Northampton General Hospital NHS
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Monday 23 September 2013, 09.30 am

at

The Boardroom
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

MONDAY 23 SEPTEMBER 2013
09:30 am. Boardroom, Northampton General Hospital

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1	Introduction and Apologies	Note	Chair	**Verbal**
	2	Declarations of Interest in the Proceedings	Note	Chair	**Verbal**
	3	Minutes of the 24 July 2013 meeting of the Board	Decision	Chair	**A**
	4	Matters arising from the 24 July 2013	Receive	Chair	**B**
	5	Chief Executive's Report	Receive	Dr S Swart	**C**
09.45	**CLINICAL QUALITY AND SAFETY**				
	6	Medical Director's Quality Report	Assurance	Dr N Robinson	**D**
	7	Patient Experience Report	Assurance	Ms S Loader	**E**
	8	Infection Prevention Performance Report	Assurance	Ms S Loader	**F**
	9	Duty of Candour – Board Assurance Statement	Assurance	Ms S Loader	**G**
	10	Patient Safety Academy Progress Report	Assurance	Ms J Bradley	**H**
10.45	**OPERATIONAL ASSURANCE**				
	11	Operational Performance Report	Assurance	Mr C Walsh	**I**
	12	Urgent Care Update	Assurance	Mr C Walsh	**J**
	13	Finance Report	Assurance	Mr A Foster	**K**
	14	Workforce Report	Assurance	Ms J Brennan	**L**
	15	Transformation Report	Assurance	Ms J Brennan	**M**
	16	Self-Certification Report	Decision	Mr C Walsh	**N**
11.45	**STRATEGY AND PLANNING**				
	17	Healthier Northamptonshire Programme Update	Assurance	Mr C Pallot	**O**
	18	Equality and Human Rights Strategy	Decision	Ms J Brennan	**P**
12.00	**ANY ITEMS OF OTHER BUSINESS**				
	19	**DATE AND TIME OF NEXT MEETING** 31 October 2013 09:30 Danetre Hospital, London Rd, Daventry, Northamptonshire NN11 4DY	Note	Chair	**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
Wednesday 24 July 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 G Kershaw	Non-Executive Director
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr D Noble	Non-Executive Director
Mrs E Searle	Non-Executive Director
Dr S Swart	Chief Executive Officer – Interim / Medical Director
Mr C Walsh	Interim Chief Operating Officer

In Attendance:

Mr D Bebb	Deputy Director of Finance – Interim
Mrs D Needham	Care Group Director - Medicine
Mr C Sharples	Head of Corporate Affairs

Apologies:

Mr A Foster	Acting Director of Finance
Ms K Spellman	Deputy Director of Strategy and Partnerships
Mr N Robertson	Non-Executive Director
Mr P Zeidler	Non-Executive Director

TB 13/14 056	**Declarations of Interest**
	No further interests or additions to the Register of Interests were declared.
TB 13/14 057	**Minutes of the meeting held on 27 June 2013**
	The minutes of the Board meeting held on the 27 June 2013 were presented to the Board for approval. Ms Loader requested that paragraph three of minute TB 13/14 052 'Nursing and Midwifery Staffing Strategy Implementation' be amended to read "She advised that the Trust had benchmarked each ward against the AUKUH benchmark data to understand the comparative nurse to bed ratio of each ward". **Subject to that amendment, the Board APPROVED the minutes of the 27 June 2013 as a true and accurate record of proceedings.**
TB 13/14 058	**Action Log and matters arising**
	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 13/14 059	**Chief Executive's Report**
	Dr Swart presented her Chief Executive's Report to the Board. Dr Swart advised the Board that on the 16 July, NHS England published the final overview report from Sir Brue Keogh which presented the findings of a review into the quality of care and treatment provided by 14 NHS hospital trusts in England. The report findings presented a number of common themes identified at the trusts which were felt to be barriers to delivering high quality care, which included; listening to patients, ensuring they and staff were

	involved and engaged in improving services, the complexity of using HSMR and SHMI to measure mortality and Board leadership in relation to quality. The report advised that professors Lord Ara Darzi and Nick Black had been requested by Sir Brue Keogh to conduct a study into the relationship between "excess mortality rates" and actual avoidable deaths. This would be used to inform a new measure based on clinical case note reviews. The Board was reminded that this approach was used by the Trust last year and was still used in the analysis of mortality on a regular basis. Dr Swart informed the Board that the Trust was undertaking a detailed review of the recommendations made within the report and an update on progress and an action plan would be presented to the Board in September 2013. **ACTION: Dr Swart** Dr Swart informed that Board that a government led review of the Liverpool Care Pathway in response to concerns raised about poor care had recently concluded. The outcome of the review was that the government had requested that the Liverpool Care Pathway be phased-out of use over the forthcoming 6-12 months and replaced with an individual approach to end of life care for each patient. In response to the report, the Trust was seeking to undertake a clinical review of each patient on the Liverpool Care Pathway or similar to ensure that the care they were receiving was appropriate. The review would also ensure that a senior clinical was assigned as the responsible clinician accountable for the care of every patient in the dying phase of their care. Dr Swart reminded the Board that in April 2013, the Trust Board received significant assurances on the quality of care provided to patients on the Liverpool Care Pathway from a presentation by senior clinicians within the Trust. She further reassured the Board that staff at the Trust had always supported the personalised care planning element of the pathway and trained staff to communicate with patients and relatives when people are nearing the end of their lives and will continue to work on ways of offering personalised care plans in a proactive way which met the needs of patients and carers as patients reach the end of their lives. Ms Searle commented that the Trust must ensure that the shift to the new pathway from the Liverpool Care Pathway did not compromise the high quality of care which the Trust currently provided during end of life care. Dr Swart informed the Board that NHS England had issued a new publication 'The NHS belongs to the people: a call to action' which set out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The publication proposed a programme of engagement to enable all stakeholders to contribute to the debate on the future of healthcare in England and inform future commissioning plans to address the challenges facing the NHS. Locally the programme of work taking place across Northamptonshire following the launch of Healthier Northamptonshire will embrace these fundamental principles with the clear understanding that we must find different ways of delivering healthcare if we are to rise to the challenge of improving quality whilst curtailing cost. Dr Swart informed the Board that the NHS Trust Development Authority had

	visited the Trust to review its infection prevention and control processes. The overall message was that the Trust broadly had good standards of infection prevention in place but there were a number of minor issues identified which required addressing. The Trust had begun the implementation of a Board led inspection regime of the hospital, where members of the Board would review quality issues and speak to patients and staff. A full report and action plan was scheduled to be presented to the Integrated Healthcare Governance Committee. Dr Swart summarised a number of other key internal items of business including the progress of the Listening into Action programme, the forthcoming Trust Festival and recent positive media stories relating to the Trust. **The Board NOTED the Chief Executive's Report.**
TB 13/14 060	**Medical Director's Report**
	Dr Swart presented the Medical Director's Report to the Board. The Board was informed that the Hospital Standardised Mortality Ratio (HSMR) for April 2013 was disappointingly high at 110 but the 12 month rolling HSMR was within the as expected range. This position was a deterioration when benchmarked against the position this time last year. It was felt that the high HSMR was due to a cohort of patients from the community hospitals which were yet to be coded appropriately, and once resolved the HSMR would reduce for April 2012. Work was ongoing to ensure timely and accurate coding of all discharges from the community hospitals to minimise data inaccuracies from those sources. Dr Swart re-emphasised that the community hospitals were not recorded as separate sites following their acquisition and that the community hospitals affected the overall HSMR of the Trust due to the variety of types of care provided, including terminal care, to patients which were predominantly elderly. The Board was informed that there was no update to present on the Standardised Hospital Mortality Indicator (SHMI) as the current data provided by the HSCIC was 6-9 months in arrears as it could not also be analysed in detail and accurately compared with the data provided by Dr Foster at this stage. Dr Swart informed the Board that there continued to be a modest improvement in mortality from fractured neck of femur, and the improvement work was continuing with clinical teams. The mortality review group retained oversight of progress. Mortality from congestive heart failure remained significantly high, but it was noted that the Trust had the lowest admission rate for heart failure in the East Midlands which suggested that the community heart failure team were effective in reducing avoidable admissions. This meant that those patients who were admitted were likely to be those of the highest risk. Focus remained on what could be done better, but it was highlighted that further improvements in the service may well result in an apparent deterioration in performance for the Trust. Dr Swart informed the Board that individual consultant survival outcome data had now been published. There had been a number of data quality issues identified relating to appropriate coding of episodes of care which were being

	addressed but that aside, the Trust lay within the normal range for each of the five specialist areas. Dr Swart presented the lessons learnt from serious incidents and never events. The report outlined the actions and improvements which had been taken as a result of investigations into serious incidents in order to improve the quality of care provided. In relation to mortality from congestive heart failure, Mr Noble requested assurance that the low rates of admission were definitely the cause of the high level mortality figures reported. Dr Swart assured Mr Noble that the issue was constantly being looked at in detail and re-iterated the impact that the complexities of coding diagnosis had on overall mortality data. Dr Swart presented the Trust Monthly Quality Scorecard. She advised that work was continuing to align internal dashboards throughout the Trust to inform the Board report and ensure that the dashboard presented maps performance from ward to Board on all local and national indicators. Dr Swart summarised the exceptions within the report, reporting variance from targets and outlining the actions which were being implemented to address performance. Mr Farenden commented that he found the detailed level of knowledge of Dr Swart for all areas reassuring as it provided him with confidence that all the challenges faced by the Trust were known and that actions were being taken. The Board **NOTED** the Medical Director's Report.
TB 13/14 061	**Patient Experience Report**
	Ms Loader presented the Patient Experience Report to the Board. She advised that the purpose of the report was to update the Board on the implementation of the Patient Experience Strategy. Ms Loader informed the Board that four patient experience champions had been identified within clinical areas which provided the opportunity for a co-ordinated approach to developing and implementing patient experience initiatives. Work was also underway to align the dignity forum agenda with that of the patient experience agenda to ensure cohesion of the two work streams. The Board was informed that the Trust had piloted the 15 step challenge in four areas. The 15 step challenge is a national audit framework used to identify how patients may perceive a clinical area. The pilot had not identified any immediate concerns but had flagged the need to enhance the information which was provided to patients and carers. Ms Loader introduced the concept of goldfish bowl events to the Board. The events were meetings where a patients or carers presented their thoughts and experiences on their care received to the team of clinicians involved in their care, and the clinicians then reflected on what they had heard, identifying lessons which could be learnt. The first event had been held with surgeons and on reflection it was identified that the methodology would be reviewed to enhance the learning. Mr Kershaw asked what feedback had been received from the surgeons on the goldfish bowl events. Ms Loader advised that they felt hearing feedback directly from patients was more meaningful.

	Ms Loader reported that volunteer audits were being reviewed to support PPI volunteers in undertaking observational studies and patient interviews specifically in relation to noise at night audits and protected mealtime audits with renewed focus on the salient points as identified from previous audits. With regard to the Friends and Family Test, Ms Loader advised that following targeted pieces of work A&E had improved their response rate significantly, and as such, the Trust had surpassed its 15% response rate target. Further targeted work was planned with Paediatrics and Eye Casualty to improve performance. Ms Searle asked if all patient experience data was collected and presented in a single format as she felt that the current reports presented different elements in isolation. Ms Loader advised that a working group had been established to triangulate all patient experience data with the intent of developing a comprehensive dashboard to inform future patient experience reports to the Board. Dr Swart commented that the Patient Experience Report presented was in fact an attempt to bring together a number of different types of patient experience work together and that this would evolve in the forthcoming months. Mr Farenden asked what the timescale completion of the dashboard was. Ms Loader advised that it was very much still working progress and a definitive timescale and progress update would be presented to the next meeting of the Board. **ACTION: Ms Loader** The Board **NOTED** the Patient Experience Report.
TB 13/14 062	**Monthly Infection Prevention Performance Report**
	Ms Loader presented the Monthly Infection Prevention Performance Report to the Board. Ms Loader reported that there had been no incidences of MRSA bacteraemia during the reporting period. MRSA screening was also positive with elective screening performance of 99.71% and emergency screening performance of 98%. Ms Loader stated that she was pleased to report that there had not been any cases of C.Diff since the last Board meeting in June 2013. Whilst the overall number of C.Diff cases was exceeding the Trust target, Ms Loader assured Board members that there was not a clinical risk posed to patients in respect of an outbreak, and the performance was attributed to sampling issues. The Board was informed that hand hygiene audit compliance for the reporting period was 82.2% due to 14 areas failing to submit completed audits. Ms Loader advised that due to the poor response rate she was writing to matrons to understand reasons for not completing audits and requesting improvement plans. Mr Farenden requested Ms Loader feedback the responses received to the next Board meeting as he wished to Board to remain sighted on the matter. **ACTION: Ms Loader** The Board **NOTED** the Monthly Infection Prevention Performance Report.

TB 13/14 063	**Francis Report Action Plan Update**
	The Francis Report Action Plan Update was presented to the Board by Ms Loader. She advised that the action plan tracked the Trust's progress in implementing all actions within the Francis Report. The Board was informed that the implementation of al actions was progressing and it was expected that the plan would deliver to timescale. Dr Swart added that a formal report on the Trust's requirements and compliance under the contractual Duty of Candour would be presented to the September Board meeting. Mr Noble asked what mechanisms were in place to ensure that the actions would be effective once implemented. Ms Loader advised that outcomes were associated with the actions, a good example of which was the development of the Nursing and Midwifery Staffing Strategy and associated dashboards. Dr Swart further added that a number of actions were broad organisational actions which would improve overall patient experience which could be measured through existing metrics such as a reduction in Serious Incidents, complaints and an increase in staff and patient surveys. The Board **NOTED** the Francis Report Action Plan Update.
TB 13/14 064	**CQC Report**
	Ms Loader presented the Trust's annual self-assessment of compliance against the CQC essential standards of quality and safety to the Board. She advised that the intention of the report was to provide an update on the current self-assessed position and provide an overview of the sources of evidence and assurance which underpinned the self-assessment. In summary, the Trust was declaring overall compliance with the CQC Essential Standards. The compliance assessment was determined through a number of mechanisms including internal confirm and challenge meetings with care groups, quarterly compliance reports to the Clinical Quality and Effectiveness Group and detailed review of the Quality Risk Profile on a quarterly basis with improvements identified and addressed. Ms Loader advised the Board that Internal audit had provided 'good assurance' on the evidence, systems and processes which underpinned CQC compliance self-assessment following their review. The Board was informed that the CQC conducted an inspection in July 2012, the outcomes of which had been generally positive. Two outcomes were identified by the CQC which required remedial action – the management of medicines and staffing. All concerns raised by the CQC had been addressed and progress reported to the CQC. Ms Loader concluded that overall compliance was good but that there was always room for improvement. Mr Farenden asked how the Trust could ensure that staff were prepared for the new inspection regime suggested in the Keogh Report. Dr Swart advised that a working group was being established to ensure the Trust is prepared for the introduction of a new inspection regime. Staff engagement and ownership were key work streams which were to be considered by the working group as it was acknowledged that they would be key to ensuring organisational readiness and success. Mr Walsh drew the Board's attention to the one red rated outcome, outcome

	12 relating to criminal records checks (CRB) for contractors and asked what actions were being taken to address compliance. Mr Abolins advised that a policy was under development to ensure compliance which would be ready by the end of September 2013. Until the policy was in place and effective, CRB checks were undertaken on a risk assessed basis. Mr Kershaw asked if in light of the learning points presented by the Keogh Report and the proposed changes to the CQC inspection process, if it was prudent to reflect on the current compliance and assurance systems and processes within the Trust to ensure that it was doing the right thing for the patient. Dr Swart advised that the Trust was undertaking a review of the current mechanisms in place and consulting on what the Trust should be doing with the intention of developing a comprehensive and cohesive plan to ensure that the Trust fully understood what was expected by the CQC and the Keogh Report, which would be presented to the Board in September or October 2013. The Board **NOTED** the CQC Report.
TB 13/14 065	**Quality Account Update**
	Ms Loader presented an update on the 2012/13 Quality Account. Ms Loader reminded Board members that the 2012/13 Quality Account was presented and approved by the Board in May 2013, subject to the outstanding comments to be received from commissioners, the Health Overview and Scrutiny Committee and Healthwatch. The feedback received was included in the quality account. The May Board had delegated authority to Ms Loader to make minor editorial changes to the report following Board approval. Ms Loader brought to the board's attention the fact that one material change had needed to be made following the May board as a result of changes to the Healthier Northamptonshire programme following advice received from the TDA – this had been discussed at the board development day and was subsequently approved.. The final 2012/13 Quality Account was submitted for approval to the Trust's external auditors, and once approved, was uploaded to the Trust website and a copy sent to the Secretary of State for Health. The Board **NOTED** the update on the Quality Account.
TB 13/14 066	**Operational Performance Report**
	Mr Walsh presented the Operational Performance Report to the Board. He advised that the Trust had not achieved the four hour transit time for patients referred to A&E during June; the Trust achieved 93.42% against the standard of 95%. Year to date performance was 92.62% as at 13th June against a recovery trajectory of 93%. The Board was informed that there was an improvement programme for urgent care in place to address the performance which had been scrutinised in detail by the Integrated Healthcare Governance Committee. In addition to the plan it had been agreed that more medical and nursing resource would go into A&E, consideration was being given to the addition of external expertise, such as a GP, to support initial assessments of patients, and placing senior clinicians at the front desk in A&E to signpost and re-direct patients who they felt would be more appropriately cared for in a primary or community care setting. Despite the work being done internally to address the performance issues in

	A&E, the volumes of patients attending are on the increase, and attendances in July to date were 18% higher than July 2012. Mr Kershaw asked if there was any underlying reason for the increase in attendance. Mr Walsh advised that had spoken local GPs who were also busy, ambulance traffic had not increased and admissions from A&E were not increasing, although there were more patients attending with major injuries. He added that patients were having difficulty accessing out of hours care which was in turn affecting attendance at A&E. Another factor driving performance was the flow of admitted patients to the assessment units and other inpatient beds. With regard to increases in staffing, Mr Kershaw commented that he was under the impression that staffing levels in A&E had been addressed. Mr Walsh advised due to the current volume of attendance, staffing cover needed to be strengthened. Three consultant posts had been recruited to, with the incumbents taking up post between October and January. A further consultant post was to be recruited to. Mr Farenden commented that the national message from NHS England was that increasing volumes were not a problem. He informed members that at a recent local Chief Executives and Chairs meeting, there was a wide variation in the expectation of volumes of attendees at A&E departments, with CCGs forecasting reductions in attendance from 2012/13 performance, which was at odds with what was happening in reality. He added that he did not feel there was a sense of urgency from CCG colleagues and allied with the message from NHS England, he was concerned that CCGs were not appropriately escalating the urgency of the matter. Mr Walsh added that he had recently attended the local Urgent Care Board with CCGs, at which he had not received a satisfactory response from CCG colleagues regarding the urgency of actions and plans required to address short term or long term urgent care pressures. It was his view that there was not a concerted plan in place to address urgent care pressures, a concern that had been shared with the Local Area Team representatives at the meeting and also escalated to the NHS Trust Development Authority. Mr Farenden stated that the Trust should begin focussing on the measures required to ensure it is prepared for winter, but was concerned that there appeared to be little action to address this from elsewhere within the health economy. Dr Swart stated that the Local Area Team should be further engaged so they could make every effort to accelerate progress with CCGs. Mr Walsh informed the Board that the CCG QIPP plan showed an expected reduction in A&E attendances, which presented a reduction in income of £600k, through the introduction of initiatives and projects which he found difficult to understand. As such, he had requested transparency from the Local Area Team as to how the CCGs would be reinvesting MRET and 2% transformation funding to enable the Trust to deal with the increasing numbers of attendances and plan effectively for winter. Meetings with the CCG and Local Area Team were ongoing to further understand how the money would be used. Mr Bebb informed the Board that the increase in attendees was presenting a cost pressure to the Trust due to the CCG QIPP plans. Mr Farenden stated that must be progressed at a Chief Executive and Chair level. Mr Kershaw stated that the continued efforts of staff in A&E should be recognised, a sentiment which all Board members shared.

	In presenting the remainder of the report, Mr Walsh reported that the Trust had achieved all Referral to Treatment, diagnostic, stroke and cancelled operations standards during June 2013, with the exception of one patient that waited over 52 weeks to start their treatment. The Board was informed that the Trust has not achieved the cancer standard; 62 days from GP referral to start of treatment, the performance for June 2013 was 82.9% against a standard of 85%. A comprehensive action plan to address performance was scheduled to be presented to the August 2013 Integrated Healthcare Governance Committee. The Board **NOTED** the Operational Performance Report.
TB 13/14 067	**Urgent Care Update**
	Ms Needham presented the Urgent Care Programme Update Report to the Board. Ms Needham reported that the Urgent Care Programme continued to be led by the Chief Executive and met monthly in response to the continued inconsistent performance against A&E targets. There had been increases in attendances at A&E by between 30 – 50 people per day. The majority of those attending had not been in contact with primary care or the NHS 111 service and were attending from between 4pm and midnight. The Trust's benchmarked performance compared to other east midlands trusts was average. Ms Needham presented an overview of the work stream priorities of the Urgent Care Programme to the Board, and updated members on their progress. With regards to ambulatory care, eight pathways were now in place, with five pathways demonstrating a significant reduction in the length of stay. An interim ambulatory care centre was expected to be in place within 4-6 weeks. The recruitment of additional medical staff was underway to assist in improving flow and nurse facilitated discharge was in place on every large medical ward, with plans in place to roll out on all wards by the end of July 2013. Contracts had been signed and the electronic Visual Hospital was due to be rolled out imminently. Mr Farenden asked for more clarity on the establishment of an ambulatory care centre. Ms Needham advised that an interim centre was currently being established through the utilisation of existing space within the Trust, and that a substantial capital proposal was under development. Mr Abolins added that the plans were currently under development with a view to completion in 2014/15. Mr Noble asked if patients who were on an ambulatory care pathway were also considered as A&E attendees. Ms Needham stated that would be dependent on the intervention, but if working effectively, ambulatory care pathways would reduce the number of people attending A&E. Ms Searle asked if progress in establishing the interim ambulatory care centre was satisfactory or if more could be done to expedite the process. Ms Needham advised that the biggest risk and only potential hold up was the availability of medical staff. Dr Swart added that staffing was essential in ensuring the pathway worked.

	The Board **NOTED** the Urgent Care Report.
TB 13/14 068	**Finance Report**
	Mr Bebb presented the Finance Report to the Board. He reported to the Board that the financial position at month three had improved. The Trust had delivered £1.2m deficit, a favourable variance of £200k against plan. The most significant component of the favourable position was income from over performance. Mr Bebb also noted that pay costs had continue to rise, but were within plan. With regard to over performance, the Trust was over performing to the extent of £3.3m against the Nene CCG contract for the year to date. The Trust had written to the CCG to formally record the over performance. Mr Bebb added the level of over performance may not be financially sustainable for CCGs and was driven by a range of unsupported QIPP initiatives which were agreed as negative or zero entries within the main contract. The matter was now being discussed with the CCG and a letter highlighting the resulting over performance had been sent to the host CCGs for comment. The matter had also been reported to the TDA. Mr Bebb informed the Board that provisions were continuing to be made within the financial plans to reflect financial fines and penalties likely to be levied by the CCG in relation to the delivery of operational performance and CQUIN delivery. The extent of the provisions totalling £2.2m. Due to this, the Trust was seeking active cooperation with regard to the reinvestment of MRET. The Board was advised that the Transformation Programme was not delivering to plan, which was adding further pressure to the delivery of financial targets. Further details on mitigations would be presented by Ms Brennan in the Transformation Report. Mr Bebb reported that the Capital Programme had been amended to reflect the Ambulatory Care centre, which would now commence on a phased basis as previously reported. The full cost for the scheme was expected to be in the order of £1.6m with major expenditure phased toward the end of the current financial year and into 2014/2015. The financial forecast indicated that liquidity would be of concern moving forward. As the Board was aware, access to liquidity had been sought though an application for a temporary borrowing loan. The application was now being considered by the NHS Trust Development Authority and the Finance Committee and Board would be informed of the outcome. The Board was informed that the financial recovery plan had been shared with the NHS Trust Development Authority and was well received. It was acknowledged that more work needed to happen with the CCGs to further enhance the robustness of the plan. The Board **NOTED** the Finance Report.
TB 13/14 069	**Workforce Report**
	Ms Brennan presented the Workforce Report to the Board. In presenting the key points from the report, Mrs Brennan reported that there had been an increase in the substantive workforce employed by the Trust to 3999.64 FTE, 89.64% of contracted against establishment.

	Mrs Brennan reported that there had been a slight increase in staff turnover. There were no trends or patterns for turnover apparent on review. The Board was informed that overall sickness absence had decreased to 3.9%. With regard to appraisals, Mrs Brennan advised that there appeared to be significant disparity between the appraisal rates reported in the annual staff survey and those which were reported centrally, an issue which would be addressed going forward. Ms Brennan advised the future reports would be presented in the same format as the report presented to the Integrated Healthcare Governance Committee which she felt would be more informative. Mr Kershaw agreed that the report presented to the committee was good in presenting the key issues to the reader. The Board **NOTED** the Workforce Report.
TB 13/14 070	**Transformation Programme Update**
	Ms Brennan presented the Transformation Programme Update to the Board. Ms Brennan reported that the target plan for 2013/14 was £13m. The latest thinking forecast based on current scheme delivery stood at £11.3m. She informed the Board that a mitigation pipeline of schemes to potential value of £1.2m had been developed, which if delivered in full would reduce the shortfall to £0.5m. In presenting performance against plan, Ms Brennan advised that the actual delivery for the first three months of 2013/14 was £2.12m, a negative variance of £157k against the plan of £2.28m. Ms Brennan advised that unlike previous years, the QIPP plan had not been included within the Transformation Programme due to the concerns of its ability to deliver. The Finance Committee reviewed the Transformation Programme in detail at its last meeting. It concluded that the Trust could not continue to pick small elements for efficiencies without eventually compromising quality. As such, Ms Brennan had proposed a new approach to transformation which focused on enhancing quality, safety and effectives, which in turn would delivery cost improvements, the detail of which was presented in the Board report. The approach was reliant on engagement with staff to drive workforce and service re-design, their involvement would drive the changes and effect a wider cultural change as would be articulated within the Organisational Development Strategy. Dr Swart informed the Board she and those who attended the Finance Committee were supportive of the new approach. Mr Noble observed that the Board should not underestimate the size of the challenge the approach would present due to the cultural change required. With regard to the Quality Impact Assessment Scorecard, Ms Loader noted that there were a number of red rated schemes and asked what had happened with them. Dr Swart advised that they were to be presented in detail to the Integrated Healthcare Governance Committee for consideration and scrutiny.

	Mr Bebb asked if the CCGs should be engaged in the development of the new transformation programme. Mr Farenden agreed that would be a good idea in principle and should be driven through the local Chief Executives and Chairs forum. The Board **NOTED** the Transformation Programme Update and APPROVED the new approach to transformation presented by Ms Brennan.
TB 13/14 071	**Self-Certification Return**
	Mr Walsh presented the Self-Certification Return and informed the Board of changes to the monitoring and self-certification framework, which had been driven by the NHS Trust Development Authority Accountability Framework. The self-certification process was now based on demonstrating compliance with a number of conditions within Monitor's Provide Licence and a set of Board Statements which the Board should consider and formally sign off. For a short period of time, the Board were also requested to sign off elements of the superseded Single Operating Model, namely the governance, quality, financial and contractual elements. Mr Walsh advised that once the Board was content with the compliance assessment, the self-certifications would be submitted to the NHS Trust Development Authority then used to inform the agenda at the regular oversight meetings. The Board was informed that there were three areas of non-compliance identified within the Board statements relating to financial risk ratings and operational performance targets, specifically A&E, Cancer and C.Diff. Action plans and timescales for each area of non-compliance were presented in the report. Ms Loader identified that the compliance ratings relating to C.Diff required amending. **Action: Mr Walsh** Mr Noble stated that he did not have confidence that the timescale presented for delivering compliance with A&E targets due to the reliance of the Trust on the wider health economy approach to urgent care. Dr Swart advised that the timescale was related to the delivery of internal actions, and that Mr Noble should be confident that those would deliver following the presentation of the Urgent Care Programme Updates. Mr Walsh agreed to amend the wording in the compliance statement to reflect the levels of risk prior to submission. **ACTION: Mr Walsh** 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 13/14 072	**Risk Management Strategy**
	Ms Loader presented the Risk Management Strategy to the Board for approval. She advised that the strategy reflected all risk related activities within the Trust and had been updated to reflect changes to the organisational structure and improved systems and processes, and explicit links had been made between the strategy and the revised NHS Constitution and the contractual Duty of Candour.

	The strategy outlined the organisational risk management structure, the role of the Board, its committees and management in reviewing and challenging risk, organisational roles and responsibilities for the management of risk, how the strategy would be implemented and how its effectiveness would be measured. Ms Loader stressed that it was vitally important that the strategy was implemented correctly and a training plan had been developed to underpin its delivery, particularly within the care group structure. Mr Kershaw informed the Board that the strategy had been the subject of discussion at the previous Integrated Healthcare Governance Committee, at which a comprehensive implementation plan had been requested to assure the delivery of the strategy. It was also acknowledged by the Board that there were areas of the strategy which would continue to develop as the care group governance structure embedded and the strategy should remain aligned with that. As such, the Board requested that the Risk Management Strategy be updated to reflect those changes and presented to the November 2013 Board meeting. **ACTION: Ms Loader** The Board **APPROVED** the Risk Management Strategy.
TB 13/14 073	**Complaints Annual Report 2012/13**
	Ms Loader presented the Complaints Annual Report for 2012/13 to the Board to provide assurance regarding the standard of complaints handling arrangements within the Trust, and provide an overview of activity for 2012/13. Ms Loader reported that the Trust received 538 complaints in 2012/13, compared with 517 the previous year. Of the complaints received, 84% were responded to within the accepted timeframe compared to 1005 the previous year. Of the 538 complaints received in 2012/13, Patient care' and 'Communication' provoked the highest number of complaints. However, there was a significant improvement in the number of complaints that relate to communication, with a significant reduction from 226 last year, to 103 this year. Complaints relating to staff attitude and behaviour also improved this year: 45 when compared to last year's 61. Head & Neck, Facilities and Radiology saw the biggest improvement in terms of a reduction in the number of complaints received. However, Accident & Emergency, Anaesthetics and Oncology saw the most significant rise in the number of complaints received about their services. Ms Loader informed the Board that there had been 16 new Ombudsmen cases received, one of which was upheld from a previous year. She added that it was anticipated there would be dramatic increase in complaints reported to the Ombudsman, the risk of which will need to be managed. Further changes to the complaints management process were likely following the publication of the Francis Report, which would be kept under careful review. Ms Loader concluded by saying that the Complaints and PALS teams would continue to work very closely in order to fully support the 4 C's within the Trust. It was recognised that ongoing improvements must be considered at all times, in order to continually review the process with the aim to providing an

	improved service to visitors to the site, and those who use either the Complaints or PALS services. In view of this the leaflets and posters have been rebranded to ensure that they are easily identifiable to those who access our services. Mr Farenden stressed that it was important that the Trust could evidence that lessons were learnt following complaints, and welcomed the report which he felt demonstrated this. With Regards to the complaint upheld by the ombudsmen, Mr Walsh asked what the Trust failed to do to resolve the complaint. Ms Loader advised that the concerns raised by the complainant were not addressed adequately; adding that the complaint was raised two years ago and systems had since improved. Ms Searle asked if the number of complaints received by the Trust was benchmarked to understand if the Trust was receiving significantly more or less that other similar Trusts. Ms Loader advised that she did not have the data to hand, but would obtain annual benchmarking data and share with Board members. **ACTION: Ms Loader** The Board **RECEIVED** the Complaints Annual Report 2012/13.
TB 13/14 074	**Health and Safety Annual Report 2012/13**
	Mr Abolins presented the Health and Safety Annual Report for 2012/13 to the Board. He advised that the report provided an analysis of the Trust's health and safety performance for 2012/13 and presented the priorities for the forthcoming year. The Trust had appointed a new Health and Safety Manager in April 2013 following a period of five months without a Health and Safety Manger in post. Upon taking up post, the incumbent undertook a retrospective analysis gap analysis of health and safety within the Trust. Mr Abolins reported that a total of 500 health and safety related incidents were recorded on the DATIX system for 2012/13 which is a reduction on the previous two years. With regard to staff incidents, the main themes were relating to 'Violence and Aggression', 'Sharps', and 'Manual Handling'. The Board was informed that a total number of 16 employer liability claims were received in 2012/13, resulting in total damages of £135k. The main themes of the claims were 'slips, trips and falls', 'physical strain/lifting' and 'Sharps Injuries'. These themes correlated with the three themes of incident reporting. Mr Abolins summarised the remainder of the report highlighting progress in areas including the completion of risk assessments, the completion of health and safety inspections, changes to RIDDOR regulations and the HSE 'inspection fee' to be levied on Trust's which the HSE inspect following an incident. Ms Searle asked what plans were in place to address the number of sharps incidents reported. Mr Abolins advised that the Health and Safety Committee oversaw the process for addressing the issue and had developed a plan to mitigate the risks, which was being refined by the care groups. The Integrated

	Healthcare Governance Committee and the Clinical Quality and Effectiveness Group would receive updates on progress. The Board **RECEIVED** the Health and Safety Annual Report 2012/13.
TB 13/14 075	**Fire Safety Annual Report 2012/13**
	Mr Abolins presented the Fire Safety Annual Report for 2012/13 which had been produced to provide the Board with an overview of the Trust's position on fire safety and to provide assurance that the Trust was meeting its statutory responsibilities. Mr Abolins informed the Board that the fire safety arrangements within the Trust were modelled on the recommendations made by the Department of Health's Firecode fire safety guidance. During 2012 - 13 new fire risk assessments continued to be completed for all areas owned or occupied by the Trust, in addition to reviewing the existing assessments. Findings from the assessments are used to prioritise fire safety works within the rolling annual capital programme. The Trust's fire alarm had also been extended and modified to ensure that it covered the whole site in accordance with relevant codes of practice and guidance. With regard to statutory fire training, records of attendance for 2012/13 demonstrated that 3694 members of staff received training which equated to 77%, an increase of 150 (3%) over the previous year's attendance. This remains a high risk to the Trust and Directorate managers are being tasked with ensuring that staff that out of date attend fire refresher training as soon as possible. Mr Abolins advised that there were a total of 134 fire alarm activations during 2012/13, of which only three related to actual fires. Fifteen activations were 'good intents' where members of staff operated the alarm suspecting a fire after smelling burning, and 79 activations were pre-warnings. The remainder of activations were due to sensor errors. Two external audits of the Trust's fire safety compliance arrangements were undertaken during 2012/13. Action plans were developed in response to the audits, performance against which was reported through the Fire Safety Committee. Mr Walsh observed that there was a specific action identified in the Northamptonshire Fire and Rescue Service audit which was rated red relating to compartmentation and asked what plans were in place to resolve the issue. Mr Abolins advised that the method of construction of the specific areas the action related to did not support fire compartmentation. To retrospectively fit fire compartmentation in those areas would require the closure of theatres and HDU for a number of months which was not feasible. Due to this, the risk was being mitigated by the installation of an automatic fire suppression system throughout the basement and other high-risk areas such as kitchens, stores and medical records, automatic fire detection system, staff training, emergency plans and an on-site Fire Response Team. The Board **RECEIVED** the Fire Safety Annual Report 2012/13.
TB 13/14 076	**Equality and Human Rights Annual Report 2012/13**
	Ms Brennan presented the Equality and Human Rights Annual Report for 2012/13 to outline the progress the Trust has made in promoting equality and

	celebrating diversity during 2012/13. Ms Brennan introduced the report and outlined that the Trust aimed to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of the different groups and individuals we serve and the staff we employ. To achieve that aim, we want to ensure that service users and employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances. The Trust had in 2011/12 agreed a four year plan with reference to public sector and other duties and to equality target groups. The objectives set in the plan encouraged an outcome focussed approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff. Each of the four objectives and the progress made against achievement were outlined for the Board by Ms Brennan. Ms Brennan further added that the report demonstrated that the Trust had an understanding of the service needs of the Northamptonshire population and that services were being developed in response to those needs. Areas of good practice included providing reasonable adjustments for individuals with learning disabilities and those patients with dementia. The Trust had also demonstrated the language support provided for patients and alternative methods of communication through the continued use of pictorial folders in ward areas. The Board **RECEIVED** the Equality and Human Rights Annual Report 2012/13.
TB 13/14 077	**Any Other Business**
	Mr Farenden took the opportunity to reminded Board members and the Shadow Governors and members of the public in attendance of the Trust Annual General Meeting which was taking place on the 14 September and would be following by the NGH festival.
TB 13/14 078	Mr Farenden called the meeting to a close at 12.35. Date of next meeting: 23 September 2013, 9.30 Boardroom NGH
TB 13/14 079	**The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted**

Actions from Trust Board

Last update 18/09/2013

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
27/06/2013	TB 13/14 052	Nursing & Midwifery Staffing Implementation Strategy	Post Implementation review of the e-rostering system to be considered at the Audit Committee.	Ms S Loader Mrs J Brennan	18/09/2013	On Track	
27/06/2013	TB 13/14 052	Nursing Staffing Implementation Strategy	Complete the diagnostic review of the eRostering system and bring back the outcome of that review, together with actions required to enhance the efficiency and effectiveness of the system. Bring this back to the IHCGC.	Ms S Loader Mrs J Brennan	18/09/2013	On Track	
24/07/2013	TB 13/14 059	Chief Executive's Report	Present NGH response and action plan in response to the Sir Bruce Keough Report	Dr Swart	23/09/2013	Completed or on Agenda	On Agenda
24/07/2013	TB 13/14 061	Patient Experience Report	Inform the Board of the Timescales involved in developing the comprehensive patient experience dashboard	Ms S Loader	23/09/2013	On Track	
24/07/2013	TB 13/14 062	Monthly Infection Prevention Performance Report	Feedback to the Board on the outcome of the review into poor complaince with the Hand Hygiene Audits.	Ms S Loader	23/09/2013	On Track	
24/07/2013	TB 13/14 071	Self-Certification Return	Amend the submission to ensure that it reflected correct complaince ratings for C.Diff	Mr C Walsh	31/04/2013	Completed or on Agenda	Self-Certification updated prior to submission to the NHS TDA.
24/07/2013	TB 13/14 071	Self-Certification Return	Amend the wording wihtin the complaince statement to reflect the relevant levels of risk prior to submission to the NHS TDA, particulalry in relation to the urgent care situation.	Mr C Walsh	31/04/2013	Completed or on Agenda	Self-Certification updated prior to submission to the NHS TDA.
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	On Track	

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Chief Executive's Report
Agenda item	5
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Author(s)	Dr Sonia Swart, Chief Executive Officer (Interim) and Medical Director
Purpose	Information and Assurance

Executive summary

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

Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N)
Legal implications / regulatory requirements	No

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
23 September 2013
Chief Executives Report

1. AGM and Festival

The NGH AGM and Festival took place on the 14 September. The AGM was very well attended by over 80 members of the public who were informed about the Trust's performance during 2012-13 as well as receiving an insightful presentation from Professor Hany Eldeeb, Professor and Consultant Clinical Oncologist on advances in radiotherapy and a video featuring members of the Trust Patient Safety Academy and a patient from this hospital outlining what quality meant to them.

The AGM ended with a rousing inaugural performance of the NGH Choir which marked the opening of the festival, with various stalls and exhibits across the hospital grounds. All the staff involved deserve a huge thank you for their efforts, with special thanks to Nell Morton Membership Manager and Sally-Ann Watts Head of Communications for organisation the event.

2. CQC Concerns

During August, members of Trust staff contacted the CQC to raise serious concerns about some of the care provided at the Trust. The concerns related to the lack of basic, safe and dignified nursing care, especially for vulnerable adults.

As a result we took a number of immediate actions to ensure patients were cared for safely with compassion and dignity, and that our staff were supported during what was a difficult time for all concerned. A thorough investigation was undertaken to examine all the issues raised, the outcomes of which will be shared with the Board upon completion of the investigation.

The Trust is assured that the remedial work undertaken following the notification continues to make the environment safe for patients. Staff have reported that they are much happier and the organisation of the wards concerned had much improved. We anticipate that the external multi-agency investigation will be completed by the end of September and then further actions will be taken by the Trust to prevent this kind of issue occurring again in any clinical area of the organisation.

There is also ongoing work to ensure that the planned investment in nursing continues and that there is support for monitoring basic standards of nursing care across the organisation in a way that is meaningful to clinical staff.

3. Allocation of Winter Pressure Funding

On 5 September the Trust received notification that it would receive £4m in additional funding in 13/14 on behalf of the whole health economy. This followed a bidding process and assessment of bids by regional teams (NHS England / Monitor / TDA) and the EC IST.

The additional funding represents an opportunity for targeted investment to improve pathways of care and the experience and safety for patients. This funding will need to be used wisely to ensure that the Trust will be able to make suitable investments to improve our current performance against

the A and E 4 hour target and other key standards of care. There will be 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 will now take place in September and October, culminating in the submission of a feasible and affordable seasonal plan to the Trust Board.

4. NGH consultant to attend the Women of the Year Lunch

NGH consultant anaesthetist and associate medical director Dr Natasha Robinson has been invited in recognition of her personal contribution to society to join 400 women from all walks of life at the Women of the Year Lunch. Dr Robinson is attending in recognition of her work on patient safety at the Royal Society of Medicine.

Dr Robinson is the first elected president of the section, which provides a forum for discussion and debate concerning all aspects of the delivery of safe care. It also aims to increase understanding of risk management, why adverse events occur, and the resolution of clinical disputes and legal claims.

The Women of the Year Lunch and Awards ceremony brings together more than 400 extraordinary women from all walks of life, all of whom have achieved something of significance. Each guest is regarded as a 'Woman of the Year' and represents not only herself, but the millions of extraordinary women who make a difference every day. Natasha has made significant contributions to clinical governance work at NGH for many years and is currently acting as Deputy Medical Director.

5. Nicholas Robertson re-appointed as Non-Executive Director

NGH is pleased to announce that the NHS Trust Development Authority (NHS TDA) has confirmed the re-appointment of Nick Robertson as Non-Executive Director. Nick has been has been appointed from 1 October 2013 until 30 September2015.

6. Partnership Working

NGH continues to support the Healthier Northamptonshire programme of work and a partnership approach to planning and delivering care across health and social care. This will be particularly important to resolve the pressures on the urgent care system and allow strategic planning of sustainable services for the future. The NGH Board met the Nene Clinical Commissioning Board on September 17 to discuss and agree key actions towards this aim and will meet with the Corby Clinical Commissioning Board on September 24.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Medical Director's Quality Report
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Interim Chief Executive and Medical Director
Author(s)	Dr Natasha Robinson, Associate Medical Director Mrs Jane Bradley, Patient Safety Programme Director & Assistant to Medical Director Dr Sonia Swart, Interim Chief Executive and Medical Director
Purpose	(assurance/information)

Executive summary

- Overall mortality as measured by HSMR is as expected and improving but mortality as measured by SHMI is higher than average. There are a number of factors which may explain this result and further analysis is awaited
- 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
- Data quality is being addressed through the new Data Quality Group
- Data quality and coding of community hospital discharges are being monitored for accuracy, and additional support provided
- Coding is examined, revised as appropriate and reported to the Mortality & Coding Review Group
- An external review of data quality, coding and outcomes has been undertaken
- 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

1. Introduction

This paper provides a brief summary relating to mortality and safety indicators provided by Dr Foster Intelligence (to end June 2013) and the information relating to SHMI (to end 2012). It is of note that the SHMI data is not current as compared to the Dr Foster data.

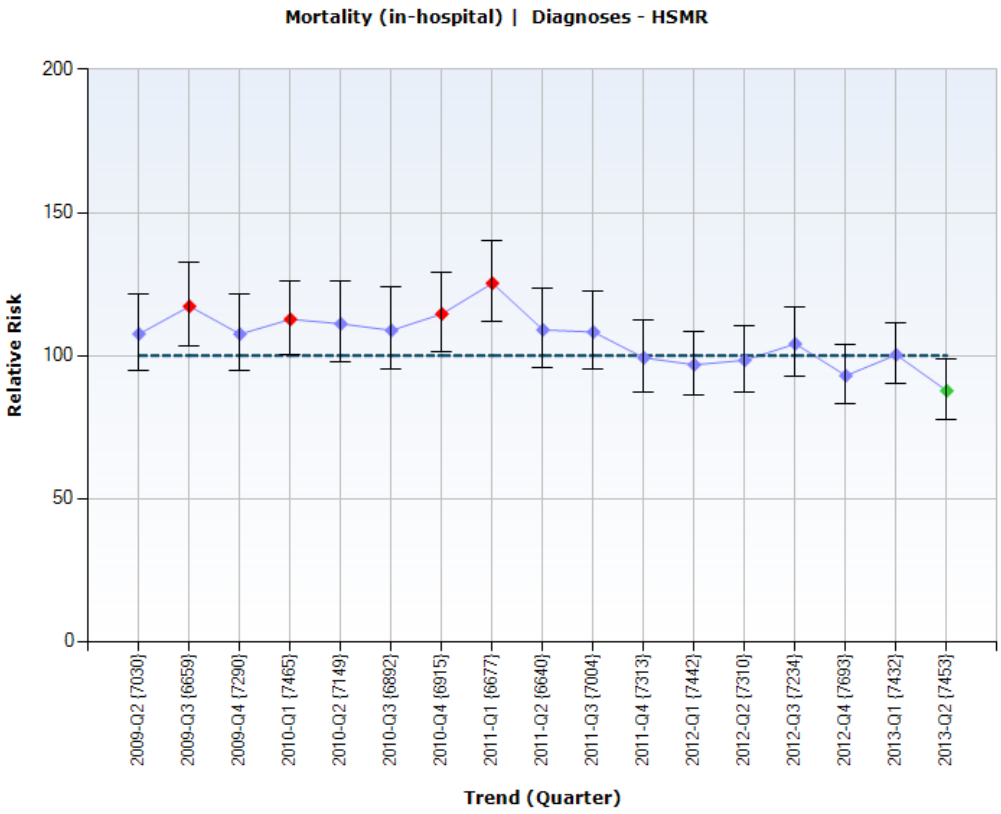
2. Current Position HSMR (Hospital Standardised Mortality Ratio)

HSMR was developed as a tool to assist hospitals in monitoring mortality and there has been continual debate as to the way it should be used. At NGH there is a detailed monitoring process where the in addition to looking at overall HSMR which is based on the 56 conditions most likely to result in mortality, SMR [standardised mortality ratio specific to a condition] is examined in any area thought to be of concern. Whereas there can be considerable debate relating to how to use HSMR to compare hospitals, for any individual hospital adverse changes in HSMR and SMR's should always be investigated.

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

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

The following graph shows the progressive improvement in HSMR by quarter over since 2011.



3. HSMR Comparison (see below)

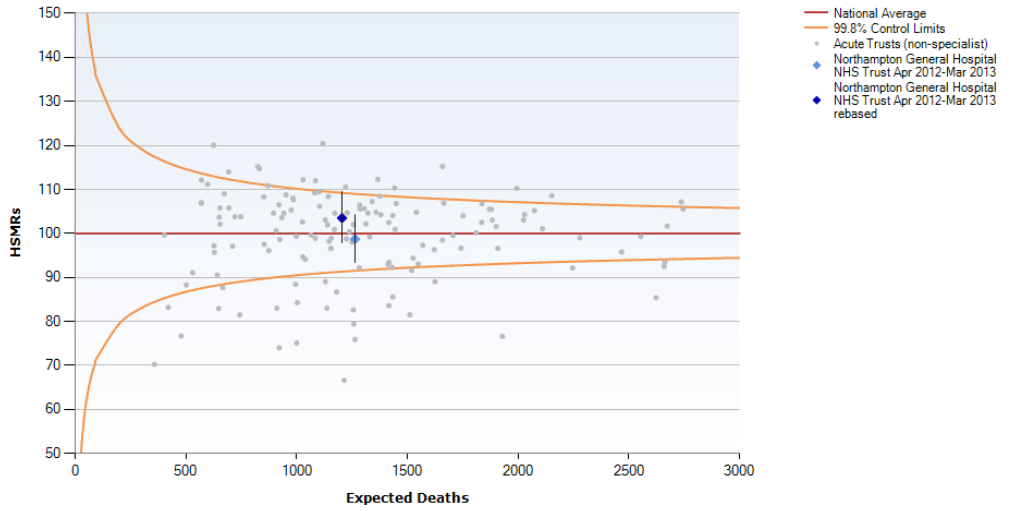
The purpose of the HSMR Comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. The funnel plot reflects the HSMR position for the last year. The light blue diamond represents our current position, the dark blue our end of year position once the data was rebased to reflect overall England performance. The grey dots are the remaining 146 acute trusts, rebased using projected 2012-3 national performance. The 2012-3 benchmark has now been applied and confirmed.

The 2012-3 HSMR using the 2011/12 benchmark has reduced to **98.7** with the indicative rebased HSMR using the 2012/13 FYD benchmark also reducing to **104** (this remains within the as expected band and continues to show a small improvement due to ongoing data corrections).

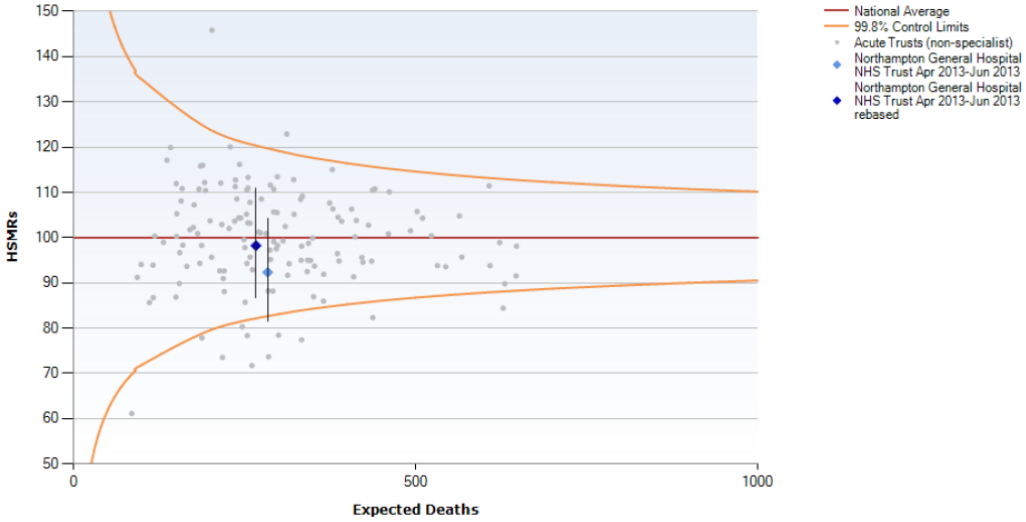
The HSMR for 2013-4 Q1 has fallen to **92.4** (266 deaths, 288 expected).

Unadjusted mortality for the HSMR basket of diagnoses for the quarter has fallen to **3.5%** (4.2% for 2012-3). This markedly improved performance follows a previous period of higher than expected mortality which has been noted throughout England and for which no explanation has yet been found. It is reassuring that our mortality is now better than expected. Preliminary internal data suggests that this improvement trend is continuing through the summer.

Acute Trust HSMRs Apr 2012 - Mar 2013



Acute Trust HSMRs April 2013 - June 2013



4. Standardised Hospital Mortality Indicator (SHMI)

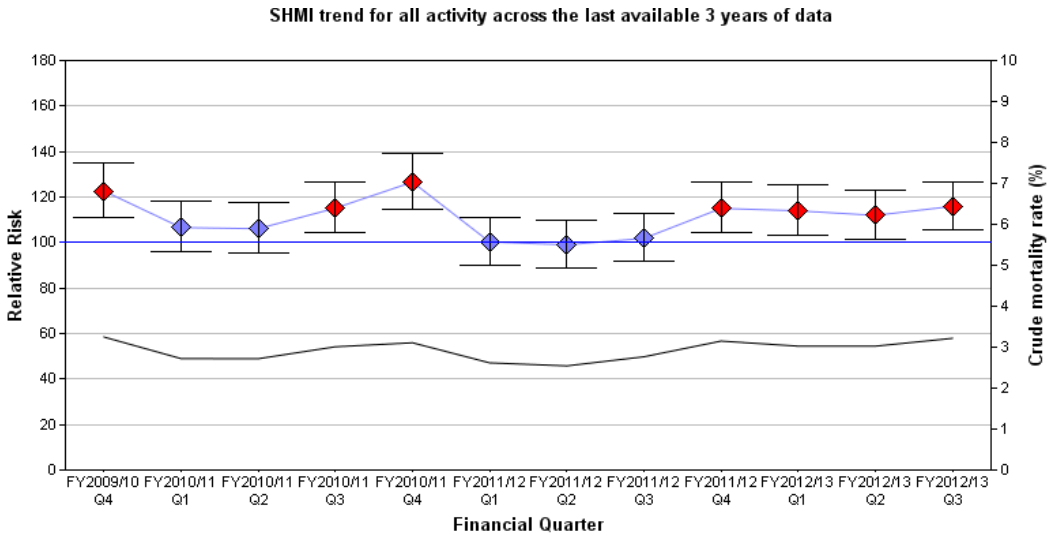
This data is now provided by HSCIC as of April 2013. However it remains 6-9 months in arrears and it is not currently possible to analyse the information in any detail, as compared to that provided by Dr Foster.

The SHMI for 2012, released in July 2013, has risen to 114. This is now amongst the 10 highest in the country. (HSMR for the same period is 99). The SHMI is rebased each time it is calculated, unlike the HSMR.

The SHMI and HSMR do not correlate well for some diagnostic groups. The significance of this is unclear, but may be explained by the SHMI model including deaths up to 30 days after discharge, and without adjusting for palliative care. The availability of a second metric is helpful in further understanding outcomes in some areas, but in depth analysis of SHMI to individual patient level is currently unavailable. Following the most recent SHMI data release a further diagnostic group identified by SHMI as showing poor performance is undergoing review.

It is likely that the SHMI will remain adverse for the following quarter (data release end October 2013) before showing some improvement, reflecting the very marked improvement in both Dr Foster and internal crude mortality data. The data from April 2013 will be interrogated to determine further information specifically in relation to patients admitted to the community hospitals with the help of Dr Foster Intelligence.

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



It seems likely that some of the issue relates to the patient mix in the community hospitals where mortality indicators may not be an appropriate measure of care. The SHMI started to rise following acquisition of the 3 community hospitals one of which offers palliative care, and 2 of which provide rehabilitation following discharge from the other acute hospital in the county and these patients are often very long-stayers, which adversely affects both in hospital and post-discharge mortality. It is of note that the previous downward trend in SHMI (and HSMR) reversed at the point when the community sites were enjoined in 2011. Work is currently underway to understand whether the overall mortality performance of the organisation has been adversely affected by the service change, and whether the continued improvement being shown by the acute trust until 2011 is being masked by a higher mortality at the community sites.

Northampton General Hospital has poor access to specialist palliative care services and palliative care beds. Although palliative care codes are not reflected in SHMI, the net result is an increased number of admissions for end of life care, and a failure to transfer those patients to a more appropriate place of care.

Overall depth of coding of comorbidities is lower at NGH than nationally. This may or may not reflect inappropriately low coding of comorbidities locally, and work is underway to ensure that this is not the case. As SHMI is a comparative tool our performance will be affected by the accuracy of coding in other organisations.

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

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

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	34,973	28	23.8	0.8	0.7	118
Decubitus Ulcer	9,405	227	217.7	24.1	23.2	104
Deaths after Surgery	326	53	41.1	162.6	125.9	129
Infections associated with central line *	15,936	0	0.8	0.0	0.1	0
Postoperative hip fracture *	25,384	1	1.7	0.0	0.1	59
Postoperative Haemorrhage or Haematoma	23,352	5	14.3	0.2	0.6	35
Postoperative Physiologic and Metabolic Derangement *	19,772	2	1.5	0.1	0.1	130
Postoperative respiratory failure	18,121	17	14.0	0.9	0.8	121
Postoperative pulmonary embolism or deep vein thrombosis	23,541	33	43.0	1.4	1.8	77
Postoperative sepsis	580	8	3.7	13.8	6.4	216
Postoperative wound dehiscence *	973	0	1.1	0.0	1.2	0
Accidental puncture or laceration	65,994	37	74.1	0.6	1.1	50
Obstetric trauma - vaginal delivery with instrument *	512	32	42.3	62.5	82.7	76
Obstetric trauma - vaginal delivery without instrument *	2,460	78	91.9	31.7	37.4	85
Obstetric trauma - caesarean delivery *	1,200	0	4.1	0.0	3.4	0

[note new format]

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

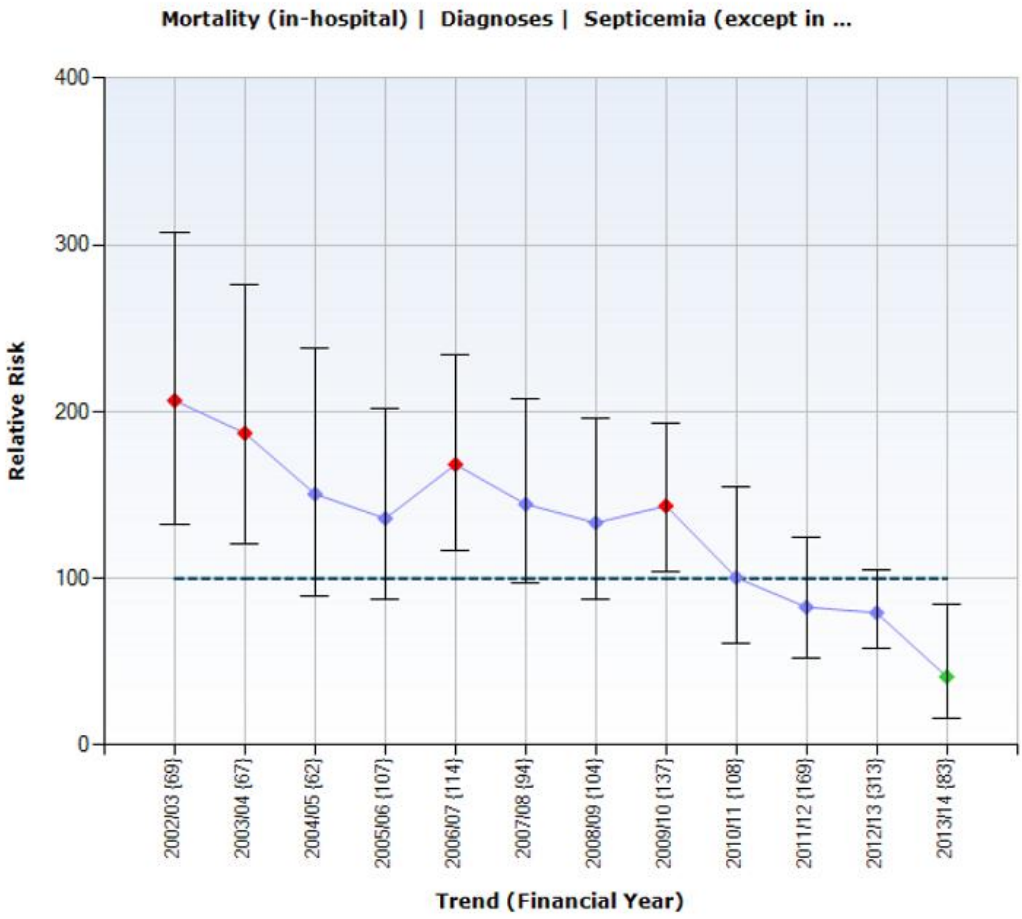
Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease (Stroke), Pneumonia. Acute Myocardial Infarction, Congestive Heart Failure and Fractured Neck of Femur** are subject to particular scrutiny. Overall SMR for this group for the rolling year to date is **79** which is significantly lower than expected (507 deaths with 639 expected from 3298 spells).

There has been a continuing modest improvement in mortality from **fractured neck of femur**. The SMR for YTD is **127** (43 deaths with 34 expected) and no deaths occurring in June, the latest month available. A review of the medical care of these patients has now been reviewed and a plan for support from elderly care physicians is in place awaiting the appointment of an orthogeriatrician.

Mortality from **heart failure** remains significantly high but is reducing. SMR is **129** (68 deaths whereas 53 were expected). The heart failure team continue to identify inpatients prior to discharge including those with a secondary diagnosis of heart failure in order to ensure good community care and reduce future admissions.

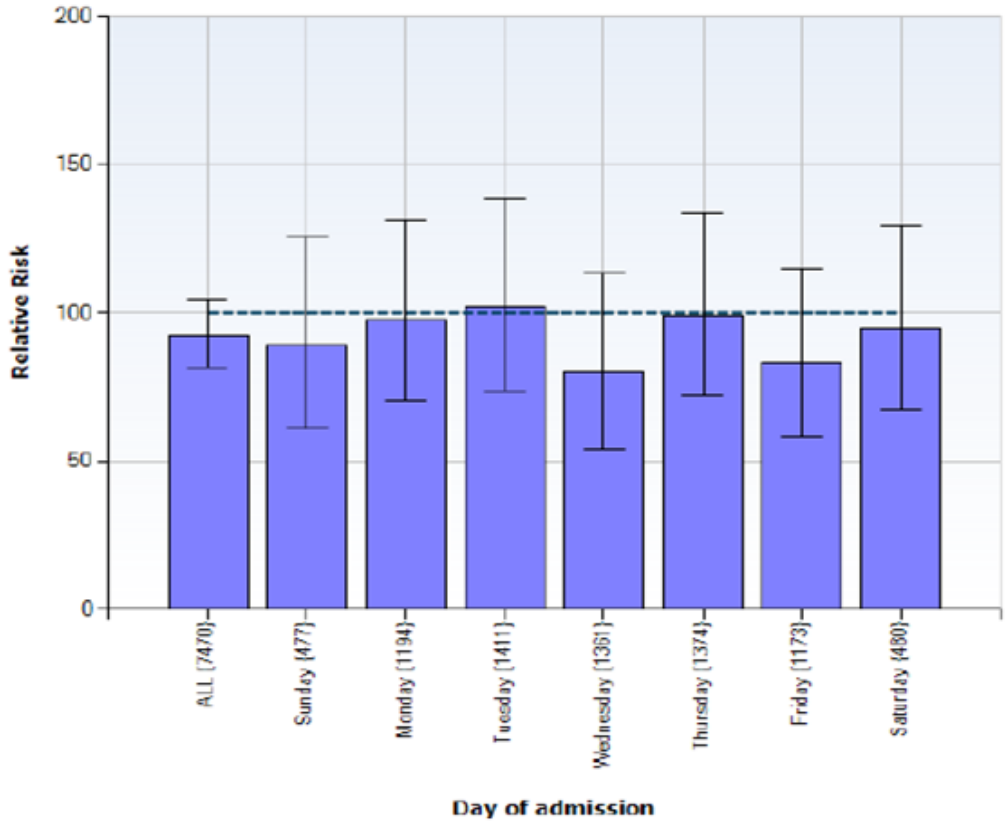
The remaining 3 clinical groups are all performing better than expected.

There has been significant media interest in death rates from Septicaemia. The graph below illustrates the current position at NGH using the 2011/12 benchmark and shows an improving position over time.



There has also been concern raised nationally in relation to the mortality for patients admitted over the weekend versus the mortality for those patients admitted during the week.

The current position for NGH is shown in the table below for the first quarter of 2013. This shows no increased mortality for weekend admissions in this period of time.



7. Possible areas for concern under investigation

A review of patients dying with **secondary malignancy** has been received and discussed. There were no avoidable deaths, and a lack of alternative provision for end of life care was identified. A subgroup of patients with known or newly diagnosed lung cancer was identified, and this will be followed up through the Lung Cancer MDT. A newly appointed Acute Oncologist will continue to monitor mortality in this group.

The data related to **perinatal outcomes** has been reviewed to understand whether deaths in this group [which include stillbirths] are adverse for our population. This work is complex and we are being assisted by Dr Foster, and seeking triangulation with other sources of national data. The report related to obstetric care has identified some concerns regarding use of new assessment tools for which additional training is to be provided. A report from the neonatal paediatricians is due in October.

A review of patients admitted with '**intestinal infection'** has proved complex due to the wide range of final diagnoses, and is due for discussion in October.

An alert for mortality and readmission following **peritonitis** is the only new area for concern during Q1 2013-4. Once the coding has been validated for all deaths (10 deaths, 5 expected) these will be reviewed for clinical care if required, by the appropriate clinical specialty.

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

Following the concerns in relation to SHMI further reporting to the Board was agreed to allow increased scrutiny and understanding in relation to data issues , coding and crude mortality and a new group has been set up to monitor these parameters.

The Data Quality Steering Group will report monthly to the Trust Board via the Medical Director's Trust Board paper on priorities and actions undertaken as well as reporting specific routine data quality monitoring which will include:

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

This report is included as Appendix 1 and will be used as a tool for continuous improvement.

There is work to be done to ensure all palliative care patients are coded correctly, all co-morbidities are captured and the accuracy of primary diagnoses is improved. All these parameters will have a significant impact on mortality ratios.

Crude mortality rates can be used as a rough indicator and early warning that there is an improving or deteriorating position.

In addition the Board will receive information regarding nursing levels per bed and the percentage bank and agency usage. In this way the Board can receive information regarding these key quality indictors on a regular basis.

The current nursing levels are included in Appendix 2.

8. Further actions in place or planned

Future reports will be presented using the numbers of bed for which each registered nurse is responsible in order to give a clearer idea of the levels of care provided. There is on-going work to present speciality specific dashboards which is not yet complete. The Trust will receive further comment and support from an external medical director identified by the Trust Development Authority who will review our current processes and make suggestions if required.

9. Learning from Serious Incidents

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

During July and August 2013 16 SIs were submitted to the CCG for closure: 12 pressure ulcers were closed due to a large number of delayed reports. Of these, half were considered unavoidable. 1 fracture occurring as an inpatient (hip). The 3 remaining cases were as follows: an unexpected death postoperative following minor abdominal hernia surgery (due to previously unsuspected primary pulmonary hypertension); a postoperative death following complex elective abdominal hernia surgery; death of a young child with complex congenital cardiac problems who was readmitted with septicaemia.

Being Open meetings have been declined, held or are planned for all cases. An inquest has been opened for the complex abdominal hernia case.

All SI's are reviewed at consultant appraisal as part of revalidation, but this may be specified as part of the action plan for certain investigations. Further action taken is in accordance with the NPSA Decision Tree. Where doctors in training are involved in a serious incident they are identified at the start of the investigation process and a referral is made to the Director of Medical Education to ensure they receive

appropriate support, and that there is educational supervision where required. This support is also necessary as part of the preparation for an inquest if this has been opened.

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

- The Deputy Director of Nursing is continuing to lead on thematic reviews of all pressure SIs. SSKIN has been implemented across the Trust and is part of the monthly Board to Ward reviews.
- The Falls Prevention Group continues to monitor risk assessments and the use of preventative measures for high risk patients across the Trust.
- A thematic review of all SI's involving patients with LD is continuing to identify learning needs
- Ward areas need to be made aware of carers policy when managing patients with special needs
- Training on use of NEWS and Trust escalation guidance needs to be revisited for nursing and trainee medical staff
- Weekend ward rounds for postoperative patients need to be formalised
- Process for out of hours escalation of ward staffing to be reviewed
- Failed day case discharges must be informed to the on call surgeons and reviewed the following morning
- Handover plans on paediatric ward need strengthening
- Links with tertiary centres must be used more effectively for seeking advice for complex cases

Process for ensuring actions completed and organisation learning is shared

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

11. Recommendation

The Board is asked to note the report and debate any issues that arise from it. The Board should note that considerable detailed analysis occurs as part of on-going mortality monitoring which has been in place for many years. This is reported at the Mortality and Coding Review Group, through the Clinical Quality & Effectiveness Group (CQEG), in the Quarterly Patient Safety and Quality and Governance Report and is discussed at Integrated Healthcare Governance Committee (IHGC). The emphasis of all mortality analysis is to recommend improvement plans and many actions are included in the Trust Patient Safety work streams.

Section 2

NGH Monthly Quality Exception Quality Scorecard

Introduction

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

Directorate Scorecards are improving and becoming more comprehensive 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.

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 includes new indicators to monitor the safety improvement work.

Performance

Within August's exception scorecard there were 136 indicators, **39** (**26/13**) 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 **22** indicators that are rated grey.

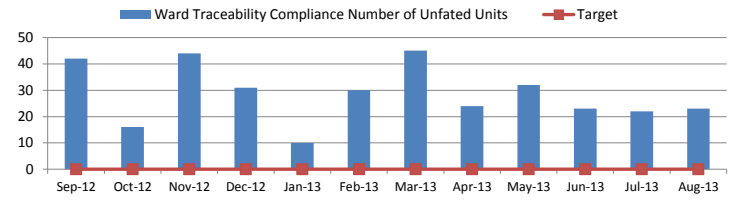
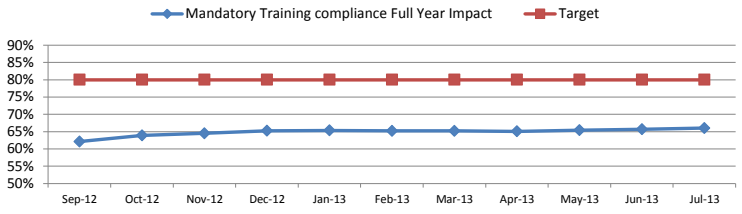
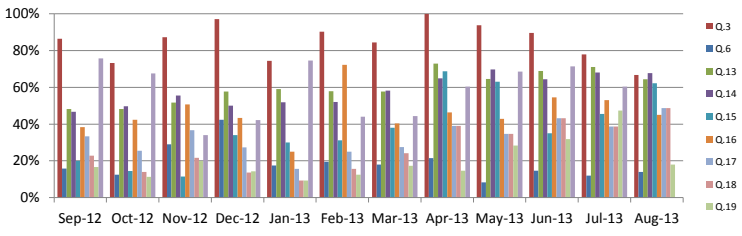
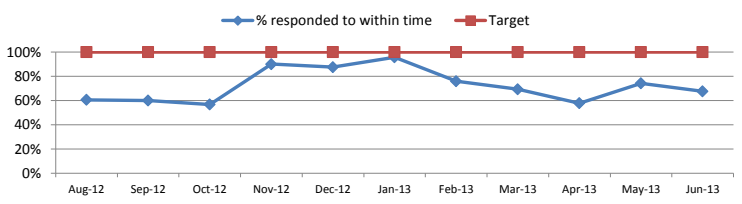
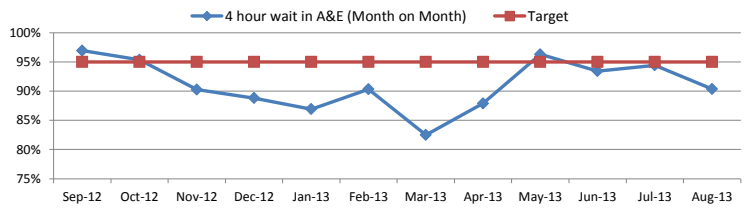
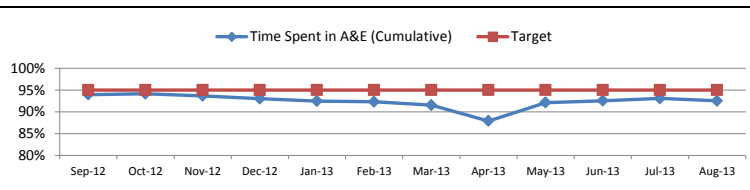
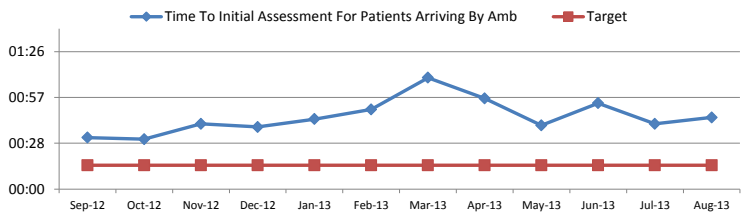
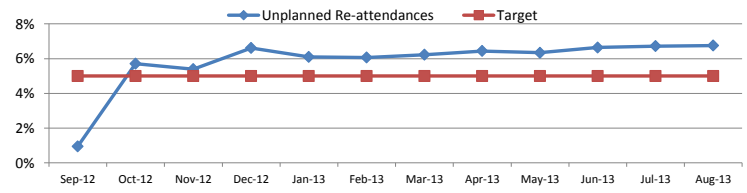
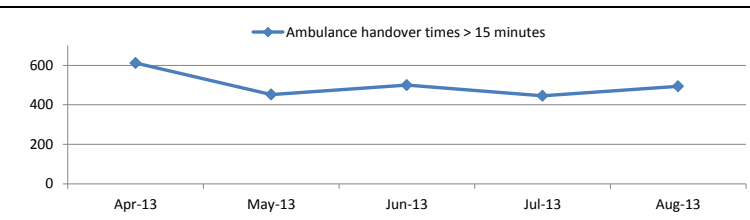
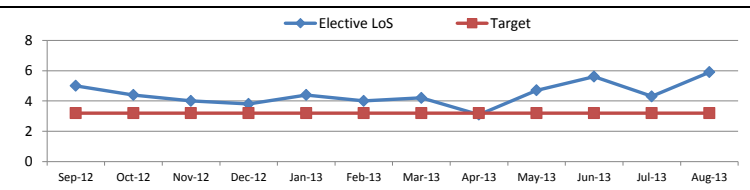
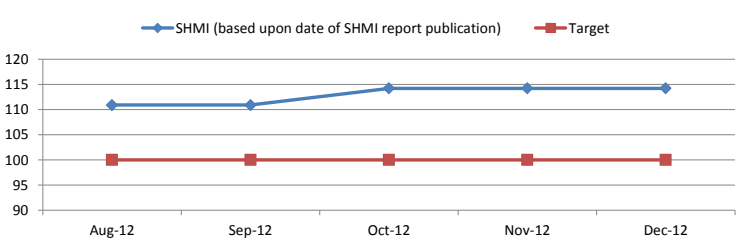
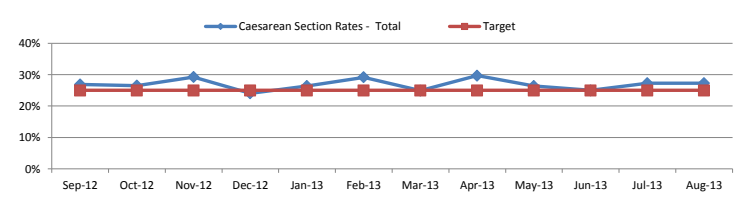
In comparison to July`s report an improvement can be acknowledged there is a decline in the number of indicators that have been rated as red or amber as these have now been converted to green. The Indicators rated as grey have also reduced, as final agreement for some of these indicators has now been agreed.

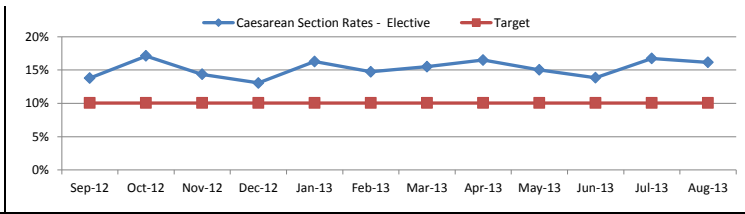
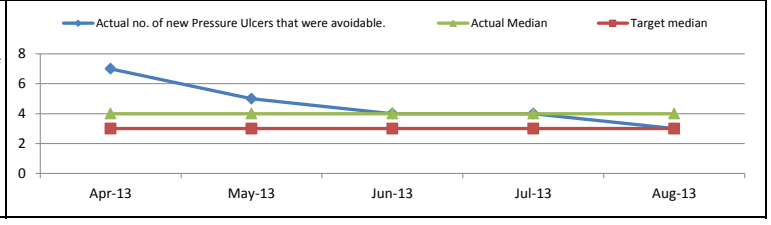
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**15**	**3**	**30**	**8**	**56**
Clinical Outcomes	**7**	**2**	**21**	**3**	**33**
Patient Safety	**3**	**2**	**8**	**11**	**24**
Patient Experience	**1**	**6**	**16**	**0**	**23**
TOTAL	**26**	**13**	**75**	**22**	**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	↓	Autofate compliance slightly deterioration on last month from 22 unfated units in July to 23 units in Aug. (Total ward compliance was reported as 97.6% in August, although legislation requires 100% compliance with traceability of blood as per the Blood Safety and Quality Regulations 2005.)	
Patient Safety	Mandatory Training compliance Full Year Impact	0	↑	June 2013 saw a slight increase in the number of staff being trained (65.7% in June to 66% in July). Work is underway looking at the target audience for all the mandatory training courses to ensure that the correct staff groups have been identified with a reminder system being implemented 3 months prior to refresher course requirements. The existing 23 mandatory training courses were reviewed at the IHGC meeting and August with approved given to reduce the number of courses to 9 for all staff, whilst other training becomes Role Specific Essential Training. A RAG rating reporting mechanism of Mandatory Training compliance also is planned for the future.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↓	Key issues identified on the Healthcare Notes audit in Aug 13: Following items flagged as red - the recording of vital patient information (patient name, date of birth, hospital number and NHS number) on the front page of notes where the addressograph was absent, staff name in capitals, recording of staff designation & whether the GMC number is present, evidence of communication with relatives, how alterations/deletions are managed and amount of loose sheet in medical notes. Improving the Healthcare Records Audit results is being overseen by one of the leads for the Patient Safety Academy with actions plans underway. Improvements seen for the recording of dates and times.	
Patient Experience	Complaints Responded to within agreed timescales	100%	↓	The response rate decreased from 74% to 68% for complaints received in June mainly due the need to extend and send holding letters to 13 of the 37 complainants. The most prominent reasons provided for this are due to staffing issues for turning around complaints and also the complexity of complaints continues to rise year on year.	
Patient Experience	A & E Quality Indicators (5 indicators)		↓	**A&E Clinical Indicators:**	
			↓	4 hour wait in A&E (Month on Month) decreased from 94.43% in July to 90.35% in August.	
			↓	Time Spent in A&E (Cumulative) - This indicator has been negatively affected by the non-achievement of the monthly 95% 4hrs for August wait resulting in a cumulative of 92.52%.	
			↓	The time to initial assessment for patients arriving by ambulance deteriorated 41 mins in July to 45 mins in August (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 increase to 6.76% (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.	
			↓	August saw an increase in both handovers over 15 mins and over 60 mins with the data now undergoing further validation. In addition, new electronic methods of accurately capturing ambulance handover times are currently being implemented and work is being undertaken between the ambulance service and trust (new target).	
Patient Experience	SRS08: Length of Stay (Acute & MH) - Elective	3.2 days	↓	The Elective LoS proved increased from 4.3 days the previous month to 5.9 days. It should be acknowledged that the comorbidities associated with the patients who were admitted during this time are not considered. Reviewing Dr Foster data which does acknowledge the comorbidities shows the latest data for the Trust was only just above the expected LoS for the period which was 5.4 days).	
Clinical Outcomes	SHMI (based upon date of SHMI report publication)	<100	→	SHMI has been rising during the last few months of data which was updated last September but does not mirror HSMR in all specialities. The mortality monitoring process continues and is described in the Medical Directors' report. Individual areas for concern for HSMR are also contained in that report. Current figures for SHMI reflect the position as reported to last December 12 and not the figures for the month in question.	
Clinical	Caesarean	<25%	→	The total caesarean section for Aug remained static at 27.3% and the elective section rate improved slightly at 16.2% from 16.7%. However there are continuing issues with elective caesarean section rates being higher than the national	

Outcomes	Section Rates	10.1%	↑	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 will be assured.	
CQUIN	50% reduction in all new Pressure Ulcers that are avoidable.	Median of 3	↑	Although the median for the period Apr - Aug is reported as 4 against the target of 3 for the period April - Sept, there has been sustained progress in reducing the number of new avoidable pressure ulcers following extensive efforts across the Trust. There is a Trust action plan now in place and also the appointment of a lead Tissue Viability Nurse following a vacancy for several months.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Frequency	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Aug 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	Monthly	1	0	0	0	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	Monthly	2	1	3	4	2	2	5	7	2	4	1	3		
HQU08: MSSA Numbers	No national ceiling set	Monthly	0	2	2	1	1	0	0	1	0	1	1	0		
E Coli ESBL Quarterly Average	7 per month	Monthly	1	0	4	2	3	2	0	2	3	3	4	2		
VTE Risk Assessment completed	95% month on month	Monthly	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	96.8%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	Monthly	91.8%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	Monthly	100%	100%	99.74%	99.40%	99.73%	99.54%	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%		
MRSA Screening Non-Elective Patients	100% month on month	Monthly	95.25%	96.10%	96.80%	95.78%	95.12%	96.56%	97.00%	100%	100%	100%	100%	100%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	Monthly	42	16	44	31	10	30	45	24	32	23	22	23		
Incidence of pressure ulcers																
Grade 3 - New avoidable pressure ulcer		Monthly	lit not availa	1	0	2	2	3	4	0	4	3	0	0		
Grade 3 - New unavoidable pressure ulcer		Monthly		0	1	2	0	0	1	3	2	4	0	1		
Total Grade 3 - New pressure ulcer		Monthly	3	1	1	4	2	3	5	3	6	7	0	1		
Grade 4 - New avoidable pressure ulcer		Monthly	lit not availa	2	3	1	3	0	1	0	0	0	0	0		
Grade 4 - New unavoidable pressure ulcer		Monthly		0	3	1	0	0	0	0	0	0	0	0		
Total Grade 4 - New pressure ulcer		Monthly	0	2	6	2	3	0	1	0	0	0	0	0		
Reduce harm from falls																
Catastrophic	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
Major/Severe	0	Monthly	0	2	3	0	1	2	1	0	1	1	1	2		
Moderate	0	Monthly	1	0	0	1	2	3	1	1	3	1	1	0		
Mandatory Training compliance Full Year Impact																
Primary Levels Excluding B&H	80%	Monthly	62.1%	63.9%	64.5%	65.2%	65.4%	65.2%	65.2%	65.1%	65.4%	65.7%	66.0%	N/Avail		6 week turnaround delay for data
Attendance at Trust Induction	80%	Monthly	85.5%	98.6%	90.8%	87.9%	87.5%	87.6%	87.5%	87.3%	87.4%	86.9%	87.4%	N/Avail		6 week turnaround delay for data
Number of surgical site infections																
Fracture neck of femur - Number of Operations	-	Monthly	26	26	36	34	39	31	45	17	27	29	20	28		
Number of infections	-	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
% infection rate (monthly)		Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly	1.1%		0%			0.9%			0%		Quarterly report			Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
Abdominal hysterectomies		Monthly	Abdominal hysterectomies infection rates monitored as from April 2013							16	16	14	22	21		
Number of infections		Monthly								1	0	0	0	0		
% infection rate (monthly)		Monthly								6%	0%	0%	0%	0%		
% 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	0	1	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	Monthly	84.2%	87.0%	87.9%	89.0%	89.1%	89.3%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%		
Serious Untoward Incidents	-	Monthly	5	7	14	9	19	25	36	41	35	51	21	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	77%	73%	68%	79%	80%	79%	72%	79%	72%	74%	80%	75%		
Q.2 Does addressograph include the NHS Number?	100%	Monthly	90%	90%	93%	88%	99%	88%	92%	90%	97%	97%	98%	95%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	Monthly	86%	73%	87%	97%	74%	90%	84%	100%	94%	90%	78%	67%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	Monthly	62%	60%	62%	82%	53%	73%	64%	85%	69%	77%	63%	49%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	Monthly	60%	64%	74%	91%	53%	63%	46%	61%	67%	69%	51%	49%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	Monthly	16%	13%	29%	42%	18%	20%	18%	21%	8%	15%	12%	14%		
Q.7 Is record legibly written	100%	Monthly	99%	98%	97%	99%	99%	98%	99%	95%	100%	98%	99%	97%		
Q.8 Written in blue/black ink	100%	Monthly	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	99%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Monthly	100%	100%	100%	99%	98%	99%	100%	99%	98%	99%	100%	100%		
Q.10 Is date recorded for each entry	100%	Monthly	94%	89%	93%	91%	88%	90%	88%	86%	87%	86%	89%	92%		
Q.11 Is time recorded for each entry	100%	Monthly	77%	73%	70%	72%	71%	66%	75%	86%	87%	86%	89%	92%		
Q.12 Is there a signature of the person making the entry	100%	Monthly	92%	87%	91%	92%	90%	94%	94%	96%	97%	92%	97%	91%		
Q.13 Is surname printed in block capitals	100%	Monthly	48%	48%	52%	58%	59%	58%	58%	73%	65%	69%	71%	64%		
Q.14 Is the staff designation recorded	100%	Monthly	47%	50%	55%	50%	52%	52%	58%	65%	70%	64%	68%	68%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	Monthly	20%	14%	11%	34%	30%	31%	38%	69%	63%	35%	46%	62%		
Q.16 Are any alterations / deletions scored through with a single line	100%	Monthly	38%	42%	51%	43%	25%	72%	40%	46%	43%	55%	53%	45%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	Monthly	33%	26%	37%	27%	16%	25%	28%	39%	35%	43%	39%	49%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	Monthly	23%	14%	22%	14%	9%	16%	24%	39%	35%	43%	39%	49%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	Monthly	17%	11%	20%	14%	9%	13%	17%	15%	28%	32%	47%	18%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	Monthly	N/a	100%	99%	95%	97%	96%	100%	99%	97%	88%	100%	90%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	Monthly	N/a	76%	68%	34%	42%	75%	44%	44%	60%	69%	71%	60%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	Monthly	N/a	100%	100%	100%	100%	100%	100%	100%	96%	80%	100%	100%		
Q.23 Are there any loose sheets in the Healthcare record	0%	Monthly	N/a	8%	10%	17%	10%	0%	13%	10%	3%	3%	7%	7%		

Patient Experience	Target 2013-14	Frequency	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Aug 13 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	Monthly	0	0	0	6	4	1	2	1	0	0	0	0		
Hospital Cancelled Operations	6.0%	Monthly	5.8%	6.9%	7.9%	5.4%	9.3%	6.3%	11.5%	11.1%	9.6%	9.5%	12.0%	N/Avail		
Number of written complaints received	-	Monthly	35	44	40	24	68	54	52	45	58	37	29	38		
Complaints Responded to within agreed timescales	100.00%	Monthly	60.0%	56.8%	90.0%	87.5%	95.6%	75.9%	69.2%	57.8%	74.1%	68%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits																
Admitted Patients	90.00%	Monthly	96.34%	96.08%	95.93%	96.47%	96.10%	95.12%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%		
Non Admitted Patients	95.00%	Monthly	98.44%	98.52%	98.36%	98.48%	98.60%	97.90%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%		
Ongoing Patients	92.00%	Monthly	97.12%	96.91%	96.85%	96.33%	95.45%	95.74%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%		
A&E Quality Indicators (5 measures)																
Time Spent in A&E (Month on Month)	95%	Monthly	96.93%	95.35%	90.25%	88.81%	86.91%	90.33%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%		
Time Spent in A&E (Cumulative)	95%	Monthly	93.95%	94.15%	93.67%	93.04%	92.47%	92.30%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%		
Total time in A&E (95th percentile)	95th	Monthly	03:59	04:00	06:09	06:18	07:12	06:21	08:08	06:45	03:59	04:43	04:17	05:19		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	Monthly	00:32	00:31	00:41	00:39	00:44	00:50	01:10	00:57	00:40	00:54	00:41	00:45		
Time to treatment decision (median)	<60 mins	Monthly	00:48	00:41	00:46	00:48	00:34	00:45	00:52	00:57	00:51	00:51	01:05	00:54		
Unplanned re-attendance rate	=<5%	Monthly	0.95%	5.71%	5.40%	6.62%	6.10%	6.07%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%		
Left without being seen	>1% and <5%	Monthly	0.18%	0.07%	0.25%	0.12%	0.18%	0.22%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%		
Ambulance handover times > 15 minutes	0	Monthly	New for 2013-14							612	452	500	446	494		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	Monthly	New for 2013-14							68	3	29	7	39		No hand over greater then 15 minutes
Cancer Wait Times																
2 week GP referral to 1st outpatient	93%	Monthly	96.6%	97.2%	98.3%	98.6%	96.7%	96.9%	98.3%	96.0%	95.4%	96.2%	95.4%	94.8%		
2 week GP referral to 1st outpatient - breast symptoms	93%	Monthly	98.5%	96.1%	99.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%		
31 Day	96%	Monthly	99.3%	98.9%	97.7%	95.6%	97.3%	98.7%	99.2%	98.0%	98.2%	98.1%	96.3%	98.1%		
31 day second or subsequent treatment - surgery	94%	Monthly	96.6%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%		
31 day second or subsequent treatment - drug	98%	Monthly	100.0%	100.0%	98.6%	95.0%	91.8%	96.8%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%		

31 day second or subsequent treatment - radiotherapy	94%	Monthly	98.2%	98.4%	99.0%	98.8%	96.4%	97.8%	95.8%	98.3%	98.6%	95.8%	96.5%	94.1%	
62 day referral to treatment from screening	90%	Monthly	100.0%	100.0%	100.0%	95.7%	95.7%	93.3%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	
62 day referral to treatment from hospital specialist	80% (local target)	Monthly	85.0%	100.0%	92.6%	100.0%	63.6%	73.7%	100.0%	77.8%	50.0%	0.0%	50.0%	57.1%	
62 days urgent referral to treatment of all cancers	85%	Monthly	86.4%	85.8%	89.7%	78.3%	81.3%	77.6%	76.5%	85.2%	79.0%	83.4%	79.1%	85.5%	
SRS08: Length of Stay (Acute & MH)															
Elective	3.20	Monthly	5	4.4	4	3.8	4.4	4	4.2	3.1	4.7	5.6	4.3	5.9	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	4.9	4.5	4.2	4.4	4.6	4.3	4.7	4.3	4.3	5.8	4.7	5.3	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	85.0%	84.7%	83.0%	85.7%	85.5%	84.8%	84.6%	85.9%	84.9%	84.6%	86.4%	N/Avail	
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	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Aug 13 RAG Rating	Comments
HSMR - monthly position for 2013-14	<100	Monthly	111.9	93.5	83.8	100.5	96.9	100.21	103.7	108.5	76.8	76.93	N/Avail	N/Avail		Latest DFI position - 12 months to Jun 13
HSMR - 12 Monthly cumulative position		Monthly	97.9	98.3	98.2	99.0	99.1	N/Avail	100.1	100.8	N/Avail	96.2	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
HSMR- cumulative position for 2013-14																
Pneumonia	<100	Monthly	50.6	49.7	48.7	52.2	54.8	N/Avail	57.5	60.4	N/Avail	59.42	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Fracture of neck of femur (hip)	<100	Monthly	163.1	155.8	168.5	168.4	169.08	N/Avail	148.7	135.89	N/Avail	127.47	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Acute Cerebrovascular disease	<100	Monthly	104.8	110	101.6	107.1	105.6	N/Avail	105	108.2	N/Avail	101.95	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	Monthly	114.4	121.4	131.3	131.9	133.5	N/Avail	133.5	135.88	N/Avail	128.8	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
Acute myocardial infarction	<100	Monthly	76.4	70.1	61.9	71	76.7	N/Avail	77.5	84.6	N/Avail	82.29	N/Avail	N/Avail		Latest DFI FY trend Jul 12 - Jun 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	Monthly	110.9	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 July 13 reflects Jan 12 to Dec 12.
SQU12: Maternity 12 weeks	90%	Monthly	99.0%	98.0%	97.0%	93.2%	95.4%	95.2%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%		Figure subject to change following final data collation
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	Monthly	3.2%	3.1%	4.3%	5.7%	3.9%	3.4%	4.0%	2.5%	2.7%	3.7%	3.3%	N/Avail		
Fractured neck of Femur																
Patients fit for surgery within 36hrs	-	Monthly								17	29	26	23	N/Avail		
Number of patients admitted with FNOF who were operated on within 36 hrs	-	Monthly				New for 2013-14				14	21	23	22	N/Avail		
% 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%	N/Avail		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	Monthly	85.0%	93.0%	89.0%	100.0%	91.3%	90.6%	69.6%	90.9%	82.8%	81.3%	92.6%	88.9%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	Monthly	54%	46%	47%	47%	39%	67%	48%	43%	38%	38%	66%	59%		
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	Monthly	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	Monthly	76.0%	68.0%	88.9%	72.7%	68.8%	60.0%	69.2%	72.7%	68.0%	69.6%	83.9%	60.0%		
Patients who spend at least 90% of their time on a stroke unit	80%	Monthly	93.3%	91.0%	90.2%	84.2%	81.6%	86.1%	96.4%	80.0%	88.7%	98.2%	94.1%	91.9%		
Breast Feeding initiation	75%	Monthly	100.0%	99.3%	99.7%	74.9%	75.2%	77.4%	79.4%	80.6%	81.4%	76.9%	79.7%	78.9%		
Caesarean Section Rates - Total	<25%	Monthly	26.9%	26.5%	29.3%	24.1%	26.4%	29.2%	24.9%	29.7%	26.4%	25.0%	27.3%	27.3%		
Caesarean Section Rates - Emergency	14.98%	Monthly	13.7%	9.4%	14.9%	11.1%	10.1%	12.7%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%		
Caesarean Section Rates - Elective	10.06%	Monthly	13.8%	17.1%	14.4%	13.1%	16.3%	14.7%	15.5%	16.5%	15.0%	13.9%	16.7%	16.2%		
Home Birth Rate	>=6%	Monthly	6.8%	4.4%	4.5%	7.5%	2.1%	5.9%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%		
Number of readmissions within 28 days (Adult)	-	Monthly				New for 2013-14				396	383	422	498	N/Avail		Min 28 day turnaround before monthly dta available
Number of readmissions within 28 days (Children)	-	Monthly				New for 2013-14				146	136	163	126	N/Avail		Min 28 day turnaround before monthly dta available

CQUIN 2013-14	Target 2013-14	Frequency	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Aug 13 RAG Rating	Comments
NATIONAL CQUINS																
1.VTE																
1a. 95% of all adult inpatients to have a VTE risk assessment		Monthly	91.7%	92.5%	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	96.8%		RAG rating if under 95% = Red.
	95% month on month CQUIN payment to be received if both 1a and 1b are achieved. 60% of all root cause analyses completed					New for 2013-14					Awaiting Quarterly report					
1b. VTE Root Cause Analysis.		Quarterly														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%	N/Avail		
3b.initial diagnostic assessment	90% 3 consecutive months	Monthly		N/A	N/A	N/A	N/A	N/A	Not avail	-	0%	100%	50%	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%	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 COUINS																
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 COUINS																
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%		Q1 accumulative FFT response rate = 10.77%
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		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%	67%		OCQUIN'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%	61.30%		OCQUIN'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				

Medical Director's Quality Report

APPENDIX 1

Data Quality Report - September 2013

A Data Quality Steering Group has been established, which has met twice over the past 3 months; it is made up from managerial representatives that includes Finance Department, Information & Data Quality Department, Information Technology (IT) Department, Coding Department and Care Group Directorates.

This group will meet once a month to discuss data quality issues and key priorities. The Steering Group will receive feedback from the Data Quality Working Group and the Clinical Coding management team on significant coding issues. The steering group will then direct the working group on the priorities and will discuss significant coding issues to help shape the trust's coding in relation to the coding improvement plan.

A Data Quality Working Group has also been established with a core group of individuals from Information & Data Quality Department, Information Technology (IT) Department, Coding Department and Training, with guest representation from ward clerks, nursing, receptionists, etc. as appropriate The Data Quality Working Group meets once a month and reports directly to the Data Quality Steering Group.

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. This facility is to be in September.

A data quality escalation policy has been written and is 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 currently being reviewed to ensure they are fit for purpose and still required.

The Data Quality Steering Group will report monthly to the Trust Board via the Medical Director's Trust Board paper on priorities and actions undertaken as well as reporting specific routine data quality monitoring which will include:

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

A full programme of internal coding audit started in April 2012 as part of an ongoing assurance framework. Error identification and training provision are currently the focus based on these randomly selected individual audits.

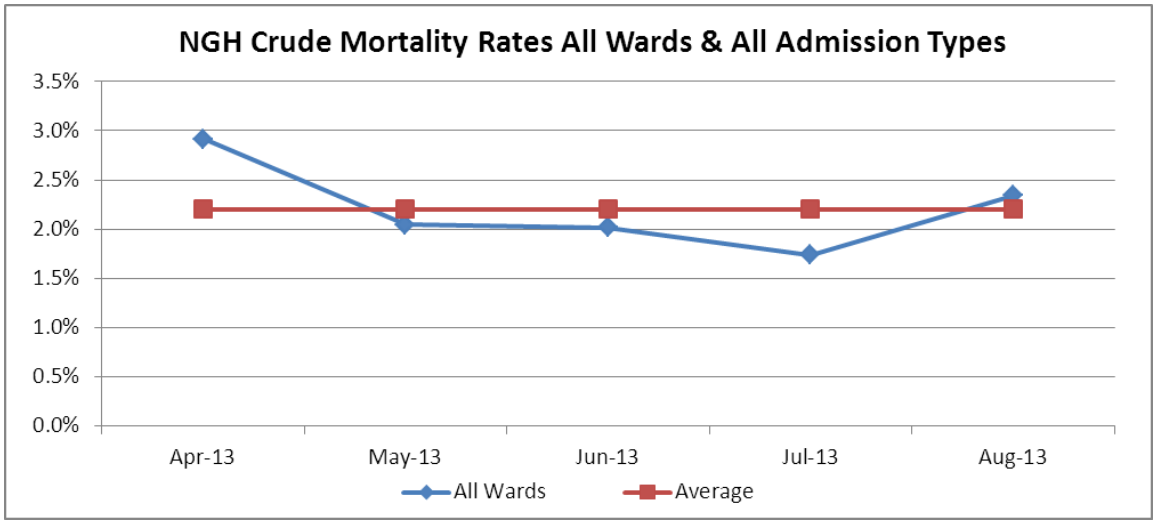
The coding of deceased patients is also audited internally on a weekly basis and the work is directed by the coding and mortality review group and reported back in to that group.

A future introduction to the data quality audit process will be a suite of internal reports specifically tailored to service needs. Of these will be a suite of coding specific reports aimed at identifying common coding errors. This will mean that 100% of coded data will be audited for certain coding standards rather than just the 1-2% audited currently. This is jointly being developed between the information team and coding team and is anticipated to

be completed by the end of October 2013. This will have an impact on the overall accuracy of coding rather than being directed toward deceased patients.

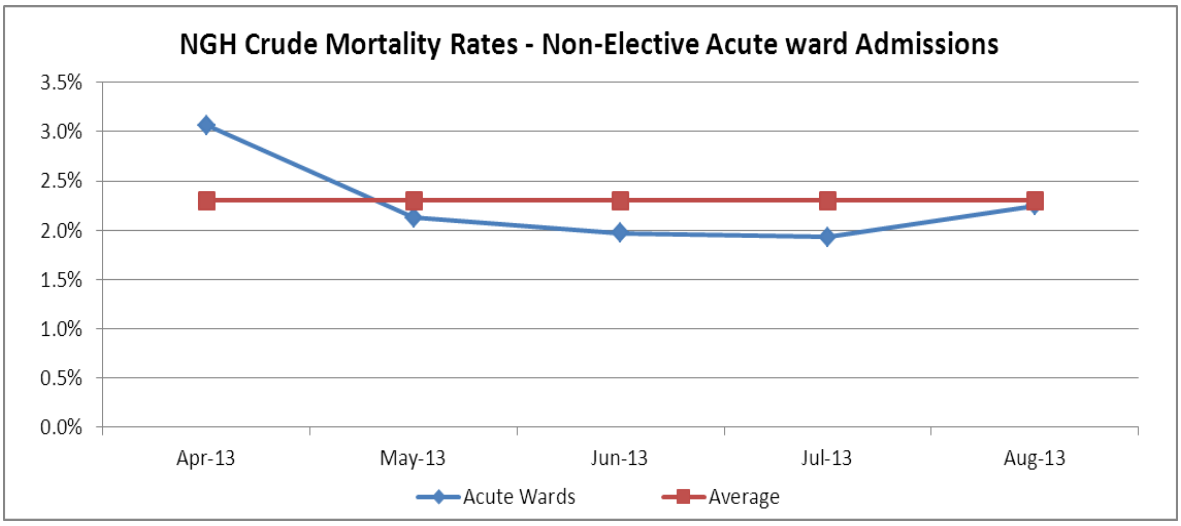
Crude Mortality Rates

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.



A comparison with the peer group used by Scunthorpe & Goole Hospitals (12 trusts) would suggest that our rate is a little high with the peer group showing 1.56%. It should be noted that NGH has community wards and this has slightly increased the crude mortality rate, removing the community wards brings the average down to 2%.

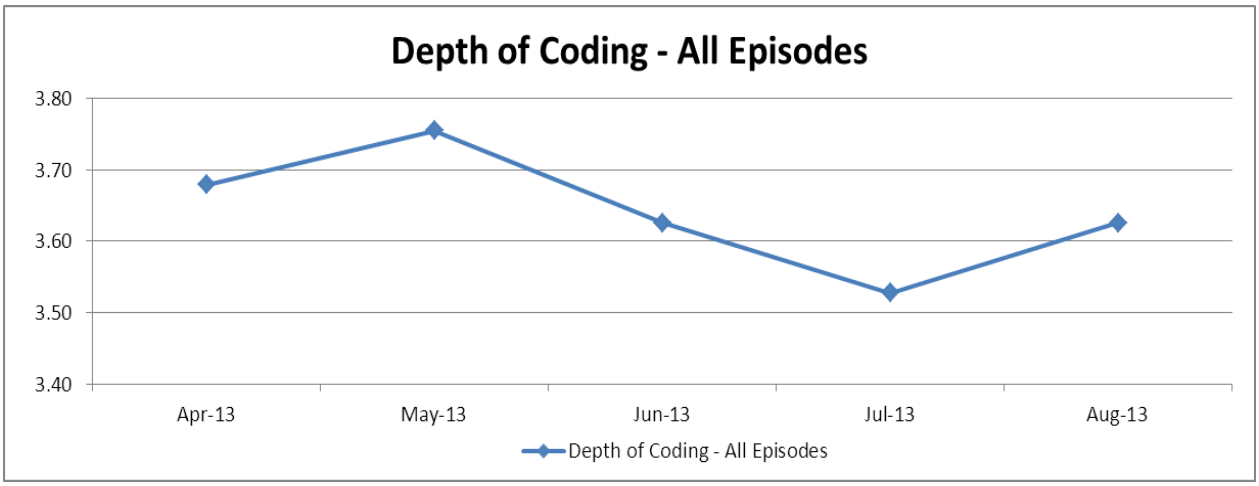
The majority of deaths would be associated with non-elective admissions, reviewing this cohort and excluding the community ward identifies that contrasted with the same peers from above, NGH is lower than the peer's average value of 3.1%



Depth of Coding

The depth of coding is the average number of diagnosis codes per episode of care. Each additional diagnosis code can be termed a co-morbidity.

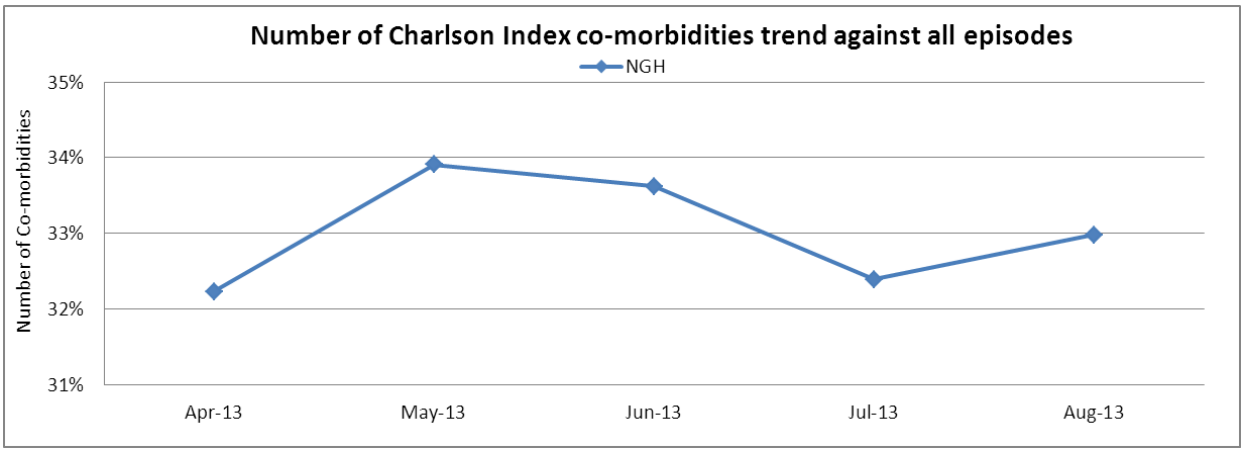
Though not a measure of coding accuracy overall, a higher depth of coding tends to suggest an adequate level of conditions and co-morbidities are being captured which may then be reflected within mortality indicators such as HSMR and SHMI; the greater the depth of coding would potentially more accurately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



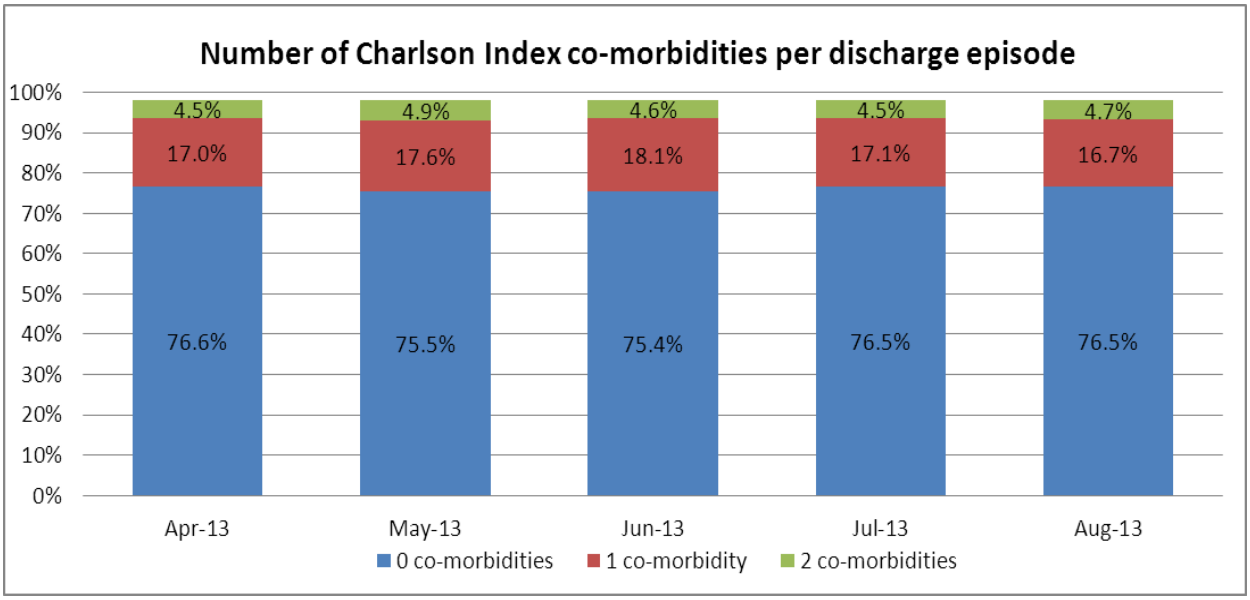
A review of some other trusts’ depth of coding levels would suggest that NGH is slightly low; with these trusts showing an average in the region of 4 ,but as with the other trusts, as well as Nationally, an increase in the depth of coding is noted over the past 5 months. Again, care is required when 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 a stable figure of around 33%.



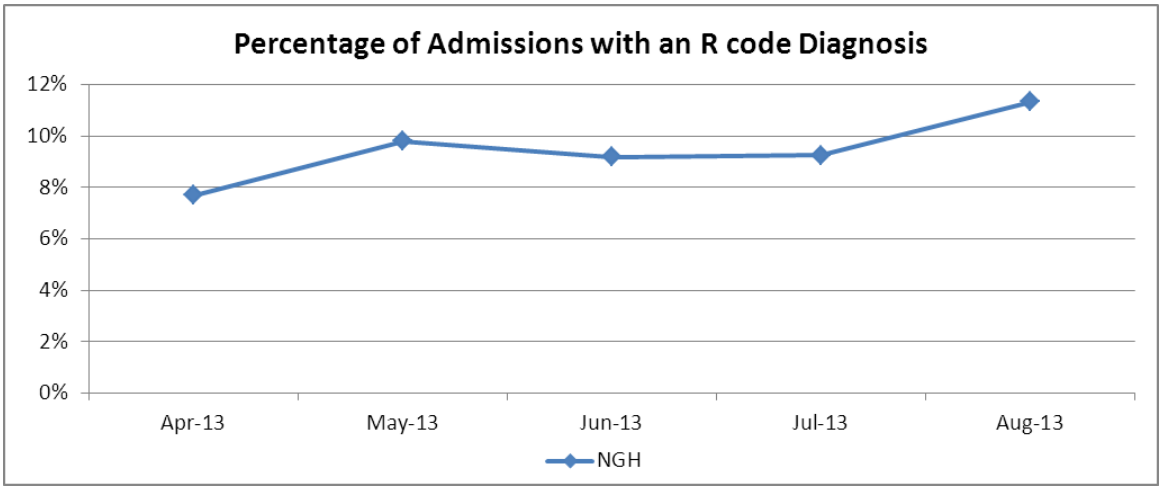
A further analysis of the data identifies that an average of 76% have none of the specific co-morbidities recorded against them with 17% having one comorbidity these figures are relatively consistent across the months. The Charlson Index is a little lower than the national average.



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.

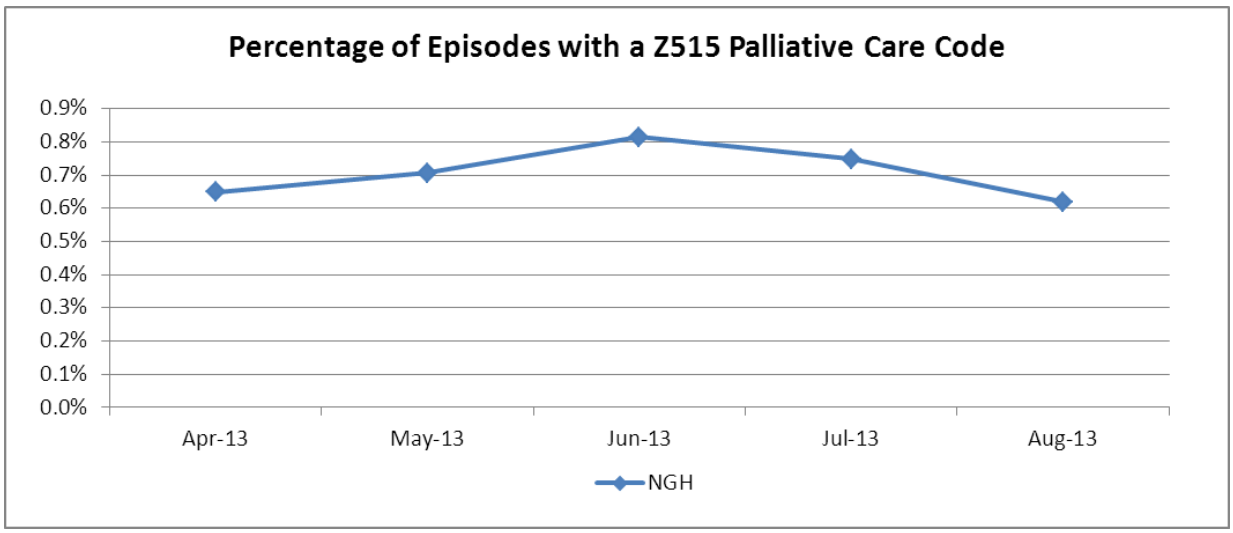


The chart above shows an increase from 7.7% up to 11.3% over the past 5 months. A review of other hospitals shows that they have made significant improvements in their levels over the past 8 months, dropping from 12% down to 3% in May 2013. This reflects the work that was carried out with Clinicians by Clinical Coding.

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.

Palliative Care Coding

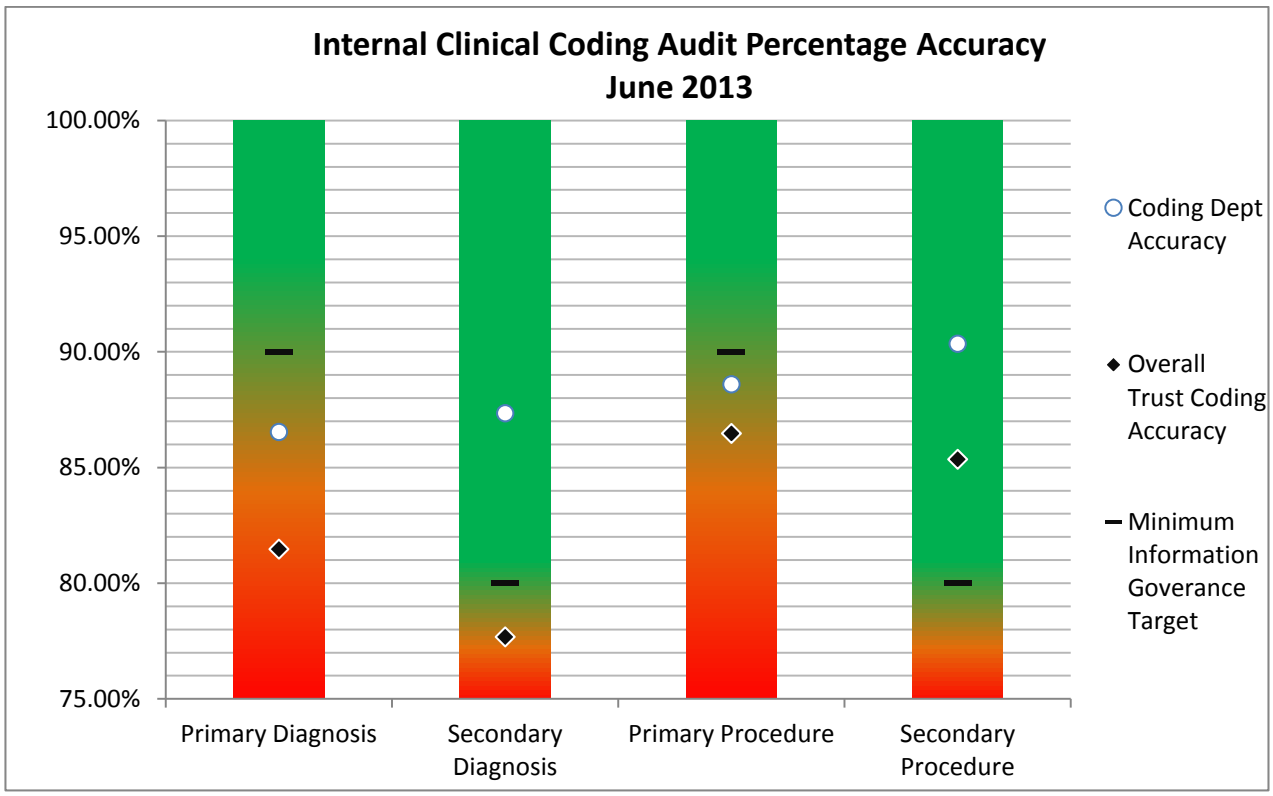
The recording and coding of palliative care (Z515) for appropriate patients, although not affecting the SHMI score, is used to adjust the Dr Foster HSMR statistic as the deaths are expected.



The figures shown above are comparable with the peer group of 12 trusts used by Scunthorpe & Goole Hospitals but below the national rate for those diagnoses included in HSMR.

Internal Clinical Coding Audit

At present, each individual coder is audited on a bi-monthly basis. The last full round of internal audits was completed in June 2013. August 2013 was completed in an alternative shorter format due to departmental pressures being faced. The next complete set of results is expected in early October.



The results for June 2013 show the trust performing under expected information governance levels for each category other than secondary procedure coding.

Coding department accuracy reflects individual accuracy based on the source information provided to the coder. Trust coding accuracy takes into account the deficiencies in the source documentation and flow of information through to the department, beyond the control of the coder. This will commonly be lower as it is a more comprehensive representation.

Key findings reported by the Coding Auditor were:

- There were a number of secondary diagnosis (co-morbidity) codes not coded because they were not in the source documentation given to the coder. Namely, where notes were unavailable for coding, the electronic discharge note did not include the diagnosis codes that were documented in the notes.

- A number of primary diagnosis errors were found to be repeated mistakes. Feedback should correct those mistakes. This is an important influence in terms of mortality ratios

- The level of accuracy in secondary procedure coding was excellent.

Sean McGarvey and Ben Greasley September 2013

Medical Director's Quality Report

Appendix 2. Nurse to bed ratio by ward

The figures below include both qualified and unqualified nursing staff that worked on the ward, the focus is on acute wards therefore maternity and community wards have been excluded.

The colour coding was derived by looking at the National Quality dashboard and selecting a medium Acute Trust in the Midlands & East as a bench mark. This gave an average figure of 1.49. The colour coding is green within 5% of this bench mark, amber for between 5% and < 10% and red for 10% and above difference.

Nurse to Bed Ratio

Ward	Apr-13	May-13	Jun-13	Jul-13	Aug-13
ABINGTON WARD	1.3	1.3	1.3	1.2	1.2
ALLEBONE WARD	1.3	1.2	1.2	1.4	1.4
ALTHORP (T&O)	1.8	1.7	1.7	1.5	1.5
BECKET WARD	1.6	1.7	1.8	1.8	1.8
BENHAM (ASSESS UNIT)	1.5	1.5	1.5	1.5	1.5
BRAMPTON WARD	1.2	1.1	1.2	1.2	1.3
CEDAR	1.1	1.3	1.3	1.2	1.3
COMPTON WARD	1.4	1.7	1.5	1.4	1.4
CREATON WARD	1.5	1.4	1.4	1.4	1.5
DISNEY WARD	1.4	1.3	1.4	1.3	1.4
DRYDEN WARD	1.4	1.3	1.3	1.3	1.2
EAU - NEW	1.9	1.9	1.8	1.9	1.8
ELEANOR WARD	1.7	1.8	1.8	1.8	1.8
FINEDON WARD	1.3	2.1	2.0	2.1	2.0
GOSSET WARD	1.8	1.9	1.8	1.8	1.8
HAWTHORN & SAU	1.8	1.8	1.9	1.9	1.8
HEAD & NECK WARD	1.9	1.7	1.9	2.0	2.0
KNIGHTLY WARD	1.4	1.4	1.4	1.2	1.3
PADDINGTON WARD	1.5	1.5	1.5	1.5	1.5
ROWAN (LSSD)	1.2	1.3	1.3	1.2	1.2
SPENCER WARD	1.7	1.6	1.6	1.5	1.5
TALBOT BUTLER WARD	1.6	1.6	1.7	1.7	1.6
VICTORIA WARD	1.3	1.5	1.4	1.6	1.5
WILLOW (+ LEVEL 1)	1.6	1.6	1.7	1.6	1.6

The tables over the page identify the percentage of the workforce on each ward which was made up of either Agency or Bank staff. With a further table showing the split between Bank and Agency as a percentage of the total staffing by ward; this could affect the quality of care delivered.

The percentage usage of Bank and Agency staff for the trust across the acute wards showed an average of 12.6%; the split identifies that an average of 9.5% Bank staff and 3.1% Agency staff are used.

Bank & Agency use across the trust

	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Trust	13.5%	12.6%	12.1%	11.8%	13.0%

Bank & Agency use by Ward

Ward	Apr-13	May-13	Jun-13	Jul-13	Aug-13
ABINGTON WARD	9%	8%	8%	11%	13%
ALLEBONE WARD	18%	18%	19%	29%	30%
ALTHORP (T&O)	8%	4%	8%	3%	3%
BECKET WARD	12%	7%	6%	3%	4%
BENHAM (ASSESS UNIT)	24%	15%	15%	13%	17%
BRAMPTON WARD	12%	9%	14%	10%	19%
CEDAR	11%	18%	19%	15%	21%
COMPTON WARD	11%	7%	3%	3%	2%
CREATON WARD	26%	31%	23%	20%	21%
DISNEY WARD	1%	2%	2%	1%	2%
DRYDEN WARD	11%	11%	10%	8%	9%
EAU - NEW	14%	16%	19%	23%	17%
ELEANOR WARD	14%	8%	9%	9%	11%
FINEDON WARD	14%	7%	6%	8%	6%
GOSSET WARD	1%	1%	2%	3%	5%
HAWTHORN & SAU	18%	17%	14%	15%	15%
HEAD & NECK WARD	16%	9%	8%	8%	11%
KNIGHTLY WARD	13%	12%	8%	6%	19%
PADDINGTON WARD	13%	18%	20%	20%	18%
ROWAN (LSSD)	13%	15%	11%	8%	9%
SPENCER WARD	14%	5%	6%	2%	6%
TALBOT BUTLER WARD	18%	16%	13%	14%	13%
VICTORIA WARD	21%	31%	31%	23%	22%
WILLOW (+ LEVEL 1)	9%	10%	10%	10%	8%

Bank & Agency use by Ward

Ward	Apr-13		May-13		Jun-13		Jul-13		Aug-13	
	Bank	Agency	Bank	Agency	Bank	Agency	Bank	Agency	Bank	Agency
ABINGTON WARD	7%	2%	6%	2%	7%	0%	10%	1%	13%	0%
ALLEBONE WARD	9%	9%	14%	4%	14%	6%	15%	14%	15%	15%
ALTHORP (T&O)	5%	3%	4%	0%	6%	2%	3%	0%	3%	0%
BECKET WARD	6%	6%	6%	1%	4%	2%	2%	1%	2%	1%
BENHAM (ASSESS UNIT)	14%	9%	11%	3%	9%	5%	10%	3%	10%	7%
BRAMPTON WARD	11%	2%	9%	0%	14%	0%	10%	0%	19%	1%
CEDAR	9%	2%	16%	2%	15%	4%	14%	1%	17%	4%
COMPTON WARD	8%	3%	7%	0%	3%	0%	3%	0%	2%	0%
CREATON WARD	17%	9%	24%	7%	16%	6%	15%	5%	16%	5%
DISNEY WARD	0%	1%	0%	2%	0%	2%	1%	1%	2%	1%
DRYDEN WARD	4%	7%	8%	3%	8%	2%	5%	3%	8%	1%
EAU - NEW	11%	4%	14%	3%	14%	5%	16%	7%	11%	5%
ELEANOR WARD	8%	6%	7%	1%	6%	3%	9%	0%	9%	2%
FINEDON WARD	12%	2%	7%	0%	5%	1%	7%	1%	6%	0%
GOSSET WARD	1%	0%	1%	0%	2%	0%	3%	0%	5%	0%
HAWTHORN & SAU	15%	3%	16%	1%	14%	1%	15%	0%	14%	1%
HEAD & NECK WARD	13%	3%	8%	1%	8%	0%	8%	0%	11%	0%
KNIGHTLY WARD	10%	4%	11%	1%	7%	1%	6%	0%	15%	4%
PADDINGTON WARD	3%	10%	4%	14%	4%	16%	5%	15%	7%	10%
ROWAN (LSSD)	9%	4%	13%	2%	9%	1%	8%	0%	9%	1%
SPENCER WARD	7%	7%	3%	1%	4%	2%	2%	0%	5%	1%
TALBOT BUTLER WARD	18%	0%	15%	0%	13%	0%	14%	0%	13%	0%
VICTORIA WARD	14%	7%	25%	6%	27%	4%	23%	0%	21%	2%
WILLOW (+ LEVEL 1)	8%	2%	7%	2%	8%	2%	7%	3%	5%	3%

Bank & Agency use by Ward

Ward	Apr-13		May-13		Jun-13		Jul-13		Aug-13	
	Bank	Agency	Bank	Agency	Bank	Agency	Bank	Agency	Bank	Agency
ABINGTON WARD	7%	2%	6%	2%	7%	0%	10%	1%	13%	0%
ALLEBONE WARD	9%	9%	14%	4%	14%	6%	15%	14%	15%	15%
ALTHORP (T&O)	5%	3%	4%	0%	6%	2%	3%	0%	3%	0%
BECKET WARD	6%	6%	6%	1%	4%	2%	2%	1%	2%	1%
BENHAM (ASSESS UNIT)	14%	9%	11%	3%	9%	5%	10%	3%	10%	7%
BRAMPTON WARD	11%	2%	9%	0%	14%	0%	10%	0%	19%	1%
CEDAR	9%	2%	16%	2%	15%	4%	14%	1%	17%	4%
COMPTON WARD	8%	3%	7%	0%	3%	0%	3%	0%	2%	0%
CREATON WARD	17%	9%	24%	7%	16%	6%	15%	5%	16%	5%
DISNEY WARD	0%	1%	0%	2%	0%	2%	1%	1%	2%	1%
DRYDEN WARD	4%	7%	8%	3%	8%	2%	5%	3%	8%	1%
EAU - NEW	11%	4%	14%	3%	14%	5%	16%	7%	11%	5%
ELEANOR WARD	8%	6%	7%	1%	6%	3%	9%	0%	9%	2%
FINEDON WARD	12%	2%	7%	0%	5%	1%	7%	1%	6%	0%
GOSSET WARD	1%	0%	1%	0%	2%	0%	3%	0%	5%	0%
HAWTHORN & SAU	15%	3%	16%	1%	14%	1%	15%	0%	14%	1%
HEAD & NECK WARD	13%	3%	8%	1%	8%	0%	8%	0%	11%	0%
KNIGHTLY WARD	10%	4%	11%	1%	7%	1%	6%	0%	15%	4%
PADDINGTON WARD	3%	10%	4%	14%	4%	16%	5%	15%	7%	10%
ROWAN (LSSD)	9%	4%	13%	2%	9%	1%	8%	0%	9%	1%
SPENCER WARD	7%	7%	3%	1%	4%	2%	2%	0%	5%	1%
TALBOT BUTLER WARD	18%	0%	15%	0%	13%	0%	14%	0%	13%	0%
VICTORIA WARD	14%	7%	25%	6%	27%	4%	23%	0%	21%	2%
WILLOW (+ LEVEL 1)	8%	2%	7%	2%	8%	2%	7%	3%	5%	3%

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD / COMMITTEE
23 September 2013

Title	Patient Experience Report
Agenda item	7
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Anil Garcia - Interim Patient Experience Lead 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**

Actions required by the Board

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

Trust Board
23 September 2013
Patient Experience Report

1. Introduction

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

1.1 The Patient Experience Strategy

Following the appointment of the substantive patient experience lead who commenced in post on the 9th September, the review of the timescales will be undertaken and reported on in Octobers board report. In addition the contents of this report will be reviewed and a new look report presented.

1.2 Current Patient Experience Activities

- **15 Step Challenge**
  The 15 step challenge model has been revised to include greater emphasis on patient safety and a review undertaken across all ward areas. This was lead by the Director of Nursing. More detail regarding this process is provided in the safeguarding report. A summary report of the key findings will be circulated shortly and attached to the next patient experience report.

- **Goldfish bowl events**
  A modified pilot goldfish bowl session was held within Maternity in August. This involved the PALS manager reading out two patient accounts of experience and then leading a discussion and analysis of how the staff felt hearing the stories and what could have been done differently to affect the outcome. The session was very well reviewed and resulted in a lot of animated discussion.

  A key outcome was a review of those areas identified as stressful to staff – e.g. visiting restrictions and an analysis of how this could be addressed. First and foremost this centred around owning the polices rather than blaming the system, identifying a more comfortable approach and then agreeing how to make the changes.

  Visiting restrictions are often cited as an issue for patients so a review of comments in 3 months time may be useful to ascertain any changes.

  The use of patient experience accounts is now to be used at all monthly maternity meetings where possible. The matron has been asked to collate feedback from the staff who attended the first session into how the session has informed practice.

- **Volunteer audits and observational studies**
  Audit questions are in development to support the Patient & Public Involvement (PPI) volunteer group to undertake observational studies and patient interviews in relation to Noise at Night and Protected Mealtimes, in order to ascertain what the issues are. Previous audits have not had an impact on improving the patient experience as reported in the National Inpatient Survey. This work is continuing with audits expected to commence in October.

- **Further activities**
  Mapping current patient experience activities against the NICE guidelines
  The Patient Experience Lead and the Workforce development Lead are mapping the NICE guidelines in relation to current Patient experience activity to identify priority activities. This work is being led by the Assistant Director of Workforce Development,

1.3 Friends and Family Test

The FFT response rate for **In Patients and A&E** received for the month of **August 2013 was a very disappointing: 9.7%** and came on the back of a very positive 16.93% in July.

Data shows a decline in completion across both inpatient areas and A&E – although the inpatient areas response rate remained above the target set for August - 24.61% in July to 16.52% in August against a target of 16.4%

With A&E – response rates declined from 12.87% in July to 6.23% in August. Although A&E and Eye Casualty data is reported in combination the causes of the low responses rates are specific to each area. Discussion with the A&E Matron cites the reduction in response rates as a result of poor staff engagement. As a result, the following actions are being taken by A/E to enhance future response rates:

- Matron has held 1:1's with Band 2's and 5's, 7's and 8's re FFT requirements
- Response rate data is to be reviewed on a shift by shift basis – to enable oversight of individual staff response rates, and where necessary individuals will be challenged
- The Patient Experience Lead is to be given log in details to enable weekly oversight of response rates
- A&E staff – Governance lead and Matron to keep in touch with the Patient Experience Lead about all FFT issues, updates and planned activities.

Eye Casualty:

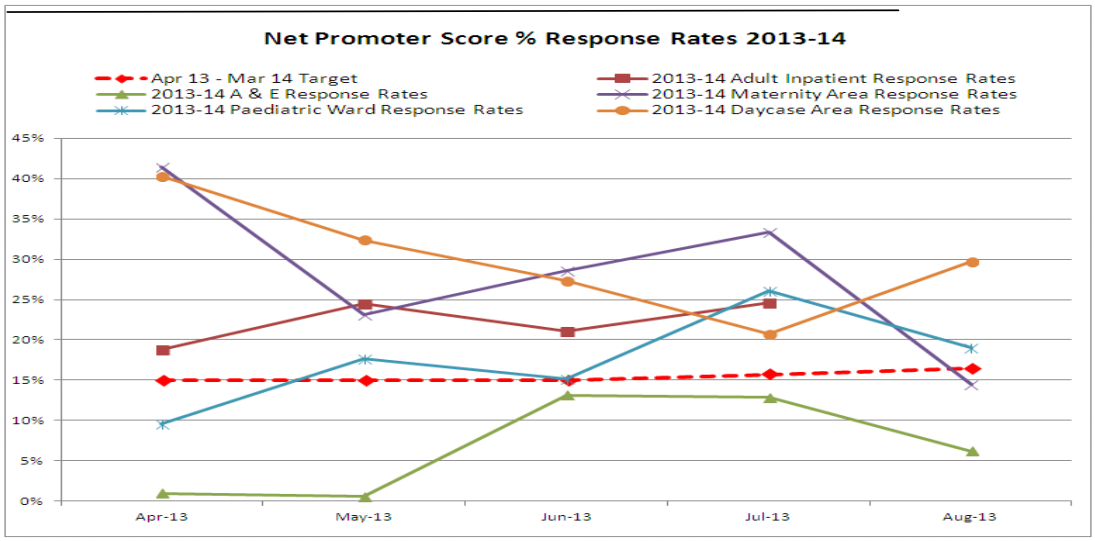
Over the month of August, Volunteers have been undertaking sessions within Eye Casualty to increase response rates. They have been asking people on discharge to complete / answer the FFT question. This has not improved response rates; in fact there has been a dip in the responses possibly due to staff relying on the volunteers capturing the data. As a result, the following actions are being taken:

- Moving away from volunteers covering hour slots, and use Health Watch to base themselves in the department for a morning or afternoon. This approach worked successfully within Radiology.
- Costing the feasibility of installing a token system to collect responses within the Dept. Ipads and forms are not accessible enough for this client group. Previous costs from Estates department are in region of £650 +VAT for the token system
- Working party being set up by Ian Beattie, Service Manager to discuss this – Patient Experience Lead to attend

Details of individual ward response rates can be found in **Appendix 1.** Results below show the scores for June 2013 in those areas now being reported nationally.

Satisfaction Levels

It is important to note when looking at the figures that whilst response rates are below target and clearly not acceptable, when looking at the data and considering the Extremely likely and likely satisfaction ratings in combination – in August 96% of patients reported that they were happy with inpatient care and 94% of A&E attendees.



Graph 1: FFT Score % Response Rates 2013-14

	Q1			Q2		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%	15.7%	16.4%	17.2%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	

Table 1: FFT activity and Scores - CQUIN Target

1.6 Extension to the current FFT data collection

FFT Maternity roll out starts in October 2013. Data collection will be via pre paid questionnaire, distributed by midwifery staff at the three target points.

1.7 EAU and Benham Feedback

Since May of this year there have been 3 comments received from patients in relation to Benham ward. 1 of these comments was negative and related to delayed discharge and in particular waits for medication. This is a theme across the trust with a work stream set up to

identify changes to the ward round process and earlier completion of the electronic discharge notice.

Since May of this year 3 comments have been received in relation to EAU – all of these have spoken positively about the service received.

1.8 Oversight of the Patient experience.

Trend analysis:
FFT comments are uploaded onto Datix to enable themes to be reviewed in comparison with other accounts of patient experience e.g. Complaints / PALS. A meeting is to be held on the 17th September with the governance team, PALS and complaints to review the process behind reviewing all these information sources, with the aim of triangulating them to provide more meaningful data for the Directorates and Care Groups.

1.9 The Patient Experience Dashboard.

All clinical teams have been contacted to request:

1. Indication of any national and local survey going to within their area that captures **any patient experience feedback.**
2. To forward any reports / proposals and or action plans to Patient Experience Lead (PEL) by the 20th September
3. PEL to collate Patient Experience questions and responses
4. PEL to analyse and identify key themes
5. To be discussed at the Metrics Task and Finish group arranged for October to agree next steps in relation to issues raised.

1.7 Conclusions

The Patient Experience activity continues to grow across the trust with the integration between the Dignity and Patient Experience agenda and the identification of Patient Experience Champions. The link between the Patient Safety leads and the Patient Experience Agenda is currently being defined with the proposal that the Patient Safety leads undertake ward based audits in relation to areas of lower scores evidenced within the inpatient survey.

2. Assessment of Risk

The low FFT response rate has resulted in the trust failing to meet the CQUIN target for quarter 1, which means a loss of income of £40k. This remains a risk until the issues within A&E and Eye Casualty are addressed. The next CQUIN target is to achieve 20% by quarter 4.

3. Recommendations/Resolutions Required

Note the issues identified and where requested provide support.

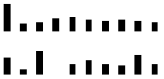
4. Next Steps

Once all patient experience data sources are known, the Metrics Group will be able to review the data, theme it and identify the key areas which need to be incorporated into future reports. This work is really important, as is the triangulation of patient experience data with complaints, compliments and incidents.

APPENDIX 1 - Friends & Family RAG rating shown related to previous target of 80%

Friend & Family Net Promoter Score - Period: 1st - 31st August 2013

	Total responses in each category for each ward								Aug 2013 Target = 16.4%	Target yet to be agreed
Ward / area name (Inpatient discharges aged 16yr and over)	**Extremely Likely**	**Likely**	**Neither likely or unlikely**	**Unlikely**	**Extremely unlikely**	**Don't Know**	**Total no. of people eligible to respond (discharged)**	**Total responses for each ward**	**Response rate for each ward**	**Score for each ward / area**
ABINGTON WARD	2	2	0	1	0	1	51	6	11.76%	20
ALLEBONE WARD	2	2	2	1	0	1	56	8	14.29%	-14
ALTHORP WARD	35	4	1	0	1	0	69	41	59.42%	80
ANAESTHETICS DAY CARE WARD	0	0	0	0	0	0	1	0	0.00%	
BECKET WARD	12	0	0	0	0	0	69	12	17.39%	100
BENHAM WARD	19	9	0	0	1	1	205	30	14.63%	62
BRAMPTON WARD	9	2	0	0	0	0	32	11	34.38%	82
CEDAR WARD	11	3	1	0	3	0	101	18	17.82%	39
CLIFTONVILLE WARD	0	0	0	0	0	0	29	0	0.00%	
COLLINGTREE	15	4	0	0	0	0	92	19	20.65%	79
COMPTON WARD	4	8	0	0	0	0	12	12	100.00%	33
CORBY COMMUNITY	2	3	0	0	0	0	19	5	26.32%	40
CREATON WARD	2	1	0	0	0	1	63	4	6.35%	67
DANETRE WARD	5	1	0	0	0	0	38	6	15.79%	83
DAY SURGERY	0	0	0	0	0	0	47	0	0.00%	
DISNEY WARD	0	0	0	0	0	0	9	0	0.00%	
DRYDEN WARD	1	3	0	0	0	1	117	5	4.27%	25
ELEANOR WARD	16	5	1	0	0	0	64	22	34.38%	68
EMERGENCY ASSESSMENT UNIT	16	5	0	0	0	0	269	21	7.81%	76
EMERGENCY OBSERVATION AREA	0	0	0	0	0	0	123	0	0.00%	
ENDOSCOPY UNIT	0	0	0	0	0	0	5	0	0.00%	
FINEDON WARD	9	5	0	0	1	1	51	16	31.37%	53
GYNAECOLOGY DAY CARE	0	0	0	0	0	0	10	0	0.00%	
HAWTHORN WARD	41	10	1	2	1	1	216	56	25.93%	67
HAZELWOOD WARD, ISEBROOK HOSP	7	4	0	0	0	0	19	11	57.89%	64
HEAD AND NECK WARD	20	1	0	0	0	0	103	21	20.39%	95
HIGH DEPENDENCY UNIT	0	0	0	0	0	0	12	0	0.00%	
HOLCOT STROKE UNIT	6	4	0	0	0	0	20	10	50.00%	60
INTENSIVE THERAPY UNIT	0	0	0	0	0	0	9	0	0.00%	
KNIGHTLEY WARD	8	0	0	0	0	0	43	8	18.60%	100
MAIN THEATRES ADMISSIONS	0	0	0	0	0	0	46	0	0.00%	
MANFIELD SURGERY UNIT	0	0	0	0	0	0	32	0	0.00%	
NORTHAMPTON HEART CENTRE	0	0	0	0	0	0	44	0	0.00%	
NORTHAMPTONSHIRE KIDNEY CENTRE	0	0	0	0	0	0	10	0	0.00%	
NUCLEAR MEDICINE	0	0	0	0	0	0	1	0	0.00%	
ORAL SURGERY DAY UNIT	0	0	0	0	0	0	4	0	0.00%	
PADDINGTON	0	0	0	0	0	0	10	0	0.00%	
PADDINGTON HIGH DEPENDENCY	0	0	0	0	0	0	1	0	0.00%	
RADIOTHERAPY DAY WARD	0	0	0	0	0	0	19	0	0.00%	
ROWAN WARD	21	3	0	0	0	0	175	24	13.71%	88
SINGLEHURST DAY CARE	0	0	0	0	0	0	9	0	0.00%	
SPENCER WARD	21	6	0	0	0	0	193	27	13.99%	78
TALBOT BUTLER WARD	32	7	0	0	0	0	108	39	36.11%	82
VICTORIA WARD	4	3	0	0	0	0	41	7	17.07%	57
WILLOW WARD	11	3	0	0	1	0	93	15	16.13%	67
X-RAY DAY CARE UNIT	0	0	0	0	0	0	9	0	0.00%	
Inpatient Ward Total	**331**	**98**	**6**	**4**	**8**	**7**	**2749**	**454**	16.52%	**70**
A & E UNIT	203	91	8	2	6	3	4745	313	6.60%	60
EYE CASUALTY	24	7	0	0	1	1	812	33	4.06%	72
Accident & Emergency Total	**227**	**98**	**8**	**2**	**7**	**4**	**5557**	**346**	6.23%	**61**
MATERNITY OBSERVATION WARD	0	0	0	0	0	0	77	0	0.00%	
ROBERT WATSON	26	24	1	1	1	2	303	55	18.15%	43
Maternity Ward Total	**26**	**24**	**1**	**1**	**1**	**2**	**380**	**55**	14.47%	**43**
Inpatient discharges aged under 16yrs										
DISNEY WARD	42	7	0	0	1	0	169	50	29.59%	82
PADDINGTON	24	13	0	2	1	0	294	40	13.61%	53
PADDINGTON HDU	0	0	0	0	0	0	11	0	0.00%	
Paediatric Ward Total	**66**	**20**	**0**	**2**	**2**	**0**	**474**	**90**	18.99%	**69**
DAVENTRY DAY SURGERY	33	3	0	0	0	3	82	39	47.56%	92
MAIN THEATRES ADMISSIONS	51	7	0	0	0	0	96	58	60.42%	88
DAY SURGERY UNIT	40	4	0	0	0	0	252	44	17.46%	91
SINGLEHURST DAY CARE	24	2	0	0	0	0	132	26	19.70%	92
Daycase Area Total	**148**	**16**	**0**	**0**	**0**	**3**	**562**	**167**	29.72%	**90**

Friends & Family Net Promoter Response Rates		Target 2012-13 = 10%					Target Q1 13-14 = 15%			Target 15.7%	Target 16.4%
Ward	Graph	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Abington		27.06%	43.42%	28.95%	37.50%	43.33%	25.00%	30.61%	27.03%	23.64%	11.76%
Allebone		18.97%	16.05%	38.46%	28.57%	22.83%	51.02%	32.98%	23.75%	25.40%	14.29%
Althorp		111.76%	36.84%	31.94%	31.76%	43.00%	54.84%	33.33%	32.93%	70.21%	59.42%
Becket		19.18%	36.96%	21.88%	31.08%	32.08%	40.43%	43.28%	42.65%	37.97%	17.39%
Benham		10.99%	13.11%	8.91%	30.18%	7.91%	12.00%	21.43%	19.41%	23.94%	14.63%
Brampton		34.38%	23.81%	44.12%	41.94%	67.86%	37.84%	40.00%	9.38%	38.89%	34.38%
Cedar		18.28%	29.47%	36.36%	28.57%	25.71%	19.18%	10.34%	7.55%	34.12%	17.82%
Collingtree Medical		18.64%	8.66%	0.0%	20.19%	13.56%	7.06%	37.33%	28.46%	25.83%	20.65%
Compton			77.27%	91.30%	111.11%	77.78%	80.00%	156.25%	84.21%	106.67%	100.00%
Corby Comm.		0%	71.43%	50.00%	0.00%	30.00%	0.00%	9.52%	39.13%	92.86%	26.32%
Creaton		7.41%	16%	32.35%	33.33%	21.05%	7.81%	18.07%	16.67%	11.25%	6.35%
Danetre		0%	0%	57.14%	34.62%	39.53%	39.47%	54.29%	24.24%	43.93%	15.79%
Dryden		16.36%	29.41%	2.38%	27.03%	24.79%	28.32%	19.67%	2.15%	9.65%	4.27%
Eleanor		21.62%	17.91%	16.67%	36.36%	21.74%	38.10%	51.11%	29.31%	44.07%	34.38%
EAU		5.86%	8.40%	13.16%	4.66%	3.15%	14.45%	26.77%	22.79%	11.00%	7.82%
Finedon		37.25%	38.89%	36.21%	29.17%	21.62%	31.25%	46.51%	22.92%	57.89%	31.37%
Hawthorn		75.28%	21.97%	25.47%	36.61%	37.68%	33.85%	30.04%	33.02%	27.78%	25.93%
Hazelwood Comm.		93.75%	25.00%	127.78%	0.00%	60.71%	77.78%	60.00%	50.00%	105.56%	57.89%
Head & Neck		9.38%	19.20%	33.33%	45.45%	40.46%	17.48%	29.81%	38.32%	31.30%	20.39%
Holcot		54.84%	21.21%	68.75%	75.00%	53.57%	83.33%	54.55%	68.75%	72.73%	50.00%
Knightley		53.85%	37.50%	26.67%	31.82%	52.17%	25.64%	40.38%	43.64%	59.57%	100.00%
Rowan		25.95%	24.85%	34.62%	45.56%	32.84%	16.15%	18.18%	13.48%	24.71%	13.71%
Spencer		18.75%	8.04%	21.70%	13.07%	12.79%	10.73%	15.86%	15.30%	15.43%	13.99%
Talbot Butler		23.91%	12.31%	30.56%	10.64%	12.00%	8.93%	26.42%	24.75%	47.52%	36.11%
Victoria			9.88%	23.91%	4.00%	10.45%	15.07%	17.31%	6.98%	34.92%	17.07%
Willow		41.11%	21.33%	29.51%	22.99%	21.30%	11.11%	27.37%	28.95%	11.46%	16.13%
Adult Inpatient Area Total		15.01%	14.77%	16.45%	19.00%	15.15%	18.78%	24.53%	21.13%	24.61%	16.52%
Accident & Emergency Unit		Recorded from January 2013		0.54%	1.75%	0.48%	1.02%	0.25%	15.22%	13.49%	6.60%
Eye Casualty Unit		Recorded from April 2013					0.72%	2.38%	1.04%	9.23%	4.06%
Accident & Emergency Total		Recorded from April 2013					0.97%	0.57%	13.16%	12.87%	6.23%
Balmoral		51.85%	65.69%	55.87%	46.15%	37.34%	54.59%	60.82%	Closed	Closed	Closed
Maternity Observation Ward		Recorded from June 2013							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%
Maternity Ward Total		Previously included within Inpatient Area Total					41.42%	23.08%	28.57%	33.33%	14.47%
Disney		19.16%	16.26%	16.55%	29.48%	10.13%	17.46%	32.66%	24.74%	35.82%	29.59%

Paddington	9.95%	7.94%	8.67%	13.30%	9.79%	5.88%	10.41%	10.57%	21.23%	13.61%
Paddington HDU	Recorded from July 2013								9.09%	0.00%
Paediatric Ward Total	Previously included within Inpatient Area Total					9.55%	17.65%	15.14%	26.09%	18.99%
Danetre Day Surgery	Recorded from January 2013	66.67%	54.64%	30.88%		50.00%	60.64%	29.25%	34.19%	47.55%
Main Theatre Admissions	Recorded from February 2013		50.92%	50.00%		67.47%	52.42%	24.14%	17.28%	60.42%
NGH Day Surgery	Recorded from January 2013	38.86%	29.43%	12.43%		29.17%	28.62%	34.49%	23.20%	17.46%
Singlehurst Day Unit	Recorded from April 2013					2.44%	5.48%	9.93%	9.43%	19.70%
Daycase Area Total	Previously included within Inpatient Area Total					40.30%	32.40%	27.34%	20.70%	29.72%

REPORT TO THE TRUST BOARD
23 September 2013

Title	Monthly Infection Prevention Performance Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Wendy Foster, Specialist Infection Prevention Practitioner
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the months of July and August 2013.
Executive summary A monthly update on reportable Healthcare associated infections (HCAIs) and review of incidents and trend analysis of HCAIs is paramount to improving learning, patient safety and quality of care and also impacts on staff safety and wellbeing. The rate of C.diff is rising significantly, which puts the Trust's annual trajectory of 29 at risk.	
Related strategic aim and corporate objective	Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way Patient safety there will be no avoidable harm to patients from the healthcare they receive.
Risk and assurance	The Trust has an annual target of 29 C.diff cases and in the first 5 months of the year has sustained 17 cases. There will be significant fines if the Trust exceeds 29 for the year, putting the Trust financial position at risk.
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No**
Legal implications / regulatory requirements	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections.(DH 2008)

Actions required by the Board

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

Trust Board
2013
July, August 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.

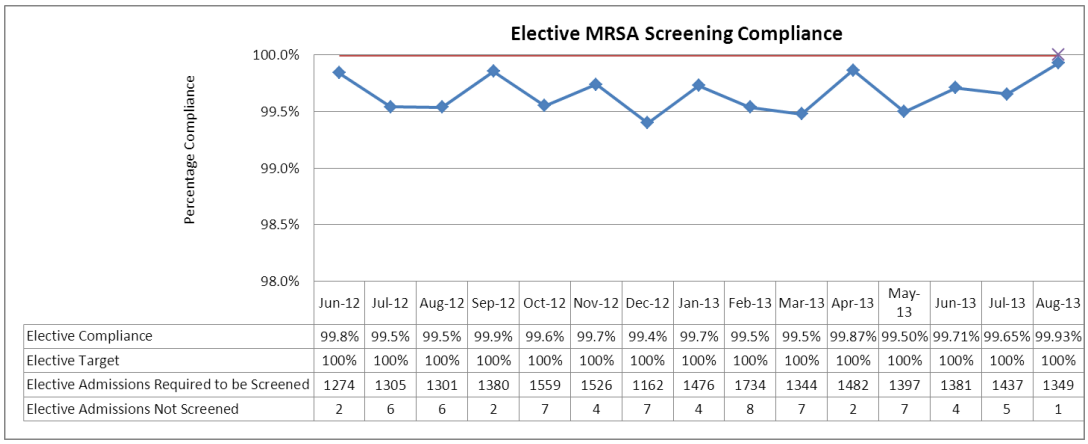
2. Report

2.1 MRSA Bacteraemia (July, August)

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

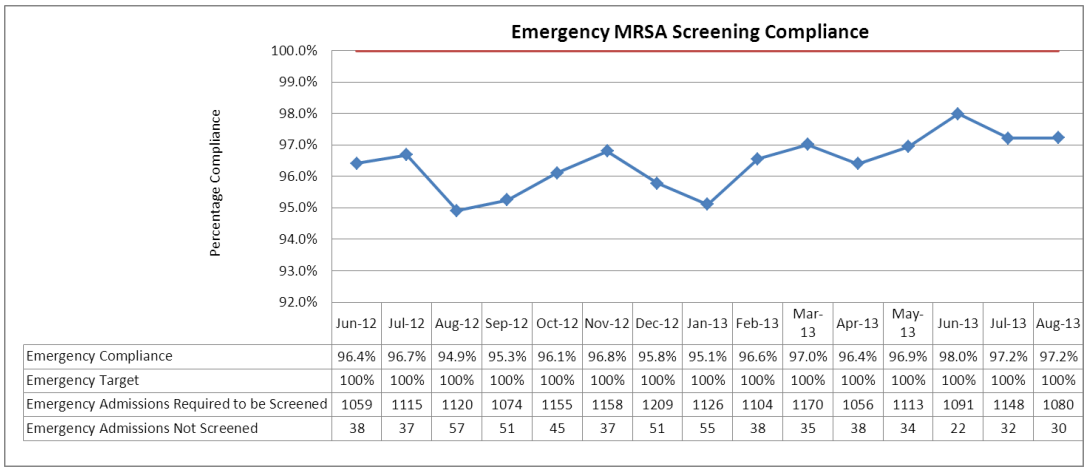
	MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
July	0	2	99.65%	97.2%	0	1
August	0	0	99.93%	97.2%	0	0

Elective MRSA screening compliance



	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Elective Compliance	99.8%	99.5%	99.5%	99.9%	99.6%	99.7%	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%	99.71%	99.65%	99.93%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1274	1305	1301	1380	1559	1526	1162	1476	1734	1344	1482	1397	1381	1437	1349
Elective Admissions Not Screened	2	6	6	2	7	4	7	4	8	7	2	7	4	5	1

Emergency MRSA screening compliance



	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Emergency Compliance	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%	98.0%	97.2%	97.2%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1059	1115	1120	1074	1155	1158	1209	1126	1104	1170	1056	1113	1091	1148	1080
Emergency Admissions Not Screened	38	37	57	51	45	37	51	55	38	35	38	34	22	32	30

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

During July 2013 there were 4<48hrs and 1 **>48hrs** MSSA bacteraemia case
The RCA was undertaken and it was identified that the visual infusion phlebitis scores (VIP) which is a tool to enable early detection of line infection had not always been completed. Following the RCA actions have been put into place to rectify this.

During August 2013 there were 3<48 hours and 0 **>48 hours** MSSA bacteraemias

3. *Clostridium difficile*

The Trust has an annual target of 29 C. diff. cases or less for the financial year. During July 1 **>3 day case of *C. diff*** was identified against a monthly target of 3 for July of post 72 hours cases, which totalled 14 for the year. **No ward** needed to be put onto Special Measures during the month.

During August 3 **>3 day cases of *C.diff*** was identified against a monthly target of 1 for August of post 72 hours which totalled 17 for the year. No ward needed to be put on to special measures. However, as the table details below samples are still being inappropriately sent.

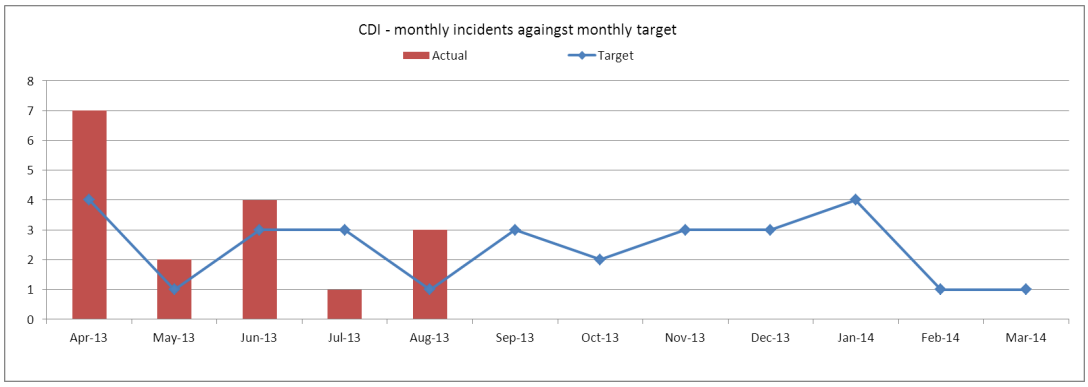
The Consultant microbiologist has sent out an email on behalf of the infection prevention team reiterating the importance of determining if the patient has infected diarrhoea. This has also gone as a text message to all junior doctors. The infection prevention team have sent a screen saver across the Trust utilising the acronym STOOL (Stop, Think, Observe, Odour and Liaise with the Senior nurse before sending a specimen). The IPT have also commenced *Clostridium difficile* focus week for any ward that has sent an inappropriate sample.

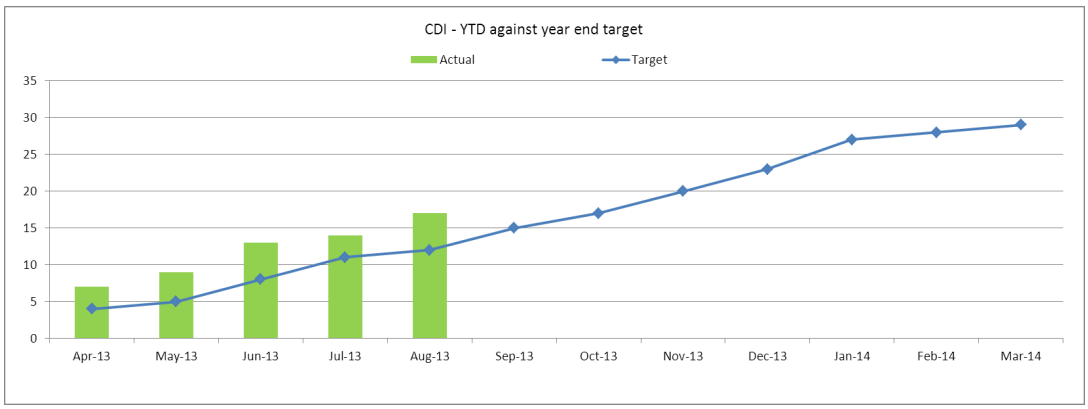
Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1
Total	**8**	**9**

Cdif Action Plan – (see attachment A)

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

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





4. *Escherichia coli* (*E.coli)*

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

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

During July there were 13<48hrs and **5 >48 hrs.**
During August there were 13< 48hours **and 7>48 hours**

The Infection Prevention Team with the Consultant Microbiologist investigate all >48 hours cases, to identify if there are any issues which need to be dealt with. Since July 2013 we have been undertaking Root Cause Analysis (RCA) on Hospital Acquired post 48 hours onset. We know that they are hospital acquired *Ecoli* bacteraemias and that they are commonly associated with Urinary tract infections, post-surgery, neutropenic sepsis, with these patients it can be impossible to demonstrate the source of infection.

Of the 8 RCA's to date that have been undertaken, 3 cases had no obvious lessons learnt. In 2 cases, although the bacteraemias could not have been avoided, there was poor documentation of blood culture practice. In a further 2 cases gentamicin prophylaxis on catheter insertion had not been considered. In a case of post transurethral resection of prostate (TURP) antibiotic prophylaxis had not been recorded on the anaesthetic chart and presumed therefore not to have been given. The RCA process enables findings to be identified and actioned.

5. Surgical Site Infection Surveillance Scheme (SSIS)

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

The patient is monitored from operation until discharge for up to 30 days following admission. When submitting the results to the Board, it should be noted that surveillance is still on-going, and therefore these are classed as **interim results**.

The **interim** results for July 2013:

- Repair of fractured neck of femurs (#NOF) show that there were ***no infections*** resulting from 20 operations in July 2013. August 2013, 28 operations showing ***no infections***

- Total Abdominal Hysterectomies show that there were ***no infections*** resulting from 22 operations in July 2013. August 2013, 21 operations showing ***no infections***

Update on Surgical Site Infection Surveillance:

September 2013: Althorp are piloting surgical site infection surveillance on hips and knees.

October 1st 2013 SSIS will be reported quarterly to the Public Health England (PHE)

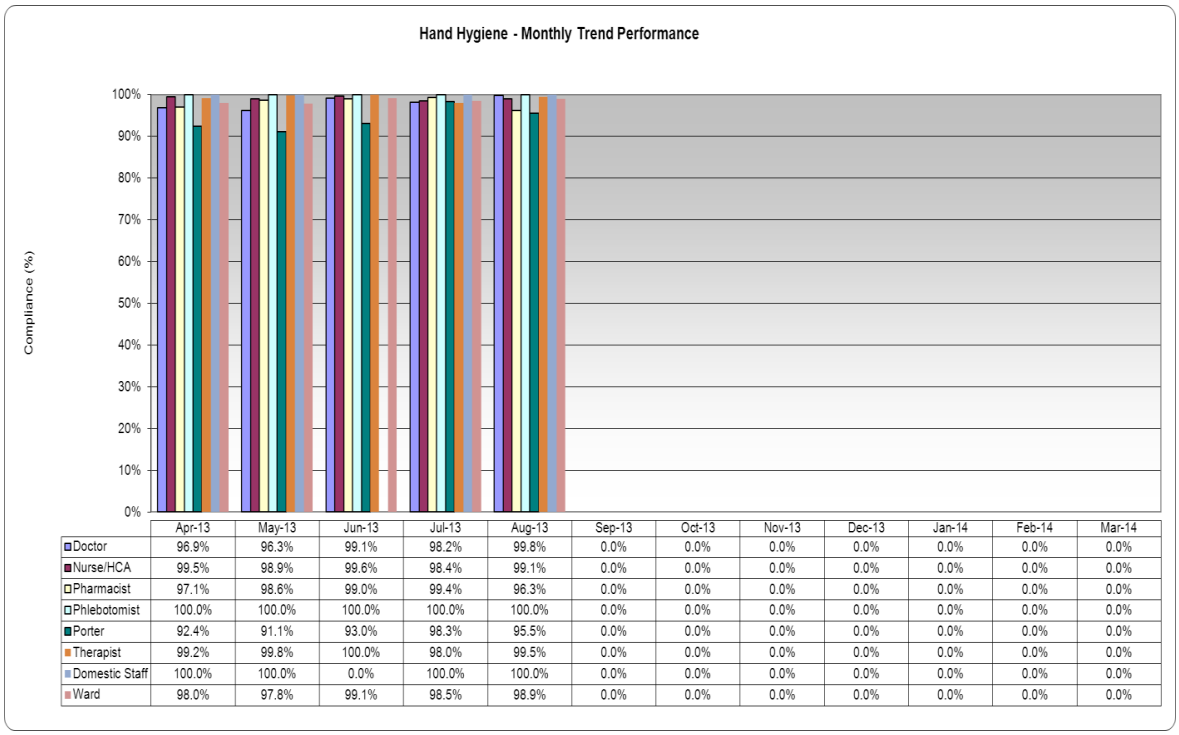
Therefore from October 1st 2013 SSIS will be continuous for both Hips and Knees.

Caesarean SSIS will commence October 2013 – December

6. Hand Hygiene Audit

The graph below demonstrates hand hygiene compliance in the ward areas is considerably higher than the overall Trust score. The score for this is July 2013, 98.5% and August, 98.9%.

To ensure that staff are submitting their hand hygiene observational audits on the correct date. Information management sent out communication across the organisation to inform that the Nursing Indicator dashboards will be locked at the end of the first working day of each month. Any data input after that point will not be included in any month end dashboards.



	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	99.5%	98.9%	99.6%	98.4%	99.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	97.1%	98.6%	99.0%	99.4%	96.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	92.4%	91.1%	93.0%	98.3%	95.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	99.2%	99.8%	100.0%	98.0%	99.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Domestic Staff	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ward	98.0%	97.8%	99.1%	98.5%	98.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

7. Assessment of Risk

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

8. Recommendations/Resolutions Required

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

9. Next Steps

The Infection Prevention Team will continue to work collaboratively across the Trust to keep levels of infection to a minimum, whilst focusing on ensuring that appropriate C. diff sampling is undertaken.

The Infection Prevention Team reviewed the Executive and Non -Executive walk arounds. This resulted following the *Stapyhlococcus aureus* Scalded Skin outbreak in maternity where learning occurred and it was evident that a new review of ward areas was required. This was presented to the board and at trust core brief.' Beat the Bug; Stop the Clot, save the Skin which also incorporates VTE and Pressure ulcers. These patient quality reviews have now commenced and the process will be reviewed in 6 months.

Theme	Action points	Lead/ Responsible Person (s)	Timescale	RAG	Review by	Review date
To reduce the number of post 72 hour Clostridium difficle cases External ceiling is **29** Actual total up to 9/9/13 2013 is **= 18**	Stop Think Ask before you send specimen formulated as screen saver and send to Jane Bradley	IPT	30th April 2013		IPCC	15th August 2013
	Continue to emphasise the 'appropriate sampling' slide in IP&C annual update for clinical staff which was inserted in July 2011.	IPT	Achieved at regular IP sessions.		IPCC	15th August 2013
	Laminated poster Stop Think Ask before you send the sample given to wards to place on the specimen pots container	IPT	30th April 2013		IPCC	15th August 2013
	Laminated poster Stop, Think Ask before you send a stool specimen poster emailed to ward mangers to be laminate and displayed by the macerator in the dirty utility room.	IPT	30th April 2013		IPCC	15th August 2013
	A cleaning section in April IP&C newsletter	IPT	April 2013		IPCC	15th August 2013
	Education sessions for nursing staff, engage IP link nurses as clinically based champions to ensure staff follow protocol and use of Isolation /stool chart and care bundle. Education needs to be based on patient 'real life' examples.	IPT	Achieved at regular IP sessions. Sessions held every 2 weeks.		IPCC	15th August 2013

	Action points	Lead/ Responsible Person (s)	Timescale	RAG	Review by	Review date
	Continue to promote excellent Hand Hygiene, including education and promotion of products	IPT	Ongoing		IPCC	15th August 2013
	Ward managers responsible for completing a Root Cause Analysis (RCA) providing evidence and action plan.	Ward manager	Within 2 weeks of the RCA.		IPCC	15th August 2013
	Weekly C.diffward round with IPNurse, Antimicrobial pharmacist, consultant microbiologist and cons gastroenterologist to review all symptomatic *Cdifficile* patients.	IPT	Weekly		IPCC	15th August 2013
	Protocol for antimicrobial prescribing poster currently being reviewed and updated. To be forwarded to all Consultants and to be laminated and displayed in the doctors area within the ward.	IPT /Antimicrobial pharmacist	1st May 2013		IPCC	15th August 2013
	Record of 'high risk' patients (antigen positive) to be documented in medical notes to assist doctors with appropriate antibiotic prescribing via infection prevention sticker. Ensuring antibiotics, laxatives and PPIs are reviewed and symptomatic patients are isolated	IPT	Within 24 hours of each confirmed case.		IPT	15th August 2013

	Action points	Lead/ Responsible Person (s)	Timescale	RAG	Review by	Review date
	No infection control surveillance system. In purchasing an infection control surveillance system (ICNet) the Trust would expect outcomes that would include better use of infection control resources leading to real improvements in healthcare associated infection rates. Unsuccessful for this year to relook for 2013/14	Gus Lusack	October 2013		IPCC	15th August 2013
	Prompts regarding appropriateness of sample collection to be embedded into the ICE requesting system when requesting stool specimens to reduce the risk of inappropriate samples being sent to Pathology	IPT	1st May 2013		IPCC	15th August 2013
	Prompts or laminates regarding the signs and symptoms of infective diarrhoea to be disseminated to all wards	IPT	1st May 2013		IPCC	15th August 2013
	"Before you send stool" specimen information emailed to the ward managers, bank office and modern matrons asking them to ensure all staff read and sign they have read the information.	IPT	1ST May 2013		IPCC	15th August 2013
	Meeting held with matrons and ward Sisters, presentation performed and discussion took place around appropriate faecal sampling. To highlight the necessity for staff to clinically review patients before sending a faecal sample. Patients to be discussed with the	IPT	10th June 2013		IPCC	15th August 2013

	ward coordinator. To ensure appropriate sampling					
	Diarrhoea Awareness day held in the cyber café at NGH. Promoting appropriate sampling and management of patients with diarrhoea. Formulated pocket size prompt card of when to send a specimen for the staff. Copies of all posters mentioned above. Commode cleaning competition Question and answer sessions	IPT	14th June 2013		IPCC	15th August 2013
Further inappropriate sampling of post admission *C.diff* cases in August	Send STOOL (Stop, Think, Observe, Odour, Liaise) trustwide screen saver to Liane Reynolds (Medical Director team PA) to reinforce appropriate sampling procedure	IPT	9th September 2013		IPCC	9th November 2013
	Insert STOOL sampling procedure into IPT annual infection prevention update for all clinical staff, including Trust induction and cluster days	IPT	9th September 2013		IPCC	9th December 2013
	Ensure that the October Infection Prevention Newsletter focuses on appropriate sampling procedures and *C.diff* infection rate update	IPT	30th September 2013		IPCC	30th September 2013
	Email out to consultants, matrons and ward managers and text junior doctors to reiterate the importance of appropriate sampling and following the pop up box on the ICE requesting system	Dr Bentley on behalf of IPT	29th August 2013		IPCC	29th August 2013
	Send 'Stop, think, ask before you send a stool specimen' poster to Debbie Moore (Bank Office Nurse) to distribute to agencies that NGH use	IPT	6th September 2013		IPCC	6th September 2013

	Implement *C.diff* focus weeks for wards that send specimens inappropriately – Creaton will be the first ward to receive this intensive support	IPT	9th September 2013		IPCC	29th November 2013
	Reiterate to the infection prevention link nurses the importance of appropriate sampling and the consequences of continued inappropriate sampling – for them to cascade back to their ward colleagues	IPT	29th August 2013		IPCC	October link nurse meeting 29th October 2013
To ensure that the new intake of junior doctors are informed of the NGH antimicrobial prescribing policy and *C.diff* management	Resend antimicrobial prescribing poster to consultants, ward managers and Jane Bradley (Medical Director Assistant) to disseminate to Junior Doctors	IPT	9th September 2013		IPCC	29th November 2013
	Update the *C.diff* management flowchart that is put into the medical notes – now called *C.diff* treatment algorithm to reflect updated *C.diff* DH guidance	IPT	22nd August 2013		IPCC	29th November 2013
Prompt identification and isolation of admitted with previous or current *C.diff* infection	Consider implementation of the *C.diff* passport as a whole health economy by contacting CCG areas who maybe using this passport	IPT	29th October 2013		IPCC	29th November 2013
	Trust policy to isolate patients with diarrhoea within 4 hrs. IPT to review whether possible to isolate within 2 hours, update *C.diff* Policy accordingly and take changes to IPCC for discussion	IPT	19th September IPCC meeting		IPCC	29th November 2013

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Duty of Candour – Board Assurance Statement
Agenda item	9
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Craig Sharples, Head of Corporate Affairs Caroline Corkerry, Deputy Director of Quality and Governance
Purpose	Assurance

Executive summary

The purpose of this Board assurance statement is to outline the contractual duty of candour and assure the Trust Board that there are robust systems in place to ensure that on the rare occasion that an incident which results in moderate harm, severe harm or death occurs, the Trust complies with its duties.

Related strategic aim and corporate objective	All
Risk and assurance	Positive assurance that there are robust systems in place to ensure that on the rare occasion that an incident which results in moderate harm, severe harm or death occurs, the Trust complies with its duties.
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 acknowledge the responsibilities of the Trust presented under the duty of candour and be assured that there are systems in place to ensure compliance with the duty.

Northampton General Hospital NHS
NHS Trust

Report to the Trust Board – 23 September 2013

A Contractual Duty of Candour

Northampton General Hospital Board Assurance Statement

1. Background

On 30 November 2012, the Department of Health published its analysis of the consultation on a new contractual duty of candour on providers, following consultations that took place between October 2011 and January 2012. The Government subsequently issued the National Health Service and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. Regulations 16-18 require the NHS Commissioning Board to include the duty of candour in the contract. A contractual duty of candour is now included within the NHS Standard Contract in 2013/14.

The publication of the Francis Report further increased nationally focus on the duty of candour. Recommendation 181 of the report provided that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury.

The report defined candour as: “The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.”

The duty of candour is not a new concept for the NHS; it is in effect a contractual reinforcement of existing requirements relating to openness that apply as part of professional codes of practice as well as core pieces of guidance and standards including the NHS Constitution and ‘Being Open’.

Currently, the Health Act 2009 requires all NHS organisations to have regard to the NHS Constitution which already provides that: “The NHS also commits … when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.” The Health Act 2009 only required NHS organisations to have regard to the NHS Constitution, not to mandatorily follow it. In contrast, as stated above, the duty of candour is now contractual, thus creating a contractual obligation for the Trust.

The purpose of this Board assurance statement is to outline the contractual duty of candour and assure the Trust Board that there are robust systems in place to ensure that on the rare occasion that an incident which results in moderate harm, severe harm or death occurs, the Trust complies with its duties.

2. The Contractual Duty

The contractual duty requires the Trust to report and investigate “reportable safety incidents” further defined as any incident which involves moderate harm or severe harm, which includes

all grade 2 pressure ulcers and above. Providers are also required to notify the service user (or somebody lawfully acting on their behalf) and this notification must include an appropriate apology, both face-to-face and in writing, and a copy of the final investigation report, within set timeframes. It is also incumbent upon the Trust to notify its commissioners when a complaint has been received which makes reference to a failure to disclose a patient safety incident.

Failure by the Trust to comply with its obligations under the contractual duty can result in (among other things) a notification by the commissioner to the CQC, financial penalty up to £10,000, a requirement for a formal apology and/or publication of the details of the failure on the Trust website.

The detailed requirements of the contractual duty of candour appear in Specific Condition 35 of the NHS Standard Contract and operate on the following basis:

- It will apply to individual patient safety incidents that result in moderate harm, severe harm or death (using National Patient Safety Agency definitions) (SC 35.1)
- The patient, family or carer will have to be informed that the incident has occurred or is suspected to have occurred within ten working days of it being reported to local systems. This should be face to face where possible (SC 35.1.4)
- Providers should notify commissioners if they receive a complaint that there has been a failure to disclose a patient safety incident (35.2)
- A sincere apology for the harm that resulted from the incident should be provided (SC 35.1.4.3)
- An offer of a step-by-step explanation of what happened should then follow as soon as is practicable. This may be initial view pending findings of an investigation (SC 35.1.5)
- Full written documentation of meetings must be maintained (SC 35.1.9)
- Appropriate investigations, in accordance with any local policies set out in the schedules of the NHS Standard Contract should be undertaken (SC 35.1.3)
- Any investigation reports will have to be shared within ten days of being signed off as complete (SC 35.1.6)
- Where a provider is found to have failed to be open, the commissioner shall implement the consequences set out in the contract (SC 35.3 and SC 35.4)

  Those consequences for failure to be open are:

- Direct written apology and explanation for the breach to the individual affected from the provider's Chief Executive and copied to the commissioner (SC35.3.2)
- Publication of the fact of a breach prominently on the provider's website (SC 35.3.3)
- Notification by the commissioner to the CQC (SC 35.3.1)

Discretionary powers are also possible such as:

- Recovery of the cost of the episode of care or £10,000 on each occasion the Trust has been deemed to be in breach of the duty
- Agreement and implementation of a remedial action plan
- Full independent investigation of the Trust's policy and practices in relation to openness paid for by the Trust and reporting to the commissioner
- Implementation of actions as set out in the NHS Standard Contract.

3. Northampton General Hospital NHS Trust Compliance

The Trust recognises that a culture of openness is a prerequisite to improving patient safety and enhancing the quality of care provided.

In 2007, the Board approved the first of three iterations of the Trust's Being Open Policy, which established the key principles of Being Open with patients, their carers and their families following a patient safety incident in which an individual was harmed. The policy supports a culture of openness, honesty and transparency, including apologising and explaining what happened.

As such, the Trust has a well-established system in place whereby patients who have experienced poor quality care where this has been reported as a Serious Incident have been invited into the Trust for a meeting where their experiences are discussed, a formal apology is provided by senior management and they are informed of the outcomes of any investigations arising from an incident.

The Trust has comprehensive risk management systems in place to ensure that all patient safety incidents are recorded and investigated accordingly. There are policies and procedures in place for the recording of and responding to Incidents, Serious Incidents and Complaints.

The Trust has an electronic risk management system in place for the recording of all incidents, DATIX. Datix has a mechanism in place whereby the individuals completing the incident form are prompted to advise if the incident had been discussed with the patient or appropriate next of kin.

The most serious of incidents which occur are reported to the commissioners as soon as practical via the STIES Reporting System, as per the Serious Incident Policy. All subsequent investigations are required to be signed off by the commissioners, and they are informed if a Being Open meeting has been conducted in response to the incident. The outcomes of the incident investigations and Being Open meetings are monitored by the Risk Management Team which works in partnership with the Care Groups to ensure lessons are learnt and learning disseminated.

There is monthly reporting to the Board and its committees on compliance with the duty of candour, with reports outlining the number of Being Open meetings conducted in response to incidents, as well as outlining the lessons learnt.

External assurances have also been provided on the robustness of Being Open processes through compliance with the NHSLA Risk Management Standards for Trusts.

4. Next Steps

Whilst there are robust compliance and reporting systems in place, it is acknowledged that there is room for improvement and embedding of systems and processes. As such, a plan is under development to extend the being open principles to cover all moderate incidents moderate as well as serious incidents, ensuring that all relevant policies, procedures and guidance for staff on openness and communication with patients are reviewed and are consistently reflective of this. The plan will reflect the associated training and development needs of staff to ensure that staff have the skills and confidence to facilitate conversations with the patient and/or their carers and/or family. This training will be underpinned by wider communications to ensure staff are aware of their responsibilities in regard to the duty of candour.

Further enhancements to the DATIX system are under way to ensure the Trust can provide demonstrable evidence of compliance with the duty of candour for all moderate and serious

patient safety incidents. This will allow the system to be audited and provide assurance to the Board and commissioners that the contractual obligations are being satisfied.

To ensure that staff are complying with their responsibilities, spot checks will be conducted on patients notes to ensure that Being Open discussions and meetings are documented. Reporting on compliance will be presented to the Care Groups, the Integrated Healthcare Governance Committee and the Board periodically.

5. Recommendation

The Board is asked to acknowledge the responsibilities of the Trust presented under the duty of candour and be assured that there are systems in place to ensure compliance with the duty.

REPORT TO THE TRUST BOARD
23 September 2013

Title	Patient Safety Academy Programme Update
Agenda item	10
Sponsoring Director	Dr Sonia Swart – Interim Chief Executive and Medical Director
Author(s)	Jane Bradley – Patient Safety Programme Director & Assistant to Medical Director Celia Warlow – Patient Safety & Resuscitation Services Manager
Purpose	To update the Board with the progress made against the programme of work set out in the Patient Safety Strategy

Executive summary

The Safety Academy has five reportable work streams each led by a Clinician. The following report provides a pictorial representation of progress for each of the work streams, providing "status at a glance".

Each of the metrics illustrates the number of projects within the work stream and the number of elements within each project (the measurement). The current month's compliance is presented as a comparator to the previous month; this will be identified by an upward, downward or horizontal arrow. A more detailed operational progress report will be provided to SMB on a monthly basis. This will represent the progress of the 34 safety projects encompassed within the Safety Academy portfolio.

Related strategic aim and corporate objective	Patient Safety Strategy
Risk and assurance	There has been a marked increase in the focus on quality and safety at all levels internal and external to the Trust. To sustain the positive improvements achieved, the continued engagement from staff to support the improvement projects is essential. This will result in an improved safety culture and reduction in avoidable harm at NGH.
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 (Yes/**No).** Is there potential for or evidence that the proposed decision/policy will effect different population groups differently (including possibly discriminating against certain groups) (Yes/**No**)
Legal implications / regulatory requirements	Regulators will consider safety and quality indicators and will take action where appropriate. Assurance for regulators can be provided through the demonstration that the analysis of issues is combined with the necessary quality and safety improvement work

Actions required by the Board

Board members are asked to note the content of this report and approve the pictorial presentation of progress for each of the work streams, providing “status at a glance” and debate the issues that arise from it.
The Board are asked to support the Patient Safety Academy to provide a detailed report with comprehensive narrative to SMB bi- monthly.

Patient Safety Academy Progress Report
Trust Board
23 September 2013

Introduction

NGH has for some time defined safety as one of the three quality components

- Patient Safety
- Patient Experience
- Clinical Outcomes

The Patient Safety Strategy 2012-2015 articulates the aims of the Patient Safety Improvement Programme and supports the Trust quality strategy.

The overall aim of the Patient Safety Strategy is to increase staff engagement in a programme of quality and improvement projects related to Patient Safety thereby bringing positive changes to clinical processes and practices which will ultimately improve patient care and patient experience. The positive improvements in clinical processes and the delivery of care will improve the safety culture whilst reducing avoidable harm in hospital.

The vision at Northampton hospital is to provide the very best care for all of our patients. This requires NGH to be recognised as a hospital that delivers safe, clinically effective acute services focused entirely on the needs of patients their relatives and carers. These services may be delivered from our acute or community hospital sites or by NGH staff in the community. The Trust has introduced a high level aim that can be understood by staff and patients. This is articulated as follows “at NGH we aim to reduce all avoidable harm to patients and save every life we can. We aim to save 300 lives over the next three years.” This is the aim that the Patient Safety Academy support and work with the NGH workforce to deliver.

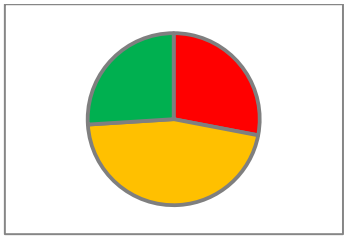
The five safety work streams are:

- Failure to Rescue
- Failure to Plan
- Failures from Care
- Learning and Sharing from Successes and Failures
- Human Factors

The above work streams were identified as the five main themes that the majority of safety concerns and avoidable harm could be attributed to. The projects within the work streams were identified from lessons learnt from serious incidents, audit results from case note reviews or areas for improvement identified by operational staff employed at NGH.
The safety improvement work dovetails and compliments mandatory assurance standards. The refined reporting methodology from the Safety Academy will make progress to date and current challenges more transparent.
A high level safety progress report will be provided to the Trust Board quarterly.

A more detailed bi- monthly progress report will be presented to the Strategic Management Board (SMB) to consider any other improvements required to ensure the aim of continually improving safety is achieved and the programme of work is as successful and sustainable as possible.
The status at a glance presentation of progress will be replicated in the pending patient safety clinical quality and governance quarterly progress report.

Safety Academy Project Progress



Metrics	Measurements	Month performance
34	**127**	↔

The above is a pictorial representation of the aggregated progress to date for the safety improvement projects encompassed within Patient Safety Academy portfolio.
The above illustrates that there are 34 current projects encompassed within the five work streams and they are 127 elements that are being monitored and measured for progress.
Where possible the indicators show performance against national or regional comparators, local or national targets or where neither of these are available they show trends over time in each case the performance is categorised as follows:

- Green - performance is better than average or the Trust/project is meeting the specific target.
- Amber - the Trust/project performance is at a national average or is a near miss with regard to a specific target.
- Red - the Trust/project performance is below average or well below a specific target.

It should be acknowledged that the number of projects that are “active” is expected to fluctuate throughout the year, as new projects are identified and attributed to the five work streams.

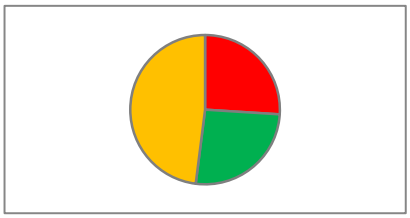
As well as the above metrics the overall successes of the Safety Academy can be triangulated with the following:

- Biannual safety cultural questionnaire results.
- Monthly safety point prevalence audits.
- Monitoring of progress against projects objectives via project plans.
- Number of Safety Champions nominated, trained and active in clinical areas.
- Reduction in crude patient death rates
- Reduction in avoidable harm.
- Improved communication with clinical staff regarding learning from serious incidents and complaints.
- Patient safety perception on how safe they feel during their inpatient stay.

The above will have a tangible link with the staff survey and positive patient experience.

It should be acknowledged that the following five work streams represent a very challenging programme of work, yet continue to receive considerable support and engagement from clinical and nonclinical staff.
Recent high profile reports only serve to reemphasise the importance of the safety academy work to ensure that staff are engaged in a programme of work that continually thrives to improve patient safety acknowledging “we can never be safe enough”.

Failure to Plan – Lead, Dr Jonny Wilkinson



Metrics	Measurements	Month performance
9	27	↑

Progress

7 measurements, 26% -
13 measurements, 48% -
7 measurements, 26%

Projects

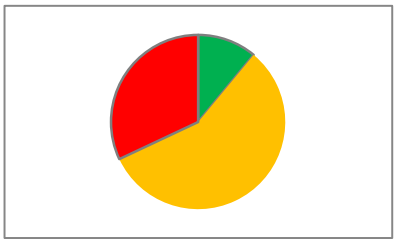
Communication with GPs & Social/ intermediate care (4 measurements)
Documented medical plans in notes (3 measurements)
Electronic discharge notification (3 measurements)
Electronic Handover system (4 measurements)
Healthcare Record audit (3 measurements)
Nursing documentation (2 measurements)
Pneumonia (3 measurements)
Time to consultant review (2 measurements)
Ward round communication (3 measurements

7 measurements, 26% -

Report via exception:

Poor engagement with GPs
Audit and feedback opportunities for staff ref documentation in medical notes
Development of a clerking satisfaction survey
Further development of the Electronic Handover System
Individual feedback mechanism for poor health care records
Pneumonia relaunch education and training for all staff groups

Failures from Care – Lead, Mary Burt



Metrics	Measurements	Month performance
9	38	↔

Progress

12 measurements, 32% -
22 measurements, 57% -
4 measurements, 11%

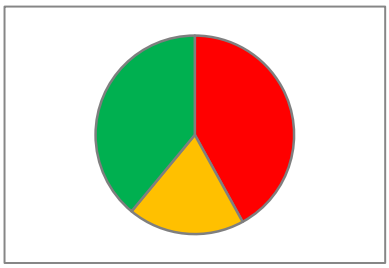
Projects

Reduce Harm from poor medicine management (5 measurements)
Reduce Harm from High risk medicine's (3 measurements)
Reduce Harm from falls (5 measurements)
Reduce pressure ulcers (6 measurements)
Reduce Harm from VTE (3 measurements)
Reduce Catheter related urinary Tract infections (3 measurements)
Reduce Harm from failure to manage patients with dementia/ poor mental capacity (4 measurements)
Reduce Harm from fluids and nutrition management (4 measurements)
Reduce harm from MRSA/MSSA/C Diff/SSI (5 measurements)

12 measurements, 32% -

Report via exception:
Staff training with and protocols for decolonisation
Reduction of SSI
Antimicrobial audit
Compliance with antibiotic prescribing
100% allergies documented on all drug charts
Develop guidelines for all staff regarding high risk medicine
Review VTE RCA action plans
Demonstrate a year on year reduction in catheter related UTI
Develop audit for high risk patient's nutritional intake
Review dementia audits

Failures to Rescue – Lead, Dr Jono Hardwick



Metrics	Measurements	Month performance
8	31	↔

Progress

13 measurements, 42% -
6 measurements, 19% -
12 measurements, 39%

Projects

Compliance with EWS recording standards (6 measurements)
Compliance with escalation protocol fro Nursing staff (2 measurements)
Compliance with escalation protocol fro medical staff (5 measurements)
Education re the acutely ill and deteriorating patient (4 measurements)
Failures to escalate care (7 measurements)
Sepsis care bundle compliance (2 measurements)
Code Red compliance (3 measurements)
Outreach Team usage (2 measurements)

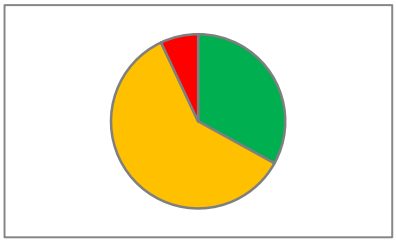
13 measurements, 42% -

Report via exception

100% recorded observations taken at the correct time
SAP usage 100% compliant

100% action plans returned
Improve timely medical review when escalation plan commences
Completion of TEP for triggered patients
Link TEP to electronic junior doctor's task list.
Review antecedents prior to emergencies
PDSA cycles to ward test Cardiac Arrests
Include Maternity in sepsis bundle
Monitor number of patients classed as code red
Introduce forcing measures for outreach

Learning & Sharing from Successes & Failures – Lead, Dr Lyndsey Brawn



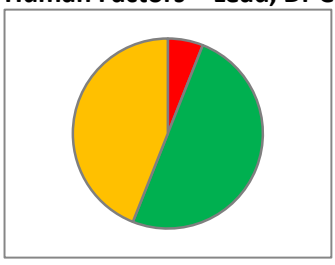
Metrics	Measurements	Month performance
3	15	↑

Progress

1 measurements,72% -
9 measurements, 60% -
5 measurements, 33%

Projects
Map existing pathways for learning from Serious Incidents (6 measurements)
Improve the presentation and understanding of incident & Complaint data (5 measurements)
Improve Safer care at weekends and nights (4 measurements)
1 measurements,72% -
Report via exception:
Identify a core group of staff to be trained to investigate serious incidents

Human Factors – Lead, Dr Chris Frerk



Metrics	Measurements	Month performance
5	16	↑

Progress

1 measurements,6% -
8 measurements, 50% -
7 measurements, 44%

Projects
Working with safety champions (9 measurements)
Human factors and Simulation centre (3 measurements)
Mandatory Training (1 measurement)
Measuring Harm (1 measurement)
Deaths over Discharges (1 measurement)

1 measurements,6% -

Report via exception
Develop a metrics to measure the number of deaths versus discharge (aim to reduce deaths by 300 on 3 years)

Conclusion

The Safety Academy Programme of work remains a challenging programme but one which has received considerable support with over 200 safety champions in place in all clinical and non-clinical wards and departments at NGH.
Some challenges remain to the time commitment required from everyone involved in this programme. Recent high profile reports only serve to re-emphasise the importance of this programme for which the success and sustainability of progress made is reliant on staff engagement, those who deliver and are responsible for the fundamentals of patient care.

Recommendations

Board members are asked to note the progress to date regarding the patient safety programme and the expanding portfolio of projects.

The Board is asked to approve the pictorial presentation of progress for each of the work streams, providing “status at a glance” and debate the issues that arise from it.

The Board are asked to support the release of staff to attend educational and development events and the time to complete audit projects and improvement cycles for tests of change. Engagement of staff and” listening to staff “is the essential framework that underpins the success and sustainability for the majority of the safety projects encompassed within the Safety Academy’s Portfolio.

Jane Bradley
Assistant to the Medical Director for Quality and Safety
Patient Safety Programme Director
September 2013

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Operational Performance Report
Agenda item	11
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 presented for discussion and assurance

Executive summary

The Trust achieved all the RTT, diagnostic, stroke and cancelled operations standards during August 2013.

Unvalidated data indicates the Trust has achieved all the cancer standards.

The Trust did not achieve the 4 hour transit time for patients referred to A&E during August; the Trust achieved 90.35% against the standard of 95%. Year to date performance is 92.46% as at 13th September 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 is asked to discuss the content of the report and agree any further action as necessary.

Access Rating - Summary

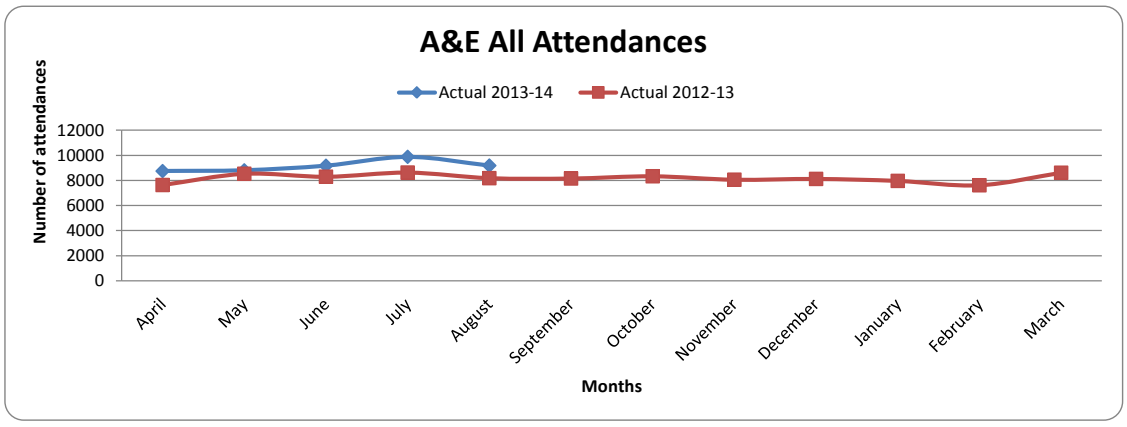
Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.79%	95.75%	96.87%
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.99%	98.99%	98.43%
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%	96.80%
RTT waiting times - ongoing >26 weeks			63	46	63	40	35
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	0
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0
A&E: Total time in A&E (monthly)	CCG & TDA	95%	87.89%	96.28%	93.42%	94.43%	90.35%
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	93.06%	92.52%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.40%	94.80%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	98.90%	100.00%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.90%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	94.10%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	95.20%	100.00%	95.20%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.50%
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%	60.00%
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%	91.94%
Trolley Waits waiting > 12hours	CCG	0	0	0	0	0	0
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	446	476
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	125	112
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31

Key Message:

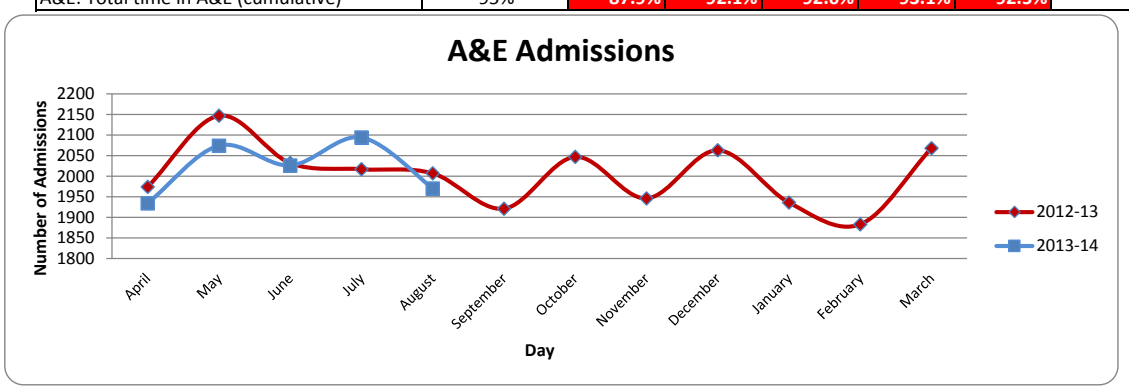
The Trust achieved all targets within August with the exception of the 4 hour A&E standard. The number of patients waiting over 26 weeks from referral has reduced to 35. The Trust has achieved the 18 week admitted, non admitted and on-going standards for all specialties. During August, the Trust achieved all the cancer waiting times standards.

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 August 2013 that waited over 15 minutes for handover is 112 and 31 waited over 60 minutes.

A&E Quality Indicators



A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%	94.4%	90.4%	
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%	93.1%	92.5%	



* Note: Total Admissions from the Symphony system

Summary

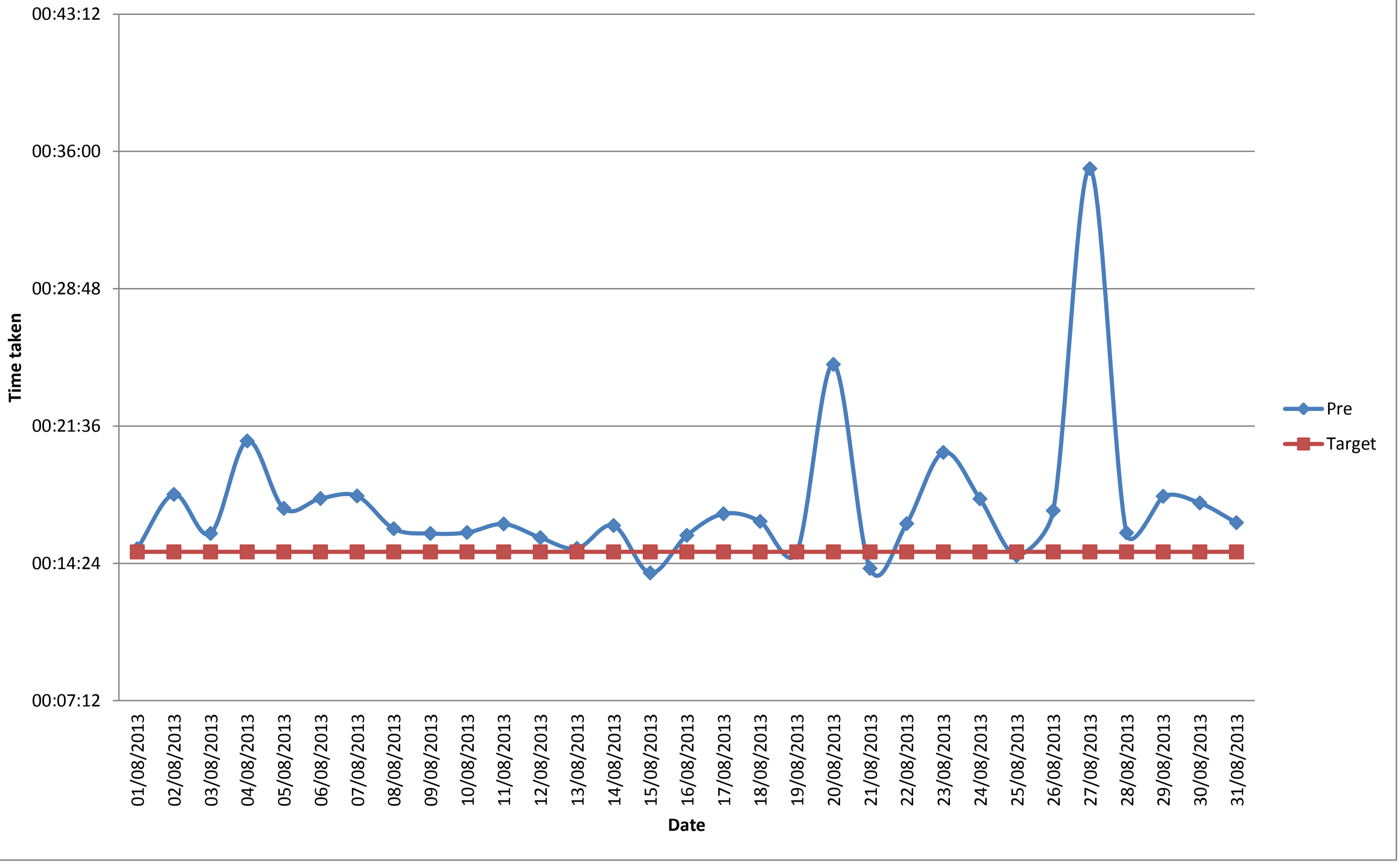
The performance of the Hospital against the 95%, 4 hour A&E transit time standard showed a deterioration from July to August and in August the Trust achieved 90.4%.

The main reasons for this were;
-The number and timing of daily discharges of medical patients
-Internal processes within A&E

The new Ambulatory Care centre opens on the 16th September which will reduce pressure on A&E and hospital admissions.

An update from the Urgent Care Programme Board has been discussed at the IHGC.

Average Ambulance Handover Times – July 2013



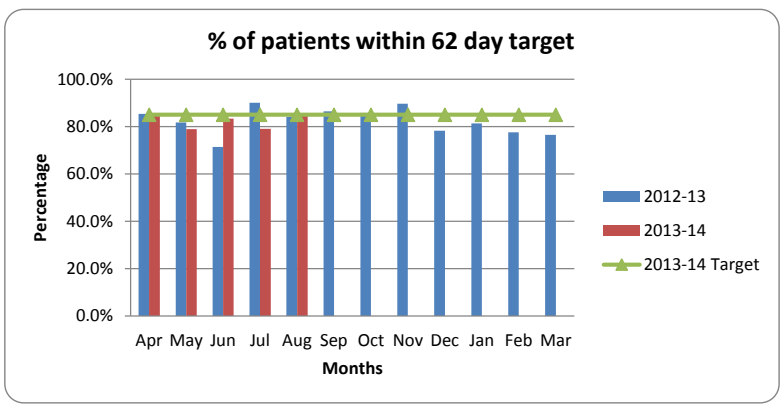
Cancer

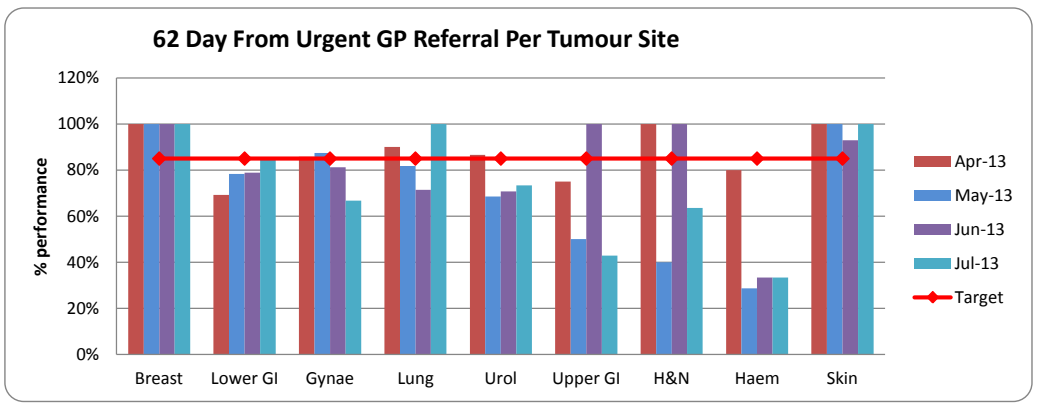
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.40%	94.80%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	98.90%	100.00%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.90%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	95.80%	96.50%	94.10%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	95.20%	100.00%	95.20%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	83.40%	79.10%	85.50%

Key Issues:

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

The first meeting of the Cancer Recovery Board took place in August and there is continued focus on delivering the key actions of the Recovery Plan and a review of the following pathways;
Head and Neck
Urology
Lower GI
Upper GI





Key Issues:

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 24 July 2013

Title	Urgent Care Update
Agenda item	12
Sponsoring Director	Clive Walsh, Interim Chief Operating Officer
Author(s)	Laura Sharpe, Emergency Care Pathway Project Manager
Purpose	Information and Assurance

Executive summary

- Performance against the 95% Four Hour Transit Time Standard remains inconsistent and generally below standard
- 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 is expected in 12/13

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

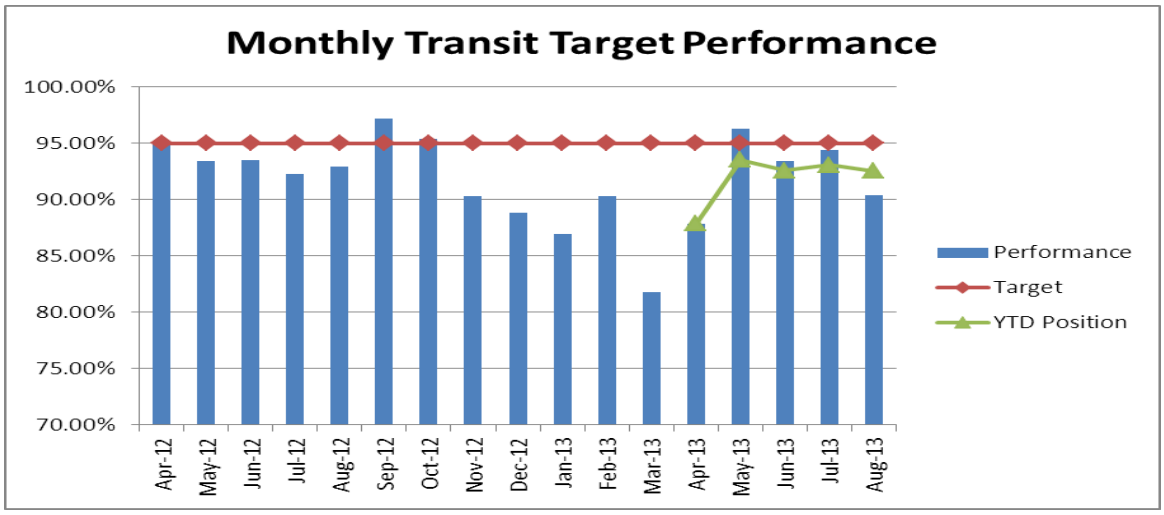
Trust Board – 23 September 2013

1. Introduction

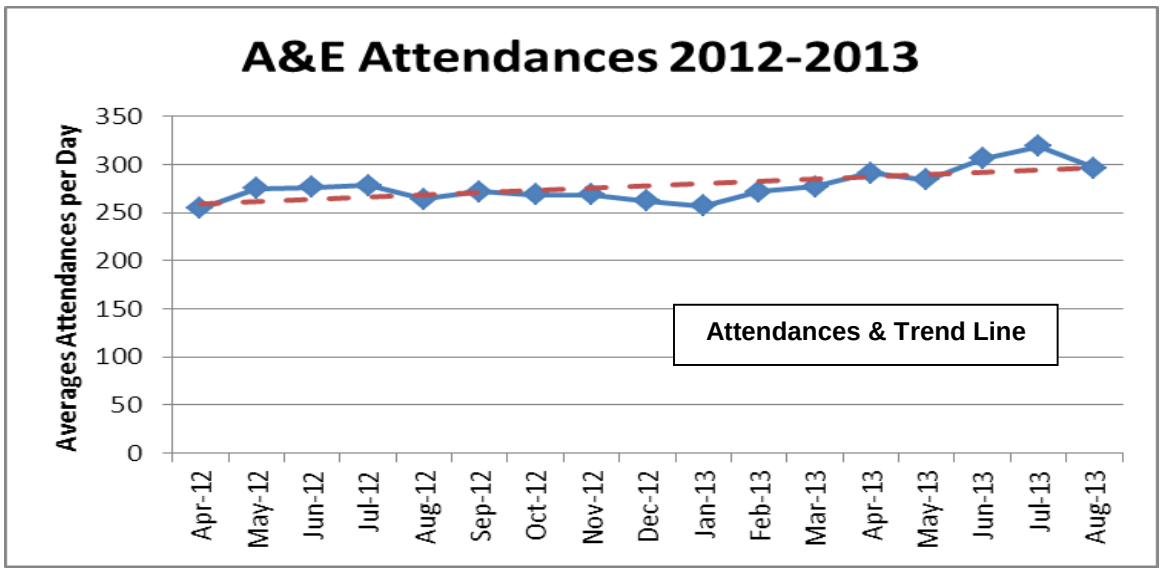
The Urgent Care Programme (UCP) continues to be led by the Chief Executive with the Programme Board meeting monthly. This report aims to provide an update on each of the UCP work streams and a summary of current performance. The last report to the Board was submitted in July 2013.

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%.



However, the Trust continues to see high numbers of A&E attendees throughout the first quarter of 2013. Over the first quarter of this year there has been an average of 25 additional patients attending A&E each day compared to the same quarter last year (9% increase). This pattern has continued throughout July and August.



3. Overview of Work Stream Priorities

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

The main areas of priority are:

- Development of an Ambulatory Care Unit
  - Streamlining A&E attendances by establishing an Ambulatory Care Centre starting 16th September 2013
  - Ambulatory Care Pathways now in place, 1 to follow showing significant reduction in length of stay

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

- Increasing discharge rates by rolling out Nurse Facilitated Discharge
  - Now implemented across medical and surgical wards, further consultant engagement still needed
  - Project plan and training plan for embedding in remaining wards and roll out to Community beds

- Development of Dementia pathway with NCC to be in place by October 2013

- Introduction of Discharge to Assess planned for November 2013

- 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)

- Pilot across Knightley and surgical ward planned for 1st October 2013

- Ward workspace training to cover therapies, ward sisters, matrons, site management team, to be initiated from 23rd September

- Go live phase 1 due w/c 21st October to include enhanced ward handover, discharge planning, whiteboard functionality and bed state module, providing 'patient status at a glance'

- Phase 2 planning to commence November onwards once phase 1 firmly embedded in the Trust.

4. Additional Winter Funding

The Secretary of State announced £250m of additional non-recurring funding for the NHS on 10th September 2013.

Northampton is one of 53 recipient health economies and expects to benefit by £4m. Kettering has received similar funding. The effective use of the funding will be monitored at the health economy Urgent Care Board, which will be accountable to the County Leader Operational Group.

5. Recommendation

The Board is asked to review and discuss this paper.

REPORT TO THE TRUST BOARD
DATE 23 September 2013

Title	Finance Report Month 5 – August 2013
Agenda item	13
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 August 2013.

Executive summary

- Performance against the TDA financial plan in August 2013 has significantly worsened by £1.0m as the level of over performance has reduced beyond planned levels.
- The key reasons are:
    - Reduction in income run rate, notably elective & daycase income
    - planned deficit increase £269k
    - Increase in provisions
- The TDA requested the Trust to submit a breakeven plan in September. A forecast position setting out the range of actions to deliver this has been prepared based on the month 5 financial position adjusted for forecast CIP delivery, known cost pressures. Key to further defining the forecast range and risk to delivery of breakeven is the level of reinvestment of fines and penalties, CCG 2% reserves and national A&E funding.

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 recommendations of the report and feedback from the NTDA in relation to the financial plan for 2013-14.

Trust's Financial Report as at 31 August 2013

Month 5 2013/2014

1.0 Summary Performance – Financial Duties

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

Table 1 – Key Financial Duties

	YTD Actual £'000	YTD Target £'000	Variance £'000	FOT £'000	Full Year Target £'000	Variance £'000
Delivering Financial perfromance	-£2,730	-£1,573	£ 1,157 Adv	-£4,822	-£4,822	£0
Achieving EFL (£000's)	N/A	N/A	N/A	£5,304	£5,304	£0
Achieving the Capital Resource Limit (£000's)	£2,663	£3,241	£ 578 Fav	£13,424	£13,424	£0
Subsidiary Duties						
Better Payment Practice Code:						
Volume of Invoices	87.28%	95%	-8%	90%	95%	-5%
Value of Invoices	89.26%	95%	-6%	90%	95%	-5%

Key Issues:-

- **Financial Performance –** Performance against the TDA financial plan in August 2013 has significantly worsened by £1.0m as the level of over performance has reduced beyond planned levels with the consequential loss of contribution. The key reasons are i. planned deficit increase £269k, ii. Increase in provisions not offset by contribution activity of £731k.

- **Income over performance –** income recognised against CCG contracts continues to show over performance although the trend has fallen with the largely planned fall in elective and other activity in August.

- **Quarter 1 contract reconciliation –** CCGs have lodged significant contract challenges amounting to £3m for the first quarter. The Trust has responded to these challenges rebutting claims, noting that many claims are unsupported by the prerequisite data sets to validate the initial challenge. Negotiation of settlement will be required to finalise income levels for quarter 1 which is expected to be concluded in September.

- **Fines and Penalties –** Provisions for fines and penalties have been included in the year to date position. In addition CQUIN has only been recognised at 75% of plan. The delivery of operational performance targets and delivery of CQUIN indicators have clear link to the potential level of fines and penalties which have continued to increase in month 5.

- **CIP Delivery –** There are still a significant level of CIP schemes which have not yet been identified and allocated as part of the financial plan. The year to date variance for these unidentified CIPs is a £2,112k adverse variance. The latest thinking forecast for CIP delivery is £10.9m (84% of plan), noting that in addition red scheme of £520k and amber of £1,421k present a further risk to the delivery of the forecast position.

- **Forecast –** The TDA requested the the Trust to submit a breakeven plan in September. A forecast position setting out the range of actions to deliver this has been prepared based on the month 5 financial position adjusted for forecast CIP delivery, known cost pressures. Key to further defining the forecast range and risk to delivery of breakeven is the level of

reinvestment of fines and penalties, CCG 2% reserves and national A&E funding. Further analysis can be found in section 5.

Table 2 – I&E Position

I&E Summary	Annual Plan 2013/2014	YTD Plan	YTD Actual	Variance to Plan	August 2013/14 Budget	August 2013/14 Actuals	July 2013/14 Actuals	June 2013/14 Actuals
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,979	96,284	**97,181**	**897**	19,326	18,903	19,895	19,640
Other Clinical Income	2,803	1,168	**1,050**	**(118)**	234	173	268	171
Other Income	25,661	10,598	**10,295**	**(303)**	2,058	2,087	2,147	2,089
Total Income	**259,443**	**108,050**	**108,526**	**476**	**21,618**	**21,164**	**22,310**	**21,901**
Pay Costs	(175,489)	(72,511)	**(72,007)**	**504**	(14,567)	(14,441)	(14,491)	(14,487)
Non-Pay Costs	(78,899)	(32,914)	**(33,309)**	**(394)**	(6,456)	(6,523)	(7,046)	(6,487)
CIPs	5,260	2,112	**0**	**(2,112)**	419	0	0	0
Reserves/ Non-Rec	(1,143)	(369)	**0**	**369**	(41)	0	0	0
Total Costs	**(250,272)**	**(103,682)**	**(105,315)**	**(1,633)**	**(20,645)**	**(20,964)**	**(21,536)**	**(20,975)**
EBITDA	9,171	4,367	**3,211**	**(1,156)**	973	200	773	926
Depreciation	(10,184)	(4,368)	**(4,379)**	**(11)**	(886)	(886)	(897)	(865)
Amortisation	(10)	(4)	**(4)**	**0**	(1)	(1)	(1)	(1)
Impairments	0	0	**0**	**0**	0	0	0	0
Net Interest	29	12	**12**	**(0)**	2	4	1	2
Dividend	(4,106)	(1,711)	**(1,711)**	**(0)**	(342)	(342)	(342)	(342)
Surplus / (Deficit)	**(5,100)**	**(1,703)**	**(2,871)**	**(1,168)**	**(254)**	**(1,025)**	**(466)**	**(280)**
Donated Assets Depreciation	**278**	**130**	**141**	**(11)**	**44**	**44**	**44**	**44**
Normalised for Impairment	**(4,822)**	**(1,573)**	**(2,730)**	**(1,157)**	**(210)**	**(981)**	**(422)**	**(236)**

- Financial performance for the year to date is now a £2,730k deficit against a plan of £1,573k, an adverse variance of £1,157k. This performance recognises the considerable levels of unmet CIP reported in month, the fall in levels of activity and provision for fines and penalties.

- The income position has continued to include a prudent provision for likely fines and penalties which may be levied by CCGs. Despite this, additional risk still exists in the process of negotiating contract challenges and contract penalties for matters such as MRET.

- Capital expenditure is behind of plan by £578k as scheme delivery in some of the Estates and Medical equipment schemes has slipped. The capital programme is currently being reviewed by the capitla sub-committee.

- During July the Trust continued to retain sufficient cash ahead of its plans and with improvements in BPPC has seen the level of creditors fall and in particular cash fall to £5.4m at the end of August.

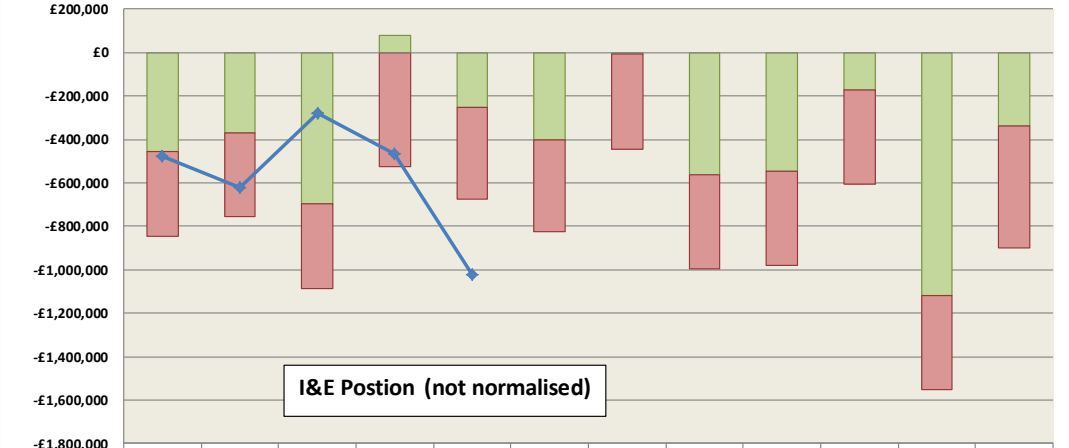
- The use of temporary staff has fallen in August with expenditure in month of £1.5m particularly in medical locums. Whilst pay costs have underspent in month continued action is required to investigate the use of all temporary staff and the justification for use of temporary rather than permanent staff established. Increased reporting of temporary staff has been developed and is covered elsewhere on this agenda.

2.0 Income and Expenditure Position of the Trust

Surplus/ (Deficit) Position

2.1 Appendix 2 provides details of the Trusts summary I&E position. The Trusts year to date I&E position for the period ended 31 August 2013 is a deficit of £2,730k. Performance against the TDA plan has worsened in month by £771k.

Graph 1 – Income & Expenditure Profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unal. CIP	-388,541	-388,541	-388,541	-527,292	-419,090	-418,401	-435,067	-435,067	-432,567	-432,567	-432,567	-561,302
Plan	-458,522	-369,478	-697,086	75,999	-253,998	-405,080	-9,098	-561,855	-545,859	-170,937	-1,119,197	-340,622
Actual	-476,650	-623,174	-280,089	-465,665	-1,025,237							

2.2 Graph 1 shows the I&E plan for 2013-14. The unidentified CIP is shown as an additional risk to the planned position (highlighted in red) each month. The failure to deliver CIPs in full in month 5 have also adversely impacted the financial position. The position for August highlights the Trust's reliance on over performance to maintain its financial plans.

3.0 Income and Activity

3.1 Year to date total operating income is reported at £108,526k which is £476k ahead of plan. The principal drivers behind the performance are set out below.

SLA and Other Clinical Income

3.2 SLA income and other clinical income is reported at £98,231k year to date at month 5 exceeding planned levels by £780k as set out in table 3 below.

3.3 Case mix adjustments have been processed for months 1-4 and month 5 will be processed when final case mix data is available.

3.4 In additional provision has also been made for 2013/14 income which has been mis-appropriated to the wrong CCG due to a data processing inconsistency. The matter has been corrected however there is a risk of the correct invoices, valued at £220k being rejected.

3.5 It is noted that a considerable level of contract challenges have been lodged by CCGs of approximately £3m. This is in addition to MRET and Readmissions fines. The Trust has responded to these challenges rebutting claims, noting that many claims are unsupported by the prerequisite data sets to validate the initial challenge. Negotiation of settlement will be required to finalise income levels for quarter 1, which is expected to be concluded in September.

Table 3 SLA and Other Clinical Income year to date

	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Income Plan £'000	Income Actual £'000	Income Variance £'000	% Var	August 2013/14 Budget £'000	August 2013/14 Actuals £'000	July 2013/14 Actuals £'000	June 2013/14 Actuals £'000
Elective Daycase	9,448	9,912	464 Fav	4.9%	1,872	1,771	2,130	1,895
Elective Inpatients	6,975	7,376	401 Fav	5.8%	1,382	1,407	1,508	1,465
Elective excess bed days		264	264 Fav		-	-	56	114
Non Elective	26,767	25,612	(1,156) Adv	-4.3%	5,422	5,536	5,119	6,568
Non elective excess bed days		2,866	2,866 Fav		-	-	709	798
New Outpatients	4,338	3,986	(351) Adv	-8.1%	859	719	865	852
Follow Up Outpatients	4,478	4,317	(162) Adv	-3.6%	887	783	823	879
Non Cons Led Outpatients New	1,074	1,023	(51) Adv	-4.8%	213	177	207	210
Non Cons Led Outpatients Follow Up	1,282	1,252	(30) Adv	-2.4%	254	221	260	253
Outpatient Procedures	2,636	2,941	305 Fav	11.6%	522	649	746	475
CQUIN	-	1,629	1,629 Fav		-	326	1,304	-
Block Contracts - Fixed	16,675	18,322	1,646 Fav	9.9%	3,344	3,472	3,747	4,013
Cost Per Case	9,795	7,980	(1,815) Adv	-18.5%	1,959	1,644	751	1,495
A&E	3,907	4,361	454 Fav	11.6%	792	871	891	872
Pathology	2,489	2,713	224 Fav	9.0%	498	543	561	528
Excluded Medicines	6,117	5,801	(316) Adv	-5.2%	1,239	1,243	1,215	1,180
Excluded Devices	512	576	64 Fav	12.4%	102	110	120	130
Fines, Penalties and Challenges	(1,500)	(2,249)	(749) Adv	49.9%	(300)	(550)	(250)	(350)
Productivity CIP's	976	-	(976) Adv	-100.0%	218	-	-	-
Other Central SLA Income	314		(314) Adv	-100.0%	62	(17)	333	(1,737)
Other Clinical Income	1,168	1,050	(118) Adv	-10.1%	234	173	268	171
Sub-Total SLA Clinical Income	97,451	98,231	780 Fav	0.8%	19,560	19,076	21,363	19,811

Table 4 Activity by Point of Delivery

Income & Activity Summary	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Activity Plan	Actual Activity	Activity Variance	% Var	August 2013/14 Plan	August 2013/14 Actuals	July 2013/14 Actuals	June 2013/14 Actuals
Elective Daycase	16,027	16,342	315 Adv	2.0%	2,807	2,978	3,628	3,027
Elective Inpatients	2,630	2,815	185 Adv	7.0%	458	548	570	549
Non Elective	13,079	13,764	685 Adv	5.2%	2,649	2,573	2,874	2,756
New Outpatients	25,296	25,469	173 Adv	0.7%	4,426	4,443	5,492	5,047
Follow Up Outpatients	45,109	47,833	2,724 Adv	6.0%	7,902	8,577	9,918	9,463
Non Cons Led Outpatients New	11,311	11,452	141 Adv	1.2%	1,987	1,790	2,562	2,311
Non Cons Led Outpatients Follow Up	24,673	25,886	1,213 Adv	4.9%	4,310	4,546	5,501	5,185
Outpatient Procedures	17,488	19,385	1,897 Adv	10.8%	3,066	4,432	3,997	3,568

3.6 Provisions to cover potential fines and penalties have been included as set out below. A more detailed analysis of the likely impact of the fines and associated mitigations is set out in appendix 4. The most significant increase in fines and penalties relates to the application of MRET which has now been triggered and the provision reassessed to include Specialised Commissioners.

3.7 CQUIN has only been recognised at 75% of plan resulting in an adverse variance of £543k. This has continued to rise from month 4 noting deterioration in dementia and paediatrics. The current updates on CQUINS report that many are on track to deliver as set out in appendix 5 however this performance should be scrutinised in more detail to support the delivery of these CQUINS. Further details are contained in appendices 3,4 and 5.

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

3.9 The matter is now being discussed with CCGs and a letter reporting the facts sent to CCGs for comment. To date no response has been received by the Trust. This matter has now been raised with the CCGs. A summary of the over performance by CCG is set out below and more comprehensive analysis contained in appendix 4:

Table 5 – Activity and Performance by Clinical Commissioning Group

	Plan Year to Date			Actual Year to Date			Income Variance year to date		
	Nene	Corby	Specialised	Nene	Corby	Specialised	Nene	Corby	Specialised
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	6,277	106	344	6,638	106	256	361 Fav	(0) Adv	(88) Adv
Non elctive	21,548	383	1,620	25,064	368	1,743	3,516 Fav	(15) Adv	124 Fav
Days Case	8,513	52	220	8,679	74	308	166 Fav	22 Fav	88 Fav
Outpatienmts	10,559	87	792	11,475	62	658	916 Fav	(25) Adv	(134) Adv
Blocks	13,513	650	2,775	13,490	651	2,681	(24) Adv	0 Fav	(94) Adv
Others	13,188	590	6,980	13,738	241	7,822	550 Fav	(350) Adv	841 Fav
Total	73,598	1,869	12,731	79,084	1,500	13,469	5,486 Fav	(368) Adv	737 Fav

3.10 The importance of accurate and timely data reporting was noted in the last Finance Committee report along with the potential consequences. The importance of accurate and timely patient level data cannot be underestimated as punitive contractual penalties can be applied for failure to comply. This has been demonstrated with the increased risk to income attributed to the wrong CCG which may be lost.

3.11 A quarter 1 'freeze' date has been discussed with host CCGs and Specialised Commissioners to enable any challenges, data quality and coding issues to be resolved so that challenges and any loss of income is minimised. This 'freeze' date will be trigger to transact any settlement of performance, offset by penalties and fines as well as associated contract challenges. This may have a significant impact on the cash position of the Trust in October.

Other Income

3.12 Other income is reported at £10,295k year to date at month 4 which is now behind plan by £303k. Whilst this performance has marginally improved from the month 4 position the performance needs still close monitoring.

3.13 Private and Overseas patient income has improved from the performance reported in month 5 and is now only marginally behind planned levels.

4.0 Expenditure

4.1 The Trust total expenditure is reported at £105,315k to August 2013 which is over plan by £1,633k. This is largely driven by the unmet year to date CIP of £2,112k (original, full year CIP gap of £4.5m); this position has been offset by the year to date release of contingency reserves of £369k.

Pay Expenditure

4.2 Permanent and temporary pay costs year to date were £72,007k against a plan of £72,511k reporting a favourable variance of £504k year to date as set out in table 2 and graph 2.

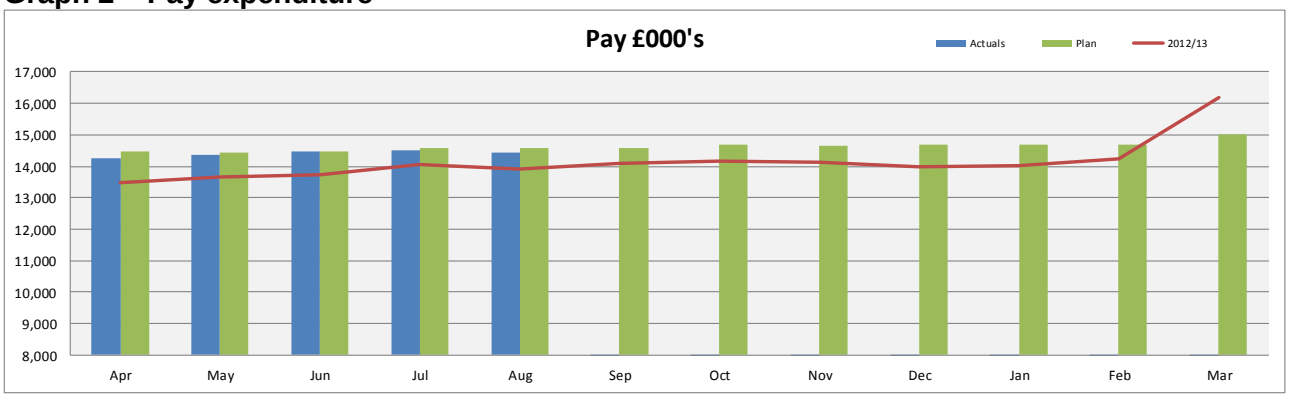
4.3 In month 5 permanent staff costs were £12,923k (FTE 3,898) and temporary staff costs were £1,518k (FTE 436.72); a total pay expenditure of £14,441k (FTE 4,334) The Trust does however continue to make use of temporary staff to support this under establishment incurring the associated premium costs.

4.4 Pay costs in month underspent by £126k in August which included the considerable over spend in medical and other staff costs.

4.5 Overall pay costs, especially all temporary staff are close to full establishment and must be closely monitored to ensure that pay costs remain within plan. Medical staffing temporary costs have seen a particular large increase in the month especially against ADHs (Additional hours; policies in place need reviewing to ensure we are scrutinising appropriately). Directorates have also been requested to review nurse agency costs relating

to specialing. A wider trust initiative is underway to review all contractor spend across the organisation.

Graph 2 – Pay expenditure



4.6 The Trust is operating below the planned WTE budget (by 166.89) as at the end of August – this is despite using 436.7 WTE of temporary staffing; so the Trust continues to utilise significant numbers of temporary staff as set out in the tables below.

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

	Pay Cost Analysis						Permanent Staff Worked Trend			Temporary Staff Worked Trend		
	Budget Month 5	Contracted Staff	Permanent Staff worked Month 5	Temporary Staff worked Month 5	Total Staff Worked	Variance	June 2013/14	July 2013/14	August 2013/14	June 2013/14	July 2013/14	August 2013/14
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical Staff	483.24	478.71	456.08	24.29	480.37	(2.87)	447.37	446.26	456.08	27.41	40.01	24.29
Nursing Staff	1947.7	1770.79	1653.86	183.59	1837.45	(110.25)	1677.75	1680.98	1653.86	180.21	184.43	183.59
Managerial and Administration	924.26	757.74	757.60	169.42	927.02	2.76	742.71	748.23	757.60	124.95	157.99	169.42
Other Clinical Staff	324.92	283.6	282.59	7.79	290.38	(34.54)	278.19	279.80	282.59	12.77	13.06	7.79
Scientific and Technical Staff	391.92	366.32	355.23	6.18	361.41	(30.51)	364.96	351.94	355.23	7.80	7.51	6.18
Estates Staff	35.5	25	28.08	7.88	35.96	0.46	27.60	28.64	28.08	5.56	0.75	7.88
All other Staff	394.16	332.44	364.65	37.57	402.22	8.06	343.75	361.53	364.65	30.71	46.24	37.57
Total WTE	4501.70	4014.60	3898.09	436.72	4334.81	(166.89)	3882.33	3897.38	3898.09	389.41	449.99	436.72

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

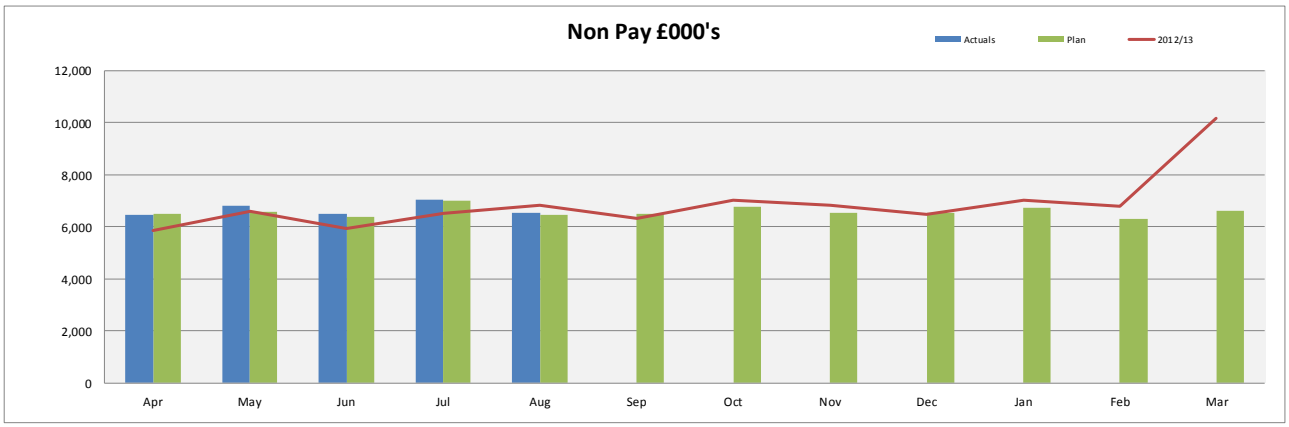
	Pay Cost Analysis					Permanent Staff Worked Trend			Temporary Staff Worked Trend		
	Budget Month 5	Permanent Staff worked Month 5	Temporary Staff worked Month 5	Total Staff Costs Month 5	Variance	June 2013/14	July 2013/14	August 2013/14	June 2013/14	July 2013/14	August 2013/14
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical Staff	3,856	3,596	423	4,019	162	3,529	3,444	3,596	397	518	423
Nursing Staff	5,645	4,868	557	5,426	(220)	4,972	4,967	4,868	602	582	557
Managerial and Administration	2,231	1,832	367	2,199	(32)	1,854	1,819	1,832	330	376	367
Other Clinical Staff	998	910	54	963	(35)	893	905	910	40	58	54
Scientific and Technical Staff	1,157	1,046	35	1,081	(77)	1,064	1,070	1,046	30	16	35
Estates Staff	95	82	16	98	3	78	80	82	10	1	16
All other Staff	584	590	67	656	72	575	574	590	113	81	67
Total Pay Cost	14,567	12,924	1,518	14,441	(126)	12,966	12,858	12,924	1,522	1,633	1,518

4.7 Levels of bank and agency usage have continued to be high reducing to £1,518k in August (July £1,633k). This trend is concerning and emphasises the urgency of permanent recruitment to substantive nursing posts. However, there is also a need to re-align utilisation of staff to budgeted levels, there are areas where this is in excess and communication has been issued to affected areas. In addition an increase in agency management and medical staff has also contributed to this temporary costs increase, especially across ADHs payments within medical staffing. A review is now required to analysis the data for medical and other staff groups which must reduce to continue to deliver the CIP plans. Whilst the August Junior Doctor rotation has contributed to a reduction in agency costs the matter must remain under close scrutiny.

Non Pay Expenditure

4.8 Non Pay costs year to date were £33,309k against a plan of £32,914k reporting an adverse variance of £394k as set out in graph 3 below.

Graph 3 – Non Pay expenditure



4.9 The level of non-pay expenditure has not continued to overspend in month 5 however non pay expenditure did fall in month when compared to previous month levels. The overall position still remains overspent by £394k. However, this includes some costs which are directly offset within additional other income – this is pointed out below

4.10 Key year to date variances are against outsourced activity to support targets in T&O and Ophthalmology as well as medical devices. All of these are recovered within other income but a stringent process is required to ensure all outsourced activity is recovered as a minimum. Other non-pay key variances are against hired equipment such as mattresses and maintenance costs as some have not been included in the budget or are additional.

4.11 A key message on non-pay to note is that some items are favourable to budget in the year to date position, but a catch up is expected over the future months i.e. drugs spend and building and engineering spend. When this starts to be incurred at a higher rate it will be essential to bring in line other over-spends so that the overall position to budget is not compromised.

Transformation Programme

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

Table 7 Status of Transformation CIP Schemes

	All schemes	Most Likely	Worst Case
	£'000s	£'000s	£'000s
Green	9,007	9,007	9,007
Amber	1,895	1,421	1,421
Red	1,037	415	0
Mitigation Pipeline	263	105	0
Gap	799	2,052	2,572
Total	**13,000**	**13,000**	**13,000**

4.13 The Transformation Team have assessed each scheme with their respective owners and RAG rated them. This shows that there are still 16% of schemes which are high risk or not identified as shown above. This assumes the most likely PMO delivery scenario.

4.14 Actual performance is £4.2m against a TDA plan of £4.0m. Whilst this is encouraging it is noted that the level of CIP delivery increases significantly from month 6 onwards which may quickly offset any early over delivery.

4.15 It is also noted that there is a significant proportion of schemes which are being delivered on a non recurrent basis. This will present a far more significant challenge in 2014/2015 CIP planning.

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

Contingency Reserves

4.17 As previously highlighted, £2m of general reserves have been drawn against to support a range of business cases, which has left the contingency reserves depleted. The identified reserves have been allocated as set out in the table below.

	£'000
General Reserve	2,000
Increases to Reserves	
SIFT Recalculation	131
Budget Adjustment for PDC	144
Total reserves available	**2,275**
Allocated Reserves	
A&E Nursing	-158
A&E Gen Med Medical	-280
SAU Nursing & Staff Grade	-216
PAOU SPR Nursing & Admin	-248
Rowan Level 1 Beds	-168
A&C Band 3 for HR Service Centre	-15
MRI / CT Business Case M4	-37
X-Ray tube	-15
CIP Non Delivery	-389
Ring Fenced Reserves	
MRI / CT Business Case M5-M12	-240
Un Allocated Reserves	**510**

4.18 The use of remaining contingency reserves continued in month 4 to support the under-delivery of the CIP (as reserves were phased in over the 12 months).

4.19 The level of reserves remaining uncommitted is £510k which will continue to be used to support the non delivery of CIP on an equal basis and will be exhausted by the end of the financial year. This approach leaves no available funding to support investment without identification of further CIP.

5.0 Financial Forecast

5.1 The Trust forecast prepared at month 4 has been updated based on month 5 results. This forecast has considered a range of factors and uncertainties. Given the considerable level on uncertainty a best, likely and worst case forecast has been prepared which consider the relative likelihood of risk and uncertainties.

5.2 The forecast has been based on the month 5 position extrapolated on 'run rate' basis adjusted for known changes. A range of assumptions have also been included based on the latest information available but accepts that more work is required to develop some aspects with a greater degree of certainty.

5.3 The updated forecast for month 5+7 is a deficit of £3m. This update includes the deterioration in the month 4 position and assumes that the lower level of income will be recovered through case mix adjustments and activity for the remainder of the financial year. Work continues with the TDA regarding a Financial Recovery Plan noting the considerable levels of uncertainty regarding the re-investment of fines and penalties.

5.4 A meeting with the TDA Finance Director on Friday 13th September took place followed by the standard escalation meeting. The key points from this meeting are as follows:

- The TDA had not formally accepted the Trusts deficit plan.
- The Trust needed to do more to manage our CIP position and control costs.
- The deficit was "small" and should be capable of being sorted at a local level.
- The best case scenarios indicated that the Trust could get itself back on track. We explained the rationale of the report and the range of actions shown.
- The side letter to the NENE CCG contract contravened PbR guidance for MRET and readmissions particularly and the TDA would challenge this on our behalf.
- We are expected to submit a balanced plan with a revised timetable of mid-October to coincide with the Q2 return.
- The CCG would receive the A&E funding and the governance arrangements to manage the funding across the health economy were key.

5.5 The detailed view of the forecast is set out in Appendix 7.

6.0 **Statement of Financial Position and Cash Flow**

6.1 The Trust's Statement of Financial Position (Balance Sheet) as at 31st August 2013 is set out within appendix 8.

6.2 The Trust's actual and forecast cash flow for the year is shown in appendix 9. The cash balance at the end of August stood at £5.5m (July £7.0m). This position is ahead of the current plan.

6.3 An analysis of income earned by the Trust but unpaid as at 31st August 2013 is shown in the table below.

Table 8 – Aged Debtor analysis

Aged Receivables/Payables: Current Month	Sub Code	Sign	Total at Period End	0-30 days		30 - 60 Days		60-90 Days		Over 90 Days	
			(mc 01)	(mc 02)	(mc 03)	(mc 04)	(mc 05)	(mc 06)	(mc 07)	(mc 08)	(mc 09)
			£000s	£000s	%	£000s	%	£000s	%	£000s	%
Receivables Non NHS	550	+	1,469	357	24	258	18	157	11	697	47
Receivables NHS	560	+	3,415	1,065	31	1,299	38	315	9	736	22
Payables Non NHS	570	-	(1,665)	(1,593)	96	(72)	4	0	0	0	0
Payables NHS	580	-	(373)	(373)	100	0	0	0	0	0	0

6.4 Work has continued to ensure that all NHS income due from SLAs is paid within the month of invoice. For the first time all SLA income was paid on the 15th of the month leading to a positive impact on the cash flow and liquidity position.

6.5 NHS debt due over three months relates to over performance with NHS Milton Keynes and other PCTs. Settlement has already been discussed but final settlement is now linked to the wider national timescales for PCT closures which has been extended. The overall level of risk has been assessed at £100k.

6.6 A significant element of the outstanding non NHS debt relates to payroll and service charges for the CRIPPS Recreation Centre. Work is now being undertaken to assess the

viability of transferring the service to an alternative provider who can provide a more sustainable future for the centre.

6.7 The Trust has continued to manage its cash position closely and to make use of creditor payment flexibility. The table below shows performance against the Better Payment Practice Code. The position has continued to improve with performance at 93% for August and an average for the year of 87% by volume and 89% by value

6.8 The development of a more robust framework for invoice payment has now been developed which monitors the actual payment of invoices once received as approved by finance and the performance by individual supplier and Trust Directorate on time for approval. Support is now being delivered to those areas which are not meeting the necessary approval timescales.

6.9 Cash reserves have continued to be sufficient to meet the Trust key statutory duties. Whilst longer term liquidity and cash position is ahead of plan the longer term resilience of the cash position remains poor should the CCG begin to levy penalties. Given the levels of fines and penalty provision this is now becoming far more likely.

6.10 A Temporary Borrowing Loan (TBL) loan application is now progressing with the TDA for a draw down when necessary. Current cash forecast assume this may be necessary in October (previously September) dependent on the income agreement with CCGs.

7.0 Capital Programme and Performance against Capital Resource Limit

7.1 The Trust capital plan including the impact of CEF funding is £10,664k The Trust has updated the latest forecast and included this in a separate paper for further discussion. The current performance against plan is set out below.

Table 10 – Capital Expenditure

Key Data: Capital and Cash	Sub Code	Sign	2012/13 Full Year Accounts (mc 01) £000s	Current Year to date Plan (mc 02) £000s	Current Year to date Actual (mc 03) £000s	Current Year to date Variance (mc 04) £000s	Forecast Outturn Plan (mc 05) £000s	Forecast Outturn Forecast (mc 06) £000s	Forecast Outturn Variance (mc 07) £000s
Capital Position									
Under/(Over) spend against Capital Resource Limit (CRL):									
Total Charge against the Capital Resource Limit (CRL) incl IFRS impact	350	+/-		3,241	2,663	(578)	10,694	13,424	2,730
Forecast Outturn Capital Resource Limit (CRL)									
Current CRL	354							12,944	
Anticipated Adjustments (see below)	356							480	
Total CRL	360	+/-		**3,151**		**(3,151)**	**10,664**	**13,424**	**2,760**
Under/(Over) spend against Capital Resource Limit (CRL)	370	+/-		**0**	**(2,663)**	**(2,573)**	**0**	**0**	**30**

7.2 The total cumulative spend for month 4 is £2,663k against an initial plan of £3,241k. This is below plan by £578k largely due to Estates and Medical equipment schemes slipping. Full analysis of capital expenditure is set out in appendix 10.

7.3 **Carbon Energy Fund (CEF) –** The CEF mini competition has now been concluded and the tenders evaluated. A decision to appoint preferred bidder is required which is set out in a separate paper.

7.4 **Managed Equipment Service (MES)** – The Trust developed a MES scheme to replace its ageing Radiotherapy and Radiology diagnostic equipment in 2012/13. Invitation to submit final bids phase has now been commenced and tender and contractual documentation issued. The financial accounting and business case will now be updated for onward approval with the TDA. It is noted that recent discussions with the TDA may have an impact on the approval of this case.

8.0 Monitor Financial Risk Rating

8.1 Appendix 10 contains the Trusts indicative financial risk ratings calculated as if it were a Foundation Trust.

8.2 The overall risk rating for the Trust to August 2013 if it were a Foundation Trust would be 2. This is due to the EBITDA margin falling slightly below -2% based on monthly performance.

9.0 Risks to Financial Position

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

Table11 – Risks

		£000s		%	£000s
Downside Risk	**Action to mitigate risk**	Risk	Likelihood		Residual Risk
Contract Challenges raised by CCGs are successful	Robust rebuttal of contract challenges making use of experienced resources	(3,000)	High	33%	(1,000)
Transformation Programme Slippage in CIP delivery.	Continued focus on delivery of CIP and development of mitigation pipeline. Downside LTF is £9.8m with high level of amber and red rated schemes still to be delivered.	(3,602)	Medium	50%	(1,801)
Lack of Funding to implement Transformation Programme Schemes	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)	High	90%	(270)
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.	Engagement with CCG QiPP schemes, estbalish joint QiPP Board. Regular reports from CCG. Consideration of contract query for failure to manage demand.	(4,800)	High	50%	(2,400)
Funding cuts to LDA impact on level of income received from LETB and loss of recognised medical training posts	Effective Negotiation with LETB and use of alternative funding streams to offset shortfall. Draft LDA challenged with updates agreed.	(300)	Low	17%	(50)
Cost of winter pressures exceed allocated funding	Trust has recieved allocation of £2.2m to manage Winter presures and A&E delivery. Winter plan and commitments to be agreed at UCB and SMB.	(1,100)	High	90%	(990)
CQUIN schemes are not delivered and further penalty imposed by CCGs / EMSCG. Current thinking on delivery included in financial position however further risk is evident	Robust monitoring and performance framework to be established. Risk to be identified and 25% provision made in monthly reporting.	(1,300)	Medium	50%	(650)
Net Revenue Risk		**(14,402)**			**(7,161)**

Table 12 – Opportunities

Key opportunities not included in Financial Plan 2013-14		Value of opportunity £000s	Likelihood	Probability %	Adjusted Risk £000s
Income opportunities through coding review	Ensure coding is key areas is as detailed as practical	750	Medium	50%	375
Quality Assurance of Income processing	Quality Assurance of Patient to cheque payment process for all patient streams	750	Medium	50%	375
Release of Income Provisions and Fines	Improvements to operational targets leading to release of income provisions	1,000	Medium	50%	500
Bidding for Readmissions funding	Development of bids to draw down re-admissions fines in part or in whole to extent not built into FRP	£ 2,400	Medium	50%	2,400
Invest to Save Schemes - Capital Invesment from possible underspend in capital programme	Schemes to be developed and worked up for delivery when capital is available. Revenue savings to be generated	£ 500	Medium	50%	250
		4,900			**3,650**

9.2 The range of ideas above have already been commenced by Finance staff in some areas however consideration of the full list should be undertaken by the Transformation Team for qualification and development as part of the Transformation agenda.

10.0 Conclusion

10.1 The financial position has continued to worsen in August and the Trust is now performing significantly behind its plans. This performance is largely due to the over performance on clinical income contracts offset by non delivery on CIP schemes, underperformance on some of its income other targets and the need to make additional provision for contractual fines and penalties. Urgent attention is now required to avoid further deterioration.

10.2 A quarter 1 ‘freeze’ date has been discussed with host CCGs and Specialised Commissioners to enable any data quality and coding issues to be resolved so that challenges and any loss of income is minimised. This ‘freeze’ date will be trigger to invoice over performance, offset by penalties and contract challenges. Robust negotiations must take place to secure a favourable settlement.

10.3 There is a range of potential CIP delivery currently being identified and developed by the Transformation team. Many of these are high risk giving rise to a significant risk to the overall financial position. The level of CIP delivery also steps up significantly from month 6 onwards. These factors present a direct risk to the delivery of the financial plan and could see the deficit increase further beyond the forecast. Urgent action is now required to support the delivery of the existing CIP programme required to meet the Trust financial targets. Immediate action is necessary to ensure that schemes deliver the necessary financial savings to deliver the Trust statutory obligations.

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

11.0 Recommendations

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

- More robust performance management of CQUIN to ensure that the risk associated with non delivery are minimised and performance improved for the remaining months of the financial year.

- Action is now expedited to agree the quarter 1 freeze data, rebutting contract challenges and agreeing where possible the levels of fines and associated re-investment.

- Deliver robust reconciliation process with Nene CCG to ensure all revenue is collected promptly.

- Immediate attention is now given to the development and delivery of additional CIP schemes within the Trust to support and develop additional schemes sufficient to meet the Trust statutory duties.

- Consideration of the manner in which A&E funding monies will be applied particularly when considered with the investments in capacity and resources that have already been made.

- Continued work is required to refine monthly income forecasts and associated case mix to.

- Clarity is required regarding the expenditure plans for Winter pressures to support the refinement of the forecast position.

- To develop more stringent measures to reduce the underlying run rate expenditure to support financial recovery plans.

- In conjunction with the CCG, to further develop the financial forecast and consider the resubmission of a balanced financial plan in line with TDA requirements.

Finance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	August		April	May	June	July
Financial Risk Rating (Shadow)	2	Overall FRR shadow score of 2	3	3	2	3
EBITDA %	3.0%	EBITDA % scores 2 under Monitor FRR	3.6%	3.0%	3.4%	3.4%
Liquidity (days cover)	19.0	Achieves FRR score of 3.	18.7	18.4	17.9	21.9
Surplus Margin	-2.65%	Achieves FRR score of 2	-1.9%	-1.9%	-2.1%	-2.11%
Pay / Income	66.3%	Cumulative pay 66.3% of cumulative income	67.5%	67.5%	66.2%	65.9%
I&E Position	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Reported Position	(2,871)	Deficit of £2.87m. £1,168k behind of plan	(492)	(1,188)	(1,380)	(1,846)
Impairment and Donated Assets	141	Donated asset depreciation of £141k ytd	44	88	132	157
Normalised Position	(2,730)	I&E position excluding donated asset depreciation	(448)	(1,100)	(1,248)	(1,689)
TDA Plan (Year to date)	(1,573)	NTDA Plan for year to August 2013	(464)	(740)	(1,393)	(1,303)
PCT SLA Income Variance	897	Ahead of plan ytd, trend fallen, subject to penalties and case mix changes	87	391	1,244	1,325
TDA Normalised annual plan	(4,822)	Full year NTDA control total.	(4,856)	(4,856)	(4,822)	(4,822)
Forecast EOY I&E postion	(4,822)	Current I&E forecast	(4,856)	(4,856)	(4,822)	(4,822)
EBITDA Performance	£000's		£000's	£000's	£000's	£000's
Variance from plan	(1,168)ADV	Ytd position £1,168k behind of plan	12FAV	(285)ADV	145FAV	(397)ADV
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
YTD Plan	4,000	TDA Plan to Month 5	760	758	2,281	3,207
YTD Actual	4,200	Actual delivered to month 5	755	679	2,124	3,092
% Delivered	105%		99%	90%	93%	96%
LTF	10,900	Latest thinking forecast	11,100	10,820	11,331	10,200
Annual Plan	13,000	Annual Transformation Target.	13,000	13,000	13,000	13,000
LTF v. Plan	84%		85%	83%	87%	78%
Capital	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Year to date expenditure	2,663	Capital expenditure for year to date £578k behind plan	126	460	1,382	2,143
Committed as % of plan YTD	30%	% of plan committed for year to date.	13%	26%	22%	30%
Annual Plan	13,424	Capital Resource Limit of £10.6m plus CEF fund £2.6m for 2013-2014	10,664	10,664	13,448	13,448
SoFP (movement in year)	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Non-current assets	(250)	Depreciation in excess of additions	(740)	(44)	(89)	(244)
Current assets	(4,037)	Decreased debtors, inventory and cash	3,481	704	1,295	3,585
Current Liabilities	3,158	Reductions in creditors and accruals	3,189	(309)	(280)	(466)
Cash	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
In month movement	(1,485)	Payment of disputed creditors and timing of payment runs	2,801	(392)	(2,759)	3,109
In Year movement	1,235	Catch up of NHS debtors from year end and improved cash management.	2,801	2,409	(350)	2,685
DH Temporary Loans	0	No approvals for 2013/14 to date but application submitted	0	0	0	0
Debtors Balance > 90 days	1,433	Collection of some PCT debt and CRIPPS debt ageing	1,013	1,059	1,537	1,644
Creditors % > 90 days	0.00%	No creditors over 90 days.	1.24%	1.22%	0	2.83%
Cummalative BPPC (by volume) YTD	87.3%	BPPC improved but still missed missed in August due to late approvals	81.7%	85.0%	85.7%	86.0%

Appendix 2

Income & Expenditure Position

I&E Summary	Annual Plan 2013/2014	YTD Plan	YTD Actual	Variance to Plan	August 2013/14 Budget	August 2013/14 Actuals	July 2013/14 Actuals	June 2013/14 Actuals
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	230,979	96,284	**97,181**	**897**	19,326	18,903	19,895	19,640
Other Clinical Income	2,803	1,168	**1,050**	**(118)**	234	173	268	171
Other Income	25,661	10,598	**10,295**	**(303)**	2,058	2,087	2,147	2,089
Total Income	**259,443**	**108,050**	**108,526**	**476**	**21,618**	**21,164**	**22,310**	**21,901**
Pay Costs	(175,489)	(72,511)	**(72,007)**	**504**	(14,567)	(14,441)	(14,491)	(14,487)
Non-Pay Costs	(78,899)	(32,914)	**(33,309)**	**(394)**	(6,456)	(6,523)	(7,046)	(6,487)
CIPs	5,260	2,112	**0**	**(2,112)**	419	0	0	0
Reserves/ Non-Rec	(1,143)	(369)	**0**	**369**	(41)	0	0	0
Total Costs	**(250,272)**	**(103,682)**	**(105,315)**	**(1,633)**	**(20,645)**	**(20,964)**	**(21,536)**	**(20,975)**
EBITDA	9,171	4,367	**3,211**	**(1,156)**	973	200	773	926
Depreciation	(10,184)	(4,368)	**(4,379)**	**(11)**	(886)	(886)	(897)	(865)
Amortisation	(10)	(4)	**(4)**	**0**	(1)	(1)	(1)	(1)
Impairments	0	0	**0**	**0**	0	0	0	0
Net Interest	29	12	**12**	**(0)**	2	4	1	2
Dividend	(4,106)	(1,711)	**(1,711)**	**(0)**	(342)	(342)	(342)	(342)
Surplus / (Deficit)	**(5,100)**	**(1,703)**	**(2,871)**	**(1,168)**	**(254)**	**(1,025)**	**(466)**	**(280)**
Donated Assets Depreciation	**278**	**130**	**141**	**(11)**	**44**	**44**	**44**	**44**
Normalised for Impairment	**(4,822)**	**(1,573)**	**(2,730)**	**(1,157)**	**(210)**	**(981)**	**(422)**	**(236)**

Detailed Analysis Activity and Income Performance by Clinical Commissioning Group

Nene CCG

Activity

	Plan					Actual					Activity Variance				
Point of Delivery	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Elective	470	470	448	515	402	470	505	464	505	505	0 Fav	35 Fav	16 Fav	(10) Adv	103 Fav
Non elctive	2,135	2,206	2,135	2,206	2,206	2,408	2,608	2,497	2,596	2,298	273 Fav	402 Fav	362 Fav	390 Fav	92 Fav
days Case	2,428	2,428	2,313	2,659	2,081	2,814	2,783	2,538	3,045	2,768	386 Fav	355 Fav	225 Fav	386 Fav	687 Fav
Outpatienmts	22,034	22,034	20,985	24,132	18,886	23,187	23,152	22,160	23,441	21,346	1,153 Fav	1,118 Fav	1,175 Fav	(691) Adv	2,460 Fav
Blocks															
others	7,193	7,193	7,193	7,193	7,193	223,059	221,446	230,273	227,116	225,474	215,866 Fav	214,253 Fav	223,080 Fav	219,923 Fav	218,281 Fav

Income

	Plan					Actual					Income Variance				
	M1	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	1,280	1,280	1,219	1,402	1,097	1,324	1,318	1,325	1,400	1,271	44 Fav	38 Fav	106 Fav	(1) Adv	174 Fav
Non elctive	4,225	4,366	4,225	4,366	4,366	4,878	5,348	4,990	5,070	4,779	653 Fav	982 Fav	765 Fav	704 Fav	413 Fav
days Case	1,736	1,736	1,653	1,901	1,488	1,747	1,794	1,629	1,839	1,670	11 Fav	59 Fav	(24) Adv	(62) Adv	182 Fav
Outpatients	2,153	2,153	2,050	2,358	1,845	2,303	2,319	2,224	2,384	2,244	150 Fav	166 Fav	173 Fav	27 Fav	399 Fav
Blocks	2,706	2,706	2,706	2,698	2,698	2,698	2,698	2,698	2,698	2,698	(8) Adv	(8) Adv	(8) Adv	-	(0) Adv
Others	2,634	2,634	2,634	2,642	2,642	2,658	2,787	2,681	2,903	2,709	24 Fav	152 Fav	47 Fav	261 Fav	66 Fav
Total	14,734	14,874	14,487	15,367	14,136	15,608	16,264	15,547	16,295	15,370	875 Fav	1,389 Fav	1,059 Fav	928 Fav	1,234 Fav
															4,611 Fav

Corby ccg

Activity

	Plan					Actual					Activity Variance				
Point of Delivery	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Elective	8	8	8	9	7	8	12	12	11	13	(0) Adv	4 Fav	4 Fav	2 Fav	6 Fav
Non elctive	27	28	27	28	28	25	33	33	28	30	(2) Adv	5 Fav	6 Fav	0 Fav	2 Fav
days Case	18	18	17	20	16	33	35	35	36	38	15 Fav	17 Fav	18 Fav	16 Fav	22 Fav
Outpatienmts	186	186	177	203	159	111	134	121	143	117	(75) Adv	(52) Adv	(56) Adv	(60) Adv	(42) Adv
Blocks															

Income

	Plan					Actual					Income Variance				
	M1	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	22	22	21	24	19	17	24	17	31	16	(4) Adv	3 Fav	(4) Adv	8 Fav	(2) Adv
Non elctive	75	78	75	78	78	51	116	69	67	66	(24) Adv	38 Fav	(7) Adv	(11) Adv	(12) Adv
days Case	11	11	10	12	9	5	25	15	13	16	(6) Adv	14 Fav	5 Fav	2 Fav	7 Fav
Outpatienmts	18	18	17	19	15	11	13	12	13	12	(7) Adv	(4) Adv	(5) Adv	(6) Adv	(3) Adv
Blocks	130	130	130	130	130	130	130	130	130	130	0 Fav	0 Fav	0 Fav	-	(0) Adv
others	118	118	118	118	118	45	46	50	59	41	(73) Adv	(72) Adv	(68) Adv	(68) Adv	(59) Adv
Total	373	376	371	380	369	259	355	293	313	281	(114) Adv	(21) Adv	(10) Adv	(77) Adv	(70) Adv
						84	179	113							(178) Adv

Specialised

Activity

	Plan					Actual					Activity Variance				
Point of Delivery	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Elective	21	21	20	23	17	22	32	14	9	15	1 Fav	11 Fav	(6) Adv	(14) Adv	(2) Adv
Non elctive	294	303	294	90	90	187	161	133	105	122	(107) Adv	(142) Adv	(161) Adv	15 Fav	32 Fav
days Case	69	69	66	76	59	108	133	79	104	86	39 Fav	64 Fav	13 Fav	28 Fav	27 Fav
Outpatienmts	1,888	1,888	1,798	2,068	1,619	1,286	1,064	1,207	1,400	1,163	(602) Adv	(824) Adv	(591) Adv	(668) Adv	(456) Adv
Blocks															

Income

	Plan					Actual					Income Variance				
	M1	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**	**M1**	**M2**	**M3**	**M4**	**M5**
Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'001
Elective	70	70	67	78	59	47	60	63	26	60	(23) Adv	(10) Adv	(4) Adv	(52) Adv	1 Fav
Non elctive	319	327	319	327	327	302	362	405	286	388	(17) Adv	34 Fav	86 Fav	(41) Adv	61 Fav
days Case	45	45	43	49	39	86	74	44	61	45	41 Fav	29 Fav	1 Fav	12 Fav	6 Fav
Outpatienmts	162	162	153	180	135	126	128	129	146	130	(36) Adv	(34) Adv	(24) Adv	(34) Adv	(5) Adv
Blocks	555	555	555	555	555	536	536	536	536	536	(19) Adv	(19) Adv	(19) Adv	(19) Adv	(19) Adv
others	1,396	1,396	1,396	1,396	1,396	1,634	1,677	1,415	1,531	1,564	238 Fav	281 Fav	19 Fav	135 Fav	168 Fav
	2,547	2,556	2,532	2,585	2,511	2,731	2,837	2,591	2,586	2,723	184 Fav	281 Fav	59 Fav	1 Fav	212 Fav
															553 Fav

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

Appendix 4

Fines and Penalties – Year to Date

Detailed Analysis Activity and Income Performance by Clinical Commissioning Group

Fine/Penalty	Description of Fine / Penalty	Basis for Calculation	Included within Financial position	Best Case	Likely case	Worst Case
A&E	Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department. Operating standard of 95%	2% of revenue derived from the provision of the locally defined service line in the quarter of under-achievement	83	83	83	83
Cancer 62 day wait	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer. Operating standard of 90%	2% of revenue derived from the provision of the locally defined service line in the quarter of under-achievement	78	78	78	78
C-Diff	Annual fine for breaches. Threshold set at 29.	Fines calculated using national formulae.	406	0	406	500
MRET	If the Trust's emergency activity value goes above a certain baseline then the Trust will only reimbursed at 30% of the normal income for the activity over above the baseline	The Trust will only received 30% of the relevant tariff for activity above the MRET baseline (set at 08/09 activity priced at 13/14 tariff)	1,500	700	1,500	1,800
Readmissions	National guidance states that: Providers should not be reimbursed for the proportion of readmissions judged to have been avoidable.	The agreed readmissions rate in the contract is 22.4%. The monthly plan is £200,000.	1,000	600	1,000	1,000
Challenges	Possible successful challenges from commissioners resulting in NGH having to provide a refund.	Estimated value based on previous years.	250	50	250	1,000
Case mix	Provision for possible increase in the value of activity once case mix data is costed.	Estimated value based on previous years.	100	-100	100	200
Paeds diabetes	If the Trust cannot show compliance to the extensive list of criterion then commissioners may not pay for a the increased BPT tariff.	Assuming NGH will be able to show compliance for 85% of patients.	104	104	104	104
Incorrect Commisioner Code attached to NCA Activity	Trust has issued NCA invoices to wrong commisioner.	This income can only be re-billed within a two month time horizon and some of this income is outside this time period. Income has been billed but CCGs may reject and refuse to pay.	220	220	220	0
Ambulance handover Times	Fines can be levied if ambulance turnaround times are outside permitted parameters	Methodology within the contract currently being quantified however indication are that fines could be significant in the event of breach.	0	0	0	500
Total Provisions for Fines and Penalties			**3,742**	**1,735**	**3,742**	**5,265**

CQUIN Delivery

Nene CCG & Associate CCG CQUINS									
	Indicator Number & Name	Contract Value %	Indicator Weighting %	CQUIN Value £'000	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013
National 1 Friends & Family Test	1.1. Phased expansion of Friends and Family Test	0.0375%	1.5%	68	4	4	4	4	4
	1.2 increase response rate to at least 20%	0.0500%	2.0%	91	6	6	6	6	6
	1.3 Improve performance on staff Friends & Familty Test	0.0375%	1.5%	68	4	4	4	4	4
National 2 NHS Safety Thermometer	2.2 50% reduction in all new Pressure Ulcers that are avoidable.	0.1250%	5.0%	227	14	14	14	14	14
National 3 Dementia	3.1 Find, Assess, Investigate and refer	0.0750%	3.0%	136	9	9	9	9	9
	3.2 Clinical Leadership	0.0125%	0.5%	23	1	1	1	1	1
	3.3 Supporting Carers	0.0375%	1.5%	68	4	4	4	4	4
National 4 VTE	4.1 95% of all adult inpatients to have a VTE risk assessment CQUIN payment to be received if both 4.1 and 4,2 are achieved	0.1250%	5.0%	227	14	14	14	14	14
	4.2 VTE Root Cause Analysis. CQUIN payment to be received if both 4.1 and 4,2 are achieved				0	0	0	0	0
Local 1	Development and implementation of AECP for Chest Pain	0.25%	10.0%	455	28	28	28	28	28
Local 2	Development and implementation of AECP for Pulmonary Embolism	0.25%	10.0%	455	28	28	28	28	28
Local 3	Development and implementation of AECP for Supraventricular Tachycardia	0.25%	10.0%	455	28	28	28	28	28
Local 4	Development and implementation of AECP for Pleural Effusion	0.25%	10.0%	455	28	28	28	28	28
Local 5	Development and implementation of AECP for Painless Jaundice	0.25%	10.0%	455	28	28	28	28	28
Local 6	Development of HOT Clinic for Paediatrics	0.25%	10.0%	455	28	28	28	28	28
Local 7	Development of HOT Clinic for Surgery	0.25%	10.0%	455	28	28	28	28	28
Local 8	Development of HOT Clinic for Medicine	0.25%	10.0%	455	28	28	28	28	28
Total	**CQUIN worth 2.5% of contract million**		100.0%	4,547,486	284,218	284,218	284,218	284,218	284,218

	MESCG CQUINS								
	Indicator Number & Name	Contract Value %	Indicator Weighting %	CQUIN Value £'000	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013
National 1 Friends & Family Test	1.1. Phased expansion of Friends and Family Test	0.0375%	1.5%	10,000	1	1	1	1	1
	1.2 increase response rate to at least 20%	0.0500%	2.0%	13,333	1	1	1	1	1
	1.3 Improve performance on staff Friends & Familty Test	0.0375%	1.5%	10,000	1	1	1	1	1
National 2 NHS Safety Thermometer	2.2 50% reduction in all new Pressure Ulcers that are avoidable.	0.1250%	5.0%	33,333	2	2	2	2	2
National 3 Dementia	3.1 Find, Assess, Investigate and refer	0.0750%	3.0%	20,000	1	1	1	1	1
	3.2 Clinical Leadership	0.0125%	0.5%	3,333	0	0	0	0	0
	3.3 Supporting Carers	0.0375%	1.5%	10,000	1	1	1	1	1
National 4 VTE	4.1 95% of all adult inpatients to have a VTE risk assessment. CQUIN payment to bereceived if both 4.1 and 4,2 are achieved	0.1250%	5.0%	33,333	2	2	2	2	2
	4.2 VTE Root Cause Analysis. CQUIN payment to bereceived if both 4.1 and 4,2 are achieved		0.0%	0	0	0	0	0	0
	20% of specialist cquin value so proportions right but % wrong			0	0	0	0	0	0
1	Quality Dashboards		20%	133,333	8	8	8	8	8
NIC	Timely Simple Discharge		15%	100,000	6	6	6	6	6
NIC	Improve access to breast milk in preterm infants		15%	100,000	6	6	6	6	6
Renal	Acute Kidney Injury		30%	199,999	12	12	12	12	12
Total	**CQUIN worth 2.5% of contract million**			666,664	41,667	41,667	41,667	41,667	41,667

Appendix 6

2013/2014 Cost Improvement Delivery against Plan

Finance Summary for FY13/14

Scheme	FY13/14 LTF £'000							
	R	A	G	Total Identified	% Identified	Total Unidentified	% Unidentified	Annual Target
A1: Surgery	40	89	204	333	60	222	40	555
A2: Anaesthetics	13	69	761	843	106	(46)	(6)	797
A3: T&O	153	214	129	496	92	44	8	540
A4: Head & Neck	61	191	299	551	147	(176)	(47)	375
A5: Child Health	-	103	620	723	139	(205)	(39)	518
A6: Obs & Gynae	100	109	239	448	67	216	33	664
SCG sub total	**367**	**775**	**2,251**	**3,393**		**56**		**3,449**
B1: General Medicine	221	439	1,367	2,028	100	0	0	2,028
B2: Oncology	81	111	289	481	100	0	0	481
B3: Pathology	40	145	423	608	104	(22)	(4)	586
B4: Radiology	36	114	219	369	101	(5)	(1)	364
B5: Pharmacy	100	6	71	177	103	(5)	(3)	172
B6: Therapies	-	28	58	86	81	20	19	106
MCG sub total	**478**	**842**	**2,428**	**3,749**		**(12)**		**3,737**
C1-7: Support Functions	-	16	688	704	711	95	12	799
C8: Facilities	191	262	430	884	100	(1)	(0)	883
Support sub total	**191**	**278**	**1,118**	**1,588**		**95**		**1,682**
Care Group & Corporate CIP Total	**1,037**	**1,895**	**5,797**	**8,729**		**139**		**8,868**
FYE of 12/13 Transformation Schemes	-	-	337	337		-		337
Admin Review	-	-	108	108		-		108
Tactical HR (Enhancements)	-	-	120	120		(0)		120
Tactical HR (Overtime)	-	-	338	338		(233)		104
Outpatient Skill Mix	-	-	-	-		45		45
3rd party Pharmacy	-	-	-	-		30		30
Agency Nursing	-		2,008	2,008		(700)		1,308
Long term SSP withdrawn	-	-	-	-		33		33
Mattresses Total Bed Management	-	-	30	30		5		35
Locum Managed Service	-	-	138	138		38		175
Consultant Annual Leave Accrual	-	-	35	35		-		35
Salary sacrifice year 2 (technology & car sceme expansion)	-	-	96	96		-		96
Mitigation list	-	-	-	-		1,205		1,205
Plans to be identified	-	-	-	-		501		501
Total	**1,037**	**1,895**	**9,007**	**11,938**		**1,062**		**13,000**

Financial Forecast

NORTHAMPTON GENERAL HOSPITAL
DRAFT FINANCIAL FORECAST / RECOVERY PLAN 2013-14

Key
Costs / deficits are **-ve**
Income / Savings are **+ve**

	Ref	Plan / FYE £000's	Best Case £000's	Most Likely £000's	Worst Case £000's	Comments
I&E Surplus / (Deficit) ***YTD***	1		-1,689	-1,689	-1,689	Position to Month 4
Baseline I&E Forecast *YTG*	2		-4,555	-4,555	-4,555	Run-rate forecast position for months 4-8
Baseline Forecast I&E *EOY*	**A**		**-6,244**	**-6,244**	**-6,244**	**Expected year end position before FRP actions / business cases**
Additional Cost Pressures arising in year:						
Orthogeriatrician x 3	3	-168	-42	-84	-112	3x Clinical Fellows approved at SMB July
SMB Business Cases Approved 13-14:						
Ambulatory Care	4	0				Self funding
Radiology Expansion (MRI)	5	-332	-249	-277	-277	Net cost of MRI expansion
A&E	6	-1,947	-638	-850	-850	
SAU	7	-259	-162	-216	-216	
PAU	8	-506	-214	-285	-285	
Level 1 Beds Rowan	9	-174	-98	-131	-131	
Nursing Staff	10	-1,900	-950	-1,267	-1,267	
Ophthalmologist(s)	11	-161	-104	-138	-138	
Cancer Trackers	12	-60	-24	-32	-32	
Baseline Forecast	**B**		**-8,724**	**-9,524**	**-9,552**	**M4+8 run rate forecast is for a deficit of £9.5m**
Recovery Plan Actions						
Additional Funding Streams:						
A&E National funding	13	5,567	4,000	2,200	2,000	Bid submitted to CCG for £5.5m for 13/14. TDA estimate £3m.
Additonal Winter Pressures costs	14	-1,000	-750	-1,100	-2,000	Estimated additonal costs (in addition to business cases above)
CCG 2% Reserve	15	1,300	0	0	0	CCG have stated no access to 2% reserve available
Contracting & Fines:						
Reinvestment of MRET	16	3,600	3,600	0	0	MRET £1.2m est. for M4. CCG have indicated no NGH reinvestment.
Reinvestment of Readmissions	17	2,400	2,400	0	0	Readmissions est. @ £2.4m pa. CCG state £1m pre-committed.
Achievement of CQUIN	18	1,300	1,300	650	0	CQUIN Accrued at 75% (£0.375m penalty Q1)
Avoid further CDIFF Fines	19	1,300	1,300	650	0	£0.325m included in Q1 position (Jul= 14 cases /29 threshold)
Avoid further A&E Fines	20	200	150	100	0	£50k included in Q1 position
Avoid further CA 62DW Fines	21	200	150	100	0	£50k included in Q1 position
Avoid other penalties and fines	22	1,000	1,000	250	-1,000	£0.25m provided at Q1. Gross challenges of £3m received at Q1.
Transformation Programme:						
Value of CIP Schemes Green **YTG**	23	7,719	1,682	1,529	1,376	Year to go impact
Value of CIP Schemes Amber **YTG**	24	2,239	2,239	1,679	1,120	Year to go impact %(100/75/50)
Value of CIP Schemes Red **YTG**	25	1,130	0	0	0	Year to go impact - assume no delivery for red rated schemes
New Schemes & Mitigations **YTG**	26	1,100	1,100	440	0	New schemes to be delivered
Unidentified	27	812	0	0	0	Unidentified gap - no delivery assumed
Sub-total Cost pressures & actions	**C**		**18,171**	**6,498**	**1,496**	
I&E position incl. FRP actions	**B+C**		**9,447**	**-3,025**	**-8,056**	

Note: The financial forecast has remained consistent with the 8+4 forecast produced last month. Overperfromance levels and case mix are expected to compensate for the deterioration in the month 5 position.

Appendix 8

Statement of Financial Position as at 31 August 2013

TRUST SUMMARY BALANCE SHEET MONTH 5 2013/14						
	Balance at 31-Mar-13	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789	0	133,789	0
IN YEAR REVALUATIONS	0	339	339	0	396	396
IN YEAR MOVEMENTS	0	2,037	2,674	637	13,698	13,698
LESS DEPRECIATION	0	(3,493)	(4,380)	(887)	(10,184)	(10,184)
NET BOOK VALUE	**133,789**	**132,672**	**132,422**	**(250)**	**137,699**	**3,910**
CURRENT ASSETS						
INVENTORIES	4,934	4,890	4,618	(272)	4,862	(72)
RECEIVABLES						
NHS DEBTORS	4,103	9,808	7,699	(2,109)	4,214	111
OTHER TRADE DEBTORS	2,295	1,419	1,560	141	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	580	360	(220)	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,587	2,530	(57)	2,514	0
OTHER RECEIVABLES	676	1,089	1,076	(13)	675	(1)
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,199	2,177	(22)	2,053	666
	10,149	**16,724**	**14,444**	**(2,280)**	**10,925**	**776**
NON CURRENT ASSETS FOR SALE		0	0	0	0	0
CASH	4,342	7,023	5,538	(1,485)	4,654	312
NET CURRENT ASSETS	**19,425**	**28,637**	**24,600**	**(4,037)**	**20,441**	**1,016**
CURRENT LIABILITIES						
NHS	628	1,636	1,131	505	4,411	(3,783)
TRADE CREDITORS REVENUE	1,255	2,668	1,752	916	2,921	(1,666)
TRADE CREDITORS FIXED ASSETS	1,744	1,219	952	267	1,876	(132)
TAX AND NI OWED	1,769	3,393	3,286	107	1,800	(31)
NHS PENSIONS AGENCY	2,013	2,142	2,141	1	2,030	(17)
OTHER CREDITORS	495	354	359	(5)	494	1
SHORT TERM LOANS	669	669	669	0	6,285	(5,616)
ACCRUALS AND DEFERRED INCOME	6,132	10,231	8,746	1,381	4,000	2,132
PDC DIVIDEND DUE	36	1,405	1,747	(342)	0	36
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	4,472	4,124	3,796	328	1,400	3,072
PROVISIONS over 1 year	310	1,281	1,281	0	1,298	(988)
NET CURRENT LIABILITIES	**20,309**	**29,908**	**26,646**	**3,158**	**27,144**	**(6,835)**
TOTAL NET ASSETS	**132,905**	**131,401**	**130,376**	**(1,129)**	**130,996**	**(1,909)**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115	0	102,899	2,784
REVALUATION RESERVE	32,486	32,828	32,828	0	32,893	407
DONATED ASSET RESERVE	0	0	0	0	0	0
I & E ACCOUNT BALANCE	304	304	304	(145)	304	0
I & E CURRENT YEAR	0	(1,846)	(2,871)	(984)	(5,100)	-5100
FINANCING TOTAL	**132,905**	**131,401**	**130,376**	**(1,129)**	**130,996**	**(1,909)**

2013/2014 Cash flow

	ACTUAL					FORECAST						
MONTHLY CASHFLOW	**APR £000s**	**MAY £000s**	**JUN £000s**	**JUL £000s**	**AUG £000s**	**SEP £000s**	**OCT £000s**	**NOV £000s**	**DEC £000s**	**JAN £000s**	**FEB £000s**	**MAR £000s**
RECEIPTS												
SLA Base Payments	17,721	19,030	15,721	23,380	19,172	17,584	21,301	17,478	17,478	21,301	17,478	17,478
SLA Performance / Other CCG investment												
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	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Salix Capital Loan							112	70	60	75		163
EFL / PDC									2,784			
Temporary Borrowing								4,000				2,000
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	21,639	24,376	24,590	23,364	24,118	20,221	22,443
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	6,500	6,500	6,000	5,500	5,500	4,500	2,474
NHS Creditors	1,617	1,296	1,619	2,162	2,215	2,114	2,114	2,114	2,114	2,114	1,000	1,000
Capital Expenditure	477	526	727	528	840	801	1,298	1,507	1,766	1,955	1,602	1,613
PDC Dividend						2,089						2,053
Repayment of Salix loan						143						203
TOTAL PAYMENTS	18,761	22,909	21,900	22,275	23,955	25,496	23,762	23,471	23,230	23,419	20,952	21,193
Actual month balance	2,801	-392	-2,833	3,144	-1,485	-3,857	615	1,120	135	700	-731	1,250
Cash in transit & Cash in hand												
Balance brought forward	4,303	7,104	6,712	3,880	7,023	5,538	1,681	2,295	3,415	3,550	4,250	3,519
Balance carried forward	7,104	6,712	3,880	7,023	5,538	1,681	2,295	3,415	3,550	4,250	3,519	4,769

Best Payment Performance Audit

Narrative	Number of Invoices	Analysis of Performance %	Value of Invoices £000's	Analysis of Performance %	Department
Total Paid	5,692		7,887		
On Time	5,613		7,659		
Processed by Payments Team	**98.61%**		**97.10%**		
N.B. Based on processing invoices comparing input date to payment date					
Total Paid	5,692		7,887		
On Time	5,310		7,405		
Within Target Compliance	**93.29%**	**93.29%**	**93.89%**	**93.89%**	
Paid Late	**382**		**482**		
TOP TEN BY NUMBER & VALUE					
Combined Energy Solutions Ltd	4	0.07%	6	0.08%	
Daywebster	4	0.07%	7	0.08%	
Hays Specialist Recruitment	13	0.23%	9	0.12%	Bank/Agency Office
Mayday Healthcare Plc	185	3.25%	39	0.50%	Bank/Agency Office
Medacs Healthcare Plc	14	0.25%	45	0.58%	Medical Staffing
NHSBA	1	0.02%	87	1.10%	Pharmacy
NHSBA Presecription Pricing Division	1	0.02%	86	1.09%	Pharmacy
Padsca Ltd	11	0.19%	2	0.03%	Bank/Agency Office
The Care Bureau	26	0.46%	4	0.05%	Bank/Agency Office
University Hospitals of Leicester NHS Trust	9	0.16%	41	0.52%	
Sub Total	**260**	**4.34%**	**314**	**3.98%**	
Sub Total - % of late approvals in August	**68%**		**65%**		
Revised - BPPC (if resolved)		**97.63%**		**97.87%**	
Regular Delay in Processing - Bank Office	235	4.13%	55	0.69%	Bank/Agency Office
	14	0.25%	45	0.58%	Medical Staffing
	2	0.04%	173	2.19%	Pharmacy

2013/2014 Capital Programme

Category	Approved Annual Budget 2013/14 £000's	TDA M5 Plan £000's	Year to Date as at Month 5 M5 Plan £000's	M5 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 5 Actual Committed £000's	Plan Achieved
Linear Accelerator Corridor	400	100	0	0	0	0%	0	0%
Improving Birthing Environments	399	344	379	381	2	96%	386	97%
Endoscopy	150	150	121	119	-3	79%	142	95%
Urodynamics	170	90	0	4	4	2%	4	2%
Haematology (Trust)	82	82	0	1	1	1%	23	28%
Annual Strategic Planning Approvals	841	214	0	0	0	0%	0	0%
MESC	1,468	496	360	188	-172	13%	397	27%
Estates	4,086	1,045	960	929	-31	23%	1,560	38%
IT	2,824	690	1,047	935	-111	33%	1,680	59%
Other	465	30	109	106	-3	23%	142	30%
Carbon Energy Efficiency Fund (CEEF)	2,760	0	0	0	0	0%	0	0%
Total - Capital Plan	**13,644**	**3,241**	**2,976**	**2,663**	**-313**	**20%**	**4,333**	**32%**
Less Charitable Fund Donations	-220	-90	0	-4	-4	2%	-7	3%
Total - CRL	**13,424**	**3,151**	**2,976**	**2,659**	**-317**	**20%**	**4,327**	**32%**
Resources - Trust Actual								
Internally Generated Depreciation	10,184							
SALIX	480							
CEEF	2,760							
Total - Available CRL Resource	**13,424**							
Uncommitted Plan	**0**							

- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker
- Improving Birthing Environments completes first stage works from 2012/13 and commences second stage in new financial year
- Endoscopy works were approved last financial year by the Capital Committee
- Urodynamics is being funded by monies donated by Mr Staden
- The Capital Committee have a contingency of £0.841 million (was £0.969 million) available funding for 2013/14 - options for Electronic Document and Records Management will be discussed at the next meeting in October - approvals given for Oracle Licenses £56k, Surgical HOT Room £13k, Rowan Level 1 Monitoring £4 Room C Equipment £37k (was £30k), MRI Extended Hours Business case £15k, Additional 2 Beds Althorpe £16k (was £10k), Staff Identification / security £118k, Ambulatory Care £72k and Portable Ultrasound (Radiology) £50k
- The Haematology scheme works are completed, although final account is still under dispute
- Full year depreciation forecast is currently £10.323 million (was £10.184 million) and this has increased as the MES contract start date has now been delayed till 2014/15 financial year
- Charitable Donations assumptions for additions in year are assumed £50k medical equipment & £170k Urodynamics, donated from Mr Staden

Financial Risk Rating (Monitor)

FINANCIAL RISK RATING — **Northampton General Hospital**

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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Board Action
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	4	4	3	5	
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	2	3	2	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		100%						2.3	2.7	2.2	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			

Finance Risk Triggers (SOM)

FINANCIAL RISK TRIGGERS — **Northampton General Hospital**

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

Refresh Triggers for New Quarter

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

REPORT TO THE TRUST BOARD
23 September 2013

Title	Workforce Report
Agenda item	14
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. • Recent Policy changes that have been adopted • Recruitment highlights. • Report on changes to the appraisal system linked to incremental pay	
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.	

Trust Board Report
23rd September 2013

Workforce Report

1. Introduction

This report identifies the key themes emerging from August 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 0.22% in August to 3.8% which is equal to the Trust target. Ward based areas of concern are within Trauma & Orthopaedics and General Medicine.

To support managers in the management of sickness absence, in conjunction with the Unions, the HR Business Partners/Advisors and Learning and Development Manager have carried out, on a twice monthly basis, sickness absence management training for approximately 140 attendees. This training has been organised throughout the year and continues to have high levels of attendance.

NHS Employers have recently released the national NHS staff sickness absence figures for 2012-13. These show that NHS staff in England took an average of 9.5 working days off sick and also show a slight increase in sickness absence rates nationally. The report shows an increase in overall sickness absence, rising from 4.12% in 2011-12 to 4.24% in 2012-13.

For 2012–13 the Trust's overall sickness absence was 4.56%, which is a rise of 0.45% from the previous year. There were 10,604 episodes of sickness, which equates to:

- 77,327 calendar days lost
- 64,263.30 WTE days lost

Workforce Capacity

Total workforce capacity (excluding Medical Locums) decreased by 3.96 FTE in August. The substantive workforce capacity decreased by 3.17 FTE to 4,012.71 FTE and the temporary workforce capacity decreased by 0.78 FTE to 328.57 FTE.

2.2 Workforce Information Update

Recruitment

From April 1st 2013 to August 2013 the Trust has recruited a total of 508 staff to the following disciplines:

Additional Clinical	95
Professional and Technical	6
Allied Health Professions	21
Estates	52
Nursing and Midwifery	93
Admin and Clerical	120
Bank	82
Volunteers	23
Honorary	16

As at August 2013 there are 336 successful candidates waiting to be cleared and of these the department has 600 reference requests in progress.

The HR Service Centre is clearing approximately 30 successful candidates a week through pre-employment checks and securing approximately 120 new starters a month. The recruitment time line for the Trust for August was 13 weeks.

In relation to nursing it is anticipated by the end of September the Trust will have recruited to 61.1 whole time equivalent (WTE) Healthcare Assistant posts and 44.8 whole time equivalent (WTE) qualified nursing posts. This includes the increase in establishment due to the nursing strategy investment and replacement of staff.

Policy Changes

The following policy was approved in August:

- **Injury Allowance Policy** (following the NHS Staff Council partnership review of the NHS Injury Benefit Scheme, a new Injury Allowance scheme was introduced nationally in March 2013).

Appraisal Update

The current appraisal process is being redeveloped to integrate the need to link incremental pay awards with individual performance. Training will be provided for managers prior to implementation in 2014. The appraisal process will be further developed to reflect the revised Trust values that are currently under development.

3. Assessment of Risk

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

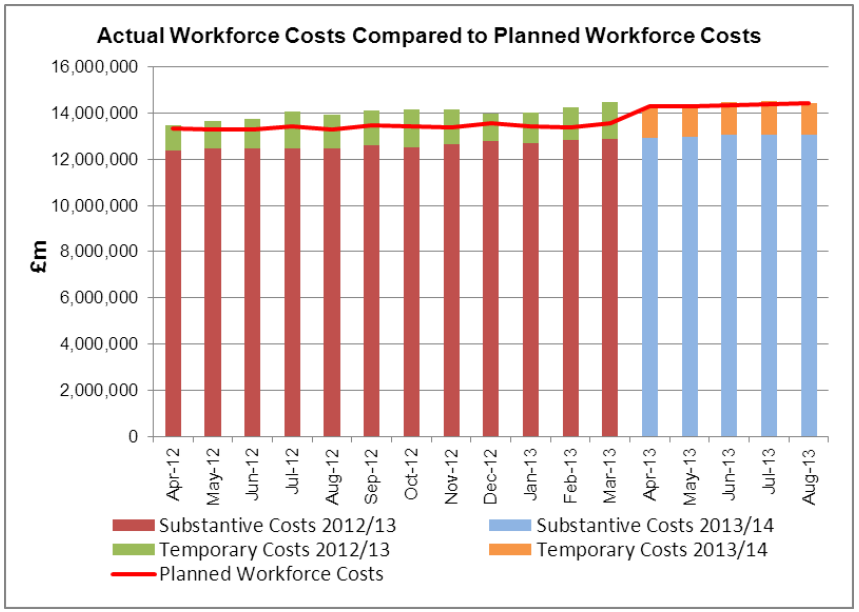
4. Recommendation

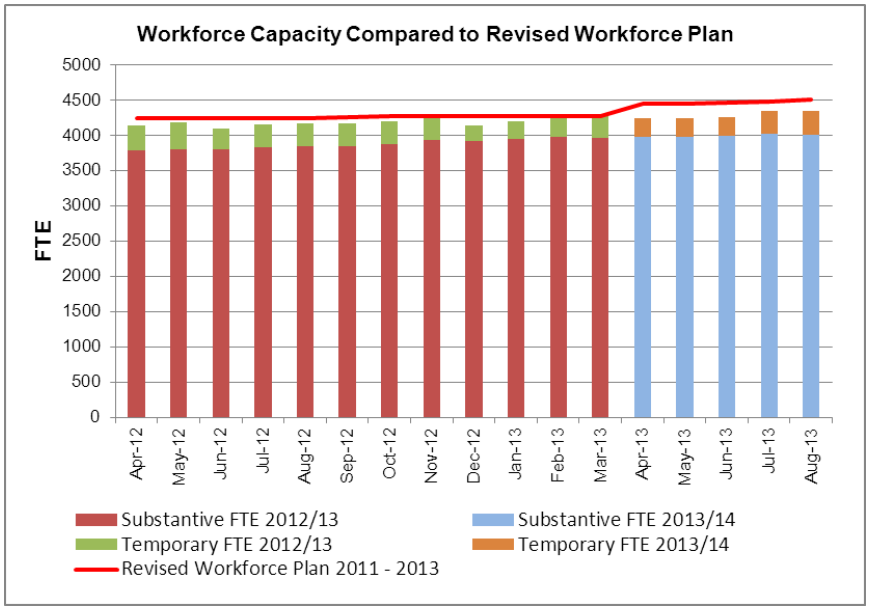
The Board is asked to note the report.

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 5





Workforce Expenditure

Total workforce Expenditure (all pay elements) decreased by £57,952 in August to £14.441m (this is below plan for Month 5).

- This is as a result of a decrease in temporary staff expenditure of £72,770.

Substantive workforce expenditure increased by £14,818 to £13,070,391.

- This was despite a decrease in substantive workforce capacity.

Temporary Workforce Expenditure (including Medical Staff) has decreased by £72,770 to £1,370,944 = to 9.49% of the of the total workforce expenditure.

- The use of nurse bank and agency staff increased by 12.7 WTE in August. Work continues within the Care Groups to ensure that operational processes are scrutinised ensure that spend is managed as effectively as possible.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 3.96 FTE in August to 4,341.28 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,501.70 FTE.**

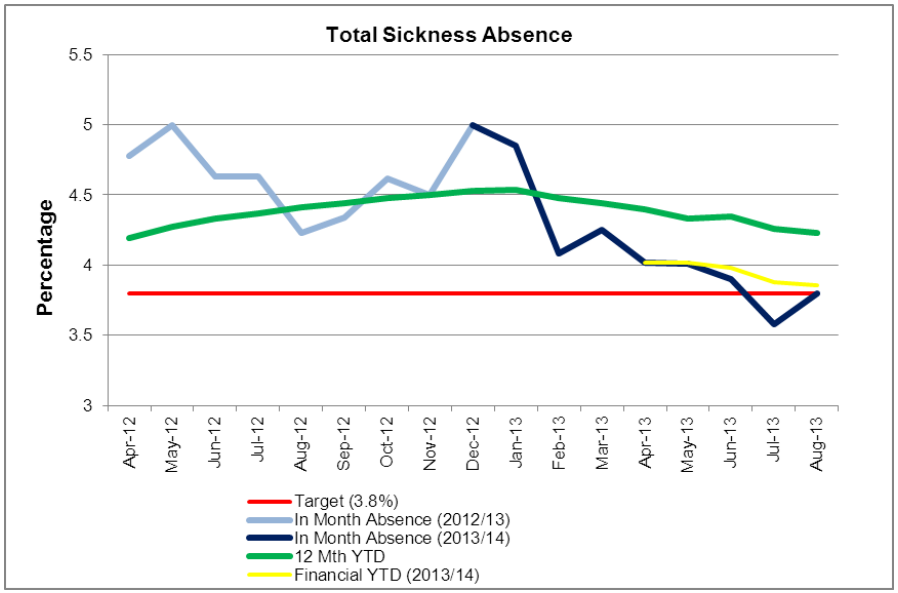
Substantive workforce capacity decreased by 3.17 FTE to 4,012.71 FTE.

- Recruitment to meet the increased budgeted establishment for nursing staff continues, contracted staff for general nursing areas in August was 92% of budgeted establishment.

Temporary workforce capacity (excluding Medical Locums) **decreased by 0.78 FTE to 328.57 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 5

	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	89.14%	90.33%	91.40%	80.46%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.57%	8.75%	6.12%	7.96%
Total Substantive Workforce plus Temporary Workforce against Budgeted Establilshment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	**96.44%**	97.49%	99.00%	87.41%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.07%	8.49%	8.57%	11.92%



Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 29,604 hours (182.17 FTE), which is an increase of 2,065 hours (12.7 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 51.03% (decrease of 1.63%), Agency fill rate = 19.87% (decrease of 5.46%). Total bank & agency fill rate = 70.90% (decrease of 7.09% 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 4 FTE compared with the previous month.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.23% in August 2013.

In month Sickness Absence has increased by 0.22% to 3.80% which is equal to the Trust target.

- Short term sickness absence increased by 0.12%.
- Long term sickness absence increased by 0.10%.
- The total calendar days lost to sickness absence increased by 193 to 5,448 days lost.
- The number of days lost per employee has increased to 1.16 days.

Human Resources Workforce Performance Indicators 2013/14 Month 5

		Surgery Care Group							
		Directorate							
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck		Women	Children
Short Term Sickness Absence		1.60%	2.27%	1.58%	2.62%	3.16%		3.21%	1.96%
Long Term Sickness Absence		2.20%	3.40%	0.68%	1.63%	2.12%		1.83%	2.43%
Total Sickness Absence	Over 4.2%	3.80%	5.67%	2.26%	4.25%	5.28%		5.04%	4.39%
	3.9-4.2%								
	Under 3.8%								

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery increased by 0.06%. There were also increases within Anaesthesia, Critical Care & Theatres of 0.74% and Head & Neck of 0.43%.

  The hot spot for ward based total sickness absence is within Trauma & Orthopaedics on Althorp ward, whilst short term sickness absence has decreased, the total sickness absence has increased on this ward from 7.39% to 10.27%. The HR Business Advisor is continuing to address both short and long term sickness absence.

		Medicine Care Group							
		Directorate							
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	2.31%	2.24%	2.03%	2.56%		2.73%	2.70%
Long Term Sickness Absence		2.20%	0.64%	0.60%	1.76%	0.00%		3.27%	1.77%
Total Sickness Absence	Over 4.2%	3.80%	2.95%	2.84%	3.79%	2.56%		6.00%	4.47%
	3.9-4.2%								
	Under 3.8%								

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency remains static. There was a significant decrease on Compton ward decreasing from 11.04% to 5.96%.

  Hot spots for Ward based total sickness absence are Allebone 11.12% which will reduce with 4 long-term sick due to return in October, Eleanor at 8.68% with 3 long term sick and Stroke Unit at 8.24% which is intensified by the heavy workload on the ward.

		Hospital Support				M&D
		Directorate				
	Threshold	Target	Facilities	Hospital Support		Medical & Dental
Short Term Sickness Absence		1.60%	1.85%	1.76%		0.14%
Long Term Sickness Absence		2.20%	0.89%	2.46%		0.63%
Total Sickness Absence	Over 4.2%	3.80%	2.74%	4.22%		0.77%
	3.9-4.2%					
	Under 3.8%					

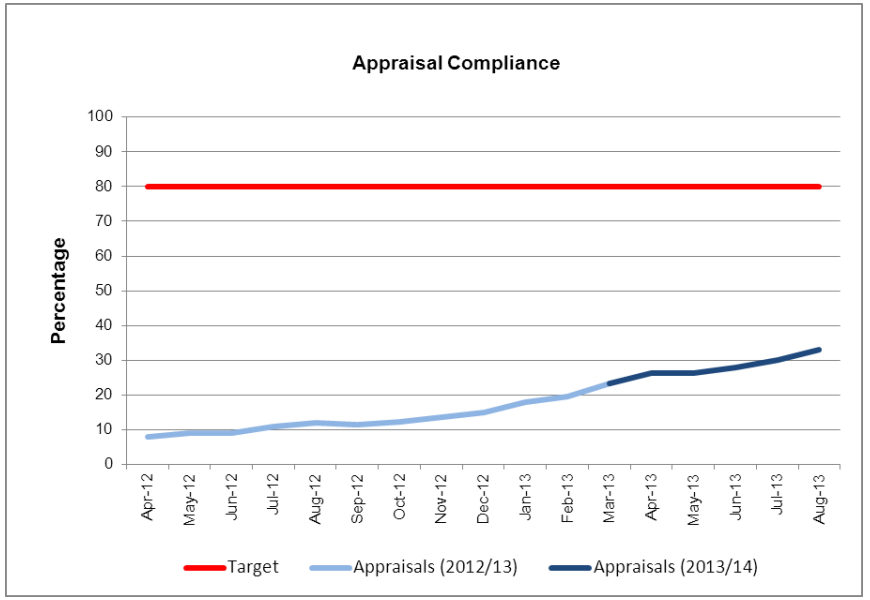
Hospital Support and Medical & Dental Summary

- The total sickness absence recorded for Facilities decreased by 0.27% to 2.74% and within Hospital Support total sickness absence increased by 0.89%

  It is unlikely that Medical & Dental is a true representation of the sickness absence rate within this staff group and the challenge will be to put processes in place to accurately record sickness absence.

Human Resources Workforce Performance Indicators 2013/14 Month 5

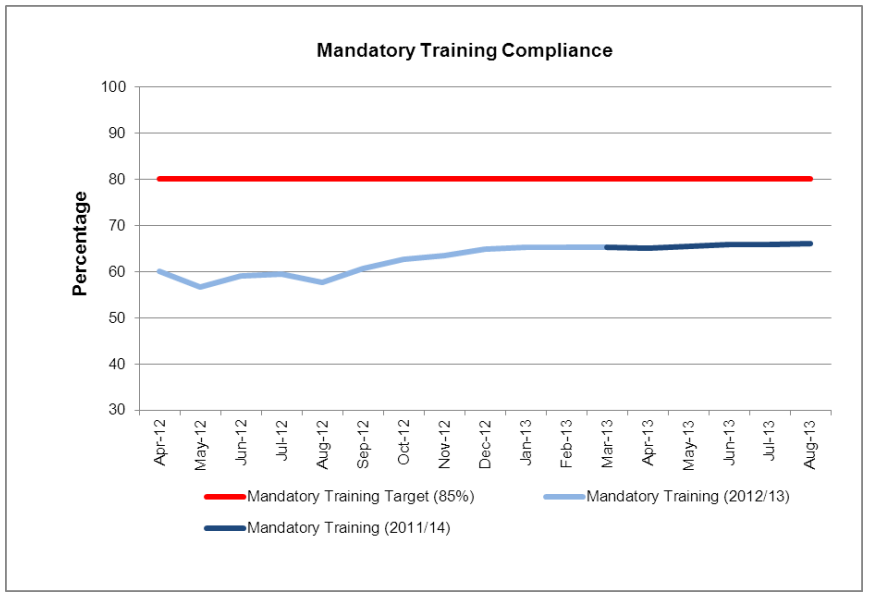
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	3.80%	3.89%	3.82%	3.46%
% Appraisals Complete	Under 50% 50-79% 80% & over	80%	33.06%	29.57%	37.14%	32.42%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	80%	66.09%	67.67%	65.60%	62.03%



Appraisal & Mandatory Training Compliance

Please Note: the reporting of Appraisal Compliance was quarterly up until April 2012 at which point reporting changed to YTD.

- The number of staff trained in Safeguarding Adults, Mental Capacity Act and Conflict Resolution seeing a significant increase in June compared to May, this fell again slightly in July.
  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 33.06%, this is an increase on July which was 30.12%.



Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 SEPTEMBER 2013

Title	Transformation Programme Report
Agenda item	15
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 5. To receive an update on the current mitigation explored to close the current gap of £1.1m in the 2013/14 Transformation Programme. To present the 2013/14 Q1, Quality Impact Assessment dashboard.

Executive summary

1. The Transformation Programme latest thinking forecast delivery is £11.9m savings against a plan of £13.0m for 2013/14.

2. Month 5 cumulative financial delivery is favourable to planned delivery reported to the National Trust Delivery Authority (NTDA) by £210k

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

Related strategic aim and corporate objective	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 actions being taken by the Transformation Delivery Group to deliver the Trust financial plan requirement of £13.0m during 2013/14.

Northampton General Hospital NHS
NHS Trust

Board Meeting
23 September 2013
Transformation Programme Report

1. Introduction

The agreed Trust financial Plan for 2013/14 set a target for the Transformation Programme including Directorate and Corporate cost improvement plans is £13.0m. The latest thinking forecast for 2013/14 based on current schemes in delivery stands at £11.9m.

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

2. Latest thinking forecast and month 5 delivery of the 2013/14 Transformation Programme

- The upside latest thinking forecast at M3 is £11.9m (4.6%), against the £13m required delivery, off plan by £1.1m.
- A mitigation pipeline of schemes to the potential value of £0.262m has been developed through the Trust Strategic Executive Team which if delivered in full and the current LTF achieved (£12.2m 4.7%) leaves a residual minimum mitigation requirement of £0.8m to achieve the plan of £13m.
- The plan submitted to the TDA required delivery of £4m in the first 5 months. Actual delivery is £4.2m, ahead of plan by £210k.

3. Transformation programme delivery

- Care Group and Corporate CIPs are forecast to be off plan by £139k at the year end. Care Groups have been tasked with developing plans to bridge this gap by 30th September 2013.
- The LTF for the care groups has improved by £282k over the position reported in M4. This has predominantly resulted from an increase in forecast delivery of a single scheme.
- There has been a significant acceleration in on the agency run rate reduction. At the end of month 5 a £774k year on year reduction in nursing agency expenditure has been achieved. The forecast LTF has increased based on the current run rate reduction continuing.
- The restriction on overtime continues to deliver financial savings in excess of the monthly requirement.

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

The mitigation list of schemes is being reviewed and acted on by the Transformation Team, scheme leads and sponsors. These opportunities are over and above the current LTF and the current estimated value (£263k) represents the potential 2013/14 in year financial impact. This value will fluctuate as schemes are added to the LTF or discounted and as schemes progress to a more granular level of details.

- The Transformation Team are investigating additional opportunities for CIP schemes to add to the mitigation list. These will then be scoped and developed (where appropriate) in accordance with the processes of the overall programme.

5. Quality Impact Assessment

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

- The baseline metrics have now been completed and systems are now in place to capture the data. As new schemes arise full QIAs will be produced and their metrics added to the scorecard.
- A revised policy and process for QIAs has been developed and progressing through the appropriate Trust committees for consideration, sign off or revision.

6. Risk Assessment

The Trust is over trading at the end of M5 against the contract activity plan agreed with CCG in the 2013/14 Contract. This is impacting upon the non-pay savings plans developed by care groups.

- All schemes, including individual Care Group, Corporate and Trust wide initiatives have been RAG rated.
- The upside latest thinking forecast (£11.9m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.
- The downside assessment of current schemes has been assessed based on none of the red rated schemes are achieved and 75% of the amber rated schemes deliver the identified financial benefits.
- Utilising this methodology agreed at the Finance Committee at its meeting in June 2013, the downside case based on current RAG rating would see the programme realise £10.4m.
- The focus of the TDG will be to ensure that we convert the red schemes into delivery and identify and develop mitigation schemes.

7. Conclusions

Month 5 financial delivery showed a variance of £325k favorable to the plan submitted to the NTDA and a cumulative favorable variance of £210k. Therefore, the Trust is delivering 105% of the year to date plan.

Performance has improved significantly in month 5 through the efforts of many stakeholders, however, the LTF is still showing a gap of £1.1m, significant red rated schemes and a high delivery expectation in the final months of the year. There is a need, therefore, to retain these efforts and continue to drive up performance in this area.

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

Work is being undertaken by care group and corporate teams, supported by the trust PMO to identify and submit for QIA additional short term schemes are currently being scoped.

8. Recommendation

The Board is asked to discuss and note:

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

2013/14 Transformation Quality Impact Assessment Scorecard

	Workstream	Changes planned	Metric	Frequency	Monitoring Group	Target	RAG descriptor	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Comments
Carried forward from 2012/13	Theatres	None	Utilisation (trust)	Project team		>85%	R = < 75%, A = 75%-84%, G = 85%	74.1%	72.5%	76.1%	75.9%	74.5%	73.0%	72.7%	
			Utilisation (Danetre - Theatre & procedure room)				R = < 75%, A = 75%-84%, G = 85%	54.3%	60.5%	51.0%	53.5%	55.5%	46.0%	46.2%	
			Utilisation (DSU)				R = < 75%, A = 75%-84%, G = 85%	71%	69.7%	72.8%	67.0%	70.0%	68.0%	67.5%	
			Utilisation (Eyes)				R = < 75%, A = 75%-84%, G = 85%	68%	64.4%	66.8%	63.0%	66.8%	66.6%	54.9%	
			Utilisation (Gynae)				R = < 75%, A = 75%-84%, G = 85%	72%	78.0%	77.8%	77.3%	79.2%	74.2%	78.0%	
			Utilisation (Main)				R = < 75%, A = 75%-84%, G = 85%	77%	73.5%	77.8%	80.0%	75.9%	77.0%	78.1%	
			Utilisation (Manfield)				R = < 75%, A = 75%-84%, G = 85%	80%	77.5%	83.5%	84.3%	83.0%	79.2%	77.0%	
			Cancelled sessions due to equipment issues					0	0	1	8	0	2	0	
			Cancellations on the day for non-clinical reasons - Excl Beds			<35 pts	R = 45, A = 35-45, G = <35	34	13	31	36	5	34	21	
			Complaints - theatres	Project team		0	R = > 5/m, A = < 5/m, G = 0			0	2	1	1	2	
			Never events							0	0	0	0	0	
			Serious incidents - theatres					0	0	0	0	0	0	0	
			Session overrun (Late finish)					6%	4.3%	4.5%	4.4%	4.0%	5.0%	4.5%	
	Workforce Bank & Agency	Recruitment of nursing staff to reduce use of bank & agency staff.	Safety Thermometer (Harm free %)	Monthly	Nursing & Midwifery Board	95% from Dec	R = < 85%, A = 85-90%, G = > 90%	92.17%		93%	91%	92%	94%	91%	
			Patient experience - Family & Friends question	Monthly	Nursing & Midwifery Board	80		68.33		60	67	62	62	70	
	Admin Review	Pooling and standardising of administrative staff and medical secretaries. Rationalisation and standardisation of junior managers.	Average turnaround time for clinic letters in days (Medicine) - areas not using digital dictation	Monthly	Manual audit	5 days	R = over 5 days, G = 5 days or under	17.5	17	22	18.875	17.83333	12.5	5.4	
			Average turnaround time for clinic letters in days (Medicine) - areas using digital dictation	Monthly	Digital dictation system	5 days	R = over 5 days, G = 5 days or under	2.5		7.92	6.24	5.83			New system of reporting being worked on by IT to ensure accurate reporting going forward.
			Average turnaround time for clinic letters in days (Surgery) - areas not using digital dictation	Monthly	Manual audit	5 days	R = over 5 days, G = 5 days or under								Data is not captured by Surgery
			Average terag turnaround time for clinic letters in days (Surgery) - areas using digital dictation	Monthly	Digital dictation system	5 days	R = over 5 days, G = 5 days or under	2		8.01	12.15	4.08			New system of reporting being worked on by IT to ensure accurate reporting going forward.
	Therapies	Reconfiguration of therapy staff to link to Care Group structures	Response time to referral within 1 working day - Physio	Monthly	Therapies Governance Group	100%	R = <99%, G = >99%	99.9%	99.70%	99.80%	99.90%		99.90%		
			Response time to referral within 1 working day - OT	Monthly	Therapies Governance Group	100%	R = <99%, G = >99%	84%	82.60%	89.20%	87.50%		89.70%		Data for August not yet completed. Always report 1 month in arrears
			% of repeat patient contacts not seen within 1 working day - Physio	Monthly	Therapies Governance Group	<7%	R = >12%, A = 7% - 12% G = <7%	13%	17%	18%	13%		11%		
			% of repeat patient contacts not seen within 1 working day - OT	Monthly	Therapies Governance Group	<7%	R = >12%, A = 7% - 12% G = <7%	17%	14%	13%	24%		33%		
	Pharmacy	Continuation of pricing and practice changes	Datix incidents relating to contract changes				R = > 0, G = 0	0	0	0	0	1	0	0	
	Pathology	Restructure management & admin	Pathology quality management report aggregate	Monthly	Pathology Directorate Management Board	100%	R = < 80%, A = 80-90%, G = 90-100%	83%	75%	100%	100%	100%	100%	100%	
GM 04/06	General Medicine	Savings through vacancies, band reductions or flexible working reductions	WTE against budgeted establishment	Monthly	Admin managers & service managers	100%	R = <75%, A = 75-100%, G = 100%		95.71	96.08	90.8	90.16	91.63	89.35	
			Link to admin review metrics re: typing turnaroun time	Monthly		5 days	R = over 5 days, G = 5 days or under			7.92	6.24	5.83			See above re admin review
			Complaints	Monthly		0	R = >1, A = 1, G = 0			0	0	0	2	0	
GM 08		Improved ward rosters	E-roster report - spend on agency staff	Monthly	Ward managers & matrons			586996.63							As per finance report
			Sickness absence	Monthly		< 3.5%	R = > 3.5%, G = < 3.5%	4.47	4.55	4.71	4.9		4.00	4.02	
			% Annual leave taken in-year	Monthly											Not possible to measure
			Complaints	Monthly		0	R = >1, A = 1, G = 0			7	5	7	15	1	
TO 02	Trauma & Orthopaedics	Changes to NORTH team to include more therapeutic lead than nursing.	Length of stay for hips	Monthly	Care Group Board		R=> 5 days, A=5 days or less, G=<3 days		4	4	5.73	3	2.67		
			Length of stay for knees	Monthly			R=> 5 days, A=5 days or less, G=<3 days		4.13	3.37	4.31	3.85	3.54		
			Re-admissions	Monthly			R=>3 A= 1-2, G=0		2	2	2	3	2		
			Wound infections	Monthly			R=>2, A=1, G=0		0	0	1	0	1		Data not available until 16th September due to staff absence
			Post-op pain relief	Monthly			R=>2, A=1, G=0		0	0	0	0	0		
			Post-op complications	Monthly			R=>6, A= 5, G = 1		1	0	0	0	0		
TO 03		Band reduction from 7 to 6	Datix reported incidents relating to fracture clinic nursing	Monthly	Care Group Board	0	R = >1, A = 1, G = 0			0	0	0	0	0	
			Complaints relating to fracture clinic nursing	Monthly		0	R = >1, A = 1, G = 0			0	0	0	0	1	
CH 10	Child Health	Play specialist downgrade	Sickness absence	Monthly	Child Health Management Team	<3.5%	R = > 3.5%, G = < 3.5%	4.18	3.93	2.8	1.96		3.50	3.57	
CH 12		Vacancy factor while recruiting	Paediatric oncology reported incidents	Monthly	Paediatric Risk Management	< 4 / month	R = > 4 / month, G = < 4 / month			0	0	0	0	0	
CH 13		Vacancy factor while recruiting	11 week breaches for new referrals	Monthly		0	R = 1 or more, G = 0	0	0	0	0	0	0	0	
OG 06	Obstetrics & Gynaecology	Band reduction from 4 to 3.	Sickness absence	Monthly	O&G Matron's team meeting	< 3.5%	R = > 3.5%, G = < 3.5%	4.17	4.52	4.09	3.75		3.73	4.61	
ON 02	Oncology & Haematology	Radiotherapy band 7 to band 6	CQUIN target for IMRT	Monthly	Directorate management board	33%				15%	15%	17%	23%	15%	
ON 04		Radiotherapy reduction in hours	Staffed Linac Hours	Monthly	Directorate management board	28hrs per week	R = <28.00, G = > 28.00			26.62	29.06	28.05	27.6	28.3	
ON 05		Radiotherapy mid-point vacancy						0							
ON 08		Chemotherapy OPD - matron led service (non-recurrent)	Clinical adverse events	Monthly	Directorate management board	5	R= <5, G= >5				37	29			Data is being validated.
ON 10		Medical Physics band 8a	No additional downtime	Monthly	Local management meeting	2% downtime	R = <98.00, G = > 98.00			98	99	98	98	99	
PA 10		Antenatal vacancies income							48.30%	38.70%	47.20%	47.20%	47.20%		Data not provided
PNS 01/02	Patient & Nursing Services	Post removal currently vacant (0.85 WTE band 8b) Post reduction budget lint (0.08 WTE)	Safety Thermometer outcomes	Monthly	Nursing & Midwifery Board			92.17%		93%	91%	92%	94%	91%	
			Incidence of pressure ulcers	Monthly						10	8	9	7	10	
			FFT Score	Monthly				68.33		60	67	62	62	70	
			FFT Response rate	Monthly						7%	9%	16%	17%	10%	

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 SEPTEMBER 2013

Title	Self-Certification Return
Agenda item	16
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 August 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:
August 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:	August 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 ha 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:	Sonia Swart
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer (Interim)	
Signed by :		Print Name :	Paul Farendon
on behalf of the Trust Board	Acting in capacity as:	Chairman	

Governance declaration 2

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

Signed by :		Print Name :	Sonia Swart
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer (Interim)	
Signed by :		Print Name :	Paul Farendon
on behalf of the Trust Board	Acting in capacity as:	Chairman	

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain bri 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	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Board Action
1	SHMI - latest data	Score	106.0	104.8	104.8	104.8	107.8	107.8	107.8	110.9	110.9	110.9	114.2	114.2	
2	Venous Thromboembolism (VTE) Screening	%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	92.36%	93.10%	95.50%	98.43%	96.80%	
3a	Elective MRSA Screening	%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	99.90%	99.50%	99.71%	99.65%	99.93%	
3b	Non Elective MRSA Screening	%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	96.40%	96.95%	97.98%	97.21%	97.14%	
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	10	13	14	24	19	25	35	41	35	51	21	10	There are 10 ongoing SI investigation - 4 of which were reported during August.
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	0	1	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	2	4	1	1	2	1	1	3	1	1	4	2	The 2 x red rated area relates to Induction of Labour (IOL) – 29.3% (red flag at >25%) and caesarean section rates – 27.3% (red flag at >26%).
10	Falls resulting in severe injury or death	Number	0	2	3	1	0	2	1	1	2	2	2	2	1st incident to be declared as a SI within the month of September. 2nd incident which occurred in August is under review for a SI
11	Grade 3 or 4 pressure ulcers	Number	2	3	7	7	6	3	6	3	6	7	0	1	1 x Grade 3 avoidable to be confirmed following receipt of a root cause analysis report.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
13	Formal complaints received	Number	35	44	40	24	68	57	52	45	58	37	29	38	
14	Agency as a % of Employee Benefit Expenditure	%	7.3%	8.50%	7.40%	5.00%	6.40%	6.60%	6.70%	5.80%	6.40%	6.70%	6.80%	6.20%	Aug 2013 - Medical Agency / Total Medical Expenditure was 7.5% and Nursing Agency / Total Nursing Expenditure was 3.9%
15	Sickness absence rate	%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	4.11%	4.01%	3.90%	3.58%	4.23%	
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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	4	4	3	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3	2	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.3**	**2.7**	**2.2**	**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			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes			
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	No	Yes	Yes	Yes	Yes			
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	Yes	No			
6	Two or more changes in Finance Director in a twelve month period	Yes	Yes	Yes	Yes	Yes			
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No			
10	Yet to identify two years of detailed CIP schemes	Yes	Yes	Yes	Yes	Yes			

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	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			
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a			
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a			
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes			
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	No	Yes	Yes	Yes			
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	No	No	No	Yes			
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes			
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No			A&E 4hr transit time performance for August 2013 = 90.35%
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a			
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a			
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a			
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a			
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a			
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a			
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a			
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	No	No	No			There have been a total of 17 cases of C-Dif from April - Aug 2013 (Year to date ceiling as at Aug is 12 cases)
			Is the Trust below the YTD ceiling	*29 (2013/14)*		Yes	Yes	Yes	Yes	No			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*0*		No	No	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			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	No	No	No	No	No			
				TOTAL		**1.0**	**3.0**	**3.0**	**3.0**	**2.0**	**0.0**	**0.0**	
						AG	AR	AR	AR	AR	G	G	

RAG RATING :

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

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

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			
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			
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No			
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	Yes	Yes	Yes	Yes	Yes			
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No			
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter	N/a	N/a	N/a	N/a	N/a			
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No			
		Adjusted Governance Risk Rating	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**0.0**	**0.0**	
			R	R	R	R	R	G	G	

CONTRACTUAL DATA

Information to inform the discussion meeting

Northampton General Hospital

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			
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes			
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	Yes	No	No	No			
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes			
5	Are there any disputes over the terms of the contract?	No	No	No	No	No			
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No			
7	Are the parties already in arbitration?	No	No	No	No	No			
8	Have any performance notices been issued?	No	No	No	Yes	Yes			
9	Have any penalties been applied?	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 • Monthly QRP reporting to the Integrated healthcare Governance Committee • Annual CQC assurance report to the Board. • Active CQC compliance regime audited regularly.
G8 – Patient Eligibility and Selection Criteria	The condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.	Compliant	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 Progress against the agreed Improvement Plan for Urgent Care is satisfactory and is reviewed in detail at the Trust Integrated Healthcare Governance Committee. There is an existing risk relating to the recruitment of appropriately skilled medical and nursing staff and an emerging risk regarding the steep rise in attendances at A&E in the current year. 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
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.

Board Statement	NGH Compliance	Assurance/Actions Required for Compliance
12. The Board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Compliant	Standards of Business Conduct Policy Register of Interests in place. Board vacancies currently being recruited to. Board members signed up to NHS Code of Conduct for Board members.
13. The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Compliant	Outcomes of external Board assessments – Deloitte Job descriptions for Board members Appraisal process in place for Board members. Board development programme being implemented.
14. The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Compliant	Outcomes of external Board assessments – Deloitte Job descriptions for Board members Appraisal process in place for Board members. Board development programme being implemented. Board vacancies filled with interims whilst active recruitment for substantive post holders is underway.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Healthier Northamptonshire Programme Update
Agenda item	17
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s)	Chris Pallot, Director of Strategy and Partnerships
Purpose	Information and Assurance

Executive summary

This presentation provides an overview of the scope of the Healthier Northamptonshire programme, in particular it covers:

- Purpose and vision
- The consolidated workstreams brought into the programme
- The contents of the Healthier Northamptonshire Strategy paper
- Expectations over the responsibilities and behaviours of organisations involved

Related strategic aim and corporate objective	Strategic Aim 2 & 5
Risk and assurance	Positive assurance on the delivery of the Healthier Northamptonshire Programme.
Related Board Assurance Framework entries	BAF 8, 9, 10, 20, 23, 24
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

- To endorse the revised Healthier Northamptonshire Programme,
- To commit our support to the relevant workstreams

Overview of the Healthier Northamptonshire Programme

Northampton General Hospital NHS Trust Board
23 September 2013

Overview of this presentation

This presentation provides an overview of the scope of the Healthier Northamptonshire programme, in particular it covers:

- Purpose and vision
- The consolidated workstreams brought into the programme
- The contents of the Healthier Northamptonshire Strategy paper
- Expectations over the responsibilities and behaviours of organisations involved

Action: For note and approval by the Members of the Board

Purpose and vision

The purpose of the programme is to deliver a clinically and financially sustainable health and social economy

Purpose of the Programme

To deliver a clinically and financially sustainable health and social economy

Vision

County Leaders agreed a vision which was summarised as "*needing to be both radical and transformational with the requirement for integration being high on all participants' agendas*"

Aims

- Ensure **sustainability** of the Northamptonshire health and social care economy
- Improve **access and quality of care** for patients and service users
- Provide care in the most **appropriate setting** and in line with best practice
- Support people to **manage their own health** and reduce use of hospital beds and services
- Ensure that people have a **positive experience** of care
- Reduce **health inequalities** in Northamptonshire
- Enhance **staff satisfaction** throughout the health and social care economy

To achieve this there needs to be an agreed definition of sustainability

Healthier Northamptonshire
Better care *in the right place*

Sustainability

Sustainability is defined as all **organisations being financially balanced to agreed clinical quality standards and performance expectations**, it does not presuppose that organisational structures will remain as is

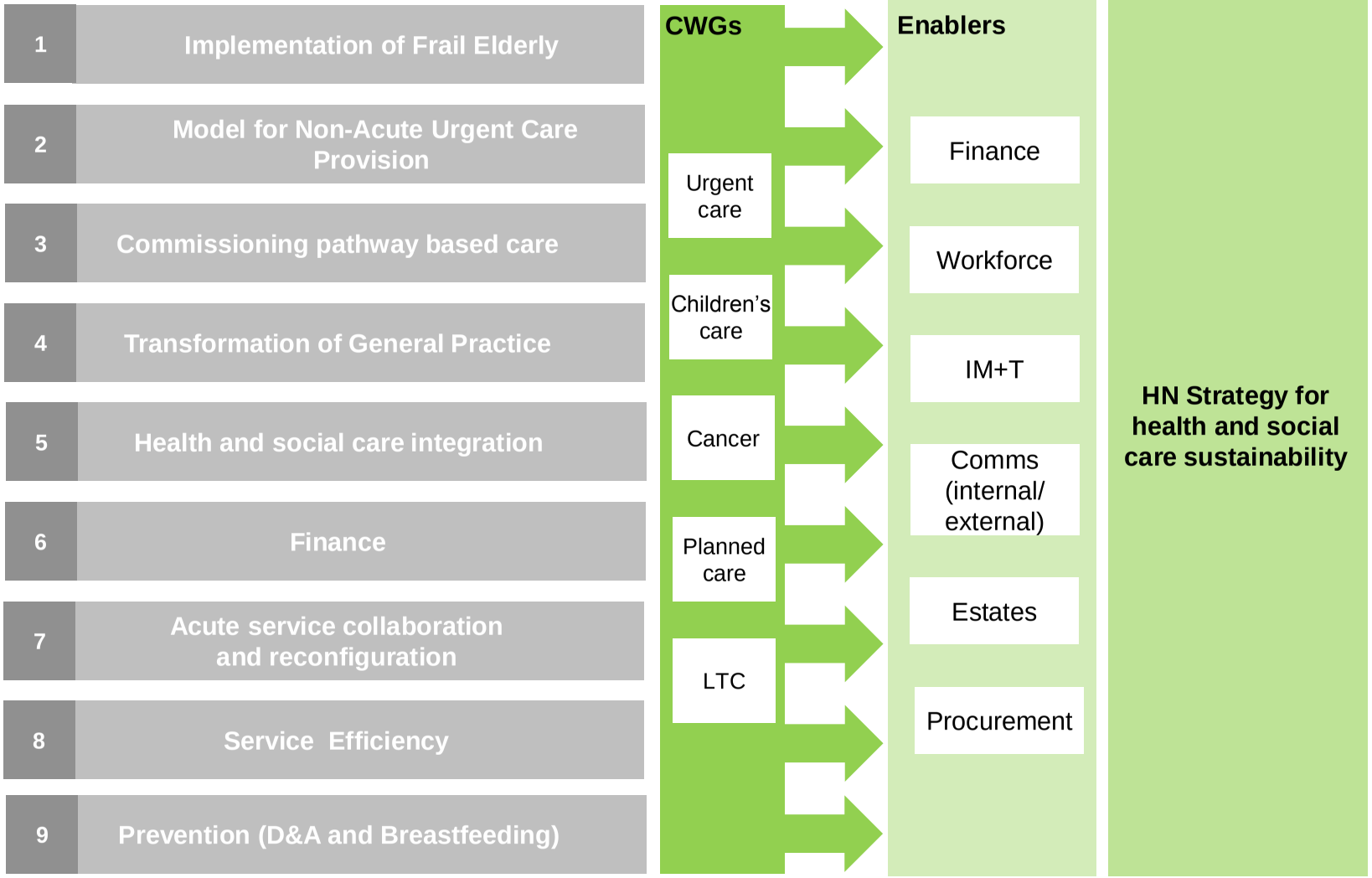
What does success look like

- All organisations able to at least break even in the medium term
- Increase access to 24/7 care across the health and social care system
- Improve life expectancy at age 75 for males and females
- Reduce potential years of life lost from causes considered amenable to healthcare
- Reduce unplanned hospital attendances and admissions
- Increase number of pathways aligned with best practice and contracts in place
- Reduce number of total bed days in acute and community hospitals
- Improve results on friends and family test
- Reduce gap between Northamptonshire and national average for life expectancy at birth and at age 65 between ethnic groups, and between most and least deprived areas of the county
- CQC clean bill of health
- High recruitment and retention of top performing staff at all organisations

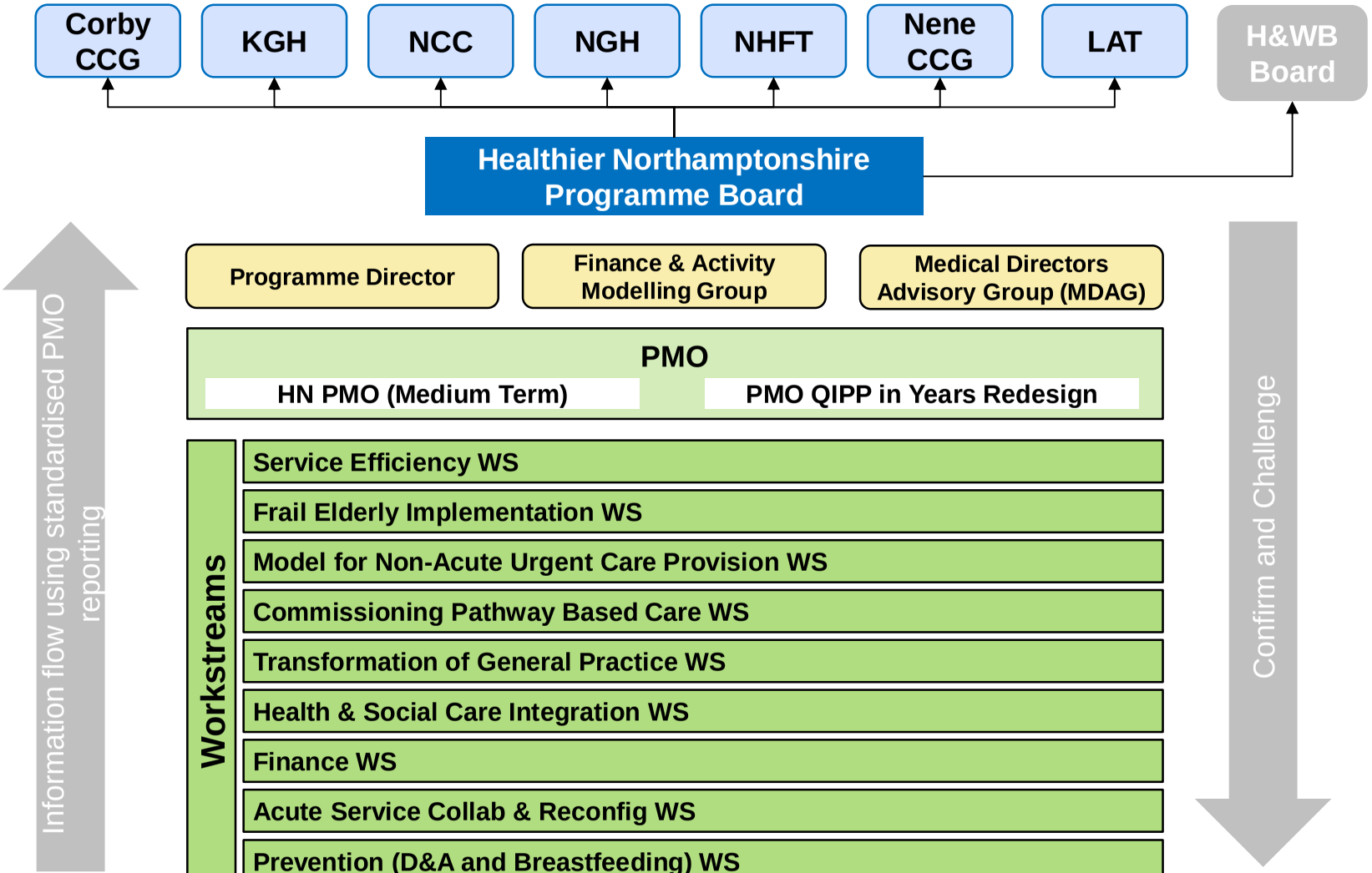
Consolidated workstreams

Following on from County Leaders and further meetings, HN programme has looked to bring in nine consolidated workstreams which will develop an overall plan to deliver a balanced health and social care system

Healthier Northamptonshire
Better care *in the right place*



To deliver these a single Programme Board is required which will provide advice to the statutory bodies above it, while working with scrutiny bodies



The workstreams have a clear remit and deliverable, but need to be worked into full plans over the next month (1/2)

Healthier Northamptonshire
Better care *in the right place*

1 Service efficiency

Core Remit: Develop proposals for service efficiency for commissioners and providers, and areas where activity could be reduced significantly

Deliverable: Proposals for service efficiency leading to Countywide QIPP plan

2 Implementation of Frail Elderly

Core Remit: : Implement the Crisis Hub and pilot MDTs in some localities to test the concept, inform the commissioning specification, and feed into modelling work

Deliverable: Implement the Crisis Hub and pilot MDTs, and develop a plan to evaluate the implementations January – March 2014

3 Model for non-acute urgent care provision

Core Remit: Develop proposals for non-acute urgent care provision across Northamptonshire

Deliverable: Options appraisal for longer term non acute urgent care provision

4 Commissioning pathway based care

Core Remit: Refresh existing analysis to identify which patient cohorts are the next priority following the Frail Elderly implementation

Deliverable: Recommendation on patient cohorts for priority implementation

5 Transformation of general practice

Core Remit : Develop locality vision for primary and community care and pilot specialist practices and GP networks in selected localities.

Deliverable: Recommended approach to transformation of general practice and plan for piloting specialist practices and GP networks

The workstreams have a clear remit and deliverable, but need to be worked into full plans over the next month (2/2)

Healthier Northamptonshire
Better care *in the right place*

6 **Health and social care integration**

Core Remit : Develop a shared vision across organisations for integrated care, and develop a high level operational model to achieve this vision

Deliverable: Vision and high level operational model for health and social care integration

7 **Finance**

Core Remit: Advise on approach to budgeting which enables collaboration and integration of services(pooled budgeting)

Deliverable: Report identifying changes to budgeting to improve collaboration

8 **Acute service collaboration and reconfiguration**

Core Remit: Identify clinical and non-clinical opportunities for collaboration and reconfiguration, and develop selected opportunities

Deliverable: Recommendations of acute clinical and non-clinical opportunities for collaboration and reconfiguration

9 **Prevention**

Core Remit: Support implementation of key health prevention initiatives, in particular the H&WB priorities relating to breastfeeding and drug and alcohol services

Deliverable: Paper on plans to support H&WB priorities

Expectations over the responsibilities and behaviours of organisations involved

Expectations over the responsibilities and behaviours of organisations involved in the Healthier Northamptonshire programme

- Following on from the principles agreed at the establishment of the Healthier Northamptonshire programme in April 2013, all organisations party to the establishment of the Programme Board are asked to review and agree the following points
- These points will underpin the planning of the health and social care services across Northamptonshire
- They apply to both commissioners and providers alike, unless specifically indicated to apply to one or the other only
- Once agreed they will constitute a Memorandum of Understanding (MOU) between all organisations

As a member of the Healthier Northamptonshire programme, we will… (1/3)

1. Put patients and taxpayers, not our organisations, first when planning health and social care services for the future
2. Ensure that no decision is made on behalf of health and social care patients without working with them to develop ideas and inititiatives
3. Plan, commission and deliver services, according to population need and evidence-based practice, within the resources available to us as a health community
4. Plan to live within our collective financial means
5. Ensure quality and equality will be at the heart of all that we do, and in developing plans, organisations commit to upholding and improving the quality of care for patients
6. Work collegiately to develop coherent plans for the Northamptonshire health and social care system

As a member of the Healthier Northamptonshire programme, we will… (2/3)

7. Be transparent and open with regard to the challenges we face and in sharing our cost saving schemes (CIP and QIPP plans) for the Northamptonshire health and social care system

8. Not take unilateral action that potentially results in a cost or workload shift to other organisations which would destabilise it without prior review and discussion at the Programme Board

9. Take action as necessary to ensure that decisions are implemented and benefits realised quickly. Consequently, “Over achievement” of QIPP and CIP savings will be positively recognised and organisations will not be penalised in subsequent years for their commitment to partnership and delivery

10. Agree that the work projects undertaken through the Programme will constitute the main initiatives of our annual plan rounds up to 2016/17

11. Commit necessary resources and support to the programme including to the PMO, programme workstreams, clinical working groups, and all other sub-groups as agreed by the Programme Board

As a member of the Healthier Northamptonshire programme, we will… (3/3)

12. Engage, involve and consult stakeholders, patients and the public in our planning and delivery of services for the future

13. Abide by the communications plan and media protocols of the Programme

14. Work with third sector and cross-regional organisations, such as the Local Education and Training Board (LETB), to ensure they are consulted and informed in the work of the Programme

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
23 September 2013

Title	Equality and Human Rights Strategy 2013/16
Agenda item	18
Sponsoring Director	Janine Brennan, Director of Workforce and Transformation
Author(s)	Sarah Kinsella, Corporate HR Officer
Purpose	Decision

Executive summary

The Equality and Human Rights Strategy for the Trust is presented to the Board for approval. This is the reviewed Equality and Human Rights Strategy 2013 to 2016 for Northampton General Hospital NHS Trust. It updates and replaces the Equality and Human Rights Strategy 2011 to 2013. It details how the Trust will eliminate discrimination, advance equality and foster good relations between people who share certain characteristics and those who do not: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. It builds on the work already done and progress made on equality, diversity and human rights over the years and sets out our co-ordinated and integrated approach.

Implementation of the Equality and Diversity strategy will commence implementation during autumn.

The Strategy has been approved by the Equality & Diversity Strategy Group.

Related strategic aim and corporate objective	All
Risk and assurance	Assurance
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)

Actions required by the Board

The Board is asked to approve the Equality and Human Rights Strategy 2013/16

Northampton General Hospital NHS
NHS Trust

Equality and Human Rights Strategy

2013 - 2016

CONTENTS

Foreword

This is the reviewed Equality and Human Rights Strategy 2013 to 2016 for Northampton General Hospital NHS Trust. It updates and replaces the Equality and Human Rights Strategy 2011 to 2013. It details how the Trust will eliminate discrimination, advance equality and foster good relations between people who share certain characteristics and those who do not: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. It builds on the work already done and progress made on equality, diversity and human rights over the years and sets out our co-ordinated and integrated approach.

We aim to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of the different groups and individuals we serve and those we employ.

To achieve these aims we want to ensure that service users and employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work of the Trust.

Leadership and commitment at all levels of the organisation is central to the success of this Strategy. It is the duty of the Trust Board to implement the Strategy successfully. Trust staff will also have an important role to play with implementation and we welcome the opportunity to involve and work with all stakeholders to promote equality and human rights in order to improve the services and working environment we provide.

The Trust Board will receive regular feedback on the implementation and promotion of this Strategy and we will evaluate progress to ensure we are striving towards what we set out to achieve.

Equality for Patients

People are individuals with a wide range of health needs who we support to make choices about their lives and their care. From prevention through to admission, assessment, treatment and aftercare, we promote the health, wellbeing and dignity of everyone we care for.

Our care is accessed and provided by a large diverse population. We listen to our communities and workers to plan our services around their priorities. Where there is evidence of unfair barriers or unlawful discrimination we improve our services to ensure they are removed.

Equality for Staff

Our staff are our greatest resource. We actively promote a culture that encourages their richly diverse talents to lead services that deliver inclusive care.

This strategy promotes inclusive employment practices because well supported staff can deliver better care for our patients.

1 NATIONAL EQUALITY AND HUMAN RIGHTS AGENDA

1.1 NHS Values

Everyone's lives – all of our patients, service-users, carers, relatives and staff – are invaluable. Upon this self-evident idea are built the NHS values:

- Respect and Dignity
- Commitment to Quality of Care
- Compassion
- Improving Lives
- Working Together for Patients
- Everyone Counts

These values serve to motivate and inspire us to deliver good quality care. They also are the values that through the NHS constitution provide the public with guarantees about the services provided by the Trust. As such they can also be used to judge us, including by the government through formal inspection and review.

1.2 The NHS Constitution

The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this constitution in their decisions and actions.

The principles that guide the NHS are set out in the NHS constitution which states:

- The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status
- Access to NHS services is based on clinical need, not an individual's ability to pay
- The NHS aspires to the highest standards of excellence and professionalism
- The NHS aspires to put patients at the heart of everything it does
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients that it serves.

In addition to the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998 provide the framework for recognising the importance of equality and respecting diversity in all aspects of the work at Northampton General Hospital (NGH).

1.3 The Francis Report

The Trust will work together to introduce the recommendations of the Francis Report which focuses on the following themes:

- Emphasis on and commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- No tolerance of non compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all the system's business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles
- A level playing field for accountability
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

1.4 Equality and Human Right Commission

The Equality and Human Rights Commission published technical guidance on the Public Sector Equality Duty in January 2013. This has highlighted a number of issues Northampton General Hospital needs to take note of. These include:

- Recent case law examples which clarifies the role of the Trust Board, managers and employees in relation to equality, diversity and inclusion
- Confirmation of the need to consider equality in respect of our policies and functions

Ongoing consideration of the impact of the technical guidance will be monitored through the Equality and Human Rights Steering Group.

1.5 Commitment to Equality and Human Rights

The Trust's commitment to equality and human rights is not simply to ensure legislative requirements are met, but to continuously improve its working practices so that it creates an organisation which is recognised both internally and externally for embracing diversity and human rights and demonstrating equality in practice.

The Trust is committed to putting the principles of equality and human rights into practice, both for its workforce and in the services it offers and the Trust pledges it will:

- Promote equality and diversity and human rights and work towards eliminating all forms of discrimination
- Develop a culture that values individuals and groups regardless of their backgrounds
- Provide responsive and accessible services to the population it serves

- Forge partnerships with users, carers, staff and stakeholders so they can influence the development and improvement of services.

The Trust will achieve this by:

- Developing and improving its services by mainstreaming equality and human rights into our policies, procedures and service planning
- Having a robust performance framework to monitor and assess progress
- Forging partnerships with users, carers, staff and stakeholders to influence the developing of its workforce through training
- Having transparency in decision making.

1.6 The Equality Act 2010

The Equality Act 2010 protects people from discrimination on the basis of 'protected characteristics'. These are the differences in peoples' identity and circumstances that are protected by the Equality Act from disadvantage and discrimination in our care:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership.

1.7 Our General Duties

The strategy contains actions that meet our obligations from the public sector equality duty (Section 149 of the Equality Act 2010). This obliges that the Trust in the exercise of its functions, has due regard to the need to:

- Eliminate discrimination, harassment and prohibited conduct
- Advance equality of opportunity between different people
- Foster good relations between different people.

The Act indicates that the 'need to advance equality of opportunity' includes the need to:

- Remove or minimise disadvantage suffered by particular groups
- Take steps to meet different needs of particular groups and,
- Encourage participation by particular groups in areas of public life or other activity where they are under-represented.

The Act specifies that 'the need to foster good relations' includes the need to tackle prejudice and promote understanding.

The disadvantages this strategy addresses are gaps between different people's health and work opportunities called 'inequalities'.

Disadvantage can sometimes amount to unlawful discrimination or abuses of people's rights and this strategy details the way people can hold us to account if these occur.

1.8 Our Specific Duties

To help deliver the general duty, there are also specific duties which form the aims of this strategy:

Publication of Information
Publish information annually about employees, patients and service-users to demonstrate compliance with the general duty.

Equality Objectives
Publish specific and measurable objectives to deliver the general duty.

Accessible Publication
Ensure that information published to meet the other two specific duties is accessible to the public.

The Equality and Human Rights Commission (EHRC) is a statutory body independent of government. It has powers to enforce the Equality Act, including by investigation and launching legal proceedings.

1.9 The Human Rights Act 1998

The Human Rights Act places all public authorities in the UK under a duty to respect the rights it contains in everything we do. We are under a duty not only to ensure that we do not commit human rights abuses but also we have a duty to take proactive steps in order to ensure that human rights are respected, protected and fulfilled.

These rights affect the rights of individuals:

- Human rights are about our basis needs as human beings
- Human rights belong to everyone, all of the time – not only certain groups at certain times
- They cannot be 'given' to us – only claimed or fulfilled
- They cannot be taken away from us, only limited or restricted in some circumstances
- They are about how public authorities, such as NHS organisations, must treat everyone as human beings.

In essence human rights are a set of universal minimum standards that must be met. They are not only about the protection of particular individuals and groups in society but are a practical framework to protect the rights of everyone.

Human rights values such as Fairness, Respect, Equality, Dignity and Autonomy (FREDA) underpin the public service ethos, the NHS Constitution and NHS Professional Codes of Conduct.

By putting human rights at the heart of health services we can not only comply with the law but also improve the quality of patient care.

As a Trust we have the responsibility to respect people's rights to ensure that everyone counts. For example patients having the right to be treated with dignity and respect such as ensuring that patient nutritional needs are met. There are various forums in the Trust which lead on these issues including:

- The Dignity Forum
- The Dementia Care Action Committee
- The Nutritional Group
- The Falls Group
- The Safeguarding of Vulnerable Adults Group.

2 THE TRUST'S EQUALITY AND HUMAN RIGHTS STRATEGY

The Trust believes in the dignity of all people and their right to respect and equality of opportunity. The Trust values the strength that comes with difference and the positive contribution that diversity brings to the hospital. The Trust operates within a national framework of equality legislation, however, the Trust aims beyond simple compliance with the law. Equality is central to all that we do.

The Trust sees equality of opportunity and access as a vital part of its approach to delivering quality patient care and becoming a model employer. It is committed to providing services which respect and respond to the diversity of the local population. It is also committed to ensuring staff are recruited fairly and are provided with a positive and valuing work environment which supports them to achieve their maximum potential.

2.1 The Equality Delivery System (EDS)

Northampton General Hospital has adopted the EDS which is a Department of Health initiative designed to support NHS organisations deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is all about making positive differences to healthy living and working lives so that everyone counts.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The goals are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels.

The outcomes have shaped and been mapped onto the actions planned within this equality and human rights strategy.

2.2 The Trust's Four Year Action Plan

The Trust has agreed a four year plan with reference to public sector and other duties and to equality target groups. The objectives set encourage an outcome focussed approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff.

The objectives address the biggest and most pressing issues facing the protected groups that we provide services for and employ, prioritising the most significant issues for the protected characteristics.

During 2011, in full engagement with local interests, the Trust developed four year equality objectives and priorities, based on a grading of our equality performance against a set of EDS goals and outcomes.

Goal	Objective
1. Better Health outcomes for all	We will develop a programme of data collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire
2. Improved access and experience	The Trust will increase the engagement and involvement with representatives from protected groups. In 2 years we will aim to achieve representation from 100% of the protected groups.
3. Empowered, engaged and well supported staff	We will aim by 2014 to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trust's for response to the question regarding whether staff would recommend the Trust as place to work.
4. Inclusive leadership at all levels	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS Leadership Framework and its supporting frameworks.

The detailed action plan of the Trust's equality objectives which are updated on a six monthly basis can be access via the Trust's internet. The link to this is:

www.northamptongeneral.nhs.uk/WorkforUs/Downloads/Equality-Objectives-2012-to-2016.pdf

2.3 Reporting Structure for Monitoring and Evaluating the Trust's Four Year Plan

The Trust has an Equality and Human Rights Steering Group which is co-chaired by the Trust's Chairman and the Director of Workforce and Transformation. The multidisciplinary group meet quarterly and are committed to embedding a culture of equality and human rights into all aspects of everyday life at the hospital.

The aim of the Equality and Human Rights Steering Group (E&HRSG) is to successfully implement and monitor the progress of the Equality and Human Rights Strategy and the agreed four year plan and objectives. This will not only enable the hospital to fulfil its legal duties but will support the continued promotion of equality and human rights across the hospital.

The E&HRSG reports to the Strategic Management Board twice yearly and annually to the Trust Board by way of the Director of Workforce and Transformation.

The terms of reference for the group have been attached at **Appendix 1.**

3 THE TRUST'S DELIVERY OF THE EQUALITY DUTIES

3.1 Eliminating Discrimination, Harassment and Other Conduct which is Unlawful

The Trust proactively aims to eliminate discrimination, harassment and other prohibited conduct by carrying out equality impact analysis on policies and services. When incidents of discrimination do occur we have robust policies and practices in place to address this and these are monitored on a regular basis.

Staff Harassment and Discrimination Policies
Staff wishing to raise a complaint of harassment against a colleague or manager may do so through the Harassment and Bullying policy which is linked to the Trust's Grievance procedure and where allegations are founded these matters are dealt with through the Trust's Disciplinary policy and procedure. The Grievance procedure covers all other types of discrimination including failure to make reasonable adjustments.

In addition, the Trust has a policy 'Protecting Staff against Violence, Aggression and Harassing Situations from Patients and the Public' as it believes that all staff have the right to work in an environment free from violence, aggression and harassment and where appropriate can take and support action to protect staff. The purpose of this policy is to provide managers and staff with a clear process for the prevention and management of violent aggressive and harassing incidents towards staff by patients and members of the public.

Further advice on these policies is available from the Human Resources department or Trade Union officers.

Patient Harassment and Discrimination Policies
The '4 'C'S' (comments, concerns, complaints, compliments) policy incorporates PALs / Bereavement and Complaints Management outlines the Trust's procedures for patient discrimination. Should patients, carers or members of the public be dissatisfied with the care provided by this Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. Under no circumstances should patients, relatives or carers be treated adversely as a result of raising concerns/complaints about any aspect of the service provided by this Trust.

The Trust welcomes all forms of feedback and information which is used to improve the service that is provided to the local community.

Further advice on this policy is available from all members of staff and the Patient Advice and Liaison Service.

Training
Every employee of NGH must comply with equality law and the statutory equality duties, including the elimination of unlawful discrimination and the promotion of equality in employment and service provision.

Training for staff regarding these issues, as well as training regarding issues related to specific protected characteristics, will be provided in a variety of formats to ensure training regarding equality, diversity and human rights is available for all staff.

The promotion of equality and human rights in both service provision and employment requires the development of appropriate learning and development arrangements.

The Trust provides equality and diversity training for all staff including the Trust Board and it forms part of the Trust's mandatory training programme. Avoiding and tackling discrimination, harassment and other prohibited conduct is also a specific feature of the Trust's induction.

3.2 Advancing Equality of Opportunity

'Equity and Excellence: Liberating the NHS' (DoH, 2010) sets out a vision for the NHS focused on improving quality and achieving world-class outcomes by ensuring that care providers:

- Are genuinely centred on patients and carers
- Achieve quality outcomes that are amongst the best in the world
- Refuse to tolerate unsafe and substandard care
- Reduce mortality and morbidity.

Quality Strategy
The ultimate purpose of the Quality Strategy is to provide the very best care for all of our patients.

There is a fundamental and complementary relationship between the Quality Strategy and the Equality and Human Rights Strategy and this will ensure the advancement of

equality and human rights is at the heart of everything the Trust does to develop and deliver its Quality Strategy and equality agenda.

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

In order to achieve this vision, the Trust has set out five aims, all of which reflect our vision for quality;

- Be a provider of quality care for all our patients
- Enhance our range of specialist services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care.

Every Patient will:

- Receive the right treatment at the right time in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their individual needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision making about their care
- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

We will develop our staff so that:

- All staff will recognise their contribution to quality and its improvement
- All staff will have the necessary training and development to improve service quality
- All workplaces will be safe with effective management of risks and hazards
- All staff will be appraised annually, and have agreed PDPs which harness their potential for quality improvement
- Staff concerns will be listened to
- When things have not gone well, we will focus on learning lessons and improving quality
- When things go well, information and learning will be shared so others can learn

Making Improvements

In order to meet the general duty, as well as to demonstrate the outcomes in the specific duties, it will be necessary before decisions are taken, policies adopted or practices changes, to ensure that assessment is made of the equality impact of what is proposed. After undertaking the assessment, action can be taken to prevent direct and indirect discrimination and promote equality. Any negative consequences for a particular group or section of service users/staff can be eliminated, minimised or counterbalanced by other measures wherever possible in order to take account of and meet the needs of all our communities.

Consideration will be given to:

- Effective processes and communication between staff and service users
- Physical access
- Provision of information in a format which can be understood
- Cultural norms, preferences and practices of equality groups taken into account
- Available relevant data and service user / staff feedback.

Trust and Directorate service plans will include reference to, and specific actions of, equality actions.

In advancing equality the action plan and analyses through the assessments ensure that the Trust is able to:

- Remove or minimise disadvantage experienced by people connected to 'protected characteristics'
- Take steps to meet the needs of people who share a protected characteristic where these are different from people who do not share it
- Encourage people who share a protected characteristic to participate in public life or any other activity where participation is disproportionately low.

3.3 Fostering Good Relations

Equality and diversity is one of the Knowledge and Skills Framework core dimensions and as such is part of the annual personal development review undertaken by all staff each year. Evidence of understanding and knowledge of diversity issues needs to be provided by staff and discussed at personal development review interviews.

To tackle prejudice and promote understanding, this strategy includes actions to address the inclusion of diversity.

Engagement, Involvement and Consultation for Patients
The Trust is committed to involving and consulting patients, carers and the public by developing close links with our local population through governors, members and staff to provide a framework for: -

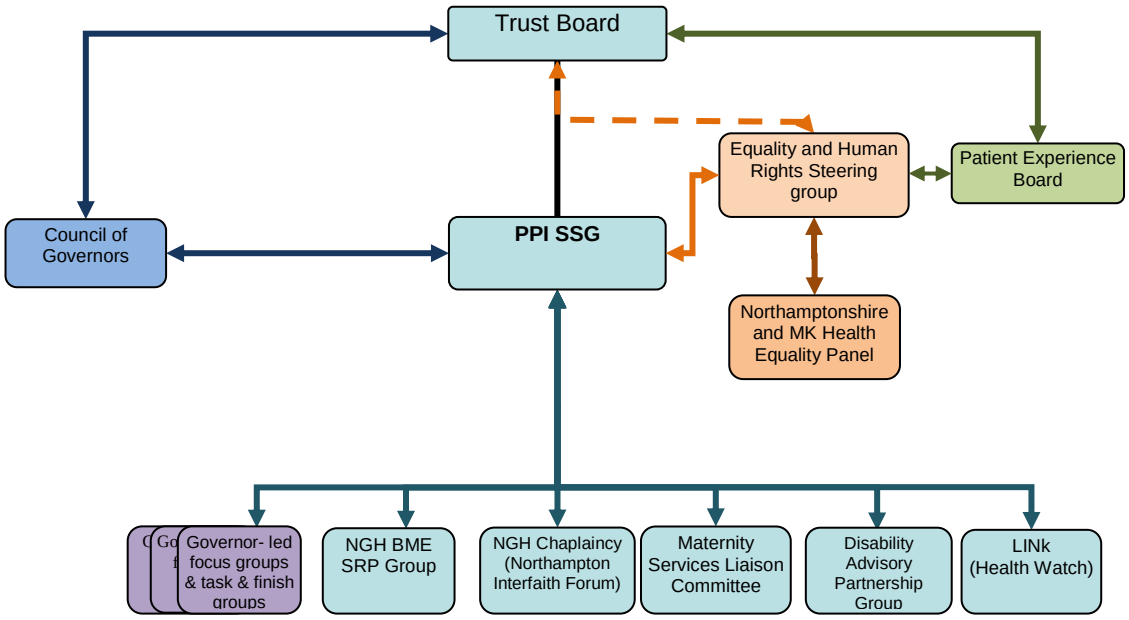
- Changes to existing services and how these changes are implemented
- The quality of services we provide
- The planning of new services

The Trust works towards ensuring that there is a flexible approach to involvement so that everyone, despite their background, location or particular needs can be involved.

The aim of the Northampton General Hospital Public and Patient Involvement (PPI) Strategy is to involve patients, carers and the public in order for the Trust to: -

- Obtain the best outcomes for the patient
- Improve the patient experience
- Help us to run our services more efficiently and effectively
- Have a say in future service developments.

The patient experience is at the heart of everything we do and in order to ensure that the Trust has sustained and meaningful engagement with representatives of service users from all protected and disadvantaged groups, the Trust ensures that issues raised through the different patient involvement groups and actions taken are reported, via the Patient and Public Involvement Steering Group (PPISG) to the Equality and Human Rights Steering Group (E&HRSG) and the Trust Board. In addition, in 2012, the Trust established the Patient Experience Board which also reports to the Trust Board. The reporting structure is demonstrated in the organisational chart below.



The Trust has established a variety of patient groups which represent services users from protected groups:

- The Trust Disability Advisory Partnership Group
- The Trust Maternity Services Liaison Committee
- The Trust Black and Minority Sub Regional Partnership User Group (BME, SRP Group)
- The Chaplain is a member of Northampton Interfaith Forum (NIFF)
- Local Involvement Networks (LINks) and their successors (Health Watch) help the Trust to engage with local interests from other protected or hard to reach groups.

The Equality Lead for patient services and the Deputy Director of Human Resources are members of the Northamptonshire Health Equality Group through which the Trust is able to engage with communities from protected groups and representatives from other Northamptonshire Healthcare providers regarding how health needs can be met, well-being promoted and inequalities reduced.

The terms of reference of the Northamptonshire Health Equality Group is attached in **Appendix 2.**

The Trust endeavours to ensure that people find it easy to raise their concerns, including those from the “hard to reach” groups.

- Using the annual Patient and Staff surveys, results from the Friends and Family question and issues raised in the ‘4Cs’ (Comments, concerns, complaints and compliments)
- Analysing the results of the equality and diversity monitoring exercises to improve patient, visitor and staff experience.

Engagement, Involvement and Consultation for Staff

Joint Consultative and Negotiating Committee
The Trust has an active local Joint Consultative and Negotiating Committee (JCNC) as well as a Local Negotiation Committee that meets on a regular basis. Unions and management of the Trust attend both committees.

The hospital promotes partnership working and is currently in the process of jointly developing a partnership agreement. The intention is to take the involvement and engagement of the staff side to an even more powerful level.

The Partnership Agreement will be based on the Trust’s vision, values and a set of shared principles. The Chief Executive is leading this work and is working closely with Staff Side to develop a suitable Partnership Agreement Model for the Trust.

Staff Involvement – Staff Survey
Our intention to become an Employer of Choice is based on developing an organisational culture whereby all staff can give their best and thrive. Our belief is that all staff should feel respected and valued and that individual commitment and dedication is recognised. Our actions in respect of this are translated into our Care Group staff action plans, which are based on the results of the survey and the views of our staff as to what matters most to them at work.

Listening into Action (LiA)
The Trust has embarked on the Listening into Action programme (LiA) which is a new and engaging way of working. The programme is led by the Chief Executive and the aim of Listening into Action (LiA) is to empower staff to drive the changes they want to see for the benefit of their patients - with ownership firmly in their hands, and the backing of the Trust’s leadership and management teams, whose job it is to help unblock the way.

There are four phases to the LiA programme. These are as follows:

Phase 1: Committing to a new way of working
Phase 2: Engaging staff around what matters
Phase 3: Mobilising and empowering staff to drive change
Phase 4: Embedding LiA as 'the way we do things around here'.

Each of the phases is designed to build momentum and a sense of ‘something different’ happening at the Trust for staff, which helps challenge existing convention in a positive way, and overcomes staff scepticism that this is ‘just another initiative’.

3.4 Monitoring and Publishing Information

Equalities monitoring data is the information the Trust collects about the demographics of our community, service users and staff. We will utilise the information to understand those who are experiencing discrimination or barriers to using our services or for those employed by the Trust.

Monitoring can be used to:

- Improve our knowledge and understand our service users and their requirements
- Find out what barriers exist to people who cannot or do not use our services
- Understand what kind of improvements also improve satisfaction with the Trust and its services
- Identify whether we are treating people fairly, with dignity and respect
- Inform service development and planning.

The Trust believes that monitoring is an important way of measuring the effects of policies in practice and is a vital part of any strategy to promote equality and human rights in the organisation. Without monitoring there is no reliable way of knowing whether discrimination might be taking place, how or why it takes place or whether the Trust's policies to prevent or tackle it are working.

In service delivery, monitoring can inform us which groups are using the services, in order that we can consider ways of reaching under-represented groups and making sure that our services are relevant to their needs and provided fairly.

Monitoring of service and workforce data is collected relating to the protected characteristics as defined in the Equality Act 2010. As part of our action plan, improvement will be made to ensure better quality data is provided and work is continuing in partnership with other NHS organisations in Northamptonshire. Data analysis will influence the Trust on future services and this information will also identify areas of under representation across the workforce whether this is in specific areas of work or in relation to salary bands.

In addition to the monitoring process the Trust will collect information by a range of different methods so that it is capable of assessing its performance and improving its services, these include:

- Keeping records to identify who is using Trust services and when
- Satisfaction surveys, with results analysed by target groups
- Random or targeted personal interviews
- Data on complaints, incidents and PALS enquiries, reviewed according to target groups
- Engagement with external reference groups regarding health matters
- Engagement with partner organisations, including the voluntary sector
- Engagement with patient participation groups in locally focused services
- Public consultation meetings and structured focus groups.

The Trust's Patient Administrative System is used to collect patient data relating to the protected characteristics. The Employee Staff Record (ESR) is used to collect this

information in respect of all employees. The Trust will review the type and amount of information collected to ensure that adequate data is available to determine the effect its functions and policies have on minority groups.

Directorates are encouraged to research local population data to highlight known health needs of the clients, particularly the minority groups, they serve and to take this information into consideration when developing or reviewing services and policies.

Under the lead of the Human Resources Directorate, each Directorate will ensure that there is fair recruitment and aim for a representative workforce so as to create a working environment that is safe, accessible for all, and free from harassment and discrimination.

The Trust is required to publish sufficient information to demonstrate our compliance with the general duty across our functions.

3.5 Procurement and Commissioning

Many of the goods and services provided to the Trust are procured or commissioned from external suppliers/contractors. The NHS Purchasing and Supply Agency's procurement terms and conditions used by the Trust have specific clauses covering equality and diversity. Trust staff responsible for purchasing/commissioning will use these conditions as a minimum to ensure fair and proper practice is followed.

4 QUALITY AND COMPLIANCE – INSPECTION AND ENFORCEMENT

Care Quality Commission
The Trust is registered with the Care Quality Commission (CQC) to deliver certain types of care to a wide range of standards: the 'Essential Standards of Quality and Safety'. The Trust participates in CQC reviews and inspections of our health care. These standards were introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. The regulations include 28 outcomes grouped under the following headings:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management.

The activities contained within this strategy are harmonised with the relevant CQC outcomes because addressing equality for all the people we serve is a marker of good quality.

The Care Quality Commission is the independent regulator of health and social care in England. The Care Quality Commission measures the quality of health care provided by the Trust and as part of that includes equality.

Equality and Human Rights Commission
The Equality and Human Rights Commission (EHRC) is a statutory body independent of government. Its responsibilities include:

- Ensuring people are aware of their rights and how to use them
- Helping employers and service providers develop best practice
- Ensuring policymakers promote equality
- Using their powers to enforce the laws that are already in place:
    - Investigations
    - Agreements not to commit an unlawful act
    - Judicial review and interventions
    - Inquiries
    - Injunctions
    - Applications to restrain from unlawful advertising,
    - pressure to discriminate.

The Equality and Human Rights Commission have formal joint-working practices with the Care Quality Commission.

How to give us feedback
We welcome feedback on our Equality and Human Rights Strategy 2013 to 2016. You can do this by contacting the Trust using the information below:

Sue Campling
Service Equality Lead
Northampton General Hospital
Cliftonville
Northampton NN1 5BD

Alternatively you can email Sue at the following email address:

Sue.campling@ngh.nhs.uk

Accessible Information

The Equality and Human Rights Strategy, this summary, the appendices and the results of public feedback and the Annual Reports are available online at www.northamptongeneral.nhs.uk/WorkforUs/Downloads/Equality--Human-Rights-Strategy-2011---2015.pdf. They can be made available in a range of accessible formats and languages upon request.

Other information required in different formats or languages can be obtained by contacting the listed author in a publication or leaflet or the signatory on a letter. Alternatively, you can speak directly to The Service Equality Lead (Sue Campling), Human Resources Department or to a member of the PALS (Patient Advice and Liaison Service) team.

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

MONDAY 23 SEPTEMBER 2013
09:30 am. Boardroom, Northampton General Hospital

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1	Introduction and Apologies	Note	Chair	**Verbal**
	2	Declarations of Interest in the Proceedings	Note	Chair	**Verbal**
	3	Minutes of the 24 July 2013 meeting of the Board	Decision	Chair	**A**
	4	Matters arising from the 24 July 2013	Receive	Chair	**B**
	5	Chief Executive's Report	Receive	Dr S Swart	**C**
09.45	**CLINICAL QUALITY AND SAFETY**				
	6	Medical Director's Quality Report	Assurance	Dr N Robinson	**D**
	7	Patient Experience Report	Assurance	Ms S Loader	**E**
	8	Infection Prevention Performance Report	Assurance	Ms S Loader	**F**
	9	Duty of Candour – Board Assurance Statement	Assurance	Ms S Loader	**G**
	10	Patient Safety Academy Progress Report	Assurance	Ms J Bradley	**H**
10.45	**OPERATIONAL ASSURANCE**				
	11	Operational Performance Report	Assurance	Mr C Walsh	**I**
	12	Urgent Care Update	Assurance	Mr C Walsh	**J**
	13	Finance Report	Assurance	Mr A Foster	**K**
	14	Workforce Report	Assurance	Ms J Brennan	**L**
	15	Transformation Report	Assurance	Ms J Brennan	**M**
	16	Self-Certification Report	Decision	Mr C Walsh	**N**
11.45	**STRATEGY AND PLANNING**				
	17	Healthier Northamptonshire Programme Update	Assurance	Mr C Pallot	**O**
	18	Equality and Human Rights Strategy	Decision	Ms J Brennan	**P**
12.00	**ANY ITEMS OF OTHER BUSINESS**				
	19	**DATE AND TIME OF NEXT MEETING** 31 October 2013 09:30 Danetre Hospital, London Rd, Daventry, Northamptonshire NN11 4DY	Note	Chair	**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)