Northampton General Hospital NHS
NHS Trust

A G E N D A

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

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 28 February 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.40	5.	Chief Executive's Report	Mrs C Allen	**Verbal**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Ms S Loader	**3**
10.00	7.	Patient Experience	Ms S Loader	**4**
10.10	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
10.20	9.	Urgent Care Update	Ms R Brown/Dr J Timperley	**6**
10.30	10.	Resilience Report	Ms R Brown	**7**
Operational Assurance				
10.40	11.	Operational Performance Report	Ms R Brown	**8**
10.50	12.	Finance Report	Mr P Hollinshead	**9**
11.00	13.	Human Resources Report	Ms G Opreshko	**10**
11.10	14.	Transformation Programme Update	Ms G Opreshko	**11**
11.20	15.	Self-Certification Return	Mrs K Spellman	**12**
Governance				
11.30	16.	Any Other Business		
	17.	**Date & time of next meeting:** 25 April 2013		
	18.	**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	

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on
Thursday 28th February 2013 at 9.30am
Boardroom, Northampton General Hospital

Present:

Mr P Zeidler	Non-Executive Director/Vice Chair (Chair)
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

In attendance:

Mr J Bufford	Interim Head of Corporate Affairs (minutes)
Mr R Kelso	Shadow Governor
Mr A MacPherson	Shadow Governor
Ms E Gascoigne	Shadow Governor
Mrs McVicar	Shadow Governor
Ms W Meredith	Shadow Governor

Apologies

Mr P Farenden	Chairman

TB 12/13 129 Declarations of Interest

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

TB 12/13 130 Minutes of the meeting held on 31st January 2013

Page 3 the last line of the penultimate paragraph should read “Mr Robertson felt that the bed occupancy figure of 84% appeared low – Dr Swart felt that this may have included beds not used for acute adult patients.

Page 4 – the first part of the third paragraph should read “Pressure ulcers had increased – possibly because of increased reporting from better validation and improved training and awareness

Page 5 – the penultimate paragraph should read “There has been a great deal of analysis into A&E performance. There had been significant pressures in A&E during December 2012, and subsequently 88.64% of patients admitted or discharged within 4 hours. The Board was informed that the key reason for this was the continued increase in the length of stay for patients staying over 14 days combined with increased activity levels.”

Subject to these amendments Board APPROVED the minutes of 31st January as a true and correct record.

TB 12/13 131 Action Log and matters arising

Ms Allen confirmed that she would be picking up urgent care in her report this month and would present fuller reports bimonthly.

All other actions and matters arising were on the agenda.

TB 12/13 132 Chief Executive's Report

Dr McSorley provided a verbal report. The Chief Executive of the County Council had advised him of some changes to the management structure of the Council. From 1 April the public health function would be transferred there; the council was moving towards a more community led focus and the government's focus on troubled families would have an impact. As a result of this some changes would be made to the management structure. A new post, Director of Health and Wellbeing had been created and the adult services and children's services would be separated.

The Board of Directors NOTED Dr McSorley's report

TB 12/13 133 Francis Report

Ms Loader and Dr Swart presented the report. A reverse gap analysis was being undertaken against the recommendations, to identify any issues not already being tackled by the Trust. In addition, listening events were being held with staff and the emergent themes would be incorporated into the next Board report. This would allow a more detailed report to be taken to the April meeting.

The report had been discussed at the Healthcare Governance Committee. Dr Swart felt that the three things that the Trust had to focus on were listening to staff, listening to patients and embedding a culture where everyone understood their responsibilities to both patients and staff.

Mr Kershaw favoured focussing on six key priorities rather than diffusing energy on all 290 recommendations. Mrs Searle asked what the feedback was from staff – Ms Loader reported that a full analysis would be done once the listening exercise was complete and then reported to the April Board meeting.

Action: Ms Loader

Mrs Searle also felt that it would be useful to collect qualitative feedback in addition to quantitate data. Dr Swart commented that she was already doing this through reading patient letters in the confidential part of the Board while Ms Loader was piloting exercises where patients came to feedback directly to staff. Dr Swart noted that it was important that when patients did report back there was sufficient time allocated.

The Board of Directors NOTED the report and the importance of this work and AGREED that a further report should be brought to the April meeting.

TB 12/13 134 Medical Directors Report

Dr Swart introduced her report.

Dr Swart reported that the Hospital Standardised Mortality Ratio for the first seven months of 2012/13 was 98 which was predicted to rise to 105 following a re-benchmarking exercise. She advised that the Trust was not an outlier in respect to mortality as measured by the Hospital Standardised Mortality Ratio. With regard to the Standardised Hospital Mortality Indicator, Dr Swart informed the Board that the Trust was reporting 'as expected' at 108.

There was on-going work to improve the positions through targeted initiatives with continued focus on the emergency pathway. Partnership with the health care economy would be necessary to ensure reductions in length of stay and readmissions.

Dr Swart reported that the Hospital Standardised Mortality Ratio and the Standardised Hospital Mortality Indicator did not correlate positively for a number of diagnostic groups, the significance of which was uncertain, although the Trust was working with Dr Foster to enhance this reporting and gain a greater understanding.

Mr Robertson recognised the huge improvements made and asked whether there were sufficient resources available to embed those. Dr Swart felt that there was a need to invest in systems but that it was also important that the right parts of the data set were targeted.

In presenting section two of the report, Dr Swart reported that a data quality issue had been identified which presented uncertainty around the reported nurse to bed ratio, which appeared low when considered against national benchmarking data. Ms Loader commented that the Trust was still on track to be fully up to nurse establishment by the end of April; Mrs Opreshko noted that the Trust would be recruited to nurse establishment by the end of March 2013.

In section three of the report, Dr Swart presented the key issues on the monthly quality scorecard. The Board was informed that 54 of the 136 indicators were rated as either red or amber status. She reported that there had been an overall improvement in the number of reported pressure ulcers although it was acknowledged that was still a great deal of work to do. The reduction could be attributed to the implementation and embedding of the improvement plan across the Trust.

The Board was informed that there had been deterioration in the number of falls during January 2013 when compared to December 2012. In January 2013, one major/severe fall and two moderate falls had been reported. Dr Swart advised that a focussed piece of work was being led by the falls prevention lead in conjunction with key wards and clinical staff to review documentation to strengthen the risk assessments and ensure preventative measures are in place for those patients which are deemed to be more susceptible to falling.

The Board of Directors NOTED the report.

TB 12/13 135 Patient Experience

Ms Loader presented her report. The overall figure for friends and family test had remained static at 68 through December and January. The Trust had set itself stretch targets for the return of questionnaires and was meeting those.

Ms Loader drew attention to the patient experience CQUIN questions – she was working with ward sisters to address the issues of talking through

medication with patients on discharge. A listening into action group was looking at signage and improving patient letters. She was also including a breakdown of responses on a ward by ward basis – wards with figures under 70% had been asked to draw up improvement plans.

Mr Robertson asked if there were any areas where it was difficult to provide privacy. Ms Loader reported that this was an issue in four bedded bays and also for patients who had dementia who might be wandering. The Trust was doing its best to make sure that privacy and dignity was borne in mind. Mr Robertson suggested that the solution for addressing patient privacy was not just to do with the physical environment but also to do with staff attitudes.

The Board of Directors NOTED the report.

TB 12/13 136 Monthly Infection Prevention Performance Report

Ms Loader presented the Monthly Infection Prevention Performance Report. She informed the Board that there were no reported cases of MRSA bacteraemia in January 2013, and as such, the cumulative number of cases reported during 2012/13 was two (one above the ceiling).

With regard to clostridium difficile, Ms Loader reported that the Trust had an annual ceiling of 36 cases or less for the financial year. During January two cases were identified**,** which totalled 23 cases of C. diff for 2012/13. Next year, the ceiling has been set at 29 cases for the year.

Ms Loader reported to the Board on an outbreak of scalded skin syndrome (SSS), an infection which is caused by certain strains of staphylococcus aureus bacteria. Four babies born at the Trust in December 2012 were diagnosed with scaled skin syndrome. Ms Loader reported that figure had since increased to seven cases. All babies had been treated and were well. The Health Protection Agency were actively involved in the supporting the Trust in managing the outbreak and had assured the Trust that it felt confident that the Trust was doing all it could to manage the outbreak appropriately. The Trust continues to investigate the situation to identify the underlying cause.

Mr Noble asked how patients were informed about scalded skin syndrome – Ms Loader explained that people were informed about it when they came in, with the emphasis on openness about the cause and reassurance. Patients appreciated the hospital being pro-active and open with the families. In addition the Health Protection Agency (HPA) had sent out an email to all GP's in the area, raising awareness of the issue, requesting that if they suspected a case, then to send the patient into the hospital.

The Board of Directors NOTED the report.

TB 12/13 137 Patient Safety Academy Report

Dr Swart presented the patient safety academy report which updated the Board on the progress made against the programme of work outlined in the patient safety strategy. The overall aim of the Patient Safety Strategy was 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 Board was informed that the programme of work which was established

to support the patient safety strategy was now in place. Whilst it was a challenging programme, it had received considerable support from clinical and non-clinical staff. There had been challenges relating to the time commitment required from everyone involved in this programme which had consequently delayed the formal start of some of the project management aspects but the as the programme was built on previous work this had not resulted in any gap in ' safety activity'.

Mr Robertson asked what Board should do to appreciate this work – Dr Swart felt it would be helpful for Board members to attend events. Dr McSorley noted that, following an education visit, the General Medical Council had highlighted the work the Trust conducted in engaging and involving foundation doctors as being exemplary.

The Board of Directors NOTED the report and the excellent work being carried out.

TB 12/13 138 Quality Accounts

Ms Loader introduced the paper. The Trust had set out four key priorities for 2012/13 which were fundamental to ensuring that patients have a good experience through the delivery of high quality and safe patient care in its quality accounts for the present year. Those priorities were:

- 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

Ms Loader recommended to the Board that those priorities should remain the priorities for the following year albeit with updated benchmarks and plans.

The Board of Directors APPROVED the use of the same four priorities for 2013/14

TB 12/13 139 Operational Performance Report

Ms Allen presented the report which set out the key areas of performance for the Trust for January 2013.

In summary, Ms Allen informed the Board that the Trust did not achieve the four hour A&E transit time target for January 2013 with 86.91% of patients being treated within four hours against a target of 95%. The Chief Operating Officer and Care Group Directors were 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, with progress being continually monitored through the Urgent Care Programme Board.

Mr Zeidler noted that the report clearly demonstrated the consistent year on year A&E deterioration and asked for local area data to be included in the

March Urgent Care report.

Action: Ms Allen

In response to a question from Mr Noble, Ms Allen noted that the improvements to delayed discharges from working with other providers were likely to be slow and steady and would take three or four months to emerge. Mrs Searle thought that the whole system approach was a good one and asked how confident Ms Allen was that this would deliver – Ms Allen felt that more signs of them being delivered were needed before she could be fully confident. Mr Robertson asked if improvement in discharges would impact on bed day statistics – Ms Allen confirmed that they would.

Ms Allen also reported that the Trust was working with Age UK to pilot a scheme whereby trained helpers were placed in A&E to act as advocates for frail elderly patients and who would also be able to go home with them and handover to primary care the following day.

Ms Allen reported that during January 2013 there continued to be an increase in the number of breaches of the cancer target 62 day standard from urgent referral. There had been 19 breaches during January 2013 against a trajectory of 11, performance of 79.1% against a target of 85%. The year to date position was 83%. The reasons for the breaches included patient choice to defer treatment and complex diagnostic pathways particularly in Head and Neck and Lower GI tumour sites.

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

Ms Allen reported that the Trust was meeting all other required targets.

The Board of Directors NOTED the report.

TB 12/13 140 Finance Report

Mr Hollinshead presented the finance report which summarised the Trust's financial performance for the ten months to the end of January 2013.

Mr Hollinshead reported that the overall financial position had significantly improved as the Trust had negotiated an SLA income settlement covering the remainder of the financial year. The income settlement of £201m was with the local CCGs, and included an additional £2.2m notified to the Local Area Team and CCG in October and Winter pressures funding of £1.3m.

The Trust's year to date income and expenditure position as at 31 January 2013 was a £0.95m deficit, an improvement from £4.3m deficit in December 2012. Risks remained around the transformation programme and control totals, but Mr Hollinshead assured the Board he was confident the Trust would achieve a planned year end was a surplus of £1.0m.

Mr Hollinshead reported that whilst the Trust is forecasting meeting the statuary External Financing Limit target the, position for the first quarter of the new financial year will necessitate further temporary borrowing. The Capital Resource Limit was expected to be achieved by year end, but only £4.8m had spent at end of Jan; £8.6m orders placed and position complicated by late release of funds for radiotherapy, cancer and maternity.

The Board of Directors NOTED the report

TB 12/13 141 Human Resources Report

Mrs Opreshko presented the Human Resources Report.

In presenting the key points from the report, Mrs Opreshko advised that there had been an increase in the substantive workforce of 25.12 full time equivalent staff, although the Trust remained below its target establishment of 4278.12 full time equivalents at 3951.68 full time equivalents. Mrs Opreshko highlighted that some parts of the Trust appeared to be over establishment. Ms Allen thought that this might be the result of the additional capacity opened as a result of winter pressures.

The use of temporary staffing had increase in January 2013 by 0.75% from 5.19% to 5.94% which remained above the target of 5%.

With regard to sickness absence, the Board was informed that the total number of calendar days lost to sickness had decreased by 236 days in January 2013.Mrs Opreshko informed the Board that from 1 April 20113, national changes to the Agenda for Change rules would come into force which meant that enhancements would not be payable to staff whilst they were on sick leave.

Mr Kershaw noted that appraisal rates were only 18% in January. Mrs Opreshko felt that appraisals were being carried out but were not always reported to the centre. It was also noted that the change to an annualised rate was only now feeding into the figures.

Mrs Opreshko also reported that the Trust was looking at the age profile of staff and that over 25% of the nursing and midwifery staff were over 50 and appropriate workforce planning and recruitment arrangements were being put in place.

Mrs Searle asked what benchmarking was being undertaken. Mrs Opreshko advised that the Trust was now using national benchmarking tools but these depended on the quality of data put in to databases in the first place.

The Board of Directors NOTED the report

TB 12/13 142 Transformation Report

Mrs Opreshko reported that the current performance was £10.4m, £100k over the £10.3m target. Work had also been carried out to identify projects for the next two years and it was hoped to have all those agreed by the end of March.

Dr Swart and Ms Loader had been involved in on-going discussions regarding the Quality Impact Assessments, stressing the importance of all schemes being Quality Impact Assessed as early as possible prior to CIP's being agreed. Dr Swart noted that the ongoing Quality Impact Assessment of schemes was often more complex than the initial assessment. Ms Loader assured the board that no CIP would be approved until the QIA had been signed off by the Medical and Nursing Directors.

The Board of Directors NOTED the report

TB 12/13 143 Self-certification return

Mr Pallot presented the return. The Trust was amber-red for governance because of A&E, cancer and MRSA and continued to have a Financial risk rating of 2.

He noted that on page 139 the Trust had reviewed quality measures. The SI figure had increased because of the need to include those closed by the Trust but not yet by the PCT.

The Board of Directors APPROVED signing Declaration 2

TB 12/13 144 Any Other Business

Noting that this was Dr McSorley's last meeting the Board of Directors formally recorded their thanks to him for his clear and collaborative leadership over the last two years.

TB 12/13 145 Date of next meeting: ~March 28th 2013, 9.30 Boardroom NGH

TB 12/13 146 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 28 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	March 2013	
TB 12/13 133	**Francis Report**	28 Feb 2013	Report to the Board on the outcomes of the staff listening exercise in response to the Francis Report & to present the reverse gap analysis against the recommendations	Ms Loader	April 2013	
TB 12/13 139	**Operational Performance Report**	28 Feb 2013	Include local area comparative data on A&E performance in March 13 urgent care report to the Board	Ms Allen	March 2013	

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

Enclosure 2

Trust Board 28 March 2013	
Title:	Medical Director's Report
Presented by:	Ms Suzie Loader for Dr Sonia Swart
PURPOSE OF PAPER: Update on Mortality and Clinical Scorecards	

CRITICAL POINTS:

- Overall mortality as measured by Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (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

Medical Directors Report

Section 1 - Review of Current Mortality and Safety Data provided by Dr Foster

1. Introduction

This paper provides a brief summary relating to mortality and safety indicators provided by Dr Foster and the information relating to Summary Hospital Level Mortality Indicator (SHMI).

2. Current Position Hospital Standardised Mortality Ratio (HSMR)

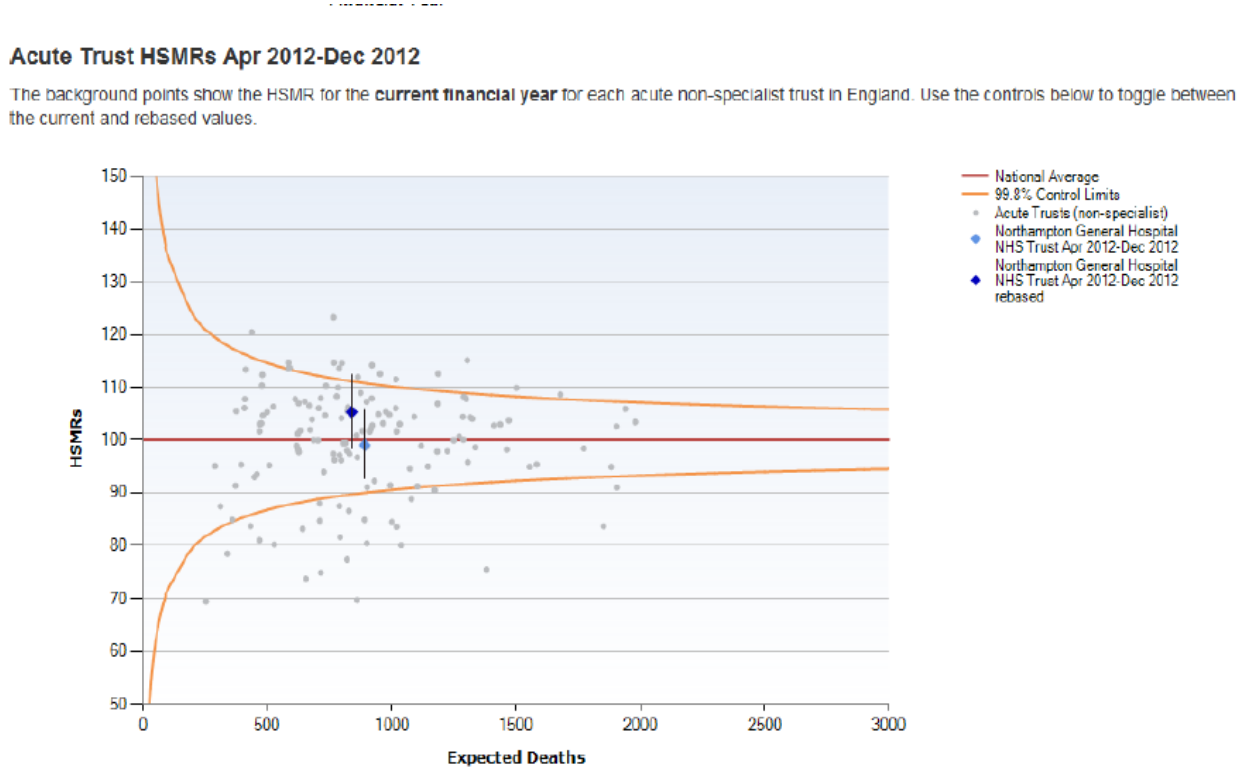
The HSMR for the first six months of 2012/13 is 99 (883 deaths versus 892 expected deaths) which is predicted to rise to 105 after re-benchmarking. Unadjusted mortality is 4.0 % which is slightly less than the average of 4.1% in the SHA.

For December the HSMR was 100 **(**120 deaths, 120 expected).

3. Acute Trust HSMRs April 2011 - March 2012

The Trust 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 acute on specialist Trust in England.



4. Standardised Hospital Mortality Indicator (SHMI)

The SHMI for the first two quarters of 2012/13 remains higher than the HSMR and higher than at this point in 2011/12 at 111. The rolling SHMI to the end of these six months was 108 which represents a SHMI in the ‘as expected’ category (using 95% confidence levels). The SHMI is rebased each time it is calculated unlike the HSMR.

The SHMI and HSMR do not correlate well for some diagnostic groups. The significance of this is as yet uncertain. Dr Foster is 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:

Jan 2012 to Dec 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		31	24.6	0.86	0.68	more information
Decubitus Ulcer		143	208.5	15.67	22.85	more information
Deaths after surgery		42	31.2	145.33	108.11	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	13.6	0.26	0.59	more information
Post-operative physiologic and metabolic derangements*		0	1.5	0.00	0.09	more information
Post-operative respiratory failure		13	13.3	0.71	0.73	more information
Post-operative pulmonary embolism or deep vein thrombosis		28	39.3	1.21	1.69	more information
Post-operative sepsis		4	4.2	5.77	6.03	more information
Post-operative wound dehiscence*		2	1.1	2.15	1.18	more information
Accidental puncture or laceration		36	74.1	0.55	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		23	39.7	47.92	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		77	93.1	30.90	37.37	more information
Obstetric trauma - caesarean delivery*		3	4.3	2.42	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:

6.1 Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups; Acute Cerebrovascular Disease, Pneumonia, Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur, are subject to particular scrutiny. Within this group there no overall concerns with a Standardised Mortality Ratio (SMR) of 77 (344 deaths with 446 expected from 2300 spells).

There continues to be cause for concern in relation to mortality from fractured neck of femur. The SMR for 2012/13 is 166 (37 deaths with 22 expected) and all deaths are under review. The Clinical Director will be presenting findings on this issue to the HealthCare Governance Committee this month (34 deaths versus 20 expected). 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 Clinical Quality and Effectiveness Group.

6.2 Possible areas for Concern under investigation

The Mortality and Coding Group continue to receive reports in relation to any areas of concern which are thoroughly investigated. There are no new areas flagged for concern at present. The detailed case review of deaths is awaiting analysis at present.

6.3 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 Length of Stay 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.

6.4 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 a report is awaited.

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 Trust has made some further progress in 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. The need to provide consultant level data with respect to surgical outcomes will require a review of information systems and act as a further lever to ensure clinical engagement in information recording and flows.

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

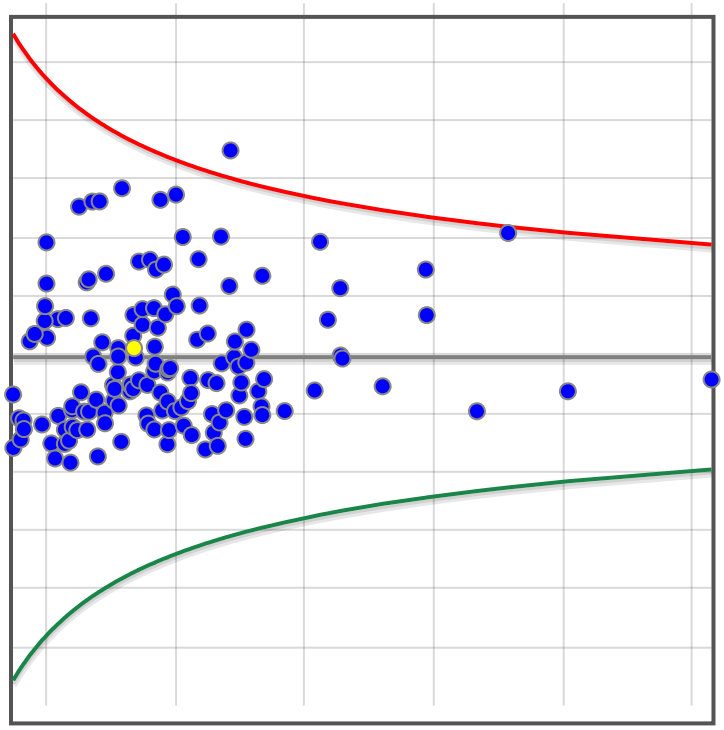
The dashboard will be viewable across the whole of the Commissioning Board including providers and commissioners at all levels and is to be used in quality surveillance meetings , Monitor, the Trust Development Authority , Health Education England and the CQC.

The Dashboard high level report indicates no adverse alerts for Northampton General Hospital. The metrics are updated at different intervals and are not necessarily current (an outline is presented in Appendix 1 - this is printed from the website and is not available in another format).

The specific metrics reported are:

- Preventing People from dying prematurely – results as expected
- Amenable mortality – results as expected
- Quality of life for patients with Long Term Conditions – average
- Number of admissions under 19 – this has risen since the last report reflecting emergency pressures in paediatrics but the position of NGH on the funnel chart is ‘ average’
- 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- average and stable (see funnel plot)
- Timely Care – RTT greater than 18 weeks and cancer waits – average and within target
- Safe Environment – Infections , serious incidents , never events , harm free care are all average or slightly better than average
- Organisational indicators – staff sickness and bed occupancy – higher than average
- Organisational indicators – doctor to patient ratio – average
- Organisational indicators – nurses to bed ratio (reported as to November 2012) – below average at 1.37 but clarification of the bed base and metrics is required . This figure does not include agency staff and ther recent recruitment and bed base recalculation will be required to ensure accuracy.

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



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 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

1. 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.

Directorate Scorecards are improving and becoming more comprehensive providing the Care Groups with a dashboard 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.

2. Performance

Of 138 indicators, 49 (33/16) are rated as either red or amber status. The Exception Summary Report outlines the underperforming indicators and details the remedial action(s) being taken. There are 10 indicators that are rated grey. This is a slight increase in comparison to Februarys report (9) Indicators rated as grey continue to await final agreement or the information is currently not available.

Summary Rating

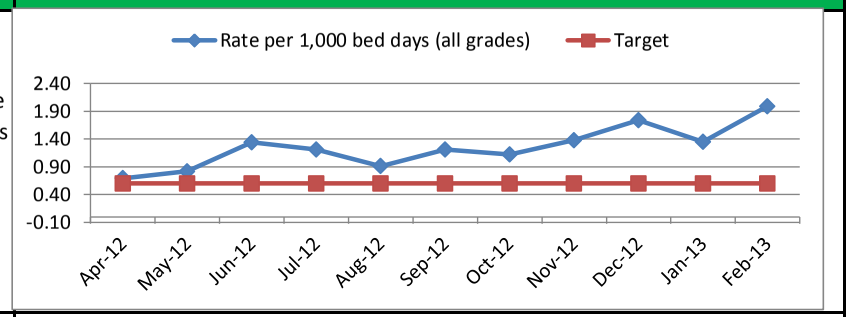
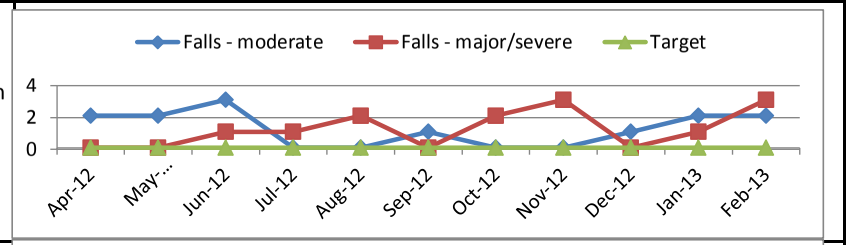
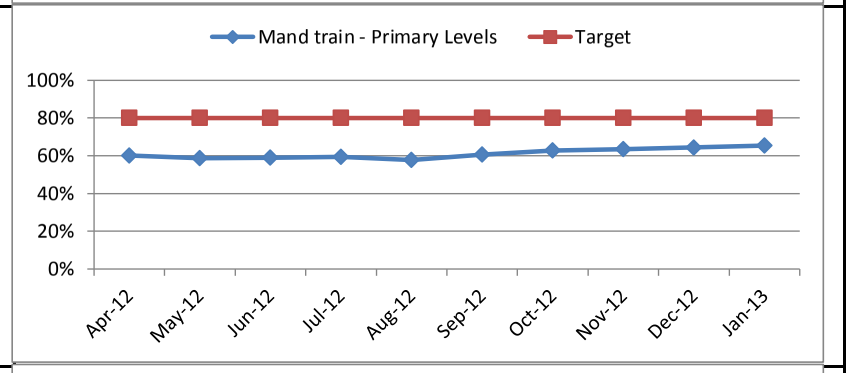
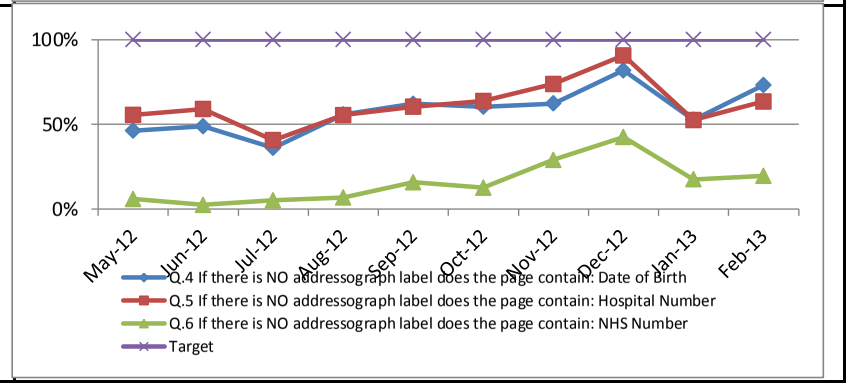
Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**2**	**6**	**27**	**1**
Clinical Outcomes	**6**	**1**	**12**	**4**
Patient Safety	**14**	**8**	**22**	**4**
Patient Experience	**9**	**4**	**17**	**1**
TOTAL	**33**	**16**	**79**	**10**

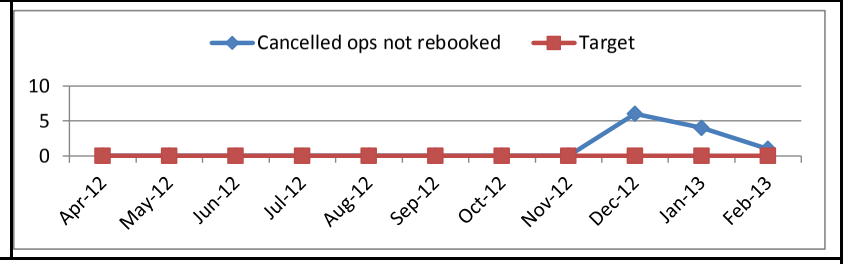
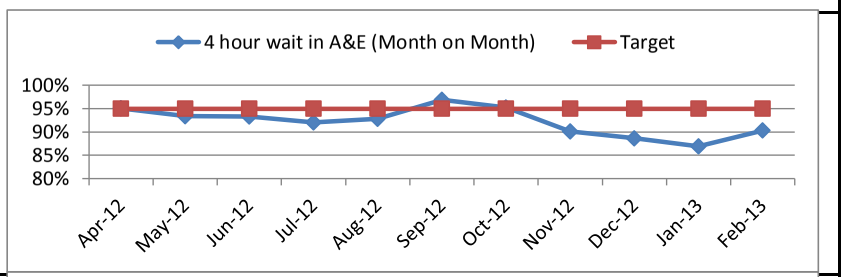
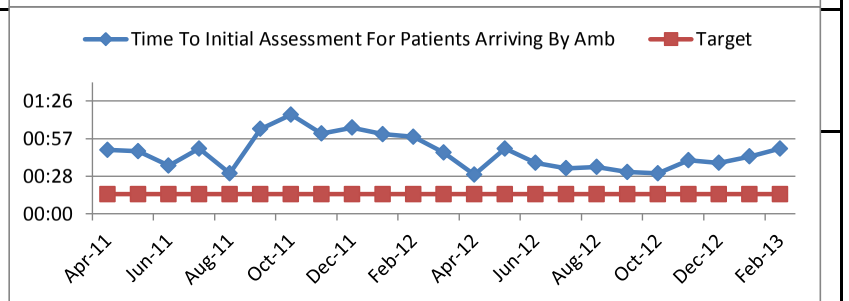
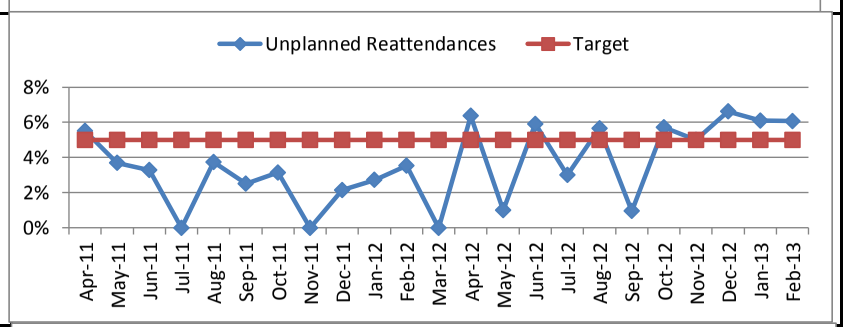
The performance measures acknowledge a small improvement in February those rated as red have marginally decreased in comparison to January (33/35), Amber rated measures

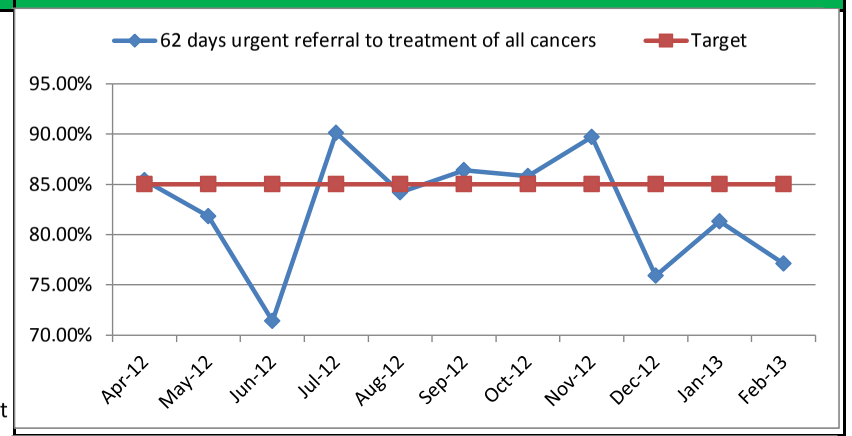
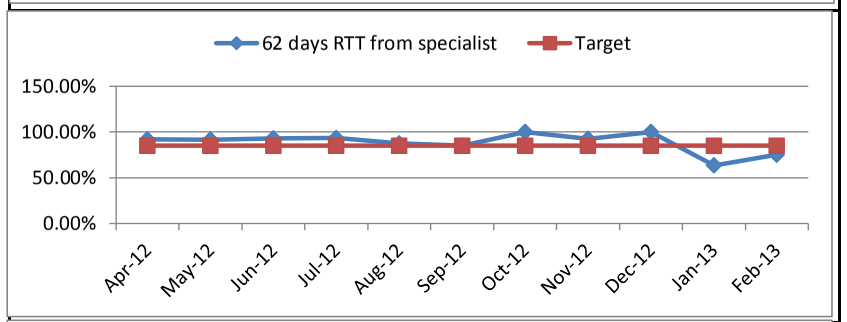
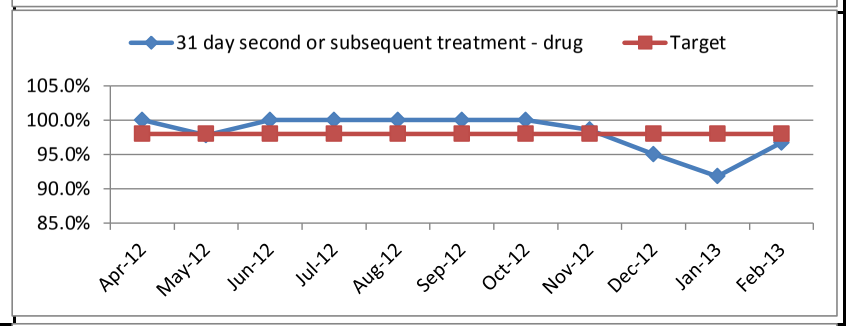
have also decreased (16/19) with the performance measures rated as green increasing (79/73).

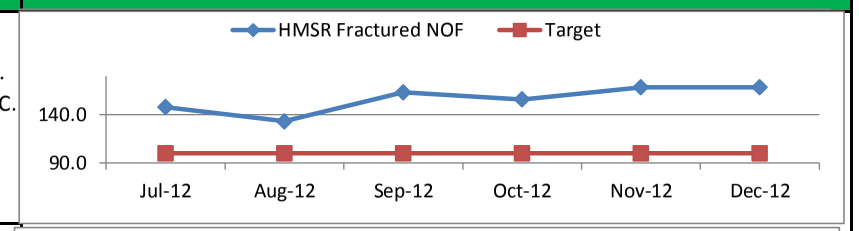
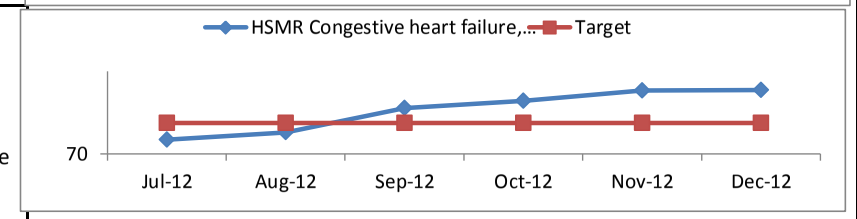
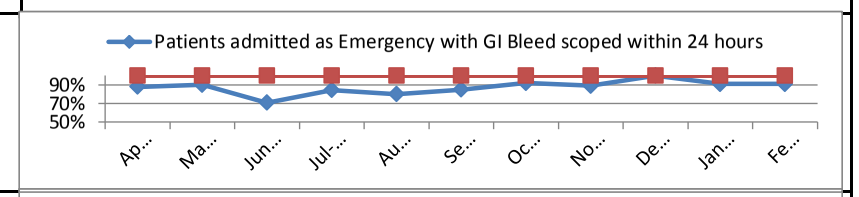
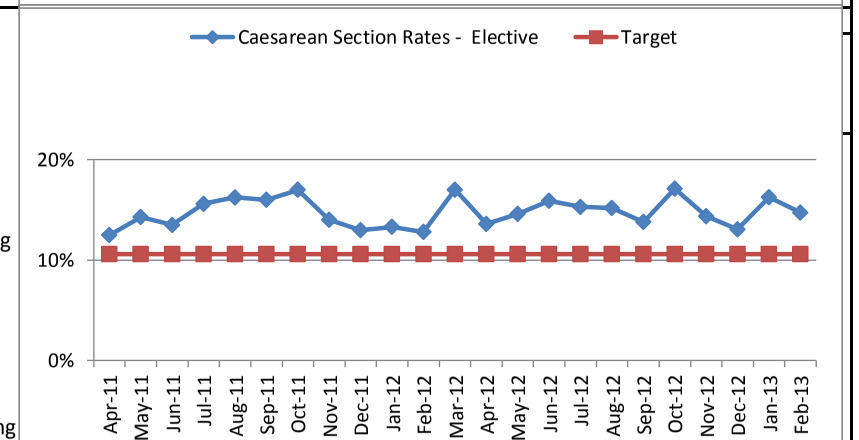
3. Recommendation

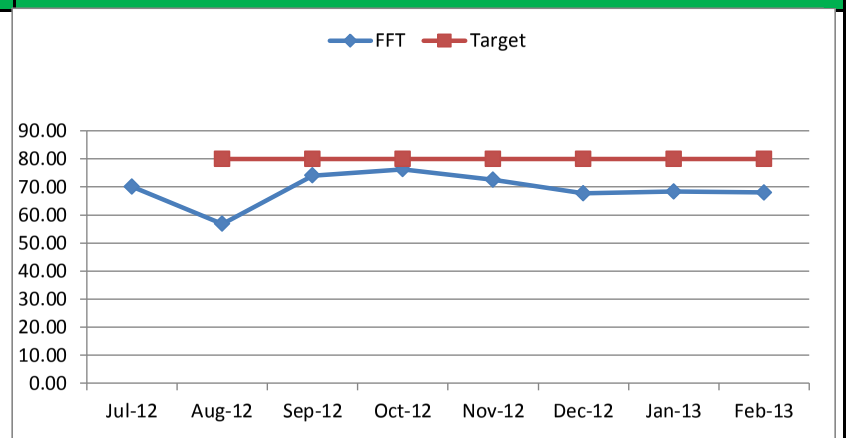
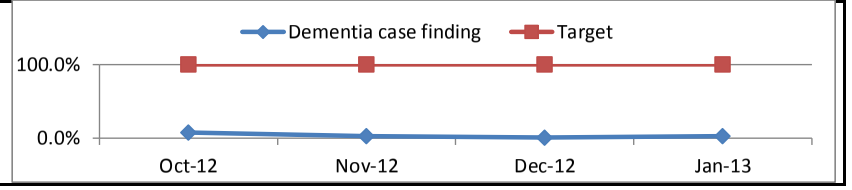
The Board is asked to note this scorecard and debate any issues that arise from it.

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	↑	Incidence of pressure ulcers - the target rate of pressure ulcers remained un-met in February with 1.99 pressure ulcers per 1000 bed days vs a target of 0.6. There were 3 grade 3 ulcers and no grade 4 pressure ulcers in February which is an improvement from January but the rate per 1000 bed days worsened, due to fewer bed days in February. With the return of the TVN there has been an increase in training, raised awareness and increase in reporting of all Pressure Ulcers which can been seen in the graph. There is a detailed Improvement Plan that has been rolled out, starting In January to reduce the number of avoidable pressure ulcers across the trust.	
Patient Safety	Reduce harm from falls Moderate/Major/Severe	0	↓	There were 2 falls in the major/severe category in February compared to 1 in January and 3 falls in the moderate category against 2 in the previous month. The Trust remains positively under the national falls per 1000 bed days trajectory.	
Patient Safety	Mandatory Training complaince	80%	→	Mandatory Training compliance for Primary Levels has continued to improve slightly in recent months, but continues to be below target at 65.4%. It is the responsibility of managers 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. Alternatives to attending face to face learning have been introduced e-learning and DVD`s are now available. Work has commenced to confirm accuracy of training reports through discussion with managers and raising concerns with the Mandatory Training Leads raising concerns with Mckeeson and data cleansing ESR.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↑	The key issues identified on the Healthcare Notes audit in February 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 but has improved since last month. 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. The importance of this has been reiterated to doctors in training and is planned to be discussed at the pending junior doctors induction and via screen saver communication .	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	Cancelled Operations not rebooked within 28 days	0%	↑	This target has again not been met in February with 1 cancelled operation not rebooked within 28 days. Whilst this does demonstrate an improvement in performance over the last two months, the recovery plan continues to be monitored at patient level through the Trust performance weekly meeting. The plan is forecast to demonstrate 100% compliance in April 2013.	
Patient Experience	A & E Quality Indicators (5 indicators)		↑	A & E Clinical Indicators: The A&E 4 hour wait target was again not met in February, with 90.3% of patients seen within 4 hours against the 95% target, although this was an improvement from the previous 3 months. 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.	
			↓	The time to initial assessment for patients arriving by ambulance was 50 minutes 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 has been submitted and waiting approval for increased clinical staff and workforce development within A&E and Acute Medicine.	
			↑	Unplanned reattendance rate - February 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.	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	Cancer Wait times		↓ ↓ ↑	All cancer standards are monitored quarterly however in February the Trust did not achieve the following standards: 62 days from urgent referral. During February the Trust achieved 75.8% against the standard of 85%. The reason for the breach include patient choice, complex diagnostic pathways. A recovery plan is being monitored through weekly performance meetings. The 31 day standard from decision to treat to start of subsequent drug treatment. During February the Trust achieved 96.7% against the standard of 98%, quarter 4 position is 93.8% and the year to date is 97.8%. The two breaches in February were as a result of patients not being medically fit to start their treatment. All of these figures are currently being validated.	  

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Clinical Outcomes	HSMR	<100	⬅	There continues to to be cause for concern in relation to mortality from Fractured Neck of Femur . All deaths are under review the Clinical Director will be presenting findings from the review to HGC. The surgical care group have been asked to develop an improvement plan for this cohort of patients.	
			⬅	Mortality for Congestive Heart Failure is a high risk diagnoses which is subject to scrutiny and continues to be monitored closey via the Medical Care Group reporting to HGC and via governance reports to CQEG.	
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 continued to be below target at 91% in February. This service is incorporated into the 7 day working planning proposal.	
Clinical Outcomes	Caesarean Section Rates	10.1%	⬆	The elective caesarean section rate remains above national average, 16.5% in February 2013. The emergency caesarean section rate is below national average and stable. The overall caesarean section rate is 29.4%. Actions to improve the elective caesarean section rate include implementation of a 'Birth After Caesarean' clinic from March 2013, accessible to all women having had a previous caesarean section. The pathway for women with a previous caesarean section has changed to become more midwife-led for those of low risk and remains consultant –led for those with additional complexity; all women are allocated a named consultant. Actions to demonstrate compliance with NICE guidance include, quarterly audits and a formalised debrief service for all women prior to discharge from hospital. The remaining action to normalise birth within NGH continues to limit the need for a caesarean section in the first pregnancy; a midwife led unit is being developed for implementation Summer 2013.	

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
CQUIN	Friends & Family Score	10 point improvement	⬅	The manual collection of the Friends and Family Test continues to elicit positive patient experience results. The FFT score received for the month of January 2013 was 68. This is the same result that was achieved in December 2012. Action plans have been requested from all areas which scored below 70.The focus for improvement is related to medicines and discharge processes. There is difficult capturing data and a blanced view of patient experience at the point of discharge. In addition, the Patient Experience Lead is visiting all wards to provide support for wards who are not meeting the data collection target. 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.	
CQUIN	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	90%	⬅	Performance against the Dementia case finding has been been poor this year to date, however reconfiguration of admission documentation and inclusion of this question on eDN is expected to improve compliance . Improvements have already been noted in the other dementia indicators in January.	

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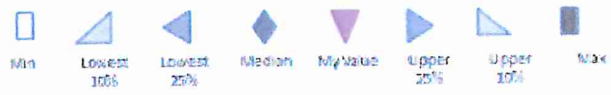
CNO reveals plans to make 6Cs a reality < >

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

Undesirable Alerts

No Alerts are available for this Organisation

Toyota Chart Key



Preventing People from Dying Prematurely

SHMI 1
09/2009 - 06/2012
Quarterly

Amenable Mortality	Deaths	%
11/2011 - 10/2012 *Monthly*	9	0.88

Distribution of Trusts for Amenable Mortality

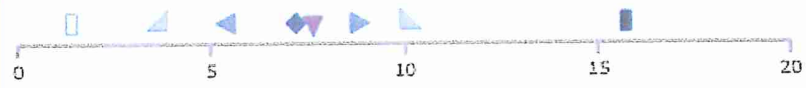
Quality of Life for People with LTC

Adults	Emergencies	%
11/2011 - 10/2012 *Monthly*	89	5.43

Distribution of Trusts for Adults

Under 19s	Emergencies	%
11/2011 - 10/2012 *Monthly*	31	7.64

Distribution of Trusts for Under 19s

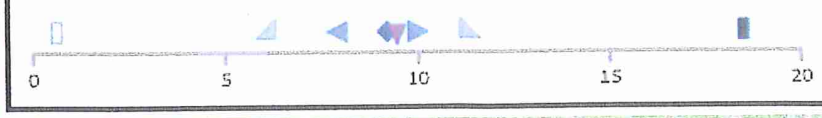


Helping People to Recover

Emergency Readmissions 30 days	Readmissions	%
11/2011 - 10/2012 *Monthly*	649	9.09

Emergency adm not usually requiring adm	Emergencies	%
11/2011 - 10/2012 *Monthly*	153	9.43

Distribution of Trusts for Emergency adm not usually requiring adm



Timely Care

A&E > 4Hrs	Waiting	%
16/12/2012 - 03/03/2013 *Weekly*	177	10.54

RTT> 18 weeks	Waiting	%
01/2012 - 12/2012 *Monthly*	49	3.53

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

Safe Enviroment and Protecting People from avoidable harm

Infections	Incidents	per 1,000 beds
01/2012 - 12/2012 *Monthly*	18	0.89

Serious Incidents	Incidents	per 1,000 beds
01/2012 - 12/2012 *Monthly*	10	0.49

Never Events	Incidents	per 1,000 beds
03/2010 - 12/2012 *Quarterly*		

Harm Free Care	%
02/2012 - 01/2013 *Monthly*	90.8

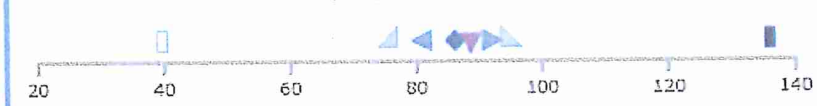
Organisational Indicators

Staff Sickness	%
01/2012 - 12/2012 *Monthly*	4.87

Distribution of Trusts for Staff Sickness

Bed Occupancy	Rate
01/2010 - 10/2012 *Quarterly*	88.54

Distribution of Trusts for Bed Occupancy



Nurses to Bed Ratio	Ratio
12/2011 - 11/2012 *Monthly*	1.37

Distribution of Trusts for Nurses to Bed Ratio

Doctor to Patient Ratio	Ratio
12/2011 - 11/2012 *Monthly*	0.15

Distribution of Trusts for Doctor to Patient Ratio

Trust Board meeting: 28 March 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 February 2013.

CRITICAL POINTS:

- Friends and Family Test (FFT) Scores for February 2013
- A&E pilot FFT scores
- CQUIN quality results

ACTION REQUIRED BY BOARD:

The Board is requested to:

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

Enclosure 4

PATIENT EXPERIENCE

1.0 Introduction

The purpose of this report is to: -

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

2.0 Patient Experience monitoring

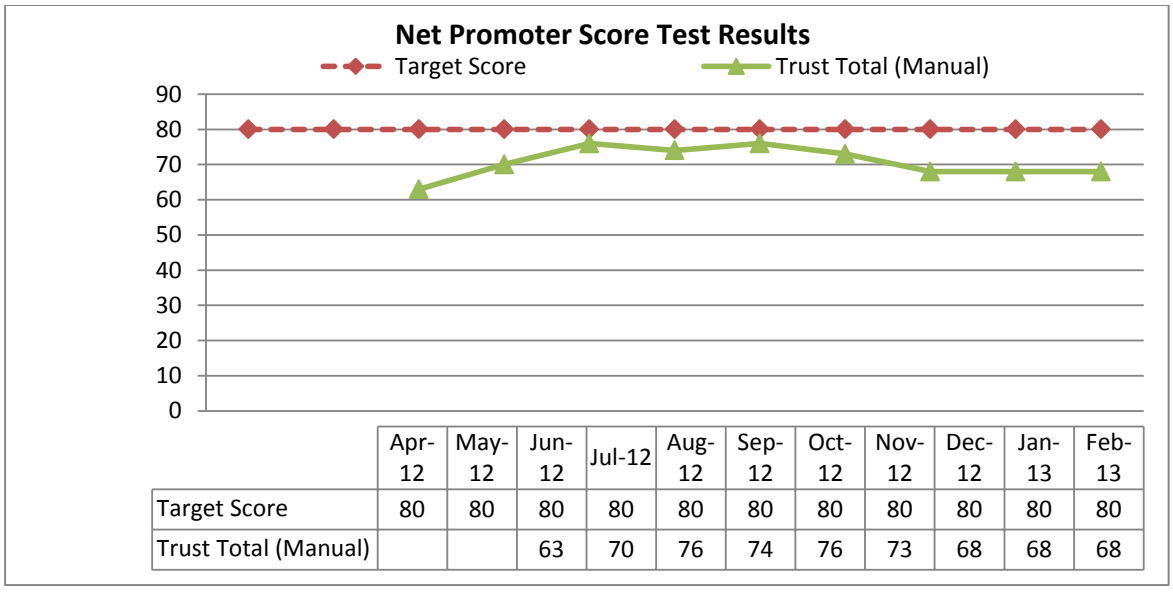
2.1 Friends and Family Test

The Friends and Family Test (FFT) 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 as part of an East of England SHA pilot. The national rollout takes place from 1 April 2013. The data from April will be published nationally from July 2013. There is a change to the question and to the scoring system. From 1 April 2013 patients will be required to comment on a six point scale ranging between: 'extremely likely' to recommend to 'don't know'. Work is now underway to ensure that the teams are aware of these changes in scores and presentation of results.

2.2 The latest FFT Results: February 2013

Feedback received through the manual collection of the Friends and Family Test continues to be positive – See below. The FFT score received for the month of February 2013 was again 68. This is the same result that was achieved in January 2013 and below the 73 which was scored in November 2012.

Table 1: Monthly Friends and Family (Net Promoter) scores April – February 2013



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

FFT data collection
4438 patients were discharged from Northampton General Hospital in February 2013 of which, 844 patients responded to the FFT question i.e. 19% (this is above both the 10% target for this year and next year's target of 15%).

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.

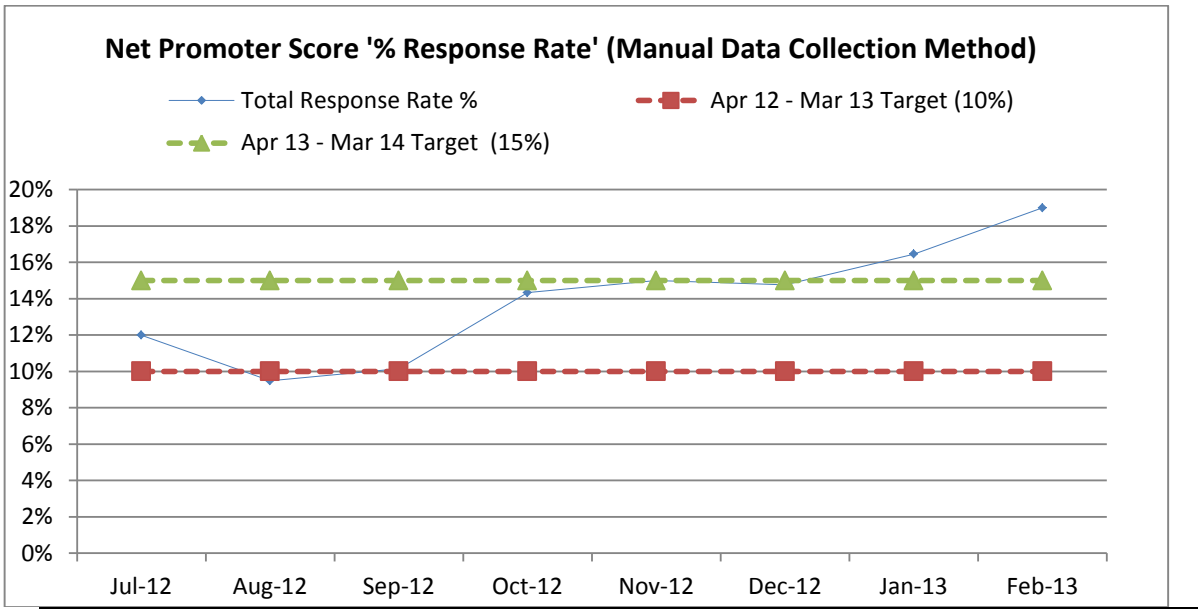
Comments received from these patients were circulated to Ward Sisters. Actions taken as a result of these comments continue to be included in the "You said: We did" comments on the Patient Quality Board located within ward areas.

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.

The FFT is now going to be available in alternative languages – starting with Polish to ensure equity of access to all.

A presentation was made to the Matrons meeting reaffirming the FFT data collection process and expectations. Following this meeting a series of 1:1 meetings have been held with the ward sisters to identify ways of increasing response rates and discussing how the score is calculated. Where comments have been included with the scores, discussion centred on steps that could be taken the address these.

Table 2: FFT results for % footfall – target is over 19%



Work is now underway to hold a raising awareness session with ward staff to reinvigorate the importance of the FFT and reiterate the need for all patients to have an opportunity to comment. Where wards have a larger elderly popluation or patients for whom the paper based tool is not easily accessible – work is underway to look at other ways of accessing patient statisfaction data to ensure a triangulation of ward feedback from all areas.

Within A&E work continues to increase the opportunities for patients to complete the FFT question as follows:

- Via the use of an e-kiosk.
- Approval has been received 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. This has been completed

2.0 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.

CQUIN 2012-13	Target 2012-13	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	RAG (based on most
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)									
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	63.2%	74.6%	79.2%	72.0%	72.4%	66.7%	34.8%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	66.6%	83.2%	82.5%	76.2%	84.9%	65.2%	86.4%	
Did you have enough privacy when discussing condition or treatment?	>82.3	73.1%	81.5%	85.0%	86.4%	87.0%	79.2%	76.2%	
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5	55.9%	52.2%	21.4%	50.0%	32.0%	48.4%	60.0%	
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	56.5%	50.0%	50.0%	48.8%	37.5%	63.6%	58.3%	

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.). 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 was not successful with no applicants coming forward. The Patient Experience Lead has spent time talking to the ward sisters to understand what the issues are and where possible discuss ways of making this proposal work.

Whilst the ward staff are keen on the concept - the issues centre around staff being required to undertake further duties / responsibilities as part of existing roles with no allowance being made for their time commitment. The Patient Experience Lead is meeting the clinical leads who have expressed an interest in patient experience to discuss this further and agree the next steps.

The next meeting of the Patient Experience Board in 26 April 2013 at which the new proposals will be presented.

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:
Following a meeting with the Head of Medical Records and Patient Administration – the plan is to meet with the directorate managers from the areas where complaints about the existing patient letters were made – then to trial the new look letter and via the use of volunteers measure the response. The Patient Experience Manager is currently scoping this piece of work.

Patient Information:
The process for agreeing the on-going 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 is 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

The Board is requested to:-

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

Enclosure 4

Friends & Family Net Promoter Score Results (Manual)

Ward	Graph	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Abington		50	40	40	67	39	70	73	63
Allebone		0		50	50	64	-8	32	45
Althorp		40	50	15	67	89	71	87	93
Balmoral		63	73	78	80	79	69	78	79
Becket		56	56	40	41	93	68	21	43
Benham		89	100	70	70	70	41	50	53
Brampton		50	90	70	60	45	70	93	77
Cliftonville		100							
Cedar		38	56	58	64	53	50	65	65
Collingtree Medical		83	25	80	78	82	82		29
Compton							88	81	70
Corby Comm.						67	87	100	
Creaton		83	100	40	72	100	64	36	40
Danetre								92	67
Disney		79	82	68	71	69	82	96	67
Dryden		33	80	80	94	67	80	100	80
EAU		80	100	57	36	77	67	60	73
Eleanor		86	67	82	100	75	92	100	50
Finedon		100	0	78	80	58	67	71	50
Hawthorn		91	89	75	90	85	65	56	78
Hazelwood Comm.		60		33	67	47	86	83	
Head & Neck		81	100		96	78	92	76	80
Holcot		68	85	70	68	65	100	91	92
Knightley		89	69	64	63	90	72	75	100
Paddington		24	87	57	57	51	33	56	46
Robert Watson		68	83	76	76	83	69	54	85
Rowan		57	69	75	93	65	62	67	65
Spencer		93	90	100	68	77	89	87	91
Talbot Butler		100	100	92	80	68	63	77	70
Victoria							50	27	33
Willow		90	100	83	90	84	94	89	75
Trust Inpatient Area Total		70	76	74	76	73	68	68	68
Accident & Emergency Dept								0	4
Danetre Day Surgery								91	96
Main Theatre Admissions									92
NGH Day Surgery								91	97

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

PURPOSE OF PAPER: -

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

February 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.

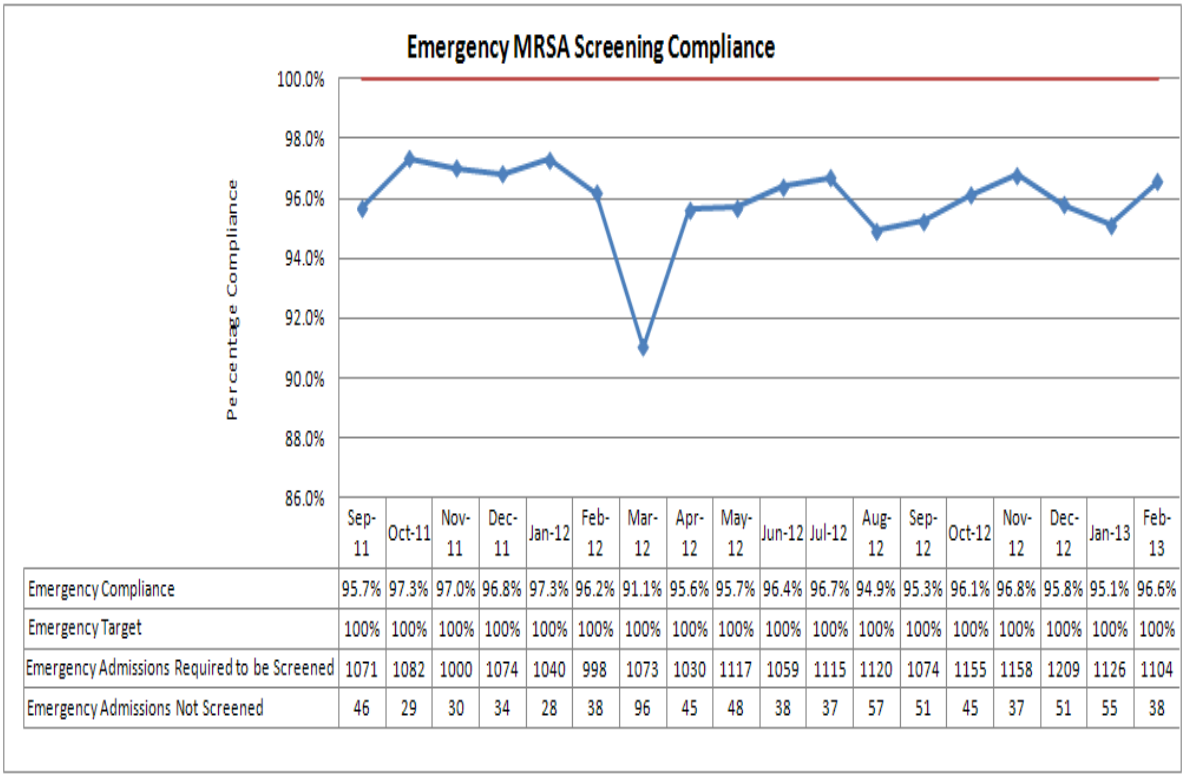
2.1 MRSA Bacteraemia

The Trusts trajectory for MRSA bacteraemia in 2012/13 is one case. During February 2013 there were 0 >48hrs MRSA bacteraemia. The total remains at two cases.

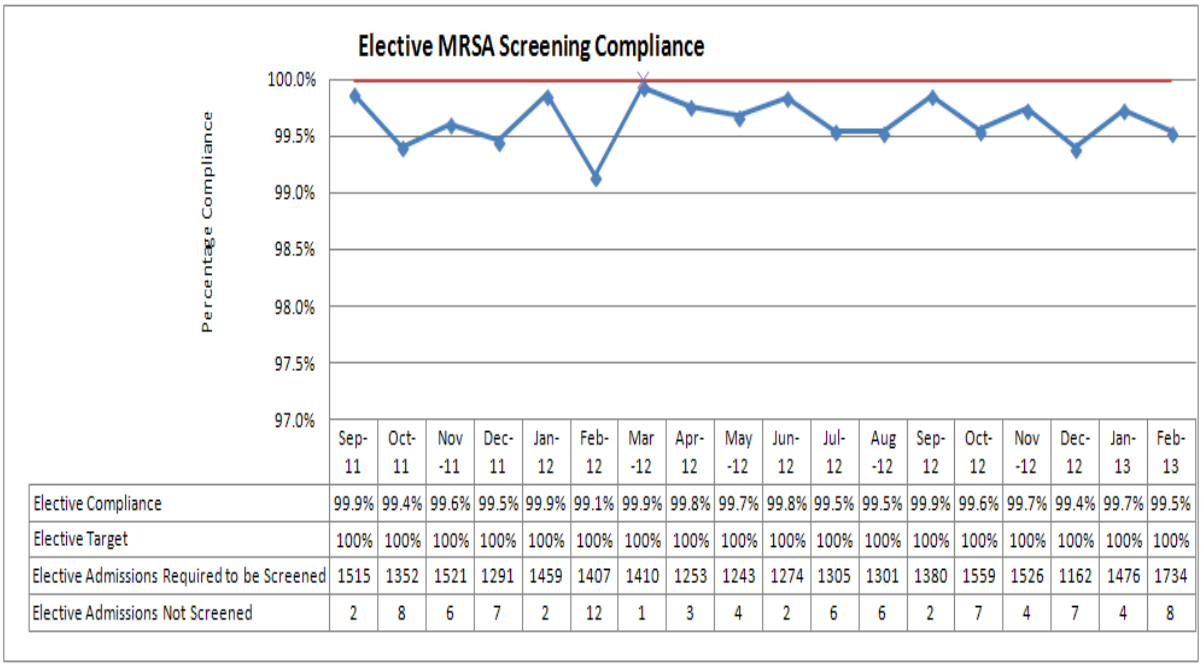
2.2 MRSA Colonisation & Screening

During February there were 7 <48hrs and 6 >48hrs cases of MRSA colonisation.

Compliance with elective and emergency screening is demonstrated via the graphs below. Elective has dropped slightly this month (possibly due to 'winter pressures'), and the emergency screening compliance has increased from last month. They continue 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	Feb-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%	96.6%
Emergency Target	100%	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	1104
Emergency Admissions Not Screened	46	29	30	34	28	38	96	45	48	38	37	57	51	45	37	51	55	38



	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	Feb-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%	99.5%
Elective Target	100%	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	1734
Elective Admissions Not Screened	2	8	6	7	2	12	1	3	4	2	6	6	2	7	4	7	4	8

2.3 Special Measures - MRSA

Definition

A period of increased incidence is defined by the Health Protection Agency as two 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.

There was no ward on special measures for February 2013

2.4 Guidance on the reporting and monitoring arrangements and Post Infection Review (PIR) process for MRSA bloodstream infections from April 2013

The guidance has been developed by the Department of Health (DH) in conjunction with the NHS Commissioning Board to facilitate delivery of the zero tolerance MRSA objective set out in the Planning Guidance '*Everyone counts: Planning for Patients 2013/14'*. This document outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

The Post infection Review process (PIR) replaces the current requirement to undertake Root Cause Analysis (RCA). Instead, the review will be conducted by a multidisciplinary clinical team that will review the bloodstream infection event and identify factors that contributed to it. The PIR process requires strong partnership working by all organisations involved in the patient's care pathway. This close collaboration will enable organisations to jointly identify and agree both the possible causes and any factors contributing to the patient's MRSA BSI.

The organisation to which the case is initially assigned (either the acute trust or CCG (Clinical Care Group) will be the lead organisation responsible for completing a PIR within one week of the date of assigning. The outcome of the PIR should establish the organisation to which the bloodstream infection (BSI) should be finally assigned. The final

assignment will identify the organisation best placed to ensure that any lessons learned are acted upon, although it is recognised that there may also be cross organisational learning. The final assignment must be logged on the data capture system (DCS) within 7 days of the initial assigning.

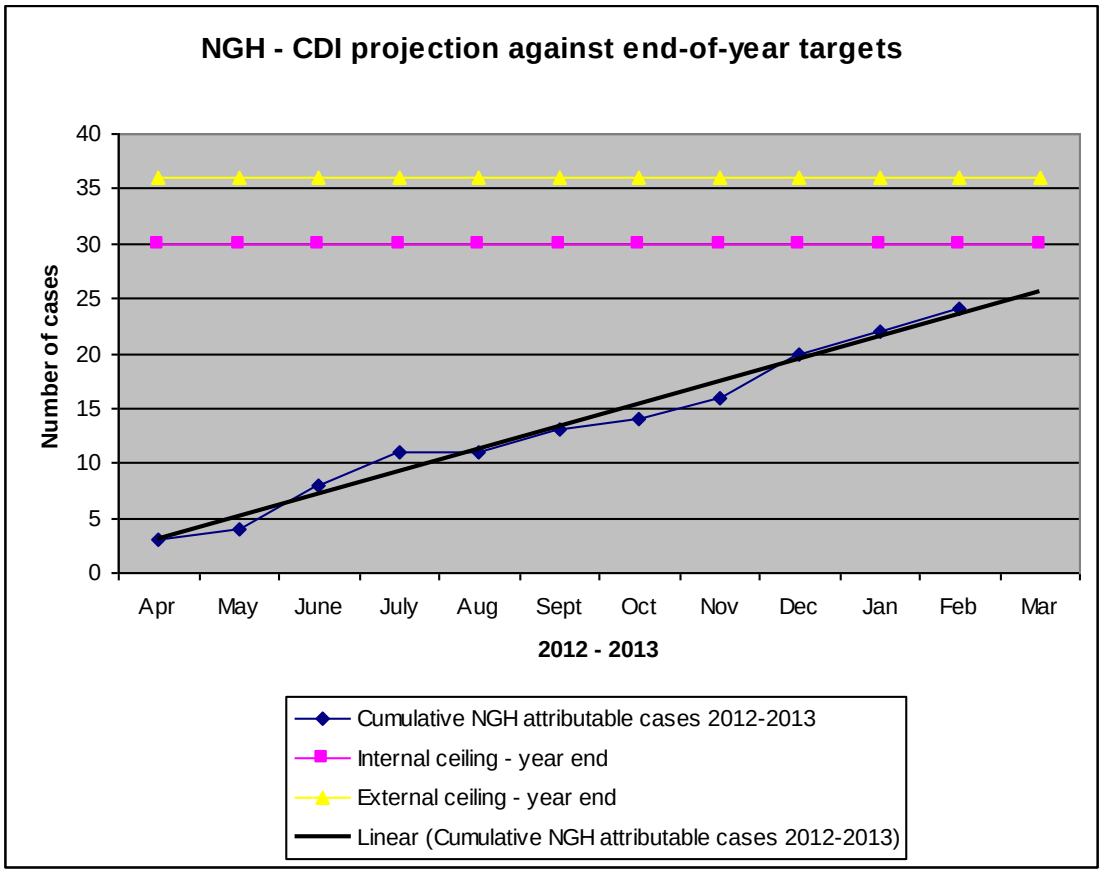
This process emphasises a whole health care approach and within our Trust we have always maintained this approach through our root cause analysis (RCA) and robust networking within the community and the local hospitals. Our new Serious Incident process also supports this PIR approach.

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

During February 2013 there were 3 <48hrs and 0 >48hrs MSSA bacteraemia case.

3. Clostridium difficile

The Trust has an annual target of 36 C. diff. cases (3 per month) or less for the financial year. During February 2 *>3 day case of C. diff* were identified**,** which totals 25 >3 day cases of C. diff for the year, which is slightly below trajectory.



In February 2013, there were no wards on special measures.

The new C Diff target has been set for 2013/14 as 29 cases (a reduction of 7 cases from this year). Unlike this year where 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.

4. 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).

4.1 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 February 2013:

- Repair of fractured neck of femurs(#NOF) show that there were *no infections* resulting from 31 operations
- Vascular surgery show that there were *no infections* resulting from 15 operations
- Spinal surgery operations show that there was *no infections* resulting from 14 operations

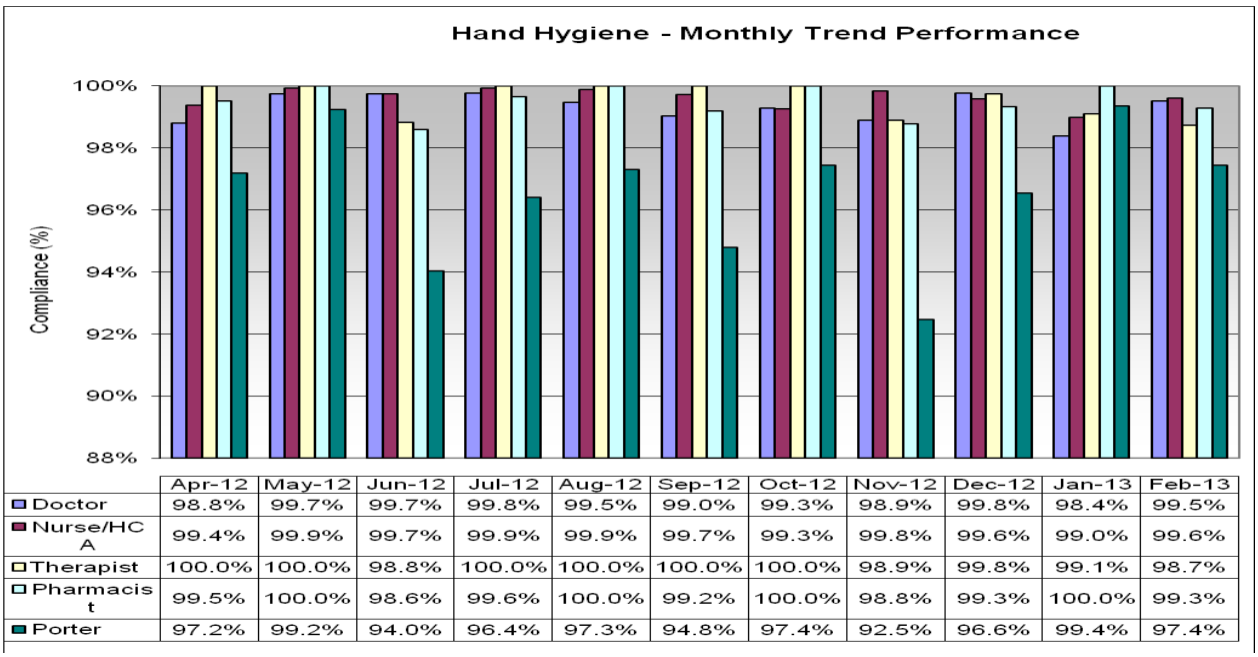
All these results are fed back to Clinical Quality and Effectiveness Group (CQEG) on a monthly basis.

5. Hand Hygiene Audit

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

- February overall Trust compliance for hand hygiene = 92%**,** due to 6 areas failing 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. One of the reasons for failing to submit is that the date of submitting was changed to a week earlier and some areas had forgotten. This will be discussed this month at the Infection Prevention Committee meeting and the findings reported in the next board report. The graph below demonstrates hand hygiene compliance in the ward areas, is considerably higher than the overall trust score.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Doctor	98.8%	99.7%	99.7%	99.8%	99.5%	99.0%	99.3%	98.9%	99.8%	98.4%	99.5%
Nurse/HCA	99.4%	99.9%	99.7%	99.9%	99.9%	99.7%	99.3%	99.8%	99.6%	99.0%	99.6%
Therapist	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	98.9%	99.8%	99.1%	98.7%
Pharmacist	99.5%	100.0%	98.6%	99.6%	100.0%	99.2%	100.0%	98.8%	99.3%	100.0%	99.3%
Porter	97.2%	99.2%	94.0%	96.4%	97.3%	94.8%	97.4%	92.5%	96.6%	99.4%	97.4%

6. Update of Scalded Skin Syndrome

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

Cases are still being reported and at the last meeting there were eight confirmed cases and potentially a ninth case. The Health Protection Agency (HPA) reported that seven babies' swabs went for typing and these cases had the same DNA fingerprint. The 8th case has come back with a totally different strain.

Environmental swabs of the ward, including high and low surfaces were taken and the results are negative. Additional swabs are being taken of external & internal vents above the observation area, birthing pool and training area. The results came back negative.

As the ad hoc case continues to be identified, it was agreed that approximately 350 staff who work within or enter the maternity environment would be comprehensively screened and any staff who identified as positive would be decolonised if a further attempt to identify the source of the outbreak.

Post Script: On the 20 March 2013, it was confirmed that the last 3 babies who had been identified as possible scalded skin syndrome were tested negative to the outbreak strain. This now reduces the outbreak to two defined periods of time in December 2012/January 2013 (4 babies) and February 2013 (3 babies). The Trust will continue to monitor the situation and will not conclude the outbreak until it confirms with the HPA that it is appropriate to do so.

7. Special measures for Vancomycin Resistant Enterococci (VRE)

Enterococci is a bacterium that colonises the gut of most healthy people, it can cause infection from patients own body flora. More frequently in recent years it has been shown to cause healthcare associated infection. Enterococci are resistant to many commonly used antibiotics for example, Cephalosporin. However enterococci may develop resistance to Vancomycin making the treatment of an infection with the bacterium problematic. Patients

admitted to a renal ward are at greater risk of becoming infected or colonised with VRE (Vancomycin Resistant Enterococci).

The renal ward had 2 patients identified with Vancomycin Resistant Enterococci (VRE) within a 28 day period during the month of February 2013. Special Measures included a meeting with the modern matron, ward Sister and a member of the infection prevention team. The special measures included daily saving lives audits undertaken by the ward over a two week period. This included the renal dialysis care bundle, care of central vascular access devices (CVC) and an audit of the prescribing of Octenisan decolonisation treatment which is prescribed for all patients undergoing renal dialysis. Daily observational hand hygiene audits were undertaken and observation of 23 members of staff. Hand hygiene technique was observed by a member of the infection prevention team. The hand hygiene technique was found to be excellent. This is still ongoing and a final report will be given in the next board report.

8. Blood Borne Virus (BBV) Incident

An incident occurred on a ward in January 2013, when a patient was commenced on haemodialysis without Blood Borne Virus (BBV) screening being performed. DH (Department of Health) guidelines state that all patients should be tested for blood borne virus (BBV) prior to commencing haemodialysis. It was determined that the patient was chronically infected with Hepatitis B. Two further patients had subsequently been dialysed on the same machine as this patient before staff were aware of the situation. These patients were managed appropriately with immunoglobulin and HB vaccine. However during the investigation, it became apparent that BBV screening was not being routinely undertaken on any patient prior to haemodialysis. This was rectified immediately it was identified. A serious incident (SI) meeting has been undertaken and a report is being generated by the ward manager and the clinical leads of the department.

9. 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.

10. Recommendation

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

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 28 March 2013	
Title	Urgent Care Programme Update
Presented by	Dr J Timperley

PURPOSE OF PAPER: -

This paper outlines the programme of the Urgent Care Project Board and work plan of the working groups.

SUMMARY OF CRITICAL POINTS: -

- Performance against the 95% Four Hour Targets remains inconsistent
- Attendances and emergency admissions are higher than the previous year
- The work streams within the urgent care programme continue to work to plan and updates are provided within the report
- Benchmark performance is included within the report

RECOMMENDATION:-.

The Board is asked to review and discuss this paper.

Northampton General Hospital NHS
NHS Trust

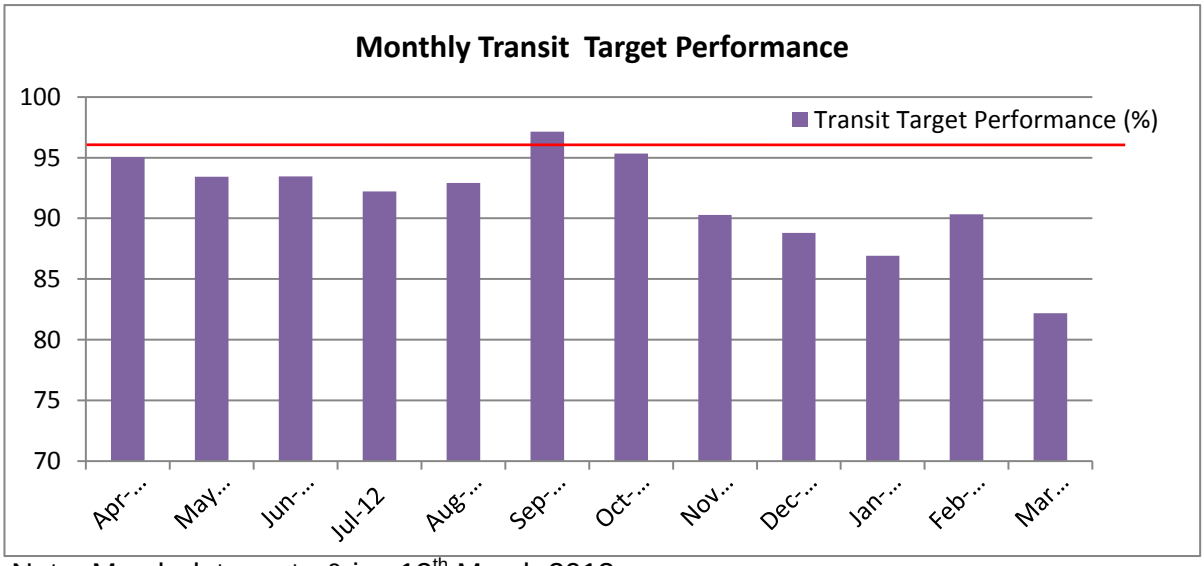
Urgent Care Programme Update
Trust Board – 28 March 2013

1. Introduction

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

2. Current Performance

Throughout 2012/13 performance has been variable with achievement of the 95% standard in April, September and October 2012. The Year to date performance is 92%.



Note: March data up to & inc 12th March 2013

During 2012/13 attendances have been 2% higher and emergency admissions have been 5% higher than the previous year.

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

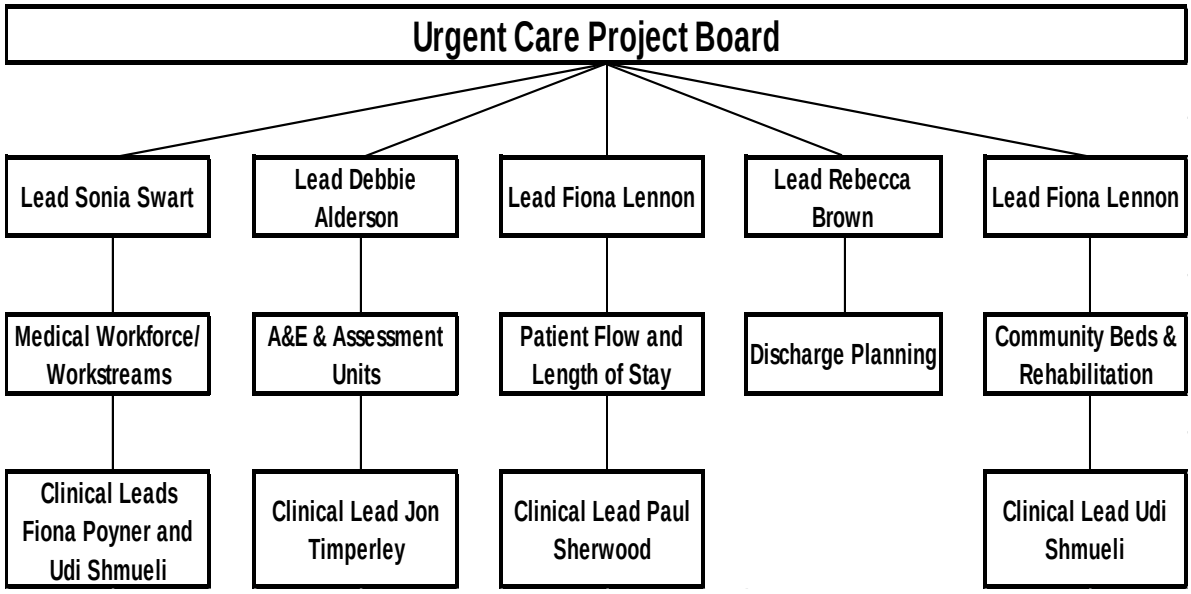
The following information highlights the year to date performance (up to and inc. Feb 2013) for all acute Trusts within the East Midlands.

Trust 1	96.20%
Trust 2	95.55%
Trust 3	94.47%
Trust 4	94.44%
Trust 5	93.73%
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	92.25%
Trust 7	92.24%
Trust 8	92.77%
Trust 9	91.82%

Currently there are no regions where all acute Trusts are performing above the 95% standard YTD.

4. Overview of Work Streams

The framework for the project remains unchanged and work streams are highlighted below.



Each work stream is clinically led and works to a project plan which in turn informs the Urgent Care Board (UCB) and update reports are given by each work stream at the monthly UCB.

Since the last report to Trust Board in January 2012, additional achievements for each work stream are outlined below:

4.1 Medical Manpower

- Objective:

The Medical Manpower group was established to develop solutions to the current issues arising from difficulty in recruiting and retaining Middle Grade and Consultant staff in Accident and Emergency areas.

- Achievements:

- Draft strategy written
- New medical model identified, to ensure greater level of senior input
- Draft business case completed, to provide flexibility to recruit a range of medical staff

4.2 A&E and Assessment Units

- Objective:

The working group is focusing on actions which reduce delays in A&E and assessment areas; and where appropriate implementing best practice from across the NHS.

➢ Achievements:

- Age UK pilot commenced 15th March 2013 to enable volunteers to support frail and elderly patients
- 6 ambulatory care pathways agreed to avoid admission
- Review of medical handover and changes implemented
- Review of ward rounds on Emergency Assessment Unit (EAU) and changes made to ensure work is completed by the most appropriate person at the time of the round to identify patients for discharge as soon as possible

4.3 Patient Flow and Length of Stay Working Group

➢ Objective:

The patient flow group was established to improve processes pertaining to patient flow and discharge. Areas focussed on include acute adult wards and bed management.

➢ Achievements:

- Further development of professional standards for acute wards
- Implementation of the visual hospital to enable easy review of patients
- Review and changes to ward rounds within medicine to enable timely discharge

4.4 Discharge Planning Working Group

➢ Objective:

The focus of the group is to review the interface between the Trust and external partners on all aspects of hospital discharge. To objective is to reduce actual delays within the current discharge processes.

➢ Achievements:

- Process developed for reimbursement
- Interim Placement Process in place
- Changes made to the Continuing Healthcare Funding process
- Senior review in place

4.5 Community Beds and Rehabilitation Working Group

➢ Objective:

The focus of the working group is to ensure effective utilisation of community based beds and improve patient flow for patients requiring rehabilitation as part of their patient pathway.

➢ Achievements:

- Weekly Multi-disciplinary team meetings
- Therapy input to Cliftonville Ward
- Daily patient review to enable timely discharge

5. Risks to Delivery

Each project has identified risks to delivery. The summary for the whole programme is outlined below:

	Risk	Score/ RAG	Mitigation
1	Project work does not realise reduced waiting times, planned reduction in length of stay, or increased discharges.		Effective and robust project management established to identify delays/risks at earliest opportunity.
2	Lack of staff engagement cause project to not deliver expected efficiency gains		Managed via Urgent Care Project Board. Ensure adequate communications plan is embedded throughout programme / work plan. Escalate through Transformation Delivery Group when necessary.
3	If A&E attendances are not reduced and capacity is not created in the Trust, patients may experience increased waiting times in A&E.		Improving patient flow of admissions will ensure that delayed patients in A&E or other admission areas will be reduced.
4	Nurse Facilitated Discharge (NFD) – if protocols are not followed opportunities for discharges reduce.		Strict and robust policy for NFD, regularly reviewed with consultants.

6. Recommendation

The Board is asked to review and discuss this paper.

TRUST BOARD – 28 March 2013	
Title:	**Resilience Planning Update**
Presented by:	**Rebecca Brown**

SUMMARY OF CRITICAL POINTS:

- The Trust has completed much of its Resilience Programme with Major Incident and Business Continuity Plans in place across the Trust.
- In order to embed this planning a programme of training and exercising is now in place.

RECOMMENDATION:

The Board is recommended to accept the proposed activity for the coming year and to support staff in its delivery.

Resilience Planning Group
Annual report to the Trust Board

1. Introduction

Resilience Planning at Northampton General Hospital NHS Trust (NGH) is made up of two distinct but closely linked work streams:

- Major Incident Planning is the activity of the trust to ensure its capability to contribute to the county response to a major incident. This is likely to involve the provision of urgent health care to those affected by the incident.
- Business Continuity Management is the activity of the trust to ensure its ability to continue to provide its critical services in the face of an incident or event directly affecting the staff, resources, property or suppliers of the trust.

Some incidents may require the trust to implement both its major incident and business continuity plans, one example of this may be a pandemic influenza outbreak.

2. Legislative Background

The Civil Contingencies Act 2004 created two tiers of responder to major incidents. As a Category One responder the trust has six duties:

- Risk assessment
- To plan
- To develop a business continuity programme
- Co-operate with other responders
- Warn and inform the public
- To share Information with partner agencies

In addition to this the DH and Commissioning Board have published a range of guidance material, the key element being the Department of Health Emergency Planning Guidance 2005 (due for review) which places a responsibility on the Chief Executives of all NHS Trusts to:

> 'Ensure that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisations arrangements for ensuring business continuity as required by the CCA 2004'

The provision of Resilience Planning is included in the CQC standards 4, 6 and 10.

The Chief Operating Officer is currently the Trusts nominated Emergency Planning Officer (EPO), however the day to day responsibility is delegated to the Care Group Director (Medicine) who chairs the trust's Resilience Planning Group and line manages the Head of Resilience.

3. Resilience Planning Group

The aim of the NGH Resilience Planning Group is:

> **'**To provide assurance of trust-wide engagement in the development and implementation of resilience planning at Northampton General Hospital NHS Trust.'

This is to be achieved through the following objectives:

- To provide a forum for all directorates and departments of the trust to engage in the on-going development of the trusts resilience plans
- To ensure that all resilience planning activity undertaken both corporately and within directorates has trust-wide acceptance and relevance
- To provide assurance to the trust's Strategic Management Board of the trust's preparedness for major incident, business continuity or related events
- To provide a single point of reference and forum for discussion for all aspects of resilience planning within the trust

4. Resilience Planning Group Priorities

The Resilience Planning Group will in 2013 prioritise the following areas of work:

- Review, training and exercising of the trusts local and corporate Major Incident Pans
- Review and further development of Business Continuity Plans for the trust's high level risks
- Delivery of further CBRN training and exercising

5. Recommendations

The Board is recommended to accept the proposed activity for the coming year and to support staff in its delivery.

Appendix 1: Activity to Date and Programmed Activity

Work Stream	Legislative/Quality Standard Requirements	Activity	Current Status and 2012/13 Progress	Priorities for 2013/14
Major Incident Planning	• Civil Contingencies Act 2004 • DH Emergency Planning Guidance 2005 • CQC Standards 4 and 6 • DH Estates Lockdown Guidance • Commissioning Board EPRR Guidance	**Corporate Major Incident Planning**	• The trust has a completed Resilience Policy. • The group has ratified the Corporate Major Incident Plan. • A Lockdown procedure has been ratified and exercised. • A draft Trust Evacuation Plan has been developed by a sub-group and is under review. • Local plans have been ratified trained exercised and reviewed in all areas. • The trust has an electronic notification system in place. • The trust has completed a large scale 'Emergo' style exercise. • The trust has responded to a local major incident and a post incident report has been published. • All key roles have received training and this process is on-going.	The trust will during 2012/13: • Continue to deliver training to staff filling key roles in the corporate plan. • Finalise, train and exercise appropriate evacuation procedures. • Further implement the use of the electronic call out system to all areas of the trust. • Support the review of training and exercising of local plan.

Work Stream	Legislative/Quality Standard Requirements	Activity	Current Status and 2012/13 Progress	Priorities for 2013/14
		Multi-agency Engagement	• The trust is represented at the Local Health Resilience Partnership (LHRP) by the Care Group Director (Medicine). • The Head of Resilience is engaged in key local resilience forum groups. • The trust is represented at Northamptonshire Local Resilience Forum (NLRF) by the CB LAT. • The trust is engaged in multi-agency exercises and training. • The Trust is engaged in various regional resilience activity.	
		Internal Engagement	• The Head of Resilience has full access to and support from the Care Group Directors, General Managers and Service Managers across the trust. • Agreement by senior managers to pursue and support the resilience agenda. • All areas of the trust are represented and engaged at the Resilience Planning Group.	

Work Stream	Legislative/Quality Standard Requirements	Activity	Current Status and 2012/13 Progress	Priorities for 2013/14
Business Continuity Management (BCM)	• Civil Contingencies Act 2004 • British Standard BS25999 • DH Resilience Project Guidance • CQC Standards 4, 6, 10 and 11 • CB EPRR Guidance	**Corporate BCM**	• The trust's BCM policy is ratified. • Business Impact Analysis (BIA) Plans and action cards completed in all directorates. • The trust has tested and updated its Adverse Weather Plan. • BCPs are in place in Estates and IT. • Corporate BCM Plan completed	• Develop a trust-wide Business Continuity Response plan based on the outputs of the local plans and the Major Incident Plan. • Support the delivery of BCM training across the Trust. • Review current BCM plans in all areas and develop those for high risk areas. • Development of specific plans for very high risk functions (i.e. A+E, Gosset).
Pandemic Influenza Planning		**Corporate Pan Flu Planning**	• The trust's Pandemic Influenza Plan was tested during 2010/11 and lessons identified. • The trust's Admissions and Triage Plan was tested during 2010/11 and lessons identified. • The trust vaccination programme is well established. • ITU surge response plan has been tested and lessons identified. • Paediatric Flu response plan has been ratified and trained.	• Lead a review and update of the trust plan. • Support an update of local plans.

Work Stream	Legislative/Quality Standard Requirements	Activity	Current Status and 2012/13 Progress	Priorities for 2013/14
Chemical Biological Radiological and Nuclear (CBRN) Planning		**Corporate CBRN Planning**	• The trust CBRN plan has been ratified trained and exercised. • A training programme is on-going. • The trust decontamination facilities have undergone a major overhaul and exercised. • The county 'on-site' plan is completed and agreed.	• Deliver further training for A+E and ward staff. • Identify and train appropriate staff to manage the decontamination facilities during and incident. • Finalise the works required to the decontamination facilities identified in the exercise. • Continue to work in conjunction with outside partners.

TRUST BOARD - 28th MARCH 2013	
Title: -	Performance Report
Presented by: -	Christine Allen – Interim Chief Executive

PURPOSE OF PAPER: -

This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 11 (February 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 11 **(February 2013)**.

- The Trust did not achieve the 4 hour transit time standard for February 2013 with 90.33% of patients being treated within 4 hours against the standard of 95%. Year to date position is 92%

- The cancer targets are monitored on a quarterly basis. For February the Trust did not achieve three cancer standards;
  - 62 days from referral to treatment with 77.1% of patients treated against the standard of 85%. Quarter 4 performance to date is 79% and year to date is 82.8%
  - 62 days from consultant upgrade to start of treatment with 75% against the standard of 85%. Quarter 4 performance to date is 70.05% and year to date is 88.5%.
  - 31 day standard from decision to treat to start of subsequent drug treatment with 96.7% against the standard of 98%. Quarter 4 performance to date is 93.8% and year to date is 97.8%.

- The Trust achieved all the other performance standards for February 2013.

ACTION REQUIRED BY BOARD: -

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

PERFORMANCE REPORT – MARCH 2013

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 11 (February 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 the detailed score card.

2.1 February Performance

During February the Trust continued to achieve all of the 18 week standards of 90% for admitted and 95% for 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 February 100% of 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 for stroke patients to spend at least 90% of their time on a stroke ward.

2.2 A&E Clinical Indicators

There continued to be significant pressures from non-elective demand across the Trust during February, when 90.33% of patients were admitted, transferred or discharged from A&E within 4 hours. The year to date position is 92%.

Details of progress of the work streams within the urgent care programme and benchmark performance across the East Midlands are included within the Urgent Care Update Board paper.

2.3 Cancer Standards

All cancer standards are monitored quarterly. During February, however, the Trust did not achieve the following standards:

- **62 day standard from urgent referral**

The Trust achieved 77.1% against the standard of 85% and is forecast to achieve 79% for quarter 4 performance. As a result the Trust is forecast not to achieve year end performance. The year end forecast is 82.8% against the standard of 85%.

There continued to be an increased number of breaches during February. The reasons for the breaches include patient choice to defer appointments and diagnostic tests, complex diagnostic pathways particularly in Head and Neck and Lower GI tumour sites, and the

complex specialist urology pathways that require time for patients to consider all the treatment options available to them before making a decision regarding their treatment.

A recovery plan has been implemented which is being monitored through the weekly performance meeting and all breaches are reviewed to identify any further improvements that can be made. In February the following improvements were put in place: referral processes between hospitals for Head and Neck patients have been reviewed and improved to reduce delays; the Trust has also increased capacity to ensure all Head and Neck patients are reviewed at the next combined clinic with an oncologist and surgeon thus reducing delays.

- **62 day standard from consultant upgrade**

During February the Trust achieved 75% against the standard of 85%. To date the quarter 4 position is 70.05% and the year to date position is 88.5%. A small number of patients is included under this standard and in February only 10 patients were treated, many of whom have complex diagnostic pathways which in themselves have led to delays. This is a local standard which is not monitored nationally. However, the Trust aims to ensure all patients are treated within 62 days.

- **31 day standard from decision to treat to start of subsequent drug treatment**

During February, the Trust achieved 96.7% against the standard of 98%. The quarter 4 position to date is 93.8% and the year to date position is 97.8%. There were two breaches in February due to patients not being medically fit to start their treatment. The Trust continues to monitor this target closely but is at risk of not delivering quarter 4 position.

2.4 Referral to Treatment Time (RTT)

During February 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	Feb-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%	95.1%
Non-admitted	95.0%	97.7%	98.3%	98.8%	98.6%	98.5%	98.4%	98.5%	98.4%	98.5%	98.6%	97.9%
Incomplete pathways	92.0%	98.2%	97.8%	97.1%	97.3%	97.5%	97.1%	96.9%	96.8%	96.3%	95.4%	95.7%
No of patients on an incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	49	55	43	21	33	40	50
Number of diagnostic waits > 6 weeks	0	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%	92.3%
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%	90.3%
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6.0%	5.9%	7.1%	8.8%	5.6%	5.3%	5.8%	6.9%	7.9%	5.4%	9.3%	
Cancelled Operations rebooked within 28 days (as per SITREP definition)	75%	100%	100%	100%	100%	100%	100%	100%	92.5%	93.8%	92.5%	Not avail till month end
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%	96.9%
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%	100.0%
31 Day	96.0%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.6%	97.3%	98.0%
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%	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%	91.8%	96.7%
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%	96.4%	97.8%
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%	93.3%
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%	63.6%	75.0%
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%	81.3%	77.1%
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%	60.0%
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%	86.1%
Activity vs. Plan												
Elective Inpatients	>0%	17.8%	24.6%	16.4%	10.0%	-0.9%	18.4%	21.4%	31.4%	4.3%	7.9%	17.0%
Daycase	>0%	9.2%	12.0%	1.7%	4.5%	1.9%	4.9%	7.8%	2.2%	-2.9%	1.5%	5.0%
Non- Elective	>0%	17.1%	25.9%	18.7%	14.4%	15.2%	13.7%	21.6%	20.9%	19.2%	14.8%	9.0%
OP 1	>0%	6.1%	16.1%	8.5%	1.9%	-4.8%	4.8%	5.1%	3.8%	-8.5%	4.5%	4.0%
OP Procedures	>0%	10.3%	3.9%	5.2%	2.8%	-1.3%	5.9%	7.5%	13.1%	-2.7%	1.6%	2.0%
New to Follow UP Ratio	2.01	2.03	1.90	1.95	1.95	1.94	2.05	2.01	1.97	2.12	2.03	
GP Referrals	>0%	2.5%	1.4%	1.1%	0.4%	-2.0%	-2.1%	-1.3%	-1.3%	-2.7%	-2.9%	-2.9%
Day Case Rates	81%	85.7%	85.0%	84.9%	85.7%	86.6%	85.0%	84.7%	83.0%	85.7%	85.5%	
Sleeping Accommodation Breach	0	0	0	0	0	0	0	0	0	0	0	0

Trust Board, 28 March 2013.	
TITLE: -	Finance Report M11 – February 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 eleven months ended February 2013.

CRITICAL POINTS: -

- 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 month of the financial year.
- The Trust has repaid £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 month of the financial year.
- Final confirmation of the EFL for 2012-13 is being sought from DH.

ACTION REQUIRED: -

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

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The Trust's Financial and Contracting Performance as at 28 February 2013

Month 11 2012/13

1. Summary Performance – Financial Duties

1.1. Table 1 summarises the Trust's financial performance for the eleven months to the end of February 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

	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	£63	-£610	£0	£1,000	-£1,000
Achieving EFL (£000's)	N/A	N/A	£457	£457	£0
Achieving the Capital Resource Limit (£000's)	£6,245	£6,924	£9,988	£10,098	£110
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	86%	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 month of the financial year.
- The Trust has repaid £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 month of the financial year.
- Final confirmation of the EFL for 2012-13 is being sought from DH.

Enclosure 9

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

	Actual	Actual	Actual	Actual	Forecast	
	M9	*M10*	*M11*	*YTD*	*M12*	*Total*
	£000	£000	£000	£000	£000	**£000**
SLA Income	18,339	22,449	20,746	211,468	20,900	**232,149**
Other Clinical Income	145	447	184	2,715	104	**2,819**
Other Income	3,452	2,095	2,231	24,263	3,880	**29,022**
Total Income	**21,936**	**24,991**	**23,160**	**238,447**	**24,884**	**263,989**
						0
Pay Costs	(13,973)	(14,027)	(14,221)	(153,444)	(14,627)	**(168,071)**
Non-Pay	(6,361)	(7,013)	(6,569)	(71,446)	(9,646)	**(81,091)**
Transformation Costs	(110)	0	(217)	(715)	(167)	**(882)**
						0
Total Costs	**(20,444)**	**(21,040)**	**(21,007)**	**(225,605)**	**(24,440)**	**(250,045)**
						0
EBITDA	**1,492**	**3,951**	**2,153**	**12,842**	**443**	**13,945**
						0
Depreciation	(740)	(812)	(812)	(8,919)	(812)	**(9,731)**
Amortisation	(1)	(1)	(1)	(9)	(1)	**(10)**
Impairments	(1,587)	161	528	(898)	0	**(898)**
Net Interest	2	3	2	19	2	**21**
Dividend	(354)	(354)	(329)	(3,871)	(354)	**(4,225)**
Surplus / (Deficit)	**(1,188)**	**2,948**	**1,541**	**(835)**	**(722)**	**(898)**
Normalised	**399**	**2,787**	**1,013**	**63**	**(722)**	**(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 February. The overall level of financial risk of delivery of the breakeven position is reduced

1.3 Plans are in place to undershoot the Capital Resource Limit (CRL) by £0.1m. This figure is reduced from £1.7m due to the recent notification from EMCN in support of radiotherapy equipment and final confirmation of the approved CRL by the SHA in March. The Trust has now confirmed receipt of £0.5m of PDC funding in relation to Maternity services.

1.4 The Trust has now repaid £4m of DH temporary borrowing at the end of February and has no outstanding DH borrowing at the financial year end.

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

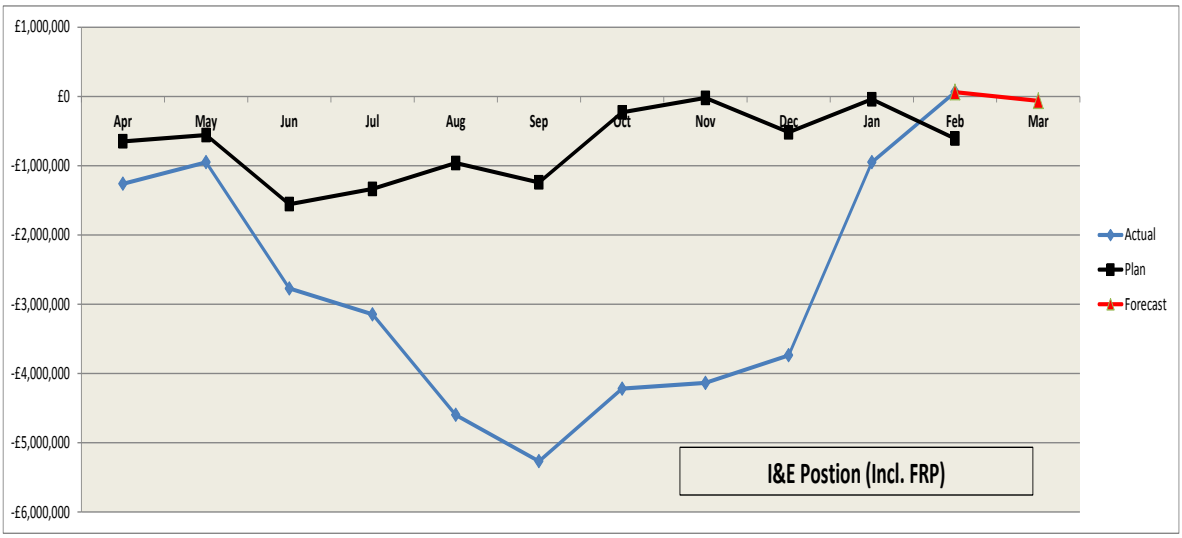
2.1 Appendix 2 provides details of the Trusts summary Income and Expenditure (I & E) position. The Trusts year to date I&E position for the period ended 28th February 31st is a surplus of £63k (January: £0.95m). The plan submitted to the SHA in March predicted a £610k year to date deficit therefore the result was £0.7m better than planned. The planned position for the full year is a surplus of £1.0m.

2.2 The year to date position above excludes the impact of non-current asset impairments of £0.9m which had been charged to the I&E account, but do not count towards the measurement of NHS performance.

2.3 The month 11 position is a surplus of £1.0m. The improvement in the position is largely due to the accrual of an additional £1.9m of income representing the corresponding year to date value of the CCG income settlement.

2.4 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 11 total operating income stands at £23.16m compared to a forecast of £19.9m. Year to date operating income stands at £238.4m, compared to an original forecast of £225.6m.

3.2 SLA income amounted to £20.75m in February exceeding forecast levels by £3.0m. This figure includes an additional £1.9m in respect of the income settlement. SLA income totalling £211.47m has been recorded for the year to date, £17.3m (9%) better than plan. The actual level of income generated in month 11 (February) 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.

Enclosure 9

Table 3 – SLA Activity & Income Performance

	ACTIVTY				INCOME						
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var	Volume Variance £	Price Variance £	Total £
DC	33,744	35,003	1,259	3.7%	20,065,529	20,606,310	540,781	2.7%	569,339	-28,559	540,781
EL	5,320	6,107	787	14.8%	16,046,046	15,855,103	-190,944	-1.2%	1,442,326	-1,633,270	-190,944
NEL	37,779	41,107	3,328	8.8%	63,327,332	70,571,989	7,244,657	11.4%	4,680,323	2,564,334	7,244,657
OPFA	58,531	59,456	925	1.6%	9,581,054	9,968,331	387,276	4.0%	-665,683	1,052,959	387,276
OPFUP	106,818	109,889	3,071	2.9%	9,792,064	10,054,545	262,481	2.7%	16,938	245,543	262,481
OPFASPNCL	21,814	24,745	2,931	13.4%	1,928,308	2,222,272	293,964	15.2%	131,436	162,528	293,964
OPFUSPNCL	59,525	53,973	-5,552	-9.3%	2,857,647	2,639,441	-218,207	-7.6%	-258,387	40,180	-218,207
OPPROC	35,495	36,943	1,448	4.1%	5,138,267	5,435,845	297,579	5.8%	202,045	95,534	297,579
A&E	71,330	84,447	13,117	18.4%	6,819,618	8,435,782	1,616,163	23.7%			
BLOCK / CPC	6,661	4,911	-1,750	-26.3%	55,763,446	58,312,534	2,549,089	4.6%			
MRET											
ARMD	3,399	3,722	323	9.5%	961,261	1,053,534	92,273	9.6%			
Provisions					-3,376,531	-5,482,288	-2,105,757	62.4%			
CQUIN					4,613,103	4,274,002	-339,101	-7.4%			
Other					657,281	7,519,671	6,862,390	1044.1%			
Total					**194,174,426**	**211,467,070**	**17,292,644**	**8.9%**			

3.4 The Trust has over performed on activity which equates to £17.3m 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.

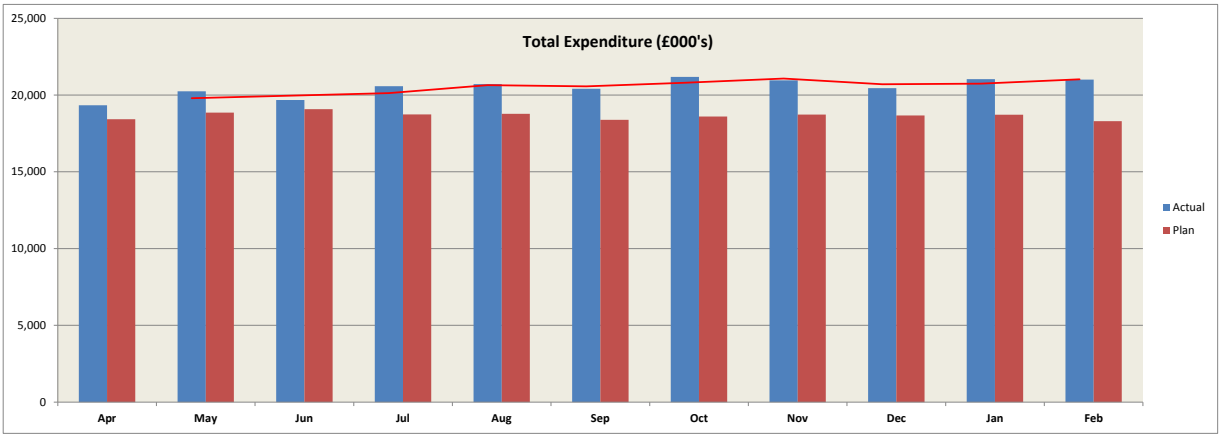
3.6 Non Elective activity is performing 9% above plan. This coupled with the 18% over performance for A&E attendances has meant the continued need for the Trust to keep open additional escalation areas.

3.7 Outpatient first attendances are 1.6% above plan whilst outpatient follow up attendances are 2.9% above plan.

4.0 Expenditure

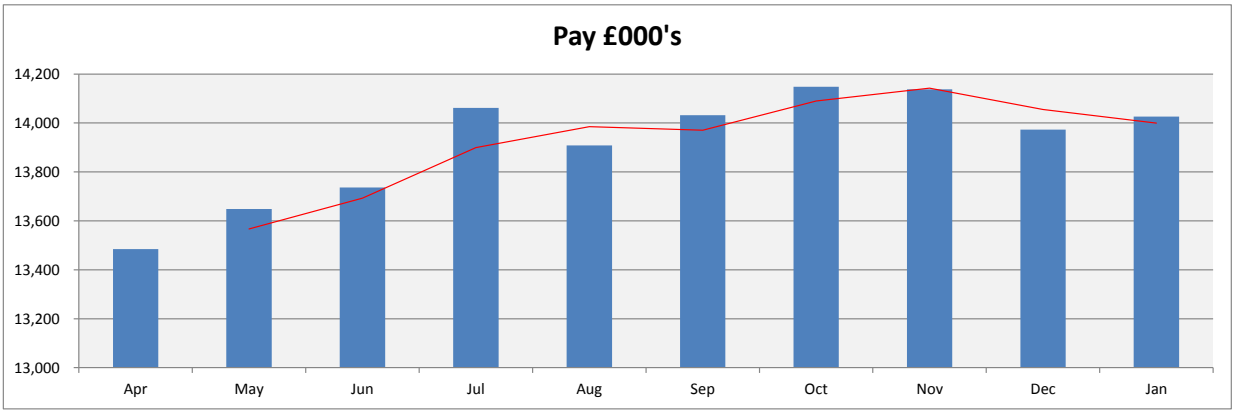
4.1 The Trust has overspent expenditure budgets by £20.4m in the 11 months to 28th February. The primary reason for the over spend is that insufficient Transformation Programme schemes have been identified and delivered within the first part of the financial year combined with the need to respond to non-elective pressures.

Graph 2 - Monthly Expenditure Run Rate 2012-13



4.2 Pay costs in the month were £0.3m higher than forecast and standing at £14.2m (£200k higher than January). Cumulatively to month 11 pay costs amounted to £153.4m, £11.6m (7.6%) 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



4.3 The Trust is operating below the planned WTE budget (by 79.33WTE at Month 11), but is utilising significant numbers of temporary staff.

Table 4.1 – WTE Analysis – February 2013

	Worked Mth 11 WTE	WTE Budget 2012/13 M11	Worked V Bud Var	Contracted Mth 11 WTE
Medical Staff	465.20	464.98	*-0.22*	467.06
Nursing Staff	1,833.20	1,760.00	*-73.20*	1,760.57
Managerial & Administration	825.41	897.31	*71.90*	741.42
Other Clinical Staff	268.32	310.77	*42.45*	271.16
Scientific & Technical Staff	378.46	411.60	*33.14*	390.40
Estates Staff	29.53	36.19	*6.66*	26.00
All other Staff	398.68	407.47	8.79	322.83
Cost Challenges		-10.19	*-10.19*	
Total WTE	**4,198.80**	**4,278.13**	***79.33***	**3,979.43**

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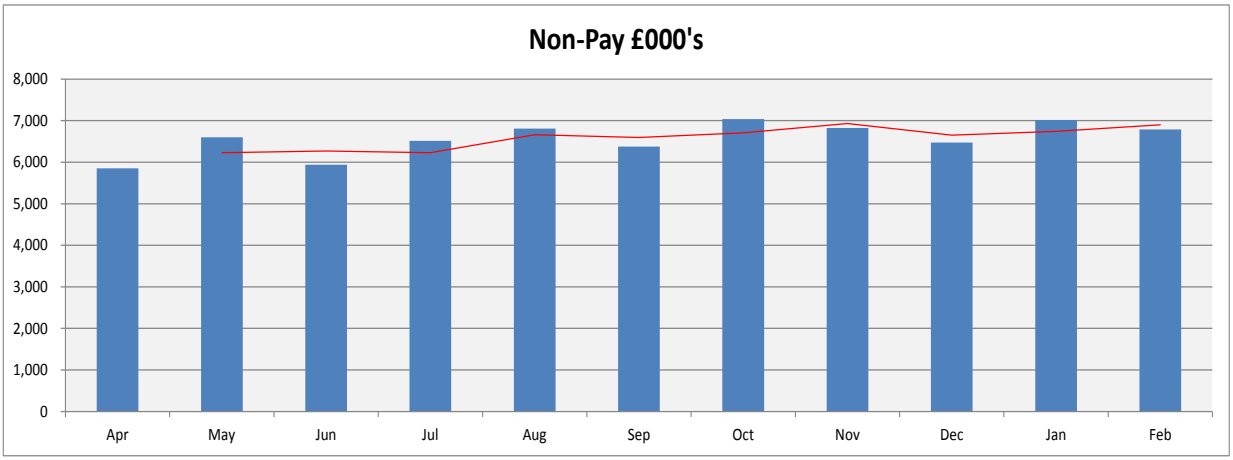
Table 4.2 – Temporary Staffing Costs

Staff Group £000's	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec 12 Actual	Jan 13 Actual	Feb 13 Actual	Av. YTD	YTD Actuals
Medstaff WLI & ADH's	130	99	103	84	76	87	87	89	975
Agency Medstaff (Senior)	143	130	191	96	15	120	105	108	1,184
Agency Medstaff (Junior)	171	171	189	194	178	128	198	179	1,966
Bank Staff - Nursing	357	390	361	377	422	370	378	379	4,171
Agency Staff - Senior Nursing	275	307	333	307	197	219	246	266	2,929
Agency Staff - Junior Nursing	106	140	145	128	76	113	90	124	1,363
Agency Staff - Management	78	78	146	138	130	156	86	66	728
Bank Staff - Admin	117	130	115	115	125	115	131	110	1,209
Agency Staff - Admin	38	29	44	43	9	43	76	36	399
Bank & Agency Staff - Other	148	105	157	148	92	121	94	114	1,258
Total Temporary Staff	**1,563**	**1,580**	**1,784**	**1,629**	**1,321**	**1,472**	**1,491**	**1,471**	**16,182**

4.4 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.

4.5 Non Pay cost incurred were £10.3m (14%) higher than planned for the year to date. Expenditure in February amounted to £6.8m (£0.3m above forecast).

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



5.0 Transformation Programme (CIP Programme)

5.1 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. Significant risks in delivering this programme emerged during the financial year and in response the Trust has developed a number of non-recurrent schemes to mitigate this risk.

5.2 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).

5.3 The Trust originally planned to achieve cumulative CIP savings of £14.2m by month 11 and actually achieved £9.2m which represent delivery of only 65% of target.

5.4 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.

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

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

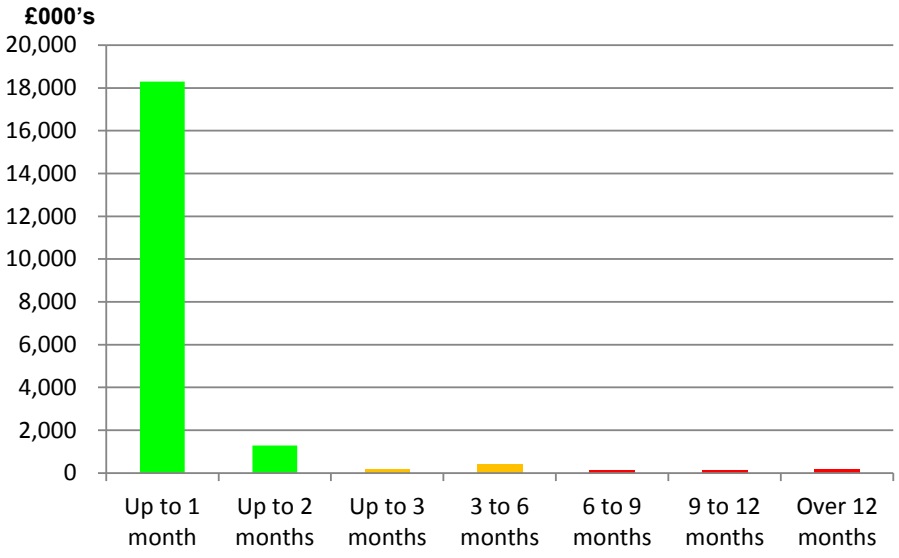
6.1 The Trust's Statement of Financial Position (Balance Sheet) as at 28th[t] February is contained within appendix 4 of this report.

6.2 The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of February stood at £0.8m (January £5.9m). Cash balances have reduced in month primarily due to the repayment of temporary borrowing of £4m on 28th February 2013.

6.3 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. In March the SHA have agreed to release additional £0.2m MPET funding and a further £0.3m to support the costs of FT application incurred during the financial year.

6.4 An analysis of income earned by the Trust but unpaid as at 31st January 2013 is shown in the graph below. The increase in outstanding debtors in February relates to £16m of invoices raised in support of the CCG Income settlement. The Trust has received confirmation these invoices will be paid to the Trust by mid- March 2013.

Graph 5 – Aged Debtor analysis – February 2013



7.0 Capital Programme and Performance against Capital Resource Limit

7.1 The CRL target has decreased to £10.1m following review and confirmation with the SHA.

Capital Resource Limit (CRL)	Plan	YTD	Forecast	Underspend
	£000	£000	£000	£000
Internally Funded (Depreciation)	8,849	7,180	9,519	-670
Salix Loan	469	0	469	0
PDC Increases	480			
Asset Sales	300			
Total	**10,098**	**7,180**	**9,988**	**110**

7.2 The Trust has plans approved to underspend the CRL by £0.1m. The level of underspend has been reduced due to recently approved bids notably in support of new Radiotherapy equipment.

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

8.0 Financial Risk Rating

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

8.2 The overall risk rating for the Trust as at the 28th February 2013 if it were a Foundation Trust would be 3 due to the improvement in the overall financial position. The Trust is forecast to end the year with a risk rating of 3 (based on a breakeven position).

8.3 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 normalised and forecast FRR score.

9.0 Financial Risks

9.1 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 – February 2012.

Risks not included in Financial Forecast 12-13		Value of Risk £000s	Likelihood	Probability %	Adjusted Risk £000s
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage	Agency - escalate through TDG.	(500)	Low	20%	(100)
Delivery of Control Totals	Directorates to manage within agreed targets	(500)	Low	20%	(100)
	Unforseen Cost Pressures (eg RTT)	(500)	Low	20%	(100)
Net Revenue Risk		**(1,500)**			**(300)**
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

10.0 Conclusion

10.1 The Trust faces a significantly lower level of financial risk given the agreement and confirmation of payment of invoices supporting the 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 11 above.

10.2 The Trust is in a strong position to deliver the remaining statuary duties and will have sufficient cash in March to meet creditor demand and live within the prescribed External Financing Limit (EFL).

11.0 Recommendations

11.1 The Board are asked to note the requirement by the Department of Health and Strategic Health Authority to deliver a financial breakeven position for the year (agreed plan is for a surplus of £1.0m) requiring on-going financial management of control totals and risk in March and in preparation of the year end accounts.

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

11.3 Note the level of capital expenditure required to meet the CRL forecast in the final month of the financial year.

11.3 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.

11.4 There is a need to address the projected cashflow deficit in quarter 1and plans should now be put in place to this effect.

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Appendix 1

Finance Dashboard

KPIs	M11		M10	M9	M8	M7	M6
Financial Risk Rating (Shadow)	3	FRR shadow score of 3	2	1	2	1	1
EBITDA	102.1%	EBITDA achieved 102% of plan	89.7%	66.0%	55.3%	47.0%	30.5%
Liquidity (days cover)	24.9	Incl. unused WCF of £18m	22.1	19.7	18.6	17.1	-15.4
Surplus Margin	0.0%	+1% required for FRR score of 3	-0.5%	-2.1%	-2.5%	-3.0%	-4.3%
Pay / Income	64.4%	Pay 65% of Income for YTD	64.7%	65.8%	66.1%	66.5%	67.5%
I&E Position	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Reported Position	(835)	Deficit of £0.8m to month 11.	(2,376)	(5,324)	(4,135)	(4,447)	(5,265)
Impairment	(898)	Impairment due to Indexation of NCAs.	(1,426)	(1,587)			
Normalised Position	63	I&E position excluding impairment.	(950)	(3,737)	(4,135)		
FIMS Plan (Year to date)	(610)	£0.6m deficit plan to month 11.	(42)	(518)	(21)	(230)	(1,332)
PCT SLA Income Variance	17,293	9% above plan.	12,298	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	1,000
Financial Recovery Target	0	Forecast is for breakeven by March 2013	0	0	0	0	0
EBITDA Performance	£000's		£000's	£000's	£000's	£000's	£000's
Variance from plan	268FAV	£0.3m ahead of plan	(1,221)ADV	(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**	**£000's**
YTD Plan	14,226	£14.2m target to month 11.	12,735	11,267	9,714	8,252	6,760
YTD Actual	9,215	£9.2m delivered to month 11.	8,460	7,621	6,667	5,961	4,724
% Delivered	65%	CIPs delivered as a % of plan .	66%	68%	69%	72%	70%
LTF	10,496	Latest Thinking Forecast for year.	10,379	10,419	10,541	11,098	11,142
Annual Plan	16,100	Annual Transformation Target.	16,100	16,100	16,100	16,100	16,100
LTF v. Plan	65%	% of LTF compared to annual plan.	64%	65%	65%	69%	69%
Capital	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Year to date expenditure	6,245	Capital expenditure for period	4,889	4,384	4,126	3,229	2,943
Committed as % of plan YTD	90%	% of plan committed for year to date.	90%	89%	81%	92%	88%
Annual Plan	10,069	Capital Resource Limit of £10.0m for 2012-13.	10,364	10,131	10,336	10,336	10,403
SoFP (movement in year)	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Non-current assets	(4,283)	Revaluation+Additions - depreciation	(6,078)	(6,818)	(2,656)	(2,250)	(1,743)
Current assets	7,497	NHS debtors.	9,335	4,729	5,122	3,146	1,036
Current Liabilities	4,965	Accruals & Deferred Income , PDC dividend.	39	20	6,180	4,921	4,136
Cash	**£000's**		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
In month movement	(5,174)	Decrease between January and February.	2,729	1,897	(926)	1,169	(192)
In Year movement	(3,145)	Decrease since March 2012.	2,029	(700)	(2,597)	(1,671)	(2,840)
DH Temporary Loans	0	Temporary borrowing reapied Feb 13.	4,000	3,000			
Debtors Balance > 90 days	870	4% of balances outstanding over 90 days	802	686	566	558	611
Creditors > 90 days	4	1% of creditors waiting over 90 days	36	33	486	988	423
BPPC (by volume) YTD	85.3%	Target 95% paid in 30 days	86.4%	88.5%	88.5%	90.0%	91.5%

Income & Expenditure Position – February 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	194,174	211,467	17,293	232,149
Other Clinical Income	2,663	2,441	2,716	275	2,819
Other Income	23,219	21,202	24,264	3,061	29,022
Total Income	**238,558**	**217,818**	**238,446**	**20,629**	**263,989**
Pay Costs	(153,692)	(141,800)	(153,443)	(11,643)	(168,071)
Non-Pay Costs	(67,588)	(61,812)	(72,162)	(10,350)	(81,091)
Reserves/ Non-Rec	(2,068)	(1,811)	0	1,811	(882)
Total Costs	**(223,143)**	**(205,244)**	**(225,605)**	**(20,360)**	**(250,045)**
EBITDA	**15,415**	**12,574**	**12,842**	**268**	**13,945**
Depreciation	(10,184)	(9,305)	(8,918)	387	(9,731)
Amortisation	(10)	(9)	(9)	(0)	(10)
Impairments	0	0	(898)	(898)	(898)
Net Interest	29	27	19	(7)	21
Dividend	(4,250)	(3,896)	(3,871)	25	(4,225)
Surplus / (Deficit)	**1,000**	**(610)**	**(835)**	**(225)**	**(898)**
Normalised for Impairment		**(610)**	**63**	**673**	**(0)**

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Appendix 3

Statement of Financial Position as at February 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		(2,861)	(1,610)	1,251	(2,079)	(2,079)
IN YEAR MOVEMENTS		4,889	6,245	1,356	9,550	9,550
LESS DEPRECIATION		(8,106)	(8,918)	(812)	(9,730)	(9,730)
NET BOOK VALUE	**135,075**	**128,997**	**130,792**	**1,795**	**132,816**	**(2,259)**
CURRENT ASSETS						
INVENTORIES	4,723	4,939	4,689	(250)	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	11,298	16,188	4,890	5,742	12
OTHER TRADE DEBTORS	985	1,149	1,071	(78)	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31					(31)
NON NHS OTHER DEBTORS	70	274	339	65	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,784	2,666	(118)	2,654	100
OTHER RECEIVABLES	549	683	598	(85)	505	(44)
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,245	1,491	(754)	1,460	2
	10,945	**18,001**	**21,921**	**3,920**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300					(300)
CASH	3,944	5,973	799	(5,174)	4,363	419
NET CURRENT ASSETS	**19,912**	**28,913**	**27,409**	**(1,504)**	**20,141**	**229**
CURRENT LIABILITIES						
NHS	1,673	1,346	1,747	(401)	1,963	(290)
TRADE CREDITORS REVENUE	3,655	2,487	3,014	(527)	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	1,144	2,093	(949)	2,759	
TAX AND NI OWED	3,454	3,478	3,466	12	1,946	1,508
NHS PENSIONS AGENCY	1,784	1,949	1,985	(36)	1,950	(166)
OTHER CREDITORS	510	322	262	60	510	
DH SHORT TERM LOANS		4,000		4,000		
SHORT TERM LOANS	488	734	812	(78)	688	(162)
ACCRUALS AND DEFERRED INCOME	4,018	9,125	8,846	279	4,331	(313)
PDC DIVIDEND DUE		1,417	1,746	(329)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,577	842	888	(46)	2,440	(887)
PROVISIONS over 1 year	336	349	360	(11)	360	
NET CURRENT LIABILITIES	**20,883**	**27,822**	**25,848**	**1,974**	**21,231**	**(310)**
TOTAL NET ASSETS	**134,104**	**130,088**	**132,353**	**2,265**	**131,726**	**(2,340)**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		100,115	480
REVALUATION RESERVE	34,046	31,761	32,485	724	32,193	(1,853)
DONATED ASSET RESERVE						
GENERAL RESERVES	385	1,068	1,068		583	198
I & E CURRENT YEAR		(2,376)	(835)	1,541	(1,165)	(1,165)
FINANCING TOTAL	**134,066**	**130,088**	**132,353**	**2,265**	**131,726**	**(2,340)**

Appendix 4

Cost Improvement Delivery

£000's	Feb		YTD		
Workstream	**Plan**	**Actual**	**Plan**	**Actual**	**Var**
Beds / Patient Flow	22	-	278	17	(261)ADV
Theatres	58	10	366	102	(264)ADV
Outpatients	19	31	146	339	193FAV
Admin Review	55	5	330	10	(320)ADV
Procurement	100	69	1,100	1,015	(85)ADV
Pathology	16	35	131	113	(18)ADV
Therapies	10	9	70	38	(32)ADV
Medical	20	-	230	-	(230)ADV
Estates	6	4	61	41	(19)ADV
Outsourcing	16	3	95	27	(68)ADV
Nursing	8	1	50	2	(49)ADV
Back Office Phase	75	33	431	139	(292)ADV
Contract Compliance	72	80	802	1,320	519FAV
Pharmacy	38	20	413	506	94FAV
Controls	46	15	504	149	(355)ADV
HR Workforce Planning	166	-	1,017	-	(1,017)ADV
Workforce, Bank & Agency	79	-	871	-	(871)ADV
Directorate 3% Schemes	535	441	5,670	5,397	(273)ADV
New Schemes					
NGH Mitigation	151	-	1,661	-	(1,661)ADV
Grand Total	**1,490**	**755**	**14,226**	**9,215**	**(5,010)ADV**

	Plan	LTF	Var
Workstream	**£000**	**£000**	
Beds / Patient Flow	300	17	(283)ADV
Theatres	424	112	(312)ADV
Outpatients	165	371	206FAV
Admin Review	385	37	(348)ADV
Procurement	1,200	1,084	(116)ADV
Pathology	147	109	(38)ADV
Therapies	80	47	(33)ADV
Medical	250		(250)ADV
Estates	316	45	(271)ADV
Outsourcing	111	30	(81)ADV
Nursing	58	2	(56)ADV
Back Office Phase 2	506	172	(333)ADV
Contract Compliance	1,000	1,400	400FAV
Pharmacy	450	527	77FAV
Controls	550	311	(239)ADV
HR Workforce Planning	1,183	8	(1,175)ADV
Workforce, Bank & Agency	950		(950)ADV
Directorate 3% Schemes	6,205	6,222	18FAV
New Schemes			-
Mitigation Required	1,820		(1,820)ADV
Grand Total	**16,100**	**10,496**	**(5,604)ADV**

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Cashflow

		ACTUAL												FORECAST		
MONTHLY CASHFLOW	**Annual**	**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	205,639	15,448	17,959	18,311	17,011	17,091	16,677	17,627	16,930	17,084	20,996	15,183	15,322	17,116	17,116	17,116
SLA Performance / Other CCG investment	27,702				1,965	151	309	1,544	3,420	3,000		755	16,559	1,500		
SHA Payments (SIFT etc)	9,229	266	1,300	671	942	672	841	723	809	1,271	833	880	20	741	741	741
Other NHS Income	18,680	1,932	2,568	1,108	1,420	1,495	1,858	1,852	1,164	1,314	1,036	1,407	1,526	1,530	1,530	1,530
PP / Other (Specific > £250k)	1,528		259							291		258	720			
PP / Other	10,757	821	768	796	1,013	793	972	927	858	779	1,059	871	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	27	2	2	2	2	2	1	3	1	1	3	2	4	2	2	2
TOTAL RECEIPTS	**277,944**	**18,469**	**22,857**	**20,888**	**22,352**	**20,204**	**20,659**	**22,676**	**23,304**	**26,740**	**25,108**	**19,436**	**35,251**	**21,749**	**20,179**	**20,389**
PAYMENTS																
Salaries and wages	162,590	13,081	13,813	13,339	13,233	13,513	13,433	13,356	13,507	13,391	13,717	13,842	14,365	13,820	13,820	13,820
Trade Creditors	75,935	4,285	6,274	5,734	5,915	6,238	3,908	6,197	8,328	7,046	6,426	5,526	10,056	7,000	5,500	5,500
NHS Creditors	20,212	1,546	1,938	1,480	2,151	965	973	1,498	1,980	3,711	1,677	793	1,500	1,152	1,152	1,152
Capital Expenditure	10,348	789	1,503	763	517	371	375	455	443	617	581	427	3,509	795	1,500	592
PDC Dividend	4,164						2,069						2,095			
Repayment of Loans	4,000											4,000				
Repayment of Salix loan	238						95						143			
TOTAL PAYMENTS	**277,487**	**19,701**	**23,528**	**21,316**	**21,815**	**21,087**	**20,854**	**21,506**	**24,257**	**24,765**	**22,402**	**24,588**	**31,668**	**22,767**	**21,972**	**21,064**
Actual month balance	457	-1,232	-671	-428	537	-883	-195	1,170	-954	1,975	2,706	-5,152	3,584	-1,018	-1,793	-675
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	779	4,363	3,345	1,551
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**	**779**	**4,363**	**3,345**	**1,551**	**876**

Capital

Approved Annual Budget 2012/13 £000's	Year to Date as at Month 11 M11 Plan £000's	M11 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 11 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 11 M11 Forecast £000's	Plan Achieved
59	59	59	0	100%	59	100%	59	100%
177	178	177	-1	100%	177	100%	177	100%
60	60	52	-8	87%	52	87%	60	100%
55	55	73	18	134%	73	134%	73	134%
44	5	5	0	11%	23	51%	20	45%
13	13	13	0	100%	13	100%	13	100%
1,452	762	621	-141	43%	1,206	83%	1,325	91%
3,567	3,002	2,507	-496	70%	3,753	105%	3,731	105%
3,273	2,435	2,270	-165	69%	3,068	94%	3,162	97%
183	64	64	0	35%	183	100%	183	100%
679	0	0	0	0%	679	100%	679	100%
307	307	307	0	100%	307	100%	307	100%
180	0	46	46	25%	154	86%	180	100%
317	240	227	-12	72%	315	99%	315	99%
10,365	**7,180**	**6,421**	**-759**	**62%**	**10,061**	**97%**	**10,283**	**99%**
-295	-255	-177	79	60%	-177	60%	-295	100%
10,069	**6,924**	**6,245**	**-680**	**62%**	**9,885**	**98%**	**9,988**	**99%**

Financial Risk Rating (Monitor)

Financial Criteria	Metric	Weight %	Feb	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	102%	5	0.50
Underlying Performance	EBITDA Margin %	25%	5.4%	5	1.25
Financial Efficiency	Return on Assets	20%	1.61%	2	0.40
Financial Efficiency	I&E Surplus Margin	20%	0.0%	2	0.40
Liquidity	Liquidity Ratio (Days cover)	25%	24.92	3	0.75
Weighted Average		100%		Calculated Score	3
				Override	
				Reported Score	3

	< Good >		Score		< Bad >
	5	4	3	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	Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	Yes	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	Yes
3	Working capital facility (WCF) agreement includes default clause	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	No
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No
7	Interim Finance Director in place over more than one quarter end	No	Yes	No	No	No
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No
10	Yet to identify two years of detailed CIP schemes			Yes	Yes	Yes

TRUST BOARD 28 March 2013	
Title	Human Resources Report
Presented by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for February 2013 which focuses on the following Human Resource Workforce Indicators for Month 11:

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

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

Enclosure 10

Human Resource Report
Trust Board

1.0 WORKFORCE CAPACITY

1.1 Substantive Workforce Capacity

Substantive Workforce Capacity increased by 27.76 FTE from 3,951.68 FTE to 3,979.43 FTE which is below the plan (4,278.12 FTE) for the month.

The % FTE of contracted workforce against budgeted establishment has increased by 0.68% to 93.05%.

Substantive Workforce Capacity

Directorate	Month 10 Contracted (FTE)		Month 11 Contracted (FTE)		Budgeted Establishment (FTE)	M11 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	243.93	↓	243.42	↑	268.49	-10.07%	24.6
Child Health	217.74	↑	220.82	↑	221.97	-1.94%	4.23
Facilities	277.67	↑	278.67	↑	344.56	-24.09%	66.9
General Medicine	890.88	↑	907.08	↑	962.43	-8.03%	71.6
General Surgery	224.85	↑	226.44	↑	242.25	-7.74%	17.4
Head & Neck	117.20	↑	119.26	↑	128.22	-9.40%	11
Hospital Support	309.91	↓	308.04	↑	346.87	-11.93%	37
Medical & Dental	468.67	↓	468.06	↓	468.86	-0.04%	0.19
Obstetrics & Gynaecology	333.96	↓	335.26	↑	348.45	-4.34%	14.5
Oncology & Clinical Haematology	199.72	↓	201.92	↓	198.82	0.45%	-0.9
Pathology	186.06	↑	186.49	↑	213.55	-14.77%	27.5
Pharmacy (Dir)	101.14	↓	101.74	↑	101.65	-0.51%	0.51
Radiology	116.27	↑	117.27	↑	125.87	-8.25%	9.6
Therapy Services (Dir)	65.75	↑	63.75	↑	79.37	-20.71%	13.6
Trauma & Orthopaedics	203.18	↓	201.22	↑	226.76	-11.60%	23.6
Grand Total	**3956.93**	↑	**3979.43**	↑	**4278.12**	**-8.12%**	**321**

1.2 Temporary Workforce Capacity

Temporary Workforce Capacity increased by 0.88% to 6.82% and remains above the planned Temporary FTE of 5%.

Temporary Workforce Capacity

Directorate	Month 10 Temporary Workforce (FTE)		Month 11 Temporary Workforce (FTE)	Temporary Workforce Capacity M11 (Percentage)	M11 Variance Against Target (5%) (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	14.97	↓	14.45	5.60%	0.6%	1.55
Child Health	13.92	↑	15.24	6.46%	1.5%	3.43
Facilities	6.82	↑	8.48	2.95%	-2.0%	-5.9
General Medicine	112.61	↑	140.19	13.39%	8.4%	87.8
General Surgery	25.22	↑	28.66	11.23%	6.2%	15.9
Head & Neck	12.46	↑	15.05	11.20%	6.2%	8.33
Hospital Support	16.83	↑	17.14	5.27%	0.3%	0.88
Medical & Dental	N/A		N/A	N/A	N/A	N/A
Obstetrics & Gynaecology	6.48	↑	7.26	2.12%	-2.9%	-9.9
Oncology & Clinical Haematology	14.21	↑	15.09	6.95%	2.0%	4.24
Pathology	5.85	↑	7.46	3.85%	-1.2%	-2.2
Pharmacy (Dir)	0.00	↑	0.00	0.00%	-5.0%	-5.1
Radiology	0.00	↑	0.00	0.00%	-5.0%	-5.9
Therapy Services (Dir)	8.04	↓	6.15	8.80%	3.8%	2.66
Trauma & Orthopaedics	12.08	↑	16.12	7.42%	2.4%	5.25
Grand Total	**249.51**	↑	**291.27**	**6.82%**	**1.8%**	**77.7**

1.3 Total Workforce Capacity (including Temporary Staff)

Total Workforce Capacity % FTE against budgeted establishment FTE has increased by 1.66% from 98.20% to 99.86%.

Total Workforce Capacity (Including Temporary Staff)

Directorate	Month 10 Total Workforce (FTE)		Month 11 Total Workforce (FTE)		Budgeted Establishment (FTE)	M11 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	258.90	↓	257.87	↑	268.49	-3.70%	9.59
Child Health	231.67	↑	236.05	↓	221.97	4.19%	-9.7
Facilities	284.49	↑	287.14	↑	344.56	-21.11%	60.1
General Medicine	1003.49	↑	1047.27	↓	962.43	4.09%	-41
General Surgery	250.07	↑	255.10	↓	242.25	3.13%	-7.8
Head & Neck	129.66	↑	134.30	↓	128.22	1.11%	-1.4
Hospital Support	326.74	↓	325.18	↑	346.87	-6.16%	20.1
Medical & Dental	N/A		N/A		N/A	N/A	N/A
Obstetrics & Gynaecology	340.44	↑	342.53	↑	348.45	-2.35%	8.01
Oncology & Clinical Haematology	213.93	↑	217.01	↓	198.82	7.06%	-15
Pathology	191.92	↑	193.95	↑	213.55	-11.27%	21.6
Pharmacy (Dir)	101.14	↑	101.74	↓	101.65	-0.51%	0.51
Radiology	116.27	↑	117.27	↑	125.87	-8.25%	9.6
Therapy Services (Dir)	73.79	↓	69.90	↑	79.37	-7.56%	5.58
Trauma & Orthopaedics	215.26	↑	217.34	↑	226.76	-5.34%	11.5
Grand Total	**4206.44**	↑	**4270.71**	↑	**4278.12**	**-1.70%**	**71.7**

1.4 Temporary Workforce Expenditure

Temporary Workforce Expenditure has increased by £69,073 from £1,334,329 to £1,403,403 which is equal to 9.87% of the total workforce expenditure.

1.5 Recruitment Timeline

Recruitment Timeline is below the threshold target at 12 weeks.

1.6 Staff Turnover (leavers)

Staff Turnover has increased by 0.37% on the month to 8.70%, which remains above the Trust target of 8%.

Staff Turnover (leavers)

Directorate	Month 9 Turnover (Percentage)		Month 10 Turnover (Percentage)		Month 11 Turnover (Percentage)	M11 Variance Against Target (8%) (Percentage)
Anaesthesia, Critical Care & Theatres	4.84%	◆	5.61%	◆	6.11%	-1.89%
Child Health	13.86%	◆	13.98%	◆	14.13%	6.13%
Facilities	10.50%	●	9.74%	●	9.47%	1.47%
General Medicine	7.03%	●	6.60%	◆	7.33%	-0.67%
General Surgery	7.97%	◆	8.71%	◆	9.92%	1.92%
Head & Neck	6.30%	●	6.28%	◆	7.20%	-0.80%
Hospital Support	12.85%	●	12.72%	●	12.69%	4.69%
Medical & Dental	N/A		N/A		7.21%	-0.79%
Obstetrics & Gynaecology	6.05%	◆	7.01%	●	6.75%	-1.25%
Oncology & Clinical Haematology	10.10%	●	9.59%	●	8.92%	0.92%
Pathology	9.38%	●	8.75%	◆	10.70%	2.70%
Pharmacy (Dir)	6.55%	●	6.50%	◆	7.91%	-0.09%
Radiology	4.97%	●	4.92%	●	4.06%	-3.94%
Therapy Services (Dir)	14.53%	●	12.99%	◆	14.45%	6.45%
Trauma & Orthopaedics	6.39%	◆	7.84%	◆	8.40%	0.40%
Grand Total	**8.31%**	◆	**8.33%**	◆	**8.70%**	**0.70%**

2.0 HEALTH AND WELLBEING

2.1 Short Term Sickness Absence

Short Term Sickness Absence has decreased by 0.53% to 1.88% (Trust target 1.4%).

2.2 Long Term Sickness Absence

Long Term Sickness Absence has decreased by 0.24% to 2.20% (Trust target 2%).

2.3 Total Sickness Absence

Total Sickness Absence has decreased by 0.77% to 4.08% (Trust target 3.4%).

Sickness Absence

Directorate	Short Term Sickness Rate (Target 1.4%)		Long Term Sickness Rate (Target 1.4%)		Total Sickness Rate (Target 1.4%)	
	Jan-13	Feb-13	Jan-13	Feb-13	Jan-13	Feb-13
Anaesthesia, Critical Care & Theatres	1.69%	1.18%	0.89%	0.94%	2.58%	2.12%
Child Health	3.20%	2.04%	2.20%	2.99%	5.40%	5.03%
Facilities	3.31%	3.34%	2.71%	3.35%	6.01%	6.69%
General Medicine	2.76%	2.89%	2.38%	2.08%	5.14%	4.98%
General Surgery	1.43%	1.68%	3.91%	4.65%	5.34%	6.33%
Head & Neck	1.61%	1.44%	4.30%	2.55%	5.91%	3.99%
Hospital Support	1.32%	2.22%	1.94%	1.62%	3.26%	3.84%
Medical & Dental	N/A	0.19%	N/A	1.12%	N/A	1.31%
Obstetrics & Gynaecology	3.21%	2.12%	2.41%	2.17%	5.61%	4.30%
Oncology & Clinical Haematology	1.09%	0.56%	3.23%	2.02%	4.32%	2.57%
Pathology	2.89%	1.12%	2.39%	2.77%	5.28%	3.89%
Pharmacy (Dir)	1.97%	1.36%	0.00%	0.00%	1.97%	1.36%
Radiology	1.38%	1.96%	1.85%	2.13%	3.22%	4.09%
Therapy Services (Dir)	2.74%	1.32%	1.56%	2.81%	4.31%	4.13%
Trauma & Orthopaedics	3.26%	1.83%	3.40%	2.89%	6.66%	4.72%
Grand Total	**2.41%**	**1.88%**	**2.44%**	**2.20%**	**4.85%**	**4.08%**

2.4 Calendar Days Lost to Sickness

Calendar Days Lost to Sickness decreased by 1,676 from 7,041 to 5,365.

2.5 No. Days Lost to Sickness per Employee

No. Days Lost to Sickness per Employee decreased by 0.37 from 1.52 days to 1.15 days.

Calendar Days Lost to Sickness Absence

Directorate	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Jan-13	Feb-13	Jan-13	Feb-13	Jan-13	Feb-13
Anaesthesia, Critical Care & Theatres	198	93	124	87	322	180
Child Health	291	155	217	203	508	358
Facilities	308	275	247	290	555	565
General Medicine	999	855	930	638	1929	1493
General Surgery	172	150	403	348	575	498
Head & Neck	84	51	247	116	331	167
Hospital Support	143	223	248	174	391	397
Medical & Dental	N/A	24	N/A	145	N/A	169
Obstetrics & Gynaecology	433	231	337	232	770	463
Oncology & Clinical Haematology	78	36	248	116	326	152
Pathology	191	62	155	145	346	207
Pharmacy (Dir)	72	45	0	0	72	45
Radiology	65	75	93	87	158	162
Therapy Services (Dir)	73	29	31	58	104	87
Trauma & Orthopaedics	313	132	341	290	654	422
Grand Total	**3420**	**2412**	**3621**	**2784**	**7041**	**5365**

Sickness Absence by Reason

Sickness Reason	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Jan-13	Feb-13	Jan-13	Feb-13	Jan-13	Feb-13
Asthma	8	3	0	0	8	3
Eye problems	17	9	0	0	17	9
Skin disorders	15	22	0	0	15	22
Dental and oral problems	14	31	0	0	14	31
Endocrine / glandular problems	15	35	0	0	15	35
Headache / migraine	68	35	0	0	68	35
Nervous system disorders	6	10	62	29	68	39
Infectious diseases	15	54	0	0	15	54
Heart, cardiac & circulatory problems	19	27	31	29	50	56
Benign and malignant tumours, cancers	19	23	31	58	50	81
Ear, nothroat (ENT)	57	55	31	58	88	113
Pregnancy related disorders	64	69	62	58	126	127
Injury, fracture	137	76	62	58	199	134
Chest & respiratory problems	184	90	0	58	184	148
Other musculoskeletal problems	163	61	93	116	256	177
Back Problems	204	91	122	87	326	178
Genitourinary & gynaecological disorders	84	83	214	174	298	257
Gastrointestinal problems	289	190	93	87	382	277
Cold, Cough, Flu - Influenza	362	295	31	29	393	324
Other known causes - not elsewhere classified	163	159	186	174	349	333
Anxiety/stress/depression/other psychiatric illnesses	268	241	403	435	671	676
Unknown cau/ Not specified	1696	953	1580	1479	3276	2432
Total	**3867**	**2612**	**3001**	**2929**	**6868**	**5541**

3.0 WORKFORCE DEVELOPMENT

3.1 Mandatory Training Compliance

Mandatory Training Compliance shows a decrease of 0.11% compliance in February 2013 with a Trust total compliance of 65.20%.

Mandatory Training Compliance

Directorate	Month 9 (Percentage)	Month 10 (Percentage)	Month 11 (Percentage)	Variance Against Target (100%) (Percentage)
Anaesthesia, Critical Care & Theatres	66.8%	68.0%	70.0%	30.0%
Child Health	72.5%	73.7%	78.0%	22.0%
Facilities	56.1%	55.7%	54.7%	45.3%
General Medicine	64.3%	64.5%	67.8%	32.2%
General Surgery	64.8%	63.4%	68.7%	31.3%
Head & Neck	56.7%	57.4%	62.3%	37.7%
Hospital Support	61.1%	61.2%	60.8%	39.3%
Medical & Dental	N/A	N/A	46.5%	53.5%
Obstetrics & Gynaecology	62.5%	62.2%	63.8%	36.2%
Oncology & Clinical Haematology	65.5%	65.4%	66.7%	33.3%
Pathology	64.1%	68.6%	71.6%	28.4%
Pharmacy (Dir)	73.3%	73.6%	75.1%	25.0%
Radiology	79.1%	79.1%	78.9%	21.1%
Therapy Services (Dir)	78.0%	78.6%	78.4%	21.6%
Trauma & Orthopaedics	63.5%	65.3%	67.6%	32.4%
Grand Total	**64.9%**	**65.31%**	**65.20%**	**34.80%**

4.0 Forecasts and Risks

A review of sickness absence reasons has been carried out by the Trust Short Term Sickness Absence Task & Finish Group. Further analysis will be carried out from hard data on sickness absence levels in terms of directorate, department, team and individual and also regular patterns of sickness absence where underlying trends become apparent.

This will allow information to be prepared for line managers to illustrate where there may be opportunities to potentially reduce sickness absence, including the identification of “hot spots” and areas experiencing high levels of sickness absence.

Intense 3 months project work is underway targeted at every leaver within the organisation to understand better the reasons for leaving. This is primarily due to exit interviews not being completed in full to enable accurate analysis.

Northampton General Hospital NHS
NHS Trust

Board Meeting – 28 March 2013	
Title: -	Transformation Programme Update
Presented by: -	Geraldine Opreshko – Director of Human Resources and Organisational Development (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 £10.49m savings against a plan of £11,1m
2. Mitigation action has been taken by the Transformation Delivery/Steering Groups to ensure delivery of the minimum £10.3m
3. Care Groups & corporate teams are continuing to identify schemes for the next two year Transformation Programme.

ACTION REQUIRED BY BOARD: -

The Board is asked to discuss and note:

1. The actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.49m savings plan.
2. The progress to date on the development of the Transformation Programme for the two years ending 2014/15.

Northampton General Hospital NHS
NHS Trust

Transformation Programme Update

Board Meeting – 28 March 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 £10.49m, which represents a marginal improvement on the reported February 2013 forecast by £40k. All project teams continue to focus on schemes which can deliver financial benefits by the year end are prioritised.

Additionally Care Groups and Corporate teams, supported by the Transformation Programme Management Office (PMO) are seeking to identify schemes and cost improvement initiatives for the next two years of the Transformation Programme to 2014/2015.

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

The 2012/13 latest forecast for the Transformation Programme stands at £10.49m. The positive movement of £40k from the position reported to the Board in February is predominantly due to:-

- Overtime payment reductions for January and February 2013 exceeded the required in month planned reductions. Sustaining this reduction through the introduced controls will ensure that the pay reduction remains into the subsequent year's Transformation Programme.

3. Risks to the 2012/13 programme.

The outstanding risk to the programme relates to final agreement on an outstanding service level agreement, which will not materially impact upon the current forecast.

4. Development of the 2013/15 Cost Improvement Plans (CIPs) & Governance Review implementation.

- The CIP identification for 2013/15 has continued with Care Groups and Corporate Directorates and assessment of transformation schemes. Confirm and challenge meetings have been held through the Integrated Business Planning Process with lead budget holders.
- The identified quantum of schemes is currently at 67% of the £13m (5%) base requirement for 2013/14.
- A pipeline of potential schemes, which bridge the shortfall to the £13m minimum 2013/14 CIP requirement is currently under review through the Transformation Delivery Group and Transformation Steering Board..
- Draft Quality Impact Assessments for the identified schemes have been developed for consideration by the respective Care Group Boards, prior to sign off by the Medical Director and the Director of Patient and Nursing Services.
- Assessment and identification of potential schemes remains a priority, with the focus of the Transformation Business Partners supporting the Clinical Care Groups and the Corporate Teams to develop and finalise work stream plans for the 2013/14 and quantification of transformation schemes into 2015.

5. Conclusion

5.1 The Trust is on track to deliver £10.49m transformation programme for 2012/13.

5.2 Mitigations continue to be sought to offset any potential risk to delivery of the programme.

5.3 Progress has been made to identify a further two years of the Transformation Programme to 2014/15.

6. Recommendation

The Board is asked to discuss and note:

3. The actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.49m savings plan.
4. The progress to date on the development of the Transformation Programme for the two years ending 2014/15.

Northampton General Hospital NHS
NHS Trust

Enclosure 12

TRUST BOARD – 28 March 2013	
Title	Self-Certification Return
Presented by	Mrs Karen Spellman – Deputy Director of Strategy and Partnerships

SUMMARY OF CRITICAL POINTS

A nationally agreed self-certification process based on the Monitor Compliance Framework for NHS Trusts has been introduced as part of the Foundation Trust Single Operating Model (Part two).

The Board is required to sign off one of two governance declarations, either that the Trust is compliant with all requirements or that it is not compliant with some aspect and/or there is insufficient assurance available with the discussion minuted.

The declaration for February is; Governance Risk Rating (Amber Red), Financial Risk Rating (2).

There are a number of Board Statements where the Trust is not fully compliant and for this reason it is proposed that Declaration 2 is signed. The area of non-compliance is:

- Board statement 4 – maintaining a financial risk rating of at least 3 for the next 12 months
- Board statement 11 – compliance with all targets
- Board statement 12 – compliance at Level 2 with the Information Governance Toolkit

RECOMMENDATION:

The Board is asked to approve the governance declaration.

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
February 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:	February 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 :	Christine Allen
on behalf of the Trust Board	Acting in capacity as:	Acting Chief Executive	
Signed by :		Print Name :	Paul Farendon
on behalf of the Trust Board	Acting in capacity as:	Chairman	

If Declaration 2 has been signed:

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

Target/Standard:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**The Trust will breakeven in 12-13 but is currently forecasting a recurrent deficit plan of £6.8m**
Action :	**Recurrent postion is being adressed through TDA 13-14 plannining process and CCG negoatiations.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**A&E Transit Time: 90.33%. Cancer: 31-day sub drug txt 96.7%, 62-day urgent GP ref 77.1%**
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

February 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*
EO			
hair			

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Board Action
1	SHMI - latest data	Score		109	109	109	106	106	106	104.8	104.8	104.8	107.8	107.8	
2	Venous Thromboembolism (VTE) Screening	%	90.9%	91.4%	91.9%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	
3a	Elective MRSA Screening	%	99.93%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	
3b	Non Elective MRSA Screening	%	91.05%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	
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	21	12	12	17	14	11	10	13	14	24	19	25	Feb comments : 25 open investigations. 21 are ongoing, 4 have been submitted to CCG and the investigation considered completed however we are currently awaiting confirmation of closure from CCG
6	"Never Events" occurring in month	Number	0	0	0	0	0	1	0	0	0	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	1	1	0	0	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	3	1	2	1	1	2	2	4	1	1	2	1	
10	Falls resulting in severe injury or death	Number	2	0	0	1	2	2	0	2	3	1	0	2	
11	Grade 3 or 4 pressure ulcers	Number	0	2	3	3	2	0	2	3	7	7	6	3	February 2013 pressure ulcer figures consist of 3 x avoidable Grade 3.
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	49	50	51	39	48	33	35	44	40	24	68	57	
14	Agency as a % of Employee Benefit Expenditure	%	5.5%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	6.60%	
15	Sickness absence rate	%	Not Av	4.78%	5.0%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Board Action
			Insert the Score (1-5) Achieved for each Criteria Per Month									
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	5	3	3	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	4	3	2	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3	2	1	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	1	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	2	2	£4m Temporary borrowing repaid.
Weighted Average		**100%**						**3.3**	**2.9**	**2.4**	**1.6**	
Overriding rules								3		2	2	
Overall rating								**3**	**3**	**2**	**2**	FRP plan delivered for 12-13.

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"						2
3	One Financial Criterion at "2"		3				
1	Two Financial Criteria at "1"						
2	Two Financial Criteria at "2"					2	2

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

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to 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	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	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	No			M11 postion offset by CCG income settlement invoices raised.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No			
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	Yes	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No			
10	Yet to identify two years of detailed CIP schemes			Yes	Yes	Yes			

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	N/a			
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a			
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a			
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes			
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	No	No			Unverified February figures show 31-da subsequent drug treatment as being 96. 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	No			Unverified February figures show 62-da urgent GP referral being 77.1% against t target of 85% (Q1 62-days urgent GP refe 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	Yes			
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No			February 2013 = 90.33% against the targe 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	N/a			
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a			
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a			
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a			
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a			
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a			
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a			
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*Enter contractual ceiling - 36*		Yes	Yes	Yes	Yes	Yes			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*Enter contractual ceiling - 1*		Yes	No	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	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No			
				TOTAL		**1.0**	**1.0**	**1.0**	**3.0**	**3.0**	**0.0**	**0.0**	
						AG	AG	AG	AR	AR	G	G	

RAG RATING :

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

GOVERNANCE RISK RATINGS

Northampton General Hospital

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				
Overriding Rules - Nature and Duration of Override at SHA's Discretion										
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters	No	No	No	No	No			
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No			
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No			
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	Yes	Yes	Yes	Yes	Yes			
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No			
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter	N/a	N/a	N/a	N/a	N/a			
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No			
		Adjusted Governance Risk Rating	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**0.0**	**0.0**	
			R	R	R	R	R	G	G	

CONTRACTUAL DATA

Information to inform the discussion meeting

Northampton General Hospital

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

Refresh Data for new Quarter

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

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

TFA Progress

Mar-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	The Trust is on track to sign off the IBP for 13/14 and the TDA submission at the March Board
24	Final LTFM approved by Board	Mar-13		Will not be delivered on time	
25	Trust/NTDA readiness review meeting	Mar-13		Will not be delivered on time	
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		Will not be delivered on time	The Trust is continuing partnership talks with KGH as part of the next stage of Healthier Together.
29	Board and Sub committee observation	Apr-13		Will not be delivered on time	Board sub committee observation not taking place in agreement with the SHA
30	FT submission to NTDA	May-13		Will not be delivered on time	FT submission not taking place in agreement with the SHA
31	Board interviews	May-13		Will not be delivered on time	Board interviews not taking place in agreement with the SHA
32	NGH/NTDA Board to Board meeting	Jun-13		Will not be delivered on time	Board to Board meeting not taking place in agreement with the SHA
33	NTDA Board approval	Jun-13		On track to deliver	
34	Application submitted to DH	Jul-13		Will not be delivered on time	Application submission to the DH not taking place in agreement with the SHA
35					
36					
37					
38					
39					
40					

ES

	Indicator	Details
lds	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%.	
	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.
	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.
	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.
	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.
	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.
	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.
	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
	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.
	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.
	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
	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.
	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
	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.
	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.
	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
	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.
	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.
	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

Enclosure 12

Northampton General Hospital NHS
NHS Trust

A G E N D A

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

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 28 February 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.40	5.	Chief Executive's Report	Mrs C Allen	**Verbal**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Ms S Loader	**3**
10.00	7.	Patient Experience	Ms S Loader	**4**
10.10	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
10.20	9.	Urgent Care Update	Ms R Brown/Dr J Timperley	**6**
10.30	10.	Resilience Report	Ms R Brown	**7**
Operational Assurance				
10.40	11.	Operational Performance Report	Ms R Brown	**8**
10.50	12.	Finance Report	Mr P Hollinshead	**9**
11.00	13.	Human Resources Report	Ms G Opreshko	**10**
11.10	14.	Transformation Programme Update	Ms G Opreshko	**11**
11.20	15.	Self-Certification Return	Mrs K Spellman	**12**
Governance				
11.30	16.	Any Other Business		
	17.	**Date & time of next meeting:** 25 April 2013		
	18.	**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	