Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 29th November 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.	Minutes of the meeting held on 25th October 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 January 31st 2013		
	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 25th October 2012 at 9.30am
Boardroom, Northampton General 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 P Hollinshead	Interim 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

In attendance:

Mr J Bufford	Interim Head of Corporate Affairs (minutes)
Mr T Delaney	Head of Communications
Mr R Kelso	Shadow Governor
Mr A MacPherson	Shadow Governor
Mrs M McVicar	Shadow Governor

Five other members of the public and staff

TB 12/13 70 Apologies and opening remarks

Mr Zeidler had sent apologies.

Mr Farenden welcomed the Shadow Governors and nursing and midwifery colleagues to the meeting.

TB 12/13 71 Declarations of Interest

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

TB 12/13 72 Minutes of the meeting held on 27th September 2012

The minutes were agreed. There were two amendments:

TB12/13 58: The second sentence should be worded as follows:

> The score for August was 57; which was not as good as hoped due to the fact that the combined manual/Hospedia score had to be used because there were insufficient (under 10%) manually collected surveys for August. Data collection would be solely from the manual method from September.

TB 12/13 64: The last sentence should be worded as follows: “The Board of Directors APPROVED the signing of the PMR for onward submission”

Subject to these amendments the minutes were accepted as a true and correct record.

TB 12/13 73 Action Log and matters arising

TB 12/13 62: Mrs Opreshko reported that the appraisal work was on-going and proposals were being taken forward. Work on mandatory training had been discussed at HGC who would be monitoring this on a monthly basis.

All other actions and matters arising were on the agenda.

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TB 12/13 74 Chief Executive's Report

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

- The Haematology unit opening had gone well. He thanked Dr Swart and her colleagues for helping to bring this project to such a successful fruition.

- Chris Head, the national handwashing champion and the Diabetic Foot Team who had also won an award would join Board for lunch.

- There had been considerable media coverage of the Healthier Together programme. He had done a number of presentations to staff on the programme. The Corby and East Northamptonshire by-election had now been called and election rules meant that the NHS could not make any major statements on this until after the election on 15th November.

The Board of Directors NOTED the report

TB 12/13 75 Medical Director's Report

Dr Swart presented her report. There had been national interest in higher weekend mortality rates and she had covered this in her report. For NGH the difference in mortality rates at weekends was less marked than previously, with particular improvements in stroke and vascular services. Mr Farenden asked what had caused this improvement. Dr Swart felt that this was the result of focus on particular conditions from the teams involved.

Mr Kershaw asked about coding issues. Dr Swart explained that when the data was reviewed it was important to understand whether the issue was the quality of the care or the way in which the case has been coded. It was important to distinguish between different conditions as the primary cause. If Northampton was applying a different primary diagnosis to specific conditions this would show up in the data despite there being no difference in the quality of care.

Dr McSorley asked if the review of the emergency care pathway would impact on the SMR work – Dr Swart agreed that it would offer some benefits.

Ms Loader drew Board's attention to the CQUIN issues referred to in the exception report on page 19. The key issue was information about medication given on discharge. She had asked for the CQUIN questions to be added to the manual Friends and Family test collection form and also to be added to the "pop-up" question on Hospedia which is aimed at patients who are being discharged that day. This will commence from November.

The Board of Directors NOTED the report.

TB 12/13 76 Patient Experience – Friends and Family Test

Ms Loader introduced her report. The score for September was 74. The Trust was focusing on the feedback it had received and addressing the issues patients raised.

Mr Abolins reported that in response to the issues raised by patients about food in the FFT feedback his department had conducted a more detailed survey so specific issues could be tackled. A concordat outlining specific responsibilities between nursing and hostess staff on the ward had been agreed between himself and Ms Loader – this was due to go to the Ward Sisters/Matrons meeting in November for final agreement and implementation. Dr McSorley added that work was also being done to improve the supper menu and three hundred volunteers were being recruited to offer assistance to patients who needed help in feeding.

The governors and volunteers had been doing some valuable work on ward audits which were focusing on noise at night, protected mealtimes and ward notice boards.

As a result of feedback Creaton ward is to be redecorated using charitable funding to make it easier for dementia patients to find their bed space – using pictograms and colour schemes. It was agreed that this should be visited as part of the Board to Ward Programme.

Action: Dr Swart

Mr Robertson asked whether the use of manual data collection might be seen by some as open to suspicion. Ms Loader reported that new guidance appeared to be moving away from face to face collection of data – she was looking at the implications of this. Ms Allen noted that from April 2013 the Friends and Family Test would be rolled out to A&E – Ms Loader added that the questions to be used had not been finalised. She would report this to board once information became available.

Action: Ms Loader

Mr Farenden asked if the Friends and Family Test would be rolled out to other areas – Ms Loader and Ms Allen thought that this would be the case.

The Board of Directors NOTED the report and supported action to role out the test to other areas

TB 12/13 77 Monthly Infection Prevention Performance Report

Ms Loader introduced the report. Disappointingly there had been a second confirmed case of MRSA bacteraemia. This occurred when a patient had been transferred in from another hospital without full transfer documentation. The patient was screened on arrival but the time to turn round test results meant that decolonisation treatment had not happened immediately. The Trust was working with the other hospital to look at lessons that could be learned which included the introduction of a joint transfer letter form.

Ms Loader also noted that whilst the Trust had a very good track record of decolonisation of elective patients it was not so successful with emergency patients. As a result, the Infection Control Team had been asked to draw up an action plan to rectify this.

Mr Farenden asked for assurance that the Trust was not complacent on this issue. Ms Loader and Dr Swart reported that a thorough investigation was taking place. In addition to working with the hospital the message that no patients should be accepted without transfer information.

Mr Robertson queried the drop in emergency screening compliance in March 2012 data on page 34. Dr McSorley asked whether absolute numbers rather than just percentages would help give a better position. Ms Loader agreed to look into the reasons for the drop and to add numbers to future graphs.

Action: Ms Loader

Dr McSorley asked whether, given the time it took to turn round tests it would be worth assuming that patients had MRSA until screening showed otherwise. Ms Loader had discussed this with the infection control team and had concluded that it was worth doing for high risk patients but not for all patients. It was proposed to widen the definition of high risk patients.

The Board were shown a hand hygiene video featuring Trust staff – this was proving popular on the intranet and Youtube. .

The Board of Directors NOTED the report, supported the actions proposed and expressed their expectation that performance is maintained

TB 12/13 78 Operational Performance Report

Ms Allen presented her report. The Trust had achieved 96.89% for the A&E target in September and the year to date performance was 93.95% which was ahead of trajectory.

The Trust had achieved all of its Referral to Treatment Time (RTT) standards. She drew attention to pathways where patients had not started their treatment after 26 weeks. There were 55 of these as at September the bulk of which were complex orthodontic cases. By increasing capacity and systems within orthodontics this number will reduce from November onwards.

The Trust had achieved the quarterly cancer targets although the in-month standard of 62 days from consultant upgrade to start of first treatment had not been achieved; it should be borne in mind that this standard represented very small numbers of patients.

Mr Kershaw noted that the Trust had put in considerable effort to turn round A&E performance and felt that the Board should recognise this. Mr Farenden agreed, but felt it was important that the Trust did not lose impetus. Dr McSorley noted that the Trust had just broken its record for the number of emergency patients admitted in a single day.

Mr Kershaw asked about progress on the emergency care pathway work. Ms Allen reported that the Emergency Care Group and individual project groups had been set up. Dr McSorley emphasised the importance of this project: the need was to develop practical and realistic solutions – such as getting

geriatricians into A&E. There had been a substantial shift in the types of patients using A&E and it was no longer just used by trauma and minor injuries patients.

The Board of Directors NOTED the report and confirmed their commitment to the achievement of the trajectory targets.

TB 12/13 79 Finance Report

Mr Hollinshead introduced his report. He focused on the key statutory financial duties of the Trust. The Trust was now forecasting a £2.5m deficit, but expected to meet its External Financing Limit and Capital Resource limit.

The main concern was the income and expenditure deficit. If the Trust took no action the present trajectory would result in a forecast deficit of £11.1m – Executive Directors had developed a Financial Recovery Plan and with support from the SHA/CCG believed that this could be contained to £2.5m. The main reasons for the deficit were the slippage of the Transformation Programme and a substantial rise in non-elective activity above plan which had resulted in higher than average costs to deliver.

There were three main strands to the Recovery Plan. The Trust was working to confirm funding for prevailing activity levels with commissioners; would seek non-recurrent funds from the SHA for the costs of Transformation and ensure expenditure control totals were in place across the Trust and were tightly monitored. Dr Swart emphasised that the Trust was committed to maintaining the quality of services and Mr Hollinshead noted that good quality services were also the most efficient services.

Dr McSorley said that the Executive Team believed that the planned savings were the maximum that could be achieved without compromising quality. Accepting that a deficit, which was in breach of the Trust's legal duties, was not a decision to be taken lightly and that further discussions with the SHA and CCG should be held.

Mr Robertson asked about plans for 2013/14. Mr Hollinshead would be taking an early view and this would be discussed at the next Finance and Performance committee. Mr Pallot was seeking the views of care groups and others to inform his discussions with commissioners.

Mr Hollinshead noted that the Trust's cash position was very tight and that it might be necessary to take a short term loan to cover this. In response to a question from Mr Abolins he confirmed that there would be a cost for this but that it should be very low given the current level of interest rates.

The Board of Directors AGREED that the Trust should work towards financial balance, SUPPORTED the Financial recovery Plan, AGREED that in the absence of external support the forecast deficit of £2.5m was realistic in the light of prevailing performance and measures proposed and AGREED that further discussions should be held with CCGs and the SHA regarding the Financial Recovery Plan assumptions.

TB 12/13 80 HR Report

Mrs Opreshko presented her report. An increase of 60 staff had been offset against leavers. Considerable inroads had been made on tackling sickness and the long term sickness in the Trust was now the lowest for six months. Her team were now beginning to focus on short term absence. Work on addressing mandatory training had already been mentioned (TB 12/13 73).

Mr Robertson noted the reduction of temporary workforce as a percentage of the total, but asked about the cost and in particular the expense of locums. Dr Swart noted that the temporary workforce included both nursing and medical locums. A variety of solutions were used to reduce this but gaps in the junior doctor training programme meant some medical locums were needed.

The Board of Directors AGREED the report and supported the initiatives being taken which would have a positive effect on staff costs.

TB 12/13 81 Transformation Programme Newsletter

Mrs Opreshko presented the Newsletter. This month a more balanced approach had been adopted, with a feature on tackling some of the myths that had grown up around transformation.

She drew attention to the recruitment of 78 qualified nurses and 70 Healthcare Assistants – with plans to recruit more. This would allow agency usage to be stopped. Once the new nurses were trained and on the wards new controls would be put in place. With a few specified exceptions Ms Loader would be the only person to authorise the use of agency nurses.

Dr McSorley noted that there had been some adverse press coverage on recruitment which had been misleading. The Trust's comments had been ignored by the paper that published the story and he had written to the paper requesting a retraction.

The Board of Directors NOTED the newsletter and supported the action taken

TB 12/13 82 Provider Management Self Certification

Mr Pallot presented the proposed self-certification. The governance risk rating was green – although the second MRSA meant that the MRSA target was now red rated. The Financial Risk Rating was 1. Dr McSorley noted that nationally a "de minimus" number of 6 MRSA cases was required before MRSA was red rated and so the Trust would remain green for national reporting purposes – however this should in no way detract from the Trust's work to reduce HCAIs.

The Board of Directors APPROVED the signing of declaration 2 of the PMR

TB 12/13 83 Any Other Business

None raised.

TB 12/13 84 Date of next meeting: November 29th 9.30 Boardroom NGH

TB 12/13 85 **The Board of Directors resolved 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**

Action Log for the Board meeting held in public at 25 October 2012

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 76	Friends and Family Test	25 Oct 2012	Visit to Creaton ward to be added to Board to Ward programme	Dr Swart	November 2012	
TB 12/13 76	Friends and Family Test	25 Oct 2012	Update Board on FFT A&E questions once available	Ms Loader	November 2012	
TB 12/13 77	Infection Prevention and Control	25 Oct 2012	Include numbers as well as percentages on IPC graph	Ms Loader	November 2012	

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

TRUST BOARD 29th NOVEMBER 2012	
Title: -	Chief Executive's Report
Submitted by: -	Dr G McSorley, Chief Executive

SUMMARY OF CRITICAL POINTS: -

There are five issues to be brought to Board's attention:

- NHS Mandate
- Northampton Care Zone
- Partnership working
- Hospital Heroes
- Medical Illustrations Award

RECOMMENDATION: -

The Board is asked to note the report.

CHIEF EXECUTIVE'S REPORT
NOVEMBER BOARD MEETING

1. The Mandate

As part of the Governments reforms of the NHS, the Department of Health will issue a clear set of requirements, called the Mandate, which it requires the new NHS Commissioning Board to deliver on. The attached Mandate identifies 5 key priorities:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The Mandate will form part of the priorities that commissioners will use in the next contracting round and should be reflected in the Operating Framework for 2013/14 due to published in December

2. Northampton Care Zone

The summit to discuss the development of a 'healthcare zone' for Northampton was held at St Andrews Hospital on the 21st November. There was very good representation from the health, social care and local authorities and the University of Northampton. It was agreed that the meeting had been a useful contribution to the strategic planning of services and that a further meeting would be helpful going forward.

3. Partnership working

I am delighted to report that at the most recent Joint Consultation and Negotiating Committee it was agreed to formally develop a 'partnership agreement' which embodies the new ways of working together between the Trust and our trades unions and professional bodies. This work will begin in the New Year.

4. Hospital Heroes

I am pleased to report that members of NGH staff have been honoured in the national NHS Heroes campaign. Members of the public are invited to nominate members of staff who they think have gone above and beyond the call of duty as NHS Heroes. We have had eight nominations for awards – including the entire staff of two wards.

I would like to offer my congratulations to all the winners. Timing makes it difficult to do so by name since some of the awards will be presented in the next few days and naming the winners now would spoil some of the surprise. However, all their achievements will be publicised in due course.

5. Medical Illustrations

I am delighted to inform you that several members of our staff in the Department of Medical Illustrations were awarded Gold and Bronze Awards in the IMI awards 2012.

Lee Hillyard and Duncan Kempson each won a Bronze Award, and Duncan also won a Gold Award for a stunning photograph of basal cell carcinoma.

The awards are made for submissions that show outstanding applications of technique in the fields of photography, graphics and vido, and were made at the IMI's Annual Awards Dinner in Glasgow on 15th September 2012. The winning entries may be viewed on II's website: www.imi.org.uk.

Dr Gerry McSorley
Chief Executive
November 2012

Richmond House
79 Whitehall
London
SW1A 2NS

Date: 13 November 2012

To:
All Chairs and Chief Executives in NHS trusts in England
All Chairs and Chief Executives in NHS foundation trusts in England
All Chairs and Chief Executives in primary care trusts in England
All Chairs and Chief Executives in strategic health authorities in England
Regional Directors, NHS Commissioning Board

Cc:
All Chief Executives of Local Authorities in England
Monitor

Gateway reference: **18383**

Dear colleagues

PUBLICATION OF THE NHS MANDATE

The Secretary of State for Health has today published the first mandate to the NHS Commissioning Board (NHS CB). The NHS mandate sets out the Government's ambitions for the NHS, which it is asking the NHS CB to achieve from April 2013 to the end of 2015.

The mandate has been informed by a wide range of organisations and stakeholders across the health and care system. It sets a number of objectives for the Commissioning Board, based on the five domains identified in the NHS Outcomes Framework, an updated version of which is also published today.

As leaders of the health and care system, it is important that you understand exactly what the NHS is being asked to do over the next few years. This applies both to those of you supporting organisations in their transition to the new system, and to those of you who will be helping deliver these objectives. You can read the NHS mandate at www.dh.gov.uk/mandate.

In the coming weeks I will be writing out to many of you in my role as Chief Executive of the NHS CB to set out details of the Board's approach to the 2013/14 planning round.

I look forward to continue to working with you all as we continue our transition to the new health and care system.

Kind regards

Sir David Nicholson KCB CBE
NHS Chief Executive

TRUST BOARD 29th NOVEMBER 2012	
Title: -	Medical Director's Report
Presented by: -	Dr Sonia Swart, Medical Director
PURPOSE OF PAPER: - Update on Mortality and Clinical Scorecard	
CRITICAL POINTS: - • Overall mortality as measured by HSMR and SHMI is within acceptable parameters. • On-going analysis and risk based audit continues in order to define any coding or quality of care issues. • Further scrutiny of information flows will continue. • In addition to the monitoring of mortality information about readmission rates and length of stay is of importance in order to understand the resolve the emergency pressures. • The clinical scorecard outlines areas where there is on-going concern in relation to performance. • Tracking of appropriate quality measures is an increasingly important tool which should be used to allow the Board is able to challenge the quality of care provided.	
ACTION REQUIRED BY BOARD: - The Board is asked to note the report and debate key issues	

Section 1

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 five months of 2012/13 is **96** (435 deaths versus 453 expected deaths) which is predicted to rise to 102 after re-benchmarking.

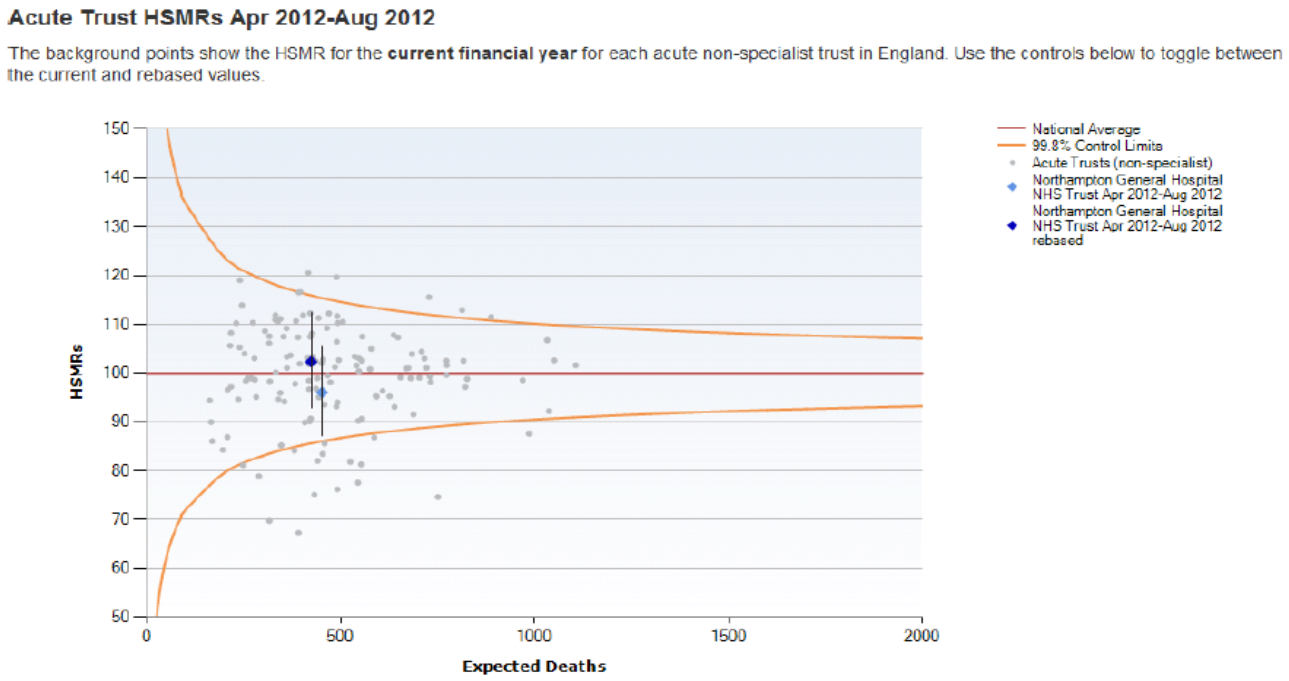
There continues to be concern relating to clarity of the recording of primary versus secondary diagnosis for some diagnoses such as secondary malignancy, diabetes and senility.

For August the HSMR was **99.6 (**87 deaths, 87 expected).

3. Acute Trust HSMRs April 2011 - March 2012

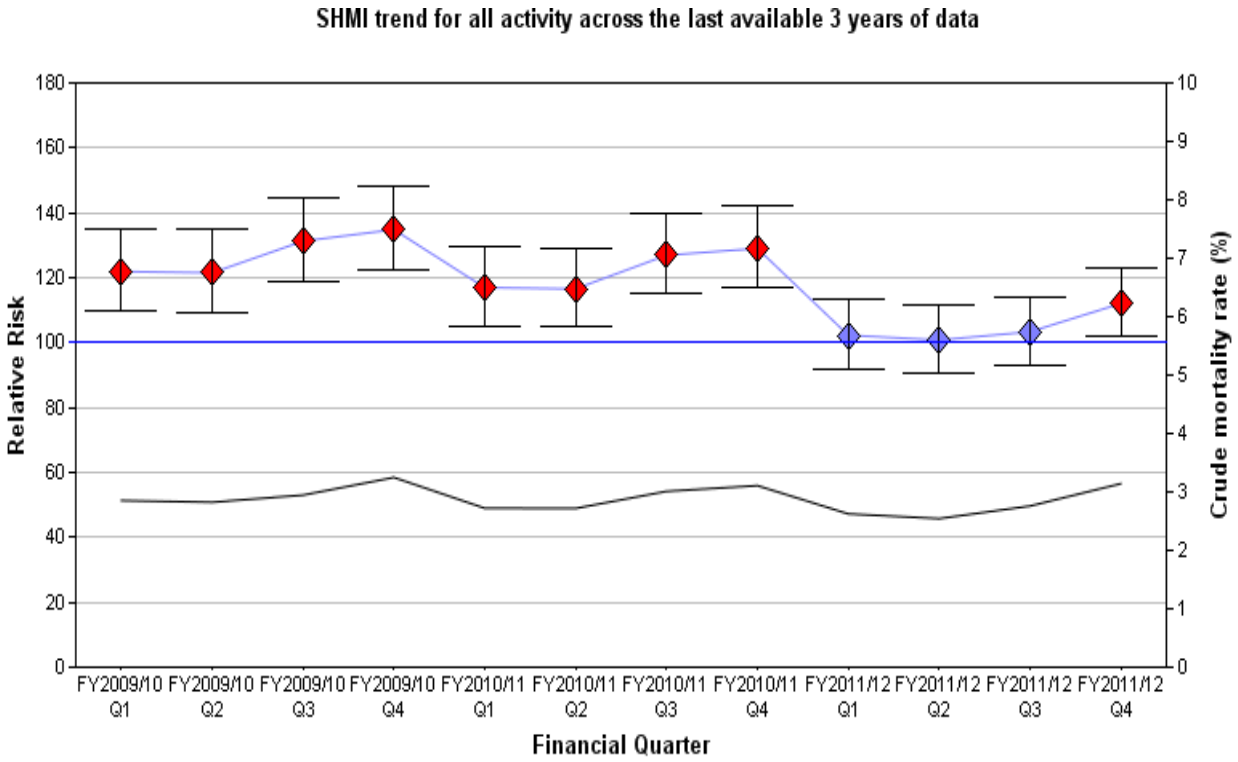
NGH is not an outlier with respect to mortality as measured by HSMR as shown below.

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



4. Standardised Hospital Mortality Indicator (SHMI)

The SHMI for the last quarter of 2011/12 was higher than in the previous 3 quarters at **112**. The rolling SHMI to the end of this quarter was **105** which represents a SHMI in the 'as expected' category. The SHMI is rebased each time it is calculated unlike the HSMR. The SHMI and HSMR do not correlate well for some diagnostic groups. The significance of this is as yet uncertain.



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

There are currently no concerns in relation to the Dr Foster Patient Safety Indicators. This is shown on the table below:

The Patient Safety Indicators are adapted from the set of 20 devised by the Agency of Healthcare Research and Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and consultation and they have the benefit of being based on routinely available data. We have translated the US codes (ICD-9 for diagnoses and procedures) to the ICD-10 diagnosis codes and OPCS 4.3 procedure codes used in HES and NHS Wide Clearing Service in the NHS.

Sep 2011 to Aug 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		25	24.6	0.69	0.68	more information
Decubitus Ulcer		120	197.9	13.58	22.40	more information
Deaths after surgery		42	33.2	138.16	109.17	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		12	13.5	0.64	0.72	more information
Post-operative pulmonary embolism or deep vein thrombosis		25	38.3	1.06	1.62	more information
Post-operative sepsis		5	4.4	6.87	6.09	more information
Post-operative wound dehiscence*		2	1.1	2.21	1.18	more information
Accidental puncture or laceration		24	74.2	0.37	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		19	38.4	40.95	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		89	90.4	36.78	37.37	more information
Obstetric trauma - caesarean delivery*		6	4.4	4.69	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.

6. 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. Although the mortally in this group has been higher than in the previous year, this has not yet reached statistical significance.

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 has now been re-established. 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 although there may be data issues relating to the relative use of primary versus secondary diagnoses, the clinical coding was broadly speaking correct. It may be that different Trusts are allocating patients in different ways to the primary diagnosis of senility or secondary malignancy. There were no specific issues relating to quality of care. When the denominator includes all primary and secondary codes for these conditions there is no excess mortality.

c) Areas of general relevance with respect to overall Trust performance

The Trust has a higher than expected readmission rate. This was recently the subject of a multidisciplinary audit. During this process many of the readmissions were thought to have been necessary due to factors unrelated to the care at NGH. The Trust also has a higher number of excess beds days than might be expected. This may relate to the presence of rehabilitation beds on site, the use of community hospitals and delays in transfers of care. There is on-going work to improve the emergency pathway in order to ensure that patients receive timely and appropriate care in the most appropriate setting. As part of the excessive pressures in the emergency areas there are however a number of patients who have their surgery cancelled on the day of operation. This is only necessary when there is a priority to ensure that patient safety is preserved. The Trust has succeeded in increasing day case rates over a period of years and performs well in this area. There has been an above expected performance in particular for day case laparoscopic cholecystectomy.

7. Further Comments and Actions Planned

The detailed monitoring process based on the use of the Dr Foster Intelligence tool continues and the Mortality and Coding group has now been set up as a formal extension to this process in order to ensure wide clinical and managerial ownership of the issues. The planned work to examine information flows, clinical coding and patient flow has now been commissioned and will commence within the next few weeks. A new coding manager has been recruited.

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.

8. Conclusion

The position with regards to overall mortality as measured by HSMR and SHMI indicates that performance is ‘as expected’. There is on-going work to improve the position through targeted improvement work. Continued focus on the emergency pathway in partnership with the Health Care Economy will be necessary to ensure reductions in length of stay and readmissions.

9. Recommendation
The board is asked to note the report and debate any issues that arise from it.

Section 2

NGH Monthly Quality Scorecard and NGH Monthly Quality Scorecard

1. Introduction
This scorecard includes indicators selected by the Trust or 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. **(see Appendix 1**). The Midlands and East Quality dashboard is also attached **(Appendix 2).**

Performance is reported by exception, i.e. where performance is below standard (red), where specific pressures that present a risk to the on-going 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 and SMR by diagnosis group is reported as 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.

2. Performance
Of 137 indicators, **41** (**28/13**) are rated as either red or amber status. The exception summary report outlines the underperforming indicators and details the remedial action(s) being taken. There are 35 indicators that are rated grey. This has increased in comparison to October's Report as the CQUINS and indicator elements are more refined. Indicators rated as grey are either baseline data which still to be agreed or information which is currently not available.

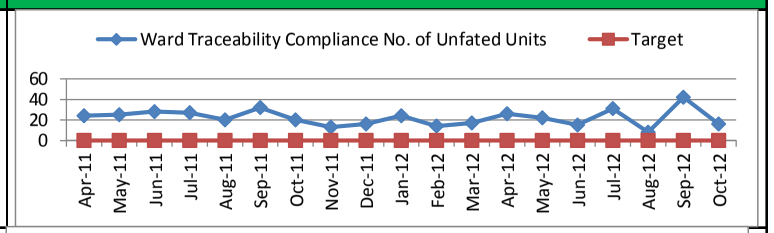
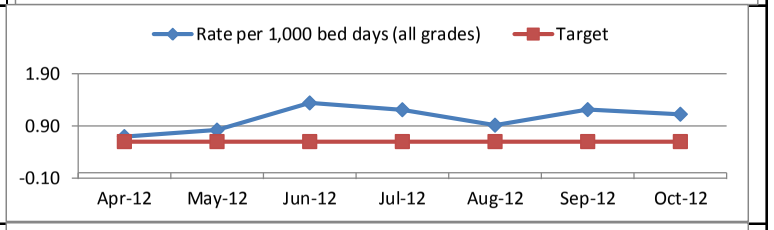
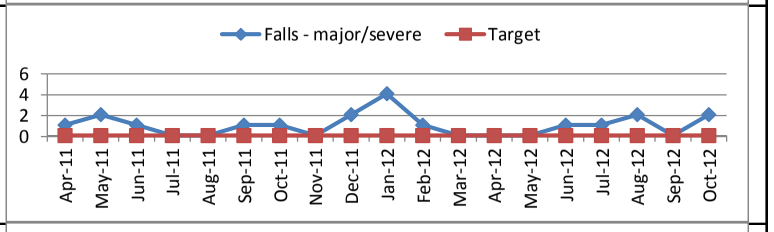
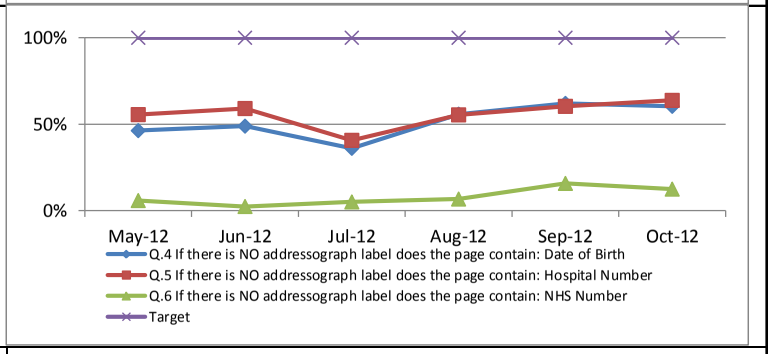
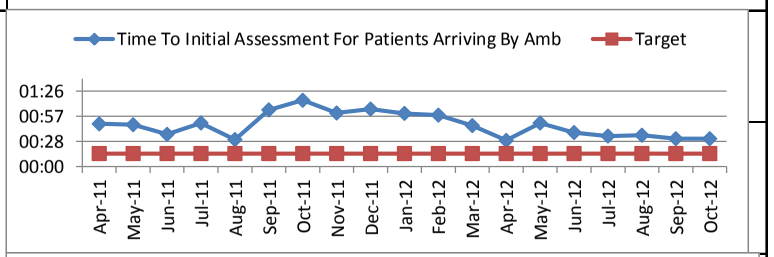
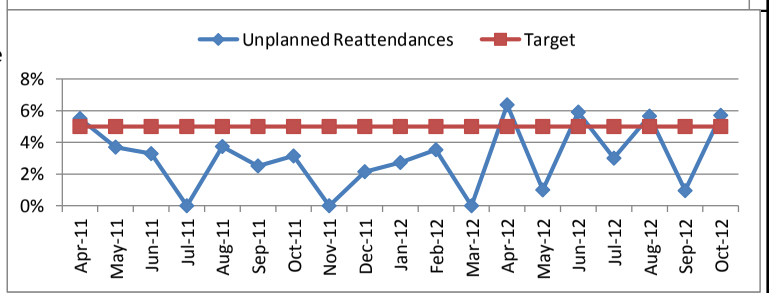
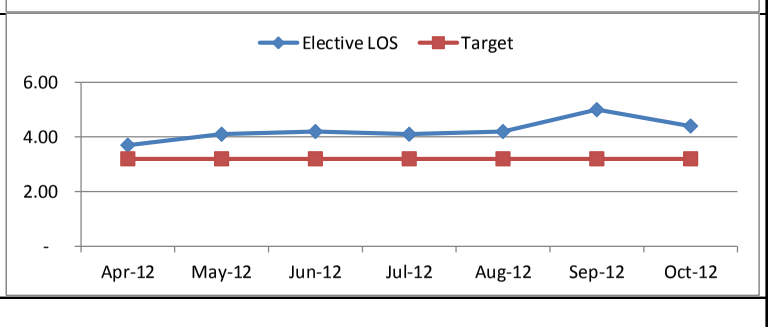
Summary Rating

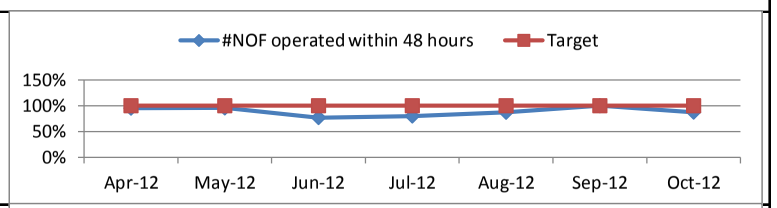
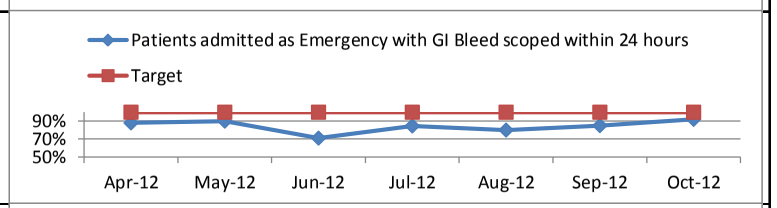
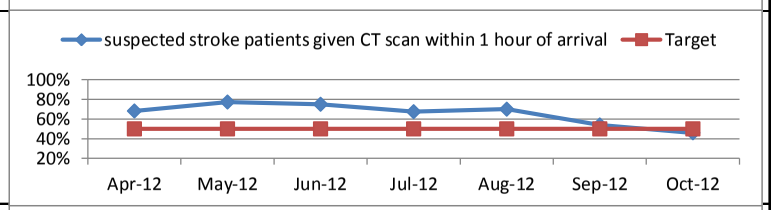
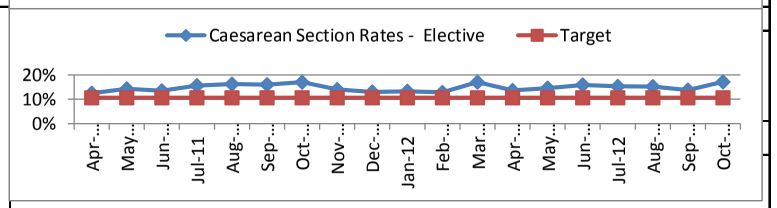
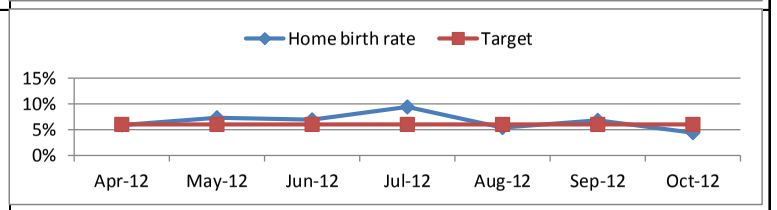
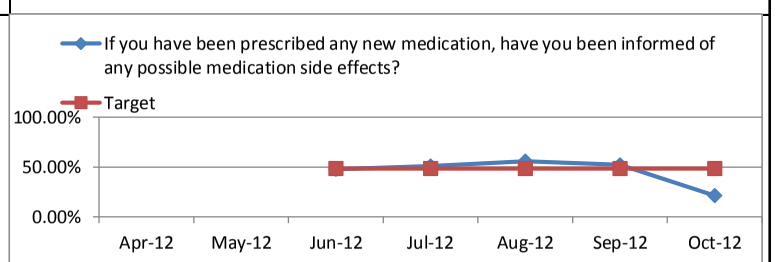
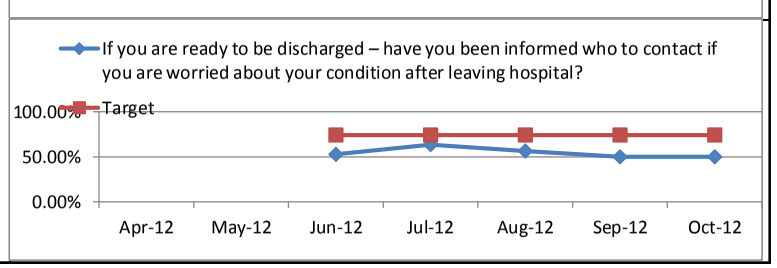
Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**2**	**1**	**14**	**20**
Clinical Outcomes	**8**	**0**	**11**	**5**
Patient Safety	**13**	**9**	**17**	**8**
Patient Experience	**5**	**3**	**19**	**2**
TOTAL	**28**	**13**	**61**	**35**

3. Exception Report (see table)

4. Conclusion
Many of the areas of poor performance remain those which were highlighted in previous months. Although there has been on-going work to improve matters there are clear challenges. The poor results of the Healthcare Records audit should be noted and a measure relating to this will now be included on directorate scorecards.

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

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Un-fated Units	0	↑	Ward Traceability Compliance Number of Un-fated Units - There were 16 cases of un-fated units in October compared to 42 in September. September increase partly due to obstetric emergency which impacted on 8 units. Ward and directorate managers are notified daily of un-fated units which allows immediate investigation and feedback to individual staff involved. Training is available to ensure staff are kept up-to-date with required processmonitoring of unfated cases has been added to the weekly performance meeting. Training is also available for staff	
Patient Safety	Incidence of Pressure Ulcers Rate per 1,000 Bed Days (All Grades)	0.6	↑	Incidence of pressure ulcers - the target rate of pressure ulcers remained un-met in October with 1.12 pressure ulcers per 1000 bed days vs a target of 0.6. There were 2 type 3 pressure ulcers reported in October (compared to 3 in September), but there have been no type 4 pressure ulcers since May 2012.	
Patient Safety	Reduce harm from falls Major/Severe	0	↓	There were 2 falls in the major/severe category in October which resulted in Fracture Neck of Femur. Root Cause Analyses are being undertaken for these cases.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	**Composite measure to be developed**	The key issues identified on the Healthcare Notes audit in October were around the recording of vital patient information (date of birth, hospital number and nhs number) on the front page of notes where the addressograph was absent. The recording of this information is well below the target although has improved since the start of the audit, bearing in mind that the number of records audited has increased and the percentage of notes with an addressograph has also significantly improved. The other areas where the target is not being met are around whether the surname is capitalised, whether the staff designation is recorded, whether the GMC number is present (particularly poor at 14%) and how alterations/deletions are managed.	
Patient Experience	A & E Quality Indicators (5 indicators)		↑ ↓	**A&E Clinical Indicators:** The time to initial assessment for patients arriving by ambulance was 31 mins with the national target being 15 minutes. This is largely due to difficulty meeting the target out of hours. When the FIT (Fast Intervention Team) is operational (usually between 11am and 6pm) this target is met, but out of hours limited Senior Doctor cover means that the time to initial assessment is increased. A business case is going to SMB on 6th December for increased clinical staff and workforce development. The Trust is currently advertising for 4 senior A&E clinicians. Unplanned reattendance rate - October performance was 5.7% against a target of 5%. Performance has fluctuated across the year so data validation is being undertaken to ascertain the accuracy of this position. This will include investigation of whether some planned reattendances are being recorded as unplanned. There is also a genuine concern related to patients reattending when they have been unable to access aftercare in primary care.	 
Patient Experience	Elective Average Length of Stay	3.2 days	↑	Elective Average Length of stay - Average length of stay has gradually increase throughout the year, with a significant spike in September, and subsequent reduction towards normal levels in October. This is being investigated further to identify trends at specialty/procedure level	

Patient Experience	PROMS Scores	80%	71.80%	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	HSMR overall	<100		The cumulative HSMR figure for 11-12 (rebased in September 12) has deteriorated slightly to 102 against a target of 100. However the rolling 12 months figure, reflecting Sep 11 - Aug 12 is considerably improved at 95.7. All specified conditions are well within target with the exception of Fractured Neck of Femur (see below for further details).	
Clinical Outcomes	HSMR #NOF/ Patients admitted with #NOF operated on within 48 hours	<100	133	Mortality for Fractured Neck of Femur is rising in this finacial year, although , some deaths are ocurring in community hospitals and may not be attributable to surgery at NGH. It should be notd that performance against the target for patients admitted with #NOF to be operated on within 48 hours has not been met throughout this year (with the exception of September).	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100.0%			
Clinical Outcomes	Suspected stroke patients given CT scan within 1 hour of arrival	50.0%			
Clinical Outcomes	Caesarean Section Rates	10.1%	17.1%	There was another rise in Elective C-section rates in October, alongside a decrease in Emergency rates. This may be that higher risk patients are electing for c-sections, with the supporting NICE guidance also having an impact.	
Clinical Outcomes	Home births	6.0%		Home births have generally been above target throughout this year, but performance in October was significantly below.	
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. If you have been prescribed any new medication, have you been informed of any possible medications side effects? This target has been met until October, reasons to be investigated 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 2012-13

Patient Safety	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	RAG (based on most recent month)
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	1	0	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	2	1	
HQU08: MSSA Numbers	No national ceiling set	1	1	1	1	1	0	2	
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	1	0	
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	
MRSA Screening Elective Patients	100% month on month	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	99.5%	
MRSA Screening Non-Elective Patients	100% month on month	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	42	16	
Incidence of pressure ulcers									
Type 3	0	0	2	2	1	0	3	2	
Type 4	0	1	2	0	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	1.12	
Reduce harm from falls									
Catastrophic	0	0	0	0	0	0	0	0	
Major/Severe	0	0	0	1	1	2	0	2	
Moderate	0	2	2	3	0	0	1	0	
Mandatory Training compliance Full Year Impact									
Primary Levels Excluding B&H	80%	104.67%	90.14%	80.64%	59.42%	57.71%	60%	Not avail	
Attendance at Trust Induction	80%	88.14%	87.70%	87.70%	87.80%	81.40%	73%	Not avail	
Number of surgical site infections									
Fracture neck of femur - Number of Operations		27	29	21	26	53	26	26	
Infections	0	0	1	0	0	0	0	0	
Spinal Surgery - Number of Operations		Spinal and Vascular Surgery Infection rates monitored from Oct 2012						7	
Infections								0	
Vascular Surgery - Number of Operations								24	
Infections								0	
Breast Surgery		30	40	29	38	30	38	Breast Surgery and Limb Amputations infection rates monitored up until Sept 2012	
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	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	84.2%	Not avail	
Serious Untoward Incidents	-	12	3	9	5	4	5	7	
Never Events	0	0	0	0	0	1	0	0	
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	
Healthcare Notes Audit									
Q.1 Does the front page of every sheet contain an addressograph label	100%		57%	67%	77%	71%	77%	73%	
Q.2 Does addressograph include the NHS Number?	100%		99%	96%	95%	86%	90%	90%	
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%		72%	83%	56%	87%	86%	73%	
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%		46%	49%	36%	56%	62%	60%	
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%		56%	59%	41%	55%	60%	64%	
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%		6%	2%	5%	7%	16%	13%	
Q.7 Is record legibly written	100%		93%	98%	97%	92%	99%	98%	

4

Q.8 Written in blue/black ink	100%	Audit commenced in May 12	98%	100%	100%	99%	100%	100%	
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%		97%	98%	99%	98%	100%	100%	
Q.10 Is date recorded for each entry	100%		73%	86%	89%	91%	94%	89%	
Q.11 Is time recorded for each entry	100%		64%	67%	79%	68%	77%	73%	
Q.12 Is there a signature of the person making the entry	100%		98%	91%	95%	94%	92%	87%	
Q.13 Is surname printed in block capitals	100%		42%	56%	57%	47%	48%	48%	
Q.14 Is the staff designation recorded	100%		37%	44%	55%	42%	47%	50%	
Q.15 Medical Records Audit only: Is the GMC number present	100%		0%	19%	11%	5%	20%	14%	
Q.16 Are any alterations / deletions scored through with a single line	100%		29%	41%	36%	51%	38%	42%	
Q.17 Is there a signature recorded next to any alterations/deletions	100%		19%	33%	15%	33%	33%	26%	
Q.18 Is there a date recorded next to any alterations/deletions	100%		3%	5%	9%	27%	23%	14%	
Q.19 Is there a time recorded next to any alterations/deletions	100%		3%	5%	3%	16%	17%	11%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%		Questions not asked until Oct-12					100%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%							76%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%							100%	
Q.23 Are there any loose sheets in the Healthcare record	0%							8%	

Patient Experience	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%	0%	0%	
Hospital Cancelled Operations	6.0%	5.9%	7.1%	8.9%	5.7%	5.3%	5.3%	**Not available until 16th Nov**	
Number of written complaints received		50	51	39	48	33	35	44	
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	83%	61%	N/Avail	N/Avail	
Referral to Treatment waits									
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.99%	96.34%	96.00%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.46%	98.44%	98.50%	
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.53%	97.12%	98.60%	
A&E Quality Indicators (5 measures)									
Time Spent in A&E (Month on Month)	95%	95.05%	93.37%	93.33%	92.01%	92.80%	96.89%	95.23%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	93.39%	93.27%	93.87%	94.07%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	03:59	04:00	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:30	00:50	00:39	00:35	00:36	00:32	00:31	
Time to treatment decision (median)	<60 mins	00:46	00:54	00:54	00:52	00:42	00:48	00:41	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	0.95%	5.71%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	3.50%	0.18%	0.18%	0.07%	
Cancer Wait Times									
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.1%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.2%	
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.6%	
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	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%	98.2%	97.3%	
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.2%	
SRS08: Length of Stay (Acute & MH)									
Elective	3.20	3.70	4.1	4.2	4.1	4.2	5	4.4	
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	4.9	4.5	
SRS09: Daycase Rate	85%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	**Not available until 16th Nov**	
SQU11: PROMS Scores - Pre Operative participation rates									

Groin Hernia - Participation Rate	lat.Ave 60.5% (target 80%	42.30%			48.20%				
Hip Replacement - Participation Rate	lat.Ave 82.0% (target 80%	97.40%			91.40%				
Knee Replacement - Participation Rate	lat.Ave 87.5% (target 80%	94.90%			88.20%				
Varicose Vein - Participation Rate	lat.Ave 49.1% (target 80%	31.10%			33.30%				
All Procedures - Participation Rate	lat.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	Oct-12
HSMR - cumulative position for 2011-12 (Rebased Sept-12)	<100				101.9	102	Data not yet available	
HSMR - cumulative position current financial year		NA	NA	85.0	95.0	96.1		
HSMR- cumulative position for 2012-13								
Pneumonia	<100				47.4	50.2		
Fracture of neck of femur (hip)	<100				148.0	133.1		
Acute Cerebrovascular disease	<100				86.0	96		
Congestive heart failure, nonhypertensive	<100				83.7	90.9		
Acute myocardial infarction	<100				66.5	76.7		
HSMR (Rolling 12 months)					96.6	95.7		
SHMI (based upon date of SHMI report publication)		109.2	109.2	109.2	106.0	106.0	106.0	104.8
SQU12: Maternity 12 weeks	90%	86%	97%	87%	98%	98%	99%	98%
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.8%	3.4%	3.0%	3.6%	2.7%	3.2%	Not available until 16th Nov
Fractured neck of Femur								
Number of patients admitted with FNOF	-	27	30	21	26	52	26	26
Patients fit for surgery within 48hrs	-	21	23	13	25	47	22	24
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	22	21
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	100%	87.5%
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	80%	85%	92%
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	68%	77%	75%	67%	70%	54%	46%
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	95%	100%	96%	97%	97%	83%	100%
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	68.0%	75.0%	90.9%	71.4%	95.8%	76.0%	68.0%
Patients who spend at least 90% of their time on a stroke unit	80%	100.0%	95.6%	96.7%	98.6%	92.6%	93.3%	91.1%
Breast Feeding initiation	75%	73.6%	74.6%	76.6%	76.1%	73.7%	73.1%	81.0%
Caesarean Section Rates - Total	<25%	25.1%	25.6%	27.1%	25.1%	28.5%	26.9%	26.5%
Caesarean Section Rates - Emergency	14.98%	12.1%	11.0%	11.2%	9.8%	13.3%	13.7%	9.4%
Caesarean Section Rates - Elective	10.06%	13.6%	14.6%	15.9%	15.3%	15.2%	13.8%	17.1%
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.4%	6.8%	4.4%

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
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%	92.5%
1b. High risk patients receive appropriate treatment *(inadequate volume of data Q2)*	100% Month on month	93.3%	90.6%	85.5%	97.5%	90.9%	91.9%	97.6%
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%	79.2%
Were hospital staff available to talk about any worries or concerns that you had?	>63.4			74.9%	84.0%	66.6%	83.2%	82.5%
Did you have enough privacy when discussing condition or treatment?	>82.3			73.8%	81.0%	73.1%	81.5%	85.0%
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%	21.4%
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%	50.0%
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting								
a) Dementia case finding	90%	Awaiting data- Review and validation of data required.						
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 catheter, *Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter*	-	Monthly data			All data submitted in October			
	RAG							
Regional CQUIN								
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%	12.0%	15.3%	10.1%	14.3%
2, Board and Commissioner reporting	Submission to HCG				Submitted to HCG			

4

3. Weekly reporting	-					Target from Q2				
4. Performance improvement by 10%	10 point improving	-	29.98	-	30.86	0.42	70.10	56.83	74.08	76.33
Local CQUINS										
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	-					Baseline audit undertaken				
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	-					Audit agreed and currently in progress				
2b. Appropriate referrals to CECs/ Intermediate service from A&E						Baseline audit 50 cases in Q1				
3a. Accuracy of medicines information on discharge	75% error free					Q4 primary care audit, internal assurance programme being formalised				
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	-					Dataset sent to PCT for approval, meetings to be arranged with relevant parties.				
3c. Oral nutritional supplements (ONS) - reduce the use of ONS										
- % of patients for whom a nutritional score was completed on admission										93.67%
- % of patients that had supplements prescribed	Q2 & Q4 Audits - stretch targets to be agreed					Data collection in progress for submission by the end of October-12				95.29%
- % of patients that had a review within 48hrs of discharge										30.86%
- % of patients where ongoing treatment was planned and communicated										47.73%
3d. Triptorelin	Quarterly Audit 10% increase on 50% baseline (80% @Q4)		Q1 Not applicable.			Q2 Audit result = 70%				Data not yet available
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates interna					Further clarification required from the commissioners				Data not yet available
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care									Data not yet available
MESCG CQUINS										
1. Quality Dashboards	-									
Identify and provide contact details of the following:										
- an overall dashboards lead for the Provider						Confirmed				
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-					Clinical Directors (TBC)				
Provide a summary setting out the plans for implementation of the dashboards within the required timescale										
3. Use of Intensity Modulated Radiotherapy	Target to be derived from Q1 data		Q1 9%				Q2 22%			
4a. Cancer Chemotherapy Performance Status	-		91.7%		93.3%	99.2%	95.1%	95.5%	96.8%	93.9%
4b. Cancer Chemotherapy Performance status 2 or above			-		-	100%	100%	-	100%	-
4c. Improve appropriate assessment and Improve mortality rates										
Number of Oncology patients deaths within 30 days of receiving chemotherapy			1		0	1	1	2	1	Not avail until Dec 12
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy			0.10%		0.00%	0.21%	0.18%	0.35%	0.20%	
Number of Haematology patients deaths within 30 days of receiving chemotherapy			0		0	0	0	1	0	
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy			0.00%		0.00%	0.00%	0.00%	2.12%	0.00%	
5. Hepatitis C. Compliance with treatment / improved patient outcomes	-					Quarterly audit undertaken				
7. Reduction of catheter - related CONS	7% Baseline 2011-12		0%		0%	0%	0%	0%	0%	

Release 5.00 : Autumn 2012

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Acute Trust Quality Dashboard

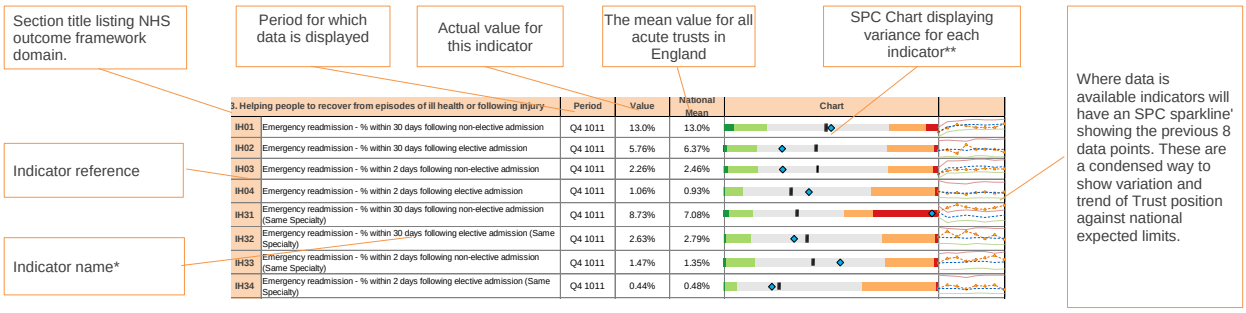
NORTHAMPTON GENERAL HOSPITAL NHS TRUST

The Acute Trust Quality Dashboard provides an assessment of quality across the 5 domains of the NHS Outcomes Framework:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protect them from avoidable harm

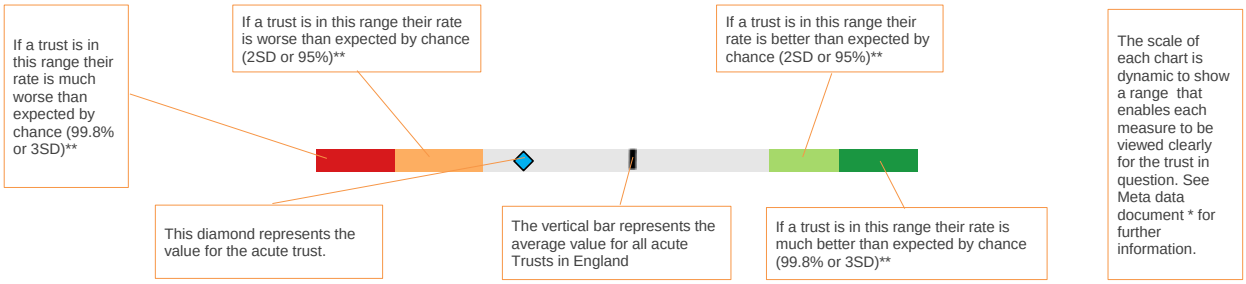
A sixth domain has been created "Organisational Context" which contains a number of metrics which look at organisational behaviour and measures useful in interpreting other metrics in the Dashboard.

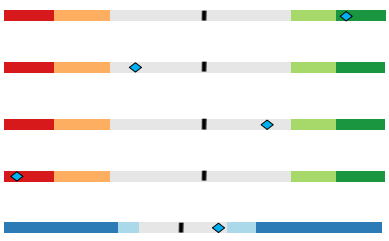
Report Overview



3. Helping people to recover from episodes of ill health or following injury		Period	Value	National Mean	Chart
IH01	Emergency readmission - % within 30 days following non-elective admission	Q4 1011	13.0%	13.0%	
IH02	Emergency readmission - % within 30 days following elective admission	Q4 1011	5.76%	6.37%	
IH03	Emergency readmission - % within 2 days following non-elective admission	Q4 1011	2.26%	2.46%	
IH04	Emergency readmission - % within 2 days following elective admission	Q4 1011	1.06%	0.93%	
IH31	Emergency readmission - % within 30 days following non-elective admission (Same Specialty)	Q4 1011	8.73%	7.08%	
IH32	Emergency readmission - % within 30 days following elective admission (Same Specialty)	Q4 1011	2.63%	2.79%	
IH33	Emergency readmission - % within 2 days following non-elective admission (Same Specialty)	Q4 1011	1.47%	1.35%	
IH34	Emergency readmission - % within 2 days following elective admission (Same Specialty)	Q4 1011	0.44%	0.48%	

How to interpret charts





The chart on the left shows a trust whose performance on this indicator is better than the national picture by a degree that is unlikely to be explained by random chance**

The two charts on the left shows a trust whose performance on this indicator does not differ from the national picture by more than can be explained by random chance**

The chart on the left shows a trust whose performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance**

The chart on the left is for an indicator that does not have a desired direction for improvement. The Trust shown in this example is within the expected range based on the national picture.

* For a full description of each metric and metadata, please see technical guidance available at http://www.emqo.eastmidlands.nhs.uk/welcome/atqd/

** These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display 'normal cause variation' in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display 'special cause variation' at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display 'special cause variation' but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

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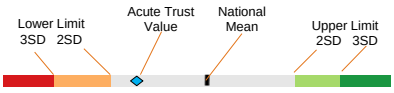
Acute Trust Quality Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

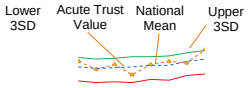
Release 5.00 : Autumn 2012

Northampton General Hospital NHS Trust (NGH) is a medium sized acute hospital with a busy emergency department, maternity unit, acute renal unit and interventional cardiology unit. NGH is a cancer centre providing services for patients form Northampton, Kettering and Milton Keynes and is a designated Stroke Centre. Outpatient and Day Surgery services are also provided at Danetre Community Hospital, Daventry.

Spine Charts



SPC Sparklines



Clinical Effectiveness

	1. Preventing People from dying prematurely	Period	Value	National Mean	Chart	Trend
PD02	Age / Sex standardised hospital mortality from conditions amenable to healthcare	RY Q1 1213	82.4	100.0		
PD03	Age / Sex standardised in hospital mortality in low risk HRGs	RY Q1 1213	62.2	100.0		
PD04	Crude in hospital perinatal mortality per 1,000 births (including still births)	RY Q1 1213	9.26	8.35		
PD06	Summary Hospital-level Mortality Indicator (SHMI) - Emergency & Elective	RY Q4 1112	104.8	100.3		
PD07	SHMI - Elective (pending data)	xxx	xxx	xxx		
PD08	SHMI - Emergency (pending data)	xxx	xxx	xxx		
PD09	SHMI - Stroke (sub-group 66)	RY Q4 1112	86.1	100.3		
PD10	SHMI - COPD (sub-group 75)	RY Q4 1112	117.5	100.3		
PD11	SHMI - MI (sub-group 57)	RY Q4 1112	85.7	100.1		
PD12	SHMI - #NOF (group 120)	RY Q4 1112	104.2	99.8		
PD13	SHMI - Pneumonia (sub-group 73)	RY Q4 1112	121.5	100.1		
PD14	SHMI - CHF (sub-group 65)	RY Q4 1112	99.0	100.0		
PD15	SHMI - Renal (sub-group 99)	RY Q4 1112	120.1	100.2		
PD16	SHMI - Diabetes (sub-group 34+35)	RY Q4 1112	177.1	100.7		
PD25	% of patients with a fractured neck of femur operated on within 48 hours	Q1 1213	72.1%	76.3%		
PD30	Cancer waits – % waiting less than 31 Days from decision to treat to first treatment	Q1 1213	97.5%	98.4%		
PD31	Cancer waits – % waiting less than 62 days from GP referral to first treatment (HOU15)	Q1 1213	81.0%	87.7%		
	2. Enhancing quality of life for people with long term conditions	**Period**	**Value**	**National Mean**	**Chart**	
EQ01	% emergency admissions for >65 years old with dementia	Q1 1213	14.2%	13.4%		
EQ02	LOS (Days) for patients >65 years old admitted in an emergency with Dementia	Q1 1213	20.4	14.5		
EQ03	LOS (Days) for patients >65 years old admitted in an emergency	Q1 1213	12.0	10.2		
EQ04	Ambulatory care sensitive conditions - % of emergency admissions for cellulitis and DVT (based on SQU04_01)	Q1 1213	1.79%	1.61%		
EQ05	% of admissions with zero day LOS for emergency ambulatory care conditions	Q1 1213	33.8%	39.5%		
	3. Helping people to recover from episodes of ill health or following injury	**Period**	**Value**	**National Mean**	**Chart**	
IH01	Emergency readmission - % within 30 days following non-elective admission	Q1 1213	13.48%	13.08%		
IH02	Emergency readmission - % within 30 days following elective admission	Q1 1213	7.26%	6.65%		
IH03	Emergency readmission - % within 2 days following non-elective admission	Q1 1213	2.16%	2.50%		
IH04	Emergency readmission - % within 2 days following elective admission	Q1 1213	1.05%	1.02%		
IH31	Emergency readmission - % within 30 days following non-elective admission (Same Specialty)	Q1 1213	8.10%	6.87%		
IH32	Emergency readmission - % within 30 days following elective admission (Same Specialty)	Q1 1213	3.29%	2.89%		
IH33	Emergency readmission - % within 2 days following non-elective admission (Same Specialty)	Q1 1213	1.35%	1.33%		
IH34	Emergency readmission - % within 2 days following elective admission (Same Specialty)	Q1 1213	0.22%	0.50%		
IH05	Emergency readmission - % within 30 days following discharge - Angina	Q1 1213	17.78%	15.09%		
IH35	Mean length of stay (LOS) for patients admitted for Angina	Q1 1213	6.4	4.1		
IH06	Emergency readmission - % within 30 days following discharge - Asthma	Q1 1213	10.68%	12.12%		
IH36	Mean length of stay (LOS) for patients admitted for Asthma	Q1 1213	13.4	6.0		
IH07	Emergency readmission - % within 30 days following discharge - CCF	Q1 1213	19.75%	19.04%		
IH37	Mean length of stay (LOS) for patients admitted for CCF	Q1 1213	13.8	11.1		
IH08	Emergency readmission - % within 30 days following discharge - COPD	Q1 1213	18.24%	23.28%		
IH38	Mean length of stay (LOS) for patients admitted for COPD	Q1 1213	7.9	7.2		
IH09	Emergency readmission - % within 30 days following discharge - Diabetes	Q1 1213	13.24%	15.99%		
IH39	Mean length of stay (LOS) for patients admitted for Diabetes	Q1 1213	6.4	11.2		
IH10	Emergency readmission - % within 30 days following discharge - Epilepsy	Q1 1213	18.94%	15.38%		
IH40	Mean length of stay (LOS) for patients admitted for Epilepsy	Q1 1213	4.9	6.4		
IH11	Emergency readmission - % within 30 days following discharge - Renal	Q1 1213	19.45%	14.93%		
IH41	Mean length of stay (LOS) for patients admitted for Renal	Q1 1213	8.5	7.5		
IH21	% patients discharged to usual place of residence	Q1 1213	96.0%	95.1%		
IH22	% of eligible patients taking part in PROMS (eligible FCEs) (Apr-Sept 11)	1112	65.8%	68.8%		
IH23	Patient Reported Outcome Measures - % Patients reporting an improvement following hip replacement (Apr-Dec 11)	1112	85.2%	87.0%		
IH24	Patient Reported Outcome Measures - % Patients reporting an improvement following knee replacement (Apr-Dec 11)	1112	79.2%	78.7%		
IH25	Patient Reported Outcome Measures - % Patients reporting an improvement following varicose vein procedure (Apr-Dec 11)	1112	0.0%	52.0%		
IH26	Patient Reported Outcome Measures - % Patients reporting an improvement following hernia procedure (Apr-Dec 11)	1112	56.5%	51.6%		

Acute Trust Quality Dashboard

Patient Experience	4. Ensuring that people have a positive experience of care	Period	Value	National Mean	Chart
PE00	95th Percentile wait for elective inpatient treatment (weeks)	Aug-12	17.8	21.0	
PE01	Median wait for elective inpatient treatment (weeks)	Aug-12	8.00	8.60	
PE02	Diagnostic Waits - % of patients waiting over 5 weeks	Q1 1213	0.00%	5.79%	
PE03	Cancer waits – % seen within 14 days of GP referral to first out-patient appointment (HQU14)	Q1 1213	95.6%	95.2%	
PE23	A&E - % of patients admitted, tranferred or discharged within 4 hours of arrival	Q1 1213	92.5%	94.0%	
PE08	A&E re-attendance - % within 7 days (HQU09)	Q1 1213	7.3%	6.9%	
PE10	Median total time in minutes spent in A&E for admitted and non admitted patients (HQU10)	Q1 1213	132	132.0	
PE11	A&E attendances - % of patients who leave without being seen (HQU11)	Q1 1213	3.6%	2.9%	
PE12	A&E - Median Time to initial assessment for patients brought in via ambulance in minutes (HQU12)	Q1 1213	7.0	3.0	
PE13	A&E - Median Time to treatment in minutes (HQU13)	Q1 1213	70.0	56.0	
PE14	A&E - % Admissions with zero day LOS	Q1 1213	23.1%	25.3%	
PE15	Mixed sex accommodation breach rate per 1000 FCEs (HQU08)	Sep-12	0.00	0.12	
PE16	On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons	Q1 1213	15.8	8.4	
PE17	Overall inpatient experience measure	1011	7.4	7.4	
PE18	Overall outpatient experience measure	1011	7.8	7.9	
PE19	Overall A&E experience measure	0809	75.7	75.7	
PE20	Mother satisfaction measure	2010	84.7	83.8	
PE21	Delayed Transfers of Care per 1,000 occupied beds - NHS Responsibility	Q1 1213	1307.5	598.0	
PE22	Delayed Transfers of Care per 1,000 occupied beds - Social Care Responsibility	Q1 1213	24.5	167.3	

Patient Safety	5. Treating and caring for people in a safe environment and protecting them from avoidable harm	Period	Value	National Mean	Chart
SC01	Rate of patient safety incidents reported in trusts per 100 admissions	OCT11-MAR12	6.30	6.58	
SC02	Rate of "serious harm" patient safety incidents reported in trusts per 100 admissions	OCT11-MAR12	0.23	0.43	
SC03	% of all admissions who have venous thromboembolism risk assessment (SQU01)	Jun-12	90.3%	93.3%	
SC04	Rate of surgical site infections per 10,000 specified orthopaedic operations	1011	175.4	97.1	
SC05	HCAI - MRSA bacteraemia rate per 1,000,000 occupied beds (HQU01)	Q1 1213	16.5	10.7	
SC06	HCAI - C. diff bacteria rate per 100,000 bed days (HQU02)	Q1 1213	2.98	5.11	
SC20	HCAI - MSSA rate per 100,000 bed days	Q1 1213	5.0	8.2	
SC07	Adult - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q1 1213	81.2	81.4	
SC21	Paediatric - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q1 1213	85.6	86.0	
SC08	% of planned day case procedures that are converted to inpatients on the day	Q1 1213	3.8%	4.4%	
SC09	% of deliveries via Caesarean Section - Elective	Q1 1213	13.63%	10.53%	
SC10	% of deliveries via Caesarean Section - Non Elective	Q1 1213	14.01%	14.58%	
SC11	% Admission of full-term babies to neonatal care	Q1 1213	Methodology Currently Being Reviewed		
SC12	Emergency readmission - % babies within 30 days following delivery	Q1 1213	8.54%	7.15%	
SC17	Medication errors per 1,000 bed days	OCT11-MAR12	7.72	7.17	
SC19	Incidence of patients with pressure ulcers per 1000 admissions	Jun-12	1.08	3.54	

Organisational Context	6. Organisational Context	Period	Value	National Mean	Chart
OQ01	Admitted Patient Care - % Valid data (Average for all fields)	Aug-12	99.8%	97.95%	
OQ02	Out Patient - % Valid data (Average for all fields)	Aug-12	93.0%	95.26%	
OQ03	Accident and Emergency - % Valid data (Average for all fields)	Aug-12	99.5%	96.74%	
OQ21	Admitted Patient Care - % Records submitted with valid HRG on first submission	Jun-12	99.5%	94.7%	
OQ04	Elective - Depth of coding (mean number of secondary diagnosis)	Q1 1213	1.58	2.21	
OQ05	Non-elective - Depth of coding (mean number of secondary diagnosis)	Q1 1213	3.57	4.35	
OQ06	Rate of palliative care (ICD10: Z515) per 1,000 episodes	Q1 1213	3.71	8.14	
OQ20	Rate of palliative care (main specialty 315) per 1,000 episodes	Q1 1213	0.00	0.38	
OQ18	Rate of use of integrated palliative care pathway (ICD10: Z518) per 1,000 episodes	Q1 1213	6.08	5.45	
OQ07	Rate of written complaints per 1,000 episodes	1112	4.92	4.43	
OQ08	NHSLA Claims per 10,000 bed days	1112	1.75	1.91	
OQ09	Workforce - FTE Nurses per bed day	Aug-12	1.52	1.96	
OQ10	Workforce - Sickness % - Medical	Aug-12	0.86%	0.94%	
OQ11	Workforce - Sickness % - Nurse	Aug-12	4.3%	4.2%	
OQ12	Workforce - Sickness % - Midwife	Aug-12	6.4%	4.5%	
OQ13	Workforce - Sickness % - Other	Aug-12	4.6%	4.2%	
OQ14	Staff recommendation of the trust as a place of work (CQC survey)	2011	47.5%	52.4%	
OQ15	Staff recommendation of the trust as a place to receive treatment (CQC Survey)	2011	52.4%	62.8%	
OQ16	Overall medical trainees global satisfaction score (GMC survey)	2012	77.8	78.6	
OQ17	Consultant clinical supervision trainers given to their trainees	2012	87.6	86.8	
OQ19	% of A&E attendances which are "inappropriate" (V08 / VB11Z)	Q1 1213	14.8%	15.6%	

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Acute Trust Quality Dashboard

This section of the dashboard is included to allow hospitals to provide notes on the content of the dashboard and indicators where required.

There are no notes for this trust.

TRUST BOARD 29th NOVEMBER 2012	
Title: -	Patient Experience – Friends and Family Test
Presented by: -	Suzie Loader, Director of Nursing, Midwifery and Patient Services
PURPOSE OF PAPER: - To inform the members of the Board of the actions taken in response to Patient Experience feedback received during October 2012.	
CRITICAL POINTS: - Friends and Family Test Scores in October 2012: +76 Sub optimal performance in two Patient Experience CQUIN outcomes	
ACTION REQUIRED BY BOARD: - The Board are requested to: - • Note and challenge the content of the report • Note the results from the October 2012 Friends and Family • Test • Endorse the work being taken forward to create a customer service culture across the organisation	

Patient Experience

1. Introduction

The purpose of this report is to: -

- Inform members of the patient experience activities in place across the trust
- Share actions taken to implement a Customer Service culture across the organisation.

This report will evolve during the forthcoming months as Care Group Management Teams and Directorate Teams embed Patient Experience activities into their governance structures.

2.0 Patient Experience monitoring

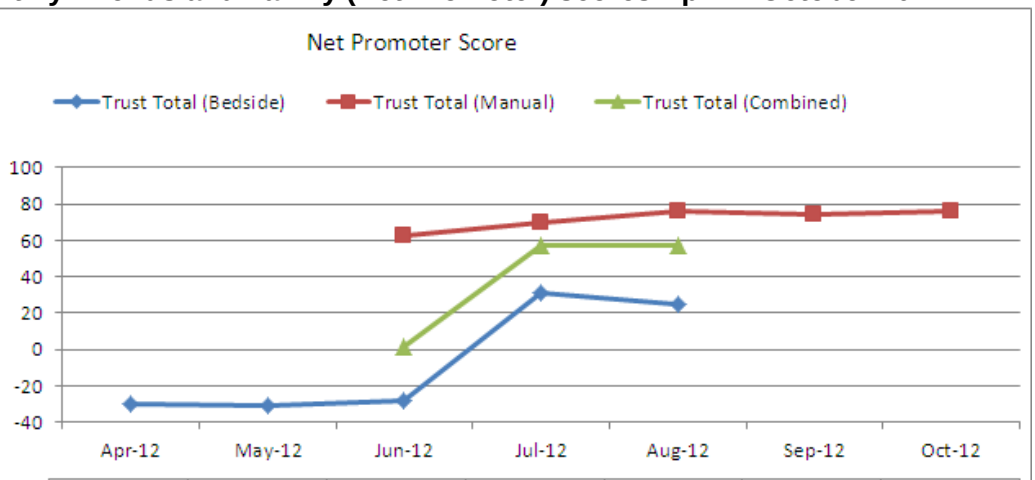
2.1 Friends and Family Test

The Friends and Family Test 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.

2.2 FFT Results: October 2012

The manual collection of the Friends and Family Test continues to elicit positive patient experience results which are demonstrated in the table below. The FFT score received for the month of October 2012 was **+76**

Table 1: Monthly Friends and Family (Net Promoter) scores April – October 2012



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Trust Total (Bedside)	-30	-31	-28	31	25		
Trust Total (Manual)			63	70	76	74	76
Trust Total (Combined)			1	57	57		

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

2.4 FFT Manual data collection
4597 patients were discharged from Northampton Hospital in October 2012 of which, 14% responded to the FFT question. From April 2013, every patient discharged from every NHS Trust is expected to be questioned and the minimum response rate will increase from 10% to 15%. Comments received from these patients were circulated to Ward Managers. Actions taken as a result of these comments are included in the "You said we did" comments on Patient Quality Board located outside of ward areas.

2.5 NHS Friends and Family Test (FFT) Guidance
The NHS Friends and Family Test implementation guidance was published by the Department of Health in October 2012. The guidance includes the requirements and implications of implementing the national Friends and Family Test within the NHS. The principles of the guidance offer a mechanism for organisations to demonstrate they are adhering to the NHS Outcomes Framework Domain 4, which emphasises a focus on ensuring people have a positive experience of care. Friends and Family Test data must be collected by all providers of NHS funded acute services for inpatients and patients discharged from A&E following treatment but without admission from April 2013.

2.6 The revised question
All NHS organisations providing acute care will use the same question, question format and response scale. The wording of the question has been changed slightly as follows: -

"How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"

There are minor implications for this organisation as we have an established mechanism to collect this information from every patient.

2.7 Collection of FFT information from the Emergency Department (A&E)
Asking patients whether they *"Would recommend the A&E department to friends and family if they need similar care or treatment"* is a recent concept from the department of Health. All NHS organisations with an Emergency department will collect this data from 1 April 2013.

We will trial the Friends and Family question in the A&E Department, inviting all patients who are treated but not admitted to share their experiences. Arrangements for collecting the data are still being finalised but is hoped to use plinth-mounted machines that are sited and designed for easy access by patients. The experiences and scores received from these patients will be included in the monthly reports from 1 January 2013
.

3.0 Patient Experience CQUIN
The total value of the Patient Experience CQUIN for the financial year is £629,000. This CQUIN is consists of five quality monitoring questions which are located on the Hospedia Bedside Unit and a 10 point Friends and Family Test improvement which has four sub-sections.

3.1 Patient Experience Quality monitoring CQUIN
The CQUIN questions relate to communication between hospital staff and patients. The questions are on the Hospedia Bedside Unit. Patients are encouraged to complete the survey during their period of hospitalisation and are made aware of the questions through a daily "pop-up" feature on their bedside unit.

Progress against the targets set for each question is monitored quarterly by Northamptonshire Commissioners as the financial value attached to this CQUIN is £251,000. At the end of September it was evident that we are failing to reach two of the five targets. The questions are: -

- Did you have enough privacy when discussing your condition or treatment
- If you are ready to be discharged, have your been informed who to contact if you are worried or have concerns?

Table 3 illustrates progress against each of the Patient Experience CQUIN questions

Table 3 Patient Experience CQUIN progress: April – September 2012

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	RAG
2. Improve responsiveness to personal needs of patients (5 questions based on								
Were you involved as much as you wanted to be in decisions about your treatment or	>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	>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	>74.3			52.7%	63.6%	56.5%	50.0%	

3.2 Action to improve these results

Senior nurses were requested to prompt ward and medical staff to improve their communication with patients and ensure patients receive comprehensive information during their period of hospitalisation or in receipt of outpatient services.

The Director of Nursing met all Ward Sisters to share her concerns regarding current results, challenging them to identify actions which would lead to an improvement in these scores. Improvements will be made if Ward Sisters raise the awareness of these questions with doctors and nurses and encourage them to respond accordingly to patients.

It is suggested that because originally these questions could only be found on Hospedia, that some patients may have been completing them prior to the day of discharge, which would mean they would not be able to respond to the last 2 questions. As a result, these 5 questions have been added to the FFT manual data collection sheets, to try to encourage as many patients as possible to complete these questions on discharge. A comparison will be undertaken between those responses collected manually and those collected on Hospedia.

4.0 Trust responses to Patient Experience feedback

4.1 A&E national survey results

Acute Trusts providing Accident and Emergency facilities in England are required to carry out patient experience surveys by the Care Quality Commission. The most recent Accident and Emergency Patient Experience survey was completed in February 2012 when a random sample of 850 patients who attended the Accident and Emergency department at Northampton Hospital were contacted. The results demonstrate the experience of patients is marginally better than experienced in the last survey which was taken in 2008.

The department demonstrated an improved score of 5% or more in the 4 questions (table 1) and a decline of 5% or more in 4 questions (table 2).

The Trust was in the top 20% of Trusts in England in 5 of the 41 questions.

Question
Q13 Did the doctors and nurses listen to what the patient had to say?
Q24 Did a member of staff explain why you needed the tests in a way you could understand?
Q26 Did staff explain test results to patient in an understandable way for them?
Q37 Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?
Q39 Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

The Trust was in the bottom 20% of Trusts in 4 of the 41 questions.

Question
Q5 Once at Hospital, how long was the wait with ambulance crew before your care was handed over?
Q6 Were you given enough privacy when discussing your condition with receptionist?
Q32 Were you able to get suitable food or drinks?
Q Did a member of staff tell you about medication side effects to watch for?

The responses for the additional 32 questions placed the trust in the intermediate section shared with 60% of acute trusts in England.

Actions instituted in the Department

The following actions were implemented in the department prior to and following receipt of the report

- The results from the patient survey have been discussed and shared with the medical and nursing team within the Emergency Department.
- Since the time of the patient survey the department has undergone a significant amount of investment. This has resulted in the increase in the size of the department and a change in the admission process for emergency care patients. The increase in size has resulted in the reduction in the length of time ambulances are held in the department.
- The implementation of a Single Point of Access and a Fast Intervention team has allowed all patients presenting to Majors to undergo an initial assessment by a member of the nursing staff and at peak times this includes an assessment by a senior doctor to facilitate investigations and treatment decisions.
- The redevelopment of the department has created a larger waiting area and new reception. This reception has allocated partition screens between desks to assist in the privacy of patients, and an intercom system to prevent patients having to raise their voices.
- The department has submitted a business case for additional Nursing Staff. If approved this will allow greater ability to provide observation and care to the additional rooms
- The department will pilot the Friends and Family Test question from 1 December 2012. Additionally to the FFT questions, further questions have been added to reflect the patient survey to allow on-going monitoring.

A comprehensive summary of the A&E Patient Experience survey results is available from the Patient Experience Lead. These results will be published nationally by the Care Quality Commission in January 2013.

4.2 Patient Experience Board
The inaugural meeting of the Patient Experience Board was held 31 October 2012. Chaired by the Director of Nursing and Patient Experience the Patient Experience Board is accountable to the Healthcare Governance Committee and will meet monthly.

Patient Experience Implementation plan
The Patient Experience Implementation plan is monitored by members of the Patient Experience Board. The recruitment process for two Patient Experience Leads (one from each Care Group) and the nomination of Patient Experience Champions representing Directorates was agreed at the meeting. Nominations for the Patient Experience Leads will be sought in December, with the recruitment process being undertaken early in the New Year. A Metrics sub-committee is in the process of being established, with its first meeting planned for early December.

4.3 Patient Experience Strategy Launch
The Patient Experience Strategy will be launched on 3 December 2012, with the keynote speech being given by Joanna Goodrich from the Kings Fund. Presentations will reflect the vision of the strategy with patients invited to share their stories in two of the four presentations.

4.4 SHA call to action: 12 Days of Christmas
The Chief Nurse from Midlands and East SHA has invited all Directors of Nursing across the region to participate in the "12 Days of Christmas" campaign. Nurses at Northampton Hospital agreed that the way they wanted to participate was to ask every patient during each interaction the following question "Is there anything I can do to make you more comfortable today?"

Screensavers with the same catchphrase will appear on computers across the Trust during the week of 3 December 2012.

5.0 Conclusions
Significant patient experience activity continues across the Trust. National and regional initiatives will continue to dominate this agenda during the forthcoming months.

6.0 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
October 2012

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

OCTOBER Monthly Report for Manual Date
Date: 30/09/12 - 27/10/12

	Green	Amber	Red
Benchmark against:	1	0	

Ward Name	Responses	Results			NET Promoter Score
		Promoter	Passive	Detractor	
Collingtree Medical	18	14	4		78
Cedar	22	15	7		68
Rowan	28	26	2		93
Allebone	8	4	4		50
Creaton	18	14	3	1	72
Dryden	16	15	1		94
Finedon	15	12	3		80
Abington	15	10	5		67
Talbot Butler	15	12	3		80
Willow	20	18	2		90
Eleanor	12	12			100
Paddington	14	8	6		57
Robert Watson	34	26	8		76
Spencer	19	15	2	2	68
Disney	31	24	5	2	71
Althorp	8	6	2		75
Hawthorn	54	50	3	1	91
Balmoral	105	84	21		80
Head & Neck	14	14			100
Becket	22	10	11	1	41
Collingtree Surgical	51	44	7		86
Holcot	22	15	7		68
Knightley	14	10	4		71
Benham	19	15	2	2	68
EAU	14	6	7	1	36
Brampton	10	6	4		60
Head and Neck	13	12	1		92
Collingtree Surgical	**9**	**7**		**2**	**56**
Isebrook - Hazelwood	6	4	2		67
Grand Total	646	508	126	12	77

TRUST BOARD 29th NOVEMBER 2012	
Title: -	Monthly Infection Prevention Performance Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC

PURPOSE OF PAPER: -

To update the Board on infection, prevention and control within the hospital for the month of October 2012.

CRITICAL POINTS: -

- Monthly update on reportable Healthcare associated infections (HCAIs)
- Review of incidents and trend analysis of HCAIs is paramount to improving learning, patient safety and quality of care and also impacts on staff safety and wellbeing

ACTION REQUIRED BY BOARD: -

- The Board has a statutory obligation to ensure appropriate infection prevention and control mechanisms are in place.
- Failure to review infection prevention and control would be considered to be high risk.
- The Board is asked to discuss and where appropriate challenge the content of this report.

October 2012 Infection Prevention Performance Report

1. 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.

2. MRSA Bacteraemia

The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. During October 2012 there were 0 >48hrs MRSA bacteraemia, the total remains at 2 cases. This puts the Trust over trajectory.

The Root Cause Analysis (RCA) meeting held on 15 October 2012 for the September MRSA bacteraemia showed a breakdown in communication between a neighbouring hospital and ourselves on transfer of this patient. This patient was high risk due to a skin condition, Lichenified eczema and a current MRSA colonisation. A working party has been formed to address the patient transfer documentation for all transfer between both hospitals. All high risk patients should be screened and given decolonisation treatment promptly and this was not followed with this patient. A campaign to raise awareness has been undertaken by the matron, ward manager and infection prevention team to prevent a re-occurance across the Trust.

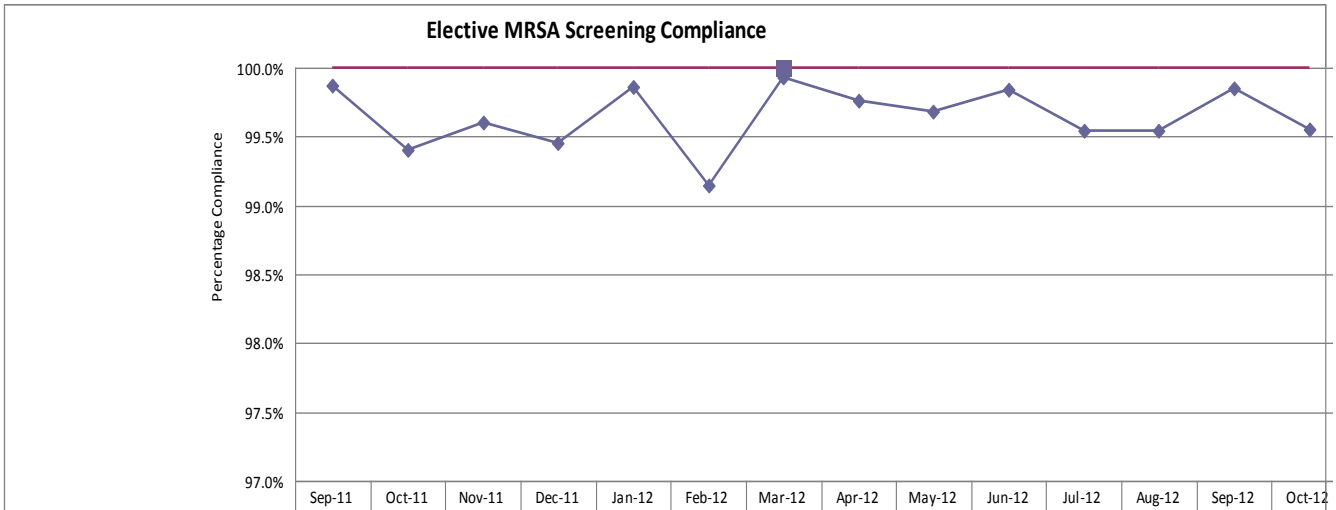
3. MRSA Colonisation & Screening

During October there were 11<48hrs and 2 >48hrs cases of MRSA colonisation. Compliance with the screening of elective admissions: 99.6 %(1559 admissions and 7 were not screened) during October and for emergency screening: 96.1 %(1155 admissions and 45 were not screened – a slight increase on the previous month). Compliance will be monitored regularly by the Care Groups from now on as well as the Infection, Prevention team.

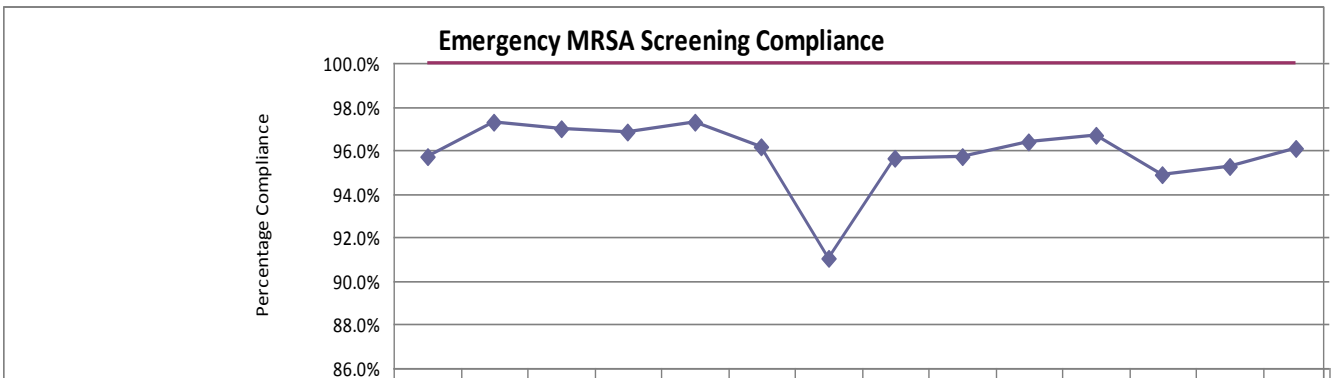
The graphs below indicate how the Trust is doing against its 100% compliance target for both elective and emergency screening. The compliance with emergency screening dropped in February 2012, and after investigation, this coincided with the emergency admission proforma being streamlined and the patient checklist for HCAIs being removed. The Trust has since been assured that the checklist will be re inserted in the next print run, and as a temporary measure the checklist is being stapled to the proforma. The Infection Prevention and Control team have produced an action plan to address reduction in emergency compliance, which was presented at the November Infection Prevention Committee meeting for agreement and implementation

There are specific areas which are classed as ‘High Risk’, identified by the Trust due to the reluctance to give decolonisation to all patient admissions. This is because the decolonisation nasal ointment can cause a low level of resistance in some patients and the additional the cost involved. Patients admitted to these ‘High Risk’ areas receive prophylactic decolonisation. High Risk areas include:

- ITU/HDU
- Willow (vascular)
- Finedon (Renal dialysis and patients with central venous catheters)
- Talbot Butler (Oncology/Haematology patients often have long lines and central venous catheters)
- Paediatrics (Child oncology patients may have long lines and central venous catheters)
- Cedar (Orthopaedics - Fractured Neck of Femurs)
- All patients on Abington (Orthopaedics)



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Elective Compliance	99.9%	99.4%	99.6%	99.5%	99.9%	99.1%	99.9%	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	99.6%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1515	1352	1521	1291	1459	1407	1410	1253	1243	1274	1305	1301	1380	1559
Elective Admissions Not Screened	2	8	6	7	2	12	1	3	4	2	6	6	2	7



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Emergency Compliance	95.7%	97.3%	97.0%	96.8%	97.3%	96.2%	91.1%	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1071	1082	1000	1074	1040	998	1073	1030	1117	1059	1115	1120	1074	1155
Emergency Admissions Not Screened	46	29	30	34	28	38	96	45	48	38	37	57	51	45

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

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.

Holcot ward were put onto Special Measures as they had **1** post MRSA colonisation, **1** MRSA bacteraemia in September and **1** post MRSA colonisation for October. The ward embraced the special measures and MRSA screening was highlighted as not completing a full screen. Therefore a raised awareness was undertaken with full usage of the patient white board. The daily hand hygiene technique was extremely good.

The Infection Prevention and Control Team maintain a robust system of monitoring areas on special measures; each member of the team have allocated wards and make contact with their areas weekly. If there are issues then further work is carried out in those areas as required.

4. MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

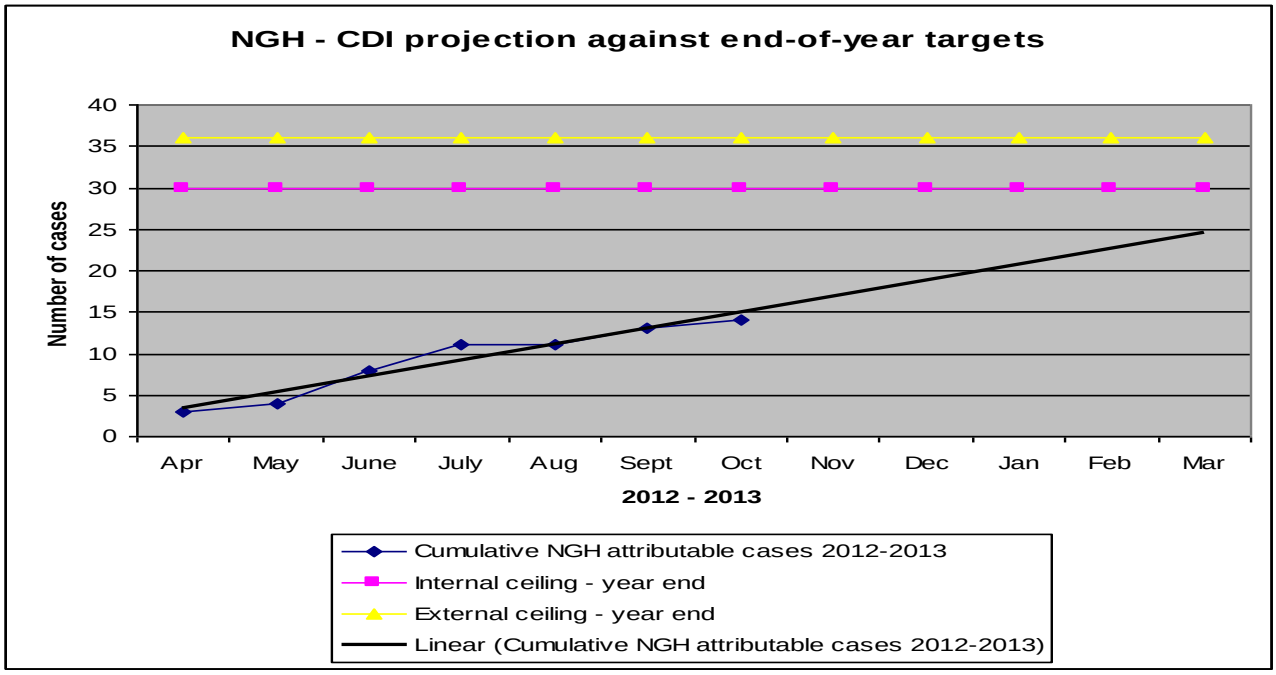
During October there were11 <48hrs and 2 >48hrs MSSA bacteraemia cases.
These 2 bacteraemias were on Allebone and Sturtridge ward. The Root Cause Analysis (RCA) for Allebone is due on the 12th November 2012 and will be reported on in the January meeting.

Sturtridge/Balmoral ward RCA has taken place and actions taken to prevent a re-occurrence, which includes improving compliance with the Peripheral Vascular Cannula (PVC) documentation.

The Root Cause Analysis (RCA) which was undertaken on the 1 post 48 hours MSSA bacteraemia case on Finedon ward for August identified poor documentation around PVCs. A daily morning handover to highlight the importance of effective documentation for insertion and ongoing care of the PVC lead by the Ward Sister has been introduced and is ongoing. This was a complex case and the good practice highlighted by the RCA is being shared with all the staff.

Clostridium difficile

The Trust has an annual target of 36 C. diff. cases (3 per month) or less for the financial year. During October 1*>3 day case of C. diff was identified,* which totals 14 >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.



5. 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 October 2012

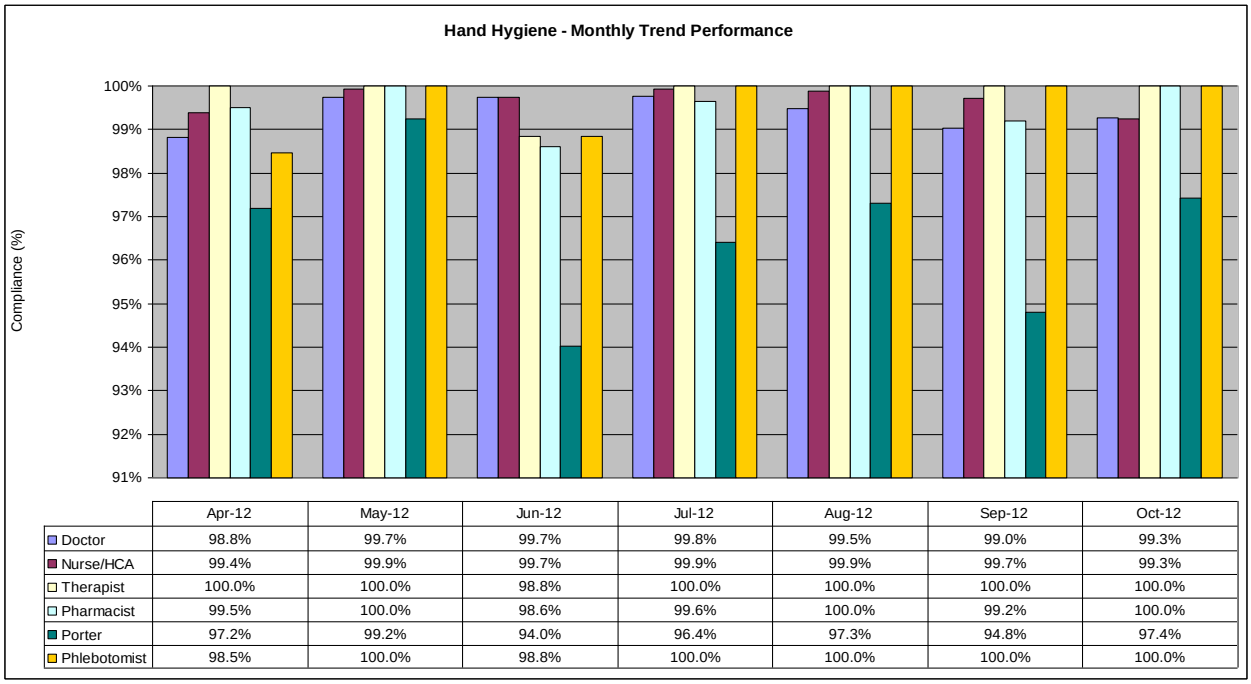
- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from 26 operations
- Vascular surgery show that there were ***no infections*** resulting from 24 operations
- Spinal surgery operations show that there were ***no infections*** resulting from 7 operations

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

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

- Overall Trust compliance for hand hygiene = 95.8%, three areas failed to submit the completed audit.

The graph below demonstrates hand hygiene compliance in the ward areas, is considerably higher than the overall trust score.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Doctor	98.8%	99.7%	99.7%	99.8%	99.5%	99.0%	99.3%
Nurse/HCA	99.4%	99.9%	99.7%	99.9%	99.9%	99.7%	99.3%
Therapist	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%
Pharmacist	99.5%	100.0%	98.6%	99.6%	100.0%	99.2%	100.0%
Porter	97.2%	99.2%	94.0%	96.4%	97.3%	94.8%	97.4%
Phlebotomist	98.5%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%

Infection Prevention Society (IPS) holds an Annual Infection Prevention Awareness week. The Infection Prevention and Control Team held a road show within the Cyber cafe, in October with display boards, quizzes, prizes and sweets. They raised awareness of the new peripheral vascular cannula (PVC) care plan and invited Occupational Health to man a stand for Flu vaccinations. One of the infection Prevention and Control team has become a vaccinator and helped vaccinate 360 members of staff against influenza over that week. It has been agreed that a further vaccination week will be held in the Cyber Café this month as it was so successful last time to increase the number of staff vaccinated across the Trust.

Conclusion

The team maintains collaborative working across the Trust and healthcare associated infection remains a top priority for the public, patients and staff. This has been possible due to the commitment to infection prevention and control which is demonstrated at all levels across the organisation.

Recommendation

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

TRUST BOARD 29th NOVEMBER 2012	
Title: -	Performance Paper
Presented by: -	Christine Allen – Chief Operating Office and Deputy Chief Executive
PURPOSE OF PAPER: - This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 7 (October 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.	
CRITICAL POINTS: - This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 7 **(October 2012)**. • The Trust achieved all the key standards for October 2012 • The Trust achieved the A&E standard for October 2012 with 95.24% of patients being treated within 4 hours against the standard of 95% • The Trust achieved all of the cancer standards for the month.	
ACTION REQUIRED BY BOARD: - Trust Board are asked to discuss the contents of this report and agree any further action necessary	

PERFORMANCE REPORT – NOVEMBER 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 7** (October 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 October Performance

During October 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 October 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 and was sustained throughout October. During October 95.25 % of patients were treated or admitted within 4 hours against the standard of 95%.
The year to date performance is 93.89%. There have been significant pressures in A&E during the first two weeks of November. The Trust continues to work towards the agreed trajectory to achieve year end performance

2.3 Referral to Treatment Time (RTT)

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

Pathways over 26 weeks include all patients who have not yet started their first elective treatment after 26-weeks. In October there were 45 patients waiting to start elective treatment in this category down from 55 in September. 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 October 2012. The Trust achieved 86.5% of patients treated within 62 days from urgent referral to start of first treatment. This is compared to the standard of 85%.

3. RECOMMENDATIONS

Trust Board is asked to discuss the contents of this report and agree any further actions felt necessary.

Appendix 1 Score Card

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
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%	96.1%
Non-admitted	95.0%	97.7%	98.3%	98.8%	98.6%	98.5%	98.4%	98.5%
Incomplete pathways	92.0%	98.2%	97.8%	97.1%	97.3%	97.5%	97.1%	96.8%
No of patients on n incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	49	55	45
Number of diagnostic waits > 6 weeks	0	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%	94.1%
Month on Month	95.0%	95.0%	93.4%	93.3%	92.0%	92.8%	96.9%	95.2%
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%	5.8%	N/A
Cancelled Operations not rebooked within 28 days	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%	96.6%	96.2%
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	99.5%
31 Day	96.0%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	99.4%
31 day second or subsequent treatment - surgery	94.0%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	98.7%
31 day second or subsequent treatment - drug	98.0%	100.0%	97.8%	100.0%	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%	98.2%	98.6%
62 day referral to treatment from screening	85.0%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	93.2%
62 day referral to treatment from hospital specialist	85.0%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	89.2%
62 days urgent referral to treatment of all cancers	85.0%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	87.1%
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%	68.0%
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%	91.1%
Activity vs. Plan								
Elective Inpatients	>0%	16.6%	23.2%	15.2%	8.8%	-1.5%	17.5%	20.3%
Daycase	>0%	8.7%	11.3%	1.0%	3.7%	1.3%	4.3%	9.8%
Non- Elective	>0%	13.4%	26.0%	6.4%	2.5%	3.8%	10.3%	13.3%
OP 1	>0%	5.1%	14.9%	7.5%	0.9%	-5.7%	3.9%	3.3%
OP Procedures	>0%	10.2%	3.6%	5.0%	2.3%	-1.5%	5.6%	8.7%
New to Follow UP Ratio	2.01	2.05	1.92	1.97	1.97	1.96	2.07	N/A
GP Referrals	>0%	2.5%	1.4%	1.1%	0.4%	-2.0%	-2.1%	-1.3%
Day Case Rates	81%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	N/A
Sleeping Accommodation Breach	0	0.0%	0.0%	0.0%	0	0	0	0

TRUST BOARD 29th NOVEMBER 2012	
TITLE: -	The Trust's Financial and Contracting Performance as at 31st October 2012.
PRESENTED BY: -	Mr Peter Hollinshead, Interim Director of Finance.

PURPOSE OF PAPER: -

The paper sets out the financial position for the period ended October 2012 (Month 7).

CRITICAL POINTS: -

1. The Trusts year to date I & E position as at 31st October 2012 was a £4.4m deficit.
2. The Trust is forecasting a breakeven position by the financial year end. This position is arrived at after the application of £11.2m of recovery actions set out in the latest financial recovery plan.
3. The main risk relates to delivery of the financial recovery plan, notably reducing bank and agency expenditure and the successful negotiation of funding from the CCG.
4. There are a range of risks not factored into the financial forecast which will need to be managed.
5. Slippage in the delivery of savings in the Transformation programme requires urgent attention and greater management focus in the second half of the financial year.
6. The Trust is experiencing ongoing liquidity issues. The position has improved marginally with £3.9m of unmet creditor demand at the start of November.

ACTION REQUIRED: -

The Board is asked to note and discuss the recommendations set out in this report.

The Trust's Financial and Contracting Performance as at 31st October 2012

Month 7 2012/13

1. Summary Performance – Financial Duties

Table 1 summarises the Trust's financial performance for the seven months to the end of October 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)	-£4,447	-£230	£0	£1,000	-£1,000
Achieving EFL (£000's)	N/A	N/A	-£268	-£268	£0
Achieving the Capital Resource Limit (£000's)	£2,955	£3,229	£8,582	£10,336	£1,754
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	91%	95%	95%	95%	0%
Value of Non-NHS Invoices	66%	95%	85%	95%	-10%

Key Issues:-

- The Trust is forecasting a breakeven position by the financial year end. This position is arrived at after the application of £11.2m of recovery actions set out in the latest financial recovery plan.
- The SHA have been made aware of the forecast position. Breakeven will meet the statutory duty but not delivering a planned surplus could impact on the Trusts FT application.
- The main risk relates to delivery of the financial recovery plan, notably reducing bank and agency expenditure and the successful negotiation of funding from the CCG. Additional risks are included in this report including winter pressures (section 7).
- The impact of contract overperformance is driving excess costs in the form of additional temporary staffing and the requirement for additional ward capapcity. Bids to manage winter pressures totalling £1.3m have been submitted to the CCG although there is no guarantee these will be funded.
- Slippage in the delivery of savings in the Transformation programme requires urgent attention and greater management focus in the second half of the financial year.
- 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 is experiencing ongoing liquidity issues. The position has improved marginally with a closing cash balance of £2.2m at the end of October.

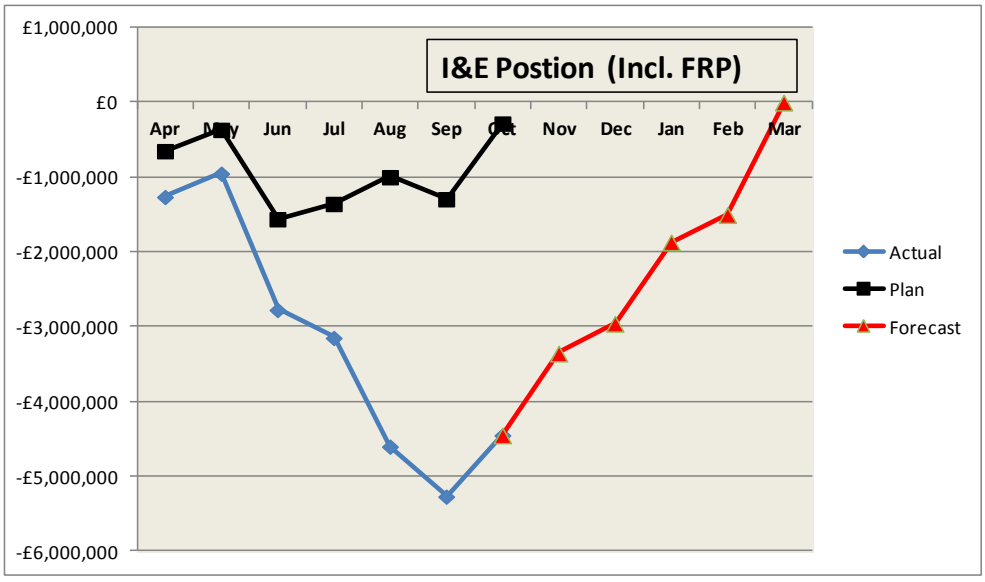
Income and Expenditure Position of the Trust

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 31st October 2012 was a £4.4m deficit (September: £5.3m). The plan submitted to the SHA in March predicted a £0.2m year to date deficit therefore the result was £4.2m worse than planned. The planned position for the full year is a surplus of £1.0m.

1.1.2. The month 7 position is a surplus of £0.8m. It should be noted that this position includes the unwinding of £0.5m of income provisions (post contract reconciliation for months 1-4), £0.3m of Transformation funding and £0.1m of Emergency Care Project funding (to offset costs incurred for the year to date).

1.1.3. The Financial Recovery plan to address the forecast deficit has been further developed and an update is provided under separate cover. At present actions totalling £11.2m have been identified leading to a forecast breakeven position. The graph below sets out the predicted path of the recovery plan for the remainder of the financial year which will require robust performance management.



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

1.2. Income and Activity

1.2.1. Total operating income in month 7 was £23.2m compared to a forecast of £21.8m. Year to date operating income stands at £145.9m, compared to a forecast of £144.3m.

1.2.2. SLA income amounted to £20.7m in October exceeding forecast levels by £1.1m. SLA income totalling £145.9m has been recorded for the year to date, £5.9m (4.8%) better than plan. The final level of income generated in month 7 (October) remains subject to final casemix validation.

1.2.3. The Trust is intending to agree an income settlement with the local CCG's to provide greater certainty over delivery of the financial recovery plan. As a first step the Trust and CCG have agreed the forecast activity and corresponding financial value for the remainder of the financial year.

1.2.4. 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	21,568	22,859	1,291	6.0%	12,826,263	13,304,394	478,131	3.7%	600,655	-122,524	478,131
EL	3,403	3,916	513	15.1%	10,257,008	10,185,522	-71,487	-0.7%	1,064,549	-1,136,036	-71,487
NEL	24,211	26,375	2,164	8.9%	40,581,217	44,337,672	3,756,455	9.3%	3,049,579	706,876	3,756,455
OPFA	37,493	38,780	1,287	3.4%	6,109,506	6,410,950	301,444	4.9%	-344,184	645,628	301,444
OPFUP	68,655	69,802	1,147	1.7%	6,277,803	6,377,339	99,537	1.6%	-55,321	154,858	99,537
OPFASPNCL	13,942	16,087	2,145	15.4%	1,232,440	1,457,998	225,557	18.3%	80,555	145,003	225,557
OPFUSPNCL	38,044	35,847	-2,197	-5.8%	1,826,409	1,955,726	129,317	7.1%	-77,678	206,995	129,317
OPPROC	22,731	23,838	1,107	4.9%	3,290,794	3,459,252	168,458	5.1%	131,084	37,374	168,458
A&E	45,411	46,782	1,371	3.0%	4,341,484	5,418,384	1,076,901	24.8%			
BLOCK / CPC MRET					35,592,687	36,194,614	601,926	1.7%			
ARMD	2,163	2,424	261	12.1%	611,712	687,603	75,892	12.4%			
Provisions					-2,148,701	-3,174,288	-1,025,587	47.7%			
CQUIN					2,935,611	2,657,889	-277,722	-9.5%			
Other					417,767	809,397	391,630	100.0%			
Total					**124,152,000**	**130,082,452**	**5,930,452**	**4.8%**			

1.2.5. The Trust has over performed on activity which equates to £5.9m of additional income. The majority of over performance is against the Northamptonshire CCG contract with under performance on some smaller contracts.

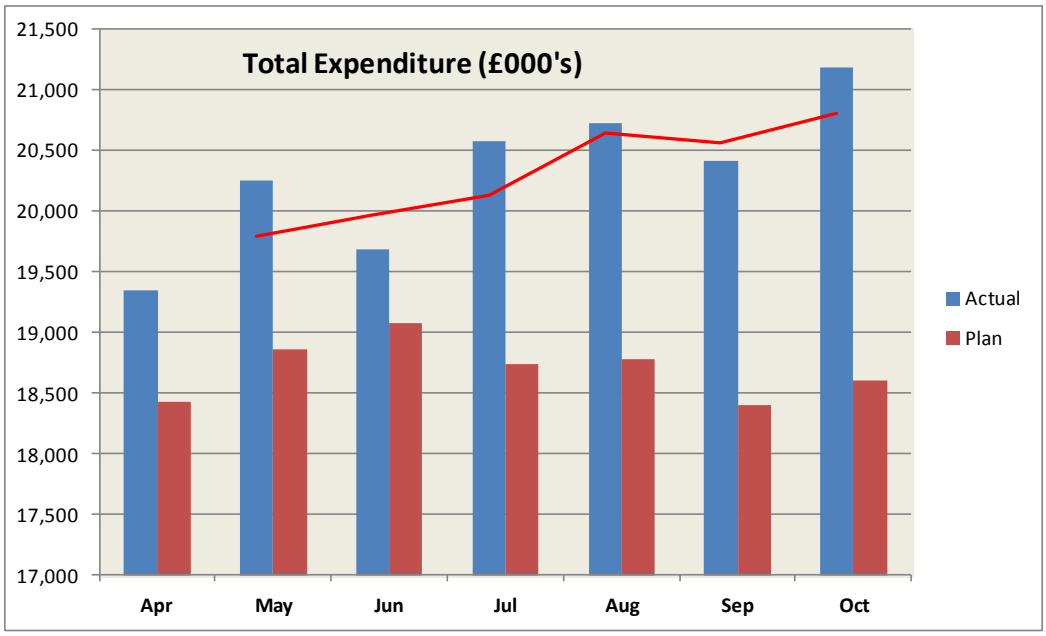
1.2.6. Elective admissions activity is 15% higher than planned although weaker casemix has seen associated revenues fall below plan in 2012/13. This is due in part to the proposed impact of PCT QiPP schemes during the year on elective income.

1.2.7. Outpatient first attendances are 3.4% above plan whilst outpatient follow up attendances are 1.7% above plan.

1.2.8. The Trust has reconciled and agreed the contractual position with the main commissioners for the period April to July and has invoiced the CCGs accordingly.

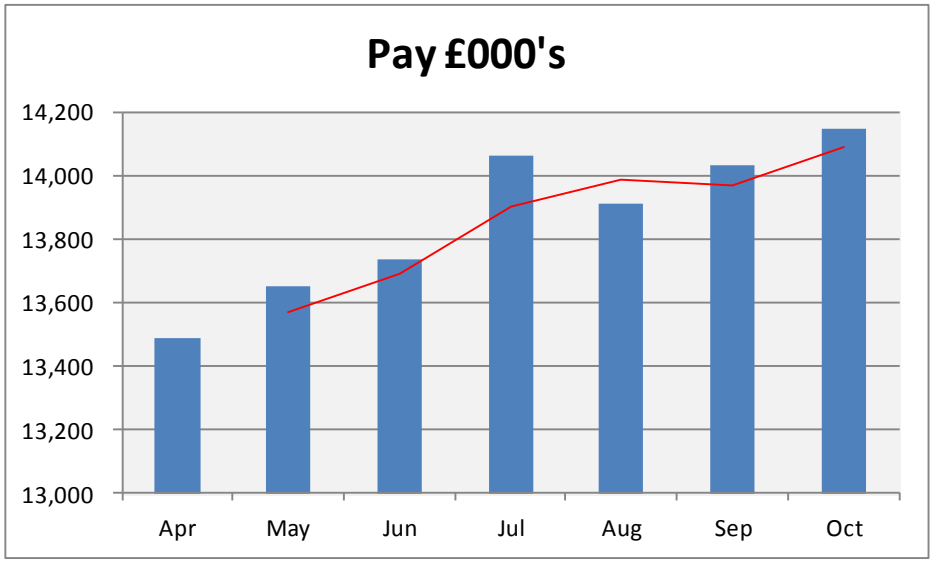
1.3. Expenditure

1.3.1. The Trust has overspent expenditure budgets by £11.3m in the 7 months to 31st October. The primary reason for the over spend is that insufficient Transformation Programme 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 £0.2m higher than forecast at £14.2m an increase of £0.2m compared to September. Cumulatively to month 6 pay costs were £97.1m, £6.4m higher than planned. An element of Pay costs associated with the Winter Pressures plans have been factored into the financial recovery plan but this may not be sufficient to meet demand.



Graph 3 – Pay expenditure monthly run rate 2012-13

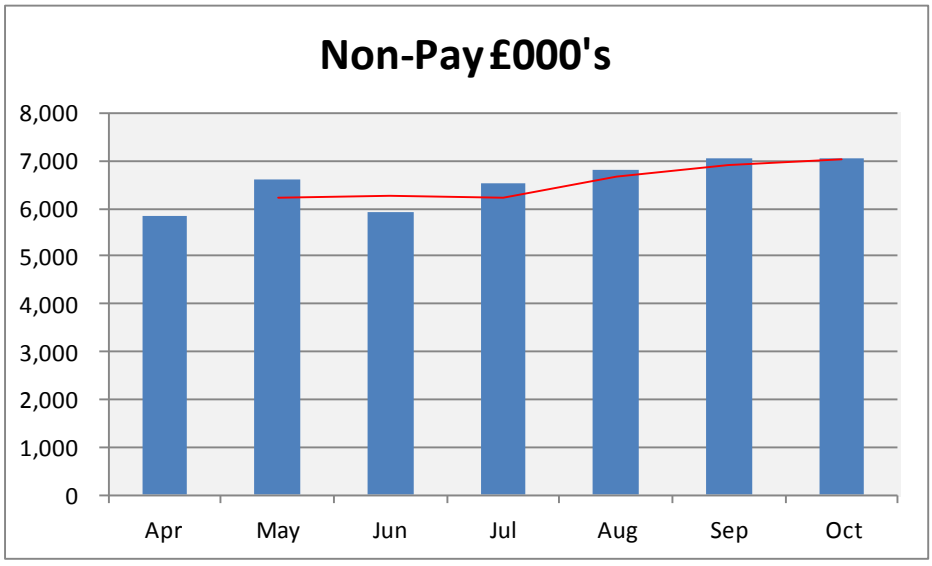
1.3.3. The Trust is operating below the planned WTE budget but is utilising significant numbers of temporary staff.

Table 3.1 – WTE Analysis – October 2012.

	Worked Mth 7 WTE	WTE Budget 2012/13 M7	Worked V Bud Var	Contracted Mth 7 WTE
Medical Staff	**477.87**	**464.36**	***-13.51***	**467.33**
Nursing Staff	**1,767.65**	**1,757.27**	***-10.38***	**1,672.51**
Managerial &	**834.43**	**892.49**	***58.06***	**747.84**
Other Clinical Staff	266.98	308.97	*41.99*	265.19
Scientific & Technical Staff	372.47	412.08	*39.61*	378.86
Estates Staff	29.52	36.19	*6.67*	25.00
All other Staff	**404.78**	**407.99**	**3.21**	**319.93**
Cost Challenges		**-10.19**	*-10.19*	
Total WTE	**4,153.70**	**4,269.16**	***115.46***	**3,876.67**

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 initiatives. Despite this, there remains some risk to the previously stated aim of reducing temporary staffing requirements from November.

1.3.5. Non Pay cost incurred were £5.5m higher than planned for the year to date. Expenditure in October amounted to £7.0m (£0.6m above forecast).



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" the risks against which are discussed under separate cover.

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 Care Group and Directorate 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 £8.3m by month 7 and actually achieved £5.9m which represent delivery of 72% 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 £0.9m have been categorised as red rated.

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

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 31st October 2012

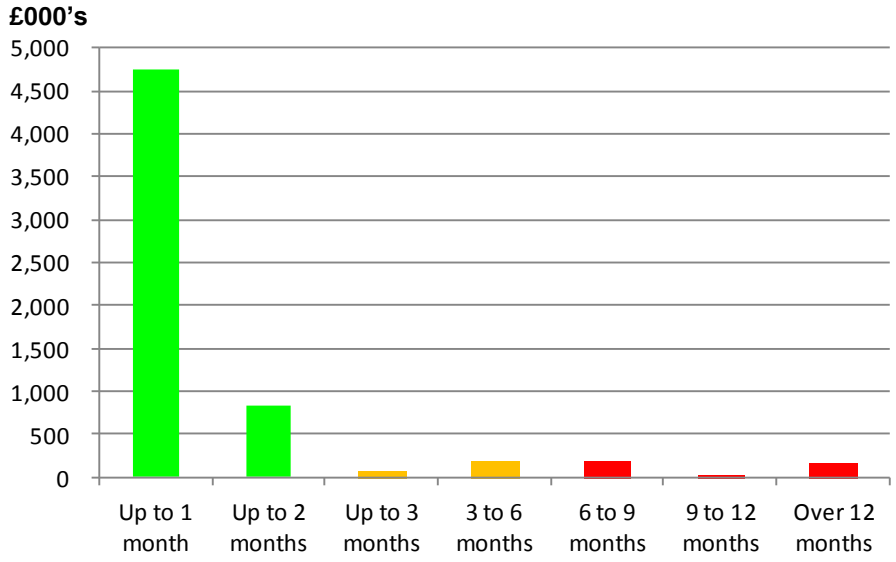
3.1. The Trust's Balance Sheet (Statement of Financial Position) as at 31st October 2012 is contained within appendix 4 of this report.

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 October stood at £2.3m (September £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 Trust has received final notification from DH of it's EFL for the year which determines that cash position needs to increase by £0.3m by the financial year end.

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 has been submitted to the SHA for this purpose.

3.4. The Trust continues to work with the CCG to find ways of alleviating short term cashflow problems. The SHA has written to Trusts notifying them of it's intention to pay all MPET invoices for the remainder of the financial year in December (c. £2m cash inflow).

3.5. An analysis of income earned by the Trust but unpaid as at 31st October 2012 is shown in the graph below:



Graph 5 – Aged Debtor analysis - October 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 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 31st October 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 is forecast to end the year with a risk rating of 3, subject to the successful 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 not included in the forecast financial position are set out in the table below:

Table 4 – Financial Risk Assessment – October 2012.

Risks not included in Financial Forecast 12-13		Value of Risk £000s	Likelihood
Downside Risk	**Action to mitigate risk**		
Winter Pressures	Bid to CCG / escalation by CEO,COO,FD.	(1,000)	High
Transformation Programme Slippage	Escalate through TDG.	(1,100)	Medium
Unfunded Cost Pressures	Manage through performance monitoring .	(350)	High
CCG confirmation of forecast income	DoF/DoS&P escalate to CCG/LAT/SHA	(5,000)	Medium
Net Revenue Risk		**(7,450)**	
Other Risks			
Cashflow constrained / unmet creditor demand	Business case to SHA for temporary borrowing / Negotiation with CCG.	3,500	Medium

7. Conclusion

7.1. The Trust is clearly facing a challenging financial year and at present is forecasting a breakeven position by the financial year end.

7.2. Achievement of a breakeven position is subject to the Trust being able to successfully manage and mitigate against the risks highlighted in section 6 above.

7.3. The Trust is continuing to face liquidity issues and has applied for temporary borrowing of c. £7m. A formal response to this requests is awaited from the SHA. The long term liquidity position is likely to remain a concern unless a permanent cash solution can be found.

8. Recommendations

8.1. The Board is 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 is 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.

Finance Dashboard

KPIs

	Financial Risk Rating (Shadow)	1	Overriding rules apply
	EBITDA	47.0%	EBITDA achieved 47% of plan
	Liquidity (days cover)	17.1	Incl. unused WCF of £18m
	Surplus Margin	-3.0%	+1% required for score of 3
	Pay / Income	66.5%	Pay 67% of Income for YTD

I&E Position

		£000's	
	Reported Position	(4,447)	Deficit of £4.4m to month 7.
	FIMS Plan (Year to date)	(230)	£0.2m deficit plan to month 7.
	PCT SLA Income Variance	5,931	4.8% above plan.
	Unmitigated Forecast	-9,730	Forecast before mitigating actions.
	SHA control total (NGH)	1,000	SHA control total £1m surplus.
	Financial Recovery Target	0	Forecast after recovery & mitigating actions.

EBITDA Performance

		£000's	
	Variance from plan	(4,272)ADV	£3.99m behind plan

Cost Improvement Schemes

		£000's	
	YTD Plan	8,252	£8.3m target to month 7.
	YTD Actual	5,961	£5.9m delivered to month 7.
	% Delivered	72%	CIPs delivered as a % of plan .
	LTF	11,098	Latest Thinking Forecast for year.
	Slippage Identified	0	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	3,229	Capital expenditure for period
	Committed as % of plan YTD	92%	% of plan committed for year to date.
	Annual Plan	10,336	Capital Resource Limit of £10.4m for 2012-13.

SoFP (movement in year)

		£000's	
	Non-current assets	(2,250)	Revaluation+Additions - depreciation
	Current assets	3,146	Reduction in cash balance offset by NHS debtors.
	Current Liabilities	4,921	NHS and Trade creditors increasing.

Cash

		£000's	
	In month movement	1,169	Increase between September and October.
	In Year movement	(1,671)	Reduction since March 2012
	Debtors Balance > 90 days	558	9% of balances outstanding over 90 days
	Creditors > 90 days	988	16% of creditors waiting over 90 days
	BPPC (by volume) YTD	90.0%	Target 95% paid in 30 days

Appendix 2

Income & Expenditure Position – October 2012

I&E Summary	Plan 2012/13	YTD Actual	YTD Plan	Variance to plan	Baseline Forecast EOY	Recovery Plan Actions	Forecast EOY
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	212,676	130,082	124,152	5,931 Fav	220,476	8,580	229,056
Other Clinical Income	2,663	1,625	1,552	73 Fav	2,505	67	2,572
Other Income	23,219	14,232	13,178	1,053 Fav	23,715	3,043	26,758
Total Income	**238,558**	**145,939**	**138,882**	**7,057 Fav**	**246,696**	**11,690**	**258,386**
Pay Costs	(153,668)	(97,086)	(90,637)	(6,448) Adv	(165,780)	42	(165,738)
Non-Pay Costs	(67,612)	(45,066)	(39,548)	(5,518) Adv	(76,444)	(611)	(77,055)
Reserves/ Non-Rec	(2,068)	0	(751)	751 Fav		(1,591)	(1,591)
Total Costs	**(223,143)**	**(142,152)**	**(130,823)**	**(11,329) Adv**	**(242,224)**	**(2,160)**	**(244,384)**
EBITDA	**15,415**	**3,787**	**8,060**	**(4,272) Adv**	**4,472**	**9,530**	**14,002**
Depreciation	(10,184)	(5,761)	(5,822)	61 Fav	(9,962)	200	(9,762)
Amortisation	(10)	(6)	(6)	(0) Adv	(10)		(10)
Impairments	0	0	0	-			0
Net Interest	29	11	17	(6) Adv	20		20
Dividend	(4,250)	(2,479)	(2,479)	0 Fav	(4,250)		(4,250)
Surplus / (Deficit)	**1,000**	**(4,447)**	**(230)**	**(4,217) Adv**	**(9,730)**	**9,730**	**0**

Statement of Financial Position as at October 2012

	Balance at 31-Mar-11	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		546	556	10	2,247	2,247
IN YEAR MOVEMENTS		2,599	2,955	356	8,533	8,533
LESS DEPRECIATION		(4,888)	(5,761)	(873)	(10,188)	(10,188)
NET BOOK VALUE	**135,075**	**133,332**	**132,825**	**(507)**	**135,667**	**592**
CURRENT ASSETS						
INVENTORIES	4,723	4,778	4,774	(4)	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	8,074	9,039	965	5,742	12
OTHER TRADE DEBTORS	985	1,021	1,077	56	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31				31	
NON NHS OTHER DEBTORS	70	293	232	(61)	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,547	2,565	18	2,554	
OTHER RECEIVABLES	549	506	550	44	574	25
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,757	2,680	(77)	1,460	2
	10,945	**14,766**	**15,711**	**945**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300	300	300			(300)
CASH	3,944	1,104	2,273	1,169	4,363	419
NET CURRENT ASSETS	**19,612**	**20,648**	**22,758**	**2,110**	**20,141**	**229**
CURRENT LIABILITIES						
NHS	1,673	4,198	4,565	(367)	2,070	(397)
TRADE CREDITORS REVENUE	3,655	5,305	5,207	98	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	1,019	941	78	2,046	713
TAX AND NI OWED	3,454	3,459	3,455	4	3,454	
NHS PENSIONS AGENCY	1,784	1,927	1,927		1,784	
OTHER CREDITORS	510	421	436	(15)	510	
SHORT TERM LOANS	526	431	431		688	(162)
ACCRUALS AND DEFERRED INCOME	4,018	7,175	7,448	(273)	4,031	(13)
PDC DIVIDEND DUE			354	(354)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	163	119	44	914	625
PROVISIONS over 1 year	310	330	330		374	
NET CURRENT LIABILITIES	**20,921**	**25,057**	**25,842**	**(785)**	**20,155**	**766**
TOTAL NET ASSETS	**133,766**	**128,923**	**129,741**	**818**	**135,653**	**1,587**
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	386	386		343	(42)
I & E CURRENT YEAR		(5,265)	(4,447)	818		
FINANCING TOTAL	**134,066**	**129,223**	**130,041**	**818**	**135,653**	**1,587**

Cost Improvement Delivery

£000's	Oct		YTD		
Workstream	**Plan**	**Actual**	**Plan**	**Actual**	**Var**
Beds / Patient Flow	48	-	256	17	(239)ADV
Theatres	30	10	201	63	(138)ADV
Outpatients	10	38	71	216	144FAV
Admin Review	55	-	110	-	(110)ADV
Procurement	100	72	700	507	(193)ADV
Pathology	16	12	65	30	(36)ADV
Therapies	10	4	30	8	(22)ADV
Medical	30	-	130	-	(130)ADV
Estates	6	4	39	26	(12)ADV
Outsourcing	16	3	32	13	(19)ADV
Nursing	8	-	17	-	(17)ADV
Back Office Phase	75	10	133	73	(60)ADV
Contract Compliance	52	508	419	1,000	582FAV
Pharmacy	38	38	263	391	129FAV
Controls	46	14	321	39	(282)ADV
HR Workforce Planning	166	-	354	-	(354)ADV
Workforce, Bank & Agency	79	-	554	-	(554)ADV
Directorate 3% Schemes	558	525	3,502	3,577	75FAV
New Schemes					
NGH Mitigation	151	-	1,057	-	(1,057)ADV
Grand Total	**1,492**	**1,238**	**8,252**	**5,961**	**(2,291)ADV**

	Plan	LTF	Var
Workstream	**£000**	**£000**	
Beds / Patient Flow	300	17	(283)ADV
Theatres	424	112	(312)ADV
Outpatients	165	374	209FAV
Admin Review	385	37	(348)ADV
Procurement	1,200	869	(331)ADV
Pathology	147	135	(12)ADV
Therapies	80	37	(43)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	187	(319)ADV
Contract Compliance	1,000	1,000	-
Pharmacy	450	604	154FAV
Controls	550	416	(134)ADV
HR Workforce Planning	1,183	250	(933)ADV
Workforce, Bank & Agency	950	700	(250)ADV
Directorate 3% Schemes	6,205	6,254	49FAV
New Schemes			-
Mitigation Required	1,820		(1,820)Decrease
Grand Total	**16,100**	**11,098**	**(5,002)ADV**

Cashflow

MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
		ACTUAL							FORECAST				
RECEIPTS													
SLA Base Payments	205,699	15,448	17,959	18,311	17,011	17,091	16,677	17,627	17,099	17,121	17,119	17,119	17,119
SLA Performance / Other CCG investment	17,474				1,965	151	309	1,544	3,400	3,000		3,000	4,106
SHA Payments (SIFT etc)	9,324	266	1,300	671	942	672	841	723	765	765	765	765	849
Other NHS Income	19,733	1,932	2,568	1,108	1,420	1,495	1,858	1,852	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	259		259										
PP / Other	11,590	821	768	796	1,013	793	972	927	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	402								106		80	128	88
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	271,514	18,469	22,857	20,888	22,352	20,204	20,659	22,676	23,972	30,489	20,567	23,616	24,766
PAYMENTS													
Salaries and wages	160,648	13,081	13,813	13,339	13,233	13,513	13,433	13,356	13,400	13,280	13,400	13,400	13,400
Trade Creditors	70,752	4,285	6,274	5,734	5,915	6,238	3,908	6,197	7,600	11,600	5,500	4,500	3,000
NHS Creditors	17,283	1,546	1,938	1,480	2,151	965	973	1,498	2,277	1,777	1,277	700	700
Capital Expenditure	10,940	789	1,503	763	517	371	375	455	698	1,706	1,442	1,260	1,062
PDC Dividend	4,194						2,069						2,125
Repayment of Loans	7,000												7,000
Repayment of Salix loan	240						95						145
TOTAL PAYMENTS	271,057	19,701	23,528	21,316	21,815	21,087	20,854	21,506	23,975	28,363	21,619	19,860	27,432
Actual month balance	457	-1,232	-671	-428	537	-883	-195	1,170	-3	2,125	-1,053	3,756	-2,666
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,112	1,229	1,034	2,204	2,201	4,326	3,273	7,029
Balance carried forward	4,363	2,675	2,003	1,575	2,112	1,229	1,034	2,204	2,201	4,326	3,273	7,029	4,363

Capital

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 7 M7 Plan £000's	M7 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 7 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 7 M7 Forecast £000's	Plan chieved
Breast Screening Business Case	59	59	59	0	100%	59	100%	59	100%
Emergency Care	385	185	177	-7	46%	177	46%	377	98%
Endoscopy / Urodynamics	160	60	51	-9	32%	51	32%	160	100%
Mortuary Refurbishment	80	60	55	-5	69%	55	69%	55	69%
Macmillan (Trust)	91	6	5	-1	5%	23	25%	91	100%
Macmillan (Non Trust)	13	13	13	0	100%	13	100%	13	100%
MESC	951	371	371	0	39%	462	49%	951	100%
Estates	3,667	1,280	1,163	-117	32%	1,693	46%	3,667	100%
IT	3,373	1,303	1,083	-219	32%	1,683	50%	3,373	100%
Other	158	41	117	76	74%	146	92%	190	120%
Total - Capital Plan	**8,936**	**3,378**	**3,096**	**-282**	**35%**	**4,363**	**49%**	**8,936**	**100%**
Less Charitable Fund Donations	-354	-149	-141	8	40%	-141	40%	-354	100%
Total - CRL	**8,582**	**3,229**	**2,955**	**-274**	**34%**	**4,222**	**49%**	**8,582**	**100%**
Resources									
Internally Generated Depreciation	9,934								
SALIX	402								
Total - Available CRL Resource	**10,336**								
Uncommitted Plan	**-1,754**								

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (due for completion November 2012)
- Emergency Pressures - £200k allocation subject to Capital Committee approval
- Endoscopy (only fees in 2012/13) / Urodynamics (initial w orks 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 w orks are completed, although final account is under dispute
- Full year depreciation forecast is currently £9.934 million (w as £10.184 million)
- Follow ing Capital Committee meeting £368k w as agreed to slip till next financial year - endoscopy £218k and Estates schemes £150k
- Charitable Donations assumptions for additions in year has reduced by £225k to £354k
- The 2012/13 is undercommitted against resource in year by £1.754 million as a result of managing cash constraints

Financial Risk Rating (Monitor)

Financial Criteria	Metric	Weight %	Oct	Shadow Rating	YTD Score	Fcst Score	Fcst Rating
Achievement of Plan	EBITDA Achieved (% of plan)	10%	47%	1	0.10	3	0.30
Underlying Performance	EBITDA Margin %	25%	2.6%	2	0.50	2	0.50
Financial Efficiency	Return on Assets	20%	-1.51%	2	0.40	3	0.60
Financial Efficiency	I&E Surplus Margin	20%	-3.0%	1	0.20	2	0.40
Liquidity	Liquidity Ratio (Days cover)	25%	17.13	3	0.75	3	0.75
Weighted Average		100%		Calculated Score	2		3
				Override	-1		
				Reported Score	1		3

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			
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	Yes	Yes			Yes
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	Yes	Yes			Yes
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
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	No	No	Yes			Yes
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No
7	Interim Finance Director in place over more than one quarter end	No	No	No	No			No
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes			Yes
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No			No

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 29th November 2012	
Title	HR REPORT
Presented by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for October 2012 which focuses on the following Human Resource Workforce Indicators for Month 7:

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

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

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 7

The Human Resource Workforce Indicators have been updated for Month 7. Please refer to the following pages of this report.

The salient points of change to date are:

Workforce Capacity

Substantive Workforce Capacity increased by 23.48 FTE from 3,853.19 FTE to 3,876.68 FTE which is below the plan (4,269.15 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has increased by 0.23% to 90.81%.

Temporary Workforce (excluding Medical Staffing) usage increased by 0.31% from 7.46% to 7.77% 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 increased by 0.58% from 97.88% to 98.46%.

Staff turnover (leavers) has increased by 0.11% on the month to 8.29%, which remains above the Trust target of 8%.

Recruitment Timeline is on the threshold target of 13 weeks.

Health and Wellbeing

Calendar Days Lost to Sickness The number of calendar days lost to sickness increased by 602 from 5,964 to 6,566 in October 2012.

No. of Days Lost per Employee increased by 0.13 from 1.32 days to 1.45 days.

Long term sickness absence decreased by 0.15% to 1.73% which is below the Trust target of 2%

Short Term Sickness Absence absence has increased by 0.44% to 2.90% (Trust target 1.4%).

Total Sickness Absence has increased by 0.28% to 4.62% (Trust target 3.4%).

Workforce Expenditure

Temporary Workforce Expenditure has increased by £139,583 from £1,480,861 to £1,620,444 which is equal to 11.45% of the total workforce expenditure.

Workforce Development

Appraisals are centrally recorded on OLM and are 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 continue to work with Managers to implement the process of submitting appraisal records. The percentage of staff with completed appraisals for October was 12.24%, compared to 11.35% the previous month.

Mandatory Training Compliance shows an increase of 2.09% compliance in October 2012 with a total Trust compliance of 62.68%.

Forecast and Risks

The HR Advisors are continuing a focus on long term sickness absence. As a result, long term sickness absence has decreased to 1.73% which is below Trust target. This is the lowest percentage for 11 months. A Trust-wide task and finish group has been set up to address short term sickness absence, the first meeting will take place on 22nd November 2012.

In line with the nursing recruitment programme, there will be a ban on nursing agency staff for general nursing areas from December 1st 2012.

The planned opening of Compton Ward and MDSU will require an additional 40 FTE staff. There will be a requirement for temporary staff until permanent staff are in post.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 7

WORKFORCE CAPACITY (Temporary Workforce Capacity Excludes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Sep-12	Oct-12	Peformance vs. Prev. Month	Comments and or Plans
Budgeted Workforce Establishment (FTE)			4,253.85	4,269.15	Higher	
Contracted Substantive Workforce (FTE)			3,853.19	3,876.67	Higher	
Temporary Workforce Utilised (FTE)			310.59	326.59	Higher	
Total Substantive Workforce plus Temporary Workforce (FTE)			4,163.79	4,203.26	Higher	
Contracted Workforce against Budgeted Establishment (% FTE)	95% to 97%		90.58%	90.81%	Higher	
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)	100%		97.88%	98.46%	Higher	
Temporary Workforce Rate (%FTE)	5%		7.46%	7.77%	Higher	Temporary Workforce Rate excludes Medical Staffing
Staff Turnover (% FTE)	8%		8.18%	8.29%	Higher	
Recruitment Timeline	13 Weeks		12.45	13%	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	Sep-12	Oct-12	Peformance vs. Prev. Month	Comments and or Plans
Contracted Workforce Expenditure		87,320,161	12,616,745	12,527,612	Lower	
Contracted Workforce Enhanced Overtime		473,860	57,734	65,537	Higher	
Contracted Workforce Plain Time OT		36,083	8,695	10,191	Higher	
Temporary Workforce Expenditure		9,765,448	1,480,861	1,620,444	Higher	Temporary Workforce Expenditure = Bank, Agency and Locum (including Medical Staffing)
Total Utilised Workforce Expenditure		97,085,609	14,097,607	14,148,056	Higher	
Temporary Workforce Expenditure (% of Total Workforce Expenditure)		10.06%	10.50%	11.45%	Higher	

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 7

HEALTH AND WELLBEING

Performance Indicator	Performance Target	Trust YTD	Sep-12	Oct-12	Peformance vs. Prev. Month	Comments and or Plans
Trust Headcount (Permanent & FTC)			4,523	4,543	Higher	
Calendar Days Lost to Sickness Absence		45,437	5,964	6,566	Higher	
Days Lost Per Employee			1.32	1.45	Higher	
Short Term Sickness Absence	1.4%		2.46%	2.90%	Higher	
Long Term Sickness Absence	2%		1.88%	1.73%	Lower	
Total Sickness Absence	3.40%		4.34%	4.62%	Higher	

WORKFORCE DEVELOPMENT

Performance Indicator	Performance Target	Trust YTD	Sep-12	Oct-12	Peformance vs. Prev. Month	Comments and or Plans
Mandatory Training Compliance	100%		60.59%	62.68%	Higher	

WORKFORCE APPRAISALS

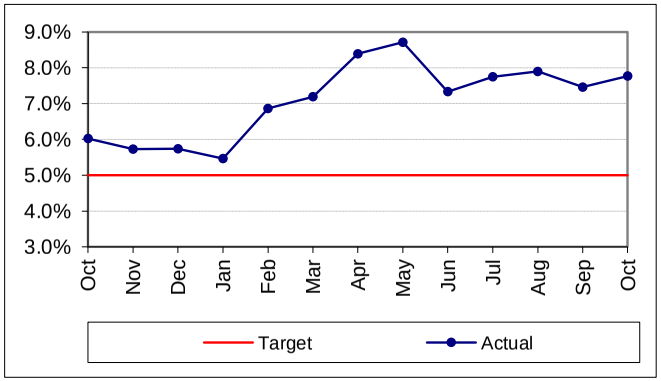
Performance Indicator	Performance Target	Trust YTD	Sep-12	Oct-12	Peformance vs. Q1 2011	Comments and or Plans
12 Month Cumulative Completed Personal Development Review / Plan	100%		11.35%	12.24%	Higher	Managers are responsible for submitting PDR/P's which are recorded and reported from central source (OLM)

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 7

DIRECTORATE WORKFORCE PERFORMANCE SUMMARY

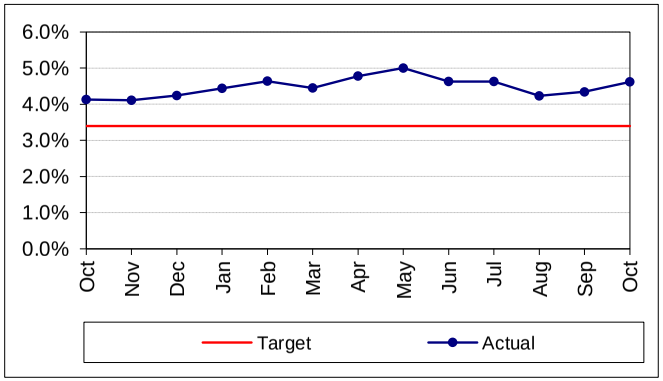
Temporary Workforce Rate

Directorate	Bank & Agency (Excl. Locum) M7	Variance Against Target	Variance From M6
Target = 5.0%		<-1.0%	>0.0%
Medicine	13.98%	8.98%	0.68%
Surgery	8.89%	3.89%	-0.34%
Anaesthetics	6.28%	1.28%	-0.46%
Trauma & Orthopaedics	7.39%	2.39%	-1.07%
Head & Neck	7.16%	2.16%	-0.72%
Child Health	5.66%	0.66%	1.36%
Obstetrics & Gynae	4.33%	-0.67%	0.23%
Oncology	6.07%	1.07%	-0.10%
Pathology	3.55%	-1.45%	0.17%
Radiology	0.00%	-5.00%	0.00%
Pharmacy	0.00%	-5.00%	0.00%
Therapies	12.10%	7.10%	0.20%
Facilities	3.80%	-1.20%	0.73%
Hospital Support	5.08%	0.08%	0.85%
Total	7.77%	**2.77%**	0.31%



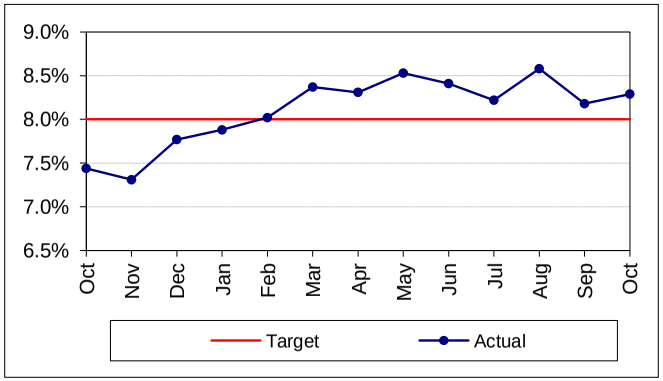
Staff Sickness Absence Rate

Directorate	Sickness Absence M7	Variance Against Target	Variance From M6
Target = 3.4%		<-0.0%	>0.0%
Medicine	4.47%	1.07%	0.71%
Surgery	3.59%	0.19%	0.20%
Anaesthetics	4.51%	1.11%	-0.65%
Trauma & Orthopaedics	3.86%	0.46%	0.30%
Head & Neck	5.70%	2.30%	-0.73%
Child Health	4.97%	1.57%	1.72%
Obstetrics & Gynae	6.20%	2.80%	-0.42%
Oncology	3.68%	0.28%	-0.50%
Pathology	3.19%	-0.21%	1.03%
Radiology	4.25%	0.85%	-0.44%
Pharmacy	1.93%	-1.47%	-0.97%
Therapies	6.00%	2.60%	-1.33%
Facilities	5.73%	2.33%	0.14%
Hospital Support	5.23%	1.83%	1.36%
Total	**4.62%**	**1.22%**	**0.28%**



Staff Turnover

Directorate	Turnover M7	Variance Against Target	Variance From M6
Target = 8.0%		<-0.0%	>0.0%
Medicine	7.04%	-0.96%	-0.08%
Surgery	7.50%	-0.50%	-0.40%
Anaesthetics	4.68%	-3.32%	0.37%
Trauma & Orthopaedics	7.00%	-1.00%	0.01%
Head & Neck	5.19%	-2.81%	-0.34%
Child Health	12.79%	4.79%	0.31%
Obstetrics & Gynae	8.33%	0.33%	0.38%
Oncology	9.52%	1.52%	0.76%
Pathology	8.80%	0.80%	-0.50%
Radiology	4.19%	-3.81%	-0.01%
Pharmacy	7.04%	-0.96%	1.08%
Therapies	10.92%	2.92%	0.41%
Facilities	11.25%	3.25%	-0.17%
Hospital Support	12.06%	4.06%	0.39%
Total	**8.29%**	**0.29%**	**0.11%**

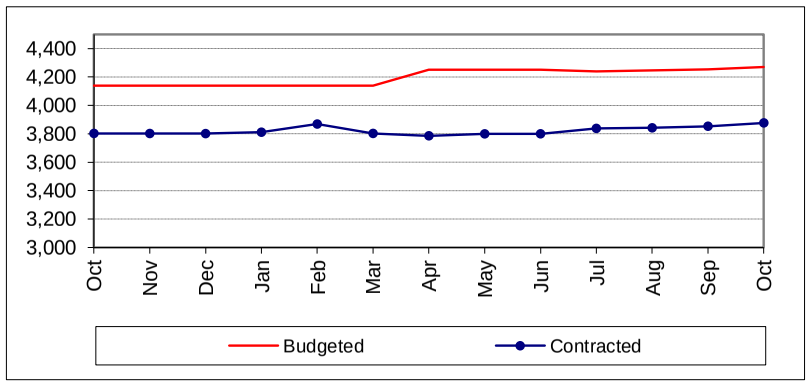


HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 7

DIRECTORATE WORKFORCE CAPACITY SUMMARY

Substantive Workforce Capacity FTE (Target = 95%)

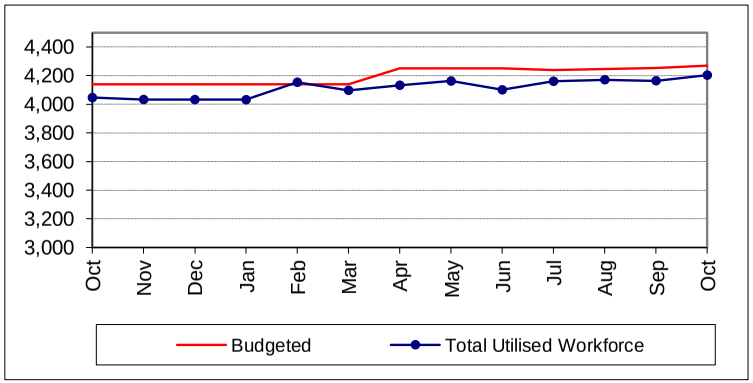
Directorate	Budgeted Establishment	M7 Contracted	Variance %	Variance FTE
Medicine	1,097.80	973.43	-11.33%	-124.37
Surgery	292.82	270.02	-7.79%	-22.80
Anaesthetics	328.34	308.09	-6.17%	-20.25
Trauma & Orthopaedic	254.90	228.81	-10.24%	-26.09
Head & Neck	173.33	150.89	-12.95%	-22.44
Child Health	266.30	264.31	-0.75%	-1.99
Obstetrics & Gynae	379.79	366.92	-3.39%	-12.87
Oncology	223.95	226.46	1.12%	2.51
Pathology	225.85	190.09	-15.83%	-35.76
Radiology	143.45	132.59	-7.57%	-10.86
Phamacy	101.65	97.88	-3.71%	-3.77
Therapies	79.37	67.36	-15.13%	-12.01
Facilities	344.56	278.28	-19.24%	-66.28
Hospital Support	357.04	321.55	-9.94%	-35.49
Total	**4,269.15**	**3,876.68**	**-11.90%**	-392.47



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	1,097.80	1,131.61	33.81
Surgery	292.82	296.35	3.53
Anaesthetics	328.34	328.73	0.39
Trauma & Orthopaedic	254.90	247.07	-7.83
Head & Neck	173.33	162.52	-10.81
Child Health	266.30	280.16	13.86
Obstetrics & Gynae	379.79	383.52	3.73
Oncology	223.95	241.09	17.14
Pathology	225.85	197.09	-28.76
Radiology	143.45	132.59	-10.86
Phamacy	101.65	97.88	-3.77
Therapies	79.37	76.63	-2.74
Facilities	344.56	289.26	-55.30
Hospital Support	357.04	338.77	-18.27
Total	**4,269.15**	**4,203.27**	-65.88



Northampton General Hospital NHS
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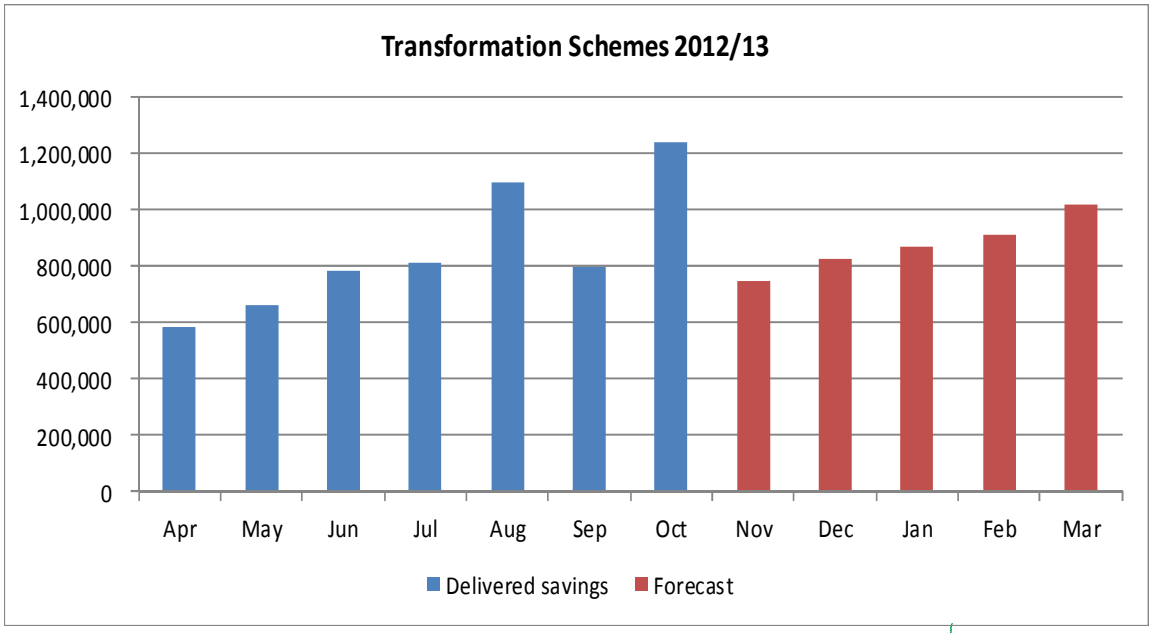
Transformation Programme

November 2012

2012/13 Transformation Programme Update

The plan for the 2012/13 transformation programme is to deliver £11.1m savings. The table below shows the savings already delivered through the programme (in blue), and those anticipated for the rest of the year (in red).



Each of the workstreams within the programme has a target to deliver. The Trust has recently received some funding for transformation from the SHA. This will be used to support the MAR scheme and the costs incurred so far.

However some of the schemes have slipped due to delays in implementation, and the Trust's financial position is very challenging, so it is important that we continue to work together to deliver all elements of the programme.

Transformation Programme

MARS update

On the 7th of November, the Trust opened a Mutually Agreed Resignation Scheme (MARS). MARS is a form of voluntary severance that has been developed with the aim of increasing the flexibility of the Trust as we address change and service redesign through the Transformation Programme. The principles of the scheme have been developed and agreed by the NHS Staff Council.

The Mutually Agreed Resignation Scheme will support the Trust by creating job vacancies which can be filled by the redeployment of staff from other jobs, or as a suitable alternative job for those facing redundancy and to help to minimise, where possible, the need for any future redundancies.

Applications for the Mutually Agreed Resignation Scheme have been open to all Trust employees who have been continuously employed as a permanent member of staff by the Trust for a minimum of 12 months as at 5th November 2012, with the exception of doctors in training.

There is no automatic right to severance payments under the Scheme. Each case will be considered on its own individual merits against objective criteria. The final decision on each application will be made by the Mutually Agreed Resignation Executive Director Panel.

Applicants will be informed of the outcome of their application. If an employee's application has been approved their line manager will arrange a meeting to confirm their acceptance of the offer and to discuss the next steps and the leaving arrangements. An HR Business Partner will also attend the meeting.

At the time of writing 74 staff members had submitted declarations of interest, the closing date for submissions is Friday 23rd November 2012.

Transformation Programme

Bank & Agency update

The trust spends over £7m per year on bank and agency staffing, majority of which is for nursing positions. One of the ways that we are seeking to reduce this cost is by recruiting more substantive nursing staff. The table below shows how many additional staff have been recruited throughout the year so far.

Staff group	Starters	Leavers	Balance
Health Care Assistants	115	44	71
Registered Nurses	140	87	53

Note: Leavers data is based on information HR have received

Unfortunately the number of staff leaving the organisation has reduced the impact of the new starters, but the team continue to recruit as part of a rolling programme.

In order to continue to support temporary staffing in key areas and still contribute to the transformation programme a large majority of shifts will be filled through Bank staff from Dec 2012.

Overtime update

As part of the Transformation programme we are now looking at the reduction of overtime usage and spend in the last 5 months of the year. Although we appreciate that in some cases overtime is unavoidable, we are on track to spend over £1 million for the year, which we need to see significantly reduce. There will be certain exceptions to the overall overtime reduction, as we are aware of particular departments that have a specific need for overtime that has been agreed by the executive team.

We will work in conjunction with Care Group managers to implement an appropriate sign off process for overtime, as well as ensuring that no service is adversely affected by these reductions.

Transformation Programme

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)

- General transformation enquiries
- 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

Gail Tatsis (gail.tatsis@ngh.nhs.uk—Ext 3983)

- Medical Productivity

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
October 2012

NHS Trust Over-sight self certification template

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

TFA Progress

Oct-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 in time		
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12	Fully achieved in time		
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	Fully achieved in time		
5	Recovery plan agreed at Board to stabilise financial position	Oct-12	Fully achieved in time		
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:	October 2012

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)	2
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 :	
on behalf of the Trust Board	Acting in capacity as:		

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

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 Oct 2012 but is still currently behind trajectory YTD (….7% YTD**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

Target/Standard:	**FRR**
The Issue :	**YTD defcit of £4.4m leading to FRR score of 2.**
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	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-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			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			Yes	
			Patients dying at home / care home	50%		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			Yes	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	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	
	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	
	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	Yes	Yes	Yes			Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	Yes	Yes	Yes			Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	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	No	Yes	Yes			Yes	
			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	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	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	Yes			Yes	94.1% YTD as at 31 October 2012
	3f	Care Programme Approach (CPA) patients,	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a			Yes	

	comprising:	Having formal review within 12 months	95%	**1.0**	N/a	N/a	N/a	N/a			Yes	
	3g	Minimising mental health delayed transfers of care		≤7.5%	**1.0**	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			Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**0.5**	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			Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	**1.0**	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	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	**1.0**	Yes	Yes	No	Yes			Yes	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	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	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	
				TOTAL		**1.5**	**2.0**	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	

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				
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	No	No	No	No				

		Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.								
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				
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.	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				
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				
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				
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	Yes	Yes	Yes	Yes				
		Number of Overrides Triggered	***2.0***	***2.0***	***2.0***	***2.0***	***0.0***	***0.0***	***0.0***	

FINANCIAL RISK RATING

Northampton General Hospital

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: 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	3	2	2	YTD Deficit of £4.4m. Normalised position excludes CCG non-rec investment of £5m.
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	3	1	2	YTD Deficit of £4.4m. Normalised position excludes CCG non-rec investment of £5m.
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3	2	2	YTD and normalised deficit.
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	YTD and normalised deficit.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Includes notional WCF of £18m.
Weighted Average		**100%**						**2.0**	**2.8**	**2.0**	**2.3**	
Overriding rules								2		2	2	
Overall rating								**2**	**3**	**2**	**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"					
1	Two Financial Criteria at "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 Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	Yes	Yes			Yes	EBITDA £4.3m adverse to plan.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	Yes	Yes			Yes	Normlaised FRR expected to be 2.
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	9% in October.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	No	No	Yes			Yes	16% in October.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No	
7	Interim Finance Director in place over more than one quarter end	No	No	Yes	No			No	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes			Yes	-12 days if WCF of £18m excluded.
9	Capital expenditure < 75% of plan for the year to date	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 Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
Are the prior year contracts* closed?	Yes	No	Yes	Yes			Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes			Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes			Yes	
Are there any disputes over the terms of the contract?	No	No	No	No			No	
Might the dispute require SHA intervention or arbitration?	No	No	No	No			No	
Are the parties already in arbitration?	N/a	N/a	No	No			No	
Have any performance notices been issued?	Yes	Yes	No	No			No	
Have any penalties been applied?	No	No	No	No			No	

QUALITY

Northampton General Hospital

Insert Performance in Month

	Criteria	Unit	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Comments on Performance in Month
1	SHMI - latest data	Ratio						109	109	109	106	106	106	104.8	SHMI - Apr 12 to Jun 12 = Oct 10 to Sept 11 position. Jul 12 to Sep 12 = Jan 11 to Dec 11 position. Latest position reported in Oct 12 reflects Apr 11 to Mar 12.
2	Venous Thromboembolism (VTE) Screening	%	93.4%	93.3%	92.2%	93.6%	90.9%	91.4%	91.9%	90.3%	93.0%	90.7%	93%		VTE data for Oct 12 unavailable as at 22.11.12
3a	Elective MRSA Screening	%	99.6%	99.5%	100.0%	99%	99.93%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	
3b	Non Elective MRSA Screening	%	97.0%	96.8%	97.3%	96.20%	91.05%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	
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	6	5	15	12	14	12	3	9	5	4	5	7	
6	"Never Events" in month	Number	0	0	1	0	0	0	0	0	0	1	0	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	2	0	1	1	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	5	3	4	2	3	1	2	1	1	2	2	4	One of red flags relates to more than 400 births in October (a maternity unit with a birth rate over 4500 should be working to a 98 hour Consultant Obstetrician presence on labour ward with a second tier of middle grade trainees, therefore births over 400 per month are flagged red - 403 in Oct), others relate to a decrease in home birth rates, an increase in C-section rates and an increase in complaints.
10	Falls resulting in severe injury or death	Number	4	1	1	0	2	0	0	1	2	2	0	2	
11	Grade 3 or 4 pressure ulcers	Number	3	0	3	5	0	1	4	2	1	0	3	2	
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	44	29	39	48	49	50	51	39	48	33	35	44	
14	Agency as a % of Employee Benefit Expenditure	%	4.8%	5.5%	5.4%	5.5%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.10%	Oct Bank & Agency Spend was £1.637m / £ 23.219m income = 7.1%
15	Sickness absence rate	%	4.1%	4.2%	4.4%	4.6%	Not Av	4.78%	5.0%	4.6%	4.6%	4.2%	4.34%	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	%	No	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

Board Statements

Northampton General Hospital

October 2012

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.	Yes
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

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 29th November 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.	Minutes of the meeting held on 25th October 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 January 31st 2013		
	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	