Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 25th October 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 27th September 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**3**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**4**
09.55	7.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.05	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.15	9.	Operational Performance Report	Mrs C Allen	**7**
10.35	10.	Finance Report	Mr P Hollinshead	**8**
10.55	11.	Human Resources Report	Ms G Opreshko	**9**
11.05	12.	Transformation Programme Newsletter	Ms G Opreshko	**10**
11.10	13.	Self-Certification Return	Mr C Pallot	**11**
Governance				
11.15	14.	Any Other Business		
	15.	**Date & time of next meeting:** 9.30am Thursday 29th November 2012, Boardroom, NGH		
	16.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Minutes of the Trust Board Meeting held in public on
Thursday 27th September 2012 at 9.30am
Boardroom, Danetre Hospital

Present:	Mr P Farenden	Chairman
	Mr C Abolins	Director of Facilities & Capital Development
	Mrs C Allen	Deputy Chief Executive and Chief Operating Officer
	Mr C Astbury	Non-executive Director
	Mr A Foster	Deputy Director of Finance
	Ms S Loader	Director of Nursing, Midwifery and Patient Services
	Mr G Kershaw	Associate Non-executive Director
	Dr G McSorley	Chief Executive
	Mrs G Opreshko	Interim Director of Workforce and Transformation
	Mr C Pallot	Director of Strategy and Partnerships
	Mr N Robertson	Non-executive Director
	Dr S Swart	Medical Director
	Mr P Zeidler	Non-executive Director
In attendance:		
	Mr J Bufford	Interim Head of Corporate Affairs (minutes)
	Mr T Delaney	Head of Communications
	Mr F Evans	Shadow Governor
	Mrs M McVicar	Shadow Governor
	One member of the public	

TB 12/13 52 Apologies and opening remarks

Mr Farenden welcomed the Shadow Governors to the meeting. There were no apologies.

TB 12/13 53 Declarations of Interest

No interests in items on the agenda or additions to the Register of Interests were declared.

TB 12/13 54 Minutes of the meeting held on 25th July 2012

The minutes were agreed. There were no amendments.

TB 12/13 55 Action Log and matters arising

TB 12/13 43: Ms Loader reported that the total cost of the Friends and Family Test was £33k; There were other tests on the system but £11k was directly attributable to the particular software for this test. She was continuing to look for ways to reduce this figure.

TB 12/13 44: The Monthly Infection Prevention Performance Report (TB 12/13 59, below) covered hand hygiene.

TB 12/13 46: Ms Allen would be bringing an update on discharge in October.

TB 12/13 48 Mrs Opreshko's Human Resources Report (TB 12/13 62 below) would cover this.

TB 12/13 56 Chief Executive's Report

Dr McSorley presented his report. He drew attention to the following issues:

- The Annual General Meeting had been a successful meeting with over 100 members of the public attending, a presentation from Dr Timperley on the work of Northampton Heart Centre and a number of questions from the floor.

- The Trust had formally asked to submit its Foundation Trust application in 2013 to allow time to fill the vacancies on the Board and to make some improvements to operational performance. This timetable would be published once formal approval was given.

- The Listening into Action (LiA) programme was proving to be a success and 12 rather than the initially planned 10 pioneer teams had been set up. There would be a feedback in event in February but he would keep Board briefed in the meantime.

The Board of Directors NOTED the report

TB 12/13 57 Medical Director's Report

Dr Swart presented her report. The mortality information had now been formally benchmarked and showed the expected improvement.

While the Trust's mortality figures showed considerable improvement it was important to ensure that it continued to be closely monitored. Accordingly work was continuing in some areas that had been identified as potential outliers. The main issues emerging were linked to data quality and the way in which events were coded. Dr Swart was pleased to report that good progress was being made in building the better links between coders and clinicians that would enable this to be addressed.

Dr Swart also drew Board's attention to the graphs on page 16 -18 of her report which showed reductions in the relative risk rates for mortality from higher risk diagnoses. .

Mr Farenden asked how the Trust would avoid complacency and also how clinicians were responding to this work. Dr Swart planned to continue to give this work a high profile and to closely monitor indicators, especially those from Dr Foster. She reported that clinicians were now much more enthusiastic and recognised the importance of correct coding.

Mr Astbury asked about progress on recruiting information and coding staff. Mr Pallot reported that the Trust was advertising for coders and that the process for recruiting to vacancies in the information team had begun.

In response to a question from Mr Kershaw, Dr Swart confirmed that the project management referred to on page 17 was now in place

Section 2 of Dr Swart's report included the Quality Observatory Scorecard. There was little in this that the Trust was not already aware of. Mr Zeidler asked about benchmarking and progress on emergency re-admissions: Dr Swart explained that this was based on a sample and that audit had shown that some were not in fact re-admissions. Samples varied which made national comparisons difficult.

Mr Zeidler also asked about delayed transfers: Dr Swart reported that in some cases the data included cases where the delay was not caused by NGH.

Mr Robertson asked how the Trust generally compared with others nationally. Dr Swart felt that it was important to compare the Trust with similar hospitals – large teaching hospitals had a very different mix of patients and did not make good comparators. She reported that NGH had the lowest crude mortality rate and very good day case rates. It was also worth noting that NGH's performance was consistently good – which implied robustness in both data and processes.

Mr Robertson asked about the sickness rates – noting that these appeared low for doctors and high for other staff. Mrs Opreshko noted that more up to date figures were available which showed that this had improved – and that work was being done to improve sickness rates. Medical under-reporting of sickness was common, although it was also noted that doctors generally did have low rates of sickness absence.

Dr Swart also drew Board's attention to the following issues in her exception report:

- Considerable work was under way on mandatory training.
- A never event had been recorded involving wrong site surgery; while lessons were being learnt from this it was a case where treatment had been effective and the patient was satisfied.
- The visits of Executive and Non-Executive Directors to theatres as part of the Safer Surgery week and the WHO checklist work were under way – and appreciated by staff.

The Board of Directors NOTED the report.

TB 12/13 58 Patient Experience – Friends and Family Test

Ms Loader introduced her report. The score for August was 57; which was not as good as hoped. Part of the problem was the lack of manual surveys achieved. As a result work to make it easier for patients to return and the Trust to collect feedback (for example by improving the visibility of collection points). It was proposed to continue collecting data by both methods.

The manual score was improving and the Trust had received more positive than negative comments (207 as against 152). Food was one of the key areas for improvement that had been flagged. Mr Abolins was now looking to get more detailed comments from patients so that work could be done to address patient concerns.

A second area of work was to look at the way in which staff communicated with patients. Ms Loader and Mrs Opreshko were working to improve staff attitudes. Ms Loader also explained that the reason for a large number of comments being categorised under “generalised” on page 35 was due to non-specific comments being made.

Mr Farenden asked if the learning from Sherwood Forest NHS FT (the Trust with the best score) was being taken on board – Ms Loader reported that it had. Mr Zeidler asked how the Trust compared nationally: Dr McSorley explained that the Friends and Family Test had only been rolled out in the East Midlands but the Trust was now in the upper quartile.

The Board of Directors NOTED the report and APPROVED the continued dual collection of patient experience data

TB 12/13 59 Monthly Infection Prevention Performance Report

Ms Loader introduced the report. The Trust had had two post 48 hour cases of MRSA. C.diff was slightly below trajectory – which was positive as cases were likely to be higher in the winter.

Matrons continued to focus on hand hygiene. Having trialled peer-review audits alongside the existing self-assessment it had been found that these were more accurate. Accordingly matrons were now looking at ways in which peer review could be rolled out.

The Board of Directors NOTED the report and supported the roll out of peer reviews

TB 12/13 60 Operational Performance Report

Ms Allen presented her report. In August the A&E figure was 92.8%, bringing the year to date performance to 93.43%. A detailed action plan was in place. The Trust had achieved referral to treatment (RTT) times for all specialties. The Trust was focusing on incomplete pathways – all patients had plans in place.

In terms of the cancer standards the Trust achieved 82.2% against 85% target for the urgent referral to start of treatment standard in August. The Trust was still on track to meet the quarterly standard. The Trust achieved 87.5% against 90% for the 62 day screening standard – but it should be noted that the numbers of patients were very low.

The Board of Directors NOTED the report and supported the actions being implemented to improve performance which would be kept under continuous close review.

TB 12/13 61 Finance Report

Mr Foster introduced the report. The position had deteriorated in August. The Year-to-date deficit was £4.6m, £1.1m worse during August and, project forward; this would lead to £10m at the end of the year. The Trust had plans to cover approximately £8m of this leaving a further £3m to be found if it was to meet its planned £1m surplus.

The audit of re-admissions would reduce the level of "fines" that the PCT would impose and there had been a successful bid for PCT monies to fund emergency care work.

Mr Foster drew Board's attention to the Trust's cash position –payment of the Treasury's PDC in September meant that this was becoming increasingly tight. Mr Farenden asked that Mr Foster bring a paper detailing options to handle this be brought to the October Board meeting.

Action: Mr Foster

The Board of Directors expressed its disappointment at the deterioration of the financial position and requested a paper outlining proposed actions and a clear year end forecast for the October meeting.

TB 12/13 62 HR Report

Mrs Opreshko presented her report. The report was now based on August figures in line with the rest of the Trust's reports. August had seen an increase in temporary staff use (due to the holiday season) a decrease in sickness absence (not unexpected in the summer). Although long term sickness had not yet shown a decrease she was confident that this would change as the initiative to support wards in tackling long term sickness was beginning to bear fruit.

Mr Robertson noted the scale of the problem and the potential costs. Mr Kershaw felt that culture was important and that line managers were supported in dealing with staff. Ms Allen agreed with Mr Kershaw and reported that she and Mrs Opreshko were working together. Ms Loader felt that ward sisters were grasping the issue.

Information on sickness was being looked at – at present data was often provided late. It was planned that in the next six months this would start to become available in real time and would also be available for analysis to identify patterns and potential problems.

Dr McSorley outlined several strands of work that were building cultural changes across the organisation. These included employee relations, the Listening into Action programme, quality strategy and plan to recruit permanent staff to avoid the use of temporary staff. All of these would help staff feel valued and impact on sickness absence.

Mrs Opreshko drew Board's attention to the way in which appraisals were reported. As most appraisals were carried out at the end of the year the existing indicator was not helpful in reflecting performance against a realistic target. Mr Kershaw agreed and Mr Zeidler suggested that a rolling target would be most appropriate. Mrs Opreshko would amend the target

Action Mrs Opreshko

Mrs Opreshko also drew attention to the mandatory training figure which at 57.1% seemed low. However, this had to be looked at in the context of every job role having up to 23 competencies – across the organisation there were nearly 100,000 competencies to be covered. The big issues were staff booking onto courses but not turning up or cancelling at short notice.

Mr Zeidler asked whether figures could be made available for the number of staff achieving 100% mandatory training. Mr Farenden asked Mrs Opreshko to work with Ms Allen and Ms Loader to bring a proposal for tackling this issue to the October meeting.

Action: Mrs Opreshko

Ms Loader updated Board on nurse recruitment. The nursing ward staff would be at establishment at the end of November. They would undergo 3-week skills/orientation training before working on the wards. The Healthcare Assistant recruitment exercise was successfully under way and she was confident that all vacancies would be filled – these staff would also be fully trained before being placed.

Mr Astbury asked about the Trust's ability to retain staff. Ms Loader noted that NGH had very good retention rates compared to its peers.

Dr McSorley noted that staff involved in the Listening into Action exercise were developing a plan to help streamline the recruitment process.

The Board of Directors NOTED the report and supported the actions being taken to address the issues of concern.

TB 12/13 63 Transformation Programme Newsletter

Dr McSorley suggested that Mrs Opreshko look at the developing the report to focus on the challenges as well as achievements.

Action: Mrs Opreshko

The Board of Directors NOTED the newsletter and looked forward to receiving the next report which would include challenges as well as achievements

TB 12/13 64 Provider Management Self Certification

Mr Pallot outlined the new format of the self-certification report. The governance risk rating was amber because of the A&E performance and it was proposed that the financial risk rating (FRR) should be 1.

The Board of Directors APPROVED the signing of the PMR f

TB 12/13 65 Equality and Human Rights Annual Report

Mrs Opreshko presented the report. It was a statutory duty of the Trust to present the report annually to Board. She had not included all the details of appendix two in the report but this was available on request.

Mr Robertson noted that that section 3.2 on page 149 should be coloured amber, not green.

The Board of Directors NOTED the report

TB 12/13 66 Seasonal Plan

Ms Allen introduced the report. Winter planning was embedded in the detailed work to look at demand had been carried out. Work had also been done to reinforce the discharge process at ward level. Plans were in place to avoid excessive use of temporary staff.

Mr Farenden asked whether the Trust was working with social services, and how successful this had been; Ms Allen confirmed that plans were coordinated through the PCT/CCG and that there had been some success in influencing social services.

Mr Pallot would ask commissioners to ensure that they have commissioned enough capacity through the winter.

The Board of Directors NOTED the report and looked forward to receiving assurances that sufficient capacity will be available to manage winter pressures

TB 12/13 67 Fire Safety Report

Mr Abolins presented his report. The Trust had upgraded its fire systems in the year and made other fire safety investments. Attendance at fire safety training was up by 10%. He appended the Department of Health Fire Safety Certificate to the report.

The Trust only had one fire safety officer and Mr Kershaw queried whether this was satisfactory. Mr Abolins was looking at arrangements whereby cover for this post, if needed, could be obtained from other neighbouring Trusts – this would mitigate the risk of technical advice and training not being available in case of absence. Mr Robertson asked for confirmation of which areas the report covered: Mr Abolins confirmed that it covered only sites that the Trust owned.

Mrs Opreshko noted that the fire training was a legal requirement for all, including the Board; Mr Bufford would add this to the Board training agenda.

Action: Mr Bufford

The Board of Directors NOTED the report and supported the recommendations

TB 12/13 68 Any Other Business

Mr Farenden noted that Mike Essery, Shadow Lead Governor had stood down from his role and expressed his grateful thanks to him for his considerable contribution to the work of the Board and the Shadow Council of Governors over a number of years

The Board of Directors recorded their thanks to Mr Essery for his hard work and contribution to the Trust

TB 12/13 69 Date of next meeting: October 25th 9.30 Boardroom NGH

Action Log for the Board meeting held in public at 27 September 2012

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 46	Performance Report	25 July 2012	Board to be briefed on progress to tackle discharge	Ms Allen	October 2012	
TB 12/13 61	Finance Report	27 Sept 2012	Prepare proposals for cash position management	Mr Foster	October 2012	
TB 12/13 62	Human Resources Report	27 Sept 2012	Prepare new appraisal reporting target	Mrs Opreshko	October 2012	
TB 12/13 62	Human Resources Report	27 Sept 2012	Prepare proposals for addressing poor completion of mandatory training	Mrs Opreshko	October 2012	
TB 12/13 63	Transformation Newsletter	27 Sept 2012	More challenging newsletter to be developed	Mrs Opreshko	October 2012	
TB 12/13 67	Fire Safety report	27 Sept 2012	Board fire safety training to be added to the Board training agenda	Mr Bufford	October 2012	

Key	
	Completed or on agenda
	On Track
	To be reported at this meeting
	Some slippage

BOARD SUMMARY SHEET	
Title: -	Chief Executive's Report
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	25th October 2012
Corporate Objectives Addressed: -	All
SUMMARY OF CRITICAL POINTS: -	
PATIENT IMPACT: -	
STAFF IMPACT: -	
FINANCIAL IMPACT: -	
EQUALITY AND DIVERSITY IMPACT: -	
LEGAL IMPLICATIONS: -	
RISK ASSESSMENT: -	
RECOMMENDATION: - The Board is asked to note the report.	

CHIEF EXECUTIVE'S REPORT
OCTOBER BOARD MEETING

1. Official Opening of the new Haematology Unit

The official Opening of the new Haematology Unit by Lady Halifax, National President of Macmillan Cancer Support took place on the 16th October and was a great success. I would like to thank all involved in this project over a number of years.

2. Handwashing Champion

A Northampton General Hospital healthcare assistant has been presented with a national award for Hand Hygiene Champion of 2012 by the Infection Prevention Society (IPS).

Christopher Head was awarded the honour for his proactive and enthusiastic teaching of effective hand hygiene - not just to hospital staff, but also to children and adults in his local St John Ambulance group.

3. Brachytherapy Coverage

In October 2011, NGH introduced a treatment called high dose rate (HDR) brachytherapy - an innovative form of internal radiation therapy for the treatment of cancer. On the first anniversary of his successful operation, the first patient we treated with this technique has praised the staff of Northampton General Hospital for his care.

4. Healthier Together

There has been much coverage of the impact of the emerging, but not yet agreed, models of care proposed for the South East Midlands. As the Corby and East Northampton by-election is imminent the programme will become subject to the normal election guidance.

Dr Gerry McSorley
Chief Executive
October 2012

BOARD SUMMARY SHEET	
Title	Medical Director's Report – Mortality, Clinical Scorecard & Exception Report
Submitted by	Dr Sonia Swart
Prepared by	Dr Sonia Swart
Date of meeting	October 25 2012
Corporate Objectives Addressed	To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred.

SUMMARY OF CRITICAL POINTS

Significant progress has been made to ensure improving clinical outcomes as illustrated by the falling mortality rates at NGH. There will continue to be a focus on improving on patient safety, improving patient experience and improving flows of information. The work on the redesign of the emergency pathway has started and there is now increased focus and support for patient safety work. The need to ensure that there are clear and robust measures for quality remains paramount. The quality scorecard is presented with an exception report.

PATIENT IMPACT

High quality care for patients remains a priority. Patients can view quality indicators in the public domain and commissioners will increasingly commission on the basis of quality.

STAFF IMPACT

Staff morale relating to failure to deliver high quality care in the face of increasing emergency pressures and adverse publicity relating to the NHS has been a recognised issue. The current projects designed to focus primarily on quality and ensuring that staff are able to deliver should improve matters.

FINANCIAL IMPACT

The ability to continually drive forward quality is increasingly important and will also affect our income. Investment in quality is likely to reduce cost in the long term.

LEGAL IMPLICATIONS

Trust Boards are mandated to examine quality across a range of services and failure to provide requisite quality standards will result in the risk of litigation. The high number of NHSLA claims compared to our SHA should be noted.

RECOMMENDATION

Board members are asked note the report and to challenge and debate the issues raised

Mortality, HSMR 2011 - 12
Review of Current Mortality and Safety Data provided by Dr Foster

1. Introduction

This paper provides a brief summary relating to mortality and safety indicators provided by Dr Foster

2. Current Position HSMR

The HSMR for the first four months of 2012/13 is **95** (346 deaths versus 364 expected deaths) which is predicted to rise to 101 after re-benchmarking.

There continues to be a need to ensure that there is an improved understanding of the issues relating to the recording of primary diagnoses, secondary diagnoses and palliative care coding as reflected by the fact that the rate of palliative care coding is 2/3 of the national rare and the Charlson co-morbidity score is lower than average (88 versus an average of 100). In addition there remain issues with the recording of primary versus secondary diagnosis for some diagnoses such as secondary malignancy, diabetes and senility.

For July the HSMR was **92.3 (**80 deaths, 87 expected).

3. Weekend Mortality issues

There is renewed interest in the subject of the increased mortality of patients admitted at the weekends. This is a problem that has been recognised in the UK and also world-wide. Last year some hospitals were listed as having a greater than average increase in weekend mortality. There is considerable debate as to whether the Dr Foster tool adequately examines the risk profile of patients admitted at the weekend. Certainly the volume of admissions is lower and the case-mix is different. Standardised mortality ratios remain a crude measure in terms of assessing the acuity of the patients. The SMR for patients admitted at the weekend at NGH is higher (117) than for those admitted during the week although this figure has improved compared to previous years. However for key conditions where there has been a focus on care the weekend mortality rate has decreased. For Stroke patients the SMR for weekend patients has fallen from **130** in 2011/12 to **79** in 2012/13. For Vascular Procedures it has fallen from **98** in 2011/12 to **46** in 2012/13. Regardless of the precise explanations for variation of mortality for patients admitted at the weekend it is clear that there will need to be a focus on an improved level of medical input and greater availability of investigations during the weekends.

4. Acute Trust HSMRs April 2011 - March 2012

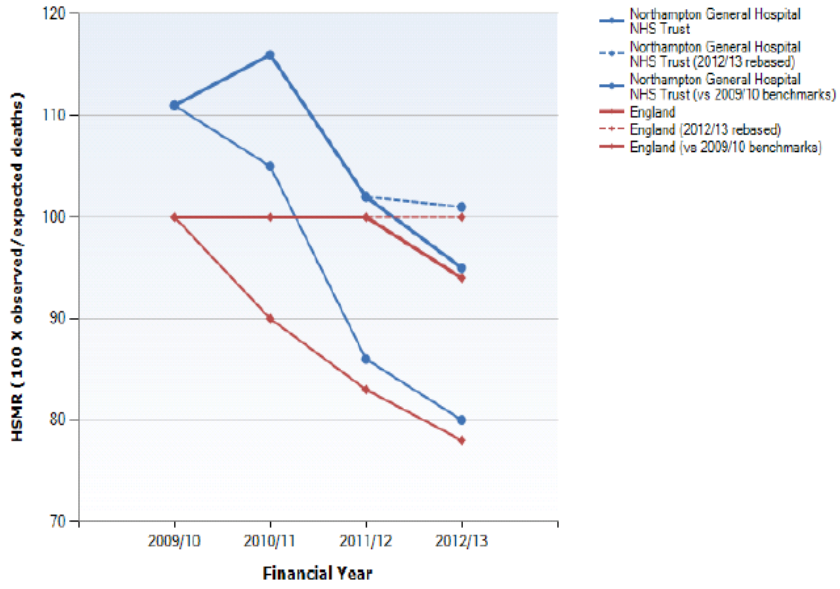
NGH is not an outlier with respect to mortality as measured by HSMR as shown below.

The background points show the HSMR (rebased) for the first quarter of 2012/13 for each acute non specialist Trust in England.

The Board is reminded that the rebased position reflects the fact that each year the mortality figures improve for all Trusts.

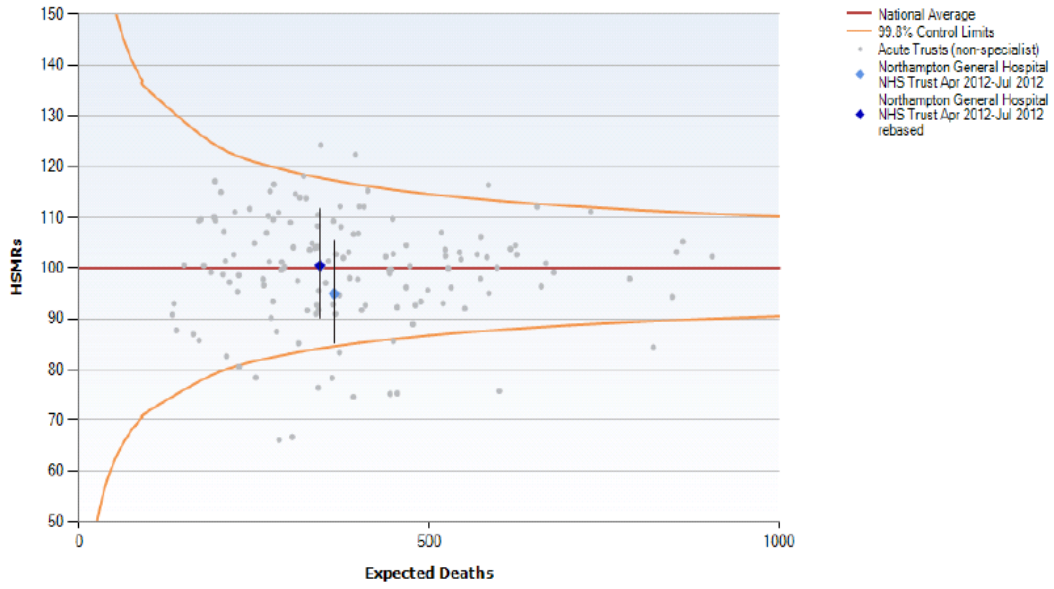
HSMR Trend

Trend in HSMR



Acute Trust HSMRs Apr 2012-Jul 2012

The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England. Use the controls below to toggle between the current and rebased values.



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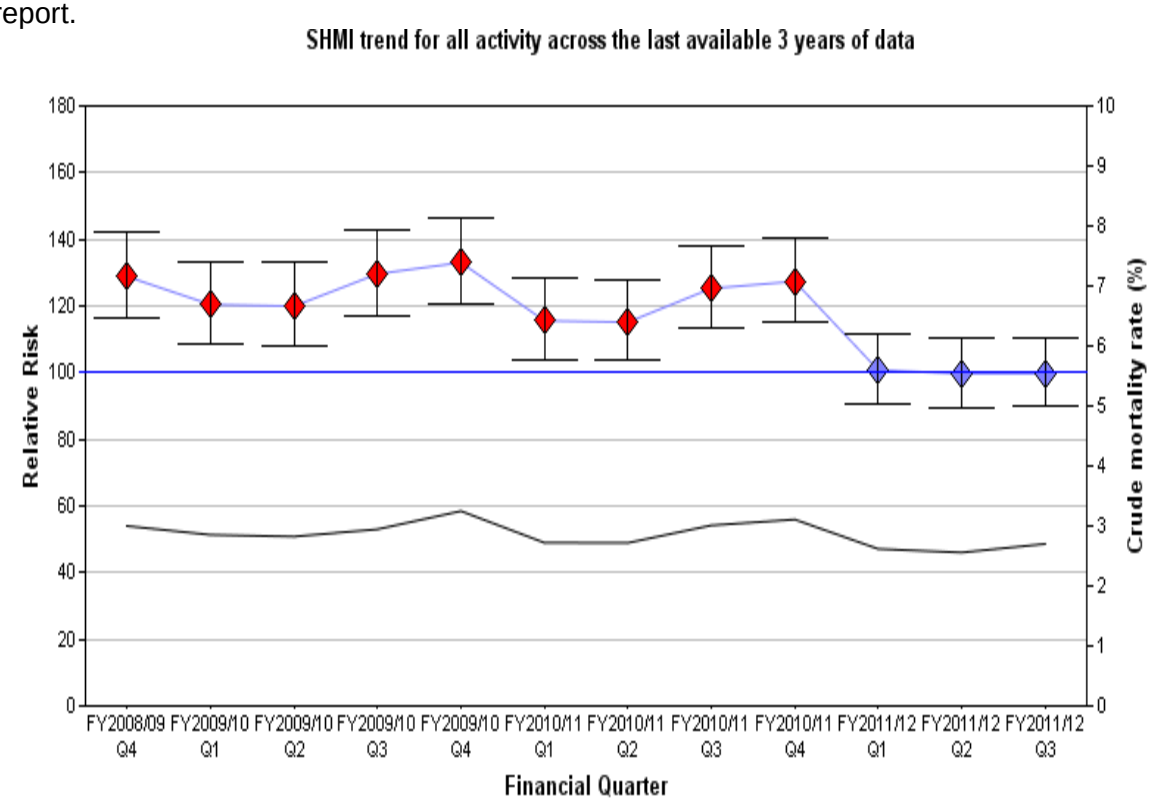
5. Standardised Hospital Mortality Indicator (SHMI)

There is no updated figure for the SHMI. The graph is the same one included in last month's report.



At present, the SHMI roughly mirrors the HSMR for NGH. The latest SHMI is reported on rolling 12 months basis and shows an improvement from 114 for the financial year April 2010-April 2011 to **106** (period up to December 2011 – rolling 12 months). The quarterly position for the first 3 quarters of 2011/12 is as expected at **99.6.** In addition crude mortality fell during this period from 3% to 2.6%. The SHMI is benchmarked each quarter unlike HSMR which is benchmarked at the end of the year**.**

6. Dr Foster Patient Safety Indicators (March 2011 - March 2012)

There are currently no concerns in relation to the Dr Foster Patient Safety Indicators. The previous alert relating to obstetric trauma related to a data issue which has been corrected.

Aug 2011 to Jul 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		23	24.6	0.64	0.68	more information
Decubitus Ulcer		111	194.4	12.85	22.51	more information
Deaths after surgery		41	31.7	138.51	107.25	more information
Infections associated with central line*		0	0.8	0.00	0.05	more information
Post-operative hip fracture*		0	1.7	0.00	0.07	more information
Post-op Haemorrhage or Haematoma		4	13.6	0.17	0.58	more information
Post-operative physiologic and metabolic derangements*		0	1.6	0.00	0.08	more information
Post-operative respiratory failure		10	13.7	0.53	0.72	more information
Post-operative pulmonary embolism or deep vein thrombosis		25	38.2	1.06	1.62	more information
Post-operative sepsis		5	4.5	6.80	6.06	more information
Post-operative wound dehiscence*		2	1.1	2.22	1.18	more information
Accidental puncture or laceration		25	74.0	0.38	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		22	38.6	47.11	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		94	89.2	39.40	37.37	more information
Obstetric trauma - caesarean delivery*		6	4.3	4.75	3.43	more information

Key

A red bar signifies an indicator for which the lower end of the 95% confidence interval is above the national average.

A green bar signifies an indicator for which the higher end of the 95% confidence interval is below the national average.

A blue bar signifies an indicator for which the relative risk equals the national average value within 95% confidence.

* For indicators marked with an asterisk expected values are derived from the national average crude rate and are not casemix adjusted.

7. Reports on Key Areas for action or of importance:

a) Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease, Pneumonia. Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur** has been within acceptable parameters and steadily improving during 2011/12. This has remained the case in the first 4 months of 2012/13 with the exception of fractured neck of femur. There is an on-going audit of these patients and it has been noted that there may be some issues relating to the attribution of patients in community hospitals. This will be investigated further.

b) Possible areas for Concern under investigation

Analysis of performance in 2011/12 has been undertaken to identify diagnosis groups responsible for the highest number of deaths and highest SMR to inform the Mortality and Coding Group which will be re-established before the end of 2012. These include diagnoses already under review e.g. secondary malignancies, “senility”, diabetes and also new areas of concern. The work to investigate the concerns relating to senility and secondary malignancy indicates that there are data issues relating to the relative use of primary versus secondary diagnoses rather than any specific issues relating to quality of care. When the denominator includes all primary and secondary codes for these conditions there is no excess mortality.

8. Further Comments and Actions Planned

The detailed monitoring process based on the use of the Dr Foster Intelligence tool will continue and the planned work to examine information flows has now been commissioned and will commence shortly. A new coding manager is now being recruited and the mortality coding group will be revised and strengthened to ensure that the improved clinical engagement with these issues is sustained and continually improved.

Issues emerging from the reviews and monitoring will be linked into the current improvement work underway as part of the emergency care redesign project and the patient safety programme.

The Trust Board asked to note the contents of this report.

Section 2

1. NGH Monthly Quality Scorecard and NGH Monthly Quality Scorecard

The indicators in this scorecard match those required by our commissioners and by the provider monitoring framework required by the SHA, although further work is required to ensure that the alignment is accurate.

Performance is reported by exception, i.e. where performance is below standard (red), where specific pressures that present a risk to the ongoing achievement of any of the standards or where there are high profile issues. Commentary and associated actions are provided against the identified non-compliant indicators.

Further work is required to ensure that all measures are relevant and timely to facilitate on-going comprehensive monthly reporting. This report includes both current and previous CQUIN measures. HSMR is year to date. A continual process of refinement of indicators is required and this will include new indicators to monitor the safety improvement programme and the emergency pathway redesign project.

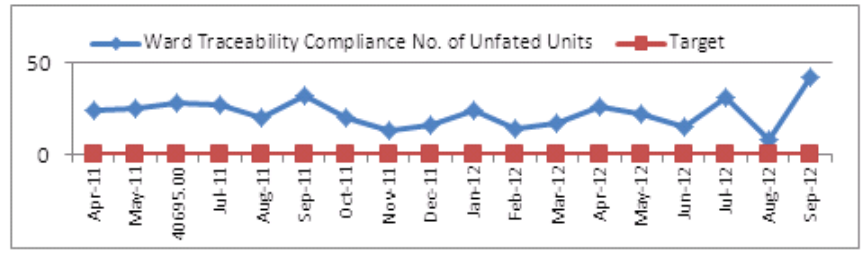
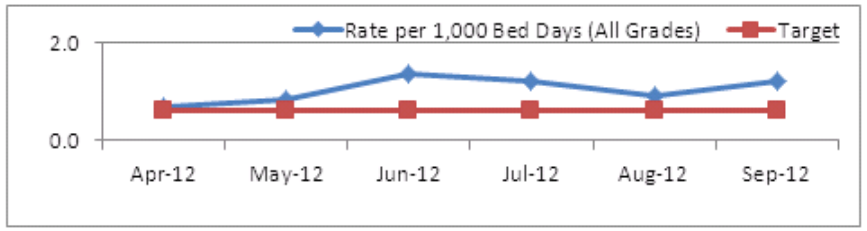
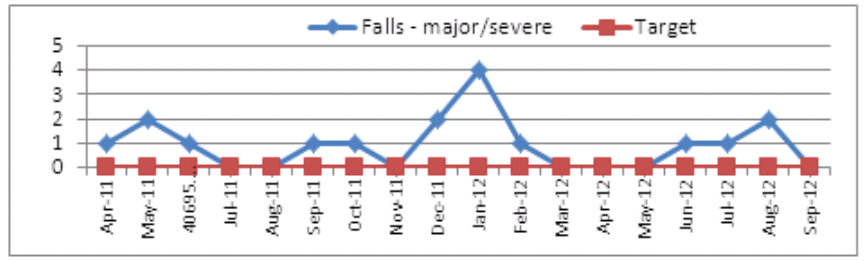
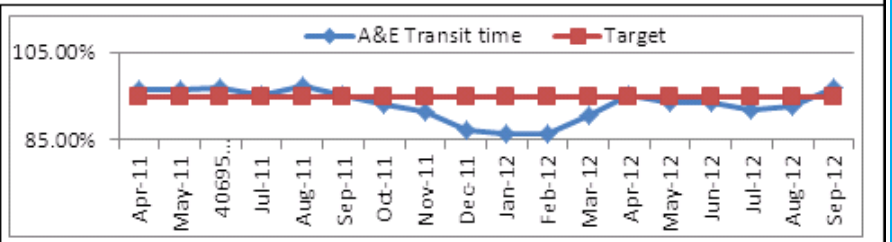
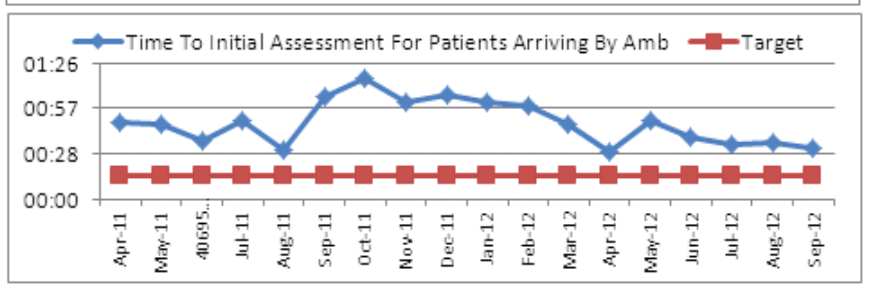
Of 116 indicators, **34** (**17/17**) are rated as either red or amber status. This report outlines the underperforming indicators and details the remedial action(s) being taken. There are still 14 indicators that are rated grey. This is because either baseline data is still to be agreed or information is currently not available.

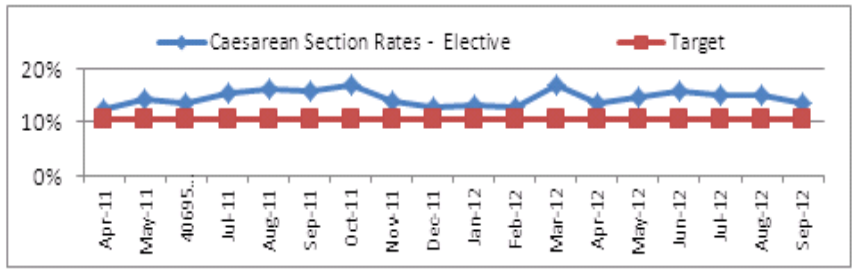
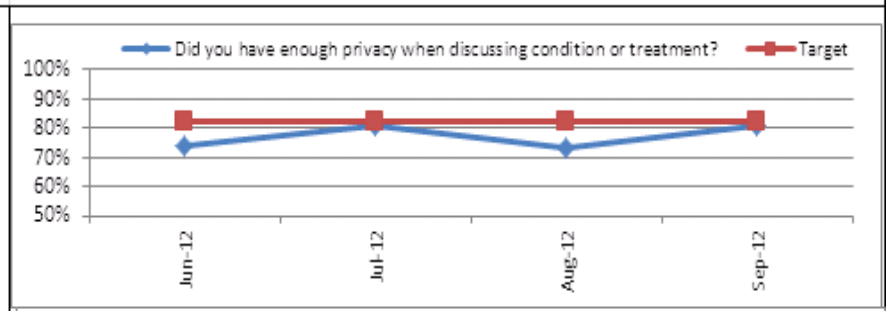
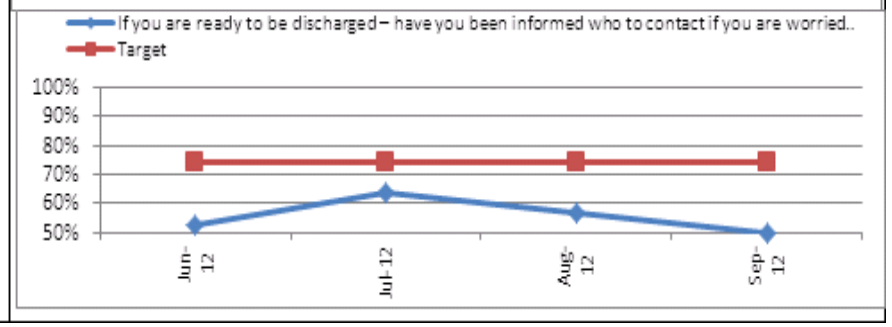
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**2**	**5**	**21**	**7**
Clinical Outcomes	**5**	**6**	**11**	**3**
Patient Safety	**4**	**2**	**15**	**4**
Patient Experience	**5**	**4**	**21**	**1**
TOTAL	**16**	**17**	**68**	**15**

The Board is asked to note this scorecard and debate any issues that arise from it.

EXCEPTION REPORT – SEPTEMBER 2012

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	**Ward Traceability Compliance Number of Un-fated Units**	0	↓ **81**	Ward Traceability Compliance Number of Un-fated Units - There were 81 cases of un-fated units in Q2 2012-13 against a total of 63 for Q1 2012-13. Ward and directorate managers are notified daily of un-fated units which allows immediate investigation. Monitoring of unfated cases has been added to the weekly performance meeting.	
Patient Safety	**Incidence of Pressure Ulcers** **Rate per 1,000 Bed Days (All Grades)**	0.6	↓ **1.11**	This target was not achieved throughout Q2 with an average rate of 1.11 in comparision to 0.95 in Q1. RCA tool for all grade 2 pressure ulcers in development. Training planned for all RNs and HCAs on a monthly basis commencing Q3. E-learning for PU prevention developed.	
Patient Safety	**Reduce harm from falls Major/Severe**	0	↓ **3**	There were no falls in this category reported in September 2012, however there were a total of 3 for Quarter 2. This contrasts with only 1 in Quarter 1. Poor complaince with completion of falls care plan discussed with Matrons and will improve with uptake of national e-learning package.	
Patient Safety	**Never Events**	0	↓ **1**	Third independent WHO audit completed in August incorporating direct observation, self reporting and records review. Formal records of training utilising the WHO DVD have commenced, cascade training remains in place. Educational DVD now part of midwifery induction. All theatres monitoring SSI compliance bundle.	
Patient Experience	**A & E Quality Indicators (5 indicators)**		↔	**A&E Clinical Indicators:** Transit time target The Trust has not delivered the 95% A&E transit time target in quarter 2 (93.8%) but remedial action plans have been developed and put in place that enabled the trust to achieve 96.9% in September. The time to initial assessment for patients arriving by ambulance was 32 mins with the national target being 15 minutes. The Trust is investing in increased medical and nursing staff to improve the clinical care in A&E and redesigning emergency pathways to improve flow through the hospital whilst continuing to focus on quality, safety and patient experience.	 

Patient Experience	**PROMS Scores**	80%	↓ **71.8% Overall Score**	The Trust is reliant on national data for this indicator. The overall score of 71.8 reflects the latest figures (August 2012) for the period Apr-11 to Mar-12. This is a slight reduction on the previous score of 72.8 (May 2012) for the period April 11 to Dec 11.	
Clinical Outcomes	**Elective Caesarean Section Rates**	10.6%	↔ **13.8%**	Ongoing issue with elective caesarean section rate. Emergency caesarean section remains lower than national average. Action plan developed May 2011 and monitored quarterly at Obstetric Governance Group and 6 monthly at Integrated Healthcare Governance Meeting. All caesarean sections audited and reasons compliant with NICE guidance. Re-audit commenced 1st April 2012. On Risk register	
Clinical Outcomes	**HSMR Fracture of neck of femur (hip)**	<100	↓ **148**	Mortality for Fractured Neck of Femur is rising in this finacial year, some deaths are ocurring in community hospitals and may not be attributable to surgery at NGH. Further investigations are under way.	
CQUIN	**Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)**	1. 82.3% 2. 74.3%	↔	There are 5 quality questions as part of the CQUIN. Two of the 5 questions for improving responsiveness to personal needs of patients have returned as under target. These being: 1. Did you have enough privacy when discussing condition or treatment? (81% against a target of 82.3%) 2. If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital? (50% against a target of 74.3%) These responses are currently collected via the Hospedia system which is in the process of constructive review .	 

CORPORATE SCORECARD SEPTEMBER 2012

Corporate Scorecard 2012-13								
Patient Safety	**Target 2012-13**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**RAG**
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	1	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	2	
HQU08: MMSA Numbers	0	0	0	0	0	0	0	
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	1	
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	
MRSA Screening Elective Patients	100% month on month	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	
MRSA Screening Non-Elective Patients	100% month on month	95.4%	95.5%	96.3%	96.7%	94.6%	95.0%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	42	
Incidence of pressure ulcers								
Type 3	0	0	2	2	1	0	3	
Type 4	0	1	2	0	0	0	0	
Rate per 1,000 Bed Days (All Grades)	0.60	0.70	0.82	1.34	1.21	0.91	1.21	
Reduce harm from falls								
Catastrophic	0	0	0	0	0	0	0	
Major/Severe	0	0	0	1	1	2	0	
Moderate	0	2	2	3	0	0	1	
Mandatory Training compliance Full Year Impact								
Primary Levels Excluding B&H	80%	104.67%	90.14%	80.64%	59.42%	57.71%	Not avail	
Attendance at Trust Induction	80%	88.14%	87.70%	87.70%	87.80%	81.40%	Not avail	
Number of surgical site infections								
Frac neck of femur Number of Operations		27	29	21	26	53	26	
Infections	0	0	1	0	0	0	0	
Breast Surgery		30	40	29	38	30	38	
Infections	0	0	0	0	0	0	0	
Limb Amputations		11	7	10	16	12	7	
Infections	0	0	0	0	0	0	0	
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc								
Open Central Alert System (CAS) Alerts	0	1	0	0	0	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	84.2%	
Serious Untoward Incidents	-	12	3	9	5	4	5	
Never Events	0	0	0	0	0	1	0	
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	
Patient Experience	**Target 2012-13**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**RAG**
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%	0%	
Hospital Cancelled Operations	6.0%	5.9%	7.1%	8.9%	5.7%	5.3%	5.3%	
Number of written complaints received		50	51	39	48	33	35	
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	83%	Avail end of Oct		
Referral to Treatment waits								
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.99%	96.34%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.46%	98.40%	
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.53%	97.10%	
A&E Quality Indicators (5 measures)								
Time Spent in A&E (Month on Month)	95%	95.05%	93.37%	93.33%	91.98%	92.80%	96.89%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	93.38%	93.27%	93.87%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	03:59	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:30	00:50	00:39	00:35	00:36	00:32	
Time to treatment decision (median)	<60 mins	00:46	00:54	00:54	00:52	00:42	00:48	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	0.95%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	3.50%	0.18%	0.18%	
Cancer Wait Times								
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.5%	96.3%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.4%	100.0%	
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	96.3%	
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	
31 day second or subsequent treatment - radiotherapy	94%	100.0%	99.2%	100.0%	98.5%	99.2%	98.1%	
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	87.5%	75.0%	
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	84.2%	85.2%	
SRS08: Length of Stay (Acute & MH)								
Elective	3.20	3.70	4.1	4.2	4.1	4.2	5	
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	4.9	
SRS09: Daycase Rate	85%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	
SQU11: PROMS Scores - Pre Operative participation rates								
Groin Hernia - Participation Rate	t.Ave 60.5% (target 80		42.30%			48.20%		
Hip Replacement - Participation Rate	t.Ave 82.0% (target 80		97.40%			91.40%		
Knee Replacement - Participation Rate	t.Ave 87.5% (target 80		94.90%			88.20%		
Varicose Vein - Participation Rate	t.Ave 49.1% (target 80		31.10%			33.30%		
All Procedures - Participation Rate	t.Ave 74.0% (target 80		72.80%			71.80%		

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	
HSMR - cumulative position for 2011-12 (Rebased Sept-12)	<100				101.9			
HSMR - cumulative position from Apr 12 - July 2012		NA	NA	85.0	95.0			
SMR- cumulative position for 2011-12								
Pneumonia	<100				47.4			
Fracture of neck of femur (hip)	<100				148.0			
Acute Cerebrovascular disease	<100				86.0			
Congestive heart failure, nonhypertensive	<100				83.7			
Acute myocardial infarction	<100				66.5			
HSMR (Rolling 12 months Aug 11 to Jul 12)					96.6			
SHMI *(to Dec-11 rolling)*					106.0			
SQU12: Maternity 12 weeks	90%	86%	97%	86%				
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.6%	3.0%	2.7%	3.4%	2.5%	3.1%	
Fractured neck of Femur								
Number of patients admitted with FNOF	-	27	30	21	26	52	26	
Patients fit for surgery within 48hrs	-	21	23	13	25	47	22	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	22	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	100%	
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	84%	83%	
25% of suspected stroke patients given CT scan within 3 hours of arrival	25%	68%	77%	75%	67%	70%	54%	
75% of suspected stroke patients given CT scan within 24 hours of arrival	75%	95%	100%	96%	97%	97%	83%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hc	60%	68.0%	75.0%	90.9%	71.4%	95.8%	76.5%	
Patients who spend at least 90% of their time on a stroke unit	80%	100.0%	95.6%	96.7%	81.9%	82.9%	85.4%	
Breast Feeding initiation	75%	73.6%	74.6%	76.6%	76.1%	73.7%	73.1%	
Caesarean Section Rates - Total	<25%	25.1%	25.6%	27.1%	25.1%	28.5%	26.9%	
Caesarean Section Rates - Emergency	14.98%	12.1%	11.0%	11.2%	9.8%	13.3%	13.7%	
Caesarean Section Rates - Elective	10.06%	13.6%	14.6%	15.9%	15.3%	15.2%	13.8%	
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.4%	6.8%	

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	RAG
National CQUINS								
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	
1b. High risk patients receive appropriate treatment *(inadequate volume of data Q2)*	100% Month on month	94.9%	96.3%	93.7%	90.6%	82.9%	85.0%	
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)								
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0			69.7%	78.0%	63.2%	74.6%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4			74.9%	84.0%	66.6%	83.2%	
Did you have enough privacy when discussing condition or treatment?	>82.3			73.8%	81.0%	73.1%	81.5%	
If you have been prescribed any new medication, have you been informed of any possible medication side	>48.5			47.8%	51.0%	55.9%	52.2%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your	>74.3			52.7%	63.6%	56.5%	50.0%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting								
a) Dementia case finding	90%							
b) initial diagnostic assessment	90%							
c) referral for specialist diagnosis	90%							
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a	-							
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG							
Regional CQUIN								
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%	12.0%	15.3%	10.1%	
2. Board and Commissioner reporting	Submission to HCG							
3. Weekly reporting	-							
4. Performance improvement by 10%	10 point improving	- 29.98	- 30.86	0.42	70.10	56.83	74.08	
Local CQUINS								
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	-							
2a. Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	-							
2b. Appropriate referrals to CECs/ Intermediate service from A&E								
3a. Accuracy of medicines information on discharge	75% error free							
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	-							
3c. Oral nutritional supplements (ONS) - reduce the use of ONS	Q2 & Q4 Audits - stretch targets to be							
3d. Triptorelin	Qu Audit 10% increase on 50% baseline (80% @Q4)							
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.								
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	uarterly Updates interr Quarterly Updates Primary Care							
MESCG CQUINS								
1. Quality Dashboards	-							
Identify and provide contact details of the following:								
- an overall dashboards lead for the Provider								
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-							
Provide a summary setting out the plans for implementation of the dashboards within the required								
3. Use of Intensity Modulated Radiotherapy	Target to be derived from Q1 data							
4a. Cancer Chemotherapy Performance Status	-	17.8%	20.1%	22.6%	19.7%	18.4%	19.8%	
4b. Cancer Chemotherapy Performance status 2 or above		-	-	100%	100%	-	100%	
4c. Improve appropriate assessment and Improve mortality rates								
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy		0.10%	0.43%	0.27%	0.25%	0.39%	Not avail.	
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy		0.00%	0.00%	0.00%	0.00%	2.12%		
5. Hepatitis C. Compliance with treatment / improved patient outcomes	-							
7. Reduction of catheter - related CONS	7% Baseline 2011-12	0%	0%	0%	0%	0%	0%	

Monthly data submitted for all ward areas from Apr 12.
Theatre recovery area submission from June 12.

Submitted to HCG
Target from Q2

Baseline audit undertaken

Audit agreed and currently in progress

Baseline audit 50 cases in Q1

Q4 primary care audit, internal assurance programme being formalised

sent to PCT for approval, meetings to be arranged with relevar

Data collection in progress for submission by the end of October-12

Monthly audit currently being undertaken. Data validation is ongoing

Further clarification required from the commissioners

Confirmed
Clinical Directors (TBC)

Q1 9%

Awaiting Q2 data

Quarterly audit undertaken

BOARD SUMMARY SHEET	
Title	Patient Experience – Friends and Family Test
Submitted by	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Prepared by	Jan Grant, Patient Experience Lead (Interim)
Date of meeting	October 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS:

This report shares Patient Experience activities implemented across the Trust.

Friends & Family Test Scores (FFT) data for October: -

Manual collection: +74

CQUIN target for Friends and Family Test improvement by 31 March 2013 is +80. This figure is a 10% increase on the baseline figure of +70 (July's manually collected FFT result rate)

PATIENT IMPACT
The Friends and Family Test score is designed to capture perceptions of patients on the day of discharge about the service that they have received whilst an inpatient at NGH.

STAFF IMPACT
The FFT Score provides staff with real time feedback.

FINANCIAL IMPACT
The ability to continually drive forward quality is increasingly important and has the potential to affect NGH income.

If the Trust fails to achieve the regionally set CQUIN, this will have financial implications through the reduction of the CQUIN payment

EQUALITY & DIVERSITY
The Hospedia television system may need to be made more accessible for patients with communication difficulties.

LEGAL IMPLICATIONS
Nil

RECOMMENDATIONS
Members of the Board are asked to note the contents of this report and to challenge as appropriate.

1.0 Introduction

The purpose of this report is to share the Patient Experience activities instituted across the Trust and the FFT monthly score. This report will evolve in the forthcoming months as Directorates formally embed Patient Experience activities into their governance structures, share their findings and implementing processes which improve the service they deliver to patients.

2.0 Patient Experience monitoring

2.1 Family and Friends Test

The Friends and Family Test (FFT) captures perceptions of patients about the health care that they have received, by asking the question: '*Would you or your family recommend this hospital service to family and friends?'* Data collection against this metric commenced in April 2012 whereby the Trust is required to capture 10% of inpatient discharges per week at or within 48 hours of discharge.

The FFT score is a regional CQUIN which is calculated and reported monthly to Midlands and East SHA. The FFT score calculated for September 2012 was **+74.**

2.2 Calculation of the FFT score

'The number of promoters (people who scored between 10-9) – the number of detractors (people who scored between 6-0) divided by the total number of responses received, multiplied by 100 = FFT'. (September calculation 414 – 10/544 = 74)

2.3 FFT Results: September 2012

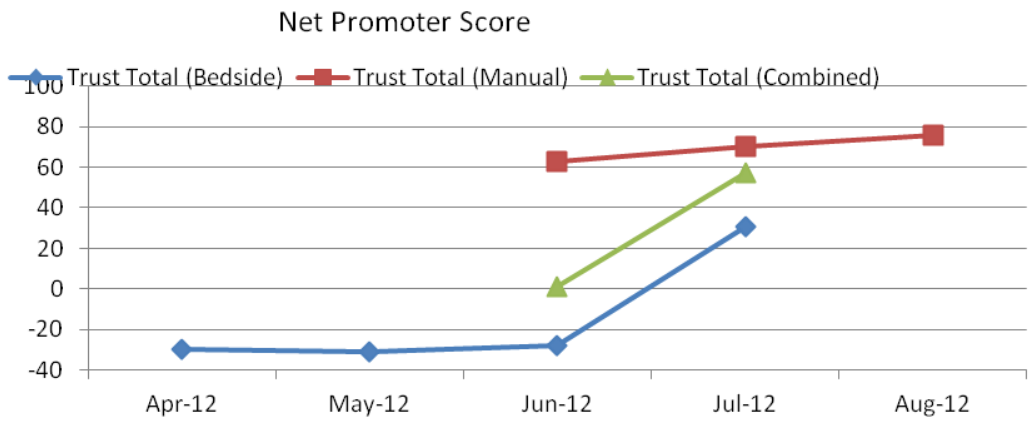
The manual collection of the Family and Friends Test continues to demonstrate positive results as indicated in the table below.

Table 1: FFT manual collection results to date: September 2012

Monthly FFT results	June 2012	July 2012	August 2012	September 2012
Manual collection	+63	+70	+76	+74
Bedside (Hospedia collection)	-28	+31	+25	
Combined collection	0.417	+57	+57	

The following graph demonstrates the monthly FFT scores.

Table 2: Monthly Friends and Family (Net Promoter) scores April – September 2012



	Apr-12	May-12	Jun-12	Jul-12	Aug-12
Trust Total (Bedside)	-30	-31	-28	31	
Trust Total (Manual)			63	70	76
Trust Total (Combined)			1	57	

(Footnote: Manual and combined data collection commenced in June 2012, reducing to manual data collection only from September onwards)

2.3 Manual data collection

The manual collection of data in August fell below 10% which would have had a negative impact on the CQUIN payment. Therefore the combined score was submitted with the agreement of the CEO, Director of Nursing and Midlands and East SHA. However, as from September 2012, data is only collected manually so this option won't be available in future. A concerted effort from all ward sisters ensured that this month's manually collected data was above 10% of the 5361 patients discharged from the hospital.

3.0 FTT improvement: CQUIN baseline score

Northampton Commissioners agreed to adopt the baseline score from July 2012, which was agreed as 70. Therefore the CQUIN challenge for this Trust will be to improve our FFT scores to **80** by 31 March 2013.

Ward Sisters are aware of the challenge to achieve this increase. Ward targets for manual data collection have been agreed between Ward Managers and Matrons. These will be monitored closely to ensure the Trust scores continue to improve.

4.0 Trust responses to Patient Experience feedback

4.1 Food

Since May 2012 regular ward meal service audits have taken place to identify the patient's mealtime experience. These audits are performed by the Hotel Services Manager, Catering Services Manager and Ward Sisters. The purpose of these audits is to monitor "protected meal" time observance, the quality of food and food service. The

results of these audits are sent to the Deputy Director of Nursing and Matrons to be shared across their Directorates.

The 'Patient Meal Experience Survey' was loaded onto the Hospedia Bedside Unit system on 01 September 2012. This survey is available for patients to complete at their bedside. A revised Patient Supper menu created following patient feedback on choice, availability and popular food menu items will be launched during November 2012.

A "Patients meal service" responsibility guide will be distributed to all wards and catering services, following discussion at the Sister/Matron meeting in November, to ensure uniformity and clearly identified responsibilities to all involved with the patient meal experience. A copy of the draft agreement can be found at appendix 2.

4.2 Ward Audits
Following the national adult in-patient survey (2011) and CQC inspection in August 2011, a cohort of Trust Member volunteers were inducted to assist the organisation to evaluate the implementation of actions following receipt of this valuable feedback. The following areas were identified for improvement and the focus for ward audits: -

- Noise at night (preventable noise generated through staff activity)
- Protected mealtimes (opportunities for patients to eat their meals undisturbed, with assistance where needed and in an environment conducive to creating an appetite for eating and nutrition)
- Patient information boards (containing readily available and relevant patient information)

Audits of these areas were trialled in June 2012 prior to implementation in July 2012. A summary of the ward audit results are illustrated below.

4.2.1 Summary of ward audit results
Noise at night audits

The initial audits found: -

- Many of the wards did not have a portable phone
- Staff could not put the desk phone onto silent, because if they are with patients, they would not be able to see the flashing light
- The door closing mechanism on some wards is set too light, so the door bangs unless it is held
- Bin closures were often noisy at night

4.2.2 Actions instituted as a result of the first audits
Noisy bins

Infection Prevention has undertaken an audit of the bins on the wards. All bins no longer fit for purpose will be replaced by bins with soft closing lids.

Portable phones:
The electronics department do not support the use of cordless phones as they may be displaced or no longer be effective (if they are inadvertently removed from the ward and are not within range of the base station). They have a large supply of the new desk phones with an option for silent ringing. Wards have been invited to request a replacement phone if they are still using the older desk phone.

Noisy doors:
The maintenance department have agreed to assess the closing mechanisms on the ward doors, correcting this where necessary to reduce the risk of the doors slamming.

Protected mealtimes
Wards are monitored and audited on a bi-monthly basis. It must be noted this is a challenge to maintain due to volunteer availability. Overall the feedback has been very positive. The Auditors offered feedback in three areas: examples of good practice, areas for improvement and general comments.

Examples of good practice
- Auditors commented on the quiet and calm atmosphere of the ward
- Ward was very busy, patients moved to new wards very quickly because of the nature of the ward. Auditor expressed how diligently staff tended to patients' needs, despite the high level of activity on the ward.
- Food bell used to indicate mealtime. Where patients refused hot food, efforts made to provide sandwiches. Notice on the closed door stating that mealtime was in progress. Volunteers were on the ward to assist in patient feeding
- Food preparation was the best observed so far. Everything was done to make sure patients were helped as far as I could observe with their food. Paper towels were given where needed

Areas for improvement
- There is a need to continually assess patients who might need support to eat their meals, to ensure that the right 'magnet' indicator is used and to provide them with the support they require.
- Sometimes patient's bedside tables appeared cluttered, leaving only a small space for their meal – nurses should ensure that tables are as clear as possible before placing a meal in front of a patient to enhance the meal experience.

General comments
- Hand wipes handed out after the meal.
- About half to a third of patients had wipes on their tables.
- The ward was closed as it was 'Protected meal time', with a notice stating this.. All visitors left the ward. Student doctor on ward, left when reminded by staff that mealtime had begun. Lady unable to sit up for clinical reasons and so she was assisted.

Patient Information Boards
A Task and Finish group have revised the patient information boards. The Boards now known as Patient Quality Boards are located on every ward area and contain relevant

and timely patient quality and patient safety metrics. Ward Sisters are responsible for maintaining these boards.

4.3 Care Group feedback regarding Patient Experience

General surgery

FTT results are integrated into Performance scorecards which are presented monthly to the Directorate Management Boards. This ensures a wide understanding and commitment to improve. Results from the FTT are actively displayed on the wards to ensure staff and the public are aware of the findings.

General medicine

Similar to General surgery, FFT results are shared at Ward, Directorate Governance and Care Group meetings.

Dementia Project

Creaton Ward received £2,600 from Charitable Funds to improve the ward environment for patients with Dementia. The programme commencing this month (October) will include painting the walls in different colour blocks behind twelve observable beds. Bedside lockers will be painted in the same colour to match the walls. Each bed space will have a three dimensional picture of a different animal placed above the bed which will assist confused or vulnerable patients to differentiate their bed from beds of other patients.

Toilet doors will be painted Sunflower Yellow and pictorial and enlarged signage will define these areas for confused patients.

4.4 Patient Experience Quick Wins

The Director of Nursing, Midwifery and Patient Services challenged Ward Sisters in June 2012 to identify with their teams, three quick wins to improve the Patient Experience. Many wards have developed action plans to implement their quick wins. An example of good practise is highlighted by the work of Rowan Ward, who have made a great impact with very little investment as follows: -

- Increasing the number of volunteers on the ward who are able to spend time with patients chatting
- Supplying all patients admitted as an emergency with an information leaflet regarding operation treatment as soon as possible, post arrival on the ward.
- Increased the staffing allocations for each shift which has enabled increased patient and staff interactions. (This has been possible with the recruitment of additional staff into vacancies).

4.5 Radiology Patient Experience Surveys

Following the introduction of the Hospedia Bedside Unit for the collection of patient experience from in-patient areas, the Radiology department continued to survey patients using a paper format. The diverse nature of episodes in Radiology, ranging from antenatal ultrasound scans, to major interventional procedures, prompted the development of individual audits in each sub-section of the department on a rolling 3-monthly rota. The Forrest Centre continued with monthly audits in keeping with national guidelines for Breast Screening.

The questions were adapted from the Trust questionnaires and tailored appropriate to the Radiology department, in a simple Yes/No format to reduce ambiguity, with space for comments. The areas audited since November 2011 following the introduction of these questionnaires are:

- MRI
- Daventry Outpatients
- NGH walk-in GPs
- Obstetric US
- Interventional procedures (Included in nurse-led telephone phone-up questionnaire)
- Breast Screening Unit (monthly)

Summary of Results in 2012
A summary of the results indicates: -

- The response numbers have been significantly higher than when the Dr Foster tracker was being used.
- Some radiographers have performed the audits as part of their training and presented data at in-house meetings.
- Cleanliness and directions for finding the department have not been significant issues in the current year.
- Waiting times at Daventry were considerably longer on Tuesdays, as it was closed on Mondays. Since then, Monday opening has commenced.
- The currently the questionnaire (which has had some modification to reflect the speciality) is being used in CT

Recently, the patient experience question “Would you recommend this Department to friends and family?’ was introduced to replicate the Family and Friends Test question implemented across the Trust – results will be presented in a future report.

5.0 Recommendations

Members of the Board are requested to:-

- Challenge the content of the report and support the actions defined.

Appendix 1

Family and Friends Test -Manually Collected Results by Ward: September 2012

Northampton General Hospital (T3)

How likely is it that you would recommend this service to Friends or Family?

September Monthly Report - Manual & Late Submissions Data
Date: 26/08/10 - 29/09/12

	Green	Amber	Red
Benchmark against:	1	0	

Ward Name	Responses	Results			NET Promoter Score
		Promoter	Passive	Detractor	
Collingtree Medical	13	10	3		77
Cedar	12	7	5		58
Rowan	20	15	5		75
Allebone	2	1	1		50
Creaton	5	3	1	1	40
Dryden	15	12	3		80
Finedon	9	7	2		78
Abington	5	3	1	1	40
Talbot Butler	13	12	1		92
Willow	18	15	3		83
Eleanor	22	18	4		82
Paddington	7	4	3		57
Robert Watson	38	30	7	1	76
Spencer	9	9		0	100
Disney	25	19	4	2	68
Althorp	13	2	11		15
Hawthorn	40	30	10		75
Balmoral	94	74	19	1	78
Head & Neck	3	3			100
Becket	10	4	6		40
Collingtree Surgical	46	38	6	2	78
Holcot	10	7	3		70
Knightley	14	9	5		64
Benham	30	23	5	2	70
EAU	6	3	3		50
Brampton	10	7	3		70
Head and Neck	19	17	2		89
Collingtree Surgical	15	15			100
EAU	1	1			100
Collington Surgical	15	13	2		87
Collington Medical	2	2			100
Isebrook - Hazelwood	3	1	2		33
Grand Total	544	414	120	10	74

Appendix 2

Patient Food Service Responsibilities – DRAFT

Ward Team Responsibilities	Catering Services Responsibilities
Ward staff to distribute the following days menu's to patients (with evening supper meals), assist completion and place in the wards catering collection tray prior to the following day's breakfast.	Menu's to the Ward for the following day. (usually delivered with the previous day's supper meal). Collection of completed menus with delivery of breakfast provisions.
Identify any special dietary requirements (ensuring correct identification of patients needs on menus, including nil by mouth).	Menu office and meal assembly to check requirements and ensure correct special diet is provided.
Prior meal service preparation (protected meal time).	Correct meal assembly in accordance with patient's choice.
Assist meal service (trays to patients) ensuring meals are served as quickly as possible to maintain temperatures and palatability.	Monitor regeneration of meals to ensure correct temperatures achieved.
Identify patients requiring assisted feeding using correct labelling system.	Ensure meals for assisted service are clearly identified to the ward team (yellow sticker/salmon tray). Meal trolley to ward on time with the correct meals.
Ensure all condiments and gravy are provided and offered to patients with meals.	Stock control and top up of condiments/preserves etc to appropriate levels.
Ward staff to identify any additional meals or other patient requirements and inform catering through the "out of hours" telephone help line or the menu office (after utilising remaining spare meals on trolley).	Preparation and prompt delivery of additional meal items requested.
Ask and assist patients with unwrapping packaging if required (cheese portions, juice cuplets, yoghurts etc).	Minimise unnecessary packaging on meal tray.
Check with patients if they are happy with their meal and meal service. (This 'front of house' check should be carried out by the ward staff on a daily basis). Encourage/assist the patients to complete the "Patient Mealtime experience" bedside TV survey.	Bedside TV "Patient mealtime experience "survey (prompt cards for patients on meal tray). Share results with ward teams on regular basis.
Identify patients not eating throughout each meal time and take appropriate action.	Work with ward clinicians / dieticians to help improve food intake by making available alternative (bespoke) food options particularly for

Ward Team Responsibilities	Catering Services Responsibilities
	long-term/" in tolerant" patients.
Ward staff to know where the ward catering book is located (ideally located at central nursing station) and be familiar with content e.g. OOH meal availability.	To ensure all Catering literature is kept up to date with the correct information. (Ward books. Ooh menus & current menu cycle).
Inform Catering department if meals are not meeting expectations.	Catering department to note patients/staff feedback and where appropriate Catering Manager/catering staff to visit patient.
Ensure that cleanliness of beverage trolleys, toasters and kitchens is of a high standard.	Ensure beverage machines and toasters are maintained in serviceable condition.
Ward sisters ensure staff involved in food service attends a ward food service workshop.	Catering Manager to provide catering service and hygiene training for ward teams and to inform wards of workshop training dates.

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Prepared by	Wendy Foster Infection Prevention and Control Specialist Practitioner Nurse
Date of meeting	25th October 2012
Corporate Objectives Addressed	To develop and embed measures for quality and clinical outcomes to achieve the highest standards
SUMMARY OF CRITICAL POINTS Monthly update on reportable HCAIs	
PATIENT IMPACT High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care.	
STAFF IMPACT High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care and also impacts on staff safety and wellbeing.	
FINANCIAL IMPACT Will be identified as required	
EQUALITY AND DIVERSITY IMPACT Applicable to all	
LEGAL IMPLICATIONS The Board has a statutory obligation to ensure appropriate infection prevention and control mechanisms are in place.	
RISK ASSESSMENT Failure to review infection prevention and control would be considered to be high risk.	
RECOMMENDATION The Board is asked to discuss and where appropriate challenge the content of this report.	

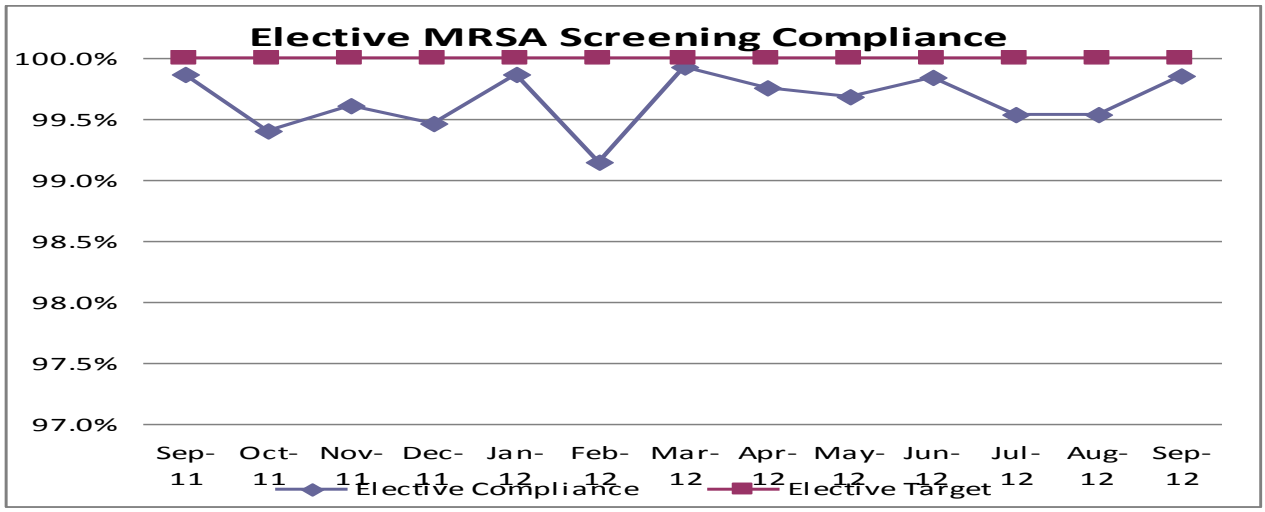
Introduction
The Board is aware of its duty to ensure appropriate infection prevention and control mechanisms are in place to promote patient safety and quality of care. This report provides the assurance required by the Board to satisfy its statutory requirements by providing an update as to the current situation in relation to Healthcare Associated Infections (HCAIs) within the Trust.

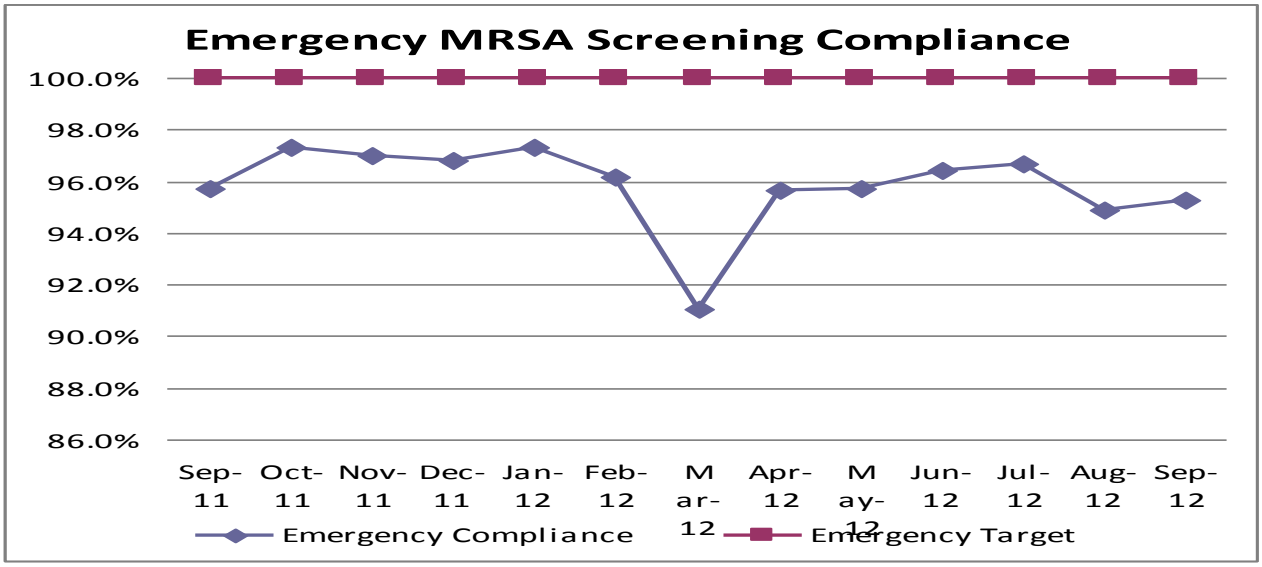
MRSA Bacteraemia

The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. Unfortunately, during September 2012 there was **1 >48hrs** MRSA bacteraemia, which takes the total for the year up to 2 cases. This puts the Trust over trajectory.

The Root Cause Analysis (RCA) meeting regarding this case is being held on October 15 2012. Because the patient had been transferred from another hospital to NGH, it has been agreed that a member of that hospital's infection prevention and control team will join the meeting. The RCA should provide us with in depth details as to why this occurred, which will be presented in next month's private board report as individual patient details will be discussed.

MRSA Colonisation & Screening
During September there were 11<48hrs and **5 >48hrs** cases of MRSA colonisation. Compliance with the screening of elective admissions: 99.9% in September and for emergency screening: 95.3%. The graphs below indicate how well the Trust is doing against its 100% compliance target for both elective and emergency screening. It should be noted that compliance with emergency screening has dropped (this is the first time the figures have been presented in this way) and as a result, the Infection Prevention team are pulling together an action plan to address this, which will be presented at the next Infection Prevention meeting for agreement and implementation.





Special Measures - MRSA

Definition

A period of increased incidence is defined by the Health Protection Agency as 2 or more new cases of post admission *C.difficile* or MRSA colonisation on a ward in a 28-day period. Post admission is defined as:

- *C.difficile* sample dated over three days after admission
- MRSA swab dated over 48 hours after admission

Action

If this occurs on a ward, **Special Measures** will be implemented. Special Measures actions will vary for *C.difficile* and MRSA due to the nature of each organism.

Dryden ward was on special measures due to two>48hrs cases of MRSA colonisations in August. These measures highlighted ceiling vents being very dusty. The vents were cleaned thoroughly by estates and it was highlighted to the cleaning staff regarding the importance of regular cleaning of the vents, to prevent the build-up of dust.

Althorp ward is on special measures due to two>48hrs cases of MRSA colonisations in September. These measures also highlighted environmental issues. The modern matron has put together an action plan which is being implemented – the outcome of which will be reported to the November board report.

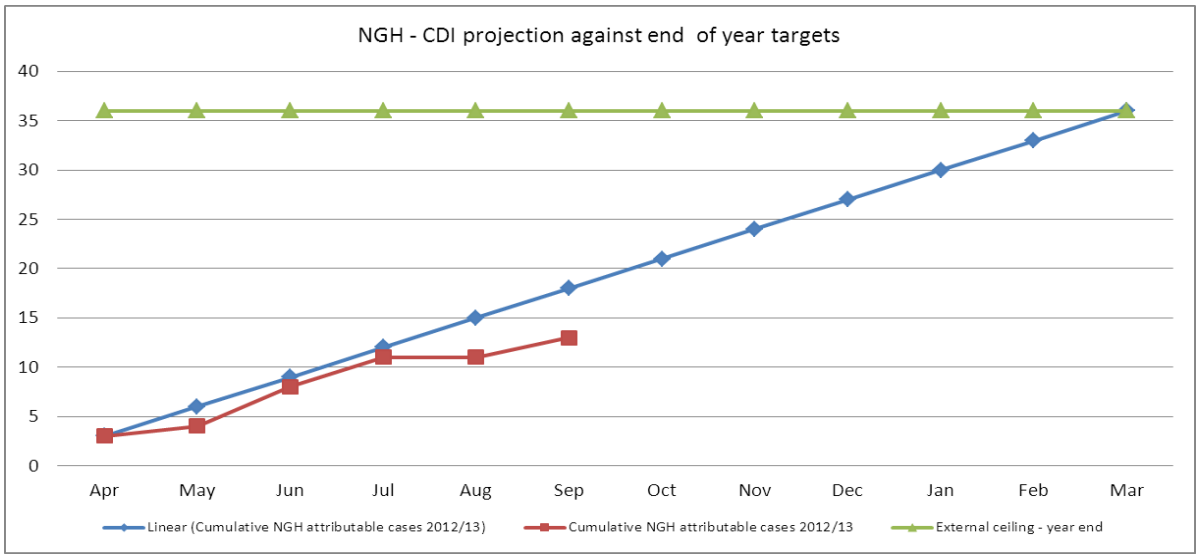
MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

During September there were 3<48hrs and **0>48hrs** MSSA bacteraemia cases.
For August a Root Cause Analysis (RCA) was undertaken on the 1 post 48 hours MSSA bacteraemia case on **Finedon ward.** This is a complex case; the patient is a renal patient with an invasive device (permacath) who was originally a patient in ITU at Kettering General Hospital. The RCA has not yet been completed and so results will be presented to the November meeting.

Clostridium difficile

The Trust has an annual target of 36 C. diff. cases (3 per month) or less for the financial year. During September

***2>3 day cases of C. diff** were identified,* which totals 13 >3 day cases of C. diff for the year, which is slightly below trajectory; however, we are now moving into the winter months when the cases of C Diff tend to escalate. Careful monitoring of this continues.



Surgical Site Infection Surveillance Scheme (SSIS)
The Trust takes part in the national surgical site infection surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical wound infection and be sure that patients are given the highest possible standard of care. The national programme is coordinated by the Health Protection Agency (HPA).

Surgical Site Infection Surveillance

Background
The patient is monitored from operation until discharge for up to 30 days following admission. When submitting the results to the Board, it should be noted that surveillance is still on-going, and therefore these are classed as **interim results**.

The interim results for September 2012

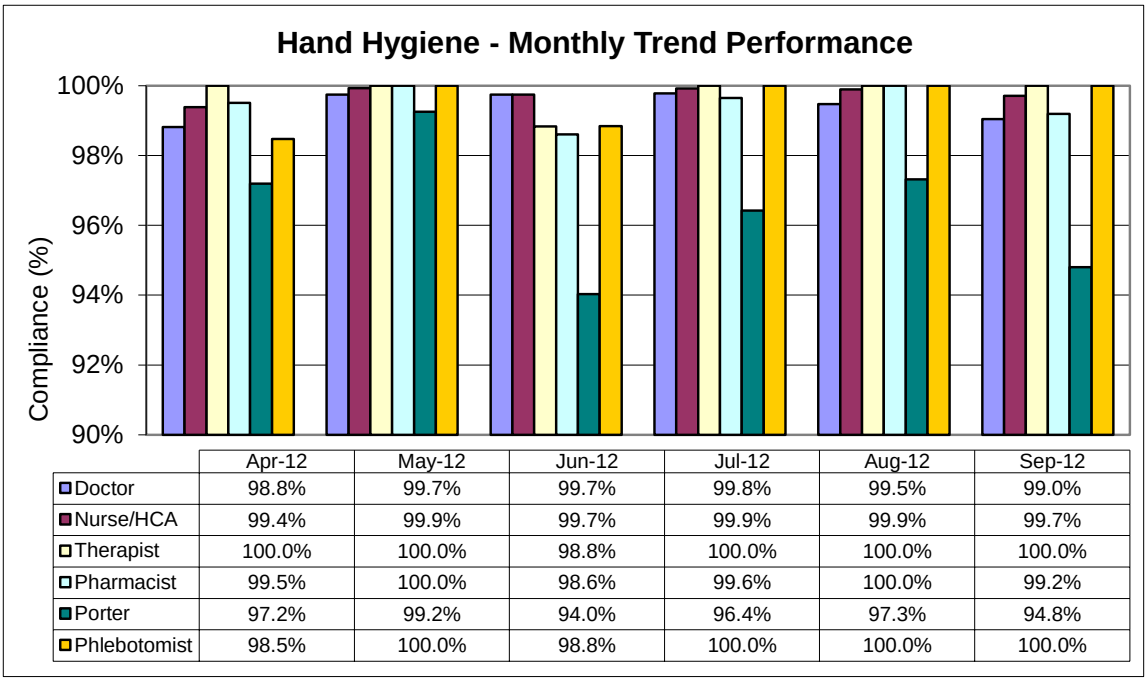
- Repair #NOF's. show that there were ***no infections*** resulting from 26 operations
- Breast operations show that there were ***no infections*** resulting from 38 operations
- Limb amputation operations show that there were ***no infections*** resulting from 7 operations

All these results are fed back to Clinical Quality and Effectiveness Group (CQEG) on a monthly basis.

Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) data shows that in September 2012:

- Overall Trust compliance for hand hygiene = 91.2%, seven areas failed to submit the completed audit.

The non-compliant areas are being investigated by the Matrons, who presented improvement plans to the October Infection Prevention meeting. Clinical Directors/Ward Sisters of non-compliant areas have been invited to the November Infection Control Committee to present their improvement plans. The graph below demonstrates hand hygiene compliance in the ward areas only, which is considerably higher than the overall trust score.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Doctor	98.8%	99.7%	99.7%	99.8%	99.5%	99.0%
Nurse/HCA	99.4%	99.9%	99.7%	99.9%	99.9%	99.7%
Therapist	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%
Pharmacist	99.5%	100.0%	98.6%	99.6%	100.0%	99.2%
Porter	97.2%	99.2%	94.0%	96.4%	97.3%	94.8%
Phlebotomist	98.5%	100.0%	98.8%	100.0%	100.0%	100.0%

One of Northampton General Hospital's Infection Prevention Link staff has been awarded the Infection Prevention Society Hand Hygiene, 2012 award. This was presented at the Infection Prevention Society Conference, Liverpool on Tuesday 2nd October 2012.

Recommendation
The Board is asked to discuss and challenge the content of this report.

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen – Chief Operating Office and Deputy Chief Executive
Date of meeting: -	25th October 2012
Corporate Objectives Addressed: -	

SUMMARY OF CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 6 **(September 2012)**.

- The Trust achieved all the key standards for September 2012
- The Trust achieved the A&E standard for September 2012 with 96.89% of patients being treated within 4 hours against the standard of 95%
- The Trust achieved all of the cancer standards for the quarter. All targets were also met in-month with the exception of the 62 day standard from consultant upgrade to start of first treatment. The Trust achieved 75% against the standard 85%.

PATIENT IMPACT: -

Patients waiting longer than maximum wait time

STAFF IMPACT: -

N/A

FINANCIAL IMPACT: -

Failure to achieve standards could result in contractual penalties

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board are asked to discuss the contents of this report and agree any further action necessary.

PERFORMANCE REPORT – OCTOBER 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 6** (September 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

More detailed performance is reported by exception i.e. where performance is below standard, where there are specific pressures that present a risk to the ongoing achievement of any of the standards or where there are high profile issues e.g. new targets.

2. SERVICE PERFORMANCE

See Appendix 1 for score card

2.1 September Performance

During September the Trust continued to achieve all of the 18 week standards of 90% for admitted and 95% of non-admitted patients treated across all specialties.

The Trust continues to exceed the national standard for all diagnostic tests to be carried out within 6 weeks of the request. During September all diagnostic tests were carried out within 4 weeks of the request.

The Trust achieved all of the Stroke standards for patients to have a scan within 24-hours following a TIA and stroke patients to spend at least 90% of their time on a stroke ward.

2.2 A&E Clinical Indicators

Significant progress has been made in delivering the 4-hour A&E transit time. During September 96.89% of patients were treated or admitted within 4 hours against the standard of 95%. The year to date performance is 93.95% and the Trust is progressing against the set trajectory to achieve the year end performance.

2.3 Referral to Treatment Time (RTT)

During September 2012, the Trust achieved all of the RTT standards by each specialty.

NHS Midlands and East are undertaking monthly monitoring on incomplete pathways over 26 weeks. These are pathways where a patient has not yet started their first treatment after 26-weeks. In September there were 55 patients waiting to start elective treatment in this category. Reasons for waits include patient choice and capacity within the Orthodontic Department. Plans are in place to increase capacity and reduce waits within orthodontics thus reducing the number of incomplete pathways from November 2012 onwards.

2.4 Cancer Standards

The Trust has achieved all the cancer standards for quarter 2.

During September the Trust did not achieve the standard for 62 days from consultant upgrade to start of first treatment. The Trust achieved 75% against the standard of 85%. Small numbers of patients are treated within this standard per month (10 patients) and the standard is monitored quarterly. The Trust achieved the quarter 2 performance with 85.6% of patients treated within 62 days.

3. RECOMMENDATIONS

Trust Board is asked to discuss and approve the contents of this report.

Appendix 1

Service Performance

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Q1	Jul-12	Aug-12	Sep-12	Q2	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups										
Admitted	90.0%	96.4%	96.6%	97.4%		96.6%	97.0%	96.3%		
Non-admitted	95.0%	97.7%	98.3%	98.8%		98.6%	98.5%	98.4%		
Incomplete pathways	92.0%	98.2%	97.8%	97.1%		97.3%	97.5%	97.1%		
No of patients on n incomplete pathwaty with a wait time > 26 weeks	0	27	26	25		49	49	55		
Number of diagnostic waits > 6 weeks	0	0	0	0		0	0	0		
A&E 95% Transit time target										
Cumulative	95.0%	95.0%	94.2%	93.9%		93.4%	93.3%	93.9%		
Month on Month	95.0%	95.0%	93.4%	93.3%		92.0%	92.8%	96.9%		
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6.0%	5.9%	7.1%	8.9%		5.7%	5.3%	5.3%		
Cancelled Operations not rebooked within 28 days	0	0.0%	0.0%	0.0%		0	0	0		
Cancer Wait Times										
2 week GP referral to 1st outpatient	93.0%	96.3%	95.6%	95.0%		96.6%	95.5%	96.3%		
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%	100.0%	100.0%		100.0%	100.0%	98.6%		
31 Day	96.0%	96.5%	98.9%	96.9%		99.4%	99.4%	100.0%		
31 day second or subsequent treatment - surgery	94.0%	96.2%	97.5%	100.0%		100.0%	100.0%	96.3%		
31 day second or subsequent treatment - drug	98.0%	100.0%	97.8%	100.0%		100.0%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94.0%	100.0%	99.2%	100.0%		98.5%	99.2%	98.1%		
62 day referral to treatment from screening	85.0%	100.0%	100.0%	100.0%		90.0%	87.5%	100.0%		
62 day referral to treatment from hospital specialist	85.0%	92.0%	91.7%	93.1%		93.3%	87.5%	75.0%		
62 days urgent referral to treatment of all cancers	85.0%	85.4%	81.8%	71.4%		90.1%	84.2%	85.2%		
Stroke Indicators										
Proportion of people who have a TIA who are scanned and treated within 24 hours	60.0%	68.0%	75.0%	90.9%		71.4%	95.8%	76.5%		
Proportion of people who spend at least 90% of their time on a stroke unit	80.0%	100.0%	95.6%	95.6%		81.9%	82.9%	87.8%		
Activity vs. Plan										
Elective Inpatients	>0%	16.6%	23.2%	15.2%		8.8%	-1.5%	17.5%		
Daycase	>0%	8.7%	11.3%	1.0%		3.7%	1.3%	4.3%		
Non- Elective	>0%	13.4%	26.0%	6.4%		2.5%	3.8%	10.3%		
OP 1	>0%	5.1%	14.9%	7.5%		0.9%	-5.7%	3.9%		
OP Procedures	>0%	10.2%	3.6%	5.0%		2.3%	-1.5%	5.6%		
New to Follow UP Ratio	2.01	2.05	1.92	1.97		1.97	1.96	2.07		
GP Referrals	>0%	2.5%	1.4%	1.1%		0.4%	-2.0%	-2.1%		
Day Case Rates	81%	85.7%	85.0%	85.0%		85.7%	86.6%	85.0%		
Sleeping Accommodation Breach	0	0.0%	0.0%	0.0%		0	0	0		

The Trust's Financial and Contracting Performance as at 30th September 2012

Month 6 2012/13

1. Summary Performance – Financial Duties

Table 1 summarises the Trust's financial performance for the six months to the end of September 2012. The table summarises the year to date and full year forecast performance against the financial duties of the Trust, the financial performance dashboard is included in Appendix1.

Table 1 – Key Financial Duties

	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	-£5,265	-£1,332	-£2,542	£1,000	-£3,542
Achieving EFL	N/A	N/A	1,687	1,687	0
Achieving the Capital Resource Limit	2,597	2,943	8,646	10,403	-1,757
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	94%	95%	95%	95%	0%
Value of Non-NHS Invoices	73%	95%	85%	95%	-10%

Key Issues:-

- The Trust is forecasting an overall deficit of £2.5m. This position is arrived at after the application of £8.4m of recovery actions set out in the financial recovery plan. This position is subject to the mitigation of the identified risks (section 7).
- The main risk relates to delivery of the financial recovery plan, notably the successful negotiation of additional funding from the CCG and SHA for the legitimate costs incurred outside of the contract.
- The Trust is agreeing control totals with each of its Care Groups to ensure delivery of stretch targets to reduce forecast overspends.
- The impact of contract overperformance is driving excess costs in the form of additional temporary staffing and the requirement for additional ward capapcity.
- Slippage in the delivery of savings in the Transformation programme requires attention and greater management focus in the second half of the financial year. The Trust will deliver £11.1m savings this year which has a full year effect of £14m.
- Plans are in place to undershoot the Capital Resource Limit (CRL) by £1.7m. This will help alleviate some of the cashflow problems currently being experienced.
- The Trust experienced liquidity issues in September. The closing cash balance at the end of September was £1.1m.

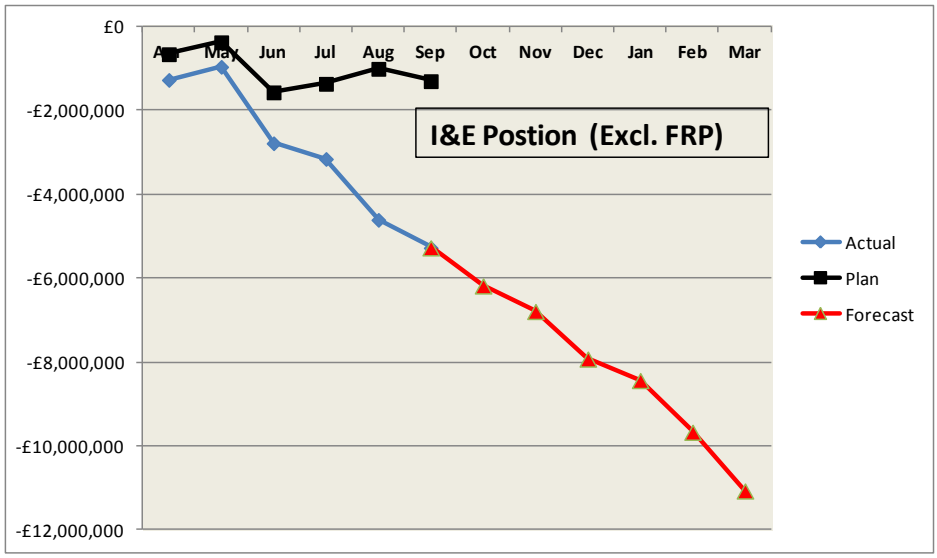
Income and Expenditure Position of the Trust

1.1. Surplus/(Deficit) Position

1.1.1. Appendix 2 provides details of the Trusts summary Income and Expenditure (I & E) Position. The Trusts year to date I & E position as at 30th September 2012 was a £5.3m deficit (August: £4.6m). The plan submitted to the SHA in March predicted a £1.3m year to date deficit therefore the result was £4.0m worse than planned. The planned position for the full year is a surplus of £1.0m.

1.1.2. The month 6 position is a deficit of £0.7m. Unless recovery actions are implemented, the latest forecast predicts an overall deficit of £11m by the end of the financial year.

1.1.3. A recovery plan to address this deficit has been developed and a further update will be shared with the Trust Board in October. At presents actions totalling £8.8m have been identified leaving an unmitigated deficit of £2.5m. The financial recovery plan will require robust performance management over the remainder of the financial year.



Graph 1 – Income & Expenditure forecast (excluding Financial Recovery Plan actions).

1.2. Income and Activity

1.2.1. Total operating income in month 6 was £20.9m. Year to date operating income stands at £122.7m, compared to a plan of £118m.

1.2.2. SLA income met forecast levels for September amounting to £18.6m. SLA income totalling £109.4m has been recorded for the year to date, £3.9m (3.7%) better than plan. The Trust is intending to agree an income settlement with the local CCG's that removes many of the risks previously reported.

1.2.3. The Table below summarises the Trusts SLA income and activity figures and includes provisions for known contractual and data challenges for the year to date.

Table 2 – SLA Activity & Income Performance

	ACTIVTY				INCOME						
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var	Volume £	Price £	Total £
DC	18,188	19,113	925	5.1%	10,813,962	11,118,118	304,156	2.8%	415,562	-111,406	304,156
EL	2,862	3,237	375	13.1%	8,647,586	8,382,896	-264,690	-3.1%	731,188	-995,877	-264,690
NEL	20,702	22,326	1,624	7.8%	34,688,203	37,497,798	2,809,595	8.1%	2,110,290	699,305	2,809,595
OPFA	31,641	32,892	1,251	4.0%	5,144,815	5,426,092	281,276	5.5%	-317,322	598,599	281,276
OPFUP	58,040	58,499	459	0.8%	5,301,104	5,343,387	42,283	0.8%	-84,671	126,954	42,283
OPFASPNCL	11,761	13,667	1,906	16.2%	1,039,609	1,229,061	189,452	18.2%	64,279	125,173	189,452
OPFUSPNCL	32,092	30,146	-1,946	-6.1%	1,540,645	1,481,731	-58,914	-3.8%	-77,380	18,466	-58,914
OPPROC	19,192	19,963	771	4.0%	2,778,509	2,881,498	102,988	3.7%	79,117	23,872	102,988
A&E	38,918	46,782	7,864	20.2%	3,720,763	4,627,381	906,618	24.4%			
BLOCK / CPC					30,400,991	31,021,613	620,622	2.0%			
ARMD	1,854	2,038	184	9.9%	524,324	561,389	37,065	7.1%			
Other					930,439	-172,170	-1,102,609	-118.5%			
Total					**105,530,952**	**109,398,794**	**3,867,843**	**3.7%**			

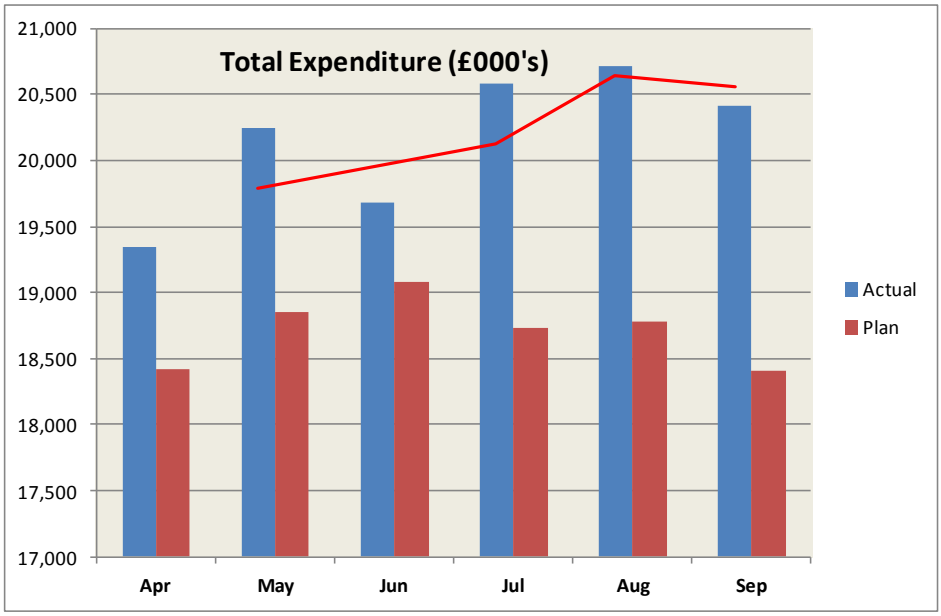
1.2.4. The Trust has over performed on activity which equates to £3.9m of additional income. The majority of over performance is against the Northamptonshire CCG contract with under performance on some smaller contracts.

1.2.5. Elective admissions activity is significantly higher than planned although weaker casemix has seen associated revenues fall below plan in 2012/13. This is due in part to the proposed impact of PCT QiPP schemes during the year on elective income.

1.2.6. Outpatient first attendances are 4.0% above plan whilst outpatient follow up attendances are broadly on plan.

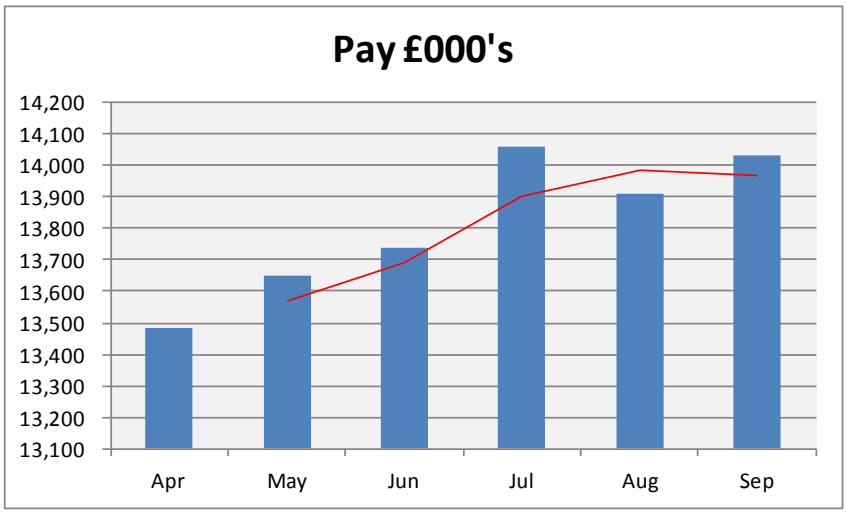
1.3. Expenditure

1.3.1. The Trust has overspent expenditure budgets by £8.6m in the 6 months to 30th September 2012. The primary reason for the over spend is that insufficient CIP schemes have been identified and delivered within the first part of the financial year.



Graph 2 - Monthly Expenditure Run Rate 2012-13

1.3.2. Pay costs in the month were £0.8m higher than planned at £14.0m an increase of £0.1m compared to August. Cumulatively to month 6 pay costs were £82.9m, £4.9m higher than planned. Pay costs associated with the Winter Pressures plans have been factored into the financial recovery plan.



Graph 3 – Pay expenditure monthly run rate 2012-13

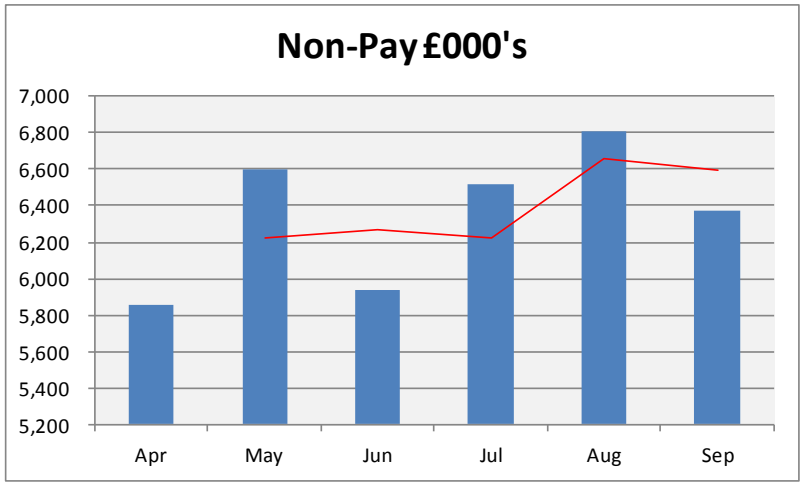
1.3.3. The Trust is operating below the planned WTE budget but is utilising significant numbers of temporary staff.

Table 3 – WTE Analysis – September 2012.

	Worked Mth 6 WTE	WTE Budget 2012/13 M6	Worked V Bud Var	Contracted Mth 6 WTE
Medical Staff	470.86	464.36	*-6.50*	468.24
Nursing Staff	1,768.62	1,744.47	*-24.15*	1,643.33
Managerial &	825.88	889.99	*64.11*	748.84
Other Clinical Staff	264.47	308.97	*44.50*	262.32
Scientific & Technical Staff	369.80	412.08	*42.28*	383.98
Estates Staff	29.04	36.19	*7.15*	25.00
All other Staff	412.11	407.99	-4.12	321.48
Cost Challenges		-10.19	*-10.19*	
Total WTE	**4,140.78**	**4,253.86**	***226.15***	**3,853.19**

1.3.4. The nursing workforce plan has been updated and measures are being put in place to ensure nursing WTE's are increased with additional international recruitment due to increase substantive Nurse staffing numbers and reduce temporary staffing requirements from December.

1.3.5. Non Pay cost incurred were £4.2m higher than planned for the year to date. Expenditure in September was £6.4m, a reduction of £0.4m from August, but consistent with average spend for the year.



Graph 4 – Non-Pay expenditure run rate 2012-13

1.3.6. The Trust has taken remedial action to cover the previously forecasted deficit. The actions were agreed as part of the "Financial Recovery Plan" but rely heavily on successful negotiation of a suitable settlement with the CCG/PCT.

1.3.7. As part of the Recovery plan "Control Totals" have been agreed with each care group. This requires individual Care groups to improve on their current forecast outturns through delivering improvements in the form of stretch targets against which they will be performance managed between now and the financial year end.

1.3.8. There are risks to expenditure budgets from winter pressures, performance targets and contract overperformance. Plans have been put in place to mitigate these risks which will be monitored and escalated as necessary in divisional performance reviews.

2. Transformation Programme (CIP Programme)

2.1. The Trust has a total CIP target for 2012/13 of £19m (£16.1m net of PCT QiPPs cost impact) to be delivered in year, which represents 8% of budgeted costs. There are significant risks in delivering this programme and the Trust has developed a number of non-recurrent schemes to mitigate this risk.

2.2. The Trust planned to achieve cumulative CIP savings of £6.7m by month 6 and actually achieved £4.7m which represent delivery of only 70% of target.

2.3. Appendix 3 details the identified schemes by workstream. In total schemes have been identified to deliver £11.1m in year against the £16.1m target however of these schemes £0.23m have been categorised as red rated.

2.4. The Trust does not currently have remedial action to cover the forecast slippage of £5m.

2.5. Any CIP savings that are not delivered on a recurrent basis will become additional requirements in 2012/13.

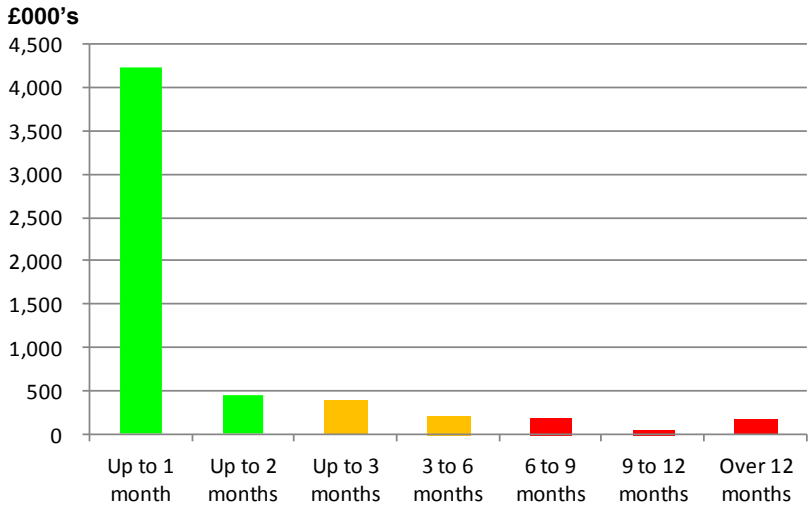
3. Balance Sheet and Cash Flow as at 30th September 2012

3.1. The Trust's Balance Sheet (Statement of Financial Position) as at 30th September 2012 is contained within appendix 4 of this report.

3.2. The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of September was £1.0m. Cash has decreased significantly since the year end largely due to the level of opening creditors and the in year I&E deficit. The cash position needs to increase by £1.7m over the course of the year in order to achieve the Trust's External Finance Limit. In practice this may require the suppression of creditor payments in March to achieve the EFL.

3.3. The forecast cashflow includes an assumption that the Trust will receive temporary borrowing of £7m to alleviate the immediate creditor backlog. A business case will need to be made to the SHA to support this.

3.4. An analysis of income earned by the Trust but unpaid as at 30th September 2012 is shown in the table below:



Graph 5 – Aged Debtor analysis September 2012

4. Capital Programme and Performance against Capital Resource Limit

4.1. The initial CRL target of £10.4m was set equal to the Trust's capital programme requirements as seen in the table below:

Capital Resource Limit (CRL)	Plan	YTD	Forecast	Underspend
	£000	£000	£000	£000
Internally Funded (Depreciation)	9,934	2,943	8,177	1,757
Salix Loan	469	0	469	0
Total	**10,403**	**2,943**	**8,646**	**1,757**

4.2. The Trust has plans approved to underspend up to the CRL by £1.7m. The capital committee recently considered plans to increase this underspend by a further £0.5m by the financial year end. This position has been verified as acceptable with the SHA.

5. Financial Risk Rating

5.1. Appendix 7 contains the Trusts indicative financial risk ratings calculated as if it were a Foundation Trust.

5.2. The overall risk rating for the Trust as at the 30th September 2012 if it were a Foundation Trust would be 1, which would be insufficient for the Trust to be licensed as a Foundation Trust. The Trust expected to end the year with a risk rating of 2, subject to delivery of the financial recovery plan.

5.3. The Trust reports the shadow FRR scores above to the SHA as part of the EMSHA Performance Management Report (PMR). At present the score gives rise to the requirement for the Trust board to make a governance disclosure to the SHA given the low FRR score.

6. Financial Risks

6.1. A summary of the Trusts financial risks are set out in the table below:

		Value of Risk £000s	Likelihood	Probability %	Adjusted Risk £000s
Downside Risk	**Action to mitigate risk**				
Delivery of Financial Recovery Plan	FRP monitored by Executive Team and board.	8,000	Medium	50%	4,000
CIP Delivery	Formal Transformation Programme in place.	5,000	High	90%	4,500
Impact of PCT QIPP Schemes	QiPP monitoring with lead PCT / fixed cost funding	4,550	Low	20%	910
NEL demand	Emergency Care Pathway / A&E action plans	3,600	High	90%	3,240
Funding for reorganisation costs	Liaison with PCT / bid to strategic reserve	2,200	Medium	50%	1,100
Upside Risk	**Action to mitigate risk**				
SLA contract overperformance	Ongoing contract review with host commissioner.	(12,500)	High	90%	(11,250)
Net Revenue Risk		**10,850**			**2,500**
Other Risks					
Cashflow constrained / unmet creditor demand	Business case to SHA to secure Temporary Borrowing	7,000	High	90%	6,300

7. Conclusion

7.1. The Trust is clearly facing a challenging financial year and at present is forecasting an unmitigated deficit of £2.5m by the financial year end.

7.2. The Trusts costs continue to be higher than planned due to the costs of over performing against the contract and having insufficient CIP schemes; this will become more significant in the remainder of the year as the unitary payment ramps up. The Trust has identified an action plan to mitigate the higher than planned expenditure.

7.3. The Trust is facing liquidity issues and needs consider applying for temporary borrowing of c. £7m to alleviate creditor backlog at the end of September.

8. Recommendations

8.1. The Board are asked to note the requirement by the Department of Health and Strategic Health Authority to achieve at least a financial breakeven position for the year (agreed plan is for a surplus of £1.0m).

8.2. The Board are asked to ensure that the actions to mitigate risks are discussed and understood. (Para 7.1)

8.3. The Board should closely monitor the financial recovery plan and seek assurance to understand the following key issues:

8.3.1. The negotiation of an income settlement with CCGs.
8.3.2. The delivery of prescribed control totals within the organisation.
8.3.3. The management and delivery of the Transformation Programme.

Appendix 1

Finance Dashboard

Financial Risk Rating (Shadow)	1	Overriding rules apply
EBITDA	30.5%	EBITDA achieved 31% of plan
Liquidity (days cover)	15.4	Incl. unused WCF of £18m
Surplus Margin	-4.3%	+1% required for score of 3
Pay / Income	67.5%	Pay 68% of Income for YTD

I&E Position	**£000's**	
Reported Position	(5,265)	Deficit of £5.3m to month 6.
FIMS Plan (Year to date)	(1,332)	£1.3m deficit plan to month 6.
PCT SLA Income Variance	3,868	3.7% above plan.
Unmitigated Forecast	-10,940	Forecast before mitigating actions
SHA control total (NGH)	1,000	SHA control total £1m surplus.
Mitigated Forecast	-2,049	Forecast after mitigating actions.

EBITDA Performance	£000's	
Variance from plan	(3,989)ADV	£3.99m behind plan

Cost Improvement Schemes	**£000's**	
YTD Plan	6,760	£6.7m target to month 6.
YTD Actual	4,724	£4.7m delivered to month 6.
% Delivered	70%	CIPs delivered as a % of plan .
LTF	11,142	Latest Thinking Forecast for year.
Slippage Identified	4,958	Mitigation Target in LTF
Annual Plan	16,100	Annual Transformation Target.
LTF v. Plan	69%	% of LTF compared to annual plan.

Capital	**£000's**	
Year to date expenditure	2,943	Capital expenditure for period
Committed as % of plan YTD	88%	% of plan committed for year to date.
Annual Plan	10,403	Capital Resource Limit of £10.4m for 2012-13.

SoFP (movement in year)	**£000's**	
Non-current assets	(1,743)	Revaluation+Additions - depreciation
Current assets	1,036	Reduction in cash balance offset by NHS debtors.
Current Liabilities	4,136	NHS and Trade creditors increasing.

Cash	**£000's**	
In month movement	(192)	Decrease between August and September.
In Year movement	(2,840)	Reduction since March 2012
Debtors Balance > 90 days	611	16% of balances outstanding over 90 days
Creditors > 90 days	423	5% of creditors waiting over 90 days
BPPC (by volume) YTD	91.5%	Target 95% paid in 30 days

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Appendix 2

Income & Expenditure Position - September 2012

I&E Summary	Plan 2012/13	YTD Actual	YTD Plan	Variance to plan	Forecast EOY
	£000's	£000's	£000's	£000's	
SLA Clinical Income	212,676	109,399	105,531	3,868 Fav	220,476
Other Clinical Income	2,663	1,349	1,330	18 Fav	2,505
Other Income	23,219	11,972	11,197	776 Fav	23,715
Total Income	**238,558**	**122,720**	**118,058**	**4,662 Fav**	**246,696**
Pay Costs	(153,668)	(82,872)	(77,945)	(4,927) Adv	(165,780)
Non-Pay Costs	(67,612)	(38,094)	(33,910)	(4,183) Adv	(76,444)
Reserves	(2,068)	0	(558)	558 Fav	(1,210)
Total Costs	**(223,143)**	**(120,966)**	**(112,316)**	**(8,650) Adv**	**(243,434)**
EBITDA	**15,415**	**1,754**	**5,742**	**(3,989) Adv**	**3,262**
Depreciation	(10,184)	(4,898)	(4,959)	61 Fav	(9,962)
Amortisation	(10)	(5)	(5)	(0) Adv	(10)
Impairments	0	0	0	-	0
Net Interest	29	9	15	(6) Adv	20
Dividend	(4,250)	(2,125)	(2,125)	0 Fav	(4,250)
Surplus / (Deficit)	**1,000**	**(5,265)**	**(1,332)**	**(3,933) Adv**	**(10,940)**
Recovery Plan Actions					**8,398**
Mitigated Forecast Surplus / (Deficit)					**(2,542)**

Appendix 3

Statement of Financial Position – September 2012

	Balance at 31-Mar-11	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		533	546	13	2,116	2,116
IN YEAR MOVEMENTS		2,224	2,599	375	8,533	8,533
LESS DEPRECIATION		(4,130)	(4,888)	(758)	(10,188)	(10,188)
NET BOOK VALUE	**135,075**	**133,702**	**133,332**	**(370)**	**135,536**	**461**
CURRENT ASSETS						
INVENTORIES	4,723	4,474	4,778	304	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	6,273	8,074	1,801	5,742	12
OTHER TRADE DEBTORS	985	950	1,021	71	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31				31	
NON NHS OTHER DEBTORS	70	348	293	(55)	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,531	2,547	16	2,554	
OTHER RECEIVABLES	549	716	506	(210)	574	25
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,695	2,757	62	1,460	2
	10,945	**13,081**	**14,766**	**1,685**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300	300	300			(300)
CASH	3,944	1,296	1,104	(192)	5,690	1,746
NET CURRENT ASSETS	**19,912**	**19,151**	**20,948**	**1,797**	**21,468**	**1,556**
CURRENT LIABILITIES						
NHS	1,673	3,551	4,198	(647)	4,886	(3,213)
TRADE CREDITORS REVENUE	3,655	3,738	5,305	(1,567)	4,197	(542)
TRADE CREDITORS FIXED ASSETS	2,759	1,057	1,019	38	2,046	713
TAX AND NI OWED	3,454	3,441	3,459	(18)	3,454	
NHS PENSIONS AGENCY	1,784	1,963	1,927	36	1,784	
OTHER CREDITORS	510	258	421	(163)	510	
SHORT TERM LOANS	526	526	431	95	526	
ACCRUALS AND DEFERRED INCOME	4,018	5,542	7,175	(1,633)	4,031	(13)
PDC DIVIDEND DUE		1,715		1,715		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	233	163	70	914	625
PROVISIONS over 1 year	310	310	330	(20)	374	
NET CURRENT LIABILITIES	**20,921**	**22,963**	**25,057**	**(2,094)**	**23,351**	**(2,430)**
TOTAL NET ASSETS	**134,066**	**129,890**	**129,223**	**(667)**	**133,653**	**(413)**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	34,467	34,467		35,675	1,629
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	385	(82)	386	468	885	500
I & E CURRENT YEAR		(4,130)	(5,265)	(1,135)	-2542	-2542
FINANCING TOTAL	**134,066**	**129,890**	**129,223**	**(667)**	**133,653**	**(413)**

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Appendix 4

Cost Improvement Delivery

£000's	Sep		YTD		
Workstream	**Plan**	**Actual**	**Plan**	**Actual**	**Var**
Beds / Patient Flow	53	-	208	17	(191)ADV
Theatres	38	9	171	53	(118)ADV
Outpatients	10	21	61	178	117FAV
Admin Review	55	-	55	-	(55)ADV
Procurement	100	72	600	435	(165)ADV
Pathology	16	2	49	18	(31)ADV
Therapies	10	1	20	4	(16)ADV
Medical	40	-	100	-	(100)ADV
Estates	6	4	33	23	(11)ADV
Outsourcing	16	3	16	10	(6)ADV
Nursing	8	-	8	-	(8)ADV
Back Office Phase	58	10	58	63	5FAV
Contract Compliance	155	70	367	492	125FAV
Pharmacy	38	45	225	354	129FAV
Controls	46	6	275	25	(250)ADV
HR Workforce Planning	166	-	188	-	(188)ADV
Workforce, Bank & Agency	79	-	475	-	(475)ADV
Directorate 3% Schemes	537	551	2,944	3,052	108FAV
New Schemes					
NGH Mitigation	151	-	906	-	(906)ADV
Grand Total	**1,582**	**796**	**6,760**	**4,724**	**(2,036)ADV**

	Plan	LTF	Var
Workstream	**£000**	**£000**	
Beds / Patient Flow	300	17	(283)ADV
Theatres	424	142	(282)ADV
Outpatients	165	352	187FAV
Admin Review	385	81	(304)ADV
Procurement	1,200	870	(330)ADV
Pathology	147	99	(48)ADV
Therapies	80	39	(41)ADV
Medical	250		(250)ADV
Estates	316	75	(241)ADV
Outsourcing	111	29	(82)ADV
Nursing	58	2	(56)ADV
Back Office Phase 2	506	205	(301)ADV
Contract Compliance	1,000	1,000	-
Pharmacy	450	600	150FAV
Controls	550	459	(91)ADV
HR Workforce Planning	1,183	250	(933)ADV
Workforce, Bank & Agency	950	700	(250)ADV
Directorate 3% Schemes	6,205	6,222	17FAV
New Schemes			-
Mitigation Required	1,820	4,958	3,138 Increase
Grand Total	**16,100**	**16,100**	**0FAV**

Appendix 5

Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	FORECAST OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	205,713	15,448	17,959	18,311	17,011	17,091	16,677	17,622	17,119	17,119	17,119	17,119	17,119
SLA Performance / Other CCG investment	16,000				1,965	151	309	2,000		2,000		3,000	6,575
SHA Payments (SIFT etc)	9,490	266	1,300	671	942	672	841	890	765	765	765	765	849
Other NHS Income	19,381	1,932	2,568	1,108	1,420	1,495	1,858	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	259		259										
PP / Other	11,763	821	768	796	1,013	793	972	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	469								300		169		
EFL / PDC													
Temporary Borrowing	7,000									**7,000**			
Interest Receivable	31	2	2	2	2	2	1	3	3	3	3	4	4
TOTAL RECEIPTS	270,107	18,469	22,857	20,888	22,352	20,204	20,659	23,115	20,787	29,487	20,656	23,488	27,147
PAYMENTS													
Salaries and wages	160,572	13,081	13,813	13,339	13,233	13,513	13,433	13,280	13,400	13,280	13,400	13,400	13,400
Trade Creditors	69,706	4,285	6,274	5,734	5,915	6,238	3,908	6,500	5,600	**12,600**	5,772	5,600	**1,279**
NHS Creditors	15,562	1,546	1,938	1,480	2,151	965	973	1,277	1,277	1,277	1,277	700	700
Capital Expenditure	10,770	789	1,503	763	517	371	375	899	1,138	1,153	1,329	992	942
PDC Dividend	4,194						2,069						2,125
Repayment of Loans	7,000												**7,000**
Repayment of Salix loan	249						95						154
TOTAL PAYMENTS	268,053	19,701	23,528	21,316	21,815	21,087	20,854	21,956	21,415	28,310	21,778	20,692	25,600
Actual month balance	2,054	-1,232	-671	-428	537	-883	-195	1,158	-629	1,176	-1,123	2,796	1,547
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,112	1,229	1,034	2,192	1,563	2,740	1,617	4,413
Balance carried forward	5,960	2,675	2,003	1,575	2,112	1,229	1,034	2,192	1,563	2,740	1,617	4,413	5,960

Appendix 6

Capital

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 6 M6 Plan £000's	M6 Spend £000's	Under (-) / Over £000's	Plan Achieved £000's	Year to Date as at Month 6 Actual Committed £000's	Plan Achieved £000's
Breast Screening Business Case	59	59	59	0	100%	59	100%
Emergency Care	385	185	177	-7	46%	177	46%
Endoscopy / Urodynamics	157	50	42	-8	27%	49	31%
Mortuary Refurbishment	80	60	55	-5	69%	55	69%
Macmillan (Trust)	91	6	4	-1	5%	22	24%
Macmillan (Non Trust)	13	13	13	0	100%	13	100%
MESC	951	475	359	-116	38%	455	48%
Estates	3,734	1,205	1,012	-194	27%	1,383	37%
IT	3,373	1,003	905	-99	27%	1,560	46%
Other	158	35	111	76	71%	146	92%
Total - Capital Plan	**9,000**	**3,092**	**2,738**	**-354**	**30%**	**3,920**	**44%**
Less Charitable Fund Donations	-354	-149	-141	8	40%	-141	40%
Total - CRL	**8,646**	**2,943**	**2,597**	**-346**	**30%**	**3,778**	**44%**
Resources							
Internally Generated Depreciation	9,934						
SALIX	469						
Total - Available CRL Resource	**10,403**						
Uncommitted Plan	**-1,757**						

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (due for completion October 2012)
- Emergency Pressures - £200k allocation subject to Capital Committee approval
- Endoscopy (not yet out to tender) / Urodynamics (initial works completed Sept) - subject to business case approval and charitable funds donation
- Other costs include Topcon scanner & Medaphor scan trainer - transferred from revenue M6
- The Macmillan scheme works are completed, although final account is under dispute
- Full year depreciation forecast is currently £9.934 million (was £10.184 million)
- Following Capital Committee meeting £368k was agreed to slip till next financial year - endoscopy £218k and Estates schemes £150k
- Charitable Donations assumptions for additions in year has reduced by £225k
- The 2012/13 is undercommitted against resource in year by £1.757 million as a result of managing existing Trust cash constraints

Financial Risk Rating (Monitor)

	Metric	Weight %	Sep	Shadow Rating	YTD Score	Fcst Score	Fcst Rating
Achievement of Plan	EBITDA Achieved (% of plan)	10%	31%	1	0.10	3	0.30
Underlying Performance	EBITDA Margin %	25%	1.4%	2	0.50	2	0.50
Financial Efficiency	Return on Assets	20%	-2.43%	1	0.20	3	0.60
Financial Efficiency	I&E Surplus Margin	20%	-4.3%	1	0.20	2	0.40
Liquidity	Liquidity Ratio (Days cover)	25%	15.45	3	0.75	3	0.75
Weighted Average		100%		Calculated Score	2		3
				Override	-1		-1
				Reported Score	1		2

Note: As the Trust has scored 1 in more than two FRR metrics overriding rules apply limiting the overall score to a 1.

	< Good >		Score	< Bad >	
	5	4	3	2	1
Achievement of Plan	100	85	70	50	<50
Underlying Performance	11	9	5	1	<1
Financial Efficiency	6	5	3	-2	<-2
Financial Efficiency	3	2	1	-2	<-2
Liquidity	60	25	15	10	<10
Weighted Average					

Finance Risk Triggers (SHA PMR)

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	No	No	No	No	Yes	Yes	Not achieved H1 12-13.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	No	No	No	No	No	No	Forecast to achieve Level 3 by Q4 subject to recovery plan and overriding rules.
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	£611k (16%)
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	No	No	No	No	No	£423k (4.7%).
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	Yes	Yes	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-14 days excluding WCF.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)
Prepared by	Mark Ingram, Head of e-Workforce
Date of meeting	25th October 2012
Corporate Objectives Addressed	To develop an effective, efficient and flexible workforce to support the changing environment

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for September 2012 which focuses on the following Human Resource Workforce Indicators for Month 6:

- Workforce Capacity
- Workforce Expenditure
- Health & Wellbeing
- Workforce Development

PATIENT IMPACT – High

STAFF IMPACT – High

FINANCIAL IMPACT- High

EQUALITY AND DIVERSITY IMPACT – Low

LEGAL IMPLICATIONS – None

RISK ASSESSMENT: Managing workforce risk is a key part of the Trust's risk assessment programme.

RECOMMENDATION: The Board is asked to discuss and support the ongoing actions.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 6

The Human Resource Workforce Indicators have been updated for Month 6. Please refer to the following pages of this report.

The salient points of change to date are:

Workforce Capacity

Substantive Workforce Capacity increased by 11.41 FTE from 3,841.78.97 FTE to 3,853.19 FTE which is below the plan (4,253.85 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has increased by 0.09% to 90.58%.

Temporary Workforce (excluding Medical Staffing) usage decreased by 0.44% from 7.90% to 7.46% and remains above the planned temporary FTE target of 5%.

Total Substantive Workforce plus Temporary Workforce (excluding Medical Staffing) % FTE against budgeted establishment FTE has decreased by 0.37% from 98.25% to 97.88%.

Staff turnover (leavers) has decreased by 0.4% on the month to 8.18%, which remains above the Trust target of 8%.

Recruitment Timeline is below the threshold target of 13 weeks at 12.45 weeks.

Health and Wellbeing

Calendar Days Lost to Sickness The number of calendar days lost to sickness decreased by 603 from 6,096 to 5,964 in September 2012.

No. of Days Lost per Employee decreased by 0.03 from 1.35 days to 1.32 days.

Long term sickness absence decreased by 0.46% to 1.88% which is below the Trust target of 2%

Short Term Sickness Absence absence has increased by 0.57% to 2.46% (Trust target 1.4%).

Total Sickness Absence has increased by 0.11% to 4.34% (Trust target 3.4%).

Workforce Expenditure

Temporary Workforce Expenditure has increased by £47,241 from £1,433,620 to £1,480,861 which is equal to 10.55% of the total workforce expenditure.

Workforce Development

Appraisals are centrally recorded on OLM and as agreed, from this month are now reported on a cumulative 12 month basis. The Training and Development Department is responsible for the centralised management of recording appraisals, the HR Business Partners are working with Managers to implement the process of submitting appraisal records. A focus will be required over the coming months for managers to complete appraisals and submit records to the Training & Development
The percentage of staff with completed appraisals for September was 11.35%, compared to 11.98% the previous month.

Mandatory Training Compliance shows an increase of 2.19% compliance in September 2012 with a total Trust compliance of 59.90%.

Forecast and Risks

Following the recruit to HR Advisor Roles, there has been a focus on long term sickness Absence. As a result of this additional support, long term sickness has decreased to 1.88%, which is below Trust target and the lowest percentage for 7 months.
Within the overseas recruitment programme for Nurses, there has been a reduction in the number of trained nurses available from Ireland from 27 candidates to 16, which will have an impact on the utilisation of temporary nursing staff.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 6

WORKFORCE CAPACITY (Temporary Workforce Capacity Excludes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Aug-12	Sep-12	Peformance vs. Prev. Month	Comments and or Plans
Budgeted Workforce Establishment (FTE)			4,245.56	4,253.85	Higher	
Contracted Substantive Workforce (FTE)			3,841.78	3,853.19	Higher	
Temporary Workforce Utilised (FTE)			329.34	310.59	Lower	
Total Substantive Workforce plus Temporary Workforce (FTE)			4,171.12	4,163.79	Lower	
Contracted Workforce against Budgeted Establishment (% FTE)	95% to 97%		90.49%	90.58%	Higher	
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)	100%		98.25%	97.88%	Lower	
Temporary Workforce Rate (%FTE)	5%		7.90%	7.46%	Lower	Temporary Workforce Rate excludes Medical Staffing
Staff Turnover (% FTE)	8%		8.58%	8.18%	Lower	
Recruitment Timeline	13 Weeks		13.8	12.45	Lower	Recruitment Timeline is adjusted to take into account the 3 weeks Regional Restricted Access

WORKFORCE EXPENDITURE (Temporary Workforce Expenditure Includes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Aug-12	Sep-12	Peformance vs. Prev. Month	Comments and or Plans
Contracted Workforce Expenditure		74,727,250	12,474,591	12,551,445	Higher	
Contracted Workforce Enhanced Overtime		408,324	70,250	57,734	Lower	
Contracted Workforce Plain Time OT		25,892	4,473	8,695	Higher	
Temporary Workforce Expenditure		8,145,004	1,433,620	1,480,861	Higher	Temporary Workforce Expenditure = Bank, Agency and Locum (including Medical Staffing)
Total Utilised Workforce Expenditure		82,872,254	13,908,212	14,032,307	Higher	
Temporary Workforce Expenditure (% of Total Workforce Expenditure)		9.83%	10.31%	10.55%	Higher	

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 6

HEALTH AND WELLBEING

Performance Indicator	Performance Target	Trust YTD	Aug-12	Sep-12	Peformance vs. Prev. Month	Comments and or Plans
Trust Headcount (Permanent & FTC)			4,516	4,523	Higher	
Calendar Days Lost to Sickness Absence		38,871	6,096	5,964	Lower	
Days Lost Per Employee			1.35	1.32	Lower	
Short Term Sickness Absence	1.4%		1.89%	2.46%	Higher	
Long Term Sickness Absence	2%		2.34%	1.88%	Lower	Interim HR Business Partner support in place to specifically manage short and long term sickness absence
Total Sickness Absence	3.40%		4.23%	4.34%	Higher	

WORKFORCE DEVELOPMENT

Performance Indicator	Performance Target	Trust YTD	Aug-12	Sep-12	Peformance vs. Prev. Month	Comments and or Plans
Mandatory Training Compliance	100%		57.71%	59.90%	Higher	

WORKFORCE APPRAISALS

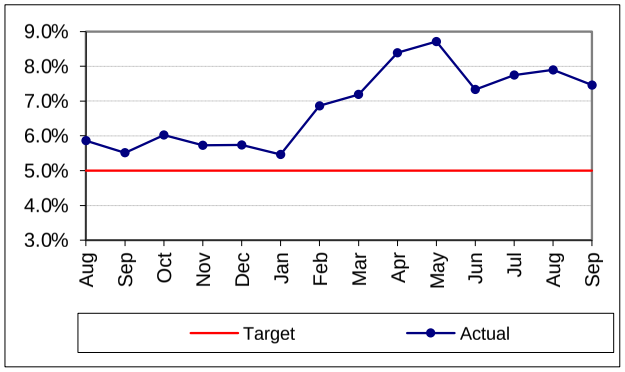
Performance Indicator	Performance Target	Trust YTD	Aug-12	Sep-12	Peformance vs. Q1 2011	Comments and or Plans
12 Month Cumulative Completed Personal Development Review / Plan	100%		11.98%	11.35%	Lower	Managers are responsible for submitting PDR/P's which are recorded and reported from central source (OLM)

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 6

DIRECTORATE WORKFORCE PERFORMANCE SUMMARY

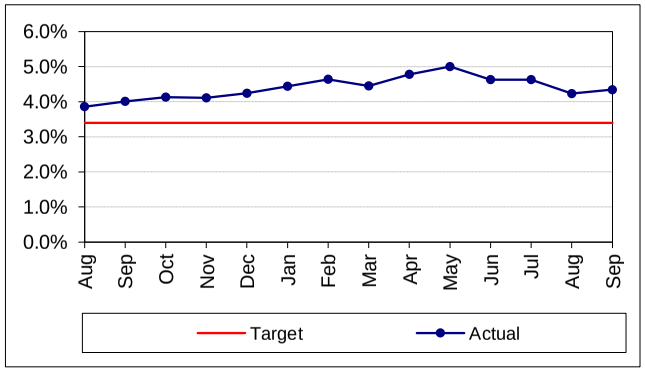
Temporary Workforce Rate

Directorate	Bank & Agency (Excl. Locum) M6	Variance Against Target	Variance From M5
Target = 5.0%		<-1.0%	>0.0%
Medicine	13.30%	8.30%	-0.31%
Surgery	9.23%	4.23%	-1.41%
Anaesthetics	6.73%	1.73%	-0.51%
Trauma & Orthopaedic	8.47%	3.47%	0.63%
Head & Neck	7.88%	2.88%	-1.16%
Child Health	4.29%	-0.71%	0.79%
Obstetrics & Gynae	4.09%	-0.91%	0.07%
Oncology	6.17%	1.17%	-0.60%
Pathology	3.39%	-1.61%	-0.91%
Radiology	0.00%	-5.00%	0.00%
Pharmacy	0.00%	-5.00%	0.00%
Therapies	11.90%	6.90%	-4.01%
Facilities	3.06%	-1.94%	-0.36%
Hospital Support	4.23%	-0.77%	-1.07%
Total	7.46%	**2.46%**	-0.44%



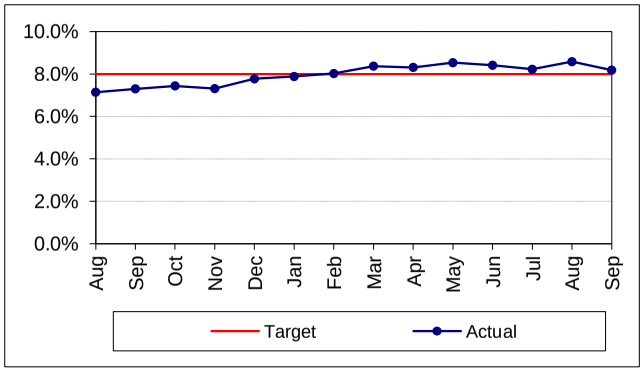
Staff Sickness Absence Rate

Directorate	Sickness Absence M6	Variance Against Target	Variance From M5
Target = 3.4%		<-0.0%	>0.0%
Medicine	3.76%	0.36%	-0.38%
Surgery	3.39%	-0.01%	-0.37%
Anaesthetics	5.16%	1.76%	1.39%
Trauma & Orthopaedic	3.56%	0.16%	-0.54%
Head & Neck	6.43%	3.03%	-0.69%
Child Health	3.25%	-0.15%	0.01%
Obstetrics & Gynae	6.62%	3.22%	0.63%
Oncology	4.18%	0.78%	0.14%
Pathology	2.16%	-1.24%	0.04%
Radiology	4.69%	1.29%	1.74%
Pharmacy	2.90%	-0.50%	0.36%
Therapies	7.33%	3.93%	0.22%
Facilities	5.59%	2.19%	-0.22%
Hospital Support	3.87%	0.47%	0.62%
Total	**4.34%**	**0.94%**	**0.11%**



Staff Turnover

Directorate	Turnover M6	Variance Against Target	Variance From M5
Target = 8.0%		<-0.0%	>0.0%
Medicine	7.12%	-0.88%	-1.02%
Surgery	7.90%	-0.10%	0.85%
Anaesthetics	4.31%	-3.69%	-0.17%
Trauma & Orthopaedic	6.99%	-1.01%	0.15%
Head & Neck	5.53%	-2.47%	0.06%
Child Health	12.48%	4.48%	-1.27%
Obstetrics & Gynae	7.95%	-0.05%	0.47%
Oncology	8.76%	0.76%	0.13%
Pathology	9.30%	1.30%	-0.30%
Radiology	4.20%	-3.80%	0.50%
Pharmacy	5.96%	-2.04%	0.68%
Therapies	10.51%	2.51%	1.75%
Facilities	11.42%	3.42%	-1.73%
Hospital Support	11.67%	3.67%	-1.15%
Total	**8.18%**	**0.18%**	**-0.40%**

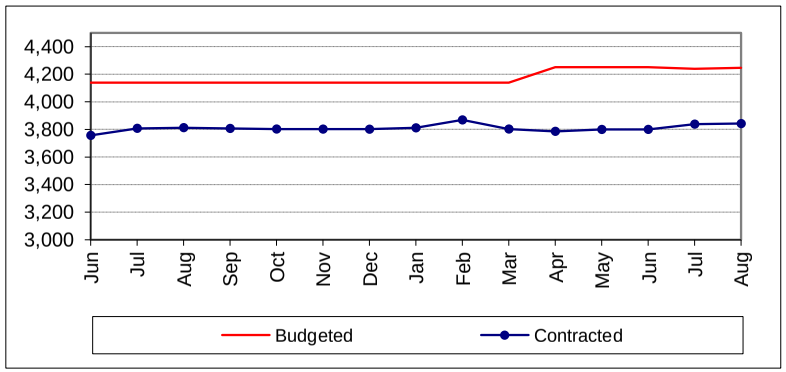


HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 6

DIRECTORATE WORKFORCE CAPACITY SUMMARY

Substantive Workforce Capacity FTE (Target = 95%)

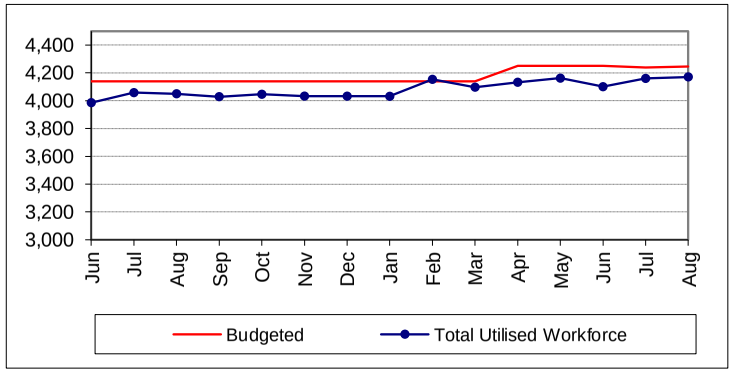
Directorate	Budgeted Establishment	M6 Contracted	Variance %	Variance FTE
Medicine	1,082.80	950.25	-12.24%	-132.55
Surgery	292.82	266.71	-8.92%	-26.11
Anaesthetics	328.34	306.98	-6.51%	-21.36
Trauma & Orthopaedic	254.9	231.55	-9.16%	-23.35
Head & Neck	173.33	151.66	-12.50%	-21.67
Child Health	266	260.39	-2.11%	-5.61
Obstetrics & Gynae	379.79	365.01	-3.89%	-14.78
Oncology	223.95	223.87	-0.04%	-0.08
Pathology	225.85	190.74	-15.55%	-35.11
Radiology	143.45	132.59	-7.57%	-10.86
Phamacy	101.65	99.09	-2.52%	-2.56
Therapies	79.37	68.50	-13.70%	-10.87
Facilities	344.56	280.03	-18.73%	-64.53
Hospital Support	357.04	325.82	-8.74%	-31.22
Total	**4,253.85**	**3,853.19**	**-11.90%**	-400.66



Total Workforce Capacity FTE (Excluding Medical Staff)

<95% = Under Establishment (-)	95% to 97% Establishment	97% to 100% Establishment	Over Establishment

Directorate	Budgeted Establishment	Total Utilised Workforce	Variance
Medicine	1,082.80	1,096.04	13.24
Surgery	292.82	293.82	1.00
Anaesthetics	328.34	329.15	0.81
Trauma & Orthopaedic	254.90	252.97	-1.93
Head & Neck	173.33	164.63	-8.70
Child Health	266.00	272.06	6.06
Obstetrics & Gynae	379.79	380.60	0.81
Oncology	223.95	238.58	14.63
Pathology	225.85	197.42	-28.43
Radiology	143.45	132.59	-10.86
Phamacy	101.65	99.09	-2.56
Therapies	79.37	77.75	-1.62
Facilities	344.56	288.87	-55.69
Hospital Support	357.04	340.22	-16.82
Total	**4,253.85**	**4,163.79**	-90.06



Northampton General Hospital NHS
NHS Trust

Transformation Programme

October 2012

Overall Transformation update

The Transformation project for 2012/13 was always going to be particularly challenging due in part to the success of the programme in making £16.1million worth of savings in the last financial year.

Whilst the programme is about the development of the organisation it is also about identifying savings by doing things more effectively and efficiently and ensuring that we are fit for purpose in the changing health landscape.

The Transformation target for the current year is £16.1 million, however the forecast stands at £11.1 million and we are not likely to be able to improve this in the current financial climate, due to high levels of activity and cost. The priority for the rest of the year will be to ensure that all current work streams deliver against the targets that have been agreed – and this includes the 3% CiPS allocated to individual departments.

The newsletter this month covers some of the challenges and successes of the programme so far and also some **organisational myths** that we have identified as part of the LiA initiative. Dispelling these myths will also in part help improve our approach to staffing and recruitment! Read on…..

Fact or fiction?

The Director of Workforce and Transformation recently lead a focus group on recruitment for regular recruiters, a direct result of the big conversations we had in the summer as part of Listening into action. Here are a couple of the myths we were able to dispel, and we share them as they have a direct impact on maintaining our establishment figures and reducing reliance on Bank and Agency staff. Please see http://thestreet/CorporateInformation/Departments/HumanResources/Recruitment.aspx for the full Q&A sheets from the event.

Continued over page……..

Overall Transformation update

When do I start the recruitment process (why do I have to wait until somebody leaves)?

As soon as you are informed that a member of staff is leaving you must complete a recruitment authorisation form and submit this to your authorised signatory by Friday of each week so that the vacancy can be considered at establishment control. When your vacancy is authorised start your recruitment process immediately, do not wait until the member of staff has left as this will cause a considerable delay and you will have nobody to replace your leaver.

Do you build in delays to the recruitment process to save money?

We do not do this, in fact in many instances it would be counterproductive as we could end up using bank or agency staff to cover where posts are vacant.

Further meetings with Ward Sisters and Matrons also identified another myth!

We have to agree to every request for flexible working/reduction in hours!

NGH is certainly a family friendly employer, but our priority has to be the needs of the service

We have identified that we are losing around 2 WTE nursing posts every month – in fact it was four in September, simply by reduction in working hours/flexible working requests and often with no idea about how to then cover the 'vacant hours' except to increase costs through bank/agency usage. Please contact your HR business partner or the HR service centre manager for support in how this policy should be implemented.

Bank & Agency update

The bank & agency (B&A) nursing spend for 2011/12 was £7.4 million, the target for 2012/13 is to reduce this spend by over £1 million . However, high spend has continued linked mainly to vacancies on wards and sickness absence levels. The Trust has an extensive recruitment plan that has also seen registered nurses (RNs) being recruited from Portugal and Ireland. From October the trust anticipate seeing the recruitment plan come into fruition with a large number of nursing staff starting. Due to the extensive recruitment the bank & agency steering group expect to see a decline in B&A usage across the trust with savings scheduled for the remaining months of 2012/13.

As well as recruiting, the trust is also working with ward sisters/ matrons to ensure Rosters are planned in advance so that B&A usage can be minimised. Rosters are being challenged to ensure roster efficiencies improve and that B&A usage begins to reduce as newly recruited members of staff start. At present we are still receiving too many last minute requests for cover.

The challenges faced by this workstream include:

Recruitment – In order to fulfil the recruitment of RNs NGH has had to also recruit internationally to support existing recruitment plans to ensure the volume of starters required would be fulfilled. The process is driven by an external organisation and NGH staff have been involved with interviews to ensure patient safety, patient experience and clinical outcome remain a priority. 39 RNs are joining us from Portugal & Ireland. In total 90 RNs & HCAs will start in October & November. There are a further 25 nurses to join before Christmas. Since 1st April 47 RNs & 72 HCAs have joined.

Identifying ward vacancies – It has been identified that nurses leaving the organisation are compounding the recruitment challenge. The immediate communication of leavers to the HR service centre is crucial as once this is identified the recruitment process can begin. It is often a common misperception that recruitment cannot begin until the post is vacant. We also need manager to ensure exit interviews are undertaken to understand why staff are leaving.

Vacancies created through adjustment of working hours – On a monthly basis there are at least 2 wte vacancies created within the trust through the adjustment of staff working hours.

Please see 'Fact or Fiction' for more on these topics.

Salary Sacrifice update

The green car scheme has been a great success so far, with 34 members of staff already ordering a green car, and a further 57 live quotes.

Janet Waterfield said 'The process was so easy I have recommended 3 others to have a look at the scheme.'

The cycle to work scheme has also been popular with 29 members of staff ordering a bike.

Both of these schemes are run all year round, so if you are considering replacing your car or would like a brand new bike, visit the rewardwise portal at https://ngh.rewardwise.co.uk. Logging on to the system is easy as your details will be the ones you received in a letter sent out to you in February at the launch of the salary sacrifice scheme. Your username will be your surname followed by your ESR (payroll) number. If you have any problems, please send your name and ESR number to salarysacrifice@ngh.nhs.uk.

If you have any questions or would like to know more about any of the schemes within Salary Sacrifice, we will be holding a promotional event in the Cyber Café during November, and will be advertising the date and time of this very soon.

Overtime update

As part of the Transformation programme we have been looking at the overtime spend across the whole Trust, and have identified areas of high usage. Although we appreciate that in some cases overtime is unavoidable, and is preferable to Agency, with the increased recruitment in nursing and with vacancies being filled in other areas, we would expect a reduction in the majority of areas from November.

The PMO is reviewing overtime usage every month and is working with Care Group & Directorate leads to ensure all overtime is agreed.

We are at present on target to spend almost £1 million in the current year & we must see this reduced by at least £200k.

Transformation Mitigation

The trust's Transformation target of £16.1m savings this year has been very challenging and we still need to identify new projects & make every effort to reduce spending where it is safe to do so.

We are currently implementing additional mitigation plans which includes:

- Office furniture freeze—the trust has put a freeze on the acquisition of new office furniture and are promoting recycling and sharing of furniture.
- Printing rationalisation
- Detailed analysis of overtime

If you have any ideas for schemes that can deliver cost or quality benefits, please discuss them with your manager, or contact one of the Transformation Team Members below.

Who to contact……..

If you have any comments or questions related to anything contained within this newsletter, please don't hesitate to contact any member of the Transformation team listed below

Jenny Briggs, (Jenny.briggs@ngh.nhs.uk—Ext 3711)

- Pathology
- Back Office (HR, Finance, IT, MFDs, R&D)
- Pharmacy
- Procurement
- Outsourcing (3rd Party Pharmacy, Hybrid Mail)

Chris Albone, (Christopher.albone@ngh.nhs.uk—Ext 5909)

- Outpatients
- Patient Flow
- Contract Compliance
- On-Call

Jatinder Singh (Jatinder.singh@ngh.nhs.uk—Ext 3317)

- Nursing
- Estates
- Bank & Agency
- Therapies

Lorna Gould (Lorna.gould@ngh.nhs.uk—Ext 5909)

- Theatres
- Administration Review
- Controls

BOARD SUMMARY SHEET	
Title: -	Self-Certification Return
Submitted by: -	Chris Pallot, Director of Strategy & Partnerships
Date of meeting: -	25th October 2012
Corporate Objectives Addressed: -	Performance Assurance.

SUMMARY OF CRITICAL POINTS: -

This report details the hospital's current position as at September 2012 with regard to:

- Effectiveness
- Patient Experience
- Quality
- Patient Safety
- Financial Risk

PATIENT IMPACT: -
N/A

STAFF IMPACT: -
N/A

FINANCIAL IMPACT: -
N/A

RISK ASSESSMENT: -
N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -
N/A

RECOMMENDATION: -

Trust Board are asked to discuss the contents of this report and sign off the return.

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
September 12
NHS Trust Over-sight self certification template

Returns to providerdevelopment@eoe.nhs.uk by the last working day of each month

TFA Progress

Sep-12

Northampton General Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Comments where milestones are not delivered or where a risk to delivery has been identified
1	Deloite Board Development / BGAF review	Jul-12	Fully achieved but late		Board development and BGAF review is ongoing. Board Development programme finalised at the Board Development session facilitated by Deloitte on 20/09/12
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12		On track to deliver	
3	Trust to review the TFA in response to the Healthier Together Consultation	Oct-12		Risk to delivery within timescale	
4	In-month delivery of 95% A&E 4-hour indicator	Oct-12		On track to deliver	
5	Recovery plan agreed at Board to stabilise financial position	Oct-12		On track to deliver	
6	Director of Finance appointed	Nov-12		On track to deliver	
7	Director of Workforce and Transformation appointed	Nov-12		On track to deliver	
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12		On track to deliver	
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12		On track to deliver	
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12		On track to deliver	
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12		On track to deliver	
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12		On track to deliver	
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12		On track to deliver	
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12		On track to deliver	
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12		On track to deliver	
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13		On track to deliver	

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Northampton General Hospital	Period:	September 12

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	
Financial Risk Rating (Assign number as per SOM guidance)	1
Contractual Position (RAG as per SOM guidance)	

*** Please type in R, A or G**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	Gerry McSorley
on behalf of the Trust Board	Acting in capacity as:		Chief Executive

Signed by :		Print Name :	Paul Farendon
on behalf of the Trust Board	Acting in capacity as:		Chairman

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**A&E: Total time in A&E**
The Issue :	**The Trust delivered the Transit time target in Sept 2012 but is still currently behind trajectory YTD (93.87% YTD as at 30 September 2012).**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

Target/Standard:	**FRR**
The Issue :	**YTD defcit of £5.3m leading to FRR score of 1.**
Action :	**Addional CIP and mitigating actions to be developed and actioned.**

GOVERNANCE RISK RATINGS

Northampton General Hospital

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	N/a	N/a	Yes	Yes	Yes	Yes	Yes	Incomplete pathway target of 92% monitored from April 2012. (Previous year targets were monitored for compliance against median and 95 percentile waits)
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	Yes	Yes	Yes	Yes	Yes	Partially compliant for Q3 & Q4 2011-12
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	Yes	No	Yes	No	The Quarter 2 target for 62-day urgent GP referral has been met (86.6%) as has the 62-day screening target (93%). (The spread sheet format is protected and does not allow for the Q2 cell to be changed to reflect this.)
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No	Yes	No	93.87% YTD as at 30 September 2012
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3j	Category A call –emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes	No	No	2 infections YTD (1 x Apr 12 and 1 x Sept 12). Yearly target = 1 infection.
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
				TOTAL		**1.5**	**1.5**	**2.0**	**1.0**	**2.0**	**1.0**	**3.0**	

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

	Overriding Rules - Nature and Duration of Override at SHA's Discretion								
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	No	No	No	No	No	No	No	
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No	No	No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No	No	No	
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	Yes	Yes	Yes	Yes	Yes	Yes	
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No	No	No	
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	Yes	Yes	Yes	Yes	Yes	Yes	
		Number of Overrides Triggered	***0.0***	***2.0***	***2.0***	***2.0***	***2.0***	***2.0***	***2.0***	

FINANCIAL RISK RATING

Northampton General Hospital

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	YTD 1.4%; FOT 3.4%
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	2	1	2	YTD 31%;FOT 57%
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	1	1	1	YTD Deficit £5.3m;FOT £5.2m
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	1	1	1	YTD Deficit £5.3m;FOT £5.2m
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	2	2	2	YTD 16 days; FOT 13 days (incl. WCF £18m).
Weighted Average		**100%**						**1.8**	**1.6**	**1.5**	**1.6**	
Overriding rules								1	2	1	2	
Overall rating								**1**	**2**	**1**	**2**	

Overriding Rules :

Max Rating	Rule							
3	Plan not submitted on time	No						
3	Plan not submitted complete and correct	No						
2	PDC dividend not paid in full	No						
2	One Financial Criterion at "1"			2		2		
3	One Financial Criterion at "2"		3					
1	Two Financial Criteria at "1"		1		1			
2	Two Financial Criteria at "2"			2	2	2		

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Northampton General Hospital

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	No	No	No	No	Yes	Yes	Not achieved H1 12-13.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	No	No	No	No	Yes	Yes	Forecast to achieve Level 3 by Q4 subject to recovery plan and overriding rules.
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	£611k (16%)
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	No	No	No	No	No	£423k (4.7%).
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	Yes	Yes	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-14 days excluding WCF.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	

CONTRACTUAL DATA

Northampton General Hospital

Insert "Yes" / "No" Assessment for the Month

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	No	No	Yes	Yes	Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
Might the dispute require SHA intervention or arbitration?	N/a	N/a	N/a	No	No	No	No	
Are the parties already in arbitration?	N/a	N/a	N/a	No	No	No	No	
Have any performance notices been issued?	Yes	Yes	Yes	Yes	No	No	No	
Have any penalties been applied?	No	No	No	No	No	No	No	

QUALITY

Northampton General Hospital

Insert Performance in Month

	Criteria	Unit	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Comments on Performance in Month
1	SHMI - latest data	Ratio							109	109	109	106	106	106	SHMI - Latest position reported in Sept 12 reflects Jan 11 - Dec 11
2	Venous Thromboembolism (VTE) Screening	%	93.1%	93.4%	93.3%	92.2%	93.6%	90.9%	91.4%	91.9%	90.3%	93.0%	90.7%		September data is due to be generated last week of October
3a	Elective MRSA Screening	%	99.4%	99.6%	99.5%	100.0%	99%	99.93%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	
3b	Non Elective MRSA Screening	%	97.3%	97.0%	96.8%	97.3%	96.20%	91.05%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	5	6	5	15	12	14	12	3	9	5	4	5	
6	"Never Events" in month	Number	1	0	0	1	0	0	0	0	0	0	1	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	2	0	1	1	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	3	5	3	4	2	3	1	2	1	1	2	2	Number of deliveries; benchmarked to 4500 deliveries per annum. Highlighted in view of requirement for second middle tier of obstetricians in line with the recommendations from Safer Childbirth
10	Falls resulting in severe injury or death	Number	2	4	1	1	0	2	0	0	1	2	2	0	
11	Grade 3 or 4 pressure ulcers	Number	2	3	0	3	5	0	1	4	2	1	0	3	There were 3 x Grade 3 acquired pressure ulcers recorded in Sept 12
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	51	44	29	39	48	49	50	51	39	48	33	35	
14	Agency as a % of Employee Benefit Expenditure	%	5.0%	4.8%	5.5%	5.4%	5.5%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.70%	Sept 12 - Bank & Agency Spend £1.580m / £20.391m income
15	Sickness absence rate	%	4.1%	4.1%	4.2%	4.4%	4.6%	Not Av	4.78%	5.0%	4.6%	4.6%	4.2%	N/a	Sickness absence rates are not available prior to 6 weeks post month end.
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	This information is not currently available in the trust. Discussions are to take place on the viability and benefits of routinely collecting this data.

Board Statements

Northampton General Hospital

September 12

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes

	For FINANCE, that:	Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	No
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes

	For GOVERNANCE, that:	Response
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 25th October 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 27th September 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**3**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**4**
09.55	7.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.05	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.15	9.	Operational Performance Report	Mrs C Allen	**7**
10.35	10.	Finance Report	Mr P Hollinshead	**8**
10.55	11.	Human Resources Report	Ms G Opreshko	**9**
11.05	12.	Transformation Programme Newsletter	Ms G Opreshko	**10**
11.10	13.	Self-Certification Return	Mr C Pallot	**11**
Governance				
11.15	14.	Any Other Business		
	15.	**Date & time of next meeting:** 9.30am Thursday 29th November 2012, Boardroom, NGH		
	16.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	