Northampton General Hospital NHS
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 28 November 2013, 09.30 am

at

The Boardroom
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 28 November 2013
09:30 am. Boardroom, Northampton General Hospital

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3	Minutes of the 31 October 2013 meeting of the Board	Decision	Mr P Farenden	**A**
	4	Matters arising from the 31 October 2013	Receive	Mr P Farenden	**B**
	5	Chief Executive's Report	Receive	Dr S Swart	**C**
	6	Patient Story	Receive	Ms S Loader	**Presentation**
09.45	**CLINICAL QUALITY AND SAFETY**				
	7	Medical Director's Quality Report	Assurance	Dr N Robinson	**D**
	8	Patient Experience Report	Assurance	Ms S Loader	**E**
	9	Infection Prevention Performance Report	Assurance	Ms S Loader	**F**
	10	Francis Report Action Plan	Assurance	Ms S Loader	**G**
	11	Nurse Staffing Report	Assurance	Ms S Loader	**H**
10.45	**OPERATIONAL ASSURANCE**				
	12	Operational Performance Report	Assurance	Mrs R Brown	**I**
	13	Urgent Care Update	Assurance	Mrs D Needham	**J**
	14	Finance Report	Assurance	Mr A Foster	**K**
	15	Workforce Report	Assurance	Ms J Brennan	**L**
	16	Improving Quality and Efficiency Report	Assurance	Ms J Brennan	**M**
	17	TDA Self-Certification	Decision	Mr C Pallot	**N**
11.40	**STRATEGY AND GOVERNANCE**				
	18	Strategic Aims and Corporate Objectives	Decision	Mr C Pallot	**O**
11.45	**ANY ITEMS OF OTHER BUSINESS**				
	19	**DATE AND TIME OF NEXT MEETING** 30 January 2013 – Boardroom, NGH	Note	Mr P Farenden	**Verbal**

	RESOLUTION – CONFIDENTIAL ISSUES: The Trust Board is invited to adopt the following: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on

Thursday 31 October 2013 at 9.30am

the Boardroom, Danetre Hospital, London Road, Daventry, NN11 4DY

Present:

Mr P Farenden	Chairman
Mr C Abolins	Director of Facilities & Capital Development
Ms F Barnes	Deputy Director of Nursing
Mrs J Brennan	Director of Workforce and Transformation
Mrs R Brown	Acting Chief Operating Officer
Mr A Foster	Acting Director of Finance
Mr G Kershaw	Non-Executive Director
Mrs D Needham	Acting Chief Operating Officer
Mr D Noble	Non-Executive Director
Mr C Pallot	Director of Strategy and Partnerships
Mr N Robertson	Non-Executive Director
Dr N Robinson	Associate Medical Director
Mrs E Searle	Non-Executive Director
Dr S Swart	Chief Executive Officer
Dr M Wilkinson	Acting Medical Director

In Attendance:

Mr C Sharples	Head of Corporate Affairs

Apologies:

Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr C Walsh	Interim Chief Operating Officer
Mr P Zeidler	Non-Executive Director

TB 13/14 100	**Declarations of Interest in the Proceedings**
	No further interests or additions to the Register of Interests were declared.
TB 13/14 101	**Minutes of the meeting held on 23 September 2013**
	The minutes of the meeting of the 23 September 2013 Board meeting were presented for approval. The following amendments to the minutes were discussed and agreed: TB 13/14 089 - Operational Performance Report. Mr Noble requested that paragraph three be amended read "…it was anticipated that it would be December 2013 before its impact was felt …." TB 13/14 090 - Urgent Care Update. It was felt that paragraph 7 did not accurately reflect to discussion and should be reworded to read "….Mr Walsh replied that there were 36 extra permanent beds with permanent, funded establishments this year compared to last. Any flexible or short-term winter capacity required in 2013/14 would be on top of those 36 beds. In order to meet the anticipated demands brought about by the winter pressure, the Trust was considering the use of beds off site alongside how the patient pathway could be further improved." TB 13/14 090 - Urgent Care Update. It was agreed that paragraph eight required re-wording to reflect the discussion. Mrs Needham agreed to re-word

	the paragraph. TB 13/14 091 - Finance Report. Mr Pallot requested that the wording of paragraph to be amended. He advised that the Trust had not issued rebuttal claims but had challenged the contract queries from the CCG. Subject to those amendments, the Board resolved to **APPROVE** the minutes of the 23 September 2013 as a true and accurate record of proceedings.
TB 13/14 102	**Action Log and matters arising from the 23 September Board**
	The action log was considered and the Board **NOTED** that all actions had been implemented or were due to be within the defined timeframe.
TB 13/14 103	**Chief Executive's Report**
	Dr Swart presented the Chief Executive's Report. Dr Swart reminded Board members of the importance of continuing the development of strategic working with Nene CCG following the recent Board to Board meeting of the two organisations. The agreement at the meeting was that the two organisations must foster a much closer working relationships built upon a long term focus rather than an annual contract. A draft proposal had been agreed for this work which would include a new approach incentivising NGH to take part in assisting commissioners to reduce spend whilst at the same time providing reward for their efforts. She advised that following the meeting, numerous further meetings had taken place with key officers from both organisations. The plan was for Nene CCG to organise a board to board away day where those principles could be discussed and agreed within the next couple of months. Dr Swart reported that the creation of an Integrated Transformation Fund would require an investment of £30m from Nene CCG in 2015/16 which could only come from budgets for NGH, KGH, NHFT or prescribing. The purpose of the fund was to be a "game changer" in the design of out of hospital care and will be committed at local level by the Health and Wellbeing Board. Whilst some of this funding would be available for reinvestment there would be an undoubted pressure placed on current providers. In anticipation of that, the Chief Executives from across the county were meeting for a day to discuss strategic working across organisations. Dr Swart would ensure emergency care would be high on the agenda as the Trust was requiring increasing support from partners across the health economy. Mr Robertson asked how the momentum could be maintained following the Board to Board meeting with Nene CCG. Dr Swart responded that would be discussed at the Chief Executives away day. There needed to be balance found between immediate priorities and strategic systemic planning problems. Dr Swart reported that the Trust had been informed it would be included in the next 19 acute and specialist trusts to be inspected by the CQC as part of their new hospital inspection programme. NGH had been selected because we were in band 1, the highest risk of the CQC's new intelligent monitoring system, which also took account of local information from partners and the public. Dr Swart stated the Trust being selected for an inspection was expected,

	and informed the Board that there were a number of factors which contributed to the Trust being rated as highest risk. They included the failure to deliver the four hour transit time performance target and the associated impact that had on the safe delivery of care; a number of staff raising concerns directly to the CQC and mortality indices were amongst other indicators. Dr Swart added that all of the risk issues identified by the CQC were reported to the Board on a monthly basis, and as such there has been nothing unexpected within the CQC report. Dr Swart informed the Board that in order to assure ourselves that we were delivering the high quality care our patients expected we were setting up a new internal inspection process known as QuEST, quality, effectiveness and safety. The aim is that, by the end of the year, all wards would have undergone a QUEST inspection. The outcome of each inspection would be fed back to the ward staff so they could address any issues. Alongside that a comprehensive review of the organisational governance structures was being undertaken to ensure it supported managers in making decisions quickly when required and facilitated the escalation of risks and issues. Dr Swart emphasised that allied with A&E pressure, addressing the issues identified was the single most important priority for the Trust. The inspection should be seen as a tool for improvement, and that message needed to made clear to staff. Mr Farenden re-emphasised that the CQC inspection process would not focus solely on front line staff, and that there would be an expectation that the Board understood and were influencing and leading quality and governance arrangements. Mr Farenden asked if there had been an indicative date for the inspection provided as yet. Dr Swart advised that the inspection was expected to take place in January 2014. The inspection would focus on urgent care pathways and quality governance. There will be a clear focus on the Board and how it linked to the wards. Whistleblowing in particular was likely to be a key issue. Mrs Searle observed that it appeared the inspections would place more emphasis on tracking patients, and questioned if the Trust should begin testing existing systems and processes regarding the patient's journey. Dr Swart agreed that the principle was a good idea and was already underway looking at the patient journey from A&E, but would be difficult to achieve across all specialities in time for the inspection. Dr Swart updated the Board on the progress in appointing a substantive executive team. She reported that Mrs Needham and Mrs Brown had jointly agreed to fill the role of Chief Operating Officer on an acting basis whilst the recruitment process for a substantive post holder continued. The arrangement would provide continuity for the Trust during very challenging times. Dr Swart took the opportunity to formally thank Mr Walsh who had held the post on an interim basis for the previous six months for his hard work and efforts at the Trust. Dr Swart advised that she was actively recruiting for a substantive Director of Finance, and that there had been a number of expressions of interest. With regards to the post of Medical Director, Dr Swart advised that the Trust had advertised for a substantive Medical Director and were looking for an

	experienced medical manager to join the executive team as we move forward with our programme of quality improvement and efficiency. Whilst the recruitment process was ongoing, Dr Mike Wilkinson had agreed to act as interim Medical Director. He would be supported by Dr Natasha Robinson and Dr Amanda Bisset, who would continue as acting deputy Medical Directors. The Board **NOTED** the Chief Executive's Report and looked forward to receiving further progress reports at subsequent meetings.
TB 13/14 104	**Patient Story**
	Dr Swart presented the story of a patient who had requested to see her whilst on a ward to discuss their care. The root cause of the patient's concerns revolved mainly around staffing levels on Allebone ward. Dr Swart informed the Board that the issue had been raised on a weekend which was a particularly busy weekend for the hospital. The patient was diabetic and a frequent user of the Trust's services. They had attended A&E, been triaged by a Dr and admitted to a ward quickly. The patient was admitted for the insertion of a PICC line which was delayed for a number of reasons. The intravenous antibiotics which were required were also delayed. The patient felt that staff were unable to do a good job as they were too busy. Other issues the patient raised included staff not listening to the opinion of the patient, drugs being administered out of phase – an issue symptomatic of agency nurses on shift being unable to administer intravenous drugs. They added that the intravenous line, once inserted, was not changed often enough. The patient noted that the quality of the agency nurses on shift was not to the same level as Trust staff and felt that the Healthcare Assistants should be encouraged to always read the medical notes for their patients. From the patients perspective, staff didn't hand over well all of the time, and they felt patients should be included in handovers, and that there were not enough doctors available over the weekend. On a positive note, the patient did feel that all nurses had done their very best at all times and treated them with dignity and respect. In response to the patients concerns and observations, Dr Swart summarised for the Board actions which were being implemented. Those included: • Increasing nursing staff on the ward • Reducing the reliance on agency nurses • Increase the prevalence of PICC lines • The patient Safety Academy were working on improving handovers Dr Swart reported that a piece of work needed to be undertaken to ensure that agency nurses on shift could administer intravenous drugs to avoid delays in patients receiving antibiotics. Following the meeting, Dr Swart advised the patient that their story would be shared with the Board, that the patient would receive a full written response to their concerns and observations and Dr Swart had invited the patient to be a member on a patient improvement group. She assured the Board that

	actions were being taken to address all of the issues raised by the patient. Mr Farenden re-emphasised that the patient must be at the centre of everything the Trust does, and stressed that patients must be listened to. He added that by bring the story to the Board outlined the Trust's open approach and commitment to ensuring action was taken. The Board **NOTED** the Patient Story and supported the ensuing actions to ensure an improved quality of service.
TB 13/14 105	**Medical Director's Quality Report**
	Dr Robinson presented the Medical Director's Quality Report, which the Board then reviewed in detail, page by page. She highlighted that the Data Quality Steering Group had produced a number of reports that were designed to help the Trust understand the issues relating to mortality indicators and improve information and data flows. It was noted that the reports indicated further coding improvements were required. The Board was then informed that the report contained a detailed breakdown of nurse staffing levels for the first time. Dr Swart stated that she could not emphasise enough that the information contained within the report was presented to demonstrate the desire to use data to drive improvement. The nurse staffing table presented in the report was presented in a simplified manner to be meaningful and informative. She added that transparency and clarity of data were key indicators of quality and safety. Ms Searle welcomed the nurse staffing information. She stated that she was finding it difficult to feel assured that the Trust would be able to deliver the required levels of nursing. In response to a question regarding the composition of nurse ratios and the inclusion of staff undertaking management duties, Ms Barnes advised that the 1:8 ratio was a national recommended benchmark, and it was her interpretation that the ratio only counted those on shift who were physically providing care, thus nursing staff undertaking management duties were not included in the ratio. Ms Barnes added that clinical managers rotas currently clearly distinguished between clinical and management days. Ms Searle raised concern that the 1:8 ratio should be seen as an absolute point with escalation mechanisms built into it, and it should not be seen as a target. Dr Swart assured her that would not be the case. The Trust was using the 1:8 ratio as a minimum standard, and there was a great deal of work ongoing to understand the required ratios for each individual ward. Mr Kershaw commented that the basic standards of care being delivered should be seen as important as nursing ratios, and both indicators should be considered alongside each other. Dr Swart agreed and advised that discussions had been taking place to ensure that a complete picture can be meaningfully presented to the Board, with the nurse to bed ratio being just one of many indicators. Ms Searle asked if the planned recruitment of nurses was on track. Ms Brennan reported that the recruitment system had been streamlined to speed up the process, but the Trust was finding difficulty in recruiting the required numbers due to large numbers of other Trusts recruiting in response to the Francis Report. As such, the available pool of nurses was much smaller than anticipated. In response to this, Ms Brennan advised that

	the Trust would be seeking to recruit internationally as well as nationally. Mr Farenden commented that nurse recruitment needed to be closely monitored and stated that the Board needed to receive monthly assurance that improvements were achieved. With regard to pages 20 and 22 of the Board papers, Mr Noble asked if mortality and coding relating to GI Bleeding and post-operative unexpected deaths should be scrutinised in greater detail by the Integrated Healthcare Governance Committee. Dr Robinson advised a review into those areas was ongoing with the findings still awaited. Once the review had been concluded, a decision could then be made to determine the level of scrutiny required. Dr Robertson added that deaths due to those factors were reported as serious incidents requiring investigation, all of which were reported to the Integrated Healthcare Governance Committee. Dr Swart commented that the outcomes of all mortality group findings were reported to the Board via the Medical Director's Report, and they also featured in the Quarterly Safety Book reviewed in depth at the Integrated Healthcare Governance Committee. Mr Robertson observed that crude mortality rates appeared to be very low whilst SHMI was very high and questioned why that was the case. Dr Robinson advised that metrics used to derive the numbers were complex and confusing but fundamentally risk adjustment was done very differently for HSMR and SHMI which impacted on the reported rates. She added that the Board should take encouragement from the fact that the overall numbers were decreasing. Dr Swart commented that she was working with Dr Foster to understand what the data was telling us and added that the Trust needed to focus on reducing avoidable deaths. The Board **NOTED** the Medical Director's Quality Report and supported the actions outlined.
TB 13/14 106	**Patient Experience Report**
	Ms Barnes presented the Patient Experience Report. In presenting the highlights of the paper, Ms Barnes reported that the Patient Experience Strategy was being reviewed, along with the associated implementation plan, following a review of themes which had been identified after a detailed review of internal and external patient experience feedback. In the context of national patient experience activities, the Board noted that there had been a marked improvement in the Friends and Family Response rate in September. The priority moving forward was to re-engage with staff regarding the friends and families test in light of the urgent care pressures faced. Ms Barnes added that the friends and families test had recently been launched in in-patient areas and in maternity services. Mr Farenden asked when results for those areas would be available for Board members and was advised January 2014. Ms Barnes reported that the net-promoter score for the Trust was 63. The score had been benchmarked as reasonable and above average, but it was noted that the response rates needed to improve to ensure the results were meaningful. Dr Swart informed the Board that the Patient Experience Lead was working on developing enhanced collection mechanisms for collating patient experience data.

	The Board **NOTED** the Patient Experience Report and looked forward to receiving the results of the inpatient and maternity tests in January 2014.
TB 13/14 107	**Infection Prevention Performance Report**
	Ms Barnes presented the Infection Prevention Performance Report. In presenting the highlights of the report, Ms Barnes reported that year to date there had been 18 incidences of C.Diff, with one case discovered in September. The ward where the case had been discovered had been placed in special measures as the case was linked to a previous case in August, which was indicative of failings in infection control procedures. Mr Farenden asked if there had been any further cases found on the ward during October. Ms Barnes confirmed that there had not. The Board **NOTED** the Infection Prevention Performance Report.
TB 13/14 108	**Infection Control Annual Report**
	Ms Barnes presented the Infection Control Annual Report. Ms Barnes informed the Board that there was a statutory duty upon Trusts to prepare an annual report for infection control matters. The report presented outlined the key infection prevention and control initiatives and activities of the Trust for the year April 2012 to March 2013. It also presented assurances on the Infection Prevention and Control Programme and activity for 2012/13. Mr Noble asked; of the 30 cases of C.Diff identified during the reporting period, how many could be classed as inappropriate samples. Ms Barnes responded that information could not be accurately reported due to a change in the national monitoring and reporting guidance and procedures which occurred during the year. Because of the changes it was not possible to report a year on year comparison. The overall reduction in incidences could be attributed to the monitoring and reporting requirements becoming much more stringent. Mr Farenden noted that over a number of years comparatively, the Trust was one of the best performers in the country, and it was important that the success was recognised, alongside the challenge faced by the Trust. The Board **RECEIVED** the Infection Control Annual Report.
TB 13/14 109	**Safeguarding Adults and Children's Annual Report**
	Ms Barnes presented the Safeguarding Adults and Children's Annual Reports. She advised that both reports had been considered by the Integrated Healthcare Governance Committee prior to presentation at the Board. Ms Barnes stated that currently the scrutiny of Trusts had increased substantially as national interest and awareness of safeguarding increase through media interest. The reports summarise the overall provision for safeguarding vulnerable adults and children at the Trust for 2012/13 and outlined the priorities for the forthcoming year. Dr Swart commented that the reports were important in the context of

	staffing levels, particularly in relation to those patients which were most vulnerable. Ms Searle complimented the work of the respective teams, highlighting in particular the PARs assessment tool. Ms Searle asked what the compliance levels were for the Trust in relation to mandatory safeguarding training. Ms Barnes advised that for safeguarding vulnerable adults, compliance levels were positive, but safeguarding children compliance was proving more challenging although there were plans in place to significantly improve overall compliance. Ms Searle requested assurance that the challenges faced in relation to pre-birth plans were documented on the Trust corporate risk register. Ms Barnes undertook to find out and confirm it was documented on the risk register. Dr Swart commented that Ms Barnes had undertaken a significant amount of work in improving safeguarding systems and processes in the Trust in light of the national challenges, and was re-assured that there were plans in place to maintain improvements moving forward. The Board **RECEIVED** the Safeguarding Adults and Children's Annual Reports.
TB 13/14 110	**Annual Clinical Audit Plan**
	Dr Robinson presented the Annual Clinical Audit Plan to the Board for approval. In presenting the report, Dr Robinson informed the Board that the Annual Clinical Audit Plan comprised of both risk and compliance based audits which had been aligned with the Trust corporate objectives and the Board Assurance Framework. The work of the Department of Clinical Audit, Safety and Effectiveness was rapidly expanding but the Department was not fully-staffed. Recruitment of the DCASE Lead and a new Senior Audit Officer post was ongoing. A Mortality and Coding Review Group had been formed to promote Trust wide ownership of issues raised by Dr Foster data to engage clinicians in clinical audits relating to mortality alerts and in the monitoring of mortality as well as in acting on this outcome data. The role of this group would be expanded to incorporate the deliberations from Morbidity and Mortality meetings with recommended actions and these will be formally reported in the Quarterly report on Safety, Quality and Governance. It was noted that no NGH surgeons had been identified as outliers in the specialty reports published as part of the Everyone Counts initiative and that all relevant surgeons had agreed to the publication of their data. Mr Robertson asked if the self-assessment conducted, attached at appendix 2 of the report, was something which was unique to the Trust. Dr Robinson advised it was a national self-assessment which was used to aid continual development. Mr Robertson asked if there were sufficient resources available to deliver the plan. Dr Robinson advised that the department had recently been restructured and active recruitment was ongoing for substantive staff. Once appointed to, there would be sufficient resource to deliver the plan.

	Dr Swart commented that clinical audit would be an area which may require additional investment in the future to support clinical quality improvement. The Board **APPROVED** that Annual Clinical Audit Plan.
TB 13/14 111	**Operational Performance Report**
	Mrs Brown presented the Operational Performance Report to the Board. She reported that the Trust achieved the RTT, diagnostic, stroke and cancelled operations standards during September 2013. The Board was informed that un-validated data indicates the Trust had achieved all the cancer standards with the exception of 31 days from decision to treat for subsequent surgery in September. The Trust was on target to achieve all the quarterly standards with the exception of the 62 day from urgent referral standard. With regards to 4 hour transit time, the Trust did not achieve the target during September; the Trust achieved 90.20% against the standard of 95%. Year to date performance is 92.13%. Mr Farenden asked what the timeframe expectation of the TDA was in respect of the Trust meeting the 4 hour transit target. Ms Brown reported that the Trust had informed the TDA the Trust would not meet the 95% target by the year end, but it would aim to achieve 95% month on month from November 2013 to March 2014. Mr Farenden queried if that was a health economy target, for example were the TDA cognisant of the role of the CCG in enabling that to happen. Mrs Brown advised that the aim had been agreed at the Urgent Care Board by all partners, but realistically, the TDA would hold NGH to account for its delivery. Mr Farenden commented that he would like to see the rest of the health economy held to account for their respective actions in supporting the Trust to meet the monthly target. Mrs Brown informed the Board that the RTT target would not be achieved for orthopaedics in October due to issues with the spinal service. Dr Swart added that the issues were symptomatic of services being provided single handed and contingency planning needed to improve. Mr Pallot reported that remedial action plans had been submitted to the CCG in respect of the 31 day cancer target and the 4 hours transit targets, for which there would likely be financial implications for the Trust in the way of fines. The Board **NOTED** the Operational Performance Report.
TB 13/14 112	**Urgent Care Update**
	Mrs Brown presented the Urgent Care Report to the Board and outlined the key actions which were being taken to address the pressures in urgent care and their impact on the 4 hour transit time target. She reported that the work streams of the urgent care programme had been reviewed to ensure there was an increased focus on a number of areas key to delivering improvements and provided a detailed overview of the work stream priorities to the Board. The Board was informed that the Trust was a recipient of additional winter funding £4m had been assigned to the health economy and would be

	utilised to increase staffing, provide extra capacity in the community for dementia patients, provide additional emergency theatres and increase therapy and social services staff at the A&E front door. The effective use of the funding would be monitored at the health economy urgent care board. Dr Swart emphasised that urgent care pressure was a local and national issue, and she had agreed the current priorities and actions to address them with the TDA. She continued that she was determined to solve the issues as they were impacting on the quality of care delivered by the Trust. For further context, Mrs Needham informed the Board that the Trust had seen an increase in attendances at A&E of 16.5% from the same time last year, whereas the rest of the country had seen on average an increase in attendances at A&E of 0.17%. NGH had seen the highest increase in attendances in the country. Dr Swart advised that the TDA had offered external support in working to achieve sustained 95% compliance with the 4 hour transit target, to which the Trust had agreed to accept, but she stressed that the thoughts and ideas needed to be embedded in the Trust for the to work and deliver sustained improvement. The Board **NOTED** the Urgent Care Report and supported the focus on addressing the issue as a matter of urgency.
TB 13/14 113	**Finance Report**
	Mr Foster presented the Month 6 Finance Report to the Board. With regards to the I&E position, the Board was asked to note that the position at the end of August was a deficit of £2.7m, £1m of which had arisen during August itself as income levels fell away. The position for September was better with a further deficit of just £0.3m bringing the year to date position to a deficit of £3m overall. The Board was advised the Trust had been unable to agree the Q1 contractual reconciliation with Nene CCG which was due to be completed to an extended deadline in September. The CCG were citing operational problems with the Business Intelligence Unit of the CSU (GEM). This meant that SLA income and fines remained estimates which presented additional risk to the financial position. Mr Foster advised that he had personally requested that the CCG formally agree the Q1 and M4 position. As a result of the protracted reconciliation, the finance team were continuing to make significant provision for potential fines and penalties within the position. At month 6, £4.7m had been set aside for a range of potential issues which were presented within the report. Mr Foster reported that there had been a great deal of activity, both internally and externally with key stakeholders in an attempt to reach a position where the Board could confidently sign off a balanced financial plan. Mr Foster informed the Board that over the last two weeks he had been engaged in a series of conversations with the Chief Financial Officer at Nene CCG to try and agree the reinvestment of fines. At a recent Directors of Finance meeting some Trusts had managed to negotiate up to 60% of fines back but not all Trusts had achieved that.

	At the meeting with Nene CCG, it was clear that the CCG were willing to agree a minimum income level for 2013/14, but if that could not be achieved then the full force of fines and penalties would be levied against the Trust. Following further negotiations it was became clear that there was a £2m difference between the CCG and the Trust's minimum income levels, and as such a deal was not agreed. In providing additional regional context, Mr Foster informed the Board that the Local Area Team required the CCG to deliver a 1% or £7m surplus. In addition, the Local Area Team had advised that the regional position had deteriorated by £40m. Mr Foster advised that following the negotiations with the CCG he had concluded that there remained no basis for the Trust to submit a balanced plan to the TDA. He added that there were grounds to consider declaring a higher deficit in readiness for fines and penalties. With regard to cash flow, Mr Foster reported that as predicted, the cash flow at the beginning of October was problematic following the first instalment of Public Dividend Capital dividend made in September. Subsequently, the Trust had submitted the temporary borrowing request for an initial £4m to the TDA and awaited the outcome of the request. It was anticipated that the Trust would be able to draw down against the facility by December 2013. Dr Swart informed the Board that she was hopeful that an agreement could be reached with the CCG, although the regional Local Area Team position would impact on that. The Board **NOTED** the Finance Report and support the Director of Finance's position not to declare a balanced year end position.
TB 13/14 114	**Workforce Report**
	Ms Brennan presented the Workforce Report to the Board. She highlighted that the Trust sickness absence rate had increased during September, although it remained significantly better than the same point last year. Workforce capacity remained within plan, although there were areas which remained of concern which were being actively focussed on. With regard to appraisals, she advised that the revised appraisal paperwork and process to support the changes in Terms & Conditions to Agenda for Change would be launched on 1 November. Training to support staff and managers for the changes was being provided. Ms Brennan reported that following the recent review of mandatory training which has seen the reduction of the number of subjects from 23 to 9, a pilot has commenced where staff can have their knowledge and competency assessed by Mandatory Training Leads thus demonstrating compliance. This approach would consist of stations where Mandatory Training Leads would discuss scenarios with a group of up to 4 staff members and assess their knowledge and competence on the given subject; staff rotate around the different stations and upon successful completion are deemed compliant with those subjects. If staff are not competent they will be required to complete either face-to-face or an e-learning training in the subject. If the pilot was found to be successful it would become part of the blended provision for Mandatory training.

	Ms Searle asked what the turnaround time for recruitment was, from notification to appointment. Ms Brennan advised that it currently stood at 12-13 weeks but the system was being streamlined to reduce the timeframe. The Board **NOTED** the Workforce Report, particularly the anticipated improvements in mandatory training and the recruitment timeframe.
TB 13/14 115	**Transformation Report**
	Ms Brennan presented the Transformation Report to the Board. It was reported that the latest thinking forecast at month 6 was £12.1m, against a plan of £13m. The downside position stood at £11.6m. Overall, despite improved performance, there remained a shortfall in the £13m target. Ms Brennan advised that whilst mitigations were still being identified and developed with QIAs, the Trust needed to consider schemes which had previously been felt to be unpalatable in an attempt to close the gap. She advised that examples of schemes being consideration were to increase staff parking charges, restrict new contracts to a maximum of 35 hours per week, and to reduce the staff restaurant subsidy. She added that if agreed, those schemes still would not completely meet the shortfall. Mr Kershaw voiced his concern around schemes which affected staff being considered unless significant returns could be guaranteed, particularly in light of current operational pressures and staff morale. He requested that any plans which affected staff be presented to the Board for consideration and approval. Dr Swart commented that the Trust was in a position now where it had to consider difficult and unpalatable schemes. She added that the alternative to the schemes presented was to remove front line posts, which was not an option. The outline plans were due to be presented to the JCNC to gauge the views of staff prior to any schemes being worked up in detail. Mr Farenden requested that any business case be presented to the Finance Committee for detailed consideration prior to presentation to the Board for approval. The Board **NOTED** the Transformation Report.
TB 13/14 116	**Self-Certification Report**
	Mr Pallot presented the self-certification report and asked that the Board approve a submission of Declaration 2 of the Single Operating Model. The Trust showed a financial risk rating of 2 and a governance risk rating of red. The governance risk rating was held at red due to the Trust not achieving the 4 hour transit time and cancer targets. The Board **APPROVED** the self-certification returns for Monitor Compliance and Board Statements based upon the evidence provided, and **APPROVED** the signing of Declaration Two of the Single Operating Model.
TB 13/14 117	**Standards of Business Conduct**
	Mr Foster presented the Standards of Business Conduct to the Board for approval. He advised that the documents outlined the roles and responsibilities of Trust staff in conducting business in accordance with sound corporate

	governance principles. It covered the issues of declarations of conflicts of interest arising from giving and receipt of gifts and hospitality, educational and training events; speaking arrangements, provision of private clinical opinions, private practice, commercial sponsorship, contracting, procurement and intellectual property rights. It set out the arrangements for all staff in relation to their conduct inside work, and where this has a bearing on their position within the Trust, outside work. This document replaced the 2009 version approved by the Board, and had been strengthened to reflect the duties placed upon the Trust and its staff following the introduction of the Bribery Act 2010. The document has been subject to wide organisational consultation and was approved at the September 2013 Audit Committee. The Board **APPROVED** the Standards of Business Conduct.
TB 13/14 118	**Emergency Preparedness, Resilience and Response**
	Mrs Needham presented the Emergency Preparedness Resilience and Response Audit Return to the Board for approval. She advised that the return was a response formed part of a national assurance programme and was a benchmarking exercise based on a number of pre-set questions relating to the Trust's ability to prepare and respond to a range of incidents both internal and external. The report reflected the key gaps which were included within the accompanying work plan. The Board **ENDORSED** the Emergency Preparedness, Resilience and Response Audit Return and the accompanying action plan.
TB 13/14 119	**Research and Development Annual Report**
	Dr Swart presented the Research and Development Annual Report to the Board. Dr Swart summarised the paper and provided an overview of the Trust performance in research through 2012/13. She advised that the report also presented the Trust's Research Capability Statement which is a national requirement on Trust which needs required endorsing by the Board. In she advised that the paper introduced research and development key performance indicators which were a local prerequisite for infrastructure funding and also required approval. Mr Noble asked if any surplus generated through research and development was being fully absorbed. Mr Foster confirmed that it was. The Board **ENDORSED** the Trust's Research Capability statement and **APPROVED** the Key performance matrix for Research and Development for reporting to the Trust Board.
TB 13/14 120	**Any Other Business**
	No items of any other business were raised.
TB 13/14 121	Mr Farenden called the meeting to a close at 12.00.

	Date of next meeting: 9.30am, Thursday 28 November 2013, Boardroom, NGH.
TB 13/14 122	**The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted**

Actions from Trust Board

Last update 22/11/2013

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
24/07/2013	TB 13/14 072	Risk Management Strategy	The Board requested that the Risk Management Strategy be updated to reflect the agreed changes and presented to the November 2013 Board meeting.	Ms S Loader	28/11/2013	Some Slippage	To be presented to the December Board Development Day and December Audit Committee.
24/07/2013	TB 13/14 073	Complaints Annual Report 2012/13	Obtain annual benchmarking data for complaints and share with Board members.	Ms S Loader	Ongoing	On Track	
23/09/2013	TB 13/14 091	Urgent Care Report	Present a comprehensive Urgent Care Report to the November Board	Mrs D Needham	28/11/2013	Completed or on Agenda	

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

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

Northampton General Hospital NHS
NHS Trust

Trust Board
28 November 2013
Chief Executive's Report

1. Barratt Birth Centre Opening

Our new Barratt Birth Centre opens on Monday 2nd December, the first midwife-led unit in the county. The new centre has four birthing rooms, three with pools, plus kitchenettes and double beds so dads can stay over. Mums-to-be will be able to have their baby in a more homely and calming environment, with all the benefits of having expert medical support very close by should the need arise.

Earlier in the year we opened a new birthing pool room on the obstetric labour ward which has proved to be very popular with new mums. A maternity observation ward was also opened alongside the labour ward, providing an area for mothers who require increased monitoring either before or after birth. These improvements mean we are able to offer a complete range of birth options for women and their families, ensuring women receive the right care, in the right environment for them, at the right time.

2. Governments Response to the Francis Report

Last week the government published its final response to the Francis report accepting all but nine of the original 290 recommendations. Robert Francis QC had stressed that the majority of his recommendations could be implemented without the need for new legislation and the response reflected the fact that many of the recommendations were already being implemented by providers of NHS services. The key points from the response included:

- **Staffing**: Hospital boards will be ordered to review and publish nurse staffing levels. There will be no national minimum staffing levels but there will be nurse to patient ratios for different types of wards. NGH has already begun to report nurse staffing levels within the Medical Director's Quality Report to the Trust Board.
- **New criminal offence of wilful neglect**: The government intends to legislate at the earliest available opportunity to introduce this offence so that those responsible for the worst failures in care are held accountable. Under this any staff, including managers, found guilty of the most extreme cases could face up to five years imprisonment. This will not criminalise unintended error but instead is focused on cases of patients being neglected or deliberately ill-treated.
- **The introduction of a statutory duty of candour on organisations**. The government will consult on proposals whereby a Trust should reimburse a proportion or all of the NHS Litigation Authority compensation costs where the Trust has not been open with a patient. The professional duty of candour on individuals will be strengthened through changes to professional codes. NGH already has well established being open procedures in place, which are being expanded upon in light of the Francis Report.
- **No regulation of healthcare assistants**. There will however be a new care certificate to ensure that healthcare assistants and social care support workers have appropriate skills and training.

- **Introduction of a "fit and proper person's test"** Managers who have failed in the past will be barred from taking up posts. The Care Quality Commission will police the tests and get new powers to investigate whether an individual is fit to hold a director level position.
- **Improving the complaints process**. All hospitals to clearly set out how patients and their families can raise concerns or complain, with independent support available from NHS complaints advocacy services, Healthwatch or alternative organisations. Quarterly reporting of complaints data and lessons learned by trusts, with the Ombudsman to significantly increase the number of cases considered.

Further details on the actions the Trust has taken in response of to the Francis Report are presented in a separate agenda item to the Trust Board.

3. The NHS Mandate

The Government recently published its NHS Mandate to the NHS Commissioning Board. The Mandate sets out the desired strategic direction for the NHS Commissioning Board, which will in turn influence the local commissioning strategies, and ultimately influence NGH's clinical strategy.

The objectives presented in the Mandate focus on those areas identified as being of greatest importance to people. They include transforming how well the NHS performs by:

- preventing ill-health, and providing better early diagnosis and treatment of conditions such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age;
- managing ongoing physical and mental health conditions such as dementia, diabetes and depression – so that we, our families and our carers can experience a better quality of life; and so that care feels much more joined up, right across GP surgeries, district nurses and midwives, care homes and hospitals;
- helping patients to recover from episodes of ill health such as stroke or following injury;
- making sure we experience better care, not just better treatment, so that we can expect to be treated with compassion, dignity and respect;
- providing safe care – so that we are treated in a clean and safe environment and have a lower risk of the NHS giving us infections, blood clots or bed sores.

As part of this, the Government has identified the following priority areas where it is expecting particular progress to be made:

- improving standards of care and not just treatment, especially for older people and at the end of people's lives;
- the diagnosis, treatment and care of people with dementia;
- supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally;
- preventing premature deaths from the biggest killers;
- Furthering economic growth, including supporting people with health conditions to remain in or find work.

4. Cancer Partnership

The first meeting has now been held with UHL at which colleagues from both NGH and KGH were present. The aim of the first meeting was to ensure that all parties were aligned to the vision of producing a proposal which initially delivers a unified oncology service which then widens to cover a joint cancer service serving Leicestershire, Northamptonshire and Rutland.

Leadership for the programme will come from Chris Pallot, Christine Elwell and Tracey Harris with other clinical representation from around the Trust at relevant times.

It was agreed that a paper would be prepared for each of the constituent boards in January which signalled a joint intent to pursue this work with a proposal for oncology services being delivered in March.

5. Prior Approval Policies

In recent weeks the Trust has been notified by NHS Nene Commissioning that it is altering the way in which certain procedures are classified according to their referral criteria. We have been advised that the following will now be classed as "red" meaning that explicit approval has to be given for each referral being made from primary to secondary care:

- Tonsillectomy in Adults and Children
- Carpal Tunnel Decompression
- Dupuytrens Contracture Surgery
- Ganglion and Mucoid Cyst
- Grommets in Children
- Hip and Knee Replacements
- Male Circumcision
- Rhinoplasty & Septorhinoplasty

In the past, the Trust has been able to treat these patients as long as their clinical presentation meets the set criteria.

The Trust is concerned at the process that is being adopted and will continue to manage the issue through established contract routes. In 2012/13 the Trust undertook approximately 2,000 of these procedures which could therefore have considerable impact on patient expectation & experience and associated income for the Trust.

6. Hospital Inspection

As indicated in last month's Board report NGH will be included in the next 19 acute and specialist trusts to be inspected by the CQC as part of their new hospital inspection programme and the inspection will start on January 15th. It will consist of a mixture of announced and unannounced visits and will include a broad range of services across the hospital.

It is clear from the experience of other hospitals that the inspection process mandates significant preparation and clear communication with staff before, during and after the inspection itself. For NGH this will largely be a matter of communicating our plans for improvements in communication, engagement, development and quality governance all centred on patient safety.

A programme of work is in preparation in readiness for the inspection which will include a continued emphasis on the fact that we know that there are areas where we need to take action to ensure our services are of a consistently high quality , that we need to build on the good work underway to strengthen this work.

Our own new internal inspection process, known as QuEST (quality, effectiveness and safety) is currently in the active pilot phase and good progress is being made towards our aim of ensuring that all wards will have undergone a QUEST inspection by the end of the calendar year. A key message for staff remains that this is a formal acknowledgement of the fact that we need to challenge ourselves to be as good as we can be and testing ourselves is one way to do this – in a true QuEST for excellence.

Experience from other hospitals confirms that the CQC inspection will be able to provide us further opportunities to identify improvements that we need to make to our services. We need to ensure that this message above all others is communicated to staff and patients and there is a clear understanding that the inspection , along with the feedback from our patients and our staff and our own internal inspection processes appropriately channelled , will enable us to provide even better care for our patients.

Dr Sonia Swart
Chief Executive
November 2013

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

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

Executive summary

- Overall mortality as measured by HSMR is significantly better than expected but mortality as measured by SHMI is significantly higher than average. The very marked divergence is not fully explained by investigations undertaken so far.
- Detailed review of adverse clinical outcomes is undertaken and monitored for improvement by the Mortality & Coding Review Group [M&CRG]where recommendations for improvement are made if necessary
- Crude mortality for 2013-4 is substantially lower so far than in 2012-3
- Data quality is being addressed through the new Data Quality Group
- Data quality from community Trusts remains a concern but can now be separated from the acute site since April 2013.
- Coding is examined, revised as appropriate and reported to M&CRG
- 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. Additional tools are becoming available which may provide complementary information, but require validation before adoption
- Themes for any issues of care identified through mortality reviews and Serious Incidents are fed in to the Trust Patient Safety Programme.
- Mortality reviews are being strengthened at directorate level and will be monitored by M&CRG
- Trustwide mortality review process is to be repeated as in previous years, but increased to twice yearly
- Review of a CQC mortality alert is underway [gastro/liver diseases]
- Dr Foster 'Good Hospital Guide' will be published shortly and will highlight previous high HSMR [3 yr average 2010-2013]

Related strategic aim and corporate objective	Strategic Aim 1
Risk and assurance	High mortality scores and red rated safety indicators present a risk to reputation and quality of service. Actions underway are described in each section
Related Board Assurance Framework entries	BAF 1, 2

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N)** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	Regulators will consider quality indicators and take action where appropriate. Assurance for regulators can be provided through the demonstration that analysis of issues is combined with the necessary quality improvement work.

Actions required by the Board

The Board is asked to note the report and debate the issues that arise from it.

Medical Director's Quality Report

Section 1

Review of current mortality and safety data provided by Dr Foster

1. Introduction

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end August 2013 and SHMI (to March 2013). Other providers have recently entered the market to supply hospitals with similar mortality monitoring tools, but as yet these have not been widely validated. They may yet prove to be complementary but are not currently used at NGH.

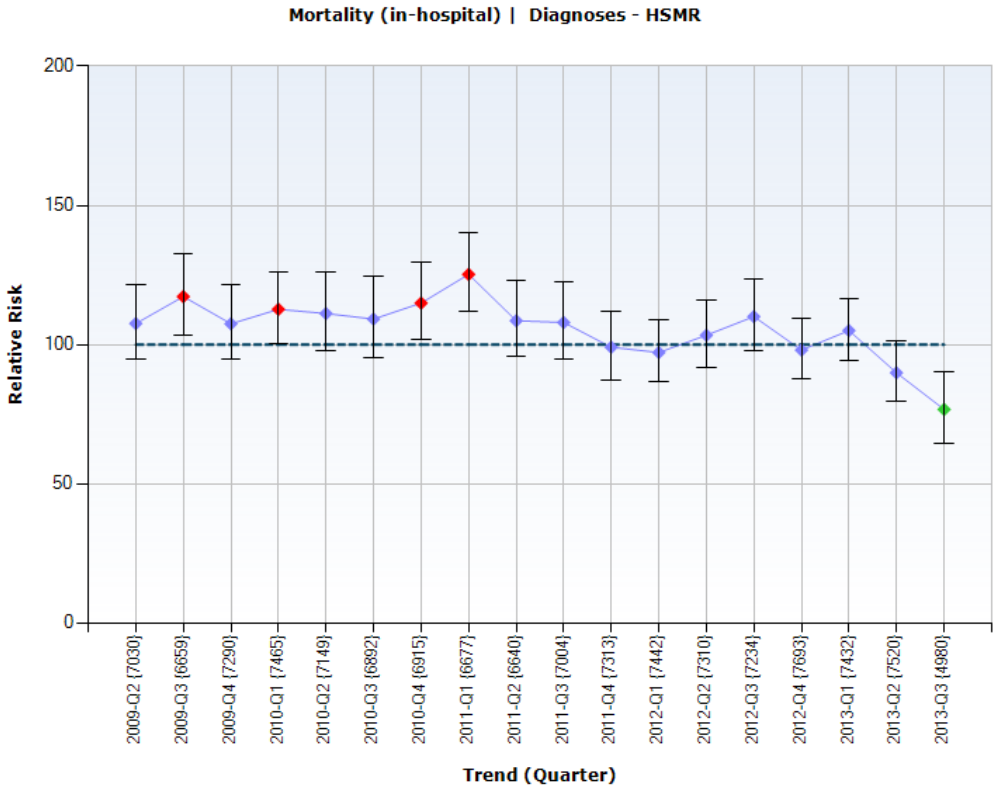
2. Current Position HSMR (Hospital Standardised Mortality Ratio, Dr Foster Intelligence)

HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its use continues. It is based on mortality in 56 CCS (Clinical Classification Software) groups. These diagnostic groups account for 80% of hospital mortality. The remaining 200 groups account for the remainder. They are not included in HSMR as predictive risk modelling for these small volume diagnoses is not as reliable. At NGH there is a detailed monitoring process which tracks HSMR and investigates individual diagnoses whose SMR (standardised mortality ratio) is persistently adverse.

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

Northampton General Hospital Trust includes 3 community sites. As previously described, the casemix between the acute Trust and the community wards is very different, the latter admitting patients directly from and to KGH, from and under the care of GP's, and also long-term patients for rehabilitation. It is now possible to monitor HSMR performance back to April 2013 for each site, generating 5 consecutive months' data. It is helpful to be able to monitor performance on the acute site without any confounding impact from the community wards. However there is as yet insufficient data to be able to draw any robust conclusions about current performance.

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



3. HSMR Comparison

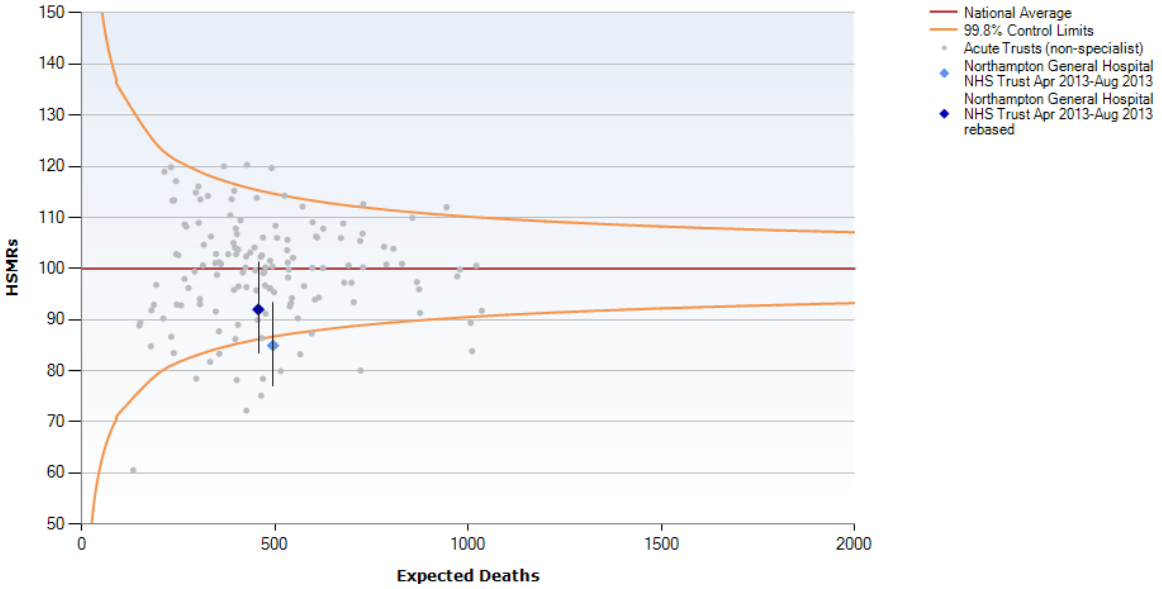
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture.

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 8 points since 2012-3. NGH HSMR for the rolling year to date is **96**, and for 2013-4 is **85, 92** when rebased. This shows a continued marked improvement.

Crude mortality for 2013-4 is currently 3.4%, showing marked improvement as compared to 2012-3 (4.2%) and the lowest in the previous SHA group of hospitals. The current average for Trusts in previous SHA is 3.8% (range 3.4% - 4.9%).

Acute Trust HSMRs Apr 2013 - Aug 2013

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



4. Standardised Hospital Mortality Indicator (SHMI)

The most recent data release (to end March 2013) shows, as predicted, a further deterioration in performance for 2012-3 at **115.8**. HSMR for the same period was **104.** The marked divergence between the 2 is of real concern especially because SHMI data is not available for analysis to identify areas of poor performance. It is likely that the some of the discrepancy can be attributed to the lack of allowance for palliative care for the hospice admissions to the community wards, and the less discriminating methodology used by SHMI which includes all CCS groups. It is expected to show an improvement over the next 2 quarters, but meanwhile all possible areas of risk indicated by SHMI are being monitored to ensure that there is evidence of improvement in 2013-4 (using Dr Foster) and investigated where this is not the case.

Dr Foster patient safety indicators (September 2012 - August 2013)

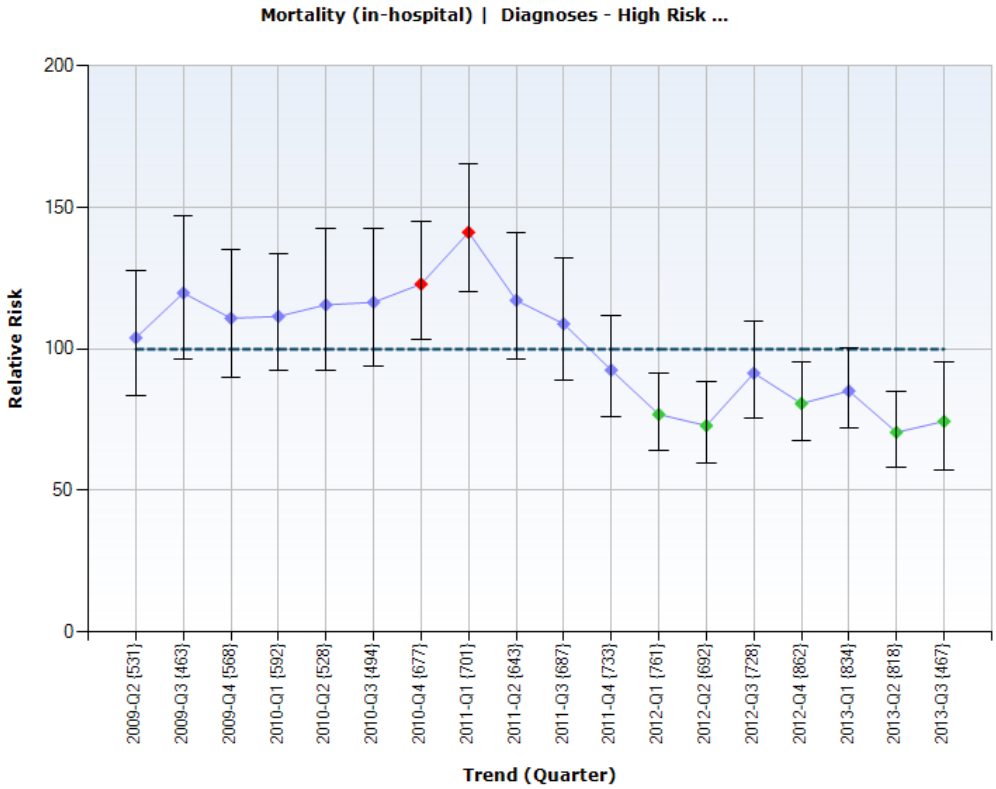
Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	38,685	27	30.5	0.7	0.8	88
Decubitus Ulcer	9,326	239	305.5	25.6	32.8	78
Deaths after Surgery	337	53	39.8	157.3	118.1	133
Infections associated with central line *	15,842	1	1.1	0.1	0.1	94
Postoperative hip fracture *	25,475	2	1.6	0.1	0.1	127
Postoperative Haemorrhage or Haematoma	23,474	5	13.8	0.2	0.6	36
Postoperative Physiologic and Metabolic Derangement *	19,845	2	1.6	0.1	0.1	124
Postoperative respiratory failure	18,124	15	15.5	0.8	0.9	97
Postoperative pulmonary embolism or deep vein thrombosis	23,656	34	45.0	1.4	1.9	76
Postoperative sepsis	560	4	3.8	7.1	6.9	104
Postoperative wound dehiscence *	986	0	1.4	0.0	1.5	0
Accidental puncture or laceration	66,202	38	76.4	0.6	1.2	50
Obstetric trauma - vaginal delivery with instrument *	525	32	43.4	61.0	82.7	74
Obstetric trauma - vaginal delivery without instrument *	2,451	83	94.0	33.9	38.4	88
Obstetric trauma - caesarean delivery *	1,194	0	4.4	0.0	3.7	0

The metric ‘deaths after surgery’ has returned to within the ‘as expected’ range since the previous month. There are no other significantly adverse patient safety indicators for the rolling year to date.

6. Reports on key areas for action or of importance

As would be expected with the very marked improvement in HSMR during 2013-4 there are fewer adverse outliers: no new areas for investigation have arisen since last month.

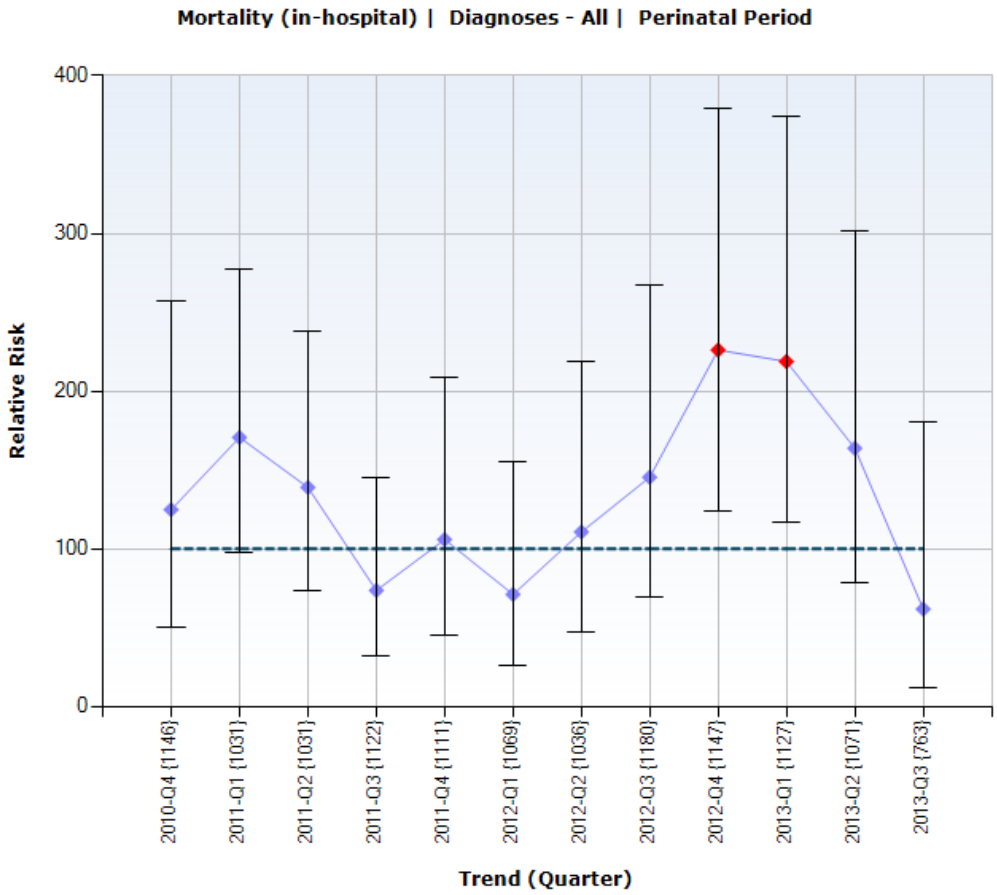
Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for 2013 - 4 at **72**.



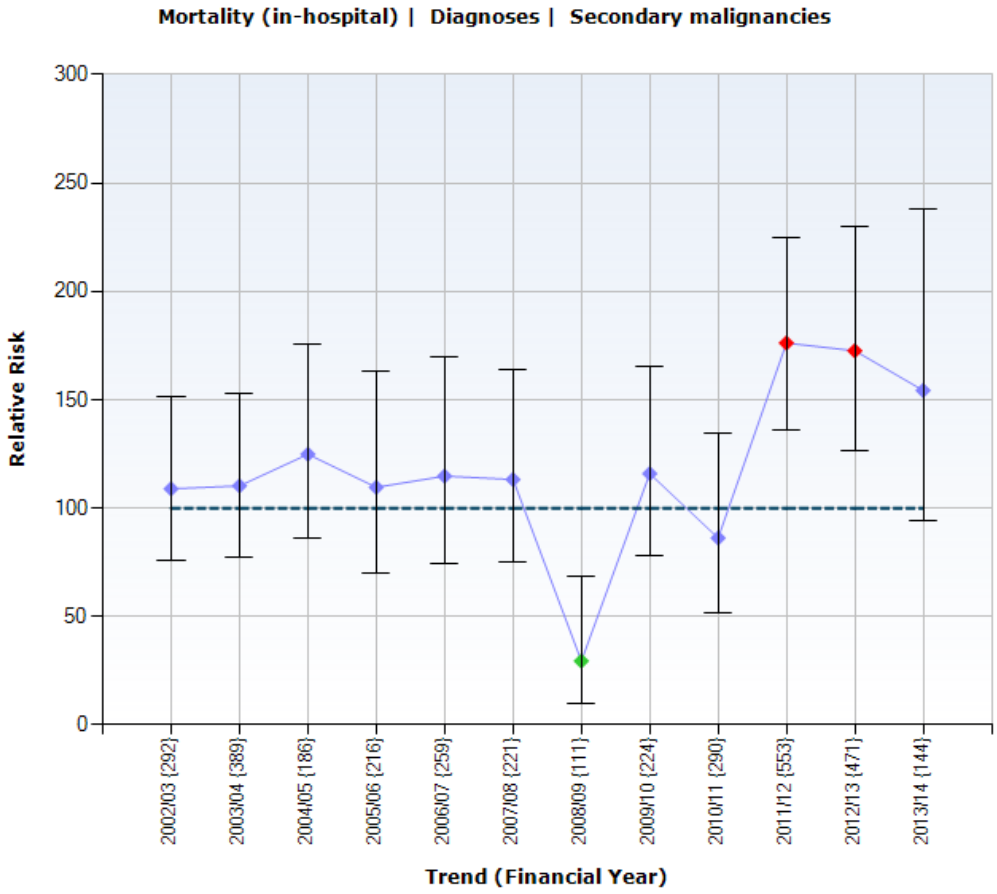
SMR for both fractured neck of femur (**69**) and heart failure (**72**) have shown very marked improvement in 2013 -4.

7. Possible areas for concern under investigation

Perinatal mortality: a final report reviewing stillbirths has been received as previously discussed. Preliminary findings of a review of neonatal deaths show no concerns regarding clinical care, with several of the babies having lethal congenital conditions (the final report is due 28/11/13). It is possible that the rise in perinatal deaths in 2012-13 reflects normal cause variation (including the death of very premature triplets), however both obstetric and paediatric teams will be strengthening their mortality case review processes in line with hospital standards.



Secondary malignancy: this diagnosis, which includes patients newly presenting with disseminated cancer and also those known to have widespread disease and who may be admitted for palliative care, is showing no obvious improvement. Mortality in this patient group rose with the addition of the community wards, including the Danetre Palliative Care unit. Previous review of deaths at NGH has suggested problems with the delivery of Acute Oncology, a service which is currently undergoing significant clinical staffing concerns at NGH, and also patients admitted with metastatic lung cancer [an improved pathway is under development].



Palliative Care: A more rigorous approach to coding palliative care has increased the used of this code in 2013-4 from 2.5% (less than national average) to 3.4% (above national average) which affects performance in HSMR but not SHMI. The code for palliative care is being used both for patients with cancer and those with long-term conditions such as heart failure and chronic lung disease.

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

The Dr Foster 'Good Hospital Guide' is expected to be published in December. Preliminary information provided by Dr Foster suggests that we will be an adverse outlier for HSMR over the previous 3 years at **106.9** (due to the high HSMR in 2010-11) and also for weekday cancer admissions (due to the persisting overall high mortality from secondary malignancy previously mentioned). We have shown better than expected performance for complications of stroke (hospital acquired pneumonia, **59**0.

In preparation for a review by CQC in January 2014 we have been alerted to a composite mortality outlier for gastrointestinal and liver diseases in 2012-3. It is likely that the overall SMR for this group was approximately **140** in 2012-3. In 2013-4 it has already fallen to <**120.** A detailed analysis of the data is underway, including a review of work already undertaken during the relevant period for previously recognised areas of concern described in this report. Where appropriate, further casenote and service reviews will be carried out.

9. Further actions in place or planned:

A review of mortality monitoring over the previous 3 years is planned in readiness for a TDA Quality Visit due 16th December 2014. This will focus on previous areas of concern, work undertaken to improve, and its impact on mortality. Areas where mortality has failed to improve will be presented for discussion.

Directorate mortality reviews to include all deaths that occur in patients admitted to the acute hospital site are under development. To assist departments with reliable case identification a list of all inpatient deaths is circulated 2 weeks in arrears by the Department of Clinical Audit, Safety & Effectiveness. All inpatient departments currently undertake regular mortality reviews in a variety of formats appropriate to their specialty, and guidance is being provided to ensure that there are clear outcomes and action points from these meetings.

To quality assure specialty mortality reviews a Trustwide process of 50 case reviews randomly selected across all specialties is undertaken annually by a multidisciplinary group of consultants to ensure that any identified avoidable deaths have previously been rigorously reviewed within their specialty, recognise any themes, and compare with performance in the previous year. This process is led by the Medical Director and Associate Medical Director, and is to be increased to twice yearly.

Data Quality (to end October 2013):

Continuous monitoring of data quality, focusing on

- Depth of coding and coding of comorbidities
- Crude mortality rates and coding of deceased patient records
- Coding of 'signs and symptoms' [R codes]
- Palliative care coding

Data to the end of October 2014 shows:

- A steady increase in depth of coding and use of comorbidity codes [this is likely favourably to affect HSMR. Effect on SHMI is less predictable]
- Steady crude mortality which has fallen since April 2013
- A rising use of R codes [this needs to be addressed as it has an unpredictable impact on mortality measures, and is a priority for the Coding Department]]
- Increasing use of palliative care codes (a new SOP cross references the Specialist Palliative Care team records).

Weekly audits, monitoring, reporting and feedback processes are in place in the Coding Department, focusing on improvement in coding of the primary diagnosis to ensure that all derived measures accurately reflect the organisations performance.

Recognising the importance of adequate nursing numbers and its impact on quality and safety, a separate report will be provided by the Director of Nursing to provide this information in detail across all wards in the Trust.

10. Learning from Serious Incidents and Inquests

Two serious incidents were closed in October. The first case was a young man with significant learning and behavioural disabilities who was admitted with severe constipation and who died unexpectedly. Key learning points included adequacy of staffing on the ward (this has been addressed) and the need to consider provision of additional nursing support for patients with special needs, and the appropriate involvement of family members under the 'Carer's Policy'. The patient was noted to have serious pre-existing medical problems which should have been managed in the community and this action has been referred back to CCG for joint working with the colorectal team. The family have declined a 'Being Open' meeting but have written with further questions which are being addressed.

The second case related to an elderly man with many medical problems. His deterioration was not appropriately escalated by the trainee doctor to the consultant in charge of the ward despite the nursing staff expressing anxieties about the patient's inappropriate treatment arrangements. Key

learning points identified a need for clearer consultant cover arrangements on the ward, training needs for one of the doctors, and strengthened training in use of EWS/DNAR/TEP training for all staff. The family have been sent a report and offered a further meeting should they wish.

Three inquests took place in October. Two cases (Martin & Gordon) were SI's and have already been discussed and learning points are as follows:

- Increased staffing in A&E
- Escalation arrangements within surgery
- availability of bariatric equipment
- pain management in A&E
- discharge arrangements for day case surgery
- training for consultants undertaking new surgical procedures
- Induction arrangements for new consultants

A third inquest, which was not an SI, highlighted the need for families to have sufficient opportunities to discuss the events surrounding the death of their family member. The family raised various unexpected questions at inquest which had not previously been resolved with hospital staff or through their legal representative in the 18 months between the death of the patient and the inquest. Additional focus on meeting the needs of bereaved families as soon as possible after death is to be put into place through PALS and the legal department.

Section 2

NGH Monthly Quality Exception Quality Scorecard – October

Introduction

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

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

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

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

Performance

The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. There are **34** indicators that are rated grey.

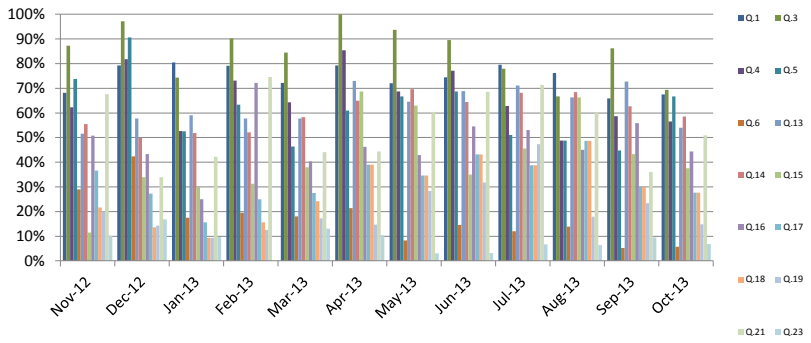
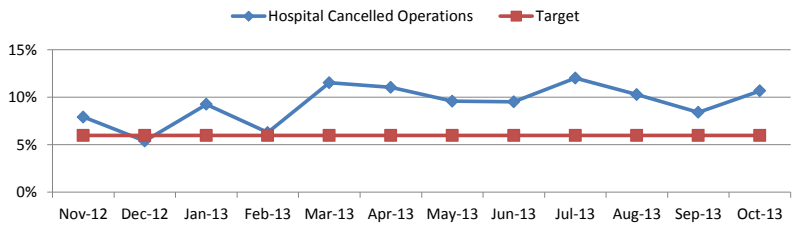
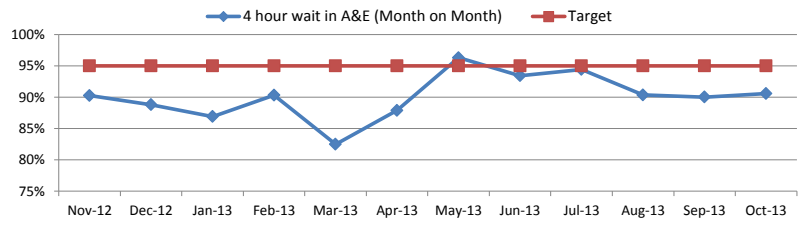
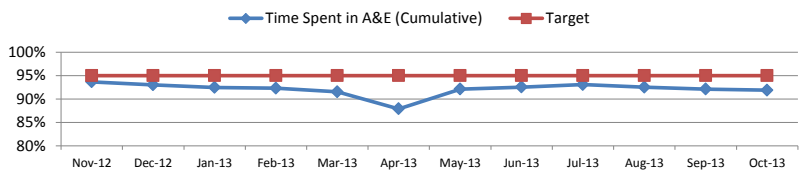
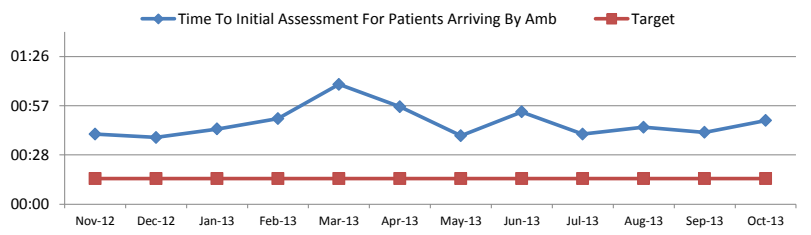
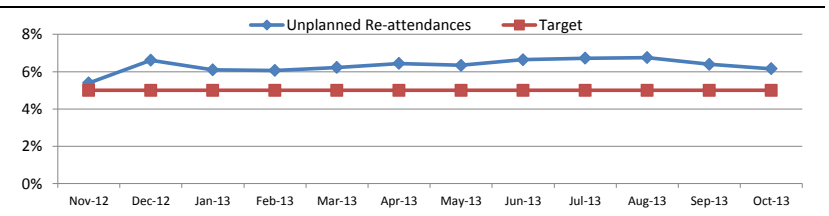
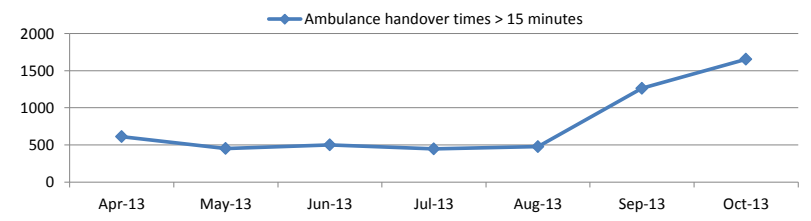
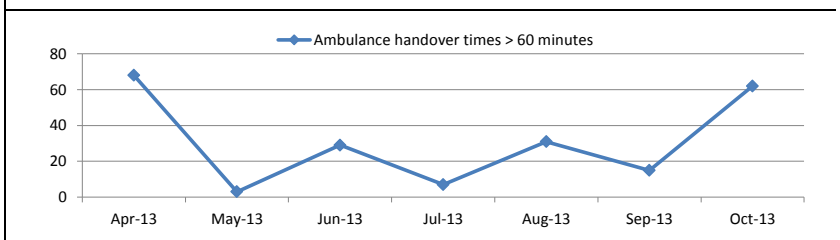
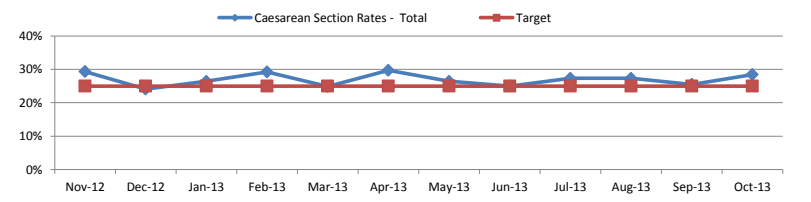
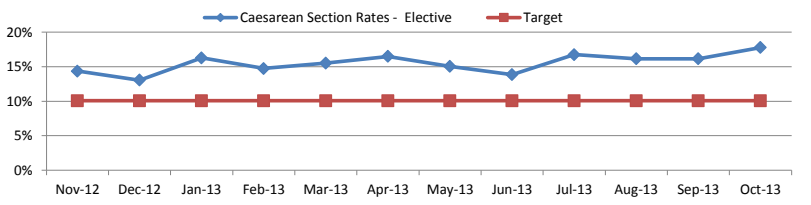
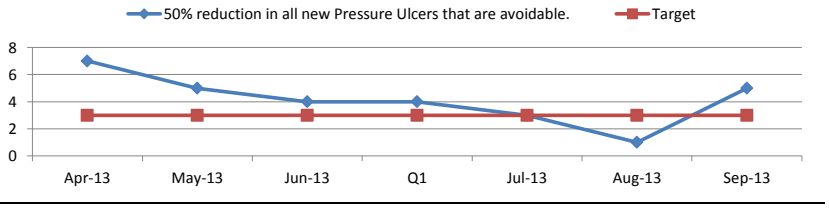
In comparison to Septembers report the number of indicators that have been rated as red has reduced by one indicator **26/25** amber has increased from **14/19** and green has decreased from **75/67.** The Indicators rated as grey have increased from **21** to **34,** as further agreement for some of these indicators continues to be agreed.

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**14**	**10**	**28**	**12**	**64**
Clinical Outcomes	**7**	**5**	**19**	**2**	**33**
Patient Safety	**2**	**1**	**5**	**17**	**25**
Patient Experience	**2**	**3**	**15**	**3**	**23**
TOTAL	**25**	**19**	**67**	**34**	**145**

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	Healthcare Notes audit (23 questions)	100%	↓	***The healthcare notes audit questions account for all 14 red performance scores in the Patient Safety category .*** Key issues identified on the Healthcare Notes audit in October 13: Following items flagged as red - front page of every sheet contain an addressograph label, the recording of vital patient information (patient name, date of birth, hospital number and NHS number) on the front page of notes where the addressograph was absent, is time recorded for each entry, is surname printed in block capitals, is the staff designation recorded, Medical Records Audit only: Is the GMC number present, are any alterations / deletions scored through with a single line, is there a signature recorded next to any alterations/deletions, Is there a date recorded next to any alterations/deletions, Is there a time recorded next to any alterations/deletions, Medical Records Audit only: Is there evidence of communication to relatives and teams, Are there any loose sheets in the Healthcare record.	
Patient Experience	Hospital Cancelled Operations (%)	6%	↓	Hospital cancellations for October 2013 as a percentage of total elective admissions has shown a significant increase from 8.4% in Sept to 10.7% in Oct 2013 and continues to be above the minimum target level of 6%. Key areas were: Pain Management, Plastic Surgery, Gynaecology & General Surgery.	
Patient Experience	A & E Quality Indicators (5 indicators)		↑	**A&E Clinical Indicators:** 4 hour wait in A&E (Month on Month) improved slightly from 90.2% in September to 90.56% in October.	
			→	Time Spent in A&E (Cumulative) - This indicator has been negatively affected by the non-achievement of the monthly 95% 4hrs for October wait resulting in a cumulative of 91.88%.	
			↓	The time to initial assessment for patients arriving by ambulance deteriorated from 42 mins in Sept to 49 mins ins Oct (national target being 15 minutes). These figures are currently being revalidated following recent identification of issues around the way the information is captured. When the FIT (Fast Intervention Team) is operational (usually between 11am and 6pm) this target is generally met, but out of hours limited Senior Doctor cover means that the time to initial assessment is increased. A business case will be going to SMB for increased clinical staff and workforce development.	
			↑	Unplanned re-attendance rates saw a further monthly improvement from 6.39% to 6.16% (target of 5%). There is genuine concern relating to patients reattending when they have been unable to access aftercare in primary care. In addition, there is validation work underway in respect to data recording of the re-attendance event.	
			↓	October saw a further increase in the handovers times over 15 mins and 60 mins. This is due to a new validation method of only validating those handovers of 60 or more minutes as we are not being fined at the moment for those handovers of 30 minutes.	
			↓		
Clinical Outcomes	Caesarean Section Rates (Total)	<25%	↓	An audit was conducted for the August inductions to assess NICE compliance and adherence to local guidelines. The audit report concluded that the decision to induce primiparous women was largely NICE & local guidance compliant. However, the decision to induce multiparous women demonstrated less compliance. The audit was discussed at the Obstetric Governance Meeting in October 2013 and it was agreed to undertake a prospective audit to understand the reasons for the increase. This will be reported back to Obstetric Governance in December 2013.	
Clinical Outcomes	Caesarean Section Rates (Elective)	10.06%	↓	Elective caesarean section rate remains persistently higher than the national average despite full implementation of the action plan, including monthly audit of NICE (CG 132) compliance. The Directorate can report 100% NICE compliance, but will continue with monthly audit until we can demonstrate sustained improvement and assurance.	
CQUIN	Improve performance on staff Friends & Family Test		↓	Staff survey to be undertaken in Q3. Predicted RAG rating of red determined following feedback from Care Group Directorates.	*Chart not applicable for this indicator*
CQUIN	50% reduction in all new avoidable Pressure Ulcers	Max 3 incidents p/m	↓	The increase in avoidable pressure ulcers has been identified as being linked to poor documentation leading to inadequate assessment of patient and repositioning regimes as identified by the newly appointment Lead TVN Nurse. A full thematic review for the last three months is currently in progress to support the training needs analysis across the Trust.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Frequency	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Oct 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	Monthly	3	4	2	2	5	7	2	4	1	3	1	2		
HQU08: MSSA Numbers	No national ceiling set	Monthly	2	1	1	0	0	1	0	1	1	0	0	1		
E Coli ESBL Quarterly Average	7 per month	Monthly	4	2	3	2	0	2	3	3	4	2	2	3		
VTE Risk Assessment completed	95% month on month	Monthly	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4`		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	Monthly	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	Monthly	99.74%	99.40%	99.73%	99.54%	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	100.0%		
MRSA Screening Non-Elective Patients	100% month on month	Monthly	96.80%	95.78%	95.12%	96.56%	97.00%	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%	97.1%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	Monthly	44	31	10	30	45	24	32	23	22	23	15	13		
Incidence of pressure ulcers																
Grade 3 - New avoidable pressure ulcer		Monthly	0	2	2	3	4	0	4	3	0	0	0	3		
Grade 3 - New unavoidable pressure ulcer		Monthly	1	2	0	0	1	3	2	4	0	1	4	3		
Total Grade 3 - New pressure ulcer		Monthly	1	4	2	3	5	3	6	7	0	1	4	6		
Grade 4 - New avoidable pressure ulcer		Monthly	3	1	3	0	1	0	0	0	0	0	0	0		
Grade 4 - New unavoidable pressure ulcer		Monthly	3	1	0	0	0	0	0	0	0	0	0	0		
Total Grade 4 - New pressure ulcer		Monthly	6	2	3	0	1	0	0	0	0	0	0	0		
Reduce harm from falls																
Catastrophic	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
Major/Severe	0	Monthly	3	0	1	2	1	0	1	1	1	2	1	1		
Moderate	0	Monthly	0	1	2	3	1	1	3	1	1	0	1	1		
Mandatory Training compliance Full Year Impact																
Primary Levels Excluding B&H	80%	Monthly	64.5%	65.2%	65.4%	65.2%	65.2%	65.1%	65.4%	65.7%	66.0%	66.1%	68.7%	N/Avail		6 week turnaround delay for data
Attendance at Trust Induction	80%	Monthly	90.8%	87.9%	87.5%	87.6%	87.5%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%	N/Avail		6 week turnaround delay for data
Number of surgical site infections																
Fracture neck of femur - Number of Operations	-	Monthly	36	34	39	31	45	17	27	29	20	28	26	33		
Number of infections	-	Monthly	0	0	0	0	0	0	0	0	0	0	1	0		
% infection rate (monthly)		Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3.8%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly		0%		0.9%			0%			Awaiting Quarterly report				
Caesarean sections - Number of Operations	-	Monthly												109		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
Number of infections	-	Monthly												0		
% infection rate (monthly)		Monthly												0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly														
Total hip replacements - Number of Operations	-	Monthly												23		
Number of infections	-	Monthly												0		
% infection rate (monthly)		Monthly												0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly														
Total knee replacements - Number of Operations	-	Monthly												13		
Number of infections	-	Monthly												0		
% infection rate (monthly)		Monthly												0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	Quarterly														
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc																
Open Central Alert System (CAS) Alerts	0	Monthly	0	0	0	0	0	1	0	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	Monthly	87.9%	89.0%	89.1%	89.3%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%	79.9%		
Serious Untoward Incidents	-	Monthly	14	9	19	25	36	41	35	51	21	10	10	9		
Never Events	0	Monthly	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	Monthly	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	98%		
Healthcare Notes Audit																
Q.1 Does the front page of every sheet contain an addressograph label	100%	Monthly	68%	79%	80%	79%	72%	79%	72%	74%	80%	76%	66%	68%		
Q.2 Does addressograph include the NHS Number?	100%	Monthly	93%	88%	99%	88%	92%	90%	97%	97%	98%	95%	93%	94%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	Monthly	87%	97%	74%	90%	84%	100%	94%	90%	78%	67%	86%	69%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	Monthly	62%	82%	53%	73%	64%	85%	69%	77%	63%	49%	59%	57%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	Monthly	74%	91%	53%	63%	46%	61%	67%	69%	51%	49%	45%	67%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	Monthly	29%	42%	18%	20%	18%	21%	8%	15%	12%	14%	5%	6%		
Q.7 Is record legibly written	100%	Monthly	97%	99%	99%	98%	99%	95%	100%	98%	99%	97%	99%	99%		
Q.8 Written in blue/black ink	100%	Monthly	100%	100%	100%	99%	100%	100%	100%	100%	100%	99%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Monthly	100%	99%	98%	99%	100%	99%	98%	99%	100%	100%	99%	98%		
Q.10 Is date recorded for each entry	100%	Monthly	93%	91%	88%	90%	88%	86%	87%	86%	89%	93%	88%	83%		
Q.11 Is time recorded for each entry	100%	Monthly	70%	72%	71%	66%	75%	86%	87%	86%	89%	93%	88%	83%		
Q.12 Is there a signature of the person making the entry	100%	Monthly	91%	92%	90%	94%	94%	96%	97%	92%	97%	91%	91%	87%		
Q.13 Is surname printed in block capitals	100%	Monthly	52%	58%	59%	58%	58%	73%	65%	69%	71%	66%	73%	54%		
Q.14 Is the staff designation recorded	100%	Monthly	55%	50%	52%	52%	58%	65%	70%	64%	68%	68%	63%	59%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	Monthly	11%	34%	30%	31%	38%	69%	63%	35%	46%	66%	43%	38%		
Q.16 Are any alterations / deletions scored through with a single line	100%	Monthly	51%	43%	25%	72%	40%	46%	43%	55%	53%	45%	56%	44%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	Monthly	37%	27%	16%	25%	28%	39%	35%	43%	39%	49%	30%	28%		

Caesarean section, total hip replacement and total knee replacement infection rates monitored from Oct 2013

Q.18 Is there a date recorded next to any alterations/deletions	100%	Monthly	22%	14%	9%	16%	24%	39%	35%	43%	39%	49%	30%	28%	
Q.19 Is there a time recorded next to any alterations/deletions	100%	Monthly	20%	14%	9%	13%	17%	15%	28%	32%	47%	18%	23%	15%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	Monthly	99%	95%	97%	96%	100%	99%	97%	88%	100%	91%	94%	96%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	Monthly	68%	34%	42%	75%	44%	44%	60%	69%	71%	60%	36%	51%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	Monthly	100%	100%	100%	100%	100%	100%	96%	80%	100%	100%	98%	91%	
Q.23 Are there any loose sheets in the Healthcare record	0%	Monthly	10%	17%	10%	0%	13%	10%	3%	3%	7%	6%	9%	7%	

Patient Experience	Target 2013-14	Frequency	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Oct 13 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	Monthly	0	6	4	1	2	1	0	0	0	0	0	0		
Hospital Cancelled Operations	6.0%	Monthly	7.9%	5.4%	9.3%	6.3%	11.5%	11.1%	9.6%	9.5%	12.0%	10.3%	8.4%	10.7%		
Number of written complaints received	-	Monthly	40	24	68	54	52	45	58	37	29	38	41	55		
Complaints Responded to within agreed timescales	100.00%	Monthly	90.0%	87.5%	95.6%	75.9%	69.2%	57.8%	94.8%	92%	90%	86.8%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits																
Admitted Patients	90.00%	Monthly	95.93%	96.47%	96.10%	95.12%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%		
Non Admitted Patients	95.00%	Monthly	98.36%	98.48%	98.60%	97.90%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%		
Ongoing Patients	92.00%	Monthly	96.85%	96.33%	95.45%	95.74%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%		
A&E Quality Indicators (5 measures)																
Time Spent in A&E (Month on Month)	95%	Monthly	90.25%	88.81%	86.91%	90.33%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%		
Time Spent in A&E (Cumulative)	95%	Monthly	93.67%	93.04%	92.47%	92.30%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%		
Total time in A&E (95th percentile)	95th	Monthly	06:09	06:18	07:12	06:21	08:08	06:45	03:59	04:43	04:17	05:19	05:22	05:18		
Time to initial assessment (95th percentile) patients arriving by ambulanc	<15 mins	Monthly	00:41	00:39	00:44	00:50	01:10	00:57	00:40	00:54	00:41	00:45	00:42	00:49		
Time to treatment decision (median)	<60 mins	Monthly	00:46	00:48	00:34	00:45	00:52	00:57	00:51	00:51	01:05	00:54	00:54	00:49		
Unplanned re-attendance rate	=<5%	Monthly	5.40%	6.62%	6.10%	6.07%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%	6.16%		
Left without being seen	>1% and <5%	Monthly	0.25%	0.12%	0.18%	0.22%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%	0.15%		
Ambulance handover times > 15 minutes	0	Monthly	New for 2013-14					612	452	500	446	476	1263	1656		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	Monthly	New for 2013-14					68	3	29	7	31	15	62		No hand over greater then 15 minutes
Cancer Wait Times																
2 week GP referral to 1st outpatient	93%	Monthly	98.3%	98.6%	96.7%	96.9%	98.3%	96.0%	95.4%	96.2%	95.5%	95.1%	96.6%	96.0%		
2 week GP referral to 1st outpatient - breast symptoms	93%	Monthly	99.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.6%		
31 Day	96%	Monthly	97.7%	95.6%	97.3%	98.7%	99.2%	98.0%	98.2%	98.1%	96.3%	97.6%	99.3%	98.5%		
31 day second or subsequent treatment - surgery	94%	Monthly	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	94.1%	100.0%		
31 day second or subsequent treatment - drug	98%	Monthly	98.6%	95.0%	91.8%	96.8%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	Monthly	99.0%	98.8%	96.4%	97.8%	95.8%	98.3%	98.6%	95.8%	96.5%	97.4%	96.5%	96.9%		
62 day referral to treatment from screening	90%	Monthly	100.0%	95.7%	95.7%	93.3%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%	100.0%		
62 day referral to treatment from hospital specialist	80% (local target)	Monthly	92.6%	100.0%	63.6%	73.7%	100.0%	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%	66.7%		
62 days urgent referral to treatment of all cancers	85%	Monthly	89.7%	78.3%	81.3%	77.6%	76.5%	85.2%	79.0%	83.4%	79.1%	85.4%	84.7%	84.9%		
SRS08: Length of Stay (Acute & MH)																
Elective	3.20	Monthly	4	3.8	4.4	4	4.2	3.1	4.7	5.6	4.3	5.9	3.8	3.8		Based on DFI Peer Group UQ. Fig reported in Oct 13 relates to rolling 12 months up until Aug 13
Non-Elective	5.30	Monthly	4.2	4.4	4.6	4.3	4.7	4.3	4.3	5.8	4.7	5.3	4.9	4.8		Based on DFI Peer Group UQ. Fig reported in Oct 13 relates to rolling 12 months up until Aug 13
SRS09: Daycase Rate	85%	Monthly	83.0%	85.7%	85.5%	84.8%	84.6%	85.9%	84.9%	84.6%	86.4%	85.3%	84.5%	84.6%		
SQU11: PROMS Scores - Pre Operative participation rates																
Groin Hernia - Participation Rate	Eng.Ave 59.8% (target 80%)	Quarterly		88.6%			98.0%		81.3%			75.3%		84.1%		Information based on 12 months HES data to Apr 12 - Mar 13 (published Nov 13). Target for 2013-14 is measured against the England average for the period and not the national target of 80% for all procedures
Hip Replacement - Participation Rate	Eng.Ave 81.5% (target 80%)	Quarterly		125.8%			93.0%		94.6%			91.5%		95.2%		
Knee Replacement - Participation Rate	Eng.Ave 89.6% (target 80%)	Quarterly		95.9%			110.5%		107.1%			102.6%		113.6%		
Varicose Vein - Participation Rate	Eng.Ave 43.6% (target 80%)	Quarterly		71.4%			54.1%		66.7%			68.7%		69.9%		
All Procedures - Participation Rate	Eng.Ave 74% (target 80%)	Quarterly		99.1%			96.0%		90.5%			86.4%		93.7%		

Clinical Outcomes	Target 2013-14	Frequency	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Oct 13 RAG Rating	Comments
HSMR - monthly position for 2013-14 (YTD)	<100	Monthly	83.8	100.5	96.9	100.21	103.7	108.5	76.8	76.93	88.0	84.96	N/Avail	N/Avail		Latest DFI FY trend Apr 12 - Aug 13 (HSMR)
HSMR - 12 Monthly cumulative position		Monthly	98.2	99.0	99.1	N/Avail	100.1	100.8	N/Avail	96.2	99.01	96.17	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
HSMR- cumulative position for 2013-14																
Pneumonia	<100	Monthly	48.7	52.2	54.8	N/Avail	57.5	60.4	N/Avail	59.42	65.8	62.92	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
Fracture of neck of femur (hip)	<100	Monthly	168.5	168.4	169.08	N/Avail	148.7	135.89	N/Avail	127.47	125.72	121.88	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
Acute Cerebrovascular disease	<100	Monthly	101.6	107.1	105.6	N/Avail	105	108.2	N/Avail	101.95	90	100.93	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	Monthly	131.3	131.9	133.5	N/Avail	133.5	135.88	N/Avail	128.8	135.46	120.63	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
Acute myocardial infarction	<100	Monthly	61.9	71	76.7	N/Avail	77.5	84.6	N/Avail	82.29	87.3	82.95	N/Avail	N/Avail		Latest DFI FY trend Sept 12 - Aug 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	Monthly	114.24	114.24	114.24	115.84	115.84	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail		Latest position reported in Oct 13 reflects Apr 12 - Mar 13.
SQU12: Maternity 12 weeks	90%	Monthly	97.0%	93.2%	95.4%	95.2%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%	97.7%		
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	Monthly	4.3%	5.7%	3.9%	3.4%	4.0%	2.6%	2.7%	3.7%	3.3%	4.4%	2.6%	2.9%		
Fractured neck of Femur																
Patients fit for surgery within 36hrs	-	Monthly	New for 2013-14					17	29	26	23	25	28	28		
Number of patients admitted with FNOF who were operated on within 36	-	Monthly						14	21	23	22	21	19	24		
% of patients admitted with FNOF who were operated on within 36 hrs of	100%	Monthly						82.4%	72.4%	88.5%	95.7%	84.0%	67.9%	85.7%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	Monthly	89.0%	100.0%	91.3%	90.6%	69.6%	90.9%	82.8%	81.3%	92.6%	85.7%	93.0%	N/Avail		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	Monthly	47%	47%	39%	67%	48%	43%	38%	38%	66%	59%	51%	N/Avail		
100% of suspected stroke patients given CT scan within 24 hours of arri	100%	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/Avail		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	Monthly	88.9%	72.7%	68.8%	60.0%	69.2%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%	N/Avail		
Patients who spend at least 90% of their time on a stroke unit	80%	Monthly	90.2%	84.2%	81.6%	86.1%	96.4%	80.0%	88.7%	98.2%	89.8%	87.1%	87.0%	N/Avail		
Breast Feeding initiation	75%	Monthly	99.7%	74.9%	75.2%	77.4%	79.4%	80.6%	81.4%	76.9%	79.7%	78.9%	78.0%	78.6%		

Caesarean Section Rates - Total	<25%	Monthly	29.3%	24.1%	26.4%	29.2%	24.9%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%	28.4%	
Caesarean Section Rates - Emergency	14.98%	Monthly	14.9%	11.1%	10.1%	12.7%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%	8.0%	
Caesarean Section Rates - Elective	10.06%	Monthly	14.4%	13.1%	16.3%	14.7%	15.5%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%	17.8%	
Home Birth Rate	>=3%	Monthly	4.5%	7.5%	2.1%	5.9%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%	6.0%	
Number of readmissions within 28 days (Adult)	-	Monthly	New for 2013-14					395	385	424	496	422	392	415	Min 28 day turnaround before monthly data available
Number of readmissions within 28 days (Children)	-	Monthly	New for 2013-14					146	136	163	126	96	106	155	Min 28 day turnaround before monthly data available

CQUIN 2013-14	Target 2013-14	Frequency	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Oct 13 RAG Rating	Comments
NATIONAL CQUINS																
1.VTE																
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month CQUIN payment to be received if both 1a and 1b are achieved.	Monthly	92.0%	90.0%	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4`		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.		Quarterly	New for 2013-14					Reporting timescales submitted to CCG for Q2-Q4 agreement								RAG rating in accordance with latest CQUIN Status report
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting																
3a.Dementia case finding	90% 3 consecutive months	Monthly	2.4%	0.3%	2.4%	2.9%	2.2%	0.86%	4.35%	2.37%	3.3%	55.70%	70.8%	68.80%		3b & 3c no numerator or denominator Facilitator in post from beginning Aug 2013. Oct 2013 data yet to be validated.
3b.initial diagnostic assessment	90% 3 consecutive months	Monthly	N/A	N/A	N/A	N/A	Not avail	-	0%	100%	50%	46.70%	60.00%	35.7%		
3c. referral for specialist diagnosis	90% 3 consecutive months	Monthly	0.0%	0.0%	100.0%	100.0%	Not avail	-	100%	100%	100%	58.30%	36.40%	60.0%		
3d.Lead clinician and appropriate training of staff	Yes	Monthly	New for 2013-14					On track								RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes	Monthly	New for 2013-14					Q2 audit to be completed by newly appointed Dementia CQUIN facilitator								RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS																
1. Develop and implement AECP																
1a AECP for Chest Pain		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1c. AECP for Supraventricular Tachycardia		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic																
2a. HOT Clinic for Paediatrics		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine		Monthly	New for 2013-14						Q1 achieved			Q2 achieved		On track		RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS																
1. Friends & Family																
1a. Phased expansion of Friends and Family Test (maternity services)		Monthly	New for 2013-14							From Oct 2013				19.01%		RAG rating in accordance with latest CQUIN Status report
1b. increase response rate to at least 20%		Monthly	New for 2013-14					7.09%	9.23%	15.88%	16.93%	9.73%	16.8%	22.17%		Q2 accumulative FFT response rate = 14.45%
1c. Improve performance on staff Friends & Family Test		Annual	New for 2013-14							Survey due Autumn 2013						No action required for Q1. LIA group in place - staff survey to be undertaken in Q3. Predictied RAG rating determined following feedback from Care Group Directorates.
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	Monthly	New for 2013-14					7	5	4	4	3	1	5		RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards		Quarterly	New for 2013-14					On track, Q1 data submitted and feedback provided. Q2 data submitted on time.								
4. Timely Simple Discharge	TBA (>60% each quarter or action plan)		New for 2013-14					N/A	50.0%	0.0%	66.7%	66.7%	100.0%	30.0%		RAG rating in accordance with latest CQUIN Status report
5. Improve access to breast milk in preterm infants	TBA (20% imp on 12/13 perf (58.5%))		New for 2013-14					55.9%	37.5%	45.5%	51.3%	61.3%	64.2%	50.0%		RAG rating in accordance with latest CQUIN Status report
6. Acute Kidney Injury	Q1 Process recorded and definition in place		New for 2013-14					Q1 & Q2 achieved. Q3 on track								

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

Title	Patient Experience Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Rachel Lovesy – Patient Experience Lead
Purpose	This report is being presented to the Board for Assurance and Information
Executive summary • **Update on existing Patient Experience Work** showing current activity • **Friends and Family Test (FFT) Responses** - a single question selected as a headline metric for the clear and concise measuring and monitoring of patients' perceptions as to the quality of the health services they recently received.	
Related strategic aim and corporate objective	Be a Provider of Quality Care for All our Patients
Risk and assurance	*Does the content of the report present any risks to the Trust or consequently provide assurances on risks* Yes – failure of FFT CQUIN and loss of income
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	*Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**)* *Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)*
Legal implications / regulatory requirements	*Are there any legal/regulatory implications of the paper* - **NO**

Enclosure E - Patient Experience Report

Actions required by the Board

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

Trust Board
November 2013

Patient Experience Report

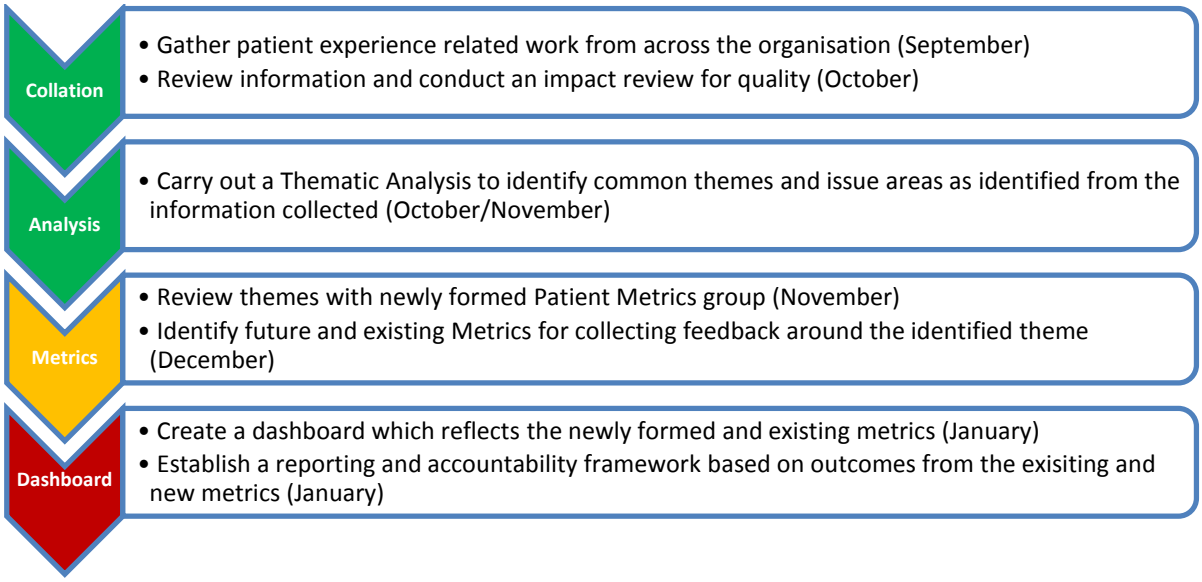
Overview

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

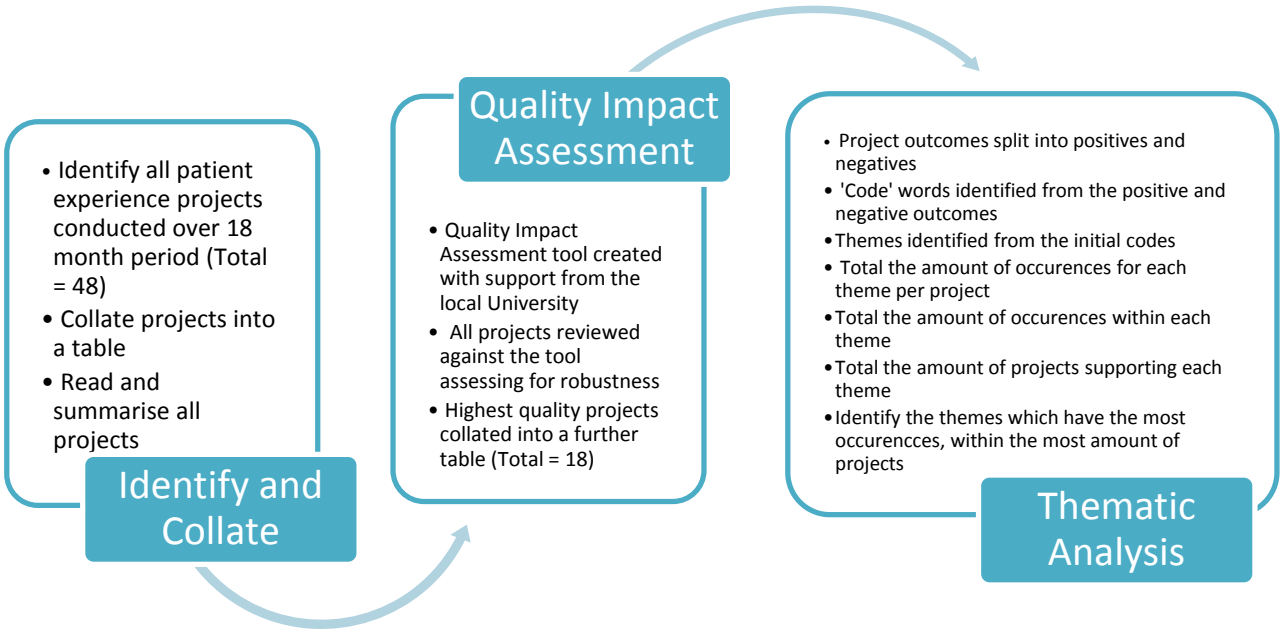
1.1 Patient Experience Monitoring

1.1.2 Patient Experience Collation and Trend Analysis

As previously highlighted within Octobers Board Report, it has been identified that there is a need to be able to continuously review how our patients are receiving our services, and to identify any problem areas in a timely manner to allow for effective resolutions. The ultimate aim is for the creation of a dashboard which reflects a continuous, fluid response to the key issue areas identified from previous patient experience measures. A vast amount of progress has been made within this area since the previous Board Report as reflected in the RAG ratings below.



The main development which has taken place is the completion of the Thematic Analysis, carried out to identify trends and issues as identified within previously conducted patient experience projects. A rigorous process was used to ensure the themes identified were a true representation of the views of our patients. The diagram below summarises the process:



The Thematic Analysis identified 7 Key Themes, with the largest 4 Key Themes breaking down into 12 sub themes to allow the organisation to look more intricately into the areas of concern.

The themes are as follows:

1 Involvement in care
- 1.1 Informed choice
- 1.2 Involvement in decisions

2 Communication/Information
- 2.1 Key Points in Care Pathway
  - 2.1.1 *Waiting Times*
  - 2.1.2 *Treatment/operation/condition information*
  - 2.1.3 *Post operation/Treatment*
  - 2.1.4 *Information at/following Discharge*
- 2.2 Appropriateness
- 2.3 Emotional Wellbeing
- 2.4 Medication

3 Discharge
- 3.1 Information on discharge
- 3.2 Delays
- 3.3 Discharge planning

4 Pain Control

5 Wellbeing Support

6 Privacy, Respect & Dignity

7 **Facilities**
- 7.1 Car Parking
- 7.2 Food and Refreshments
- 7.3 Waiting Rooms

The Key Themes were reviewed in line with the Top 6 PALS issues raised and Top 5 Complaints as identified within their quarterly reports. Both PALS and Complaints have

consistent issues raised with regards to Discharge and Communication – two of the largest themes represented within this work.

The next stage of this process (as detailed within the process map) is to identify how as an organisation we can begin to collect new patient experience information to review and monitor these key areas through a Patient Experience Dashboard. Once developed, the Dashboard will dovetail into the Trusts Quality Dashboard which is currently being created.

1.1.3 Patient Metrics Group

A core group of staff have been invited to attend a newly reformed Patient Metrics Group to begin the process of identifying future metrics based around the themes and triangulated PALS and Complaints data. Attendance is likely to change and new Terms of Reference (ToR) will be created to represent the work this group will undertake.

1.2 National Patient Experience Activities

1.2.1 The Friends & Family Test (FFT)

The Friends & Family Test has seen some key developments throughout the month of October.

Maternity Services-

October saw the launch of the Maternity Services FFT, with the friends and family question being asked a possible 4 times across 3 touch points. The results from this first month have been mixed, with the overall figure reaching a positive **19.01%** (minimum response rate required = 15%)**.** The table below shows a breakdown of these figures:

ANTENATAL COMMUNITY	4	0	0	0	0	0	350	4	1.14%	100
BIRTH CENTRE (Unit to open soon)	0	0	0	0	0	0	0	0	N/A	N/A
HOME BIRTH	10	0	0	0	0	0	28	10	35.71%	100
LABOUR WARD	88	25	3	0	0	3	360	119	33.06%	73
MATERNITY OBSERVATION WARD	3	0	0	1	0	0	23	4	17.39%	50
ROBERT WATSON WARD	63	28	4	1	0	2	277	98	35.38%	60
POSTNATAL COMMUNITY	8	0	0	0	0	0	240	8	3.33%	100
Maternity Services Total	**176**	**53**	**7**	**2**	**0**	**5**	**1278**	**243**	**19.01%**	**70**

As can be seen from the table, Maternity inpatient services and the Home Birth team had an impressive beginning to their collections. Some improvements need to be made with the Antenatal Community and Postnatal Community response rates. A review of the process used to collect this data will be undertaken if results do not improve for November.

The accumulated Net Promoter Score (NPS) for the whole of the Maternity services reached **70**. The lowest score within Maternity was **50** for the Maternity Observation Ward, and the highest for the Home Birth team of **100**, from a response rate of 35.71%.

The Maternity FFT figures will be released officially to the public in January.

Eye Casualty-

Eye Casualty have seen an extremely impressive surge in their response rates in October, increasing from **1.11%** in September to **31.22%** for October.

September

EYE CASUALTY	7	2	0	0	0	0	812	9	1.11%	78

October

EYE CASUALTY	208	51	2	3	1	6	868	271	31.22%	76

This achievement is largely down to the increased engagement of staff within the service. Throughout October Health Watch supported the service by allocating their members to stand in the doorway of Eye Casualty for 2 hours at a time at random periods throughout the week to remind patients to complete the form and prompt the handing out of the forms by staff. This has been extremely positive both for patients and for staff. Concerns were raised that response rates may dip following Health Watch discontinuing their support, however this has not happened. Indeed November has seen response rates continue to be high, and this is due to the engagement and proactive nature of the staff. The Board will continue to be updated on their figures in the next Board Report to ensure sustainability. The momentum created by this increase has also led to Eye Casualty deciding against the purchase of the token system to collect their data. They will continue with their paper based method for the foreseeable future.

It is also worth noting Eye Casualty's continued high Net Promoter Score which has only seen a drop of 2 despite the increase in response rates. This is excellent and shows high levels of satisfaction from our patients with this service.

Emergency Assessment Unit (EAU)

EAU have seen routinely poor response rates for the Friends & Family Test and work is underway by the Matron, Ward Sister and Patient Experience Lead to identify a tailored approach to their data collection. The Matron and Sister have identified the Ward Trackers as leads for the FFT on the ward. Discussions are taking place for how this will work in practice. Progress will be reported in future Board Reports.

Results

<u>Response Rates</u>

The results for October saw the Trust reach its highest levels of response rates to date with a combined Inpatient and A&E score of **22.17%**, and each accumulating area exceeding the required response rate of 15% putting all areas into 'Green' for the RAG rating:

Period: 1st to 31st October 2013	Total responses in each category for each ward								**Target = 15%**	**Target yet to be agreed**
Ward / area name	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate**	**Score for each ward / area**
Inpatient Ward Total	474	144	21	8	4	8	2051	659	32.13%	68
Accident & Emergency Total	725	242	17	9	22	19	5584	1034	18.52%	67
IP & A&E	1199	386	38	17	26	27	7635	1693	22.17%	67
Maternity Services Total	176	53	7	2	0	5	1278	243	19.01%	70

Inpatient Services obtained the highest response rate reaching **32.13%** increasing from 27.26% in September and 16.52% in August. The largest increase can be seen within A&E services (inc Eye Casualty) which saw an increase from 6.23% in August, 13.08% in September to **18.52%** in October. This large increase in response rates for A&E sees them achieve their target for the first time since collections began.

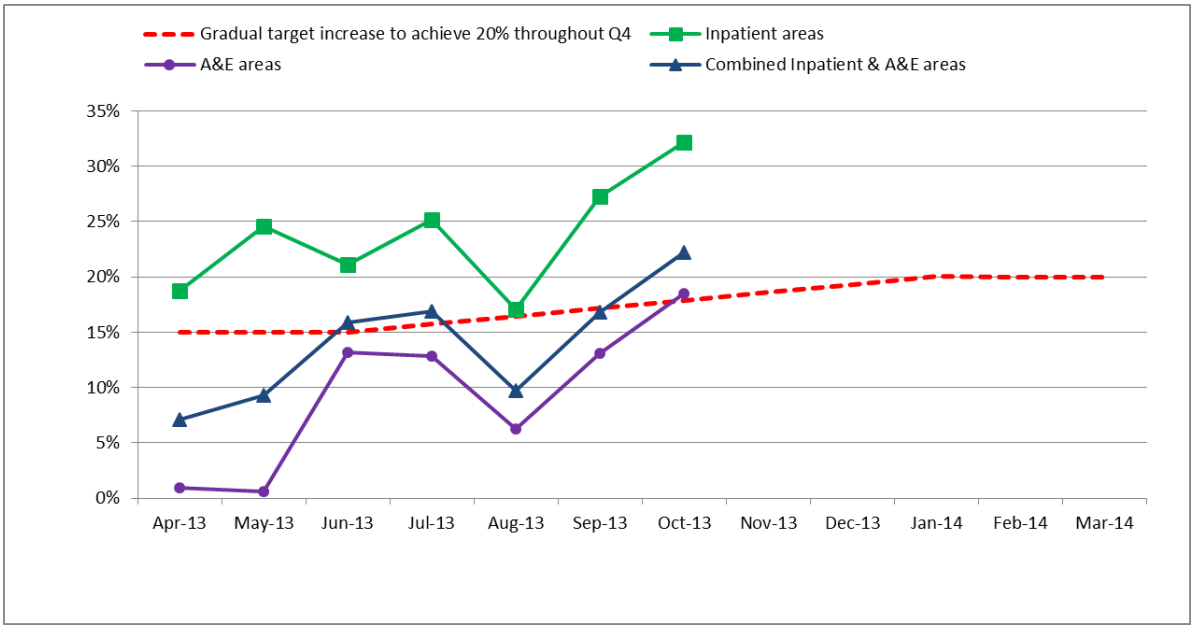
Friends & Family Net Promoter Response Rates		Target 2012-13 = 10%				Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%
Ward	**Graph**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**
Accident & Emergency Total		**Recorded from April 2013**				**0.97%**	**0.57%**	**13.16%**	**12.87%**	**6.23%**	**13.08%**	**18.52%**

Broken down further, the increase in the A&E Total response rate can largely be accounted for by the increase in Eye Casualty's results, however A&E themselves have seen a steady

increase in their response rates, increasing from 6.60% in August, 15.12% in September to their highest response rate yet of **16.06%** in October. A large amount of this improvement is due to the proactive nature of the A&E Matron who has worked hard to promote staff engagement and create a tailored approach to collections in A&E.

A & E UNIT	501	187	15	6	21	13	4627	743	16.06%	63
AMBULATORY CARE CENTRE	16	4	0	0	0	0	89	20	22.47%	80
EYE CASUALTY	208	51	2	3	1	6	868	271	31.22%	76
Accident & Emergency Total	**725**	**242**	**17**	**9**	**22**	**19**	**5584**	**1034**	**18.52%**	**67**

The graph below displays the Trusts response rates in line with the increasing gradual target set by the Trust to prepare for the response rate increase in January. This graph shows each individual area exceeding this target for the first time this financial year.



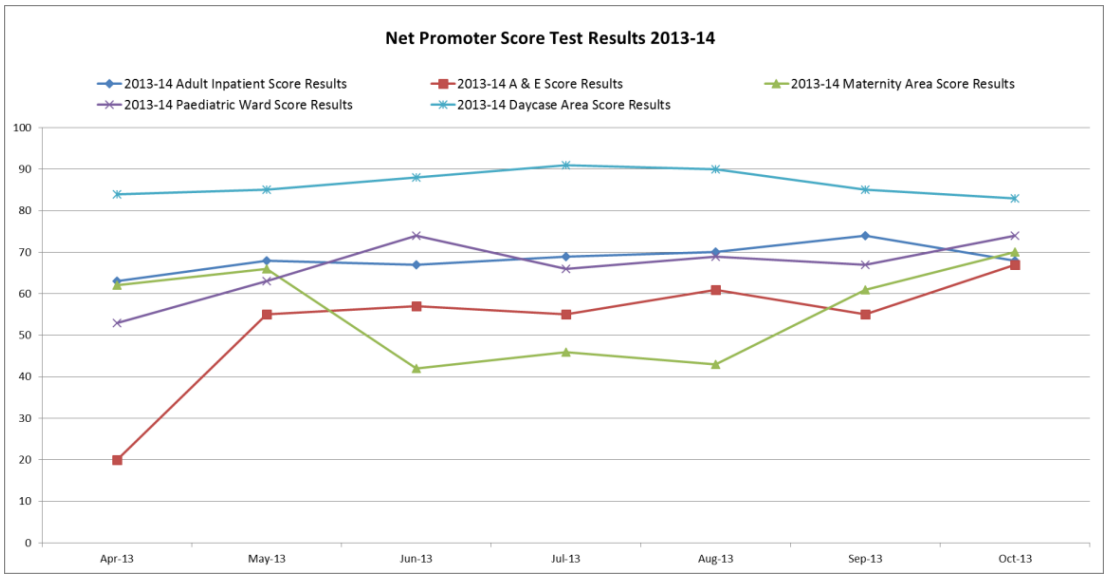
Response rates per ward can be seen within Appendix A.

Net Promoter Scores

The Net Promoter Scores (NPS) continue to increase in their importance as the response rates increase per area. The focus to date has been largely on the response rates to ensure the NPS's for each area can be seen as being representative of the majority of patients, or 'statistically significant'.

Net Promoter Score Test Results	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
2013-14 Inpatient Score Results	**63**	**68**	**67**	**69**	**70**	**74**	**68**
2013-14 A & E Score Results	**20**	**55**	**57**	**55**	**61**	**55**	**67**
2013-14 Maternity Area Score Results	**62**	**66**	**42**	**46**	**43**	**61**	**70**
2013-14 Daycase Area Score Results	**53**	**63**	**74**	**66**	**69**	**67**	**74**
2013-14 Paediatric Ward Score Results	**84**	**85**	**88**	**91**	**90**	**85**	**83**

October saw a decrease of 6 for the NPS within Inpatient services from September, dropping from 74 to **68**, however A&E saw an increase of 12 climbing from 55 to **67**. Paediatric services have seen a slight drop in their score, however they continue to obtain high levels of reported satisfaction obtaining an NPS of **83** for October. Inpatient Services and A&E accumulated obtained a score of **67** for October, the highest score since May. Individual ward scores can be seen within Appendix B.



Graph: Net Promoter Scores tracked per area

The scores can be broken down further to display the percentages per score given throughout the Trust (below). For September 67.9% of our patients said they were extremely likely to recommend our services, this has increased to **70.8%** for October. October saw a decrease in the amount of patients 'likely' to recommend falling from 25% in September to 22.8% in October. However, the lack of change within the other categories implies the largest changes can be seen through the decrease in the amount of 'likely' and increase in the amount of 'extremely likely responses. This would explain the increase in the Trusts overall NPS and is a positive move in the right direction.

Friend & Family Score and Response Rate (%) - Adult inpatient and A&E areas only

Period: 2013-14

	% Response per category								
Month (IP and A&E areas)	**Extremely Likely**	**Likely**	**Neither likely or unlikely**	**Unlikely**	**Extremely unlikely**	**Don't Know**	**Total no. of responses**	**Response rate**	**Score**
Apr-13	63.0%	26.4%	3.1%	0.7%	2.3%	4.5%	554	7.1%	60
May-13	70.2%	23.7%	2.4%	0.8%	1.1%	1.8%	739	9.3%	67
Jun-13	65.4%	28.2%	2.4%	1.8%	0.6%	1.7%	1268	15.9%	62
Q1 Total	7.1%	2.9%	0.3%	0.1%	0.1%	0.2%	23769	10.8%	63
Jul-13	66.8%	26.7%	3.6%	1.2%	0.6%	1.1%	1488	16.9%	62
Aug-13	69.8%	24.5%	1.8%	0.8%	1.9%	1.4%	800	9.7%	66
Sep-13	67.9%	25.0%	2.3%	1.3%	1.8%	1.5%	1194	16.8%	63
Q2 Total	9.8%	3.7%	0.4%	0.2%	0.2%	0.2%	24099	14.4%	63
Oct-13	70.8%	22.8%	2.2%	1.0%	1.5%	1.6%	1693	22.2%	67

National and Local Context

National scores are now available online for the month of September, the tables below show how NGH compared nationally and locally and places our scores into national and local context:

A&E National and Local Comparisons (SEPTEMBER)

Trust	NPS	Response Rate
National Average	**52**	**13.2%**
Northampton General Hospital	**55**	**13.1%**
Kettering General Hospital	43	21%
Milton Keynes General Hospital	50	0.3%
University Hospital of Leicester	58	11.1%

Inpatient National and Local Comparisons (SEPTEMBER)

Trust	NPS	Response Rate
National Average	**71**	**29.4%**
Northampton General Hospital	**74**	**27.3%**
Kettering General Hospital	65	36.9%
Milton Keynes General Hospital	73	23.6%
University Hospital of Leicester	68	25.8%

Sharing, Monitoring and Tracking

It has been acknowledged that the information gathered through the FFT, both NPS and the free text comments provide a real time monitoring tool for how patients are receiving the service. This can be done in a number of ways. Tracking the trends in the NPS is a good indicator of any potential changes in a services performance. Appendix C displays the NPS's for areas that are collecting FFT tracked since they first started collecting. Once created, this information will be available on the Patient Experience Dashboard.

Work is currently underway to identify how best to analyse and share the free text responses received weekly from Hospedia. At present, any negative comments which are received from the forms are sent directly to the Matron and Ward Sister along with a short form for them to return to the Patient Experience Lead detailing what actions they have taken as a result of the information. This information is also stored within a spreadsheet to track progress and entries are made onto the Datix system. The weekly comments provided by Hospedia are also sent through to the Matrons and Ward Sisters with the expectation that they are read and shared within their own areas.

Overall, the majority of the comments received on the FFT forms are extremely positive, below are some examples taken from the month of October:

Eye Casualty, 1st October 2013 *'The service and care was courteous and kind and under the circumstances the waiting time was totally acceptable. Thank you all very much.'*

Spencer Ward, 20th October 2013 *'The nurses have been brilliant, always having a smile and just being lovely in general, thank you for making me feel safe and comfortable.'*

Althorp Ward, 18th October 2013 *'All staff - cleaners, food lady, nurses, assistants, physios, dr and consultant were knowledgeable, friendly supportive and kind. My operation went well and the pre and post care were excellent. Thanks.'*

Becket Ward, 17th October 2013 *'I would like to compliment all the members of staff on Becket as it is clear that care for them is a vocation and not employment. I feel that A of the hospitality staff is especially deserving of praise as he was able to source for me a vegetarian option'*

In addition to the comments being circulated regularly, an email report is being circulated monthly to Matrons, Ward Sisters, Heads of Services, Operations Managers and General Managers giving a breakdown of all wards response rates and scores in comparison to each other and previous months. Each area is placed within 4 categories:

- Star Area – gives particular praise to an area that has seen a significant increase in response rate or NPS
- Congratulations – those areas that have improved or maintained high levels of recruitment and NPS (areas cannot have one without the other within this area)
- Needs a little more attention – Areas where they are close to their recruitment target and/or have a slightly low NPS
- Needs urgent attention – Areas where response rates have been consistently low/ have decreased significantly and are not meeting the response rate required. Areas where the NPS is very low.

Appendix D contains an example of the email sent out for the October results. **This also gives a good overview of those areas that have made particular improvements, or are struggling and compliments the information provided in Appendix A and B.**

1.2.2 The National Cancer Patient Experience Survey 2013

The National Cancer Patient Experience Survey results were published in September and work has been undertaken by the Cancer Lead and Patient Experience Lead to identify any potential issue areas. This has been identified by comparing the results against those from the previous year's survey, and any areas where the Trust performs significantly worse than other areas nationally.

Issue areas identified are as follows:

Question	NGH Score 2012/13	NGH Score 2011/12	National 20% Highest Threshold	National 20% Lowest Threshold
Patient given a choice of different types of treatment	77%	82%	89%	82%
Staff gave complete explanation of what would be done	84%	84%	89%	85%
Patient given written information about the operation	74%	77%	79%	69%
Staff explained how operation had gone in understandable way	73%	72%	81%	73%
Nurses did not talk in front of patient as if they were not there	81%	80%	88%	81%
Always given enough privacy when being examined or treated	93%	96%	96%	93%
Hospital staff did everything to help control pain all of the time	80%	80%	88%	82%
Always treated with respect and dignity by staff	81%	81%	86%	81%
Family definitely given all information needed to help care at home	60%	63%	65%	57%
Staff definitely did everything they could				

to help control pain	78%	81%	85%	78%
Doctors had the right notes and other documentation with them	95%	95%	97%	95%
Hospital and community staff always worked well together	61%	60%	69%	61%
Patient offered written assessment and care plan	23%	27%	26%	18%
Patient's rating of care 'excellent'/'very good'	86%	86%	91%	86%
Taking part in cancer research discussed with patient	25%	23%	23%	25%

Each question is broken down into particular service areas, the questions above have been reviewed to see where the problem areas lie. This information has now been circulated to each individual MDT and each MDT have been requested to create an action plan detailing the improvements they will make. The action plans will be available within the next board report.

1.3 Local Patient Experience Activities

Quality Effectiveness and Safety Team QuEST
The Original 15 step challenge audit has now come to an end having been conducted within every ward in the Hospital. The outputs they produced have been extremely valuable and the decision was made to incorporate this work into the Trusts new peer review programme QuEST.

The QuEST tool includes other patient experience related aspects, including questions based around previously identified issue areas within the National Inpatient Survey for 2012; Noise at night and Protected Mealtimes.

Health Watch – Eye Casualty
During the period in October where Health Watch supported Eye Casualty in their distribution and collections of the Friends and Family Test they also conducted their own survey based around areas they had identified previously as potential issue areas. The results from this are currently being compiled and will be fed back to the Board in the next Board Report.

Training by the University of Northampton
Dr Jackie Parkes from the University of Northampton has advertised a training course free of charge to lay members in involvement in research projects. This training runs over the course of 3 days and will equip attendees with the knowledge and skills to become involved in projects. It is considered that this training would be beneficial to anyone wishing to get involved in any form of audit, service evaluation or research type work within the NHS. For this reason the details have been circulated to the Shadow Governors and to date, 5 have expressed they wish to attend.

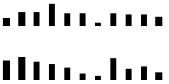
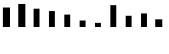
1.4 Key Points

- Patient Experience Surveys: Identification of 7 Key Themes and 12 Sub themes for areas which require future monitoring

- Formulation of a Patient Metrics Group to identify new metrics based around the identified problem areas
- Maternity services achieved **19%** response rate for their first month of collecting the FFT
- All areas achieved their required and highest FFT response rate to date:
    - Inpatient FFT = **32.13%**
    - A&E FFT = **18.52%**
    - Combined Inpatient and A&E = **22.17%**
    - Eye Casualty increased their FFT score from 1.11% in September to **31.22%** for October
- Highest accumulated A&E and Inpatient NPS since May of **67**
- Slight decrease in Inpatient NPS from 74 (Sep) to **68** (Oct)
- Large increase in A&E NPS from 55 (Sep) to **67** (Oct)
- NGH scoring above the national average for NPS scores in September
- National Cancer Patient Experience Survey results identified problem areas and action plans in production
- Health Watch survey carried out in Eye Casualty, results to be included in next Board Report
- Number of shadow governors potentially attending a training programme to equip them with research/audit/evaluation skills

Appendix A

Friends & Family Net Promoter Response Rates

Ward	Graph	Target 2012-13 = 10% Dec-12	Jan-13	Feb-13	Mar-13	Target 15% Apr-13	Target 15% May-13	Target 15% Jun-13	Target 15% Jul-13	Target 15% Aug-13	Target 15% Sep-13	Target 15% Oct-13
Abington		43.42%	28.95%	37.50%	43.33%	25.00%	30.61%	27.03%	23.64%	11.76%	8.16%	33.33%
Allebone		16.05%	38.46%	28.57%	22.83%	51.02%	32.98%	23.75%	25.40%	14.29%	11.11%	25.93%
Althorp		36.84%	31.94%	31.76%	43.00%	54.84%	33.33%	32.93%	70.21%	59.42%	56.52%	52.17%
Becket		36.96%	21.88%	31.08%	32.08%	40.43%	43.28%	42.65%	37.97%	17.39%	23.33%	55.26%
Benham		13.11%	8.91%	30.18%	7.91%	12.00%	21.43%	19.41%	23.94%	14.63%	19.82%	40.00%
Brampton		23.81%	44.12%	41.94%	67.86%	37.84%	40.00%	9.38%	38.89%	34.38%	34.62%	30.00%
Cedar		29.47%	36.36%	28.57%	25.71%	19.18%	10.34%	7.55%	34.12%	17.82%	22.11%	13.04%
Collingtree Medical		8.66%	0.0%	20.19%	13.56%	7.06%	37.33%	28.46%	25.83%	20.65%	18.60%	13.73%
Compton		77.27%	91.30%	111.11%	77.78%	80.00%	156.25%	84.21%	106.67%	100.00%	18.60%	107.69%
Corby Comm.		71.43%	50.00%	0.00%	30.00%	0.00%	9.52%	39.13%	92.86%	26.32%	61.54%	100.00%
Creaton		16%	32.35%	33.33%	21.05%	7.81%	18.07%	16.67%	11.25%	6.35%	17.39%	20.37%
Danetre		0%	57.14%	34.62%	39.53%	39.47%	54.29%	24.24%	43.93%	15.79%	70.59%	41.94%
Dryden		29.41%	2.38%	27.03%	24.79%	28.32%	19.67%	2.15%	9.65%	4.27%	17.58%	24.11%
Eleanor		17.91%	16.67%	36.36%	21.74%	38.10%	51.11%	29.31%	44.07%	34.38%	39.58%	50.82%
EAU		8.40%	13.16%	4.66%	3.15%	14.45%	26.77%	22.79%	11.00%	7.82%	10.16%	10.75%
Finedon		38.89%	36.21%	29.17%	21.62%	31.25%	46.51%	22.92%	57.89%	31.37%	34.62%	26.79%
Hawthorn		21.97%	25.47%	36.61%	37.68%	33.85%	30.04%	33.02%	27.78%	25.93%	47.65%	48.47%
Hazelwood Comm.		25.00%	127.78%	0.00%	60.71%	77.78%	60.00%	50.00%	105.56%	57.89%	73.33%	120.00%
Head & Neck		19.20%	33.33%	45.45%	40.46%	17.48%	29.81%	38.32%	31.30%	20.39%	32.50%	40.70%
Holcot		21.21%	68.75%	75.00%	53.57%	83.33%	54.55%	68.75%	72.73%	50.00%	155.56%	88.24%
Knightley		37.50%	26.67%	31.82%	52.17%	25.64%	40.38%	43.64%	59.57%	100.00%	51.28%	36.11%
Rowan		24.85%	34.62%	45.56%	32.84%	16.15%	18.18%	13.48%	24.71%	13.71%	29.41%	23.63%
Spencer		8.04%	21.70%	13.07%	12.79%	10.73%	15.86%	15.30%	15.43%	13.99%	16.20%	23.31%
Talbot Butler		12.31%	30.56%	10.64%	12.00%	8.93%	26.42%	24.75%	47.52%	36.11%	38.37%	23.53%
Victoria		9.88%	23.91%	4.00%	10.45%	15.07%	17.31%	6.98%	34.92%	17.07%	7.14%	25.37%
Willow		21.33%	29.51%	22.99%	21.30%	11.11%	27.37%	28.95%	11.46%	16.13%	16.83%	52.75%
Adult Inpatient Area Total		14.77%	16.45%	19.00%	15.15%	18.78%	24.53%	21.13%	24.61%	16.52%	27.26%	32.31%
Accident & Emergency Unit		Recorded from January	0.54%	1.75%	0.48%	1.02%	0.25%	15.22%	13.49%	6.60%	15.12%	16.06%
Ambulatory Care Centre		Recorded from September 2013									45.83%	22.47%
Eye Casualty Unit		Recorded from April 2013				0.72%	2.38%	1.04%	9.23%	4.06%	1.11%	31.22%
Accident & Emergency Total		Recorded from April 2013				0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%

Antenatal Community		Recorded from October 2013										1.14%
Birth Centre		To be recorded from December 2013										
Home Birth		Recorded from October 2013										35.71%
Labour Ward		Recorded from October 2013										33.06%
Maternity Observation Ward		Recorded from June 2013					0.00%	0.00%	0.00%	0.00%	17.39%	
Balmoral		65.69%	55.87%	46.15%	37.34%	54.59%	60.82%	Closed	Closed	Closed	Closed	Closed
Robert Watson		30.73%	42.02%	37.20%	30.00%	26.32%	32.41%	33.96%	40.06%	18.15%	26.22%	35.38%
Postnatal Community		Recorded from October 2013										3.33%
Maternity Services Total		Previously included within Inpatient Area Total				41.42%	23.08%	28.57%	33.33%	14.47%	21.28%	19.01%
Disney		16.26%	16.55%	29.48%	10.13%	17.46%	32.66%	24.74%	35.82%	29.59%	79.05%	50.91%
Paddington		7.94%	8.67%	13.30%	9.79%	5.88%	10.41%	10.57%	21.23%	13.61%	35.84%	36.97%
Paddington HDU		Recorded from July 2013							9.09%	0.00%	22.22%	0.00%
Paediatric Ward Total		Previously included within Inpatient Area Total				9.55%	17.65%	15.14%	26.09%	18.99%	51.22%	40.73%
Danetre Day Surgery		Recorded from Jan 13	66.67%	54.64%	30.88%	50.00%	60.64%	29.25%	34.19%	47.55%	20.54%	24.39%
Main Theatre Admissions		Recorded from February 2013		50.92%	50.00%	67.47%	52.42%	24.14%	17.28%	60.42%	17.82%	18.59%
NGH Day Surgery		Recorded from Jan 13	38.86%	29.43%	12.43%	29.17%	28.62%	34.49%	23.20%	17.46%	48.61%	41.13%
Singlehurst Day Unit		Recorded from Apr 13				2.44%	5.48%	9.93%	9.43%	19.70%	11.11%	6.50%
Daycase Area Total		Previously included within Inpatient Area Total				40.30%	32.40%	27.34%	20.70%	29.72%	28.59%	24.33%

Appendix B

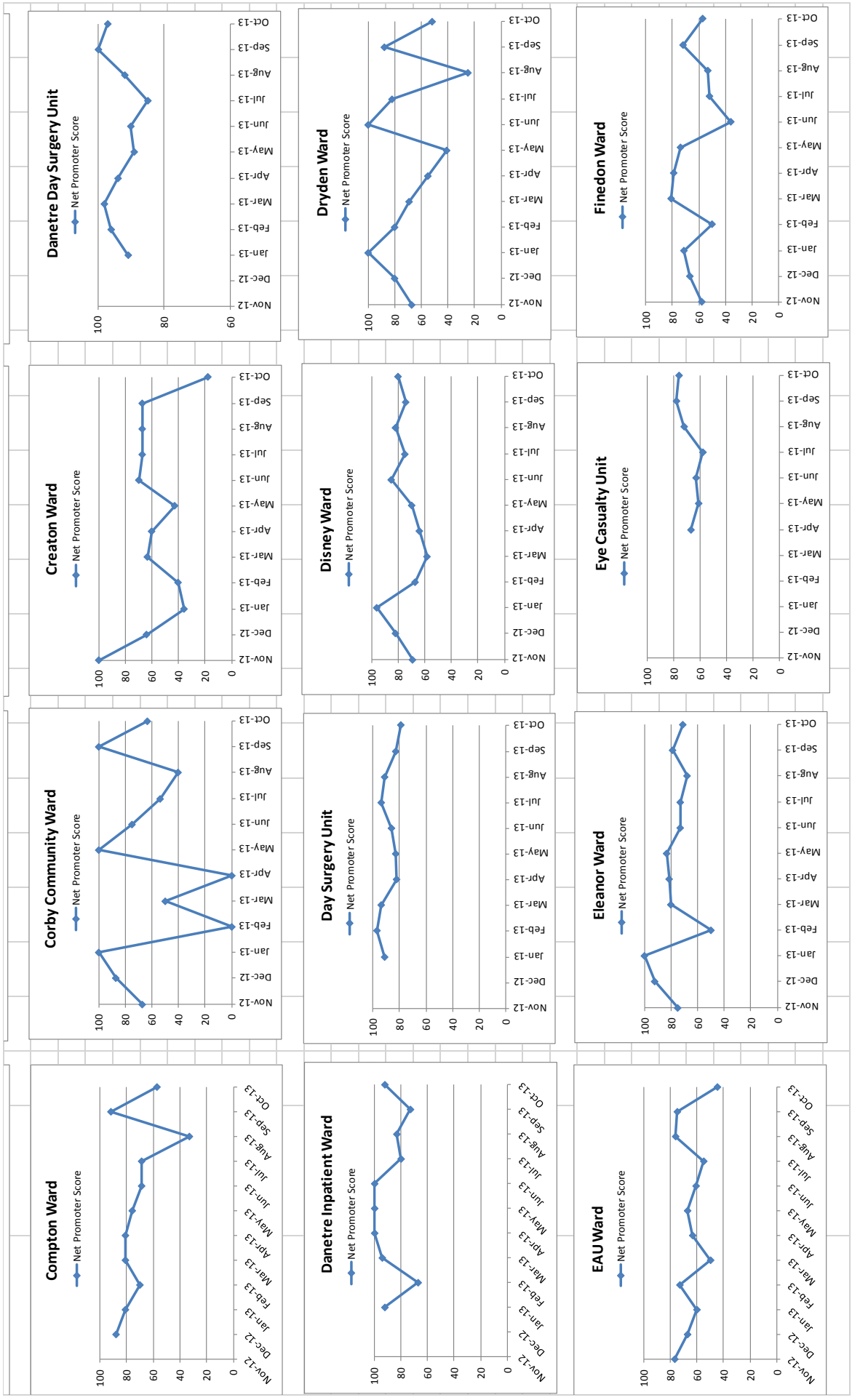
Friends & Family Net Promoter Score Results

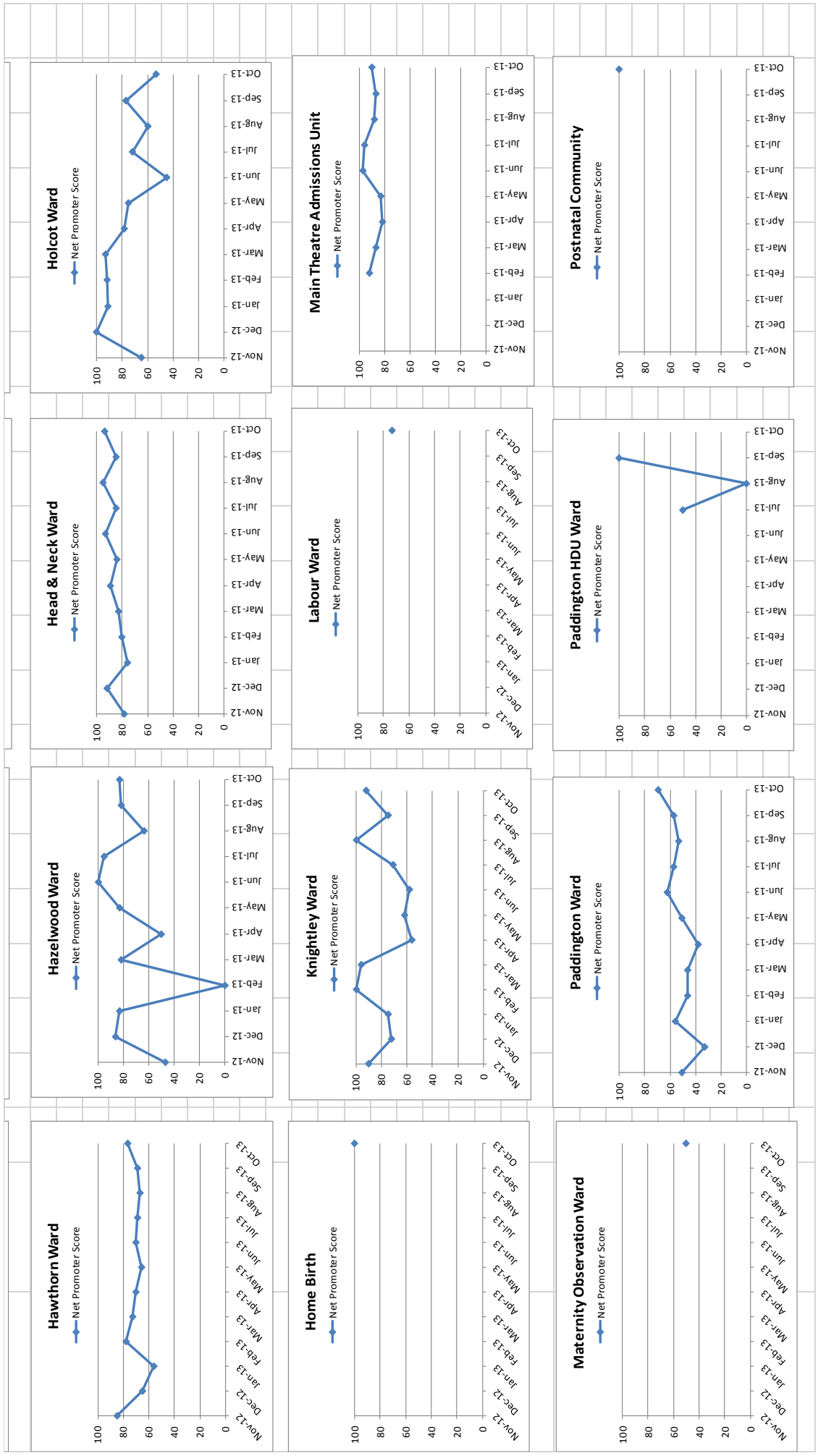
Ward	Graph	2012-13 Target = Score of 80											
		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
Abington		39	70	73	63	42	31	80	70	46	20	-25	25
Allebone		64	-8	32	45	52	33	33	41	44	-14	75	57
Althorp		89	71	87	93	81	74	82	77	86	80	72	83
Becket		93	68	21	43	47	50	79	62	87	100	69	74
Benham		70	41	50	53	70	77	66	54	47	62	73	60
Brampton		45	70	93	77	68	64	56	67	86	82	67	58
Cedar		53	50	65	65	61	31	17	75	41	39	52	63
Collingtree Medical		82	82		29	55	83	58	63	55	79	69	86
Compton			88	81	70	81	81	76	69	69	33	92	57
Corby Comm.		67	87	100		50		100	75	54	40	100	63
Creaton		100	64	36	40	63	60	43	70	67	67	67	18
Danetre				92	67	94	100	100	100	80	83	73	92
Dryden		67	80	100	80	69	55	41	100	82	25	88	52
Eleanor		75	92	100	50	80	81	83	73	73	68	79	71
EAU		77	67	60	73	50	63	67	61	55	76	75	45
Finedon		58	67	71	50	81	79	74	36	52	53	72	57
Hawthorn		85	65	56	78	73	70	66	70	69	67	69	77
Hazelwood Comm.		47	86	83		82	50	83	100	95	64	82	83
Head & Neck		78	92	76	80	83	89	84	93	85	95	85	94
Holcot		65	100	91	92	93	78	75	45	72	60	77	53
Knightley		90	72	75	100	96	56	62	58	71	100	75	92
Rowan		65	62	67	65	79	32	54	58	72	88	78	58
Spencer		77	89	87	91	79	72	61	75	62	78	86	57
Talbot Butler		68	63	77	70	87	50	96	84	85	82	73	88
Victoria			50	27	33	0	25	50	67	55	57	67	56
Willow		84	94	89	75	74	67	73	62	82	67	93	71
Adult Inpatient Area Total		73	68	68	68	72	63	68	67	69	70	74	68
Accident & Emergency Unit				0	4	4	13	45	57	55	60	54	63
Ambulatory Care Centre		Recorded from September 2013										91	80
Eye Casualty Unit							67	61	63	58	72	78	76
Accident & Emergency Total							20	55	57	55	61	55	67

Antenatal Community	Recorded from October 2013											100
Birth Centre	To be recorded from December 2013											
Home Birth	Recorded from October 2013											100
Labour Ward	Recorded from October 2013											73
Maternity Observation Ward	Recorded from October 2013											50
Balmoral	79	69	78	79	86	64	74	Closed	Closed	Closed	Closed	Closed
Robert Watson	83	69	54	85	76	56	59	42	46	43	61	60
Postnatal Community	Recorded from October 2013											100
Maternity Services Total	Previously included within Inpatient Area Total					62	66	42	46	43	61	70
Disney	69	82	96	67	58	64	70	85	75	82	74	80
Paddington	51	33	56	46	46	38	51	62	57	53	57	69
Paddington HDU									50	0	100	Not applic
Paediatric Ward Total						53	63	74	66	69	67	74
Danetre Day Surgery			91	96	98	94	89	90	85	92	100	97
Main Theatre Admissions				92	87	82	83	97	96	88	87	90
NGH Day Surgery			91	97	94	82	83	86	94	91	83	79
Singlehurst Day Unit						100	88	73	80	92	79	77
Daycase Area Total						84	85	88	91	90	85	83

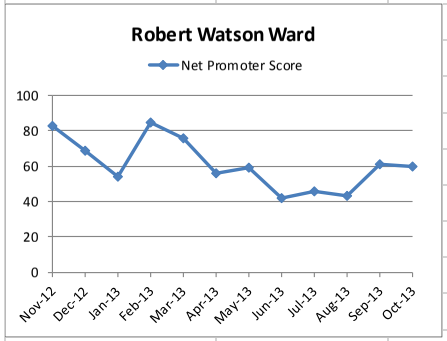
Appendix C

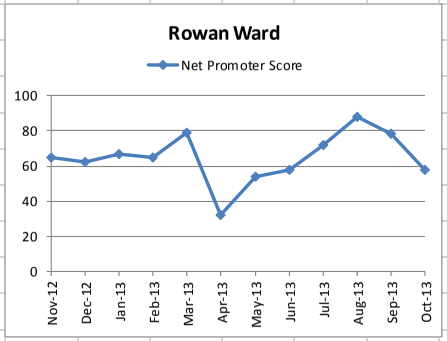

Abington Ward
Net Promoter Score
A & E Unit
Net Promoter Score
Allebone Ward
Net Promoter Score
Althorp Ward
Net Promoter Score
Ambulatory Care Unit
Net Promoter Score
Antenatal Community
Net Promoter Score
Becket Ward
Net Promoter Score
Benham Ward
Net Promoter Score
Birth Centre
Net Promoter Score
Brampton Ward
Net Promoter Score
Cedar Ward
Net Promoter Score
Collingtree Ward
Net Promoter Score
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13

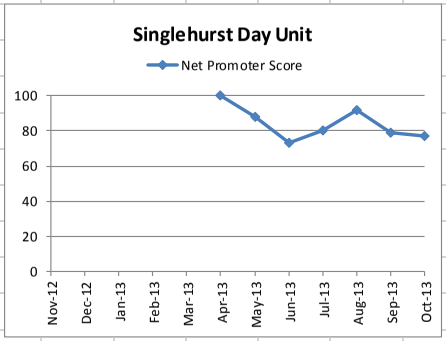

Danetre Day Surgery Unit
Net Promoter Score
Dryden Ward
Net Promoter Score
Finedon Ward
Net Promoter Score
Creaton Ward
Net Promoter Score
Disney Ward
Net Promoter Score
Eye Casualty Unit
Net Promoter Score
Corby Community Ward
Net Promoter Score
Day Surgery Unit
Net Promoter Score
Eleanor Ward
Net Promoter Score
Compton Ward
Net Promoter Score
Danetre Inpatient Ward
Net Promoter Score
EAU Ward
Net Promoter Score

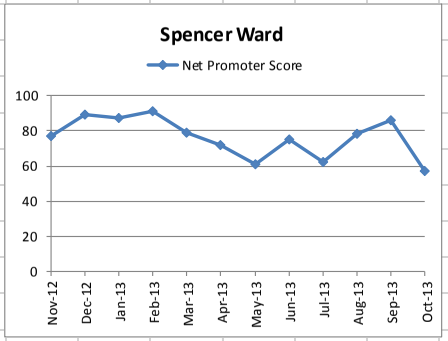


Enclosure E - Patient Experience Report


Robert Watson Ward
Net Promoter Score
100
80
60
40
20
0
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13


Rowan Ward
Net Promoter Score
100
80
60
40
20
0
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13


Singlehurst Day Unit
Net Promoter Score
100
80
60
40
20
0
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13


Spencer Ward
Net Promoter Score
100
80
60
40
20
0
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
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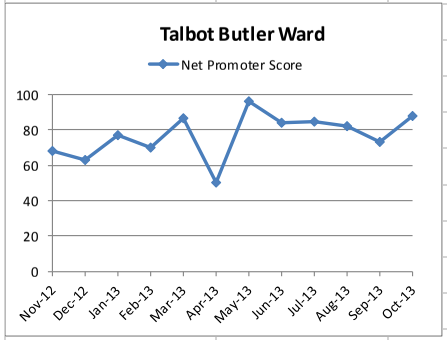
Oct-13


Talbot Butler Ward
Net Promoter Score
100
80
60
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Nov-12
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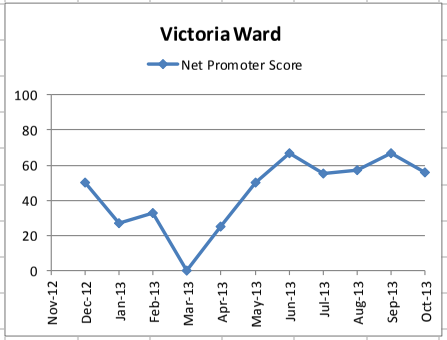
Victoria Ward
Net Promoter Score
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Nov-12
Dec-12
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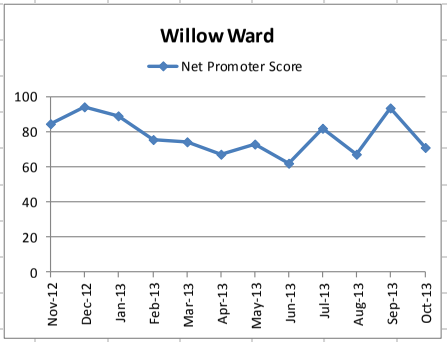
Oct-13


Willow Ward
Net Promoter Score
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80
60
40
20
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Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13

Appendix D

Star Area:

Every month an area that has made a particularly significant improvement either in their NPS or their response rate will be specially mentioned and for the month of October this goes to Eye Casualty who have seen an incredible increase in their response rates from September:

September:

EYE CASUALTY	7	2	0	0	0	0	812	9	1.11%	78

October:

EYE CASUALTY	208	51	2	3	1	6	868	271	31.22%	76

Climbing from a 1.11% response rate to 31.22%!! Whilst maintaining an excellent NPS of 76. This truly is remarkable and is down to the commitment and hard work of the team to ensure FFT worked to the best of its ability within their area! Excellent work and congratulations to you all.

Particular congratulations to:

ALTHORP WARD	20	4	0	0	0	0	46	24	52.17%	83

Althorp continue to have excellent response rate reaching 52.17% for October and an NPS of 83! Well done!

BECKET WARD	32	9	0	0	1	0	76	42	55.26%	74

Becket ward have nearly doubled their response rate for October climbing from 23.33% for September to 55.26% for October with a 74 NPS. They managed to gain responses from 42 patients our of a possible 76 – well done!

CORBY COMMUNITY	5	3	0	0	0	0	8	8	100.00%	63

Corby community have an outstanding 100% response rate! Just need to keep an eye on the NPS which is slightly low.

DANETRE WARD	12	1	0	0	0	0	31	13	41.94%	92

Danetre continue to have excellent response rates, and an extremely impressive NPS of 92!

ELEANOR WARD	23	7	1	0	0	0	61	31	50.82%	71

Eleanor ward have a excellent response rate of 50.82% increasing from 39.58% in September.

HAWTHORN WARD	74	18	1	1	0	1	196	95	48.47%	77

Hawthorn ward have a brilliant response rate of 48.47 % for October and a fantastic NPS of 77 – and this is from 95 patients! A great achievement!

HEAD AND NECK WARD	33	2	0	0	0	0	86	35	40.70%	94

Head and neck ward have achieved a fantastic response rate of 40.70% and an NPS to really be proud of at 94 with 33 patients out of 35 saying they were ‘extremely likely’ to recommend the service! Very well done!

KNIGHTLEY WARD	12	1	0	0	0	0	36	13	36.11%	92

Knightley have an impressive response rate of 36.11% and a fantastic NPS of 92!

TALBOT BUTLER WARD	21	3	0	0	0	0	102	24	23.53%	88

Talbot Butler continues to have good response rates, and have improved their NPS from 73 in September to 88 in October!

WILLOW WARD	36	5	4	0	0	3	91	48	52.75%	71

Willow ward have doubled their response rates from September and still maintained a healthy 71 NPS – Excellent work!

A & E UNIT	501	187	15	6	21	13	4627	743	16.06%	63

A&E have worked extremely hard to improve their response rates and managed a 16.06% this month with 743 patients giving their feedback! Fantastic progress. The NPS needs to be monitored to ensure it doesn't slip any lower.

AMBULATORY CARE CENTRE	16	4	0	0	0	0	89	20	22.47%	80

Ambulatory care, despite being new, have achieved a fantastic 22.47% response rate and an impressive NPS of 80! Well done!

Areas which need a little extra attention

ALLEBONE WARD	9	4	0	1	0	0	54	14	25.93%	57

Allebone too have seen a fantastic increase in their response rate climbing from 11.11% in September to 25.93% for October – however again the NPS is just falling short and this needs to be considered.

BENHAM WARD	34	12	2	2	0	0	125	50	40.00%	60

Benham have seen a big jump in response rates, however their NPS has dropped from 73 in September to 60 for October with patients stating that were 'likely' to recommend as opposed to 'extremely likely'.

BRAMPTON WARD	8	3	1	0	0	0	40	12	30.00%	58

Brampton too has a good response rate but the NPS has dropped from 67 to 58 from September to October

COMPTON WARD	8	6	0	0	0	0	13	14	107.69%	57

Compton ward achieved a 107.69% response rate which unfortunately means more people that were eligible have completed a questionnaire. Please ensure the questionnaire is only given to those being discharged home.

DRYDEN WARD	18	5	3	0	1	0	112	27	24.11%	52

Dryden ward have increased response rates, but have seen a big drop in the NPS from 88 in September to 52 in October.

FINEDON WARD	9	4	1	0	0	1	56	15	26.79%	57

Finedon ward have seen a drop in response rate from 34.62% in September to 26.79% in October and a drop in NPS from 72 to 57.

HAZELWOOD WARD, ISEBROOK HOSPT	15	3	0	0	0	0	15	18	120.00%	83

The 120% response rate for Hazelwood means a patient has completed the form when they are not eligible. Please ensure it is only given to a patient that is being discharged home.

HOLCOT STROKE UNIT	10	3	2	0	0	0	17	15	88.24%	53

Holcot have brilliant response rates, but the drop from 77 in the NPS to 53 requires attention.

ROWAN WARD	27	14	2	0	0	0	182	43	23.63%	58

Rowan ward have a great response rate, but there has been a drop in the NPS from 78 to 58, this requires attention.

SPENCER WARD	19	9	1	1	0	1	133	31	23.31%	57

Spencer ward have improved response rates from 16.2% in September to 23.31% but have seen a big drop in the NPS from 86 to 57, this needs consideration.

VICTORIA WARD	10	5	1	0	0	1	67	17	25.37%	56

Victoria ward have had a huge surge in response rates from Septembers 7.14% to Octobers 25.37%, however the NPS of 56 is slightly low and needs consideration.

Areas which require immediate attention are:

ABINGTON WARD	6	8	1	1	0	0	48	16	33.33%	25

Abington ward have seen a huge improvement in their response rates increasing from 8.16% in September to 33.33% in October – however the NPS is falling quite short of the 80 we are aiming for within NGH – attention needs to be paid to this and how we can make small changes to ensure our patients are 'extremely likely' to recommend

CEDAR WARD	5	3	0	0	0	1	69	9	13.04%	63

Cedar ward have seen a big drop in response rates for October dropping from 22.11% in September to just 13.04% for October. This requires urgent attention.

COLLINGTREE	12	2	0	0	0	0	102	14	13.73%	86

Collingtree ward have also seen a drop in the response rates, dropping from 18.6% in September to 13.73% in October. Please review this.

CREATON WARD	5	3	1	0	2	0	54	11	20.37%	18

Creaton ward have a good response rate, but the NPS is low, with a drop from 67 to 18, with 2 patients stating they're 'unlikely' to recommend.

EMERGENCY ASSESSMENT UNIT	**11**	**7**	**0**	**2**	**0**	**0**	**186**	**20**	**10.75%**	**45**

EAU continue to have problems with response rates, however work in being undertaken to improve this.

REPORT TO THE TRUST BOARD
28 November 2013

Title	Monthly Infection Prevention Performance Report
Agenda item	9
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Pat Wadsworth, Lead Infection Prevention Nurse
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the month of October
Executive summary A monthly update on reportable Healthcare associated infections (HCAIs) and review of incidents and trend analysis of HCAIs is paramount to improving learning, patient safety and quality of care and also impacts on staff safety and wellbeing. The rate of *C.diff* is rising significantly, which puts the Trust's annual trajectory of 29 at risk.	
Related strategic aim and corporate objective	Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way Patient safety there will be no avoidable harm to patients from the healthcare they receive.
Risk and assurance	The Trust has an annual target of 29 *C.diff* cases and in the first 7 months of the year has sustained 20 cases. There will be significant fines if the Trust exceeds 29 for the year, putting the Trust financial position at risk.
Related Board Assurance Framework entries	*BAF 1*
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No**
Legal implications / regulatory requirements	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections. (DH 2008)

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
28 November 2013
Infection Prevention & Control Report

1. Introduction

The Board is aware of its duty to ensure appropriate infection prevention and control mechanisms are in place to promote patient safety and quality of care. This report provides the assurance required by the Board to satisfy its statutory requirements by providing an update as to the current situation in relation to Healthcare Associated Infections (HCAIs) within the Trust.

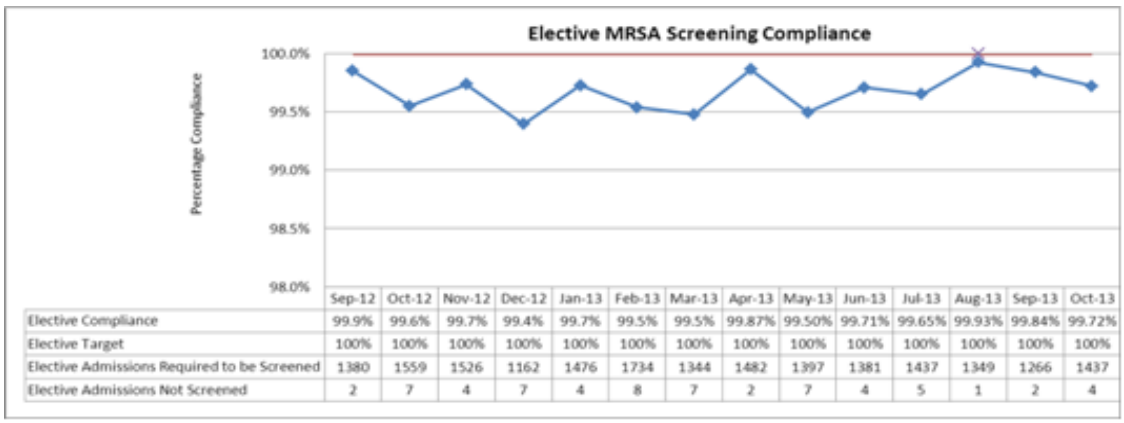
2. Report

2.1 MRSA Bacteraemia (October)

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

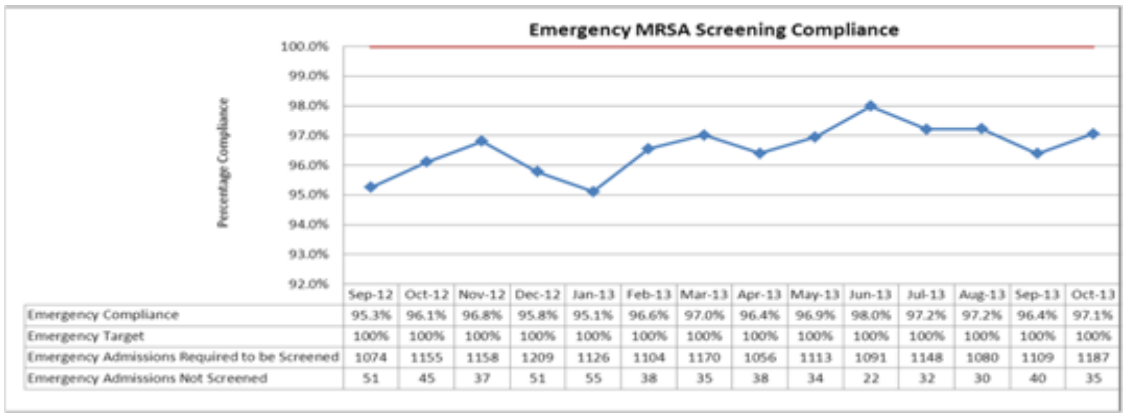
	MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
October	0	0	99.72%	97.1%	0	1

2.2 Elective MRSA screening compliance



	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
Elective Compliance	99.9%	99.6%	99.7%	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1380	1559	1526	1162	1476	1734	1344	1482	1397	1381	1437	1349	1266	1437
Elective Admissions Not Screened	2	7	4	7	4	8	7	2	7	4	5	1	2	4

2.3 Emergency MRSA screening compliance



	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
Emergency Compliance	95.3%	96.1%	96.8%	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%	98.0%	97.2%	97.2%	96.4%	97.1%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1074	1155	1158	1209	1126	1104	1170	1056	1113	1091	1148	1080	1109	1187
Emergency Admissions Not Screened	51	45	37	51	55	38	35	38	34	22	32	30	40	35

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

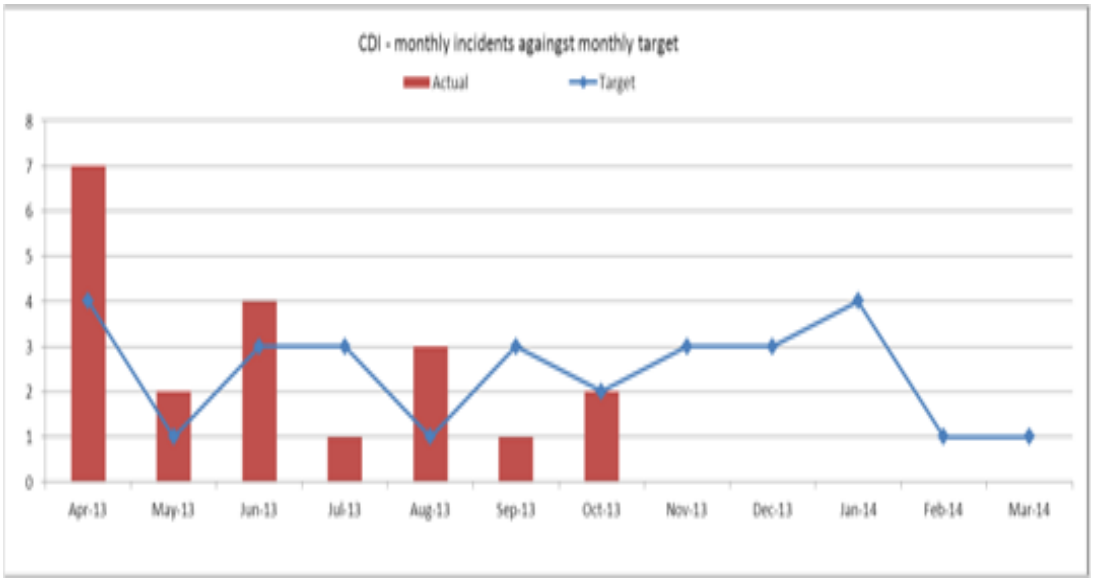
During October 2013 there were 0 <48hrs and 1 **>48hrs** MSSA bacteraemia cases. This was taken on in A&E but was allocated to Collingtree Medical due to the patient having been discharged a few hours earlier. An RCA will be taking place and the results will be fed back in the next Board Report.

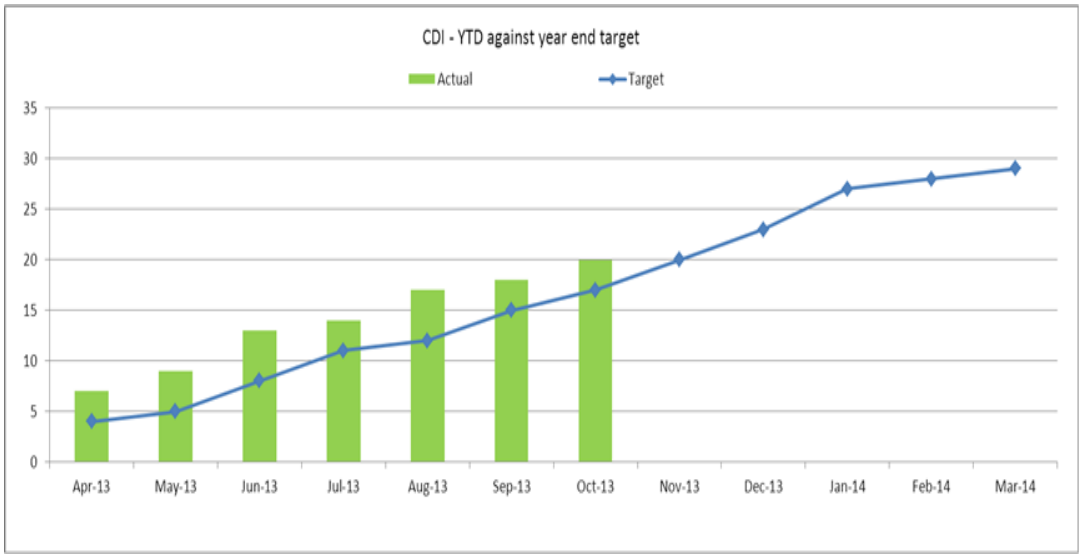
3. *Clostridium difficile*

The Trust has an annual target of 29 *C.diff* cases or less for the financial year. During October 2 **>3 day case of *C.diff*** were identified against a monthly target of 3 post three day cases, which totalled 20 for the year. These 2 *C.diff* cases were attributed to Collingtree ward and Victoria ward. They were both appropriate samples. However, in both cases the samples could have been taken earlier therefore not resulting in post 72 hours cases. As a result of this both wards had support from infection prevention and *C.diff* focus weeks were undertaken.

Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1
September 2013	0	1
October 2013	0	2
Total	**8**	**12**

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





1* >3 day case of *C.diff on Hazelwood ward at Isebrook Hospital in October 2013

The patient was admitted to Kettering General Hospital (KGH) in August and C.difficile toxins were first isolated at KGH on 19/8/13. Patient was then transferred to the Royal Free Hospital in London and repatriated to KGH in September. KGH took a subsequent specimen that identified the patient as a C.difficile carrier on 22/9/13 (not unexpected in a patient recovering from C.difficile infection). KGH treated the patient after this result with 7 days of Vancomycin and then 14 days of Metronidazole and the patient was subsequently discharged.

The patient was then admitted to Hazelwood on 23/10/13 with type 7 stools and they sent a specimen (KGH lab) on 26/10/13 which isolated C.diff toxins. So this is a relapse case and the patient is quite poorly, they are considering transferring the patient to one of the acute trusts, but we will keep a close eye on her.

With regards to the figures, as this latest sample went through the KGH laboratory, the lead IPN at KGH has put this onto the DH data capture system as a community case as the patient is in a community hospital and the data capture system automatically allocates Corby/Danetre/Hazelwood as such. This means that although this case was attributed to Hazelwood ward, it is not counted in our numbers. However, the specimen should have been taken earlier and the ward have received 3 weeks of support and education from the Infection Control team around the management of C Diff.

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

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

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

Whilst there is currently no national benchmarking for *E.coli* bacteraemias, at NGH we have been closely monitoring these and conducting root cause analyses to determine causes for infection and lessons that can be shared across the trust to prevent further patients developing *E.coli* bacteraemias. For 2013-14 we have had a mean of four **>48 hrs** *E.coli* bacteraemias a month. During October 2013 there were 15 <48hrs and 2 **>48 hrs,** which is below our monthly average.

5. Publication of National Public Health Data relating to: Adult and Antenatal & Newborn National Screening Programme

The UK NSC which is now part of Public Health England (PHE) will be publishing key performance indicator (KPI) data, each quarter, commencing with the 2013/4 Quarter 1 submission.

It is anticipated that the data will be routinely available in the public domain from the end of November 2013. Where providers do not meet acceptable standards for a KPI there is the potential for adverse publicity and press interest. At NGHT we already report our KPI data quarterly to the regional leads and will continue to monitor the quality of our service until further guidance is available. We will also inform the Trust Communication and press spokesperson of any failures to submit, or failures to meet minimum acceptable standards for a KPI, so that a reactive response can be available from us.

6. Surgical Site Infection Surveillance (SSIS) Scheme

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

	Caesarean Sections	Infection	Fractured neck of femur	Infection	Total Hip Replacement	Infection	Total Knee Replacement	Infection
Oct	109	0	33	0	23	0	13	0

The Trust takes part in the national surgical site infection surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical wound infection and be sure that patients are given the highest possible standard of care. The national programme is coordinated by Public Health England (PHE). The patient is monitored from operation until discharge and then followed up 30 days after the operation to determine if they sustained a surgical site infection. When submitting the results to the board, it should be noted that surveillance is still on-going as it is reported quarterly to the PHE and the directorate consultants and therefore these are classed as interim results.

The Infection Prevention Team conducts continuous SSIS on all fractured neck of femur patients admitted to the trust and from the 1st October 2013, will commence continuous SSIS on all total hip replacement and total knee replacement patients admitted to the trust. Monitoring infection rates for these surgeries enables us to ensure that the quality of care we deliver to these high risk patient groups is of a good standard.

For October 2013, 33 repair of fractured neck of femur operations (NOF) were conducted and no infections. Total Hip Replacement operations (THR) were 23 and no infections and Total Knee Replacement (TKR) operations were 13 with no infections.

SSIS is currently being undertaken on Caesarean sections for October-December 2013 (Quarter 3) to ensure that wound infection rates remain below the national average for this category of surgery. For October there were 109 Caesarean sections, with no infections.

The Infection Prevention Team also conducts a rolling programme of quarterly SSIS on general surgery which includes abdominal hysterectomies, breast surgery, Caesarean sections, limb amputation, spinal surgery and vascular surgery. The rates of wound infections for each category are fedback to the relevant directorates and consultants each quarter.

7. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data shows that in October 2013 the overall Trust compliance for hand hygiene is 95.0% due to 2 areas failing to submit the completed audit. Ward compliance equated to 97.4%.

The 2 areas who did not submit this month were Danetre Out Patients and the Eye Casualty, due to the members of staff who complete the audit being on annual leave. We have asked these

departments to ensure that there is somebody available to deputise during periods of absence in the future.

8. Update on Beat the Bug, Save the Skin, Stop the Clot: Board Quality Visit

October saw the second month of the Board Quality visits, with 21 areas being reviewed in the month. Unfortunately, 11 areas were not reviewed due to sickness, operational activity and unforeseen circumstances.

The themes identified from the October 2013 reviews included:

- Patients were happy with the cleanliness and tidiness of the wards and noted that staff were observed washing their hands.
- Estates issues are being reported and the estates department are now signing the estates record book on completion of the job.
- High level dust appears to be less within the ward areas this month, however, the cleaning of the racking system which houses patient equipment within the treatment areas, appears to be an issue. It has been suggested that wards/departments adopt a daily/weekly cleaning check list, which will reinforce the need to clean those areas which may not appear obvious in the first instance. In addition, stickers which indicate that equipment is clean, are not being so widely utilised – their use will be reinforced by the infection prevention team.
- VTE assessments are being completed, and the use of the GMC stamp appears to have improved.
- Oxygen cylinders were found to be rusty and visibly dirty, discussion has taken place with the portering services and the cylinders are in the process of being replaced. There is a checklist for oxygen cylinders and cleaning is being added to this list.
- Commodes this month were not as clean as September. This issue has been fed back to the specific staff who cleaned the commode and shared with the rest of the ward team during huddles.
- Intravenous line labels are not being utilised across the whole of the organisation, this has been highlighted on the November Infection Prevention newsletter.

The reviews are still being seen as very positive by staff on the wards, and the output from the reviews is beneficial, therefore it is important to maintain regular visits.

9. Education and Training

9.1 Speed training

October 16th 2013 the infection prevention and control team took part in the trial of the mandatory training 'speed training' process, which proved to be successful. However, there are some improvements to be made, which will be tested out in the second pilot during December 2013.

9.2 Annual Study Day

24th October 2013 the Infection Prevention Team celebrated their fourth annual study day where 50 members of nursing, health care assistants (HCA)'s therapies and domestic staff came together from across the trust to learn more about different aspects of infection prevention and control. The event was sponsored by five companies whose infection prevention products we use in the organisation.

Suzie Loader, the Director of Nursing, Midwifery & Patient Services who is also the Director of Infection Prevention and Control attended and gave a motivating welcoming address. She discussed the trust MRSA and *C.diff* ceilings for 2013-14 and how staff can help achieve this

through checking that stool samples are appropriate before being sent to the lab. Feedback from the delegates was positive; staff found the day very educational, motivating and enjoyable and are very much looking forward to next year's study day!

10. Communications Award

24th October 2013 The Hand washing Gangnam Video won the Best use of YouTube awards at the UK Social Media Communications Awards.

11. Assessment of Risk

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

12. Recommendations/Resolutions Required

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

13. Next Steps

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE Trust Board
28 November 2013

Title	Francis Report Action Plan Update
Agenda item	10
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Author(s)	Sue Cross, CQC compliance Manager
Purpose	This report is being provided to provide the Board with a progress update on the Trusts Action Plan, to address issues arising from the Francis Report

Executive summary

- Six actions have been completed since the previous report presented in July 2013
- Six actions are on track to meet the planned completion dates
- There has been some "slippage" in six actions and revised completion dates have been put in place. However, it should be noted that in two of these actions, slippage has only occurred in one part of the action, with progress being made in the other sections within that action.

Related strategic aim and corporate objective	*1 & 3*
Risk and assurance	*Does the content of the report present any risks to the Trust or consequently provide assurances on risks*
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	*Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N* *Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N*
Legal implications / regulatory requirements	*Are there any legal/regulatory implications of the paper? No*

Actions required by the Board
The Board is requested to:

- Discuss and challenge the content of this report
- Endorse the actions being taken forward to provide assurance

APPENDIX 2: Francis Report Action Plan

Action Plan Lead: Suzie Loader (Director of Nursing, Midwifery & Patient Services)

Sign Off: Dr Swart, Chief Executive Officer

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

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update	Status
Nursing and Clinical Care		Review Nursing & Midwifery Strategy to include the 6Cs.	Suzie Loader	NMB	September 2013	Review of N&M strategy and gap analysis 6C's & Francis Report outcome to inform new strategy Action completed – next stage: Gap analysis has been undertaken of national guidance, national reports and our current Nursing & Midwifery Strategy. Focus groups based on each of the 6C's have commenced and fed back to a workshop on 7th November 2013. This will provide the basis of the new N&M Strategy that is due for completion in the New Year.	Complete
		Inclusion of dignity, values and beliefs assessment at registered nurse interviews To expand this to non-registered workforce and midwifery.	Suzie Loader	NMB	Revised to December 2013	Included in generic Band 5 recruitment. Requested as part of specialist Band 5 appointments. To liaise with the Matrons/Sisters. To be included in Band 2 recruitment.	Slippage
		Develop an approach to CPD and Portfolio management for all professional groups that submit a portfolio: • Develop Trust Portfolio template for staff to use • Gap analysis of staff maintaining an up to date contemporary portfolio • Random reviews of portfolios (in line with NMC) All nursing & midwifery staff to submit their portfolio as part of their appraisal.	Suzie Loader	IHGC	October 2014	Added into the new appraisal documentation for the N&M. Standard template example to be developed. Process for review to be agreed through NMB.	On Track

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update	Status
		Development of a specific in-house training course for care of the older person with the potential for accreditation with the University to address a gap in knowledge in our nursing workforce with specific older persons training.	Suzie Loader Sonia Swart	NMB	April 2014	Meeting with LETC to scope and agree process with a University in the Contract	On Track
		Review discharge information • Ward level information • How we ensure medicines are with the patient when they are discharged How the Trust codes and monitors out of hours discharges.	Natalie Green	Urgent Care Board	December 2013	To include a shared learning segment on the quarterly reports and possibly meet on monthly basis to the plans and identify the points to share prior to the CG meeting. Identified: There must be clear information given to patients on who to contact post-discharge both in and out of hours. Calls from patients must be logged and advice given noted – it is advised that telephone triage systems be set up to ensure that patients are being given the most appropriate advice. (completed) Induction programmes for all senior staff should be reviewed to ensure that all are aware of relevant policies, procedures, colleagues and sources of information. (on going)	On Track
		Review dietician involvement in nutrition work	Sue Thornton	CQEG	September 2013	MUST Training throughout Trust completed Enteral Feeding Study Day completed Attended and presented at the nutrition link nurse meeting in Sept 2013 Had stand at Pressure Ulcer Prevention Day Nutrition & catering strategy meeting in Sept 2013	Complete
Accountability		Develop a Trust behavioural framework and implement it successfully across the Trust as part of the new appraisal process	Suzie Loader/ Janine Brennan	HGC	December 2013	It was agreed that a set of trust values would be developed as opposed to a behavioural framework (see below) and that the information gathered as part of that process be used to inform the values. Values agreed.	On Track

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update	Status
		Revise the Trust appraisal system to incorporate the behavioural framework and draw a clear line of sight between corporate objectives, set within the Trust's performance management system and individual objectives and expected behaviours.	Janine Brennan	HGC	August 2013	New appraisal process developed,. Training of managers in the new process is underway.	Complete
		Develop core performance objectives for Matrons/Ward sisters as part of the annual appraisal process.	Suzie Loader	Operational Board Meeting	June 2013	Agreed with care Groups. Implementation plan to be agreed. Objectives circulated to Ward Sisters in September 2013 for immediate implementation.	Complete
		Further work on dashboards is needed to support accountability frameworks	Care Group Directors	Care Group Boards Task and finish group	Sept 2013 Revised to Dec 2013	Quality & CQUINS added to Care Group Scorecards Work on nursing and midwifery dashboards has been underway. Care Group dashboards were adjusted. A further review is taking place to include elements of the National Quality Dashboard and to reflect the Trust's revised corporate objectives. This is out for a second round of consultation currently. A revised version of the dashboard will be presented to Board following consultation – January 2014. This process has taken longer than desirable due to competing priorities.	Slippage
Culture Including: • Values and standards • Openness, transparency and candour		Review and refresh the Trust values, based on the behavioural framework, adopting a bottom up approach to ensure staff engagement.	Janine Brennan	Trust Board	March 2014	Focus groups completed. Values in final stage of completion for approval by the trust board in November	On Track
		Conduct an organisational development diagnostic to identify aspects of organisational culture that need addressing and develop OD interventions to reflect the changes required.	Janine Brennan	HGC	March 2014	Diagnostic fed back to Board and high level OD strategy agreed by Trust Board on 16th September 2013	Complete

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update	Status
		Revitalise and raise awareness of the NHS constitution: • Review Standard Terms and Conditions of Service for Agenda for Change contracts to include reference to the NHS Constitution. • Review the Job Description Template to include reference to the NHS Constitution. • Addition of NHS Constitution to the Induction programme. • Consider inclusion of NHS Constitution reference in policy template	Janine Brennan	HGC	May 2013 Revised to April 2014	All completed with the exception of the Standard T&C's. The review has taken place, awaiting the confirmation of the new appraisal process linked to incremental progression. New appraisal process has been established for implementation from April 2014 and training is currently taking place.	Slippage
		Incident management • Improve the mechanisms to feedback to individuals using the appropriate local channels. • Improve the review of themes and trends locally • Improve monitoring compliance with action plans, notably for SIs.	Deputy Director of Quality & Governance with Care Group Management	CQEG	September 2013 Revised to December 2013	Action plans & themes/trends being discussed at Care Group governance Meetings. With the appointment of the Care Group Quality Governance managers & Governance Facilitators this will be taken forward.	Slippage
		Being Open and Duty of Candour Review Trust arrangements	Deputy Director of Quality & Governance	CQEG Trust Board	September 2013 Revised January 2014	Being open process embedded in organisation all patients / carers who have been involved in a SI's are offered a Being Open meeting. Duty of Candour compliance is being logged on Datix system. Consideration being given as to how this can be further embedded across Trust. **Achieved** Both the requirements for Duty of Candour and Being Open are included within the updated Trust Risk Management Strategy **Achieved** Being open & SI policies being updated to ensure robustly reflect and give documented guidance for Duty of Candour process	Slippage

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update	Status
Francis – recommendation 113 The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS. A review of the report has been completed by the Complaints Manager and the outcome is detailed here.		***Learning*** *25% of Trust's had a culture of learning from complaints which was insufficiently developed* Develop the process of learning from complaints (in conjunction with incidents and claims)	Lisa Cooper / Care Group Governance leads (new post)	CQEG Trust Board	September 2013 Revised to December 2013	The aggregated analysis report is in the process of being reviewed. This incorporates complaints, PALS, incidents, claims & patient experience. Being prepared via Senior Risk /Litigation Manager.	Slippage
		Reporting *Trust's must produce regular complaints reports and provide access to these on their website* Review which quarterly reports may be most suitable or adaptable for use in the public domain.	Lisa Cooper / Eileen Ingram	CQEG	December 2013	Annual reports are uploaded on to the website once reviewed/approved by the Trust Board. 2012-2013 report has been passed on to IT for uploading to the website (October 2013). Quarterly reports to be discussed with Deputy Director of Governance to consider suitability.	On Track
		Policy Trusts should have their complaints policy accessible on their web site. It must be: -Up to date -Clearly state the responsibilities -Detail the complaints handling process -List its reporting mechanism's to the board (The Trust 4C's policy is awaiting new regulation changes which are to be released later this year. Once the new regulations are complete an updated policy will be uploaded to the NGH website.)	Lisa Cooper / Eileen Ingram	CQEG	June 2013	Complete 05.07.13 via Lisa Cooper. Website verified and details are incorporated into the patients/visitors 4 C's section for ease of access.	Complete

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

Actions	Responsible committee	Reporting Frequency
Nursing and Midwifery Staffing Strategy Implementation Nursing & Midwifery Skill mix reviews	Nursing and Midwifery Board (NMB)	Monthly On-going
Monitoring reports (Patient Safety Book)	HGC	Quarterly report, monthly review
Human Resources performance management (including mandatory training, appraisal etc.)	HGC	Monthly
Patient Safety Academy	Patient Safety Board	Monthly
Patient Experience (including inpatient survey, Friends and Family Test, etc.	Patient Experience Board	Monthly
CQC action plans, CGRS	HGC	Quarterly
CQUIN Management (including Pressure Ulcer, VTE, dementia, etc.)	Care Group Boards Finance & Performance	Monthly Monthly
Board to ward	Trust Board	Monthly
Quarterly directorate reports (including risk, mortality and morbidity, being open, complaints)	Care Group Boards CQEG	Quarterly
Improving compliance with policies, such as record keeping, completion of patient assessments and escalation of care, etc. Through clinical audit process, directorate reports, also through Governance stream	CQEG	Monthly
Dashboards	A range of groups	

NB/ This list is not exhaustive.

REPORT TO THE TRUST BOARD
28 NOVEMBER 2013

Title	Nurse Staffing Report
Agenda item	11
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Author(s)	Suzie Loader, Director of Nursing, Midwifery & Patient Services Janine Brennan, Director of Transformation & Organisational Development
Purpose	To update the board on nurse recruitment

Executive summary

This paper outlines nurse recruitment activity over the past 18 months; current recruitment activity, forecast for achieving 95% establishment on the general wards, actions being taken to enhance recruitment and an update on implementation of year 1 of the Nursing & Midwifery Staffing Strategy.

Related strategic aim and corporate objective	1 & 3
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks **NO**
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper **NO**

The Board is asked to:

- Discuss the content of this report and to challenge where appropriate
- Note the actions which are being taken to mitigate recruitment slippage

Trust Board
28 November 2013
Nurse Staffing Report

1) The Issue

There is much scrutiny of nurse staffing currently, both internally and externally, as it is proven to have a direct impact on the quality of care delivered to patients. This report aims to update the board on progress regarding implementation of year 1 of the Nursing & Midwifery Staffing Strategy, including achievement against recruitment milestones, use of bank and agency and development of the Nursing & Midwifery Quality Dashboard (N&MQD). A summary of the recently published Secretary of State for Health's Expectations on Nurse Staffing is also presented (November 2013).

2) Background

The Board approved a 4 year Nursing and Midwifery Staffing Strategy in March 2013 and supported the implementation of year 1, with an investment of £1.9m. In June, an update regarding implementation progress was presented to the board which outlined changes to ward establishments, which had occurred as a result of:

a) Re-base lining of existing budgets
b) Introduction of 2 additional wards to help cope with increasing demand
c) Business case investment (Rowan Level 1 beds & Introduction of SAU on Hawthorn)
d) Allocation of the £1.9m investment

This resulted in an additional 58.45 RN's & 65.18 HCA's being added to ward establishments.

Prior to the establishments being uplifted, the Trust had successfully recruited to 95% of HCA posts by March 2013 and 95% of RN posts by June 2013, which equated to a total of 350 RN/HCA staff being recruited to the general wards during 2012/13.

A recruitment plan was presented to the June board, which forecast wards would have achieved 95% of their uplifted establishments for both HCA's and RN's by October 2013.

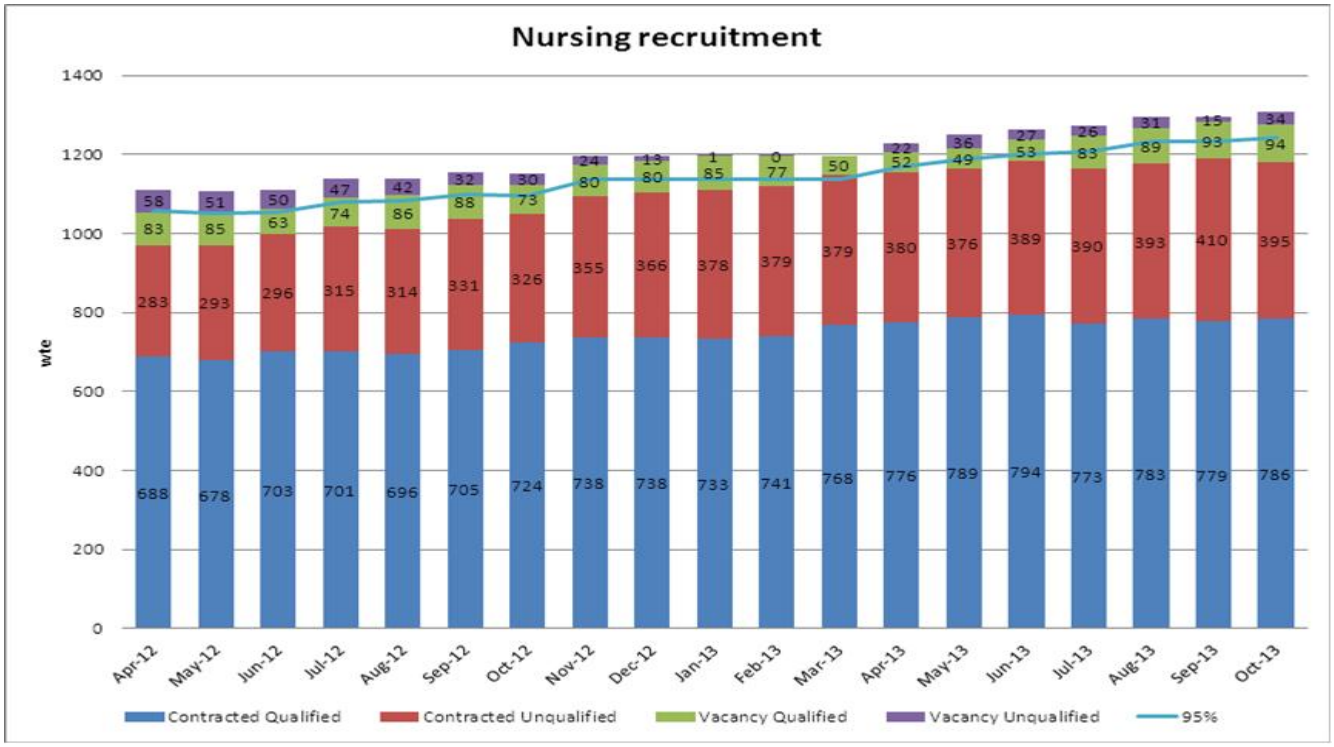
However, concerns were raised at last month's board meeting regarding slippage against the October forecast. This report aims to provide assurance to the board by presenting data on recruitment activity and actions being taken to mitigate this situation:

a) Recruitment activity over the past 18 months
b) Current recruitment figures (which have slipped from the original forecast)
c) Current number of RN's WTE's worked against budget / general ward including achievement against the 1:8 ratio's
d) A forecast relating to when the trust anticipates achieving the 95% establishment on the general wards
e) Plans for the future (short and long term) which aim to secure more successful recruitment of RN's moving forward

3) Nursing Recruitment

3.1. Recruitment activity over the past year

The following graph demonstrates the number of RN's and HCA's recruited to work on the general wards since April 2012. This highlights an increase of 98 RN's from 688WTE to 786WTE (April '12 – October '13) and 112 HCA's from 283 – 395 (April '12 – October '13) over the past 18 months. It also demonstrates that the trust is closer to achieving 95% of establishment now (which includes the 120WTE uplift) than April last year.



3.2. Current Recruitment Figures

The HR pipeline report indicates that at the end of month 7, the remaining vacancies on the general wards are as follows:

- Main wards – vacancies total: RN's 60.37WTE (decrease from 64.77WTE in September) & HCA's 23.81WTE
- Specialist areas – vacancies total: RN's 33.9WTE (decrease from 43.09 WTE in September)) & HCA's 10.65 wte

Total vacancies for October = 128.77 (an increase from 107.86 WTE (September))

From April to the present day, the general wards have recruited a total of 113 RN's and 77 HCA's.

Whilst the Trust did not achieved 95% establishment by October as forecast, it has achieved 92% for RN's and 95% for HCA's. The reasons for this are twofold:

- The Trust had agreed to introduce a maths, literacy and values test for new recruits, to ensure an acceptable standard of practise in this area. This was meant to be piloted before being introduced to ensure it was 'fit for purpose', but due to a breakdown in communication, this didn't happen. This has resulted in two outcomes: a) the test was longer than it should have been b) potential recruits were invited to undertake the test prior to being invited for interview. Both these actions reduced the number of potential recruits by 10/month who might have otherwise been interested in joining the Trust over a 3 month period. The Trust is actively trying to redeem this situation, with a number of actions being taken, outlined below.
- Several surrounding hospitals have uplifted their nursing establishments this year as a direct result of the Francis report. We are therefore all trying to recruit from a reduced pool of available staff.

Several actions are being taken to expedite recruitment in the short-term:

Action to expedite recruitment	Achievement date
Mapping out of the full recruitment process to include expected timelines and explicit responsibilities (between managers and HR) for each stage of the process to enhance clarity and to provide performance indicators	15.11.13
An open day is arranged for 25 November 2013	25.11.13
Scoping out the possibility of further overseas recruitment (India, Canada, Europe, Malta etc.) to support on-going UK recruitment initiatives 14 nurses recruited from Malaga in conjunction with Bedford Hospital	30.11.13 20.11.13
Targeting areas that we would like to recruit from, including Scotland and Wales by placing adverts in local papers to see if we can attract additional candidates this way. In addition, offering both permanent and 6 month temp/perm contracts for potential recruits	30.11.13
Targeting other universities in addition to our local university	February 2014

As a result of these actions, the Trust anticipates that it will achieve 95% establishment of RN's in December for the Surgical Care Group and 95% in Medicine by February 2014.

In the longer term, the HR department is working with the Corporate Nursing/Midwifery team to develop an HR Recruitment Strategy which will forecast demand and supply requirements, and then map recruitment activities to these (end of February 2014).

In addition, other actions are being taken to enhance temporary staffing provision across the Trust to help close the substantive WTE gap:

Actions being taken to enhance temporary staffing provision across the Trust	Achievement Date
Successful reduction in agency rates (particularly for specialist areas)	07.10.13
Enhancing the pro-active nature of the in-house bank, and increasing the hours that bank admin staff are available to contact staff to include unsocial hours. Bank hours are now: 8am to 9pm Monday to Friday and 9am – 1pm Saturday and Sunday. These staff are also being employed to update the eRoster system to ensure that it is a timely and accurate record of shifts worked / ward.	09.11.13
A rolling advert for Bank HCA's and RN's has been set up with large numbers of applicants to the HCA advert although smaller numbers are applying to register with the RN Bank. During November, 60 candidates have been invited for interview with a further 39 planned for December; these are a combination of HCA's and RN's although the vast majority are HCA applicants. This is currently a pilot.	On-going
Exploring block bookings with agencies to cover the leaner period before staffing starts to improve	In progress
Automatically giving those staff who have commenced with the Trust since September 2013, a contract with the Nurse Bank in addition to their substantive contracts	20.11.13
The HR Business Partners and HR Advisors support the managers in all areas of the	On-going

Actions being taken to enhance temporary staffing provision across the Trust	Achievement Date
Trust with the management of sickness absence. HR Advisors meet with their designated managers on a monthly basis and review trigger points and actions required on individuals who have been off sick. In addition, HR Advisors monitor return to work interviews and cross reference the information with the reports that are received from e-workforce. Where there are low percentages the HR Business Partners report to the Directorate Management Boards. Some directorates such as medicine are provided with the top five worst areas where sickness absence is high. The HR Business Partners and HR Advisors focus on these areas. The HR Department are also in the process of reviewing this management of sickness absence policy. Consultation has taken place, further consultation will take place with staff side in the coming months.	

3.3. Performance against Recruitment Key Performance Indicators

The Trust currently has a 13 week key performance indicator relating to the recruitment timeline. This timeline measures from advert through to clearance being obtained by the HR Service Centre. Work is in progress to extend the timeline measure from when the employee informs their manager they intend to leave until they start. KPI's will be identified for each stage of this process. The flow chart in appendix A, outlines the current KPI's, giving an indication of how the indicators measure process.

3.4. Worked WTE's for month 7, including achievement of 1:8 ratio's

The uplifted nursing budgets from the ward areas have been reviewed in relation to whether they are achieving the nationally recommended 1 registered nurse (RN):Patient ratio. The table below outlines the budgeted level of RN's per shift per ward and indicates whether or not the 1:8 ratio is achieved (non-achievement = box coloured red). This has then been compared with the actual number of RN's who 'worked' / ward for month 7 ('worked' equates to the total number of substantive and temporary WTE's who worked). Unfortunately, it is not possible to show this per shift, but we can show it in relation to WTE's – we have then indicated in the last right-hand column, the RN worked budgeted level % against the total WTE establishment. The table below outlines the number of WTE's worked against funded establishment for month 7 and includes achievement (or not) of the 1:8 RN:Patient ratio.

Ward	No. of Beds	RN Shifts Needed for '1 RN for 8 Beds'	Budget - Post 13/14 Investment			Budget Qual RNs WTE (M7)	RN Budget WTE : Beds	Mth 7 - WORKED RN&HCA WTEs				Number of Qual RNs WTE (M7)	RN Worked WTE : Beds	RN Worked : Budgeted Level %
			Qualified Shift No.					Core	Bank	Agency	Total Worked			
			E	L	N									
Abington	28	4	5	4	3	21.3	0.76	30.9	4.1	1.5	36.6	13.2	0.47	62%
Althorp	18	2	3	3	2	13.7	0.76	23.2	1.0	0.1	24.3	14.2	0.79	103%
Cedar	29	4	5	4	3	20.9	0.72	33.1	6.6	1.2	40.9	20.6	0.71	99%
Hawthorn	30	4	6	5	3	24.3	0.81	36.2	4.3	0.5	41.0	22.6	0.75	93%
Head & Neck	14	2	3	3	2	16.0	1.14	22.3	2.6		24.9	16.2	1.16	102%
Rowan	30	4	6	4	3	26.3	0.88	32.3	5.3	0.4	37.9	20.7	0.69	79%
Spencer	14	2	3	2	2	13.9	0.99	17.5	2.5	1.1	21.2	13.9	1.00	100%
Willow	28	4	7	6	5	31.8	1.13	41.6	2.9	1.1	45.6	32.0	1.14	101%
Surgical Group	**191**		**38**	**31**	**23**	**168.2**	**0.88**	**237.1**	**29.3**	**5.9**	**272.4**	**153.4**	**0.80**	**91%**
Allebone	28	4	4	4	3	20.2	0.72	27.8	5.9	8.0	41.8	21.8	0.78	108%
Becket	26	4	6	5	4	27.6	1.06	41.1	2.5	1.4	45.0	25.7	0.99	93%
Benham	28	4	5	5	4	26.6	0.95	34.1	5.5	2.6	42.2	25.6	0.91	96%
Brampton	27	4	4	3	2	16.2	0.60	28.7	5.5	0.4	34.6	17.0	0.63	105%
Collingtree	40	5	6	6	4	30.7	0.77	45.3	4.2	2.1	51.5	26.3	0.66	86%
Compton	18	3	3	2	2	13.5	0.75	24.0	2.1	1.2	27.3	14.4	0.80	107%
Corby	22	3	2	2	2	12.4	0.56	21.4	2.6	0.8	24.8	11.6	0.53	93%
Creaton	28	4	6	4	3	24.1	0.86	33.1	5.7	2.4	41.2	18.5	0.66	77%
Daventry	28	4	3	3	2	14.9	0.53	35.3	2.9	1.4	39.5	16.1	0.57	108%
Dryden	22	3	5	5	4	26.6	1.21	28.4	3.1	2.3	33.8	24.7	1.12	93%
EAU	32	4	6	6	5	32.3	1.01	38.9	8.1	3.5	50.5	30.8	0.96	95%
Eleanor	12	2	4	2	2	14.1	1.17	19.8	1.6	1.1	22.5	14.4	1.20	102%
Finedon	18	3	7	7	3	25.3	1.41	27.7	2.7	0.2	30.6	23.2	1.29	92%
Hazelwood	34	5	3	2	2	12.4	0.36	29.5	6.1	2.8	38.4	14.0	0.41	113%
Holcot	27	4	5	3	3	20.8	0.77	30.5	2.6	0.9	34.0	15.6	0.58	75%
Knightley	21	3	3	2	2	13.5	0.64	21.9	4.1	1.8	27.8	13.3	0.63	98%
Talbot Butler	30	4	8	6	3	29.9	1.00	33.1	5.0	3.2	41.3	26.3	0.88	88%
Victoria	18	3	4	3	2	16.2	0.90	23.7	4.1	1.3	29.1	15.7	0.87	97%
Medical Group	**459**		**84**	**70**	**52**	**377.1**	**0.82**	**544.3**	**74.4**	**37.2**	**655.82**	**354.7**	**0.77**	**94%**
Grand Total	**650**		**122**	**101**	**75**	**545.3**	**0.84**	**781.4**	**103.7**	**43.1**	**928.2**	**508.0**	**0.78**	**93%**

It should be noted that these figures do not include those staff who have been moved from one ward to another in order to maintain safe staffing levels across the organisation.

Some wards are currently budgeted to staff below the 1 RN:8 Patients on *some* shifts, these are highlighted in red in the blue column in the table above.

Those wards highlighted in red achieved 79% or less against their funded establishment, with the biggest cause for concern being Abington ward who only achieved 62%. However, the board should note that 3 WTE are due to start on the ward this month with a further 3 commencing in December, which will improve this situation greatly. Those wards outlined in green achieved 99% - 113% of their establishment. One of these wards; Allebone is showing an over establishment due to the uplift in the establishments following a review of case mix and a decision to increase the number of RN's on every shift to reflect the needs of the patients – this is currently being treated as a cost pressure. Some of the other wards are showing an over establishment due to: long term sickness / maternity leave and in some minor cases specialing of acutely unwell patients. In addition, Althorp Ward has been allocated an additional RN who acts as a transfer nurse due to the distance from the ward to theatres. Willow ward has been accommodating an increased number of level 1 patients' on the ward (over and above the agreed level) which has resulted in additional staff being utilised to ensure safe care.

A noticeable change this month is that the Rowan RN budget increased, as we originally expected Level 1 beds to open in October, when budget setting took place. However, this will not now occur until

February due to the inability to recruitment experienced RN's within the timescales; existing ward staff also require additional training. As a result, Rowan only achieved 79% of their revised establishment.

There are also a number of wards planning to staff above the 1:8 ratio, due to the complexity of patients on the unit. For instance, Willow Ward (vascular ward with Level 1 beds), staff at 1RN:4 patients on an early and roughly 1RN:5 patients on a Late shift.

In order to provide a benchmark, it is useful to calculate the Trust average RN:Patient ratio. This is achieved by taking the total budgeted WTE and dividing it by the total number of beds, giving an average of 0.83 WTE RN:Patient ratio. 'Worked' Staffing levels in October, totalled 508 WTE, a reduction of 0.9WTE from last month. This coupled with the budget increase on Rowan ward has led to a slight drop in the overall worked percentage to 93% (a reduction of 1% from the previous month).

3.4. Use of Bank & Agency

During 2012/13, the Trust spent £9.2m on bank and agency to cover short-falls in the ward/specialist areas. This year, the Trust agreed to invest in nursing to the tune of £1.9m which equated to an increase in nursing establishment by 120WTE. However, there was an expectation that spend on bank and agency would be reduced by £1.3m this year.

The table below outlines bank and agency spend during 2012/13 averaging 14% of the total nursing workforce. When compared to spend during the first 6 months of this year, it appears that the average has reduced to 11% and within that agency has reduced by a third (7% down to 5%) from last year. It is anticipated that this will continue to drop as staff are recruited into substantive posts.

£000's	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	12/13 Avg
Bank	£ 418	£ 336	£ 355	£ 406	£ 357	£ 390	£ 361	£ 377	£ 422	£ 370	£ 378	£ 426	£ 383
	8%	6%	7%	7%	7%	7%	7%	7%	8%	7%	7%	7%	7%
Agency	£ 344	£ 412	£ 383	£ 470	£ 381	£ 447	£ 478	£ 435	£ 273	£ 333	£ 336	£ 346	£ 386
	7%	8%	7%	9%	7%	8%	9%	8%	5%	6%	6%	6%	7%
Bank + Agency	£ 762	£ 749	£ 738	£ 876	£ 739	£ 837	£ 838	£ 811	£ 696	£ 703	£ 714	£ 773	£ 770
	15%	14%	14%	16%	14%	16%	16%	15%	13%	13%	13%	13%	14%
Nursing Total	**£ 5,248**	**£ 5,377**	**£ 5,276**	**£ 5,417**	**£ 5,265**	**£ 5,358**	**£ 5,389**	**£ 5,488**	**£ 5,400**	**£ 5,498**	**£ 5,558**	**£ 6,082**	**£ 5,446**

Total nursing spend peaks in Mar-13 due to year end provisions.

£000's	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13						13/14 Avg
Bank	£ 390	£ 344	£ 353	£ 354	£ 346	£ 403	£ 366						£ 365
	7%	6%	6%	6%	6%	7%	7%						7%
Agency	£ 278	£ 336	£ 249	£ 228	£ 211	£ 246	£ 278						£ 261
	5%	6%	4%	4%	4%	4%	5%						5%
Bank + Agency	£ 668	£ 680	£ 602	£ 582	£ 557	£ 649	£ 643						£ 626
	12%	12%	11%	10%	10%	12%	12%						11%
Nursing Total	**£ 5,610**	**£ 5,615**	**£ 5,574**	**£ 5,548**	**£ 5,426**	**£ 5,554**	**£ 5,508**						**£ 5,548**

4. Implementation of year 1 of the Nursing & Midwifery Staffing Strategy

The following table identifies the key actions identified within the Nursing & Midwifery Staffing Strategy and outlines achievement against each of them:

Description	Progress	RAG rating
Efficient use of nursing/midwifery resource which included: 1. Roster efficiency 2. Triangulation of workforce, finance & operational data 3. Recruitment of staff 4. Standards of shift patterns and handover times 5. Review of flexible working	1. A diagnostic has been conducted on the eRoster system and training has been given to ward sisters. There is still more work to undertake in this area. 2. Operational meetings are held monthly to ensure triangulation of key data which informs the recruitment pipeline 3. Recruitment of staff is on-going but has reduced over a 3 month period for reasons	

Description	Progress	RAG rating
contracts 6. Manage sickness down to 3.8% (trust target) 7. Reduce the use of agency once wards are recruited 8. Achieve a significant reduction in spend in bank and agency 9. Increase the nursing bank by 100 WTE	outlined above 4. A task and finish group has been established to review shift patterns and handover times. They are just completing the proposal prior to it going out to consultation in December 2013. 5. On-going 6. Sickness has reduced, but not to the 3.8% on every ward 7. The use of agency has been reduced, however this needs to be reduced still further 8. A reduction in bank and agency spend has been achieved, but not as much as has been anticipated 9. The nurse bank have not yet been able to increase the number of substantive staff. However, actions are being taken to enhance this service (see above) and the Trust has 60 applicants to interview of the next couple of weeks.	Amber
Implement Maternity Pool	Achieved	Green
Identify the top 8 wards requiring investment	Achieved. However, when the trust risk assessed the wards, instead of identifying the top 8 wards, it was felt that a safer option would be to identify the top 4 and then to divide the remainder of the funding to providing additional staff on specific shifts (such as night shifts) and to address 'specialling' requirements. This funding has been allocated to budgets and the trust is actively recruiting.	Green
Ensure all Ward Sisters have 2 days supervisory time	Achieved	Green
Review domestic staff cover 7 days / week	Deadline March 2013. Not achieved as yet. However a review of ward clerk provision has been undertaken and a business case submitted for additional resource in this area. (this action was scheduled for 2016/17)	On track
Review Paediatric nursing skill mix	Achieved.	Green
Review Midwifery staffing	Achieved. A business case has been submitted to support the outcome from this review.	Green
Review Francis recommendations & develop action plan Review the Nursing & Midwifery Strategy to encompass the recommendations from Francis, the 6 C's and development of the Nursing & Midwifery Quality Dashboard (N&MQD)	Achieved On-going Strategy day to present the work of the 6 C's task and finish groups held 07 November 2013 N&MQD revised to ensure that healthcare outcomes incorporated into the strategy have been incorporated into the dashboard. RAG rating system also reviewed to facilitate improvement	Green
Review ward sisters job descriptions Design a leadership / management	• Ward Sister's job descriptions have been reviewed and will shortly go out to	

Description	Progress	RAG rating
programme to meet development needs	consultation. This will include the need to work towards 7 day working, as current ward sister contracts preclude them from working unsocial hours • It is no longer appropriate to develop a leadership / management programme just for ward sisters. Any leadership needs will be met through a trust wide leadership programme developed by the organisational development department.	Amber
Conduct a skill mix review across the general wards	Achieved. A business case has recently been submitted to support year 2 of the nursing & midwifery staffing strategy implementation	

The Nursing & Midwifery Strategy is currently being reviewed to incorporate the 6C's, recommendations from Francis etc., however this review will not be complete until the recommendations published by the Secretary of State for Health (20.11.13) have been taken into consideration, these are summarised below:

5. How to ensure the right people, with the right skills, are in the right place at the right time; A guide to nursing, midwifery and care staffing capacity and capability
In a direct response to Francis, Keogh and Berwick, the National Quality Board has published a set of expectations which aim to support organisations to be able to make the right decisions about their staffing requirements and to help them to create an environment in which staff feel supported. It is suggested that if organisations do as much as possible to support staff, they will be able to provide high quality, compassionate care. The expectations outlined in the document are summarised as follows:

Expectation 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to shift basis.

Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Expectation 7: Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.

Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.

Expectation 10: Commissioners actively seek assurance that the right people, with the right skills are in the right place at the right time within the providers with whom they contract.

This is a comprehensive document and requires consideration about how it might be implemented at NGH. Actions identified as a result of this document will be published in next month's nurse staffing report.

6) Conclusions

Whilst it is acknowledged that recruitment of RN's has slipped from the original forecast, much activity is underway to achieve 95% establishment of RN's by December for the Surgical Care Group and February '14 for the Medical Care Group. In the meantime, there are a number of additional actions being taken to enhance the provision of NGH bank staff who are trained in the quality standards expected by NGH. The Trust has already achieved 95% recruitment of HCA's.

Although the number of substantive RN's has dropped slightly from forecast, it should be recognised that a number of wards have achieved >100% of their establishment during October as a result of the support from temporary staff.

The development of a recruitment strategy for Nursing & Midwifery will help to minimise the slippage outlined in this report, presenting a more robust plan moving forward.

A number of the actions identified in year 1 of the Nursing & Midwifery Staffing Strategy have been achieved. However, the strategic action plan for year 2 will be adjusted to accommodate the 'expectations published around nurse/midwifery staffing' (DH, November 2013).

7) Recommendations

The board is asked to:

- Discuss and challenge the content of this report
- Note the actions being taken to mitigate recruitment slippage

Appendix A

TIMELINE FOR RECRUITMENT PROCESS

KPI	Activity		Timeline
KPI 1	Date Vacancy Advertised	=	ASAP
KPI 2	Closing Date	=	2 Weeks Appointing Officer
	E mail appointing officer applications	=	2 day HR Service Centre
KPI 3	Shortlisting	=	1 week Appointing Officer
KPI 4	Interview Schedule	=	3 Days HR Service Centre
KPI 5	Interview Date	=	2 Weeks Appointing Officer
KPI 6	Successful candidate form received in HR Service Centre	=	1 week Appointing Officer
KPI 7	Offer letter sent to candidate	=	1 week HR Service Centre/ Appointing Officer
KPI 8	Clearances, CRB, references, occupational health etc.	=	5 Weeks HR Service Centre
	Total		**13 weeks**

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

Title	Performance Report
Agenda item	12
Sponsoring Director	Mrs Rebecca Brown, Interim Chief Operating Officer
Author(s)	Deborah Needham, Interim Chief Operating Officer Karen Spellman, Deputy Director of Strategy and Partnerships
Purpose	The paper is presented for discussion and assurance

Executive summary

The Trust has not achieved the following standards during October 2013; Urgent Care 4 hour standard, 62 day standard from urgent GP referral, 18 weeks admitted and non-admitted specialty standard for T&O.

The number of patients waiting over 26 weeks from referral has reduced to from 31 to 19. Ambulance handover times – the standard is for patients arriving to the A&E department by ambulance to be handed over to the nursing team within 15 minutes of arrival. The CCG contract monitors all those over 30 minutes and over 60 minutes. The Trust continues to be in discussion with EMAS and the CCG to validate all ambulance handover data prior to contractual consequences being applied to this standard.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering A&E and 62 day performance standards
Related Board Assurance Framework entries	BAF 17
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N)

Actions required by the Board

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

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Q1	Q2
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	91.00%	N/A	N/A
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.70%	N/A	N/A
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.28%	N/A	N/A
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	19	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	N/A	N/A
RTT T&O Admitted	CCG & TDA	90%	91%	90%	91%	90%	90%	90%	62%		
RTT T&O Non-Admitted	CCG & TDA	95%	95%	95%	95%	98%	95%	95%	92%		
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%	100%	100%	N/A	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0	0
*A&E: Total time in A&E (Calendar month)	CCG & TDA	95%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	N/A	N/A
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.55%	91.70%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	96.00%	95.87%	95.74%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.90%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	98.50%	98.12%	97.76%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	98.15%	98.08%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	96.90%	97.73%	97.30%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	94.12%	98.72%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	83.40%	82.04%	83.44%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%	69.57%	83.87%	73.33%	82.61%		N/A	N/A
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	88.71%	98.18%	89.83%	87.14%	86.96%		N/A	N/A
Trolley Waits waiting > 12hours	CCG	0	0	0	0	0	0	0	0	N/A	N/A
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	446	476	1263	1656	N/A	N/A
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	125	112	206	346	N/A	N/A
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31	15	62	N/A	N/A

* A&E data is calendar month.

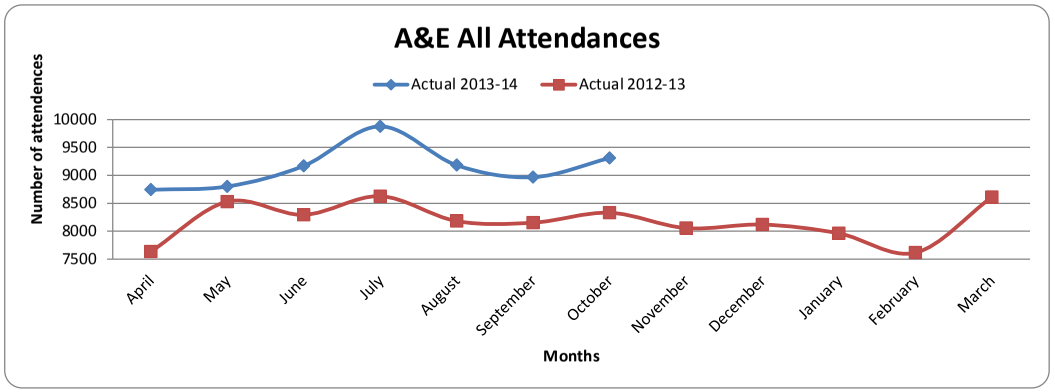
Key Message:

The Trust has not achieved the following standards during October 2013; Urgent Care 4 hour standard, 62 day standard from urgent GP referral, 18 weeks admitted and non-admitted specialty standard for T&O.

The number of patients waiting over 26 weeks from referral has reduced to from 31 to 19.

Ambulance handover times – the standard is for patients arriving to the A&E department by ambulance to be handed over to the nursing team within 15 minutes of arrival. The CCG contract monitors all those over 30 minutes and over 60 minutes. The Trust continues to be in discussion with EMAS and the CCG to validate all ambulance handover data prior to contractual consequences being applied to this standard.

A&E Quality Indicators

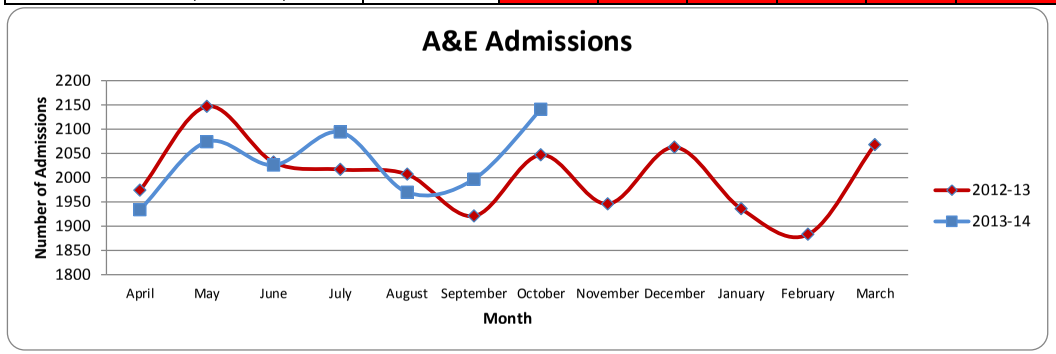


Summary

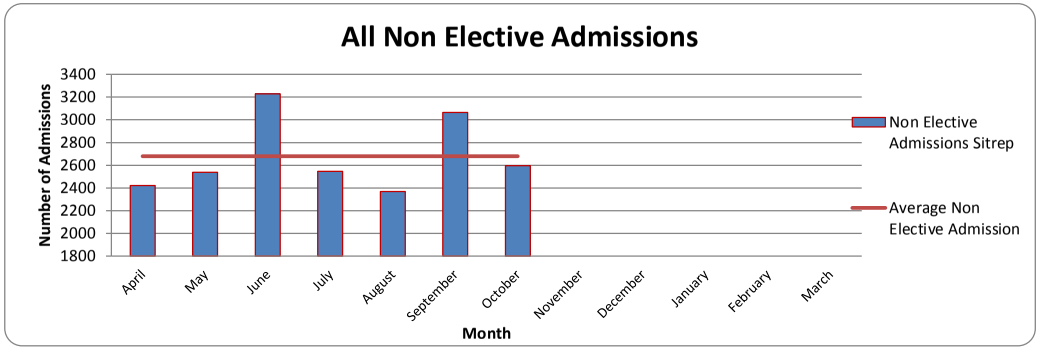
During October 90.56% of patients were seen treated and discharged or transferred within 4 hours. The YTD position at the end of October was 91.88%, this has now increased to 92.16% (as at 12th November 2013)

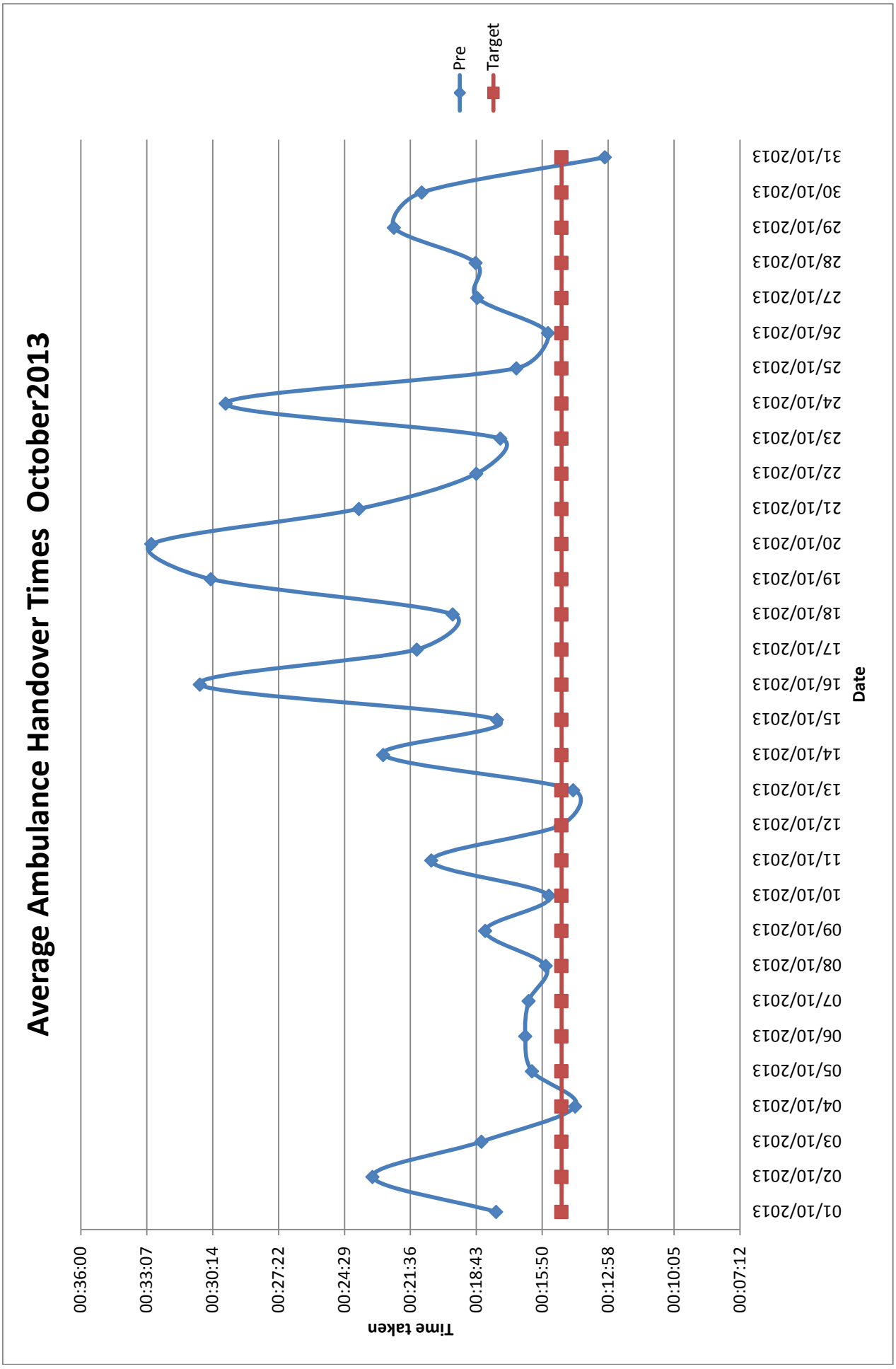
The Urgent care board continues to meet monthly and is currently being redefined, a summary is provided in the Urgent care update and a full briefing on Urgent care will be provided at the Board development day on 2nd December 2013.

A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%	94.4%	90.4%	90.0%	90.6%							
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%	93.1%	92.5%	92.1%	91.9%							



* Note: Total Admissions from the Symphony system




Average Ambulance Handover Times October2013
Pre
Target
Time taken
00:36:00
00:33:07
00:30:14
00:27:22
00:24:29
00:21:36
00:18:43
00:15:50
00:12:58
00:10:05
00:07:12
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Cancer

Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Q1	Q2
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	96.00%	95.87%	95.74%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.90%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	98.50%	98.12%	97.76%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	98.15%	98.08%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	96.90%	97.73%	97.30%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	94.12%	98.72%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	83.40%	82.04%	83.44%

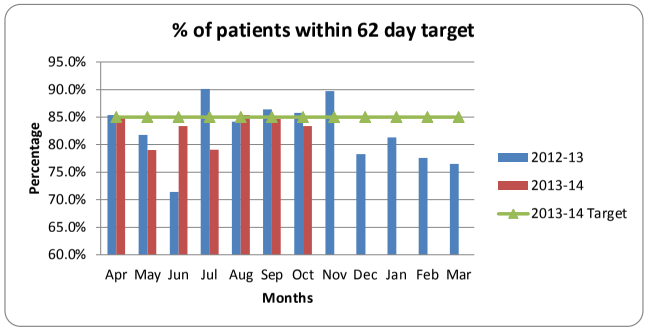
Key Issues:

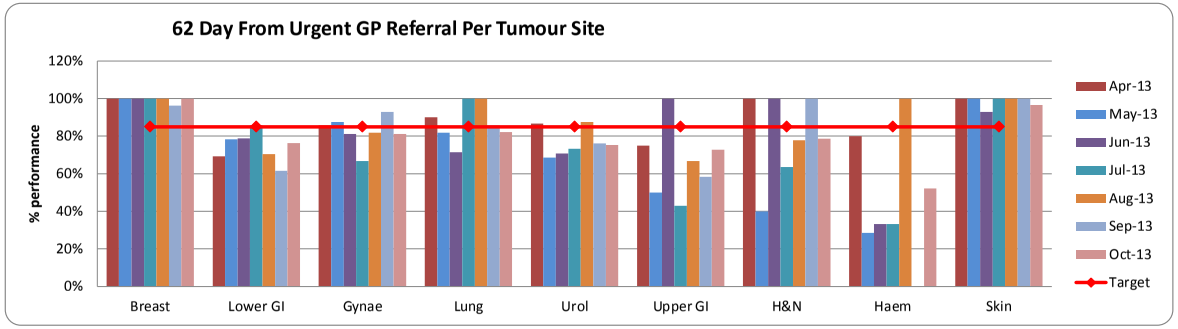
The Trust did achieve the 62 day standard from urgent GP referral to start of first treatment for September (validated 7th November 2013). This standard was missed by 1.5 treatments within target or a reduction of a 0.5 breach. The Trust was expecting to meet this target but a breach patient was unexpectedly treated within September.

In October the Trust achieved 83.4% however the data is not validated until the 7th December.

The Trust did not achieve quarter 2 for 62 days from Urgent GP referral.

The cancer Recovery Board continues to monitor progress against the recovery plan with the focus on pathway reviews. As part of the Contract Query, the CCG is monitoring review of progress through a Remedial Action Plan.



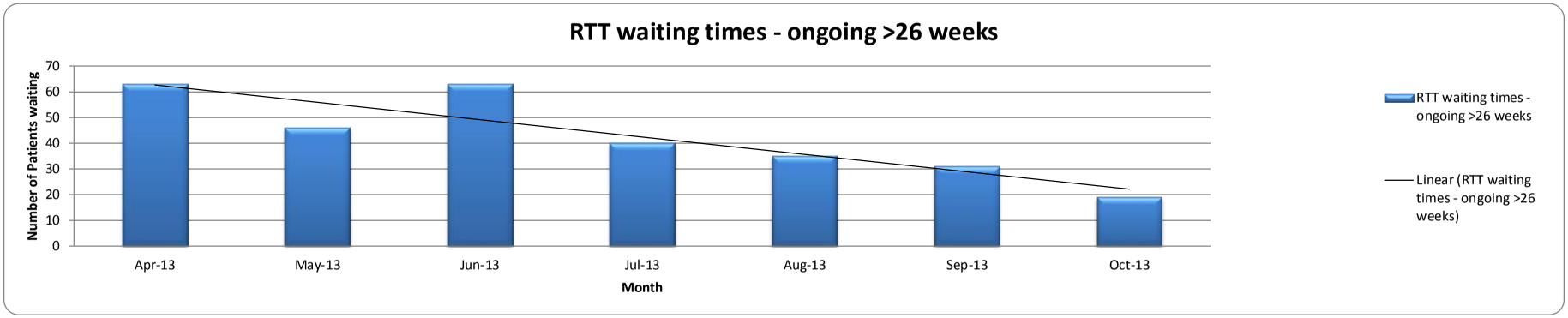


Key Issues:

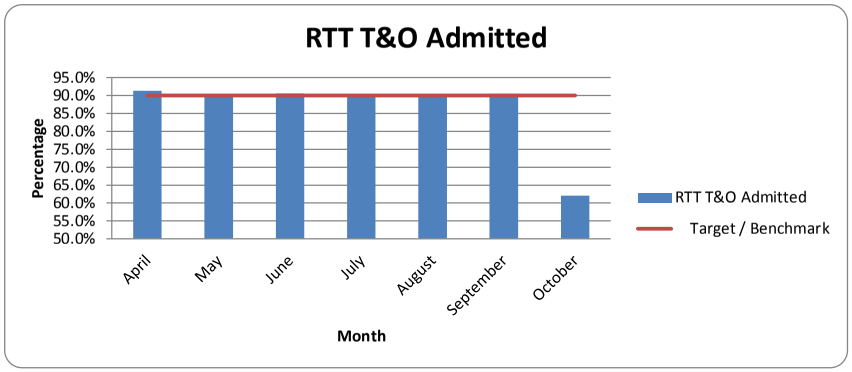
RTT Waiting Times

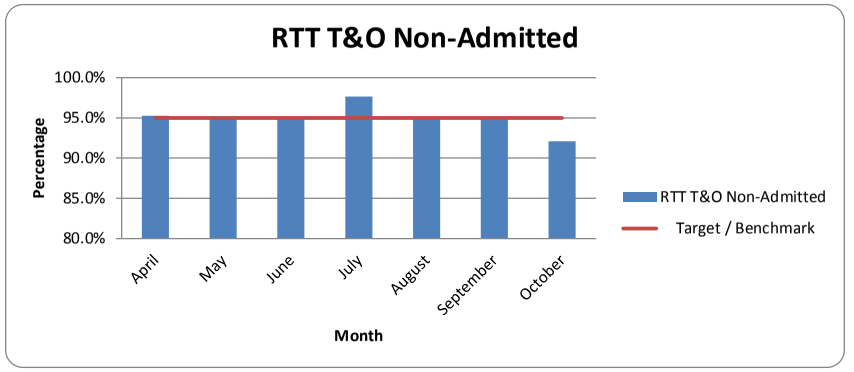
Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	19
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0

Key Notes:
The total number of patients waiting over 26 weeks continues to fall in October. All specialties have achieved the RTT target except for orthopaedics. A recovery plan is being developed and the paper detailing this has been discussed in full at the Integrated Healthcare Governance meeting on 21st November 2013.



Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	April	May	June	July	August	September	October
RTT T&O Admitted	CCG & TDA	**90%**	91.3%	90.3%	90.5%	90.1%	90.1%	90.5%	62.1%
RTT T&O Non-Admitted	CCG & TDA	**95%**	95.3%	95.2%	95.0%	97.7%	95.1%	95.0%	92.1%





Northampton General Hospital NHS
NHS Trust

REPORT TO THETRUST BOARD
28 November 2013

Title	Urgent Care Update
Agenda item	13
Sponsoring Director	Deborah Needham, Interim Chief Operating Officer
Author(s)	Deborah Needham, Interim Chief Operating Officer
Purpose	For Information

Executive summary

This report gives a brief update on the Urgent Care Board and work underway to improve the flow of patients through the hospital and keep the quality of care and safety to patients high.

Related strategic aim and corporate objective	Provider of quality care
Risk and assurance	Risk of achievement of national targets
Related Board Assurance Framework entries	*11*
Equality Impact Assessment	*Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N)* *Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)*
Legal implications / regulatory requirements	The consistent failure to achieve the transit time standard means that the Trust is in default in the regulatory framework provided by the Trust Development Authority (TDA)

Actions required by the Board

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

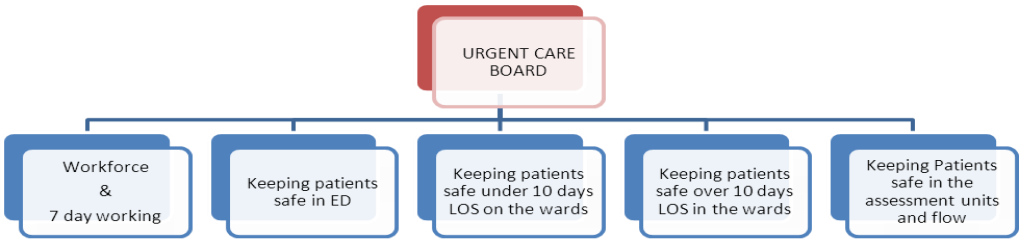
Trust Board
28 November 2013
Urgent Care Programme Update

1. Introduction

The Urgent Care Programme (UCP) has been led by the Chief Executive since it commenced in 2012.

A review and refresh of the project groups has taken place and a revised structure has now been agreed, the project groups are now based around keeping patients safe. Terms of reference for each project group are currently being defined along with work plan and key performance indicators.

The new structure is outlined below:

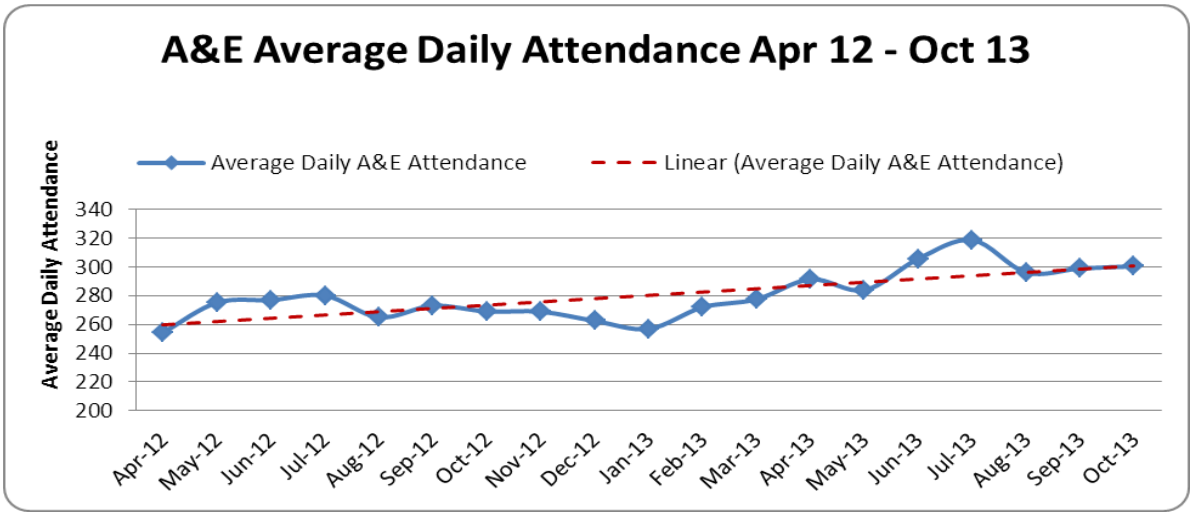


2. Current Performance

During 2013 performance against the four hour target has fluctuated, and has only been achieved during May (96.28%). The Q1 position was 92.56%, the Q2 position was 92% and Q3 is currently 93% (to 21 Nov 2013).

Quarterly information taken from #NGH Validated A&E Performance 2013-14.xls report as at 14/11/2013

Quarter	Target	Total Attendances	Total <4hr	total % < 4hr
Quarter 1	95%	26713	24725	93%
Quarter 2	95%	28028	25697	92%
Quarter 3 as at the moment	95%	13290	12311	93%



Monthly information from Infoview A_and_E_Daily_-_

Month	Total	< 4 hrs	> 4 hrs	%	Average Daily A&E Attendance
Apr-12	7633	7255	378	95.05%	254.5
May-12	8529	7968	561	93.42%	275.2
Jun-12	8293	7751	542	93.46%	277.0
Jul-12	8626	7956	670	92.23%	280.0
Aug-12	8180	7601	579	92.92%	265.0
Sep-12	8152	7920	232	97.15%	273.0
Oct-12	8330	7943	387	95.35%	269.0
Nov-12	8055	7271	784	90.27%	268.9
Dec-12	8118	7210	908	88.81%	262.5
Jan-13	7961	6919	1042	86.91%	256.9
Feb-13	7614	6878	736	90.33%	272.0
Mar-13	8611	7103	1508	82.49%	277.5
Apr-13	8742	7683	1059	87.89%	291.4
May-13	8799	8472	327	96.28%	283.8
Jun-13	9170	8567	603	93.42%	305.7
Jul-13	9879	9329	550	94.43%	318.7
Aug-13	9180	8295	885	90.36%	296.1
Sep-13	8968	8073	895	90.02%	298.9
Oct-13	9311	8432	879	90.56%	300.4
Nov-13	4011	3907	104	97.41%	284.9

Tight daily controls in A&E, Site Management, with an emphasis on specialty response timeliness, proactive use of the medical and surgical assessment units as well as timely ward discharges is beginning to make an impact on patient flow through the hospital. Performance for November to date is encouraging. On-going discussions and plans with primary care (timely access & treatment for patients with long term conditions) as well as reductions in community hospitals LOS will enable the conveyance of patients who require mainly acute hospital intervention to balance our demand within available capacity.

3. Overview of Work Stream Priorities

The project groups have continued to work on their actions over the last month and the main developments are:

- Increasing discharge rates by rolling out Nurse Facilitated Discharge (NFD)
  - A Ward Sister has been released in order to focus on Nurse Facilitated Discharge (NFD). Throughput achieved for week commencing 21st October 2013 is that 92 patients were discharged as nurse led. These discharges are predominantly taking place at the weekends. This will continue to be monitored and re-iterated in line with the new ratified policy.
  -
- Winter funding plans (£4m allocation): Key developments underway:
  - Additional staffing, bed capacity for dementia patients, new pathways of care and equipment
  - Project governance structure is in place with the second meeting arranged for 29th November, each scheme has associated KPI's
  - Additional schemes are being worked up in the event of slippage in already agreed schemes and or to mitigate against non or partial-delivery

- Discharge to Assess (DtA) for patients
  - Commenced on 4th November and although uptake is gradual with 10 DtA in the first week, this figure is rising.
  - Early indications are positive and interagency work is continuing
  -

- Frail & Elderly project
  - Commenced on 2nd November with Brampton Ward going live on 18th November.
  - Indications on early discharge are positive
  - The Length of Stay for patients at our community Hospitals is reducing in line with the planned programme of work. Process mapping and benchmarking are scheduled to be completed in early December to ensure we are within the national range

- Improving safety in ED
  - Incorporated the red flag safety initiative for specific patient pathways
  - Commenced 2 hrly safety rounds
  - A new A&E Consultant commenced in November and a locum will commence in February 2014. This will augment senior clinician presence for clinical decision making and supervision to all junior staff. Planning is underway to explore how geriatrician support can be increased in the Emergency Department to enable senior clinician review for elderly patients.
  - Medical specialty review of patients is being expedited and the response rate as well as onward follow up for admitted patients has improved to deliver in line with the Royal College of Physicians timeliness standards.
  - The Ambulatory Care Unit is seeing approximately 8 – 10 patients each day and this figure will increase the Ambulatory Care Unit nurse is also taking the calls from GP expected patients.

4. Recommendation

The Board is asked to review and discuss this paper.

REPORT TO THE TRUST BOARD
28 November 2013

Title	Finance Report Month 7
Agenda item	14
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance
Purpose	To report the financial position and associated risks for year to October 2013.

Executive summary

The report sets out the financial position for October 2013 (month 7). The year to date I&E position is a deficit of £3.1m, £1.14.m adverse to the plan submitted to the TDA in April.

The key reasons for the adverse position are:

- A continuing requirement to increase provisions for CCG contractual fines and penalties.
- Identification of measures to close the CIP gap and the increasing trajectory of CIP targets required in the latter half of the financial year.
- Non-elective over performance and the costs of excess capacity and escalation areas.
- Increasing temporary staffing costs.

The position as reported has been submitted to the TDA on Friday 15th November. This includes a change to the forecast I&E outturn which has now increased to a deficit of £4.8m, consistent with the plan for the year.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	There are a range of financial risks which pose a direct risk to delivery of the financial plan for 2013-14.
Related Board Assurance Framework entries	BAF 17, 18,19
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board

The Board is asked to note the current financial position and forecast I&E position.

Northampton General Hospital NHS
NHS Trust

Financial Position Month 7 2013/14

Report to
Trust Board
November 2013

Performance against Statutory Duties – Year to October 2013 and full year forecast

	YTD Actual £'000	YTD Target £'000	Variance £'000	Forecast outturn £'000	Full Year Target £'000	Variance £'000
Delivering Financial perfromance	-£3,163	-£2,016	£ 1,147 Adv	-£4,799	-£4,822	£23
Achieving EFL (£000's)	N/A	N/A	N/A	£4,303	£4,303	£0
Achieving the Capital Resource Limit (£000's)	£3,991	£4,331	£ 340 Fav	£13,424	£13,424	£0
Subsidiary Duties						
Better Payment Practice Code:						
Volume of Invoices	88%	95%	-7%	90%	95%	-5%
Value of Invoices	90%	95%	-5%	90%	95%	-5%

Financial Performance

- Financial performance to October 2013 £3,163k deficit. TDA Planned deficit £2,016k. Adverse variance £1,147k. Marginal deterioration from Month 6 position and ahead of the current forecast.
- Income position continues to over perform and includes £5,494k of fines and penalties Note still subject to case mix changes for October activity.
- Forecast position is a deficit of £4,799km which has deteriorated from the month 6 position, and is now in line with TDA plan for the year.
- Action necessary to achieve this level of deficit are covered under the Financial Recovery Plan agenda item 6.
- Income levels continue to over perform with pay costs remaining within plan before allocation of CIP. Continued pressure on non pay for outsourcing and drugs.
- Target trajectory for CIP delivery increasing. Risk to planned agency staff reductions.

Capital Expenditure

- Capital spend to September £3,991k. Plan £4,331k. Favourable variance £340k. Due to slippage in Estates and IT schemes.
- Outcome of bid to National IT Innovation Fund awaited. Vital Pac contract now signed under a capital arrangement which will make use of capital contingency. CEF fund now at preferred bidder stage and now incurring costs.
- Forecast to fully commit Capital Resource Limit for 2013/14.`

External Financing Limits (EFL) & Better Payment Practice Code (BPPC)

- Continued improvement in BPPC. Key areas of non compliance identified for support and corrective action to further improve performance to meet statutory obligations.
- TBL loan application now submitted to TDA and verbal assurance of support offered. Chasing for facility to be formally approved before December when cash deteriorates.

Key finance issues

- Financial position has largely broken even in month with I&E performance ahead of forecast levels.
- Provisions for CCG fines and penalties continue to be made totalling £5.5m for the YTD.
- Contract management process with Nene CCG escalated through a formal contract query.
- M1-4 contract reconciliation nearing agreement with total fines limited to 3% of income.
- M5 and M6 reconciliation requested in accordance with contract deadlines.
- Forecast year end position increased to £4,799k deficit recognising latest position with CCG on fines reinvestment.
- Continued focus required to support delivery of CIP programme in year and in developing schemes for 2014/15. Essential that all planned schemes are delivered are in full together with the additional items set out in the Financial Recovery Plan.

Actions

- Finalise agreement for M1-4 income and review forecast fines and penalties in light of agreed position.
- Agree M5 and M6 SLA income with CCG and use as basis to jointly agree likely forecast outturn for 2013-14.
- Focus on delivery of existing CIP schemes through IQEG and ensure CIP forecast is robust.
- Development of further CIP schemes and controls to support the 13/14 financial position in line with the Financial Recovery Plan. See Agenda item 6 for further details.

Financial Performance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	October		August	September
Financial Risk Rating (Shadow)	2	Overall FRR shadow score of 2	2	2
EBITDA %	3.4%	EBITDA % scores 2 under Monitor FRR	3.0%	3.2%
Liquidity (days cover)	14.6	Achieves FRR score of 2. Improved with advance from CCG £2m	19.0	8.5
Surplus Margin	-2.06%	Achieves FRR score of 2. Falling from month 6	-2.65%	-2.34%
Pay / Income	65.8%	Cumulative pay 65.8% of cumulative income	66.3%	66.3%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	(1,850)	Deficit of £1.85m before add back of impairment and donated assets.	(2,871)	(1,747)
Impairment and Donated Assets	(1,314)	Donated asset depr and impairment to be added back to performance	141	(1,314)
Normalised Position	(3,163)	I&E position excl donated asset depr and impairment	(2,730)	(3,061)
TDA Plan (Year to date)	(2,016)	TDA Plan for year to September 2013 (Normalised)	(1,573)	(2,045)
PCT SLA Income Variance	1,783	Ahead of plan ytd, trend fallen, subject to penalties and c/m changes	897	1,470
TDA Normalised annual plan	(4,822)	Full year NTDA control total.	(4,822)	(4,822)
Forecast EOY I&E postion	(4,799)	Current I&E forecast	(2,625)	(3,000)
EBITDA Performance	£000's		£000's	£000's
Variance from plan	(1,147)	Marginal deterioration from month 6 in line with forecast	(1,168)	(1,038)
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	6,148	TDA Plan to October	4,000	4,905
YTD Actual	6,429	Actual delivered to month 6 inc bank and agency	4,200	5,421
% Delivered	105%	% delivery of Plan year to date	105%	111%
LTF	12,218	Latest thinking forecast. All R,A,G schemes will deliver in full	11,900	12,098
Annual Plan	13,000	Annual Transformation Target.	13,000	13,000
LTF v. Plan	94%		84%	93%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	3,991	Capital expenditure for year to date £578k behind plan	2,663	3,308
Committed as % of plan YTD	47%	% of plan committed for year to date.	30%	37%
Annual Plan	13,424	Capital Resource Limit of £10.6m plus CEF fund £2.6m for 2013-2014	13,424	13,424
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	(156)	Depreciation offset by addition and capital expenditure	(250)	3,468
Current assets	5,378	Rise in cash balance as block contracts paid 1/4ly and CCG advance	(4,037)	(2,427)
Current Liabilities	(5,324)	Increase in deferred income for quarterly payments and advances	3,158	2,215
Cash	**£000's**		**£000's**	**£000's**
In month movement	3,487	Timing of quarterly mandate payments and PDC payment	(1,485)	(3,312)
In Year movement	1,371	Timing of quarterly mandate payments and PDC payment	1,235	(2,116)
DH Temporary Loans	0	TBL Loan of £4m now applied for	0	0
Debtors Balance > 90 days	1,829	Collection of some PCT debt and CRIPPS debt ageing	1,433	1,607
Creditors % > 90 days	0.00%	No creditors over 90 days.	0.00%	0.00%
Cummalative BPPC (by volume) YTD	88.0%	BPPC improved again in September	87.3%	87.7%

Key issues

KPIs

- FRR shadow risk rating has remained at 2 (target 3) given the adverse performance against plan and ongoing liquidity issues. Forecast to recover to 3.

I&E Position

- I&E position remained on forecast trajectory in October.
- Fines and penalties continue to be increased in line with latest CCG position and stance on reinvestment.

Cost Improvement Programme

- CIP programme latest thinking forecast £12.2m. Assumes delivery of red, amber and gap schemes in this figure totalling £1,7304k – high risk.
- Forecast delivery set to increase from month 6 onwards, with considerable target for delivery in March.

Capital

- Underspent against plan but with forecast to spend full CRL. Spend forecast to increase in second half of the year due to CEF (£3.2m).

Statement of Financial position

- Non current asset increase due to indexation of Land and Buildings offset by depreciation.
- Increase in current liabilities with provisions for income received in advance from CCG and Block contract payments in advance.

Cash

- Liquidity has improved in October with the quarterly block contract payments and an advance of £2m that has not yet been clawed back by CCGs
- TBL loan now submitted for draw down in December.
- Ongoing action to collect outstanding debt, particularly NCAs and over performance from CCGs.

Income and Expenditure Position (summary year to October 2013)

I&E Summary	Annual Plan 2013/2014	YTD Plan	YTD Actual	Variance to Plan	October 2013/14 Budget	October 2013/14 Actuals	September 2013/14 Actuals	August 2013/14 Actuals	7+5 Forecast
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	135,777	137,559	1,783	20,271	20,583	19,795	18,903	238,282
Other Clinical Income	2,803	1,635	1,574	(61)	234	342	182	173	2,624
Other Income	25,991	15,025	14,589	(437)	2,245	2,151	2,142	2,087	24,706
Total Income	**260,544**	**152,437**	**153,722**	**1,285**	**22,750**	**23,076**	**22,120**	21,164	265,612
Pay Costs	(175,851)	(101,999)	(101,206)	793	(14,876)	(14,646)	(14,554)	(14,441)	(175,109)
Non-Pay Costs	(79,288)	(46,412)	(47,218)	(806)	(6,974)	(7,280)	(6,629)	(6,523)	(80,801)
CIPs	4,910	2,749	0	(2,749)	358	0	0	0	0
Reserves/ Non-Rec	(1,143)	(413)	0	413	(61)	0	0	0	0
Total Costs	**(251,373)**	**(146,074)**	**(148,424)**	**(2,350)**	**(21,553)**	**(21,926)**	**(21,183)**	**(20,964)**	**(255,910)**
EBITDA	9,171	6,363	**5,298**	**(1,065)**	1,196	1,150	937	200	9,702
Depreciation	(10,184)	(6,084)	(6,138)	(54)	(830)	(873)	(886)	(886)	(10,491)
Amortisation	(10)	(6)	(6)	(0)	(1)	(1)	(1)	(1)	(10)
Impairments	0	0	1,414	1,414	0	0	1,414	0	2,559
Net Interest	29	17	16	(1)	2	2	2	4	28
Dividend	(4,106)	(2,395)	(2,434)	(39)	(342)	(381)	(342)	(342)	(4,341)
Surplus / (Deficit)	**(5,100)**	**(2,105)**	**(1,850)**	**255**	**25**	**(102)**	**1,124**	**(1,025)**	**(2,553)**
Adjustments to Normalise Statutory Duties									
Donated Assets Depreciation	278	89	100	(11)	(41)	(41)	(16)	44	313
Impairments	0	0	(1,414)	(1,414)		0	(1,414)	0	(2,559)
Statutory Duties (I&E Position)	**(4,822)**	**(2,016)**	**(3,163)**	**(1,147)**	**(16)**	**(143)**	**(306)**	**(981)**	**(4,799)**

Financial Performance

- Normalised Financial performance to October 2013 **£3,163k deficit**.
- TDA planned cumulative deficit £2,016k with an in month deficit of £143k. Cumulative a**dverse variance £1,147k**. Significantly better than forecast performance in month.
- Income position is ahead of plan by £1,783k and includes £5,494k of fines and penalties and remains subject to validation of October's final case mix.
- Revised forecast position increased to £4,799k deficit, in line with the TDA plan for the financial year. Further improvement to break even subject to agreement of the Financial Recovery Plan and reinvestment of MRET and Readmissions penalties.
- Income levels continue to over perform with pay costs remaining within plan. Continued pressure on non pay due to
- CIP delivery on plan for year to date but subject to delivery of increasing trajectory in latter half of year. Risk to maintaining downward pressure on Nurse Bank & Agency costs.

Key issues

Clinical Income (SLA and Other)

- Ahead of plan by £1,722k to October
- Fines and penalties of £5,494k included in position.

Other Income

- Behind plan by £437k to October. Profile expected to improve as other income historically improved significantly toward the end of the financial year.

Pay Expenditure

- Favourable to plan by £793k to date, an underlying improvement from month 6.
- Excludes allocation of bank and agency CIP target.
- Bank and Agency usage has increased in many staff groups in October.

Non Pay Expenditure

- Behind plan by £806k to October with a continued trend of deterioration.

Cost Improvement Programme

- Delivery noted as ahead of plan to October.
- CIP unallocated to budgets represent central CIP schemes. Not offset by underspend in pay and non pay leading to overall overspend.

Depreciation and PDC

- In line with plan to September noting that the forecast has risen given changes revaluation adjustments and PDC loans.
- Impact on depreciation now included in forecast.

Income and Expenditure Position (Clinical Income year to October 2013)

Income & Activity Summary	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Activity Plan	Actual Activity	Activity Variance	% Var	October 2013/14 Plan	October2013/14 Actuals	September 2013/14 Actuals	August 2013/14 Actuals
Elective Daycase	22,866	22,937	71 Fav	0.3%	3,573	3,354	3,228	3,004
Elective Inpatients	3,759	3,955	196 Fav	5.2%	587	613	574	507
Non Elective	18,302	19,391	1,089 Fav	5.9%	2,650	2,905	2,671	2,621
New Outpatients	36,092	35,890	(202) Adv	-0.6%	5,643	5,311	5,358	4,543
Follow Up Outpatients	64,356	68,443	4,087 Fav	6.4%	10,056	10,522	9,928	8,829
Non Cons Led Outpatients New	15,724	15,769	45 Fav	0.3%	2,454	2,328	2,073	1,924
Non Cons Led Outpatients Follow Up	35,212	36,196	984 Fav	2.8%	5,506	5,338	4,985	4,805
Outpatient Procedures	24,948	28,726	3,778 Fav	15.1%	3,896	4,883	4,327	3,934

	YEAR TO DATE				MONTHLY BUDGET AND TREND			
	Income Plan	Income Actual	Income Variance	% Var	October 2013/14 Plan	October2013/14 Actuals	September 2013/14 Actuals	August 2013/14 Actuals
	£'000	£'000	£'000		£'000	£'000	£'000	£'000
Elective Daycase	13,370	13,988	618 Fav	4.6%	2,049	2,097	1,966	1,783
Elective Inpatients	9,870	10,495	625 Fav	6.3%	1,513	1,631	1,508	1,386
Elective excess bed days		387	387 Fav		-	-	55	67
Non Elective	36,968	35,952	(1,016) Adv	-2.7%	5,354	5,844	4,915	5,118
Non elective excess bed days		4,397	4,397 Fav		-	-	748	783
New Outpatients	5,605	5,507	(98) Adv	-1.7%	859	813	825	602
Follow Up Outpatients	5,799	6,172	373 Fav	6.4%	889	950	893	795
Non Cons Led Outpatients New	1,399	1,406	7 Fav	0.5%	214	210	183	167
Non Cons Led Outpatients Follow Up	1,705	1,741	36 Fav	2.1%	261	257	238	215
Outpatient Procedures	3,731	4,654	923 Fav	24.8%	572	856	720	786
CQUIN	3,039	2,492	(547) Adv	-18.0%	434	239	624	326
Block Contracts - Fixed	24,641	25,559	919 Fav	3.7%	3,543	3,768	3,470	3,472
Cost Per Case	10,792	11,143	351 Fav	3.3%	1,542	1,602	1,592	1,613
A&E	5,465	6,081	616 Fav	11.3%	792	873	847	871
Pathology	3,484	3,719	235 Fav	6.7%	498	536	515	497
Excluded Medicines	8,556	8,254	(303) Adv	-3.5%	1,239	1,311	1,108	1,276
Excluded Devices	717	837	120 Fav	16.8%	102	145	100	126
Fines, Penalties and Challenges	(2,100)	(2,918)	(818) Adv	38.9%	(300)	(226)	(250)	(250)
Productivity CIP's	1,956	-	(1,956) Adv	-100.0%	612	-	-	-
Other Central SLA Income	780		(780) Adv	-100.0%	96	45	174	(429)
Other Clinical Income	1,635	1,574	(61) Adv	-3.7%	234	342	182	173
Sub-Total SLA Clinical Income	137,412	139,134	1,722 Fav	1.3%	20,505	21,295	20,414	19,376

Activity Performance

- Activity continues to over perform against all points of delivery with the exception of critical care, and first outpatient appointments.
- General Medicine have a significant non elective excess bed days over performance. This is being challenged by the CCG and we need to investigate the drivers of this.
- The OPPROC over performance is reported to the CCG as being linked to the increase of the number of mandatory outpatient procedures included within the 2013/14 PbR guidance.
- The CCG have undertaken a first stage deep dive process into looking at the drivers of the over-performance. The key findings are increased non elective performance as a result of increased A&E attendances leading to admissions, Ambulatory Care Pathway activity, and case mix changes.

Financial Performance

- The reported over-performance for SLA income is £1,722k. The drivers are: A&E, Non elective activity, non elective excess bed days and outpatient procedures.
- CQUIN income for NENE CCG is accrued at 85% of plan and has been agreed for the first quarter.
- The reconciliation process for M1-4 is nearing completion and the results are consistent with the provisions being made.
- The CCG have raised a query in relation to the charging for Obstetric Ultrasound activity which is currently being investigated.

Income and Expenditure Position (CCG Income year to October 2012)

Activity

Actvity Over / (Under) Performance -Year to Date	NHS NENE CCG	Associate CCG	Specialised Services	Non Contracted Activity
AandE	6,872	(85)	0	242
Crit Care	(559)	(225)	758	(39)
DC	1,993	274	212	47
EL	89	52	(24)	13
ELXBD	(147)	85	(28)	2
NEL, NELNE, NELST	1,668	61	62	52
NELXBD	3,818	79	(120)	(156)
OPFA	1,992	(515)	(400)	(21)
OPFUP	1,518	(1,505)	(1,292)	(155)
OPNCL	(1,490)	(1,115)	(1,757)	(173)
OPPROC	1,785	1,272	2	267
RADIOTHERAPY	0	0	1,144	0
Total	**17,538**	**(1,623)**	**(1,444)**	**80**

Financial

Finance Over / (under) performance	NHS NENE CCG	Associate CCG	Specialised Services	Non Contracted Activity
AandE	617,074	(6,484)	0	17,030
Crit Care	(595,126)	(226,101)	855,104	(45,229)
DC	(80,334)	(65,307)	120,448	14,082
EL	401,579	160,221	(71,570)	50,995
ELXBD	(36,674)	18,467	(5,519)	439
NEL, NELNE, NELST	3,565,547	51,530	(9,344)	20,462
NELXBD	1,022,292	21,933	(68,145)	(31,352)
OPFA	322,278	(89,183)	(65,892)	(5,633)
OPFUP	282,656	(140,871)	24,550	(14,747)
OPNCL	(80,413)	(54,530)	(134,346)	(7,681)
OPPROC	433,766	217,463	395	39,206
RADIOTHERAPY	0	0	211,021	0
OTHER	323,071	(242,347)	(426,062)	30,166
Total	**6,175,716**	**(355,207)**	**430,640**	**67,738**

Activity & Financial Performance

Nene CCG

- Activity for Nene CCG continues to over perform against plan.
- The most significant areas driving this are:
  - A&E (which has a significant QIPP plan attached to it),
  - non elective excess bed days,
  - non elective activity and outpatient procedures .
- Discussions with CCGs now formalised with a contract query which has now been followed up with a statement of fines limited to 3% as agreement has not been reached in a timely manner.
- There are £2m challenges not agreed for M1-4 which have been rejected on the basis they are not a valid challenge with an associated penalty.
- Provisions to cover similar future data challenges and any penalties from agreed remedial actions plans are not provided for in the year to date and forecast financial position.
- The CCG have imposed additional restrictions for Low Priority Treatments on the Trust from December 2013.

Associate CCGs

- Activity for the Associate CCGs are underperforming overall and is mainly driven by outpatient activity. There are areas of over performance in inpatient activity and outpatient procedures.

Specialised Services

- Activity for the Specialised CCGs are under performing overall mainly driven by outpatient activity. Financially we are over performing due to Critical Care, Day Case and Radiotherapy.

Non Contracted Activity

- Non Contracted Activity is underperforming against our plan. There is a risk that we will not recover all of the actual income due to the incorrect commissioner being charged in Q1.
- Bad debt provisions are already set up to mitigate against this financial impact.

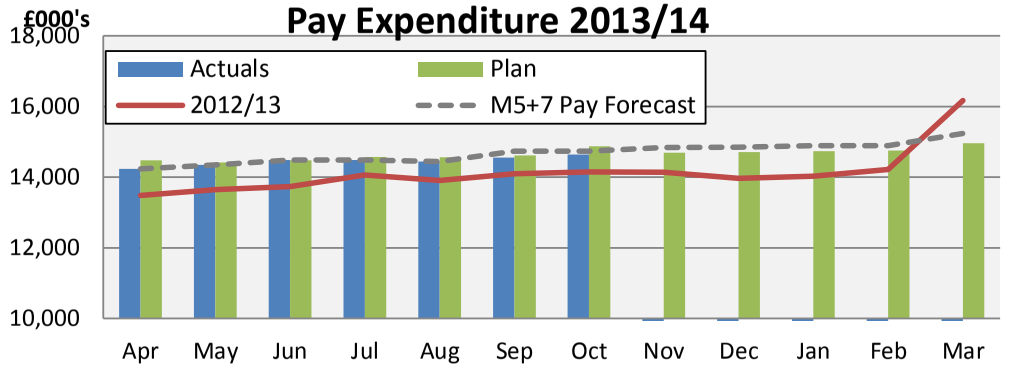
Income and Expenditure Position (Pay Year to October and Forecast)

Highlights

- Overall pay expenditure is £231k favourable in the month and £793k year to date.
- Temporary staffing costs are still high with an increase from last month in nursing spend as well as a considerable increase in medical staffing driven partially by price rather than WTE..
- Temporary staffing costs represent 11% of total pay cost (12% Nursing).
- Recruitment is still below expected levels and despite significant nursing investment this year £1.9m.
- Actual pay costs marginally ahead of forecast as a result of increased temporary staff costs.
- There is a risk that the forecast level of Bank and Agency savings may deteriorate significantly in the latter stages of the financial year.

Actions

- Nursing recruitment to be expedited recruitment to continue to reduce bank and agency costs.
- Nursing usage which is in excess of planned financial levels needs to be controlled by lead nurses and General Managers.
- Permanent recruitment plans to be put in place to reduce the reliance in temporary staff in all other areas, particularly administration
- Further controls are necessary to approve medical bank and agency staff to ensure only essential staff are used and that the costs remain within the overall finance forecast..
- To be reviewed by the Care Group Directors to reduce non essential expenditure.



	Staff Numbers (WTE) Analysis				Permanent Staff Worked Trend			Temporary Staff Worked Trend		
	Budget Month 7	Permanent Staff worked Month 7	Temporary Staff worked Month 7	Variance	August 2013/14	September 2013/14	October 2013/14	August 2013/14	September 2013/14	October 2013/14
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical Staff	488.94	470.38	21.36	2.80	456.08	461.12	470.38	24.29	26.17	21.36
Nursing Staff	1963.39	1677.13	189.28	(96.98)	1653.86	1650.32	1677.13	183.59	186.22	189.28
Managerial and Administration	942.23	780.51	131.86	(29.86)	757.60	766.32	780.51	169.42	116.02	131.86
Other Clinical Staff	331.51	285.20	8.86	(37.45)	282.59	288.34	285.20	7.79	7.98	8.86
Scientific and Technical Staff	392.46	352.15	8.27	(32.04)	355.23	358.44	352.15	6.18	6.32	8.27
Estates Staff	35.22	26.09	9.49	0.36	28.08	27.35	26.09	7.88	5.29	9.49
All other Staff	396.16	379.02	33.75	16.61	364.65	381.25	379.02	37.57	61.89	33.75
Cost Challenges	-	-	-	-	-	-	-	-	-	-
Total WTE	4549.91	3970.48	402.87	-176.56	3898.09	3933.14	3970.48	436.72	409.89	402.87

Nursing WTE = 96.98 WTE below establishment despite 189.28 temporary WTE being used

	Pay Costs Analysis (Month 7)				Permanent Staff Pay Costs			Temporary Staff Pay Costs		
	Budget Month 7	Permanent Staff worked Month 7	Temporary Staff worked Month 7	Variance	August 2013/14	September 2013/14	October 2013/14	August 2013/14	September 2013/14	October 2013/14
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical Staff	3,870	3,638	440	208	3,596	3,631	3,638	423	304	440
Nursing Staff	5,590	4,865	643	(82)	4,868	4,905	4,865	557	649	643
Managerial and Administration	2,282	1,881	277	(124)	1,832	1,887	1,881	367	321	277
Other Clinical Staff	1,015	921	52	(42)	910	926	921	54	52	52
Scientific and Technical Staff	1,131	1,063	19	(49)	1,046	1,057	1,063	35	24	19
Estates Staff	94	74	15	(6)	82	77	74	16	8	15
All other Staff	629	632	125	129	590	602	632	67	112	125
Cost Challenges	266	-	-	(266)	-	-	-	-	-	-
Total Pay Cost	14,876	13,075	1,571	(231)	12,924	13,083	13,075	1,518	1,470	1,571

Temporary Staffing = 11% of total pay costs / 12% Temps of Total Nursing Costs

Income and Expenditure Position (Non Pay Year to October and Forecast)

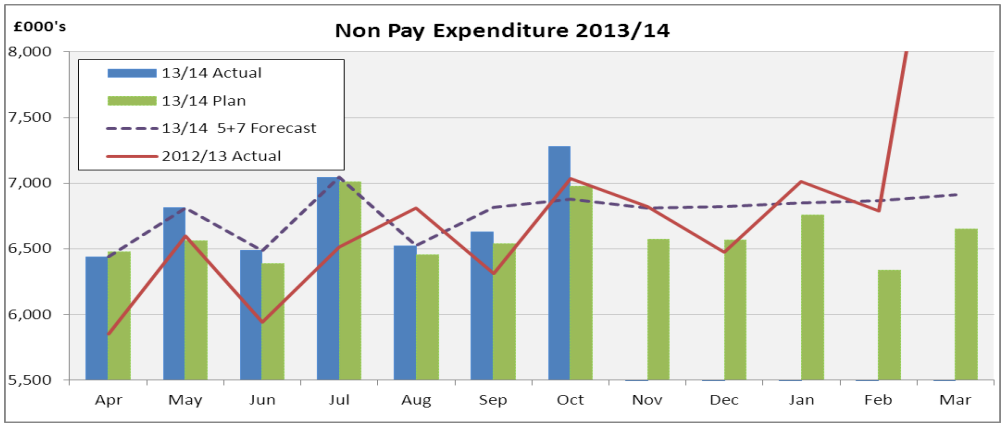
Highlights

- Non pay in the month is £306k adverse to plan; £806k adverse Year to date. A significant deterioration from forecast trajectory.
- Key driver behind position is due to outsourcing costs, which are largely offset in income ,
- Drugs spend has significantly picked up this month as expected. Much of this spend is also passed through to CCGs directly/
- Items such as building & engineering and training are below planned levels which may cause some pressure on the financial forecast if these types of spend increase in the latter part of the year.

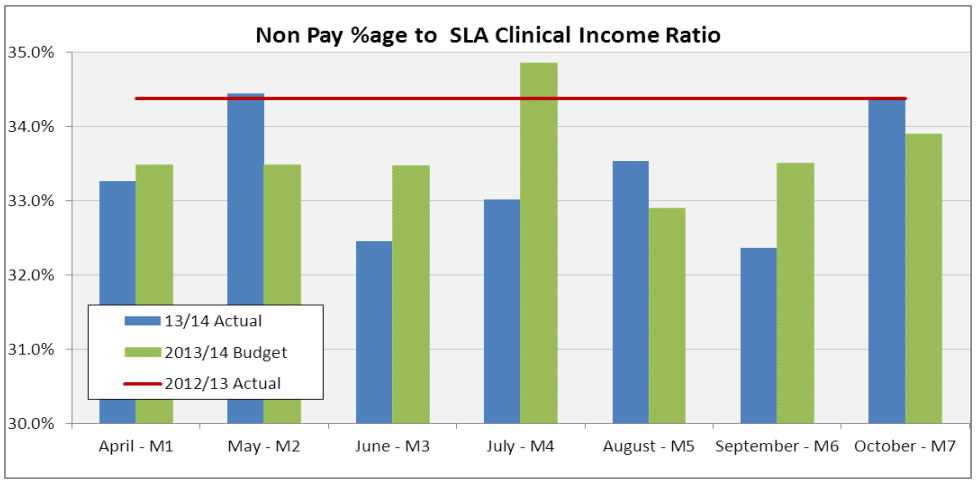
Actions

- Enhanced monitoring of all outsourced activity to ensure that all costs and income are coded, recorded and costed correctly. Rudimentary trading account to be set up to capture all these types of arrangements.

- Supress run rate increases to minimise overspend by implementing more cost control measures.
    - Stop avoidable material expenditure items that have not commenced.
    - Reduce loan equipment costs and other high value items.
    - Reduce printing costs by utilising multi function devices.



As predicted non pay costs on the increase / drugs & outsourcing costs rise above forecast levels - requiring greater controls



Non pay = 34% of gross Income YTD

Income and Expenditure (risks and opportunities)

Risks not Included in Financial Forecast

Downside Risk	£000s Unmitigated Risk	Action to mitigate risk	£000s Residual Risk
Contract Challenges raised by CCGs are successful. Contractual Fines may be imposed by commissioners for failure to deliver key performance	(2,000)	Robust rebuttal of contract challenges making use of experienced resources	(500)
Transformation Programme Slippage in CIP delivery of red and amber schemes	(1,935)	Continued focus on delivery of CIP and development of mitigation pipeline.	(1,100)
Lack of Funding to implement Transformation Programme Schemes	(600)	CCG unable to release any of the 2% reserve to support the costs of Transformation team and programme in 2013-14. Planned VSS scheme now abandonned.	(300)
CCG QiPP schemes fail to deliver leading to excess demand for NEL activity and cancellation of EL activity and no re-investment of MRET and readmissions penalty.	(4,800)	Engagement with CCG QiPP schemes, estbalish joint QiPP Board. Regular reports from CCG. Consideration of contract query for failure to manage demand.	(2,400)
Cost of winter pressures exceed allocated funding	(1,400)	Trust has recieved allocation to manage Winter presures and A&E delivery. Winter plan and commitments to be agreed at UCB and SMB.	(700)
CQUIN schemes are not delivered and further penalty imposed by CCGs / EMSCG. Current non achievement of £548k included in financial position however further risk is evident	(1,300)	Robust monitoring and performance framework to be established. Risk to be identified and 25% provision made in monthly reporting. Now updated following CCG agreements	(548)
Hospital Inspection regime requires immediate investment in additional resources above that included within the current financial plan and forecast	(1,000)	Range of inititaives have already been set up to deminstrate the Trust quality and safety delivery e.g. QuEST	(500)
Net Revenue Risk	**(13,035)**		**(6,048)**

Key opportunities not incl	Value of opportunity £000s		Adjusted Risk £000s
Income opportunities through coding review	375	Ensure coding is key areas is as detailed as practical and achievable in 13/14	50
Release of Income Provisions and Fines	1,500	Improvements to operational targets leading to release of income provisions	850
Bidding for Readmissions funding	£ 2,400	Development of bids to draw down re-admissions fines in part or in whole to extent not built into FRP	200
	4,275		**1,100**

Risks

- Risk table has been updated to show the unmitigated and mitigated risk to the financial position.
- Financial risks associated with delivery of targets in the winter within agreed plans remains significant.
- CIP slippage or non delivery also continues to be a risk. Full year forecast for CIP delivery is now proposed to provide more certainty regarding the year end delivery.

Opportunities

- Income opportunities have continued to be developed supported by the SLR/ Service reviews being undertaken with Directorates.
- Further work is planned to provide further assurance that that all income is being correctly coded and collected where possible.
- Work on securing reinvestment of fines continues with CCGs and discussions have now led to a statement of fines set at 3% to crystallise the matter through formal contractual arrangements.

Statement of Financial Position as at October 2013

TRUST SUMMARY BALANCE SHEET MONTH 7 2013/14	Balance at 31-Mar-13	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789		133,789	
IN YEAR REVALUATIONS		3,883	3,880	(3)	4,262	4,262
IN YEAR MOVEMENTS		3,483	4,202	719	16,197	16,197
LESS DEPRECIATION		(5,265)	(6,137)	(872)	(10,511)	(10,511)
NET BOOK VALUE	**133,789**	**135,890**	**135,734**	**(156)**	**143,737**	**9,948**
CURRENT ASSETS						
INVENTORIES	4,934	4,709	5,366	657	5,662	728
RECEIVABLES						
NHS DEBTORS	4,103	8,783	9,722	939	4,144	41
OTHER TRADE DEBTORS	2,295	1,387	1,478	91	2,295	
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(443)		(443)	
CAPITAL RECEIVABLES						
NON NHS OTHER DEBTORS	132	468	376	(92)	132	
COMPENSATION DEBTORS (RTA)	2,514	2,523	2,621	98	2,514	
OTHER RECEIVABLES	676	901	897	(4)	675	(1)
IRRECOVERABLE PROVISION	(515)	(515)	(515)		(515)	
PREPAYMENTS & ACCRUALS	1,387	2,238	2,440	202	2,053	666
	10,149	**15,342**	**16,576**	**1,234**	**10,855**	**706**
NON CURRENT ASSETS FOR SALE						
CASH	4,342	2,226	5,713	3,487	4,654	312
NET CURRENT ASSETS	**19,425**	**22,277**	**27,655**	**5,378**	**21,171**	**1,746**
CURRENT LIABILITIES						
NHS	628	1,257	1,283	(26)	5,911	(5,283)
TRADE CREDITORS REVENUE	1,255	2,366	2,558	(192)	6,577	(5,322)
TRADE CREDITORS FIXED ASSETS	1,744	1,121	1,390	(269)	2,726	(982)
TAX AND NI OWED	1,769	3,438	3,404	34	1,800	(31)
NHS PENSIONS AGENCY	2,013	2,166	2,173	(7)	2,030	(17)
OTHER CREDITORS	495	329	348	(19)	494	1
SHORT TERM LOANS	669	527	527		785	(116)
ACCRUALS AND DEFERRED INCOME	6,132	7,586	12,256	(4,670)	4,000	2,132
PDC DIVIDEND DUE	36		381	(381)		36
STAFF BENEFITS ACCRUAL	786	786	786		629	157
PROVISIONS	4,472	3,678	3,472	206	1,400	3,072
PROVISIONS over 1 year	310	1,281	1,281		1,138	(828)
NET CURRENT LIABILITIES	**20,309**	**24,535**	**29,859**	**(5,324)**	**27,490**	**(7,181)**
TOTAL NET ASSETS	**132,905**	**133,632**	**133,530**	**(102)**	**137,418**	**4,513**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115		102,875	2,760
REVALUATION RESERVE	32,486	34,960	34,960		36,792	4,306
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	304	304	304		304	
I & E CURRENT YEAR		(1,747)	(1,849)	(102)	(2,553)	(2,553)
FINANCING TOTAL	**132,905**	**133,632**	**133,530**	**(102)**	**137,418**	**4,513**

Key Issues

Non Current Assets

- Little movement in month, depreciation exceeded capital additions as spend in month was low.

Net Current assets

- Increased during the month by £4.9m.
- Inventories increased by £0.7m which predominantly relates to high value pharmacy drugs.
- Cash balances increased by £3.5m driven by block contract payments and CCGs not clawing back their advance made earlier in the financial year.
- NHS debt increased by £0.9m driven by CCG over performance which has been billed but not yet paid.
- Agreement of balances now to be used as a driver to collect this debt.

Net Current Liabilities

- Increased during the month by £5.3m.
- Accruals and deferred income increased by £4.7m which includes £2.1 m paid on account and £2.2m relating to the phasing of the quarterly SLA invoices

Financing

- £2.7m additional PDC anticipated from Carbon Energy Fund.

Statement of Financial Position (Capital Expenditure year to date and forecast)

Category	Approved Annual Budget 2013/14 £000's	TDA M7 Plan £000's	Year to Date as at Month 7 M7 Plan £000's	M7 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 7 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 7 Forecast M7 £000's	Under (-) / Over £000's
Linear Accelerator Corridor	0	300	0	0	0	0%	0	0%	0	0
Improving Birthing Environments	399	344	399	403	5	101%	403	101%	403	4
Endoscopy	150	150	150	140	-10	93%	155	104%	150	0
Urodynamics	170	150	150	150	0	88%	170	100%	170	0
Haematology (Trust)	82	82	0	1	1	1%	23	28%	82	0
Annual Strategic Planning Approvals	302	466	0	0	0	0%	0	0%	302	0
MESC	1,468	687	523	482	-41	33%	881	60%	1,468	0
Estates	3,846	1,650	1,796	1,631	-165	42%	2,440	63%	3,842	-4
IT	3,289	1,104	1,203	1,103	-100	34%	2,218	67%	3,289	0
Other	738	36	285	257	-28	35%	275	37%	738	0
Carbon Energy Efficiency Fund (CEEF)	3,200	0	0	0	0	0%	0	0%	3,200	0
Total - Capital Plan	**13,644**	**4,969**	**4,506**	**4,166**	**-340**	**31%**	**6,565**	**48%**	**13,644**	**0**
Less Charitable Fund Donations	-220	-175	-175	-175	0	80%	-197	90%	-220	0
Total - CRL	**13,424**	**4,794**	**4,331**	**3,991**	**-340**	**30%**	**6,367**	**47%**	**13,424**	**0**
Resources - Trust Actual										
Internally Generated Depreciation	10,184									
SALIX	480									
CEEF	2,760									
Total - Available CRL Resource	**13,424**									
Uncommitted Plan	**0**									

Key Issues

Capital Expenditure

- Expenditure lower than planned at October by £340k.
- Full year forecast expected to fully achieve CRL limits.
- Vital Pac investment now increased by £466k relating to the SCC contract relating to the capital option.
- Carbon Energy Scheme now increased by £200k, signed at preferred bidder stage with contract signature planned for December 2013.
- IT Innovation Funding of £683k now reached stage 2 with financial proformas submitted and interviews with DH concluded. Project successful Vita Pac and e-prescribing. Still awaiting outcome originally due at the end of October.
- Some slippage in Estates and IT schemes which will be recovered in the remainder of the financial year.

Statement of Financial Position (Cash Flow and Liquidity)

MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
		ACTUAL							FORECAST				
RECEIPTS													
SLA Base Payments	226,768	17,721	19,030	15,721	23,380	19,172	17,506	23,166	17,450	17,450	21,273	17,450	17,450
SLA Performance / Other CCG investment	4,263	0	0	0	0	0	0	650	109	2,280	408	408	408
Health Education Payments (SIFT etc)	8,902	22	1,511	764	664	728	781	672	834	762	722	722	722
Other NHS Income	18,745	2,923	877	1,596	616	1,709	1,154	1,804	2,450	1,983	1,573	1,030	1,030
PP / Other (Specific > £250k)	329	0	0	329	0	0	0	0	0	0	0	0	0
PP / Other	11,430	892	1,096	655	758	857	1,142	1,030	1,000	1,000	1,000	1,000	1,000
Salix Capital Loan	480	0	0	0	0	0	0	0	0	92	55	170	163
EFL / PDC	2,760	0	0	0	0	0	0	0	438	604	994	724	0
Temporary Borrowing	4,000	0	0	0	0	0	0	0	0	1,000	3,000	0	0
Interest Receivable	30	3	3	2	2	3	2	2	2	2	2	3	3
TOTAL RECEIPTS	277,707	21,562	22,518	19,067	25,419	22,469	20,586	27,324	22,283	25,173	29,026	21,506	20,775
PAYMENTS													
Salaries and wages	164,369	12,168	13,743	13,749	13,881	13,870	13,775	13,883	13,850	13,850	13,850	13,850	13,901
Trade Creditors	69,740	4,499	7,344	5,805	5,704	7,029	5,603	7,551	6,500	6,500	6,276	4,500	2,428
NHS Creditors	20,885	1,617	1,296	1,619	2,197	2,295	1,642	1,876	2,114	2,114	2,114	1,000	1,000
Capital Expenditure	13,680	477	526	727	528	840	531	526	1,182	2,084	2,413	2,118	1,728
PDC Dividend	4,245	0	0	0	0	0	2,089	0	0	0	0	0	2,156
Repayment of Loans	4,000	0	0	0	0	0	0	0	0	0	0	0	4,000
Repayment of Salix loan	346	0	0	0	0	0	143	0	0	0	0	0	203
TOTAL PAYMENTS	277,264	18,761	22,909	21,900	22,310	24,035	23,783	23,837	23,646	24,548	24,653	21,468	25,416
Actual month balance	443	2,801	-392	-2,833	3,109	-1,565	-3,197	3,487	-1,363	626	4,373	38	-4,641
Cash in transit & Cash in hand	0												0
Balance brought forward	4,303	4,303	7,104	6,712	3,880	6,988	5,423	2,226	5,713	4,350	4,976	9,349	9,387
Balance carried forward	4,746	7,104	6,712	3,880	6,988	5,423	2,226	5,713	4,350	4,976	9,349	9,387	4,746

Key Issues

- October month end balance includes £2.4 million representing the November & December elements of advanced quarterly block contract invoices paid by the CCG and a £2m advance from Nene CCG which has not yet been clawed back.
- Corby CCG have now paid their October invoice and have assured the Trust that the November invoice will be paid promptly.
- Trust continues to rely on SLA contracts being paid by 15th of each month. Continued effort is still required to ensure invoices are paid on time.
- Forecast cash flow has been based on forecast deficit position of £4,799m.
- The capital plan is heavily phased for the second half of the financial year which includes the Carbon Energy Efficiency Scheme.
- There is uncertainty in the forecast as it only estimates the likely impact of fines, contract over / under performance and impact of MRET
- Cash flow is now being reviewed on a weekly basis and monitored on a daily basis to ensure the Trust meets it's financial obligation.
- The position regarding the application for temporary borrowing has now been followed up and a daily cash flow statement has been requested to support the application.

Financial Risk rating

Key Issues

- The shadow FRR has continued to be operate at level 2 for both the reported and normalised position. Forecast is to return to 3.
- This performance is lower than planned and is driven by the poor EBITDA, I&E margin and liquidity days. Forecast expects these factors to recover.
- The Trust is no longer required to submit a Governance declaration top the TDA each month as set out opposite.
- The TDA financial monitoring now included arrange of financial check and KPIs.
- Monitor have recently consulted on revised guidance regarding the monitoring regime which will place new reporting requirements which focus on continuity of service as a key domain for assessment.
- The TDA reporting of financial KPI is proposed to be included in this section of future reports, with the updated Monitor reporting.

FINANCIAL RISK RATING — Northampton General Hospital

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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Board Action
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	3	5	3	5	
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	2	3	2	3	
Weighted Average		100%						2.3	2.8	2.3	2.8	
Overriding rules								2	3	2	3	
Overall rating								2	3	2	3	

REPORT TO THE TRUST BOARD
28 November 2013

Title	Workforce Report
Agenda item	15
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Mark Ingram, Head of e-Workforce
Purpose	This report provides an overview of key workforce issues
Executive summary The key matters affecting the workforce include: • The key performance indicators show an increase in Total Workforce Capacity employed by the Trust and an increase in total sickness absence. • Recent Policy changes that have been adopted	
Related strategic aim and corporate objective	Strategic Aim 4: Foster a culture where staff can give their best and thrive. Corporate Objective: To develop and implement new ways of engaging & supporting staff to enable them to achieve their potential
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate
Related Board Assurance Framework entries	BAF 7: High bank & agency costs.
Equality Impact Assessment	No
Legal implications / regulatory requirements	No
Actions required by the Board The Board is asked to note the report.	

Trust Board Report
28 November 2013

Workforce Report

1. Introduction

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

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

The total sickness absence rate increased by 0.52% in October to 4.45%, which is above the Trust target. Ward based areas of concern are within General Medicine (EAU 11.36%, Compton 10.72% and Brampton 9.51%).

Workforce Capacity

Total workforce capacity (excluding Medical Locums) increased by 34.80 FTE in October. The substantive workforce capacity increased by 24.32 FTE to 4,059.43 FTE and the temporary workforce capacity (excluding Medical Locums) increased by 10.48 FTE to 315.14 FTE.

2.2 Workforce Information Update

Staff Survey

As at 4th November 2013 the Staff Survey percentage return rate is 27%, 226 have been returned from a sample of 837; therefore 611 surveys are still to be completed. For the departments that can be reported on (more than 10 surveys sent) the response rates by Care Group are:

Care Group	Total Sent	Total Received	% Return
Medicine	118	27	22.88
Surgery	123	34	27.64
Hospital Support	35	9	25.71

The closing date for surveys to be returned by is 3rd December 2013.

The Trust would like to achieve more than a 50% response rate.

Influenza Vaccinations

To date 1,760, 40% of members of staff have been vaccinated against influenza. 1,500 of these were completed in the Cyber Café during the two weeks OH were present there. During the coming months it is anticipated that OH will be carrying out further vaccinations in all ward areas as well as from the department.

Policy Changes

The following policy was ratified in October:

- Raising Concerns at Work (Whistleblowing)

3. NGH Trust Values

Trust values, (see below) have been developed via a collaborative exercise between staff and the Trust Board thus ensuring that they are meaningful and resonate with large numbers of the workforce.

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect & support one another

For each of these Trust values, behaviours will be aligned and will then be imbedded within all relevant processes across the Trust. Currently the Trust values have been integrated into the revised appraisal process and will form part of the decision making, alongside meeting objectives and attendance at Mandatory and Role Specific Essential Training which will enable staff to incrementally progress.

Trust values could also be incorporated into the recruitment process to ensure that we recruit staff from the outset with the required attitude as well as aptitude.

As the Trust develops an Organisational Development Strategy the values and behaviours will become an integral part of the desired culture and should be reflected within improved patient experiences and better staff engagement.

4. Assessment of Risk

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

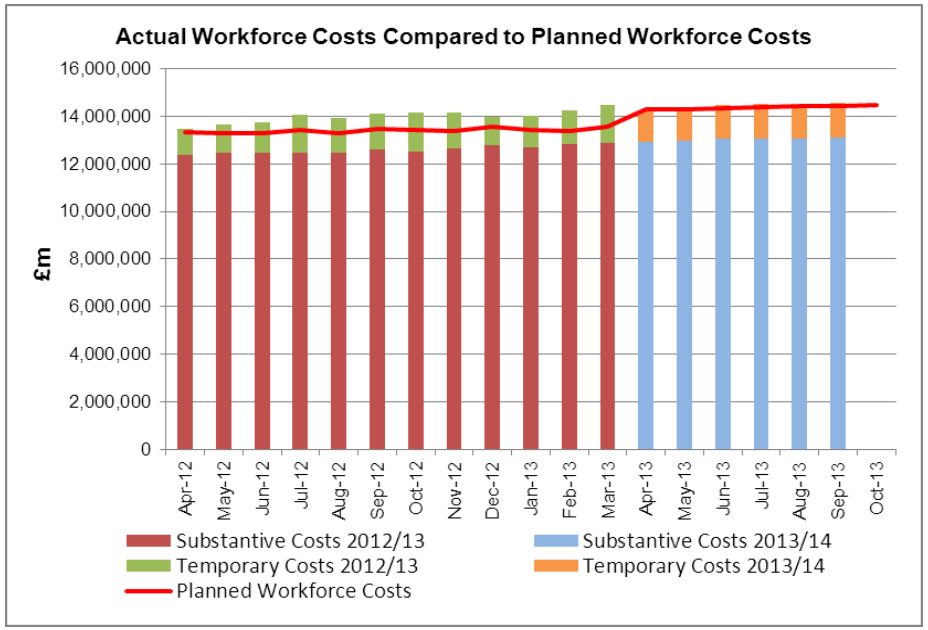
5. Recommendation

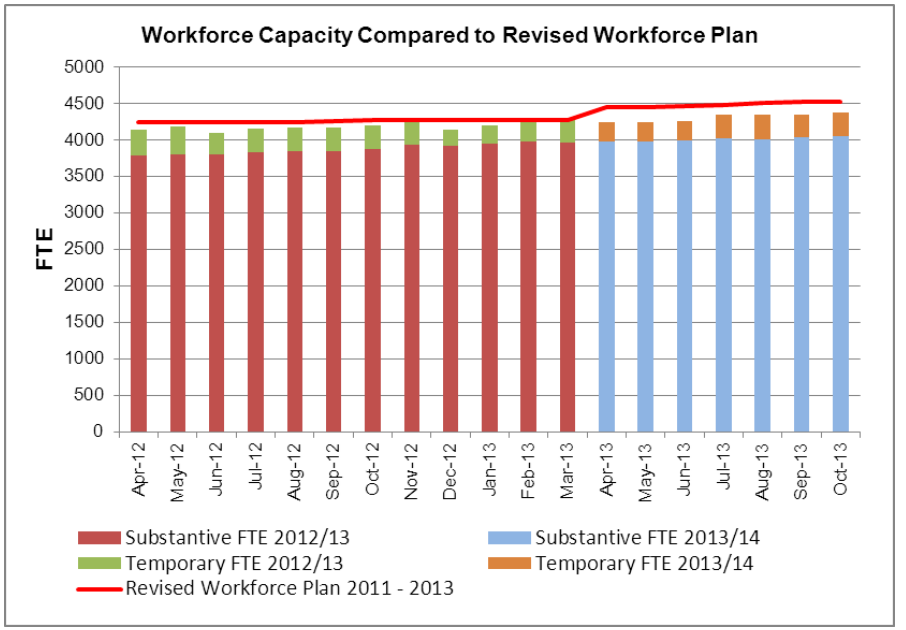
The Board is asked to note the report.

6. Next Steps

Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Human Resources Workforce Performance Indicators 2013/14 Month 7





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2012/13 (£1,000's)	12349	12460	12446	12447	12475	12617	12528	12648	12759	12692	12818	12881
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111						
Temporary Costs 2012/13 (£1,000's)	1136	1189	1291	1615	1434	1481	1620	1489	1213	1334	1403	1568
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443						
Planned Workforce Costs2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14480	14466	14476	14453	14466	14414

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2012/13	3,786	3,799	3,800	3,838	3,842	3,853	3,877	3,937	3,927	3,952	3,979	3,968
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059					
Temporary FTE 2012/13	347	388	301	322	329	311	327	332	215	250	291	334
Temporary FTE 2013/14	266	263	260	329	329	305	315					
Revised Workforce Plan 2011/12	4,250	4,250	4,250	4,238	4,246	4,254	4,269	4,279	4,278	4,278	4,278	4,278
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,522				

Workforce Expenditure

Total workforce Expenditure (all pay elements) increased by £91,519 in October to £14.645m (this is below plan for Month 7).

Substantive workforce expenditure increased by £42,388 to £13,152,948.

Temporary Workforce Expenditure (including Medical Staff) has increased by £49,131 to £1,492,611 = to 10.19% of the of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **increased by 35.68 FTE in October to 4,375.44 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,522.18 FTE.**

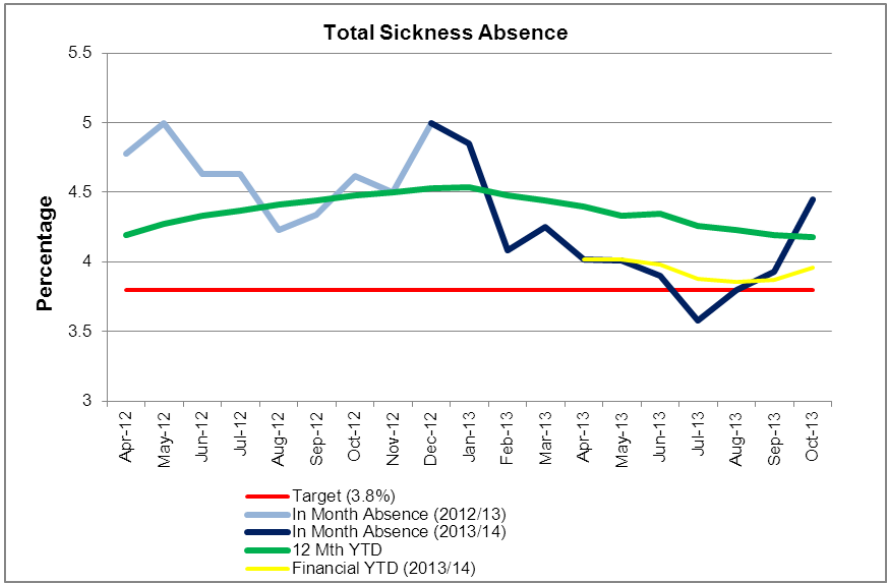
Substantive workforce capacity increased by 24.32 FTE to 4,059.43 FTE.

- Further overseas recruitment is planned to meet the increased budgeted establishment for trained nurses.

Temporary workforce capacity (excluding Medical Locums) **increased by 11.36 FTE to 316.01 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 7

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Hospital Support
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 -97% Over 100%	95%	89.77%	91.03%	91.87%	81.45%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 -5% Under 4.5%	5%	7.22%	8.40%	6.48%	5.62%
Total Substantive Workforce plus Temporary Workforce against Budgeted Establilshment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 -97% Over 100%	100%	**96.76%**	99.37%	86.29%	98.23%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.22%	8.49%	8.42%	13.42%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence 2012/13	4.78	5.00	4.63	4.63	4.23	4.34	4.62	4.50	5.00	4.85	4.08	4.25
In Month Absence 2013/14	4.02	4.01	3.90	3.58	3.80	3.93	4.45					
12 Mth YTD	4.40	4.33	4.35	4.26	4.23	4.19	4.18					
Financial YTD (2013/14)	4.02	4.02	3.98	3.88	3.86	3.87	3.96					

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 28,471 hours (175.21 FTE), which is an increase of 686 hours (4.22 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 46.32% (decrease of 5.95%), Agency fill rate = 21.02% (increase of 2.2%). Total bank & agency fill rate = 67.34% (decrease of 0.19% compared with the previous month).
- Monitoring of Admin & Clerical bank usage is in place which categorises types of bank working- with agreed time frames for usage.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.18% in October 2013.

In month Sickness Absence has increased by 0.52% to 4.45% which is above the Trust target.

- Short term sickness absence increased by 0.51% to 2.64%
- Long term sickness absence increased by 0.01% to 1.81% which is below Trust Target.
- The total calendar days lost to sickness absence increased by 969 to 6,505 days lost.
- The number of days lost per employee has increased to 1.37 days.

Human Resources Workforce Performance Indicators 2013/14 Month 7

		Surgery Care Group						
		Directorate						
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck	Women	Children
Short Term Sickness Absence		1.60%	2.63%	2.33%	4.73%	2.57%	3.91%	2.41%
Long Term Sickness Absence		2.20%	4.43%	2.21%	1.42%	1.64%	0.80%	2.67%
Total Sickness Absence	Over 4.2%	3.80%	7.06%	4.54%	6.15%	4.22%	4.71%	5.08%
	3.9-4.2%							
	Under 3.8%							

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery Care Group increased by 0.43%. There were also increases within Surgery of 0.63%, Trauma & Orthopaedics of 1.28%, Head & Neck of 0.99% and Anaesthesia, Critical Care & Theatres of 0.85%

  There have been improvements on Althorp ward where sickness absence decreased by 5.64% to 5.12%, Cedar ward decreased by 0.89% to 7% and Rowan ward decreased by 0.84% to 5.24%.

		Medicine Care Group						
		Directorate						
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies	Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	1.77%	1.85%	3.74%	3.35%	2.35%	3.58%
Long Term Sickness Absence		2.20%	1.39%	2.21%	0.87%	0.92%	3.74%	1.65%
Total Sickness Absence	Over 4.2%	3.80%	3.16%	4.06%	4.61%	4.27%	6.10%	5.23%
	3.9-4.2%							
	Under 3.8%							

		Hospital Support				M&D
		Directorate				
	Threshold	Target	Facilities	Hospital Support		Medical & Dental
Short Term Sickness Absence		1.60%	2.77%	1.83%		0.01%
Long Term Sickness Absence		2.20%	1.34%	2.15%		0.62%
Total Sickness Absence	Over 4.2%	3.80%	4.11%	3.98%		0.64%
	3.9-4.2%					
	Under 3.8%					

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency has increased by 0.44%. There was a significant decrease on Eleanor ward decreasing from 14.50% to 6.24%.

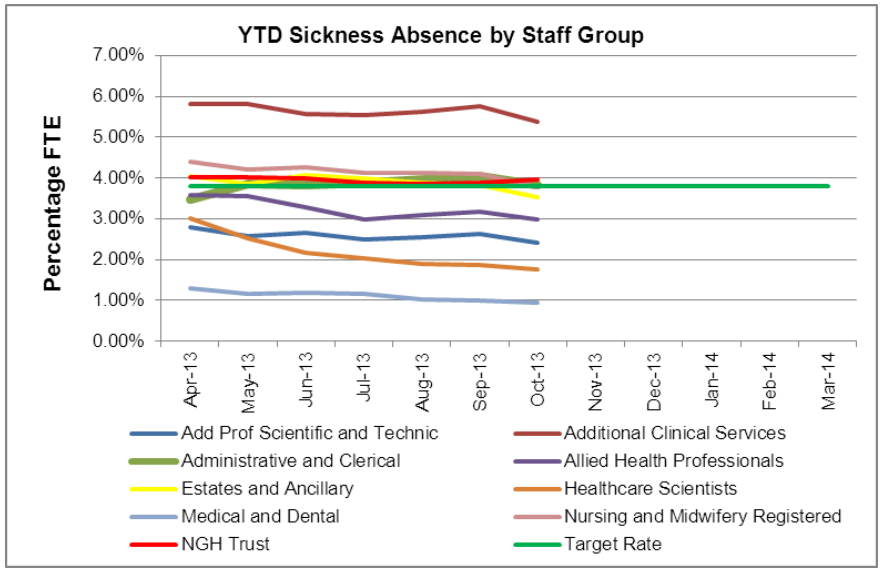
  Hot spots for Ward based total sickness absence are EAU which has increased from 6.84% in September to 11.36% in October, Compton at 10.72% and Brampton at 9.51%.

Hospital Support and Medical & Dental Summary

- The total sickness absence recorded for Facilities continues to increase and increased by a further 0.94% to 4.11%. Hospital Support total sickness absence has also increased by 1.13% to 3.91% in October.

  Medical & Dental sickness absence is not recorded in total and therefore is not a true representation of the sickness absence rate within this staff group.

Human Resources Workforce Performance Indicators 2013/14 Month 7



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Add Prof Scientific and Technic	2.78%	2.57%	2.66%	2.50%	2.55%	2.64%	2.41%					
Additional Clinical Services	5.82%	5.81%	5.56%	5.54%	5.61%	5.75%	5.39%					
Administrative and Clerical	3.47%	3.85%	3.84%	3.88%	3.97%	4.05%	3.82%					
Allied Health Professionals	3.58%	3.56%	3.27%	2.97%	3.08%	3.18%	2.99%					
Estates and Ancillary	4.04%	3.84%	4.08%	3.98%	3.87%	3.82%	3.52%					
Healthcare Scientists	3.00%	2.51%	2.18%	2.04%	1.89%	1.86%	1.75%					
Medical and Dental	1.29%	1.15%	1.18%	1.16%	1.03%	0.99%	0.94%					
Nursing and Midwifery Registered	4.40%	4.21%	4.27%	4.14%	4.14%	4.09%	3.78%					
NGH Trust	4.02%	4.02%	3.98%	3.88%	3.86%	3.87%	3.96%					
Target Rate	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%

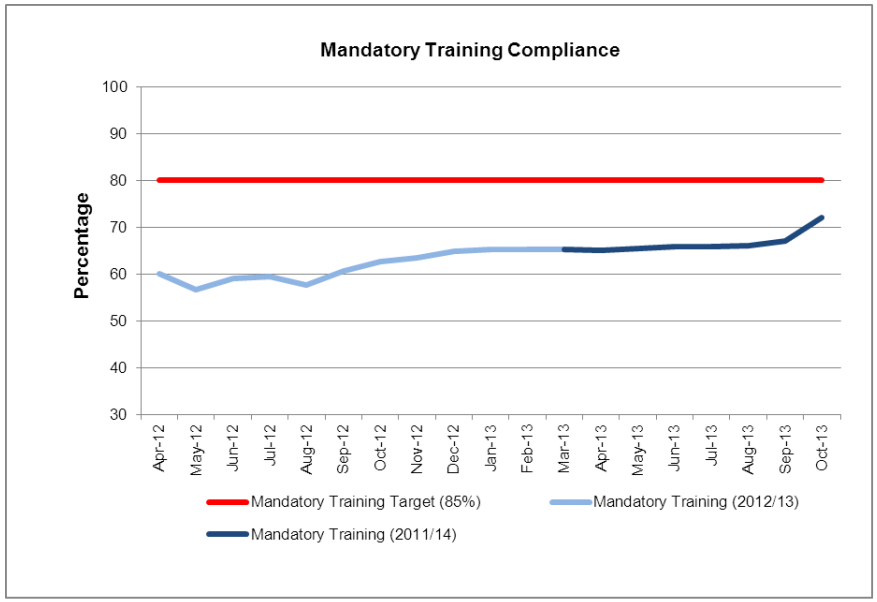
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.45%	4.59%	4.47%	4.00%
% Appraisals Complete	Under 50% 50-79% 80% & over	80%	35.17%	30.88%	39.84%	36.77%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	80%	72.00%	73.44%	71.61%	67.71%

Appraisal & Mandatory Training Compliance

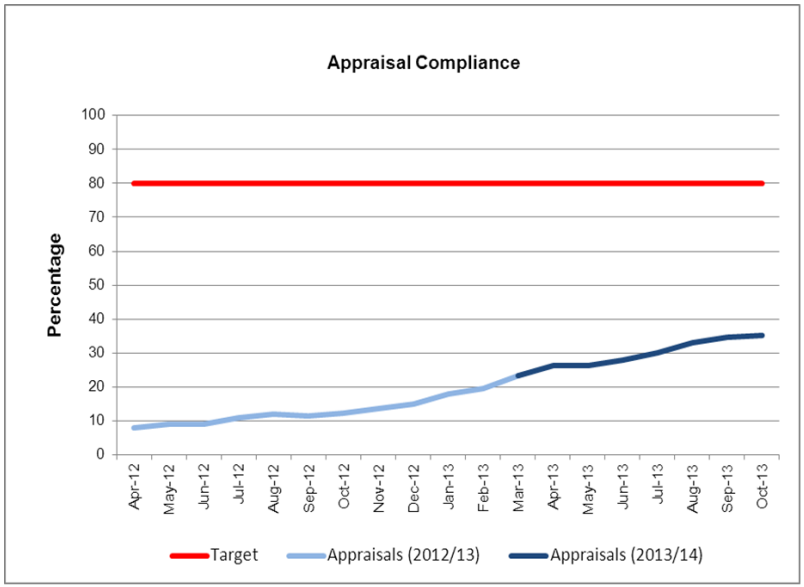
Please Note: the reporting of Appraisal Compliance was quarterly up until April 2012 at which point reporting changed to YTD.

- The current number of staff having had Appraisals is 35.17%; this is an increase on October which was 34.62%.
- Following the review on Mandatory Training on 9 subjects, the overall mandatory training compliance increased from 66.97% to 72%.

Human Resources Workforce Performance Indicators Month 7



Mandatory Training Target 85%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2011/14)	65.14	65.4	65.75	65.93	66.09	66.97	72.00					



Appraisal Target 80%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Appraisals (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
Appraisals (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17					

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

Title	Improving Quality and Efficiency Report
Agenda item	16
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Mike Hyne – Transformation / PMO
Purpose	Assurance and Information

Executive summary

1. The upside latest thinking forecast at M7 is £12.2m, against the £13m (4.7%) required delivery, off plan by £0.8m. This is up by £0.1m on M6 due to additional schemes added.

2. The downside scenario has also improved to delivery of £11.8m.

3. All the mitigation schemes have now been developed, which if delivered in full and the LTF achieved (£12.2m 4.7%) leaves a residual minimum mitigation requirement of £0.8m to achieve the plan of £13m.

4. Whilst the improved performance is encouraging, there is still a real need to drive greater value from existing schemes, to deliver red and amber schemes and to generate and deliver additional schemes.

5. The plan submitted to the TDA required delivery of £6.1m in the first 7 months. Actual delivery is £6.4m, ahead of plan by £288k.

Related strategic aim and corporate objective	Strategic Aim 5: To be a financially viable organisation • Deliver the Transformation programme 2013/14
Risk and assurance	The Transformation Programme is off trajectory on its planned cost reduction plan for 2013/14 which increases risk of failure to meet the Trust Strategic aim of being a financially viable organisation.
Related Board Assurance Framework entries	BAF 21
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS
NHS Trust

Board Meeting
23 September 2013
Transformation Programme Report

1. Introduction

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

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

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

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

3. Transformation programme delivery

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

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

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

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

5. Quality Impact Assessment

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

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

6. Risk Assessment

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

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

7. Conclusions

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

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

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

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

8. Recommendation

The Board is asked to discuss and note:

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

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

NOVEMBER 2013

Executive Summary

Northampton General Hospital NHS
NHS Trust

Transformation Plan for 2013/14	The target plan for 2013/14 is £13m which is constructed from the national minimum delivery requirement of 5% of turnover.
The latest thinking forecast for Month 6 September 2013)	The upside latest thinking forecast at M7 is £12.2m, against the £13m (4.7%) required delivery, off plan by £0.8m. This is up by £0.1m on M6 due to additional schemes added. The downside scenario has also improved to delivery of £11.8m. All the mitigation schemes have now been developed, which if delivered in full and the LTF achieved (£12.2m 4.7%) leaves a residual minimum mitigation requirement of £0.8m to achieve the plan of £13m. Whilst the improved performance is encouraging, there is still a real need to drive greater value from existing schemes, to deliver red and amber schemes and to generate and deliver additional schemes. The plan submitted to the TDA required delivery of £6.1m in the first 7 months. Actual delivery is £6.4m, ahead of plan by £288k.
The Improving Quality & Efficiency Group & Strategic Executive Team	Additional schemes are still required to bridge the £0.8m gap. However, the pipeline is now exhausted.
2014-15 Programme	An outline programme of key themes for 2014-15, including executive sponsors for each theme has been agreed. These themes will now establish steering groups and fully scope the opportunity for quality improvement and cost reduction for each theme. Themes will present progress to Strategic Executive Team on the 17th December and the IQE Team will update Finance Committee in January. Schemes already identified and in the process of development will be allocated to this structure by the IQET.
Risks and Issues	IQET is still operating significantly below full capacity, which presents a risk to delivery. An additional interim has been appointed to mitigate this. Recruitment to the lead role in the team was not successful at the first attempt. Options are being explored to attract a suitable candidate. There is significant risk concerning the delivery, in full, of the bank and agency CIP. The value of this scheme is critical to the programme and variable factors such as recruitment, attrition rate and winter pressures make performance volatile. The figures in this paper are based on forecast delivery of £1.9m as per the Finance Committee paper. This figure is under review to incorporate the latest developments and mitigations but is likely to reduce. There is a significant proportion of back loaded CIP plans.

Scheme Pipeline 2013-15

Northampton General Hospital NHS
NHS Trust

Mitigation 2013/14

Care Groups have revised their LTFs up by £8k in M7.

IQEG are awaiting updates on the following schemes:

- Increase staff car parking charges
- Reduce the staff restaurant subsidy

No further schemes are being considered currently, although work continues to try to identify immediate opportunities and to stretch existing schemes.

As schemes are being developed project plans and quality impact assessments will be created. IQEG will drive the development of the schemes and monitor implementation via the respective Executive Sponsors and Project Leads.

Care Group & Corporate CIPs

- Both Care Groups are reporting an over achievement of CIPs this year.
- The Surgical Care Group are reporting £88k ahead of plan and the Medicine Care Group £32k ahead of plan.
- 3 corporate areas are short of target by a combined £66k (Corporate Affairs, Medical Director, Patient Nursing Services).

Immediate Priorities

Immediate priorities are:

- to continue to test the feasibility of the mitigating schemes, and quickly discount any that will not generate a financial return.
- to scope the schemes likely to generate a financial return and identify and agree a project lead to be accountable for each scheme.
- to complete the scoping document for each scheme, including details of the project, key actions required, phased financials etc.
- to complete a Quality Impact Assessment (QIA) for each scheme involving all relevant staff and ensuring that the revised QIA policy is followed.
- to set-up steering groups for the 2014-15 programme
- to fully scope the themes for 2014-15 and develop detailed plans to delivery quality and efficiency improvements

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M6 LTF £000s		M7 LTF £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	12,098	↑	12,218	94%	3,726
Mitigation	0	0	146	↓	0	0%	0
Total needed to be identified	4,508	35%	756	↓	782	6%	-3,726
Total Efficiency	**13,000**	**100%**	**13,000**		**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.7%**		**4.7%**		

Identification of the Transformation Programme 2013/14
The table outlines the current LTF compared to the plan submitted to the TDA in April 2013.
The current LTF of £12.2m if delivered in full would be a 4.7% CIP against our planned requirement of 5%.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	10,068	77%
Non-recurrent schemes	2,150	17%
Total needed to be identified	782	6%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	6,036	46%
Non pay	3,447	27%
Income	2,735	21%
Total needed to be identified	782	6%
Total Efficiency	**13,000**	**100%**

The table demonstrates a £0.1m increase in LTF between M6 & M7, due to development of mitigation schemes into delivering schemes.

Pay schemes account for 46% whereas pay costs are 68% of turnover.

This suggests that there are likely to be more opportunities from workforce related schemes.

Latest thinking forecast 2013/14

Northampton General Hospital NHS
NHS Trust

Workstream	Exec Lead	Current LTF	Plan	Variance
		2013/14	2013/14	2013/14
		£000s	£000s	£000s
FYE 12/13 schemes	A. Foster	337	337	0
Workforce Transformation	J. Brennan	2,767	1,979	788
Clinical service redesign	D. Needham / R. Brown	85	110	(25)
Non-Clinical service redesign	C. Abolins	106	0	106
Directorate Schemes	A. Foster	8,923	8,868	55
Sub total		**12,218**	**11,294**	**924**
Plans to be identified	J. Brennan	782	1,706	(924)
Total		**13,000**	**13,000**	**0**

Month 7 – Latest Thinking Forecast

The Transformation Programme is currently projecting a LTF shortfall £0.782m against the required plan of £13m.

Care Group and Corporate CIPs are currently ahead of plan by £55k.

The LTF for the care groups has increased by £8k over the position reported in M6. This is due to a change in the valuation of schemes and a change in start dates.

At the end of month 7 a £1.2m year on year reduction in nursing bank and agency expenditure has been achieved. The forecast LTF is based on the current run rate reduction being achieved.

The restriction on overtime continues to exceed the monthly financial requirement. The monthly saving dipped slightly in month 7. Managers within the Trust have been working with their HR Business Partners to ensure that authorisation compliance is maintained.

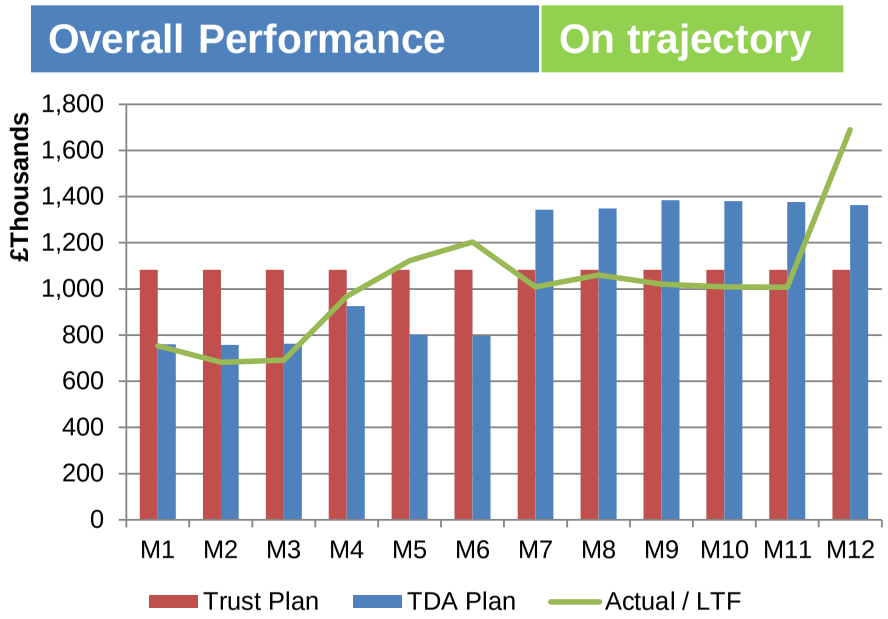
TDA Return

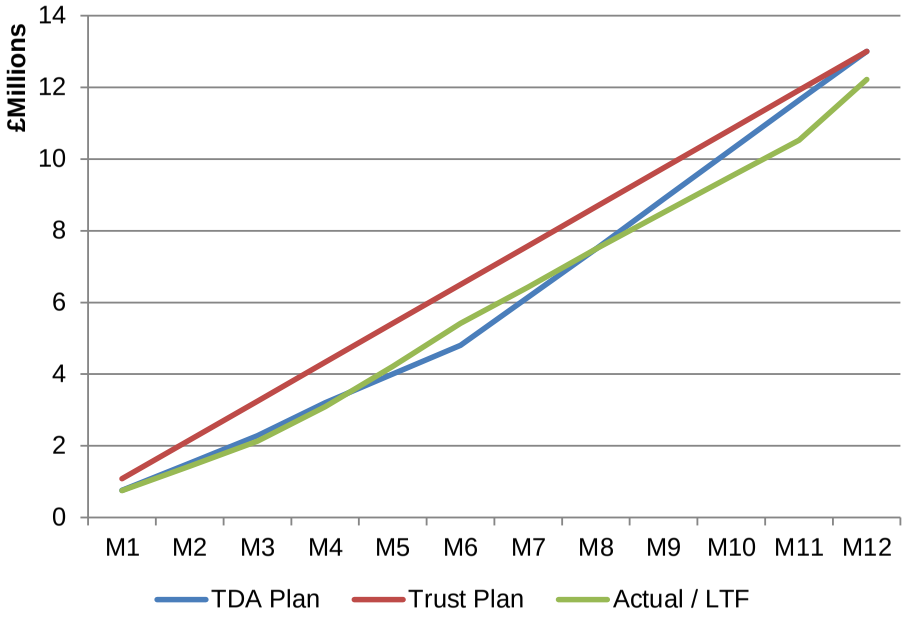
Northampton General Hospital NHS
NHS Trust

Efficiency Programmes	Identified (I) or Unidentified (U)	Recurring (R) or Non Recurring (NR)	Cashable (C), Non Cashable (NC) or Income (Inc)	If Cashable Pay (P) or Non Pay (NP)	Current Month			Year to Date			Forecast Outturn		
					Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 08) £000s	Forecast (mc 09) £000s	Variance (mc 10) £000s
Description of scheme													
FYE of 12/13 Transformation Schemes	I	R	C	P	35	35	0	262	262	0	337	337	0
Directorate CIPs	I	R	C	NP	265	187	(78)	1,729	1,472	(257)	3,050	2,938	(112)
Directorate CIPs	I	NR	C	NP	7	2	(4)	46	112	66	84	243	159
Directorate CIPs	I	R	C	P	208	155	(53)	1,362	939	(422)	2,478	1,809	(669)
Directorate CIPs	I	NR	C	P	18	123	105	203	704	502	293	1,207	914
Directorate CIPs	U	R	C	P	97	0	(97)	677	0	(677)	1,164	0	(1,164)
Directorate CIPs	I	R	Inc	NP	138	199	61	966	1,045	79	1,656	2,171	515
Directorate CIPs	I	NR	Inc	NP	5	57	52	163	390	227	187	554	367
Workforce Transformation - Admin Review	I	R	C	P	16	9	(8)	27	19	(8)	108	106	(2)
Workforce Transformation - Tactical HR (B|A)	I	R	C	P	10	195	185	70	1,167	1,097	120	1,869	1,749
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	13	28	15	91	196	105	104	336	232
Productivity | Efficiency - Outpatient Skill Mix	I	R	C	P	5	0	(5)	20	0	(20)	45	0	(45)
Services Transformation - Rehabilitation/Community	U	R	C	P	0	0	0	0	0	0	200	0	(200)
Services Transformation - 3rd party Pharmacy	I	R	C	NP	0	0	0	0	0	0	30	0	(30)
Other	U	NR	C	NP	526	0	(526)	526	0	(526)	3,144	0	(3,144)
New Programmes Identified In Year:													
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P	0	10	10	0	70	70	0	120	120
Workforce Transformation - Salary sacrifice year 2 (technology & car sceme expansion)	I	R	C	P	0	9	9	0	52	52	0	96	96
Clinical service redesign - Mattresses Total Bed Management	I	R	C	NP	0	0	0	0	0	0	0	25	25
Workforce Transformation - Locum Managed Service	I	R	C	P	0	0	0	0	0	0	0	125	125
Workforce Transformation - Consultant Annual Leave Accrual	I	R	C	P	0	0	0	0	0	0	0	35	35
Maximising formulary compliance (TVN)	U	R	C	NP	0	0	0	0	0	0	0	10	10
Emergency care porters for Benham Ward	U	R	C	P	0	0	0	0	0	0	0	40	40
Private patients at Danetre	U	NR	C	Inc	0	0	0	0	0	0	0	10	10
Reduction in compensation payments	U	R	C	NP	0	0	0	0	0	0	0	1	1
PDC impairment in Capital charges (EY)	U	NR	C	NP	0	0	0	0	0	0	0	0	0
Recovery of pay owed	U	R	C	P	0	0	0	0	0	0	0	5	5
Contractor Review	U	R	C	P	0	0	0	0	0	0	0	75	75
Increase staff car parking charges	U	R	C	NP	0	0	0	0	0	0	0	100	100
Commercial sponsorship	U	NR	C	NP	0	0	0	0	0	0	0	5	5
Grand Total (sc100)					**1,342**	**1,008**	**(333)**	**6,142**	**6,430**	**288**	**13,000**	**12,218**	**(782)**

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust





The cumulative delivery of schemes is now £288k ahead of the TDA plan. The plan submitted to the TDA requires savings to accelerate from month 7 onwards. The Trust Plan shows delivery spread evenly throughout the year. This highlights that although we are ahead of the TDA plan after 7 months we are some way off meeting the Trust Plan (£1.15m). The challenge is to make sure that all schemes identified in the LTF due to start in the second half of the year, deliver as planned. Some schemes contained within the Care Groups still require re-phasing to bring delivery forward to ensure that any delivery risk is identified early and contingency and mitigations are developed.

The graph outlines the LTF, the downside potential as well as a most likely calculation. As outlined in the paper, whilst we have utilised the Monitor methodology in the downside planning assumptions of 0% of red schemes delivering, the more likely scenario is that the schemes will deliver financial and quality improvement benefits and the mitigation schemes will improve the LTF.

The additional support sourced to support the care groups and the PMO, supported by Executive Sponsors the IQEG and the Trust Strategic Executive are focussed on ensuring that all schemes are accelerated to ensure maximum in year delivery. New schemes are still required to bridge the gap between the target and the LTF.

Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

	All schemes £'000s	% of Total target	Most Likely £'000s	Worst Case £'000s
Green	11,270	87%	11,270	11,270
Amber	715	5%	536	536
Red	233	2%	93	0
Total	**12,218**	**94%**	**11,899**	**11,806**
Gap	782	6%	1,101	1,194

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

The upside latest thinking forecast (£12.2m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.

The downside assessment of current schemes has been assessed based on none of the red rated schemes are achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

Utilising this methodology agreed at the Finance Committee at its meeting in June 2013, the downside case based on current RAG rating would see the programme realise £11.8m.

The focus of the IQEG will be to ensure that we convert the red schemes into delivery and continue to work on new schemes.

	FY13/14 LTF £'000			
Scheme	R	A	G	Total Identified
A1: Surgery	-	50	373	423
A2: Anaesthetics	-	9	838	846
A3: T&O	34	115	255	404
A4: Head & Neck	10	-	581	592
A5: Child Health	-	58	766	825
A6: Obs & Gynae	5	-	443	448
SCG sub total	**49**	**232**	**3,256**	**3,537**
B1: General Medicine	-	-	2,027	2,027
B2: Oncology	-	4	487	491
B3: Pathology	-	2	578	580
B4: Radiology	-	15	383	397
B5: Pharmacy	-	30	161	191
B6: Therapies	-	-	83	83
MCG sub total	**-**	**51**	**3,718**	**3,769**
C1-7: Support Functions	-	1	742	743
C8: Facilities	84	129	659	873
Support sub total	**84**	**131**	**1,401**	**1,616**
Care Group & Corporate CIP Total	**133**	**414**	**8,376**	**8,922**
FYE of 12/13 Transformation Schemes	-	-	337	337
Admin Review	-	-	106	106
Bank & Agency	-	-	1,869	1,869
Tactical HR (Overtime)	-	-	336	336
Tactical HR (Enhancements)	-	-	120	120
Salary sacrifice year 2	-	-	96	96
Locum Managed Service		125	-	125
Consultant Annual Leave Accrual		35	-	35
Mattresses Total Bed Management			25	25
Maximising formulary compliance (TVN)		10	-	10
Emergency care porters for Benham Ward		40	-	40
Private patients at Danetre		10	-	10
Reduction in compensation payments		1	-	1
PDC impairment in Capital charges (EY)	-	-	-	-
Recovery of pay owed	-	5		5
Contractor Review	-	75	-	75
Increase staff car parking charges	100	-	-	100
Commercial sponsorship	-	-	5	5
Mitigation list	-	-	-	-
Plans to be identified	-	-	-	782
Total	**233**	**715**	**11,270**	**13,000**

REPORT TO THE TRUST BOARD
28 NOVEMBER 2013

Title	TDA Self-Certification
Agenda item	17
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s)	Craig Sharples, Head of Corporate Affairs
Purpose	Decision

Executive summary

At the beginning of April 2013, the NHS Trust Development Authority (TDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of 'Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.

In accordance with the Accountability Framework, the Trust is required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix A and B.

At the time of the launch of the Accountability Framework, the TDA requested that on an interim basis, the Trust continue to complete and submit the Governance Risk Rating, Financial Risk Rating, quality and contractual data elements of part two of the Single Operating Model (SOM) published by the Department of Health in August 2012.

The TDA have subsequently clarified that the submission of these returns is no longer a mandatory requirement. Having taken advice, from this month onwards the Trust will no longer be submitting these to the returns to the TDA.

Related strategic aim and corporate objective	All
Risk and assurance	Compliance with performance targets and financial statutory duties
Related Board Assurance Framework entries	BAF 19-25
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Meeting financial statutory duties

Actions required by the Board

The Board is asked to approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for October 2013 (attached as Appendix A and Appendix B)

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

April	May	June
July	August	September
October	November	December
January	February	March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Enclosure N - TDA Self Certification

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. **Condition G7** – Registration with the Care Quality Commission.

3. **Condition G8** – Patient eligibility and selection criteria.

4. **Condition P1** – Recording of information.

5. **Condition P2** – Provision of information.

6. **Condition P3** – Assurance report on submissions to Monitor.

7. **Condition P4** – Compliance with the National Tariff.

8. **Condition P5** – Constructive engagement concerning local tariff modifications.

9. **Condition C1** – The right of patients to make choices.

10. **Condition C2** – Competition oversight.

11. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Comment where non-compliant or at risk of non-compliance

1. Condition G4
Fit and proper persons as Governors and Directors.

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

9. Condition C1
The right of patients to make choices.

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

April	May	June
July	August	September
October	November	December
January	February	March

BOARD STATEMENTS:

Enclosure N - TDA Self Certification

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (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.

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. 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.

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate.

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans.

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. 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 relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
28 November 2013

Title	Strategic Aims and Corporate Objectives
Agenda item	18
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s)	Karen Spellman, Deputy Director of Strategy and Partnerships
Purpose	The paper is represented for discussion and agreement

Executive summary

This paper includes the following;

1. **A summary of the six month progress review of the 2013/14 corporate objectives**

   - These are RAG rated and a summary of the committee where assurance is provided is included.

2. **Revised values, strategic aims and proposed corporate objectives that have been developed for 2014-15 in conjunction with a wide range of staff from across the organisation.**

   - The revised values have been developed through staff focus groups, the Trust's annual strategy planning session and agreed at the Board Development Session in October.

   - The Corporate Objectives have been developed to achieve our strategic aims. Trust Board are asked to agree the final draft and these will form the basis of the business planning round for 2014/15 and 15/16. The objectives will be subject to a final review following the publication of local and national commissioning intentions and presented for sign off with the Integrated Annual Business Plan in March 2014.

Related strategic aim and corporate objective	Proposed revised strategic aims and corporate objectives
Risk and assurance	Assurance on the delivery of the Trust's Strategic Aims
Related Board Assurance Framework entries	All
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N)

Actions required by the Board

Board are asked to note the progress in achieving the 2013/14 corporate objectives and agree the corporate objectives for 2014-15

Northampton General Hospital NHS
NHS Trust

NGH Vision, Values, Strategic Amis and Corporate Objectives- 2014/15.

Our Vision;

NGH is committed to providing the best possible care for all our patients

Our Values
The behaviours against which we will be judged as we deliver our vision

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect & support each other

Our Strategic Aims

At NGH we have 5 Strategic aims;

1. Focus on Quality and Safety
- To be an organisation focussed on quality outcomes, effectiveness and safety

2. Exceed Patient Expectations
- Continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients

3 Strengthen our local services
- Provide a sustainable range of services delivered locally

4. Enabling excellence through our people
- Develop, support and value our staff

5. Ensure a sustainable future
- To provide effective and commercially viable services for our patients ensuring a sustainable future for NGH.

Our Corporate Objectives for 2014/15 to achieve our aims are;

Strategic Aims	**Corporate Objective 2014-15**	**Outcomes** *What is the desired result*	**Output measures** *How will the successful implementation of the action be measured*	**Planned completion date**	**Owner**
1. Focus on Quality and Safety					
1 To be an organisation focussed on quality outcomes, effectiveness and safety	Improve our core clinical standards To provide a high quality environment for our patients.	Avoid harm Save lives Continue to implement and extend the NGH Safety Academy Implement the nursing and midwifery staffing strategy	Reduction in SHMI and HSMR Reduce measurable harm from failures of care (e.g. reduction in HCAI and pressure ulcers), failure to plan and failure to rescue (escalation campaign). Achievement of operating framework standards e.g. RTT, 4 hour transit time, cancer waits Improved compliance with CQC Essential standards	March 2015	Medical Director
2. Exceed Patient Expectations					
2 To improve continuously our patient experience and satisfaction by delivering personalised care	Integrate under one framework our patient engagement and involvement strategies Implement new ways of learning from patient experience so we learn lessons more quickly and more effectively.	Demonstrable improvement in patient experience and engagement Listening and communicating to patients	Improved Patient Survey results Increased uptake and improvement of score on the Friends and Family test Improved Reviews on NHS Choices and Patient Opinion	October 2014 From March 2014 From March 2014	Director of Nursing, Midwifery & Patient Services

Strategic Aims	Corporate Objective 2014-15	Outcomes *What is the desired result*	Output measures *How will the successful implementation of the action be measured*	Planned completion date	Owner
	Involve patients in everything we do				
3. Strengthen our local services					
3 Provide a sustainable range of services delivered locally	To develop partnerships to support redesign of services around the needs of patients through Healthier Northamptonshire To continue to develop excellence in our existing services	Clinically and financially viable services developed alongside other healthcare partners To deliver safe and sustainable services	Completed strategic reviews undertaken with plans of action developed and signed off by Board Cancer peer Reviews Acute Stroke measures Vascular Centre measures	March 2014 From March 2014 Quarterly reviews from March 2014 Quarterly reviews from March 2014	Director of Strategy and Partnerships
4 Enabling excellence through our people					
4 Develop, support and value our staff	Design and commence implementation of the ***Connecting for Quality, Committed to Excellence*** strategy to include: Staff engagement, Improving Quality &	Improved staff satisfaction and engagement	Improvement in staff ratings from 2012 baseline in relation to: - Staff engagement - Support from immediate managers - Staff feeling satisfied with the quality of work and patient care they are able to deliver - Staff job satisfaction	2014 - 2019	Director of Workforce & Transformation

Strategic Aims	Corporate Objective 2014-15	Outcomes *What is the desired result*	Output measures *How will the successful implementation of the action be measured*	Planned completion date	Owner
	Efficiency programme, Leadership & Management development and review of trust values		- Staff motivation at work - Staff recommendation as a place to work or receive treatment		
5. Ensure a sustainable future					
5 To provide effective and commercially viable services for our patients ensuring a sustainable future for NGH.	Develop an agreed framework so that finance can be used as an enabler to quality and efficiency	Understand the business Agreed long term financial model (LTFM) Achieve balance against the plan To develop the Improving Quality & efficiency programme Deliver the Income and Expenditure, Capital Resource Limit and External Finance Limit targets	Financial and transformation targets met Board approval of the Long Term Financial Model in place and endorsed by the Board and milestones achieved Annual Improving Quality & Efficiency (IQE) programmes for at least 50% of services	March 2015 March 2015	Director of Finance Director of Workforce & Transformation

NGH Corporate Objectives 2013/14 - Updated Six Month Review

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner	6 Month Progress Review
Strategic Aim 1: Be a provider of quality care for all our patients						
1	Invest in enhanced quality including improvements in the environment in which we deliver care	Demonstrated improved clinical effectiveness as demonstrated through NICE compliance and effective use of clinical audit Reduction in harm to patients as measured through implementation of the patient safety programme Increase nursing establishment through the implementation of the nursing and midwifery staffing strategy	Reduction in SHMI and HSMR Improved CQC Scores Improvements in results of Patient & Staff Surveys Positive PLACE Scores Positive performance of Estate KPIs Progress on Safety Academy Priorities until 2015 Achievement of operating Framework standards e.g. RTT, Cancer Waits, 4 hour transit time Improvements in Healthcare Acquired Infection KPIs Delivery of the Estates Strategy and Capital Programme Improvement in pressure ulcer KPIs	Mar-14	Suzie Loader Dr Sonia Swart	At risk of delivery due to; SHMI, HSMR, T&O RTT, Cancer Waits, A&E 4 hour transit time. Full recovery plans in place and presented to sub committees and Board for approval and monitoring.
Strategic Aim 2: Enhance our range of hyper acute services and maintain the clinical viability of services for the wider community of Northamptonshire						
2	Develop critical clinical care pathways to deliver effective integrated care.	To deliver a safe and sustainable countywide vascular and stroke services A strategic review of cancer services undertaken by 31 October 2013 Urgent Care	Completed strategic reviews undertaken with plans of action developed and signed off at Board.	Mar-14	Chris Pallot	On track to deliver a review of Cancer services by April 2014. Full plans in place for Urgent Care Board for the Urgent care developments. Improvement plans in place and monitored through operational groups for Stroke and Vascular.
3	To develop strategic approaches to stakeholder engagement in order to develop a clinically safe and sustainable organisation. Specifically, develop strategic approaches to relationships with: - Local partners - Commissioners - Local Authorities, Health and Wellbeing Boards - Trust Development Agency - MPs - Regulators	Enhanced clinical links with NHS Nene Commissioning developed Closer links with KGHFT through the establishment of a joint Partnership Board Clinically viable services developed alongside other healthcare partners	Stakeholder strategy reviewed, approved at Board and implemented. PMO appointed to and strategic options developed.	Mar-14	Chris Pallot	At risk of delivery due to change in focus of Healthier Northamptonshire Proposals for review of the Clinical Strategy to include partnership working agreed at the October Board Development Day

NGH Corporate Objectives 2013/14 - Updated Six Month Review

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner	6 Month Progress Review
Strategic Aim 3: Provide appropriate care for our patients in the most effective way						
4	Implement the recommendations of the quality strategy	Demonstrable improvement in quality, patient safety, and patient experience Wards using bi-monthly governance 'ward pack' for sharing of learning from incidents / complaints and evidence of discussion of this	Reduction in omission of medicines by 50% Oxygen correctly prescribed, administered and documented for >90% of patients Number of patients that receive sepsis 6 bundle within 1 hour of arrival in A&E. Improvement of 10% on baseline Number of deaths in hospital (with the aim of monitoring lives saved over 3 years) Number of staff trained in basic human factors in simulation suite Number of patients that receive antibiotics within one hour of sepsis being suspected on the ward Consultant review within 12hours Number of unauthorised EDN's on the ward Audit of action plans from 'Never Events'. Number of actions completed / outstanding Improvements in the friends and families test - • *How likely are you to recommend our Ward to friends and family if they needed similar care treatment?* - 15% response rate per ward, score over 70 • *Were you involved as much as you wanted to be in decisions about your treatment or care?* - 50% Response rate, improvement to 50% positive • *Were hospital staff available to talk about any worries or concerns that you had?* 50% response rate, improvement to 50% positive • *Did you have enough privacy when discussing your condition or treatment?* 50% response rate, improvement to 50% positive • *If you have been prescribed any new medication, have you been informed of any possible medication side effects?* - 50% response rate, improvement to 50% positive • *If you are ready to be discharged - have you been informed about who to contact if you are worried about your condition after leaving hospital?* - 50% response rate, improvement to 50% positive • *Arrival at hospital to bed / ward – did you feel that you had to wait a long time.* Increase on National Inpatient survey score from 7.4 – 8.0 (previously 7.4) *Overall did you feel that you were treated with privacy and dignity while you were in the hospital?* Increase on National Inpatient survey score from 8.6 – 9.1 (previously 9.0)	Mar-14	Suzie Loader Dr Sonia Swart	At risk of delivery - full overight and detialed scrutiny at IHGC
5	Further develop service planning through utilisation of business intelligence	Specialty scorecards implemented including service line reporting, quality and activity information Clinical acceptance of basis of preparation of service line reporting and confidence to use in decision making Service Line Reporting becomes core to delivering enhanced internal and external planning processes	Speciality scorecards in place. Corporate assurance reporting and decision making based on service line reporting.	Mar-14	Chris Pallot Andrew Foster	Review of Scorecards underway and process to ease reporting is underway. SLR being developed

NGH Corporate Objectives 2013/14 - Updated Six Month Review

Ref No.	Corporate Objective 2013/14	Outcomes *What is the desired result*	Output Measure *How will the successful implementation of the action be measured*	Planned Completion Date	Owner	6 Month Progress Review
Strategic Aim 4: Foster a culture where staff can give their best and thrive						
6	To develop and implement new ways of engaging and supporting staff to enable them to achieve their potential	Improved staff satisfaction, Development of a high performance, patient focussed culture driven by common values, appropriate behaviours and effective teamwork.	Improvements in relevant key findings in the annual staff survey results e.g. staff advocacy rates. Optimal staff turnover rates achieved: within 1% tolerance of 8% target, Reduction in sickness absence from 4.6% to 3.8% Roll out of behavioural framework system and integration with related core systems e.g. appraisal, Increase in mandatory training rates, Increase in appraisal rates from 73% to 80% or greater (staff survey data) and Increase in quality of appraisal ratings from 23% to 35% or greater. Successful implementation of the nursing and midwifery strategy	March 2014. Note: this will be part of a 3- 5 year organisational development strategy	Janine Brennan	At risk of delivery. Full details within workforce reports to Board and IHGC
7	To develop and implement an integrated management and leadership development strategy	Improved Management & and leadership effectiveness,	Improvements in management effectiveness indicator ratings in the annual staff survey, for example staff reporting good communication between senior management and staff increasing from 20% to 30%	March 2014. Note: this will be part of a 3- 5 year organisational development strategy	Janine Brennan	Staff survey results not available until February 2014. Organisation Development strategy being developed.
Strategic Aim 5: To be a financially viable organisation						
8	To develop an integrated Business Plan that meets operational and financial targets in the short and medium term	Deliver the Income and Expenditure, Capital Resource Limit and External Finance Limit targets Deliver the Transformation programme Deliver and implement the financial governance review To deliver against the Tripartite Formal Agreement, ensuring NGH becomes a Foundation Trust either in its current or alternative form Agreed Long Term Financial Model (LTFM)	Financial targets met Board approved Long Term Financial Model in place and endorsed by the Board Milestones achieved	Mar-14	Andrew Foster	Forecast deficit in line with plan. Increased gap in-year transformation delivery. Scrutiny at Finance Committee.

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 28 November 2013
09:30 am. Boardroom, Northampton General Hospital

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3	Minutes of the 31 October 2013 meeting of the Board	Decision	Mr P Farenden	**A**
	4	Matters arising from the 31 October 2013	Receive	Mr P Farenden	**B**
	5	Chief Executive's Report	Receive	Dr S Swart	**C**
	6	Patient Story	Receive	Ms S Loader	**Presentation**
09.45	**CLINICAL QUALITY AND SAFETY**				
	7	Medical Director's Quality Report	Assurance	Dr N Robinson	**D**
	8	Patient Experience Report	Assurance	Ms S Loader	**E**
	9	Infection Prevention Performance Report	Assurance	Ms S Loader	**F**
	10	Francis Report Action Plan	Assurance	Ms S Loader	**G**
	11	Nurse Staffing Report	Assurance	Ms S Loader	**H**
10.45	**OPERATIONAL ASSURANCE**				
	12	Operational Performance Report	Assurance	Mrs R Brown	**I**
	13	Urgent Care Update	Assurance	Mrs D Needham	**J**
	14	Finance Report	Assurance	Mr A Foster	**K**
	15	Workforce Report	Assurance	Ms J Brennan	**L**
	16	Improving Quality and Efficiency Report	Assurance	Ms J Brennan	**M**
	17	TDA Self-Certification	Decision	Mr C Pallot	**N**
11.45	**STRATEGY AND GOVERNANCE**				
	18	Strategic Aims and Corporate Objectives	Decision	Mr C Pallot	**O**
12.00	**ANY ITEMS OF OTHER BUSINESS**				
	19	**DATE AND TIME OF NEXT MEETING** 30 January 2013 – Boardroom, NGH	Note	Chair	**Verbal**

	RESOLUTION – CONFIDENTIAL ISSUES: The Trust Board is invited to adopt the following: “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)