Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 31 October 2013, 09.30 am

at

The Boardroom
Danetre Hospital
London Road
Daventry
NN11 4DY

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 31 October 2013
09:30 am. Boardroom
Danetre Hospital, London Road, Daventry

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of the 23 September 2013 meeting of the Board	Decision	Mr P Farenden	**A.**
	4.	Matters arising from the 23 September 2013	Note	Mr P Farenden	**B.**
	5.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.45	**CLINICAL QUALITY AND SAFETY**				
	6.	Patient Story	Note	Dr S Swart	**Verbal**
	7.	Medical Director's Quality Report	Assurance	Dr N Robinson	**D.**
	8.	Patient Experience Report	Assurance	Ms F Barnes	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms F Barnes	**F.**
	10.	Infection Control Annual Report	Assurance	Ms F Barnes	**G.**
	11.	Safeguarding Adults & Children's Annual Reports	Assurance	Ms F Barnes	**H.**
	12.	Annual Clinical Audit Plan	Decision	Dr N Robinson	**I.**
11.00	**OPERATIONAL ASSURANCE**				
	13.	Operational Performance Report	Assurance	Mr C Walsh	**J.**
	14.	Urgent Care Update	Assurance	Mr C Walsh	**K.**
	15.	Finance Report	Assurance	Mr A Foster	**L.**
	16.	Workforce Report	Assurance	Mrs J Brennan	**M.**
	17.	Transformation Report	Assurance	Mrs J Brennan	**N.**
	18.	Self-Certification Report	Decision	Mr C Walsh	**O.**
11.45	**GOVERNANCE**				
	19.	Standards of Business Conduct	Decision	Mr A Foster	**P.**

	20.	Emergency Preparedness, Resilience and Response	Decision	Mrs D Needham	**Q.**
	21.	Research and Development Annual Report	Assurance	Dr S Swart	**R.**
12.00	**ANY ITEMS OF OTHER BUSINESS**				
	22.	**DATE AND TIME OF NEXT MEETING** 28 November 2013 09:30 Boardroom, NGH	Note	Mr P Farenden	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on
Monday 23 September 2013 at 9.30am
Boardroom, Northampton General Hospital

Present:

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

In Attendance:

Mrs E Morton	Membership Manager (Minutes)
Mrs J Bradley	Patient Safety Programme Director & Assistant to Medical Director

Apologies:

No apologies were received for the meeting

TB 13/14 080 **Declarations of Interest in the Proceedings**

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

TB 13/14 081 **Minutes of the meeting held on 24 July 2013**

The minutes of the Board meeting held on the 24 July 2013 were presented to the Board for approval.

Ms Loader requested the following amendments:
TB 13/14 062 Final paragraph: Matrons should read Heads of Departments
TB 13/14 073 Second paragraph: 1005 should read 100%

Subject to that amendment, the Board APPROVED the minutes of the 24 July 2013 as a true and accurate record of proceedings.

TB 13/14 082 **Action Log and matters arising from the July Board**

Mr Farenden informed the Board that Dr Sonia Swart had been appointed as substantive Chief Executive and offered his congratulations on her appointment. The Board also extended their congratulations to Dr Swart.

Mrs Searle requested that Ms Loader provide benchmarking data for the number of complaints received by the Trust in comparison to similar trusts. Ms Loader agreed to bring the data to the November Board meeting which would incorporate Quarter 2 data.

ACTION Ms Loader

The action log was considered and the Board **NOTED** that all actions had been implemented or were due to be within the defined timeframe.

TB 13/14 083 **Chief Executive's Report**

Dr Swart presented the Chief Executive's report.

She asked the Board to recognise the work that had been undertaken in the organisation of the Trust's AGM and the festival. She particularly commended the standard of the newly formed NGH Choir, and remarked on the standard of the performance given the relatively short time that that it had had to rehearse. Dr Swart then went on to praise the standard of the stalls and displays and the positive atmosphere of the event. She extended thanks to Mrs Morton and Mrs Watts for their work in organising the day.

Following recent concerns raised to the CQC by a member of Trust staff, a number of remedial actions had been taken and all areas across the Trust had been reviewed to ensure patients were comprehensively cared for safely with compassion and dignity, and that our staff were supported during what was a difficult time for all concerned.

Whilst the Trust was assured that the remedial work undertaken following the notification continued to make the environment safe for patients was apparent that the workforce was demoralised, particularly in light of the recent negative media attention.

Dr Swart stressed that patients attending the Trust should be reassured that there were sufficient resources available to provide the required standards of care. This would continue to be a major focus over the next three to four months and would include the development of a peer review process. An internal inspection regime was also under development which would report to the Board on a monthly basis once established.

Dr Swart reiterated to the Board that the continued focus on nursing staff recruitment would ensure a correct level of substantive staff for the Trust with a reduced reliance on agency staff.

Dr Swart informed the Board that the Trust had received notification it would receive £4m in additional funding in 2013/14 on behalf of the whole health economy in respect of winter pressures. The additional funding represented an opportunity for targeted investment to improve pathways of care and the experience and safety for patients.

The Trust was required to sign a declaration that it would use the monies allocated wisely to make suitable investments to improve our current performance against the A and E 4 hour target and other key standards of care. There was an expectation within the health economy that part, at least, of this funding will be used to support or expand services in primary and community care and in social services. A series of meetings and discussions would now commence culminating in the submission of a feasible and affordable seasonal plan to the Trust Board.

Dr Swart informed the Board that Dr Natasha Robinson, Associate Medical Director and Consultant Anaesthetist has been invited to attend the Woman of the Year lunch in recognition of her work on patient safety at the Royal School of Medicine.

The Board was informed that Mr Nick Robertson has been reappointed as Non-Executive Director until September 2015.

The Board **NOTED** the Chief Executive's report

TB 13/14 084 Medical Director's Report

Dr Robinson presented the Medical Director's report.

HSMR was within expected levels and was below 104. The graph on page 24 of the report showed a continued fall from 2009-10 which was the result of targeted work carried out to improve the measure. The last data point on the graph demonstrated a significant improvement over the previous month, where nationally a higher than expected mortality rate had been recorded for which no explanation had been found.

The SHMI for 2012, released in July 2013, had risen to 114. This was now amongst the 10 highest in the country. Dr Robinson advised it was anticipated that the SHMI would remain adverse for the following quarter before demonstrating improvement, reflecting the very marked improvement in both Dr Foster and internal crude mortality data.

The Board was informed that the SHMI started to rise following the acquisition of the community hospitals one of which offers palliative care, and two of which provide rehabilitation following discharge from the other acute hospitals. The patients cared for in those hospitals were often very long-stayers, which adversely affects both in hospital and post-discharge mortality.

It was noted that the previous downward trend in SHMI reversed at the point when the community hospitals were acquired in 2011. The Board was assured that work was underway to understand whether the overall mortality performance of the organisation had been adversely affected by the service change, and whether the continued improvement being shown by the acute trust until 2011 was being masked by a higher mortality at the community hospitals.

With regard to high risk diagnosis groups, mortality rates for monitoring of fractured neck of femur and congestive heart failure had shown a modest improvement. Mortality rates relating to septicaemia showed a marked improvement and there were no concerns expressed regarding weekend mortality rates.

In introducing the learning from serious incidents, Dr Robinson informed the Board that following completion of each serious incident investigation, an action plan was produced to determine the improvements required both in the relevant area, but also across the organisation as necessary. Dr Robinson presented a number of key actions which had been implemented across the Trust as a result of completed serious incident investigations.

Mr Robertson enquired whether the Dr Foster Patient Safety Indicators presented in the report was a subset of HSMR. Dr Robinson advised that the indicators were set up as part of Dr Foster data monitoring but were a separate group from HSMR itself.

A discussion ensued with regard to how SHMI and HSMR covered palliative care. The Board was informed that it was not possible to record palliative care unless the care is specifically coded using a code designed to indicate specialist palliative care under the direction of a palliative care team. It was noted that the Trust did not have sufficient access to either sufficient consultant palliative care input or to specific palliative beds – those were only available at Cynthia Spencer Hospice and Danetre Hospital.

Dr Swart noted that the Trust had always endeavoured to offer the highest quality of palliative care despite this. Mr Farenden added that SHMI painted

a worse picture than HSMR and that there might be data anomalies and supported further work in this area.

Mrs Searle enquired about the palliative care plans of the Trust. Dr Swart replied that the Oncology Department were taking this forward. She added that palliative care needed to be commissioned by the CCG.

Dr Robinson presented the quality exception report and advised that the quality dashboard was being redeveloped. The A & E quality indicators were standing out as an area of concern; and it was highlighted that the Trust must continue to look at its internal early warning indicators to ensure that everything is being done to keep patients safe during times of exceptional pressure.

It was noted that elective length of stay performance had shown a marginal improvement which had a positive effect on bed pressures.

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

TB 13/14 085 Patient Experience Report

Ms Loader presented the Patient Experience Report.

She reported that the Trust had now appointed a substantive Patient Experience Lead who commenced in post on the 9 September. Subsequently, a review of the timescales in relation to theming the patient experience data and producing a dashboard would be undertaken and reported to the October Board Meeting.

Ms Loader reported that the most recent Friends and Family Test (FFT) results were disappointing which had led to a drive to reinforce the importance in obtaining feedback from service users. The Trust had explored the use of a token system in eye casualty similar to those found in some supermarkets for voting. This was proving a costly alternative and further investigation was underway to find a more cost effective way to manage this, possibly through the use of sponsorship.

With regard to the Patient Experience Dashboard, all clinical teams had been contacted in order to collect and centrally collate information on any local patient experience feedback exercises being undertaken.

Dr Swart noted that in addition to the dashboard, the Trust would need to collect real-time patient experience feedback and comments. Junior doctors had been conducting Trustwide audits to establish what could to be done on a daily basis to improve patient experience. This would provide an opportunity to demonstrate a timely response to patient comments.

Mr Farenden asked why the noise at night audits had not been successful. Ms Loader replied that the surveys had originally been purely observational, and that they were under redevelopment to make them more interactive.

Mr Robertson asked how the intelligence gathered would be used in a meaningful way. Dr Swart replied that the "you said, we did" response would be incorporated into the actions for the wards and could be communicated back to patients via the ward patient information boards.

Mrs Searle noted that the A & E area was very small, and would create problems for the collection of the FFT data and asked whether a member of staff could be identified within the department to focus on the collection of

responses. Dr Swart replied that rather than having a specific individual identified to collect responses, it would be preferable to ensure that this became embedded into normal practise.

Ms Loader added that the FFT surveys would be indicated to attendees in Minor Injuries via a visual indicator. She reinforced Dr Swart's comment that the collection of the responses should be embedded into normal practise.

The Board **NOTED** the results from the August Friends and Family Test and **ENDORSED** the action being taken to create a customer service culture across the organisation

TB 13/14 086 Infection Prevention Performance Report

Ms Loader presented the infection prevention performance report.

The Trust to date had reported 18 cases of Clostridium Difficile against an annual trajectory of 29. In response to inappropriate samples again being collected, the Infection Control Team had developed a focus week for the wards which sent inappropriate samples in order to stress the importance of appropriate testing, a factor which has adversely affected the Trust's performance against its target. If the Trust was not able to remain within its target it would be at risk of considerable financial penalties.

Ms Loader stressed to the Board that the Trust's current status was due to inappropriate testing and not a matter of patient safety.

Hand hygiene audits for August showed a compliance of 98.9% in ward areas. This was higher than for any other area. Actions had been put in place to ensure that all observational audit data was submitted on the correct date. If it was submitted after the deadline, it would not be included in the month-end dashboard results.

Mr Farenden expressed his concern with performance against the C.Diff targets.

The Board **NOTED** the report

TB 13/14 087 Duty of Candour – Board Assurance Statement

Ms Loader presented the Duty of Candour - Board Assurance Statement.

Ms Loader outlined the background, informing the Board that the Trust had a contractual duty of candour within the NHS Standard Contract in 2013/14.

The report outlined the penalties that the Trust would be liable for should it fail in its duty of candour. The report also gave the incidence of grade 2 pressure ulcers as an example of moderate to severe harm.

She went on to inform the Board that all incidents of moderate and severe harm would be captured through the Datix System. A plan was under development to ensure staff were correctly trained in the reporting process.

Mr Farenden noted that he felt assured by the process outlined in the paper. He asked for clarity of the term moderate harm and Ms Loader responded there was a clear definition found on Datix.

The statement will be reported on a monthly basis to the Board via the Medical Directors report.

Dr Swart emphasised the importance of dealing with any Datix incidents immediately and the need to communicate with the patient involved to ensure that the Trust complied with its duty to be open and honest. She added that all incidences should be discussed at staff meetings, and there should be support provided to do this. She concluded by reiterating that patients and relatives should be kept up to date at all times to reduce the risk of the Trust receiving complaints.

The Board **ACKNOWLEDGED** the responsibilities of the Trust presented under the duty of candour and were **ASSURED** that there are systems in place to ensure compliance with the duty.

TB 13/14 089 Operational Performance Report

Mr Walsh presented the Operational Performance Report.

The Trust achieved all RTT, diagnostic, stroke and cancelled operations targets during August 2013. Unvalidated data indicated that the Trust achieved all the cancer standards. The Trust did not achieve the 4 hour transit time target of 95%. The figure for August was 90.35%, with a year to date performance of 92.46% at the 13 September 2013.

A Cancer Improvement Board had been established in August to examine how the Trust could improve performance against the cancer targets. Its remit was wide-ranging and would examine all aspects of the patient pathway. Considerable progress had already been made on the upper GI pathway, and there was further work to complete on the urology pathway.

The Cancer Improvement Board would continue to meet regularly but it was anticipated that it would be some time before its impact was felt in driving improvements forward.

A & E performance was hindered due to there are not being enough medical beds available to clear the flow. The Trust experienced very high levels of activity on the Tuesday following the Bank Holiday.

The ambulatory care centre opened on the 16 September. It was expected that the ambulatory care centre would help to reduce pressure within A & E.

There had been increasing levels of assurance with regard to the quality of care provided within A & E; the department had continued to be challenged by the high number of attendances. A pilot had started in September whereby patients were assessed by senior doctors as they attended to assess whether they required admission; approximately 30% of patients attending did not require care through the Trust but could have received their treatment elsewhere within the health community.

The Board expressed its concern over the poor performance, although acknowledging the efforts being made to improve. The Board **NOTED** the report.

TB 13/14 088 Patient Safety Academy Progress Report

This agenda item was presented following the operational performance report.

Mrs Bradley presented the report and asked the Board to approve its format.

Mrs Bradley informed the Board that the report covered 34 projects with a total of 127 elements. The programmes were all very ambitious with very aspirational targets. The pictorial presentation would enable readers to ascertain the status quickly. The report would be presented at this format to the Board, with greater detail being incorporated for the Strategic Management Board presentation.

Dr Swart added that there would be a campaign to improve escalation in order to improve the care of deteriorating patients. She added that there was a requirement to standardise observations and to ensure that they were undertaken in a timely manner and that this included the escalation of concerns.

Mr Robertson commended the report and enquired whether any other trusts were using a similar method. Mrs Bradley replied that this was a practice used elsewhere, and that she was in contact with these trusts. She added that she had been approached for advice on how to progress similar programmes.

Mrs Farenden thanked Mrs Bradley.

The Board **NOTED** the report and **APPROVED** the format.

TB 13/14 090 Urgent Care Update

Mr Walsh informed the Board that both Mrs Needham and Dr Wilkinson were unable to attend the Board meeting, but would ensure that a full report will be presented to the November Board.

He reported that the work streams within the Urgent Care Programme continued to work to plan. It was also noted that performance against the four hour transit time target had remained inconsistent. Attendances and emergency admissions remained higher than the previous year.

The ambulatory care centre, located in what was previously called the Tiger's Den in the fracture clinic area of the site has proved to be working well; within the first 2-3 months it was anticipated that up to 20 patients per day will be seen that would have previously attended through A & E.

The Emergency Care and Intensive Support Team planned to visit the Trust in mid-October to ensure that robust plans were in place to manage the anticipated winter pressures across the health economy were in place. The report following the visit would be made available to the Board when finalised.

Mr Walsh reported that plans for the management of winter pressures and flu vaccination were currently being refreshed and would be submitted to the October Board for consideration. Part of the improvement programme would be to commit the CCG to reinvest MRET in the provision of acute care. This had been considered in detail at the meeting of the Integrated Healthcare Governance Committee.

Mr Farenden noted that he felt assured by the improvement in the performance relating to cancer care that the Trust continues to deliver a safe level of care in this area.

Mr Noble enquired over the level of bed capacity, whether the Trust was

fully utilising early discharge and had identified extra escalation beds. Mr Walsh replied that there were currently 36 beds extra in use compared with the previous year due to the reopening of Compton and Victoria Wards. This was to deal with the increase in emergency admissions which were beyond plan. Approximately nine of the escalation beds were in use. In order to meet the anticipated demands brought about by the winter pressure, the Trust was considering the use of beds off site alongside how the patient pathway could be further improved.

Dr Swart noted that there were still a number of medically fit patients within the Trust who could not be discharged due to the unavailability of external care packages. She added that there was a commitment to understand as a health economy the best way to proceed.

Mr Robertson asked for the Trust's current level of capacity. Mr Walsh replied that the wish would be for a capacity of 87%, but it was currently at 95%. Leading to a requirement for 20 extra beds.

Mrs Searle commended the appearance of the new Ambulatory Care Centre.

The Board **NOTED** the contents of the paper

TB 13/14 091 Finance Report

Mr Foster presented the Finance Report

He reported that performance against the Trust Development Authority financial plan has significantly worsened by £1.0m as the level of over performance had reduced beyond planned levels. The key reasons for the adverse performance were a planned deficit increase of £269k and an increase in provisions not offset by contribution activity of £731k.

Mr Foster informed the Board that there had been delays in completing the quarter 1 contract reconciliation. The Clinical Commissioning Groups had lodged challenges amounting to £3m for Q1. The Trust replied by issuing rebuttal claims, the negotiation of the settlement would therefore be delayed and was expected to reach a conclusion during September.

CQUIN performance was reported as 75% of plan, and the provision for fines and penalties had been included in the year to date position.

The Trust's contingency level was at £500k, which represents a minimum level which did not include additional income

Cashflow was currently reported as above plan, but it was anticipated that this position would reduce during September and October.

A temporary borrowing loan application was in progress with the Trust Development Authority for drawdown when required; the cash forecast indicated that would be required in October.

Mr Foster advised that the Trust had presented an updated financial recovery plan to Trust Development Authority, which in turn tasked the Trust with returning a balanced financial plan by October. This would be dependent on the Trust receiving reinvestment through penalties incurred through MRET and readmissions.

Mr Farenden noted that the Trust must retain its level of reserves.

The Trust **NOTED** the financial report and the feedback from the NTDA in relation to the financial plan for 2013/14.

TB 13/14 092 Workforce Report

Mrs Brennan presented the workforce report.

She advised that although sickness rates had increased slightly, the Trust was seeing an overall improvement in sickness levels. With regards to recruitment, year to date the Trust had recruited 508 staff.

It was noted that progression through the Agenda for Change banding for staff would now be dependent on the results of appraisals and the completion of mandatory training.

Mr Noble enquired whether 13 weeks was an acceptable timeline for the recruitment of staff. Mrs Brennan replied this would cover all the stages of the process, which included the obtaining of CRB checks and references from previous employers. Vacancies were first offered internally, then to at risk staff in the local health economy prior to being advertises externally. This part of the process had been reduced by offering the advert both internally and externally simultaneously which had reduced the lead time by approximately 2 weeks. She added that every candidate was tracked through the recruitment process and managers had sight of this through the recruitment system. Mrs Brennan added that 13 weeks compared favourably with other trusts.

Dr Swart noted that there had been an improvement in staff understanding of the process.

The Board **NOTED** the report.

TB 13/14 093 Transformation Report

Mrs Brennan presented the Transformation Report.

The Trust's position had shown an improvement to a latest thinking forecast of £11.9m against a target of £13m. This was partly due to traction from the reduction in the use of bank and agency staff.

The mitigation list of schemes was being reviewed and acted on by the Transformation Team, scheme leads and sponsors. Those opportunities were over and above the current latest thinking forecast and the current estimated value, £263k, represented the potential 2013/14 in year financial impact. That value would fluctuate as schemes were added to the latest thinking forecast or discounted and as schemes progressed to a more granular level of detail.

It was noted that winter period could put the delivery of some plans at risk

A new system for recording and tracking quality impact assessments had been developed. This was reported to the Integrated Healthcare Governance Committee for assurance.

The Board **NOTED** the report

TB 13/14 094 Self-Certification Report

Mr Walsh presented the self certification report and asked that the Board approve a submission of Declaration 2 of the Single Operating Model

The Trust showed a financial risk rating (FRR) of 2 and a governance risk rating of 4 (red). The governance risk rating was held at red due to the Trust not achieving the A&E 4 hour transit time over a period of time.

Agency costs were restated as a percentage and showed a reduction of 0.5% and agency nursing costs were reported at less than 4%.

Mr Zeidler queried the status pertaining to the interim finance director position. Dr Swart replied that the Trust was using its own member of staff who was acting up to the position of Finance Director rather than using an interim. Mr Zeidler expressed concern over the consistency of the definition. Mr Walsh undertook to clarify and confirm the definition

Action Mr Walsh

Dr Swart enquired how long the Trust would need to be compliant to improve its status with regard to non-compliance of targets. Mr Walsh replied that the indication was this would need to be at least 2 quarters of sustained improvement.

The Board **APPROVED** the self-certification returns for Monitor Compliance and Board Statements based upon the evidence provided, and **APPROVED** the signing of Declaration Two of the Single Operating Model.

TB 13/14 095 Healthier Northamptonshire Programme Update

Mr Pallot presented the Healthier Northamptonshire Programme Update. He advised that the purpose of the programme was to deliver a clinically and financially sustainable health and social economy in Northamptonshire.

The presentation included the remits for each workstream which would be worked into full plans in the next month.

Significant to the success of the work streams was the need to look at the transformation of general practice which would help to ensure that acute trusts were provided solely for patients who required that level of patient care.

Mr Farenden asked if there was a sense of impetus behind this work. Mr Pallot replied that this was not always the case. However, the acute trusts were aware of the importance of this work.

Mr Zeidler asked how the links would be created and the worked integrated. Mr Pallot drew the Board's attention to the structure of the Programme Board held within the presentation. Mr Zeidler asked whether there was financial representation. Mr Foster replied that that meeting had been convened for the 23 September.

Dr Swart added that the Trust had bought into the process and had ensured the correct representation. It was noted that that there had been debate over who should attend because of resource issues over urgent care. The frail elderly implementation workstream also had links to finance as well as winter planning and MRET.

The Board was informed that Dr Bissett represented the Trust at on the Medical Directors Advisory Group and that the QIPP group included Mr Foster and members of the Transformation Team

Mr Zeidler acknowledged that the programme would be difficult to deliver

and enquired how its progress would be monitored by the Board. Mr Pallot replied that an update would be given at every Board meeting.

Dr Swart noted that the plan demonstrated an overriding need to look at the provision of care differently and emphasised the importance of driving the programme forward.

The Board thanked Mr Pallot and **NOTED** the update.

TB 13/14 096 **Equality and Human Rights Strategy**

Mrs Brennan presented the Equality and Human Rights Strategy for approval.

She reported that the strategy had been refreshed and was designed to ensure the Trust met its responsibilities in regards to the Equalities Act.

The strategy retained the quality objectives contained within the previous iteration of the strategy, and built on the need to engage both staff and patients.

It was noted that the strategy had been approved by the Equality and Diversity Steering Group.

The Board **APPROVED** the Equality and Human Rights Strategy.

TB 13/14 097 **Any Other Business**
No items of any other business were raised.

TB 13/14 098 Mr Farenden called the meeting to a close at 12.35.

Date of next meeting: 31st October 9.30 the Boardroom, Danetre Hospital, Daventry

TB 13/14 099 **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 24/10/2013

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
24/07/2013	TB 13/14 072	Risk Management Strategy	The Board requested that the Risk Management Strategy be updated to reflect the agreed changes and presented to the November 2013 Board meeting.	Ms S Loader	28/11/2013	On Track	
24/07/2013	TB 13/14 073	Complaints Annual Report 2012/13	Obtain annual benchmarking data for complaints and share with Board members.	Ms S Loader	23/09/2013	Slippage - to be updated at the Meeting	to be presented at the November meeting
23/09/2013	TB13/14 091	Urgent Care Update	Present a comprehensive Urgent Care Report to the November Board	Mr C Walsh	28/11/2013	On Track	A full report to be presented to the November Trust Board
23/09/2013	TB 13/14 094	Self-Certification Report	Clarification of the difference between declaring an Interim DoF and an Acting DoF	Mr C Walsh	31/10/2013	Completed or on Agenda	Distinction made between the terms 'Acting' and 'Interim' in the TDA submission.

KEY	
	Completed or on Agenda
	On Track
	Slippage - to be updated at the Meeting
	Significant Slippage

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Chief Executive's Report
Agenda item	5
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer
Author(s)	Dr Sonia Swart, Chief Executive Officer
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 - CEO Report

Northampton General Hospital NHS
NHS Trust

Trust Board
31 October 2013
Chief Executives Report

1. Strategic Approach with Nene CCG

At the recent Board to Board meeting the two organisations agreed to have discussions on how we could design a more strategic approach to the issues facing the health economy. This meeting took place on 16 October and focussed on how we could alter our approach from the minute details of the contract to jointly working on transformational change.

The creation of an Integrated Transformation Fund will require an investment of £30m from Nene CCG in 2015/16 and can only come from budgets for NGH, KGH, NHFT or prescribing. The purpose of the fund is to be a "game changer" in the design of out of hospital care and will be committed at local level by Health and Wellbeing Board. Whilst some of this funding will be available for reinvestment there will be an undoubted pressure placed on current providers.

The agreement at the meeting was that the two organisations must foster a much closer working relationships that are built upon a long term focus rather than an annual contract. A draft proposal has been agreed for this work which would include a new approach incentivising NGH to take part in assisting commissioners to reduce spend whilst at the same time providing reward for their efforts.

By the very nature of the challenge facing the health economy, this approach would need to include an agreement to how the organisations plan financially to reduce risk to both parties.

The plan is for Nene CCG to organise a board to board away day where these principles can be discussed and agreed in the next couple of months.

2. CQC Inspection Programme

The Trust has been informed it will be included in the next 19 acute and specialist trusts to be inspected by the CQC as part of their new hospital inspection programme.

We have been selected because we are in Band 1 (highest risk) of the CQC's new intelligent monitoring system, which also takes account of local information from partners and the public. The results of the intelligent monitoring for each trust were published on 24th October. The risk issues identified for the Trust in the CQC report are already known to us through the staff survey and our own governance and monitoring processes. However, we do not yet know what the outcome of the detailed inspection will be.

We know there are areas where we need to take action to ensure our services are of a consistently high quality and there is an enormous amount of work already underway across the Trust to improve the safety and quality of our services through the work currently underway by the Patient Safety Academy and our own patient safety champions. To assure ourselves that we are delivering the high quality care our patients expect we are setting up our own new internal inspection process, known as QuEST (quality, effectiveness and safety). Our aim is that, by the end of the year, all wards will have undergone a QUEST inspection. The outcome of each inspection will be fed back to the ward staff so

they can address any issues. We need to challenge ourselves to be as good as we can be and testing ourselves is one way to do this – in a true QuEST for excellence.

Alongside this we are undertaking a comprehensive review of the organisational governance structure to ensure it supports managers to make decisions quickly when required and facilitates the escalation of risks and issues.

We are also looking to improve our communication and engagement with staff through the work we have done as part of Listening into Action, introducing daily ward huddles, refreshing our monthly core/team brief, introducing a weekly bulletin and the CEO's blog.

The CQC inspection will provide us further opportunities to identify improvements that we need to make to our services. That, coupled with the feedback from our patients and our staff, along with our own internal inspection processes, scrutiny and constructive challenge will enable us to provide even better care for our patients.

3. Executive Appointments

I am working towards recruiting a stable executive team focussed on quality and safety , working together to ensure that our hospital provides the care for patients that we would all want for our own families. There have been a number of interim and acting positions over recent months and the high turnover of executives has been problematic.

I am pleased to announce that Debbie Needham and Rebecca Brown have agreed to fill the role of Chief Operating Officer (COO) on an acting basis while we work through the recruitment process for a substantive COO. They have worked as Care Group Directors supporting the COO for over a year now and are now willing and able to provide continuity for us in these very challenging times and have proved their commitment to this.

Over the last two weeks they have been taking a handover over from Clive Walsh, who is leaving us at the end of the month. Clive has been working with us as an interim COO for the last six months and has helped us implement a variety of improvement plans in A&E and added some very useful perspective in relation to our very significant issues in emergency care. We will be building on this as we move forward. I know many of you will wish to join me in thanking Clive for all his efforts here.

We are actively recruiting for a substantive Director of Finance and have a number of expressions of interest.

We have advertised for a substantive Medical Director post and are looking for an experienced medical manager to join the executive team as we move forward with our programme of quality improvement and efficiency. There has never been a more challenging time for Medical Directors and we hope to attract a high quality candidate.

In the meantime Dr Mike Wilkinson has agreed to act as interim Medical Director. He will be supported by Dr Natasha Robinson and Dr Amanda Bisset, who will continue as acting deputy Medical Directors. I am very grateful for the commitment that all these individuals have shown in taking on additional challenging roles to support me in the last few months.

Dr Sonia Swart
Chief Executive Officer
October 2013

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Medical Director's Quality Report
Agenda item	7
Sponsoring Director	Dr Natasha Robinson, Associate Medical Director
Author(s)	Dr Natasha Robinson , Associate Medical Director Mrs Jane Bradley, Patient Safety Programme Director & Assistant to Medical Director Dr Sonia Swart, Chief Executive Officer
Purpose	Assurance

Executive summary

- Overall mortality as measured by HSMR is as expected and improving but mortality as measured by SHMI is higher than average.
- Detailed review of adverse clinical outcomes is undertaken and monitored for improvement by the Mortality & Coding Review Group where recommendations for improvement are made if necessary and highlighted in this report as required
- 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- further work is required to understand this issue
- Coding is examined, revised as appropriate and reported to the Mortality & Coding Review Group by the clinical teams
- Any issues relating to clinical care are reported to relevant areas and general issues requiring improvement such as escalation of care are the subject of improvement work through the safety academy and an update of work during September is provided
- Nurse staffing levels are considered a major factor underpinning safe care and are improving but require further improvement
- 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.
- Themes for any issues of care identified through mortality reviews and Serious Incidents are fed in to the Trust Patient Safety Programme.

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 / regulatory requirements	Regulators will consider quality indicators and take action where appropriate. Assurance for regulators can be provided through the demonstration that analysis of issues is combined with the necessary quality improvement work.
Actions required by the Board The Board is asked to note the report and debate the issues that arise from it.	

Medical Director's Quality Report

Section 1

Review of current mortality and safety data provided by Dr Foster and related actions and improvement work including learning from serious incidents

1. Introduction

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence (to end July 2013) and SHMI (to end 2012). It also provides an outline of progress in the safety programme and an update in relation to nurse staffing levels.

When considering this information in respect of previous reports it should be noted that

- the Dr Foster data has now been re-benchmarked for 2012-3
- there has been no update on SHMI which is now > 9 months in arrears

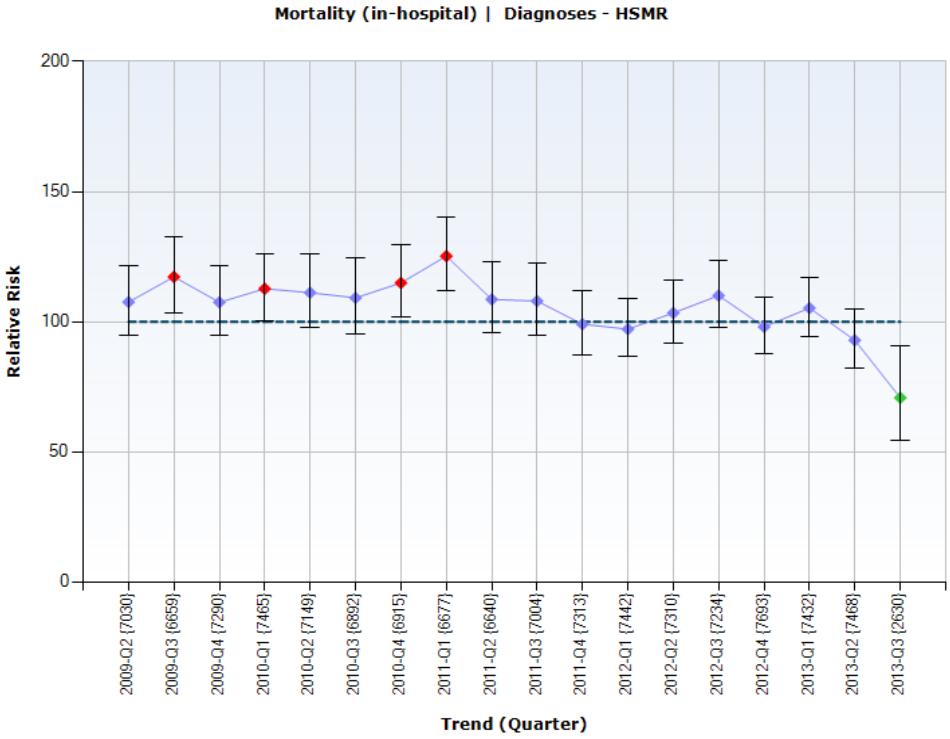
2. Current Position HSMR (Hospital standardised mortality ratio, Dr Foster Intelligence)

HSMR was developed as a tool to assist hospitals in monitoring mortality and debate as to its use continues. The Medical Director of the NHS, Sir Bruce Keogh, has expressed the view that it would be 'academically reckless' to use the tool to quantify excess deaths. However monitoring of trends in individual diagnostic groups, and aggregate indicators is undoubtedly helpful when identifying possible areas for concern. At NGH there is a detailed monitoring process which tracks HSMR (56 diagnostic groups resulting in 80% of inpatient deaths), and investigates individual diagnoses whose SMR (standardised mortality ratio) is persistently adverse.

The Trust systematically investigates all such areas of concern for both clinical care and data quality (including clinical coding). The Board should note that the expected mortality for any given condition cannot take into account the severity of that condition in an individual patient, but is based on the diagnosis, age, presence of other conditions (comorbidities) and any surgical procedures carried out. Hospital mortality rates are also known to reflect local community and primary care provision. A high standard of care in the community may have a confounding effect on admissions, reducing numbers such that only the highest risk cases are admitted to hospital. Lack of access to primary care may also mean that patients present late to hospital in a more serious condition.

Northampton General Hospital Trust includes three community sites which are not separated within the data, and which care for predominantly elderly patients receiving rehabilitation and palliative care. Some of these patients are admitted directly from Kettering General Hospital. 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. Although it is now easier to identify those patients admitted to the community hospitals on a case by case basis, it is not currently possible to analyse performance for the individual sites

The following graph shows progressive improvement in HSMR by quarter since 2011:



3. HSMR Comparison

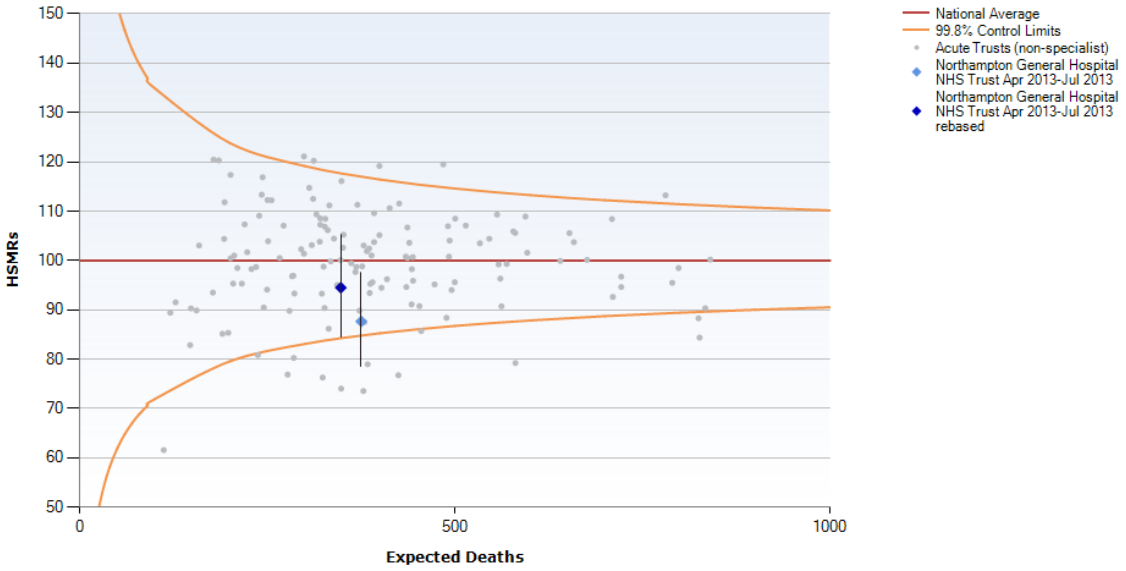
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. Since the last report this has now been updated to show performance for 2013-4.

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 6 points since 2012-3.
HSMR for the rolling year to date is **99**, and for 2013 - 4 is **88, 94** when rebased. This shows a very marked improvement over 6 months.

Crude mortality for 2013-4 is currently 3.3%, showing continuous improvement as compared to 2012-3 (4.2%) The current average for Trusts in previous SHA is 3.8% (range 3.3% - 5.1%).

Acute Trust HSMRs Apr 2013 - Jul 2013

The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England.



4. Standardised Hospital Mortality Indicator (SHMI)

There has been no further data release from HSCIC. The data is now > 9 months in arrears and is **114** for 2012.. In view of the high mortality in Q4 2012-3 already demonstrated by Dr Foster and internal Trust data, it is anticipated that the SHMI data for the next quarter will show a further deterioration before improvement is seen in 2013-4.

The very marked disaprity between current HSMR and latest SHMI reflects the different time periods to which they refer. However the methodology is significantly different:

	HSMR	**SHMI**
Case mix	80% of inpatient admissions Includes cases transferred to other hospitals	100% inpatient admissions Includes cases up to 30 days post discharge
Palliative care	Risk adjustment	No risk adjustment
Daignosis risk adjustment	Complex	Single level
Performance benchmark	Annual	Real time
Date of publication	Monthly, 2-3 months in arrears (depending upon local data upload timescales)	Quaterly, 6-9 months in arrears

There is only one diagnosis group (gastorintestinal bleeding) where SHMI indicates significantly worse than expected performance not apparent through Dr Foster and a review of deaths in 2012 (the period for which this occurred) is underway and will report to the mortality & coding review group later this year.

5. Dr Foster Patient Safety Indicators (August 2012 – July 2013)

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	38,839	26	30.6	0.7	0.8	85
Decubitus Ulcer	9,416	235	306.9	25.0	32.6	77
Deaths after Surgery	324	51	37.5	157.4	115.9	136
Infections associated with central line *	15,979	0	1.1	0.0	0.1	0
Postoperative hip fracture *	25,568	2	1.6	0.1	0.1	126
Postoperative Haemorrhage or Haematoma	23,531	4	13.8	0.2	0.6	29
Postoperative Physiologic and Metabolic Derangement *	19,910	2	1.6	0.1	0.1	124
Postoperative respiratory failure	18,223	17	15.4	0.9	0.8	111
Postoperative pulmonary embolism or deep vein thrombosis	23,721	31	44.3	1.3	1.9	70
Postoperative sepsis	572	6	3.9	10.5	6.8	154
Postoperative wound dehiscence *	977	0	1.4	0.0	1.5	0
Accidental puncture or laceration	66,449	35	76.7	0.5	1.2	46
Obstetric trauma - vaginal delivery with instrument *	530	32	43.8	60.4	82.7	73
Obstetric trauma - vaginal delivery without instrument *	2,442	81	93.7	33.2	38.4	86
Obstetric trauma - caesarean delivery *	1,207	0	4.5	0.0	3.7	0

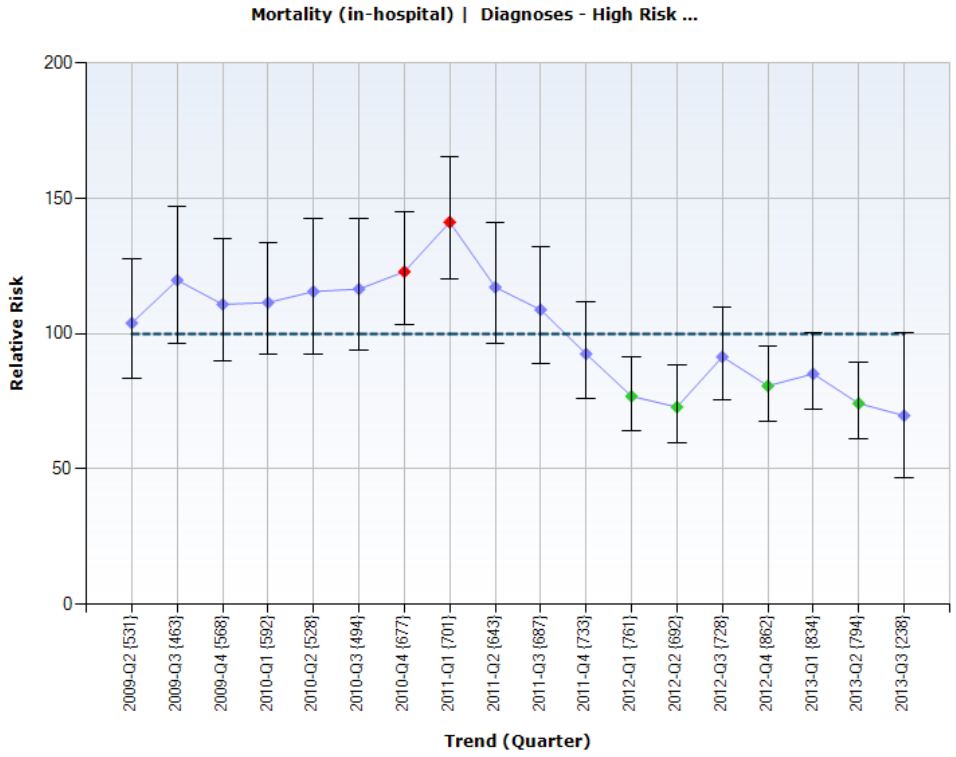
* For Indicators marked with an asterisk expected values are derived from the national average crude rate and are not casemix adjusted

The metric 'deaths after surgery' includes not only surgical procedures, but invasive diagnostic procedures in which the death is related to the underlying diagnosis (eg cancer). 2 such procedures are currently under review (biliary tract and upper GI therapeutic endoscopy) to assess

quality of care and appropriateness of treatment decisions. All unexpected postoperative deaths have been reviewed and subject to SI investigation where appropriate.

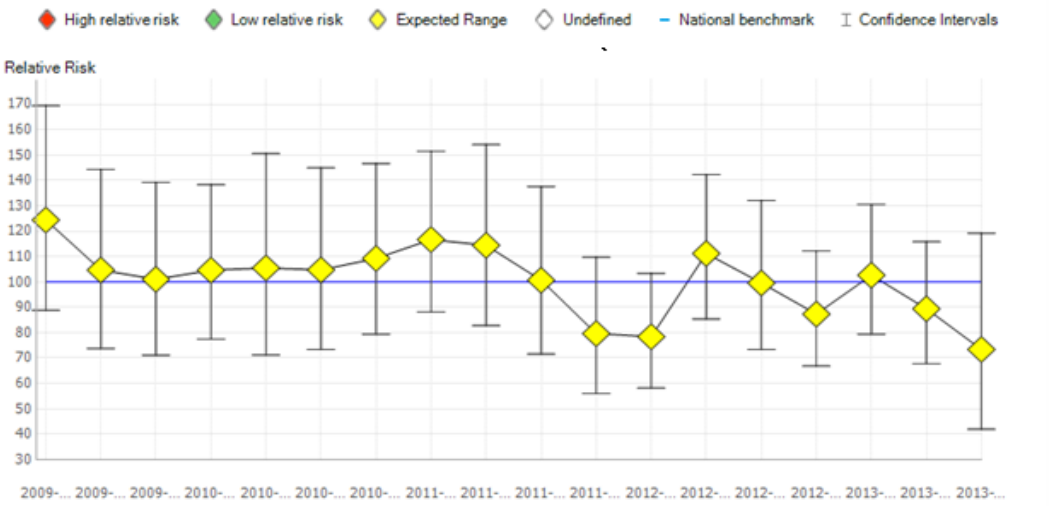
6. Reports on key areas for action or of importance

Aggregate mortality resulting from the 5 high risk diagnosis groups (Acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is as expected for 2013-4 at **70**, showing continued improvement.



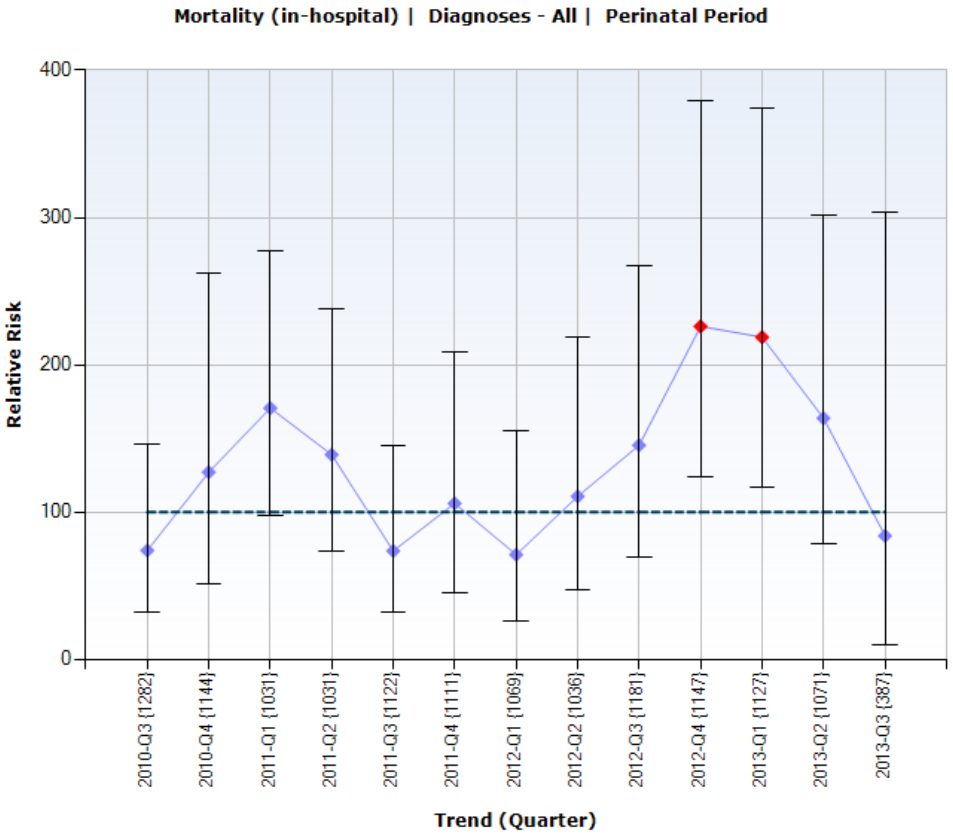
SMR for both fractured neck of femur (**80**) and heart failure (**92**) have shown marked improvement in 2013 -4.

Overall mortality for patients suffering with dementia admitted for any reason shows that mortality is similar to or better than overall mortality in the Trust.



7. Possible areas for concern under investigation and reported through the Mortality and Coding Group

Perinatal mortality: a final report reviewing stillbirths has been received as previously discussed. Preliminary findings of a review of neonatal deaths show no concerns regarding clinical care. It is possible that the rise in perinatal deaths in 2012-13 reflects normal cause variation (including the death of very premature triplets), however both teams will be strengthening their mortality case review processes in line with hospital standards.



Diabetes with complications: Following publication of a national audit (2011 data) suggesting higher than expected mortality in this patient group a comprehensive audit of care of patients with diabetes in hospital has been undertaken. This has highlighted that linkage of complications (renal, cardiac and vascular) to the primary diagnosis of diabetes is not always stated in the record, which impacts on coding accuracy. Use of the 'Think Glucose' sticker to identify patients with diabetes and trigger referral to the diabetes team is inconsistent, and early referral to the diabetes foot team was infrequent. The hospital diabetes team will follow up on all points. SMR for 2013-4 is **62 (**2012-3 was **161)**.

Peritonitis: 11 deaths have been reviewed. 3 will have their codes reassigned and 3 will be returned to the consultant involved for further review of clinical care. SMR for 2013-4 is **193** (2012-3 was **209)**

Intestinal infection: 43 cases (16 deaths) have been reviewed. National coding guidance has changed for this group and 10 cases (6 deaths, 4 survivors) will be reassigned. However brief initial admission episodes where no definitive diagnosis is made make recoding difficult. 1 case will be returned to the consultant involved for further review of clinical care, and 2 for amendment of the notes in the light of PM findings. There is no evidence of higher than expected mortality from C

Difficile, but coding of CDiff antigen vs toxin was inconsistent. SMR for 2013-4 is 75 (2012-3 was 258).

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

8.1 Data Quality

In response to issues relating to coding and information as discussed in the mortality and coding group and through other sources a Data Quality Steering Group has been established, has met twice over the past 3 months and included representatives from general management, finance ,information & data quality , IT, and Coding. The group covers data quality issues and directs the data working group on the priorities and significant coding issues to help shape the trust's coding in relation to the coding improvement plan. A generic data quality e-mail address has now been established to enable staff from across the trust to e-mail data quality issues as they are identified and a data quality escalation policy has been written for discussion at the next steering group and working group. Additionally, in line with this policy, a Data Quality Issue and Risk log has been developed.

Currently, a review of the Data Quality reports held on Infoview are being reviewed to ensure they are fit for purpose and still required.

The Data Quality Steering Group has produced a number of reports to include

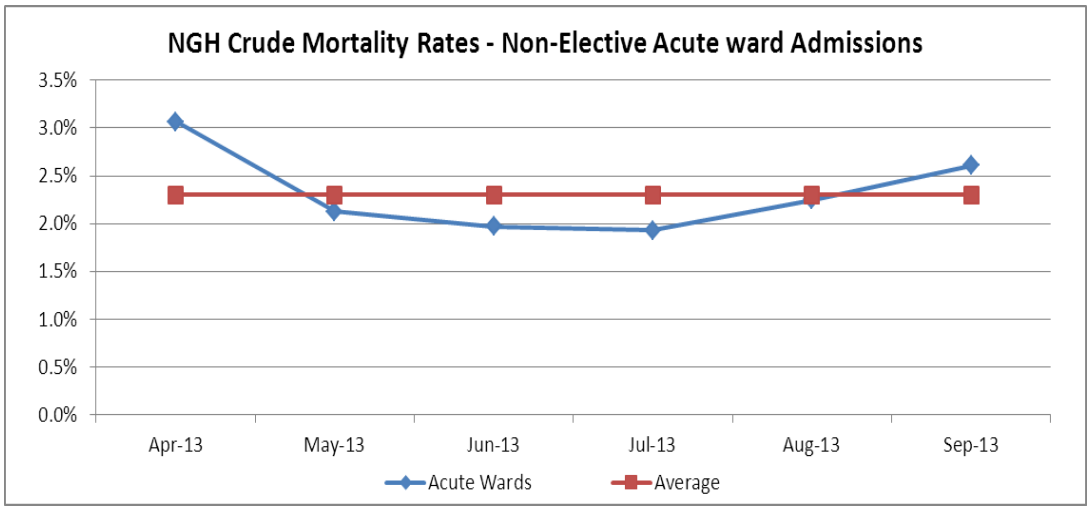
- Depth of Coding
- Crude Mortality Rates
- Recording of co-Morbidities
- Signs & Symptoms recording
- Palliative Care coding

These reports are designed to help the Trust to understand issues relating to mortality indicators and improve information and data flows. The reports indicate that further improvements in coding are required.

Crude Mortality Rates

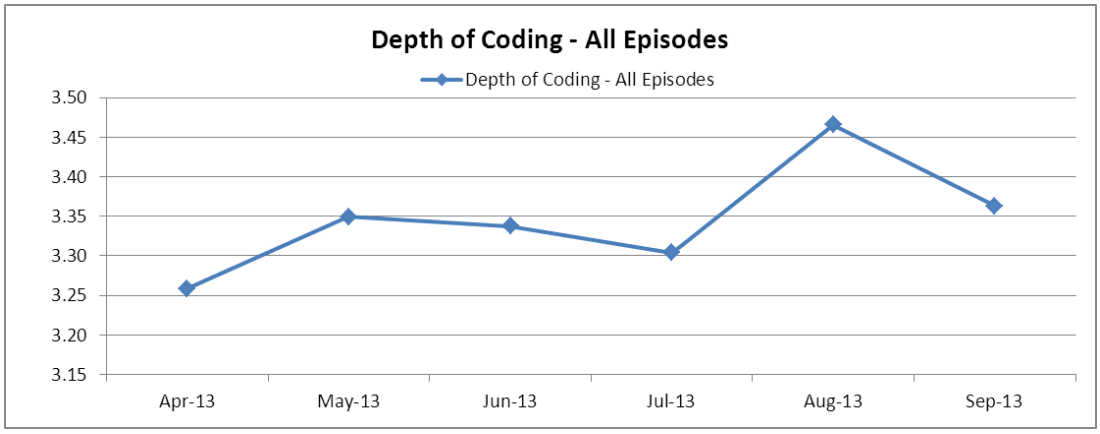
The Crude Mortality rate is calculated by using the number of deaths against the number of admissions with the exclusion of day cases maternity admissions. Unlike HSMR and the SHMI statistics it does not adjust the risk. The advantage of this statistic is that it is readily available internally in a timelier manner, therefore identifying any possible concern quickly.

The majority of deaths would be associated with non-elective admissions. For this cohort (excluding the community hospitals) NGH is lower than the peer's average value of 3.1%.



Depth of Coding

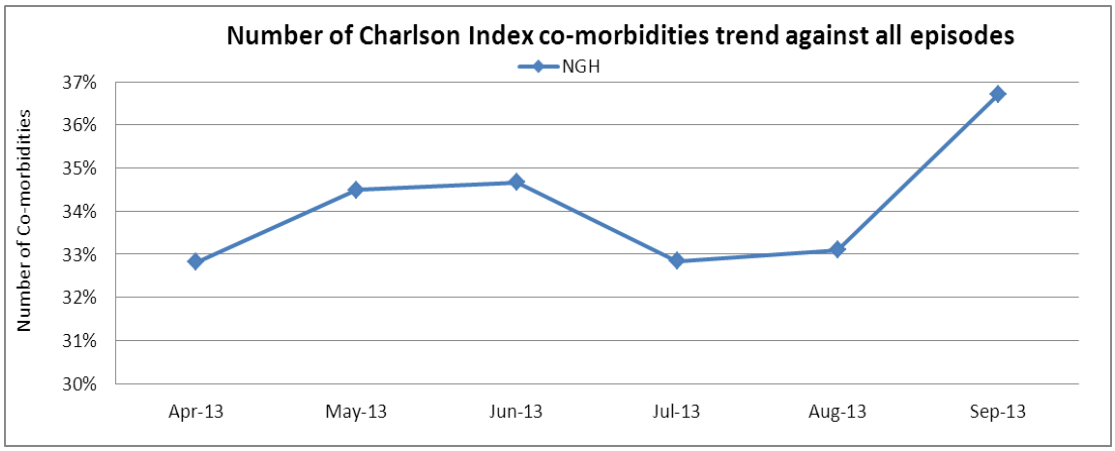
The depth of coding is the average number of diagnosis codes per episode of care.
Though not a measure of coding accuracy overall, a higher depth of coding tends to suggest an adequate level of conditions and co-morbidities are being captured which may then be reflected within mortality indicators such as HSMR and SHMI; the greater the depth of coding would potentially more accurately reflect the “expected deaths”.



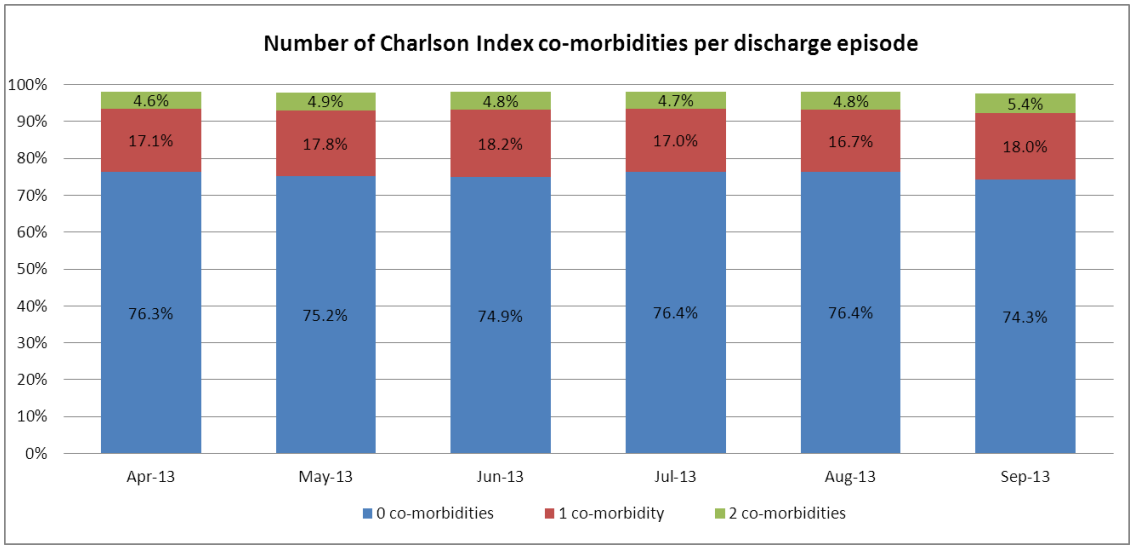
A review of some other trusts’ depth of coding levels would suggest that NGH is slightly low but an increase in the depth of coding is noted over the past 5 months reducing slightly in September 2013.Care is required when interpreting against other trusts as they themselves may not be coding completely accurately.

Co-Morbidity Codes

Though each additional secondary diagnosis code is a co-morbidity, there are specific codes monitored which affect the SHMI and HSMR risk of death statistic (Charlson Index). The sum of all of these specific co-morbidities recorded set against the number of discharge episodes within each month shows an increase in September 2013. The historical trend has been that NGH has scored fewer than average co-morbidities. A focus on the casemix from the community hospitals is planned in order to address comorbidity coding in this group



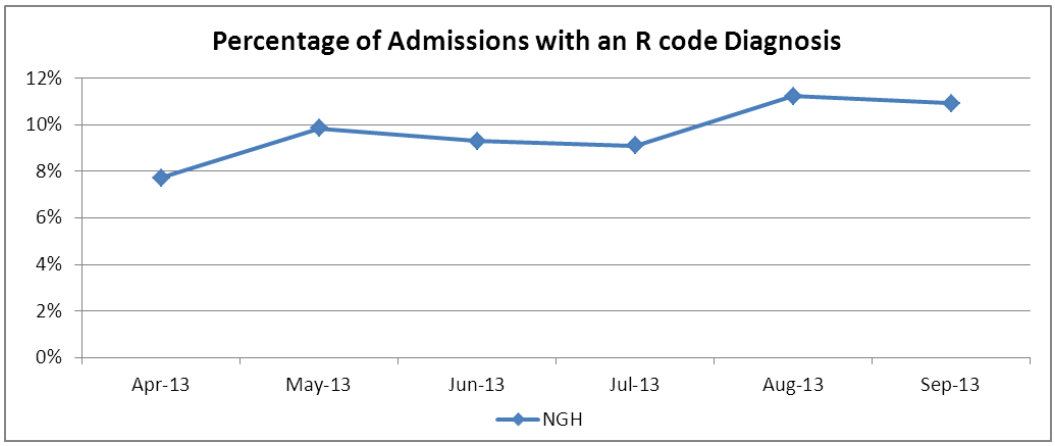
A further analysis of the data identifies that an average of 76% have none of the specific co-morbidities recorded against them with 17% having one comorbidity these figures are relatively consistent across the months. An increase was noted in September 2013 in the 1st, 2nd 3rd level recording of co-morbidities. This area will require further scrutiny.



Signs and Symptoms "R" codes

Signs and symptom codes are legitimate ICD10 codes which are used to indicate that a specific diagnosis has not yet been made. The primary diagnosis is a key factor when calculating the "risk" of a patient's death.

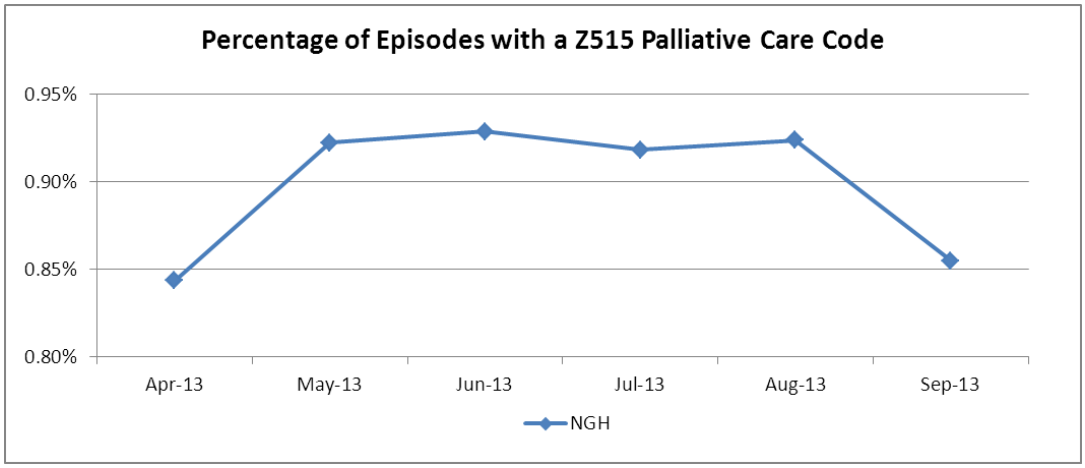
The use of these codes as a primary diagnosis could have a significant effect on a trust's SHMI scores. Therefore a high number of "R" codes could skew the expected in-hospital mortality.



The chart above shows an increase from 7.7% up to 11.3% over the 5 months to August but dropping marginally to 10.9% in September 2013. Consultant transfers can have a significant impact on the coding of 'R' codes as they can coincide with clinical diagnosis. If a patient has a very short or inappropriate first consultant episode recorded, they are more likely to end up with an 'R' diagnosis, as a clinical diagnosis had not been made before the transfer occurred. This is another area where further work needs to be done. The new model of medical care in the acute admissions area will improve continuity of care and should improve this situation

Palliative Care Coding

The recording and coding of palliative care (Z515) for appropriate patients, although not affecting the SHMI score, is used to adjust the Dr Foster HSMR statistic as the deaths are expected. The level of palliative care coding is lower than the national average. This may reflect poor access to palliative care. The coding department are working with the speciality palliative care team aiming for 100% coding accuracy.



8.2 Outcome Metrics

Two further metrics have recently become available (in addition to the National Quality Dashboard currently under development): 'HED' and 'Stethoscope'. Each includes one or more mortality outcome measures. Both of these use algorithms, casemix and metrics which are different from the 2 currently in use at NGH (Dr Foster & SHMI), and the scientific validation of both is unknown. In depth analysis of the data is not provided to enable investigation of adverse performance. It is possible that some aspects of these dashboards may be complementary to those in local use when providing new information to that currently available, but the availability of numerous analyses providing conflicting information is not helpful. This is especially so when different monitoring bodies use different data sources.

During a visit from TDA, the Deputy Medical Director used HED, to which we do not currently have access, to explore NGH mortality performance. This tool appears to be at variance with Dr Foster, apparently showing substantially worse than average performance (see below for further information). This will be explored further during further discussions with the TDA team.

9. Reducing Mortality and Harm

9.1 Safety Academy Progress/Update – September

Any areas of concern discovered through mortality reviews arising from Dr Foster Alerts or through other data sources are subject to case note review and recommendations for improvements are made. These recommendations are fed into the patient safety programme.

Safety Academy Campaign

To enable and sustain the improvement work of the Patient Safety Academy, the academy's constitution is made up of interested staff (Safety Champions) and led by 5 clinical leads, a project manager and a safety programme director who have joined the Medical Director, and other key individuals to lead on initiatives to improve patient safety.

With effect from October the five work stream leads from the safety academy:

- Reducing Harm from failure to Plan
- Reducing Harm from failures of Care
- Reducing Harm from failures of Care
- Learning from and sharing lessons from failures and successes
- Human factors and Safety Science

Work in being undertaken on one campaign the "Escalation Campaign", this campaign will focus on and support staff with the early recognition and escalation of the deteriorating patient and is planned for approximately 6 months.

All in patient's wards will be allocated a senior nurse and consultant medical lead who will visits the wards on a two weekly cycle. This challenging programme will focus on the accuracy and timeliness of clinical observations, accurate calculation of the Early Warning Score and appropriate escalation and management of the deteriorating patient. Ward staff will be supported with the context and data on the patient safety boards whilst raising the profile and usage of the patient safety DVD and booklet.

The campaign, although in its infancy, has received some considerable support from clinical and non-clinical staff.

Working with Safety Champions

- Monthly safety climate questionnaires undertaken by safety Champions
- Safety Culture questionnaires scheduled for completion by safety champions October 2013
- 3 Monthly update for safety champions in place
- Safety Academy Day planned for 22/11/13

Safer care at weekends and Nights

- Night team allocation of wards realigned and operational
- Attendance at night team handover improved during August
- Additional FY1 Doctor hours pilot completed and assessed –received board agreement to proceed – Approval and support from deanery received –went live 05/10/13
- HCA support addressing non-medical duties in place

Board to Ward

- Revised board to ward process focused on capturing staff and patient views and their experience regarding patient safety and the care we provide on our wards.
- The visits are themed around “How safe do patients feel”.
- Board members ask patients their views on the patient safety bards and their understanding of the data, patient safety DVD and supporting booklet “Keeping you safe during your hospital stay”.
- All information received is shared with the ward teams. During Q2 four non-clinical areas and seven ward areas were visited.

Junior Doctors Safety Board (JDSB)

There is a new initiative developed by members of the junior doctor safety board.
A ten question audit has been developed and trialled using rapid cycles for improvement (PDSA).

The focus for the audit questions are:

- Have you thought what matters most to patients when you treat them?
- Have you considered how you behave has a direct impact on how that patient feels?
- Think about doctors you have observed that communicate to patients in a way that the patient feels that the doctor really does care – it is not about the content of the message its more about how you deliver the message.
- If we don’t ask patients the right questions and receive and listen to their responses – how do we make the correct management plans and judgment call?

The final iteration of the above is planned to become a monthly audit for all FY1s who will speak with 5 patients who are pending discharge. The audit is planned to go live in November 2013.

Registrar Leadership and management course - Delivering Excellence

Following the success of last year’s leadership course for registrars, a second leadership and management course presented their audit findings on Friday 18th October.

The six modular courses covered some of the key elements of medical leadership and management whilst engaging this senior cohort of medical staff with ongoing quality and safety improvement work.

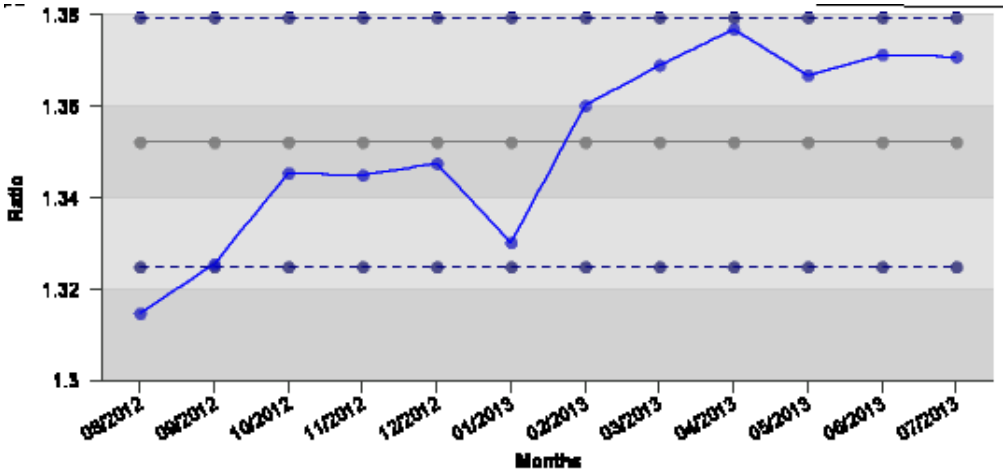
This bespoke Programme was delivered from current members of the Safety Academy, Consultant medical staff and Executive Board members. This was very much building on the work we are doing with the foundation doctors, where we involve them in quality improvement projects based around patient safety and with final year medical students as part of the ‘ Aspiring to Excellence’ course.

The 18 registrars that attended this course agreed the course gave them a sense of the wider issues facing the hospital and in the NHS generally and introduced them to the management and leadership issues with actual projects to take forward.
The group has requested to continue to meet outside of working hours providing peer support and have agreed to provide mentorship for the JDSB and junior doctors in training at NGH. A number of projects completed indicated a potential for sustainable improvement in quality at reduced cost and will be supported by the Trust Improving Quality and Efficiency Group.

9.2 Nurse Staffing Levels:

Adequate numbers of nurses per bed are a key factor in determining safe care. The numbers of nurses in post is gradually increasing although there are still areas where further improvement is required.

The graph below taken from the National Quality Dashboard indicates an improving position.



Registered Nurse (RN) Staffing Levels (General Wards)

The uplifted nursing budgets from the ward areas have been reviewed in relation to whether they are achieving the nationally recommended 1registered nurse (RN):Patient ratio. The table below outlines the budgeted level of RN's per shift per ward and indicates whether or not the 1:8 ratio is achieved (non-achievement = box coloured red). This has then been compared with the actual number of RN's who 'worked' / ward for month 6 ('worked' equates to the total number of substantive and temporary WTE's who worked). Unfortunately, it is not possible to show this per shift, but we can show it in relation to WTE's – we have then indicated in the last right-hand column, the RN worked budgeted level % against the total WTE establishment. Whilst there are a couple of wards who only achieved 70% and 79%, the majority of wards achieved >90%, with the average for both care groups being 94%.

Ward	No. of Beds	RN Shifts Needed for '1 RN for 8 Beds'	Budget - Post 13/14 Investment			Budget Qual RNs WTE (M6)	RN Budget WTE : Beds	Mth 6 - WORKED RN&HCA WTEs				Number of Qual RNs WTE (M6)	RN Worked WTE : Beds	RN Worked : Budgeted Level %
			Qualified Shift No.					Core	Bank	Agency	Total Worked			
			E	L	N									
Abington	28	4	5	4	3	21.3	0.76	31.4	4.8	0.6	36.8	15.0	0.54	70%
Althorp	16	2	3	3	2	13.7	0.86	22.2	0.5	0.2	22.9	13.3	0.83	97%
Cedar	30	4	5	4	3	20.9	0.70	33.0	4.9	0.9	38.8	19.7	0.66	94%
Hawthorn	30	4	6	5	3	24.3	0.81	34.5	5.8	0.8	41.2	22.1	0.74	91%
Head & Neck	14	2	3	3	2	16.0	1.14	23.8	3.4	0.1	27.3	18.2	1.30	114%
Rowan	30	4	6	4	3	22.7	0.76	33.9	4.0	0.8	38.7	21.9	0.73	96%
Spencer	14	2	3	2	2	13.9	0.99	17.4	2.2	0.1	19.7	13.5	0.96	97%
Willow	28	4	7	6	5	31.8	1.13	39.8	2.6	0.2	42.6	31.3	1.12	98%
Surgical Group	**190**		**38**	**31**	**23**	**164.7**	**0.87**	**236.0**	**28.3**	**3.8**	**268.0**	**155.0**	**0.82**	**94%**
Allebone	28	4	4	4	3	20.2	0.72	26.1	4.0	5.5	35.6	18.4	0.66	91%
Becket	26	4	6	5	4	27.6	1.06	43.7	1.5	1.5	46.6	24.9	0.96	90%
Benham	28	4	5	5	4	26.6	0.95	34.1	5.4	1.8	41.4	26.2	0.93	98%
Brampton	27	4	4	3	2	16.2	0.60	27.0	6.0	0.5	33.6	16.8	0.62	104%
Collingtree	40	5	6	6	4	30.7	0.77	43.9	5.4	2.2	51.6	24.2	0.61	79%
Compton	18	3	3	2	2	13.5	0.75	23.3	2.1	0.4	25.9	13.0	0.72	96%
Corby	22	3	2	2	2	12.4	0.56	20.8	4.6	0.4	25.8	13.0	0.59	105%
Creaton	28	4	6	4	3	24.1	0.86	35.6	5.8	1.8	43.2	21.2	0.76	88%
Daventry	28	4	3	3	2	14.9	0.53	37.8	3.2	1.6	42.5	16.8	0.60	113%
Dryden	22	3	5	5	4	26.6	1.21	30.0	3.3	2.4	35.7	24.4	1.11	92%
EAU	32	4	6	6	5	32.3	1.01	39.7	7.0	3.3	50.0	29.3	0.92	91%
Eleanor	12	2	4	2	2	14.1	1.17	21.8	1.7	1.2	24.7	15.3	1.28	109%
Finedon	18	3	7	7	3	25.3	1.41	28.9	1.8	0.2	30.9	23.3	1.29	92%
Hazelwood	34	5	3	2	2	12.4	0.36	27.9	6.0	1.9	35.7	14.0	0.41	113%
Holcot	27	4	5	3	3	20.8	0.77	29.3	2.5	1.9	33.7	16.4	0.61	79%
Knightley	21	3	3	2	2	13.5	0.64	24.9	3.3	2.9	31.1	15.2	0.72	112%
Talbot Butler	30	4	8	6	3	29.9	1.00	33.2	5.7	0.4	39.3	26.3	0.88	88%
Victoria	18	3	4	3	2	16.2	0.90	22.4	3.6	1.4	27.3	15.4	0.86	95%
Medical Group	**459**		**84**	**70**	**52**	**377.1**	**0.82**	**550.3**	**72.9**	**31.2**	**654.4**	**354.0**	**0.77**	**94%**
Grand Total	**649**		**122**	**101**	**75**	**541.7**	**0.83**	**786.3**	**101.2**	**34.9**	**922.4**	**508.9**	**0.78**	**94%**

In order to provide a benchmark, it is useful to calculate the Trust average RN:Patient ratio. This is achieved by taking the total budgeted WTE and dividing it by the total number of beds, giving an average of 0.83 WTE RN:Patient ratio. 'Worked' Staffing levels in September, totalled 508.9 WTE, which achieved a ratio of 0.78 WTE RN:Patient ratio or 94% of the budgeted level.

Key Themes which emerge from the data presented above:

- Whilst some wards still have vacancies, others are over established. Additional staff will be moved to those wards who still have vacancies to even out the provision.
- Many wards are currently budgeted to staff below the 1 RN to 8 Beds on *some* shifts, these are highlighted in red in the table above. The Community Hospitals are of particular concern as none of their shifts are currently compliant with the 1:8 ratio – this will be addressed in the current skill mix review. However, it should be noted that both Daventry and Hazelwood are currently over established for RN's at 113%.
- There are also a number of wards planning to staff above the 1:8 ratio, due to the complexity of patients on the unit. For instance, Willow Ward (vascular ward with Level 1 beds), staff at 1RN:4 patients on an early and roughly 1RN:5 patients on a Late shift.
- Both Care Groups, managed to staff at 94% of the budgeted level of RNs in September.
- Several wards are staffing above the budgeted level of RNs e.g. Head & Neck ward are at 114%, Brampton are at 104% and Knightly are at 112%.

10. Further actions in place or planned:

Following a visit from TDA, during which the Deputy Medical Director Mr Stanley Silverman reviewed current mortality outcomes at NGH and local investigation processes, there will be a further visit to explore the data in more detail.

The specialty based mortality and morbidity review programmes are currently being strengthened across the Trust to provide assurance that all deaths are reviewed in order to address any issues relating to avoidable death. The metric of amenable mortality (currently in the lowest quartile according to National Quality Dashboard) has not raised any alarms but the Trust will continue to focus on possible avoidable death using the case note review process. The current mortality and morbidity meetings will report into the mortality and coding group and significant issues will be reported quarterly to IHGC via the quarterly report on Patient Safety, Quality and Governance.

11. Learning from Serious Incidents

Following completion of each SI investigation an action plan is produced to enable implementation of recommendations within the specialty and also across the organisation (through Patient Safety Learning Forum).

During September 6 SI's were submitted to CCG for closure: 3 were pressure ulcers of which one was thought unavoidable. 3 were fractures of femur, of which one occurred in a patient who had left the outpatient department and was returning to their car, one occurred in a community hospital, and one on an inpatient ward at NGH.

In only one of the occurrences of pressure ulcer was there a being open meeting with the family, and this has been identified as a necessary learning point for staff. In both in-hospital falls a Being Open meeting was held, and in the outpatient case the family were present with the patient at the time. This case has been downgraded in view of its unpreventability.

All the above cases are being included in the thematic reviews of pressure ulcers and falls.

The following actions have been taken as a result of the closed SIs in September:

- The Falls Prevention Group continues to monitor risk assessments and the use of preventative measures for the prevention of falls across the Trust
- The Deputy Director of Nursing continues to lead on the thematic reviews of pressure ulcers SIs. SSKIN has been implemented across the Trust and is part of the monthly reviews by Members of the Board.
- The importance of Being Open meetings has been emphasised

Organisational learning from Serious incidents continues to be a high priority and various initiatives are in place to improve this.

12. Recommendation

The Board is asked to note this report and to debate any issues that arise from it. The Board should also note that the analysis of data that occurs is challenging in the face of new indicators but that all areas of possible concern are highlighted and where possible improvements are recommended and taken up through the patient safety academy or within directorates. The high level of scrutiny which is currently in place externally relates to the SHMI data. This is likely to remain an issue while the hospital inspection regime is rolled out in the New Year.

It is essential that there is wide ownership of all safety and quality improvement work and that this is given sufficient support as part of the improving quality and efficiency group and a programme of organisational development around quality improvement.

Section 2

NGH Monthly Quality Exception Quality Scorecard – September

Introduction

This scorecard includes indicators selected by the Trust or required by our commissioners and by the provider monitoring framework required by the CCG. Work continues to ensure that the alignment is accurate.

Directorate Scorecards are improving and becoming more detailed providing the Care Groups with a dash board relevant to their areas. The directorate scorecards will continue to be informed by more detailed Trust specific measures that are selected according to Trust priorities and pressures and in time be aligned with the national quality dashboard. This work is still in progress.

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.

HSMR and SMR by diagnosis group are reported as year to date. A continual process of refinement of indicators is in working progress and this month includes new indicators to monitor the safety improvement work.

Performance

Within August's exception scorecard there were 136 indicators, **40** (**26/14**) are rated as either red or amber status. The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. There are **21** indicators that are rated grey.

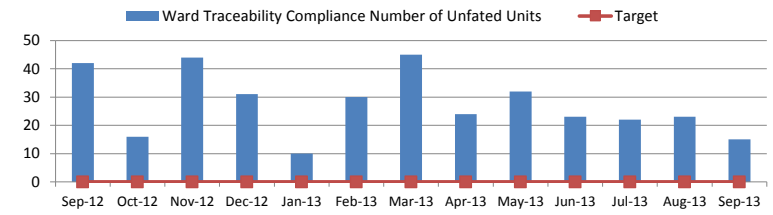
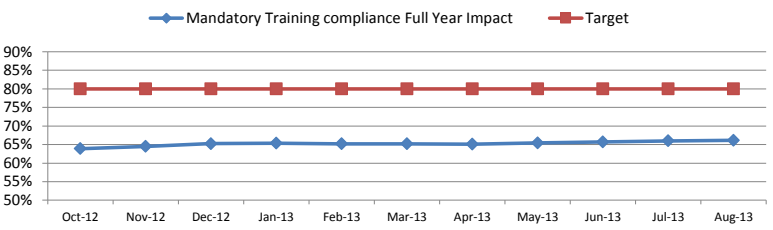
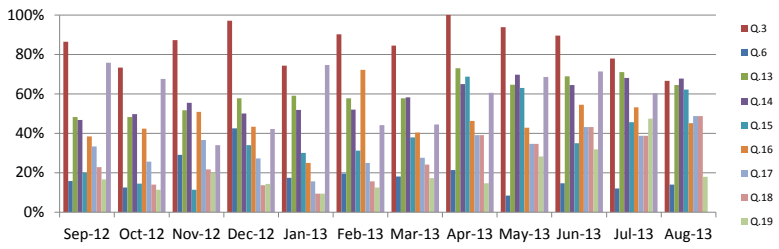
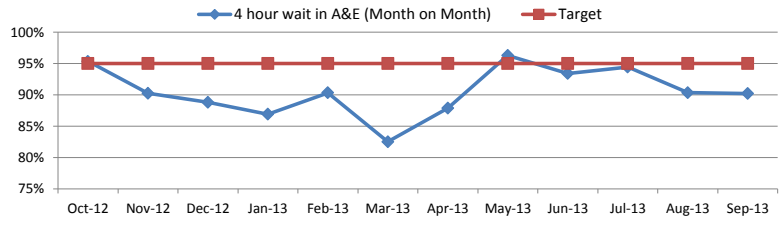
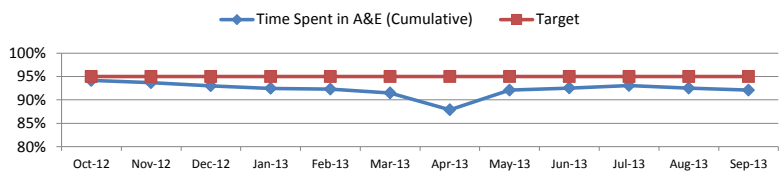
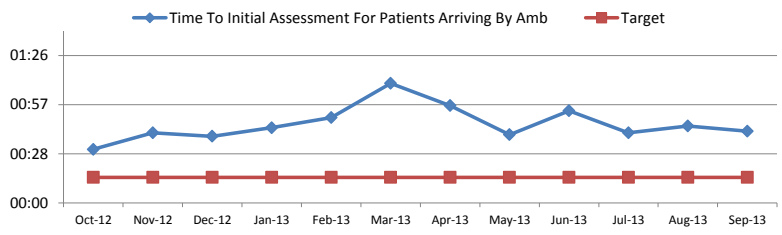
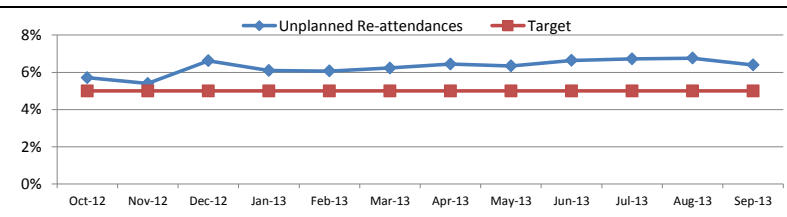
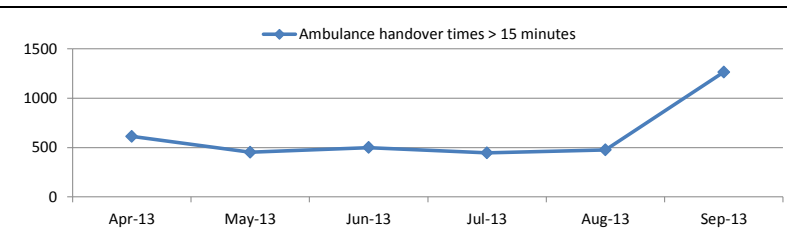
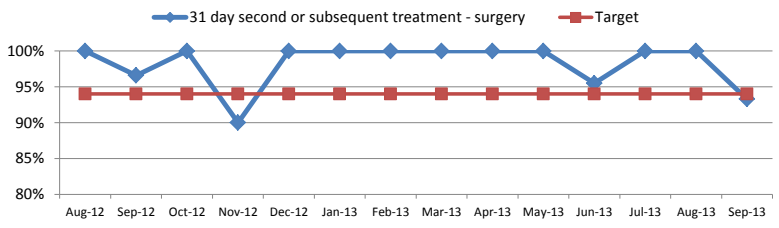
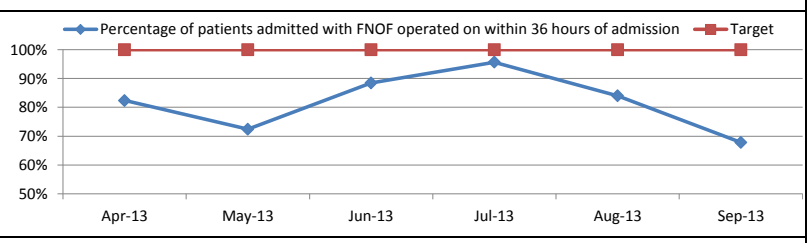
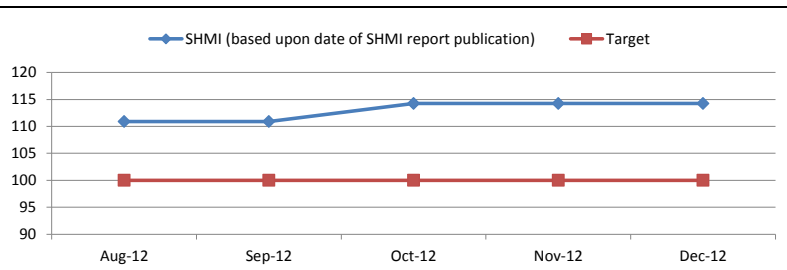
In comparison to August`s report the number of indicators that have been rated as red and green remains static **26/75**. The Indicators rated as grey have reduced from **22** to **21,** as further agreement for some of these indicators continues to be agreed.

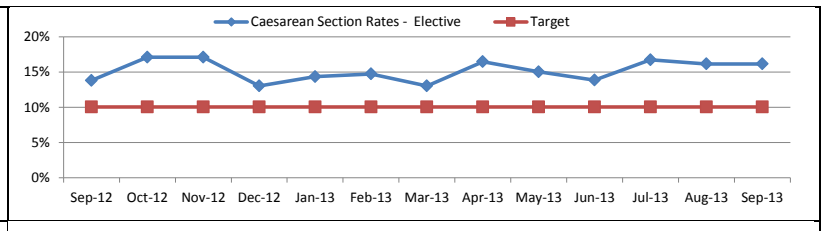
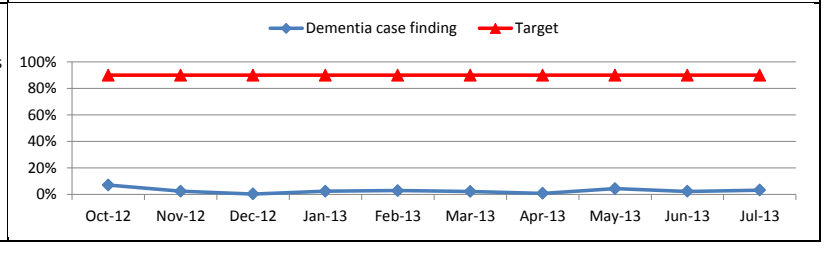
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**15**	**3**	**30**	**8**	**56**
Clinical Outcomes	**7**	**2**	**21**	**2**	**32**
Patient Safety	**3**	**3**	**8**	**11**	**25**
Patient Experience	**1**	**6**	**16**	**0**	**23**
TOTAL	**26**	**14**	**75**	**21**	**136**

Recommendation

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

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Unfated Units	0	↑	From 833 units used in September, 15 were unfated. Ward compliance is 98.2% with all units accounted for this has resulted in 100% compliance as a Trust, fully complying with the requirements of the Blood Safety and Quality Regulations SI 2005/50.	
Patient Safety	Mandatory Training compliance Full Year Impact	0	→	August 2013 saw a slight increase in the number of staff being trained at 66.1% (July = 66.0%). A full review has taken place resulting in the core Mandatory Training subjects being reduced from 23 to 9. Mandatory training is identified as being for all staff, whilst other training subjects are Role Specific Essential Training. This will become effective from 1st October 2013. A RAG rating reporting mechanism for Mandatory Training compliance will be in place with effect from Oct 2013.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↓	Key issues identified on the Healthcare Notes audit in September 13: Red rag rated items remain consistent throughout the audited period i.e. is time recorded for each entry, is surname printed in block capitals, is the staff designation recorded etc. An options appraisal is planned to be discussed at SMB, results will be available in Q3.	
Patient Experience	A & E Quality Indicators (5 indicators)		→	**A&E Clinical Indicators:** 4 hour wait in A&E (Month on Month) decreased slightly from 90.35% in August to 90.2% in September.	
			↓	Time Spent in A&E (Cumulative) - This indicator has been negatively affected by the non-achievement of the monthly 95% 4hrs for September wait resulting in a cumulative of 92.11%.	
			↑	The time to initial assessment for patients arriving by ambulance improved slightly from 45 mins in Aug to 42 mins in September (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 rates saw another slight monthly improvement from 6.76% to 6.39%(target of 5%). There is genuine concern relating to patients reattending when they have been unable to access aftercare in primary care. In addition, there is validation work underway in respect to data recording of the re-attendance event.	
			↓	September noted an increase in the handovers times > 15 mins and a reduction in the handover times < 60 mins . A new validation method has been introduced validating those handovers > 60mins or more.	
Patient Experience	31 day second or subsequent treatment - surgery	94%	↓	One Patient breached for medical reasons. Septembers figures will not be validated until November 2013.	
Patient Experience	% of patients admitted with FNOF who were operated on within 36 hrs of being fit for surgery	100%	↓	Theatre capacity and/or waiting for space on theatre lists is challenging and presents a particular problem at weekends, when half day operating lists are in place. The unpredictability for when # NOF patients require surgery (this can be 3 or 4 in one day or 0) has an impact on planning surgery within 36 hrs, and must be triaged and prioritised alongside other emergency trauma patients.	
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 September 2012 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 December 2012 .	

Clinical Outcomes	Caesarean Section Rates	10.1%	→	The elective C-Section rate remains the same as the previous month at 16.2%. Elective caesarean section rates continue to be higher than the national average. An action plan was developed May 2011 and is monitored quarterly at Obstetric Governance Meeting. The Directorate will continue with monthly audit until compliance with NICE guidelines can be assured.	
CQUIN	Dementia case finding	90% 3 consecutive months	→	There are 3 sections to this CQUIN. The key one is the dementia case finding question. Changes have been made to the data collection system to support this with a nurse now in place as of 2nd week of August to provide further support and guidance. An audit was undertaken on the paper forms completed which suggested strong compliance with these measures but further support is required to facilitate robust reporting.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Frequency	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Sept 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	Monthly	1	3	4	2	2	5	7	2	4	1	3	1		
HQU08: MSSA Numbers	No national ceiling set	Monthly	2	2	1	1	0	0	1	0	1	1	0	0		
E Coli ESBL Quarterly Average	7 per month	Monthly	0	4	2	3	2	0	2	3	3	4	2	2		
VTE Risk Assessment completed	95% month on month	Monthly	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	Monthly	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	Monthly	100%	99.74%	99.40%	99.73%	99.54%	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%		
MRSA Screening Non-Elective Patients	100% month on month	Monthly	96.10%	96.80%	95.78%	95.12%	96.56%	97.00%	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	Monthly	16	44	31	10	30	45	24	32	23	22	23	15		
Incidence of pressure ulcers																
Grade 3 - New avoidable pressure ulcer		Monthly	1	0	2	2	3	4	0	4	3	0	0	0		
Grade 3 - New unavoidable pressure ulcer		Monthly	0	1	2	0	0	1	3	2	4	0	1	4		
Total Grade 3 - New pressure ulcer		Monthly	1	1	4	2	3	5	3	6	7	0	1	4		
Grade 4 - New avoidable pressure ulcer		Monthly	2	3	1	3	0	1	0	0	0	0	0	0		
Grade 4 - New unavoidable pressure ulcer		Monthly	0	3	1	0	0	0	0	0	0	0	0	0		
Total Grade 4 - New pressure ulcer		Monthly	2	6	2	3	0	1	0	0	0	0	0	0		
Reduce harm from falls																
Catastrophic	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	N/Avail		
Major/Severe	0	Monthly	2	3	0	1	2	1	0	1	1	1	2	N/Avail		
Moderate	0	Monthly	0	0	1	2	3	1	1	3	1	1	0	N/Avail		
Mandatory Training compliance Full Year Impact																
Primary Levels Excluding B&H	80%	Monthly	63.9%	64.5%	65.2%	65.4%	65.2%	65.2%	65.1%	65.4%	65.7%	66.0%	66.1%	67.2%		6 week turnaround delay for data
Attendance at Trust Induction	80%	Monthly	98.6%	90.8%	87.9%	87.5%	87.6%	87.5%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%		6 week turnaround delay for data
Number of surgical site infections																
Fracture neck of femur - Number of Operations	-	Monthly	26	36	34	39	31	45	17	27	29	20	28	26		
Number of infections	-	Monthly	0	0	0	0	0	0	0	0	0	0	0	1		
% infection rate (monthly)		Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3.8%		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.)
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly		0%			0.9%			0%			Quarterly report			
Abdominal hysterectomies		Monthly	Abdominal hysterectomies infection rates monitored as from April 2013						16	16	14	22	21	18		
Number of infections		Monthly							1	0	0	0	0	1		
% infection rate (monthly)		Monthly							6%	0%	0%	0%	0%	5.6%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly								2%			Quarterly 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	1	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	Monthly	87.0%	87.9%	89.0%	89.1%	89.3%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%		
Serious Untoward Incidents	-	Monthly	7	14	9	19	25	36	41	35	51	21	10	10		
Never Events	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	Monthly	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%		
Healthcare Notes Audit																
Q.1 Does the front page of every sheet contain an addressograph label	100%	Monthly	73%	68%	79%	80%	79%	72%	79%	72%	74%	80%	75%	66%		
Q.2 Does addressograph include the NHS Number?	100%	Monthly	90%	93%	88%	99%	88%	92%	90%	97%	97%	98%	95%	92%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	Monthly	73%	87%	97%	74%	90%	84%	100%	94%	90%	78%	67%	87%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	Monthly	60%	62%	82%	53%	73%	64%	85%	69%	77%	63%	49%	61%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	Monthly	64%	74%	91%	53%	63%	46%	61%	67%	69%	51%	49%	44%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	Monthly	13%	29%	42%	18%	20%	18%	21%	8%	15%	12%	14%	5%		
Q.7 Is record legibly written	100%	Monthly	98%	97%	99%	99%	98%	99%	95%	100%	98%	99%	97%	99%		
Q.8 Written in blue/black ink	100%	Monthly	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	99%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Monthly	100%	100%	99%	98%	99%	100%	99%	98%	99%	100%	100%	99%		
Q.10 Is date recorded for each entry	100%	Monthly	89%	93%	91%	88%	90%	88%	86%	87%	86%	89%	92%	88%		
Q.11 Is time recorded for each entry	100%	Monthly	73%	70%	72%	71%	66%	75%	86%	87%	86%	89%	92%	68%		
Q.12 Is there a signature of the person making the entry	100%	Monthly	87%	91%	92%	90%	94%	94%	96%	97%	92%	97%	91%	91%		
Q.13 Is surname printed in block capitals	100%	Monthly	48%	52%	58%	59%	58%	58%	73%	65%	69%	71%	64%	74%		
Q.14 Is the staff designation recorded	100%	Monthly	50%	55%	50%	52%	52%	58%	65%	70%	64%	68%	68%	63%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	Monthly	14%	11%	34%	30%	31%	38%	69%	63%	35%	46%	62%	43%		
Q.16 Are any alterations / deletions scored through with a single line	100%	Monthly	42%	51%	43%	25%	72%	40%	46%	43%	55%	53%	45%	58%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	Monthly	26%	37%	27%	16%	25%	28%	39%	35%	43%	39%	49%	28%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	Monthly	14%	22%	14%	9%	16%	24%	39%	35%	43%	39%	49%	22%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	Monthly	11%	20%	14%	9%	13%	17%	15%	28%	32%	47%	18%	22%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	Monthly	100%	99%	95%	97%	96%	100%	99%	97%	88%	100%	90%	95%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	Monthly	76%	68%	34%	42%	75%	44%	44%	60%	69%	71%	60%	39%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	Monthly	100%	100%	100%	100%	100%	100%	100%	96%	80%	100%	100%	98%		
Q.23 Are there any loose sheets in the Healthcare record	0%	Monthly	8%	10%	17%	10%	0%	13%	10%	3%	3%	7%	7%	12%		

Patient Experience	Target 2013-14	Frequency	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Sept 13 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	Monthly	0	0	6	4	1	2	1	0	0	0	0	0		
Hospital Cancelled Operations	6.0%	Monthly	6.9%	7.9%	5.4%	9.3%	6.3%	11.5%	11.1%	9.6%	9.5%	12.0%	N/Avail	N/Avail		
Number of written complaints received	-	Monthly	44	40	24	68	54	52	45	58	37	29	38	41		
Complaints Responded to within agreed timescales	100.00%	Monthly	56.8%	90.0%	87.5%	95.6%	75.9%	69.2%	57.8%	94.8%	92%	90%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits																
Admitted Patients	90.00%	Monthly	96.08%	95.93%	96.47%	96.10%	95.12%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%		
Non Admitted Patients	95.00%	Monthly	98.52%	98.36%	98.48%	98.60%	97.90%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%		
Ongoing Patients	92.00%	Monthly	96.91%	96.85%	96.33%	95.45%	95.74%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%		
A&E Quality Indicators (5 measures)																
Time Spent in A&E (Month on Month)	95%	Monthly	95.35%	90.25%	88.81%	86.91%	90.33%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%	90.20%		
Time Spent in A&E (Cumulative)	95%	Monthly	94.15%	93.67%	93.04%	92.47%	92.30%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%		
Total time in A&E (95th percentile)	95th	Monthly	04:00	06:09	06:18	07:12	06:21	08:08	06:45	03:59	04:43	04:17	05:19	05:22		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	Monthly	00:31	00:41	00:39	00:44	00:50	01:10	00:57	00:40	00:54	00:41	00:45	00:42		
Time to treatment decision (median)	<60 mins	Monthly	00:41	00:46	00:48	00:34	00:45	00:52	00:57	00:51	00:51	01:05	00:54	00:54		
Unplanned re-attendance rate	=<5%	Monthly	5.71%	5.40%	6.62%	6.10%	6.07%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%		
Left without being seen	>1% and <5%	Monthly	0.07%	0.25%	0.12%	0.18%	0.22%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%		
Ambulance handover times > 15 minutes	0	Monthly			New for 2013-14				612	452	500	446	476	1263		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	Monthly			New for 2013-14				68	3	29	7	31	15		No hand over greater then 15 minutes
Cancer Wait Times																
2 week GP referral to 1st outpatient	93%	Monthly	97.2%	98.3%	98.6%	96.7%	96.9%	98.3%	96.0%	95.4%	96.2%	95.5%	95.1%	96.7%		
2 week GP referral to 1st outpatient - breast symptoms	93%	Monthly	96.1%	99.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%		
31 Day	96%	Monthly	98.9%	97.7%	95.6%	97.3%	98.7%	99.2%	98.0%	98.2%	98.1%	96.3%	97.6%	99.2%		
31 day second or subsequent treatment - surgery	94%	Monthly	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	93.3%		
31 day second or subsequent treatment - drug	98%	Monthly	100.0%	98.6%	95.0%	91.8%	96.8%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	Monthly	98.4%	99.0%	98.8%	96.4%	97.8%	95.8%	98.3%	98.6%	95.8%	96.5%	97.4%	94.4%		
62 day referral to treatment from screening	90%	Monthly	100.0%	100.0%	95.7%	95.7%	93.3%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%		
62 day referral to treatment from hospital specialist	80% (local target)	Monthly	100.0%	92.6%	100.0%	63.6%	73.7%	100.0%	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%		
62 days urgent referral to treatment of all cancers	85%	Monthly	85.8%	89.7%	78.3%	81.3%	77.6%	76.5%	85.2%	79.0%	83.4%	79.1%	85.4%	86.1%		
SRS08: Length of Stay (Acute & MH)																
Elective	3.20	Monthly	4.4	4	3.8	4.4	4	4.2	3.1	4.7	5.6	4.3	5.9	3.8		Based on DFI Peer Group UQ. Fig reported in Aug 13 relates to rolling 12 months up until Jun 13
Non-Elective	5.30	Monthly	4.5	4.2	4.4	4.6	4.3	4.7	4.3	4.3	5.8	4.7	5.3	4.9		Based on DFI Peer Group UQ. Fig reported in Aug 13 relates to rolling 12 months up until Jun 13
SRS09: Daycase Rate	85%	Monthly	84.7%	83.0%	85.7%	85.5%	84.8%	84.6%	85.9%	84.9%	84.6%	86.4%	85.5%	84.9%		
SQU11: PROMS Scores - Pre Operative participation rates																
Groin Hernia - Participation Rate	Eng.Ave 52.5% (target 80%)	Quarterly	48.5%		88.6%			98.0%			81.3%		75.3%			Information based on 12 months HES data to Apr 12 - Mar 13 (published Aug 13). Target for 2012-13 is measured against the England average for the period and not the national target of 80% for all procedures
Hip Replacement - Participation Rate	Eng.Ave 77.1% (target 80%)	Quarterly	92.3%		125.8%			93.0%			94.6%		91.5%			
Knee Replacement - Participation Rate	Eng.Ave 83.7% (target 80%)	Quarterly	97.1%		95.9%			110.5%			107.1%		102.6%			
Varicose Vein - Participation Rate	Eng.Ave 40.6% (target 80%)	Quarterly	32.9%		71.4%			54.1%			66.7%		68.7%			
All Procedures - Participation Rate	Eng.Ave 68.4% (target 80%)	Quarterly	74.5%		99.1%			96.0%			90.5%		86.4%			

Clinical Outcomes	Target 2013-14	Frequency	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Sept 13 RAG Rating	Comments
HSMR - monthly position for 2013-14	<100	Monthly	93.5	83.8	100.5	96.9	100.21	103.7	108.5	76.8	76.93	88.0	N/Avail	N/Avail		Latest DFI position - 12 months to Jun 13
HSMR - 12 Monthly cumulative position		Monthly	98.3	98.2	99.0	99.1	N/Avail	100.1	100.8	N/Avail	96.2	99.01	N/Avail	N/Avail		Latest DFI FY trend Aug 12 - Jul 13 (HSMR)
HSMR- cumulative position for 2013-14																
Pneumonia	<100	Monthly	49.7	48.7	52.2	54.8	N/Avail	57.5	60.4	N/Avail	59.42	65.8	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Fracture of neck of femur (hip)	<100	Monthly	155.8	168.5	168.4	169.08	N/Avail	148.7	135.89	106.08	0	52.27	N/Avail	N/Avail		Latest DFI FY trend Aug 12 - Jul 13 (HSMR)
Acute Cerebrovascular disease	<100	Monthly	110	101.6	107.1	105.6	N/Avail	105	108.2	N/Avail	101.95	90	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	Monthly	121.4	131.3	131.9	133.5	N/Avail	133.5	135.88	N/Avail	128.8	N/Avail	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Acute myocardial infarction	<100	Monthly	70.1	61.9	71	76.7	N/Avail	77.5	84.6	N/Avail	82.29	87.3	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	Monthly	114.24	114.24	114.24	114.24	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail		Latest position reported in Sep 13 reflects Jan 12 to Dec 12.
SQU12: Maternity 12 weeks	90%	Monthly	98.0%	97.0%	93.2%	95.4%	95.2%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%		Figure subject to change following final data collation
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	Monthly	3.1%	4.3%	5.7%	3.9%	3.4%	4.0%	2.6%	2.7%	3.7%	3.3%	4.3%	2.5%		
Fractured neck of Femur																
Patients fit for surgery within 36hrs	-	Monthly							17	29	26	23	25	28		
Number of patients admitted with FNOF who were operated on within 36 hrs	-	Monthly			New for 2013-14				14	21	23	22	21	19		
% of patients admitted with FNOF who were operated on within 36 hrs of being fit for surgery	100%	Monthly							82.4%	72.4%	88.5%	95.7%	84.0%	67.9%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	Monthly	93.0%	89.0%	100.0%	91.3%	90.6%	69.6%	82.4%	72.4%	88.5%	95.7%	84.0%	67.9%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	Monthly	46%	47%	47%	39%	67%	48%	91%	83%	81%	93%	86%	93%		
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	Monthly	100%	100%	100%	100%	100%	100%	43%	38%	38%	66%	59%	51%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	Monthly	68.0%	88.9%	72.7%	68.8%	60.0%	69.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Patients who spend at least 90% of their time on a stroke unit	80%	Monthly	91.0%	90.2%	84.2%	81.6%	86.1%	96.4%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%		
Breast Feeding initiation	75%	Monthly	99.3%	99.7%	74.9%	75.2%	77.4%	79.4%	80.0%	88.7%	98.2%	94.1%	87.0%	91.5%		
Caesarean Section Rates - Total	<25%	Monthly	26.5%	26.5%	24.1%	29.3%	29.2%	24.1%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%		
Caesarean Section Rates - Emergency	14.98%	Monthly	9.4%	14.9%	11.1%	10.1%	12.7%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%		
Caesarean Section Rates - Elective	10.06%	Monthly	17.1%	17.1%	13.1%	14.4%	14.7%	13.1%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%		
Home Birth Rate	>=3%	Monthly	4.4%	4.5%	7.5%	2.1%	5.9%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%		
Number of readmissions within 28 days (Adult)	-	Monthly			New for 2013-14				396	383	422	498	423	393		Min 28 day turnaround before monthly data available
Number of readmissions within 28 days (Children)	-	Monthly			New for 2013-14				146	136	163	126	96	106		Min 28 day turnaround before monthly data available

CQUIN 2013-14	Target 2013-14	Frequency	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Sept 13 RAG Rating	Comments
NATIONAL CQUINS																
1.VTE																
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month	Monthly	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	CQUIN payment to be	Quarterly	New for 2013-14						Awaiting Quarterly report							RAG rating in accordance with latest CQUIN Status report
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting																
3a.Dementia case finding	90% 3 consecutive months	Monthly	7.1%	2.4%	0.3%	2.4%	2.9%	2.2%	0.86%	4.35%	2.37%	3.3%	55.7	83.5%		
3b.initial diagnostic assessment	90% 3 consecutive months	Monthly	N/A	N/A	N/A	N/A	N/A	Not avail	-	0%	100%	50%	46.7	N/Avail		3b & 3c no numerator or denominator Facilitator in post from beginning Aug 2013
3c. referral for specialist diagnosis	90% 3 consecutive months	Monthly	0.0%	0.0%	0.0%	100.0%	100.0%	Not avail	-	100%	100%	100%	58.3	N/Avail		
3d.Lead clinician and appropriate training of staff	Yes	Monthly	New for 2013-14								On track					RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes	Monthly	New for 2013-14								Audit from Q2					RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS																
1. Develop and implement AECP																
1a AECP for Chest Pain		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
1c. AECP for Supraventricular Tachycardia		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic																
2a. HOT Clinic for Paediatrics		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine		Monthly	New for 2013-14								Q1 achieved, Q2 on track					RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS																
1. Friends & Family																
1a. Phased expansion of Friends and Family Test		Monthly	New for 2013-14								From Oct 2013					RAG rating in accordance with latest CQUIN Status report
1b. increase response rate to at least 20%		Monthly	New for 2013-14						7.09%	9.23%	15.88%	16.93%	9.73%	16.8%		Q2 accumulative FFT response rate = 14.45%
1c. Improve performance on staff Friends & Family Test		Annual	New for 2013-14								Survey due Autumn 2013					No action required for Q 1 LIA group in place - staff survey to be undertaken in Q 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	4	3	1		RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards		Quarterly	New for 2013-14						On track, Q1 data submitted and feedback provided							
4. Timely Simple Discharge	TBA (>60% each quarter or action plan)		New for 2013-14						N/A	50.0%	0.0%	66.7%	66.7%	100.0%		QCQUIN's to be agreed, awaiting sign off
5. Improve access to breast milk in preterm infants	TBA (20% imp on 12/13 perf (58.5%))		New for 2013-14						55.9%	37.5%	45.5%	51.3%	61.3%	64.2%		QCQUIN's to be agreed, awaiting sign off
6. Acute Kidney Injury	Q1 Process recorded and definition in place		New for 2013-14								Q1 achieved, Q2 on track					

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Patient Experience Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Rachel Lovesy, Patient Experience Lead
Purpose	This report is being presented to the Board for Assurance and Information
Executive summary • Update on existing Patient Experience Work 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 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 - Patient Experience Report

Actions required by the Board

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

Trust Board
31 October 2013

Patient Experience Report

1. Overview

The purpose of this report is to update the Board on any Patient Experience related activities being undertaken within the Trust, providing a comprehensive overview of how our patients are experiencing our hospital and any measures being taken to improve, where satisfaction levels are not meeting the Trusts own high standards.

1.1 Implementation of the Patient Experience Strategy

A review is currently being undertaken of the Patient Experience Strategy – Implementation Plan to reflect developments and changes in timescales. A great deal of work has already been completed in the drive to implement the strategy, however it has been acknowledged that there is a need for this to be fluid in nature in order for it to be receptive of change. Two examples of this can be seen below:

- *12. Identify how education will be provided / resourced to the programme, Original Deadline, 20 October 2012* – A draft behavioural framework has been created by an external body and Workforce Development are in the process of identifying how this will work for the organisation, ensuring it is cohesive with the trusts Strategic Objectives. In addition to this it has been identified that the NICE Guidelines for Patient Experience are focussed around the conduct of staff and therefore needs to be considered at all times throughout this work. It has been agreed that the Patient Experience Lead will have an allotted slot within the Trust Induction based around our vision of 'Customer Service'- this will be directly related to this work being carried out with Workforce Development.

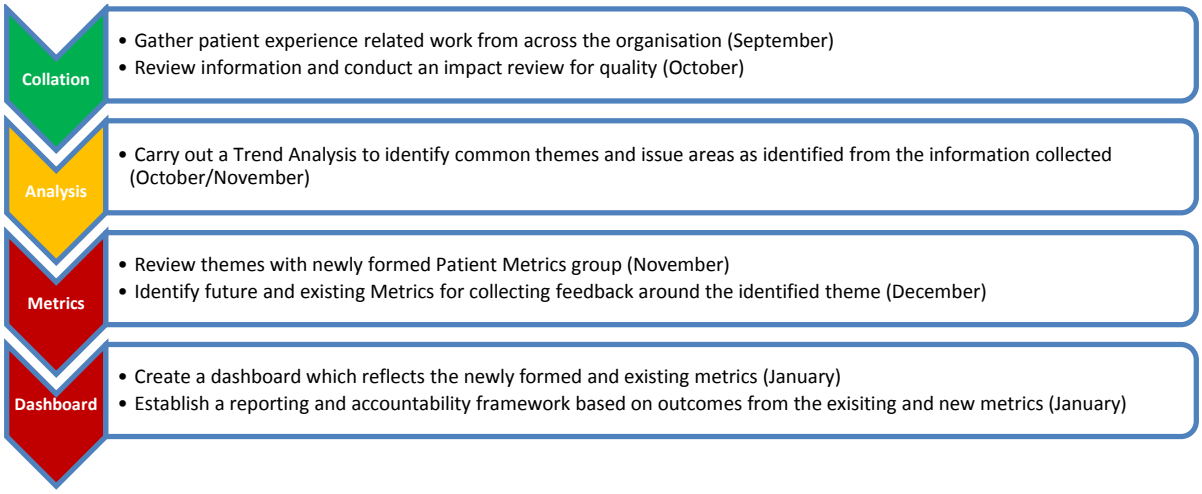
- *18. Develop plans to improve key corporate aspects of the patient experience including: .. b Noise at night* – Audits have been carried out routinely over the past year identifying that patients are still not satisfied with the noise at night. This has also been identified as a key issue within the Trusts Inpatient Survey results. It has been decided by the group leading on this that further investigation into this is needed and the team are in the process of finalising a further survey which is more qualitative in its methods and allows for deeper exploration into the reasons for the nightly disturbances, and what we as an organisation can do to improve this. Once the review has been completed and timescales amended a copy will be provided for review by the Board.

1.2 Patient Experience Monitoring

1.2.1 Patient Experience Collation and Trend Analysis

It has been identified that there is a need to be able to continuously review how our patients are receiving our services, and to identify any problem areas in a timely manner to allow for effective resolutions. The ultimate aim is for the creation of a dashboard which reflects a continuous, fluid response to the key issue areas identified from previous patient experience measures. The process needed to reach this aim has begun and is outlined below with a

RAG rating for its progress; this will continue to be updated throughout Board reports until the task is completed:



Once developed, the Patient Experience Dashboard will dovetail into the Trusts Quality Dashboard which is currently being created. The Board report will reflect the outcomes and any actions taken as a result of them.

An email was distributed Trust wide on the 12th of September requesting all Patient Experience related work to be sent to the Patient Experience Lead by the 20th of September. To date, 47 different pieces of information have been received and collated from throughout the Trust, varying from National Surveys (Inpatient, A&E, Maternity, Cancer) through to individual pieces of work - created locally, to gather feedback on specific elements of care. This has been an extremely positive and encouraging response.

1.2.2 Patient Metrics Group

As mentioned above the Patient Metrics Group will be re-established and membership evaluated to ensure there is adequate representation from all areas.

1.3 National Patient Experience Activities

The Friends & Family Test continues to be one of the primary methods of data collection for patient experience throughout the Trust. The drop in response rates for August saw the Trust fail to reach their CQUIN target for Quarter 2 and actions are being undertaken to ensure that the Trust does not face this position in the future.

Stratification of eligible patients

Information received from our Clinical Commissioning Group (CCG) outlining further ways in which our eligible patients can be stratified was received in September. This information had been taken from the Strategic Project Teams website where a further breakdown of how to identify 'eligible' patients had been provided as part of the 'Frequently Asked Questions'. This enabled the Information Team to re-calculate the figures for September, removing:

- Deceased patients
- Patients that did not stay overnight
- Patients that were not discharged to their place of residence

This had a significant, positive impact on the figures for September and will be continued to be used hence forth.

Maternity Services

01 October saw the launch of Maternity Services FFT. Each lady is required to be asked a minimum of 3 questions and a maximum of 4 questions, at 3 'touch points' throughout their care. Appendix A gives an overview of the different questions and touch points throughout the maternity pathway. The patient experience lead worked with the Head of Midwifery and Matron for Midwife Primary Care (Community) Services, to set up the process. A further meeting has since been held with the Community Sisters to ensure they receive the support they need to carry this out. It is likely that October will be a slow start; however results will not be published nationally until January 2014.

Eye Casualty

Eye Casualty have had consistent issues with collecting FFT data with only 7 surveys being collected for the whole of September. The Patient Experience Lead attended a number of seminars in London with NHS England in September and gathered feedback from other Trusts that have previously had similar issues. After trying a number of different methods, it has been identified that a token based system is the most effective way of gaining feedback in these types of busy, fast paced environments. Opthalmology have therefore agreed to fund the token system and aim to have this running in November, with supplementary comments cards available for patients that wish to also provide a free text response. This system will be evaluated to ensure it is working effectively.

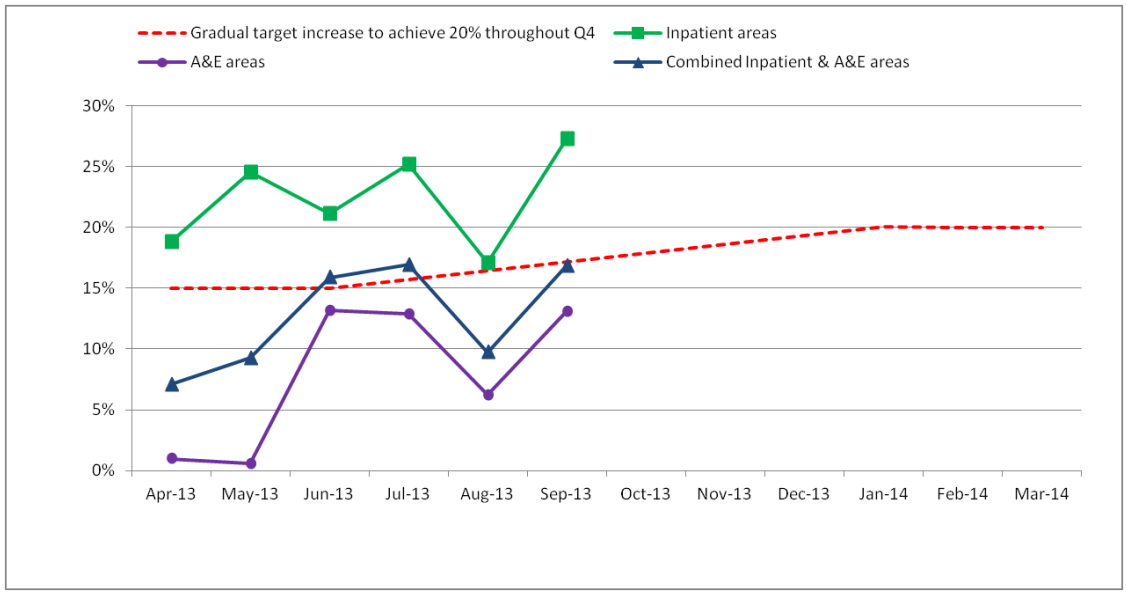
In the meantime both the Matron and Service Manager have been supporting and encouraging staff to continue with the paper format. In addition to this HealthWatch volunteers have been assisting and reminding patients at the doors of Eye Casualty at differing periods throughout the week. Both these initiatives have seen a surge in responses with **125** responses being collected in the first two weeks of October, compared with **7** for the whole of September.

Results

September saw a positive increase from August in the response rates throughout the hospital with the overall (Inpatient and A&E) response rate of **16.84%** compared with 9.7% for August. Inpatients achieved their highest response rate for this financial year achieving **27.26%** and A&E climbed from a disappointing 6.23% in August to **13.08%** for September. Although this is still lower than our target it is hoped that the improvements being made in Eye Casualty with have a positive impact on the overall A&E response rates for October. Appendix B gives an overview of the response rates broken down into individual wards

	Q1			Q2		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
National Target (raising to 20% in Quarter 4)	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	27.26%
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	16.84%

FFT response rate % against National Target



FFT Tracker against Trusts own gradual target to prepare for Q4 increase to 20%

Since April, Inpatient Services have seen a consistent monthly increase in the Trusts Net Promoter Score (NPS) with September reaching **74**. There was however a drop to **55** in the NPS for A&E bringing it back down to the score obtained in July. This will continue to be monitored. The combined NPS for A&E and Inpatients is **63.**

Net Promoter Score Test Results	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
2013-14 Inpatient Score Results	**63**	**68**	**67**	**69**	**70**	**74**
2013-14 A & E Score Results	**20**	**55**	**57**	**55**	**61**	**55**
2013-14 Maternity Area Score Results	**62**	**66**	**42**	**46**	**43**	**61**
2013-14 Daycase Area Score Results	**53**	**63**	**74**	**66**	**69**	**67**
2013-14 Paediatric Ward Score Results	**84**	**85**	**88**	**91**	**90**	**85**

Individual ward NPS's can be seen in Appendix C.

The scores can be broken down further to display the percentages per score given throughout the Trust (below). For September **67.9%** of our patients said they were extremely likely to recommend our services. **25%** were likely, and combining those scores means **93%** of our patients are extremely likely or likely to recommend us.

Friend & Family Response Rate (%)
Period: April 2013 - Sept 2013

	% Response per category								
Month (IP and A&E areas)	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total responses for each	Response rate	Score
Apr-13	63.0%	26.4%	3.1%	0.7%	2.3%	4.5%	554	7.1%	60
May-13	70.2%	23.7%	2.4%	0.8%	1.1%	1.8%	739	9.3%	67
Jun-13	65.4%	28.2%	2.4%	1.8%	0.6%	1.7%	1268	15.9%	62
Q1	7.1%	2.9%	0.3%	0.1%	0.1%	0.2%	23769	10.8%	63
Jul-13	66.8%	26.7%	3.6%	1.2%	0.6%	1.1%	1488	16.9%	62
Aug-13	69.8%	24.5%	1.8%	0.8%	1.9%	1.4%	800	9.7%	66
Sep-13	67.9%	25.0%	2.3%	1.3%	1.8%	1.5%	1194	16.8%	63
Q2	9.8%	3.7%	0.4%	0.2%	0.2%	0.2%	24099	14.4%	63

Scores are now available publically on NHS Choices, including a breakdown of the NPS into individual scores for each category ('Extremely likely, likely etc). NGH are listed as 'in the normal range' for both Inpatient and A&E services with scores of 70 for Inpatients, from 454 responses and 61 for A&E from 346 responses.

Placing NGH's scores into local context, Kettering General Hospital scored 53 for A&E from 759 responses putting them within the 'in the normal range' category. However, they are currently rated as 'amongst the worse' for inpatient services with an NPS of 58 from 683 responses. KGH are achieving excellent response rates having achieved 34.9% for Inpatient services and 21.7% for A&E for the month of August. Milton Keynes are currently rated as 'Amongst the best' with their A&E NPS of 73, however it is crucial to note that this is from **11** patients, giving them a **0.3%** response rate for August. They scored an NPS of 67 for Inpatients from 388 responses, placing them as 'in the normal range' with a response rate of 22.4%.

To date the results of the FFT have been focussed around the response rates and the Net Promoter Score (NPS). Plans are afoot to start making better use of the real-time, free text responses which are crucial for understanding (a) the reason for the score the patient has given (b) any issues the patient identifies (c) any compliments given. Discussions will take place throughout the organisation for how we can start using and reporting this information routinely.

1.3.1 Inpatient Survey 2013

The National Inpatient Survey for 2013 is currently within its data collection phase. The Information team identified the relevant sample of patients that attended the hospital in the month of August. Reports will be circulated next year.

1.3.2 Maternity Survey 2013

The results of the National Maternity Survey have been published and circulated to the Trust. The Head of Midwifery is in the process of reviewing the report and putting together an action plan based on the recommendations. The Board will be updated within subsequent reports of actions taken.

1.3.3 Cancer Survey 2013

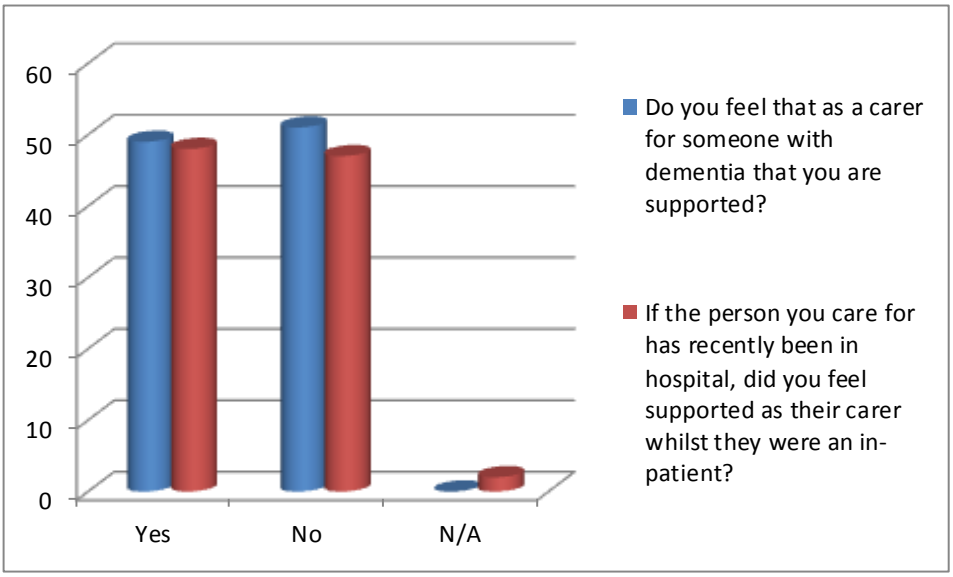
The results of the National Cancer Survey are currently being reviewed by the Patient Experience lead and Cancer Lead. An action plan will be created and reviewed within the Cancer Services. The Board will be updated of any progress.

1.4 Local Patient Experience Activities

Dementia Carers Audit

An audit has been undertaken to demonstrate whether carers of patients with dementia feel supported, and to ensure the Trust has information and processes in place to offer this support. A survey was issued to the addresses of patients with a diagnosis of dementia that had been an inpatient in NGH in Q1 2013/2014, excluding those that reside in care facilities. 251 surveys were issued with 73 returned giving a response rate of 29%.

The following chart demonstrates the findings:



The following recommendations have been made from this audit:

- The results will be discussed at the Dementia Committee to ensure all possible actions to support carers are addressed.
- Current audits are being undertaken by the Trust Dementia CQUIN Facilitator who provides advice and support to carers
- The Trust continues to support the actions from the Dementia Strategy Action Plan
- Staff have been reminded of the Trust's carer's policy.
- A plan for a carer's forum that would feed into the Trust's Dignity Forum is being reviewed.

15 Step Challenge

All of the wards have now been assessed using the 15 Steps Challenge tool and action plans have been created. A summary of the findings were reported to last month's board meeting.

This work will now be incorporated into a larger tool which is going to be used quarterly to audit every ward in the hospital. This audit will also contain specific measures for Patient Experience identified as issues areas within the previous Inpatient Survey for 2012.

Other Activities

It has been identified through the Trend Analysis that there are many Patient Experience activities taking place throughout the organisation, and many examples of excellent work. In the foreseeable future it is the aim of the patient experience lead to engage further with services to ensure this work is reported and acknowledged centrally. This will enable us to have a comprehensive and structured view of how our patients are experiencing our services across the hospital. It is with this knowledge that we can begin to identify how we can make changes to the benefit of our patients.

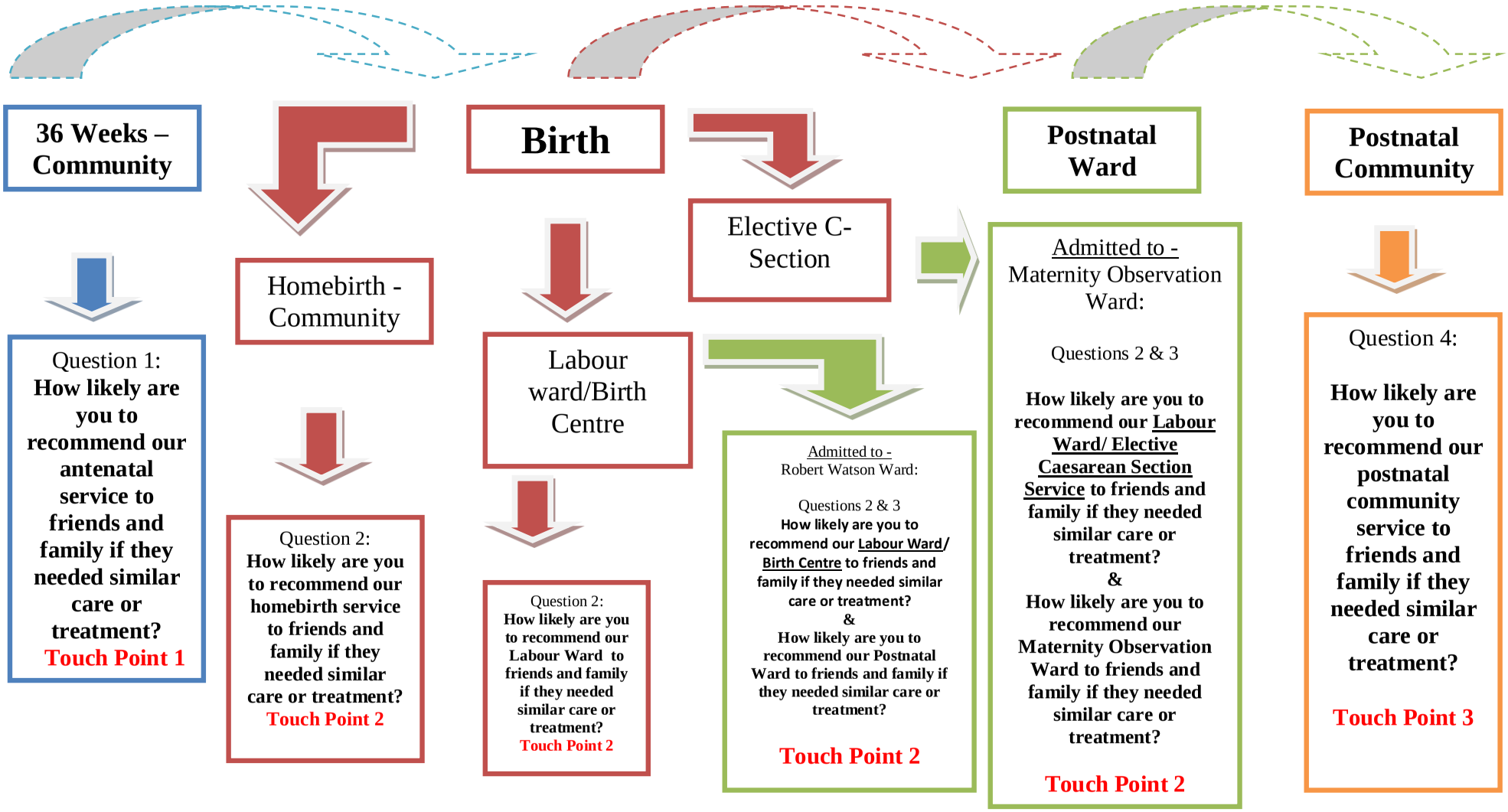
1.5 Summary of Key Actions being taken:

- Review of timelines being undertaken for the Patient Experience Strategy, Implementation Plan
- Process identified and underway for a Patient Experience – Trend Analysis and subsequent dashboard
- Changes made in the stratification of eligible patients for the FFT

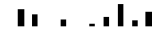
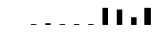
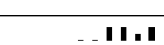
- Launch of Maternity Services FFT on October 1st
- Vast improvements in the collection of Eye Casualty FFT for October to date
- Positive increase in Septembers FFT figures – Inpatient = **27.26%** A&E= **13.08%** Combined = **16.84%**
- NPS for September, Inpatient = **74**, A&E = **55**, Combined = **63**
- NPS now available on NHS Choices, NGH showing as 'in the normal range' for both A&E and Inpatients
- A number of National Surveys currently in the process of being reviewed by services and action plans created
- Incorporation of the 15 step challenge within a regular quarterly audit tool
- Changes to the Mealtime and Noise at Night Survey for deeper exploration of root cause

Appendix A

Maternity Friends and Family: Questions and Touch Points



Appendix B

Friends & Family Net Promoter Response Rates		Target 2012-13 = 10%					Target Q1 13-14 = 15%			Target 15.7%	Target 16.4%	Target 17.2%
Ward	Graph	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Abington		27.06%	43.42%	28.95%	37.50%	43.33%	25.00%	30.61%	27.03%	23.64%	11.76%	8.16%
Allebone		18.97%	16.05%	38.46%	28.57%	22.83%	51.02%	32.98%	23.75%	25.40%	14.29%	11.11%
Althorp		111.76%	36.84%	31.94%	31.76%	43.00%	54.84%	33.33%	32.93%	70.21%	59.42%	56.52%
Becket		19.18%	36.96%	21.88%	31.08%	32.08%	40.43%	43.28%	42.65%	37.97%	17.39%	23.33%
Benham		10.99%	13.11%	8.91%	30.18%	7.91%	12.00%	21.43%	19.41%	23.94%	14.63%	19.82%
Brampton		34.38%	23.81%	44.12%	41.94%	67.86%	37.84%	40.00%	9.38%	38.89%	34.38%	34.62%
Cedar		18.28%	29.47%	36.36%	28.57%	25.71%	19.18%	10.34%	7.55%	34.12%	17.82%	22.11%
Collingtree Medical		18.64%	8.66%	0.0%	20.19%	13.56%	7.06%	37.33%	28.46%	25.83%	20.65%	18.60%
Compton			77.27%	91.30%	111.11%	77.78%	80.00%	156.25%	84.21%	106.67%	100.00%	18.60%
Corby Comm.		0%	71.43%	50.00%	0.00%	30.00%	0.00%	9.52%	39.13%	92.86%	26.32%	61.54%
Creaton		7.41%	16%	32.35%	33.33%	21.05%	7.81%	18.07%	16.67%	11.25%	6.35%	17.39%
Danetre		0%	0%	57.14%	34.62%	39.53%	39.47%	54.29%	24.24%	43.93%	15.79%	70.59%
Dryden		16.36%	29.41%	2.38%	27.03%	24.79%	28.32%	19.67%	2.15%	9.65%	4.27%	17.58%
Eleanor		21.62%	17.91%	16.67%	36.36%	21.74%	38.10%	51.11%	29.31%	44.07%	34.38%	39.58%
EAU		5.86%	8.40%	13.16%	4.66%	3.15%	14.45%	26.77%	22.79%	11.00%	7.82%	10.16%
Finedon		37.25%	38.89%	36.21%	29.17%	21.62%	31.25%	46.51%	22.92%	57.89%	31.37%	34.62%
Hawthorn		75.28%	21.97%	25.47%	36.61%	37.68%	33.85%	30.04%	33.02%	27.78%	25.93%	47.65%
Hazelwood Comm.		93.75%	25.00%	127.78%	0.00%	60.71%	77.78%	60.00%	50.00%	105.56%	57.89%	73.33%
Head & Neck		9.38%	19.20%	33.33%	45.45%	40.46%	17.48%	29.81%	38.32%	31.30%	20.39%	32.50%
Holcot		54.84%	21.21%	68.75%	75.00%	53.57%	83.33%	54.55%	68.75%	72.73%	50.00%	155.56%
Knightley		53.85%	37.50%	26.67%	31.82%	52.17%	25.64%	40.38%	43.64%	59.57%	100.00%	51.28%
Rowan		25.95%	24.85%	34.62%	45.56%	32.84%	16.15%	18.18%	13.48%	24.71%	13.71%	29.41%
Spencer		18.75%	8.04%	21.70%	13.07%	12.79%	10.73%	15.86%	15.30%	15.43%	13.99%	16.20%
Talbot Butler		23.91%	12.31%	30.56%	10.64%	12.00%	8.93%	26.42%	24.75%	47.52%	36.11%	38.37%
Victoria			9.88%	23.91%	4.00%	10.45%	15.07%	17.31%	6.98%	34.92%	17.07%	7.14%
Willow		41.11%	21.33%	29.51%	22.99%	21.30%	11.11%	27.37%	28.95%	11.46%	16.13%	16.83%
Adult Inpatient Area Total		15.01%	14.77%	16.45%	19.00%	15.15%	18.78%	24.53%	21.13%	24.61%	16.52%	27.26%
Accident & Emergency Unit		Recorded from January 2013		0.54%	1.75%	0.48%	1.02%	0.25%	15.22%	13.49%	6.60%	15.12%
Ambulatory Care Centre		Recorded from September 2013										45.83%
Eye Casualty Unit		Recorded from April 2013					0.72%	2.38%	1.04%	9.23%	4.06%	1.11%
Accident & Emergency Total		Recorded from April 2013					0.97%	0.57%	13.16%	12.87%	6.23%	13.08%
Balmoral		51.85%	65.69%	55.87%	46.15%	37.34%	54.59%	60.82%	Closed	Closed	Closed	Closed
Maternity Observation Ward		Recorded from June 2013							0.00%	0.00%	0.00%	0.00%
Robert Watson		23.46%	30.73%	42.02%	37.20%	30.00%	26.32%	32.41%	33.96%	40.06%	18.15%	26.22%
Maternity Ward Total		Previously included within Inpatient Area Total					41.42%	23.08%	28.57%	33.33%	14.47%	21.28%
Disney		19.16%	16.26%	16.55%	29.48%	10.13%	17.46%	32.66%	24.74%	35.82%	29.59%	79.05%
Paddington		9.95%	7.94%	8.67%	13.30%	9.79%	5.88%	10.41%	10.57%	21.23%	13.61%	35.84%
Paddington HDU		Recorded from July 2013								9.09%	0.00%	22.22%
Paediatric Ward Total		Previously included within Inpatient Area Total					9.55%	17.65%	15.14%	26.09%	18.99%	51.22%
Danetre Day Surgery		Recorded from January 2013		66.67%	54.64%	30.88%	50.00%	60.64%	29.25%	34.19%	47.55%	20.54%
Main Theatre Admissions		Recorded from February 2013			50.92%	50.00%	67.47%	52.42%	24.14%	17.28%	60.42%	17.82%
NGH Day Surgery		Recorded from January 2013		38.86%	29.43%	12.43%	29.17%	28.62%	34.49%	23.20%	17.46%	48.61%
Singlehurst Day Unit		Recorded from April 2013					2.44%	5.48%	9.93%	9.43%	19.70%	11.11%
Daycase Area Total		Previously included within Inpatient Area Total					40.30%	32.40%	27.34%	20.70%	29.72%	28.59%

Appendix C

Friends & Family Net Promoter Score Results

2012-13 Target = Score of 80

Ward	Graph	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Abington		67	39	70	73	63	42	31	80	70	46	20	-25
Allebone		50	64	-8	32	45	52	33	33	41	44	-14	75
Althorp		67	89	71	87	93	81	74	82	77	86	80	72
Becket		41	93	68	21	43	47	50	79	62	87	100	69
Benham		70	70	41	50	53	70	77	66	54	47	62	73
Brampton		60	45	70	93	77	68	64	56	67	86	82	67
Cedar		64	53	50	65	65	61	31	17	75	41	39	52
Collingtree Medical		78	82	82		29	55	83	58	63	55	79	69
Compton				88	81	70	81	81	76	69	69	33	92
Corby Comm.			67	87	100		50		100	75	54	40	100
Creaton		72	100	64	36	40	63	60	43	70	67	67	67
Danetre					92	67	94	100	100	100	80	83	73
Dryden		94	67	80	100	80	69	55	41	100	82	25	88
Eleanor		100	75	92	100	50	80	81	83	73	73	68	79
EAU		36	77	67	60	73	50	63	67	61	55	76	75
Finedon		80	58	67	71	50	81	79	74	36	52	53	72
Hawthorn		90	85	65	56	78	73	70	66	70	69	67	69
Hazelwood Comm.		67	47	86	83		82	50	83	100	95	64	82
Head & Neck		96	78	92	76	80	83	89	84	93	85	95	85
Holcot		68	65	100	91	92	93	78	75	45	72	60	77
Knightley		63	90	72	75	100	96	56	62	58	71	100	75
Rowan		93	65	62	67	65	79	32	54	58	72	88	78
Spencer		68	77	89	87	91	79	72	61	75	62	78	86
Talbot Butler		80	68	63	77	70	87	50	96	84	85	82	73
Victoria				50	27	33	0	25	50	67	55	57	67
Willow		90	84	94	89	75	74	67	73	62	82	67	93
Adult Inpatient Area Total		76	73	68	68	68	72	63	68	67	69	70	74
Accident & Emergency Unit					0	4	4	13	45	57	55	60	54
Ambulatory Care Centre		Recorded from September 2013											91
Eye Casualty Unit								67	61	63	58	72	78
Accident & Emergency Total								20	55	57	55	61	55
Balmoral		80	79	69	78	79	86	64	74	Closed	Closed	Closed	Closed
Robert Watson		76	83	69	54	85	76	56	59	42	46	43	61
Maternity Ward Total		Previously included within Inpatient Area Total						62	66	42	46	43	61
Disney		71	69	82	96	67	58	64	70	85	75	82	74
Paddington		57	51	33	56	46	46	38	51	62	57	53	57
Paddington HDU											50	0	100
Paediatric Ward Total								53	63	74	66	69	67
Danetre Day Surgery					91	96	98	94	89	90	85	92	100
Main Theatre Admissions						92	87	82	83	97	96	88	87
NGH Day Surgery					91	97	94	82	83	86	94	91	83
Singlehurst Day Unit								100	88	73	80	92	79
Daycase Area Total								84	85	88	91	90	85

REPORT TO THE TRUST BOARD
31 October 2013

Title	Monthly Infection Prevention Performance Report
Agenda item	9
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 September
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 6 months of the year has sustained 20 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 is asked to discuss and where appropriate challenge the content of this report.

Northampton General Hospital NHS
NHS Trust

Trust Board
31 October 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.

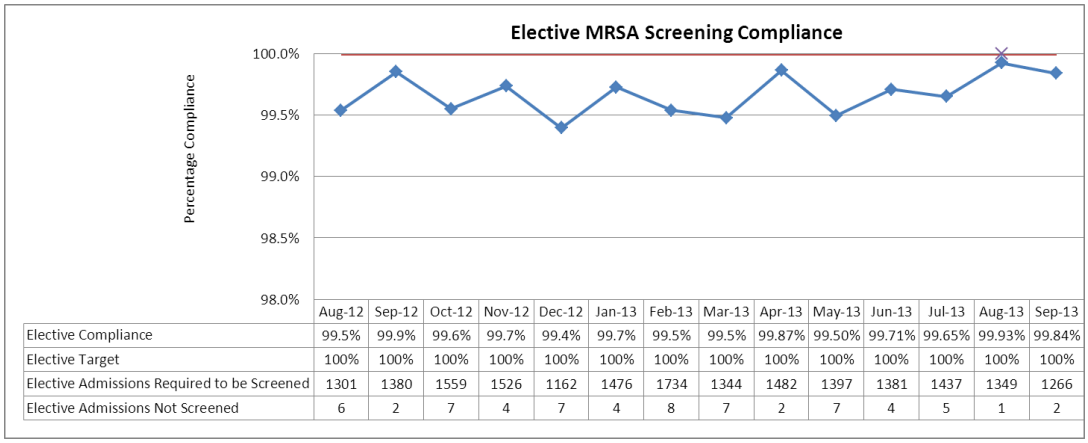
2. Report

2.1 MRSA Bacteraemia (July, August)

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

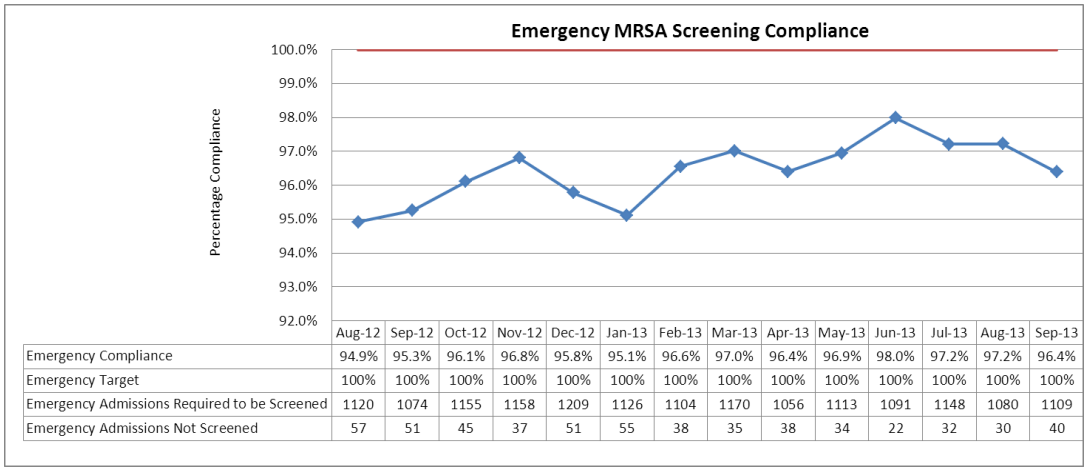
	MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
September	0	1	99.84%	96.4%	0	0

2.2 Elective MRSA screening compliance



	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Elective Compliance	99.5%	99.9%	99.6%	99.7%	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1301	1380	1559	1526	1162	1476	1734	1344	1482	1397	1381	1437	1349	1266
Elective Admissions Not Screened	6	2	7	4	7	4	8	7	2	7	4	5	1	2

2.3 Emergency MRSA screening compliance



	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Emergency Compliance	94.9%	95.3%	96.1%	96.8%	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%	98.0%	97.2%	97.2%	96.4%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1120	1074	1155	1158	1209	1126	1104	1170	1056	1113	1091	1148	1080	1109
Emergency Admissions Not Screened	57	51	45	37	51	55	38	35	38	34	22	32	30	40

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

During September 2013 there were 6 <48hrs and 0 **>48hrs** MSSA bacteraemia cases.

3. *Clostridium difficile*

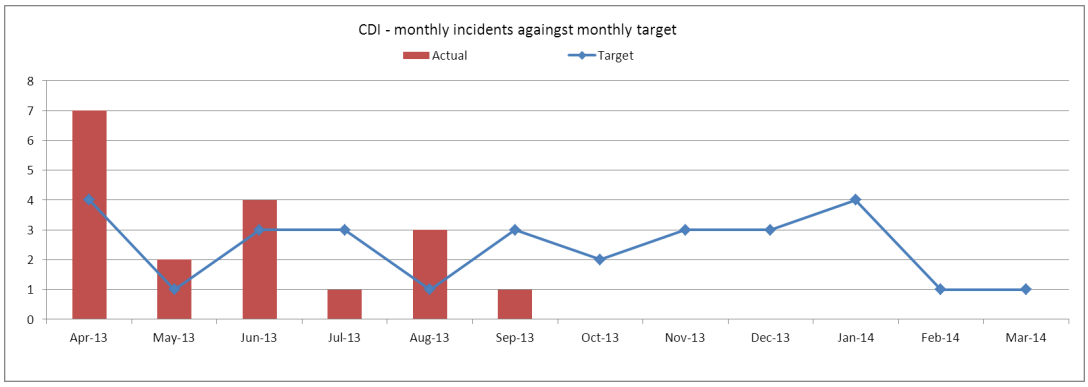
The Trust has an annual target of 29 *C.diff* cases or less for the financial year. During September 1 **>3 day case of *C.diff*** was identified against a monthly target of 3 post three day cases, which totalled 18 for the year. This was an appropriate sample. With the result of this case, Rowan ward were put on to 'special measures' as they had 2 post 72 hours cases within a 28 day period.

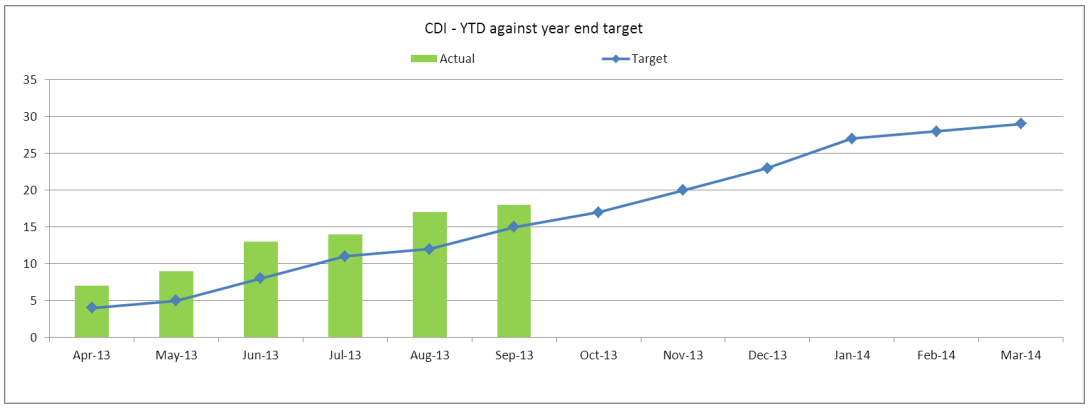
Rybotyping
The Trust does not routinely rybotype all new *C.diff* isolates. However, we do rybotype isolates from samples where we suspect an epidemiological link, as required and requested by the *C.diff* rybotype network.

Both faecal specimens from Rowan ward were sent for rybotyping and the results showed that they were of the same rybotype which could suggest a gap in infection prevention and control measures. The Infection Prevention Team have therefore supported Rowan through three subsequent weeks of 'Not so special measures' which incorporates a weekly cleaning/environmental audit, weekly hand hygiene audit and a weekly infection prevention and control practice audit. Results show good standards of practice and cleanliness, no cause for concern with regards to cross-infection and to date no further incidents of *C.diff*.

Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1
September 2013	0	1
Total	**8**	**10**

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)* bacteraemia

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 for 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.

Whilst there is currently no national benchmarking for *E.coli* bacteraemias, at NGH we have been closely monitoring these and conducting root cause analyses to determine causes for infection and lessons that can be shared across the trust to prevent further patients developing *E.coli* bacteraemias. For 2013-14 we have had a mean of four **>48 hrs** *E.coli* bacteraemias a month. During September 2013 there were 18 <48hrs and 3 **>48 hrs,** which is below our monthly average.

5. Surgical Site Infection Surveillance (SSIS) Scheme

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 Public Health England (PHE). The patient is monitored from operation until discharge and then followed up 30 days after the operation to determine if they sustained a surgical site infection. When submitting the results to the board, it should be noted that surveillance is still on-going as it is reported quarterly to the PHE and the directorate consultants and therefore these are classed as interim results.

The Infection Prevention Team conducts continuous SSIS on all fractured neck of femur patients admitted to the trust and from the 1st October will commence continuous SSIS on all total hip replacement and total knee replacement patients admitted to the trust. Monitoring infection rates for these surgeries enables us to ensure that the quality of care we deliver to these high risk patient groups is of a good standard. For September 2013, 26 repair of fractured neck of femur operations were conducted of which one developed a wound infection. This means that our Quarter 2 surgical site infection rate for repair of fractured neck femurs was 1.4% which was below the national average of 1.5% for Quarter 2.

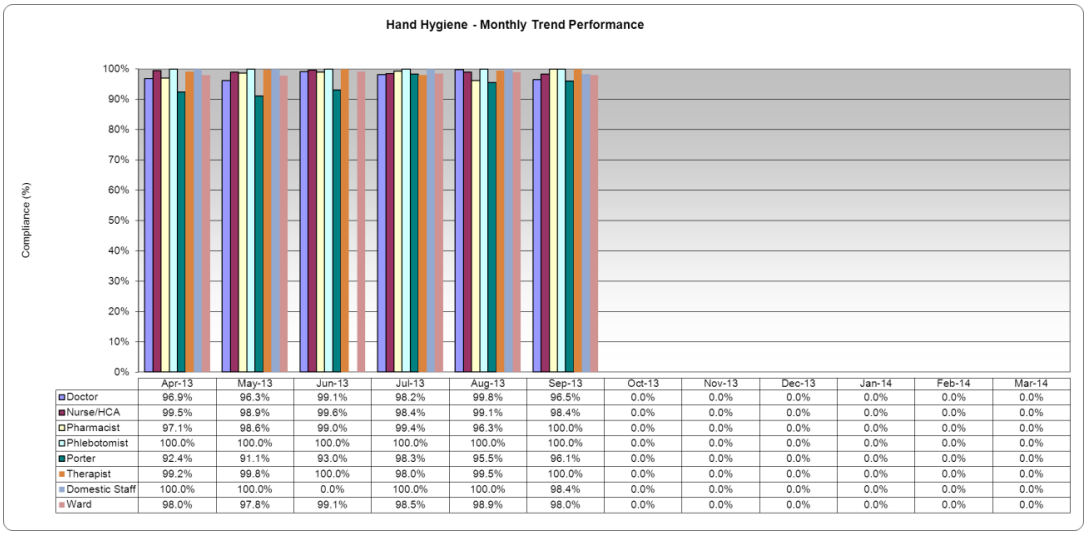
The Infection Prevention Team also conducts a rolling programme of quarterly SSIS on general surgery which includes abdominal hysterectomies, breast surgery, Caesarean sections, limb amputation, spinal surgery and vascular surgery. The rates of wound infections for each category are fedback to the relevant directorates and consultants each quarter. For Quarter 2 SSIS has been conducted on abdominal hysterectomies. For September 2013, 18 operations were conducted of which one developed a wound infection. This means that our Quarter 2 surgical site infection rate for abdominal hysterectomies was 1.6% which was comparable to the national

average of 1.4% for Quarter 2. SSIS is currently being undertaken on Caesarean sections for October-December 2013 to ensure that wound infection rates remain below the national average for this category of surgery.

6. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data shows that in September 2013 the overall Trust compliance for hand hygiene is 95.6% due to 2 areas failing to submit the completed audit.

This is a significant improvement from previous months due to face to face conversations with the areas who persistently were failing to submit. The 2 areas who did not submit this month were the Radiotherapy Linear Accelerator Department and CT Oncology Department and this was due to the member of staff who completes this audit being on annual leave. The staff were unsure where the data had been stored. Assurance has been given by the radiotherapy manager that measures have been put in place to cover future annual leave.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Doctor	96.9%	96.3%	99.1%	98.2%	99.8%	96.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	99.5%	98.9%	99.6%	98.4%	99.1%	98.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	97.1%	98.6%	99.0%	99.4%	96.3%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	92.4%	91.1%	93.0%	98.3%	95.5%	96.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	99.2%	99.8%	100.0%	98.0%	99.5%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Domestic Staff	100.0%	100.0%	0.0%	100.0%	100.0%	98.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ward	98.0%	97.8%	99.1%	98.5%	98.9%	98.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

7. Update on achievement against the TDA action plan

In July 2013, the Trust Development Authority (TDA) visited the trust to review infection prevention and control. Whilst the feedback from the visit was largely positive (previously fed back to the Board), there were areas that the TDA felt that we could improve upon. An action plan was developed which is monitored on a regular basis by the Infection Prevention Committee. Appendix A outlines achievements against that plan.

8. Update on Beat the Bug, Save the Skin, Stop the Clot

September 2013 saw the commencement of the above board visits to clinical areas. 27 clinical areas out of a possible 32 were reviewed. Reasons for the 5 areas that were missed included a car breakdown, a mix up of dates and sickness.

It was noted from the September 2013 reviews that:

- Staff were supportive of the beat the bug visits and motivated to improve
- Staff were welcoming, friendly and approachable
- Staff had a good comprehension of SSKIN and the pressure ulcer safety cross
- Good hand hygiene and appropriate use of personal protective equipment (PPE) observed

- The wards were generally very tidy and uncluttered
- High level and low level dust was an issue and was observed across the trust, as was dusty radiators and a lack of domestic staff. As a result of these walk rounds, business cases have been put forward for increased domestics on Talbot Butler and A&E. Singlehurst were also short of domestic staff.
- There were concerns with VTE assessments as not all staff had GMC stamps, which Dr Swart has agreed will be fed back
- There were concerns with the Estates log books on the wards as the ward staff complete the relevant section, but Estates do not complete their relevant section, which Charles Abolins will feed back to the Estates team
- Not all wards had isolation signs in situ for patients in source isolation, so replacement signs have been issued and the Infection Prevention Team will formally audit this practice in November 2013 to ensure that correct isolation procedures are in place to reduce the risk of infection to other patients, including appropriate signage
- Not all wards clearly displayed the previous months achievement for the SSKIN safety cross, this has been fed back to Mandy Massey.

Whilst it is early days, it is apparent from the first month of reviews that the reviews are being seen by staff as very positive and more rigorous in their approach, but with good results. Monthly updates on these reviews will continue to be provided within this report.

9. 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. Continued actions are being taken to try to mitigate this risk.

10. Recommendations/Resolutions Required

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

11. 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.

TDA Infection Control Inspection Action Plan (September 2013)

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
Paperwork (TDA had concerns regarding the quality of the paperwork submitted prior to the visit, but was re-assured during the visit that infection, prevention was embedded within the organisation.)	Rigor of evidence provided against the CQC Hygiene Code to demonstrate compliance needs to be enhanced.	30.09.13	To update and include additional information as appropriate. **Health Assure evidence and links are now up to date.**	
	• Infection Control Minutes (review Trust Board minutes to note how they are documented)	31.07.13	Completed from July IPC. Each section of the agenda and minutes are mapped across to the different sections of the Hygiene Code to demonstrate compliance in these areas.	
	• References in policies need updating	31.08.13	The IPT have reviewed the C.diff, MRSA and Major Outbreak policies which were ratified by IPC on 19th September 2013 and submitted to the Procedural Document Group (PDG) for ratification in October 2013. Here the Major Outbreak policy was ratified and uploaded on to the intranet, but the MRSA and C.diff policies required further minor amendments to be made and resent for ratification to the PDG chair via email by 11th November 2013.	
	• Estates report needs time lines (ICC)	31.08.13	The IPC report will be updated with timelines – agreed at September IPC that this would be done, but is currently outstanding. It has been put on the agenda for the November IPC meeting.	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
	• Legionella Review happened in March and it didn't go forward to ICC	31.08.13	Legionella risk assessment has been completed. Due to be presented at September IPC, but not achieved. It has been put on the agenda for the November IPC meeting.	
	• NGH need to sell the good work we are doing	31.03.14	The Gangnam style video rap on hand washing is now included in the IP Trust Induction and has been nominated for a DH award. The 4th annual IPT study day is booked for October 24th 2013.	
	• Decontamination policy was not reviewed	30.09.13	This policy is now under review by interim Decontamination Lead.	
	• Diarrhoea – Trust policy to isolate within 4 hrs. Trust to review whether possible to isolate within 2 hours and audit compliance.	15.08.13	This was discussed at the August IPC. The 2012 DH guidance advocates two hours, the 2013 DH guidance is ambiguous – the IPT are currently liaising with the author to clarify best practice Best practice identified as 2 hours to isolate. C.diff policy updated to support this.	
	• Outbreak policy – states that a major outbreak will only be determined after 24 hours or the weekend. The wording of this should be used to demonstrate this is based on risk assessment and not time.	31.08.13	Wording reflected the observation of a possible outbreak not a confirmed one. Policy ratified by September IPC, ratified by the Procedural Document group in October and has now been uploaded on to the intranet.	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
	• MRSA policy / action plan does not include training of staff / patients to apply treatment.	TBC	TDA have responded to state that the policy does not need to be changed	
	• HCAI Trust Programme of work and Action plan to be reviewed and all action are identified and included	31.10.13	In the process of being reviewed, reference to the hygiene code is being revisited to check this reflects the programme of work. To present at the monthly IPC from September. Part of this is presented through various audits, and Alerts. Progress update: to be reviewed at IP team away day planned for November 2013.	
	• Appropriate timelines and accountability to be included in documents and regularly reviewed.	31.10.13	IP root cause analysis action plans have now been reviewed and evidence of actions attached to provide much greater assurance that actions have been completed and lessons have been learnt and shared across the trust	
	• Suggested the team may benefit from a part time analyst to support team with data inputting & analysis to then free up team to increase clinical work.	31.10.13	In discussion with Directorate manager regarding additional support. A further band six IP support nurse post has been sent to HR to go out for advert in November	
	• Root Cause analysis carried out as and when required. The paperwork submitted to the TDA suggested that these were doen by the IPCT in isolation and	30.09.13	A review of the multi team paperwork has been undertaken to reflect that this is a multi – disciplinary team approach	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
	didn't include the clinical teams. However, on discussion with the TDA, it was agreed that this was a multi-disciplinary approach.			
Ward visits	• High dusting	31.07.13	High dusting was discussed at July 2013 IPC and the findings of this review were disseminated to all matrons and housekeepers to ensure this remains integral to daily cleaning schedules. The IPT will monitor through the beat the bug ward visits.	
	• No decontamination wipes on BP machines	31.08.13	Posters sent out to all areas 30.7.13, areas are ordering-completed. Also presented at August IPC.	
	• Review of how long Urinary Catheters are in situ on the wards and when they need to be changed	31.08.13	IPT completed a urinary catheter point prevalence and on-going care audit in July. This also reviewed how long catheters were in situ and when they needed to be changed or removed. Results were fed back to the September IPC. The audit demonstrated that form 546 patients' who were reviewed, that there does not appear to be a problem with the length of time that a catheter remains in situ. Results showed: The average number of days for a short term catheter were: 7 days. Long term catheter: 24 days.	
	• HOUDINI Study – pilot study demonstrated a good reduction when implemented	31.08.13	To be discussed at October IPC with urology specialist nurses and matrons, however due to specialist nurses not being able to attend,	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
			this has been put back to November.	
	• Catheter Care – Trust not able to provide evidence to the challenge of removing devices as soon as they are no longer needed.	31.08.13	Monthly saving lives audits conducted on each ward regarding catheter care challenge the removal of catheters when no longer required. Assurance that this is satisfactory is gained annually by the IPT. In July 2013 the IPT audit confirmed that the average number of days for a short term catheter was 7 days and long term catheter was 24 days, both of which are within best practice guidance durations, which are 28 days and 12 weeks, respectively.	
	• Becket Ward – Toilet raiser dirty	31.07.13	Toilet seat was for one individual patient and has been removed	
	• No documentation for Chlorclean which should be made up daily. Compliance with COSHH needs to be reviewed in association with Chlorclean.	30.08.13	Screen saver sent out and poster sent out to matrons in July	
	• No fridge temperatures recorded	31.08.13	The fridge temperature check list has been updated and distributed across the organisation, with an addition at the end advising staff the procedure to follow if the temperature is not within the acceptable limits.	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
	• Paddington Ward's laundry area needs de-commissioning until the IP and estates issues have been dealt with	10.07.13	(1)Laundry area has been decommissioned and refurbished. Policy written and circulated for comments. To be ratified through Childrens Directorate Practice Development Forum in October.	
	• Two areas of concern: 1) Washing of laundry on site 2) Lime scale on taps	31.08.13	(2) Works complete.	
Infection Control Committee / Other Meetings	• I.C.C need another consultant representative who needs to tackle poor 'bare below the elbows', wrist watches, stone rings and general ICC compliance issues with junior doctors	31.08.13	Dr Brian Richardson, Chest physician is going to offer support until January, 2014 and following this Dr Rippin Consultant Physician is going to attend the meetings.	
	• Review of ICC sub groups (e.g. Water Group, Decontamination Group)	15.09.13	Completed	
	• Review of Governance Committees across the Trust	31.12.13	This is currently being reviewed by the Governance Lead	
	• Antimicrobial Stewardship group – poor attendance noted	31.08.13	The antimicrobial stewardship group is still not well attended, despite reminders sent to staff. Additional actions need to be identified to improve this. There are a few paragraphs to check on the antimicrobial stewardship guidance – to be uploaded onto the intranet in October	

Subject	Actions	Deadline Dates	Progress Update	Rag Rating
	• Last date since meeting of decontamination group noted 2011	30.09.13	ToR and membership is being reviewed – the monthly end users group is already in place and the decontamination group ToR have been completed, and the quarterly decontamination group meetings will be resumed in November once the interim Decontamination Lead returns from leave	
Miscellaneous	• Public facing website was difficult to navigate	31.10.13	Meeting arranged with Head of Communications in November.	
	• HPA have provided a simple epi-database (email dated 10th July) to assist with analytical support of C Diff.	31.07.13	IPT to use from August to analyse the post *C.diff* cases and feedback at monthly IPC any findings.	
	• Consider implementation of the C difficile passport as a health economy	30.10.2013	This has been reviewed on the website and it would appear that the supermarket ASDA has sponsored this in the North West. A *C.diff* task and finish group is planned for October to identify how this can be utilised across the Whole Health Economy with GP endorsement	
	• Blood culture contamination rates last monitored 4 years ago in 2009. Trust will undertake a repeat audit in the near future.	30.09.13	This was completed in August 2013. Blood culture contamination rate has reduced to 4.4%, which remains below the national average of 7%.	

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Infection Prevention and Control Annual Report 2012-2013
Agenda item	10
Sponsoring Director	Suzie Loader, Director of nursing, Midwifery, Patient and Nursing Services/DIPC
Author(s)	Patricia Wadsworth Lead Infection Prevention Nurse and Wendy Foster Acting Lead Infection Prevention Nurse
Purpose	To update the board on infection prevention annual report April 2012- March2013.
Executive summary Annual Report 2012-2013 on infection prevention and the service that is provided across the organisation.	
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 now has an annual target of 29 C.diff cases and in the first 6 months of the year has sustained 20 cases. There will be significant fines if the Trust exceeds 29 for the year, putting the Trust financial position at risk. This is a challenge for 2013-2014
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 is asked to discuss and where appropriate challenge the content of this report.	

Northampton General Hospital NHS
NHS Trust

Infection Prevention

&

Control

Annual Report

April 2012 to March 2013

CONTENTS

1.0 Executive Summary

This report outlines a summary of the key infection prevention and control initiatives and activities of Northampton General Hospital (NGH) for the year April 2012 to March 2013. It also provides assurance on the Infection Prevention and Control Programme and activity for 2012/13.

Infection prevention and control continues to be a national priority. Public opinion polls year on year demonstrate that cleanliness within healthcare settings and patient safety remain the top concern regarding the National Health Service (NHS) from a patient's perspective.

The Director of Infection Prevention and Control (DIPC) is responsible for producing an annual report. The purpose of the report is to inform the Board of Directors of progress in delivering the infection prevention and control programme. This includes providing the Board with assurance that appropriate measures are being taken to maintain the safety of patients and staff and to agree the action plan for sustained reduction and improvements in Healthcare Associated Infections (HCAIs).

There has been continuing focus on reducing both MRSA bacteraemia rates and *Clostridium difficile* rates, monitored by the Health Protection Agency (HPA) now Public Health England (PHE). This report identifies how the Trust has continued to exceed its target reduction in *Clostridium difficile* infection.

The number of post 48hrs MRSA bacteraemia infections during 12/13 was 2.

Screening for MRSA has continued within NGH, with elective screening achieving 99.6% compliance. Emergency screening during 12/13 achieved 96.00% compliance.

The number of *Clostridium difficile* infections was 30 compared to 52 cases in 11/12. The Trust remained below the contract ceiling of 36 cases.

Continued progress has been made with the 'Saving Lives' (DH, 2005) programme across the Trust to ensure compliance with the requirements of the 'High Impact Interventions' (HII's), with all staff held to account for the clinical care they provide. The profile of good hand hygiene practice has been a priority with compliance rates continuously improving. The 'Matron's Dashboard' has proved a successful tool in firmly embedding the culture of accountability and securing improvements in infection prevention. New and updated HIIs are added as these are developed.

The ongoing promotion of 'Ward to Board' and clinical accountability in relation to infection prevention has been further developed and updated with Executive and non executive Directors and the Trust Chairman undertaking 'Infection Prevention Inspections' in all ward areas, truly embedding the ethos that infection prevention is everyone's business.

However, the improved performance in relation to infection prevention and control within the Trust is no reason for complacency. The Infection Prevention and Control Team will continue to raise awareness of specific issues surrounding healthcare associated infections (HCAI's) with both our staff and local population and to promote and monitor clinical practice to minimise the risk of HCAIs for patients who have their care at Northampton General Hospital Trust (NGH).

2.0 Background

The Infection Prevention and Control Team (IPCT) provide infection prevention and control services for Northampton General NHS Hospital Trust. This report relates to infection prevention and control within the Trust and provides a summary of the work undertaken by the IPCT.

The Trust continues to base its infection prevention and control agenda on the national strategic framework, identified through the following documents:

- *Winning ways* (DH 2003).
- *A matron's charter: an action plan for cleaner hospitals* (DH, 2004).
- *The National specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes* (NPSA, *2007).*
- *Saving Lives: A delivery programme to reduce healthcare associated infection (HCAI) including MRSA* (DH, 2007).
- *The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections* (DH, 2008).
- *Board to ward how to embed a culture of HCAI prevention in acute trusts* (DH, 2008).
- *Safe, Clean, Care*: - reducing infections and saving lives (DH, 2008).
- The Operating Framework for 2010/11
- *Clostridium difficile* infection: How to Deal with the Problem (HPA/DH, 2009).
- Updated Guidance on the diagnosis and reporting of *Clostridium difficile* (DH,2012)
- The Francis Report 2013
- Supporting planning 2013/14 for clinical commissioning group
- Department of Health Planning Guidance-Everyone counts: Planning for patients 2013/14

The Trust is required to meet the duties of the Hygiene Code, NHS Litigation Authority (NHSLA) and the Care Quality Commission (CQC) standards.

3.0 Infection Prevention and Control Arrangements

The IPCT consists of the following:

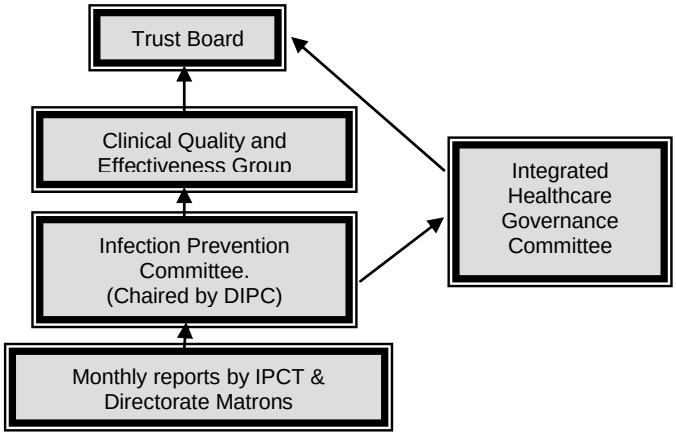
- Director of Infection Prevention and Control (DIPC): Director of Nursing, Midwifery and Patient Services
- Deputy Director of Infection prevention and Control (DDIPC) Deputy Director of Nursing
- Consultant Microbiologist
- Lead Infection Prevention Nurse (Band 8A)
- Infection Prevention Nurse (IPC qualified): 2 WTE (Band 7)
- Infection Prevention Support Nurse: 3 WTE (Band 6)
- Administrative/Surveillance support: 1 WTE (Band 3)

The Infection Prevention and Control Department has a budget to cover all nursing and administrative staff costs. The IPC Department includes: microbiology, virology, wound surveillance and epidemiology. The IPCT works with: pharmacy, facilities, directorate matrons, ward sisters, infection prevention and control link staff and sterile services. The core service includes an infection prevention and control advisory service, active infection prevention work, education and training throughout the organisation, audit, policy formulation and advice, surveillance, epidemiology, outbreak and control management.

In common with many other trusts, the workload of the core infection prevention and control team continues to increase. Examples of this include the requirement for training of all staff in infection prevention and control and hand hygiene. Another is in the reports (verbal and written) to demonstrate performance and compliance with guidance, standards, targets or reporting frameworks. The addition of a further infection prevention nurse has greatly supported the team to achieve this workload.

Infection prevention is central to the delivery of safe, cost effective healthcare. It impinges upon all aspects of healthcare delivery, and consequently has a unique place in the Trust. Throughout 2012-13 the Infection Prevention and Control Team (IPCT) were actively involved in managing the risk of infection both to patients and staff. This involved identifying risks of infection and advising of interventions likely to minimise or eliminate those risks. The team has worked with Directorates to ensure that infection prevention and control remains everybody's responsibility and ownership for it can be demonstrated at all levels in the Trust.

Infection Prevention and Control Governance and Reporting Arrangements at NGH



4.0 Governance

During this period, Trust wide improvements were made in the governance structure. There was also an emphasis on clinical engagement and participation in risk, safety and quality. This included ownership of infection prevention and control issues by staff are now discussed and supported at all levels from board to ward.

The work undertaken during this period reflected Trust priorities and the Infection Prevention and Control Annual programme and objectives.

4.1 DIPC Reporting to the Board

The Director of Nursing, Midwifery and Patient Services is the designated lead; Director of Infection, Prevention and Control (DIPC). She reports directly to the Chief Executive and the Board and is the chair of the Infection Prevention and Control Committee (IPCC). The DIPC reports to the Trust Board on a monthly basis, including monthly surveillance figures and any matters by exception. The DIPC meets frequently with the Consultant Microbiologist and Lead Infection Prevention Nurse as well as quarterly meeting the IPCT.

The Chief Executive holds the ultimate responsibility for all aspects of the Infection Prevention and Control within the Trust.

The Infection Control Doctor (ICD) is also a consultant microbiologist and is the deputy chair of the IPCC.

The Lead Infection Prevention and Control Nurse is responsible for the operational management of the Infection Prevention and Control Team and for ensuring that the Infection Prevention and Control Plan is embedded.

The Infection Prevention and Control Nurses and support nurses provide clinical infection control advice and support Trust staff in the delivery of the plan.

4.2 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets monthly. The membership has been reviewed to ensure all staff groups are represented and participating, with the terms of reference updated (Appendix 1). Decontamination and sterile services also report through the IPCC.

4.3 Integrated Healthcare Governance Committee (IHGC)

The IHGC is a sub committee of the Trust Board and reviews areas of concern arising from the IPCC by exception.

4.4 Links to Clinical Governance and Patient Safety

The Infection Prevention Team reports the Trust position in relation to infection prevention and control to the Clinical Quality and Effectiveness Group (CQEG) on a monthly basis. The Directorates include their monthly infection prevention data within their own quarterly reports to CQEG. Learning from MRSA bacteraemia infections is reported through the Patient Safety Learning Forum to representatives from all Directorates for dissemination to Directorate Governance Groups.

4.5 Northamptonshire Whole Health Economy HCAI Group

The DIPC, Consultant Microbiologist and members of the IPCT are active members of the whole health economy group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equal good quality.

4.6 Infection Prevention Focus Group

The Infection Prevention Focus group is one of six similar groups first established in August, 2010 as part of the Patient and Public Involvement membership strategy at NGH. The group has continued to meet every two months and has also carried out regular spot checks for visitors hand hygiene against a predetermined schedule of wards. During the year, three new recruits joined the group, which enabled five teams of two to be formed. Evening spot checks were introduced, and as expected more visitors were recorded compared to afternoon sessions.
Compliance figures continued to be a cause for concern as illustrated by the following table:-

Apr '12	May '12	June '12	July	Aug '12	Sept '12	Oct '12	Nov '12	Dec '12	Jan '13
24%	39%	21%	19%	10%	15%	24%	33%	36%	12%

These figures represent overall compliance for visitors both entering and leaving wards however the figures for entering are significantly higher than those for leaving. Nevertheless, the low point of 4.5% in January has highlighted the need for a fresh approach. This matter was addressed at the March meeting and a number of proposals were agreed. These included:

- Audits by identifying 3 high risk areas which it is essential that hand gel audit takes place, undertake hand hygiene audits in these 3 areas, implement methods and communication to improve hand gelling.
- Undertake further foaming sanitiser audits and If new methods successful, roll out to 6 mores wards.
- Checks to carry out a "secret shopper" audit as if a visitor to the hospital also noting where foaming sanitiser units are and signage.
- Check all leaflets where infection prevention and control is mentioned, pre admission documentation and identify location of leaflets and how visitors and patients access these and question visitors and patients if they have seen these leaflets.
- To question visitors as part of audit and review current questionnaire for the foaming sanitiser units.

Commencing in May 2013, three high risk wards have been selected for enhanced attention on the basis of their particular need for good hand hygiene. These are Oncology, Vascular and Renal wards. The ideas listed above will be implemented on a more intensive basis during the first three weeks in May 2013 and when the results have been analysed it is hoped that improvements can be adopted elsewhere.

During the year, the Infection Prevention Team identified certain gaps in the evidence required by NICE for their "Quality Improvement Guide for Prevention and Control of Healthcare Associated Infections". The Infection Prevention Focus Group was invited to devise a questionnaire which was subsequently used to identify the level of knowledge and awareness of infection prevention amongst patient visitors and other hospital users. This revealed some potential for improvement in these two areas and the results have been fed back to the infection prevention team so that gaps may be closed.

It is not within the remit of the focus group to monitor hand hygiene compliance of staff members and they are aware that wards have their own disciplines for this purpose. However, it is perhaps relevant that team members frequently observe and report incidents of non-compliance by many different categories of staff and have drawn this to the attention of their professional colleagues on the focus group.
As can be seen from these comments, there is considerable scope for the Focus Group to continue its work in the coming year when it is hoped that much needed improvements to visitors hand hygiene will be made.

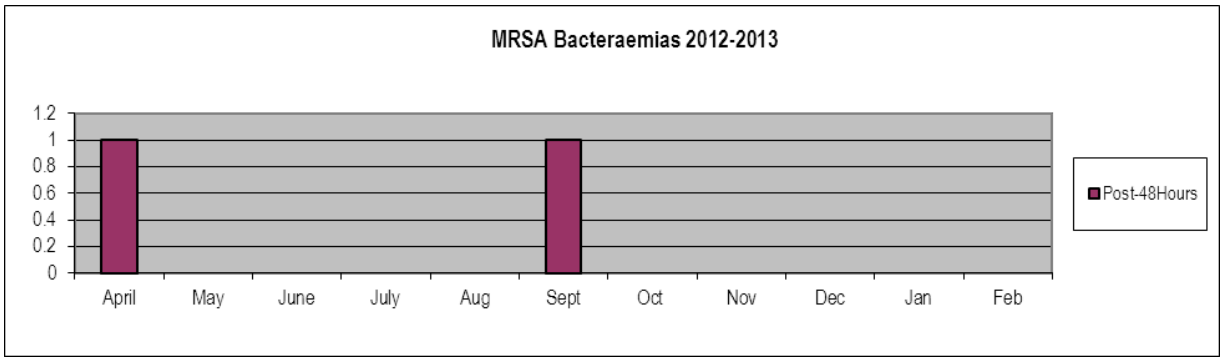
5.0 National and Local Surveillance

The IPCT and Infection Prevention and Control Department undertake the following national and local surveillance:

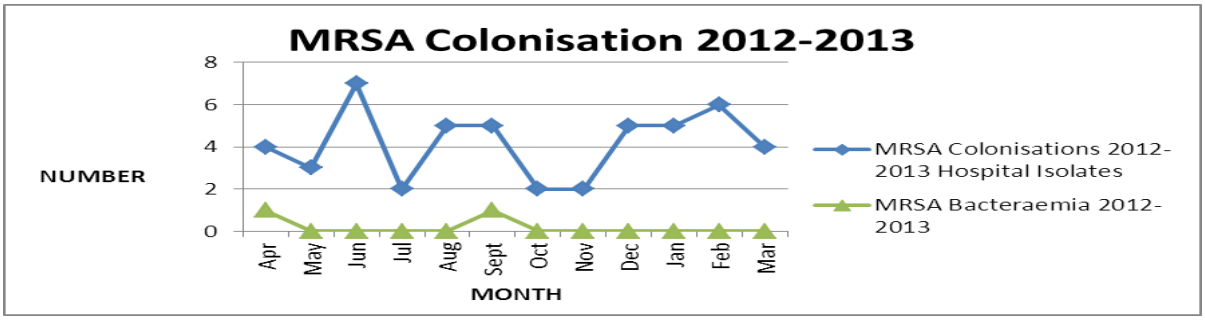
- National MRSA bacteraemia reporting
- National MSSA bacteraemia reporting
- National E coli bacteraemia reporting.
- National *Clostridium difficile* reporting
- National Glycopeptide Resistant Enterococci reporting
- Surgical site infection reporting
- Local surveillance of all 'Alert' organisms and an extensive surgical site surveillance programme.

5.1 MRSA bacteraemia

The reporting of MRSA bacteraemiasis is mandatory for all NHS Trusts. The ceiling for this year was 1 post case. The Trust was attributed 2 post 48 hours cases in total.



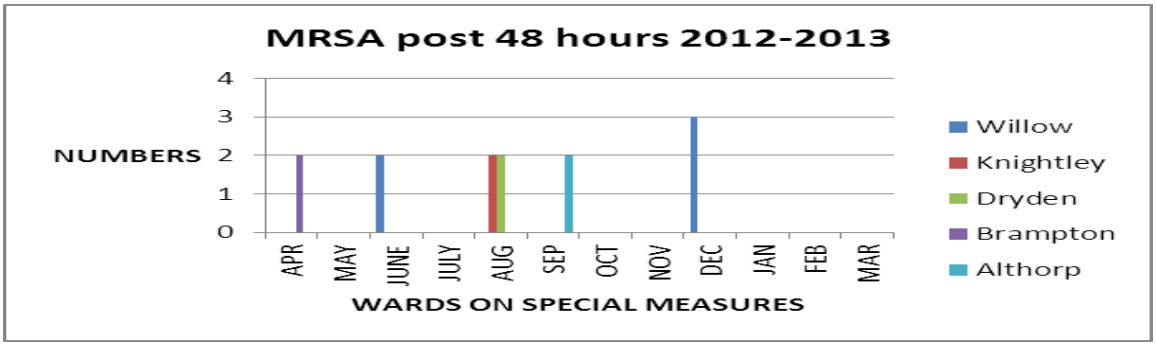
Patients newly identified with MRSA Infection and Colonisation:



The Trust continues to work with the Clinical Commissioning Group (which at this time was the Primary care Trust, PCT) and the whole health economy in continuing to promote excellent HCAI policy and practice.

The IPCT identified a range of 'special measures' (Appendix 2) which were implemented on any ward that had 2 or more incidences of colonised new patients with MRSA or *Clostridium difficile* in a 28-day period. The graph below reflects the wards that have been on special measures for MRSA colonisation. The actions from all these special measures are fed back to the board monthly through the board report.

Wards - that have 2 or more incidences of MRSA colonisation



5.2 MRSA Screening

Northampton General Hospital achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the DH.The overall compliance for the year for electives was 99.6% (patient specific verified data) and the overall compliance for non-electives was 96.0%. Efforts continue to achieve greater compliance.

5.3 MSSA bacteraemia

There is a mandatory requirement for all NHS acute trusts to report Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia from the 1st January 2011. This reflects the zero tolerance approach that the Government has made clear that the NHS should adopt for all Healthcare Associated Infections (HCAIs), while recognising that not all MSSA bacteraemia are HCAIs. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. What has been achieved is a remarkable turnaround from where we were five years ago. It is believed that the introduction of mandatory surveillance for MSSA is timely and appropriate to help establish the extent to which these are healthcare associated. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The trust records MSSA bacteraemia cases separately on the web-based system, as they do already for MRSA bacteraemia and the Chief Executive will sign-off on the 15th of the month. The first MSSA Chief Executive sign-off for the January 2011 mandatory data was the 15 February 2011.

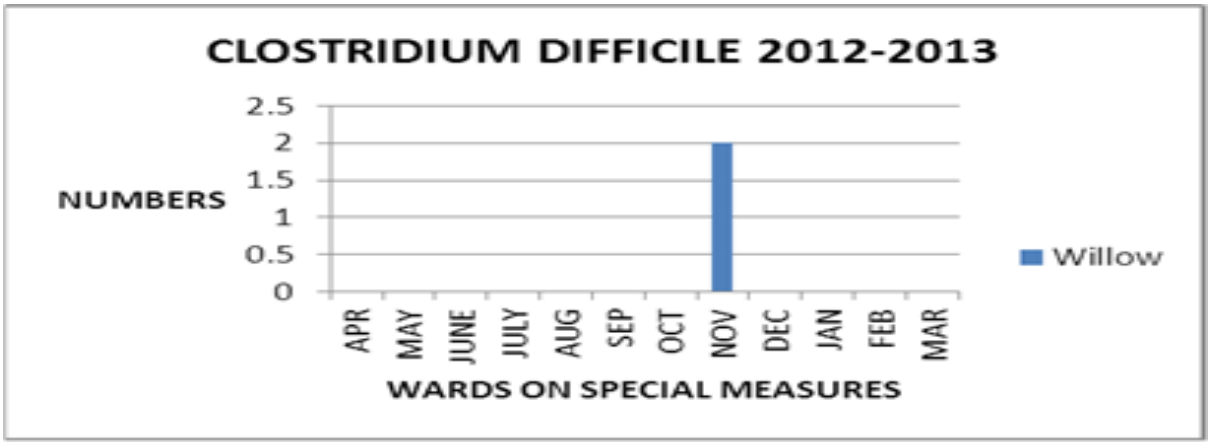
Trusts have not been set a trajectory for MSSA (meticillin-sensitive *Staphylococcus aureus*) bacteraemias. However, we have been collecting data for the past 3 years. This year 2012-13 we identified 11 “post-48 hour” hospital-onset cases of MSSA bloodstream infection. Root cause analysis were undertaken on these cases and the findings improved practice relating to central venous catheters (CVC) in areas such as haematology, oncology and renal medicine.

The IPCT believes the number can be reduced even further if we continue to focus on CVC care and spread the lessons learned/good practice to other areas where CVCs are used. In addition junior doctors need to ensure blood cultures are taken promptly on admission in patients who may have a *Staphylococcus aureus* bacteraemia, to properly identify community onset cases and to take extreme care when performing blood cultures on patients with exfoliative skin conditions, as *Staphylococcus aureus* bacteraemias occasionally occur as a contaminant. Nonetheless, this still has to be reported as a case.

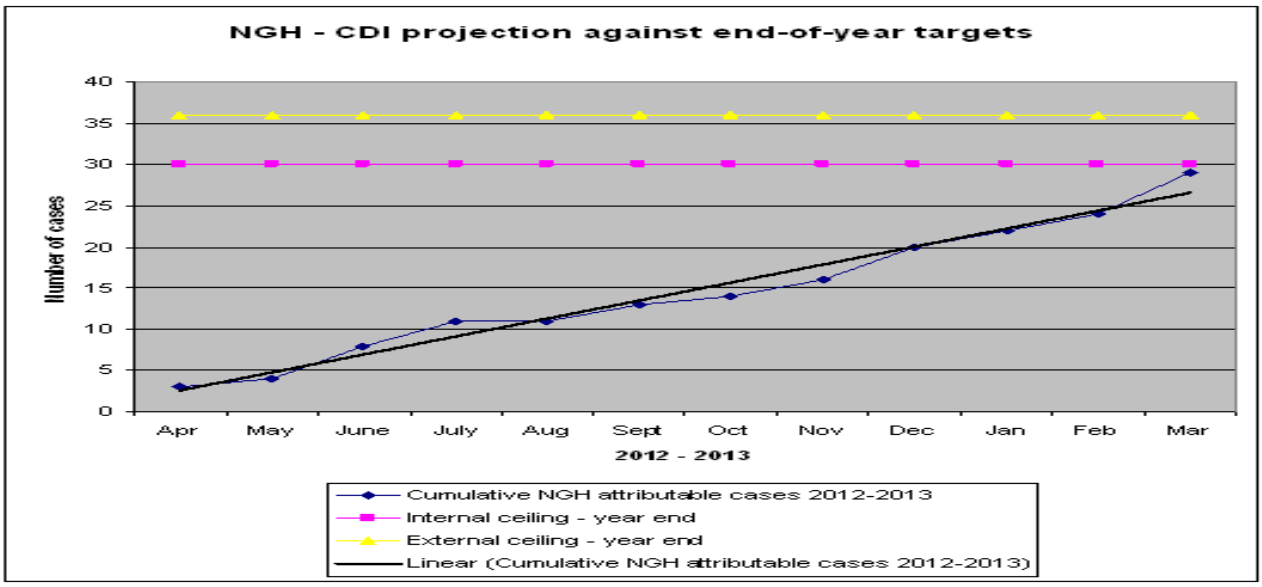
When reviewing post 48 hours admission MSSA bacteraemias from April 2012 to March 2013 we have identified areas related to long-term central venous access devices, surgical site or soft tissue infections and *Staphylococcus aureus* urinary tract infections leading to urosepsis.

5.3 *Clostridium difficile*

The 2012/ 2013 ceiling for cases of *Clostridium difficile* associated diarrhoea (CDAD) was 36 by the PCT contract. The Trust had 30 CDAD cases (post 3 days) attributed to the Trust during 12/13.



Special Measure actions were implemented for wards that have two or more incidences of *Clostridium difficile* in a 28-day period. Willow ward was the only ward that had been on special measures in this period due to having 2 incidences of CDAD in November. Allebone was put on special measures as a preventative measure due to the ward having one CDAD in December and one in January.



The weekly C.diff review team comprising of a Consultant gastroenterologist, Consultant microbiologist, a member of the infection prevention and control team and the antimicrobial pharmacist continues. All patients who have *Clostridium difficile* have their antibiotic management proactively reviewed.

While it is a significant achievement to have met the 2012-13 target the "ambition" set for us for 2013-14 is a further reduction to 29 cases. This will only be met by maintaining the high standards of environmental cleanliness and careful antibiotic prescribing that we have seen this year. Until now we have reported all *C.diff* toxin A and B positive cases. The clinical areas must try to ensure that all patients admitted with diarrhoea have a sample sent within the first 3 days post admission to ensure correct case attribution.

5.4 Local Surveillance of ESBLs

A local surveillance system to monitor the numbers of infections with ESBL (Extended- Spectrum Beta-Lactamase) producing coliform in the south of the country has been established based on reports generated by the laboratory.

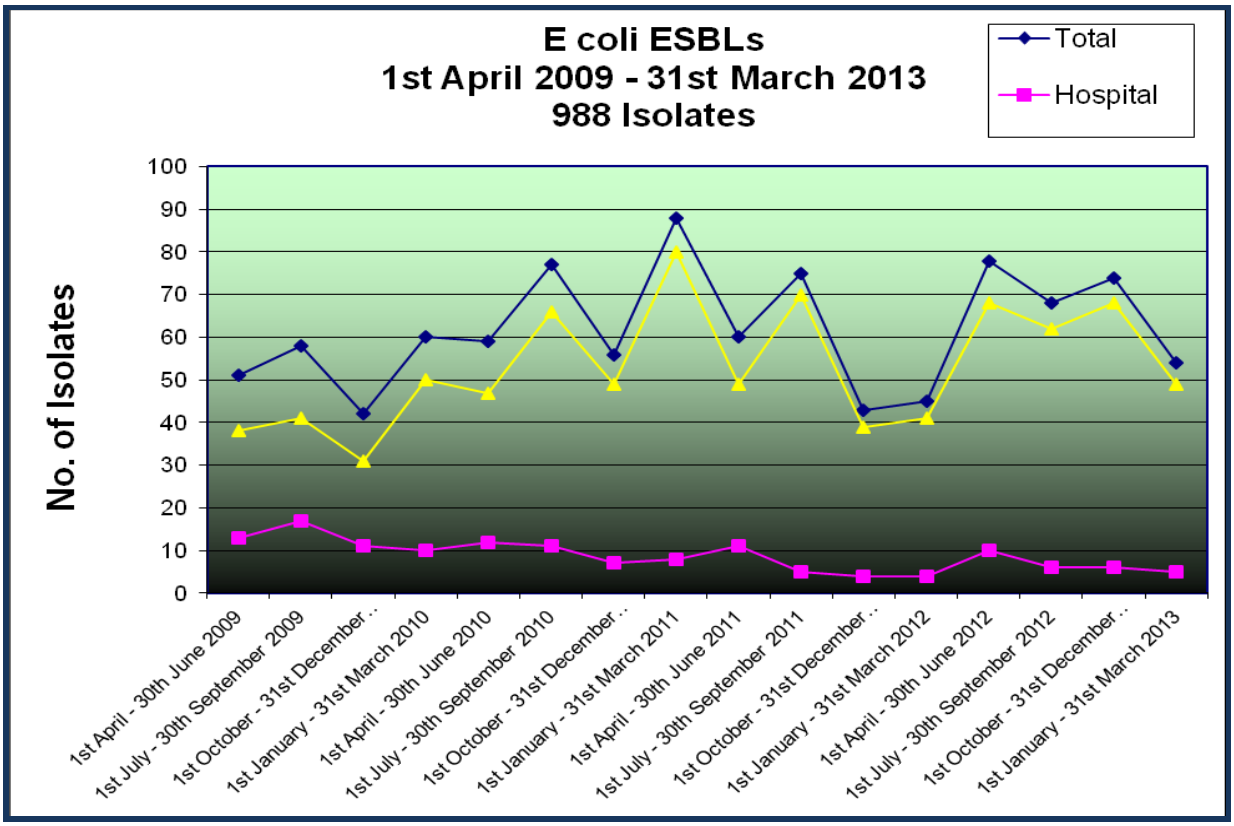
ESBL (Extended-Spectrum Beta-Lactamase)-producing *Escherichia coli* are antibiotic-resistant strains of *E. coli*. *E. coli* are very common bacteria that normally live harmlessly in the gut.

Infections caused by ESBL-producing *E. coli* are a growing worldwide phenomenon and are not unique to the United Kingdom (UK). The Public Health England (PHE) formerly the Health Protection Agency is one of the leading institutions worldwide in terms of research into this area and has been providing advice about these infections for many years and, in particular, increasing frequency of these infections.

Since 2003 the PHE has been working with NHS hospital microbiologists to ensure they are aware of these infections and are able to advise and provide information to their local GPs and hospitals about their diagnosis and treatment. The PHE has also published information in scientific journals and issued advice directly to GPs via its

website and leaflets. It also continues to review the activity of new antibiotics against bacteria with these enzymes.

Antibiotic resistance in micro-organisms is an ongoing challenge to the health care system. There is still a great deal to learn about the epidemiology, antibiotic resistance patterns and risk factors for these organisms.



In 2012-2013, out of 169 E.coli bacteraemias only 39 were attributed to hospital care in the current admission (post 48 hours) and were made up of:

Urosepsis	13
Unknown	8
Peritonitis	5
Neutropenic sepsis	5
Biliary sepsis	4
Line sepsis	3
Wound sepsis	1

The majority of these *Ecoli* bacteraemia admissions were from the community with urinary and biliary tract sepsis.

6.0 Outbreaks

6.1 Norovirus

Norovirus is estimated to cost the NHS in excess of £100 million per annum in years of high incidence. Approximately 3000 people are admitted to hospitals in England with norovirus each year and this infection spreads very quickly and places a huge burden on healthcare services.

New guidelines were launched in November 2011: Guidelines for the Management of Norovirus in Acute and Community Health and Social Care Settings. These were produced by the Norovirus Working Party, a multidisciplinary group from the Healthcare Infection Society, Health Protection Agency (now PHE), Infection Prevention Society and other stakeholders. The document focuses on organisational preparedness and actions required during and after outbreaks. One of the key elements within the guidance is the ability to close small areas, e.g. bays, rather than whole wards if the environment permits this. This reduces the impact on patients and healthcare services as the operational impact may be less severe.

During April 2012 to March 2013 NGH had no Norovirus outbreaks.

6.2 Scalded Skin Syndrome(SSS)

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

Between December 2012 and March 2013, a total of 8 babies were diagnosed with SSS isolating the same SPA type and toxin profile. The initial 7 babies were born between December 2012 and January 2013, the 8th baby was born in March 2013.

Consultant microbiologist reported on 4/4/2013 that 209 sets of swabs from staff had been received, of which 205 had been reported on. *Staphylococcus aureus* had been isolated in about 20%. One of the isolates was confirmed as the outbreak strain. This member of staff was treated and closely followed up by Occupational Health.

One of the actions from a previous meeting was to redesign the cleaning/environmental audit providing a common sense approach. A meeting has been held involving Hotel Services Lead, Domestic Services Lead, Housekeeper, Matron, patient and public focus group member and a member of the infection prevention team. The action from this meeting was to put together an educative power point presentation which can be accessed via the 'Street' pre undertaking the audit. This incorporates prompts that are recommended in the Patient-Led Assessments of the Care Environment (PLACE) which is the new system for assessing the quality of the patient environment.

The executive lead and non - executive lead, Matron and infection prevention nurse monthly inspection is also being reviewed and a new checklist list also with prompts is being produced. The new presentation may prove invaluable prior to undertaking this inspection too.

7. Special measures for Vancomycin Resistant Enterococci (VRE)

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

The renal ward had 2 patients identified with Vancomycin Resistant Enterococci (VRE) within a 28 day period during the month of February 2013. The ward was put onto special measures. As part of the Special Measures an RCA tabular timeline was undertaken on both patients. This identified that for one patient the Octenisan antimicrobial decolonisation treatment, which should be prescribed for all renal patients undergoing renal dialysis, was not promptly prescribed. An audit of decolonisation treatment was undertaken by the Infection Prevention Team and the results and actions discussed at the May 2013 Infection Prevention and Control Committee. There were also gaps in the documentation and the following of the sepsis protocol. An action plan has been produced. Both timelines show that both renal patients were compromised patients and at a greater risk of becoming colonised with VRE. Following Special Measures there have not been any further cases of VRE on the renal unit.

7.0 Antimicrobial Stewardship

7.1 Compliance to Trust antibiotic policy

The point prevalence audits were performed by Clinical Pharmacists at the Trust over a one day period (21st March 2012 and 2nd October 2012). The aim was to audit antimicrobial prescribing at the Trust and compliance to the Trusts Antibiotic Policy. This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Criteria 9 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship, there should be an ongoing programme of audit, revision and update.

March 2012:

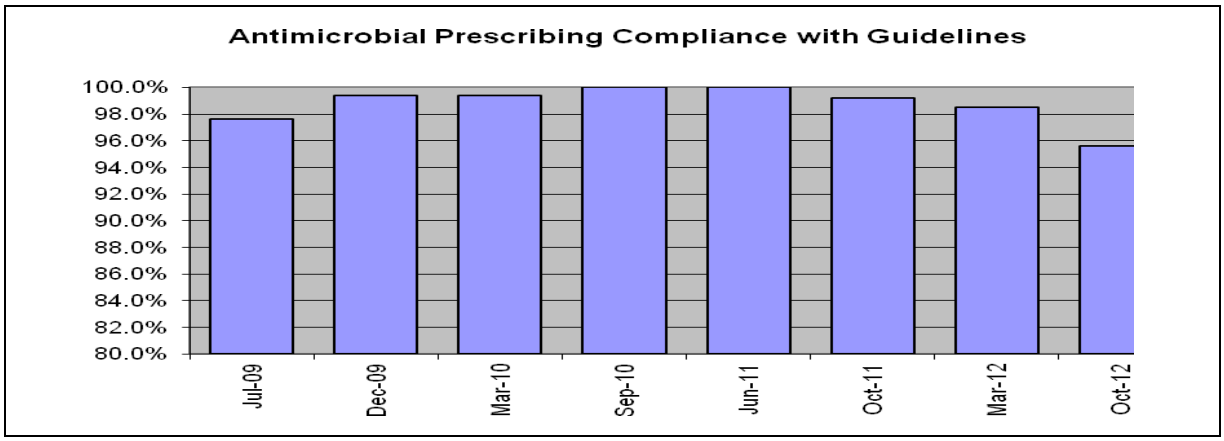
Descriptor	Number	Proportion	Comments
Total number of patients seen	**456**		The average number seen as per previous audits: 466.25 patients.
Number of patients on Antibiotics	**164**	**35.96%**	The median number of patients receiving antibiotics as per previous audits is 26.78% therefore a higher number noted in this audit.
Total number of antibiotics prescribed.	**207**	**1.26 per patient**	
Number adhered to the policy	**204**	**98.5%**	The average compliance rate as per previous audits is 99.25%.
Number of intravenous (IV) prescriptions	**120**	**57.9%**	The number of patients on IV antibiotics in this audit is lower compared to the average percentage from previous audits (61.7%).
Number of oral (PO) prescriptions	**87**	**42%**	Previous audits show an average of 38.95% of patients on oral antibiotics. 16 prescriptions had been switched from IV treatment.
Average duration of IV antibiotics	**4 days**		The duration of administration for IV antibiotics is higher then the average of 3.48 days from previous audits. There were a few patients with severe infections on long-term

Descriptor	Number	Proportion	Comments
			treatment hence longer treatment.
Average duration of PO antibiotics.	**2.9 days**		Antimicrobials should be prescribed for a maximum of seven days. Therefore the duration of treatment with oral antibiotics was within the recommended duration.
Duration of antibiotic administration stated on prescription chart.	**66**	**31.9%**	All these were within the recommended durations stated in the Trust Antimicrobial Guidelines however the figure was lower than that noted in the previous audit of 41.6%.

October 2012:

Descriptor	Number	Proportion	Comments	
Total number of patients seen	**547**			
Number of patients on antibiotics	**158**	**28.9%**	This is comparable to October 2011 when 28.6% of patients were prescribed antibiotics and lower than March 2012 when it was 35.96%.	
Total number of antibiotics prescribed.	**206**	**1.3 per patient**		
Number adhered to the policy	**197**	**95.6%**	Valid reasons for non-compliance; • Micro approved = 16 (7.8%) • Based on culture and sensitivities = 2 (1%) • No guidelines for infection =12 (5.8%) 9 prescriptions (4.4%) did not comply with NGH antimicrobial guidelines.	
	(includes valid reasons for non-compliance)			
Number of intravenous (IV) prescriptions	**117**	**57%**	This is much lower than October 2011 (68.8%) but comparable to March 2012 (57.9%)	
Number of oral (PO) prescriptions	**89**	**43%**	This is similar to March 2012 (42%) and higher than October 2011 (32.6%) 26 prescriptions had been switched from IV treatment.	
Average duration of IV antibiotics	**4.3 days**		The average IV course for the previous two audits was 3.85 days. This increase may be due to a number of patients on long term courses that have skewed the data.	As this is a point prevalence audit data is not available for the total course lengths actually given to each
Average duration	**5.4 days**		There has been an	

Descriptor	Number	Proportion	Comments	
of PO antibiotics.			increase in average course length from 3.3 days in October 2011 and 2.9 days in March 2012.	individual patient.
Duration of antibiotic administration stated on prescription chart.	**90**	**44%**	Although this has increased from 31.9% in March 2012 and 38.4% in October 2011 more work needs to be done. The new chart which has a prompt box for antimicrobial course length was launched in May 2012.	



These biannual audits will be repeated and are scheduled for April 2013 and October 2013. If poor compliance is noted, then this is followed up immediately, for example each report comments on the very low numbers of prescribing deviations. The Antimicrobial Stewardship Group discusses action planning which needs to be integrated with other performance management processes [Medication Safety Group and Head Nurse Indicators etc].

7.2 Training initiatives

The infection prevention and control team have delivered many training sessions throughout the year, for example regularly performing infection prevention and control training on the Trust induction. We are part of the Trust's cluster days where staff can access mandatory training as required. Aspiring to Excellence saw the infection prevention team being involved with training 'very' junior doctors. The Infection prevention team have also had a regular place with the Trusts anaesthetists on a Friday afternoon. It could also be viewed that as part of the role of an infection prevention nurse, on a daily basis infection prevention is being conveyed to staff across the organisation. The University of Northampton also benefits from training provided by the infection prevention team to student nurses.

7.3 Antibiotic campaigns

European Antibiotic Awareness Day provides a platform to support and promote national campaigns about prudent antibiotic use in the community and in hospitals. On November 18th 2012 awareness was raised via a presentation on the Trusts corporate screensaver focusing on the Department of Health's Antimicrobial Stewardship Start Smart – Then Focus campaign.

7.4 Antimicrobial Stewardship Group

An Antimicrobial Stewardship Group has been set up. The first meeting was July 2012. The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults admitted to hospital.

8.0 Saving Lives

The Trust has taken significant steps in embedding the Saving Lives programme into daily activities of clinical care. The overall aim of Saving Lives is to ensure that all staff recognise how they can contribute to reducing infection rates and adopt best practice to achieve this. High impact interventions are used to reduce the risk of healthcare associated infection. Each of these interventions has a simple evidence based tool that reinforces the actions that clinical staff must undertake 'every time' for key procedures in order to significantly reduce infection. The aim is to increase the reliability of clinical processes and reduce unwarranted variation in care delivery. The compliance ranges from 80% to 100% each month and is RAG rated accordingly.

8.1 Matrons Dashboard

The Matrons are required to populate an Infection Prevention compliance chart each month with the percentages from the high impact interventions within the Saving Lives. The results are RAG rated and fedback at the IPCC, receiving constructive challenge from the DIPC. Areas that are non compliant are raised by exception to the Integrated Healthcare Governance Committee (IHGC) to report actions being undertaken to resolve any issues.

9.0 The Health Assure formally the Performance Accelerator

The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring health care associated infections by compliance with the Hygiene Code.

The Hygiene Code evidence has been loaded onto the Health Assure platform which is on-line corporate software that provides boards and management teams with assurance and information needed to plan, manage and report on key performance indicators.

All the evidence has been uploaded and there is one area that is partially compliant (amber).This is criteria 9 which is to have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections.

These policies relate to: the Estates Building and Refurbishment Policy, and Waste Management Policy.

- The Building and Refurbishment Policy has been out for consultation and the deadline was 2nd March 2013. The responses are now back, therefore this is partially met and this can now go to the next stage. As part of this new forms have been completed and any new build will be reviewed by IPC and signed off accordingly.

- The Waste Management Policy. The waste management policy had been ratified will be compliant with CQC and the Hygiene Code.

10.0 Infection Prevention Study Day

The third Infection Prevention annual awareness day known as the "Ugly Bug Ball" was held at the Cripps Postgraduate Centre on 29th November 2012

The event was well supported by our team of NGH staff and was also attended by several suppliers. We had 50 staff attend and the topics varied from Group A Strep and Tuberculosis.

Over fifty members of staff mainly infection prevention link nurses attended the event. Suzie Loader, Director of Nursing, Midwifery & Patient Services & Director of Infection Prevention and Control gave the welcome address.

Speakers included our own Dr.A.Bentley, Consultant Microbiologist, Maggie Chappell Tuberculosis Specialist Nurse and Doreen Marsden founder and chair of The Lee Spark Necrotising Fasciitis Foundation

The day was very successful, and the evaluation forms provided some excellent feedback. We had some very interesting presentations from speakers on topics including HIV, necrotising fasciitis, and whooping cough.

The evaluation forms provided valuable feed-back, feedback comments about the day included:

- "I enjoyed the study day and found it very informative"
- "Very moving, incredible and informative talk on necrotising fasciitis, Interesting patient perspective"
- "The study was absolutely brilliant as always! "

Sponsorship for the day was provided by company representatives who also provided exhibition stands that were supported well by the candidates during coffee and lunch break. Prizes of vouchers and chocolates were given to the winning candidates who completed the quiz questions answers were found at the exhibition stands.

2012-2013 also saw the success of hand washing disco style. Where a member of the infection prevention team, matron, nurses, healthcare assistant, doctors and Consultants and many others took part in a 'funky hand washing video' bringing Ayliffe's 6 stage hand hygiene technique into the present day. This went viral and has been utilised for teaching the nursing students at the University of Northampton. Many other infection Prevention teams have contacted NGH with positive comments and wanting to undertake something similar. It was also highlighted on GMTV that NGH had made hand hygiene fun.

11.0 Ward to Board

To support the on-going HCAI agenda across the Trust all Executive and Non Executive Directors and the Trust Chairman participate in an 'Infection Prevention Inspection' on a monthly basis. This 'inspection', facilitated by the IPCT involves

visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive Directors visits 2/3 areas and audits the clinical area against set criteria. Data from the visits is collated by the IPCT for the monthly IPCC to review. This is being updated, reviewed and planned to “look outside the box” in the next year 2013/14.

12.0 The 2012/13 IPCT Annual Plan

The IPCT Annual Plan (Appendix 3) provides an overview of the commitment to prevention and control of infection by the IPCT within the clinical directorates. The Infection Prevention and Control audit is a vital component of robust infection prevention and control service. The objectives of the audits are to inform the Trust of their level of compliance to national IPC standards, local policies and procedures and allow improvements to be made based upon findings. It also identifies target areas for training.

Review of Annual Plan

The annual plan was achieved except for one area regarding the further development of an ESBL database. The department was not successful with the anticipated web based surveillance application, ICNet. However a business case is currently being undertaken.

The following audits were undertaken during the year:

Infection Prevention Audits April 2012- March 2013

Audit	Overall Hospital Score
Sharps	98%
Environment	91%
Linen	94%
Isolation	98%
Waste	95%
Total Hospital Compliance	95%

13.0 Training and Education

Development opportunities for the members of the infection prevention and control team are agreed at annual appraisal.

13.1 Induction training

Induction prevention and control training is provided to all new staff during induction training. This session covers a basic awareness of standard precautions including hand washing, MRSA, *Clostridium difficile,* cleaning, safe handling and disposal of sharps, management of sharps injuries and the transmission of infection. Induction training is also provided for junior doctors.

13.2 Mandatory Update training

Infection prevention and control has been included in the mandatory training programme being delivered by cluster days. The main objectives of this training is to provide an update for all staff on current infection control issues, national guidance and the importance of hand hygiene and standard precautions.

13.4 Ward and Department Based Training

Numerous ad hoc training sessions have been provided to staff in their work place. These have been either requested by the ward and department staff or as a result of audit or special measures. However the greatest challenge has been releasing staff from clinical areas to attend training.

14.0 Infection Prevention Annual Programme For Surgical Site Surveillance 2012/13 (Appendix 4)

Since 2004, all NHS hospitals where orthopaedic procedures are performed are required to carry out a minimum of three months surveillance of surgical site infections. This information is reported to the Health Protection Agency who analyse the data and provide reports for local hospitals and produce a national report.
This year the IPT developed and collaborated with T&O to introduce a continuous surveillance of fractured neck of femur (NOF) which is proving very successful.

15.0 Hospital cleaning

The Patient Environmental Action Team (PEAT) which is an annual assessment of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the nonclinical aspects of patient care including environment, food, privacy and dignity. The assessment results help to highlight areas for improvement and shares best practice across healthcare organisations in England. The IPCT is always present at these assessments and we continue to achieve acceptable scores in the majority of the assessment process. This will be replaced in 2013/14 for Patient-Led Assessments of the Care Environment (PLACE) which is the new system for assessing the quality of the patient environment.

Monthly cleaning audits are performed in all directorates with the table below providing a monthly average and overall average at the end of the year.

2012/2013	
Month	**%**
April	97
May	96
June	95
July	94
August	95
September	96
October	97
November	97
December	97
January	97
February	96
March	97
Average	96

19.0 Decontamination Arrangements

Sterile Service Unit

The Sterile Service department processed nearly 90,000 trays and procedure packs between April 2012 and March 2013, the department also took on an additional new contract for providing an additional sterile service provision for a local private hospital, this started during February 2012 providing the Trust with an additional income.

The Sterile Service Department successfully demonstrated compliance against European and British decontamination guidance during a one day external audit and have maintained its ISO9000 accreditation for 2012/13.

The existing NVQ level 3 qualifications in decontamination have now been replaced with the: “Institute of Decontamination Sciences Technician Certificate”, we currently have 4 technicians enrolled on this course and are working through the syllabus, exams will take place in London at the beginning of 2013.

Our traceability system was fully updated including new hardware and switching to the new software. The system will allow for real time despatch of product to our users, this will provide the department to monitor its key performance indicators within our service level agreement.

Following the withdrawal and review of certain decontamination guidance papers (HTMs Hospital Technical Memorandums) the new CFFP (Choice Framework for Local Policy) guidance was made available during March 2013, these documents include:

- CFPP 01-01 2013 Management and decontamination of surgical instruments used in acute care
- CFPP 01-06 2013 Management and decontamination of flexible endoscopes
- HTM 01-05 2013 Decontamination in primary care dental practices

Medical Equipment Library

The Medical Equipment Library (MEL) has been working in conjunction with Patient and Nursing Services to streamline the way the Trust orders Ad-Hoc rental mattresses. The entire order process has been looked over and rewritten to improve mattress availability both in and out of working hours.

We have introduced a T Card system to aid the library in the tracking of VAC therapy pumps, Infusion and Syringe pumps and the new T34 24hr Syringe Drivers. The chart gives the MEL team and immediate picture of equipment distribution and the ability to clearly mark out items that have been on loan for long periods of time.

Over the next month the MEL is trialling along with Patient and Nursing Services use of the ICE internal request system to order mattresses and cushions from the Equipment Library. If successful this will be rolled out across the trust and replace telephone orders for therapeutic equipment.

Medical Equipment Library will be heavily involved in the implementation of the new Autologic pressure relieving mattress from Arjo-Huntleigh over the coming months.

This system is being put into the Trust to enable us to remove all overlay systems. The implementation of 180 new systems is aimed at reducing the need for ad-hoc orders and provide patients with another medium to high risk therapeutic mattress system.

Endoscopy
Following the final installation of two Wassenberg Automatic Endoscope Re-Processors (AERs) and an Elga Reverse Osmosis (RO) water system were installed in April 2012 and Final commissioning and pdq testing which was carried out mid May 2012, the machines were released for use.

The department is now fully equipped with new AERs, Drying Cabinets and RO water systems. A new scope transportation system manufactured by lancer has been delivered this will be commissioned during May 2013. The scope transportation system allows flexible endoscopes to be transported safely in a vacuum sealed plastic pouch between users and the endoscopy reprocessing room.

Training was also carried out with all staff during and after the installation including the process management system (electronic traceability system) additional days have been allocated throughout the year both at Northampton and Sheffield (Wassenberg's new headquarters)

Trust wide
Following the recent MHRA safety alert bulletin regarding hospitals' to review the rep-processing of TOE /TEE and intra body cavity probes (transducers) it was agreed to replace the existing cleaning wipes with a high level disinfectant wipe for intra body cavity ultrasound probes. Working closely with the radiology department clear protocols have been implemented for cleaning and disinfecting all ultrasound probes across the Trust.

Forward Plan 2012 - 13

- Plans are in place to remove paper quality system and implement an electronic quality system in Sterile Services; this will save considerable time prior to audits and will also improve quality control with forms and procedures. The system is fully integrated with our standards (1485) and can be linked to our 'standard operating procedures'.
- A review and business case to be developed to replace the existing sterile service washer disinfectors (which are now over 5 years old) with larger machines and more efficient machines to meet the additional activity increase for capital plan 2013.

Conclusion:
In conclusion the infection prevention and control team has continued to provide a proactive service, utilising a joined up approach and working closely with many disciplines throughout the organisation. In providing a service which enables staff to ensure that the patients journey though the Trust is as safe as it can be. 2013-2014 will see new challenges, and the infection prevention and control team will rise to these challenges and continue to provide an effective service.

Appendix 1

NORTHAMPTON GENERAL HOSPITAL NHS TRUST INFECTION PREVENTION AND CONTROL COMMMITTEE

Purpose of Committee

The role of the Infection Prevention and Control Committee is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at a strategic and operational level to the Trust.

Functions

Trust

1. To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008), (the "Hygiene Code").
2. To fulfil its statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies for example, Saving Lives.
3. To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance.
4. To monitor Directorate performance regarding adherence to infection control practice by reviewing "High Impact Intervention" scores, the Trust Hand Hygiene Observational Audit Tool" scores and other relevant information provided on the matron's information dashboard.
5. To ensure that there is an annual infection control programme of activity submitted to and approved by the Trust Board and to ensure that the programme has clearly defined objectives, to provide advice on the effective use of resources for implementation of the plan and to provide assistance in the effective implementation of the plan.
6. To receive, review and endorse the annual Infection Control Report.
7. To receive reports on specific problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations.
8. To discuss relevant issues presented by The Infection Prevention & Control Team (IPCT) and any other member of the committee.
9. To be responsible for major decisions related to control of infection matters.
10. To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.
11. To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.
12. To ensure that prevention and control of infection is considered as part of all service development activity.
13. To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.
14. To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
INFECTION PREVENTION AND CONTROL COMMMITTEE

Membership

The membership of the group will consist of:

- Director of Nursing, Midwifery & Patient Services (Chair and DIPC)
- Deputy Director of Nursing
- Director of Facilities/Deputy Director of Facilities
- Senior Infection Prevention & Control Nurse
- Consultant Microbiologist
- Modern Matron
- Sterile Services Manager/Trust Decontamination Lead
- Occupational Health Manager
- Infection prevention and Control Nurse (HPA)
- Patient Representative
- Commissioning Services

The Committee would have the power to co-opt any person necessary to assist in its deliberations

Relationships to other Committees

The Infection Prevention and Control Committee is a subgroup of the Clinical Quality and Effectiveness Group, which in turn reports to the Healthcare Governance Committee and through to Trust Board.

In attendance

Minute taker

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

INFECTION PREVENTION AND CONTROL COMMMITTEE

Reporting Arrangements

The DIPC reports to the Trust Board monthly.
The Lead IPC Nurse reports to Healthcare Governance Committee monthly operational IP issues.
The Lead IPC Nurse produces an Annual Report for the Trust Board through the Healthcare Governance Committee.
The DIPC, Director of Nursing and Lead IPC Nurse reports and participates in the Whole Health Economy Infection Control meeting.

Distribution of Minutes

1. All members of the Committee
2. Chairman
3. Chief Executive
4. Medical Director
5. Clinical Directors
6. Directorate Managers

Minutes on the Intranet Site

Frequency of meetings

Duration – 2 hours

Meetings should take place monthly but extraordinary meetings may be arranged at the discretion of the Chair e.g. at the time of an outbreak of infection.
Attendance at a minimum of 8 meetings per annum is required by all members. Meetings take place monthly a week before CQEG

Quorum

A quorum shall consist of seven members, who should include the Chair or Director of Patient and Nursing Services (DIPC) or his/her nominated deputy and a senior member of the Infection Prevention Team.
There is an expectation that were a core member cannot attend that they nominate a deputy. This representative should have delegated decision making responsibility.

Decision Making

The terms of reference will be reviewed every two years or sooner if necessary. The date of the next review will be August 2013.
IPCC is authorised by the Trust to monitor and assist in compliance with the Code of Practice for the prevention and control of Healthcare Associated Infections. It authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by IPCC.

Declaration of Interest

Nil to declare

APPENDIX 2

Special Measures – Period of Increased Incidence

Definition

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

C.difficile sample dated three days (72 hours) after admission

MRSA swab dated two days (48 hours) after admission

Action

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

C.difficile special measures:

The domestic staff will clean the ward with Chlorclean daily for a week The IP&CT will inform the Clinical Lead, Modern Matron, Ward Manager, Directorate Manager and Domestic Supervisor

The Ward Manager and/or Infection Prevention & Control link nurse will conduct weekly *C.difficile* Saving Lives audits until compliance is over 90% for three weeks and no further new cases of *C.difficile* occur

The Ward Manager and/or Infection Prevention & Control link nurse will conduct daily HHOT audits for a week

The IP&C Nurse or Hand Hygiene Cascade Trainer will conduct intensive hand hygiene training on the ward for a week

The IP&C Nurse and Antibiotic Pharmacist will conduct a weekly antibiotic review on the ward

The IP&CT & Modern Matron will conduct PPE, isolation room and environment audits

The Consultant Microbiologist will consider PCR ribotyping of the isolates

The Modern Matron will arrange a Special Measures meeting

The Ward Manager will complete a timeline of events associated with the episode

The Ward Manager will be responsible for completing an action plan and providing evidence that actions are completed.

All periods of increased incidence and actions taken will be reported to the monthly Infection Control Committee meeting by the Modern Matron for further discussion.

MRSA special measures

The IP&CT will inform the Clinical Lead, Modern Matron, Ward manager, Directorate Manager and Domestic Supervisor

The Ward Manager and/or Infection Prevention & Control link nurse will conduct weekly central line, cannula and urinary catheter Saving Lives audits until compliance is over 90% for three weeks and no further new cases of MRSA occur

The Ward Manager and/or Infection Prevention & Control link nurse will conduct daily HHOT audits for a week

The IP&C Nurse or ward Hand Hygiene Cascade Trainer will conduct intensive hand hygiene training on the ward for a week

The IP&CT & Modern Matron will conduct audits that reflect any low scores on the dashboard or areas of concern

The Modern Matron will consider arranging a Special Measures meeting

The Ward Manager will complete a timeline of events associated with the episode

The Ward Manager will be responsible for completing an action plan and providing evidence that actions are completed

All periods of increased incidence and actions taken will be reported to the monthly Infection Control Committee meeting by the Modern Matron for further discussion.

Appendix 3

Infection Prevention and Control Team Annual Programme of Work April 2012 – March 2013

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
CQC 1- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them **CQC 3**- Provide suitable accurate information on infections to service users and their visitors **CQC- 5-** Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing the infection to other people	• Board level agreement regarding responsibility for minimising HCAI • Surveillance of "alert organisms" & Surgical Site Infections • Infection Prevention and control Annual plan, incorporating annual plan of work • Provide suitable and sufficient assessment	DIPC, Lead IPN, Director of Nursing and Midwifery	• Daily Surveillance of alert organisms • Daily surveillance of previous MRSA positive inpatient's. • Mandatory surveillance MRSA/MSSA /E coli Bacteraemia and C-diff in collaboration with HPA, Other alert organisms i.e. PVL • Surveillance of previous MRSA positives. • Maintenance of IPCT data bases • Develop the annual audit plan to include audit of specific IPC policies • Specific IPC documentation for in-patient areas include actions and risk assessments • Monitor elective/emergency screening compliance • Maintenance of MRSA screening compliance. • Report SI's and provide support for directorates to investigate with Root	• Advice to wards/clinical areas via daily ward visits, telephone enquiries and advice on treatment management • Face to face discussions with ward staff on identification of positive Alert Organism • Monthly graphs/charts to Information and Contracting. • Monthly reports Heads of Nursing, Clinical leads, Monthly reports to HMB, CQEG and Trust Board via IPCC and IHGC minutes. • Achieving of Trust National and locally agreed targets for MRSA/MSSA bacteraemia and *Clostridium difficile*		Daily Monthly Monthly Monthly Quarterly	Monthly IPC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
CQC- 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **CQC- 7** Provide or secure adequate isolation facilities **CQC- 8** Secure adequate access to laboratory support as appropriate **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is implemented and monitored	risks to patients within healthcare settings • Surgical Site Surveillance		Cause Analysis • RCA all MRSA bacteraemia <48hrs for Trust learning • RCA all MSSA bacteraemia <48hrs for Trust learning • Maintenance of compliance with patients checklist and audit 2 monthly • Mandatory SSIS hips & knees undertaken by Orthopaedic teams with support from IPCT. • To maintain SSSI via a rolling programme via HPA Colindale – Vascular, Large Bowel. Hysterectomy Caesarean section and breasts. • Surveillance and management of outbreaks of Infection, e.g. Clusters of MRSA colonisation or clinical specimens, *Clostridium difficile,* Norovirus outbreaks requiring closure of wards and impacting on Trust business • Facilitates the SI report of outbreaks with risk management	• Feedback from Region via quarterly reports • Feedback to directorate Leads via Surveillance nurse as reports received from HPA • Daily meetings, as required, during outbreaks of infection, reporting to CE, Director of Nursing, PCT and SHA • Advice to medical staff re: antibiotic treatment via Microbiologists • Advice to wards regarding appropriate isolation and nursing practice • Advice to Heads of Nursing, on-call managers and Site Management Team as appropriate as per Policy for Outbreaks of Infection		Monthly Daily	

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
CQC 2- *Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections* Towards Cleaner Hospitals **CQC- 6** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **CQC- 9** Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections		DIPC, Lead IPCN, Director of Nursing Midwifery, Lead for Facilities, Lead for Estates	***Programme of Audit*** Environmental Use of IPS/DH Audit tool to develop database, maintain safe environment. Collaborative working with Facilities to deliver a robust audit programme to monitor and maintain compliance with national Cleaning standards ***Practice*** • Point Prevalence- Urinary catheters - 4 monthly • **MRSA IPCP audit – compliance with Policy** • MRSA screening Point prevalence monitoring of compliance in admission and high risk areas • **Isolation- Compliance with Policy** • Monthly Time to isolation audit • Hand hygiene monthly by each ward within Saving Lives audit programme • Special measures • Ad hoc following outbreaks of clusters of infection • Monthly Saving Lives	• Feed back to Head of Nursing and ward managers via IPCC • Provide infection prevention and control advice • Ensure support of Ward managers and More involvement of link nurses • Plan audits in advance to ensure link nurse availability • Emphasise realistic action plans. • Re-audit within a realistic time-frame • Review of audit tool and care plan • From clinical areas and Leads – use findings to direct education • Further Audits will be added as required.		Monthly, Quarterly, six monthly and annually	Monthly IPC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
			audit *Clostridium Difficile* • On-going audit of TB precautions and management. • Yearly theatre attire outside of theatres				
CQC 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion **CQC- 5-** Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing the infection to other people **CQC- 6** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections		DIPC, Lead IPN, Director of Nursing	***Clostridium Difficile Associated Diarrhoea) –*** • *Daily Laboratory based surveillance* • Mandatory reporting of all CDT on HPA HCAI web based surveillance system • Reporting of CDT deaths or SI's on STEIS • Identification of Hotspots (2 or more positives in one ward area within 28 days) • RCA all positive Cdiff specs >3 days • Maintain Antigen positive surveillance.	• Achieving of trust and nationally decided target • Advice to wards regarding appropriate management including isolation and nursing practice • Advice to medical staff re: antibiotic treatment via Microbiologists • Monthly graphs to HN and ward Managers • Monthly reports Heads of Nursing, Directorate leads, Monthly reports to HMB and Trust Board via IPCC • Discharge letter to GPs on all positive Clostridium difficile positives.		Monthly Monthly Monthly Ongoing	Monthly ICC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
CQC- 7 Provide or secure adequate isolation facilities							
CQC- 9 Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections		DIPC, Lead IPCN, Director of Nursing Midwifery	• Review and update policies in line with National Guidance Review. All policies updated and endorsed by Infection Prevention and Control Committee • Review each policy as necessary • Collaboration with other specialists e.g. Occupational Health Department, Site Management, Facilities and Estates Leads • Policies available on Intranet Web Page **Provision of policies for individual organisms will include** • MRSA/MSSA • *Clostridium Difficile* • GRE • Gram Negative infections including ESBLs and Acinetobacter • Tuberculosis • Meningococcal infections • Viral Haemorrhagic Fever • CJD	All new and updated policies will be ratified by Infection Prevention and Control Committee prior to Trust ratification at the Quality Governance Board		Monthly	Monthly IPCC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
CQC- 10 Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitable educated in the prevention and control of infection associated with the provision of health and Social care **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is implemented and monitored		DIPC, Lead IPCN, Director of Nursing Midwifery and Quality	**Provision of Education for all staff** **Mandatory** Monthly induction Monthly refresher (x2) Developing infection prevention cascade trainers **Infection Prevention and Control Link nurses** 6 meetings - monthly Jan – March and July – Sept **As requested** Housekeepers, Porters, Radiographers, Physiotherapists, Phlebotomists Occupational Therapists, Estates Staff, Hospital Volunteers Teach on the IV study days, Ward Sisters / HCA's/Aseptic technique **Monthly** Obstetrics NICU Paediatrics **Night Staff sessions** 1night shift every 6 months. **Hand Hygiene** Ad hoc by directorate IPCT leads and following hot spots or outbreaks of Infection Cascade hand	• Monitoring of attendance at mandatory sessions by Staff Development via OLM • Monitor ad hoc attendance by IPCT • Audit practice to evaluate learning and application • Education and Feedback of Practice Audits to address issues/ review guidelines. Inform and participate in establishing evidence to support good Infection Control Practice trust wide. • Liaise with Directorate Practice Development Nurses. Training and Development Department, and Clinical Development Nurse • Continue liaison with University College Northampton			Monthly ICC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
			hygiene trainers Target Medical Staff **<u>Alert Organisms</u>** Ad hoc by IPCT leads, cascade trainers and following special measures or outbreaks of Infection Target Medical Staff **Nursing and Midwifery Students** As requested from University Northampton First year students and return to practice allocated one day with infection prevention.				
CQC- 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has		DIPC, Lead IPCN, Director of Nursing Midwifery and Director of HR, Lead for Facilities and Estates.	Collaborative working with other Departments within the Trust and External to the Trust Involving attendance at Trust wide and External meetings • 6 weekly meetings with estates and IPT • Regular meetings with OH working together on common policies, discuss staff and infection prevention policies. • IPCT nominated representative to attend directorate governance meeting.	• Raise awareness with Directorate Managers and Clinical Directors • Raise awareness via Link Nurses, Ward Managers and Directorate Head Nurses • Raise awareness of		Monthly via Infection Prevention and Control Committee.	Monthly ICC

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is implemented and monitored			• Health Economy HCAI Group, Led by Commissioning PCT • Practice Development Forum • Estates issues – collaboration with Preventative Maintenance Programme, Advice re future builds/improvements • Procurement Group working with the Materials management and Supplies Department. Participation in product reviews • Decontamination group • Water management Group • Audit and assurance Group – re Cleaning Specifications and Standards lead Facilities • Participation in PEAT self-assessment. • Health and Safety Group • Northamptonshire Clinical Investigatory Group	purchasing issues with wards • Liaise with wards via housekeepers • Feedback of PEAT assessment to wards, etc • Monitoring process changes following RCA on a county wide basis			

This programme of work will be significantly influenced and added to by tasks assigned to Infection Prevention and Control Team as situations arise.

Audit of this programme is ongoing by the IPCT.

This programme to be reviewed annually or as indicated from feedback.

Appendix 4

Infection Prevention and Control Team SSI Surveillance Programme of Work April 2012 – March 2013

Quarter	Categories under surveillance	SSI NGH rates	SSI national rates	Actions
Apr-June 2012	Breast surgery 98 Limb amputations 25 # Neck of femurs 77	**0.0%** **4.0%** **1.3%**	**1.0%** **3.8%** **1.6%**	Breast surgery – results reported to IPC, board meeting & sent to Consultant Gynaecologists. Limb amputations – repeated surveillance in quarter two to increase sample size # Neck of femurs – results reported to IPC, T&O Consultants and T&O Governance
July-Sept 2012	Breast surgery 105 Limb amputations 33 # Neck of femurs 90	**1.0%** **3.0%** **1.1%**	**1.0%** **3.5%** **1.6%**	Breast surgery – results reported to IPC, board meeting & sent to Consultant Gynaecologists. Limb amputations – results under national average and reported to IPC and surgical directorate Consultants and Governance # Neck of femurs – rates now consistently below national average, results reported to IPC, T&O Consultants and T&O Governance
Oct-Dec 2012	Spinal surgery 26 Vascular surgery 62 # Neck of femurs 75	**0.0%** **1.6%** **1.3%**	**1.0%** **3.1%** **1.6%**	Spinal surgery – results under national average and reported to IPC and T&O directorate Consultants and Governance Vascular surgery – results under national average and reported to IPC and surgical directorate Consultants and Governance # Neck of femurs – results reported to IPC, T&O Consultants and T&O Governance
Jan-Mar 2013	Spinal surgery 38 Vascular surgery 52 # Neck of femurs 115	**0.0%** **0.0%** **0.9%**	Awaiting Health Protection Agency report	To disseminate results to directorates once the national averages are reported from the Health Protection Agency in July 2013

SSI = surgical site infection
 # = fractured

REPORT TO THE TRUST BOARD
31 October 2013

Title	Safeguarding Adults & Childrens Annual Reports
Agenda item	11
Sponsoring Director	Suzie Loader- Director of Nursing, Midwifery & Patient Services
Author(s)	Fiona Barnes, Deputy Director of Nursing Lorraine Hunt, SOVA Lead Julie Quincey, Safeguarding Childrens Lead
Purpose	The Safeguarding Adults & Childrens Annual reports have been presented and discussed at the Trusts Integrated Healthcare Governance Committee. The reports are presented to the Trust Board for assurance.

Executive summary

The attached reports summarise the overall provision for safeguarding vulnerable adults and children at Northampton General Hospital NHS Trust (NGH) for the financial year April 2012-March 2013.

The Safeguarding of Vulnerable Adults Annual Report provides:

- A summary of the activities undertaken by the Safeguarding of Vulnerable Adults (SOVA) lead for the Trust during 2012/2013
- An overview of notifications raised against the Trust and those that the Trust has raised on the behalf of vulnerable adults over the same period
- Inter- agency Partnership working and the Trust's contribution to Serious Case Reviews.
- Commissioner Reviews undertaken regarding compliance in Safeguarding Adults
- Dementia Action Committee role and work undertaken 2012/2013, including Dementia CQUIN
- Support for patients with Learning Disability and work undertaken.
- Actions taken to improve the safety and care of patients who deliberately self- harm.

The Safeguarding Children Annual Report is set out in a format guided by the LSCBN and provides:

- A summary of the activities undertaken by the team for the Trust during 2012/2013
- Trust involvement in Serious Case reviews
- Training statistics and on-going focus areas
- Governance arrangements
- Ofsted/CQC inspection
- Safeguarding team achievements from 2012/13
- Safeguarding team priorities for 2013/14

Related strategic aim and corporate objective	Be a provider of quality care for all out patients – Invest in enhanced quality including improvements in the environment in which we deliver care
Risk and assurance	This report highlights the actions taken over the year to address concerns raised and forthcoming actions to maintain the safety of Vulnerable patients in the care of the Trust.

Related Board Assurance Framework entries	BAF1. Be a provider of quality care for all our patients
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 Trust must be able to demonstrate compliance and adherence to the CQC Outcome standard 7

Actions required by the Board

The Trust Board is asked to note the reports.

ANNUAL SAFEGUARDING ADULTS REPORT (2012- 2013)

1. INTRODUCTION

Northampton General Hospital NHS Trust (the Trust) is committed to protecting the welfare of vulnerable adults and responding promptly when abuse is suspected. This involves promoting a culture where abuse of any kind is not to be tolerated and is dealt with promptly if it does occur. The Trust is fully committed to partnership working in order to protect and promote the interests of vulnerable people. Therefore the Trust fully endorses and follows the "Procedures for Interagency Approach for Protecting Vulnerable Adults from Abuse" (2010) as published by the Northamptonshire Intra- agency Safeguarding Adults Board.

2. ACCOUNTABILITY

Trust Board has overall accountability for protecting vulnerable adults within Northampton General Hospital NHS Trust. The Trust is represented on the Interagency Northamptonshire Safeguarding Adults Board (NSAB) by the Deputy Director of Nursing, Midwifery & Patient Services. The Trust has in post a Safeguarding Vulnerable Adult Lead. The Lead has established a process within the Trust for alerting and responding to suspected abuse in line with the inter-agency procedures.

3. RECENT DEVELOPMENTS IN SAFEGUARDING ADULTS

3.1 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry "Francis Report" (February 2013) Robert Francis QC

This report published key recommendations for the NHS. The overall recommendation was to ensure "the need for a patient centred culture, no tolerance of non- compliance with fundamental standards. Openness and transparency, candour to patients, strong cultural leadership and caring compassionate nursing and useful and accurate information about services".

The report highlights the importance of quality safe care and assurance and stresses that staff must act and report poor care or neglect, ensuring the protection of patients in their care. The Trust has undertaken an extensive review of the recommendations within the Francis report and have identified that the Trust safeguarding policies and procedures will, when implemented on an individual basis, protect vulnerable adults.

3.2 Department of Health "Statement of Government Policy on Adult Safeguarding" (May 2013)

This report was published to provide an update of the Governments policy on safeguarding adults vulnerable to abuse and neglect. It includes the statement of principles for Local Authority Social Services and housing, health, the police and other agencies to use for both developing and assessing the effectiveness of their local safeguarding arrangements. It also describes, in the broad terms, the outcomes for adult safeguarding, for both individuals and organisations. This report outlines the next steps that Government is taking.

NGH and Government Policy on Adult Safeguarding

The Trust Safeguarding Adults policies and procedures adhere to current government policy.

3.3 CORPORATE ACCOUNTABILITY AND SAFEGUARDING- JANUARY 2013

'Care and Corporate Neglect' briefing paper by Paul Burstow MP former Care Services Minister, explores how corporate bodies could be held criminally responsible for abuse and neglect that takes place in hospital and care homes. The paper reviewed the current legal framework and seeks the precedent and guidance that would allow the Government to create a new criminal sanction of corporate neglect. It also suggests that safeguarding and serious case reviews could be strengthened in order to ensure

stronger corporate accountability. Principally the paper recommends that where corporations, by their actions or omissions, facilitate abuse or neglect in their care settings then they must be held criminally accountable.

'Care and Corporate Neglect' suggests that senior manager/ executives have a responsibility to ensure that appropriate quality systems are in place. If there is a system failure then senior managers and ultimately the Board are responsible.

NGH Corporate Accountability and Adult Safeguarding
Within "Care and Corporate Neglect" the current legislation regarding the care and protection of vulnerable adults is summarised. A gap analysis has been undertaken to demonstrate compliance and on-going work. The Trust has procedures and processes in place regarding the protection of Safeguarding of Vulnerable Adults and complies with the current legislation

4. GOVERNANCE STRUCTURES FOR SOVA WITHIN THE TRUST

4.1 Trust Safeguarding of Vulnerable Adults Steering Group

The Safeguarding of Vulnerable Adults Steering Group provides leadership to the Trust on all matters relating to the strategic and operational delivery of safeguarding adults.

The group is chaired by the Deputy Director of Nursing and membership of the group is from various professional and directorate groups, including the Dementia Action group, Dignity Forum, and Safeguarding Vulnerable Adults Forum. There is also representation from the Clinical Commissioning Group (CCG) and Patient representation. Until recently there was Non-Executive representation however this member of the Board has since left the Trust, so we are seeking new NED membership.

4.2 Safeguarding Assurance Group

The Safeguarding Assurance Group (SAG) was formed to ensure effective management of all Safeguarding of Vulnerable Adults notifications that occur within and are notified against the organisation. SAG ensures that robust systems and process are in place to support a timely investigation process, monitor outcomes, action plans and ensure lessons learnt are disseminated through other Trust Forums and Groups.

4.3 Reporting Arrangements

The SOVA Lead reports to the Clinical Quality and Effectiveness Group (CQEG) and to the Trust Board through the quarterly Patient Safety, Clinical Quality and Governance Progress Report.

4.4 Care Quality Commission (CQC) Review of Compliance

The CQC made an unannounced visit to the Trust in July 2012 to gain assurance that the Trust was complaint with the protection of adults. The review consisted of visits to wards and departments. The inspectors engaged with both staff and patients.

The final report stated that for Outcome 07- *People should be protected from abuse and staff should respect their human rights that*:

'The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.'

Care Quality Commission Essential Standards for Quality & Safety Outcome 7A
The SOVA Lead and all directorates provide assurance and evidence regarding compliance with regulations relating to safeguarding of vulnerable adults. The SOVA Lead also gives assurance to the Executive and Non executive leads for safeguarding adults through Confirm and Challenge meetings which are held bi-annually.

4.5 Commissioner Reviews

The Trust has participated in NHS Northamptonshire's commissioner reviews during 2012/13. The reviews have demonstrated that NGH has consistently met all its requirements.

Self-Assessment and Assurance Framework (SAAF)

In February 2012, the Trust undertook a self-assessment regarding Safeguarding Adults, (Self-Assessment and Assurance Framework SAAF). This was reviewed by both SHA and PCT safeguarding leads. It was noted that the self-assessment was comprehensive and the Trust provided a good level of evidence to demonstrate our safeguarding arrangements. From the initial amendments, the Trust identified seven areas that needed to be implemented to enhance further understanding and awareness of safeguarding adults:

Action Ref	Action from SAAF March 2012
1	Recruit a designated/ Lead medical champion for safeguarding adults
2	Extend the flagging system to Identify patients across all groups who may be particularly vulnerable.
3	Develop and implement a random sampling system which captures the experience of patients who have been part of the safeguarding process.
4	'Prevent' agenda to be introduced within the organisation via policy and training
5	Develop assurance that training and awareness of Safeguarding/ MCA has been delivered across the organisation and is leading to improved outcomes.
6	Introduce a system of clinical supervision for staff involved in safeguarding adult incidents
7	Review the arrangements for agency nurses and enhanced observation to assure agency staff have sufficient competence and knowledge of the patient to respond to their needs.

In November there was a formal interview to review progress that demonstrated improvements against the initial seven areas to action. Thus leaving the following four areas to continue to be improved upon during the coming year:

1. Identify key objectives for the new medical lead and report on how this role is improving outcomes in safeguarding adults. Initially a medical lead supported the SOVA agenda however in recent months, due to clinical workload, this individual has had to leave and we are currently looking for further medical representation. If however, we are unsuccessful, we will review alternative options regarding the provision of a Medical Lead for Safeguarding Adults within the Trust.

2. Continue to build our flagging system for vulnerable patients, exploring potential cost effective IT solutions to support this. The Trust has explored the current IT system however there is not a 'simple' cost-effective solution. The trust continues to use other papers systems to identify patients that are vulnerable until a suitable IT system is identified.

3. Extend patient involvement, considering other good practice models such as 'patient quality checkers' and embedding random sampling audit of the patients experience of the 'alert' stage of the safeguarding process. Currently the Trust is working with the County-wide SOVA team to review how to take this work forward across the county.

4. Build on the good practice of dignity champions to encompass safeguarding

and provide resilient leadership across the organisation and avoid over reliance on the safeguarding adults lead. The Team has undertaken extensive training across the trust to enhance the knowledge and experience of ward staff to facilitate proactive trouble-shooting for SOVA cases. The Dignity Champions have also received further safeguarding training.

Quality monitoring visit

A quarterly quality monitoring visit by PCT/Nene Commissioning took place in October 2012. During the visit, two wards were reviewed in relation to the practise of Safeguarding, Mental Capacity and Deprivation of Liberties. It was reported that the staff had good awareness and understanding of all subjects and were able to demonstrate implementation of this knowledge within practice.

Monitoring of Progress and Implementation

The Safeguarding Vulnerable Adults Steering Group receive and discuss the progress of the implementation of the actions regularly, monitoring where appropriate. The Quality Schedule 2012/13 regarding safeguarding state that the Trust must comply to the schedule by undertaking the safeguarding self-assessment and assurance. The self-assessment includes participation in bi-annual assurance visits. The Trust can demonstrate compliance within this.

5. PATIENTS WITH A LEARNING DISABILITY

The Trust has recognised the importance of ensuring that they provide accessible and equitable healthcare to patients with a Learning Disability.

The Trust has continued to develop its work to ensure ease and equality of access for patients with a Learning Disability, improve their patient journey and achieve some positive health outcomes.

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
  - Scan for pregnant ladies
  - How 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, so that they can then ensure they are receiving the appropriate care whilst they are an inpatient.
- There are a number of pieces of work that are in progress including:
  - Development of “accessible “ appointment letters
  - Easy read patient feedback forms
  - Easy read version of the Trusts equality objectives.

5.1 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. In addition, 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, where people with a Learning Disability presented their experiences of hospital care 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.

5.2 Challenging and Complex Needs

The Trust has seen an increase in the number of individuals admitted who have Learning Disability and Challenging behaviour; many of these individuals have Autism. Coming into hospital brings many challenges for this group of patients, many of whom do not cope well with changes to their environments, routines and carers.

Healthcare staff have worked with carers and support teams to make the patient's journey as 'stress free' as possible.

One example has been following an assessment of support needs; NGH has funded carers from a 'supported living team' who knew the patient very well to support him as part of the "care team" during his time in hospital. By supporting the patient with staff who he was familiar with and had confidence in, enabled the patient to have timely investigations and treatments and clearly reduced his anxieties, reduced his hospital stay and had positive health outcomes for the individual.

5.3 Winterbourne View Care Home

Winterbourne View Care home was a treatment and assessment unit for people with Learning Disabilities and challenging behaviour run by Castle Beck. In May 2011 BBC Panorama exposed serious levels of abuse by staff members against service users. Eleven ex staff members have since been convicted regarding abuse against patients. The South Gloucestershire Safeguarding Vulnerable Adults Board commissioned a Serious Case Review (SCR) that was published in August 2012.

Following the publication of the findings of the Serious Case Review there were a number of significant recommendations. As a result of the recommendations from the review, NGH conducted a gap analysis. The trust concluded that it was fully compliant against those recommendations as a result of actions already taken or actions in progress – the outcome of the review was presented to the Healthcare Governance Committee. The remaining action plan is monitored by the SOVA steering group. A copy of this gap analysis was sent to Nene clinical commissioning group as evidence of compliance.

5.4 One Health Group Engagement

The purpose of the One Health Group is to take the strategic lead and be accountable to NHS Northamptonshire & Milton Keynes Cluster / Clinical commissioning groups for development and effective delivery of Learning Disability Better Health Care Plan for Northamptonshire. The Trust is a key stakeholder of this group and is represented by the Deputy Director of Nursing and the Learning Disability Liaison Nurse also attends this group as Strategic Health Facilitator.

On a quarterly basis, each provider has to present their progress of developments against their current Learning Disability action plan. The Trust presented an update in May 2013 that was received very positively, with recognition being given to the trust for the progress it is making to support patients with LD to improving their experience of hospital.

5.5 CQC July 2012

The CQC visited NGH in July 2012. As part of their review they tracked a patient with LD from attendance in A & E, throughout his admission to discharge. The CQC saw evidence

that the LD Liaison Nurse had been involved in supporting the patient from early on in his admission and that he had a completed Hospital passport which was in use. The newly developed "flagging alert system" alerted the LD Liaison nurse of his attendance in A & E and subsequent admission to the ward, this enabled her to ensure appropriate support was been given to the patient, who had very complex needs in an effective and timely way.

The CQC stated:

"*Since our last inspection, better arrangements had been put in place to help staff understand the needs of people with Learning Disabilities. We saw information about how they communicated including how to tell if they were in pain*". However, they did raise a concern regarding the fact that although 'easy read' booklets had been developed to help people understand what will happen when they have x ray, CT scan or MRI, these were not available when they visited the Radiology department. There are now systems in place to ensure that 'easy read' leaflets are always available in departments which routinely use them.

6. PATIENTS WITH DEMENTIA

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 monitor the delivery of the plan.

The use of the butterfly logo which has been adopted by the Trust as a means of identification of patients with dementia is now well embedded on the wards. A 'butterfly magnet' is used on the ward patient 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 via the practice development department.

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.

6.1 The National Dementia CQUIN

Introduced in 2012, the national Dementia CQUIN aims to improve awareness and diagnosis of patient with dementia in an acute hospital setting. We are required to identify the proportion of patients aged 75 and over to whom case finding is applied following emergency admission;, the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred to specialist services. The medical admission document has been reviewed to include this information.

Further requirements for the 2013/14 Dementia CQUIN involve the confirmation of a named lead clinician, the development and delivery of a training plan and a monthly audit of carers of people with dementia to test whether they feel supported. Work is in progress to ensure the requirements of the CQUIN are achieved in 2013 /14.

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.

7 NORTHAMPTONSHIRE SAFEGUARDING ADULTS BOARD - SERIOUS CASE REVIEWS

As a member of the Northamptonshire Safeguarding Adults Board (NSAB) we formally support and participate in Serious Case Reviews. A summary of those reviews which occurred during the year is provided below, along with any learning identified.

SCR 1
The Trust received a formal request from the Northamptonshire Safeguarding Adults Board (NSAB) to contribute to a serious case review, regarding the care and treatment of a 51 year old male patient with Learning Disabilities and related physical conditions in July 2012. The Patient had received care within the Trust on two occasions: January 2008- August 2009. The Trust submitted a management review report to the board, the Serious Case Overview was completed and published by NSAB in November 2012.

Summary of overview report and NGH

1. *The period of care received by the patient as an inpatient at NGH did not generate any concerns*.

2. *The Trust did not make a sufficient link with the patient's poor condition on admission and the grounds to make a referral to safeguarding. NGH have since strengthened these areas.*

Trust Actions
The Trust has responded to the SOVA board, request for actions to be identified and implemented. The Trust has adhered to the request and has taken appropriate action.

SCR2
In October 2012 the Trust received formal request to complete an Internal Management Review (IMR) report for the NSAB. The report was to consider the care and support of an 87 year old male patient who been admitted to the Trust on two occasions between August 2010 - October 2010. The Trust has completed an initial report within the requested time frame. There has been no formal outcome for the Trust to date.

Serious Incident and safeguarding
The Trust had been involved in a serious incident which related to safeguarding during the year 2011/2012.

The incident involved the care and treatment of a patient with moderate learning disabilities.

Action Plan
An action plan in relation to the recommendations from the Serious Incident report has been produced and all actions have been implemented within the Trust. Regular updates on actions taken and implemented have been made through the SOVA Steering Group.

8. LIGATURE POINTS ASSURANCE FRAMEWORK

The NHS Midlands and East Ligature Points Assurance Framework (August 2012)
The NHS Midlands and East Ligature Points Assurance Framework explores: Policy and Risk Management, Staff Training and Clinical Communication. It is intended to support healthcare organisations to review their local systems and processes and offer appropriate

assurances to their Commissioners that they have robust measures in place to promote patient safety.

Self-Assessment
The Trust undertook a self-assessment regarding its compliance with Ligature assurance framework and as a result has formed a Ligature Assurance Group to formulate an action plan and monitored progress of actions that have been identified. Currently we are waiting for the revised Self Harm policy to be ratified before the Trust is compliant with the framework.

9. "PREVENT"

The Department of Health have issued guidance to all health organisations to ensure that the "Prevent" agenda is addressed. "Prevent" is concerned with the protection of vulnerable adults who may be drawn into terrorism.

Prevent Training
In order for the 'Prevent' agenda to be addressed in health, the Home Office and the Department of Health have devised a training programme for staff: Health WRAP. Within the Trust it has been identified that staff in these specific areas will require training:-

- Accident and Emergency
- Assessment units (Medical and Surgical)
- Child Health

Currently we are continuing to train key staff groups from the identified specialities.

Prevent Trainers
The Safeguarding Children's Lead and Matron for Accident & Emergency & Safeguarding Vulnerable adult Lead have undertaken the Department of Health Cascade training for Prevent. 60% of staff who require training have been trained to date. Prevent awareness training is being presented within all Safeguarding Adults training sessions as a matter of course.

Reporting of compliance and Prevent Referrals
The Trust reports training activity and any prevent referrals to the CCG. The safeguarding lead also represents the Trust at regular Regional and National meetings regarding the prevent agenda.

10. COMMUNICATION AUDIT

The Trust has undertaken two communication audits, regarding the Trust compliance in the use of tools and appropriate consent forms and assessments for people who lack capacity, regarding inpatients setting. The results in September were disappointing at 50% compliance. This audit is part of the Quality Schedule which identified the need for audit and compliance for the use of the Mental Capacity Act.

In March 2013 a further audit found that there had a small improvement to 60% compliance.

Monitoring
The results of the audits have been reviewed and are monitored by the Safeguarding Steering Group, regarding the use of appropriate communication tools and assessment for people for who lack capacity. The results of the audit have also been discussed and reviewed by the Trust Consent Committee. Both groups have identified that further action is required to ensure compliance, which includes: the use of correct documentation when consenting patients who lack capacity and the need to include staff compliance in training regarding the Mental Capacity Act and.

11. SAFEGUARDING ADULT LEAD

The Safeguarding Lead has undertaken the NHS Safeguarding Adults Leadership Course. The course has been jointly facilitated by NHS London and NHS Midlands and East. The

course comprised of four modules reviewing all aspect of adult safeguarding and ensuring that further awareness of the role of safeguarding adults in a health care organisation. The SOVA Lead, following completion of the course, has identified areas that could improve the effectiveness of the operational process for safeguarding within the Trust. The Lead identified and recommended the need for further accountability by operational staff within safeguarding. This included increased awareness of staff to their responsibilities in relation to process and their understanding of internal and external assurance in that are required to be given relating to safeguarding. The Safeguarding Lead will, within her role, support and facilitate the recommendations identified.

12. EDUCATION & TRAINING FOR SOVA

The SOVA Lead provides the following training within the Trust in conjunction with the Training and Development Department.

Safeguarding Adults

Level 1

This training is mandatory for all staff. During 2012/2013, 70% of staff received Level 1 SOVA training.

Level 2

Level 2 safeguarding training is a mandatory training requirement for specific staff groups. During 2012/2013: 54% of all staff received Level 2 SOVA training.

Level 3

5 members of the senior nursing staff who are involved in conducting SOVA investigations are complaint in Level 3 safeguarding training. The percentage of staff trained is adequate and appropriate for the organisation.

Mental Capacity Act (MCA) Training

Training is offered to specific staff groups. 74% of staff are compliant with training in the use of the Mental Capacity Act.

13. ACTIVITY DATA 2012/2013

The Trust has a responsibility to protect vulnerable adults from abuse and to report all forms of abuse if it occurs.

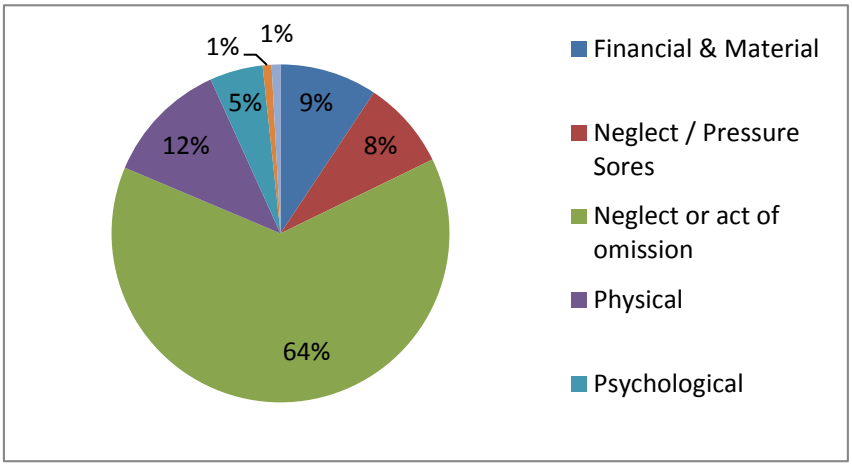
Safeguarding Alerts raised by NGH

118 alerts were raised by staff regarding patients within our care, 84 required full investigations. The graph below shows the breakdown of these alerts:

- 10 incidents involved Neglect/Pressure Sores
- 75 incident involved Neglect/Act of Omission
- 11 incidents involved Financial abuse
- 14 incidents involved Physical abuse
- 6 incidents involved Psychological abuse
- 1 incident involved Self-Neglect
- 1 incident involved Sexual abuse

The remaining 34 alerts were withdrawn, unfounded or assessed as self-neglect and therefore did not require full investigation.

SOVAs Raised by NGH April 2012 – March 2013



Neglect or act of omission (64%)
The alerts regarding neglect were from patients admitted with pressure sores or gross dehydration. Of the cases 58%of the patients were from nursing or care homes. The other 6% were from supported care within their own home.

Cases of Physical Abuse (12%)
Referrals due to physical abuse occurred mainly within a domestic setting. One alert regarding an adult that had been physically abused had also highlighted concerns regarding a child. Staff also raised an alert regarding the child in question.

Finance & Material (9%)
The reported cases of financial abuse had mainly involved carers or family members. In most cases it was found that the patients lacked Mental Capacity.

Neglect/Pressure Sores (8%)

Psychological Abuse (5%)
Referral due to verbal abuse found to have taken place in a domestic setting.

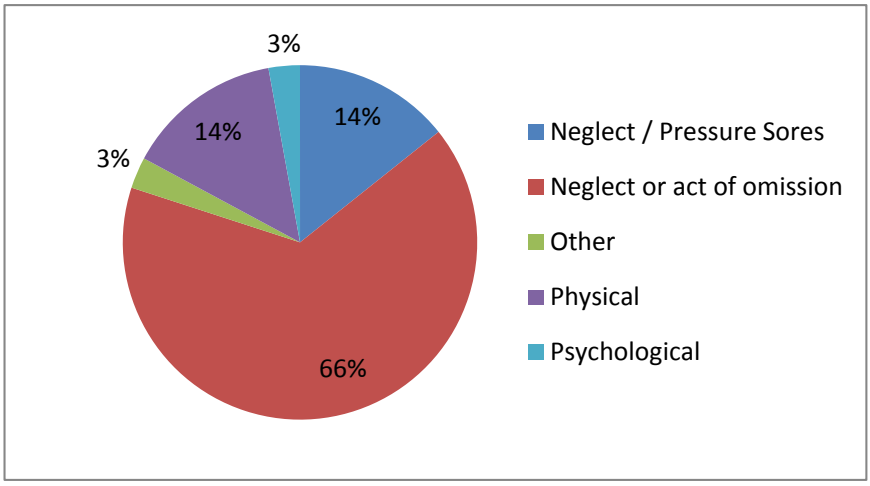
Self-Neglect (1%)

Sexual (1%)

Referral Activity 2012/2013
There has been an increase of approximately 10% in referrals by trust staff regarding safeguarding matters in comparison to the same time last year. This demonstrates a wider awareness of staff and is a positive outcome of productive training.

Safeguarding Alerts raised against NGH
During the same period there have been 35 alerts raised against NGH. The graph below shows the breakdown of these alerts:

- 28 incidents involved “neglect” or an “act of omission”.
- Incidents were due to poor standard of care within a ward setting and have also been investigated through the Trust complaints procedure.



Neglect
Of the 35 cases of "neglect" or "act of omission" involving NGH, 13 related to the discharge of the patients, namely:

- Discharged with pressure ulcers into the community without any communications regarding further treatment or referrals to relevant community services.
- Discharged without any communication/discharge letters regarding further treatment or future appointments, including appropriate medication.

The majority of the patients above had been discharged either to a care/nursing home environment and the remaining patients were discharged to their own home.

Seven of the safeguarding alerts raised against the Trust were upheld, the remaining 28 were unfounded.

14. LESSONS LEARNT

The seven notifications concerning neglect that were raised against NGH that were upheld either related to failures in the discharge process or patients discharged with pressure ulcers.

Actions taken to improve discharges from hospital
Communication
The Trust strives to ensure that where a patient has either complex needs or from a residential home that good communication links are formed with all parties. The Hospital Discharge Team works closely with wards, departments and the community to ensure where possible a seamless discharge.

The Trust SOVA Lead along with other leads in health have met formally with the Care Homes Managers in relation to formalising lines of communications regarding discharge. The Trust had identified that there is a need for a standardised operational guidance on discharge. This should incorporate communication with all care and nursing home facilities and their requirements for acceptance of patients on discharge including additional communication regarding equipment and training may be required.

Discharge procedures and concerns have been discussed by the Care Group Lead Nurses at the Nursing and Midwifery Board. It was identified by this group that there was a need for further actions to be taken by the Trust regarding current discharge procedures to ensure that all patient groups are discharge safely from the Trust. The SOVA Lead and members of the Dignity Forum are currently reviewing their findings and will implement any actions that may be required regarding the discharge process within wards and departments. The Trust discharge process has also been reviewed by the Trust Discharge Team and further

work regarding improvement will be implemented. The SOVA Lead works closely with this team regarding the discharge of patients with complex needs

It is expected that with greater communication and a standardisation of the discharge process the Trust's notifications regarding neglect on discharge, will be reduced.

Action regarding patients admitted with Pressure Ulcers
The Trust has identified that initial assessment in A/E regarding the condition of the patient's skin and whether or not they have pressure areas on admission, are not always documented. An improvement plan has been launched within the Trust to reduce avoidable pressure ulcers, which includes the development of assessment and standards of documentation on admission. Since this work was launched, the Trust has seen a big increase in the number of pressure ulcers identified by A/E staff on admission, which means that treatment of these and further prevention work can commence immediately the patient enters hospital. This work also provides evidence regarding a patient's condition on admission if the Trust is required to investigate any safeguarding concerns.

15. MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY 2012/2013

The Trust has applied on 5 occasions for authorisation to deprive a patient of their liberty under the Mental Capacity Act. All applications were assessed and did not meet the criteria for authorisation. The Trust had ensured that there was adequate care plans for the protection of each of the patients.

16. 2012/2013 ACHIEVEMENTS SUMMARISED

16.1 Patients with Learning Disability

The Trust has continued its work to ensure that patients with a Learning Disability, to improve the patients journey within NGH

16.2 Patients with Dementia

Work continued to improve the experience of patients with dementia and quality of care within NGH.

16.3 Safeguarding Adults

16.3.1 Commissioner Reviews

The Commissioner reviews demonstrated that NGH meet all requirements regarding safeguarding adults.

16.3.2 Care Quality Commission

CQC reported that NGH meet all standards the procedure in place to protect vulnerable adults.

16.3.3 Strategic and Partnership working

NGH has continued its commitment to interagency partnership working. The Trust has been represented on the interagency Northamptonshire Safeguarding Adults Board. Through its membership on the board the Trust has contributed to

- Safeguarding Adults Board Strategy Plan 2012-2015.
- Serious Case Review.
- Review of inter- agency Governance procedures and Safeguarding.

16.3.4 Prevent

The Trust Prevent training plan has been devised for the delivery of training. 60% of staff who require training, have been trained to date.

16.3.5 Ligature Point Assurance Framework

The Trust undertook a self-assessment regarding the care and protection of patient deliberately self-harm. Following the assessment the Trust formed a Ligature Assurance Group and action plan was formulated.

17. 2013/2014 PRIORITIES

The Trust will be addressing the following priorities within 2013/2014:

1. Develop further integration of children/adults safeguarding where possible.

2. Further integrate the process for managing and learning from safeguarding incidents and serious incidents within the Trust's clinical governance structure, including the new Care Group governance structures.

3. Implementation of local and national recommendations for safeguarding by corporate and operational staff.

4. Ensuring safeguarding and MCA training levels meet Trust targets throughout the year, which includes implementing SOVA competency frameworks in all ward areas.

5. Further implementation of actions and monitoring of compliance, regarding the safety of patients who deliberately self-harm.

6. Monitoring of the Trust compliance and implementation the use of communication tools and assessment, for people who lack capacity .

7. Further implementation of actions and compliance regarding the 'Prevent' agenda.

8. Continue to monitor the work identified to ensure equitable and quality care for patients with complex needs.

2012-2013 Annual Safeguarding Children Report

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Contributors: Michelle Dominic Named Doctor
Jackie Clarke Named Midwife

Approved by-
Integrated Healthcare Governance Committee :17th July 2013

This report acknowledges contribution from:

- Julie Quincey, Named Nurse Safeguarding Children
- Dr. Michelle Dominic, Named Doctor Safeguarding Children, and Designated Doctor-Child Death Review
- Dr. Bhala, Doctor for Looked After Children
- Jackie Clarke, Named Midwife Safeguarding Children and Women
- Wendy Irons, Safeguarding Children's Advisor

Northampton General Hospital NHS
NHS Trust

1	**Executive Summary**
	This report summarises the Safeguarding Midwifery, Children and Young People provision at Northampton General Hospital NHS Trust from April 1st 2012- March 31st 2013. The report will cover Safeguarding provision in relation to: • Executive engagement • Named Professionals • Safeguarding team effectiveness and activity • Training • Allegations against staff • Complaints • External and internal assurance • LSCBN interface and interagency working • Key risks, challenges and opportunities
2	**Summary of Agency Role, Remit and Responsibilities**
	Northampton General Hospital (NGH) NHS Trust is an Acute District General Hospital providing a full range of acute clinical services from Northampton General Hospital, Danetre Hospital in Daventry, Corby Community Hospital and Isebrook Hospital. The Trust also has a designated cancer centre, in-patient renal services and interventional cardiology. The trust has recently undertaken a Clinical governance reconfiguration which when implemented will create an integrated Safeguarding Team to cover Adult, Child and Midwifery Safeguarding. This team will be led by a new post: Head of Safeguarding and Dementia; this post will lead on the vision of creating integrated safeguarding for vulnerable adults, children and the unborn ensuring there are no gaps in service delivery leading to an integrated safeguarding care pathway. This reflects the move by the LSCBN to eventually combine adult and child safeguarding boards. In addition the three safeguarding teams will move from being hosted by the clinical directorates to being hosted by Governance leading to greater executive ownership. We believe this approach will ensure that safeguarding is embedded into the heart of the Trust, and that vulnerability is recognised across the ages. NGH meets all the duties and responsibilities as laid down in Working Together To Safeguard Children (2013 DoH), Section 11 audit requirements as detailed in the Children's Act (2004) and Markers of Good Practice. In summary : • We are a statutory partner on the Local Safeguarding Children's Board (LSCB) • Our Director of Nursing provides executive representation to the LSCB • Our Named Professionals attend the LSCB subgroups and contribute to the training pool

	• We have a Named Doctor, Named Nurse and Named Midwife in post supported by Paediatric and Midwifery safeguarding Advisers • All NGH staff can access safeguarding children training in accordance with the Intercollegiate Guide: Safeguarding Children and Young people: roles and competences for health care staff (2010) to enable them to recognise signs of abuse and to make appropriate referrals. In addition staff are actively encouraged to take a *"Think Family"* approach and are encouraged to seek support from the Safeguarding Children Team members when they are uncertain as how best to proceed • The Safeguarding Children's team provide a comprehensive Liaison services in line with the Laming Report (2003) thus ensuring our primary care colleagues are kept fully informed of all paediatric admissions and discharges into the hospital. The team reviews all child cases seen in A&E and provides follow up where Safeguarding concerns may have been overlooked to ensure the right actions are taking. The team also provides Safeguarding support and advice to staff members across the hospital. • The Midwifery Safeguarding team promotes Safeguarding within Maternity and Gynaecology Services giving advice, supervision and support to all staff with casework where there are vulnerabilities highlighted in pregnancy. • Northampton General Hospital hosts the county wide Child protection medical assessment service. Community paediatricians from across the county provide medical assessment and opinions on children undergoing section 47 enquiries. • The Clinical lead for 'Looked After Children' (LAC) and the team provide LAC medicals and advice for looked after children accommodated in the South of the county. • NGHT hosts the Designated Doctor for Child Deaths providing a comprehensive service in line with best practice
3	**Trust Safeguarding Executive ownership**
	Executive Director for Safeguarding Children: This post is undertaken by our Director of Nursing, Midwifery & Patient Services who sits on the LSCB Board and ensures that the LSCB business plan and priorities are cascaded down to the NGHT Safeguarding Children Named Professionals via the Trust's Safeguarding Steering Group which in turn reports to the Trust's Clinical Quality and Effectiveness Group. **Non-Executive Director:** We currently do not have a non-executive director who holds the brief for safeguarding children due to staff leaving the Trust. This is in the process of being addressed.

4	**Named Professionals remit and update**
	Named Nurse: This is a fulltime position, the Named Nurse is corporately responsible for Safeguarding Children and Young People across the Trust, and is supported by 2 Safeguarding Nurse Advisers 0.75 WTE band 7 and 0.9 WTE band 6. The Safeguarding Children's Advisers cover A&E and Paediatrics and will assertively outreach to advise staff on any safeguarding concerns including advice on making interagency referrals, attending case conferences and strategy meetings. They also provide the liaison service to the community primary healthcare team. Where cases are complex these are escalated to the Named Nurse for support and direction. The Named Nurse is operationally responsible for all other areas in the Trust barring Midwifery and Gynaecology and again provides assertive outreach to assist staff when engaged in safeguarding activity. **Named Midwife:** This is full time position and is supported by 3 Safeguarding Midwives 1.77 WTE and admin support 1.0 wte; they are line managed by the Named Midwife. The Named Midwife is the line manager for the 'Central team' midwives working with vulnerable women. The role of the Named Midwife and Safeguarding Midwives is to support and advise staff, undertake supervision for staff where required. To liaise with the multi-professional team to ensure there are plans in place where required for the safety of the new born and liaise with Vulnerable Adults where applicable. Where the cases are complex these are escalated to the Named Midwife for support. The Named Midwives role has expanded over 2012/2013 leading to closer working with Gynaecology, Safeguarding Adults and Learning Disabilities. The Named Midwife within NGH, co-ordinates Maternity & Gynaecology Safeguarding unborn/baby casework working with frontline midwives and staff in these areas. This service provides advice and guidance to staff dealing with the unborn and their families to ensure support is in place for successful parenting of the child. This service continues to grow in the number of cases identified due to their vulnerabilities in both children and adults. Recent cases have been identified linking with SOVA and close liaison with the Safeguarding Adult Lead and Lead Nurse for Learning Disabilities in NGH. **Named Doctor:** Two and a half programmed activity sessions are allocated for the Named Doctor role. This is utilised to provide staff with safeguarding advice and support. For complex cases, support is provided for case conferences, medical reports, and support for medical staff attending court in connection with safeguarding issues. The Named Doctor provides training for doctors at induction as well as bespoke training and peer

	review for senior medical staff. The Named Doctor supports the Executive Director for safeguarding through the Trust's Safeguarding Steering Group, input to serious case reviews and representation at the LSCB Quality assurance committee. The Named Doctor works with the Named Nurse and Named Midwife to fulfil the overall safeguarding agenda of the Trust.
5	**Safeguarding Children Effectiveness**
	The Named Nurse and Safeguarding Paediatric Nurse Advisers provide a comprehensive Liaison services in line with the Laming Report (2003) thus ensuring our primary care colleagues are kept fully informed of all paediatric admissions and discharges into the hospital. The team reviews all child cases seen in A&E and provides follow up where Safeguarding concerns may have been overlooked to ensure the right actions are taken. The team also provides assertive outreach to members of staff across the trust who are working active safeguarding cases. This outreach approach provides case by case supervision in real time, support for making referrals, assistance in contributing to strategy meetings and preparation for case conferences. We also support staff in the initial stages of completing common assessment framework assessments or contributing to the Team Around the Family meetings. Our main areas of concentration when outreaching to staff this year has been to raise awareness with staff around the following themes: • Children at risk of sexual exploitation • Think family in relation to parents/carers who attend A&E and the adult ward setting who may be struggling with mental health issues, and substance misuse • Domestic Abuse and the effects on children
6	**Safeguarding Midwifery Effectiveness**
	The Named Midwife and Safeguarding Midwives review all high risk Child Protection cases with the Central Team ensuring that there are robust pre- birth plans in place; this then ensures that there are clear safety plans in place for discharge of mother and baby from NGHT. This service liaises closely with a multitude of services in health across the County, Region and Country to ensure information is shared about vulnerable women and families that could have an impact on the unborn /baby. This will ensure the safety of mother and baby is paramount. When babies are removed into Local Authority care then the LAC Named nurse is informed to ensure continuity of medical care for the baby. Administration support within the Safeguarding team ensures all Safeguarding paperwork is transferred routinely into baby's medical records, ensuring all information is available when the child attends for an LAC medical at NGHT. Close liaison with NGHT security and child and adult safeguarding is

maintained and risks are escalated to risk management as appropriate, thus ensuring excellent internal communications.

The Safeguarding Midwives attend all case conferences where the community midwife or Central team midwife is unable to attend. The Safeguarding team have attended Case conferences in 2012-2013 leading to 51 unborn children being placed on Child Protection Plans in this period. Pre-birth planning meetings are attended by the Safeguarding team and 58 pre-birth plans were created in this period. In 2012-2013, 12 babies were removed at birth, which requires sensitive handling by the midwifery staff involved fully supported by the safeguarding midwives.

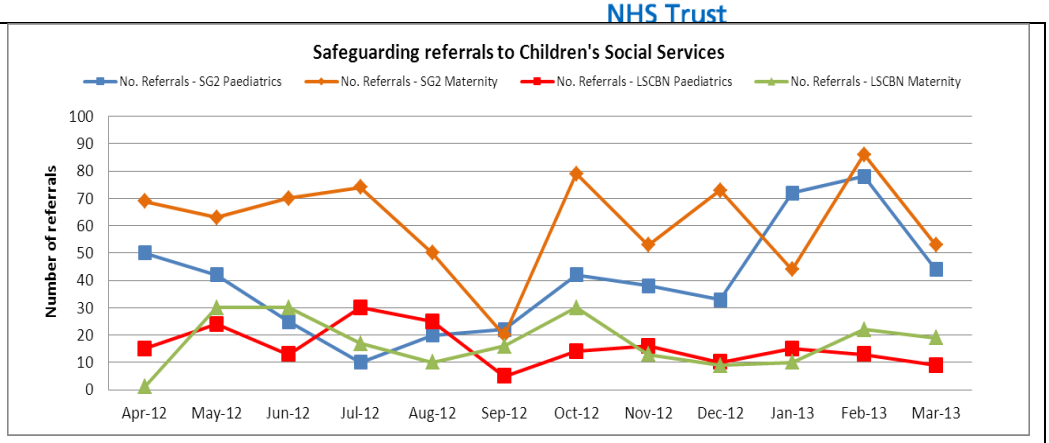
A number of themes have been noted over the past year this includes:

- The number of pre-birth cases with identified Learning Disabilities has risen in Maternity and in response led to the Learning Disability Guideline being developed in NGHT, but also working across the County to ensure all disciplines are reviewing guidance in line with national legislation.
- Safeguarding adult concerns are now being recognised better within midwifery which has led to referrals increasing to Adult social services and a closer working relationship with the NGHT SOVA lead.

7 Safeguarding Midwifery and Paediatric activity

Safeguarding Midwifery and Paediatric Activity

	April 1st 2011- March 31st 2012	**April 1st 2012- March 31st 2013**	**Percentage increase**
Paediatric Concerns (SG2)	422	476	+12.7%
Maternity Concerns (SG2)	618	690	+17%
Total Concerns shared with community health colleagues for year end	**1040**	**1166**	**+12.1%**
Paediatric Interagency Referrals	222	172	-22%
Maternity Interagency Referrals	145	197	+36%
Birth rate	5547	4681	-16% birth rate decrease.
Total referrals sent to Adult and Children Services for year end	**367**	**369**	**=0.5%**



Commentary

Within the Midwifery Safeguarding team we can evidence an increasing rate of SG2 (+17%) and interagency referrals (36%) this demonstrates that professionals working in Gynaecology & Obstetrics are embedding Safeguarding into their practise and are highlighting concerns and referring in a timely manner. The Safeguarding Midwifery team are reviewing ways in collecting the data to evidence how this 36% increase has an impact on the service and the work load.

Within paediatric safeguarding we can evidence an increase rate of SG2 (+12.7%) but a decrease in the number of referrals (-22%). However in other areas of activity the paediatric safeguarding team have increased their activity and now attend MARAC and the CSE Forum. All of the children highlighted at risk of domestic abuse, child sexual exploitation or on a child protection plan or looked after are now flagged on our A&E system and followed up by the safeguarding nurse advisers when they attend A&E.

8 Serious Case Reviews (SCR)

Two Individual Management Reports (IMR) were completed in the last financial year and one was started in January 2013, being submitted in May 2013.

In the first serious case review there were no specific recommendations for NGHT

In the second serious case review recommendations for NGHT included

- Review Domestic Abuse (D/A) guideline and procedures within NGHT
- Improve the system for discharge system from Midwife to Health Visitor
- Ensure all clinical staff use name stamps
- Ensure local protocol for management of child deaths fully reflects LSCBN protocol
- Ensure all conversations with external agencies are accurately recorded
- Roll out bespoke training for recognition of non-accidental injury

A comprehensive action plan is in place and we are on track to achieve all actions within the LSCBN time frame.

In the third serious case review the following recommendations for NGHT were made:

	• Strengthen midwifery bespoke training to understand the specific vulnerabilities for families in the armed forces • Know when to refer cases for consideration for serious case review • Strengthen the messages around the risk of hidden men
9	**Training**
	All NGH staff can access safeguarding children training in accordance with the Intercollegiate Guide: Safeguarding Children and Young people: roles and competences for health care staff (2010) to enable them to recognise signs of abuse and to make appropriate referrals. Training is provided at three levels • Level 1: Non-clinical staff working in health care settings equating to one hour every three years
	• Level 2: Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers equating to two hours every three years • Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. Equating to three hours every year to include face to face training, experiential learning and interagency training within a three year cycle. Level 3 candidates also benefit from a training passport to evidence all aspects of their learning and a level 3 learning zone providing articles on key topical subjects for example lessons learnt from the Savile investigation and the warning signs to look for when children are at risk sexual exploitation. • Level 4: Named professional equating to four hours per year of specialist level training and exposure Training uptake continues to be a problem and was highlighted as inadequate by the recent unannounced Ofsted inspection. The Ofsted target is 85% compliance across levels 1, 2 and 3 training. We have achieved 97% compliance at level 1 but are averaging 60% compliance for levels 2 and 3. A training uptake improvement plan has been in place with a number of key actions: • All out of date staff or about to be out of date staff receive an email which is copied to their manager to encourage them to attend training • Course spaces have increased from 25 per session to 40 per session increasing capacity across the training • Cluster training days increased to two per month which is showing a gradual

improvement in figures. Cluster now includes combined lever 2-3 training.

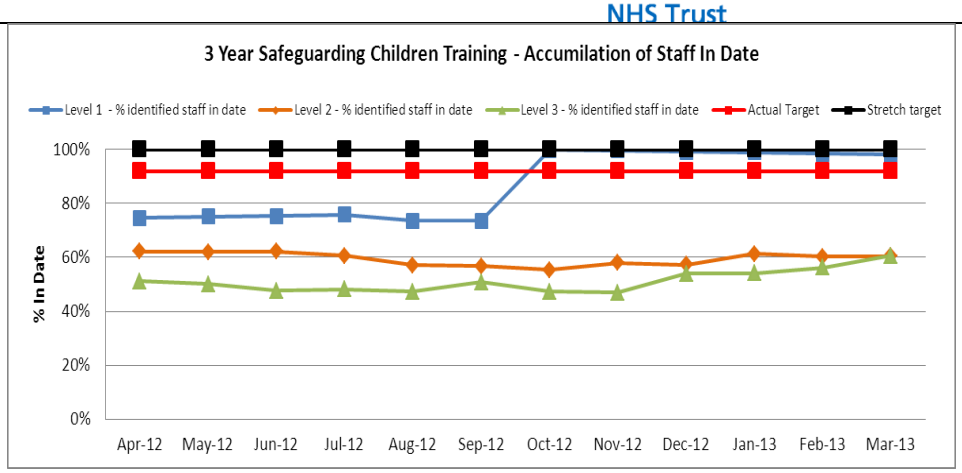
- Level 2/3 now included on induction programme, two cluster days per month delivering levels 1-3 training
- A training increase trajectory per department has been provided to the Safeguarding Children Steering group which will be cascaded to departments heads for action
- The trust now has access to level 1-3 on-line training which is available to all staff

The safeguarding Teams also provide bespoke level 3+ training to teams within A&E, paediatrics and Obstetrics and Gynaecology, all doctors in these areas receive safeguarding level 3 training at their induction and all consultants receive a yearly update session facilitated by the Named Professionals. In addition all midwives rotating into the community have an update with the Safeguarding team to ensure Safeguarding is embedded into practise. All midwives and paediatric nurses on induction receive 1:1 time with their relevant safeguarding teams to ensure they understand the hospital procedures for safeguarding.

The training presentations are updated regularly and now include specific slides to address:

- Hearing the child's voice
- Child Sexual Exploitation
- Lessons learnt from local serious case reviews
- And themes related to hidden men, domestic abuse and other family risk factors
- The training has also been reviewed to reflect changes from Working Together 2013 and local LSCB procedural changes

Training Statistics



Comments: Though Level 1 has reached full compliance (85 %+), level 2 and 3 remain a concern this has also led to us receiving an inadequate rating from CQC/Ofsted unannounced inspection. The figures for level 2/3 training are disappointing however the capacity of training places offered is adequate to meet the needs of the Trust.

10 **Child Abuse Allegations Against Members of Staff**

During 2012/2013 seven cases were considered under the policy for staff with allegations of abuse against children.

Only one member of staff has required suspension but was then reinstated after an appeal to the Independent Safeguarding Authority was successful. All other members of staff were either deployed to non-patient contact areas whilst investigations took place or took time on sickness leave to attend to their mental health. None of the investigations required any further action and all staff were reinstated.

11 **Complaints**

There were three complaints to the Trust during April 1st 2012- March 31st 2013

Complaint one related to parents whose infant had been referred to social services for alleged non-accidental injury, the learning was as follows:

- Paediatric Team to work in consultation with Radiology Department regarding the protocol for parents attending for imaging with children.
- Nursing staff to be informed that they must ensure that diagnostic testing/investigations and a child regular routine, are discussed fully with the parent/s at the time.
- Staff will be told that they should explain to parents that where a Social

	Services referral has been made, the police may be involved at some stage. Complaint two related to parents not agreeing to a referral being made to children's social services, the investigation showed that all safeguarding procedures were followed appropriately. Complaint three related to an extended family member alleging that safeguarding procedures had not been followed correctly after an infant was referred to social services. The investigation showed that safeguarding procedures had been followed but that the outcome from social services was not what the family had expected. All the complaints show that when families are referred to social services due to safeguarding concerns that this is a stressful experience for the family. Complaints give us an opportunity to explain in full the safeguarding processes and hopefully give the family some resolution in what are very difficult circumstances.
12	**Governance and Monitoring**
	The Safeguarding Children Steering group is led by the Deputy Director of Nursing with support from the named professionals and senior representation from nurses across the two care groups. The Safeguarding Children Steering group sits monthly and reviews the following plans: • The Safeguarding Children Improvements Plan • The Safeguarding Children Audit Schedule • Any new national or regional safeguarding documents, legislation, schematic reviews, on receipt of these a full gap analysis is completed and required actions taken • Training compliance data • Local LSCBN actions for interagency partners • Feedback on LSCBN policies, procedures and assurance score cards In addition specific action plans related to serious case reviews and the recent Ofsted post inspection action plan are reviewed. The Safeguarding Children Steering Group reports directly to the Clinical Quality and Effectiveness Group (CQEG). A quarterly patient safety exception report is produced and a bi-annual safeguarding children report is produced for CQEG. During 2012/13 the Safeguarding Children Policy was rewritten and ratified by the trust. In addition the Midwifery Safeguarding team reviewed the following midwifery specific

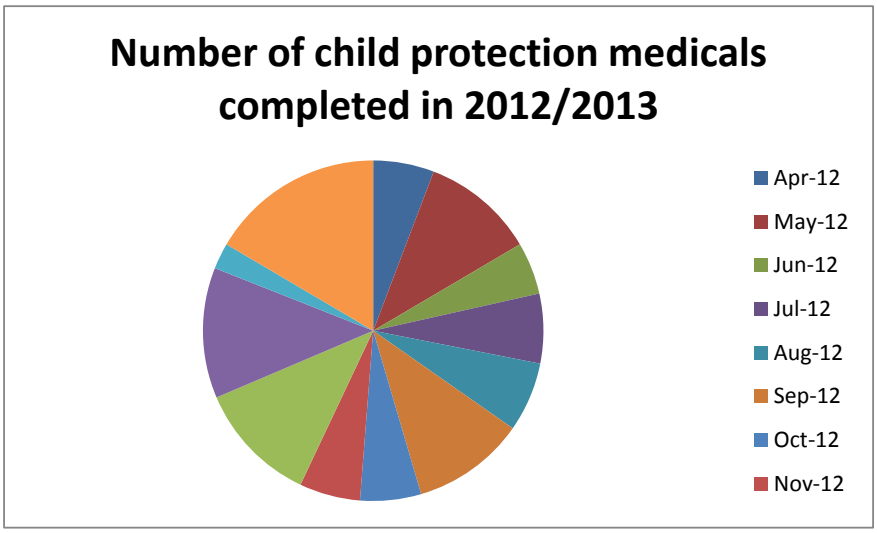
	guidelines: • Domestic abuse, • Safeguarding supervision, • Learning disabilities and concealed pregnancy. The named nurse attends quarterly confirm and challenges for outcome 7b and ensures that Health Assure is kept updated. Currently we are green in all areas apart from training compliance and youth involvement in service delivery. The Named Nurse coordinates the trust's response to the LSCBN on the Looked After Children and safeguarding children dashboard. A number of audits have been completed or are in process, these include: • Audit Report for Paediatric Safeguarding Children Notes 2012 • Audit report for Midwifery Safeguarding children documentation 2012 • Monthly post training questionnaire to establish if learning has been effective started in September 2012 to present • Midwifery safeguarding caseload report 2012-2013 • Midwifery Domestic Abuse Audit 2013 The findings for each audit are fed back into the Safeguarding Children improvement plan and within training lessons learnt are emphasised.
13	**Looked after Children and child protection Medical Assessment Service**
	Since January 2013, there has been a new Lead Paediatrician for 'Looked After Children's Services' for the South of the County. The comprehensive health assessments are provided locally to ensure that unmet health needs of these children are addressed and for each child there is a comprehensive health care plan provided. The lead clinician has regular meetings with the county wide designated doctor and is also part of the 'Be Healthy' subgroup of the county council and has input in multi-professional strategic meetings There is an audit in place in South of county regarding health assessment of Looked after children which will be completed by October 2013. This audit will provide further information regarding quality assurances on both the processes and effectiveness of these assessments locally and to ensure that national standards are achieved. For this year, 231 clinic appointments were offered for these assessments and out of that 165 were attended. For more than 98%, the health care reports were sent in

agreed time frame. There is significantly improvement in attendance rate since January 2013 and a great deal of effort is included in engaging these children and young people. The high DNA rate particularly for 16 to 18 year cohort remains a challenge however new systems are included to make this process efficient.

Child protection medicals

This service provides medical assessments and opinions on children undergoing section 47 enquiries referred by social services. Input is provided by community paediatricians from the north and south of the county and is hosted by NGHT led by the Designated Doctor for Looked After Children. Quality assurance and peer support is provided by the designated doctor, the Named Doctor at NGH and the Designated Doctor for Child Death. There is an on-going programme of audits undertaken by these staff.

Child protection medicals activity 2012/2013													**to-tal**
	Apr -12	May -12	Jun -12	Jul - 12	Aug -12	Sep -12	Oct -12	Nov -12	Dec -12	Jan -13	Feb -13	Mar -13	
number of medi-cals com-pleted	7	13	6	8	8	13	7	7	14	15	3	20	**121**



The spread of child protection medicals completed per month ranges from 3-20, average per month ranges from 7-10.

14	**Compliance with Section 11 of the Children Act 2004**
	The Section 11 Audit was submitted in March 2013 and we were able to evidence the

	following: • 27 areas exceed requirements • 20 areas are effective • 3 areas are less effective Two of the three areas that are less effective relate to youth involvement in service development this has been raised as an issue across the Trust and is not just in relation to safeguarding. The third area relates to training uptake for level 2 and 3 not reaching the Ofsted requirement of 85% as mentioned earlier in the report and training improvement uptake plan is in place. Though we are less effective in 3 areas we are exceeding practice in 27 areas in the previous combined section 11 and markers of good practice audit (see below) we only rated ourselves as effective in 24 areas and exceeding requirements in one area, this shows a considerable rise in quality for safeguarding within the trust. The youth involvement area has dropped as previously the Named Nurse had met with the adolescent youth council and for three quarters of the previous financial year met regularly with the youth focus group. Unfortunately these young people have moved on and new candidates were not forthcoming. We await feedback from commissioners on the submitted audit.
15	**Compliance with Markers of Good Practice**
	In May 2012 we submitted a combined markers of good practice and Section 11 audit are self- assessment was as follows: • 24 areas effective • 1 area exceeds requirements Commentary from commissioners was as follows: **2012 S11/MoGP Self-assessment-key risks & issues:** • Leadership and strategic direction is being addressed proactively within the organisation. **(positively addressed)** • The organisation address Level 1 training to all staff by producing a safeguarding leaflet that is distributed to all staff with their payslips on annual basis. **(positively addressed)** • It is recognised that there is significant turnover of staff within acute hospital trusts including a rotation programme of medical staff of up to 2 times a year, this needs to be factored into the organisational timetable to ensure that at vulnerable times safeguarding is addressed and covered. **(risk)** **NGHT response: All new doctors and nurses now receive level 2/3**

safeguarding children training at induction rather than level 1 training

- The Emergency Department within the organisation has been particularly targeted during the past 12 months to raise their awareness of safeguarding children and vulnerable adults especially in relation to initiating the self-harm pathway, recognition of child sexual exploitation and the wider safeguarding agenda to include vulnerable adults and revolving door patients. **(positively addressed)**

- The quality of referrals have improved within midwifery services, the Named Midwife has completed an audit on the quality of referrals and this has shown significant improvements. **(positively addressed)**

- Supervision is offered on a case by case basis ensuring assertive outreach to live cases to support clinicians

Key Development for 2012/2013:

- To progress the implementation of the safeguarding vulnerable midwives team, the posts have been recruited to but there have been capacity issues in releasing the staff to take up their new respective posts**. (risk)**

  NGHT response: This team has now been recruited to and was launched in Q1 2013

- Training numbers may fall due to capacity issues owing to increased workload pressures and remains a challenge for the organisation. The Named Nurse for Safeguarding undertakes bespoke training to enhance uptake of training across the organisation. **(risk)**

  NGHT response: This issue is being addressed through the safeguarding training improvement uptake plan (see section 9)

- The Emergency Department (ED) is an area that requires extra support in relation to safeguarding children especially out of hours. There has been a drive to increase dedicated Paediatric Nurses to increase the overall capacity of Paediatric Nurses to the department with the appointment of 3 extra Nurses. **(positive)**

- There has been on-going work to address the specific needs of young people nursed in adult areas and recognise safeguarding concerns in relation to this group of young people. **(risk)**

  NGHT response: Assertive outreach by the Named Nurse continues to the adult areas when a young person is admitted this approach is providing upward skilling of adult clinicians in relation to child safeguarding issues.

- There are on-going concerns regarding a consistent approach to pre-birth plans. The Named Midwife is in discussions with the Children's Social Care

	within the Local Authority to re-dress this shortfall in safeguarding vulnerable expectant mothers and unborn infants. **(risk)** **NGHT response; considerable progress has been made with social services by the Named Midwife and pre-birth plans are more robust and timely.** • The development of the Multi Agency Safeguarding Hub (MASH) and how the Safeguarding Named & Designated Professionals will feed into the MASH & Joint Child Protection Team (JCPT**)**. **(positive)** • The introduction of the training passport within the organisation to build a portfolio of training undertaken including safeguarding. **(positive)** • To continue to build on the good work initiated by the Named Nurse by involving members of the Young People's Shadow Board to shape and participate in service delivery within the hospital especially in relation to safeguarding. **(positive)**
16	**Vacancy Turnover**
	In the last financial year the band 7 Safeguarding Adviser Nurse retired, the post was re-banded from a 7 to a band 6 leading to an increase of hours when the team is available and the opportunity for career progression. The Midwifery Safeguarding team has been at full compliment. The Central midwifery team for vulnerable woman secured a further 1.4 WTE still to be recruited to. The Named Doctor has remained in post and in addition she now represents all health agencies as the Designated Doctor for child death reviews.
17	**Inspections**
	In January 2013 the Trust was visited by Ofsted and CQC inspectors as part of an unannounced inspection for Children's Safeguarding; this formed part of the inspection of all interagency partners including police and the local authority. The outcome of the inspection was inadequate across all aspects however health was deemed adequate in all areas. An interagency action plan has commenced and the key areas for NGHT include: • Representation at the MASH. Providing 3 to 4 days per month as part of the Health rota (achieved) • Capturing the voice of child and family through assessment process-universal to statutory processes: training has been enhanced and a monthly quality of referrals and safeguarding documentation is in progress to monitor improvements. • Audit the effectiveness of training currently delivered that captures the voice of the child (VoC) through admissions to hospital (ED, admission and discharge processes) interface with universal services, community midwifery, health

visiting & Family Nurse Partnership: a training article has been circulated to all staff in the trust and level 2/3 training has a section on eliciting the voice of the child and family. We are auditing monthly the effectiveness of training through a multiple choice questionnaire to candidates who have attended all levels of training.

- A universal evidenced base 'Early Intervention risk assessment tool' for pre-birth to 2 ½ year olds: the Named Midwife has been working at the interagency level to produce the peri-natal-pathway which is due to be launched later this year

- Embed the acute hospitals 'deliberate self-harm pathway' from Emergency Department through to child/young person's discharge. The DSH paperwork has been revised as part of an interagency project and will be re-launched in quarter 2.

- Review the effectiveness of the SG2 safeguarding health form through the Named and Designated Professionals forum. The SG2 for maternity has been significantly revised to reflect the interagency vulnerability matrix and will be renamed as the maternity safeguarding risk assessment tool. The SG2 for paediatrics and the wider hospital is to be replaced by a paediatric liaison form already developed and trialled by KGH. We aim to go live with this in August 2013.

- Increase the number of CAF's (common assessment frameworks) undertaken by universal health clinicians (Community midwives, Health Visitors & Children Young People Nurses) and within acute hospitals. CAF training is provided quarterly to level 3 staff, and when CAF's have been identified the safeguarding team give assertive outreach to the CAF lead clinician in producing the assessment. Few CAFS are currently being completed in the hospital however in an acute setting it is unlikely that we would initiate a CAF we are more likely to contribute to the Team around the Family meeting. The importance of CAF assessment is being stressed at all levels of training and through day to day case work.

- Review & refresh health representation at LSCBN-representatives to have the authority to make decisions on behalf of their organisations and have capacity to attend and contribute regularly to the safeguarding agenda. The Executive lead NGH's Director of Nursing is attending all LSCBN board meetings and is part of the Safeguarding Strategic Health Forum the integrated health response to the Ofsted/CQC inspection.

- Contribute to the development of a quality-based performance management framework to be implemented across the partnership

This integrated health action plan is being monitored by the newly formed Strategic Health Safeguarding Forum attended by all Named Nurses and Midwives and

	Executive leads for Safeguarding within all the health trusts in Northamptonshire.
18	**Staff Workforce Arrangements for Contracted and Agency Staff**
	All Staff that are recruited at Northampton General Hospital are subject to the NHS Employment Check Standards which includes Disclosure and Barring Service checks. All Job Descriptions include a paragraph relating specifically to safeguarding children. Reference requests include a question relating to safeguarding children. The appointing officer training now incorporates a reference to safeguarding children and the need to ask questions at interview. All agencies used at the Trust are obtained from the buying solutions framework. These agencies are audited by the Department of Health and are required to adhere to the NHS Employment Check Standards which includes Disclosure and Barring Service checks Wherever possible, Northampton General Hospital Trust seek to procure temporary staff from agencies that are validated on the Government Procurement Service Framework and adhere to the NHS Employment Check Standards. Any temporary staff that are supplied by an agency that do not appear on the Government Procurement Framework are individually assessed by the Trust against the NHS Employment Check Standards.
19	**LSCBN interface and interagency working**
	The Named Midwife attends the Named and Designated Professionals meetings along with her colleagues to share practises across the County and represent NGH. She also attends the Practise and Policy subgroup of the Local Safeguarding Children's Board Northants (LSCBN) reviewing the LSCBN procedures and other new practises within the County. She attends the East Midlands Network Safeguarding Board representing Midwifery and the Named Midwife group across the East Midlands; however this has been difficult to facilitate in 2013 due to the increasing volume of work. Other meetings which she attends are the County HBV meeting and support group for Named Midwives in the East Midlands. The Named Midwife is the single point of contact (SPOC) for NGH and represents NGH at Multi Agency Risk Assessment Conference for Domestic Abuse (MARAC) and liaises closely with the Police. The format of MARAC has developed over 2012/2013, meeting monthly and reviewing high risk domestic abuse cases ensuring safety plans are in place. Also information is shared with Children Safeguarding, Accident and Emergency and Safeguarding Adults to see if cases are known to NGH to share information about high risk cases of Domestic abuse. The named Midwife has led on the NGHT contribution to the multi-agency working party to design the pre-birth assessment pathway for the unborn to ensure there is a robust process in place. The Named Nurse attends the Named and Designated professionals meeting for

	NGHT at the LSCBN and also sits on the LSCBN subgroup for Learning and Development. She is a member of the interagency training pool delivering two courses related to parenting capacity and learning disability and mental health. She is currently future proofing the LSCBN training courses against Working Together 3013 and local agency changes. The Named Nurse represents the Health Economy for Northants on the local Child Sexual Exploitation (CSE) operational and strategic groups, ensuring that young people at risk of CSE are flagged within the two Hospitals A&E systems and that health information is collated when assessing children at risk. She also sits on the National Working Group (health) for CSE in association with the Children's Commissioner. The Named Nurse and Named Midwife in conjunction with the Executive Lead for Safeguarding, Suzie Loader attend the Strategic Health Forum which is monitoring and developing the CQC/Ofsted post visit action plan. The Named Nurse and Named Midwife contributed to the consultation and review of the Interagency Vulnerability matrix ensuring the acute hospital perspective was captured in the access criteria process.
20	**Areas of Good Practice and achievements**
	A number of service developments to improve the quality and robustness of the safeguarding process have been developed as follows: • The Named Nurse becoming an accredited trainer for the Prevent Strategy the coordinated government response to identifying vulnerable people at risk of radicalisation ensuring that staff receive training on the recognising key risk factors. • Common Assessment Framework (CAF) training now provided on a quarterly basis in conjunction with the CAF co-ordinators from Northamptonshire County Council. Over 300 members of staff have now received their CAF training. We hope this training will highlight to staff when a CAF should be undertaken, the increase of CAF assessments is a key action within the Ofsted/CQC post assessment action plan to ensure early help is forthcoming to families. • Midwifery Safeguarding Team presented at a local conference on female genital mutilation and honour based violence raising the profile of NGHT amongst our interagency partners. • Safeguarding Children policy ratified in quarter two • Annual Safeguarding Children update sent to all NGHT staff members via their payslip thus achieving 100% compliance with level 1 training • The Named Nurse and Named Midwife contributed to the development of the Multi-agency Safeguarding Hub and providing input with other health partners to the rota providing a voice for health at the early stages of safeguarding

referral assessments

- All paediatric and midwifery Doctors now trained on induction at level 3 ensuring a more robust understanding of safeguarding for Doctors.
- Secure emailing of referrals established the only health trust to achieve this in Northamptonshire, ensuring that referrals for safeguarding to children's social services arrive quickly and there is a clear audit trail allowing the monitoring of outcomes.
- Level 3 safeguarding children learning zone launched to assist staff in achieving their level 3 experiential component of their required safeguarding competency recognised by the LSCBN as a good practice initiative in our combined MOGP and Section 11 audit in Quarter one of the last financial year.
- The launch of the' Central team Western' Midwives working with vulnerable women in the west of Northampton, leading to an earlier more in-depth assessment of the needs of women who have vulnerabilities reaching level 3 to 4 of the interagency vulnerability matrix. The specialist team of midwives is managed by the named Midwife and they provide more intensive midwifery support with women with known vulnerabilities.

21 Review of last year's Key Risks and Challenges from last year Annual Report

Indicator	Actions Progress to date	Actions to carry forward?	RAG
Develop Trust wide ownership of safeguarding children	The Safeguarding Children Steering Group (SGCSG) has now achieved full representation from both care groups and thus safeguarding plans have been shared effectively across the Trust. The learning and Development subgroup meets monthly and is well attended all training developments are reviewed at this group. Other task and finish groups are created as needed.	Ensure care groups continue to be represented at the SGCSG	G
Implement training strategy robustly around the organisation to ensure all staff are trained at the	The Training Needs Analysis was completed and all staff are now in the right training level. Training uptake continues to be an issue for the Trust and was highlighted by the CQC/Ofsted inspection as	Risk: inadequate CQC rating Solution: The Trust has initiated a safeguarding training	A

	appropriate level and compliance with all levels of child protection training.	inadequate as we do not reach 85% across level 1-3, currently level 1 is compliant at 98% and level 2/3 is non-compliant at 60%	improvement uptake plan which has been circulated to all directorate managers. A projection of month on month percentage uptake has been calculated and will be reviewed monthly at the SGSG	
	Expand Level 3 training opportunities for the required staff group. Include opportunities for; • Bespoke training provided • Training for trainers • Improved attendance at LSCBN inter-agency training	Level 1-3 e-learning is now available to staff and is accessed via *the street.* Level 1-3 training has been reviewed and now includes references to latest serious case reviews. Working Together 2013 is fully referenced throughout. Emphasis on eliciting the voice of the child has been strengthened in line with the post CQC/Ofsted action plan. Opportunities for bespoke training to defined departments have been utilised with training provided to A&E, Midwifery, Doctors Induction and Senior managers receiving bespoke approach. Level three learning zone on the intranet has been launched to encourage opportunities for capturing experiential learning in line with best practice. Staff are now clear that they are required to attend interagency level 3 training on the third year of their safeguarding competency evidence.	Continue to develop bespoke training see Key risk and challenges for 2013/14	G
	Develop facilitators and Safeguarding Children Champions within other areas of the Trust to provide training and support staff	Much effort was employed to secure safeguarding champions across the Trust however staff identified either changed roles or left the Trust. Therefore the Named Nurse in agreement with SGCSG has decided not to move forward with this objective as it is not sustainable	No longer for action	
	Implement outstanding	All SCR action plans from this period have been completed,	see Key risk and challenges for	G

	actions from all serious case reviews	new IMRs have been completed and associated action plans are in place.	2013/14	
	Implement and monitor the revised Safeguarding Children audit schedule	The audit schedule was reviewed and key audits around documentation, quality of referrals, caseload, and training attainment have been implemented.	Carry forward to Key risk and challenges for 2013/14	G
	Prepare and complete new combined LSCBN Section 11/MOGP audit expected March 2012	Achieved	See section 14 of this report	G
	Monitor and update the Performance Accelerator outcome 7B quarterly to ensure the Trust remains compliant with CQC registration	Achieved	Carry forward see Key risk and challenges for 2013/14	G
	Ensure all named professionals continue to maintain their level 4 training requirements	Achieved		G
	Following Adult and Children Service (ACS) restructure continue to ensure that outcomes are received following Child Safeguarding referrals	Obtaining of outcomes from ACS continues to be an issue; all referrals that have not received an outcome are escalated to senior management in ACS. Ofsted/CQC inspection highlighted that health needs to challenge ACS when outcomes have not been received or are not effective.	Challenge-Risk Solution: close liaison with Adult and Children Service leads, ensure systems for monitoring late outcomes are in place and escalated as necessary carry forward see Key risk and challenges for 2013/14	G
	Establish Youth Involvement in the development	The youth involvement group was established but as the young people moved on replacements	The group therefore will not be taken forward the Named	No further action

	of Safeguarding Children Services	could not be found and the Named Nurse did not have the capacity to provide enough contact with the youth group to maintain involvement	Nurse has flagged with governance as a Trust wide need to involve young people in service development	
	Aspire to meet all five key objectives from the LSCBN Business Plan	The Trust has worked closely with the LSCBN to help achieve their objectives. After the CQC/Ofsted inspection in January an integrated health action plan has been developed and is included into the Safeguarding Children Improvement Plan	Improvement to Service: Solution: all objectives to achieve the Business plan have been incorporated into the Trust's Safeguarding Children Improvement Plan and are monitored bi-monthly at the SGCSG	G
	Achieve closer interagency cooperation with Northamptonshire Healthcare NHS Foundation Trust Child and Adolescent Mental Health Service (CAMHS) to achieve objectives of the Interagency Self-Harm Pathway	Achieved: the named Nurse now acts as the main point of contact with CAMHS clinicians where safeguarding concerns are identified for young people who self-harm. The Named Nurse has worked closely with the Modern matron for Emergency medicine, the Named Nurse for KGH and the Nurse Consultant at CAMHS to develop a more robust deliberate self-harm care pathway	Once pathway is in place will need to monitor its effectiveness through quarterly audit therefore carry forward see Key risk and challenges for 2013/14	G
	Ensure Integrated Working Procedures and Common Assessment Framework (CAF) approach is embedded into the Trust	CAF training is provided quarterly to level 3 clinicians by the CAF coordinators. The integrated working procedures are used in training as part of a group exercise and all clinicians who attend level 2/3 training receive a copy. The number of CAFS however initiated by the Trust is disappointedly low and this was highlighted as an area of improvement by the Ofsted/CQC inspection team	RISK: Trust will not achieve objective from LSCBN to increase CAF initiation Solution: Community teams were tasked with reviewing caseloads to see if any cases require a CAF, this action will need to be taken forward see Key risk and challenges for	A

				2013/14	
	Strengthen the Trust's Safeguarding approach to Young People aged 16 plus who choose to be cared for in adult areas and for children under the age of 13 who require termination of pregnancy	Achieve: an assertive outreach approach has been taken with the adult wards, whereby when a child is admitted to the adult ward the safeguarding team are informed if safeguarding issues have been raised. The safeguarding team member make it a high priority to attend the ward in hours to support staff in progressing any safeguarding required actions. Training emphasises the needs of the 16 plus age group and there is evidence of more referrals being initiated from the adult areas.		Achieved	G
	Develop easy read leaflets for clients with learning disabilities or language problems in line with the other leaflets that have been developed by the Modern Matron for Paediatrics and Learning Disability	Named Midwife	A Task and Finish group to be established to look at key safeguarding midwifery documentation that requires easy read format	Improvement of Service: Solution: Task and finish group in Midwifery Stretched Solution: Task and Finish group to also include paediatric safeguarding literature. Debbie Wigley Safeguarding Nurse for Adult LD has completed a number of leaflets and will complete the project shortly	Green
	Policy Development	Named Professionals	Task and Finish groups to be established to develop key policies for: ✓ children who miss appointments ✓ missing children protocol; ✓ Trust wide Safeguarding Supervision policy	The Safeguarding Children Policy was ratified in August 2012 however due to the three SCR and retirement of Safeguarding nurse band 7 when the Named Nurse was operational for 4 months the other two policies were not achieved. Therefore will need to be taken forward see Key risk and challenges for	Partially achieved

			2013/14	
Safeguarding Vision and Training Strategy	Named professionals	This piece of work will not commence until the Government's review of Working Together to Safeguard Children 2010 is complete	The Working together 2013 was only published in May 2013 and therefore will need to be taken forward see Key risk and challenges for 2013/14	Not started
Review opportunities for closer working between Paediatric and Midwifery Safeguarding Children Teams	Named professionals	The Trust's Transformation Programme has led to the Midwifery and Paediatric departments being managed within the same care family, this is an ideal opportunity to look at how assurance and practice can be brought closer together if appropriate	Closer working between Midwifery and Paediatric safeguarding teams has been achieved. In addition closer working has also been achieved with Adult Safeguarding. The Governance review has now been completed and Safeguarding is now placed within governance as an integrated team. The appointment of a Head of Safeguarding and Dementia is due to take place in June 2013 their role will be to lead on full integration of the three safeguarding remits within the Trust.	G
Review current systems of liaison between NGH paediatrics and A&E and community health services	Named Nurse Safeguarding Nurse Advisers NHFT Modern Matron for Safeguarding Children NHFT Safeguarding Liaison Nurse	Review the SG2 paperwork and current system of liaison in conjunction with the Northamptonshire Healthcare NHS Foundation Trust Safeguarding Liaison Team	The SG2 for midwifery has been rewritten to reflect interagency vulnerability matrix and requirements of the common assessment framework. The SG2 for paediatrics will be replaced with the Paediatric Liaison Form which has been piloted by	In progress

			KGH, this change over will happen in August 2013	
Establish electronic transfer of interagency safeguarding children referrals to Adult and Children Services (ACS)	Named Nurse NGH IT project lead ACS Governance lead	Currently referrals are faxed but ACS have now developed a secure web portal and the faxed facility will be phased out	Achieved all staff have access to instructions on how to use the secure email route and this is also embedded in all levels of safeguarding children training	G
Improve data collection re Vulnerable pregnant women	Named Midwife	Review and develop the data collected around vulnerabilities in Maternity to ensure the correct services are in place and meets the requirements for NHLSA ,NICE and CNST	Improvement of service: Solution: more robust data collection will lead to improved service delivery for vulnerable women. This is in progress and will be more comprehensive when the central team achieved full establishment by Autumn 2013	amber
Develop new community midwifery team for vulnerable pregnant women	Named Midwife	A team specification has been developed and recruitment to the team is in progress	Achieved the team went live in May 2013	G

22 **Key Risks and Challenges and plans for the future 2012/13**

Objective	Actions	Progress to date	Risk, challenge or future plan to improve Safeguarding Children Service
85% compliance rate for level 2 and 3 training is required by CQC/Ofsted	Monitor training improvement uptake plan, directorate	Plan in place, all directorate managers have been asked to forward an action plan by July 2013 which will be monitored by SGCSG and	Currently we are maintaining 98% at level 1 and only 60% at level 2 and 3,

	management to ensure 85% target is reached	reported to CQEG	assertive ownership of the improvement trajectory to achieve 85% needs to be shown by the directorate management
Continue to develop bespoke training for level 3	The learning and Development Subgroup will produce specific level 3 topics that meet the needs of targeted areas, e.g. Midwifery and A&E	The Named Midwife is developing level 3 refresher training that highlights lessons learnt from SCR in relation to domestic abuse, hidden men, and escalation of concerns. The named Nurse is developing Non-Accidental Injury training that will be targeted at A&E staff and paediatrics.	The two areas of training development will improve the quality of training for level 3 clinicians and will contribute to our response to the recommendations from SCRs.
Implement ensure all SCR recommendations are met	Monitor all SCR action plans through the SGCSG	A composite action plan from the LSCBN has been developed and the Named Nurse is maintaining the actions and evidence to be inputting into the composite action plan	The key areas where we need to show embedment of lessons learnt are in A&E in relation to CDRA and DSH and within Midwifery in relation to hidden men, and domestic abuse and historical abuse and the impact on parenting
monitor and review the revised Safeguarding Children audit schedule	Review bi-monthly through the SGCSG	Audit schedule now populated and audits scheduled for next financial year to meet Safeguarding Improvement plan objectives	Audit schedule provides the evidence to show compliance with S11 and MOGP
Following Adult and Children Service (ACS) restructure continue to ensure that outcomes are	Review monthly and monitor in SGCSG	Systems in place within maternity and paediatric safeguarding to track referrals and outcomes. System for escalation to ACS management in place	This is a risk area as due to the capacity issues within ACS outcomes information is not being received in

received following Child Safeguarding referrals			a timely manner
Establish Youth Involvement in the development of Safeguarding Services	To put forward to Head of Safeguarding to lead	Named professionals to assist head of safeguarding to establish sustainable youth involvement strategy	This is a risk area under our S11 audit we are at less than expected practice
Meet objectives set by the Strategic Health Safeguarding Forum as part of the post CQC/Ofsted action plan	SGCSG to review plan monthly and monitor input and effectiveness	Named Nurse to ensure objectives are captured in the Trust's Safeguarding Children Improvement Plan	This is a high priority for the Trust to ensure we meet all objectives for raising quality across the partnership for safeguarding children
Develop Safeguarding Children element of the Three year Strategy for Safeguarding	Named professionals in conjunction with head of Safeguarding and Dementia to contribute to the three year strategy for integrated Safeguarding	Not started	To ensure that an integrated safeguarding service is achieved to ensure seamless transition between the three elements of safeguarding.
Establish paediatric liaison form in the Trust	Named Nurse Safeguarding Children	In progress due for completion by August 2013	Improve information sharing between hospital and community services to include health and social services
Establish use of revised midwifery SG2	Named Midwife	Already developed and piloted needs embedding	Improve information sharing between hospital and community health services
Bespoke training	Named professional	Named Midwife to develop bespoke refresher training	Ensure high quality training is

		s monitored by SGCSG	for midwifery. Named Nurse to develop bespoke training on NAI Named Doctor to continue to offer experiential learning to paediatricians	available to clinicians who need to maintain their level 3 competency
	Midwifery Group Supervision	Named Midwife monitored by SGCSG	Named Midwife to embed monthly supervision for Midwives scheduled to start June 2013	Meets requirements from SCR
	Ensure more CAF initiated within the acute setting	Named Midwife, named Nurse monitored by SGCSG	Number of CAFS initiated by the hospital to increase in line with commissioner targets	To ensure early help for vulnerable families is achieved
	Ensure that safeguarding systems and processes within he Trust fully reflect Working Together 2013	Named Nurse with support of Named Nurse and Named Doctor	Scope WTG 2013 and provide gap analysis and action plan for meeting gaps	Ensure safeguarding is robust across the Trust
	Monitor and review Safeguarding Children Improvement Plan	Named Nurse, monitored by SGCSG	The Safeguarding Children Improvement plan to capture all aspects of the annual plan, LSCBN, CQC and commissioner requirements,	The plan ensures all activity to achieve objectives for safeguarding is both captured and monitored

23	**Summary**
	The Safeguarding Team has developed considerably over the past year with the closer working between the three individual safeguarding teams, with the new investment in the Head of Safeguarding and Dementia post we envisage a fully integrated safeguarding approach which will ensure patients from unborn, children or adult will have their effectively risk assessed and managed ensuring a seamless service delivery approach.

REPORT TO THE TRUST BOARD
31 October 2013

Title	Audit Forward Plan and Clinical Audit Report
Agenda item	12
Sponsoring Director	Dr Natasha Robinson, Associate Medical Director
Author(s)	Liz Gill, Interim DCASE Lead
Purpose	Approval of the Annual Clinical Audit Plan

Executive summary

- The Audit Forward Plan 2013/14 comprises both risk and compliance based audits which are aligned with corporate objectives and the Board Assurance Framework.
- The work of the Department of Clinical Audit, Safety and Effectiveness [DCASE] is rapidly expanding but the Department is not fully-staffed. Recruitment of the DCASE Lead and a new Senior Audit Officer post is needed.
- The Mortality and Coding Review Group was formed to promote trust wide ownership of issues raised by Dr Foster data to engaging clinicians in clinical audits relating to mortality alerts and in the monitoring of mortality as well as in acting on this outcome data. The role of this group is to be expanded to incorporate the deliberations from Morbidity and Mortality meetings with recommended actions and these will be formally reported in the Quarterly report on Safety, Quality and Governance.
- NGH participated in 100% of national audits and 100% of confidential enquiries on the Quality Account in 2012/13.
- There were no NGH surgeons identified as outliers in the specialty reports published as part of the Everyone Counts initiative. All relevant surgeons agreed to the publication of their data.
- Charges have been introduced for 8 HQIP national audits and the Patient Reported Outcomes Service [PROMS]. Provision will be made in future budgets.

Related strategic aim and corporate objective	(1) Be a provider of quality care for all our patients (3) Provide appropriate care for our patients in the most effective way
Risk and assurance	Risk: DCASE is not currently fully-staffed and the workload is increasing Assurance: DCASE activities provide assurance of compliance with clinical standards..
Related Board Assurance Framework entries	BAF1 BAF2 BAF4
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	Audit programme provides assurance of compliance with current statutory and mandatory requirements for healthcare providers.

Actions required by the Board

- Approve the Annual Forward Plan 2013/14
- Support the appointment of Senior Audit Officer (Band 6) post
- Note the increasing workload, particularly in engaging clinicians in monitoring outcome data

Clinical Audit Annual report and forward plan

1. Background

Clinical audit is designed to improve patient outcomes. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care (Ref: HQIP).

A structured programme of audits is needed

- to meet requirements for external monitoring eg, commissioners, CQC, NHSLA
- to monitor progress in completing audits
- to monitor the quality of clinical audit activity
- to monitor the impact of the programme
- To identify risks

2. DCASE Organisational changes

As part of the Governance Review responsibility for the Department of Clinical Audit, Safety and Effectiveness moved from the Nursing Director to the Medical Director from April 2013. Permanent funding for a 0.5 Specialty Doctor Audit and Governance reporting to the Associate Medical Director was secured and a full-time Band 6 Senior Clinical Audit Officer post with responsibility for Dr Foster replaced an existing Band 5 vacancy (0.6 WTE). An interim DCASE Lead is currently in post and recruitment to this vacancy and the Band 6 post has been agreed. The current interim's previous responsibility for monitoring and reporting monthly clinical outcome data has continued and is a planned addition to the work of the Department. Quality improvement and assurance is a rapidly expanding area of work.

3. Mortality and Coding Review Group

This group was formed in 2011 under the chairmanship of the Medical Director and was re-launched in a different form and with increased support in November 2012 with the aim of promoting trustwide ownership of issues raised by Dr Foster data and engaging clinicians in monitoring and acting on this outcome data. Meetings are held bi-monthly and are chaired by the Associate Medical Director (Clinical Governance). Attendees include Care Group Chairs and Care Group Managers for Medicine and Surgery; Coding Manager and Coding Audit Officer; Head of Information; Specialty Doctor Audit and Governance and DCASE Lead; clinicians from a variety of specialties and Dr Foster customer support.

The group determines for each issues whether there are issues that imply coding errors or whether there are issues relating to clinical care. This is determined for each area by means of a detailed case note review undertaken by the speciality and a review of the case note information and coding. In the case of issues relating to coding problems, the coding manager is tasked with making improvements in the coding department. Where clinical care issues are identified these are acted on locally where appropriate and are articulated in the monthly Medical Director's report if they are significant. Where the issues are more general as check is made that the issue has been incorporated into the patient safety programme

The Group has commissioned work and received presentations related to the following areas of concern:

Fig 1: Clinical care and coding reviews for Mortality and Coding Review Group

Reviews for Mortality and Coding Review Group
#NOF - mortality. Review of medical and anaesthetic care
Biliary disease / Patients receiving therapeutic ERCP - mortality
Chronic ulceration - mortality. Coding review
Congestive heart failure - mortality
Diabetes with complications - mortality
GI haemorrhage - mortality
Intestinal infection - a mortality
Leukaemia's - mortality
Oesophageal cancer - readmissions
Perinatal deaths including stillbirths - mortality
Peritonitis - a mortality
Pleurisy / Pneumothorax / Pulmonary collapse - mortality. Coding review
Secondary malignancy - mortality
Upper GI endoscopy - mortality

4. Case Note review Process

The clinical audit department supports a programme of case note review.

In 2011 at the time of concerns in relation to high mortality, the Medical Director commissioned a case note review of 3 months of each consecutive death in the hospital. This was done using a detailed structured case note review form where care was examined against certain standards by a team of 12 clinicians examining the case notes of patients who they had not cared for personally. Each clinician involved in the care of each patient received a letter from the Medical Director outlining the issues raised. A weekly challenge meeting was held to discuss the cases. The results were analysed and formed the basis for a trust-wide safety improvement programme which was formally launched in the summer of 2012 following the Trust Board approval of a Patient Safety Strategy. A process to refine and repeat this process every 6 months on 50 consecutive deaths was agreed and is in progress. This process has replaced previous attempts to examine all hospital deaths which had met with limited success in terms of driving improvement. Improvement work is now themed under five headings which cover the on-going themes of the patient safety programme. These are programmes to reduce harm from failures of care, failure to plan, failure to rescue and learning from serious incidents. Another work stream examines the human factor issues which cut across these programmes of work.

5. Prioritisation of Audits on the Audit Forward Plan

The first step in developing the Audit forward Plan is to identify all clinical audits which **must** be undertaken. It is essential that these audits are treated as priority and appropriate resources are provided to support them. Failure to participate may carry a penalty for the trust either financial or in the form of a failed target or non-compliance.

These are the core activities and include:

- NCAPOP and other national clinical audits reported on the Quality Account
- Audits demonstrating compliance with regulatory requirements e.g. NICE guidance, NSFs.
- Audits required by external accreditation schemes e.g. NHSLA, cancer peer review standards.
- Commissioner priorities including national and regional CQUINS audits.

The approval of additional audits for inclusion on the Audit Forward Programme is undertaken using a risk-based approach. From the initial discussion with the clinician and the information detailed on the 'Audit Proposal Form' the audit is assessed, aligned with the corporate objectives and key Trust strategies such as the Clinical Audit Strategy; Quality Strategy; Patient Safety Strategy and prioritised accordingly. Resources and support from DCASE will only be available for those audits that are 'risk based' and which aligned to corporate objectives, relevant strategies and target high risk areas.

Risks are identified by

- Review of audit proposal forms by the Associate Medical Director and Clinical Audit lead to align with corporate/BAF objectives, Trust priorities, and risks identified on Corporate/Directorate risk registers
- Identification of audit requirements arising as a result of serious untoward incidents or complaints.
- Identification of audits arising from poor clinical outcomes as notified by the Medical Director or Associate Medical Director.

The audit is entered onto the Audit Forward Plan, aligned with the relevant corporate objective, BAF No and linked risk. Audits that do not meet this risk based approach will not be undertaken by the department. However the audit may be undertaken locally with resource identified from within the Directorate. Details of the audit are still required for the Audit Forward Plan to maximize organizational learning.

6. Monitoring Progress

On a quarterly basis Directorates are required to report on published clinical audits reports and to identify actions and recommendations arising as a result of these audits. For national audits this is a formal system in place monitored via Health Assure. Information and milestones are tracked for each audit and feedback is sent to the relevant Directorate. Exception reports are reviewed by the Audit Strategy Group and follow-up actions are agreed. It is a requirement that doctors reflect on the findings of relevant national audits as part of their appraisal and revalidation process.

Recent focus of activity to improve performance has included:

- identifying barriers to data collection and/or submission of national audit data and supporting/facilitating the clinical teams to enable participation e.g. identification of qualifying cases; obtaining clinical notes; on-line data entry.
- supporting the revised standardized process for dissemination of findings from national audits
- assisting in the identification of data quality issues with national audit data related to individual surgical outcomes
- development of a site on the Intranet to make information on national audits available for appraisal and revalidation
- training for appraisers about the use of national clinical audits for appraisal and revalidation. It is planned to extend this training to consultants and SAs doctors.

7. Audit Forward Plan 2013/14

There are 155 audits included on the 2013/14 audit forward plan with a further 21 audits which require further clarification or the audit has been postponed or delayed. The Audit Forward Plan is available to view on the Governance shared drive and is updated on a monthly basis.

Fig 2: Percentage distribution by category of audits entered onto Audit Forward Plan 2013/14

Category	%
National Clinical Audits	34.8%
Regional Audits	1.3%
Compliance Audits e.g. NICE	27.1%
Patient Safety/ Mortality outcomes	13.5%
Local Audits	23.2%

32 of audits entered onto the Audit Forward Plan for 2012/13 were not undertaken for the following reasons;

- Failure by clinician to progress the audit following initial discussion with DCASE
- Delayed/deferred until 2013/14 [15 audits]
- Rejected
- Directorate resource issues

8. National Audits

Since the first Confidential Enquiry in 1952, national clinical audits have evolved and increased in number and there are now national audits relating to almost all areas of clinical practice. The audits may involve continuous data collection (e.g. MINAP, ICNARC) or can be snapshot audits (e.g. The National Comparative Audits of Blood Transfusion). The national clinical audits for inclusion in the Quality Account 2013/14 are listed in Appendix 1.

Participation in National Clinical Audits at Northampton General Hospital was excellent during the reporting period 2012/13; NGH participated in 100% of national audits and 100% of confidential enquiries on the Quality Account. Participation in clinical audit is regarded as an indicator of good performance by external regulators (e.g. NHSLA, CQC).

a. Participation

Fig 3: List of all National Audits (Quality account audits and other) in which NGH participates.

List of all National Audits (Quality Account audits and other) in which NGH participates
Accidental Awareness during General Anaesthesia in the UK [NAP5]
Acute Coronary Syndrome or Acute Myocardial infarction (MINAP)
Adult Critical Care (Case mix programme) (ICNARC / CMP
BAUS (British Association of Urology)
Bowel Cancer (NBOCAP)
BRONJ (Royal College of Surgery)
Cardiac Arrhythmia (HRM)
Chronic Kidney Disease in Primary Care (TBC new topic under development)
Chronic Obstructive Pulmonary Disease (COPD)

Clinical Outcome Review Programme - Child Health Programme (CHR-UK)

Clinical Outcome Review Programme - Maternal Infant & New born Clinical Outcome Review Programme (MBRRACE-UK)

Coronary angioplasty (NICOR)

Diabetes (Adult NDA)

Diabetes (Paediatric) (PNDA)

Elective Surgery (National PROMs Programme Hip & Knee)

Elective Surgery (National PROMs Programme Varicose Vein and Groin Hernia)

Emergency Oxygen Audit

Emergency Use of Oxygen (BTS)

Epilepsy 12 Audit (Childhood Epilepsy)

Falls & Fragility Fractures Audit Programme includes National Hip Fracture database (FFFAP)

Head & Neck Oncology (DAHNO)

Heart Failure (HF)

Inflammatory Bowel Disease (IBD)

Lung Cancer (NLCA

Moderate or severe asthma in children (care provided in Emergency Departments)

National Audit - Comparative Audit of use of anti-D

National Audit of Dementia (NAD)

National Audit of Seizure Management (NASH 2)

National Audit - Audit of patient information and consent

National Cardiac Arrest Audit (NCAA)

National Care of the Dying Audit Hospitals (NCDAH) Round 4

National Diabetes Inpatient Audit

National Emergency Laparotomy Audit (NELA)

National hip fracture data base

National Joint Registry (NJR)

National Pregnancy in Diabetes (NPID) Audit

National Vascular Registry (NVR)

NCEPOD - Gastrointestinal Bleed

NCEPOD - Sepsis

NCEPOD Lower Limb Amputation

NCEPOD Tracheostomy care

Neonatal Intensive & Special Care (NNAP)

NGH - BSUG database for Incontinence and Prolapse Surgery Royal College of Obstetricians and Gynaecologist)

NICE BAD National Audit on Psoriasis (British Association of Dermatologists

Oesophago-gastric Cancer (NAOGC)

Ophthalmology (TBC new topic under development)

Paediatric Asthma

Paediatric Bronchiectasis

Paracetamol Overdose (Care provided in Emergency Departments)

Prostate Cancer

Renal Replacement Therapy (Renal Registry)

Rheumatoid and Early Inflammatory Arthritis (TBC new topic under development)

Sentinel Stroke National Audit Programme (SSNAP) includes SINAP

Severe Sepsis & Septic Shock

b. Everyone Counts

HQIP has recently coordinated the project 'Everyone Counts' which has produced activity, clinical quality measures and mortality rates from national audits for consultants practising in the following areas:

Adult cardiac surgery [not carried out at NGH]
Bariatric surgery [not carried out at NGH]
Colorectal surgery for bowel cancer
Head & Neck Surgery for cancer
Interventional cardiology
Orthopaedic surgery [hip and knee replacement and revision]
Thyroid & Endocrine surgery
Upper GI surgery
Urology
Vascular surgery.

All reports have been published [July-September 2013] and no NGH surgeons have been identified as outliers. The preliminary outcome data from the bowel cancer audit was inaccurate and the report was delayed to enable corrections prior to publication. This initiative has highlighted the importance of surgeons owning their own data and more work is required to ensure 100% contribution of relevant cases; accurate attribution of procedures; completeness of data items.

c. Charges

Charges for participation have been made for the first time for 8 HQIP national audits [approx £20,000] and the Patient Reported Outcomes Service [PROMS] service [approx. £4,000]. Some audits not on the Quality Account have also begun charging before registration e.g. College of Emergency Medicine audits [£1,000]. Provision will be made in the budget for 2014/15 for this additional expenditure.

9. Other Audits

Audits may be undertaken as a result of risks identified by the Patient Safety Academy or through locally identified risks. Other priority audits include audits to measure compliance against national standards including NICE.

Fig 4: List of all audits undertaken as a result of locally identified risks

List of all audits undertaken as a result of risks identified through the Patient Safety Academy or locally identified
Drug Allergy Documentation at NGH (Audit Abstract 2013)
Early Warning Score Trustwide Audit
Effective handover of elderly care patients between medical and rehab wards (Knightly/Brampton Wards to Compton Ward)
End of Life Care Audit (including Liverpool Care Pathway)
Exclusion of orbital lenses on CT head examinations - reaudit and comparison with previous audits (Audit Abstract 2013)
Fluid Balance Completion
Patient safety - improving the ward round (Audit Abstract 2013)
Pressure ulcer prevention documentation process (Northampton University Student Nurses)
Safe Patients - Safe Handover - The Electronic handover system
Theatre Infection Prevention Practice Audit (refer 02-2012 evidence file and email)
Time to Consultant Review
Treatment plans - documentation in notes (Audit Abstract 2013)

Ward round at NGH - an assessment of structure and content (Audit Abstract 2013)
Whiteboard Audit (6 monthly)

10. Current Progress

Fig 5: List of audits for which we are awaiting the start date for data collection

Awaiting start date of audit
Pre and post-operative cataract assessments and complication rates in NGH (Audit Abstract 2013)
Accuracy of MRI for endometrial cancer staging
Missed cancers in DCBE examination 2012 - reaudit
Whiteboard Audit (6 monthly)
Rheumatoid and Early Inflammatory Arthritis (start date February 2014)
National Audit - Audit of patient information and consent [start January 2014]
National Emergency Laparotomy Audit (NELA) [patient data collection]
Prostate Cancer
NCEPOD - Gastrointestinal Bleed
NCEPOD – Sepsis

Fig 8: List of completed audits where report has been published and actions and recommendations are awaited

Report published but actions and recommendations are awaited
Adult Asthma (Q2 report)
Bowel Cancer (Q2 Report)
Bronchiectasis (Q2 report)
Emergency Oxygen (Q2 report)
Fever in Children (Q1 Report)
Fractured Neck of Femur (Q1 Report)
Head & Neck (Q2 report)
National Diabetes Inpatient Report (Q2 Report)
National Oesophago-gastric Cancer (Q2 report)
NHFD (Q2 report)
NJR (Q2 report)
Renal Colic (Q1 Report)
TARN (Q.1 report)
TARN (Q.2 report)

11. National Audits – Exceptions / Points of Interest

<u>NDA: National Diabetes Audit</u>
A Diabetes Register for adult patients has been purchased and staff received training but there appear to be teething problems with the data collection process.

<u>National Sudden Arrhythmic Death Audit</u>
NGH is now registered and has an agreed lead. However the audit admin team have delayed the start as the data collection software is in transition to a new system. This is not a Quality Account audit.

National Paediatric Diabetes Audit
Data collection is due to start in November but there are potential problems with the Paediatric diabetes software being unavailable.

Inflammatory Bowel Disease (IBD Audit)
There has been no data entry to the Biologics Therapy strand of the National IBD audit. Details of all new patients receiving this treatment should be recorded using an on-line tool. It is hoped that the appointment of a specialist nurse may lead to new patients receiving treatment being registered on the database.

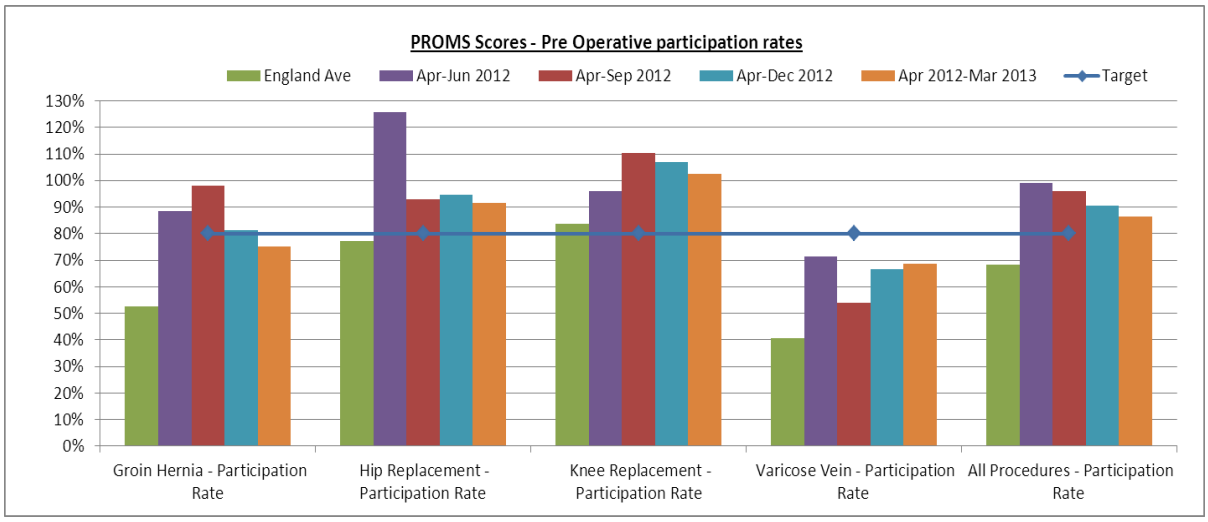
New Audits on Quality Account
The following audits have been added to the 2013/14 Quality Account. Further information is awaited prior to the start of data collection in 2014. The topics are as follows

- Chronic Obstructive Pulmonary Disease
- Prostate Cancer
- Rheumatoid and early inflammatory arthritis

Patient Reported Outcome Measures

The Patient Reported Outcome Measures programme is a compulsory audit that measures a patient's health status or health-related quality of life. The measures are a means of collecting information on the clinical quality of care delivered to the NHS patients as perceived by the patients themselves. The procedures covered in the survey are hip and knee replacement, groin hernias and varicose veins.

The latest Quarterly HES data (published 14.8.13) on pre-operative participation rates for PROMS is illustrated in the chart below. This includes patient episodes from April 2012- March 2013 and shows that participation for all procedures is above the national average.



12. Self-Assessment Matrix

Appendix 2 contains the annual review of progress against the Self-assessment matrix published by HQIP. Limited progress has been achieved this year because the Department is yet to be fully staffed and there have been difficulties with continuity of staff in Care Group and Directorate governance teams.

13. Recommendation

The Board is asked to note this report which is provided for assurance and to consider the increasing requirement for robust clinical audit. The requirements are likely to increase as the focus on accurate data relating to clinical outcomes increased**.**

14. Next Steps

The recruitment of the substantive posts in the audit department must be expedited and the essential links between clinical risk and clinical audit need to be strengthened**.** This will be facilitated once the new governance structure is embedded in the organisation.

Appendix 1

National audits for inclusion in Quality Accounts 2013/4

- Coverage - intention to achieve participation by all relevant providers in England.
- Data collected on individual patients
- Provides comparisons of providers
- Recruiting patients during 2013-14

**** Services are not provided by Northampton General Hospital***

Peri-and Neo-natal

Neonatal intensive and special care (NNAP)
Maternal, Infant and new born clinical outcome review programme (MBRRACE-UK)

Children

Paediatric asthma (British Thoracic Society)
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
*Paediatric intensive care (PICANet)**
*Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit**
Diabetes (RCPH National Paediatric Diabetes Audit)
Moderate or severe asthma in children (care provided in emergency departments (College of Emergency Medicine)

Acute care

Emergency use of oxygen (British Thoracic Society)
Cardiac Arrest (National Cardiac Arrest Audit)
Adult critical care (ICNARC CMPD)
Emergency Laparotomy
Trauma (Trauma Audit & Research Network)
Paracetamol Overdose (care provided in emergency departments (College of Emergency Medicine)
Severe sepsis & septic shock (College of Emergency Medicine)
National Audit of Seizure Management (NASH 2)
National Vascular Registry, including CIA and elements of NVD

Long term conditions

Diabetes (National Adult Diabetes Audit)
Inflammatory Bowel Disease (IBD Audit)
Paediatric Bronchiectasis (British Thoracic Society)
National Joint Registry
Renal Registry (Renal Replacement Registry)
Chronic Obstructive Pulmonary Disease
Elective Surgery (National PROMs Programme)
Rheumatoid and early inflammatory arthritis
Ophthalmology TBC
Chronic kidney disease in primary care TBC
Specialist rehabilitation for patients with complex needs

Heart

Acute Myocardial Infarction & other ACS (MINAP)
Heart failure (Heart Failure Audit)
Cardiac arrhythmia (Cardiac Rhythm Management Audit)
Coronary angioplasty (NICOR Adult cardiac interventions audit
Pulmonary Hypertension
*Adult cardiac surgery audit (ACS)**

Older People

Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database
Stroke National Audit Programme (Sentinel & SINAP)
National Audit of Intermediate Care 2013

Cancer

Lung cancer (National Lung Cancer Audit)
Bowel cancer (National Bowel Cancer Audit Programme)
Head & neck cancer (DAHNO)
Oesophago-gastric cancer (National O-G Cancer Audit)
Prostate Cancer

Mental health

*Prescribing Observatory for Mental Health (POMH-UK)**
National audit of schizophrenia*
National Audit of Dementia

Blood & Transplant

National comparative audit of blood transfusion

Confidential Enquiries

Asthma Deaths (NRAD)
Child Health (CHR-UK)
Patient Outcome & Death (NCEPOD)
Suicide & Homicide in Mental Health (NCISH)

End of life

National Care of the Dying Audit Hospitals (NCDAH) Round 4

Appendix 2. Clinical Audit Self-Assessment Matrix

Key Elements	1. Basic Level	2. Principle Accepted	3. Developing	4. Working Well	5. Exemplar	*Review Date & Actions*	RAG Status
1. Use clinical audit as a tool in strategic management	Clinical audit is integral to the core strategy the board is seeking to address.	Clinical Audit programme is resourced to provide assurance against risks to strategic objectives.	There is a capable and confident team leading and delivery audit.	The Audit committee oversee the clinical audit programme focussing on topic selection, gaps, and completeness and supporting the skills of NEDs to seek assurance of service compliance to standards.	The Board directors lead as part of a unified board supported by appropriate sub committees, commissioners and the Nursing or Medical Director.	• *The AFP including Quality Account audits is overseen by the Audit Strategy Group and is published on the governance shared drive. All audits are approved by ASG Chair.* • *Audits that appear on the AFP are aligned with Corporate objective and Risk identified from the Board Assurance Framework, Corporate and Directorate risk registers*	**2**
2. Develop an annual programme of work	There is a confirmed direction and focus for clinical audit.	This is clarity on how/which clinical audit activity will be supported.	An annual programme is prioritised and resourced.	Resources and correct skill-base have been identified for each audit.	There is an expectation and commitment from Board to see action plans arising from clinical audit implemented.	• *Link with Pharmacy/Safety Academy/NMCTB for inclusion of other audits.* • *Email circulated to Directorates in January 2012 requesting details of planned audit s for 13/14* • *As guidelines are approved, DCASE to be notified of audit requirements for inclusion on AFP*	**4**
3. Instigate clinical audit as a direct result of mortality ratios, adverse clinical events, critical incidents and breaches in	Appropriate processes in place to respond to incidents complaints and SMR trends.	Audit process linked with clinical leaders who initiate data collection and report on the findings.	Audits are designed to check alignment to complaints and incident recording with resources in place for prompt response to	Agreed structure of audit champions in place who have received appropriate training to promote and initiate audit and ensure actions are followed through.	Board is able to identify and anticipate priority areas of concern.	• *AMD Governance instigates audits as a result of monitoring mortality outcomes. Findings are reported to M&CRG.* • *Audits may be a result of SUI's e.g. Surgical site*	**3**

Appendix 2. Clinical Audit Self-Assessment Matrix

patient safety.			adverse events.			*infections* • *Audits may be undertaken as part of inquest preparation..*	
4. Ensure the clinical audit programme is relevant to board strategic interests and concerns.	Board has rehearsed priorities and can match audit programme to its priorities.	The clinical audit programme should align to the strategic objectives through the board assurance framework generated by the board and used as an ongoing working document.	Board challenge focuses on clinical compliance with standards and better practice and asks the appropriate assurance questions about clinical audit.	The audit programme is itself subject to audit for materiality, completeness and return on investment.	Results are always turned into action plans, followed through and re-audit completed.	• *Each audit is mapped to the strategic objectives.* • *HGC can highlight audits to Audit Strategy Group* • *Audit milestones including the requirement for action plans are monitored using Health Assure.*	***3***
5. Ensure there is a lead clinician who managed clinical audit within the trust, with partners / suppliers outside.	Lead clinician identified who is clearly accountable at board level.	Lead clinician is clear of role and resources available and has access to the corporate board.	Lead clinician has adequate resources and commitment is supported through CQUINS, job descriptions, induction, job plans and merit payments.	Lead clinician is strategically linked, with high level leadership skills and is delivering on key outcomes.	Lead clinician has national as well as a local profile on networks to drive integrated audit possibly as a shared post across a healthcare economy.	• *Access to Board via Medical Director.*	***4***
6. Ensure patient involvement is considered in all elements of clinical audit.	Share with patients priority setting, means of engagement, sharing of results and plans for sustainable improvement.	Patients influence is recorded and has impact.	Patients and health and social care partners involved in priority setting for clinical audit.	Users have direct access and influence over audit selection, planning and results without need for mediators between the patient and the audit.	For FTs share the development audit strategy with governors so that they have a context to inform them. Use the Healthwatch to inform priorities.	• *Patient Experience Lead in post.* • *Through Patient Surveys.* • *AFP is sent out to Directorate PPI Groups/Links/ Governors.* • *SUI's/ Being Open.*	***2***
7. Build clinical audit into planning, performance	Clinical audit cycle aligned to planning cycles.	Long term and immediate (one year plans) draw on audit results and capacity.	Reporting is integrated and covers systems and behaviours,	Clinical and finance/system audit programmes are integrated.	Clinical audit is an integral part of the culture and the operating process of	• *National Audit Programme implemented.* • *Clinical audit outcomes on Directorate scorecards.*	***5***

Version 1	**Issue Date: 9th May 2011**		**Review Date: October 2013**	**Identify Final Completion Date TBC**
Meeting: Audit Strategy Group	**V5. October 2013**	**Reviewed by: Clinical Audit Strategy Group / reviewed annually**		

Appendix 2. Clinical Audit Self-Assessment Matrix

management reporting			quality and costs.		the organisation.	• *Safety Academy audit programme*	
8. Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway.	Primary, acute, mental health ambulance. Independents and social care invited to engage in joint audit plan.	Joint audit plan agreed across primary, acute and social care.	Audits cover the patient journey not just our component of it.	Action plans agreed across primary, acute and social care.	Whole system approach seeking to rationalise service improvement is the norm.	• *>75s admitted to A&E audit completed (SMPACT)* • *Mott MacDonald audit* • *Hospital Deaths Review completed annually.*	**5**
9. Agree the criteria of prioritisation of clinical audits.	Balance national and local interests and the need to address specific local risks, strategic interests and concerns.	Recognise the tension between national and local audit – Boards must realise there is a tension.	Boards are allowed to prioritise audit subjects.	Criteria for prioritisation of clinical audits is in place, explicit and applied Boards agree the audit programme.	Audit shows the board has agreed the clinical audit programme using the agreed risk assessed prioritisation approach.	• *AFP to be approved by Board October 2012* • *Quality Account audits and compliance audits against national standards are prioritised* • *Process in place for prioritising audits as a result of local concerns/risks.*	**4**
10. Confirm clinical audit is leading to improved outcomes.	A clear process in place that links areas of failing service to inform the annual clinical audit programme.	A system of expected outcome improvements as a return on investment (ROI) is in place.	Action plans are developed setting out both service improvement and cost savings and implementation is audited against these expectations.	Re-audits/monitoring takes place that demonstrates improvements in patient care related to patient feedback/complaints.	An exemplar organisation would come out in the top quartile of patient satisfaction, renowned for its customer care and have a low number of complaints referred onto the Ombudsman.	• *Audits undertaken in response to Dr Foster /SOVA* • *Audits results reported at CQEG* • *Patients Safety quarterly report includes performance data monitoring improvements in patient care.* • *Patient satisfaction surveys undertaken via Hospedia system and national surveys.*	**3**

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Operational Performance Report
Agenda item	13
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 the RTT, diagnostic, stroke and cancelled operations standards during September 2013.

Unvalidated data indicates the Trust has achieved all the cancer standards with the exception of 31 days from decision to treat for subsequent surgery in September. The Trust is on target to achieve all the quarterly standards with the exception of the 62 day from urgent referral standard.

The Trust did not achieve the 4 hour transit time for patients referred to A&E during September; the Trust achieved 90.20% against the standard of 95%. Year to date performance is 92.13% as at 14th October 2013.

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
Related Board Assurance Framework entries	BAF 17
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)

Actions required by the Board

Board 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	Jul-13	Aug-13	Sep-13	Q1	Q2
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	N/A	N/A
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	N/A	N/A
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	N/A	N/A
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	N/A	N/A
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%	100%	N/A	N/A
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%	100%	N/A	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0
*A&E: Total time in A&E (Calendar month)	CCG & TDA	95%	87.89%	96.28%	93.42%	94.43%	90.35%	90.20%	N/A	N/A
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	92.55%	91.70%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.70%	95.87%	95.75%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	98.90%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.20%	98.12%	97.64%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	100.00%	100.00%	93.30%	98.15%	98.00%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	97.40%	94.40%	97.73%	97.04%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	94.12%	98.63%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.40%	86.10%	82.04%	83.80%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%	69.57%	83.87%	73.33%	82.61%	N/A	N/A
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	88.71%	98.18%	94.12%	86.96%	91.53%	N/A	N/A
Trolley Waits waiting > 12hours	CCG	0	0	0	0	0	0	0	N/A	N/A
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	446	476	1263	N/A	N/A
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	125	112	206	N/A	N/A
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31	15	N/A	N/A

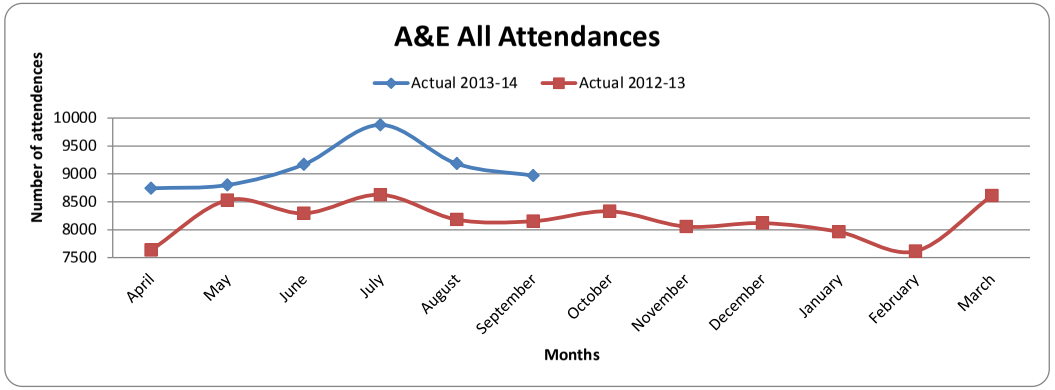
* A&E data is calendar month.

Key Message:

The Trust achieved all targets within September with the exception of the 4 hour A&E standard. The number of patients waiting over 26 weeks from referral has reduced to 31. The Trust has achieved the 18 week admitted, non admitted and on-going standards for all specialties. During September, the Trust achieved all the cancer waiting times standards with the exception of 31 days from decision to treat for subsequent surgery treatment.

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 September 2013 that waited over 30 minutes for handover is 206 and 15 waited over 60 minutes. The total number waiting over 15 minutes has not been validated. The Trust is in discussion with EMAS and the CCG to validate all ambulance handover data prior to contractual consequences being applied to this standard.

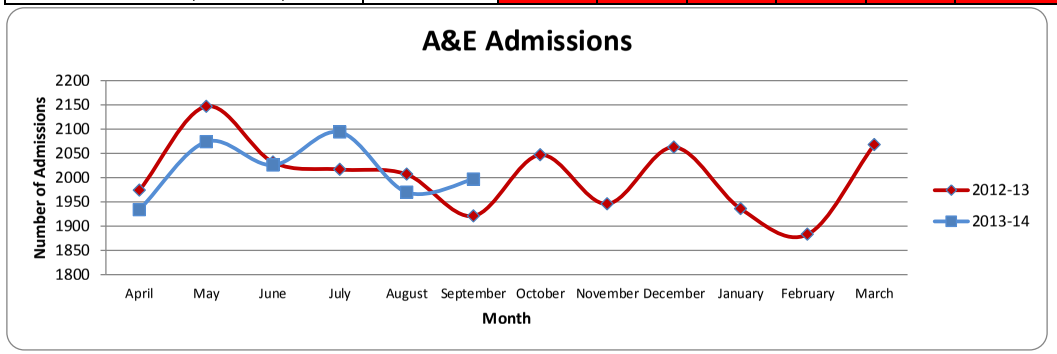
A&E Quality Indicators



Summary

Actual A&E total Attendance = 8968, activity remains above last years levels.
4Hr Standard Performance report is included in appendix 1.

A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%	94.4%	90.4%	90.2%								
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%	93.1%	92.5%	92.1%								

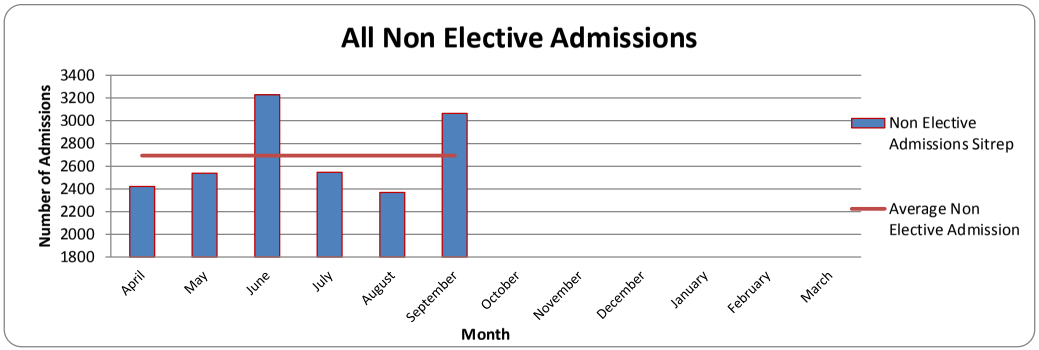


The Trust Non-Elective admissions total = 1,997 for September 2013.

A&E process and bed shortages were the 2 main causative factors of breaches

Total NEL and elective admissions = 3066.

* Note: Total Admissions from the Symphony system



Cancer

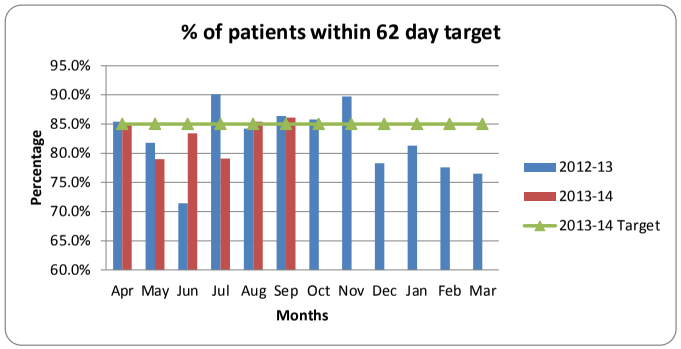
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Q1	Q2
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.70%	95.87%	95.75%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	98.90%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.20%	98.12%	97.64%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	100.00%	100.00%	93.30%	98.15%	98.00%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	95.80%	96.50%	97.40%	94.40%	97.73%	97.04%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	94.12%	98.63%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	83.40%	79.10%	85.40%	86.10%	82.04%	83.80%

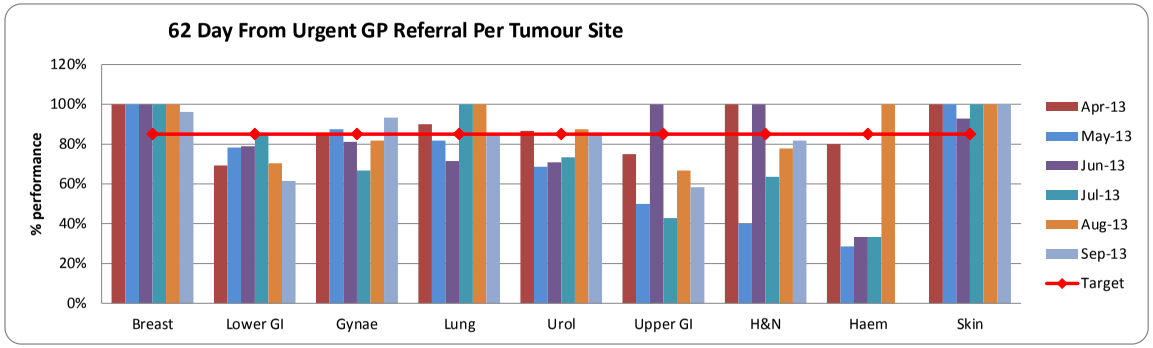
Key Issues:

Provisional data indicates that the Trust did achieve the 62 day standard from urgent GP referral to start of first treatment for September (the completion date for final validation of the data is the 7th November 2013).

The Trust will not achieve quarter 2 for 62 days from Urgent GP referral. The cancer Recovery Board continues to monitor progress against the recovery plan with the focus on pathway reviews. As part of the Contract Query, the CCG is monitoring review of progress through a Remedial Action Plan.

The Trust has not achieved 31 days from decision to treat to treatment for subsequent surgery. The Trust will achieve the quarter for this standard.

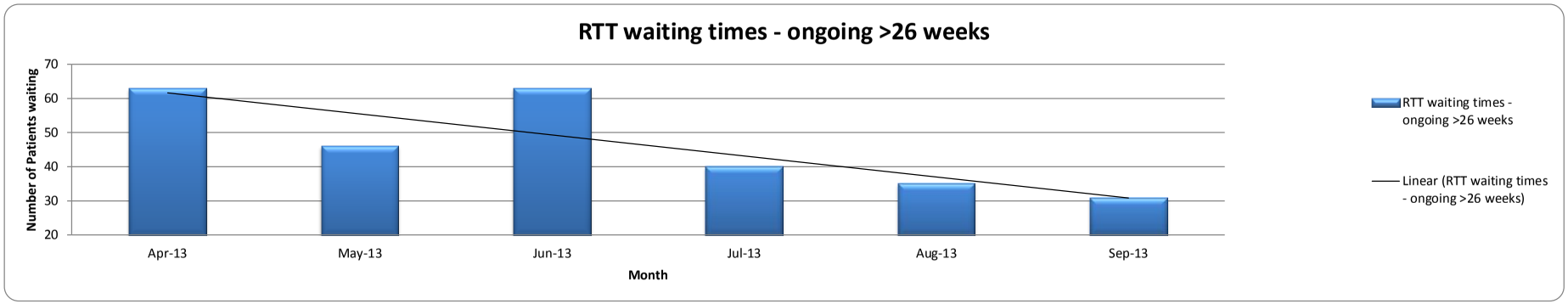




RTT Waiting Times

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Q1	Q2
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	N/A	N/A

Key Notes:
Key specialities that have patients over 26 weeks are Orthodontics, Orthopaedics and Urology, with all three having plans in place to actively reduce these waiting times. Orthodontic and Urology will be under 26 weeks by the end of November as planned. Orthopaedics will take longer due to an unforeseen issue within spinal surgery which has led to a delay in the recovery plan in this speciality.



REPORT TO THE TRUST BOARD
31 OCTOBER 2013

Title	Urgent Care Update
Agenda item	14
Sponsoring Director	Deborah Needham, Care Group Director
Author(s)	Clive Walsh, Interim Chief Operating Officer
Purpose	Information and Assurance

Executive summary

- Performance against the 95% Four Hour Transit Time Standard remains inconsistent and has been below standard since late August 13
- 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
- Additional winter funding from NHS England of £4m is confirmed
- A high-level meeting has been held with the Trust Development Authority (TDA)

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	The consistent failure to achieve the transit time standard means that the Trust is in default in the regulatory framework provided by the Trust Development Authority (TDA)

Actions required by the Board

The Board is asked to note the contents of this paper.

Urgent Care Programme Update

Trust Board – 31 October 2013

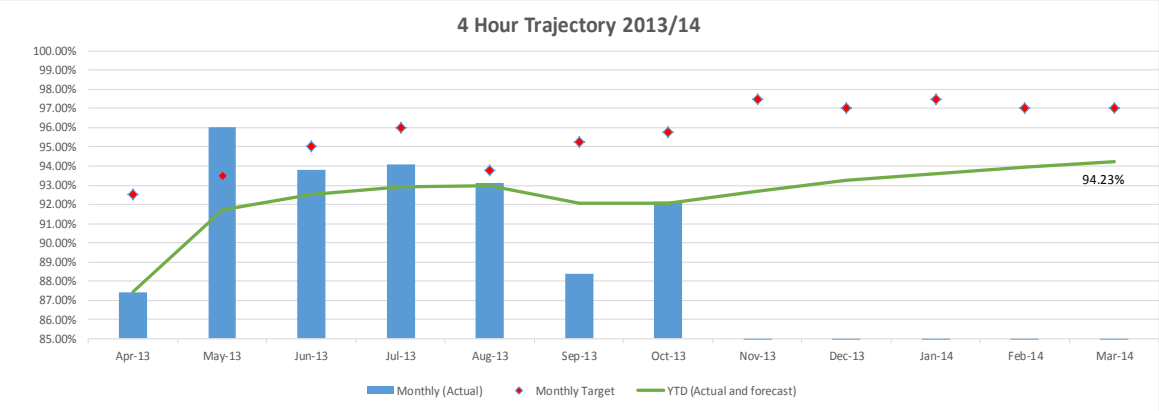
1. Introduction

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 and a summary of current performance. The last report to the Board was submitted in September 2013. Usually, the Board would receive reports bi-monthly.

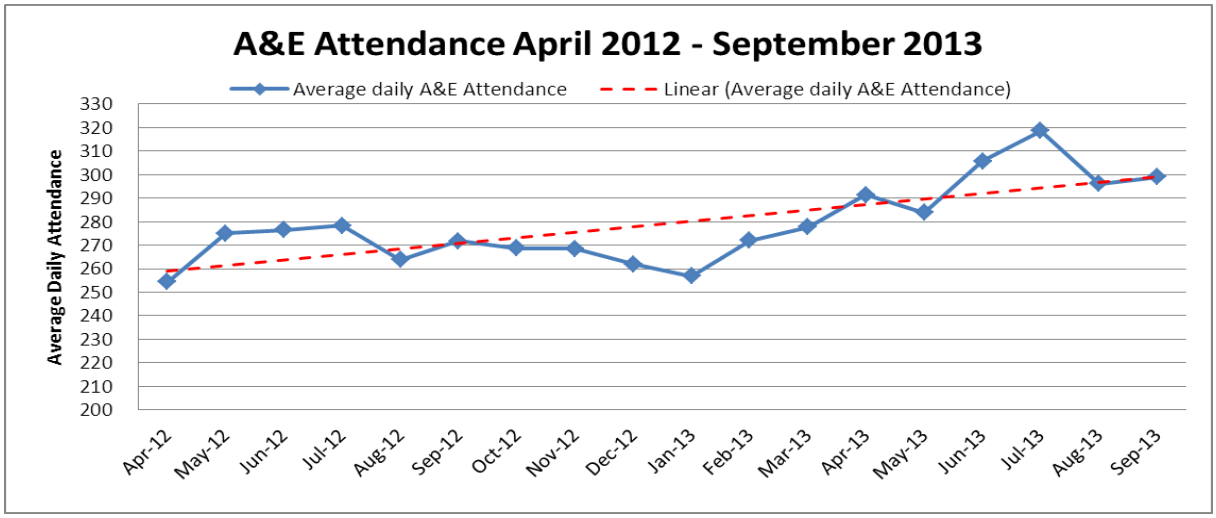
2. Current Performance

During 2013 performance against the four hour target has fluctuated, and has only been achieved during May (96.28%). The Q1 position was 92.56%.

4 HOUR TRAJECTORY 2013/14



However, the Trust continues to see high numbers of A&E attendees throughout the first six months of 2013. This rise is the subject of extensive joint work with Nene CCG, first, to agree the volumes and data, and secondly, to understand the reasons for the change.



Enclosure K - Urgent Care Report

3. Overview of Work Stream Priorities

The framework for the project remains unchanged until October 2013. The Chief Executive is currently considering how the work of the project can be revised and improved. 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.

The main areas of priority are:

- Development of an Ambulatory Care Unit
  - Ambulatory Care Centre started 16th September 2013 and has worked well at times within the pilot period. Evaluation of pilot phase to be undertaken at the UCB in December

- Managing ED patient flow safely and effectively by ensuring the recruitment of Medical and Nursing staff
  - Additional staffing currently out to advert: Sept - Dec 2013
  - Fifth consultant now joined the Department, with the likelihood of obtaining an 8 consultant workforce by Feb 2014.

- Increasing discharge rates by rolling out Nurse Facilitated Discharge
  - Early indications from the roll-out programme is an expansion from 50 patients / month to 50 patients / week

- Agreed expansion of Dementia beds (12) with NCC and NHFT to be in place by November 2013 (two phase project)

- Agreed expansion of Palliative care beds (4) with NHFT to be in place by November 2013

- Discharge to Assess for patients awaiting Continuing Healthcare Assessment to be in place for 4 November 2013 (the likely benefit is the equivalent of 6 – 10 beds)

- The Trust is working in partnership with health and social care colleagues to implement a new programme of care for Frail and Elderly patients. NGH and KGH have invested the £1.8m - £2.0m required for this programme in 13/14. During the initial stages the programme expects to deliver a moderate benefit at NGH by avoiding admission (7patients / week) and promoting discharge (2 patients /week)

- 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) with pilots taking place in October 2013.

4. Additional Winter Funding

Northampton is confirmed as one of 53 recipient health economies and will benefit by £4m. Kettering has received similar funding. The effective use of the funding will be monitored at the health economy Urgent Care Board, and the NGH proposals was received and accepted at the UCB meeting on 22 October 2013. There will need to be clear financial monitoring and reporting arrangements to the UCB which will be accountable to the County Leaders' Operational Group.

5. Review by the Emergency Care Intensive Support Team (ECIST)

The reviewers from ECIST made an assessment of Winter preparations and joint working across the health economy in early October (a further visit to community services is required).

The observations specific to NGH are set out below (high-level feedback has been received so far):

- "Recommend that model is developed to meet increased demand in ED while trying to assess reason for significant growth
- Early senior assessment in ED
- Streaming to decongest ED
- GP referral pathway
- Potential high impact change is to develop front door/assessment model for frail older people - most effective will be multi-disciplinary team approach with cross-over of roles (reduces reliance on consultants who will be difficulty to recruit)
- Urgently need to reduce number of patients over 7 days LOS
- Reducing duplication of assessments
- Consider trusted assessment process
- Discharge planning from admission (clinical criteria for discharge and IPS)"

6. Discussion with the TDA regarding the ED (A&E) performance in the Trust

The Chief Executive and the Care Group Director (Medicine) were invited to discuss current performance and the improvement plan with the TDA on 17 October 2013.

7. Visit by Clinical Team from Leeds Teaching Hospitals

A small team of clinicians were invited to NGH on 22 October 2013 to provide some observations and suggestions on the Urgent Care pathway. The Board will receive oral feedback from the visit at the meeting on 31 October.

8. Recommendation

The Board is asked to review and discuss this paper.

REPORT TO THE TRUST BOARD
31 October 2013

Title	Finance Report Month 6 – September 2013
Agenda item	15
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance
Purpose	To report the financial position and associated risks for year to September 2013.

Executive summary

- The year to date I&E position is a deficit of £3m. The position has improved in September with I&E performance ahead of plan in month.
- Considerable risk still exists to meeting financial targets.
- An application for £4m temporary borrowing has been submitted to the TDA to support cash flow over the second half of the financial year.
- Provisions for fines and penalties continue to be made on a prudent basis and will require reassessment upon reconciliation of the Q1 contract position with the CCG.
- Discussions have taken place regarding forecast outturn position with Nene CCG to inform possibility of resubmitting balanced financial plan to TDA at end of October.
- Continued work is required to support delivery of the CIP programme in year and for 2014/15 and to ensure all schemes forecast for delivery are materialised in full.
- The I&E forecast year end position remains at £3.0m deficit, subject to risk.

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 Board

The Board is asked to note the current financial plan and to confirm that the resubmission of balanced plan to the TDA is not currently feasible.

Northampton General Hospital NHS
NHS Trust

Financial Position Month 6 (Q2) 2013/14

Report to
Trust Board
October 2013

Performance against Statutory Duties – Year to September 2013 and full year forecast

	YTD Actual £'000	YTD Target £'000	Variance £'000	Forecast outturn £'000	Full Year Target £'000	Variance £'000
Delivering Financial perfromance	-£3,061	-£2,045	£ 1,016 Adv	-£3,000	-£4,822	£1,822
Achieving EFL (£000's)	N/A	N/A	N/A	£4,303	£4,303	£0
Achieving the Capital Resource Limit (£000's)	£3,308	£3,402	£ 94 Fav	£13,424	£13,424	£0
Subsidiary Duties						
Better Payment Practice Code:						
Volume of Invoices	88%	95%	-7%	90%	95%	-5%
Value of Invoices	90%	95%	-5%	90%	95%	-5%

Financial Performance

- Financial performance to September 2013 £3,061k deficit. TDA Planned deficit £2,045. Adverse variance £1,016k. Improvement on month 5 position and month 6 forecast position.
- Income position continues to over perform and includes £4.6m of fines and penalties Note still subject to case mix changes for September activity.
- Forecast position is a deficit of £3m, £1,822k ahead of the TDA plan. Further improvement to break even remains subject to agreement on fines and penalties with CCGs and delivery of planned CIPs.
- Income levels continue to over perform with pay costs remaining within plan. Continued pressure on non pay due CIP slippage in delivery and associated run rate trajectory.

Capital Expenditure

- Capital spend to September £3,308k. Plan £3,402k. Favourable variance £94k. Due to slippage in Estates and IT schemes.
- Bid to national IT innovation fund - Noted Vital Pac contract now signed under a capital arrangement which will make use of capital contingency. CEF fund now at preferred bidder stage and now incurring costs.
- Forecast to fully commit Capital Resource Limit.

External Financing Limits (EFL) and Best Payment Practice Code (BPPC)

- Continued improvement in BPPC despite liquidity issues at beginning of September
- TBL loan application now submitted to TDA. EFL changes to plan will be required due to TBL loan and PDC draw down for CEF.

Key finance issues

- Financial position has improved in September with I&E performance ahead of plan in month. Considerable risk still exists to meeting financial targets.
- Provisions for fines and penalties continue to be made on a prudent and will require reassessment based on latest discussions with CCG. Discussions now taking place regarding forecast outturn position with Nene CCG to inform possibility of resubmitting balanced financial plan to TDA at end of October.
- Continued work is required to support delivery of CIP programme in year and for 2014/15 and to ensure all schemes forecast for delivery are materialised in full.
- Forecast year end position remains at £3.0m deficit.

Actions

- Progress CCG negotiations and consider 'minimum income guarantee' for 2013/14.
- Consider ability of Trust to resubmit a balanced financial plan to the TDA at end of October.
- Finalise agreement for Quarter 1 income and review forecast fines and penalties in light of agreed position.
- Agree SLA income forecast with CCG and seek agreement for reinvestment of fines and penalties.
- Focus on delivery of existing CIP schemes through IQEG and ensure CIP forecast is robust.
- Development of further CIP schemes and controls to support the 13/14 financial position.

Financial Performance Dashboard

KPIs	September		July	August
Financial Risk Rating (Shadow)	2	Overall FRR shadow score of 2	3	2
EBITDA %	3.2%	EBITDA % scores 2 under Monitor FRR	3.4%	3.0%
Liquidity (days cover)	8.5	Achieves FRR score of 2.	21.9	19.0
Surplus Margin	-2.34%	Achieves FRR score of 2	-2.11%	-2.65%
Pay / Income	66.3%	Cumulative pay 66.3% of cumulative income	65.9%	66.3%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	(1,747)	Deficit of £1.7m after impairment.	(1,846)	(2,871)
Impairment and Donated Assets	(1,314)	perfromance	157	141
Normalised Position	(3,061)	I&E position excl donated asset depr and impairment	(1,689)	(2,730)
TDA Plan (Year to date)	(2,045)	TDA Plan for year to September 2013 (Normalised)	(1,303)	(1,573)
PCT SLA Income Variance	1,470	Ahead of plan ytd, trend fallen, subject to penalties and c/m changes	1,325	897
TDA Normalised annual plan	(4,822)	Full year NTDA control total.	(4,822)	(4,822)
Forecast EOY I&E postion	(3,000)	Current I&E forecast	(4,822)	(4,822)
EBITDA Performance	£000's		£000's	£000's
Variance from plan	(1,038)ADV	Improvement against plan from m5 £85k	(397)ADV	(1,168)ADV
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	4,905	TDA Plan to Month 5	3,207	4,000
YTD Actual	5,421	Actual delivered to month 6 inc bank and agency	3,092	4,200
% Delivered	111%	% delivery	96%	105%
LTF	12,098	Latest thinking forecast. All R,A,G schemes will deliver in full	10,200	10,900
Annual Plan	13,000	Annual Transformation Target.	13,000	13,000
LTF v. Plan	93%		78%	84%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	3,308	Capital expenditure for year to date £578k behind plan	2,143	2,663
Committed as % of plan YTD	37%	% of plan committed for year to date.	30%	30%
Annual Plan	13,424	2014	13,448	13,424
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	3,468	Indexation adjustment to land and building assets#	(244)	(250)
Current assets	(2,427)	Fall in cash balances	3,585	(4,037)
Current Liabilities	2,215	Reductions inPDC accrual, creditors and accruals	(466)	3,158
Cash	**£000's**		**£000's**	**£000's**
In month movement	(3,312)	Timing of quaterly mandate payments and PDC payment	3,109	(1,485)
In Year movement	(2,116)	Timing of quaterly mandate payments and PDC payment	2,685	1,235
DH Temporary Loans	0	TBL Loan of £4m now applied for	0	0
Debtors Balance > 90 days	1,607	Collection of some PCT debt and CRIPPS debt ageing	1,644	1,433
Creditors % > 90 days	0.00%	No creditors over 90 days.	2.83%	0.00%
Cummalative BPPC (by volume) YTD	87.7%	BPPC improved again in September	86.0%	87.3%

Key issues

KPIs

- FRR shadow risk rating has remained at 2 (target 3) given the adverse performance against plan and ongoing liquidity issues. Forecast to recover to 3.

I&E Position

- I&E position has improved in September with marginal improvement against TDA plan
- Reversal of prior year impairment now processed. Positive impact on reported position but NOT allowable as part of statutory break even duty and must be added back (normalised position).

Cost Improvement Programme

- CIP programme latest thinking forecast £12.1m. Noting assumed delivery of red and amber schemes in this figure totalling £1,034k
- Delivery to date included run rate reduction for bank and agency

Capital

- Underspent against plan but with forecast to spend full CRL. Spend forecast to increase in second half of the year due to CEF.

Statement of Financial position

- Non current asset increase due to indexation of Land and Buildings.
- Fall creditors and cash due to PDC payment and reduction in underlying accruals.

Cash

- Liquidity has fallen in month and required an early advance of £2m from host CCG in the early part of the October to maintain creditor payments.
- TBL loan now submitted for draw down in December.
- Ongoing action to collect outstanding debt, particularly over performance from CCGs.

Income and Expenditure Position (summary year to September 2013)

I&E Summary	Annual Plan 2013/2014	YTD Plan	YTD Actual	Variance to Plan	September 2013/14 Budget	September 2013/14 Actuals	August 2013/14 Actuals	July 2013/14 Actuals	4+8 Forecast
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,279	115,506	116,976	1,470	19,222	19,795	18,903	19,895	240,834
Other Clinical Income	2,803	1,401	1,232	(169)	233	182	173	268	2,632
Other Income	25,693	12,780	12,437	(343)	2,176	2,142	2,087	2,147	27,860
Total Income	**259,775**	**129,687**	**130,646**	**959**	**21,631**	**22,120**	**21,164**	22,310	**271,326**
Pay Costs	(175,479)	(87,126)	(86,560)	565	(14,615)	(14,554)	(14,441)	(14,491)	(179,634)
Non-Pay Costs	(78,963)	(39,438)	(39,938)	(500)	(6,541)	(6,629)	(6,523)	(7,046)	(80,230)
CIPs	4,982	2,391	0	(2,391)	279	0	0	0	0
Reserves/ Non-Rec	(1,143)	(352)	0	352	17	0	0	0	0
Total Costs	**(250,603)**	**(124,524)**	**(126,498)**	**(1,974)**	**(20,859)**	**(21,183)**	**(20,964)**	**(21,536)**	**(259,863)**
EBITDA	9,171	5,163	**4,148**	**(1,016)**	772	937	200	773	11,463
Depreciation	(10,184)	(5,254)	(5,265)	(11)	(886)	(886)	(886)	(897)	(10,491)
Amortisation	(10)	(5)	(5)	0	(1)	(1)	(1)	(1)	(10)
Impairments	0	0	1,414	1,414	0	1,414	0	0	2,580
Net Interest	29	15	14	(0)	2	2	4	1	24
Dividend	(4,106)	(2,053)	(2,053)	(0)	(342)	(342)	(342)	(342)	(4,299)
Surplus / (Deficit)	**(5,100)**	**(2,134)**	**(1,747)**	**387**	**(454)**	**1,124**	**(1,025)**	**(466)**	**(733)**
Adjustments to Normalise Statutory Duties									
Donated Assets Depreciation	278	89	100	(11)	(41)	(41)	(16)	44	313
Impairments	0	0	(1,414)	(1,414)		(1,414)	0	0	(2,580)
Statutory Duties (I&E Position)	**(4,822)**	**(2,045)**	**(3,061)**	**(1,038)**	**(495)**	**(331)**	**(1,041)**	**(422)**	**(3,000)**

Financial Performance

- Normalised Financial performance to September 2013 **£3,061k deficit**.
- Includes negative impairment of £1.4m which must be added back in determining the Trust statutory duties along with donated assets.
- TDA Planned cumulative deficit £2,045 with an in month deficit of £472k. Cumulative **Adverse variance £1,016k**. Marginal improvement on month 5 position. Significantly better in month than plan and forecast.
- CQUIN Q1 position validated with CCG. Accrual increased from 75% to 85% year to date.
- Income position included £4.6m of fines and penalties and is subject to case mix changes
- **Forecast position £3m deficit**, **£1.8m ahead of the TDA plan**. Further improvement to break even subject to agreement of re-investment on fines and penalties with CCGs.
- Income levels continue to over perform with pay costs remaining within plan. Continued pressure on non pay due to CIP slippage in delivery and associated run rate trajectory.

Key issues

Clinical Income

- Ahead of plan by £1,470k to September. £4.6m of fines and penalties included in position.

Other Income

- Behind plan by £512k to September. Profile expected to improve as other income historically improved significantly toward the end of the financial year.

Pay Expenditure

- Ahead of plan by £565k to date, an underlying improvement from month 5 before allocation bank and agency CIP.
- Bank and Agency usage has increased in many staff groups in September.

Non Pay Expenditure

- Behind plan by £500k to September with a continued trend of deterioration.

Cost Improvement Programme

- Delivery noted as ahead of plan to September.
- CIP unallocated to budgets represent central CIP schemes. Not offset by underspend in pay and non pay leading to overall overspend.

Depreciation and PDC

- In line with plan to September noting that the forecast has risen given changes revaluation adjustments and PDC loans. Impact on depreciation now included in forecast.

Income and Expenditure Position (Clinical Income year to September 2013)

Income & Activity Summary	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Activity Plan	Actual Activity	Activity Variance	% Var	September 2013/14 Plan	September 2013/14 Actuals	August 2013/14 Actuals	July 2013/14 Actuals
Elective Daycase	19,293	19,583	290 Fav	1.5%	3,266	3,228	3,004	3,615
Elective Inpatients	3,172	3,342	170 Fav	5.4%	542	574	507	564
Non Elective	15,652	16,486	834 Fav	5.3%	2,573	2,671	2,621	2,877
New Outpatients	30,449	30,579	130 Fav	0.4%	5,153	5,358	4,543	5,179
Follow Up Outpatients	54,300	57,921	3,621 Fav	6.7%	9,191	9,928	8,829	9,870
Non Cons Led Outpatients New	13,270	13,441	171 Fav	1.3%	2,246	2,073	1,924	2,473
Non Cons Led Outpatients Follow Up	29,706	30,858	1,152 Fav	3.9%	5,033	4,985	4,805	5,258
Outpatient Procedures	21,052	23,843	2,791 Fav	13.3%	3,564	4,327	3,934	4,676

	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Income Plan	Income Actual	Income Variance	% Var	September 2013/14 Plan	September 2013/14 Actuals	August 2013/14 Actuals	July 2013/14 Actuals
	£'000	£'000	£'000		£'000	£'000	£'000	£'000
Elective Daycase	11,320	11,891	571 Fav	5.0%	1,872	1,966	1,783	2,130
Elective Inpatients	8,356	8,863	507 Fav	6.1%	1,382	1,508	1,386	1,508
Elective excess bed days		387	387 Fav		-	55	67	56
Non Elective	31,614	30,108	(1,506) Adv	-4.8%	5,184	4,915	5,118	5,119
Non elective excess bed days		4,248	4,248 Fav		-	599	783	709
New Outpatients	4,746	4,694	(52) Adv	-1.1%	785	825	602	865
Follow Up Outpatients	4,910	5,222	312 Fav	6.4%	812	893	795	823
Non Cons Led Outpatients New	1,185	1,196	11 Fav	1.0%	196	183	167	207
Non Cons Led Outpatients Follow Up	1,444	1,484	40 Fav	2.8%	239	238	215	260
Outpatient Procedures	3,159	3,798	639 Fav	20.2%	522	720	786	746
CQUIN	2,605	2,253	(352) Adv		434	624	326	1,304
Block Contracts - Fixed	21,097	21,791	694 Fav	3.3%	3,504	3,470	3,472	3,747
Cost Per Case	9,250	9,541	291 Fav	3.1%	(545)	1,592	1,613	751
A&E	4,673	5,208	535 Fav	11.4%	766	847	871	891
Pathology	2,986	3,183	196 Fav	6.6%	498	515	497	561
Excluded Medicines	7,317	6,942	(375) Adv	-5.1%	1,199	1,108	1,276	1,215
Excluded Devices	614	692	78 Fav	12.6%	102	100	126	120
Fines, Penalties and Challenges	(1,800)	(2,587)	(787) Adv	43.7%	(300)	(250)	(250)	(250)
Productivity CIP's	1,344	-	(1,344) Adv	-100.0%	368	-	-	-
Other Central SLA Income	685		(685) Adv	-100.0%	33	323	(429)	333
Other Clinical Income	1,401	1,232	(169) Adv	-12.1%	233	182	173	268
Sub-Total SLA Clinical Income	116,907	118,208	1,302 Fav	1.1%	17,284	20,414	19,376	21,363

Activity Performance

- Activity continues to over perform against all points of delivery with the exception of critical care, elective bed days and first outpatient appointments.
- General Medicine have a significant non elective excess bed days over performance, which is being driven by only a few elderly long stay patients.
- The OPPROC over performance is mainly being driven by Ophthalmology, (Vitreous Retinal Procedures), there is a risk this activity will be challenged, as it is outside of the contract.
- The CCG are undertaking a 'deep dive' process to look into NGH over performance and it will be necessary to be able to demonstrate and test the robustness of our data sets and external reporting.

Financial Performance

- Income recognised against the Nene CCG contracts continue to show over performance year to date and this rate has slowed during August and September.
- QIPP accounts for 45% of this and there is over performance against most points of delivery with the exception of critical care and day case. The main areas of over performance are non elective, bed days and A&E.

Income and Expenditure Position (CCG Income year to September)

Activity Performance

Actvity Over / (Under) Performance -Year to Date	NHS NENE CCG	Associate CCG	Specialised Services	Non Contracted Activity
AandE	6,872	(85)	0	242
Crit Care	(559)	(225)	758	(39)
DC	1,993	274	212	47
EL	89	52	(24)	13
ELXBD	(147)	85	(28)	2
NEL, NELNE, NELST	1,668	61	62	52
NELXBD	3,818	79	(120)	(156)
OPFA	1,992	(515)	(400)	(21)
OPFUP	1,518	(1,505)	(1,292)	(155)
OPNCL	(1,490)	(1,115)	(1,757)	(173)
OPPROC	1,785	1,272	2	267
RADIOTHERAPY	0	0	1,144	0
Total	**17,538**	**(1,623)**	**(1,444)**	**80**

Financial Performance £

Finance Over / (under) performance	NHS NENE CCG	Associate CCG	Specialised Services	Non Contracted Activity
AandE	617,074	-6,484	0	17,030
Crit Eare	-595,126	-226,101	855,104	-45,229
DC	-80,334	-65,307	120,448	14,082
EL	401,579	160,221	-71,570	50,995
ELXBD	-36,674	18,467	-5,519	439
NEL, NELNE, NELST	3,565,547	51,530	-9,344	20,462
NELXBD	1,022,292	21,933	-68,145	-31,352
OPFA	322,278	-89,183	-65,892	-5,633
OPFUP	282,656	-140,871	24,550	-14,747
OPNEL	-80,413	-54,530	-134,346	-7,681
OPPROC	433,766	217,463	395	39,206
RADIOTHERAPY	0	0	211,021	0
OTHER	323,071	-242,347	-426,062	30,166
Total	**6,175,716**	**-355,207**	**430,640**	**67,738**

Activity & Financial Performance

Nene CCG

- Activity for Nene CCG continues to over perform against plan. The areas driving this are: A&E (which has a significant QIPP plan attached to it), day case, non elective excess bed days, outpatient procedures and non elective activity. We are close to agreeing a Q1 position and we await feedback from the CCG. The CCG have agreed to pay £2.3m over performance in the meantime which will help with our cash flow position.

Associate CCGs

- Activity for the Associate CCGs are underperforming overall and is mainly driven by outpatient activity. There are areas of over performance in inpatient activity and outpatient procedures.

Specialised CCG

- Activity for the Specialised CCGs are under performing overall mainly driven by outpatient activity. Financially we are over performing due to Critical Care, Day Case and Radiotherapy.

Non Contracted Activity

- Non Contracted Activity is underperforming against our plan. There is a risk that we will not recover all of the actual income due to the incorrect commissioner being charged in Q1. There is a bad debt provision which may help to mitigate against this financial impact.

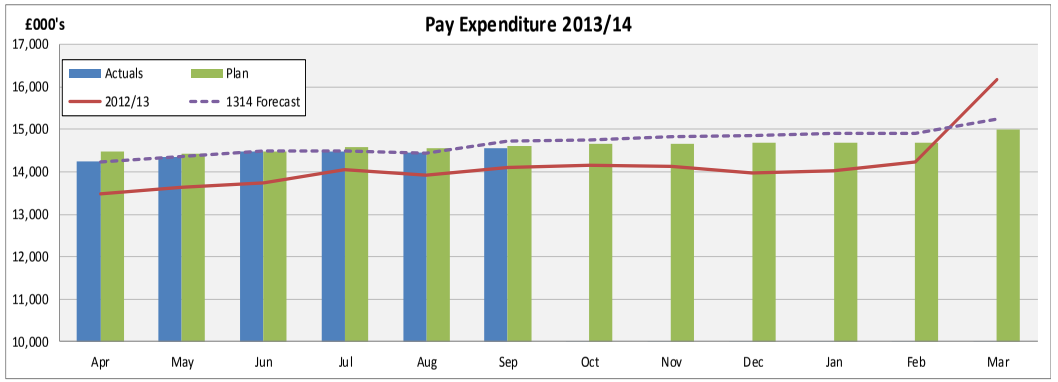
Income and Expenditure Position (Pay Year to September and Forecast)

Highlights

- Overall pay expenditure is £61k favourable in the month and £565k YTD.
- Temporary staffing costs are still high with an increase from last month in nursing spend.
- Temporary staffing costs represent 10% of total pay cost.
- Recruitment is still below expected levels and despite significant nursing investment this year £1.9m this is still not fully visible in ward establishments.
- The trust needs to reduce the total temporary cost bill and focus on expedited recruitment before the winter pressures impact otherwise there will be a risk to further cost increase above planned levels.

Actions

- Nursing recruitment to be expedited recruitment to continue to reduce bank and agency costs.
- Nursing usage which is in excess of planned financial levels needs to be controlled by lead nurses and General Managers. One to one reviews are already in place with effected wards.
- Medical staffing costs exceed planned levels. Which requires urgent attention. Authorisation policy to be reviewed by the Care Group Directors to reduce non essential expenditure.
- Admin staffing still below plan, however permanent roles are largely filled with bank staff and relatively small agency staff. Permanent recruitment plans to be put in place to reduce the reliance in temporary staff in this key area.
- Further actions are also covered in the Transformation report.



	Staff Numbers (WTE) Analysis				Permanent Staff Worked Trend			Temporary Staff Worked Trend		
	Budget Month 6	Permanent Staff worked Month 6	Temporary Staff worked Month 6	Variance	July 2013/14	August 2013/14	September 2013/14	July 2013/14	August 2013/14	September 2013/14
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical Staff	485.34	461.88	14.40	(9.06)	446.26	456.08	461.88	40.01	24.29	14.40
Nursing Staff	1946.7	1659.00	186.22	(101.48)	1680.98	1653.86	1659.00	184.43	183.59	186.22
Managerial and Administration	939.55	766.32	116.02	(57.21)	748.23	757.60	766.32	157.99	169.42	116.02
Other Clinical Staff	330.51	288.34	7.98	(34.19)	279.80	282.59	288.34	13.06	7.79	7.98
Scientific and Technical Staff	390.42	358.44	4.39	(27.59)	351.94	355.23	358.44	7.51	6.18	4.39
Estates Staff	35.5	27.35	5.29	(2.86)	28.64	28.08	27.35	0.75	7.88	5.29
All other Staff	394.16	381.25	61.89	48.98	361.53	364.65	381.25	46.24	37.57	61.89
Cost Challenges	-	-	-	-	-	-	-	-	-	-
Total WTE	4522.18	3942.58	396.19	-183.41	3897.38	3898.09	3942.58	449.99	436.72	396.19

Nursing WTE = 101.48 WTE below establishment / 186.22 temporary WTE being utilised

	Pay Cost Analysis				Permanent Staff Cost Trend			Temporary Staff Cost Trend		
	Budget Month 6	Permanent Staff worked Month 6	Temporary Staff worked Month 6	Variance	July 2013/14	August 2013/14	September 2013/14	July 2013/14	August 2013/14	September 2013/14
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical Staff	3,852	3,631	304	83	3,444	3,596	3,631	518	423	304
Nursing Staff	5,667	4,905	639	(123)	4,967	4,868	4,905	582	557	639
Managerial and Administration	2,272	1,887	337	(48)	1,819	1,832	1,887	376	367	337
Other Clinical Staff	1,023	926	51	(47)	905	910	926	58	54	51
Scientific and Technical Staff	1,122	1,057	19	(46)	1,070	1,046	1,057	16	35	19
Estates Staff	95	77	8	(10)	80	82	77	1	16	8
All other Staff	649	602	112	64	574	590	602	81	67	112
Cost Challenges	(65)	-	-	65	-	-	-	-	-	-
Total Pay Cost	14,615	13,083	1,470	(61)	12,858	12,924	13,083	1,633	1,518	1,470

Temporary Staffing = 10% of total pay costs

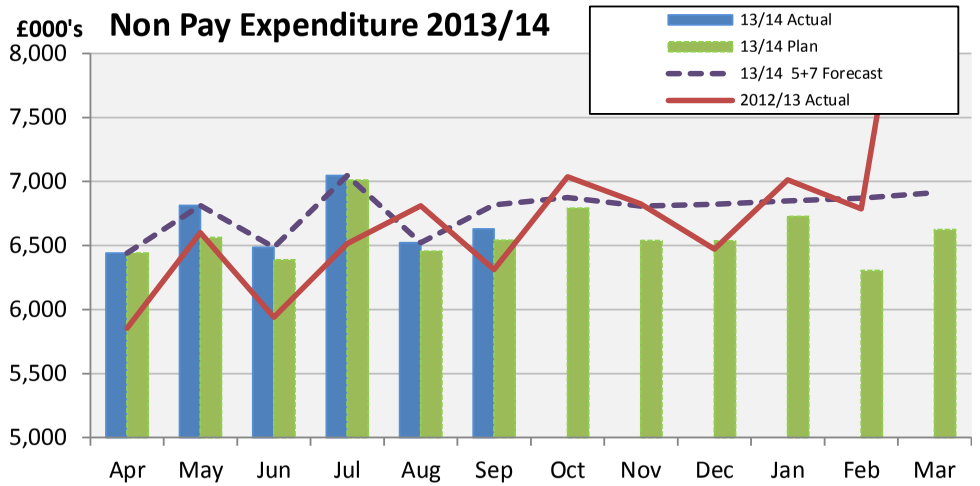
Income and Expenditure Position (Non Pay Year to September and Forecast)

Highlights

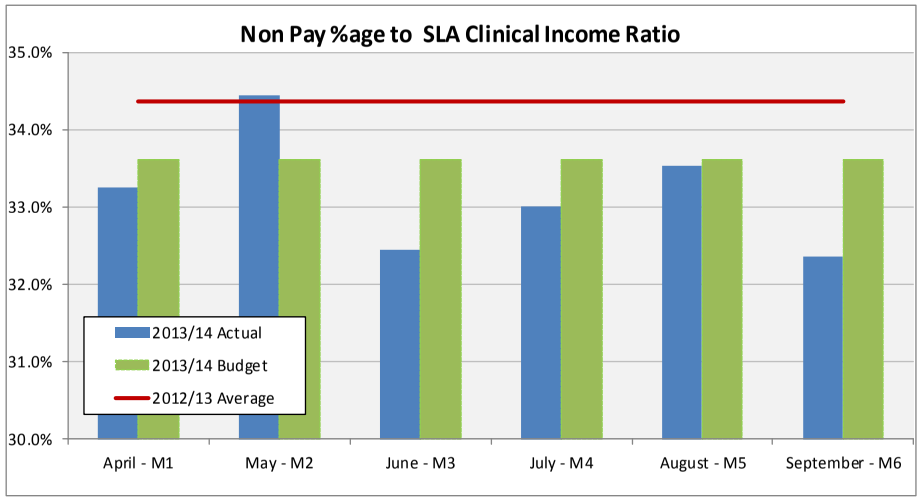
- Non pay in the month is £88k adverse to plan; £500k adverse YTD.
- This is against a significant over-performance on activity across the Trust.
- It also includes non pay cost for outsourced activity in the region of £350k which are offset in income; hence the underlying non pay position tracks even better to plan
- However, a significant risk for non pay is that the general trend is that costs do pick up in the second half as can be seen from the 2012/13 red line on the graph opposite.
- These tend to relate to drugs spend and building & engineering work which are both tracking very favourable to budget at this stage.
- In terms of non pay spend to income achieved, this is tracking at around 33% and as such is an improvement to last year. (Income here excludes provisions for fines etc.)

Actions

- Reduce current run rate to minimise overspend by implementing
- Develop cost reduction measures to supplement those already developed including mattress hire, dressings and any other generic high value items.
- Reduce printing costs by utilising MFDs for the functionality that it has
- Develop processes to control high value items such as loan equipment, interventional radiology procedures
- Closely monitor outsourced activity to ensure this remains viable and necessary.
- Further actions are also covered in the Transformation report.



Non pay costs run rate forecast to increase in H2 requiring greater controls



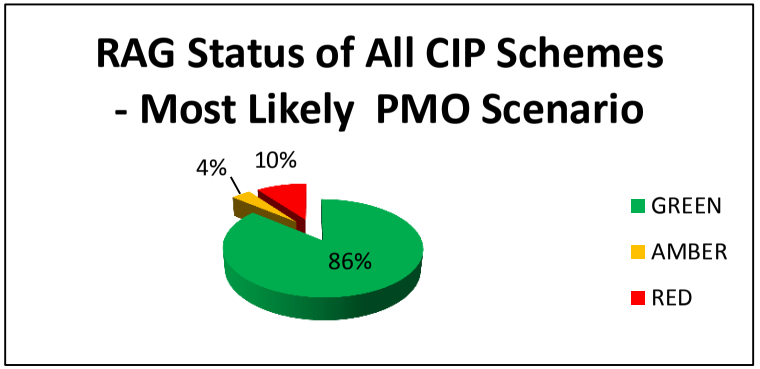
Ratio is calculated on Income before provisions for MRET, Challenges, etc are applied.

Non pay = 33% of gross Income YTD

Income and Expenditure Position (Cost Improvement Delivery year to date and forecast)

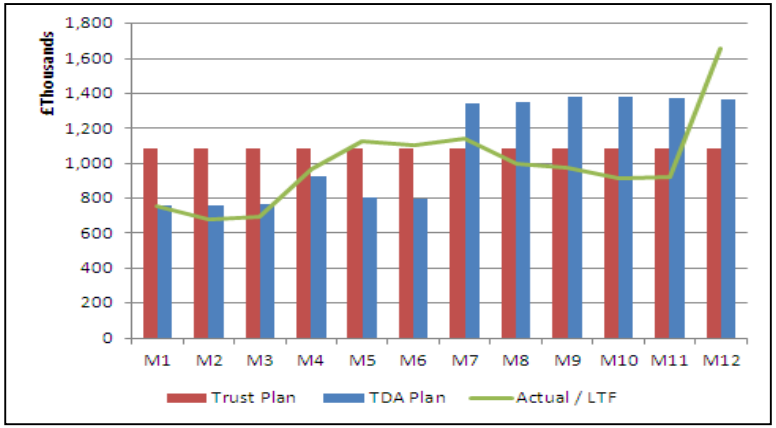
Scheme	FY13/14 LTF £'000 R	A	G	Total Identified	% Identified	Total Unidentified	% Unidentified	Annual Target
A1: Surgery	-	90	332	423	76	132	24	555
A2: Anaesthetics	-	9	838	846	106	(49)	(6)	797
A3: T&O	40	143	238	422	78	118	22	540
A4: Head & Neck	17	11	563	592	158	(217)	(58)	375
A5: Child Health	1	95	711	807	156	(289)	(56)	518
A6: Obs & Gynae	-	95	357	452	68	212	32	664
SCG sub total	**59**	**443**	**3,040**	**3,542**		**(93)**		**3,449**
B1: General Medicine	100	25	1,903	2,028	100	0	0	2,028
B2: Oncology	29	5	455	488	101	(7)	(1)	481
B3: Pathology	25	3	551	578	99	8	1	586
B4: Radiology	-	18	375	393	108	(28)	(8)	364
B5: Pharmacy	-	33	159	192	112	(20)	(12)	172
B6: Therapies	-	-	83	83	78	23	22	106
MCG sub total	**153**	**83**	**3,526**	**3,762**		**(25)**		**3,737**
C1-7: Support Functions	-	-	727	727	734	73	9	799
C8: Facilities	149	146	589	883	100	(0)	(0)	883
Support sub total	**149**	**146**	**1,315**	**1,610**		**73**		**1,682**
Care Group & Corporate CIP Total	**361**	**673**	**7,880**	**8,914**		**(46)**		**8,868**
FYE of 12/13 Transformation Schemes	-	-	337	337		-		337
Admin Review	-	-	106	106		1		108
Tactical HR (Enhancements)	-	-	120	120		-		120
Tactical HR (Overtime)	-	-	336	336		-		336
Outpatient Skill Mix	-	-	-	-		-		-
3rd party Pharmacy	-	-	-	-		-		-
Agency Nursing	-		1,986	1,986		-		1,986
Long term SSP withdrawn	-	-	-	-		-		-
Mattresses Total Bed Management	-	-	30	30		-		30
Locum Managed Service	-	-	138	138		-		138
Consultant Annual Leave Accrual	-	-	35	35		-		35
Salary sacrifice year 2 (technology & car sceme expansion)	-	-	96	96		-		96
Mitigation list	-	-	-	-		263		263
Plans to be identified	-	-	-	-		684		684
Total	**361**	**673**	**11,064**	**12,098**		**902**		**13,000**

	All schemes £'000s	Most Likely £'000s	Worst Case £'000s	LTF (TDA) £'000s
Green	11,064	11,064	11,064	11,064
Amber	673	505	505	673
Red	361	144	£ -	£ 361
Mitigation Pipeline	146	58	£ -	
Unidentfied Gap	756	1,228	1,431	
Total	13,000	13,000	13,000	12,098



Key issues

- Likely case scenario – Green Schemes £11,064 (86%), Amber £505k (4%), Red, Mitigation and to be identified (10%) £1,427k
- TDA reported position £12,098k forecast delivery (93%). Based on best case scenarios
- Delivery to September ahead of the TDA plan.
- Delivery at a Directorate level £458k behind plan with mitigation schemes now being developed
- Still considerable risk in CIP portfolio with forecast by scheme required to assure year end forecast position
- Cost control measures required to support the delivery of financial targets.



Income and Expenditure (risks and opportunities)

Risks not Included in Financial Forecast

Downside Risk	£000s Unmitigated Risk	Action to mitigate risk	£000s Residual Risk
Contract Challenges raised by CCGs are successful	(500)	Robust rebuttal of contract challenges making use of experienced resources	(500)
Transformation Programme Slippage in CIP delivery of red and amber schemes	(1,935)	Continued focus on delivery of CIP and development of mitigation pipeline.	(1,935)
Lack of Funding to implement Transformation Programme Schemes	(600)	CCG unable to release any of the 2% reserve to support the costs of Transformation team and programme in 2013-14. Planned VSS scheme now abandonned.	(300)
CCG QiPP schemes fail to deliver leading to excess demand for NEL activity and cancellation of EL activity and no re-investment of MRET and readmissions penalty.	(4,800)	Engagement with CCG QiPP schemes, estbalish joint QiPP Board. Regular reports from CCG. Consideration of contract query for failure to manage demand.	(2,400)
Funding cuts to LDA impact on level of income received from LETB and loss of recognised medical training posts	(300)	Effective Negotiation with LETB and use of alternative funding streams to offset shortfall. Draft LDA challenged with updates agreed.	(50)
Cost of winter pressures exceed allocated funding	(1,400)	Trust has recieved allocation to manage Winter presures and A&E delivery. Winter plan and commitments to be agreed at UCB and SMB.	(700)
CQUIN schemes are not delivered and further penalty imposed by CCGs / EMSCG. Current non achievement of £328k included in financial position however further risk is evident	(1,300)	Robust monitoring and performance framework to be established. Risk to be identified and 25% provision made in monthly reporting. Now updated following CCG agreements	(328)
Net Revenue Risk	**(10,835)**		**(6,213)**

Key opportunities not incl	Value of opportunity £000s		Adjusted Risk £000s
Income opportunities through coding review	375	Ensure coding is key areas is as detailed as practical and achievable in 13/14	50
Release of Income Provisions and Fines	1,000	Improvements to operational targets leading to release of income provisions	500
Bidding for Readmissions funding	£ 2,400	Development of bids to draw down re-admissions fines in part or in whole to extent not built into FRP	2,400
Invest to Save Schemes - Capital Invesment from possible underspend in capital programme	£ 500	Schemes to be developed and worked up for delivery when capital is available. Revenue savings to be generated	250
	3,775		**2,950**

Risks

- Risk table has been updated to show the unmitigated and mitigated risk to the financial position.
- Financial risks associated with delivery of targets in the winter within agreed plans remains significant.
- CIP slippage or non delivery also continues to be a risk. Full year forecast for CIP delivery is now proposed to provide more certainty regarding the year end delivery.

Opportunities

- Income opportunities have continued to be developed supported by the SLR/ Service reviews being undertaken with Directorates.
- Further work is planned to provide further assurance that that all income is being correctly coded and collected where possible.
- Work on securing reinvestment of fines continues with CCGs and discussions have now focused on development of a 'cap' type income agreement.

Statement of Financial Position as at September 2013

TRUST SUMMARY BALANCE SHEET MONTH 6 2013/14	Balance at 31-Mar-13	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789	0	133,789	0
IN YEAR REVALUATIONS	0	339	3,883	3,544	4,262	4,262
IN YEAR MOVEMENTS	0	2,674	3,483	809	16,197	16,197
LESS DEPRECIATION	0	(4,380)	(5,265)	(885)	(10,511)	(10,511)
NET BOOK VALUE	**133,789**	**132,422**	**135,890**	**3,468**	**143,737**	**9,948**
CURRENT ASSETS						
INVENTORIES	4,934	4,618	4,709	91	5,662	728
RECEIVABLES						
NHS DEBTORS	4,103	7,803	8,783	980	4,144	41
OTHER TRADE DEBTORS	2,295	1,560	1,387	(173)	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	360	468	108	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,530	2,523	(7)	2,514	0
OTHER RECEIVABLES	676	1,076	901	(175)	675	(1)
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,177	2,238	61	2,053	666
	10,149	**14,548**	**15,342**	**794**	**10,855**	**706**
NON CURRENT ASSETS FOR SALE		0	0	0	0	0
CASH	4,342	5,538	2,226	(3,312)	4,654	312
NET CURRENT ASSETS	**19,425**	**24,704**	**22,277**	**(2,427)**	**21,171**	**1,746**
CURRENT LIABILITIES						
NHS	628	1,131	1,257	(126)	5,411	(4,783)
TRADE CREDITORS REVENUE	1,255	1,752	2,366	(614)	5,463	(4,208)
TRADE CREDITORS FIXED ASSETS	1,744	952	1,121	(169)	2,376	(632)
TAX AND NI OWED	1,769	3,286	3,438	(152)	1,800	(31)
NHS PENSIONS AGENCY	2,013	2,141	2,166	(25)	2,030	(17)
OTHER CREDITORS	495	359	329	30	494	1
SHORT TERM LOANS	669	669	527	142	**785**	(116)
ACCRUALS AND DEFERRED INCOME	6,132	8,850	7,586	1,264	**4,000**	2,132
PDC DIVIDEND DUE	36	1,747	0	1,747	**0**	36
STAFF BENEFITS ACCRUAL	786	786	786	0	**629**	157
PROVISIONS	4,472	3,796	3,678	118	**1,400**	3,072
PROVISIONS over 1 year	310	1,281	1,281	0	**1,138**	(828)
NET CURRENT LIABILITIES	**20,309**	**26,750**	**24,535**	**2,215**	**25,526**	**(5,217)**
TOTAL NET ASSETS	**132,905**	**130,376**	**133,632**	**3,256**	**139,382**	**6,477**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115	0	102,875	2,760
REVALUATION RESERVE	32,486	32,828	34,960	2,132	36,792	4,306
DONATED ASSET RESERVE	0	0	0	0	0	0
I & E ACCOUNT BALANCE	304	304	304	0	304	0
I & E CURRENT YEAR	0	(2,871)	(1,747)	1,124	(589)	(589)
FINANCING TOTAL	**132,905**	**130,376**	**133,632**	**3,256**	**139,382**	**6,477**

Key Issues

Non Current Assets

- Capital additions and revaluation have increased non current asset base. Depreciation increase now included in full year forecast.

Net Current assets

- Fall during the month by £2.4m
- Cash balances fallen by £3.3m
- NHS debt increased during September driven by income provisions for over performance.

Net Current Liabilities

- Fell during the month by £2.2m.
- PDC payment has now been made reducing PDC dividend creditor.
- Accruals and deferred income reduced based on income profiling.

Statement of Financial Position (Capital Expenditure year to date and forecast)

Category	Approved Annual Budget 2013/14 £000's	TDA M6 Plan £000's	Year to Date as at Month 6 M6 Plan £000's	M6 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 6 Actual Committed £000's	Plan Achieved	Year end forecast £000's
Linear Accelerator Corridor	400	200	0	0	0	0%	0	0%	
Improving Birthing Environments	399	344	389	391	2	98%	396	99%	399
Endoscopy	150	150	150	139	-11	92%	144	96%	150
Urodynamics	170	150	150	150	0	88%	170	100%	170
Haematology (Trust)	82	82	0	1	1	1%	23	28%	82
Annual Strategic Planning Approvals	578	302	0	0	0	0%	0	0%	578
MESC	1,468	541	389	397	8	27%	471	32%	1,468
Estates	3,846	1,363	1,324	1,261	-63	33%	1,727	45%	3,846
IT	2,824	911	1,025	976	-48	35%	1,584	56%	2,824
Other	728	33	151	168	17	23%	230	32%	1,128
Carbon Energy Efficiency Fund (CEEF)	3,000	0	0	0	0	0%	450	100%	3,000
Total - Capital Plan	**13,644**	**4,076**	**3,577**	**3,483**	**-94**	**26%**	**5,194**	**38%**	**13,644**
Less Charitable Fund Donations	-220	-175	-175	-175	0	80%	-175	80%	-220
Total - CRL	**13,424**	**3,901**	**3,402**	**3,308**	**-94**	**25%**	**5,019**	**37%**	**13,424**

Key Issues

Capital Expenditure

- Expenditure lower than planned at September by £94k.
- Full year forecast expected to fully achieve CRL limits
- Vital Pac investment now approved through a capital route which will use the remaining capital contingency.
- Carbon Energy Scheme now signed at preferred bidder stage with contract signature planned for December 2013
- IT Innovation Funding of £683k now reached stage 2 with financial proformas submitted and interviews with DH concluded. Project successful Vita Pac and e-prescribing
- Some slippage in Estates and IT schemes which will be recovered in the remainder of the financial year.

Statement of Financial Position (Debtors and Creditors)

	Total at September £000s	0-30 days £000s	31 - 60 Days £000s	61-90 Days £000s	Over 90 Days £000s
Receivables Non NHS	1,387	280	270	121	716
Receivables NHS	4,309	1,881	897	640	891
Total Receivables	**5,696**	**2,161**	**1,167**	**761**	**1,607**
Payables Non NHS	(2,468)	(2,466)	0	0	(2)
Payables NHS	(361)	(361)	0	0	0
Total Payables	**(2,829)**	**(2,827)**	**0**	**0**	**(2)**

	Total at August £000s	0-30 days £000s	31 - 60 Days £000s	61-90 Days £000s	Over 90 Days £000s
Receivables Non NHS	1,469	357	258	157	697
Receivables NHS	3,415	1,065	1,299	315	736
Total Receivables	**4,884**	**1,422**	**1,557**	**472**	**1,433**
Payables Non NHS	(1,665)	(1,593)	(72)	0	0
Payables NHS	(373)	(373)	0	0	0
Total Payables	**(2,038)**	**(1,966)**	**(72)**	**0**	**0**

Key Issues

- NHS debt has increased in month by £812k as over performance invoices have now been issued for quarter 1, excluding Nene.
- Payables have increased in month as further queries on invoices are now being resolved and recorded on the purchase ledger more promptly.

	Volume in month	Volume YTD	£'000 in month	£'000 YTD
Total Invoices paid	6,267		7,161	
Total Invoices paid on time	6,265		7,161	
Processed by Payments Team	**99.97%**		**100.00%**	
Total Invoices paid	6,267	39,337	7,161	46,737
Total Invoices paid on time	5,617	34,482	6,735	42,061
Approved and paid within thirty days	**89.63%**	**87.66%**	**94.05%**	**90.00%**
Paid Invoices paid later than thirty days	**650**		**426**	

BPPC Compliance

- BPPC has continued to improve from last month with 99.97% of invoices being paid by the payments team within the targets once approved.
- The Trust has continued to work hard to approve invoices paid in time however problems persist in the processing of bank and agency invoices. Further work is now planned to provide further support to this area

Statement of Financial Position (Cash Flow and Liquidity)

Key Issues

- Cash flow has been based on forecast deficit position.
- Stopping of creditor payments will be necessary to meet EFL target if the TBL loan is repaid.
- Funding requirements now monitored on a weekly basis to allow for continued payments through the month without the main contract payment which are paid mid month.
- October will be supported by agreement of Nene over performance for month 4 of £2.3m. Other CCGs (excluding Specialised) are under performing and will require adjustment to payments now planned for December.
- Agreement still not reached with CCG to fund Q1 over performance which could result in application of fines and penalties.
- TBL Loan now submitted for £4m which is the estimated impact of fines and penalties being applied together with further delays in payment and settlement of over and under performance in December.
- TBL loan will be repaid/refinanced in March from cash surplus if these exist or PDC loan if they do not and will consider the ongoing liquidity needs of the Trust.

	ACTUAL						FORECAST					
MONTHLY CASHFLOW	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
RECEIPTS												
SLA Base Payments and estimate of overperfromance	17,721	19,030	15,721	23,380	19,172	17,584	23,601	17,478	17,478	21,301	17,478	17,478
Health Education Payments (SIFT etc)	22	1,511	764	664	728	785	710	710	710	710	710	769
Other NHS Income	2,923	877	1,596	616	1,709	2,269	1,251	1,330	1,330	1,030	1,030	1,030
PP / Other	892	1,096	655	758	857	800	850	850	850	850	850	850
Salix Capital Loan							112	70	60	75		163
EFL / PDC								238	804	994	216	508
Temporary Borrowing									4,000			-4,000
Interest Receivable	3	3	2	2	3	2	2	2	2	2	3	3
TOTAL RECEIPTS	21,562	22,518	19,067	25,419	22,469	21,439	26,526	20,678	25,234	24,962	20,287	16,801
PAYMENTS												
Salaries and wages	12,168	13,743	13,749	13,881	13,870	13,850	13,850	13,850	13,850	13,850	13,850	13,850
Trade Creditors	4,499	7,344	5,805	5,704	7,029	5,755	6,500	6,000	5,500	5,500	4,500	
NHS Creditors	1,617	1,296	1,619	2,162	2,215	2,114	2,114	2,114	2,114	2,114	1,000	
Capital Expenditure	477	526	727	528	840	801	1,298	1,507	1,766	1,955	1,602	1,474
PDC Dividend						2,089						2,053
Repayment of Salix loan						143						203
TOTAL PAYMENTS	18,761	22,909	21,900	22,275	23,955	24,751	23,762	23,471	23,230	23,419	20,952	17,580
Actual month balance	2,801	-392	-2,833	3,144	-1,485	-3,312	2,765	-2,792	2,005	1,544	-665	-779
Cash in transit & Cash in hand												
Balance brought forward	4,303	7,104	6,712	3,880	7,023	5,538	2,226	4,990	2,198	4,203	5,747	5,082
Balance carried forward	7,104	6,712	3,880	7,023	5,538	2,226	4,990	2,198	4,203	5,747	5,082	4,303

Financial Risk rating

Key Issues

- The Trust must make a Governance declaration top the TDA each month. The finance tables opposite are included in this statement to the TDA.
- The shadow FRR has continued to be operate at level 2 for both the reported and normalised position. Forecast is to return to 3.
- This performance is lower than planned and is driven by the poor EBITDA, I&E margin and liquidity days. Forecast expects these factors to recover.
- Monitor have recently consulted on revised guidance regarding the monitoring regime which will place new reporting requirements which focus on continuity of service as a key domain for assessment.
- This revised guidance is being considered and will be updated accordingly.

FINANCIAL RISK RATING — Northampton General Hospital

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	2	2	2
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	3	5	3	5
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	3	3
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	2	3	2	3
Weighted Average		100%						2.3	2.8	2.3	2.8
Overriding rules								2	3	2	3
Overall rating								**2**	**3**	**2**	**3**

FINANCIAL RISK TRIGGERS — Northampton General Hospital

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

	Criteria	Historic Data Qtr to Dec-12	Qtr to Mar-13	Qtr to Jun-13	Current Data Jul 13	Aug-13	Sep-13	Qtr to Sep-13
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	Yes	Yes
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	No	Yes	Yes	Yes	Yes	Yes	Yes
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	Yes	No	No	No
6	Two or more changes in Finance Director in a twelve month period	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	Yes	Yes
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No	Yes	Yes
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	Yes

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Workforce Report
Agenda item	16
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Mark Ingram, Head of e-Workforce
Purpose	This report provides an overview of key workforce issues
Executive summary The key matters affecting the workforce include: • The key performance indicators show a decrease in Total Workforce Capacity employed by the Trust and an increase in sickness absence.	
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	Workforce risks are identified and placed on the Risk register as appropriate
Related Board Assurance Framework entries	BAF 7: High bank & agency costs.
Equality Impact Assessment	No
Legal implications / regulatory requirements	No
Actions required by the Board The Board is asked to note the report.	

Northampton General Hospital NHS
NHS Trust

Trust Board Report
31st October 2013

Workforce Report

1. Introduction

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

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

Sickness Absence

The total sickness absence rate increased by 0.13% in September to 3.93%, which is above the Trust target. Ward based areas of concern are within General Medicine (Eleanor 14.50% and Finedon 12.52%) and Surgery (Althorp 10.76% and Cedar 7.89%).

Workforce Capacity

Total workforce capacity (excluding Medical Locums) decreased by 1.51 FTE in September. The substantive workforce capacity increased by 22.40 FTE to 4,035.11 FTE and the temporary workforce capacity (excluding Medical Locums) decreased by 23.91 FTE to 304.66 FTE.

2.2 Workforce information Update

Appraisals

The revised appraisal paperwork & process to support the changes in Terms & Conditions to Agenda for Change will be launched on November 1st. Training to support staff and managers with the changes is currently being provided.

Mandatory Training

Following the recent review of Mandatory Training, which has seen the reduction of the number of subjects from 23 to 9, a pilot has commenced where staff can have their knowledge and competency assessed by Mandatory Training Leads thus demonstrating compliance using an OSCE (Objectively Structured Competency Examination) approach. This consists of “stations” where Mandatory Training Leads will discuss scenarios with a group of up to 4 staff members and assess their knowledge and competence on the given subject; staff rotate around the different stations and upon successful completion are deemed compliant with those subjects. If staff are not competent they will be required to complete either face-to-face or an e-learning training in the subject. If this pilot is found to be successful it will become part of the blended provision for Mandatory training.

3. Assessment of Risk

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

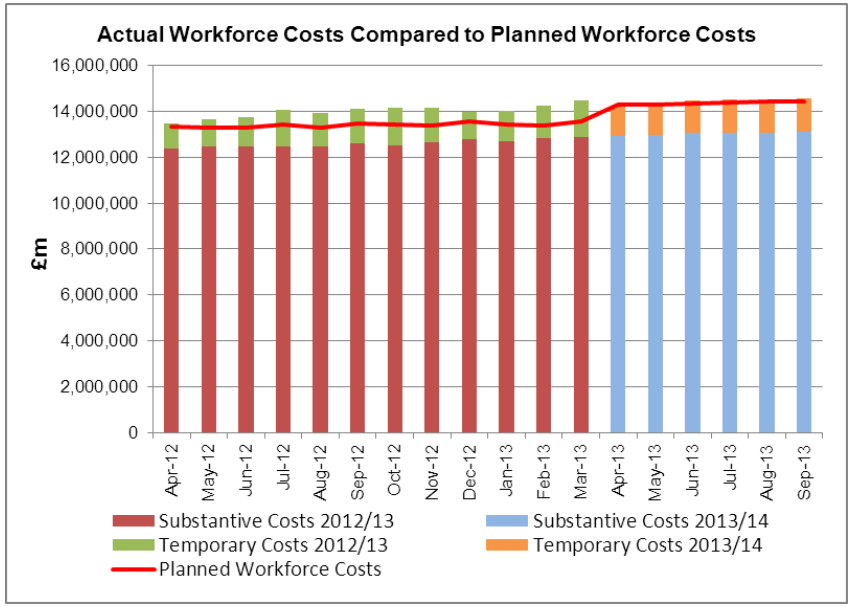
4. Recommendation

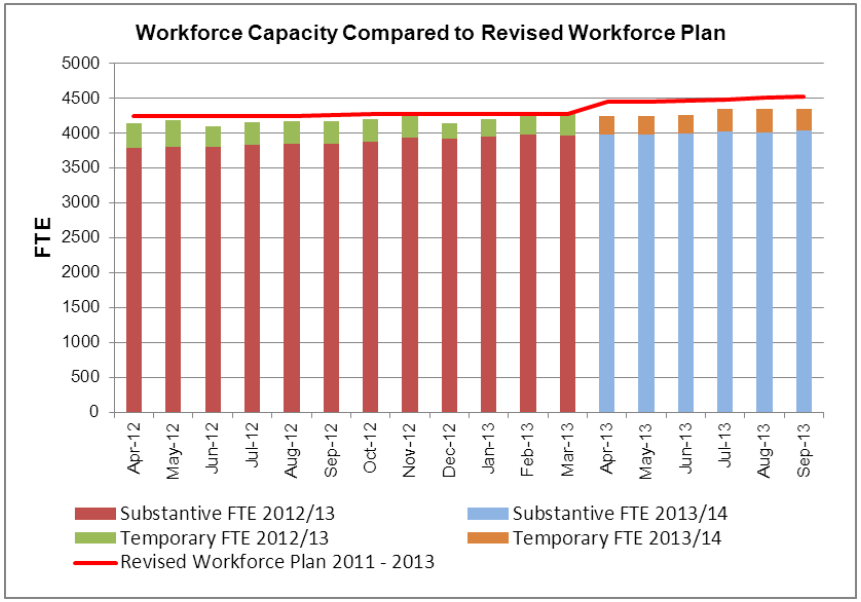
The Board is asked to note the report.

5. Next Steps

Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Human Resources Workforce Performance Indicators 2013/14 Month 6





Workforce Expenditure

Total workforce Expenditure (all pay elements) increased by £112,706 in September to £14.554m (this is below plan for Month 6).

- This is as a result of an increase in temporary staff expenditure and contracted substantive workforce.

Substantive workforce expenditure increased by £40,170 to £13,110,560.

Temporary Workforce Expenditure (including Medical Staff) has increased by £112,706 to £1,443,480 = to 9.92% of the of the total workforce expenditure.

- The use of nurse bank and agency staff decreased by 5.6 WTE in September
- Long Term A&C bank assignments are being scrutinised by the HR Business Partners.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 1.51 FTE in September to 4,339.77 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,522.18 FTE.**

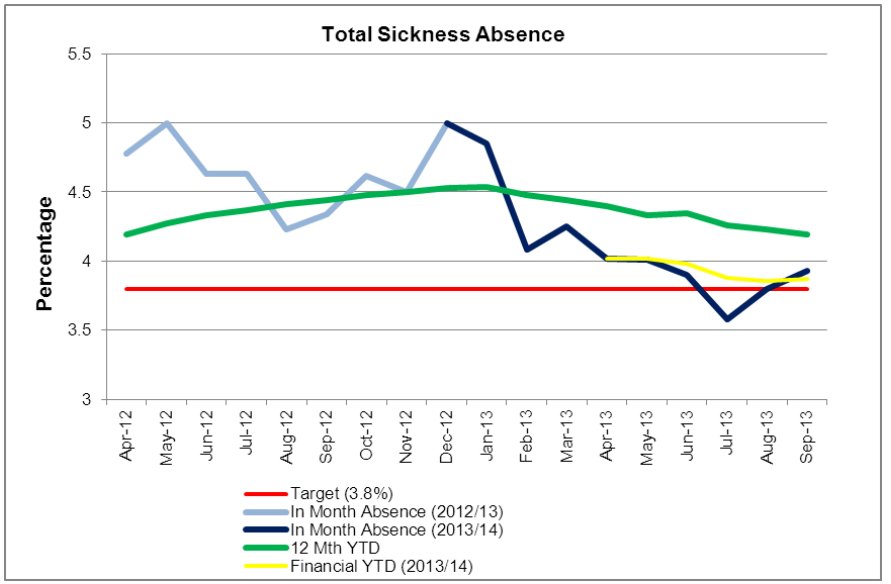
Substantive workforce capacity increased by 22.40 FTE to 4,035.11 FTE.

- Recruitment to meet the increased budgeted establishment for nursing staff continues.

Temporary workforce capacity (excluding Medical Locums) **decreased by 23.91 FTE to 304.66 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 6

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Hospital Support
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	89.23%	90.44%	91.84%	79.84%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.02%	8.00%	6.01%	6.77%
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	**95.97%**	98.30%	97.71%	85.63%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.40%	**7.80%**	11.02%	15.75%



Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 27,785 hours (170.98 FTE), which is a decrease of 1,819 hours (11.2 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 52.27% (increase of 1.24%), Agency fill rate = 18.82% (decrease of 1.05%). Total bank & agency fill rate = 71.09% (decrease of 0.19% compared with the previous month).
- Over utilisation of temporary nursing staff continues to be monitored and strict restrictions on bank & agency are in place. Agency usage decreased by 0.22 FTE compared with the previous month.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.19% in September 2013.

In month Sickness Absence has increased by 0.13% to 3.93% which is above the Trust target.

- Short term sickness absence remained the same at 2.13%.
- Long term sickness absence increased by 0.13%.
- The total calendar days lost to sickness absence increased by 88 to 5,536 days lost.
- The number of days lost per employee has increased to 1.17 days.

Human Resources Workforce Performance Indicators 2013/14 Month 6

		Surgery Care Group							
		Directorate							
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck		Women	Children
Short Term Sickness Absence		1.60%	3.12%	2.37%	2.65%	1.52%		2.79%	2.66%
Long Term Sickness Absence		2.20%	2.84%	1.39%	2.01%	2.11%		2.15%	3.28%
Total Sickness Absence	Over 4.2%	3.80%	5.97%	3.76%	4.65%	3.63%		4.94%	5.94%
	3.9-4.2%								
	Under 3.8%								

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery increased by 0.22%. There were also increases within Surgery of 0.85%, Trauma & Orthopaedics of 0.33%. There was a decrease in Head & Neck of 1.88%

  The hot spots for ward based total sickness absence are Cedar at 7.89% and Rowan 6.08% and within Trauma & Orthopaedics on Althorp ward which has increased to 10.76%.

		Medicine Care Group								Hospital Support				M&D
		Directorate								Directorate				
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	General Medicine & Emergency	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	0.91%	2.48%	1.49%	1.98%		1.84%	2.89%		1.60%	2.18%	1.63%	0.00%
Long Term Sickness Absence		2.20%	1.10%	0.61%	2.64%	2.32%		4.79%	1.96%		2.20%	0.99%	1.21%	0.00%
Total Sickness Absence	Over 4.2%	3.80%	2.01%	3.10%	4.12%	4.30%		6.63%	4.85%	Over 4.2%	3.80%	3.17%	2.84%	0.00%
	3.9-4.2%									3.9-4.2%				
	Under 3.8%									Under 3.8%				

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency has increased by 0.26%. There was a significant decrease on Compton ward decreasing from 11.04% to 5.96%.

  Hot spots for Ward based total sickness absence are Eleanor which has increased from 8.68% in August to 14.50% in September, Finedon at 12.52% and Allebone at 7.83%

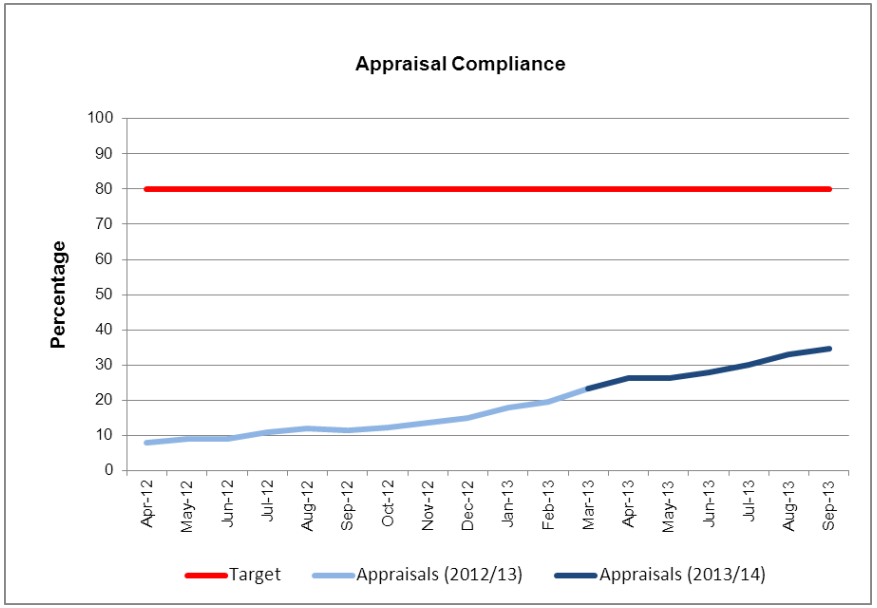
Hospital Support and Medical & Dental Summary

- The total sickness absence recorded for Facilities increased by 0.44% to 3.17% and within Hospital Support total sickness absence decreased by 1.34%.

  Medical & Dental sickness absence is not recorded in total and therefore is not a true representation of the sickness absence rate within this staff group.

Human Resources Workforce Performance Indicators 2013/14 Month 6

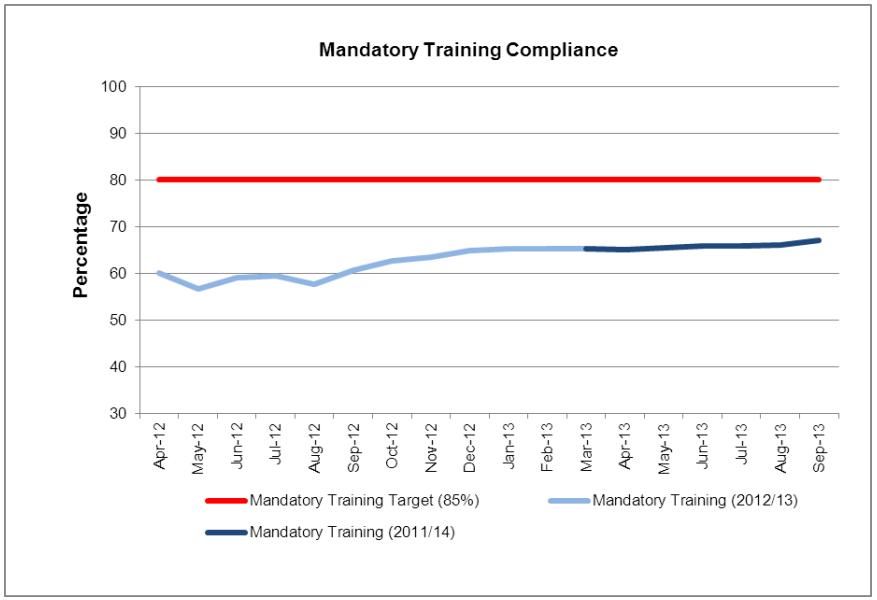
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	3.93%	4.15%	4.04%	2.96%
% Appraisals Complete	Under 50% 50-79% 80% & over	80%	34.62%	29.55%	38.73%	39.45%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	80%	66.97%	68.52%	66.77%	63.77%



Appraisal & Mandatory Training Compliance

Please Note: the reporting of Appraisal Compliance was quarterly up until April 2012 at which point reporting changed to YTD.

- Revised reporting as per the agreed Mandatory Training Review on 9 subjects will commence in October 2013.
- The current number of staff having had Appraisals is 34.62%, this is an increase on July which was 33.06%.



REPORT TO THE TRUST BOARD
31 October 2013

Title	Transformation Report
Agenda item	17
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Mike Hyne – Transformation / PMO
Purpose	To update the board on the final financial savings achieved through the 2013/14 Transformation Programme at month 6.

Executive summary

1. The upside latest thinking forecast at M6 is £12.1m, against the £13m (4.7%) required delivery, off plan by £0.9m. This is up by £0.2m on M5 due to Care Groups closing the gap and a focus on bank and agency costs and other minor schemes.

2. The downside scenario has also improved to delivery of £11.6m.

3. Mitigation schemes to the potential value of £146k under development, which if delivered in full and the LTF achieved (£12.2m 4.7%) leaves a residual minimum mitigation requirement of £0.8m to achieve the plan of £13m.

Related strategic aim and corporate objective	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 21
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS Trust

Transformation Report for Trust Board

OCTOBER 2013

Executive Summary

Northampton General Hospital NHS
NHS Trust

Transformation Plan for 2013/14	The target plan for 2013/14 is £13m which is constructed from the national minimum delivery requirement of 5% of turnover .
The latest thinking forecast for Month 6 September 2013)	The upside latest thinking forecast at M6 is £12.1m, against the £13m (4.7%) required delivery, off plan by £0.9m. This is up by £0.2m on M5 due to Care Groups closing the gap and a focus on bank and agency costs and other minor schemes. The downside scenario has also improved to delivery of £11.6m. Mitigation schemes to the potential value of £146k under development, which if delivered in full and the LTF achieved (£12.2m 4.7%) leaves a residual minimum mitigation requirement of £0.8m to achieve the plan of £13m. Whilst the improved performance is encouraging, there is still a real need to drive greater value from existing schemes, to deliver red and amber schemes and to generate and deliver additional schemes. The plan submitted to the TDA required delivery of £4.8m in the first 6 months. Actual delivery is £5.4m, ahead of plan by £616k.
The Transformation Delivery Group & Strategic Executive Team	Mitigations are still being identified and worked up into project plans with QIAs, therefore their value may change. The Improving Quality & Efficiency Group (IQEG) next meet weekly to support the closing of the current year CIP gap and development of a structured programme for 2014-15.
2014-15 Programme	The IQEG Meeting on the 15th October was dedicated to the consideration and development of an outline programme proposed by the Improving Quality & Efficiency Team (IQET). The Group agreed an outline programme of key themes for 2014-15, including executive sponsors for each theme (appendix 2). These themes will now establish steering groups and fully scope the opportunity for quality improvement and cost reduction for each theme. Schemes already identified and in the process of development will be allocated to this structure by the IQET.
Risks and Issues	IQET is still operating significantly below full capacity, which presents a risk to delivery. An additional interim has been appointed to mitigate this. The Trust is over trading at the end of M6 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. There is still a significant proportion of back-loaded CIP plans. This is partially mitigated by performance being ahead of plan currently.

Scheme Pipeline 2013-15

Northampton General Hospital NHS
NHS Trust

Mitigation 2013/14 and pipeline 2014/15

Care Groups have revised their LTFs up by £185k in M6. This is mainly in the Surgical Care Group due to an increase in value of existing schemes, specifically one scheme relating to an increase in maternity income.

IQET are investigating additional opportunities for CIP schemes to add to the mitigation pipeline.

The mitigation list of schemes is being reviewed by IQET, Project Leads and Executive Sponsors. The potential value has been revised to £146k and will continue to be revised as the detail of schemes is worked up. These opportunities are over and above the current LTF and the value represents the potential 2013/14 financial impact.

Three additional schemes identified for next year currently being considered are:

- Increase staff car parking charges
- Restrict new contracts to a maximum of 35 hours per week
- Reduce the staff restaurant subsidy

As schemes are being developed project plans and quality impact assessments will be created. IQEG will drive the development of the schemes and monitor implementation via the respective Executive Sponsors and Project Leads.

External Support

External support continues as the Transformation Team remains under established. Progress to recruitment to substantive posts continues.

Care Group & Corporate CIPs

- Both Care Groups are reporting an over achievement of CIPs this year.
- The Surgical Care Group are reporting £93k ahead of plan and the Medicine Care Group £25k ahead of plan.
- 3 corporate areas are short of target by a combined £100k (Corporate Affairs, Medical Director, Patient Nursing Services).

Immediate Priorities

Immediate priorities are:

- to continue to test the feasibility of the mitigating schemes, and quickly discount any that will not generate a financial return.
- to scope the schemes likely to generate a financial return and identify and agree a project lead to be accountable for each scheme.
- to complete the scoping document for each scheme, including details of the project, key actions required, phased financials etc
- to complete a Quality Impact Assessment (QIA) for each scheme involving all relevant staff and ensuring that the revised QIA policy is followed.
- to set-up steering groups for the 2014-15 programme
- to fully scope the themes for 2014-15 and develop detailed plans to delivery quality and efficiency improvements

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M5 LTF £000s	M6 LTF £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	11,938	↑ 12,098	93%	3,606
Mitigation	0	0	263	↓ 146	1%	146
Total needed to be identified	4,508	35%	799	↓ 756	6%	-3,752
Total Efficiency	**13,000**	**100%**	**13,000**	**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.6%**	**4.7%**		

Identification of the Transformation Programme 2013/14
The table outlines the current LTF compared to the plan submitted to the TDA in April 2013.
The current LTF of £12.1m if delivered in full would be a 4.7% CIP against our planned requirement of 5%.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	10,014	77%
Non-recurrent schemes	2,085	16%
Mitigation schemes	146	1%
Total needed to be identified	756	6%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	6,002	46%
Non pay	3,566	27%
Income	2,530	19%
Mitigation schemes	146	1%
Total needed to be identified	756	6%
Total Efficiency	**13,000**	**100%**

The table demonstrates a £0.2m increase in LTF between M5 & M6, due to further identification of Care Group CIPs.

Pay schemes account for 46% whereas pay costs are 68% of turnover.

This suggests that there are likely to be more opportunities from workforce related schemes.

Latest thinking forecast 2013/14

Northampton General Hospital NHS
NHS Trust

Workstream	Exec Lead	Current LTF	Plan	Variance
		2013/14	2013/14	2013/14
		£000s	£000s	£000s
FYE 12/13 schemes	C. Walsh	337	337	0
Workforce Transformation	J. Brennan	2,817	1,979	837
Clinical service redesign	C. Walsh	30	110	(80)
Directorate Schemes	A. Foster	8,915	8,868	46
Sub total		**12,098**	**11,295**	**804**
Mitigation	J. Brennan	146	1,204	(1,058)
Plans to be identified	J. Brennan	756	501	255
Total		**13,000**	**13,000**	**0**

Month 6 – Latest Thinking Forecast

The Transformation Programme is currently projecting a LTF shortfall £0.9m against the required plan of £13m.

Care Group and Corporate CIPs are currently ahead of plan by £46k.

The LTF for the care groups has increased by £185k over the position reported in M5. This is due to a change in the valuation of schemes and a change in start dates.

At the end of month 6 a £972k year on year reduction in nursing bank and agency expenditure has been achieved. The forecast LTF has increased based on the current run rate reduction being achieved.

The restriction on overtime continues to exceed the monthly financial requirement. The monthly saving dipped slightly in month 6. Managers within the Trust have been working with their HR Business Partners to ensure that authorisation compliance is maintained.

TDA Return

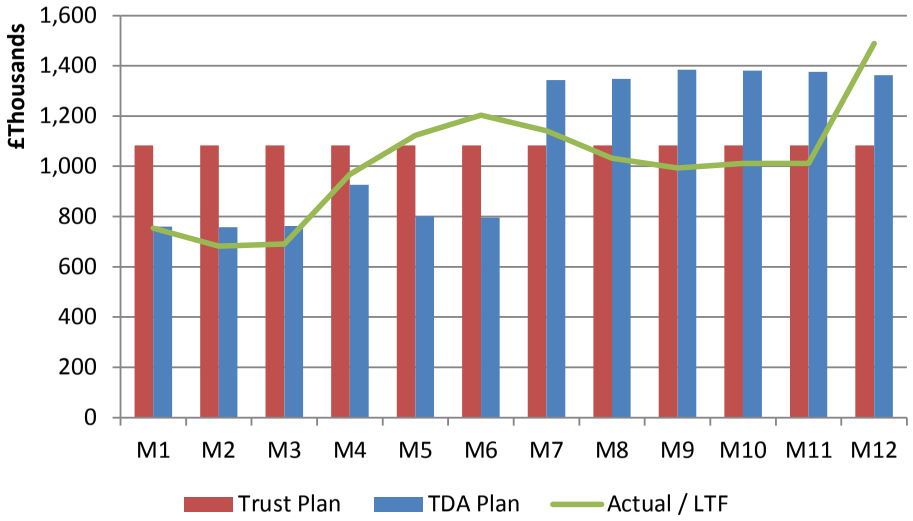
Northampton General Hospital NHS
NHS Trust

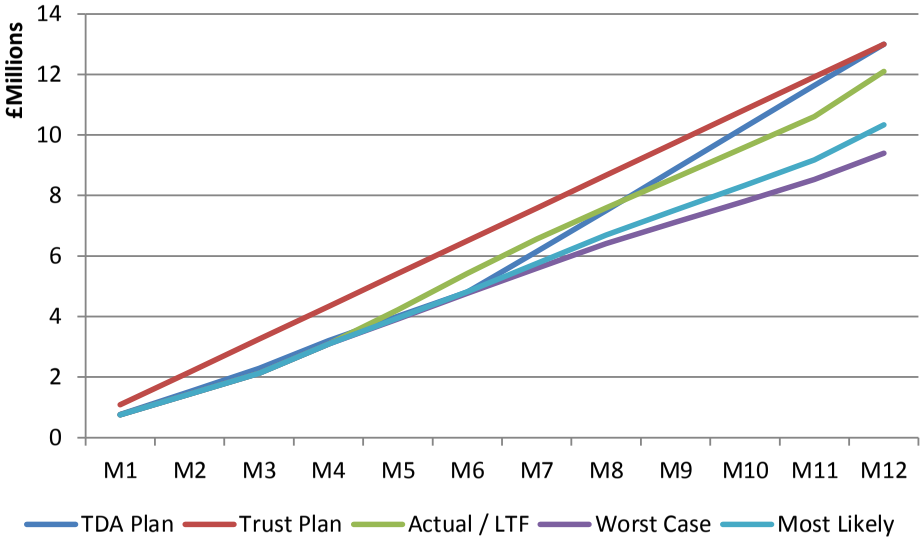
Efficiency Programmes	Identified (I) or Unidentified (U)	Recurring (R) or Non Recurring (NR)	Cashable (C), Non Cashable (NC) or Income (Inc)	If Cashable Pay (P) or Non Pay (NP)	Current Month			Year to Date			Forecast Outturn		
					Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 08) £000s	Forecast (mc 09) £000s	Variance (mc 10) £000s
Description of scheme													
FYE of 12/13 Transformation Schemes	I	R	C	P	37	37	0	226	227	1	337	337	0
Directorate CIPs	I	R	C	NP	252	337	85	1,465	1,285	(180)	3,050	3,104	54
Directorate CIPs	I	NR	C	NP	7	0	(7)	42	110	68	84	294	210
Directorate CIPs	I	R	C	P	205	156	(49)	1,155	784	(371)	2,478	1,804	(674)
Directorate CIPs	I	NR	C	P	24	70	46	185	581	396	293	1,182	889
Directorate CIPs	U	R	C	P	97	0	(97)	582	0	(582)	1,164	0	(1,164)
Directorate CIPs	I	R	Inc	NP	138	303	165	828	846	18	1,656	2,052	396
Directorate CIPs	I	NR	Inc	NP	5	54	49	157	333	176	187	478	291
Workforce Transformation - Admin Review	I	R	C	P	4	4	0	12	11	(1)	108	106	(2)
Workforce Transformation - Tactical HR (B|A)	I	R	C	P	10	197	187	60	972	912	120	1,986	1,866
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	13	26	13	78	168	90	104	336	232
Productivity | Efficiency - Outpatient Skill Mix	I	R	C	P	5	0	(5)	15	0	(15)	45	0	(45)
Services Transformation - Rehabilitation/Community	U	R	C	P	0	0	0	0	0	0	200	0	(200)
Services Transformation - 3rd party Pharmacy	I	R	C	NP	0	0	0	0	0	0	30	0	(30)
Other	U	NR	C	NP	0	0	0	0	0	0	3,144	0	(3,144)
New Programmes Identified In Year:					0								
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P	0	10	10	0	60	60	0	120	120
Workforce Transformation - Salary sacrifice year 2 (technology & car sceme expansion)	I	R	C	P	0	9	9	0	44	44	0	96	96
Workforce Transformation - Long term SSP withdrawn	I	R	C	P	0	0	0	0	0	0	0	0	0
Clinical service redesign - Mattresses Total Bed Management	I	R	C	NP	0	0	0	0	0	0	0	30	30
Workforce Transformation - Locum Managed Service	I	R	C	P	0	0	0	0	0	0	0	138	138
Workforce Transformation - Consultant Annual Leave Accrual	I	R	C	P	0	0	0	0	0	0	0	35	35
Grand Total (sc100)					**796**	**1,203**	**407**	**4,805**	**5,421**	**616**	**13,000**	**12,098**	**(902)**

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance | **On trajectory**





The cumulative delivery of schemes is now £616k ahead of the TDA plan. The plan submitted to the TDA requires savings to accelerate from month 7 onwards. The Trust Plan shows delivery spread evenly throughout the year. This highlights that although we are ahead of the TDA plan after 6 months we are some way off meeting the Trust Plan (£1.1m). The challenge is to make sure that all schemes identified in the LTF due to start in the second half of the year, deliver as planned. Some schemes contained within the Care Groups still require re-phasing to bring delivery forward to ensure that any delivery risk is identified early and contingency and mitigations are developed.

The graph outlines the LTF, the downside potential as well as a most likely calculation. As outlined in the paper, whilst we have utilised the Monitor methodology in the downside planning assumptions of 0% of red schemes delivering, the more likely scenario is that the schemes will deliver financial and quality improvement benefits and the mitigation schemes will improve the LTF.

The additional support sourced to support the care groups and the PMO, supported by Executive Sponsors the IQEG and the Trust Strategic Executive are focussed on ensuring that all schemes are accelerated to ensure maximum in year delivery. New schemes are brought into the LTF as quickly as possible and additional mitigations are constantly being explored.

Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

	All schemes £'000s	% of Total target	Most Likely £'000s	Worst Case £'000s
Green	11,064	85%	11,064	11,064
Amber	673	5%	505	505
Red	361	3%	144	0
Mitigation Pipeline	146	1%	58	0
Total	**12,244**	**94%**	**11,772**	**11,569**
Gap	756	6%	1,228	1,431

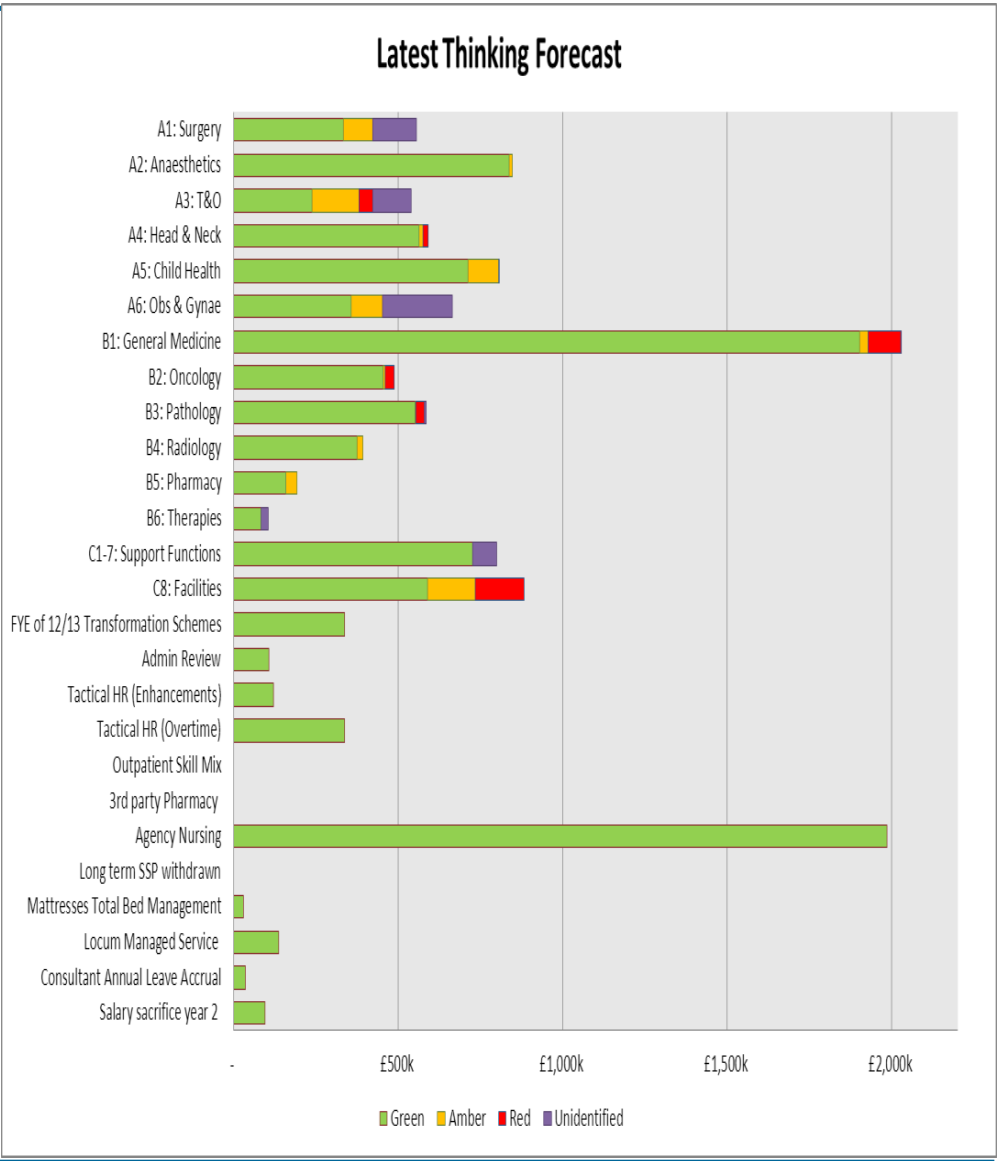
All schemes, including individual Care Group, Corporate and Trust wide initiatives have been RAG rated.

The upside latest thinking forecast (£12.1m) 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, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

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 £11.6m.

The focus of the IQEG will be to ensure that we convert the red schemes into delivery and bring the mitigation schemes.



Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 OCTOBER 2013

Title	Self-Certification Return
Agenda item	18
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 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 September 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 Committee

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.

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

Returns to TDA.MidlandsEast@nhs.net by the last working day of each month

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

Name of Organisation:	Northampton General Hospital	Period:	September 2013

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

Signed by :		Print Name :	Sonia Swart
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer	
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

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Board Action
1	SHMI - latest data	Score	104.8	104.8	104.8	107.8	107.8	107.8	110.9	110.9	110.9	114.2	114.2	114.2	
2	Venous Thromboembolism (VTE) Screening	%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	92.36%	93.10%	95.50%	98.43%	96.80%	97.31%	
3a	Elective MRSA Screening	%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	99.90%	99.50%	99.71%	99.65%	99.93%	99.80%	
3b	Non Elective MRSA Screening	%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	96.40%	96.95%	97.98%	97.21%	97.14%	96.40%	
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	13	14	24	19	25	35	41	35	51	21	10	10	As at 30.9.13 there was 10 ongoing SI investigations - 7 of which were reported during September
6	"Never Events" occurring in month	Number	0	0	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	1	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	4	1	1	2	1	1	3	1	1	4	2	2	The 2 x red rated area relates to Induction of Labour (IOL) – 29.0% (red flag at >25%) and 3rd/4th Degree Tear (without instruments) – 4.2% (red flag at >3.7%).
10	Falls resulting in severe injury or death	Number	2	3	1	0	2	1	1	2	2	2	2	1	1 fall occurred in September however 2 were reported as SI - the 2nd incident occurred in August.
11	Grade 3 or 4 pressure ulcers	Number	3	7	7	6	3	6	3	6	7	0	1	4	4 x Grade 3 unavoidable to be confirmed following validation and receipt of a root cause analysis report.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	
13	Formal complaints received	Number	44	40	24	68	57	52	45	58	37	29	38	41	
14	Agency as a % of Employee Benefit Expenditure	%	8.50%	7.40%	5.00%	6.40%	6.60%	6.70%	5.80%	6.40%	6.70%	6.80%	6.20%	6.30%	Sept 2013 - Medical Agency / Total Medical Expenditure was 7.3% and Nursing Agency / Total Nursing Expenditure was 4.3%
15	Sickness absence rate	%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	4.11%	4.01%	3.90%	3.58%	4.23%	3.93%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

			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	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	3	5	3	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	2	3	2	3	
Weighted Average		**100%**						**2.3**	**2.8**	**2.3**	**2.8**	
Overriding rules								2	3	2	3	
Overall rating								**2**	**3**	**2**	**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		
1	Two Financial Criteria at "1"							
2	Two Financial Criteria at "2"		2		2			

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

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Dec-12	Qtr to Mar-13	Qtr to Jun-13	Jul 13	Aug-13	Sep-13	Qtr to Sep-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	Yes	Yes	£1m adverse variance at end of Q2.
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	No	Yes	Yes	Yes	Yes	Yes	Yes	£1.6m over 90 days. Action to reduce NHS debtors expeditied.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	Yes	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	Yes	Yes	Acting DoF from Apr 13 - Sep 13.
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No	Yes	Yes	8.5 days (excl. estimated WCF)
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	No	2014-15 CIP schemes to be reviewed by Finance Committee in October.

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Historic Data: Qtr to Jun-13	Current Data: Jul 13	Current Data: Aug-13	Current Data: Sep-13	Current Data: Qtr to Sep-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	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	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	No	Yes	Yes	Yes	No	Yes	Monthly Cancer: 31 day second or subsequent treatment - surgery stands at 93.3% in Sept. There was 1 breached patient due to medical reason. (Q2 achieved at 98%)
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	No	No	No	Yes	Yes	No	Quarterly cancer 62 days urgent referral to treatment of all cancers for July was 80.5%. However the target for August and September have been achieved.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No	No	No	A&E 4hr transit time performance for Sept 2013 = 90.2% (YTD = 92.11%)
	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	No	No	No	No	No	There have been a total of 18 cases of C-Diff from April - Sept 2013 (Year to date ceiling as at Sept is 15 cases)
			Is the Trust below the YTD ceiling	*29 (2013/14)*		Yes	Yes	Yes	Yes	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	*0*		No	No	Yes	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**	**3.0**	**3.0**	**3.0**	**2.0**	**3.0**	**3.0**	
						AG	AR	AR	AR	AR	AR	AR	

RAG RATING :

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

GOVERNANCE RISK RATINGS

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

			Northampton General Hospital							
			Insert YES, NO or N/A (as appropriate)							Refresh GRR for New Quarter
			Historic Data			Current Data				
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 signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No	No	No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No	No	No	
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	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	Yes	
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No	No	No	
		Adjusted Governance Risk Rating	4.0	4.0	4.0	4.0	4.0	4.0	4.0	
			R	R	R	R	R	R	R	

CONTRACTUAL DATA

Northampton General Hospital

Information to inform the discussion meeting

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

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Dec-12	Qtr to Mar-13	Qtr to Jun-13	Jul 13	Aug-13	Sep-13	Qtr to Sep-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?	Yes	Yes	No	No	No	No	No	Host CCG have not released 2% funding to the Trust.
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	No	No	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	Pending agreemet of MRET / Readmissions and fines.
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	Yes	Yes	Yes	Yes	A&E and Cancer RTT.
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.

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 • Quarterly 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	Low Clinical Priorities Policy in place

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
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.

Board Statement	NGH Compliance	Assurance/Actions Required for Compliance
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 The delivery of the agreed actions in the improvement plan for Urgent Care is satisfactory and is reviewed in detail at the Trust Integrated Healthcare Governance Committee. However, the Board recognises that this is insufficient to deliver a consistent and satisfactory standard of service. There is an existing risk relating to the recruitment of appropriately skilled medical and nursing staff and a risk regarding the steep rise in attendances at A&E in the current year. The risk in relation to rising attendances is subject to a joint investigation with Nene CCG. At present, the Board has insufficient assurance that there are adequate mechanisms in place to reduce or divert demand. The Cancer Improvement Plan has been considered by the IHGC, and, when delivered, will ensure a timely pathway for cancer patients. Timescale for compliance: December 2013 subject to delivery of a health economy wide improvement plan.

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 suitable interims and or appropriate acting officers whilst active recruitment for substantive post holders is underway.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Standards of Business Conduct
Agenda item	18
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Craig Sharples, Head of Corporate Affairs
Purpose	The revised Standards of Business Conduct Policy is presented to the Board for formal ratification.

Executive summary

The Trust will be and must be seen to be impartial and honest in the conduct of business in accordance with sound corporate governance principles and the public service values of accountability, probity and openness.

The Trust requires high standards of corporate and personal conduct of its staff, based on the recognition that patients come first. The purpose of this policy is to describe the principles to be followed by each member of staff to ensure that is the case.

This policy covers the issues of declarations of conflicts of interest arising from giving and receipt of gifts and hospitality, educational and training events; speaking arrangements, provision of private clinical opinions, private practice, commercial sponsorship, contracting, procurement and intellectual property rights.

The policy has been subject to wide consultation and was approved at the September 2013 Audit Committee.

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)

Actions required by the Board

The Board is asked to approve the Standards of Business Conduct.

STANDARDS OF BUSINESS CONDUCT FOR TRUST STAFF

(Declarations of Interest, Gifts and Hospitality and Commercial Sponsorship)

NGH-ST-132

Ratified By:	
Date Ratified:	
Version No:	1.4
Supersedes Document No:	1.3
Previous versions ratified by (group & date):	Trust Board – 2009
Date(s) Reviewed:	August 2013
Next Review Date:	September 2016
Responsibility for Review:	Head of Corporate Affairs
Contributors:	Head of Corporate Affairs

STANDARD

CONTENTS

Version Control Summary

Version	Date	Author	Status	Comment
V1.1	April 2013	Head of Corporate Affairs	Draft	Re-draft of policy document – revision of 2009 Policy Document
V1.2	August 2013	Head of Corporate Affairs	Draft	Re-write of initial draft following comments from colleagues in light of consultation and further input from an internal audit review.
V1.3	August 2013	Head of Corporate Affairs	Draft	Updated to reflect the comments of the Policy Development Group.
V1.4	September 2013	Head of Corporate Affairs	Draft	Updated to reflect further comments following second consultation
V1.5	October 2013	Head of Corporate Affairs	Draft	Updated to reflect comments of the Pharmacy Department

SUMMARY

It is the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

Staff should understand that failure to follow this policy may damage the Trust and its work and so may be viewed as a disciplinary matter. Staff should also be aware of, and adhere to, their own professional codes of conduct where applicable.

Declarations of Interest and the Acceptance of Gifts and Hospitality

Staff should declare any actual or potential conflicts of interest in writing to the Head of Corporate Affairs on the form attached at Appendix 2 for recording on the Trust's Register of Interests.

Personal gifts (or any kind, whatsoever) must not, under any circumstances, be solicited.

Individual staff must not, under any circumstances, accept money.

Small, one off, tokens of gratitude from patients, their relatives or carers, of low intrinsic value (less than £10) may be accepted. If in doubt, staff should consult their line manager. However, substantial gifts should be politely declined, quoting this policy.

Unsolicited gifts or low intrinsic value (such as calendars, pens and diaries) which have a use in connection with the recipients work, may be accepted. Other personal gifts should be refused.

Hospitality must not, under any circumstances, be solicited.

The principle of integrity requires that staff should not place themselves under an obligation that might influence, or be perceived to influence, the conduct of their duties. This means that the receipt of hospitality (or gifts – as above) must be subject to clear controls, and that any that is accepted must be declared and recorded using the form found at Appendix 3.

Whilst modest hospitality is an accepted courtesy of a business relationship, staff should not accept hospitality, of any kind, which could be interpreted as a way of exerting an improper influence over the way they carry out their duties.

Commercial Sponsorship

It is important to have a transparent approach to any sponsorship proposed to the Trust and for the Trust to consider fully the implications of a proposed sponsorship deal before entering into any arrangement. If any such partnership is to work, there must be trust and reasonable contact between the sponsoring company and the NHS.

For the purposes of this policy, commercial sponsorship is defined as:

Funding provided to the Trust from an external non-NHS source for any purpose, including but not restricted to:- NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (e.g. speakers), buildings or premises.

In all these cases, the Trust and its employees must publicly declare sponsorship (including the sponsorship of meetings through the provision of lunch) or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it, using the form found at Appendix 3.

1. INTRODUCTION

This document should be read in conjunction with the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation, together with the relevant clauses in staff employment contracts.

The Trust will be and must be seen to be impartial and honest in the conduct of business in accordance with sound corporate governance principles and the public service values of accountability, probity and openness.

The Trust requires high standards of corporate and personal conduct of its staff, based on the recognition that patients come first. The purpose of this policy is to describe the principles to be followed by each member of staff to ensure that is the case.

The Bribery Act (2010) came into effect from the 1 July 2011. The act created five basic offences:

- Bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so.
- Accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result.
- Bribing a foreign public official.
- A director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation (NHS Trusts would in likelihood be deemed as a commercial organisation in this sense).
- Failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show, in its defence, that it had adequate procedures in place to provide bribery.

All individuals within healthcare organisations (including the private sector) are capable of being prosecuted for taking or offering a bribe. For example, the giving or receipt of hospitality could be interpreted as a bribe. There is no maximum level of fines that can be imposed and an individual convicted of an offence can be imprisoned for up to ten years.

2. PURPOSE

This policy is intended to:

- Make all staff aware of the Trust's expectations of their conduct and behaviour.
- Give staff the knowledge and information they need to protect themselves from situations that may draw criticism or disciplinary action.
- Enable members of staff to express their concerns in an open and unthreatening way.

This policy sets out the arrangements for all staff in relation to their conduct inside work, and where this has a bearing on their position within the Trust, outside work.

3. SCOPE

This policy applies to all employees of The Trust, Non-Executive Directors, Shadow Governors, Lay Members, contracted third parties (including agency staff) students/trainees, secondees and other staff on placement with the Trust and staff of partner organisations with approved access, collectively referred to as "staff" throughout this policy.

This policy covers the issues of declarations of conflicts of interest arising from giving and receipt of gifts and hospitality, educational and training events; speaking arrangements, provision of private clinical opinions, private practice, commercial sponsorship, contracting, procurement and intellectual property rights.

4. 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.

5. DEFINITIONS

Accountability	Means that everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
Bribery	Means inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other privileges
Corruption	Means the offering or acceptance of inducements, gifts or favours, payments or benefits in kind which may influence the improper action of any person
Openness	Means that there should be sufficient transparency about NHS activities to promote confidence between the Trust and its staff, its patients and the public.
Probity	Means that there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
Gifts of Low Intrinsic Value	Items of low monetary value such as diaries, pens, calendars.

6. ROLES AND RESPONSIBILITIES

Chief Executive	The Chief Executive has overall responsibility for the effective implementation and operation of this policy.
Trust Board	The Trust Board must approve and ratify the Standards of Business Conduct for Trust Staff Policy
Head of Corporate Affairs	The Head of Corporate Affairs is the author and lead officer in ensuring the effective implementation and operation of this policy, with specific responsibilities for registers or interest declarations, gifts and hospitality and sponsorship
Executive Team	The Executive Team approves sponsorship proposals over £5,000 or where there are sensitive issues or precedents are set
All Directors	All Directors will approve sponsorship proposals relating to their Directorate, submitting to the Executive Team if required.

Line Managers	Line Managers must ensure their staff adhere to this policy and particular follow the procedures for declarations of interests, gifts and hospitality and sponsorship.
All Staff	It is the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies and has particular relevance to: • Those who commit resources directly (e.g. ordering of goods or services); • Those who do so indirectly; • Those who make decisions which could benefit them, their relatives or colleagues. Further, all NHS Staff are expected to: • Ensure that the interests of patients remain paramount at all times. • Are impartial and honest in the conduct of their official business. • Use public funds entrusted to them to the best advantage of the service, always ensuring value for money. • Do not abuse their official position for personal gain or to benefit family or friends. • Do not seek to further private business or other interests in the course of their official duties. • Be aware that it is both a serious criminal offence (Bribery Act 2010) and gross misconduct to act in a corrupt manner. Staff should understand that failure to follow this policy may damage the Trust and its work and so may be viewed as a disciplinary matter. Staff should also be aware of, and adhere to, their own professional codes of conduct where applicable.

7. SUBSTANTIVE CONTENT

7.1. PROCEDURES

7.1.1 Declarations of Interest

It is a contractual obligation for staff that have a significant interest (either financial or honorary) in an organisation which may compete which may compete for an NHS contract, to declare this, either on commencement of employment or on the acquisition of the interest. Failure to declare such an interest could result in disciplinary action. Any such interests relating to staff member's family or close friends should also be declared. Examples of "significant interest "include:

- Directorships, including Non-Executive Directorships held in companies.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- Significant (3% or more) shareholding in a company supplying or manufacturing goods which are or might be purchased by the Trust.
- Ownership or part-ownership of private companies, business or consultancies likely or possibly seeking to do business with the NHS.
- Membership of the governing body or committee of an organisation which may supply goods or services to the Trust, or compete with the Trust for business.
- A position of authority in a charity or voluntary body in the field of health or social care.
- Employment of a close family member by a company supplying or seeking to supply goods or services to the Trust.

Staff should declare any actual or potential conflicts of interest in writing to the Head of Corporate Affairs on the form attached at Appendix 2 for recording on the Trust's register of interests.

It may be necessary to bring entries to the attention of senior officers and/or the Board and it will be made available to the Trust's auditors if requested. It shall also be regularly scrutinised by Audit Committee and published in accordance with Freedom of Information Act requirements.

Periodic reminders for staff to declare any interests will be sent to staff by the Head of Corporate Affairs.

It is impossible to prescribe a comprehensive set of rules on interests but some examples are set out below:

Example 1

An NHS staff member holds a beneficial interest in private care homes or hostels to which the Trust may make referrals.

Example 2

Expectation of future employment with a particular company / organisation.

Individuals should not give, or appear to give, advice or take decisions that might be influenced by the hope or expectation of future employment. This is to ensure that the company / organisation involved does not gain an unfair advantage over its competitors.

They should report an approach or offer of employment covered by these rules to their line manager.

Example 3

This could include (depending on their significance) trusteeships, unpaid functions, membership of voluntary organisations, or the non-financial interest of a spouse, partner or close relative. (However, it is accepted that individuals may not always be aware of the relevant interests of a family member).

A "Short Guide for Staff" has been included at the end of this policy for ease of reference.

7.1.2 Gifts

Personal gifts (or any kind, whatsoever) must not, under any circumstances, be solicited.

Individual staff must not, under any circumstances, accept money. In addition, an offer of money from a potential or existing contractor should be firmly refused and reported immediately to the Director of Finance and Head of Corporate Affairs.

Patients and relatives may be directed towards making a contribution to charitable funds should they wish in instances where cash gifts are offered.

Small, one off, tokens of gratitude from patients, their relatives or carers, of low intrinsic value (less than £10) may be accepted, and declared using the form found at Appendix 3. If in doubt, staff should consult their line manager. However, substantial gifts should be politely declined, quoting this policy.

Unsolicited gifts of low intrinsic value (such as calendars, pens and diaries) which have a use in connection with the recipients work, may be accepted. Other personal gifts should be refused or if this is impossible, should be accepted and immediately handed over to the line manager and a record of the circumstances made and retained by the recipient.

Staff must not, under any circumstances, accept personal gifts with a significant financial value, or any benefits in kind, such as offers of holiday accommodation.

7.1.3. Acceptance of Hospitality

The principle of integrity requires that staff should not place themselves under an obligation that might influence, or be perceived to influence, the conduct of their duties. This means that the receipt of hospitality (or gifts – as above) must be subject to clear controls, and that any that is accepted must be declared and recorded.

Hospitality must not, under any circumstances, be solicited.

Staff should never accept lavish hospitality. The level of subsistence offered must be appropriate and not out of proportion to the occasion. The costs involved must not exceed that level which the recipients would normally adopt when paying for themselves.

Whilst modest hospitality is an accepted courtesy of a business relationship, staff should not accept hospitality, of any kind, which could be interpreted as a way of exerting an improper influence over the way they carry out their duties.

Examples of hospitality which may be accepted include:

- Invitation to a society or institute dinner or similar function.
- Attendance at an event at which there is a genuine need to impart information or represent the Trust in the community.

• Attendance at an event which is clearly part of the life of the community or where the Trust should be seen to be represented.

• The hospitality arises during attendance at a relevant conference or course, where it is clear that the hospitality is corporate rather than personal.

Even in the context of acceptable types of hospitality, their frequency and/or scale should not be significantly greater than the NHS, as an employer, would be likely to offer.

Hospitality may also be an issue in relation to sponsorship by external organisations from industry (see later section of this policy for sponsorship issues in general). Travel and subsistence expenses of staff attending suppliers, potential suppliers or third parties in connection with purchases by the Trust should be paid by the Trust unless prior written approval to external funding has been given by the authorised officer.

With the exception of modest hospitality as referenced above, hospitality offered (even if declined) or received must be notified in writing, by the recipient, to the Head of Corporate Affairs using the form attached at Appendix 3, who will enter the notification into the Trust's Hospitality Register. The register shall be routinely published in accordance with Freedom of Information Act requirements.

Notification should be made as soon as practically possible after the receipt and, if possible, beforehand. If in doubt, staff should always err on the side of making a declaration.

Staff may accept modest working meals and light refreshments (or more significant hospitality which is clearly integral to a training course etc.) without making any declaration.

The following examples are intended as a (non-exhaustive) illustration of what would be not regarded as acceptable hospitality:

- A holiday or weekend in any holiday centre.
- Offers of hotel accommodation, or tickets for the theatre, shows, concerts, sporting events etc.
- Corporate hospitality "events" or other similar types of activities.
- Use of an external company's flat or hotel suite.
- Any form of hospitality which is extended to immediate members of the family.

When a specific, external person or body has a matter currently in issue with the Trust, for example an arbitration arising from a contract, or if the Trust is making purchasing or procurement decisions, common sense dictates that an offer of hospitality be refused, even if, in normal circumstances, it would be regarded as hospitality of an acceptable nature.

When staff decline hospitality, they should do so in a polite but firm manner and draw the attention of the person making the offer to the existence of this policy. If necessary, staff should pay their share of any costs and, where eligible under Trust rules, claim these from the Trust in the usual way.

7.1.4 Provision of Hospitality by the Trust or its Employees

The proposed use of public funds for hospitality and/or entertainment should be considered very carefully. Inappropriate or excessive spending can cause lasting damage to the reputation of the Trust and the NHS. Hospitality is not the "norm" when conducting business; it should be provided only when necessary and appropriate. Advice should always be sought in cases of doubt. All expenditure on hospitality provided should be capable of justification to the Trust's internal and external auditors.

7.1.5. Commercial Sponsorship

"The New NHS: Modern and Dependable" placed an obligation on NHS bodies to work together, and in collaboration with other agencies, to improve the health of the population they serve and the health services provided for that population.

Collaborative partnerships with industry can have a number of benefits in the context of this obligation. It is important to have a transparent approach to any sponsorship proposed to the Trust and for the Trust to consider fully the implications of a proposed sponsorship deal before entering into any arrangement. If any such partnership is to work, there must be trust and reasonable contact between the sponsoring company and the NHS. Such relationships, if properly managed, are of mutual benefit to the organisations concerned.

For the purposes of this policy, commercial sponsorship is defined as:

- Funding provided to the Trust from an external non-NHS source for any purpose, including but not restricted to:- NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (e.g. speakers), buildings or premises.

In all these cases, the Trust and its employees must publicly declare sponsorship (including the sponsorship of meetings through the provision of lunch) or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it, using the form found at Appendix 3.

Where such collaborative partnerships involve a pharmaceutical company, the proposed arrangements must comply fully with the Medicines (Advertising) Regulations 1994 (regulation 21 'Inducements and hospitality'). See Annex 1 for more detail on the regulations on inducements and hospitality. Annex 2 provides more detailed guidance for staff on maintaining professional relationships whilst conducting business pharmacy representatives. For particular provisions relating to research and development see Annex 3.

Whatever type of agreement is entered into, a clinician's judgement must always be based upon clinical evidence that the product is the best for their patients.

Before entering into any formal sponsorship agreement (i.e. the sponsoring of a post) a full business case and draft sponsorship agreement should be developed and approved by the Executive Team to ensure the Trust:

- Can satisfy itself, with reference to information available, that there are no potential irregularities that may affect a company's ability to meet the conditions of the agreement or impact on it in any way, for example checking financial standing by referring to company accounts;
- Can assess the costs and benefits in relation to alternative options where applicable, and to ensure that the decision making process is transparent and defensible;
- Can ensure that legal and ethical restrictions on the disclosure of confidential patient information, or data derived from such information, are compiled with;
- Can determine how clinical and financial outcomes will be monitored;
- Can ensure that the sponsorship agreement has break clauses built in to enable the Trust to terminate the agreement if it becomes clear that it is not providing expected value for money and/or clinical outcomes.

The Trust will apply the following principles to commercial sponsorship:

- Purchasing decisions, including those concerning pharmaceutical and appliances, will always be taken on the basis of best clinical practice and value for money. Such decisions will take into account their impact on other parts of the health care system, for example, products dispensed in hospital which are likely to be required by patients regularly at home.
- When the Trust is offered significant discounts on drugs, it will consult the relevant commissioners about possible implications for subsequent prescribing in primary care.
- When making purchasing decisions on products which originate from NHS intellectual property, ethical standards will ensure that the standard is based on best clinical practice and not on whether royalties will accrue to an NHS body.
- Deals whereby sponsorship is linked to the purchase of particular products, or to supply from particular source, will not be allowed, unless as a result of a transparent tender for a defined package of goods and services.
- Patient information attracts a legal duty of confidence and is treated as particularly sensitive under Data Protection legislation. Professional codes of conduct also include clear confidentiality requirements. The Trust will assure itself, taking advice when necessary, that sponsorship arrangements are both lawful and meet appropriate ethical standards.
- Where a sponsorship arrangement permitting access to patient information appears to be legally and ethically sound (for example, where the sponsor is to carry out or support NHS functions, where patients have explicitly consented), a contract will be drawn up which draws attention to obligations of confidentiality, specifies security standards that should be applied, limits use of the information to purposes specified in the contract and makes it clear that the contract will be terminated if the conditions are not met.
- Where the major incentive to entering into a sponsorship arrangement is the generation of income rather than other benefits, then the scheme should be properly governed by income generation principles rather than sponsorship arrangements. Such schemes should be managed in accordance with income generation requirements, i.e. they must not interfere with the duties or obligations of the Trust. A memorandum trading account should be kept for all income generation schemes.
- As a general rule, sponsorship arrangements involving the Trust will be at a corporate, rather than individual level.
- If publications are sponsored by a commercial organisation, that organisation should have no influence over the content of the publication. The company logo can be displayed on the publication, but no advertising

The Trust will ensure that all sponsorship deals are documented through the use of a register held by the Head of Corporate Affairs, which can be audited as appropriate. In order to demonstrate openness, the Register will be available on request to the public. It shall also be routinely published in accordance with Freedom of Information Act requirements.

7.1.6. Speaking Engagements and Other Similar Arrangements

Where Trust employees or those where the Trust funds their activity are invited to speak at a range of engagements e.g. Professional Body's, Conferences et al they should ensure

that they have their Line Manager's permission to do so and that their costs and expenses are covered by the inviter unless it is part of a discounted wider attendance.

Where the Speaker receives a fee for the speaking engagement other than in kind, then the income must be declared. Where the Speaker takes the time as annual leave they must declare the income as additional income.

In such cases the Speaker must make it clear that they are speaking in their own capacity and must not use Trust resources in the preparation of materials.

Where the Speaker has agreement from their Line Manager that it forms part of their NGH duties then any fee must be declared and the amount paid back into the appropriate Trust Budget.

7.1.7. Private Clinical Opinion and Other Similar Arrangements

Where Trust employees, or those where the Trust funds their activity, are asked to provide a private clinical opinion and/or report then the activity and income must be declared as follows;

- Where the clinician takes the time as annual leave or undertakes the activity outside of contracted work time with the Trust, then they must declare the income as additional income.

In such cases the clinician must make it clear that they are providing the review and/or report in their own private clinical capacity. They must not use Trust resources in the preparation of materials without prior agreement. They must not use their Trust employee privilege to access records or information other than to request them as an external agent. They must not use Trust staff's time or other resources to construct the report. They must not provide the report on Trust letterhead or imply in any way that they are undertaking work for or on behalf of the Trust or as part of their employment with the Trust. Doing so is regarded as a breach of contract and a disciplinary matter.

Where the clinician provides any such opinion as agreed with their Line Manager as part of their NGH duties, then any fees received must be paid into the appropriate Trust budget.

Where employed staff provide private clinical opinion and/or court reports they should ensure that this work is covered by or secure individual professional indemnity insurance that covers liability risks pertaining to these reports. This activity being private falls outside Trust business and the Trust cannot accept any liability in connection with it and/or them.

In this context Private Clinical opinion and/or Court Reports include any witness statement(s) submitted to Court for private fee payment. Therefore in essence any evidence (written or attending Court in person to give oral evidence) is covered herein and is outside of the indemnity arrangements of the organisation.

Any employed member of staff sending evidence to Court must be aware that they are thereby offering to be a witness and immediately expose themselves to be called to attend (even by witness summons / subpoena). As Court hearings can be listed for full days, or a number of days, this potentially means that witness' may not be able to fulfil their contractual obligation to be available to attend to NHS duties. In such cases, where the statement has been made as an employee then the Line Manager must make arrangements for availability and backfill. Where this is as a result of private opinion the employee must make their Line Manager aware of their absence which must be taken as leave (paid or unpaid).

7.1.8. Secondary Employment/Outside Interests

The Trust considers that any employment with the Trust is the employee's principal employment. Staff must ensure that they are not in breach of the Working Time Directive, and the Trust will not accept any legal responsibility for contravention of the law as a result of secondary employment. Staff must ensure that their manager is aware of any secondary employment, including any private medical work, management consultancy, lecturing etc undertaken or intended to be undertaken.

7.1.9. Private Practice

Any professional employed by the Trust may carry out private practice. For consultants and associate specialists this may be done subject to the terms and conditions of the consultant contract – schedule 9. Consultants must inform the Medical Director of any regular commitments, which will form part of their job plan review.

All private practice should be declared and should not be allowed to conflict with the interests of the Trust or its patients.

7.1.10. Intellectual Property Rights

All innovative, invented and developed products or services carried out by an employee whilst working for the Trust are the property of the Trust. The Trust will honour the principle of sharing income generated from intellectual property with inventors. If an employee collaborates with a manufacturer for research and evaluation purposes, arrangements will be made, if appropriate, at the discretion of the Trust for some of the reward to be passed to the employee from the manufacturer.

Where staff provide external services by virtue of their position in the Trust and in relation to their work for the Trust (such as seminars, presentations etc), any monies paid must be to the benefit of the Trust and not to the individual.

For more information on intellectual property rights, particularly in relation to research and development, reference should be made to the Department of Health's Policy Framework for the Management of Intellectual Property.

7.1.11. Free of Charge/Donated Goods/Services

Free of charge or donated goods or services may only be accepted in accordance with Standing Financial Instructions.

7.2. OTHER RELATED ISSUES

This section reminds staff about other issues, for their attention, in terms of the principles of good business conduct, which are also addressed in other Trust publications.

7.2.1. Employment Issues

- Staff involved in the appointment of new staff should ensure that these are made on the basis of merit alone. It is unlawful to make an appointment based on anything other than the ability of the candidate to undertake the duties of the post. In order to avoid any possible accusation of bias, staff should not be

involved in the recruitment process where they are related to an applicant, or have a close personal relationship outside work with him or her.

- Similarly, staff should not be involved in decisions relating to discipline, promotion or pay adjustments, or any other employment matter, for any other employee who is a relative, partner or close personal friend.
- Candidates making an application for any appointment with the Trust are required to disclose in writing whether, to their knowledge, they are related to a Director of the Trust. Failure to disclose such a relationship could disqualify a candidate and, if he/she is appointed, could render him/her liable to immediate dismissal.
- Staff are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. Staff are advised to seek advice from their manager if they think a conflict of interest may arise.

7.2.2. Maintaining Confidentiality

- All employees of the Trust have a duty to maintain confidentiality of information at all times. As a public body, the Trust recognises the need for openness. However, this should not be confused with a breach of confidentiality. All employees of the Trust must be aware that a breach of confidentiality is potentially a serious disciplinary office that could result in dismissal.
- Staff must not disclose anything learned about a patient to anyone not authorised to receive it.
- It is important that information about staff should also be regarded as confidential and not disclosed to anyone who is not authorised to receive it, without the prior approval of the employee.
- Trust employees may frequently find that, as part of their work, they have access to confidential reports and information concerning the business of the Trust and other NHS organisations. The fact that they do have access to this information places a responsibility on them to honour the trust placed on them by the nature of their employment. In addition, “Commercial in Confidence” information must not be disclosed to any unauthorised person or organisation, since its disclosure would prejudice the principle of a purchasing system based on competition.

7.2.3.Tendering and Contracting Procedures

- Staff involved in tendering and purchasing are perhaps more vulnerable than other colleagues to accusations of impropriety. Even the appearance of impropriety can be highly damaging to the employee and to the Trust. It is vital that all purchasing decisions are made on an objective basis, and seen to be so.
- Please refer to Standing Orders.

8. IMPLEMENTATION & TRAINING

This is an ongoing policy which has already been implemented across the Trust.

Awareness of this document will be raised through utilisation of existing internal communications media including, but not exclusively, inclusion in the Point/Insight

Magazine, presentation at Strategic Management Board and Core Brief and signposting through screensavers on staff IT hardware.

To ensure that all staff are aware of compliance requirements, regular reminders will be issues to all senior staff within the Trust by the Head of Corporate Affairs with line managers cascading reminders further.

9. 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
Annual audit inspection of record of gifts and hospitality	Documentation audit	Head of Corporate Affairs and External Audit	Annual	Audit Committee	Head of Corporate Affairs	Executive Team
Review of recruitment process to confirm compliance with full declaration process.	Internal audit of recruitment process included as a standard requirement within annual audit plan	Head of Corporate Affairs and Internal Audit	Annual	Audit Committee	Head of Corporate Affairs	Executive Team
Annual inspection of declarations of interest	Documentation audit	Head of Corporate Affairs and External Audit – Internal Audit	Annual	Audit Committee	Head of Corporate Affairs	Executive Team
Compliance with rules associated with contracting processes.	Contract reviews and internal audit of supplies process	Head of Corporate Affairs and Internal Audit	Annual	Audit Committee	Head of Corporate Affairs	Executive Team

10. REFERENCES & ASSOCIATED DOCUMENTATION

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ANNEX ONE - Extract from the Medicines (Advertising Amendments) Regulations 2005 Inducements and Hospitality

Extract from the Medicines (Advertising Amendments) Regulations 2005

Inducements and Hospitality

(1) Subject to paragraph (2) and (4), where relevant medicinal products are being promoted to persons qualified to prescribe or supply relevant medicinal products, no person shall supply, offer or promise to such persons any gift, pecuniary advantage or benefit in kind, unless it is inexpensive and irrelevant to the practice of medicine or pharmacy.

(2) The provisions of paragraph (1) shall not prevent any person offering hospitality (including the provision of travelling or accommodation expenses) at events for purely professional or scientific purposes to persons qualified to prescribe or supply relevant medicinal products, provided that –

(a) such hospitality is strictly limited to the main scientific objective of the event, and
(b) it is offered only to health professionals.

(3) No person shall offer hospitality (including the provision of travelling or accommodation expenses) at a meeting or event held for the promotion of relevant medicinal products unless –

(a) such hospitality is strictly limited to the main purpose of the meeting or event, and

(b) the person to whom it is offered is a health professional.

(4) No person qualified to prescribe or supply relevant medicinal products shall solicit or accept any gift, pecuniary advantage, benefit in kind, hospitality or sponsorship prohibited by this regulation.

ANNEX TWO – Professional Relationships with Pharmaceutical Companies

Scope
This guidance applies to all medical, nursing and pharmacy staff who interact with pharmaceutical company representatives within the course of their duties and to pharmaceutical company representatives who visit the hospital in the course of their business activities.

Introduction
It is acknowledged that interaction between representatives from pharmaceutical companies and staff at NGH is legitimate and often mutually beneficial. In addition to providing information to health practitioners, the prime function of company representatives is to promote and sell their products and services. This function should be carried out in a proper and ethical manner and must not contravene trust, NHS or government policies.

Appointments and visits
All representatives visiting the Trust for the first time should receive copies of this guidance should any relevant additional information about relevant Trust policies and procedures provided/signposted.

Representatives should visit senior pharmacy staff by appointment only.

Appointments may be booked via the departmental secretary. The purpose of the visit should be clearly stated. Educational presentations to pharmacy staff may be arranged through the secretarial staff at NGH pharmacy.

Company representatives must not enter wards or other clinical areas of the hospital without the express prior invitation of a senior member of medical/ nursing staff or other healthcare professional. Representatives invited into wards or clinical areas must comply with Trust policies and procedures, particularly those relating to infection control and patient confidentiality.

All meetings and appointments with medical staff must be booked by telephone through consultant/department secretaries. Permission must be sought from consultants/heads of service before any interaction with junior medical staff and logged.

Samples
Samples of medicines or dressings must not be left on wards or in departments without the express permission of the pharmacy. Controlled drug samples are not permitted under any circumstances (ref clause 17 ABPI code of practice 2011).

Managed entry of new medicines
The Formulary Committee considers the status of new and existing medicines or dressings. New medicines or dressings will not be included on the formulary or routinely stocked, until a formal submission has been approved by the committee, and funding agreed. Information regarding the Formulary Committee ’s decision is only given to the representative once all the relevant clinicians have been informed. Information regarding new products or changes to existing products should be directed to appropriate senior pharmacy staff.

Comprehensive information on new products for use in hospital or general practice is essential e.g. product monographs. In addition, it is helpful to receive updates on existing products e.g. new licensed indications, recently published comparative trials, product discontinuation, future developments, cost changes. Copies of the NGH formulary or medical staff lists are not provided from the pharmacy (although representatives may be directed to information which is in the public domain via the Trust's website).

Purchasing and Contracts
Any discussions regarding NGH purchasing arrangements should be initiated through pharmacy. These are often lower than the basic NHS price, are negotiated at either a national, regional or local level and are commercially confidential. NGH prices will not be divulged or discussed with competitor companies.

All matters relating to drug contracts should be directed to the head of pharmacy. Drug usage information will only be provided if associated with contract negotiations and this information should not be requested from other pharmacists.

RESPONSIBILITIES

NGH STAFF

NGH staff should not disclose the names of members of the Formulary Committee or Formulary committee. Hospital staff are reminded of the confidential nature of hospital medicine prices. NGH prices must not be divulged or discussed with competitor companies.

The Trust expects that all staff will abide by the highest standards of business conduct and ensure at all times that they do not abuse their official position for personal gain or to benefit their family or friends nor seek to advantage or further private business or other interests in the course of their official duties.

Pharmaceutical Company Representatives
Representatives are not permitted to use internal hospital telephones except to enable authorised access to departments. Mobile telephones should be switched off when inside the hospital.

Representatives should be able to provide identification when in the hospital. This should be provided by their company.

NGH staff may not be bleeped from within or outside the hospital.

Representatives are reminded to keep the pharmacy department informed of their activities within the trust, particularly with respect to the promotion of new products.

Representatives are not permitted to use NGH treatment guidelines for promotional purposes outside the Trust.

ANNEX THREE - Research and Development

Research and Development

1. Exceptionally, in the case of non-commercial research and development (R&D)originated or hosted by the Trust, commercial sponsorship may be linked to the purchase of particular products, or to supplies from particular sources. This should be in accordance with the guidance in HSG (97)32 Responsibilities for Meeting Patient Care Costs Associated with R&D in the NHS. Where there is industry collaboration in such studies, companies may alternatively make a contribution towards the study's costs, rather than supplying the product.

2. Any funding for research purposes must be transparent. There should be no incentive to prescribe more of any particular treatment or product other than in accordance with a peer reviewed and ethically approved protocol which has been agreed between the principal investigator, Medical Director and research funder. When considering a research proposal, whether funded in whole or part by industry, the Trust will wish to consider how the continuing costs of any pharmaceutical or other treatment initiated during the research will be managed once the study has ended.

3. Separate guidelines exist for pharmaceutical company sponsored Safety Assessments of Marketed Medicines (SAMM).

4. Where R&D is primarily for commercial purposes, the Trust expects to recover the full costs from the commercial company on whose behalf it is carried out. An industry sponsored trial should not commence until an indemnity agreement is in place – see the guidelines in HSC (96)48 NHS Indemnity, Arrangements for Clinical Negligence Claims in the NHS. A standard form of indemnity can be found at Annex B of that guidance.

5. The NHS should benefit from commercial exploitation of intellectual property derived from R&D that the NHS has funded, or for which it has been funded, even where the intellectual property itself is owned by people outside the NHS. The Trust should ensure that an agreement to this effect is included in any contracts concerning R&D. The guidelines in HSC 1998/106 Policy Framework for the Management of Intellectual Property should be followed.

APPENDICES

Appendix 1 Short Guide for Staff - Guidance on the Standards of Business Conduct

DO

- Make sure you understand the rules and guidance on standards of conduct, and consult your manager if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict.
- Declare to your employer any relevant interests; if in doubt ask yourself:
    - Am I, or might I be in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
    - Do I have access to information with which I could influence purchasing decisions?
    - Could my outside interests be in any way detrimental to the NHS or patients' interests?
    - Do I have any other reasons to think I may be risking a conflict of interest?

IF IN DOUBT – DECLARE IT

- Observe the Trust Standing Orders and Tendering and Contracting Procedures if you are involved in any way with the purchase of goods and services.
- Obtain your managers permission before accepting any commercial sponsorship

DO NOT

- Accept any inducements, personal gifts (other than items of nominal value or of no personal nature) or inappropriate hospitality.
- Abuse your official position to obtain preferential rates for private deals
- Unfairly advantage one competitor over another or show favouritism in awarding contracts.
- Misuse or make available official "commercial in confidence" information.

Appendix 2 Declaration of Interest Form

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

DECLARATION OF INTEREST

1. Name:

2. Position:

3. Department:

4. Other employment:

5. Relevant interests in business firms, partnerships, limited companies:

6. Relevant membership of voluntary and charitable organisations:

7. Other (including spouse/partner/family member)

I have read the notes for completion and understand my responsibility to supply any information that may give rise to conflict of interest in my employment with the Trust. I have understood the Trust's Policy on Standards of Business Conduct

Signed…….Date……..

DECLARATION OF INTERESTS
NOTES FOR COMPLETION

1. Other Employment
Please list any other employers you may have. Please also list any employers of your immediate family (i.e. spouse/partner, sons/daughters)

2. Relevant interest in business firms, partnerships, limited companies
Please list your own interests and those of your immediate family (as defined in 1) in the following:

- Directorships in all limited companies (including non-executive directorships held in private or public limited companies)

- Proprietorship/shareholdings in companies or business firms undertaking business or possibly seeking to do business with the Trust

- Any connection with a voluntary or other organisation contracting for NHS services

Shareholdings need not be disclosed if:

The total nominal value of the share do not exceed £5000 or one hundredth of the total nominal value of the issued share capital of the company (whichever is less), and

if the share capital is of more than one class, the nominal value of share of any one class in which the beneficial interest does not exceed one hundredth of the total issued share capital of that class

3. Relevant membership of voluntary and charitable organisations
Please list any memberships held by yourself and your immediate family (as defined in 1) or charitable or voluntary bodies in the field of health and social care, indicating any positions of responsibility

4. Other
Please detail any other matter relevant to yourself and your immediate family (as defined in 1) which could possibly lead to any conflict of interest.

Appendix 3 Declaration in relation to Gifts, Sponsorship or Hospitality from Third Parties Offered

Modest hospitality is an accepted courtesy of a business relationship; however, recipients should not allow themselves to reach a position whereby they might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality

NAME: _____

JOB TITLE: _____

WARD: _____

DIRECTORATE: _____

FULL DETAILS OF GIFT, SPONSORSHIP OR HOSPITALITY BEING OFFERED:

Name of Organisation or individual providing benefit _____

Nature and purpose of offer

Estimated value .....

Other Information

Decision of Person Offered Benefit

Declined ☐ Accepted ☐

Authorisation (By Line Manager/Director)
(Sums over £200 must be authorised by the Director)

Yes ☐ No ☐

STANDARD

Reason for non authorisation

If hospitality, sponsorship or a gift has been accepted, please have this form authorised by your line manager

Line Manager's Name .....

Line Manager's Signature .....

Date .....

Signature of person making the Declaration: ..... Dated _____

Please send this form to:

Head of Corporate Affairs
Chief Executives Office
Northampton General Hospital
01604 544206

REPORT TO THE TRUST BOARD
31 October 2013

Title	NHS England: Emergency Preparedness Resilience and Response(EPRR) Audit Return
Agenda item	20
Sponsoring Director	Deborah Needham, Care Group Director
Author(s)	James Rogers, Head of Resilience
Purpose	NHS England, via the Area Teams, requires all NHS funded bodies to complete a board approved EPRR return on an annual basis.

Executive summary

The Emergency Preparedness Resilience and Response(EPRR) Audit Return responds to a number of pre-set questions relating to the Trusts ability to prepare and respond to a range of incidents both internal and external. No evidence is required to be submitted for this year's return.

The associated Action Plan details the planned work of the Trust's Resilience Planning Group to address any areas of limited assurance.

Related strategic aim and corporate objective	All
Risk and assurance	Risk with local Business Continuity plans being tested – all plans tested except AE and Theatres. Dates have been planned for testing.
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? 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	The Trust is legally required to plan and prepare for Incidents and disruptions to its service delivery. (Civil Contingencies Act).

Actions required by the Board

The Board is asked to endorse the attached Audit return and associated Action Plan.

Northampton General Hospital
Acute Trust
James Rogers
Debbie Needham
Insert submission date

GREEN - arrangements in place now, compliant with core	GREEN - Assured
AMBER - draft or scheduled on action plan for completion by Dec	AMBER - Partially assured, seeking clarification/ draft
RED - arrangements not in place or scheduled for completion	RED - Not assured; insufficient evidence provided
N/A - Not applicable to organisation	N/A - Not applicable to organisation
N/R - Not rated by reviewing team	N/R - Not rated by reviewing team

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	● Accountable Emergency Officer (AEO) details (name, role) ● AEO job description ●Evidence that AEO completed relevant training (SLC, witness familiarisation etc - dates completed) ● Competency assessed against National Occupational Standards	COO is designated AEO. Currently interim post. Care Group Director (med) has delegated responsibility	G		
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	● Articulated in Incident Response Plans (IRP) ● MoU/ mutual aid arrangements, evidence of participation in multiagency planning groups/ LHRP as appropriate	The Trust is fully engaged at the LHRP and sub group. The local MOU is currently in need of revision as it is a legacy document.	A		
3	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	● Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) where applicable ● Borough Resilience Forum (BRF)/ subgroup participation	The Trust is fully engaged at the LHRP and sub group.	G		
3 . 1	director-level representation at the LHRP; and	● LHRP Terms of Reference (ToR), membership list ● most recent LHRP minutes	The Trust is represented by the Care Group Director.	G		
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	● Participation in annual NHS Safe System process ● EPRR Board report/ formal reporting structure outlined ● Training and exercise programmes ● Post exercise reports, showing lessons identified, with an action plan to address gaps	Board reporting, Training programme in place, Exercise programme in place, post exercise and incident plans published.	G		
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	● Work plan for EPRR ● Risk Register reflects community risk register ● EPRR Board report, issues/ lessons log	The Trust maintains a resilience Work programme	G		
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	● Risk register ● Details on the process/ schedule of review	Risk Register held by HOR and reviewed by Resilience Planning Group. Any High Risks would be escalated to Trust Board as per policy.	G		
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	● PLEASE SUPPLY ONE COPY OF YOUR MAJOR INCIDENT/ INCIDENT RESPONSE PLAN AND APPENDICES	Trust and Local directorate MI plans	G		
5 . 1	be based on risk-assessed worst-case scenarios;	● Page/ section reference in arrangements demonstrating how the organisation plans for incidents ● Demonstration of risk assessments ● ToR of MI/BC Planning Groups	All NGH resilience plans are scalable, resource based as per IEM best practice.	G		
5 . 2	make sure that all arrangements are trialled and validated through testing or exercises;	● Testing and Exercising programme / log that complies with national exercising standards ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	The Trust exercises all plans as per schedule. Next 'live' exercise is due in spring 2014	G		
5 . 3	make sure that the funding and resources are available to cover the EPRR arrangements;	● Details of agreed budget ● EPRR business cases/ papers for funding, ● EPLO job description showing WTE	Resilience expenditure is managed locally. Corporate resilience funding is managed through business cases.	G		
5 . 4	plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	● Demonstrate representation on relevant planning groups, ToR/ minutes (eg: Security Liaison Groups for COMAH sites etc) ● Associated risk reflected on local risk register ● IRPs recognise specific local challenges	N/A	N/A		
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	● Business Continuity planning arrangements demonstrate joint working between EP and estates/ facilities staff (ToR for related meetings, task and finish groups) ● Action card for E&F in IRP/ BCP	The Trust has in place: Corporate BCM response plans, Estates BCM response plans. Facilities are represented at the Trust Resilience Group	G		
	Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:					
5 . 6	refer to all relevant national guidance, other supporting and threat-specific plans (eg pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	● Page/ section references in IRP, annexes to plans or standalone plans	The trust uses generic scaleable resource based planning as per best practice. In addition The trust has CBRN, Severe Weather, Pan Flu, Fuel Shortage, lock down and Evacuation plans	G		
5 . 7	refer to all other associated plans identified by local, regional and national risk registers;	● Page/ section references in IRP, annexes to plans or standalone plans	Corporate plans contain reference to local response activity buy responding partners.	G		
5 . 8	have been written in collaboration with all relevant partner organisations;	● Page/ section references in IRP, annexes to plans or standalone plans	Plans are shared with responding partners through the LRF	G		
5 . 9	refer to incident response plans used by partners, including LRF plans;	● Page/ section references in IRP, annexes to plans or standalone plans	Corporate plans contain reference to local response activity buy responding partners.	G		
5 . 10	have been written in collaboration with PHE;	● Page/ section references in IRP, annexes to plans or standalone plans	Plans are shared with responding partners through the LRF	G		
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	● Page/ section references in IRP, annexes to plans or standalone plans ● Information how to access capabilities	The Trust A+E plan is under review to ensure all network pathways are maintained.	A		
5 . 12	define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	**Not rated in 2013**		N/R		N/R

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
	Incident response plans must follow NHS governance arrangements. They must:					
5 . 13	be approved by the relevant board;	● Page/ section references in IRP, annexes to plans or standalone plans ● Notes from relevant approving Board meeting	The Resilience Planning group provides an annual report to the board and audit committee. All local plans are approved by local boards. Corporate plans are approved by the trust procedural documents group.	G		
5 . 14	be signed off by the appropriate Senior Responsible Officer;	● Page/ section references in IRP, annexes to plans or standalone plans	The Resilience Planning group provides an annual report to the board and audit committee. All local plans are approved by local boards. Corporate plans are approved by the trust procedural documents group.	G		
5 . 15	set out how legal advice can be obtained in relation to the CCA;	● Page/ section references in IRP, annexes to plans or standalone plans	The Trust has internal legal support that can be contacted by local teams	G		
5 . 16	identify who is responsible for making sure the plan is updated, distributed and regularly tested;	● Page/ section references in IRP, annexes to plans or standalone plans	All plans.	G		
5 . 17	explain how internal and external consultation will be carried out to validate the plan;	● Page/ section references in IRP, annexes to plans or standalone plans	All plans.	G		
5 . 18	include version controls to be sure the user has the latest version;	● Page/ section references in IRP, annexes to plans or standalone plans	All plans.	G		
5 . 19	set out how the plan will be published – for example, on a website;	● Page/ section references in IRP, annexes to plans or standalone plans	All plans.	G		
5 . 20	include an audit trail to record changes and updates;	● Page/ section references in IRP, annexes to plans or standalone plans	All plans.	G		
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	● Page/ section references in IRP, annexes to plans or standalone plans	The Trust will use existing financial procedures to allocate costs for a response. A formal procedure for this is due from the financial team.	A		
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	● Page/ section references in IRP, annexes to plans or standalone plans	All plans are trained and exercised with all lessons and risks and lessons reported.	G		
	Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.					
5 . 23	Key staff must know where to find the plan on the intranet or shared drive.	● Training plan for staff with a specific role ● Training Needs Analysis for those staff ● Training materials ● Training records	Allocated Area on trust intranet and all plans are on the trust document store. All training session include finding the local plan.	G		
5 . 24	There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	● Testing and Exercising schedule ● Details on process for reviewing plans in light of lessons learnt	The Trust maintains a resilience Work programme	G		
5 . 25	Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	All key staff are trained to NOS standards.	G		
5 . 26	It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	Training programmes	G		
5 . 27	It must be clear how key staff can achieve and maintain suitable knowledge and skills.	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	Training programmes and session plans	G		
	Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.					
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	● Page/ section references in IRP, annexes to plans or standalone plans	Trust Switch Board Procedures. 360 contact system. Corporate plan.	G		
5 . 30	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	● Provide detail on how this is delivered ● Provide detail on contingency arrangements regarding call-out ● Function assigned to IRP/ ICC Action Card	Director call out/shifts process. 3060 contact system, Switchboard procedures	G		
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	● On-call arrangements/ processes, On-call pack, On-call staff lists ● Responsibility assigned to an Action Card ● Admin / support role assigned to maintain systems ● Reports from COMMEX/ regular cascades using contact lists	Trust Switch Board Procedures. 360 contact system. Corporate plan.	G		
5 . 32	Set out the responsibilities of key staff and departments.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Local Plans and Action Cards	G		
5 . 33	Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Highlighted in corporate MI plan and action cards	G		
5 . 34	Explain how mutual aid arrangements will be activated and maintained.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Corporate Plan	G		
5 . 35	Identify where the incident or emergency will be managed from (the ICC).	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Control Room Procedures	G		
5 . 36	Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Corporate Plan and Control room Procedures	G		
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	**Not rated in 2013, unless organisation provides evidence**				
5 . 38	**Best Practice:** Use the National Resilience Extranet.	**Not rated in 2013, unless organisation provides evidence**				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
5 . 39	Refer to specific action cards relating to using the incident response plan.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Local Plans and Action Cards	G		
5 . 40	Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Control Room Procedures	G		
5 . 41	Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Key plans (Corporate MIP and Control Room Procedures) contain detail regarding ensuring shifts are maintained and the hand over process. Local Plans contain reference to ensuring staff called in to support a response are not due to work on the next shift.	G		
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	The Trust is engaged in the LRF Warning and Informing Sub-group. The Trust will use comms standard procedures	G		
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	111 provider is engaged through the LHRP.	G		
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	The use of Helplines has been discussed by the Trust and is not considered a priority.	A		
5 . 45	Describe how stores and supplies will be maintained.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Facilities maintain an emergency response stock for key areas. Procedures are in place to utilise existing stocks across the trust and obtain additional stock as required.	G		
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	The Trust is not a burns centre. All other patients will be treated as per clinical need using standard procedures.	G		
5 . 47	Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	The Trust is engaged with the local police force to provide operation consort.	G		
5 . 48	Explain the process of recovery and returning to normal processes.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	All plans	G		
5 . 49	Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Corporate and local plans	G		
5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	The Trust has procedures in place to support staff via occupational health. The trust is engaging the local authority to proved friends and family services.	G		
	Set out how surges in demand will be managed.					
5 . 51	Explain who will be responsible for managing escalation and surges.	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Action Cards	The Trust's Escalation Plan contains detail of how escalation and surge will be managed both corporately and locally. It details the command and control structures, meeting schedules and provides action cards for all relevant staff.	G		
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Escalation framework including trigger points for ambulance, acute and community ● Action Cards	The Trusts Escalation Plan contains detail of the trigger points and actions required at each level for key roles and for partner agencies	G		
	Link the Incident Response Plan to threat-specific incidents					
5 . 53	CBRN incidents;	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific CBRN plans	The Trust's CBRN plan contains detail of who the trust will receive, assess, decontaminate and treat self presenters from a CBRN incident.	G		
5 . 54	mass casualty incidents;	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Mass Casualties plans	The trust will utilise its existing MI plans for Mass Casualty incidents. The trust is engaged with the CCG and LAT to support the development of a county wide Mass Casualty plan.	A		
5 . 55	pandemic flu;	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Pandemic Flu plans	Pan Flu Plan	G		
5 . 56	patients with burns requiring critical care; and	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Bums plans	The Trust is not a burns Centre	G		
5 . 57	severe weather.	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Severe Weather plans	Severe Weather plan	G		
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	Control Room Procedures	G		
6 . 1	There must be a plan setting out how the ICC will operate.	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	Control Room Procedures	G		
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	Control Room Procedures	G		

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6 . 3	There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	Control Room Procedures	G		
6 . 4	Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards ● Provide detail on equipment available within ICC ● Provide detail on the programme for exercising ICC arrangements	Control Room Procedures	G		
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	● PLEASE SUPPLY ONE COPY OF YOUR BUSINESS CONTINUITY POLICY, BUSINESS CONTINUITY PLAN AND APPENDICES ● Arrangemetns dealing with site/organisation specific risks (eg: flooding) ● Action plan for transition to/ alignment with ISO22301	BCM policy and programme, Corporate Plan and Local Plans	G		
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	● Page/ section references in Business Continuity Management System arrangements/ Business Continuity Policy/ Business Continuity Plan, annexes to plans or standalone plans	BCM is financially supported at all levels. All local BCM leads are trained and support by the HoR	G		
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	● Page/ section references in BC arrangements	The Trust will use existing financial procedures to allocate costs for a response. A formal procedure for this is due from the financial team.	A		
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	● Page/ section references in BC arrangements	Corporate and Local BCM plans	G		
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	● Page/ section references in BC arrangements	Corporate and Local BCM plans	G		
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.					
7 . 5	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	● Page/ section references in BC arrangements	Corporate and Local BCM plans, BIAs	G		
7 . 6	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	● Page/ section references in BC arrangements	All plans are shared with local partners and are agreed at executive level.	G		
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	● Page/ section references in BC arrangements	On Intranet	G		
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	● Page/ section references in BC arrangements	The Resilience Planning group provides an annual report to the board and audit committee. All local plans are approved by local boards. Corporate plans are approved by the trust procedural documents group.	G		
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	● Page/ section references in BC arrangements	In Plans	G		
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	● Page/ section references in BC arrangements	The Trust has used a range of relevant tool kits to develop and assess its plans.	G		
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.					
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	● Page/ section references in BC arrangements	The Trust maintains a Resilience Risk register and is engaged with the LRF risk group	G		
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	● Page/ section references in BC arrangements ● Risk assessments/ methodology	The Trust maintains a Resilience Risk register and is engaged with the LRF risk group	G		
7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	● Page/ section references in BC arrangements ● Risk registers and arrangements for review	The Trust maintains a Resilience Risk register and is engaged with the LRF risk group	G		
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	● Page/ section references in BC arrangements	All plans are Use BIAs, BCM programme	G		
7 . 15	They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	● Prioritised list of critical activities/ services ● Business Impact Analysis methodology	All plans are Use BIAs, BCM programme	G		
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	● Appropriate risk register	The Trust maintains a Resilience Risk register and is engaged with the LRF risk group	G		
	Business continuity plans must set out how the plans will be called into use, escalated and operated.					
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	The trust is engaged in local resilience communication procedures and exercises.	G		
7 . 18	Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Trust Switch board procedures, Local plans, Escalation policy, BCM plans	G		
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Responsibility assigned to Action Card	Corporate Plan	G		
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	● On-call arrangements/ processes, On-call pack, On-call staff lists ● Responsibility assigned to an Action Card ● Admin / support role assigned to maintain systems ● Reports from COMMEX/ regular cascades using contact lists	Switch Board procedures and 360 contact system	G		

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
7 . 21	the responsibilities of key staff and departments;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Local Action Cards	G		
7 . 22	the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Action Cards	G		
7 . 23	how mutual aid arrangements will be called into use and maintained;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Corporate Plan	G		
7 . 24	where the incident or emergency will be managed from (the ICC);	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Control Room Procedures, Corporate Plan	G		
7 . 25	how the independent healthcare sector may help if required; and	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	The Trust does not currently have any formal links with local Private sector providers to support its MIP or BCM response.	R		
7 . 26	the insurance arrangement that are in place and how they may apply.	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	The trust has sufficient relevant insurance in place and has generic procedures for implementing this.	G		
	Business continuity plans must describe the effects of any disruption and how they can be managed. Plans must include:					
7 . 27	contact details for all key stakeholders;	● Page/ section references in BC plans, annexes to plans or standalone plans	Local Plans, 360 contact system	G		
7 . 28	alternative locations for the business;	● Page/ section references in BC plans, annexes to plans or standalone plans	Local Plans	G		
7 . 29	a scalable plan setting out how incidents will be managed and by whom;	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Local and Corporate Plans	G		
7 . 30	recovery and restoration processes and how they will be set up following an incident;	● Page/ section references in BC plan, annexes to plans or standalone plans ● Action Cards ● Link to IRP (Standard 5.48) if using these arrangements	Local and Corporate Plans	G		
7 . 31	how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	● Page/ section references in BC plan, annexes to plans or standalone plans ● Action Cards ● Sample incident log ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Local and Corporate Plans	G		
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	● Page/ section references in BC plan, annexes to plans or standalone plans ● Spokespersons identified and assigned to an Action Card	Local and Corporate Plans	G		
7 . 33	how staff will be accommodated overnight if necessary;	● Page/ section references in BC plan, annexes to plans or standalone plans	Facilities Plans	G		
7 . 34	how stores and supplies will be managed and maintained; and	● Page/ section references in BC plan, annexes to plans or standalone plans	Facilities Plans	G		
7 . 35	details of a surge plan to maintain critical services.	● Page/ section references in BC plan, annexes to plans or standalone plans	Escalation Plan, ITU Surge Plan	G		
	Business continuity plans must specify how they will be used, maintained and reviewed.					
7 . 36	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	● Testing and Exercising programme / log that complies with national exercising standards ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Exercise Programme, Exercise reports.	G		
7 . 37	Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	● Page/ section references in BC plan, annexes to plans or standalone plans	Local Plans and Corporate Plan	G		
7 . 38	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	● Page/ section references in BC plan, annexes to plans or standalone plans ● Reports to Board or Management Teams	Exercise Programme, Exercise and Incident reports.	G		
7 . 39	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	● Page/ section references in BC plan, annexes to plans or standalone plans ● Business Continuity strategies developed in response to problems identified ● Reports to Board or Management Teams ● Post incident / exercise debrief reports ● Details of expenditure/ investment	BCM incident reports	G		
	Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:					
7 . 40	details of the training provided to staff and how the training record is maintained;	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training Programme and attendance records	G		
7 . 41	reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Not specifically used at present.	A		
7 . 42	details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training programme and exercise programme	G		
7 . 43	details of how suitable knowledge and skills will be achieved and maintained.	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training programme and exercise programme	G		

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
8	**NHS Acute Trusts must also include:**					
8 . 1	detailed lockdown procedures;	● Page/ section references in IRP, annexes or standalone plans	Lockdown Procedures and exercise reports	G		
8 . 2	detailed evacuation procedures;	● Page/ section references in IRP, annexes or standalone plans	The trust is currently developing its wide area evacuation plans. Local plans are in place	A		
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	● Page/ section references in IRP, annexes or standalone plans	The trust is currently developing procedures for the local authority to provide support to friends and family at the trust.	A		
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	● Page/ section references in IRP, annexes or standalone plans	The trust will utilise existing standard procedure to manage fatalities and families of fatalities.	G		
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.	● Page/ section references in IRP, annexes or standalone plans	A+E key staff are aware of the guidelines	G		
9 . 42	explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	● Detail arrangements for MTPAS enabled telecoms in the service/ invocation arrangements	The trust does not use the MTPAS system as it has been shown to not provide acute trusts with any further resilience	G		
19	**Urgent care centres must also:**					
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	● Page/ section references in IRP, annexes or standalone plans ● Commissioning specifications should include provisions for appropriate support	The Trust is supporting local providers to develop this facility	A		

Northampton General Hospital
EPRR
Action Plan
22nd October 2013

Action Required	EPPR Check List Reference	Action Lead	Due date	EPRR Checklist RAG	Current Progress and Notes
Support the CCG and LAT to develop and gain agreement for, a county wide EPRR MOU	2	Local Area Team	As per LAT time scales	**Amber**	The LRHP sub group is due to meet on the 25th of October
Complete the A+E Major Incident Plan Review and include reference relevant to networks.	5.11	Head of Resilience, A+E Major Incident Consultant lead	November	**Amber**	The plan review is underway with commitment from A+E staff and the Head of Resilience to complete with the time frame
Formal Financial procedures for Major Incidents and BCM response in place	5.21, 7.2	Director Of Finance	November	**Amber**	Care Group Director (Medicine) has previously requested that this be completed.
Support the LAT and other responders to develop a county Mass casualty plan	5.54, 19.1	LAT and LHRP agencies	As Per LHRP time scales	**Amber**	The LRHP sub group is due to meet on the 25th of October
Investigate potential links to local private healthcare responders for Major Incident and BCM responses	7.25	Head of Resilience	January	**RED**	Head of Resilience to engage with Private providers as soon as possible. Previous efforts have had limited success.
Review the NOS for Major Incident responders and officer and incorporate and changes to the training programme as required	7.41	Head of Resilience	November	**Amber**	Head of Resilience currently reviewing the NOS against our existing training. Little or no need for change is expected.
Complete and deliver a Corporate Evacuation Plan	8.2	Head of Resilience, Head of Estates, Head of Capacity	December	**Amber**	Evacuation Planning Group is currently meeting. A draft plan has been developed. Key areas for work are the role of the site team and the command initial triage and movement of patients.
Develop and agree Friends and Family Centre Plans with NCC.	8.3	Head of Resilience, NCC	December	**Amber**	Head of Resilience has met with NCC and is awaiting provisional quotes to develop the plans and for activation.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
31 October 2013

Title	Annual Research and Development Report
Agenda item	21
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer
Author(s)	Mrs Julie Wilson, Research and Development Manager
Purpose	• To review and endorse the Trust Research Capability statement • To endorse KPI for R&D and reporting matrix to the Trust Board

Executive summary

The paper provides an overview of the Trust performance in research through 2012/13. Furthermore it presents the Trusts Research Capability Statement which is a national requirement on Trust which needs the Board approval. In addition the paper is introduces R&D Key Performance Indicators which is local prerequisite for infrastructure funding

Related strategic aim and corporate objective	*Be a provider of Quality of Care BAF1*
Risk and assurance	*Does the content of the report present any risks to the Trust or consequently provide assurances on risks*
Related Board Assurance Framework entries	BAF 1, 4
Equality Impact Assessment	*Not assessed*
Legal implications / regulatory requirements	*Governance arrangements for research are scrutinised carefully*

Actions required by the Board

- To review and endorse the Trust's Research Capability statement
- To endorse a Key performance matrix for R&D for quarterly reporting matrix to the Trust Board

Northampton General Hospital NHS
NHS Trust

Research and Development - Annual Report July 2013

1. Introduction

Research is considered core business in the NHS and the NHS Operating Framework 2012/13 underlines this. Northampton General Hospital (NGH) remains committed to research. The NHS Constitution confirms: "The commitment of the NHS to the promotion and conduct of research". This principle is further underpinned in the constitution that states that "The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them".

The National Picture in relation to research in the NHS is confusing and the whole research landscape is subject to change. This year, 2013/14 is seen as the transition year. This annual report addresses a number of changes that Trusts are required to make as well as providing a brief overview of the performance for 2012/13

2. Achievements this year

a. R&D integrated to the organisational structure

The R&D office and the Clinical Trials Unit have been integrated into the Trust structure and now sit within the Medicine Care group and report in to the Care Group Manager. Within the Care group, R&D will be located within the Support Services Division.

b. Appointment of a Clinical Lead

Dr Farhad Alexander-Sefre has been appointed as the Clinical Lead for R&D. His role is to take the medical leadership of R&D and his ambition is to work with consultant colleagues to increase the scope of research across the Trust. Dr Alexander-Sefre will be the Trust representative on the Comprehensive Research Network Board and will take the lead on Intellectual property for the Trust. Dr Alexander-Sefre reports to the Medical Director

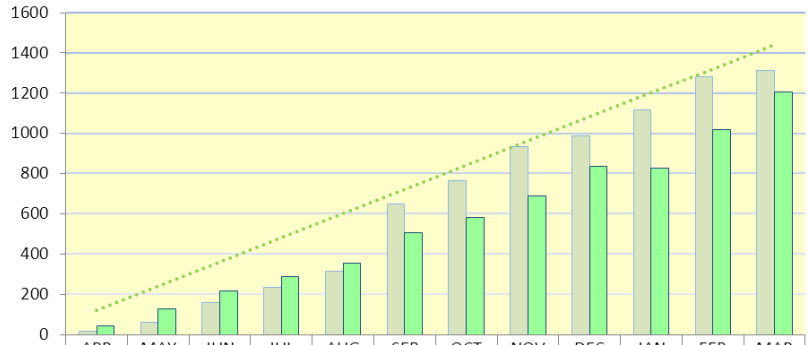
c. Increasing R&D across the Trust

In the last annual report, we reported that the Trust's research profile was developing within A&E and also ITU. We are pleased to report this activity is continuing. In addition, in the last year we have seen studies emerging in Dermatology and Renal. On the Paediatric front, the Trust is nationally the top recruiting hospital for the Addit study, a complicated interventional study for children with diabetes.

3. Recruitment to national portfolio trials

Each year the Trust is set a recruitment target by the Comprehensive Research Network for recruitment of patients into national portfolio trials. These are research studies which have been adopted onto a national portfolio and are regarded as trials of national importance. The recruitment target is incrementally based with a percentage increase which Trusts are required to achieve. Our recruitment target for 2012-2013 was 1442 patients which was a 15% increase on the preceding year with no increase in research infrastructure to deliver this demanding target.

The chart below shows what we achieved.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2011-12	15	62	157	235	316	650	764	934	989	1116	1281	1311
2012-13	44	126	215	286	356	505	584	687	836	827	1018	1208
2012-13 Goal	120	240	361	481	601	721	841	961	1082	1202	1322	1442

Figure 1 – Recruitment for NGH 2012/13

The year end position was a total recruitment of 1208 patients and therefore we were Red rag rated for recruitment.

a) Issue within NGH

The reason we did not hit our recruitment target is that we anticipated 250 patients to be recruited to a cardiovascular study called BRICCS which did not happen. Despite the research team's best endeavours, this study was let down by a failure of cooperation between information technology departments. The study finally began recruitment in May and has remained problematic since.

The positive aspect of recruitment within the Trust has been the broadening portfolio and the contribution of many departments across the Trust shown overleaf. The Cancer team has made a good contribution this year as well as A&E, Paediatrics, Diabetes and Renal.

The development of the research portfolio with NGH is limited by a number of factors. The two most important include time for consultant taking on the role of Principal Investigator., Dr Alexander Sefre is considering how best to mitigate this risk. The second biggest factor to recruitment is lack of radiology time particularly with MRI. Many studies require scans as an integral part of the study. The Trust has such a lack of capacity with the current scanners that we are declining many studies and this reduces both recruitment. Both in terms of number of patient to trials, as well as a reduction type of studies we can take part in and the consequence is the loss of external commercial income to the Trust. The Trust also need to consider the impact of lack of participation in radiology based studies in terms of the requirement of the contribution of research in the peer review of services It is hoped that the plans to incense MRI capacity may help

2.2 2012/13 NGH recruitment by topic network and CCRN specialty group

Figure 2.2 looks at NGH recruitment by topic network and specialty group. For studies that have been formally co-adopted, recruitment has been counted for all relevant topic networks and specialty groups. Therefore, recruitment may have been counted more than once.

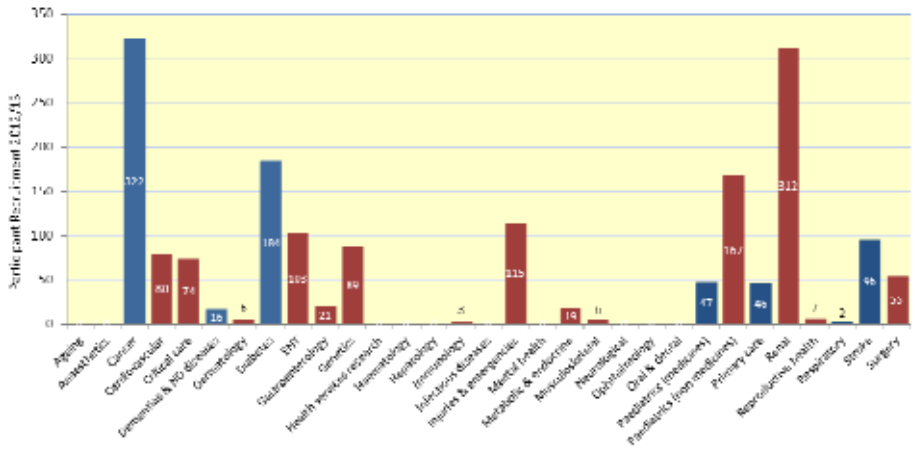


Figure 2.2: NGH recruitment in by Topic Network and CCRN Specialty Group 2012/13

b) Comparative data with other Trusts in the network

Trust	12/13 Year End Target	12/13 Year End data cut	12/13 M12% mid
East Midlands Ambulance Service NHS Trust	14	36	257.14 %
Kettering General Hospital NHS Foundation Trust	1,261	1049	83.19%
Leicester City PCT	997	1940	194.58%
Leicestershire County and Rutland PCT	599	1663	277.63%
Leicestershire Partnership NHS Trust	390	511	131.03%
Northampton General Hospital NHS Trust	1,442	1208	83.77%
Northamptonshire Healthcare NHS Foundation Trust	473	524	110.78%
Northamptonshire Teaching PCT	795	2002	251.82%
University Hospitals of Leicester NHS Trust	9,721	7982	82.11%

Figure 2 – Recruitment data within our Comprehensive Research Network

In summary, NGH had the highest recruitment in terms of percentage of target for acute care. The three acute Trusts had difficulties this year with the national portfolio which favoured studies in primary care. The two mental health Trusts did better than expected as they both incorporated community services within the year which added to their recruitment numbers.

c) **National League table for recruitment**

						Primary Study Design		
Trust Name	Trust Type	2012/13 Baseline Recruitment	Number of Recruiting Studies - 2011/12	Number of Recruiting Studies - 2012/13	Number of Recruiting Studies - Bracket	Number of Recruiting Observational Studies	Number of Recruiting Interventional Studies (this includes studies listed as "both")	Number of Recruiting Studies with primary study design not specified
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	Acute - Medium acute	4238	94	98	51 to 100 stu	34	64	0
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	Acute - Medium acute	4042	94	108	101 to 150 s	52	56	0
GATESHEAD HEALTH NHS FOUNDATION TRUST	Acute - Medium acute	2220	61	75	51 to 100 stu	41	34	0
THE DUDLEY GROUP NHS FOUNDATION TRUST	Acute - Medium acute	2181	56	72	51 to 100 stu	33	39	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Acute - Medium acute	2120	59	61	51 to 100 stu	32	29	0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	Acute - Medium acute	1911	43	49	0 to 50 studi	22	27	0
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	Acute - Medium acute	1666	54	62	51 to 100 stu	28	34	0
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	Acute - Medium acute	1581	83	92	51 to 100 stu	39	53	0
IPSWICH HOSPITAL NHS TRUST	Acute - Medium acute	1430	96	96	51 to 100 stu	45	51	0
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	Acute - Medium acute	1317	94	97	51 to 100 stu	37	60	0
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Acute - Medium acute	1260	46	45	0 to 50 studi	24	21	0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Acute - Medium acute	1208	63	65	51 to 100 stu	32	33	0
POOLE HOSPITAL NHS FOUNDATION TRUST	Acute - Medium acute	1207	82	83	51 to 100 stu	31	52	0
BOLTON NHS FOUNDATION TRUST	Acute - Medium acute	1188	35	35	0 to 50 studi	14	21	0
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Acute - Medium acute	1172	52	50	0 to 50 studi	22	28	0

Figure 3 – National Recruitment Data

Northampton General Hospital is classified as a medium sized acute general hospital and in the comparative data above we came 12th out of 48 in the National leagues table (top 14 only shown).

4. Research Support Services (RSS) Framework - Operational Capability Statement

The National Institute of Health Research (NIHR) has established the NIHR Research Support Services as a national framework for local health research management. The framework aims to standardise good practice within the NHS and this is one of the recent changes within the NHS landscape.

One element of this national framework is that each NHS trust involved in health research must maintain an R&D Operational Capability Statement. This statement provides an overview of the organisation's capabilities and includes such factors as available resources, possible constraints that would make a study difficult to support and key decision-makers in service departments. The framework is a standard approach, which we are asked to complete. The National Institute of Health Research expects that all organisations intending to sponsor or participate in NIHR funded research have a R&D Operational Capability Statement. The capability statement for NGH is attached as appendix 1

The Board is asked to comment and endorse this statement

5. Key performance indicators for Research and Development

Another of the changes seen this year is a requirement to introduce the reporting of research key performance indicators to NHS Trust Boards. In July we were in receipt of a letter from our Comprehensive Network - the essential paragraph is as follows:-

"In 2012/13, the Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network (LNR CLRN) conducted a review on the reporting of research related Key Performance Indicators (KPIs) to NHS Trust Boards locally. This was at the request of the NIHR Comprehensive Clinical Research Network Coordinating Centre who expects all CLRNs to achieve a minimum of 75% of member NHS Trusts reporting KPIs at Board level in 2013. It has therefore been decided that in order to release CLRN funding for the second half of 2013/14, evidence of quarterly KPI Board-level reporting will be required."

In order to fulfil this requirement the R&D office would propose the introduction of an R&D score card, to be presented quarterly - we would propose the following Key Performance Indicators may be useful to the Board via the quarterly report on Patient Safety, quality and governance board. But we would welcome feedback on the proposed template. The style and presentation of the dashboard is attached as appendix 2

The R&D Dashboard would be

- RAG rated performance of recruitment in each division compared to target recruitment.
- The exception reporting would give some more detail and would include a commentary and action plan for time and target and first patient first visits timeframes.
- Figure 1 would graphically illustrate the recruitment of the whole Trust against the target - this relates to portfolio trials only.
- Table 2 would give a quarterly update on R&D related income

6. Finance for April 2012 - 2013

Income £

CLRN	948,786
Other network funding embedded in Directorate - in the region of	100,000
Income	262,000
Direct support income approximately	86,000
Research Capability funding (Awarded from the Department of Health because the Trust achieved the Research Capability Criteria which is a new funding stream)	20,000

Total R&D income:- approx £ 1.4 million

Surplus income to the Trust

Research and Development generate an operating surplus at the year end. The funding comes from efficiencies from the income received and utilising the workforce effectively. Surpluses are shown below and vary year on year.

Surplus income to the Trust £:

2012/13	56 k
2011/12	62.3k
2010/11	391k
2009/10	94k

7. Future plans for R&D

- **The role of NGH in Academic Health Science Networks (AHSN)**

  The relationship between R&D and the AHSN is still developing and this partnership needs to be nurtured.

- **Review the National changes within R&D and the position of NGH**

  Whilst this is a year of transition for the new R&D structures, it remains important that the R&D Office still keep on top of everyday business and business continuity. In addition, we need to play a part in the East Midlands R&D Managers Network, the newly emerging East Midlands Research Network and the East Midlands CLARHC. Finally, the Health Research Authority (A Special Health Authority) is driving changes in the governance and management of research and the R&D Office needs to be in a position to respond.

Recommendations

The Trust Board is asked to consider the content of this report and provide a view on Key performance Indicators for R&D. Also to endorse the Trust Capability Statement such that it can put submitted to the National Institute of Health Research for publication.

NIHR Guideline B01
R&D Operational Capability Statement

Version History

Version number	Valid from	Valid to	Updated by
Statement 001	01/09/2013	#######	Julie Wilson

Contents

Organisation R&D management arrangements

Information on key contacts.

Organisation details	
Name of organisation	Northampton General Hospital NHS Trust
R&D lead / Director (with responsibility for reporting on R&D to the organisation Board)	Dr Sonia Swart - Medical Director
R&D office details:	
Name:	Julie Wilson
Address:	R&D Office, Northampton General Hospital NHS Trust, Cliftonville Northampton NN! 5BD
Contact number:	01604 545941
Contact email:	Julie.Wilson@ngh.nhs.uk
Contact 1:	
Role:	R&D Clinical Lead
Name:	Dr Farhad Alexender Safre
Contact number:	01604 544221
Contact email:	Farhad.Alexander- Safre
Contact 2:	
Role:	Research Governance Manager
Name:	Michelle Spinks
Contact number:	01604 545941
Contact email:	michelle.spinks@ngh.nhs.uk
Contact 3:	
Role:	Lead Research Nurse
Name:	Jenny Spimpolo
Contact number:	01604 545941
Contact email:	jenny.spimpolo@ngh.nhs.uk

Information on reporting structure in organisation (include information on any relevant committees, for example, a clinical research board / research committee / steering committee).

Reporting structures
The R&D office sits within the support services division of the Medicine Care Group. The R&D Office formally report to the Trust Board on a minimum of an annual basis although this is currently being reviewed.. The Research Governance Sub committee provides the robust review of all R&D Projects and the committee is made up of representativesfrom the appropriate support services -i.e medical Physics, Pharmacy finance and information governance as well as the R&D Office team. The committee has represenation from patients and the public . There are clear polices for the escalation of issues and this is highlighted in the Terms of Reference for the committee. In essence issues are supported and investigated by the R&D Office and will escalate to the CEO if necessary

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Information on how the organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research networks	
Research network (name/location)	Role/relationship of the research network e.g. host organisation
Leicestershire, Northamptonshire & Rutland Comprehensive Local Research Network	We have signed a formal partnership agreement with LNR CLRN. We host a number of CLRN funded staff and are in receipt of infrastructure funding which supports many of the support departments. In addition we claim service support costs for portfolio studies
Leicestershire Northamptonshire and Rutland Cancer Research Network	The Cancer networks funds us to host 1.0WTE Research nurse and a little medical time plus 1.0 WTE research admin post to support NCRN adopted portfolio studies
Trent Stroke Research Network	The Stroke network funds 0.8 WTE post to support SRN adopted portfolio studies
Trent Medicines for Children Research network	Coverage from this network across the patch. NGH reports our recruitment to this network
East Midlands and South Yorkshire Primary Care Research network	Coverage from this network across the patch.
Thames Valley Dementia and Neurodegenerative Research network	TV DeNDRON supports 0.5 WTE Research Nurse - it support Dendron
East Midlands and South Yorkshire Primary Care Research network	Coverage from this netwrok across the patch
South East Midland Diabetes Research network	Coverage from this network across the patch
East Midlands Medilink	member
LNR Collaboration for Leadership in Applied Health Research and Care (LNR CLAHRC)	Board Member representation
East Midlands Health Innovation and Education cluster	member
East Midlands Academic Health Sciences Network	Formal Member

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Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, other NHS organisations, higher education institutes, industry).

Current collaborations / partnerships			
Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to	Email address	Contact number
Kettering General Hospital	Shared approach to Research Management and Governance	gwyn.mccreanor@kgh.nhs.uk	01536 492692
Northamptonshire Healthcare NHS Foundation Trust	Shared approach to Research Management and Governance	stephen.Zingwe@nht.northants.nhs.uk	
University Hospital of Leicester NHS Trust	Shared approach to Research Management and Governance	carolyn.maloney@uhl-tr.nhs.uk	0116 2584109
Unversity of Northampton	Commitment to working together when appropriate	carol.phillips@northampton.ac.uk	

East Midlands Research Design Service	Support for protocol development and fundign applications	rdeastmidlands.ac.uk	0116 2523276

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Organisation study capabilities

Information on the types of studies that can be supported by the organisation to the relevant regulatory standards.

Types of studies organisation has capabilities in (please tick applicable)					
	CTIMPs (indicate phases)	Clinical trial of a medical	Study administering questionnaires	Qualitative study	OTHER
As sponsoring organisation	No	no	yes	yes	yes
As participating organisation	yes (2,3,and 4)	yes	yes	yes	yes
As participant identification centre	yes (2,3,and 4)	yes	yes	yes	yes

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Information on any licences held by the organisation which may be relevant to research.

Organisation licences			
Licence name Example: Human Tissue Authority licence	Licence details	Licence start date (if applicable)	Licence end date (if applicable)
Human Tissue Authority Licence	HTA Post mortem Licence number 12254	n/a	n/a
ARSAC	The Trust hold a range of Arsac Licences which relate to a range of commonly used	n/a	n/a
Pharmacy	Manufacturing Licence from the MHRA - MS/13646	n/a	n/a
Pharmacy	Registration number from GpHc 1102806	n/a	n/a

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Organisation services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting R&D governance decisions across the organisation.

Clinical service departments				
Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Head of Service	Contact number	R&D contacts and other comments
Pathology	Full range of laboroatory services	Gus Lusac		Lyne Luxton
Medical Physics	ARSAC, IRMER Radiation Protection advise	Stephen Evans	01604 545765	David Whitwam
Pharmacy	Specialsit dedicated R&D support in both dispensary and Aspetic services	Paul Rowbotham	01604 545695	Via Simon Stapely
Radiology Services	CT MRI X Ray Fluoro	David White	01604 545634	Yasmin Govani
nuclear Medicine	3 Gamma Cameras (including specialsist cardiac camera and SPECT CT)_	Nicky Whilde	01604 543781	
Radiotherapy	3 Linacs and other associated equipment	Nicky Whilde	01604 543781	

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Information on key management contacts for supporting R&D governance decisions across the organisation.

Management Support e.g. Finance, legal services, archiving				
Department	Specialist services that may be provided		Contact number	Details of any internal agreement templates and other comments
Archiving		Julie Wilson	01604 545941	Agreement with TNT offsite archiving provision at a cost
Contracts		Julie Wilson	01604 545941	NIHR agreed model CTA - un modified accepted without
Data management support		Julie Wilson	01604 545941	
Finance		Liz Smilie	01604 544383	national costing template
Legal		Julie Wilson	01604 545941	
HR		Sarah Ash	01604 545171	
Radiation Protection		Stephen Evans	01604 545795	
Research passports		Michelle spinks	01604 545941	

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Organisation R&D interests

Information on the research areas of interest to the organisation (provide detailed or summary information as appropriate).

Organisation R&D areas of interest			
Area of interest	Details	Contact email	Contact number
Abdominal Aortic Aneurysm Screening in Northamptonshire			
Accident and Emergency			
Acute Pain Service			
Acute Stroke Services			
Adult Audiology Service			
Artificial Limb Services / Amputee Rehabilitation			
Breast Screening			
Cardiology			
Child Development Centre			
Child Health			
Children's Audiology Service			
Critical Care Service			
Dermatology			
Diabetes Centre			
Ear, Nose and Throat (ENT)			
Elderly Medicine			
Endoscopy		Please click on the hyperlink for further Information	
Fertility Service			
Finedon ward and Kidney Centre			
Gastroenterology			
Gynae Endoscopy / Colposcopy			
Gynaecological Cancer Services			
Gynaecology and Obstetric Outpatients			
Gynaecology Emergency Admission Clinic (GEAC)			
Head and Neck			
Interventional radiology			
Maternity services			
Maxillofacial Unit and Orthodontics			
Nephrology			
Neurology			
Neurophysiology			
Newborn Hearing Screening Service			
Nuclear Medicine			
Obstetrics and Gynaecology			
Ophthalmology			
Orthopaedics			
Orthoptics			
Radiology			
Radiotherapy			
Respiratory / Chest Clinic			
Rheumatology			
Pain Management Unit			
Radiology			
Radiotherapy			
Respiratory / Chest Clinic			
Rheumatology			
Stroke Services			
Surgery			
Trauma and Orthopaedics			
Vascular Services			

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Information on local / national specialty group membership within the organisation which has been shared with the CLRN.

Specialty group membership (local and national)				
National / local	Specialty group	Contact name	Contact email	Contact number
local - LNR	Age and Ageing	Dr Simon Conroy	simon.conroy@uhl-tr.nhs.uk	
local - LNR	Anaesthetica, Peri operative medicine and Pain	Dr Jonathon Thompson	jt@le.ac.uk	
local - LNR	Cardiovascuar	Prof. Kamlesh Khunti and Prof Nilesh Samani	Kk22@le.ac.uk and njs@le.ac.uk	
local - LNR	Criticial Care	Dr Jonathon Thompson	jt@le.ac.uk	
local - LNR	Dematology	Dr Anton Alexandrov	Anton.alexandrov@uhl-Trust.nhs.uk	
local - LNR	Opthamology	Prof. Irene Gottlob	ig15@le.ac.uk	
local - LNR	hepatology	Dr Toby Delahooke	toby.delahooke@uhl-tr.nhs.uk	
local - LNR	Gastroenterolgy	Dr John DeCaestecker		
local - LNR	infectious Disease and Microbiology	Dr Adrian Palfreeman	Adrian.palfreeman@uhl-tr.nhs.uk	
local - LNR	Injuries and emergencies	Professor Tim Coats	tc61.le.ac.uk	
local - LNR	Musculoskeletal	Dr Waji Hassan	waji.hassan@uhl-tr.nhs.uk	
local - LNR	Paediatrics (non medicines)	Dr Elaine Boyle - Acute Lead Dr Munhib Haroon - Community Lead	munib.haroon@leicspart.nhs.uk wb124@le.ac.uk	
local - LNR	Renal	Dr Jonathan Barratt	jonathona.barratt@uhltr.nsh.uk	
local - LNR	Reproductive Health and Childbirth	Professor Doug Tincello	dgt4@le.ac.uk	
local - LNR	Respiratory	Professor Chris Brightling	ceb17@le.ac.uk	
local - LNR	Surgery	Mr Matt Bown		

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Organisation R&D planning and investments

Planned investment			
Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
None			

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Organisation R&D standard operating procedures register

Standard operating procedures				
SOP ref number	SOP title		Valid from	Valid to
SOP ref number 001	Processing and storage of blood for research purposes		Annual Review	
SOP ref number 002	Handling of Dry Ice		Annual Review	
SOP ref number 003	Cleaning of the centfuges		Annual Review	
SOP ref number 004	Temperature control logs		Annual Review	

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Information on the processes used for managing research passports.

Indicate what processes are used for managing research passports
The Trust R&D Office and HR department work closely together managing Research Passports, A Trust policy has been developed according to NIHR guidelines .The point of contact for Research passport is Michelle Spinks. The HR contact for Research passports is Geraldine Harrison

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Information on the agreed escalation process to be used when R&D governance issues cannot be resolved through normal processes.

Escalation process
The escalation policy is set out in the terms of Reference for the R&d Committee . Issues will be escaclatred form the R&D Office in consultation with the Clinical lead for R&D to the Medical Director and then to the Chief exectuvie Officer for the Trust

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Planned and actual studies register

The organisation should maintain or have access to a current list of planned and actual studies which its staff lead or in which they are involved.

Comments
The Trust maintains a ReDA database of approved studies since 2005. This includes all research within the Trust both Portfolio and non portfolio. All studies are registered on this database with the R&D office coordinating all required regulatory issues.

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APPENDIX 2

Research and Development Dashboard

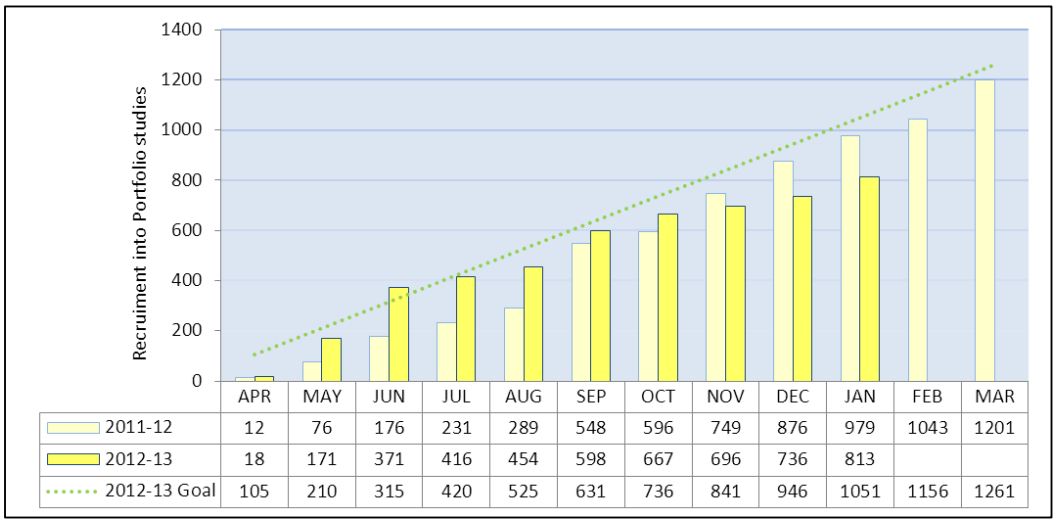
Key Performance Indicators (KPI) Report
Quarter 3
(1 October 2013 to 31 December 2013)

Table 1: Recruiting studies and participant recruitment

	Total Recruiting Studies					Total Participant Recruitment				
Study Type	**2012/13 Total**	**This QTR**	**2012/13 YTD**	**2013/14 Target**	**RAG**	**2012/13 Total**	**This QTR**	**2013/14 YTD**	**2013/13 Target**	**RAG**
Medicine										
Oncology										
Trauma and Orthopaedics										
Surgery										
Critical care and Anaesthesia										
Obstetrics and Gynaecology										
Child Health										
Head and Neck										

Exception Reporting			
RAG	**Comments**	**Actions**	**Date**
	For example - Insufficient Studies recruiting	New Study expected	
	For example - Not recruiting to time and target	Look at the balance of workload versus staffing and adjust	

Figure 1: TRUST Recruitment into Portfolio studies against 2012/13 recruitment target



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2011-12	12	76	176	231	289	548	596	749	876	979	1043	1201
2012-13	18	171	371	416	454	598	667	696	736	813		
2012-13 Goal	105	210	315	420	525	631	736	841	946	1051	1156	1261

Table 2: R&D related income

Funding Source	Amount	Comments
Commercial	£0.00	
Research Networks	£0.00	
Service support costs	£0.00	
Research Capability Funding	£0.00	
Other income	£0.00	
Total Income	£0.00	

Risks to R&D Delivery and Performance

This section could discuss any current and upcoming changes or perceived risks to R&D delivery and performance.

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 31 October 2013
09:30 am. Boardroom
Danetre Hospital, London Road, Daventry

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of the 23 September 2013 meeting of the Board	Decision	Mr P Farenden	**A.**
	4.	Matters arising from the 23 September 2013	Note	Mr P Farenden	**B.**
	5.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.45	**CLINICAL QUALITY AND SAFETY**				
	6.	Patient Story	Note	Dr S Swart	**Verbal**
	7.	Medical Director's Quality Report	Assurance	Dr N Robinson	**D.**
	8.	Patient Experience Report	Assurance	Ms F Barnes	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms F Barnes	**F.**
	10.	Infection Control Annual Report	Assurance	Ms F Barnes	**G.**
	11.	Safeguarding Adults & Children's Annual Reports	Assurance	Ms F Barnes	**H.**
	12.	Annual Clinical Audit Plan	Decision	Dr N Robinson	**I.**
11.00	**OPERATIONAL ASSURANCE**				
	13.	Operational Performance Report	Assurance	Mr C Walsh	**J.**
	14.	Urgent Care Update	Assurance	Mr C Walsh	**K.**
	15.	Finance Report	Assurance	Mr A Foster	**L.**
	16.	Workforce Report	Assurance	Mrs J Brennan	**M.**
	17.	Transformation Report	Assurance	Mrs J Brennan	**N.**
	18.	Self-Certification Report	Decision	Mr C Walsh	**O.**
11.45	**GOVERNANCE**				
	19.	Standards of Business Conduct	Decision	Mr A Foster	**P.**

	20.	Emergency Preparedness, Resilience and Response	Decision	Mrs D Needham	**Q.**
	21.	Research and Development Annual Report	Assurance	Dr S Swart	**R.**
12.00	**ANY ITEMS OF OTHER BUSINESS**				
	22.	**DATE AND TIME OF NEXT MEETING** 28 November 2013 09:30 Boardroom, NGH	Note	Mr P Farenden	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)