Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board

to be held on

Wednesday 24 July 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

Wednesday 24 July 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 27 June 2013	Mr P Farenden	**A**
	4.	Matters Arising	Mr P Farenden	**B**
09.35	5.	Chief Executive's Report	Dr S Swart	**C**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**D**
10.05	7.	Patient Experience Report	Ms S Loader	**E**
10.15	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**F**
10.25	9.	Francis Report Action Plan Update	Ms S Loader	**G**
10.35	10.	CQC Report	Ms S Loader	**H**
10.40	11.	Quality Account Update	Ms S Loader	**I**
Operational Assurance				
10.45	12.	Operational Performance Report	Mr C Walsh	**J**
10.55	13.	Urgent Care Update	Mr C Walsh	**K**
11.05	14.	Finance Report	Mr D Bebb	**L**
11.15	15.	Workforce Report	Mrs J Brennan	**M**
11.25	16.	Transformation Programme Update	Mrs J Brennan	**N**
11.35	17.	Self-Certification Return	Mr C Walsh	**O**
Strategy				
11.40	18.	Risk Management Strategy	Ms S Loader	**P**
11.50	19.	Complaints Annual Report 2012/13	Ms S Loader	**Q**
12.00	20.	Health and Safety Annual Report 2012/13	Mr C Abolins	**R**
12.10	21.	Fire Safety Annual Report 2012/13	Mr C Abolins	**S**
12.20	22.	Equality and Diversity Annual Report 2012/13	Mrs J Brennan	**T**

Any Other Business				
12.30	23.	Any Other Business	Mr P Farenden	
	24.	**Date & time of next meeting:** 23 September 2013 – 09.30am. Boardroom, Northampton General Hospital		
	25.	**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.		

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on
Thursday 27 June 2013 at 9.30am
Boardroom, Northampton General Hospital

Present:

Mr P Zeidler	Non-Executive Director/Vice Chair - Chairman
Mrs C Allen	Interim Chief Executive
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
Dr S Swart	Medical Director
Mr C Walsh	Interim Chief Operating Officer

In Attendance:

Ms A Chown	Deputy Director of Human Resources
Mr C Porter	Assistant Director of Transformation
Dr N Robinson	Associate Medical Director
Mr C Sharples	Head of Corporate Affairs
Ms K Spellman	Deputy Director of Strategy and Partnerships

Apologies:

Mr C Abolins	Director of Facilities & Capital Development
Mrs J Brennan	Director of Workforce and Transformation
Mr P Farenden	Chairman
Mrs E Searle	Non-Executive Director

TB 13/14 041 **Declarations of Interest**
No further interests or additions to the Register of Interests were declared.

TB 13/14 042 **Minutes of the meeting held on 30 May 2013**
The minutes of the Board meeting held on 30 May 2013 were presented to the Board for approval.

Mr Zeidler queried the wording of minute TB 13/14 026 relating to the increase in cases for the year to date. He requested that it be amended to read “Ms Loader informed the Board that April 2013 had seen an increase in the number of identified Clostridium Difficile cases, with number of cases to date for 2013/14 totalling nine.”

ACTION: Mr Sharples

Ms Spellman requested that minute TB 13/14 029 paragraph five relating to cancer targets be amended to read “Mr Walsh reported that the Trust met all cancer standards in April with the exception of the 62 day cancer standard from urgent GP referral to start of first treatment.

ACTION: Mr Sharples

Mr Zeidler requested that the final paragraph of minute TB 13/14 030 read that there would be an increase in the number of junior and middle grade vacancies, not positions.

ACTION: Mr Sharples

Subject to those amendments, The Board APPROVED the minutes of 30 May 2013 as a true and accurate record of proceedings.

TB 13/14 043 Action Log and matters arising

All actions and matters arising were considered.

Mr Zeidler requested that the log be updated to reflect the request of the Board to receive quarterly updates on the Francis Report.

ACTION: Mr Sharples

TB 13/14 044 Chief Executive's Report

Ms Allen presented her Chief Executive's report.

Ms Allen reported that the Board had recently met with the NHS Trust Development Authority and had been advised that given the challenges faced by the Trust the NHS Trust Development Authority had confirmed that they would support the continuation of our quality improvement and transformation programmes and requested that the Trust confirm its financial viability with a view to establishing long term sustainability for the Trust and the services it provides.

The Trust Development Authority support the Trust plans to develop strategic partnerships with other providers, however the Trust would retain its focused on meeting all standards of care and delivering financial duties as a priority. Ms Allen stressed that the Trust must not divert its focus from those priorities which would be at significant risk should a merger programme subject to short timescales be embarked upon.

Ms Allen reported that in light of the meeting, the Healthier Northampton programme would be considering a number of issues such as how the commissioner work-stream could be developed to define and implement an out of hospital care strategy, how the Clinical Working Groups would operate to ensure collaboration and buy-in is retained to drive service improvements and how the hospitals would individually review their strategic direction to take account of the changes.

Ms Allen stressed that the Trust would remain committed to meaningful and appropriate engagement with Northamptonshire residents, patients, carers, NHS staff and our stakeholder partners on all potential service changes.

Dr Swart commented that the out of hospital strategy would be key, with the Trust needing to work with Clinical Commissioning Groups to advise what was required and what could be delivered, confirming how the Trust could support delivery.

Mr Robertson asked if the Clinical Commissioning Groups has the expertise to deliver the programme. Dr Swart advised that Ernst and Young had been commissioned to support delivery and senior leadership was in place to lead the programme.

Mr Robertson asked that as part of the programme, would the right fit for community hospitals be considered. Dr Swart confirmed that was the case.

The Board was updated on the development of the Organisational Development Strategy, the establishment of a new archive section on the Trust website and the successful formation of the Northampton General Hospital Choir.

Ms Allen reported that a new emergency bay for cancer patients recently opened on Talbot Butler ward had been hailed a success by patients, nursing staff and doctors, with more than 200 patients seen in the four bedded assessment bay since it opened.

The Board NOTED the Chief Executive's Report.

TB 13/14 045 Medical Director's Report

Dr Swart presented the Medical Director's Report.

The Board was informed that there remained a national focus on the Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indictor (SHMI) as indictors for mortality, and they remained key indicators for the Trust. Fourteen hospitals nationally were being investigated based on their mortality data as part of the Keogh reviews.

Dr Swart re-emphasised to the Board that the acquisition of community hospitals were not recorded as separate sites and where predominantly elderly patients are admitted for a variety of types of care, including terminal care, which was likely to affect the HSMR for the Trust.

The Board was advised that the year to date HSMR was reported at 105 which was an 'as expected' position, although marginally worse that the position last year. The overall unadjusted mortality was reported at 4.1%, which was in line with the regional NHS Trust Development Authority average.

The Board was informed that there were no concerns in relation to the Dr Foster Patient Safety Indicators.

In reported Dr Swart reported that there had been slight improvement in the last two months in relation in relation to mortality resulting from fractured neck of femur, although issues remained which were being addressed though the bundle of interventions reported at the previous Board meeting.

Another area of concern escalated to the Board related to congestive heart failure. Dr Swart assured the Board that detailed investigation of the issue had taken place and no serious care concerns identified.

Mr Zeidler noted that the Board had received significant assurance with regard to mortality from fractured neck of femur, but that issues with mortality related to congestive heart failure had not been reported to the Board as frequently. Dr Swart reiterated that following the investigation that had been reported in a previous Board report, there had been no causes for concern in terms of the quality of clinical care identified. There was ongoing work to ensure that this area remained under scrutiny and improvements were being suggested whether possible. Dr Swart advised that the Trust comparatively had fewer admissions due to a well-established community heart failure team being in place The admissions which were received were likely to be of increased acuity, a sensitivity which could not be presented clearly in mortality data. Mr Zeidler requested that the issue be reviewed in more detail at a future Integrated Healthcare Governance Committee.

ACTION: Mr Sharples

Mr Kershaw reported to the Board that the Integrated Healthcare Governance Committee had received a comprehensive presentation on HSMR and fractured neck of femur which provided significant assurances that activities

and actions were underway with challenging yet realistic milestones in place.

The Board was updated on the progress in publishing outcome data for individual consultants, with Dr Swart advising that the Trust was prepared for the data to be published although there were concerns regarding the completeness of the data, and how the data could then be interpreted by the media, a concern which was shared nationally. Ms Allen noted that there had been significant media interest in the publishing of the data and asked if there had been any issues with consultants consenting to the data being published. Dr Robinson confirmed that there were no issues with consent, although there were concerns from staff regarding the accuracy of the data which was being validated.

Dr Swart presented lesson learnt from serious incidents and never events. The report provided an overview of the actions and improvements required as a result of investigations into serious incidents in order to improve the quality of care, thus ensuring learning happened. Upon review of serious incidents, the highest risk areas identified were the incidence of pressure ulcers and falls and embedding the mechanisms for improvement.

Dr Swart presented the National Quality Dashboard. She advised the dashboard consisted of national indicators which informed local performance to enable organisations to focus on quality improvements. The dashboard would continue to be strengthened through the addition of intelligence based on local indicators. In presenting the Trust's performance against the indicators, Dr Swart highlighted the Dr to patient and nurse to bed ratios as indicators which continued to be priority.

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. The Board was informed that the improvements were planned to the reporting hierarchy which informed the quality scorecard to ensure that the correct indicators were included and reported appropriately to the correct audience.

Dr Swart summarised the exceptions within the report, reporting variance from targets and outlining the actions which were being implemented to address performance.

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

TB 13/14 046 **Patient Experience Report**

Ms Loader presented the Patient Experience Report to the Board.

The Board was informed that no steer had been received from the Department of Health regarding the scores achieved via the Friends and Families Test, but Trusts nationally continue to monitor the response rate.

The Friends and Families Test response rate for In Patients received for the month of May 2013 was 24.22%, the highest the Trust has achieved to date. 2932 patients were discharged from Northampton General Hospital in May 2013 of which, 710 patients responded to the Friends and Families Test question. However the response rate for A&E was only 0.57%. Work continues with A&E to address the low response rate.

Ms Loader advised that work had been ongoing to triangulate the outcomes of the Friends and Families Test with other audit intelligence such as the infection control audits and patient experience surveys to ascertain if there were any correlation between outcomes and poorer performing areas. Ms Loader advised that there appeared to be no direct correlation identified upon review of the intelligence.

Ms Loader reported to the Board that the Trust would not achieve the CQUIN targets for the first two months of 2013, and did not expect to be compliant until month four. Mr Zeidler asked what the financial consequence of this was and was advised £30k per month whilst not achieving the target.

Ms Allen observed that it would be difficult for under pressure areas such as A&E to routinely complete the test, particularly at weekends. Ms Loader advised that the use of iPADs in A&E had begun to show improvements in the Friends and Families Test being completed. Ms Spellman asked how other Trusts performed in this area. Ms Loader advised that anecdotally other Trusts were also struggling.

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

TB 13/14 047 Monthly Infection Prevention Performance Report

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

Ms Loader reported that there had been no incidence of MRSA bacteraemia during the reporting period. With regard to MRSA screening, elective screening achieved 99.5% whilst emergency screening achieved 96.9%. Ms Loader confirmed that there were no wards on special measures.

The Board was informed that there remained problems with regards to clostridium difficile. At 26 June, there had been 13 cases recorded. The Trust had an annual ceiling of 29 cases or less for the financial year.

Of the cases which had occurred to date, only five had shown clinical indications of clostridium difficile, the remainder of cases had received laxatives prior to the specimen being taken and should not have been sent. As a result, a number of actions were implemented to avoid the continuance of inappropriate screening, which appears to have been effective.

Mr Robertson asked what would be the impact of breaching the annual ceiling. Ms Loader advised that the Trust would be fined £50k per case of clostridium difficile over the ceiling, which presented a significant financial risk to the Trust.

Mr Noble requested that future reports clearly distinguish cases which have been identified though appropriate and inappropriate sampling. He added that clinicians feel empowered to take samples as they deem clinically appropriate. Ms Loader assured Mr Noble that the measures introduced were introduced to safeguard patients. No clinical risks were presented by the introduction of the measures; the measures were introduced to enhance the education of staff and to avoid incorrect sampling.

ACTION: Mr Sharples

Ms Allen asked if anything could have been done to avoid the confirmed cases of clostridium difficile. Ms Loader advised that the patients were on multiple antibiotics and pump inhibitors which were contraindicated. Dr Swart

added the work was ongoing to look at the appropriateness of antibiotics prescribed. Ms Loader confirmed that full root cause analysis were being undertaken for each case.
Mr Zeidler requested that the clostridium difficile graph presented in the report be amended to include a cumulative total of cases for the year.

ACTION: Ms Loader

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

TB 13/14 048 Operational Performance Report

Mr Walsh presented the Operational Performance Report to the Board which set out key areas of performance for the Trust in May 2013. The Performance paper was presented in a revised format this month. The format of the report was being developed as part of the move towards integrated performance reporting.

In reporting the Trust's performance, he reported that the Trust achieved all referral to treatment, diagnostics, stroke and cancelled operations standards during May 2013.

The Board was informed that Trust did not achieve the cancer standard; 62 days from GP referral to start of treatment, the performance for May 2013 was 75% against a standard of 85%. A cancer improvement plan was scheduled to be presented at the Integrated Healthcare Governance Committee in June 2013 to outline the actions in place to address the adverse performance. Dr Swart added that a Cancer Recovery Board had been established which she would chair to provide operational oversight of the action plans.

Mr Walsh informed the Board that 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 was 92.62% as at 13 June against a recovery trajectory of 93%. Mr Walsh emphasised that the improved performance was demonstrated the importance of the flow of admitted patients.

A revised trajectory for compliance with the 4 hour transit time target was presented. The trajectory took into account a number of in year factors and had been developed with the full involvement of clinical staff.

Mr Walsh informed the Board that commissioners had been requested to develop a collaborative economy wide recovery plan in regard to urgent care. Once developed, the recovery plans are submitted for national scrutiny. The Northamptonshire recovery plan had been submitted to NHS England and been deemed insufficient, has had every other plan submitted nationally. Further work would be ongoing at the County Leaders forum to develop a credible plan.

Mr Robertson asked if concerns remained with the data quality surrounding ambulance handovers. Mr Walsh advised that the data was still being validated with the ambulance service. Ms Allen added that an electronic system was now in place but issues regarding data quality still needed to be ironed out, an issue which was being replicated nationally.

Mr Zeidler noted that there was a significant difference in A&E performance between the months of May and early June whilst the level of attendance did not vary. Mr Walsh advised that whilst increase in attendance at A&E was a

factor in performance, the flow of patients through the hospital to timely discharge was fundamental to ensuring good performance.

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

TB 13/14 049 Finance Report

Mr Foster presented the Finance Report to the Board.

The Board was informed that the Trust incurred a deficit in the first two months of the financial year of £1.1m. This was £0.3m worse than plan. The position had been submitted to the TDA along with a copy of this report as part of the monthly monitoring process.

In summarising the report, Mr Foster reported that the Trust was over performing on SLA income by £0.4m, under spending on pay by £0.3m and overspending on non-pay expenditure by £0.2m. The Transformation programme was showing a deficit of £777k which meant that the Trust's overall expenditure was showing as £0.4m adverse to plan.

The pay position was favourable to plan but could be significantly improved through the limitation of the premium costs of temporary staffing across all pay categories. Developments had been agreed from reserves through the recruitment of additional nursing staff which would start to impact the pay run rate as we move through the financial year

Mr Foster informed the Board that there had been a number of changes to contract rules for 2013/14 and the finance department had been working had to validate income earnt under the new rules. This included validation of critical care activity and best practice tariffs, changes to the specification of services classed as specialised services, potential fines and current information governance issues with the sharing of SUS data nationally. The case mix for the first two months of the financial year had been completed and was overall positive.

Mr Foster advised that there had been several meetings with Nene CCG in recent weeks which had presented a number of concerns. It was clear that Nene CCG had a significant financial gap for the current financial year and was therefore stating that they would be unable to consider the distribution of strategic reserves. Of equal concern, the CCG had included QIPP schemes, the majority of which were for non-elective activity at the Trust, which to date would appear to be undeliverable due to the Trust's over performance in that area.

Dr Swart informed the Board that the Trust, alongside the CCGs, was required to present a health economy QIPP plan to the Local Area Team, which would be problematic as the financial plans of the Trust and the CCGs was not aligned. Mr Zeidler felt that it was appropriate for the Board to review and approve the plan prior to its presentation to the Local Area Team. He asked if the plan would also be approved at the County Leaders forum prior to presentation to the Local Area Team. Dr Swart advised that the quantum of savings to be delivered had been had been discussed at the county Leaders forum, although the process for delivery had yet to be agreed. An extraordinary meeting would meet the following week to develop the delivery plan. Dr Swart stressed to the Board that the indicative timescales for delivery of the plan would provide a challenge which had not as yet been resolved.

The Board were informed that The TDA had yet to formally agree the Trust's

financial plan submission and had requested the Trust develop a formal financial recovery plan. The Finance Committee discussed an approach to this with the TDA but as yet but there was not a formally agreed approach. With the delay in mind and due to the cash flow impact of the deficit plan, Mr Foster recommended the Trust should proceed with the first stage of a working capital loan application of £4m, and sought approval from the Board for this.

The Board **APPROVED** the Mr Foster progressing the application of a working capital loan of £4m.

The Board **NOTED** the Finance Report.

TB 13/14 050 Transformation Programme Update

Mr Porter presented the Transformation Programme Update to the Board.

He reported that the target plan for 2013/14 was £13m which was constructed from the national minimum delivery of 5% of turnover. The latest thinking forecast for 2013/14 based on current schemes in delivery stood at £10.82m.

The value of identified schemes submitted to the TDA in April 2013 was £8.5m which presented a gap of £4.5m, which had been partially mitigated to present a current shortfall of £2.18m. A pipeline of additional schemes to the potential value of £1.26m was under development, which if delivered would leave a residual mitigation required of £0.92m to achieve the plan of £13m.

Mr Porter informed the Board that a comprehensive recovery plan would be presented to the July Finance Committee, with a subsequent update presented to the Board.

Dr Swart commented that external consultants had recently advised Monitor would expect all schemes rated as red within transformation plans to be forecast to deliver zero percent, and questioned if the Trust should adopt that methodology. Mr Porter advised that the current red rated schemes within the Trust plan were rated red due to delays in delivering against milestones as opposed to non-delivery and felt it prudent to forecast 50% delivery.

The Board **RECEIVED** the Transformation Programme Update.

TB 13/14 051 Self-Certification Return

Ms Spellman presented the Self-Certification to the Board. She advised that the Trust was rated Amber –Green for governance and had a financial risk rating of three. Due to the non-compliance against two of the Board Statements; maintaining a financial risk rating of three for the next 12 months and compliance with all targets, Ms Spellman recommended to the Board that declaration two of the return be signed.

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

TB 13/14 052 Nursing & Midwifery Staffing Strategy Implementation

Ms Loader presented the Nursing & Midwifery Staffing strategy implementation update paper to the Board.
The paper detailed how the investment made by the trust of £1.9m this financial year would be deployed, she presented accelerated recruitment plans to meet the requirement for additional staff indicating when they would commence in the trust, the management actions being taken to reduce

agency usage and run rate spend, enhance the efficiency of the e-roster system and outlined the underpinning governance and operational controls which would be implemented.

The Board was informed that there had been a number of changes in ward budgets to those which had been agreed during the 2013/14 budget setting process based upon the base lining of budgets and equitable distribution of spend across the directorates alongside the introduction of budgets for two additional wards. The outcome of the changes was additional investment of 25.92 registered nurses and 37.52 healthcare assistants. The areas requiring investment had been identified and recruitment was actively underway.

Ms Loader informed the Board of the impact the strategy would have on the nurse to bed ratio moving forward. She advised that the Trust had benchmarked each ward against the AUKUH benchmark data to understand which wards were over and under resourced. An overview was presented of the total investments by ward alongside the anticipated recruitment timeline for 2013/14. The decision has been based on the AUKUH benchmarking data and the professional judgement of Ward Sisters and Care Group Lead Nurses and their assessment of risk. An outcome of those reviews was that minimum staff coverage for night shifts would increase from two to three register nursing staff on each of the larger wards (30 beds).

Ms Loader advised that with the exception of two wards, she anticipated wards would be established to 95% of the new establishment numbers by the end of September 2013, with 5% of budgets allocated for short-term bank cover.

Mr Robertson observed that for some wards there appeared to be disparities between the AUKUH benchmark nurse to bed ratio and the Trust's proposed ratio. Ms Loader advised that sometimes the AUKUH benchmarks had been overridden by the Trust based on local intelligence (i.e. small ward sizes which increased the RN/bed ratios due to the need to have a minimum of 2 registered nurses per shift) and the professional judgement of Ward Sisters and Lead Nurses.

Mr Noble asked if the 95% establishment was aiming high enough, particularly anticipating other factors such as turnover. Ms Loader advised that factors such as turnover had been considered and were included in the 95% projections and budgets. The remaining 5% was allocated purely for short-term cover and sickness, which would prove to be more cost effective.

Ms Loader asked Board members if they were supportive of the increase in nursing staff at night. The Board was unanimously in support of the proposal.

Ms Loader informed the Board that the use of e-roster continued to prove problematic and as such additional investment had been identified to support a diagnostic of the system which should be completed within a few weeks.

Mr Kershaw suggested that the Integrated Healthcare Governance receive a copy of the resulting action plan which would follow the diagnostic. It was also suggested that the Audit Committee undertake a post implementation review of the system to ascertain why the intended benefits had not been realised within the two years of its operation in the Trust.

ACTION: Ms Loader

Ms Loader advised that the implementation of the Strategy would be

monitored via the Bank & Agency Group and Nursing & Midwifery Board. Six monthly updates will be presented to the Trust Board.

ACTION: Mr Sharples

The Board **NOTED** the Nursing Staffing Implementation Strategy update.

TB 13/14 053 **Any Other Business**

Noting that the meeting was Ms Allen's last meeting of the Board, the Board formally recorded their thanks to Ms Allen for her hard work and commitment during her 30 years at the Trust.

TB 13/14 054 **Date of next meeting: 24 July 2013, 9.30 Boardroom NGH**

Mr Zeidler called the meeting to a close at 11:45

TB 13/14 055 **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**

Actions from Trust Board

Last update 18/07/2013

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
27/06/2013	TB 13/14 042	Minutes of 30 May 2013 Board Meeting	Updated minutes to reflect amendments requested by Board members.	Craig Sharples	25/07/2013	Completed or on Agenda	Minutes updated.
27/06/2013	TB 13/14 043	Maters Arising	Update the matters arising log to include quarterly updates on the Francis Report	Craig Sharples	25/07/2013	Completed or on Agenda	Minutes amended and quarterly updates on the Francis Report added to the Board forward planner.
27/06/2013	TB 13/14 045	Medical Directors Report	Add scrutiny of HSMR and congestive heart failure to future Integrated Healthcare Governance Committee meeting	Craig Sharples	25/07/2013	Completed or on Agenda	Items added to the forward planner for IHGC, dates to be finalised with presenting officers.
27/06/2013	TB 13/14 047	Infection Prevention Performance Report	Future reports to explicitly distinguish between appropriate and inappropriate samples for C.Diff Testing.	Suzie Loader	25/07/2013	Completed or on Agenda	Completed, within Monthly Infection Prevention Performance Report.
27/06/2013	TB 13/14 047	Infection Prevention Performance Report	C.Diff graph presented in the report to be updated to include the cumulative number and present the ceiling	Suzie Loader	25/07/2013	Completed or on Agenda	Completed, within Monthly Infection Prevention Performance Report.
27/06/2013	TB 13/14 052	Nursing & Midwifery Staffing Implementation Strategy	Post Implementation review of the e-rostering system to be considered at the Audit Committee.	Suzie Loader Janine Brennan	18/09/2013	On Track	
27/06/2013	TB 13/14 052	Nursing Staffing Implementation Strategy	Complete the diagnostic review of the eRostering system and bring back the outcome of that review, together with actions required to enhance the efficiency and effectiveness of the system. Bring this back to the IHCGC.	Suzie Loader Janine Brennan	18/09/2013	On Track	
27/06/2013	TB 13/14 052	Nursing Staffing Implementation Strategy	Update the Board annual cycle of business to include six monthly updates on the Nursing Staffing Implementation Strategy	Craig Sharples	25/07/2013	Completed or on Agenda	Annual cycle of business updated

KEY	
	Completed or on Agenda
	On Track
	To be Reported at the Meeting
	Some Slippage

Enclosure B

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 July 2013

Title	Chief Executive's Report
Agenda item	5
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Author(s)	Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Purpose	Information and Assurance
Executive summary The report highlights key business and service developments for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N)
Legal implications / regulatory requirements	No
Actions required by the Board The Board is asked to note the content of the report.	

Enclosure C

Northampton General Hospital NHS
NHS Trust

Trust Board
24 July 2013
Chief Executives Report

1. Keogh Review

On the 16 July 2013, NHS England published the final overview report from Sir Bruce Keogh which presented the findings of a review into the quality of care and treatment provided by 14 hospital trusts in England. The review was requested by the Prime Minister and the Secretary of State for Health in response to the Mid Staffs NHS Foundation Trust incident and focused on those trusts with persistently high mortality rates.

Following the conclusion of the reviews across the 14 hospitals, common challenges facing the wider NHS were identified. The report outlined Sir Bruce Keogh's ambitions for improvement based on the challenges which seek to tackle some of the underlying causes of poor care, and outlined his expectation that significant progress towards achievement of those should be made within two years.

The common themes articulated as barriers to delivering high quality care were:

- A limited understanding of how important and simple it can be to genuinely listen to the views of patients and staff, and engage them in how to improve services.
- The ability of hospital boards and leaders to use data to drive quality improvement. This theme is made more difficult by how hard it is to access data held in different places and different ways across hospitals systems.
- The complexity of using and interpreting summary measures of death (HSMR and SHMI).

There has been a further announcement that professors Lord Ara Darzi and Nick Black will conduct a study into the relationship between "excess mortality rates" and actual avoidable deaths. This would be used to inform a new measure based on clinical case note reviews. The Board will be aware that this approach was used at NGH last year and is still used in the analysis of mortality on a regular basis.

The Trust is undertaking a detailed review of the recommendations made within the report and will present an update on progress and action plan to the Board in September.

2. Independent Review of the Liverpool Care Pathway

The Liverpool Care Pathway for the Dying Patient, commonly shortened to the LCP, was originally developed by the Royal Liverpool University Hospital and the Marie Curie Hospice in Liverpool to be used for the care of terminally ill cancer patients. The LCP has since been rolled out nationally and aims to ensure that uniformly good care is given to everyone, wherever they are – in hospitals, nursing homes, or in their own homes – when it is thought that they will die.

In January 2013, an independent review of the LCP was commissioned by the Minister of State for Care and Support in response to concerns raised about poor care experienced by patients who were put on the LCP. The report published following the independent review recognised that the

Enclosure C

principles of care which underpin the LCP are sound and when used appropriately, the LCP supports good care for the dying. However, the report identified specific instances of poor practice and poor quality care.

Following the outcome of the review, it is now the intention of the Government to phase-out the LCP over the forthcoming 6-12 months, replacing it with an individual approach to end of life care for each patient consisting of a personalised care plan backed up by condition specific good practice guidance with oversight from a named senior clinician responsible for its implementation.

In response to the report, the Trust will seek to:

- undertake a clinical review, led by a senior clinician, of each patient who is currently being cared for using the LCP or a similar pathway for the final days and hours of life, to ensure that the care they are receiving is appropriate and that the patient, where possible, and their family is involved in decisions about end of life care; and

- assure itself that a senior clinician is assigned as the responsible clinician to be accountable for the care of every patient in the dying phase, now and in the future.

In April 2013, the Trust Board received significant assurances on the quality of care provided to patients on the LCP from a presentation by senior clinicians within the Trust. The presentation looked at the key enablers to providing high quality end of life care to patients and presented the actions the Trust had taken, and were proposing to take, to drive improvements in the area. The Board noted that NGH has implemented the LCP with support from specialists trained in end of life care, has a programme of training ward staff in the use of the LCP and has taken part in the national audits of its use. Staff at NGH have always supported the personalised care planning element of the pathway and trained staff to communicate with patients and relatives when people are nearing the end of their lives and will continue to work on ways of offering personalised care plans which meet the needs of patients and carers as patients reach the end of their lives in a proactive way.

Further progress and developments will be reported to the Trust Board in due course.

3. NHS England – "The NHS belongs to the people: a call to action".

NHS England has this month called on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. This is set against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap which could grow to £30bn between 2013/14 to 2020/21.

A new publication, 'The NHS belongs to the people: a call to action' sets out these challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The document says clearly that the NHS must change to meet these demands and make the most of new medicines and technology and that it will not contemplate reducing or charging for core services.

The essence of the document is a proposal that there is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This will be used to produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

Locally the programme of work that is taking place across Northamptonshire following the launch of Healthier Northamptonshire will embrace these fundamental principles in the clear understanding that we must find different ways of delivering healthcare if we are to rise to the challenge of improving quality whilst curtailing cost.

4. Infection Control Visit from the NHS Trust Development Authority

The NHS Trust Development Authority visited the Trust in July to review our infection prevention and control processes. The overall message was that infection prevention was embedded within the organisation, but there were a few things which needed attention. A full report and action plan will be presented to the Integrated Healthcare Governance Committee in due course.

Members of the Board will soon be visiting all the clinical areas in a regular programme of quality reviews to look at infection prevention as well as other important quality issues and to speak with patients and staff.

5. Listening into Action

The Listening into Action (LiA) initiative was introduced in July 2013. The initial focus of the initiative was to focus on engaging with staff to identify positive changes for the workplace and ensuring actions were completed which included; new patient menus, new nursing documentation, IT consultation, extended opening hours of Café Royale, revision of equipment maintenance, Core Brief, and increased use of volunteers to assist patients at mealtimes.

Since then, 18 clinical and non-clinical teams have participated in LiA workshops and produced outcomes to improve their day to day working, to benefit their service delivery, quality and patient experience. The main themes from this work both corporately and from the teams are; Communication (team and with other Trust colleagues and departments), IT, discharge, staffing, documentation, patient experience and MDT.

This methodology has enabled teams to structure conversations and meetings to discuss how together they can improve their service and become empowered to make changes required and communicate with their managers and trust colleagues to assist them in achieving their actions. The key task now is to embed this way of working into normal managerial processes and develop all our managers and other staff in a way that assists quality improvement. This will be our agreed way forward and will form an essential component of our future strategy for engaging staff and improving patient care. Our transformation programme will also be based on this approach.

6. Northampton General Hospital NHS Trust Festival

There has been further development of the plans for the NGH Festival on the day of our Annual General Meeting on September 14th. A large number of departments are preparing to host displays and there will be Sikh dancing as well as a performance of a local Jazz Band. This is in addition to the planned debut performance of the NGH Choir which is proving to be a success and now has almost 100 members. I know that those taking part are enjoying the opportunity to meet colleagues from NGH and from outside the Trust and share their common enjoyment of music.

7. Northampton General Hospital NHS Trust in the news

We have received positive media coverage regarding the Board's decision to invest in additional nursing staff, with coverage in local and regional print, broadcast and online media. Twelve of the volunteers from the Friends of NGH were recently pictured in the Northampton Chronicle & Echo having received long service awards from the Mayor. The charity has been operating now for 24 years and some of the volunteers received an award for 20 years' service. There are about 200 Friends of NGH who volunteer in the hospital and we are indebted to them all for their contribution and commitment.

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Medical Director's Report
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Author(s)	Dr Natasha Robinson, Associate Medical Director Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Purpose	This report is presented for information and to provide assurance

Executive summary

- Overall mortality as measured by HSMR and SHMI is as expected
- Detailed review of adverse clinical outcomes is undertaken and monitored for improvement by the Mortality & Coding Review Group
- Data quality is being addressed through the new Data Quality Group
- Data quality and coding of community hospital discharges are being monitored for accuracy, and additional support provided
- Coding is examined, revised as appropriate and reported to the Mortality & Coding Review Group
- An external review of data quality, coding and outcomes has been undertaken
- Consultant outcomes ['Everyone Counts'] have been published for 5 specialties with full local participation and no adverse performance
- The clinical scorecard exception report indicates areas of 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.

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? (Y/**N)** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications /	Regulators will consider quality indicators and take action where

Enclosure D

regulatory requirements	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.

Trust Board
24th July 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 April 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. A high standard of care in the community may also have a confounding effect as only the highest risk patients are admitted to hospital, so apparently increasing hospital mortality rates.

In addition the Board should note that the community hospitals are not recorded as separate sites and where predominantly elderly patients are admitted for a variety of types of supportive care, including terminal care, this is likely to affect the HSMR for this Trust. Record keeping standards reflect the community setting and may not provide the level of information necessary for accurate clinical coding of the patient's diagnosis and health status.

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 picture. The funnel plot reflects the HSMR position for the last year [2013-4 will not be available until later this year]. The light blue diamond represents our current position, the dark blue our projected end of year position once the data is rebased to reflect overall England performance. The grey dots are the remaining 146 acute trusts, rebased using projected 2012-3 national performance.

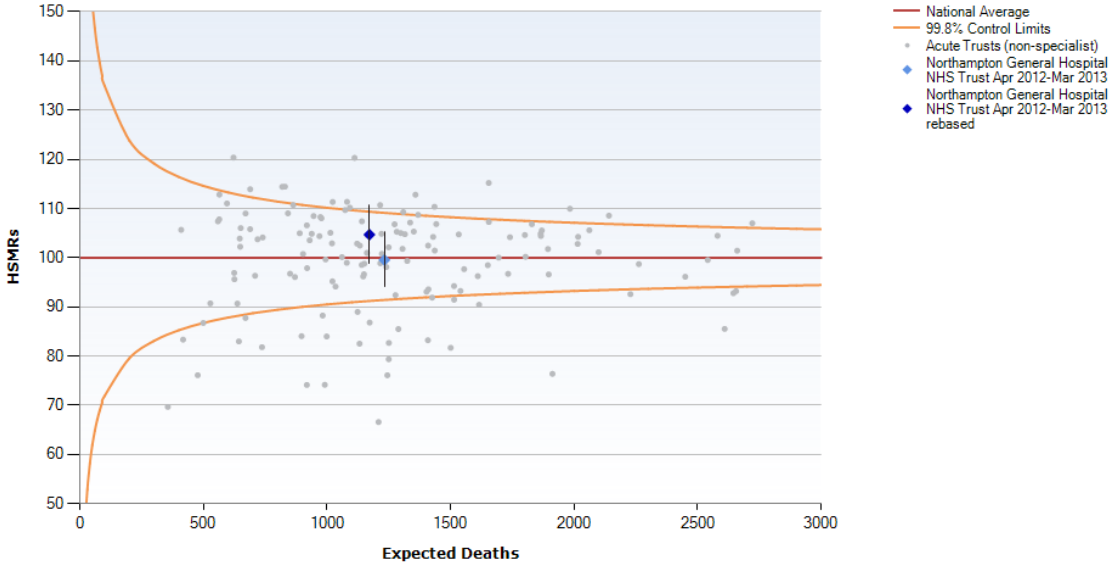
The 2012-3 HSMR using the 2011/12 benchmark is **99.6** with the indicative rebased HSMR using the 2012/13 FYD benchmark being **105** (this remains within the as expected band and shows a small improvement since last month due to ongoing data revisions).

The HSMR for 2013-4 [one month only - April] is **110** [104 deaths, 94 expected]

Unadjusted mortality for the month is **4.1 %** [4.2% for 2012-3] but the *expected* rate is unusually low at 3.7% [this is due to a cohort of patients from the community hospitals who have yet to be fully coded]. This has resulted in a disappointingly high HSMR for the month which should reduce somewhat once the information has been fully updated.

Work is ongoing to ensure timely and accurate coding of all discharges from the community hospitals to minimise data inaccuracies from these sources.

Acute Trust HSMRs Apr 2012 - Mar 2013



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 . The availability of a second metric is helpful in further understanding outcomes in some areas, but in depth analysis of SHMI to individual patient level is currently unavailable. The next data release is expected at the end of July 2013 [to December 2012], at which point any persistent adverse variance between HSMR and SHMI will be identified and a preliminary analysis undertaken.

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

5. Dr Foster Patient Safety Indicators (May 2012-April 2013)

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

May 2012 to Apr 2013

Indicator		Observed	Expected	Observed rate/K	Expected rate/K
Deaths in low-risk diagnosis groups*		28	24.1	0.79	0.68
Decubitus Ulcer		199	215.4	21.15	22.89
Deaths after surgery		49	38.4	152.65	119.71
Infections associated with central line*		0	0.8	0.00	0.05
Post-operative hip fracture*		1	1.7	0.04	0.07
Post-op Haemorrhage or Haematoma		4	14.1	0.17	0.61
Post-operative physiologic and metabolic derangements*		1	1.5	0.05	0.08
Post-operative respiratory failure		14	13.8	0.78	0.76
Post-operative pulmonary embolism or deep vein thrombosis		32	42.2	1.37	1.81
Post-operative sepsis		8	3.9	12.90	6.33
Post-operative wound dehiscence*		2	1.1	2.08	1.18
Accidental puncture or laceration		36	74.2	0.55	1.13
Obstetric trauma - vaginal delivery with instrument*		26	40.4	53.17	82.71
Obstetric trauma - vaginal delivery without instrument*		84	93.6	33.55	37.37
Obstetric trauma - caesarean delivery*		1	4.2	0.82	3.43

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 for the rolling year to date is **82** which is significantly lower than expected (506 deaths with 617 expected from 3091 spells).

There has been a continuing modest improvement in mortality from **fractured neck of femur**. The SMR for YTD is **136** (45 deaths with 33 expected) and this is no longer significantly raised. The improvement work continues and clinical teams report bimonthly to the mortality review group.

Mortality from **heart failure** remains significantly high. SMR is **136** (68 deaths whereas 50 were expected). It is notable that the Trust has the lowest admission rate for heart failure in the East Midlands, suggesting that the Community Heart Failure team are effective in reducing avoidable admissions. Those who are admitted are therefore likely to be the highest risk patients and the casemix may not reflect the national profile. The hospital heart failure team are currently identifying all patients admitted with a diagnosis of heart failure to optimise care before discharge into the community. Any further improvement in the service may well result in an apparent deterioration in hospital performance. All deaths will continue to be reviewed by the heart failure team.

7. Possible areas for concern under investigation

Currently a number of other areas remain under investigation. These include **secondary malignancies**, '**perinatal conditions**' (which includes still births) and **adult leukaemia**. The reviews of the first 2 groups are now complete and due for report to the Mortality & Coding Review Group at the end of July. There have been no deaths from leukaemia for 5 consecutive months.

The new Dr Foster tool 'Quality Investigator', which is undergoing beta testing in the Trust, provides scope for additional analysis and has identified several new areas for further investigation. The significance is not always immediately clear and monthly tracking will help direct further work. One area '**Intestinal Infection'** is currently undergoing review with the microbiology department to confirm whether local mortality from C Diff and related illnesses is higher than expected. This is of especial importance in the light of our recent increase in reported cases of CDiff.

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

Individual consultant survival outcome data ('Everyone Counts') in 5 specialist areas (vascular surgery, urological cancer, interventional cardiology, thyroid surgery and joint replacement) has now been published. 3 further specialties [bowel cancer, head & neck cancer and gastro-oesophageal cancer] will publish in the autumn. There has been a high rate of local participation and all published outcomes for the Trust lie within the normal range. This NHS England initiative has highlighted the need for all consultants to be closely involved in the provision of accurate information related to their practice.

9. Further actions in place or planned

The accurate application of codes for palliative care and serious coexisting illness (comorbidity) can have a marked effect on predicted survival rates. Dr Foster tools indicate that use of both palliative care and comorbidity codes are lower than average at NGH and this will adversely affect HSMR. An extensive review by Mott Macdonald has confirmed this to be the case and the detailed findings of their report are shortly to be presented to the executive team, care groups, clinical directors and general managers. This report should be available for the September Board.

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.

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 June 2013 7 SI's were submitted to the CCG for closure: 1 pressure ulcer, 1 fracture occurring as an inpatient [hip], 2 infection outbreaks (Norovirus on an adult ward and 'scalded skin' amongst babies in maternity), a failure to follow up an MRI scan (the case occurred in 2010), and 2 missed complications of procedures [one fatal].

In line with the SI process a 'Being Open' meeting is offered to the patient and/or carers/family to discuss the findings of the report. During the reporting period there was one Being Open meeting held; it was attended by the deceased patient's family, Falls Consultant, A&E Consultant, Matron and Risk Management. The family have further queries which are being addressed by Risk Management. The meeting for the fatal complication after surgery is being held at KGH as the family do not wish to return to NGH. It is recognised that the unexpected late offer of such a meeting can be distressing for families who are recovering from bereavement and that as part of the Duty of Candour requirements, patients, families and carers must be made aware of the possibility of an investigation at the earliest possible stage.

All SI's are reviewed at consultant appraisal as part of revalidation, but this may be specified as part of the action plan for certain investigations. 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. This support is also necessary as part of the preparation for an inquest if this has been opened.

Actions taken as a result of SIs closed in June 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.
- 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 Duty of Candour requirements are reflected.
- SI policy to be updated to strengthen implementation and monitoring of action plans
- 'Copying Letters to Patients' has been re-established in the ophthalmology Dept
- A process for tracking the ordering and reviewing of diagnostic imaging is being set up by radiology in conjunction with ophthalmology [and for roll out to all specialties]
- Radiology Dept is developing an alerting system to inform clinicians of a significant abnormal finding on diagnostic imaging
- Programme for induction of locum medical staff has been strengthened in ophthalmology
- The Vascular Service will review the need to upgrade the imaging and injection equipment available for aortic stent procedures
- When unexpected discrepancies between planning measurements and operative findings are noted, a full review of all imaging will be undertaken before proceeding
- Escalation arrangements within the surgical directorate are to be clarified and incorporated in induction arrangements for the new doctor in take [August 2013]
- Clear postoperative care protocols are to be produced for vascular procedures

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 should note that considerable detailed analysis occurs as part of on-going mortality monitoring which has been in place for many years. This is reported at the mortality and coding group, through the Clinical Effectiveness and Quality Group (CQEG), in the Quarterly Patient Safety and Quality and Governance Report and is discussed at Integrated Healthcare Governance Committee (IHGC). The emphasis of all mortality analysis is to recommend improvement plans and many actions are encompassed in the Trust Patient Safety work streams.

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.

Section 2

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 May's exception report there were 141 indicators, of which 51 were rated as either red or amber status. For June there are 141 indictors of which **46** 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. Indicators rated as grey are those which are awaiting final agreement or the information is currently not available.

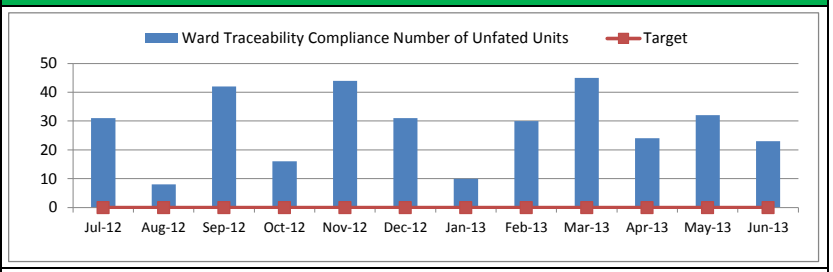
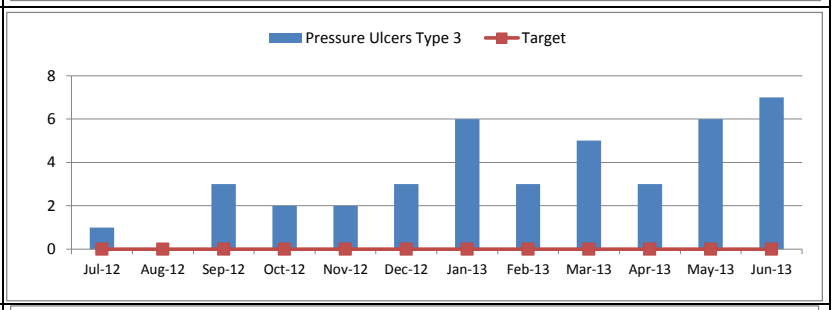
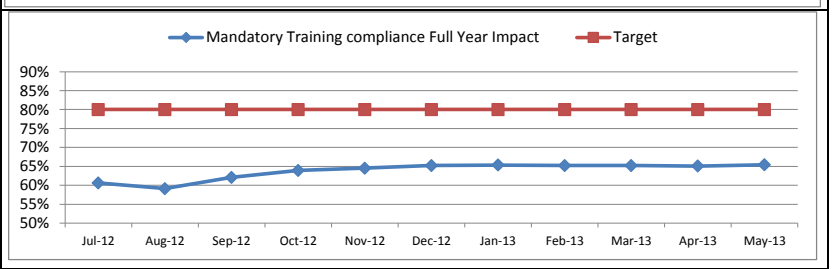
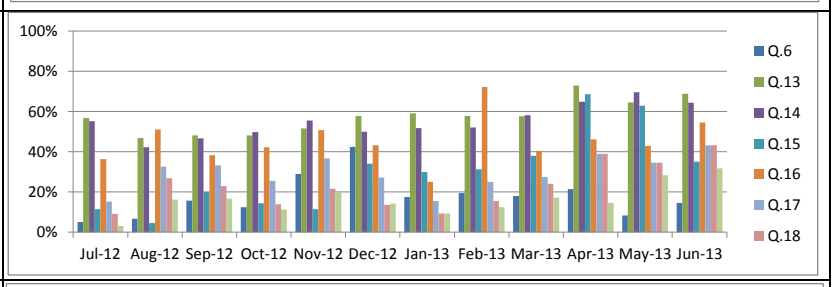
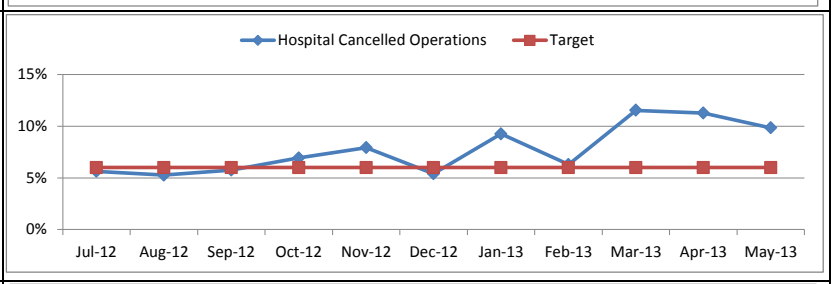
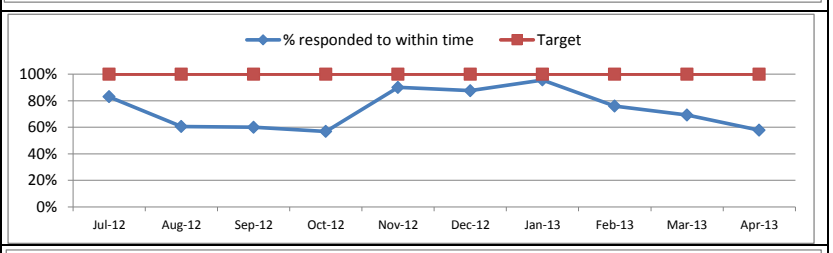
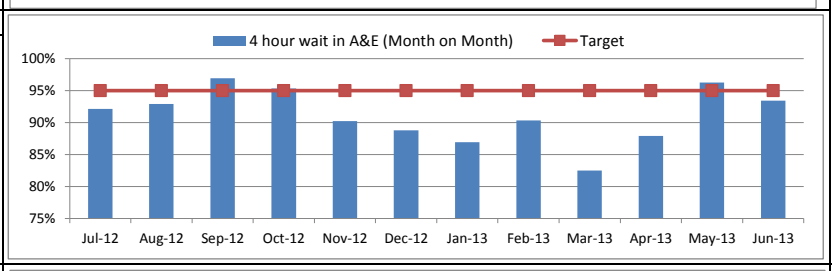
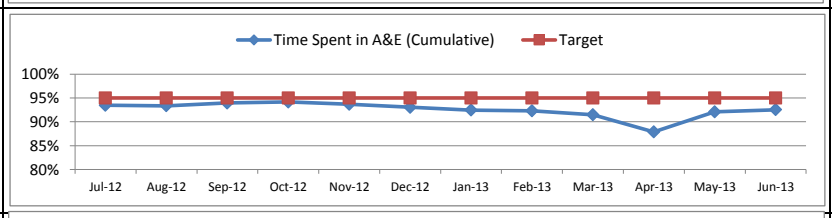
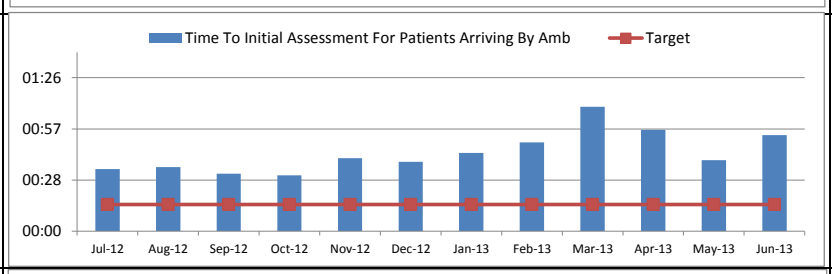
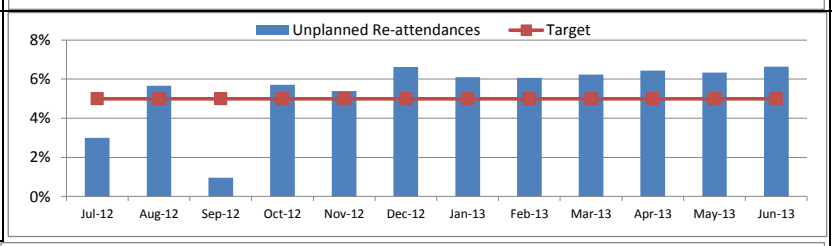
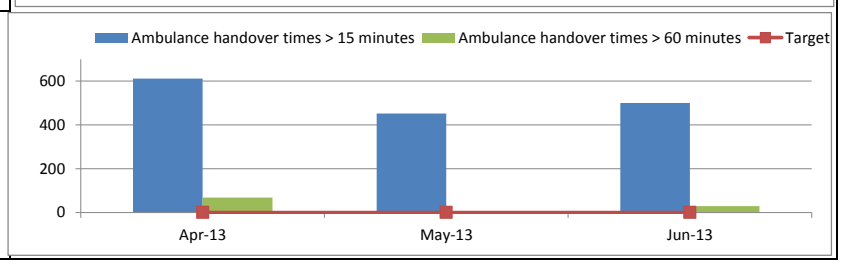
Summary Rating

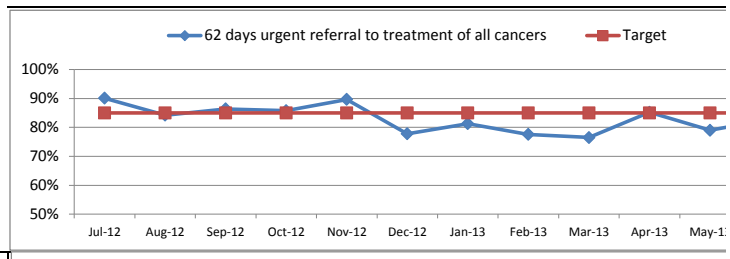
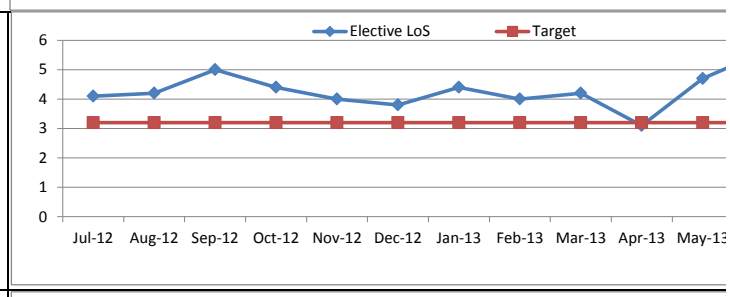
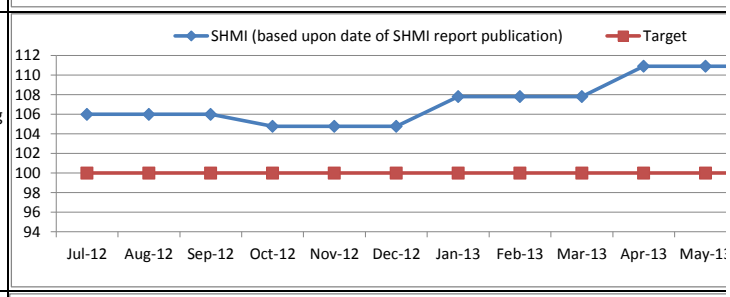
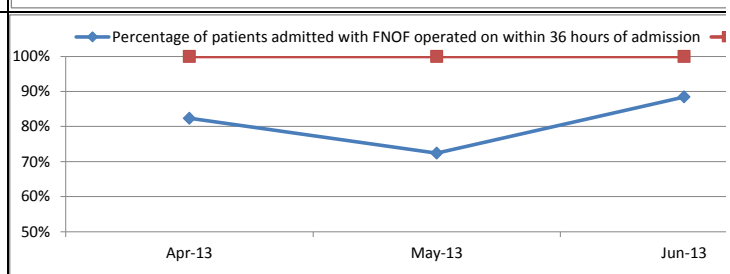
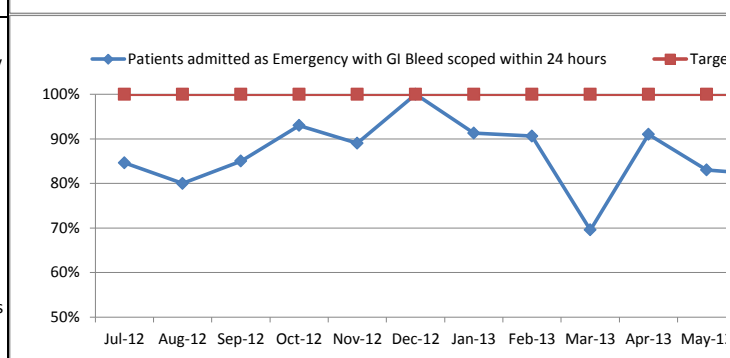
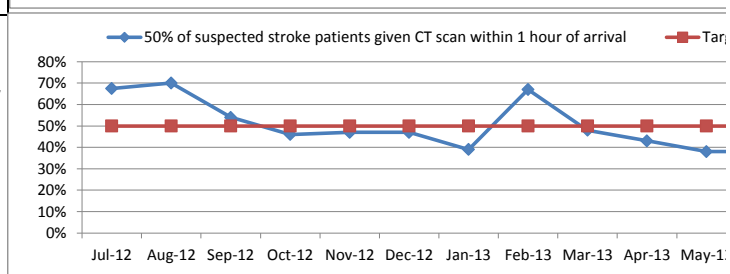
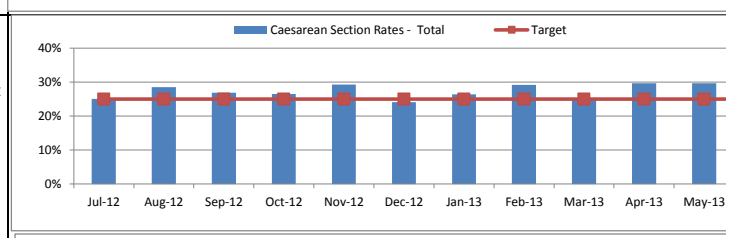
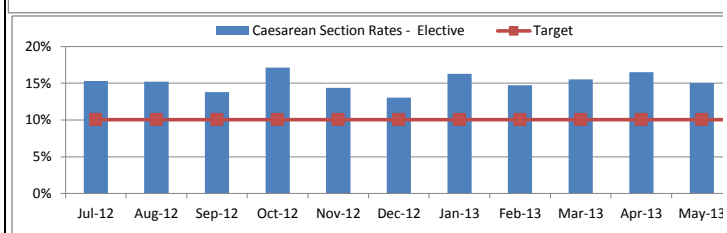
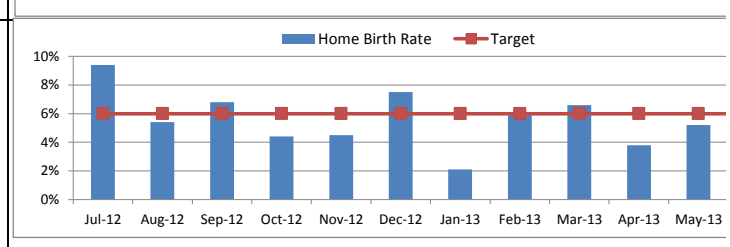
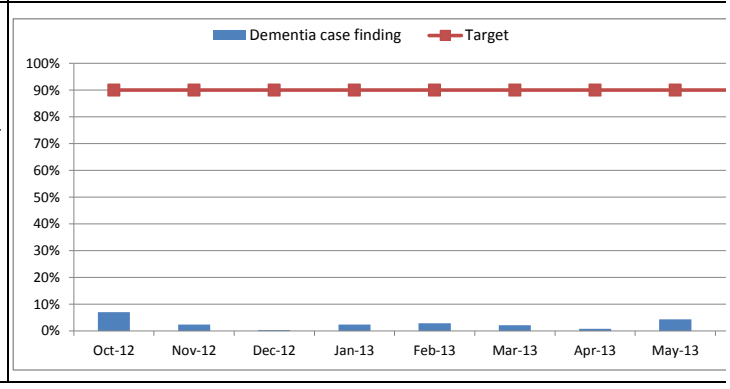
Section	Red Rated	Amber Rated	Green Rated	N/A	Total
Patient Safety	13	10	21	8	52
Patient Experience	10	0	21	2	33
Clinical Outcomes	7	0	6	15	28
CQUIN 2013-14	1	5	17	5	28
TOTAL	**31**	**15**	**65**	**30**	**141**

Recommendation

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

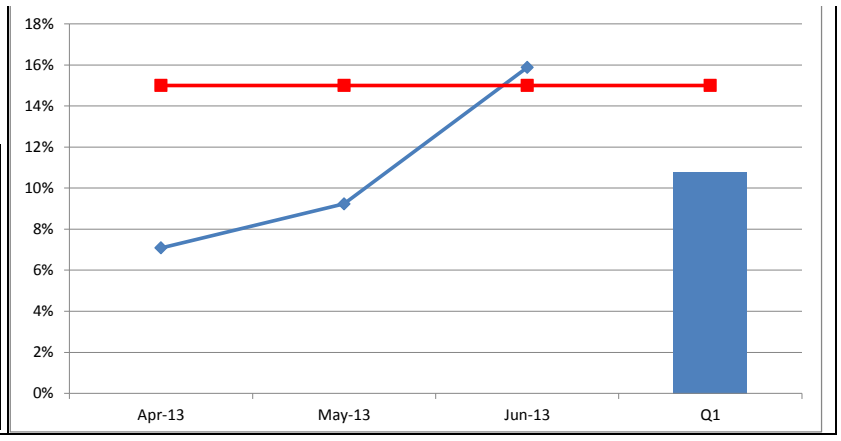
Enclosure D

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Unfated Units	0	↑	Autofate compliance improved on last month from 32 unfated units in May to 23 units in June. (Total ward compliance was reported as 99.9% in June, although legislation requires 100% compliance with traceability of blood as per the Blood Safety and Quality Regulations 2005.)	
Patient Safety	Incidence of Pressure Ulcers Type 3	0	↓	June 2013 showed 7 pressures ulcer incidents which consisted of 3 x grade 3 avoidable and 4 x grade 3 unavoidable incidents. . 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	Mandatory Training compliance Full Year Impact	0	→	May 2013 saw a decrease in the number of staff being trained. This has meant that 14 of the 18 reported mandatory training courses have seen a decrease of staff being trained, with Safeguarding Adults, Mental Capacity and Conflict Resolution seeing the biggest decrease against last months report. 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 June 13 : the recording of vital patient information (date of birth, hospital number and NHS number) on the front page of notes where the addressograph wasabsent,capitalisation of surname is capitalised, recording of staff designation , whether the GMC number is present, how alterations/deletions are managed and evidence of communication to relatives and teams. The majority of these areas saw improved rates compared to the previous month. Improving the Healthcare Records Audit results is being overseen by one of the leads for the Patient Safety Academy with actions plans underway. The lead has agreed to prepare options for accelerating this work as progress is very slow.	
Patient Experience	Hospital Cancelled Operations	6%	↑	Hospital cancellations for May 20103 as a percentage of total elective admissions has shown a slight decrease to 9.8% since March 2013 when it was at its highest rate (11.5%). However this still remains over the target of 6%	
Patient Experience	Complaints Responded to within agreed timescales	100%	↓	The complaints response rate has gradually decreased from January 2013 - 96% through to April -58% (latest available figure due to 40 day turnaround). The main reason for this is the late or incomplete reports that are received from the care groups. However, to address this staff from the complaints team have met with senior colleagues from the medicine care group to look at how the process could be improved. This is currently being taken forward by the care group.	
Patient Experience	A & E Quality Indicators (4 indicators)		↓	**A&E Clinical Indicators:** 4 hour wait in A&E (Month on Month) decreased from above target in May to below target in June (93.42%)	
			↑	Time Spent in A&E (Cumulative) - June's position of 92.55% saw repeated improvement from the month before (May - 92.1%) but is still behind target.	
			↓	The time to initial assessment for patients arriving by ambulance increased from 40 mins in May to 54 mins in June (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 will be going to SMB for increased clinical staff and workforce development.	
			↓	Unplanned re-attendance rate - June's performance was 6.64% against a target of 5%. 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). June saw an increase in both handovers over 15 mins (500 cases) and handovers over 60 mins (29 cases).	

Patient Experience	Cancer Wait times	90%	↑	The Trust did not meet the 62 day cancer standard from urgent GP referral to start of first treatment. During June the Trust achieved 82.9%% against the standard of 85% (subject to final validation), up from 79% in May. Factors affecting the June performance were radiotherapy and planning capacity, complex diagnostic pathways, patient choice to decline or defer appointments and internal processes. A Cancer Recovery Plan has been developed and will be monitored through a board charied by the CEO.	
Patient Experience	SRS08: Length of Stay (Acute & MH) - Elective	3.2 days	↓	Although the LoS of 5.6 for June was 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 below the expected LoS for the period which was 6.0 days).	
Clinical Outcomes	SHMI (based upon date of SHMI report publication)	<100	→	SHMI has been rising during the last few months of data which was updated last September 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. Current figures for SHMI reflect the position as reported to last September and not the figures for the month in question.	
Clinical Outcomes	Percentage of patients admitted with FNOF operated on within 36 hours of admission	100%	↑	June has seen an increase in the % of fractured neck of femur (FNOF) patients operated on within 36 hours of admission from 72.4% in May to 88.5% in June. The department has put in place an extra 0.5 day operating session each week and has now also got 7 day operating capacity. In addition, a FNOF specialist nurse is now in place.	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	↓	June's % of patients with GI bleed were scoped within 24hours decreased slightly from 83% (May) to 83%. 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 routinely 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%	↑	Although June's Total and Emergency Caesarean Section Rates remains above the national averages, both areas saw an improvement during the period. 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. It is hoped that the expansion of the Birth after Caesarean Section (BAC) clinic which opened in March 2013, 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.	
		10.1%	↑		
Clinical Outcomes	Home Birth Rate	>=6%		Despite an increase from April 2013 (3.8%) to May (5.2%), June saw the home birth rate decrease back to 3.8%	
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 (June = 2.37% against the target of 90%). Despite an increase in the number of patients being screened, this has not been reflected on the data collated from the eDN (electronic discharge notification) mainly due to the data was not being transcribed on the system. To mitigate this the dementia screening questions on the eDN has now been updated and it has been made mandatory as of 8.7.13. In addition a newly appointed CQUIN facilitator has been appointed and will visit each ward daily to ensure screening and assessments are being completed.	

CQUIN	Friends and Family Test Response Rate	Q1 - 15% rising to 20% by Q4 2013-14		the Inpatient and A&E totals were above target for June, however the quarterly total position was not met (10.77%). The main issue around the data collection within A&E in relation to the number of completed returned forms received has been resolved through new feedback mechanisms put in place since mid-June 2013.

Period: Q1 2013-14 1st April to 30th June 2013	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Month	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	Total responses for each area	Response rate for each ward	Score for each ward / area
Apr-13	349	146	17	4	13	25	7816	554	7.09%	60
May-13	519	175	18	6	8	13	7968	739	9.27%	67
Jun-13	829	358	30	23	7	21	7985	1268	15.88%	62
Q1	1697	679	65	33	28	59	23769	2561	10.77%	63



Enclosure D

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Frequency	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	June 13 RAG Rating	Comments
HOU01: HCAI measure (MRSA)	0	Monthly	0	0	0	1	0	0	0	0	0	0	0	0	0		
HOU02: HCAI measure (CDI)	29 per year	Monthly	4	3	0	2	1	3	4	2	2	5	7	2	4		
HOU08: MSSA Numbers	No national ceiling set	Monthly	1	1	1	0	2	2	1	1	0	0	1	0	1		
E Coli ESBL Quarterly Average	7 per month	Monthly	1	0	5	1	0	4	2	3	2	0	2	3	3		
VTE Risk Assessment completed	95% month on month	Monthly	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	95.5%		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%	100.0%		
MRSA Screening Elective Patients	100% month on month	Monthly	100%	100%	100%	100%	100%	99.74%	99.40%	99.73%	99.54%	99.40%	99.87%	99.50%	99.71%		
MRSA Screening Non-Elective Patients	100% month on month	Monthly	96.41%	96.68%	94.91%	95.25%	96.10%	96.80%	95.78%	95.12%	96.56%	97.00%	96.40%	96.95%	97.98%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	Monthly	15	31	8	42	16	44	31	10	30	45	24	32	23		
Incidence of pressure ulcers																	
Type 3	0	Monthly	2	1	0	3	2	2	3	6	3	5	3	6	7		
Type 4	0	Monthly	0	0	0	0	0	3	4	0	0	1	0	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	1	1	2	0	2	3	0	1	2	1	0	1	1		
Moderate	0	Monthly	3	0	0	1	0	0	1	2	3	1	1	3	1		
Mandatory Training compliance Full Year Impact																	
Primary Levels Excluding B&H	80%	Monthly	60.3%	60.6%	59.1%	62.1%	63.9%	64.5%	65.2%	65.4%	65.2%	65.2%	65.1%	65.4%	N/Avail		6 week turnaround delay for data
Attendance at Trust Induction	80%	Monthly	76.8%	87.8%	81.4%	85.5%	98.6%	90.8%	87.9%	87.5%	87.6%	87.5%	87.3%	87.4%	N/Avail		6 week turnaround delay for data
Number of surgical site infections																	
Fracture neck of femur - Number of Operations	-	Monthly	21	26	53	26	26	36	34	39	31	45	17	27	29		
Number of infections	-	Monthly	0	0	0	0	0	0	0	0	0	0	1	0	0		
% infection rate (monthly)		Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	6%	0%	0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly			1.1%			0%			0.9%		Awaiting final Q1 report				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 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
Abdominal hysterectomies		Monthly											16	16	14%		
Number of infections		Monthly				Abdominal hysterectomies infection rates monitored as from April 2013							0	0	0%		
% infection rate (monthly)		Monthly											0%	0%	0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly											Awaiting final Q1 report				
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	1	0	0		
NICE clinical practice guidelines and TAG compliance	80%	Monthly	82.2%	0.0%	84.0%	84.2%	87.0%	87.9%	89.0%	89.1%	89.3%	89.3%	84.7%	86.1%	84.6%		
Serious Untoward Incidents	-	Monthly	9	5	4	5	7	14	9	19	25	36	41	35	51		
Never Events	0	Monthly	0	0	1	0	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%	99%	100%		
Healthcare Notes Audit																	
Q.1 Does the front page of every sheet contain an addressograph label	100%	Monthly	67%	77%	71%	77%	73%	68%	79%	80%	79%	72%	79%	72%	74%		
Q.2 Does addressograph include the NHS Number?	100%	Monthly	96%	95%	86%	90%	90%	93%	88%	99%	88%	92%	90%	97%	97%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	Monthly	83%	56%	87%	86%	73%	87%	97%	74%	90%	84%	100%	94%	90%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	Monthly	49%	36%	56%	62%	60%	62%	82%	53%	73%	64%	85%	69%	77%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	Monthly	59%	41%	55%	60%	64%	74%	91%	53%	63%	46%	61%	67%	69%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	Monthly	2%	5%	7%	16%	13%	29%	42%	18%	20%	18%	21%	8%	15%		
Q.7 Is record legibly written	100%	Monthly	98%	97%	92%	99%	98%	97%	99%	99%	98%	99%	95%	100%	98%		
Q.8 Written in blue/black ink	100%	Monthly	100%	100%	99%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Monthly	98%	99%	98%	100%	100%	100%	99%	98%	99%	100%	99%	98%	99%		
Q.10 Is date recorded for each entry	100%	Monthly	86%	89%	91%	94%	89%	93%	91%	88%	90%	88%	86%	87%	86%		
Q.11 Is time recorded for each entry	100%	Monthly	67%	79%	68%	77%	73%	70%	72%	71%	66%	75%	86%	87%	86%		
Q.12 Is there a signature of the person making the entry	100%	Monthly	91%	95%	94%	92%	87%	91%	92%	90%	94%	94%	96%	97%	92%		
Q.13 Is surname printed in block capitals	100%	Monthly	56%	57%	47%	48%	48%	52%	58%	59%	58%	58%	73%	65%	69%		
Q.14 Is the staff designation recorded	100%	Monthly	44%	55%	42%	47%	50%	55%	50%	52%	52%	58%	65%	70%	64%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	Monthly	19%	11%	5%	20%	14%	11%	34%	30%	31%	38%	69%	63%	35%		
Q.16 Are any alterations / deletions scored through with a single line	100%	Monthly	41%	36%	51%	38%	42%	51%	43%	25%	72%	40%	46%	43%	55%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	Monthly	33%	15%	33%	33%	26%	37%	27%	16%	25%	28%	39%	35%	43%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	Monthly	5%	9%	27%	23%	14%	22%	14%	9%	16%	24%	39%	35%	43%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	Monthly	5%	3%	16%	17%	11%	20%	14%	9%	13%	17%	15%	28%	32%		
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	100%	99%	95%	97%	96%	100%	99%	97%	88%		
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	76%	68%	34%	42%	75%	44%	44%	60%	69%		
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	100%	100%	100%	100%	100%	100%	100%	96%	80%		
Q.23 Are there any loose sheets in the Healthcare record	0%	Monthly	N/a	N/a	N/a	N/a	8%	10%	17%	10%	0%	13%	10%	3%	3%		

Patient Experience	Target 2013-14	Frequency	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	June 13 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	Monthly	0	0	0	0	0	0	6	4	1	2	1	0	0		
Hospital Cancelled Operations	6.0%	Monthly	8.8%	5.6%	5.3%	5.8%	6.9%	7.9%	5.4%	9.3%	6.3%	11.5%	11.3%	9.8%	N/Avail		June 20103 SLAM data not available at time of report production
Number of written complaints received	-	Monthly	39	48	33	35	44	40	24	68	54	52	45	58	37		
Complaints Responded to within agreed timescales	100.00%	Monthly	87.2%	83.0%	60.6%	60.0%	56.8%	90.0%	87.5%	95.6%	75.9%	69.2%	57.8%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits																	
Admitted Patients	90.00%	Monthly	97.40%	96.61%	96.99%	96.34%	96.08%	95.93%	96.47%	96.10%	95.12%	95.13%	95.02%	96.16%	95.79%		
Non Admitted Patients	95.00%	Monthly	98.80%	98.61%	98.46%	98.44%	98.52%	98.36%	98.48%	98.60%	97.90%	97.97%	97.87%	98.02%	98.01%		
Ongoing Patients	92.00%	Monthly	97.13%	97.30%	97.53%	97.12%	96.91%	96.85%	96.33%	95.45%	95.74%	95.64%	96.36%	96.46%	96.67%		
A&E Quality Indicators (5 measures)																	
Time Spent in A&E (Month on Month)	95%	Monthly	93.40%	92.16%	92.93%	96.93%	95.35%	90.25%	88.81%	86.91%	90.33%	82.49%	87.89%	96.28%	93.42%		
Time Spent in A&E (Cumulative)	95%	Monthly	93.92%	93.47%	93.36%	93.95%	94.15%	93.67%	93.04%	92.47%	92.30%	91.51%	87.89%	92.10%	92.55%		
Total time in A&E (95th percentile)	95th	Monthly	04:50	05:19	05:04	03:59	04:00	06:09	06:18	07:12	06:21	08:08	06:45	03:59	04:43		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	Monthly	00:39	00:35	00:36	00:32	00:31	00:41	00:39	00:44	00:50	01:10	00:57	00:40	00:54		
Time to treatment decision (median)	<60 mins	Monthly	00:54	00:52	00:42	00:48	00:41	00:46	00:48	00:34	00:45	00:52	00:57	00:51	00:51		
Unplanned re-attendance rate	=<5%	Monthly	5.91%	3.00%	5.66%	0.95%	5.71%	5.40%	6.62%	6.10%	6.07%	6.23%	6.44%	6.34%	6.64%		
Left without being seen	>1% and <5%	Monthly	0.20%	0.16%	0.18%	0.18%	0.07%	0.25%	0.12%	0.18%	0.22%	0.22%	0.24%	0.19%	0.31%		
Ambulance handover times > 15 minutes	0	Monthly					New for 2013-14						612	452	500		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	Monthly					New for 2013-14						68	3	29		No hand over greater then 15 minutes
Cancer Wait Times																	
2 week GP referral to 1st outpatient	93%	Monthly	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	96.7%	96.9%	98.3%	96.0%	95.4%	96.2%		
2 week GP referral to 1st outpatient - breast symptoms	93%	Monthly	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%		
31 Day	96%	Monthly	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.3%	98.7%	99.2%	98.0%	98.2%	99.3%		
31 day second or subsequent treatment - surgery	94%	Monthly	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%		
31 day second or subsequent treatment - drug	98%	Monthly	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	95.0%	91.8%	96.8%	98.3%	100.0%	98.4%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	Monthly	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.8%	96.4%	97.8%	95.8%	98.3%	98.6%	94.7%		
62 day referral to treatment from screening	90%	Monthly	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	95.7%	93.3%	84.2%	87.9%	100.0%	94.1%		
62 day referral to treatment from hospital specialist	80% (local target)	Monthly	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	63.6%	73.7%	100.0%	77.8%	50.0%	0.0%		
62 days urgent referral to treatment of all cancers	85%	Monthly	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	77.8%	81.3%	77.6%	76.5%	85.2%	79.0%	82.9%		
SRS08: Length of Stay (Acute & MH)																	
Elective	3.20	Monthly	4.2	4.1	4.2	5	4.4	4	3.8	4.4	4	4.2	3.1	4.7	5.6		Based on DFI Peer Group UO. Fig reported in June 13 relates to rolling 12 months up until April 13
Non-Elective	5.30	Monthly	4.4	4.4	4.3	4.9	4.5	4.2	4.4	4.6	4.3	4.7	4.3	4.3	5.8		Based on DFI Peer Group UO. Fig reported in June 13 relates to rolling 12 months up until April 13
SRS09: Daycase Rate	85%	Monthly	84.9%	85.7%	86.6%	85.0%	84.7%	83.0%	85.7%	85.5%	84.8%	84.6%	85.7%	85.0%	N/Avail		June 20103 SLAM data not available at time of report production
SOU11: PROMS Scores - Pre Operative participation rates																	
Groin Hernia - Participation Rate	Nat.Ave 55.0% (target 80%)	Quarterly		42.3%			48.5%			88.6%			98.0%		81.3%		Information based on 9 months HES data to Apr 12 - Dec 12 (published May 13). Target for 2012-13 is measured against national average for the period and not the national target of 80% for all procedures
Hip Replacement - Participation Rate	Nat.Ave 74.4% (target 80%)	Quarterly		97.4%			92.3%			125.8%			93.0%		94.6%		
Knee Replacement - Participation Rate	Nat.Ave 80.1% (target 80%)	Quarterly		94.9%			97.1%			95.9%			110.5%		107.1%		
Varicose Vein - Participation Rate	Nat.Ave 39.4% (target 80%)	Quarterly		31.1%			32.9%			71.4%			54.1%		66.7%		
All Procedures - Participation Rate	Nat.Ave 67.1% (target 80%)	Quarterly		72.8%			74.5%			99.1%			96.0%		90.5%		

Clinical Outcomes	Target 2013-14	Frequency	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	June 13 RAG Rating	Comments
HSMR - monthly position for 2013-14	<100	Monthly	106.9	99.2	104.6	113.9	98.1	87.5	101.7	94.8	102.5	105.5	110.5	N/Avail	N/Avail		Latest DFI position 2012-13 - 12 months to Apr 13
HSMR - 12 Monthly cumulative position		Monthly	85.0	95.0	96.1	97.9	98.3	98.2	99.0	99.1	N/Avail	100.1	100.8	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
HSMR- cumulative position for 2013-14																	
Pneumonia	<100	Monthly	0	47.4	50.2	50.6	49.7	48.7	52.2	54.8	N/Avail	57.5	60.4	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
Fracture of neck of femur (hip)	<100	Monthly	0	148	133.1	163.1	155.8	168.5	168.4	169.08	N/Avail	148.7	135.89	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
Acute Cerebrovascular disease	<100	Monthly	0	86	96	104.8	110	101.6	107.1	105.6	N/Avail	105	108.2	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	Monthly	0	83.7	90.9	114.4	121.4	131.3	131.9	133.5	N/Avail	133.5	135.88	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
Acute myocardial infarction	<100	Monthly	0	66.5	76.7	76.4	70.1	61.9	71	76.7	N/Avail	77.5	84.6	N/Avail	N/Avail		Latest DFI FY trend May 12 - Apr 13 (HSMR)
SHMI (based upon date of SHMI report publication)		Monthly	109.2	106	106	106	104.77	104.77	104.77	107.81	107.81	107.81	110.9	110.9	110.9		Latest position reported in Jun 13 reflects Oct 11 to Sept 12.
SQU12: Maternity 12 weeks	90%	Monthly	87.0%	98.0%	98.0%	99.0%	98.0%	97.0%	93.2%	95.4%	95.2%	94.1%	92.0%	96.7%	97.3%		Figure subject to change following final data collation
SRS10: Delaved Transfers of Care – Acute & MH	3.0%	Monthly	2.9%	3.6%	2.7%	3.2%	3.1%	4.3%	5.7%	3.9%	3.4%	4.0%	2.5%				Requires SLAM data
Fractured neck of Femur																	
Number of patients admitted with FNOF	-	Monthly	21	26	52	26	26	36	34	39	31	46	19	31	29		
Patients fit for surgery within 48hrs	2012-13 standard	Monthly	13	25	47	22	24	34	27	37	29	45	17	31	29		
No. of patients admitted with FNOF who were operated on within 48 hrs of being fit for surgery	2012-13 standard	Monthly	0	0	0	0	0	0	0	0	0	0	16	29	26		
% of patients admitted with FNOF who were operated on within 48 hrs of being fit for surgery	2012-13 standard	Monthly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	84.2%	93.5%	89.6%		
Patients fit for surgery within 36hrs	-												17	29	26		
Number of patients admitted with FNOF who were operated on within 36 hrs	-						New for 2013-14						14	21	23		
% of patients admitted with FNOF who were operated on within 36 hrs of being fit for surgery	100%												82.4%	72.4%	88.5%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	Monthly	71.0%	84.6%	80.0%	85.0%	93.0%	89.0%	100.0%	91.3%	90.6%	69.6%	91.0%	83.0%	82.0%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	Monthly	75%	67%	70%	54%	46%	47%	47%	39%	67%	48%	43%	38%	38%		
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	Monthly	96%	97%	97%	83%	100%	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	90.9%	71.4%	95.8%	76.0%	68.0%	88.9%	72.7%	68.8%	60.0%	69.2%	72.7%	68.0%	69.6%		
Patients who spend at least 90% of their time on a stroke unit	80%	Monthly	96.7%	98.6%	92.6%	93.3%	91.0%	90.2%	84.2%	81.6%	86.1%	96.4%	80.0%	90.4%	97.4%		
Breast Feeding initiation	75%	Monthly	96.0%	96.0%	96.0%	100.0%	99.3%	99.7%	74.9%	75.2%	77.4%	79.4%	80.6%	81.4%	76.9%		
Caesarean Section Rates - Total	<25%	Monthly	27.1%	25.1%	28.5%	26.9%	26.5%	29.3%	24.1%	26.4%	29.2%	24.9%	29.7%	29.7%	26.4%		
Caesarean Section Rates - Emergency	14.98%	Monthly	11.2%	9.8%	13.3%	13.7%	9.4%	14.9%	11.1%	10.1%	12.7%	9.4%	13.2%	11.3%	11.1%		
Caesarean Section Rates - Elective	10.06%	Monthly	15.9%	15.3%	15.2%	13.8%	17.1%	14.4%	13.1%	16.3%	14.7%	15.5%	16.5%	15.0%	13.9%		
Home Birth Rate	>=6%	Monthly	6.9%	9.4%	5.4%	6.8%	4.4%	4.5%	7.5%	2.1%	5.9%	6.6%	3.8%	5.2%	3.8%		
Number of readmissions within 28 days (Adult)	-	Monthly					New for 2013-14						396	379	362		
Number of readmissions within 28 days (Children)	-	Monthly					New for 2013-14						146	136	138		

CQUIN 2013-14	Target 2013-14	Frequency	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	June 13 RAG Rating	Comments
NATIONAL COUINS																	
1.VTE																	
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month	Monthly	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	95.5%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	CQUIN payment to be						New for 2013-14						Awaiting quarterly report				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	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%	66.7%	34.8%	77.4%	58.3%	75.0%	69.7%		
2b. Were hospital staff available to talk about any worries or concerns that you had?	>63.4	Monthly	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%	65.2%	86.4%	83.3%	23.5%	53.3%	48.7%		
2c.Did you have enough privacy when discussing condition or treatment?	>82.3	Monthly	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%	79.2%	76.2%	73.3%	33.3%	20.0%	38.6%		
2d.If you have been prescribed any new medication, have you been informed of any possible me	>48.5	Monthly	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%	48.4%	60.0%	61.1%	68.4%	71.4%	72.7%		
2e. If you are ready to be discharged – have you been informed who to contact if you are worried	>74.3	Monthly	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%	63.6%	58.3%	57.1%	59.0%	70.3%	65.0%		
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%	2.37%		
3b.initial diagnostic assessment	0% 3 consecutive months						N/A	N/A	N/A	N/A	N/A	Not avail	-	0%	100%		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%	100%		
3d.Lead clinician and appropriate training of staff	Yes						New for 2013-14							On track			RAG rating in accordance with latest COUIN 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 COUIN Status report
LOCAL COUINS																	
1. Develop and implement AECP																	
1a AECP for Chest Pain							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
1b. AECP for Pulmonary Embolism							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
1c. AECP for Supraventricular Tachycardia							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
1d. AECP for Pleural Effusion							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
1e..AECP for Painless Jaundice							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
2. Development of HOT Clinic																	
2a. HOT Clinic for Paediatrics							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
2b. HOT Clinic for Surgery							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
2c. HOT Clinic for Medicine							New for 2013-14						Q1 achieved				RAG rating in accordance with latest COUIN Status report
NHS ENGLAND COUINS																	
1. Friends & Family																	
1a. Phased expansion of Friends and Family Test							New for 2013-14						From Oct 2013				RAG rating in accordance with latest COUIN Status report
1b. increase response rate to at least 20%		Monthly					New for 2013-14						7.09%	9.23%	15.88%		
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	4		RAG rating in accordance with latest COUIN Status report
3. Quality Dashboards							New for 2013-14										
4. Timely Simple Discharge	>60% each quarter or action plan						New for 2013-14						N/A	50.0%	0.0%		OCOUIN's to be agreed, awaiting sign off
5. Improve access to breast milk in preterm infants	20% imp on 12/13 perf (58.5%)						New for 2013-14						55.9%	37.5%	45.5%		OCOUIN's to be agreed, awaiting sign off
6. Acute Kidney Injury	Q1 Process recorded and definition in place						New for 2013-14							Q1 achieved			

Enclosure D

REPORT TO THE TRUST BOARD
DATE: 24 July 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 • Update on existing Patient Experience Work, in relation to the implementation of the patient experience strategy showing current activity • Friends and Family Test (FFT) Responses - 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.	
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 the consequence loss of income
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? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - **NO**

Enclosure E

Actions required by the Board

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

Trust Board
July 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 June 2013.

1.1 The Patient Experience Strategy

The Patient Experience Strategy implementation plan, whilst behind target due to the changes within the Patient Experience lead position, is making steady progress. The plan is currently being revised to reflect new timescales and will then be reported on in the September Board Report.

With the recent identification of Patient Experience champions within 4 clinical areas, the opportunity for there to be a co-ordinated approach to developing, implementing and evaluating patient experience initiatives is enormous.

Work is underway to integrate the Dignity Forum agenda into the Patient experience agenda, with dignity champions driving patient experience work in the clinical areas, being supported by the Patient Experience Champions. To ensure cohesion between the two work streams, the Patient Experience Lead will sit on the Dignity Forum. Quarterly updates which monitor compliance with the Dignity Forum's action plan will be presented to the Patient Experience Board. Appendix 1 outlines the revised Patient Experience Board structure, which will be changed in the Patient Experience Strategy.

1.2 Current Patient Experience Activities

- **15 Step Challenge**
  The '15 Step Challenge' is a national audit framework used to identify how patients may perceive a clinical area; with the aim of enhancing the patient experience as changes are made following results of audits.

  A total of four '15 step challenges' have been undertaken within the medical directorate, with no immediate concerns being identified. However, findings did identify that in some cases there could be improved information provision.

  The Patient Experience Champions are developing a timetable of '15 step challenges' to enable all clinical areas to have undertaken the process by the end of summer. Audit teams will be clinical, with a minimum of 2 in each team. The challenge takes a maximum of 30mins including feedback time and so could be scheduled during a management day.

- **Goldfish bowl events**
  The first Goldfish Bowl event was held with the Surgeons. Following the session, evaluation of the technique was undertaken by a junior doctor, via a series of face to face interviews with 9 of the 12 consultants involved. The results of this was presented to the Patient Experience Board in July, where it was identified the methodology would be tweaked to enhance the learning.

  Next steps include a similar session to be held with the midwives in August.

The technique has been presented at the Ward Sisters meeting and a number of Wards Sisters have come forward to request similar sessions be arranged for their multi professional teams.

- **Volunteer audits and observational studies**
  Audit questions are in development to support the PPI volunteer group to undertake observational studies and patient interviews in relation to 'Noise at Night' and 'Protected Mealtimes', in order to ascertain in more detail what the issues. Previous audit results have not had the impact the trust had hoped for, which is why the methodology has been reviewed. Following the results, Protected Mealtimes will be re-launched to enhance the focus on this really important activity.

- **Further activities**
  The Patient Experience Lead, together with the Workforce development Lead are mapping the requirements of the NICE guidelines to the current Patient experience activity, to identify priority activities for further improvement.

1.3 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.

A meeting has been arranged with IT, Deaf Connect, the RNIB and senior nursing team to identify if texting appointment notifications could be implemented.

1.4 Patient Experience monitoring

1.5 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 rates. The FFT response rate for **In Patients and A&E** received for the month of **June 2013 was 15.88%**.

Details of individual ward response rates can be found in **Appendix 2.** Results below show the scores for June 2013 in those areas now being reported nationally.

Table 1: FFT activity and Scores - CQUIN Target

	Q1		
	Apr-13	May-13	Jun-13
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%
Inpatient areas	18.78%	24.53%	21.13%
A&E areas	0.97%	0.57%	13.16%
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%

1.6 Extension to the current FFT data collection

Work is underway to get the FFT Maternity roll out set up for September 2013 ensuring that there is time to test the process prior to the national implementation data.

The process will centre around the distribution and collation of pre printed cards which will be handed to the mothers for completion at three points during the care.

1.7 Conclusions

The Patient Experience activity continues to grow across the trust with the integration between the Dignity and Patient Experience agenda and the identification of Patient Experience Champions.

2. Assessment of Risk

Whilst the Trust has achieved the FFT CQUIN for June, work is underway to ensure that this continues**.**

3. Recommendations/Resolutions Required

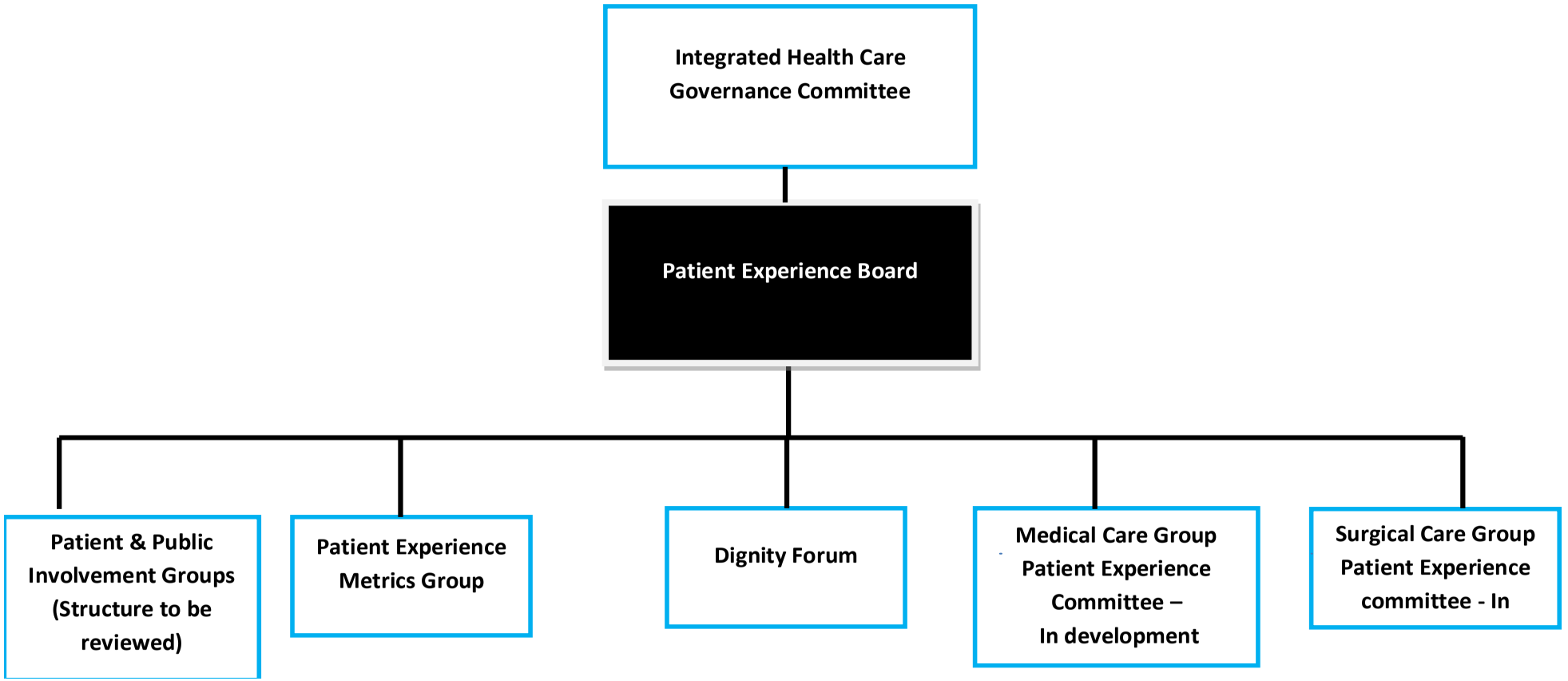
Note the issues identified and where requested provide support.

4. Next Steps

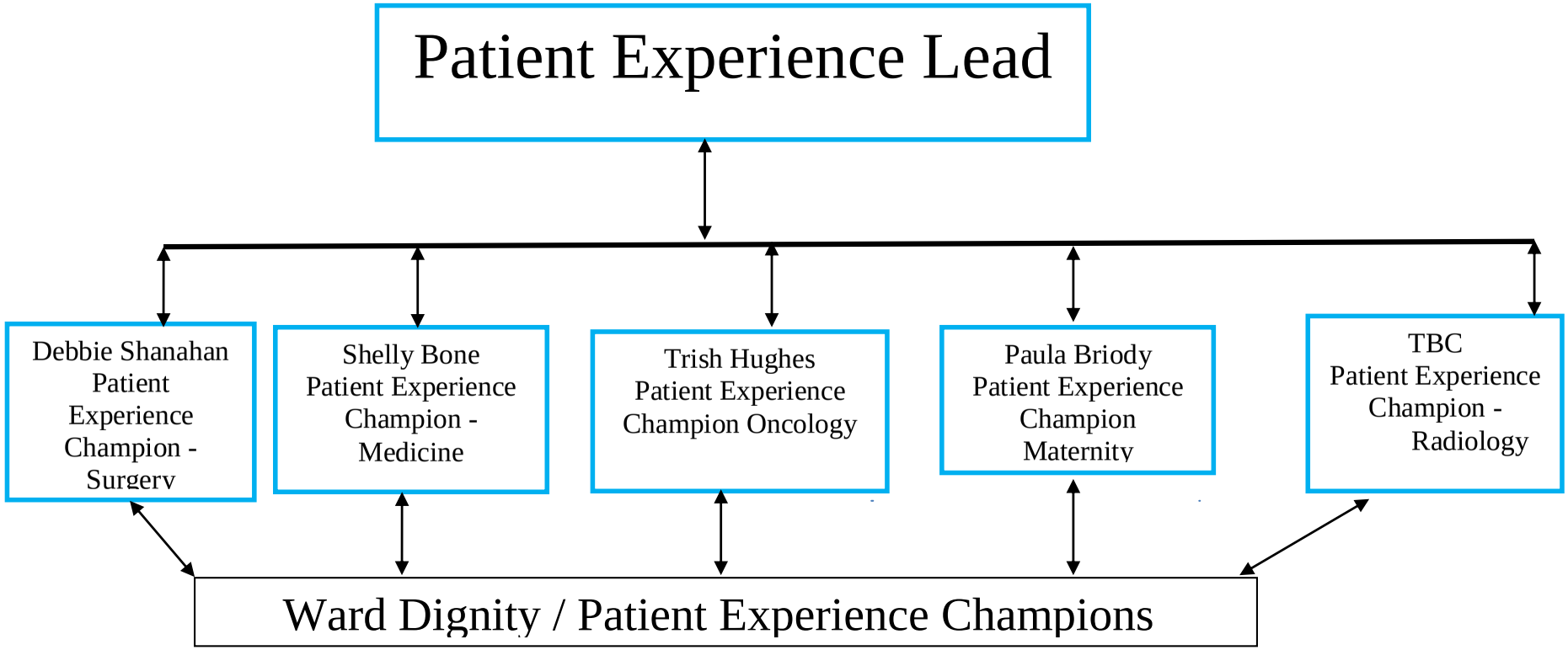
Challenge the content of the report and support the actions defined.

Northampton General Hospital NHS
NHS Trust

Patient Experience Strategy Board Structure



Patient Experience communication flow – Current Picture July 2013



Friends & Family Net Promoter Response Rates

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	Jun-13
Abington		27.06%	43.42%	28.95%	37.50%	43.33%	25.00%	30.61%	27.03%
Allebone		18.97%	16.05%	38.46%	28.57%	22.83%	51.02%	32.98%	23.75%
Althorp		111.76%	36.84%	31.94%	31.76%	43.00%	54.84%	33.33%	32.93%
Becket		19.18%	36.96%	21.88%	31.08%	32.08%	40.43%	43.28%	42.65%
Benham		10.99%	13.11%	8.91%	30.18%	7.91%	12.00%	21.43%	19.41%
Brampton		34.38%	23.81%	44.12%	41.94%	67.86%	37.84%	40.00%	9.38%
Cedar		18.28%	29.47%	36.36%	28.57%	25.71%	19.18%	10.34%	7.55%
Collingtree Medical		18.64%	8.66%	0.0%	20.19%	13.56%	7.06%	37.33%	28.46%
Compton			77.27%	91.30%	111.11%	77.78%	80.00%	156.25%	84.21%
Corby Comm.		0%	71.43%	50.00%	0.00%	30.00%	0.00%	9.52%	39.13%
Creaton		7.41%	16%	32.35%	33.33%	21.05%	7.81%	18.07%	16.67%
Danetre		0%	0%	57.14%	34.62%	39.53%	39.47%	54.29%	24.24%
Dryden		16.36%	29.41%	2.38%	27.03%	24.79%	28.32%	19.67%	2.15%
Eleanor		21.62%	17.91%	16.67%	36.36%	21.74%	38.10%	51.11%	29.31%
EAU		5.86%	8.40%	13.16%	4.66%	3.15%	14.45%	26.77%	22.79%
Finedon		37.25%	38.89%	36.21%	29.17%	21.62%	31.25%	46.51%	22.92%
Hawthorn		75.28%	21.97%	25.47%	36.61%	37.68%	33.85%	30.04%	33.02%
Hazelwood Comm.		93.75%	25.00%	127.78%	0.00%	60.71%	77.78%	60.00%	50.00%
Head & Neck		9.38%	19.20%	33.33%	45.45%	40.46%	17.48%	29.81%	38.32%
Holcot		54.84%	21.21%	68.75%	75.00%	53.57%	83.33%	54.55%	68.75%
Knightley		53.85%	37.50%	26.67%	31.82%	52.17%	25.64%	40.38%	43.64%
Rowan		25.95%	24.85%	34.62%	45.56%	32.84%	16.15%	18.18%	13.48%
Spencer		18.75%	8.04%	21.70%	13.07%	12.79%	10.73%	15.86%	15.30%
Talbot Butler		23.91%	12.31%	30.56%	10.64%	12.00%	8.93%	26.42%	24.75%
Victoria			9.88%	23.91%	4.00%	10.45%	15.07%	17.31%	6.98%
Willow		41.11%	21.33%	29.51%	22.99%	21.30%	11.11%	27.37%	28.95%
Adult Inpatient Area Total		15.01%	14.77%	16.45%	19.00%	15.15%	18.78%	24.53%	21.13%
Accident & Emergency Unit		Recorded from January 2013		0.54%	1.75%	0.48%	1.02%	0.25%	15.22%
Eye Casualty Unit		Recorded from April 2013					0.72%	2.38%	1.04%
Accident & Emergency Total		Recorded from April 2013					0.97%	0.57%	13.16%

Balmoral	51.85%	65.69%	55.87%	46.15%	37.34%	54.59%	60.82%	Closed
Maternity Observation Ward	Recorded from June 2013							0.00%
Robert Watson	23.46%	30.73%	42.02%	37.20%	30.00%	26.32%	32.41%	33.96%
Maternity Ward Total	Previously included within Inpatient Area Total					41.42%	23.08%	28.57%
Disney	19.16%	16.26%	16.55%	29.48%	10.13%	17.46%	32.66%	24.74%
Paddington	9.95%	7.94%	8.67%	13.30%	9.79%	5.88%	10.41%	10.57%
Paediatric Ward Total	Previously included within Inpatient Area Total					9.55%	17.65%	15.14%
Danetre Day Surgery	Recorded from January 2013		66.67%	54.64%	30.88%	50.00%	60.64%	29.25%
Main Theatre Admissions	Recorded from February 2013			50.92%	50.00%	67.47%	52.42%	24.14%
NGH Day Surgery	Recorded from January 2013		38.86%	29.43%	12.43%	29.17%	28.62%	34.49%
Singlehurst Day Unit	Recorded from April 2013					2.44%	5.48%	9.93%
Daycase Area Total	Previously included within Inpatient Area Total					40.30%	32.40%	27.34%

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Monthly Infection Prevention Performance Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Wendy Foster, Specialist Infection Prevention Practitioner
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the month of June 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 3 months of the year has sustained 13 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	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? **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)

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
July 24th 2013
June 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.

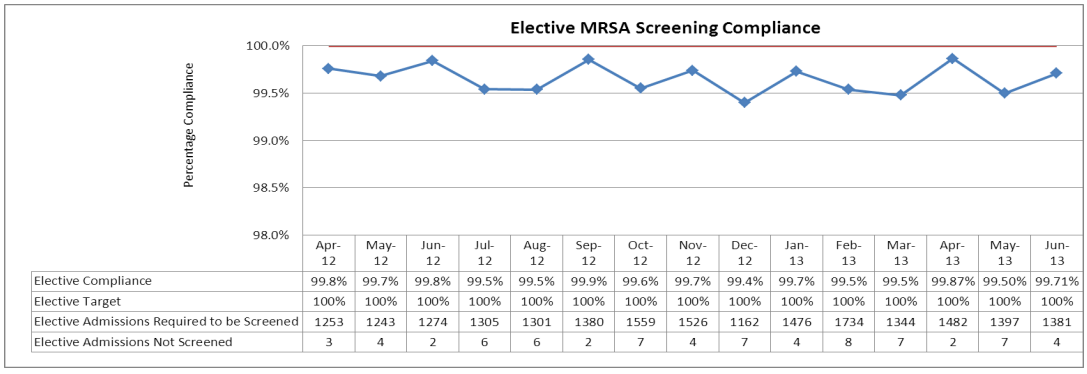
2. Report

2.1 MRSA Bacteraemia (June)

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

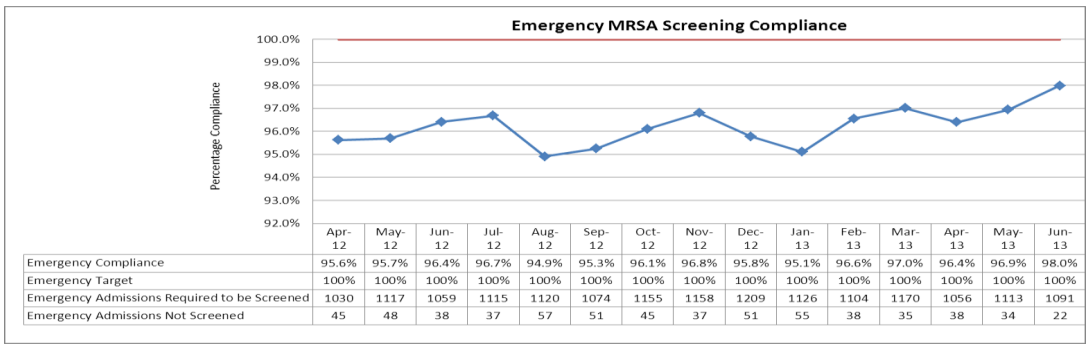
MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
0	0	99.71%	98%	0	1

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	Jun-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%	99.71%
Elective Target	100%	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	1381
Elective Admissions Not Screened	3	4	2	6	6	2	7	4	7	4	8	7	2	7	4

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	Jun-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%	98.0%
Emergency Target	100%	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	1091
Emergency Admissions Not Screened	45	48	38	37	57	51	45	37	51	55	38	35	38	34	22

3. Clostridium difficile

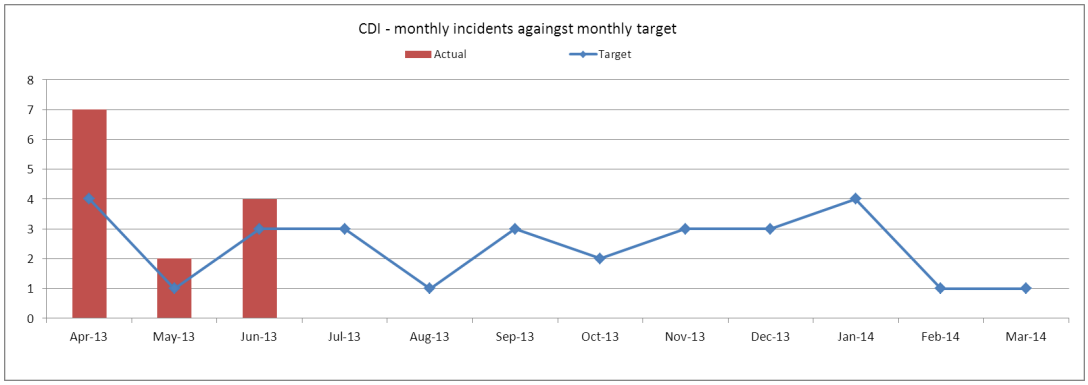
The Trust has an annual target of 29 C. diff. cases or less for the financial year. During June 4 **>3 day cases *of C. diff*** were identified against a monthly target of 3 for June of post 72 hours cases, which totalled 13 for the year. **No ward** needed to be put onto Special Measures during the month.

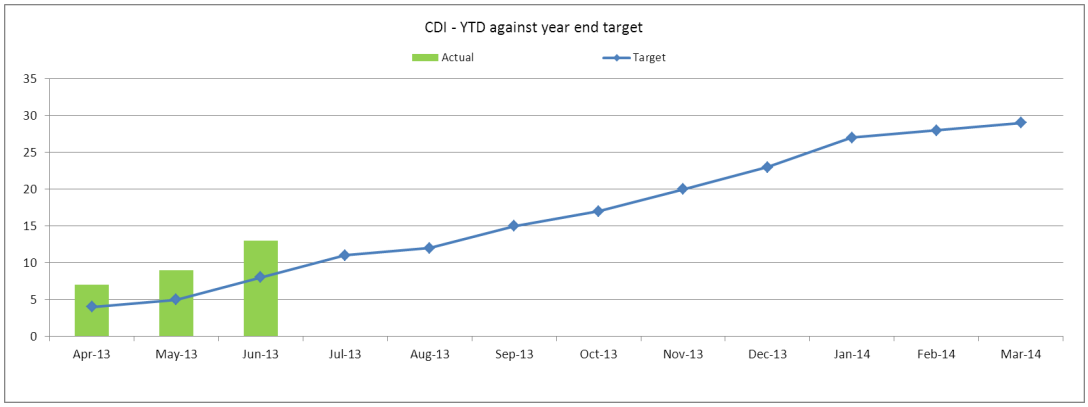
Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
Total	**6**	**7**

Whilst the number of C Diff is exceeding the Trust target, the board should be re-assured that there is no clinical risk to patients from an outbreak point of view – this is purely a sampling issue.

Rybotyping
The Trust does not routinely rybotype all new C.diff isolates. However, we do rybotype isolates from samples where we suspect an epidemiological link, as required and requested by the C.diff rybotype network.

The graphs below show the monthly incidents of *Clostridum difficile* infection against the Trusts monthly target and the incidents of *Clostridium difficile* infection against the year-end target for CDAD for 2013/14.





4. *Escherichia coli* (*E.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 Department of Health (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 June there were 9<48hrs and **7>48 hrs.**

The Infection Prevention Team with the Consultant Microbiologist investigate all >48 hours cases, to identify if there are any issues which need to be dealt with – there were none in June.

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).

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 June 2013:

- Repair of fractured neck of femurs (#NOF) show that there were ***no infections*** resulting from 29 from operations in June

- Total Abdominal Hysterectomies show that there were ***no infections*** resulting from 14 operations in June

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

- Overall Trust compliance for hand hygiene = 82.2% due to 14 areas failing to submit the completed audit.

The areas who have failed to submit their audits were: Chemotherapy Suite, Haematology Outpatients, Camelot Way, LINACS, Head and Neck, ENT Outpatients, Eye Outpatients and Eye Casualty, Maxillo-Facial, Singlehurst ward, Radiotherapy, Willow, Post anaesthetic recovery and Althorp. Matrons have been asked to give their rationale for not inputting the audit data. This will be discussed at the July Infection Prevention and Control Committee

Hand hygiene compliance in the ward areas is considerably higher than the overall Trust score, at 98.8%.

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 collaboratively across the Trust to keep levels of infection to a minimum, whilst focusing on ensuring that appropriate C. diff sampling is undertaken.

Enclosure G

REPORT TO THE TRUST BOARD
DATE 24 July 2013

Title	Francis Report Action Plan
Agenda item	9
Sponsoring Director	Suzie Loader, Director of Nursing ,Midwifery & Patient Services
Author(s)	Caroline Corkerry, Deputy Director of Quality & Governance
Purpose	To provide the Trust Board with an update regarding progress against the Francis Report action plan.
Executive summary There has been progress against all actions within the Francis report action plan. All actions are planned to be completed within timescales stated.	
Related strategic aim and corporate objective	Strategic Aim 1 – Be a provider of quality care for all out patients Strategic Aim 3-Provide appropriate care for our patients in the most effective way Strategic Aim 4- Foster a culture where staff can give their best and thrive
Risk and assurance	No risks identified
Related Board Assurance Framework entries	BAF 4 & 6
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	None identified
Actions required by the Board The Board is requested to note the progress against the Trusts Francis Report action plan	

Francis Report Action Plan

Action Plan Lead: Suzie Loader (Director of Nursing, Midwifery & Patient Services) and Dr Sonia Swart (Medical Director)

Sign Off: Chief Executive Officer

Monitoring Committee: Integrated Healthcare Governance Committee **Date:** July 2013

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
Nursing and Clinical Care	1,4,7	Review Nursing & Midwifery Strategy to include the 6Cs.	Suzie Loader	NMB	September 2013	Review of N&M strategy and gap analysis 6C's & Francis Report outcome to inform new strategy Deadline will be met
	1,4,7 12, 14	Inclusion of dignity, values and beliefs assessment at registered nurse interviews To expand this to non-registered workforce and midwifery.	Suzie Loader	NMB	September 2013	Has already been included in generic Band 2 & Band 5 recruitment process. Also included in Ward Sister, Matron and senior post recruitment processes. Consultation on - going to include in specialist area recruitment
	1,4,5 7	Develop an approach to CPD and Portfolio management for all professional groups that submit a portfolio: • Develop Trust Portfolio template for staff to use • Gap analysis of staff maintaining an up to date contemporary portfolio • Random reviews of portfolios (in line with NMC) All nursing & midwifery staff to submit their portfolio as part of their appraisal.	Janine Brennan / Suzie Loader	HGC	April 2014	Portfolio request included in the Appraisal Documentation Review Portfolio template to be developed Gap analysis TBC Random reviews TBC

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
	1,4,6 9,21	Development of a specific in-house training course for care of the older person with the potential for accreditation with the University to address a gap in knowledge in our nursing workforce with specific older persons training.	Suzie Loader Sonia Swart	NMB	April 2014	Initial contact made with University of Northampton regarding partnership working Process for development defined
		Review discharge information • Ward level information • How we ensure medicines are with the patient when they are discharged How the Trust codes and monitors out of hours discharges.	Natalie Green	Urgent Care Board	September 2013 December 2013	To include a shared learning segment on the quarterly reports and possibly meet on monthly basis to the plans and identify the points to share prior to the CG meeting. Further areas Identified: There must be clear information given to patients on who to contact post-discharge both in and out of hours. Calls from patients must be logged and advice given noted. Development of telephone triage systems suggested to ensure that patients are being given the most appropriate advice. Induction programmes for all senior staff to be reviewed to ensure that all are aware of relevant policies,

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
						procedures, colleagues and sources of information.
	5	Review dietician involvement in nutrition work	Sue Thornton	CQEG	September 2013	Weekly meetings set up to progress nutrition work, Dietician to attend. Dietician attends PU strategy meetings. Dietician involvement in nutrition link nurse meetings, nutrition committee meetings and nutrition and catering meetings. Dieticians present at 6 monthly nutrition study days.
Accountability	12	Develop a Trust behavioural framework and implement it successfully across the Trust as part of the new appraisal process	Suzie Loader/ Janine Brennan	HGC	December 2013	Working group in place and work is in progress.
	12	Revise the Trust appraisal system to incorporate the behavioural framework and draw a clear line of sight between corporate objectives, set within the Trust's performance management system and individual objectives and expected behaviours.	Janine Brennan	HGC	August 2013	Working group in place and work is in progress.
	12	Develop core performance objectives for Matrons/Ward sisters as part of the annual appraisal process.	Suzie Loader	Operational Board Meeting	June 2013	Objectives agreed with Care Groups. Implementation plan to be agreed.
	12	Further work on dashboards is needed to support accountability frameworks	Care Group Directors	Care Group Boards Task and finish group	Sept 2013	Quality & CQUINS added to Care Group Scorecards

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
Culture Including: • Values and standards • Openness, transparency and candour	4	Review and refresh the Trust values, based on the behavioural framework, adopting a bottom up approach to ensure staff engagement.	Janine Brennan	Trust Board	March 2014	Focus groups completed. Work is in progress to identify values.
	4	Conduct an organisational development diagnostic to identify aspects of organisational culture that need addressing and develop OD interventions to reflect the changes required.	Janine Brennan	HGC	March 2014	Steering group established. Diagnostics in progress. Outline strategic concept to be discussed at Board in August
	16	Revitalise and raise awareness of the NHS constitution: • Review Standard Terms and Conditions of Service for Agenda for Change contracts to include reference to the NHS Constitution. • Review the Job Description Template to include reference to the NHS Constitution. • Addition of NHS Constitution to the Induction programme. • Consider inclusion of NHS Constitution reference in policy template	Janine Brennan	HGC	May 2013	• Review of entire contract in progress. Reference to NHS Constitution has been included. • Completed and published on the intranet April 2013. • Included as from April 2013 Induction. Agreement to include at May 2013 Procedural Documents Group. Suggested wording provided to Governance for inclusion into Trust Policy Template.
	4,16	**Incident management** • Improve the mechanisms to feedback to individuals using the appropriate local channels. • Improve the review of themes and trends locally • Improve monitoring compliance with action plans, notably for SIs.	Deputy Director of Quality & Governance with Care Group Management	CQEG	September 2013	Action plans & themes/trends being discussed at Care Group governance Meetings.

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
	1,4, 10, 11	**Being Open and Duty of Candour** Review Trust arrangements	Deputy Director of Quality & Governance	CQEG Trust Board	September 2013	Being open process embedded in organisation all patients / carers who have been involved in SI's are offered a Being Open meeting. Duty of Candour compliance is being logged on Datix system. Consideration being given as to how this can be further embedded across Trust. Both the Duty of Candour and the Being Open are included within the updated Trust Risk Management Strategy
Francis – recommendation 113 The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	17	***Policy*** *Trusts should have their complaints policy accessible on their web site. It must be:* *-Up to date* *-Clearly state the responsibilities* *-Detail the complaints handling process* *-List its reporting mechanism's to the board* The Trust 4C's policy is currently under review awaiting new regulation changes which are to be released later this year. Interim update underway and the policy will be added to the documents available on the NGH web site.	Lisa Cooper / Eileen Ingram	CQEG	June 2013	Complete 05.07.13 via Lisa Cooper. Website verified and details are incorporated into the patients/visitors 4 C's section for ease of access.
	16, 17	***Learning*** *25% of Trust's had a culture of learning from complaints which was insufficiently developed*	Lisa Cooper / Care Group Governance leads (new	CQEG Trust Board	September 2013	The aggregated analysis report is in the process of being reviewed. This

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
A review of the report has been completed by the Complaints Manager and the outcome is detailed here.		Develop the process of learning from complaints (in conjunction with incidents and claims)	post)			incorporates complaints, PALS, incidents, claims and will in future include patient experience.
	16, 17	***Reporting*** *Trust's must produce regular complaints reports and provide access to these on their website* Review which 1/4ly reports may be most suitable or adaptable for use in the public domain.	Lisa Cooper / Eileen Ingram	CQEG	December 2013	Annual reports are uploaded on to the website once reviewed/approved by the Trust Board. 2012-2013 report awaiting board approval. 1/4ly reports to be discussed with Deputy Director of Quality &Governance

Existing initiatives or action plans and their monitoring committees are listed below:

Actions	Responsible committee	Reporting Frequency
Nursing and Midwifery Staffing Strategy Implementation Nursing & Midwifery Skill mix reviews	Nursing and Midwifery Board (NMB)	Monthly Ongoing
Monitoring reports (Patient Safety Book)	HGC	Quarterly report, monthly review
Human Resources performance management (including mandatory training, appraisal etc.)	HGC	Monthly
Patient Safety Academy	Patient Safety Board	Monthly
Patient Experience (including inpatient survey, Friends and Family Test, etc.	Patient Experience Board	Monthly
CQC action plans, CGRS	HGC	Quarterly
CQUIN Management (including Pressure Ulcer, VTE, dementia, etc.)	Care Group Boards Finance & Performance	Monthly Monthly
Board to ward	Trust Board	Monthly
Quarterly directorate reports (including risk, mortality and morbidity, being open, complaints)	Care Group Boards CQEG	Quarterly
Improving compliance with policies, such as record keeping,	CQEG	Monthly

Actions	Responsible committee	Reporting Frequency
completion of patient assessments and escalation of care, etc. Through clinical audit process, directorate reports, also through NHSLA project stream		
Dashboards	A range of groups	

NB/ This list is not exhaustive.

Northampton General Hospital NHS
NHS Trust

REPORT TO TRUST BOARD
DATE: 24 July 2013

Title	Trust Annual Self-Assessment of Compliance against the CQC Essential Standards of Quality and Safety (CQC-ESQS)
Agenda item	10
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Author(s)	Sue Cross – NHSLA Manager Caroline Corkerry - Deputy Director of Quality & Governance
Purpose	To provide assurance to the Board that processes are in place to monitor compliance with the Care Quality Commission (CQC) throughout the Trust on an annual basis

Executive summary

To provide an update on the Trust's current self-assessed position in relation to compliance with CQC Essential Standards of Quality and Safety and to inform the Trust Board of the sources of evidence that have relied upon to support the compliance self-assessment.

In July 2012, a CQC inspection identified two standards as being non-compliant (moderate concerns):

- Outcome 9 Medicines Management
- Outcome 13 Staffing.

Actions have been taken to address the concerns and updates have been provided to the CQC.

There is one "red rating" against Outcome 12, which reflects the requirement for external contractors to provide evidence of Criminal Records Bureau status.

Report Summary: The Trust is currently declaring compliance with CQC standards.

Evidence sources used for self-assessment of compliance with the CQC Outcomes include:

- Departmental self-assessments
- Nurse Sensitive Indicators Dashboard
- NHS Friends and Family Test
- NHSLA (evidence of compliance)
- CQC's Quality Risk Profile
- Decontamination, Medical Devices and Medical Records Groups

The Trust Board should take assurance from this paper that the organisation continues to meet the CQC requirements and is addressing any areas of concern identified on an on-going basis to ensure continuous improvement.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients. Clinical excellence through best practice. Quality working environment through training and support.
Risk and assurance	Provides assurance on risk through maintenance of a programme of review and policy development in line with changes in practice or regulation.

Enclosure H

Related Board Assurance Framework entries	Providing Quality Care BAF 1 and BAF 4
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	Are there any legal/regulatory implications of the paper – No

Actions required by the Board

- Discuss and challenge the contents of the report as appropriate
- Take assurance from this paper that the organisation continues to meet the CQC requirements.

Northampton General Hospital NHS
NHS Trust

Trust Board
July 2013
CQC Report

1. Background

In line with the Health and Social Care Act 2008 (the act) the Trust registered with the CQC in April 2010 with no conditions on its registration. The Trust is registered to deliver the following regulated activity defined by the act:

- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Of the 28 regulations within the act, 16 relate to the quality and safety of care and is the focus of the CQC registration standards Essential Standards of Quality and Safety (ESQS).

- **Involvement & Information**
  Outcome 1- Respecting and involving people who use services
  Outcome 2- Consent to care and treatment

- **Personalised care, treatment and support**
  Outcome 4- Care & welfare of people who use services
  Outcome 5- Meeting nutritional needs
  Outcome 6- Cooperating with other providers

- **Safeguarding & safety**
  Outcome 7-Safeguarding vulnerable people who use services
  Outcome 8- Cleanliness and Infection Control
  Outcome 9- Management of medicines
  Outcome 10- Safety & suitability of premises
  Outcome 11- Safety, availability and suitability of equipment

- **Suitability of staffing**
  Outcome 12-Requirements relating to workers
  Outcome 13-Staffing
  Outcome 14-Supporting staff

- **Quality & management**
  Outcome 16- Assessing & monitoring the quality of service provision
  Outcome 17- Complaints
  Outcome 21- Records

2. Registration

An update has been provided to the CQC to inform them of the change in Chief Executive to Dr Sonia Swart, who will be the nominated individual for the Trust.

Enclosure H

To maintain registration the Trust is required to establish systems to monitor and review compliance with the ESQS.

3. Compliance

CQC compliance is monitored at corporate level via Health Assure.

- Appendix 1 provides an overview of Self-assessments using Provider Compliance Assessment (PCA) scores for year period 2012/2013.

Trust compliance score key:

	Evidence available at the time of assessment shows that the outcome is met.
	Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate that the outcome is met. The impact on people who use services, visitors or staff is low. The action required is minimal.
	Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate the outcome is met. The impact on people who use services, visitors or staff is medium. The action required is moderate.
	Evidence available at the time shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met. The impact on people who use services, visitors or staff is high. Action is required quickly

NGH recognise that providing a safe and effective service is of paramount importance. The Executive and Non-Executive Directors have undertaken a series of 'Confirm and Challenge' meetings to monitor on-going compliance.

3.1 Confirm and Challenge Meetings

Two rounds of confirm and challenge meetings took place in 2012/13 (reviewing Q3 & 4 2011/12 and Q1 & 2 2012/13) for each of the 16 Essential Standards for Quality and Safety. The purpose of the meetings was to gain assurance of compliance with each standard and to ensure that there are detailed action plans in place to resolve any areas that require improvement.

The confirm & challenge team consist of an Executive Director, Non-Executive Director, a governance team representative and corporate lead/s for each outcome (later referred to as the team).

The following reports were reviewed:

• A report for each outcome provided by the lead/s giving an overview of the outcome and the list of evidence available.
• A directorate clinical governance framework report which was cross-referenced to the Essential Standards.
• A status report which indicates when the last update was provided on Health Assure by the lead/s.

To inform the 'Confirm and Challenge' process the team also used:
• CQC Judgment Framework
• Quality and Risk Profile (QRP)

All actions are then updated onto Health Assure and the leads are asked to update their evidence accordingly.

4. Quality and Risk Profile

The current self-assessed compliance levels identified above are compared with the Quality Risk Profiles (QRP) published by the CQC - these are reviewed by IHGC when each new QRP is published, with any major concerns being escalated to Trust Board.

5. Directorate Compliance

Directorates routinely monitor clinical governance performance against CQC Essential Standards. All directorates discuss their performance levels and progress with identified actions at their monthly Clinical Governance Meetings.

Quarterly reports are presented to CQEG detailing the compliance levels of the individual directorates, any actions required to improve levels and the progress of implementation of actions. The associated compliance bundles were reviewed in 2011/12 and this will be repeated throughout 2013/14.

Moving forward the report will reflect compliance at both directorate and care group governance structure level.

6. Internal Audit Report (12/N/04)

In January CEAC (Internal Audit) carried out an assessment of the control environment and procedures, including guidelines, policies and procedures adopted by the Trust to ensure the effective and efficient management of compliance with the CQC essential standards of quality and safety.

Based on the results of their work, their overall opinion is that the systems controls provide management with 'good assurance'. Two 'low' level recommendations were made, ensuring that the Health Assure system is updated by colleagues in a timely manner and to consider the use of dashboards for reporting purpose. Both of these recommendations are being taken forward.

7. CQC Visits and Requests

CQC Inspection Visit July 2012

The Trust had CQC Inspection Visits covering outcomes 2, 4, 7, 9 and 13. The final report for this inspection was received on 4th September 2012. The report commended:

- Accident and emergency upgrades and improvement to ambulance handover times
- Staffing working hard to provide good standards of care within difficult working environments (pressure / capacity)
- Safeguarding of adults and children

Two outcomes were identified as being non-compliant and of *Moderate Concern* (A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly)

The require actions were:

- ***Outcome 9 – Management of Medicines***

  The service did not fully protect people against the risks associated with the unsafe use and management of medicines as appropriate arrangements for the storage and recording of medicines were not followed consistently (extract from CQC report).
  The specific issues related to:
    - Storage of medications (e.g. personal medicines not always being locked away and unlocked drug cupboards, incorrect medications in the fridge)
    - Refrigeration of medicines and checking of fridge temperatures
    - Administration of drugs - omitted doses (failure to record omitted doses)

Enclosure H

- Administration of drugs - variable doses (not recording what was actually given when the dose is variable)

- ***Outcome 13 – Staffing***

  The provider did not always protect people against the risks associated with not having sufficient numbers of suitably qualified, skilled and experienced staff to meet the individual needs of patients (extract from CQC report).
  The specific issues related to:
  - Evidence that there were not always enough staff to meet patient's needs (e.g. inability to do observations on time, long waits in ED to see a specialty doctor, inability to release staff to attend mandatory training)

The Trust did question the 'moderate' non-compliance relating to outcome 13 with the CQC, requesting information as to the criteria on which this decision had been made. The CQC Judgement Framework states that when considering non-compliance, the 'CQC should judge whether or not the provider has done all that is reasonably practicable in relation to one or more of the regulations'.

As a Trust, we believe that we have taken all necessary steps to mitigate the nurse staffing concerns. However, the CQC responded by saying that this concern was identified because the date for achieving full nursing establishment had moved from June to November 2012. In addition, they had concerns regarding medical staffing and requested a statement from the Trust which demonstrated how we were managing this risk.

All concerns were addressed via action plans, many of these actions have been implemented and some are on-going with updates provided to CQC on a regular basis.

The action plan has been regularly updated and monitored through Integrated Healthcare Governance Committee to ensure that continuous improvement is maintained.

CQC Requests and Concerns
Actions related to several individual concerns raised by the CQC to the Trust are reported to the Integrated Healthcare Governance committee and concerns raised to Trust Board.:

There have been 10 enquiries and one further official review.

	CQC Ref	**Outcome**	**Latest status against action plan**
1.	ENQ1-31012013	Outcome 1,7a,17,9	
2.	ENQ1-22022013	Outcome 4,1,16,13,1,7a,	
3.	Ofsted Inspection of safeguarding children Feb 2013	Outcome 7b – this area is being co-ordinated by the safeguarding children's lead	
4.	ENQ1-608685704	Outcome 4	
5.	ENQ1-1032013	Outcome 13	
6.	ENQ1-791376525A - 18/06/12	Outcome 6,16,	
7.	ENQ1-791376525B 18/06/12	Outcome 6,16,	
8.	ENQ1-791376525C 18/06/12	Outcome 6,16,	
9.	ENQ1-790871602 18/06/12	Outcome 4,6,16,	

10.	ENQ1-782270816 18/06/12	Outcome 7a	

The main themes have been Outcome 1) respecting and involving people who use services; Outcome 6) Cooperating with other providers; Outcome 7) Safeguarding vulnerable people who use services; Outcome 13) Staffing; Outcome 16) Assessing & monitoring the quality of service provision; Outcome 17) Complaints.

Recommendations
In light of the internal restructuring, it is recommended that a review of corporate leads is undertaken to ensure that those identified as a corporate lead, remain appropriate. Where possible to ensure robust Governance we recommend Executives do not review an area for which they are responsible.

IHGC will monitor the recommendations by Internal Audit to improve assurance. A quarterly report will be submitted to the executive leads to provide assurance on progress of action plans but CQEG will monitor progress and IHGC will be responsible for gaining assurance of completion.

8. CQC
The Trust has been able to provide evidence of actions taken to date and supporting action plans providing assurance. The CQC have not undertaken any further actions.

A regular meeting has been established between the Director of Nursing; the Deputy Director of Quality & Governance and the local Compliance Inspector to ensure good communication and regular progress updates.

9. Future Developments
The next round of confirm and challenge, to review the Q3 & Q4 2012/13 evidence is underway. The timeliness of status updates from corporate leads has been highlighted. as a concern.

A re-launch of the assurance process to include updating confirm and challenge methodology is planned which, will ensure the process is on schedule.

It is vital that leads update their information onto Health Assure quarterly. Ensuring the evidence provided is up to date, reflected in the narrative held within Health Assure and triangulated with other available information. It is recognised the evidence is often available but there is a gap in the information contained on Health Assure to reflect this.

Comprehensive review of the evidence provided to support the standard declaration will take place by end of Dec 2013. The “mock” CGRS inspections are being re-launched to gain further real time assurance of compliance. Triangulation intelligence from KPI, audits, patient and staff feedback/survey and quality review will inform the system as well as the current QRP.

10. Conclusion
The Trust has assurance in relation to the capture of information for corporate compliance and the essential standards.

11. Recommendations
The Board is asked to:
- Discuss and where appropriate challenge the content of this report.
- Take assurance from this paper that the organisation continues to meet the CQC requirements.

Appendix 1

The table below illustrates the corporate position against the CQC standards as at June 2013.

Northampton General Hospital Trust
CQC Outcome compliance as at June 2013

Outcome	Outcome Name	Overall outcome compliance	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	Respecting and involving people who use services													n/a	n/a													
2	Consent to Care and Treatment							n/a																				
4	Care and welfare of people who use services															n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a		n/a		
5	Meeting nutritional needs							n/a	n/a	n/a																		
6	Cooperating with other providers											n/a	n/a	n/a		n/a												
7	Safeguarding people who use services from abuse - adult														n/a	n/a	n/a		n/a									
7	Safeguarding people who use services from abuse - children														n/a	n/a	n/a		n/a									
8	Cleanliness and infection control (Health act)- (see Hygine																											
9	Management of medicines						n/a				n/a																	
10	Safety and suitability of premises										n/a	n/a	n/a	n/a	n/a													
11	Safety, availability and suitability of equipment								n/a																			
12	Requirements relating to workers					n/a																						
13	Staffing																											
14	Supporting workers						n/a				n/a																	
16	Assessing and monitoring the quality of service provision																											
17	Complaints																											
21	Records				n/a	n/a																						

The red rating against Outcome 12 reflects issues concerning requirement for external contractors to provide evidence of CRB status. The HR department is currently negotiating this with the relevant contractors.

REPORT TO TRUST BOARD
Date: 24 July 2013

Title	Quality Account update
Agenda item	11
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Author(s)	Sue Cross and Caroline Corkerry Deputy Director of Quality & Governance
Purpose	To provide assurance to the Board that the Quality Accounts 2012/13 process has been completed and progress will be monitored with regards to the Quality Priorities identified for 2013/14

Executive summary

- The Quality Accounts were presented to Trust Board in May 2013 and were approved subject to comments from the Commissioners, Overview and Scrutiny Committee and Health watch.
- Feedback from the Commissioners, Overview and Scrutiny Committee and Health watch have now been included (from page 82).
- Feedback from the May Board, and the Governors resulted in minor changes to ensure accuracy and improve the presentation of the report
- One amendment was discussed and agreed at the Board Development day in June, regarding the changes to Healthier Northamptonshire following the meeting with the Trust Development Agency
- The Quality Account was submitted to external audit for approval and their report included (appendix 1).
- Final Quality Account document has been uploaded onto the NHS Choices website and the NGH website.
- A copy of the 2012/13 Quality Accounts has been sent to the Secretary of State

Next steps

- The quality priorities identified within the document will be monitored through the patients safety book on a quarterly basis for the year 2013.14

Enclosure I

Related strategic aim and corporate objective	Be a provider of quality care for all our patients. Clinical excellence through best practice. Quality working environment through training and support.
Risk and assurance	Provides assurance on risk through maintenance of a programme of review and policy development in line with changes in practice or regulation.
Related Board Assurance Framework entries	Providing Quality Care BAF 1 and BAF 4
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	Are there any legal/regulatory implications of the paper – No
Actions required by the Board Board Members are asked to note of the completion of the Quality Accounts 2012/13.	

Quality account 2012-13 final.pdf

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Operational Performance Report
Agenda item	12
Sponsoring Director	Clive Walsh, Interim Chief Operating Officer
Author(s)	Clive Walsh, Interim Chief Operating Officer Karen Spellman, Deputy Director of Strategy and Partnerships
Purpose	The paper is represented for discussion and assurance

Executive summary

The Trust achieved all the RTT, diagnostic, stoke and cancelled operations standards during June 2013. With the exception of 1 patient that waited over 52 weeks to start their treatment.

The Trust has not achieved the cancer standard; 62 days from GP referral to start of treatment, the performance for June 2013 is 82.9% against a standard of 85%.

The Trust did not achieve the 4 hour transit time for patients referred to A&E during June; the Trust achieved 93.42% 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 CCG contract monitors all those over 30 minutes and over 60 minutes. The total number of patients brought by ambulance during June 2013 that waited over 15 minutes for handover is 193 and 29 waited over 60 minutes.

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	Link to the Board Assurance Framework
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

IHCG are asked to discuss the content of the report and agree any further action as necessary.

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Q1
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.70%	N/A
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.80%	N/A
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.46%	95.60%	N/A
RTT waiting times - ongoing >26 weeks			63	46	92	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	1	N/A
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	N/A
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0
A&E: Total time in A&E (monthly)	CCG & TDA	95%	87.89%	96.28%	93.42%	N/A
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	92.55%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.88%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	100.00%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	99.30%	98.48%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	98.15%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	99.30%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	94.70%	97.60%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	94.10%	93.83%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	82.90%	82.17%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%	69.57%	N/A
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	90.38%	97.37%	N/A
Trolley Waits waiting > 12hours	CCG	0	0	0	0	N/A
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	N/A
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	N/A
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	N/A

Summary:

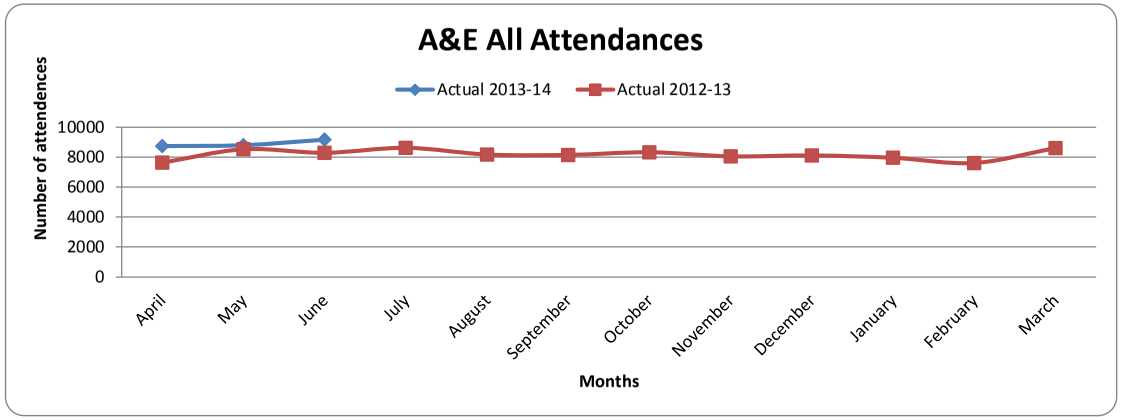
The Trust achieved all the RTT , diagnostic, stoke and cancelled operations standards during June 2013. With the exception of 1 patient that waited over 52 weeks to start their treatment.

The Trust has not achieved the cancer standard; 62 days from GP referral to start of treatment, the performance for June 2013 is 82.9% against a standard of 85%.

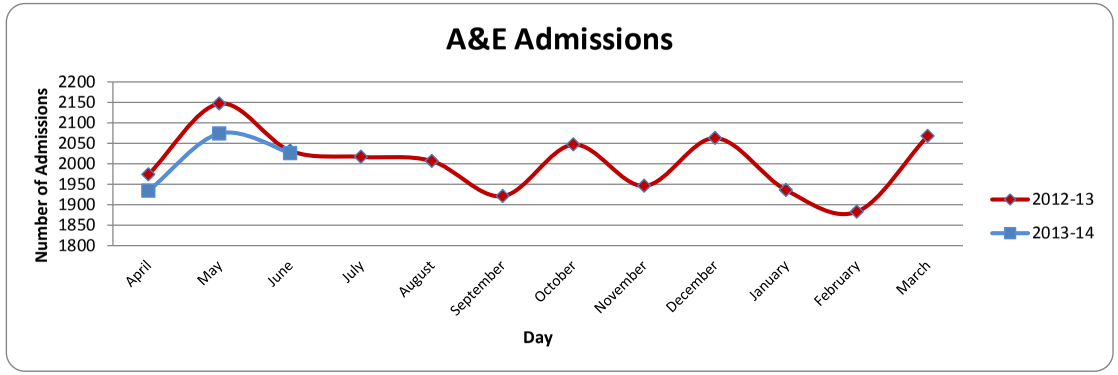
The Trust did not achieve the 4 hour transit time for patients referred to A&E during June, the Trust achieved 93.42% against the standard of 95%. Year to date performance is 92.62% as at 13th June against a recovery trajectory of 93%.

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 CCG contract monitors all those over 30 minutes and over 60 minutes. The total number of patients brought by ambulance during June 2013 that waited over 15 minutess for handover is 193 and 29 waited over 60 minutes.

A&E Quality Indicators



A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%		
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%		



* Note: Total Admissions from the Symphony system

Summary

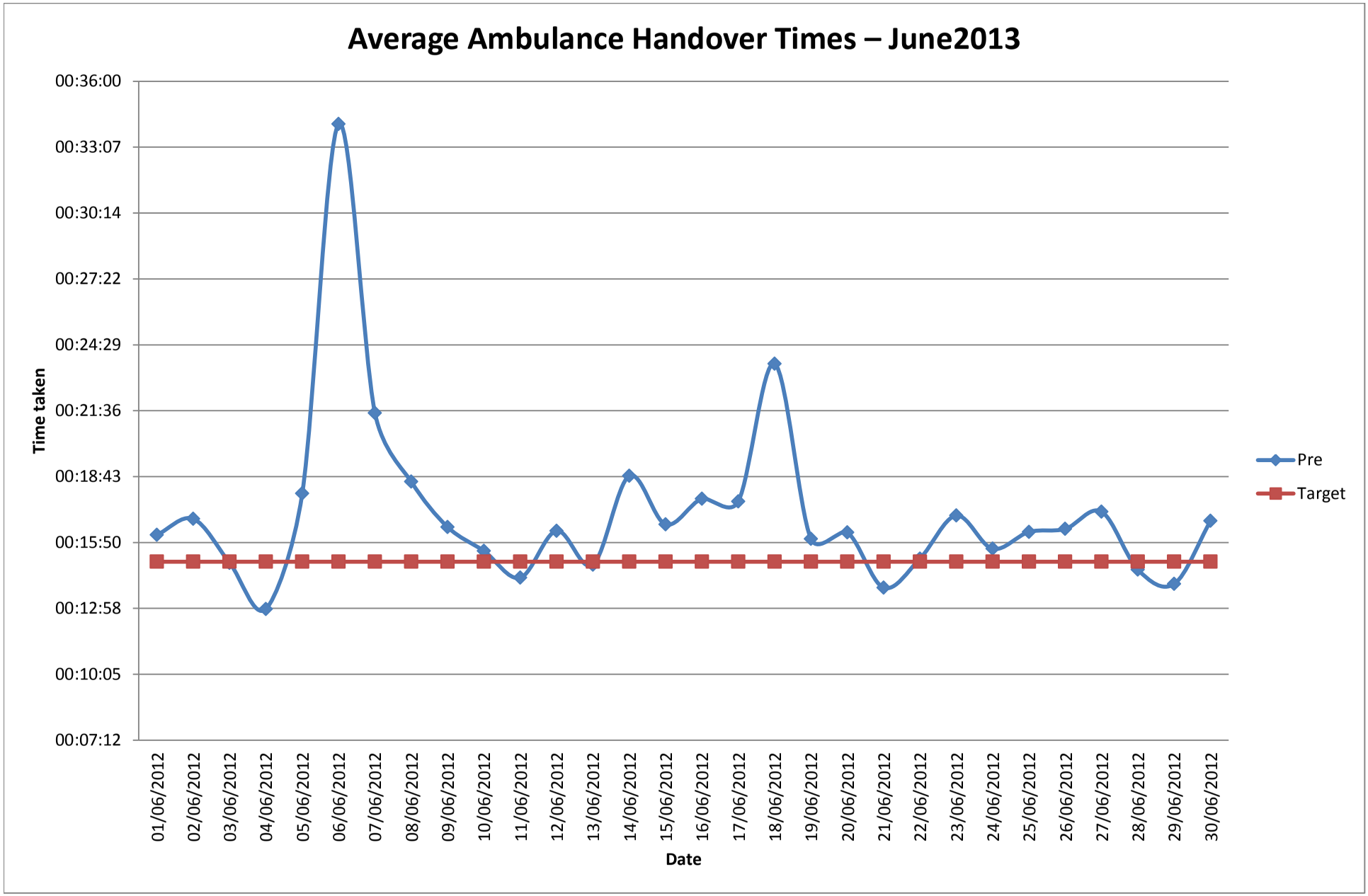
The performance of the Hospital against the 95%, 4 hour A&E transit time standard showed a deterioration from May to June, and in June was below the trajectory value (94.5%) set in the plan submitted to the TDA.

There appears to be one overwhelming factor driving performance and this is the flow of admitted patients to the assessment units and other inpatient beds. This is why the main focus of the Trust's (and health economy's) improvement plan is about flow.

The Trust's Urgent Care Board met on 10th July and the highlight report is enclosed (appendix 1). Satisfactory progress is being made in most areas.

On 3rd July the Emergency Care Intensive Support Team visited the Trust to review progress against its previous recommendations. The written report has not been required, but is expected to be complimentary.

Demand continues to be significantly above last year's level and there is a marked disparity, between this actual situation and the latest iteration of the CCG QiPP (received 5th July). This indicates a plan for reduced volumes in 13/14.


Average Ambulance Handover Times – June2013
Time taken
00:36:00
00:33:07
00:30:14
00:27:22
00:24:29
00:21:36
00:18:43
00:15:50
00:12:58
00:10:05
00:07:12
01/06/2012
02/06/2012
03/06/2012
04/06/2012
05/06/2012
06/06/2012
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24/06/2012
25/06/2012
26/06/2012
27/06/2012
28/06/2012
29/06/2012
30/06/2012
Date
Pre
Target

Enclosure J

Cancer

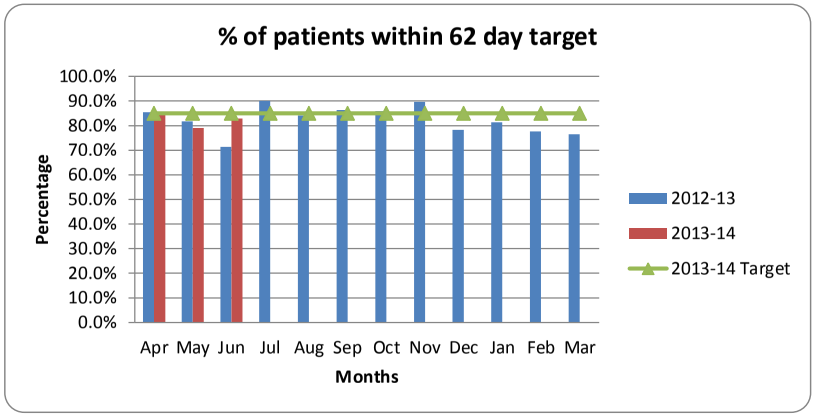
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Q1
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.88%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	100.00%
Cancer: 31 Day	96%	98.00%	98.20%	99.30%	98.48%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	98.15%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	99.30%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	94.70%	97.60%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	94.10%	93.83%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	82.90%	82.17%

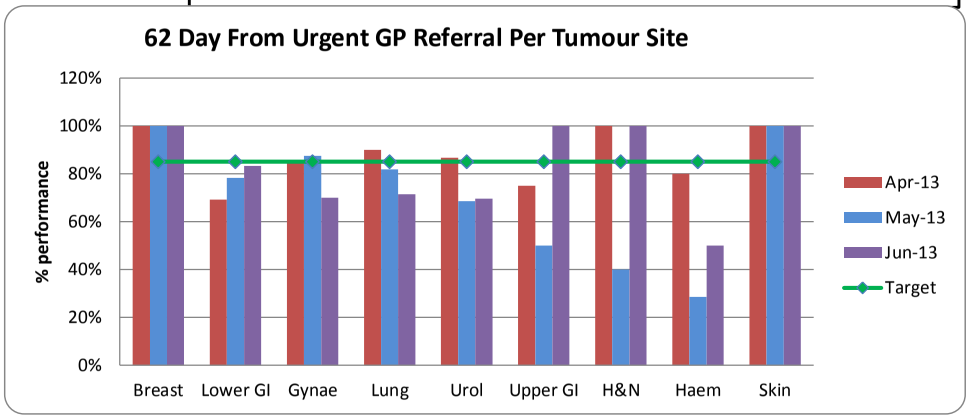
Key Issues:

The Trust has not met the 62 day cancer standard from urgent GP referral to start of first treatment for June and as a result of May and June's performance is not predicted to meet the quarter 1 performance (the completion date for final validation of the data is the 5th August).

During June the Trust achieved 82.9%% against the standard of 85% (subject to final validation), up from 79% in May. There were 9.5 breaches over 62 days (12 patients) complared to 18.5 breaches(25 patients) in May. The following is a summary of the breach reasons for June;

- -Radiotherapy and planning capacity
- -Complex diagnostic pathways
- -Patient choice to decline or defer appointments
- -Internal processes





Cancer

Recovery Plan

The Trust is in the process of revising and strengthening the governance arrangements for monitoring the revised recovery plan. The latest recovery plan is attached in appendix 2. There will be a dedicated Cancer Board that will be chaired by the Chief Executive. The first meeting is to be held in August. The aim of the meeting is to ensure clinical leadership and accountability for implementation of the plan. This is based on the governance model of the Urgent Care Board.

Details of the recovery plan and key actions being taken have been reviewed at Integrated Healthcare Governance Committee.

In summary the key actions include:

-Review of all escalation and administration process for scheduling patients
-Review of specific stages of the pathways for example diagnostics and planning treatments
-Review of the stages and timings of the following pathways;
- Head and neck
- Urology
- Upper GI
- Lower GI
- Gynae

-Review of inter trust referral processes

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Urgent Care Update
Agenda item	13
Sponsoring Director	Deborah Needham, Care Group Director, Medicine
Author(s)	Deborah Needham, Care Group Director, Medicine
Purpose	Information and Assurance

Executive summary

- Performance against the 95% Four Hour Transit Time Standard remains inconsistent
- Attendances and emergency admissions are higher than the previous year
- The work streams within the NGH Urgent Care Programme continue to work to plan and updates are provided within the report
- Benchmark performance for East Midlands hospitals is included within the report which shows highly variable performance across the area
- The Chief Operating Officer of NHS England has required all Area Teams via local urgent care boards to provide further information on the recently submitted recovery and improvement plans

Related strategic aim and corporate objective	All
Risk and assurance	Risk of achievement of national targets
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)
Are there any legal/regulatory implications	No

Actions required by the Board

The Board Is asked to review and discuss the paper.

Northampton General Hospital NHS
NHS Trust

Urgent Care Programme Update

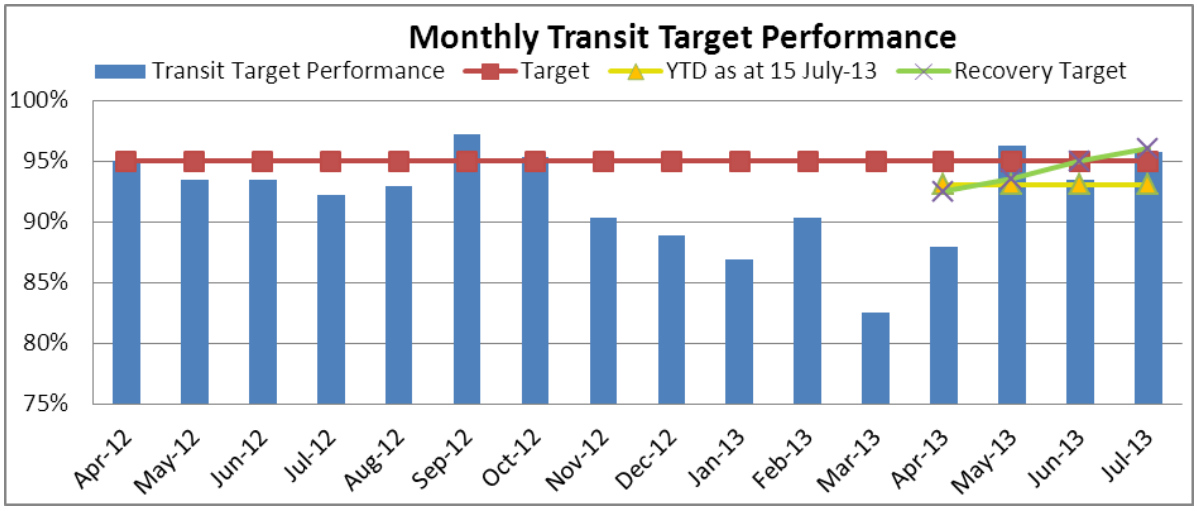
Trust Board – 24th July 2013

1. Introduction

The Urgent Care Programme (UCP) continues to be led by the Chief Executive with the Programme Board meeting monthly. This report aims to provide an update on each of the UCP work streams, a summary of current performance and a benchmark review of performance against other acute Trusts. The last report to the Board was considered on in May 2013.

2. Current Performance

During 2013, performance has remained variable with achievement in one month which was May (96.28%), both April (87.89%) and June (93.42%) were below the 95% standard.



Note: July data up to & inc 15th July 13

The Trust has seen high numbers of A&E attendees throughout the first quarter of 2013. In June 2013 on average there have been an additional 30 patients attending A&E each day compared to June 2012 (10% increase). This pattern appears to be continuing into July 2013.

An urgent meeting with the CCG is being arranged to understand the effect of their demand management plans and agree further actions to reduce A&E attendances.

3. Performance in Comparison to Other Acute Trusts within East Midlands

The following information highlights performance for all acute Trusts within the East Midlands in the month of May 2013:

Trust	Attendance	> 4Hours	Performance
Hospital A	10,333	165	**98.4%**
Hospital B	5,426	173	**96.8%**
Hospital C	12,043	396	**96.7%**
Hospital D	14,243	544	**96.2%**
Northampton General Hospital NHS Trust	8,100	323	**96.0%**
Hospital E	11,850	794	**93.3%**
Hospital F	5,701	561	**90.2%**
Hospital G	16,972	2,024	**88.1%**
England	1,721,155	59,812	**96.5%**

4. Overview of Work Stream priorities

The framework for the project remains unchanged. Each work stream is clinically-led, and works to a project plan which in turn reports to the NGH Urgent Care Board (UCB) which meets monthly.

It was recently agreed that specific work streams would be discussed at more detail at the monthly Integrated Healthcare Governance Committee's commencing in August 2013.

The main areas of priority are:

1. Development of an Ambulatory Care Unit
    a. Streamlining A&E attendances by establishing an Ambulatory Care Centre
    b. 8 Ambulatory Care Pathways now in place, 5 to follow showing significant reduction in length of stay: August 2013

2. Improving ED patient flow by ensuring the recruitment of Medical and Nursing staff
    a. Additional staffing currently out to advert: Sept - Dec 2013

3. Increasing discharge rates by rolling out Nurse Facilitated Discharge
    a. In place on every large medical ward
    b. Timeline in place for remaining wards with roll out to Community: June/July 2013

4. Improving Trust wide patient flow and discharge rates by the roll out of Visual Hospital in all ward areas (whiteboard process and Teleologic electronic system)
    a. Contract signed for Teleologic: Commence July 2013

5. MDT focus in community
    a. Implementation of the visual hospital

5. Local and National Considerations

On 5th July 2013, the Trust received the revised QIPP for 2013/14 form Nene CCG.

Against the original planning assumption of £6.9m, the revised plan showed savings in reduced demand for patient activity of £3.6m. However, a considerable proportion relates to reducing volumes in A&E and reducing emergency admissions. This is in contrast to the current trends in both these areas, and as such it would be unwise to adjust the hospitals internal capacity plan to reflect the QIPP.

The latest week's data illustrates the issue of growth, compared to a similar week in previous years:

	2010	2011	2012	2013
All A&E Attendances (types 1+3)	1730	1831	1964	2347
All Emergency Admissions	511	565	633	684

Usually, 70% - 75% of all emergency admissions come via the A&E Department. This changes over time with changes in the patient pathway.

The level of activity has led to significant over performance on the contract with Nene CCG, and the Trust has issued an Activity Query Notice (AQN) identifying the problem and asking for a considered response.

In May, the Board received the briefing letter from Barbara Hakin, setting out the process for NHS England to receive and assess A&E Recovery Plans for every locality. A first draft was submitted by Nene CCG and as a result of feedback from the Area Team, this has been enhanced. The revised plan will be considered by the Health Economy Wide Urgent Care Board on the 23rd July 2013 before resubmission at the end of the month.

The plan needs to address clearly the rising demand for A&E Services in Northampton, and the role of commissioning in managing this issue.

It is anticipated that NHS England will announce the results of its nationwide review of Urgent and Emergency Care in mid-August.

6. Recommendation

The Board is asked to review and discuss this paper.

REPORT TO THE TRUST BOARD

DATE 24 July 2013

Enclosure L

Title	Finance Report Month 3 – June 2013
Agenda item	14
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance David Bebb, Deputy Director of Finance (Interim)
Purpose	To report the financial position and associated risks for year to June 2013.

Executive summary

The report sets out the financial position for June 2013-14 (month three).

Financial performance for the year to date is now a £1.25m deficit against a plan of £1.39m, a favourable variance of £145k.

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.

Capital expenditure is marginally behind of plan as schemes delivery in some of the estates area have slowed. This marginal underspend is due to phasing of the expenditure profile. The Trust still expects to spend its planned capital expenditure and meet its revised CRL duties.

During June the Trust continued to retain sufficient cash to make all payments due to the majority of key suppliers, although liquidity worsens in September as set out in section 5, which necessitates the requirements for a working capital facility.

The use of temporary staff has continued with expenditure in month of £1.5m. A revised investment plan for nursing has now been advanced and is being implemented. Availability and speed of recruitment to permanent posts together with discipline in the withdrawal of bank and agency use is key to the success of this strategy.

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 Report as at 30 June 2013

Month 3 2013/2014

1. Summary Performance – Financial Duties

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

Table 1 – Key Financial Duties

Financial Duties	YTD Actual £'000	YTD Target £'000	Variance £'000	FOT £'000	Full Year Target £'000	Variance £'000
Delivering Financial perfromance	-£1,248	-£1,393	£ 145 Fav	-£4,822	-£4,822	£0
Achieving EFL (£000's)	N/A	N/A	N/A	£5,304	£5,304	£0
Achieving the Capital Resource Limit (£000's)	£1,382	£1,548	£ 166 Fav	£13,448	£13,448	£0
Subsidiary Duties						
Better Payment Practice Code:						
Volume of Invoices	86%	95%	-9%	90%	95%	-5%
Value of Invoices	86%	95%	-9%	90%	95%	-5%

Key Issues:-

- **Financial Performance –** Financial performance in June 2013 has improved and is now marginally ahead of the planned deficit. Over performance income net of fines has been the most significant component of this recovery which has been delivered with a marginal increase in base costs. Provisions for fines and CIP non delivery however continues to draw the financial position back to its deficit plan. It is also noted that the run rate in pay costs has continued to increase above the levels reported in April and May. Activity and CIP delivery are also planned to rise in July, giving rise to a planned surplus, which will place pressure on delivery of planned financial targets for July.

- **Income Over performance -** CCG income has continued to show a clear over performance which has now been released to the financial position offset by appropriate provision for fines. The position reported assumes that all over performance will be paid in full by CCGs as required under the terms of the contract and that month 3 activity remains subject to case mix validation.

- **Fines and Penalties -** The risks reported previously associated with a change of contractual emphasis by CCGs are now becoming real and CCGs have indicated that they will be active in levying the full remedies permissible under the contract for failures. Provisions for such measures of £1.9m with a further £0.3m for failure to deliver CQUINs. The delivery of operational performance targets has a clear link to the levels of fines and penalties and must continue to be closely linked and actively managed.

- **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 £1,166k adverse variance. Whilst the release of contingency reserves, underspend in pay and over performance in income have partially offset this in June, this trend cannot be expected to continue. This will place significant financial pressure on the existing financial plans. CIP delivery in month 3 has also fallen behind plan, adding further pressure to the delivery of financial targets. Details of the mitigating actions being developed are reported under separate cover.

- **Performance against contract** – The Trust continues to significantly over perform against its key contracts as set out in section 3. 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. The matter has also been reported to the TDA. No CCG response has yet been received and the matter will be discussed at the next CCG operational meeting.

- **Forecast –** The current forecast position has been based on the planned levels of income and expenditure. Now that three months of the financial year has been reported a more refined forecast can be prepared. This work has commenced and will be reported in the August Finance Committee.

- **Financial Recovery Plan** – The Financial Recovery Plan (FRP) has now been shared with the TDA and discussed at the July escalation meeting. The plan was well received but will require work with CCGs to develop plans into more robust arrangements which can be forecast into the financial position. Discussions also took place to develop the application for Temporary Borrowing Loan (TBL) with the TDA. This work has now progressed and the application is being prepared for TDA review.

- **Capital Plans** – During July a series of changes were approved to the Capital Programme. The agreement of the Ambulatory Care centre will now commence on a phased basis. The full cost for the scheme is expected to be in the order of £1.6m with major expenditure phased toward the end of the current financial year and into 2014/2015. In addition smaller schemes to extend the reception area in the Eye clinic and the Paediatric Assessment area were also approved. This additional capital expenditure being funded from the Capital Contingency. One key scheme of £0.4m which will cover the creation of a corridor in the Radiotherapy areas is also being reviewed and may be ear marked as a further contingency should this be necessary in the latter part of the financial year. The Trust has also been successful in its bid to the DH for energy infrastructure and the associated PDC funding and £2.7m capital expenditure now included within plans.

Table 2 – I&E Position

I&E Summary	Annual Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	June Plan	June Actuals	May Actuals	April Actuals	Forecast EOY (Excl FRP)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	57,139	**58,383**	**1,244**	18,787	19,640	19,587	19,156	**230,904**
Other Clinical Income	2,803	701	**609**	**(91)**	233	171	179	259	**2,803**
Other Income	25,575	6,328	**6,061**	**(267)**	2,104	2,089	1,965	2,007	**25,575**
Total Income	**259,281**	**64,167**	**65,053**	**886**	**21,125**	**21,901**	**21,731**	**21,421**	**259,281**
Pay Costs	(175,015)	(43,374)	**(43,075)**	**299**	(14,481)	(14,487)	(14,349)	(14,238)	**(175,015)**
Non-Pay Costs	(78,307)	(19,446)	**(19,740)**	**(294)**	(6,389)	(6,487)	(6,813)	(6,441)	**(78,307)**
CIPs	4,663	1,166	**0**	**(1,166)**	389	0	0	0	**4,663**
Reserves/ Non-Rec	(1,451)	(420)	**0**	**420**	(136)	0	0	0	**(1,451)**
Total Costs	**(250,110)**	**(62,075)**	**(62,815)**	**(740)**	**(20,616)**	**(20,975)**	**(21,161)**	**(20,679)**	**(250,110)**
EBITDA	9,171	2,092	**2,238**	**146**	509	926	570	742	**9,171**
Depreciation	(10,184)	(2,595)	**(2,595)**	**0**	(865)	(865)	(865)	(865)	**(10,184)**
Amortisation	(10)	(2)	**(2)**	**0**	(1)	(1)	(1)	(1)	**(10)**
Impairments	0	0	**0**	**0**	0	0	0	0	**0**
Net Interest	29	7	**7**	**(1)**	2	2	3	1	**29**
Dividend	(4,106)	(1,026)	**(1,027)**	**(0)**	(342)	(342)	(330)	(354)	**(4,106)**
Surplus / (Deficit)	**(5,100)**	**(1,525)**	**(1,380)**	**145**	**(697)**	**(280)**	**(623)**	**(477)**	**(5,100)**
Donated Assets Depreciation	**278**	**132**	**132**	**0**	**44**	**44**	**44**	**44**	**278**
Normalised for Impairment	**(4,822)**	**(1,393)**	**(1,248)**	**145**	**(653)**	**(236)**	**(579)**	**(433)**	**(4,822)**

1.2. Financial performance for the year to date is now a £1.25m deficit against a plan of £1.39m, a favourable variance of £145k. This performance recognises the considerable levels of unmet CIP reported in month and the levels of over performance and associated fines.

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.

1.4. Capital expenditure is marginally behind of plan as schemes delivery in some of the estates area have slowed. This marginal underspend is due to phasing of the expenditure profile. The Trust still expects to spend its planned capital expenditure and meet its revised CRL duties.

1.5. During June the Trust continued to retain sufficient cash to make all payments due to the majority of key suppliers, although liquidity worsens in September as set out in section 5, which necessitates the requirements for a working capital facility.

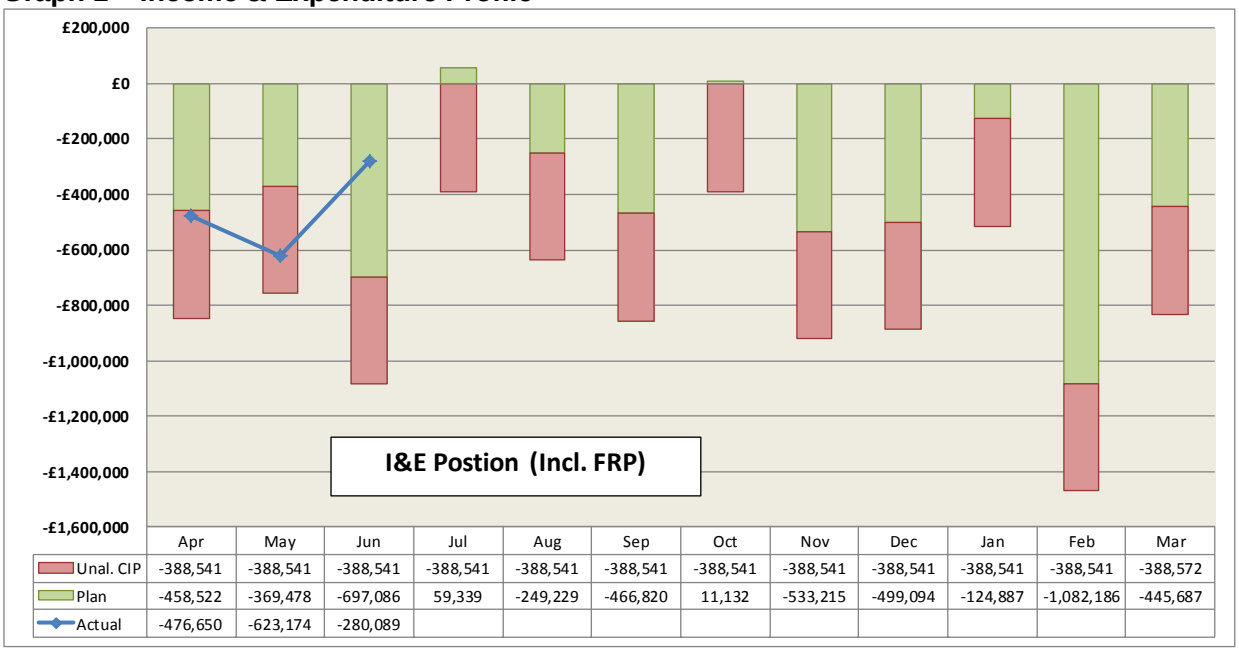
1.6. The use of temporary staff has continued with expenditure in month of £1.5m. A revised investment plan for nursing has now been advanced and is being implemented. Availability and speed of recruitment to permanent posts together with discipline in the withdrawal of bank and agency use is key to the success of this strategy.

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 £1,248k. This performance is £145k favourable to the month 3 cumulative planned deficit of £1,393k.

Graph 1 – Income & Expenditure Profile



	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	-458,522	-369,478	-697,086	59,339	-249,229	-466,820	11,132	-533,215	-499,094	-124,887	-1,082,186	-445,687
Actual	-476,650	-623,174	-280,089									

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 3 have also adversely impacted the financial position together with the levels of pay and non pay expenditure increasing.

2.3. Levels of bank and agency usage have continued to be high increasing at £1,522k in June. 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 strategy has now been approved to reduce this expenditure and is now being implemented. The implementation of this strategy is key to deliver the necessary improvements in quality with a corresponding reduction in temporary staff use.

3. Income and Activity

3.1. Year to date total operating income is reported at £65,053k which is £886k 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 is reported at £58,992k year to date at month 3 exceeding planned levels by £1,152k as set out in table 3 below. Case mix adjustments now have been posted for month 1 and 2 and month 3 will be processed once coding data is available. This may change the overall income position which will be reported verbally to FC as appropriate. Provisions to cover potential contractual fines and penalties totalling £1.9m have been accrued in the month 3 position with an additional provision of £0.3m to allow for the non delivery of CQUIN. Further details are contained in appendices 3,4 and 5

Table 3 SLA and Other Clinical Income year to date

	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Income Plan £'000	Income Actual £'000	Income Variance £'000	% Var	June 2013/14 Budget £'000	June 2013/14 Actuals £'000	May 2013/14 Actuals £'000	April 2013/14 Actuals £'000
Elective Daycase	5,527	6,021	(494) Fav	-8.9%	1,783	1,904	2,076	2,041
Elective Inpatients	4,079	4,604	(525) Fav	-12.9%	1,316	1,607	1,512	1,484
Elective excess bed days					-	(95)	43	52
Non Elective	15,923	17,083	(1,160) Fav	-7.3%	5,922	8,695	4,094	4,295
Non elective excess bed days					-	(1,359)	858	501
New Outpatients	2,537	2,368	169 Adv	6.7%	818	817	769	782
Follow Up Outpatients	2,619	2,711	(92) Fav	-3.5%	845	880	901	931
Non Cons Led Outpatients New	628	641	(12) Fav	-1.9%	203	211	214	215
Non Cons Led Outpatients Follow Up	750	767	(18) Fav	-2.4%	242	249	287	231
Outpatient Procedures	1,542	1,539	3 Adv	0.2%	497	467	542	530
Block Contracts - Fixed	9,986	10,143	(156) Fav	-1.6%	1,913	3,054	4,484	1,646
Cost Per Case	5,877	6,479	(601) Fav	-10.2%	2,696	2,389	1,860	3,188
A&E	2,324	2,548	(224) Fav	-9.7%	766	822	842	884
Pathology	1,493	1,603	(110) Fav	-7.4%	498	523	518	563
Excluded Medicines	3,638	3,476	162 Adv	4.5%	1,199	1,314	1,084	1,079
Excluded Devices	307	346	(38) Fav	-12.5%	102	130	94	121
Fines, Penalties and Challenges	(900)	(1,945)	1,045 Adv	-116.2%	(300)	(350)	(193)	(207)
Productivity CIP's	599	-	599 Adv	100.0%	209	-	-	-
Other Central SLA Income	208		208 Adv	100.0%	77	(1,618)	(396)	818
Other Clinical Income	701	609	91 Adv	13.1%	233	171	179	259
Sub-Total SLA Clinical Income	57,840	58,992	(1,152) Fav		19,021	19,811	19,766	19,415

Table 4 Activity by Point of Delivery

Income & Activity Summary	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Activity Plan	Actual Activity	Activity Variance	% Var	June 2013/14 Budget	June 2013/14 Actuals	May 2013/14 Actuals	April 2013/14 Actuals
Elective Daycase	9,648	9,759	111 Adv	1.2%	3,115	3,033	3,328	3,398
Elective Inpatients	1,585	1,694	109 Adv	6.9%	509	540	596	558
Non Elective	9,035	7,449	(1,586) Fav	-17.6%	2,980	2,684	2,472	2,293
New Outpatients	15,224	15,444	220 Adv	1.4%	4,914	4,962	5,161	5,321
Follow Up Outpatients	27,150	30,201	3,051 Adv	11.2%	8,765	9,807	9,974	10,420
Non Cons Led Outpatients New	7,553	14,568	7,015 Adv	92.9%	2,445	9,637	2,548	2,383
Non Cons Led Outpatients Follow Up	14,856	15,898	1,042 Adv	7.0%	4,790	5,118	5,345	5,435
Outpatient Procedures	10,525	10,219	(306) Fav	-2.9%	3,397	3,118	3,618	3,483

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 as set out below. A more detailed analysis of the likely full year impact of the fines and associated mitigations is set out in appendix 4.

3.4. The provisions included at month3 are set out below:

- A&E 50,000
- Cancer 62 day wait 50,000
- C-Diff 375,000
- MRET 600,000
- Readmissions 600,000
- Challenges 150,000
- Casemix 100,000
- Paeds diabetes 20,237

3.5. CQUIN income has been accrued at 75% of the full target giving rise to an adverse variance of £325k. 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 monitoring of this area. The current updates on CQUINS report that many are on track to deliver as set out in appendix 5 however this performance should be scrutinised in more detail to support the delivery of these CQUINS.

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 its 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. A summary of the over performance by CCG is set out below and more comprehensive analysis contained in appendix 4:

Table 5 – Activity and Performance by Clinical Commissioning Group

	Plan Year to Date			Actual Year to Date			Income Variance year to date		
	Nene	Corby	Specialised	Nene	Corby	Specialised	Nene	Corby	Specialised
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	3,778	64	207	3,946	57	241	168 Fav	(7) Adv	34 Fav
Non elctive	12,816	228	965	15,108	286	959	2,292 Fav	58 Fav	(6) Adv
Days Case	5,124	31	133	5,169	45	202	45 Fav	14 Fav	70 Fav
Outpatienmts	6,356	52	477	6,835	38	357	479 Fav	(15) Adv	(120) Adv
Blocks	8,117	390	1,665	8,117	390	1,609	-	-	(56) Adv
Others	7,903	354	4,188	8,219	190	4,679	315 Fav	(164) Adv	491 Fav
Total	44,095	1,120	7,635	47,394	1,005	8,048	3,299 Fav	(114) Adv	412 Fav

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. The ICT Department have now committed to deliver this data as part of the month 3 CCG SUS submission.

3.8. A quarter 1 'freeze' date has been discussed with host CCGs and Specialised Commissioners to enable any data quality and coding issues to be resolved so that challenges and any loss of income is minimised. This 'freeze' date will be trigger to invoice agreed over performance.

Other Income

3.9. Other income is reported at £6,061k year to date at month 3 which is now behind plan by £0.25m. Whilst this performance has not deteriorated beyond the month 2 levels the performance is still of concern.

3.10. The level of SIFT and MADEL funding has also now been confirmed below the target originally set. This reduced income has been reported in the financial position as the revised levels.

3.11. Private and Overseas patient income has also fallen behind plan for the year to June. Following analysis there has been a number of occurrences of income being reported later than expected. A review of the processes associated with this type of income is already being undertaken which will supplement the work already being undertaken by Internal Audit. A further update will be given to the August Finance Committee.

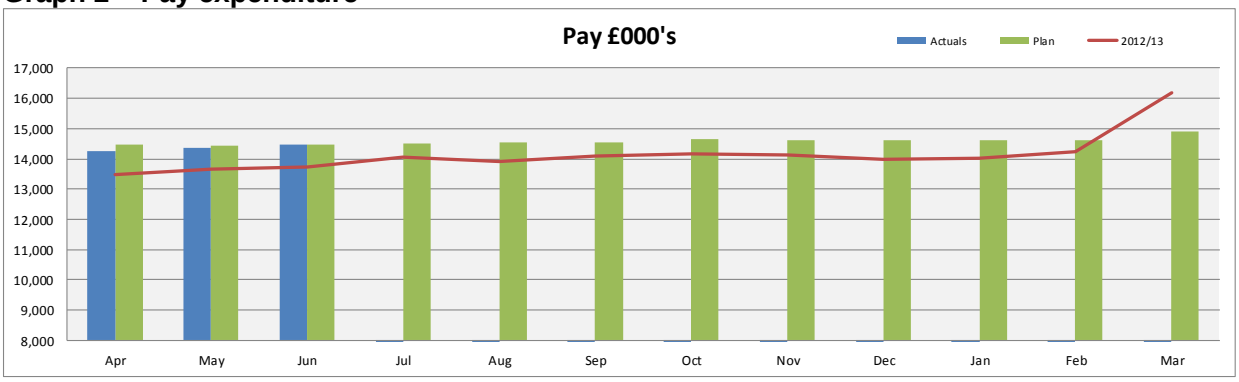
4. Expenditure

4.1. The Trust has overspent on its expenditure plans by £740k in year to June 2013. This position included unmet CIP of £1,116k, partly offset by the year to date release of contingency reserves of £420k.

Pay Expenditure

4.2 Permanent and temporary Pay costs year to date were £43,075k (FTE 4,267) against a plan of £43,374k (FTE 4,469) reporting a favourable variance of £299k (FTE 192) 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. Pay costs in month overspent by £7k in June which included the considerable over spend in medical and other staff costs. This indicate a rising trend which must be closely monitored to ensure that pay costs remain within plan.

Graph 2 – Pay expenditure



4.3 The Trust is operating below the planned WTE budget (by 192.39**)** in June but has continued to utilise significant numbers of temporary staff as set out in the tables below.

Table 4 – Monthly Whole Time Equivalent Analysis and Trend – Permanent and temporary Staff

	Pay Cost Analysis					Permanent Staff Trend			Temporary Staff Trend		
	Budget Month 3	Contracted	Permanent Staff worked month 3	Temporary Staff worked month 3	Variance	April 2013/14	May 2013/14	June 2013/14	April 2013/14	May 2013/14	June 2013/14
	WTE	FTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical Staff	481.24	463.49	449.75	23.72	(7.77)	441.46	445.84	449.75	25.40	27.09	23.72
Nursing Staff	1934.47	1787.03	1686.68	175.33	(72.46)	1652.63	1665.90	1686.68	184.18	170.85	175.33
Managerial and Administration	913.48	742.88	743.41	114.16	(55.91)	733.50	735.54	743.41	103.80	103.58	114.16
Other Clinical Staff	322.79	278.35	281.42	12.77	(28.60)	272.87	277.46	281.42	2.64	2.00	12.77
Scientific and Technical Staff	389.72	371.43	367.96	7.80	(13.96)	375.33	367.19	367.96	7.51	5.04	7.80
Estates Staff	35.5	25	27.60	5.56	(2.34)	26.59	27.82	27.60	2.74	3.92	5.56
All other Staff	384.9	331.46	343.14	30.41	(11.35)	332.93	338.04	343.14	25.02	24.72	30.41
Total WTE	4462.10	3999.64	3899.96	369.75	-192.39	3835.31	3857.79	3899.96	351.29	337.2	369.75

Enclosure L

Table 5 Monthly Pay Costs Analysis and Trend – Permanent and temporary Staff

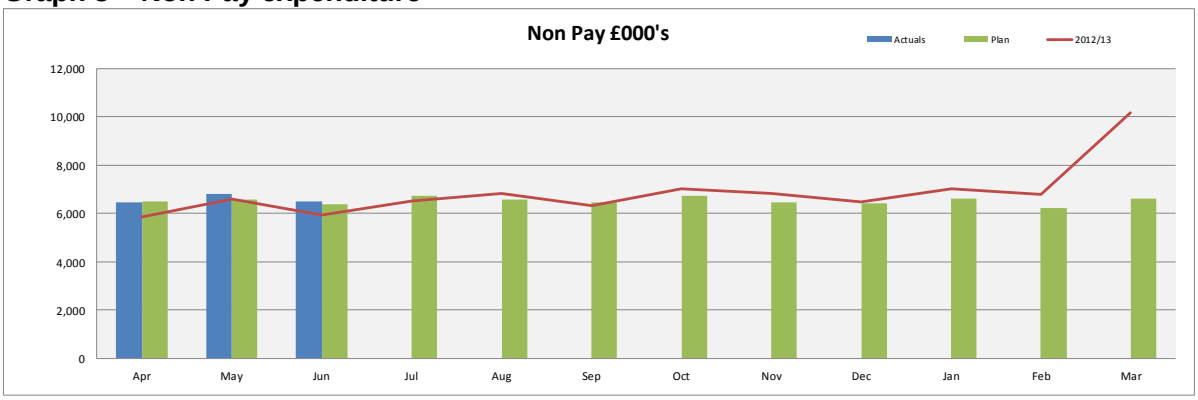
	Budget Month 3	Permanent Staff worked month 3	Temporary Staff worked month 3	Variance	April 2013/14	May 2013/14	June 2013/14	April 2013/14	May 2013/14	June 2013/14
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical Staff	3,840	3,529	397	86	3,492	3,467	3,529	344	357	397
Nursing Staff	5,678	4,972	602	(105)	4,942	4,935	4,972	668	680	602
Managerial and Administration	2,213	1,854	330	(29)	1,837	1,835	1,854	258	317	330
Other Clinical Staff	1,003	893	40	(70)	885	905	893	30	40	40
Scientific and Technical Staff	1,123	1,064	30	(30)	1,086	1,041	1,064	38	18	30
Estates Staff	95	78	10	(7)	70	84	78	5	18	10
All other Staff	529	575	113	160	517	572	575	65	77	113
Total Pay Cost	14,481	12,966	1,522	7	12,829	12,839	12,966	1,410	1,509	1,522

4.2. Levels of bank and agency usage have continued to be high increasing to £1,522k in June (May £1,509k). 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 now required to analysis the data for medical and other staff groups which are contributing to a significant over spend.

Non Pay Expenditure

4.3. Non Pay costs year to date were £19,740k against a plan of £19,446k reporting an adverse variance of £294k as set out in graph 3 below.

Graph 3 – Non Pay expenditure



4.4. Maintenance costs have continued to overspend largely due to mattress and other rental charges which were not identified a budget setting.

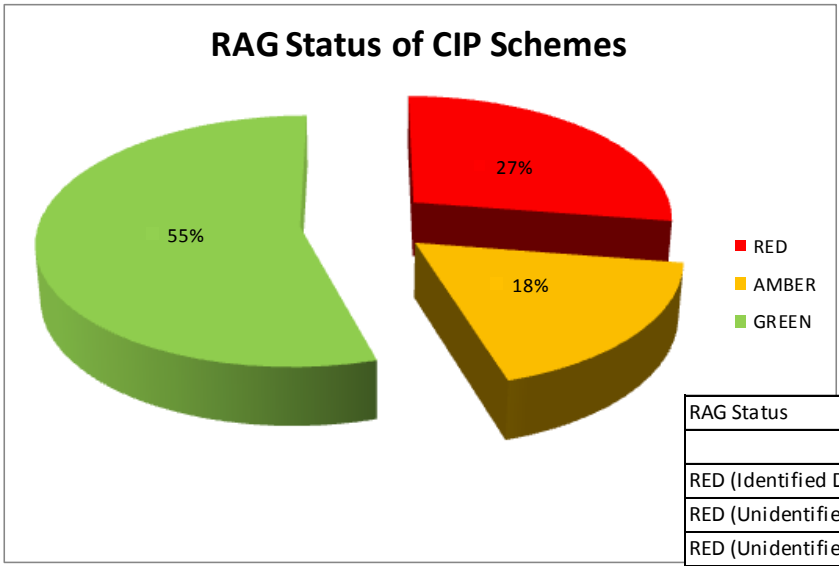
4.5. Unmet CIPs are also now creating further pressure in non-pay as performance falls behind plan on identified CIP plans.

4.6. Other key variances include a considerable overspend in outsourced activity with Newmedica and Three Shires for T&O and Ophthalmology income which is offset by income overachievement.

Transformation Programme

4.7. 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 5 details the identified schemes by work stream. The status of identified schemes is set out in table 7. With unidentified schemes being classified as RED schemes.

Table 7 Status of Transformation CIP Schemes



RAG Status	Value	
	£'000	%
RED (Identified Directorates)	1,899	14.61%
RED (Unidentified Directorates)	181	1.39%
RED (Unidentified)	1,489	11.45%
AMBER	2,325	17.88%
GREEN	7,107	54.67%
	13,000	

4.8. The Transformation Team have assessed each scheme with their respective owners and RAG rated them. This shows that there are still 27% of schemes which are high risk or not identified as shown above.

4.9. Performance against the TDA plan is monitored each month. The detailed results by schemes can be found in Appendix 5. This shows an adverse performance within Directorate CIPs of £524k offset by the over achievement of CIP plans in central CIP measures notably tactical HR CIP measures. Overall CIP plans are behind plan by £157k at month 3.

4.10. A more detailed update on CIP delivery and the expected delivery full year delivery is contained under separate cover.

Contingency Reserves

4.11. No further developments were funded from contingency in month 3 however an additional £244k has been identified from a change to the deficit budget to reflect the gross deficit of £5,100k submitted to the TDA (£4.82m after donated asset adjustments).

4.12. This reserve will be used to support the funding associated with the recent business cases approved in Ambulatory care should negotiations to secure revenue neutral funding to support the case fail. Remaining reserves continue to be released on an equal basis over the remaining months of the financial year to support the level of unmet CIP.

5. Statement of Financial Position and Cash Flow

5.1. The Trust's Statement of Financial Position (Balance Sheet) as at 30th June 2013 is set out within appendix 7.

5.2. The Trust's actual and forecast cash flow for the year is shown in appendix 8. The cash balance at the end of June stood at £3.9m (May £6.6m). This balance excludes £2.7m of cash in transit from host CCGs following the actions agreed at the June Finance Committee which was received on the 1st July.

5.3. An analysis of income earned by the Trust but unpaid as at 30th June is shown in the table below.

Table 8 – Aged Debtor analysis

Aged Receivables / Payables: Current I	Sub Code	Sign	Total at Period End	0-30 days		31 - 60 Days		61-90 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	+	1,237	342	28	151	12	110	9	634	51
Receivables NHS	560	+	6,266	5,051	81	212	3	100	2	903	14
Payables Non NHS	570	-	(1,989)	(1,905)	96	(61)	3	(23)	1	0	0
Payables NHS	580	-	(135)	(71)	53	(20)	15	(2)	1	(42)	31

5.4. NHS debt due over three months relates to over performance with NHS Milton Keynes and other PCTs. Settlement has already been discussed but final settlement is now linked to the wider national timescales for PCT closures which has been extended.

5.5. A significant element of the outstanding non NHS debt relates to payroll and service charges for the CRIPPS Recreation Centre. Work is now being undertaken to assess the viability of transferring the service to an alternative provider who can provide a more sustainable future for the centre.

5.6. 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. The position has continued to improve but still has not met its target of 95%.

Table 9 – 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	+	18,315	19,452	12,513	12,733
Total bills paid within target	635	+	15,838	17,423	10,725	11,165
Percentage of bills paid within target	640	+	**86.5**	**89.6**	**85.7**	**87.7**
NHS						
Total bills paid in the year	650	+	459	2,797	291	1,794
Total bills paid within target	655	+	257	1,617	167	934
Percentage of bills paid within target	660	+	**56.0**	**57.8**	**57.4**	**52.1**
Total						
Total bills paid in the year	670	+	18,774	22,249	12,804	14,527
Total bills paid within target	675	+	16,095	19,040	10,892	12,099
Percentage of bills paid within target	680	+	**85.7**	**85.6**	**85.1**	**83.3**

5.7. Analysis has now taken place regarding the key drivers for the poor performance in this area. The analysis undertaken demonstrates that many invoices in areas such as pathology

Enclosure L

and bank and agency are being submitted for payment when they have already breached the BPPC code. The manner in which this data is being reported is now being updated to report which areas are submitting for approval too late and the actual payment performance once invoices are submitted. A further update will be provided to the August Finance Committee supported by a report which will show the performance in the above categories.

5.8. Cash reserves have been sufficient to meet the Trust key statutory duties but the longer term resilience of the cash position remains poor. A Temporary Borrowing Loan (TBL) loan application is now progressing with the TDA for a draw down to meet the Trust PDC commitments in September.

6. Capital Programme and Performance against Capital Resource Limit

6.1. The original 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. This plan has now been increased to reflect the recent approval of the £2.7m DH funding for the energy infrastructure. The table below sets out the performance against plan.

Table 10 – Capital Expenditure

Northampton General Hospital NHS Trust
Org Code: RNS
Period: Financial Data 2013/14 Quarter 1
Key Data Summary

Key Data Item	sub Code	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								
Gross Capital Expenditure	280		1,439	1,382	(57)	10,914	13,698	2,784
Other adjustments relating to grants, losses on disposal of donated assets and Donations	300		0	0	0	(250)	(250)	0
Charge against Capital Resource Limit	310		1,439	1,382	(57)	10,664	13,448	2,784
Capital Resource Limit (CRL)	320		1,439	1,439	0	10,664	13,448	2,784
Under/(Over) spend against CRL	330		**0**	**57**	**57**	**0**	**0**	**0**

6.2. The total cumulative spend for month 3 is £1,382k against an initial plan of £1,548k. This is marginally below plan by £166k largely due to estates expenditure falling below plan. Full analysis of capital expenditure is set out in appendix 9.

6.3. **Carbon Energy Fund (CEF) –** The Trust has been successful in the initial bidding, securing £2.7m to invest in energy infrastructure. This has now been included within the plan and tendering activities have now commenced. The phasing of this project has been initially set based on the programme submitted to DH however bidders have already identified risk concerning the lead time for key items of equipment. As a precaution discussions are now taking place with DH to confirm whether any slippage will be considered.

6.4. **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. Following agreement by the July Finance Committee a risk workshop has now been arranged which will confirm the key risk elements of the contract prior to tender submissions.

6.5. During July a series of changes were approved to the Capital Programme. The agreement of the Ambulatory Care centre will now commence on a phased basis. The full cost for the scheme is expected to be in the order of £1.6m with major expenditure phased toward the end of the current financial year and into 2014/2015. In addition smaller schemes to extend the reception area in the Eye clinic and the Paediatric Assessment area were also approved.

6.6. This additional capital expenditure being funded from the Capital Contingency. One key scheme of £0.4m which will cover the creation of a corridor in the Radiotherapy areas is also being reviewed and may be ear-marked as slippage to create further contingency should this be necessary in the latter part of the financial year.

6.7. The overall level of Capital Expenditure for the financial year is £13,448k (including anticipated donations). The Trust is planning to meet it statutory duty to meet its CRL limit.

7. Monitor Financial Risk Rating

7.1. Appendix 10 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 June 2013 if it were a Foundation Trust would be 2, a fall in month from 3. This is due to the EBITDA margin falling slightly below -2% based on the phasing of the plan. The measure recovers as the plan advances through the year. The Trust is forecast to end the year with a risk rating of 3 based on delivery of 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 11 – Risks

		£000s		%	£000s
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage - Latest thinking forecast £10.5m likely delivery £2.5m risk	Early focus on delivery of identified schemes and development of new schemes.	(4,800)	High	60%	(2,500)
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 capacity. Application of 2% strategic reserve funding to meet excess costs.	(3,000)	Medium	50%	(1,500)
CCG QiPP 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. Current thinking on delivery included in financial position however further risk is evident	Monitoring and performance framework to be put in established. Risk to be identified and 25% provision made in monthly reporting. Risk of non delivery in addition to this provision e.g. Ambulatory Care activity	(1,300)	Medium	20%	(260)
Net Revenue Risk		**(17,200)**			**(7,000)**
Other Risks					
Cash flow projections show weakening cash position in first half of the 13/14 financial year.	Cash flow position to be discussed at FPC in June. Process for application for loans to be agreed with TDA.	(6,000)	High	70%	(4,200)
There has been a significant change in the Commissioner landscape leading to contractual uncertainty and loss of continuity in some Commissioners	Data quality and compliance contract query has been narrowly avoided in M3 and is still subject to provision of reliable data for M3. Risk in contract query is to withhold 1% of contract value	(2,000)	Medium	50%	(1,000)

Table 12 – Opportunities

Key opportunities not included in Financial Plan 2013-14		Value of opportunity £000s	Likelihood	Probability %	Adjusted Risk £000s
Income opportunities through coding review	Ensure coding is key areas is as detailed as practical	750	Low	50%	375
Quality Assurance of Income processing	Quality Assurance of Patient to cheque payment process for all patient streams	750	low	50%	375
Release of Income Provisions and Fines	Improvements to operational targets leading to release of income provisions	1,000	MED	50%	500
Bidding for Readmissions funding	Development of bids to draw down re-admissions fines in part or in whole to extent not built into FRP	4800	MED	50%	2,400
Invest to Save Schemes - Capital Invesment from possible underspend in capital programme	Schemes to be developed and worked up for delivery when capital is available. Revenue savings to be generated	500	MED	50%	250
		7,300			**3,650**

Enclosure L

8.2. The range of opportunities will now be developed with the Transformation team to identify and Executive sponsor and to develop the scheme so that it can be included within the overall CIP Programme.

9. Conclusion

9.1. The financial position has improved during June and the Trust is now performing in accordance with its plans. This performance is largely due to the over performance on clinical income contracts offset by non delivery on CIP schemes, underperformance on some of its income other targets and the need to make provision for contractual fines and penalties. It is also noted that the financial targets for the coming quarter become more challenging; the planned deficit of £1.5m quarter 1 reduces to a planned deficit of £0.6m for quarter 2. This will place further pressure on achievement of financial targets.

9.2. The validation of the income position for month 3 has now been completed with no material change. Reconciliation and challenge of performance under the terms of the agreed contract with the CCG is still however to be undertaken. This may change the clinical income position.

9.3. A quarter 1 ‘freeze’ date has been discussed with host CCGs and Specialised Commissioners to enable any data quality and coding issues to be resolved so that challenges and any loss of income is minimised. This ‘freeze’ date will be trigger to invoice over performance.

9.4. The contract with Nene CCG is currently over performing by £3.3m and an Activity Query Notice is now being prepared this formally with CCGs as permitted under the terms of the contract.

9.5. 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.

9.6. As a matter of priority, substantive recruitment is required to minimise the use of all groups bank and agency staff and an analysis of medical and other staff groups undertaken to establish the corrective action required.

9.7. A working capital loan of £4m is required in September and has been discussed with the TDA and application process is now progressing with the TDA.

9.8. The Trust will need to continue 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

13.1 The Board is asked to note the contents of the report and ensure that the actions to manage emerging risks are discussed and understood. It is recommended that the following action is taken:

- Analysis of the use of medical and other staff group bank and agency and the considerable overspend this has created to establish what corrective action may be necessary.
- Consideration of the operational performance and the links to the levels of fines and whether further mitigations can be put in place to reduce the financial impact
- Review of delivery against detailed CQUIN targets and associated allocation to Directorates. Updates to the delivery status of CQUIN and the associated financial impact to be included in the month 4 financial; position.
- To acknowledge that a TBL loan completed for consideration by the TDA followed by a longer term working capital loan as appropriate.
- A detailed month 4 forecast is prepared based on the information reported in months 1-3 and the best estimates of the likely activity and performance for the remainder of the financial year, including the expected delivery of CIPs.
- Plans are discussed to consider schemes that could be developed to secure part or all of the reinvestment of re-admissions and MRET fines levied by the CCGs.
- Work with the LAT,TDA and CCGs to develop options for a financial recovery plan
- Deliver robust reconciliation process with Nene CCG to ensure all revenue is collected promptly.

Finance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	June		April	May
Financial Risk Rating (Shadow)	2	Overall FRR shadow score of 3	3	3
EBITDA %	3.4%	EBITDA % scores 2 under Monitor FRR	3.6%	3.0%
Liquidity (days cover)	17.9	Achieves FRR score of 3.	18.7	18.4
Surplus Margin	-2.12%	Achieves FRR score of 2	-1.9%	-1.9%
Pay / Income	66.2%	Cumulative pay 66.2% of cumulative income	67.5%	67.5%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	(1,380)	Deficit of £1.38m. £145k ahead of plan	(492)	(1,188)
Impairment and Donated Assets	132	Donated asset depreciation of £132k ytd	44	88
Normalised Position	(1,248)	I&E position excluding impairment.	(448)	(1,100)
TDA Plan (Year to date)	(1,393)	NTDA Plan for June 2013	(464)	(740)
PCT SLA Income Variance	(1,244)	Ahead of plan ytd subject to case mix changes	87	391
TDA Normalised annual plan	(4,822)	Full year NTDA control total.	(4,856)	(4,856)
Forecast EOY I&E postion	(4,822)	Current forecast is to achieve plan	(4,856)	(4,856)
EBITDA Performance	£000's		£000's	£000's
Variance from plan	145 FAV	Ytd position £145k ahead of plan	12FAV	(285)ADV
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	2,281	Ytd target £2.2m	760	758
YTD Actual	2,124	Ytd delivered £2.1m	755	679
% Delivered	93%	Increase in % of delivery from June	99%	90%
LTF	11,331	Value of Schemes rated Green and Amber Schemes	11,100	10,820
Annual Plan	13,000	Annual Transformation Target.	13,000	13,000
LTF v. Plan	87%	% of LTF compared to annual plan. Increase from may	85%	83%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	1,382	Capital expenditure for year to date £166k behind plan	126	460
Committed as % of plan YTD	22%	% of plan committed for year to date.	13%	26%
Annual Plan	13,448	Capital Resource Limit of £10.6m plus CEF fund £2.6m for 2013-2014	10,664	10,664
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	(89)	Depreciation in excess of additions	(740)	(44)
Current assets	1,295	Increase in accrued income for overperformance	3,481	704
Current Liabilities	(280)	Pay down of creditors and release provision	3,189	(309)
Cash	**£000's**		**£000's**	**£000's**
In month movement	(2,759)	Receipt £2.7m Specilised Commisioning 1 July	2,801	(392)
In Year movement	(350)	Catch up of NHS debtors.	2,801	2,409
DH Temporary Loans	0	No approvals for 2013/14 to date but application submitted	0	0
Debtors Balance > 90 days	1,537	Increase as PCT debt and CRIPPS debt ages	1,013	1,059
Creditors % > 90 days	0.00%	Creditors over 90 dyas paid down	1.24%	1.22%
BPPC (by volume) YTD	85.7%	BPPC improved but still missed missed in June due to late approvals	81.7%	85.0%

Enclosure L

Appendix 2

Income & Expenditure Position

I&E Summary	Annual Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	June Plan	June Actuals	May Actuals	April Actuals	Forecast EOY (Excl ERR)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	57,139	**58,383**	**1,244**	18,787	19,640	19,587	19,156	**230,904**
Other Clinical Income	2,803	701	**609**	**(91)**	233	171	179	259	**2,803**
Other Income	25,575	6,328	**6,061**	**(267)**	2,104	2,089	1,965	2,007	**25,575**
Total Income	**259,281**	**64,167**	**65,053**	**886**	**21,125**	**21,901**	**21,731**	**21,421**	**259,281**
Pay Costs	(175,015)	(43,374)	**(43,075)**	**299**	(14,481)	(14,487)	(14,349)	(14,238)	**(175,015)**
Non-Pay Costs	(78,307)	(19,446)	**(19,740)**	**(294)**	(6,389)	(6,487)	(6,813)	(6,441)	**(78,307)**
CIPs	4,663	1,166	**0**	**(1,166)**	389	0	0	0	**4,663**
Reserves/ Non-Rec	(1,451)	(420)	**0**	**420**	(136)	0	0	0	**(1,451)**
Total Costs	**(250,110)**	**(62,075)**	**(62,815)**	**(740)**	**(20,616)**	**(20,975)**	**(21,161)**	**(20,679)**	**(250,110)**
EBITDA	9,171	2,092	**2,238**	**146**	509	926	570	742	**9,171**
Depreciation	(10,184)	(2,595)	**(2,595)**	**0**	(865)	(865)	(865)	(865)	**(10,184)**
Amortisation	(10)	(2)	**(2)**	**0**	(1)	(1)	(1)	(1)	**(10)**
Impairments	0	0	**0**	**0**	0	0	0	0	**0**
Net Interest	29	7	**7**	**(1)**	2	2	3	1	**29**
Dividend	(4,106)	(1,026)	**(1,027)**	**(0)**	(342)	(342)	(330)	(354)	**(4,106)**
Surplus / (Deficit)	**(5,100)**	**(1,525)**	**(1,380)**	**145**	**(697)**	**(280)**	**(623)**	**(477)**	**(5,100)**
Donated Assets Depreciation	**278**	**132**	**132**	**0**	**44**	**44**	**44**	**44**	**278**
Normalised for Impairment	**(4,822)**	**(1,393)**	**(1,248)**	**145**	**(653)**	**(236)**	**(579)**	**(433)**	**(4,822)**

Appendix 3

Detailed Analysis Activity and Income Performance by Clinical Commissioning Group

Nene CCG

Activity

	Plan			Actual			Activity Variance		
Point of Delivery	**M1**	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Elective	470	470	448	470	505	464	0 Fav	35 Fav	16 Fav
Non elctive	2,135	2,206	2,135	2,408	2,608	2,497	273 Fav	402 Fav	362 Fav
days Case	2,428	2,428	2,313	2,814	2,783	2,538	386 Fav	355 Fav	225 Fav
Outpatienmts	22,034	22,034	20,985	23,187	23,152	22,101	1,153 Fav	1,118 Fav	1,116 Fav
Blocks									
others	7,193	7,193	7,193	223,059	221,446	221,931	215,866 Fav	214,253 Fav	214,738 Fav

Income

	Plan			Actual			Income Variance		
	M1	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	1,280	1,280	1,219	1,316	1,309	1,321	36 Fav	30 Fav	102 Fav
Non elctive	4,225	4,366	4,225	4,867	5,207	5,035	641 Fav	841 Fav	810 Fav
days Case	1,736	1,736	1,653	1,753	1,786	1,631	17 Fav	50 Fav	(23) Adv
Outpatients	2,153	2,153	2,050	2,323	2,318	2,194	170 Fav	165 Fav	144 Fav
Blocks	2,706	2,706	2,706	2,706	2,706	2,706	-	-	-
Others	2,634	2,634	2,634	2,686	2,771	2,761	52 Fav	137 Fav	127 Fav
Total	14,734	14,874	14,487	15,650	16,097	15,647	917 Fav	1,222 Fav	1,160 Fav
									3,299 Fav

Corby ccg

Activity

	Plan			Actual			Activity Variance		
Point of Delivery	**M1**	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Elective	8	8	8	8	12	12	(0) Adv	4 Fav	4 Fav
Non elctive	27	28	27	25	33	33	(2) Adv	5 Fav	6 Fav
days Case	18	18	17	33	35	35	15 Fav	17 Fav	18 Fav
Outpatienmts	186	186	177	111	134	121	(75) Adv	(52) Adv	(56) Adv
Blocks									

Income

	Plan			Actual			Income Variance		
	M1	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	22	22	21	17	24	15	(4) Adv	3 Fav	(5) Adv
Non elctive	75	78	75	51	116	119	(24) Adv	38 Fav	43 Fav
days Case	11	11	10	5	25	15	(6) Adv	14 Fav	5 Fav
Outpatienmts	18	18	17	11	14	12	(7) Adv	(3) Adv	(4) Adv
Blocks	130	130	130	130	130	130	-	-	-
Total	373	376	371	260	357	389	(113) Adv	(19) Adv	18 Fav
				84	180	162			(114) Adv

Specialised

Activity

	Plan			Actual			Activity Variance		
Point of Delivery	**M1**	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Elective	21	21	20	22	32	14	1 Fav	11 Fav	(6) Adv
Non elctive	294	303	294	187	161	222	(107) Adv	(142) Adv	(72) Adv
days Case	69	69	66	108	133	79	39 Fav	64 Fav	13 Fav
Outpatienmts	1,888	1,888	1,798	1,286	1,064	1,207	(602) Adv	(824) Adv	(591) Adv
Blocks									

Income

	Plan			Actual			Income Variance		
	M1	**M2**	**M3**	**M1**	**M2**	**M3 Estimate**	**M1**	**M2**	**M3 Estimate**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	70	70	67	72	107	62	2 Fav	37 Fav	(5) Adv
Non elctive	319	327	319	302	357	300	(17) Adv	30 Fav	(19) Adv
days Case	45	45	43	86	77	40	41 Fav	32 Fav	(3) Adv
Outpatienmts	162	162	153	127	110	120	(35) Adv	(52) Adv	(33) Adv
Blocks	555	555	555	536	536	536	(19) Adv	(19) Adv	(19) Adv
others	1,396	1,396	1,396	1,630	1,663	1,387	234 Fav	267 Fav	(9) Adv
	2,547	2,556	2,532	2,753	2,850	2,445	206 Fav	294 Fav	(88) Adv
									412 Fav

Note: The over levels of performance are against contract level of activity and not the internal capacity plan and do not include any fines or provisions.

Fines and Penalties

Fine/Penalty	Description of Fine / Penalty	Basis for Calculation	Included within Financial position	Maximum full year risk
A&E	Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department. Operating standard of 95%	2% of revenue derived from the provision of the locally defined service line in the quarter of under-achievement	50,000	**200,000**
Cancer 62 day wait	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer. Operating standard of 90%	2% of revenue derived from the provision of the locally defined service line in the quarter of under-achievement	50,000	**200,000**
C-Diff	Annual fine for breaches. Threshold set at 29.	Fines calculated using national formulae.	375,000	**1,500,000**
MRET	If the Trust's emergency activity value goes above a certain baseline then the Trust will only reimbursed at 30% of the normal income for the activity over above the baseline	The Trust will only received 30% of the relevant tariff for activity above the MRET baseline (set at 08/09 activity priced at 13/14 tariff)	600,000	**2,400,000**
Readmissions	National guidance states that: Providers should not be reimbursed for the proportion of readmissions judged to have been avoidable.	The agreed readmissions rate in the contract is 22.4%. The monthly plan is £200,000.	600,000	**2,400,000**
Challenges	Possible successful challenges from commissioners resulting in NGH having to provide a refund.	Estimated value based on previous years.	150,000	**600,000**
Case mix	Provision for possible increase in the value of activity once case mix data is costed.	Estimated value based on previous years.	100,000	**400,000**
Paeds diabetes	If the Trust cannot show compliance to the extensive list of criterion then commissioners may not pay for a the increased BPT tariff.	Assuming NGH will be able to show compliance for 85% of patients.	20,237	**80,948**
Data Quality payment retention	If Trust cannot comply with data requirements and timescales % of contract payment can be withheld	1% of contract value. Noted as a penalty not fine. Once data quality is satisfactory payment will be released	0	**1,900,000**
Ambulance handover Times	Fines can be levied if ambulance turnaround times are outside permitted parameters	Methodology within the contract currently being quantified however indication are that fines could be significant in the event of breach.		

CQUIN Delivery

Nene CCG & Associate CCG CQUINS					Year End Predicted RAG
	Indicator Number & Name	Contract Value %	Indicator Weighting %	CQUIN Value £'000	Q1
National 1 Friends & Family Test	1.1. Phased expansion of Friends and Family Test	0.0375%	1.5%	68	
	1.2 increase response rate to at least 20%	0.0500%	2.0%	91	
	1.3 Improve performance on staff Friends & Familty Test	0.0375%	1.5%	68	
National 2 NHS Safety Thermometer	2.2 50% reduction in all new Pressure Ulcers that are avoidable.	0.1250%	5.0%	228	
National 3 Dementia	3.1 Find, Assess, Investigate and refer	0.0750%	3.0%	137	
	3.2 Clinical Leadership	0.0125%	0.5%	23	
	3.3 Supporting Carers	0.0375%	1.5%	68	
National 4 VTE	4.1 95% of all adult inpatients to have a VTE risk assessment CQUIN payment to be received if both 4.1 and 4,2 are achieved	0.1250%	5.0%	228	
	4.2 VTE Root Cause Analysis. CQUIN payment to be received if both 4.1 and 4,2 are achieved				
Local 1	Development and implementation of AECP for Chest Pain	0.25%	10.0%	455	
Local 2	Development and implementation of AECP for Pulmonary Embolism	0.25%	10.0%	455	
Local 3	Development and implementation of AECP for Supraventricular Tachycardia	0.25%	10.0%	455	
Local 4	Development and implementation of AECP for Pleural Effusion	0.25%	10.0%	455	
Local 5	Development and implementation of AECP for Painless Jaundice	0.25%	10.0%	455	
Local 6	Development of HOT Clinic for Paediatrics	0.25%	10.0%	455	
Local 7	Development of HOT Clinic for Surgery	0.25%	10.0%	455	
Local 8	Development of HOT Clinic for Medicine	0.25%	10.0%	455	
Total	**CQUIN worth 2.5% of contract million**		100.0%	4,553,343	

	MESCG CQUINS				Year End Predicted RAG
	Indicator Number & Name	Contract Value %	Indicator Weighting %	CQUIN Value £'000	Q1
National 1 Friends & Family Test	1.1. Phased expansion of Friends and Family Test	0.0375%	1.5%		
	1.2 increase response rate to at least 20%	0.0500%	2.0%		
	1.3 Improve performance on staff Friends & Familty Test	0.0375%	1.5%		
National 2 NHS Safety Thermometer	2.2 50% reduction in all new Pressure Ulcers that are avoidable.	0.1250%	5.0%		
National 3 Dementia	3.1 Find, Assess, Investigate and refer	0.0750%	3.0%		
	3.2 Clinical Leadership	0.0125%	0.5%		
	3.3 Supporting Carers	0.0375%	1.5%		
National 4 VTE	4.1 95% of all adult inpatients to have a VTE risk assessment. CQUIN payment to bereceived if both 4.1 and 4,2 are achieved	0.1250%	5.0%		
	4.2 VTE Root Cause Analysis. CQUIN payment to bereceived if both 4.1 and 4,2 are achieved		0.0%		
	20% of specialist cquin value so proportions right but % wrong				
1	Quality Dashboards		20%		
NIC	Timely Simple Discharge		15%		
NIC	Improve access to breast milk in preterm infants		15%		
Renal	Acute Kidney Injury		30%		
Total	**CQUIN worth 2.5% of contract million**			660,807	

Appendix 6

2013/2014 Cost Improvement Delivery against Plan

Scheme	FY13/14 LTF £'000 R	A	G	Total Identified	FY13/14 Actual Delivery Against TDA Plan £'000 Planned Savings M2	Actual Delivery M2	Variance from Plan
A1: Surgery	50	262	134	446	136	84	52 Adv
A2: Anaesthetics	140	38	421	599	193	90	103 Adv
A3: T&O	150	365	31	546	124	55	69 Adv
A4: Head & Neck	224	76	270	570	98	68	30 Adv
A5: Child Health	224	72	272	568	98	60	38 Adv
A6: Obs & Gynae	250	140	193	584	132	46	86 Adv
SCG sub total	**1,039**	**952**	**1,321**	**3,313**	781	403	377 Adv
B1: General Medicine	236	748	1,043	2,028	510	424	86 Adv
B2: Oncology	152	54	275	481	115	89	26 Adv
B3: Pathology	92	57	432	581	105	104	1 Adv
B4: Radiology	118	76	167	361	91	75	16 Adv
B5: Pharmacy	100	38	221	359	26	7	19 Adv
B6: Therapies	-	-	12	12	27	0	26 Adv
MCG sub total	**699**	**973**	**2,150**	**3,821**	874	698	175 Adv
C1-7: Support Functions	-	29	674	702	214	212	3 Adv
C8: Facilities	162	371	351	883	229	260	(31) Fav
Support sub total	**162**	**399**	**1,024**	**1,585**	443	471	(28) Fav
Care Group & Corporate CIP Total	**1,899**	**2,325**	**4,496**	**8,719**	**2,097**	**1,573**	524 Adv
FYE of 12/13 Transformation Schemes	-	-	337	337	115	116	(1) Fav
Admin Review	-	-	108	108			-
Tactical HR (Enhancements) and BJA	-	-	120	120	30	328	(298) Fav
Tactical HR (Overtime)	-	-	154	154	39	89	(50) Fav
Outpatient Skill Mix	-	-	45	45			-
3rd party Pharmacy	-	-	29	29			-
Agency Nursing	-		1,447	1,447			-
Long term SSP withdrawn	-	-	30	30			-
Mattresses Total Bed Management	-	-	35	35			-
Locum Managed Service	-	-	175	175			-
Consultant Annual Leave Accrual	-	-	35	35			-
Salary sacrifice year 2 (technology & car sceme expansion)	-	-	96	96		18	(18) Fav
Unidentidied Directorate Schemes	181			181			-
Gap on Cip target unidentified	1,489			1,489			-
Total	**3,568**	**2,325**	**7,107**	**13,000**	**2,281**	**2,124**	157 Adv

Statement of Financial Position as at June 2013

TRUST SUMMARY BALANCE SHEET MONTH 3 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	340	339	(1)	396	396
IN YEAR MOVEMENTS	0	606	1,383	777	13,698	13,698
LESS DEPRECIATION	0	(1,730)	(2,595)	(865)	(10,184)	(10,184)
NET BOOK VALUE	**133,789**	**133,005**	**132,916**	**(89)**	**137,699**	**3,910**
CURRENT ASSETS						
INVENTORIES	4,934	4,860	4,911	51	4,862	(72)
RECEIVABLES						
NHS DEBTORS	4,103	6,389	10,057	3,668	4,214	111
OTHER TRADE DEBTORS	2,295	1,162	1,237	75	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	496	587	91	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,551	2,528	(23)	2,514	0
OTHER RECEIVABLES	676	889	832	(57)	675	(1)
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	1,594	1,904	310	2,053	666
	10,149	**12,123**	**16,187**	**4,064**	**10,925**	**776**
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	4,342	6,774	3,954	(2,820)	4,654	312
NET CURRENT ASSETS	**19,425**	**23,757**	**25,052**	**1,295**	**20,441**	**1,016**
CURRENT LIABILITIES						
NHS	628	1,554	1,418	136	4,411	(3,783)
TRADE CREDITORS REVENUE	1,255	1,595	2,236	(641)	2,921	(1,666)
TRADE CREDITORS FIXED ASSETS	1,744	1,082	972	110	1,876	(132)
TAX AND NI OWED	1,769	3,404	3,417	(13)	1,800	(31)
NHS PENSIONS AGENCY	2,013	2,138	2,145	(7)	2,030	(17)
OTHER CREDITORS	495	356	363	(7)	494	1
SHORT TERM LOANS	669	669	669	0	6,285	(5,616)
ACCRUALS AND DEFERRED INCOME	6,132	6,802	7,549	(747)	4,000	2,132
PDC DIVIDEND DUE	36	720	1,063	(343)	0	36
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	3,501	4,228	4,202	26	1,400	2,101
PROVISIONS over 1 year	1,281	1,281	1,281	0	1,298	(17)
NET CURRENT LIABILITIES	**20,309**	**24,615**	**26,101**	**(1,486)**	**27,144**	**(6,835)**
TOTAL NET ASSETS	**132,905**	**132,147**	**131,867**	**(280)**	**130,996**	**(1,909)**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115	0	102,899	2,784
REVALUATION RESERVE	32,486	32,828	32,828	0	32,893	407
DONATED ASSET RESERVE	0	0	0	0	0	0
I & E ACCOUNT BALANCE	304	304	304	0	304	0
I & E CURRENT YEAR	0	(1,100)	(1,380)	(280)	-5,100	-5,100
FINANCING TOTAL	**132,905**	**132,147**	**131,867**	**(280)**	**130,996**	**(1,909)**

2013/2014 Cash flow

	ACTUAL			FORECAST								
MONTHLY CASHFLOW	**APR £000s**	**MAY £000s**	**JUN £000s**	**JUL £000s**	**AUG £000s**	**SEP £000s**	**OCT £000s**	**NOV £000s**	**DEC £000s**	**JAN £000s**	**FEB £000s**	**MAR £000s**
RECEIPTS												
SLA Base Payments	17,721	19,030	15,721	25,095	17,479	17,479	21,302	17,479	17,479	21,302	17,479	17,479
SLA Performance / Other CCG investment												
Health Education Payments (SIFT etc)	22	1,511	764	699	699	699	699	699	699	699	699	699
Other NHS Income	2,923	877	1,596	1,511	1,514	1,150	1,150	1,150	1,150	1,150	1,150	1,150
PP / Other	892	1,096	655	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan					60	60	60	60	120	60	60	
EFL / PDC						2,784						
Temporary Borrowing						4,000						2,000
Interest Receivable	3	3	2	3	2	2	2	2	2	2	3	3
TOTAL RECEIPTS	21,562	22,518	19,067	28,408	20,854	27,274	24,313	20,490	20,550	24,313	20,491	22,431
PAYMENTS												
Salaries and wages	12,168	13,743	13,749	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745
Trade Creditors	4,499	7,344	5,805	8,000	7,000	7,000	6,500	6,000	6,000	6,000	5,500	2,829
NHS Creditors	1,617	1,296	1,619	1,614	1,614	1,614	1,614	1,614	1,614	1,614	1,000	1,000
Capital Expenditure	477	526	727	633	980	1,215	1,298	1,388	1,222	1,341	2,203	1,772
PDC Dividend						2,053						2,053
Repayment of Salix loan						161						203
TOTAL PAYMENTS	18,761	22,909	21,900	23,992	23,339	25,788	23,157	22,747	22,581	22,700	22,448	21,602
Actual month balance	2,801	-392	-2,833	4,416	-2,485	1,487	1,157	-2,256	-2,030	1,614	-1,957	829
Cash in transit & Cash in hand			74									
Balance brought forward	4,303	7,104	6,712	3,954	8,370	5,885	7,372	8,528	6,272	4,242	5,855	3,899
Balance carried forward	7,104	6,712	3,954	8,370	5,885	7,372	8,528	6,272	4,242	5,855	3,899	4,728

Enclosure L

2013/2014 Capital Programme

Category	Approved Annual Budget 2013/14 £000's	TDA M3 Plan £000's	Year to Date as at Month 3 M3 Plan £000's	M3 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 3 Actual Committed £000's	Plan Achieved
Linear Accelerator Corridor	400	0	0	0	0	0%	0	0%
Improving Birthing Environments	369	294	200	199	-1	54%	282	76%
Endoscopy	150	150	15	13	-2	9%	140	94%
Urodynamics	150	0	0	0	0	0%	0	0%
Haematology (Trust)	82	82	0	1	1	1%	23	28%
Annual Strategic Planning Approvals	1,000	0	0	0	0	0%	0	0%
MESC	1,518	174	93	91	-2	6%	242	16%
Estates	4,131	439	529	412	-117	10%	1,159	28%
IT	2,824	276	675	634	-41	22%	1,068	38%
Other	291	24	36	32	-4	11%	59	20%
Carbon Energy Efficiency Fund (CEEF)	2,784	0	0	0	0	0%	0	0%
Total - Capital Plan	**13,698**	**1,439**	**1,548**	**1,382**	**-165**	**10%**	**2,973**	**22%**
Less Charitable Fund Donations	-250	0	0	0	0	0%	0	0%
Total - CRL	**13,448**	**1,439**	**1,548**	**1,382**	**-166**	**10%**	**2,973**	**22%**

Resources - Trust Actual	
Internally Generated Depreciation	10,184
SALIX	480
CEEF	2,784
Total - Available CRL Resource	**13,448**

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 £1.00 million (was £1.193 million) available funding for 2013/14 - options for Electronic Document and Records Management will be discussed at the next meeting in July - approvals given for Oracle Licenses £56k, Surgical HOT Room £13k, Rowan Level 1 Monitoring £45k Room C Equipment £30k and Staff Identification / security £118k
- The Haematology scheme works are completed, although final account is still under dispute
- Full year depreciation forecast is currently £10.184 million and this will increase as the MES contract delays till 2014/15 financial year
- Charitable Donations assumptions for additions in year are £100k medical equipment & £150k from Mr Staden
- The Carbon Energy & Efficiency Fund has been added to the plan, this is DH funded and will be allocated as public dividend capital of £2.784 million

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	Note based on achievement of plan defcit
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	5	5	5	Note based on achievement of plan defcit
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	3	3	Note based on achievement of plan defcit
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	2	2	Note based on achievement of plan defcit
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		100%						2.6	2.8	2.8	2.8	
Overriding rules								2	3	3	3	
Overall rating								2	3	3	3	

Finance Risk Triggers (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	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	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	Yes		
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No		
6	Two or more changes in Finance Director in a twelve month period	No	No	Yes	Yes	Yes	Yes		
7	Interim Finance Director in place over more than one quarter end	Yes	No	No	No	No	No		
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	No		
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No		
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes	Yes	Yes		

Enclosure L

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Workforce Report
Agenda item	15
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Mark Ingram, Head of e-Workforce
Purpose	This is the monthly Human Resource report for July 2013 which focuses on the following Human Resource Workforce Indicators for Month 3: • Workforce Capacity • Workforce Expenditure • Health & Wellbeing • Workforce Development
Executive summary Substantive Workforce Capacity increased by 22.52 FTE equal to 89.64% contracted workforce against budgeted establishment. Temporary Workforce Capacity decreased to 6.10% (Trust target 5%). Over utilisation of temporary nursing staff is being monitored and strict restrictions on bank and agency use have been implemented. Total Sickness Absence has decreased to 3.90% (Trust target 3.8%). Calendar Days Lost to Sickness decreased by 376 to 5,411.	
Related strategic aim and corporate objective	Strategic Aim 4: Foster a culture where staff can give their best and thrive. Corporate Objective: To develop and implement new ways of engaging & supporting staff to enable them to achieve their potential
Risk and assurance	There is a risk (Pathology) identified under the section entitled Forecasts and Risks, which is to be brought to the Board's attention.
Related Board Assurance Framework entries	BAF 7: High bank & agency costs.
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	No
Actions required by the Board The Board is asked to discuss and support the on-going actions.	

Enclosure M

Northampton General Hospital NHS
NHS Trust

Trust Board Meeting
24 July 2013

Human Resources Workforce Performance Indicators (June 2013)

1. Introduction

This report identifies the key themes emerging from June 2013 performance and identifies trends against Trust targets.

2. Body of Report

This report focuses on the following topics:-

- Substantive Workforce Capacity
- Temporary Workforce Capacity
- Total Workforce Capacity
- Temporary Workforce Expenditure
- Staff Turnover
- Sickness Absence Rates
- Calendar Days Lost to Sickness Absence
- Sickness Absence by Reason
- Staff Appraisals
- Mandatory Training Compliance

3. Assessment of Risk

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

4. Recommendations/Resolutions Required

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

5. Next Steps

It is anticipated that the format of the next HR Workforce Performance Indicators Report will change; this is subject to approval of the revised format by the Integrated Healthcare Governance Committee.

Enclosure M

WORKFORCE CAPACITY

Substantive Workforce Capacity increased by 22.52 FTE from 3,977.45 FTE to 3,999.64 FTE which is below the plan (4,462.10 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has increased by 0.27% to 89.64%.

Substantive Workforce Capacity

Directorate	Month 2 Contracted (FTE)		Month 3 Contracted (FTE)		Budgeted Establishment (FTE)	M3 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	243.78	↓	243.10	↑	275.25	-11.68%	-32.15
Child Health	223.49	↓	218.26	↑	242.18	-9.88%	-23.92
Facilities	288.64	↓	284.00	↑	350.66	-19.01%	-66.66
General Medicine	915.74	↑	919.02	↑	1035	-11.21%	-115.98
General Surgery	230.34	↑	260.62	↓	256.19	1.73%	4.43
Head & Neck	114.91	↑	119.87	↑	133.9	-10.48%	-14.03
Hospital Support	293.54	↑	295.52	↑	399.96	-26.11%	-104.44
Medical & Dental	473.72	↓	466.99	↑	477.33	-2.17%	-10.34
Obstetrics & Gynaecology	328.53	↓	328.17	↑	348.33	-5.79%	-20.16
Oncology & Clinical Haematology	203.64	↓	208.56	↑	200.09	4.23%	8.47
Pathology	176.69	↓	169.78	↑	192.57	-11.83%	-22.79
Pharmacy (Dir)	101.34	↑	102.28	↓	116.22	-11.99%	-13.94
Radiology	114.06	↑	113.46	↓	125.52	-9.61%	-12.06
Therapy Services (Dir)	65.71	↑	67.73	↑	85.3	-20.60%	-17.57
Trauma & Orthopaedics	203.00	↓	202.28	↑	223.6	-9.53%	-21.32
Grand Total	**3977.12**	↑	**3999.64**	↑	**4462.1**	**-10.36%**	**-462.46**

Temporary Workforce Capacity decreased by 0.11% to 6.10% and remains above the planned Temporary FTE of 5%.

Temporary Workforce Capacity

Directorate	Month 2 Temporary Workforce (FTE)		Month 3 Temporary Workforce (FTE)	Temporary Workforce Capacity M3 (Percentage)	M3 Variance Against Target (5%) (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	17.01	↓	14.72	5.71%	0.71%	1.83
Child Health	11.82	↓	11.37	4.95%	-0.05%	-0.11
Facilities	6.75	↑	8.15	2.79%	-2.21%	-6.46
General Medicine	111.55	↑	118.00	11.38%	6.38%	66.15
General Surgery	30.64	↓	26.30	9.16%	4.16%	11.95
Head & Neck	8.21	↓	7.29	5.73%	0.73%	0.93
Hospital Support	23.64	↓	20.99	6.63%	1.63%	5.17
Medical & Dental	N/A		N/A	N/A	N/A	N/A
Obstetrics & Gynaecology	7.89	↑	8.58	2.55%	-2.45%	-8.26
Oncology & Clinical Haematology	17.57	↓	15.89	7.08%	2.08%	4.67
Pathology	8.23	↑	8.65	4.85%	-0.15%	-0.27
Pharmacy (Dir)	0.00	↑	0.00	0.00%	-5.00%	-5.11
Radiology	0.00	↑	0.15	0.13%	-4.87%	-5.53
Therapy Services (Dir)	5.21	↓	4.93	6.78%	1.78%	1.29
Trauma & Orthopaedics	14.68	↑	14.88	6.85%	1.85%	4.02
Grand Total	**263.18**	↓	**259.89**	**6.10%**	**1.10%**	**46.91**

Total Workforce Capacity (including Temporary Staff) % FTE against budgeted establishment FTE has increased by 0.18% from 95.28% to 95.46%.

Total Workforce Capacity (including Temporary Staff)

Directorate	Month 2 Total Workforce (FTE)		Month 3` Total Workforce (FTE)		Budgeted Establishment (FTE)	M3 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	260.78	↓	257.82	↑	275.25	-6.33%	-17.43
Child Health	235.31	↓	229.63	↑	242.18	-5.18%	-12.55
Facilities	295.39	↓	292.15	↑	350.66	-16.69%	-58.51
General Medicine	1027.28	↑	1037.02	↓	1035	0.20%	2.02
General Surgery	260.98	↑	286.92	↓	256.19	11.99%	30.73
Head & Neck	123.11	↑	127.16	↑	133.9	-5.04%	-6.74
Hospital Support	317.18	↓	316.51	↑	399.96	-20.86%	-83.45
Medical & Dental	N/A		N/A		N/A	N/A	N/A
Obstetrics & Gynaecology	336.42	↑	336.75	↑	348.33	-3.32%	-11.58
Oncology & Clinical Haematology	221.21	↑	224.45	↓	200.09	12.18%	24.36
Pathology	184.92	↓	178.43	↑	192.57	-7.34%	-14.14
Pharmacy (Dir)	101.34	↑	102.28	↑	116.22	-11.99%	-13.94
Radiology	114.06	↓	113.61	↑	125.52	-9.49%	-11.91
Therapy Services (Dir)	70.92	↑	72.66	↑	85.3	-14.82%	-12.64
Trauma & Orthopaedics	217.68	↓	217.16	↑	223.6	-2.88%	-6.44
Grand Total	**4240.30**	↑	**4259.53**	↑	**4462.1**	**-4.54%**	**-202.57**

Temporary Workforce Expenditure has increased by £28,703 from £1,370,024 to £1,398,727 which is equal to 9.68% of the total workforce expenditure.

Staff Turnover (leavers) has increased by 0.01% on the month to 9.18%, which remains above the Trust target of 8%.

Staff Turnover (leavers)

Directorate	Month 1 Turnover (Percentage)		Month 2 Turnover (Percentage)		Month 3 Turnover (Percentage)	M3 Variance Against Target (8%) (Percentage)
Anaesthesia, Critical Care & Theatres	5.53%	●	5.51%	●	5.27%	-2.73%
Child Health	15.71%	●	14.89%	●	14.74%	6.74%
Facilities	6.76%	◆	6.97%	●	6.80%	-1.20%
General Medicine	7.73%	●	7.72%	●	7.58%	-0.42%
General Surgery	8.90%	●	8.06%	◆	9.04%	1.04%
Head & Neck	7.70%	●	5.25%	●	5.18%	-2.82%
Hospital Support	17.14%	●	16.91%	●	16.80%	8.80%
Medical & Dental	7.49%	●	7.01%	●	5.48%	-2.52%
Obstetrics & Gynaecology	7.13%	◆	7.31%	◆	7.86%	-0.14%
Oncology & Clinical Haematology	10.02%	◆	10.77%	◆	10.77%	2.77%
Pathology	13.25%	◆	14.83%	◆	15.18%	7.18%
Pharmacy (Dir)	7.87%	◆	8.95%	◆	9.02%	1.02%
Radiology	4.50%	◆	6.70%	◆	7.55%	-0.45%
Therapy Services (Dir)	13.30%	◆	13.62%	●	13.36%	5.36%
Trauma & Orthopaedics	7.44%	◆	8.19%	◆	8.60%	0.60%
Grand Total	**9.11%**	◆	**9.17%**	◆	**9.18%**	**1.18%**

HEALTH AND WELLBEING

Short Term Sickness Absence has increased by 0.19% to 2.08% (Trust target 1.6%).
Long Term Sickness Absence has decreased by 0.31% to 1.81% (Trust target 2.2%).
Total Sickness Absence has decreased by 0.11% to 3.90% (Trust target 3.8%).
Year to Date Total Sickness Absence has increased by 0.06% to 4.35%

Sickness Absence Rates

Directorate	Short Term Sickness Rate (Target 1.6%)		Long Term Sickness Rate (Target 2.2%)		Total Sickness Rate (Target 3.8%)	
	May-13	Jun-13	May-13	Jun-13	Apr-13	Jun-13
Anaesthesia, Critical Care & Theatres	2.23%	3.97%	3.04%	1.55%	5.27%	5.52%
Child Health	0.94%	1.88%	1.43%	1.20%	2.37%	3.08%
Facilities	1.69%	2.26%	2.30%	2.34%	3.99%	4.60%
General Medicine	3.00%	2.93%	2.29%	1.59%	5.29%	4.52%
General Surgery	1.24%	1.92%	3.46%	1.73%	4.70%	3.65%
Head & Neck	1.80%	1.69%	2.61%	2.79%	4.41%	4.48%
Hospital Support	0.01%	0.02%	1.26%	1.69%	1.28%	1.71%
Medical & Dental	1.87%	1.44%	2.40%	2.61%	4.28%	4.05%
Obstetrics & Gynaecology	2.34%	2.64%	1.79%	1.51%	4.13%	4.16%
Oncology & Clinical Haematology	1.39%	2.08%	2.35%	3.13%	3.74%	5.21%
Pathology	2.01%	1.17%	2.15%	2.15%	4.15%	3.33%
Pharmacy (Dir)	0.83%	1.07%	0.66%	0.65%	1.48%	1.73%
Radiology	1.44%	0.92%	3.03%	2.54%	4.48%	3.46%
Therapy Services (Dir)	1.56%	1.81%	1.15%	1.12%	2.71%	2.93%
Trauma & Orthopaedics	3.54%	3.24%	1.37%	0.97%	4.91%	4.20%
Grand Total	**1.89%**	**2.08%**	**2.12%**	**1.81%**	**4.01%**	**3.90%**

Calendar Days Lost to Sickness decreased by 376 from 5,787 to 5,411.
No. Days Lost to Sickness per Employee decreased by 0.09 from 1.24 days to 1.15 days.

Calendar Days Lost to Sickness Absence

Directorate	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	May-13	Jun-13	May-13	Jun-13	Apr-13	Jun-13
Anaesthesia, Critical Care & Theatres	188	329	248	120	436	449
Child Health	98	159	124	90	222	249
Facilities	164	201	246	240	410	441
General Medicine	992	932	805	570	1797	1502
General Surgery	132	180	308	179	440	359
Head & Neck	78	69	93	120	171	189
Hospital Support	197	138	248	240	445	378
Medical & Dental	2	3	186	240	188	243
Obstetrics & Gynaecology	293	307	216	180	509	487
Oncology & Clinical Haematology	101	146	154	210	255	356
Pathology	116	69	124	120	240	189
Pharmacy (Dir)	30	39	31	30	61	69
Radiology	59	33	124	90	183	123
Therapy Services (Dir)	45	40	31	30	76	70
Trauma & Orthopaedics	261	248	93	59	354	307
Grand Total	**2756**	**2893**	**3031**	**2518**	**5787**	**5411**

Sickness Absence by Reason

Sickness Reason	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	May-13	Jun-13	May-13	Jun-13	May-13	Jun-13
Burns, poisoning, frostbite, hypothermia	3	0	0	0	3	0
Substance abuse	0	27	0	0	0	27
Blood Disorders	6	12	0	0	6	12
Asthma	16	19	0	0	16	19
Skin disorders	25	22	0	0	25	22
Dental and oral problems	15	19	0	0	15	19
Endocrine / glandular problems	17	20	31	30	48	50
Eye problems	103	45	0	0	103	45
Nervous system disorders	30	50	0	0	30	50
Heart, cardiac & circulatory problems	21	13	31	30	52	43
Infectious diseases	36	40	0	0	36	40
Headache / migraine	83	91	0	0	83	91
Benign and malignant tumours, cancers	27	22	62	120	89	142
Other musculoskeletal problems	122	350	310	150	432	500
Ear, nose, throat (ENT)	91	108	62	60	153	168
Injury, fracture	169	119	62	150	231	269
Pregnancy related disorders	89	139	62	60	151	199
Back Problems	209	162	61	30	270	192
Chest & respiratory problems	73	111	31	30	104	141
Gastrointestinal problems	265	216	30	29	295	245
Genitourinary & gynaecological disorders	103	116	154	119	257	235
Other known causes - not elsewhere classified	253	356	217	150	470	506
Cold, Cough, Flu - Influenza	200	181	0	0	200	181
Anxiety/stress/depression/other psychiatric illnesses	179	344	494	300	673	644
Unknown causes / Not specified	621	311	1424	1260	2045	1571
Total	**2756**	**2893**	**3031**	**2518**	**5787**	**5411**

WORKFORCE DEVELOPMENT

Appraisals are centrally recorded on OLM and are reported on a cumulate 12 month basis. The percentage of staff with completed appraisals for June 2013 was 28.04%, compared to 26.22% the previous month. A Task and Finish Group is progressing with reviewing the appraisal reporting mechanisms.

Mandatory Training Compliance increased in June 2013 by 0.35% to a Trust total compliance of 65.75%.

Mandatory Training Compliance

Directorate	Month 1 (Percentage)	Month 2 (Percentage)	Month 3 (Percentage)	Variance Against Target (100%) (Percentage)
Anaesthesia, Critical Care & Theatres	71.02%	70.76%	71.53%	28.47%
Child Health	78.08%	78.94%	80.89%	19.11%
Facilities	55.04%	54.20%	55.87%	44.13%
General Medicine	67.25%	67.51%	67.89%	32.11%
General Surgery	68.92%	70.20%	70.55%	29.45%
Head & Neck	61.97%	60.81%	59.80%	40.20%
Hospital Support	60.78%	63.27%	63.26%	36.74%
Medical & Dental	48.29%	48.11%	48.65%	51.35%
Obstetrics & Gynaecology	62.24%	62.75%	62.79%	37.21%
Oncology & Clinical Haematology	66.39%	66.37%	66.52%	33.48%
Pathology	70.18%	70.13%	69.36%	30.64%
Pharmacy (Dir)	74.85%	75.22%	73.52%	26.48%
Radiology	77.22%	77.57%	78.24%	21.76%
Therapy Services (Dir)	76.22%	78.54%	78.02%	21.98%
Trauma & Orthopaedics	68.29%	67.59%	67.09%	32.91%
Grand Total	**65.14%**	**65.40%**	**65.75%**	**34.25%**

Forecasts and Risks

Nursing temporary staff total utilisation (Bank & Agency Filled) was 28,173.27 hours (173.4 FTE), which is an increase of 347.55 hours (2.16 FTE) compared with the previous month.

Bank fill rate = 53.19% (decrease of 6.03%), Agency fill rate = 22.70% (increase of 3.66%).

Total bank & agency fill rate = 75.89% (decrease of 2.37% compared with the previous month).

Over utilisation of temporary nursing staff is being monitored and strict restrictions on bank & agency use have been implemented.

Nine of the 15 Directorates have increased their Mandatory Training compliance within Month 3 and there has been a small percentage increase of 0.35% on Month 2 overall in Trust compliance. There is currently a review of Mandatory Training subjects and the findings of this will be shared with Integrated Healthcare Governance Committee in August 2013.

REPORT TO THE TRUST BOARD
DATE: 24 JULY 2013

Title	Transformation Programme Update
Agenda item	16
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Craig Porter – Assistant Director of Transformation
Purpose	To provide assurance on the delivery of the Transformation Programme.

Executive summary

Section 1 of this report presents an overview of the current and forecast positions of the Transformation Programme:

1. The Transformation Programme latest thinking forecast delivery is £11.3m savings against a plan of £13.0 m for 2013/14.

2. Month 3 cumulative financial delivery is adverse to planned delivery reported to the National Trust Delivery Authority (NTDA) by £157K

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.

Section 2 of the report sets out a revised approach to Transformation. This was considered and approved by Finance Committee on 17th July 2013.

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 20
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Enclosure N

Actions required by the Board

The Board is asked to:

- Note Month 3 cumulative delivery of the 2013/14 Transformation Programme
- Approve the adoption of a new model for delivering cost improvements.

Section 1.

Board Meeting
July 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 £11.3m.

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

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

- The upside latest thinking forecast at M3 is £11.3m (4.3%), against the £13m required delivery, off plan by £1.7m.
- A mitigation pipeline of schemes to the potential value of £1.2m has been developed through the Trust Strategic Executive Team which if delivered in full and the current LTF achieved (£12.5m 4.8%) leaves a residual minimum mitigation requirement of £0.5m to achieve the plan of £13m.
- The plan submitted to the TDA required delivery of £2.28m in the first 3 months. Actual delivery is £2.12m, off plan by £157k, 93% of the plan.

3. Transformation programme delivery

- Care Group and Corporate CIPs are currently off plan by £181k. A significant element of the shortfall is due to under-recovery of income specifically within best practice tariff for orthopaedics and maternity income.
- The LTF for the care groups has improved by £293k over the position reported in M2. Care Group Directors have signed off the additional schemes as part of confirm and challenge sessions with the finance team.
- There has been a significant acceleration in month 3 on the agency run rate reduction. At the end of month 3 a £298k year on year reduction in nursing agency expenditure has been achieved. The forecast LTF has increased based on the current run rate reduction continuing.
- The restriction on overtime continues to deliver financial savings in excess of the monthly requirement, although there has been an increase in month 3 compared to the preceding two months. Managers within the Trust whose areas have experienced an increase have in Month 3 are working with their HR Business Partners to ensure that authorisation compliance is maintained.

Impact of health economy QIPP

- Initial CCG that the impact of schemes to the value of £6.5m had been identified which would impact upon the Trusts income for QIPP in 2013/14.
- The Trust as part of the Transformation programme in the previous years has reduced capacity within the Trust, notably the bed base based on QIPP impact analysis. The current identified CCG plan is £3.6m. The plans have been refreshed by the CCG and outline Point of Delivery (POD) and specialty mix. The current plans do not sufficiently deliver a critical mass of OBDs, outpatient sessions or attendances which would enable significant opportunities to reduce our cost.

- A planning assumption of the marginal cost saving associated with QIPP is £1.08m. Unlike prior years transformation programme, the reduction in Trust costs relating to QIPP have not been included within the Transformation Plan.
- Two major elements of the plan were to reduce A&E attends and reduce non-elective admissions. Phasing by the CCG on both of these schemes at the end of Q1 was to reduce spend by £143k in A&E and for NEL by £243k. At the end of M3 both A&E and NEL activity is in excess of contract.
- We will continue to work collaboratively with the CCG PMO to identify opportunities and develop trigger points for QIPP delivery which enable the Trust confidently implement schemes which enable the reduction in associated costs.
- The County Leaders Group are to establish a QIPP board to oversee QIPP implementation across the health economy.

4. Mitigation to achieve the plan and Identification of additional schemes and cost improvement initiatives

The Strategic Executive Team has considered the schemes to mitigate the current shortfall within the programme to the value of £1.2m. The potential schemes have been reviewed by the Transformation Delivery Group. These opportunities are over and above the current LTF and the value represents the potential 2013/14 in year financial impact.

- Care Groups have identified an additional £293K of schemes which are currently under development and QIAs being finalised. These have been signed off by the Care Group Directors as part of the consolidation process of M3 and are therefore contained in the LTF.
- Additional mitigation to the value of £1.2m has been reviewed by the Transformation Delivery Group and the Strategic Executive Team. These opportunities are over and above the current LTF and the value represents the potential 2013/14 financial impact.
- The opportunities have been prioritised and work plans for the priority one schemes are being developed and will undergo quality impact assessment. The Transformation Delivery Group will drive the development of the schemes and monitor implementation via the respective Executive Sponsors.
- Schemes for 2014/15 have also been identified and additional capacity has been sourced to support the Trust PMO bring these schemes to delivery.

5. Quality Impact Assessment

Quality Impact Assessments have been signed off for the current schemes in delivery. The quarter one dashboard is attached to this report as appendix 1.

- The baseline metrics have now been completed and systems are now in place to capture the data. As new schemes arise full QIAs will be produced and their metrics added to the scorecard.
- The Care Groups have identified a number of schemes to mitigate their current LTF which have QIAs under development.
- One scheme has been formally rejected based on quality impact assessment. Mobile optometry has been removed following due diligence and assessment of anticipated benefits

6. Risk Assessment

The Trust is over trading at the end of M3 against the contract activity plan agreed with CCG in the 2013/14 Contract. This is impacting upon the non-pay savings plans developed by care groups.

- All schemes, including individual Care Group, Corporate and Trust wide initiatives have been RAG rated.

- The upside latest thinking forecast (£11.3m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.
- The downside assessment of current schemes has been assessed based on none of the red rated schemes are achieved and 75% of the amber rated schemes deliver the identified financial benefits.
- Utilising this methodology agreed at the Finance Committee at its meeting in June 2013, the downside case based on current RAG rating would see the programme realise £8.84m.
- The focus of the TDG will be to ensure that we convert the red schemes into delivery and bring the mitigation schemes.

7. Conclusions

Month 3 financial delivery showed a variance of £73k adverse to the plan submitted to the NTDA and a cumulative variance of £157k. To date the Trust have delivered 93% against the NTDA plan.

Some schemes contained within the Care Groups require re-phasing to bring delivery forward to ensure that any delivery risk is identified early and contingency and mitigations to be developed

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.

8. 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.

Enclosure N

Section 2.

Trust Board

24 July 2013

Transformation (Quality & Efficiency Improvement)

1. Introduction

There is a national requirement for 4% cost efficiency year on year, leading to an annual cost improvement programme for the Trust of around £13m. The Trust is now in its 3rd year of transformation and it is acknowledged that delivering cost improvement in a traditional manner will not achieve the required savings needed over the next 2 years or indeed longer term. This paper outlines a revised approach to delivering those efficiency savings and integrates the approach within a broader organisational development strategy.

2. From Transformation to Quality and Efficiency Improvement

The Trust has delivered £29.6m CIP over 2 years equating to 4% CIP each year. The approach has included some aspects of what may be considered transformational however by and the large the approach has been to adopt percentage CIPs applied to directorates plus trust wide pay and non- pay programmes. This approach is not sustainable long term and therefore a new approach needs to be adopted if we are to deliver the on-going cost improvements. This new approach must not impact adversely on quality; rather it must deliver improvements in quality at the same time as driving down cost and increasing efficiency.

2.1 Quality, Safety and Efficiency as an Organising Principle.

In 2012, research by Grant Thornton identified that the average Trust CIP target was £5.1%, of which 4.8% on average was saved. The report states that in a health care environment that has to deliver such significant savings, there must be engagement of clinicians in improving efficiency and cost effectiveness will not be deliverable as indicated by Grant Thornton:

"It is clear that those trusts that have a major focus on continually improving standards appear significantly more successful at delivering on-going financial savings. Reducing waste or duplicate appointments improves quality but also saves money".

There is an increasing view that by concentrating on redesigning services and processes to drive up quality and reduce waste, this could lead to services being delivered in a more cost effective and productive way thus leading to cost reductions.

20-30% of health spending is waste with no benefit to patients.... to reconstruct a health care industry that is both affordable and relentlessly focussed on meeting the needs of every single patient and family, a waste reduction is the best strategy by far"

Don Berwick M.D.

Adopting a quality driven approach has been taken in a number of organisations both nationally *(Salford Royal et al)* and internationally *(Virginia Mason Medical Centre et al)*.

The evidence from organisations that have adopted a rigorous and systematic approach to driving up quality demonstrates that they have undoubtedly achieved significant quality improvements, however what is often lacking is the failure to directly correlate quality improvement with cost reductions, productivity increases or efficiency measurements.

The challenge for NGH therefore is to be able to effectively combine quality improvement with cost reduction and develop a method whereby the actual costs of delivery, and failures in delivery, are clearly identified and built into transformation programmes.

Our vision is to deliver highest quality and highest value care by integrating quality, patient safety, and cost improvement and engaging all our staff around delivering this thereby enabling us to achieve viable and sustainable cost reductions:

Making Quality Count!

This approach will see a focus and energy on implementing quality and safety improvements and clearly identifying the benefits that will flow from this including:

- Cost reductions,
- Efficiency improvements e.g. throughput and flow leading to reduced length of stay
- Improved productivity, leading to the ability to deliver more with fewer resources
- Improvements in patient experience
- Reduction in costly patient safety incidents
- Redesigned pathways that improve patient experience and efficiency
- Reduction in unnecessary waste and duplication
- Rationalisation/elimination of unnecessary, non-value added activities that improve cost effectiveness
- Improvements in levels of staff engagement and commitment.

The new approach will see the development of new ways of measurement and tracking to ensure that qualitative improvements result in reliable, deliverable costs savings.

2.2 Changing the Focus

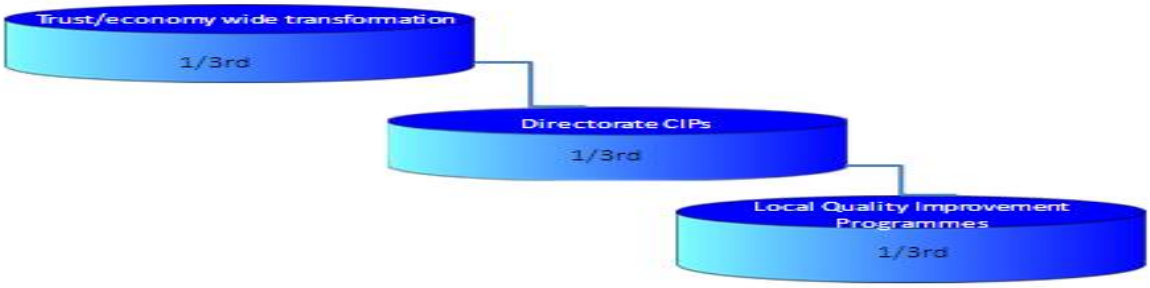
Not only will we look at cost improvement in a different way but we will also deliver it in a different way.

The traditional approach has been that:

- Approximately 70% of the CIP target is given to directorates to identify and deliver traditional CIP programmes, by requiring 5% savings against the overall directorate/Care Group budget
- The remaining 30% of CIP has been linked to trust wide CIP.

As indicated above, it would be unwise to assume that continuing to adopt this approach, which lends itself leads to transactional methods of cost reduction, will deliver the level of savings required.

We need therefore to shift from the traditional 70% directorate CIPs and 30% trust wide programmes to approximately a third, a third, and a third approach. It is therefore proposed that the future approach would be as follows:



This does not necessarily mean that 30% of costs will come from each area but that the **drivers** for ideas and change will come from those areas. For example a trust wide transformation programme could improve efficiency and reduce costs across all care groups, therefore the savings and benefits are within Care Groups.

In spreading the levels of engagement and thereby increasing the numbers of staff involved in delivering quality and efficiency improvements this will widen our channels for new sources of ideas and engage the knowledge and expertise of staff to identify and deliver improvements that will have the impact on their service and therefore improve rather than reduce quality.

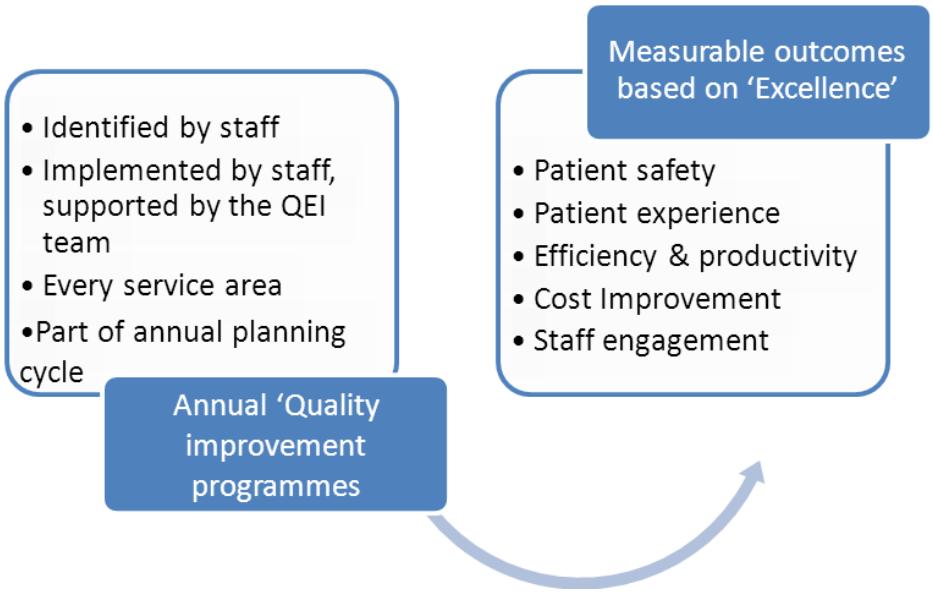
As such the programme will shift to increasingly driven from the bottom up, by involving all staff within Care Groups and Corporate Directorates to deliver quality and safety improvements that lead to improvements in other aspects of Trust performance.

This will work on the following basis:

Trust/economy wide transformation:
This will entail the Quality & Efficiency Improvement team (QEI team - formerly the Transformation team), based on external horizon scanning and internal expertise, identifying opportunities to improve services and reduce costs across the whole trust, or significant parts of it.

Directorate CIP's:
All directorates will, as now, need to continue to deliver cost improvements targets.

Local Quality improvement programmes:
The greatest change will be in introducing local quality improvement programmes. An annual programme will be developed based on diagnostics undertaken in service areas and staff/team ideas. It will look like this:



In order to drive this forward there will be a development programme focussed on quality, safety and efficiency improvements that will not be optional. As part of this there will be an agreed NGH improvement methodology developed, supported by a toolkit that helps teams identify, develop and implement change cycles.

It should be noted that the traditional Quality Impact Assessments will be strengthened to become a Quality and Staff Impact Assessment, which considers the impact on staff and staff engagement as part of this process.

2.3 Changing Mind-sets

As with any change simply changing the label from CIP or Transformation will not in itself create a momentum for change. Whilst the focus on *quality, safety and efficiency as an organising principle,* will undoubtedly create some of the mind-set shift, we also need to think differently about how we consider cost and this will require us to educate staff and raise awareness of what cost & financial effectiveness means in practice.

A key aspect of the change will therefore be to equip people with the knowledge and skills to be able to do this. To achieve this Quality and Efficiency Improvement team will work with staff to start to view financial effectiveness based on the following:

- Adopting a **sustainable approach** to cost reductions: for example lokign for ways to innovate and work differently rather than cost cutting.
- Understanding **where our key costs lie** and how resources are consumed.
- Understanding the **return on investment**
- Continually seeking to **improve and save** (*quality, safety and efficiency as an organising principle*
- **Ownership** of costs: all staff consume costs and all staff must have an interest in using those resources effectively and containing cost wherever possible.

In this way we aim to help staff to understand the importance of continuously improving our performance, both in terms of quality but also cost effectiveness.

2.5 Summary Overview

The overall approach is based on:

What will be different?

- Using quality improvements to drive down cost and increase efficiency and effectiveness
- Quality improvements will be systematically identified, measured and monitored with a robust process for identifying tangible financial benefits. There will be new forms of identifying costs e.g. the cost of patient failures. The quality and financial benefits will be identified and tracked using key performance indicator metrics, in conjunction with the revised Quality & Staff Impact Assessment tracking.
- Adopting an integrated strategic approach to quality and cost, rather than isolated initiatives
- Engaging staff through a bottom up approach to quality improvement, in which quality improvement is everyone's responsibility and is a continuous process rather than an 'initiative'.
- Motivating staff to make a difference and empowering them to make change happen in the right way, by finding ways to incentivise teams to deliver quality and efficiency improvements.

What will remain unchanged?

- Existing governance and reporting arrangements to ensure we deliver the year on year CIP target, albeit with a clearer escalation process for programmes that appear to be heading off track.
- Accountability for delivery - which lies at the point of delivery and where the resources are owned.
- On-going annual Cost Improvement Programmes.

2.6 Conclusion

This is more than simply a different way of delivering CIPs; rather it is part of a broader organisational development strategy that creates more cohesive way of doing business and improving overall organisational effectiveness and performance. This will be achieved by:

- Using quality & safety to drive improvements to deliver reductions in cost and improvements in productivity and efficiency.

- Reframing the financial challenge around improving quality and patient safety which will engage staff and motivate them to become involved.

- Changing how we think about cost improvement and educating and developing staff to help them to make a difference.

- Developing new (and unique) methods of costing quality improvements and quality failures that will enable us to tie cost improvement into quality improvement and create a sustainable means of continuously improving efficiency and cost effectiveness.

Achieving such an organisational change of this significance will not happen overnight. Therefore we will continue to run our current approach in parallel for the remainder of this financial year and into the next financial year.

To support this new way of working, the Transformation team will be reconfigured as the Quality and Efficiency Improvement team (QEI) and will provide expertise in service improvement,

business process redesign, quality improvement. Additionally the team will be expanded to ensure an integrated approach around staff engagement, change management, leadership and management development.

3. Assessment of Risk

There is a risk, as with any change programme, that the change could shift the focus away from in year transformational programme delivery, thus impacting on our ability to deliver £13m savings for 2013/14.

This risk is being mitigated by bringing in an interim team to focus on in year delivery whilst the development of the new structure and system will be managed by the Director of Workforce & Transformation. This will include building the team, the process, infrastructure and costing methodologies that will enable us to implement and embed the approach over the next 2 years

4. Recommendations/Resolutions Required

The Board/Committee is asked to endorse the proposal to move towards a new model of delivery.

Janine Brennan
Director of Workforce and Transformation.

2013/14 Transformation Quality Impact Assessment Scorecard

APPENDIX 1

	Workstream	Changes planned	Metric	Frequency	Monitoring Group	Target	RAG descriptor	Mar-13	Apr-13	May-13	Jun-13	Comments
Carried forward from 2012/13	Theatres	None	Utilisation (trust)	Project team		>85%	R = < 75%, A = 75%-84%, G = 85%	72.5%	76.1%	75.9%	74.5%	
			Utilisation (Danetre - Theatre & procedure room)				R = < 75%, A = 75%-84%, G = 85%	60.5%	51.0%	53.5%	55.5%	
			Utilisation (DSU)				R = < 75%, A = 75%-84%, G = 85%	69.7%	72.8%	67.0%	70.0%	
			Utilisation (Eyes)				R = < 75%, A = 75%-84%, G = 85%	64.4%	66.8%	63.0%	66.8%	
			Utilisation (Gynae)				R = < 75%, A = 75%-84%, G = 85%	78.0%	77.8%	77.3%	79.2%	
			Utilisation (Main)				R = < 75%, A = 75%-84%, G = 85%	73.5%	77.8%	80.0%	75.9%	
			Utilisation (Manfield)				R = < 75%, A = 75%-84%, G = 85%	77.5%	83.5%	84.3%	83.0%	
			Cancelled sessions due to equipment issues					0	1	8	0	
			Cancellations on the day for non-clinical reasons - Excl Beds			<35 pts	R = 45, A = 35-45, G = <35	13	31	36	5	
			Complaints - theatres	Project team		0	R = > 5/m, A = < 5/m, G = 0		0	2	1	
			Never events						0	0	0	
			Serious incidents - theatres					0	0	0	0	
			Session overrun (Late finish)					4.3%	4.5%	4.4%	4.0%	
	Workforce Bank & Agency	Recruitment of nursing staff to reduce use of bank & agency staff.	Safety Thermometer (Harm free %)	Monthly	Nursing & Midwifery Board	95% from Dec	R = < 85%, A = 85-90%, G = > 90%		93%	91%	92%	
			Patient experience - Family & Friends question	Monthly	Nursing & Midwifery Board	80			60	67	62	
	Admin Review	Pooling and standardising of administrative staff and medical secretaries. Rationalisation and standardisation of junior managers.	Average turnaround time for clinic letters in days (Medicine) - areas not using digital dictation	Monthly	Manual audit	5 days	R = over 5 days, G = 5 days or under					
			Average turnaround time for clinic letters in days (Medicine) - areas using digital dictation	Monthly	Digital dictation system	5 days	R = over 5 days, G = 5 days or under		7.92	6.24	5.83	
			Average turnaround time for clinic letters in days (Surgery) - areas not using digital dictation	Monthly	Manual audit	5 days	R = over 5 days, G = 5 days or under					
			Average turnaround time for clinic letters in days (Surgery) - areas using digital dictation	Monthly	Digital dictation system	5 days	R = over 5 days, G = 5 days or under		8.01	12.15	4.08	
	Therapies	Reconfiguration of therapy staff to link to Care Group structures	Response time to referral within 1 working day - Physio	Monthly	Therapies Governance Group	100%	R = <99%, G = >99%	99.70%	99.80%	99.90%		June data currently being validated
			Response time to referral within 1 working day - OT	Monthly	Therapies Governance Group	100%	R = <99%, G = >99%	82.60%	89.20%	87.50%		
			% of repeat patient contacts not seen within 1 working day - Physio	Monthly	Therapies Governance Group	<7%	R = >12%, A = 7% - 12% G = <7%	17%	18%	13%		
			% of repeat patient contacts not seen within 1 working day - OT	Monthly	Therapies Governance Group	<7%	R = >12%, A = 7% - 12% G = <7%	14%	13%	24%		
	Pharmacy	Continuation of pricing and practice changes	Datix incidents relating to contract changes				R = > 0, G = 0	0	0	0	1	June is mitigated
	Pathology	Restructure management & admin	Pathology quality management report aggregate	Monthly	Pathology Directorate Management Board	100%	R = < 80%, A = 80-90%, G = 90-100%	75%	100%	100%	100%	
GM 04/06	General Medicine	Savings through vacancies, band reductions or flexible working reductions	WTE against budgeted establishment	Monthly	Admin managers & service managers	100%	R = <75%, A = 75-100%, G = 100%	95.71	96.08	90.8	90.16	
			Link to admin review metrics re: typing turnaround time	Monthly		5 days	R = over 5 days, G = 5 days or under		7.92	6.24	5.83	
			Complaints	Monthly		0	R = >1, A = 1, G = 0		0	0	0	
GM 08		Improved ward rosters	E-roster report - spend on agency staff	Monthly	Ward managers & matrons							As per finance report
			Sickness absence	Monthly		< 3.5%	R = > 3.5%, G = < 3.5%	4.55	4.71	4.9		
			% Annual leave taken in-year	Monthly								
			Complaints	Monthly		0	R = >1, A = 1, G = 0		7	5	7	
TO 02	Trauma & Orthopaedics	Changes to NORTH team to include more therapeutic lead than nursing.	Length of stay for hips	Monthly	Care Group Board		R=> 5 days, A=5 days or less, G=<3 days	4	4	5.73	3	
			Length of stay for knees	Monthly			R=> 5 days, A=5 days or less, G=<3 days	4.13	3.37	4.31	3.85	
			Re-admissions	Monthly			R=>3 A= 1-2, G=0	2	2	2	3	
			Wound infections	Monthly			R=>2, A=1, G=0	0	0	1	0	
			Post-op pain relief	Monthly			R=>2, A=1, G=0	0	0	0	0	
			Post-op complications	Monthly			R=>6, A= 5, G = 1	1	0	0	0	
TO 03		Band reduction from 7 to 6	Datix reported incidents relating to fracture clinic nursing	Monthly	Care Group Board	0	R = >1, A = 1, G = 0		0	0	0	
			Complaints relating to fracture clinic nursing	Monthly		0	R = >1, A = 1, G = 0		0	0	0	
CH 10	Child Health	Play specialist downgrade	Sickness absence	Monthly	Child Health Management Team	<3.5%	R = > 3.5%, G = < 3.5%	3.93	2.8	1.96		
CH 12		Vacancy factor while recruiting	Paediatric oncology reported incidents	Monthly	Paediatric Risk Management	< 4 / month	R = > 4 / month, G = < 4 / month		0	0	0	
CH 13		Vacancy factor while recruiting	Complaints about community paediatrics	Monthly	Divisional governance team	1 or less / month	R = > 1 per month, G = 1 or less		0	0	0	
			11 week breaches for new referrals	Monthly		0	R = 1 or more, G = 0	0	0	0	0	
OG 06	Obstetrics & Gynaecology	Band reduction from 4 to 3.	Sickness absence	Monthly	O&G Matron's team meeting	< 3.5%	R = > 3.5%, G = < 3.5%	4.52	4.09	3.75		
ON 02	Oncology & Haematology	Radiotherapy band 7 to band 6	CQUIN target for IMRT	Monthly	Directorate management board	33%						This target has been changed as per the commissioners to 24%, the data captured was against the old target. Therefore for this quarter this data is unavailable.
ON 04		Radiotherapy reduction in hours	Staffed Linac Hours	Monthly	Directorate management board	28hrs per week	R = <28.00, G = > 28.00		26.62	29.06	28.05	
ON 05		Radiotherapy mid-point vacancy										
ON 08		Chemotherapy OPD - matron led service (non-recurrent)	Clinical adverse events	Monthly	Directorate management board	5	R= <5, G= >5			37	29	
ON 10		Medical Physics band 8a	No additional downtime	Monthly	Local management meeting	2% downtime	R = <98.00, G = > 98.00		98	99	98	
PA 03	Pathology	General Haematology nursing vacancy band 4	Pathology quality management report aggregate	Monthly	Directorate management board	100%	R = < 80%, A = 80-90%, G = 90-100%					
PA 10		Antenatal vacancies income						48.30%	38.70%	47.20%	47.20%	
PNS 01 and	Patient & Nursing Services	Post removal currently vacant (0.85 WTE band 8b) Post reduction budget lint (0.08 WTE)	Safety Thermometer outcomes	Monthly	Nursing & Midwifery Board				93%	91%	92%	
			Incidence of pressure ulcers	Monthly					10	8	9	
			FFT Score	Monthly					60	67	62	
			FFT Response rate	Monthly					7%	9%	16%	

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Self-Certification Return
Agenda item	11
Sponsoring Director	Clive Walsh, Chief Operating Officer
Author(s)	Craig Sharples, Head of Corporate Affairs Christine Johnson, Information Manager
Purpose	Decision and Assurance on compliance with the NHSTDA compliance framework

Executive summary

The NHS Trust Development Authority (TDA) published the accountability framework for NHS Trust Boards in April 2013. The framework outlines the TDA's approach to:

- Oversight of NHS Trusts – assessing organisations to "determine whether we believe an organisation is delivering high quality care."
- Development and support for organisations moving to become Foundation Trusts.
- The approval of Foundation Trust applications, of transactions and of business cases or capital investment.

A key element of the oversight regime identified by the TDA is the self-certification process which is based on compliance with a number of the conditions within Monitor's Provider Licence and a set of Board Statements. This process is replacing Single Operating Model self-certification which has been completed by the Board historically.

This paper outlines the new process and presents the new compliance requirements including evidence based assessment for the committee to consider prior to the Board signing off the self-certification.

The governance and finance declaration for June 2013 is; Governance Risk Rating (Amber Red), Financial Risk Rating (2).

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 Board is asked to review the content of the submission and:

- Approve the self-certification returns for Monitor Compliance and Board Statements based upon the evidence provided.
- Approve the signing of declaration two of the Single Operating Model .

NHS Trust Development Authority (TDA) – Self Certification

Introduction

The NHS Trust Development Authority (TDA) published the accountability framework for NHS Trust Boards in April 2013. The framework outlines the TDA's approach to:

- Oversight of NHS Trusts – assessing organisations to "determine whether we believe an organisation is delivering high quality care."
- Development and support for organisations moving to become Foundation Trusts.
- The approval of Foundation Trust applications, of transactions and of business cases or capital investment.

A key element of the oversight regime identified by the TDA is the self-certification process which is based on compliance with a number of the conditions within Monitor's Provider Licence and a set of Board Statements. This process is replacing Single Operating Model self-certification which has been completed by the Board historically.

This paper outlines the new process and presents the new compliance requirements including evidence based assessment for the committee to consider prior to the Board signing off the self-certification.

NHS TDA Self-Certification Requirements

The self-certification process as outlined within the NHS TDA Accountability Framework is based on compliance with a number of conditions within Monitor's Provider Licence and a set of Board statements related to quality governance and statutory compliance.

Monitor's new Provider Licence and requires the Trust to confirm compliance against 12 conditions contained within Monitor's new requirements for provider licence as follows:

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. Condition G5 – Having regard to monitor Guidance.
3. Condition G7 – Registration with the Care Quality Commission.
4. Condition G8 – Patient eligibility and selection criteria.
5. Condition P1 – Recording of information.
6. Condition P2 – Provision of information.
7. Condition P3 – Assurance report on submissions to Monitor.
8. Condition P4 – Compliance with the National Tariff.
9. Condition P5 – Constructive engagement concerning local tariff modifications.
10. Condition C1 – The right of patients to make choices.
11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

Appendix one of the report details the Monitor Provider Licence conditions including an assessment of the Trust's compliance against the conditions with the evidence used to inform that assessment.

Appendix two of the report details the Board statements. It should be noted that the statements are similar to those statements which the Board have signed off historically as part of the Single Operating Model self-certification.

The TDA have requested that until their oversight and escalation process is fully 'up and running' that Trusts continue to submit elements of the old format Single Operating Model self-certification, namely – governance indicators, financial risk ratings, quality and contracts (the intention is for the TDA analytical team to compute these from national data sources/financial returns in the fullness of time).

Appendix three of the report contains the governance indicators, financial risk ratings, quality indicators and contract information required for submission – complete for June 2013.

Once completed, the self-certifications require formal sign off by the Board then submission to the TDA before the last working day of the month. The self-certification is then used to inform the agenda at the regular Trust/TDA oversight meetings.

Recommendations

The Board is asked to review the content of the submission and:

- Approve the self-certification returns for Monitor Compliance and Board Statements based upon the evidence provided.
- Approve the signing of declaration two of the Single Operating Model .

Craig Sharples

Head of Corporate Affairs

July 2013

APPENDIX 1 – MONITOR LICENCE CONDITIONS

License Condition	Description	NGH Compliance	Assurance
G4 – Fit and Proper Persons Test	This condition requires that licenses do not allow unfit persons to become or continue as Governors or Directors. "Unfit persons are: undischarged bankrupts, individuals who have served a prison sentence of three months or longer during previous five years, and disqualified directors. A company may also be an unfit person.	Compliant	• Standing Orders • Standing Financial Instructions • Code of Conduct for Boards • Code of Conduct for Shadow Governors • Draft FT Constitution • Monitor Code of Governance Compliance
G5 – Monitor Guidance	This condition requires licensees to have regard to any guidance that Monitor issues.	Compliant	NGH complies with all mandatory Monitor (and TDA) guidance and would always consider Monitor's best practice guidance as and when published.
G7 – Registration with the Care Quality Commission (CQC)	This condition reflects the obligation in the Health and Social Care Act 2012 for licensees to be registered with the CQC. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully provide services.	Compliant	• Current CQC Registration • Monthly QRP reporting to the Integrated healthcare Governance Committee • Annual CQC assurance report to the Board. • Active CQC compliance regime audited regularly.
G8 – Patient Eligibility and Selection Criteria	The condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.	Compliant	Adherence with the Prior Approvals Policy Signposting to the CCG websites from the Trust website.

APPENDIX 1 – MONITOR LICENCE CONDITIONS

License Condition	Description	NGH Compliance	Assurance
P1 – Recording of Information	Under this licence condition, Monitor may require licensees to record information, particularly information on their costs, in line with approved guidance Monitor will publish. The licence condition is worded in a way that any costs and other information that may be required can be collected from both licensees and their sub-contractors. This licence condition may also require licensees to record other information, such as quality and outcome data, in line with Monitor guidance and for the purpose of carrying out Monitor's pricing functions.	Compliant	• Care Group level income and expenditure, quality, outcome and activity reporting monthly to Board, IHGC, Finance, SMB and Care Groups with supporting narrative explaining main variance from plan. • Monthly returns to the TDA on plan.
P2 – Provision of Information	Under this condition, once the information has been recorded in line with Licence Condition P1, Monitor can request licensees to submit this data.	Compliant	The Trust would comply with Monitor's requests for information.
P3 – Assurance Report on Submissions to Monitor	Under this condition, Monitor may require licensees to submit an assurance report confirming the accuracy of the data they have provided under License Condition P2.	Compliant	The Trust would comply with Monitor's request for an assurance report.
P4 – Compliance with the National Tariff	This licence condition imposes the obligation to charge for NHS healthcare services in line with the National Tariff. *The Health and Social Care Act 2012 defines the National Tariff as a document published by Monitor, so Pricing Condition 4 will not apply until Monitor publish the National Tariff (expected to be 2014/15)*	Compliant	Activity is charged in line with National Tariff where applicable.

APPENDIX 1 – MONITOR LICENCE CONDITIONS

License Condition	Description	NGH Compliance	Assurance
P5 – Constructive Engagement Concerning Local Tariff Modifications	This licence condition requires licensees to engage constructively with commissioners and to try and reach a local agreement before applying to Monitor for modification.	Compliant	The Trust will engage constructively with commissioner to try and reach a local agreement before applying to Monitor (or the TDA) for a local modification.
C1 – The Right of Patients to Make Choices	This condition: • Requires licensees to tell their patients when they have a choice of provider and to tell them where they can find information about the choices they have – this must be done in a way that is not misleading. • Requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour one provider over another and is presented in a manner that helps patients to make well-informed choices. • Prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services.	Compliant	The Trust complies with the patient choice requirements of the NHS Constitution. Gifts and Hospitality Policy in place.
C2 – Competition Oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of distorting competition to the extent it is against the interest of health care users. It also prohibits the licensee from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent it is against the interests of health care users.	Compliant	The Trust is cognisant of the Competition Act and Merger Laws and responds accordingly

APPENDIX 1 – MONITOR LICENCE CONDITIONS

License Condition	Description	NGH Compliance	Assurance
IC1 – Provision of Integrated Care	This condition requires the licensee to not do anything that could be reasonably regarded as detrimental to enabling integrated care. The purpose of this licence condition is to enable Monitor to step in where integrated care is not being delivered, in spite of decisions and efforts made by commissioners.	Compliant	The Trust works in an integrated manner with commissioners and partner organisations e.g. County wider urgent care programme.

APPENDIX 2 – NHS TDA SELF-CERTIFICATION BOARD STATEMENTS

Board Statement	NGH Compliance	Assurance/Actions Required for Compliance
FOR QUALITY THAT:		
1. The Board is satisfied that, to the best of its knowledge and using its own processes and having regard to the TDA's oversight mode; (supported by the 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 purposes of monitoring quality of healthcare provided to its patients.	Compliant	Reports to the Board, Integrated Healthcare Governance Committee, CQEG.
2. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Compliant	Reports to the Board, Integrated Healthcare Governance Committee, CQEG.
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.	Compliant	Medical revalidation report to the Board.
FOR FINANCE THAT:		
4. The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.	Risk	The Trust has submitted a deficit plan for 2013/14. A financial recovery plan has been developed and is with the TDA for comment and agreement. Timescale for compliance: September 2013
FOR GOVERNANCE THAT:		
5. The Board will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.	Risk	The Trust is not meeting its national performance targets. See statement 10 for further details.
6. All current key risks to compliance with the NTDA's Accountability Framework 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.	Compliant	Board Assurance Framework Finance Report to the Board Performance Report to the Board

Board Statement	NGH Compliance	Assurance/Actions Required for Compliance
7. The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	Compliant	Board Assurance Framework Finance Report to the Board Performance Report to the Board
8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Board are implemented satisfactorily.	Compliant	Integrated Business Planning Cycle agreed by the Board Integrated Business plan in place Performance Management Framework Monthly performance reporting Board Assurance Framework Corporate Risk Register Risk Management Strategy
9. 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	Compliant	Annual Governance Statement in place. Head of Internal Audit Opinion.
10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.	Risk	The Trust is failing or is at risk of failing the following targets: • A&E 4 hour transit time • Cancer - 62 Days • C.Diff Full action plans have been presented to the Board with trajectories for compliance. Updates are presented to the Board on a monthly basis. Timescale for compliance: December 2013

Board Statement	NGH Compliance	Assurance/Actions Required for Compliance
11. The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Compliant	The Trust achieved level 2 for the Information Governance for 2012/13. Assurance from Internal Audit.
12. 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.	Compliant	Standards of Business Conduct Policy Register of Interests in place. Board vacancies currently being recruited to. Board members signed up to NHS Code of Conduct for Board members.
13. 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.	Compliant	Outcomes of external Board assessments – Deloitte Job descriptions for Board members Appraisal process in place for Board members. Board development programme being implemented.
14. The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Compliant	Outcomes of external Board assessments – Deloitte Job descriptions for Board members Appraisal process in place for Board members. Board development programme being implemented. Board vacancies filled with interims whilst active recruitment for substantive post holders is underway.

NHS Trust Governance Declarations : 2013/14 In-Year Reporting

Name of Organisation:	#REF!	Period:	#REF!

Organisational risk rating

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

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	AR
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	2

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

Signed by :		Print Name :	Sonia Swart
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer (Interim)	
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:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

QUALITY

Information to inform the discussion meeting

#REF!

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	Board Action
1	SHMI - latest data	Score	106.0	106.0	106.0	104.8	104.8	104.8	107.8	107.8	107.8	110.9	110.9	110.9	
2	Venous Thromboembolism (VTE) Screening	%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	92.36%	93.10%	95.50%	
3a	Elective MRSA Screening	%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	99.90%	99.50%	99.70%	
3b	Non Elective MRSA Screening	%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	96.40%	96.95%	98.00%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	14	11	10	13	14	24	19	25	35	41	35	51	18 new SI's reported during the month (15 of which were pressure ulcers - 6 from May). +4 SI's remain onging 29 remain pending awaiting closure from CCG
6	"Never Events" occurring in month	Number	0	1	0	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	1	0	0	
9	RED rated areas on your maternity dashboard?	Number	1	2	2	4	1	1	2	1	1	3	1	1	The one red rated area relates to the number of women whose labour was induced which was recorded as 25.5% againgst a target of <25%.
10	Falls resulting in severe injury or death	Number	2	2	0	2	3	1	0	2	1	1	2	2	2 falls during June: 1 x moderate and 1 x severe. Both awaiting EMR / SI investigation.
11	Grade 3 or 4 pressure ulcers	Number	2	0	2	3	7	7	6	3	6	3	6	7	June 2013 pressure ulcer incidents = 7 in total. This consisted of 3 x grade 3 avoidable and 4 x grade 3 unavoidable incidents.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	
13	Formal complaints received	Number	48	33	35	44	40	24	68	57	52	45	58	37	

14	Agency as a % of Employee Benefit Expenditure	%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	6.60%	6.60%	6.90%	6.94%	6.90%	
15	Sickness absence rate	%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	4.11%	4.01%	3.90%	
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

#REF!

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								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	Note based on achievement of plan defcit
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	Note based on achievement of plan defcit
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	Note based on achievement of plan defcit
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	2	2	Note based on achievement of plan defcit
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.6**	**2.8**	**2.8**	**2.8**	
Overriding rules								2	3	3	3	
Overall rating								**2**	**3**	**3**	**3**	

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	3

1	Two Financial Criteria at "1"				
2	Two Financial Criteria at "2"	2			

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

FINANCIAL RISK TRIGGERS

#REF!

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	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	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	Yes	Yes	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	Yes	Yes	Yes	Yes	Yes	
7	Interim Finance Director in place over more than one quarter end	Yes	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	No	No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes	Yes	Yes	Yes	

GOVERNANCE RISK RATINGS

#REF!

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 #REF!	Historic Data #REF!	Historic Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	No	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	No	No	No	No	June 2013 unverified performance: 62 day urgent GP referrals 82.9% (9.5 patients breached out of a total of 55.5 treated) Q1 preliminary position not achieved at 82.2%
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									

Quality	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	**1.0**	No	No	No	No	Yes	No	No	June 2013 = 93.42% Q1 / YTD 2013-14 = 92.56%
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	**1.0**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	**1.0**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	**1.0**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**0.5**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	**0.5**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	**0.5**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	**1.0**	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	**1.0**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	There were 13 cases of C-Diff in Q1 2013 against a YTD target trajectory of 8.
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 29*		Yes	Yes	Yes	No	No	No	No	
	4b	MRSA	Is the Trust below the de minimus	*6*	**1.0**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 0*		No	No	No	Yes	Yes	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	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	No	No	No	No	No	No	No	
				TOTAL		**1.0**	**1.0**	**3.0**	**2.0**	**1.0**	**2.0**	**2.0**	
						AG	AG	AR	AR	AG	AR	AR	

RAG RATING :

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

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

CONTRACTUAL DATA

#REF!

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

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Risk Management Strategy
Agenda item	18
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Risk and Litigation Manager Governance Facilitator
Purpose	For approval

Executive summary

Risk Management is an integral part of good clinical and corporate governance and the Trust has adopted an approach to risk management that ensures that risks are managed accordingly. Where risks cannot be addressed internally by the Trust they are considered alongside other partners such as commissioners of services. This approach is clearly defined within the Risk Management Strategy presented to the Board for approval.

This strategy covers the following aspects and applies to all risk related activities within the Trust:

- •The organisational risk management structure
- •How organisational risks are reviewed by the Trust Board and their committees and sub-committees
- •The roles, responsibilities, processes and structures for managing risk locally
- •How compliance with this strategy will be monitored

Related strategic aim and corporate objective	All
Risk and assurance	The strategy provides the framework for the management of risk within the Trust
Related Board Assurance Framework entries	The Risk Management Strategy underpins the Board Assurance framework
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	Strategy ensures compliance with legislation including the Health and Safety at Work Act and CQC/Monitor/NHSLA compliance

Actions required by the Board

The Board is asked to approve the Risk Management Strategy

Northampton General Hospital NHS
NHS Trust

This document is uncontrolled once printed.
Please refer to the Trusts Intranet site for the most up to date version

RISK MANAGEMENT

NGH-SY-426

Ratified By:	Trust Board
Date Ratified:	July 2013
Version No:	V12.4
Supersedes Document No:	NGH-SY-426 v11
Previous versions ratified by (group & date)	For previous versions See version control summary
Date(s) Reviewed:	July 2013
Next Review Date:	July 2014
Responsibility for Review:	Director of Nursing Midwifery & Patient Services / Head of Corporate Affairs
Contributors:	Senior Risk and Litigation Manager

STRATEGY

CONTENTS

VERSION CONTROL SUMMARY

Version	Date	Committee	Comments
v1	April 2003	Trust Board	
v2	December 2004	Trust Board	
v3	December 2005	Trust Board	
v4	August 2006	Trust Board	
v5	September 2007	Trust Board	
v6	September 2008	Trust Board	
v7	October 2009	Trust Board	
v8	September 2010	Trust Board	
v9.2	January 2011	Trust Board	
v9.3	February 2011	Trust Board	
v10	October 2011	Trust Board	
V11	July 2012	Trust Board	
V12.4	July 2013	Trust Board	Draft presented for approval

STATEMENT OF INTENT

Northampton General Hospital NHS Trust's vision is to provide the very best care for all of our patients. This requires the Trust to be recognised as delivering safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community.

The complexity of healthcare and the ever-growing demands to meet health care needs means that there will always be an element of risk in providing high quality, safe health care services; this document sets out the strategic direction for how the Trust intends to meet these demands and builds on the strategic direction set out in the previous Northampton General Hospital NHS Trust Risk Management Strategy.

INTRODUCTION

Northampton General Hospital NHS Trust recognises that the nature of providing healthcare means that risk is inherent in everything we do and as an organisation. This requires identification, management and minimisation of risks that could cause unnecessary risks to patients, staff and visitors. The management of risk is a key organisational responsibility and involves all staff being aware of risk and understanding their responsibilities for managing it. This is a key component of providing good quality care to patients.

The Trust has a legal duty to deliver safe care to patients and to ensure that Northampton General Hospital is a safe place to work and visit. Failure to manage risks effectively can result in injury; loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation or unwanted publicity.

Risk Management is an integral part of good clinical and corporate governance and the Trust has adopted an approach to risk management that ensures that risks are managed accordingly. Where risks cannot be addressed internally by the Trust they are considered alongside other partners such as commissioners of services.

This strategy sets out the structure and processes in place to manage risks in the Trust and should be read in conjunction with the Assessment and Management of Risk Policy, the Quality Strategy, the Patient Safety Strategy, the Quality Impact Assessment Policy and the Being Open Policy (for a full listing of associated policies see section11). This Risk Management Strategy also covers the requirements of the Care Quality Commission; the NHS Litigation Authority, Commissioners, other quality assurance processes and any recommendations following Royal College reviews.

1. PURPOSE

The purpose of this strategy is to set out the framework for managing risks at Northampton General Hospital NHS Trust.

2. SCOPE

This strategy covers the following aspects:

- The organisational risk management structure
- How organisational risks are reviewed by the Trust Board and their committees and sub-committees
- The roles, responsibilities, processes and structures for managing risk locally
- How compliance with this strategy will be monitored

This strategy applies to all risk related activities (e.g. corporate, financial, clinical, non-clinical, and health and safety) and to all Trust premises, staff employed by the Trust, including persons engaged in business on behalf of the Trust. The effectiveness of the strategy will be reviewed by key stakeholders who are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public Board meetings, the Health Watch and the local Overview and Scrutiny Committees.

3. COMPLIANCE STATEMENTS

Equality & Diversity

This document has been designed to support the Trust's effort to promote Equality and Human Rights in the work place and has been assessed for any adverse impact using the Trust's Equality Impact Assessment tool as required by the Trust's Equality and Human Rights Strategy. It is considered to be compliant with current equality legislation and to uphold the implementation of Equality and Human Rights in practice.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

Duty of Candour

Every individual who comes into contact with the Northampton General Hospital should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs aspirations and priorities and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staffs communicate clearly and openly with patients, relatives and carers

Health & Safety

This documents is designed to support the Trust Health and Safety Policy commitment to ensure so far as reasonably practicable the health, safety and welfare at work of our employees and others who may affected by our workplace and work activities, both on and off Trust premises in accordance with current legal duties and best practise.

4. DEFINITIONS

Risk	The potential of an unwanted outcome or the possibility of incurring misfortune or loss, which may be in relation to people, buildings, equipment, systems, management, finance, the Trust's reputation or the achievement of corporate objectives.
Risk Management	The use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives.(see appendix 9 for Risk Management Model Matrix)
Board Assurance Framework	The Board Assurance Framework is used for the effective and focused management of the principal risks to meeting the Trust objectives. It also provides a structure for the evidence to support the Annual Governance Statement
Corporate Risk Register	A register comprising risks rated 15 and above identified through risk registers and /or high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), claims, complaints, and PALs.
Risk Register	A register comprising of all risks identified through locally owned risk registers which may include high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), claims, complaints, and PALs.
CAS Alerts	The NHS Central Alerting System that identifies and issues safety alerts, emergency alerts, drug alerts, Alerts letters (registered individuals) and Medical Device Alerts on behalf of the Medicines and Healthcare products Regulatory Agency, Estates and Facilities Alerts; Field Safety Notices, any internal alerts and the Government Department of Health
Annual Governance Statement	is the Annual Governance Statement is a public accountability document that describes the effectiveness of internal controls in an organisation and is personally signed by the Accountable Officer and forms part of the Annual Report and Accounts

5. ROLES & RESPONSIBILITIES

5.1 Roles and Responsibilities of Individuals

The following individuals have responsibilities for risk as summarised below:

Role	Responsibilities
Chief Executive	Accountable Officer for risk management at Northampton General Hospital NHS Trust, which includes signing the Annual Governance Statement but has delegated the roles as listed below. The CEO is in attendance at Finance; IHGC and Trust Board.
Medical Director	Executive Directors with delegated responsibility for the management of clinical risk within the framework approved by the Trust Board. The Medical Director is the named Caldicott Guardian. Joint chair of the Clinical, Quality and Effectiveness Group and in attendance at IHGC and Trust Board.
Caldicott Guardian	Responsibility for ensuring that organisational risks associated with protecting the confidentiality of patients and service-user information and with information sharing are managed effectively with the Trust
Director of Nursing Midwifery & Patient Services	Executive Directors with delegated responsibility for the management of clinical risk within the framework approved by the Trust Board. Joint chair of the Clinical, Quality and Effectiveness Group; SI; Infection Prevention committee and director with responsibility for infection control and also attendance at IHGC and Trust Board.
Director of Finance	Executive Director with delegated responsibility for financial risk management, including financial probity, Standing Financial Instructions (SFIs), financial schemes of delegation
Director of Strategy and Partnerships	Executive Director has responsibility for contracting, market development, clinical coding and medical records, information management, and service improvement provision. The Director of Strategy and Partnerships is the named SIRO
Senior Information Risk Owner (SIRO)	The SIRO has overall accountability and responsibility for Information Governance in the Trust, specifically: • Acting as an advocate for information risk on the Trust Board • Ensuring the Trust Board is adequately briefed on information risk issues. • Ensuring the Trust's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff • Providing assurance, through the Annual Governance Statement that all risks to the Trust, including those relating to information, are effectively managed and mitigated • Raising the profile of information risks, embedding information risk management into the overall risk management culture of the Trust.

Role	Responsibilities
Director of Facilities and Capital Development	Executive Director with delegated responsibility for Health & Safety, Security and Fire.
Deputy Director of Nursing	Deputising for the Director of Nursing Midwifery & Patient Services The Deputy Director of Nursing is the chair of Safeguarding groups.
Deputy Director of Quality and Governance	Deputising for the Director of Nursing Midwifery & Patient Services where there are responsibilities for risk and risk management.
Executive Directors	Responsibility for ensuring that the risk management framework approved by Trust Board is implemented across the organisation and is embedded within their teams. Responsibility for managing the Trust's principal risks which relate to their directorates, for example, Director of Workforce & Transformation is responsible for managing the Trust's principal risks related to workforce planning.
Executive Team	The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to the CEO for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the Trust's Scheme of Delegation. Receives and moderates the Corporate Risk Register and Board Assurance Framework for consideration by the Integrated Healthcare Governance Committee (IHGC) Ensures that the Board Assurance Framework appropriately reflects principle risks, controls and assurances, including the identification of new risks Reviews the Board Assurance Framework for consideration by the Audit Committee and Trust Board
Other Trust Board Members including Non-Executive Directors	Collective responsibility for ensuring that risk is an integrated element of all major discussions and decisions and that the risk management processes are providing them with adequate and appropriate information and assurances relating to risks to the Trust's objectives. The Non executives are nominated to chair a number of the meetings such as IHGC; Audit Committee.
Care Group Management Team	Responsibility for ensuring that arrangements for identifying, assessing and managing risk as set out in the Assessment and Management of Risk Policy are embedded within their Care Groups. Each Directorate within a Care Group has an established and active governance structure which reports into a Directorate Management Board and Directorate Governance Committee; these in turn report directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks

Role	Responsibilities
Directorate Governance Lead	Responsibility for ensuring that the Directorate Risk Register is reviewed at Directorate Governance meetings; appropriate measures are put in place to mitigate risks and that High and Medium risks are reported to Care Group Governance and Clinical Quality and Effectiveness Group
All members of staff	Responsibility for ensuring that risks are identified, reported, assessed and managed in accordance with this strategy
Head of Corporate Affairs	Responsibility for managing and reporting on the systems of internal control, including the Risk Management Strategy, Board Assurance Framework and Corporate Risk Register. The Head of Corporate Affairs is responsible for monitoring and reporting the corporate risk register to the Trust Board
Deputy Director of Quality & Governance	Responsibility for leading the implementation of the Risk Management Strategy.
Senior Risk and Litigation Manager	Responsibility for ensuring that clinical and non-clinical risk management processes are appropriately followed; effective processes are in place for managing risk including CAS alerts; training programmes are in place to support a pro-active risk culture; the organisation learns from adverse events to minimise risk in future. Monitoring the completion of the Clinical and Support Directorate risk registers and reporting as necessary.
Health and Safety Manager	Responsibility for ensuring that organisational risks associated with Health and Safety legislation (including training) are managed effectively across the trust and that appropriate systems are in place to support this.

5.2 Roles and Responsibilities of Committees/ Sub-Committees

The following committees have responsibilities for risk as summarised below:

Roles	Responsibilities of Committees/ Sub-Committees
Trust Board	The Trust Board is responsible for ensuring that the Trust has an effective programme for managing all types of risk and receives and considers the Board Assurance Framework on a quarterly basis and the Trust risk register at least annually. The Trust Board is responsible for approving the Risk Management Strategy to identify and ensure strategic risks are managed effectively and ensuring mitigating actions are taken over an agreed timeframe.
Audit Committee	The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives. IHGC and the Audit Committee shall hold bi-annual meetings to

Roles	Responsibilities of Committees/ Sub-Committees
	ensure that systems are integrated between the committees and across the organisation and to jointly review all corporate risks. All risks 15 and above are reviewed by the joint meeting. The Audit Committee reviews the Board Assurance Framework and seeks assurance on specific key risks as part of a rolling programme. (full terms of reference can be found in appendix 1)
Integrated Healthcare Governance Committee (IHGC)	The Integrated Healthcare Governance Committee (IHGC) is a committee of the Board and responsibility for ensuring an effective system of integrated governance, risk management, performance, workforce and internal control across the clinical activities of the organisation that support the organisation's objectives. In conjunction with the Audit Committee and the Finance Committee, IHGC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation. (full terms of reference can be found in appendix 2)
Clinical Quality and Effectiveness Group (CQEG)	CQEG reports to the Integrated Healthcare Governance Committee (IHGC) and is responsible for reviewing, challenging and moderating on a quarterly basis the high and moderate risks on Care Group and Directorate Risk Registers; assuring IHGC that risk is managed effectively within the Care Group and Directorates; and raising any issues of concern to IHGC. Oversees the operation of directorate processes and ensures directorates are working collaboratively to manage risks. (full terms of reference can be found in appendix 3)
Finance Committee	The Finance Committee (FC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management and internal control across the finance activities of the organisation that support the organisation's objectives. In conjunction with the Audit Committee and the IHGC Committee, FC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation. Reviews all Quality Impact Assessments and ensures that all risks to achievement the project are identified and assessed in line with Trust Board policy. (full terms of reference can be found in appendix 4)
Strategic Management Board (SMB)	SMB is responsible for identifying and escalating risks as appropriate. This includes identifying directorate risks that should be factored into wider business planning processes. Reports any areas of concern relating to Quality Impact Assessments to IHGC. (full terms of reference can be found in appendix 5)
Care Group Boards	The Care Group Board is established as the key assurance and

Roles	Responsibilities of Committees/ Sub-Committees
(CGB)	decision making group of the Care group in relation to operational performance, quality, safety, risk, and strategic planning. It reports to the Clinical Strategy Board (name to be confirmed) in terms of: • Finance including, Cost Improvement and Transformation program • Operational performance including activity and HR • Governance, Quality and Patient Safety • Strategic Planning & service improvement (full terms of reference can be found in appendix 6)
Care Group Governance Board	The Care Group Governance Boards are responsible for providing assurance to Northampton General Hospital Integrated Healthcare Governance Committee (IHGC), via the CQEG that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety. (full terms of reference can be found in appendix 7)
Directorate Governance Groups	Responsible for receiving regular reports on the management of risks at Directorate level and will review the risk register to ensure it reflects current risks and monitors progress with mitigating action plans. The Clinical Governance Managers and Facilitators in conjunction with the Governance Lead, General Manager, Clinical Director and Lead Nurse will report quarterly to Care Group Governance; CQEG on the management of High Risks within the Directorate and will specifically identify where expected actions or progress has not been taken or met. Responsible for reviewing and monitoring Quality Impact Assessments and associated risks via the Directorate Risk Register.
Risk Group	To advise the Chief Executive and Executive Directors on Risk, the Corporate Risk Register and Board Assurance Framework, taking into account of the views of CQEG; making sure that these are refreshed, consistent and accurately reflect the organisation's view of its risk and to identify any gaps and commission action plans to address these. (full terms of reference can be found in appendix 8)
Patient Safety Learning Forum	Responsible for reviewing learning from incidents (including serious incidents), complaints, claims and disseminating learning so as to reduce risk for the organisation. This forum has its own TOR and they present the learning from the forums to IHGC on a quarterly basis.
Directorate Management Boards (DMB)	Risk management is a key feature of the Directorate Management Board process, the Directorate's Risk Register is discussed and considered to ensure that all high and moderate clinical risks are actively managed and escalated to Care Group Governance and CQEG. These groups have their own agreed TOR's.

All committees would be expected to meet 75% of the annual year. It is expected that individuals attend for 75% of the meeting or send a representative.

6. NORTHAMPTON GENERAL HOSPITAL TRUST STRATEGIC AIMS

6.1. Strategic Aim 1: Be a provider of quality care for all our patients

6.2. Strategic Aim 2: Enhance our range of hyper acute services and maintain the clinical viability of services for the wider community of Northamptonshire

6.3. Strategic Aim 3: Provide appropriate care for our patients in the most effective way

6.4. Strategic Aim 4: Foster a culture where staff can give their best and thrive

6.5. Strategic Aim 5: To be a financially viable organisation

7. RISK MANAGMENT STRATEGIC OBJECTIVES

7.1. Ensure understanding at all levels of the organisation of the processes and responsibilities for incident reporting; risk assessment, identification and management

7.2. Cultivate and foster an 'open culture' in which risk management is identified as part of continuous improvement of patient care and staff well being;

7.3. Integrate Risk Management into all our business decision making, planning, performance reporting and delivery processes to achieve a confident and rigorous basis for decision-making

7.4. Ensure a systematic approach to the identification, assessment and analysis of risk and the allocation of resources to eliminate, reduce and/or control them in order that the Board of Directors can meet its objectives;

7.5. Encourage learning (individual and organisational) from all incidents, mistakes, accidents and 'near misses' be they related to clinical, financial, environmental or organisational events;

7.6. Minimise damage and financial losses that arise from avoidable, unplanned events;

7.7. Ensure the Trust complies with relevant statutory, mandatory and professional requirements

This document has been produced to support the Trust's 2013/14 strategic aims and corporate objectives. The Trust's Board Assurance Framework, which is aligned to the Trust's strategic aims and corporate objectives, is a high-level document based on structured and on-going assessment of the principal risks to the Trust achieving its aims and objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The SMB and the IHGC regularly review the Board Assurance Framework, with the most significant risks being reported to each public Trust Board meeting. Directorate Risk Registers are reviewed regularly by the by the Care Group with high-level risks being reported to the IHGC.

8. RISK MANAGEMENT FRAMEWORK

8.1 Corporate Risk Management Structure

Northampton General Hospital NHS Trust operates risk management at a number of levels within the organisational structure.

The organisational structure for risk management and assurance is approved by the Trust Board annually through the strategy with further explanations in relation to responsibilities of committees contained in section 5.2 and further information in relation to reporting arrangements found in section 9 and in the diagram in appendix 10.

8.2 Process for Review of Corporate Risk Register

The Corporate Risk Register comprises high risks identified through Care Group and Directorate Risk Registers as well as high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), claims, complaints, clinical audit results and PAL's bi-annual horizon scanning of external risks to the Trust. Where relevant, risks are aggregated to enable the Trust Board and its sub-committees to increase its focus. Risks are assigned to a named senior officer who will be responsible for managing the risk and to a sub-committee of the Board for review as appropriate.

The following reviews are undertaken:

- The Executive Team are responsible for reviewing the Corporate Risk Register on a monthly basis
- The Audit Committee and IHGC meet at 6 monthly joint meetings to review the Corporate Risk Register.
- In conjunction with the IHGC Committee, the Audit Committee will satisfy itself on the assurances gained from the clinical audit function. The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.
- IHGC is responsible for reviewing the clinical risks within the Corporate Risk Register quarterly and escalating any concerns to the Trust Board and seeks assurance on any specific risks
- CQEG is responsible for reviewing directorate level moderate and high clinical risks and escalating any concerns to IHGC quarterly.
- The Care Group Governance Boards are responsible for providing assurance to IHGC via the CQEG that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

8.3 Board Assurance Framework (BAF)

The BAF comprises the strategic risks that represent major threats to the Trust Board achieving its organisational objectives and gives the Trust Board assurance that these risks are being appropriately managed. Monitoring arrangements are outlined in section nine. (see appendix 11 for BAF accountability process)

8.4 Process for identifying, assessing, managing, monitoring and recording risk locally within Directorates

Wards and departments will use the process for identifying, assessing, managing, monitoring and recording risk as outlined in the Assessment and Management of Risk

Policy ensuring that risks are a key agenda item at their meetings and at Care Group and Directorate Governance Meetings. Directorates report moderate and high risks to CQEG on a quarterly basis and through Directorate Performance Reviews.

8.5. Risk Management Team

The Risk Management Team supports the Senior Risk and Litigation Manager in ensuring that clinical and non-clinical risks are appropriately managed.

The Trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The committee structure in appendix 10 provides an effective and robust system of risk management across the trust.

9. IMPLEMENTATION & TRAINING

9.1. Risk Awareness Training

The effective implementation of this Strategy will facilitate the delivery of a high quality service and, with staff training and support, will increase awareness of risk management. Northampton General Hospital NHS Trust actively promotes staff training and education. All senior managers should ensure that they are proactively involved in the management of risks and should make sure that they attend appropriate training in order to manage risks in line with this strategy and associated policies.

To implement this Strategy the Trust will:

- Provide all staff with access to the Risk Management Strategy via the Trust's intranet
- Include the principles of this Strategy and the Trust's approach to risk management in all induction programmes for staff. This includes Executive Directors, Non-Executive Directors and Senior Managers
- Ensure that Risk Management Awareness training programs are in place across the organisation
- Ensure that Mandatory training addresses key risk areas for the Trust
- Develop update and implement appropriate underpinning policies
- Ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies associated with this Strategy
- Provide training for Executive Directors and Non-Executive Directors to support their Board level role

10. MONITORING & REVIEW

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Corporate risk register will be reviewed by Trust Board/ IHGC and Audit Committee as set out in this policy	Mins IHGC Mins Audit Committee Mins Trust Board	Head of Corporate Affairs/ Senior Risk and Litigation Manager	Annual	Trust Board	Head of Corporate Affairs/ Senior Risk and Litigation Manager	Trust Board
Risk registers are reviewed by Directorate Governance Groups and high clinical risks escalated and discussed at CQEG	Mins Directorate Governance Groups Mins CQEG/ Directorate Governance ¼ reports	Deputy Director of Quality & Governance	Annual	Trust Board	Head of Corporate Affairs/ Senior Risk and Litigation Manager	Trust Board
Implementation of Trust Risk Management systems	Annual Governance Statement Control	Director of Finance / Head of Corporate Affairs	Annual	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
Specific Internal and External audit reviews prioritised by the Assurance Framework and Trust Risk Register	Audit Committee minutes as necessary	Director of Finance / Head of Corporate Affairs	Bi- monthly	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
IHGC updates on the management of relevant clinical risks on the Corporate Risk Register	IHGC minutes	Deputy Director of Quality & Governance	Monthly	IHGC	Deputy Director of Quality & Governance	IHGC

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Audit Committee updates on the management of relevant risks on Corporate Risk Register	Audit Committee minutes	Audit Committee	6 monthly	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
'High' and 'Extreme' risks – risk control contingency measures introduced	Corporate Risk Register moderated by the and reviewed	Executive Team Director of Nursing Midwifery & Patient Services, Head of Corporate Affairs	Monthly	IHGC, Audit Committee and Trust Board	Director of Nursing Midwifery & Patient Services, Head of Corporate Affairs	IHGC, Audit Committee and Trust Board
Responsibilities for risk management activities are reflected in the job descriptions of key individuals	Job descriptions of key individuals with responsibility for risk management activity	Internal Audit	Annual	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
Provision of risk management training including provision of awareness training for senior managers and board members	Review and data analysis	Training Department and Risk department	In accordance with the Trust & Local Induction Policy NGH-PO-386			

11. REFERENCES & ASSOCIATED DOCUMENTATION

Associated NGH Policies / Strategies

4 'C's -Comments, Concerns, Complaints, Compliments; Joint Policy – NGH-PO-483

Being Open - NGH-PO-254

Business Continuity Management - NGH-PO-420

Cancer Strategy 2012-2016 - NGH-SY-356

Capital and Service Investment – NGH-PO-629

Clinical Audit Strategy – NGH-SY-696

Communications and Engagement Strategy 2012-2013 – NGH-SY-674

Equality Strategy - NGH-tbc-tbc

Estates Maintenance - NGH-PO-635

Health and Safety Policy – NGH-PO-246

Health Record Improvement Strategy – NGH-tbc-tbc

Health Records Management- NGH-PO-58

Information Security Policy - NGH-PO-11

Infection prevention and control - NGH-PO-248

Investigating, Analysing and Learning from Incidents, Complaints, Inquests and Claims to Improve Practice –NGH-PO-333

Major Incident Corporate Plan – NGH-PL-683

Management of Incidents (Including Serious Incidents) – NGH-PO-393

Mandatory Training - NGH-PO-306

Nursing and Midwifery Staffing Strategy

Paper Health Record Improvement Strategy – NGH-SY-691

Patient and Public Involvement Strategy – NGH-ST-201

Patient Experience Strategy – NGH-SY-697

Patient Safety Strategy 2012-2015 – NGH-SY-689

Policy for Handling Clinical and Non Clinical Claims – NGH-PO-13

Quality Impact Assessment – NGH-PO-516

Quality Strategy 2012-2015 – NGH-SY-565

Recruitment, Selection and Retention – NGH-PO-33

Resilience Policy – NGH-PO-389

Risk Assessment and Management of Risk – NGH-PO-122

Safeguarding Vulnerable Adults - NGH-PO-241

Staff Engagement Strategy – NGH-SY-692

Standards of Business Conduct for Trust Staff – NGH-ST-132

Standing Financial Instructions – NGH-ST-182

Support for Staff involved in an Incident, Complaint or Claim – NGH-PO-245

Whistleblowing – NGH-PO-002

External documentation:

MID STAFFORDSHIRE NHS FOUNDATION TRUST 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Executive summary London: Crown Copyright.http://www.midstaffspublicinquiry.com/report

Health and Social Care Information Centre (HSCIC) -http://www.hscic.gov.uk/

APPENDICES see separate documents attached to policy

Appendix 1	Terms of Reference Audit Committee
Appendix 2	Terms of Reference Integrated Healthcare Governance Committee (IHGC)
Appendix 3	Terms of Reference Clinical and Quality Effectiveness Group
Appendix 4	Terms of Reference Finance Committee
Appendix 5	Terms of Reference Strategic Management Board
Appendix 6	Terms of Reference Care Group Board
Appendix 7	Terms of Reference Care Group Governance Board (Example of the Surgical Care Group provided)
Appendix 8	Terms of Reference for the Risk Group
Appendix 9	Risk Management Model Matrix
Appendix 10	NGH Committee structure (finalised document to follow)
Appendix 11	BAF accountability process

Northampton General Hospital NHS
NHS Trust

Appendix 1

Terms of Reference
Audit Committee

Purpose of Committee

The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

Functions/Duties

Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurance, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

- Considering the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation

- Annual review of the effectiveness of Internal Audit

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the independence, appointment and performance of the External Auditor, as far as the Audit Commission's rules permit

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all External Audit reports, including the report to those charged with governance, the annual audit letter before submission to the Trust Board and any work in the nature of audit work carried out outside the annual audit plan, together with the appropriateness of management responses

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the committee will work in close liaison with the Integrated healthcare governance and Finance Committees and will meet formally with these committees at least twice per year..

In conjunction with the Integrated healthcare governance Committee, the Audit Committee will satisfy itself on the assurances gained from the clinical audit function.

Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

Other Matters

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership
The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed chair of the committee by the Board. The chair of the Trust shall not be a member of the committee.

In attendance
The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive is invited to attend any meeting and will attend and discuss at least annually the process for assurance that supports the Annual Governance Statement. He or she is also

specifically invited to attend when the committee discusses the draft internal audit plan and the annual accounts. All other executive directors are invited to attend when the committee is discussing areas of risk or operation for which they are responsible.

Secretariat:

The committee will be supported administratively by the Head of Corporate Affairs whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of matters arising and issues to be carried forward
- advising the committee on pertinent issues/areas
- enabling the development and training of Committee members

Reporting Arrangements

The Audit Committee is a committee of the Board. The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Frequency of Meetings

The committee will meet a minimum of 5 times a year. The external auditors or Head of internal audit may request a meeting if they consider it necessary.

Quorum

The quorum comprises 3 Non-Executive Directors.

Approved 30 May 2013 – Trust Board
Review May 2014

Northampton General Hospital NHS
NHS Trust

Appendix 2

Terms of Reference

Integrated Healthcare Governance Committee

Purpose of Committee

The Integrated Healthcare Governance Committee (IHGC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management, performance, workforce and internal control across the clinical activities of the organisation that support the organisation's objectives.

In conjunction with the Audit Committee and the Finance Committee, IHGC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation.

Functions/Duties

1. Receive assurance from any relevant operational body that quality, safety or infection control standards are appropriately implemented and monitor progress relating to any of those areas where concerns are raised

2. Receive reports from the Clinical Quality and Effectiveness Committee (CQEG), where concerns have been identified and require escalation to a higher committee.

3. Receive reports where concerns are identified either internally or externally, reassure the board that appropriate preventable action is taken.

4. Review the performance and activity levels of the Trust and make recommendations to the Trust Board as necessary

5. To review workforce performance against agreed performance indicators and make recommendations to the Trust Board as necessary.

6. Enable adequate time for detailed discussion about key clinical issues at committee level where assurance needs to be gained, involving the appropriate Clinicians / Managers whoever appropriate.

7. To be responsible for detailed scrutiny of any patient safety, clinical quality and governance reports including the regular quarterly report. Where directorates / care groups are not performing against agreed standards for quality and performance the committee will monitor actions in place to improve performance

8. Review the corporate risk register at each meeting, the BAF quarterly and oversee arrangements for managing high clinical risks.

9. Ensure that appropriate clinical risk management arrangements are in place for the Trust, including using clinical audit to assure the Board that actions are taken appropriately.

10. Review Trust Development Authority Self-Certifications and make recommendations to the Trust Board as necessary.

11. Receive and challenge the following annual reports: Safeguarding Adults and Children , Infection control, NICE compliance, Clinical Audit forward plan and have an overview of priorities for the Trust.

12. Gain assurance on behalf of the Board regarding:

    - Accreditation and inspection visits, Independent reviews and Care Quality Commission visits/ inspections
    - Clinical Quality and Patient Safety issues
    - Monitor of implementation of patient safety and experience strategies
    - Receive reports / gap analysis on external reports which are significant to ensure actions are taken to prevent occurrence at NGH e.g. Winterbourne View, Francis report etc.

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership

- Three Non-Executive Directors
- Medical Director
- Director of Nursing, Midwifery and Patient Services
- Chief Executive Officer
- Chief Operating Officer
- Director of Workforce and Transformation
- Deputy Director of Quality & Governance
- Care Group Directors

In attendance
Head of Corporate Affairs
Chairman
Any Director/officer by invite as appropriate

Secretariat:

The Head of Corporate Affairs department will provide secretarial support to the committee.

Reporting Arrangements
The Integrated Healthcare Governance Committee is a committee of the Board. The Chair of the Committee will report regularly to the Board and minutes of IHGC meetings will be formally recorded and form part of Trust Board papers.

IHGC will meet twice a year with the Audit Committee and Finance Committee to ensure that risks are adequately managed across the organisation.

Reporting Group to IHGC
Clinical Quality and Effectiveness Group

Authority
The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert

advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Distribution of Minutes
The minutes are formally received by the Board.

Frequency of Meetings
Meetings shall be usually held on a monthly basis.

Quorum
Two Non-Executive Directors in conjunction with one Executive Director will constitute a quorum. In the absence of the Chair, a Non-Executive Chair will be nominated by the Committee.

Approved 30 May 2013 – Trust Board
Review May 2014

Appendix 3

Clinical Quality and Effectiveness Group -Terms of Reference

Definition: The Clinical Quality and Effectiveness Group (CQEG) is responsible for providing assurance to Northampton General Hospital Trust Board via the Hospital Management Group that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

Clinical Quality and Effectiveness Group
Purpose of Committee To act as the central committee to facilitate an integrated approach to clinical quality and effectiveness.
Functions Trust 1. Ensure a strategic framework is developed to meet national, regional and local policy in relation to clinical governance issues. 2. Formally receive regular reports, both internal and external, on clinical governance, quality assurance of clinical services, and other related issues. Reports will be received from groups and committees identified in organogram attached In doing so, ensure that appropriate action is taken and consider whether further strategic review is required. 3. The reports and papers received by CQEG form the basis for the quarterly patient safety, clinical quality and governance report which is available to members of HMG and the Trust Board. 4. CQEG is responsible for identifying areas for action and discussion at HMG and or Trust Board /IHCG. CQEG will recommend that the Trust Board requests the IHCG to discuss key issues of concern as indicated on the quarterly clinical performance scorecard presented in the Trustboard papers 5. Develop a systematic approach to clinical effectiveness by ensuring that; --systems are in place to monitor the performance of clinical staff and the quality of service which they offer 6. Pro-actively review systems, which support clinical governance processes. 7. Monitor the actions of the Directorate Governance groups in respect of their clinical governance responsibilities including the monitoring of clinical action plans. 8. Monitor and review evidence that Directorates have received, publicised and acted on the results of national confidential enquiries/ reviews/ inspections /reports/ accreditation visits/legislation (e.g NICE/CEMACH, NCEPOD) 9. Monitor all processes in relation to Medicines Management this is a function of the medicines management group perhaps we should reword 10. Promote and monitor education and training within the Trust related to clinical governance issues 11. Directorate Governance Groups and reporting committees can use the Group to raise issues that cannot be resolved at a local level or through other routes to enable more efficient and effective resolution 12. The Directorate representative is responsible for feeding back to their Directorate Governance Group. 13. Guide the development and monitor KPI's and CQUIN results County wide Work in partnership with the PCT quality contract representative.

Clinical Quality and Effectiveness group	Title: Terms of Reference –	
Document type: Terms of Reference	Document/Index no: N/a	Version: 5.1
Date presented toCQEG :	CQEG minute no: Aug 09/ Sept 09. Oct 09, Mar10	Date of first issue: Nov 2007
Approved by:	Date of current issue: 23/3/10	Review date:
Reviewer: Director of Nursing and Midwifery		Page 1 of 4

Clinical Quality and Effectiveness Group

Membership

Chair — Medical Director (Alternate Chair); Director of Nursing (Alternate Chair),
Deputy Chair — Deputy Director of Nursing (Governance) Deputy Medical Director
Patient & Staff representative — Governor TBC 2010

Clinical Representation It is expected that these members will attend each meeting or send an appropriate deputy. Should any member fail to attend, or send a deputy, on two consecutive occasions the Chair of the Group will write to the member to request attendance.
Associate Medical Director – Governance Lead; Clinical Governance Leads from each Directorate/Chair of Directorate Governance Group; Governance Lead from Facilities; Clinical Audit and effectiveness; Chief Pharmacist; Head of Patient and Public Involvement; Senior Risk and Litigation Manager; Infection Control ; Training and Development representative. Quality Assurance Manager

Committees/ sub groups
Attendance as required reporting back from sub groups (see page 4)

Executives
A standing invitation shall be extended to the Deputy Directors of Finance, Deputy Director of Nursing, Assistant Director of Operations, Director of Human Resources, and Director of Service Development to attend meetings of this Committee if they consider it appropriate to do so in light of the business to be transacted at any particular meeting.

PCT representation
The PCT has a seat on the membership of CQEG to provide assurance to the Clinical Quality monitoring of the commissioner/provider contract.

Other
Other staff may attend as appropriate. In addition senior managers, and advisors, will be invited to attend Committee meetings as and when required.

In attendance
Minute taker- Personal assistant to chair or deputy director of governance.

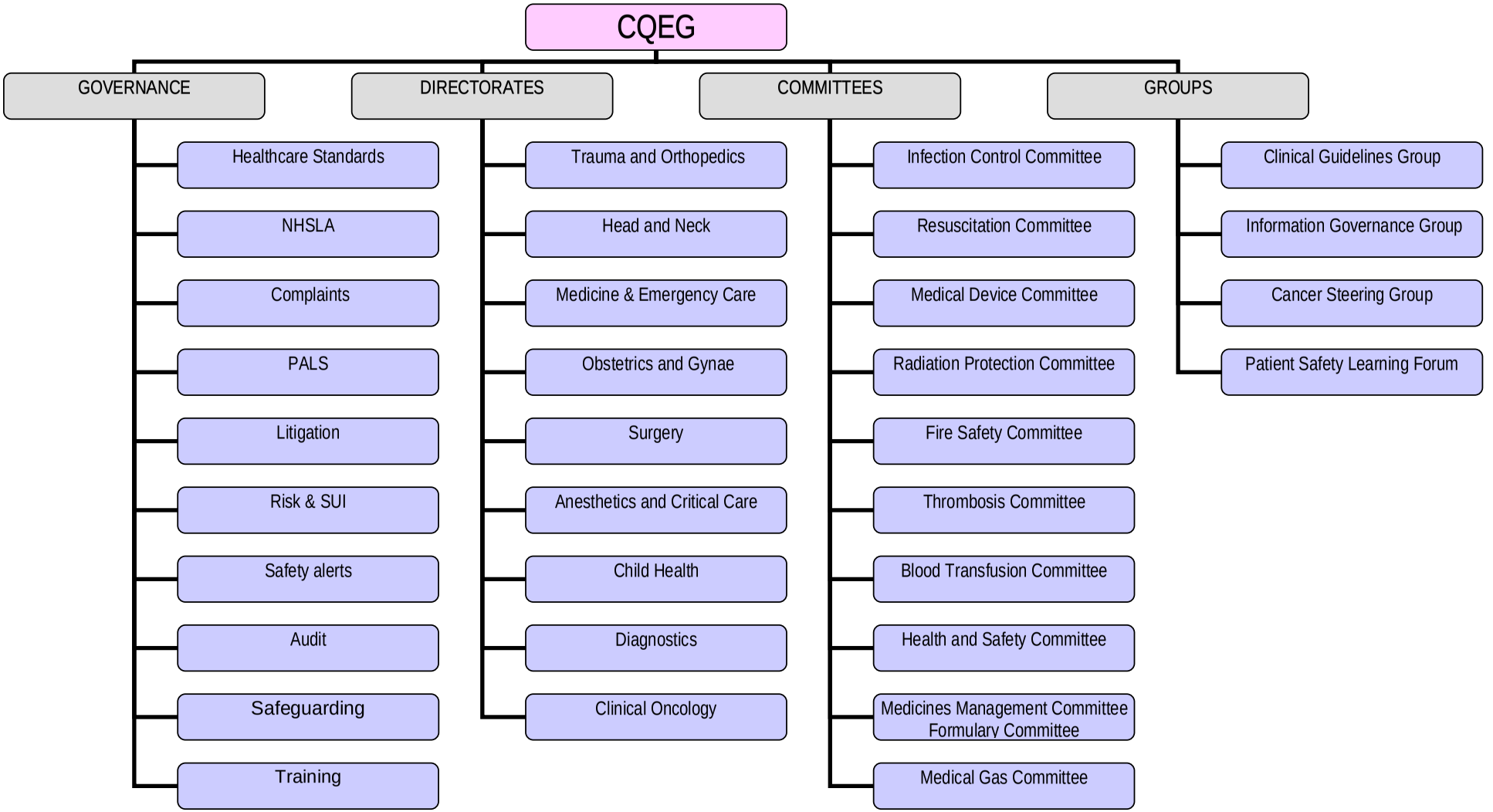
Reporting Arrangements (see structure)
The Group will receive reports from the various clinical sub groups as defined on the organisational chart (page 4) and will provide minutes to the Hospital Management Group as evidence of the process.
The Group reports directly to the Hospital Management Group who will delegate matters as they arises to the Integrated Healthcare Governance Committee.

Level of Authority
The Clinical Quality and Effectiveness Group (CQEG) will support the Board of Directors in discharging their responsibilities by providing objective assurance to the Trust Board that processes are in place across the Trust to ensure high quality clinical services are provided. This is provided through the Clinical Quality and Safety Report.
The Group reports directly to the Hospital Management Group (Via Mins)

The group is supported by a number of trust wide groups as identified in the organisational chart.

Clinical Quality and Effectiveness Group	
Distribution of Minutes • Members of CQEG and sub groups that report into CQEG • Minutes will be stored on the Governance Shared drive and will be accessed there by members	**'These minutes may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified**
Terms of Office Appointments should be reviewed after each three years of office.	
Frequency of meetings No less than 10 meetings each year. Every 4-6 weeks.	
Quorum The Clinical Quality and Effectiveness Group will be considered quorate when there are at least 6 members including: • Chair/ deputy chair • Three Clinical Governance Leads or nominated Deputy from directorates • Governance representative from risk or quality assurance team	
Decision Making 'One member, one vote' shall apply. If a split decision, the Chair will carry the casting vote.	
Declaration of Interest Members of the CQEG should declare any competing interests to the Chairman who shall decide on the appropriate action.	

CQEG Reporting Structure Sept 2009- this Is currently being reviewed



Clinical Quality and Effectiveness group	Title: Terms of Reference –	
Document type: Terms of Reference	Document/Index no: N/a	Version: 5.1
Date presented toCQEG :	CQEG minute no: Aug 09/ Sept 09. Oct 09, Mar10	Date of first issue: Nov 2007
Approved by:	Date of current issue: 23/3/10	Review date:
Reviewer: Director of Nursing and Midwifery		Page 4 of 4

Appendix 4

Terms of Reference

Finance Committee

Purpose of Committee

The Finance Committee (FC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management and internal control across the finance activities of the organisation that support the organisation's objectives.

In conjunction with the Audit Committee and the Integrated Healthcare Governance Committee, FC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation.

Functions/Duties

1. To review and challenge the medium and long term Financial Strategy
2. Scrutinise the development of the Trusts annual IBP with reference to the mitigation of risks on the Corporate risk register
3. Review the Trusts monthly and forecast financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board. Review the mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
4. To review the Trusts short and medium term financial performance of the Transformation Programme, including any mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
5. To review the Trust liquidity strategy and cash forecasts against performance
6. Review and evaluation of key financial risks, linking to the Board Assurance Framework
7. To review controls around business case investments.
8. Review the development and management of the rolling capital programme
9. To review and support the development of key external stakeholder partnerships

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership

- Three Non-Executive Directors
- Director of Finance
- Chief Operating Officer
- Director of Strategy and Partnerships
- Director of Workforce and Transformation
- Transformation Programme Director

In attendance

Head of Corporate Affairs
Any directors/officers by invite as required

Secretariat:

The Head of Corporate Affairs department will provide secretarial support to the committee.

Reporting Arrangements

The Finance Committee is a committee of the Board. The Chair of the Committee will report regularly to the Board and minutes of FC meetings will be formally recorded and form part of Trust Board papers.

FC will meet twice a year with the Audit Committee and Integrated Healthcare Governance Committee to ensure that risks are adequately managed across the organisation.

Reporting Group to Finance Committee

There are no groups established which formally report into the Finance Committee.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Distribution of Minutes

The minutes are formally received by the Board.

Frequency of Meetings

Meetings shall be usually held on a monthly basis.

Quorum

Two Non-Executive Directors in conjunction with one Executive Director will constitute a quorum. In the absence of the Chair, a Non-Executive Chair will be nominated by the Committee.

Approved 30 May 2013 – Trust Board
Review May 2014

DRAFT - Terms of Reference
Strategic Management Board

Purpose of the Strategic Management Board
The Strategic Management Board (SMB) is responsible for ensuring an effective system of integrated governance, risk management and controls across the activities of the organisation that support the organisation's objectives.

Functions

1. Receive reports from each of the Care Groups to provide operational assurance and escalate risks to the Trust Board

2. Receive reports where concerns are identified, for example by the Board, external sources, Finance & Performance Committee, Healthcare Governance Committee

3. Discuss strategic issues to maintain the strategic vision, aims and objectives set by the Trust Board

4. To receive and approve reports from the Procedural Document Group regarding the approval of policies and procedures

5. To ensure that risks to the organisation are minimised through the application of a comprehensive risk management system including the review of the corporate risk register at each meeting and oversee arrangements for managing high risks.

6. To receive and review the Board Assurance Framework which sets out risks to the achievement of the Trust's objectives

7. To receive and approve Service Development proposals

8. To receive and approve Capital Development proposals

9. To receive and approve Care Group Budgets

Membership
Trust Directors
Care Group Chairs
Care Group Directors
Care Group Lead Nurses
Clinical Directors
General Managers

The Chief Executive shall be the Chair of the SMB. In the absence of the Chair, the Chair for that meeting will be taken by the Deputy Chief Executive and in the absence of them both the Chair shall be a Chair nominated by the SMB.

Members of the SMB should attend each meeting, or nominate a deputy to attend in their absence.

Each member must attend a minimum number of 5 meetings per year.

Reporting Groups to Strategic Management Board

Transformation Steering Board
Education Strategy Board
Capital Group
Sustainability Development Committee
Strategic Planning Group

In attendance
Head of Corporate Affairs
Minute taker
Other members of staff may be invited to attend, particularly when discussing areas for which they have responsibility.

Reporting Arrangements
The Strategic Management Board will report to the Trust Board. The Minutes of this meeting will be formally recorded and submitted to the Trust Board. The Chair of the SMB shall draw to the attention of the Board any issues that require disclosure to the full Board.

Level of Authority
The SMB is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the SMB. [The SMB can also seek outside expert advice] The SMB shall make recommendations to the Board it deems appropriate on any area within its Terms of Reference where action or improvement is required.

Distribution of Minutes
The minutes are formally received by the Board.

Frequency of Meetings
Meetings shall be usually held on a six weekly basis and there will no less than 7 meetings per year.

Quorum
Two representatives from each Care Group in conjunction with 4 Trust Directors will constitute a quorum. The Head of Corporate Affairs will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the SMB.

Appendix 6

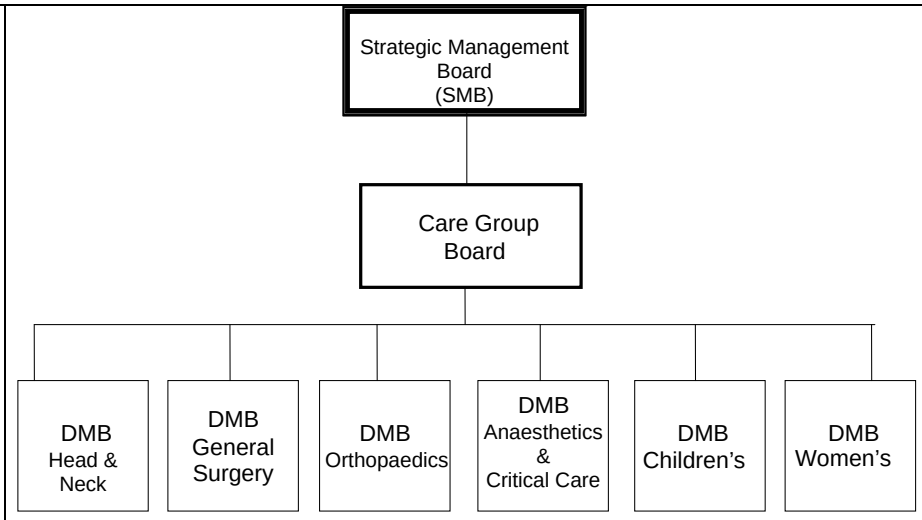
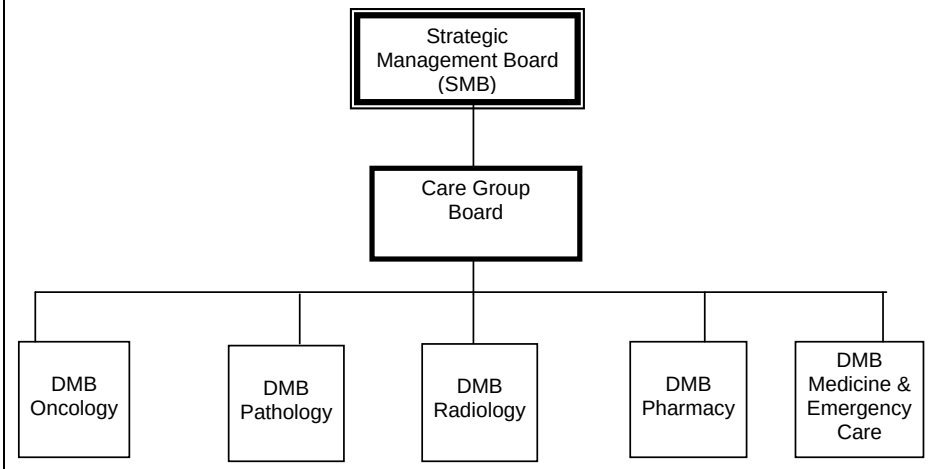
NORTHAMPTON GENERAL HOSPITAL
CARE GROUP BOARD TERMS OF REFERENCE

TITLE	**CARE GROUP BOARD (CGB)**
Membership	Care Group Chair (Chair) Care Groups Director Clinical Directors General Managers Lead Nurse Care Group Finance Lead Care Group Human Resources Lead Care Group Quality and Safety (Clinical Governance Lead) Head of Midwifery (Surgery) Heads of Pathology / Radiology / Pharmacy / Therapies (Medicine)
Purpose	The Care Group Board (CGB) is established as the key assurance and decision making group of the Care group in relation to operational performance, quality, safety, risk, and strategic planning. It reports to the Strategic Management Board (SMB) in terms of: • Finance including, Cost Improvement and Transformation program • Operational performance including activity and HR • Governance, Quality and Patient Safety • Strategic Planning & service improvement Each Directorate within the Care Group will be requested to complete directorate scorecards which will be used by exceptional reporting for issues or concerns. The Care Group Board will feed into directorates via their Directorate Management Board which will take place monthly chaired by the Clinical Directors. The Directorate Management Boards (DMB) (chaired by the Clinical Directors) are decision making and will continue to be responsible and accountable for the operational and strategic management of the directorates.

Northampton General Hospital NHS
NHS Trust

Appendix 6

NORTHAMPTON GENERAL HOSPITAL
CARE GROUP BOARD TERMS OF REFERENCE

Diagram **Surgery Care Group**	
Diagram **Medicine Care Group**	
Clinical Governance	Each Directorate will continue to strengthen their monthly Directorate Clinical Governance meetings which are chaired by the Clinical Governance Leads and fed into the Directorate Management Boards. The Care Group Board will have Clinical Governance as a standard agenda item which will be used for exceptional reporting only. Clinical Governance leads will continue to attend the Trust-wide CQEG.
Deputies	While it is expected that members will make every effort to attend meetings of the Care Group Board, it shall be permissible for deputies to attend by exception.

Appendix 6

NORTHAMPTON GENERAL HOSPITAL
CARE GROUP BOARD TERMS OF REFERENCE

Quorum	A quorum shall be 5 members including either, the Care Group Director, Chair, or Lead Nurse.
Attendance	The Care Group Board will request the attendance of other post-holders at its meetings if it considers this necessary. The executive team will be invited to attend quarterly
Frequency	Meetings shall be held monthly. Additional meetings may be convened by the Chairperson in exceptional circumstances.
Secretary	The PA to the Care Group Team shall attend to take minutes of the meeting and provide appropriate support to the Chairman and members. Minutes will be shared across both care groups

(Updated with minor amendments in July 2013)

Appendix 7

Northampton General Hospital NHS
NHS Trust

Surgical Care Group Governance Board

Terms of Reference

The purpose of the terms of reference is to set out written guidelines that clarify the role of the care group governance board, its purpose, membership and responsibilities.

Aim:
The Surgical Care Group Governance Board (SCGGB) is responsible for providing assurance to Northampton General Hospital Healthcare Governance Committee (HGC), via the CQEG that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

Purpose:

To act as the central board for the Surgical Care Group to facilitate an integrated approach to clinical quality and effectiveness.

Functions:

1. Formally receive assurance via directorate reports on clinical governance, quality assurance and other related issues. To ensure that appropriate action is being taken and consider whether further strategic review is required.
2. The reports and papers received by the SCGGB will be included in the Trusts quarterly patient safety, clinical quality and governance report which is available to members of SMB and the Trust Board.
3. Review the quarterly reports that are submitted to CQEG, discuss any areas that remain non-compliant, discuss the action plan required to achieve compliance and any areas that need to be raised at the SCG Board meeting
4. SCGGB will be responsible for identifying areas for action and discussion at CQEG /HCG as raised by the directorate governance leads. SCGGB will recommend that the Trust Board requests the HCG to discuss key issues of concern as indicated on the quarterly clinical performance scorecard presented in the Trust board papers

5. SCGGB will systematically review the Care Groups Serious Incidents, Never Events, claims, litigation and any attributed action plans to ensure completion and shared learning
6. Develop a systematic approach to clinical effectiveness by ensuring that systems are in place to monitor the performance of clinical staff and the quality of service which they offer. Review the governance and quality aspects of the SCG Quality dashboard on a regular basis and discuss the plans to improve any areas of non-compliance.
7. Pro-actively review systems, which support clinical governance processes.
8. Monitor the actions of the Directorate Governance groups in respect of their clinical governance responsibilities including the monitoring of clinical action plans.
9. Monitor and review evidence that Directorates have received, publicised and acted on the results of national confidential enquiries/ reviews/ inspections /reports/ accreditation visits/legislation (e.g. NICE, NCEPOD etc)
10. Promote and monitor education and training within the Care Group related to clinical governance issues
11. SCGGB is the reporting mechanism for the directorate governance leads to raise issues that cannot be resolved at a local level or through other routes to enable more efficient and effective resolution
12. The Directorates representatives are responsible for feeding back to their Directorate Governance Groups.
13. Guide the development of and monitor KPI's and CQUIN results

Membership:

Dr Mike Wilkinson	Care Group Chair
Natalie Green	Care Group Lead Nurse
vacant	SCG Governance Manager
Christine Ainsworth	Quality & Safety Assurance Manager
vacant	SCG Facilitator
Mr Jon Campion	T&O Governance Lead
Mr John Evans	General Surgery Governance Lead
Dr Prashant Kakodkar	A&CC Governance Lead
Mr Paul Jervis Mr James Gallagher	HN Governance Lead
Mr Maharatnam Lonendran	Opthalmology Governance Lead
Dr Anne Smith	Paediatrics Governance Lead
Mrs Sue Lloyd	Obstetrics Governance Lead
Mr Wesley Mccullough	Gynaecology Governance Lead

It is expected that these members will attend each meeting or send an appropriate deputy. Other staff may be invited to attend meetings as and when required.

Reporting Arrangements:

The SCGG Board will receive reports from the various clinical Directorates and will provide minutes to the CQEG and SCG Board.
The SCGG reports directly to CQEG who will delegate matters as they arise to the Trust's Healthcare Governance Committee.

Distribution of Minutes:

Members of SCGGB, CQEG and SCG

Frequency of meetings

No less than 10 meetings each year. Every 4-6 weeks.

Quorum

The Surgical Care Group Governance Board will be considered quorate when there are at least 6 members present including:

- Chair/ deputy chair
- Three Clinical Governance Leads or nominated Deputy from the Directorates
- Governance representation from the Care Groups risk or quality assurance teams

Appendix 8

RISK GROUP

TERMS OF REFERENCE

Accountable to: Chief Executive/Executive Team

Membership:
Director of Finance
Director of Nursing, Midwifery and Patient Services
Head of Corporate Affairs (Chair)
Deputy Director of Quality and Governance
Senior Risk and Litigation Manager
Patient Safety Programme Manager
Deputy Director Strategy and Partnerships
Care Group Director/Lead nurse Medicine
Care Group Director/ Lead nurse Surgery
Quality Assurance Manager
Deputy Director HR

Purpose:
To advise the Chief Executive and Executive Directors on Risk, the Corporate Risk Register and Board Assurance Framework, taking into account of the views of CQEG; making sure that these are refreshed, consistent and accurately reflect the organisation's view of its risk and to identify any gaps and commission action plans to address these.

Key responsibilities/duties/tasks:

1. Advise Executive Directors on ways to ensure that risk and risk management processes are embedded and implemented across the organisation.

2. Ensure that the Risk Management Strategy and other risk policies are fit for purpose.

3. Make recommendations to the organisation on risk.

4. Ensure that directorate risk registers are adequately incorporated into the corporate risk register.

5. Report at least annually to the Audit Committee to provide assurance to that committee.

6. Review the Corporate Risk Register, considering the appropriateness of assessment of each risk, making recommendations to escalate or de-escalate risks as appropriate and ensuring that there are action plans in place to mitigate risks.

7. Review the Board Assurance Framework and any associated action plans.

8. Form a view on the top risks to the organisation and report this to Board.

9. Analyse and "RAG" rate action plans to mitigate risks and report progress to Board Committees and CQEG.

Frequency of Meetings:	Monthly.
Quorum:	One Executive Director and one other member
Status	This is an advisory group and makes recommendations only.
Review	These terms of reference to be reviewed annually: date of next review December 2013.

National Patient Safety Agency

Model matrix

For the full *Risk matrix for risk managers*, go to www.npsa.nhs.uk

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

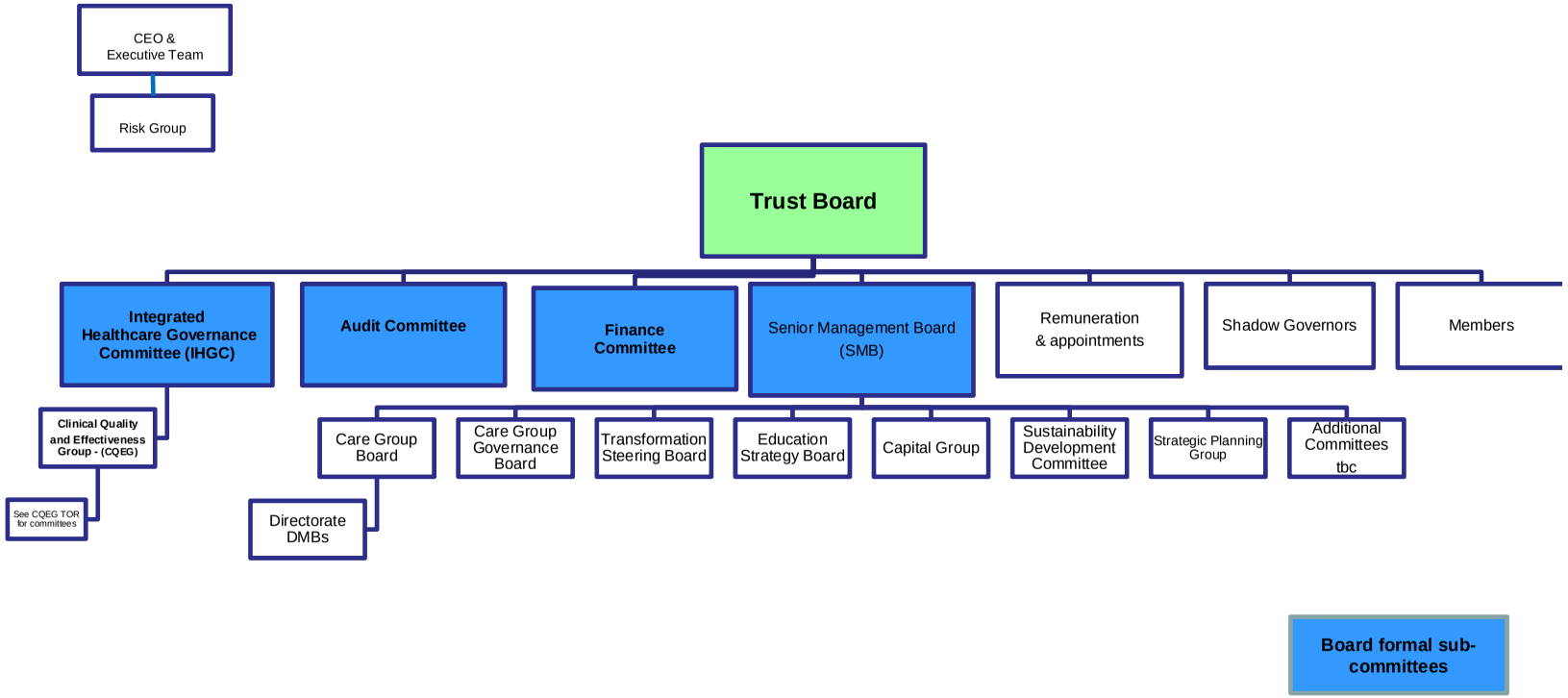
4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 10

NGH BOARD COMMITTEE STRUCTURE

Northampton General Hospital NHS
NHS Trust



NGH-SY-426 V12.4

Last updated July 2013

Appendix 11

Board Assurance Framework – Accountability and Process Structure

Trust Board
Responsibilities • Overarching responsibility for Risk Management • Identification, evaluation and assessment of risk through intelligence reported to the Board. • Approval and subsequent review of the BAF
Mechanism(s) • **MONTHLY**: Horizon Scanning informed by external business intelligence reporting (based on private Board reports presenting stakeholder performance intelligence, media reports, regulatory information, outputs from DH/think tanks/journals, external assessments etc). • **MONTHLY**: Internal performance reporting presenting trends and forecasts on KPI's. • **MONTHLY**: Exception/highlight reports from committees on prospective and current risk issues for Board attention. • **QUARTERLY**: BAF presented in full to the Board supported by assurance mapping report which highlights those positive and negative assurances received on risks, informing debate and providing assurance. • **ANNUAL**: Workshop to review risk profile and appetite.
Outputs • Annual Governance Statement
Accountable Officer(s) • Chief Executive & Chairman

Audit Committee
Responsibilities • To provide independent scrutiny that there is an effective risk management system embedded within the Trust and it is functioning to the required standards. • The Audit Committee will review the controls involved in the management and monitoring of the BAF in order to provide assurance of effectiveness to the Board.
Mechanism(s) • QUARTERLY: Detailed review of the BAF at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided. • SIX MONTHLY (In conjunction with IHGC): Confirm and Challenge review of the top risks in the Corporate Risk Register with risk owners. • MONTHLY: Review of clinical, internal and external audit outputs to identify areas of risk for further investigation.
Outputs • Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Audit Committee. • Annual Head of Internal Audit Opinion based upon Audit Committee oversight and Board review of the BAF.
Accountable Officer(s) • Director of Finance

Integrated Healthcare Governance Committee
Responsibilities • To provide independent scrutiny that clinical, operational and workforce risks are being reported, monitored and managed effectively, challenging management assurance. • To review the robustness of the controls involved in the management and monitoring of the risks in order to provide assurance of effectiveness to the Board.
Mechanism(s) • MONTHLY: Detailed review of the relevant BAF risks at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided. • MONTHLY: Review of internal intelligence (including CRR) to inform areas prospective of risk to be considered within the BAF. • MONTHLY: Horizon scanning of risk issues not included within the BAF.
Outputs • Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Committee.
Accountable Officer(s) • Medical Director and Director of Nursing, Midwifery and Patient Services

Finance Governance Committee
Responsibilities • To provide independent scrutiny that financial and capital risks are being reported, monitored and managed effectively, challenging management assurance. • To review the robustness of the controls involved in the management and monitoring of the risks in order to provide assurance of effectiveness to the Board.
Mechanism(s) • MONTHLY: Detailed review of the relevant BAF risks at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided. • MONTHLY: Review of internal intelligence (including CRR) to inform areas prospective of risk to be considered within the BAF. • MONTHLY: Horizon scanning of risk issues not included within the BAF.
Outputs • Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Committee.
Accountable Officer(s) • Director of Finance

Enclosure Q

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Complaints Annual Report 2012-2013
Agenda item	19
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Author(s)	Lisa Cooper, Complaints Manager Jill Birmingham, Complaints Administrator
Purpose	This paper is presented in accordance with: • NHS Statutory Complaints Regulations • CQC Outcome 17 To provide the Committee / Board with assurance regarding the management of complaints within the Trust
Executive summary A summary of complaints for 2012-2013, incorporating any reports that were released during the year (Francis report, Listening & Learning: The Ombudsman's review of complaints handling for the year 2011-2012)	
Related strategic aim and corporate objective	To improve clinical quality and safety
Risk and assurance	This report does not present any risks to the Trust but provides reassurance on the complaints handling arrangements that are in place
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? **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	There are no legal/regulatory implications of the paper

Actions required by the Board

The Board / committee is asked to challenge where appropriate the contents of this report

Northampton General Hospital NHS
NHS Trust

Trust Board
July 2013
Complaints Annual Report 2012-2013

Enclosure Q

1. Introduction

This report is provided annually to offer board assurance regarding the standard of complaints handling arrangements that are currently in place within the organisation. The reformed NHS Complaints system is now in its 4th year of operation. We recognise that during this time, complaints have become more complex and may involve a number of different organisations (NHS and Social Care for Adults). It is our aim to ensure that the pathway, for each complaint received, is acted upon in a way that meets the needs of each individual / organisation involved.

We openly encourage people to contact us with concerns, comments, complaints and compliments (the 4 'C's) and let them know that we will listen and take all issues seriously and act upon and learn from their experiences. The 4 C's process is advertised across the organisation through posters and leaflets, and information is also available through our website. Our focus is on putting things right and getting it right first time. Complaints are handled promptly with full consideration given to the remedies that are available, to those who have complained.

We demonstrate a culture of effective complaint handling which is evident across the whole organisation. Our emphasis with all employees is to ensure that they understand that their role is not only in resolving complaints, but learning from them and preventing them from reoccurring. It is essential for us to be open and honest and to reassure complainants that the appropriate action has been taken. Learning from complaints, and offering timely and effective outcomes provides the best and most effective form of customer satisfaction which benefits both us and the complainant.

Learning from complaints is a very powerful and positive way of helping us to develop and to improve the level of trust between us and those members of the public who use our services. Learning is monitored through action plans and supporting tracking documents. Evidence to show that we have done what we said that we will do to improve our services is monitored by the corporate complaints team and this information is incorporated into our quarterly reporting schedule. Learning is shared across the organisation through this process, and assurance is provided and monitored through our CQC standards, updates and confirm and challenge review process.

2. Key points

- The Trust received 538 complaints in 2012-2013 when compared to 517 in 2011-2012.
- 84% of complaints were responded to within accepted time frame vs. 100% in 2011-2012 (at the time of writing this report)
- 16 new Ombudsmen cases were received, 1 of which was upheld from a previous year. A summary of this is detailed within the main body of the report, along with the recommendations made, and the Trust's progress to date
- 'Patient care' and 'Communication' provoked the highest number of complaints this year. However, there has been a significant improvement in the number of complaints that relate to communication, with a significant reduction from 226 last year, to 103 this year. Complaints relating to attitude and behaviour have also improved this year (45) when compared to last year (61).
- Head & Neck, Facilities and Radiology saw the most improvement in terms of a reduction in the number of complaints received. However, Accident & Emergency, Anaesthetics and Oncology saw the most significant rise in the number of complaints received about their services.

3. Assessment of Risk

Complaints management is a valuable mandatory process, which has been given even greater emphasis following publication of the Francis Report in February 2013. The Trust has policies and resources in place to manage the process and mitigate the risk posed by complaints and the handing of them.

A dramatic increase in Ombudsman cases is expected, the risk of which will need to be managed. Further changes to the complaints management process are likely following Francis, which will be kept under careful review.

4. Recommendations/Resolutions Required

The Board/Committee is asked to note the content of this report.

5. Next Steps

The service will continue to operate in an effective and positive manner.

The impact of any changes in national guidance and Ombudsman cases will be kept under review and reported in future updates.

Northampton General Hospital NHS
NHS Trust

Enclosure Q

COMPLAINTS ANNUAL REPORT

1 APRIL 2012 - 31 MARCH 2013

Date:	July 2013
Prepared by:	Lisa Cooper-Complaints Manager
	Jill Birmingham-Complaints Administrator
Approved by:	Eileen Ingram, Head of PALS, Complaints & Bereavement Service
	Sarah Norrie, Deputy Director of Governance

TRUST OVERVIEW

1. Introduction

This report provides information on complaints received by Northampton General Hospital NHS Trust during the period 1st April 2012 – 31st March 2013.

2. Performance monitoring

There were 538 complaints recorded from 1st April 2012 to 31st March 2013 compared to 517 complaints received the previous year. From the 1st April 2009 the NHS Complaints Regulations state that the timescale in which the Trust should respond to the complaint must be agreed / negotiated directly with the complainant. The Trust's overall performance has been detailed in the table below and is recorded every month in the Trust's Balanced Scorecard.

	2011/12	**2012/13**
Total no of complaints for the year *an increase of 3.9% versus last year	517	538*
Total no of complaints responded to within the agreed timescale **including 246 renegotiated timescales	517 (100%)	452** (84%)
Total no of points (issues) of dissatisfaction (see section 2.3) Average points (issues) of dissatisfaction per complaint	2241 4.33	2209 4.11
Total patient contacts/episodes	497,469	483,408
Percentage of complaints versus number of patient contacts/episodes	0.10%	0.11%

Complainants continue to be offered a meeting involving members of the complaints and clinical teams. Additionally, increased efforts are being put into achieving resolution at a local level.

Complaints data is submitted on a quarterly basis to the Clinical Quality & Effectiveness Group and is also included within the Patient Safety, Clinical Quality & Governance Progress Report. The data relates to the following specific areas:

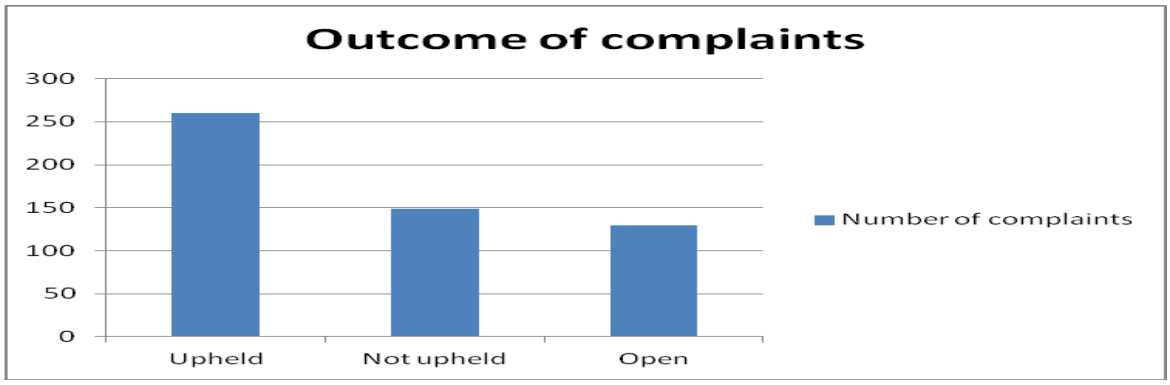
- trend analysis
- learning from complaints
- total numbers of complaints received
- 4 C's forms received + subject
- fundamentals of nursing care

2.1 Acknowledgements & timescales

100% of complainants were sent a letter of acknowledgement within 3 working days. 84% of complainants received a full response in line with the NHS Complaints Procedure (within agreed timescales) in comparison to 100% the previous year. For those people who waited longer than the agreed timescale for a response, the majority agreed to an extension of time, in line with the Complaints Regulations, and all were offered remedies to their complaints as outlined in the Parliamentary & Health Service Ombudsman's 'Principles for Remedy' publication.

2.2 Outcome of complaints

For every complaint that is received the Trust is required to categorise the outcome. This information is now provided annually to the Department of Health in the KO41a report and is included here for the first time. Therefore there is currently no historical data to complete a comparison.



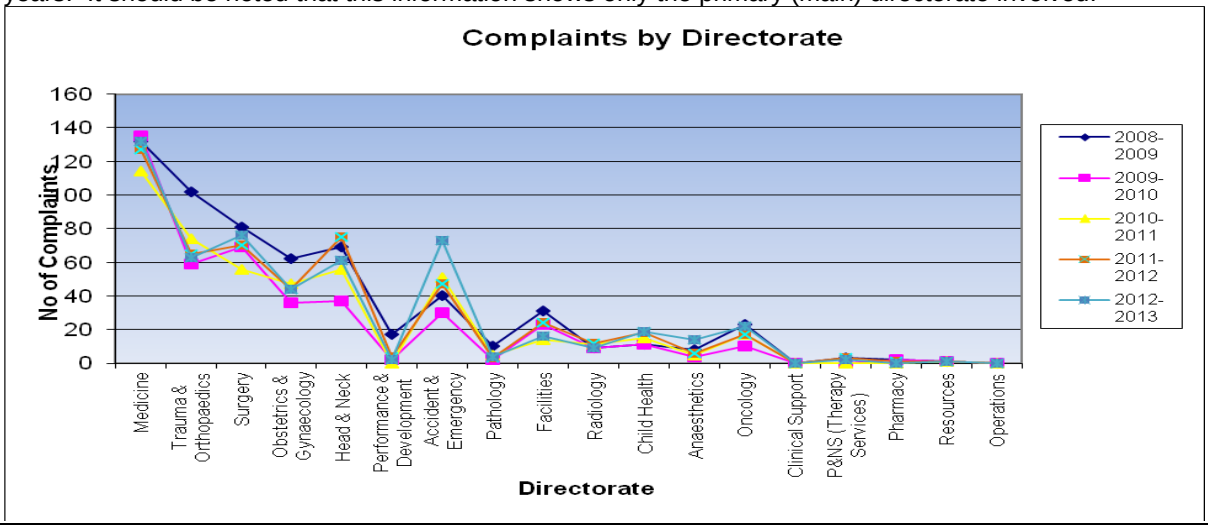
In the Department of Health KO41a report the outcome of complaints is only split between those that are upheld, and those that are not upheld. In the context of KO41a, upheld must be recorded if any aspect of the complaint was substantiated. This is detailed on the graph above, along with the number of complaints that were 'open' at the time that this report was prepared. As these complaints are not yet concluded it is not possible to assign a category to them at this stage. However, it should also be noted that the number of upheld complaints consists of a number of sub-outcomes, which are detailed in the table below:

Sub-outcome	Number
Partially upheld	71
Procedural Change	12
Staff Reminded	145
Training Required	3
Fully upheld	29

It is only possible to assign one sub-outcome to each complaint. Many complaints may have been partially upheld, or fully upheld, but also had a staff reminded sub-outcome and be recorded under that category. It is not therefore possible, using this information to say to what extent complaints were upheld fully or partially. There is a further sub-outcome which refers to complaints where no further action was required. As these are complaints that are not upheld they are not included within the table above. There were 149 complaints that sat within this category.

2.3 Complaints by Directorate

The graph below shows the number of complaints, by directorate as a comparison, for the last 5 financial years. It should be noted that this information shows only the primary (main) directorate involved.



Of the 538 complaints received, 175 related to more than one directorate and/or another NHS healthcare provider or Social Care for Adults. When compared to the previous year (2011/2012) this number has increased once again, although only very slightly. However, the size and complexity of complaints (i.e. number of questions being raised and the number of directorates/organisations involved) continues to rise. This should not be confused with the points of dissatisfaction, which relate to the different type of issues being raised and which have decreased slightly this year.

2.4 Parliamentary & Health Service Ombudsman (PHSO)

Where the Trust was unable to resolve complaints locally, the complainants were advised that they may wish to contact the Parliamentary & Health Service Ombudsman to seek an Independent Review of their case.

Whilst the majority of complaints were resolved through local resolution a total of 16 new cases progressed to the Parliamentary and Health Service Ombudsman for investigation, in comparison to 23 the previous year. 1 case was fully upheld with recommendations made, which related to a complaint received within the financial year 2010-2011. In addition to this 6 cases were closed without investigation, 6 were referred back for further local work, with the Trust's agreement and 4 currently remain open. A breakdown of the cases is detailed below:

Total number of complaints that progressed to the PHSO in 12/13	**Cases currently under review**	**Cases not investigated**	**Cases referred back for further local work**	**Cases upheld with recommendations**	**Financial remedies for PHSO cases (total costs paid)**
16 (a number of which relate to previous years)	4	6 (some of which refer to previous years)	6	*1 (from 2010-2011)	£700 (0 in the previous reporting year)

Listening & Learning: the Ombudsman's review of complaint handling by the NHS in England 2011-2012

Benchmarking exercise (this information was received after the release of the annual report for 2011-2012 and this year's report has not yet been released)

Following the receipt of the above report the Trust has undertaken a benchmarking exercise against 3 other Trust's of a similar size within what was the East Midlands Strategic Health Authority. The findings are detailed below:

Trust	**Number of complaints referred to the PHSO in 2009-2010**	**Number of complaints referred to the PHSO in 2010-2011**	**Number of complaints referred to the PHSO in 2011-2012**
Chesterfield Hospital	16	16	30
Sherwood Forest Hospital	23	37	41
Kettering General Hospital	28	33	29
Northampton General Hospital	42	34	43

It is very difficult to undertake any accurate benchmarking as a number of factors must be considered:

- Not all of the complaints referred to the PHSO in each reporting year will have been investigated by the relevant Trust during that financial year. Some complaints (as with a number of those relating to NGH) will be older complaints relating to previous reporting years i.e. 2009-2010 / 2010-2011

- The number of very detailed complex complaints that relate to a number of different directorates and/or other organisations may vary between Trusts'. It is quite often these complaints that are not able to be resolved at local Trust level (despite all of the work and efforts made using the different remedies recommended by the PHSO). At NGH the complexity of our complaints rose by over 100% in the reporting year 2010-2011, with 150 of the total 466 (32%) received falling within this category in comparison to 70 of the 430 (16%) received the previous year (2009-2010). Of the 517 complaints received in 2011-2012, 173 (33%) related to more than one directorate and/or another NHS healthcare provider or Social Care for Adults and this number continues to rise year on year.

- It should be noted that of the 43 cases that progressed to the PHSO for NGH in 2011-2012, the PHSO requested information on 23 cases. The Trust is not made aware of the other (20) cases as this is where no information or contact is required i.e. the complaint has not warranted further enquiries via the PHSO / Trust.

- Of the 23 cases where the Trust was required to provide additional information i.e. copy records and case files, only 1 case was upheld and this related to a complaint that was received in 2009-2010.

***A summary of the complaint that was upheld by the Ombudsman in the reporting year 2012-2013:**

Summary of case – 10/11-093

The patient was a 73 year old gentleman who had a history of vascular type dementia and high blood pressure and had experienced a stroke some years previously. He had lived with his civil partner until three weeks prior to his admission to hospital, when he had been transferred to a care home. The patient was admitted to NGH following a number falls and increased confusion. Nothing significant was identified on examination, he had no fractures, and a scan showed no evidence of a bleeding problem in his brain. The patient was admitted to an acute stroke unit and was initially drowsy and very confused. The patient was treated for a chest infection and urinary tract infection and responded well to treatment. Following the appropriate assessments the patient was discharged back to the care home. The following day the patient had a further fall and was less responsive and he was therefore readmitted. His condition improved and he was discharged again. The patient died 3 months later at his care home.

The patient's civil partner complained about the level of care and treatment that the patient had received and this predominantly related to communication and nutrition. The complainant stated that he did not feel that adequate attention was paid to the patient's nutritional status, he was not weighed appropriately and the weight loss was significant as a result of this. Issues were also raised regarding the fact that the nursing staff omitted to include the patients partner in his day to day needs or inform him when tests / investigations were due to be so that he could attend to support him.

The Ombudsman upheld the complaint on two counts;

- Communication – service failure, including a failure to instigate the Carer's Policy
- Nutritional care - service failure, including a failure to act upon the risk of malnourishment with the adequate steps not taken to address this
- Injustice to the partner for the Trust's failure to include him in his partner's care

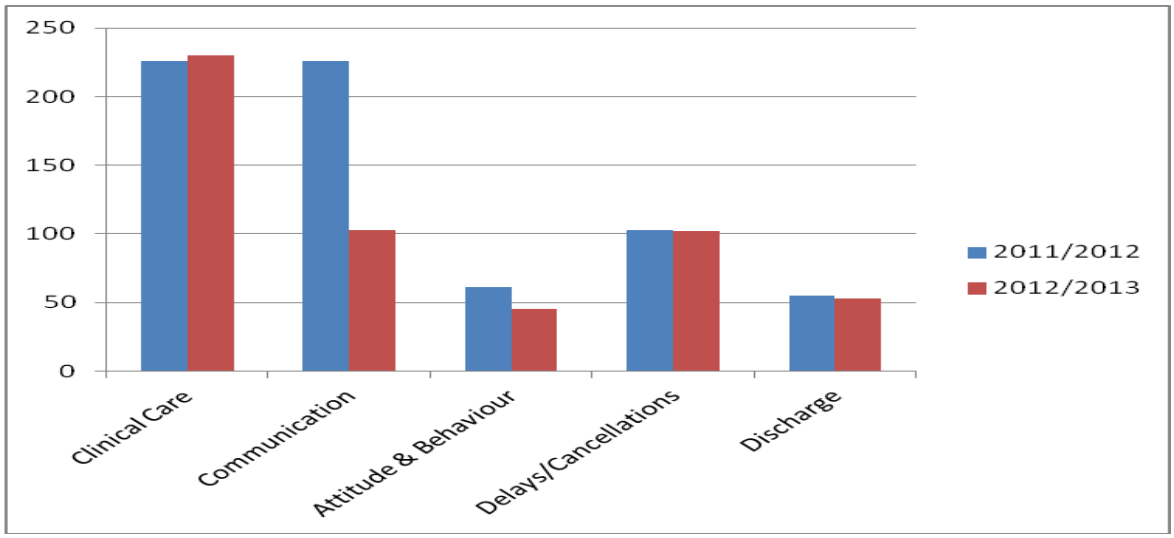
In line with the ombudsman's principles for remedy the Trust responded to the complainant with an explanation, an apology and confirmation of the learning/action taken in light of his complaint. As recommended by the Ombudsman financial redress of £500 was paid to the complainant.
In line with the recommendations made an action plan has been prepared (led by the Trust's Consent Committee) with a copy being issued to the complainant, the SHA, PCT, CQC and the ombudsman. An update will be issued in June 2013. The action plan is now complete and evidence has been received to provide assurance that we have done what we said that we would do.

NGH FINAL ACTION:

- Remedial action was, and continues to be taken in light of the Ombudsman's investigation by both the Trust and the areas concerned. The outcome of the investigation was presented at the Ward Managers meeting by the lead matron and ward sisters of the main areas involved.
- The complainant has been invited to join a Carer's Forum which is being developed through the action plan (he has since accepted the invitation)
- Apology provided along with reassurance of the action taken, and financial redress issued
- The action plan is being monitored by the Complaints Department. Evidence has been provided to offer reassurance of the action taken, and a further letter providing an update will be issued to the complainant and the relevant external organisations, once complete. This is in accordance with the Ombudsman's recommendations.

2.5 Trend Analysis

The following table provides the top 5 themes emerging from complaints, in line with the Trust's quarterly reporting process. Last year's data has also been provided in order to show comparison data.



Each of these themes breaks down into a number of sub-categories and the main issue for the top 5 themes are as follows:

Primary theme	**Sub-category (includes)**
Clinical care (this consists of a number of different aspects)	Diagnosis (delay, failure, incorrect), Procedure, Opinion, Pain Management, Tests, Documentation, Results, Other
Communication	General verbal or written communication with either a patient or a relative
Delays	Delay in appointment being issued
Discharge	All aspects relating to patient discharges
Attitude & Behaviour	Attitude, Behaviour of staff

The following actions have/will be taken to improve the quality and safety of patient care:

Primary theme	**Action being taken**
Clinical care	The Trust has introduced a Patient Safety Academy which involves 6 safety leads and work streams with over 100 safety champions across the Trust. The work streams / project groups are all linked to aspects of clinical care: Human Factors Failure to plan Learning lessons Failure to rescue Emergency care Failure to care A full review of nursing documentation is being undertaken. This is being led by the Head of Nursing & Midwifery, Professional & Practice Development • Additional resources have been agreed to support the A&E teams including 2 additional consultants and 10 additional nurses. • Emergency physicians are available 13 hours per day, Monday-Friday, 2 physician ward rounds at the weekends in addition to existing on-call arrangements. • Ambulatory care pathways are being established, which are patient focused services whereby some conditions can be safely treated without the need for an overnight stay. • New interim Continuing Health Care process is in place with a reduction of the assessment time from 14 to 3 days. • Develop and introduce a care pathway for patients with dementia
Communication	The number of complaints received regarding communication has reduced significantly this year. However, the Complaints Manager (and team members) and the Head of PALS, Complaints & Bereavement Service continue to provide both bespoke and ad-hoc training sessions on the 4 C's which incorporates communication and attitude and behaviour.
Delays / cancellations	Issues were highlighted in last year's report regarding the number of complaints received in relation to the Eye Department. Following this significant action was taken by the Trust to improve this area, and work remains ongoing at the present time as follows: • A comprehensive action plan was prepared by the directorate • Additional staff were recruited (both clinical and non-clinical) • A series of specific governance meetings were set up to support the process, and were attended by representatives from the complaints team. • A new service manager was appointed to manage the Eye Department • New administrative processes have been introduced • An external company has been contracted to provide additional support to reduce a backlog of patients who required appointments

Primary theme	Action being taken
	A number of complaints have been received regarding the transfer of patients between the A&E Department and the Fracture Clinic. Patients appeared to be lost in the system, or were not being contacted to arrange appointments. The problem had arisen through a paper based system reliant on individuals to deliver the documents from one area to another. The following action is being taken: • A meeting has taken place involving key staff from both areas • A new process has been agreed with the support of IT Any referrals from the A&E department to the Fracture Clinic will be completed using the ICE system, which is already in use within other areas across the Trust
Discharge	The number of complaints received regarding discharge have improved slightly when compared to last year. However, the Trust continues to remain focused on improving this further. • Victoria ward has been designated as the discharge ward/lounge. This ensures that patients who require discharge via a bed/trolley/stretcher, as well as ambulant patients can all be cared for in this area immediately prior to them going home. • Work is currently being undertaken to look at the problems surrounding medication to take home, and the associated difficulties experienced when they are not ready in time • Late discharges of elderly/frail patients are currently being looked at by the SOVA lead and complaints are discussed at the Trust's dignity forum • A discharge forum is in place and is being taken forward this year to look at ways in which the discharge process can be improved, including the paperwork in use. • Nurse facilitated discharges have been implemented, resulting in a higher quality discharge process whilst reducing the delays to patients.
Attitude & Behaviour	There has been an improvement in the number of complaints received regarding the attitude and behaviour of staff. However, the Complaints Manager and Head of PALS, Complaints & Bereavement continue to incorporate attitude and behaviour aspects within their training sessions.

2.6 Compliments

As part of the 4 'C's process members of the public are also encouraged to tell us when they believe that we have 'got it right'. This feedback is monitored through the Trust's quarterly reporting schedule (along with complaints).

What our patients are saying about Northampton General Hospital NHS Trust:
(Source 4 'C's compliment forms)

"We just want to commend and thank all the staff, nursing, medical, catering and cleaning, on Abington ward for the quality of professional care. It was evident from the time.. .....was admitted to the ward, to the present. Time with the staff nurse explaining.....condition and needs (for someone with severe Alzheimer's is great), was so helpful. The positive and welcoming approach has been equally evident on subsequent visits."

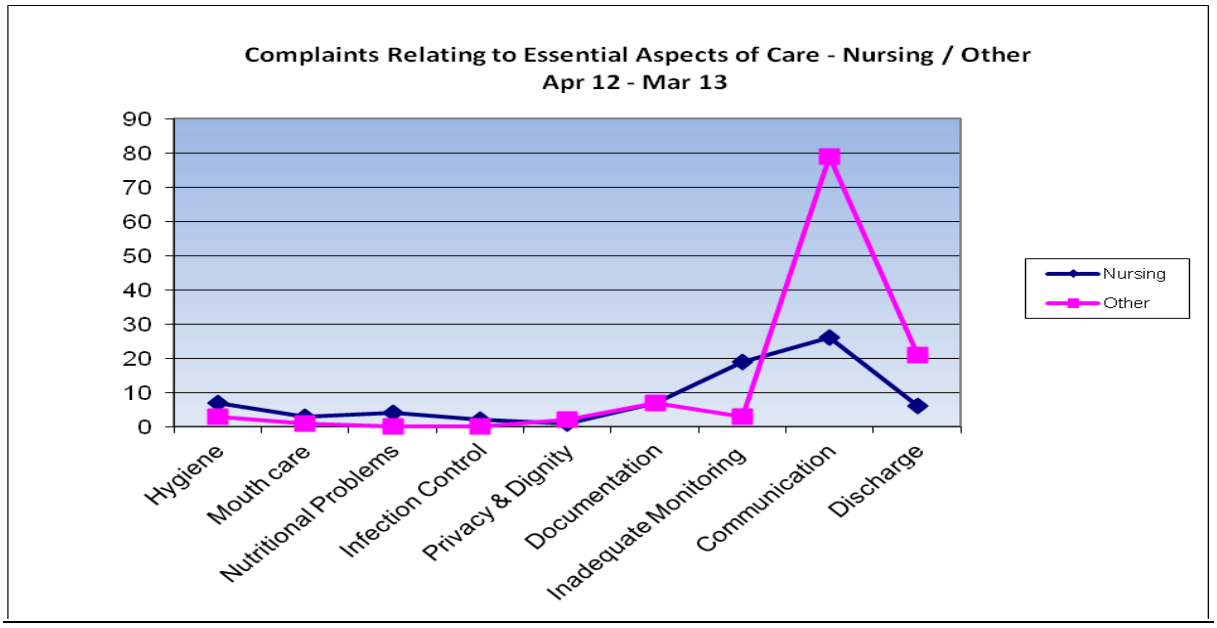
"The staff at the A&E unit were all very professional and polite and exceedingly good at their roles. About midnight I was transferred to EAU and they too were excellent in every way. I was then transferred to

Creaton ward and I must say all the staff were exceptionally professional and knowledgeable about medications and exceedingly polite, helpful and understanding."

"All staff on Gossett ward, thank you all for your care and support over the last month. Not only do you carry out the job you are employed to do you go way beyond your roles. We could never thank you enough for the care you have given to .....and to be taking her home so content and happy is down to your enthusiasm and hard work"

2.7 Complaints relating to Essential Aspects of Nursing Care

The Trust continues to report on the essential aspects of nursing care, which has previously been included within the Quality Accounts. The table below shows the categories that have been identified within complaints received within 2012-2013, and the numbers received.



(N.B. other - relates to medical, AHP, administrative, portering, security and all non clinical staff)

Please note that this is incorporated into the previous table in terms of the action being taken. However, it should also be noted that communication has improved this year, when compared to last year.

3. Learning from complaints

The Trust requests action plans for ALL complaints where learning has been identified.

The following subjects have been identified through the learning from complaints:

- Communication
- Infection Control
- Procedural changes
- Discharge
- Confidentiality
- Administration
- Waiting times
- Attitude & Behaviour
- Documentation
- Nursing & medical care

The Trust's Complaints Department track and monitor learning and action plans through to completion via an excel spreadsheet which is accessible to the directorates through a shared drive. All action plans must be fully completed and are not closed on the tracking document until evidence has been provided and a member of the directorate's senior team has signed it off as complete. This is monitored through the quarterly complaints report which is issued to the Clinical Quality & Effectiveness Group (CQEG) and via the Patient Safety, Clinical Quality & Governance Progress Report.

It has been reported upon through the quarterly reporting process that further work needs to be undertaken with regard to learning. The directorates have been unable to maintain their action plan trackers, or provide evidence to support the learning for a number of their complaints which has been due to the resources available. However, the Governance department has recently undergone a major restructure and additional resource / support has been allocated to the care groups.
It is hoped that this will underpin the governance processes within the care groups and ensure that they are accountable and able to fully close the loop on their complaints.

Learning through consultants appraisals

Each consultant has an annual appraisal with a member of the Trust's senior team. Through this process the consultant must provide details of all complaints that have been received about them (or a member of their clinical team) during the previous 12 months. A summary/list of the complaints is provided by the Complaints Team to ensure that the appropriate information is available for each appraisal and that the Trust is compliant with current external guidance. Additionally, any complaints that are received which relate directly to the attitude & behaviour of a consultant are immediately copied to the Medical Director, as part of the initial process. An essential part of this process is to ensure that consultants and their clinical teams learn from complaints.

Reporting Forums

Learning from complaints is disseminated across the organisation through the Trust's Patient Safety, Clinical Quality & Governance Progress Report and the CQEG report. These reports are produced on a quarterly basis by the Complaints Team. The Complaints Manager attends the Patient Safety Learning Forum and the CQEG at which time high level learning is presented/discussed before being disseminated to other staff by the managers present.

This report will be presented to the Trust's Healthcare Governance Committee and a copy issued to our commissioners, in line with the NHS Complaints Regulations.

4. Complaints Surveys & Audits

Survey / Audit

There is 1 survey planned for 2013-2014 through the Trust's internal audit schedule and there have not been any audits completed this year.

5. Staff Support

The internal memorandum that is sent out with new complaints now includes a more detailed section on supporting staff. The following information is now included within all internal memo's that relate to new complaints:

"NGH is committed to ensuring that staff are supported in the undertaking of their roles and responsibilities. As such the Trust has developed a 'Policy for the support of staff following a complaint, claim or incident'. This policy can be accessed via the Trust's intranet. Additionally if you feel that it would be helpful to discuss this complaint and/or your report, please do not hesitate to contact me on extension 5774"

When complaints are sent out internally, they are accompanied by a memo with the above information detailed therein.

6. Key Priorities / Improvements

The Complaints and PALS teams continue to work very closely in order to fully support the 4 C's within NGH. It is recognised that ongoing improvements must be considered at all times, in order to continually review the process with the aim to providing an improved service to visitors to the site, and those who use either the Complaints or PALS services. In view of this the leaflets and posters have been rebranded to ensure that they are easily identifiable to those who access our services.

Subject	**Key priorities/ improvements**
PALS, Bereavement & Complaints - Delivering a high standard of service	The aim is to maintain a high standard of service to members of the public, internal customers (staff) and other organisations including the provision of support, advice, information and guidance. Following the recent review of the governance structure it has been recognised that the resources that were in place did not meet the demands of the service, given the increased number of PALS enquiries and complaints received, and the complexity of these cases. In view of this, some changes are in the process of being made including the increase in hours for two of the part time staff, plus some additional administrative support to be shared across the service.
Improved working practices	With the exception of 1 or 2 areas all complaint responses are being prepared by the corporate team, following the successful transfer back from the directorates.
Training	• Formal complaints training continues to be provided, is featured within the mandatory training prospectus and is offered at 2 levels. Bespoke training sessions are also provided individually and as a group. • PALS awareness briefings • Communication (best practice) sessions
4 C's implementation	The Complaints Manager and Head of PALS, Complaints & Bereavement deliver talks to explain the process and the importance of trying to resolve any issues as and when they arise and the benefits that a pro-active approach to local resolution provides for both patients and staff. This underpins the Trust's aim to achieve local resolution at the earliest opportunity. Following the release of the inpatient survey it was recognised that work needed to be done to ensure that patients and visitors have easy access to information as to how to raise any of the 4 C's. Following this an audit was completed by selecting a random number of areas to check the availability of posters and leaflets. The posters and leaflets have subsequently been amended to make them stand out more for patients and visitors. The outcome of the audit was good but it was clear that further work is required. This will remain a priority for the coming year.
Response rate	The response rate has dropped significantly through this reporting year and overall was 84% at the time that this report was prepared. There have been a number of contributory factors to this: • Incomplete / late responses provided by the directorates • Resources within the complaints team due to long term sickness / absence of a member of the administration staff and the other person leaving the department. These posts were initially backfilled by other team members, and the sickness / absence was covered throughout by colleagues. Work needs to be undertaken to look at ways in which this can be improved as the number of extension of time requests and holding letters have significantly increased.

Subject	Key priorities/ improvements
Reopened complaints	The Trust has a target of less than 5% of reopened complaints, which is set by the CCG. The team has worked hard to provide high quality responses that fully address the points raised. Currently reporting at 5%.
Care group implementation	The Complaints team are aligned with the care group structure by having a named point of contact for each area. This is working well.
Reporting	Following receipt of the Francis Report the Complaints Manager completed an in depth gap analysis of areas relating complaints, PALS and the Bereavement Service. This has since been incorporated into the Trust's ongoing action plan. Further information on this is detailed in the recommendations for 2013-2014. Complaints data is provided for the following reports / groups: • Trust financial report • KO41a (Department of Health) • Quality Account • Learning Disability annual report • Equality annual report • Healthcare Governance Committee • CQEG + PALS • Patient Safety + PALS • Corporate Balanced Scorecard • Directorate monthly compliance/assurance reports • Aggregated analysis report + PALS • Consultant (doctors) appraisal reports • Adhoc reports

Recommendations for 2013-2014:

- To maintain the high standard of service that has been achieved by the teams as recognised in the CEAC internal audit report 2012, and to regularly review the resources and practice in both PALS/Bereavement & Complaints Services to ensure the service meets the need of the organisation and the patients/relatives that access it.
- To support the implementation of the care group governance structure following the recent restructure.
- To maintain compliance with the NHSLA and CQC standards and ensure that evidence is monitored accordingly.
- To continue to work on the development of a more refined internal process for handling SI's that also link to PALS, Complaints, Claims, Inquests, and Bereavement Services.
- Improve the process for monitoring action plans and evidence through the care groups governance teams
- Review and implement any recommendations from the Francis report, where learning has been identified, with the support of the Trust's senior team.

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Health and Safety Annual Report 2012/13
Agenda item	20
Sponsoring Director	Charles Abolins, Director of Facilities and Capital Development
Author(s)	Diana Salvio, Health and Safety Manager
Purpose	For information and assurance
Executive summary The annual report provides an overview of Health and Safety performance during 12/13, highlighting areas which need to be addressed in order to provide improved assurance.	
Related strategic aim and corporate objective	• To be a provider of quality care for all patients • Provide appropriate care for our patients in the most effective way • Foster a culture where staff can give their best and thrive
Risk and assurance	Failure to meet statutory Health and Safety obligations and potentially increased costs of litigation
Related Board Assurance Framework entries	BAF 5 Failure of the Estate infrastructure
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	Failure to meet statutory obligations under Health and Safety legislation
Actions required by the Board The Board is asked to consider the report and note the issues highlighted together with the actions proposed to address the areas of concern.	

Enclosure R

Northampton General Hospital NHS
NHS Trust

Health & Safety Annual Report 2012-2013

Enclosure R

Compiled by: Diana Salvio
Version No.: 2
Date: July 2013

1.0 Introduction

This report provides an analysis of the Northampton General Hospital NHS Trust's health and safety (H&S) performance during the financial year 2012 – 2013. The report highlights relevant issues pertaining to the management of health and safety in the Trust.
The report concludes with a forward look, which gives a outline of the work planned for the new financial year to address the issues highlighted. This has identified some issues that will need to be addressed during the coming year.

During the year there has been a change in Health and Safety manager, David Johnston, Health and Safety manager left the Trust in December 2012. Diana Salvio the Trusts new Health & Safety manager commenced on 29 April 2013 and has undertaken a retrospective analysis of the management of Health and Safety within the Trust.

2.0 Risk Assessments

The Trust uses a combination of proactive and reactive systems to identify key H&S risks. Predominantly the proactive sytems are risk assessment based and supported by an H&S inspection process.

Completion of health and safety (H&S) risk assessments is a statutory requirement under the Management of H&S at Work Regulations 1999. The Trust monitors compliance by reviewing the corporate risk register on Datix. A gap has been identified in monitoring of compliance and completing of risk assessments throughout the Trust. There is also a lack of visibility of local and specific risk assessments at a corporate level. The H&S Manager and the Risk & Litigation Manager are reviewing the current Trust risk assessment and management process and will be proposing changes for improving the process and includes training of risk assessors and upgrade of currently used Datix version 9.2 to the latest available version 12.2.

Going forward, progress of proposed action plans and compliance will be monitored via Datix risk register and reported to the Trust H&S Committee. Any significant new H&S risks identified will also be brought to the attention of the H&S committee for consideration, escalation or further action.

3.0 H&S Inspections

The Health and Safety Executive (HSE) recommends that all areas are inspected regularly. The Trust has a quarterly H&S Inspection process that should be completed in all areas. However, historically compliance with this has been very low in corporate areas. The inspection process will be reviewed and improvements put in place to ensure improved compliance in 2013 / 2014.

4.0 Incidents

Datix Incident management system is the reactive performance monitoring system used by the Trust. A total of 10063 incidents were reported on Datix in the financial year 2012-2013 which demonstrates that the staff have good

incident reporting culture. A total of 500 staff Health and Safety related incidents causing harm were reported which is less than the last two years (Ref figure 4.1)

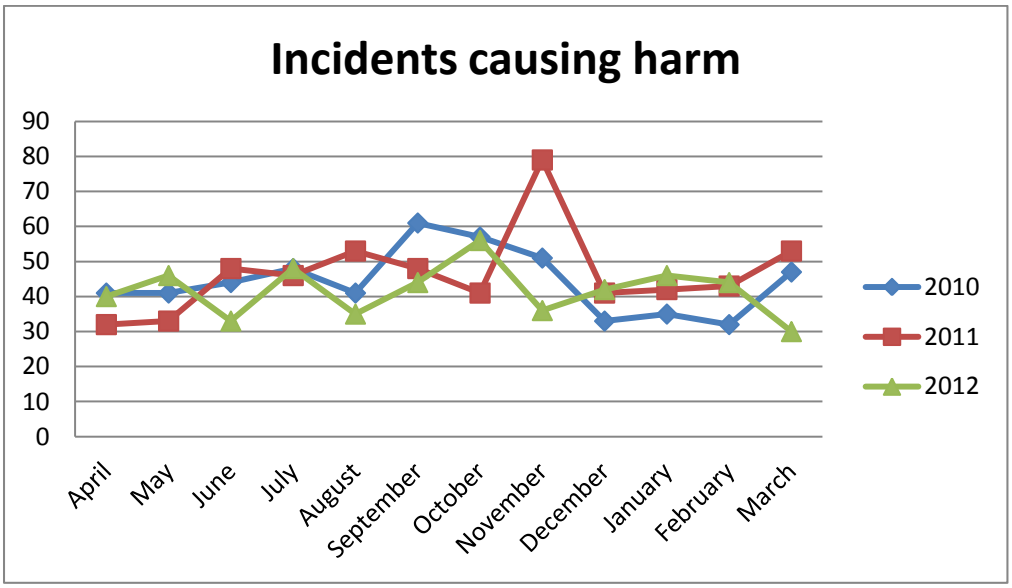


Figure 4.1

4.1 Staff Incidents

The top three main themes were violence and aggression, sharp incidents and manual handling for the financial year 2012/2013.

The highest number of staff incidents fall within the Abuse, Violence & Aggression category The incidents of violence and aggression have been covered in some detail within the 2012/13 Annual Security report already presented to the Board. This report therefore excludes these statistics.

4.2 Sharps Incidents

In sharps incidents (refer Figure 4.2) injury from dirty sharps was the main contributor.

The Trusts Health and Safety Committee is concerned that there is a trend of increasing sharps incidents within the Trust. In order to understand the reasons for this, a Safer Sharps Group (SSG) has been set up and is still in operation as a working sub group reporting to H&S Committee, with the remit to look into reducing sharps incidents, reviewing current sharp prevention and management process and recommending actions to ensure compliance with the new sharps legislation (Sharps Instruments in Healthcare) Regulations 2013.

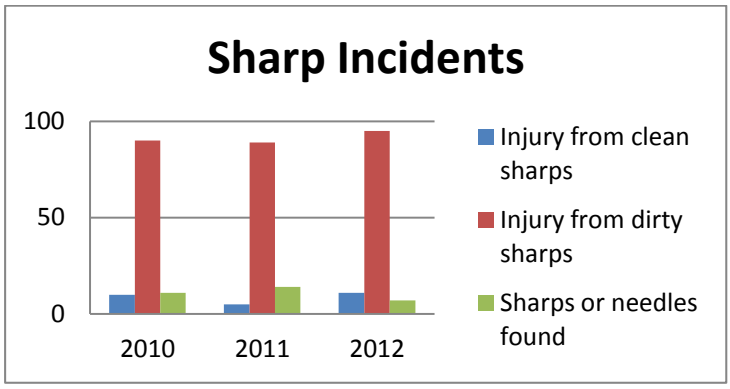


Figure 4.2

4.3 Manual Handling

Staff Manual Handling Incidents (ref figure 4.3) have shown an increase compared to last reporting period. Trust has mandatory manual handling training in place and the manual handling team to provide expert guidance and techical advice. Additionally there are physio services and self refferal systems in place that the employees can use.

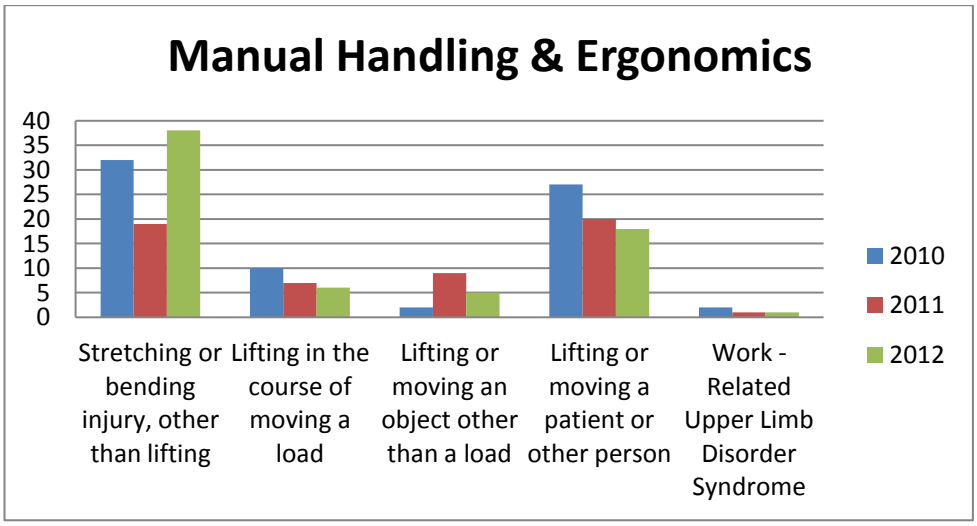


Figure 4.3

4.4 RIDDOR Incidents

There was a much lower number of incidents reported under RIDDOR in 2012-2013 financial year compared to previous years (Ref Figure 4.4).

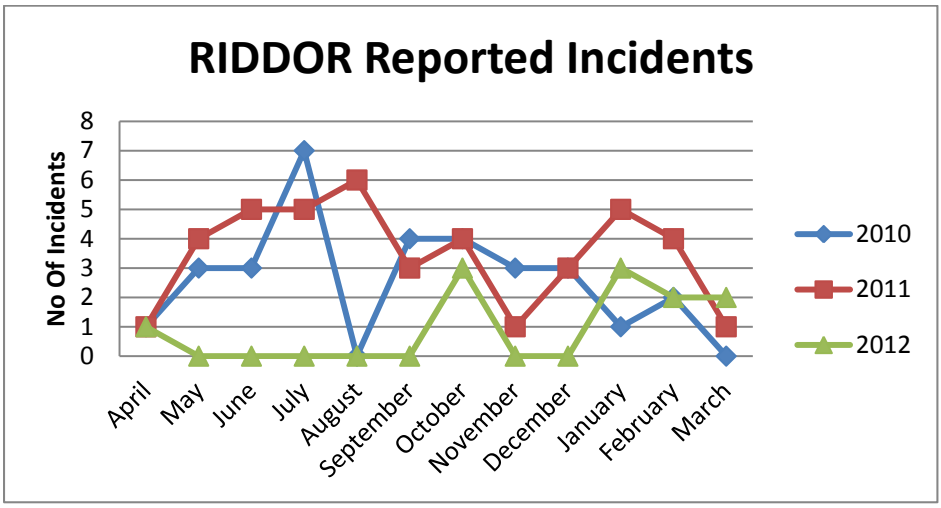


Figure 4.4

Part of the drop in number of RIDDOR incidents can be attributed to the change in RIDDOR legislation that came into force from 6 April 2012 onwards, whereby only over seven day incidents require to be reported to the HSE as opposed to the previous over three day incidents.

A gap in RIDDOR reporting has been indentified as the notification from departments of incidents meeting RIDDOR criteria is not being received by the Risk Management department in a timely way especially for over seven day incidents to ensure the RIDDOR report is sent to HSE within approved timescale of 15 days. Additionally, there is lack of assurance that actions are being completed timely to prevent reoccurence and the learnings shared.

The incident data above is based on final approved incidents. There is also an issue with timely investigation, final approval and closure of incident reports on Datix. Only 38 % of opened incidents causing harm were closed during 2012/13 reporting period. Better staff awareness and clarity of procedure is required to drive improvements.

Actions to be taken this year include publishing a Trust RIDDOR policy guide that explains the reporting criteria and managers responsibilities in this respect. In addition to the guide, there is a plan to have a learning panel under the H&S committee that would review all RIDDOR incident investigation reports and report learnings and actions required Trust wide.

5.0 Employer Liability Claims

A total of 16 employer liability claims were received in 2012/13 reporting with total damages of £135,700. The three main incident types resulting in claims are slips trip and falls , physical strain /lifting and sharps injury (refer Figure 4.5)

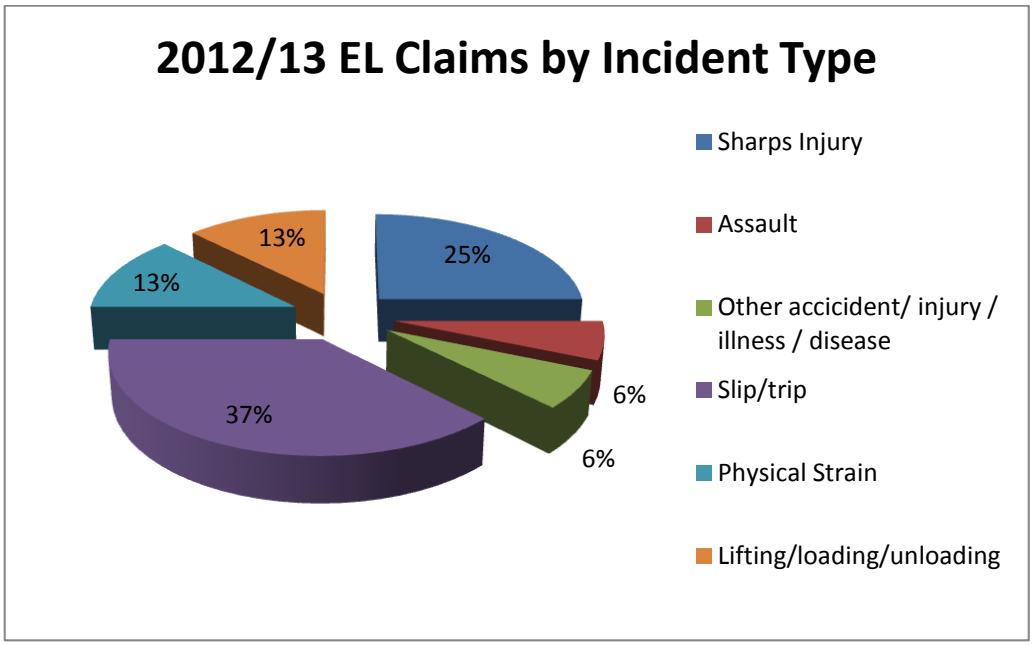


Figure 4.5

6.0 H&S Legislation Updates

The main H&S legislation changes in the financial year 2012/13 requiring action are:

Legislation	Implications	Action
Amendment (2012) to RIDDOR 95	Amendment came into force in April 2012, changes the reporting criteria from over three day to over seven day under RIDDOR.	Report over seven day incidents to HSE within timeline of 15 days after accident. A record of over three day incidents must still be kept on Datix.
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	Came into force May 2013. Implements the Sharps Directive (2010/32/EU) concerned with preventing injuries from medical sharps and applies to work in the hospital and healthcare sector.	Safer Sharps Group set up that is reviewing the impact of the new legislation and recommending actions for compliance.

7.0 Health Safety Executive (HSE) Inspection April 2012 Update

The HSE visited the Trust in April 2012, with a focus on COSHH, Dermatitis and Latex. Following the visit, list of recommendations were set out. H&S Action Plan Steering Group was set up to devise and action a plan to meet the recommendations of the HSE. The majority of the actions have now been completed. COSHH compliance audits are planned in 2013 to monitor compliance levels to provide assurance that all departments are complying with legislation

8.0 HSE Changes and Development Updates:

The HSE has started 'Fee for Intervention'(FFI) cost recovery scheme effective from 1st October 2012 which means that the Trust could now be held liable for the HSE's inspection, investigation and enforcement action costs if a breach of health and safety is identified. The FFI hourly rate for 2013 – 2014 is £124.

9.0 H&S Training

All employees are required to have Health and Safety awareness training. This is provided as part of the Trusts induction process. However prior to 2009 when the process was started the training data has not been captured accurately. Therefore Trust OLM report at the end of April 2013 shows the mandatory training 'Risk Management Awareness' which includes H&S is at 32.3%. Therefore it is most likely that more personnel have been trained than is reflected by the 32 %.

However in order to improve the compliance level significantly a new H&S training schedule for 2013/14 is being published. Additionally an H&S workbook is also being developed that will help all staff to achieve the mandatory level of H&S awareness, without the need to attend a formal training session.

10.0 H&S Committee

The Health and Safety Committee has continued to meet on a regular basis throughout the year. It is now appropriate to review these arrangements going forward and therefore the current Trust H&S Committee terms of reference and membership are being reviewed to ensure appropriate constitution in line with the new care group structure.

11.0 Forward Look

The following are the areas requiring improvement and the overview of the future proposed actions over the next two years is set out below:

Sl No	Theme	Actions
1	Risk Assessment and Management	▪ Risk Register updated ▪ Specific Risk assessments completed and corporately visible. ▪ Risk Assessment Training
2	H&S Policies and Procedures	▪ Review the following: • Lone working • Display screen Equipment • HSE committee TOR & membership • H&S Inspections • Powered vehicle • Staff Slips trip and falls • H&S Policy ▪ Following new policies are to be drafted: • RIDDOR Policy • First Aid Policy
3	H&S Training	▪ Develop H&S training matrix and schedule. ▪ Deliver training ▪ Develop H&S workbook
4	Communication	▪ Develop and implement H&S communication strategy. ▪ H&S link on intranet with quick reference links.
5	H&S Performance Monitoring and measurement	▪ Develop key performance indicators (KPIs) for the main risks to ensure H&S performance is monitored. ▪ Develop internal surveillance plan for evaluating compliance.

12.0 Summary

The report highlights the H&S performance of the Trust. Though a number of issues have been identified especially in incident reporting, risk assessments,

H&S training and communication, a plan has already been formulated to drive improvements over the coming 12 - 24months.

With the new substantive Health and Safety manager now in post there is a high degree of confidence that the proposed actions will be implemented thereby providing improved assurance in relation to the effective management of Health and Safety across the Trust.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Fire Safety Annual Report 2012/13
Agenda item	21
Sponsoring Director	Charles Abolins, Directors of Facilities and Capital Development
Author(s)	Head of Estates and Deputy Director of Facilities
Purpose	Information and Assurance
Executive summary The annual report provides an overview of Fire Safety performance and compliance during 12/13, highlighting areas which need to be addressed in order to provide improved assurance.	
Related strategic aim and corporate objective	• To be a provider of quality care for all patients • Provide appropriate care for our patients in the most effective way • Foster a culture where staff can give their best and thrive
Risk and assurance	Failure to meet statutory Fire Safety obligations.
Related Board Assurance Framework entries	BAF 5 Failure of the Estate infrastructure
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)
Actions required by the Board The Board is asked to consider the report and note the issues highlighted together with the actions proposed to address the areas of concern.	

Enclosure S

Northampton General Hospital NHS

NHS Trust

ANNUAL FIRE SAFETY REPORT

2012 - 2013

Enclosure S

1.0 Introduction

This report has been produced to provide the Trust Board with an overview of the current position of fire safety and to provide assurance that the Trust is meeting its statutory responsibilities.

2.0 Governance and Assurance

All fire safety arrangements within the Trust are modelled on the recommendations made by the Department of Health's Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

The Department of Health has announced this year, that the Annual Certificate of Fire Safety Compliance is no longer necessary but the Trust should implement a similar local certificate – see appendix 1 for the Trust's local annual certificate. To provide assurance to enforcing bodies that the Trust is complying with its statutory obligations and has a plan of action for dealing with gaps in compliance an independent review of fire safety compliance was completed in 2012. The resulting action plan is being monitored through Fire committee.

3.0 Fire Risk Assessments

During 2012 - 13 new fire risk assessments continued to be completed for all areas owned or occupied by the Trust, in addition to reviewing the existing assessments. There are four main areas identified in these risk assessments that impact on the ability of the Trust to provide a safe environment for patients, visitors and staff.

These are; Buildings/structural, Fire alarm, Vertical evacuation and Staff training.

Findings from these assessments have been used to prioritise fire safety works within the rolling annual capital programme. These works, as completed, will reduce or eliminate the risk but ongoing investment is required to maintain risks at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risk.

3.1 Buildings/Structural

Hospitals are designed and constructed to allow patients to remain inside, within fire safety compartments should a fire occur in another part of the building. This requires them to be constructed using high levels of fire resistance to divide the building into designated compartments. The Trust occupies many buildings dating from 1793, some of which have been built using construction methods that no longer satisfy current standards, for example the "Oxford Method". The affected buildings using "Oxford" were built in the late 1970s and currently house: Main Theatres, A&E, Fracture Clinic, Radiology, ITU/HDU and neighbouring wards. This construction method relied on the fire integrity of a suspended asbestos ceiling to provide fire resistance to the floor above and the steel frame of the building. The void created by the suspended ceiling was not provided with cavity barriers, allowing a very large uncompartmented area through which fire, smoke and heat could spread unchecked.

The Trust has carried out remedial work, on a phased basis, by installing cavity barriers in the voids during capital upgrading works. Asbestos ceiling tiles require specialist removal that would require lengthy closure of areas during the work, it is therefore operationally impractical to check the extent to which further fire compartmentation is required however it is considered that the areas still requiring work include: Radiology and part of Main theatres.

The risk has been mitigated by the installation of an automatic fire suppression system throughout the basement and other high-risk areas such as kitchens, stores and medical records, automatic fire detection system, staff training, emergency plans and an on site Fire Response Team. Over the past two years there have been substantial works to upgrade the fire alarm system by the installation of additional automatic fire detection and the upgrade of the systems control panels.

When the opportunity arises through capital refurbishment or emergency repair works fire safety improvements are always included wherever practicable.

Building works incorporating Fire Safety completed during 2012 – 13:

- New external fire exit from ITU/HDU
- Completion of alterations including improved fire barriers, dampers, fire detection, etc in Estates offices, Rheumatology, Strutridge ward, Cancer Information Centre and new Changing places facility
- Completion of new fire suppression system in the Trust's IT data centre
- Installation of flashing beacon/sounders across site to improve evacuation for the hard of hearing
- Fire panel improvement works to improve the functionality of the fire detection system

3.2 Fire Alarm System

The Trust's fire alarm has been extended and modified to ensure that it covers the whole site in accordance with relevant codes of practice and guidance.

Works to take advantage of the new fire control panels installed during 2011/12 has continued with improved communications between individual panels.
However, investment to improve the alarm system will need to extend into future years as part of a continued phased improvement.
The remaining risks are being monitored and mitigation plans are in place but ongoing investment is required to maintain risks at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risk.

3.3 Vertical Evacuation

Patient evacuation stretchers were purchased and deployed in all areas where vertical evacuation is required. This completes the provision of evacuation equipment and therefore reduces the risk to the Trust.

3.4 Staff Training

It is a statutory requirement of the Regulatory Reform (Fire Safety) Order and a mandatory requirement of Firecode that all members of staff undertake annual fire training and take part in a fire drill. Where patients are dependent on the staff for their safe evacuation this training is vital.

i. Training sessions

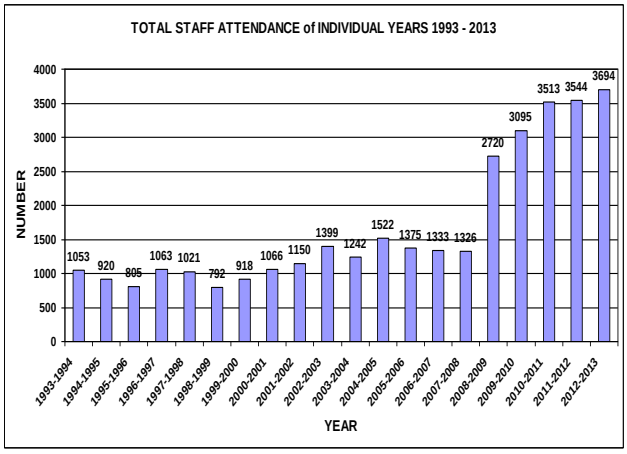
The Trust Fire Safety Advisor organises and delivers fire training throughout the Trust.
Until early 2013 this involved using the Training and Development facilities to deliver monthly training, however due to falling attendances at this venue it was discontinued. Training now takes place through Learning and Development cluster and mandatory training days.

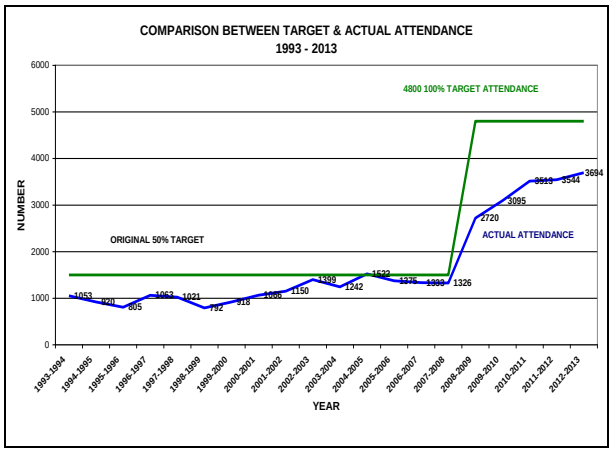
In addition to these pre planned sessions, training is now being delivered on request to departments – in the short time these departmental sessions have been run we have seen an improvement in the training figures.

ii. Attendance

From the records of attendance during 2012/13 3694 members of staff received training which equates to 77%, an increase of 150 (3%) over the previous year's attendance.
This remains a high risk to the Trust and Directorate managers are being tasked with ensuring that staff that out of date attend fire refresher training as soon as possible.

The Trust Fire Safety Advisor has continued regular contact with Directorate managers reminding them of the requirement for all staff to attend fire training and advising them on how to achieve compliance. This is also being monitored by the Trust Fire Committee and reported through CQEG.
In order to improve attendance, training has been provided in various flexible ways. This includes holding them locally in wards/departments and the option of completing via E learning. There has been an increase in attendance through these means and locally delivered departmental training now exceeds those attending sessions held in the Training and Development Centre.





iii. Fire Drills

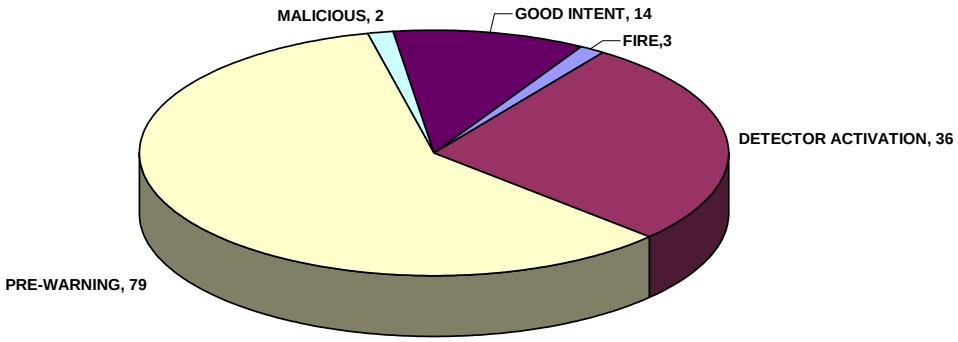
Fire drills have continued during 2012/13 and although there has been an increase in the number of areas where a drill has taken place there is still a shortfall against the 100% target.
Areas with a current drill have continually increased year on year; 2011 – 17%, 2012 – 26% and 2013 – 44%.
Without effecting service delivery and patient care, further increases in fire drills will prove challenging. The current method of conducting a drill is under review by the Trust's Fire Manager and Fire Safety Advisor with the intention of developing a process of testing fire plans and providing assurance without effecting patient care.
In the meantime the Trust Fire Safety Advisor has started regular contact with Directorate managers reminding them of the requirement to have a current emergency/evacuation plan. This is also being monitored by the Trust Fire Committee and reported through CQEG.

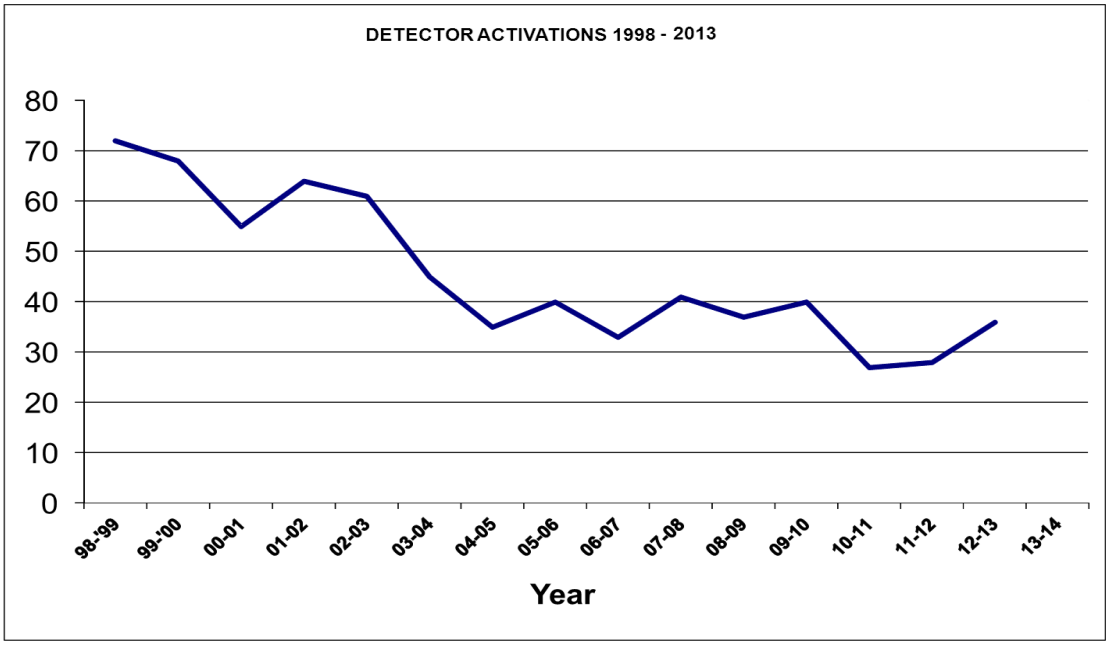
iv. Evacuation Training

In conjunction with the supplier, the Manual Handling Department and the Fire Safety Adviser have received training in the deployment of evacuation stretchers. The Manual Handling team, who have devised a specific training package, continue to train staff who will use these stretchers.

4.0 Fire Alarm Activations

There were a total of 134 actuations of the fire alarm during the reporting period, an increase of 51 from the last report.
It can be seen from the year on year trend that activations have been reducing despite the sharp increase in the number of detectors installed across the same period.





Fires
Three fire incidents occurred on site (1 recorded for 2011/12 due to a faulty charging circuit on an electric tug), 2 were caused by smoking materials and the third was a car fire outside Accident and Emergency.

Good Intents
The 15 (14 recorded for 2011/12) good intents were caused by members of staff operating a call point suspecting a fire after smelling smoke/burning.

Pre Warnings
There were 79 pre-warnings (36 recorded for 2011/12) - 23 were caused by high temperature in voids, 28 were unknown causes (further analysis of unknown causes were attributed to 3 individual detectors which have now been replaced), the remainder were detectors either going out of sensitivity or, briefly sensing smoke/dust/aerosols but were not enough to trigger a full alarm.

High temperature pre warnings in voids were caused by high external temperatures heating the roof spaces and activating new heat and smoke detectors. This has now been addressed by reprogramming the detectors to smoke only.

Detector Actuations
36 actuations (24 recorded for 2011/12) of detectors can be summarised as follows –
Contractors caused 5 (3 recorded for 2011/12)
Unknown caused 6 (2 recorded for 2011/12)
Detectors sensing smoke, dust or fumes caused 25 (19 recorded for 2011/12)

Equipment Faults
These were both caused by faults within the control and indicating equipment.

Misting System
The misting system interfaces with the fire alarm system for raising the alarm – there was one alarm from this cause due to a leaking joint on the pipe work

5.0 External audit

5.1 Independent external audit of fire safety arrangements December 2012

An independent audit of fire safety arrangements and the Trust's compliance with HTM Firecode was completed in December 2012 – commissioned by the Trust's Fire Manager.
The audit was completed using guidance provided in Health Technical Memorandum 05-01 ISBN 0-11-322741-8.
The report found the Trust remained compliant with its responsibilities under current guidance but gave recommendations for improvements. An action plan has been developed and is being monitored through the Fire Committee.

5.5 Northamptonshire Fire and Rescue Service (FRS) audit March/April 2013

Northamptonshire Fire and Rescue Service (FRS) carried out an audit of NGH fire safety arrangements in March and April 2013.
The audit, completed over two separate days, primarily concentrated on staff sleeping accommodation (William Kerr block) and high risk areas such as A&E and ITU/HDU.

The FRS audit report highlighted a number of concerns and observations which must be addressed by NGH to comply with legislation ie Regulatory Reform (Fire Safety) Order 2005. Following a review of the audit report by the Trust's Fire Manager and Fire Safety Officer, FRS attended site to clarify their findings. The majority of the report referred to, and quoted legislation but was not clear on how the Trust was failing to comply.

A number of observations from the audit were made in the report but, it was felt that the report lead the reader to believe there was little or no fire safety arrangements in place, which is clearly not the case.
The Trust has developed an action plan to address the issues with in the report and requested that FRS signed to confirm their acceptance of the action plan. The action plan has now been signed by FRS and is being monitored through the Fire Committee.

6.0 Conclusion:

Continued investment in fire safety through the annual capital plan has allowed the Trust to ensure that building/structural fire risks are eliminated or mitigated as much as practicable.

The independent audit completed towards the end of 2012 has provided additional assurance that our arrangements for Fire Safety management are satisfactory but, it has also given us direction for continued improvement over the next 12 months.

The Fire and Rescue Service audit completed in 2013 supported the findings of the independent report in December 2012 and highlighted further gaps from the site tour.
All urgent actions have been addressed and we have an action plan in place for the remainder with timescales approved by the Fire and Rescue Service.

There has been an increase in alarm activations over the previous year and although the causes have been minor, the responses to these have been timely and effective.
Continued analysis of these activations has identified causes and lessons learned have been used for new works.

Training all Trust staff on an annual basis continues to be a challenge. Attendance figures have improved year on year but further work is still required within the Care Groups to improve performance in this area.

Appendix 1 – Annual Statement of Fire Safety 2012

Northampton General Hospital NHS
NHS Trust

Annual Statement of Fire Safety 2012

I confirm that for the period 1st January 2012 to 31st December 2012, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and *(please tick the appropriate boxes)*		
1	There are no significant risks arising from the fire risk assessments	
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment	√
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	
* Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire and Rescue Authority? If Yes – Please give details of the enforcement action	No
5	Does the organisation have any unresolved enforcement action pre-dating this Statement? If Yes - Please outline details of unresolved enforcement action	No
AND 6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method	Yes

Fire Safety Manager:	Name: Stuart Finn 16 July 13
	E-Mail: stuart.finn@ngh.nhs.uk
Contact Details:	Telephone: 01604 545903
	Mobile: 07879 473407
Chief Executive Name:	Dr Sonia Swart
Signature of Chief Executive:	
Date:	16.7.13

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Equality and Human Rights Annual Report 2012 / 2013
Agenda item	22
Sponsoring Director	Janine Brennan, Director of Workforce and Transformation
Author(s)	Sue Campling, Equality Service Lead Andrea Chown, Deputy Director of Human Resources
Purpose	Assurance to the Trust Board that the Trust is compliant with the Public Sector Equality Duty and Equality Act 2010

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Annual Report for 2012/2013 aims to demonstrate this compliance and provide assurance that the Trust is meeting its duty by reviewing the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2012 to 2013. In addition, our legal duty to monitor our workforce is also addressed in the Annual Report.

Related strategic aim and corporate objective	All
Risk and assurance	A lack of patient information does not enable sufficient monitoring on all the protected characteristics. The Trust is exploring through its equality network how best to collect further patient information. Likewise there is limited information recorded on some of the protected characteristics for employees. The Trust has recently carried out a data cleanse for all staff across the Trust which should improve future reporting.
Related Board Assurance Framework entries	All
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**

Enclosure T

Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 (Specific Duties) Regulations 2011 All Equality and Human Rights legislation Regulations and Codes of Practice including NHS and DoH standards.

Actions required by the Board

The Trust Board are asked to endorse the content of the Equality and Human Rights Annual Report 2012 / 2013.

Northampton General Hospital NHS
NHS Trust

Trust Board
July 2013
Equality and Human Rights Annual Report 2012 / 2013

Executive Summary

1. Introduction

The Equality and Human Rights Annual Report for 2012 / 2013 aims to demonstrate compliance and provide assurance that the Trust is meeting its public sector duty by reviewing the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2012 to 2013.

From a Service prospectus this report demonstrates that the Trust has an understanding of the service needs against the Northamptonshire population and that the Trust is developing services in response to these needs as well as making improvements to the estate that will support service users.

The Trust's legal duty to monitor its workforce is also addressed in the Annual Report and it provides equal opportunities information, analysis and actions to take for some of the protected characteristics in the following areas:

- Trust's Workforce Profile
- Human Resources (HR) Recruitment Activity
- HR Caseload Activity
- Learning and Development Activity

2. Body of Report

Key points from the Annual Report are as follows:

- Progress made on the Trust's Four Year Plan which provides the key objectives to encourage an outcome focussed approach to setting challenging but measurable targets to improve service outcomes and the way the Trust employs its staff. The objectives address the biggest and most pressing issues facing the protected groups that the Trust provides services for and employ, and it prioritises the most significant issues for the protected characteristics

- Progress made in relation to engagement, consultation and involvement from both patient, carers, the public and the Patient and Public Involvement Strategy aims to involve patients, carers and the public in order for the Trust to:

  - Obtain the best outcome for the patient
  - Improve the patient experience
  - Help the Trust to run services more efficiently and effectively
  - Incorporate the views of service users in future service developments

- The Trust's commitment to staff engagement with the work that has been carried out through the Listening into Action (LiA) programme and the actions that have been implemented as a result of the staff engagement programme

- The Trust's continued commitment to utilise its systems for carrying out equality analysis on policies, functions and change programmes to assess whether they have the potential to affect people differently

- Areas of good practice such as examples of providing reasonable adjustments for individuals with Learning Disabilities and those patients with Dementia. In addition, the language support the Trust provided and alternative ways of communicating to patients with the continued use of pictorial folders for the ward areas to aid basic communication and easy read leaflets suitable for the use by people with learning disabilities, reading or cognitive problems or patients whose first language is not spoken English

- The monitoring of the workforce profile against the local population within recruitment activity, HR casework and learning and development activity.

Finally, the Annual Report was approved by the Equality and Human Rights Steering Group in June 2013.

3. Assessment of Risk

By publishing the Annual Report the Trust has met its duty to publish information to demonstrate compliance with the Public Sector Equality Duty. However, the risks associated with this report are that the Trust has insufficient information for patients and staff on some of the protected characteristics. This limits the Trust's ability to analyse data to tackle discrimination, improve access and outcomes and reduce health inequalities amongst the protected groups and other disadvantaged communities.

The Four Year Plan recognises this and one objective is to develop a programme of data collection and analysis for patient information to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire. In addition, the programme of improving data collection and analysis for staff has commenced with a Trust Wide data cleanse of the Electronic Staff Record system.

4. Recommendations/Resolutions Required

The Board is asked to endorse the Equality and Human Rights Annual Report 2012 / 2103.

5. Next Steps

Following approval of the Annual Report at the Equality and Human Rights Steering Group it has been agreed that the Equality & Human Rights Steering Group would be provided with an action plan giving assurance of the actions that are in progress to address the issues that became evident during the work carried out on the Annual Report for 2012 / 2013. This will be presented at the meeting in August 2013, together with, a progress report on the Four Year Plan.

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital

Equality and Human Rights Annual Report 2012/2013

Including Workforce and Service Data

June 2013

CONTENTS

EXECUTIVE SUMMARY

The Equality and Human Rights Annual Report for 2012/2013 reviews the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2012 to 2013.

From a Service prospectus this report demonstrates that we have an understanding of the service needs against the Northamptonshire population and we are developing services in response to these needs as well as making improvements to the estate that will support our service users.

In addition, we have provided areas of good practice such as examples of providing reasonable adjustments for individuals with Learning Disabilities and those patients with Dementia. We have also demonstrated the language support we have provided and alternative ways of communicating to our patients with the continued use of pictorial folders for the ward areas to aid basic communication and easy read leaflets suitable for the use by people with learning disabilities, reading or cognitive problems or patients whose first language is not spoken English.

Our legal duty to monitor our workforce is also addressed in this document. The report provides equal opportunities information for some of the protected characteristics in the following areas:

- Trust's Workforce Profile
- Human Resources (HR) Recruitment Activity
- HR Caseload Activity
- Learning and Development Activity

INTRODUCTION

Northampton General Hospital believes that Equality and Diversity (E&D) is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfill their potential.

In 2012/2013 there was a review of the Trust's Equality and Human Rights Strategy which recognises the right of all patients, visitors and employees to be treated fairly and considerably in access to services and employment, irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability and social status.

The Trust aims to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of the different groups and individuals we serve and the staff we employ.

To achieve this aim, we want to ensure that service users and employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances.

It is important to us that we eliminate discrimination in the way we provide our services and the way we recruit, train and support our workforce. The Trust does not tolerate any forms of unlawful or unfair discrimination. In addition it recognises that all people have rights and entitlements.

Equality and Diversity remains high on the Trust's agenda and progress is being made to implement the Four Year Equality Plan which was agreed in 2011/2012. This work is overseen by the Equality and Human Rights Steering Group.

TRUST OVERVIEW

Northampton General Hospital NHS Trust (NGH) is a 619 bed acute hospital (excluding day case and community beds) providing services from four main sites and a number of smaller facilities. The largest hospital site is based in Northampton town centre providing a full range of acute services. It has operated on this site since 1793. The other hospital site is in Daventry, providing further acute services. We also provide care at Isebrook Hospital and Corby Community Hospital. We serve a growing population which is currently around 380,000 inhabitants. The Trust is also an accredited Cancer Centre delivering cancer services to a wider population of 880,000 from the whole of Northamptonshire, and parts of Buckinghamshire. Hyper acute service development has included cancer, vascular, renal, stroke and enhanced cardiology services.
The Trust has recognised that the landscape for the provision of acute healthcare is changing rapidly and developed a strategy that will consolidate and enhance our position as one of the hyper acute hospitals in the South-East Midlands network.

The Trust employs 3844 whole time equivalent (wte) members of staff, a headcount of 4776 people, (as at 31 March 2013). There is a Clinical Care Group Structure in place, which supports the delivery of the strategic aims of the Trust by enabling increased ownership of Clinical Service Unit performance and assisting with transformation delivery.

OUR STRATEGY

Strategic Aims:

The Trust strategy was written in partnership with senior clinicians and managerial staff.

The NGH vision is to provide the very best care for all our patients.

We aim to:

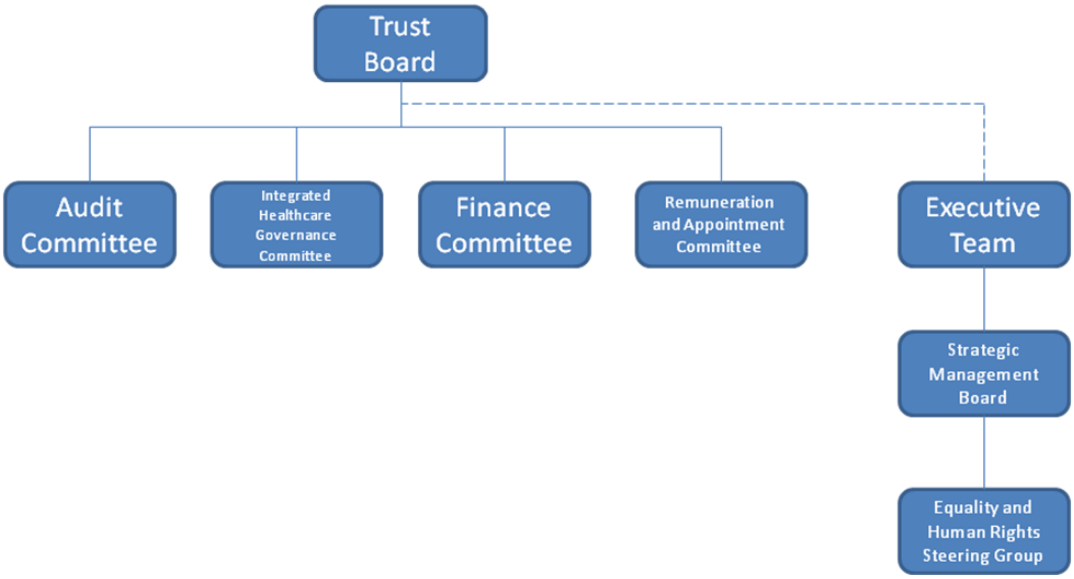
- Be a provider of quality care for all our patients
- Enhance our range of hyper acute services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- To be a financially viable organisation

A partnership has been developed to progress the commissioner-led work on the configuration of acute services and provider led work to discuss partnership working with Kettering General Hospital up to and including formal merger across Northamptonshire.

GOVERNANCE ARRANGEMENTS

The Governance arrangements at the Trust are provided in the framework below and demonstrate that the Equality and Human Rights Steering Group is in a position to lead the way in setting the strategic direction as well as monitoring and providing assurance of the delivery of equality issues.

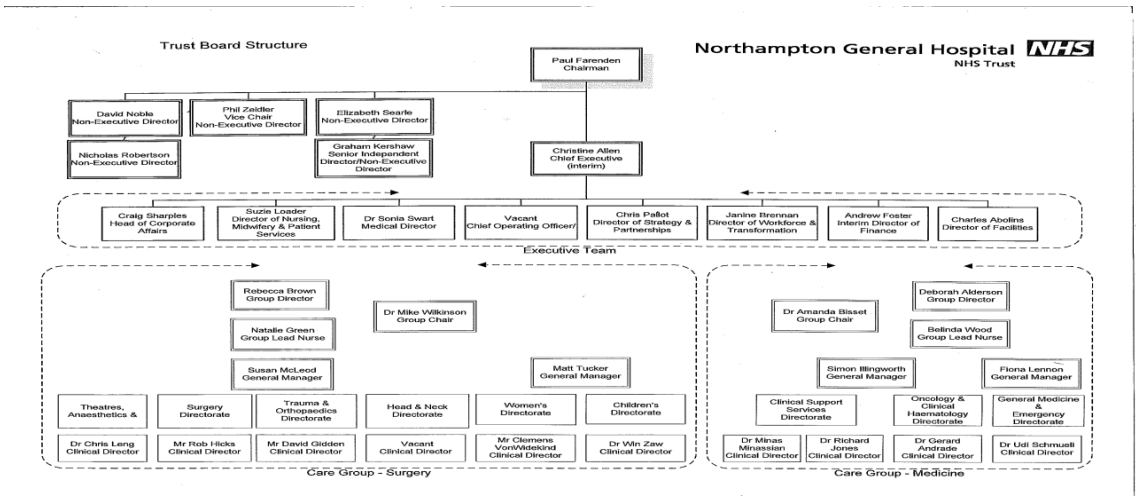
Equality and Human Rights Steering Group Governance



In April 2012 the Trust changed its management structure from a Directorate based one to two Care Groups. The new Care Group structure supports the strategic direction of the Trust and enables decision making to be devolved, wherever possible, to the Directorate caring for groups of patients. Directorates work together and share resources, under one large group – the Care Group.

In order to integrate the Trust's equality obligations, senior representatives from each of the Care Groups are members of the Equality and Human Rights Steering Group and provide regular reports on equality initiatives taking place within the Care Group.

The Care Group structure has been provided below.



DEMOGRAPHICS WITHIN NORTHAMPTONSHIRE

Northamptonshire has a population of 691,900 people, an increase of 9.8%, since the last census in 2001, with over 76% living in town and urban areas. Using Birth & Death data between 2001 and 2011, 76% of the total increase in population size can be accounted for, the remainder being due to migration in and out of the county. The level of migration into Northamptonshire, however, both internationally and internal to the UK has reduced in recent years.

In 2010 there were 69.45 live births per thousand women aged between 15 and 44 in Northamptonshire, reversing a previously declining trend and a higher rate than the general fertility rate for England. The birth rate in Corby has grown by three times as much as the rest of the country at 63%. About 1 in 5 children were born to mothers born outside the United Kingdom (source: JSNA 2011).

Black and minority ethnic groups constitute approximately 8.5% of the population of Northamptonshire. Corby is less ethnically diverse than Northamptonshire or the East Midlands overall where 95% of the population is estimated to be white particularly in the older age groups.

Northampton General Hospital NHS Trust has ensured that its strategic direction is aligned with that of the wider NHS community. An aging population is likely to impact significantly on health services, with the number of people living in Northamptonshire with long term conditions increasing. This can be seen by an increase of 33% in the over-85 age group between 2001 and 2011; this has required services changes to respond accordingly.

PANSI* Projections	2012	2016	2020	Change
Diabetes adults 18-64	14273	14677	15321	6% increase
Longstanding health condition caused by a stroke adults 18-64	1348	1375	1424	5% increase
Adults 18-64 with a drug or alcohol problem	14,759	14933	15269	3% increase
Moderate Hearing impairment adults 18-64	17349	17717	18734	8% increase
Adults 18-64 with moderate physical disability	34260	34821	36177	6% increase
Adults 18-64 with a common mental disorder	70109	70873	72443	3% increase

Projecting Adult Needs & Service Information: May 2013

Northamptonshire has responded by developing a stroke service at NGH, transferring PPCI to Kettering General Hospital NHS Foundation Trust and developing a countywide model for vascular surgery.

LOCAL HEALTH ECONOMY Key Points:

- A higher proportion of birth to mothers born outside the UK compared to the rest of the East Midlands however a smaller proportion compared to the national average.
- Increasing population
- Increasing elderly population (increase in long term conditions)
- 8.5% black and ethnic minority
- The estimated level of adult smoking is worse than the England average
- 24.9% of the population under 20 years of age
- 15.3% of the population over 65 years of age
- Life expectancy is 9.4 years lower for men and 5.8 years lower for women in the most deprived areas of Northamptonshire than in the least deprived areas.

THE LEGAL FRAMEWORK

The Equality Act 2010, its regulations and guidance replaces previous anti-discrimination laws with a single act. It has simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways, to help tackle discrimination and equality. The public sector equality duty, which applies to all NHS organisations, is made up of a general duty which is supported by specific duties.

The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Act
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Having due regard entails considering the above three aims of the equality duty and how they are an integral component of the decision making in:

- How the organisation acts as an employer
- How policies are developed, reviewed and evaluated
- How services are designed, delivered and reviewed
- How they procure from others.

Advancing equality of opportunity involves removing or minimising disadvantage encountered by people due to their characteristic, meeting the needs of people with protected characteristics and encouraging people with protected characteristics to participate in public life where participation is low.

Fostering good relations involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

The Equality General Duty is supported by specific duties, set out in regulations which came into force in September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty and to set themselves specific, measurable equality objectives.

The protected characteristics covered by the Equality Duty are;

- Age
- Disability
- Gender-reassignment
- Marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex
- Sexual orientation

We are required to publish information to show our compliance with the Equality Duty, at least annually. This has been included in this Annual Report.

The Equality and Human Rights Commission published technical guidance on the Public Sector Equality Duty in January 2013. This has highlighted a number of issues Northampton General Hospital needs to take note of. These include:

- Recent case law examples which clarifies the role of the Trust Board, managers and employees in relation to equality, diversity and inclusion
- Confirmation of the need to consider equality in respect of our policies and functions

Ongoing consideration of the impact of the technical guidance will be monitored through the Equality and Human Rights Steering Group.

PROGRESS IN 2012 -2013

Four Year Plan

The Trust has agreed a four year plan with reference to public sector and other duties and to equality target groups. The objectives set, encourage an outcome focussed approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff.

The objectives address the biggest and most pressing issues facing the protected groups that we provide services for and employ, prioritising the most significant issues for the protected characteristics.

During 2011, in full engagement with local interests, the Trust developed four year equality objectives and priorities, based on a grading of our equality performance against a set of EDS goals and outcomes.

Goal	Objective
1. Better Health outcomes for all	We will develop a programme of data collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire
2. Improved access and experience	The Trust will increase the engagement and involvement with representatives from protected groups. In 2 years we will aim to achieve representation from 100% of the protected groups.
3. Empowered, engaged and well supported staff	We will aim by 2014 to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trust's for response to the question regarding whether staff would recommend the Trust as place to work.
4. Inclusive leadership at all levels	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS Leadership Framework and its supporting frameworks.

The detailed action plan of the Trust's equality objectives and progress made can be accessed via the Trust's internet. The link to this is: www.northamptongeneral.nhs.uk/WorkforUs/Downloads/Equality-Objectives-2012-to-2016.pdf

In addition the progress made was reported to the Equality and Human Rights Steering Group in February 2013 and has been provided below:

Equality Objectives 2012 to 2016
Progress Report
February 2013

Equality Delivery System Goal	Narrative: The NHS is asked to……	Objective	Executive Lead	Key Actions	Progress Report February 2013	Timescales
1. Better Health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence needs and results.	We will develop a programme of data collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire	Director of Strategy and Partnerships	Identify the Trust's annual service priorities within the Quality Programme. Target data collection and analysis by protected groups on annual service priorities. In conjunction with NHS Northamptonshire target specific areas where health inequalities are known and collect and analyse information by protected groups. Report findings on a six monthly basis to the Equality and Human Rights Steering Group. Put in place action plans across the services to	Annual Service Priorities within the quality programme completed Data required from Public Health in order for analysis to take place	April 2012 From October 2012 October 2012/ongoing December 2012/ongoing February 2012/ongoing

				address identified inequalities in service delivery, where possible.		

2. Improved access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	The Trust will increase the engagement and involvement with representatives from protected groups. In 2 years we will aim to achieve representation from 100% of the protected groups.	Director of Nursing and Patient Services	Review of the Service User Engagement structure and reporting mechanism to the Equality and Human Rights Steering Group. Every six months themes from the protected groups via the Public and Patient Involvement Steering group (PPI) will be reviewed and reported to the Equality and Human Rights Steering Group. Action plans from the PPI group will be developed where appropriate. Consultation mechanisms will be developed to further improve involvement and feedback in service delivery.	Review completed and structure agreed following the development of the Patient Experience Strategy. NGH Disability Partnership Group established and action plan agreed. Summary of issues raised and actions taken by Trust Engagement Groups tabled at the PPISG and reported to E&HRSG. Patient Experience Strategy launched December 2012. Patient Experience Board established. Members of NGH Disability Partnership Group working with LIA re signage and patient letters.	July 2012 January 2013 January 2013/ongoing Ongoing

3. Empowered, engaged and well supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non paid workforce supporting all staff to better respond to patients' and communities' needs	We will aim by 2014 to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trust's for response to the question regarding whether staff would recommend the Trust as place to work.	Chief Executive	Develop and implement a staff engagement programme centered on the Trust's vision and values and the desired behaviors and performance of staff.	The Trust commenced the Listening into Action (LiA) programme in July 2012 which encompasses the Trust's vision and values. The programme is now being delivered at Directorate level with LiA meetings taking place on a regular basis and actions carried out by the Care Groups	April 2012 to March 2015
				Carry out focus groups to identify the key annual priorities for improvement as identified in the Staff Survey and develop action plans to implement these priorities.	Focus groups took place in July 2012 with staff from all directorates and staff survey action plans produced by Care Group. Implementation of the action plans needs to be embedded into the Care Group structures.	April 2012 onwards
				Develop a Staff Wellbeing forum.	Staff and Wellbeing will be Developed under the Umbrella of the recently Established Workforce Planning and Education and Training Steering Group	August 2012/ongoing
				Develop systems to	The ESR system captures most protected characteristics but further	September

				capture data on all of the protected characteristics to analyse to identify if any staff groups are being disadvantaged	analysis is required. Discussions still to take place across Northamptonshire Trusts Some progress has been made with the development of an HR database through ESR for the Trust.	2012/ongoing

4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS Leadership Framework and its supporting frameworks.	Director of Workforce and Transformation	To continue the development of the accredited leadership and management programme tailored to the needs of managers bands 6 to 8. Embed equality within the new Care Group structure. Senior members of the Care Group to be members of the Equality and Human Rights Steering Group and report to the group on action plans in place to address equality issues. To adopt and implement a talent management and succession planning	The second cohort of students Bands 6 to 8 have recently undertaken the Trust's accredited leadership and management programme. Recent discussions with the recently appointed Northamptonshire liaison officer for the East Midlands NHS Leadership Academy will provide better links and understanding of what is available to the Trust. Senior members of the Care Group are represented on the Equality and Human Rights Steering Group. Discussions are in progress regarding the structure of the reports required to address equality issues. Member of the Trust attended an inclusive talent Management Learning Event and it is the intention to engage with the NHS	October 2012 April 2012/ongoing October 2012/ongoing

				strategy that encompasses all protected groups at a Care Group and Corporate level.	Leadership Academy to be part of the 4th cohort for introducing a talent management and succession planning strategy.	

Health Equality Group

The Trust has continued to work with the Health Equality Group which was established in December 2011 and is a partnership between the community sector and local NHS organisations.

The Health Equality Group has recruited community equality representatives from the community to work with each organisation to provide a 'critical friend', who provides access to broader community views through their organisations.

ENGAGEMENT, CONSULTATION and INVOLVEMENT

Service Engagement - Patients and the Community

The involvement of patients and the public is core to healthcare reform and to a 'patient led NHS'. The Trust recognises the importance of listening, understanding and responding to patient and public needs, perceptions and expectations ensuring patients' experiences and preferences inform continuing improvement.

The term 'patient and public involvement' (PPI) has become synonymous with a number of activities in the NHS. It encompasses patients, carers, families, service users, clients, individuals, groups and communities. It is a national structure designed to ensure that the voice of patients is central to the planning, development, improvement and delivery of health services. It is also the framework by which we encourage patients to have a voice in decisions made about their own care.

The Patient and Public Involvement Strategy aims to involve patients, carers and the public in order for NGH to:

- Obtain the best outcome for the patient
- Improve the patient experience
- Help us to run our services more efficiently and effectively
- Incorporate the views of our service users in future service developments.

NGH is committed to involving and consulting patients, carers and the public on developing closer links with our local population through Governors, members and staff to provide a framework for:

- Changes to existing services and how these changes are implemented
- The quality of services we provide
- The planning of new services.

With the development and implementation of the Patient Experience Board at NGH in 2012, the PPI Strategy has been updated to reflect the changes and align the PPI Strategic Steering Group (PPISSG) with the Patient Experience Board.

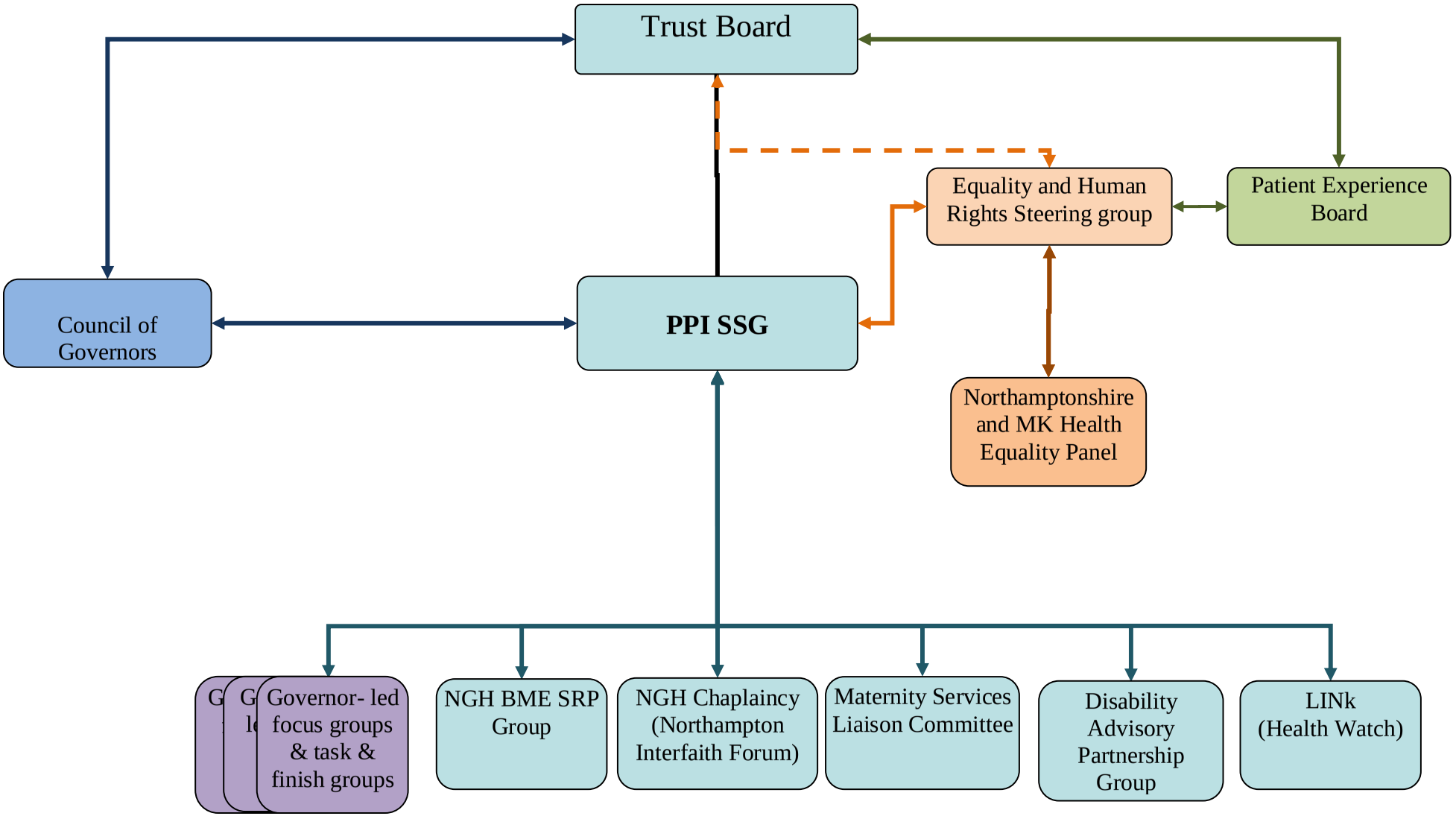
The Patient and Public Involvement Strategy has seven areas of focus:

- NGH will work towards ensuring that systems are in place so that there is consultation and involvement with patients and the public when planning a new service, changing an existing service or making a decision about how a service operates
- NGH will work towards ensuring that there is a flexible approach to involvement so that everyone, whatever their background, location or particular needs can be involved
- NGH will work towards ensuring that the Governors and members are kept informed of patient and public involvement activities and are in a position to influence developments
- NGH will work towards ensuring that the membership of the Trust is representative of the general population and is organised in such a way so their views can be accessed
- NGH will work towards ensuring it provides a simple and effective way that people can raise their concerns, and will ensure that the mechanisms are in place to enable those from hard to reach and minority groups to be able to voice their opinions
- NGH will work towards ensuring that patients, the public and staff are kept informed of developments within the Trust
- NGH will work towards ensuring that the culture of NGH supports the involvement of patients and the public in all levels in the organisation.

The Trust's PPI Strategic Steering Group coordinates input from a wide range of service users' groups. Changes were made to the NGH Patient and Public Involvement Strategy in 2012 to ensure that the Trust engages with a wider group of service users. A robust reporting mechanism for all current and new user groups was introduced and ensured that representation of patients from all protected groups were included.

The reporting structure of the groups is demonstrated in the diagram below:

Equality and Human Rights Annual Report 2012 2013
Approved June 2013
Equality and Human Rights Steering Group



The following groups who represent the protected groups, report to the PPISSG:

- The NGH Black and Minority Ethnic Sub Regional Partnership User Group meets quarterly
- The Hospital Chaplain attends the Northampton Interfaith Forum
- The Head of Midwifery attends the Maternity Northants Group
- The Disability Advisory Partnership Group is a new group established at NGH in 2012. The group comprises of both senior NGH health professionals and representatives of people with disabilities from appropriate local organisations. The group meets quarterly and acts as an advisory body regarding the provision of services at NGH from the perspective of people with disabilities
- The LINk representative is the representative for all other minority community groups and assists in the equality of access to engagement opportunities for all sections of the community.

The Trust has many other mechanisms for engaging patients. These include the Patient Advice and Liaison Scheme (PALS), LINKs, the complaints process and focus groups. We work with patients' groups and advocates and with individual patients, families and carers to gather their views on their experiences and ideas for improvement. We seek feedback from anyone who uses our services, and uses it as a means to learn lessons and drive improvement. We aim for early and local complaint resolution and to reduce complaints wherever possible.

The Trust has undertaken a scoping exercise in 2013 to identify which groups within the Trust have patient representation. These groups will also be required to send a summary report to the PPISSG.

The Trust engages in partnership working with other agencies and healthcare professionals regarding equality issues through the Equality Lead.

By enhanced engagement with local interests we are able to focus on those matters that are most important to patients and communities. This will help the Trust to plan, develop and manage our services as well as reduce health inequalities.

The improved service user engagement constitutes one of the Trust's Equality Objectives for the next four years.

Best Practice Example from Engagement Groups

Members of the newly established Disability Advisory Partnership Group, identified problems that some patients with sensory impairments encounter in the Eye Department and the Audiology Department.

Northampton Association for the Blind and Deafconnect were commissioned to complete audits within these departments. Utilising the expertise of these specialist organisations, action plans have been developed in both of the departments and progress against the action plan is monitored within the care group and is reported to the Equality and Human Rights Steering Group.

Staff Engagement

The Trust recognises the need to make improvements in involving and engaging with staff as we have set out to become one of the best places to work. Our approach to this clear aspiration is how we engage our staff in how the hospital 'runs'. To support this aspiration we had a clear approach to staff engagement and used 'Listening into Action' as the mechanism to engage with our staff.
Listening into Action (LiA) was launched in the Trust in June 2012 to improve Northampton General Hospital as a place to work and to ensure the Trust engages with our staff in changes to their roles and areas. Teams and individuals are encouraged to make localised changes to their service for the benefit of staff and our patients.

LiA commenced with 5 'BIG' staff conversations held by the Chief Executive Officer who asked the question:

'What can we do together to improve our staff's day to day working and ensure that we deliver quality care and service to our patients.'

The outcome of these conversations was to deliver suggested actions corporately. The actions delivered were as follows:

- A Trust 'Core Brief' was introduced to ensure all staff are fully up to date with what is happening within our Trust
- New and improved patient menus were introduced
- Extended opening hours in Café Royale for our visitors and patients
- Revised standardised nursing documentation
- New and updated signage within the hospital grounds
- An initiative called 'In Your Shoes' to provide shadowing opportunities for staff
- Recruitment of additional volunteers to assist our patients at mealtimes.

Twenty One clinical and non-clinical teams are using LiA to collaborate and share ideas to ensure their working day and area benefits them and the patients of their services. Some of the delivered actions are;

- Theatres and other teams are holding daily team 'huddles' to keep staff updated and communicated
- Pathology and Cardiology have worked closely together to save 100 bed days per month with timely patient Troponin tests in A&E
- Children Community Nursing have revised all patient letters and information leaflets they send out

- Cardiac physiology have updated their departmental signage for better patient orientation
- Facilities have increased the number of wheelchairs available within the Trust.

Listening into Action has been successful and is part of the Trust's Staff Engagement Strategy and training will start to be delivered in July 2013 for all team managers to attend. This training will ensure that our staff are empowered and fully engaged in the improvement of all our services.

Leadership and Management Training

The Trust recognises the importance that leaders play and their role in developing an engaged and empowered workforce in the Trust. This message has been considerably strengthened with the release of the Francis Report in February 2013. To this end NGH plan to develop and implement an integrated management and leadership development programme as part of a wider Organisational Development Strategy to ensure leaders and managers at all levels and in all areas have appropriate skills & behaviours. In addition to this, the Trust is supporting staff to access the Core Programme from the East Midlands Leadership Academy and the use of the Leadership Qualities Framework 360^{o} assessment. Clinical Leaders have also been supported through a number of individual development programmes.
A "Values-Based Behavioural Framework" is currently being developed for the Trust supported by external facilitators. The purpose of this is to identify and embed shared organisational values; inspire employees to behave positively and to create a framework for staff recruitment, selection, education/ training and appraisal.

Consultation and Involvement

The hospital promotes partnership working and during the year carried out a number of workshops to jointly develop a Partnership Agreement with the Trade Unions recognised by the Trust (Staff Side). The intention is to take the involvement and engagement of the Staff Side to an even more powerful level.

The Partnership Agreement will be based on the Trust's vision, values and a set of shared principles. The Partnership Institute has been instrumental in providing external support for developing the suitable Partnership Agreement Model for the Trust.

EQUALITY ANALYSIS

Although Equality Impact Assessments are no longer a legal requirement, identifying and responding to the affect of activities on different groups remains of fundamental importance in the context of giving due regard to meeting the three aspects of the general duty.

Equality analysis remains a key component in delivering service excellence, by helping to ensure that the needs of different communities are met, and that people are not being excluded. Therefore the Trust has continued to utilise its systems for carrying out Equality Analysis on policies, functions and change programmes to assess whether they have the potential to affect people differently. The Trust recognises this process identified and addresses real or potential inequalities resulting from policy, practice or service development and in particular at a time when the Trust is making significant changes through its Transformation Programme.

Any negative consequences for a particular group or section of service users/staff can be eliminated, minimised or counterbalanced by other measures, wherever possible, in order to take account of and meet the needs of all our communities so the continuation of the equality impact assessments will ensure that consideration will be given to:

- Effective processes and communication between staff and service users
- Physical access
- Provision of information in a format which can be understood
- Cultural norms, preferences and practices of equality groups taken into account
- Available relevant data and service user / staff feedback.

SERVICE INFORMATION

Patient Profile

In 2012/13 there were 96,952 admissions to NGH, 331,996 outpatient attendances and 21,919 non attendances.

Ethnicity

The ethnicity of the patients attending NGH 2012/13 is shown in the table below. This shows that there are a disproportionate number of non-attendances at outpatient departments from most of the ethnic minority groups. By working with the Health Equality Group we will identify the specific needs of these groups to address any shortfalls identified in this report.

Ethnic Group description	% Total Admissions	% Total Out patient	% Total DNAs
Not known	0.91	3.44	5.15
White – British	80.88	76.28	67.43
White – Irish	1.29	1.48	1.29
Any other white background	4.61	2.84	4.03
Mixed – White and Black Caribbean	0.59	0.47	0.85
Mixed – White and Black African	0.24	0.13	0.35

Mixed – White and Asian	0.24	0.20	0.22
Mixed – Any other mixed background	0.37	0.21	0.40
Asian or Asian British – Indian	1.51	1.59	1.42
Asian or Asian British – Pakistani	0.53	0.40	0.62
Asian or Asian British – Bangladeshi	0.84	0.57	0.94
Asian or Asian British – any other Asian	0.62	0.44	0.76
Black or Black British – Caribbean	0.88	0.92	1.28
Black or Black British – African	1.84	1.18	2.61
Black or Black British – Any other Black	0.38	0.33	0.60
Other Ethnic Group - Chinese	0.30	0.29	0.27
Other Ethnic Group	0.81	0.59	0.95
Not stated	3.16	8.64	10.83

Gender

The Gender of patients attending NGH 2012/2013 is shown in the table below and correlates with the population of Northamptonshire. There is a disproportionate percentage of male DNAs.

% Total Admissions		**% Total Outpatients**		**%Total DNAs**	
Male	**Female**	**Male**	**Female**	**Male**	**Female**
41.29	58.70	43.31	56.68	48.05	51.93

Age

The Age profile of patients attending NGH 2012/2013 is shown in the table below. This demonstrates that 36% of admissions were over the age of 60 years and the age group with the largest % of non attendance at outpatients was the 17-30 age group. Whilst there is some correlation with the age ranges within Northamptonshire such as a high proportion being over the age of 70 there needs to be an understanding as to why the numbers not attending in the 17-30 age range is occurring. With the implementation the Care Group structure in 2012 and representatives of the Care Group forming part of the Equality and Human Rights Steering Group membership, there is opportunity for discussions to be held and measure put in place to address this issue wherever possible.

Age Group	**% Total Admissions**	**% Total Out patient**	**%Total DNAs**
0-16	15.18	9.22	18.22
17-30	15.8	10.87	19.71

31-40	11.54	10.61	14.29
41-50	9.79	12.31	13.64
51-60	11.15	14.17	11.55
61-70	15.22	19.04	9.72
71-80	11.99	15.12	7.24
81-90	7.8	7.7	4.81
91-103	1.51	1.01	0.85

Faith and Belief

Patients admitted to NGH in 2012/13 identified 61 different faiths and beliefs. The following is a summary of the main faiths:

Faith or Belief	**% of Total Admissions**
Christian (all denominations)	49.54
Not Known	35.24
No faith or belief	10.71
Muslim	1.65
Atheist	0.34
Hindu	0.64
Sikh	0.33
Jewish	0.08
Buddhist	0.14
Agnostic	0.11

Disability - Reasonable Adjustments

The Equality Duty acknowledges that the needs of people with disabilities may be different from those of non-disabled people. The Trust must therefore take account of disabled people's impairment when making decisions about policies or services. The latter may entail making reasonable adjustments or treating disabled people differently in order to meet their needs.

Best Practice Examples of Reasonable Adjustments:

Learning Disabilities.

The Trust has continued to develop its work to ensure ease and equality of access for patients with a Learning Disability.

The Trust continues to jointly fund the cost of the Learning Disability Liaison Nurse

There have been a number of developments made throughout the year to support and improve the patient journey for people with a Learning disability. These include:

- The development of a pain assessment tool for people with a Learning

Disability or Cognitive impairment.

- Development of “easy read” leaflets for Ultrasound scan and scan for pregnant ladies.
- Easy read information to support parents with a Learning Disability to care for their babies.
- The development of an electronic flagging system that sends an alert to the Learning Disability Liaison Nurse when a patient with a Learning Disability attends A & E.

Training:

Learning Disability Awareness training continues to be part of the healthcare Induction and Preceptorship Programmes. In the past 12 months 160 HCA’S and 109 Preceptors have received training. Bespoke training has been provided to individual wards and departments.

In September 2012 60 healthcare staff from the Trust attended a Road Show facilitated by Mencap and co presented by people with a Learning Disability as part of their “Getting it Right” campaign. Feedback from the workshops was extremely positive and attendees stated how beneficial it was to learn from people with a Learning Disability about their experiences of healthcare and being in hospital.

48 Hospital volunteers have been trained in Learning Disability Awareness, communication and their roles as “Keep safe” advocates, again people with a Learning Disability co presented the training. NGH is now a registered” Keep Safe” location and there are 3 Keep safe locations based at each of the hospital entrances at the guides desks, manned by volunteers.

Dementia Care

The aim of the Trust’s multi-disciplinary Dementia Care Action Committee, established in 2011, is to improve the experience of patients with dementia and the quality of their care while at NGH. The Committee developed a comprehensive action plan based on national and local strategies and have met monthly to deliver the plan.

The use of the butterfly logo which has been adopted by Trust as a means of identification of patients with dementia or memory problems is now well embedded within the wards.
A ‘butterfly magnet’ is used on the ward white boards in order that all staff are made aware that the patient may require additional support due to their condition.

Two audits were undertaken on the wards throughout the year to ensure that the magnets and associated documentation, including Patient Profiles, were being used appropriately.

A Patient Profile is completed with carers and kept at the bedside. The Profile makes all staff groups and volunteers aware of information about the patient which may help with communication and understanding the patient's behaviour. Awareness of this information can also help to avoid distress and frustration for the patient.

Training in dementia care was delivered throughout the year and approximately 50% of nursing staff have now received some dementia care training through the practice development department, cascade trainers of university modules.

Two wards have utilised charitable funds to help improve the environment for patients with dementia: Creaton Ward have successfully introduced colour to identify each bed space to help avoid patient confusion and Abington Ward converted a disused bathroom into a rehabilitation room for their patients.

The Committee have developed a detailed action plan for 2013/14 to embed and build on the achievements to date. This includes environmental work on some wards to make them 'dementia friendly' by the introduction of colour, improved signage and date and time clocks as per the recommendations of the Kings Fund.

A Disability Resource Folder is kept in all ward areas and the majority of Out Patient Departments within the Trust. This folder contains information referencing best practice and signposting to the various advice and support groups; deaf and deafened patients, patients with visual impairments, learning disabilities and physical disabilities. This folder was developed utilising information sourced from local and national disability groups.

PATIENT COMPLAINTS 2012 to 2013

The Complaints department and Patient Advice and Liaison Service (PALS) are a valuable source of information on dissatisfied patients and evidence for whether the services provided do not meet the needs of protected groups.

In the reporting year 2012-2013 the Trust received 538 complaints that were investigated through the NHS Complaints Regulations. This is in comparison to the 517 complaints that were received in the previous year. 291 complainants provided their ethnicity status and the remainder declined to even though the information is handled on an anonymised basis. The ethnicity of the complainants who responded, is detailed in the table below. 262 of those complainants were white British which reflects the Northamptonshire population.

Year 2012 - 2013

Ethnicity	No
White British	262
White Irish	5
White other	10

Mixed white & black Caribbean	
Mixed white & black African	
Mixed white & black Asian	
Mixed other	1
Asian or Asian British Indian	4
Asian or Asian British Pakistani	2
Asian or Asian British Bangladeshi	
Asian or Asian British other	1
Black or black British Caribbean	4
Black or black British African	1
Black or black British other	1
Chinese/other Chinese	
Not stated	247
Total	538

There was an equality issue identified within 1 of the complaints. This was concerning disability. The Complaints department have confirmed that this complaint has been resolved.

283 complainants identified their age, the data is as follows:

Age	Number of complainants
18 & under	11
19 - 40	52
41 - 60	84
61 - 70	53
71 - 80	43
81 - 90	36
91+	4
Not stated	255

COMMUNICATION FOR PATIENTS AND CARERS

Language Support

The Trust recognises that patients who have a first language which is not spoken English, have the right to professional language support. Inadequate communication with people whose first language is not spoken English limits their ability to access services. It can also have a major impact on the quality of care and treatment they receive when they do access care when communications between clinicians and patients is inadequate.

Throughout 2012/13 the Trust has utilised Face to Face interpreters in over 30 different languages on 1,184 occasions with the most demand being for Polish, British Sign Language (BSL), Russian, Bengali and Romanian interpreters. In addition, the telephone interpreting service has been

accessed 428 times. There has been a 10% increase in the number of occasions BSL / English interpreters have been accessed this year.

The translation of information into different languages or alternative formats can be made on request. This year we have had one request for leaflets to be provided in large print and this was supplied by the desktop publishing department within the Trust.

Easy Read Leaflets

The Trust has continued to develop easy read leaflets regarding some clinical interventions. The leaflets are suitable for the use by people with learning disabilities, reading or cognitive problems or patients whose first language is not spoken English.

Pictorial Communication

The ability for patients to be able to communicate with both staff and visitors is recognised as a priority by the Trust. All wards have a pictorial folder to aid basic communication for patients who may have difficulty communicating, for example, following a stroke, where the patient has dementia or learning difficulties as well as where the patient's first language is not spoken English.

The Estates department are increasing the pictorial signage on toilet and bathroom doors across the ward areas in the Trust.

ESTATES CAPITAL SCHEMES AND WORKS

As in previous years provision has been made within the annual capital plan to improve the environment and access for staff, patients and visitors with a disability. Below is a summary of the works carried out during 2012/2013 some of which are dedicated access works in response to access surveys and assessments whilst others have been incorporated as part of phased building upgrading work.

Summary of Works:

- Automated doors to chest clinic
- Automated doors to Fracture Clinic
- Automated doors to Pain Relief Clinic
- Automated doors to Pre-operative assessment unit
- Automated doors to Neurophysiology
- Automated doors to Diabetic Clinic
- Accessible pathways adjacent to Pathology to give independent access without having to use the road
- New reception desk to gynaecology
- New reception desk to Chest Clinic
- New reception desk to Pre Operative Assessment Unit
- Mirrors in all lifts to assist persons with mobility scooters when they reverse out of the lift

- Fire alarm beacons to public toilets and corridor areas to indicate that there is a fire to people with hearing impairments
- Further gearing loops installed to non patient receptions
-

WORKFORCE PROFILE – APRIL 2012 to MARCH 2013

The Trust continues to monitor the demographics of the workforce and in particular, analyse data on applications through to appointment for employment in the Trust. This enables us to closely monitor the diversity of applicants and highlight any trends or concerns that need to be addressed. This monitoring takes place through the Equality and Human Rights Steering Group. In addition, reporting of monitoring will continue to take place in relation to training access and our Human Resources caseload activity.

Currently several of the protected characteristics are not recorded on the Trust's Electronic Staff Record (ESR) system as the systems have not included these newer protected characteristics when they were first designed. The ESR is a national payroll system for the NHS and the Trust currently awaits information on whether these characteristics will be added. It will be difficult to monitor fully some of the characteristics such as gender reassignment and this is recognised in the government guidance which accompanied the Equality Act 2012.

The Trust does not capture workforce data through ESR on gender reassignment or pregnancy and maternity and therefore limited information is available on those protected characteristics.

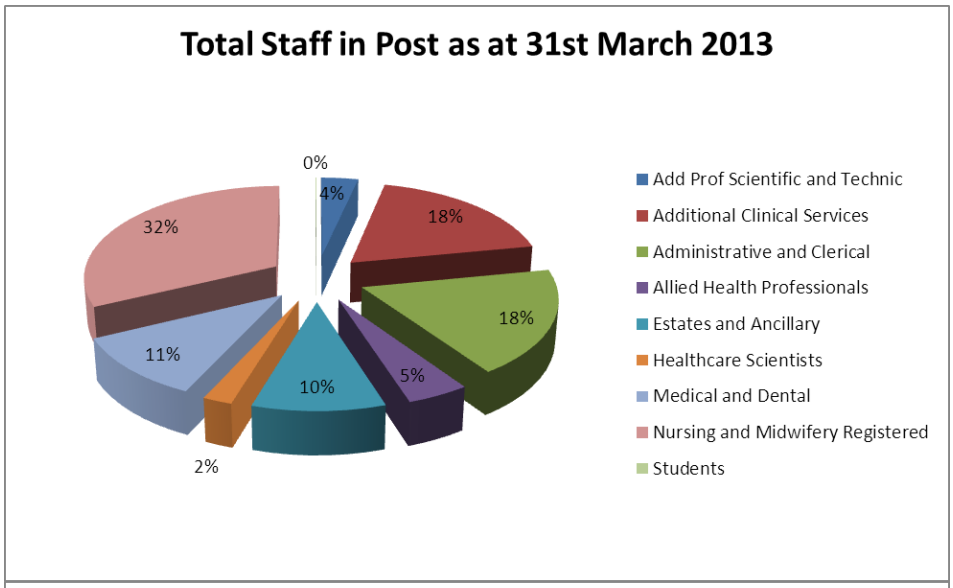
However, this section of the report provides an overview of the Trust's workforce profile as at the end of March 2013 for the following:

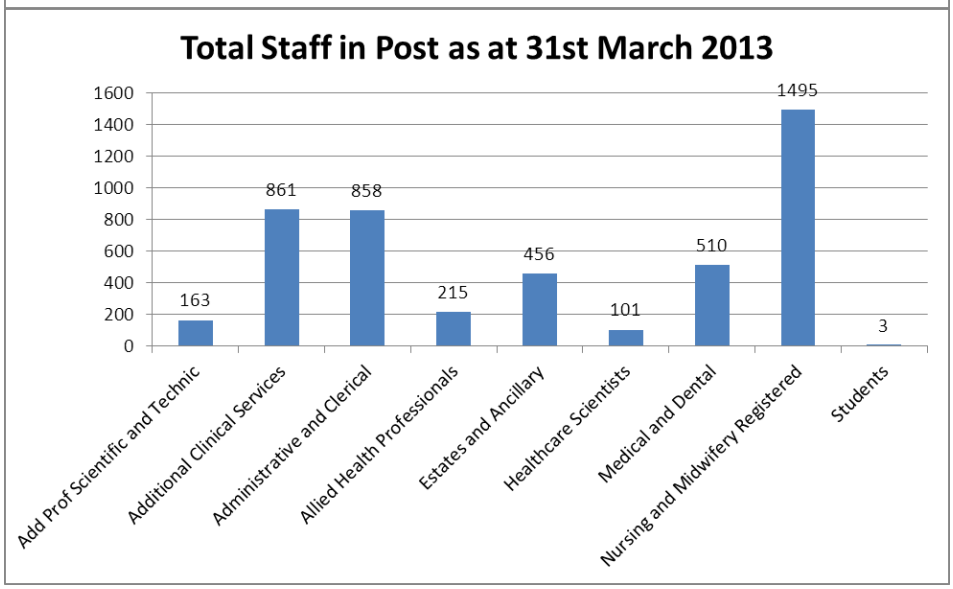
- Ethnicity of the working population, staff group and pay band
- Age of the working population
- Gender breakdown of the working population
- Disability
- Religion and Belief
- Sexual Orientation
- Marriage*****

All figures used in these reports have been based on headcount (Staff in Post) on primary roles only, not the whole time equivalents (WTE).

***This is a newly reported protected characteristic**

The NGH workforce has 4662 Headcount (March 31st 2013)

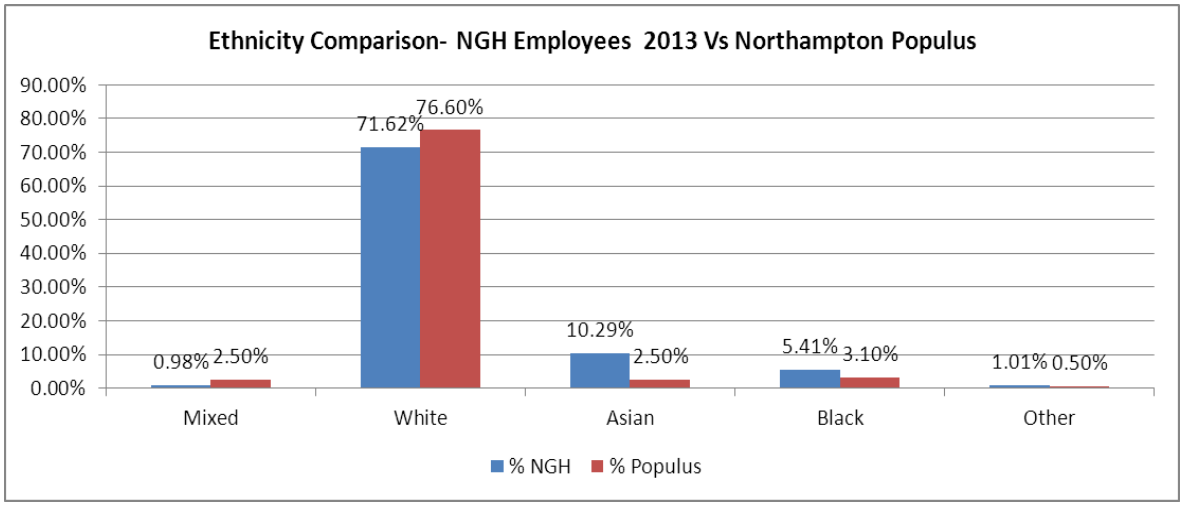




Staff Group	Total HC
Add Prof Scientific and Technic	163
Additional Clinical Services	861
Administrative and Clerical	858
Allied Health Professionals	215
Estates and Ancillary	456
Healthcare Scientists	101
Medical and Dental	510
Nursing and Midwifery Registered	1495
Students	3
Grand Total	4662

Workforce Ethnicity

The table below shows the ethnicity breakdown for Northampton in comparison with the percentage number of staff in post by ethnicity as at 31 March 2013.



The Trust has a lower proportion of white and mixed race employees against the Northamptonshire local population profile. However, this is not the case with those staff within the Asian and Black ethnic minority categories as the Trust continues to have a higher proportion against the local population figures.

A further breakdown of staff in post is detailed in the charts below, A & B. The first chart shows the percentage number of staff in post by ethnicity (% rounded up) whilst the second details ethnicity by staff group.

Chart A

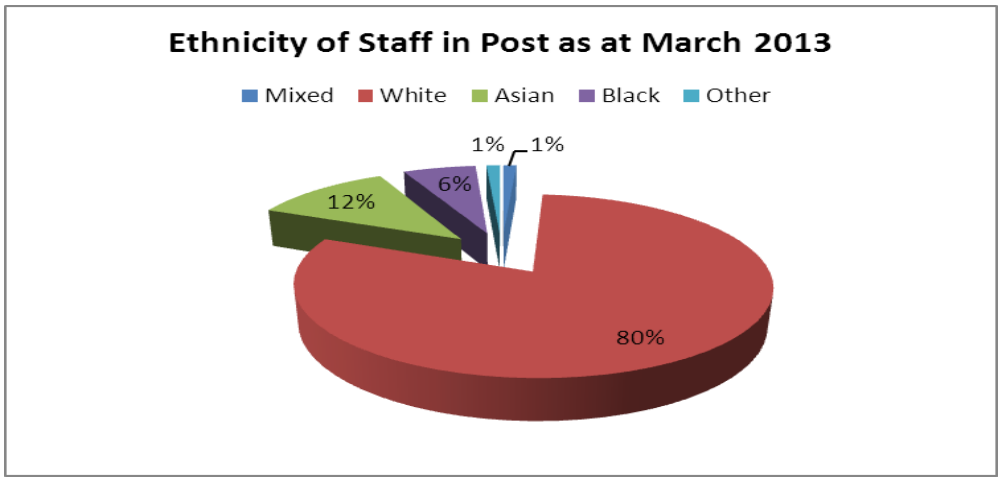


Chart
B

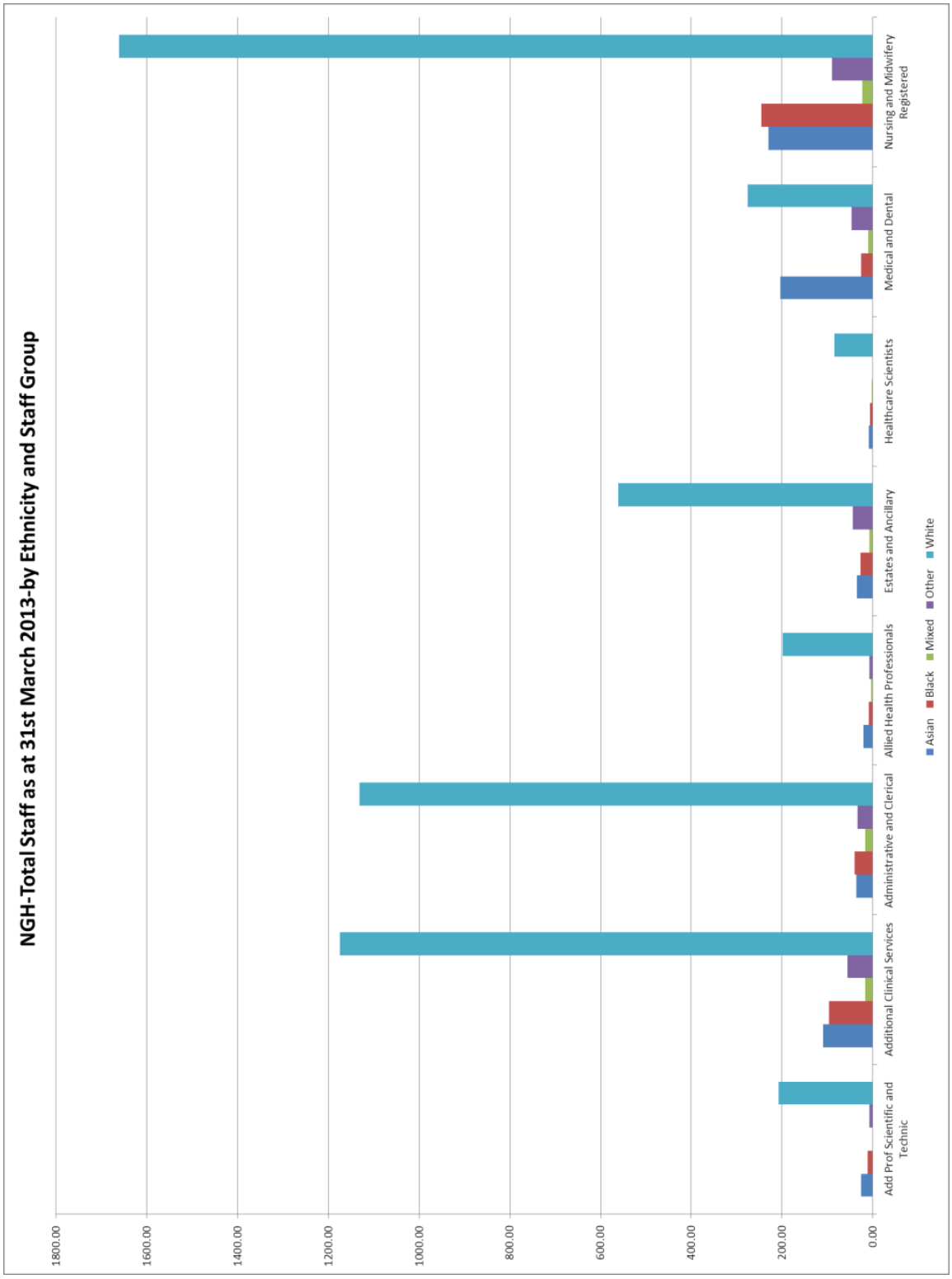
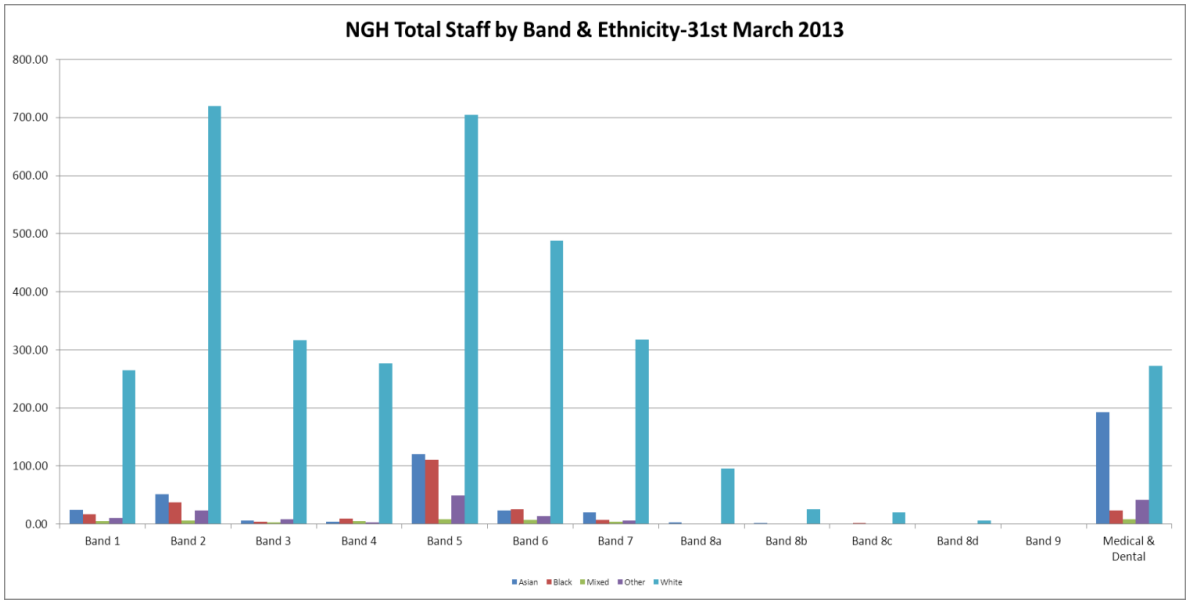


Chart C below shows the numbers of staff in post by ethnicity for medical staff and staff on agenda for change pay bands 1 to 9. The medical staff group

identifies that there is a greater diversity in the medical staff workforce with a high percentage of staff within the White and Asian categories. These two ethnic types far exceed the numbers employed in all other ethnic categories.

There is some concern at the higher pay bands 6 to 9 as these are largely filled by staff that are from a white ethnicity.

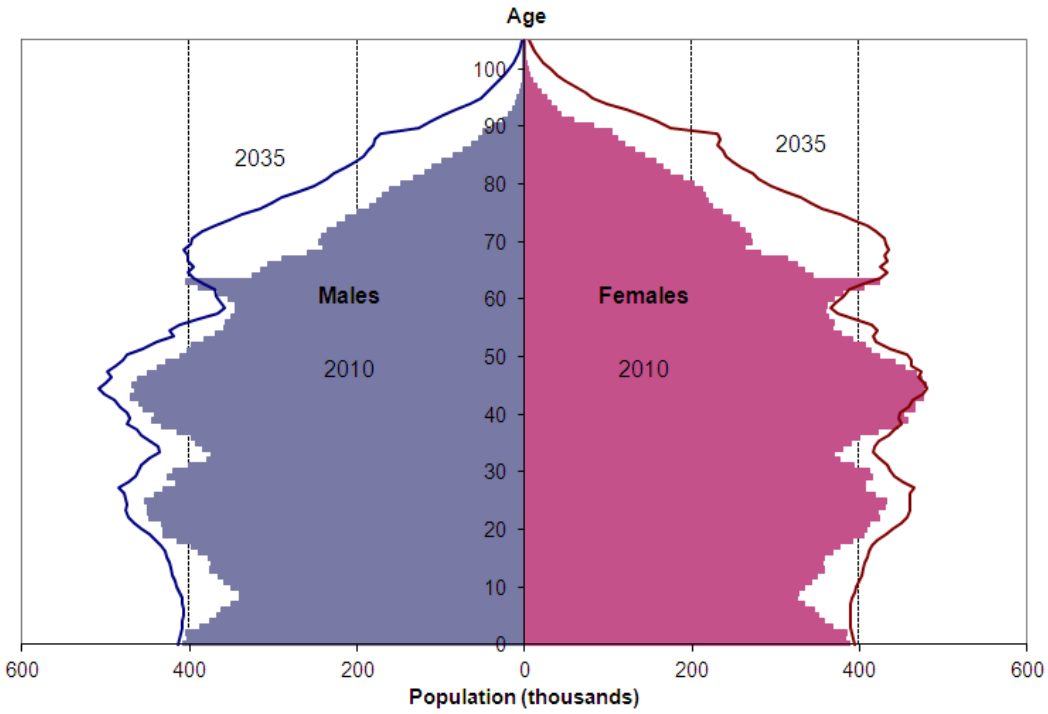
Chart C



Workforce – Age

Population projections nationally- (ONS data)
Chart D

Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035



The UK population is projected to increase by 4.9 million to 67.2 million over the ten year period to 2020. This increase is equivalent to an average annual rate of growth of 0.8 per cent.

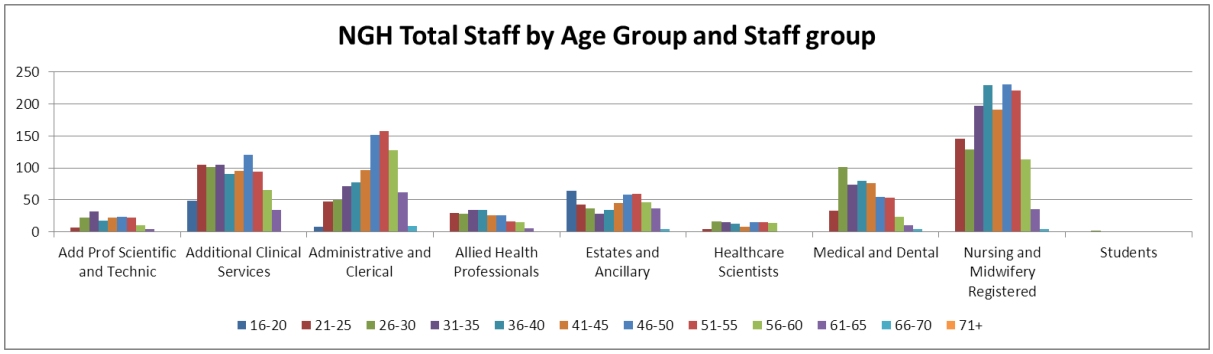
If past trends continue, the population will continue to grow, reaching 73.2 million by 2035. This is due to natural increase (more births than deaths) and because it is assumed there will be more immigrants than emigrants (a net inward flow of migrants).
In common with other European countries, the UK has an ageing population. The population is projected to continue ageing with the average (median) age rising from 39.7 years in 2010 to 39.9 years in 2020 and 42.2 years by 2035.

As a result, despite the forthcoming increases to state pension age under current legislation, the number of people of state pension age (SPA) is projected to increase by 28 per cent from 12.2 million to 15.6 million by 2035. This reflects the higher number of people born immediately after the 2nd World War and also those who were born in the 1960s 'baby boom' reaching state pension age within the 25 year period to 2035.

The underlying potential workforce changes over the next twenty five years are shown in Chart D

The pattern of change in the age structure suggests that the Trust will be more likely to recruit and retain workers in the higher age ranges in future years. This affects the Nursing workforce most significantly. Although on a smaller scale the Admin & Clerical workforce also appears to having an ageing workforce.

Chart E



It must be noted that the age ranges used by projected 2012 population are different to the recognised NHS age ranges on ESR

NHS Workforce Census 2001 to 2011 – NHS Information Centre (as at September 2011)							
	All Ages	Under 25	25 to 34	35 to 44	45 to 54	55 to 64	65 & over
Total non-medical staff	**1,083,637**	**54,603**	**226,472**	**289,851**	**332,080**	**168,111**	**12,520**

Despite the Government's focus to provide more employment opportunities for the under 25 age range, the numbers employed in the younger age group is not increasing significantly.

Workforce – Gender

The gender chart (Chart G) shows a significant difference between the ratio of male and female employees against the gender ratio by population within Northamptonshire (Chart H). The NHS is notorious for having a higher number of female employees because of the numbers of nursing posts within the workforce. Nationally as at September 2011 the gender mix for non-medical staff is 80.9% female with 19.1% male. (Source of Information – NHS Workforce Non-Medical Census 2001 to 2011)[1]

[1] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-non-medical

Chart G

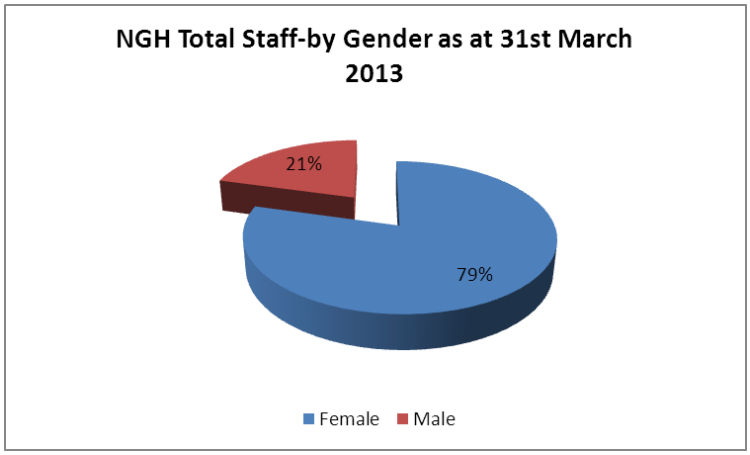
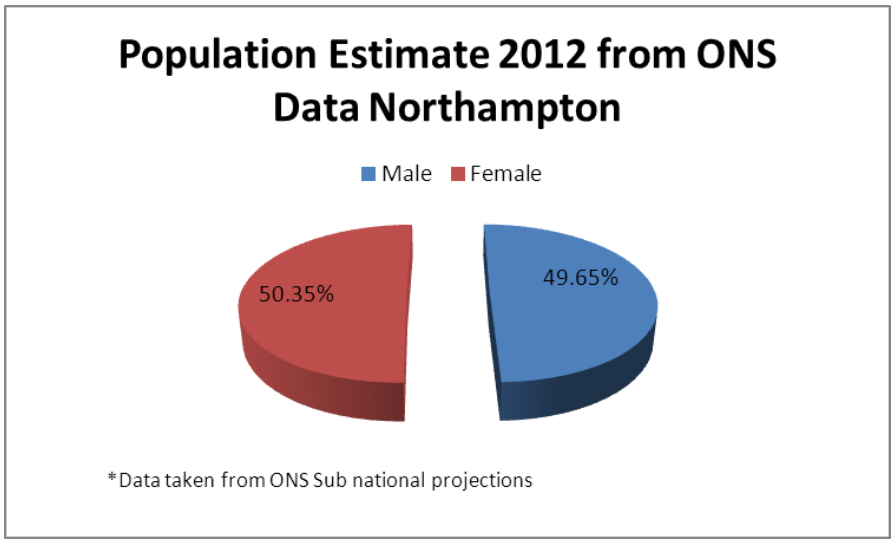


Chart H



Workforce – Disability

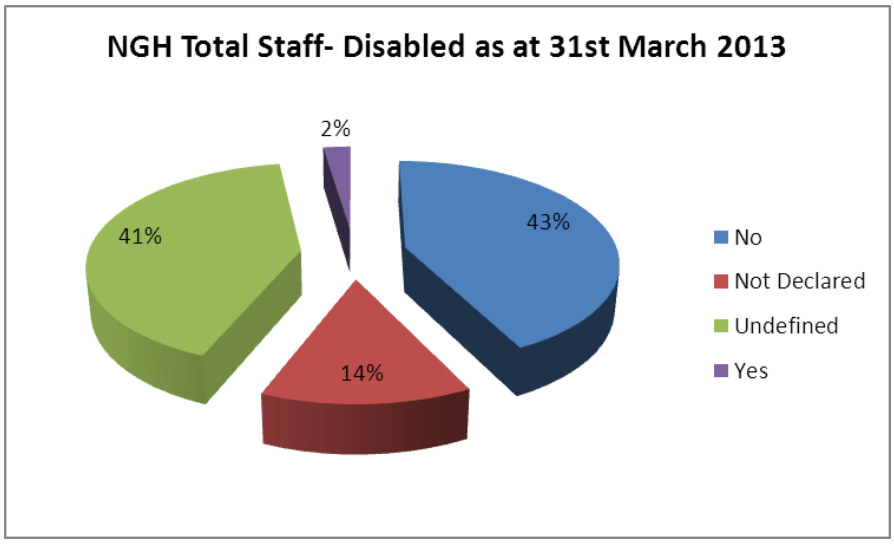
Following a data verification exercise in the trust using WOVEN* data there has been an increase in the numbers of staff who have declared that they do not have a disability. However, the percentage numbers declaring that they have a disability have not changed significantly and records still demonstrate a high proportion of individuals have not declared either, as demonstrated in the undefined category in Chart I. Further work is required to improve the Trust's data collection on disability as there could be a variety of reasons why the undefined category is at 41%. Reasons such as:

- Individuals do not consider their condition to be a disability

- Individuals feel uncomfortable declaring that they are disabled because they have concerns that they may not be able to continue in their role.

* The Workforce Validation Engine (WOVEN) is a monthly data quality report on data in the Electronic Staff Record (ESR). This is sent to individual organisations, allowing them to correct their data at source. It also provides national rankings for data quality scores against an agreed list of criteria.

Chart I

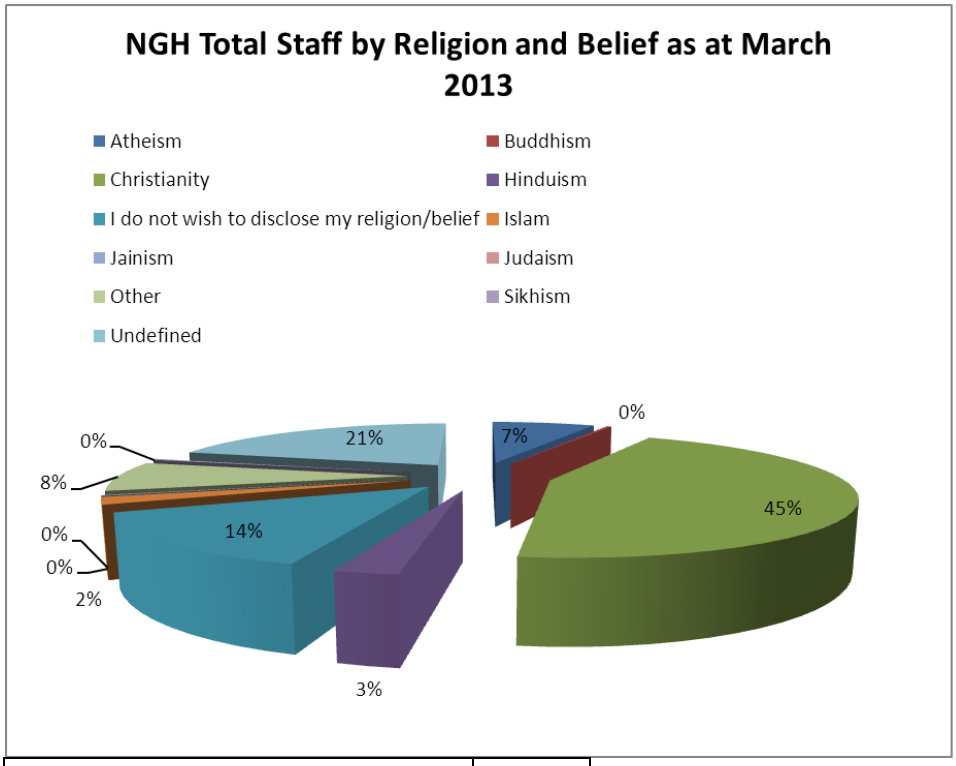


The Trust is committed to supporting staff with a Disability and has mechanisms in place to do this. The HR staff work closely with the Occupational Health department who provide advice on reasonable adjustments and phased returns to work. In addition, the Trust has revised its Employment of Disabled People Policy which includes support to take Disability leave. The Disability Leave Scheme (DLS) provides a newly disabled employee, or a disabled employee whose condition has deteriorated, with a period of time off work to adjust to the change in personal and professional circumstances. This scheme is applicable to all existing employees whether full or part time.

Workforce - Religion and Belief

Chart J below confirms that the majority of staff are Christians with small percentages of staff confirming that they have other religions such as Hinduism, Islamic and Sikhism. Concerns remain at the numbers of staff who are reported in the undefined category even though the Trust is currently using WOVEN data to regularly carry out data verification with staff data.

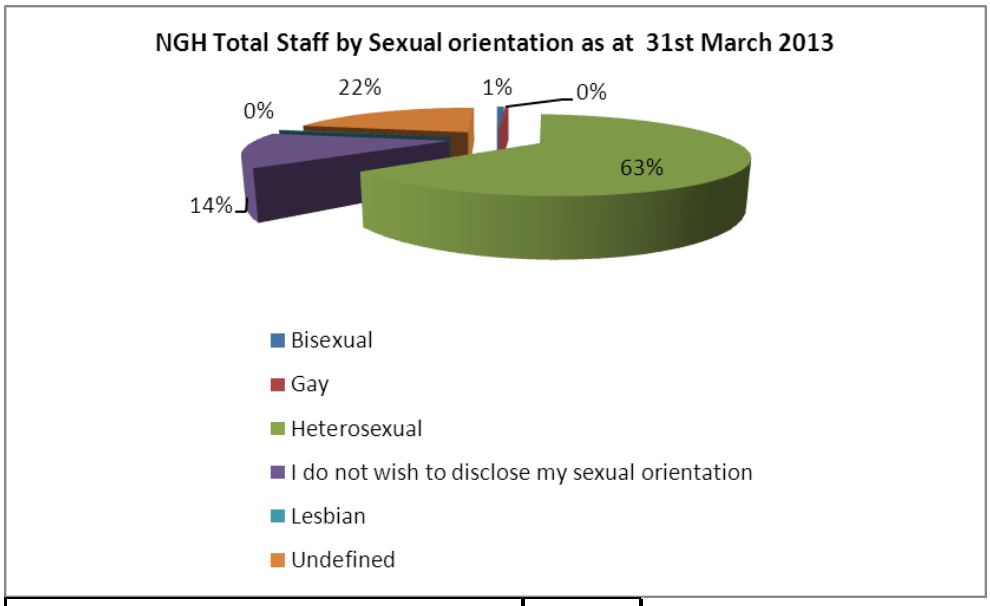
Chart J



Religious Belief	%
Christianity	44.62%
Undefined	20.76%
I do not wish to disclose my religion/belief	13.94%
Other	7.92%
Atheism	7.34%
Hinduism	2.64%
Islam	1.91%
Sikhism	0.34%
Buddhism	0.32%
Jainism	0.13%
Judaism	0.09%

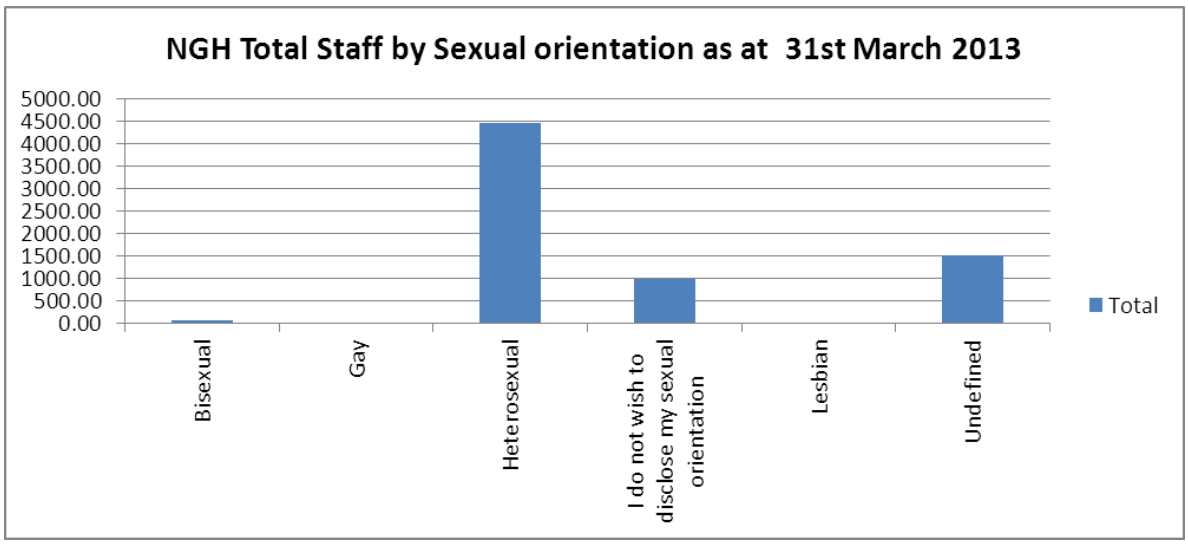
Workforce - Sexual Orientation

Although regular data quality checks are being undertaken at NGH there still remains a high proportion at 22.91% this is a -10% reduction on the previous year (30.87%) who have not defined their sexual orientation.



Sexual Orientation	%
Heterosexual	63.21%
Undefined	22.91%
I do not wish to disclose my sexual orientation	12.63%
Bisexual	0.69%
Gay	0.36%
Lesbian	0.19%

Chart
K



Workforce – Marriage

Chart L

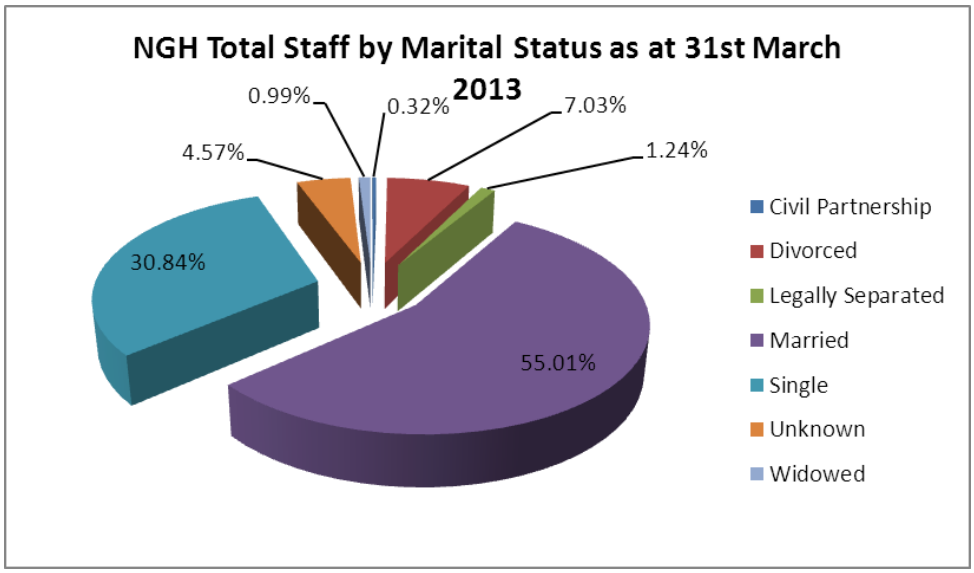
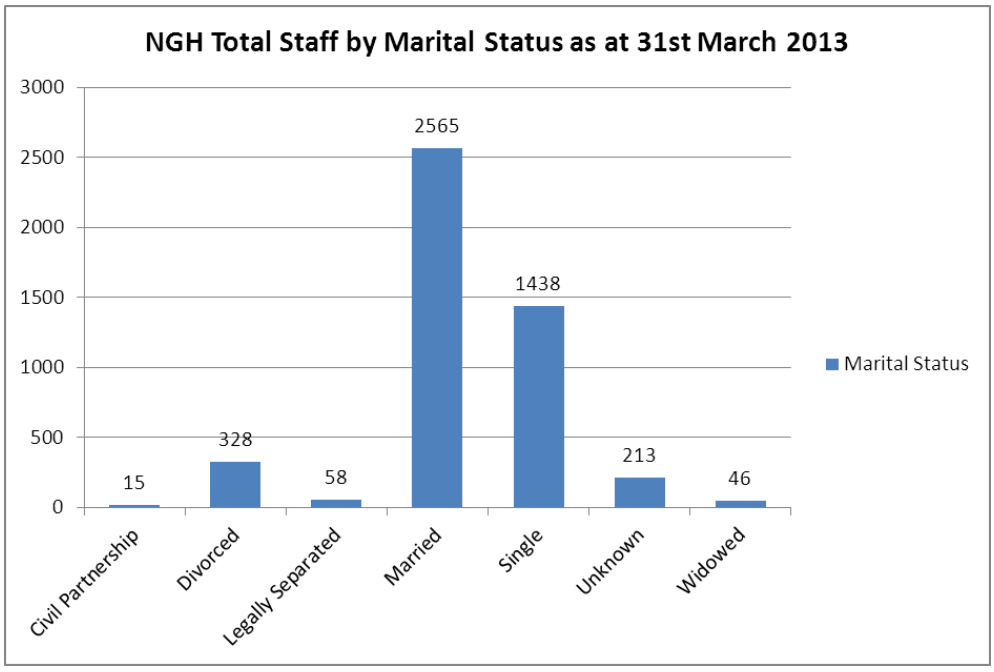


Chart L above indicates that there is a small minority of staff that are recorded as being in a civil partnership this equates to 0.32% of the workforce. Chart M below identifies that this equates to 15 Headcount.

Chart M



RECRUITMENT ACTIVITY – APRIL 2012 TO MARCH 2013

This report is based on the information collected by the HR Service Centre between April 2012 and March 2013 and consists of the numbers of applicants, those short listed and the staff appointed from the protected characteristics for which information is collected.

Equality and Diversity is addressed throughout the recruitment process from advertisement to appointment, such as following the Trust's advertisement process targeting a wide range of audiences.

Managers receive anonymous applications to ensure the selection process is equal and fair. Shortlisted candidates for interview are based on their education, qualification, experience and the personal specification.

The HR Service Centre staff have received training on Equality and Diversity to support them in their role.

Recruitment - Ethnicity

The three charts (Charts A to C) below show the number of applications that have been received, shortlisted and appointed to between April 2012 and March 2013 by ethnicity. *It must be noted that where the number of applications were very small, the pie chart has not been populated. It is only at the shortlisting and appointment stage that this has been identified; hence the reason why there are more ethnicity groups shown in the shortlisting and appointment pie charts.*

The most significant change has been the shift of the most prominent ethnic group to the Asian or Asian British - Indian Category, which shows an increase of applications received to 50% (compared to 36% in 2011/2012). This is in contrast to 2011/2012 where White – British was the most prominent with 50% (now 25%). There has also been a marked increase in the number of applications received from the Asian or Asian British category, with 25% applications received. There has been a decrease of applications received from the Black or Black British – Caribbean and African categories.

The White – British category continues to shortlist and appoint the highest number of applicants, with 64% being shortlisted and 73% being appointed. The Black or Black British – African category saw a slight increase to 10% being shortlisted but a decrease to 6% being appointed (compared to 9% shortlisted and 9% appointed in 2011/2012). Smaller numbers in the mixed categories applied for posts and were appointed.

Whilst it is encouraging that more Asian individuals applied for posts in this financial year, which reflects the higher number of Asians within the local population, a trend continues as the percentage of Asian individuals are not being appointed to positions within the Trust, with only 9% being shortlisted and 7% being appointed. As highlighted earlier in order to understand the

reasons for this, work needs to continue with the local community groups and this will be discussed as to how to approach this at the Health Equality Group.

Chart A

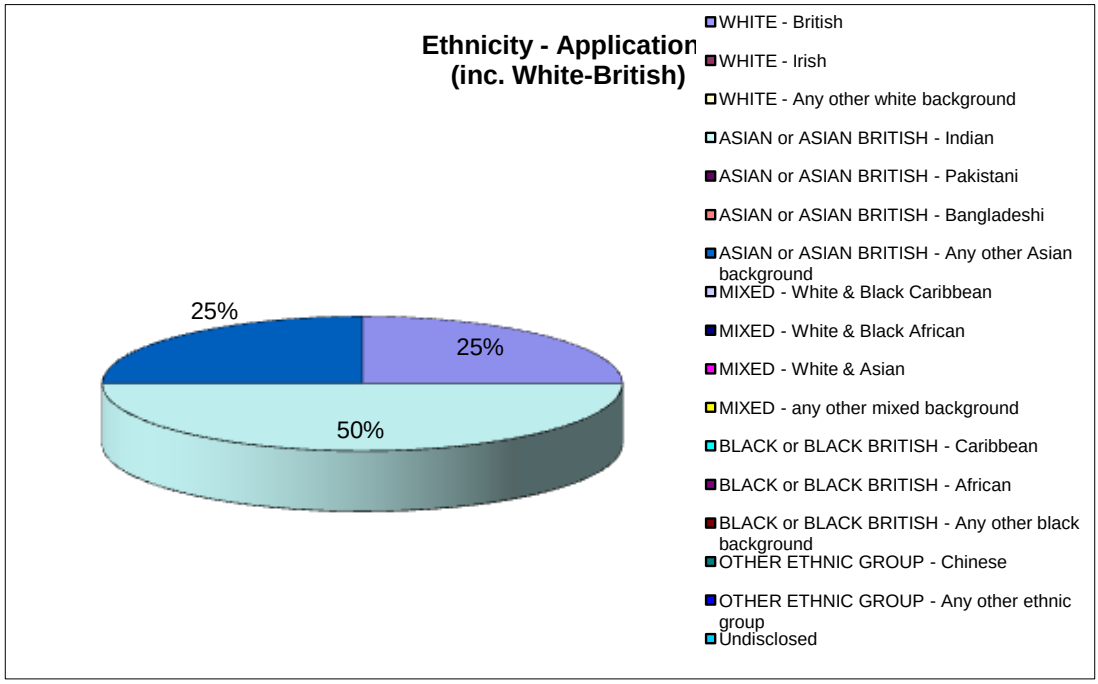


Chart
B

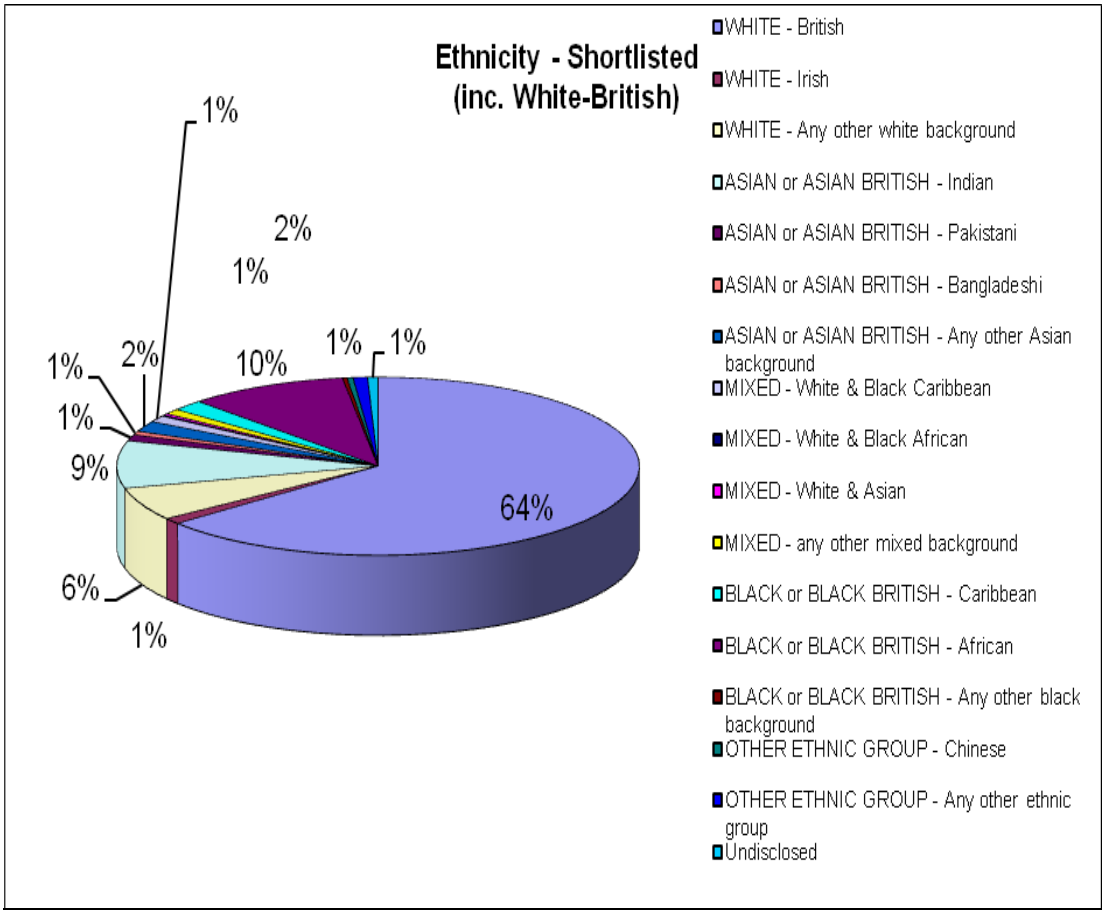
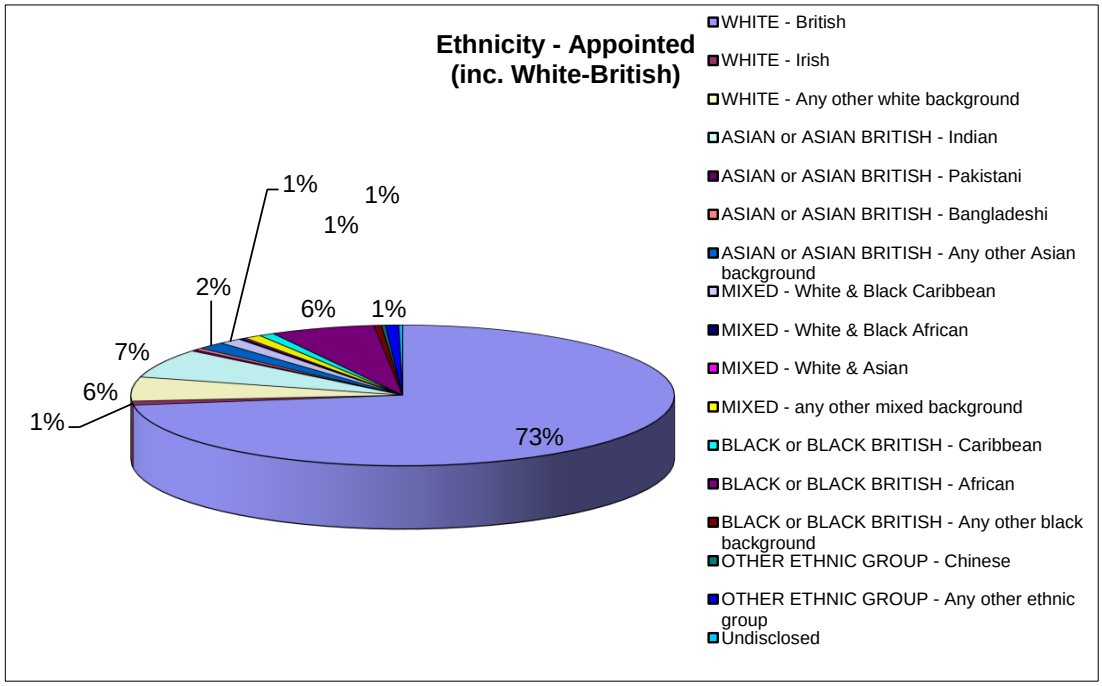

Ethnicity - Shortlisted
(inc. White-British)
1%
2%
1%
1%
2%
10%
1%
1%
1%
1%
9%
64%
6%
1%
WHITE - British
WHITE - Irish
WHITE - Any other white background
ASIAN or ASIAN BRITISH - Indian
ASIAN or ASIAN BRITISH - Pakistani
ASIAN or ASIAN BRITISH - Bangladeshi
ASIAN or ASIAN BRITISH - Any other Asian background
MIXED - White & Black Caribbean
MIXED - White & Black African
MIXED - White & Asian
MIXED - any other mixed background
BLACK or BLACK BRITISH - Caribbean
BLACK or BLACK BRITISH - African
BLACK or BLACK BRITISH - Any other black background
OTHER ETHNIC GROUP - Chinese
OTHER ETHNIC GROUP - Any other ethnic group
Undisclosed

Chart C



Recruitment - Age

The four charts (Charts D to G) below show the number of applications that have been received and those shortlisted and appointed between April 2012 and March 2013 by age group. *It must be noted that where the number of applications were very small the pie chart has not been populated. It is only at the shortlisting and appointment stage that this has been identified, hence the reason why there are more age bands shown in the shortlisting and appointment pie charts. This is further demonstrated in the age band – data comparison chart where the numbers are so small it is difficult to see the representation.*

In 2012/2013 the highest number of applications were received from the 35–39 age range (50%), compared to 14% from last year. Of these, 12% were shortlisted and appointed. This is in contrast to last year, where the highest number of applications were received from the 30–34 and 40–44 age ranges, with 29% each.

There has been a slight decrease in number of applications received for the 20-24 age range, with 18% shortlisted and 21% appointed (compared to 22% and 23% last year respectively). However, the Trust undertook overseas recruitment campaigns to recruit from Portugal, Ireland and Spain. A total of 60 nurses were appointed, the majority of those were within the 20-24 age range. However, these figures are not reflected in the charts below as they did not apply via NHS Jobs but through an accredited agency.

There has been an increase in applications received within the 25–29 age range, with 25% applying, compared to 14% last year. Of these, 17% were shortlisted and 16% were appointed. Within the 30-34 age range, there has been a slight decrease with 25% applying (compared to 29% last year), 13% were shortlisted and 14% appointed.

Within the 40-44 age range, 11% were shortlisted and 8% appointed (compared to 11% in 2011/2012). The 45-49 age group shortlisted 11% and appointed 9%. The age group 50-54 shortlisted 7% and experienced a slight increase to 7% being appointed. The 55-59 age group shortlisted and appointed 3%.

The legislative changes in relation to retirement has not shown an increase in the higher age ranges applying for posts and only 1% in the 60-64 age range have been shortlisted and 1% appointed, this is the same as 2011/2012. The investigations that have been carried out in the Trust show that there is an increase of older people wishing to join the Trust's Bank which enables them to have a more flexible working arrangement as they can choose when they wish to work. It was envisaged that we might receive an increase in applications and successful appointments from the 60+ age ranges due to the removal of the default retirement age, but we haven't seen any evidence of this.

The Trust is leading the initiative to introduce apprentices to the workplace and we have been successful in appointing further apprentices across the Trust this year. This is not reflected in the charts below as some apprenticeship posts are appointed through the Job Centre and are not recorded through our Electronic Staff Record (ESR).

The Trust has developed its Work Experience programme to attract younger people to the Trust in order to address the shortfall of numbers of younger people working in the Trust against the local population figures.

In addition, discussions will take place around the way the Trust advertises posts as currently the predominant method is through NHS Jobs. Consideration will need to be made in relation to expanding the methods used such as through media sites and mobile applications, in order to attract a wider range of job seekers.

Chart D

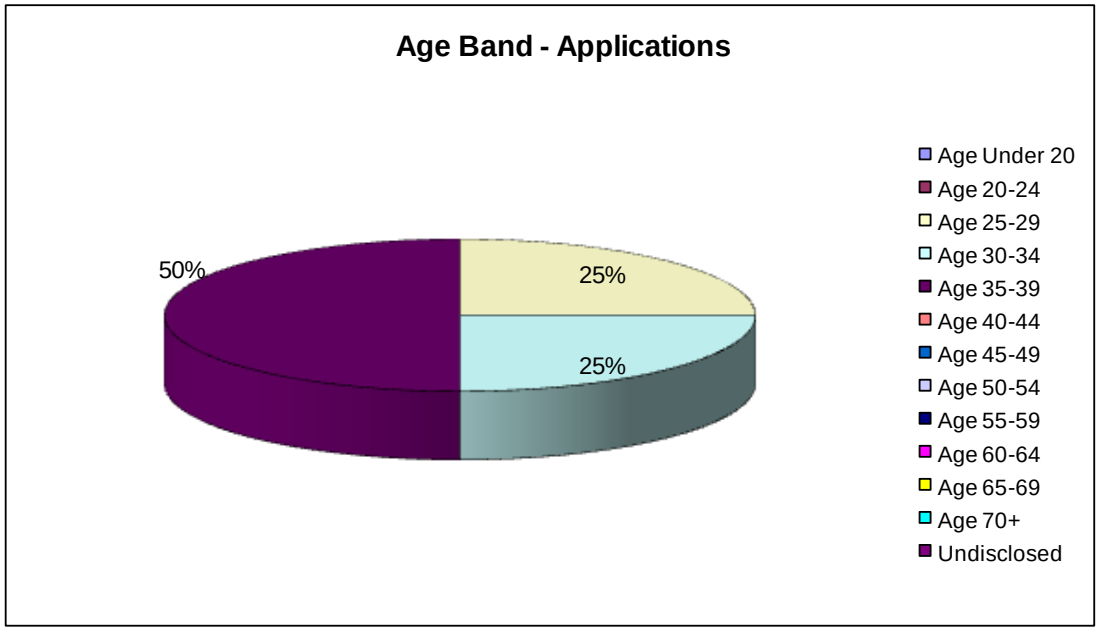


Chart E

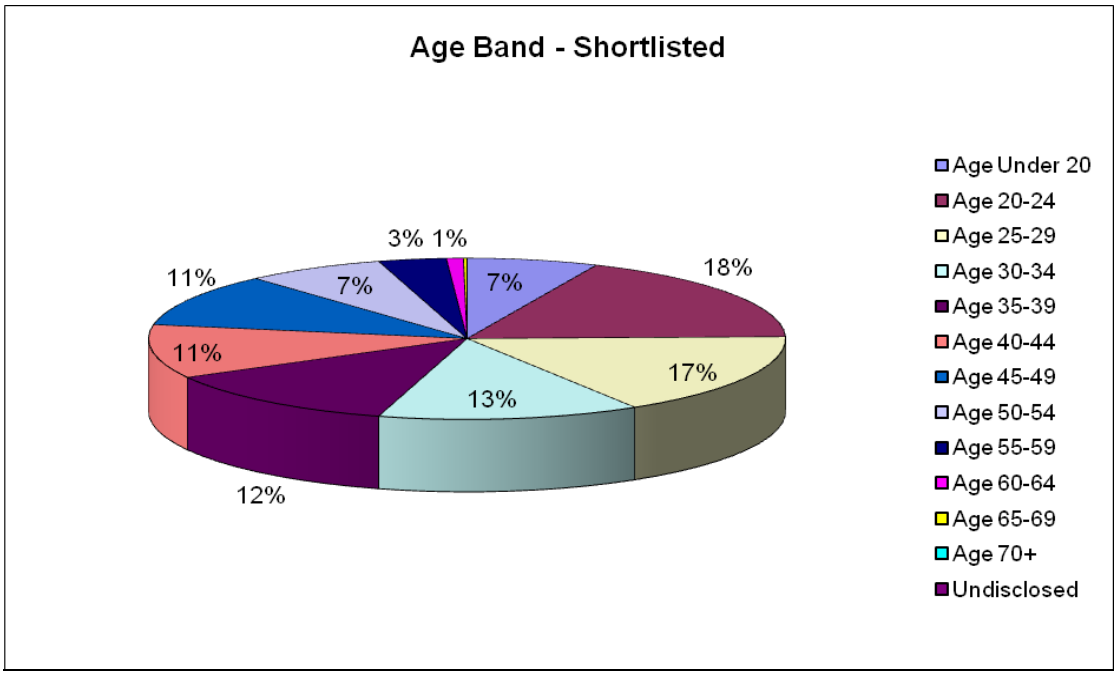


Chart F

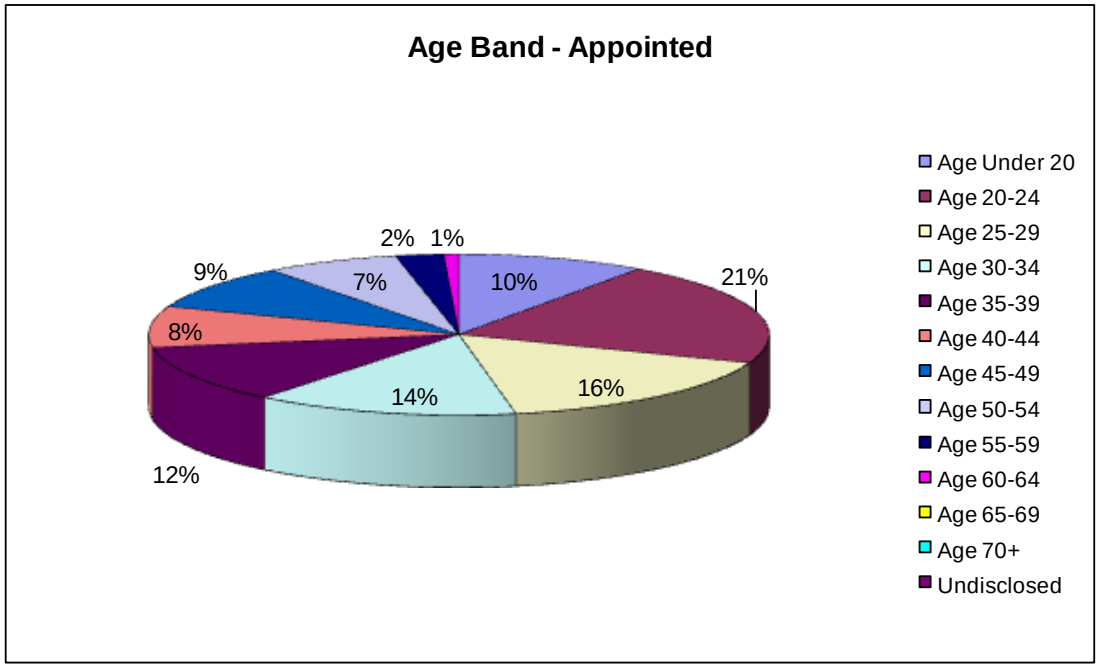
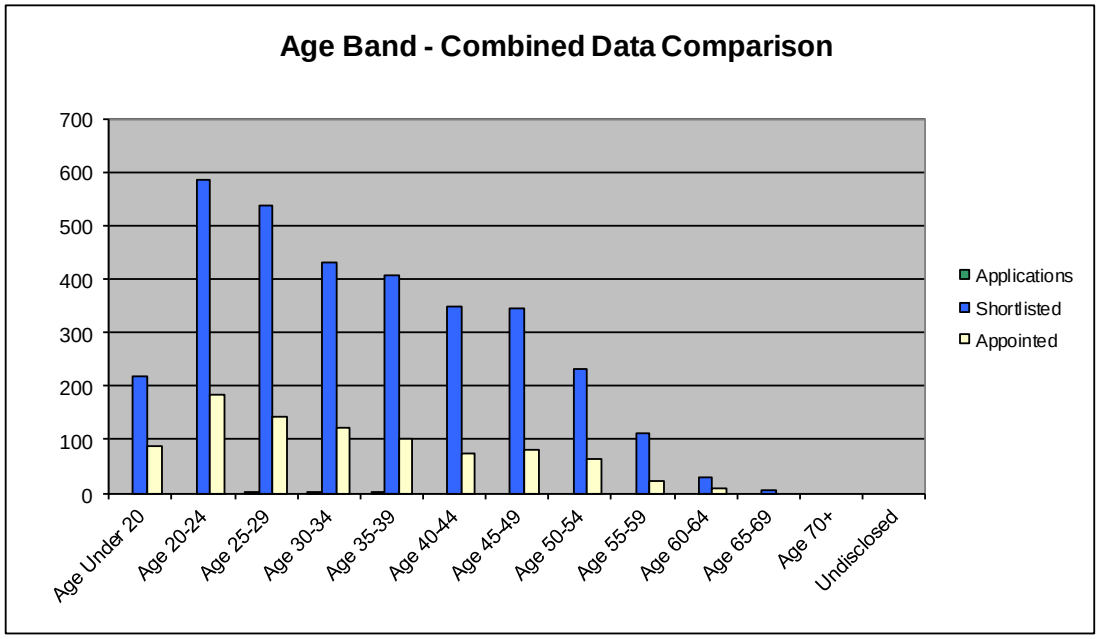


Chart G



Recruitment - Gender

As in previous years there is a significant correlation between the gender population of the Trust and the recruitment to posts by gender and this year is no different with the Trust appointing a higher proportion of females with 75% applying for posts, 80% being shortlisted and 82% being appointed. There has been a slight decrease with applications from males – 25% applied, 20% short listed and 18% appointed.

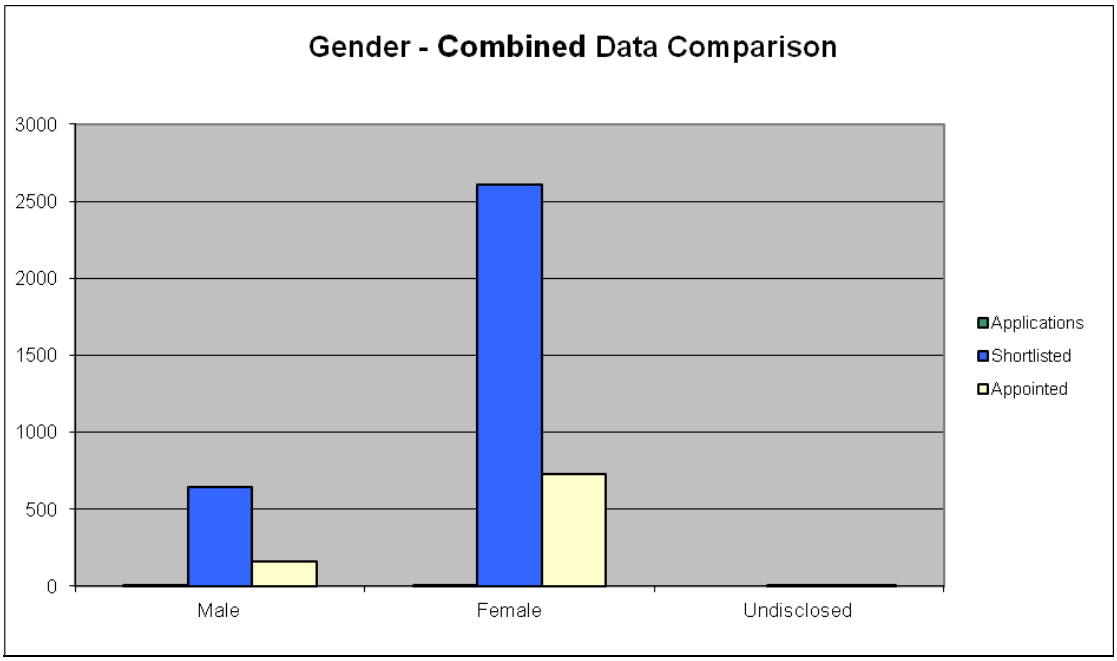
The Trust undertook overseas recruitment campaigns to recruit from Portugal, Ireland and Spain. A total of 60 nurses were appointed, the majority of those were female. However, these figures are not reflected in the table below as they did not apply via NHS Jobs but through an accredited agency.

Explanations for the correlations have been provided in the Workforce Gender Profile section of this Annual Report.

Applications are anonymised so that Recruitment Managers are unable to identify the protected characteristics of individuals at both the application and shortlisting stages. This provides reassurance that this significant difference is not discriminatory at any stage.

	Males	Females
Applicants	25%	75%
Shortlisted	20%	80%
Appointed	18%	82%

Chart H



Recruitment - Disability

The Trust is committed to supporting disabled people as it has retained the 'Two Ticks' symbol which provides recognition by Job Centre Plus that employers have made certain commitments regarding employment, retention training and career development of disabled people. The Trust believes that its' continued commitment will encourage disabled people to apply for the jobs within the Trust and the evidence in the table below suggests that the Trusts' Guaranteed Interview Scheme is being applied as 5% of disabled people were shortlisted and 4% were appointed, which is an increase on 2011/2012 figures of 4% and 3% respectively. *It must be noted that where the number of applications were very small the pie chart I has not been populated. It is only at the short listing and appointment stage (Charts J and K) that this has been identified, hence the reason why there are more disability percentages shown in the short listing and appointment pie charts.*

	With a Disability	**Without a Disability**	**Undisclosed**
Applicants	3%	96%	1%
Shortlisted	5%	94%	1%
Appointed	4%	95%	1%

Chart I

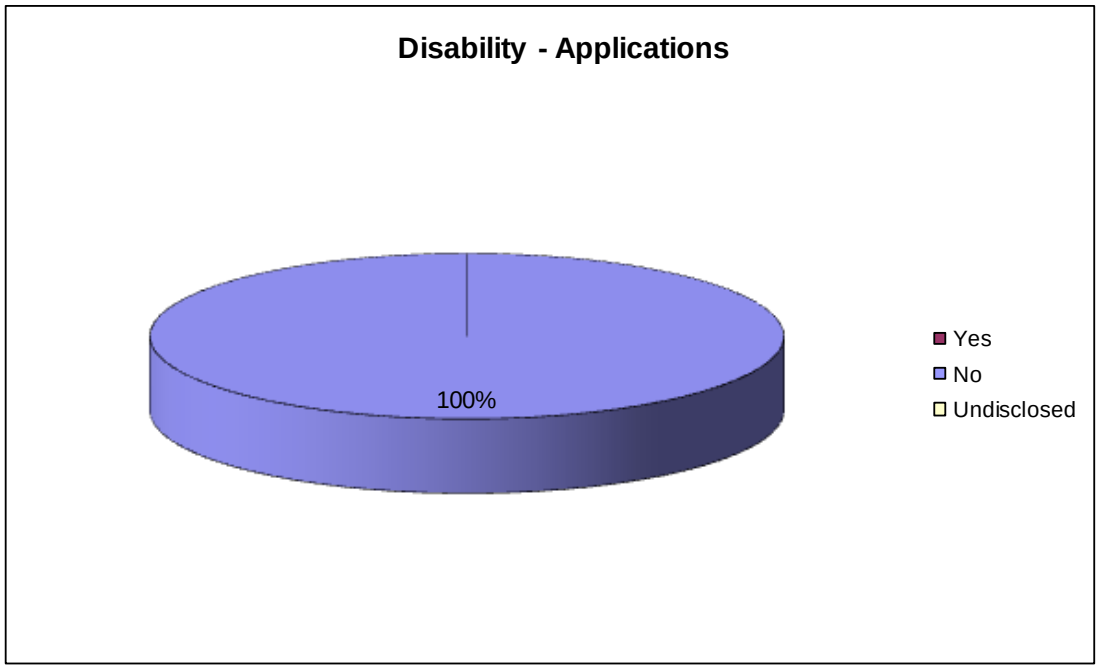


Chart J

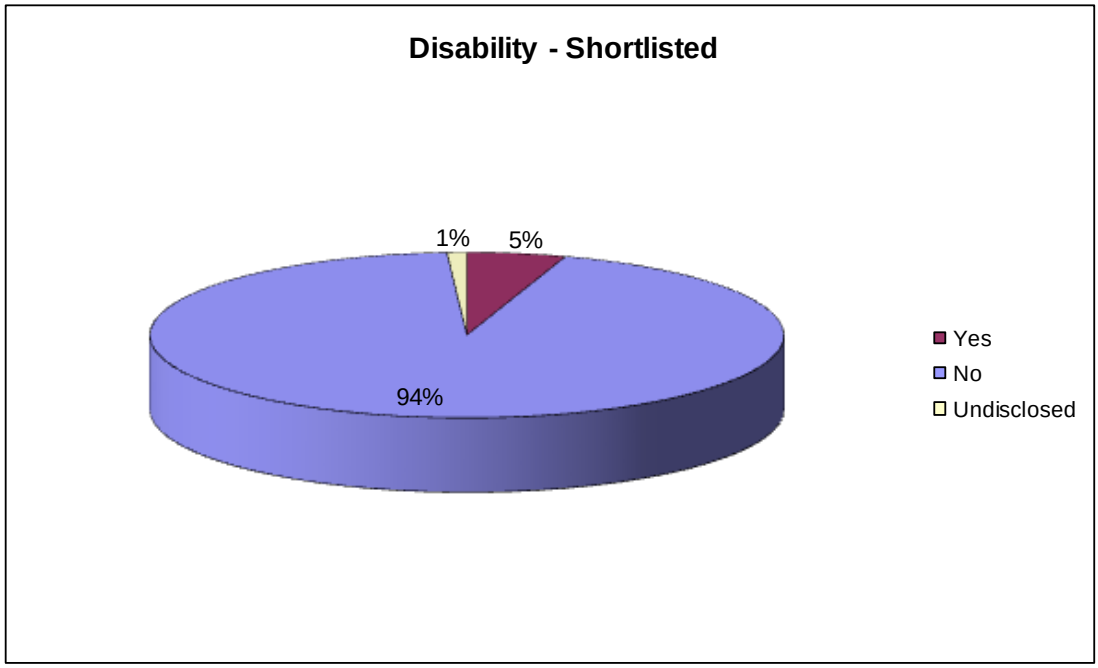


Chart K

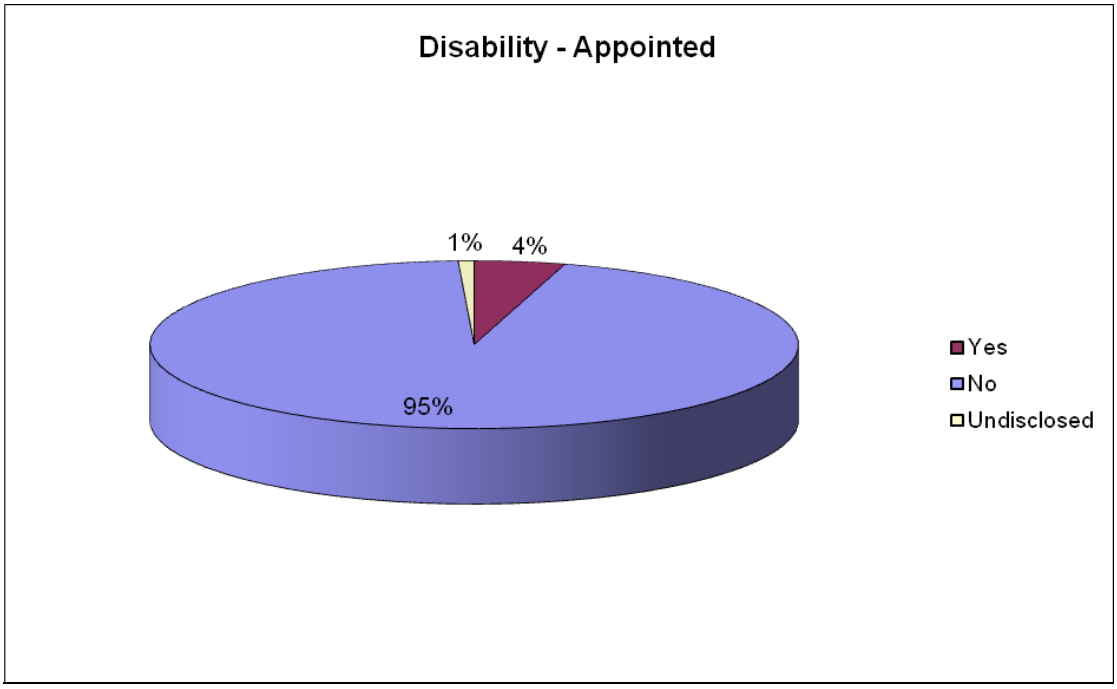
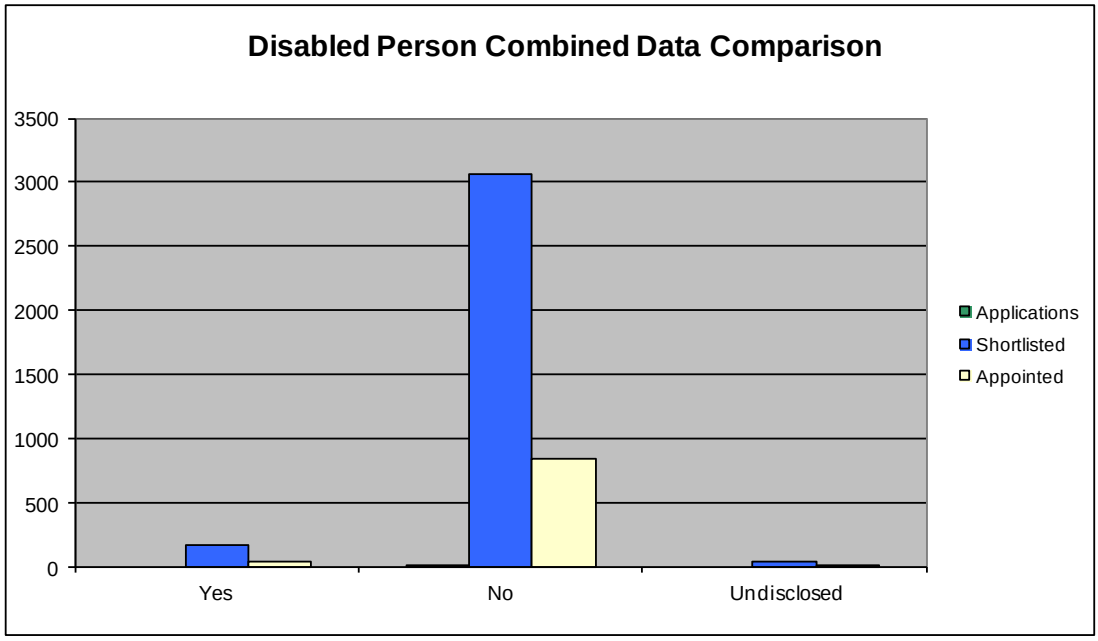


Chart L



Recruitment - Religious Belief

Charts M to P identify the number of applications that have been received, shortlisted and appointed between April 2012 and March 2013. *It must be noted that where the number of applications were very small the pie chart has not been populated. It is only at the shortlisting and appointment stage (Charts N and O) that this has been identified, hence the reason why there are more religious belief percentages shown in the shortlisting and appointment pie charts.*

Compared to last years' figures (29%), there has been a significant increase in the number of applications received from the Hinduism category, rising to 75%. However, the numbers being shortlisted remain low in comparison with 3% being shortlisted and 2% being appointed (compared to 2011/2012 figures of 3% and 1% respectively).

We have seen an increase in the number of applications received from the Atheism category of 25%, with 12% being shortlisted and 15% being appointed (compared to 12% in 2011/2012).

There was a decrease in the number of applications received from the Christianity category of 60%, with 58% being appointed (compared to 66% from 2011/2012).

In addition, although the number of applicants who recorded their religion in the other category has reduced, we have seen an increase to 11% being

shortlisted and 12% being appointed. There has also been an increase in the number of appointed candidates who did not disclose their religious belief (rising to 9% compared to 7% last year). This does raise some concern that in future it may be more difficult to understand trends within the religious belief protected characteristics as it is not possible to know the religion of those recording the 'other' or "undisclosed" categories.

In the future it is now important to consider working with all religious groups and as mentioned previously this will be carried out in conjunction with the Health Equality Group.

Chart M

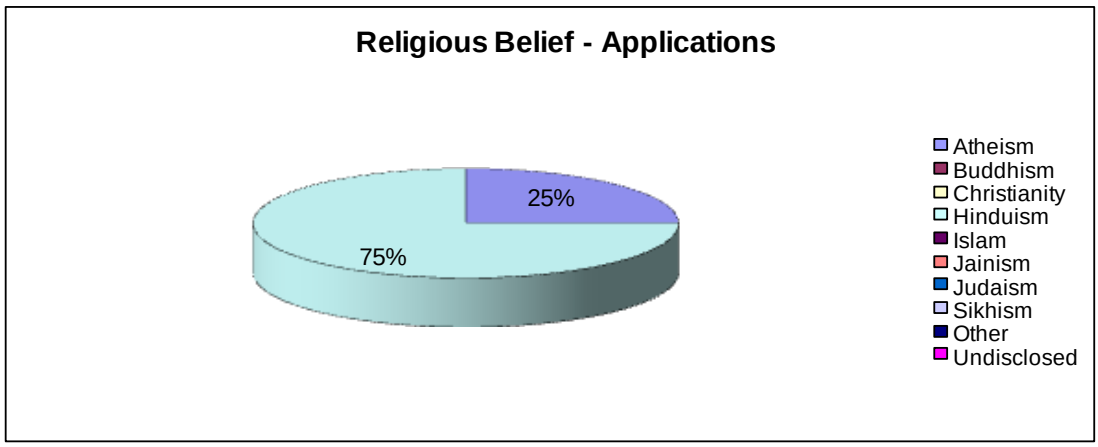


Chart N

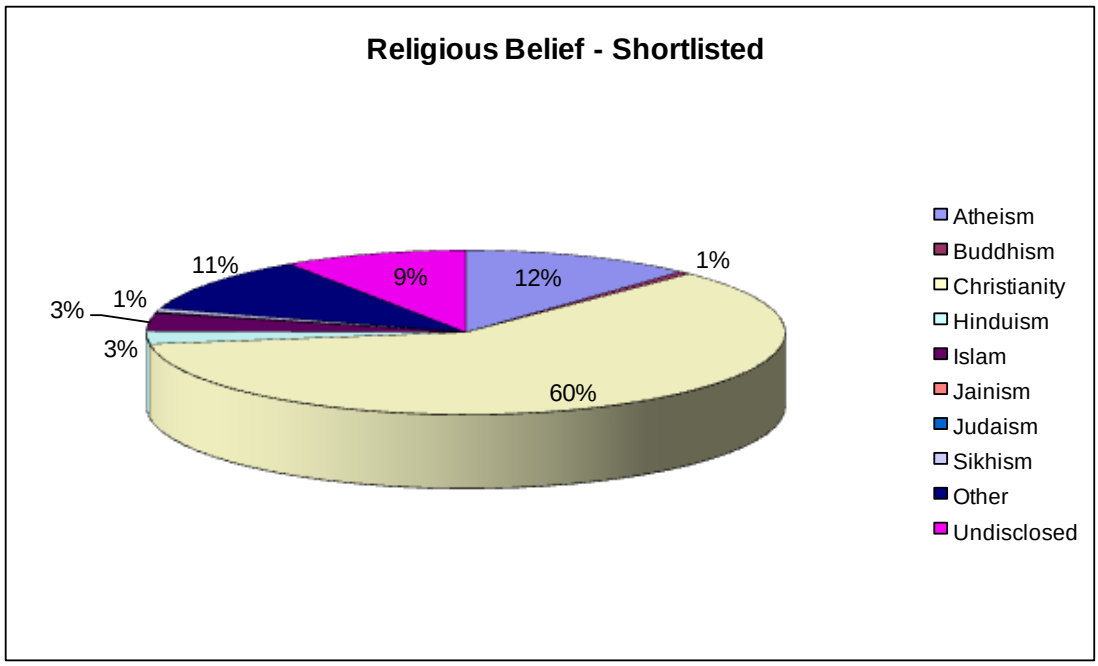


Chart O

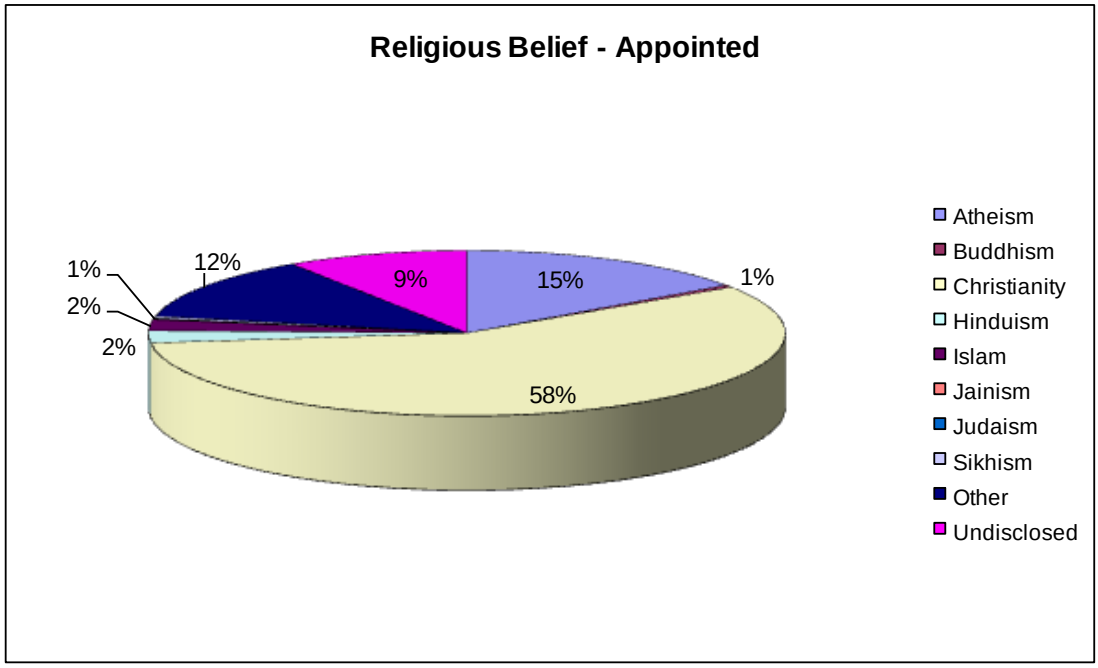
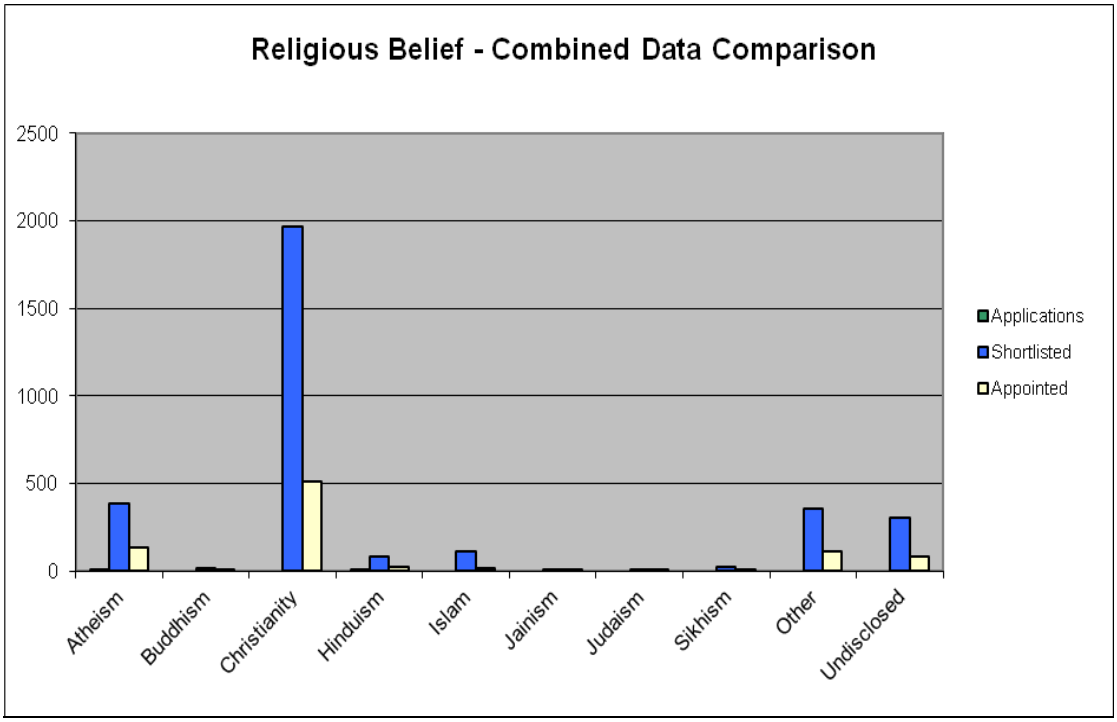


Chart P



Recruitment - Sexual Orientation

The highest number of individuals applying for posts and being appointed still remains within the heterosexual group, with 92% being shortlisted and 94% being appointed. *It must be noted that where the number of applications were very small, the pie chart has not been populated. It is only at the shortlisting and appointment stage that this has been identified; hence the reason why there are more sexual orientation groups shown in the shortlisting and appointment pie charts.*

There has been a change in trend in disclosure of sexual orientation with more or less 100% of applicants who are willing to disclose their sexual orientation.

Although the number of applicants who did not disclose their sexual orientation has reduced, there was an increase in the number being shortlisted of 6%, with 4% being appointed. This is also reflected in the Lesbian, Gay and Bisexual Groups with a reduction in the number of applications received, with 2% being shortlisted. We did see an increase to 2% of those being appointed within this group.

Chart Q

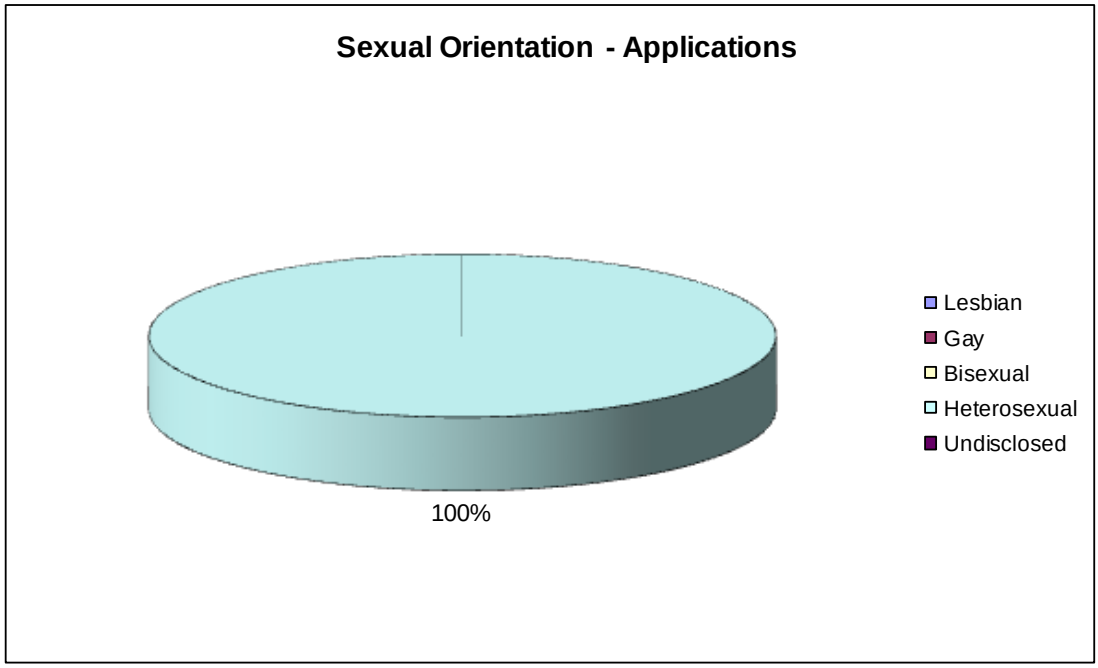


Chart R

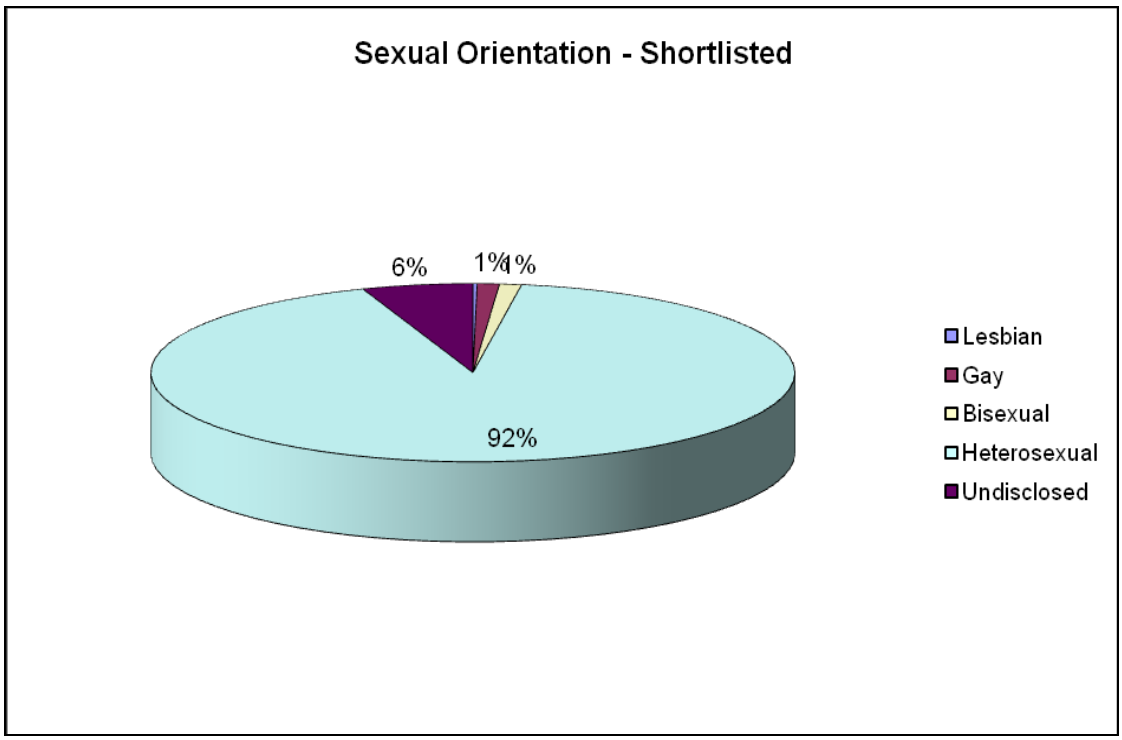


Chart S

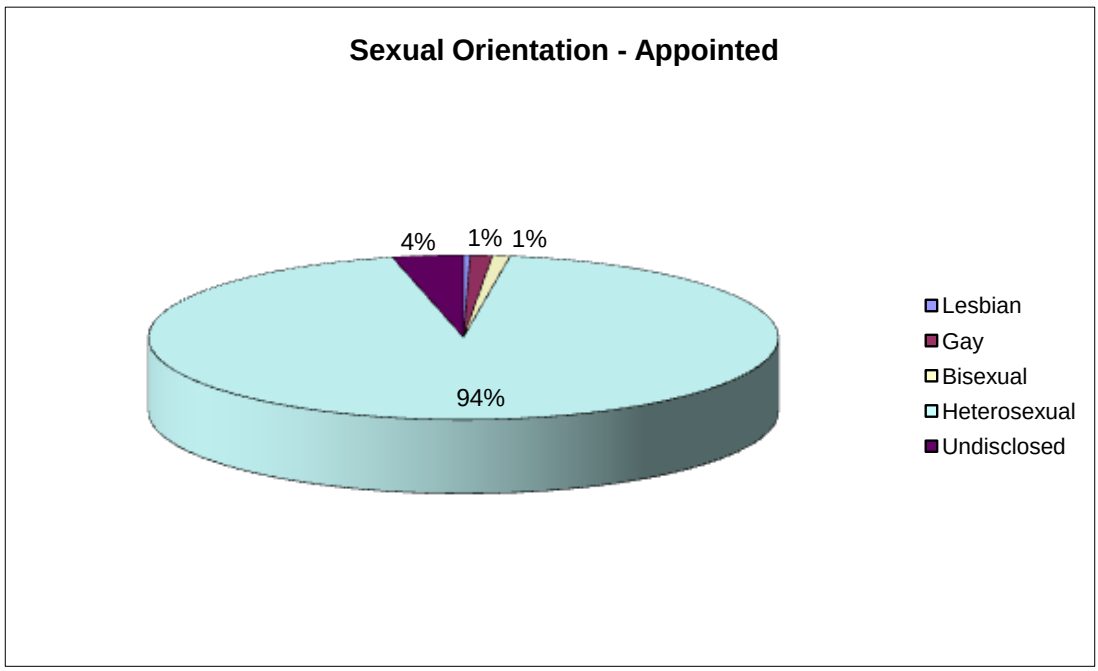
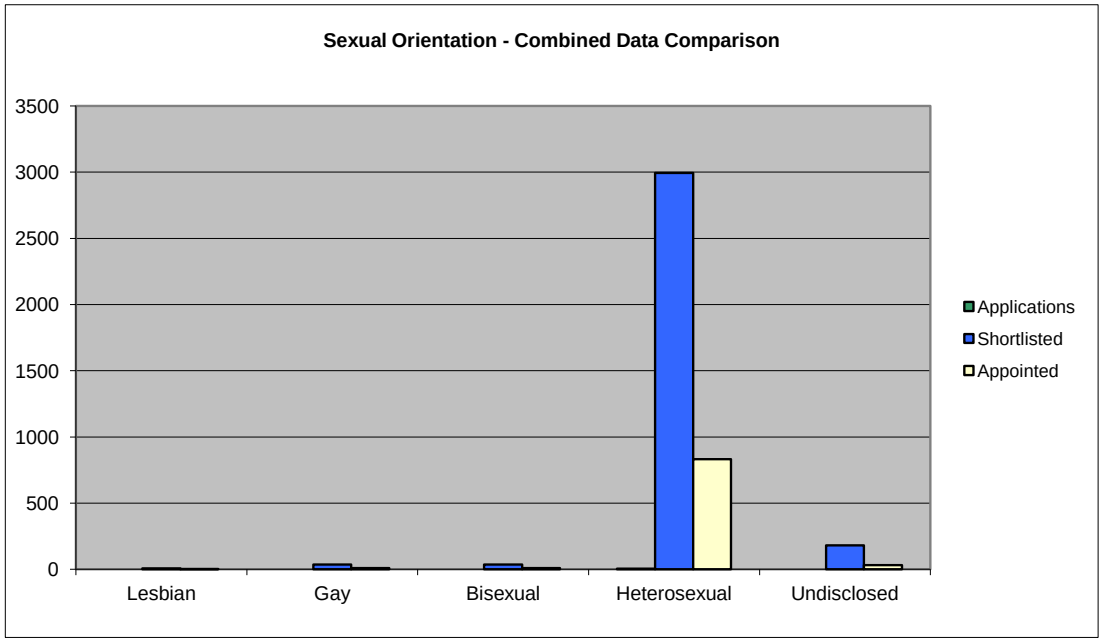


Chart T



HUMAN RESOURCES (HR) CASELOAD ACTIVITY – APRIL 2012 TO MARCH 2013

Background

This section of the report provides the equal opportunities breakdown of 6 of the 9 protected characteristics as per the Equality Act 2010 for the formal Human Resources (HR) caseload activity across the Trust between the period of April 2012 and March 2013 for both open and closed formal cases.

The protected characteristics reported on are: age, disability, race, religion or belief, gender and sexual orientation.

The Trust does not currently record any data for its employees in the area of gender reassignment. Whilst the Trust does collate data on the other two equality strands; pregnancy and maternity and marriage and civil partnership, a report detailing this data in relation to HR caseload is not possible to obtain at this time due to technical difficulties with the system.

There are still a considerable number of staff who choose not to disclose information in relation to the protected characteristics and therefore this is reflected in some of the high figures showing in each of the sections below.

The HR activity has been broken down into the following categories:

- Conduct – Disciplinary
- Harassment and Bullying
- Grievances
- Sickness Absence
- Employment Tribunals
- Flexible Working

HR Caseload - Ethnicity

The majority of case work relating to sickness absence involves employees from 'White' origin, which is proportionate to the 'White' ethnicity of the Trust. The highest percentage of cases involving the 'Ethnic Minority' category relates to Employment Tribunals and conduct related cases. Overall, the higher percentage of employees from 'White' origin involved in cases is proportionate with the ethnicity data for the Trust.

Ethnicity	Ethnic Minority	%	White	%	Unknown	%	Total Cases	%
Conduct	6	25.00	18	75.00	0	0.00	**24**	12.83
Harassment & Bullying	0	0.00	4	100.00	0	0.00	**4**	2.14
Grievance	2	16.67	10	83.33	0	0.00	**12**	6.42
Sickness	15	11.72	111	86.72	2	1.56	**128**	68.45
Employment Tribunal	1	33.33	2	66.67	0	0.00	**3**	1.60
Flexible Working	3	18.75	12	75.00	1	6.25	**16**	8.56
Total Cases	**27**		**157**		**3**		**187**	**100.00**

HR Caseload - Age

The majority of the formal casework being dealt with by the HR Department is within the '41-45' and '46-50' age groups. This correlates with the numbers of staff within the Trust as the highest proportion of staff are within these age ranges.

Age	%	Numbers
16 - 20	2.67	5
21 -25	6.95	13
26 - 30	9.63	18
31 - 35	10.70	20
36 - 40	11.76	22
41 - 45	16.04	30
46 - 50	17.65	33
51 - 55	11.23	21
56 - 60	9.63	18
61 - 65	3.74	7
65+	0.00	0
Total Cases	**100%**	**187**

HR Caseload - Gender

The table below demonstrates that the majority of formal HR cases are in relation to females. This is reflective of the Trust's workforce which consists of predominantly females in employment. However the statistics show that there is a very close gap between the number of grievance cases being raised by males in comparison to females. Further information surrounding this data does not identify a specific reason for the increase in grievance cases raised by males, however the information suggests this a number of these cases are focussed within one area and by one staff group. This is being looked into further.

Gender	Male	%	Female	%	Total Cases	%
Conduct	4	16.67	20	83.33	**24**	12.83
Harassment & Bullying	0	0.00	4	100.00	**4**	2.14
Grievance	5	41.67	7	58.33	**12**	6.42
Sickness	11	8.59	117	91.41	**128**	68.45
Employment Tribunal	0	0.00	3	100.00	**3**	1.60
Flexible Working	0	0.00	16	100.00	**16**	8.56
Total Cases	**20**		**167**		**187**	**100.00**

HR Caseload - Disability

There is a large proportion of staff involved in formal cases where disability is classified either as 'undefined' or 'not declared', therefore making a true analysis of this protected characteristic difficult. However, for those staff that have declared whether or not they have a disability, with the exception of the sickness absence category, the majority of employees involved in formal action do not have a disability.

The lack of definitive data in relation to disability demonstrates the need to undertake further work in obtaining this data. A data cleanse has been carried out by the workforce information department so it is anticipated that there will be an increase in recording in the future.

Disability	Yes	%	No	%	Undefined	%	Not Declared	%	Total Cases	%
Conduct	0	0%	16	66.67	7	29.17	1	4.17	**24**	**12.83**
Harassment & Bullying	0	0%	2	50.00	2	50.00	0	0.00	**4**	**2.14**
Grievance	0	0%	6	50.00	6	50.00	0	0.00	**12**	**6.42**
Sickness	7	547%	52	40.63	62	48.44	7	5.47	**128**	**68.45**
Employment Tribunal	0	0%	1	33.33	2	66.67	0	0.00	**3**	**1.60**
Flexible Working	1	625%	5	31.25	10	62.50	0	0.00	**16**	**8.56**
Total Cases	**8**		**82**		**89**		**8**		**187**	**100.00**

HR Caseload - Marriage / Civil Partnership

Whilst the Trust records data in relation to Pregnancy and Maternity, for the HR cases at the present time, it has not been possible to break this protected characteristic down into categories for the purposes of reporting.

HR Caseload - Pregnancy / Maternity

Whilst the Trust records data in relation to Pregnancy and Maternity, for the HR cases at the present time, it has not been possible to break this protected characteristic down into categories for the purposes of reporting.

HR Caseload - Religion / Belief

The highest percentage of staff involved in formal cases, involve employees from the 'Christian' category. Across all the categories, sickness cases, in the main, have the highest percentage. However, there are a vast number of staff involved in formal HR cases, whom have chosen either not to disclose their religion or belief or whose religion / belief is recorded as 'Unknown'.

Religion	Atheism	%	Christianity	%	Islam	%	Not Disclosed	%	Other	%	Unknown	%	Total Cases	%
Conduct	4	16.67	10	41.67	3	12.50	0	0.00	5	20.83	2	8.33	24	12.83
Harassment & Bullying	0	0.00	1	25.00	0	0.00	0	0.00	3	75.00	0	0.00	4	2.14
Grievance	0	0.00	5	41.67	2	16.67	2	16.67	2	16.67	1	8.33	12	6.42
Sickness	17	13.28	47	36.72	1	0.78	16	12.50	16	12.50	31	24.22	128	68.45
Employment Tribunal	0	0.00	0	0.00	0	0.00	1	33.33	1	33.33	1	33.33	3	1.60
Flexible Working	1	6.25	7	43.75	0	0.00	1	6.25	3	18.75	4	25.00	16	8.56
Total Cases	**22**		**70**		**6**		**20**		**30**		**39**		187	100.00

HR Caseload - Sexual Orientation

The category of 'Heterosexual' shows the highest proportion of staff involved in formal cases which correlates with the number of staff in the Trust who report they are heterosexual. Again, there is a large proportion of staff involved in HR cases who do not wish to disclose or whose sexual orientation is unknown.

Sexual Orientation	Bisexual	%	Gay	%	Heterosexual	%	Lesbian	%	Unknown	%	Not Disclosed	%	Total Cases	%
Conduct	0	0%	0	0%	19	79.17	0	0%	3	12.50	2	8.33	**24**	**12.83**
Harassment & Bullying	0	0%	0	0%	4	100.00	0	0%	0	0.00	0	0.00	**4**	**2.14**
Grievance	0	0%	0	0%	8	66.67	0	0%	2	16.67	2	16.67	**12**	**6.42**
Sickness	1	78%	0	0%	78	60.94	0	0%	32	25.00	17	13.28	**128**	**68.45**
Employment Tribunal	0	0%	0	0%	0	0.00	0	0%	2	66.67	1	33.33	**3**	**1.60**
Flexible Working	0	0%	0	0%	10	62.50	0	0%	4	25.00	2	12.50	**16**	**8.56**
Total Cases	1		0	0%	119		0		43		24		**187**	**100.00**

LEARNING AND DEVELOPMENT – APRIL 2012 TO MARCH 2013

Background

The Trust uses the Oracle Learning Management System (OLM) to record all training information. This is a centralised system and the focus since its implementation in 2009 has been to record and report on mandatory training. However, the Trust also records clinical training such as venepuncture and dementia training which are also included in this section of the report. In addition, this year, we have offered courses in Interview skills, Assertiveness,

Communication skills, Appraisal Training for Managers, Appraisal Training for Staff and Attendance Management Training.

The tables below show the Trust headcount by protected characteristics and the number of training courses attended. We currently collect data on 6 of the 9 protected characteristics, those not included are; Gender Reassignment, Marriage and Civil Partnership and Pregnancy and Maternity. The variance indicates whether the protected characteristics are accessing the training by proportion of headcount. It is important to note that these reports will differ from the information above as they include the Trust's bank staff.

The trained headcount includes all training that staff have attended, but not all staff are required to attend all courses. Some of the courses are only pertinent to some staff, for example staff induction is only relevant to new staff, refresher periods differ to job role and some courses are only applicable to certain the roles. Therefore it is difficult to directly correlate the variance in headcount to the headcount trained.

During the year the Learning & Development department have worked with Mandatory Training Leads to look at offering training in other methods. This resulted in the production of a DVD which is made available to staff and teams and a question paper is completed and marked to demonstrate competence. Further work was carried out and a workbook was produced to offer an additional method of receiving the training.

During 2012/13 there was an overseas recruitment campaign and the staff recruited were predominately aged 21-25 and female which has a direct effect on the variance within those protected characteristics.

There has been a reduction in the number of staff stating 'undefined' and 'not stated' within the following reports from last year. As part of the monthly data cleanse, the Trust receives reports identifying missing data, e.g. Sexual Orientation, which has enabled us to ask staff for the information which has then been uploaded into the database. The monthly report only covers staff who have joined us on or after April 2010 in the areas of Sexual Orientation, Religious Beliefs and/or Disability.

Within Ethnic Origin it isn't acceptable to state undefined, but they can put 'not stated'.

Equality and Diversity Training

Our commitment to ensuring all our staff have appropriate equality and diversity training is borne out in the results of the Staff Survey which demonstrates we compare most favourably with other acute Trusts in this area. The statistics show a significant improvement in the percentage of staff having equality & diversity training in the last 12 months. This is as a result of several years of ensuring equality and diversity training is mandatory for all staff and including it on the Staff Induction.

To ensure staff are able to access this subject, we have various delivery styles; the NHS E-learning package and classroom sessions. In addition, all new staff are trained in Equality and Human Rights as part of their Trust Induction.

All staff attending the Equality & Human Rights training are given an awareness of the nine protected characteristics under the Equalities Act 2010 and the adverse impact on clinical care if they are not respected.

Ethnicity Profile of Staff Undertaking Training & Development

The figures indicate that training is provided to all staff and the Trust headcount and numbers of training courses attended by all staff reflects the Trust's ethnic population. For example the highest number of staff in the Trust are of white ethnicity with the second group being Asian and the third category from Black / Black British.

The highest variance in attendance is within the White Irish group which reflects the recruitment drive held in Ireland which led to the recruitment of a number of Irish Nurses.

There has been a decrease in the number of staff who had 'undefined' but there has been an increase in 'not stated'.

Ethnic Origin	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
A White - British	4,061	72.56%	27,576	67.15%	-5.40%
B White - Irish	81	1.45%	1,113	2.71%	1.26%
C White - Any other White background	200	3.57%	1,658	4.04%	0.46%
C3 White Unspecified	3	0.05%	24	0.06%	0.00%
CA White English	5	0.09%	17	0.04%	-0.05%
CC White Welsh	1	0.02%	3	0.01%	-0.01%
CFWhite Greek	4	0.07%	18	0.04%	-0.03%
CG White Greek Cypriot	0	0.00%	0	0.00%	0.00%
CH White Turkish	0	0.00%	0	0.00%	0.00%
CK White Italian	9	0.16%	51	0.12%	-0.04%
CP White Polish	9	0.16%	49	0.12%	-0.04%
CX White Mixed	2	0.04%	16	0.04%	0.00%
CY White Other European	44	0.79%	687	1.67%	0.89%
D Mixed - White & Black Caribbean	28	0.50%	215	0.52%	0.02%
E Mixed - White & Black African	6	0.11%	57	0.14%	0.03%
F Mixed - White & Asian	14	0.25%	76	0.19%	-0.07%
G Mixed - Any other mixed background	16	0.29%	92	0.22%	-0.06%
GA Mixed - Black & Asian	1	0.02%	1	0.00%	-0.02%
GC Mixed - Black & White	1	0.02%	2	0.00%	-0.01%
GD Mixed - Chinese & White	0	0.00%	0	0.00%	0.00%
GF Mixed - Other/Unspecified	0	0.00%	0	0.00%	0.00%
H Asian or Asian British - Indian	375	6.70%	3,259	7.94%	1.24%
J Asian or Asian British - Pakistani	41	0.73%	203	0.49%	-0.24%
K Asian or Asian British - Bangladeshi	12	0.21%	46	0.11%	-0.10%
L Asian or Asian British - Any other Asian background	67	1.20%	613	1.49%	0.30%
LD Asian East African	0	0.00%	0	0.00%	0.00%
LE Asian Sri Lankan	8	0.14%	38	0.09%	-0.05%
LG Asian Sinhalese	1	0.02%	11	0.03%	0.01%
LH Asian British	2	0.04%	5	0.01%	-0.02%
LJ Asian Caribbean	0	0.00%	0	0.00%	0.00%
LK Asian Unspecified	3	0.05%	39	0.09%	0.04%
M Black or Black British - Caribbean	62	1.11%	444	1.08%	-0.03%
N Black or Black British - African	239	4.27%	2,145	5.22%	0.95%
P Black or Black British - Any other Black background	24	0.43%	137	0.33%	-0.10%
PC Black Nigerian	4	0.07%	55	0.13%	0.06%
PD Black British	8	0.14%	41	0.10%	-0.04%
PE Black Unspecified	1	0.02%	1	0.00%	-0.02%
R Chinese	20	0.36%	234	0.57%	0.21%
S Any Other Ethnic Group	30	0.54%	269	0.66%	0.12%
SB Japanese	0	0.00%	0	0.00%	0.00%
SC Filipino	5	0.09%	74	0.18%	0.09%
SD Malaysian	0	0.00%	0	0.00%	0.00%
SE Other Specified	14	0.25%	111	0.27%	0.02%
Z Not Stated	163	2.91%	1,592	3.88%	0.96%
Undefined	33	0.59%	93	0.23%	-0.36%
Total	**5,597**		**41,065**		

* *This Trust Headcount includes Bank staff*

Age Profile of Staff Undertaking Training & Development

Training is offered to all age groups and there has been an increase in the number of staff within 16 to 40 from last year's figures.

The biggest variance is within the age range of 21-25 which correlates to the number of staff recruited within this range, and attending staff induction, which has 14 different training sessions. The highest number of staff in post are in

the 46-50 age range and this correlates to having the second highest in attendance. The greater variance of non-attendance is in 56-60 age range and 61-65 age range, which may be contributed to having more part-time staff and staff working evenings and weekends.

Age Band	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
16 - 20	215	3.84%	1,309	3.19%	-0.65%
21 - 25	612	10.93%	6,102	14.86%	3.92%
26 - 30	611	10.92%	4,744	11.55%	0.64%
31 - 35	670	11.97%	4,853	11.82%	-0.15%
36 - 40	675	12.06%	5,155	12.55%	0.49%
41 - 45	630	11.26%	4,486	10.92%	-0.33%
46 - 50	739	13.20%	5,490	13.37%	0.17%
51 - 55	676	12.08%	4,767	11.61%	-0.47%
56 - 60	440	7.86%	2,684	6.54%	-1.33%
61 - 65	242	4.32%	1,202	2.93%	-1.40%
66 - 70	74	1.32%	239	0.58%	-0.74%
71 & above	13	0.23%	34	0.08%	-0.15%
Total	5,597		41,065		

* *This Trust Headcount includes Bank staff*

Gender Profile of Staff Undertaking Training & Development

More females are attending training than males which correlate to the workforce profile. However, the table also identifies that less males are completing training by proportion.

The recruitment data shows that we have recruited more females which again demonstrate this higher number of trained staff due to attending staff induction.

Gender	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Female	4,394	78.51%	33,633	81.90%	3.40%
Male	1,203	21.49%	7,432	18.10%	-3.40%
Not Stated	0	0.00%	0	0.00%	0.00%
Total	5,597		41,065		

* *This Trust Headcount includes Bank staff*

Disability Profile of Staff Undertaking Training and Development

The table below demonstrates that training is accessible to disabled staff as they completed more training (2.51%) than the Trust disabled headcount (2.22%).

All training rooms provide good access for disabled staff members and with an increase in the opportunity to access the training subjects by e-learning, DVD and workbook, staff have greater access because they can complete their training at their usual place of work.

The number of 'not stated' has reduced from last year and this year has seen a slight increase on the number of staff disclosing a disability.

Disability	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Yes	124	2.22%	1,032	2.51%	0.30%
No	2,344	41.88%	18,977	46.21%	4.33%
Not Stated	3,129	55.90%	21,056	51.27%	-4.63%
Total	**5,597**		**41,065**		

* *This Trust Headcount includes Bank staff*

Religious Belief Profile of Staff Undertaking Training & Development

The highest proportion of training was completed by the Christian religious group which correlates with the workforce profile. Likewise for those religious groups where the Trust headcount is higher i.e. Atheism, Hinduism, Islamic and the other categories training is being completed proportionately.

The number of 'not stated' has reduced from last year, but the number of staff who do not wish to disclose their religion/belief has increased.

Religious Belief	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Atheism	426	7.61%	3,512	8.55%	0.94%
Buddhism	16	0.29%	169	0.41%	0.13%
Christianity	2,415	43.15%	19,043	46.37%	3.22%
Hinduism	135	2.41%	1,235	3.01%	0.60%
Islam	98	1.75%	659	1.60%	-0.15%
Jainism	8	0.14%	65	0.16%	0.02%
Judaism	6	0.11%	34	0.08%	-0.02%
Other	431	7.70%	3,691	8.99%	1.29%
Sikhism	18	0.32%	139	0.34%	0.02%
I do not wish to disclose my religion/belief	883	15.78%	5,718	13.92%	-1.85%
Not Stated	1,161	20.74%	6,800	16.56%	-4.18%
Total	**5,597**		**41,065**		

* *This Trust Headcount includes Bank staff*

Sexual Orientation of Staff Undertaking Training & Development

The figures demonstrate that all categories of sexual orientation are attending the Trust training programmes and this correlates with numbers of staff in post. The fact that those who do not wish to disclose their sexual orientation and those who have not stated their sexual orientation remains high continues the trend. A data cleanse is currently being carried out so that those not stated may change.

The number of 'not stated' has reduced from last year, but the number of staff who do not wish to disclose their sexual orientation has increased.

Sexual Orientation	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Bisexual	34	0.61%	278	0.68%	0.07%
Gay	19	0.34%	166	0.40%	0.06%
Heterosexual	3,457	61.77%	27,612	67.24%	5.47%
Lesbian	12	0.21%	120	0.29%	0.08%
I do not wish to disclose my sexual orientation	815	14.56%	5,259	12.81%	-1.75%
Not Stated	1,260	22.51%	7,630	18.58%	-3.93%
Total	**5,597**		**41,065**		

* *This Trust Headcount includes Bank staff*

Conclusion

With an increase in attendance of training for 2012/13, we can conclude that access to training and learning and development for all staff has improved. To this end, provision has been developed to offer flexible approaches to learning that remove barriers to access for groups with protected characteristics. With the introduction of a workbook and DVD, this training can be accessed outside of normal working hours. Further work has been carried out to ascertain the requirement for early morning, evening and weekend training and as a result some training is now offered during these times.

Learning and Development have plans to reduce the number of Mandatory Training courses and to develop the work already started in looking at methods of delivery. Staff are being communicated with to ensure that all proposed methods of delivery do not exclude any of the protected characteristics. Work has been carried out in certain areas to look at the way the training is delivered and the depth of knowledge required, this has led to some courses being adapted for those areas E.g. Domestic Services.

We are aware that training and information accessed through attending training do not meet all of the different languages and cultures. Therefore future plans are to provide literature in different languages and to work with the relevant departments in making training easier to understand.

A piece of work which has just started is to look at creating a training passport within the county. The piece of work involves all the learning and development leads from neighbouring Trusts to create one set of learning outcomes, delivery methods and assessment methods for 10 core subjects. This will help staff who are moving from one Trust to another or who bank in different Trusts to have their training recognised.

Learning and Development continues to communicate to staff the Trust Mandatory Training Policy. This policy ensures that all staff are aware of the mandatory training they are required to undertake and for the Trust to be compliant against is regulatory requirements.

A prospectus is also made available to all staff detailing the clinical training that is available.

Work is being carried out on centralising all Personal Development Plans, which will identify the training requirements throughout the Trust and to ensure that all staff have equal access to training. External training is also offered and future plans include that a panel will be created to approve training funding, to ensure equity of access via a transparent process.

A data cleanse has started which means that all staff have received a form asking them to complete the missing data or to update the data. This piece of work will be completed during 2013. The results should be reflected in next year's report.

COMMENTS OR FEEDBACK

If you have any comments or wish to provide feedback on this report, please send them to the Trust's Service Equality Lead at:

Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC

Wednesday 24 July 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 27 June 2013	Mr P Farenden	**A**
	4.	Matters Arising	Mr P Farenden	**B**
09.35	5.	Chief Executive's Report	Dr S Swart	**C**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**D**
10.05	7.	Patient Experience Report	Ms S Loader	**E**
10.15	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**F**
10.25	9.	Francis Report Action Plan Update	Ms S Loader	**G**
10.35	10.	CQC Report	Ms S Loader	**H**
10.40	11.	Quality Account Update	Ms S Loader	**I**
Operational Assurance				
10.45	12.	Operational Performance Report	Mr C Walsh	**J**
10.55	13.	Urgent Care Update	Mr C Walsh	**K**
11.05	14.	Finance Report	Mr D Bebb	**L**
11.15	15.	Workforce Report	Mrs J Brennan	**M**
11.25	16.	Transformation Programme Update	Mrs J Brennan	**N**
11.35	17.	Self-Certification Return	Mr C Walsh	**O**
Strategy				
11.40	18.	Risk Management Strategy	Ms S Loader	**P**
11.50	19.	Complaints Annual Report 2012/13	Ms S Loader	**Q**
12.00	20.	Health and Safety Annual Report 2012/13	Mr C Abolins	**R**
12.10	21.	Fire Safety Annual Report 2012/13	Mr C Abolins	**S**
12.20	22.	Equality and Diversity Annual Report 2012/13	Mrs J Brennan	**T**

Any Other Business				
12.30	23.	Any Other Business	Mr P Farenden	
	24.	**Date & time of next meeting:** 23 September 2013 – 09.30am. Boardroom, Northampton General Hospital		
	25.	**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.		