Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 31st January 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 29th November 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**3**
09.55	7.	Patient Experience	Ms S Loader	**4**
10.05	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
Operational Assurance				
10.15	9.	Operational Performance Report	Mrs C Allen	**6**
10.30	10.	Urgent Care Update	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr P Hollinshead	**8**
10.55	12.	Human Resources Report	Ms G Opreshko	**9**
11.05	13.	Transformation Programme Update	Ms G Opreshko	**10**
11.15	14.	Self-Certification Return	Mr C Pallot	**11**
Governance				
11.20	15.	Any Other Business		
	16.	**Date & time of next meeting:** 28th February 2013		
	17.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Minutes of the Trust Board Meeting held in public on
Thursday 29h November 2012 at 9.30am
Boardroom, Northampton General Hospital

Present:	Mr P Farenden	Chairman
	Mr C Abolins	Director of Facilities & Capital Development
	Mrs C Allen	Deputy Chief Executive and Chief Operating Officer
	Mr P Hollinshead	Interim Director of Finance
	Ms S Loader	Director of Nursing, Midwifery and Patient Services
	Mr G Kershaw	Associate Non-executive Director
	Mrs G Opreshko	Interim Director of Workforce and Transformation
	Mr N Robertson	Non-executive Director
	Dr S Swart	Medical Director
In attendance:		
	Mrs R Brown	Care Group Director
	Mrs K Spellman	Deputy Director Strategy and Partnerships
	Mr J Bufford	Interim Head of Corporate Affairs (minutes)
	Mr T Delaney	Head of Communications
	Mr R Kelso	Shadow Governor
	Mrs M McVicar	Shadow Governor
	Ms W Meredith	Shadow Governor
	Mr F Evans	Shadow Governor
	Nine other members of the public and staff	
Apologies	Dr G McSorley	Chief Executive
	Mr C Pallot	Director of Strategy and Partnerships
	Mr P Zeidler	Non-executive Director

TB 12/13 86 Opening remarks

Mr Farenden welcomed the Shadow Governors and nursing and midwifery colleagues to the meeting.

TB 12/13 87 Declarations of Interest

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

TB 12/13 88 Minutes of the meeting held on 25th October 2012

There were two amendments:

TB12/13 77: The last sentence of the third paragraph from the bottom should read: However, it was agreed that the Infection Control team would re-emphasise to the ward staff the importance of risk assessing patient and where it was thought a patient might be at risk, it is recommended that the patient be given de-colonisation treatment which could be stopped if their results came back negative. This would not cause the patient any harm and is pro-active."

TB 12/13 78: The last sentence should be deleted.

Subject to these amendments the minutes were accepted as a true and correct record.

TB 12/13 89 Action Log and matters arising

TB 12/13 77: Ms Loader had amended the graphs to add figures.

All other actions and matters arising were on the agenda.

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TB 12/13 90 Chief Executive's Report

In Dr McSorley's absence, Ms Allen presented his report. She drew attention to the following issues:

- The NHS mandate had been published and would inform the NHS' priorities and the new Operating Framework. Mr Kershaw asked about the status of the document – Ms Allen confirmed that it was a guidance document.

  Ms Allen also drew the Trust Board's attention to a successful discussion between social care, health care, local authorities and the University of Northampton which had taken forward the idea of a 'healthcare zone' for Northampton.

- The most recent Joint Consultation and Negotiating Committee had agreed to formally develop a 'partnership agreement' – work on which would begin in January.

- The names of the 'Hospital Heroes' had been announced. They were:

  Olivia King from Paddington Ward
  Nigel Carter from Willow ward
  Collingtree Ward staff
  Ruby Coles from Collingtree Ward
  Spencer Ward Staff
  Amy Atkinson from Paddington Ward
  Alex Highton, Samantha Zajac, Andrew McLeod and Janet Waithaka from the Gosset Special Care Baby Unit

  Ms Allen congratulated all these staff, who had been nominated by members of the public for going beyond the call of duty. She also congratulated the staff in Medical Illustration who had received a number of IMI awards.

The Board of Directors NOTED the report

TB 12/13 91 Medical Director's Report

Dr Swart presented her report. Overall, the mortality indicators were at acceptable levels and there were no concerns relating to the Dr Foster patient safety indicators. Investigations into individual outliers had not found any significant deficits in the quality of care although work was continuing on improving the quality of coding.

The Trust had a higher than expected readmission rate, which had been the subject of a recent audit. This had established that most of the causes of readmissions had been from factors outside the control of NGH. Work was being done to look at improving communications for these patients. The Trust also had a comparatively high number of excess bed days. The main reasons for this were that (unlike many other Trusts) there was rehabilitation on site and there were a high number of delays in transfer of care. Work being carried out alongside patient safety work to improve emergency pathways and patient flow would help reduce this.

Dr Swart noted that as a result of the pressure from emergency admissions the Trust had been forced to cancel operations – but this had been kept to a minimum and a risk analysis had been carried out before each cancellation.

Mr Farenden noted that the Trust would not be able to address these issues without co-operation across the local health economy. He hoped that the sense of urgency being applied by the Trust would be replicated across the health economy. Ms Allen commented that local partners were engaged in the process.

Dr Swart drew Board's attention to the scorecards. She was working with the information team to improve scorecards, linking these to the NHS mandate so that Department of Health priorities were included. The following were particular issues:

- Pressure ulcers, essentially a nursing issue. Awareness was the key issue. Ms Loader added that the complexity of conditions that patients presented with made them more susceptible to these. A major programme was under way to raise awareness on wards – the goal was still to reduce these to zero.
- Falls; there had been fewer this year but increasing numbers of frail elderly patients made this a more difficult area to manage
- The average length of stay was improving but there was a need to separate those who stayed a very long time from others
- There had been an increase in fractured neck of femur and this was being looked at in more detail. Some cases were patients who had not been operated on at NGH.
- The number of caesarean sections had prompted an audit against NICE guidance. This had established that the Trust was conforming to the guidance – thereby giving patients sufficient choice. The next stage was to work on the advice given. Ms Loader added that the new matron appointment would help with this.
- There were issues on the CQUINs. Ms Loader reported that it was possible that the questions on medication were being answered before the patients were discharged. By adding these to the manual Friends and Family Test and to the "pop-up" questions and by raising this issue with staff it was hoped to establish whether this was the cause of the lower than expected results.

Dr Swart also noted that a coding manager had now been recruited.

The “Liverpool Care Pathway” had been in the news recently and was a contentious national issue.. Because of this, Dr Swart had done an audit. She had found that appropriate discussions were taking place and documented with families about pain relief and making patients comfortable. She was confident that the pathway would not be used inappropriately.

The Board of Directors were encouraged by the ability to sustain HSMR rates and noted that it was important that the Trust provided safe and good care for all patients. The Board of Directors NOTED the report.

TB 12/13 92 Patient Experience – Friends and Family Test

Ms Loader introduced her report. The score for October was 76 – which was an increase on the previous month. In response to a question from Mr Kershaw, Ms Loader commented that a key element for staff was not just what was done but how it was done. Eye contact and welcoming patients to the ward were very important.

Ms Loader noted that the Friends and Family Test (FFT) would change as a result of national guidance. A slightly revised question was being asked on wards and patients in A&E would be asked if they would recommend the A&E to their friends and family. NGH would be piloting this in A&E from January 2013.

The A&E national survey had been carried out some time ago – so some of the issues had already been addressed, but there was still some learning to be done. This was detailed on page 35 of the report. In response to a question from Mr Farenden, Ms Loader confirmed that the issues were picked up in the action plan, which was being monitored by the Patient Experience Board.

The Patient Experience Strategy was being launched on 3 December with Joanna Goodrich of the King’s Fund giving a keynote speech at the event. As part of the event patients were being invited to share their stories.

As part of the SHA’s “Call to action” nurses at NGH would be asking patients “is there anything I can do to make you more comfortable”.

The Board of Directors felt that encouraging progress being made and NOTED the report.

TB 12/13 93 Monthly Infection Prevention Performance Report

Ms Loader introduced the report. There had been no MRSA’s this month. A meeting had taken place to consider the learning from the case that had occurred in September. This had established that there had been a breakdown in communication between NGH and a neighbouring hospital on the transfer of the patient. Work was now under way to look at patient transfer documentation for transfer between the hospitals concerned.

The hospital was being more pro-active about starting decolonisation for more patients as they arrived. Although it was not prudent or practical to do this automatically for all patients, a list of high risk areas had been defined. .

As winter months often saw an increase in c.diff, measures were in place to ensure that there was extra vigilance in place.

Active discussions were taking place where areas were not achieving hand hygiene targets. The Trust's hand hygiene video had been shown on both the BBC and ITV.

Ms Allen and Dr Swart noted that norovirus in the community represented a big challenge to the Trust.

The Board of Directors NOTED the report. They felt that while performance was encouraging the time of the year made vigilance absolutely vital.

TB 12/13 94 **Operational Performance Report**

Mrs Brown presented the report. The Trust had achieved all targets in October, including the A&E target and cancer standards.

There was currently extreme pressure in A&E due to a marked increase in activity. There were a number of initiatives in train to address this, including additional beds, the opening of the Surgical Assessment Unit (SAU) and other ways of improving ways of working. Weekly performance meetings were held to ensure the position was closely monitored. However achieving the A&E target in November would be challenging.

Mr Farenden asked what the main cause of pressure in A&E was – Mrs Brown felt that the main cause was the high volume of attendances and higher acuity of patients admitted. Admission rates were as expected.

Mr Farenden also asked about the work with the ambulance service. Ms Allen reported that the Trust had met with the ambulance service to discuss handover arrangements and as a result of this things had improved. The position was still challenging. Dr Swart was looking at ways in which GP visiting patterns could be changed to bring admissions in earlier in the day – but there was more work to do on this. Increasing the number of "hot clinics" that the Trust ran was another option. Mr Robertson asked if there were particular GP practices that were an issue – Ms Allen reported that information was shared with CCGs but there were no clear outliers.

Mr Robertson asked about the staffing position. Ms Allen reported a good response to nursing vacancies but a poor response to consultant vacancies. Dr Swart commented that there was a national shortage of consultants and middle grades and the problem was particularly acute in the East Midlands. The Trust had developed "fellow posts" which it was hoped would be attractive to doctors wanting to get into training

Ms Allen agreed that an overview of the urgent care programme would be brought to the next Board meeting.

Action: Ms Allen

The Board of Directors NOTED the report and congratulated the Trust on achieving the A&E target in October. The Board also noted the potential problems of achieving the target in November.

TB 12/13 95 **Finance Report**

Mr Hollinshead introduced his report. The Trust was now forecasting breakeven, following £11.2m of recovery actions set out in the latest financial recovery plan (FRP). The Trust.expected to meet its other two statutory duties – the External Financing Limit and Capital Resource limit.

At Month 7 the Trust had a year to date deficit of £4.4m. The Trust had agreed a FRP to address the forecast deficit which included actions totalling £11.2m. The two main risks to this were the challenging nature of the transformation programme and the costs associated with providing for additional activity as a result of winter pressures.

There had been a considerable improvement to the Trust's liquidity position. The receipt of £3m transitional funding from the SHA along with payments on contract from the CCG meant that the Trust might not need a short term loan. However, there was still a need for a long term solution and the Trust was in discussions with the SHA.

Mr Hollinshead drew attention to the key outstanding issues highlighted in paragraph 8.3 – the need to achieve control totals; to ensure that the Transformation programme was managed and delivered and the need to conclude negotiations with CCGs.

The Board of Directors NOTED the improvement in the Trusts financial position but also NOTED that this was dependent on achieving the Transformation Programme, achieving control totals and a successful outcome of negotiations with the CCGs.

TB 12/13 96 **HR Report**

Mrs Opreshko presented her report. The Trust was still recruiting, with a net increase of staff in October. The Portuguese nurse recruits were now on wards while the Irish nurses were being inducted.

There had been an increase in leavers. Work had been done to see why nurses were leaving and the main cause was high retirement levels – due in part to there now being no fixed retirement age. A workforce planner had joined the department and would be looking at these issues.

Long term sickness continued to decrease and was at its lowest for 11 months – but short term sickness had increased. The HR department was now developing a campaign to address short term sickness absence. This would highlight the impact sickness had on those staff who had to cover as well as the financial and quality impact. Mr Farenden noted the need for a fit and responsive workforce.

Appraisal rates were now going up and it was hoped that this trend would come through in the December and January figures. Mandatory training attendance rates were slowly improving.

The vaccination programme was progressing well with 1400 staff having been vaccinated to date.

The Board of Directors NOTED the report and supported the initiatives being taken to address staff absence.

TB 12/13 97 Transformation Programme Newsletter

Mrs Opreshko presented the Newsletter. The Newsletter highlighted the challenge of making £11.1m in savings.

There had been 108 expressions of interest in the Mutually Agreed Resignation Scheme (MARS). These would be examined carefully to ensure that the posts could be safely removed from the organisation.

An audit on the use of overtime was now being carried out with a view to ensuring tighter controls while not impacting on service quality.

The Board of Directors NOTED the newsletter and supported the action taken

TB 12/13 98 Provider Management Self Certification

Mr Pallot presented the proposed self-certification. The governance risk rating was green and, following the improvements in the financial performance the Financial Risk Rating now 2.

Noting the ongoing finance performance and A&E pressures the Board of Directors APPROVED the signing of declaration 2 of the PMR

TB 12/13 99 Any Other Business

Mr Farenden asked the meeting to note that Colin Astbury had resigned as a Non-Executive Director. Colin had made a consistent and constructive contribution to the work of the Board and of the Hospital, and would be much missed.

The Board of Directors noted their thanks for Mr Astbury's contribution to the Trust.

TB 12/13 100 Date of next meeting: January 31st 2013, 9.30 Boardroom NGH

TB 12/13 101 The Board of Directors resolved to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted

Action Log for the Board meeting held in public on 31 January 2013

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 93	Operational Performance Report	29 Nov 2012	Overview of urgent care programme be brought to Board	Ms Allen	January 2013	

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

TRUST BOARD 31st January 2013	
Title: -	Medical Director's Report
Presented by: -	Dr Sonia Swart
PURPOSE OF PAPER: - Update on Mortality and Clinical Scorecards	

CRITICAL POINTS: -

- Overall mortality as measured by HSMR and SHMI is within acceptable parameters.
- On-going analysis and risk based audit continues in order to define any coding or quality of care issues.
- Further scrutiny of information flows will continue.
- The clinical scorecard outlines areas where there is on-going concern in relation to performance.
- Tracking of appropriate quality measures is an increasingly important tool which should be used to allow the Board is able to challenge the quality of care provided.
- The National Quality Dashboard which has been recently released will be a nationally mandated tool to be used for quality improvement and a hierarchy of measures will need to underpin the system level indicators that will be available.
-

ACTION REQUIRED BY BOARD: -
The Board is asked to note the report and debate key issues

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

1. Introduction

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

2. Current Position HSMR

The HSMR for the first six months of 2012/13 is **98** (629 deaths versus 640 expected deaths) which is predicted to rise to 105 after re-benchmarking. **Unadjusted mortality is 3.7% which is the second lowest in the SHA.**

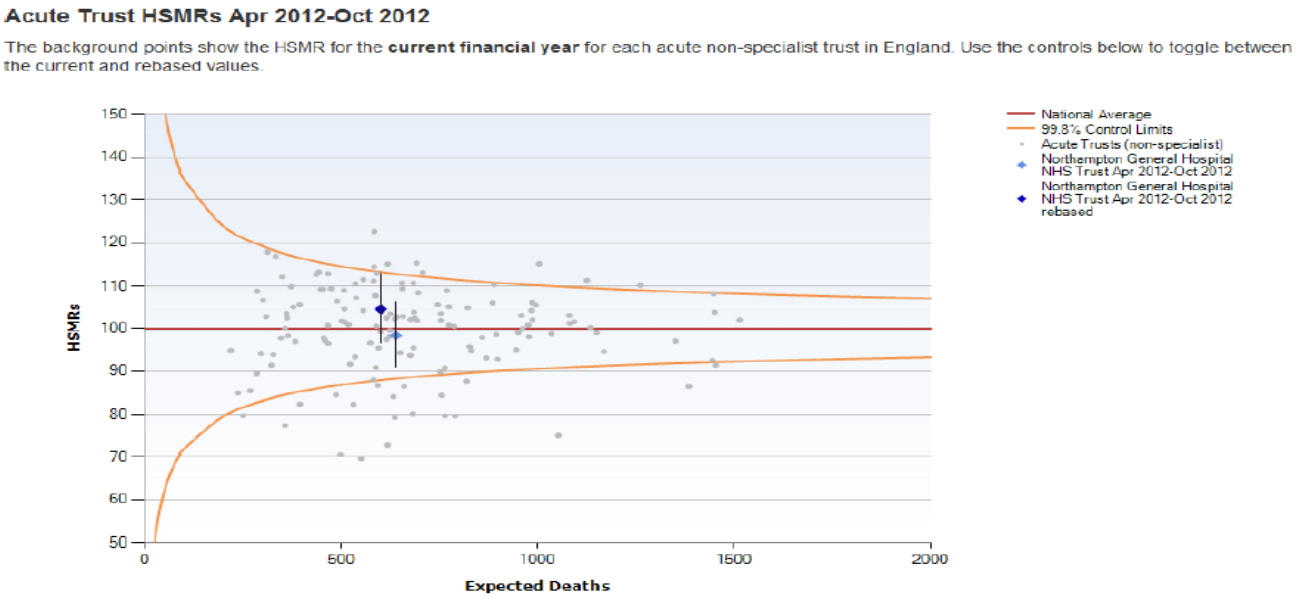
There continues to be concern relating to clarity of the recording of primary versus secondary diagnosis for some diagnoses such as secondary malignancy, diabetes, leukaemia and senility.

For October the HSMR was **93** (89 deaths, 95 expected).

3. Acute Trust HSMRs April 2011 - March 2012

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

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



4. Standardised Hospital Mortality Indicator (SHMI)

The SHMI for the last quarter of 2011/12 was higher than in the previous 3 quarters at **112**. The rolling SHMI to the end of this quarter was **105** which represents a SHMI in the 'as expected' category. The SHMI is rebased each time it is calculated unlike the HSMR.

For the financial year 2011/12 NGH was amongst 2 Trusts in the SHA with a SHMI in the 'as expected' category. There were 5 Trusts with a higher than expected value and only 1 with a lower than expected value.

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

The Current SHMI for the 12 months to June 2012 is 108. This remains in the 'as expected 'category. There are 8 groups of disorder showing a significantly high SHMI and the Trust will need to consider how to investigate these. One of these is pneumonia which contains the largest numbers of patients. This almost certainly relates to the fact that the SHMI algorithm does not adjust for the type of pneumonia. The Trust has made some significant improvements in the treatment of pneumonia and will need to consider what further actions are required. Two of the other categories are secondary malignancy and senility. Both these areas are under investigation.

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

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

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

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

The Patient Safety Indicators are adapted from the set of 20 devised by the Agency of Healthcare Research and Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and consultation and they have the benefit of being based on routinely available data. We have translated the US codes (ICD-9 for diagnoses and procedures) to the ICD-10 diagnosis codes and OPCS 4.3 procedure codes used in HES and NHS Wide Clearing Service in the NHS.

Nov 2011 to Oct 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		28	24.6	0.77	0.68	more information
Decubitus Ulcer		131	200.3	14.79	22.61	more information
Deaths after surgery		44	32.5	140.58	103.75	more information
Infections associated with central line*		0	0.8	0.00	0.05	more information
Post-operative hip fracture*		0	1.7	0.00	0.07	more information
Post-op Haemorrhage or Haematoma		6	13.8	0.26	0.59	more information
Post-operative physiologic and metabolic derangements*		0	1.6	0.00	0.08	more information
Post-operative respiratory failure		15	13.6	0.80	0.73	more information
Post-operative pulmonary embolism or deep vein thrombosis		30	38.9	1.27	1.65	more information
Post-operative sepsis		5	4.4	6.93	6.08	more information
Post-operative wound dehiscence*		2	1.1	2.18	1.18	more information
Accidental puncture or laceration		33	74.4	0.50	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		23	37.8	50.33	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		89	92.9	35.81	37.37	more information
Obstetric trauma - caesarean delivery*		4	4.3	3.17	3.43	more information

Key

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

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

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

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

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

a) Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease, Pneumonia. Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur** is subject to particular scrutiny. In this group there is cause for concern in relation to mortality from fractured neck of femur. The SMR for 2012/13 is 156 (27 deaths versus 17 expected). An audit of care is underway in the directorate and this has so far indicated an extremely frail group of patients. The Surgical Care Group has been asked to develop an improvement plan for this group of patients and the Medical Care Group has been asked to develop improved plans to assist with medical input to the frail elderly group of patients involved. This will be included in the Trust improvement plan priorities and will be reported through to HealthCare Governance as well as through the directorate governance reports to CQEG.

b) Possible areas for Concern under investigation

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

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

The Trust has a higher than expected readmission rate. This was recently the subject of a multidisciplinary audit. During this process many of the readmissions were thought to have been necessary due to factors unrelated to the care at NGH. The Trust also has a higher number of excess beds days than might be expected. This may relate to the presence of rehabilitation beds on site, the use of community hospitals and delays in transfers of care. There is on-going work to improve the emergency pathway in order to ensure that patients receive timely and appropriate care in the most appropriate setting.

d) Further Comments and Actions Planned

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

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

The detailed review of over 200 case notes related to patients who had died conducted last year has been re-commenced with the plan to look at 50 sets of notes.

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

7. Recommendation
The board is asked to note the report and debate any issues that arise from it. The Board is asked specifically to note that the emergency pressures which have been increasing over the last 6 months provide a challenge and there is a need to continually balance quality and safety risks in the light of mandatory targets.

Section 2 - The National Quality Dashboard

1. Introduction

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

2. Outline of the Dashboard principles with current examples

There is a stated intention that there must be an emphasis on understanding 'common cause' variation versus 'special cause' variation and hence to understand the causes of system problems when they occur.

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

It includes a small number of system level metrics. The philosophy is to include metrics that reflect the performance of the whole health care system including the performance in primary care, patient self-care, community services, social care and crisis intervention in the community.

Trusts are asked to consider the dashboards quarterly as a minimum but preferable monthly. The data is still under refinement and there are plans to make it as real time as possible. Access to the dashboards is currently available for Medical Directors and Nursing Directors after induction Webex sessions. The headline principles of the dashboard are as illustrated in Figure 1 on the following page.

The Trust will need to develop the relevant contributory metrics in order to maximise the use of the Dashboard as an improvement tool.

There is an interrogation facility so that the detail behind each metric can be investigated further and there is access for all Trusts so that it will be possible to see which organisations are doing well and learn from these. It will also be possible to leave comments to explain local situations and metrics where this is appropriate.

There is some controversy relating to some of the metrics. For example one of the most contentious ones relates to the numbers of nurses per bed as this relates only to substantive staff.

Appendix 1 contains examples of the dashboard to illustrate what will be available.

The first chart (**Appendix 1a**)shows the preformance for quality for the Midlands and East as a whole . This indicates that there are a number of undesirable alerts (greater than 3 SD from the mean) . Of particular interest is the graph realting to the 4 hour A and E target.

The second chart (**Appendix 1b**) shows the dashboard for NGH . There are no alerts for NGH at present. The A and E performance mirrors that of the SHA generally. The Nurse to Bed ratio is however low and the board will be aware of the recruitment drive in this area.

The last chart (**Appendix 1c**) gives some more detail relating to the A and E target upt to 16.12.12 and the funnel chart indicates the position compared to all available Trusts.

3. Actions Required

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

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

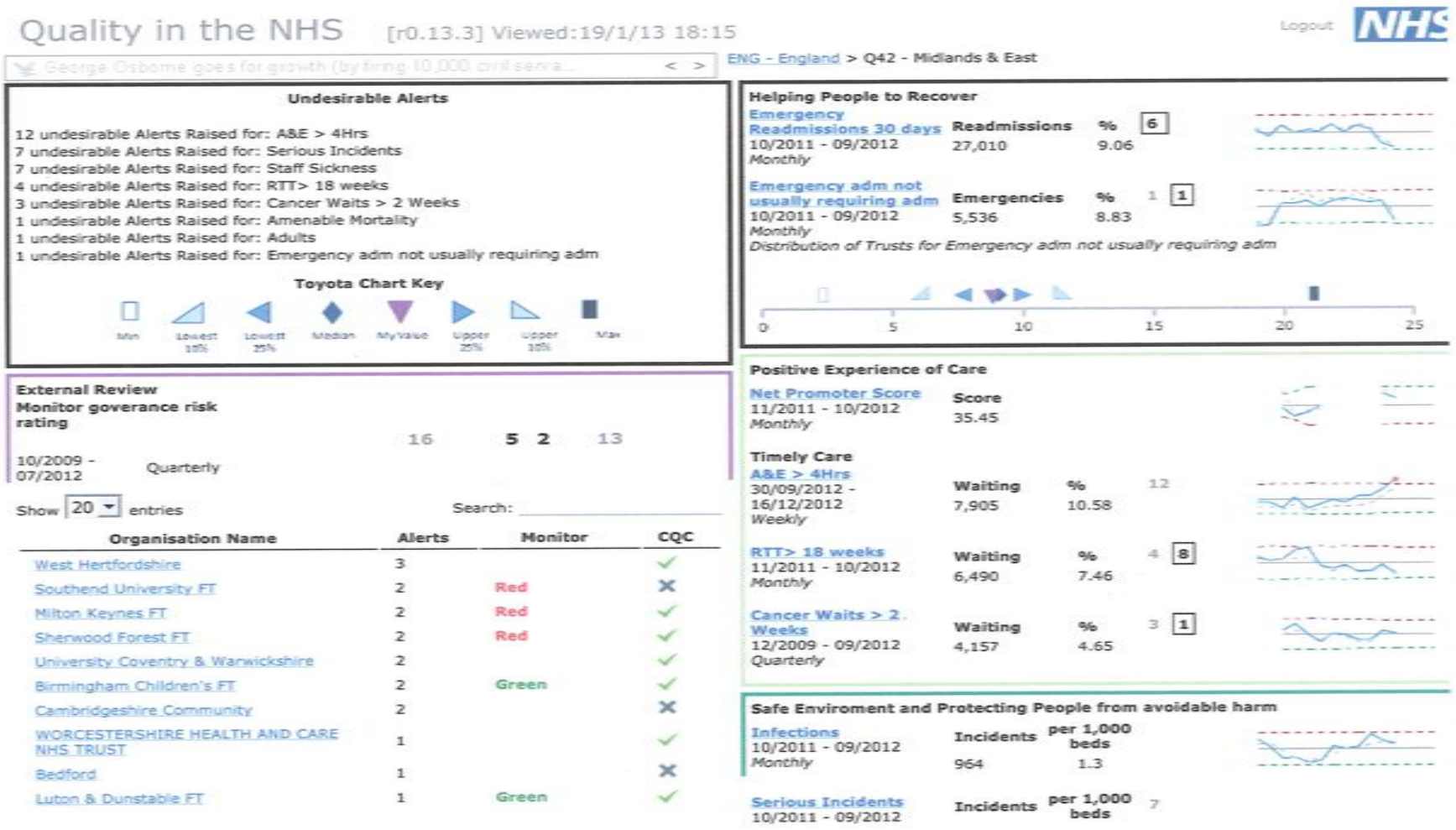
There will need to be close cooperation between the clinical teams and the information teams to ensure we capture these issues effectively.

4. Recommendation

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

The Board is asked to debate any issues that arise from this.

APPENDIX 1a



Quality in the NHS [r0.13.3] Viewed:19/1/13 18:15

Logout NHS

George Osborne goes for growth (by firing 10,000 civil servants...

ENG - England > Q42 - Midlands & East

Undesirable Alerts

12 undesirable Alerts Raised for: A&E > 4Hrs
7 undesirable Alerts Raised for: Serious Incidents
7 undesirable Alerts Raised for: Staff Sickness
4 undesirable Alerts Raised for: RTT> 18 weeks
3 undesirable Alerts Raised for: Cancer Waits > 2 Weeks
1 undesirable Alerts Raised for: Amenable Mortality
1 undesirable Alerts Raised for: Adults
1 undesirable Alerts Raised for: Emergency adm not usually requiring adm

Toyota Chart Key

Min | Lowest 10% | Lowest 25% | Median | My Value | Upper 25% | Upper 10% | Max

External Review
Monitor goverance risk rating

16 **5** **2** 13

10/2009 - 07/2012 Quarterly

Show 20 entries Search:

Organisation Name	Alerts	Monitor	CQC
West Hertfordshire	3		✓
Southend University FT	2	Red	✗
Milton Keynes FT	2	Red	✓
Sherwood Forest FT	2	Red	✓
University Coventry & Warwickshire	2		✓
Birmingham Children's FT	2	Green	✓
Cambridgeshire Community	2		✗
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	1		✓
Bedford	1		✗
Luton & Dunstable FT	1	Green	✓

Helping People to Recover

Emergency Readmissions 30 days
10/2011 - 09/2012
Monthly
Readmissions 27,010 | % 9.06 | 6

Emergency adm not usually requiring adm
10/2011 - 09/2012
Monthly
Emergencies 5,536 | % 8.83 | 1 | 1

Distribution of Trusts for Emergency adm not usually requiring adm

0 5 10 15 20 25

Positive Experience of Care

Net Promoter Score
11/2011 - 10/2012
Monthly
Score 35.45

Timely Care

A&E > 4Hrs
30/09/2012 - 16/12/2012
Weekly
Waiting 7,905 | % 10.58 | 12

RTT> 18 weeks
11/2011 - 10/2012
Monthly
Waiting 6,490 | % 7.46 | 4 | 8

Cancer Waits > 2 Weeks
12/2009 - 09/2012
Quarterly
Waiting 4,157 | % 4.65 | 3 | 1

Safe Enviroment and Protecting People from avoidable harm

Infections
10/2011 - 09/2012
Monthly
Incidents 964 | per 1,000 beds 1.3

Serious Incidents
10/2011 - 09/2012
Incidents | per 1,000 beds | 7

https://wfacog.westmidlands.nhs.uk/Cognos10/cgi-bin/cognosisapi.dll 19/01/2013

The Queen Elizabeth Kings Lynn FT	1	Red	✓
Papworth FT	1	Green	✓
Peterborough & Stamford FT	1	Red	✓
James Paget University FT	1	Red/Amber	✓
South Warwickshire FT	1	Red/Amber	✓
Burton FT	1	Red	✗
The Royal Wolverhampton	1		✗
North Staffordshire Combined Healthcare	1		✓
Kettering General FT	1	Red	✗
The Princess Alexandra	1		✗

Showing 1 to 20 of 28 entries Previous Next

Preventing People from Dying Prematurely

SHMI
06/2009 - 03/2012
Quarterly
4 35 2

Amenable Mortality
10/2011 - 09/2012
Monthly
Deaths 448 % 1.31 1

Distribution of Trusts for Amenable Mortality

0 2 4 6 8

Ambulance: Cat A > 8 mins
11/2011 - 10/2012
Monthly
Not Reached 16,202 % 23.93

Quality of Life for People with LTC

Adults
10/2011 - 09/2012
Monthly
Emergencies 3,785 % 5.96 1 1

Distribution of Trusts for Adults

0 10 20 30 40 50 60

Under 19s
Emergencies %

Monthly	892	1.01	
Never Events 12/2009 - 09/2012 *Quarterly*	Incidents 7	per 1,000 beds 0.06	
Unexpected Deaths (MH) 10/2011 - 09/2012 *Monthly*	Incidents 53	per 1,000 beds 0.4	
Harm Free Care 11/2011 - 10/2012 *Monthly*	% 92.23	9	

Organisational Indicators

Staff Sickness
11/2011 - 10/2012
Monthly
% 4.58 7 3

Distribution of Trusts for Staff Sickness

1 2 3 4 5 6 7 8

Bed Occupancy
10/2009 - 07/2012
Quarterly
Rate 86.36

Distribution of Trusts for Bed Occupancy

40 50 60 70 80 90 100

Nurses to Bed Ratio
11/2011 - 10/2012
Monthly
Ratio 1.91 29

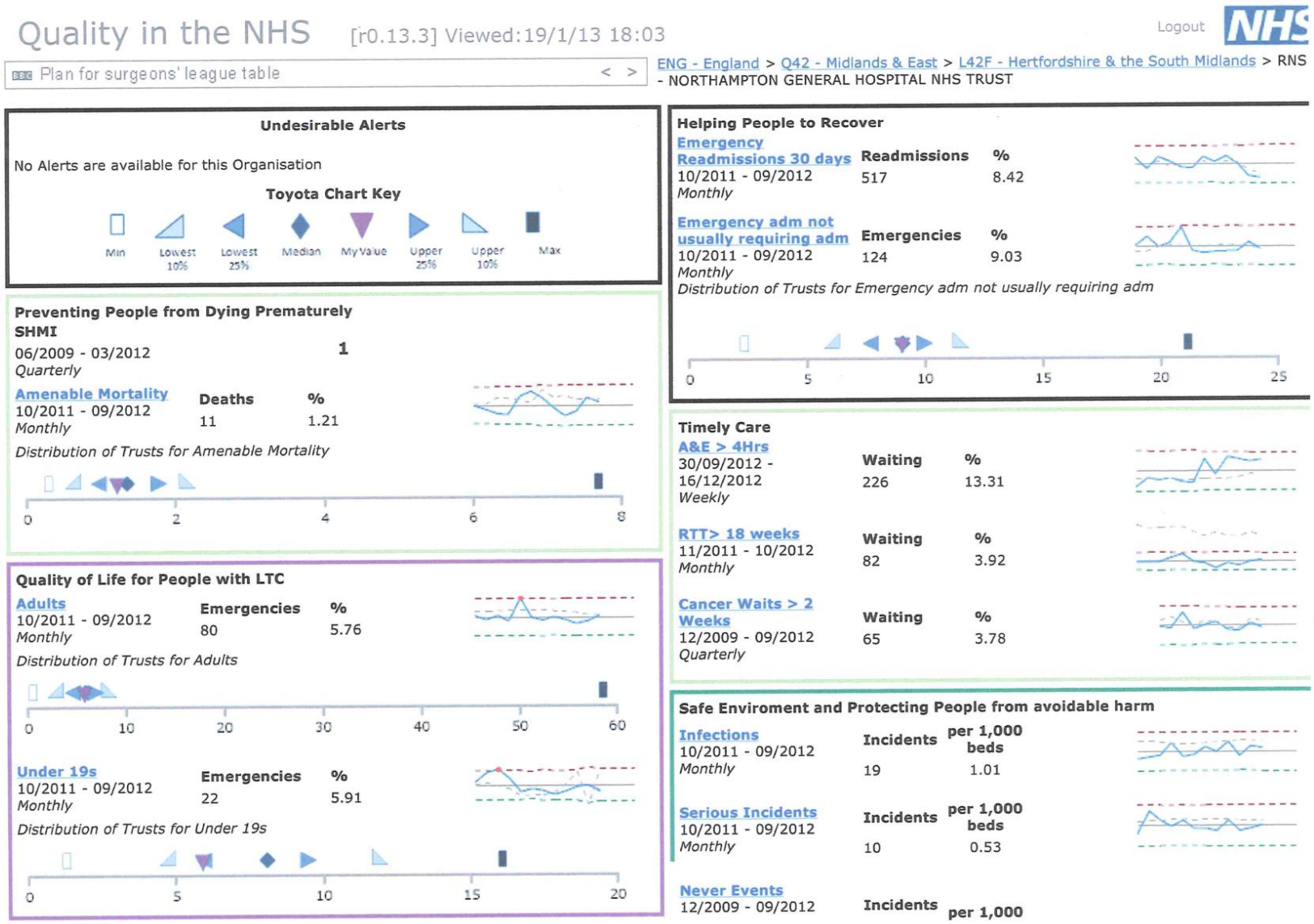
Distribution of Trusts for Nurses to Bed Ratio

0 5 10 15 20

Doctor to Patient Ratio
11/2011 - 10/2012
Monthly
Ratio 0.16 22

0 5 10 15

APPENDIX 1b

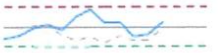

Quality in the NHS [r0.13.3] Viewed:19/1/13 18:03
Logout
NHS
Plan for surgeons' league table
ENG - England > Q42 - Midlands & East > L42F - Hertfordshire & the South Midlands > RNS - NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Undesirable Alerts
No Alerts are available for this Organisation
Toyota Chart Key
Min
Lowest 10%
Lowest 25%
Median
My Value
Upper 25%
Upper 10%
Max
Preventing People from Dying Prematurely
SHMI
06/2009 - 03/2012
Quarterly
1
Amenable Mortality
10/2011 - 09/2012
Monthly
Deaths
11
%
1.21
Distribution of Trusts for Amenable Mortality
0
2
4
6
8
Quality of Life for People with LTC
Adults
10/2011 - 09/2012
Monthly
Emergencies
80
%
5.76
Distribution of Trusts for Adults
0
10
20
30
40
50
60
Under 19s
10/2011 - 09/2012
Monthly
Emergencies
22
%
5.91
Distribution of Trusts for Under 19s
0
5
10
15
20
Helping People to Recover
Emergency Readmissions 30 days
10/2011 - 09/2012
Monthly
Readmissions
517
%
8.42
Emergency adm not usually requiring adm
10/2011 - 09/2012
Monthly
Emergencies
124
%
9.03
Distribution of Trusts for Emergency adm not usually requiring adm
0
5
10
15
20
25
Timely Care
A&E > 4Hrs
30/09/2012 - 16/12/2012
Weekly
Waiting
226
%
13.31
RTT> 18 weeks
11/2011 - 10/2012
Monthly
Waiting
82
%
3.92
Cancer Waits > 2 Weeks
12/2009 - 09/2012
Quarterly
Waiting
65
%
3.78
Safe Enviroment and Protecting People from avoidable harm
Infections
10/2011 - 09/2012
Monthly
Incidents
19
per 1,000 beds
1.01
Serious Incidents
10/2011 - 09/2012
Monthly
Incidents
10
per 1,000 beds
0.53
Never Events
12/2009 - 09/2012
Incidents
per 1,000

Quarterly **beds**

Harm Free Care **%**
11/2011 - 10/2012 91.89
Monthly

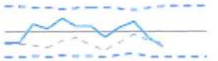
Organisational Indicators

Staff Sickness **%**
11/2011 - 10/2012 4.59
Monthly

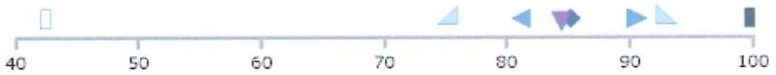


Distribution of Trusts for Staff Sickness

Bed Occupancy **Rate**
10/2009 - 07/2012 84.46
Quarterly

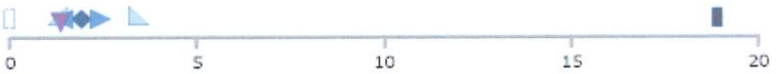


Distribution of Trusts for Bed Occupancy



Nurses to Bed Ratio **Ratio**
11/2011 - 10/2012 1.38
Monthly

Distribution of Trusts for Nurses to Bed Ratio



Doctor to Patient Ratio **Ratio**
11/2011 - 10/2012 0.15
Monthly

Distribution of Trusts for Doctor to Patient Ratio

APPENDIX 1 c

A&E > 4Hrs

A&E attenders who waited > 4 hours from arrival to admission, transfer or discharge - Data Quality Report

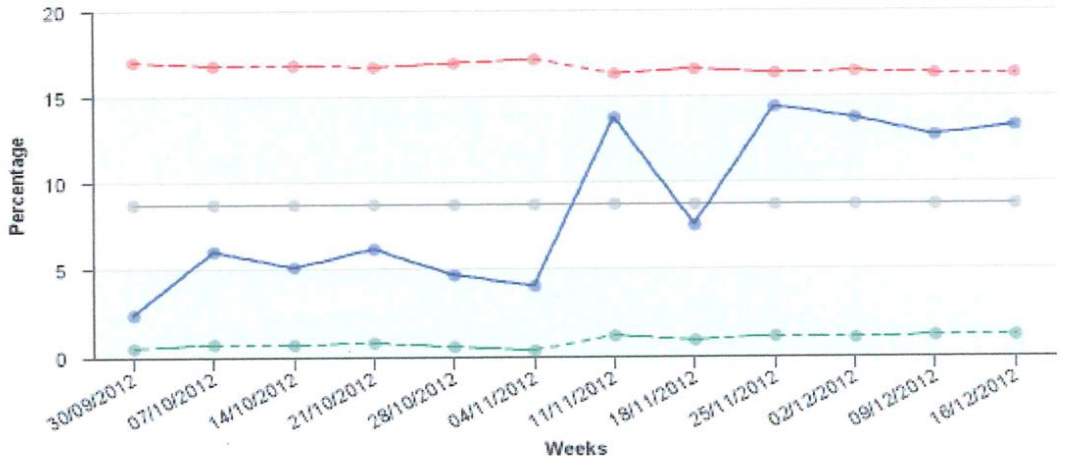
All

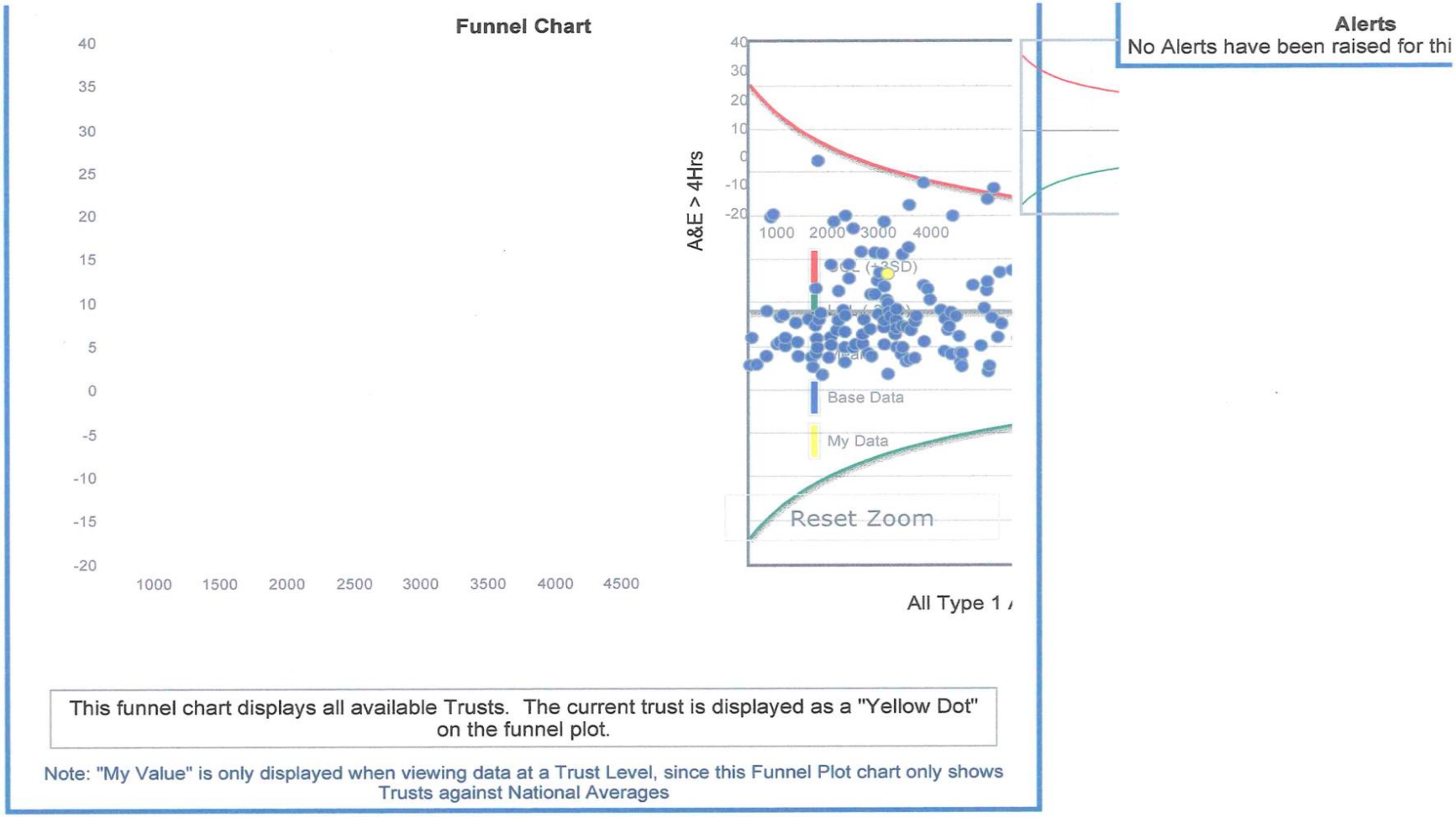
Type Here to Search

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

Trend Data	30/09/2012	07/10/2012	14/10/2012	21/10/2012	28/10/2012	04/11/2012	11/11/2012	18/11/2012	25/11/2012	02/12/2012	09/12/2
Value	2.43	6.07	5.14	6.20	4.70	4.08	13.79	7.57	14.43	13.77	1
Mean	8.78	8.78	8.78	8.78	8.78	8.78	8.78	8.78	8.78	8.78	
Upper Control Limit (+3SD)	17.04	16.82	16.85	16.74	16.97	17.19	16.35	16.61	16.38	16.48	1
Lower Control Limit (-3SD)	0.51	0.74	0.70	0.81	0.59	0.36	1.21	0.95	1.18	1.08	
A&E attenders who waited > 4 hours from arrival to admission, transfer or discharge	39	99	84	103	75	62	233	128	240	225	
All Type 1 A&E attenders	1,604	1,631	1,633	1,660	1,596	1,521	1,690	1,692	1,663	1,634	1

Trend Chart




Funnel Chart
40
35
30
25
20
15
10
5
0
-5
-10
-15
-20
1000
1500
2000
2500
3000
3500
4000
4500
A&E > 4Hrs
40
30
20
10
0
-10
-20
1000
2000
3000
4000
Base Data
My Data
Reset Zoom
Alerts
No Alerts have been raised for thi
All Type 1 /
This funnel chart displays all available Trusts. The current trust is displayed as a "Yellow Dot" on the funnel plot.
Note: "My Value" is only displayed when viewing data at a Trust Level, since this Funnel Plot chart only shows Trusts against National Averages

Section 3 - NGH Monthly Quality Scorecard and NGH Monthly Quality Scorecard Q3

Introduction

This scorecard includes indicators selected by the Trust or required by our commissioners and by the provider monitoring framework required by the SHA, although further work is required to ensure that the alignment is accurate. The National Quality Dashboard which has recently been released is at a very high level and it is expected that improvement work required will be informed by more detailed Trust specific measures that are selected according to Trust priorities and pressures. These will need to be built in over the coming months. Other performance measures are also to be mandated such as the performance in certain types of surgery by consultant but the details of this are not yet available.

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

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

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

Performance

Of 136 indicators, **49** (**34/15**) are rated as either red or amber status. The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. There are 10 indicators that are rated grey. This is a significant decrease in comparison to Novembers report as the CQUINS and indicators have now been confirmed. The remaining Indicators rated as grey continue to await final agreement or the information is currently not available.

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**5**	**5**	**24**	**2**
Clinical Outcomes	**5**	**1**	**12**	**4**
Patient Safety	**16**	**7**	**24**	**2**
Patient Experience	**8**	**2**	**17**	**2**
TOTAL	**34**	**15**	**77**	**10**

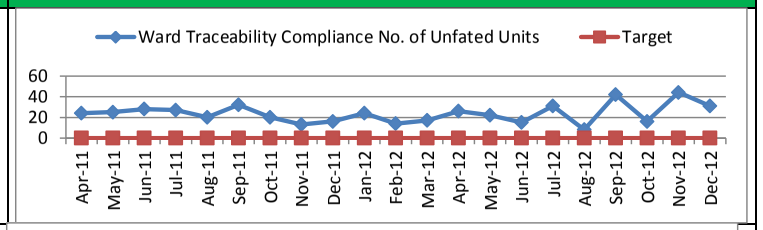
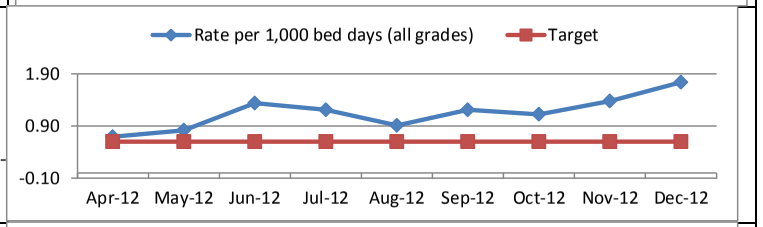
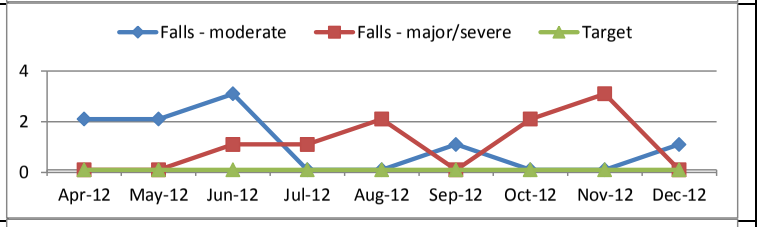
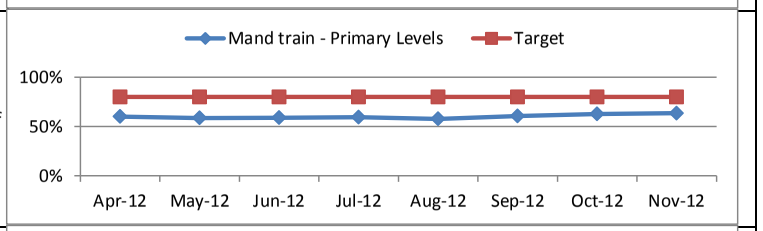
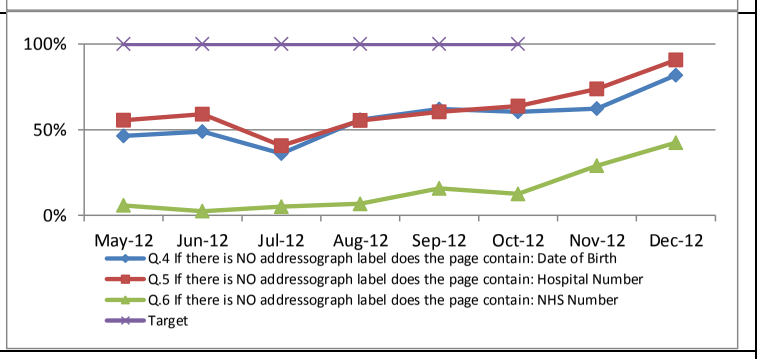
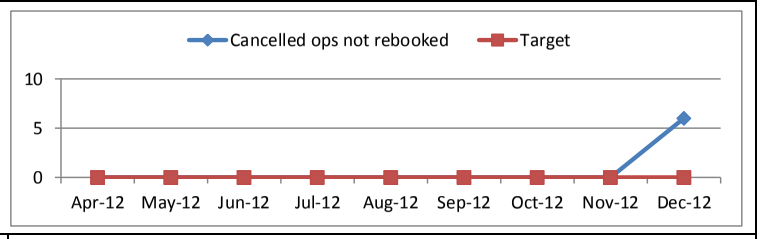
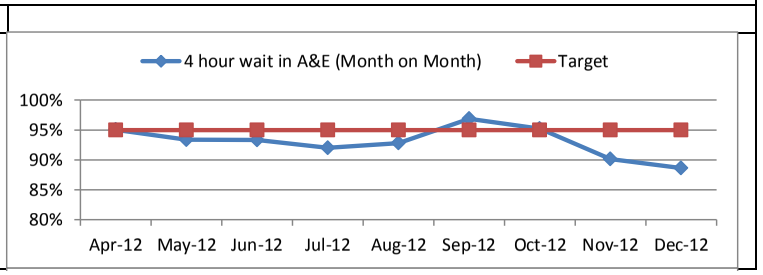
The performance measures rated as red have marginally increased in comparison to November (28/34) whist the performance measures rated as green has significantly increased (61/77).

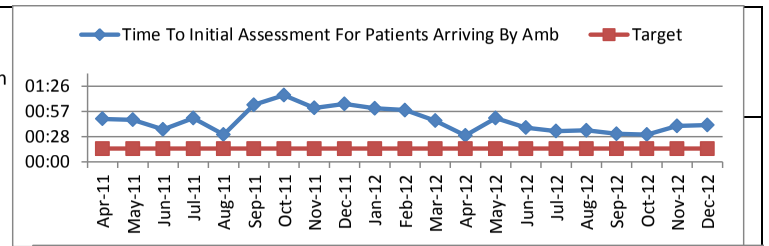
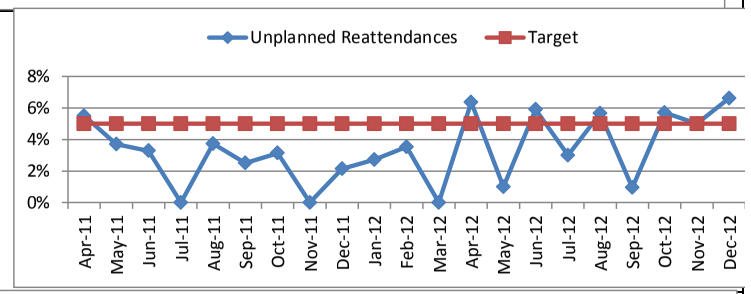
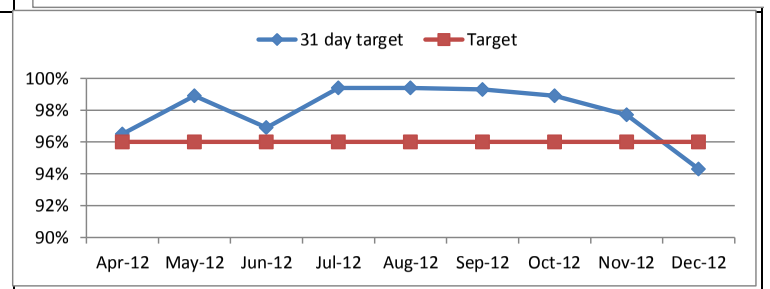
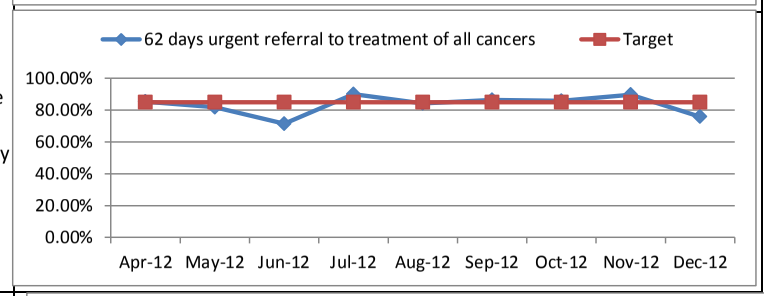
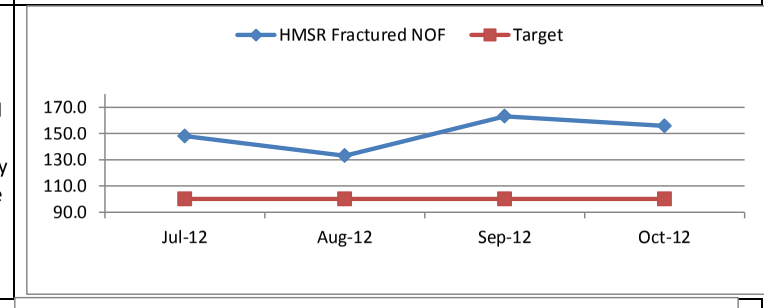
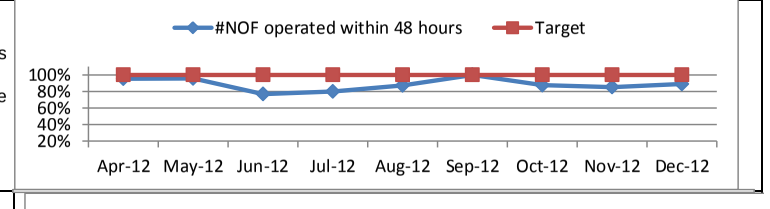
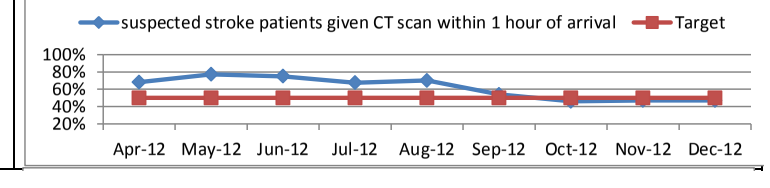
The unmet Cancer wait times and cancelled operations not rebooked within 28 days can be attributed to complex patient pathways and significant emergency pressures coupled with the lack of inpatient ITU/HDU beds.

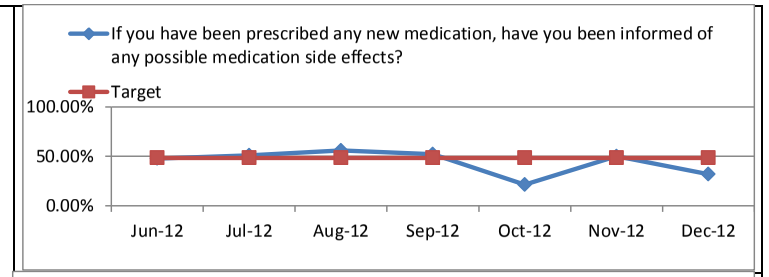
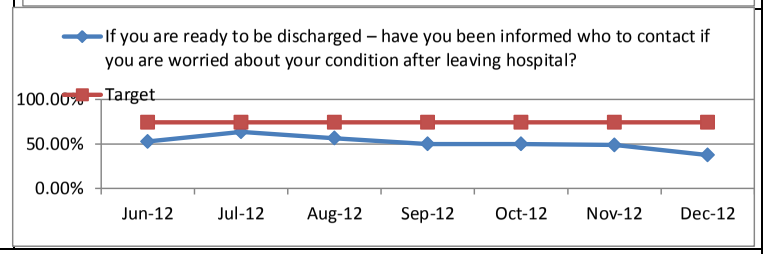
There is a detailed improvement plan that will be rolled out across the Trust during the next 6 months to address the increase in avoidable pressure ulcers.

Recommendation

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

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Un-fated Units	0	↑	Ward Traceability Compliance Number of Un-fated Units - There were 10 unfated units & 4 presumed transfused from the same case which involved major haemorrhage - it is unusual to have so many unfated units from the same case. In Decemebr 7 unfated units from the haem unit was related to a broken wrist band printer therfore the team could not use the electronic system. Thr number of unfated units tends to increase kn the winter months as generally we transfuse more patients. All satff involved have been made aware of the consequence of their lack of action.	
Patient Safety	Incidence of Pressure Ulcers Rate per 1,000 Bed Days (All Grades)	0.6	↓	Incidence of pressure ulcers - the target rate of pressure ulcers remained un-met in December with 1.74 pressure ulcers per 1000 bed days vs a target of 0.6. With the return of the TVN there has been an increase in training, raised awareness and increase in reporting of all Pressure Ulcers which can been seen in the graph. Out of the grade 3 pressure ulcers one was unavoidable and there was one grade 4 pressure ulcer that was also unavoidable. There is a detailed Improvement Plan that will roll-out over the next 6 months to reduce the number of avoidable pressure ulcers across the trust.	
Patient Safety	Reduce harm from falls Moderate/Major/Severe	0	↑	There has been improvement during the year with regards to the number of moderate/major and severe falls which is reflected in the rolling data for the year. However there has been 1 fall in the moderate category for December. There were 0 falls in the major/severe category in December compared to 3 in November.	
Patient Safety	Mandatory Training complaince	80%	↑	Mandatory Training compliance for Primary Levels has improved slightly in recent months, but continues to be below target at 64%. It is the manager's responsibility to ensure their staff are in date with their mandatory training and to support this, reports are sent out monthly stating the staff who are in date and those that are out of date. The reports also show which staff will be going out of date with the named course within the next 3 months, which can help to plan shifts around training. The Mandatory Training Leads ensure that there are enough places available for the number of staff and are looking at introducing different ways to deliver training eg workbook and DVD.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↑	The key issues identified on the Healthcare Notes audit in December were around the recording of vital patient information (date of birth, hospital number and nhs number) on the front page of notes where the addressograph was absent. The recording of this informationremains below the target although has improved significantly since the start of the audit, bearing in mind that the number of records audited has increased and the percentage of notes with an addressograph has also significantly improved. The other areas where the target is not being met are around whether the surname is capitalised, whether the staff designation is recorded, whether the GMC number is present and how alterations/deletions are managed. Evidence of communication to relatives and teams was previously around 70% but this dropped to 34% in December.	
Patient Experience	Cancelled Operations not rebooked within 28 days	0%	↓	This target has been met all year until December when there were 6 cancelled operations not rebooked within 28 days. These were due to significant emergency pressures and lack of inpatient or ITU/HDU beds in November/December. All patients have new TCIs.	
			↓	**A&E Clinical Indicators:** The A&E 4 hour wait target was not met in December, with 89% of patients seen within 4 hours against the 95% target. This was primarily due to significant bed pressures within the Trust relating to winter pressures. The Urgent Care Project Group are focusing on reducing length of Stay by changing processes both internally and wiht external partners to ensure bed occupancy reduces and timely patient flow helps to achieve the transit target.	

Patient Experience	A & E Quality Indicators (5 indicators)		↓	The time to initial assessment for patients arriving by ambulance was 42 mins with the national target being 15 minutes. These figures are currently being revalidated following recent identification of issues around the way the information is captured. When the FIT (Fast Intervention Team) is operational (usually between 11am and 6pm) this target is generally met, but out of hours limited Senior Doctor cover means that the time to initial assessment is increased. A business case is going to SMB shortly for increased clinical staff and workforce development.	
			↓	Unplanned reattendance rate - December performance was 6.62% against a target of 5%. Performance has fluctuated across the year so data validation is being undertaken to ascertain the accuracy of this position. This will include investigation of whether some planned reattendances are being recorded as unplanned. There is also a genuine concern related to patients reattending when they have been unable to access aftercare in primary care.	
Patient Experience	Cancer Wait times		↓	The Trust did not achieve the following two cancer standards: • 62 days from urgent referral to treatment. The Trust achieved 75.4% against the standard of 85%. The Trust achieved 84.5% against the standard of 85% for quarter 3. • 31 days from decision to treat to start of first treatment. The Trust achieved 94.6% against the standard of 96%. The Trust has achieved the quarter 3 performance with 97.3 patients treated within 31days against the standard of 96%. 31 days from decision to treat to start of first treatment During December the Trust achieved 94.6% against the standard of 96% . The Trust however has achieved the quarter 3 position. 62 day standard During December there were an increased number of breaches of this standard. The reasons for the breaches include complex pathways particularly in Head and Neck and Urology, patient choice and cancellations as a result of non-elective pressures during the month. A clinical review of the Urology and Head and Neck pathways is underway and all proposed changes will be implemented immediately and progress monitored at the weekly performance meeting.	 
Clinical Outcomes	HSMR	<100	↑	Mortality for Fractured Neck of Femur is rising in this finacial year, although , some deaths are ocurring in community hospitals and may not be attributable to surgery at NGH. This may be related to performance against the target for patients admitted with #NOF(see below) to be operated on within 48 hours has not been met throughout this year (with the exception of September). Mortality in 2011/12 was as expected. Within a 6 month period the SMR has been rising. A detailed case note review is underway. The directorate have been asked to develop an improvement plan.	
Clinical Outcomes	Patients admitted with #NOF operated on within 48 hours	100.0%	↑	This target has not been met throughout the year with the exception of September. In December 89% of patients admitted with a Fractured Neck of Femur were operated on within 48 hours. A # NOF operating lsit has been implemented for Sundays and Tuesdays which facilaites the abiity to operate daily on all #NOF patients who are fit for surgery. It should be acknowledged 50% of patients who were fit for surgery recieved surgery within 36hours. The directorate continues to monitor this regularly.	
Clinical Outcomes	Suspected stroke patients given CT scan within 1 hour of arrival	50.0%	←	This target has been narrowly missed since October, with 47% of suspected stroke patients given a CT scan within 1 hour of arrival in December against the target of 50%. Consultant medical satff are working closely with Radiology to ensure timely completion of scans especially when only one scanner is working.	

CQUIN	Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)	1. 82.3% 2. 74.3%	↓	There are 5 quality questions as part of the CQUIN. Two of the 5 questions for improving responsiveness to personal needs of patients have returned as under target. These being: 1. If you have been prescribed any new medication, have you been informed of any possible medications side effects? This target was achieved in November following a dip in October, but performance subsequently deteriorated again in December. 2. If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital? (38% in December against a target of 74.3%) These responses are currently collected via the Hospedia system which is in the process of constructive review .	 
CQUIN	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	90%	↓	Performance against the 3 dementia CQUIN indicators appear to have been poor this year to date but this is largely due to data collection/extraction issues. The target of 90% has to be met for 3 consecutive months to receive payment of the CQUIN. Considerable amounts of work has been undertaken to ensure this is achieved for Q4. Improved clinical and data collection processes are being led by a dedicated dementia nurse and performance is expected to improve in January. Validation of December figures is ongoing prior to the submission deadline of December figures at the end of January.	

Corporate Scorecard 2012-13

Patient Safety	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	RAG (based on most recent month)
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	1	0	0	0	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	2	1	3	4	
HQU08: MSSA Numbers	No national ceiling set	1	1	1	1	1	0	2	2	1	
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	1	0	4	2	
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92%	90.0%	
MRSA Screening Elective Patients	100% month on month	99.8%	99.7%	99.8%	99.5%	99.5%	99.9%	99.6%	99.7%	99.4%	
MRSA Screening Non-Elective Patients	100% month on month	95.6%	95.7%	96.4%	96.7%	94.9%	95.3%	96.1%	96.8%	95.8%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	42	16	44	31	
Incidence of pressure ulcers											
Type 3	0	0	2	2	1	0	3	2	2	3	
Type 4	0	1	2	0	0	0	0	0	3	4	
Rate per 1,000 Bed Days (All Grades)	0.60	0.70	0.82	1.34	1.21	0.91	1.21	1.12	1.38	1.74	
Reduce harm from falls											
Catastrophic	0	0	0	0	0	0	0	0	0	0	
Major/Severe	0	0	0	1	1	2	0	2	3	0	
Moderate	0	2	2	3	0	0	1	0	0	1	
Mandatory Training compliance Full Year Impact											
Primary Levels Excluding B&H	80%	60.10%	58.70%	59.00%	59.40%	57.70%	60.60%	62.70%	63.50%	Not Avail	
Attendance at Trust Induction	80%	89.47%	90.70%	76.79%	87.80%	81.40%	85.48%	98.61%	90.82%	Not Avail	
Number of surgical site infections											
Fracture neck of femur - Number of Operations	-	27	29	21	26	53	26	26	36	34	
Infections	-	0	1	0	1	0	0	0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%				1.1%				0%		
Spinal Surgery - Number of Operations	-	Spinal and Vascular Surgery Infection rates monitored from Oct 2012						7	10	7	
Infections	-							0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.7%								0%		
Vascular Surgery - Number of Operations	-							24	20	25	
Infections								0	0	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 4.0%								0%		
Breast Surgery	-	30	40	29	38	30	38	Breast Surgery and Limb Amputations infection rates monitored up until Sept 2012			
Infections		0	0	0	0	0	1				
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.0%					1.0%					
Limb Amputations	-	11	7	10	16	12	7				
Infections	-	0	0	0	0	0	1				
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 3.8%					3.0%					
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc											
Open Central Alert System (CAS) Alerts	0	1	0	0	0	0	0	0	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	84.2%	87%	87.9%	89%	
Serious Untoward Incidents	-	12	3	9	5	4	5	7	5	1	
Never Events	0	0	0	0	0	1	0	0	0	0	
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Healthcare Notes Audit											
Q.1 Does the front page of every sheet contain an addressograph label	100%		57%	67%	77%	71%	77%	73%	68%	79%	
Q.2 Does addressograph include the NHS Number?	100%		99%	96%	95%	86%	90%	90%	93%	88%	
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%		72%	83%	56%	87%	86%	73%	87%	97%	
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%		46%	49%	36%	56%	62%	60%	62%	82%	
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%		56%	59%	41%	55%	60%	64%	74%	91%	
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%		6%	2%	5%	7%	16%	13%	29%	42%	
Q.7 Is record legibly written	100%		93%	98%	97%	92%	99%	98%	97%	99%	
Q.8 Written in blue/black ink	100%		98%	100%	100%	99%	100%	100%	100%	100%	

Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	Audit commenced in May 12	97%	98%	99%	98%	100%	100%	100%	99%	
Q.10 Is date recorded for each entry	100%		73%	86%	89%	91%	94%	89%	93%	91%	
Q.11 Is time recorded for each entry	100%		64%	67%	79%	68%	77%	73%	70%	72%	
Q.12 Is there a signature of the person making the entry	100%		98%	91%	95%	94%	92%	87%	91%	92%	
Q.13 Is surname printed in block capitals	100%		42%	56%	57%	47%	48%	48%	52%	58%	
Q.14 Is the staff designation recorded	100%		37%	44%	55%	42%	47%	50%	55%	50%	
Q.15 Medical Records Audit only: Is the GMC number present	100%		0%	19%	11%	5%	20%	14%	11%	34%	
Q.16 Are any alterations / deletions scored through with a single line	100%		29%	41%	36%	51%	38%	42%	51%	43%	
Q.17 Is there a signature recorded next to any alterations/deletions	100%		19%	33%	15%	33%	33%	26%	37%	27%	
Q.18 Is there a date recorded next to any alterations/deletions	100%		3%	5%	9%	27%	23%	14%	22%	14%	
Q.19 Is there a time recorded next to any alterations/deletions	100%		3%	5%	3%	16%	17%	11%	20%	14%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	Questions not asked until Oct-12						100%	99%	95%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%							76%	68%	34%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%							100%	100%	100%	
Q.23 Are there any loose sheets in the Healthcare record	0%							8%	10%	17%	

Patient Experience	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	RAG
Cancelled Operations not rebooked within 28 days	0	0	0	0	0	0	0	0	0	6	
		5.9%	7.1%	8.9%						Not available until 21st Jan	
Hospital Cancelled Operations	6.0%				5.7%	5.3%	5.8%	7.0%	7.8%		
Number of written complaints received	-	50	51	39	48	33	35	44	40	24	
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	83%	61%	60%	57%	N/Avail	N/Avail	
Referral to Treatment waits											
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.99%	96.34%	96.08%	95.93%	96.70%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.46%	98.44%	98.52%	98.36%	98.48%	
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.53%	97.12%	96.91%	96.85%	96.33%	
A&E Quality Indicators (5 measures)											
Time Spent in A&E (Month on Month)	95%	95.0%	93.4%	93.3%	92.0%	92.8%	96.9%	95.2%	90.1%	88.64%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	93.39%	93.27%	93.87%	94.07%	93.58%	93.04%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	03:59	04:00	06:09	06:18	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:30	00:50	00:39	00:35	00:36	00:32	00:31	00:41	00:42	
Time to treatment decision (median)	<60 mins	00:46	00:54	00:54	00:52	00:42	00:48	00:41	00:46	00:48	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	0.95%	5.71%	5.40%	6.62%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	0.16%	0.18%	0.18%	0.07%	0.25%	0.12%	
Cancer Wait Times											
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%	
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	94.3%	
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%	
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	
31 day second or subsequent treatment - radiotherapy	94%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	97.6%	
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%	
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%	
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	75.9%	
SRS08: Length of Stay (Acute & MH)											
Elective	3.20	3.70	4.1	4.2	4.1	4.2	5	4.4	4	3.8	
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	4.9	4.5	4.2	4.4	
		85.7%	85.0%	85.0%				84.8%	82.0%	Not available until 21st Jan	
SRS09: Daycase Rate	85%				85.7%	86.6%	85.0%				
SQU11: PROMS Scores - Pre Operative participation rates											
Groin Hernia - Participation Rate	Nat.Ave 55.6% (target 80%		42.30%			48.20%			88.6%		
Hip Replacement - Participation Rate	Nat.Ave 78.7% (target 80%		97.40%			91.40%			125.8%		
Knee Replacement - Participation Rate	Nat.Ave 83.6% (target 80%		94.90%			88.20%			95.9%		
Varicose Vein - Participation Rate	Nat.Ave 47.5% (target 80%		31.10%			33.30%			71.4%		
All Procedures - Participation Rate	Nat.Ave 69.7% (target 80%		72.80%			71.80%			99.1%		

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	
HSMR - monthly position for 2012-13	<100	93.7	96.2	98.7	94.0	101	104.1	93.4	Data not yet available		
HSMR - cumulative position current financial year		NA	NA	85.0	95.0	96.1	97.9	98.3			
HSMR- cumulative position for 2012-13											
Pneumonia	<100				47.4	50.2	50.6	49.7			
Fracture of neck of femur (hip)	<100				148.0	133.1	163.1	155.8			
Acute Cerebrovascular disease	<100				86.0	96	104.8	110	Data not yet available		
Congestive heart failure, nonhypertensive	<100				83.7	90.9	114.4	121.4			
Acute myocardial infarction	<100				66.5	76.7	76.4	70.1			
SHMI (based upon date of SHMI report publication)		109.2	109.2	109.2	106.0	106.0	106.0	104.8	104.8	104.8	
SQU12: Maternity 12 weeks	90%	86%	97%	87%	98%	98%	99%	98%	97%	93%	
		3.8%	3.4%	3.0%	3.6%	2.7%	3.2%	3.1%	4.3%	**Not available until 21st Jan**	
SRS10: Delayed Transfers of Care – Acute & MH	3.0%										
Fractured neck of Femur											
Number of patients admitted with FNOF	-	27	30	21	26	52	26	26	36	34	
Patients fit for surgery within 48hrs	-	21	23	13	25	47	22	24	34	27	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	22	21	29	24	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	100%	87.5%	85.3%	88.9%	
Cardiac Arrests (Numbers)											
Peri Arrests (Numbers)											
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	80%	85%	93%	89%	100%	
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	68%	77%	75%	67%	70%	54%	46%	47%	47%	
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	95%	100%	96%	97%	97%	83%	100%	100%	100%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hour	60%	68.0%	75.0%	90.9%	71.4%	95.8%	76.0%	68.0%	88.9%	72.7%	
Patients who spend at least 90% of their time on a stroke unit	80%	100.0%	95.6%	96.7%	98.6%	92.6%	93.3%	88.5%	86%	84.0%	
Breast Feeding initiation	75%	98.0%	97.0%	96.0%	96.0%	96.0%	100.0%	99.3%	99.7%	74.9%	
Caesarean Section Rates - Total	<25%	25.1%	25.6%	27.1%	25.1%	28.5%	26.9%	26.5%	29.3%	24.1%	
Caesarean Section Rates - Emergency	14.98%	12.1%	11.0%	11.2%	9.8%	13.3%	13.7%	9.4%	14.91%	11.1%	
Caesarean Section Rates - Elective	10.06%	13.6%	14.6%	15.9%	15.3%	15.2%	13.8%	17.1%	14.4%	13.1%	
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.4%	6.8%	4.4%	4.5%	7.5%	

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	RAG
National CQUINS											
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	91.4%	91.4%	90.3%	93.0%	90.7%	91.7%	92.5%	92.0%	90.0%	
1b. High risk patients receive appropriate treatment *(inadequate volume of data Q2)*	95% Month on month	98.3%	93.1%	88.7%	98.0%	100.0%	96.1%	98.6%	97.3%	98.7%	
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)								Internal assurance results			
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	Not Avail	Not Avail	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	Not Avail	Not Avail	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%	
Did you have enough privacy when discussing condition or treatment?	>82.3	Not Avail	Not Avail	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%	
If you have been prescribed any new medication, have you been informed of any possible medication side	>48.5	Not Avail	Not Avail	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your	>74.3	Not Avail	Not Avail	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting											
a) Dementia case finding	90%							7.1%	2.4%	0.3%	
b) initial diagnostic assessment	90%				Review and validation of data required			0.0%	0.0%	0.0%	
c) referral for specialist diagnosis	90%							0.0%	0.0%	0.0%	
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a	-										
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG	Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.									
Regional CQUIN											
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%	12.0%	15.3%	10.1%	14.3%	15.0%	14.8%	
2, Board and Commissioner reporting	Submission to HCG					Submitted to HCG					
3. Weekly reporting	-		Target from Q2				Weekly reports submitted from Hospedia				

4. Performance improvement by 10 points from July 2012 position	10 point improving	-	29.98	-	30.86	0.42	70.10	56.83	74.08	76.33	72.53	67.65
Local CQUINS												
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	50% adoption by Q4				Baseline audit undertaken					Repeat audit in progress		
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	65% for Q3, 75% for Q4				Baseline audit undertaken (59%)					60%	68%	N/Avail
2b. Appropriate referrals to CECs/ Intermediate service from A&E					Baseline audit 50 cases in Q1 - follow up meeting undertaken but no representation from commissioners, discussions ongoing							
3a. Accuracy of medicines information on discharge	75% error free				Q4 primary care audit, internal assurance programme being formalised							
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	TBC				Q4 audit currently being undertaken in Rheumatology and Pain clinic.							
3c. Oral nutritional supplements (ONS) - reduce the use of ONS	50% reduction between Q1 and Q4				Data extraction and validation underway for Q1 - 3							
3d. Triptorelin	Q3 - 70% compliance, Q4 - 80% compliance		Q1	Not applicable.		73%				71%		
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal				Project plan submitted quarterly to commissioners.							
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care				Project plan submitted quarterly to commissioners.							
MESCG CQUINS												
1. Quality Dashboards	-											
Identify and provide contact details of the following:												
- an overall dashboards lead for the Provider					Head of Information & Data Quality							
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-				Clinical Directors							
Provide a summary setting out the plans for implementation of the dashboards within the required timescale					4 out of 5 national data entry toolkits released in December, 5th due in Quarter 4. Work ongoing to populate.							
3. Use of Intensity Modulated Radiotherapy	33%			Q1 = 9%			Q2 = 22%			Q3 = 52%		
4a. Cancer Chemotherapy Performance Status	90%		91.7%	93.3%	99.2%	95.1%	95.5%	96.8%	93.9%	96.0%	95.8%	
4b. Cancer Chemotherapy Performance status 2 or above	100%		-	-	100%	100%	-	100%	-	-	100%	
4c. Improve appropriate assessment and Improve mortality rates												
Number of Oncology patients deaths within 30 days of receiving chemotherapy	-		1	0	1	1	2	1		4	Data not	
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy	-		0.10%	0.00%	0.21%	0.18%	0.35%	0.20%		1.31%	available	
Number of Haematology patients deaths within 30 days of receiving chemotherapy	-		0	0	0	0	1	0		1	until Feb	
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy	-		0.00%	0.00%	0.00%	0.00%	2.12%	0.0%		1.3%	2013	
5. Hepatitis C. Compliance with treatment / improved patient outcomes	Audit undertaken					Quarterly audit undertaken						
7. Reduction of catheter - related CONS	7% Baseline 2011-12		0%	0%	0%	0%	0%	0%	0%	0%	0%	

TRUST BOARD 31st January 2013	
Title: -	Patient Experience
Presented by: -	Suzie Loader, Director of Nursing, Midwifery and Patient Services

PURPOSE OF PAPER: -

To inform the members of the Board of the actions taken in response to Patient Experience feedback received during December 2012.

CRITICAL POINTS: -

- Friends and Family Test (FFT) Scores for December 2012
- Preliminary results from the National Inpatient Survey
- A&E pilot FFT scores for first 3 weeks
- CQUIN quality results
- Trust response to patient experience feedback
- Patient Experience Care Group Leads appointment timescale

ACTION REQUIRED BY BOARD: -

The Board are requested to: -

- Note and challenge the content of the report
- Endorse the work being taken forward to create a customer service culture across the organisation

PATIENT EXPERIENCE

1. Introduction

The purpose of this report is to: -

- Inform members of the board about patient experience activities in place across the trust
- Share actions taken to implement a Customer Service culture across the organisation.

2.0 Patient Experience monitoring

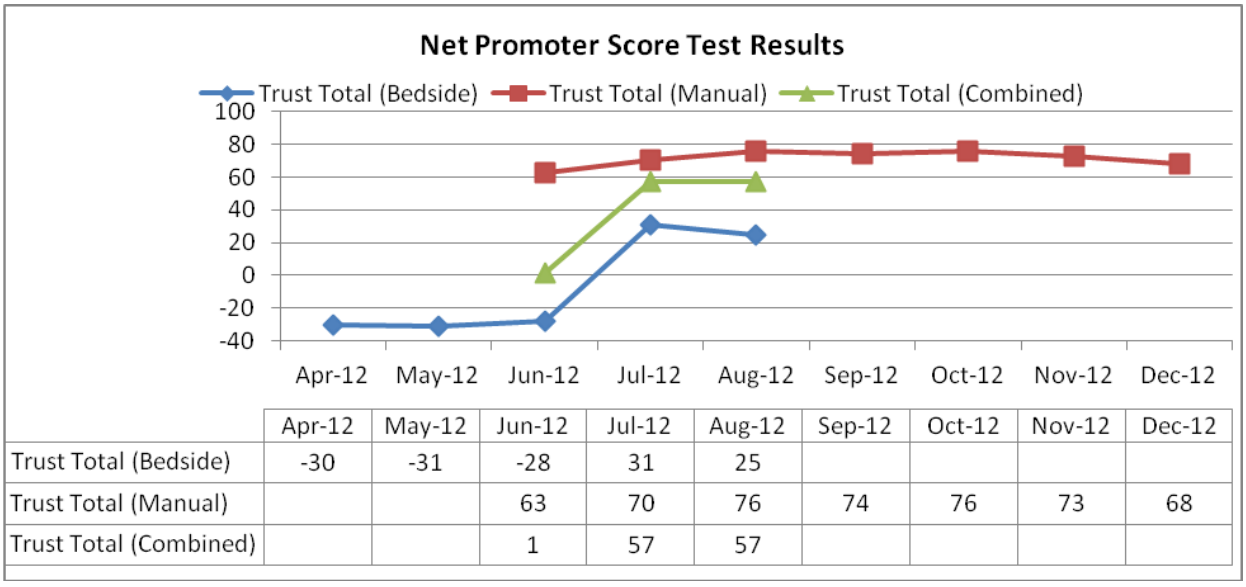
2.1 Friends and Family Test

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

2.2 FFT Results: December 2012

The manual collection of the Friends and Family Test continues to elicit positive patient experience results which are demonstrated in the table below. The FFT score received for the month of December was 68. This is a significant reduction from the November figure of 73. Action plans have been requested from all areas which scored below 70, with the aim of achieving a score of 80 by March 2013. (please see Appendix 1 with scores by ward area)

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



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Trust Total (Bedside)	-30	-31	-28	31	25				
Trust Total (Manual)			63	70	76	74	76	73	68
Trust Total (Combined)			1	57	57				

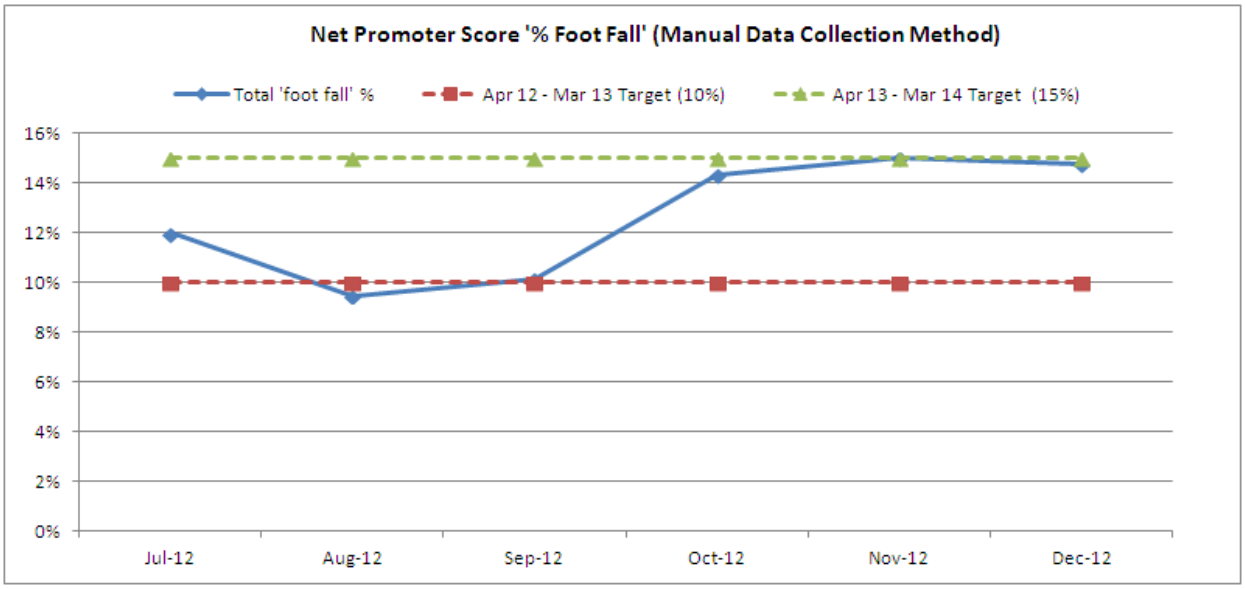
FFT Manual data collection

5484 patients were discharged from Northampton Hospital in December 2012 of which, 14.8% responded to the FFT question (this is above the 10% target for this year but below the 15% required for 2013/14). From April 2013, every patient discharged from every NHS Trust is expected to be questioned, with the minimum response rate increasing to 15%. Comments received from these patients were circulated to Ward Managers. Actions taken as a result of these comments are included in the "You said we did" comments on the Patient Quality Board located within ward areas.

It has been agreed, that in an attempt to achieve the prerequisite 15% from April 2013 onwards, the internal stretch target will be set to 20%, to enable the Trust to have an appropriate flex in the FFT outcome to meet the target overall.

In addition, the Patient Experience Lead is visiting all wards who are not meeting the data collection target to help in identifying how to improve the score, facilitating development of action plans to improve the score in readiness for the 2013/14 target.

Table 2 : Percentage of discharged patients who responded to the FFT question("% footfall") – target is over 10%



FFT results from the Emergency Department (A&E)

Asking patients whether they *"Would recommend the A&E department to friends and family if they need similar care or treatment"* is a recent concept from the department of Health. All NHS organisations with an Emergency department will collect this data from 1 April 2013.

A pilot collection commenced in A&E from 1 December 2012. To date we have received responses from 28 patients in a three week timeframe, from a total of 3,050 patients attending but not admitted to the department. The percentage responding has ranged from 0.38% and 1.5% of the total attending with a net promoter score at the end of December of 25. An action plan is in place to increase the percentage responding and net promoter score up to the 15% and 80 by March 2013. It is appreciated that the trial is in its infancy and it has been a busy Christmas and New Year period, however, the score needs to significantly improve. The department are looking into SMS messaging and have also included alerting patients via the power point information presentations which run as a loop in the department.

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

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

Progress against the targets set for each question is monitored monthly in the Trust and quarterly by Northamptonshire Commissioners as the financial value attached to this CQUIN is £251,000. At the end of September it was evident that we are failing to reach two of the five targets. The questions were: -

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

The actions being taken to improve this are part of the ward action plans for improving the patient experience and that ward sisters and matrons are putting in place a standardised process for discharge to include contact numbers. The issue of privacy and dignity is being reviewed by wards in 2 ways: questionnaire and highlighting to staff the importance of always reviewing the environment, prior to having confidential discussions about the patient's condition or treatment.

Interim results from the national adult in-patient survey 2012.
The interim national adult in-patient survey results were forwarded to the Trust in November. Of a total of 850 surveys sent out, there was a response of 444 which equates to a 54% overall response rate. The final results of the survey will be confirmed in early 2013 and sent out by the Care Quality Commission(CQC). The CQUIN payment is predicated on an improvement of these results compared with the baseline results of 2011/12. The Trust is required to maintain or improve upon the scores and this will attract the following payments based on the 5 CQUIN questions:

2 out of 5 indicators = 25% payment
3 out of 5 = 50% payment
4 out of 5 = 75% payment
5 out of 5 = 100% payment
Any other result will result = 0 payment

The trust routinely monitors responses to these questions and there appears to be a discrepancy between the real time survey results (collected via Hospedia whilst the patient is still an inpatient) and the posted National survey results. The reason for this is because the postal survey is posted to patients up to four weeks after their period of hospitalisation and could be described by some as a 'historical' survey. The internal assurance results are collected whilst the patient is hospitalised from the bedside unit and is perceived as a real-time perspective of the patient experience.

The results received in November show that there are a number of areas where we need to improve our scores and other areas where we are performing in the upper centile. We received a score < 50% in the following areas:

- How would you rate the hospital food?
- Were the side effects of medicines to watch for when home explained ?
- Did you see/were you given any information explaining how to complain about care received?
- During your stay, were you ever asked views on quality of care?

And above target (>90% positive response) for the following:

- After moving ward, was it to a mixed sex room or bay?
- Were you given enough privacy when being examined/treated?
- Did you ever feel threatened by other patients/visitors?
- Were hand washing gels available for patients and visitors to use?
- Was the specialist you saw given all condition/illness information by the person referring you?

The table below demonstrates the interim patient experience CQUiN results against the internal assurance results.

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

CQUIN 2012-13	Target 2012-13		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)		Interim National Results (Nov 12)			Internal assurance results						
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	73%	Not Avail	Not Avail	69.7%	78.0%	63.2%	74.6%	79.2%	72.0%	72.4%
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	53%	Not Avail	Not Avail	74.9%	84.0%	66.6%	83.2%	82.5%	76.2%	84.9%
Did you have enough privacy when discussing condition or treatment?	>82.3	85%	Not Avail	Not Avail	73.8%	81.0%	73.1%	81.5%	85.0%	86.4%	87.0%
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5	43%	Not Avail	Not Avail	47.8%	51.0%	55.9%	52.2%	21.4%	50.0%	32.0%
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3	72%	Not Avail	Not Avail	52.7%	63.6%	56.5%	50.0%	50.0%	48.8%	37.5%

Actions to improve the CQUIN results

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

These questions were originally located on the Hospedia Bedside Unit. It is proposed that some patients may have been completing them prior to the day of discharge, which would mean they would not be able to respond to the last two questions. These five CQUIN questions have been added to the Friends and Family Test manually collected questionnaires to increase the number of patient responses at the point of discharge. A comparison will be undertaken between those responses collected manually and those collected on Hospedia.

As part of a concerted focus on the medication agenda the ward teams have been advised about the importance of explaining new medications and their side effects to patients. This

action is repeated by the ward pharmacist as they perform their daily rounds where appropriate. It was noted that many of these conversations take place on discharge when nurses are dispensing 'take home' medications and an effort is being made to have these conversations with patients earlier.

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

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

4.0 Trust responses to Patient Experience feedback

4.1 Local Day Case survey results

Results of the local day case patient survey were received in December. 450 patients (50.1%) returned their questionnaires and overall the results were very positive with minor actions to be implemented. Heads of Departments received the survey results to share within their area and are developing local action plans.

4.1. 2 Areas of good practice

The areas of good practice are illustrated below

Confidence in care

- Overall, 90% rated their care as very good or excellent.
- Patients report high levels of confidence in doctors and nurses treating them

Privacy and dignity

- Most patients felt feeling they were treated with respect and dignity, kindness and understanding.
- The Trust scores well on privacy for patients when they are being examined or treated.

Cleanliness and hygiene

Scores are also good on cleanliness of the hospital ward or bay, especially relating to hygiene and the use of hand wash gels by staff, coupled with high levels of patient awareness of hand wash gels.

Mixed sex accommodation

- Scores on mixed sex accommodation have improved. Of the 6% of patients who were admitted to a mixed sex bay, only 3% state that they were moved to a mixed sex bay whilst an in-patient.

4.1.3 Areas for improvement

Opportunities to discuss care and treatment pre and post –operatively

- Although patients report high levels of confidence in doctors treating them, the opportunity to discuss their care and treatment with the doctor could improve - especially before an operation or procedure with regard to how they could expect to feel afterwards.
- Information to patients after their procedure or operation on how it had gone could improve, with clearer detail given on who to talk to in the hospital if they had any worries or fears.

Medication side effects

- More explanations are needed of any medicine side-effects with only 44% feeling completely informed, and 30% only informed to some extent or not at all.

Discharge information

- Information on discharge could improve with 24% of patients reporting not receiving any printed or written information about what they should or should not do after leaving hospital
- Similarly for information on danger signals to watch for once home with 46% feeling completely informed, and 29% only informed to some extent or not at all.
- Overall, 11% of patients felt their discharge was delayed. Of these, 20% waited more than 4 hours with 56% delayed waiting for medicines.

Specific advice was suggested by the researchers that wards should consider notifying the pharmacy about delays; reviewing systems for ordering and dispensing medicines; warning patients in advance that there may be a wait for medicines; allowing patients to return to pick up medicines if appropriate.

A Trust wide multi-disciplinary approach to improving discharges is required and will be discussed with Senior Nurses across the organisation.

4.2 Patient Experience Implementation plan appointment of Patient Experience Clinical Leads

The Patient Experience Implementation plan is monitored by members of the Patient Experience Board. The recruitment process for two Patient Experience Leads (one from each Care Group) and the nomination of Patient Experience Champions representing Directorates was agreed at the meeting. The advert for nominations to the Lead roles will be sent out on the 23rd January, applications with supporting statements based on the role description will close on the 6 February, shortlisting by the 12 February, interviews to held in the week beginning the 18 February and Leads to commence this work on 1 March 2103.

4.3 Patient Experience Strategy Launch

The Patient Experience Strategy was launched on 3 December 2012, with the keynote speech being given by Joanna Goodrich from the Kings Fund. Presentations reflected the vision of the Patient Experience strategy and two patient's stories were well received by the audience.

4.4 Patient information: Listening in Action subgroup

A Listening in Action (LIA) Task and Finish Group met twice in November and December. Four public and patient representatives were actively engaged as members of this group and included representatives from Northampton Institute for the Blind, Northampton Deaf Connect and hospital governors. The aim of this subgroup was to establish existing practice and offer recommendations to improve hospital letters, signage and patient information. A progress report was submitted to the sponsor group on 30 December 2012.

4.5 East Midlands Patient Experience Survey

176 patients admitted to Northampton Hospital for a Patient Reported Outcomes Measure (PROM's) procedure from 1 October - 31 December 2011 were requested to complete the East Midlands Patient Experience questionnaire. 124 patients (70%) responded to the survey which closed on 20 April 2012. Their responses offered an insight into the following categories: -

- The hospital and ward

- Doctors and nurses
- Care and treatment
- Operations and procedures
- Leaving hospital

Each question was the same or similar to the validated questions in the annual national adult in-patient survey. The questionnaire was reviewed by Northampton PCT (Commissioners) and they requested that action plans were developed to address the questions that yielded a response less than 70%.

The following areas scored below 70%.

- Rating of cleanliness of toilets and bathrooms
- Perceptions of, or increase in the numbers of Doctors washing or cleaning their hands between touching patients is improved
- Perceptions of/ or increase in the number of nurses washing their hands between touching patients
- Number of nurses knowing about the patient's medical condition and history
- Patient's have access to someone on the hospital staff to talk to them about their worries and fears
- Family or someone close to the patient has enough opportunity to talk to a doctor if they wished to
- Members of staff available to explain test results
- Patients having an operation told how they could expect to feel afterwards
- Patients informed about medication side effects to watch out for when they went home
- Patient's informed about danger signals to watch for after they went home
- Patient given clear written or printed information about their condition and treatment

The action plan developed to address these areas is completed. It was shared with the Commissioners in December and copies are available from the Patient Experience Lead.

5.0 Conclusions

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

6.0 Recommendations

Members of the Board are requested to challenge the content of the report and support the actions defined.

Appendix 1

Family and Friends Test: Manually Collected Results by Ward December 2012

Last Ward Name	Total Inpatient Discharges	No of Manual responses	Percentage responding (target 10%)	Score Target 80
			% responses	Net Promoter Score
ABINGTON WARD	76	33	43.42%	70
ALLEBONE WARD	81	13	16.05%	-8
ALTHORP WARD	19	7	36.84%	71
BALMORAL	239	157	65.69%	69
BECKET WARD	92	34	36.96%	68
BENHAM WARD	244	32	13.11%	41
BRAMPTON WARD	42	10	23.81%	70
CEDAR WARD	95	28	29.47%	50
COLLINGTREE - MEDICAL	127	11	8.66%	81.8
COLLINGTREE - SURGICAL	54	16	29.63%	75
COMPTON	22	17	77.27%	88
CORBY COMMUNITY	21	15	71.43%	87
CREATON WARD	69	11	16%	64
DISNEY WARD	203	33	16.26%	82
DRYDEN WARD	136	40	29.41%	80
ELEANOR WARD	67	12	17.91%	92
EMERGENCY ASSESSMENT UNIT	250	21	8.40%	67
FINEDON WARD	54	21	38.89%	67
HAWTHORN WARD	223	49	21.97%	65
HAZELWOOD WARD, ISEBROOK HOSPT				
HEAD AND NECK WARD	125	24	19.20%	92
HOLCOT STROKE UNIT	33	7	21.21%	100
KNIGHTLEY WARD	48	18	37.50%	72
PADDINGTON WARD	491	39	7.94%	33
ROBERT WATSON - MOTHERS	179	55	30.73%	69
ROWAN WARD	169	42	24.85%	62
SPENCER WARD	224	18	8.04%	89
TALBOT BUTLER WARD	130	16	12.31%	63
VICTORIA WARD	81	8	9.88%	50
WILLOW WARD	75	16	21.33%	94
Non-applicable wards	1787	0	0%	
Total	5484	810	14.77%	68

TRUST BOARD 31st January 2013	
Title: -	Monthly Infection Prevention Performance Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC

PURPOSE OF PAPER: -

To update the Board on infection, prevention and control within the hospital for the months of November and December 2012.

CRITICAL POINTS: -

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

ACTION REQUIRED BY BOARD: -

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

January 2013 Infection, Prevention & Control Report

1. Introduction

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

2. MRSA Bacteraemia

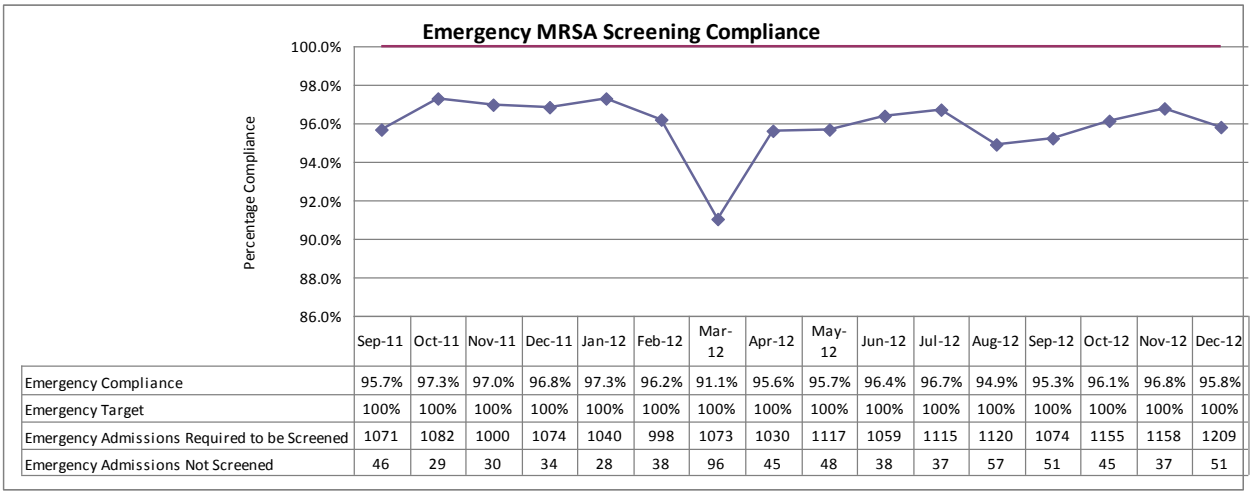
The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. During November and December there were **0 >48hrs** MRSA bacteraemia. The total remains at 2 cases.

The **1 <48hrs** MRSA bacteraemia was confirmed from a client residing in a nursing /care home where the Trust rents the beds for patients who are medically fit for discharge. This client was in the care home for 35 days before being admitted back to the Trust. On admission a blood culture was taken which grew MRSA. The Trust is conducting a joint investigation with the home as the client was still under the care of an NGH consultant. However, the home is responsible for all other aspects of care, and has a statutory responsibility to adhere to the CQC standards. The findings from the root cause analysis (RCA) meeting will be reported in the February board report.

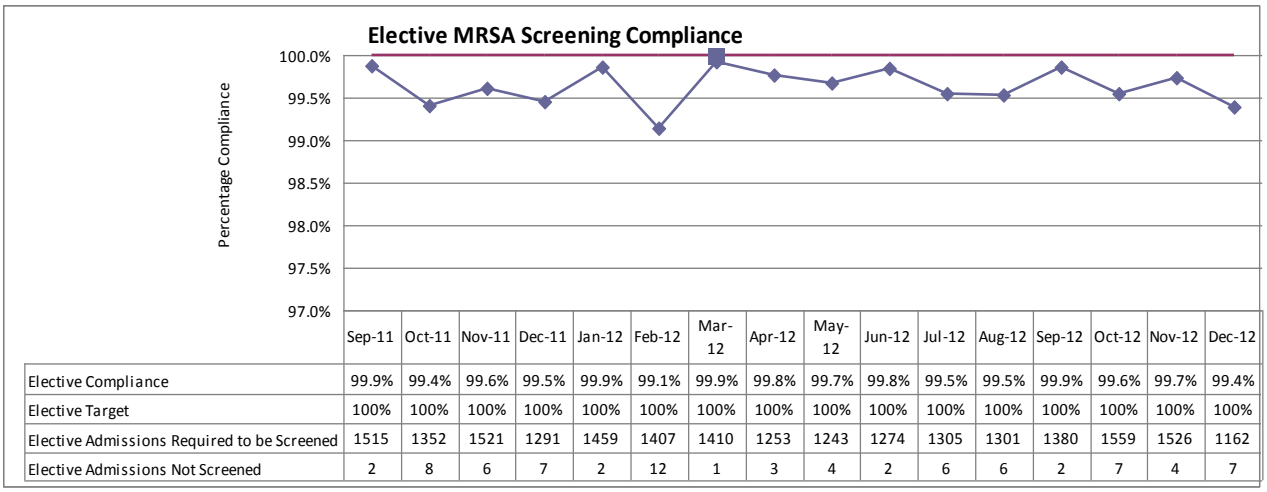
3. MRSA Colonisation & Screening

During November there were 11<48hrs and **2>48hrs** and in December 12 <48hrs and **5>48 hrs** cases of MRSA colonisation.

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



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



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

Special Measures - MRSA

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

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

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

Willow ward was put onto Special Measures for 3 post MRSA colonisations in December. As a result of the special measures process, it was highlighted that the MRSA screening process could be improved. Patients were not being screened on admission, only after 48 hours resulting in post colonisation. The clinicians were not completing the MRSA decolonisation prescription chart and it was also highlighted that the radiators were very dusty. The ward manager spoke to another ward who are doing very well with elective screening of patients and has adopted their processes. She will feed back progress at the Infection Prevention Committee in February 2013.

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

During November there were 5 <48hrs and **1 >48hrs** MSSA bacteraemia case on Allebone.

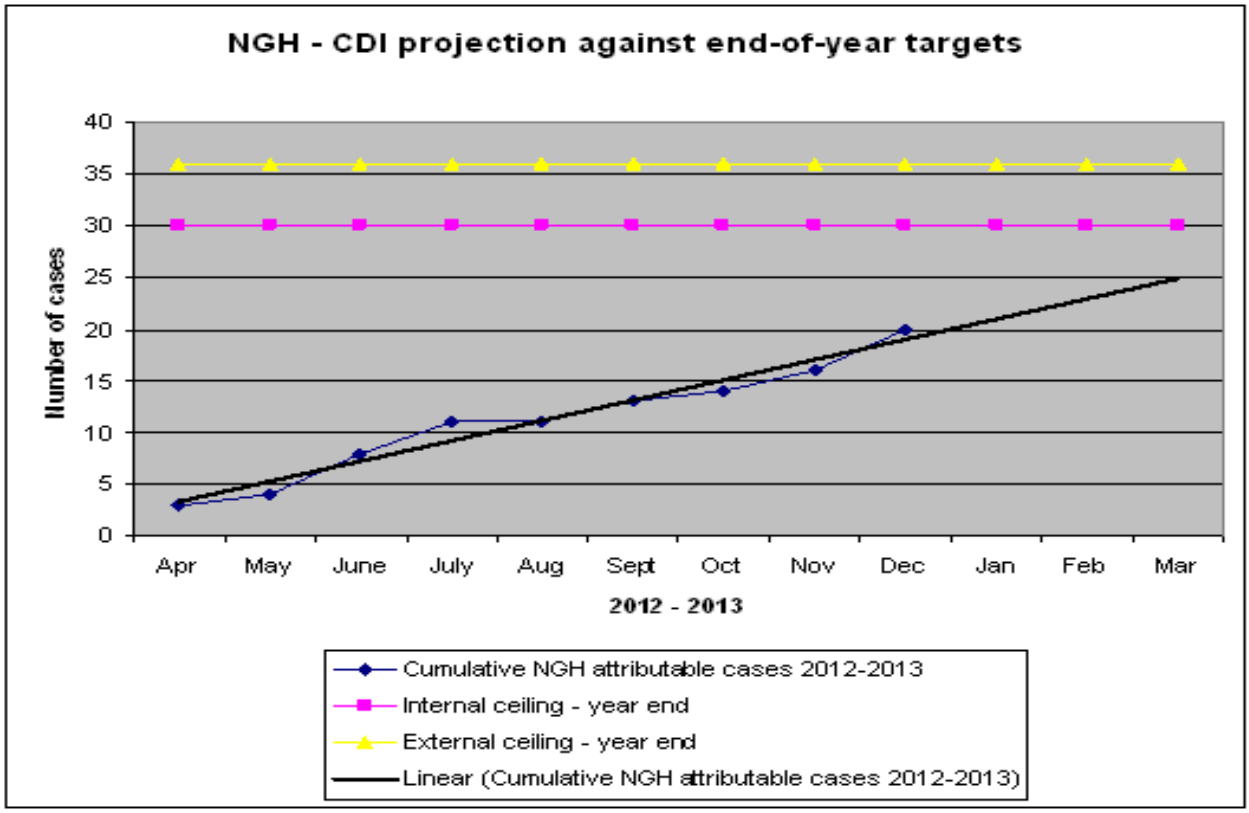
The **Allebone** ward RCA investigation meeting was held on 12th November and actions taken to prevent a re-occurrence were identified, which includes improving compliance with the Peripheral Vascular Cannula (PVC) documentation.

During December there were 1<48hrs and **1>48hrs** MSSA bacteraemia cases. This case was on **Eleanor** and a RCA investigation meeting was help on the 20th December. Unfortunately no clinician attended, so a further meeting has been arranged for January. This will be reported in the February board report.

Clostridium difficile

The Trust has an annual target of 36 C. diff. cases (3 per month) or less for the financial year. During November ***3>3 day case of C. diff*** and during December ***4>3 day cases were*** identified**,** which totals 21 >3 day cases of C. diff for the year, which is slightly below

trajectory; however, we are continuing into the winter months when the cases of C diff tend to escalate.



In November Willow was put on special measures due to 2 post CDAD, however on ribotyping (this denotes whether there is cross infection) 1 case was found to be a false positive.

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

5. Surgical Site Infection Surveillance Scheme (SSIS)

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

Surgical Site Infection Surveillance

Background

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

The **interim** results for November 2012

- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from 36 operations

- Vascular surgery show that there were ***no infections*** resulting from 20 operations
- Spinal surgery operations show that there were ***no infections*** resulting from 10 operations

The **interim** results for December 2012

- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from 34 operations
- Vascular surgery show that there were ***no infections*** resulting from 25 operations
- Spinal surgery operations show that there were ***no infections*** resulting from 7 operations

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

Health Protection Report received January 2013

During Quarter 2 of 2012-13, surgical site infection surveillance was completed for repair of fractured neck of femurs (NOFs), limb amputations and breast surgery.

The HPA has now reported on the surveillance and the results are as detailed below:

July	Breast Surgery Limb amputations #Neck of Femurs	Breast surgery 39 Limb Amputations12 #Neck of Femurs 24	0 0 1	0% 0% 3.8%	HPA report Received January 2013
August		Breast surgery 29 Limb Amputations 13 #Neck of Femurs 46	0 for all	0% 0% 0%	
September		Breast surgery 37 Limb Amputations 8 #Neck of Femurs 20	1 1 0	2.7% 12.5% 0%	
Q2 TOTAL		Breast surgery 105 Limb Amputations 33 #Neck of Femurs 90	**1** **1** **1**	**1.0%** **3.0%** **1.1%**	**National averages** Breast surgery **1.0%** Limb Amputations **3.5%** #Neck of Femurs **1.6%**

The Trust continues to be at or below the national average for infections in all three surgical categories.

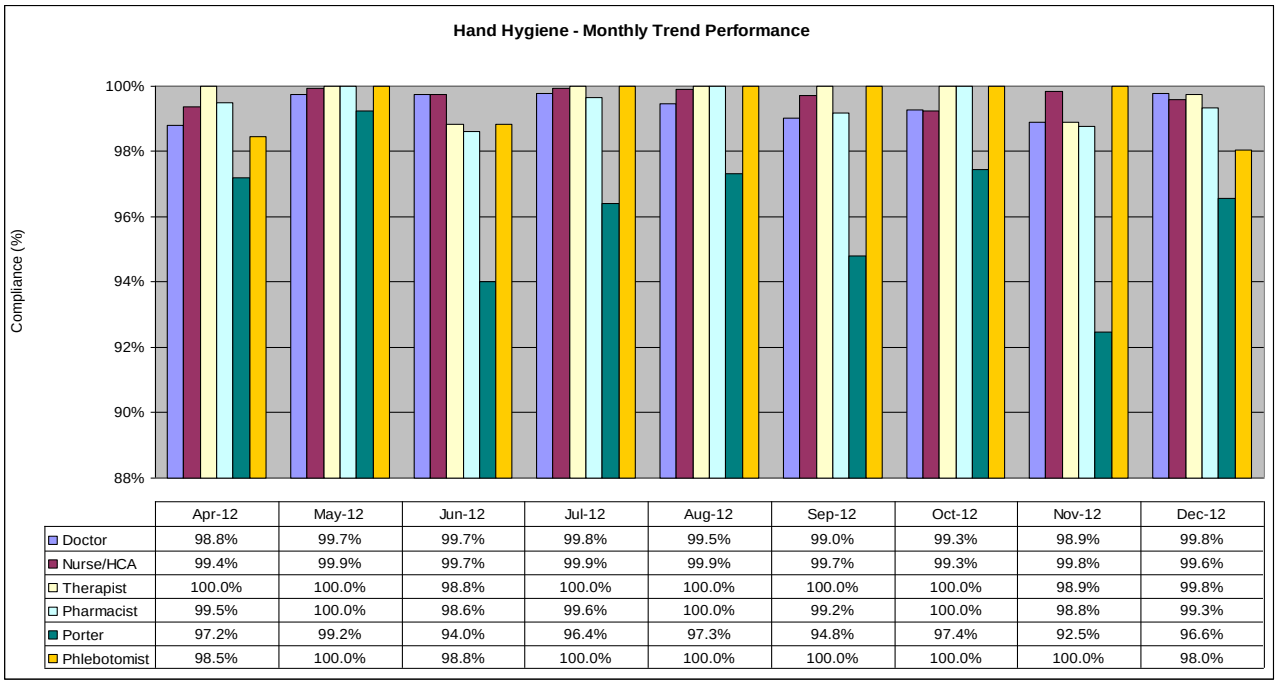
6. Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) data shows that in:

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

- December overall Trust compliance for hand hygiene = 92.5%, 8 areas failed to submit the completed audit.

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

The graph below demonstrates hand hygiene compliance in the ward areas, is considerably higher than the overall trust score.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Doctor	98.8%	99.7%	99.7%	99.8%	99.5%	99.0%	99.3%	98.9%	99.8%
Nurse/HCA	99.4%	99.9%	99.7%	99.9%	99.9%	99.7%	99.3%	99.8%	99.6%
Therapist	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	98.9%	99.8%
Pharmacist	99.5%	100.0%	98.6%	99.6%	100.0%	99.2%	100.0%	98.8%	99.3%
Porter	97.2%	99.2%	94.0%	96.4%	97.3%	94.8%	97.4%	92.5%	96.6%
Phlebotomist	98.5%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%

The third Infection Prevention annual awareness day known as the “Ugly Bug Ball” was held at the Cripps Postgraduate Centre on 29th November. The event was well supported by our team of 45 NGH staff and was also attended by several suppliers. We had 50 staff attend and the topics varied from Group A Strep and Tuberculosis.

Infection prevention support nurse Jean Hart said: "The day was very successful, and the evaluation forms provided some excellent feedback. We had some very interesting presentations from speakers on topics including HIV, necrotising fasciitis, and whooping cough."

Feedback comments about the day included:

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

A Healthcare-Associated Infection and Antimicrobial Resistance Report for 2010-2011 was published in August 2012 by the Health Protection Agency.
In summary the report highlights the following nationally:

Epidemiology

- Meticillin-resistant Staphylococcus aureus (MRSA) blood infection (bacteraemia) cases dropped by 22% in 2010/2011 compared to the previous financial year and

Clostridium difficile infection fell by 15%, a sustained year-on-year fall in both infections

- PVL-MRSA (Pantine Valentine Leukocidin is a powerful poison (toxin) that can destroy white blood cells and cause more serious infections) – increasing numbers of these isolates continue to be submitted to the reference laboratory for investigation and a range of different types have been found.
- C. difficile ribotyping network: a marked change in the different strains(ribotypes) causing severe disease and outbreaks in England
- MRSA as a cause of surgical site infection continues to show a decrease.
- Resistance to carbapenems (specific antibiotics for the treatment of severe infections) continues to rise
- Gonococcal resistance – untreatable gonorrhoea is becoming a possibility as antibiotic resistance continues to rise
- Norovirus – hospital outbreaks are down from the previous year.
- Antiretroviral resistance – careful and controlled use of drugs in combination for the treatment of HIV is leading to a reduction in rates of antiviral resistance

New developments

- Enhanced meticillin-susceptible Staphylococcus aureus (MSSA) and Escherichia coli mandatory surveillance was launched in 2011.
- New application of technology to determine the likelihood that generic material came from a particular individual or group (whole genome sequencing) as a tool for infection control – a report from an outbreak of MRSA in a neonatal unit

Rolling the Dice: Could IPC be a victim of its own success?

This is a new report by the Patients Association which is calling for a renewed focus on infection prevention and control services across the NHS.

The survey of NHS staff found that almost all felt improvements in safety and outcomes had been delivered in recent years as a result of the high profile rise in infections such as MRSA but that more needs to be done to address new risks.

Over three quarters of respondents (77%) see financial pressures as posing the biggest threat to further improvements and over one third (34%) identified new infections or antimicrobial resistance as a major challenge for the future.

Almost 90% of respondents reported that compared to a year ago, the capacity of infection prevention and control teams to meet their organisations IPC needs has either remained constant or decreased, with almost half (45%) reporting a reduced capacity.

The report urges the Department of Health to renew its focus on infection control through four key calls to action:

- A new national conversation on improving infection prevention and control to ensure it remains a key priority following the implementation of the Health and Social Care Act from April 2014.
- Introduce an agreed framework to enable comparison, and ensure the NHS Commissioning Board alongside the Department of Health and Government; work together to ensure that there is appropriate and sustainable strategic leadership on issues of national performance across all sectors.
- Broaden the aims of infection prevention and control to deliver action beyond MRSA and C-difficile through targets on other infections such as sepsis.

- Promote a stricter emphasis on infection prevention and control within the social care system, so that monitoring matches that which takes place in the acute and secondary sector.

Once the specifics are known regarding strict monitoring other areas of infection prevention, systems will be set up to achieve this and data will be presented as part of this report.

Conclusion

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

Recommendation

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

TRUST BOARD 31st JANUARY 2013	
Title: -	Performance Report
Presented by: -	Christine Allen – Deputy Chief Executive and Chief Operating Officer

PURPOSE OF PAPER: -

This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 9 (December 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 9 **(December 2012)**.

- The Trust did not achieve the 4 hour transit time standard for December 2012 with 88.64% of patients being treated within 4 hours against the standard of 95%
- The cancer targets are monitored on a quarterly basis. For quarter 3, the Trust did not achieve the standard for 62 days from referral to treatment with 84.5% of patients treated against the standard of 85%. All other standards were met for quarter 3.
- The Trust achieved all the other key standards for December 2012.

ACTION REQUIRED BY BOARD: -

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

PERFORMANCE REPORT – JANUARY 2013

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 9** (December 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

See Appendix 1 for score card.

2.1 December Performance

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

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

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

2.2 A&E Clinical Indicators

Significant progress had been made in delivering the 4-hour A&E transit time during September and October. However there have been significant pressures in A&E during November and December 2012.

During December, 88.64% of patients were admitted or discharged within 4 hours. The key reason for this was the continued increase in length of stay for patients staying over 14 days combined with increased activity levels resulting in continued pressure on bed capacity.

To address these challenges the bed base was reconfigured in November to provide additional capacity and the early implementation of the Surgical Assessment Unit.

The Chief Operating Officer and Care Group Directors are continuing to work closely with external partners to make changes to discharge pathways, early changes include an interim placement process for Continuing Health Care and Social Care patients.

Progress is monitored through the Urgent Care Programme Board (UCPB).

The four sub group leads of the UCPB will update the Strategic Management Board of progress at the end of January 2013.

2.3 Ambulance handover times

The national target is for a maximum of 15 minutes from arrival in the A&E Department to handover of a patient to the A&E staff (pre handover), there is also a post handover target which is also 15 minutes.

Prior to the implementation of the FIT (initial assesment) process, ambulances at times could wait in excess of 30 minutes to hand over, the average length of time being 22 minutes. With the introduction of FIT and the increase in capacity within the A&E department the average wait has dropped to 17 minutes. The average handover time in the East Midlands is 21 minutes.

There is a strict protocol in place to ensure delays are escalated through to Director level both in and out of hours. Ambulance handover data is currently under review in conjunction with EMAS once this has been concluded ambulance handover data will be included in furture reports.

2.4 Cancer Standards

The Trust did not achieve the following cancer standard for quarter 3:

- **62 day standard**

During December there were an increased number of breaches of this standard; three additional breaches. The reasons for the breaches include complex pathways particularly in Head and Neck and Urology, patient choice and cancellations due to non-elective pressures during the month. A full review of the Urology and Head and Neck pathways is being undertaken to identify any further improvements that can be made. As a result of the December performance, the Trust did not achieve the standard for quarter 3, achieving 84.5% against the standard of 85%.

The Trust achieved all the other cancer standards for quarter 3 but did not achieve the following standards for December.

- **31 days from decision to treat to start of first treatment**

During December the Trust achieved 95.5% against the standard of 96%. This was as a result of cancellations due to non-elective pressures. The Trust however has achieved the quarter 3 position at 97.5%.

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

During December, 94.8% of patients were treated within 31 days against the standard of 98%. This was as a result of patients being medically unfit for treatment. The Trust has achieved the quarter 3 position at 98.1%.

2.5 Referral to Treatment Time (RTT)

During December 2012, the Trust achieved all of the RTT standards by each specialty.

3. RECOMMENDATIONS

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

Appendix 1 Score Card

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups										
Admitted	90.0%	96.4%	96.6%	97.4%	96.6%	97.0%	96.3%	96.1%	95.9%	96.7%
Non-admitted	95.0%	97.7%	98.3%	98.8%	98.6%	98.5%	98.4%	98.5%	98.4%	98.5%
Incomplete pathways	92.0%	98.2%	97.8%	97.1%	97.3%	97.5%	97.1%	96.9%	96.8%	96.3%
No of patients on an incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	49	55	43	21	33
Number of diagnostic waits > 6 weeks	0	0	0	0	0	0	0	0	0	0
A&E 95% Transit time target										
Cumulative	95.0%	95.0%	94.2%	93.9%	93.4%	93.3%	93.9%	94.1%	93.6%	93.0%
Month on Month	95.0%	95.0%	93.4%	93.3%	92.0%	92.8%	96.9%	95.2%	90.1%	88.6%
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6.0%	5.9%	7.1%	8.9%	5.7%	5.3%	5.8%	7.0%	7.0%	
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Cancer Wait Times										
2 week GP referral to 1st outpatient	93.0%	96.3%	95.6%	95.0%	96.6%	95.5%	96.6%	97.2%	98.3%	98.6%
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	96.1%	99.0%	100.0%
31 Day	96.0%	96.5%	98.9%	96.9%	99.4%	99.4%	99.3%	98.9%	97.7%	95.5%
31 day second or subsequent treatment - surgery	94.0%	96.2%	97.5%	100.0%	100.0%	100.0%	96.6%	100.0%	90.0%	100.0%
31 day second or subsequent treatment - drug	98.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	94.8%
31 day second or subsequent treatment - radiotherapy	94.0%	100.0%	99.2%	100.0%	98.5%	99.2%	98.2%	98.4%	99.0%	98.4%
62 day referral to treatment from screening	85.0%	100.0%	100.0%	100.0%	90.0%	87.5%	100.0%	100.0%	100.0%	95.7%
62 day referral to treatment from hospital specialist	85.0%	92.0%	91.7%	93.1%	93.3%	87.5%	85.0%	100.0%	92.6%	100.0%
62 days urgent referral to treatment of all cancers	85.0%	85.4%	81.8%	71.4%	90.1%	84.2%	86.4%	85.8%	89.7%	75.4%
Stroke Indicators										
Proportion of people who have a TIA who are scanned and treated within 24 hours	60.0%	68.0%	75.0%	90.9%	71.4%	95.8%	76.5%	68.0%	88.9%	72.7%
Proportion of people who spend at least 90% of their time on a stroke unit	80.0%	100.0%	95.6%	95.6%	81.9%	82.9%	87.8%	91.1%	85.7%	84.2%
Activity vs. Plan										
Elective Inpatients	>0%	16.6%	23.2%	15.2%	8.8%	-1.5%	17.5%	20.5%	40.6%	4.6%
Daycase	>0%	8.7%	11.3%	1.0%	3.7%	1.3%	4.3%	7.4%	2.0%	-2.2%
Non- Elective	>0%	17.0%	25.7%	18.6%	14.1%	15.1%	13.7%	21.4%	20.9%	7.9%
OP 1	>0%	5.1%	14.9%	7.5%	0.9%	-5.7%	3.9%	4.4%	3.0%	-6.5%
OP Procedures	>0%	10.2%	3.6%	5.0%	2.3%	-1.5%	5.6%	7.0%	12.5%	-3.4%
New to Follow UP Ratio	2.01	2.05	1.92	1.97	1.97	1.96	2.07	2.02	1.99	
GP Referrals	>0%	2.5%	1.4%	1.1%	0.4%	-2.0%	-2.1%	-1.3%	-1.3%	-2.7%
Day Case Rates	81%	85.7%	85.0%	85.0%	85.7%	86.6%	85.0%	84.8%	82.0%	
Sleeping Accommodation Breach	0	0	0	0	0	0	0	0	0	0

Trust Board Meeting – 31st January 2013	
Title: -	Urgent Care Programme Update
Presented by: -	Christine Allen – Chief Operating Officer/Deputy Chief Executive

PURPOSE OF PAPER: -

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

CRITICAL POINTS: -

- Performance against the 95% Four Hour Targets remains inconsistent with attendances at A&E and non-elective admissions above planned levels.
- In collaboration with external partners and national support teams the Trust is continually reviewing leading practice, which where appropriate is incorporated into Urgent Care Programme
- The governance structure for the Urgent Care Programme has been revised.
- The Trust continues to benchmark performance metrics to enable identification of areas for improvement.

ACTION REQUIRED BY BOARD: -

The Board is asked to:

1. Review and discuss this paper.
2. Note the revised governance structures implemented by the Urgent Care Project Board.
3. Support the Urgent Care Programme objectives of the Urgent Care Project Board and Working Groups.

Urgent Care Programme Update – January 2013

1. Introduction

This update to the Board outlines the Urgent Care Plan for the Trust and sets out the objectives, operational initiatives and high level governance framework for the urgent care pathway improvement work, being undertaken through Trust's Urgent Care Programme Board. The focus of the work stream is to improve non elective patient flow through the hospital following attendance at A&E or admission, and support achievement of required performance standards, i.e. A&E Four Hour Transit for at least 95% of patients.

The work stream is supported by five clinically led working groups, which will ensure that each step of the urgent care pathway has a focus on improvement. The paper includes an overview of the work Northampton General Hospital NHS Trust has undertaken to review all elements of the urgent care pathway against leading practice within the National Health Service. Each of the initiatives proposed and underway has been subject to a Quality Impact Assessment (QIA), reviewed by the Medical Director and the Director of Nursing. Key indicators are routinely monitored to assess whether expected benefits are being realised.

The Trust has experienced year on year increases in A&E attendances with an associated increase in non-elective patient demand for 2012/13. The current and projected increase in non-elective activity has required the opening of additional substantive bed capacity, requiring additional nursing, medical and professional staff with an additional 680 emergency patients being admitted to the hospital in the year to date compared to the same period in 2011/12.

The Urgent Care Project Board will oversee the implementation of changes to the urgent care pathway and have reviewed recommendations from a range of studies on the urgent care pathway undertaken by external organisations. A current exercise is underway to benchmark the Trust against additional urgent care metrics across a range of NHS providers.

The National Commissioning Board (NCB) has recently outlined their intention to review Urgent Care Services led by Sir Bruce Keogh. In the recently released planning guidance, published in December 2012, the NHS Commissioning Board said it would review urgent and emergency care as part of plans for more seven-day services. The Terms of Reference for the review are to be published by the National Commissioning Board in the near future.

2. Overview of Work Stream

The work stream has been designed to ensure additional focus on continual improvement in the care which is given to patients attending the hospital either via the A&E Department or following admission.

The Urgent Care Work stream reports to the Urgent Care Project Board, which is chaired by the Trust Chief Executive. The Urgent Care Project Board is supported by five working groups, these are:-

- Accident and Emergency Attendance and Assessment
- Medical Manpower

- Patient Flow and Length of Stay
- Patient Discharge
- Community Beds and Rehabilitation

A breakdown of each of the work streams is contained later within this paper.

The Urgent Care Project Board and each of the working groups have clinical representation and each has developed a detailed action plan, revised governance arrangements. An urgent care dashboard has been developed to provide monthly metrics to support assessment of the impact of changes implemented.

In addition the Trust has been receiving support from a number of external agencies and organisations including the Emergency Care Intensive Support Team (ECIST) who re-visited the Trust in September 2012 providing a further review of our progress. ECIST are due to return in January 2013.

The SHA undertook a review of capability and capacity of the NGH system and team on behalf of the SHA in October 2012. The recommendations identified within that review have been included within the plans developed by the Urgent Care Programme Board and associated working Groups.

An assessment of potential additional opportunities within the patient pathway is currently being undertaken through the Mott Macdonald Team who commenced work with the Trust in December 2012. The team from Mott McDonald has significant experience supporting hospitals and health economies to improve the pathway for patients who are attending the hospital or require community based care and support. The Urgent Care Programme Board will be reviewing the recommendations of this assessment in January 2013.

3. Current Urgent Care Activity profile

3.1 National Performance standards

A detailed breakdown of the performance for A&E and Non Elective Admissions is contained within the performance paper. To place the challenge within context, the Trust year to date have exceed planned attendances to A&E by 4.8% and is projected to have received 98,270 attending A&E by the end of 2012/13.

3.2 Impact of Increases in A&E Attendances and Non-Elective Admissions

This increase in attendances to the main A&E Department and growth in non-elective admissions has put an increased pressure on the required bed capacity of the Trust.

There has been a 2.9% increase in the number of admissions when compared with 2011/12. The bed capacity requirement has risen to an additional 18 beds daily throughout the year to accommodate the additional numbers of patients requiring admission. Whilst some of the additional capacity had been part of the forecast requirements, additional bed capacity has also been utilised including the continued use of escalation areas, additional beds at Cliftonville Care Home and recently Victoria Ward for patients who are being discharged in the next 24 hours.

This additional capacity has increased the pressure on the ward nursing teams and temporary staffing has been utilised to backfill staff moved to cover these additional areas.

The length of stay for non-elective patients (October 2012) compares favourably against regional peer group averages at 4.4 bed days per admission.

3.3 Ambulance Services

The increasing demand for A&E services has led to Ambulance hand over delays for EMAS and an increase in delays for patients being admitted or assessed/treated due to lack of cubicle capacity.

The Trust has worked with EMAS to reduce hand over times by increasing the physical cubicle space by 5 to a total of 16. Additional trolleys and staff have been made available to care for patients until cubicle space is available thereby releasing ambulance crews. ECIST have acknowledged that the refurbishment of the Emergency Department provided a more conducive environment for patients and staff.

This has led to some improvement and the Trust is participating in a workshop in March 2013 led by EMAS to work with them on improving patient flow to A&E and improving the handover process.

3.4 Impact on Elective Care

The impact of additional patients above planned levels has increased pressure on the Trust's elective workload. A key interdependency is the increasing demand for ITU beds. The Trust developed a 'surge plan' to respond to variations in ITU demand, based on patterns of utilisation in 2011/12, however the additional volume of non-elective patients requiring ITU still significantly exceeds the plan. Additional consequences for the Trust have included:-

- Cancellation of patients on day or at short notice due to the need to care for increased non-elective patients.
- Income reduction over and above forecast due to the number of elective patients who were not able to have surgery.

4. The Urgent Care Programme & Work Plan

The Urgent Care Project Board has agreed a work plan to ensure that patients receive effective and safe care, which is based on leading practice and is able to respond to the increasing demand for urgent care services. The work of the Urgent Care Programme is closely aligned with the work on Patient Safety.

The high level priorities for the Board are:-

- Prioritise pathway design and delivery.
- Institute quality measures and seek ways to exceed them.
- Analyse services, their systems and processes, roles and responsibilities to identify change opportunities and recommend actions.
- Work with Social Care and Health Partners continually to ensure a focus on quality and the patient
- Development of Internal Professional Standards which will be developed in conjunction with the ECIST.
- Regularly review the work programme to adapt to emerging benchmarking and best practice including ECIST recommendations.
- Establish the further 9 Ambulatory Care Pathways, (the chest pain pathway is now completed).

- Ensure that projects are supported by an up to date QIA and Risk Report.
- Regularly review the KPIs and metrics using the urgent care dashboard.
- Review the outcome of Mott MacDonald work and ensure that recommendations feed into the relevant project areas for action.

4.1 Review of leading practice: Our Joint Work with ECIST

Leading practice from other hospitals is constantly under review. Following their visit in January 2013, the ECIST team shared that a few Trusts have commenced a pilot scheme to assess the integration of the enhanced recovery approach into medicine. This is an approach which is widely used to support patients who are recovering from surgery. We will be reviewing documentation provided by the ECIST and other Trusts to assess any potential benefits for the programme developed here at Northampton General Hospital.

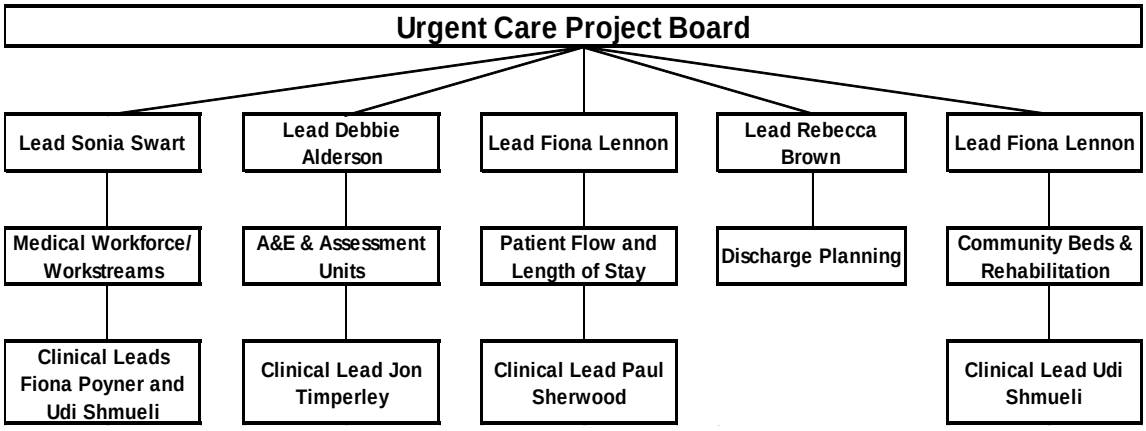
Another scheme that the Trust is assessing has been developed at a Trust in the North West of England to support discharge of patients. The 'flow bundle' approach has recently been adopted to support implementation of criteria led discharge. The discharge group will be closely following the impact that this scheme is having and reviewing how any improved outcomes can be considered locally.

The Trust is currently reviewing a number NHS benchmarks, those most relevant to the services provided by the Trust will be added to urgent care dashboard which is routinely reviewed via the Urgent Care Project Board.

4.2 Urgent Care Project Board Governance

The Urgent Care Project Board has reviewed the governance of all the urgent care work streams and revised the urgent care dashboard to ensure that all appropriate metrics are captured and any early signs of variation from expectations can be identified, reviewed by senior clinicians, directors and operational staff at the Urgent Care Project Board.

To support development and implementation of the Urgent Care Programme the Trust has now employed a dedicated Project Manager for a 6 month period to support the recovery plan.



4.3 Objectives & Priorities of the Urgent Care Working Groups

The objectives, key priorities and achievements to date for each of the Urgent Care Board Working Groups is outlined below:-

4.3.1 Medical Manpower Working Group

- **Objectives**

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

The focus of the group is on developing novel training posts to fill the recurrent vacancies in training rotas and on development of alternative consultant posts to support A&E. This is based on the fact that most of the patients attending A&E and requiring admission have general medical problems.

- **Key Priorities**

The group is also considering ways to support increased 7 day a week working for medical staff.

- Proposals have been developed for new middle grade posts rotating between A&E and Medical Specialities with 20% of time earmarked for specific training to be tailored to the individual.
- Consideration given to developing a leadership management post to undertake supervision of the A&E and emergency ward flow process.
- Develop models to assess efficacy of new ways of working.
- Ensure link to the need for 7 day working for consultant medical staff and 7 day consultant presence in A&E as well as support for the medical wards

- **Achievements**

- Two NHS 12 month locum posts to be advertised, model of medical support in A&E under development
- Additional resources have been agreed to support the A&E teams including 2 additional consultants and 10 additional nurses, this resource has been implemented supported by funding from NHSN utilising locum and temporary staff whilst permanent staff are recruited.

4.3.2 A&E and Assessment Units Working Group

- **Objectives**

This objective of the working group is to focus on actions which reduce delays in A&E and assessment areas and to assess; and where appropriate implement best practice from across the NHS.

- **Key Priorities**

- Involve all senior managers and clinicians from clinical and support directorates.
- Working with external partner organisations to identify and address unnecessary admissions.
- Development of the Ambulatory Care Pathways with processes to support early discharges.
- Development of a Patient Safety Academy.
- Identify opportunities to support seven-day working week.
- Identify and propose Information technology solutions such as:
  - Summary Care Record
  - Symphony in admission unit
- Development of dedicated assessment unit for oncology patients.
- Review operating hours for the paediatric assessment unit.
- Develop joint assessment documentation.
- Extend ward round trials to surgical unit with the incorporation of pharmacy.

- **Achievements**

- Emergency physician 13 hours per day Monday-Friday, 2 physician ward rounds at the weekend.
- Improved weekend junior doctor weekend cover with access to specialist consultant
- Successful pilot of consultant sessions in ED extended to new consultant posts.
- Clinical colleagues from peer Trusts including the Lead Urgent Care Clinician from Nottingham University Hospital and the Lead Nurse from Sherwood Forrest Hospital have been commissioned to work with the project manager to review the Urgent Care Pathways and A&E processes to ensure that the plan covers all improvement areas necessary and helps prioritise our efforts and improve safety and quality.
- Introduction of an observation area co-located with EAU and A&E.
- Daily breach analysis led by the lead consultant in A&E.
- Introduction of a new model of working within A&E (FIT).
- Acceptance of Standard Operating Procedures in ED with electronic store.
- Improved weekend junior doctor weekend cover with access to specialist consultant.
- Successful pilot of consultant sessions in ED extended to new consultant posts.
- Aligned and updated paperwork within in ED to complement that of EAU.

4.3.3 Patient Flow and Length of Stay Working Group

➢ **Objectives**

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

➢ **Key Priorities**

- Development and implementation of Board-round/MDT meeting best practice guidelines, handover notes, discharge levelling.
- Continue to roll out Nurse Facilitated Discharge.
- Continue to improve Visual Hospital and link to ward coordination (plan for every patient).

➢ **Achievements**

- Nurse facilitated discharge (NFD) operationalised.
- Introduction of therapy goal setting.
- Visual Hospital (VH) implemented:-
- The information on the whiteboards is summarised to highlight issues and themes.
- Issues/bottlenecks identified are escalated [with supporting information] to the appropriate person/team.
- Patient flow performance relating to complex medically fit patients can be monitored easily and effectively.

4.3.4 Discharge Planning Working Group

➢ **Objectives**

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

➢ **Key Priorities**

- Develop a project plan, utilising the diagnostic work completed by Jeffrey Worrell (external adviser) based on leading practice information.
- Link to the visual hospital programme to reinforce leading practice guidance across wards.
- Consolidate and streamline multidisciplinary teams on wards.

➢ **Achievements**

- New Interim Continuing Healthcare (CHC) placement process in place (reduction of assessment time from 14 days to 3 days).

4.3.5 Community Beds and Rehabilitation Working Group

➢ **Objectives**

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

➢ **Key Priorities**

- Consider options to consolidate/streamline multi-disciplinary teams on wards.
- Review of the day case unit.
- Develop case for additional Stroke (step-down) beds across community sites.
- Refine functioning of the health economy multi-disciplinary team.
- Increase step-up from the community.

➢ **Achievements**

- Community bed operational processes standardised.
- Community bed admission processes refined.

5. Conclusion

Improvements in the Urgent Care pathway were agreed by the Trust Board to be a priority for the Trust. The work outlined within this paper gives context to the challenges the trust has faced and describes fully the actions taken, and the remaining areas for us to focus on. It is essential that we offer safe and timely care to patients and that we closely link the work on patient safety. The clinical leads for the urgent care work streams will continue to update board members on a monthly basis of their progress.

6. Recommendation

The Board is asked to:

- Review and discuss this paper.
- Note the revised governance structures implemented by the Urgent Care Project Board.
- Note the work programme objectives of the Urgent Care Project Board and working Groups.

TRUST BOARD 31st January 2013.	
TITLE: -	Finance Report M9 – December 2012
PRESENTED BY: -	Mr Peter Hollinshead, Interim Director of Finance.

PURPOSE OF PAPER: -

The paper sets out the latest Financial Position of the Trust for the nine months ended December 2012.

CRITICAL POINTS: -

- The Trust has negotiated an SLA income settlement covering the remainder of the financial year. The Trust has negotiated an income settlement of £201m with the local CCGs which includes an additional £2.2m notified to the LAT and CCG in October and Winter pressures funding of £1.3m.
- Once the income settlement is finalised the level of clinical income the Trust can earn for the financial year becomes 'fixed.' As a result it is imperative the costs are tightly controlled and that all directorates live within their control totals. Key to this will be agreeing adjustments to cover the impact of winter pressures on the agreed control totals.
- The revised forecast for the Transformation Programme of £10.3m is required to achieve the breakeven forecast.
- Plans are in place to undershoot the Capital Resource Limit (CRL) by £0.9m. This figure is reduced from £1.7m due to the recent notification from EMCN in support of radiotherapy equipment.

ACTION REQUIRED: -

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

The Trust's Financial and Contracting Performance as at 31st December 2012

Month 9 2012/13

1. Summary Performance – Financial Duties

Table 1 summarises the Trust's financial performance for the nine months to the end of December 2012. The table summarises the year to date and full year forecast performance against the financial duties of the Trust, the financial performance dashboard is included in Appendix1.

Table 1 – Key Financial Duties

	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	-£3,737	-£518	£0	£1,000	-£1,000
Achieving EFL (£000's)	N/A	N/A	£220	£220	£0
Achieving the Capital Resource Limit (£000's)	£3,923	£4,384	£9,255	£10,131	£876
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	92%	95%	95%	95%	0%
Value of Non-NHS Invoices	71%	95%	75%	95%	-20%

Key Issues:-

- The Trust has negotiated an SLA income settlement covering the remainder of the financial year. The Trust has negotiated an income settlement of £201m with the local CCGs which includes an additional £2.2m notified to the LAT and CCG in October and Winter pressures funding of £1.3m.
- Once the income settlement is finalised the level of clinical income the Trust can earn for the financial year becomes 'fixed.' As a result it is imperative the costs are tightly controlled and that all directorates live within their control totals. Key to this will be agreeing adjustments to cover the impact of winter pressures on the agreed control totals.
- The revised forecast for the Transformation Programme of £10.3m is required to achieve the breakeven forecast.
- Plans are in place to undershoot the Capital Resource Limit (CRL) by £0.9m. This figure is reduced from £1.7m due to the recent notification from EMCN in support of radiotherapy equipment.

2. Income and Expenditure Position of the Trust

2.1 Surplus/(Deficit) Position

The Trust has negotiated an income settlement with local CCG with the following conditions:

2.1.1. That the Trust delivers break even – this still requires Care Groups and Corporate Control totals and Transformation schemes to be delivered.

2.1.2. Delivery of the Trust Transformation programme (£10.3m) but also ensuring the recurrent £16.1m is delivered.

2.1.3. That the Community Care Act (Delayed discharges) fining is introduced where there is failure to provide social service assessment or social services.

2.1 Appendix 2 provides details of the Trusts summary Income and Expenditure (I & E) Position. The Trusts year to date I & E position as at 31st December 2012 was a £3.7m deficit (November: £4.1m). The plan submitted to the SHA in March predicted a £518k year to date deficit therefore the result was £3.2m worse than planned. The planned position for the full year is a surplus of £1.0m.

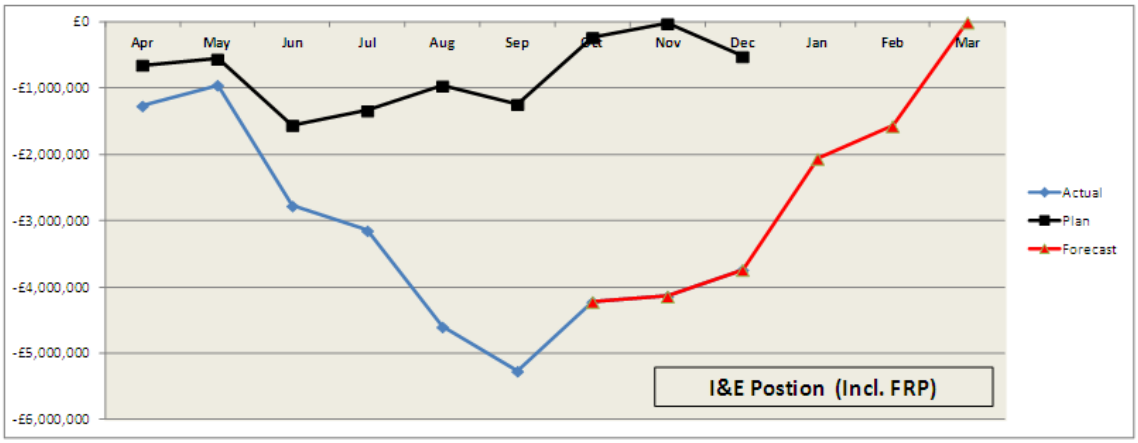
2.2 The year to date position above excludes the impact of non-current asset impairments of £1.5m which have been charged to the I&E account in December but do not count towards the measurement of NHS performance.

2.3 The month 9 position is a surplus of £0.4m. It should be noted that this position includes the accrual of an additional £1.2m of Transformation and £0.6m of the CCG income settlement income in the month of December. The additional £1.1m of recovery actions accrued in November is also included in the year to date position (this remains subject to agreement by the CCG).

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

	Actual YTD M8 £000	YTD Av. £000	**Actual** *M9* £000	**Forecast** *M10* £000	*M11* £000	*M12* £000	*Total* £000
SLA Income	149,934	18,742	18,339	20,938	19,429	22,269	**230,910**
Other Clinical Income	1,940	242	145	242	242	162	**2,732**
Other Income	16,486	2,061	3,452	3,283	3,033	3,713	**29,967**
Total Income	168,360	21,045	**21,936**	**24,464**	**22,705**	**26,144**	**263,609**
Pay Costs	(111,223)	(20,327)	(13,973)	(14,437)	(14,405)	(14,755)	**(168,794)**
Non-Pay	(51,503)	(9)	(6,361)	(6,632)	(6,642)	(8,509)	**(79,648)**
Transformation Costs	(388)	0	(110)	(550)	0	(150)	**(1,198)**
							0
Total Costs	(163,114)	(20,389)	**(20,444)**	**(21,620)**	**(21,048)**	**(23,415)**	**(249,640)**
EBITDA	5,246	656	**1,492**	**2,844**	**1,657**	**2,730**	**13,969**
Depreciation	(6,554)	(1)	(740)	(811)	(811)	(811)	**(9,729)**
Amortisation	(7)	0	(1)	(1)	(1)	(1)	**(10)**
Impairments	0	2	(1,587)	0	0	187	**(1,400)**
Net Interest	13	(354)	2	2	2	2	**19**
Dividend	(2,833)	0	(354)	(354)	(354)	(354)	**(4,250)**
Surplus / (Deficit)	(4,135)	(517)	**(1,188)**	**1,679**	**492**	**1,752**	**(1,400)**
Normalised	(4,135)	(519)	**399**	**1,679**	**492**	**1,565**	**(0)**
Cumulative YTD	(4,135)		**(3,737)**	**(2,058)**	**(1,565)**	**(0)**	

2.4 The Financial Recovery Plan actions to address the forecast deficit have been further updated and is provided under separate cover. At present actions totalling £10.3m have been identified representing slippage of £0.8m compared to the original forecast. This slippage has been compensated through the proposed income settlement with the CCG which means that the latest forecast I&E position is a breakeven (assuming CCG income settlement and winter pressures funding are received). The graph below sets out the predicted path of the recovery plan for the remainder of the financial year which will require robust performance management.



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

3 Income and Activity

3.1 Total operating income in month 9 was £21.336m compared to a forecast of £19.16m. Year to date operating income stands at £189.7m, compared to a forecast of £184.6m.

3.2 SLA income amounted to £17.7m in December exceeding forecast levels by £0.74m (largely due to adjustment for November casemix). SLA income totalling £167.7m has been recorded for the year to date, £8.4m (5.3%) better than plan. The final level of income generated in month 9 (December) remains subject to final casemix validation.

3.3 The Trust has negotiated an income settlement with the local CCG's to provide greater certainty over delivery of the financial recovery plan.

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

Table 3 – SLA Activity & Income Performance

	ACTIVTY				INCOME						
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var	Volume £	Price £	Total £
DC	27,581	28,760	1,179	4.3%	16,400,922	16,819,969	419,048	2.6%	534,715	-115,668	419,048
EL	4,348	5,063	715	16.4%	13,115,516	12,952,718	-162,798	-1.2%	1,104,022	-1,266,819	-162,798
NEL	31,111	33,826	2,715	8.7%	52,141,633	57,173,866	5,032,233	9.7%	3,711,192	1,321,041	5,032,233
OPFA	47,880	48,948	1,068	2.2%	7,823,768	8,147,713	323,944	4.1%	-488,227	812,171	323,944
OPFUP	87,498	89,198	1,700	1.9%	8,013,126	8,153,328	140,202	1.7%	-59,598	199,801	140,202
OPFASPNCL	17,831	20,318	2,487	13.9%	1,576,182	1,821,620	245,438	15.6%	96,598	148,839	245,438
OPFUSPNCL	48,655	43,790	-4,865	-10.0%	2,335,816	2,140,714	-195,102	-8.4%	-226,281	31,179	-195,102
OPPROC	29,036	30,384	1,348	4.6%	4,203,327	4,440,631	237,304	5.6%	172,318	64,986	237,304
A&E	58,383	62,036	3,653	6.3%	5,581,738	6,955,654	1,373,917	24.6%			
BLOCK / CPC					45,716,272	46,957,868	1,241,596	2.7%			
MRET											
ARMD	2,781	3,075	294	10.6%	786,486	865,502	79,015	10.0%			
Provisions					-2,762,616	-4,408,288	-1,645,672	59.6%			
CQUIN					3,774,357	3,464,981	-309,376	-8.2%			
Other					537,346	2,187,575	1,650,229	100.0%			
Total					**159,243,873**	**167,673,851**	**8,429,978**	**5.3%**			

3.5 The Trust has over performed on activity which equates to £8.4m of additional income. The majority of over performance is against the Northamptonshire CCG contract with under performance on some smaller contracts.

3.6 Elective admissions activity is 16% higher than planned although weaker casemix has seen associated revenues rise only marginally above plan for the year to date. This is due in part to the proposed impact of PCT QiPP schemes during the year on elective income.

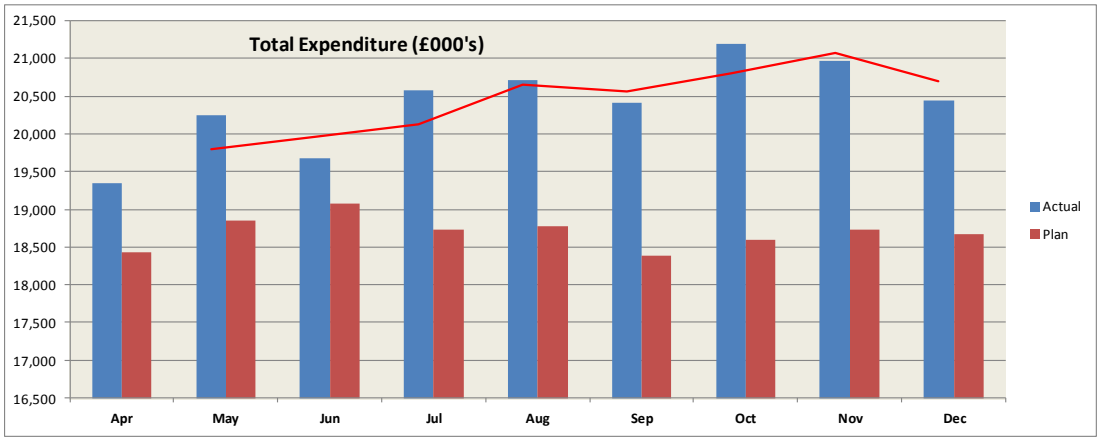
3.7 Non Elective activity is performing 9% above plan. This coupled with the 6% overperformance for A&E attendances has meant the continued need for the Trust to keep open additional escalation areas.

3.8 Outpatient first attendances are 2.2% above plan whilst outpatient follow up attendances are 1.9% above plan.

3.9 The Trust has reconciled and agreed the contractual position with the main commissioners for the period April to July and has invoiced the CCGs accordingly.

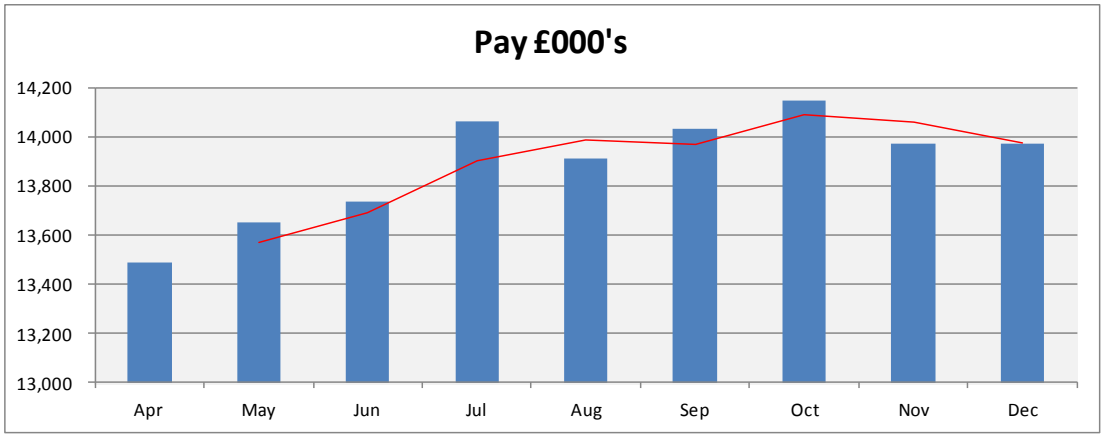
4 Expenditure

4.1 The Trust has overspent expenditure budgets by £15.3m in the 9 months to 31st December. The primary reason for the over spend is that insufficient Transformation Programme schemes have been identified and delivered within the first part of the financial year combined with the need to respond to non-elective pressures..



Graph 2 - Monthly Expenditure Run Rate 2012-13

4.2 Pay costs in the month were £0.1m higher than forecast at £13.97m (£0,2m lower than November). Cumulatively to month 9 pay costs amounted to £125.2m, £8.9m (7.7%) higher than planned. The costs of Winter Pressures are being tracked with £90k identified in December and an increased run rate expected in the final quarter of the financial year.



Graph 3 – Pay expenditure monthly run rate 2012-13

4.3 The Trust is operating below the planned WTE budget but is utilising significant numbers of temporary staff.

Table 4.1 – WTE Analysis – December 2012.

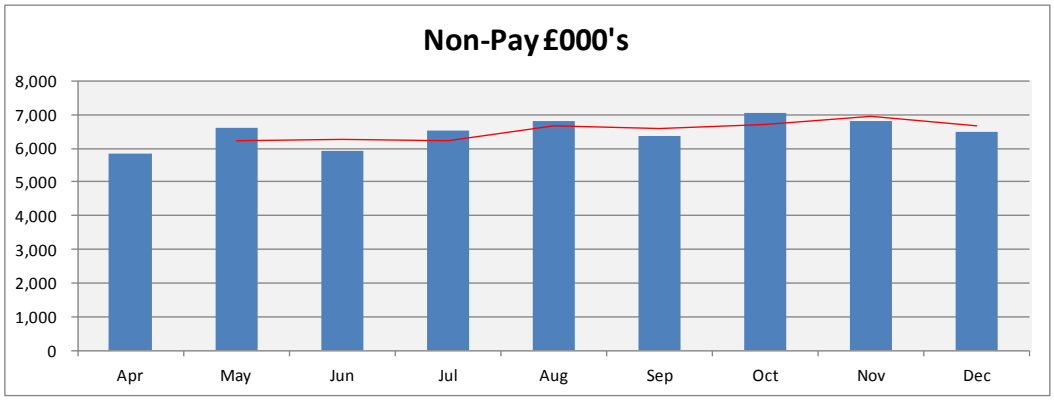
	Worked Mth 9 WTE	WTE Budget 2012/13 M9	Worked V Bud Var	Contracted Mth 9 WTE
Medical Staff	465.88	464.98	*-0.90*	464.16
Nursing Staff	1,823.19	1,760.00	*-63.19*	1,719.78
Managerial &	820.81	897.31	*76.50*	745.80
Other Clinical Staff	262.36	310.77	*48.41*	263.53
Scientific & Technical Staff	381.89	411.60	*29.71*	384.90
Estates Staff	28.56	36.19	*7.63*	25.00
All other Staff	393.77	407.47	13.70	323.39
Cost Challenges		-10.19	*-10.19*	
Total WTE	**4,176.46**	**4,278.13**	***101.67***	**3,926.56**

Table 4.2 – Temporary Staffing

Staff Group £000's	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Av. YTD	YTD Actuals
Medstaff WLI & ADH's	130	99	103	84	76	89	801
Agency Medstaff (Senior)	143	130	191	96	15	107	959
Agency Medstaff (Junior)	171	171	189	194	178	182	1,640
Bank Staff - Nursing	357	390	361	377	422	380	3,422
Agency Staff - Senior Nursing	275	307	333	307	197	274	2,463
Agency Staff - Junior Nursing	106	140	145	128	76	129	1,160
Agency Staff - Management	78	78	146	138	130	84	752
Bank Staff - Admin	117	130	115	115	125	107	963
Agency Staff - Admin	38	29	44	43	9	31	279
Bank & Agency Staff - Other	148	105	157	148	92	116	1,043
Total Temporary Staff	**1,563**	**1,580**	**1,784**	**1,629**	**1,321**	**1,498**	**13,482**

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

4.5 Non Pay cost incurred were £7.6m (15%) higher than planned for the year to date. Expenditure in December amounted to £6.5m (£0.1m above forecast).



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

4.6 As part of the Recovery plan "Control Totals" have been agreed with each care group. This requires individual Care groups to improve on their current forecast outturns through delivering improvements in the form of stretch targets against which they will be performance managed between now and the financial year end.

4.7 There are risks to expenditure budgets from winter pressures, performance targets and contract overperformance. Plans have been put in place to mitigate these risks which will be monitored and escalated as necessary in divisional performance reviews.

5 Transformation Programme (CIP Programme)

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

5.2 The financial recovery plan includes the requirement to deliver £11.1m of savings by the financial year end. The Latest Thinking Forecast for the Transformation programme indicates that there is expected to be a shortfall £681k against this target (see Transformation Report for further details).

5.3 The Trust delivered cumulative CIP savings of £7.6m for the period April to December 2012.

5.4 Appendix 3 details the identified schemes by workstream. In total schemes have been identified to deliver £10.3m in year against the £16.1m target however of these schemes £0.2m have been categorised as red rated.

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

6 Balance Sheet and Cash Flow as at 31st December 2012

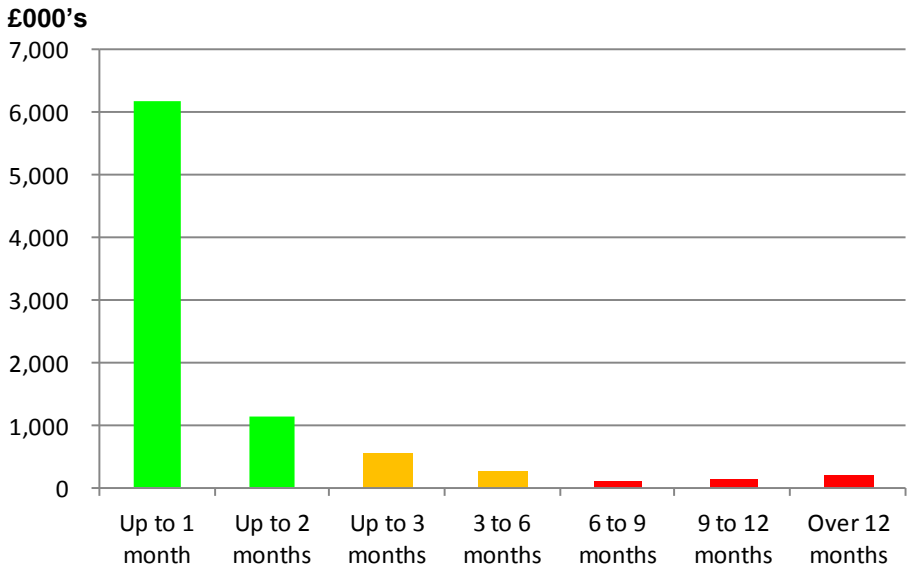
6.1 The Trust's Balance Sheet (Statement of Financial Position) as at 31st December is contained within appendix 4 of this report.

6.2 The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of December stood at £3.2m (November £1.3m). Cash balances have been supported in December by the drawdown of £3m of temporary borrowing from DH in December enabling the Trust to pay all overdue creditor balances as at 31st December. The Trust has received final notification from DH of its EFL for the year which determines that cash position needs to increase by £0.2m by the financial year end.

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

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

6.5 An analysis of income earned by the Trust but unpaid as at 31st December 2012 is shown in the graph below:



Graph 5 – Aged Debtor analysis - December 2012

7 Capital Programme and Performance against Capital Resource Limit

7.1 The initial CRL target of £10.4m was set equal to the Trust's capital programme requirements as seen in the table below:

Capital Resource Limit (CRL)	Plan	YTD	Forecast	Underspend
	£000	£000	£000	£000
Internally Funded (Depreciation)	9,729	4,208	8,853	876
Salix Loan	402	0	402	0
Total	**10,131**	**4,208**	**9,255**	**876**

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

8 Financial Risk Rating

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

8.2 The overall risk rating for the Trust as at the 31st December 2012 if it were a Foundation Trust would be 1, which would be insufficient for the Trust to be licensed as a Foundation Trust. The Trust is forecast to end the year with a risk rating of 2 (based on £2.7m deficit).

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

9 Financial Risks

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

Table 5 – Financial Risk Assessment – December 2012.

Risks not included in Financial Forecast 12-13		Value of Risk £000s	Likelihood	Probability %	Adjusted Risk £000s
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage	Agency - escalate through TDG.	(1,000)	Low	20%	(200)
Delivery of Control Totals	Directorates to manage within agreed targets	(1,075)	Medium	50%	(538)
	Unforseen Cost Pressures (eg RTT)	(500)	Medium	50%	(250)
Net Revenue Risk		**(2,575)**			**(988)**

10 Conclusion

10.1 The Trust continues to face a challenging financial year and at present is forecasting a breakeven position subject to finalising the SLA income settlement with the host CCG, to include an additional £1.3m in respect of winter pressures funding

10.2 Achievement of a breakeven position is contingent upon all directorates achieving their control totals meaning that cost control is of paramount importance in the final quarter of the financial year.

10.3 The Trust needs to carefully plan cashflow for Q4 and for the opening quarter of the new financial year.

11 Recommendations

11.1 The Board is asked to note the requirement by the Department of Health and Strategic Health Authority to achieve at least a financial breakeven position for the year (agreed plan is for a surplus of £1.0m).

11.2 The Board are asked to ensure that the actions to mitigate risks are discussed and understood. (Para 7.1)

11.3 The Board should closely monitor the financial recovery plan and seek assurance to understand the following key issues:

11.3.1 The negotiation of an income settlement with CCGs.

11.3.2 The delivery of prescribed control totals within the organisation.

11.3.3 The management and delivery of the Transformation Programme.

Appendix 1

Finance Dashboard

KPIs	M9		M8	M7	M6
Financial Risk Rating (Shadow)	1	Overriding rules apply	2	1	1
EBITDA	66.0%	EBITDA achieved 66% of plan	55.3%	47.0%	30.5%
Liquidity (days cover)	19.7	Incl. unused WCF of £18m	18.6	17.1	-15.4
Surplus Margin	-2.1%	+1% required for score of 3	-2.5%	-3.0%	-4.3%
Pay / Income	65.8%	Pay 66% of Income for YTD	66.1%	66.5%	67.5%
I&E Position	**£000's**		**£000's**	**£000's**	**£000's**
Reported Position	(5,324)	Deficit of £5.3m to month 9.	(4,135)	(4,447)	(5,265)
Impairment	(1,587)	Impairment due to Indexation of NCAs.			
Normalised Position	(3,737)	I&E position excluding impairment.	(4,135)		
FIMS Plan (Year to date)	(518)	£0.5m deficit plan to month 9.	(21)	(230)	(1,332)
PCT SLA Income Variance	8,430	5.3% above plan.	7,852	5,931	3,868
Unmitigated Forecast	-13,515	Forecast before mitigating actions.	-9,730	(9,730)	(10,940)
SHA control total (NGH)	1,000	SHA control total £1m surplus.	1,000	1,000	1,000
Financial Recovery Target	0	Forecast after recovery & mitigating actions.	0		
EBITDA Performance	£000's		£000's	£000's	£000's
Variance from plan	(3,464)ADV	£3.4m behind plan	(4,238)ADV	(4,272)ADV	(3,989)ADV
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**	**£000's**
YTD Plan	11,267	£11.3m target to month 9.	9,714	8,252	6,760
YTD Actual	7,621	£7.6m delivered to month 9.	6,667	5,961	4,724
% Delivered	68%	CIPs delivered as a % of plan .	69%	72%	70%
LTF	10,419	Latest Thinking Forecast for year.	10,541	11,098	11,142
Slippage Identified	0	Mitigation Target in LTF	559	0	4,958
Annual Plan	16,100	Annual Transformation Target.	16,100	16,100	16,100
LTF v. Plan	65%	% of LTF compared to annual plan.	65%	69%	69%
Capital	**£000's**		**£000's**	**£000's**	**£000's**
Year to date expenditure	4,384	Capital expenditure for period	4,126	3,229	2,943
Committed as % of plan YTD	89%	% of plan committed for year to date.	81%	92%	88%
Annual Plan	10,131	Capital Resource Limit of £10.1m for 2012-13.	10,336	10,336	10,403
SoFP (movement in year)	**£000's**		**£000's**	**£000's**	**£000's**
Non-current assets	(6,818)	Revaluation+Additions - depreciation	(2,656)	(2,250)	(1,743)
Current assets	5,029	Reduction in cash balance offset by NHS debtors.	5,122	3,146	1,036
Current Liabilities	20	NHS and Trade creditors increasing. DH Loans	6,180	4,921	4,136
Cash	**£000's**		**£000's**	**£000's**	**£000's**
In month movement	1,897	Increase between November and December.	(926)	1,169	(192)
In Year movement	(700)	Reduction since March 2012	(2,597)	(1,671)	(2,840)
DH Temporary Loans	3,000	Temporary borrowing drawn down from DH			
Debtors Balance > 90 days	686	8% of balances outstanding over 90 days	566	558	611
Creditors > 90 days	33	2% of creditors waiting over 90 days	486	988	423
BPPC (by volume) YTD	91.5%	Target 95% paid in 30 days	88.5%	90.0%	91.5%

Income & Expenditure Position – December 2012

I&E Summary	Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan	Forecast EOY
	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	212,676	159,244	168,274	9,030	230,910
Other Clinical Income	2,663	1,997	2,085	88	2,732
Other Income	23,219	17,184	19,937	2,753	29,967
Total Income	**238,558**	**178,425**	**190,296**	**11,871**	**263,609**
Pay Costs	(153,692)	(116,280)	(125,196)	(8,916)	(168,794)
Non-Pay Costs	(67,588)	(50,794)	(58,362)	(7,568)	(79,647)
Reserves/ Non-Rec	(2,068)	(1,295)	0	1,295	(1,198)
Total Costs	**(223,143)**	**(168,223)**	**(183,558)**	**(15,335)**	**(249,639)**
EBITDA	**15,415**	**10,202**	**6,738**	**(3,464)**	**13,970**
Depreciation	(10,184)	(7,547)	(7,294)	253	(9,729)
Amortisation	(10)	(7)	(7)	(0)	(10)
Impairments	0	0	(1,587)	(1,587)	(1,400)
Net Interest	29	22	14	(8)	19
Dividend	(4,250)	(3,188)	(3,188)	0	(4,250)
Surplus / (Deficit)	**1,000**	**(518)**	**(5,324)**	**(4,806)**	**(1,400)**
Normalised for Impairment		**(518)**	**(3,737)**	**(3,219)**	**0**

8

Appendix 3

Statement of Financial Position as at December 2012

	Balance at 31-Mar-11	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		554	(3,267)	(3,821)	(3,039)	(3,039)
IN YEAR MOVEMENTS		3,344	3,751	407	9,550	9,550
LESS DEPRECIATION		(6,554)	(7,302)	(748)	(9,730)	(9,730)
NET BOOK VALUE	**135,075**	**132,419**	**128,257**	**(4,162)**	**131,856**	**(3,219)**
CURRENT ASSETS						
INVENTORIES	4,723	4,862	4,928	66	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	11,980	9,838	(2,142)	5,742	12
OTHER TRADE DEBTORS	985	1,036	1,122	86	(149)	(1,134)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		1,460	1,609
CAPITAL RECEIVABLES	31				31	
NON NHS OTHER DEBTORS	70	346	491	145	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,688	2,668	(20)	968	(1,586)
OTHER RECEIVABLES	549	543	553	10	474	(75)
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,364	2,229	(135)	2,654	1,196
	10,945	**18,525**	**16,469**	**(2,056)**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300	300		(300)		(300)
CASH	3,944	1,347	3,244	1,897	4,363	419
NET CURRENT ASSETS	**19,912**	**25,034**	**24,641**	**(393)**	**20,141**	**229**
CURRENT LIABILITIES						
NHS	1,673	4,253	1,435	2,818	1,963	(290)
TRADE CREDITORS REVENUE	3,655	2,818	524	2,294	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	730	588	142	2,759	
TAX AND NI OWED	3,454	3,442	3,486	(44)	3,506	(52)
NHS PENSIONS AGENCY	1,784	1,934	1,947	(13)	1,950	(166)
OTHER CREDITORS	510	345	443	(98)	510	
DH SHORT TERM LOANS			3,000	(3,000)		
SHORT TERM LOANS	526	552	552		688	(162)
ACCRUALS AND DEFERRED INCOME	4,018	11,258	11,178	80	4,331	(313)
PDC DIVIDEND DUE		708	1,062	(354)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	102	837	(735)	938	665
PROVISIONS over 1 year	310	330	330		350	(40)
NET CURRENT LIABILITIES	**20,921**	**27,101**	**26,011**	**1,090**	**21,279**	**(358)**
TOTAL NET ASSETS	**134,066**	**130,352**	**126,887**	**(3,465)**	**130,718**	**(3,348)**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	34,467	31,993	(2,474)	32,193	(1,853)
DONATED ASSET RESERVE						
GENERAL RESERVES	385	385	583	198	583	198
I & E CURRENT YEAR		(4,135)	(5,324)	(1,189)	-1693	-1693
FINANCING TOTAL	**134,066**	**130,352**	**126,887**	**(3,465)**	**130,718**	**(3,348)**

Cost Improvement Delivery

Workstream	Exec Lead	Current LTF 2012/13 £	Plan 2012/13 £	RAG
Patient Flow	C. Allen	16,833	16,833	Complete
Theatres	R. Brown	111,987	141,987	Mitigation of £30k required from surgery
Outpatients	S. Swart	371,342	351,957	Over achieved
Admin Review	C. Allen	37,083	81,249	Mitigation through VSS route
Procurement	C. Abolins	869,856	869,856	On track
Pathology	S. Swart	109,346	91,083	Mitigation through VSS route
Therapies	R. Brown	46,855	39,467	Over achieved
Medical	S. Swart	0	0	No identified workstreams
Estates	C. Abolins	45,000	75,000	Mitigation through procurement over-delivery
Outsourcing	P. Hollinshead	30,197	28,790	On track
Nursing	S. Loader	2,000	1,500	In negotiation
Back Office	C. Pallot	159,598	172,466	On track
Contract Compliance	P. Hollinshead	1,414,228	1,000,525	Over achieved
Pharmacy	S. Swart	580,006	600,000	On track
Controls	P. Hollinshead	299,000	459,000	Dependent on overtime reduction
HR Workforce Planning	G. Opreshko	8,000	250,000	Dependent on VSS response
Workforce, Bank & Agency	S. Loader	0	700,000	Reduced LTF due to agency spend
Directorate 3% Schemes	P. Hollinshead	6,222,359	6,222,359	Mitigation through control totals
Total		10,323,690	11,102,072	

Appendix 5

Cashflow

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	205,487	15,448	17,959	18,311	17,011	17,091	16,677	17,627	16,930	17,084	20,821	15,264	15,264
SLA Performance / Other CCG investment	15,787				1,965	151	309	1,544	3,420	3,000		899	4,500
SHA Payments (SIFT etc)	9,151	266	1,300	671	942	672	841	723	809	1,271	827	809	20
Other NHS Income	19,862	1,932	2,568	1,108	1,420	1,495	1,858	1,852	1,164	1,314	1,476	1,884	1,791
PP / Other (Specific > £250k)	550		259							291			
PP / Other	11,027	821	768	796	1,013	793	972	927	858	779	1,100	1,100	1,100
Salix Capital Loan	402								121		182	99	
EFL / PDC													
Temporary Borrowing	4,000									3,000	1,000		
Interest Receivable	28	2	2	2	2	2	1	3	1	1	3	4	4
TOTAL RECEIPTS	266,295	18,469	22,857	20,888	22,352	20,204	20,659	22,676	23,304	26,740	25,409	20,060	22,679
PAYMENTS													
Salaries and wages	161,706	13,081	13,813	13,339	13,233	13,513	13,433	13,356	13,507	13,391	13,520	14,000	13,520
Trade Creditors	66,288	4,285	6,274	5,734	5,915	6,238	3,908	6,197	8,328	7,046	5,493	3,933	2,936
NHS Creditors	18,818	1,546	1,938	1,480	2,151	965	973	1,498	1,980	3,711	1,576	500	500
Capital Expenditure	10,604	789	1,503	763	517	371	375	455	443	617	927	1,869	1,977
PDC Dividend	4,194						2,069						2,125
Repayment of Loans	4,000											4,000	
Repayment of Salix loan	228						95						133
TOTAL PAYMENTS	265,838	19,701	23,528	21,316	21,815	21,087	20,854	21,506	24,257	24,765	21,516	24,302	21,191
Actual month balance	457	-1,232	-671	-428	537	-883	-195	1,170	-954	1,975	3,892	-4,242	1,488
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,112	1,229	1,034	2,204	1,250	3,225	7,117	2,875
Balance carried forward	4,363	2,675	2,003	1,575	2,112	1,229	1,034	2,204	1,250	3,225	7,117	2,875	4,363

Capital

Category	Approved Annual Budget 2012/13	Year to Date as at Month 9				Year to Date as at Month 9		EOY Forecast as at Month 9	
		M9 Plan	M9 Spend	Under (-) / Over	Plan Achieved	Actual Committed	Plan Achieved	M9 Forecast	Plan Achieved
	£000's	£000's	£000's	£000's		£000's		£000's	
Breast Screening Business Case	59	59	59	0	100%	59	100%	59	100%
Emergency Care	178	178	178	0	100%	178	100%	178	100%
Endoscopy / Urodynamics	60	53	52	-1	87%	52	87%	60	100%
Mortuary Refurbishment	55	55	55	0	100%	55	100%	55	100%
Macmillan (Trust)	91	5	5	0	5%	23	25%	91	100%
Macmillan (Non Trust)	13	13	13	0	100%	13	100%	13	100%
MESC	992	497	496	-1	50%	621	63%	992	100%
Estates	3,634	1,687	1,521	-166	42%	2,982	82%	3,634	100%
IT	3,373	1,667	1,404	-264	42%	2,556	76%	3,373	100%
Pharmacy Robot	183	0	0	0	0%	183	100%	183	100%
Radiotherapy Innovation Fund	599	0	0	0	0%	0	0%	599	100%
Other	319	170	140	-30	44%	264	83%	314	98%
Total - Capital Plan	**9,555**	**4,384**	**3,923**	**-461**	**41.1%**	**6,987**	**73.1%**	**9,550**	**99.9%**
Less Charitable Fund Donations	-295	-177	-177	0	59.8%	-177	59.8%	-295	100.0%
Total - CRL	**9,259**	**4,208**	**3,747**	**-461**	**40.5%**	**6,810**	**73.5%**	**9,255**	**99.9%**
Resources:									
Internally Generated Depreciation	9,729								
SALIX	402								
Total - Available CRL Resource	**10,131**								
Uncommitted Plan	**-872**								

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (completed November 2012)
- Pharmacy Robot approved for capital purchase in year
- Endoscopy (only fees in 2012/13) / Urodynamics (initial works completed Sept) - subject to business case approval and charitable funds donation
- The Trust have received £641k Radiotherapy Innovation Funding of which £599k are capital items
- Other costs include £35k Cancer Network Funding and £77k (Topcon scanner & Medaphor scan trainer) - transferred from revenue M6
- The Macmillan scheme works are completed, although final account is under dispute
- Full year depreciation forecast is currently £9.729 million (was £9.934 million)
- Following Capital Committee meeting £368k was agreed to slip till next financial year - endoscopy £218k and Estates schemes £150k
- Charitable Donations assumptions for additions in year has reduced to £295k (was £354k)
- The 2012/13 is undercommitted against resource in year by £0.872m (was £1.492m) - additional RIF + depreciation available reduction

Financial Risk Rating (Monitor)

Financial Criteria	Metric	Weight %	Dec	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	60%	2	0.20
Underlying Performance	EBITDA Margin %	25%	3.2%	2	0.50
Financial Efficiency	Return on Assets	20%	-3.42%	1	0.20
Financial Efficiency	I&E Surplus Margin	20%	-2.4%	1	0.20
Liquidity	Liquidity Ratio (Days cover)	25%	18.70	3	0.75
Weighted Average		100%		Calculated Score	2
				Override	-1
				Reported Score	1

Note: Forecast score subject to delivery of breakeven per Financial Recovery Plan.

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

Finance Risk Triggers (SHA PMR)

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

TRUST BOARD 31st January 2013	
Title	HR Report
Presented by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for December 2012 which focuses on the following Human Resource Workforce Indicators for Month 9:

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

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

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 Month 9

The Human Resource Workforce Indicators have been updated for Month 9. Please refer to the following pages of this report.

The salient points of change to date are:

Workforce Capacity

Substantive Workforce Capacity decreased by 10.65 FTE from 3,937.21 FTE to 3,926.56 FTE which is below the plan (4,278.12 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has decreased by 0.22% to 91.78%.

Temporary Workforce (excluding Medical Staffing) usage decreased by 2.59% from 7.78% to 5.19% and remains above the planned temporary FTE target of 5%.

Total Substantive Workforce plus Temporary Workforce (excluding Medical Staffing) % FTE against budgeted estsablishment FTE has decreased by 2.95% from 99.76% to 96.81%.

Staff turnover (leavers) has decreased by 0.06% on the month to 8.31%, which remains above the Trust target of 8%.

Recruitment Timeline is on the threshold target of 13.56 weeks.

Health and Wellbeing

Calendar Days Lost to Sickness The number of calendar days lost to sickness increased by 877 from 6,400 to 7,277 in December 2012.

No. of Days Lost per Employee increased by 0.19 from 1.39 days to 1.58 days.

Long term sickness absence increased by 0.74% to 2.79% which is above the Trust target of 2%.

Short Term Sickness Absence absence has decreased by 0.24% to 2.21% (Trust target 1.4%).

Total Sickness Absence has increased by 0.50% to 5.00% (Trust target 3.4%).

Workforce Expenditure

Temporary Workforce Expenditure has decreased by £275,919 from £1,489,185 to £1,213,266 which is equal to 8.68% of the total workforce expenditure.

Workforce Development

Appraisals are centrally recorded on OLM and are reported on a cumulative 12 month basis. The Training and Development Department is responsible for the centralised management of recording appraisals, the HR Business Partners continue to work with Managers to implement the process of submitting appraisal records. The percentage of staff with completed appraisals for December 2012 was 14.89%, compared to 13.72% the previous month.

Mandatory Training Compliance shows an increase of 1.46% compliance in December 2012 with a total Trust compliance of 64.93%.

Forecast and Risks

The total sickness absence rate has increased by 0.50% to 5% which is the highest rate for 7 months.

Analysis shows that the areas with the highest percentage of sickness absence rates v FTE days lost are:

Medical Records **15.00%**
Porters **14.52%**
Gosset Ward **11.77%**
A & E **10.72%**

In addition, analysis on the cost of sickness absence is being carried out to include direct sickness absence costs (derived from an average of daily cost based on basic salary including on costs) and indirect sickness absence costs (estimated costs for bank and agency cover).

The challenge to Line Managers and HR Business Partners will be to focus on pro rata high cost areas.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 9

WORKFORCE CAPACITY (Temporary Workforce Capacity Excludes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Nov-12	Dec-12	Peformance vs. Prev. Month	Comments and or Plans
Budgeted Workforce Establishment (FTE)			4,279.40	4,278.12	Lower	
Contracted Substantive Workforce (FTE)			3,937.21	3,926.56	Lower	
Temporary Workforce Utilised (FTE)			331.98	214.99	Lower	
Total Substantive Workforce plus Temporary Workforce (FTE)			4,269.19	4,141.55	Lower	
Contracted Workforce against Budgeted Establishment (% FTE)	95% to 97%		92.00%	91.78%	Lower	
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)	100%		99.76%	96.81%	Lower	
Temporary Workforce Rate (%FTE)	5%		7.78%	5.19%	Lower	Temporary Workforce Rate excludes Medical Staffing
Staff Turnover (% FTE)	8%		8.37%	8.31%	Lower	
Recruitment Timeline	13 Weeks		13%	13.56%	Higher	Recruitment Timeline is adjusted to take into account the 3 weeks Regional Restricted Access

WORKFORCE EXPENDITURE (Temporary Workforce Expenditure Includes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Nov-12	Dec-12	Peformance vs. Prev. Month	Comments and or Plans
Contracted Workforce Expenditure		112,727,627	12,648,061	12,759,405	Higher	
Contracted Workforce Enhanced Overtime		593,121	61,758	57,503	Lower	
Contracted Workforce Plain Time OT		48,472	6,729	5,660	Lower	
Temporary Workforce Expenditure		12,467,898	1,489,185	1,213,266	Lower	Temporary Workforce Expenditure = Bank, Agency and Locum (including Medical Staffing)
Total Utilised Workforce Expenditure		125,195,525	14,137,245	13,972,671	Lower	
Temporary Workforce Expenditure (% of Total Workforce Expenditure)		9.96%	10.53%	8.68%	Lower	

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 9

HEALTH AND WELLBEING

Performance Indicator	Performance Target	Trust YTD	Nov-12	Dec-12	Peformance vs. Prev. Month	Comments and or Plans
Trust Headcount (Permanent & FTC)			4,612	4,595	Lower	
Calendar Days Lost to Sickness Absence		59,114	6,400	7,277	Higher	
Days Lost Per Employee			1.39	1.58	Higher	
Short Term Sickness Absence	1.4%		2.45%	2.21%	Lower	
Long Term Sickness Absence	2%		2.05%	2.79%	Higher	
Total Sickness Absence	3.40%		4.50%	5.00%	Higher	

WORKFORCE DEVELOPMENT

Performance Indicator	Performance Target	Trust YTD	Nov-12	Dec-12	Peformance vs. Prev. Month	Comments and or Plans
Mandatory Training Compliance	100%		63.47%	64.93%	Higher	

WORKFORCE APPRAISALS

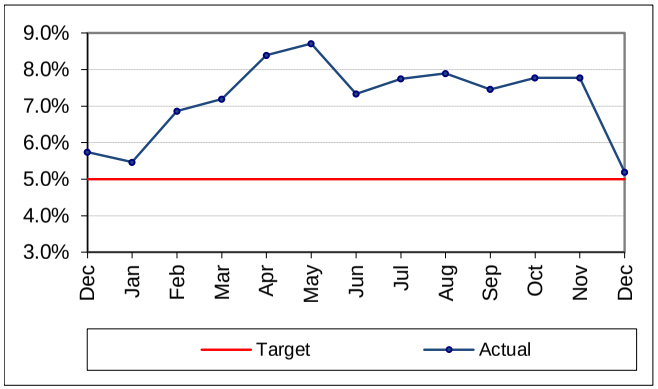
Performance Indicator	Performance Target	Trust YTD	Nov-12	Dec-12	Peformance vs. Q1 2011	Comments and or Plans
12 Month Cumulative Completed Personal Development Review / Plan	100%		13.72%	14.89%	Higher	Managers are responsible for submitting PDR/P's which are recorded and reported from central source (OLM)

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 9

DIRECTORATE WORKFORCE PERFORMANCE SUMMARY

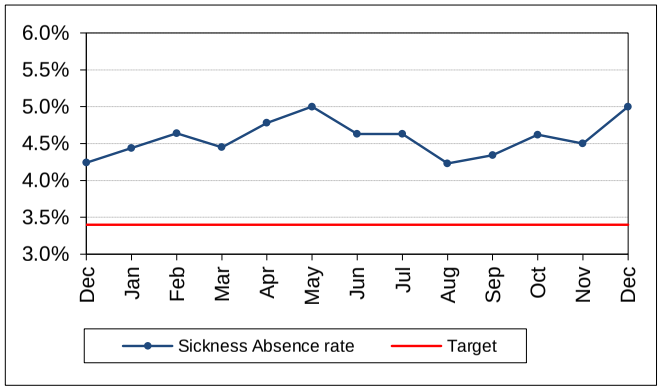
Temporary Workforce Rate

Directorate	Bank & Agency (Excl. Locum) M9	Variance Against Target	Variance From M8
Target = 5.0%		<-1.0%	>0.0%
Medicine	8.88%	3.88%	-4.64%
Surgery	6.65%	1.65%	-3.21%
Anaesthetics	4.56%	-0.44%	-2.64%
Trauma & Orthopaedics	4.29%	-0.71%	-3.81%
Head & Neck	5.35%	0.35%	-2.22%
Child Health	4.17%	-0.83%	-1.00%
Obstetrics & Gynae	2.51%	-2.49%	-1.55%
Oncology	4.61%	-0.39%	-2.18%
Pathology	2.52%	-2.48%	-0.24%
Radiology	0.00%	-5.00%	0.00%
Pharmacy	0.00%	-5.00%	0.00%
Therapies	9.65%	4.65%	-1.58%
Facilities	2.17%	-2.83%	-0.51%
Hospital Support	4.05%	-0.95%	-1.50%
Total	5.19%	**0.19%**	-2.59%



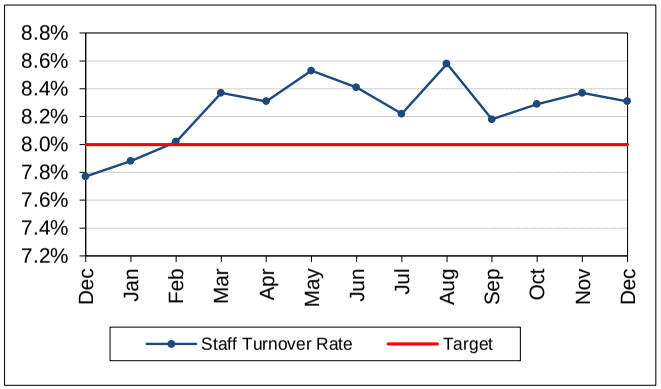
Staff Sickness Absence Rate

Directorate	Sickness Absence M9	Variance Against Target	Variance From M8
Target = 3.4%		<-0.0%	>0.0%
Medicine	5.77%	2.37%	1.18%
Surgery	4.08%	0.68%	0.43%
Anaesthetics	3.13%	-0.27%	-1.11%
Trauma & Orthopaedics	5.85%	2.45%	0.63%
Head & Neck	2.93%	-0.47%	-1.14%
Child Health	5.49%	2.09%	0.97%
Obstetrics & Gynae	6.14%	2.74%	1.30%
Oncology	4.90%	1.50%	1.39%
Pathology	5.50%	2.10%	0.59%
Radiology	2.27%	-1.13%	-0.18%
Pharmacy	3.60%	0.20%	-0.07%
Therapies	4.02%	0.62%	-1.40%
Facilities	5.91%	2.51%	0.84%
Hospital Support	4.53%	1.13%	0.32%
Total	**5.00%**	**1.60%**	**0.50%**



Staff Turnover

Directorate	Turnover M9	Variance Against Target	Variance From M8
Target = 8.0%		<-0.0%	>0.0%
Medicine	7.03%	-0.97%	0.00%
Surgery	7.97%	-0.03%	0.88%
Anaesthetics	4.84%	-3.16%	-0.20%
Trauma & Orthopaedics	6.39%	-1.61%	-1.02%
Head & Neck	6.30%	-1.70%	-0.32%
Child Health	13.86%	5.86%	1.29%
Obstetrics & Gynae	6.05%	-1.95%	-2.25%
Oncology	10.10%	2.10%	0.23%
Pathology	9.38%	1.38%	0.66%
Radiology	4.97%	-3.03%	0.00%
Pharmacy	6.55%	-1.45%	-0.44%
Therapies	14.53%	6.53%	-1.74%
Facilities	10.49%	2.49%	-0.65%
Hospital Support	12.85%	4.85%	1.91%
Total	**8.31%**	**0.31%**	**-0.06%**

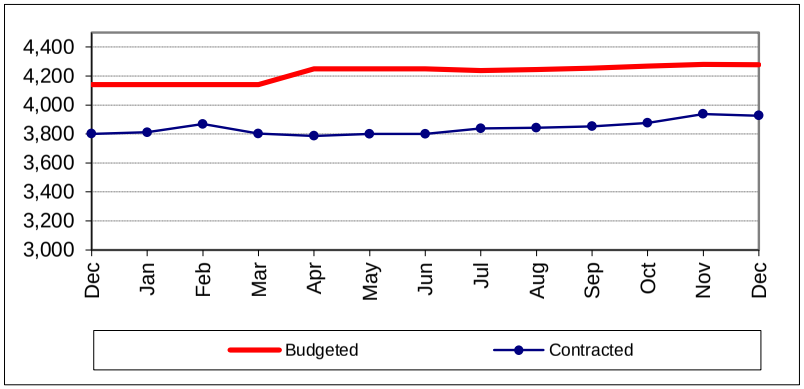


HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 9

DIRECTORATE WORKFORCE CAPACITY SUMMARY

Substantive Workforce Capacity FTE (Target = 95%)

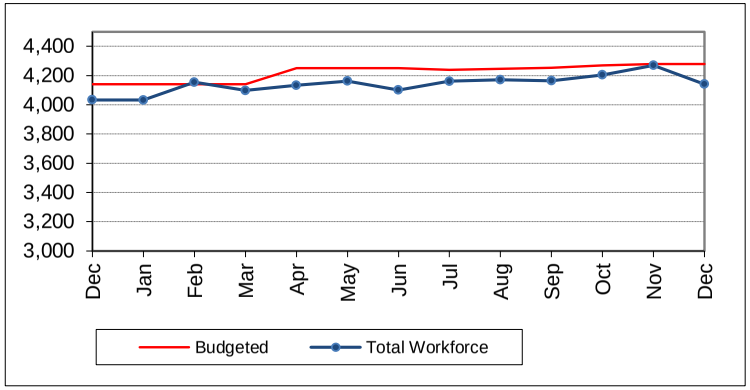
Directorate	Budgeted Establishment	M9 Contracted	Variance %	Variance FTE
Medicine	1,092.50	1,001.76	-8.31%	-90.74
Surgery	296.30	276.59	-6.65%	-19.71
Anaesthetics	332.79	309.48	-7.01%	-23.31
Trauma & Orthopaedic	257.98	231.53	-10.25%	-26.45
Head & Neck	173.33	158.29	-8.68%	-15.04
Child Health	266.30	263.14	-1.19%	-3.16
Obstetrics & Gynae	380.07	370.38	-2.55%	-9.69
Oncology	223.95	227.27	1.48%	3.32
Pathology	225.85	194.44	-13.91%	-31.41
Radiology	143.45	129.57	-9.67%	-13.88
Phamacy	101.65	99.64	-1.97%	-2.01
Therapies	79.37	64.41	-18.85%	-14.96
Facilities	344.56	280.07	-18.72%	-64.49
Hospital Support	360.02	319.99	-11.12%	-40.03
Total	**4,278.12**	**3,926.56**	**-11.90%**	-351.56



Total Workforce Capacity FTE (Excluding Medical Staff)

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

Directorate	Budgeted Establishment	Total Utilised Workforce	Variance
Medicine	1,092.50	1,099.33	6.83
Surgery	296.30	296.29	-0.01
Anaesthetics	332.79	324.26	-8.53
Trauma & Orthopaedic	257.98	241.92	-16.06
Head & Neck	173.33	167.24	-6.09
Child Health	266.30	274.58	8.28
Obstetrics & Gynae	380.07	379.93	-0.14
Oncology	223.95	238.25	14.30
Pathology	225.85	199.46	-26.39
Radiology	143.45	129.57	-13.88
Phamacy	101.65	99.64	-2.01
Therapies	79.37	71.29	-8.08
Facilities	344.56	286.29	-58.27
Hospital Support	360.02	333.50	-26.52
Total	**4,278.12**	**4,141.55**	-136.57



TRUST BOARD 31st January 2013	
Title: -	Transformation Update
Presented by: -	Geraldine Opreshko – Director of workforce & Transformation (Interim)

PURPOSE OF PAPER:

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

CRITICAL POINTS: -

1. The revised Transformation Programme is forecast to deliver £10.3m savings against a plan of £11,1m
2. A risk mitigation plan has been developed by the Transformation Delivery/Steering Groups to ensure delivery of the £10.3m
3. A Programme for the development of the 2013-2015 Transformation Programme has commenced with workshops established.
4. A review and lessons learned of the Transformation & PMO governance approach have been signed off by the Transformation Delivery Group.

ACTION REQUIRED BY BOARD: -

The Board is asked to note and discuss the actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.3m savings plan.

Board Meeting - 30 January 2013

1. Introduction

We are into the last quarter of the financial year which brings two key challenges for the Transformation team; firstly to ensure that the 2012/13 projects deliver their planned benefits, and secondly to complete the Cost Improvement Plan (CIP) work for the period 2013-2015.

Towards the end of 2012 several of the transformation schemes had been delayed, which has reduced the financial savings to be achieved in the current year.

High levels of bank and agency usage impacted on by the requirement to open additional bed capacity and an under-recovery in planned reduction in overtime payments have contributed to this position. Increased process controls over this expenditure and additional external support for managers have been introduced in an effort to reverse the trends.

The project teams are working hard to ensure that schemes which can deliver financial benefits by the year end are prioritised. The trust will not deliver the full £11.1m Transformation cost reductions at planned. The current latest thinking forecast (LTF) is that £10.3m will be achieved this year.

Plans are underway for the next two years transformation schemes and these will be submitted to the Trust Development Agency (TDA) in April for approval. The TDA are the body that has been established to hold NHS trusts to account in place of the Strategic Health Authorities.

2. Actions taken by the Transformation Delivery Group (TDG)

- In December 2012 tighter overtime controls were communicated to staff. Director authorisation is now required prior to any enhanced overtime payments. Unauthorised overtime hours are now paid at plain rate.
- A “Rostering in Partnership” programme has been established. The purpose of this programme is to support ward managers to ensure that their rosters are created in the safest and most cost efficient way to minimise the need for bank and agency staff. Transformation Business Partners have undertaken training on the electronic rostering system and the first suite of rosters are being reviewed in partnership with ward managers this in January 2013 for rosters which will commence in March 2013.

3. Key achievements

- The procurement team have exceeded their target of £869.8k, and will be providing a mitigating scheme of an additional £150k.
- An element of the controls workstream is negotiation of a rebate on the Business Rates paid by the Trust. A recent notification means that a saving of £155k has been secured against a plan of £50k.
- The Mutually Agreed Redundancy Scheme (MARs) process is nearing completion with a FYE saving of £482k (2013/14). Although the impact in 2012/13 is predicted at £8k against an original target of £200k.

4. Last quarter plans and mitigations

The priority for the remainder of the financial year is to ensure that all current work streams deliver the against the £10.3m LTF. The Transformation Delivery Group has prioritised a small number of initiatives that are currently being reviewed though the PMO to assess impact for the 2012/13 financial year. For example:

- Rapid assessment of further procurement opportunities which reduce the cost of goods paid by the trust.
- Pharmaceutical purchasing opportunities to reduce the cost to the trust of medicines.

5. Risks to the programme

5.1 The two main risks to the programme delivery of £10.3m are :-

a. Any unforeseen increases in overtime payment in the final three months of the 2012/13 financial year, and
b. Staff withdrawing from the MARs process prior to signing final agreements

6. 2013/15 Plans

The work stream framework for 2013/14 & 2014/15 and a first cut assessment of financial plans for 2013/14 are being worked on with Care Group and Corporate teams. A number of workshops have been planned, which include Quality Assessment Impact of any schemes identified. The workshops will take for the form of confirm and challenge supported by the Trust Programme Management Office (PMO) & Transformation Team. The programme will be finalised for submission to the Trust Development Authority in April 2013.

The Terms of Reference for a review and lessons learned of the Transformation & PMO governance approach have been signed off by the Transformation Delivery Group. The aim is to ensure that the Trusts governance and assurance reporting is robust and benchmarks to leading practice.

A draft report with recommendations will be submitted to the Executive Team and the Finance and Performance Committee in February 2013.

7. Conclusion

7.1 The Trust is on track to deliver £10.3m transformation programme for 2012/13.

7.2 Mitigations continue to be sought to offset risk to delivery of the programme.

8. Recommendation

Board is asked to note and discuss the actions being taken by the Transformation Delivery/Steering Groups to deliver the forecast £10.3m savings plan.

Northampton General Hospital NHS
NHS Trust

Transformation Programme

January 2013

2012/13 Transformation Programme Update

We are into the last quarter of the financial year which brings two challenges; firstly to ensure that the 2012/13 projects deliver their planned benefits, and secondly to complete the Cost Improvement Plan (CIP) work for the next two years.

Towards the end of 2012 several of the transformation schemes have been delayed, which has reduced the financial savings to be achieved in the programme. High levels of bank and agency usage, locum costs, and overtime payments have all compounded the issue, and tighter controls over this expenditure and additional support for managers have been introduced to try and reverse the trends.

The project teams are working hard to get failing schemes back on track, however the trust board have now informed the SHA that the trust will not deliver the full £11.1m as planned. The current expectation is that £10.3m will be achieved this year, although this will require additional savings to be delivered next year.

Plans are underway for the next two years transformation schemes and these will be submitted to the Trust Development Agency (TDA) in April for approval. The TDA are the body that has been established to hold NHS trusts to account in place of the Strategic Health Authorities which are disbanding from April 2013.

Transformation Programme

Overtime update

We are on target to spend in excess of £1 million pounds on overtime payments to staff in this financial year. Given the financial situation the trust is in, this level of expenditure is not sustainable, so from the 3rd December 2012 restrictions around overtime approval were implemented. This means that all overtime now needs Director level approval.

- There will be clear exceptions to this restriction (Directors' decision)
- All staff where there is service need can undertake additional hours or shifts at plain rate either on the rota or via the bank office
- Where staff offer to work some additional hours they can be given Time Off In Lieu (TOIL) as an alternative. There are many areas that put in claims for 30 minutes overtime for instance and this would be better dealt with as TOIL.

These principles will continue throughout the next year to ensure that the spend is reduced. If you have any questions or issues with this, please discuss them with your line manager in the first instance.

Procurement update

The procurement team have been working on a wide range of cost saving schemes and contracts in partnership with directorate colleagues. These deliver savings in a range of ways including negotiation of discounts on consumable items or equipment, agreement of contractual savings related to service contracts, or even reductions in price for capital schemes. So far the procurement team have delivered the following savings:

- £877,656 saved on revenue items and rebates
- £36,612 saved through cost avoidance schemes
- £192,992 saved on capital schemes

The team are currently working on the detailed plan for next year's schemes.

Third Party Pharmacy Dispensing update

The trust has commenced a tender process to set up a third party dispensary service for outpatients. Similarly to many other hospitals this will involve a branded third party dispensary on site offering OP prescriptions, a small retail outlet and potential for inclusion of take home medication for inpatients in the future.

The tender was advertised in December last year, and we are working with 15 interested parties. These parties will complete some outline tender information for the project team to review. This will be assessed against a criteria which will facilitate a shortlist of 3 suppliers to be drawn up.

Once we have selected the 3 suppliers we will work with them to explore the options in more detail before a final decision is made. It is expected that the new service will be launched in October 2013.

Multi-Functional Devices (MFDs) update

Work on the implementation of MFDs continues. The trust has benefited from a framework agreement with Ricoh which enables the trust to install MFDs instead of many of the expensive desk-top printers that are currently used.

MFDs are able to offer printing, photo-copying, scanning and potentially faxing capability and come as a fully managed service. This is a cheaper mechanism that small desktop printers, and saves staff time as the toner cartridges are ordered automatically, and any faults that occur are reported electronically by the device. The savings will be realised through cheaper consumable items and through implementing tighter controls on printing where it is practicable to do so.

All devices will be networked so it will be possible for staff to print from any device in the trust using unique pin numbers. As many areas already use MFDs the plan is to implement the networked solution in those areas first.

Transformation Programme

Northampton General Hospital NHS
NHS Trust

RICOH
imagine. change

Think Before You Print

Transformation Programme

Staff Benefits—Salary Sacrifice update

The Salary Sacrifice annual enrolment window is opening on the 18th February and will close on the 8th March. During this period you will be able to look at purchasing up to one week of additional annual leave, childcare vouchers and car parking.

There will be a Staff Benefits—Salary Sacrifice launch day on **Tuesday 19th February in The Boardroom.** At this event there will be several companies attending that will be able to explain more about Green Car, Childcare vouchers, Purchasing annual leave and the bike scheme.

More information about the schemes can be found at:
https://ngh.rewardwise.co.uk/

Can you remember your login?
If not, contact
salarysacrifice@ngh.nhs.uk

Transformation Programme

Who to contact……..

If you have any comments or questions related to anything contained within this newsletter, please don't hesitate to contact any member of the Transformation team listed below

Craig Porter (Craig.porter@ngh.nhs.uk —Ext 4743)

- General transformation enquiries

Jenny Briggs, (Jenny.briggs@ngh.nhs.uk—Ext 3711)

- General transformation enquiries
- Pathology
- Back Office (HR, Finance, IT, R&D)
- Pharmacy
- Procurement
- 3rd Party Pharmacy Dispensing
- Hybrid Mail

Chris Albone, (Christopher.albone@ngh.nhs.uk—Ext 5909)

- Outpatients
- Patient Flow
- Contract Compliance
- On-Call

Jatinder Singh (Jatinder.singh@ngh.nhs.uk—Ext 3317)

- Nursing
- Estates
- Bank & Agency
- Therapies

Lorna Gould (Lorna.gould@ngh.nhs.uk—Ext 5909)

- Theatres
- Administration Review
- Controls
- MFDs

Natasha Parkhill (Natasha.parkhill@ngh.nhs.uk) - Ext 5909

- Transformation Finance Manager

Laura Sharpe (laura.sharpe@ngh.nhs.uk) —Ext 5495

- Emergency Care Pathway

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
December 2012
NHS Trust Over-sight self certification template

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

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

Name of Organisation:	Northampton General Hospital	Period:	December 2012

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

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

If Declaration 2 has been signed:

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

Target/Standard:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**YTD deficit of £3.7m leading to FRR score of 2.**
Action :	**Addional CIP and mitigating actions to be developed and actioned.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**A&E Transit Time: Dec 2012 = 88.6% against a target of 95%**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

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

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

oard Statements

Northampton General Hospital

December 2012

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

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

	Signed on behalf of the Trust:	*Print name*	*Date*
EO			
air			

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Board Action
1	SHMI - latest data	Score				109	109	109	106	106	106	104.8	104.8	104.8	SHMI - Apr 12 to Jun 12 = Oct 10 to Sept 11 position. Jul 1 to Sep 12 = Jan 11 to Dec 11 position. Latest position reported in Dec 12 reflects Apr 11 to Mar 12.
2	Venous Thromboembolism (VTE) Screening	%	92.2%	93.6%	90.9%	91.4%	91.9%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	
3a	Elective MRSA Screening	%	100.0%	99%	99.93%	99.76%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	
3b	Non Elective MRSA Screening	%	97.3%	96.20%	91.05%	95.07%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	15	12	14	12	12	17	14	11	10	13	14	9	Total number of Active SI's as the end of each period.
6	"Never Events" occurring in month	Number	1	0	0	0	0	0	0	1	0	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	2	0	1	1	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	4	2	3	1	2	1	1	2	2	4	1	1	
10	Falls resulting in severe injury or death	Number	1	0	2	0	0	1	2	2	0	2	3	1	Reported during the month of DEC 2012
11	Grade 3 or 4 pressure ulcers	Number	1	5	0	2	3	3	2	0	2	3	7	7	Dec 2012 pressure ulcer figures consist of 5 x avoidable a 2 x unavoidable.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	39	48	49	50	51	39	48	33	35	44	40	24	
14	Agency as a % of Employee Benefit Expenditure	%	5.5%	5.4%	5.5%	5.83%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	£1.321m / £21.336m = 6.2% bank & agency to income ratio for December 2012.
15	Sickness absence rate	%	4.4%	4.6%	Not Av	4.78%	5.0%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have signed off PDP. There is no formal recording of the numb of items fully completed versus those carried over to th following year by agreement. NGH is procuring a suitab appraisal software system to allow more meaningful qua assurance for appraisals and back up the current robus paper based system. Discussions are underway with th Revalidation Support Team to develop a more meaningf method of assessing the quality of consultant appraisa rather than merely looking at the number of PDP item completed which in itself is not a robust measure and h not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	Financial Recovery Plan in place
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	2	2	2	2	Financial Recovery Plan in place
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	2	2	2	Financial Recovery Plan in place
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	Risk to achievement of breakeven postion.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	2	2	2	
Weighted Average		**100%**						**1.9**	**2.0**	**1.8**	**2.0**	
Overriding rules								2	2	2	2	
Overall rating								**2**	**2**	**2**	**2**	

Overriding Rules :

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

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

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	Yes	Yes	Yes	Yes	Yes	Trust has been in deficit and behind plan during the year.
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	Yes	Yes	Yes	Yes	Yes	Normalised Deficit c. £5.7m.
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	£686k (8%) outstanding over 90 days
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	No	No	Yes	Yes	No	No	£33k (2.5%). DH temproary loan aproved to adress backlog.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	Yes	No	No	No	No	Interim DoF will be in place until March 2013.
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Cash balance £1.3m. c£7m required to achieve 10 days cover.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	£0.9m forecast underspend.
10	Yet to identify two years of detailed CIP schemes					Yes	Yes	Yes	CIP Schemes being developped by Transformation Programme. (Criteria 10 reported as from November 2012)

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	No	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	No	Yes	Dec 2012 figures show 62-day urgent GP referral being 77.8% against the target of 85% (Q3 achieved - 85.6%)
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	No	Yes	Dec 2012 figures show 31-day as 94.3% against a target of 96%
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	Yes	No	No	No	Dec 2012 = 88.6% and Quarter 3 = 91.4% against a target of 95%
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0		Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*			Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0		Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*			Yes	No	No	No	No	No	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
				TOTAL		**1.5**	**1.0**	**1.0**	**0.0**	**2.0**	**2.5**	**1.0**	
						AG	AG	AG	G	AR	AR	AG	

RAG RATING :

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

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

CONTRACTUAL DATA

Information to inform the discussion meeting

Northampton General Hospital

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

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Are the prior year contracts* closed?	Yes	No	Yes	Yes	Yes	Yes	Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	No	No	No	Yes	Yes	Yes	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	Yes	
6	Might the dispute require third party intervention or arbitration?	No	No	No	Yes	No	No	No	
7	Are the parties already in arbitration?	N/a	N/a	No	No	No	No	No	
8	Have any performance notices been issued?	Yes	Yes	No	No	No	No	No	
9	Have any penalties been applied?	No	No	No	No	No	No	No	

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

TFA Progress

Jan-13

Northampton General Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	Deloite Board Development / BGAF review	Jul-12	Fully achieved in time		
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12	Fully achieved in time		
3	Trust to review the TFA in response to the Healthier Together Consultation	Oct-12	Not fully achieved		Consultation not yet undertaken
4	In-month delivery of 95% A&E 4-hour indicator	Oct-12	Fully achieved in time		
5	Recovery plan agreed at Board to stabilise financial position	Oct-12	Fully achieved in time		
6	Director of Finance appointed	Nov-12	Not fully achieved		Substantive Director of Finance not appointed through last appointments process. Interim DoF in post. Renumeration Committee looking at longer term solutions.
7	Director of Workforce and Transformation appointed	Nov-12	Fully achieved in time		
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12	Not fully achieved		High level CIPs are identified, fully worked-up implementation plans and QIAs being completed
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12	Fully achieved in time		
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12	Not fully achieved		Full recovery plan in place. All actions are on track to be delivered. The remaining risks to delivery are; the appointment of additional A&E consultants-the Trust has a plan in place to appoint 2 additonal physicians and reduce the number of patients remaining in hospital who no longer need acute care. The Trust is working with commissioners and social care to review this.
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12	Not fully achieved		Healthier Together consultation not yet commenced
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12	Fully achieved in time		
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12	Fully achieved in time		
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12	Fully achieved in time		
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12	Not fully achieved		as per line 10 above
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13	Not fully achieved		
17	Board and sub committee observations	Jan-13	Not fully achieved		Board observations are due to take place in February/March as part of the Quality Assurance and BGAF assessments below.
18	Quality Assurance Framework external assessment	Feb-13		Risk to delivery within timescale	Planned to take place in March 2013
19	HDD re-assessment	Feb-13		Risk to delivery within timescale	Planned to take place in March 2013
20	BGAF external assessment	Feb-13		Risk to delivery within timescale	Deloitte assessment has been completed. External assessment on hold.
21	In-month delivery of 95% A&E 4-hour indicator	Feb-13		On track to deliver	
22	NHS Acute Service Contract agreed	Mar-13		On track to deliver	
23	IBP approval by Board	Mar-13		On track to deliver	
24	Final LTFM approved by Board	Mar-13		On track to deliver	
25	Trust/NTDA readiness review meeting	Mar-13		On track to deliver	
26	YTD delivery of 4 hour indicator	Mar-13		On track to deliver	
27	Delivery of control total for 2012/13	Mar-13		On track to deliver	
28	Quarterly review of outcome of Healthier Together	Mar-13		On track to deliver	
29	Board and Sub committee observation	Apr-13		On track to deliver	
30	FT submission to NTDA	May-13		On track to deliver	
31	Board interviews	May-13		On track to deliver	
32	NGH/NTDA Board to Board meeting	Jun-13		On track to deliver	
33	NTDA Board approval	Jun-13		On track to deliver	
34	Application submitted to DH	Jul-13		On track to deliver	
35					
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Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 31st January 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 29th November 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.35	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**3**
09.55	7.	Patient Experience	Ms S Loader	**4**
10.05	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
Operational Assurance				
10.15	9.	Operational Performance Report	Mrs C Allen	**6**
10.30	10.	Urgent Care Update	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr P Hollinshead	**8**
10.55	12.	Human Resources Report	Ms G Opreshko	**9**
11.05	13.	Transformation Programme Update	Ms G Opreshko	**10**
11.15	14.	Self-Certification Return	Mr C Pallot	**11**
Governance				
11.20	15.	Any Other Business		
	16.	**Date & time of next meeting:** 28th February 2013		
	17.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	