Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Wednesday 24 April 2013
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 28 March 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Mrs C Allen	**3**
Clinical Quality & Safety				
09.40	6.	Liverpool Care Pathway Presentation	Dr David Riley	**Presentation**
09.55	7.	Medical Director's Report	Dr S Swart	**4**
10.10	8.	Patient Experience Report	Ms S Loader	**5**
10.20	9.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.30	10.	Operational Performance Report	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr A Foster	**8**
10.50	12.	Human Resources Report	Mrs J Brennan	**9**
11.00	13.	Transformation Programme Update	Mrs J Brennan	**10**
11.10	14.	Self-Certification Return	Mr C Pallot	**11**
Strategy				
11.15	15.	Corporate Objectives 2013/14	Mrs C Allen	**12**
11.20	16.	Annual Carbon Management and Sustainability Report 2012/13	Mr C Abolins	**13**
Governance				
11.25	17.	Information Governance Report 2012/13	Mr C Pallot	**14**
11.30	18.	Any Other Business	Mr P Farenden	
	19.	**Date & time of next meeting:** 30 May 2013 – 09.30am. Boardroom, Northampton General Hospital		

	20.	**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	

Northampton General Hospital NHS
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Minutes of the Trust Board Meeting held in public on
Thursday 28 March at 9.30am
Boardroom, Northampton General Hospital

Present:

Mr P Farenden	Chairman
Mr C Abolins	Director of Facilities & Capital Development
Mrs C Allen	Interim Chief Executive
Mr P Hollinshead	Interim Director of Finance
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr G Kershaw	Non-Executive Director
Mr D Noble	Non-Executive Director
Mrs G Opreshko	Interim Director of Workforce and Transformation
Mr N Robertson	Non-Executive Director
Mrs E Searle	Non-Executive Director
Mr P Zeidler	Non-Executive Director

In attendance:

Ms R Brown	Care Group Director – Surgery
Mr A Foster	Deputy Director of Finance
Mr R Kelso	Shadow Governor
Mr C Sharples	Head of Corporate Affairs (minutes)
Ms K Spellman	Deputy Director of Strategy and Partnerships
Dr J Timperley	Cardiology Consultant (Agenda Item 9)

Apologies:

Mr C Pallot	Director of Strategy and Partnerships
Dr S Swart	Medical Director

TB 12/13 147 **Declarations of Interest**
No interests or additions to the Register of Interests were declared.

TB 12/13 148 **Minutes of the meeting held on 28 February 2013**
The minutes of the Board meeting held on 28 February 2013 were presented to the Board for approval.

The Board APPROVED the minutes of 28 February as a true and correct record.

TB 12/13 149 **Action Log and matters arising**
All actions and matters arising were on the agenda.

TB 12/13 150 **Chief Executive's Report**
Mrs Allen provided a verbal report to the Board.

The Trust had recently held a successful star awards ceremony which celebrated the achievements of Northampton General Hospital NHS Trust staff. The event, and particularly the contribution of staff, had received positive feedback from patients via social media networks.

Mrs Allen updated the Board following the Listening into Action staff engagement event which had recently taken place. A number of themes had been identified from the event, and as such, the executive team were undertaking to review the communication systems and processes used,

particularly when communicating down to team level. A particular initiative which had been developed as an outcome of the event was the 'In your Shoes' initiative in which a healthcare assistant would spend the day shadowing the Chief Executive and vice versa. It was envisaged that the initiative would be more widely rolled out.

Mr Farenden commented that he was struck by the remarkable enthusiasm, commitment and desire of the staff that were at the event, which appeared at odds with the outcomes of the staff survey.

Mrs Allen updated the Board on the Trust's response to the Francis Report. She reported that a number of listening exercises with staff had been conducted, the outcomes of which would enable better understanding of how the Trust could appropriately act upon and respond to the recommendations of the report and build on the Trust's Quality Strategy.

The Board NOTED the Chief Executive's Report

TB 12/13 151 Medical Directors Report

Ms Loader presented the Medical Director's Report to the Board.

Ms Loader reported that the Hospital Standardised Mortality Ratio (HSMR) for the first six months of 2012/13 was 99, which was predicted to rise to 105 following re-benchmarking. Unadjusted mortality was 4.0%, which was slightly below the Strategic Health Authority average of 4.1%. Ms Loader informed the Board that the Standardised Hospital Mortality Indicator (SHMI) was higher than at this point in 2011/12 at 108, but the Trust remained in the "as expected" category. The Board was informed that there were no current concerns in relation to Dr Foster Patient Safety Indicators.

Ms Loader reported that despite a slight dip in numbers there continued to be concerns related to mortality from fractured neck of femur. The Board was assured that the issue was under rigorous scrutiny from Clinical Directors and the Healthcare Governance Committee, and significant work to address the issue was ongoing.

With regard to the National Quality Dashboard, Ms Loader reported that there were no adverse alerts for the Trust although there were concerns regarding an increase in the number of admissions for under 19's which reflected emergency pressures in paediatrics. Staff sickness and bed occupancy indicators were also higher than average, again influenced by emergency pressures.

In presenting the Quality Scorecard, Ms Loader reported that there had been an increase in pressure ulcers, with three 'Grade 3' incidents being reported. A detailed action plan to manage pressure ulcers would be presented to the April 2013 meeting of the Healthcare Governance Committee. Ms Loader added that work was currently focused on wards to reduce the number of pressure ulcers acquired in hospital.

The Board was advised that the target for cancelled operations had not been met in February 2013 as one patient had not had their operation re-booked in a timely manner.

Mr Robertson commented that there had been significant progress with regard to HSMR and SHMI, but it remained above 100. He asked if the work underway to address mortality due to fractured neck of femur would bring the

figure to below 100. Mrs Allen stated that as she understood it, it would not. Ms Loader was requested to speak to Dr Swart to ascertain if there were any additional actions which could be taken which would make a step change to HSMR to bring it down to below 100.

Action: Ms Loader

The Board NOTED the Medical Director's Report.

TB 12/13 152 Patient Experience Report

Ms Loader presented the Patient Experience Report to the Board. The overall figures reported for the friends and families test had remained static at 68 through December 2012 to February 2013. Ms Loader was unsure why the score remained low as the comments received were on the whole, positive.

There had been an increase in the number of patients responding, with 19% of footfall represented. A stretch target of 20% would be introduced from April 2013. The friends and families test had recently been prepared in Polish. Work continued within A&E to increase the opportunities for patients to complete the friends and families questionnaire, for example the introduction of an e-kiosk and volunteers recruited to support the initiative.

With regard to the patient experience CQUIN, Ms Loader informed the Board that an overall implementation plan had been developed to improve performance which was not good. Three of the five inpatient questions were rated as amber. She reported that she had met all ward sisters to share her concerns regarding current results, challenging them to identify actions which would lead to an improvement in the scores.

Mr Zeidler observed that the first of the five CQUIN questions had dropped significantly to 34.8% yet still remained rated as amber, not red. Ms Loader undertook to investigate and would feedback.

ACTION: Ms Loader

Mr Zeidler commented that he found the breakdown of performance by ward in appendix 1 of the report very helpful. He asked what was being done to engage with the wards that were performing well, as they should be celebrated and good practice shared. Ms Loader advised that areas of good practice had been shared across wards.

Mrs Allen noted that there were a number of wards which were under pressure but performing well, highlighting that emergency pressure should not be used as an excuse for poor patient experience.

Mr Robertson asked if there was correlation between ward level patient experience results and the outcomes of infection control audits. Ms Loader undertook to explore and feedback to the Board.

ACTION: Ms Loader

The Board NOTED the Patient Experience Report.

TB 12/13 153 Monthly Infection Prevention Performance Report

Ms Loader presented the Monthly Infection Prevention Performance Report to the Board.

She informed the Board that there were no reported cases of MRSA bacteraemia in February 2013, and as such, the cumulative number of cases

reported during 2012/13 remained at two. There had been a notable increase in emergency MRSA screening, and a slight decrease in elective screening. Screening continued to be monitored regularly by the Care Groups and the infection control team.

With regard to clostridium difficile, Ms Loader reported that during February 2013 two cases of clostridium difficile were identified**,** which totalled 25 cases for the year, which remained below trajectory.

There were no surgical site infections to report.

Ms Loader reported that information from the hand hygiene observational tool had shown that overall Trust compliance for hand hygiene was 92% due to six areas failing to submit their completed audits. The areas which had failed to submit were actively being chased and put onto special measures to ensure compliance. Ms Loader assured the Board that daily hand hygiene audits were taking place in high risk areas.

Ms Loader updated the Board on the outbreak of scalded skin syndrome, advising that the number of cases totalled 10, but that the three most recent cases were not attributable to the outbreak strain. All babies were fit and well. Regular meetings were continuing with the Health Protection Agency and it was thought that the trust may be close to resolving the outbreak.

Ms Loader reported that the renal ward had had two patients identified during the month with Vancomycin Resistant Enterococci (VRE), a bacterium which was resistant to many commonly used antibiotics. As such the ward was placed into special measures, which included daily saving lives audits undertaken by the ward over a two week period. This included the renal dialysis care bundle, care of central vascular access devices and an audit of the prescribing of Octenisan decolonisation treatment, prescribed for all patients undergoing renal dialysis. Daily observational hand hygiene audits were undertaken and observation of 23 members of staff. Hand hygiene technique was observed by a member of the infection prevention team. The hand hygiene technique was found to be excellent. The incident was still ongoing and a final report would be provided to the April Board.

Ms Loader informed the Board of a near miss which had occurred in January 2013, when a patient was commenced on haemodialysis prior to blood borne virus screening being performed. Department of Health guidelines state that all patients should be tested for blood borne virus' prior to commencing haemodialysis. It was identified that the patient was chronically infected with Hepatitis B. Two further patients had subsequently been dialysed on the same machine as the patient before staff were made aware of the situation. However, the board were reassured that there had been 10 cleaning cycles of the haemodialysis machine prior to the two additional patients using them, which significantly reduced any risk of cross infection. In addition, extra precautions were taken to ensure the safety of those patients, though the use of immunoglobulin and HB vaccine. The trust has taken this 'near miss' very seriously and have since revised protocols to ensure this doesn't happen again.

Mr Robertson requested assurance that patients were no longer at risk. Ms Loader advised that the dialysis machine was thoroughly cleaned following use, and procedures had been strengthened to ensure it would not happen again.

The Board NOTED the Monthly Infection Prevention Performance Report.

TB 12/13 154 Urgent Care Update

Ms Brown presented the Urgent Care Report and introduced Dr Timperley to the Board.

Ms Brown advised that the urgent care programme had been established due to the continued pressures faced by the A&E department. The Trust was predicting end year performance of 92% against the four hour A&E target due to unprecedented attendances and admissions during 2012/13, which had increased by 2% for attendees and 5% for admissions on 2011/12 performance.

Ms Brown reported that a benchmarking exercise looking at the performance of other acute trusts had been conducted and revealed that the Trust was not an outlier within the East Midlands. Ms Brown stressed that whilst the Trust should not become complacent with that knowledge, although it was indicative of the pressure faced nationally.

Dr Timperley presented an overview of the urgent care programme. He advised that the programme was made up of a number of key work streams which were clinically led and had their own specific objectives.

The medical manpower work stream had worked to successfully develop new models of working which ensured greater levels of senior medical input. A business case had also been completed to provide flexibility to recruit a range of medical staff.

The A&E and assessment units work stream had proved successful to date. A number of initiatives had realised a 700% increase in the number of before midday discharges and a significant increase in the quality of note taking amongst other things.

The patient flow and length of stay working group had further developed professional standards for acute wards, implemented a virtual hospital to enable the easy review of patients and reviewed ward rounds to enable timely discharge.

The discharge planning work stream was established to reduce the number of delayed discharges and had made significant inroads into making improvements including implementing an interim placement process, ensuring senior medical reviews were in place, developed processes for reimbursement and made changes to the continuing healthcare funding process.

The community beds and rehabilitation work stream was established to focus on ensuring effective utilisation of community beds and improve patient flow. Achievements to date attributable to this work stream were that weekly multi-disciplinary team meetings had been established and there was therapy input into Cliftonville ward.

Mr Farenden asked Dr Timperley if clinical colleagues were engaged and understood their roles in addressing the urgent care issues facing the Trust and if the Board could do more in articulating the impact the issue is having on the wider health economy. Dr Timperley advised that there were differing

views, and some individuals were not as engaged in the programme as others. He felt that briefings on the health economy may be beneficial. Mrs Allen added that there were clinical directors supporting Dr Timperley and the challenge lay with engaging with all consultants due to the increased pressure being faced. Dr Timperley advised the Board that the programme took a measured approach to implementation, as a big bang implementation was unrealistic.

Mr Robertson asked if the Trust was nearing its physical capacity limits with regard to the environment. Dr Timperley advised that the programme was looking at innovative ways of working rather than focusing on physical limitations and was working with trusts across the country to share learning from innovation.

Mr Zeidler stated that the urgent care performance was deteriorating, whilst the Trust's intention was to reach its target of 95% by July 2013. He commented that despite the plans in place and the assurances being received that it didn't feel that target would be achieved. Dr Timperley advised that the A&E department was currently dealing with unprecedented numbers of patients, in part due to the inclement weather and low temperatures. It was envisaged that once the temperatures improved, demand would decrease and performance would begin to improve.

Mrs Allen added that national performance for A&E for the previous two months was the worst since 2004. The Trust's trajectory to achieve its target by July 2013 was based on historical performance data and assumptions based on the impact of the urgent care programme built on work with commissioners. As such, she felt that the target was achievable.

Mr Noble asked if there was any evidence that social care partners were changing the way they worked to support the system pressures. Ms Brown advised that social care partners didn't have great scope to change, and that the whole system was working together to develop innovative ways of working.

The Board NOTED the Urgent Care Report.

TB 12/13 155 Resilience Report

Ms Brown presented the Resilience Report to the Board advising that resilience planning at the Trust was made up of two distinct work streams; major incident planning and business continuity management. She advised that the report presented the progress made in embedding major incident planning and business continuity management within the Trust, and outlined priorities for 2013/14.

In summarising the progress made, Ms Brown reported that all policies, plans and key documentation had been developed, approved and received professional validation; a training programme for staff had been conducted for appropriate staff; the Trust had engaged fully within the business of the Local Resilience Forum and; the Trust had successfully tested its pandemic influenza plans. The priorities for 2013/14 included the review and exercising of the Trust's major incident plan, maintain the currency of business continuity plans and delivery of further CBRN training.

Mr Farenden asked if the Trust was utilising external expertise to objectively test and assure systems and processes. Ms Brown advised that the Trust undertook observed testing regularly and Mrs Allen added that specific

objective assessments of critical IT infrastructure has been conducted within the last year. Mr Farenden stressed that the plans must remain contemporaneous.

Mr Robertson asked when the Trust would next be taking part in a county-wide exercise. Ms Brown advised that a county-wide table top exercise had taken place early in March, and further tests were planned regularly throughout 2013/14.

The Board NOTED the Resilience Report.

TB 12/13 156 Operational Performance Report

Mrs Allen presented the Operational Performance Report which set out the key areas of performance for the Trust for February 2013.

In summary, Mrs Allen informed the Board that the Trust continued to achieve all of the 18 week standards of 90% for admitted and 95% for non-admitted patients treated across all specialties.

The Trust continued to exceed the national standard for all diagnostic tests to be carried out within six weeks of the request. During February2013 100% of diagnostic tests were carried out within four 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 for stroke patients to spend at least 90% of their time on a stroke ward.

The Trust did not achieve the four hour A&E transit time standard for February 2013 with 90.33%. Actions to address performance were presented in the Urgent Care Report.

With regard to cancer targets, the Trust failed to achieve three targets; the 62 day standard from urgent referral, the 62 standard from consultant upgrade and the 31 day standard from decision to treat to start of subsequent treatment. Consequently the Trust would not meet its annual 62 day referral to treatment target.

Mrs Allen voiced her disappointment at not meeting the cancer target in light of the amount of work which had gone into meeting the target. She advised that the recovery plan remained in place which would be monitored weekly.

The Board NOTED the Operational Performance Report.

TB 12/13 157 Finance Report

Mr Hollinshead presented the Finance Report which summarised the Trust's financial performance for the eleven months to the end of February 2013.

Mr Hollinshead reported that the Trust has secured agreement with the Local Area Team and Nene CCG to a year-end service level agreement settlement of £201m which would deliver a forecast breakeven position by the financial year end. The year-end settlement included £1.3m of winter pressures funding which had been allocated to care groups and control totals adjusted accordingly.

The Trust's year to date income and expenditure position for the period ended 28 February 2013 was a surplus of £63k. The plan submitted to the Strategic Health Authority in March 2013 predicted a £610k year to date

deficit therefore the result was £0.7m better than planned. The planned position for the full year is a surplus of £1.0m.

Mr Hollinshead reported that the Trust continued to work with the CCG to find ways of alleviating short term cash flow problems, and had signalled a requirement for assistance in quarter one of 2013/14. In March 2013, the Strategic Health Authority had agreed to release additional £0.2m MPET funding and a further £0.3m to support the costs of Foundation Trust application incurred during the financial year.

The Capital Resource Limit target had decreased to £10.1m following review and confirmation with the SHA. The Trust had plans approved to underspend the limit by £0.1m. The level of underspend had been reduced due to recently approved bids notably in support of new Radiotherapy equipment.

The Board NOTED the Finance Report

TB 12/13 158 Human Resources Report

Mrs Opreshko presented the Human Resources Report.

In presenting the key points from the report, Mrs Opreshko informed the Board that there had been an increase in the substantive workforce of 27.76 full time equivalent staff, although the Trust remained below its target establishment of 4278.12 full time equivalent at 3979.43 full time equivalent. Due to the increase, the percentage of contracted workforce against budgeted establishment had increased by 0.68% to 93.05%.

The use of temporary staffing had increased by 0.88% to 6.82%, which remained above the target of 5%. Temporary workforce expenditure accounted for 9.87% of the total workforce expenditure.

Staff turnover had increased by 0.37% on the previous month and stood at 8.70% against a target of 8 %. Ms Opreshko advised that leaving processes were being improved to gain a better understanding of why staff were leaving the Trust.

Sickness absence had decreased by 0.77% to 4.08%, against a target of 3.4%. As such, the total number of calendar days lost decreased by 1676 from 7041 to 5365, which was a significant improvement.

Ms Searle asked if health and well-being services were being utilised and targeted towards staff on sick leave, particularly those on long term sick. Mrs Opreshko advised that a lead had been appointed to develop a staff health and well-being strategy to improve support to staff, particularly through occupational health services.

Mr Zeidler observed that there were inconsistencies between budgeted and actual establishment numbers and asked if the establishment would be more accurately budgeted for 2013/14. Mr Hollinshead advised that the inconsistencies had mainly arisen due to the Trust taking action to address urgent care pressures, for example re-opening and staffing a ward, and an appropriate budget not being allocated. He acknowledged that the process required improvement to enable the Board to receive and evaluate accurate budget and establishment data. Mrs Allen added that recent meetings with all wards to verify establishments would enable the Board to see a marked improvement going forward. Ms Loader informed the Board that would be in place from April 2013.

Mr Zeidler questioned why despite the increase in full time equivalent staffing and decrease in sickness absence, the use of temporary staffing had increased. Ms Loader advised that the increase was due to establishment and staffing of escalation areas to re-enforce A&E at short notice due to the emergency pressures.

The Board NOTED the Human Resources Report.

TB 12/13 159 Transformation Report

Mrs Opreshko presented the Transformation Report and reported that the transformation programme was forecast to deliver £10.49m savings against a plan of £11.1m.

Mrs Opreshko informed the Board that overtime payment reductions for January and February 2013 had exceeded the required in month planned reductions. As such, sustaining that reduction through the introduced controls would ensure that the pay reduction remained into the subsequent years Transformation Programme.

Focus of the transformation board had shifted to the delivery of 2013-15 programme and the governance arrangements to support that delivery. The savings target for 2013/14 was £13m. Currently, schemes had been identified, underpinned by quality impact assessments, for 67% of the target, and work would continue to deliver the remainder.

The Board NOTED the Transformation Report

TB 12/13 160 Self-certification return

Ms Spellman presented the return. She advised that the Trust was rated as Amber-Red for governance due to not meeting performance targets and continued to have a financial risk rating of 2. Ms Spellman recommended to the Board that declaration two of the return be signed due to those factors.

The Board APPROVED signing Declaration 2

TB 12/13 161 Any Other Business

Noting that the meeting was Mr Hollinshead and Mrs Opresho's last, Mr Farenden extended his sincere gratitude for their commitment and the contribution they had made to the Trust.

TB 12/13 162 Date of next meeting: 24 April 2013, 9.30 Boardroom NGH

Mr Farenden called the meeting to a close at 11.05.

TB 12/13 163 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 on 28 March 2013

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 151	Medical Director's Report	28/03/2013	Ms Loader to speak to Dr Swart to ascertain if there were any additional actions which could be taken which would make a step change to HSMR to bring it down to below 100.	Ms Loader	April 2013	
TB 12/13 152	Patient Experience Report	28/03/2013	Ms Loader undertook to investigate why the first of the five CQUIN questions had dropped significantly but was not rated as red.	Ms Loader	April 2013	
TB 12/13 152	Patient Experience Report	28/03/2013	Ms Loader undertook to explore if there was any correlation between ward level patient experience results and the outcomes of infection control audits	Ms Loader	May 2013	

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

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 24 APRIL 2013	
Title: -	Chief Executive's Report
Submitted by: -	Mrs Christine Allen, Interim Chief Executive

SUMMARY OF CRITICAL POINTS: -

This report highlights key business and service developments in Northampton General Hospital NHS Trust in recent weeks.

RECOMMENDATION: -

The Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT
APRIL 2013 TRUST BOARD

Midwifery led birthing Unit
Building work has now started to develop a Midwifery Led birthing unit within the maternity department, this unit will provide a more homely environment for maternity patients and is due to complete by the end of the summer.

Age UK support patients in A&E
A six-month pilot has started with staff from the charity Age UK Northamptonshire on-site in the A&E department during peak times to support people aged 55 and over. The volunteers act as a point of contact and offer practical and emotional support to patients who are older, vulnerable or do not have a family member to help them.

Bigley Ball's big donation to chemo suite
Northampton General Hospital NHS Trust has been given a donation of £28,000 to make over its chemotherapy suite, following the Andrew Bigley Charity Christmas Ball held at Sywell. The suite will get new flooring, pods for privacy, new sinks, and large windows and doors to brighten up the room.

More staff had flu jabs this winter
The number of NGH staff having their free flu jab this winter rose to 1,681. All staff who had their flu jab were entered into a prize draw to win one of two new iPads, generously donated to the trust.

In Your Shoes provides insight to staff
A new job shadowing initiative called In Your Shoes has been launched for staff as part of Listening into Action. It aims to enable staff to gain an insight into someone else's role within the hospital, thereby providing an opportunity to develop staff.

Congratulations to our NHS Heroes
Congratulations to two more members of staff who were nominated as NHS Heroes in the national recognition scheme, Pharmacy apprentice Tammy and Pre-op assessment healthcare assistant Charlie Preston. Members of the public can nominate dedicated NHS staff who go 'the extra mile' by nominating them on the national website www.nhsheroes.com

IT Service Desk attains national accreditation
The IT Service Desk has attained national service desk accreditation, following a robust audit process requiring evidence of policies, processes, procedures and quality standards. The senior service manager at Connecting for Health recognised the hard work put in by staff as he presented a certificate to the department in March, saying that he was very pleased with the high standard of service provided and the improvements put in place over the last year.

Christine Allen
Interim Chief Executive
April 2013

Northampton General Hospital NHS
NHS Trust

Trust Board – 24 April 2013	
Title: -	Medical Director's Report
Presented by: -	Dr Sonia Swart, Medical Director

PURPOSE OF PAPER: - Update on Mortality and Clinical Scorecards

CRITICAL POINTS: -

- Overall mortality as measured by Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (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.
- 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.
- The key metrics which are reported in the National Quality Dashboard which is the recently released nationally mandated tool to be used for quality improvement are outlined.

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 and the information relating to Summary Hospital-Level Mortality Indicator (SHMI).

2. Current Position HSMR

Hospital Standardised Mortality Ratio (HSMR) was developed as a tool to assist hospitals in monitoring mortality and there has been continual debate as to the way it should be used. At Northampton General Hospital NHS Trust (NGH) there is a detailed monitoring process where in addition to looking at overall HSMR which is based on the 56 conditions most likely to result in mortality, Standardised Mortality Ratio (SMR) is examined in any area thought to be of concern. Whereas there can be considerable debate relating to how to use HSMR to compare hospitals, for any individual hospital changes in HSMR and SMR for individual conditions should always be investigated.

This Trust investigates all possible areas of concern for both clinical care and for recording of information leading to coding changes which can affect the HMSR. The Board should be aware that the expected mortality figure calculated by Dr Foster does not allow for any variation in the severity of the condition of the patient on admission. So, for example, the likelihood of death for a patient with pneumonia is calculated purely on the diagnosis, the age and the comorbidities and not on the basis of clinical parameters. This means that mortality for the admission may also depend on the quality of primary care in the catchment area of the hospital.

In addition the Board should note that the acquisition of community hospitals are not recorded as separate sites and where predominantly elderly patients are admitted for a variety of types of care, including terminal care, is likely to affect the HSMR for this Trust.

Hospital Standardised Mortality Ratio Comparison

The purpose of the HSMR Comparison report is to enable acute trusts to monitor their Hospital Standardised Mortality Ratio throughout the year and compare against the changing national picture and the performance of a user-defined peer group.

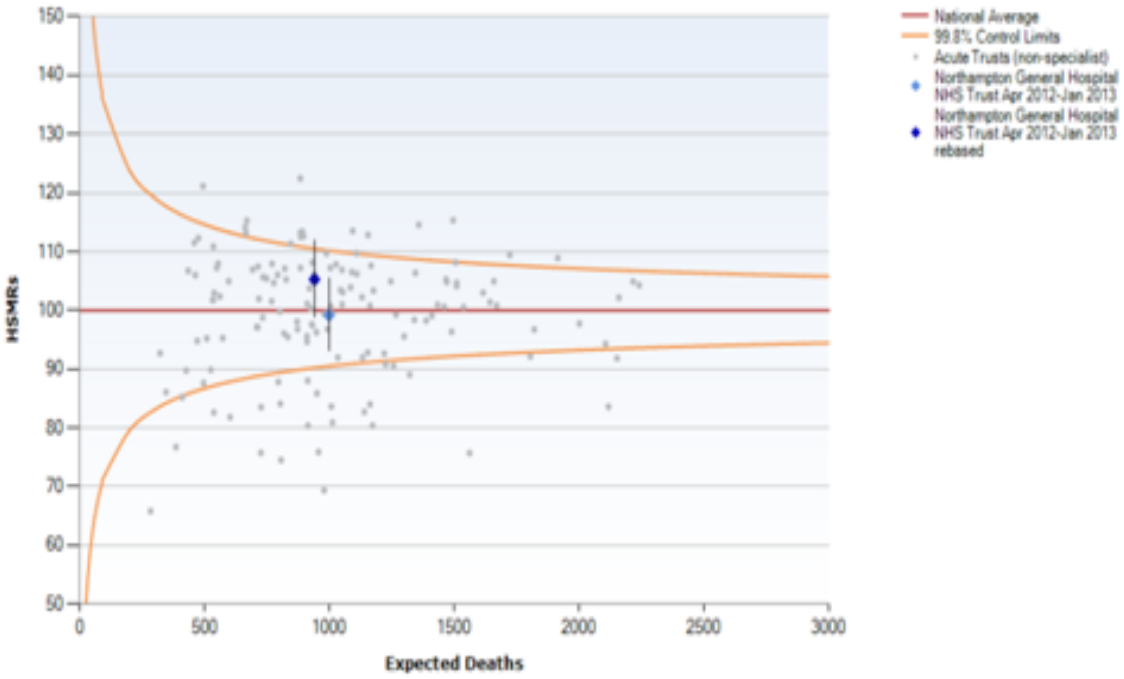
The funnel plot shows the current HSMR position plotted (light-blue diamond) against the rebased position (dark-blue diamond) for the Trust. The grey dots are the remaining 146 acute trusts rebased 2012/13 FYD benchmark HSMR.

The current year to date HSMR using the 2011/12 benchmark was **99** with the indicative rebased HSMR using the 2012/13 FYD benchmark being **105** (this remains within the as expected band).

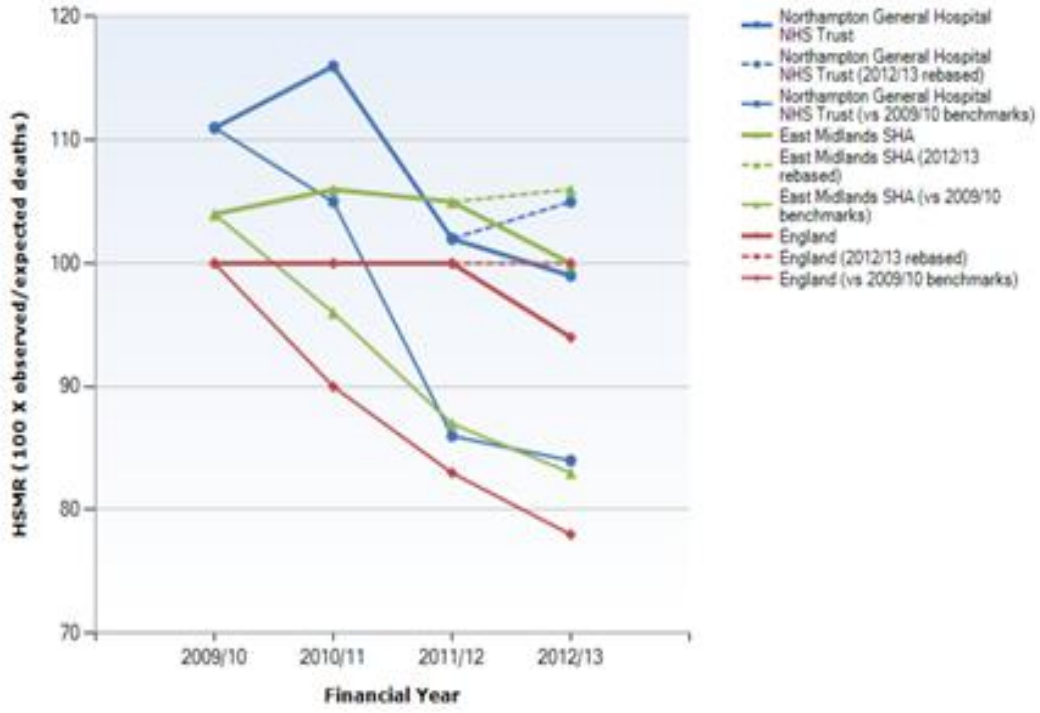
This potentially represents an increase of 3 points compared to year end 2011 / 2012
It is important to emphasize, while the HSMR for the current incomplete financial year is likely to show an improvement against the old benchmark, it will eventually be judged

against the national average improvement and therefore a trust may improve performance and still find that the annually published HSMR goes up.

Unadjusted mortality is **4.0 %** which is slightly less than the average of 4.1% in the SHA.



For January the HSMR was **95 (**101 deaths, 107 expected).



3. Standardised Hospital Mortality Indicator (SHMI)

The SHMI for the first two quarters of 2012/13 remains higher than the HSMR and higher than at this point in 2011/12 at **111**. The rolling SHMI to the end of this six months was **108** which represents a SHMI in the 'as expected' category (using 95% confidence levels). 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. Dr Foster Intelligence is working with Trusts to produce regular reports relating to SHMI as well as HSMR.

SHMI includes all deaths within 30 days even if not occurring in hospital and also does not adjust for palliative care.

The SHMI will be the indictor used in the National Quality Dashboard.

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

There is currently one concern in relation to the Dr Foster Patient Safety Indicators. This is the deaths after recorded complications after surgery. This is an indicator which is dependent on the coding of the complication and where there are information gathering issues. This is currently under investigation both internally and in discussion with the Dr Foster team. This issue emphasises the importance of accurate capture of information.

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.

Feb 2012 to Jan 2013

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		31	24.4	0.86	0.68	more information
Decubitus Ulcer		154	209.6	16.80	22.87	more information
Deaths after surgery		46	33.1	148.87	107.24	more information
Infections associated with central line*		0	0.8	0.00	0.05	more information
Post-operative hip fracture*		1	1.7	0.04	0.07	more information
Post-op Haemorrhage or Haematoma		6	13.7	0.26	0.59	more information
Post-operative physiologic and metabolic derangements*		1	1.5	0.05	0.08	more information
Post-operative respiratory failure		14	13.4	0.77	0.73	more information
Post-operative pulmonary embolism or deep vein thrombosis		31	39.6	1.33	1.71	more information
Post-operative sepsis		7	4.2	10.29	6.20	more information
Post-operative wound dehiscence*		2	1.1	2.16	1.18	more information
Accidental puncture or laceration		36	74.0	0.55	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		24	40.0	49.59	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		81	93.8	32.27	37.37	more information
Obstetric trauma - caesarean delivery*		3	4.2	2.44	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.

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

5.1 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 are subject to particular scrutiny. In this group there no overall concern with a SMR of **78.5** (396 deaths with 504 expected from 2569 spells).

There continues to be cause for concern in relation to mortality from fractured neck of femur. The SMR for 2012/13 is **167** (42 deaths with 25 expected) and all deaths are under review.

The Clinical Director presented their findings on this issue to the HealthCare Governance Committee in April and has with the help of the Surgical Care Group developed an improvement plan for this group of patients. It is clear from the work to date that no single factor has been identified which would explain the high mortality and in view of this in additional to the on-going audit, a bundle of measures likely to improve care is being supported.

As part of this, Medical Care Group has been asked to develop improved plans to assist with medical input to the frail elderly group of patients involved and both Care Groups support the provision of increased medical and nursing support to these patients. This has been included in the Trust improvement plan priorities and will be reported through to HealthCare Governance as well as through the directorate governance reports to the Clinical Quality and Effectiveness Group (CQEG).

Another area of concern relates to congestive cardiac failure where some detailed investigation has taken place. This is an area where the current SMR is **133** (54 deaths whereas 41 were expected).

A recent detailed analysis was performed on 38 patients identified through the Dr Foster database. Of these, 29 were thought to have congestive cardiac failure as the primary diagnosis. For these patients a detailed review of care was performed. The remaining 9 cases were sent for coding review and the outcome of this is not yet available. This is likely to change the SMR.

Some headline results from this work indicated that this was a group of patients which was elderly with severe symptoms on admission and most had physiological instability. Although the majority were known to have heart failure, most were not under active follow up with cardiology/care of elderly.

Large number of patients did not appear to die solely of cardiac failure. Causes of de-compensation in these patients may include: infection, Acute Coronary Syndrome, Atrial Fibrillation, Pulmonary Embolism, Iatrogenic (e.g. Medications and IV fluids). Many had inter-current infection such as chest infections with high markers of severity. Two patients with valvular lesions had confirmed gram positive bacteraemia which was classed as possible endocarditis. If this was the case the expected mortality would be high. Some patients with severe cardiac disease were lost to follow up with no long-term plans. Some patients were clearly at the end of life stage from heart failure and / or other medical illness.

The investigating team concluded that greater use of advanced treatment plans may help such patients avoid hospital admissions and that the use of BNP testing should increase but that care should be taken to avoid over diagnosis as upper limit of BNP is higher in sick patients. The team also felt that making echocardiogram reports directly available to GPs through the ICE system would be advisable. This learning will be shared with the community heart failure team. The team noted that most of the patients had been seen by a consultant

within 12 hours of admission and had also received specialist cardiac input during their stay in hospital. No major deficiencies of care were identified.

The team presented their findings to the Clinical Mortality and Coding Group in March 2013.

5.2 Possible areas for Concern under investigation

The detailed monitoring process based on the use of the Dr Foster Intelligence Tool continues. This involves looking in detail at any area of possible concern and making a decision with respect to the level of investigation required. The factors affecting SMR are complex and it is not generally possible in any area to specifically identify single factors responsible for changes in mortality or to make rapid changes in mortality figures other than by changes in clinical coding.

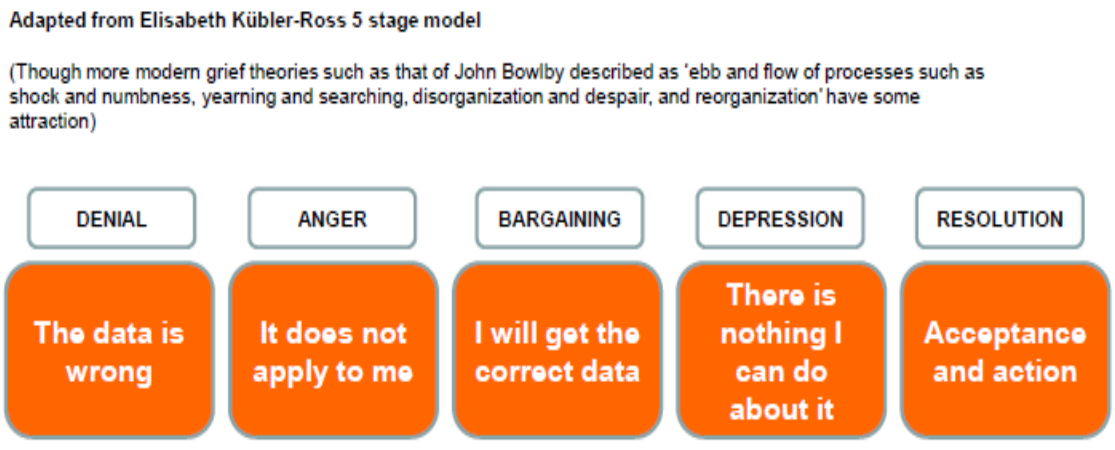
The Mortality and Coding Group is meeting regularly as a formal extension to this process in order to ensure wide clinical and managerial ownership of the issues. The planned work to examine information flows, clinical coding and patient flow has now been commissioned and a report is awaited.

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.

As part of the patient safety programme, lessons learned from audits and investigations are shared and improvement projects put in place. The aim of all the patient safety work is reduce harm and avoidable death. The Mortality and Coding Group continue to receive reports in relation to any areas of concern which are thoroughly investigated. There are no new areas flagged for concern at present. The group has received presentations from a number of teams and in these cases no quality of care issues have been identified.

The detailed case review of 50 consecutive deaths is awaited as is the clinical care report on secondary malignancy. This group has been set up to improve clinical engagement and ownership of issues based on the fact that there can be considerable challenge from clinicians who do not necessarily believe that the data collected is accurate. While this may be true, it is essential to ensure that clinicians themselves do everything possible to ensure that the data collected is the correct data.

The diagram below illustrates some features of this which apply to involvement of clinicians in this issue. The aim is to move from stage one to stage five so that we can make recommendations such as those proposed by the heart failure group.



7. Areas of general relevance with respect to overall Trust performance

The Trust currently has a readmission rate which is 'as expected' and similarly the overall length of stay is as expected. The Trust has a higher number of excess beds days than might be expected which may relate to the use of community hospitals which are not counted as separate sites from the main hospital site in these analyses and to 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.

8. Further actions in place or planned

The Trust has made some further progress in working with Dr Foster to engage in two new projects to provide clinicians with more detailed quality dashboards. One of these includes data from Theatre systems as well as HES data and has the capability to provide meaningful data at consultant level. The Trust is awaiting a more detailed proposal from Dr Foster Intelligence.

In addition our current programme of work is under extension to produce speciality based dashboards to be used by clinical teams.

The need to provide consultant level data with respect to surgical outcomes will require a review of information systems and act as a further lever to ensure clinical engagement in information recording and flows.

From June 2013 trusts will be expected to publish the data available from national audits in relation to the activity and mortality rates in 10 specialities at consultant level.

In the initial document published last December, the Commissioning Board named 10 clinical care 'specialties' and outlined how the lead data resource for these will be either a clinical audit or register. However, it is recognised success cannot be achieved without the support of the clinical community and as such a specialist society for each project has been identified to support the publication process.

The initiative which is being supported by HQIP is called 'Everyone Counts'.

'Everyone Counts' offer 2: specialties, audits/registries, supporting societies

Speciality	Clinical audit/registry title	Specialist Society
Adult cardiac surgery	National Adult Cardiac Surgery Audit	SCTS
Bariatric surgery	National Bariatric Surgery Register	BOMSS
Colorectal surgery	National Bowel Cancer Audit Programme	ACPGBI
Head and Neck surgery	National Head and Neck Cancer Audit (DAHNO	BAHNO
Interventional cardiology	Adult Coronary Interventions	BCIS
Orthopaedic surgery	National Joint Registry	BOA
Thyroid and endocrine surgery	BAETS national audit	BAETS
Upper gastro-intestinal surgery	National Oesophago-Gastric Cancer Audit	AUGIS

Urological surgery	BAUS cancer registry	BAUS
Vascular surgery	UK Audit of Vascular Surgical Services & Carotid Endarterectomy	Vascular society

All relevant consultants in the Trust have been contacted to ensure that they participate in this process and give consent for their data to be published. From next year it will formally be written into commissioning contracts. The precise details of operations to be included in this process have yet to be determined but the data will include activity and mortality data as a minimum and Trusts have been instructed to place this on their websites.

9. Learning from Serious Incidents

In the last month threeserious incidents were closed by the Trust. A summary of the issues, actions and learning events resulting from this is given below.

There were no incidents signed off by the CCG. There were three serious incidents submitted to the CCG for closure during March 2013. The key learning points are as follows:

Incident type

Failure to care - One case related to pressure ulcer prevention

Failure to escalate - Two cases related to escalation of concerns, senior review and multi-agency communication.

Actions Implemented and in place from the above Closed Incidents

- Pressure Ulcer care plans encompassed in senior nursing spot check audits focussing on Risk assessment and Body Mapping
- Process for ordering pressure relieving equipment simplified and reiterated to all staff nursing documentation reviewed and streamlined.
- Nursing documentation audit encompassed in forward plan
- Escalation to senior medical staff -process discussed with all team members, also now encompassed in annual BLS training and induction programmes
- Transfer policy for neonates now encompassed in induction programme for all relevant staff Ward transfer list to be reintroduced within the non-elective admission proforma
- Multiagency meeting held to discuss and confirm process and communication regarding MRSA bacteraemias
- Salient safety messages and processes communicated corporately via a screen saver and/or text alert system.

Process for ensuring actions completed

- The individual directorates are responsible for ensuring that the action plans are implemented through local governance processes and this is overseen via the Care Group Management Team.
- The Corporate risk management team will monitor progress and provide challenge and scrutiny to provide further assurance.
- Learning is shared more widely through Directorate Governance meeting, Morbidity and Mortality meetings and the Patient Safety Learning Forum.

Individual and organisational learning

The Patient Safety Learning Forum (PSLF) promotes individual and organisational learning from national and local incidents and initiatives via a multi-disciplinary and multi-specialty group evidencing any change on practice were appropriate. As Serious Incidents are closed, the identified Root Cause Analysis (RCA) findings and recommendations for any change in practice or process are presented at the PSLF by the investigating team. This provides an opportunity for the Trust's governance team to familiarise and update staff with Trust-wide risk/safety initiatives e.g. risk register, risk assessments, Serious Incidents, Claims etc. The forum provides the Trust's governance and PALS teams with operational guidance and reassurance on patient safety initiatives and issues requiring implementation and/or action.

To support reflection from Serious Incidents the PSLF also provides operational evidence of learning and any change in practice resulting from incidents and initiatives.

Consultant medical staff are mandated to reflect on Serious Incidents as part of Medical Revalidation. This applies to any SI in which the consultant was involved personally but also to Serious Incidents within a team. Some serious incidents are widely circulated for comment to all relevant specialities for mandated reflection.

10.Conclusion

The position with regards to overall mortality as measured by HSMR and SHMI indicates that performance is 'as expected'. There has however been deterioration since last year which cannot be easily explained. The community hospitals may well be having an impact. Patients in these hospitals are admitted by other providers as well as NGH and many of them are very frail. There is on-going work to improve the position through targeted improvement work wherever possible. Continued focus on the emergency pathway in partnership with the Health Care Economy will be necessary to ensure improvement in the flow of patients through the system and to reduce unnecessary admissions particularly for patients at the end of life. The current emergency pressures are dominating the system and putting a strain on the ability to provide high quality care.

In the light of increasing national emphasis on information owned at a clinical level it will be important to develop information sources within the Trust and ensure these are maximised in terms of their potential.

11.Recommendations

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

The Board is asked specifically to note that in the light of the challenges provided by the emergency pressures and the increasing focus on the need to ensure high quality and safety, it is increasingly important that the Trust can demonstrate appropriate use of information to articulate quality and safety risks and drive any improvements required.

The Board is asked to note the challenges inherent in providing accurate consultant level data.

Section 2

The National Quality Dashboard

1. Introduction

The National Quality Board has developed a National Quality Dashboard. The emphasis on quality is to run through all the NHS Commissioning Board operating models. The dashboard is built from real time information provided by Trusts and should be used to focus quality improvement activity rather than for performance monitoring.

2. Current Metrics on the Dashboard

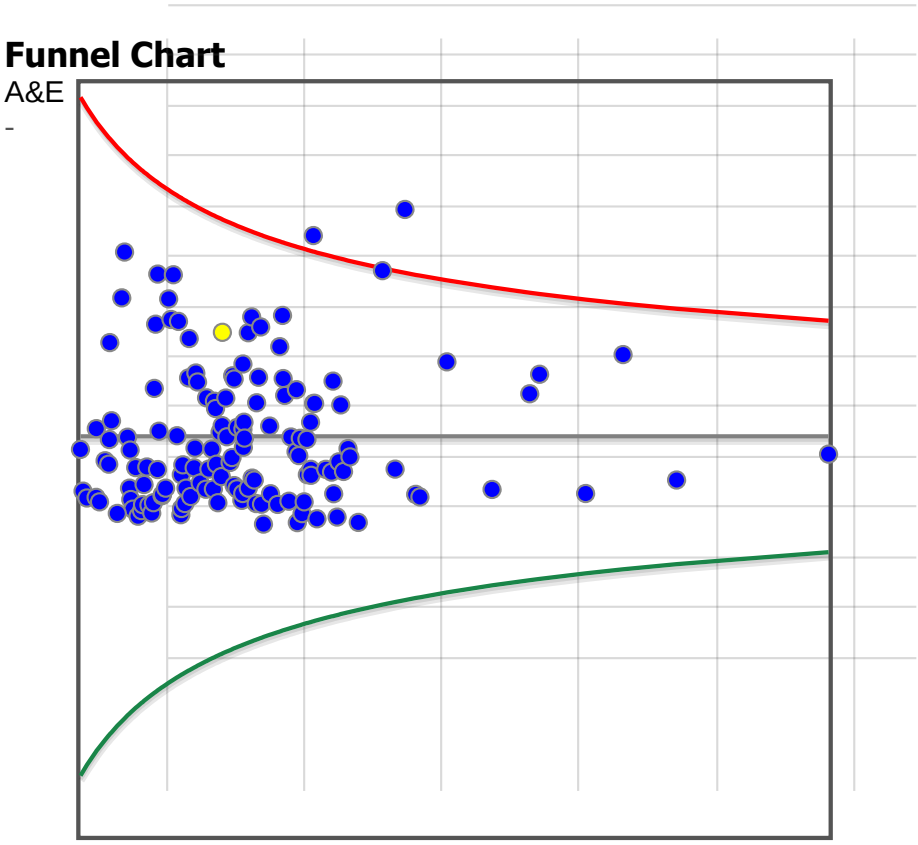
The dashboard will be viewable across the whole of the Commissioning Board including providers and commissioners at all levels and is to be used in quality surveillance meetings, Monitor, the Trust Development Authority Health Education England and the CQC.

The Dashboard high level report indicates no adverse alerts for Northampton General Hospital. The metrics are updated at different intervals and are not necessarily current (an outline is presented in Appendix 1 - this is printed from the website and is not available in another format).

The specific metrics reported are:

- Preventing People from dying prematurely – results as expected.
- Amenable mortality – results as expected.
- Quality of life for patients with Long Term Conditions – average.
- Number of admissions under 19 –as expected.
- Helping people to recover as measured by readmissions and emergency admissions for conditions that do not usually require admission – both were average but the number of admissions for conditions that do not usually require admission has increased. This will need investigation.
- Timely care – A and E patients waiting more than 4 hours- deteriorating compared to other trusts.
- Timely Care – RTT greater than 18 weeks and cancer waits – average and within target.
- Safe Environment – Infections , serious incidents , never events , harm free care are all average or slightly better than average.
- Organisational indicators – staff sickness average and bed occupancy – higher than average.
- Organisational indicators – doctor to patient ratio – average.
- Organisational indicators – nurses to bed ratio (reported as to January 2013) – below average at 1.38 but clarification of the bed base and metrics is required. This figure does not include agency staff and the recent recruitment and bed base recalculation will be required to ensure accuracy.

Northampton General Hospital Funnel Chart for A and E greater than 4 hours compared to Trusts in England



3. Actions Required

The Trust is required to set priorities using the control (trend) charts from historical performance and with consideration with regard to comparison with peers. It is then asked to review contemporary performance using the funnel charts and the Toyota charts and again to ask how this compares to others and what the improvement potential is.

The current processes in the Trust should enable us to do this but it should be noted than many sources of information will be required some of which are available through National Peer Review processes or standards set through national audits.

There will need to be close cooperation between the clinical teams and the information teams to ensure we capture these issues effectively.

4. Recommendation

The Board is asked to support further work to embed the use of this tool as part of our normal monitoring of quality.

The Board is asked to debate any issues that arise from this.

Section 3 - NGH Monthly Quality Exception Quality Scorecard

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. Directorate Scorecards are improving and becoming more comprehensive providing the Care Groups with a dashboard relevant to their areas. The directorate scorecards will continue to be informed by more detailed Trust specific measures that are selected according to Trust priorities and pressures. These will need to be built in over the coming months.

Other performance measures are also to be mandated such as the performance in certain types of surgery by consultant but the details of this are not yet available.

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.

HSMR and SMR by diagnosis group is reported as year to date. A continual process of refinement of indicators is in working progress and this will include new indicators to monitor the safety improvement programme and the emergency pathway redesign project.

Performance

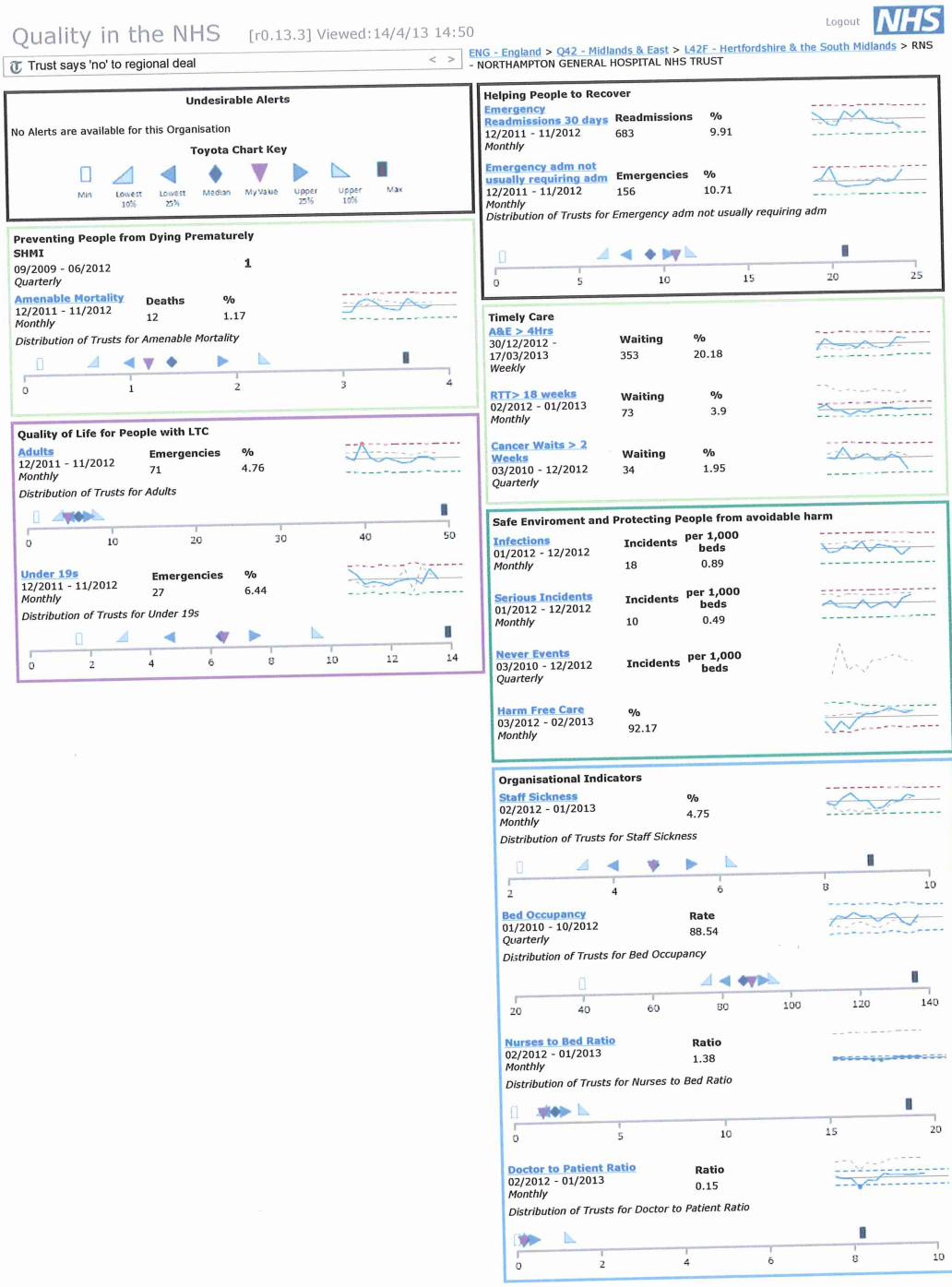
Within the March 2013 exception report 138 indicators were monitored, within April's exception report there are 145 indicators, of which **49** (**30/19**) are rated as either red or amber status, this is a marginal improvement from the previous report. The Exception Summary Report (attached) outlines the underperforming indicators and details the remedial action(s) being taken. There are 22 indicators that are rated as grey, this is a significant increase in comparison to March's report (10) Indicators rated as grey, as the CQUIN`s await final agreement or the information is currently not available.

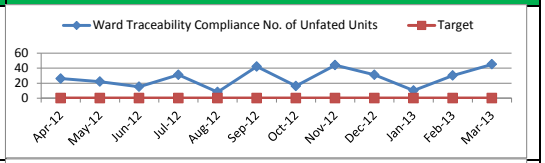
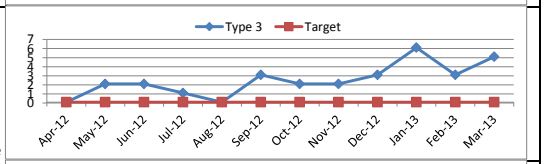
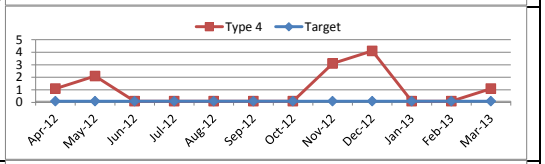
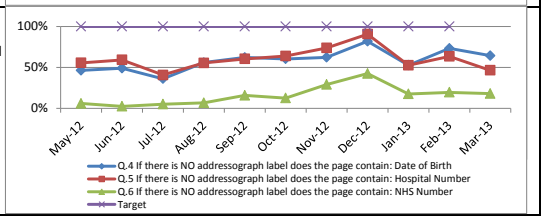
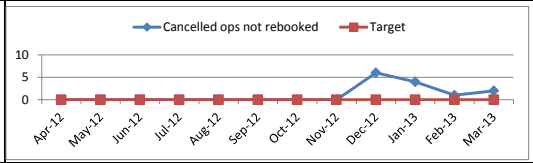
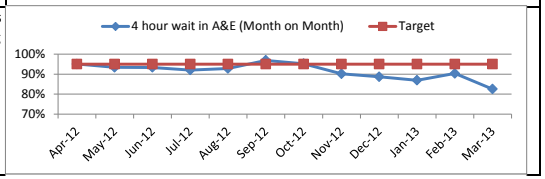
Summary Rating

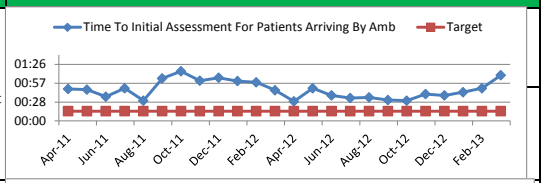
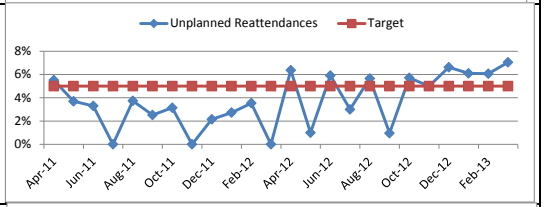
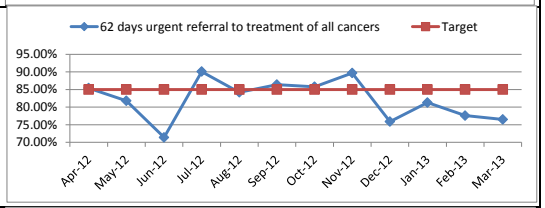
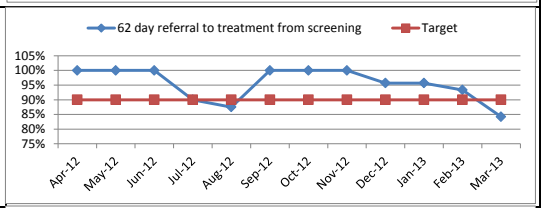
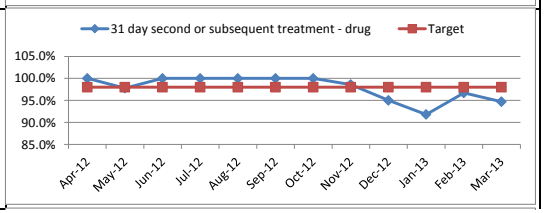
Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	1	3	25	7
Clinical Outcomes	5	4	10	5
Patient Safety	14	10	24	6
Patient Experience	10	2	15	4
TOTAL	30	19	74	22

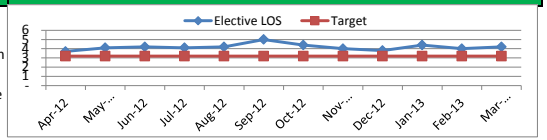
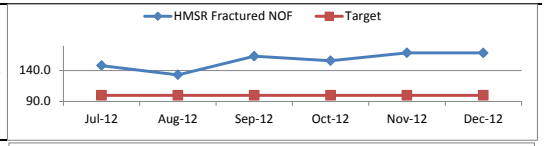
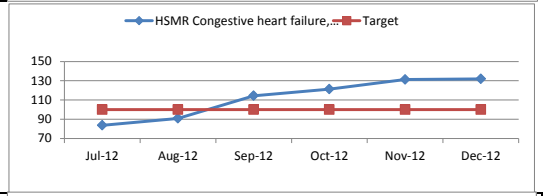
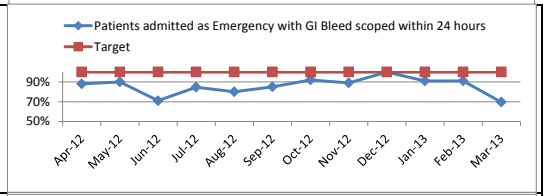
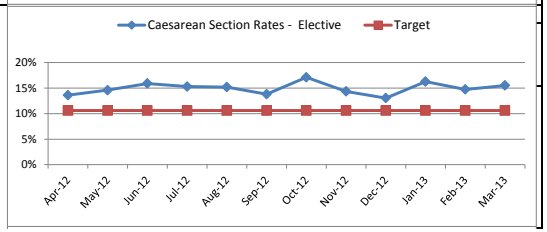
Recommendation

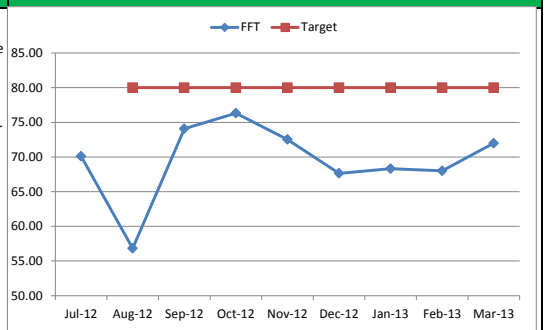
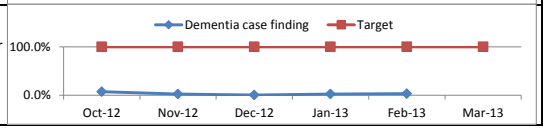
The Board is asked to note this scorecard and debate any issues that arise from it.


Quality in the NHS [r0.13.3] Viewed:14/4/13 14:50
Logout
NHS
Trust says 'no' to regional deal
ENG - England > Q42 - Midlands & East > L42F - Hertfordshire & the South Midlands > RNS - NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Undesirable Alerts
No Alerts are available for this Organisation
Toyota Chart Key
Min
Lowest 10%
Lowest 25%
Median
My Value
Upper 25%
Upper 10%
Max
Preventing People from Dying Prematurely
SHMI
09/2009 - 06/2012
Quarterly
1
Amenable Mortality
12/2011 - 11/2012
Monthly
Deaths
12
%
1.17
Distribution of Trusts for Amenable Mortality
0
1
2
3
4
Quality of Life for People with LTC
Adults
12/2011 - 11/2012
Monthly
Emergencies
71
%
4.76
Distribution of Trusts for Adults
0
10
20
30
40
50
Under 19s
12/2011 - 11/2012
Monthly
Emergencies
27
%
6.44
Distribution of Trusts for Under 19s
0
2
4
6
8
10
12
14
Helping People to Recover
Emergency Readmissions 30 days
12/2011 - 11/2012
Monthly
Readmissions
683
%
9.91
Emergency adm not usually requiring adm
12/2011 - 11/2012
Monthly
Emergencies
156
%
10.71
Distribution of Trusts for Emergency adm not usually requiring adm
0
5
10
15
20
25
Timely Care
A&E > 4Hrs
30/12/2012 - 17/03/2013
Weekly
Waiting
353
%
20.18
RTT> 18 weeks
02/2012 - 01/2013
Monthly
Waiting
73
%
3.9
Cancer Waits > 2 Weeks
03/2010 - 12/2012
Quarterly
Waiting
34
%
1.95
Safe Enviroment and Protecting People from avoidable harm
Infections
01/2012 - 12/2012
Monthly
Incidents
18
per 1,000 beds
0.89
Serious Incidents
01/2012 - 12/2012
Monthly
Incidents
10
per 1,000 beds
0.49
Never Events
03/2010 - 12/2012
Quarterly
Incidents
per 1,000 beds
Harm Free Care
03/2012 - 02/2013
Monthly
%
92.17
Organisational Indicators
Staff Sickness
02/2012 - 01/2013
Monthly
%
4.75
Distribution of Trusts for Staff Sickness
2
4
6
8
10
Bed Occupancy
01/2010 - 10/2012
Quarterly
Rate
88.54
Distribution of Trusts for Bed Occupancy
20
40
60
80
100
120
140
Nurses to Bed Ratio
02/2012 - 01/2013
Monthly
Ratio
1.38
Distribution of Trusts for Nurses to Bed Ratio
0
5
10
15
20
Doctor to Patient Ratio
02/2012 - 01/2013
Monthly
Ratio
0.15
Distribution of Trusts for Doctor to Patient Ratio
0
2
4
6
8
10

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Unfated Units	0	↓	The number of unfated units has risen over the last couple months from 10 in January to 45 in March - the highest figure in 12 months. RCA and Action Plans that were previously obtained for each unfated unit were discontinued when compliance improved. Managers are currently required to investigate each unfated unit and action improvement. RCAs and Action Plans will be now be obtained for each non-compliance with follow up on proposed improvements in the clinical area and development of the Improvement Plan through audit of each unfated unit.	
Patient Safety	Incidence of Pressure Ulcers Type 3	0	↓	Incidence of pressure ulcers - There were five grade 3 ulcers (one of which was unavoidable) and 1 grade 4 pressure ulcer in March. Through increased education and raising awareness there has been a 59% increase in datix reporting of pressure ulcers across the trust, many of these within the A&E department and detected as 'inherited'. With the new national CQUIN for 2013/14 there will be a challenging but appropriate trajectory for the reduction in pressure ulcers for the next year. Improvement plan has been updated to address the CQUIN target.	
Patient Safety	Incidence of Pressure Ulcers Type 4	0	↓		
Patient Safety	Healthcare Notes audit (23 questions)	100%	↓	The key issues identified on the Healthcare Notes audit in March 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 remains below the target but has improved since last month. 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 and how alterations/deletions are managed. Evidence of communication to relatives and teams improved significantly in February but progress was not sustained in March.	
Patient Experience	Cancelled Operations not rebooked within 28 days	0%	↓	This target has again not been met in March with 2 cancelled operation not rebooked within 28 days, this represents 7 for the quarter. Work is ongoing to ensure robust processes are in place to avoid future occurrences and is monitored through weekly performance meetings..	
			↓	**A&E Clinical Indicators:** The A&E 4 hour wait target was again not met in March, with 82.5% of patients seen within 4 hours against the 95% target. This was primarily due to significant bed pressures within the Trust relating to winter pressures. The Urgent Care Project Group are focusing on reducing length of Stay by changing processes both internally and with external partners to ensure bed occupancy reduces and timely patient flow helps to achieve the transit target.	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	A & E Quality Indicators (5 indicators)		↓	The time to initial assessment for patients arriving by ambulance was 50 mins with the national target being 15 minutes. These figures are currently being revalidated following recent identification of issues around the way the information is captured. When the FIT (Fast Intervention Team) is operational (usually between 11am and 6pm) this target is generally 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 shortly for increased clinical staff and workforce development.	
			↓	Unplanned reattendance rate - March performance was 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	Cancer Wait times		↓	The Trust achieved all cancer targets for Q3, but initial figures for quarter 4 show that the Trust did not achieve the following three cancer standards: • 62 days from urgent GP referral to treatment. Delays continue due to patinet choice to defer treatment and complex diagnostic pathways. Key actions include on-going review of the Urology, Head and neck and GI pathways. A seperate weekly cancer performance meeting is planned to commence on 18th April 2013 to focus on the review of all breach and analysis reports to facilitate focussed monitoring of the recovery plan	
			↓	• 62 days referral to treatment from screening - 1 pateint was not treated in time due to complex pathways	
			↓	• 31 day second or subsequent treatment - 2 patients were not treated in time due to being medically unfit for treatment to commence.	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	Elective Length of Stay	3.20	↓	The elective Length of Stay (LoS) target is 3.2days. The following data represents a rolling 12 months up to and including January 2013 based on Dr Foster Intelligence Peer Group UQ. Although the LoS for this period is greater than the 3.2 days target, it should be acknowledged that the comorbidities associated with the patients who were admitted during this time has influenced the expected LoS for the Trust.	
Clinical Outcomes	HSMR	<100	←	Mortality for Fractured Neck of Femur is rising in this financial year, although , some deaths are ocurring in community hospitals and may not be attributable to surgery at NGH. A detailed improvement plan is in place and is being monitored via the Care Group and corporate governance assurance processes. It is likely that a bundle of improvement measures will be required to influence this indicator as the care of these patients is complex accross many disciplines.	
			←	Mortality for Congestive Heart Failure is an area of concern - a detailed investigation has taken place - the SMR may change when outcmes from the coding review is available. Quality of care was generally judged to be good but suggestions for improvements have been made.	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100.0%	↓	This target was achieved in December after several months of improvements but performance continued to be below target throughout the quarter with the March figure dropping to 70%. The Surgical and Medical Care Group are working to address the same sex accomodation challanges that have had a negative impact on this target performance.	
Clinical Outcomes	Caesarean Section Rates	10.1%	↓	Elective C-section rates in the quarter remained above the target with March showing 16%, emergency rates remain below target. This may be that higher risk patients are electing for c-sections, with the supporting NICE guidance also having an impact.	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
CQUIN	Friends & Family Score	10 point improvement	↑	5656 patients were discharged from Northampton General Hospital in March 2013 of which, 857 patients responded to the FFT question i.e. 15.5% (this is above the 10% target for this year and the target of 15% for April 2013 onwards). From April 2013, every patient discharged from every NHS Trust is expected to receive an FFT questionnaire, with the minimum response rate of 15% of the total discharges or transfers to other units. It has been agreed, that in an attempt to achieve the prerequisite 15% from April 2013 onwards, the internal stretch target will be set to 20%. A presentation was made to the Matrons meeting reaffirming the FFT data collection process and expectations with a series of 1:1 meetings held with the ward managers to identify ways of increasing response rates and discussing how the score is calculated. Work in now underway to hold a arising awareness session with ward staff to reinvigorate the importance of the FFT and reiterate the need for all patients to have an opportunity to comment.	
CQUIN	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	90%	←	Performance against the Dementia case finding question appears to have been poor year to date, work is ongoing to capture and validate data. Improvements have already been noted in the other dementia indicators in January. The system has been updated and data for March is not currently available. Figures that are available suggest similar results to January and February. A working group lead by the Safety Academy are now supporting this project to improve compliance.	

Corporate Scorecard 2012-13

Patient Safety	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	RAG (Nov 12)	Dec-12	Jan-13	Feb-13	Mar-13
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	1	0	0		0	0	0	0
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	2	1	3		4	2	2	5
HQU08: MSSA Numbers	No national ceiling set	1	1	1	1	1	0	2	2		1	1	0	0
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	1	0	4		2	3	2	0
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92%		90.0%	91.9%	92.0%	90.1%
MRSA Screening Elective Patients	100% month on month	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%		99.4%	99.7%	99.5%	99.4%
MRSA Screening Non-Elective Patients	100% month on month	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%		95.8%	95.1%	96.6%	97.0%
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	42	16	44		31	10	30	45
Incidence of pressure ulcers														
Type 3	0	0	2	2	1	0	3	2	2		3	6	3	5
Type 4	0	1	2	0	0	0	0	0	3		4	0	0	1
Reduce harm from falls														
Catastrophic	0	0	0	0	0	0	0	0	0		0	0	0	0
Major/Severe	0	0	0	1	1	2	0	2	3		0	1	2	1
Moderate	0	2	2	3	0	0	1	0	0		1	2	3	1
Mandatory Training compliance Full Year Impact														
Primary Levels Excluding B&H	80%	61.20%	60.00%	60.30%	60.60%	59.10%	62.10%	63.90%	64.50%		65.23%	65.35%	65.20%	Not avail
Attendance at Trust Induction	80%	89.47%	90.70%	76.79%	87.80%	81.40%	85.48%	98.61%	90.82%		87.90%	87.50%	87.60%	Not avail
Number of surgical site infections														
Fracture neck of femur - Number of Operations	-	27	29	21	26	53	26	26	36		34	39	31	45
Infections	-	0	1	0	1	0	0	0	0		0	0	0	0
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%					1.1%				0%			0%	
Spinal Surgery - Number of Operations	-	Spinal and Vascular Surgery Infection rates monitored from Oct 2012						7	10		7	11	14	13
Infections	-							0	0		0	0	0	0
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.7%									0%			0%	
Vascular Surgery - Number of Operations	-							24	20		25	24	15	13
Infections								0	0		0	0	0	0
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 4.0%									0%			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	1							
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.0%					1.0%								
Limb Amputations	-	11	7	10	16	12	7							
Infections	-	0	0	0	0	0	1							
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 3.8%					3.0%								
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	0		0	0	0	0
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	84.2%	87%	87.9%		89%	89.1%	89.3%	Not avail
Serious Untoward Incidents	-	12	3	9	5	4	5	7	14		9	19	25	36
Never Events	0	0	0	0	0	1	0	0	0		0	0	0	0
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	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%	Audit commenced in May 12	57%	67%	77%	71%	77%	73%	68%		79%	80%	79%	72%
Q.2 Does addressograph include the NHS Number?	100%		99%	96%	95%	86%	90%	90%	93%		88%	99%	88%	92%
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%		72%	83%	56%	87%	86%	73%	87%		97%	74%	90%	84%
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%		46%	49%	36%	56%	62%	60%	62%		82%	53%	73%	64%
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%		56%	59%	41%	55%	60%	64%	74%		91%	53%	63%	46%
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%		6%	2%	5%	7%	16%	13%	29%		42%	18%	20%	18%
Q.7 Is record legibly written	100%		93%	98%	97%	92%	99%	98%	97%		99%	99%	98%	99%
Q.8 Written in blue/black ink	100%		98%	100%	100%	99%	100%	100%	100%		100%	100%	99%	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%	100%		99%	98%	99%	100%
Q.10 Is date recorded for each entry	100%		73%	86%	89%	91%	94%	89%	93%		91%	88%	90%	88%
Q.11 Is time recorded for each entry	100%		64%	67%	79%	68%	77%	73%	70%		72%	71%	66%	75%
Q.12 Is there a signature of the person making the entry	100%		98%	91%	95%	94%	92%	87%	91%		92%	90%	94%	94%
Q.13 Is surname printed in block capitals	100%		42%	56%	57%	47%	48%	48%	52%		58%	59%	58%	58%
Q.14 Is the staff designation recorded	100%		37%	44%	55%	42%	47%	50%	55%		50%	52%	52%	58%
Q.15 Medical Records Audit only: Is the GMC number present	100%		0%	19%	11%	5%	20%	14%	11%		34%	30%	31%	38%

Q.16 Are any alterations / deletions scored through with a single line	100%		29%	41%	36%	51%	38%	42%	51%		43%	25%	72%	40%
Q.17 Is there a signature recorded next to any alterations/deletions	100%		19%	33%	15%	33%	33%	26%	37%		27%	16%	25%	28%
Q.18 Is there a date recorded next to any alterations/deletions	100%		3%	5%	9%	27%	23%	14%	22%		14%	9%	16%	24%
Q.19 Is there a time recorded next to any alterations/deletions	100%		3%	5%	3%	16%	17%	11%	20%		14%	9%	13%	17%
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%							100%	99%		95%	97%	96%	100%
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and	100%		Questions not asked until Oct-12					76%	68%		34%	42%	75%	44%
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease	100%							100%	100%		100%	100%	100%	100%
Q.23 Are there any loose sheets in the Healthcare record	0%							8%	10%		17%	10%	0%	13%

Patient Experience	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12		Dec-12	Jan-13	Feb-13	Mar-13
Cancelled Operations not rebooked within 28 days	0	0	0	0	0	0	0	0	0		6	4	1	2
Hospital Cancelled Operations	6.0%	5.9%	7.1%	8.8%	5.6%	5.3%	5.8%	6.9%	7.9%	7.9%	5.4%	9.3%	6.3%	Not Avail
Number of written complaints received	-	50	51	39	48	33	35	44	40		24	68	54	52
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	83%	61%	60%	57%	90%		88%	96%	N/Avail	N/Avail
Referral to Treatment waits														
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.99%	96.34%	96.08%	95.93%		96.47%	96.10%	95.12%	94.70%
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.46%	98.44%	98.52%	98.36%		98.48%	98.60%	97.90%	97.80%
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.53%	97.12%	96.91%	96.85%		96.33%	95.45%	95.74%	Not avail
A&E Quality Indicators (5 measures)														
Time Spent in A&E (Month on Month)	95%	95.0%	93.4%	93.4%	92.2%	92.9%	96.9%	95.3%	90.2%		88.81%	86.91%	90.33%	82.49%
Time Spent in A&E (Cumulative)	95%	95.05%	94.19%	93.92%	93.47%	93.36%	93.95%	94.15%	93.67%		93.04%	92.47%	92.30%	91.51%
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	03:59	04:00	06:09		06:18	07:12	06:21	08:08
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	00:41		00:39	00:44	00:50	01:10
Time to treatment decision (median)	<60 mins	00:46	00:54	00:54	00:52	00:42	00:48	00:41	00:46		00:48	00:34	00:45	00:52
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	0.95%	5.71%	5.40%		6.62%	6.10%	6.07%	7.04%
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	0.16%	0.18%	0.18%	0.07%	0.25%		0.12%	0.18%	0.22%	0.22%
Cancer Wait Times														
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%		98.6%	96.7%	96.9%	98.3%
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%		100.0%	98.3%	100.0%	100.0%
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%		95.6%	97.3%	98.7%	99.2%
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%		100.0%	100.0%	100.0%	100.0%
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%		95.0%	91.8%	96.8%	94.7%
31 day second or subsequent treatment - radiotherapy	94%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%		98.8%	96.4%	97.8%	95.8%
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%		95.7%	95.7%	93.3%	84.2%
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%		100.0%	63.6%	73.7%	100.0%
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%		77.8%	81.3%	77.6%	76.5%
SRS08: Length of Stay (Acute & MH)														
Elective	3.20	3.70	4.1	4.2	4.1	4.2	5	4.4	4		3.8	4.4	4	4.2
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	4.9	4.5	4.2		4.4	4.6	4.3	4.7
SRS09: Daycase Rate	85%	85.7%	85.0%	84.9%	85.7%	86.6%	85.0%	84.7%	83.0%	83.0%	85.7%	85.5%	84.8%	Not avail
SQU11: PROMS Scores - Pre Operative participation rates														
Groin Hernia - Participation Rate	Nat.Ave 62.9% (target 80%)		42.30%			48.20%				88.6%			98.0%	
Hip Replacement - Participation Rate	Nat.Ave 79.5% (target 80%)		97.40%			91.40%				125.8%			93.0%	
Knee Replacement - Participation Rate	Nat.Ave 86.9% (target 80%)		94.90%			88.20%				95.9%			110.5%	
Varicose Vein - Participation Rate	Nat.Ave 33.3% (target 80%)		31.10%			33.30%				71.4%			54.1%	
All Procedures - Participation Rate	Nat.Ave 72.6% (target 80%)		72.80%			71.80%				99.1%			96.0%	

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12		Dec-12	Jan-13	Feb-13	Mar-13
HSMR - monthly position for 2012-13	<100	94.1	93.1	106.2	99.2	105	113.9	98.1	87.5		101.7	94.8	Data not yet published	
HSMR - cumulative position current financial year		NA	NA	85.0	95.0	96.1	97.9	98.3	98.2		99.0	99.1		
HSMR- cumulative position for 2012-13														
Pneumonia	<100				47.4	50.2	50.6	49.7	48.7		52.2	54.8		
Fracture of neck of femur (hip)	<100				148.0	133.1	163.1	155.8	168.5		168.4	169.1		
Acute Cerebrovascular disease	<100				86.0	96	104.8	110	101.6		107.1	105.6	Data not yet published	
Congestive heart failure, nonhypertensive	<100				83.7	90.9	114.4	121.4	131.3		131.9	133.5		
Acute myocardial infarction	<100				66.5	76.7	76.4	70.1	61.9		71	76.7		
SHMI (based upon date of SHMI report publication)		109.2	109.2	109.2	106.0	106.0	106.0	104.8	104.8			107.81	107.81	107.81
SQU12: Maternity 12 weeks	90%	86%	97%	87%	98%	98%	99%	98%	97%		93%	95%	95.2%	94.1%
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.8%	3.3%	2.9%	3.6%	2.7%	3.2%	3.1%	4.3%		5.7%	3.9%	3.4%	Not avail
Fractured neck of Femur														
Number of patients admitted with FNOF	-	27	30	21	26	52	26	26	36		34	39	31	46
Patients fit for surgery within 48hrs	-	21	23	13	25	47	22	24	34		27	37	29	45

Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	22	21	29		24	29	29	43
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	100%	87.5%	85.3%		88.9%	78.4%	100.0%	95.6%
Cardiac Arrests (Numbers)														
Peri Arrests (Numbers)														
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	80%	85%	93%	89%		100%	91.3%	90.6%	69.6%
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	68%	77%	75%	67%	70%	54%	46%	47%		47%	39.0%	67%	48%
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	95%	100%	96%	97%	97%	83%	100%	100%		100%	100.0%	100%	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%	88.9%		72.7%	68.8%	60.0%	69.2%
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%	91.0%	90%		84.2%	81.6%	86.1%	96.4%
Breast Feeding initiation	75%	98.0%	97.0%	96.0%	96.0%	96.0%	100.0%	99.3%	99.7%		74.9%	75.2%	77.4%	79.4%
Caesarean Section Rates - Total	<25%	25.1%	25.6%	27.1%	25.1%	28.5%	26.9%	26.5%	29.3%		24.1%	26.4%	29.2%	24.9%
Caesarean Section Rates - Emergency	14.98%	12.1%	11.0%	11.2%	9.8%	13.3%	13.7%	9.4%	14.91%		11.1%	10.1%	12.7%	9.4%
Caesarean Section Rates - Elective	10.06%	13.6%	14.6%	15.9%	15.3%	15.2%	13.8%	17.1%	14.4%		13.1%	16.3%	14.7%	15.5%
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.4%	6.8%	4.4%	4.5%		7.5%	2.1%	5.9%	6.6%

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
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%	92.0%		90.0%	91.9%	92.0%	90.1%
1b. High risk patients receive appropriate treatment *(inadequate volume of data Q2)*	95% Month on month	98.3%	93.1%	88.7%	98.0%	100.0%	96.1%	98.6%	97.3%		98.7%	99.0%	98.8%	99.4%
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)								Internal assurance results						
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	Not Avail	Not Avail	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%		72.4%	66.7%	34.8%	77.4%
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	Not Avail	Not Avail	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%		84.9%	65.2%	86.4%	83.3%
Did you have enough privacy when discussing condition or treatment?	>82.3	Not Avail	Not Avail	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%		87.0%	79.2%	76.2%	73.3%
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5	Not Avail	Not Avail	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%		32.0%	48.4%	60.0%	61.1%
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3	Not Avail	Not Avail	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%		37.5%	63.6%	58.3%	57.1%
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute														
a) Dementia case finding	90%							7.1%	2.4%		0.3%	2.4%	2.90%	Not avail
b) initial diagnostic assessment	90%			Review and validation of data required				N/A	N/A		N/A	N/A	N/A	Not avail
c) referral for specialist diagnosis	90%							0.0%	0.0%		0.0%	100%	100%	Not avail
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	-													
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG							Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.						
Regional CQUIN														
1. Establish question and baseline Net Promoter score	10%	11%	11%	13%	12.0%	15.3%	10.1%	14.3%	15.0%		14.8%	16.4%	19.0%	15.15%
2, Board and Commissioner reporting	Submission to HCG							Submitted to HCG						
3. Weekly reporting	-		Target from Q2						Weekly reports submitted from Hospedia					
4. Performance improvement by 10 points from July 2012 position	10 point improving	-30	-31	0	70	57	74	76	73		68	68	68	72
Local CQUINS														
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	50% adoption by Q4			Baseline audit undertaken					Repeat audit in progress due for completion by mid March. Year end results show 84% adoption					
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	65% for Q3, 75% for Q4			Baseline audit undertaken (59%)				80%	85%		84%	84%	83%	79%
2b. Appropriate referrals to CECs/ Intermediate service from A&E			Baseline audit 50 cases in Q1					Revised process agreed with commissioners and data currently being validated by Nene CCG						
3a. Accuracy of medicines information on discharge	75% error free							Junior doctor audit undertaken in Medicine on monthly basis for internal assurance purposes. GP audit to be undertaken in Q4. Internal audit results for Dec12 - Jan 13 = 53% error free						
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	Undertake baseline audit							Q4 audit completed in Rheumatology and Pain clinic, analysis being undertaken.						
3c. Oral nutritional supplements (ONS) - reduce the dispensing of ONS	50% reduction between Q1 and Q4				19.6% reduction from Q1				23.7% reduction from Q1				Quarterly figure	
3d. Triptorelin	Q3 - 70% compliance, Q4 - 80% compliance	Q1	Not applicable.		72.7%				76.0%			83.3%	100%	Completed & compliant as at Feb-13

4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal	Project plan submitted quarterly to commissioners.												
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	Project plan submitted quarterly to commissioners.												
MESCG CQUINS														
1. Quality Dashboards	-													
Identify and provide contact details of the following:														
- an overall dashboards lead for the Provider		Head of Information & Data Quality												
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-	Clinical Directors												
Provide a summary setting out the plans for implementation of the dashboards within the required timescale		4 out of 5 national data entry toolkits released in December, 5th due in Quarter 4. Work ongoing to populate.										Dashboards submitted		
3. Use of Intensity Modulated Radiotherapy	33%	Q1 = 9%			Q2 = 22%			Q3 = 52%				Q4 = 60%		
4a. Cancer Chemotherapy Performance Status	90%	91.7%	93.3%	99.2%	95.1%	95.5%	96.8%	93.9%	96.0%		95.8%	95.9%	98.7%	94.9%
4b. Cancer Chemotherapy Performance status 2 or above	100%	-	-	100%	100%	-	100%	-	-		100%	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		4		6	9	9	
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy	-	0.10%	0.00%	0.21%	0.18%	0.35%	0.20%		1.31%		1.77%	2.34%	2.56%	Avail May 2013
Number of Haematology patients deaths within 30 days of receiving chemotherapy	-	0	0	0	0	1	0		1		0	0	0	
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy	-	0.00%	0.00%	0.00%	0.00%	2.12%	0.0%		1.3%		0.00%	0.00%	0.00%	
5. Hepatitis C. Compliance with treatment / improved patient outcomes	Audit undertaken	Quarterly audit undertaken												
7. Reduction of catheter - related CONS	7% Baseline 2011-12	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0

Northampton General Hospital NHS
NHS Trust

Trust Board meeting: 24 April 2013	
Title: -	Patient Experience Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery and Patient Services

PURPOSE OF PAPER: - To update the Board on the implementation of the Patient Experience Strategy and its component parts for March 2013.

CRITICAL POINTS: -

- Friends and Family Test (FFT) - a single question selected as a headline metric for the clear and concise measuring and monitoring of patients' perceptions as to the quality of the health services they recently received - Scores for March 2013 = 72 with a footfall of 15.1% achieved (internal stretch target 15%)
- CQUIN quality results
- CQC National Inpatient Survey Results

ACTION REQUIRED BY BOARD: -

The Board is requested to: -

- Note and challenge the content of the report
- Note the results from the March 2013 Friends and Family Test
- Endorse the work being taken forward to create a customer service culture across the organisation

Northampton General Hospital NHS
NHS Trust

PATIENT EXPERIENCE REPORT

1. Introduction

The purpose of this report is to update the Board on the implementation of the Patient Experience Strategy and its component parts for March 2013.

2.0 Patient Experience monitoring

2.1 Friends and Family Test

The Friends and Family Test (FFT) captures perceptions of patients about the health care that they have received, by asking the question: '*Would you or your family recommend this hospital service to family and friends?'* Data collection against this metric commenced in April 2012 as part of the East of England pilot, whereby patients were asked on a 10 point scale how content they were with the quality of the service they had received.

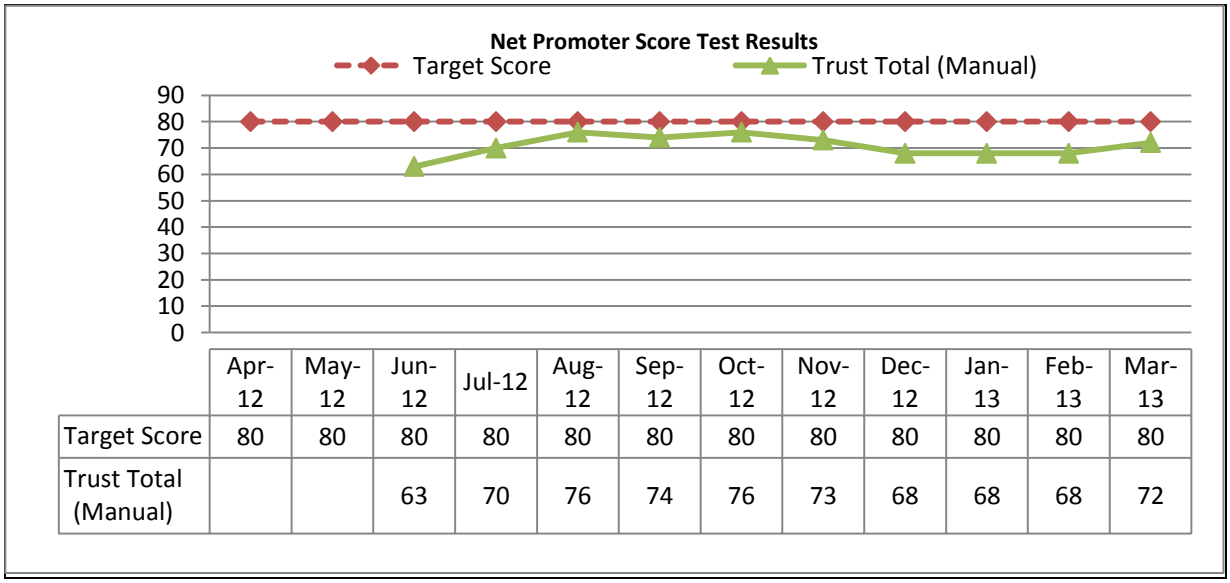
The national roll out of the FFT takes place from April 1 2013; however there are changes to the methodology being used. From 1 April patients will be required to comment on a 6 point scale ranging between "extremely likely" to recommend to "don't know". Results will be presented nationally on the NHS Choices website. The data from April will be published nationally in July 2013.

Only those scores relating to "extremely likely" will be presented, with the other results being used to make up the total response percentage.

2.2 The latest FFT Results: March 2013

Feedback received through the manual collection of the Friends and Family Test continues to be positive. The FFT score received for the month of March 2013 was 72, an increase from the 3 previous months. Details of individual ward scores can be found in Appendix 2.

Table 1: Monthly Friends and Family (Net Promoter) scores April 2012 – February 2013

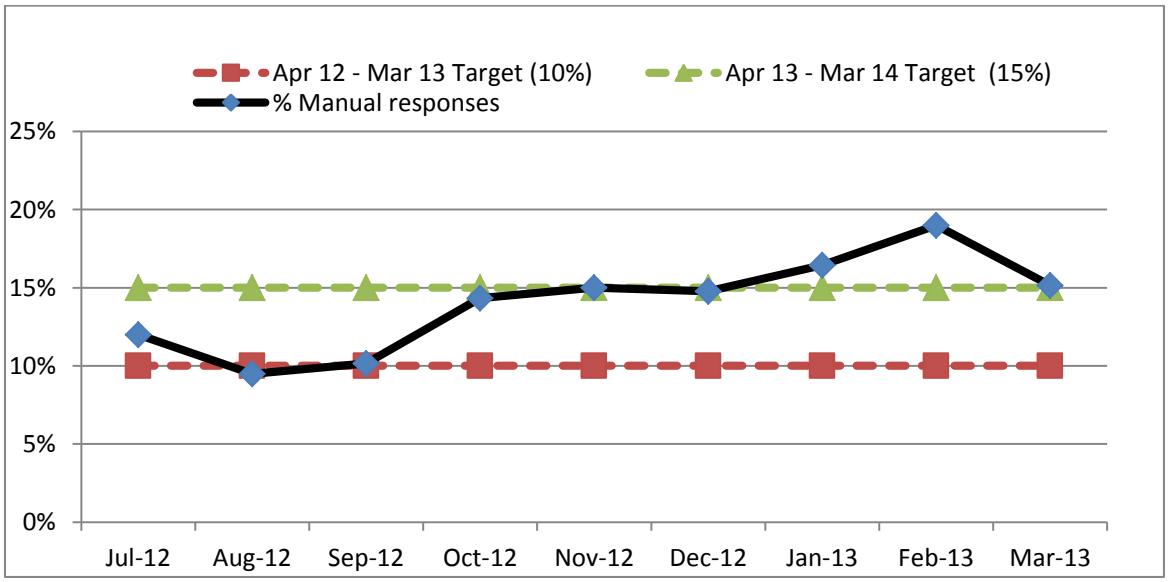


	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Target Score	80	80	80	80	80	80	80	80	80	80	80	80
Trust Total (Manual)			63	70	76	74	76	73	68	68	68	72

5656 patients were discharged from Northampton General Hospital in March 2013 of which, 857 patients responded to the FFT question i.e. 15.5% (this is above the 10% external target for this year and the internal stretch target of 15%).

From April 2013, every inpatient discharged from every NHS Trust is expected to receive an FFT questionnaire, with the target set at a 15% response rate. In an attempt to achieve this increase, the Trust has set an internal stretch target of 20%, to enable the Trust to have an appropriate flex in the FFT outcome to meet the target overall.

Table 2: FFT results for % footfall – external target is 10%, internal stretch target 15%



Comments received from patients are circulated to Ward Sisters monthly. Actions taken as a result of these comments continue to be included in the "You said, We did" comments on the Patient Quality Board located within ward areas. Wards receive a copy of their results and where wards consistently perform well, work is underway to see what learning can be shared across those teams where response rates and scores are lower.

A series of raising awareness sessions have been held with ward staff to reinvigorate the importance of the FFT question and to reiterate the need for all patients to have an opportunity to comment. Where wards have a greater elderly population or patients for whom the paper based tool is not easily accessible – work is underway to look at other ways of accessing patient satisfaction data to ensure a triangulation of ward feedback from all areas. As part of this, a presentation was made to the Matrons reaffirming the FFT data collection process and expectations. Following this meeting a series of 1:1 meetings have been held with individual ward sisters to identify ways of increasing response rates and discussing how the score is calculated.

Within A&E work continues to increase the opportunities for patients to complete the FFT question as follows:

- Via the use of an ekiosk – funding for this is being identified
- Approval has been received to enlist the help of volunteers currently recruited to work within the unit to support this initiative.
- The Patient Experience Lead is spending time in A&E to identify other ways of improving responses.

Publication materials have been ordered to display and distribute to inform patients about the FFT question, it's purpose and to request their feedback.

2.3 Patient Experience Quality monitoring: CQUIN questions

The responses to the CQUIN monitoring questions are collected via the FFT questionnaires and were identified within the 2011 inpatient survey as areas for improvement.

Progress against the targets set for each question is monitored monthly in the Trust and quarterly by Northamptonshire Commissioners as the financial value attached to this CQUIN is £251,000. It is apparent from the table below that there has been an improvement in the responses to questions 1, 2, & 4 over the past couple of months, whilst the response for question 3 has dropped slightly from the previous month, and responses to question 5 has remained static across the year.

Table 3: Monthly performance against CQUIN target

CQUIN 2012/13	Target 2012/13	Jun-12	Jul-12	Aug-12	Sept-12	Oct-12	Nov-12	Dec-12	Jan-12	Feb-12	Mar-12	RAG – 2012 In Patient Survey
Improve responsiveness to personal needs of patients based on impatient survey results		**Internal Assurance Results (%)**										
1 Were you involved as much as you wanted to be in decisions about you treatment or care?	>71	69.7	78	63.2	74.6	79.2	72.	72.4	66.7	34.8	77.4	Green
2 Were hospital staff available to talk about any worries or concerns that you had?	>63.4	74.9	84	66.6	83.2	82.5	76.2	84.9	65.2	86.4	83.3	Green
3 Did you have enough privacy when discussing condition or treatments?	>82.3	73.8	81	73.1	81.5	85	86.4	87	79.2	76.2	73.3	Amber
4 If you have been prescribed any new medication have you been informed of any possible medication side effects?	>48.5	47.8	51	55.9	52.2	21.4	50	32	48.4	60	61.1	Green
5 If you are ready to be discharged have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3	52.7	63.5	56.5	50	50	48.8	37.5	63.6	58.3	57.1	Amber

2.3.1 Actions to improve the CQUIN results

Part of addressing these results is to encourage patients to complete the FFT questionnaire and to comment on the care they have received. Through the sharing of comments and scores individual wards are encouraged to look at the issues and identify plans to rectify where necessary. In addition, senior nurses have been requested to prompt ward and medical staff to improve their communication with patients in relation to discharge

processes, ensuring patients receive comprehensive information during their period of hospitalisation or in receipt of outpatient services.

Additionally, a more inclusive type of ward round is being piloted on some wards, and those patients who are involved in this initiative are asked a series of questions relating to the ward round experience, which directly relate to the questions identified above, as follows:

A. Were you involved as much as you wanted to be in decisions about care with the ward round team?
B. Were the ward round team available to discuss any worries or concerns that you had?
C. On the ward round, did the doctors answer questions in an understandable way?
D. Did you have enough privacy when discussing your condition or treatment during the ward round?

The results from this pilot will be available at the end of May.

In relation to question four above, there is a concerted focus on the medication agenda. Ward teams have been advised of the importance of explaining new medications and their side effects to patients. This action is repeated by the ward pharmacist as they perform their daily rounds where appropriate. It was noted that many of these conversations take place on discharge when nurses are dispensing take home medications and an effort is being made to have these conversations with patients earlier. The Patient Experience Lead is meeting with a representative from Pharmacy to re-look at this current process to identify if it can be enhanced.

As regards question five above; several ideas have been discussed as to the best method of informing patients on discharge who to contact if they have any concerns (e.g. leaflets, a credit card with the ward number etc.). Examples of where this process is working more successfully are being collated for dissemination.

3.0 In Patient Survey Results

The results of the national inpatient survey will be published by the Care Quality Commission on the 16 April 2013. This survey of adult inpatients, includes a random sample of Northampton General Hospital (NGH) inpatients discharged during June 2012.

Table 4: NGH Inpatient survey response rates

		%	Number
Northampton General Hospital NHS Trust	"Responded"	61.23	507
	"Did not respond including opted out or ineligible"	38.77	321
	Eligible cases	100.00	828
	"Excluded- Undelivered or deceased"	.00	22

The results show the Trust response rate (61%) is higher than the overall rate for all Trusts (51%). NGH achieved a rating of 'about the same' as all other NHS trusts in England in 58 scores, and a 'worse' rating in just two – both in relation to noise at night, either from other patients or staff.

In relation to last year's results, in the majority of cases, the scores remain consistent, with no statistically significant change to the negative or positive. However, there are 5 cases where the scores are lower than those received by NGH last year:

Table 5: Areas where the inpatient survey shows a downward trend

Question	Result 2011	Result 2012	Trend
While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.5	7.9	⇩
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.9	7.4	⇩
If your discharge was delayed, how long was it delayed?	7.7	7.1	⇩
Overall did you feel you were treated with respect and dignity while you were in hospital?	9.0	8.6	⇩
During your hospital stay were you ever asked to give your views on the quality of your care?	1.7	1.2	⇩

Where the scores are lower than the 2011 results, the issues raised have been identified within other surveys and are currently being addressed as part of existing Patient Experience Strategy. It has been very encouraging to see that there are no areas identified by the survey that are not also being highlighted elsewhere and gives the trust confidence regarding their current processes for capturing feedback.

As part of the Friends and Family test all patients are asked to respond to key questions when they are discharged to enable us to continually monitor the areas where scores within the inpatient survey are lower, in particular these questions look at privacy, communication, A&E experience and the discharge processes. In addition other work e.g. the Noise at Night Audits are taking place to validate the results of the questionnaire and to involve lay people in the evaluation of the patient experience.

4.0 Patient Experience Implementation plan appointment of Patient Experience Clinical Leads

It was reported last month that the trust had not been successful in recruiting Patient Experience Leads or Champions for the clinical areas. As a result, the Patient Experience Board at its April meeting will be considering different ways of recruiting to these important posts and will report back in due course.

5.0 Patient information: Listening into Action sub-group

As part of the Listening into Action sub-group, a small task and finish group has been reviewing the appointment letters received by patients from the trust. The plan is to pilot the use of a new appointment letter within Cardiology, Audiology and Ophthalmology, beginning in May 2013.

6.0 Conclusions

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

8.0 Recommendations

Members of the Board are requested to:-

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

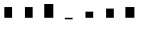
Appendix 1

FRIENDS & FAMILY FFT RESPONSE RATES (MANUAL)
Recorded from November 2012 onwards

Ward	Nov-	Dec-	Jan-	Feb-	Mar
Abington	27.06%	43.42%	28.95%	37.50%	43.33%
Allebone	18.97%	16.05%	38.46%	28.57%	22.83%
Althorp	111.76%	36.84%	31.94%	31.76%	43.00%
Balmoral	51.85%	65.69%	55.87%	46.15%	37.34%
Becket	19.18%	36.96%	21.88%	31.08%	32.08%
Benham	10.99%	13.11%	8.91%	30.18%	7.91%
Brampton	34.38%	23.81%	44.12%	41.94%	67.86%
Cedar	18.28%	29.47%	36.36%	28.57%	25.71%
Collingtree Medical	18.64%	8.66%	0.0%	20.19%	13.56%
Compton	15.79%	77.27%	91.30%	111.11%	77.78%
Corby Comm.	0%	71.43%	50.00%	0.00%	30.00%
Creaton	7.41%	16%	32.35%	33.33%	21.05%
Danetre	0%	0%	57.14%	34.62%	39.53%
Disney	19.16%	16.26%	16.55%	29.48%	10.13%
Dryden	16.36%	29.41%	2.38%	27.03%	24.79%
Eleanor	21.62%	17.91%	16.67%	36.36%	21.74%
EAU	5.86%	8.40%	13.16%	4.66%	3.15%
Finedon	37.25%	38.89%	36.21%	29.17%	21.62%
Hawthorn	75.28%	21.97%	25.47%	36.61%	37.68%
Hazelwood Comm.	93.75%	25.00%	127.78%	0.00%	60.71%
Head & Neck	9.38%	19.20%	33.33%	45.45%	40.46%
Holcot	54.84%	21.21%	68.75%	75.00%	53.57%
Knightley	53.85%	37.50%	26.67%	31.82%	52.17%
Paddington	9.95%	7.94%	8.67%	13.30%	9.79%
Robert Watson	23.46%	30.73%	42.02%	37.20%	30.00%
Rowan	25.95%	24.85%	34.62%	45.56%	32.84%
Spencer	18.75%	8.04%	21.70%	13.07%	12.79%
Talbot Butler	23.91%	12.31%	30.56%	10.64%	12.00%

Victoria	0%	9.88 %	23.9 1%	4.00 %	10.4 5%
Willow	41.1 1%	21.3 3%	29.5 1%	22.9 9%	21.3 0%
Trust Inpatient Area Total	15.0 1%	14.7 7%	16.4 5%	19.0 0%	15.1 5%
Accident & Emergency Dept			0.54 %	1.75 %	0.48 %
Danetre Day Surgery			66.6 7%	54.6 4%	30.8 8%
Main Theatre Admissions				50.9 2%	50.0 0%
NGH Day Surgery			38.8 6%	29.4 3%	12.4 3%

Appendix2: Friends & Family Net Promoter Score Results (Manual)

Ward	Graph	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Abington		50	40	40	67	39	70	73	63	42
Allebone		0		50	50	64	-8	32	45	52
Althorp		40	50	15	67	89	71	87	93	81
Balmoral		63	73	78	80	79	69	78	79	86
Becket		56	56	40	41	93	68	21	43	47
Benham		89	100	70	70	70	41	50	53	70
Brampton		50	90	70	60	45	70	93	77	68
Cedar		38	56	58	64	53	50	65	65	61
Collingtree Medical		83	25	80	78	82	82		29	55
Compton							88	81	70	81
Corby Comm.						67	87	100		50
Creaton		83	100	40	72	100	64	36	40	63
Danetre								92	67	94
Disney		79	82	68	71	69	82	96	67	58
Dryden		33	80	80	94	67	80	100	80	69
Eleanor		86	67	82	100	75	92	100	50	80
EAU		80	100	57	36	77	67	60	73	50
Finedon		100	0	78	80	58	67	71	50	81
Hawthorn		91	89	75	90	85	65	56	78	73
Hazelwood Comm.		60		33	67	47	86	83		82
Head & Neck		81	100		96	78	92	76	80	83
Holcot		68	85	70	68	65	100	91	92	93
Knightley		89	69	64	63	90	72	75	100	96
Paddington		24	87	57	57	51	33	56	46	46
Robert Watson		68	83	76	76	83	69	54	85	76
Rowan		57	69	75	93	65	62	67	65	79
Spencer		93	90	100	68	77	89	87	91	79
Talbot Butler		100	100	92	80	68	63	77	70	87
Victoria							50	27	33	0
Willow		90	100	83	90	84	94	89	75	74
Trust Inpatient Area Total		70	76	74	76	73	68	68	68	72
Accident & Emergency Dept								0	4	4
Danetre Day Surgery								91	96	98
Main Theatre Admissions									92	87
NGH Day Surgery								91	97	94

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 24 APRIL 2013	
Title: -	Monthly Infection Prevention Performance Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery & Patient Services/Director of Infection, Prevention & Control

PURPOSE OF PAPER: -

To update the Board on Infection, Prevention and Control within the hospital for the month of March 2013.

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.

Northampton General Hospital NHS
NHS Trust

March 2013 Infection, Prevention & Control 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.

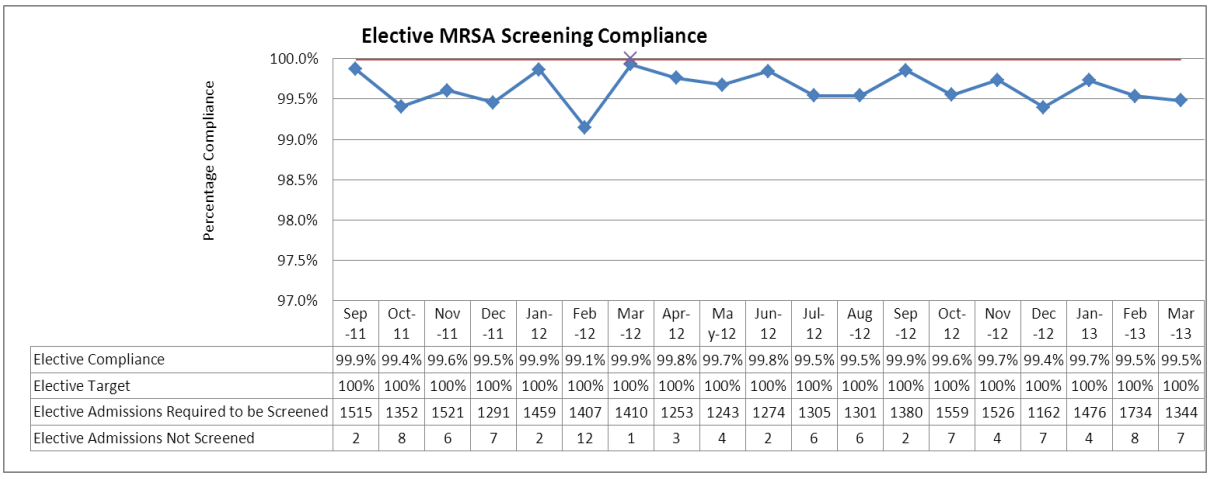
2.1 MRSA Bacteraemia

The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. During March 2013 there were **0 >48hrs** MRSA bacteraemia. The total remains at 2 cases at the end of the financial year.

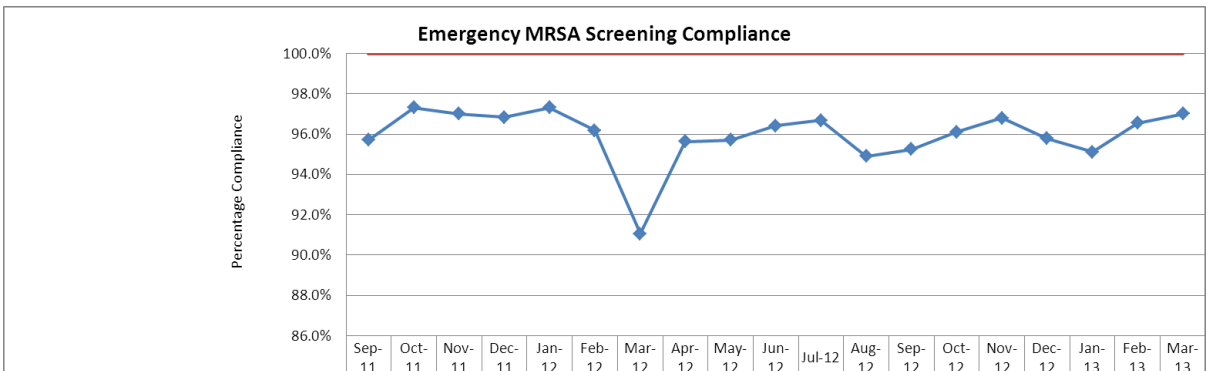
2.2 MRSA Colonisation & Screening

During March there were 14<48hrs and 4>48hrs cases of MRSA colonisation.

Compliance with elective and emergency screening is demonstrated via the graphs below. Elective screening compliance remains the same at 99.5%, with emergency screening compliance increasing to 97%, the highest score this financial year. Compliance continues to be monitored regularly by the Care Groups as well as the Infection Prevention team.



	Sep -11	Oct-11	Nov -11	Dec -11	Jan-12	Feb -12	Mar -12	Apr-12	Ma y-12	Jun-12	Jul-12	Aug -12	Sep -12	Oct-12	Nov -12	Dec -12	Jan-13	Feb -13	Mar -13
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%	99.7%	99.4%	99.7%	99.5%	99.5%
Elective Target	100%	100%	100%	100%	100%	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	1526	1162	1476	1734	1344
Elective Admissions Not Screened	2	8	6	7	2	12	1	3	4	2	6	6	2	7	4	7	4	8	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	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
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%	96.8%	95.8%	95.1%	96.6%	97.0%
Emergency Target	100%	100%	100%	100%	100%	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	1158	1209	1126	1104	1170
Emergency Admissions Not Screened	46	29	30	34	28	38	96	45	48	38	37	57	51	45	37	51	55	38	35

2.3 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.

In March 2013 Creaton ward was put onto Special Measures for 2 post 48 hours MRSA colonisations, 1 case in February and 1 case in March: these 2 specimens were taken within 28 days. Environmental audits highlighted that there was high dust levels on the curtain frames and dust on the computer key boards, this has since been resolved. The ward was cleaned daily with chlorclean and the observational audit of personal protective equipment was 100% compliant. Daily saving lives audits were undertaken and scores were found to be good.

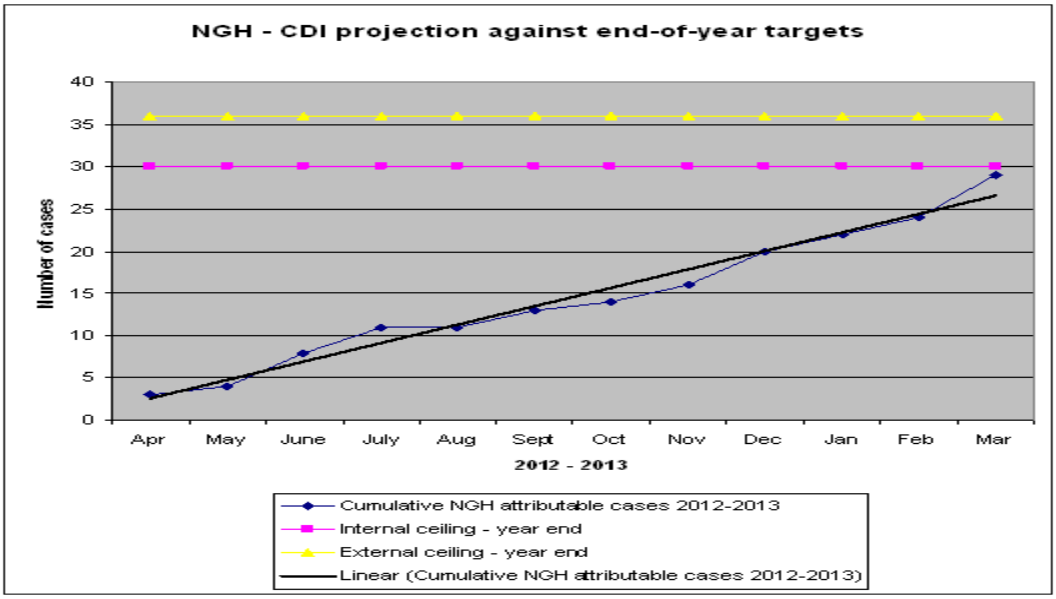
2.4. MSSA Bacteraemia (Methicillin Sensitive *Staphylococcus aureus*)

During March 2013 there were 3 <48hrs and 0 >48hrs MSSA bacteraemia case.

3. Clostridium difficile

The Trust has an annual ceiling of 36 (> 3 days) Clostridium Difficile (C. diff.) cases or less for the financial year. During March, 5 cases *of C. diff* were identified**,** which totals 30 for the year, bringing the Trust in below the annual ceiling.

A review of the 5 C. Diff cases was undertaken by the Consultant microbiologist and the Infection Prevention and Control Team. All patients were on different wards and there was no evidence of any cross infection. Predisposing factors were antibiotics and in 2 cases, laxatives. It would appear an inappropriate sample was sent for one patient. A Root Cause Analysis (RCA) is undertaken for all post 72 hours cases of C.diff. These are in progress and may highlight further themes. This will be reported in the next board report.



The 2013/14 C Diff ceiling has been set for 29 cases (a reduction of 7 cases from this year). Unlike this year where the target was divided equally per month, next year the target will be titrated against the actual incidence of data, so that the projection is more realistic.

4. 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).

4.1 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 March 2013:

- Repair of fractured neck of femurs(#NOF) show that there were *no infections* resulting from 45 operations
- Vascular surgery show that there were *no infections* resulting from 13 operations
- Spinal surgery operations show that there was *no infections* resulting from 13 operations

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

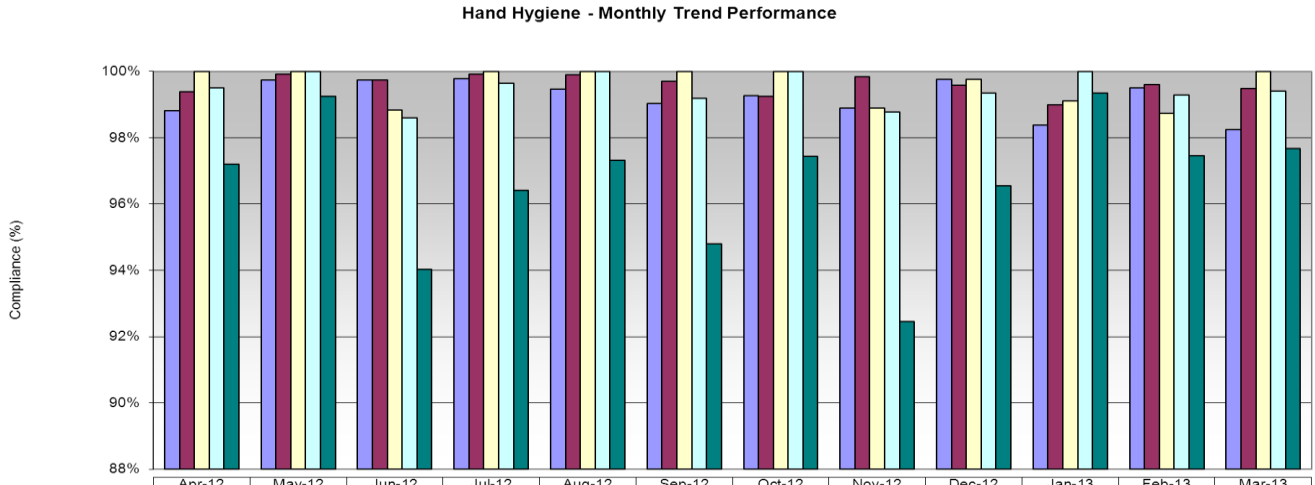
5. Hand Hygiene Audit

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

- March overall Trust compliance for hand hygiene = 90.7% due to 7 areas failing to submit the completed audit.

Areas who have failed to submit their audits are being followed up by the Infection Prevention and this will be highlighted at the next Infection Prevention Committee meeting.

A preliminary review of the matron's dashboard shows similar results to February's dashboard. This too will be discussed at the next Infection Prevention Committee meeting and the findings and actions reported in the next board report. 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	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Doctor	98.8%	99.7%	99.7%	99.8%	99.5%	99.0%	99.3%	98.9%	99.8%	98.4%	99.5%	98.3%
Nurse/HCA	99.4%	99.9%	99.7%	99.9%	99.9%	99.7%	99.3%	99.8%	99.6%	99.0%	99.6%	99.5%
Therapist	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	98.9%	99.8%	99.1%	98.7%	100.0%
Pharmacist	99.5%	100.0%	98.6%	99.6%	100.0%	99.2%	100.0%	98.8%	99.3%	100.0%	99.3%	99.4%
Porter	97.2%	99.2%	94.0%	96.4%	97.3%	94.8%	97.4%	92.5%	96.6%	99.4%	97.4%	97.7%

Hand Hygiene champions are being revisited across the Trust and a poster campaign is being developed, with the message “I wash, gel, you can too”. The poster will underpin the importance of effective hand hygiene being everybody’s business.

6. Update of Scalded Skin Syndrome

Scalded skin syndrome is caused by infection with certain strains of *Staphylococcus aureus* bacteria. The bacteria produce a toxin (poison) that causes skin damage. The damage creates blisters as if the skin were scalded. Scalded skin syndrome is found most commonly in infants and children under the age of 5.

To date, the outbreak has involved 7 confirmed cases diagnosed between the 7th January 2013 and 7th February 2013 with the same strain of organism. All subsequent cases diagnosed have had different strains of the organism. The Trust is awaiting results on a further suspected case admitted on 31/3/2013.

Since the previous board report, 209 staff have been swabbed, of which 205 have been reported on. *Staphylococcus aureus* has been isolated in about 20%. One of the isolates has been confirmed as the outbreak strain. This member of staff has been treated and will be closely followed up by Occupational Health.

Management of this outbreak has highlighted that the current observational cleaning/environmental audit needs to be strengthened to include a more ‘common sense approach’ and observation as well as the mandatory areas it currently covers. As a result, an educative power point presentation is being developed, designed to be accessed prior to undertaking an audit. The presentation will be accessed via the ‘Street’ and will incorporate prompts that are recommended in the Patient-Led Assessments of the Care Environment (PLACE); the new system for assessing the quality of the patient environment.

The monthly Executive Infection Prevention audit is also being reviewed and a new checklist list with prompts is being produced. The new presentation may prove invaluable prior to undertaking this inspection too. In addition, the schedule of audits is being reviewed to incorporate new board members. Prior to members conducting their first audit, the infection prevention team will run

through the audit process with the individuals to ensure they are clear about the purpose and process for undertaking it. Prior to implementation, the revised Executive audit tool will be brought to a Board Development day for discussion and finalisation.

7. Special measures for Vancomycin Resistant Enterococci (VRE)

Enterococci is a bacterium that colonises the gut of most healthy people, however, it can cause infection from patients own body flora. More frequently in recent years it has been shown to cause healthcare associated infection. Enterococci are resistant to many commonly used antibiotics for example, Cephalosporin. However enterococci may develop resistance to Vancomycin making the treatment of an infection problematic. Patients admitted to a renal ward are at greater risk of becoming infected or colonised with VRE (Vancomycin Resistant Enterococci).

As highlighted in the February's Board report, the renal ward had 2 patients identified with Vancomycin Resistant Enterococci (VRE) within a 28 day period during the month of February 2013. The ward was put onto special measures and an RCA tabular timeline was undertaken. A review of each patients hospital stay has been completed from patient admission to identification of VRE. For one patient the timeline highlighted that the Octenisan antimicrobial decolonisation treatment, which should be prescribed for all renal patients undergoing renal dialysis, was not promptly prescribed. An audit of decolonisation treatment is being undertaken by the Infection Prevention Team and the results and actions will be discussed at the May Infection Prevention and Control Committee. There were also gaps in the documentation and following of the sepsis protocol. An action plan has been requested. The RCA's show that both renal patients were compromised and therefore at greater risk of becoming colonised with VRE. Following Special Measures to date there have not been any further cases of VRE on the renal unit.

8. Conclusion

The Infection Prevention 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.

9. Recommendation

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

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 24 APRIL 2013	
Title: -	Operational Performance Report
Presented by: -	Christine Allen – Interim Chief Executive

PURPOSE OF PAPER: -

This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 12 (March 2013). 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 12 (March 2013).

- The Trust did not achieve the 4 hour transit time standard for March 2013 with 81.8% of patients being treated within 4 hours against the standard of 95%. Year-end position is 91.46%

- The cancer targets are monitored on a quarterly basis. For March the Trust did not achieve three cancer standards;
  - 62 days from referral to treatment with 76.5% of patients treated against the standard of 85%. Quarter 4 performance is 78.9% and year end is 83%.
  - 62 days from referral from screening to start of treatment with 84.2% against the standard of 90%. The Trust achieved Quarter 4 performance t at 91.2% and year end at 96.2%.
  - 31 day standard from decision to treat to start of subsequent drug treatment. The Trust achieved the standard for March at 98.3% against the standard of 98% but has not achieved quarter 4 performance with 95.4%. The year-end performance is 98%.

- During March there was 1 breach of the diagnostic 6 week standard.

- The Trust achieved all the other performance standards for March 2013.

ACTION REQUIRED BY BOARD: -

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

Northampton General Hospital NHS
NHS Trust

PERFORMANCE REPORT – APRIL 2013

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 12 (March 2013). 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 the detailed scorecard.

2.1 March Performance

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

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

2.2 Urgent Care Standards

There continued to be significant pressures from non-elective demand across the Trust during March, when 81.8% of patients were admitted, transferred or discharged from A&E within 4 hours. The year-end position is 91.46%.

2.3 Benchmarking

Trusts across the East Midlands have experienced increased demand for Urgent Care and pressure on their A&E departments. The following information highlights quarter 4 performance for all acute Trusts within the East Midlands and the performance across England.

A&E Attendances Local SHA
Quarter 4 2012/13

Hospital	Type 1 Departments - Major A&E	Percentage in 4 hours or less (type 1)	Total attendances	Percentage in 4 hours or less (all)
England	3,502,247	91.1%	5,292,043	94.1%
A	38,458	94.8%	38,458	94.8%
B	40,072	94.3%	44,970	94.9%
C	16,260	93.9%	16,260	93.9%
D	22,234	91.2%	30,904	93.4%
E	29,061	90.6%	29,061	90.6%
NGH	21,555	84.7%	24,411	86.4%
F	37,609	79.0%	53,406	85.1%
G	18,103	82.9%	19,443	84.1%

A recovery plan and urgent care programme is in place to improve flow through the emergency pathway and therefore improve the urgent care performance standard. Progress is monitored through the Urgent Care Programme Board (UCPB) and each project and clinical leads are responsible for the delivery of their action. Following the presentation at the March board meeting, the urgent care team will attend the May board meeting, as agreed, to provide a further update.

2.4 Cancer Standards

All cancer standards are monitored quarterly at year end performance. During March, the Trust did not achieve the following standards:

- **62 day standard from urgent referral**

During March, the Trust achieved 76.5% for 62 days from referral to treatment against the standard of 85%. Quarter 4 performance is 78.9% and year end is 83%.

There continued to be an increased number of breaches during March. The reasons for the breaches continue to include patient choice to defer appointments or diagnostic tests and complex diagnostic pathways.

A recovery plan has been implemented and an additional weekly performance meeting dedicated to delivery of the cancer standards is being set up from 18th April. The meeting will review each breach analysis and monitor the recovery plan and progress towards delivering the standards in 2013/14.

- **62 day standard from screening**

During March the Trust achieved 84.2% against the standard of 90%. The Trust achieved Quarter 4 performance at 91.2% and year end at 96.2%. Small numbers are treated within this standard and the breaches were due to clinical reasons.

- **31 day standard from decision to treat to start of subsequent drug treatment**

The Trust achieved this standard during March with 98.3% of patients being treated against the standard of 98%. The Trust however has not achieved quarter 4 performance with 95.4% of patients being treated. The year-end performance is 98%.

- **6 Week Diagnostic Standard**

During March, the Trust did not achieve the standard of no patients waiting more than 6 weeks for a diagnostic test. This was as a result of an administration error and 1 patient waited over 6 weeks. A full root cause analysis has been carried out.

- **Referral to Treatment Time (RTT)**

During March 2013 and for year end, the Trust achieved all of the RTT standards by each specialty.

3. RECOMMENDATIONS

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

Appendix 1 Scorecard

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups														
Admitted	90.0%	96.4%	96.6%	97.4%	96.6%	97.0%	96.3%	96.1%	95.9%	96.5%	96.1%	95.1%	94.7%	96.2%
Non-admitted	95.0%	97.7%	98.3%	98.8%	98.6%	98.5%	98.4%	98.5%	98.4%	98.5%	98.6%	97.9%	97.8%	98.3%
Incomplete pathways	92.0%	98.2%	97.8%	97.1%	97.3%	97.5%	97.1%	96.9%	96.8%	96.3%	95.4%	95.7%	94.2%	96.7%
No of patients on an incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	49	55	43	21	33	40	50	63	63
Number of diagnostic waits > 6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	1	1
A&E 95% Transit time target														
Cumulative	95.0%	95.0%	94.2%	93.9%	93.5%	93.4%	93.9%	94.2%	93.7%	93.0%	92.5%	92.3%	91.5%	91.45%
Month on Month	95.0%	95.0%	93.4%	93.4%	92.2%	92.9%	96.9%	95.3%	90.2%	88.8%	86.9%	90.3%	82.5%	N/A
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6.0%	5.9%	7.1%	8.8%	5.6%	5.3%	5.8%	6.9%	7.9%	5.4%	9.3%	6.30%	N/Av	N/Av
Cancelled Operations rebooked within 28 days (as per SITREP definition)	75%	100%	100%	100%	100%	100%	100%	100%	100.0%	87.5%	90.0%	98%	96%	98%
Cancer Wait Times														
2 week GP referral to 1st outpatient	93.0%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	96.7%	96.9%	98.3%	96.8%
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	98.3%	100.0%	100.0%	99.4%
31 Day	96.0%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.3%	98.7%	99.2%	98.2%
31 day second or subsequent treatment - surgery	94.0%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	98.3%
31 day second or subsequent treatment - drug	98.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	95.0%	91.8%	96.8%	98.3%	98.0%
31 day second or subsequent treatment - radiotherapy	94.0%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.8%	96.4%	97.8%	95.8%	98.5%
62 day referral to treatment from screening	85.0%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	95.7%	93.3%	84.2%	96.2%
62 day referral to treatment from hospital specialist	85.0%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	63.6%	73.7%	100.0%	89.1%
62 days urgent referral to treatment of all cancers	85.0%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	77.8%	81.3%	77.6%	76.5%	82.9%
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%	88.9%	72.7%	68.8%	60.0%	69.2%	N/Av
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%	85.7%	84.2%	93.3%	86.1%	96.4%	N/Av
Activity vs. Plan														
Elective Inpatients	>0%	17.8%	24.6%	16.4%	10.0%	-0.9%	18.4%	21.4%	31.4%	4.3%	7.9%	20.8%	16.6%	13.60%
Daycase	>0%	9.2%	12.0%	1.7%	4.5%	1.9%	4.9%	7.8%	2.2%	-2.9%	1.5%	5.2%	3.0%	3.84%
Non- Elective	>0%	17.1%	26.9%	18.7%	14.4%	15.2%	13.7%	21.6%	20.9%	19.2%	14.8%	21.5%	9.5%	8.1%
OP 1	>0%	6.1%	16.1%	8.5%	1.9%	-4.8%	4.8%	5.1%	3.8%	-8.5%	4.5%	7.2%	-8.9%	3.7%
OP Procedures	>0%	10.3%	3.9%	5.2%	2.8%	-1.3%	5.9%	7.5%	13.1%	-2.7%	1.6%	4.7%	-2.0%	4.0%
New to Follow UP Ratio	2.01	2.03	1.90	1.95	1.95	1.94	2.05	2.01	1.97	2.12	2.03	2.09	N/Av	N/Av
GP Referrals	>0%	2.5%	1.4%	1.1%	0.4%	-2.0%	-2.1%	-1.3%	-1.3%	-2.7%	-2.9%	-2.6%	-2.3%	-1.8%
Day Case Rates	81%	85.7%	85.0%	84.9%	85.7%	86.6%	85.0%	84.7%	83.0%	85.7%	85.5%	84.77%	N/Av	N/Av
Sleeping Accommodation Breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Northampton General Hospital NHS
NHS Trust

Trust Board, 24 April 2013.	
TITLE: -	Finance Report M12 – March 2013
PRESENTED BY: -	Mr Andrew Foster – Acting Director of Finance.

PURPOSE OF PAPER: -

The paper sets out the Financial Position of the Trust for the twelve months ended March 2013.

CRITICAL POINTS: -

This report considers the performance of the Trust against the statutory financial duties required of an NHS Trust.

- The Trust has delivered an Income & Expenditure surplus of £0.4m for the financial year 2012-13 (after adjustment for impairment and donated asset accounting).
- At the end of the 2012-13 financial year, the Trust has maintained a cumulative breakeven surplus of 2.6% of total income, thereby achieving the statutory breakeven duty.
- The Trust has managed cash resources within the prescribed External Financing Limit (EFL) for the financial year.
- The Trust has managed capital resources within the prescribed Capital Resource Limit (CRL) for the financial year.
- Due to cashflow restrictions earlier in the financial year the Trust did not fully achieve compliance with the Better Payment Practice Code.
- Public dividend capital dividends of £4.2m have been paid to the Treasury during the year achieving the 3.5% Capital Cost Absorption duty.

The position reported above remains subject to the external audit of annual accounts.

ACTION REQUIRED: -

The Board is asked to note the performance of the Trust against the statutory financial duties for 2012-13.

The Trust's Financial and Contracting Performance as at 31st March 2013

2012/13 Year end outturn position

1. Statutory Financial Duties

1.1. The Trust's financial performance is measured against its statutory duties. This report sets out the full year performance against those duties required of an NHS Trust for the period ended 31st March 2012/13.

1.2. The performance against these targets has been based upon the latest financial position which remains subject to the finalisation of a number of provisions and accounting entries for gross up of charitable expenditure. The position remains subject to the external audit of the year end accounts in May although the overall performance is not expected change in a materially.

1.3. On completion of final provision estimates an update to this position will be provided to the Trust Board at the end of April 2013.

2. Income and Expenditure - Statutory break even duty

2.1. The Trust is required to achieve a break even financial position after making adjustment for impairments and donated assets.

2.2. Overall financial performance for the year ended 31st March 2013 is set out in appendix 1 and reports a deficit of £0.8m, after the required adjustments for impairments of £0.9m and donated assets £0.3m have been added back the normalised financial performance is a surplus of £0.4m. This position is £0.6m adverse to the plan submitted at the start of the financial year but exceeds the breakeven financial recovery plan target agreed with the SHA during the year. The position has been submitted to the SHA as part of the Month 11+ return.

Table 1 – Income & Expenditure Position

	Year end	Full Year Plan	Variance
Delivering Planned Surplus (£'000)	£398	£1,000	£602

Table 2 sets out the impact of this performance on the Trust's forecast statutory breakeven duty. The Trust has successfully met this statutory duty and maintains a cumulative surplus of 2.6% of revenue.

Table 2 – Forecast Break Even duty

Forecast Breakeven performance	2011-12 £000	2012-13 £000
Turnover	255,481	263,746
Retained surplus/(deficit) for the year	(1,917)	(770)
Adjustments for Impairments	3,453	889
Adjustments for impact of policy change re donated assets	(1,032)	279
Break-even in-year position	**504**	**398**
Break-even cumulative position	**6,586**	**6,984**
Break-even cumulative position	2.6%	2.6%

2.3. The Trust set a Cost Improvement (CIP) target of £16.1m for the year. Indications are that the Transformation Programme has delivered £10.5m of savings in year which is consistent with the assumptions set out in the Financial Recovery Plan agreed during the year.

3. Cash Position – Statutory duty to meet the External Finance limit

3.1. The Trust was set a target of £1m by the DH for the External Financing Limit (EFL). This included additional funding approved by DH in March of £0.5m for Maternity Improvements and £0.3m for additional CRL to support the forecast capital expenditure. The Trust has delivered the statutory duty by managing total cash resources within the prescribed EFL target.

Table 3 – External Financing Limit 2012-13

	Year end	Full Year Target	Variance
Achieving EFL (£000's)	£979	£1,000	£21

3.2. The External Finance limit was delivered after repayment of the £4m temporary DH loan in February.

3.3. The Trust's Statement of Financial Position (Balance Sheet) as at 31 March 2013 and the cash flow for year are set out in appendix 2 and 3 respectively which provide further details of the Trust financial and cash position.

3.4. The Trust has made provisions at the financial year end for known liabilities and commitments requiring on-going financial obligations. A review of aged debtors has also been made and an assessment of provisions required against potential bad debts has been included at the balance sheet date.

4. Cashflow and Better Payment Practice Code (BPPC)

4.1. Cash resources were constrained for a considerable period during the year necessitating the Trust to apply for a temporary DH loan of £4m in November 2012. This loan was fully repaid at the end of February 2013.The Trust has focused payments to small and medium size enterprises and those which are essential to the delivery of clinical services in the spirit of the BPP code. Following agreement of the NENE CCG income settlement in January 2013 the Trust has been able to make sufficient creditor payments to significantly reduce the overall level of outstanding balances achieving current status by the financial year end.

4.2. The Trust is required to pay 95% of its suppliers based on value and volume within 30 days. The Trust performance against this target for the year is set out below

Table 4 Better Payment Practice Compliance:	Actual	Target	
Volume of Non-NHS Invoices	85%	95%	-10%
Value of Non-NHS Invoices	57%	95%	-38%

5. Capital Programme - Statutory duty to meet Capital Resource Limit

5.1. The Trust has successfully met the statutory CRL duty and has underspent against it CRL by £156k. This is based on the revised CRL target approved by the SHA in late March 2013.

Table 5 – Capital Resource Limit

	Year end	**Full Year Target**	**Variance**
Achieving the Capital Resource Limit (£000's)	£9,639	£9,795	£156

5.2. In March, the Trust was successful in bidding for an additional of £0.5m of Public Dividend Capital (PDC) funding in support of improving maternity environment. The majority of expenditure in relation to this initiative will be incurred in the 2013/14 financial year.

5.3. The outturn capital programme included the following key items which have been reported to the Capital Committee in April:

- Estates capital spend has exceeded plan by £174k by advancing schemes for 2013/2014.
- IT capital spend has underspent its plan by £362k as a result of raising the orders late and being unable to complete the work by the end of the year.
- Medical Equipment Sub-Committee has advanced £332k from the provisionally approved 2013/14 plan.
- The improving birthing environment works underspent by £39k which will be completed in 2013/14.
- All of these factors have been addressed in the 2013/2014 Capital Programme.

5.4. Further details of the Capital programme are set out in appendix 5.

6. Capital cost Absorption Duty 3.5%

The Trust has made Public Dividend Capital Dividend payment to HMT amounting to £4.2m during the financial year. In so doing the Trust has achieved the Capital Cost Absorption duty of 3.5% of average relevant net assets over the course of the financial year.

7. Conclusion

The Trust has met all of the key statutory duties required of an NHS Trust for the financial year 2012/13. This position remains subject to the external audit of final accounts in May 2013 and further updates will be provided to the Committee and Board in due course.

Appendix 1

Income & Expenditure Position Year ended 31 March 2013

I&E Summary	Plan 2012/13	YTD Actual M12	Variance to Plan
	£000's	£000's	£000's
SLA Clinical Income	212,676	233,725	21,049
Other Clinical Income	2,663	2,812	149
Other Income	23,219	28,555	5,336
Total Income	**238,558**	**265,092**	**26,534**
Pay Costs	(153,692)	(167,892)	(14,200)
Non-Pay Costs	(67,588)	(83,117)	(15,529)
Reserves/ Non-Rec	(2,068)		2,068
Total Costs	**(223,143)**	**(251,009)**	(27,866)
EBITDA	**15,415**	**14,083**	**(1,332)**
EBITDA %	6.5%	5.3%	
Depreciation	(10,184)	(9,740)	444
Amortisation	(10)	(10)	(0)
Impairments	0	(898)	(898)
Net Interest	29	21	(8)
Dividend	(4,250)	(4,220)	30
Surplus / (Deficit)	**1,000**	**(764)**	(1,764)
Add back Impairment		898	
Add back Donated Asset benefit		264	
Postion Reported to SHA M11+		**398**	

Appendix 2

Statement of Financial Position as at March 2013

	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		(1,610)	(1,776)	(166)	(1,776)	(1,776)
IN YEAR MOVEMENTS		6,245	10,239	3,994	10,239	10,239
LESS DEPRECIATION		(8,918)	(9,750)	(832)	(9,750)	(9,750)
NET BOOK VALUE	**135,075**	**130,792**	**133,788**	**2,996**	**133,788**	**(1,287)**
CURRENT ASSETS						
INVENTORIES	4,723	4,689	5,023	334	5,023	300
RECEIVABLES						
NHS DEBTORS	5,730	16,188	3,754	(12,434)	3,754	(1,976)
OTHER TRADE DEBTORS	985	1,071	1,579	508	1,579	594
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(424)	(275)	(424)	(275)
CAPITAL RECEIVABLES	31					(31)
NON NHS OTHER DEBTORS	70	339	93	(246)	93	23
COMPENSATION DEBTORS (RTA)	2,554	2,666	2,514	(152)	2,514	(40)
OTHER RECEIVABLES	549	598	645	47	645	96
IRRECOVERABLE PROVISION	(283)	(283)	(433)	(150)	(433)	(150)
PREPAYMENTS & ACCRUALS	1,458	1,491	2,046	555	2,046	588
	10,945	**21,921**	**9,774**	**(12,147)**	**9,774**	**(1,171)**
NON CURRENT ASSETS FOR SALE	300					(300)
CASH	3,944	799	4,342	3,543	4,342	398
NET CURRENT ASSETS	**19,912**	**27,409**	**19,139**	**(8,270)**	**19,139**	**(773)**
CURRENT LIABILITIES						
NHS	1,673	1,747	1,135	612	1,135	638
TRADE CREDITORS REVENUE	3,655	3,014	1,761	1,253	1,761	1,894
TRADE CREDITORS FIXED ASSETS	2,759	2,093	1,744	349	1,744	1,015
TAX AND NI OWED	3,454	3,466	1,796	1,670	1,796	1,658
NHS PENSIONS AGENCY	1,784	1,985	1,975	10	1,975	(191)
OTHER CREDITORS	510	262	441	(179)	441	69
SHORT TERM LOANS	526	812	669	143	669	(143)
ACCRUALS AND DEFERRED INCOME	4,018	8,846	5,962	2,884	5,962	(1,944)
PDC DIVIDEND DUE		1,746		1,746		
STAFF BENEFITS ACCRUAL	629	629	709	(80)	709	
PROVISIONS	1,577	888	3,516	(2,628)	3,516	(804)
PROVISIONS over 1 year	336	360	310	50	310	
NET CURRENT LIABILITIES	**20,921**	**25,848**	**20,018**	**5,830**	**20,018**	**2,192**
TOTAL NET ASSETS	**134,066**	**132,353**	**132,909**	**556**	**132,909**	**132**
FINANCED BY						
PDC CAPITAL	99,635	99,635	100,115	480	100,115	480
REVALUATION RESERVE	34,046	32,485	32,486	1	32,486	(1,560)
DONATED ASSET RESERVE						
GENERAL RESERVES	385	1,068	1,068		1,068	683
I & E CURRENT YEAR		(835)	(760)	75	(760)	(760)
FINANCING TOTAL	**134,066**	**132,353**	**132,909**	**556**	**132,909**	**(1,157)**

Appendix 3

Cashflow statement 2012-13

MONTHLY CASHFLOW	Annual £000s	JUN £000s	SEP £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS							
SLA Base Payments	205,607	18,311	16,677	17,084	20,996	15,183	15,290
SLA Performance / Other CCG investment	27,702		309	3,000		755	16,559
SHA Payments (SIFT etc)	9,229	671	841	1,271	833	880	20
Other NHS Income	20,296	1,108	1,858	1,314	1,036	1,407	3,142
PP / Other (Specific > £250k)	808			291		258	
PP / Other	10,582	796	972	779	1,059	871	925
Salix Capital Loan	381				182	78	
EFL / PDC	480						480
Temporary Borrowing	4,000			3,000	1,000		
Interest Receivable	25	2	1	1	3	2	2
TOTAL RECEIPTS	279,110	20,888	20,659	26,740	25,108	19,436	36,418
PAYMENTS							
Salaries and wages	163,782	13,339	13,433	13,391	13,717	13,842	15,557
Trade Creditors	75,101	5,734	3,908	7,046	6,426	5,526	9,222
NHS Creditors	20,985	1,480	973	3,711	1,677	793	2,273
Capital Expenditure	10,443	763	375	617	581	427	3,604
PDC Dividend	4,164		2,069				2,095
Repayment of Loans	4,000					4,000	
Repayment of Salix loan	238		95				143
TOTAL PAYMENTS	278,712	21,316	20,854	24,765	22,402	24,588	32,893
Actual month balance	398	-428	-195	1,975	2,706	-5,152	3,525
Cash in transit & Cash in hand	37						37
Balance brought forward	3,906	2,003	1,229	1,250	3,225	5,932	779
Balance carried forward	4,342	1,575	1,034	3,225	5,932	779	4,342

Appendix 4

Capital Programme 2012-13

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 12 M12 Plan £000's	M12 Spend £000's	Under (-) / Over £000's	Plan Achieved
Breast Screening Business Case	59	59	59	0	100%
Emergency Care	177	177	172	-5	97%
Endoscopy / Urodynamics	57	57	58	0	100%
Mortuary Refurbishment	55	55	70	15	127%
Macmillan (Trust)	167	167	132	-35	79%
Macmillan (Non Trust)	13	13	13	0	100%
MESC	1,460	1,460	1,356	-104	93%
Estates	3,567	3,567	3,741	174	105%
IT	3,273	3,273	2,911	-361	89%
Pharmacy Robot	183	183	187	4	102%
Radiotherapy Innovation Fund	679	679	679		100%
Endoscopic Ultrasound	307	307	306	-1	100%
Improving Birthing Environments	180	180	141	-39	78%
Other	317	317	416	99	131%
Total - Capital Plan	**10,492**	**10,492**	**10,239**	**-253**	**98%**
Less Charitable Fund Donations	-300	-300	-300	0	100%
Total - CRL	**10,192**	**10,192**	**9,939**	**-253**	**98%**

Resources - Trust Actual Position		SHA Plan
Internally Generated Depreciation	9,739	8,846
SALIX	377	469
Improving Birthing Environments	480	480
Sunnyside - Disposed NBV	300	300
Total - Available CRL Resource	**10,896**	**10,095**
Uncommitted Plan	**-704**	**-156**

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (completed November 2012)
- Pharmacy Robot approved for capital purchase in year
- Endoscopy (only fees in 2012/13) / Urodynamics (initial works completed Sept) - subject to business case approval and charitable funds donation
- The Trust have received £641k Radiotherapy Innovation Funding of which £599k are capital items
- Other costs include £35k Cancer Network Funding and £77k (Topcon scanner & Medaphor scan trainer) - transferred from revenue M6
- The Macmillan scheme works are completed, although final account is under dispute (additional £122k accrued in 2012/13)
- Full year depreciation forecast is £9.739 million (was £9.729 million)
- Following Capital Committee meeting £368k was agreed to slip till next financial year - endoscopy £218k and Estates schemes £150k
- Charitable Donations additions in year was £300k (was £295k)
- The 2012/13 is undercommitted against resource in year by £0.704m (was £0.827m) - additional RIF + depreciation available reduction
- Improving Birthing Environments was notified as a CRL allocation in January of £0.480 million - £141k was spent on the schemne the remaining £339k will be reprovided to complete the works in 2013/14
- Capital Committee approved the purchase of the Endoscopic Ultrasound equipment, Sim Mom and X Ray Trolies

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 24 April 2013	
Title	Human Resources Report
Presented by	Janine Brennan, Director of Workforce & Transformation

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for March 2013 which focuses on the following Human Resource Workforce Indicators for Month 12:

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

RECOMMENDATION: The Board is asked to discuss and support the on-going actions.

WORKFORCE CAPACITY

Substantive Workforce Capacity decreased by 10.98 FTE from 3,979.43 FTE to 3,968.45 FTE which is below the plan (4,278.12 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has decreased by 0.26% to 92.76%.

Substantive Workforce Capacity

Directorate	Month 11 Contracted (FTE)		Month 12 Contracted (FTE)		Budgeted Establishment (FTE)	M12 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	243.42	↓	240.84	↑	268.49	-10.30%	-27.65
Child Health	220.82	↓	220.06	↑	221.97	-0.86%	-1.91
Facilities	278.67	↑	279.83	↑	344.56	-18.79%	-64.73
General Medicine	907.08	↑	908.09	↑	962.43	-5.65%	-54.34
General Surgery	226.44	↑	232.15	↑	242.32	-4.20%	-10.17
Head & Neck	119.26	↑	119.67	↑	128.22	-6.67%	-8.55
Hospital Support	304.04	↓	302.46	↑	346.87	-12.80%	-44.41
Medical & Dental	472.06	↓	464.89	↑	468.86	-0.85%	-3.97
Obstetrics & Gynaecology	335.26	↓	330.56	↑	348.45	-5.13%	-17.89
Oncology & Clinical Haematology	201.92	↓	205.19	↓	198.82	3.20%	6.37
Pathology	186.49	↓	180.95	↑	213.55	-15.27%	-32.60
Pharmacy (Dir)	101.74	↑	100.75	↓	101.65	-0.89%	-0.90
Radiology	117.27	↑	116.89	↓	125.87	-7.13%	-8.98
Therapy Services (Dir)	63.75	↑	63.75	↑	79.37	-19.68%	-15.62
Trauma & Orthopaedics	201.22	↓	202.37	↑	226.76	-10.76%	-24.39
Grand Total	**3979.43**	↓	**3968.45**	↑	**4278.19**	**-7.24%**	**-309.74**

Temporary Workforce Capacity increased by 0.95% to 7.77% and remains above the planned Temporary FTE of 5%.

Temporary Workforce Capacity

Directorate	Month 11 Temporary Workforce (FTE)		Month 12 Temporary Workforce (FTE)	Temporary Workforce Capacity M12 (Percentage)	M12 Variance Against Target (5%) (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	14.45	↑	19.49	7.49%	2.49%	6.48
Child Health	15.24	↓	14.84	6.32%	1.32%	3.10
Facilities	8.48	↑	9.09	3.15%	-1.85%	-5.36
General Medicine	140.19	↑	159.24	14.92%	9.92%	105.87
General Surgery	28.66	↑	37.54	13.92%	8.92%	24.05
Head & Neck	15.05	↓	12.74	9.62%	4.62%	6.12
Hospital Support	17.14	↑	19.68	6.11%	1.11%	3.57
Medical & Dental	N/A		N/A	N/A	N/A	N/A
Obstetrics & Gynaecology	7.26	↑	12.05	3.52%	-1.48%	-5.08
Oncology & Clinical Haematology	15.09	↑	19.90	8.84%	3.84%	8.65
Pathology	7.46	↓	6.30	3.36%	-1.64%	-3.06
Pharmacy (Dir)	0.00	↑	0.00	0.00%	-5.00%	-5.04
Radiology	0.00	↑	0.00	0.00%	-5.00%	-5.84
Therapy Services (Dir)	6.15	↓	5.32	7.70%	2.70%	1.87
Trauma & Orthopaedics	16.12	↑	18.20	8.25%	3.25%	7.17
Grand Total	**291.27**	↑	**334.40**	**7.77%**	**2.77%**	**119.26**

Human Resources Workforce Indicators 2012/13 Month 12

Total Workforce Capacity (including Temporary Staff) % FTE against budgeted establishment FTE has increased by 0.75% from 99.86% to 100.58%.

Total Workforce Capacity (including Temporary Staff)

Directorate	Month 11 Total Workforce (FTE)		Month 12 Total Workforce (FTE)		Budgeted Establishment (FTE)	M12 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	257.87	↑	260.33	↑	268.49	-3.04%	-8.16
Child Health	236.05	↓	234.90	↓	221.97	5.83%	12.93
Facilities	287.14	↑	288.92	↑	344.56	-16.15%	-55.64
General Medicine	1047.27	↑	1067.33	↓	962.43	10.90%	104.90
General Surgery	255.10	↑	269.69	↓	242.32	11.29%	27.37
Head & Neck	134.30	↓	132.41	↓	128.22	3.27%	4.19
Hospital Support	321.18	↑	322.14	↑	346.87	-7.13%	-24.73
Medical & Dental	N/A		N/A		N/A	N/A	N/A
Obstetrics & Gynaecology	342.53	↑	342.61	↑	348.45	-1.68%	-5.84
Oncology & Clinical Haematology	217.01	↑	225.09	↓	198.82	13.21%	26.27
Pathology	193.95	↓	187.25	↑	213.55	-12.32%	-26.30
Pharmacy (Dir)	101.74	↓	100.75	↑	101.65	-0.89%	-0.90
Radiology	117.27	↓	116.89	↑	125.87	-7.13%	-8.98
Therapy Services (Dir)	69.90	↓	69.07	↑	79.37	-12.98%	-10.30
Trauma & Orthopaedics	217.34	↑	220.57	↑	226.76	-2.73%	-6.19
Grand Total	**4270.71**	↑	**4302.85**	↓	**4278.19**	**0.58%**	**24.66**

Temporary Workforce Expenditure has increased by £164,865 from £1,403,403 to £1,568,268 which is equal to 10.85% of the total workforce expenditure.

Recruitment Timeline is below the threshold target at 13 weeks.

Staff Turnover (leavers) has increased by 0.05% on the month to 8.75%, which remains above the Trust target of 8%.

Staff Turnover (leavers)

Directorate	Month 10 Turnover (Percentage)		Month 11 Turnover (Percentage)		Month 12 Turnover (Percentage)	M12 Variance Against Target (8%) (Percentage)
Anaesthesia, Critical Care & Theatres	5.61%	◆	6.11%	◆	6.49%	-1.51%
Child Health	13.98%	◆	14.13%	◆	15.17%	7.17%
Facilities	9.74%	●	9.47%	●	6.82%	-1.18%
General Medicine	6.60%	◆	7.33%	◆	7.73%	-0.27%
General Surgery	8.71%	◆	9.92%	●	8.06%	0.06%
Head & Neck	6.28%	◆	7.20%	●	7.19%	-0.81%
Hospital Support	12.72%	●	12.69%	◆	14.54%	6.54%
Medical & Dental	N/A		7.21%	●	6.84%	-1.16%
Obstetrics & Gynaecology	7.01%	●	6.75%	●	6.37%	-1.63%
Oncology & Clinical Haematology	9.59%	●	8.92%	●	8.48%	0.48%
Pathology	8.75%	◆	10.70%	◆	12.48%	4.48%
Pharmacy (Dir)	6.50%	◆	7.91%	●	7.89%	-0.11%
Radiology	4.92%	●	4.06%	◆	4.48%	-3.52%
Therapy Services (Dir)	12.99%	◆	14.45%	◆	14.51%	6.51%
Trauma & Orthopaedics	7.84%	◆	8.40%	◆	8.92%	0.92%
Grand Total	**8.33%**	◆	**8.70%**	◆	**8.75%**	**0.75%**

HEALTH AND WELLBEING

Short Term Sickness Absence has increased by 0.20% to 2.08% (Trust target 1.4%).
Long Term Sickness Absence has decreased by 0.03% to 2.17% (Trust target 2%).
Total Sickness Absence has increased by 0.17% to 4.25% (Trust target 3.4%).

Sickness Absence Rates

Directorate	Short Term Sickness Rate (Target 1.4%)		Long Term Sickness Rate (Target 1.4%)		Total Sickness Rate (Target 1.4%)	
	Feb-13	Mar-13	Feb-13	Mar-13	Feb-13	Mar-13
Anaesthesia, Critical Care & Theatres	1.18%	2.20%	0.94%	3.04%	2.12%	5.24%
Child Health	2.04%	1.86%	2.99%	2.88%	5.03%	4.74%
Facilities	3.34%	2.28%	3.35%	2.70%	6.69%	4.98%
General Medicine	2.89%	3.09%	2.08%	1.94%	4.98%	5.03%
General Surgery	1.68%	2.21%	4.65%	3.65%	6.33%	5.85%
Head & Neck	1.44%	1.71%	2.55%	0.76%	3.99%	2.47%
Hospital Support	2.22%	1.24%	1.62%	2.56%	3.84%	3.80%
Medical & Dental	0.19%	0.10%	1.12%	1.27%	1.31%	1.37%
Obstetrics & Gynaecology	2.12%	2.57%	2.17%	2.39%	4.30%	4.96%
Oncology & Clinical Haematology	0.56%	2.05%	2.02%	1.66%	2.57%	3.72%
Pathology	1.12%	3.08%	2.77%	1.65%	3.89%	4.73%
Pharmacy (Dir)	1.36%	1.08%	0.00%	0.00%	1.36%	1.08%
Radiology	1.96%	1.01%	2.13%	2.91%	4.09%	3.92%
Therapy Services (Dir)	1.32%	2.08%	2.81%	1.17%	4.13%	3.25%
Trauma & Orthopaedics	1.83%	2.70%	2.89%	2.84%	4.72%	5.54%
Grand Total	**1.88%**	**2.08%**	**2.20%**	**2.17%**	**4.08%**	**4.25%**

Calendar Days Lost to Sickness increased by 808 from 5,365 to 6,173.
No. Days Lost to Sickness per Employee increased by 0.17 from 1.15 days to 1.33 days.

Calendar Days Lost to Sickness Absence

Directorate	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Feb-13	Mar-13	Feb-13	Mar-13	Feb-13	Mar-13
Anaesthesia, Critical Care & Theatres	93	177	87	279	180	456
Child Health	155	158	203	248	358	406
Facilities	275	215	290	248	565	463
General Medicine	855	992	638	651	1493	1643
General Surgery	150	205	348	310	498	515
Head & Neck	51	77	116	62	167	139
Hospital Support	223	137	174	310	397	447
Medical & Dental	24	14	145	186	169	200
Obstetrics & Gynaecology	231	311	232	279	463	590
Oncology & Clinical Haematology	36	150	116	124	152	274
Pathology	62	182	145	93	207	275
Pharmacy (Dir)	45	46	0	0	45	46
Radiology	75	41	87	124	162	165
Therapy Services (Dir)	29	49	58	31	87	80
Trauma & Orthopaedics	132	195	290	279	422	474
Grand Total	**2412**	**2949**	**2784**	**3224**	**5365**	**6173**

Human Resources Workforce Indicators 2012/13 — Month 12

Sickness Absence by Reason

Sickness Reason	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Feb-13	Mar-13	Feb-13	Mar-13	Feb-13	Mar-13
Burns, poisoning, frostbite, hypothermia	0	1	0	0	0	1
Asthma	3	5	0	0	3	5
Skin disorders	9	5	0	0	9	5
Dental and oral problems	22	9	0	0	22	9
Endocrine / glandular problems	31	18	0	0	31	18
Eye problems	35	40	0	0	35	40
Nervous system disorders	35	9	0	31	35	40
Heart, cardiac & circulatory problems	10	16	29	31	39	47
Infectious diseases	54	17	0	31	54	48
Headache / migraine	27	55	29	0	56	55
Benign and malignant tumours, cancers	23	29	58	62	81	91
Other musculoskeletal problems	55	31	58	93	113	124
Ear, nothroat (ENT)	69	59	58	93	127	152
Injury, fracture	76	60	58	93	134	153
Pregnancy related disorders	90	108	58	62	148	170
Back Problems	61	117	116	93	177	210
Chest & respiratory problems	91	148	87	93	178	241
Gastrointestinal problems	83	223	174	62	257	285
Genitourinary & gynaecological disorders	190	74	87	217	277	291
Other known cau- not elsewhere classified	295	161	29	186	324	347
Cold, Cough, Flu - Influenza	159	286	174	62	333	348
Anxiety/stress/depression/other psychiatric illnesses	241	252	435	465	676	717
Unknown cau/ Not specified	953	1226	1479	1550	2432	2776
Total	**2612**	**2949**	**2929**	**3224**	**5541**	**6173**

WORKFORCE DEVELOPMENT

Appraisals are centrally recorded on OLM and are reported on a cumulate 12 month basis. The percentage of staff with completed appraisals for March 2013 was 23.35%, compared to 19.65% the previous month. However, the annual staff survey reports 73% of staff saying they have received an appraisal in the last 12 months. Appraisal reporting mechanisms are under review.

Mandatory Training Compliance remained the same in March 2013 with a Trust total compliance of 65.20%.

Mandatory Training Compliance

Directorate	Month 10 (Percentage)	Month 11 (Percentage)	Month 12 (Percentage)	Variance Against Target (100%) (Percentage)
Anaesthesia, Critical Care & Theatres	68.04%	69.98%	70.18%	29.82%
Child Health	73.69%	77.99%	78.14%	21.86%
Facilities	55.73%	54.69%	54.35%	45.65%
General Medicine	64.46%	67.77%	68.14%	31.86%
General Surgery	63.38%	68.69%	67.18%	32.82%
Head & Neck	57.39%	62.27%	61.39%	38.61%
Hospital Support	61.20%	60.75%	61.89%	38.11%
Medical & Dental	N/A	46.53%	47.77%	52.23%
Obstetrics & Gynaecology	62.17%	63.78%	63.22%	36.78%
Oncology & Clinical Haematology	65.38%	66.73%	66.42%	33.58%
Pathology	68.58%	71.64%	70.15%	29.85%
Pharmacy (Dir)	73.57%	75.05%	74.09%	25.91%
Radiology	79.07%	78.89%	78.19%	21.81%
Therapy Services (Dir)	78.59%	78.39%	77.75%	22.25%
Trauma & Orthopaedics	65.28%	67.57%	67.57%	32.43%
Grand Total	**65.35%**	**65.20%**	**65.20%**	**34.80%**

Forecasts and Risks

In-depth analysis and scrutiny on bank & agency utilisation is on-going, which includes the regular production of reports at directorate & ward level, therefore enabling challenges within areas of high usage.

Following the addition of 125 nursing posts to the establishment in April 2012 to support safe nursing levels across the Trust, we have now successfully recruited to establishment for HCA's and we are on track to recruit to Registered Nurses for general nursing areas by the end of April 2013. On-going recruitment will continue to fill vacancies arising from turnover. This should reduce demand for bank and agency.

Please note: *Due to year end the pay analysis was still in draft form for this summary and therefore, could be subject to adjustments.*

Northampton General Hospital NHS
NHS Trust

Board Meeting – 24 April 2013	
Title: -	Transformation Programme 2012/13
Presented by: -	Janine Brennan – Director of Workforce & Transformation

PURPOSE OF PAPER: -

1. To update the board on the final financial savings achieved through the 2012/13 Transformation Programme.

2. To receive an update on the development of the Transformation Programme for 2013/15.

CRITICAL POINTS: -

1. The Transformation Programme is forecast to deliver £10.506m savings against a plan of £11.1m plan for 2012/13.

2. Care Groups, Corporate and Transformation teams are continuing to work collaboratively to identify schemes for the next two years of the Transformation Programme.

ACTION REQUIRED BY BOARD: -

The Board is asked to discuss and note:

1. The final forecast out-turn delivery of the 2012/13 Transformation Programme.

2. The progress to date on the development of the Transformation Programme for the two years ending 2014/15.

Northampton General Hospital NHS
NHS Trust

Transformation Programme Update
Board Meeting – 24 April 2013

1. Introduction

The agreed year-end target for the Transformation Programme including Directorate and Corporate cost improvement plans was £11.1m. The forecast out-turn stands at £10.506m, which is a marginal improvement of £11k on the position reported to Trust Board in March 2013.

The marginal improvement in the forecast is attributable to savings in overtime payments. The run rate of overtime payments halved for the month of February and this has been sustained into March.

The actual forecast out-turn delivery has improved over the final quarter of the 2012/13 financial year by £250k, due to reductions on overtime expenditure, expediting planned procurement savings and mitigation being identified for smaller schemes which had slipped from their original plan.

Care Groups and Corporate teams, supported by the Transformation PMO are seeking to identify schemes and cost improvement initiatives for the next two years of the Transformation Programme to 2014/2015.

2. Financial Outturn and Quality Impact Assessment delivery 2012/13 Transformation Programme.

The 2012/13 forecast out-turn for the Transformation Programme stands at £10.506m. The positive movement of £11k from the position reported to the Board in February is predominantly due to:-

- Overtime payment reductions were sustained into March 2013 with delivery of the required in month planned reductions.

- A Quality Impact Assessment working group reporting to the Transformation Delivery Group has been established and has finalised the 2012/13 year end Quality Impact Assessment Scorecard

3. Development of the 2013/15 cost improvement plans

- The work stream leadership and project areas for the Transformation Programme over the next two years have been agreed through the TDG and TSB.
- The CIP identification for 2013/15 has continued with Care Groups and Corporate Directorates and assessment of transformation schemes.
- Confirm and challenge meetings have been held through the Integrated Business Planning Process with additional workshop meetings held with Medicine and Women's and Children's Directorates to triangulate CIPs/transformation and on-going contract discussions/budget setting to ensure transparency on the process required for in-year monitoring and reporting.

- To date 88% (£11.5m) of schemes have been quantified. The quantum of schemes which are in delivery is currently at 65% of the £13m (5%) base requirement for 2013/14.
- Additional schemes are currently in development which bridge the shortfall to the £13m minimum 2013/14 5%.
- The Transformation Steering Board has requested a detailed update on the new schemes at the meeting on 7th May 2013.
- Draft Quality Impact Assessments have been completed for schemes in delivery and have been considered and signed off by the respective Care Group Boards,

4. Conclusion

The Trust is final forecast delivery for transformation programme for 2012/13. £10.506m.

Progress has been made to identify a further two years of the Transformation Programme to 2014/15.

6. Recommendation

The Board is asked to discuss and note:

1. The actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.506m savings plan.

2. The progress to date on the development of the Transformation Programme for the two years ending 2014/15.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 24 April 2013	
Title	Self-Certification Return
Presented by	Mr Chris Pallot – Director of Strategy and Partnerships

SUMMARY OF CRITICAL POINTS

A nationally agreed self-certification process based on the Monitor Compliance Framework for NHS Trusts has been introduced as part of the Foundation Trust Single Operating Model (Part two).

The Board is required to sign off one of two governance declarations, either that the Trust is compliant with all requirements or that it is not compliant with some aspect and/or there is insufficient assurance available with the discussion minuted.

The declaration for February is; Governance Risk Rating (Amber Red), Financial Risk Rating (2).

There are a number of Board Statements where the Trust is not fully compliant and for this reason it is proposed that Declaration 2 is signed. The area of non-compliance is:

- Board statement 4 – maintaining a financial risk rating of at least 3 for the next 12 months
- Board statement 11 – compliance with all targets

RECOMMENDATION:

The Board is asked to approve the governance declaration.

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
March 2013
NHS Trust Over-sight self certification template

Returns to emsha.Providerdevelopment@nhs.net by the last working day of each month

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

Name of Organisation:	Northampton General Hospital	Period:	March 2013

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)	AR
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	2

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

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 sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

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

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

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

If Declaration 2 has been signed:

For each target/standard, 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:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**Deficit plan of £4.8m submittd to TDA giving rise to a forecast FRR of 2 for 13/14.**
Action :	**Consdieration of mitigating actions and development of financial recovery plan for 13/14.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**A&E Transit Time = 82.49%, Cancer 62-day urgent ref = 76.5% & 62-day screening referrals = 84.2%**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

oard Statements

Northampton General Hospital

March 2013

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 SOM's Oversight 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 Commission's registration requirements.	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 at all times 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 occurrence 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 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 Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	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 plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
EO			
air			

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Board Action
1	SHMI - latest data	Score	109	109	109	106	106	106	104.8	104.8	104.8	107.8	107.8	107.8	
2	Venous Thromboembolism (VTE) Screening	%	91.4%	91.9%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	
3a	Elective MRSA Screening	%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	
3b	Non Elective MRSA Screening	%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	
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	12	12	17	14	11	10	13	14	24	19	25	35	36 SIs remain ongoing, 3 categorised as pending (final report submitted to CCG, awaiting confirmation of closur 12 new SIs reported 03/13. The increased number of ongoing SIs partly relates to the backlog of pressure ulcers reported 01/13 and 02/13. An internal review shows the number of SIs as a proportion c all incidents has remained stable between 2011/12 and 2012/13.
6	"Never Events" occurring in month	Number	0	0	0	0	1	0	0	0	0	0	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	1	0	0	0	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	1	2	1	1	2	2	4	1	1	2	1	1	
10	Falls resulting in severe injury or death	Number	0	0	1	2	2	0	2	3	1	0	2	1	Comments for March 2013 - 1 incident occurring during t month however 3 SI investigations were implemented relating to this category.
11	Grade 3 or 4 pressure ulcers	Number	2	3	3	2	0	2	3	7	7	6	3	6	March 2013 pressure ulcer figures consist of 4 x grade 3 avoidable, 1 x grade 3 unavoidable and 1 x grade 4 avoidable.
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	50	51	39	48	33	35	44	40	24	68	57	52	
14	Agency as a % of Employee Benefit Expenditure	%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	6.60%	6.60%	
15	Sickness absence rate	%	4.78%	5.0%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	
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	100% of completed consultant appraisals at NGH have signed off PDP. There is no formal recording of the numb of items fully completed versus those carried over to th following year by agreement. NGH is procuring a suitab appraisal software system to allow more meaningful qua assurance for appraisals and back up the current robus paper based system. Discussions are underway with th Revalidation Support Team to develop a more meaningf method of assessing the quality of consultant appraisa rather than merely looking at the number of PDP item completed which in itself is not a robust measure and h not therefore been routinely collected.

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	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	1	2	2	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	2	1	1	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	1	1	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.6**	**2.6**	**1.9**	**1.9**	
Overriding rules								2	2	2	2	
Overall rating								**2**	**2**	**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	Unplanned breach of the PBC	No				
2	One Financial Criterion at "1"		2	2	2	2
3	One Financial Criterion at "2"					
1	Two Financial Criteria at "1"					
2	Two Financial Criteria at "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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	Yes	Yes	Yes	Yes	No	No	£0.4m I&E surplus forecast (subject to audit).
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	Yes	Yes	Yes	Yes	Yes	Yes	TDA plan indicates FRR of 2 for 13/14.
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	No	No	No	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	Yes	Yes	Acting DoF in place from 1/4/13.
7	Interim Finance Director in place over more than one quarter end	No	Yes	No	No	No	No	No	Acting DoF in place from 1/4/13.
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	EFL cash target of £4.3m at financial year end.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	
10	Yet to identify two years of detailed CIP schemes			Yes	Yes	Yes	Yes	Yes	

GOVERNANCE RISK RATINGS

Northampton General Hospital

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data: Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Current Data: Jan-13	Feb-13	Mar-13	Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1d	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	No	No	Yes	No	Unverified data shows 31-day subsequent drug treatment as being achieved for March 2013 but 95.4% for Q4 against the target of 98% 2012-13 year end position: 31-day surgery = 98.3%, drug treatment = 98.0% & radiotherapy = 98.5%
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	No	No	No	No	Unverified data shows 62-day urgent GP referral being 76.5% for March 2013 and 78.9% for Q4 against the target of 85% (Q1 62-days urgent GP referral target not delivered). Also for 62 day screening referrals March shows as 84.2% against a target of 90% but Q4 achieved (91.2%). 2012-13 year end position: 62-day urgent GP referral = 83.0%, 62-day screening referral = 96.2%
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	2012-13 year end position: 98.2%
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	2012-13 year end position: urgent referrals = 96.8% symptomatic breast = 99.4%
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No	No	No	March 2013 = 82.49% 2012-13 year end position = 91.51%
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling - 36*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling - 1*		Yes	No	No	No	No	No	No	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
				TOTAL		**1.0**	**1.0**	**1.0**	**3.0**	**3.0**	**2.0**	**3.0**	
						AG	AG	AG	AR	AR	AR	AR	

RAG RATING :

GREEN	= Score less than 1
AMBER/GREEN	= Score greater than or equal to 1, but less than 2
AMBER / RED	= Score greater than or equal to 2, but less than 4
RED	= Score greater than or equal to 4

	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 breaches the cumulative year-to-date trajectory for three successive quarters	No	No	No	No	No	No	No	
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or significant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No	No	No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No	No	No	
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No	No	No	
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No	No	No	
		Adjusted Governance Risk Rating	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	
			R	R	R	R	R	R	R	

CONTRACTUAL DATA

Northampton General Hospital

Information to inform the discussion meeting

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

Refresh Data for new Quarter

Criteria		Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	No	Yes	Yes	Yes	Yes	Yes	Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	Yes	Yes	Yes	Yes	Yes	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No	No	No	
7	Are the parties already in arbitration?	N/a	No	No	No	No	No	No	
8	Have any performance notices been issued?	Yes	No	No	No	No	No	No	
9	Have any penalties been applied?	No	No	No	No	No	No	No	

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Apr-13

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	Board Action
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	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
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	Not fully achieved		Substantive Director of Finance not appointed through last appointments process. Interim DoF in post. Renumeration Committee looking at longer term solutions.
7	Director of Workforce and Transformation appointed	Nov-12	Fully achieved in time		
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12	Not fully achieved		High level CIPs are identified, fully worked-up implementation plans and QIAs being completed
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12	Fully achieved in time		
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12	Not fully achieved		Full recovery plan in place. All actions are on track to be delivered. The remaining risks to delivery are; the appointment of additional A&E consultants-the Trust has a plan in place to appoint 2 additonal physicians and reduce the number of patients remaining in hospital who no longer need acute care. The Trust is working with commissioners and social care to review this.
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12	Fully achieved in time		
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12	Fully achieved in time		
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12	Fully achieved in time		
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12	Not fully achieved		as per line 10 above
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13	Not fully achieved		
17	Board and sub committee observations	Jan-13	Not fully achieved		Board observations are due to take place in February/March as part of the Quality Assurance and BGAF assessments below.
18	Quality Assurance Framework external assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
19	HDD re-assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
20	BGAF external assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
21	In-month delivery of 95% A&E 4-hour indicator	Feb-13	Not fully achieved		A full recovery plan Progress is monitored through the Urgent Care Programme Board.
22	NHS Acute Service Contract agreed	Mar-13	Not fully achieved		Contract being signed off by 15th April 2013
23	IBP approval by Board	Mar-13	Fully achieved in time		The Trust is on track to sign off the IBP for 13/14 and the TDA submission at the March Board
24	Final LTFM approved by Board	Mar-13	Not fully achieved		Final 13/14 plan approved by Board in readiness for submission to TDA on 5th April
25	Trust/NTDA readiness review meeting	Mar-13	Not fully achieved		TDA annula plan review meeting took place ON 25th March
26	YTD delivery of 4 hour indicator	Mar-13	Not fully achieved		A full recovery plan Progress is monitored through the Urgent Care Programme Board.
27	Delivery of control total for 2012/13	Mar-13	Fully achieved in time		
28	Quarterly review of outcome of Healthier Together	Mar-13	Not fully achieved		The Trust is continuing partnership talks with KGH as part of the next stage of Healthier Together.
29	Board and Sub committee observation	Apr-13		Will not be delivered on time	Board sub committee observation not taking place in agreement with the SHA
30	FT submission to NTDA	May-13		Will not be delivered on time	FT submission not taking place in agreement with the SHA
31	Board interviews	May-13		Will not be delivered on time	Board interviews not taking place in agreement with the SHA
32	NGH/NTDA Board to Board meeting	Jun-13		Will not be delivered on time	Board to Board meeting not taking place in agreement with the SHA
33	NTDA Board approval	Jun-13		On track to deliver	
34	Application submitted to DH	Jul-13		Will not be delivered on time	Application submission to the DH not taking place in agreement with the SHA
35					
36					
37					
38					
39					
40					

Indicator	Details
The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.9% 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%.	
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.
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.
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/mhminds4q) **Denominator:** total number of entries.
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.
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.
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.
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
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.
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.
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://www.connectingforhealth.nhs.uk/healthcare/cancerwaiting/documentation
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.
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 Department of Health's website.
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.
Mental Health: IP 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.
Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
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.
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.
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

TRUST BOARD 24 APRIL 2013	
Title	Corporate Objective 2013/14
Presented by	Mrs Christine Allen, Interim Chief Executive

SUMMARY OF CRITICAL POINTS

At the May 2012 Board meeting, the Board of Northampton General Hospital NHS Trust approved the organisational Corporate Objectives for 2012/13. The objectives were developed to encapsulate the priorities and areas of work for the year. All of the objectives were underpinned by defined outcomes and measures, and detailed action plans for delivery.

At the end of the 2012/13 financial year, the process for developing the Corporate Objectives was replicated to develop the objectives for 2013/14.

This report presents the 2013/14 Corporate Objectives for approval.

RECOMMENDATION:

The Board is asked to approve the 2013/14 Corporate Objectives

NGH Corporate Objectives 2013/14

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner
Strategic Aim 1: Be a provider of quality care for all our patients					
1	Invest in enhanced quality including improvements in the environment in which we deliver care	Demonstrated improved clinical effectiveness as demonstrated through NICE compliance and effective use of clinical audit Reduction in harm to patients as measured through implementation of the patient safety programme Increase nursing establishment through the implementation of the nursing and midwifery staffing strategy	Reduction in SHMI and HSMR Improved CQC Scores Improvements in results of Patient & Staff Surveys Positive PLACE Scores Positive performance of Estate KPIs Progress on Safety Academy Priorities until 2015 Achievement of operating Framework standards e.g. RTT, Cancer Waits, 4 hour transit time Improvements in Healthcare Aquired Infection KPIs Delivery of the Estates Stategy and Capital Programme Improvement in pressure ulcer KPIs	Mar-14	Suzie Loader Dr Sonia Swart
Strategic Aim 2: Enhance our range of hyper acute services and maintain the clinical viability of serivces for the wider community of Northamptonshire					
2	Develop critical clinical care pathways to deliver effective integrated care.	To deliver a safe and sustainable countywide vascular and stroke services A strategic review of cancer services undertaken by 31 October 2013	Completed strategic reviews undertaken with plans of action developed and signed off at Board.	Mar-14	Chris Pallot
3	To develop strategic approaches to stakeholder engagement in order to develop a clinically safe and sustainable organisation. Specifically, develop strategic approaches to relationships with: - Local partners - Commissioners - Local Authorities, Health and Wellbeing Boards - Trust Development Agency - MPs - Regulators	Enhanced clinical links with NHS Nene Commissioning developed Closer links with KGHFT through the establishment of a joint Partnership Board Clinically viable services developed alongside other healthcare partners	Stakeholder strategy reviewed, approved at Board and implemented. PMO appointed to and strategic options developed.	Mar-14	Chris Pallot
Strategic Aim 3: Provide appropriate care for our patients in the most effective way					

NGH Corporate Objectives 2013/14

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner
4	Implement the recommendations of the quality strategy	Demonstrable improvement in quality, patient safety, and patient experience Wards using bi-monthly governance 'ward pack' for sharing of learning from incidents / complaints and evidence of discussion of this	Reduction in omission of medicines by 50% Oxygen correctly prescribed, administered and documented for >90% of patients Number of patients that receive sepsis 6 bundle within 1 hour of arrival in A&E. Improvement of 10% on baseline Number of deaths in hospital (with the aim of monitoring lives saved over 3 years) Number of staff trained in basic human factors in simulation suite Number of patients that receive antibiotics within one hour of sepsis being suspected on the ward Consultant review within 12hours Number of unauthorised EDN's on the ward Audit of action plans from 'Never Events'. Number of actions completed / outstanding Improvements in the friends and families test - • *How likely are you to recommend our Ward to friends and family if they needed similar care treatment?* - 15% response rate per ward, score over 70 • *Were you involved as much as you wanted to be in decisions about your treatment or care?* - 50% Response rate, improvement to 50% positive • *Were hospital staff available to talk about any worries or concerns that you had?* 50% response rate, improvement to 50% positive • *Did you have enough privacy when discussing your condition or treatment?* 50% response rate, improvement to 50% positive • *If you have been prescribed any new medication, have you been informed of any possible medication side effects?* - 50% response rate, improvement to 50% positive • *If you are ready to be discharged - have you been informed about who to contact if you are worried about your condition after leaving hospital?* - 50% response rate, improvement to 50% positive • *Arrival at hospital to bed / ward – did you feel that you had to wait a long time.* Increase on National Inpatient survey score from 7.4 – 8.0 (previously 7.4) *Overall did you feel that you were treated with privacy and dignity while you were in the hospital?* Increase on National Inpatient survey score from 8.6 – 9.1 (previously 9.0)	Mar-14	Suzie Loader Dr Sonia Swart
5	Further develop service planning through utilisation of business intelligence	Specialty scorecards implemented including service line reporting, quality and activity information Clinical acceptance of basis of preparation of service line reporting and confidence to use in decision making Service Line Reporting becomes core to delivering enhanced internal and external planning processes	Speciality scorecards in place. Corporate assurance reporting and decision making based on service line reporting.	Mar-14	Chris Pallot Andrew Foster
Strategic Aim 4: Foster a culture where staff can give their best and thrive					
6	To develop and implement new ways of engaging and supporting staff to enable them to achieve their potential	Improved staff satisfaction, Development of a high performance, patient focussed culture driven by common values, appropriate behaviours and effective teamwork.	Improvements in relevant key findings in the annual staff survey results e.g. staff advocacy rates. Optimal staff turnover rates achieved: within 1% tolerance of 8% target, Reduction in sickness absence from 4.6% to 3.8% Roll out of behavioural framework system and integration with related core systems e.g. appraisal, Increase in mandatory training rates, Increase in appraisal rates from 73% to 80% or greater (staff survey data) and Increase in quality of appraisal ratings from 23% to 35% or greater.	March 2014. Note: this will be part of a 3- 5 year organisational development strategy	Janine Brennan

NGH Corporate Objectives 2013/14

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner
7	To develop and implement an integrated management and leadership development strategy	Improved Management & and leadership effectiveness,	Improvements in management effectiveness indicator ratings in the annual staff survey, for example staff reporting good communication between senior management and staff increasing from 20% to 30%	March 2014. Note: this will be part of a 3- 5 year organisational development strategy	Janine Brennan
Strategic Aim 5: To be a financially viable organisation					
8	To develop an integrated Business Plan that meets operational and financial targets in the short and medium term	Deliver the Income and Expenditure, Capital Resource Limit and External Finance Limit targets Deliver the Transformation programme Deliver and implement the financial governance review To deliver against the Tripartite Formal Agreement, ensuring NGH becomes a Foundation Trust either in its current or alternative form Agreed Long Term Financial Model (LTFM)	Financial targets met Board approved Long Term Financial Model in place and endorsed by the Board Milestones achieved	Mar-14	Andrew Foster

Northampton General Hospital NHS
NHS Trust

Trust Board 24 April 2013	
Title: -	Annual Carbon Management and Sustainability Report
Presented by: -	Charles Abolins, Director of Facilities and Capital Development

PURPOSE OF PAPER: -

To inform the Trust Board of progress made in relation to the Carbon Management Plan and Sustainability initiatives.

CRITICAL POINTS: -

- Carbon reduction target remains on track, despite a much colder than average year
- The effect of last year's Salix investment in energy saving measures will provide a full year benefit in 2013/14
- Project work to deliver Energy Strategy has now commenced
- Sustainability Champions network within the Trust has been set up
- 150 tonnes of Trust waste was recycled during 2012/13

ACTION REQUIRED BY BOARD: -

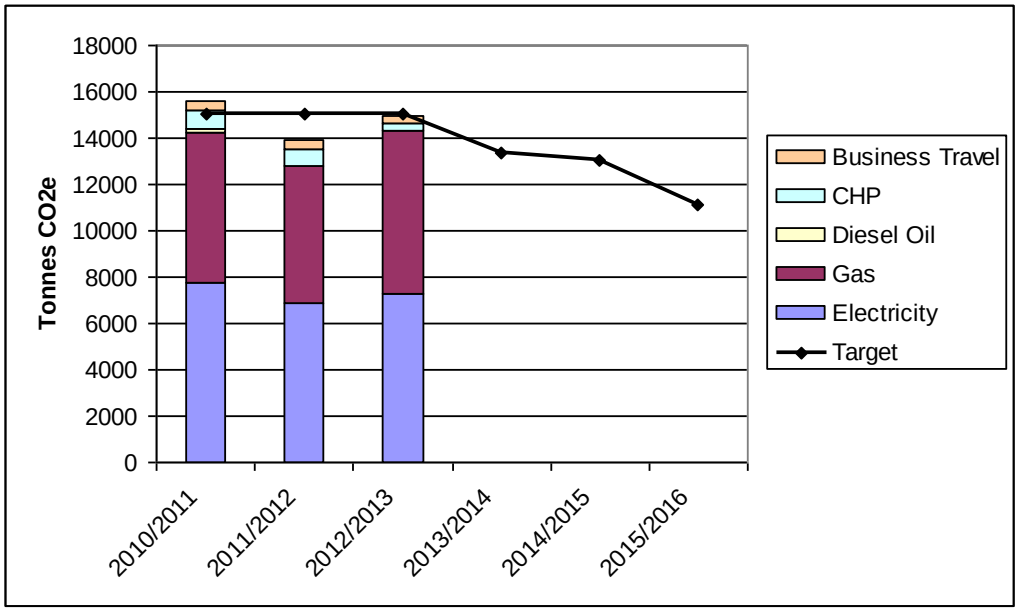
To note the progress made during the year and to continue to support the actions proposed to reduce the Trust's carbon emissions in line with agreed targets.

Annual Carbon Management and Sustainability Report 2012/13

1.0 Carbon Management Plan

In 2011-2012 Northampton General Hospital, in collaboration with the Carbon Trust, launched its five year Carbon Management Plan. This plan committed to achieve ambitious targets for carbon reduction through the identification a number of key projects to be completed over the five year period.

The Carbon Management Plan created a baseline for the emissions based on 2010/2011. Although the emissions from water, refrigerants and waste were included in the initial plan they were not included in the 25% reduction target and are therefore reported separately in this summary. The emissions from buildings and claimed business travel against the set targets are illustrated below.



	2010/2011	2011/2012	2012/2013
BUILDINGS & TRAVEL	15560	13892	14946
TARGET – ALL SOURCES	15042	15058	15075

conversion factors used are those supplied by DEFRA for the relevant years, emissions from refrigerant assumed to be static emissions from refrigerants and water excluded from the total.

Emissions from buildings have shown an increase over the last twelve months. This is due in part to the colder than average year and the reduced running of the Combined Heat and Power (CHP) plants which combined to give an increase in emissions for 2012/2013 of 510 tonnes of CO2e compared to the previous year. Despite this and the increased activity there has been a reduction of 4% since the start of the carbon management plan and we remain within the planned trajectory reaching the target of 15075 tonnes CO2e.
Vehicle emissions have remained approximately static despite the increase in business miles from 1.03 to 1.14 million in the last three years, this is due to a move to less polluting vehicles.

During 2012 the Trust has invested £397k through Salix finance to build on the projects started in the previous year and implement other projects identified within the Carbon Management Plan.

Electricity related emissions will be reduced by 196 tonnes and gas related emission by 150 tonnes through:

- More efficient lighting and better lighting controls (e.g. motion detectors)
- Replacement of external lights with more efficient LEDs (with an associated reduction in maintenance costs)
- Better insulation of steam pipes
- Installation of double glazing and cavity wall insulation in the Outpatient and Biochemistry Departments
- Installation of a pool cover in the recreation centre.

In addition, to better control the environment within the buildings, money continues to be invested in the Building Energy Management System (BEMS). In tandem, a survey of the occupied hours of the various sections of the site has been performed and will be used to determine the heating and cooling regime to be programmed into the BEMS. The installation of 150 sub electricity meters will direct investment energy efficient technologies and energy saving campaigns; down to ward and building level as well as to report energy usage and costs at a department level in the coming year.

2.0 Energy Strategy

In order to achieve the full five year target detailed in the Carbon Management Plan, to improve resilience and reduce back log maintenance it is necessary to replace some of the ageing steam system and CHP plant. A full study to determine the current distribution of energy usage and recommendations on the optimum replacement technologies was undertaken and presented to the Board. The recommendation from this study was the installation of a larger CHP unit and a biomass boiler. The latter has the advantage of lowering carbon emissions, reducing reliance on a single source of fuel and allowing the hospital to take advantage of the government's Renewable Heat Incentive payments. The Trust has now partnered with the Carbon Energy Fund to deliver this project which is expected to be completed within an 18 month time frame.

3.0 Sustainability

Sustainability is now included within the induction programme with the emphasis placed on energy, water and waste, with additional talks given at a department or group level.

Northampton General Hospital was one of the founding members of the Global Green and Healthy Hospitals Network. This is an international collaboration promoting best practice in sustainable healthcare. We committed to moving forward with our newly updated travel plan and have restarted the Bicycle User Group meetings. In addition we are promoting sustainability across the hospital through a network of more than 30 sustainability champions, regular reporting and newsletters.

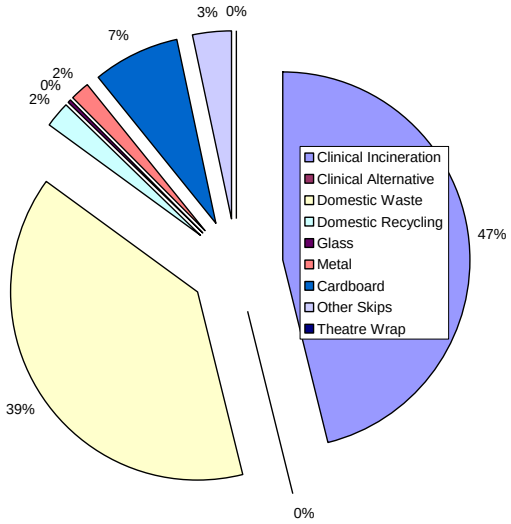
We have worked with SusTrans and, as part of NHS Sustainability Day included Dr Bike FixIt sessions for our cyclists with 23 bikes safety checked and repaired and intend to hold similar events in the coming year.

We are also participating in the local Midlands and East networking events as well as local non-NHS corporate responsibility and high energy user groups.

4.0 Recycling Initiatives

There is a desire within the Trust to improve our recycling rates from the current level of 11% by weight. The Trust has therefore included a doubling of recycling rates in its Sustainability KPIs for the coming year. Over 100 new bins have been delivered to departments around the hospital and additional recycling of metal and plastic has been started and obsolete medical equipment sent for auction. The emphasis for the coming year will be to increase the revenue from the recycling whilst moving to a recycling rate of 25% of all of the waste generated within the hospital.

An analysis of our figures show them to have remained relatively static in the last 12 months.



5.0 Looking Forward 2013/14

- A further £317k of Salix funding has been requested to reduce emissions by 642 tonnes to help to achieve the Carbon Emission target of 13396 tonnes CO_2e for this year, Salix funding will be used to
    - Continue internal lighting upgrades
    - Further improve the BEMS
    - Improve the efficiency of motors using variable speed drives

    - Complete the insulation of our steam and hot water system.
- Trial wireless technology to control buildings, more efficient air filters and steam traps and water saving shower heads.
- Increase recycling rates to 25% of our total waste stream
- Introduce orange and tiger waste streams to the clinical waste
- Create a site-wide system to advertise unwanted equipment across the Trust
- 5% reduction in water usage to be achieved through a series of projects in conjunction with Anglian Water following initial mapping of our water usage.
- NGH will be one of five UK Trusts participating in the Global Green Hospitals online collaboration platform.
- Reinvigorate the Willow Tree garden and allow access to patients and visitors

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 24 APRIL 2013	
Title	Information Governance Report 2012/13
Submitted by	Chris Pallot, Director of Strategy & Partnerships

SUMMARY OF CRITICAL POINTS -

This report summarises the risks and issues arising from the Senior Information Risk Owner review of the Information Governance Strategy and associated work programme and is provided in order to comply with the requirement to report to the Board on an annual basis.

RECOMMENDATION

The Boars is asked to note the contents of this report and the mitigations being applied to the risks

Northampton General Hospital NHS
NHS Trust

INFORMATION GOVERNANCE REPORT 2012/13

1. OVERVIEW

This report outlines current progress to deliver the proposed Information Governance strategy and its associated work programme (see appendix 1).

The Information Governance strategy has been introduced to deliver improvement in the management of non-health records and business knowledge across directorates and departments. The vision is to deliver high quality information at the right time to the right people.

All staff must understand the compliance and best practices required to maximise the value of this asset and requires the provision of skills training to help raise standards and increase knowledge sharing.

2. BACKGROUND

Information governance has a number of dimensions which are outlined below: -

Information Rights Legislation: - A range of legislative requirements set a framework for responding to information requests from companies, media and individuals. Requests relate from personal information to corporate, financial and performance statistics as part of the information rights regime, including data protection and freedom of information statutes. The public, media companies and commercial traders are becoming acutely aware of the scope and impact of information rights. Damaging media stories and fines of up to £500,000 arising from poor Information Governance practice and data losses can cause substantial reputational damage and reduce patient satisfaction.

Information Governance Toolkit: - An annual information governance assessment, via the Information Governance Toolkit, must be submitted on 31 March each year and is shared with the Care Quality Commission to assess performance. Submission of version 10 was established at 81% (appendix 2).

NGH demonstrated strong compliance when benchmarked against local and similar size NHS organisations see appendix 3.

3. KEY INFORMATION ISSUES & RISKS

3.1 Information Governance Toolkit

The Information Governance Manager has just completed submission of the annual Information Governance Toolkit; there are no significant changes to the Toolkit requirements from previous versions and the grading of either Satisfactory or Not Satisfactory remains. Satisfactory is only awarded if all requirements are scored at level 2 or higher; previously 70% achieved a Green grading, this is no longer the case meaning that many more elements could be potentially listed as “not satisfactory”.

The Trust has again used CEAC to provide an interim assessment of our position. The assessment identified two areas where focus is required to ensure delivery of a satisfactory outcome and attain a level 2 status:

- 112 Information Governance Mandatory Training – A report produced in 11/12 indicated that the Compliance rate needed to be at 95%.

  The current training rate is well below the target score of 95%. The IG team have increased the number of classroom based sessions available and promoted the E-Learning module. Although this is having a strong impact in increasing the number of IG training passes, 95% was not achieved. An email from the CEAC assessment auditor stating that the Trust may claim a level 2 was used to support the Trust position in this respect

- 300 – 324 Information Security Assurance – in many elements of this attainment, historic information was used and did not reflect a true position of the Trust. Work was undertaken in this area with IT colleagues to obtain up to date evidence which more appropriately reflected the current status of Information Security to secure a higher attainment level. This included current risk registers and contingency plans

3.2 Risks and Assurance

No serious information breaches have been reported in 2012/3 however there have been incidents of concern.

On more than one occasion patient data breaches have occurred which may be reportable to the Information Commissioners Office (ICO).

No staff members have faced disciplinary action over unauthorised access to information. However there remains an ongoing investigation in respect of such a case

Under the Data Protection Act (DPA), NGH must ensure that appropriate technical and organisational measures are taken against unauthorised, unlawful processing of information and accidental loss.

As part of the safeguards in place, the Trust has a project to encrypt all portable devices (including USB sticks). There is also a clear policy in place for the transmission of confidential information. Any incidents which may constitute a breach of the Act are reported to the Serious Incident Group for advice and investigation.

3.3 Fines for Breaching for the Data Protection Act

Under the DPA the ICO has the power to issue monetary penalties of up to £500,000 for serious data breaches. When serving fines, the Information Commissioner considers the seriousness of the breach, likelihood of substantial damage and distress to individuals and whether the breach was deliberate or negligent as well as what reasonable steps the organisation has taken to prevent breaches.

During 2012/13 the following cases have been published by the ICO

The ICO has urged organisations to review their policies on how personal data is handled, after the Nursing and Midwifery Council was issued a £150,000 civil monetary penalty for breaching the Data Protection Act.

A health trust in Torquay has been served with a £175,000 penalty after the sensitive details of over 1,000 employees were accidentally published on the Trust's website

The ICO has issued a penalty of £60,000 to St George's Healthcare NHS Trust in London after a vulnerable individual's sensitive medical details were sent to the wrong address.

Belfast Health and Social Care Trust has been served with a Civil Monetary Penalty of £225,000 following a serious breach of the Data Protection Act The breach involved the sensitive personal data of thousands of patients and staff, and included medical records, X-rays, scans and lab results, and staff records including unopened payslips.

In April 2007 six local Trusts merged into the BHSC Trust. The merger resulted in the Trust taking on the management of more than 50 largely disused sites, including Belvoir Park Hospital.

30 April 2012
A Welsh health board has become the first NHS organisation to be served a monetary penalty following a serious breach of the Data Protection Act. The Aneurin Bevan Health Board (ABHB) has been issued with a penalty of £70,000 after a sensitive report - containing explicit details relating to a patient's health - was sent to the wrong person.

Brighton and Sussex University Hospitals NHS Trust has been served with a Civil Monetary Penalty of £325,000 following a serious breach of the Data Protection Act The fine is the highest issued by the ICO since it was granted the power to issue CMPs in April 2010.

It follows the discovery of highly sensitive personal data belonging to tens of thousands of patients and staff – including some relating to HIV and Genito Urinary Medicine (GUM) patients - on hard drives sold on an Internet auction site in October and November 2010.

3.4 Prosecutions for Unlawfully Obtaining Information

Unlawfully obtaining or accessing personal data is a criminal offence under section 55 of the Data Protection Act. The offence is punishable by way of a financial penalty of up to £5,000 in a Magistrates Court or an unlimited fine in a Crown Court. It would also be considered as a breach of contract of employment.

A former receptionist at a GP surgery in Southampton has been prosecuted by the Information Commissioner's Office (ICO) for unlawfully obtaining sensitive medical information relating to her ex-husband's new wife.

Appearing at West Hampshire Magistrates she was prosecuted under section 55 of the Data Protection Act, fined £750 and ordered to pay a £15 victim surcharge and £400 prosecution costs

The ICO continues to call for more effective deterrent sentences, including the threat of prison, to be available to the courts to stop the unlawful use of personal information.

4. RECOMMENDATIONS

The Trust Board is requested to: -

- Note the current challenges arising from the Information Governance Toolkit specifically 'mandatory training' and the actions being undertaken to rectify this issue.

- Approve the updated Work Programme, Appendix 1, being led by the Information Governance team

Louise Chatwyn
Information Governance Manager

Sean McGarvey
Head of Information & Data Quality
April 2013

Appendix one – Work Programme Projects

Recommendation	Outcome	Implementation Approach	Timescale (orig / revised)	Progress	Lead Responsible
Review and revise data breach management procedures	Improved investigation and reporting process. Increased efficiency in handling data breaches	Review of current procedure against current process. Review key investigation time scales for areas requiring development.	June 2013		IG Manager
Introduce formal Privacy Impact Assessment process for new projects	Privacy considerations embedded into project planning. Reduced risk of data protection breaches	Integrate process initially with IMT project documentation.	Nov 2012	Understood to be in place	DPC Manager
Develop formal directorate data protection audit process and procedure	Raised awareness of information governance best practice. Reduced risk of information incidents.	Agree schedule and format with DMs. Agree reporting structure and frequency. External peer review of process and documentation.	June 2012	Completed January 2013	DPC Manager
Implement pseudonymisation procedure	Improved use of information for secondary purposes. Improved data processing procedures. Greater compliance with national standards.	Approved pseudonymisation procedure. Promote pseudonymisation within NGH. Monitor and review procedures.	June 2013		IG Manager
Ensure information governance policies and standards are up-to-date and fit for purpose	Best practice information processing across the Trust. Reduced risk of information incidents. Greater compliance	Review current documentation in line with current procedures. Benchmark with national guidance and best practice. Update procedures as required.	August 2013		IG Manager

Recommendation	Outcome	Implementation Approach	Timescale (orig / revised)	Progress	Lead Responsible
	with national standards and legislation.	Promote any new practices. Instigate annual review dates for policies.			
Ensure that all appropriate staff are trained in Information Governance in line with national standards	Improved information governance awareness. Reduced risk of information incidents.	Produce approved classroom session training materials. Monitor training compliance rates for continuous achievement of target rate.	Aim for Jan 2013 allowing Feb/Mar for overspill		IG Manager
Establish effective Information Asset Register	Best practice information processing across the Trust. Accountable individuals for safeguarding information reducing the risk of information incidents.	Integrate IAO process into data mapping process. Establish IA controls.	August 2013		IG Manager
Produce updated FOI Publication Scheme	Enhanced public confidence Compliance with government standards	Wider content available via FOI publication scheme Compliance with Transparency agenda by publishing contracts of £25,000 or greater	August 2013	Partially Complete Disclosure log now published Transparency Agenda remains O/S	IG Manager
Update FOI policy and procedures	Improved FOI case management Promotion of FOI rights	Benchmarking against other organisation's approach to FOI Integrate best practice into NGH documents and processes	March 2013	New policy in force from 2012 – review date 2014	IG Manager
Re-establish IG Steering Group	Established network of IG Leads and toolkit	Meet monthly with a view to enhanced toolkit	June 2013		IG Manager

Recommendation	Outcome	Implementation Approach	Timescale (orig / revised)	Progress	Lead Responsible
	contributors	preparation & evidence			

Appendix Two
IG Toolkit Version 10 Summary Scores

Information Governance Management

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	2	3	5	86%	Satisfactory
	Target	0	0	2	3	5	86%	Satisfactory

Confidentiality and Data Protection Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	6	3	9	77%	Satisfactory

Information Security Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	9	6	15	80%	Satisfactory

Clinical Information Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	1	4	5	93%	Satisfactory

Secondary Use Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	4	4	8	83%	Satisfactory

Corporate Information Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	3	0	3	66%	Satisfactory

Overall

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Current Grade
Version 10 (2012-2013)	Published	0	0	25	20	45	81%	Satisfactory

Appendix three
IG Toolkit Version 10 Benchmarking

Acute Trust	V10 Score	V10 Grade
Trust 1	85	Satisfactory
Northampton	81	Satisfactory
Trust 2	82	Satisfactory
Trust 3	80	Not Satisfactory
Trust 4	73	Satisfactory
Trust 5	77	Not Satisfactory
Trust 6	72	Satisfactory
Trust 7	62	Not Satisfactory
Trust 8	75	Satisfactory
Trust 9	70	Satisfactory

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Wednesday 24 April 2013
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 28 March 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Mrs C Allen	**3**
Clinical Quality & Safety				
09.40	6.	Liverpool Care Pathway Presentation	Dr David Riley	**Presentation**
09.55	7.	Medical Director's Report	Dr S Swart	**4**
10.10	8.	Patient Experience Report	Ms S Loader	**5**
10.20	9.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.30	10.	Operational Performance Report	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr A Foster	**8**
10.50	12.	Human Resources Report	Mrs J Brennan	**9**
11.00	13.	Transformation Programme Update	Mrs J Brennan	**10**
11.10	14.	Self-Certification Return	Mr C Pallot	**11**
Strategy				
11.15	15.	Corporate Objectives 2013/14	Mrs C Allen	**12**
11.20	16.	Annual Carbon Management and Sustainability Report 2012/13	Mr C Abolins	**13**
Governance				
11.25	17.	Information Governance Report 2012/13	Mr C Pallot	**14**
11.30	18.	Any Other Business	Mr P Farenden	
	19.	**Date & time of next meeting:** 30 May 2013 – 09.30am. Boardroom, Northampton General Hospital		

	20.	**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	