Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board

to be held on

Thursday 27 June 2013 at 09.30am

at

The Boardroom
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 June 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Zeidler	
	2.	Declarations of Interest	Mr P Zeidler	
09.35	3.	Minutes of the meeting held on 30 May 2013	Mr P Zeidler	**1**
	4.	Matters Arising	Mr P Zeidler	**2**
09.40	5.	Chief Executive's Report	Ms C Allen	**3**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**4**
10.05	7.	Patient Experience Report	Ms S Loader	**5**
10.20	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.30	9.	Operational Performance Report	Mr C Walsh	**7**
10.40	10.	Finance Report	Mr A Foster	**8**
10.50	11.	Transformation Programme Update	Mr C Porter	**9**
11.00	12.	Self-Certification Return	Mrs K Spellman	**10**
Strategy				
11.05	13.	Nurse Staffing Implementation Strategy	Ms S Loader	**11**
Any Other Business				
11.30	14.	Any Other Business	Mr P Zeidler	
	15.	**Date & time of next meeting:** 24 July 2013 – 09.30am. Boardroom, Northampton General Hospital		
	16.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Zeidler	

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on
Thursday 30 May at 9.30am
Boardroom, Northampton General Hospital

Present:

Mr P Farenden	Chairman
Mr C Abolins	Director of Facilities & Capital Development
Mrs J Brennan	Director of Workforce and Transformation
Mr A Foster	Acting Director of Finance
Mr G Kershaw	Non-Executive Director
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr D Noble	Non-Executive Director
Mr N Robertson	Non-Executive Director
Mrs E Searle	Non-Executive Director
Dr S Swart	Medical Director
Mr C Walsh	Interim Chief Operating Officer
Mr P Zeidler	Non-Executive Director

In Attendance:

Mrs D Needham	Care Group Director – Medicine
Dr J Timperley	Cardiology Consultant - (Agenda Item 12)
Mr C Sharples	Head of Corporate Affairs
Ms K Spellman	Deputy Director of Strategy and Partnerships

Apologies:

Mrs C Allen	Interim Chief Executive
Mr C Pallot	Director of Strategy and Partnerships

TB 13/14 020 Declarations of Interest
No further interests or additions to the Register of Interests were declared.

TB 13/14 021 Minutes of the meeting held on 24 April 2013
The minutes of the Board meeting held on 24 April 2013 were presented to the Board for approval.

Mr Foster noted the penultimate paragraph of minute TB 013/14 015 should read “Mr Abolins advised that the Trust Would not see a benefit from the additional investment until 2014/15”.

Subject to that amendment, The Board APPROVED the minutes of 24 April as a true and correct record.

TB 13/14 022 Action Log and matters arising
All actions and matters arising were considered.

TB 13/14 023 Chief Executive’s Report
Dr Swart presented her report to the Board which highlighted key business and service developments in Northampton General Hospital NHS Trust in recent weeks.

She reported that there had been national recognition of emergency care issues which many acute trusts including Northampton General Hospital NHS Trust were experiencing. The Board was informed that measures which had been introduced locally to improve performance were beginning to take

effect, and staff should continue to be supported with this.
The Board was advised that planning was underway for the Northampton General Hospital NHS Trust festival which would take place to coincide with the Annual General Meeting on the 14 September 2013. The festival would be a celebration of good work undertaken at the Trust, with tours and performances from the Trust Choir. Locally community groups would also be in attendance and performing.

With regard to the Listening into Action programme, Dr Swart reported that in building on the work of the first wave of the programme, the second wave of teams were starting, including teams from Pharmacy, Nuclear Medicine, Children's Physiotherapy, Community Midwifery and others. Mr Kershaw commented that he had attended a Listening into Action event recently and was heartened with the enthusiasm that was shown and the quality of the ideas being discussed.

The Board was informed that the Trust had continued to extended its reach and influence through the use of social media. Social media was used by staff, patients and carers and aimed to increase the ways in which the Trust communicated with staff, patients and others.

Dr Swart reported that the Executive Team had agreed that the role of Senior Information Risk Owner be assigned to Mr Sharples, Head of Corporate Affairs whilst Mr Pallot was seconded from the Trust. The Senior Information Risk Owner should be an Executive or Senior Manager on the Board familiar with information risks and the Trust's response to risk.

TB 13/14 024 Medical Directors Report

Dr Swart presented the Medical Directors Report to the Board.

Dr Swart introduced section one of the report – the review of current mortality and safety data provided by Dr Foster, and advised that due to national data sharing issues, she was unable to provide an update for May 2013 on the Hospital Standardised Mortality Rate (HSMR). Hospital Standardised Mortality Rate data had been interrogated in month in relation to the impact Community Hospitals had on the HSMR. The work had concluded that a fall in the HSMR of two would result if patients admitted directly into those sites by other providers were removed from the calculation. This combined with corrected palliative care coding would lower the HSMR and the Standardised Hospital Mortality Indicator (SHMI although it would not affect the actual death rate.

Dr Swart advised the Board that there had been significant media interest in higher mortality rates for surgery carried out on particular days of the week, notably Friday. The Board was assured that was not the case at Northampton General Hospital NHS Trust.

Dr Swart advised the Board that there continued to be cause for concern in relation to mortality from fractured neck of femur. She reported that all deaths continued to be reviewed, and the Clinical Director presented their findings to the Healthcare Governance Committee. It was clear from the work that no single factor had been identified which would explain the high mortality and as such, a bundle of measure likely to improve care was being implemented in addition to the improvement plan developed in conjunction with the Surgical Care Group for the group of patients.

The Board was informed that a detailed case review of 50 consecutive deaths

had been concluded. The findings of the review were broadly similar to those identified in a larger review carried out in 2012, although it was clear that the significant emergency pressures were hampering progress in resolving the issues identified to an extent. The Board was assured that the current focus on emergency care allied with the patient safety programme should result in an overall improvement.

Dr Swart reported that a key stroke outcome measure was improving and was reported as significantly better than expected, and a key colorectal measure had also significantly improved. The improvements could be attributed to increased investment in those areas and the continued hard work of staff.

Dr Swart informed the Board that within A&E, it has been agreed that there was a need to continually strengthen the systems for escalation of care, speciality review and the medical ownership of patients who had been seen by a speciality team but were still in the Emergency Department. To this end, the clinical lead in A&E had developed a number of key metrics to be put in place.

Dr Swart summarised the learning from serious incidents and never events. She advised the report provided the Board with an overview of the actions and improvements required as a result of investigations into serious incidents in order to improve the quality of care to ensure that learning happens. With regard to never events, the Board was informed that the Trust had had five never events in a four year period. The never events were five surgical events which should be considered in the context of 500,000 procedures, and no serious harm had occurred as a consequence. Learning from the never events had been amalgamated to inform learning and avoid reoccurrence.

In summarising section one of the report, Dr Swart reminded the Board of the need to pay close attention to mortality due to a slight deterioration in the position from last year as reported in the April 2013 Board report. Mr Farenden commented that the Trust had made significant progress, but the Board must maintain attention and focus on mortality rates.

With regard to pressure ulcers, Ms Searle asked if there was sufficient equipment available. Dr Swart advised that there had been equipment issues identified which were being addressed. Ms Loader added that the contract in place for the provision of equipment was being reviewed to ensure that appropriate equipment and training was in place.

In relation to never events, Mr Robertson commented that the Trust had not had any reported incidents which appeared to be national issues and asked what the Trust had done correctly to ensure that it had not had those issues. Dr Swart advised that there had been a strong focus issues such as on wrong site surgery reporting, adding that checklists were in place and followed rigorously to ensure mistakes did not occur.

Mr Walsh asked when the HSMR data would be available. Dr Swart advised the data would be available to inform the June 2013 Board report.

Dr Swart presented section two of the report – The National Quality Dashboard. She advised that the national quality dashboard consisted of national indicators which informed local performance to enable organisations to focus on quality improvement. The dashboard would be strengthened in

the future through the addition of intelligence based on local indicators. In presenting the Trust's performance against the indicators, Dr Swart highlighted the following metrics:

- Timely care – A and E patients waiting more than 4 hours- performance was improving compared to the previous position and now comparable to other Trusts.

- Organisational indicators – nurses to bed ratio (reported as to January 2013) – improved following recruitment and now stood at 1.46. The figure remained lower than other Trusts but further clarification of the bed base and metrics was required.

With regard to high bed occupancy rates, Mr Robertson asked how the Trust compared to other Trusts locally. Dr Swart advised that greater confidence in the underpinning data was required to answer the question accurately. Currently the picture presented was not a positive one, but as the quality of data improved regionally, so would the Trusts performance.

Mr Zeidler asked if the Trust's nurse to bed ratio was average compared to other Trusts. Ms Loader advised that the national ratio stood at 1.92 which the Trust was currently below. Dr Swart added that clarification of bed base and metrics would improve that position. Ms Searle asked if agency staffing were included in the ratio. Dr Swart confirmed that they were not.

Dr Swart presented section three of the report – the Trust Monthly Quality Scorecard. She informed the Board that a total of 130 indicators were monitored through the scorecard, with only the exceptions reported to the Board.

In summarising the exceptions, Dr Swart reported that there had been seven cases of Clostridium Difficile reported in April 2013 in part to inappropriate reporting and an outbreak of norovirus. Monitoring and antibiotic surveillance had improved as a result.

One safety alert remained open past its due date. The alert was related to safer spinal epidural and regional devices and was reliant on the national availability of equipment. The Board was informed that the alert would be closed when the equipment became available.

The Trust did not meet the 100% target for patients with fractured neck of femur operated on within 48hours of admission. Sixteen of the seventeen patients for surgery had their operation within the 48 hours; the remaining patient had eaten and as such was unable to be operated on that day.

The elective C-section rate in April was at 16.5% which could possibly be attributed to higher risk patients electing for C-sections, with supporting NICE guidance also having an impact. Emergency rates reminded below target. The elective rate pushed the Trust above overall target.

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

TB 13/14 025 Patient Experience Report

Ms Loader presented the Patient Experience Report to the Board.

In introducing the report, Ms Loader informed that Board that the algorithm for recording and scoring the results of the Friends and Family Test (FFT) had

changed from April 2013. As a result, the Trust was only able to monitor the response rate of the FFT until national data was published in July 2013, which would enable benchmarking. The response rate in April 2013 was 18.78%. Ms Loader reported that the results and comments received through the FFT were being systematically disseminated to wards to drive improvement with responses and progress followed up through patient experience leads. No meaningful themes across the trust had been defined to date. Ms Loader advised that the results from the FFT would be triangulated with the outputs of the infection control audits and patient experience audits to ascertain any commonalities, which would be reported in the June 2013 Board report.

Ms Loader reported than an action plan to address the areas of poor performance from the Patient Survey results had been developed and mapped into existing action plans, for example A&E actions had been mapped into the urgent care programme.

Ms Loader advised that Patient Experience Clinical Leads were being recruited to drive the patient experience agenda, although there had been some difficulty in recruiting to the posts. A patient experience champion had been identified within the Medicine Care Group who would be looking to pilot the nationally recognised '15 Steps' audit to understand how it could be most effectively used within the Trust. Further pilots included the use of new appointment letters within cardiology and a mystery shopper reviewing signage around the Trust.

Ms Loader informed the Board that further work was underway to identify and improve:

- Noise at night
- Mealtime experiences
- The use of the Carers Strategy
- The experiences of People with and caring for someone with Dementia
- The Friends and Family Response rates
- Clinician communication – via two 'Goldfish' Bowl sessions
- Peer on Peer assessment / shared learning – via the use of the '15 Step' challenge

Ms Searle asked if the FFT must be completed prior to a patient leaving the hospital. Ms Loader confirmed that national rules dictated the FFT must be completed on the day of discharge.

Mr Kershaw asked what the underpinning issues which had been raised by the Mealtime Survey Audit were and by when would they be addressed. Ms Loader advised that the issues were to do with, amongst other things, access to wipes, timeliness, the environment and protected meal times being protected. Ms Loader confirmed she would confirm the timescales for the implementation of actions to the June 2013 Board.

ACTION: Ms Loader

The Board **NOTED** the Patient Experience Report.

TB 13/14 026 **Monthly Infection Prevention Performance Report**

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

Ms Loader informed the Board that April 2013 had seen an increase in the number of identified Clostridium Difficile cases, seven cases against a ceiling of four, bringing the total number of cases for 2013/14 to nine. The increase in the number of cases in April was attributed to an outbreak of norovirus and increased sample testing. Ms Loader advised that upon investigation of the seven cases, it became clear that five of the seven cases showed no clinical indication of Clostridium Difficile and were related to the use of laxatives. Subsequently, measures have been introduced to ensure future samples are appropriate as per protocol.

Ms Loader reported that there had been no reported cases of MRSA Bacteraemia during April 2013. With regard to MRSA screening, elective screening achieved 99.9% whilst emergency screening achieved 96.4%. Ms Loader confirmed that there were no wards on special measures.

Ms Loader advised that as reported earlier, there had been an outbreak of norovirus on four wards. Due to the hard work of the staff on those wards the outbreak had been contained quickly – Ms Loader wanted to congratulate the staff for their proactive action.

The Board was informed that the scalded skin outbreak had been officially closed.

Ms Searle asked what learning there had been from the investigation into the scalded skin outbreak. Ms Loader advised that the investigation report was near conclusion but it was clear that there was a great deal of learning identified, in particular in relation to the methodology used for swabbing possible staff carriers and the way the trust conducts environmental audits.

Mr Robertson asked if the inappropriate samples which led to the increase in Clostridium Difficile cases was a one off or was it indicative of a systematic issue. Ms Loader responded the issue was not a systematic one. The increase in testing was due to the norovirus outbreak, staff were more diligent in their efforts to contain the outbreak.

The Board **NOTED** the Monthly Infection Prevention Performance Report.

TB 13/14 027 Francis Report Update

Ms Loader presented the Francis Report Update to the Board.

She informed the Board that the report provided an overview of the Government's response to the Francis Report and in turn, presents the findings of the Trust's reverse gap analysis, a comprehensive action plan and further actions and next steps required.

Ms Loader advised that the reverse gap analysis had been performed against the 290 recommendations made within the Francis Report and identified those actions would could be acted upon immediately and those actions for which the Trust is obliged to await further national direction. The gap analysis took account of the views of staff which had been expressed at listening events, the Trust's current improvement strategies, consultation with Care Group Management Boards and re-checking against the 290 recommendations to determine gaps.

Ms Loader presented the findings of the reverse gap analysis and advised that they clearly articulated the areas where the Trust was meeting the recommendations of the report, where there were programmes of work

underway to improve performance against recommendations and areas where further work was required to address identified gaps.

The Board was informed that the listening events identified issues about culture, leadership and accountability. The issues had been explored in more detail and it was agreed that the outputs would be used to inform the Organisation Development strategy which was under development.

In summarising the next steps following the reverse gap analysis, Ms Loader advised that work would continue to implement the actions contained within the action plan with quarterly reports presented to the Board which will present achievement against existing and new work streams, present performance into a succinct report. Ms Loader reiterated that new work streams would be identified in the future as national guidance was awaited for over half of the recommendations within the Francis Report.

Mr Farenden asked if there was an area within the action plan which presented real concerns. Dr Swart advised that many of the recommendations had already been addressed historically. She commented that she felt the biggest challenge would be embedding the behavioural and cultural change required to implement the organisation development plan effectively.

The Board **NOTED** the Francis Report Update and **APPROVED** the next steps and future reporting arrangements.

TB 13/14 028 **Staff Survey Report**

Ms Brennan presented the Staff Survey Report to the Board. In presenting the report, Ms Brennan reported that the results of the staff survey for the Trust had remained largely unchanged for the previous 10 years, which was indicative of a cultural issue.

Ms Brennan advised that she had reviewed the numerous action plans which had been prepared in response to previous staff surveys which had proved ineffective, had had concluded that she would not prepare another action plan in response to the latest survey but would focus resources on developing the Organisation Development Plan. Work would also focus on understanding the apparent disconnect between the results of the staff survey and other sources of information.

Ms Brennan added that all of the issues identified related to patient experience required integrating to build an effective staff engagement strategy which would form a fundamental part of the Organisation Development Plan. To inform the plan, diagnostics would be conducted to understand what would make a difference to staff.

Ms Brennan presented to the Board actions which were to be introduced immediately, including conducting a survey on communications, engaging staff in developing a values and behaviour framework, establishing an organisation development reference group and developing a training programme to build the capability of line managers.

Mr Farenden commented that his experience of ward visits had shown that staff within the Trust were highly committed towards patients. He questioned if the Board could improve its communication particularly in relation to leadership and presenting clarity of purpose to ensure staff are committed

corporately as well as to patients. He added that he felt the Board needed to become more visible and take ownership of the issues. Ms Brennan agreed that staff were committed to the provision patient care, but a more rigorous assessment was required.

Mr Zeidler observed that the Stakeholder Engagement Strategy would be key to ensuring the success of the Organisation Development Plan.

Dr Swart stated that she wholeheartedly supported the approach being taken, but reiterated that the work required the investment of time from senior staff. The challenge to taking the work forward would be to ensure that senior time is consistently available to support managers.

Mr Kershaw observed that there were a number of indicators within the report such as turnover and length of service which was indicative of staff under pressure. He commented that the implementation of the Organisation Develop Plan and Staff Engagement Strategy would be long terms and issue such as those should not be overlooked in the immediacy. Ms Brennan agreed and advised that the Trust needed to understand the issues and challenges presented and work would then begin to develop a comprehensive management and development programme specific to the Trust.

Mr Farenden welcomed the work Ms Brennan was undertaking and stated that it was fundamental to the success of the Trust.

The Board **NOTED** the Staff Survey Report.

TB 13/14 029 **Operational Performance Report**

Mr Walsh presented the Operational Performance Report to the Board which set out the key areas of performance for the Trust in April 2013.

He reported that during April 2013, the Trust achieved all of the 18 week standards of 90% for admitted and 95% for non-admitted patients treated across all specialities. All patients had their diagnostic test carried out within six weeks of request and the Trust achieved all of the stroke standards.

In updated performance against A&E clinical indicators, Mr Walsh reported that there continued to be significant pressures from non-elective demand across the Trust in April, meaning the trust substantially underperformed against target with 87.9% of patients admitted, transferred or discharged from A&E within four hours against a target of 95%. Mr Walsh advised that performance against the target was reliant on efficient patient flow throughout the hospital and the wider health economy which in turn allowed A&E to function effectively.

Admissions and attendance at A&E remained high and above plan. The urgent care programme continued in place to improve flow though the emergency pathway, and had begun to impact on performance in A&E, with most recent data showing that 96% of patients were being admitted, transferred or discharged within four hours.

Mr Walsh reported that the Trust met all cancer standards in April with the exception of the 62 days from screening to start of first treatment. He added that it was unlikely that the target would be met for May also. He stated that it had become evident that there was not a sustainable position for the delivery

of the service, and that a great deal of work was ongoing to ensure that the cancer pathways were brought into a sustainable position.

Mr Farenden commented that the Trust was now adrift from the A&E trajectory which had previously been presented and requested that a revised trajectory be presented to the Board. Mr Walsh advised that since the report was produced, the Trust was now exceeding the planned trajectory and as such it was anticipated the Trust would achieve a cumulative 95% compliance by August.

ACTION: Mr Walsh

Mr Farenden stated that the Trust remained continually vulnerable regarding compliance with the cancer standards and requested that an action plan be presented to the June 2013 Board meeting to urgently remove the vulnerability.

ACTION: Mr Walsh

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

TB 13/14 030 **Urgent Care Report**

Dr Timperley was introduced to the Board. He provided an update on the progress and impact of the ambulatory care pathways element of the urgent care programme.

He reported that the three months data which was available showed the pathways were working well and making a considerable difference to discharges before 13.00 and the average length of stay. Further work was being considered such as expansion of hot clinics and, based on national good practice the establishment of an ambulatory care centre which had the potential to lead to 30 less patients per day attending A&E.

Ms Needham presented an overview of urgent care performance reported that full year performance for 2012/13 against the monthly transit target was 91.5%, although that was presented in the context of an increase of 2% in attendances and 5% in emergency admission on the previous year. In benchmarking performance against acute Trusts within the East Midlands for April 2013, Ms Needham advised that the Trust performed just below average.

In response to poor national performance against the monthly transit target for A&E, Ms Needham informed the Board that a letter had been received from Barbara Hakin, Chief Operating Officer of NHS England which required local health economies to establish a county wide urgent care board to develop a combined recovery plan to address performance. The plan would then be reviewed and monitored by the Trust Development Authority, Monitor and NHS England. Mr Walsh informed the Board that the Trust Development Authority had emphasised those points at a recent urgent care summit he attended.

Mr Farenden asked if local discussions with partners reflected the national urgency. Ms Needham advised they did, but pulling together a combined plan would be challenging.

Mr Farenden commented that other parties would not be able to act as quickly Northampton General Hospital NHS Trust and as such, the Trust needed to collectively and cohesively with partners to ensure success. He questioned what more the Trust could do to emphasise that message and its

urgency. Ms Needham advised that the Local Area Team would be vital to ensure that a consistent message was delivered and to drive the local urgent care board.
Mr Walsh stressed that the Trust must be ambitious with its plans, and should expect the same rigour in response from partners as would be expected from staff internally.

Dr Swart commented that projects were in place which were the right things for patients and were beginning to make a difference. She added that the Trust needed to be robust with the standards expected of partners, and the Local Area Team could be the lever to enable system wide change.

Mr Noble observed that the work delivered by the urgent care programme was having a demonstrable positive impact on performance and questioned how pace could be injected into the relationships with partners to avoid undoing the work of the programme, in anticipation of winter pressures. Mr Farenden advised that the recent letter from the Secretary of State to the Trust Development Authority could be the catalyst for that.

Mr Robertson noted that the NHS England briefing proposed an increase in the numbers of junior and middle grade Doctors in training and asked what the impact of that was. Mr Walsh advised that it presented a significant risk to NHS trusts as a whole, which in turn had the possibility to restrict the availability of high quality physicians to work in A&E. Dr Swart added that the availability of high quality physicians was a national issue that had been ongoing for some time.

The Board **NOTED** the Urgent Care Update.

TB 13/14 031 Finance Report

Mr Foster presented the Finance Report to the Board.

In presenting the report, Mr Foster advised that the annual plan for the Trust which had been agreed with the Trust Development Authority presented a forecast income and expenditure deficit of £4.8m, inclusive of the £13m cost improvement target. He advised that there was risk associated to the delivery of £4.5m the £13m required cost improvement plan.

A range of business cases had been approved for funding from reserves including additional investment in A&E, Paediatric Assessment Unit, Surgical Assessment Unit and level one beds on Rowan Ward. The net impact was a reduction in the level of reserves which stood at £1m at the end of April, reducing the level of flexibility for further unplanned developments or contingencies for the remainder of the financial year.

Mr Foster advised that the cash flow problems which were reported to the April Board had largely been resolved, although there had been a negative impact on the Trust's better payments performance. With regard to future liquidity issues, the annual plan included a requirement for up to £6m additional cash support for 2013/14. The Board was informed that work was ongoing to determine the extent of requirements for the remainder of the year and a recommendation would be made to the June Finance and Performance Committee.

In summarising the report, Mr Foster advised that the Trust was performing according to plan although he expected a financial recovery plan would be required in response to the deficit plan submitted to the Trust Development

Authority.

Mr Zeidler observed that within the Workforce Report, the Trust worked on the premise that when working to full establishment there would remain a requirement for temporary staffing, equating to roughly 5% of the budgeted workforce. He commented that there did not appear to be a budget for temporary staffing identified. Mr Foster advised that the Trust did not budget for the use of temporary staff. Mrs Brennan informed the Board that the quantum of the requirement for temporary staffing was required to inform the budgeting process. Mr Farenden requested that the workforce and finance reports be aligned to present consistent data.

Action: Mr Foster/Ms Brennan

Referring to the risks presented in table seven of the report, Ms Searle asked of the Trust understood the full impact of the reduction in funding from the LETB. Mr Foster advised that it was becoming clearer but the final position would not be available until the LETB approved its financial plans. Dr Swart assured the Board that there were plans in place to mitigate the impact on the Trust.

The Board NOTED the Finance Report.

TB 13/14 032 Human Resources Report

Mrs Brennan presented the Human Resources Report to the Board.

In presenting the key points from the report, Mrs Brennan reported that there had been an increase in the substantive workforce employed by the Trust of 7.15 full time equivalents. Temporary workforce capacity decreased by 1.50% to 6.27%, which remained above target of 5%.

Mrs Brennan that for the reporting period, staff turnover had increased by 0.14% which could be attributed to a number of staff retiring.

The Board was informed that short term sickness absence had decreased by 0.27% to 1.81% whilst long term sickness absence had increased by 0.04% to 2.21%. As such, total sickness absence had decreased to 4.56%.

With regard to appraisals the Board was informed that a task and finish group had been established to explore the apparent disconnect between the results of the staff survey and the centrally held data.

The Board **NOTED** the Human Resources Report.

TB 13/14 033 Transformation Programme Update

Mrs Brennan presented the Transformation Report to the Board.

She reported that the latest forecast delivery of the programme was £10.9m savings against a plan of £13.0m for 2013/14. The Care Groups, corporate and transformation teams continued to work to identify further options and develop schemes to mitigate the shortfall. In month performance was reported at £5k below plan.

The Board was informed that the Executive Team, supported by the Transformation Delivery Group were focussed on the identification and delivery of further non-recurrent schemes to mitigate the shortfall and build in increased head room to the 2013/14 target.

Mrs Brennan informed the Board that she was planning to integrate transformation into the organisational development plan in moving forward. She advised that 70% of the transformation programme was assigned to be delivered by individual departments, and the programme needed to focus more on wider transformation driven thorough staff engagement taking into account the future business needs of the Trust.

Mr Farenden commented that the Board was feeling nervous about the delivery of the savings from the transformation programme and requested that a plan be presented to the June Board which closed the gap and presented scope for slippage.

Action: Mrs Brennan

The Board **NOTED** the Transformation Report.

TB 13/14 034 **Self-Certification Return**

Ms Spellman presented the Self-Certification Return to the Board. 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 two. As such, Ms Spellman recommended to the Board that declaration two of the return be signed.

The Board **APPROVED** the signing of declaration two.

TB 13/14 035 **Communication and Stakeholder Engagement Strategy**

Ms Spellman presented the Communication and Stakeholder Engagement Strategy to the Board.

She advised that the strategy set the overall framework of how the Trust intended to communicate and engage with its stakeholders in 2013/14, building on the previous strategy and was closely linked to the Patient Experience and Engagement Strategy.

The key developments for 2013/14 presented by the strategy were the development of a culture of staff engagement, evoking a step change in internal communications, expanding communications to new media and strengthening relationships with wider partners and stakeholders.

Mr Farenden observed that the strategy presented a significant amount of work, required ownership at the highest level and its implementation needed to be within the context of the cultural issues the Trust was trying to address.

Mr Zeidler commented that the implementation programme presented in the strategy was extensive and wondered if the timescales presented were realistic, in part due to the cultural change required to ensure the strategy was successful. He added he felt the strategy was a good building block but required underpinning by a more focused and specific action plan.

Dr Swart commented that the strategy would need to be linked to the organisational development plan as it was implemented. Mrs Brennan added that the strategy would need to evolve as the staff engagement strategy developed.

Mr Kershaw commented that a combined action plan should be developed based on the implementation of the strategy, organisational development plan and the staff engagement strategy once they were all approved to reduce overlap and duplication.

Mr Farenden commented that the combined plan would be fundamental in ensuring success and requested that updates be brought to the Board on a quarterly basis.

The Board **APPROVED** the Communication and Stakeholder Engagement Strategy.

TB 13/14 036 Annual Security Management Report

Mr Abolins presented the Annual Security Management Report to the Board.

In presenting the report, Mr Abolins reported that there were 355 reported incidents relating to criminal activity, physical assaults, verbal abuse and disturbances in 2012/13. That was a decrease of 6.5% on the previous year.

A total of 21 confirmed crimes and thefts had been reported, a reduction of 25% on the previous year. Due to good detection rates by the security team, a number of prosecutions had been successful against offenders, particularly in relation to the theft of staff property.

To support staff which care for difficult and challenging patients, staff had been supported and trained in the use of proportional restraint to reduce the risk to themselves and patients, with positive feedback. Mr Abolins added that the target for the forthcoming two years was to train approximately 1000 staff in break-away, low level intervention and restrictive physical techniques to provide staff with the skills to make situations safer. Ms Loader thanked Mr Abolins for the support staff had received in regard to the training, and the impact could be demonstrated in the reduction of incidents against staff.

Mr Abolins advised that the key developments planned for 2013/14 would include the improvement of staff identification arrangements.

The Board **NOTED** the Annual Security Management Report.

TB 13/14 037 Trust Development Authority Accountability Framework

Ms Spellman presented the report to the Board which outlined the key points from the recently published NHS Trust Development Authority's Accountability Framework.

The Board were informed that the NHS Trust Development Authority's Accountability Framework sets out the approach it will take to holding NHS Trusts to account and managing their progress towards Foundation Trust authorisation. It explained how NHS Trusts would be held to account on a range of quality, performance, finance and governance measures through what is termed an oversight process.

Ms Spellman explained the functions the NHS Trust Development Authority would provide to support the development of NHS Trusts and their Boards and clinicians, and how the framework set out the process for the approval of Foundation Trust applications which was similar to the Single Operating Model used since early 2012.

The Framework revised the limits for the approval of capital investment by NHS Trusts and set expectations of how cases for such investment will be made.

The Board **NOTED** the Trust Development Authority Accountability Framework.

TB 13/14 038 **Any Other Business**

Ms Searle reported that she had recently attended the Trust Nursing & Midwifery Conference, advising that the event was a huge success, very well attended with high quality presentations provided. She congratulated Ms Loader and her team for the conference.

Mr Farenden also congratulated the organisers of the Long Service Award Ceremony which he advised was a success.

TB 13/14 039 **Date of next meeting: 27 June 2013, 9.30 Boardroom NGH**

Mr Farenden called the meeting to a close at 12:10

TB 13/14 040 **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 30 May 2013

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 13/14 003	Matters Arising Patient Experience Report	24 April 2013	Ms Loader undertook to provide evidence that there was not a correlation between ward level patient experience results and the outcomes of infection control audits.	Ms Loader	June 2013	
TB 13/14 025	Patient Experience Report	30 May 2013	Ms Loader to confirm the timescales for the implementation of actions arising from the Mealtime Survey Audit to the June 2013 Board	Ms Loader	June 2013	
TB 13/14 029	Operational Performance Report	30 May 2013	Mr Walsh to present a revised A&E trajectory to the Board.	Mr Walsh	June 2013	
TB 13/14 029	Operational Performance Report	30 May 2013	An action plan is presented to the Board on actions to address to achieve a sustainable position against Cancer Standards.	Mr Walsh	June 2013	
TB 13/14 031	Finance Report	30 May 2013	Ensure workforce and finance data is aligned and consistent across the Board reports	Mr Foster and Ms Brennan	July 2013	
TB 13/14 033	Transformation Report	30 May 2013	Present a comprehensive plan to the Board on the actions being taken to address the gap in the transformation programme and to allow head room for slippage.	Ms Brennan	June 2013	

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 June 2013

Title	Chief Executive's Report
Agenda item	5
Sponsoring Director	Christine Allen – Acting Chief Executive
Author(s)	Christine Allen – Acting Chief Executive
Purpose	Presented to the Board for information
Executive summary Chief Executive's update to the Board for June 2013	
Related strategic aim and corporate objective	All
Risk and assurance	N/A
Related Board Assurance Framework entries	All
Equality Impact Assessment	None
Legal implications / regulatory requirements	None

Actions required by the Board

- The Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Trust Board
27 June 2013
Chief Executives Report

1. Healthier Northamptonshire Programme

As reported at previous Board meetings, NGH has been discussing options to achieve Foundation Trust status with the NHS Trust Development Agency (TDA). At a recent meeting between the TDA and the Trust Board, we were advised that given the challenges facing the NHS and the current performance of our Trust they would support us to continue our programmes of quality improvement and transformation and would wish us to confirm our financial viability, with a view to establishing the long term sustainability of NGH and our services. There is however support for our plan to develop strategic partnerships with other providers. Our current emphasis is on ensuring that we focus our resources on meeting all essential standards of care and delivering our financial duties, as our first priority. This means that we must not divert our focus from this priority which would be the significant risk of a merger programme, particularly one set in such a short timescale.

In light of our review, the Healthier Northamptonshire programme is considering:

- How we can develop the commissioner work-stream to define and implement an out of hospital care strategy ensuring patients are treated in the right place at the right time.
- How the Clinical Working Groups operate as there are still options for collaborative working in some specialities which could improve quality, develop the workforce and respond to other challenges in service provision.
- What must be done to enable each acute trust to maintain its clinical and financial viability in these challenging times.
- How the hospitals will now individually review their strategic direction to take account these changes

We feel that the next steps are:

- To agree both focus and timescale for Healthier Northamptonshire's clinical working groups.
- To start work immediately on the commissioner work-stream to bring sharper definition to our out-of-hospital strategy.
- We need to ensure that this reinforces our efforts to reduce demands upon acute hospitals.
- We remain committed to meaningful and appropriate engagement with Northamptonshire residents, patients, carers, NHS staff and our stakeholder partners on all potential service changes.

2. Organisational Development Strategy

In order to bring together the strategies we have previously agreed for Quality Improvement and Transformation of Care, the Executive team has been working on a programme of staff development and communication. Our aim is to align and engage our staff in the work of quality and safety and transformation of care for our patients. At the next board development session we aim to work with the whole board to finalise our plan. In order to support this plan we will also

be working with our staff to agree the values and behaviours our patients and colleagues should expect from us.

3. NGH Archive

We now have a new archive section available on our website to respond to the amount of interest the archive receives locally, nationally and internationally. The archive, which is open on Wednesday mornings, is run by a dedicated team of volunteers led by Sue Longworth. They welcome visitors by appointment and also accommodate evening visitors for larger groups. The archive is funded entirely by donations.

4. Improvements in Urgent Care

A new emergency assessment bay for cancer patients, which recently opened on Talbot Butler ward, has been hailed a success by patients, nursing staff and doctors. The four-bed bay provides a single point of access for patients who become unwell during their chemotherapy or radiotherapy treatment, providing care in a more appropriate setting other than A&E to assess, investigate, treat and discharge. Patients can contact the ward whenever they feel unwell and there is always a nurse at the end of the phone to provide advice and guidance. Sometimes an admission is prevented or patients are advised to come to the ward, where they are assessed and a decision made regarding admission or discharge to home. More than 200 patients have been seen in the assessment bay since it opened and the feedback from patients shows that it has really made a difference for them.

5. NGH Choir

There has been a great deal of interest and enthusiasm generated by the NGH Choir, which had its first practice on 4th June. More than 80 members of staff have signed up to join the choir, which is led by Kerry Petherbridge, who was formerly the musical director for a Military Wives' choir in Yorkshire. Rehearsals regularly have 65-70 people attending, with a cross-section of staff from across the hospital. The first public performance for the choir will be at the NGH Festival in September.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE 27 June 2013

Title	Medical Director's Report
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Medical Director
Author(s)	Dr Natasha Robinson
Purpose	Assurance

Executive summary

- Overall mortality as measured by HSMR and SHMI is within acceptable parameters.
- Data quality and coding variances are identified and revised where appropriate
- Detailed review of adverse clinical outcomes is undertaken and monitored for improvement
- 5 year review of data does not confirm increased elective surgical mortality related to day of operation
- 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 as reported in the National Quality Dashboard, the recently released nationally mandated tool to be used for quality improvement, are outlined.
- Validation of consultant performance data is underway in readiness for publication

Related strategic aim and corporate objective	Strategic Aim 1
Risk and assurance	High mortality scores and red rated safety indicators present a risk to reputation and quality of service. Actions underway are described in each section
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? N
Legal implications / regulatory requirements	Regulators will consider quality indicators and take action where appropriate. Assurance for regulators can be provided through the demonstration that analysis of issues is combined with the necessary quality improvement work.

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
27 June 2013
Medical Director's Report

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 Intelligence [to end March 2013] and the information relating to SHMI [to end September 2012].

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 NGH there is a detailed monitoring process where the in addition to looking at overall HSMR which is based on the 56 conditions most likely to result in mortality, SMR [standardised mortality ratio specific to a condition] 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 adverse changes in HSMR and SMR's 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.

3. HSMR Comparison [see below]

The purpose of the HSMR Comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national.
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 YTD HSMR using the 2011/12 benchmark is **100** with the indicative rebased HSMR using the 2012/13 FYD benchmark being **105** (this remains within the as expected band).

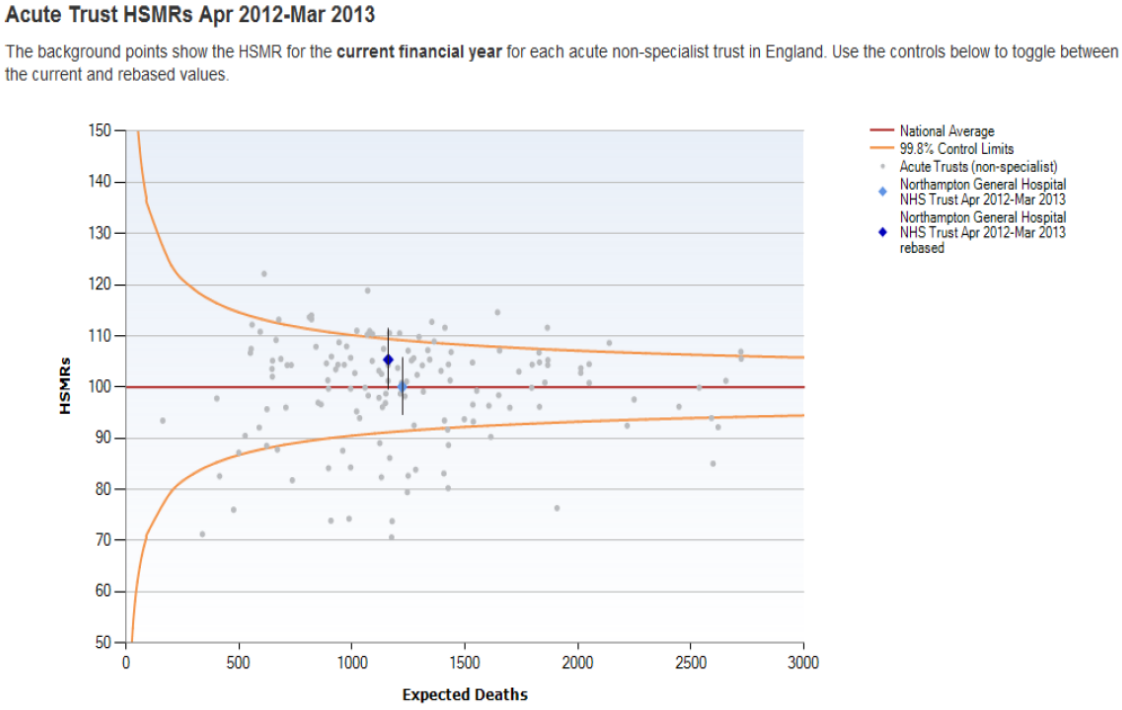
This potentially represents an increase of 3 points compared to year end 2011 / 2012. It is important to emphasize, while the HSMR for the past financial year is likely to show an improvement against the old benchmark, it will eventually be judged against the national average improvement and therefore a trust may improve performance and still find that the annually published HSMR goes up.

Unadjusted mortality is **4.1 %** which is in line with the SHA average.

For February the HSMR was **103 (**113 deaths, 110 expected).

For March the HSMR was **106** (115 deaths versus 109 expected)

These were very challenging months with unseasonally high levels of activity and a large number of very ill patients.



4. Standardised Hospital Mortality Indicator (SHMI)

This data is now provided by HSCIC as of April 2013. However it remains 6-9 months in arrears and it is not currently possible to analyse the information in any detail, as compared to that provided by Dr Foster.

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**. Due to dispersion this remains within the 'as expected' range. 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 unclear, but may be explained by the SHMI model including deaths up to 30 days after discharge, and without adjusting for palliative care In depth analysis of SHMI is not currently available to enable this to be better understood.

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

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

There are currently no concerns in relation to the Dr Foster Patient Safety Indicators.

Apr 2012 to Mar 2013

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		27	24.1	0.76	0.68	more information
Decubitus Ulcer		182	214.5	19.42	22.89	more information
Deaths after surgery		44	35.0	140.58	111.81	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		4	13.8	0.18	0.61	more information
Post-operative physiologic and metabolic derangements*		1	1.5	0.05	0.08	more information
Post-operative respiratory failure		10	13.4	0.56	0.75	more information
Post-operative pulmonary embolism or deep vein thrombosis		35	41.1	1.52	1.78	more information
Post-operative sepsis		8	4.0	12.58	6.28	more information
Post-operative wound dehiscence*		2	1.1	2.15	1.18	more information
Accidental puncture or laceration		35	73.7	0.53	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		27	41.1	54.33	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		77	93.4	30.80	37.37	more information
Obstetric trauma - caesarean delivery*		2	4.1	1.67	3.43	more information

Key

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

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

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

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

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

Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease [Stroke], Pneumonia. Acute Myocardial Infarction, Congestive Heart Failure and Fractured Neck of Femur** are subject to particular scrutiny. Overall SMR for this group is **79** which is significantly lower than expected (488 deaths with 615 expected from 3111spells).

There has been a slight improvement in the last 2 months in relation to mortality from fractured neck of femur. The SMR for 2012/13 is **149** (47 deaths with 32 expected) but for the last 2 months there were 5 deaths whereas 6 deaths were expected. The improvement work described in last month's Board report continues.

Another area of concern previously reported relates to congestive heart failure where some detailed investigation has taken place and no serious care concerns were identified. SMR is unchanged at **134** (65 deaths whereas 49 were expected). The heart failure team are currently exploring the possibility of changing referral pathways to ensure that all patients with a primary diagnosis of heart failure are identified early and referred for specialist review during admission. This will be kept under close review. All deaths will continue to be reviewed by the heart failure team.

The team presented their findings to the clinical mortality and coding group in March.

7. Possible areas for concern under investigation

Currently a number of other areas remain under investigation. These include secondary malignancies, 'other perinatal conditions' (which includes still births) and adult leukaemia. The investigations are at different stages and the principles will continue to be that we ensure we identify any quality of care issues. The work required to understand these issues can be very complex and usually takes many months. In some areas there can be difficult issues relating to data capture and definitions. This applies to the category 'other perinatal conditions'. There may be a need for thematic review. In some cases although no specific care issues are identified, putting the area under close scrutiny leads to improvement.

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

There has been considerable media interest in the issue of mortality relating to operations carried out on Friday or over the weekend. Analysis of our data shows no consistent pattern and no increased mortality for patients who have operations on Friday. It is of note that fewer operations are done on a Friday and most surgeons avoid complex surgery on this day of the week. No elective surgery is performed at the weekend, when the efforts are concentrated on providing high quality emergency surgical cover.

9. Further actions in place or planned

The Trust had planned to take forward work with Dr Foster to improve detailed dashboards for specialities to enable closer monitoring within directorates. Progress has been slow due to operational pressure but there is now renewed interest in this partly due to the planned national publication of outcomes at consultant level.

As previously reported, rom 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.

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. An enormous amount of work has taken place to ensure that data is accurate and fully reflects the activity undertaken so that organisational and individual performance. Further information should be available for the Board during the summer months.

Extensive review of health, social and demographic information related to both the local area and the hospital population has been carried out by an external provider to enable better understanding of the information provided by Dr Foster and HSCIC. This has identified some concerns with information quality (both clinical and non-clinical) and has confirmed that those areas already under scrutiny for adverse performance are appropriate. A full report on findings will be presented at the next Board.

10. Learning from Serious Incidents

Following completion of each SI investigation an action plan is produced to determine the improvements required both in the relevant area, but also across the organisation as necessary.

During May 2013 9 SI's were submitted to the CCG for closure: 5 cases of pressure ulcer [all verified as 'avoidable' by the tissue viability team] and 4 fractures occurring as an inpatient - 2 hip, one humerus and one odontoid peg fracture. The latter was thought to be an unavoidable accident and the CCG has been asked to downgrade the incident to level '0'.

In line with the SI process a 'Being Open' meeting is offered to the patient and/or carers to discuss the findings of the report. One such meeting was held during May between the surgical team and the family of a deceased patient. Concerns were raised by the family regarding the redress process followed when staff are involved in a serious incident, and reassurance was given that all staff are expected to reflect, and training needs are identified. All SI's are reviewed at consultant appraisal as part of revalidation. Further action taken is in accordance with the NPSA Decision Tree.

Where doctors in training are involved in a serious incident they are identified at the start of the investigation process and a referral is made to the Director of Medical Education to ensure they receive appropriate support, and that there is educational supervision where required.

Actions taken as a result of SIs closed in May 2013:

- All cases of pressure ulcer have been reviewed by the Interim Risk/Litigation Manager and submitted to the Director of Nursing, at the request of the CCG. A meeting is scheduled between both CCG's and providers in the county to understand possible causes and identify areas for action.
- Bodymapping of high risk patients presenting to A&E is to be introduced

- Plaster technicians to advise ward teams on use and monitoring of plasters in patients at risk of pressure damage
- The Falls prevention Group continues to monitor risk assessments and the use of preventative measures for high risk patients across the Trust
- SI Policy is to be updated to ensure that the process for supporting and referring medical staff is clearly addressed in the Terms of Reference of investigations

Process for ensuring actions completed and organisation learning is shared

- Action plans are implemented at directorate level for all directorates involved in the incident. Compliance is overseen by 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 within directorates through Directorate Governance meeting, Morbidity and Mortality meetings, and more widely through the Patient Safety Learning Forum where Root Cause Analyses are shared and discussed to identify opportunities for wider application of lessons learnt in a multidisciplinary setting.
- Never Events: there have been none reported in the year to date. Trust wide learning that relates to very important issues such as Never Events is addressed by members of the Safety Team presenting at directorate meetings. Each directorate can review their own progress with implementation to be monitored at Directorate Healthcare Governance meetings.
- Key actions arising from SI's are shared at Patient Safety Board and audits of compliance presented

11. Recommendation

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 – average
- Helping people to recover as measured by readmissions and emergency admissions for conditions that do not usually require admission – both appear to be falling
- Timely care – A and E patients waiting more than 4 hours- improving position
- Timely Care – RTT greater than 18 weeks and cancer waits –within target.
- Safe Environment – Infections, serious incidents, never events, harm free care are all average or ‘ as expected’
- Organisational indicators – staff sickness average and bed occupancy – higher than average and rising
- Organisational indicators – doctor to patient ratio – average. (last updated January 2013)
- Organisational indicators – nurses to bed ratio (reported as to January 2013) –is now reported to be 1.33 but it would appear that there is an error relating to bed numbers. Our own calculation indicates that the ratio has improved to 1.69. This figure does not include bank or agency staff. Further work is required to clarify this. Improving nurse staffing levels is a key trust priority and the nurse to bed ratio will improve over the next 12 months.

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.

There is work underway to develop the Trust dashboards to align with the national quality dashboard. We will take the opportunity to redesign our current Trust quality dashboard

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

Trust Quality Dashboard

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.

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 an improved format for reporting of performance and quality indicators and a project will take this forward over the next 3 months.

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

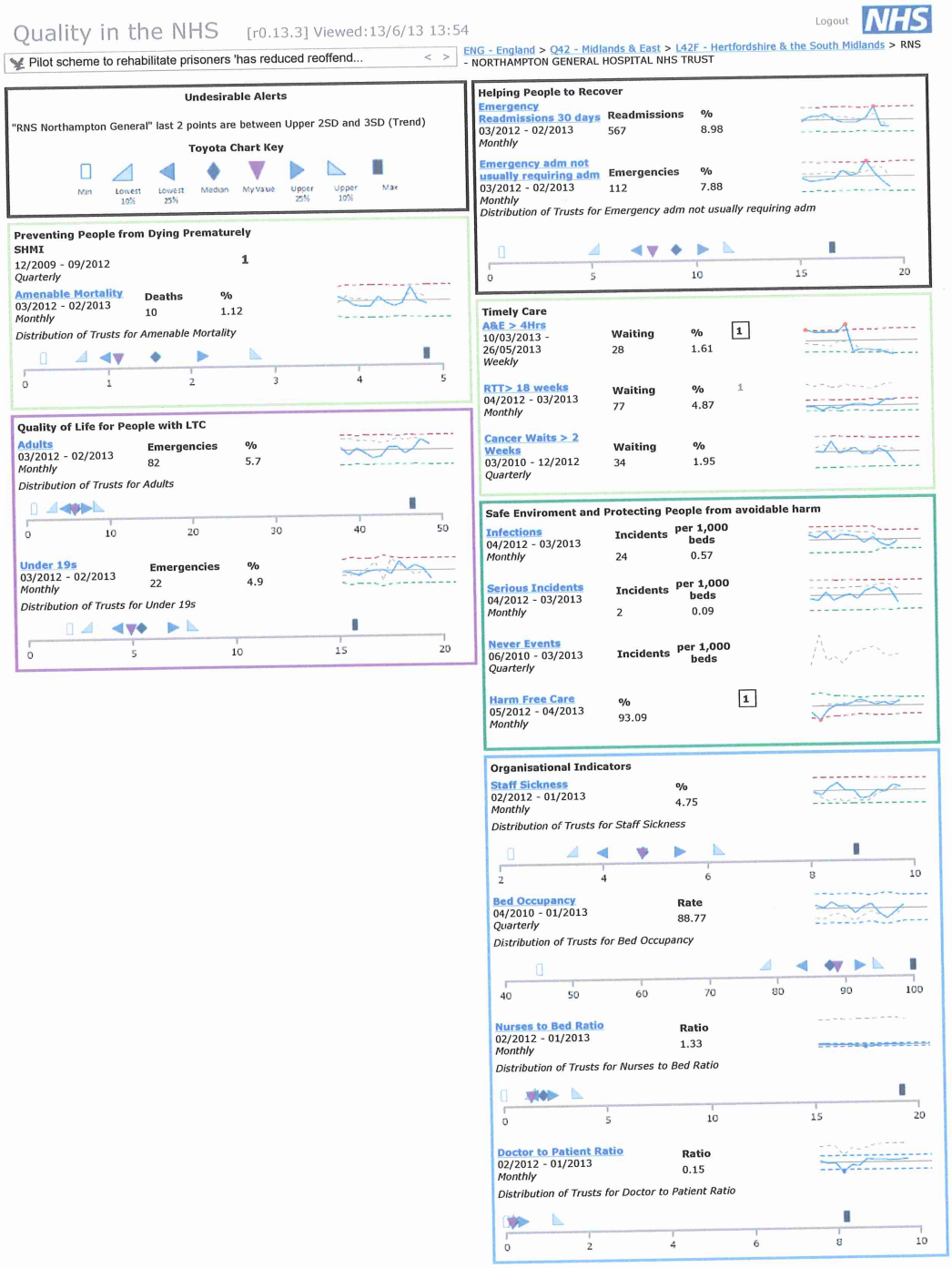
Within April's exception report there were 145 indicators, of which 49 (**30/19**) are rated as either red or amber status. For May there are 141 indictors of which **51** are rated as amber or red. The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. There are 30 indicators that are rated as grey; this is a significant increase in comparison to March's report (22). Indicators rated as grey are those which are awaiting final agreement or the information is currently not available.

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
Patient Safety	16	7	21	8	52
Patient Experience	6	3	21	3	33
Clinical Outcomes	6	2	6	14	28
CQUIN 2013-14	5	6	12	5	28
TOTAL	**33**	**18**	**60**	**30**	**141**

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:13/6/13 13:54

Logout NHS

Pilot scheme to rehabilitate prisoners 'has reduced reoffend...

ENG - England > Q42 - Midlands & East > L42F - Hertfordshire & the South Midlands > RNS - NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Undesirable Alerts

"RNS Northampton General" last 2 points are between Upper 2SD and 3SD (Trend)

Toyota Chart Key

Min | Lowest 10% | Lowest 25% | Median | My Value | Upper 25% | Upper 10% | Max

Preventing People from Dying Prematurely

SHMI 1
12/2009 - 09/2012
Quarterly

Amenable Mortality — Deaths 10 — % 1.12
03/2012 - 02/2013
Monthly
Distribution of Trusts for Amenable Mortality

0 1 2 3 4 5

Quality of Life for People with LTC

Adults — Emergencies 82 — % 5.7
03/2012 - 02/2013
Monthly
Distribution of Trusts for Adults

0 10 20 30 40 50

Under 19s — Emergencies 22 — % 4.9
03/2012 - 02/2013
Monthly
Distribution of Trusts for Under 19s

0 5 10 15 20

Helping People to Recover

Emergency Readmissions 30 days — Readmissions 567 — % 8.98
03/2012 - 02/2013
Monthly

Emergency adm not usually requiring adm — Emergencies 112 — % 7.88
03/2012 - 02/2013
Monthly
Distribution of Trusts for Emergency adm not usually requiring adm

0 5 10 15 20

Timely Care

A&E > 4Hrs — Waiting 28 — % 1.61 — 1
10/03/2013 - 26/05/2013
Weekly

RTT> 18 weeks — Waiting 77 — % 4.87 — 1
04/2012 - 03/2013
Monthly

Cancer Waits > 2 Weeks — Waiting 34 — % 1.95
03/2010 - 12/2012
Quarterly

Safe Enviroment and Protecting People from avoidable harm

Infections — Incidents 24 — per 1,000 beds 0.57
04/2012 - 03/2013
Monthly

Serious Incidents — Incidents 2 — per 1,000 beds 0.09
04/2012 - 03/2013
Monthly

Never Events — Incidents — per 1,000 beds
06/2010 - 03/2013
Quarterly

Harm Free Care — % 93.09 — 1
05/2012 - 04/2013
Monthly

Organisational Indicators

Staff Sickness — % 4.75
02/2012 - 01/2013
Monthly
Distribution of Trusts for Staff Sickness

2 4 6 8 10

Bed Occupancy — Rate 88.77
04/2010 - 01/2013
Quarterly
Distribution of Trusts for Bed Occupancy

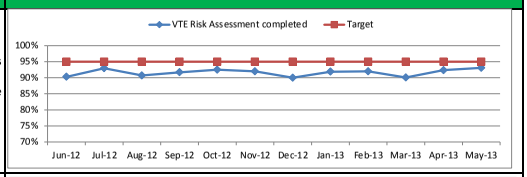
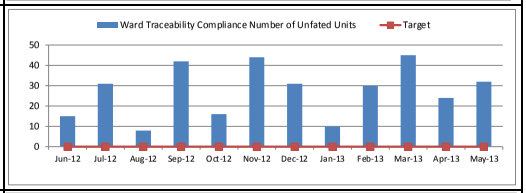
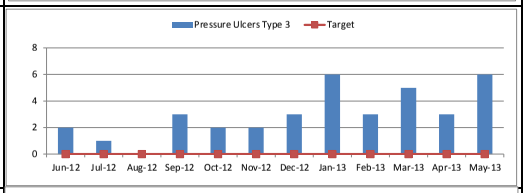
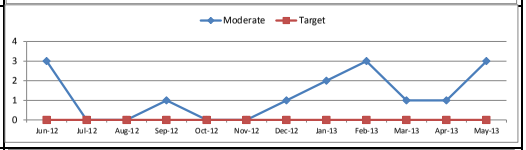
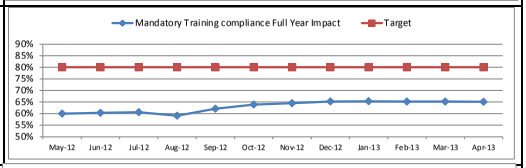
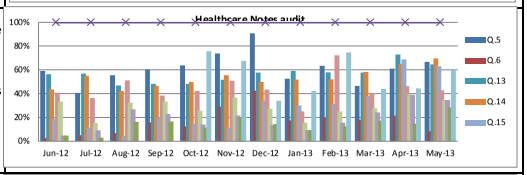
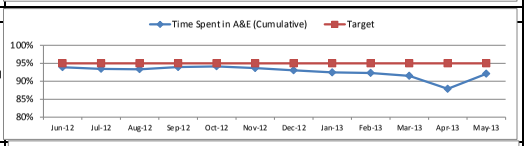
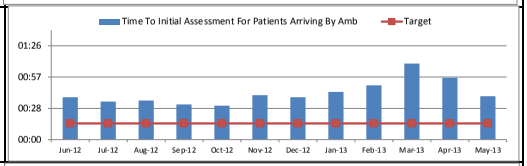
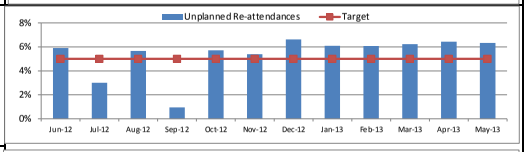
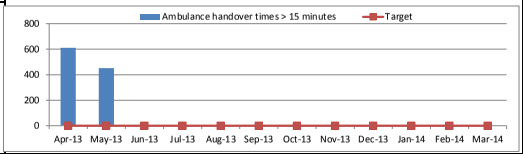
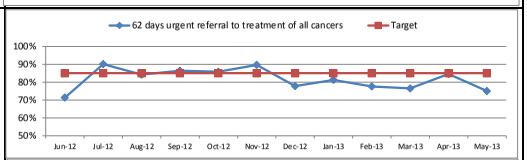
40 50 60 70 80 90 100

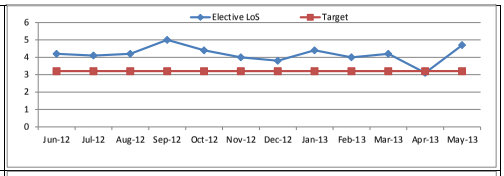
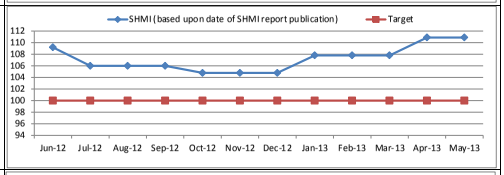
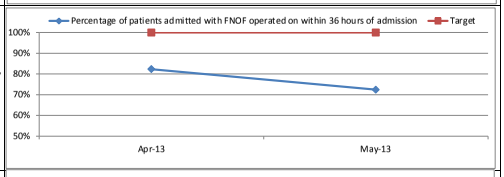
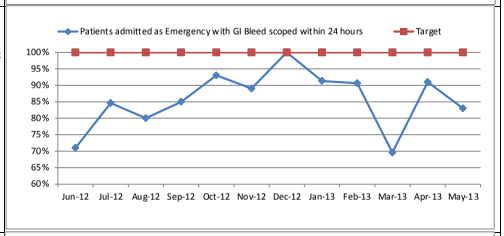
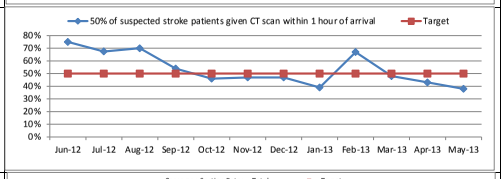
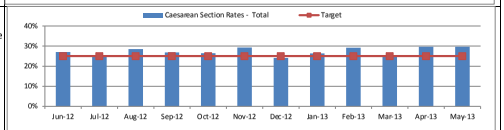
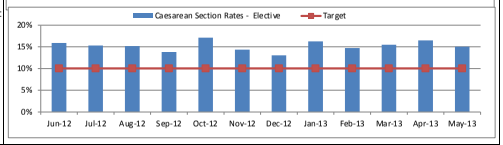
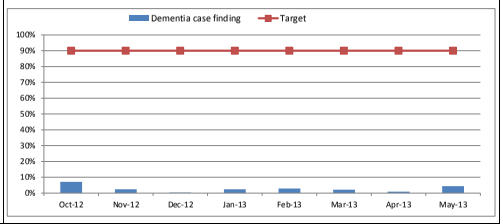
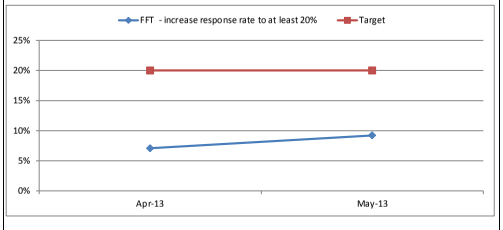
Nurses to Bed Ratio — Ratio 1.33
02/2012 - 01/2013
Monthly
Distribution of Trusts for Nurses to Bed Ratio

0 5 10 15 20

Doctor to Patient Ratio — Ratio 0.15
02/2012 - 01/2013
Monthly
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	VTE Risk Assessment completed	95%	↑	Provisional VTE risk assessment completion rates for May 2013 was 93.1% which is a 0.8% improvement on the previous month. A number of measures have been put in to improve compliance which is expected to increase in June. Analysis of the thromboprophlylaxis given to high risk patients shows that they are appropriately treated.	
Patient Safety	Ward Traceability Compliance Number of Unfated Units	0	↓	Autofate compliance decreased last month with 32 unfated units in May to 24 compared to 24 unfated units in April. (Total ward compliance was reported as 99.6% in May, although legislation requires 100% compliance with traceability of blood as per the Blood Safety and Quality Regulations 2005.) The Transfusion Team continue with the recently implemented Improvement Plan along with the use of screen savers across the Trust and reminders going out with each unit of blood issued. Meetings have been held with key stakeholders to raise awareness with the subject discussed at Medicine Care Board Governance meetings and communication notices have been issued.	
Patient Safety	Incidence of Pressure Ulcers Type 3	0	↑	May 2013 showed 6 x grade 3 pressure ulcer incidents of which 2 were unavoidable. An extensive project plan has been put in place to address the incidence of pressure ulcers to include leadership rounds, additional training and education packages. Documentation is monitored on a monthly basis to confirm compliance to process, and every ward has actions plans to address areas of noncompliance /or themes from Serious Incidents.	
Patient Safety	Reduce harm from falls	0	↓	There were 3 x moderate falls recorded during May 2013, an increase from 1 in March and April. There is a trust wide action plan in place for falls and training is currently mandatory for all clinical staff. In addition, a revised falls risk assessment and care plan and a post fall medical assessment document is due to be launched shortly.	
Patient Safety	Mandatory Training compliance Full Year Impact	0	→	Key areas of mandatory training requiring improvement are Equality & Diversity and Cardiac Prevention. Reports are being sent out on a monthly basis which identifies non-compliant staff as well as identifying staff who require a refresher within the next 3 months. A workbook and DVD has been created for Information Governance to give staff another method of receiving the training. The Trust is now looking at other areas where a workbook could be written.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↑	The key issues identified on the Healthcare Notes audit in May 13 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 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 since last month. Improving the Healthcare Records Audit results is being overseen by one of the leads for the Patient Safety Academy with actions plans underway.	
Patient Experience	A & E Quality Indicators (4 indicators)			**A&E Clinical Indicators:**	
			↑	Time Spent in A&E (Cumulative) - May's position of 92.1% recovered from the April position of 87.89% but is still behind target.	
			↑	The time to initial assessment for patients arriving by ambulance reduced from57mins in April to 40 mins in May (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 re-attendance rate - May performance was 6.79% against a target of 5% - a slight . The percentage has slightly increased from last month's position. There is also a genuine concern related to patients reattending when they have been unable to access aftercare in primary care.	
			↑	New electronic methods of accurately capturing ambulance handover times are currently being implemented and work is being undertaken between the ambulance service and trust (new target). May 2013 saw an improvement of 452 cases over 15 minutes compared to 612 in April 13.	
Patient Experience	Cancer Wait times	90%	↓	62 Day (All cancers) - During May there the Trust achieved 75% against the standard of 85% (subject to final validation). There were 18.5 breaches over 62 days. Reasons for the delays were: Highly complex management of patients, late referrals, patient choice to decline or defer appointments and internal processes	

Patient Experience	SRS08: Length of Stay (Acute & MH) - Elective	3.2 days	↓	The elective Length of Stay (LoS) target is 3.2days. 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 are not considered. Reviewing Dr foster data which does acknowledge the comorbidities shows the latest data for the Trust was only 0.2 above the expected LoS.	
Clinical Outcomes	SHMI (based upon date of SHMI report publication)	<100	↓	SHMI has been rising during the last few months but does not mirror HSMR in all specialities. The mortality monitoring process continues and is described in the Medical Directors' report. Individual areas for concern for HSMR are also contained in that report.	
Clinical Outcomes	Percentage of patients admitted with FNOF operated on within 36 hours of being fit for surgery	100%	↓	Reduction in the % of patients operated on within 36 hours of being fit for surgery affected by the high volume of admissions for the month. (31 admissions for May against 19 admissions for April)	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	↓	For May 2013, 24 out of 29 patients with GI bleed were scoped within 24hours. Unfortunately the endoscopy suite is only available Monday - Friday 5 days a week and the Gastroenterologists are the only consultants available to support this service. It is scored/triaged depending on severity, so not all are turned around in 24 hours due to availability and limited capacity within endoscopy. We are unable to provide any lists out of hours, the endoscopy suite does not have staffing to support a 24/7 service and the service runs alongside other procedures such as colorectal and bowel screening so there is limited capacity. The department's Clinical Lead is looking into extending the service to offer a session on a Saturday or Sunday, but this is still in the planning phase and currently there are not the numbers of consultants or endoscopy staff to accommodate this service within a 24 hour period 7 days per week.	
Clinical Outcomes	50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	↓	The main issues resulting in delays for this standard are: - During the day only doctors are authorised to request scans and are delayed by the need to assess the patient first. - At night unless there are specific indicators the patient is not scanned until the following morning as per CT guidelines. To resolve this, plans are underway for ratification of a new protocol to allow stroke specialist nurses to request the scans thereby reducing delays.	
Clinical Outcomes	Caesarean Section Rates	<25% 10.1%	→ ↑	Emergency caesarean section rate remains below the national average. Whilst the aim has to been to try to reduce the elective caesarean section rate this has remained fairly static. Following the publication of the NICE guideline CG132 in November 2011 there has been an extensive amount of work within the maternity services to support women having choice regarding the mode of delivery following a previous caesarean section, which is one of the priority recommendations of this guidance. In March 2013, the Birth after Caesarean Section (BAC) commenced with the support of a whole time equivalent midwife. It is hoped that the expansion of the BAC clinic will provide women with more evidence based information on which to make their decision and it is anticipated that women in the future will be more receptive to vaginal birth after a caesarean section. The impact of the BAC clinic, will not be recognized until at least the end of Quarter 2. In the meantime the Directorate are auditing compliance with the NICE guideline on a quarterly basis, the results of which are monitored by the Obstetric Governance Group and are due to be presented to HGC in June 2013.	 
CQUIN	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	90%	↓	Performance against the Dementia case finding question remains poor year to date (May = 4.35% against the target of 90%). Work is on-going to capture and validate data. The system for collecting the data has been updated. An advert is also currently out for a dementia nurse to assist with the training and understanding of staff. A working group lead by the Safety Academy are now supporting this project to improve compliance.	
CQUIN	Friends and Family Test Response Rate	20%	↑	Friends and Family Test Response Rate (new target of 20% by end of 2013-14). This response rate reflects an amalgamation of response rates across both in-patients and A&E. The table below shows the Inpatient and A&E totals – currently achieving a 24.22% target for inpatient responses. Well above the requirement. There are issues around the data collection within A&E in relation to the number of completed returned forms received. Work is under way to improve the response rates via using an IPAD to collect the data there and then from patients. This has the advantage of real time results and an ability to track when and where the questions are being asked. Thereby identifying any shifts / staff who are not asking the questions as frequently – not yet commenced due to IT issues. The trust is also exploring the use of a counter based system to collect responses – as per supermarkets. This is currently being costed by Estates and would be sited in Minors, if finances were available to support this option. Period: 1st to 31st May 2013 Ward / area name: Total no. of people eligible to respond (discharged) | Total responses for each area | Target = 15% Response rate for each ward | Target yet to be agreed Score for each ward / area Inpatient Ward Total: 2932 | 710 | 24.22% | 68 Accident & Emergency Total: 5074 | 29 | 0.57% | 55 IP & A&E: 8006 | 739 | 9.23% | 67	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Frequency	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	May 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	Monthly	0	0	0	0	1	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	Monthly	1	4	3	0	2	1	3	4	2	2	5	7	2		
HQU08: MSSA Numbers	No national ceiling set	Monthly	1	1	1	1	0	2	2	1	1	0	0	1	0		
E Coli ESBL Quarterly Average	7 per month	Monthly	4	1	0	5	1	0	4	2	3	2	0	2	3		
VTE Risk Assessment completed	95% month on month	Monthly	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	Monthly		88.7%	98.0%	100.0%	96.1%	98.6%	97.3%	98.7%	99.0%	96.1%	97.2%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	Monthly	100%	100%	100%	100%	100%	100%	99.74%	99.40%	99.73%	99.54%	99.40%	99.87%	99.50%		
MRSA Screening Non-Elective Patients	100% month on month	Monthly	95.70%	96.41%	96.68%	94.91%	95.25%	96.10%	96.80%	95.78%	95.12%	96.56%	97.00%	96.40%	96.95%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	Monthly	22	15	31	8	42	16	44	31	10	30	45	24	32		
Incidence of pressure ulcers																	
Type 3	0	Monthly	2	2	1	0	3	2	2	3	6	3	5	3	6		
Type 4	0	Monthly	2	0	0	0	0	0	3	4	0	0	1	0	0		
Reduce harm from falls																	
Catastrophic	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0		
Major/Severe	0	Monthly	0	1	1	2	0	2	3	0	1	2	1	0	1		
Moderate	0	Monthly	2	3	0	0	1	0	0	1	2	3	1	1	3		
Mandatory Training compliance Full Year Impact																	
Primary Levels Excluding B&H	80%	Monthly	60.0%	60.3%	60.6%	59.1%	62.1%	63.9%	64.5%	65.2%	65.4%	65.2%	65.2%	65.1%	N/Avail		6 week turnaround delay for data
Attendance at Trust Induction	80%	Monthly	90.7%	76.8%	87.8%	81.4%	85.5%	98.6%	90.8%	87.9%	87.5%	87.6%	87.5%	87.30%	N/Avail		6 week turnaround delay for data
Number of surgical site infections																	
Fracture neck of femur - Number of Operations	-	Monthly	29	21	26	53	26	26	36	34	39	31	45	17	27		
Number of infections	-	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively
% infection rate (monthly)		Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly				1.1%			0%			0.9%					
Abdominal hysterectomies		Monthly												16	16		
Number of infections		Monthly												0	0		
% infection rate (monthly)		Monthly												0%	0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly															
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc																	
Open Central Alert System (CAS) Alerts	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	1	0		
NICE clinical practice guidelines and TAG compliance	80%	Monthly	81.1%	82.2%	0.0%	84.0%	84.2%	87.0%	87.9%	89.0%	89.1%	89.3%	89.3%	84.7%	86.1%		
Serious Untoward Incidents	-	Monthly	3	9	5	4	5	7	14	9	19	25	36	41	35		
Never Events	0	Monthly	0	0	0	1	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%		
Healthcare Notes Audit																	
Q.1 Does the front page of every sheet contain an addressograph label	100%	Monthly	57%	67%	77%	71%	77%	73%	68%	79%	80%	79%	72%	79%	72%		
Q.2 Does addressograph include the NHS Number?	100%	Monthly	99%	96%	95%	86%	90%	90%	93%	88%	99%	88%	92%	90%	97%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	Monthly	72%	83%	56%	87%	86%	73%	87%	97%	74%	90%	84%	100%	94%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	Monthly	46%	49%	36%	56%	62%	60%	62%	82%	53%	73%	64%	85%	69%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	Monthly	56%	59%	41%	55%	60%	64%	74%	91%	53%	63%	46%	61%	67%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	Monthly	6%	2%	5%	7%	16%	13%	29%	42%	18%	20%	18%	21%	8%		
Q.7 Is record legibly written	100%	Monthly	93%	98%	97%	92%	99%	98%	97%	99%	99%	98%	99%	95%	100%		
Q.8 Written in blue/black ink	100%	Monthly	98%	100%	100%	99%	100%	100%	100%	100%	100%	99%	100%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Monthly	97%	98%	99%	98%	100%	100%	100%	99%	98%	99%	100%	99%	98%		
Q.10 Is date recorded for each entry	100%	Monthly	73%	86%	89%	91%	94%	89%	93%	91%	88%	90%	88%	86%	87%		
Q.11 Is time recorded for each entry	100%	Monthly	64%	67%	79%	68%	77%	73%	70%	72%	71%	66%	75%	86%	87%		
Q.12 Is there a signature of the person making the entry	100%	Monthly	98%	91%	95%	94%	92%	87%	91%	92%	90%	94%	94%	96%	97%		
Q.13 Is surname printed in block capitals	100%	Monthly	42%	56%	57%	47%	48%	48%	52%	58%	59%	58%	58%	73%	65%		
Q.14 Is the staff designation recorded	100%	Monthly	37%	44%	55%	42%	47%	50%	55%	50%	52%	52%	58%	65%	70%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	Monthly	0%	19%	11%	5%	20%	14%	11%	34%	30%	31%	38%	69%	63%		
Q.16 Are any alterations / deletions scored through with a single line	100%	Monthly	29%	41%	36%	51%	38%	42%	51%	43%	25%	72%	40%	46%	43%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	Monthly	19%	33%	15%	33%	33%	26%	37%	27%	16%	25%	28%	39%	35%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	Monthly	3%	5%	9%	27%	23%	14%	22%	14%	9%	16%	24%	39%	35%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	Monthly	3%	5%	3%	16%	17%	11%	20%	14%	9%	13%	17%	15%	28%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	Monthly	N/a	N/a	N/a	N/a	N/a	100%	99%	95%	97%	96%	100%	99%	97%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	Monthly	N/a	N/a	N/a	N/a	N/a	76%	68%	34%	42%	75%	44%	44%	60%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	Monthly	N/a	N/a	N/a	N/a	N/a	100%	100%	100%	100%	100%	100%	100%	96%		
Q.23 Are there any loose sheets in the Healthcare record	0%	Monthly	N/a	N/a	N/a	N/a	N/a	8%	10%	17%	10%	0%	13%	10%	3%		

Patient Experience	Target 2013-14	Frequency	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	May 13 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	Monthly	0	0	0	0	0	0	0	6	4	1	2	1	0		
Hospital Cancelled Operations	6.0%	Monthly	7.1%	8.8%	5.6%	5.3%	5.8%	6.9%	7.9%	5.4%	9.3%	6.3%	11.5%	N/Avail	N/Avail		Requires SLAM data
Number of written complaints received	-	Monthly	51	39	48	33	35	44	40	24	68	54	52	4	6		
Complaints Responded to within agreed timescales	100.00%	Monthly	80.4%	87.2%	83.0%	60.6%	60.0%	56.8%	90.0%	87.5%	95.6%	100%	100%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits																	
Admitted Patients	90.00%	Monthly	96.56%	97.40%	96.61%	96.99%	96.34%	96.08%	95.93%	96.47%	96.10%	95.12%	95.13%	95.02%	96.16%		
Non Admitted Patients	95.00%	Monthly	98.33%	98.80%	98.61%	98.46%	98.44%	98.52%	98.36%	98.48%	98.60%	97.90%	97.97%	97.87%	98.02%		
Ongoing Patients	92.00%	Monthly	97.83%	97.13%	97.30%	97.53%	97.12%	96.91%	96.85%	96.33%	95.45%	95.74%	95.64%	96.36%	96.46%		
A&E Quality Indicators (5 measures)																	
Time Spent in A&E (Month on Month)	95%	Monthly	93.43%	93.40%	92.16%	92.93%	96.93%	95.35%	90.25%	88.81%	86.91%	90.33%	82.49%	87.89%	96.28%		
Time Spent in A&E (Cumulative)	95%	Monthly	94.19%	93.92%	93.47%	93.36%	93.95%	94.15%	93.67%	93.04%	92.47%	92.30%	91.51%	87.89%	92.10%		
Total time in A&E (95th percentile)	95th	Monthly	05:00	04:50	05:19	05:04	04:59	04:00	06:00	06:18	07:12	06:21	08:08	06:45	03:59		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	Monthly	00:50	00:39	00:35	00:36	00:32	00:31	00:41	00:39	00:44	00:50	01:10	00:57	00:40		
Time to treatment decision (median)	<60 mins	Monthly	00:54	00:54	00:52	00:42	00:48	00:41	00:46	00:48	00:34	00:45	00:52	00:57	00:51		
Unplanned re-attendance rate	=<5%	Monthly	1.00%	5.91%	3.00%	5.66%	0.95%	5.71%	5.40%	6.62%	6.10%	6.07%	6.23%	6.44%	6.34%		
Left without being seen	>1% and <5%	Monthly	0.33%	0.20%	0.16%	0.18%	0.18%	0.07%	0.25%	0.12%	0.18%	0.22%	0.22%	0.24%	0.19%		
Ambulance handover times > 15 minutes	then 15 minutes	Monthly	0	0	0	0	0	0	0	0	0	0	0	612	452		
Ambulance handover times > 60 minutes	then 15 minutes	Monthly	0	0	0	0	0	0	0	0	0	0	0	68	3		
Cancer Wait Times																	
2 week GP referral to 1st outpatient	93%	Monthly	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	96.7%	96.9%	98.3%	96.0%	95.5%		
2 week GP referral to 1st outpatient - breast symptoms	93%	Monthly	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%		
31 Day	96%	Monthly	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.3%	98.7%	99.2%	98.0%	97.4%		
31 day second or subsequent treatment - surgery	94%	Monthly	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - drug	98%	Monthly	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	95.0%	91.8%	96.8%	98.3%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	Monthly	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.8%	96.4%	97.8%	95.8%	98.3%	97.9%		
62 day referral to treatment from screening	90%	Monthly	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	95.7%	93.3%	84.2%	87.9%	100.0%		
62 day referral to treatment from hospital specialist	80%	Monthly	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	63.6%	73.7%	100.0%	100.0%	100.0%		
62 days urgent referral to treatment of all cancers	85%	Monthly	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	77.8%	81.3%	77.6%	76.5%	84.6%	75.0%		
SRS08: Length of Stay (Acute & MH)																	
Elective	3.20	Monthly	4.1	4.2	4.1	4.2	5	4.4	4	3.8	4.4	4	4.2	3.1	4.7		Based on DFI Peer Group UQ. Fig reported in March 13 relates to rolling 12 months up until March 13
Non-Elective	5.30	Monthly	5.9	4.4	4.4	4.3	4.9	4.5	4.2	4.4	4.6	4.3	4.7	4.3	4.3		Based on DFI Peer Group UQ. Fig reported in March 13 relates to rolling 12 months up until March 13
SRS09: Daycase Rate	85%	Monthly	85.0%	84.9%	85.7%	86.6%	85.0%	84.7%	83.0%	85.7%	85.5%	84.8%	84.6%	N/Avail	N/Avail		Requires SLAM data
SQU11: PROMS Scores - Pre Operative participation rates																	
Groin Hernia - Participation Rate	at.Ave 62.9% (target 80%	Quarterly		48.2%			88.6%			98.0%			81.3%		N/Avail		
Hip Replacement - Participation Rate	at.Ave 79.5% (target 80%	Quarterly		91.4%			125.8%			93.0%			94.6%		N/Avail		
Knee Replacement - Participation Rate	at.Ave 86.9% (target 80%	Quarterly		88.2%			95.9%			110.5%			107.1%		N/Avail		Information based on 3 months HES data to Apr 12 - Sept 12 (published Feb 13). Target for 2012-13 is measured against national average for the period and not the national target of 80% for all procedures
Varicose Vein - Participation Rate	at.Ave 33.3% (target 80%	Quarterly		33.3%			71.4%			54.1%			66.7%		N/Avail		
All Procedures - Participation Rate	at.Ave 72.6% (target 80%	Quarterly		71.8%			99.1%			96.0%			90.5%		N/Avail		

Clinical Outcomes	Target 2013-14	Frequency	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	May 13 RAG Rating	Comments
HSMR - monthly position for 2012-13	<100	Monthly	93.1	106.9	99.2	104.6	113.9	98.1	87.5	101.7	94.8	102.5	105.5	N/Avail	N/Avail		Latest DFI position 2012-13 - 12 months to Mar 13, supersedes 2011-12 rebased position as reported previously
HSMR - 12 Monthly cumulative position		Monthly	NA	85.0	95.0	96.1	97.9	98.3	98.2	99.0	99.1	N/Avail	100.1	N/Avail	N/Avail		Latest DFI FY trend Apr 12 - Mar 13 (HSMR)
HSMR- cumulative position for 2012-13																	
Pneumonia	<100	Monthly	0	0	47.4	50.2	50.6	49.7	48.7	52.2	54.8	N/Avail	57.5	N/Avail	N/Avail		Latest DFI Apr 12 to Mar 13 (HSMR)
Fracture of neck of femur (hip)	<100	Monthly	0	0	148	133.1	163.1	155.8	168.5	168.4	169.08	N/Avail	148.7	N/Avail	N/Avail		Latest DFI Apr 12 to Mar 13 (HSMR)
Acute Cerebrovascular disease	<100	Monthly	0	0	86	96	104.8	110	101.6	107.1	105.6	N/Avail	105	N/Avail	N/Avail		Latest DFI Apr 12 to Mar 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	Monthly	0	0	83.7	90.9	114.4	121.4	131.3	131.9	133.5	N/Avail	133.5	N/Avail	N/Avail		Latest DFI Apr 12 to Mar 13 (HSMR)
Acute myocardial infarction	<100	Monthly	0	0	66.5	76.7	76.4	70.1	61.9	71	76.7	N/Avail	77.5	N/Avail	N/Avail		Latest DFI Apr 12 to Mar 13 (HSMR)
SHMI (based upon date of SHMI report publication)		Monthly	109.2	109.2	106	106	106	104.77	104.77	104.77	107.81	107.81	107.81	110.9	110.9		Latest position reported in May 13 reflects Oct 11 to Sept 12.
SQU12: Maternity 12 weeks	90%	Monthly	97.0%	87.0%	98.0%	98.0%	99.0%	98.0%	97.0%	93.2%	95.4%	95.2%	94.1%	92.0%	96.7%		Figure subject to change following final data collation
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	Monthly	3.3%	2.9%	3.6%	2.7%	3.2%	3.1%	4.3%	5.7%	3.9%	3.4%	4.0%	2.5%	N/Avail		Requires SLAM data
Fractured neck of Femur																	
Number of patients admitted with FNOF	-	Monthly	30	21	26	52	26	26	36	34	39	31	46	19	31		
Patients fit for surgery within 48hrs	-	Monthly	23	13	25	47	22	24	34	27	37	29	45	17	27		

% of patients admitted with FNOF who were operated on within 48 hrs of being fit for surgery	-	Monthly	0	0	0	0	0	0	0	0	0	0	0	16	29	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	Monthly	95.7%	76.9%	80.0%	87.2%	100.0%	87.5%	85.3%	88.9%	78.4%	100.0%	95.6%	84.2%	93.5%	
Patients fit for surgery within 36hrs	-													17	29	
Number of patients admitted with FNOF who were operated on within 36 hrs	-		New for 2013-14											14	21	
% of patients admitted with FNOF who were operated on within 36 hrs of being fit for surgery	100%													82.4%	72.4%	
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	Monthly	90.0%	71.0%	84.6%	80.0%	85.0%	93.0%	89.0%	100.0%	91.3%	90.6%	69.6%	91.0%	83.0%	
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	Monthly	77%	75%	67%	70%	54%	46%	47%	47%	39%	67%	48%	43%	38%	
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	Monthly	100%	96%	97%	97%	83%	100%	100%	100%	100%	100%	100%	100%	100%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	Monthly	75.0%	90.9%	71.4%	95.8%	76.0%	68.0%	88.9%	72.7%	68.8%	60.0%	69.2%	72.7%	68.0%	
Patients who spend at least 90% of their time on a stroke unit	80%	Monthly	95.6%	96.7%	98.6%	92.6%	93.3%	91.0%	90.2%	84.2%	81.6%	86.1%	96.4%	88.2%	87.5%	
Breast Feeding initiation	75%	Monthly	97.0%	96.0%	96.0%	96.0%	100.0%	99.3%	99.7%	74.9%	75.2%	77.4%	79.4%	80.6%	81.4%	
Caesarean Section Rates - Total	<25%	Monthly	25.6%	27.1%	25.1%	28.5%	26.9%	26.5%	29.3%	24.1%	26.4%	29.2%	24.9%	29.7%	29.7%	
Caesarean Section Rates - Emergency	14.98%	Monthly	11.0%	11.2%	9.8%	13.3%	13.7%	9.4%	14.9%	11.1%	10.1%	12.7%	9.4%	13.2%	11.3%	
Caesarean Section Rates - Elective	10.06%	Monthly	14.6%	15.9%	15.3%	15.2%	13.8%	17.1%	14.4%	13.1%	16.3%	14.7%	15.5%	16.5%	15.0%	
Home Birth Rate	>=6%	Monthly	7.3%	6.9%	9.4%	5.4%	6.8%	4.4%	4.5%	7.5%	2.1%	5.9%	6.6%	3.8%	5.2%	
Number of readmissions within 28 days (Adult)	-	Monthly	New for 2013-14											380	369	
Number of readmissions within 28 days (Children)	-	Monthly	New for 2013-14											137	129	

CQUIN 2013-14	Target 2013-14	Frequency	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	May 13 RAG Rating	Comments
NATIONAL CQUINS																	
1.VTE																	
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month CQUIN payment to be received if both 1a and	Monthly	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.			New for 2013-14											Quarterly			RAG rating in accordance with latest CQUIN Status report
2. Improve responsiveness to personal needs of patients																	
2a. Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	Monthly	Not Avail	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%	66.7%	34.8%	77.4%	96.7%	N/Avail		
2b. Were hospital staff available to talk about any worries or concerns that you had?	>63.4	Monthly	Not Avail	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%	65.2%	86.4%	83.3%	97.5%	N/Avail		
2c.Did you have enough privacy when discussing condition or treatment?	>82.3	Monthly	Not Avail	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%	79.2%	76.2%	73.3%	97.9%	N/Avail		
2d.If you have been prescribed any new medication, have you been informed of any possible medi	>48.5	Monthly	Not Avail	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%	48.4%	60.0%	61.1%	76.8%	N/Avail		
2e. If you are ready to be discharged – have you been informed who to contact if you are worried a	>74.3	Monthly	Not Avail	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%	63.6%	58.3%	57.1%	91.6%	N/Avail		
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting																	
3a.Dementia case finding	0% 3 consecutive months							7.1%	2.4%	0.3%	2.4%	2.9%	2.2%	0.86%	4.35%		
3b.Initial diagnostic assessment	0% 3 consecutive months							N/A	N/A	N/A	N/A	N/A	Not avail	-	0%		3b & 3c no numerator or denominator
3c. referral for specialist diagnosis	0% 3 consecutive months							0.0%	0.0%	0.0%	100.0%	100.0%	Not avail	-	100%		
3d.Lead clinician and appropriate training of staff	Yes		New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes		New for 2013-14											Audit from Q2			RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS																	
1. Develop and implement AECP																	
1a AECP for Chest Pain			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
1c. AECP for Supraventricular Tachycardia			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic																	
2a. HOT Clinic for Paediatrics			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine			New for 2013-14											On track			RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS																	
1. Friends & Family																	
1a. Phased expansion of Friends and Family Test			New for 2013-14											From Oct 2013			RAG rating in accordance with latest CQUIN Status report
1b. Increase response rate to at least 20%		Monthly	New for 2013-14											7.1%	9.2%		RAG rating in accordance with latest CQUIN Status report
1c. Improve performance on staff Friends & Family Test			New for 2013-14											Survey due autumn 2013			No action required for Qu 1 LIA group in place - staff survey to be undertaken in Qu 3
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	Monthly	New for 2013-14											7	5		RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards			New for 2013-14											QCQUIN's to be agreed, awaiting sign off			
4. Timely Simple Discharge			New for 2013-14														
5. Improve access to breast milk in preterm infants			New for 2013-14														
6. Acute Kidney Injury			New for 2013-14														

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 June 2013

Title	Patient Experience Report
Agenda item	7
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Anil Garcia, Interim Patient Experience Lead
Purpose	This report is being presented to the Board for Assurance and Information

Executive summary

- **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.
- **Friends and Family Test CQUIN target** relates to achieving 15% of footfall from inpatient areas + A/E (which is different to last year). The ward response rate was the highest the Trust had ever achieved at **24.22%,** but because the A/E response rate was so low (**0.57%),** the overall Trust score was **9.23%** and therefore the Trust failed the overall target.
- **Update on existing Patient Experience Work** showing the steps being taken to improve A&E response rates and achieve CQUIN Target

Related strategic aim and corporate objective	Be a Provider of Quality Care for All our Patients
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Yes – failure of FFT CQUIN and loss of income
Related Board Assurance Framework entries	BAF1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups? **N**
Legal implications / regulatory requirements	No

Actions required by the Board

- Discuss and challenge the content of the report
- Note the results from the May 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

Trust Board
June 2013
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 May 2013.

2.0 Patient Experience monitoring

2.1 Friends and Family Test

Whilst no steer has been received from the DH regarding the scores achieved via the FFT, trusts nationally continue to monitor the response rate. The FFT response rate for **In Patients** received for the month of **May 2013 was 24.22%**, the highest the Trust has ever achieved**.** 2932 patients were discharged from Northampton General Hospital in May 2013 of which, 710 patients responded to the FFT question. However response rate for **A/E was only 0.57%.**

Details of individual ward response rates can be found in **Appendix 1.** Results below show the scores for May 2013 in those areas now being reported on nationally and those which continue to be collected for local intelligence.

Table 1: FFT activity and Scores

Net Promoter Response Rate Test Results	Apr-13	May-13
Score Target	15%	15%
2013-14 Inpatient Score Results	18.78%	24.22%
2013-14 A & E Score Results	0.97%	0.57%
2013-14 Maternity Area Score Results	41.42%	23.08%
2013-14 Daycase Area Score Results	9.55%	17.65%
2013-14 Paediatric Ward Score Results	40.30%	32.40%

Net Promoter Score Test Results	Apr-13	May-13
Score Target	0	0
2013-14 Inpatient Score Results	63	68
2013-14 A & E Score Results	20	55
2013-14 Maternity Area Score Results	62	66
2013-14 Daycase Area Score Results	53	63
2013-14 Paediatric Ward Score Results	84	85

2.2 Actions taken to share the FFT results

As mentioned in the last report – a log of comments has been started which is collating responses in line with the behavioural framework. This will further support the identification of trends and themes from patients.

All comments received continue to be shared with the relevant departments.

There is a 75:25% split between comments being negative and positive. There appears to be a growing number of comments that positively rate the care.

2.3 Actions taken to improve the FFT results and meet CQUIN target

Table 2: CQUIN Target 1st to 31st May 2013
Unlike last year, the CQUIN target this year is a combined A/E plus inpatient areas. Although the response rate for the wards was the highest the Trust has ever achieved, because the response rate in A/E was so low, this brought us down below the 15% required, resulting in the Trust failing the CQUIN target for May 2013.

Period: 1st to 31st May 2013			**Target = 15%**	**Target yet to be agreed**
Ward / area name	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate for each ward**	**Score for each ward / area**
Inpatient Ward Total	2932	710	24.22%	68
Accident & Emergency Total	5074	29	0.57%	55
IP & A&E	8006	739	9.23%	67

The table above shows the combined FFT response rates. This is how the CQUIN is assessed – with no differentiation made between the two areas.

To meet the target we need A&E to be achieving 30 responses per day.

With this in mind and recognising the difficulties A&E face there are three possible innovations in place or planned:

1. Use of iPAD to collect the data there and then from patients – detailed within last board report. Piloting this opportunity was delayed due to IT issues. These are currently being addressed.
2. Use of a counter system – currently being used within other A&E's – Estates currently costing this option
3. Electronic display informing patients of the test and intentions.

Robert Bleasdale (A/E Matron) is to attend the July Patient Experience Board to feed back the results of using the IPAD, review of the Counter system and the role of the Age UK Volunteers in A&E in helping to increase the response rates.

3.0 Extension to the current FFT data collection

From September 2013 the Trust will be expected to be reporting nationally on the FFT results within Maternity Services. There are 3 points at which the information is to be accessed:

- Antenatal care (question 1) – to be surveyed at the 36 week antenatal appointment
- Birth and care on the postnatal ward (questions 2 and 3) – to be surveyed at discharge from the ward/birth unit/following a home birth
- Postnatal community care (question 4) – to be surveyed at discharge from the care of the community midwifery team to the care of the health visitor/GP (usually at 10 days postnatal)

All mothers will be asked to answer the standard FFT question – would you recommend this service to your friends and family and in addition we are required to ask at least one supplementary question. This question is up to the trust to decide but there is an expectation that it centres on drilling down further as to why they have scored the service as they have.

Work is underway to get this set up for July 2013 to ensure that there is time to test the process.

3.1 Triangulation of Infection Rates, Hand Hygiene and Friends and Family Test results.

As requested, the Patient Experience Lead (PEL) has met with the Infection and Prevention Team to ascertain any commonalities across the Patient Experience Surveys and the data collected in relation to infection, prevention and control. This was also viewed in conjunction with the Master infection prevention dashboard results. This data is available within **Appendix 2.**

The conclusions are as follows:

- Units with the lowest rates of participation and lowest scores in the FFT survey/questionnaire have been identified. Most units present satisfactory response rates for the FFT questionnaires (at least as a percentage of people responding –no figure about the number of patients participating has been considered for this analysis). The FFT scores are mostly below the target (80) for most units and during most of months included in this study.
- The compliance with the Hand Hygiene standards/policies/indicators/regulations is consistently high or very high. This includes most units, even those with relatively high number of infection cases (i.e. Benham, EAU, Willow and even A&E).
- The overall number of infection cases is not very significant. Benham and EAU are exceptions with 23 and 17 cases respectively during the period analysed. The average participation in the FFT for both these units during the six months analysed is 15.6% and 11.8% respectively. In both cases the FFT score is quite poor (average 59.5 and 63.3 respectively).
- A&E also shows low participation and scoring in the FFT survey and a relative high number of infection cases (mostly MSSA) in this period of time.
- Other units show a high level of response and high scores despite having a relatively high number of infection cases (i.e. Hazelwood).

These facts do not allow a direct correlation to be made between infection cases, hand hygiene and the results of the FFT survey.

3.2 In Patient Survey Results – Next Steps

The improvement plan was approved by the Patient Experience Board in May 2013and circulated to all teams. This will be monitored by the PEB via monthly updates. An overview of the results have been circulated to all Matrons, Consultants and Heads of Service.

3.3 Mealtime Survey Audit and Noise at Night Audits

A meeting was held on the 10th June to review the current volunteer audit programme and methodology. The process is to be extended to include face to face interviewing, which will allow the volunteers to drill down further with patients to further understand what the issues are, to enable more effective problem solving.

3.4 Patient information: Listening into Action sub-group

Appointment Letters:
The Child Development Clinic and Gynae Outpatients are currently reviewing the feasibility of piloting the revised letters within their areas.

Signage: Further issues in relation to signage have been raised by the PPI group. The PEL and patient representative are to meet with Stuart Finn to discuss these further.

4. Conclusions

The Patient Experience activity continues to grow across the trust. The PEL permanent role has now gone out to advert with an interview date set for July 2013.

5. Assessment of Risk

The Trust has not achieved the FFT CQUIN for May, which reduces income to the Trust. See steps to address this in body of report.

6. Recommendations/Resolutions Required

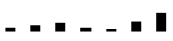
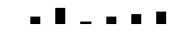
Note the issues identified and where requested provide support.

7. Next Steps

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

APPENDIX 1 - Friends & Family

Friends & Family Net Promoter Score Results

Ward	Graph	Target 2012-13 = 10%					Target Q1 13-14 = 15%	
		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
Abington		27.06%	43.42%	28.95%	37.50%	43.33%	25.00%	30.61%
Allebone		18.97%	16.05%	38.46%	28.57%	22.83%	51.02%	32.98%
Althorp		111.76%	36.84%	31.94%	31.76%	43.00%	54.84%	33.33%
Becket		19.18%	36.96%	21.88%	31.08%	32.08%	40.43%	43.28%
Benham		10.99%	13.11%	8.91%	30.18%	7.91%	12.00%	21.43%
Brampton		34.38%	23.81%	44.12%	41.94%	67.86%	37.84%	40.00%
Cedar		18.28%	29.47%	36.36%	28.57%	25.71%	19.18%	10.34%
Collingtree Medical		18.64%	8.66%	0.0%	20.19%	13.56%	7.06%	37.33%
Compton			77.27%	91.30%	111.11%	77.78%	80.00%	156.25%
Corby Comm.		0%	71.43%	50.00%	0.00%	30.00%	0.00%	9.52%
Creaton		7.41%	16%	32.35%	33.33%	21.05%	7.81%	18.07%
Danetre		0%	0%	57.14%	34.62%	39.53%	39.47%	54.29%
Dryden		16.36%	29.41%	2.38%	27.03%	24.79%	28.32%	19.67%
Eleanor		21.62%	17.91%	16.67%	36.36%	21.74%	38.10%	51.11%
EAU		5.86%	8.40%	13.16%	4.66%	3.15%	14.45%	26.77%
Finedon		37.25%	38.89%	36.21%	29.17%	21.62%	31.25%	46.51%
Hawthorn		75.28%	21.97%	25.47%	36.61%	37.68%	33.85%	30.04%
Hazelwood Comm.		93.75%	25.00%	127.78%	0.00%	60.71%	77.78%	60.00%
Head & Neck		9.38%	19.20%	33.33%	45.45%	40.46%	17.48%	29.81%
Holcot		54.84%	21.21%	68.75%	75.00%	53.57%	83.33%	54.55%
Knightley		53.85%	37.50%	26.67%	31.82%	52.17%	25.64%	40.38%
Rowan		25.95%	24.85%	34.62%	45.56%	32.84%	16.15%	18.18%
Spencer		18.75%	8.04%	21.70%	13.07%	12.79%	10.73%	15.86%
Talbot Butler		23.91%	12.31%	30.56%	10.64%	12.00%	8.93%	26.42%
Victoria			9.88%	23.91%	4.00%	10.45%	15.07%	17.31%
Willow		41.11%	21.33%	29.51%	22.99%	21.30%	11.11%	27.37%
Adult Inpatient Area Total		15.01%	14.77%	16.45%	19.00%	15.15%	18.78%	24.22%

Accident & Emergency Unit	Recorded from January 2013	0.54%	1.75%	0.48%	1.02%	0.25%
Eye Casualty Unit	Recorded from April 2013				0.72%	2.38%
Accident & Emergency Total	Recorded from April 2013				0.97%	0.57%

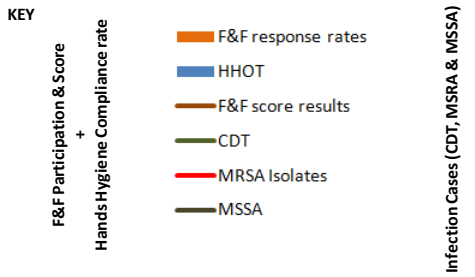
Friends & Family Net Promoter Score Results

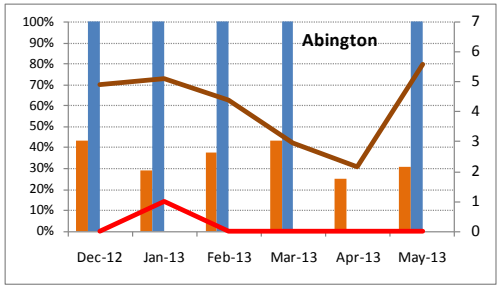
2012-13 Target = Score of 80

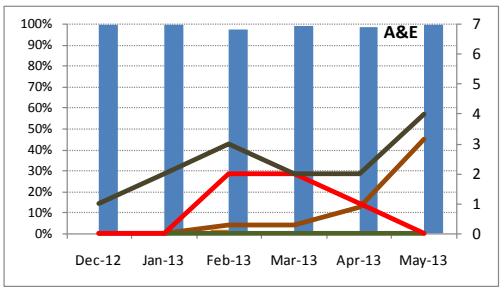
Ward	Graph	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
Abington		50	40	40	67	39	70	73	63	42	31	80
Allebone		0		50	50	64	-8	32	45	52	33	33
Althorp		40	50	15	67	89	71	87	93	81	74	82
Becket		56	56	40	41	93	68	21	43	47	50	79
Benham		89	100	70	70	70	41	50	53	70	77	66
Brampton		50	90	70	60	45	70	93	77	68	64	56
Cedar		38	56	58	64	53	50	65	65	61	31	17
Collingtree Medical		83	25	80	78	82	82		29	55	83	58
Compton		Recorded from December 2012					88	81	70	81	81	76
Corby Comm.						67	87	100		50		100
Creaton		83	100	40	72	100	64	36	40	63	60	43
Danetre								92	67	94	100	100
Dryden		33	80	80	94	67	80	100	80	69	55	41
Eleanor		86	67	82	100	75	92	100	50	80	81	83
EAU		80	100	57	36	77	67	60	73	50	63	67
Finedon		100	0	78	80	58	67	71	50	81	79	74
Hawthorn		91	89	75	90	85	65	56	78	73	70	66
Hazelwood Comm.		60		33	67	47	86	83		82	50	83
Head & Neck		81	100		96	78	92	76	80	83	89	84
Holcot		68	85	70	68	65	100	91	92	93	78	75
Knightley		89	69	64	63	90	72	75	100	96	56	62
Rowan		57	69	75	93	65	62	67	65	79	32	54
Spencer		93	90	100	68	77	89	87	91	79	72	61
Talbot Butler		100	100	92	80	68	63	77	70	87	50	96
Victoria		Recorded from December 2012					50	27	33	0	25	50
Willow		90	100	83	90	84	94	89	75	74	67	73
Adult Inpatient Area Total		70	76	74	76	73	68	68	68	72	63	68
Accident & Emergency Unit		Recorded from January 2013						0	4	4	13	45
Eye Casualty Unit		Recorded from April 2013									67	61
Accident & Emergency Total		Recorded from April 2013									20	55

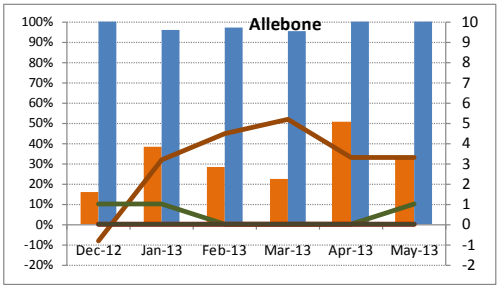
Balmoral	63	73	78	80	79	69	78	79	86	64	74
Robert Watson	68	83	76	76	83	69	54	85	76	56	59
Maternity Ward Total	Previously included within Inpatient Area Total									62	66
Disney	79	82	68	71	69	82	96	67	58	64	70
Paddington	24	87	57	57	51	33	56	46	46	38	51
Paediatric Ward Total	Previously included within Inpatient Area Total									53	63
Danetre Day Surgery	Recorded from January 2013						91	96	98	94	89
Main Theatre Admissions	Recorded from February 2013							92	87	82	83
NGH Day Surgery	Recorded from January 2013						91	97	94	82	83
Singlehurst Day Unit	Recorded from April 2013									100	88
Daycase Area Total	Previously included within Inpatient Area Total									84	85

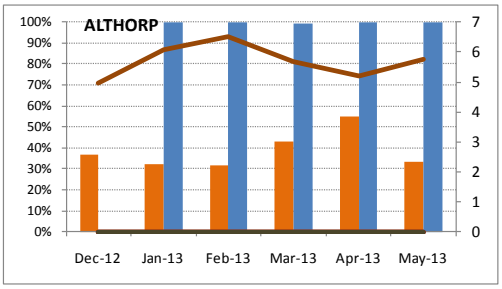
APPENDIX 2 – TRIANGULATION OF INFECTION AND FFT RESULTS

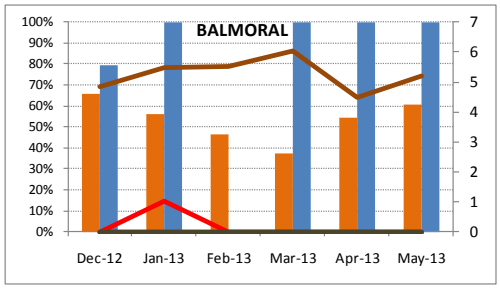


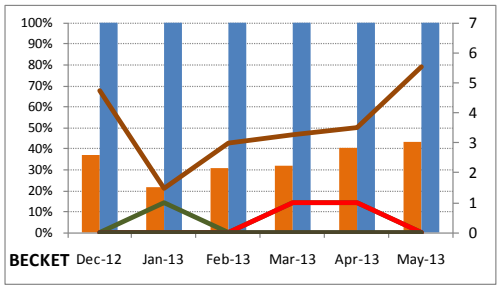


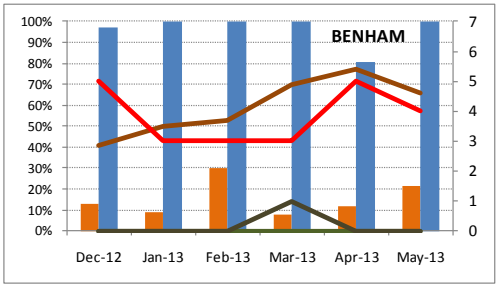


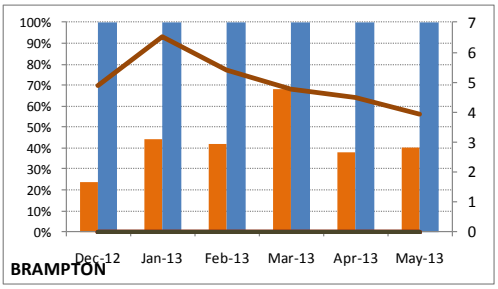


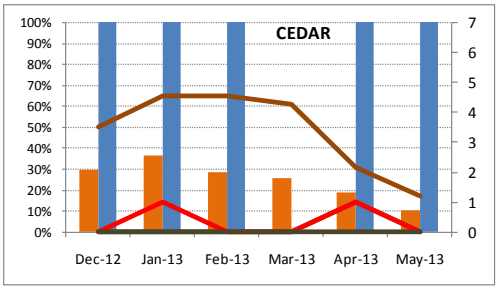


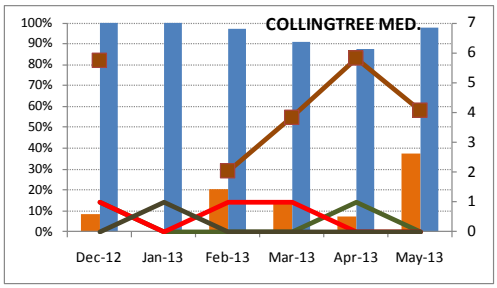








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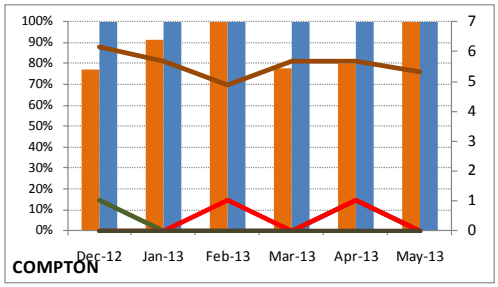
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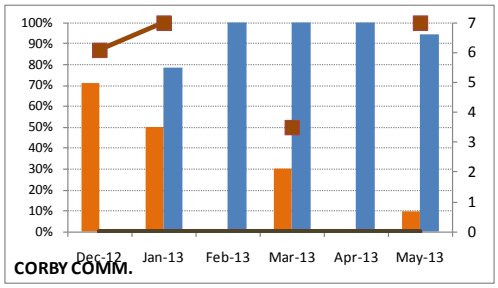
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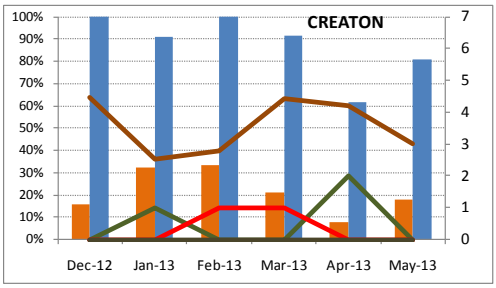
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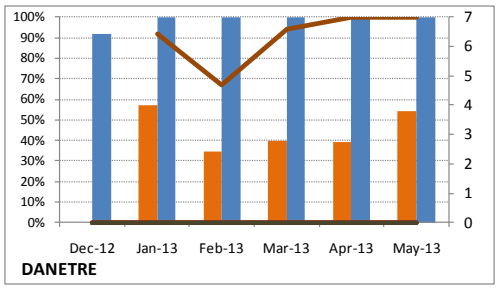
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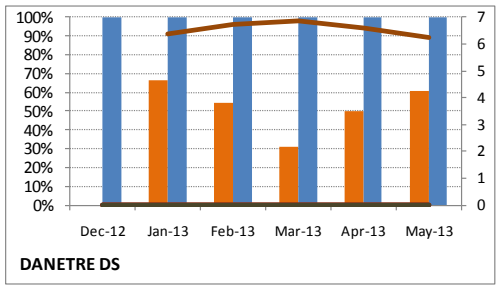
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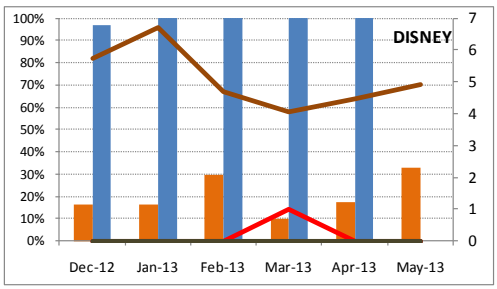
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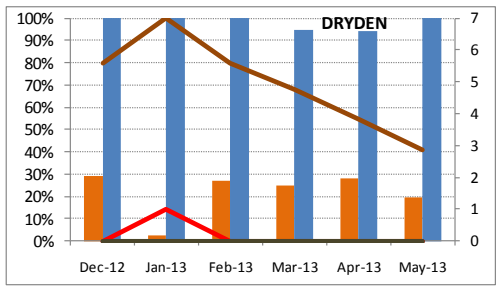
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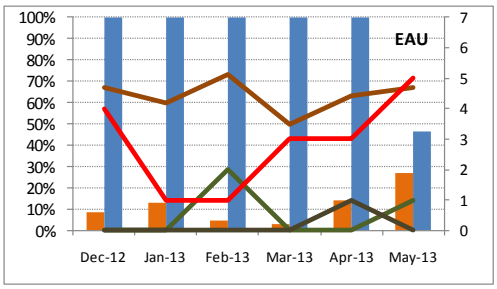
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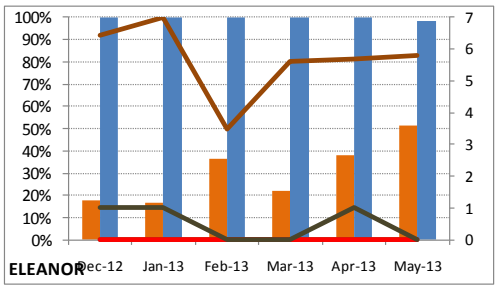
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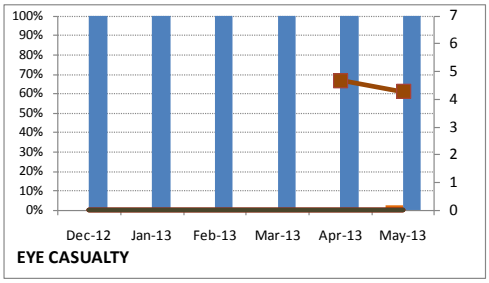

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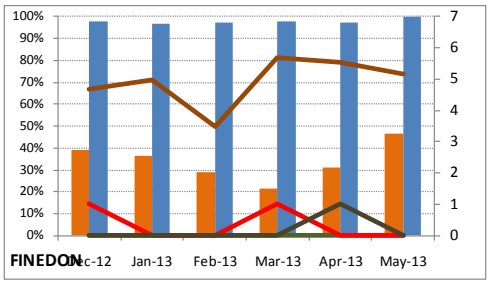

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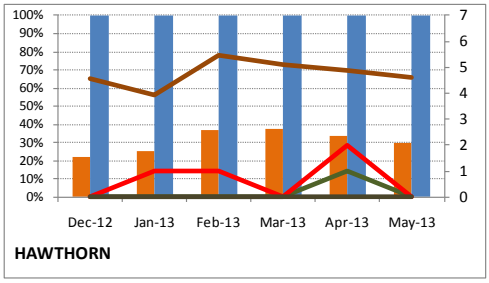

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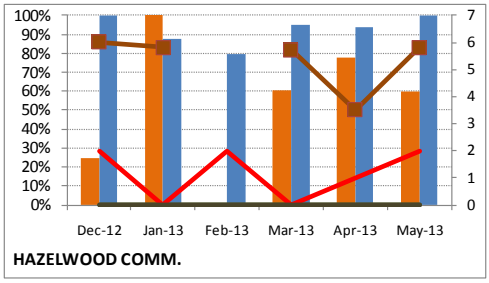

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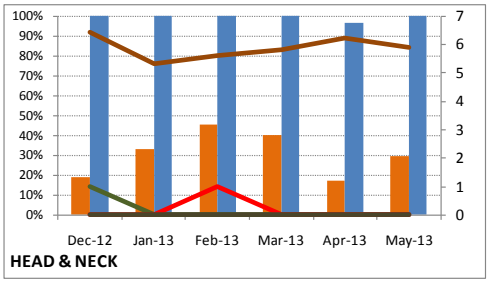

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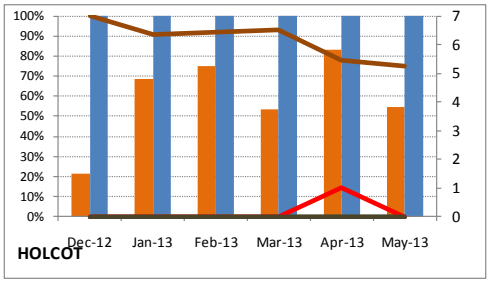

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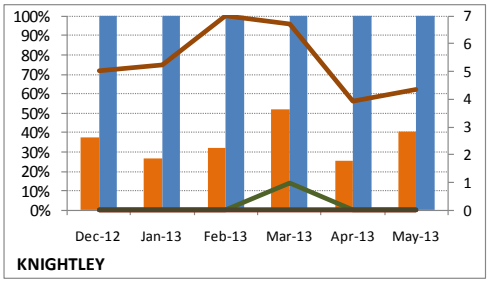

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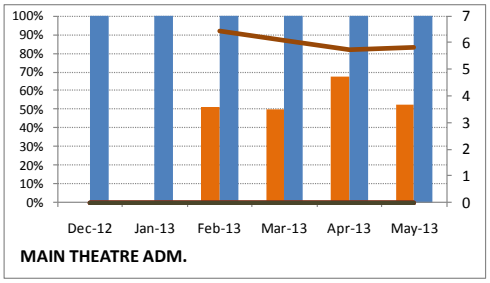

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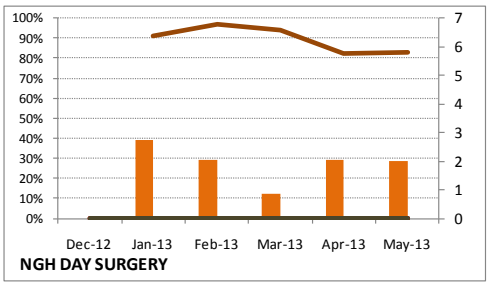
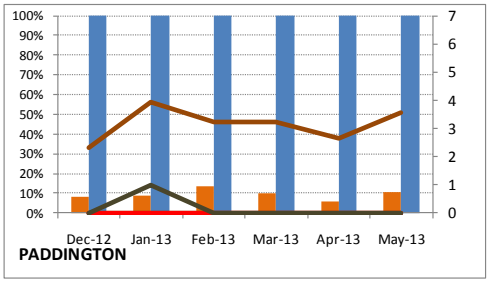


NGH DAY SURGERY



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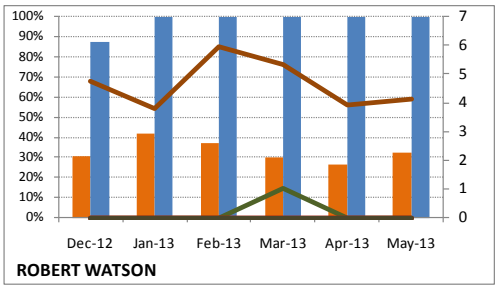

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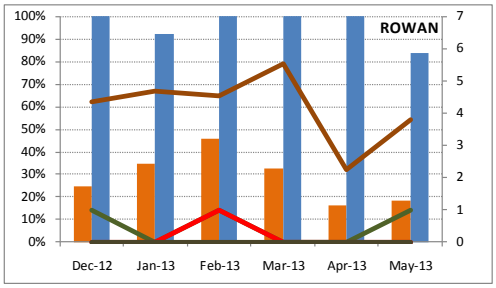
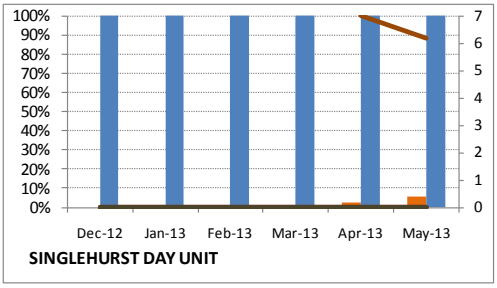
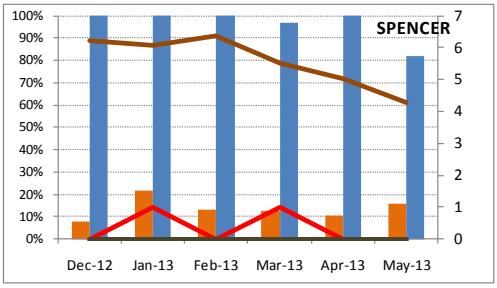
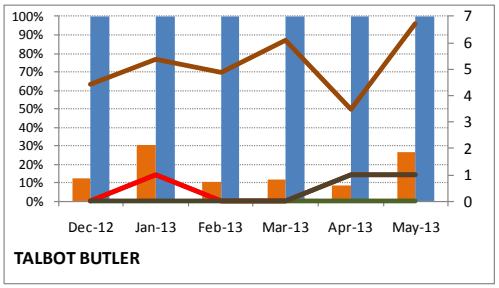


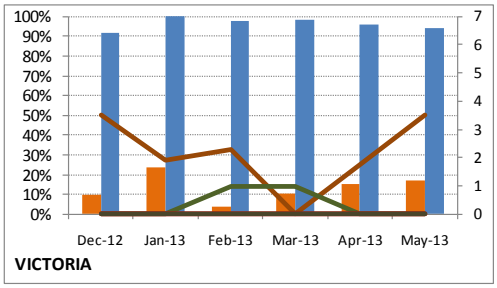


SINGLEHURST DAY UNIT

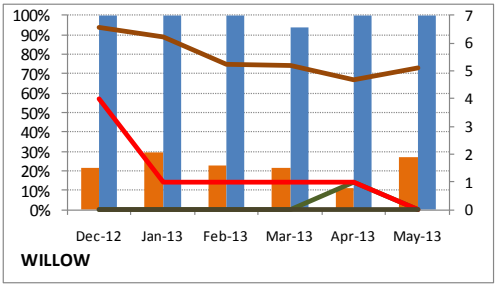




TALBOT BUTLER



VICTORIA



WILLOW

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 June 2013

Title	Monthly Infection Prevention Performance Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Pat Wadsworth, Lead Infection Prevention Nurse
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the month of May 2013.
Executive summary A monthly update on reportable Healthcare associated infections (HCAIs) and 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. The rate of C Diff is rising significantly, which puts the trust's annual trajectory of 29 at risk.	
Related strategic aim and corporate objective	Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way Patient safety there will be no avoidable harm to patients from the healthcare they receive.
Risk and assurance	The Trust has an annual target of 29 C Diff cases and in the first 2 months of the year has sustained 9 cases. There will be significant fines if the trust exceeds 29 for the year, putting the Trust financial position at risk.
Related Board Assurance Framework entries	BAF1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No**
Legal implications / regulatory requirements	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections.(DH 2008) 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.

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
27 June 2013
May 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.

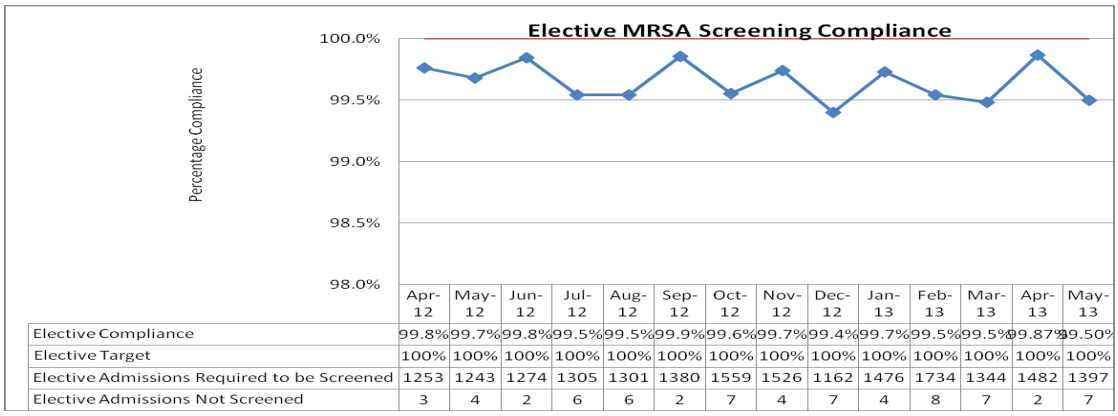
2. Report

2.1 MRSA Bacteraemia (May)

In this report, the results for MRSA have been summarised into the table below.

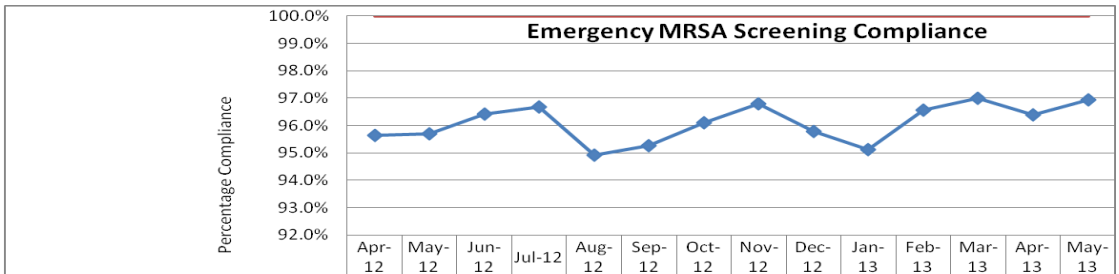
MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
0	0	99.5%	96.9%	0	0

Elective MRSA screening compliance



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
Elective Compliance	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	99.6%	99.7%	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1253	1243	1274	1305	1301	1380	1559	1526	1162	1476	1734	1344	1482	1397
Elective Admissions Not Screened	3	4	2	6	6	2	7	4	7	4	8	7	2	7

Emergency MRSA screening compliance



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
Emergency Compliance	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1030	1117	1059	1115	1120	1074	1155	1158	1209	1126	1104	1170	1056	1113
Emergency Admissions Not Screened	45	48	38	37	57	51	45	37	51	55	38	35	38	34

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

During May 2013 there were 5<48hrs and **0 >48hrs** MSSA bacteraemia case.

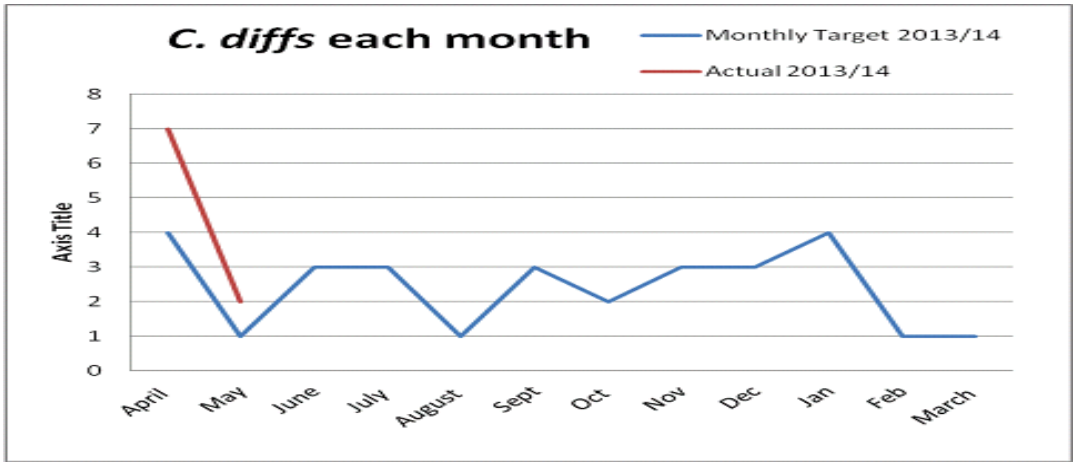
The post MSSA from April was a patient on the oncology ward who was a neutropenic patient with a facial cellulitis. Findings from the RCA were that neutropenic patients are not routinely nursed in protective isolation, even though this patient was in isolation. Hand hygiene audits were consistently 100% and the cleaning score was 89%. The low score was due to high level dust on shelves, no indicator tape on an item of equipment, minor environmental issues of shelf missing from a bathroom and a bed frame dusty. These have now been addressed.

3. Clostridium difficile

The Trust has an annual target of 29 C. diff. cases or less for the financial year. During May 2**>3 day cases *of C. diff*** were identified against a monthly target for May of 1 post 72 hours cases, which totalled 9 for the year. **No ward** needed to be put onto Special Measures during the month.

Of the 11 cases which have occurred to date, only 4 of them have had clinical indications of C Diff, the remainder had received laxatives prior to the specimen being taken and should not have been sent. As a result, a number of actions were put in place to reduce the incidence of inappropriate sampling which were outlined in the previous board report. Whilst these actions were being largely effective, it was felt that more was required. An engaged discussion was held with the Ward Sisters and Matrons who suggested that an authorisation process should be put in place. This was implemented at the beginning of June, with a joint email being sent from the Consultant Microbiologist and Director of Infection, Prevention and Control to all clinical staff and managers informing them of the new process. Since then there has been 1 more case of C Diff, but this was a re-occurrence of a previous case of C Diff and therefore appropriate.

The graph below shows the cumulative and monthly ceiling for CDAD for 2013/14.



4. E. coli

Escherichia coli (E.coli) is an anaerobic, gram-negative bacterium, which is found normally in the human intestine. It appears to be covered in small hairs, which enable it to move around the gut.

Enhanced mandatory surveillance was launched in June 2011 of all cases of E. coli bacteraemia. There is no differentiation between pre (community) and post (hospital acquired) on the DH database which was originally created to determine the size and some basic characteristics of the E.coli problem. There are no targets attached and this is for monitoring purposes only.

During April there were 9<48hrs and **2>48 hrs** and during May there were 5<48hrs and **3>48hrs.**

The Infection Prevention Team with the Consultant Microbiologist investigates through surveillance of all >48.The findings from the 5 are that the majority of these patients are neutropenic with underlying problems of sepsis, from wounds and urinary problems. The monthly Whole Health Economy Infection Control meeting reviews all these bacteraemia from the hospitals and community in a whole healthcare approach.

5. Surgical Site Infection Surveillance Scheme (SSIS)

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

5.1 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 May 2013:

- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from **27** operations
- Total Abdominal Hysterectomies show that there were ***no infections*** resulting from **13** operations in April and **16** operations in May

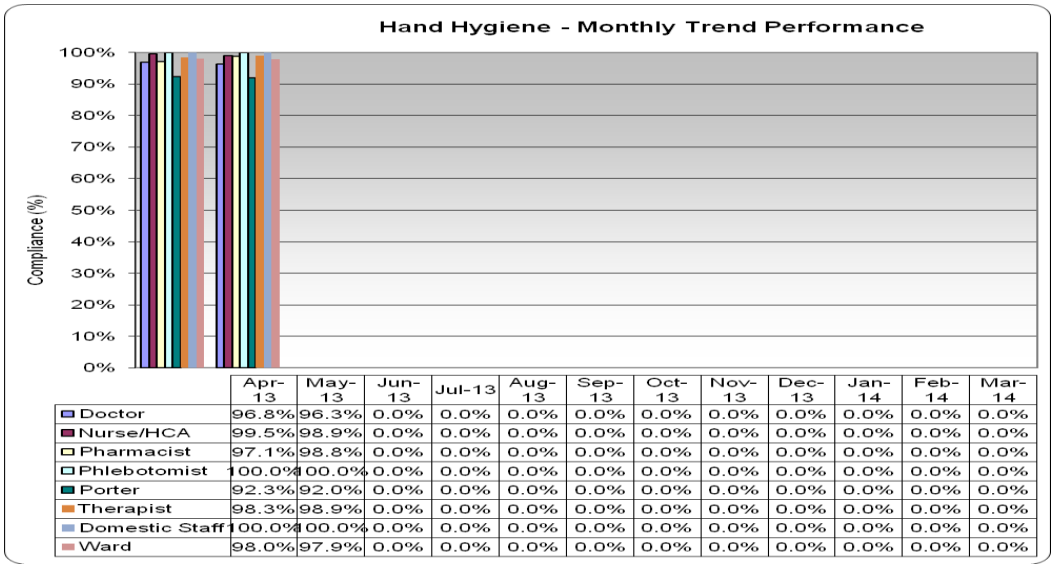
6. Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) data shows that in:

- May overall Trust compliance for hand hygiene = **94.3%** due to 3 areas failing to submit the completed audit.

The areas who have failed to submit their audits were: Chemotherapy Suite, Haematology Outpatients and Camelot Way. The audits were undertaken, but due to a shortage of admin staff, the teams were not able to input the data. As a result, the IPT have identified a member of staff to input this data for the Oncology Matron. These areas will be is highlighted and discussed at the next Infection Prevention Committee meeting.

The graph below demonstrates hand hygiene compliance in the ward areas is considerably higher than the overall trust score. The score for this is **97.9%**

Hand Hygiene -Monthly Trend Performance



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Doctor	96.8%	96.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	99.5%	98.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	97.1%	98.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	92.3%	92.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	98.3%	98.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Domestic Staff	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ward	98.0%	97.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

7. Assessment of Risk

The high rate of C Diff could result in the Trust failing its annual C Diff target, which would result in significant financial penalty. Actions are being taken to try to mitigate this risk.

8. Recommendations/Resolutions Required

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

9. Next Steps

The Infection Prevention team will continue to work collaborative across the Trust to keep levels of infection to a minimum, whilst focusing on ensuring that appropriate C Diff. sampling.
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Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE 27 June 2013

Title	Operational Performance Report
Agenda item	9
Sponsoring Director	Clive Walsh Interim Chief Operating Office
Author(s)	Deborah Needham/Karen Spellman
Purpose	The paper is presented for discussion and assurance

Executive summary

The Trust achieved all the RTT , diagnostic, stoke and cancelled operations standards during May 2013.

The Trust has not achieved the cancer standard; 62 days from GP referral to start of treatment, the performance for May 2013 is 75% against a standard of 85%.

The Trust achieved the 4 hour transit time for patients referred to A&E during May, the Trust achieved 96.28% against the standard of 95%. Year to date performance is 92.62% as at 13th June against a recovery trajectory of 93%.

Ambulance handover times – the standard is for patients arriving to the A&E department by ambulance to be handed over to the nursing team within 15 minutes of arrival. The total number of patients brought by ambulance during May 2013 was 1978 and 452 patients (23% of the total) waited over 15 minutes for handover.

The Performance paper is in a revised format this month, this is currently being developed as part of the move towards integrated performance reporting.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering A&E and 62 day performance standards. A 62 day cancer recovery plan is included in appendix 2
Related Board Assurance Framework entries	BAF 11
Equality Impact Assessment	*Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N* *Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?N*
Legal implications / regulatory requirements	*Are there any legal/regulatory implications of the paper No*

Actions required by the Board

The Board is asked to discuss the content of the report and agree any further action as necessary.

Northampton General Hospital NHS
NHS Trust

Performance Report

Trust Board

27 June 2013

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.10%
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.00%
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.10%
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0
A&E: Total time in A&E (monthly)	CCG & TDA	95%	87.89%	96.28%
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.50%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%
Cancer: 31 Day	CCG & TDA	96%	98.00%	97.40%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	97.90%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%
Cancer: 62 day referral to treatment from an upgrade by a hospital specialist	CCG	80%	100.00%	100.00%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	84.60%	75.00%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	81.40%	88.46%
Trolley Waits waiting > 12hours	CCG	0	0	0
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612.00	452.00

Summary:

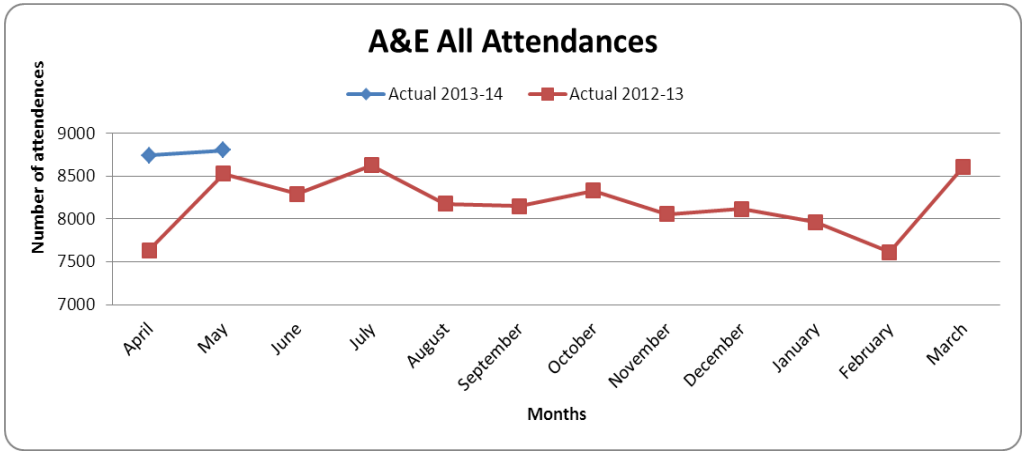
The Trust achieved all the RTT , diagnostic, stoke and cancelled operations standards during May 2013.

The Trust has not achieved the cancer standard; 62 days from GP referral to start of treatment, the performance for May 2013 is 75% against a standard of 85%.

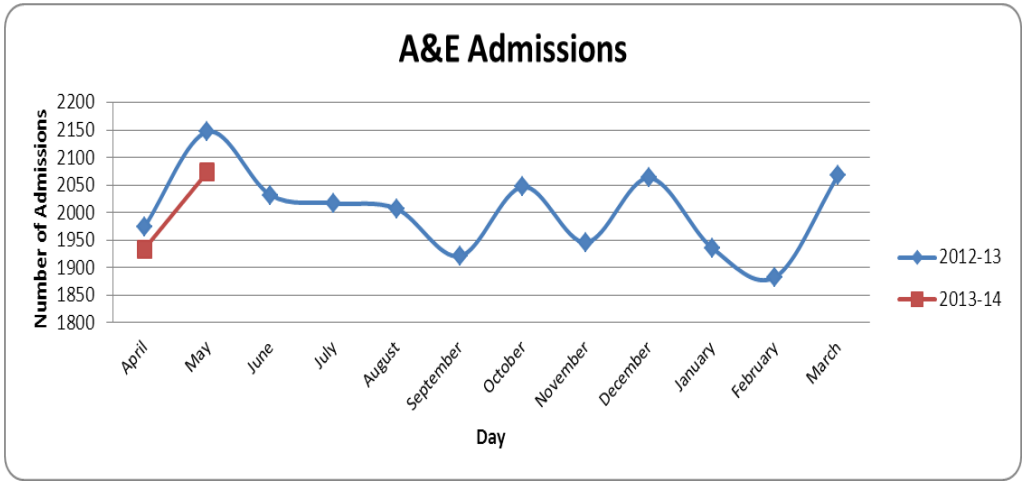
The Trust achieved the 4 hour transit time for patients referred to A&E during May, the Trust achieved 96.28% against the standard of 95%. Year to date performance is 92.62% as at 13th June against a recovery trajectory of 93%.

Ambulance handover times – the standard is for patients arriving to the A&E department by ambulance to be handed over to the nursing team within 15 minutes of arrival. The total number of patients brought by ambulance during May 2013 was 1978 and 452 patients (23% of the total) waited over 15 mins for handover.

A&E & Transit Time (4hr) Target



A&E Targets	Target	Apr-13	May-13
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%



Key Note:

A&E attendances remain higher than the same period last year.

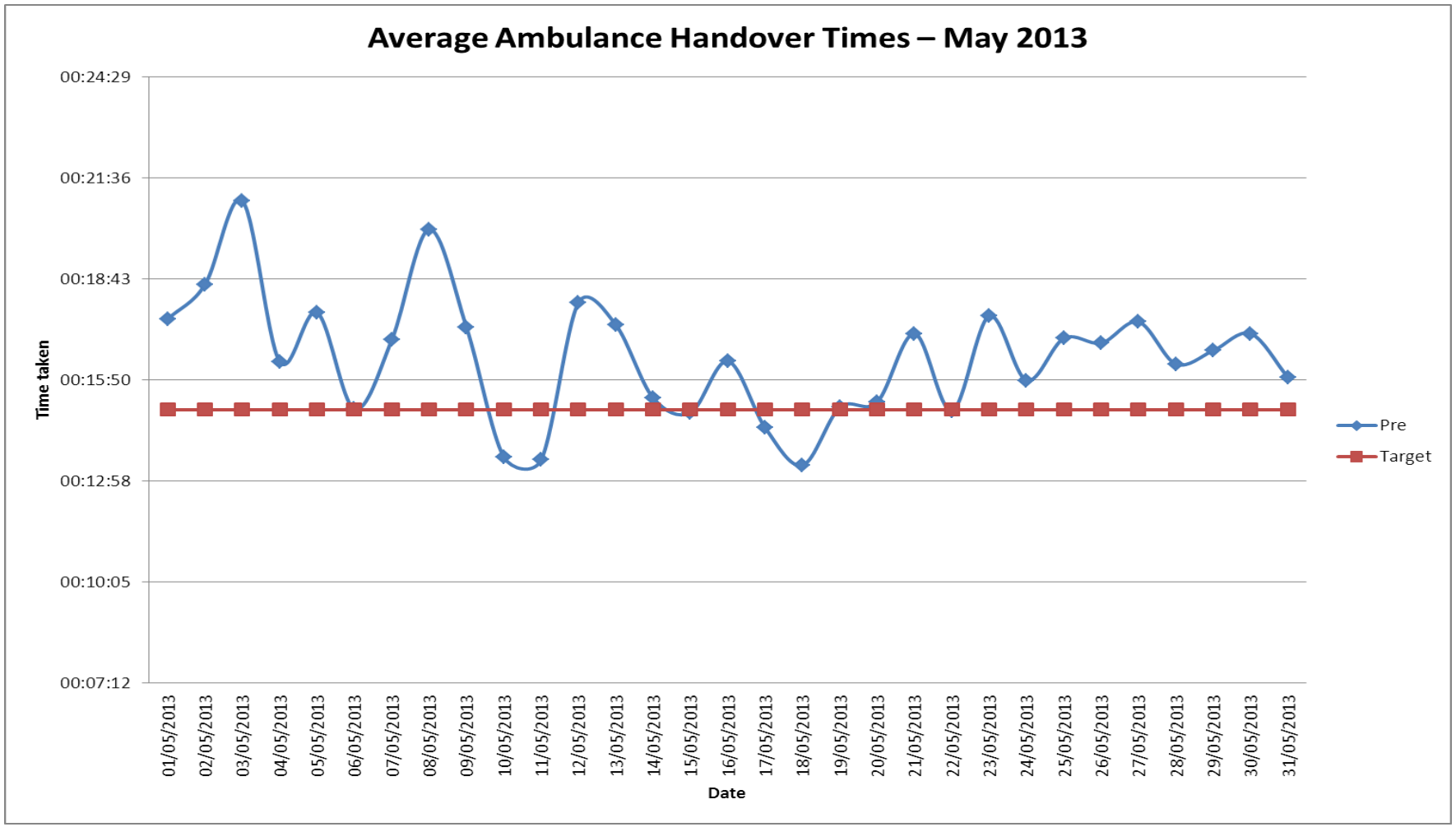
Admissions from A&E are following a similar pattern to last year although slightly lower during April and May 2013.

During May we discharged, transferred or admitted 96.3% of patients within the 4 hour timescale from A&E. This is the first month performance has been above the standard since October 2012.

The Urgent Care Programme continues to make good progress. The priority areas across the 5 work streams are:

- Development of an Ambulatory Care Unit
- Increased Nurse Led Discharge
- Recruitment of Medical staff across Medicine and A&E
- Community hospital MDT working to reduce length of stay
- Discharge to assess for CHC patients

Managing Urgent Care across England remains a challenge for many Health and Social Care providers, as the focus on this area continues to increase the Foundation Trust Network have produced a report on the Emergency Care Pathway after surveying their members. A summary of their report has been discussed at the Integrated Healthcare Governance Committee.



Key Notes:

Please note this data is unvalidated

The total number of patients brought by ambulance during May 2013 was 1978 and 452 patients (23% of the total) waited over 15 mins for handover. The average time to handover throughout the month was 16 mins.

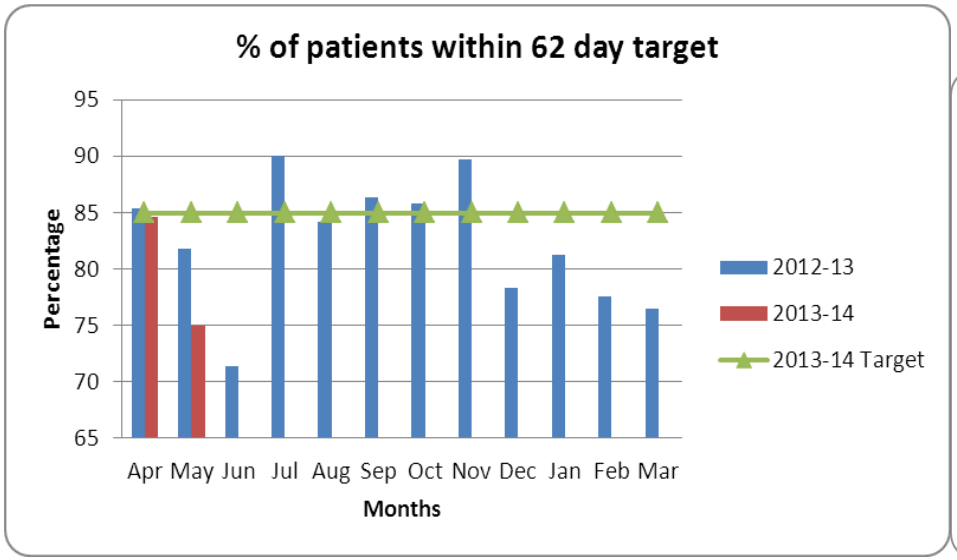
Cancer Targets

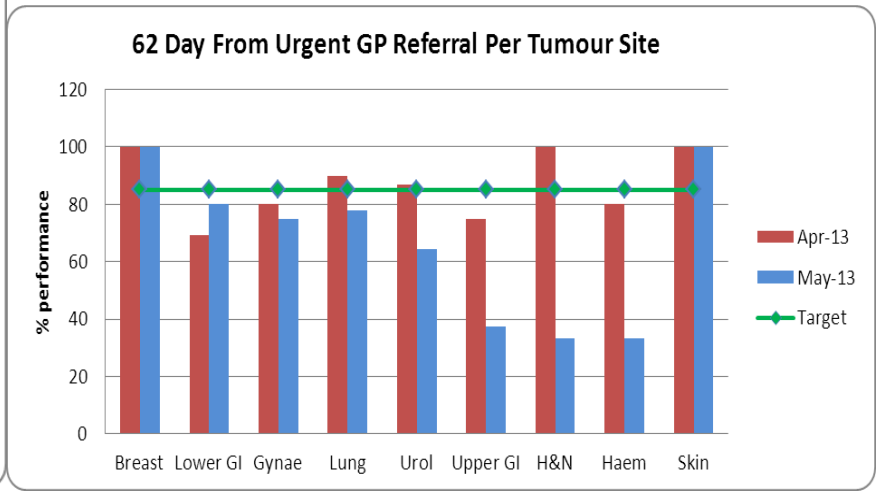
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13
Cancer: 2 week GP referral to 1st outpatient	96%	96.00%	95.50%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	98%	100.00%	100.00%
Cancer: 31 Day	99%	98.00%	97.40%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	97.90%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%
Cancer: 62 day referral to treatment from an upgrade by a hospital specialist	80%	100.00%	100.00%
Cancer: 62 days urgent referral to treatment of all cancers	85%	84.60%	75.00%

Key Notes:
The Trust has not met the 62 day cancer standard from urgent GP referral to start of first treatment for April or May. During May the Trust achieved 75% against the standard of 85% (subject to final validation). There were 18.5 breaches over 62 days (25 patients). The following is a summary of the breach reasons;

- Highly complex management of patients
- Late referrals
  Patient choice to decline or defer appointments
- Internal processes

62 day referral from Cancer Specialist
Only 2-4 patients are normally treated a month on this pathway. The Trust achieved 100% in April and May once the agreed adjustments are made. The CCG contract states that patients delayed due to reasons beyond the Trust's control will be excluded, the 4 patients that breached in April and May.





Cancer Targets

Recovery Plan

The Trust's updated recovery plan was reviewed and agreed at the Integrated Healthcare Governance Committee on 19h June. The key recovery actions are:

Management of pathways

- An interim service manager for 3-4 months whilst current cancer manager recruitment is progressed
- Increased frequency of tracking and use of the escalation policy
- Weekly review of patient pathways and performance metrics at the cancer performance meeting

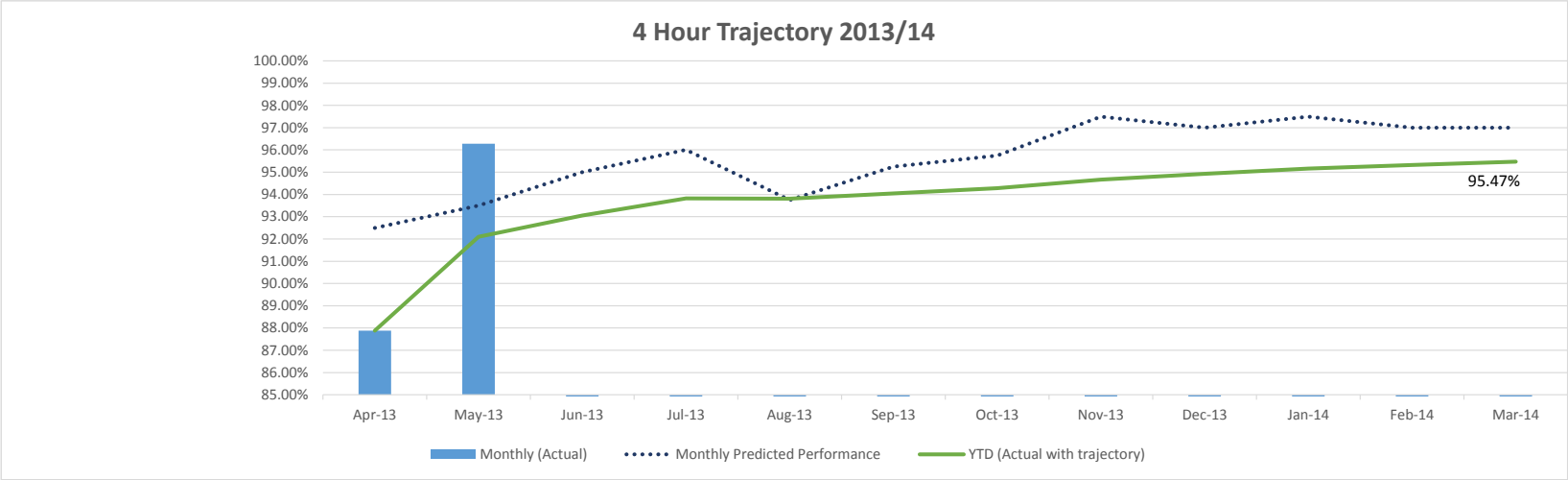
Whole pathway reviews

- Review of the following pathways by the end of July 2013
    - Inter trust referral admin and referral to MDT process
    - Colorectal
    - Head and Neck
    - Upper GI
    - Gynae

Pathway stages

- Reduction in waits for diagnostics e.g. MRI scans and Endoscopy
- Reduction in delays to Head and Neck combined clinic
- Reduction in delays in planning IMRT

4 HOUR TRAJECTORY 2013/14 (revised June 2013)



Attendances		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Actual 2012/13	7,633	8,529	8,293	8,626	8,180	8,152	8,330	8,055	8,118	7,961	7,614	8,584
	Actual 2013/14	8,742	8,801										
	Variance (Month by Month)	12.7%	3.1%										

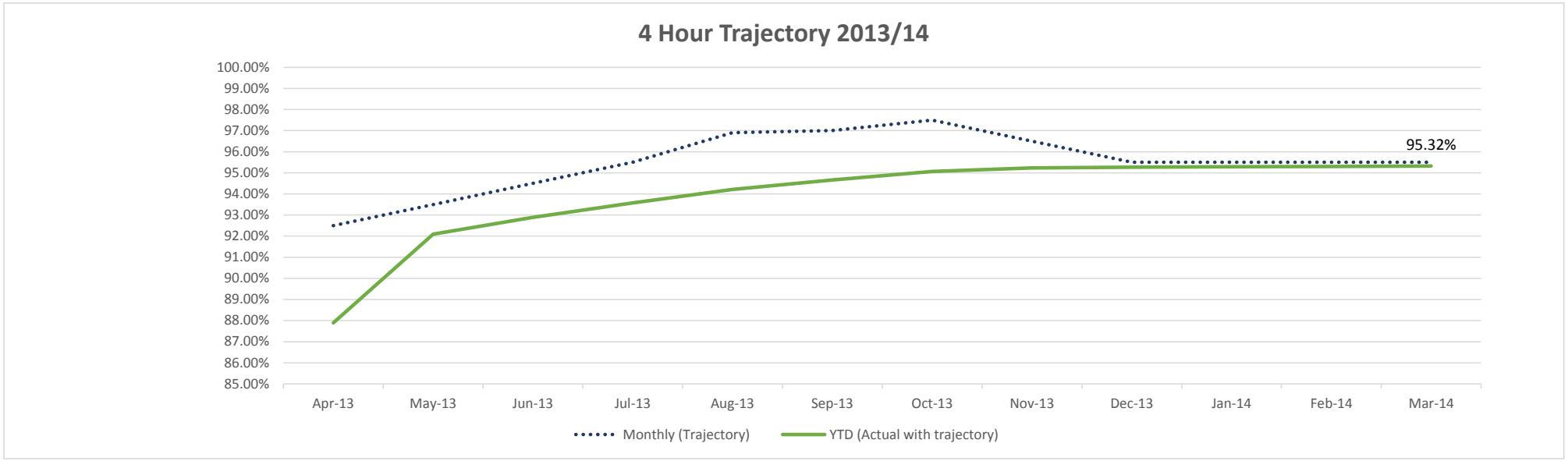
Trajectory Breakdown	Service Improvements	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
	Baseline for 2013/14	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
	Rapid Assessment & Streaming					0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%
	Ambulatory Care Unit					0.50%	0.50%	0.50%	0.50%	0.50%	1.00%	1.00%	1.00%
	ED Consultants							0.00%	0.25%	0.25%	0.25%	0.25%	0.25%
	ANP									0.00%	0.25%	0.25%	0.25%
	Acute Physicians										1.00%	1.00%	1.00%
	Discharge (Community)								2.00%	2.00%	2.00%	1.50%	1.50%
	Frail & Elderly (CCG Scheme)							1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Patient Flow (Teleologic)										0.75%	0.75%	0.75%
	Operational Adjustment	-2.5%	-1.50%	0.00%	1.00%	-1.50%	-0.50%						
	Seasonal Adjustment					-0.50%		-1.00%	-1.50%	-2.00%	-4.00%	-4.00%	-4.00%
	Projected Performance	92.50%	93.50%	95.00%	96.00%	93.75%	95.25%	95.75%	97.50%	97.00%	97.50%	97.00%	97.00%

Cumulative	Performance	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
	Monthly Predicted Performance	92.50%	93.50%	95.00%	96.00%	93.75%	95.25%	95.75%	97.50%	97.00%	97.50%	97.00%	97.00%
	Attendances	8,742	8,801	8,542	9,316	8,425	8,397	8,580	8,297	8,362	8,200	7,842	8,842
	Breaches	1,059	327	427	373	527	399	365	207	251	205	235	265
	Monthly (Actual)	87.89%	96.28%										
	Year to Date	8,742	17,543	26,085	35,401	43,826	52,223	60,803	69,099	77,461	85,661	93,503	102,345
	YTD (Actual with trajectory)	87.89%	92.10%	93.05%	93.83%	93.81%	94.04%	94.28%	94.67%	94.92%	95.17%	95.32%	95.47%

Green indicates actual 13/14 data

20/06/13 DO

4 HOUR TRAJECTORY 2013/14 (Original Projections for TDA Plan April 2013)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Actual 2012/13	7,633	8,529	8,293	8,626	8,180	8,152	8,330	8,055	8,118	7,961	7,614	8,584	98,075
Actual 2013/14	8,742	8,801											17,543
Variance (Month by Month)	12.7%	3.1%											
Variance (YTD)	12.7%	7.9%											
Trajectory Attendance Variance	3.0%	3.0%	3.0%	8.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Monthly (Trajectory)	92.5%	93.5%	94.5%	95.5%	96.9%	97.0%	97.5%	96.5%	95.5%	95.5%	95.5%	95.5%	
Attendances	8,742	8,801	8,542	9,316	8,425	8,397	8,580	8,297	8,362	8,200	7,842	8,842	102,345
Breaches (Actual, Estimated)	1,059	327	470	419	261	252	214	290	376	369	353	398	4,789
YTD (Actual with trajectory)	87.89%	92.10%	92.89%	93.57%	94.21%	94.66%	95.06%	95.23%	95.26%	95.29%	95.30%	95.32%	95.32%

Green indicates actual 13/14 data

17/06/13 DO

REPORT TO THE TRUST BOARD

DATE 27 June 2013

Title	Finance Report Month 2 – May 2013
Agenda item	10
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance
Purpose	To report the financial position and associated risks for year to May 2013.

Executive summary

The report sets out the financial position for May 2013-14 (month 2).

The overall position is a deficit of £1.1m, £0.3m adverse to the plan submitted to the TDA in April.

The key reasons for the adverse position are:

- Increase in non-pay run rate
- Requirement to make additional income provisions
- Non-delivery of CIPs.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	There are a range of financial risks which pose a direct risk to delivery of the financial plan for 2013-14.
Related Board Assurance Framework entries	BAF 17, 18,19
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Committee

The Board is asked to note the recommendations of the report.

The Trust's Financial and Contracting Performance Report as at 31 May 2013

Month 2 2013/2014

1. Summary Performance – Financial Duties

1.1. Table 1 summarises the year to date and full year forecast performance against the statutory financial duties required of the Trust. A performance dashboard is also included at Appendix 1.

Table 1 – Key Financial Duties

	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	-£1,100	-£828	-£4,856	-£4,856	-£0
Achieving EFL (£000's)	N/A	N/A	£5,304	£5,304	£0
Achieving the Capital Resource Limit (£000's)	£586	£606	£10,664	£10,664	£0
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Invoices	85%	95%	90%	95%	-5%
Value of Invoices	83%	95%	90%	95%	-5%

Key Issues:-

- **Financial Recovery Plan** – Discussions have taken place with the TDA regarding the development of a Financial Recovery Plan (FRP). The TDA requirement for the FRP is to establish a range of measures which are required for the Trust to be able to re-submit a balanced financial position. In arriving at this position the FRP will need to consider the current financial position and risks identified at month 2 and set out a range of measures which will require the support of the TDA and CCG.

- **Monthly Financial Performance –** Financial performance in May 2013 has deteriorated, particularly in other income and non-pay as non-recurrent benefits in April have fallen away. Key drivers for this change are set out in sections 2,3 and 4.

- **CIP Delivery –** There are still a significant level of CIP schemes which have not yet been identified as part of the financial plan. The year to date variance for these unidentified CIPs is a £777k adverse variance. As additional schemes are identified within the Transformation Programme, it is important for the Trust to understand their impact on the current financial plan in order to provide effective mitigation to the adverse position reported. Whilst the release of contingency reserves, underspend in pay and over performance in income have partially offset this in May, this trend cannot be expected to continue. This will place significant financial pressure on the existing financial plans. CIP delivery in month 2 has also fallen behind plan, adding further pressure to the delivery of financial targets.

- **Income, case mix and penalties** – CCG income for month 2 is based on discharge data and is subject to validation and final coding. Provisions of £700k have been included within the financial position to cover the normal range of contract penalties, including the probability of fines for exceeding the CDiff threshold. A review of the methodology for charging Critical Care bed days is underway and has been challenged by the CCG in the first two months of

the financial year. To reflect the risk in delivery of targets, CQUIN income is also currently accrued at 75% of the contract value (£209k adverse to plan for the year to date).

- **Performance Against Contract** – The Trust set itself an internal capacity plan which exceeds the contracted levels of activity. Whilst the Trust is marginally over performing against this capacity plan, it is over performing more significantly against the contract with the main Commissioners. This level of over performance may not be financially sustainable for CCGs and is driven by a range of unsupported QIPP initiatives which were agreed as negative or zero entries in the main contract. The matter is now being discussed with CCG and a letter highlighting the resulting over performance will be sent to host CCGs for comment.

Table 2 – I&E Position - May 2013

I&E Summary	Annual Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	May Plan	May Actual	April Actual	Forecast EOY Exc FRP
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	38,352	**38,743**	**391**	19,303	19,587	19,156	**230,904**
Other Clinical Income	2,803	467	**438**	**(29)**	234	179	259	**2,803**
Other Income	25,575	4,223	**3,971**	**(252)**	2,077	1,965	2,007	**25,575**
Total Income	**259,281**	**43,042**	**43,152**	**110**	**21,614**	**21,731**	**21,421**	**259,281**
Pay Costs	(175,015)	(28,893)	**(28,587)**	**306**	(14,418)	(14,349)	(14,238)	**(175,015)**
Non-Pay Costs	(78,307)	(13,058)	**(13,253)**	**(196)**	(6,564)	(6,813)	(6,441)	**(78,307)**
CIPs	4,663	777	**0**	**(777)**	389	0	0	**4,663**
Reserves/ Non-Rec	(1,207)	(285)	**0**	**285**	(168)	0	0	**(1,207)**
Total Costs	**(249,866)**	**(41,459)**	**(41,840)**	**(382)**	(20,761)	**(21,161)**	**(20,679)**	**(249,866)**
EBITDA	**9,415**	**1,583**	**1,312**	**(272)**	853	**570**	**742**	**9,415**
Depreciation	(10,184)	(1,730)	**(1,730)**	**0**	(865)	(865)	(865)	**(10,184)**
Amortisation	(10)	(2)	**(2)**	**0**	(1)	(1)	(1)	**(10)**
Impairments	0	0	**0**	**0**	0	0	0	**0**
Net Interest	29	5	**5**	**(0)**	2	3	1	**29**
Dividend	(4,106)	(684)	**(684)**	**(0)**	(330)	(330)	(354)	**(4,106)**
Surplus / (Deficit)	**(4,856)**	**(828)**	**(1,100)**	**(272)**	(341)	**(623)**	**(477)**	**(4,856)**
Normalised for Impairment		**(828)**	**(1,100)**	**(272)**	(341)	**(623)**	**(477)**	**(4,856)**

1.2. Financial performance for the year to date is now a £1.1m deficit against a plan of £828k, an adverse variance of £272k. This performance recognises the considerable levels of unmet CIP reported in month and the adverse performance of other income against plan.

1.3. The income position has continued to include a prudent provision for likely fines and penalties levied by CCGs. With the reported numbers of CDiff infections now higher than trajectory, provisions for fines have also now been included within the financial position. The potential fines for CDiff based on current incidence could amount to £1.8m by the financial year end.

1.4. Capital expenditure is marginally ahead of plan as ICT and Estates have continued and ramped up in May. This marginal overspend is due to phasing of the expenditure profile. The Trust still expects to spend its planned capital expenditure and meet its CRL duties.

1.5. During May the Trust continued to retain sufficient cash to make all payments due to the majority key suppliers. The difficulties reported by CCGs concerning SBS processing have improved slightly with key invoices now being paid as expected, accepting that the Trust is making considerable efforts were required to raise invoices early and to confirm payments. Given the liquidity situation of the Trust this work will continue.

1.6. The Trust continues to make use of extensive levels of temporary staff to meet operational needs. The Trust Board has already agreed investment in substantive nursing posts to

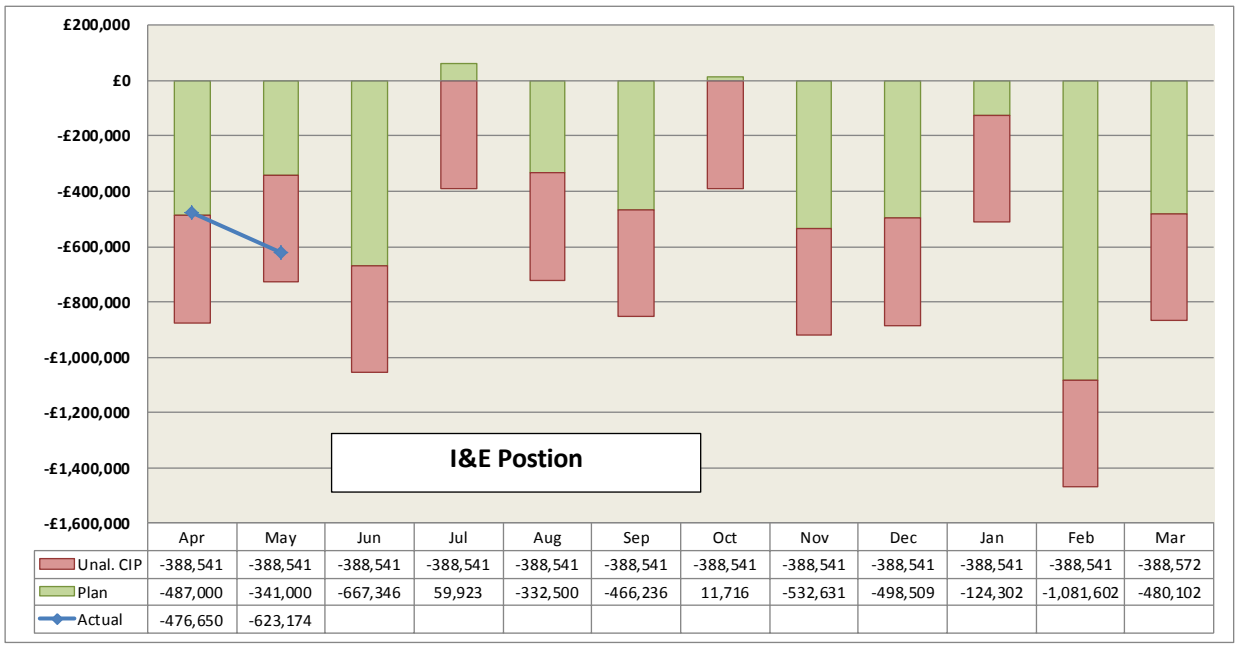
reduce this expenditure eliminating the premium such expenditure attracts. Plans to recruit to these posts must be expedited to reduce the current levels of bank and agency spend.

2. Income and Expenditure Position of the Trust

Surplus/ (Deficit) Position

2.1. Appendix 2 provides details of the Trusts summary I&E position. The Trusts year to date I&E position for the period ended 30 June 2013 is a deficit of £1,100k. This performance is £272k adverse to the month 2 cumulative planned deficit of £828k.

Graph 1 – Income & Expenditure Profile 2013-14



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unal. CIP	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,572
Plan	-487,000	-341,000	-667,346	59,923	-332,500	-466,236	11,716	-532,631	-498,509	-124,302	-1,081,602	-480,102
Actual	-476,650	-623,174										

2.2. Graph 1 shows the I&E plan for 2013-14. The unidentified CIP is shown as an additional risk to the planned position (highlighted in red) each month. The failure to deliver CIPs in full in month 2 have contributed toward the deterioration in the financial position together with the non-recurrent benefits of rebate reported in month 1 now falling away exposing the recurrent levels of non pay expenditure.

2.3. Levels of bank and agency usage have continued to be high increasing from the £1.4m in April to £1.5m in May. This trend is concerning and emphasises the urgency of permanent recruitment to substantive nursing posts. In addition an increase in agency management staff has also contributed to this increase. A review is suggested in this area to assess the reasons for the increase and to take corrective action where possible.

3. Income and Activity

3.1. Year to date total operating income stands at £43.1m which is £110k ahead of plan. The principal drivers behind the performance are set out below.

SLA and Other Clinical Income

3.2. SLA income and other clinical income amounted to £39.18m year to date at month 2 marginally exceeding planned levels by £0.36m as set out in table 3 below. Case mix adjustments have been posted for month 1 and will be processed once coding data is available. This may change the overall income position which will be reported verbally to

F&P as appropriate. Provisions to cover potential contractual fines and penalties totalling £0.7m have been accrued in the month 2 position now including £0.1m for CDiF fines. CQUIN is accrued at 75% of plan.

Table 3 SLA and Clinical Activity year to date

Income & Activity Summary	ACTIVTY				INCOME			
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var
Elective Daycase	6,533	6,701	168	2.6%	3,743,930	3,977,934	234,004	6.3%
Elective Inpatients	1,076	1,217	141	13.1%	2,763,525	3,034,858	271,334	9.8%
Non Elective	6,055	6,358	303	5.0%	12,038,911	10,254,143	-1,784,769	-14.8%
New Outpatients	10,310	10,390	80	0.8%	1,718,643	1,572,902	-145,741	-8.5%
Follow Up Outpatients	18,385	20,389	2,004	10.9%	1,774,399	1,832,736	58,337	3.3%
Non Cons Led Outpatients New	5,108	4,562	-546	-10.7%	425,600	407,445	-18,155	-4.3%
Non Cons Led Outpatients Follow Up	10,066	10,795	729	7.2%	507,877	522,271	14,394	2.8%
Outpatient Procedures	7,128	6,988	-140	-2.0%	1,044,567	1,058,746	14,179	1.4%
Block Contracts - Fixed					3,825,600	6,129,982	2,304,382	60.2%
Cost Per Case					5,391,502	5,478,944	87,442	1.6%
A&E					1,557,713	1,727,775	170,062	10.9%
Pathology					995,486	1,067,521	72,035	7.2%
Excluded Medicines					2,438,894	2,162,733	-276,161	-11.3%
Excluded Devices					204,812	215,205	10,393	5.1%
Fines, Penalties and Challenges					-599,986	-700,402	-100,416	16.7%
Productivity CIP's					389,823		-389,823	-100.0%
Other Central SLA Income					130,534		-130,534	-100.0%
Other Clinical Income					467,110	438,079	-29,030	-6.2%
Sub-Total SLA Clinical Income	64,661	67,400	2,739		38,818,940	39,180,873	361,933	

3.3. The risks reported previously associated with a change of contractual emphasis by CCGs are now becoming real and CCGs have now confirmed that they will be active in levying the full remedies permissible under the contract for failures. Provisions have been included set out below:

- Readmissions £400k
- Contract Challenges £100k
- Case Mix changes £100K
- CDiF fines £100k

3.4. CQUIN income has been accrued at 75% of the full target giving rise to an adverse variance of £209k. There is risk of non-delivery of CQUIN schemes and work is underway to allocate appropriate levels of CQUIN income to Directorates and to build a performance framework to enable more robust financial of this area. The current updates on CQUINS report that many are on track to deliver however this performance should be scrutinised in more detail to support the delivery of these CQUINS.

3.5. Following analysis of the month 1 case mix data it was noted that the historic methodology for counting critical care may require updating. This issue was highlighted to the Trust by CCGs at the June Strategic Contract Meeting. This challenge may change the overall level of critical care income reported and is considered as a further risk to the financial position. Given that the work has not yet been concluded no allowance has been included within the financial position for this issue.

3.6. The Trust set itself an internal plan which exceeded the contracted levels of activity. Whilst the Trust is marginally over performing against this capacity plan it is over performing more significantly against the contract with it main Commissioner Nene CCG. This level of over performance may not be financially sustainable for CCGs and is driven by a range of unsupported QIPP initiatives which were agreed a negative or zero entries in the main contract. The matter is now being discussed with CCGs and a letter reporting the facts sent to CCGs for comment.

3.7. Recent discussions now with CCGs have highlighted omissions in SUS data which must replace PCT with CCG codes. Work has now been expedited in this area, accepting that failure to comply may result in the withholding of up to1% of the contract value as a penalty.

Other Income

3.8. Other income amounted to £3.9m year to date at month 2 which is now behind plan by £0.25m. This adverse performance is due to a significant income target set to reflect the external secondments and non-recurrent project and other support which the Trust has traditionally secured in the latter half of the year. This income has been phased to be delivered through the year accepting that much of this is often received in the final quarter of the financial year. Performance in this area is expected and assumes that any costs associated with such activities will be contained within existing plans.

3.9. The LETB have yet to confirm to the Trust the overall level of MPET funding to be made available for 2013/14. This follows late central DH budget cuts to training and education funding. The risk associated with this income stream is still current and steps are now being taken to establish the likelihood of this occurring and the expected quantum.

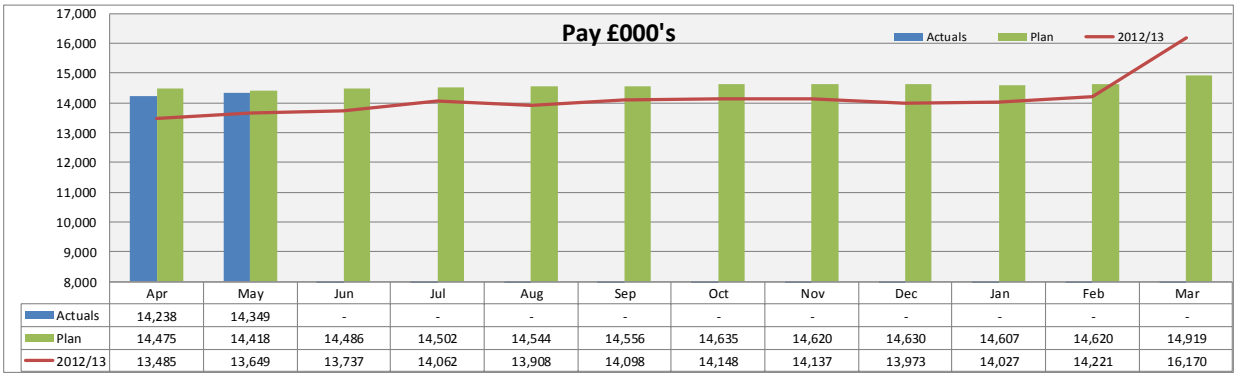
4. Expenditure

4.1. The Trust has overspent on its expenditure plans by £382k in May 2013. This position included unmet CIP of £777k, partly offset by the year to date release of contingency reserves.

Pay Expenditure

4.2 Pay costs year to date were £28.6m (FTE 4,212) against a plan of £28.9m (FTE 4,450) reporting a favourable variance of £0.3m (FTE 238) as set out in graph 2 below. The Trust does however continue to make use of temporary staff to support this under establishment incurring the associated premium costs.

Graph 2 – Pay expenditure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actuals	14,238	14,349	-	-	-	-	-	-	-	-	-	-
Plan	14,475	14,418	14,486	14,502	14,544	14,556	14,635	14,620	14,630	14,607	14,620	14,919
2012/13	13,485	13,649	13,737	14,062	13,908	14,098	14,148	14,137	13,973	14,027	14,221	16,170

4.3 The Trust is operating below the planned WTE budget (by 238.38 FTE**)** but is utilising significant numbers of temporary staff in excess of this number as set out in the tables below.

Table 4 – WTE Analysis Budget, Actual Temporary staff and Actual Permanent Staff – May 2013

	WTE Budget 2013/14 M2	Permament Staff Worked Mth 2 WTE	Temporary Staff Worked Mth 2 WTE	Worked V Bud Var
Staff Type				
Medical Staff	479.34	449.93	21.66	7.75
Nursing Staff	1920.87	1676.52	170.85	73.50
Managerial & Administration	912.00	738.34	103.58	70.08
Other Clinical Staff	322.81	281.41		41.40
Scientific & Technical Staff	390.72	375.23		15.49
Estates Staff	35.50	31.74		3.76
All other Staff	389.16	327.08	35.68	26.40
				-
Total WTE	4450.40	3880.25	331.77	238.38

Table 5 Temporary Staff Costs – May 2013

Staff Group £000's	Feb	Mar	Apr	May
	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000
Medstaff ADH's	87	141	97	114
Agency Medstaff (Senior)	105	206	75	116
Agency Medstaff (Junior)	198	131	172	127
Bank Staff - Nursing	378	426	390	344
Agency Staff - Senior Nursing	246	242	220	245
Agency Staff - Junior Nursing	90	104	58	91
Agency Staff - Management	136	226	84	127
Bank Staff - Admin	131	148	101	127
Agency Staff - Admin	76	43	74	63
Bank & Agency Staff - Other	94	131	139	154
Total Temporary Staff	**1,540**	**1,798**	**1,410**	**1,509**

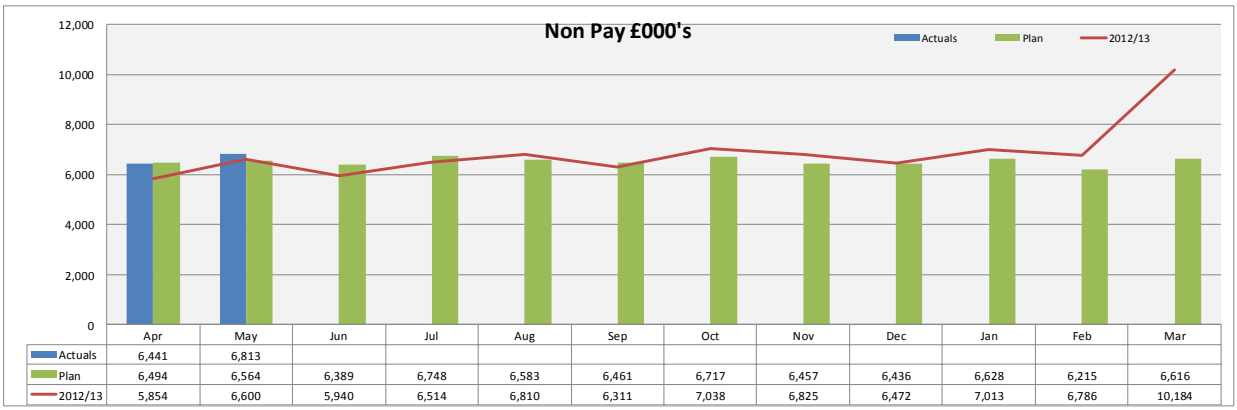
4.2. Levels of bank and agency usage have continued to be high increasing from the £1.4m in April to £1.5m in May. This trend is concerning and emphasises the urgency of permanent recruitment to substantive nursing posts. In addition an increase in agency management staff has also contributed to this increase. A review is suggested in this area to assess the reasons for the increase and to take corrective action where possible.

4.3. Discussions have also taken place with HR which have identified potential differences in counting of temporary staff number. These discussions will ensure that one set of workforce numbers is reported consistently across HR and Finance in future months.

Non Pay Expenditure

4.4. Non Pay costs year to date were £13.3m against a plan of £13.1m reporting an adverse variance of £0.2m as set out in graph 3 below. Month 1 expenditure included a £0.1m benefit due to a non-recurrent gas rebate which was reported fully in month 1 with a consequential impact on run rate.

Graph 3 – Non Pay expenditure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actuals	6,441	6,813										
Plan	6,494	6,564	6,389	6,748	6,583	6,461	6,717	6,457	6,436	6,628	6,215	6,616
2012/13	5,854	6,600	5,940	6,514	6,810	6,311	7,038	6,825	6,472	7,013	6,786	10,184

Transformation Programme (CIP Programme)

4.5. The Trusts financial plan set a CIP target of £13.0m (5% of income). A further £1.95m of additional schemes are currently being targeted to provide further contingency to support the financial position and the current level of high risk schemes. Appendix 4 details the identified schemes by work stream. The status of identified schemes is set out in table 7.

4.6. The Transformation team have made the following assessment of delivery for those schemes currently identified. Any shortfall in delivery compared to the £13m plan represents a direct risk to the overall delivery of the £4.8m deficit plan.

Table 6 Status of Transformation CIP Schemes

RAG rating / Status	£'000
Green	6,109
Amber	1,964
RED	2,747
Schemes under development	1,264
Gap	916
Total	13,000

4.7. Current planning by the Transformation team is that all green, amber and red schemes are delivered only totalling £10.82m. Further consideration by the Transformation Team is also now being given to the best, likely and worst case scenarios which could reduce delivery down to £9.6m.

4.8. To date £1.4m have been recorded as delivered which is now behind the TDA plan by £84k. Further details are contained in the Transformation report however it is noted that many of the Best practise Tariff and income schemes now appear to be failing to deliver fully, following case mix validation noted at month1.

Contingency Reserves

4.9. The Trust identified a contingency reserve of £3.9m as part of the Integrated Business Planning process. On 30 April the Strategic Management Board approved a range of developments reducing the balance to £1m.

4.10. No further developments were funded from contingency in month 2 however an additional £100k has been identified from a reduction in the PDC payment. It is also noted that the contingency is being released to support the unidentified CIPs each equally each month.

5. Statement of Financial Position and Cash Flow as at 28th February 2013

5.1. The Trust's Statement of Financial Position (Balance Sheet) as at 31st May 2013 is contained within Appendix 3 of this report.

5.2. The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of May stood at £6.7m (April £7.1m).

5.3. Cash reserves have been sufficient to meet the Trust key statutory duties but the resilience of the cash position remains poor, notably when half yearly payment of PDC dividends are due to the Treasury.

5.4. An analysis of income earned by the Trust but unpaid as at 31st May is shown in the table below.

Table 7 – Aged Debtor analysis – May 2013

Aged Receivables / Payables: Current Month	Sub Code	Sign	Total at Period End	0-30 days		30 - 60 Days		60-90 Days		Over 90 Days	
			(mc 01)	(mc 02)	(mc 03)	(mc 04)	(mc 05)	(mc 06)	(mc 07)	(mc 08)	(mc 09)
			£000s	£000s	%	£000s	%	£000s	%	£000s	%
Receivables Non NHS	550	+	1,161	269	23	198	17	196	17	498	43
Receivables NHS	560	+	4,352	2,758	63	677	16	356	8	561	13

5.5. The debt due in up to two months relates to over performance with NHS Milton Keynes and is now being actively discussed with the managing organisation to agree settlement. Appropriate provision was made in 2012/2013 for these invoices in the event that payment is not agreed in full.

5.6. A significant element of the outstanding debt relates to payroll and service charges for the CRIPPS Recreation Centre. The balance outstanding at the end of May was £386k, of which £297k has been outstanding for over one month. The Trust is currently in discussion with CRIPPs representatives regarding the on-going viability of the centre.

5.7. The Trust has continued to manage its cash position closely and to make use of creditor payment flexibility. The table below shows performance against the Better Payment Practice Code for the last three months.

Table 8 – Better Payment Policy (BPPC) compliance

Better Payments Practice Code	Sub Code	Sign	Current Year To Date		Previous Month	
				Value		Value
			(mc 01)	(mc 02)	(mc 03)	(mc 04)
			Number	£000s	Number	£000s
Non NHS						
Total bills paid in the year	630	+	12,513	12,733		
Total bills paid within target	635	+	10,725	11,165		
Percentage of bills paid within target	640	+	**86**	**88**		
NHS						
Total bills paid in the year	650	+	291	1,794		
Total bills paid within target	655	+	167	934		
Percentage of bills paid within target	660	+	**57**	**52**		
Total						
Total bills paid in the year	670	+	12,804	14,527		
Total bills paid within target	675	+	10,892	12,099		
Percentage of bills paid within target	680	+	**85**	**83**		

5.8. The Trust has continued to breach the BPPC targets in the past three months due to the back log from previous months and the need to protect liquidity for key payments toward the end of the month.

6. Capital Programme and Performance against Capital Resource Limit

6.1. The 2013/2014 Capital Plan has been set at £10.91m, which includes donations from Charitable Funds of £0.25m. The agreed Capital Resource Limit (CRL) is set net of donated fund at £10.66m.

Table 9 – Capital Expenditure – Year to May 2013

Key Data: Capital and Cash	Sub Code	Sign	2012/13 Full Year Accounts (mc 01) £000s	Current Year to date Plan (mc 02) £000s	Current Year to date Actual (mc 03) £000s	Current Year to date Variance (mc 04) £000s	Forecast Outturn Plan (mc 05) £000s	Forecast Outturn Forecast (mc 06) £000s	Forecast Outturn Variance (mc 07) £000s
Capital Position									
Under / (Over) spend against Capital Resource Limit (CRL):									
Total Charge against the Capital Resource Limit (CRL) incl IFRS impact	350	+/-		586	606	20	10,664	10,664	0

6.2. This Capital Programme has been funded through internally generated cash resources from depreciation of £10.18m supplemented by external financing from SALIX of £0.48m.

6.3. The total spend for month 2 is £606k against an initial plan of £586k. This has exceeded the planned level of expenditure by £20k which is largely to a catch up in ICT and Estates expenditure. Full analysis of capital expenditure is set out in appendix 6.

6.4. The overall level of Capital Expenditure for the financial year is £10.91m (including anticipated donations). The Trust is planning to meet it statutory duty to meet its CRL limit.

6.5. The Trust is developing two further significant capital schemes which will impact the overall level of capital expenditure in 2013/2014.

- **Carbon Energy Fund (CEF) –** The Trust has been successful in the initial bidding, securing £2.7m to invest in energy infrastructure. The bid is still subject to a final bid submission to the DH with a decision expected in June 2013. If successful the award will lead to an increase in the Trust CRL and External Financing Limit (EFL) with the cash requirements being funded through a drawdown of additional Public Dividend Capital (PDC).
- **Managed Equipment Service (MES) –** The Trust developed a MES scheme to replace its aging Radiotherapy and Radiology diagnostic equipment in 2012/13 and is currently in the procurement phase to select a preferred bidder. The scheme capital investment of approximately £14m will be funded by the Private Sector as part of a monthly unitary charge payable for the full 14 year term. This scheme is the subject to a separate paper which will be discussed at F&P.

7. Monitor Financial Risk Rating

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

7.2. The overall risk rating for the Trust as at the May 2013 if it were a Foundation Trust would be 3. The Trust is forecast to end the year with a risk rating of 3 based on the £4.8m deficit plan.

8. Risks to Financial Position

8.1. A summary of the Trusts financial risks and opportunities not included in the forecast financial position are set out in table 11 and 12 below:

Table 10 – Risks

Key Risks not included in Financial Plan 2013-14		Value of Risk £000s	Likelihood	Probability %	Adjusted Risk £000s
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage	Early focus on delivery of identified schemes and development of new schemes.	(3,800)	High	90%	(3,420)
Lack of Funding to implement Transformation Programme Schemes	Bid made to the CCG setting out requirement to meet costs of Transformation programme. Appropriate provisions made in 2012-13 accounts for known costs.	(1,300)	High	90%	(1,170)
CCG QiPP schemes fail to deliver leading to excess demand for NEL activity and cancellation of EL activity.	Engagement with CCG QiPP schemes. Regular reports from CCG. Early monitoring of activity and demand assumptions compared to planned assumptions. Review of triggers to release capapcity. Application of 2% strategic reserve funding to meet excess costs.	(3,000)	Medium	50%	(1,500)
CCG QiP Schemes are fully successful and A&E and NEL activity is significantly reduced leading to over capacity and unfunded costs.	Engagement with CCG QiPP schemes. Regular reports from CCG. Early monitoring of activity and demand assumptions compared to planned assumptions. Review of triggers to release capacity. Application of 2% CCG strategic reserve funding to meet costs of transaction.	(6,500)	Low	20%	(1,300)
Funding cuts to LDA impact on level of income received from LETB and loss of recognised medical training posts	Effective Negotiation with LETB and use of alternative funding streams to offset shortfall	(300)	High	90%	(270)
CQUIN schemes are not delivered and penalty imposed by CCGs / EMSCG. Risk evident with certain schemes (e.g. Patient Safety Thermometer).	Monitoring and performance framework to be put in established. Risk to be identified and 25% provision made in monthly reporting.	(1,300)	Medium	50%	(650)
Contractual Fines may be imposed by commissioners for failure to deliver key performance targets (e.g. A&E, CDIFF and RTT).	Performance management of key targets. Early engagement and reconcilation with CCGs. Action plans to manage key targets.	(2,000)	High	90%	(1,800)
Net Revenue Risk		**(18,200)**			**(10,110)**

Table 11 – Opportunities

Key opportunities not included in Financial Plan 2013-14		Value of opportunity £000s	Likelihood	Probability %	Adjusted Risk £000s
Income opoportunites through coding review	Ensure coding is key areas is as detailed as practical	750	Low	50%	375

9. Conclusion

9.1. The financial position has deteriorated during May and the Trust is now failing to perform in accordance with its plans. This poor performance is largely due to the non delivery on CIP schemes, underperformance on some of its income other targets and the need to make provision for fines which may be levied by CCGs under contract compliance.

9.2. The income position remains subject to validation of casemix and early engagement and reconciliation of performance under the terms of the agreed contract with the CCG. This may deliver an improvement to the clinical income position.

9.3. There is a range of potential CIP delivery currently identified by the Transformation team giving rise to a significant risk to the overall financial position. This presents a direct risk to the delivery of the financial plan and could see the deficit increase further beyond plan. Urgent action is now required to support the delivery of the existing CIP programme required to meet the Trust financial targets.

9.4. As a matter of priority, substantive recruitment is required to minimise the use of all groups bank and agency staff.

9.5. A working capital loan of £4m is required by September. The Trust will seek guidance from the NTDA in terms of the application process.

9.6. The Trust will need to work with the TDA, CCG and LAT to develop financial recovery plan with the following two aims:

- Provide assurance that the £4.8m deficit plan will be delivered as a minimum.
- Consideration of options to reduce the £4.8m planned deficit in conjunction with the CCG and TDA.

10. Recommendations

10.1. The Board is asked to note the contents of the report and ensure that the actions to manage emerging risks are discussed and understood.

Appendix 1

Finance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	M1	M2	
Financial Risk Rating (Shadow)	3	3	FRR shadow score of 3
EBITDA %	3.6%	3.0%	EBITDA % scores 2 under Monitor FRR
Liquidity (days cover)	18.7	18.4	Achieves FRR score of 3.
Surplus Margin	-1.9%	-1.9%	I&E deficit of £1.1 ytd May
Pay / Income	67.5%	67.5%	Pay 67.5% of Income for YTD
I&E Position	**£000's**	**£000's**	
Reported Position	(448)	(1,100)	Deficit £1.1m May 2013, £272k behind plan.
Impairment	0	0	No Impairments recorded to date.
Normalised Position	(448)	(1,100)	I&E position excluding impairment.
TDA Plan (Year to date)	(459)	(828)	NTDA Plan for May 2013
PCT SLA Income Variance	87	391	Ahead of plan ytd subject to case mix changes
TDA annual plan	(4,856)	(4,856)	Full year NTDA control total.
Forecast EOY I&E postion	(4,856)	(4,856)	Current forecast is to achieve plan
EBITDA Performance	£000's	£000's	
Variance from plan	12FAV	(285)ADV	Ytd position £272k behind plan
Cost Improvement Schemes	**£000's**	**£000's**	
YTD Plan	760	758	Ytd target £1.518m
YTD Actual	755	679	Ytd delivered £1.43m
% Delivered	99%	90%	Variance from plan £84k
LTF	11,100	10,820	Value of Schemes rated Green and Amber Schemes
Annual Plan	13,000	13,000	Annual Transformation Target.
LTF v. Plan	85%	83%	% of LTF compared to annual plan.
Capital	**£000's**	**£000's**	
Year to date expenditure	126	460	Capital expenditure for period
Committed as % of plan YTD	13%	26%	% of plan committed for year to date.
Annual Plan	10,664	10,664	Capital Resource Limit of £10.6m for 2013-2014
SoFP (movement in year)	**£000's**	**£000's**	
Non-current assets	(740)	(44)	Depreciation offset by additions
Current assets	3,481	704	Decrease in cash increase in debtors
Current Liabilities	3,189	(309)	Pay down of creditors and release provision
Cash	**£000's**	**£000's**	
In month movement	2,801	(392)	1/4ly block payments in April. Creditors paid down in Mar
In Year movement	2,801	2,409	Pay down of creditors and pick up in capital spend
DH Temporary Loans	0	0	No approvals for 2013/14 to date.
Debtors Balance > 90 days	1,013	1,059	19.21% of debt over 90 days
Creditors > 90 days	1.24%	1.22%	1% of creditors waiting over 90 days
BPPC (by volume) YTD	81.7%	85.0%	Target 95% paid in 30 days

Appendix 2

Income & Expenditure Position – May 2013

I&E Summary	Annual Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	May Plan	May Actual	April Actual	Forecast EOY Exc FRP
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	38,352	**38,743**	**391**	19,303	19,587	19,156	**230,904**
Other Clinical Income	2,803	467	**438**	**(29)**	234	179	259	**2,803**
Other Income	25,575	4,223	**3,971**	**(252)**	2,077	1,965	2,007	**25,575**
Total Income	**259,281**	**43,042**	**43,152**	**110**	**21,614**	**21,731**	**21,421**	**259,281**
Pay Costs	(175,015)	(28,893)	**(28,587)**	**306**	(14,418)	(14,349)	(14,238)	**(175,015)**
Non-Pay Costs	(78,307)	(13,058)	**(13,253)**	**(196)**	(6,564)	(6,813)	(6,441)	**(78,307)**
Reserves/ Non-Rec	(1,207)	(285)	**0**	**285**	(168)	0	0	**(1,207)**
Total Costs	**(249,866)**	**(41,459)**	**(41,840)**	**(382)**	(20,761)	**(21,161)**	**(20,679)**	**(249,866)**
EBITDA	**9,415**	**1,583**	**1,312**	**(272)**	853	**570**	**742**	**9,415**
Depreciation	(10,184)	(1,730)	**(1,730)**	**0**	(865)	(865)	(865)	**(10,184)**
Amortisation	(10)	(2)	**(2)**	**0**	(1)	(1)	(1)	**(10)**
Impairments	0	0	**0**	**0**	0	0	0	**0**
Net Interest	29	5	**5**	**(0)**	2	3	1	**29**
Dividend	(4,106)	(684)	**(684)**	**(0)**	(330)	(330)	(354)	**(4,106)**
Surplus / (Deficit)	**(4,856)**	**(828)**	**(1,100)**	**(272)**	(341)	**(623)**	**(477)**	**(4,856)**
Normalised for Impairment		**(828)**	**(1,100)**	**(272)**	(341)	**(623)**	**(477)**	**(4,856)**

Appendix 3
Statement of Financial Position as at May 2013

TRUST SUMMARY BALANCE SHEET MONTH 2 2013/14						
	Balance at 31-Mar-13	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	133,789	133,789	133,789	0	133,789	0
IN YEAR REVALUATIONS	0	(94)	340	434	262	262
IN YEAR MOVEMENTS	0	125	606	481	10,914	10,239
LESS DEPRECIATION	0	(771)	(1,730)	(959)	(10,184)	(9,750)
NET BOOK VALUE	**133,789**	**133,049**	**133,005**	**(44)**	**134,781**	**751**
CURRENT ASSETS						
INVENTORIES	4,934	4,938	4,860	(78)	4,862	(211)
RECEIVABLES						
NHS DEBTORS	4,103	5,279	6,389	1,110	4,214	111
OTHER TRADE DEBTORS	2,295	1,246	1,162	(84)	2,295	0
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(443)	0	(443)	0
CAPITAL RECEIVABLES	0	0	0	0	0	0
NON NHS OTHER DEBTORS	132	354	496	142	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,596	2,551	(45)	2,514	0
OTHER RECEIVABLES	676	939	889	(50)	675	(1)
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,023	2,112	89	2,053	666
	10,149	**11,479**	**12,641**	**1,162**	**10,925**	**776**
NON CURRENT ASSETS FOR SALE	0		0	0	0	
CASH	4,342	7,154	6,774	(380)	4,654	312
NET CURRENT ASSETS	**19,425**	**23,571**	**24,275**	**704**	**20,441**	**877**
CURRENT LIABILITIES						
NHS	628	1,171	1,393	(222)	4,411	(3,783)
TRADE CREDITORS REVENUE	1,255	3,647	2,114	1,533	2,921	(1,666)
TRADE CREDITORS FIXED ASSETS	1,744	947	1,082	(135)	1,744	0
TAX AND NI OWED	1,769	3,417	3,404	13	1,800	(31)
NHS PENSIONS AGENCY	2,013	2,123	2,138	(15)	2,030	(17)
OTHER CREDITORS	495	369	356	13	494	1
SHORT TERM LOANS	669	669	669	0	5,500	(116)
ACCRUALS AND DEFERRED INCOME	6,132	6,186	6,802	(616)	4,000	2,132
PDC DIVIDEND DUE	36	390	720	(330)	0	36
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	4,472	4,148	5,358	(1,210)	2,698	2,084
PROVISIONS over 1 year	310	310	310	0	785	0
NET CURRENT LIABILITIES	**20,309**	**24,163**	**25,132**	**(969)**	**27,012**	**(1,203)**
TOTAL NET ASSETS	**132,905**	**132,457**	**132,148**	**(309)**	**128,210**	**425**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115	0	100,115	0
REVALUATION RESERVE	32,486	32,486	32,828	342	32,891	0
DONATED ASSET RESERVE	0	0	0	0	0	0
I & E ACCOUNT BALANCE	304	304	304	0	304	2,678
I & E CURRENT YEAR	0	(448)	(1,099)	(651)	(5,100)	500
FINANCING TOTAL	**132,905**	**132,457**	**132,148**	**(309)**	**128,210**	**3,178**

Appendix 4

2013/2014 Cost Improvement Delivery against Plan

					Year to Date			Forecast Outturn		
Efficiency Programmes	Identified (I) or Unidentified (U) (mc 01)	Recurring (R) or non Recurring (NR) (mc 02)	Cashable (C), Non cashable (NC) or income (Inc) (mc 03)	If Cashable Pay (P) or Non Pay (NP) (mc 04)	Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 08) £000s	Forecast (mc 09) £000s	Variance (mc 10) £000s
List Programmes with savings in-year										
Programmes listed at Plan:										
FYE of 12/13 Transformation Schemes	I	R	C	P	77	78	1	337	337	0
Directorate CIPs	I	R	C	NP	472	245	(227)	3,050	2,981	(69)
Directorate CIPs	I	NR	C	NP	14	166	152	84	185	101
Directorate CIPs	I	R	C	P	360	205	(155)	2,478	1,973	(505)
Directorate CIPs	I	NR	C	P	67	203	136	293	1,221	928
Directorate CIPs	U	R	C	P	194	0	(194)	1,164	0	(1,164)
Directorate CIPs	I	R	Inc	NP	276	138	(138)	1,656	1,889	233
Directorate CIPs	I	NR	Inc	NP	12	143	131	187	277	90
0	0	0	0	0	0	0	0	0	0	0
Workforce Transformation - Admin Review	I	R	C	P	0	0	0	108	108	(0)
Workforce Transformation - Tactical HR (B|A)	I	R	C	P	20	162	142	120	1,237	1,117
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	26	65	39	104	143	39
Productivity | Efficiency - Outpatient Skill Mix	I	R	C	P	0	0	0	45	45	0
Services Transformation - Rehabilitation/Community	U	R	C	P	0	0	0	200	0	(200)
Services Transformation - 3rd party Pharmacy	I	R	C	NP	0	0	0	30	29	(1)
Other	U	NR	C	NP	0		0	3,144		(3,144)
New Programmes Identified In Year:										
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P		21	21		121	121
Workforce Transformation - Salary sacrifice year 2 (technolog	I	R	C	P		9	9		96	96
Workforce Transformation - Long term SSP withdrawn	I	R	C	P		0	0		33	33
Clinical service redesign - Mattresses Total Bed Management	I	R	C	NP		0	0		35	35
Workforce Transformation - Locum Managed Service	I	R	C	P		0	0		175	175
Workforce Transformation - Consultant Annual Leave Accrual	I	R	C	P		0	0		35	35
CIP Contingency								1950		(1,950)
							0			0
Grand Total (sc100)					**1,518**	**1,434**	**(84)**	**14,950**	**10,921**	**(4,029)**

Appendix 5

2013/2014 Cash flow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	ACTUAL MAY £000s
RECEIPTS			
SLA Base Payments	224,476	17,721	19,030
SLA Performance / Other CCG investment			
Health Education Payments (SIFT etc)	8,969	22	1,511
Other NHS Income	17,202	2,923	877
PP / Other	14,488	892	1,096
Salix Capital Loan	480		
EFL / PDC			
Temporary Borrowing	6,000		
Interest Receivable	30	3	3
TOTAL RECEIPTS	271,645	21,562	22,518
PAYMENTS			
Salaries and wages	163,360	12,168	13,743
Trade Creditors	78,806	4,499	7,344
NHS Creditors	12,823	1,617	1,296
Capital Expenditure	11,835	477	526
PDC Dividend	4,106		
Repayment of Salix loan	364		
TOTAL PAYMENTS	271,295	18,761	22,909
Actual month balance	351	2,801	-392
Balance brought forward	4,303	4,303	7,104
Balance carried forward	4,654	7,104	6,712

Appendix 6

2013/2014 Capital Programme – Month1 Expenditure

Category	Approved Annual Budget 2013/14 £000's	Year to Date as at Month 2 M2 Plan £000's	M2 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 2 Actual Committed £000's	Plan Achieved
Linear Accelerator Corridor	400	0	0	0	0%	0	0%
Improving Birthing Environments	339	0	0	0	0%	282	83%
Endoscopy	150	0	0	0	0%	140	93%
Urodynamics	150	0	0	0	0%	0	0%
Haematology (Trust)	82	0	1	1	1%	23	28%
Annual Strategic Planning Approvals	1,193	0	0	0	0%	0	0%
MESC	1,518	18	-2	-20	0%	231	15%
Estates	4,161	164	187	23	4%	1,099	26%
IT	2,824	398	414	16	15%	924	33%
Other	98	6	7	1	7%	37	38%
Total - Capital Plan	**10,914**	**586**	**606**	**21**	**6%**	**2,735**	**25%**
Less Charitable Fund Donations	-250	0	0	0	0%	0	0%
Total - CRL	**10,664**	**586**	**606**	**20**	**6%**	**2,735**	**26%**
Resources - Trust Actual							
Internally Generated Depreciation	10,184						
SALIX	480						
Total - Available CRL Resource	**10,664**						
Uncommitted Plan	**0**						

- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker
- Improving Birthing Environments completes first stage works from 2012/13 and commences second stage in new financial year
- Endoscopy works were approved last financial year by the Capital Committee
- Urodynamics is being funded by monies donated by Mr Staden
- The Capital Committee have a contingency of £1.193 million (was £1.262 million) available funding for 2013/14 - options for Electronic Document and R Management will be discussed at the next meeting in July - approvals given for Oracle Licenses £56k & Surgical HOT Room £13k
- The Haematology scheme works are completed, although final account is still under dispute
- Full year depreciation forecast is currently £10.184 million and this may increase if the MES contract delays
- Charitable Donations assumptions for additions in year are £100k medical equipment & £150k from Mr Staden

Appendix 7

Financial Risk Rating (Monitor)

FINANCIAL RISK RATING — **Northampton General Hospital**

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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Board Action
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	4	5	5	5	
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	2	2	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		100%						2.7	2.8	2.6	2.6	
Overriding rules								3	3	2	2	
Overall rating								3	3	2	2	

Finance Risk Triggers (SHA SOM)

FINANCIAL RISK TRIGGERS — **Northampton General Hospital**

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

Refresh Triggers for New Quarter

	Criteria	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Action
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	Yes	No	No	No			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes			
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	No	Yes	Yes			
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No			
6	Two or more changes in Finance Director in a twelve month period	No	No	Yes	Yes	Yes			
7	Interim Finance Director in place over more than one quarter end	Yes	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No			
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes	Yes			

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 June 2013

Title	Transformation Programme Update
Agenda item	11
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Craig Porter – Transformation / PMO
Purpose	To update the Board on the final financial savings achieved through the 2013/14 Transformation Programme at month 2 of 2013/14. To provide an update on the measures being taken to close the current gap of required schemes of £2.18m in the 2013/14 Transformation Programme.

Executive summary

1. The Transformation Programme latest thinking forecast delivery is £10.8m savings against a plan of £13.0 m for 2013/14.

2. Month 2 financial delivery is adverse to planned delivery reported to the National Trust Delivery Authority (NTDA) by £84K

3. Care Groups, Corporate and Transformation teams are continuing to work collaboratively to identify schemes to mitigate the 2013/14 shortfall in schemes and develop transformational schemes to support the development of the programme into 2014/15.

Related strategic aim and corporate objective	1. Strategic Aim 5: To be a financially viable organisation • Deliver the Transformation programme 2013/14
Risk and assurance	The Transformation Programme is off trajectory on its planned cost reduction plan for 2013/14 which increases risk of failure to meet the Trust Strategic aim of being a financially viable organisation.
Related Board Assurance Framework entries	BAF 19
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Actions required by the Board

The Board is asked to note Month 2 cumulative delivery of the 2013/14 Transformation Programme

Northampton General Hospital NHS
NHS Trust

Board Meeting
June 2013
Transformation Programme

1. Introduction

The agreed Trust financial Plan for 2013/14 set a target for the Transformation Programme including Directorate and Corporate cost improvement plans is £13.0m. The latest thinking forecast for 2013/14 based on current schemes in delivery stands at £10.82m.

The target plan for 2013/14 is £13m which is constructed from the national minimum delivery requirement of 5% of turnover (£13m).

The value of identified schemes submitted to the TDA at the end of April 2013 was £8.5m which left a required mitigation of £4.5m. The latest thinking forecast at M2 is £10.82m, which has only partially mitigated the gap within the original baseline plan from £4.5m to £2.18m.

2. Latest thinking forecast and month 2 delivery of the 2013/14 Transformation Programme

- The plan submitted to the NTDA required a cumulative month 2 delivery of £1.52m; the actual delivery is £1.43m, £84k under the required delivery target.
- The revised latest thinking forecast based on the first two months of schemes in delivery is £10.82m. This is deterioration against the month 1 LTF by £100k.
- The current shortfall against the required minimum £13m is therefore £2.18m.
- A pipeline of additional schemes to the potential value of £1.26m is under development, which if delivered would leave a residual mitigation required of £0.92m to achieve the plan of £13m.

3. Transformation programme delivery

Care Group and Corporate CIPs are currently forecast to under achieve their annual plan by £474k. A significant element of the shortfall is due to under-recovery of income and failure to realise non-pay schemes, which are being reviewed with care groups to accelerate delivery and mitigate the current projected LTF.

Workforce Transformation schemes have under-delivered in the first 2 months by £31k. Although this position has improved in M2 by £22k in main due to over achievement against the reduction in overtime spend.

Nursing and healthcare assistant agency expenditure reduction has continued into month 2 when compared with the same period in 2012. HCA and qualified Agency nursing worked WTE has halved compared to the same period in 2012/13 realising a run rate reduction of £160k. Whilst this remains £71k off the planned reduction trajectory, it represents l a significant improvement on run rate spend of the first two months of 2012/13.

4. Identification of additional schemes and cost improvement initiatives

In addition to the £1.26m of potential schemes under consideration, the strategic executive team have reviewed potential schemes for short, medium and longer term implementation, the short term schemes are currently being scoped. The Trust Finance Committee members will

be reviewing and scrutinising the additional schemes, implementation plans and quality impact assessments at their July 2013 meeting.

5. Risk Assessment

The cost improvement plans which rely upon income generation were reported at 50% delivery in M1 due to the case mix and Clinical Commissioning Group mapping challenges.

The reassessed position based on M2 actual delivery of best practice tariff schemes, and given the withdrawal of the Oral/Maxillofacial scheme, a revision downwards of the LTF in Month 2 has been required. The withdrawal of the OMFS scheme is the main contributing factor the deterioration in the LTF by £100k.

The delivery of income schemes over and above the 2013/14 contracted baseline remain the greatest risk to in year delivery following the first two months of the financial year. A prudent downside assessment based on 50% delivery would revise to a potential in year delivery of £9.4m, if income schemes do not generate the required levels of revenues.

6. Conclusions

Month 2 financial delivery showed a variance of £78k adverse to the plan submitted to the NTDA and a cumulative variance of £84k

Work is being undertaken by care group and corporate teams, supported by the trust PMO to identify and submit for QIA additional short term schemes are currently being scoped. The Trust Finance Committee will review these additional plans at its July meeting.

7. Recommendation

The Board is asked to discuss and note:

- The actions being taken by the Transformation Delivery Group to deliver the Trust financial plan requirement of £13.0m during 2013/14.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE 27 June 2013

Title	Self-Certification Report
Agenda item	12
Sponsoring Director	Karen Spellman, Deputy Director of Strategy and Partnerships
Author(s)	Christine Johnson, Information Manager
Purpose	Decision and Assurance on compliance with the NHSTDA compliance framework

Executive summary

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 May 2013 is; Governance Risk Rating (Amber Green), Financial Risk Rating (3).

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

Related strategic aim and corporate objective	All Strategic Objectives
Risk and assurance	Risks to compliance with the NHS TDA compliance and oversight framework driven by performance and finance indicators.
Related Board Assurance Framework entries	BAF 9
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Compliance with the NHS TDA compliance and oversight framework.

Actions required by the Board

The Committee is asked to review the content of the submission and approve the signing of declaration two based on the evidence provided.

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
May 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 : 2013/14 In-Year Reporting

Name of Organisation:	Northampton General Hospital	Period:	May 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)	AG
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

*** 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 :	**The Trust has reported a £4.8m deficit plan for the FY2013/2014 which has had an adverse impact on the**
Action :	**The Trust submitted a deficit plan to the TDA due to considerable uncertainty regarding a range of income from CCG disclosed within the 'side letters' to the contract. These included the approach for reinvestment of fines, readmissions, and other non-recurrent CCG support. Discussions have also taken place with the TDA on these matters. ACTION - Development of a Financial Recovery Plan to reduce this deficit which will include robust performance management against the existing deficit plan but also the agreed outcome of matters referred to in the 'side letters' and discussions with the TDA.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**Cancer target: 62 day urgent GP referrals 75% (target of 85%)**
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 :	

Board Statements

Northampton General Hospital

May 2013

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the 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*
CEO			
Chair			

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Jan-13	Mar-13	Apr-13	May-13	Board Action
1	SHMI - latest data	Score	109.2	106.0	106.0	106.0	104.8	104.8	104.8	107.8	107.8	107.8	110.9	110.9	
2	Venous Thromboembolism (VTE) Screening	%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	92.36%	93.10%	
3a	Elective MRSA Screening	%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	99.90%	99.50%	
3b	Non Elective MRSA Screening	%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	96.40%	96.95%	
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	17	14	11	10	13	14	24	19	25	35	41	35	1 New SI was reported during May 2013 23 Pending (submitted to CCG awaiting confirmation of closure) 11 Ongoing investigations
6	"Never Events" occurring in month	Number	0	0	1	0	0	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	0	0	0	0	0	0	0	0	0	0	1	0	
9	RED rated areas on your maternity dashboard?	Number	1	1	2	2	4	1	1	2	1	1	3	1	
10	Falls resulting in severe injury or death	Number	1	2	2	0	2	3	1	0	2	1	1	2	Both incidents have yet to be reported as SI's
11	Grade 3 or 4 pressure ulcers	Number	3	2	0	2	3	7	7	6	3	6	3	6	May 2013 pressure ulcer incidents = 6 in total. This consisted of 4 x grade 3 avoidable and 2 x grade 3 unavoidable incidents. These are still to be confirmed as to whether they are to be recorded as Serious Incidents.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	May 2013 = 99% (1 patient out of 103 audited did not have the WHO surgical checklist process performed)
13	Formal complaints received	Number	39	48	33	35	44	40	24	68	57	52	45	58	
14	Agency as a % of Employee Benefit Expenditure	%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	6.60%	6.60%	6.90%	6.94%	
15	Sickness absence rate	%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	4.11%	4.01%	
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 a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	4	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	2	2	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.7**	**2.8**	**2.6**	**2.6**	
Overriding rules								3	3	2	2	
Overall rating								**3**	**3**	**2**	**2**	

Overriding Rules :

Max Rating	Rule						
3	Plan not submitted on time	No					
3	Plan not submitted complete and correct	No					
2	PDC dividend not paid in full	No					
2	Unplanned breach of the PBC	No					
2	One Financial Criterion at "1"						
3	One Financial Criterion at "2"		3	3			
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 Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	Yes	No	No	No			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes			
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	No	Yes	Yes			
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No			
6	Two or more changes in Finance Director in a twelve month period	No	No	Yes	Yes	Yes			
7	Interim Finance Director in place over more than one quarter end	Yes	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No			
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes	Yes			

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-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			
			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			
			Patients dying at home / care home	50%		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			
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	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			
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	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			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	No	Yes	Yes			
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	No	No			May 2013 unverified performance: 62 day urgent GP referrals 75% (target of 85%) 18.5 patients out of a total of 74 breached
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes			
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	Yes			
	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			
			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			
	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			
	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			
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	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			
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	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			There were 7 cases of C-Diff in April and 2 case in May 2013 .
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 29*		Yes	Yes	Yes	No	No			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 0*		No	No	No	Yes	Yes			
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No			
				TOTAL		**1.0**	**1.0**	**3.0**	**2.0**	**1.0**	**0.0**	**0.0**	
						AG	AG	AR	AR	AG	G	G	

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			
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	Yes	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			
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			
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			
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			
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			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No			
		Adjusted Governance Risk Rating	4.0	4.0	4.0	4.0	4.0	0.0	0.0	
			R	R	R	R	R	G	G	

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

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

TFA Progress

Jun-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	Not fully achieved		Board sub committee observation did not take place in agreement with the SHA
30	FT submission to NTDA	May-13	Not fully achieved		FT submission not taking place in agreement with the SHA
31	Board interviews	May-13	Not fully achieved		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		Will not be delivered on time	Application submission to the DH not taking place in agreement with the SHA therefore NTDA Board approval to submit will not be requested
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					

Notes

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

Notes

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 June 2013

Title	Nursing & Midwifery Staffing Strategy (2013 – 17) Investment Plan Year 1
Agenda item	13
Sponsoring Director	Suzie Loader – Director of Nursing, Midwifery & Patient Services Clive Walsh – Chief Operating Officer (Interim)
Author(s)	Suzie Loader – Director of Nursing, Midwifery & Patient Services Clive Walsh – Chief Operating Officer (Interim) Craig Porter – Transformation / PMO
Purpose	The report is to update the Board on progress with the implementation of the Nursing and Midwifery strategy. The report outlines the apportionment and application of the £1.9m investment monies agreed through the Board This report is being presented to the Board/Committee for assurance purposes
Executive summary The report apportionment and application of investment monies agreed through the Board	
Related strategic aim and corporate objective	1. Strategic Aim 1. Be a provider of quality care to all our patients a. Increase nursing establishment through the implementation of the nursing and midwifery staffing strategy 2. Strategic Aim 3: Provide appropriate care for our patients in the most effective way a. Implement the recommendations of the quality strategy 3. Strategic Aim 5: a. Deliver the Transformation programme
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks. The report outlines potential savings on bank and agency spend, which do not equate to the £1.3m identified within the CIP programme and therefore presents a potential financial risk.
Related Board Assurance Framework entries	Link to the Board Assurance Framework
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Actions required by the Board

The Board is asked to endorse the investment strategy for year one of the Nursing & Midwifery Staffing Strategy and note the actions being taken on reducing agency run rate expenditure, E-Rostering and implementation of nursing operational controls.

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital NHS Trust Board
27 June 2013

Update on the implementation of the
Nursing and Midwifery staffing Strategy (2013-17)

1. Introduction

The paper updates the Board on progress being made towards implementation of the Nursing and Midwifery Staffing Strategy (2013-2017). The strategy, which was agreed at the Board in March 2013, outlined a 4-year investment plan. This paper identifies how year one, of the four year investment, will be deployed. The aims of the nursing and midwifery strategy are to: -

- Enhance the quality of nursing / midwifery care delivered to patients
- Improve healthcare outcomes for patients
- Where necessary, increase the number of nurses available on the general wards to benchmarked levels
- Utilise the nursing resource more effectively
- Decrease the spend on bank and agency staff

In addition to outlining where the agreed investment will be deployed, the paper will also outline to the Board the proactive management being taken to:-

- Accelerate recruitment plans to meet the requirement for additional qualified nurses and healthcare support workers
- Reduce agency use and run rate spend in 2013/14
- Enhance the efficiency and effectiveness of the eRoster
- Implement operational controls to ensure nursing spend is controlled to the levels outlined within the investment plan.

2. Implementing year one of the investment

(a) Budgetary changes for 2013/14

There have been a number of changes in the ward budget establishments which have been agreed during the budget setting process for 2013/14. These were adjusted for the following reasons:

- Base lining of budgets and apportionment of spend more equitably across Directorates according to need
- Introduction of budgets for the 2 additional wards: Victoria and Collingtree (19 beds to 40 medical beds)

Therefore the additional nursing budgetary staffing investment from 01 April 2013: included resource for an additional:-

- 25.92 RN's
- 37.52 HCA's

(b) Nursing and Midwifery staffing strategy investment - Year one

The corporate nursing team have worked collaboratively with the Care Group Lead Nurses to assess and apply the funding made available for year 1 of the strategy. Six areas of investment have been prioritised. These are:-

- Full investment for 4 wards:
    - Abington (Trauma & Orthopaedics)
    - Cedar (Trauma & Orthopaedics)
    - Collingtree (General Medicine / Gastro)
    - Creaton (General Medicine / Dementia)
- Partial investment for 8 wards in priority shifts, such as night shifts
- Specialing investment for the majority of the wards to meet 2012/13 levels of usage
- One ward was allocated 0.4 band 5 backfill to allow the ward sister to have 2 supervisory shifts per week. The remaining wards already had this within their establishments
- Band 6 post to support eRoster
- Provision of a maternity pool

Therefore the establishment increase based on the nursing strategy investment decisions taken on the 14th June 2013, have the effect of further increasing the establishment by :-

- 26.55 RN's
- 22.37 HCA's

(c) 2013/14 Business Case Investment

Business cases have been approved to increase the establishment of two ward areas within the Trust. These investments are in addition to the £1.9m identified within the strategy.

- Rowan Ward for level 1 patients,
- Surgical assessment unit

Therefore the establishment increase based on the business case investment decisions taken on the 14th June 2013, have the effect of further increasing the establishment by:-

- 5.98 RN's
- 5.29 HCA's

Therefore the overall increase, over and above the 2012/13 nursing establishment as a result of changes through: budgeting, business case investment and nursing strategy investment decisions, have increased by:-

- 58.45 RN's
- 65.18 HCA's

The table below provides a visual overview of the investment deployment across each of the ward areas within the Trust and links this to the required recruitment pipeline. We aim to ensure that vacancies are kept to a minimum which will ensure the limited use of bank and

especially agency staffing. Increases in ward roster templates will only be implemented once the recruitment of the additional nursing and healthcare assistants have been achieved.

Table 1: Total investments by ward and anticipated recruitment timeline for 2013/14

Wards	2012/13 v 2013/14 Budget	Investment Wards	Investment in Shifts	Investment in specialing	Business case investment	NGH RN/Bed ratio's	AUKUH RN/Bed ratio's	Forecast Recruited to 95% RN's	Forecast Recruited to 95% HCA's
Abington	→					0.73	0.69	Sept 13	July13
Allebone	→					0.79	0.74	July 13	July 13
Althorp	↓					0.98	0.79	June 13	June 13
Becket	→					1.04	0.92	June 13	June13
Benham	↓					0.93	1.24	Aug 13	June 13
Brampton	↓					0.61	0.58	June 13	July 13
Cedar	→					0.68	0.69	June 13	July 13
Collingtree	↑					0.73	0.74	Sept 13	July 13
Compton	→					0.73	0.58	June 13	June 13
Corby	↑					0.57	0.62	June 13	Aug 13
Creaton	↑					0.83	0.74	Sept 13	July 13
Daventry	→					0.49	0.74	Sept 13	Sept 13
Dryden	→					1.01	0.85	June 13	June 13
EAU	↑					1.06	1.24	Sept 13	Sept 13
Eleanor	→					1.40	0.63	June 13	Sept 13
Finedon	→					1.49		June 13	June 13
Hawthorn (SAU)	↑					0.81	1.07	Sept 13	Sept 13
Hazlewood	↑					0.47	0.61	July 13	Sept 13
Head & Neck	→					1.32	1.38	July 13	July 13
Holcot	→					0.78	0.63	Oct 13	July 13
Knightly	↓					0.75	0.75	June 13	June 13
Rowan	→					0.86	0.87	June 13	July 13
Spencer	↑					1.18	1.38	July 13	Sept 13
Talbot Butler	↑					1.33	1.32	June 13	Sept 13
Victoria	→					0.66	0.58	Sept 13	Oct 13
Willow	→					1.12	1.11	June 13	Sept 13
TOTAL / Average	RN Increase – 25.92 HCA increase 37.52	£747,920	£479,474	£364,563		0.86	0.86		
Grand Total	£1,539,281								

2. Accelerating Recruitment

The recruitment up to the required establishment at the end of 2012/13 was a priority agreed at the Board meeting in January 2013. The Trust recruited qualified staff through national and international recruitment campaigns and increased the local recruitment campaigns for health care assistants. By the end of March 2013 the Trust had met its recruitment target for healthcare assistants for ward areas and similarly for qualified staff by the end of May 2013.

Outline plans were in place to again accelerate recruitment to meet any investment decisions agreed by the Board in April 2013. Therefore the majority of RN recruitment to the required levels, post investment, will be achieved by the end of July 2013.

The Trust already has a healthy pipeline of applicants for both RN and HCA vacancies. To ensure recruitment to deployment timelines are kept to a minimum we have increased the number of HCA training courses to ensure staff appointed are able to join the Trust in July 2013. In addition to our ward recruitment, we are also targeting recruitment in our specialist areas to reduce agency spend. This includes:-

- Rolling recruitment for ITU
- Recruitment open day for paediatric nurses on 19th July 2013

With the exception of two wards, wards are anticipated to be established to 95% by the end of September 2013.

It has been agreed that a small element (5% of the ward establishment budget) should be allocated for bank use to be used for short term, last minute absence e.g. sickness, carers leave, specialing, maternity cover etc. Therefore the recruitment plan to support the additional investment aims to ensure 95% recruitment to all ward areas by the timeline outlined in the table above.

3. Forecast Bank & Agency reduction in spend

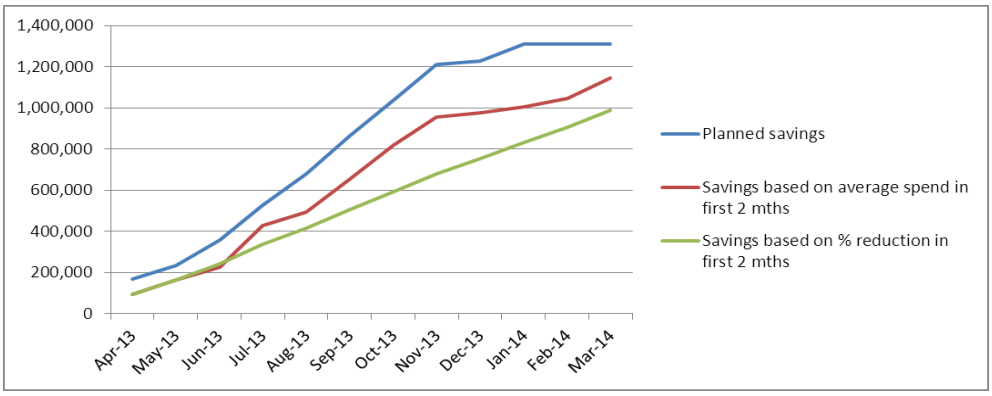
In 2012/13 the Trust spent £4.6m on agency nursing / HCA staffing. In total £9.2m was spent on bank and agency nursing / HCA staffing in 2012/13, with the majority of bank staff being predominantly utilised for vacancies within nursing. Of the £9.2m spend, approximately £1.6m was incurred due to the Trust opening additional capacity (escalation areas) in 2012/13. This was to meet the increase in urgent care demand, which on average totalled an additional 17 beds throughout the year. These beds have been re-established with staff through the 2013/14 budget setting process.

As part of the Transformation Programme for 2013/14, it was agreed that a run rate reduction in bank and agency spend of £1.3m should be achieved. This £1.3m reduction has been phased to reduce the bank / agency run rate of 2013/14 in line with the run rate of 2012/13.

Based on the first two months of the financial year there has been a year on year reduction in run rate of £160k. If this (average spend) were to continue for the remainder of the year the run rate reduction is forecast to be £1.14m.

However, the rate of reduction needs to accelerate in the coming months, to keep pace with the profile of savings. If the run rate continues at the current level of 10.7% per month, the run rate reduction is forecast to reduce by only £989k at the year end, not achieving the £1.3m.

Additional operational controls are currently being implemented to ensure the requirement for agency staff is minimised. These are outlined in section 5 of this report.



4. Enhance the efficiency and effectiveness of eRoster

E-Rostering was originally introduced into NGH in 2011 with allocated resources. The Rostering-in-Partnership project was implemented in January 2013 with 6 staff assigned to the programme to support 22 wards initially, increasing to 25 wards.

This project is still on-going, however not all the changes identified have been implemented due to an increase in the scope of the project and a reduction in the capacity of the Rostering-in-Partnership team, thereby with limited resources.

Currently there are several operational problems with e-Roster which may be as a result of system error, user capability, supporting processes or a combination of all three. In view of this an independent consultant has been contracted to carry out a diagnostic test on the system, to identify inefficiencies in its set up and to provide some additional training to a small cohort. They will commence on the 24 June 2013.

The proposed timelines to carry out a review of E-Rostering is as follows;

Plan	Action	Timescale for implementation
Short term	Review current processes and recommend changes to create efficiencies in rosters, including; • Autorostering confidence / compliance • B&A request compliance • Simplify confirmation of change processes	July 2013
Medium term	Ensure system support is effective & responsive; on-going maintenance, upgrading, help-desk support, including; • Monthly roster analysis & challenge • Robust training package in place and delivery commenced. • Helpline system in place • Drop-in sessions • Regular updates / Top Tips • Reviewing / updating Ward / Trust rules • Review rostering policy	September 2013 This will also be dependent upon successful recruitment to Roster Project Manager post
Long term	Cleansing the system to ensure on-going accuracy and reviewing of historical data for exactitude. Cleansing and updating of the system will continue, however this is also reliant upon the accuracy of the ESR system which also requires validation and further scrutiny.	This is an on-going piece of work and therefore a timescale is difficult to predict. However if historical data is to be interrogated this could take a period of 2-3 years.

The overall aim will be to get the system right in the first instance, creating a customer- focus support culture and realise benefits such as appropriate workforce utilisation & efficiencies and enhanced patient care.

5. Implement operational controls to ensure nursing spend is controlled to the levels outlined within the investment plan.

The responsibility for maintaining control over staffing levels lies with the Care Group Directors through the Chief Operating Officer. The following mechanisms have been agreed with the Care Groups:

- Monthly review of utilisation and expenditure of each Directorates staffing by the Care Group.
- Incorporation into quarterly reviews of Care Group performance by the Executive Team.
- Change to the authorisation process and timescales to allow effective review and challenge of nursing rosters by matrons, and subsequent endorsement by Directorate General Managers.
- Setting exclusion lists of wards and departments where agency staff do not need to be included in the roster to meet safe staffing levels.
- Revised budgets issued to wards, which take into account planned developments and investment in revised staffing levels.
- A bank 'pool' to reduce the requirement for agency staff booked at short notice.
- Including the need for a balanced budget, full staffing and reduced bank and agency usage within the personal objectives for ward sisters.

The area for future improvement is the use of the e-rostering system for forward planning. This will require an increase in the timeliness and accuracy of the data recorded and better management information to allow a forward look. This is necessary to provide the tools for control and adjustment, rather than retrospective monitoring of trends. An independent review of the system will take place in June.

6. Assessment of Risk

This report outlines potential savings on bank and agency spend, which do not equate to the £1.3m identified within the CIP programme and therefore presents a potential financial risk. Actions are being taken to minimise this risk as outlined in the operational control section above.

7. Recommendations/Resolutions Required

The Board is asked to endorse the investment strategy for year one of the Nursing & Midwifery Staffing Strategy and note the actions being taken on reducing agency run rate expenditure, eRostering and implementation of operational controls.

8. Next Steps

The implementation of the Nursing & Midwifery Staffing Strategy will be monitored via the Bank & Agency Group and Nursing & Midwifery Board. Six monthly updates will be brought back to Trust Board.

The impact of the investment on healthcare outcomes and staff morale / retention will be monitored via the expanded Matrons Dashboard, which captures Quality and Management metrics (such as: falls, nutrition, infection prevention, pressure ulcers, patient experience, budget management, staff appraisal rates, regular ward meetings, sickness etc.). This is monitored by the Nursing & Midwifery Board and will be incorporated into the quarterly 'Patient Safety, Clinical Quality & Governance Progress Report, which is reviewed by the Integrated Healthcare Governance committee.

A further skill mix review will be conducted in the autumn, followed by confirm and challenge meetings with the Ward Sisters and the Directors of Nursing & Finance prior to business planning and budget setting for 2014/15.

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 June 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Zeidler	
	2.	Declarations of Interest	Mr P Zeidler	
09.35	3.	Minutes of the meeting held on 30 May 2013	Mr P Zeidler	**1**
	4.	Matters Arising	Mr P Zeidler	**2**
09.40	5.	Chief Executive's Report	Ms C Allen	**3**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**4**
10.05	7.	Patient Experience Report	Ms S Loader	**5**
10.20	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
Operational Assurance				
10.30	9.	Operational Performance Report	Mr C Walsh	**7**
10.40	10.	Finance Report	Mr A Foster	**8**
10.50	11.	Transformation Programme Update	Mr C Porter	**9**
11.00	12.	Self-Certification Return	Mrs K Spellman	**10**
Strategy				
11.05	13.	Nurse Staffing Implementation Strategy	Ms S Loader	**11**
Any Other Business				
11.30	14.	Any Other Business	Mr P Zeidler	
	15.	**Date & time of next meeting:** 24 July 2013 – 09.30am. Boardroom, Northampton General Hospital		
	16.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Zeidler	