Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 28th February 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Zeidler	
	2.	Declarations of Interest	Mr P Zeidler	
	3.	Minutes of the meeting held on 31st January 2013	Mr P Zeidler	**1**
	4.	Matters Arising	Mr P Zeidler	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
09.40	6.	Francis Report	Ms S Loader & Dr S Swart	**3**
10.00	7.	Medical Director's Report	Dr S Swart	**4**
10.10	8.	Patient Experience	Ms S Loader	**5**
10.20	9.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
10.30	10.	Patient Safety Academy Report	Dr S Swart	**7**
10.40	11.	Quality Accounts	Ms S Loader	**8**
Operational Assurance				
10.45	12.	Operational Performance Report	Mrs C Allen	**9**
10.55	13.	Finance Report	Mr P Hollinshead	**10**
11.05	14.	Human Resources Report	Ms G Opreshko	**11**
11.15	15.	Transformation Programme Update	Ms G Opreshko	**12**
11.25	16.	Self-Certification Return	Mr C Pallot	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 28th March 2013		
	19.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Minutes of the Trust Board Meeting held in public on
Thursday 31st January 2013 at 9.30am
Boardroom, Northampton General Hospital

Present:	Mr P Farenden	Chairman
	Mr C Abolins	Director of Facilities & Capital Development
	Mrs C Allen	Deputy Chief Executive and Chief Operating Officer
	Mr P Hollinshead	Interim Director of Finance
	Ms S Loader	Director of Nursing, Midwifery and Patient Services
	Mr G Kershaw	Associate Non-executive Director
	Dr G McSorley	Chief Executive
	Mr D Noble	Non-executive Director
	Mrs G Opreshko	Interim Director of Workforce and Transformation
	Mr C Pallot	Director of Strategy and Partnerships
	Mr N Robertson	Non-executive Director
	Mrs E Searle	Non-executive Director
	Dr S Swart	Medical Director
	Mr P Zeidler	Non-executive Director

In attendance:	Mr J Bufford	Interim Head of Corporate Affairs (minutes)
	Mr S Watts	Head of Communications
	Mr R Kelso	Shadow Governor
	Ms W Meredith	Shadow Governor
	Mr A McPherson	Shadow Governor
	One other member of the public	

TB 12/13 102 Opening remarks

Mr Farenden welcomed Mr Noble and Mrs Searle to their first meeting.

TB 12/13 103 Declarations of Interest

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

TB 12/13 104 Minutes of the meeting held on 29th November 2012

These were agreed as a true and correct record.

TB 12/13 105 Action Log and matters arising

All other actions and matters arising were on the agenda.
.

TB 12/13 106 Chief Executive's Report

Dr McSorley gave a verbal report. Two clinical summits involving clinicians from the two acute hospitals in Northamptonshire along with primary care colleagues had now been held. These had looked at the best way of organising services across the county. The first summit had made good progress and the second, held on 30th January had built on that. It was hoped to bring a paper to a future Board meeting.

Mr Farenden asked whether there was still clinical consensus for change; Dr McSorley confirmed that there was.

Dr McSorley also noted that Nene Commissioning, the local Care Commissioning Group had been formally authorised and would formally take up its role on 1st April – although in practice it was already doing much of this already.

The Board of Directors NOTED Dr McSorley's report

TB 12/13 107 Medical Director's Report

Dr Swart presented her report. Overall, the HSMR and SHMI indicators showed the Trust to be in the expected group. No concerns had been raised through Dr Foster.

A detailed review was being undertaken of fractured neck of femur. There were variations in the data between the Dr Foster and national databases and it was important to understand the reasons for this. She had asked the team to look at this, taking advice from ortho-geriatric colleagues as appropriate.

The trust continued to look at everything that might be a problem and each speciality was being asked to focus both on coding and quality. A new coding manager had been appointed. A close review of a sample of 50 mortality cases would be undertaken to ensure that there were no further issues.

Mr Farenden asked Dr Swart if her clinical colleagues were maintaining their engagement in this process – Dr Swart reported that clinicians across the trust were very mindful of the quality of care – what was changing was the recognition of the importance of high quality notes.

Mr Robertson asked about the differences between the two mortality indicators. Dr Swart felt that HSMR was the more useful of the two and SHMI was older and not quite as good an improvement tool.

In section two of her report Dr Swart had outlined the work being done to set up a national dashboard. This was intended to allow trusts to understand variations in quality. The trust was able to set some of its own indicators. She drew attention to the national nurse to bed ratio figure which, because it did not take account of the use of bank or temporary staff was not an accurate measure.

A sample dashboard had been produced and had been included in the paper This showed no undesirable alerts but it did bring out the Trust's A&E target performance issue. It was intended to use this as a tool to investigate which trusts were performing well –from whom NGH could learn – and not as a management tool. Mr Robertson felt that the bed occupancy figure at 84% was low – Dr Swart felt that this may have included beds not used for medical patients. Ms Loader was preparing a paper on this for next month's Healthcare Governance Committee.

Mr Noble asked about the timeliness of the data – Dr Swart hoped to make it as up to date as possible. Mr Pallot would be looking to ensure that the trust's information team were able to supply the data on time. Mr Farenden noted

that the data would be available to the trust's commissioners which would improve the joint understanding of the trust's position. Mr Abolins asked whether the trust had sufficient data gathering resources – Dr Swart felt that these might need to be identified.

In Section 3 of her report Dr Swart had presented the key issues on the monthly scorecard.

Pressure ulcers had increased – possibly because the lead Tissue Viablity Nurse had returned from leave and as a result the pressure ulcers were being validated more effectively and training and awareness had increased. The Healthcare Governance Committee was following this up. The ambition was to reduce these to zero.

The number of cancelled operations had increased. Ms Allen explained that this had been due to emergency patients needing the HDU or ITU and it would have been dangerous to go ahead with the operations without these. Mr Noble asked if the patients could have been sent elsewhere; Dr Swart explained that there was a rigorous discussion with clinicians about risks and other options before any operation was cancelled and only when all options, including sending patients elsewhere, were exhausted were cancellations made.

Ms Allen explained that the lack of available ITU beds might have also been the reason behind the drop in performance on cancer – although the trust had achieved its targets for the quarter.

Mr Noble asked if this was a reflection on the number of ITU beds: Dr Swart thought the situation more complex as it may be a problem that could be solved by changing the flow of patients. Dr McSorley added that there were physical constraints on the number of ITU beds and that the trust was looking at tiered systems to allow people to step down to intermediate beds. More ITU beds would require new buildings. Mr Robertson asked how much the patient flow problem was due to the inability to discharge medically stable patients – Dr Swart felt that it would help.

Dr McSorley noted that at the time the numbers of emergency patients were peaking most other trusts were in the same position.

The Board of Directors NOTED the report and the work being done to ensure that all indicators of the quality of care were being investigated.

TB 12/13 108 Patient Experience

Ms Loader introduced her report. The Friends and Family Test (FFT) score for December was 68 – which was disappointing. This may have been as a result of the very high numbers of patients seen in that month. In advance of the national roll-out the trust had introduced the friends and family test in A&E. To date it was not capturing many patients, but it was hoped that this would improve.

The trust still had some work to do to improve its CQUIN scores and Ms Loader was speaking directly to ward sisters to share her concerns and ask them to take actions to address these.

Mr Abolins had started addressing the concerns raised about food; they were looking at how food was presented, menu changes (the supper service had been completely changed.

Ms Loader also noted that there were some areas where the trust was doing well – such as the way in which patients privacy was treated and the use of mixed sex wards.

Mr Robertson asked about the wide variation between wards in the rate of response to the data collection shown in appendix 1 – Ms Loader was investigating this – some of it could be explained by the different types of patients on wards (wards caring for patients with dementia, for example, may have a lower response rate due to some of the patients' inability to answer the question).

The Board of Directors NOTED the report.

TB 12/13 109 Monthly Infection Prevention Performance Report

Ms Loader presented her report. There had been two cases of MRSA since April, so the trust was one over its ceiling. One post 48 hour bacteraemia had come in from a nursing home where a trust commissioned beds so a joint investigation was being undertaken.

The number of c.diff cases in the trust was still below the ceiling, although the trust continued to take action to minimise these. The Patient's Association had recently emphasised the need to keep up work on infection control. Mr Noble asked about compliance with audit – Ms Loader confirmed that the trust was focusing on areas with low compliance.

The Board of Directors NOTED the report.

TB 12/13 110 Operational Performance Report

Ms Allen presented the report. The Trust had met the 18 week and stroke standards but had not met the A&E target in December.

A lot of analysis of the A&E position had been done. The trust was seeing patients of greater acuity and had 105 patients with stays of over 105 days. Statistically it was not now possible to meet the A&E target for the year.

Mr Robertson asked about ambulance handover times. Ms Allen and Dr McSorley pointed out that while the trust was performing better than other trusts there was still work to do. It was difficult to achieve the 15 minute target when ambulances arrived together – and work was being done with the ambulance trust to look at ways at which ambulance scheduling could be improved. There were also substantial issues with the data on ambulance handover times.

The Board of Directors NOTED the report.

TB 12/13 111 Urgent Care

Ms Allen presented this paper. The purpose of the report was to make Board aware of the issues and work that was being done to manage urgent care. This was not just an issue about A&E but was linked with patient flow across the organisation. All areas of improvements were being looked at; and improvements were considered with safety and quality as a prime consideration.
The A&E system had originally been designed to deal with trauma, but with increasing numbers of frail elderly arriving with different needs a fresh approach to staffing was being considered.

Dr Swart noted that the trust had not been successful in getting additional medical staff. All options were being explored but there was a national shortage of acute physicians. Accordingly the trust was looking at ways of deploying its existing staff in the best possible way.

In response to a question from Mr Zeidler, Ms Allen outlined the work that was being done to look at capacity. A project to five a forensic analysis of bed use and flow would help the trust to understand the routes by which patients arrived at the hospital, the capacity that was available (including how much non-elective capacity there was) and how the community could plan care for those patients who did not need medical care.

Ms Allen also outlined the work that had been done to address the issue of patients who were medically stable not being able to leave the trust. Work had been done to look at how other trusts were dealing with this but it appeared that relatively few had managed to solve the problem.

Mr Noble asked about the level of engagement of the community in this work. Mr Farenden noted that there was scope for this to increase this; at recent meetings the PCT had not been forthcoming on what initiatives it planned to take forward. Mrs Searle and Ms Loader both noted the importance of CQUINS being based across the health economy.

It was agreed that Ms Allen would provide regular updates on this work.

Action: Ms Allen

The Board of Directors NOTED the work on urgent care, recognising that there was more to do and that Board should receive regular updates on progress. The engagement of the whole health economy was critical to this.

TB 12/13 112 Finance Report

Mr Hollinshead introduced the finance report. Table 1 on page 62 outlined the Trust's achievement against each of its key financial duties. The Trust was forecasting breakeven, which would meet its statutory duty but would not achieve the planned surplus of £1m. This could have implications for the Trust's FT application.

The previously reported main financial risks - winter pressure funding and payment for excess activity above contract were now mitigated. The Trust had agreed a settlement with the CCG which allows the Trust to forecast break-even but requires delivery of the £10.3m transformation programme, delivery of care group and corporate budget control totals and also requires the Trust to seek recompense from social care for delays to discharge. In response to a question from Mr Zeidler, Mr Hollinshead confirmed that these were expectations.

The settlement fixed the Trust's income for the remainder of the financial year so it was vital to control costs and ensure all budgetary controls were implemented.

Mr Hollinshead also reported that the Trust was on track to achieve its external financing limit (EFL) duty without impacting on creditors. The Finance and Performance Committee would be looking at the liquidity position at its February meeting

The capital expenditure position was complicated by receipt of funding from external bodies that were being paid as revenue but would impact on the capital resource limit. This meant that the Trust might hit the capital spending limit of £10.1m.

The Board of Directors NOTED the report and the importance of achieving breakeven and the £10.3m Transformation Programme target.

TB 12/13 113 Human Resources Report

Mrs Opreshko presented the report. December had seen a reduction in the established workforce and an increase in sickness. These trends were not unusual for December. However, sickness remained a challenge with long term sickness beginning to rise again and the overall rate also increasing. HR continued to work with managers to address this.

Progress on nurse recruitment was good, with 13 nurses and 28 HCAs due to start in February and significant numbers expected to join in February and March. Mrs Opreshko was optimistic that Trust would reach establishment levels for HCAs by the end of February and for nurses by the end of April – although this might happen earlier. To address continuing turnover, a recruitment programme had been developed to the end of 2014.

The Board of Directors NOTED the report.

TB 12/13 114 Transformation Programme Update

Mrs Opreshko presented the Transformation report. The programme would not deliver £11.1m but she was optimistic that it would achieve the £10.3m.

Opening additional beds (for winter pressures) had increased the use of bank and agency staff and overtime payments – but tighter controls on overtime were beginning to bear fruit. Procurement savings were greater than originally expected and the voluntary severance scheme, although having a limited impact in the current financial year, was expected to deliver £500k savings in the longer term.

Mr Kershaw asked how the purchase of additional leave might impact on bank and agency. Mrs Opreshko stated that the system was being reviewed. Dr McSorley and Ms Allen added that the purchase of leave was only allowed where this would not impact operationally. Mr Zeidler asked if staff had the right to sell holiday back – Mrs Opreshko confirmed that this was not allowed. It was agreed that Mrs Opreshko should do some further analysis of this.

Action: Mrs Opreshko

The Board of Directors NOTED the report

TB 12/13 115 Self-Certification Return

Mr Pallot presented the return. The Governance risk rating had moved to amber-green from amber-red. He recommended that the Board of Directors signed declaration 2 as the Trust would not achieve the A&E target, the FRR score was under 3 and level 2 of the Information Governance Toolkit would not be achieved in 2012/13. He would be bringing a paper on the IG toolkit to a future Board meeting.

It was noted that on the Governance Risk rating table (page 99) the two issues were MRSA and A&E. Also noted was that question 5 on the table on page 100 needed review.

The Board of Directors APPROVED making declaration 2 on the return

TB 12/13 116 Any Other Business

None raised

TB 12/13 117 Date of next meeting: February 28th 2013, 9.30 Boardroom NGH

TB 12/13 118 The Board of Directors resolved to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted

Action Log for the Board meeting held in public on 28th February 2013

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 111	**Urgent Care**	31 Jan 2013	Provide regular updates on progress on urgent care work as part of performance report	Ms Allen	Feb 2013	
TB 12/13 114	**Transformation Programme Update**	31 Jan 2013	Carry out further analysis of annual leave purchase	Mrs Opreshko	Mar 2013	

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

BOARD OF DIRECTORS 28th February 2013	
Title	Francis Report
Presented by	Dr Sonia Swart, Medical Director and Suzie Loader Director of Nursing and Patient Services

SUMMARY OF CRITICAL POINTS

- The appalling suffering of many patients was primarily caused by a serious failure on the part of the Trust Board. The Trust Board did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care. (Robert Francis QC)

- The inquiry has made 290 recommendations which have been grouped according to themes to address the essential aims which are:
    - Foster a common culture shared by all in the service of putting the patient first;
    - Develop a set of fundamental standards,
    - Provide professionally endorsed and evidenced-based means of compliance with these fundamental
    - Ensure that the healthcare regulator's focus is on policing compliance with these standards;
    - Ensure openness, transparency and candour;
    - Make all those who provide care for patients – individuals and organisations – properly accountable;
    - Provide for a proper degree of accountability for senior managers and leaders;
    - Enhance the recruitment, education, training and support of all key contributors
    - Develop and share ever improving means of measuring and understanding the performance of individual professionals
- Key themes for this organisation are:
    - Responsibility for, and effectiveness of, healthcare standards
    - Putting the patient first
    - Effective complaints handling (Patients, Relatives and Staff)
    - Patient, public and local scrutiny
    - Medical training and education
    - Openness, transparency and candour
    - Nursing
    - Leadership
    - Professional regulation of fitness to practice
    - Care for the elderly

Next Steps

- NGH will be undertaking a reverse gap analysis and will develop an action plan, which will be presented to the April Trust Board meeting
- The findings of the inquiry were shared at the Trust core brief on 14th February, with the information being cascaded throughout the organisation with the opportunity for staff to provide feedback to the Trust by 15th March. Feedback will be incorporated into the reverse gap analysis.
-

RECOMMENDATION – The Executive team is asked to:

1. Note the summary report and support the next steps.

Francis Report

1. Introduction

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on 6th February 2013.

Robert Francis QC stated “The appalling suffering of many patients was primarily caused by a serious failure on the part of the Trust Board. The Trust Board did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care”.

The inquiry has made 290 recommendations (appendix1) which have been grouped according to themes:

- Accountability for implementation of the recommendations
- Putting the patient first
- Fundamental standards of behaviour
- A common culture made real throughout the system – an integrated hierarchy of standards of service
- Responsibility for, and effectiveness of, healthcare standards
- Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor’s healthcare systems regulatory functions
- Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings
- Enhancement of the role of supportive agencies
- Effective complaints handling
- Commissioning for standards
- Local Scrutiny
- Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and education
- Openness, transparency and candour
- Nursing
- Leadership
- Professional regulation of fitness to practice
- Care for the elderly
- Information
- Coroners and inquests
- Department of Health leadership

to address the essential aims which are:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards,
- Provide professionally endorsed and evidenced-based means of compliance with these fundamental
- Ensure that the healthcare regulator's focus is on policing compliance with these standards;
- Ensure openness, transparency and candour;
- Make all those who provide care for patients – individuals and organisations – properly accountable;
- Provide for a proper degree of accountability for senior managers and leaders;
- Enhance the recruitment, education, training and support of all key contributors
- Develop and share ever improving means of measuring and understanding the performance of individual professionals

Next Steps

- NGH will be undertaking a reverse gap analysis and will develop an action plan, which will be presented to the April Trust Board meeting

- The findings of the inquiry were shared at the Trust core brief on 14th February, with the information being cascaded throughout the organisation with the opportunity for staff to provide feedback to the Trust by 15th March. Feedback will be incorporated into the reverse gap analysis.

2. Table of recommendations

Rec. no.	Theme	Recommendation	Chapter
	Accountability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.		
1	Implementing the recommendations	It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; • In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations; • The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.	Introduction
2		The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: • A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards; • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	20
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.		
3	Clarity of values and principles	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	21
4		The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21

Rec. no.	Theme	Recommendation	Chapter
5		In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm; • They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work.	21
6		The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.	21
7		All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	21
8		Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	21
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.		
9		The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.	21
10		The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.	21
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	20
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	2

Rec. no.	Theme	Recommendation	Chapter
	A common culture made real throughout the system – an integrated hierarchy of standards of service	No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.	
13	The nature of standards	Standards should be divided into: • Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; • Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.	21
14		In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards.	9
15		All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.	11
16	Responsibility for setting standards	The Government, through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider.	21
17		The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	21
18		It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.	21
	Responsibility for, and effectiveness of, healthcare standards		
19	Gaps between the understood functions of separate regulators	There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.	10

Rec. no.	Theme	Recommendation	Chapter
20	Responsibility for regulating and monitoring compliance	The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing compliance with any enhanced standards but for regulating the accuracy of information about compliance with them.	21
21		The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern.	21
22		The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.	21
23		The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.	21
24		Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.	21
25		It should be considered the duty of all specialty professional bodies, ideally together with the National Institute for Health and Clinical Excellence, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance.	21
26		In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.	9
27		The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedied. It requires a focus on identifying what is wrong, not on praising what is right.	9
28	Sanctions and interventions for non-compliance	Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.	21

Rec. no.	Theme	Recommendation	Chapter
29		It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.	21
30	Interim measures	The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation.	9
31		Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators.	10
32		Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken.	10
33		Insofar as healthcare regulators consider they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers.	10
34		Where a provider is under regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.	9
35	Need to share information between regulators	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.	9
36	Use of information for effective regulation	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	9
37	Use of information about compliance by regulator from: • Quality accounts	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	11

Rec. no.	Theme	Recommendation	Chapter
38	• Complaints	The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.	11
39		The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.	11
40		It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	11
41	• Patient safety alerts	The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to the NHS Commissioning Board.	11
42	• Serious untoward incidents	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	11
43	• Media	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.	6
44		Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented.	11
45	• Inquests	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	11
46	• Quality and risk profiles	The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.	11
47	• Foundation trust governors, scrutiny committees	The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.	11
48		The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission.	11
49	Enhancement of monitoring and the importance of inspection	Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from: • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections.	11
50		The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.	11

Rec. no.	Theme	Recommendation	Chapter
51		The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principle to the independent sector, as well as to the NHS.	11
52		The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.	11
53	Care Quality Commission independence, strategy and culture	Any change to the Care Quality Commission's role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.	11
54		Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role.	11
55		The Care Quality Commission should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement effectively, in accordance with the principles outlined in this report.	11
56		The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date.	11
57		The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny.	11
58		Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for a patients' consultative council with which issues could be discussed to obtain a patient perspective directly.	11
59		Consideration should be given to the introduction of a category of nominated board members from representatives of the professions, for example, the Academy of Medical Royal Colleges, a representative of nursing and allied healthcare professionals, and patient representative groups.	11
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions		
60	Consolidation of regulatory functions	The Secretary of State should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.	11 10
61		A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after thorough planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. It would be vital to retain the corporate memory of both organisations.	11 10
62	Improved patient focus	For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.	11 10
63	Improved transparency	Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.	10

Rec. no.	Theme	Recommendation	Chapter
64	Authorisation of foundation trusts	The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor.	4
65	Quality of care as a pre-condition for foundation trust applications	The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.	4
66	Improving contribution of stakeholder opinions	The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: • Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards; • An accessible record of responses received is maintained; • The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.	4
67	Focus on compliance with fundamental standards	The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.	4
68		No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of Health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.	4
69		The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.	4
70	Duty of utmost good faith	A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.	4
71	Role of Secretary of State	The Secretary of State's support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.	4
72	Assessment process for authorisation	The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.	4

Rec. no.	Theme	Recommendation	Chapter
73	Need for constructive working with other parts of the system	The Department of Health's regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained.	10
74	Enhancement of role of governors	Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public's views about the services offered.	10
75		The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10
77		Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose and challenge deficiencies in the quality of the foundation trust's services.	10
78		The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence (pursuant to section 39A of the National Health Service Act 2006 as amended), or other ready access to external assistance.	10
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10
80		A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.	11
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11
82		Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.	10
83		If a "fit and proper person test" is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and the procedure it would follow to ensure due process.	10

Rec. no.	Theme	Recommendation	Chapter
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10
85		Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.	10
86	Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings		
87	Ensuring the utility of a health and safety function in a clinical setting	The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.	13
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13
90	Assistance in deciding on prosecutions	In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the Health and Safety Executive should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.	13
	Enhancement of the role of supportive agencies		
91	**NHS Litigation Authority** Improvement of risk management	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	15
92		The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.	15
93		The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiences in risk management, such as occurred at the Trust.	15

Rec. no.	Theme	Recommendation	Chapter
94	Evidence-based assessment	As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information.	15
95	Information sharing	As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.	15
96		The NHS Litigation Authority should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.	15
97	**National Patient Safety Agency functions**	The National Patient Safety Agency's resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator.	17
98		Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	17
99		The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incident has been properly reported, and invaluable where it has not been.	17
100		Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with.	17
101		While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.	17
102	Transparency, use and sharing of information	Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or others facilitated in that task.	17
103		The National Patient Safety Agency or its successor should regularly share information with Monitor.	17
104		The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other.	17
105		Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.	17
106	**Health Protection Agency** Coordination and publication of providers' information on healthcare associated infections	The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre.	16

Rec. no.	Theme	Recommendation	Chapter
107	Sharing concerns	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.	16
108	Support for other agencies	Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers' infection control arrangements.	16
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.		
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	3

Rec. no.	Theme	Recommendation	Chapter
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	3
121		The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	3
122	Handling large-scale complaints	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	3
	Commissioning for standards		
123	Responsibility for monitoring delivery of standards and quality	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	7

Rec. no.	Theme	Recommendation	Chapter
124	Duty to require and monitor delivery of fundamental standards	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub-standard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	7
125	Responsibility for requiring and monitoring delivery of enhanced standards	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	7
126	Preserving corporate memory	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.	7
127	Resources for scrutiny	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	7
128	Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.	7
129	Ensuring assessment and enforcement of fundamental standards through contracts	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	7
130	Relative position of commissioner and provider	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	7
131	Development of alternative sources of provision	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	7

Rec. no.	Theme	Recommendation	Chapter
132	Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	7
133	Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	7
134	Role of commissioners in provision of support for complainants	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	7
135	Public accountability of commissioners and public engagement	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. • There should be lay members of the commissioner's board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.	7
136		Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	7
137	Intervention and sanctions for substandard or unsafe services	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.	7

Rec. no.	Theme	Recommendation	Chapter
	Local scrutiny		
138		Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	7
	Performance management and strategic oversight		
139	The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	8
140	Performance managers working constructively with regulators	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	8
141	Taking responsibility for quality	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	8
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8
144	Need for ownership of quality metrics at a strategic level	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	8
	Patient, public and local scrutiny		
145	Structure of Local Healthwatch	There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and scrutiny.*	6
146	Finance and oversight of Local Healthwatch	Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.	6
147	Coordination of local public scrutiny bodies	Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.	6
148	Training	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.	6
149	Expert assistance	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.	6

Rec. no.	Theme	Recommendation	Chapter
150	Inspection powers	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.	6
151	Complaints to MPs	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.	6
	Medical training and education		
152	Medical training	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	18
153		The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.	18
154		The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.	18
155		The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. • There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.	18
156		The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.	18

Rec. no.	Theme	Recommendation	Chapter
157	Matters to be reported to the General Medical Council	The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.	18
158	Training and training establishments as a source of safety information	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	18
159		Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.	18
160		Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	18
161		Training visits should make an important contribution to the protection of patients: • Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used. • Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. • The opportunity can be taken to share and disseminate good practice with trainers and management. Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.	18
162		The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.	18
163	Safe staff numbers and skills	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	18
164	Approved Practice Settings	The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.	18
165		The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.	18

Rec. no.	Theme	Recommendation	Chapter
166		The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.	18
167		The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.	18
168		The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for post graduate training.	18
169	Role of the Department of Health and the National Quality Board	The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators.	18
170	Health Education England	Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.	18
171	Deans	All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.	18
172	Proficiency in the English language	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	18
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.		
173	**Principles of openness, transparency and candour**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22

Rec. no.	Theme	Recommendation	Chapter
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22
178	**Implementation of the duty** Ensuring consistency of obligations under the duty of openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	22
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	22
181	**Enforcement of the duty** Statutory duties of candour in relation to harm to patients	A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.	22
182	Statutory duty of openness and transparency	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	22
183	Criminal liability	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: • Knowingly to obstruct another in the performance of these statutory duties; • To provide information to a patient or nearest relative intending to mislead them about such an incident; • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	22

Rec. no.	Theme	Recommendation	Chapter
184	Enforcement by the Care Quality Commission	Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.	22
	Nursing		
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient well-being.	23
186	Practical hands-on training and experience	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	23
187		There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	23
188	Aptitude test for compassion and caring	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	23
189	Consistent training	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination.	23
190	National standards	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.	23
191	Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23
192	Strong nursing voice	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council.	23

Rec. no.	Theme	Recommendation	Chapter
193	Standards for appraisal and support	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	23
194		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23
195	Nurse leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	23
196		The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	23
197		Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	23
198	Measuring cultural health	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	23
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	23
200		Consideration should be given to the creation of a status of Registered Older Person's Nurse.	23
201	Strengthening the nursing professional voice	The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".	23
202		Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	23

Rec. no.	Theme	Recommendation	Chapter
203		A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.	23
204		All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	23
205		Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	23
206		The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	23
207	Strengthening identification of healthcare support workers and nurses	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	23
208		Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	23
209	Registration of healthcare support workers	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	23
210	Code of conduct for healthcare support workers	There should be a national code of conduct for healthcare support workers.	23
211	Training standards for healthcare support workers	There should be a common set of national standards for the education and training of healthcare support workers.	23
212		The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	23

Rec. no.	Theme	Recommendation	Chapter
213		Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	23
	Leadership		
214	Shared training	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.	24
215	Shared code of ethics	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	24
216	Leadership framework	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	24
217	Common selection criteria	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.	24
218	Enforcement of standards and accountability	Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.	24
219	A regulator as an alternative	An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.	24
220	Accreditation	A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initally, the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.	24
221	Ensuring common standards of competence and compliance	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.	24
	Professional regulation of fitness to practise		
222	**General Medical Council** Systemic investigation where needed	The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.	12

Rec. no.	Theme	Recommendation	Chapter
223	Enhanced resources	If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.	12
224	Information sharing	Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.	12
225	Peer reviews	The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.	12
226	**Nursing and Midwifery Council** Investigation of systemic concerns	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	12
227		The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	12
228	Administrative reform	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	12
229	Revalidation	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	12
230	Profile	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	12
231	Coordination with internal procedures	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	12

Rec. no.	Theme	Recommendation	Chapter
232	Employment liaison officers	The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	12
233	**For joint action** Profile	While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.	12
234	Cooperation with the Care Quality Commission	Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.	12
235	Joint proceedings	The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.	12
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly		
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	25
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25

Rec. no.	Theme	Recommendation	Chapter
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	25
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	25
242	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	25
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25
	Information		
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	26
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	26
246	Comparable quality accounts	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	26
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	26

Rec. no.	Theme	Recommendation	Chapter
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26
250		It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.	26
251	Regulatory oversight of quality accounts	The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.	26
252	Access to data	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	26
253	Access to quality and risk profile	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	26
254	Access for public and patient comments	While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.	26
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26
257	Role of the Health and Social Care Information Centre	The Information Centre should be tasked with the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent.	26
258		The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.	26
259		The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints.	26
260	Information standards	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information.	26

Rec. no.	Theme	Recommendation	Chapter
261		The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.	26
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	26
263		It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	26
264		In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	26
265		The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice.	26
266		In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them.	26
267		All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	26
268	Resources	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	26
269	Improving and assuring accuracy	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	26
270		There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	26
271		To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.	26

Rec. no.	Theme	Recommendation	Chapter
272		There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable.	26
	Coroners and inquests Making more of the coronial process in healthcare-related deaths		
273	Information to coroners	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	14 22
274		There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	2
275	Independent medical examiners	It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.	14
276		Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.	14
277	Death certification	National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	14
278		It should be a routine part of an independent medical examiners's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	14
279		So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	14
280	Appropriate and sensitive contact with bereaved families	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	14
281		It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.	14
282	Information for, and from, inquests	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.	14
283		Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family.	14
284	Appointment of assistant deputy coroners	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	14
285	Appointment of assistant deputy coroners	The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	14

Rec. no.	Theme	Recommendation	Chapter
	Department of Health leadership		
286	Impact assessments before structural change	Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues: • What is the precise issue or concern in respect of which change is necessary? • Can the policy objective identified be achieved by modifications within the existing structure? • How are the successful aspects of the existing system to be incorporated and continued in the new system? • How are the existing skills which are relevant to the new system to be transferred to it? • How is the existing corporate and individual knowledge base to be preserved, transferred and exploited? • How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change? • How are necessary functions to be performed effectively during any transitional period? • What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?	19
287		The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report.	19
289	Clinical input	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	19
289	Experience on the front line	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.	19
290		The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.	19

Trust Board 28th February 2013	
Title: -	Medical Director's Report
Presented by: -	Dr Sonia Swart
PURPOSE OF PAPER: - Update on Mortality and Clinical Scorecards	
CRITICAL POINTS: - • Overall mortality as measured by HSMR and SHMI is within acceptable parameters. • On-going analysis and risk based audit continues in order to define any coding or quality of care issues. • Further scrutiny of information flows will continue. • The clinical scorecard outlines areas where there is on-going concern in relation to performance. • Tracking of appropriate quality measures is an increasingly important tool which should be used to allow the Board is able to challenge the quality of care provided. • The key metrics which are reported in the National Quality Dashboard which is the recently released nationally mandated tool to be used for quality improvement are outlined.	
ACTION REQUIRED BY BOARD: - The Board is asked to note the report and debate key issues	

Section 1

Review of Current Mortality and Safety Data provided by Dr Foster

1. Introduction

This paper provides a brief summary relating to mortality and safety indicators provided by Dr Foster and the information relating to SHMI.

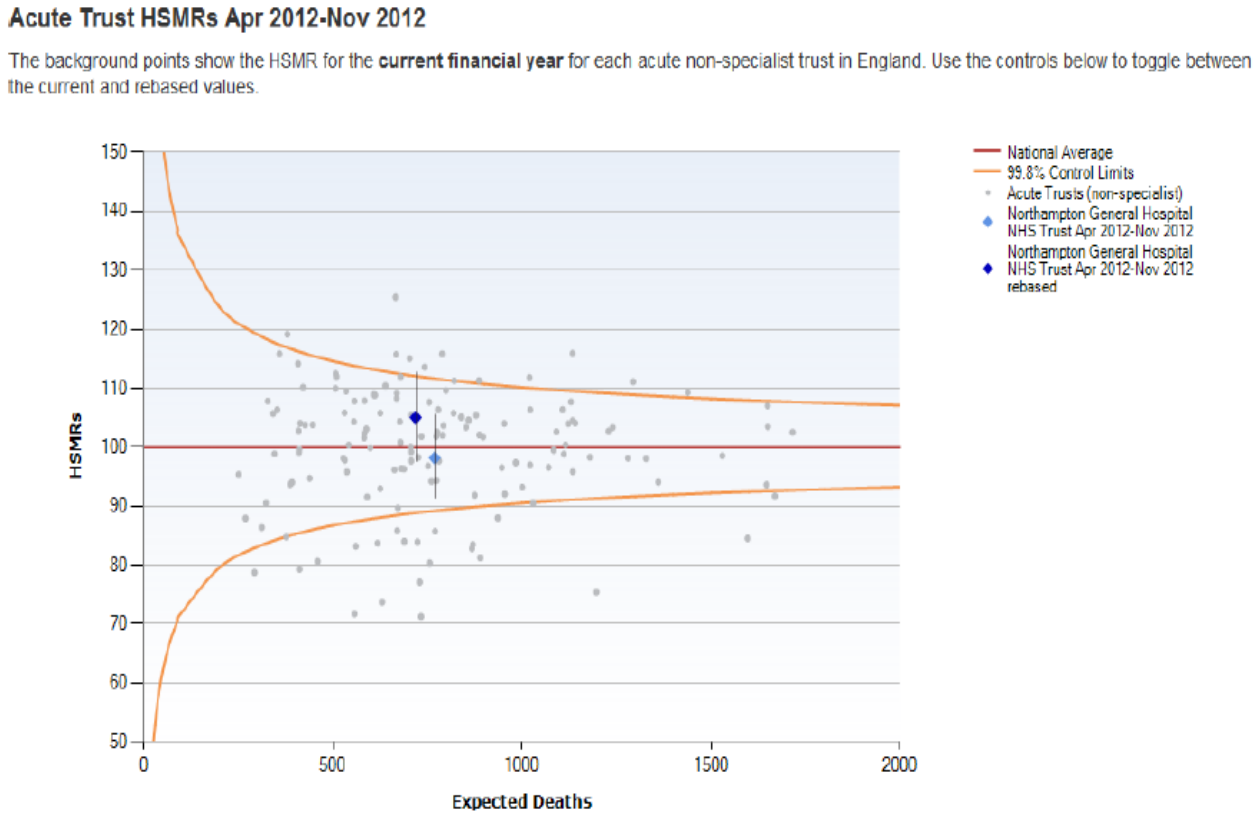
2. Current Position HSMR

The HSMR for the first seven months of 2012/13 is **98** (756 deaths versus 770 expected deaths) which is predicted to rise to 105 after re-benchmarking. **Unadjusted mortality is 3.8% which is slightly less than the average of 3.9% in the SHA.**
There continues to be concern relating to clarity of the recording of primary versus secondary diagnosis for some diagnoses such as secondary malignancy, diabetes, leukaemia and senility. Further reports are awaited in this area
For November the HSMR was **83 (**85 deaths, 102 expected).

3. Acute Trust HSMRs April 2011 - March 2012

NGH is not an outlier with respect to mortality as measured by HSMR as shown below.

The background points show the HSMR (rebased) for the first quarter of 2012/13 for each non-specialst Acute Trust in England.



4. Standardised Hospital Mortality Indicator (SHMI)

The SHMI for the first quarter of 2012/13 remains higher than the HSMR and higher than at this point in 2011/12 at **111**. The rolling SHMI to the end of this quarter was **108** which represents a SHMI in the 'as expected' category (using 98% confidence levels). The SHMI is rebased each time it is calculated unlike the HSMR.

The SHMI and HSMR do not correlate well for some diagnostic groups. The significance of this is as yet uncertain. Dr Foster are working with Trusts to produce regular reports relating to SHMI as well as HSMR.

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

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

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

There are currently no concerns in relation to the Dr Foster Patient Safety Indicators. This is shown on the table below:

Dec 2011 to Nov 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		29	24.7	0.80	0.68	more information
Decubitus Ulcer		140	206.6	15.45	22.80	more information
Deaths after surgery		43	31.9	141.91	105.13	more information
Infections associated with central line*		0	0.8	0.00	0.05	more information
Post-operative hip fracture*		1	1.7	0.04	0.07	more information
Post-op Haemorrhage or Haematoma		6	13.8	0.26	0.59	more information
Post-operative physiologic and metabolic derangements*		0	1.6	0.00	0.08	more information
Post-operative respiratory failure		15	13.5	0.81	0.72	more information
Post-operative pulmonary embolism or deep vein thrombosis		30	39.4	1.28	1.68	more information
Post-operative sepsis		5	4.4	6.96	6.06	more information
Post-operative wound dehiscence*		2	1.1	2.14	1.18	more information
Accidental puncture or laceration		36	74.6	0.55	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		23	38.7	49.15	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		84	93.4	33.61	37.37	more information
Obstetric trauma - caesarean delivery*		4	4.3	3.17	3.43	more information

Key

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

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

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

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

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

a) Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease, Pneumonia. Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur** are subject to particular scrutiny. In this group there continues to be cause for concern in relation to mortality from fractured neck of femur. The SMR for 2012/13 is 169 (34 deaths versus 20 expected). An audit of care is underway in the directorate and this has so far indicated an extremely frail group of patients. The Surgical Care Group has been asked to develop an improvement plan for this group of patients and the Medical Care Group has been asked to develop improved plans to assist with medical input to the frail elderly group of patients involved. This will be included in the Trust improvement plan priorities and will be reported through to HealthCare Governance as well as through the directorate governance reports to CQEG. This is an area where there have previously been concerns and improvement work has resulted in improvements. This same approach will be adopted again.

Possible areas for Concern under investigation
Analysis of performance in 2011/12 has been undertaken to identify diagnosis groups responsible for the highest number of deaths and highest SMR to inform the Mortality and Coding Group which has now been re-established. These include diagnoses already under review e.g. secondary malignancies, “senility”, diabetes and also new areas of concern. The work to investigate the concerns relating to senility and secondary malignancy indicates that although there may be data issues relating to the relative use of primary versus secondary diagnoses, the clinical coding was broadly speaking correct. It may be that different Trusts are allocating patients in different ways to the primary diagnosis of senility or secondary malignancy. There were no specific issues relating to quality of care. When the denominator includes all primary and secondary codes for these conditions there is no excess mortality. We have asked for further external help in order to clarify coding issues and are also asking clinicians to continue to focus on quality of care.

b) Areas of general relevance with respect to overall Trust performance

The Trust currently has a readmission rate which is ‘as expected’ and similarly the overall LOS is as expected. The Trust has a higher number of excess beds days than might be expected which may relate to the use of community hospitals which are not counted as separate sites from the main hospital site in these analyses and to delays in transfers of care. There is on-going work to improve the emergency pathway in order to ensure that patients receive timely and appropriate care in the most appropriate setting.

Further Comments and Actions Planned
The detailed monitoring process based on the use of the Dr Foster Intelligence tool continues and the Mortality and Coding group is meeting regularly as a formal extension to this process in order to ensure wide clinical and managerial ownership of the issues. The planned work to examine information flows, clinical coding and patient flow has now been commissioned and has now commenced.

Issues emerging from the reviews and monitoring will be linked into the current improvement work underway as part of the emergency care redesign project and the patient safety programme.

The detailed review of case notes conducted last year has been commenced with the plan to look at 50 sets of notes. Letters to feedback to clinicians have been refined and have been accompanied by a summary of last year’s results.

The Trust is working with Dr Foster to engage in 2 new projects to provide clinicians with more detailed quality dashboards. One of these includes data from Theatre systems as well as HES data and has the capability to provide meaningful data at consultant level.

7. Conclusion

The position with regards to overall mortality as measured by HSMR and SHMI indicates that performance is 'as expected'. There is on-going work to improve the position through targeted improvement work. Continued focus on the emergency pathway in partnership with the Health Care Economy will be necessary to ensure reductions in length of stay and readmissions.

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

8. Recommendation

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

Section 2

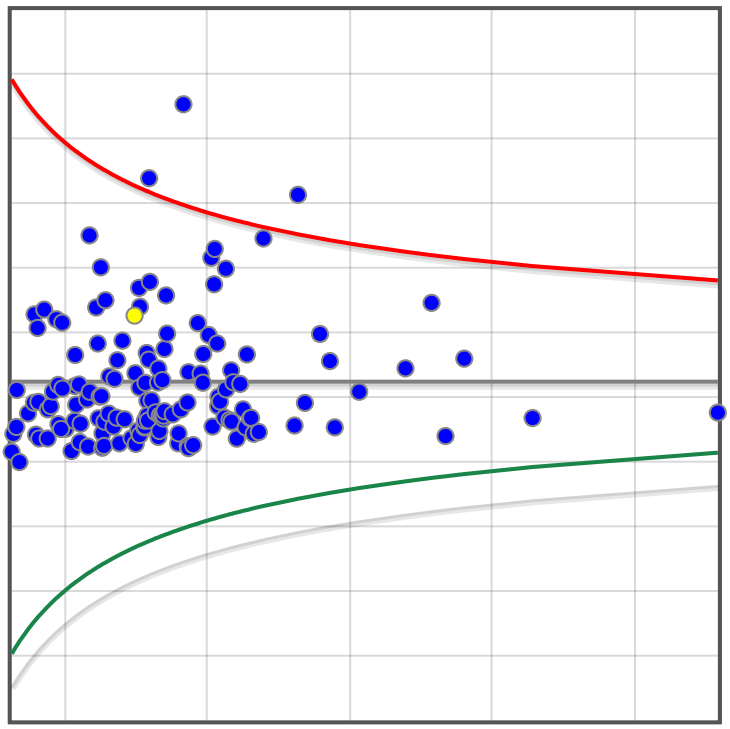
The National Quality Dashboard

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

2. Current Metrics on the Dashboard
The dashboard will be viewable across the whole of the Commissioning Board including providers and commissioners at all levels and is to be used in quality surveillance meetings , Monitor, the Trust Development Authority , Health Education England and the CQC.
The Dashboard high level report indicates **no adverse alerts for Northampton General Hospital**. The specific metrics reported are:

- Preventing People from dying prematurely – results as expected
- Amenable mortality – results as expected
- Quality of life for patients with Long Term Conditions – average
- Number of admissions under 19 – this is now as expected having previously been raised
- Helping people to recover as measured by readmissions and emergency admissions for conditions that do not usually require admission – both average
- Timely care – A and E patients waiting more than 4 hours- above average (see funnel plot)

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



- Timely Care – RTT greater than 18 weeks and cancer waits – average and within target
- Safe Environement – Infections , serious incidents , never events , harm free care are all average or slightly better than average
- Organisational indicators – staff sickness and bed occupancy – average
- Organisational indicators – doctor to patient ratio – average
- Organisational indicators – nurses to bed ratio (reported as to November 2012) – below average at 1.37. This is based on a bed number calculation which is out of date and was found to include inaccuracies. Using the correct bed figure and removing the Cliftonville beds (as we do not provide nurses for these beds) the figure would be 1.72 at current staffing levels and will be 1.83 once we have recruited to full estalishement in April. The current national average is 1.91 nurses per bed. The total bed number includes the following categories : Acute beds at NGH, Community Hospital beds and beds at Cliftonville Nursing Home.

3. Actions Required

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

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

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

4. Recommendation

The Board is asked to note this important development and support further work to embed the use of this tool as part of our normal monitoring of quality. The Board is asked to debate any issues that arise from this.

Section 3 - NGH Monthly Quality Exception Quality Scorecard

Introduction
This scorecard includes indicators selected by the Trust or required by our commissioners and by the provider monitoring framework required by the SHA, although further work is required to ensure that the alignment is accurate.

Directorates 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. These will need to be built in over the coming months.
Other performance measures are also to be mandated such as the performance in certain types of surgery by consultant but the details of this are not yet available.

Performance is reported by exception, i.e. where performance is below standard (red), where specific pressures that present a risk to the on-going achievement of any of the standards or where there are high profile issues. Commentary and associated actions are provided against the identified non-compliant indicators.

Further work is required to ensure that all measures are relevant and timely to facilitate on-going comprehensive monthly reporting.

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

Performance
Of 136 indicators, **54** (**35/19**) 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 9 indicators that are rated grey. There is a decrease in comparison to Januarys report as one of the indicators related to Patient Experience has now been confirmed. The remaining Indicators rated as grey continue to await final agreement or the information is currently not available.

Summary Rating

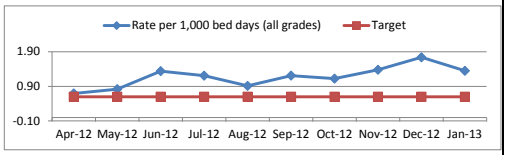
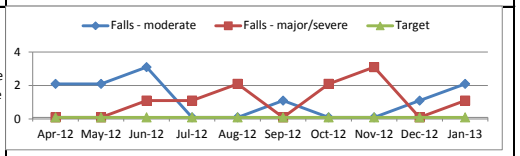
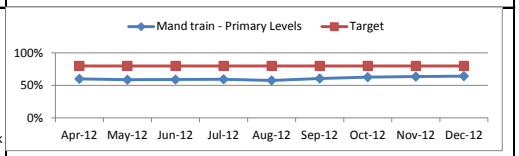
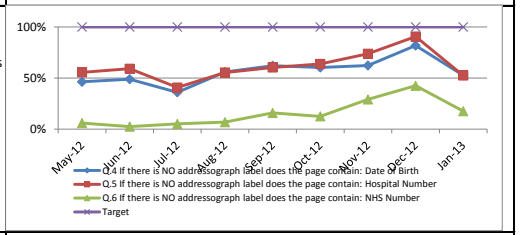
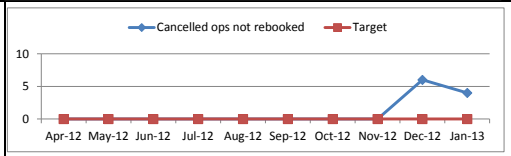
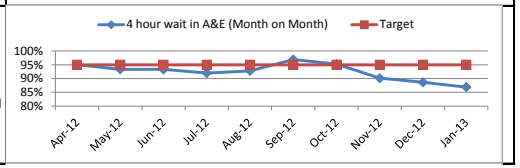
Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**1**	**8**	**26**	**1**
Clinical Outcomes	**9**	**1**	**10**	**4**
Patient Safety	**16**	**7**	**19**	**3**
Patient Experience	**9**	**3**	**18**	**1**
TOTAL	**35**	**19**	**73**	**9**

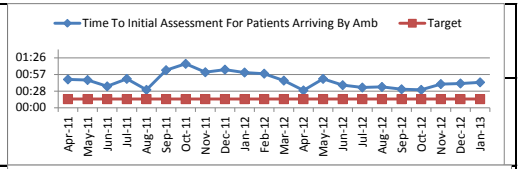
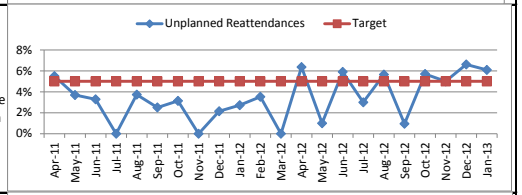
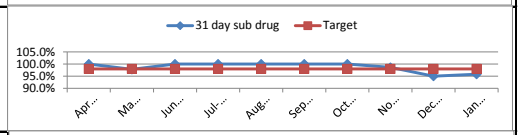
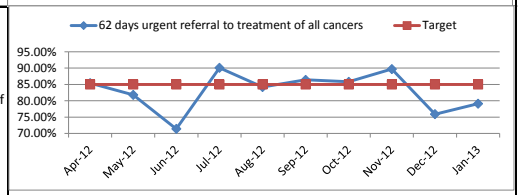
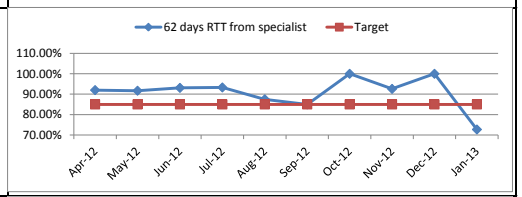
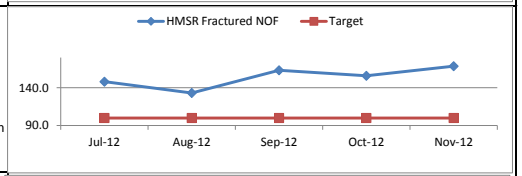
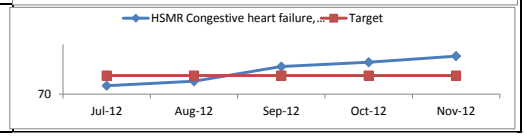
The performance measures acknowledge a small drift in January those rated as red have marginally increased in comparison to January (35/34), Amber rated measures have

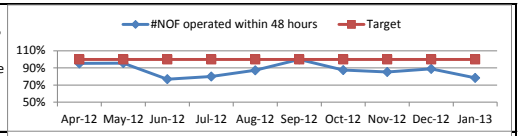
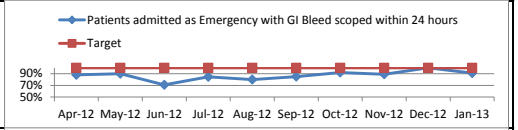
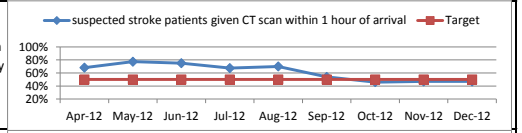
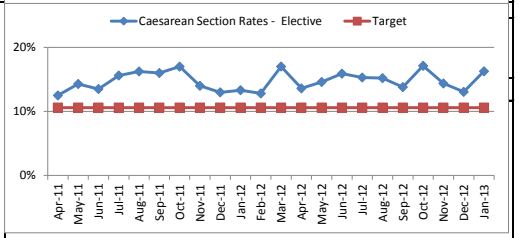
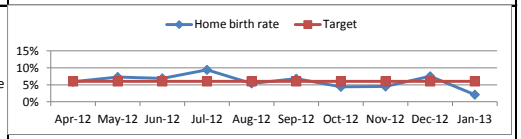
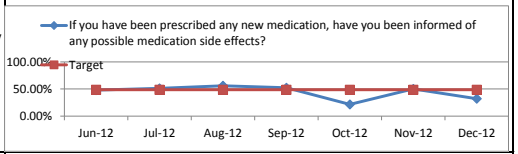
increased (19/15) with the performance measures rated as green has marginally decreased (73/77). There is a detailed improvement plan that will be rolled out across the Trust during the next 6 months to address the increase in avoidable pressure ulcers.

The Urgent Care Project Group are focussing on reducing the Length of Stay by changing processes both internally and with external partners to ensure bed occupancy reduces and timely patient flow helps to achieve the transit target.

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	Incidence of Pressure Ulcers Rate per 1,000 Bed Days (All Grades)	0.6	↑	PUP - The Improvement Plan for reducing Pressure Ulcers across the Trust is based on a roll-out of 'learns-leant' through the SHA Ambitions Project. Roles, responsibilities and accountability across the ward team has been re-enforced. There will be increased surveillance, training, and monitoring of documentation and staff knowledge to enhance the plan. Through the reported progress with Healthcare Governance Committee there is a commitment to reduce avoidable pressure ulcers to zero by the summer. There was no Grade 4 pressure ulcers during Janaury.	
Patient Safety	Reduce harm from falls Moderate/Major/Severe	0	↓	There has been improvement during the year with regards to the number of moderate/major and severe falls which is reflected in the rolling data for the year. There was 1 fall in the major/severe category in January compared to 0 in December and 2 falls in the moderate category against 1 in the previous month.Falls – Focused work with key ward areas working with all clinical staff has been the emphasis for the Falls Prevention Lead. Currently documentation is bening reviewed to encompass a risk assement for patients who may be susceptible of a fall which may enable more appropriate preventative measures being taken forward.	
Patient Safety	Mandatory Training complaince	80%	↑	Mandatory Training compliance for Primary Levels has continued to improved slightly in recent months, but continues to be below target at 64.3%. It is the manager's responsibility to ensure their staff are in date with their mandatory training and to support this, reports are sent out monthly stating the staff who are in date and those that are out of date. The reports also show which staff will be going out of date with the named course within the next 3 months, which can help to plan shifts around training. The Mandatory Training Leads ensure that there are enough places available for the number of staff and are looking at introducing different ways to deliver training eg workbook and DVD.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↓	The key issues identified on the Healthcare Notes audit in December were around the recording of vital patient information (date of birth, hospital number and nhs number) on the front page of notes where the addressograph was absent. The recording of this information remains below the target and has declined since last month, acknowledging that the number of records audited has increased and the percentage of notes with an addressograph has also significantly improved. The other areas where the target is not being met are around whether the surname is capitalised, whether the staff designation is recorded, whether the GMC number is present and how alterations/deletions are managed. Evidence of communication to relatives and teams has improved from December's position of 34% to 42% but remains below target.	
Patient Experience	Cancelled Operations not rebooked within 28 days	0%	↑	This target has not been met in January with 4 cancelled operations not rebooked within 28 days. These were due to the backlog of activity caused through the winter non elective increase in activity. All cancelled operations on the day of surgery are being monitored through the weekly performance meeting and plans are in place to ensure compliance by March 2013.	
				A&E Clinical Indicators:	
			↓	The A&E 4 hour wait target was not met in January, with 87% of patients seen within 4 hours against the 95% target. This was primarily due to significant bed pressures within the Trust relating to winter pressures. The Urgent Care Project Group are focusing on reducing length of Stay by changing processes both internally and with external partners to ensure bed occupancy reduces and timely patient flow helps to achieve the transit target.	

Patient Experience	A & E Quality Indicators (5 indicators)		↓	The time to initial assessment for patients arriving by ambulance was 44 mins with the national target being 15 minutes. These figures are currently being revalidated following recent identification of issues around the way the information is captured. When the FIT (Fast Intervention Team) is operational (usually between 11am and 6pm) this target is generally met, but out of hours limited Senior Doctor cover means that the time to initial assessment is increased. A business case is going to SMB shortly for increased clinical staff and workforce development.	
			↑	Unplanned reattendance rate - December performance was 6.1% against a target of 5%. Performance has fluctuated across the year so data validation is being undertaken to ascertain the accuracy of this position. This will include investigation of whether some planned reattendances are being recorded as unplanned. There is also a genuine concern related to patients reattending when they have been unable to access aftercare in primary care.	
Patient Experience	Cancer Wait Times		↑		
			↑	The Trust achieved all cancer targets for Q3, but initial figures for January show that the Trust did not achieve the following three cancer standards: •31 days second or subsequent treatment with drugs. The Trust achieved 95.8% against the standard of 98%. • 62 days urgent referral to treatment of all cancers. The Trust achieved 79% against the standard of 85%. • 62 days referral to treatment from hospital specialist . The Trust achieved73% against the standard of 85%. All of these figures are currently being validated.	
			↓		
Clinical Outcomes	HSMR	<100	↓	Mortality for Fractured Neck of Femur is rising in this financial year. This may be related to performance against the target for patients admitted with #NOF(see below) to be operated on within 48 hours has not been met throughout this year (with the exception of September). The findings of an audit of deaths were presented to the Mortality and Coding Review Group (31/1) and the directorate have been asked to produce an improvement plan and to consider all possible factors. All deaths are reviewed by senior and junior T&O staff at the monthly M&M meetings which are minuted. An elderly care physician is to consider the post-op care of patients who died.	
			↓	All deaths are reviewed for coding and care by the Heart Failure Group. The latest figures may not yet reflect any recent changes in coding. Mortality for Congestive Heart Failure is rising in this financial year from well below the target to 131 in November.	

Clinical Outcomes	Patients admitted with #NOF operated on within 36 hours	100.0%	↓	This target has not been met throughout the year with the exception of September. In January 80% of patients admitted with a Fractured Neck of Femur were operated on within 36 hours. A # NOF operating lsit has been implemented for Sundays and Tuesdays which facilaites the abiity to operate daily on all #NOF patients who are fit for surgery. The directorate continues to monitor this regularly.	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100.0%	↓	This target was achieved in December after several months of improvements but performance dropped to 91% in January.	
Clinical Outcomes	Suspected stroke patients given CT scan within 1 hour of arrival	50.0%	←	This target has been narrowly missed , with 47% of suspected stroke patients given a CT scan within 1 hour of arrival in December against the target of 50%. Consultant medical satff are working closely with Radiology to ensure timely completion of scans especially when only one scanner is working.	
Clinical Outcomes	Caesarean Section Rates	10.1%	↓	Whilst the aim has to been to try to reduce the elective caesarean section rate this has remained fairly static throughout the year with Quarter 1, 2 and 3 all being at 14.8%. An extensive amount of work has taken place within the maternity services to support women having choice regarding the mode of delivery following a previous caesarean section, as per the NICE guidance recommendations. In Quarter 4, the Birth after Caesarean Section (BAC) clinic will be rolled out with the support of a whole time equivalent midwife. It is hoped that the expansion of the BAC clinic will provide women with more evidence based information on which to make their decision and it is anticipated that women in the future will be more receptive to vaginal birth after a caesarean section. There was another rise in Elective C-section rates in January, alongside a decrease in Emergency rates (which is well within target). This may be that higher risk patients are electing for c-sections, with the supporting NICE guidance also having an impact. The directorate have been asked to provide deatailed audits against NICE guidance as well as a revised improvement plan.	
Clinical Outcomes	Home births	5.0%	↓	The year to date homebirth rate at NGH is 6.1% which is well above the national average of 2%. The maternity services saw a drop in women achieving a homebirth in January (2.1%). This has been attributed to a decline in the number of women choosing homebirth during January however, bookings for February appear to be within the expected range. The homebirth figure does not include the number of women who the Homebirth Team cared for in labour at home and then needed transfer to hospital for either maternal or fetal concerns, which was also noted to be slightly higher in January than previous months. This however, should not be seen as a negative outcome as the primary outcome is a healthy mother and healthy baby.	 
CQUIN	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	90%	←	This element of the CQUIN is related to a written reponse on the admission proforma confirming if the patient has been more forgetful in the past 12 months. Performance against the Dementia case finding question appears to have been poor this year to date, but work is ongoing to capture and validate data. Improvements have already been noted in the other dementia indicators in January.	

Corporate Scorecard 2012-13

Patient Safety	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	RAG (based on most recent Mth/Q)
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	1	0	0	0	0	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	2	1	3	4	2	
HQU08: MSSA Numbers	No national ceiling set	1	1	1	1	1	0	2	2	1	1	
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	1	0	4	2	3	
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92%	90.0%	91.9%	
MRSA Screening Elective Patients	100% month on month	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	99.4%	99.7%	
MRSA Screening Non-Elective Patients	100% month on month	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%	95.8%	95.1%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	42	16	44	31	10	
Incidence of pressure ulcers												
Type 3	0	0	2	2	1	0	3	2	2	3	6	
Type 4	0	1	2	0	0	0	0	0	3	4	0	
Rate per 1,000 Bed Days (All Grades)	0.60	0.70	0.82	1.34	1.21	0.91	1.21	1.12	1.38	1.74	1.35	
Reduce harm from falls												
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	
Major/Severe	0	0	0	1	1	2	0	2	3	0	1	
Moderate	0	2	2	3	0	0	1	0	0	1	2	
Mandatory Training compliance Full Year Impact												
Primary Levels Excluding B&H	80%	60.10%	58.70%	59.00%	59.40%	57.70%	60.60%	62.70%	63.50%	64.30%	Not Avail	
Attendance at Trust Induction	80%	89.47%	90.70%	76.79%	87.80%	81.40%	85.48%	98.61%	90.82%	87.90%	Not Avail	
Number of surgical site infections												
Fracture neck of femur - Number of Operations	-	27	29	21	26	53	26	26	36	34	39	
Infections	-	0	1	0	1	0	0	0	0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%					1.1%			0%			
Spinal Surgery - Number of Operations	-							7	10	7	11	
Infections	-							0	0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.7%	Spinal and Vascular Surgery Infection rates monitored from Oct 2012							0%			
Vascular Surgery - Number of Operations	-							24	20	25	24	
Infections								0	0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 4.0%								0%			
Breast Surgery	-	30	40	29	38	30	38					
Infections		0	0	0	0	0	1					
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.0%					1.0%		Breast Surgery and Limb Amputations infection rates monitored up until Sept 2012				
Limb Amputations	-	11	7	10	16	12	7					
Infections	-	0	0	0	0	0	1					
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 3.8%					3.0%						
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc												
Open Central Alert System (CAS) Alerts	0	1	0	0	0	0	0	0	0	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	84.2%	87%	87.9%	89%	89.1%	
Serious Untoward Incidents	-	12	3	9	5	4	5	7	14	9	19	
Never Events	0	0	0	0	0	1	0	0	0	0	0	
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Healthcare Notes Audit												
Q.1 Does the front page of every sheet contain an addressograph label	100%		57%	67%	77%	71%	77%	73%	68%	79%	80%	
Q.2 Does addressograph include the NHS Number?	100%		99%	96%	95%	86%	90%	90%	93%	88%	99%	
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%		72%	83%	56%	87%	86%	73%	87%	97%	74%	
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%		46%	49%	36%	56%	62%	60%	62%	82%	53%	
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%		56%	59%	41%	55%	60%	64%	74%	91%	53%	
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%		6%	2%	5%	7%	16%	13%	29%	42%	18%	
Q.7 Is record legibly written	100%		93%	98%	97%	92%	99%	98%	97%	99%	99%	
Q.8 Written in blue/black ink	100%		98%	100%	100%	99%	100%	100%	100%	100%	100%	
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%		97%	98%	99%	98%	100%	100%	100%	99%	98%	
Q.10 Is date recorded for each entry	100%		73%	86%	89%	91%	94%	89%	93%	91%	88%	

Q.11 Is time recorded for each entry	100%	Audit commenced in May 12	64%	67%	79%	68%	77%	73%	70%	72%	71%	
Q.12 Is there a signature of the person making the entry	100%		98%	91%	95%	94%	92%	87%	91%	92%	90%	
Q.13 Is surname printed in block capitals	100%		42%	56%	57%	47%	48%	48%	52%	58%	59%	
Q.14 Is the staff designation recorded	100%		37%	44%	55%	42%	47%	50%	55%	50%	52%	
Q.15 Medical Records Audit only: Is the GMC number present	100%		0%	19%	11%	5%	20%	14%	11%	34%	30%	
Q.16 Are any alterations / deletions scored through with a single line	100%		29%	41%	36%	51%	38%	42%	51%	43%	25%	
Q.17 Is there a signature recorded next to any alterations/deletions	100%		19%	33%	15%	33%	33%	26%	37%	27%	16%	
Q.18 Is there a date recorded next to any alterations/deletions	100%		3%	5%	9%	27%	23%	14%	22%	14%	9%	
Q.19 Is there a time recorded next to any alterations/deletions	100%		3%	5%	3%	16%	17%	11%	20%	14%	9%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%							100%	99%	95%	97%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%							76%	68%	34%	42%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%							100%	100%	100%	100%	
Q.23 Are there any loose sheets in the Healthcare record	0%							8%	10%	17%	10%	

Questions not asked until Oct-12

Patient Experience	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	RAG (based on most recent Mth/Q)
Cancelled Operations not rebooked within 28 days	0	0	0	0	0	0	0	0	0	6	4	
Hospital Cancelled Operations	6.0%	5.9%	7.1%	8.9%	5.7%	5.3%	5.8%	7.0%	8.0%	5.4%	Not Avail	
Number of written complaints received	-	50	51	39	48	33	35	44	40	24	68	
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	83%	61%	60%	57%	90%	N/Avail	N/Avail	
Referral to Treatment waits												
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.99%	96.34%	96.08%	95.93%	96.47%	96.10%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.46%	98.44%	98.52%	98.36%	98.48%	98.60%	
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.53%	97.12%	96.91%	96.85%	96.33%	95.45%	
A&E Quality Indicators (5 measures)												
Time Spent in A&E (Month on Month)	95%	95.0%	93.4%	93.3%	92.0%	92.8%	96.9%	95.2%	90.1%	88.81%	86.91%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	93.39%	93.27%	93.87%	94.07%	93.58%	93.04%	92.47%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	03:59	04:00	06:09	06:18	07:12	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:30	00:50	00:39	00:35	00:36	00:32	00:31	00:41	00:39	00:44	
Time to treatment decision (median)	<60 mins	00:46	00:54	00:54	00:52	00:42	00:48	00:41	00:46	00:48	00:34	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	0.95%	5.71%	5.40%	6.62%	6.10%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	0.16%	0.18%	0.18%	0.07%	0.25%	0.12%	0.18%	
Cancer Wait Times												
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	96.7%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	98.3%	
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.2%	
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	100.0%	
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	95.0%	95.8%	
31 day second or subsequent treatment - radiotherapy	94%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.8%	96.9%	
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	95.7%	
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	72.7%	
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	77.8%	79.1%	
SRS08: Length of Stay (Acute & MH)												
Elective	3.20	3.70	4.1	4.2	4.1	4.2	5	4.4	4	3.8	4.4	
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	4.9	4.5	4.2	4.4	4.6	
SRS09: Daycase Rate	85%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	84.8%	83.2%	85.7%	Not avail	
SQU11: PROMS Scores - Pre Operative participation rates												
Groin Hernia - Participation Rate	Nat.Ave 55.6% (target 80%		42.30%			48.20%			88.6%		Quarterly figure	
Hip Replacement - Participation Rate	Nat.Ave 78.7% (target 80%		97.40%			91.40%			125.8%		Quarterly figure	
Knee Replacement - Participation Rate	Nat.Ave 83.6% (target 80%		94.90%			88.20%			95.9%		Quarterly figure	
Varicose Vein - Participation Rate	Nat.Ave 47.5% (target 80%		31.10%			33.30%			71.4%		Quarterly figure	
All Procedures - Participation Rate	Nat.Ave 69.7% (target 80%		72.80%			71.80%			99.1%		Quarterly figure	

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	RAG (based on most recent Mth/Q)
HSMR - monthly position for 2012-13	<100	93.7	96.2	98.7	94.0	101	104.1	93.4	83.0	Data not yet published		
HSMR - cumulative position current financial year		NA	NA	85.0	95.0	96.1	97.9	98.3	98.2			
HSMR- cumulative position for 2012-13												

Pneumonia	<100				47.4	50.2	50.6	49.7	48.7	Data not yet published		
Fracture of neck of femur (hip)	<100				148.0	133.1	163.1	155.8	168.5			
Acute Cerebrovascular disease	<100				86.0	96	104.8	110	101.6			
Congestive heart failure, nonhypertensive	<100				83.7	90.9	114.4	121.4	131.3			
Acute myocardial infarction	<100				66.5	76.7	76.4	70.1	61.9			
SHMI (based upon date of SHMI report publication)		109.2	109.2	109.2	106.0	106.0	106.0	104.8	104.8	104.8	107.81	
SQU12: Maternity 12 weeks	90%	86%	97%	87%	98%	98%	99%	98%	97%	93%	95%	
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.8%	3.4%	3.0%	3.6%	2.7%	3.2%	3.1%	4.3%	5.7%	Not avail	
Fractured neck of Femur												
Number of patients admitted with FNOF	-	27	30	21	26	52	26	26	36	34	39	
Patients fit for surgery within 48hrs	-	21	23	13	25	47	22	24	34	27	37	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	22	21	29	24	29	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	100%	87.5%	85.3%	88.9%	78.4%	
Cardiac Arrests (Numbers)												
Peri Arrests (Numbers)												
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	80%	85%	93%	89%	100%	91.0%	
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	68%	77%	75%	67%	70%	54%	46%	47%	47%	Not avail	
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	95%	100%	96%	97%	97%	83%	100%	100%	100%	Not avail	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	68.0%	75.0%	90.9%	71.4%	95.8%	76.0%	68.0%	88.9%	72.7%	68.8%	
Patients who spend at least 90% of their time on a stroke unit	80%	100.0%	95.6%	96.7%	98.6%	92.6%	93.3%	91.0%	90%	84.2%	75.0%	
Breast Feeding initiation	75%	98.0%	97.0%	96.0%	96.0%	96.0%	100.0%	99.3%	99.7%	74.9%	75.2%	
Caesarean Section Rates - Total	<25%	25.1%	25.6%	27.1%	25.1%	28.5%	26.9%	26.5%	29.3%	24.1%	26.4%	
Caesarean Section Rates - Emergency	14.98%	12.1%	11.0%	11.2%	9.8%	13.3%	13.7%	9.4%	14.91%	11.1%	10.1%	
Caesarean Section Rates - Elective	10.06%	13.6%	14.6%	15.9%	15.3%	15.2%	13.8%	17.1%	14.4%	13.1%	16.3%	
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.4%	6.8%	4.4%	4.5%	7.5%	2.1%	

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	RAG (based on most recent Mth/Q)
National CQUINS												
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	91.9%	
1b. High risk patients receive appropriate treatment *(inadequate volume of data Q2)*	95% Month on month	98.3%	93.1%	88.7%	98.0%	100.0%	96.1%	98.6%	97.3%	98.7%	99.0%	
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)							Internal assurance results					
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	Not Avail	Not Avail	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%	66.7%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	Not Avail	Not Avail	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%	65.2%	
Did you have enough privacy when discussing condition or treatment?	>82.3	Not Avail	Not Avail	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%	79.2%	
If you have been prescribed any new medication, have you been informed of any possible medication side	>48.5	Not Avail	Not Avail	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%	48.4%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your	>74.3	Not Avail	Not Avail	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%	63.6%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting												
a) Dementia case finding	90%							7.1%	2.4%	0.3%	2.4%	
b) initial diagnostic assessment	90%				Review and validation of data required			N/A	N/A	N/A	N/A	
c) referral for specialist diagnosis	90%							0.0%	0.0%	0.0%	100%	
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, *Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter*	- RAG				Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.							
Regional CQUIN												
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%	12.0%	15.3%	10.1%	14.3%	15.0%	14.8%	16.4%	
2, Board and Commissioner reporting	Submission to HCG					Submitted to HCG						
3. Weekly reporting	-		Target from Q2				Weekly reports submitted from Hospedia					
4. Performance improvement by 10 points from July 2012 position	10 point improving	- 29.98	- 30.86	0.42	70.10	56.83	74.08	76.33	72.53	67.65	68.31	
Local CQUINS												
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	50% adoption by Q4		Baseline audit undertaken						Repeat audit in progress			
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	65% for Q3, 75% for Q4		Baseline audit undertaken (59%)					80%	85%	84%	84%	
2b. Appropriate referrals to CECs/ Intermediate service from A&E			Baseline audit 50 cases in Q1		Revised process agreed with commissioners and data currently being validated by Nene CCG							
3a. Accuracy of medicines information on discharge	75% error free		Junior doctor audit undertaken in Medicine on monthly basis for internal assurance purposes. GP audit to be undertaken in Q4.									
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	Undertake baseline audit		Q4 audit completed in Rheumatology and Pain clinic, analysis being undertaken.									
3c. Oral nutritional supplements (ONS) - reduce the dispensing of ONS	50% reduction between Q1 and Q4		364 (prescribed on EDN)		331 (prescribed on EDN)			261 (prescribed on EDN)			Quarterly figure	

3d. Triptorelin	Q3 - 70% compliance, Q4 - 80% compliance	Q1	Not applicable.			76.2%			71.4%		100%	
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal					Project plan submitted quarterly to commissioners.						
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care					Project plan submitted quarterly to commissioners.						
MESCG CQUINS												
1. Quality Dashboards	-											
Identify and provide contact details of the following:												
- an overall dashboards lead for the Provider						Head of Information & Data Quality						
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-					Clinical Directors						
Provide a summary setting out the plans for implementation of the dashboards within the required timescale						4 out of 5 national data entry toolkits released in December, 5th due in Quarter 4. Work ongoing to populate.					Dashboards submitted	
3. Use of Intensity Modulated Radiotherapy	33%		Q1 = 9%			Q2 = 22%			Q3 = 52%		Quarterly figure	
4a. Cancer Chemotherapy Performance Status	90%	91.7%	93.3%	99.2%	95.1%	95.5%	96.8%	93.9%	96.0%	95.8%	95.9%	
4b. Cancer Chemotherapy Performance status 2 or above	100%	-	-	100%	100%	-	100%	-	-	100%	100%	
4c. Improve appropriate assessment and Improve mortality rates												
Number of Oncology patients deaths within 30 days of receiving chemotherapy	-	1	0	1	1	2	1		4	6		
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy	-	0.10%	0.00%	0.21%	0.18%	0.35%	0.20%		1.31%	1.77%		
Number of Haematology patients deaths within 30 days of receiving chemotherapy	-	0	0	0	0	1	0		1	0		
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy	-	0.00%	0.00%	0.00%	0.00%	2.12%	0.0%		1.3%	0.00%		
5. Hepatitis C. Compliance with treatment / improved patient outcomes	Audit undertaken					Quarterly audit undertaken						
7. Reduction of catheter - related CONS	7% Baseline 2011-12	0%	0%	0%	0%	0%	0%	0%	0%	0%	Not avail	

Trust Board meeting: February 2013	
Title: -	Patient Experience
Presented by: -	Suzie Loader, Director of Nursing, Midwifery and Patient Services
PURPOSE OF PAPER: - To update the Board on the implementation of the Patient Experience Strategy and its component parts for January 2013.	
CRITICAL POINTS: - • Friends and Family Test (FFT) Scores for January 2012 • A&E pilot FFT scores • CQUIN quality results	
ACTION REQUIRED BY BOARD: - The Board are requested to: - • Note and challenge the content of the report • Note the results from the January 2013 Friends and Family Test • Endorse the work being taken forward to create a customer service culture across the organisation	

PATIENT EXPERIENCE

1. Introduction

The purpose of this report is to: -

- Inform members regarding the patient experience activities which have taken place across the trust during January 2013
- Share actions taken to implement a Customer Service culture across the organisation.

2.0 Patient Experience monitoring

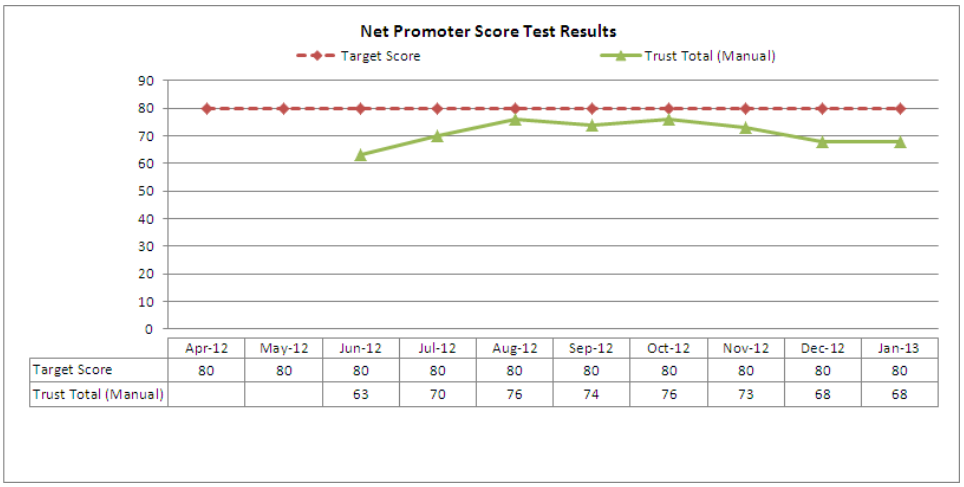
2.1 Friends and Family Test

The Friends and Family Test captures perceptions of patients about the health care that they have received, by asking the question: '*Would you or your family recommend this hospital service to family and friends?'* Data collection against this metric commenced in April 2012 whereby the Trust is required to capture 10% of inpatient discharges per week at or within 48 hours of discharge.

2.2 FFT Results: December 2012

The manual collection of the Friends and Family Test continues to elicit positive patient experience results which are demonstrated in the table below. The FFT score received for the month of January 2013 was 68. This is the same result that was achieved in December 2012 and below the 73 which was scored in November 2012. Action plans have been requested from all areas which scored below 70 (12) with the aim of achieving a score of 80 by March (Appendix 1 identifies scores by ward area). 10 wards achieved the target score.

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



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

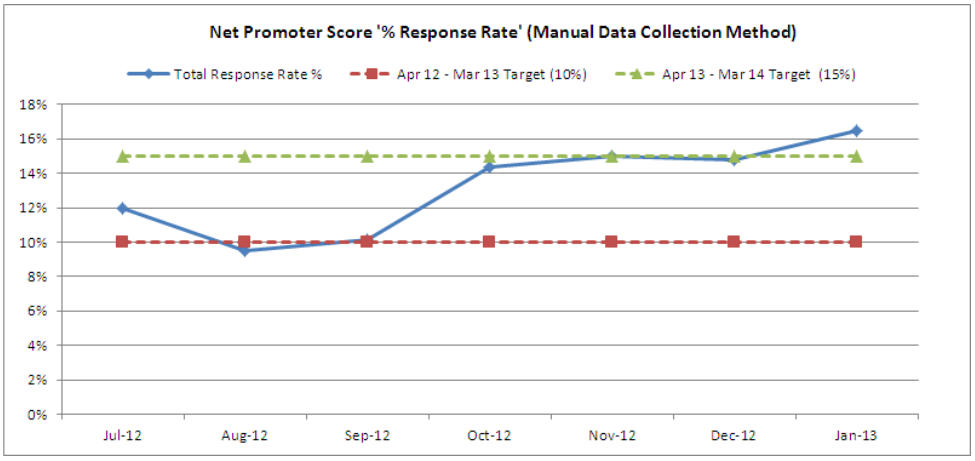
FFT Manual data collection
4201 patients were discharged from Northampton Hospital in January 2012 of which, 16.4% responded to the FFT question (this is above the 10% target for this year and the target of 15% for April 2013 onwards). From April 2013, every patient discharged from every NHS Trust is expected to receive an FFT questionnaire, with the minimum response rate of 15% of the total discharges or transfers to other units.

Comments received from these patients were circulated to Ward Sisters. Actions taken as a result of these comments are included in the "You said We did" comments on the Patient Quality Board located within ward areas.

It has been agreed, that in an attempt to achieve the prerequisite 15% from April 2013 onwards, the internal stretch target will be set to 20%, to enable the Trust to have an appropriate flex in the FFT outcome to meet the target overall. So, given this increased target we are below the 20% but above what is required nationally. So, this is good news and well done to all areas who are maintaining over 15% response rates.

In addition, the Patient Experience Lead is visiting all wards who are not meeting the data collection target to help in identifying how to improve the score, facilitating development of action plans to improve the score in readiness for the 2013/14 target. A presentation is to be made at the next Matrons meeting to review the data, process and action plans.

Table 2: FFT results for % footfall – target is over 10%



Work is underway in A&E to increase the opportunities for patients to complete the FFT question as follows:

- Via the use of an ekiosk.
- A request has been made to enlist the help of volunteers currently recruited to work within the unit to support this initiative
- A request has been made for a change in the way that data is presented back to the team so that the teams can see the benefits of taking part.

3.0 Patient Experience CQUIN

The total value of the Patient Experience CQUIN for the financial year is £629,000. This CQUIN consists of five quality monitoring questions which are located on the Hospedia Bedside Unit and a 10 point Friends and Family Test improvement which has four sub-sections.

Table 3: Preliminary national adult in- patient results/ targets published in January for comparison against Trust results

Corporate Scorecard 2012-13 CQUIN 2012-13	**Target 2012-13**	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	RAG (based on most recent Mth/Q)	Interim national results for Nov2012
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)		**Internal assurance results**									
Were you involved as much as you wanted to be in decisions about your treatment or care?	**>71.0**	69.7 %	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%	66.7%		73%
Were hospital staff available to talk about any worries or concerns that you had?	**>63.4**	74.9 %	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%	65.2%		53%
Did you have enough privacy when discussing condition or treatment?	**>82.3**	73.8 %	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%	79.2%		85%
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	**>48.5**	47.8 %	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%	48.4%		43%
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	**>74.3**	52.7 %	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%	63.6%		72%

3.1 Patient Experience Quality monitoring CQUIN

The CQUIN questions relate to communication between hospital staff and patients. The questions are on the Hospedia Bedside Unit. Patients are encouraged to complete the survey during their period of hospitalisation and are made aware of the questions through a daily “pop-up” feature on their bedside unit.

Progress against the targets set for each question is monitored monthly in the Trust and quarterly by Northamptonshire Commissioners as the financial value attached to this CQUIN is £251,000. Further progress needs to be made against two of the five targets: -

- Did you have enough privacy when discussing your condition or treatment
- If you are ready to be discharged, have your been informed who to contact if you are worried or have concerns?

The actions being taken to improve this are part of the ward action plans for improving the patient experience. Ward Sisters and Matrons are putting in place a standardised process for discharge to include required contact numbers. The issue of privacy and dignity is being reviewed by generally reviewing the environment associated with any discussions about the patient's condition or treatment.

3.2 Actions to improve the CQUIN results

The Director of Nursing met all Ward Sisters to share her concerns regarding current results, challenging them to identify actions which would lead to an improvement in these scores. Improvements will be made if Ward Sisters raise the awareness of these questions with doctors and nurses and encourage them to respond accordingly to patients.

As part of a concerted focus on the medication agenda the ward teams have been advised about the importance of explaining new medications and their side effects to patients. This action is repeated by the ward pharmacist as they perform their daily rounds where appropriate. It was noted that many of these conversations take place on discharge when nurses are dispensing take home medications and an effort is being made to have these conversations with patients earlier.

Several ideas have been discussed as to the best method of informing patients on discharge who to contact if they have any concerns (leaflets, a credit card with the ward number etc). The consensus of approach will be determined during the Ward Sisters meeting in February 2013.

Senior nurses were requested to prompt ward and medical staff to improve their communication with patients, ensuring patients receive comprehensive information during their period of hospitalisation or in receipt of outpatient services.

4.0 Patient Experience Implementation plan appointment of Patient Experience Clinical Leads

The Patient Experience Implementation plan is monitored by members of the Patient Experience Board. The recruitment process for two Patient Experience Leads (one from each Care Group) and the nomination of Patient Experience Champions representing Directorates was agreed at the meeting In January. The advert for nominations to the Lead roles has been sent out and the closing date for this was the 14th of February 2013, with interviews taking place in early March for appointment to posts for the 1st of April 2013. The leads will then commence the appointment process to the Patient Experience Champion roles in the service areas.

4.1 Patient information: Listening in Action subgroup

A Listening in Action (LIA) Task and Finish Group met twice in November and December. Four public and patient representatives were actively engaged as members of this group and included representatives from Northampton Institute for the Blind, Northampton Deaf Connect and hospital governors. The aim of this subgroup was to establish existing practice

and offer recommendations to improve hospital letters, signage and patient information. A progress report was submitted to the sponsor group on 30 December 2012.

Progress to date:
Signage:
Issues surrounding signage within Cardiology have been rectified and plans are now underway to use students currently working with Estates to act as mystery shoppers and evaluate this.

Patient Letters:
Work continues on editing patient letters to make them more user friendly for all members of the community. Issues surround changing the letter template and any impact this may have on printing and confirmation is outstanding re the level of information that needs to be included about the NHS constitution and informing patients of their rights.

Patient Information:
The process for agreeing the ongoing quality and validity of patient information was discussed by members of the PIG group and a process for ascertaining this with the wards and Care groups was discussed. PIG to contact all leads to identify the process as there are concerns surrounding what happens to information once it has been through the PIG process regarding keeping the information up to date etc

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

6.0 Recommendations

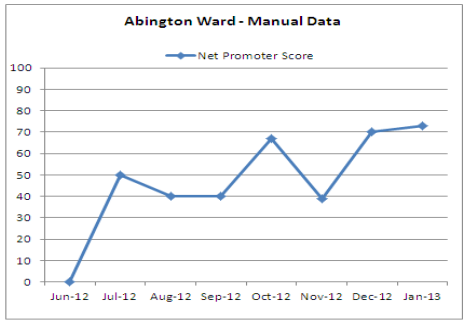
Members of the Board are requested to:-

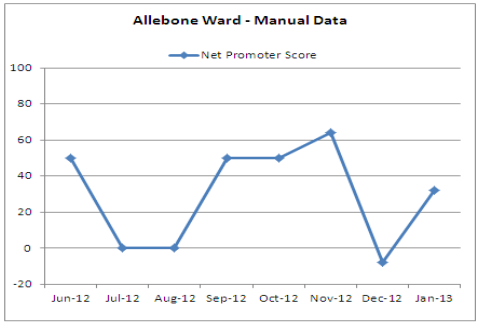
- Challenge the content of the report and support the actions defined.

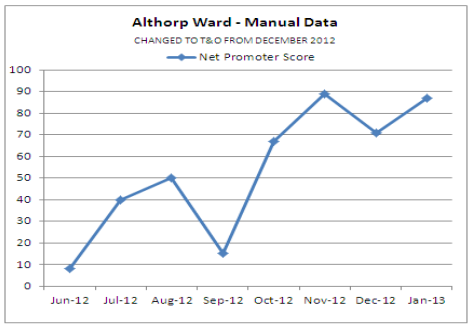
Appendix 1: Monthly Friends and Family Net Promoter Score Results and Response Rates Jan - 13

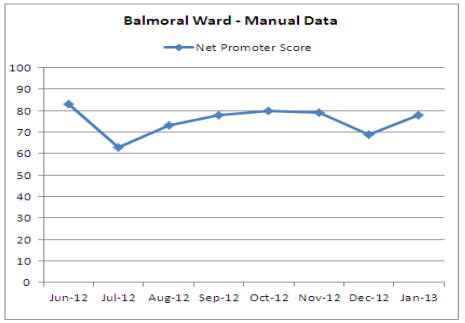
Department	Total No. of eligible A&E Attendances	No of Manual responses	% Response Target = 10%	Net Promoter Score Score Target = 80
ACCIDENT & EMERGENCY DEPT	4110	22	0.54%	0
Day Surgery Areas (Recorded from January Wk 2)	**Total No. of Daycase Discharges**	**No of Manual responses**	**% responses Footfall Target = 10%**	**Net Promoter Score Score Target = 80**
DANETRE DAY SURGERY UNIT	123	82	66.67%	91
NGH DAY SURGERY UNIT	229	89	38.86%	91
Wards	**Total Inpatient Discharges**	**No of Manual responses**	**% Response Target = 10%**	**Score Target 80 Net Promoter Score**
ABINGTON WARD	38	11	28.95%	73
ALLEBONE WARD	65	25	38.46%	32
ALTHORP WARD	72	23	31.94%	87
BALMORAL	179	100	55.87%	78
BECKET WARD	64	14	21.88%	21
BENHAM WARD	202	18	8.91%	50
BRAMPTON WARD	34	15	44.12%	93
CEDAR WARD	55	20	36.36%	65
COLLINGTREE	88		0.00%	
COMPTON WARD	23	21	91.30%	81
CORBY COMMUNITY	8	4	50.00%	100
CREATON WARD	68	22	32.35%	36
DANETRE WARD	21	12	57.14%	92
DISNEY WARD	145	24	16.55%	96
DRYDEN WARD	84	2	2.38%	100
ELEANOR WARD	18	3	16.67%	100
EMERGENCY ASSESSMENT UNIT	228	30	13.16%	60
FINEDON WARD	58	21	36.21%	71
HAWTHORN WARD	212	54	25.47%	56
HAZELWOOD WARD, ISEBROOK HOSPT	18	23	127.78%	83
HEAD AND NECK WARD	75	25	33.33%	76
HOLCOT STROKE UNIT	16	11	68.75%	91
KNIGHTLEY WARD	45	12	26.67%	75
PADDINGTON WARD	369	32	8.67%	56
ROBERT WATSON - MOTHERS	119	50	42.02%	54
ROWAN WARD	130	45	34.62%	67
SPENCER WARD	106	23	21.70%	87
TALBOT BUTLER WARD	72	22	30.56%	77
VICTORIA WARD	46	11	23.91%	27
WILLOW WARD	61	18	29.51%	89
Wards Total	**4201**	**691**	**16.45%**	**68**

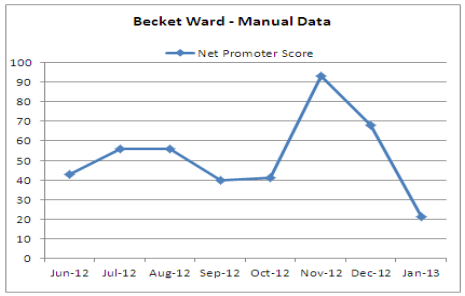
Friends & Family Test Results

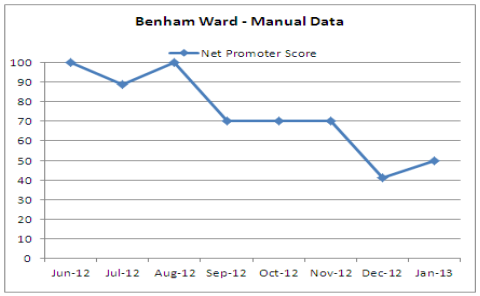


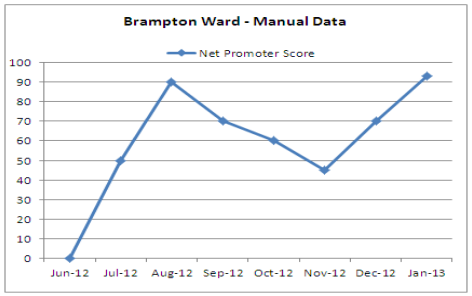


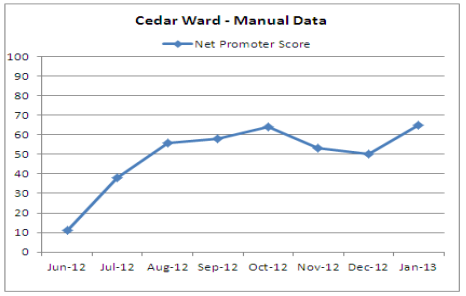


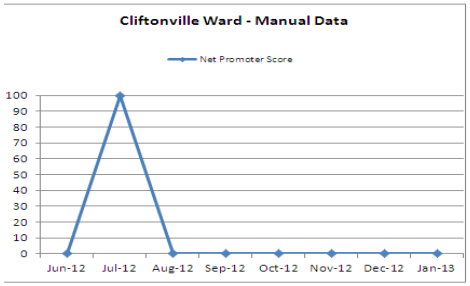


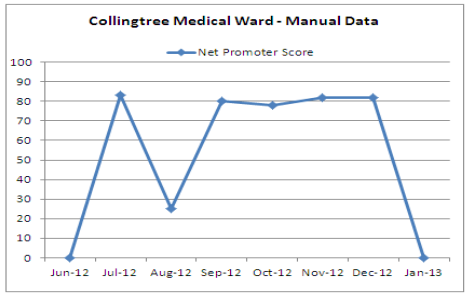


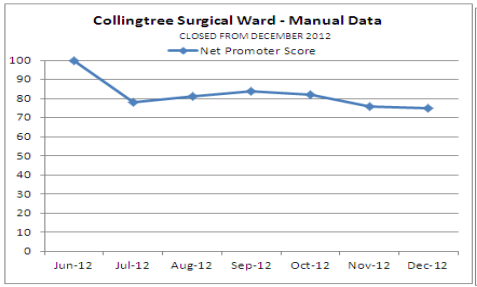


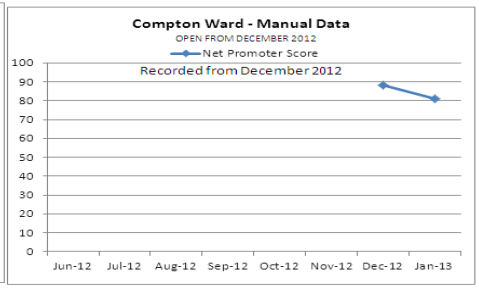


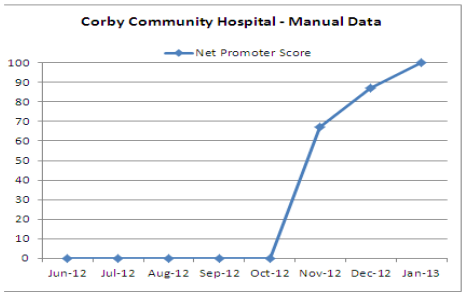


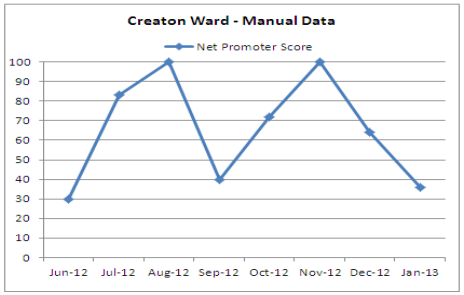


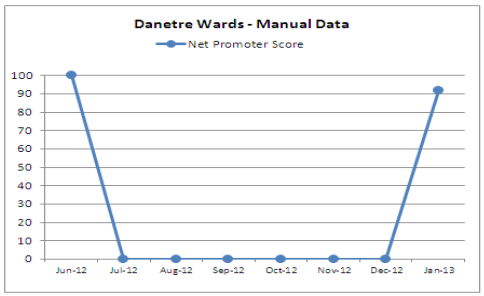


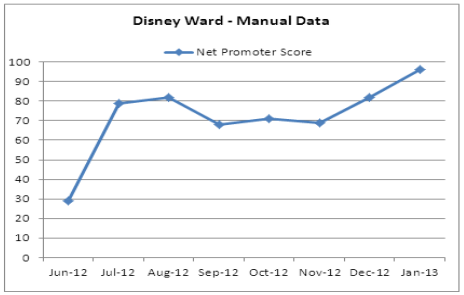


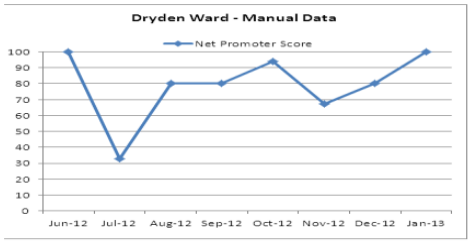


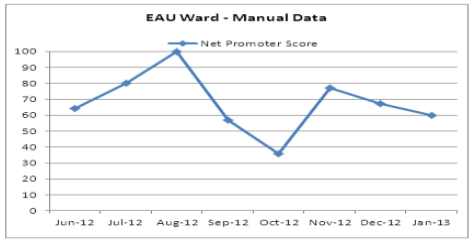


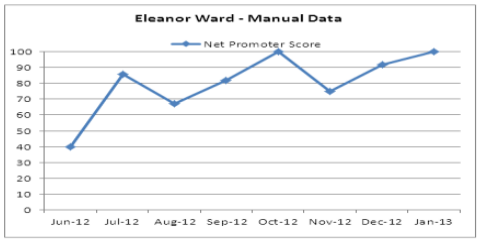


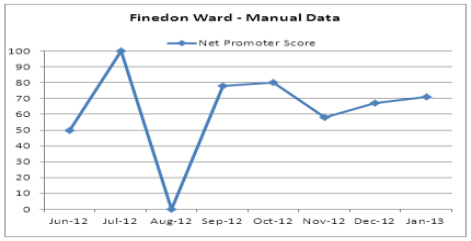


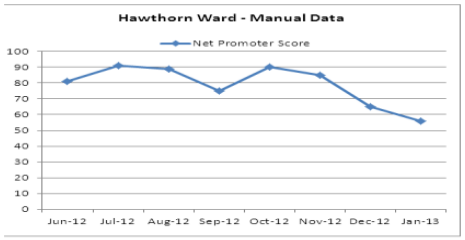


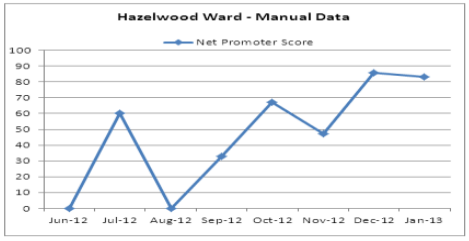

Dryden Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

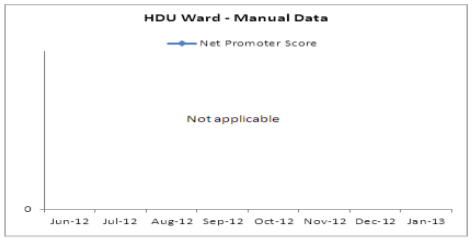

EAU Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

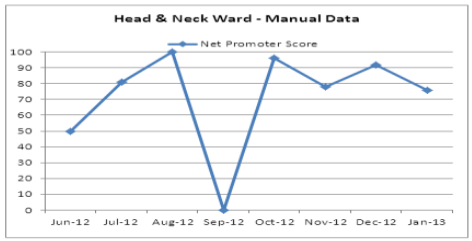

Eleanor Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

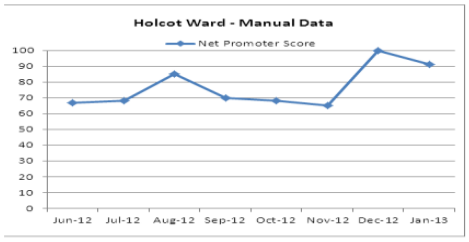

Finedon Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

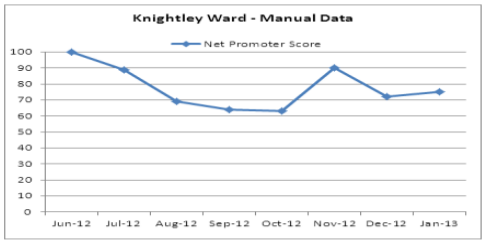

Hawthorn Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

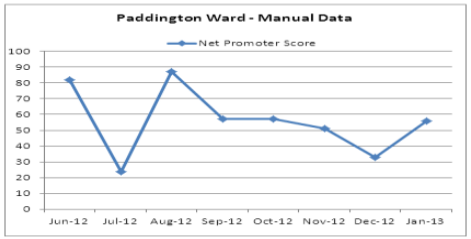

Hazelwood Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

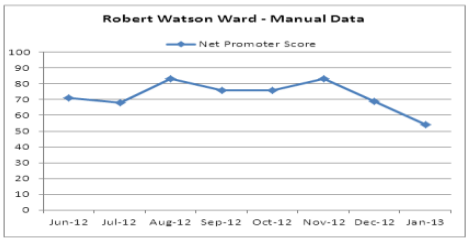

HDU Ward - Manual Data
Net Promoter Score
Not applicable
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

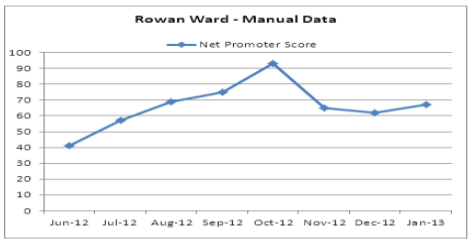

Head & Neck Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

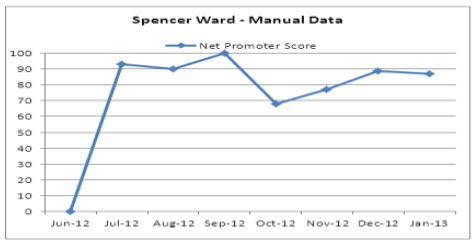

Holcot Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

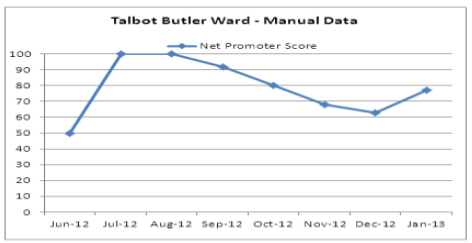

Knightley Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

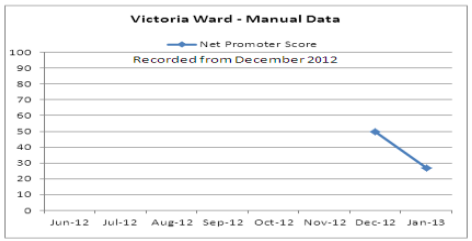

Paddington Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

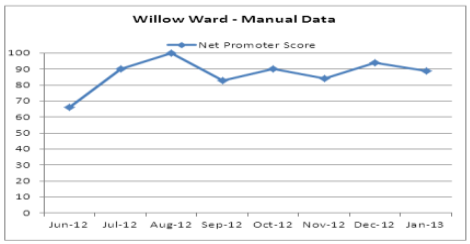

Robert Watson Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13


Rowan Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13


Spencer Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13


Talbot Butler Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13


Victoria Ward - Manual Data
Net Promoter Score
Recorded from December 2012
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13


Willow Ward - Manual Data
Net Promoter Score
Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

TRUST BOARD 28TH February 2013	
Title: -	Monthly Infection Prevention Performance Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Date:	February 2013

PURPOSE OF PAPER: -

To update the Board on infection, prevention and control within the hospital for the month of January 2013.

CRITICAL POINTS: -

- Monthly update on reportable Healthcare associated infections (HCAIs)
- Review of incidents and trend analysis of HCAIs is paramount to improving learning, patient safety and quality of care and also impacts on staff safety and wellbeing

ACTION REQUIRED BY BOARD: -

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

January 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.

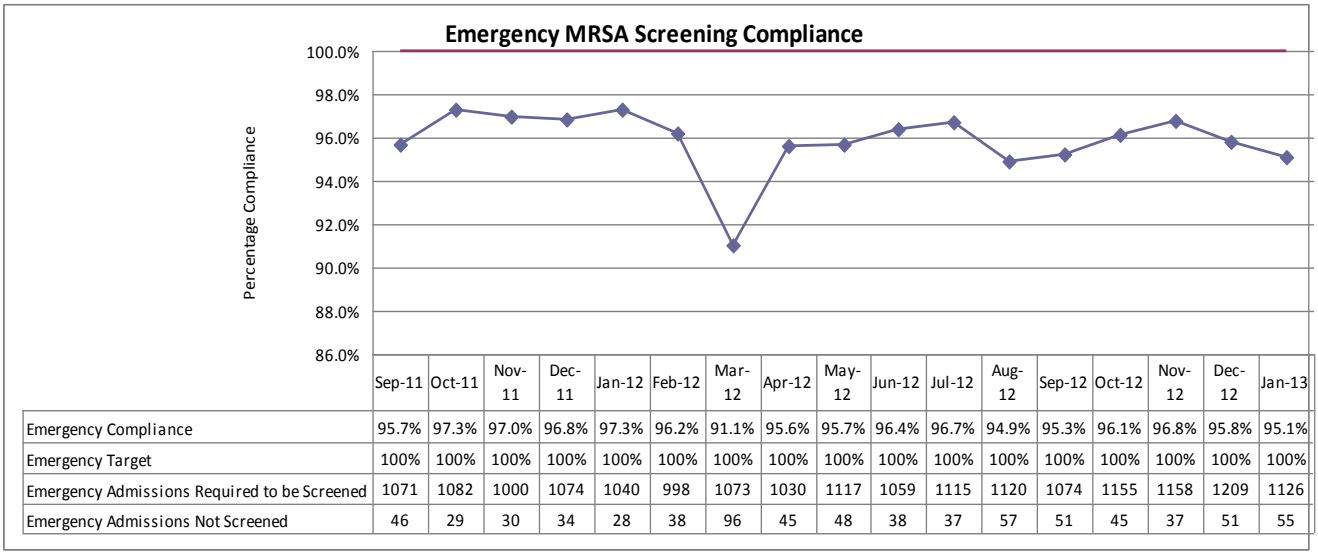
2. MRSA Bacteraemia

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

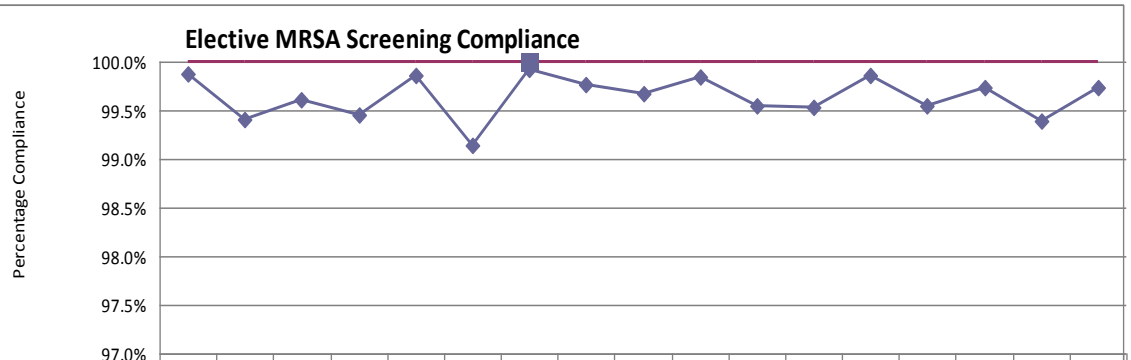
3. MRSA Colonisation & Screening

During January there were 8 <48hrs and **5>48hrs** cases of MRSA colonisation.

Compliance with elective and non-elective screening is demonstrated via the graphs below. This has dropped slightly over the past couple of months (possibly due to 'winter pressures'), but continues to be monitored regularly by the Care Groups as well as the Infection Prevention team.



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Emergency Compliance	95.7%	97.3%	97.0%	96.8%	97.3%	96.2%	91.1%	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%	95.8%	95.1%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1071	1082	1000	1074	1040	998	1073	1030	1117	1059	1115	1120	1074	1155	1158	1209	1126
Emergency Admissions Not Screened	46	29	30	34	28	38	96	45	48	38	37	57	51	45	37	51	55



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Elective Compliance	99.9%	99.4%	99.6%	99.5%	99.9%	99.1%	99.9%	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	99.6%	99.7%	99.4%	99.7%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1515	1352	1521	1291	1459	1407	1410	1253	1243	1274	1305	1301	1380	1559	1526	1162	1476
Elective Admissions Not Screened	2	8	6	7	2	12	1	3	4	2	6	6	2	7	4	7	4

Special Measures

Definition

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

- *C.difficile* sample dated over three days after admission
- MRSA swab dated over 48 hours after admission

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

No ward was on special measures for January 2013

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

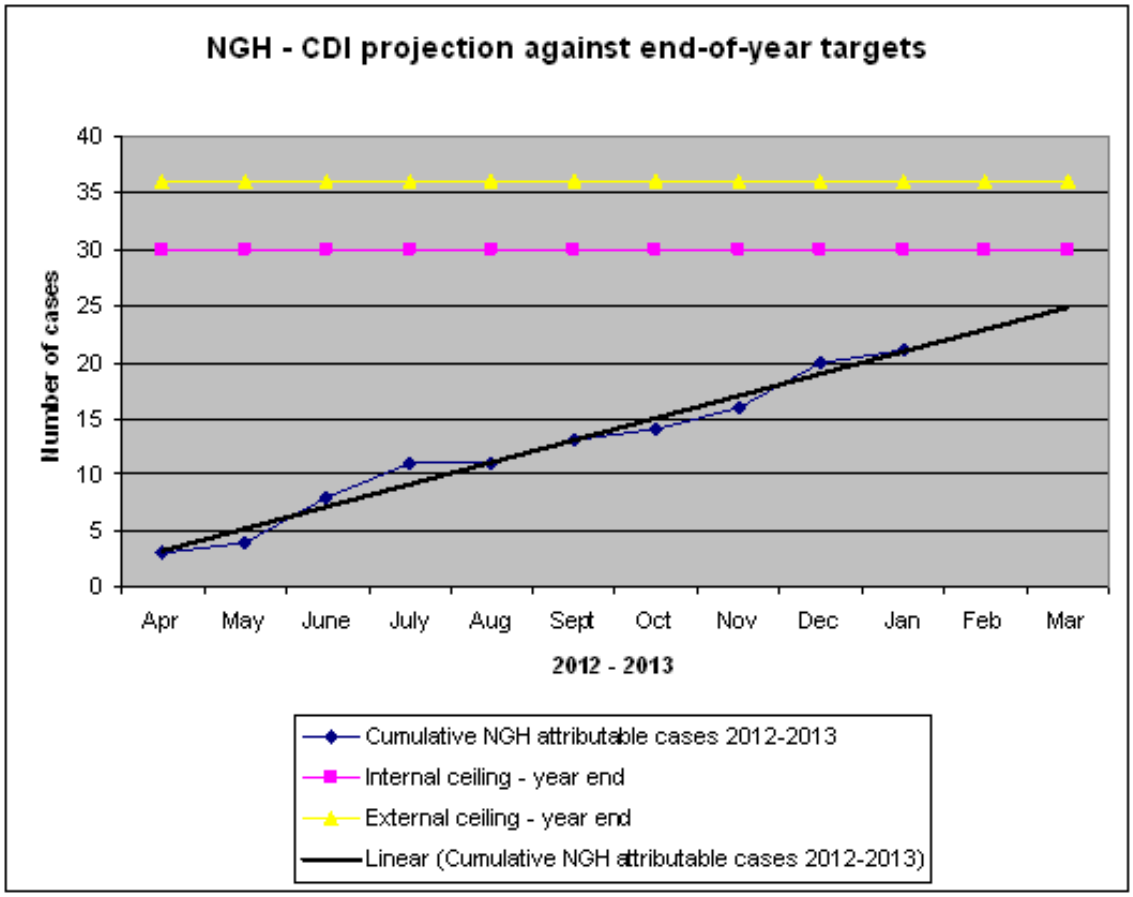
During January 2013 there were 4 <48hrs and **1 >48hrs** MSSA bacteraemia case on Collingtree.

The **Collingtree ward** RCA investigation meeting was held on the 5th February and actions were identified, which included improving compliance with the Peripheral Vascular Cannula (PVC) documentation. A group has met to review and update the Central Venous Catheter (CVC) care plan to incorporate other vascular access devices.

During December 2013 there were 1<48hrs and 1>48hrs MSSA bacteraemia cases. The post 48 case on **Eleanor ward was** attended by a clinician and an MRSA screensaver alerting clinicians to look back at previous results is to be produced as medical staff were unaware of previous urine sample taken by the GP.

Clostridium difficile

The Trust has an annual target of 36 C. diff. cases (3 per month) or less for the financial year. During January ***2>3 day case of C. diff*** were identified**,** which totals 23 >3 day cases of C. diff for the year, which is slightly below trajectory; however, we are continuing into the winter months when the cases of C diff tend to escalate.



In January 2013, **Allebone ward** was put on special measures due to 2 post CDiff, 1 in December and 1 in January (these 2 specimens were within 28 days). From the findings compliance with personal protective equipment (PPE) was poor and we instigated twice daily PPE audits and training. The PPE audits are now achieving 100% and the team are reassured regarding compliance. The cleaning audits were compromised due to estate issues and these have now been resolved.

The new C Diff target has been set for 2013/14 as 29 cases (a reduction of 7 cases from this year). This year, the target was divided equally per month. Next year, it is proposed that the target is titrated against the actual incidence of data, so that the targets are more realistic.

5. Surgical Site Infection Surveillance Scheme (SSIS)

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

5.1 Surgical Site Infection Surveillance

Background

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

The **interim** results for January 2013:

- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from 39 operations
- Vascular surgery show that there were ***no infections*** resulting from 24 operations
- Spinal surgery operations show that there were ***no infections*** resulting from 11 operations

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

A national survey of surgical site infection surveillance (SSIS) has just been reported in the Journal of Hospital Infection (Tanner et al, 2013). It states that patients develop wound infections post operatively far more often than reported to the Health Protection Agency's Surgical Site infection Surveillance Service and that there are wide variations in how hospitals collect and report this information. All 156 hospital trusts in England were sent questionnaires asking how data was collected and reported; 106 trusts replied. Results were as follows:

- There were considerable differences in data collection methods and data quality that caused wide variation in the reported SSIS rates.
- Rates of surgical site infections were much higher (e.g. knee replacement surgery 4.1%) where high quality post discharge surveillance was used e.g. telephone calls to patients and outpatient clinics than those with little follow up (1.5%).
- In reporting:
    - 9 trusts(8%) only reported infections whilst patients were in hospital
    - 24 trusts(22%) used inpatient & readmission data
    - 73 trusts (68%) used inpatient, readmission & post discharge data

- Many trusts failed to use national protocols & definitions for wound infections:
    - 10% failed to provide data on superficial infections
    - 15% did not use the recommended definition
    - 30 trusts did not submit a complete set of their data.

The authors conclude that the national surgical site infection surveillance under reports the true scale of surgical infection and because of these inconsistencies, it is not possible to benchmark hospitals against the national data. Hospitals conducting high quality surveillance will be penalised using this system. They call for a clear, standardised system to be introduced to report more infections more accurately and that would include contacting patients within 30 days of surgery.

In our Trust, the Infection Prevention Team uses the definitions given by the Health Protection Agency (HPA) in their protocol to define surgical site infections. To gain as complete a set of data as possible, our surveillance uses inpatient, readmission and post discharge data, including telephoning patients at 30 days and involving specialist or district nurses and GPs where appropriate. A complete set of data collected is always submitted to the HPA and data is also provided on superficial infections as well as on more deep or organ space infections.

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

- January overall Trust compliance for hand hygiene = 95.8%, four areas failed to submit the completed audit.

Areas who have failed to submit their audits are being chased up by the Infection Prevention team and put on special measures to ensure better compliance in the future.

Hand hygiene compliance in the ward areas, is considerably higher than the overall trust score, with the scores ranging from 98.4% (Doctors) to 100% (Pharmacists).

7. Executive and Non-executive Director infection prevention walk rounds

These were introduced to make raise the profile of infection prevention, facilitate board to ward activity and to ensure the board is more visible to the clinical areas. To expand this role from only meeting the ward sister or matron at the beginning of the round, it has been suggested that the team meet with all the ward staff to introduce themselves (so they know that directors are visiting the ward). To carry out the inspection as normal, and then at the end to spend 5 minutes feeding back to the whole team. This started in January 2013.

These last two months not all executives and non executives have been able to comply with these walk rounds and a further member of the IPT or matron have continued to facilitate these walk rounds. It is really important that all the executives and non executives comply to make this process viable within the Trust.

8. Scalded skin syndrome Outbreak

Scalded skin syndrome is caused by infection with certain strains of *Staphylococcus aureus* bacteria. The bacteria produce a toxin (poison) which causes blisters to form on the skin. Scalded skin syndrome is found most commonly in infants and children under the age of 5.

In January 2013 a cluster of 4 babies born at NGH in December '12 were diagnosed with scalded skin syndrome. This has now risen to 7. All babies have been treated and are well. The trust continues to investigate this situation to identify the underlying cause. Preventative measures have been taken to keep any spread to a minimum and the Trust continues to monitor the situation on a day to day basis.

9. Public Health England transition update

The change in management arrangements being implemented across the NHS in response to '*Liberating the NHS'* (2012) are also being reflected in the provision of public health. As a result, the responsibility for Northamptonshire will be held by the new Hertfordshire and South Midlands Public Health England (PHE) Centre (covering Beds, Herts, Northants and Milton Keynes) from April 2013.

East Midlands Health Protection Unit (HPU) is working towards ensuring a safe and smooth transition for Northants from them to the new PHE Centre. This process has already begun and it is anticipated that the new PHE centre will be able to take over Northants both in and out of hours from April 2013.

10. Public health surveillance strategy

An overview of the vision and plans for the delivery of a public health surveillance strategy, as part of Public Health England's broader information strategy, has been published.
The overview:

- sets out the key benefits and challenges in delivering such a strategy
- describes how an integrated public health surveillance system can strengthen surveillance as a component of a broader public health knowledge and intelligence function within the changing organisational context of public health delivery systems
- supports the delivery of an efficient, world-leading service that provides a robust evidence base for decision-making and action-taking in respect to both acute and chronic diseases and health determinants
- acknowledges that surveillance will underpin the protection and improvement of health and service delivery, through outputs that are timely, accurate, accessible and meaningful to users of this information at the local, national and international level.

'Surveillance' is defined as providing the right information, at the right time and in the right place, to inform decision-making and action-taking.

11. Conclusion

The team maintains collaborative working across the Trust and healthcare associated infection remains a top priority for the public, patients and staff. This has been possible due to the commitment to infection prevention and control which is demonstrated at all levels across the organisation.

12. Recommendation

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

TRUST BOARD 28th February 2013	
Title: -	Patient Safety Programme Update
Presented by: -	Sonia Swart

PURPOSE OF PAPER: - To update the Board on the progress made against the programme of work set out in the Patient Safety Strategy

CRITICAL POINTS: -

- Progress has been made since the Trust formally supported patient safety initiatives in 2008 and again in 2010 and developed a refreshed Patient Safety Strategy in 2012.
- Following the lessons learned from this work and in recognition of the critical impact of improvement and safety improvement programme has been designed to interlink with other transformation projects.
- Education and training for all staff are a key part of this programme and there is evidence that staff who understand the key principles of eliminating harm and improving processes to eliminate harm have higher job satisfaction and deliver better care to patients.
- Listening to the safety concerns raised by staff and involving them in the necessary solutions will increase staff satisfaction and motivation and improve care for patients.
- The ability to continually drive forward quality and safety is increasingly important and will also affect our income. Investment in quality is likely to reduce cost in the long term.

ACTION REQUIRED BY BOARD: -
Board members are asked to note the contents of this report and debate the issues raised and support the on-going investment required to ensure progress is made at pace.

Background

During the last 5 years there has been a marked increase in focus on quality and safety at all levels within the Trust. There has been increase in understanding from, and engagement of, clinicians and managers as well as increasing support from the executive team and Trust Board for all improvement work related to quality and safety. This has been underpinned by improvements in the clinical governance framework and strong linkages between assurance functions and the need to improve and learn.

Some of the improvements have been assisted by the framework of the previous Safety Strategies.

1. Previous Safety Strategies

Safety Strategy Achievements 2008 – 2010:

- A marked increase in the focus on quality and safety from Board to Ward
- Keen clinicians involved in projects
- A portfolio of projects in place
- Some measurable progress
- Comprehensive increases in the focus on clinical governance

What was not achieved?

- Measurement remained an issue – manual audit and collection of data was still necessary – data sources did not correlate
- No comprehensive investment in time and clinical leadership which was required to sustain this and no managerial support
- HSMR fell and then rose – no one understood exactly why
- Many changes in Trust leadership which led to difficulties in sustainability

Safety Strategy Achievements 2010 - 2013:

- Some impressive clinically led safety projects involving senior and junior doctors and linking with senior nurses
- Projects consolidated and defined as agreed
- Patient Safety Board presentations well received and focussed as a forum for sharing improvement
- Junior Doctor Safety Board increased in membership and momentum
- Measurement of Harm starting to become more robust
- Better shared ownership medicine/nursing

What was not achieved?

- Lack of clarity with respect to goals
- Lack of investment in the time and leadership necessary for safety training
- Lack of managerial ownership of safety and quality versus mandatory targets
- Emergency pressures usurping all available time
- Lack of formal links between safety and quality and operational issues

2. Safety Strategy 2012 – 2015:

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

- Patient Safety
- Patient Experience
- Clinical Outcomes

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 changes to clinical processes and practice to improve patient care. This will develop an improved safety culture and a reduction in avoidable harm in hospital.

The core of the Patient Safety Academy was established in the summer of 2012 with the appointment of 5 clinical leads and the introduction of project management support in November 2012. The recruitment of champions from a variety of clinical and non-clinical areas has commenced and these champions will be part of the safety academy as this matures. The Clinical Leads and Champions report to the Patient Safety Programme Director and to the board via the Medical Director. This is outlined in the Patient Safety Strategy which articulates the aims of the Patient Safety Improvement programme and supports the Trust Quality Strategy.

The sixth work stream acknowledges emergency pressures are creating an environment where most staff are concerned about the quality of care they are able to provide. The safety academy work dovetails and works in parallel with the redesign of the emergency care pathway. The framework for the Safety Academy can be viewed as six improvement work streams.

3. The NGH Vision for Safety via the Patient Safety Academy

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 our 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 extra lives over the next three years.'

This is the aim that the Patient Safety Academy support and will deliver.

4. The Safety Academy, Safety Projects and Workforce engagement

To enable and sustain the improvement work of the Patient Safety Academy, the academy's constitution is made up of interested staff (Safety Champions) and led by 6 clinical leads who have joined the Medical Director, the Nursing Director and other key individuals to lead on initiatives to improve patient safety. These individuals have access to training and project management support to be able to cascade and support other individuals in delivering safer care. This work reports into key committees and boards and also through structured reporting to the NGH Transformation Programme.

Following reviews of hospital complaints, detailed clinical audits of case notes and themes from Serious Incidents and from listening to staff, the five safety work streams developed in the strategy are as follows:-

i. Reducing Harm from failure to Rescue

This work stream focusses on how we can prevent avoidable patient deterioration and improve early intervention. This work stream currently includes reviewing the organisational knowledge and implementation for the Early Warning Scores (EWS) and clinical triggers for patient deterioration in practice.

Through patient safety methodology and PDSA cycles the identification, escalation and management for Pneumonia and Sepsis have been refined and embedded. Review and effective utilisation for the outreach team is also encompassed within the above work stream.

There is often some commonality and crossover with the failure to rescue work and the failure to plan work stream.

ii. Reducing Harm from failure to Plan

The hospital death case note review audit confirmed that care across the hospital is often fragmented. Patients are handed over from junior doctor to junior doctor, from consultant to consultant, from ward to ward, and from NGH to community hospitals or back to their GP. The information at the point of handover or transfer is not always clear. Every handover of care has the potential to create delay and miscommunication. It also has the potential to allow clarification of plans. The standards of record keeping laid down by the hospital are not always followed and in these days of fragmented care this has the potential to cause harm.

This work stream aims to address this problem. The themes identified within the above work stream have also included some specific key important areas relating to planning of care:

- The information included in the Electronic Discharge Notifications (EDN). This needs a system design process to ensure simplicity, accuracy and compliance.
- Standardisation and expectation for ward rounds which include the expected standardised information needed for the round, the information recorded as a result of the round, management plans, and investigations requested and results obtained and acted upon whilst confirming all patients receive a consultant review within 12 hours from the time of hospital admission.
- NGH communication with Primary Care and General Practice is being refreshed, with GP practices being allocated named “Consultant Buddies” and visits to the GP Practices are planned. This project objective includes improved communication and expectations with external partners.
- Medical handover during daytime is being reviewed to standardise the format and content.
- Night team handover is being reviewed and refreshed to reflect the recent bed reconfigurations, as the change in landscape, experience and numbers of staff that form the Hospital Night Team, have been identified as a concern. This initiative is being lead by the safety lead responsible for learning from Harm and Serious Incidents and remains under the close supervision of the Medical Director. The improvement plan for this project has been expedited. Progress and outcomes from this project will be reported to the Trust Board independently of the above work stream.

iii. Reducing Harm from failures of Care

This work stream considers nursing care and improving patient experience on the wards and is focussing on skills, education and practice required for standardisation of care and elimination of avoidable harm. This work stream is supported by the Senior Nursing Team and includes a number of key areas:

- Urinary care and accurate completion of fluid balance charts.
- Assessment and support for Safeguarding for Vulnerable Adults including assessment, identification and support for patients with memory loss and dementia are encompassed within this work stream.
- Prevention of pressure ulcers in conjunction with the lead nurse for Tissue Viability.
- Reducing harm from falls with the help of the Falls Coordinator who is assisting in the implementation of evidence based nursing practice and improvement work.
- Improving oxygen prescribing and management is a multidisciplinary project that requires a focussed approach and will be trialled as a PDSA to improve compliance.
- Infection prevention and control issues.
- Medicine Management on inpatient ward areas.

iv. Learning from and sharing lessons from failures and successes

The above work stream reviews key themes and issues from serious incidents, complaints and inquests, to ensure the organisation learns from any failures in service or care provision. This includes:

- Reviewing processes to confirm operational staff are receiving feedback and support from issues reported via the Datix system and change in practice as identified from Serious Incidents and action plans is in progress.
- Various methods for improving that lessons learnt are shared within the clinical teams. This is being trialled and supported via a PDSA cycle and will include all significant incidents for each area including those not classified as Serious Incidents.

This work stream works closely with the Patient Safety Learning Forum, Serious Incident Group and the Care Groups and Corporate Governance leads.

The key issues for the organisation that have emerged from serious incidents and other investigations have a tangible link to:

- Documentation of clear plans and findings in the medical and nursing records including handover and transfer.
- Ensuring an appropriate well planned response to the acutely ill or deteriorating patient.
- Failures of basic care.

v. Human factors and Safety Science

Human Factors training is incorporated within the above four projects and is inclusive rather than being an entirely separate work stream. Scenario based training via simulation is included within this work stream, with lessons leant from failures and success being utilised as a training opportunity.

Mandatory training, essential training and training in safety theory related to clinically relevant issues are also developed into a teaching or learning opportunity within the above.

vi. Urgent Care and a review of A&E and the emergency pathway

The progress and project portfolio for the Urgent Care review will influence and impact on the five Safety Academy Work streams, and is reported as a separate work stream.

5. How the safety work will deliver safer care in NGH

The delivery of the strategy is through the programme management of a series of projects. The programme provides the strategic direction for safety and support to managers, clinicians, project leads and safety champions to deliver the agreed safety objectives that will influence change and drive improvement.

Each of projects is monitored via a detailed project plan to ensure that objectives are achieved and patient safety is improved. Clinical leads are asked to review project plans regularly with the Project Manager, to maintain momentum and monitor progress.

As the projects continue to evolve and / or new safety issues are identified, project plans are updated.

Performance standards and metrics have been developed to monitor and provide assurance for patient safety improvement.

The Medical Director and team have been working with the Junior Doctors' Patient Safety Forum, to engage the trainee doctors in patient safety. This has continued via the Safety Academy with a number of FYIs and SPRs supporting safety projects and audits. Of note is the support of one of the Foundation Year 1 doctors in the realignment of an electronic medical handover which is currently being trialled, another doctor in training has also completed a recent audit of Electronic Discharge Notifications (EDN's) on the wards and is supporting improvement solutions.

The current and proposed projects are discussed and agreed via the Clinical Leads Safety Academy meetings which are held fortnightly, with the Medical Director and Director of Nursing attending monthly. An update on projects is requested at each meeting to allow issues to be debated and actions progressed.

6. Working with our Safety Champions

As of January 2013, there were 106 patient Safety Champions at Northampton General Hospital. This group of staff have either been nominated by their managers or self-nominated, as they are keen to improve safety in their local area.

There is an expectation that the Safety Champions are the 'eyes and ears' of patient safety in their ward or department; assisting with safety initiatives and audits and escalating any concerns to their line manager and members of the Safety Academy when appropriate.

An outline list of suggested roles and responsibilities for ward based champions has been circulated which includes; checking of the resuscitation trolley, being available on 'board to ward' visits, completing local risk assessment, attending bi-monthly safety academy training days and leading audits where suggested.

During January 2013, project workshops were held for each of the work streams. Interested champions were invited to meet with the clinical leads to discuss their active involvement in safety initiatives and project work. As a result of this the following supplementary projects are currently on going with the Safety Champions locally:-

- Allebone ward are currently auditing the use of the SAP forms on the ward.
- The Endoscopy service is reviewing the use of the green card system for referrals.
- Knightly ward are trialling regular ward 'huddles' (team meetings) to allow feedback on governance data and learning from this.
- The dementia lead nurse is being supported in work relating to the dementia CQUIN by the therapy services.
- Use of the red sepsis boxes are being audited across the trust and the implementation of the sepsis bundle in A&E.
- Staff communication is being discussed with the Porters, mainly around the issue of 'rudeness' identified.
- The Simulation Suite is being promoted and further opportunities for safety training considered.
- A pictorial fluid balance chart, to assist with fluid intake, is being trialled on Knightly ward.
- Omitted medicines are being reviewed and audits completed to see why and when this occurs on the ward.
- A review of the use of dementia butterflies has been implemented.
- A pre-assessment booklet has been reviewed, led by an FY1.
- The quality of ward rounds is being reviewed and trialled.
- An audit of consultant review of patients within 12 – 14 hours is being completed.
- Equipment related incidents have been discussed with Facilities and support with mattress management suggested.
- The GP 'buddy' system has been re-instated for contacts in NGH.
- An audit of ward EDN's has been completed and Paediatrics are being consulted on their processes around this that have led to zero unauthorised EDN's on the Children's wards.

A monthly safety newsletter is produced for champions and each ward has been issued with a resource folder and champion's badges; to identify champions in departments. **(Appendix 1)**

Safety 'academy' events have been held in November 2012 and early February 2013. The first event provided champions with training from the NHS Institute for Innovation on measurement and data collection, the second event delivered an overview of the projects and the aims of the academy; and the third event showcased the progress made and operational difficulties identified by the safety champion's who provided feedback at the workshop. Training on 'human factors that lead to error' and incident management has also been delivered.

The 'Safety Academy' has a work plan forecast for 2013, with future champion's training planned on topics such as 'What is harm? 'Testing change' and champion's 'project feedback'.

The Safety Academy meeting planned for March 2013 will be reviewing issues raised within the recently released Francis 2 report. A 'Patient Safety in Action' Conference is currently being considered for September 2013 to celebrate the safety work and progress achieved at NGH.

7. Metrics and baseline Improvement data

The Clinical Leads for the Patient Safety programme have agreed a list of 'Safety metrics' to measure the impact of the safety projects too monitor and report progress.

Listed are examples of the proposed metrics, with other metrics in working progress.

A Patient Safety dashboard is planned for completion in Quarter 4 (2012 /13):-

Safety Academy - Number of deaths in hospital (with the aim of monitoring lives saved over 3 years)
Safety Academy - Number of staff trained in basic human factors in simulation suite
Failures of care - Reduction in omission of medicines by 50% (In support of Pharmacy metric)
Failures of care - Oxygen correctly prescribed, administered and documented for >90% of patients
Failure to rescue - Number of patients that receive sepsis 6 bundle within 1 hour of arrival in A&E. Improvement of 10% on baseline (from CEM audit completed Jan 2011)
Failure to rescue - Number of patients that receive antibiotics within one hour of sepsis being suspected on the ward
Failure to plan - Consultant review within 12hours
Failure to plan - Number of unauthorised EDN's on the ward
Learning lessons - Audit of action plans from 'Never Events'. Number of actions completed / outstanding.
Leaning lessons - Number of wards with a bi-monthly governance 'ward pack' for sharing of learning from incidents / complaints and evidence of discussion of this.

8. Measuring success

Overall success is being measured in the following areas:

- Safety 'culture' questionnaire. A continuation of the previous safety 'climate' questionnaire which aimed to baseline and monitor safety locally. Champions are asked to complete this questionnaire at each meeting with the Safety Academy (approximately bi-monthly) and data is being analysed to assess the impact of safety initiatives.
- Monitoring of progress against project objectives via project plans.
- Improvements in metrics data.
- Number of champions nominated and trained in safety.
- Reduction in crude in-patient death rates.
- Improved communication with clinical staff regarding learning from serious incidents and complaints.

9. Conclusion

The programme of work which was set up to support the Patient Safety Strategy is now in place. It is a very challenging programme but one which has received some considerable support from clinical and non-clinical staff. There have been some challenges relating to the time commitment required from everyone involved in this programme and this has delayed the formal start of some of the project management aspects but the as this programme was built on previous work this has not resulted in any gap in ' safety activity'. Recent high profile reports only serve to re-emphasise the importance of programmes such as this which ensure staff engagement in the fundamentals of patient care.

10. Recommendation

The Board is asked to note the progress to date regarding the patient safety programme, and to endorse on going reporting through regular update reports and the Quarterly Patient Safety, Clinical Quality and Governance progress report.

The Board is asked to consider any other improvements required to ensure that the aim of continually improving safety is achieved and this programme of work is as successful and sustainable as possible.

The Board is asked to support the continuing resource for the Clinical Leads and Project Manager for this programme as well as the resource related to releasing staff to attend the educational and development events and time to complete their projects and cycles of tests of change.

The significant operational pressures have led to some staff being unable to attend the events or invest the time required for full participation in the programme. It is essential that this problem is addressed as staffing levels improve and that the significant element of 'listening to staff' which underpins this programme is enhanced and extended. The Board is asked to support this concept.

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

Sonia Swart
Medical Director
February 2013

How Can We Improve Patient Safety at NGH?

Tell us your ideas to improve patient safety in your area

What do you consider to be risky in your area? Tell Us!

Are you involved in any patient safety projects in your area? Tell us if you feel these would be useful to improve safety elsewhere

Tell your team about us and the projects

Attend Academy meetings

Help us with local audits/surveys where necessary – this may involve some data collection, but mainly talking and listening to your patients and colleagues

IF YOU ARE KEEN TO BE INVOLVED IN ANY OF THE PROJECTS - SIGN UP TODAY!

Dr Jonathan Hardwick
Reducing Harm from Failure to Rescue

Patient Deterioration

EWS/Code Red/SAP Process

Sepsis Pathway

Pneumonia

EWS Escalation pathway

Dr Jonathan Hardwick
Reducing Harm from Failure to Rescue

Key areas we need you to be involved in!

- **Ensure EWS is completed on wards/EWS training**
- **Promote communication using SAP**
- **Sepsis/pneumonia champions needed on wards to maintain and check sepsis box, stickers etc**
- **Code Red awareness at ward level - champions needed**
- **Basic Life Support (BLS)/EWS training champions needed**
- **Discuss with colleagues how to improve safety in your area i.e. observations completed at the wrong time, too many Doctor's in area at once etc**

Your project ideas need to be here as well - let me know your ideas for improving patient safety!

Dr Jonathan Wilkinson
Reducing Harm from Failures of Plan

Documentation – Medical and Nursing

Ward Round and Ward Communication /Implementation and follow up of medical plans

Senior Consultant Review within 12hrs of patient admission/drug chart review

Medical Handover – especially at night

EDN (Electronic Discharge Notification) Letters

Communication with GPs/Primary Care

Dr Jonathan Wilkinson
Reducing Harm from Failures of Plan

Key areas we need you to be involved in…

- **Every patient's documentation must be of impeccable quality; they tell a vital story. This could be a relative/friend's notes. Do the notes in your area meet these standards? Join us to help**

- **Are ward rounds run like clockwork? Are all of the members of the team there you think should be present? Are requests communicated and does EVERYONE including the patient know the story? What would you do and what would you want to do to help improve this? Your ideas and help are needed**

- **Are you involved in patient handover? Do you feel that your patient's needs are always communicated well or are they 'Chinese whispered'? Help us to ensure no one is the victim of bad communication**

- **Are the Electronic Discharge Notification letters completed on time in your area? Is there a training requirement for this? Tell us; we can help**

Your project ideas need to be here as well - let me know your ideas for improving patient safety!

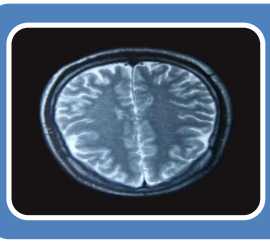
Mrs Mary Burt
Reducing Harm from Failures of Care

Reducing Harm from MRSA/MSSA /CDIFF/Surgical Site Infection

VTE

Catheter Related Urinary Infection

Medicines Management



Dementia Care

Fluids and Nutrition

Mrs Mary Burt
Reducing Harm from Failures of Care

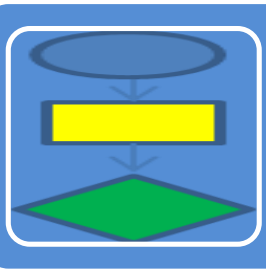
Key areas we need you to be involved in

Projects involving –

- **Ensuring all patients have a urinalysis performed on admission, and then appropriate action taken**
- **Ensuring all patients are weighed at intervals as defined in the care plan**
- **Reducing the incidence of omitted medicines**
- **Ensuring fluid balance charts are only used with patients who need them**
- **Re-designing fluid balance charts**
- **Improving communication between ward staff and hostesses regarding diet and fluids**

Your project ideas need to be here as well - let me know your ideas for improving patient safety!

Dr Lyndsey Brawn
Learning From and Sharing Lessons from Failures and Successes



Map existing pathways and forums across the Trust for learning from harmful events (SI's) and incidents

Consider how we use incident and complaint data at ward level for all disciplines to improve patient safety

Ensure learning from serious incidents as soon as an early management report (EMR) is requested of lead clinician

Training of junior medical staff regarding learning lessons

Review learning points from NGH Serious Incidents, litigation and inquests against national trends

Dr Lyndsey Brawn
Learning From and Sharing Lessons from Failures and Successes

Key areas we need you to be involved in

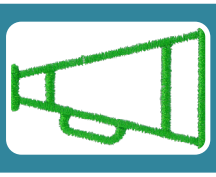
- **Assist in developing an information pack for ward managers and teams in incidents/complaints and learning from these. For discussion at ward meetings**
- **Understanding incidents – interested champions to be involved in reviewing themes and trends and highlighting issues to their team**
- **Assist in the development of a clear falls monitoring tool on all wards. Champions to be involved in the piloting of this for 2 weeks**
- **Identify themes from serious incidents via the Early Management Reports (EMR) and initiate training in local areas where needed**
- **Interested champions to be involved in learning from complaints and the early resolution of issues in clinical areas**
- **UTI and dementia care to be a clinical focus**

Your project ideas need to be here as well -let me know your ideas for improving patient safety!

Dr Chris Frerk
Human Factors & Scenario Training

Appointment of Safety Champions

Develop patient safety related cascade training



Communication

Staff interaction on wards

NGH Safety Bulletin/newsletter to be developed – contribution needed

Increased use of simulation facility

Embedding patient safety culture at NGH

80% of staff receive mandatory training

Dr Chris Frerk
Human Factors & Scenario Training

Key areas we need you to be involved in

- Talk patient safety to your colleagues
- Pass on key messages from the Safety Team
- Feed back to the Safety Team on how things are going in your area
- Encourage colleagues to attend the simulator when suitable training is arranged. If you have any ideas about this, let us know
- Advise us today of the best way to get in touch with you regarding the Patient Safety Academy and the work we have planned.

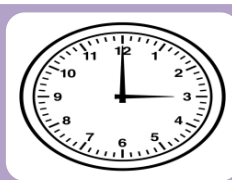
Your project ideas need to be here as well - let me know your ideas for improving patient safety!

Dr Jonathan Timperley
Emergency Care Pathway Redesign

Reduced length of stay and bed occupancy

Improved patient flow

Ward round optimisation



12 hour consultant review

Reduced time to first doctor review

Implementation of Summary Care Record, VitalPac and Symphony

Embedding patient safety culture at NGH

Dr Jonathan Timperley
Emergency Care Pathway Redesign

Key areas we need you to be involved in

- A review of the current clinical pathways and processes for:-
  - Surgical patient admissions
  - Medical patient admissions

- Ideas to improve the ward rounds through looking and listening to how these are done. We are keen to speak to champions from other disciplines e.g. Pharmacy to see how you too can be involved

- The identification of new opportunities to improve patient flow from the emergency areas to the wards – what are the blockers/issues? Do you have ideas on how this can be improved? Tell us!

Your project ideas need to be here as well - let me know your ideas for improving patient safety!

What is the Patient Safety Academy and what are we aiming to do?

'The aim of the Patient Safety Academy is to train and empower staff in NGH to deliver safer care'

This is to be done via a network of approximately 70 staff, trained in safety awareness, who are the 'eyes and ears' of the academy and who the programme will rely on to champion the work that is on-going.

These champions will be asked to participate in different pieces of work from process reviews to trialling of documentation and mini audits; to assist us in making NGH a safer place.

In order to fully empower staff to lead improvements in care, the Listening into Action programme led by the Chief Executive, will also link with the Academy to ensure that staff are able to come to work and feel they can and do deliver high quality care.

We hope to have a quarterly safety training event which combines the opportunity to present progress against projects as they develop and include inspirational speakers as well as our own teams. We will measure what we do and the improvements that we make.

Thank you for becoming a part of the Safety Academy

Safety in Numbers

Patient Safety is NGH's top priority

The Patient Safety Project has been put together by our Chief Executive Gerry McSorley, our Medical Director Sonia Swart and our Director of Nursing Suzie Loader

There are 7 safety leads in the Trust (See over) but we're calling the project **Safety in Numbers** because patient safety isn't something that just a handful of people can do. We need all staff at NGH to be thinking patient safety every day to make this work.

Over the next 3 years we aim to save an extra 300 lives and reduce harm to our patients by 50%.

Every month we'll be putting out a one page flyer highlighting safety matters to keep you up to date with how our hospital is doing and telling stories of things that have gone well and things where we could have done better. We hope to be able to share with you how you can help make the biggest difference to patients in our hospital.

This is our logo!

NSA SAFETY IN NUMBERS
NORTHAMPTON SAFETY ACADEMY

You'll see us around the hospital, stop us and tell us what's going on (good and not so good) or call or email any of us with your thoughts and ideas to make Northampton General Hospital safer.

Meet the safety leads:

Jane Bradley is in charge of the project, we know there are many reasons why patients come to harm while they are in hospital, and because of this the team have particular areas they are looking at to help improve safety Some of the

patient safety work to date has resulted in very clear improvements in care, it is essential that these improvements are extended and maintained.

The Safety Leads will be working together to take forward a very challenging programme of work under the direction of Jane Bradley who is the Patient Safety Programme Director reporting to the Medical Director, supported by a project management team trained to support improvement techniques, and linking with current individuals supporting quality and safety information flows. [Jane.Bradley@ngh.co.uk – telephone ext. 4629 or 07713081089].

Failure to plan: when patients come into hospital there should always be a clear plan for their treatment. Unfortunately this isn't always the case. Jonny Wilkinson [Jonathan.Wilkinson@ngh.co.uk]

Failures of care: Sometimes, even when the plan is clear, it is not always carried out fully - things get missed and patients can come to harm. Mary Burt [Mary.Burt@ngh.co.uk]

Failure to rescue: Occasionally patients get sicker even with appropriate treatment. We need to be able to spot this quickly and get the right people to come and review the patient as soon as possible. Jono Hardwick [Jonathan.Hardwick@ngh.co.uk]

Learning from what happens: We expect things to go well for our patients but sometimes things do go wrong. We need to understand why this happens and get better at learning how to stop the same things happening to anyone else. Lyndsey Brawn [Lyndsey.Brawn@ngh.co.uk]

Human Factors: None of us come to work to do a bad job but sometimes things just seem to make it difficult for us to do our jobs well. There are things that can be done to make it easier for all of us to do our jobs the way we'd like to be able to. Chris Frerk [chris.frerk@ngh.nhs.uk]

Emergency Care: Many (but not all) of the patients who don't do as well as we'd like have come to NGH as emergency admissions. Emergency processes will be looked at as part of the Academy. [Jonathan.Timperley@ngh.co.uk]

Project management support: The clinical leads and champions will be supported by a Project Manager, who will assist with the completion of audits, develop metrics and project monitoring tools and support Academy days. [Louise.Gilbert@ngh.co.uk – telephone ext. 3341]

.

Issue 1 : December 2012

Safety in Numbers

Patient Safety is NGH's top priority

There are 7 safety leads in the Trust but the project is called **Safety in Numbers** because patient safety isn't something that just a handful of people can do. We need all staff at NGH to be thinking patient safety every day to make this work.

Every month 2 or 3 patients die or come to severe harm in NGH because we don't recognise how unwell they are so we don't get senior doctors to review them early enough.

We have a system in place already that could save some of these patients – it's the EWS but we're not using it as well as we should.

This month (& every month!) we need your help:

Make Sure the EWS is done

If it's raised make sure the right person knows

4 or 5 = Doctor

6 = Registrar

For More information contact **Dr Jon Hardwick**

Jonathan.Hardwick@ngh.nhs.uk

If you don't have a safety champion for your area please let Jane Bradley know **Tel: Extension 4629**

Over the next 3 years we aim to save an extra 300 lives and reduce harm to our patients by 50%.

Don't forget to confirm your attendance at the project workshops!

TRUST BOARD 28th FEBRUARY 2013	
Title: -	Performance Paper
Presented by: -	Christine Allen –Deputy Chief Executive and Chief Operating Officer

PURPOSE OF PAPER: - This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 10 (January 2013). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 10 **(January 2013)**.

- The Trust did not achieve the 4 hour transit time standard for January 2013 with 86.91% of patients being treated within 4 hours against the standard of 95%
- The cancer targets are monitored on a quarterly basis. For January the Trust did not achieve the standard for 62 days from referral to treatment with 79.1% of patients treated against the standard of 85%, 62 days from consultant upgrade to start of treatment with 72.7% against the standard of 85% and 31 day subsequent treatment with 95.8% against the standard of 98%.
- The Trust achieved all the other performance standards for January 2013.

ACTION REQUIRED BY BOARD: -

Trust Board are asked to discuss the contents of this report and agree any further action necessary

PERFORMANCE REPORT – FEBRUARY2013

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 10** (January 2013). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

More detailed performance is reported by exception i.e. where performance is below standard, where there are specific pressures that present a risk to the ongoing achievement of any of the standards or where there are high profile issues e.g. new targets.

2. SERVICE PERFORMANCE

See Appendix 1 for score card

2.1 January Performance

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

The Trust continues to exceed the national standard for all diagnostic tests to be carried out within 6 weeks of the request. During January all diagnostic tests were carried out within 4 weeks of the request.

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

2.2 A&E Clinical Indicators

There have been significant pressures in A&E during November, December and January.

During January, 86.91% of patients were admitted, transferred or discharged within 4 hours. We have continued to see an increase in patients staying over 14 days. The Chief Operating Officer and Care Group Directors are continuing to work closely with external partners to make changes to discharge pathways, including an interim placement process for Continuing Health Care and Social Care patients.

Progress continues to be monitored through the Urgent Care Programme Board (UCPB) and each project and clinical lead are held to account for delivery of their action.

The reduction in performance at NGH during the winter months continues to reflect the national performance as indicated in figure 1a below.

A meeting has taken place with the Intensive support team, SHA, CCG and Care Group Director for Medicine to ensure the appropriate actions are taking place internally and the external focus and actions are in line with improving performance, maintaining patient safety and enhancing flow out of the organisation.

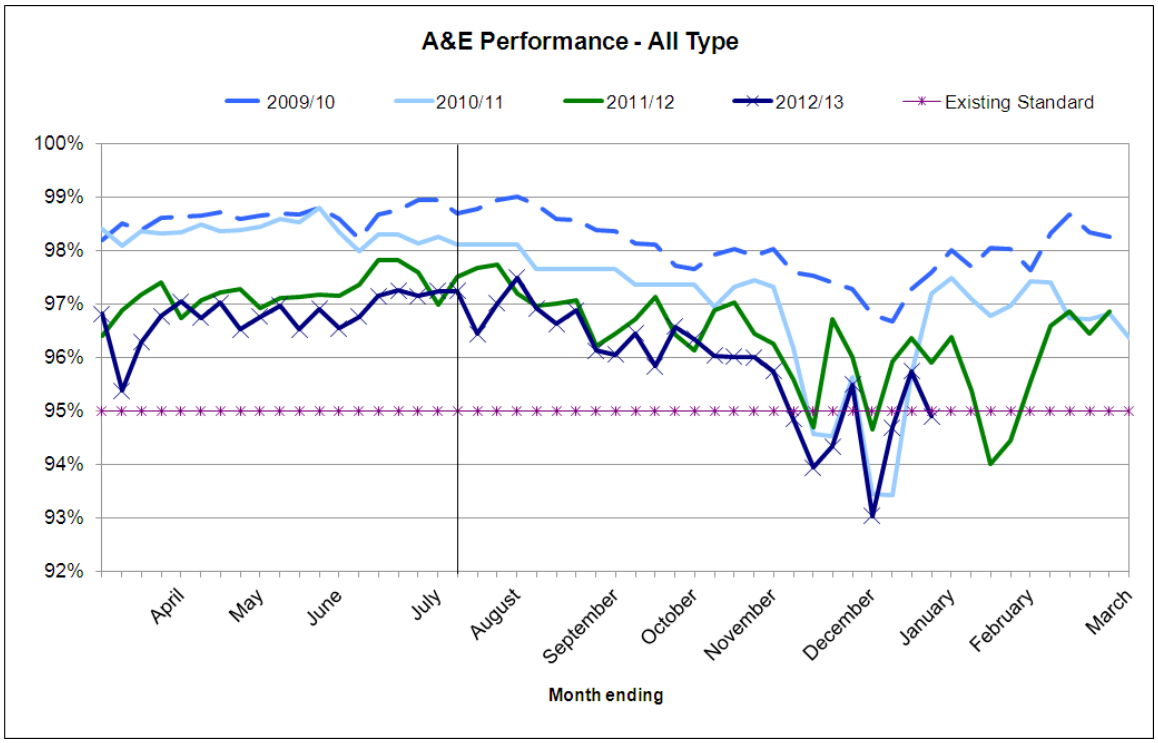


Figure 1a National A&E Performance NHS in England (updated week ending 27th January 2013)

As at 19th February 2013, the year to date performance is 92.36%.

2.3 Cancer Standards

All cancer standards are monitored quarterly however in January the Trust did not achieve the following standards:

62 day standard from urgent referral

During January there continued to be an increased number of breaches of this standard. There were 19 breaches during January against a trajectory of 11. The Trust achieved 79.1% against the standard of 85%. The year to date position is 83%. The reasons for the breaches include patient choice to defer treatment to January and complex diagnostic pathways particularly in Head and Neck and Lower GI tumour sites.

There has been a full review of the Urology and Head and Neck pathways and changes have been implemented within these pathways. A recovery plan is being monitored through the weekly performance meeting and all breaches reviewed to identify any further improvements that can be made.

Key actions for the Head and Neck pathway include a review with referring trusts of the pathway between trusts to ensure timely referrals and a review of the pathway for planning and booking radiotherapy treatments.

62 day standard from consultant upgrade

During January, the Trust achieved 72.7% against the standard of 85%, the year to date position is 89.8%. This was as a result of complex diagnostics for the Head and Neck pathway.

31days from decision to treat to start of treatment for subsequent drug therapy treatment

During January 95.8% of patients were treated within 31 days against the standard of 98%, the year to date position is 98.7%. This was as a result of patients being medically unfit for treatment.

2.4 Referral to Treatment Time (RTT)

During January 2013, the Trust achieved all of the RTT standards by each specialty.

3. RECOMMENDATIONS

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

Appendix 1 Score Card

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups											
Admitted	90.0%	96.4%	96.6%	97.4%	96.6%	97.0%	96.3%	96.1%	95.9%	96.5%	96.1%
Non-admitted	95.0%	97.7%	98.3%	98.8%	98.6%	98.5%	98.4%	98.5%	98.4%	98.5%	98.6%
Incomplete pathways	92.0%	98.2%	97.8%	97.1%	97.3%	97.5%	97.1%	96.9%	96.8%	96.3%	95.4%
No of patients on an incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	49	55	43	21	33	40
Number of diagnostic waits > 6 weeks	0	0	0	0	0	0	0	0	0	0	0
A&E 95% Transit time target											
Cumulative	95.0%	95.0%	94.2%	93.9%	93.4%	93.3%	93.9%	94.1%	93.6%	93.0%	92.5%
Month on Month	95.0%	95.0%	93.4%	93.3%	92.0%	92.8%	96.9%	95.2%	90.1%	88.8%	86.9%
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6.0%	5.9%	7.1%	8.9%	5.7%	5.3%	5.8%	7.0%	8.0%	5.4%	
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Cancer Wait Times											
2 week GP referral to 1st outpatient	93.0%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	96.7%
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	98.3%
31 Day	96.0%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.2%
31 day second or subsequent treatment - surgery	94.0%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	100.0%
31 day second or subsequent treatment - drug	98.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	95.0%	95.8%
31 day second or subsequent treatment - radiotherapy	94.0%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.8%	96.9%
62 day referral to treatment from screening	85.0%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	95.7%
62 day referral to treatment from hospital specialist	85.0%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	72.7%
62 days urgent referral to treatment of all cancers	85.0%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	77.8%	79.1%
Stroke Indicators											
Proportion of people who have a TIA who are scanned and treated within 24 hours	60.0%	68.0%	75.0%	90.9%	71.4%	95.8%	76.5%	68.0%	88.9%	72.7%	68.8%
Proportion of people who spend at least 90% of their time on a stroke unit	80.0%	100.0%	95.6%	95.6%	81.9%	82.9%	87.8%	91.1%	85.7%	84.2%	93.3%
Activity vs. Plan											
Elective Inpatients	>0%	16.6%	23.2%	15.2%	8.8%	-1.5%	17.5%	20.5%	29.3%	3.9%	12.1%
Daycase	>0%	8.7%	11.3%	1.0%	3.7%	-1.3%	4.3%	7.4%	1.8%	-3.5%	2.9%
Non- Elective	>0%	17.0%	25.7%	18.6%	14.1%	15.1%	13.7%	21.4%	20.9%	19.2%	6.2%
OP 1	>0%	5.1%	14.9%	7.5%	0.9%	-5.7%	3.9%	4.4%	3.0%	-9.4%	4.1%
OP Procedures	>0%	10.2%	3.6%	5.0%	2.3%	-1.5%	5.6%	7.0%	12.5%	-3.4%	7.1%
New to Follow UP Ratio	2.01	2.05	1.92	1.97	1.97	1.96	2.07	2.02	1.99	2.13	
GP Referrals	>0%	2.5%	1.4%	1.1%	0.4%	-2.0%	-2.1%	-1.3%	-1.3%	-2.7%	-2.9%
Day Case Rates	81%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	84.8%	83.2%	85.7%	
Sleeping Accommodation Breach	0	0	0	0	0	0	0	0	0	0	0

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 28th February 2013	
Title	Quality Accounts 2013/14
Submitted by	Dr Sonia Swart, Medical Director and Suzie Loader Director of Nursing and Patient Services

SUMMARY OF CRITICAL POINTS

- Quality Accounts are annual reports to the public that give details about the quality of services that are delivered and outline the priorities and plans for improvement for the following year;
- It is proposed that the quality priorities agreed for 2012/13 are taken forward as they have been a common theme over the past 3 years (appendix 1) and are recognised as major issues within the Trust. They are fundamental in ensuring that our patients have a good experience through the delivery of high quality and safe patient care.
- Actions plans are in place and are being progressed, but the momentum in these priority areas needs to be maintained.

RECOMMENDATION –

The Trust Board are asked to support the proposal to take forward the 4 Quality Priorities that were agreed for 2012/13.

Quality Accounts 2013/14

1. Introduction

Quality Accounts are annual reports to the public that give details about the quality of services that are delivered and outline the priorities and plans for improvement for the following year.

2. Proposal for 2013/14

It is proposed that the quality priorities agreed for 2012/13 are taken forward as they have been a common theme over the past 3 years. These are summarised below. A table outlining the priorities for the last 3 years can be found in Appendix 1:

- Redesigning the Emergency Pathway – To redesign emergency care so that we always provide best quality care using best practice standards
- Caring for Vulnerable Adults - To improve the care given to people with dementia or learning disabilities
- Patient Safety Programme - To reduce all avoidable harm and save every life we can. Our high level aim is to save 300 lives over the next 3 years and to reduce avoidable harm by 50% over this period
- Patient Experience - The Trust will achieve a 10 point improvement on the Friends and Family Test, using April 2012 as the benchmark, by the end of March 2013

The Trust has already recognised that these are major issues and are fundamental in ensuring that our patients have a good experience through the delivery of high quality and safe patient care.

Recommendations

The Trust Board is asked to support the proposal to take forward the 4 Quality Priorities that were agreed for 2012/13.

QUALITY PRIORITIES

2010/11	2011/12	2012/13
Improving the experience for patients by focusing on essential care in every ward – • Falls, increase number of patients assessed • Nutrition, increase nutritional needs assessments • Pus, Decrease the incidence by 5% • Patient Experience, Introduce a new way of understanding	• Improving the experience of people who are vulnerable – • 20% reduction (Grade 3 & 4) • 20% reduction falls • Improve patient experience so NGH is top 25% performing Trusts • Protected meal times • Hourly rounds • New dementia training programme on all wards	• Patient Experience - The Trust will achieve a 10 point improvement on the Friends and Family Test, using April 2012 as the benchmark, by the end of March 2013
Improving the effectiveness, safety and patient experience of stroke services • Eligible patients 90% of their stay on a stroke unit • Sustain and improve reduction in deaths for stroke • 90% of patients admitted with a stroke will receive a brain scan within 24 hours • The number of patients receiving all 9 indicators measured in the sentinel audit will improve	• Right care, right place, right time – To ensure that all patients receive the right care, in the right place, at the right time.	• Redesigning the Emergency Pathway – To redesign emergency care so that we always provide best quality care using best practice standards

2010/11	2011/12	2012/13
• Improving the prevention of blood clots through the implementation of best practice for risk assessments and prescription of clot preventing drugs- Embedding best practice recommendations in relation to the prevention of blood clots in hospitalised patients	• Improving patient outcomes and speeding up a patient's recovery after surgery through the Enhanced Recovery Programme – Enhanced recovery programme in 4 elective surgical specialities	• Caring for Vulnerable Adults - To improve the care given to people with dementia or learning disabilities
• Improving patient safety by reducing infections including MRSA, Cdiff and Surgical site infections – Meet all national targets for these infections .	• Improving patient safety through junior doctor engagement – To improve patient safety awareness and safety behaviour of Junior Doctors, by introducing the set of measures	• Patient Safety Programme - To reduce all avoidable harm and save every life we can. Our high level aim is to save 300 lives over the next 3 years and to reduce avoidable harm by 50% over this period

TRUST BOARD 28th February 2013.	
TITLE: -	Finance Report M10 – January 2013
PRESENTED BY: -	Mr Peter Hollinshead, Interim Director of Finance.

PURPOSE OF PAPER: -

The paper sets out the latest Financial Position of the Trust for the ten months ended January 2013.

CRITICAL POINTS: -

- The Trust has negotiated an SLA income settlement covering the remainder of the financial year. This income settlement of £201m is with the local CCGs, which includes an additional £2.2m notified to the LAT and CCG in October and Winter pressures funding of £1.3m.
- The income for Trust is now fixed and as a result it is imperative the costs are tightly controlled and that all directorates live within their 'control totals'. Control Totals adjustments, to cover the impact of winter pressures, have now been agreed by the care groups/directorates.
- The revised forecast for the Transformation Programme of £10.3m is required to achieve the breakeven forecast.
- The Trust must repay £4m of temporary DH borrowing in February. Whilst the Trust is forecasting meeting the statuary EFL target the position for the first quarter of the new financial year will necessitate further temporary borrowing. Details are set out under separate cover as part of this agenda.
- There needs to be focus on ensuring capital schemes are delivered to forecast in the remaining two months of the financial year.
- Plans are in place to undershoot the Capital Resource Limit (CRL) by £0.9m. This figure is reduced from £1.7m due to the recent notification from EMCN in support of radiotherapy equipment.

ACTION REQUIRED: -

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

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

Month 10 2012/13

1. Summary Performance – Financial Duties

1.1. Table 1 summarises the Trust's financial performance for the ten months to the end of January 2013. The table summarises the year to date and full year forecast performance against the financial duties of the Trust, the financial performance dashboard is included in Appendix1.

Table 1 – Key Financial Duties

Financial Duties	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	-£950	-£42	£0	£1,000	-£1,000
Achieving EFL (£000's)	N/A	N/A	£457	£457	£0
Achieving the Capital Resource Limit (£000's)	£4,889	£5,410	£10,069	£10,896	£827
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	87%	95%	93%	95%	-2%
Value of Non-NHS Invoices	67%	95%	75%	95%	-20%

Key Issues:-

- The Trust has secured agreement with the LAT and Nene CCG to a year end SLA settlement of £201m which will deliver a forecast breakeven position by the financial year end.
- The year-end settlement includes £1.3m of winter pressures funding. This has been allocated to care groups and control totals adjusted accordingly.
- As the majority of SLA income is now fixed the focus must be on delivering control totals for each directorate and in managing the remaining risks for the last two months of the financial year.
- The Trust must repay £4m of temporary DH borrowing in February. Whilst the Trust is forecasting meeting the statuary EFL target the position for the first quarter of the new financial year will necessitate further temporary borrowing. Details are set out under separate cover as part of this agenda.
- There needs to be focus on ensuring capital schemes are delivered to forecast in the remaining two months of the financial year.

Table 2 – Forecast I&E Position (including FRP Actions)

	Actual	Actual	Actual	Forecast		
	M9 £000	*M10* £000	*YTD* £000	*M11* £000	*M12* £000	*Total* £000
SLA Income	18,339	21,016	190,722	20,299	20,900	**231,922**
Other Clinical Income	145	447	2,532	447	367	**3,346**
Other Income	3,452	2,528	22,032	3,264	3,880	**29,176**
Total Income	**21,936**	**23,992**	**215,286**	**24,010**	**25,147**	**264,444**
Pay Costs	(13,973)	(14,027)	(139,223)	(14,405)	(14,755)	**(168,384)**
Non-Pay	(6,361)	(7,013)	(64,877)	(7,017)	(8,998)	**(80,892)**
Transformation Costs	(110)	0	(498)	(550)	(150)	**(1,198)**
Total Costs	**(20,444)**	**(21,040)**	**(204,598)**	**(21,972)**	**(23,903)**	**(250,473)**
EBITDA	**1,492**	**2,952**	**10,689**	**2,038**	**1,244**	**13,970**
Depreciation	(740)	(812)	(8,106)	(812)	(812)	**(9,731)**
Amortisation	(1)	(1)	(8)	(1)	(1)	**(10)**
Impairments	(1,587)	161	(1,426)	0	0	**(1,426)**
Net Interest	2	3	17	2	2	**21**
Dividend	(354)	(354)	(3,542)	(354)	(354)	**(4,250)**
Surplus / (Deficit)	**(1,188)**	**1,949**	**(2,376)**	**873**	**78**	**(1,426)**
Normalised	**399**	**1,788**	**(950)**	**873**	**78**	**0**
Cumulative YTD			**(950)**	**(78)**	**0**	

1.2 The forecast position is for a breakeven by the financial year end with the LTF for the Transformation Programme has being maintained at £10.4m at the end of January. Key risks relate to non Nene CCG contract performance, costs associated with achievement of RTT targets, excess costs of non-elective winter pressures and the potential requirement to write off of outstanding debt.

1.3 Plans are in place to undershoot the Capital Resource Limit (CRL) by £0.9m. This figure is reduced from £1.7m due to the recent notification from EMCN in support of radiotherapy equipment.

1.4 The Trust has drawn down a total of £4m of DH temporary borrowing at the end of January. (repayable on 28th February 2013).

1.5 Elements of the year end settlement are non-recurrent in nature giving rise to a recurrent deficit position at the start of the new financial year.

2.0 Income and Expenditure Position of the Trust

Surplus/(Deficit) Position

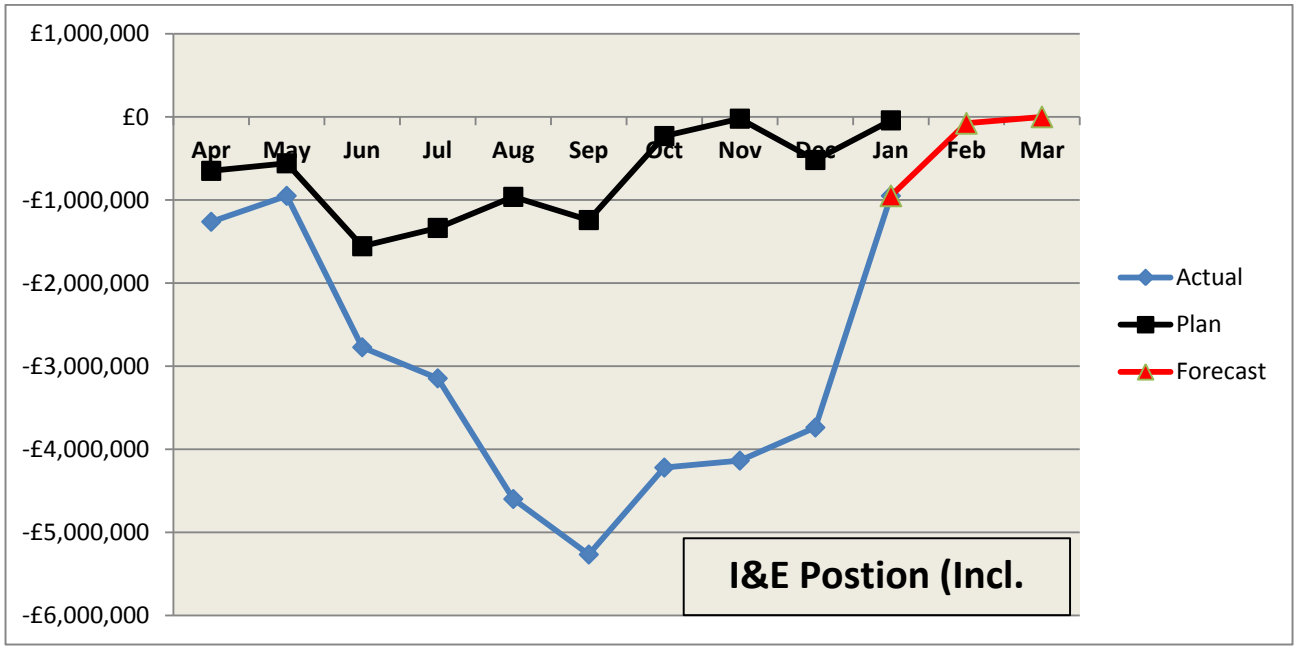
2.2 Appendix 2 provides details of the Trusts summary Income and Expenditure (I & E) Position. The Trusts year to date I&E position as at 31st January 2013 was a £0.95m deficit (December: £4.3m). The plan submitted to the SHA in March predicted a £41k year to date deficit therefore the result was £0.9m worse than planned. The planned position for the full year is a surplus of £1.0m.

2.3 The year to date position above excludes the impact of non-current asset impairments of £1.5m which have been charged to the I&E account in December, but does not count towards the measurement of NHS performance.

2.4 The month 10 position is a surplus of £2.9m. The improvement in the position is largely due to the accrual of an additional £3.9m of income representing the corresponding year to date value of the CCG income settlement.

2.5 The Trust has now secured an income settlement with Nene CCG of £201m which should provide sufficient level of revenue to achieve a forecast breakeven position by the financial year end. This settlement does not cover non Nene CCG contracts or non-contracted activity (NCAs).

Graph 1 – Income & Expenditure forecast (including Financial Recovery Plan actions).



3.0 Income and Activity

3.1 Month 10 total operating income stands at £24.991m compared to a forecast of £21.177m. Year to date operating income stands at £215.3m, compared to an original forecast of £205.759m.

3.2 SLA income amounted to £22.4m in January exceeding forecast levels by £3.4m. This figure includes an additional £3.9m in respect of the income settlement. SLA income totalling £190.7m has been recorded for the year to date, £13.3m (7%) better than plan. The final level of income generated in month 10 (January) remains subject to final casemix validation.

3.3 The Table below summarises the Trusts SLA income and activity figures and includes provisions for known contractual and data challenges for the year to date.

Table 3 – SLA Activity & Income Performance

	ACTIVTY				INCOME			
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var
DC	30,812	31,990	1,178	3.8%	18,323,238	18,756,963	433,725	2.4%
EL	4,862	5,585	723	14.9%	14,652,875	14,386,362	-266,513	-1.8%
NEL	34,620	37,593	2,973	8.6%	58,027,692	63,920,426	5,892,735	10.2%
OPFA	53,469	54,334	865	1.6%	8,745,435	9,078,898	333,463	3.8%
OPFUP	97,635	99,953	2,318	2.4%	8,946,210	9,142,095	195,885	2.2%
OPFASPNCL	19,918	22,639	2,721	13.7%	1,760,629	2,026,977	266,348	15.1%
OPFUSPNCL	54,349	49,459	-4,890	-9.0%	2,609,156	2,466,642	-142,514	-5.5%
OPPROC	32,420	34,022	1,602	4.9%	4,693,204	4,947,303	254,099	5.4%
A&E	64,876	77,313	12,437	19.2%	6,202,458	7,717,387	1,514,929	24.4%
BLOCK / CPC MRET					50,868,607	52,695,069	1,826,462	3.6%
ARMD	3,090	3,413	323	10.5%	873,874	958,248	84,374	9.7%
Provisions					-3,069,573	-4,945,288	-1,875,715	61.1%
CQUIN					4,193,730	3,881,404	-312,326	-7.4%
Other					597,313	5,689,903	5,092,589	100.0%
Total					**177,424,848**	**190,722,389**	**13,297,541**	**7.5%**

3.4 The Trust has over performed on activity which equates to £13.3m of additional income. The majority of over performance is against the Northamptonshire CCG contract with under performance on some smaller contracts.

3.5 Elective admissions activity is 15% higher than planned although weaker casemix has seen associated revenues rise only marginally above plan for the year to date. This is due in part to the proposed impact of PCT QiPP schemes during the year on elective income.

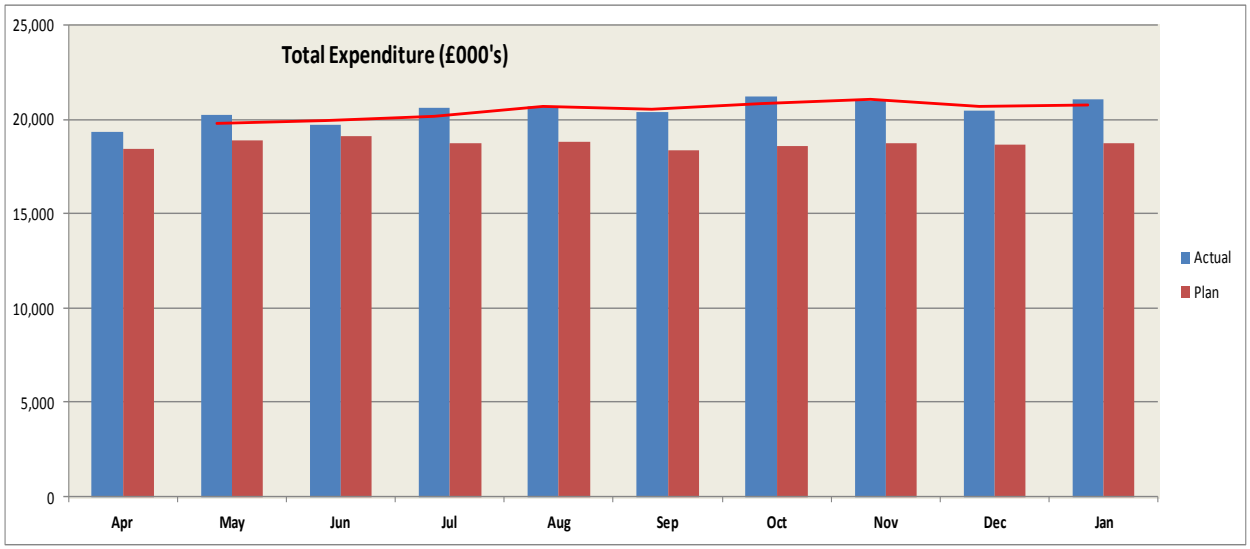
3.6 Non Elective activity is performing 9% above plan. This coupled with the 8% over performance for A&E attendances has meant the continued need for the Trust to keep open additional escalation areas.

3.7 Outpatient first attendances are 1.6% above plan whilst outpatient follow up attendances are 2.4% above plan.

4.0 Expenditure

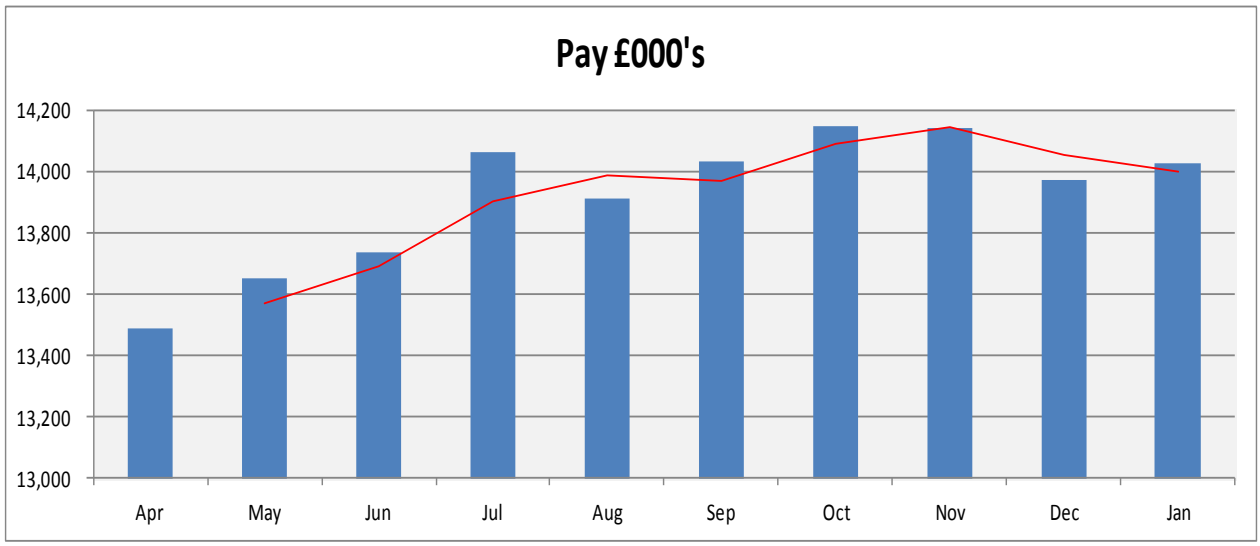
4.1 The Trust has overspent expenditure budgets by £17.7m in the 10 months to 31st January. The primary reason for the over spend is that insufficient Transformation Programme schemes have been identified and delivered within the first part of the financial year combined with the need to respond to non-elective pressures.

Graph 2 - Monthly Expenditure Run Rate 2012-13



4.2 Pay costs in the month were £0.3m lower than forecast and standing at £14.03m (£54k higher than December). Cumulatively to month 10 pay costs amounted to £139.2m, £10.1m (7.9%) higher than planned. The costs of Winter Pressures are being tracked with an increased run rate expected in the final quarter of the financial year.

Graph 3 – Pay expenditure monthly run rate 2012-13



5.0 The Trust is operating below the planned WTE budget (by 148WTE at Month 10), but is utilising significant numbers of temporary staff.

Table 4.1 – WTE Analysis – January 2013

	Worked Mth 10 WTE	WTE Budget 2012/13 M10	Worked V Bud Var	Contracted Mth 10 WTE
Medical Staff	463.93	464.98	*1.05*	467.67
Nursing Staff	1,779.79	1,760.00	*-19.79*	1,743.72
Managerial &	849.69	897.31	*47.62*	741.46
Other Clinical Staff	264.76	310.77	*46.01*	271.06
Scientific & Technical Staff	373.21	411.60	*38.39*	385.87
Estates Staff	28.74	36.19	*7.45*	25.00
All other Staff	369.97	407.47	37.50	322.15
Cost Challenges		-10.19	*-10.19*	
Total WTE	**4,130.09**	**4,278.13**	***148.04***	**3,956.93**

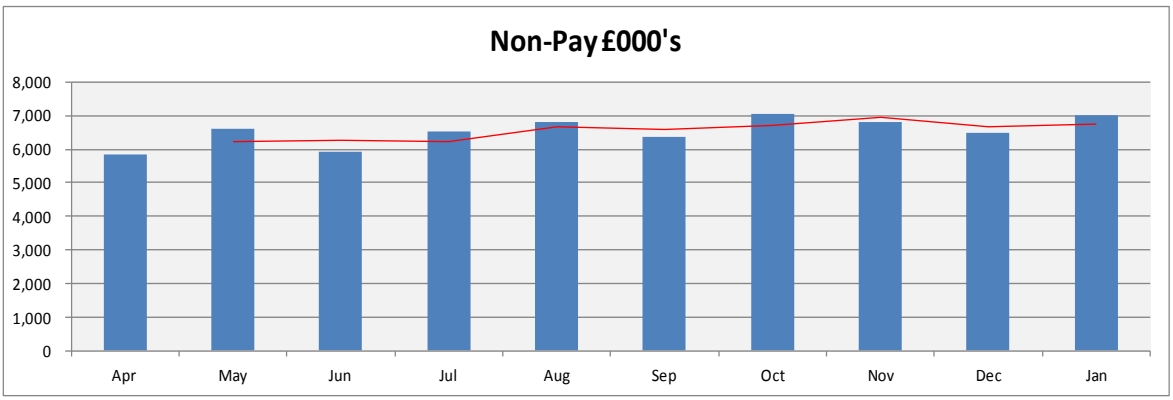
Table 4.2 – Temporary Staffing Costs

Temporary Staffing								
Staff Group £000's	**Aug**	**Sep**	**Oct**	**Nov**	**Dec 12**	**Jan 13**	**Av. YTD**	**YTD Actuals**
	Actual	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**		
Medstaff WLI & ADH's	130	99	103	84	76	87	89	888
Agency Medstaff (Senior)	143	130	191	96	15	120	108	1,079
Agency Medstaff (Junior)	171	171	189	194	178	128	177	1,768
Bank Staff - Nursing	357	390	361	377	422	370	379	3,793
Agency Staff - Senior Nursing	275	307	333	307	197	219	268	2,682
Agency Staff - Junior Nursing	106	140	145	128	76	113	127	1,273
Agency Staff - Management	78	78	146	138	130	156	91	907
Bank Staff - Admin	117	130	115	115	125	115	108	1,078
Agency Staff - Admin	38	29	44	43	9	43	32	323
Bank & Agency Staff - Other	148	105	157	148	92	121	116	1,164
Total Temporary Staff	**1,563**	**1,580**	**1,784**	**1,629**	**1,321**	**1,472**	**1,496**	**14,955**

5.1 The nursing workforce plan has been updated and additional measures are being put in place to ensure nursing WTE's are increased with additional international recruitment initiatives. A shortfall in the projected recruitment pipeline has meant that the planned reduction in Agency staffing will not now transpire in the current financial year.

6.0 Non Pay cost incurred were £8.9m (16%) higher than planned for the year to date. Expenditure in January amounted to £7.0m (£0.4m above forecast).

Graph 4 – Non-Pay expenditure run rate 2012-13



7.0 Transformation Programme (CIP Programme)

7.1 The Trust has a total CIP target for 2012/13 of £19m (£16.1m net of PCT QiPPs cost impact) to be delivered in year, which represents 8% of budgeted costs. There are significant risks in delivering this programme and the Trust has developed a number of non-recurrent schemes to mitigate this risk.

7.2 The financial recovery plan agreed in October included the requirement to deliver £11.1m of savings by the financial year end. The Latest Thinking Forecast for the Transformation programme indicates that there is expected to be a shortfall of £0.7m against this target (see Transformation Report for further details).

7.3 The Trust planned to achieve cumulative CIP savings of £12.7m by month 10 and actually achieved £8.5m which represent delivery of only 66% of target.

7.4 Appendix 3 details the identified schemes by workstream. In total schemes have been identified to deliver £10.4m in year against the £16.1m target however of these schemes £0.2m have been categorised as red rated.

7.5 Any CIP savings that are not delivered on a recurrent basis will become additional requirements in 2012/13.

8.0 Balance Sheet and Cash Flow as at 31st January 2012

8.1 The Trust's Balance Sheet (Statement of Financial Position) as at 31st January is contained within appendix 4 of this report.

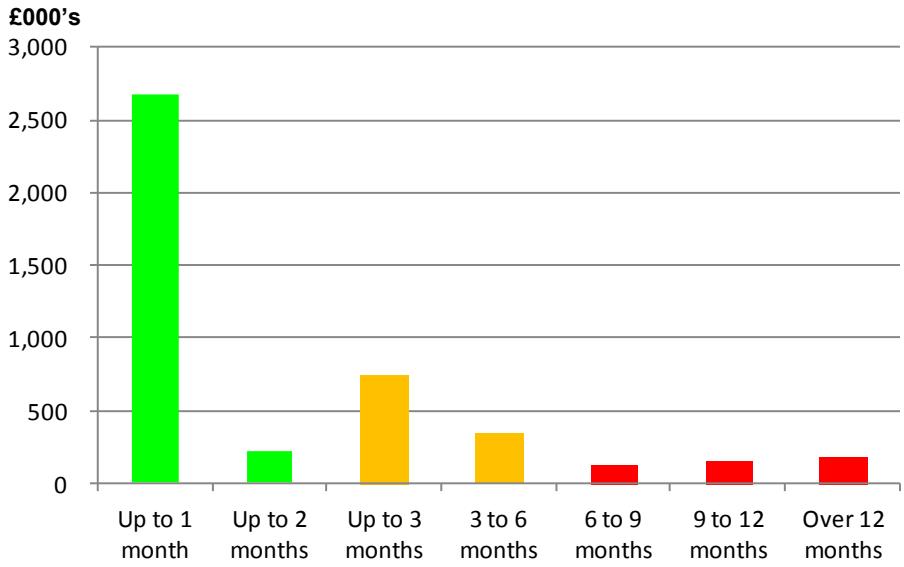
8.2 The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of December stood at £5.9m (December £3.2m). Cash balances have increased to provide resource to meet the temporary loan repayments at the end of February. As a result there has been some delay in making creditor payments in early February, pending cash receipts of additional income relating to the CCG contract settlement in mid February and March.

8.3 The forecast cashflow includes temporary borrowing of £4m to be repaid on 28th February 2013.

8.4 The Trust continues to work with the CCG to find ways of alleviating short term cashflow problems, and has signalled a requirement for assistance in Q1 2013/14. The SHA has now prepaid all MPET invoices for the remainder of the financial year.

8.5 An analysis of income earned by the Trust but unpaid as at 31st January 2013 is shown in the graph below:

Graph 5 – Aged Debtor analysis – January 2013



9.0 Capital Programme and Performance against Capital Resource Limit

9.1 The CRL target has increased to £10.9m due to additional PDC notified in January to support developments in Midwifery services.

Capital Resource Limit (CRL)	Plan	YTD	Forecast	Underspend
	£000	£000	£000	£000
Internally Funded (Depreciation)	9,739	5,632	9,692	47
Salix Loan	377	0	377	0
PDC Increases	480			
Asset Sales	300			
Total	**10,896**	**5,632**	**10,069**	**827**

9.2 The Trust has plans approved to underspend up to the CRL by £0.9m. The level of underspend has been reduced due to recently approved bids notably in support of new Radiotherapy equipment.

9.3 There is a significant amount of capital expenditure planned in the final two months of the financial year. Failure to deliver this will entail a first charge on the 2013-14 capital programme.

10.0 Financial Risk Rating

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

10.2 The overall risk rating for the Trust as at the 31st January 2013 if it were a Foundation Trust would be 2, which would be insufficient for the Trust to be licensed as a Foundation Trust. The Trust is forecast to end the year with a risk rating of 3 (based on a breakeven position).

10.3 The Trust reports the shadow FRR scores above to the SHA as part of the M&E SHA Performance Management Report (PMR). At present the score gives rise to the requirement for the Trust board to make a governance disclosure to the SHA given the low FRR score.

11.0 Financial Risks

11.1 A summary of the Trusts financial risks not included in the forecast financial position are set out in the table below:

Table 5 – Financial Risk Assessment – January 2012.

		Value of Risk £000s	Likelihood	Probability %	Adjusted Risk £000s
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage	Agency - escalate through TDG.	(1,000)	Low	20%	(200)
Delivery of Control Totals	Directorates to manage within agreed targets	(1,075)	Low	20%	(215)
	Unforseen Cost Pressures (eg RTT)	(500)	Low	20%	(100)
Net Revenue Risk		**(2,575)**			**(515)**
Other Risks					
Cashflow constrained / unmet creditor demand in Q1 2013-14	Cashflow plan for year end 12-13 and Q1 13-14 to be considered by F&PC.	6,000	High	90%	5,400

12.0 Conclusion

12.1 The Trust faces a lower level of financial risk given the agreement of a year end SLA settlement with Nene CCG. Achievement of a breakeven position is therefore forecast although this remains contingent on the successful management of the risks highlighted in section 6 above.

12.2 The Trust needs to carefully plan cashflow for Q4 and for the opening quarter of the new financial year details of which are set out under separate cover.

13.0 Recommendations

13.1 The Board are asked to note the requirement by the Department of Health and Strategic Health Authority to achieve at least a financial breakeven position for the year (agreed plan is for a surplus of £1.0m) requiring close financial management of control totals and risk in the closing months of the financial year.

14.2 The Board are asked to ensure that the actions to mitigate risks are discussed and understood. (Para 11.1)

14.3 Note the level of capital expenditure required to meet the CRL forecast in the final two months of the financial year.

14.3 The Board should closely monitor the development of the financial plan for 2013-14 seek assurance to understand the following key issues:

- The nature of the recurrent financial position.
- The level of financial risk in the 2013-14 plans.
- The cashflow impact of the proposed plan.

Appendix 1
Finance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	**M10**		**M9**	**M8**	**M7**	**M6**
Financial Risk Rating (Shadow)	2	FRR shadow score of 2	1	2	1	1
EBITDA	89.7%	EBITDA achieved 81% of plan	66.0%	55.3%	47.0%	30.5%
Liquidity (days cover)	22.1	Incl. unused WCF of £18m	19.7	18.6	17.1	-15.4
Surplus Margin	-0.5%	+1% required for score of 3	-2.1%	-2.5%	-3.0%	-4.3%
Pay / Income	64.7%	Pay 65% of Income for YTD	65.8%	66.1%	66.5%	67.5%
I&E Position	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Reported Position	(2,376)	Deficit of £2.4m to month 10.	(5,324)	(4,135)	(4,447)	(5,265)
Impairment	(1,426)	Impairment due to Indexation of NCAs.	(1,587)			
Normalised Position	(950)	I&E position excluding impairment.	(3,737)	(4,135)		
FIMS Plan (Year to date)	(42)	£0.0m plan to month 10.	(518)	(21)	(230)	(1,332)
PCT SLA Income Variance	12,298	7% above plan.	8,430	7,852	5,931	3,868
SHA control total (NGH)	1,000	SHA control total £1m surplus.	1,000	1,000	1,000	1,000
Financial Recovery Target	0	Forecast is for breakeven by March 2013	0	0	0	0
EBITDA Performance	£000's		£000's	£000's	£000's	£000's
Variance from plan	(1,221)ADV	£1.2m behind plan	(3,464)ADV	(4,238)ADV	(4,272)ADV	(3,989)ADV
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
YTD Plan	12,735	£12.7m target to month 10.	11,267	9,714	8,252	6,760
YTD Actual	8,460	£8.5m delivered to month 10.	7,621	6,667	5,961	4,724
% Delivered	66%	CIPs delivered as a % of plan .	68%	69%	72%	70%
LTF	10,379	Latest Thinking Forecast for year.	10,419	10,541	11,098	11,142
Annual Plan	16,100	Annual Transformation Target.	16,100	16,100	16,100	16,100
LTF v. Plan	64%	% of LTF compared to annual plan.	65%	65%	69%	69%
Capital	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Year to date expenditure	4,889	Capital expenditure for period	4,384	4,126	3,229	2,943
Committed as % of plan YTD	90%	% of plan committed for year to date.	89%	81%	92%	88%
Annual Plan	10,364	Capital Resource Limit of £10.1m for 2012-13.	10,131	10,336	10,336	10,403
SoFP (movement in year)	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
Non-current assets	(6,078)	Revaluation+Additions - depreciation	(6,818)	(2,656)	(2,250)	(1,743)
Current assets	9,335	Cash balance and NHS debtors.	4,729	5,122	3,146	1,036
Current Liabilities	39	Reduction in creditors offset by deferred income	20	6,180	4,921	4,136
Cash	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**
In month movement	2,729	Increase between December and January.	1,897	(926)	1,169	(192)
In Year movement	2,029	Increase since March 2012	(700)	(2,597)	(1,671)	(2,840)
DH Temporary Loans	4,000	Temporary borrowing drawn down from DH	3,000			
Debtors Balance > 90 days	802	18% of balances outstanding over 90 days	686	566	558	611
Creditors > 90 days	36	1% of creditors waiting over 90 days	33	486	988	423
BPPC (by volume) YTD	86.4%	Target 95% paid in 30 days	88.5%	88.5%	90.0%	91.5%

Income & Expenditure Position – January 2013

I&E Summary	Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	Forecast EOY
	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	212,676	177,425	190,722	13,298	230,910
Other Clinical Income	2,663	2,219	2,532	313	2,732
Other Income	23,219	19,209	22,032	2,824	29,967
Total Income	**238,558**	**198,852**	**215,287**	**16,434**	**263,609**
Pay Costs	(153,692)	(129,064)	(139,222)	(10,158)	(168,794)
Non-Pay Costs	(67,588)	(56,509)	(65,375)	(8,867)	(79,647)
Reserves/ Non-Rec	(2,068)	(1,532)	0	1,532	(1,198)
Total Costs	**(223,143)**	**(186,942)**	**(204,597)**	**(17,655)**	**(249,639)**
EBITDA	**15,415**	**11,910**	**10,689**	**(1,221)**	**13,970**
Depreciation	(10,184)	(8,426)	(8,106)	320	(9,729)
Amortisation	(10)	(8)	(8)	(0)	(10)
Impairments	0	0	(1,426)	(1,426)	(1,400)
Net Interest	29	24	17	(7)	19
Dividend	(4,250)	(3,542)	(3,542)	0	(4,250)
Surplus / (Deficit)	**1,000**	**(42)**	**(2,376)**	**(2,335)**	**(1,400)**
Normalised for Impairment		**(42)**	**(950)**	**(908)**	**0**

Appendix 3

Statement of Financial Position as at January 2013

	Balance at 31-Mar-12	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		(3,267)	(2,861)	406	(3,039)	(3,039)
IN YEAR MOVEMENTS		3,751	4,889	1,138	9,550	9,550
LESS DEPRECIATION		(7,302)	(8,106)	(804)	(9,730)	(9,730)
NET BOOK VALUE	**135,075**	**128,257**	**128,997**	**740**	**131,856**	**(3,219)**
CURRENT ASSETS						
INVENTORIES	4,723	4,928	4,939	11	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	9,838	11,298	1,460	5,742	12
OTHER TRADE DEBTORS	985	1,122	1,149	27	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31				31	
NON NHS OTHER DEBTORS	70	491	274	(217)	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,668	2,784	116	2,654	100
OTHER RECEIVABLES	549	553	683	130	474	(75)
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,229	2,245	16	1,460	2
	10,945	**16,469**	**18,001**	**1,532**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300					(300)
CASH	3,944	3,244	5,973	2,729	4,363	419
NET CURRENT ASSETS	**19,912**	**24,641**	**28,913**	**4,272**	**20,141**	**229**
CURRENT LIABILITIES						
NHS	1,673	1,435	1,346	89	1,963	(290)
TRADE CREDITORS REVENUE	3,655	524	2,487	(1,963)	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	588	1,144	(556)	2,759	
TAX AND NI OWED	3,454	3,486	3,478	8	3,506	(52)
NHS PENSIONS AGENCY	1,784	1,947	1,949	(2)	1,950	(166)
OTHER CREDITORS	510	443	322	121	510	
DH SHORT TERM LOANS		3,000	4,000	(1,000)		
SHORT TERM LOANS	526	552	734	(182)	688	(162)
ACCRUALS AND DEFERRED INCOME	4,018	11,178	9,125	2,053	4,331	(313)
PDC DIVIDEND DUE		1,062	1,417	(355)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	837	842	(5)	914	625
PROVISIONS over 1 year	310	330	349	(19)	374	
NET CURRENT LIABILITIES	**20,921**	**26,011**	**27,822**	**(1,811)**	**21,279**	**(358)**
TOTAL NET ASSETS	**134,066**	**126,887**	**130,088**	**3,201**	**130,718**	**(3,348)**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	31,993	31,761	(232)	32,193	(1,853)
DONATED ASSET RESERVE						
GENERAL RESERVES	385	583	1,068	485	583	198
I & E CURRENT YEAR		(5,324)	(2,376)	2,948	(1,693)	(1,693)
FINANCING TOTAL	**134,066**	**126,887**	**130,088**	**3,201**	**130,718**	**(3,348)**

Cost Improvement Delivery

£000's	Jan		YTD		
Workstream	**Plan**	**Actual**	**Plan**	**Actual**	**Var**
Beds / Patient Flow	-	-	256	17	(239)ADV
Theatres	58	10	308	92	(216)ADV
Outpatients	19	31	127	308	181FAV
Admin Review	55	5	275	5	(270)ADV
Procurement	100	293	1,000	946	(54)ADV
Pathology	16	16	114	78	(37)ADV
Therapies	10	9	60	30	(30)ADV
Medical	20	-	210	-	(210)ADV
Estates	6	4	55	38	(18)ADV
Outsourcing	16	4	79	24	(56)ADV
Nursing	8	1	42	1	(41)ADV
Back Office Phase	75	12	357	106	(250)ADV
Contract Compliance	72	80	730	1,240	510FAV
Pharmacy	38	20	375	486	111FAV
Controls	46	- 3	458	134	(324)ADV
HR Workforce Planning	166	-	852	-	(852)ADV
Workforce, Bank & Agency	79	-	792	-	(792)ADV
Directorate 3% Schemes	535	444	5,135	4,956	(179)ADV
New Schemes					
NGH Mitigation	151	-	1,510	-	(1,510)ADV
Grand Total	**1,468**	**925**	**12,735**	**8,460**	**(4,275)ADV**

	Orig. Plan	Revsd. Plan	LTF	Var
Workstream	**£000**	**£000**	**£000**	
Beds / Patient Flow	300	17	17	(0)ADV
Theatres	424	142	112	(30)ADV
Outpatients	165	352	371	19FAV
Admin Review	385	81	37	(44)ADV
Procurement	1,200	870	1,084	214FAV
Pathology	147	91	147	56FAV
Therapies	80	39	47	8FAV
Medical	250			
Estates	316	75	45	(30)ADV
Outsourcing	111	29	30	1FAV
Nursing	58	2	2	
Back Office Phase 2	506	172	172	0FAV
Contract Compliance	1,000	1,001	1,400	399FAV
Pharmacy	450	600	527	(73)ADV
Controls	550	459	234	(225)ADV
HR Workforce Planning	1,183	250	8	(242)ADV
Workforce, Bank & Agency	950	700		(700)ADV
Directorate 3% Schemes	6,205	6,222	6,222	
New Schemes				
Mitigation Required	1,820			
Grand Total	**16,100**	**11,102**	**10,456**	**(646)ADV**

Appendix 5

Cashflow

MONTHLY CASHFLOW	Annual 2012-13	ACTUAL										FORECAST		FORECAST Q1		
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS																
SLA Base Payments	205,663	15,448	17,959	18,311	17,011	17,091	16,677	17,627	16,930	17,084	20,996	15,264	15,264	17,116	17,116	17,116
SLA Performance / Other CCG investment	27,887				1,965	151	309	1,544	3,420	3,000		8,399	9,100			
SHA Payments (SIFT etc)	9,157	266	1,300	671	942	672	841	723	809	1,271	833	809	20	741	741	741
Other NHS Income	19,211	1,932	2,568	1,108	1,420	1,495	1,858	1,852	1,164	1,314	1,036	1,673	1,791	1,530	1,530	1,530
PP / Other (Specific > £250k)	550		259							291						
PP / Other	10,986	821	768	796	1,013	793	972	927	858	779	1,059	1,100	1,100	860	790	1,000
Salix Capital Loan	381								121		182	78				
EFL / PDC																
Temporary Borrowing	4,000									3,000	1,000					
Interest Receivable	28	2	2	2	2	2	1	3	1	1	3	4	4	2	2	2
TOTAL RECEIPTS	**277,863**	**18,469**	**22,857**	**20,888**	**22,352**	**20,204**	**20,659**	**22,676**	**23,304**	**26,740**	**25,108**	**27,328**	**27,279**	**20,249**	**20,179**	**20,389**
PAYMENTS																
Salaries and wages	162,403	13,081	13,813	13,339	13,233	13,513	13,433	13,356	13,507	13,391	13,717	13,900	14,120	13,620	13,620	13,620
Trade Creditors	75,449	4,285	6,274	5,734	5,915	6,238	3,908	6,197	8,328	7,046	6,426	7,467	7,629	6,000	6,000	6,000
NHS Creditors	20,815	1,546	1,938	1,480	2,151	965	973	1,498	1,980	3,711	1,677	1,396	1,500	1,152	1,152	1,152
Capital Expenditure	10,309	789	1,503	763	517	371	375	455	443	617	581	1,769	2,127	795	1,500	592
PDC Dividend	4,194						2,069						2,125			
Repayment of Loans	4,000											4,000				
Repayment of Salix loan	238						95						143			
TOTAL PAYMENTS	**277,407**	**19,701**	**23,528**	**21,316**	**21,815**	**21,087**	**20,854**	**21,506**	**24,257**	**24,765**	**22,402**	**28,532**	**27,644**	**21,567**	**22,272**	**21,364**
Actual month balance	457	-1,232	-671	-428	537	-883	-195	1,170	-954	1,975	2,706	-1,204	-365	-1,318	-2,093	-975
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,112	1,229	1,034	2,204	1,250	3,225	5,932	4,728	4,363	3,045	951
Balance carried forward	**4,363**	**2,675**	**2,003**	**1,575**	**2,112**	**1,229**	**1,034**	**2,204**	**1,250**	**3,225**	**5,932**	**4,728**	**4,363**	**3,045**	**951**	**-24**

Capital

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 10 M10 Plan £000's	M10 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 10 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 10 M10 Forecast £000's	Plan Achieved
Breast Screening Business Case	59	59	59	0	100%	59	100%	59	100%
Emergency Care	177	178	177	-1	100%	177	100%	177	100%
Endoscopy / Urodynamics	60	60	52	-8	87%	52	87%	60	100%
Mortuary Refurbishment	55	55	73	18	133%	73	133%	72	131%
Macmillan (Trust)	44	5	5	0	11%	23	52%	44	100%
Macmillan (Non Trust)	13	13	13	0	101%	13	101%	13	100%
MESC	1,451	668	588	-79	41%	755	52%	1,451	100%
Estates	3,567	2,265	2,116	-148	59%	3,171	89%	3,549	99%
IT	3,273	2,043	1,693	-350	52%	2,974	91%	3,274	100%
Pharmacy Robot	183	64	64	0	35%	183	100%	183	100%
Radiotherapy Innovation Fund	679	0	0	0	0%	607	89%	679	100%
Endoscopic Ultrasound	308	0	0	0	0%	247	80%	308	100%
Improving Birthing Environments	180	0	0	0	0%	0	0%	180	100%
Other	315	222	224	2	71%	266	84%	315	100%
Total - Capital Plan	**10,364**	**5,632**	**5,066**	**-566**	**49%**	**8,600**	**83%**	**10,364**	**100%**
Less Charitable Fund Donations	-295	-221	-177	45	60%	-177	60%	-295	100%
Total - CRL	**10,069**	**5,410**	**4,889**	**-521**	**49%**	**8,423**	**84%**	**10,069**	**100%**

Resources	
Internally Generated Depreciation	9,739
SALIX	377
Improving Birthing Environments	480
Sunnyside - Disposed NBV	300
Total - Available CRL Resource	**10,896**
Uncommitted Plan	**-827**

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (completed November 2012)
- Pharmacy Robot approved for capital purchase in year
- Endoscopy (only fees in 2012/13) / Urodynamics (initial works completed Sept) - subject to business case approval and charitable funds donation
- The Trust have received £641k Radiotherapy Innovation Funding of which £679k are capital items
- Other costs include £35k Cancer Network Funding and £77k (Topcon scanner & Medaphor scan trainer) - transferred from revenue M6
- The Macmillan scheme works are completed, although final account is under dispute
- Full year depreciation forecast is currently £9.739 million (was £9.729 million)
- Following Capital Committee meeting £368k was agreed to slip till next financial year - endoscopy £218k and Estates schemes £150k
- Charitable Donations assumptions for additions in year has reduced to £295k (was £354k)
- The 2012/13 is undercommitted against resource in year by £0.827m (was £0.872m) - additional RIF + depreciation available reduction
- Improving Birthing Environments was notified as a CRL allocation in January of £0.480 million - £180k will be spent on the schemne the remaining £300k will be spent on advanced medical equipment and reprovided to complete the works in 2013/14
- Capital Committee approved the purchase of the Endoscopic Ultrasound equipment

Financial Risk Rating (Monitor)

FRR

Financial Criteria	Metric	Weight %	Dec	Shadow Rating	YTD Score	< Good > 5	4	Score 3	< Bad > 2	1
Achievement of Plan	EBITDA Achieved (% of plan)	10%	81%	3	0.30	100	85	70	50	<50
Underlying Performance	EBITDA Margin %	25%	4.5%	2	0.50	11	9	5	1	<1
Financial Efficiency	Return on Assets	20%	-0.98%	2	0.40	6	5	3	-2	<-2
Financial Efficiency	I&E Surplus Margin	20%	-1.0%	2	0.40	3	2	1	-2	<-2
Liquidity	Liquidity Ratio (Days cover)	25%	22.08	3	0.75	60	25	15	10	<10
Weighted Average		100%		Calculated Score	2					
				Override	0					
				Reported Score	2					

	< Good > 5	4	Score 3	< Bad > 2	1
Achievement of Plan	100	85	70	50	<50
Underlying Performance	11	9	5	1	<1
Financial Efficiency	6	5	3	-2	<-2
Financial Efficiency	3	2	1	-2	<-2
Liquidity	60	25	15	10	<10
Weighted Average					

Finance Risk Triggers (SHA SOM)

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

TRUST BOARD 28th February 2013	
Title	HR REPORT
Presented by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for January 2013 which focuses on the following Human Resource Workforce Indicators for Month 10:

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

RECOMMENDATION: The Board is asked to discuss and support the ongoing actions.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 Month 10

The Human Resource Workforce Indicators have been updated for Month 10. Please refer to the following pages of this report.

The salient points of change to date are:

Workforce Capacity

Substantive Workforce Capacity increased by 25.12 FTE from 3,926.56 FTE to 3,951.68 FTE which is below the plan (4,278.12 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has increased by 0.59% to 92.37% in the month.

Temporary Workforce (excluding Medical Staffing) usage increased by 0.75% from 5.19% to 5.94% in the month and remains above the planned temporary FTE target of 5%.

Total Substantive Workforce plus Temporary Workforce (excluding Medical Staffing) % FTE against budgeted estsablishment FTE has increased by 1.39% from 96.81% to 98.20% in month.

Staff turnover (leavers) has increased by 0.02% on the month to 8.33%, which remains above the Trust target of 8%.

Recruitment Timeline is below the threshold target at 12 weeks.

Health and Wellbeing

Calendar Days Lost to Sickness The number of calendar days lost to sickness decreased by 236 from 7,277 to 7,041 in January 2013.

No. of Days Lost per Employee decreased by 0.06 from 1.58 days to 1.52 days in the month.

Long term sickness absence decreased by 0.35% to 2.44% in month, above the Trust target of 2%.

Short Term Sickness Absence absence increased by 0.20% to 2.41% this month (Trust target 1.4%).

Total Sickness Absence has decreased by 0.15% to 4.85% (Trust target 3.4%).

Workforce Expenditure

Temporary Workforce Expenditure has increased by £121,063 from £1,213,266 to £1,334,329 which is equal to 9.51% of the total workforce expenditure.

Workforce Development

Appraisals are centrally recorded on OLM and are reported on a cumulative 12 month basis. The Training and Development Department is responsible for the centralised management of recording appraisals, the HR Business Partners continue to work with Managers to implement the process of submitting appraisal records. The percentage of staff with completed appraisals for January 2013 was 18.07%, compared to 14.89% the previous month.

Mandatory Training Compliance shows an increase of 0.38% compliance in January 2013 with a total Trust compliance of 65.31%.

Forecast and Risks

There continues to be a heavy dependency on locum doctors due to the difficulty in EWTD Rota Compliance which is contributing to the overall temporary workforce expenditure.

Recent analysis of the workforce age profile indicates that currently 25% of our Nursing and Midwifery workforce are aged 50 years and over and therefore could be considering retirement within the next 5 to 10 years. This suggests that there will be continued increase in turnover and recruitment over this period.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 10

WORKFORCE CAPACITY (Temporary Workforce Capacity Excludes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Dec	Jan	Peformance vs. Prev. Month	Comments and or Plans
Budgeted Workforce Establishment (FTE)			4,278.12	4,278.12		
Contracted Substantive Workforce (FTE)			3,926.56	3,951.68	Higher	
Temporary Workforce Utilised (FTE)			214.99	249.51	Higher	
Total Substantive Workforce plus Temporary Workforce (FTE)			4,141.55	4,201.19	Higher	
Contracted Workforce against Budgeted Establishment (% FTE)	95% to 97%		91.78%	92.37%	Higher	
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)	100%		96.81%	98.20%	Higher	
to 92.37% in the month.	5%		5.19%	5.94%	Higher	Temporary Workforce Rate excludes Medical Staffing
Staff Turnover (% FTE)	8%		8.31%	8.33%	Higher	
Recruitment Timeline	13 Weeks		13.56	12.00	Lower	Recruitment Timeline is adjusted to take into account the 3 weeks Regional Restricted Access

in the month

WORKFORCE EXPENDITURE (Temporary Workforce Expenditure Includes Medical Staffing)

against budgeted estsablishment FTE has increased by 1.39% from 96.81% to 98.20% in month.	Performance Target	Trust YTD	Dec	Jan	Peformance vs. Prev. Month	Comments and or Plans
Contracted Workforce Expenditure		125,419,798	12,759,405	12,692,171	Lower	
Contracted Workforce Enhanced Overtime		641,765	57,503	48,644	Lower	
Contracted Workforce Plain Time OT		53,588	5,660	5,116	Lower	
Temporary Workforce Expenditure		13,802,228	1,213,266	1,334,329	Higher	Temporary Workforce Expenditure = Bank, Agency and Locum (including Medical Staffing)
Total Utilised Workforce Expenditure		139,222,026	13,972,671	14,026,501	Higher	
Temporary Workforce Expenditure (% of Total Workforce Expenditure)		9.91%	8.68%	9.51%	Higher	

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 10

No. of Days Lost per Employee decreased by 0.06 from 1.58 days to 1.52 days in the month.

Long term sickness absence decreased by 0.35% to 2.44% in month, above the Trust target of 2%.

Short Term Sickness Absence absence increased by 0.20% to 2.41% this month

	Performance Target	Trust YTD	Dec	Jan	Peformance vs. Prev. Month	Comments and or Plans
			4,595	4,633	Higher	
Calendar Days Lost to Sickness Absence		66,155	7,277	7,041	Lower	
Days Lost Per Employee			1.58	1.52	Lower	
Short Term Sickness Absence	1.4%		2.21%	2.41%	Higher	
Long Term Sickness Absence	2%		2.79%	2.44%	Lower	
Total Sickness Absence	3.40%		5.00%	4.85%	Lower	

WORKFORCE DEVELOPMENT

Performance Indicator	Performance Target	Trust YTD	Dec	Jan	Peformance vs. Prev. Month	Comments and or Plans
Mandatory Training Compliance	100%		64.93%	65.31%	Higher	

WORKFORCE APPRAISALS

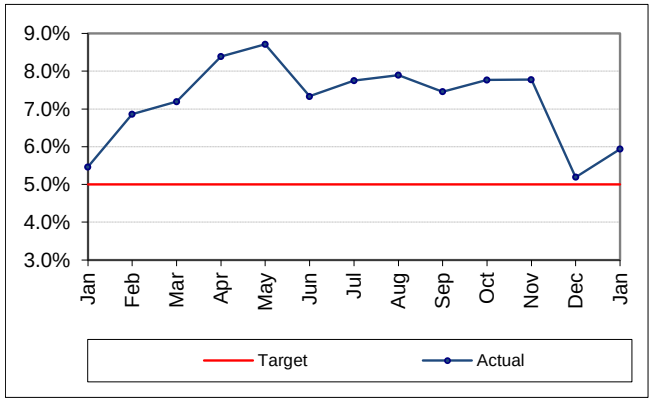
Performance Indicator	Performance Target	Trust YTD	Dec	Jan	Peformance vs. Q1 2011	Comments and or Plans
12 Month Cumulative Completed Personal Development Review / Plan	100%		14.89%	18.07%	Higher	Managers are responsible for submitting PDR/P's which are recorded and reported from central source (OLM)

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 10

DIRECTORATE WORKFORCE PERFORMANCE SUMMARY

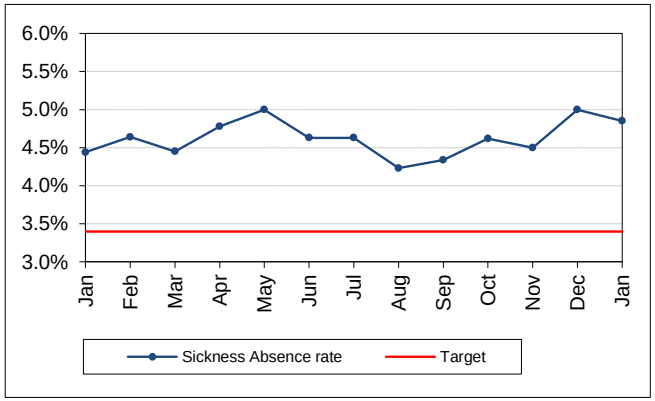
Temporary Workforce Rate

Directorate	Bank & Agency (Excl. Locum) M10	Variance Against Target	Variance From M9
Target = 5.0%		<-1.0%	>0.0%
Medicine	9.88%	4.88%	1.01%
Surgery	8.25%	3.25%	1.60%
Anaesthetics	4.62%	-0.38%	0.06%
Trauma & Orthopaedics	4.99%	-0.01%	0.70%
Head & Neck	7.13%	2.13%	1.77%
Child Health	5.05%	0.05%	0.88%
Obstetrics & Gynae	1.73%	-3.27%	-0.79%
Oncology	5.94%	0.94%	1.33%
Pathology	2.90%	-2.10%	0.38%
Radiology	0.00%	-5.00%	0.00%
Pharmacy	0.00%	-5.00%	0.00%
Therapies	10.90%	5.90%	1.24%
Facilities	2.40%	-2.60%	0.22%
Hospital Support	5.06%	0.06%	1.01%
Total	5.94%	**0.94%**	0.75%



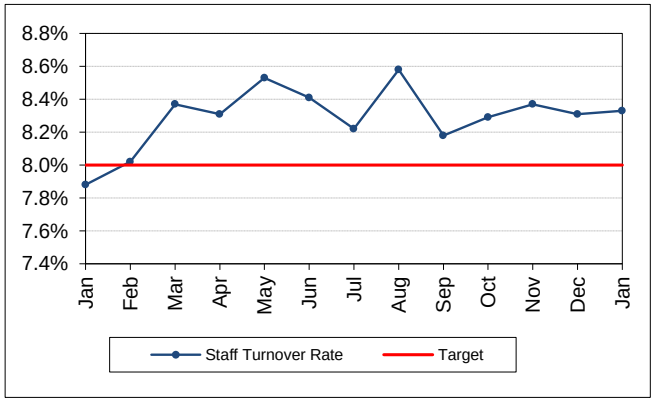
Staff Sickness Absence Rate

Directorate	Sickness Absence M10	Variance Against Target	Variance From M9
Target = 3.4%		<-0.0%	>0.0%
Medicine	5.14%	1.74%	-0.63%
Surgery	5.34%	1.94%	1.26%
Anaesthetics	2.58%	-0.82%	-0.55%
Trauma & Orthopaedics	6.66%	3.26%	0.81%
Head & Neck	5.91%	2.51%	2.98%
Child Health	5.40%	2.00%	-0.09%
Obstetrics & Gynae	5.61%	2.21%	-0.53%
Oncology	4.32%	0.92%	-0.58%
Pathology	5.28%	1.88%	-0.22%
Radiology	3.22%	-0.18%	0.95%
Pharmacy	1.97%	-1.43%	-1.63%
Therapies	4.31%	0.91%	0.29%
Facilities	6.01%	2.61%	0.10%
Hospital Support	3.26%	-0.14%	-1.27%
Total	**4.85%**	**1.45%**	**-0.15%**



Staff Turnover

Directorate	Turnover M10	Variance Against Target	Variance From M9
Target = 8.0%		<-0.0%	>0.0%
Medicine	6.60%	-1.40%	-0.43%
Surgery	8.71%	0.71%	0.74%
Anaesthetics	5.61%	-2.39%	0.77%
Trauma & Orthopaedics	7.84%	-0.16%	1.45%
Head & Neck	6.28%	-1.72%	-0.02%
Child Health	13.98%	5.98%	0.12%
Obstetrics & Gynae	7.01%	-0.99%	0.96%
Oncology	9.59%	1.59%	-0.51%
Pathology	8.75%	0.75%	-0.63%
Radiology	4.92%	-3.08%	-0.05%
Pharmacy	6.50%	-1.50%	-0.05%
Therapies	12.99%	4.99%	-1.54%
Facilities	9.74%	1.74%	-0.75%
Hospital Support	12.72%	4.72%	-0.13%
Total	**8.33%**	**0.33%**	**0.02%**



HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 10

DIRECTORATE WORKFORCE CAPACITY SUMMARY

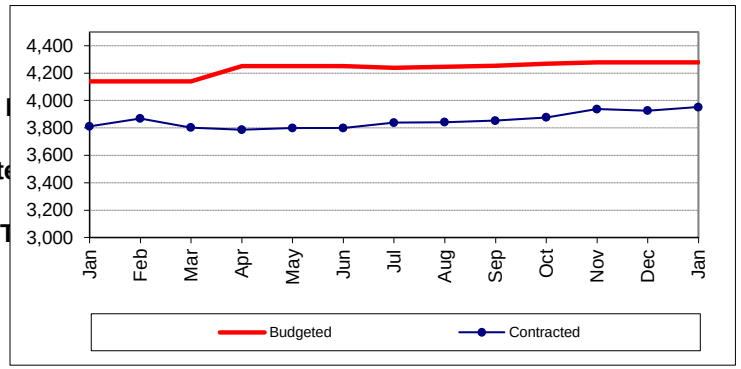
Substantive Workforce Capacity FTE (Target = 95%)

Directorate	Budgeted Establishment	M10 Contracted	Variance %	Variance FTE
Medicine	1,092.50	1,026.84	-6.01%	-65.66
Surgery	296.30	280.48	-5.34%	-15.82
Anaesthetics	332.79	309.15	-7.10%	-23.64
Trauma & Orthopaedic	257.98	230.18	-10.78%	-27.80
Head & Neck	173.33	162.29	-6.37%	-11.04
Child Health	266.30	261.85	-1.67%	-4.45
Obstetrics & Gynae	380.07	369.17	-2.87%	-10.90
Oncology	223.95	225.07	0.50%	1.12
Pathology	225.85	195.96	-13.23%	-29.89
Radiology	143.45	130.17	-9.26%	-13.28
Phamacy	101.65	101.14	-0.50%	-0.51
Therapies	79.37	65.75	-17.16%	-13.62
Facilities	344.56	277.67	-19.41%	-66.89
Hospital Support	360.02	315.96	-12.24%	-44.06
Total	**4,278.12**	**3,951.68**	**-11.90%**	-326.44

to 92.37

in the m

against



No. of

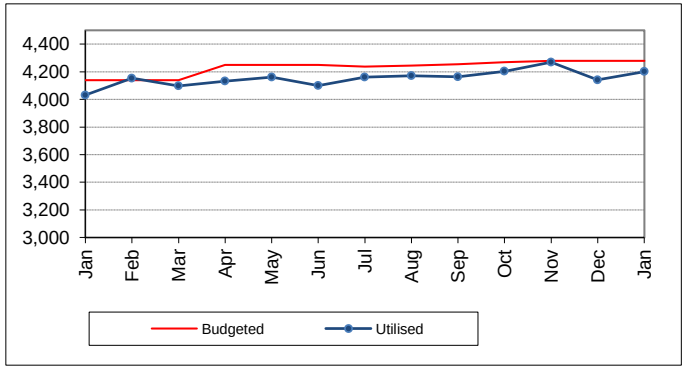
Long t

Short T

Total Workforce Capacity FTE (Excluding Medical Staff)

<95% = Under Establishment (-)	95% to 97% Establishment	97% to 100% Establishment	Over Establishment

Directorate	Budgeted Establishment	Total Utilised Workforce	Variance
Medicine	1,092.50	1,139.45	46.95
Surgery	296.30	305.70	9.40
Anaesthetics	332.79	324.12	-8.67
Trauma & Orthopaedic	257.98	242.26	-15.72
Head & Neck	173.33	174.75	1.42
Child Health	266.30	275.77	9.47
Obstetrics & Gynae	380.07	375.65	-4.42
Oncology	223.95	239.28	15.33
Pathology	225.85	201.81	-24.04
Radiology	143.45	130.17	-13.28
Phamacy	101.65	101.14	-0.51
Therapies	79.37	73.79	-5.58
Facilities	344.56	284.49	-60.07
Hospital Support	360.02	332.79	-27.23
Total	**4,278.12**	**4,201.19**	-76.93



TRUST BOARD – 28th February 2013	
Title: -	Transformation Update
Presented by: -	Geraldine Opreshko – Director of Workforce & Transformation (Interim)

PURPOSE OF PAPER:

To update the board on the latest thinking forecast on the 2012/13 Transformation Programme.

CRITICAL POINTS: -

1. The Transformation Programme is forecast to deliver £10.4m savings against a plan of £11.1m
2. Care Groups & Corporate Teams are continuing to identify schemes for the next two year programme to 2015.
3. The PMO Operating Manual will be updated to be operationalised by 1st April 2013 following recommendations contained in the recent Finance and PMO reviews.

ACTION REQUIRED BY BOARD: -

The Board is asked to note and discuss the actions being taken by the Transformation Delivery/Steering Groups to deliver a forecast £10.4m savings.

Board Meeting – 28th February 2013

1. Introduction

The 2012/13 year end financial savings target for the Transformation Programme is £11.1m. The current latest thinking forecast stands at a projected delivery against that plan of £10.4m, which represents a marginal improvement on the reported January 2013 forecast by £100k.

All project teams continue to prioritise schemes which can deliver financial benefits by the year end. The current latest thinking forecast (LTF) is that £10.4m will be achieved this year.

Care Groups and Corporate teams, supported by the Transformation Team continue to identify schemes and cost improvement initiatives for the next two year programme to 2015.

The lessons learned exercise/review of Programme Management Office (PMO) function, outlined in the January 2013 board report, has been concluded with recommendations considered and agreed at the Finance and Performance Committee for implementation from April 1st 2013.

2. Financial Delivery of the 2012/13 Transformation Programme.

The following has been successfully delivered:

- Overtime payment reductions for December 2012, exceeded the required in month planned reductions. Sustaining this reduction for the remainder of the year is now required, this will be achieved through the introduced controls that were introduced in December 2012.
- Procurement savings are once again projected to exceed their annual plan, with an increase in the savings shown in January's latest thinking forecast by £200k. The team is on target to exceed their savings target of £1.1 million for the year.
- The multifunctional device roll out is gathering pace, so far Equitrac (print management software) has been introduced to over 12 departments across the trust. These areas are now able to audit the themes of their departments printing associated spend. Whilst net savings for 2012/13 are modest, a full year's impact will be realised during 2013/14.

3. Risks to the 2012/13 programme

The two risks for the final two months of the year include:

- A reversal in the decrease in overtime payments achieved during December 2012 over the residual three months of the financial year.
- Control totals not achieved as forecast, which will impact on the achievement of the £10.4m savings.

4. Development of the 2013/15 cost improvement plans & Governance Review implementation.

The workstream framework and cost improvement plans for 2013/14 & 2014/15 continue to be developed in partnership with Care Group and Corporate teams.

A Quality Impact Assessment (QIA) working group has been established, with the initial meeting being held on February 26 2013. . The working group will:-

1. Complete a full retrospective analysis of the 2012/13 Transformation QIA dashboard and metrics
2. Provide support and capacity for scheme project and clinical leads to undertake rigorous QIA assessments for prosed transformation schemes, and
3. Develop a revised reporting dashboard.

The working group will report into the Transformation Delivery Group

The Transformation Steering Board has reviewed an initial matrix of potential larger scale transformation schemes. An assessment of these potential plans is currently being undertaken, ensuring that the impact on service quality is core.

The lessons learned review of the Transformation & PMO governance arrangements has been reviewed and discussed by the Finance and Performance Committee. The implementation of the agreed cost improvement principles and the recommendations will be facilitated through the refresh of the PMO Operating Manual, which will be completed by the end of March 2013, for implementation from the 1st April 2013.

5. Conclusion

The Trust is on track to deliver £10.4m transformation programme for 2012/13.

6. Recommendation

The Board is asked to discuss and note the actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.4m Transformation savings plan.

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

Returns to providerdevelopment@eoe.nhs.uk by the last working day of each month

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

Name of Organisation:	Northampton General Hospital	Period:	January 2013

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

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

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**YTD deficit of £1.95m leading to FRR score of 2.**
Action :	**Addional CIP and mitigating actions to be developed and actioned.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**A&E Transit Time: 86.91%. Cancer: 31-day sub drug txt 95.8%, 62-day urgent GP ref 79.1%**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**Not achieved in 2011/12**
Action :	**Work ongoing to achieve minimum level 2 in 2012-13**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Northampton General Hospital

January 2013

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	No
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Board Action
1	SHMI - latest data	Score			109	109	109	106	106	106	104.8	104.8	104.8	107.8	
2	Venous Thromboembolism (VTE) Screening	%	93.6%	90.9%	91.4%	91.9%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	
3a	Elective MRSA Screening	%	99%	99.93%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	
3b	Non Elective MRSA Screening	%	96.20%	91.05%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	12	21	12	12	17	14	11	10	13	14	24	19	There are currently 19 active incidents outstanding of which 5 have been submitted to our Commissioners for closure.
6	"Never Events" occurring in month	Number	0	0	0	0	0	0	1	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	1	1	0	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	2	3	1	2	1	1	2	2	4	1	1	2	
10	Falls resulting in severe injury or death	Number	0	2	0	0	1	2	2	0	2	3	1	0	
11	Grade 3 or 4 pressure ulcers	Number	5	0	2	3	3	2	0	2	3	7	7	6	January 2013 pressure ulcer figures consist of 3 x avoidable and 3 x unavoidable.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	48	49	50	51	39	48	33	35	44	40	24	68	
14	Agency as a % of Employee Benefit Expenditure	%	5.4%	5.5%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	
15	Sickness absence rate	%	4.6%	Not Av	4.78%	5.0%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	3	2	2	FRP in place
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	3	4	2	2	FRP in place
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3	2	2	FRP in place
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	TDA briefed. Plan submission £8m deficit.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Liquidity position reviewed at F&PC. Temporary borrowing in place.
Weighted Average		**100%**						**2.4**	**2.9**	**2.3**	**2.3**	
Overriding rules								2		2	2	
Overall rating								**2**	**3**	**2**	**2**	

Overriding Rules :

Max Rating	Rule							
3	Plan not submitted on time	No						
3	Plan not submitted complete and correct	No						
2	PDC dividend not paid in full	No						
2	Unplanned breach of the PBC	No						
2	One Financial Criterion at "1"							
3	One Financial Criterion at "2"							
1	Two Financial Criteria at "1"							
2	Two Financial Criteria at "2"		2		2	2		

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

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	Yes	Yes	Yes				FRP in place.
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	Yes	Yes	Yes				F&PC reviewing progress in agreeing plan for 2013-14. TDA breifed as to latest postion.
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes				
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No				Temporary borrowing in place to meet creditor demand. CCG income settlement agreed.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No				
7	Interim Finance Director in place over more than one quarter end	No	Yes	No	No				Current Interim finishes in March 2013. Recrutient process underway with TDA involvement.
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes				-7 days (excl WCF). Temporary borrowing to be requested for Q2 2013-14.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No				
10	Yet to identify two years of detailed CIP schemes			Yes	Yes				Executive team overseeing CIP plan development.

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 Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a				
			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				
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a				
	1c	Data completeness: identifiers MHMDS		97%	0.5	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				
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				
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	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				
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes				
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	No				Unverified January figures show 31-day subsequent drug treatment as being 95.8% against the target of 98%
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	No				Unverified January figures show 62-day urgent GP referral being 79.1% against the target of 85% (Q1 62-days urgent GP referral target not delivered)
			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				
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	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				January 2013 = 86.91% against the target of 95%
	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				
			Having formal review within 12 months	95%									

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

						Historic Data			Current Data				
	3g	Minimising mental health delayed transfers of care		≤7.5%	**1.0**	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				
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**0.5**	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				
			Red 2	75%	**0.5**	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				
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	**1.0**	Yes	Yes	Yes	Yes				
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes				
	4b	MRSA	Is the Trust below the de minimus	*6*	**1.0**	Yes	Yes	Yes	Yes				
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	No	No	No				
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	**2.0**	No	No	No	No				
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	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				
				TOTAL		**1.0**	**1.0**	**1.0**	**3.0**	**0.0**	**0.0**	**0.0**	
						AG	AG	AG	AR	G	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				
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				
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				
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				
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				
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				
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				
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	Yes	Yes	Yes	Yes				
		Adjusted Governance Risk Rating	**4.0**	**4.0**	**4.0**	**4.0**	**0.0**	**0.0**	**0.0**	
			R	R	R	R	G	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 Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	No	Yes	Yes	Yes				
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes				
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	Yes	Yes				
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes				
5	Are there any disputes over the terms of the contract?	No	No	No	No				
6	Might the dispute require third party intervention or arbitration?	No	No	No	No				
7	Are the parties already in arbitration?	N/a	No	No	No				
8	Have any performance notices been issued?	Yes	No	No	No				
9	Have any penalties been applied?	No	No	No	No				

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

TFA Progress

Feb-13

Northampton General Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	Deloite Board Development / BGAF review	Jul-12	Fully achieved in time		
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12	Fully achieved in time		
3	Trust to review the TFA in response to the Healthier Together Consultation	Oct-12	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
4	In-month delivery of 95% A&E 4-hour indicator	Oct-12	Fully achieved in time		
5	Recovery plan agreed at Board to stabilise financial position	Oct-12	Fully achieved in time		
6	Director of Finance appointed	Nov-12	Not fully achieved		Substantive Director of Finance not appointed through last appointments process. Interim DoF in post. Renumeration Committee looking at longer term solutions
7	Director of Workforce and Transformation appointed	Nov-12	Fully achieved in time		
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12	Not fully achieved		High level CIPs are identified, fully worked-up implementation plans and QIAs being completed
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12	Fully achieved in time		
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12	Not fully achieved		Full recovery plan in place. All actions are on track to be delivered. The remaining risks to delivery are; the appointment of additional A&E consultants-the Trust has a plan in place to appoint 2 additonal physicians and reduce the number of patients remaining in hospital who no longer need acute care. The Trust is working with commissioners and social care to review this.
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12	Fully achieved in time		
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12	Fully achieved in time		
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12	Fully achieved in time		
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12	Not fully achieved		as per line 10 above
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13	Not fully achieved		
17	Board and sub committee observations	Jan-13	Not fully achieved		Board observations are due to take place in February/March as part of the Quality Assurance and BGAF assessments below.
18	Quality Assurance Framework external assessment	Feb-13		Will not be delivered on time	Assessment not taking place in line with agreement with the SHA
19	HDD re-assessment	Feb-13		Will not be delivered on time	Assessment not taking place in line with agreement with the SHA
20	BGAF external assessment	Feb-13		Will not be delivered on time	Assessment not taking place in line with agreement with the SHA
21	In-month delivery of 95% A&E 4-hour indicator	Feb-13		Will not be delivered on time	A full recovery plan Progress is monitored through the Urgent Care Programme Board.
22	NHS Acute Service Contract agreed	Mar-13		On track to deliver	
23	IBP approval by Board	Mar-13		On track to deliver	
24	Final LTFM approved by Board	Mar-13		On track to deliver	
25	Trust/NTDA readiness review meeting	Mar-13		On track to deliver	
26	YTD delivery of 4 hour indicator	Mar-13		Will not be delivered on time	A full recovery plan Progress is monitored through the Urgent Care Programme Board.
27	Delivery of control total for 2012/13	Mar-13		On track to deliver	
28	Quarterly review of outcome of Healthier Together	Mar-13		On track to deliver	
29	Board and Sub committee observation	Apr-13		Will not be delivered on time	

30	FT submission to NTDA	May-13		Will not be delivered on time	
31	Board interviews	May-13		Will not be delivered on time	
32	NGH/NTDA Board to Board meeting	Jun-13		Will not be delivered on time	
33	NTDA Board approval	Jun-13		On track to deliver	
34	Application submitted to DH	Jul-13		Will not be delivered on time	
35					
36					
37					
38					
39					
40					

Notes

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

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

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 28th February 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Zeidler	
	2.	Declarations of Interest	Mr P Zeidler	
	3.	Minutes of the meeting held on 31st January 2013	Mr P Zeidler	**1**
	4.	Matters Arising	Mr P Zeidler	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
09.40	6.	Francis Report	Ms S Loader & Dr S Swart	**3**
10.00	7.	Medical Director's Report	Dr S Swart	**4**
10.10	8.	Patient Experience	Ms S Loader	**5**
10.20	9.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
10.30	10.	Patient Safety Academy Report	Dr S Swart	**7**
10.40	11.	Quality Accounts	Ms S Loader	**8**
Operational Assurance				
10.45	12.	Operational Performance Report	Mrs C Allen	**9**
10.55	13.	Finance Report	Mr P Hollinshead	**10**
11.05	14.	Human Resources Report	Ms G Opreshko	**11**
11.15	15.	Transformation Programme Update	Ms G Opreshko	**12**
11.25	16.	Self-Certification Return	Mr C Pallot	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 28th March 2013		
	19.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	