deal' exit. • Locally specific risks resulting from EU Exit.	Risks reviewed at the monthly Trust Brexit meetings and Resilience Planning Group.
Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.	Reviewing internal plans and working with partners to ensure robust plans are in place.
Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.	Scheduled for completion prior to end February.

Communications and escalation	
Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.	Yes
Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.	Regular LRF and CCG led multi-agency Brexit meetings are taking place.
Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.	Brexit Plan to be created for the period surrounding 29th March.
Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.	Awaiting further operational guidance as work progresses.
Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.	Yes
Note your nominated regional NHS lead for EU Exit and their contact details.	Yes
Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team	Yes
Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.	Yes
Reporting, assurance and information	
Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.	Yes
Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.	Noted

For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox.	Yes
Supply of medicines and vaccines	
Follow the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.	Yes
Note that there is no need to contact suppliers of medicines directly.	Noted
Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.	Yes
Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.	Noted
Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.	Noted
Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary	Yes
Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.	Yes
Regional pharmacists and emergency planning staff to meet at a local level to discuss and agree local contingency and collaboration arrangements.	NHS England's Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks in January 2019 to help inform local plans.
Supply of medical devices and clinical consumables	

Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.	Noted
Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.	Yes
Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.	Yes
Send queries regarding medical devices and clinical consumables to mdcccontingencyplanning@dhsc.gov.uk.	Yes
Supply of non-clinical consumables, goods and services	
Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.	Yes
Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.	Yes
Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.	Yes
Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.	Yes
Await further advice from the Department on what actions should be taken locally.	Yes
Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.	Self-assessment submitted 30/11/2018.

Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.	Yes
Workforce	
Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.	Yes
Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register.	Yes
Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.	HR monitor all leavers monthly. Specific EU reports will be run monthly.
Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.	HR have assessed the staff groups but not carried out a local risk assessment. Divisions will be provided with numbers of EU nationals in order for them to determine whether a local risk assessment is necessary.
Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.	Current business continuity plans take into account these risks such as lack of staff/ equipment/supplies.
Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.	Yes
Escalate concerns through existing reporting mechanisms.	Yes
Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.	Yes
Professional regulation (recognition of professional qualifications)	

Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.	Responsibility of the UK Professional Body.
Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.	Responsibility of the UK Professional Body.
Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.	Yes
Reciprocal healthcare	
Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.	Noted
Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).	Confirmed
Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.	Noted
Maintain a strong focus on correctly charging those who should be charged directly for NHS care.	Information regarding implementing the current charging regulations has been forwarded to the Overseas Visitors team.
Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.	Yes
Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.	Noted
Research and clinical trials **EU research and innovation funding schemes**	

Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.	Noted
Provide information about your Horizon 2020 grant. This should be actioned as soon as possible. All queries should be sent to EUGrantsFunding@ukri.org.	Forwarded to Clinical Trails lead.
Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.	Forwarded to Clinical Trails lead.
Clinical trials and clinical investigations	
Follow the Government's guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.	Forwarded to Clinical Trails lead.
Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.	Forwarded to Clinical Trails lead.
Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.	Forwarded to Clinical Trails lead.
Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.	Forwarded to Clinical Trails lead.
Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being	Forwarded to Clinical Trails lead.

impacted due to trial supplies.	
Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk	Forwarded to Clinical Trails lead.
Data sharing, processing and access	
Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.	Trust Data Quality, Security and Protection team are working with, and receiving guidance from Dawn Monaghan, Director of System IG Strategy at NHS Digital.
Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.	Trust Data Quality, Security and Protection team are working with, and receiving guidance from Dawn Monaghan, Director of system IG Strategy at NHS Digital.
Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.	Trust Data Quality, Security and Protection team are working with, and receiving guidance from Dawn Monaghan, Director of system IG Strategy at NHS Digital.
Ensure that your data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.	Trust Data Quality, Security and Protection team are working with, and receiving guidance from Dawn Monaghan, Director of system IG Strategy at NHS Digital.
Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.	Trust Data Quality, Security and Protection team are working with, and receiving guidance from Dawn Monaghan, Director of system IG Strategy at NHS Digital.
Finance	
Record costs (both revenue and capital) incurred in complying with	The Trust has agreed to

this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.	pay for the EU Settlement and this has been costed up. Further costs to be identified and costed.

3. Conclusion

The Trust has identified the Chief Operating Officer as the SRO to oversee the work to ensure continuity of supply of goods and services in the event of a No Deal Brexit. Some categories of spend and suppliers are best engaged at a national level and these are being managed centrally by the DHSC. All other categories and suppliers have been reviewed as part of a self-assessment methodology and submitted to the DHSC on 30th November 2018.

The Trust has arrangements in place to prepare for a No Deal Brexit and the SRO will keep the Board informed of the any implications of the withdrawal agreement as further information is provided, if this is enacted.

4. Recommendations

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

APPENDIX 1

EU Exit Operational Readiness Guidance.p

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31 January 2019

Title	**Finance Committee Exception Report**
Chair	**David Moore**
Author (s)	**David Moore**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 20 December 2018 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- Finance Report Month 08
- Initial Plan & Planning Update
- Operational Performance Report & Scorecard
- Procurement Qtly Report including Supply Chain Self-Assessment & Brexit Update
- EPRR Core Standards Review 2018/19
- Benefits Realisation – IT Projects

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

Key areas of discussion arising from items appearing on the agenda

The Chairman expressed the Committee's appreciation to the Finance Director and his team for ensuring robust and disciplined management of the financial position up to and including M8;

The Committee expressed satisfaction at the outcome of discussions with the main Commissioners around locking in income for the balance of the 2018-19 year; however the Committee also noted that the focus was now squarely on cost containment both pay and non-pay, through to year-end. The Committee was happy to recommended approval of these changes to the Trust Board

The Committee felt it would be useful to hear from Divisional Directors in future meetings concerning their financial priorities;

The Committee requested an enhanced report in future FIPC packs covering both Capital Expenditure and other major projects which may not use capital but where strategically significant (e.g. the new Accommodation Block, the new Front Entrance, etc.). The report would focus on performance against delivery targets as well as risks to delivery;

Confidence levels in meeting the A&E performance trajectory were low and this put at risk >£1M of PSF payments;

The report on Operational Performance was received and the Committee noted the

continuing challenges the Trust (and indeed the system) was having in meeting the A&E trajectory; however the Committee was also pleased to see a number of Cancer wait time indicators turning from red to green;

The Committee received the Quarterly procurement report from the Director of Estates and was assured that savings highlighted in the report flowed through to the Changing Care numbers. The Director of Estates also noted that Brexit was very much on there agenda and in view of the current lack of guidance from the centre, local mitigations were being examined to the extent possible. Note: more central guidance has been received since the meeting

The COO updated the Committee on Emergency Preparedness, Resilience and Response readiness and was able to provide the necessary assurance that the Trust was in full compliance with all mandated processes and procedures. The Committee congratulated the COO on the important work carried out in this respect;

A useful report was received from the Director of IT that articulated the benefits realized from a number of key IT projects. The Committee understood that this was work in progress and while not wishing to create additional work felt that periodic reporting of this type added to the assurance the Committee received around the value-adding contribution of IT;

The Committee received the monthly IT report from the Director of IT who, amongst other things, expanded on a number of key risk areas highlighted in the report. These included (1) data capture risks around CaMIS which had still not been fully contained (2) risks – and mitigations - around email security and specifically the move to nhs.net (3) cyber security and a number of related initiatives and (4) the implementation of a new data warehouse.

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

The Committee approved the Ambulatory Care Centre Business Case which required an investment to increase the nursing and administrative staffing levels in order to maintain a 24/7 service and to support the Nye Bevan “New Ways of Working” as well as to maximize tariff remuneration (and specifically through the Best Practise tariffs available to the Centre);

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

The Committee again expressed concern with the limited recurrent saves being generated from the Changing Care programme;

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 content of the Highlight Report.

COMMITTEEHIGHLIGHT REPORT

Report to the Trust Board: *20 December 2018*

Title	**Quality GovernanceCommittee Exception Report**
Chair	**John Archard-Jones**
Author (s)	**John Archard-Jones**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *23 November 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items: **Corporate Scorecard for Quality** **Quality Improvement Scorecard** **Nursing & Midwifery Report** **Medical Director's Report** **Compliance Report** **Infection prevention**	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*

Key areas of discussion arising from items appearing on the agenda

Patients attending A&E with the Police
Head and Neck Assurance report
Mortality rates
Friends and Family scores

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

a Trust-wide mortality review of 100 notes is being undertaken by 40 Consultants, 10 nurses and clinical experts. At current 25% of the notes had been checked. The results to date had showed that a third was excellent, a third was good and a third was adequate. This audit would be confirmed and challenged. The Committee asked for an update with themes noted once the review had been completed.

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

None

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

Continue to review Mortality rates and scrutinise the ongoing review

Northampton General Hospital NHS
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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***January 2019***

Title	**Quality Governance Committee Highlight Report**
Chair	**John Archard-Jones**
Author (s)	**John Archard-Jones**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 14 December to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

Corporate score card
QI Scorecard
Nursing and Midwifery Report
Medical Directors Report
Deteriorating patients Board
Complaints Quarterly Report
Health and Safety Report

Key areas of discussion arising from items appearing on the agenda

Friends and Family Test
New DVT pathway in ED
New Divisional scorecards
New Guidelines on Trust taking responsibility for pressure ulcers developed in the first 72 hours after admission

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

Further report on Friends and Family Test to future meeting.
Divisional scorecards to be reviewed at the January meeting to agree the most appropriate place for these to be discussed.

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

None

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

None

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***December 2018***

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 *21st November 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- **Medical Revalidation Q2**
- **Appraisals Q2**
- **Freedom to Speak Up**
- **Respect & Support Campaign update**
- **TRAC applicant management system**

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

Key areas of discussion arising from items appearing on the agenda

- **Medical Revalidation Q2 –** 366 doctors with a prescribed connection to NGH, 27 of which were due for revalidation which have now been completed, with a deferral for 3
- **Draft Consult Engagement Strategy –**41 doctors out of 66 had an appraisal. Key issue is shortage of qualified appraisers. All but one appraisal slot now filled with existing qualified appraisers taking on additional appraisals to ensure all doctors receive appraisals in 2018.
- **Freedom to Speak Up –** only 2 cases reported. Policy currently being revised in line with new national guidelines.
- **Respect & Support Campaign** – a number of programmes had been launched including Leading with Respect for team leaders and managers of which 150 attended; Challenging Bullying Behaviour, for non-managers, which 100 staff attended; Resilience training, 160 attended, Courageous conversations started in October. Helpline to be launched in January. Roundtable informal mediation to be launched once internal facilitators trained.
- **TRAC –** new applicant management system to be launched in January, which will dramatically improve recruitment processes, including speed to recruit and improve audit results.

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

Any issues of risk or gap in control or assurance for escalation to the Board	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***31st January 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 *12th December 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- **Sickness/absence reporting for junior doctors**
- **GMC Trainee Survey results – update**
- **Job Planning**
- **Apprenticeship levy**
- **Safe Nurse Staffing**

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

Key areas of discussion arising from items appearing on the agenda

- **Sickness/Absence reporting** : Concern re junior doctors' sickness rates and inconsistency in reporting by junior doctors due to lack of understanding of process. A standardised policy, and guidelines for sickness absence reporting to consultants to be provided with training. A report would be provided on junior doctors' sickness rates for review(JB update next Jan. meeting)
- **GMC trainee survey results update:** responses from Divisional Directors on action planning had been patchy. Agreed each Division to present their action plans to the Workforce Committee starting with Medicine Division in January. (Divisional Directors)
- **Job Planning:** good progress made in aligning job plans with service needs, reflected in reduction of individual job plans from 48 to 34.
- **Apprenticeship Levy:** agreed levy should be used to support recruitment/development of nursing associates, targeting mature students. A business case would be presented to the Feb/March committee for approval. (SO/AC)
- **Safe Nurse Staffing:** Fill rate for RN/HCA's being sustained at 97% due to robust process, including twice daily huddles to mitigate risk.

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

- **Sickness/Absence process, guidelines for junior doctors sickness absence reporting to consultants (JB update January committee)**
- **GMC trainee survey update – Divisional updates on action plans at committee starting with Medicine in January.**
- **Apprenticeship levy – business case presentation to Feb/March committee (SO/AC)**

Any issues of risk or gap in control or assurance for escalation to the Board	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31st January 2019

Title	**Audit Committee Exception Report**
Chair	**David Noble**
Author (s)	**David Noble**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 13th December 2018 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Reports from Internal and External Auditors Review of BAF and Corporate Risk Register Losses, Special payments, Waivers Standing Orders	

Key areas of discussion arising from items appearing on the agenda

The committee reviewed the management of the BAF and Corporate Risk Register and found that the processes were being followed through the subcommittees of the Board and that they were broadly effective. The Committee noted that there had been some movement in the assessment of risk in the risk register and, with the exception of one entry, agreed that this had been properly reviewed and reflected the risks currently facing the Trust.

The Committee did have concern around the reduction in the risk related to cyber security. The Committee considered that in the light if the perceived increased national risk combined with a recent limited assurance internal audit report and a number of overdue outstanding actions on this report that the level of this risk should be reviewed, in the first instance by the ARC Group, and the results of this review be reported back in the first instance to the Finance Committee.

The Committee were concerned by the increased level of overdue open recommendations from Internal Audit reports, up from 51 to 71. In particular the audits on GDPR and Cyber Security had outstanding actions.

The Committee noted that there continues to be a high level of Salary overpayments and that this is now rigorously reviewed at the Finance Committee.

The Committee reviewed the proposed revised Standing Orders, which are being rewritten in line with the model document and will simplify by removing information contained in other documents. At the next meeting the committee will review the SFIs before putting revised versions to the Board.

Any key actions agreed / decisions taken to be notified to the Board	
Any issues of risk or gap in control or assurance for escalation to the Board	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31st January 2019

Title	**HMT Exception Report**
Chair	**Ms Deborah Needham (Deputy CEO/COO)**
Author (s)	**Ms Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 4th December 2018 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

1. CEO update
2. Divisional scorecards
3. Ibox & Careflow demo
4. NGH/KGH collaboration update
5. Planning update
6. Business cases

Board Assurance Framework entries
1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

CEO update
An update was provided by the Deputy CEO on the monthly NHSI performance meeting, collaboration with KGH, planning for next year and brexit.

Divisional Scorecards
The divisional scorecards were highlighted for information.

Ibox and care flow demonstrations
IT gave a presentation on care flow, with roll out planned to be complete by 31 January 2019. Lee Taylor gave a presentation on ibox which has started to be used on Compton and Walter Tull wards.

NGH/KGH collaboration
Mr Pallot gave a presentation to HMT on the collaboration work with KGH including an introduction to the support which Ernst & Young are providing.

Planning update
Mr Pallot gave an update on the annual planning round including a reminder for the procedure for business case submission.

Business cases
Two business cases were presented to HMT. An electronic management system pilot within outpatients. This will reduce the need for letters and help patients manage their own appointments.

The second was the expansion of ambulatory care to include full funding for weekends and a GP liaison nurse to stream referrals to the most appropriate place.

Both cases were recommended to Finance & Performance committee.	
Any key actions agreed / decisions taken to be notified to the Board Two business cases as noted above	
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.	

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31st January 2019

Title	**HMT Exception Report**
Chair	**Ms Deborah Needham (Deputy CEO/COO)**
Author (s)	**Ms Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 8th January 2019 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

1. CEO update
2. Divisional scorecards
3. HSCN update
4. NHS mail 2
5. Nye Bevan
6. Cancer workshop

Board Assurance Framework entries
1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

CEO update
An update was provided by the Deputy CEO detailing the release of the NHS 10 year plan, the changes which have been identified in the planning guidance, especially the new blended tariff and the risk which this poses. The operational readiness guidance for brexit has been released, whilst there is no detailed guidance providers are being asked to not stockpile.

The £11m cost pressures list was noted and individual meetings will be being held with divisions over the next week due to the affordability of this.

Despite winter pressures, it was noted that our staff are doing a fantastic job in managing the daily challenge with bed capacity & the DCEO noted that the everyday heroes awards judging panel had taken place for the quarter.

It was noted that whilst the CEO is on leave, the DCEO will be acting up and the current Deputy COO's will act up as COO's. Carl Holland taking responsibility for surgery & women's, children's, oncology & haematology divisions. Lee Taylor taking responsibility for medicine and clinical support services.

Divisional Scorecards
The divisional scorecards were highlighted for information.

HSCN
An update was provided by the IT project manager on changes being made to the N3 connection, with a small amount of downtime which will be planned later during quarter 4. Divisions have their business continuity plans in place.

NHS mail 2
An update was provided on the move from NGH to NHS.net emails. This will be taking place before April 2019. Further information will be available as the work progresses.

Nye Bevan
Dr Raghuraman provided an update on the new medical model which commenced on 2nd January. Substantive consultants have formed a rota to ensure early review of patients in the Nye Bevan, with consultant cover from 7am to 10pm.

Cancer workshop
Mr Cooper led a workshop for each division to take time to review their cancer action plans, reasons for poor performance and discuss across divisions any help required.

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.

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 January 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 29 November 2018	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mrs D Needham	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Mortality and Learning from Deaths Update	Assurance	Mr M Metcalfe	**E.**
	10.	Trust-Wide Mortality Case Note Review 12	Assurance	Mr M Metcalfe	**F.**
	11.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**G.**
10:30	**OPERATIONAL ASSURANCE**				
	12.	Finance Report	Assurance	Mr P Bradley	**H.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**I.**
	14.	E&D Progress Report inc WRES update	Assurance	Mrs J Brennan	**J.**
	15.	Gender Pay Gap Report	Assurance	Mrs J Brennan	**K.**
	16.	Operational Performance Report	Assurance	Mr C Holland	**L.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	17.	Refreshing the Clinical Strategy 2019-2024	Assurance	Mr C Pallot	**M.**
	18.	HCP Partnership Update	Assurance	Mr C Pallot	**N.**
	19.	EU Exit Operational Readiness Guidance	Assurance	Mrs D Needham	**O.**
11:40	**COMMITTEE REPORTS**				
	20.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr D Moore	**P.**

Time	Agenda Item		Action	Presented by	Enclosure
	21.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Q.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**R.**
	23.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**S.**
	24.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**T.**
12:00	**25.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 28 March 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).