Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 30 May 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 24 April 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.40	5.	Chief Executive's Report	Dr S Swart	**3**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Dr S Swart	**4**
10.05	7.	Patient Experience Report	Ms S Loader	**5**
10.20	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
10.30	9.	Francis Report Update	Ms S Loader	**7**
10.40	10.	Staff Survey Report	Ms J Brennan	**8**
Operational Assurance				
10.50	11.	Operational Performance Report	Mr C Walsh	**9**
11.00	12.	Urgent Care Report	Mr C Walsh	**10**
11.10	13.	Finance Report	Mr A Foster	**11**
11.20	14.	Human Resources Report	Mrs J Brennan	**12**
11.30	15.	Transformation Programme Update	Mrs J Brennan	**13**
11.40	16.	Self-Certification Return	Mrs K Spellman	**14**
Strategy				
12.05	17.	Communication and Stakeholder Engagement Strategy	Mrs K Spellman	**15**
12.15	18.	Annual Security Report	Mr C Abolins	**16**
Governance				
12.25	19.	Trust Development Authority Accountability Framework	Mrs K Spellman	**17**
Any Other Business				
12.30	20.	Any Other Business	Mr P Farenden	**-**

	21.	**Date & time of next meeting:** 27 June 2013 – 09.30am. Boardroom, Northampton General Hospital		
	22.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Northampton General Hospital NHS
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Minutes of the Trust Board Meeting held in public on
Wednesday 24 April at 9.30am
Boardroom, Northampton General Hospital

Present:

Mr P Farenden	Chairman
Mr C Abolins	Director of Facilities & Capital Development
Mrs C Allen	Interim Chief Executive
Mrs J Brennan	Director of Workforce and Transformation
Mr A Foster	Acting Director of Finance
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr D Noble	Non-Executive Director
Mr N Robertson	Non-Executive Director
Mrs E Searle	Non-Executive Director
Dr S Swart	Medical Director
Mr P Zeidler	Non-Executive Director

In Attendance:

Dr C Elwell	(Agenda item 6 only)
Mrs D Needham	Care Group Director – Medicine
Dr D Riley	(Agenda item 6 only)
Mr C Sharples	Head of Corporate Affairs
Ms W Smith	(Agenda item 6 only)
Ms K Spellman	Deputy Director of Strategy and Partnerships

Apologies:

Mr G Kershaw	Non-Executive Director
Mr C Pallot	Director of Strategy and Partnerships

TB 13/14 001 **Declarations of Interest**
Mrs Brennan informed the Board of her additions to the register of interests.

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

TB 13/14 002 **Minutes of the meeting held on 28 March 2013**
The minutes of the Board meeting held on 28 March 2013 were presented to the Board for approval.

Mr Foster advised that on Page 7, the final paragraph should read March 2012 not March 2013.

Ms Loader advised that on page 8, the final paragraph should read “Ms Loader informed the Board that the business case would be developed by April 2013”.

Subject to those amendments, The Board APPROVED the minutes of 28 March as a true and correct record.

TB 13/14 003 **Action Log and matters arising**
All actions and matters arising were considered.

Regarding the second item on the log, Ms Loader advised that the indicator had not been rated as red as the locally determined measure for the CQUIN question which was presented in the report was recorded at 36.3%, whilst the

national benchmark was reported at 73%. As such, an average of the two metrics had been taken and provided an amber score. Ms Loader acknowledged the approach was crude and further work was required to improve reporting.

Regarding the final item on the log, Ms Loader informed the Board that there was no clear correlation between the poor results of patient experience indicators and infection control audits. Mr Robertson requested that the evidence of this conclusion be provided.

ACTION: Ms Loader

TB 13/14 004 Chief Executive's Report

Mrs Allen presented her report to the Board which highlighted key business and service developments in Northampton General Hospital NHS Trust in recent weeks.

She reported that building work had started to develop a Midwifery Led birthing unit within the maternity department, which would provide a more homely environment for maternity patients and was due to complete by the end of the summer.

A six-month pilot has started with staff from the charity Age UK Northamptonshire on-site in the A&E department during peak times to support people aged 55 and over. The volunteers act as a point of contact and offer practical and emotional support to patients who are older, vulnerable or do not have a family member to help them.

Northampton General Hospital NHS Trust has been given a generous donation of £28,000 to make over its chemotherapy suite, following the Andrew Bigley Charity Christmas Ball held at Sywell. The suite will get new flooring, pods for privacy, new sinks, and large windows and doors to brighten up the room.

The number of Trust staff who had had their free flu jab over the winter rose to 1,681. All staff who had their flu jab were entered into a prize draw to win one of two new iPads, generously donated to the Trust.

A new job shadowing initiative called In Your Shoes had been launched for staff as part of the Listening into Action initiative. It aimed to enable staff to gain an insight into someone else's role within the hospital, thereby providing an opportunity to develop staff.

Mrs Allen congratulated two members of staff who were nominated as NHS Heroes in the national recognition scheme, Pharmacy apprentice Tammy Archer and Healthcare Assistant Charlie Preston.

The IT Service Desk had attained national service desk accreditation following a robust audit process requiring evidence of policies, processes, procedures and quality standards. The senior service manager at Connecting for Health recognised the hard work put in by staff as he presented a certificate to the department in March.

Ms Searle asked if there was a mechanism in place to collate the learning from the In Your Shoes initiative. Mrs Brennan advised that there was and that the pilot would be evaluated and rolled out wider if felt to be successful.

The Board NOTED the Chief Executive's Report.

TB 13/14 005 Liverpool Care Pathway Presentation

Dr Swart introduced Dr Elwell, Dr Riley and Ms Smith to the Board who had been invited to deliver a presentation on the Liverpool Care Pathway and provide an overview of progress the Trust had made, alongside future priorities and challenges to improving end of life care pathways.

The presentation looked at the key enablers to providing high quality end of life care to patients and presented the actions the Trust had taken, and were proposing to take, to drive improvements in the area. The Board was informed that the Trust had also signed up to a Transforming End of Care Project as part of a wider health economy view on improving care.

Dr Swart concluded that the team required continued support in discussions with commissioners to ensure that there was sufficient palliative care provision within Northamptonshire.

Mr Farenden welcomed the presentation and the clear articulation of patient care in the end of life care pathway and congratulated the team on their work.

The Board **RECEIVED** the Liverpool Care Pathway Presentation.

TB 13/14 006 Medical Directors Report

Dr Swart presented the Medical Director's Report to the Board.

Dr Swart provided a more detailed overview of the metrics used to measure mortality and provided a brief summary of the mortality and safety indicators provided by Dr Foster relating to Summary Hospital-Level Mortality Indicators.

Dr Swart informed Board members that the Hospital Standardised Mortality Ratio was developed as a tool to assist hospitals in monitoring mortality and there had been continual debate as to the way it should be used. At Northampton General Hospital NHS Trust there was a detailed monitoring process where in addition to looking at overall Hospital Standardised Mortality Ratio which is based on the 56 conditions most likely to result in mortality, Standardised Mortality Ratio was examined in any area thought to be of concern. Whereas there continued to be considerable debate relating to how to use the Hospital Standardised Mortality Ratio to compare hospitals, she advised that any individual hospital changes in the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio for individual conditions were always investigated.

The Board was made aware that that the expected mortality figure calculated by Dr Foster did not allow for any variation in the severity of the condition of the patient on admission meaning that mortality for the admission may also depend on the quality of primary care in the catchment area of the hospital. In addition the Board was advised that community hospitals, where predominantly elderly patients were admitted for a variety of types of care including terminal care, were not recorded as separate sites which would likely affect the Hospital Standardised Mortality Ratio for this Trust.

Dr Swart informed the Board that the current year to date Hospital Standardised Mortality Ratio using the 2011/12 benchmark was 99 and was predicted to rise to 105 following re-benchmarking, which remained within the as expected band.

Dr Swart reported that the Standardised Hospital Mortality Indicator remained

higher than the Hospital Standardised Mortality Ratio and higher than at the same point in 2011/12 at 111. The rolling Standardised Hospital Mortality Indicator to the end of the six months was 108 which was in the 'as expected' category using 95% confidence levels.

With regard to the Dr Foster Patient Safety Indicators, Dr Swart informed the Board that there was currently one concern in relation to deaths recorded after complications after surgery. The indicator was dependant on correct coding of the complication and there were information gathering issues identified. The issue was under investigation both internally and externally with Dr Foster, and emphasised to need to ensure data was clearly and consistently captured and recorded or all patients. Dr Swart commented that the overall mortality from surgical procedures was not reflected in this indicator which was important to note.

Overall, unadjusted mortality was not raised and was recorded at 4.0 % which was slightly less than the East Midlands average of 4.1%.

Dr Swart informed the Board that there remained concerns relating to mortality from fractured neck of femur. Following review of the issue, it had become clear that there was not one particular issue but a number of underpinning factors to be addressed. A care bundle approach was being taken to resolve the issue, and there were planned increases in doctors and specialist nurses.

Dr Swart advised the Board that from June 2013, Trusts were expected to publish data available from national audits in relation to activity and mortality rates in 10 specialities at a consultant level. In preparation of this, a number of issues had arisen related to data accuracy and completeness which would need to be addressed before data could be published.

The Board was informed that the report contained a new section in relation to individual and organisational level learning from serious incidents.

In presenting the National Quality Dashboard, Dr Swart informed Board members that there remained national issues with A&E performance due to the volume of patients attending, the flow of beds and difficulties with stepped change. She advised the Board that she felt the Trust should take a pragmatic approach to the issues affecting A&E and focus on ensuring that patients received the highest quality and safest care possible rather than compliance with targets which could not be controlled. She advised that a set of quality and safety metrics were under development and should be available in draft form for the next Board meeting. Mr Farenden agreed and stated that staff and patients need to be made aware that their safety was paramount.

In presenting the monthly scorecard, Dr Swart reported that there had been deterioration in performance due to the demands and emergency pressures of the Trust. The Board was assured staff were working hard to mitigate risks and that there were robust actions underpinning each target to address performance but the overall deterioration was indicative of a system under significant pressure.

Mr Zeidler observed that performance against the improving dementia awareness and diagnosis CQUIN remained unacceptable at 0% against a target of 100% and questioned why that was the case. Dr Swart advised the report did not portray an accurate picture. She reassured the Board that the

work was happening but there were issues in recording the data. Ms Loader added that the Trust was making progress in this area and had recently appointed a new clinical lead for dementia.

The Board NOTED the Medical Director's Report.

Mr Robertson left the meeting.

TB 13/14 007 Patient Experience Report

Ms Loader presented the Patient Experience Report to the Board. The report presented the patient experience data for March 2013.

Ms Loader reported that the feedback received through the friends and families test continued to be positive. The score received for March 2013 was 72, an increase on the previous three months. The Trust was aiming to score 80 by March 2013, but unfortunately had not achieved this.

Of the 5656 patients discharged from the hospital in March 2013, 15.5% responded to the questionnaire which is above the national target of 10% and the internal Trust target of 15%.

The national target for 2013/14 will be increase to 15%, and the Trust has increased its internal stretch target to 20% from 1 April 2013.

Ms Loader advised that for 2013/14, national changes had been made to the methodology and algorithms for collection and interpretation of results of the friends and families test. The changes simplified the overall processes but meant that year on year comparison and benchmarking of data would not be possible. The Trust's results of the test would be presented nationally through the NHS Choices website from July 2013 onwards.

With regard to the Patient Experience Quality Monitoring CQUIN Questions, Ms Loader reported that there had been an improvement in the responses to questions one, two and four, the responses for question three had dropped whilst the responses to question five remained static. Work remained ongoing to address performance which included the piloting of more inclusive ward rounds and the sharing of ward level data to share best practice and learning.

Ms Loader informed the Board that the results of the national inpatient survey had been published by the Care Quality Commission on the 16 April 2013. The results of the survey show the Trust's response rate to be 10% higher than the national response rate of 51%. The Trust received a rating of 'about the same' as other NHS trusts in England which Ms Loader found disappointing considering the work which had happened in response to last year's results. There were areas of negative feedback relating to noise at night, for which there was lots of work ongoing.

Mr Zeidler commented that the negative noise at night responses could be indicative of the ageing estate of the Trust when compared to the results of trusts with modern hospitals as modern hospitals had considerably higher numbers of single rooms.

Mr Farenden requested that a breakdown of all the actions in response to the Patient Survey be presented to the next Board meeting.

ACTION: Ms Loader

The Board NOTED the Patient Experience Report.

TB 13/14 008 Monthly Infection Prevention Performance Report

Ms Loader presented the Monthly Infection Prevention Performance Report to the Board.

She informed the Board that there were no reported cases of MRSA bacteraemia in March 2013, and as such, the total number of cases reported at the end of the financial year was two, against a trajectory of one. It was noted that there had been an improvement in emergency screening which was positive considering the emergency pressures faced by the Trust. It was also noted that there had been a reduction in elective screening. The issue was being monitored closely by the care groups.

In March 2013, one ward had been placed onto special measures due to two post 48 hours MRSA colonisations to ensure staff remained extra vigilant.

With regard to clostridium difficile, Ms Loader advised the Board that five cases of clostridium difficile had been identified during March 2013 which totalled 30 cases for the year against an annual ceiling of 36. The ceiling for 2013/14 had been reduced to 29 cases.

Ms Loader informed the Board that there had been a number of cases identified in early April 2013 which were under investigation. Full details would be reported to the May 2013 Board meeting.

Ms Loader reported that there were no instances of surgical site infection for the year.

The March 2013 overall Trust compliance for hand hygiene was 90.7% due to seven areas failing to submit the completed audit. The seven areas which did not submit their audits were being followed up by the Infection Prevention and It would be highlighted at the next Infection Prevention Committee meeting.

With regards to the outbreak of scalded skin syndrome, Ms Loader reported that the source of infection had been isolated and treated, and regular monitoring remained in place.

Ms Searle asked if there was any learning for the Trust following isolation of the source of the scaled skin outbreak. Ms Loader responded that there wasn't. The source of the infection had been screened three times in total, with only the third screening showing positive, which was indicative of the organism concerned, which added to the challenge of identifying the source of infection.

The Board NOTED the Patient Experience Report.

TB 13/14 009 Operational Performance Report

Mrs Needham presented the Operational Performance Report which set out the key areas of performance for the Trust for March 2013.

She reported that the Trust did not achieve the four hour transit time standard for March 2013 with 81.8% of patients being treated within four hours against the standard of 95%. As such, the year-end for the position for the target was 91.46%

With regard to cancer targets for March 2013, the Trust did not achieve three

standards.

The 62 days from referral to treatment standard was reported as 76.5% of patients treated against the standard of 85%. Quarter four performance was 78.9% with the year-end position at 83%.

The 62 days from referral from screening to start of treatment was reported as 84.2% against the standard of 90%. The Trust achieved quarter four performance of 91.2% and year end at 96.2%.

The 31 day standard from decision to treat to start of subsequent drug treatment. The Trust achieved the standard for March at 98.3% against the standard of 98% but has not achieved quarter four performance with 95.4%. The year-end performance was reported as 98%.

During March there had been one breach of the diagnostic six week standard due to an administrative error which led to a patient waiting eight weeks. Once the error came to light the patient was treated immediately.

The Trust achieved all the other performance standards for March 2013.

Mr Noble observed that the GP referral target was reported as red and asked why that was the case. Mrs Needham advised that the target provided an indicator of referral patterns from GPs. The red performance could be attributed to a cumulative number of referrals across a number of specialist areas. She assured Mr Noble that there had not been a significant reduction in the number of referrals in one particular area and that the Finance and Performance Committee monitored the indicator closely.

The Board NOTED the Operational Performance Report.

TB 13/14 010 Finance Report

Mr Foster presented the Finance Report which summarised the Trust's financial performance for the 12 months to the end of March 2013.

Mr Foster reported that, subject to the external audit of the accounts, the Trust had delivered an income and expenditure surplus of £0.4m for the financial year 2012/13. As such, at the end of the 2012/13 financial year, the Trust maintained a cumulative breakeven surplus of 2.6% of total income, thereby achieving the statutory breakeven duty.

The Trust had managed its cash and capital resources to enable it meet the prescribed External Financing Limit and Capital Resource Limit for the year.

Mr Foster informed the Board that due to cash flow restrictions earlier in the financial year, the Trust did not fully achieve compliance with the Better Payment Practice Code.

The Board NOTED the Finance Report

TB 13/14 011 Human Resources Report

Mrs Brennan presented the Human Resources Report.

In presenting the key points from the report, Mrs Brennan reported that there had been a reduction in the substantive workforce employed by the Trust to 92.76%, the impact of which could be seen in the increase in the temporary workforce of 0.95%.

Mrs Brennan reported that whilst turnover remained above target at 8.75%, the Board could consider it a reasonable position when compared to other acute NHS trusts which generally averaged around 11% turnover.

The Board was informed that short term sickness absence had increased to 2.08% against a target of 1.4% and total sickness absence had increased to 4.25% against a target of 3.4% which was indicative of the emergency pressures faced by the Trust.

With regard to appraisals, Mrs Brennan advised that there appeared to be significant disparity between the appraisal rates reported in the annual staff survey and those which were reported centrally, an issue which would be addressed going forward.

Mr Noble observed that a large percentage of reported sickness absence was recorded as reason unknown. Mrs Brennan advised that when recording sickness absence, the Trust were bound by the categories used in the electronic staff record system, which allowed unknown reason for absence to be recorded. She advised that the Trust had previously attempted to change the categories nationally to no avail, and the Trust was now exploring ways to address the issue locally.

The Board NOTED the Human Resources Report.

TB 13/14 012 Transformation Report

Mrs Brennan presented the Transformation Report to the Board.

She reported that the Trust's Transformation Programme delivered a total of £10.506m in 2012/13 against a target of £11.1m. When combined with 2011/12 performance, the Trust had delivered a total of £29.6m of savings over a two year period.

Mrs Brennan informed the Board that the target for 2013/14 was £13m, the delivery of which would be challenging. £11.5m of schemes had been identified for 2013/14, with additional schemes in development to bridge the shortfall. Draft quality impact assessments had been complemented for schemes in delivery and were under consideration by the respective care group boards prior to final sign off.

Mr Zeidler advised the Board that the Finance and Performance Committee had received significant assurances on the systems in place to deliver the Transformation Programme, but the scale of the challenge was vast. He felt the Board should receive a comprehensive overview of the plan at a future meeting to highlight the scale.

The Board NOTED the Transformation Report

TB 13/14 013 Self-certification return

Ms Spellman presented the return. She advised that the Trust was rated as Amber-Red for governance due to not meeting performance targets and continued to have a financial risk rating of 2. Ms Spellman recommended to the Board that declaration two of the return be signed due to those factors.

The Board APPROVED signing Declaration 2

TB 13/14 014 Corporate Objectives 2013/14

Ms Allen presented the 2013/14 Corporate Objective to the Board for approval.

The corporate objectives were developed to encapsulate the priorities and areas of work for the year and would form the basis of objective setting for all members of staff. All of the objectives were underpinned by defined outcomes and measures, and detailed action plans for delivery.

Mr Farenden asked how performance against the objectives would be monitored. Mrs Allen advised that there would be quarterly performance reports presented to the Board, and any risks to delivery would be reported through the Board Assurance Framework.

Dr Swart recommended that a number of the metrics should be developed to underpin the metrics reported in the national quality dashboard. It was noted that the metrics would require development and should also be considered when developing methods of reporting against the corporate objectives. Ms Allen acknowledged that the metrics needed to further develop and would evolve as the year progressed.

The Board APPROVED the 2013/14 Corporate Objectives.

TB 13/14 015 Annual Carbon Management and Sustainability Report 2012/13

Mr Abolins presented the Annual Carbon Management and Sustainability Report 2012/13 to the Board.

In presenting the report, Mr Abolins informed the Board that the Trust remained on track to deliver its annual carbon target, despite the much colder that average winter and that the effect of last year's Salix investment in energy saving measures would begin to provide a full year benefit in 2013/14. The Trust had targeted to reduce emission by 1000 tonnes of carbon in 2013/14.

Mr Noble asked if the measures within the report could be reported on a monthly basis if required. Mr Abolins advised that monthly data would be available if requested.

Mr Abolins informed the Board that the Trust had in principle been successful in a bid to obtain additional capital funding specific to energy efficiency from the Department of Health. The Trust had in principle been awarded £2.7m from a national allocation of £50m. The allocation was subject to further information being provided to the Department of Health, and the Trust would be notified in June 2013 if it had been successful. Mr Farenden congratulated Mr Abolins and his team on their success.

Ms Loader enquired if the funding, should the Trust be successful, would reduce the Trust's energy spend in 2013/14. Mr Abolins advised that the Trust would not see a benefit from the additional investment until 2013/14.

Mr Noble asked if the savings identified within the report were predicated on the award of additional investment. Mr Abolins confirmed that was the case.

The Board NOTED the Annual Carbon Management and Sustainability Report 2012/13.

TB 13/14 016 **Information Governance Report 2012/13**

Ms Spellman presented the Information Governance Report for 2012/13 to the Board. The report also formed the Senior Information Risk Owner's report to the Board.

In summarising the report, Ms Spellman reported that the Trust had declared level two compliance against the 2012/13 Information Governance Toolkit assessment, a position which was supported by the Trust's internal auditors.

There had been no serious information breaches reported in 2012/13, although there were a number of incidents of concern which were addressed.

Ms Spellman presented the priorities for 2013/14 for improving and embedding information governance within the Trust which included the strengthening of information technology security assurances and provision of additional information governance training sessions for staff.

The Board NOTED the Information Governance Report 2012/13.

TB 13/14 017 **Any Other Business**

Mr Farenden advised members that the Chair of the CCGs had invited the Board of the Trust to attend a Board to Board meeting.

Mr Farenden had responded positively to the invitation on behalf of the Board but had yet to receive a response.

He informed the Board that he would continue to actively chase the meeting as he was keen to pursue constructive discussions with commissioners on health economy wide issues such as urgent care and the healthier together initiative.

TB 13/14 018 **Date of next meeting: 30 May 2013, 9.30 Boardroom NGH**

Mr Farenden called the meeting to a close at 11:35

TB 13/14 019 **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 24 April 2013

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 13/14 003	Matters Arising Patient Experience Report	24 April 2013	Ms Loader undertook to provide evidence that there was not a correlation between ward level patient experience results and the outcomes of infection control audits.	Ms Loader	June 2013	
TB12/13 007	Patient Experience Report	24 April 2013	Mr Farenden requested that a breakdown of all the actions in response to the Patient Survey be presented to the next Board meeting.	Ms Loader	May 2013	

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

Northampton General Hospital NHS
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TRUST BOARD 30 MAY 2013	
Title: -	Chief Executive's Report
Submitted by: -	Dr S Swart, Medical Director
Date of meeting: -	30 May 2012

SUMMARY OF CRITICAL POINTS: -

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

RECOMMENDATION: -

The Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT
MAY PUBLIC BOARD MEETING

1. Emergency care

Emergency care pressures continue with NGH experiencing some of the effects reported in the national press, a full update is provided later in the agenda.

2. CEO Update

NGH Festival

Planning is currently underway for the NGH festival which will take place on the same day as the AGM on Saturday 14th September. A day celebrating the work done here at NGH highlights include the NGH choir, tours of various departments. Other attractions will include traditional dancing from members of the Sikh community, a jazz band and other events.

Listening into Action

Building on some of the work that has come from the first wave of LiA teams the second wave of teams are now starting with teams including Pharmacy, Nuclear Medicine, Children's Physiotherapy, , Community Midwifery and others.

Social Media

We are extending our reach and influence. We now have more than 2,500 followers on Facebook (up from just over 2,000 in January 2013) with a potential reach of 678,167 people. The posting about our STAR awards reached almost 7,000 people. We are also gaining followers to our Twitter feeds – we now have more than 360 followers (up from 70 in January 2013). Social media is used by staff, patients and carers and aims to increase the ways we effectively communicate with our staff, patients and others.

3. Change to the Senior Information Risk Owner

The role of Senior Information Risk Owner (SIRO) was introduced as one of several measures to strengthen controls around information security.

The SIRO should be an Executive or Senior Manager on the Board who is familiar with information risks and the organisation's response to risk and has the knowledge and skills necessary to provide the required input and support to the Board and to the accountable officer.

To date, the role of SIRO had been held by Chris Pallot, Director of Strategy and Partnerships. Whilst Mr Pallot is seconded from the Trust, it has been agreed by the Executive Team that the responsibility for SIRO will be assigned to Craig Sharples, Head of Corporate Affairs as his remit includes board assurance and information governance.

Dr Sonia Swart
Medical Director
May 2013

Northampton General Hospital NHS
NHS Trust

Trust Board 30 May 2013	
Title: -	Medical Director's Report
Presented by: -	Dr Sonia Swart, Medical Director

PURPOSE OF PAPER: - Update on Mortality, Learning from Serious Incidents and Never Events and Clinical Scorecards

CRITICAL POINTS: -

- Overall mortality as measured by HSMR and SHMI is within acceptable parameters although there is no updated information this month
- On-going analysis and risk based audit continues in order to define any coding or quality of care issues.
- Further scrutiny of information flows will continue.
- The clinical scorecard outlines areas where there is on-going concern in relation to performance.
- Tracking of appropriate quality measures is an increasingly important tool which should be used to allow the Board is able to challenge the quality of care provided.
- The key metrics which are reported in the National Quality Dashboard which is the recently released nationally mandated tool to be used for quality improvement are outlined.
- Learning from Serious incidents and Never Events helps to augment the analysis of mortality issues and informs improvement work

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

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

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

In addition the Board should note that the acquisition of community hospitals are not recorded as separate sites and where predominantly elderly patients are admitted for a variety of types of care, including terminal care, is likely to affect the HSMR for this Trust.

HSMR Comparison

There has been no further data in the last month to provide an update on HSMR as there are national data issues. In view of the comments above relating to the community hospitals the data has been interrogated to look at the possible impact of community sites on HSMR and the work to date shows that it is likely that a fall in HSMR of around 2 would result if the patients admitted directly to these sites by other providers were removed from the calculation. It is also worth noting that the Trust has a lower than average rate of palliative care coding and that co-morbidity coding is also low. Both of these factors would tend to elevate the HSMR and improved coding would lower the HSMR and the SHMI although this would not affect the actual death rate.

3. Standardised Hospital Mortality Indicator (SHMI)

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

The SHMI is the mortality indicator used in the National Quality Dashboard and published on NHS choices remains higher than the HSMR and has also not been updated since the last Board report. It remains at 111 for the first 2 quarters of the last financial year. This is in the ‘as expected ‘ category but is higher than at this point last year which is a cause for concern.

The SHMI is significantly higher than the HSMR for some diagnostic groups. This probably relates to a different methodology in terms of calculated the expected mortality rate. This has an impact particularly on pneumonia where the Trust now has a significantly low HSMR but a SHMI running at 109. The Trust is working to set a new series of improvement measures for the care of patients with pneumonia although many of these patients are elderly and frail. It is not possible to get patient level data for the SHMI data and it is also not possible to assess the impact of community sites.

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

a) Mortality from High Risk Diagnoses

There continues to be cause for concern in relation to mortality from fractured neck of femur. The previously reported SMR for 2012/13 is **167** (42 deaths with 25 expected) and all deaths continue to be reviewed. The Clinical Director has presented his findings on this issue to the Healthcare Governance Committee this month and has with the help of the Surgical Care Group developed an improvement plan for this group of patients. It is clear from the work to date that no single factor has been identified which would explain the high mortality and in view of this in additional to the on-going audit, a bundle of measures likely to improve care is being supported. As part of this, Medical Care Group has been asked to develop improved plans to assist with medical input to the frail elderly group of patients involved and both Care Groups support the provision of increased medical and nursing support to these patients. This has been 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. A further report to HGC has occurred this month to detail progress against key areas of improvement which include:

- Further exploration of increased medical support for this group of patients
- Improved junior medical cover on the orthopaedic ward
- Optimisation of nursing care for fractured neck of femur patients
- Increased focus on infection control to ensure no surgical site infections
- On-going audit of standards against best practice to ensure rapid admission to the specialist ward and timely access to operation
- Identification of improved ways of working to share best practice with other units
- Appointment of specialist nurse for Fractured Neck of Femur
- Review of nursing levels

5. Possible areas for Concern under investigation

The detailed monitoring process based on the use of the Dr Foster Intelligence Tool continues. This involves looking in detail at any area of possible concern and making a decision with respect to the level of investigation required. The factors affecting SMR are complex and it is not generally possible in any area to specifically identify single factors responsible for changes in mortality or to make rapid changes in mortality figures other than by changes in clinical coding.

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 these complex issues. The planned work to examine information flows, clinical coding and patient flow has now been commissioned and a report is awaited. The draft report has identified information and coding issues which will need to be addressed.

All issues emerging from the reviews and monitoring are linked into the current improvement work underway as part of the emergency care redesign project and the patient safety programme.

As part of the patient safety programme, lessons learned from audits and investigations are shared and improvement projects put in place. The aim of all the patient safety work is reduce harm and avoidable death. The Mortality and Coding Group continue to receive reports in relation to any areas of concern which are thoroughly investigated. There are no new areas flagged for concern at present. The group has received presentations from a number of teams and in these cases no quality of care issues have been identified. The detailed case review of 50 consecutive deaths has now been completed and the findings are broadly similar to those from the previous larger review which led to the work streams underpinning the patient safety programme. It is clear that the very

significant emergency pressures are to some extent hampering progress in resolving the on-going quality issues but the current focus on emergency care alongside the patient safety programme which is looking at failures to plan care, escalate care and deliver basic care should result in an improvement. The mortality and coding group this month will receive reports on perinatal mortality, the medical and anaesthetic aspects of fractured neck of femur, diabetes with complications and upper gastrointestinal endoscopy. The report on secondary malignancy is awaited.

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

The Trust currently has a readmission rate which is 'as expected' and similarly the overall length of stay is as expected. Readmission rates are falling for knee and hip replacement which relates to improvements in this area. A key stroke outcome measure which is improving is return to normal residence is significantly better than expected with a relative risk of **70** (versus 100 average). This may relate to the excellent community stroke team. Elective deaths within 30 days of colorectal surgery are also very low with none in 2012-13 whereas previously there were 1 or 2 deaths per month. The Trust has a higher number of excess beds days than might be expected which may relate to the use of community hospitals which are not counted as separate sites from the main hospital site in these analyses and to delays in transfers of care. There is on-going work to improve the emergency pathway in order to ensure that patients receive timely and appropriate care in the most appropriate setting.

7. Further actions in place or planned

The Trust has made some further progress in working with Dr Foster to engage in two new projects to provide clinicians with more detailed quality dashboards. One of these includes data from Theatre systems as well as HES data and has the capability to provide meaningful data at consultant level. The Trust has received a more detailed proposal from Dr Foster Intelligence who have now agreed to perform a feasibility study using our Theatre system.

In response to the very significant emergency pressures and the acknowledgement that this presents quality and safety risks, the Trust has worked with lead clinicians to agree a number of safety metrics to be used to assess the on-going safety of the A and E department .

It has been agreed that in addition to using the Early Warning Score to triage patients, this should be augmented in certain categories of patients known to be at high risk so that they are prioritised for early medical review. To date the proposal is that patients with a high BMI, Sickle Cell Disease, Chest Pain or Neutropenic Sepsis all have a priority for early medical review regardless of Early Warning Score. There is a need to emphasise current standards for escalation of care and speciality review and to revise the standard procedure for medical ownership of patients who have been seen by a speciality team but are still in the Emergency Department.

The clinical lead in A and E is overseeing this work and agreed that the following metrics can be put in place:

- Cardiac arrests (not on admission)
- Time to first doctor assessment
- Time to speciality review
- Datix numbers relating to failure to escalate
- Serous Incident numbers relating to failure to escalate as part of issue
- Datix numbers relating to poor transfers of care from A and E
- Datix incidents relating to failures in specialist review

The department currently analyses delays to first assessment but clearly should also analyse delays to speciality review.

9. Learning from Serious Incidents and Never Events

The actions and improvements required in order to improve mortality and quality of care include those required as a result of serious incident investigations.

During the month of April 17 Serious Incidents were submitted to the Clinical Commissioning Group (CCG) for closure. The investigations submitted were: 1 unexpected death, 12 pressure

ulcers (7 of which are considered to unavoidable by the Tissue Viability Team), 1 failure to act on adverse test results, 1 fractured Neck of Femur as a result of a fall, 1 lack of review/escalation and the final investigation related to infection control issue on the Renal Ward where a significant concern was raised but no patient came to harm.

As a result of the investigations we have requested that the CCG downgrade 8 of the submitted incident to a Grade 0, effectively removing them as Serious Incidents for the Trust. These 8 incidents consist of the 7 unavoidable pressure ulcers and the incident relating to a lack of review/escalation. The pressure ulcers are considered to be unavoidable due to the patient's co-morbidities and prognosis. The investigation into the incident for lack of review/escalation did not identify any care or service delivery problems for the Trust to address. Confirmation on the downgrading is currently awaited from the CCG.

Actions taken as a result of these incidents:

- The Trust continues to meet the challenge of pressure ulcers as articulated in last month's report :
    - Pressure Ulcer care plans encompassed in senior nursing spot check audits focussing on Risk Assessment and Body Mapping
    - Process for ordering pressure relieving equipment simplified and reiterated to all staff. Nursing documentation reviewed and streamlined
    - Nursing documentation audit encompassed in forward plan
    - The Trust also records 'community acquired' pressure ulcers. This information is shared with the CCG who actively monitor and address any issues raised

- Guidelines for the prevention of blood borne virus infections and procedures in the renal unit have been clarified
- Improved fail-safe communication procedures for abnormal radiology results has been put in place
- Clarification of NICE guidance relating to spinal cord compression has been mandated
- Procedures for clarifying the escalation procedures to ensure senior medical staff are always called to attend certain categories of patient have been re-enforced
- Further work has been commissioned to look at the effective use and provision of critical care beds
- The Trust continues to emphasise the importance of staff awareness relating to the risk of falls and has issued safety alert screensavers

Process for ensuring actions completed

- The individual directorates are responsible for ensuring that the action plans are implemented through local governance processes and this is overseen via the Care Group Management Team.
- The Corporate Risk Management team will monitor progress and provide challenge and scrutiny to provide further assurance.
- Learning is shared more widely through Directorate Governance meeting, Morbidity and Mortality meetings and the Patient Safety Learning Forum.
- Trust wide learning that relates to very important issues such as Never Events is shared by members of the Safety Team at directorate meetings using presentations so that each directorate can ensure their actions are completed and presented to Healthcare Governance Meetings where updates on progress are scrutinised

Individual and organisational learning

In order to supplement discussions held at team or directorate level, the Patient Safety Learning Forum (PSLF) promotes individual and organisational learning from national and local incidents and initiatives via a trust-wide multi-disciplinary and multi-specialty group evidencing any change on practice were appropriate. As Serious Incidents are closed, the identified Root Cause Analysis (RCA) findings and recommendations for any change in practice or process are presented at the PSLF by the investigating team. This provides an opportunity for the Trust's governance team to familiarise and update staff with Trust-wide risk/safety initiatives e.g. risk register, risk

assessments, Serious Incidents (SI's), Claims etc. The forum provides the Trust's governance and PALS teams with operational guidance and reassurance on patient safety initiatives and issues requiring implementation and/or action.

To support reflection from Serious Incidents the PSLF also provides operational evidence of learning and any change in practice resulting from incidents and initiatives.

Consultant medical staff are also mandated to reflect on Serious Incidents as part of Medical Revalidation. This applies to any SI in which the consultant was involved personally but also to SIs within a team. Some SI reports are widely circulated for comment to all relevant specialities for mandated reflection. This is done when issues are raised which have the potential to change practice because the lessons learned are generic.

Never Events

The Trust has reported 5 'Never Event' incidents over a 4 year time period (2009-2012). All of these related to wrong site surgery. During this time over half a million surgical procedures were performed at NGH.

Never Events are a subset of patient safety incidents that meet certain criteria for a specific purpose. They have been chosen to represent a breadth of outcomes that are potentially or actually severe and as the name suggests should never occur. Implementation of the Never Events policy is just one part of wider safety improvement efforts, many of which have a focus on more common incidents. None of the incidents at NGH have been considered as leading to serious harm for the patients involved. As with any patient safety incident, it is expected that providers will provide explanation and an apology for Never Events that occur. 'The Being Open' guidance explains the principles behind this approach and is used at NGH for all Serious Incidents including Never Events. Each of these is investigated as serious incidents even if no serious harm occurred. The Never Event criteria have also been very strictly adhered to and the Trust remains committed to ensuring that these events are eliminated.

Following a thematic review of all these incidents a robust and very detailed action plan was generated to mitigate against re-occurrence of any similar event. The review and subsequent action plan has been submitted to the Serious Incident Group and has received, and continues to do so, their full support. The action plan has been developed with the help of the Safety Leads, Consultant Surgeons, External advisors and a wide range of Theatre Staff and has been presented at a number of meetings throughout the Trust. An update was presented to HealthCare Governance this month. The Surgical Care Group is responsible for ensuring that the actions are completed as outline.

Some of the key points in the NGH action plan produced after the thematic analysis grouped under latent organisational factors and situational factors are as follows:

- Improve audit of compliance with and documentation of the WHO checklist
- Promote accurate and robust surgical site marking with verification procedures
- Improve training for all permanent and temporary staff to include all components of WHO checklist and monitor training programme
- Develop new training methodologies to improve engagement with best practice including a new DVD and training booklet and simulation training as well as face to face meetings to share learning from the never events
- Increase emphasis on team briefings to focus on all relevant patient factors including an increased emphasis on and improvement of consent procedures

For reference, nationally during the last 4 years there have been 762 Never events. The commonest never events were as follows: 322 cases of foreign objects left inside patients during operations; 214 cases of surgery on the wrong body part; 73 cases of tubes, which are used for feeding patients or for medication, being inserted into patients' lungs; and 58 cases of wrong implants or prostheses being fitted.

10. Conclusion

The position with regards to overall mortality as measured by HSMR and SHMI has not been updated this month but last month's report indicated the need for on-going scrutiny as the position had deteriorated compared to the same period last year. The current emergency pressures are dominating the system and putting a strain on the ability to provide high quality care but there is significant work underway lead by clinicians and supported by managers to ensure that improvements are made. The learning from serious incidents and never events remains a crucial part of the continual emphasis on improving standards of care.

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

11. Recommendation

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

Section 2

The National Quality Dashboard

1. Introduction

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

2. Current Metrics on the Dashboard

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

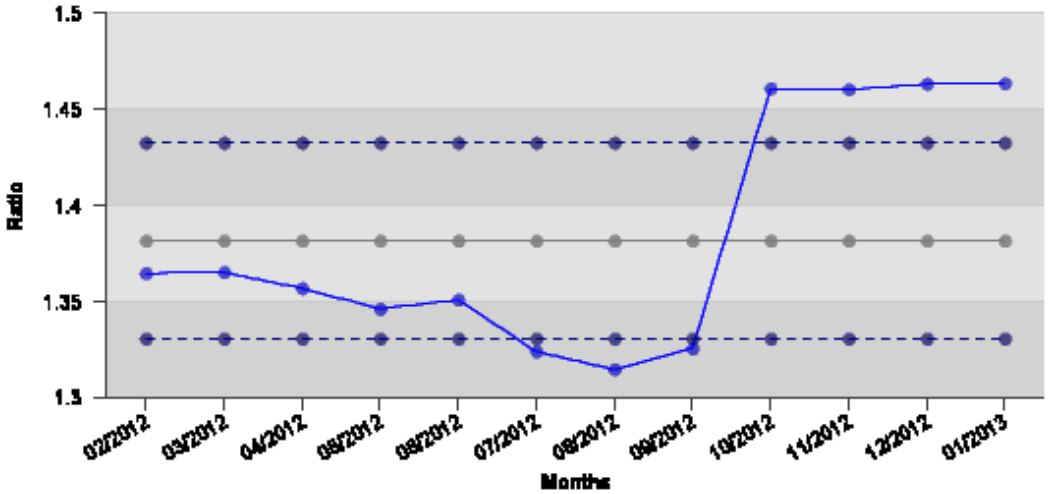
The Dashboard high level report indicates no adverse alerts for Northampton General Hospital.

The metrics are updated at different intervals and are not necessarily current (an outline is presented in **Appendix 1** - this is printed from the website and is not available in another format).

The specific metrics reported are:

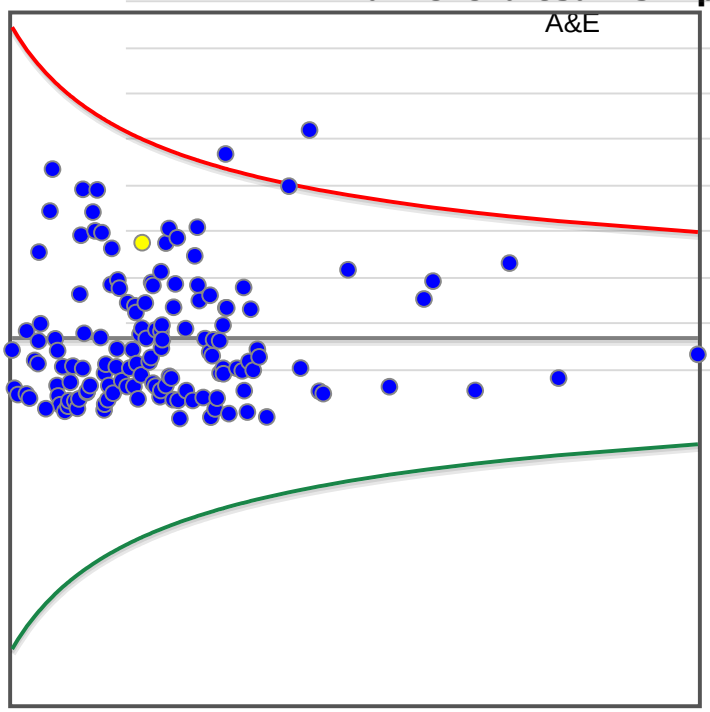
- Preventing People from dying prematurely – results as expected.
- Amenable mortality – results as expected.
- Quality of life for patients with Long Term Conditions – average.
- Number of admissions under 19 – higher than expected.
- Helping people to recover as measured by readmissions and emergency admissions for conditions that do not usually require admission – both were average
- Timely care – A and E patients waiting more than 4 hours- improving compared to the previous position and now comparable to other trusts. (see funnel plots below)
- Timely Care – RTT greater than 18 weeks and cancer waits –within target.
- Safe Environment – Infections, serious incidents, never events, harm free care are all average.
- Organisational indicators – staff sickness average and bed occupancy – higher than average.
- Organisational indicators – doctor to patient ratio – average.
- Organisational indicators – nurses to bed ratio (reported as to January 2013) – improving following recruitment and is now at 1.46 (see graph below).This figure remains lower than other Trusts but further clarification of the bed base and metrics is required. This figure does not include agency staff.

Nurse staffing per bed 2/12 – 1/13

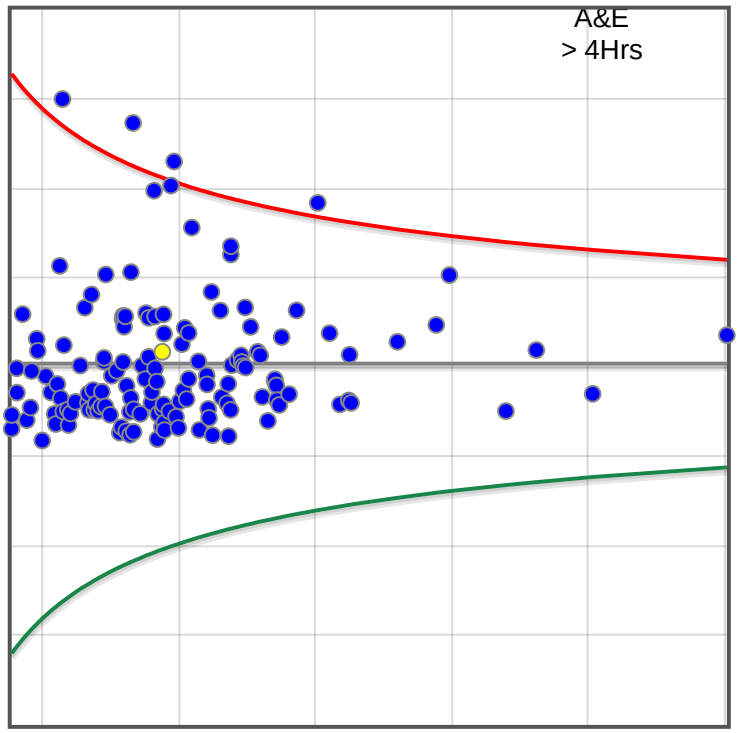


Northampton General Hospital Funnel Chart for A and E greater than 4 hours compared to Trusts in England

Funnel Chart Jan13- April 13



Funnel Chart- 17/2-5/5/13



3. Actions Required

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

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

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

4. Recommendation

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

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

Section 3

NGH Monthly Quality Exception Quality Scorecard

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.

There is still a need to improve Directorate Scorecards to provide the Care Groups with a dashboard relevant to their areas. The directorate scorecards will continue to be informed by more detailed Trust specific measures that are selected according to Trust priorities and pressures. These will need to be built in over the coming months.

Other performance measures are also to be mandated such as the performance in certain types of surgery by consultant but the details of this are not yet available.

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

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

There is no updated report on HSMR and SMR by diagnosis group as there are national data issues impacting on the Dr Foster intelligence tools. The SHMI indicator is not as contemporaneous and we cannot interrogate the data in the same way.

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. There also need to be clear links to the national quality dashboard.

Performance

Within the May 2013 exception report 130 indicators were monitored. The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken.

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	1	7	17	3	28
Clinical Outcomes	4	3	6	10	23
Patient Safety	13	9	20	4	46
Patient Experience	10	1	18	4	33
TOTAL	28	20	61	23	130

Recommendation

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

Quality in the NHS [r0.13.3] Viewed:20/5/13 18:33

Logout NHS

Privatised out-of-hours service is failing NHS patients â€" ...

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

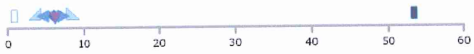
Preventing People from Dying Prematurely

SHMI 1
12/2009 - 09/2012
Quarterly

Amenable Mortality — Deaths 13 — % 1.33
02/2012 - 01/2013
Monthly
Distribution of Trusts for Amenable Mortality

Quality of Life for People with LTC

Adults — Emergencies 97 — % 6.25
02/2012 - 01/2013
Monthly
Distribution of Trusts for Adults



Under 19s — Emergencies 28 — % 6.6
02/2012 - 01/2013
Monthly
Distribution of Trusts for Under 19s

Helping People to Recover

Emergency Readmissions 30 days — Readmissions 534 — % 8.05
02/2012 - 01/2013
Monthly

Emergency adm not usually requiring adm — Emergencies 132 — % 8.61
02/2012 - 01/2013
Monthly
Distribution of Trusts for Emergency adm not usually requiring adm

Timely Care

A&E > 4Hrs — Waiting 110 — % 5.86
17/02/2013 - 05/05/2013
Weekly

RTT> 18 weeks — Waiting 81 — % 4.88
03/2012 - 02/2013
Monthly

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

Safe Enviroment and Protecting People from avoidable harm

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

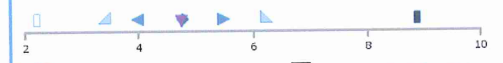
Serious Incidents — Incidents 10 — per 1,000 beds 0.49
01/2012 - 12/2012
Monthly

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

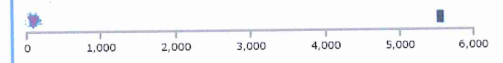
Harm Free Care — % 90.64 — 1
04/2012 - 03/2013
Monthly

Organisational Indicators

Staff Sickness — % 4.75
02/2012 - 01/2013
Monthly
Distribution of Trusts for Staff Sickness

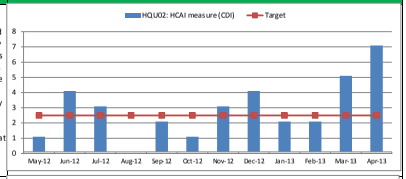
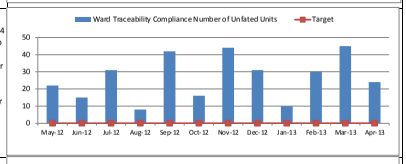
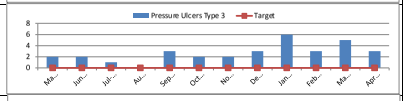
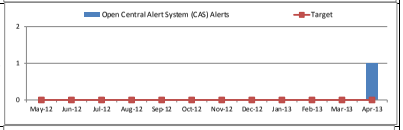
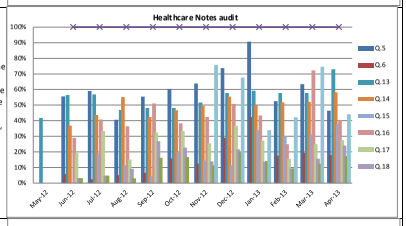
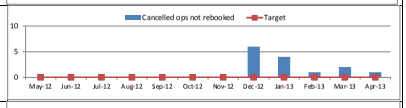
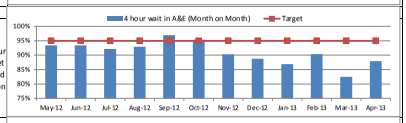
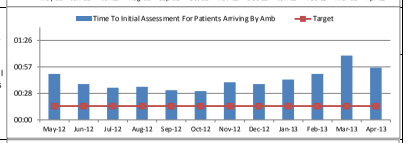
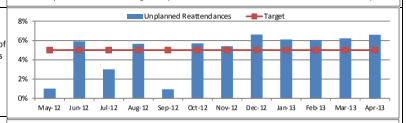
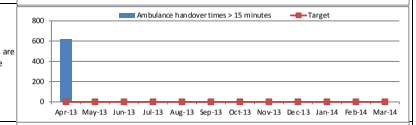
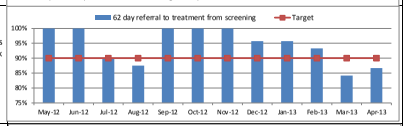
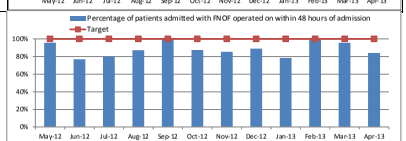
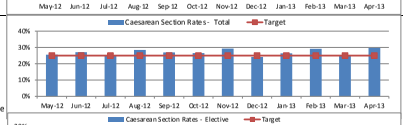
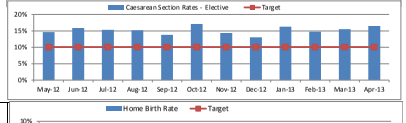
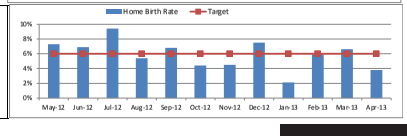


Bed Occupancy — Rate 94.05 — 1
01/2010 - 10/2012
Quarterly
Distribution of Trusts for Bed Occupancy



Nurses to Bed Ratio — Ratio 1.46 — 1
02/2012 - 01/2013
Monthly
Distribution of Trusts for Nurses to Bed Ratio

Doctor to Patient Ratio — Ratio 0.15
02/2012 - 01/2013
Monthly
Distribution of Trusts for Doctor to Patient Ratio

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	HQU02: HCAI measure (CDI)	0	↓	A review of the 7 >3 day cases of Clostridium difficile in April 2013 was undertaken by the Consultant microbiologist and the Infection Prevention and Control Team. Five of the patients were on different wards; there was not any evidence of cross infection. Two were on a medical ward and special measures were instigated. Predisposing factors were antibiotics and five of the patients also had laxatives, aperients and or enemas. It would appear an inappropriate sample was sent for five of the patients. A Root Cause Analysis (RCA) is undertaken for all post 72 hours cases of C.diff. These are in progress and may highlight further themes. These will be reported further in the June board report. A key action is the Infection Prevention team and the Consultant microbiologist have introduced a 'pop up box' on the ICE requesting system that blocks the requesting of faecal samples in patients who have had laxatives or enemas in the past 48 hours.	
Patient Safety	Ward Traceability Compliance Number of Unfated Units	0	↑	Autofate compliance improved last month from 45 unfated units in March to 24 unfated units in April. Ward compliance has improved from 95.5% in March to 97.6% in April and Overall Trust Compliance has risen from 99.7% to 99.9%, although legislation requires 100% compliance with traceability of blood as per the Blood Safety and Quality Regulations 2005. Due to poor compliance in March an Improvement Plan was put in place whereby ward managers are required to submit a Root Cause Analysis and Action Plan for improvement for every unfated unit. The data is gathered to understand the causes of these breaches so improvement efforts can be focused. Reminders to Autofate are being issued with every unit of blood and a screen saver has been developed.	
Patient Safety	Incidence of Pressure Ulcers Type 3	0	↑	All patients were end of life/Critically unwell and sufficient evidence to determine unavoidable ulcers	
Patient Safety	Open Central Alert System (CAS) Alerts	0	↓	Safer spinal (intrathecal) epidural and regional devices. Nationwide issue (just become overdue). Update from Lead Consultant indicates that no Trust can be compliant with this alert at present due to a lack of suitable devices	
Patient Safety	Healthcare Notes audit (23 questions)	100%	↑	The key issues identified on the Healthcare Notes audit in April were around the recording of vital patient information (date of birth, hospital number and nhs number) on the front page of notes where the addressograph was absent. The recording of this information remains below the target but has improved since last month. The other areas where the target is not being met are around whether the surname is capitalised, whether the staff designation is recorded, whether the GMC number is present and how alterations/deletions are managed. Evidence of communication to relatives and teams improved significantly in February but progress was not sustained in March.	
Patient Experience	Cancelled Operations not rebooked within 28 days	0%	↑	This target has again not been met in April with 1 cancelled operation not rebooked within 28 days. Work is ongoing to ensure robust processes are in place to avoid future occurrences and is monitored through weekly performance meetings..	
Patient Experience	A & E Quality Indicators (4 indicators)		↓	**A&E Clinical Indicators:** Time Spent in A&E (Month on Month) We reached 87.9% of patients seen before the 4 hour breach date for April. Our recovery plan was for 92.5%, which the Trust failed to meet and May the target has risen to 93.5%. Number of attendances in A&E for April have been high and the influx of greater numbers of A&E attenders might be due to the introduction of the new 111 service.	
			↑	The time to initial assessment for patients arriving by ambulance was 57 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 - April performance was 6.59% against a target of 5%. The percentage has slightly increased from last month's position. There is also a genuine concern related to patients reattending when they have been unable to access aftercare in primary care.	
			→	New electronic methods of accurately capturing ambulance handover times are currently being implemented and work is being undertaken between the ambulance service and trust (new target)	
Patient Experience	Cancer Wait times	90%	↑	62 day referral to treatment from screening - The Trust has 2 breaches on this pathway, two half colorectal breaches and one breast. The breast patient took time to think through her surgical options and therefore breached. The colorectal patients were due to patient choice and complex pathways respectively.	
		80%	↓	62 day referral to treatment from hospital specialist - Due to the small numbers on this pathway (4.5 patients). One breach takes the Trust below the cancer standard.	
Clinical Outcomes	Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	↓	16 out of the 17 patients fit for surgery had their op within 48hrs, the other patient had eaten so was not fit for surgery that day.	
Clinical Outcomes	Caesarean Section Rates	<25%	↓	Elective C-section in April was 16.5%, emergency rates remain below target, however with the elective result this pushes the total above target. This may be that higher risk patients are electing for c-sections, with the supporting NICE guidance also having an impact.	
		10.1%	↓		
	Home Births	>=6%	↓	Home Birth rates have dropped in April to 3.8%.	

Corporate Scorecard 2013-14 Patient Safety	Target 2013-14	Apr-13	Apr 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	0		
HQU02: HCAI measure (CDI)	29 per year	7		
HQU08: MSSA Numbers	No national ceiling set	1		
E Coli ESBL Quarterly Average	7 per month	2		
VTE Risk Assessment completed	95% month on month	91.9%		
High risk patients receive appropriate treatment	95% Month on month	100.0%		
MRSA Screening Elective Patients	100% month on month	99.87%		
MRSA Screening Non-Elective Patients	100% month on month	96.40%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	24		
Incidence of pressure ulcers				
Type 3	0	3		
Type 4	0	0		
Reduce harm from falls				
Catastrophic	0	0		
Major/Severe	0	0		
Moderate	0	1		
Mandatory Training compliance Full Year Impact				
Primary Levels Excluding B&H	80%	N/Avail		6 week turnaround delay for data
Attendance at Trust Induction	80%	N/Avail		6 week turnaround delay for data
Number of surgical site infections				
Fracture neck of femur - Number of Operations	-	19		Surgical site surveillance requires that
Infections	-	0		the post-operative wounds under
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%			surveillance are reviewed for a 30 day
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc				
Open Central Alert System (CAS) Alerts	0	1		
NICE clinical practice guidelines and TAG compliance	80%	84.7%		
Serious Untoward Incidents	-	41		
Never Events	0	0		
WHO Surgical Safety Checklist	100%	100%		
Healthcare Notes Audit				
Q.1 Does the front page of every sheet contain an addressograph label	100%	79%		
Q.2 Does addressograph include the NHS Number?	100%	90%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	100%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	85%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	61%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	21%		
Q.7 Is record legibly written	100%	95%		
Q.8 Written in blue/black ink	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	99%		
Q.10 Is date recorded for each entry	100%	86%		
Q.11 Is time recorded for each entry	100%	86%		
Q.12 Is there a signature of the person making the entry	100%	96%		
Q.13 Is surname printed in block capitals	100%	73%		
Q.14 Is the staff designation recorded	100%	65%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	69%		
Q.16 Are any alterations / deletions scored through with a single line	100%	46%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	39%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	39%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	15%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	99%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	44%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%		
Q.23 Are there any loose sheets in the Healthcare record	0%	10%		
Patient Experience	**Target 2013-14**	**Apr-13**		**Comments**
Cancelled Operations not rebooked within 28 days	0	1		
Hospital Cancelled Operations	6.0%	0.0%		Requires SLAM data
Number of written complaints received	-	45		
Complaints Responded to within agreed timescales	100.00%	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits				
Admitted Patients	90.00%	0.00%		
Non Admitted Patients	95.00%	0.00%		
Ongoing Patients	92.00%	0.00%		
A&E Quality Indicators (5 measures)				
Time Spent in A&E (Month on Month)	95%	87.89%		
Time Spent in A&E (Cumulative)	95%	87.89%		
Total time in A&E (95th percentile)	95th	06:45		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:57		
Time to treatment decision (median)	<60 mins	00:57		
Unplanned re-attendance rate	=<5%	6.59%		
Left without being seen	>1% and <5%	0.24%		
Ambulance handover times > 15 minutes	minutes	612		
Ambulance handover times > 60 minutes	minutes	68		
Cancer Wait Times				
2 week GP referral to 1st outpatient	93%	95.7%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%		
31 Day	96%	97.1%		
31 day second or subsequent treatment - surgery	94%	100.0%		
31 day second or subsequent treatment - drug	98%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	98.1%		
62 day referral to treatment from screening	90%	86.7%		
62 day referral to treatment from hospital specialist	80%	77.8%		
62 days urgent referral to treatment of all cancers	85%	85.7%		
SRS08: Length of Stay (Acute & MH)				
Elective	3.20	3.1		Based on DFI Peer Group UQ. Fig reported in March 13 relates to roling 12 months up until Jan 13
Non-Elective	5.30	4.3		Based on DFI Peer Group UQ. Fig reported in March 13 relates to roling 12 months up until Jan 13
SRS09: Daycase Rate	85%	0.0%		Requires SLAM data
SQU11: PROMS Scores - Pre Operative participation rates				
Groin Hernia - Participation Rate	Nat.Ave 62.9% (target 80%)	81.3%		Information based on 3 months HES
Hip Replacement - Participation Rate	Nat.Ave 79.5% (target 80%)	94.6%		data to Apr 12 - Sept 12 (published
Knee Replacement - Participation Rate	Nat.Ave 86.9% (target 80%)	107.1%		Feb 13). Target for 2012-13 is
Varicose Vein - Participation Rate	Nat.Ave 33.3% (target 80%)	66.7%		measured against national average for
All Procedures - Participation Rate	Nat.Ave 72.6% (target 80%)	90.5%		the period and not the national target of
Clinical Outcomes	**Target 2013-14**	**Apr-13**		**Comments**
HSMR - monthly position for 2012-13	<100			Latest DFI position 2012-13 - 12 months to Jan 13, supercedes 2011-12 rebased position as reported previously
HSMR - cumulative position current financial year				Latest DFI FY trend Apr 12 - Jan 13 (HSMR)
HSMR- cumulative position for 2012-13				
Pneumonia	<100			Latest DFI Apr 12 to Jan 13 (HSMR)
Fracture of neck of femur (hip)	<100			Latest DFI Apr 12 to Jan 13 (HSMR)
Acute Cerebrovascular disease	<100			Latest DFI Apr 12 to Jan 13 (HSMR)
Congestive heart failure, nonhypertensive	<100			Latest DFI Apr 12 to Jan 13 (HSMR)
Acute myocardial infarction	<100			Latest DFI Apr 12 to Jan 13 (HSMR)

SHMI (based upon date of SHMI report publication)	<100			SHMI - Apr 12 to Jun 12 = Oct 10 to Sept 11 position. Jul 12 to Sep 12 = Jan 11 to Dec 11 position. Oct 12 to Dec 12 reflects Apr 11 to Mar 12. Latest position reported in Mar 13 reflects Jul 11 to Jun 12.
SQU12: Maternity 12 weeks	90%	92.0%		Figure subject to change following final data collation
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	-		Requires SLAM data
Fractured neck of Femur				
Number of patients admitted with FNOF	-	19		
Patients fit for surgery within 48hrs	-	17		
Number of patients admitted with FNOF who were operated on within 48 hrs	-	16		
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	84.2%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	0.0%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	0%		
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	0%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	0.0%		
Patients who spend at least 90% of their time on a stroke unit	80%	0.0%		
Breast Feeding initiation	75%	80.6%		
Caesarean Section Rates - Total	<25%	29.7%		
Caesarean Section Rates - Emergency	14.98%	13.2%		
Caesarean Section Rates - Elective	10.06%	16.5%		
Home Birth Rate	>=6%	3.8%		
CQUIN 2013-14	Target 2013-14	Apr-13		Comments
National CQUINS				
1.VTE				
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month CQUIN	91.9%		
1b. VTE Root Cause Analysis.	payment to be received if both			
2. Improve responsiveness to personal needs of patients				
2a. Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	96.7%		
2b. Were hospital staff available to talk about any worries or concerns that you had?	>63.4	97.5%		
2c.Did you have enough privacy when discussing condition or treatment?	>82.3	97.9%		
2d.If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5	76.8%		
2e. 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	91.6%		
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting				
3a.Dementia case finding	90% 3 consecutive months	0.86%		3b & 3c no
3b.initial diagnostic assessment	90% 3 consecutive months	-		numerator or
3c. referral for specialist diagnosis	90% 3 consecutive months	-		denominator
3d.Lead clinician and appropriate training of staff	Yes			
3e.Supporting Carers of People with Dementia (monthly audit)	Yes			
Local CQUINS				
1. Develop and implement AECP				
1a AECP for Chest Pain				
1b. AECP for Pulmonary Embolism				
1c. AECP for Supraventricular Tachycardia				
1d. AECP for Pleural Effusion				
1e..AECP for Painless Jaundice				
2. Development of HOT Clinic				
2a. HOT Clinic for Paediatrics				
2b. HOT Clinic for Surgery				
2c. HOT Clinic for Medicine				
MESCG CQUINS				
1. Friends & Family				
1a. Phased expansion of Friends and Family Test				
1b. increase response rate to at least 20%				
1c. Improve performance on staff Friends & Familty Test				
2. 50% reduction in all new Pressure Ulcers that are avoidable.				
3. Quality Dashboards				
4. Timely Simple Discharge				
5. Improve access to breast milk in preterm infants				
6. Acute Kidney Injury				

Northampton General Hospital NHS
NHS Trust

Trust Board meeting: 30 May 2013	
Title: -	Patient Experience Report
Presented by: -	Suzie Loader, Director of Nursing, Midwifery and Patient Services

PURPOSE OF PAPER: - To update the Board on the implementation of the Patient Experience Strategy and its component parts for April 2013.

CRITICAL POINTS: -

- **Friends and Family Test (FFT)** - a single question selected as a headline metric for the clear and concise measuring and monitoring of patients' perceptions as to the quality of the health services they recently received – **Response rates for April 2013 = 18.78% achieved** (national target 15% increasing to 20% by April 2014)
- **CQC National Inpatient Survey Results**
- **Existing and planned Patient Experience work**

ACTION REQUIRED BY BOARD: -

The Board is requested to: -

- Discuss and challenge the content of the report
- Note the results from the April 2013 Friends and Family Test
  Discuss the action plan which has been developed as a result of the National Inpatient Survey results and challenge where appropriate
- Endorse the work being taken forward to create a customer service culture across the organisation

1. Introduction

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

2.0 Patient Experience monitoring

2.1 Friends and Family Test

The methodology and targets regarding the FFT have changed from April 2013, with a slightly different question being asked and a revised methodology as regards scoring – these were described in the previous board report. As a result, the Trust is currently only monitoring the response rate (as this is the target), rather than the scores received. The FFT response rate received for the month of **April 2013 was 18.78%.** 2683 patients were discharged from Northampton General Hospital in April 2013 of which, 504 patients responded to the FFT question.

Details of individual ward response rates with an overall action plan to increase response rates can be found in **Appendix 1.** Results show the scores for April 2013 in those areas now being reported on nationally and those which continue to be collected for local intelligence.

Actions taken to share the FFT results

To support the wards in continually improving their FFT results – all comments received from patients are circulated to Ward Sisters on a weekly basis, when they are included on the paper based form, or monthly when included on the Hospedia bedside unit surveys.

Comments are discussed with the ward sister wherever possible, or emailed. Where appropriate, follow up discussions take place to ensure actions have been implemented.

A log of comments has been started and is available for review on the Patient Experience Drive. As yet it is too early to identify any meaningful themes from these comments. The recommendation is that these be reviewed on a quarterly basis to identify key themes. The Patient Experience Lead (PEL) is to attend the Sisters and Matrons meeting on a quarterly basis to feedback these themes and update the teams on the usage of the FFT information more generally. Appendix 1 identifies the actions being taken to improve response rates.

3.0 Summary of the Midlands and East FFT dashboard.

The East of England produced an interactive dashboard recording the results collected up to the end of March 2013, prior to the national roll out. Results for Northampton showed the trust to be mid-way between trusts within the East of England, with the highest trust scoring 88 and the lowest 38. Northampton achieved an average score of 72, with the mean being 71. Further results can be viewed at: http://www.strategicprojectseoe.co.uk

4.0 Triangulation of results.

The Patient Experience Lead (PEL) has met with the Infection and Prevention Team to ascertain any commonalities across the Patient Experience Surveys and the data collected in relation to infection, prevention and control. This was also viewed in conjunction with the

Master dashboard results. Currently it is not possible to view trends month on month across all these key areas. A request has been made to the information team to enable this data to be viewable in time for the next board report.

5.0 In Patient Survey Results

The results of the national inpatient survey were published by the Care Quality Commission on the 16 April 2013 and summarised in the last board report. The survey of adult inpatients includes a random sample of Northampton General Hospital (NGH) inpatients discharged during June 2012.

An action plan has been developed to address the areas of poorer performance, which are summarised below (details in Appendix 2):

Table 1: Areas where the inpatient survey shows a downward trend

Question	Result 2011	Result 2012	Trend
While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.5	7.9	⇩
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.9	7.4	⇩
If your discharge was delayed, how long was it delayed?	7.7	7.1	⇩
Overall did you feel you were treated with respect and dignity while you were in hospital?	9.0	8.6	⇩
During your hospital stay were you ever asked to give your views on the quality of your care?	1.7	1.2	⇩

An overview of the results has been circulated to all Matrons, Consultants and Heads of Service.

6.0 Mealtime Survey Audit Results

The results of the mealtime audit are collected via the Hospedia bedside system. Response rates are low but responses consistent. To validate this data, volunteers are involved in observational studies to assess compliance with the protected mealtime policy. The proposal is now that the volunteers interview patients to ascertain the underpinning issues. The catering team are to meet with the matrons and sisters to discuss the mealtime experience from the perspective of catering; however, it is apparent from anecdotal evidence that the issues surround the wider meal time experience.

7.0 Patient Experience Implementation plan. Appointment of Patient Experience Clinical Leads

At the Patient Experience Board meeting in April 2013, it was agreed that the role of Dignity Champion would be reviewed, in order to establish whether there were any opportunities for linking the dignity agenda with the patient experience agenda. The PEL met with Judy Foglia, Matron and Chair of the Dignity Forum to ascertain feasibility of doing this and to review the forums' current agenda. Before making a decision, a trial is being conducted on two wards: Creaton and Victoria, where the roles have been combined.

A Patient Experience Champion has been identified for the Medicine Care Group: Shelly Bone - Modern Matron (Community & Elderly Services), who is working with the PEL to drive through the patient experience agenda. This will include piloting the use of the nationally recognised '15 Steps' audit to identify how it can be used most effectively at NGH. The results of the pilot will be fed back to the Patient Experience Board in June 2013.

Plans are now underway to secure the same level of accountability and commitment from Surgery.

8.0 Patient information: Listening into Action sub-group

Appointment Letters: The plan is to pilot the use of a new appointment letter within Cardiology, Audiology and Ophthalmology, beginning in May 2013. The pilot will run for two months. At the end of the pilot, an assessment will be made as to the role of the new format letter – prior to the recommendation that the letter be rolled out across the trust. Progress re formatting the letter has been delayed due to fears that the cost of a trust wide roll out would be high as a result of the large number of template letters that currently exist across the trust that would require changing. This pilot is an opportunity to test the new look letter, to look at whether the number of letters can be streamlined and to identify any costs involved, prior to a decision being taken. The pilot sites have been chosen as a result of issues raised by their teams.

Signage: Facilities used a mystery shopper to do a trial of signage around the trust. Six areas across the site were chosen and the mystery shopper was asked to go out and locate them. Apart from a couple of minor comments in relation to spacing of signs, which the Facilities team are addressing, there were no issues identified.

9.0 Conclusions

Response rates from national surveys remains higher than average – with results consistent across all surveys. Action Plans have now been developed across each of these surveys and are being linked to existing action plans where possible. All patient experience action plans are being streamlined into one document.

Within each area of lower responses or results, work is currently underway to address and implement the necessary improvements.

Across all areas observational studies are being triangulated with surveys, and patient interviews.

Work is underway to identify and improve:

- Noise at night
- Mealtime experiences
- The use of the Carers Strategy
- The experiences of People with and caring for someone with Dementia
- The Friends and Family Response rates
- Clinician communication – via two Goldfish Bowl sessions
- Peer on Peer assessment / shared learning – via the us of the 15 step challenge

Once these interventions have been assessed, and their individual value determined, the plan will be to roll out the programme across all wards and departments, with an emphasis being placed on using existing patients and staff as assessors.

The secret to improving patient experience is local ownership. Working with a Patient Experience Lead who is a Matron within Medicine will enable the trust to ascertain the best way to secure and measure the impact of these actions.

10.0 Recommendations

Members of the Board are requested to:-

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

Appendix 1: Response rates reported nationally

F & F Test Net Promoter Response Rates

Ward	Graph	Target 2012-13 = 10%					Target 13-14 = 15%
		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
Abington		27.06%	43.42%	28.95%	37.50%	43.33%	25.00%
Allebone		18.97%	16.05%	38.46%	28.57%	22.83%	51.02%
Althorp		111.76%	36.84%	31.94%	31.76%	43.00%	54.84%
Becket		19.18%	36.96%	21.88%	31.08%	32.08%	40.43%
Benham		10.99%	13.11%	8.91%	30.18%	7.91%	12.00%
Brampton		34.38%	23.81%	44.12%	41.94%	67.86%	37.84%
Cedar		18.28%	29.47%	36.36%	28.57%	25.71%	19.18%
Collingtree Medical		18.64%	8.66%	0.0%	20.19%	13.56%	7.06%
Compton			77.27%	91.30%	111.11%	77.78%	80.00%
Corby Comm.		0%	71.43%	50.00%	0.00%	30.00%	0.00%
Creaton		7.41%	16%	32.35%	33.33%	21.05%	7.81%
Danetre		0%	0%	57.14%	34.62%	39.53%	39.47%
Dryden		16.36%	29.41%	2.38%	27.03%	24.79%	28.32%
Eleanor		21.62%	17.91%	16.67%	36.36%	21.74%	38.10%
EAU		5.86%	8.40%	13.16%	4.66%	3.15%	14.45%
Finedon		37.25%	38.89%	36.21%	29.17%	21.62%	31.25%
Hawthorn		75.28%	21.97%	25.47%	36.61%	37.68%	33.85%
Hazelwood Comm.		93.75%	25.00%	127.78%	0.00%	60.71%	77.78%
Head & Neck		9.38%	19.20%	33.33%	45.45%	40.46%	17.48%
Holcot		54.84%	21.21%	68.75%	75.00%	53.57%	83.33%
Knightley		53.85%	37.50%	26.67%	31.82%	52.17%	25.64%
Rowan		25.95%	24.85%	34.62%	45.56%	32.84%	16.15%
Spencer		18.75%	8.04%	21.70%	13.07%	12.79%	10.73%
Talbot Butler		23.91%	12.31%	30.56%	10.64%	12.00%	8.93%
Victoria			9.88%	23.91%	4.00%	10.45%	15.07%
Willow		41.11%	21.33%	29.51%	22.99%	21.30%	11.11%
Adult Inpatient Area		15.01%	14.77%	16.45%	19.00%	15.15%	18.78%
A & E Unit		Recorded from January 2013		0.54%	1.75%	0.48%	1.02%
Eye Casualty Unit		Recorded from April 2013					0.72%
A & E Total		Recorded from April 2013					0.97%

For Internal reporting:

Balmoral	51.85%	65.69%	55.87%	46.15%	37.34%	54.59%
Robert Watson	23.46%	30.73%	42.02%	37.20%	30.00%	26.32%
Maternity Ward Total	Previously inlcuded within Inpatient Area To					41.42%
Disney	19.16%	16.26%	16.55%	29.48%	10.13%	17.46%
Paddington	9.95%	7.94%	8.67%	13.30%	9.79%	5.88%
Paediatric Ward Total	Previously inlcuded within Inpatient Area Total					9.55%
Danetre Day Surgery	Recorded from January 2013		66.67%	54.64%	30.88%	50.00%
Main Theatre Admissions	Recorded from February 2013			50.92%	50.00%	67.47%
NGH Day Surgery	Recorded from January 2013		38.86%	29.43%	12.43%	29.17%
Singlehurst Day Unit	Recorded from April 2013					2.44%
Daycase Area Total	Previously inlcuded within Inpatient Area Total					40.30%

Appendix 1: FFT action Plan to ensure continual improvement to response rates and scores							
FFT Area for Improvement	**Detail**	**Improvement actions**	**Owner**	**Review date**	**RAG**	**Comments**	**Target**
Outcomes: Month on month increase in response rates + achievement of 20% target by Dec 2013. All actions to achieve this. Reporting: Performance against this target will be overseen by the Patient Experience Board							
Improvement to FFT results	Current response rates above target for April 2013 but the trend suggests that there is no room for slippage. Within April from 2683 possible discharges 504 completed the FFT. The requirement is that this is given to 100% of all discharges.	Meet with Ward sisters to walk through process of handing out the FFT. ○ Identify those responsible for driving the process at ward level. ○ Understand the logistics of storage and distribution of the forms. ○ Identify opportunities for changing / refining current practice ○ Develop and agree ward based actions	AG	**30/06/13**		1`0 wards visited, 11 to be visited. PEL to visit each ward with a poor response rate and discuss the discharges that week. PEL to develop Posters for wards	**Achievement of 20% target by Dec 2013**
		Look at the feasibility of the FTT being printed in a unique colour – i.e. branded. ○ Supply wards with a stock of these forms.	AG	**01/06**		FFT to be printed on yellow paper and be available on the Essential forms list	
		PEL to attend all ward / matron meeting opportunities to discuss process, importance, outcomes and opportunities	AG	**30/0**		Ongoing	
		To scope feasibility of the night staff attaching an FFT form at the end of the bed of a patient due to be discharged the following day.	AG	**06/06**		Present at Sisters and matrons meeting 06/06/13	
		To review cost of providing locked boxes on each ward	AG	**06\0**		Ongoing	
		Work with PE Champion for Medicine to agree action Plan and Remit and then recruit lead within Surgery	AG	**06\0**		Ongoing	

Area for Improvement	Detail	Improvement actions	Owner	Due date	RAG	Comments	
Outcomes: Month on month increase in response rates + achievement of 5% target by Dec 2013. All actions to achieve this. Reporting: Performance against this target will be overseen by the Patient Experience Board							
Improvement to FFT results A&E	Current Response rate – 0.97% - organisational target 15% Footfall 5133 patients	Meet with A&E managers – Clinical and operational	AG	**06\06**		By June 2013	**Achievement of 5% target by Dec 2013**
		To remove CQUINS questions from A&E form to make it more user friendly	AG	**06\06**		By June 2013	
		Explore use of 'Waitrose' counter system to collect data	AG	**06\06**		By June 2013	
		Raising awareness session within dept to identify opportunities for collecting the feedback across minors and majors	AG RB	**06\06**		By end of June 2013	
		To trial IPAD usage for data collection – 2 IPADS identified – to be trialled in May 2013 FOR 1 month.	RB	**06/06**		By End of May 2013	

Appendix 2 – Action Plan to address In Patient Survey Results. All actions to be in line with other work currently being undertaken – and not to be duplicated.

Area for Improvement		most trusts	previous NGH results	Detail		Improvement actions	Owner	review date	RAG	Target
Measurement – To achieve 10% improvement in results by Dec 2013. Performance to be monitored via results of patient interviews and bedside audit. Results to be presented at the PEB on a monthly basis										
Q15	Noise at night from other patients	↓	≈	Nationally 39% patients were bothered by patients. NGH results are 49.6%. Actions implemented previously have not been effective.	1 2 3	Review and refine noise at night audit questions and remit. Meeting to be held 10th June Volunteers to conduct patient interviews on those wards where noise at night identified as bigger problem. Drill down to identify top 3 issues. Develop Noise at night survey for Hospedia bedside collection	AG MM EM	**10th June**		To achieve 10% Improvement in results in 2013 survey. Patient in interviews to show a change in top three issues over the next 6mth period. Patient interviews to be held on each ward monthly and involve interviewing 5 patients. To be launched on 10th June 2013
Q16	Noise at night from hospital staff	↓	≈	Nationally 20% patients were bothered by staff. NGH results are 27.1%. Actions implemented previously have not been effective.	4 5 6	Review and refine noise at night audit questions and remit. Meeting to be held 22nd May Volunteers to conduct patient interviews on those wards where noise at night identified as bigger problem. Develop Noise at night survey for Hospedia bedside collection	AG SB MM EM	**10th June**		To achieve 10% Improvement in results in 2013 survey. Patient in interviews to show a change in top three issues over the next 6mth period. Patient interviews to be held on each ward monthly and involve interviewing 5 patients. To be launched on 10th June 2013

Area for Improvement		most trusts	previous NGH results	Detail		Improvement actions	Owner	review date	RAG	Target
Results to be presented at the PEB on a monthly basis.										
Q3	Amount of info provided to the patient in A&E about condition and treatment.	≈	↓	Current score: 7.9 2011 score: 8.5 71% said they received enough information and 18% not enough.	7	Meeting to be scheduled RB, AG, PM, JC and FL to identify reasons for low score and walk through existing process for informing patients	AG RB JC	**End of June**		To audit current information provision across A&E via patient interviews on a monthly basis – to see month on month increase in results
Q9	Delay for a bed on a ward	≈	↓	Current score: 7.4 2011 score: 7.9 64% said not long, 19% yes to some extent and 17% definitely.	7 8 9	Changes to discharge process for wards and use of discharge lounge has had an impact on bed availability rates esp. in relation to delays with TTO's • To meet with Pharmacy re issuing of TTO's • Ascertain message be given to patients re Discharge ward and process for being discharged. Work underway to monitor differences Greater communication with patients about reasons for delay	JG AG JA	**End of May**		Current work stream reviewing discharge processes. Results of this work will have an impact on bed availability. To meet with JG and Jay Agostinelli to review current agenda and then agree metrics. To contact Clive Walsh – Chief Operating Officer to review current plans etc

Area for Improvement		most trusts	previous NGH results	Detail		Improvement actions	Owner	review date	RAG	Target
Results to be presented at the PEB on a monthly basis.										
Q53	Length of delay	≈	↓	Current score: 7.7 2011 score: 7.1 30% -Over 4h, 32%-Over 2h (less than 4)and 22% between 1 and 2h. Figures worsened nationally.	10 11 12	Meeting with Discharge Team – Julia Geier to review discharge process and areas of delay. To understand what actions are being taken in relation to the discharge process. Julia to share list of current issues / actions	JA JG AG	**End of May**		Current work stream reviewing discharge processes. Results of this work will have an impact on bed availability. To meet with JG and Jay Agostinelli to review current agenda and then agree metrics. To contact Clive Walsh – Chief Ops Manager to review current plans etc
Q67	Treated with respect and dignity while in hospital	≈	↓	Current score: 8.6 2011 score: 9.0 76% yes, always, 20% yes, sometimes. 4% No.	13 14 15	Awaiting information re Dignity Forum – Judy Foglia / Debbie Shanahan 15 Step Challenge across 4 wards / departments	SC GR AG	**End of June**		To pilot '15 Step Challenge' across 4 wards during May 2013 with a view to rolling out across all wards and 12depts. over next 3 months. Dementia / carers of people with dementia evaluation being included in admission / discharge documentation Audit of Carer experience to be undertaken 3 mths after roll out of documentation. Information for carers of people with dementia being produced

Area for Improvement		most trusts	previous NGH results	Detail	Improvement actions		Owner	review date	RAG	Target
Q69	Patient asked to give his/her views about quality of care	≈	↓	Current score: 1.2 2011 score: 1.7 Almost 88% said No	16 17	Presentations at Nursing meetings to ensure that patients and staff are aware of the detail behind the question – what are we trying to find out? Information leaflets to support the distribution of the FFT	AG	End of July		Month on month increase in response rates + achievement of 20% target by Dec 2013. All actions to achieve this.

Approved: Patient Experience Board
May 2013

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 30 MAY 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 month of April 2013.

CRITICAL POINTS: -

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

ACTION REQUIRED BY BOARD: -

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

Northampton General Hospital NHS
NHS Trust

April 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

2.1 MRSA Bacteraemia

The Trust has a zero approach for MRSA bacteraemia for 2013/14. During April 2013 there were **0 >48hrs** MRSA bacteraemia.

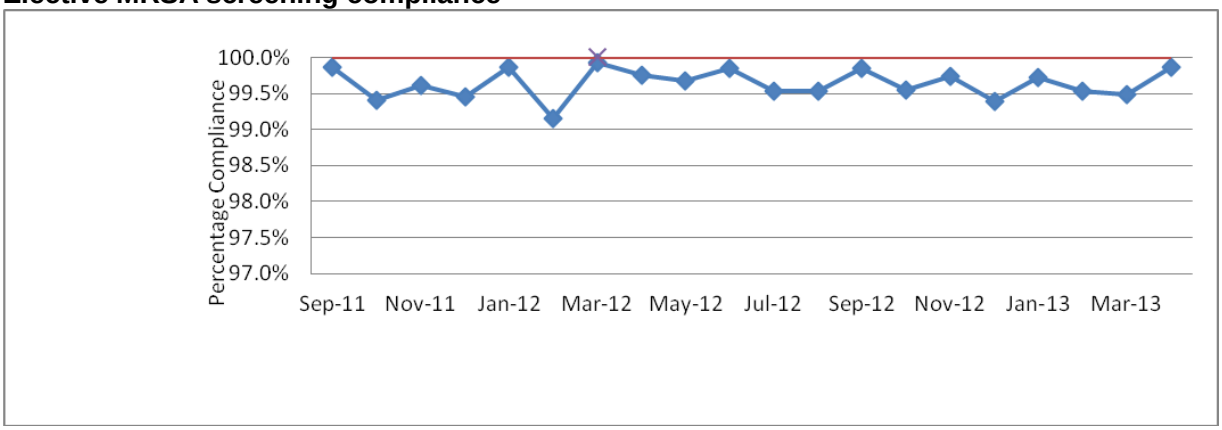
As the Trust did not achieve the MRSA BSI objective for 2012-13, the TDA (Trust Development Authority) requested an action plan. This was discussed at the April Infection Prevention & Control Committee prior to being sent to the TDA.

2.2 MRSA Colonisation & Screening

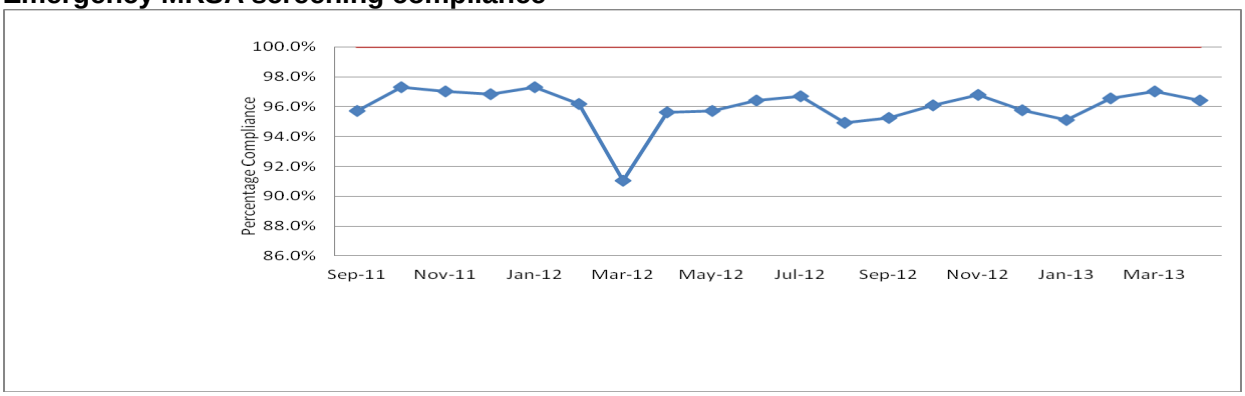
During April there were 17<48hrs and **1>48hrs** cases of MRSA colonisation.

Compliance with elective and emergency screening is demonstrated via the graphs below. ***Elective screening achieved 99.9%*** compliance with 1482 patients who required screening, with only 2 not being screened. ***Emergency screening achieved 96.4%*** compliance with 1056 patients receiving screening and 38 who were not screened. Compliance continues to be monitored regularly by the Care Groups as well as the Infection Prevention team.

Elective MRSA screening compliance



Emergency MRSA screening compliance



2.3 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.

In April 2013 there was **no** wards put onto Special Measures for 2 post 48 hours MRSA colonisations.

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

During April 2013 there were 4<48hrs and **1 >48hrs** MSSA bacteraemia case.
The post MSSA was a patient on the oncology ward who was neutropenic with a facial cellulitis. An RCA is to be undertaken and the findings presented in the next board report.

3. Clostridium difficile

The Trust has an annual target of 29 C. diff. cases or less for the financial year. Unlike last year, where a target of 3 cases or less per month was identified, this year the monthly target is based on the previous 5 years data to provide a more accurate trajectory. The targets for 2013/14 are as follows:

2013									2014		
April	May	June	July	August	September	October	November	December	January	February	March
4	1	3	3	1	3	2	3	3	4	1	1

During April **7 >3 day cases *of C. diff*** were identified against a monthly target of April of 4.

Due to the increase of CDAD during the month and the potential failure to meet CDAD ceiling/target, this issue has been put onto the risk register. This poses a potential threat not only to patient safety, but also to the organisation from a financial point of view.

A review of the 7 >3 day cases of Clostridium difficile in April 2013 was undertaken by the Consultant microbiologist and the Infection Prevention and Control Team. Five of the patients were

on different wards; there was no evidence of cross infection. Two were on a medical ward and special measures were instigated. Predisposing factors were antibiotics and five of the patients also had laxatives, aperients and/or enemas. It would appear that an inappropriate sample was sent for five of the seven patients. National guidelines state that any stool sample sent to the laboratory for C Diff testing has to be analysed irrespective of whether or not there are clinical indications of C Diff. disease. Quite a few people have C Diff toxins in their stools, but don't have C Diff disease. It is for this reason that correct sampling is very important, and only those patients who show clinical indications of C Diff disease should be tested.

A Root Cause Analysis (RCA) is undertaken for all post 72 hours cases of C.diff. These are in progress and may highlight further themes. These will be reported further in the June board report. As a result of the apparent inappropriate sampling, several actions have been taken by the Infection Prevention team and the Consultant microbiologist, which include: a 'pop up box' on the ICE requesting system that blocks the requesting of faecal samples in patients who have had laxatives or enemas in the past 48 hours, a screen saver reminding staff of the need to sample appropriately and posters called *'Stop Think Ask before you send the sample'* were developed and given to wards to display correctly. Since this action has been taken, there has only been 1 C Diff positive patient identified (up to and including 20 May 2013).
In April 2013, **Creaton ward** was put onto Special Measures for 2 >3 day C. diff. Both of these could have been avoided as the samples were sent inappropriately. First sample was sent after giving an enema and the second after the patient was given Laxido. The Infection Prevention Team gave some training to staff to ensure they know when to send a sample. The personal protective Equipment (PPE) audit and the isolation audit each scored 100%. A cleaning audit performed initially scored **89%.** The issues of concern included: high surface, heavy dust on entertainment system arm, dusty computer keyboards and the splash back in the bathroom coming off the wall which was reported the previous month. Daily cleaning audits were instigated and a great improvement in results were obtained.

4. Surgical Site Infection Surveillance Scheme (SSIS)

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

4.1 Surgical Site Infection Surveillance

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

The **interim** results for April l 2013:

- Repair of fractured neck of femurs(#NOF) show that there were ***no infections*** resulting from **17** operations

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

5. Hand Hygiene Audit

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

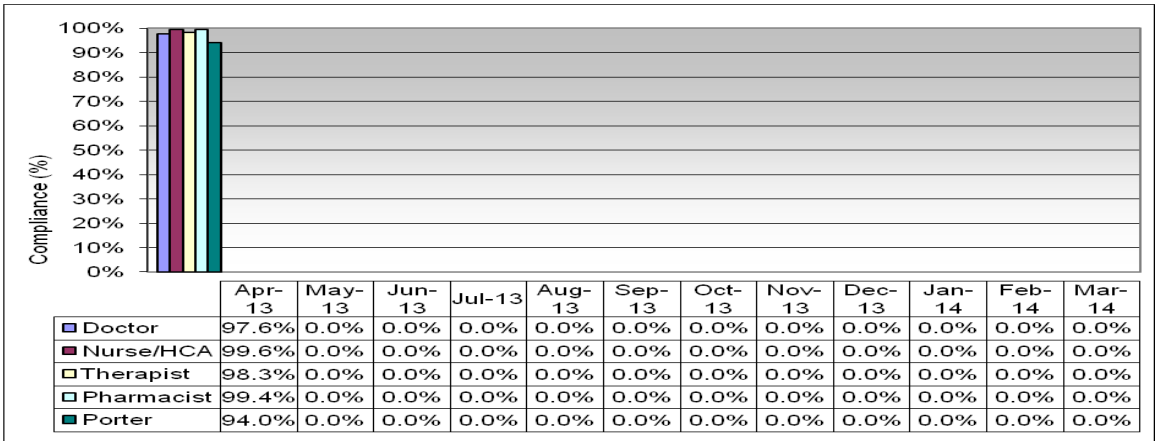
- April overall Trust compliance for hand hygiene = **92.2%** due to 5 areas failing to submit the completed audit. This was an improvement from last month's audit which achieved 90.7%.

Areas who have failed to submit their audits are being followed up by the Infection Prevention team, with issues being discussed at the next Infection Prevention Committee meeting.

A preliminary review of the matron's dashboard shows that HHOT has similar results to March's dashboard. This too will be discussed at the next Infection Prevention Committee meeting. The majority of failed areas are due to data inputting issues, which have been raised with the information and data quality manager who is looking to identify whether the issue is an IT or user issue. The remaining areas have reduced resources and are rectifying this by obtaining additional support.

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

Hand Hygiene -Monthly Trend Performance



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Doctor	97.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	99.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	98.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	99.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	94.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Norovirus Outbreak

Norovirus is estimated to cost the NHS in excess of £100 million per annum in years of high incidence. Approximately 3,000 people are admitted to hospitals in England with Norovirus each year, with infection spreading quickly, which places a huge burden on healthcare services.

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Norovirus is a highly infectious small round structured virus (SRSV). It is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales. The illness is generally mild and people usually recover fully within 2-3 days; there are no long term effects that result from being infected and it can occur at any age

During 2012/13 the Trust had no Norovirus outbreaks but unfortunately in April 2013 we had our first Norovirus outbreak which lasted from 9th April 2013, until the 1st May 2013. A total of 4 wards were closed to admissions and transfers, with 43 patients and 41 staff members affected. These areas were an acute medical, a stroke, a surgical and a chest ward. The last ward reopened on the 24th April, but the major outbreak control meetings continued until 1st May to monitor the situation. In total there were 9 confirmed cases of norovirus. This is classed as a Serious Incident and a report is being written and any learning will be fed back at the next board meeting.

6. Update regarding Scalded Skin Syndrome

Scalded skin syndrome is caused via infection with certain strains of *Staphylococcus aureus* bacteria. The bacteria produce a toxin (poison) that causes skin damage. The damage creates

blisters as if the skin were scalded. Scalded skin syndrome is found most commonly in infants and children under the age of 5.

There have been 8 babies confirmed with the outbreak strain as of the 16 May 2013. As no further cases had been identified since 31 March 2013, a decision was made by the outbreak group to close the outbreak. A serious incident report is being completed, with lessons learnt being summarised in a future board report.

8. Conclusion

The Infection Prevention 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.

9. Recommendation

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

Northampton General Hospital NHS
NHS Trust

Trust Board – 30 May 2013	
Title	Francis Report - gap analysis, staff feedback and outline action plan
Submitted by	Dr Sonia Swart, Medical Director and Suzie Loader Director of Nursing and Patient Services
Date of meeting	30 May 2013

SUMMARY OF CRITICAL POINTS

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on 6th February 2013. The inquiry made 290 recommendations on all aspects of NHS operation and regulation.

The Government published its initial response to the Francis Inquiry on 26 March 2013.

In response, the Trust has undertaken a series of listening events to understand local perception of the findings and what they mean to NGH. This included governors. These were further explored during a Board Development day in March 2013.

A reverse gap analysis of all of these findings was performed to identify areas where the Trust is already addressing the recommendations (for example through implementation of changes subsequent to the first report from Francis in 2010 and as a result of the work on Patient Safety which was started in 2008) and to consider those where further work is required to ensure that patients receive the care to which they are entitled.

There are several positives in how the Trust is already meeting the recommendations, driving improvements and working to balance the tension between cost and quality which was identified in the report. There are also areas where the Trust already has programmes of work underway to improve performance against recommendations which must continue, in order to deliver the required improvements. Gaps identified included:

- The need to understand the disconnect between the results of the national staff survey and listening events to the evidence observed by the board during ward to board visits
- Review the Duty of Candour
- Review the Nursing & Midwifery Strategy to encompass the 6 C's
- Publish the new corporate objectives
- Enhance dashboards to support accountability frameworks

The listening events revealed some uncomfortable views about the organisation's culture, leadership and accountability frameworks, and it was clear that more needs to be done in this area. These views resonate with those identified in the recent national staff survey results. The key issues and their potential solutions were reviewed at the Board Development day in March 2013.

On-going work streams which support the recommendations in the report include:

- Implementation of the Nursing & Midwifery Staffing Strategy to improve nurse staffing levels
- Patient Safety Programme
- Emergency Care Redesign and the Urgent Care Board
- Implementation of the revised governance structure to increase organisational capacity and capability in governance
- Improving links with the NHS Constitution through job descriptions, etc.

- Implementation of the Patient Experience Strategy

The Trust has made a formal commitment to use a focus on quality as the organising paradigm when considering developments and investment, but as a result of the recommendations in the Francis report will develop further key work-streams to ensure that the Trust makes a commitment to quality through:

- A review the Trust's Vision, Values and Objectives
- The development of an Organisational Development Strategy to include Leadership & Communication
- Review the arrangements for the Duty of Candour and Being Open
- Development of the Nursing & Midwifery Strategy to encompass the 6C's
- Improve compliance with key national and local targets and priorities

There are many recommendations which cannot yet be addressed since they will be reliant on national decision-making. Regular updating and monitoring of action plan implementation will be performed via the Trust Board to ensure transparency.

RECOMMENDATION – The Board is asked to:

- Review and challenge the contents of the report
- Review the proposed action plans and outlined timescales
- Agree next steps
- Agree onward reporting arrangements on progress against the action plans

Francis Report – Gap Analysis, Staff Feedback and Action Plan

1. Introduction

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on 6th February 2013. The inquiry made 290 recommendations grouped by the Trust into key themes:

- Culture, values and standards
- Openness transparency, and candour
- Nursing
- Leadership
- Accountability

The full report and recommendations is situated at http://www.midstaffspublicinquiry.com/report.

2. Government Response

The Government published its initial response to the Francis Inquiry on 26 March 2013, in five parts. A number of further national reviews have been commissioned, and further policy announcements relating to the Francis report are expected over the course of 2013. The initial Government Commitments focus on:

- ***Preventing problems***
  - A National Patient Safety Advisory Group is to be established to ensure 'safety and a zero tolerance of avoidable harm is embedded in the NHS'.
  - Appointment of Inspectors
    - A new CQC Chief Inspector of Hospitals
    - The role of CQC to become a regulator of quality not compliance
  - Publishing a revised NHS Constitution

- ***Detecting problems quickly***
  - To develop an aggregated rating system for healthcare providers similar to 'OFSTED style' ratings
  - Stop the use of clauses that intend to prevent public interest disclosure
  - Review best practice regarding complaint management / learning
  - Extend the publication of outcomes from heart surgery to other specialities
  - Further work will be undertaken on standardising quality accounts
  - A contractual duty of candour is included in the NHS Standard Contract 2013/14 for all providers to be open and honest with patients when things go wrong. The DH intend to go further and introduce a statutory duty of candour on providers as well as explore what professional regulators can do

- ***Taking action promptly***
  - Fundamental standards below which care should never fall will be developed by the CQC, NICE, commissioners, professionals, patients and the public
  - The Chief Inspector of Hospitals will be able to issue a public call to action to the hospital and the regulators responsible for the oversight. If the quality (patient safety, care and finance) issues cannot be resolved the Chief Inspector of Hospitals can initiate a failure regime

- The NHS Trust Development Authority (TDA) has the ability to agree plans for achieving Foundation Trust (FT) status beyond the initial 2014 date if in the interests of quality and sustainable services for patients.

- ***Ensuring robust accountability***
  - The Chief Inspector of Hospitals will refer criminally negligent practice in hospitals to the Health and Safety Executive, who will consider whether criminal prosecution is necessary
  - There will be an overhaul of professional regulation legislation
    A barring mechanism will be developed for unsuitable managers, based on the barring scheme for teachers. However, it is recognised that any such scheme should be developed carefully and then be consulted upon

- ***Ensuring staff are trained and motivated***
  - Treating staff well: this covers striving for excellence in recruitment, induction, training and appraisal at a local level
  - Staffing levels: work will commence to develop evidence based guidance around staffing levels that can be used by providers
  - Making time to care: ensuring that we use technology to help free up staff from duplication created by systems and paperwork
  - Rewarding high quality care: Linking pay progression to quality of care and not time served
  - Student nurses will spend up to a year on the front line working as healthcare assistants prior to commencing their training. The scheme will be piloted, evaluated and cost neutral
  - Revalidation will be introduced for nurses
  - There will be a review to ensure healthcare assistants (HCA's) are properly trained and inducted before they care for people
  - The Government will take action to attract professional and external leaders to senior management roles

3. The Trust's Immediate Response

The Trust received a summary of the report at its February 2013 Board meeting where it agreed to undertake listening events with staff and shadow governors to understand their perception of the findings and to obtain their views on where improvements can be made at NGH. During these listening events, groups reviewed the BIG question:

How can we make sure we provide every patient with a service that stays true to our core values of care and compassion?

Using three themed questions on: Leadership, Accountability and Culture Change, the groups considered what they felt to be the local issues and how they would look to resolve them.

4. Reverse Gap Analysis - Methodology

A reverse gap analysis was performed against the 290 recommendations made in the report, identifying those recommendations which can be acted upon now and those for which the Trust is obliged to wait for further national direction.

The gap analysis took into account:

- Views expressed at all the listening events
- The Trust's current improvement strategies which show where we are already complying (for example through implementation of changes subsequent to the first report from Francis in 2010)
- Checking back against the 290 recommendations to determine the gaps
- Meeting with operational leads

- Consulting with Care Group management Boards

5. Reverse Cap Analysis - Findings

Appendix 1 summarises the outputs from the reverse gap analysis. It is clear from this that there are several positives in how the Trust currently shows compliance with the Francis recommendations, driving improvements and working to balance the tension between cost and quality, notably:

- The Patient Safety Academy set up in 2012 which has evolved from the various patient safety programmes in place since 2008 and revised after the first Francis report in 2010
- Junior Doctor Leadership programmes which focus on personal responsibility and accountability
- The Board to Ward programme, where Directors visit wards, clinical and non-clinical areas to observe their performance first-hand
- Clinical Governance Review Scheme, where staff peer review the safety of each other's wards / clinical areas
- The '*Listening into Action'* programme which has emphasised personal action and leadership
- Consistent positive ratings from Internal Audit on the handling of complaints
- A comprehensive induction programme and clear identity for Health Care Support Workers
- The leadership team includes an Executive Nurse Director who sits on the Trust Board, as recommended in the report
- Significant reporting on clinical performance in the Public Board as part of the Medical Director's Report
- Detailed quality reporting available to the HealthCare Governance Committee and all Board members as part of the Quarterly Report on Patient Safety , Quality and Governance

There are also areas where the Trust already has programmes of work underway to improve performance against recommendations which must be continued in order to deliver the required improvements. These include:

- A large-scale recruitment campaign for nursing and healthcare support workers, which adheres to high standards whilst seeking to reduce vacancies on the wards
- Approval of a Nursing & Midwifery Staffing Strategy (2013-17) which will:
    - Enhance the quality of nursing / midwifery care delivered to patients
    - Improve healthcare outcomes
    - Where necessary, increase the number of nurses available on the general wards to benchmarked levels
    - Utilize the nursing resource more effectively
    - Decrease the spend on bank and agency staff
- A programme of work to improve failures in care including the recording of omissions of medications, the management of pressure ulcers, fluid balance management and many other areas.
- A programme of work to improve emergency care directed through the Urgent Care Board supported by clinical leadership and chaired by the CEO
- Reviewing employment contracts and policy templates to improve recognition of the NHS Constitution

<u>Gaps identified</u>

In addition to the above, it was clear from the reverse gap analysis that further work needs to be undertaken in the following areas:

- To understand the disconnect between the outcomes from the national staff survey and listening events with the evidence observed by the board when they visit clinical areas and talk to staff.
- Performance improvement against internal and national standards on: patient experience, CQUIN targets and key policies.

- Openness / Duty of Candour
- The need to review the Nursing & Midwifery Strategy to encompass the National Nursing & Midwifery Strategy; the 6 C's (Compassion, Care, Commitment, Courage, Competency & Communication)
- The need to publish the updated corporate objectives to enable leaders to have organisational focus
- Further work is required to enhance dashboards to support accountability frameworks

Results from the Francis Listening Events

The listening events revealed some uncomfortable views about the organisation's culture, leadership and accountability frameworks and it was clear that more needs to be done in this area. The key issues and their potential solutions were reviewed at a Board Development day in March 2013. These are summarised as follows:

ISSUES	SOLUTIONS
• Some staff feel there is a lack of clarity regarding the corporate objectives • Staff want improved communication, specifically relating to how the corporate objectives link with what individual teams need to do themselves to help achieve those objectives	• Revitalise the Trust visions, values and corporate objectives, ensuring these are cascaded and mirrored throughout the organisation to individual wards and departments and then to individual's objectives through the appraisal process, so it is absolutely clear how we are working together towards common aims • Enhance communication across the organisation. Understand how staff want to be communicated with, and what is important to them in relation to communication. • Develop an Organisational Development Strategy which incorporates communication and leadership development
• Staff want to be clearer about how we listen and respond to concerns which are raised, so they feel more confident to do so	• Ensure that the Trust responds with appropriate explanations and actions when concerns are raised • Improve feedback regarding concerns raised, whilst respecting and maintaining individual confidentiality
• Some managers don't feel empowered or supported to lead their teams	• Re-define leadership arrangements within the organisation by consulting on and developing a leadership programme which will be a part of the organisational development strategy • Enhance the appraisal process to improve quality and compliance

There is recognition that the need to embed a set of values, behaviours and skills across all staff groups has not received sufficient emphasis in recent years. The implementation of an organisational development programme is in the planning stages and will be supplemented by the introduction of a behavioural framework which can also be used as a tool in appraisal. The funding for the development of this framework has been provided via the LETC and work has commenced (in the form of focus groups) to develop the framework – the Trust is being supported in this work by a firm of Occupational Psychologists. Training sessions have been arranged.

Just over half of the recommendations within the Francis Report require further national debate and decision-making, some of which are being addressed through the Government's initial response. Some of these (estimate about 30) will have major consequences when decisions are made about their implementation. These include for example:

- Introduction of pre-registration requirements for nursing students
- Registration of Health Support Workers
- Structure and function of CQC, Monitor and the Health & Safety Executive

- The changes in ratings and compliance assessments proposed by the CQC
- Recommendations regarding sharing information, such as complaint letters on Trust websites

Just under 20% of the recommendations do not have a direct impact on the Trust, instead, they are recommendations for specialist bodies. It is possible that any changes to the national landscape which these cause may impact on care at a later date. This includes recommendations, for example; like how external bodies share information with one another, etc.

Summary of status of recommendations (approximate only)

Relevant now	76 (26%)
National guidance awaited	163 (56%)
Relevant for specialist bodies	51 (18%)

6. Actions required and next Steps

- Review and where appropriate develop all relevant individual work streams, to ensure their targets and deadlines are realistic and achievable, to ensure that they are both deliverable and measurable.
- For the board to review the action plan outlined at Appendix 2, to ensure that the proposed actions and timelines are appropriate and achievable.
- To successfully implement the Francis Report Action Plan, providing updates to the Board on a quarterly basis. The update will seek to reference achievements against existing and new work streams, pulling all results together into one document. This will ensure transparency to the public, whilst specifically demonstrating that the cultural issues identified (which have a high profile in the Francis Report) are being addressed
- New individual work streams will need additional reporting mechanisms to be identified. However, the behavioural framework and organisational development work-streams could usefully report alongside appraisal updates.
- The national emphasis on the Duty of Candour requires a specific update to the Board. The Board should note that this duty is currently embedded in the Serious Incident policy, but not robustly applied in the case of moderate incidents or moderate harm. The Trust will need to define this and ensure a consistent application of the policy.
- The national emphasis on the need to learn from complaints would suggest that a quarterly report to aggregate the learning from complaints, incidents and claims could usefully be presented to the Board. The Board should note that this is already reported in the quarterly governance, safety and quality report discussed at Healthcare Governance, but a Board focus would be appropriate at this point

7. Recommendations

The Board is asked to:

- Receive and challenge the report, including feedback on existing good practice, organisational feedback and gap analysis
- Review and challenge the proposed action plans and outline timescales
- Agree next steps
- Agree onward reporting arrangements on progress against the action plans

APPENDIX 1: MID STAFFORDSHIRE REPORT – REVERSE GAP ANALYSIS OF RECOMMENDATIONS

NB/ The top line indicates the Trust response categories (with nursing and profession-specific issues added as these weren't addressed specifically during the listening events). The second heading line indicates the Enquiry headings (not duplicated where they are the same).

Culture			Nursing and Clinical Care	Leadership	Accountability
Culture	**Values and standards**	**Openness transparency and candour**			
National and Local Recommendations					
• Putting the patient first • A common culture made real throughout the system – an integrated hierarchy of standards of service	• Fundamental standards of behaviour • Responsibility for, and effectiveness of, healthcare standards	• Effective complaints handling • Openness, transparency and candour • Coroners and inquests	• Care for the elderly • Nursing	• Medical training and education • Information	• Accountability for implementation of the recommendations • Local Scrutiny • Performance management and strategic oversight • Patient, public and local scrutiny
What are we doing at NGH?					
• Patient safety champions (106) • Patient Safety Academy • Up-to-Date- signs and symptoms in the library – link to training and education • Star Awards • Patient Safety Academy stream: Learning from error and human factors	• Existing Corporate objectives • GMC and NMC regulation • Patient Experience Strategy • Processes in place and monitoring reports: ○ NICE report ○ National audit ○ CQC compliance ○ External reviews ○ Corporate quality indicators report	• Management of complaints and incidents follows the principles of openness and honesty through 'Being Open'. • Processes in place and monitoring reports: ○ Learning from PALS ○ Complaints	• Nursing & Midwifery Staffing Strategy (2013-17) • Matrons round – hourly care rounds – to raise the profile of these • Safety Thermometer: Pressure ulcer care, falls, UTI and catheter related infections, VTE assessment and treatment • Patient Safety Academy work stream re preventing Failures of care: ○ Oxygen management	• Professional and practice development • Simulation training • Human factors training • Mandatory training • On-going recruitment, including the use of literacy, numeracy,	• Appraisal process • Performance management • Data Quality Strategy • Governance Review underway to increase the resource in Care Groups to further embed governance locally thus improving accountability for governance and

Culture			Nursing and Clinical Care	Leadership	Accountability
Culture	**Values and standards**	**Openness transparency and candour**			
safety science • Board to ward observational sessions • Family and Friends test • Safety culture questionnaire • Clinical Governance Review Scheme (CGRS) • Each specialty has • Mortality & Morbidity meetings which are reported and minuted • Speciality clinical outcome measurement in place (e.g. # NOF) • Open reporting in Board reports	○ CQUIN ○ Healthcare records audit ○ Electronic handover ○ Nursing documentation ○ Time to consultant review ○ Electronic Discharge Notification ○ Safety thermometer ○ VTE/ anticoagulation ○ WHO checklist ○ Falls prevention initiatives ○ Surgical site infection surveillance ○ Infection prevention and control processes ○ Medication safety group ○ Medication reconciliation ○ Pharmacy surveillance of medicine management on wards ○ Pressure area care ○ Oxygen management ○ Safe care of the deteriorating patient ○ Urgent care workgroup ○ Transfusion safety ○ Early warning score and response ○ Communication with GPs ○ MINAP (National audit -	analysis ○ SI (including being open) ○ Litigation and risk management ○ Aggregate analysis of incidents, complaints and claims ○ Safeguarding adults and children	○ Fluid balance ○ Patient weighing project ○ Nutrition and dietetics team (24 hour snack boxes) – TVN ○ Elderly - Pressure ulcers and falls • Link nurses and Clinical Nurse Specialists to support expert work streams • Dementia lead • Learning Disability lead • SOVA Lead • Safeguarding Childrens' Lead • Diet specific menus • Use of outreach nurses • Magnets for eating difficulties, confusion, risk of falls, etc, • Pressure Ulcer champions • Nurse led discharge • Nursing Metrics and dashboards • Mentor Awards, N&M annual Conference and quarterly away days • Patient Safety Academy work stream, preventing: Failure to Plan • Patient Safety Academy work stream, preventing: Failure to Rescue • Patient Safety Academy work stream: Learning from SIs • Patient Safety Academy stream: Learning from error	simulation assessment as well as interview • Proactive recruitment • Nursing & Midwifery Skill mix reviews • Mentorship and preceptorship • Resuscitation services lead • Leadership /Safety Programmes for Doctors in Training • Clinical Leadership for Safety work streams and Emergency	quality • Devolving of CQUIN budgets to local level to encourage local accountability for outcomes. • Board to ward observational sessions • Clinical Governance Review Scheme (CGRS) • A range of dashboards to monitor performance against which services are measured • Monitoring reports (as described elsewhere)

Culture			Nursing and Clinical Care	Leadership	Accountability
Culture	**Values and standards**	**Openness transparency and candour**			
	thrombolysis) ○ Flumazinil audit ○ Neonatal gentamycin audit • HR assurance and management processes		and human factors safety science • Up-to-date- signs and symptoms in the library – link to training and education • Continue service representation at University selection/ interview process • Frail elderly project underway. • Discharge Programme Board commencing • Pharmacy initiatives • Emergency Care Redesign Project and Urgent Care Board in place • Each specialty has Mortality & Morbidity meetings which are reported and minuted • Speciality clinical outcome measurement in place (e.g. # NOF)	Care • Away day for Ward Sisters, reviewing their role, accountability and learning / development needs. • Monitoring reports (as described elsewhere)	
NGH awaits the impact of national changes locally					
GAPS IDENTIFIED AT NGH					
• Overarching all of the recommendations and themes, there appears to be a disconnect between the initiatives on-going and findings observed within the Board to Ward visits versus the perceptions outlined within the Staff Survey and listening events. An organisational diagnostic exercise is needed to identify the current status and the reasons for these. Once this has been completed, an appropriate Organisational Development programme can be developed and delivered.					
• Performance improvement against internal and national standards on:		• The duty of candour is to be reviewed and	• Our overarching Nursing Strategy is due for review (which will include our	• Need to publicise the updated	• Further work on dashboards is needed to support

Culture			Nursing and Clinical Care	Leadership	Accountability
Culture	**Values and standards**	**Openness transparency and candour**			
○ Patient experience; including Friends and Family Test. ○ CQUIN targets such as dementia, ○ Key policies, such as Record keeping, completion of patient assessments and escalation of care, etc.		expanded to all corporate business. The Trust's approach should be captured in a revised policy and updated practice.	approach to implementing the 6C's (National Nursing & Midwifery Strategy 2012)). • Review discharge information at ward level. • Review nutritionist input • Inclusion of dignity, values and beliefs assessment at registered nurse interviews (April 2013). To expand this to non registered workforce and midwifery • Develop approach to CPD and Portfolio management for nurses • Development of a specific training in-house course for older person with the potential for accreditation with the University • Develop bespoke training for all agency and locum staff which would be mandatory before employment	Corporate objectives to enable leaders to have an organisational focus.	accountability frameworks
Recommendations which are External Only (No action required by NGH)					
			Professional regulation of fitness to practice	• Enhancement of the role of supportive agencies • Department of	• Commissioning for standards • Responsibility for, and effectiveness of, regulating

Culture			Nursing and Clinical Care	Leadership	Accountability
Culture	**Values and standards**	**Openness transparency and candour**			
				Health leadership • Leadership (of external bodies)	healthcare systems governance • Monitor's healthcare systems regulatory functions • Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings

*NB/ The list has been structured to list initiatives first and sources of assurance later. Where an item covers both (e.g. board to ward) the item sits in the middle of the list.

Where there is overlap between where individual items may sit, a best fit has been adopted to reduce duplication.

APPENDIX 2: Francis Report Action Plan

Action Plan Lead: Suzie Loader (Director of Nursing, Midwifery & Patient Services) and Dr Sonia Swart (Medical Director)

Sign Off: Chief Executive Officer

Monitoring Committee: Healthcare Governance Committee **Date:** May 30th 2013

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
Nursing and Clinical Care		Review Nursing & Midwifery Strategy to include the 6Cs.	Suzie Loader	NMB	September 2013	
		Inclusion of dignity, values and beliefs assessment at registered nurse interviews To expand this to non-registered workforce and midwifery.	Suzie Loader	NMB	September 2013	
		Develop an approach to CPD and Portfolio management for all professional groups that submit a portfolio: • Develop Trust Portfolio template for staff to use • Gap analysis of staff maintaining an up to date contemporary portfolio • Random reviews of portfolios (in line with NMC) All nursing & midwifery staff to submit their portfolio as part of their appraisal.	Janine Brennan / Suzie Loader	HGC	October 2014	
		Development of a specific in-house training course for care of the older person with the potential for accreditation with the University to address a gap in knowledge in our nursing workforce with specific older persons training.	Suzie Loader Sonia Swart	NMB	April 2014	
		Review discharge information • Ward level information • How we ensure medicines are with the patient when they are discharged How the Trust codes and monitors out of hours discharges.	Clive Walsh	Urgent Care Board	September 2013	
		Review dietician involvement in nutrition work	Liz Aldridge, Head of	CQEG	September 2013	

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
			Therapies			
Accountability		Develop a Trust behavioural framework and implement it successfully across the Trust as part of the new appraisal process	Suzie Loader/ Janine Brennan	HGC	December 2013	
		Revise the Trust appraisal system to incorporate the behavioural framework and draw a clear line of sight between corporate objectives, set within the Trust's performance management system and individual objectives and expected behaviours.	Janine Brennan	HGC	August 2013	
		Develop core performance objectives for Matrons/Ward sisters as part of the annual appraisal process.	Suzie Loader	Operational Board Meeting	June 2013	
		Further work on dashboards is needed to support accountability frameworks	Care Group Directors	Care Group Boards Task and finish group	Sept 2013	
Culture Including: • Values and standards • Openness, transparency and candour		Review and refresh the Trust values, based on the behavioural framework, adopting a bottom up approach to ensure staff engagement.	Janine Brennan	Trust Board	March 2014	
		Conduct an organisational development diagnostic to identify aspects of organisational culture that need addressing and develop OD interventions to reflect the changes required.	Janine Brennan	HGC	March 2014	
		Revitalise and raise awareness of the NHS constitution: • Review Standard Terms and Conditions of Service for Agenda for Change contracts to include reference to the NHS Constitution. • Review the Job Description Template to include reference to the NHS Constitution. • Addition of NHS Constitution to the Induction programme. • Consider inclusion of NHS Constitution reference in	Janine Brennan	HGC	May 2013	

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
		policy template				
		Incident management • Improve the mechanisms to feedback to individuals using the appropriate local channels. • Improve the review of themes and trends locally • Improve monitoring compliance with action plans, notably for SIs.	Deputy Director of Quality & Governance with Care Group Management	CQEG	September 2013	
		Being Open and Duty of Candour Review Trust arrangements	Deputy Director of Quality & Governance	CQEG Trust Board	September 2013	
Francis – recommendation 113 The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS. A review of the report has been		***Policy*** *Trusts should have their complaints policy accessible on their web site. It must be:* *-Up to date* *-Clearly state the responsibilities* *-Detail the complaints handling process* *-List its reporting mechanism's to the board* The Trust 4C's policy is currently under review awaiting new regulation changes which are to be released later this year. Interim update underway and the policy will be added to the documents available on the NGH web site.	Lisa Cooper / Eileen Ingram	CQEG	June 2013	
		Learning *25% of Trust's had a culture of learning from complaints which was insufficiently developed* Develop the process of learning from complaints (in conjunction with incidents and claims)	Lisa Cooper / Care Group Governance leads (new post)	CQEG Trust Board	September 2013	

CQC Outcome/ Francis Recommendation	Outcome	Actions	Lead	Responsible Committee	Deadline	Progress Update
completed by the Complaints Manager and the outcome is detailed here.		***Reporting*** *Trust's must produce regular complaints reports and provide access to these on their website* Review which 1/4ly reports may be most suitable or adaptable for use in the public domain.	Lisa Cooper / Eileen Ingram	CQEG	December 2013	

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

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

NB/ This list is not exhaustive.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 30 MAY 2013	
Title: -	Staff Survey
Presented by: -	Mrs Janine Brennan, Director of Workforce & Transformation

PURPOSE OF PAPER: - To update the Board on the Trust's approach to the staff survey conducted in the latter part of 2012.

CRITICAL POINTS: -

- The staff survey results have historically been consistently low compared to the national average thus indicating that there are embedded cultural issues that require addressing.
- Previous actions implemented do not appear to have made any significant impact of staff engagement or satisfaction thus requiring a need to identify root causes and develop a series of integrated interventions which address those causal issues rather than focussing on the symptoms.
- The results vary between different occupational groups and Care Groups/directorates; therefore local solutions must be developed and implemented alongside trust wide interventions.
- A staff engagement strategy is required in order to achieve longer term sustainable improvements in staff engagement and satisfaction.

ACTION REQUIRED BY BOARD: -

The Trust Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Trust Board
Staff Survey Report

1. Introduction

This paper sets out the approach to building staff engagement and staff satisfaction, following the results of the 2012 staff survey.

2. Context

Each year the NHS carries out a National annual survey, which covers 28 key areas of feedback from staff. Our response rate was 46% which equates to 385 staff. The survey has shown on-going pattern since 2003 as shown on the attached appendix.

However it should noted that the results, when triangulated with other sources of information (e.g. direct staff feedback and staff turnover rates) show a number of apparent contradictions that equally need to be understood if any real impact is to be achieved.

3. The Way Forward

It is noted that each year in response to the survey an action plan has been developed, however it is equally clear that these have not had the impact that would have been expected.

This suggests that actions targeted at individual findings are unlikely to be successful and that a different approach is warranted. This is further supported by the fact that the year on year results show the views of staff remain pretty constant, with a number of aspects declining, thus indicating that the issue is probably cultural and therefore requires a systematic, integrated and long term plan to affect a real change in staff engagement and levels of satisfaction.

Staff engagement and well-being is widely recognised a key driver of performance. There is a wealth of evidence building that indicates improving staff engagement correlates with improving performance, innovation and sickness absence rates. Conversely poor engagement results in burnout, often characterised by cynicism, exhaustion and inefficiency. Within the NHS the evidence of the value of engagement is clear, with strong evidential associations between employee engagement and:

- Better Patient Outcomes
- Better Staff Experience
- Better Overall Performance
- Better Financial Performance

It is proposed that the solution is through the development & implementation of a comprehensive staff engagement strategy. This will be developed using an Organisational Development methodology, namely a systematic process of planned interventions (solutions) based on an understanding of root causes, rather than symptoms. The preliminary work therefore requires an organisational diagnostic to be undertaken followed

by analysis which then enables us to build a staff engagement strategy based on what staff believe will make a difference – their solutions not ours. Obviously this will take time however the very act of engaging with employees to encourage them to shape the outcomes will start us on the journey of developing a staff engagement culture.

Whilst the long term strategy is being developed there are also some immediate actions that are being put in place that will signal that a different approach is being taken and convey the trusts determination to invest in staff engagement as follows:

Actions	**Alignment with key findings**
Conducting a survey on communications: Focussing on asking staff how they feel that communications can be improved.	KF4 – Effective Teamwork KF21 – communications between senior management and staff KF22 – ability to contribute towards improvements at work KF24 - staff recommendation as a place to work and be treated
Engaging staff in developing a values & behaviour framework: Developing the trust values that should guide our behaviours at work.	Engagement: KF22, 24 & 25 KF4 - Effective team working KF8 – staff having well-structured appraisal KF11 – staff suffering work related stress KF19 – staff experiencing harassment, bullying or abuse from staff KF 22 – ability to contribute towards improvements at work KF24 – recommendation as a place to work KF28 – staff experiencing discrimination at work
Established an OD reference group to contribute to the on-going programme bringing local expertise and organisational insight	Engagement: KF22, 24 & 25 KF 22 – ability to contribute towards improvements at work KF4 – Effective Teamwork
Sharing the results of the staff survey through managers discussing the findings with staff and reporting back on staff ides for change	Engagement: KF22, 24 & 25 KF21 – communications between senior management and staff KF22 – ability to contribute towards improvements at work KF24 - staff recommendation as a place to work and be treated
Developing a training programme to build the capability of line managers to undertake staff engagement as part of their day to day role, using the Listening into Action methodology. This will start to embed staff engagement as a key part of manager's responsibility.	Engagement: KF22, 24 & 25 KF4 – Effective Teamwork KF21 – communications between senior management and staff KF22 – ability to contribute towards improvements at work KF11 – staff suffering work related stress KF24 - staff recommendation as a place to work and be treated
The survey results have been re-profiled by Care Group and Occupational Group and the results are being shared with the Care Group Boards so that they may develop local responses to local issues	Engagement: KF22, 24 & 25 KF21 – communications between senior management and staff KF22 – ability to contribute towards improvements at work

Next steps

The aim is to develop and implement a staff engagement strategy in order to build a stronger more adaptable organisation with staff that are engaged and committed to NGH and therefore delivering high performance. This will be done by understanding the dynamics that are influencing staff engagement at NGH and building on ideas from staff to develop meaningful and sustainable solutions for the strategy that staff at NGH will clearly identify with.

4. Recommendation

The Board is asked to note this report.

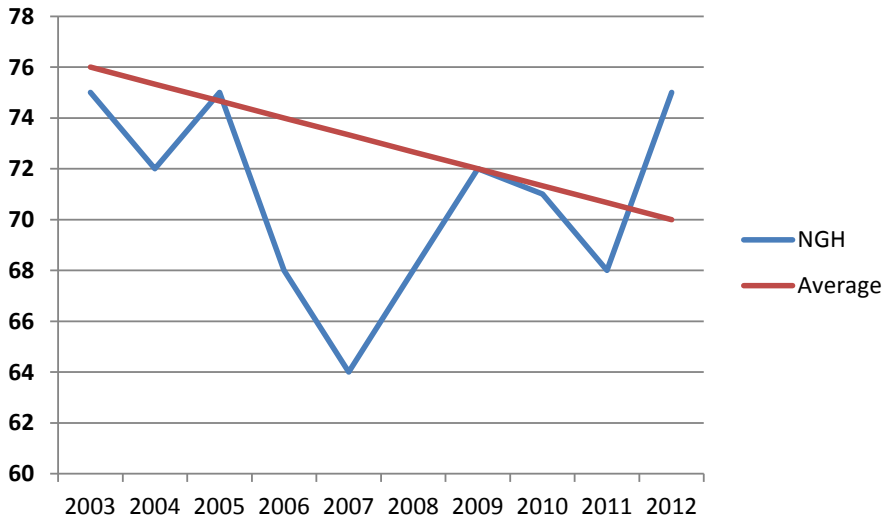
Northampton General Hospital NHS Trust

Staff Survey

May 2013

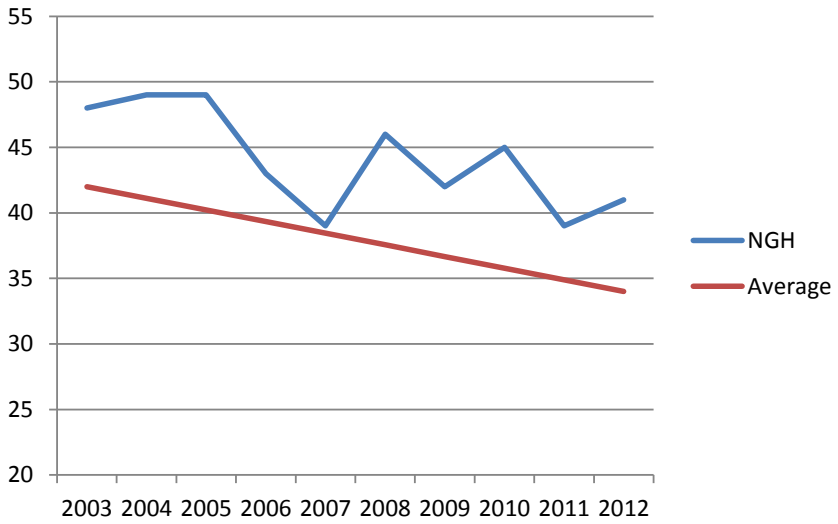
Performance Breakdown

Staff working extra hours %



Comments

% staff witnessing potentially harmful errors or near misses in previous month

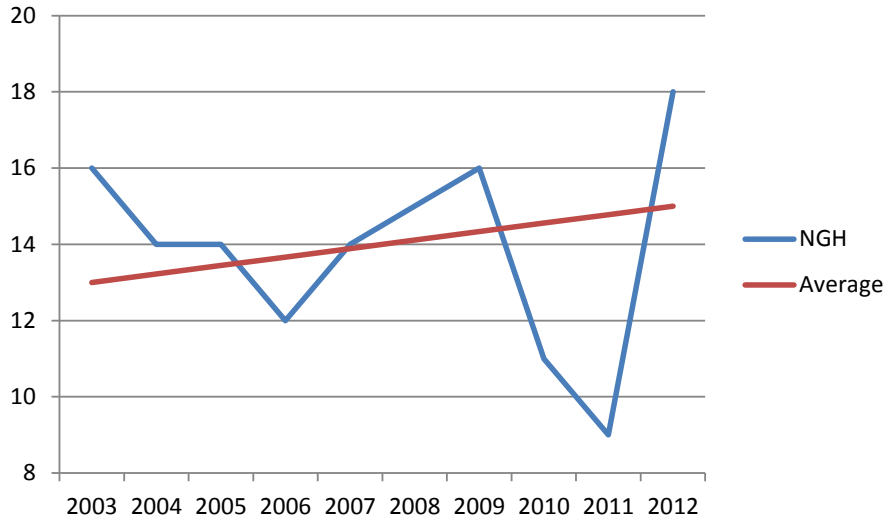


Comments

Performance Breakdown

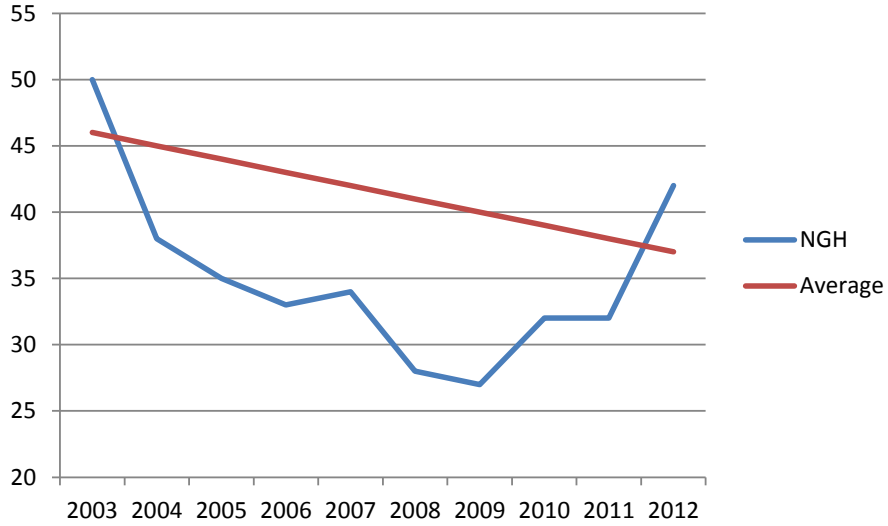
Northampton General Hospital NHS
NHS Trust

% staff witnessing experiencing physical violence in the last 12 months



Comments

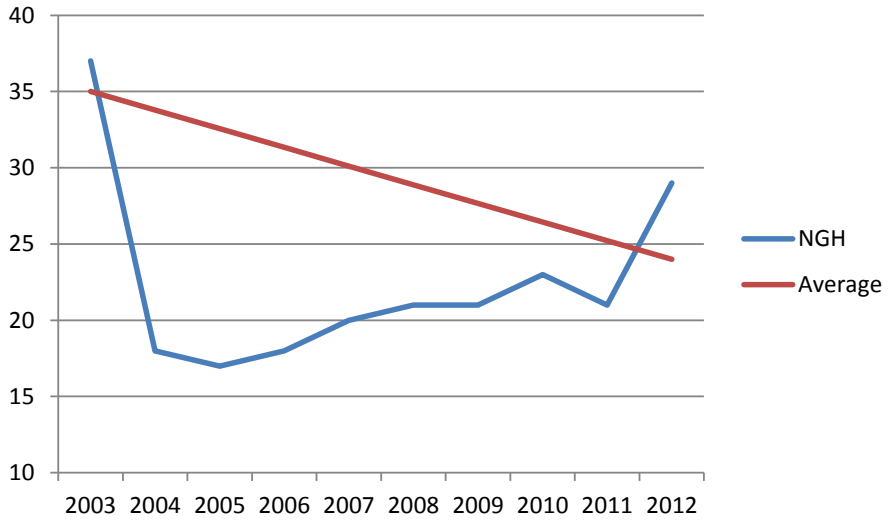
% staff suffering work related stress



Comments

Performance Breakdown

% staff experiencing harassment, bullying or abuse in previous 12 months

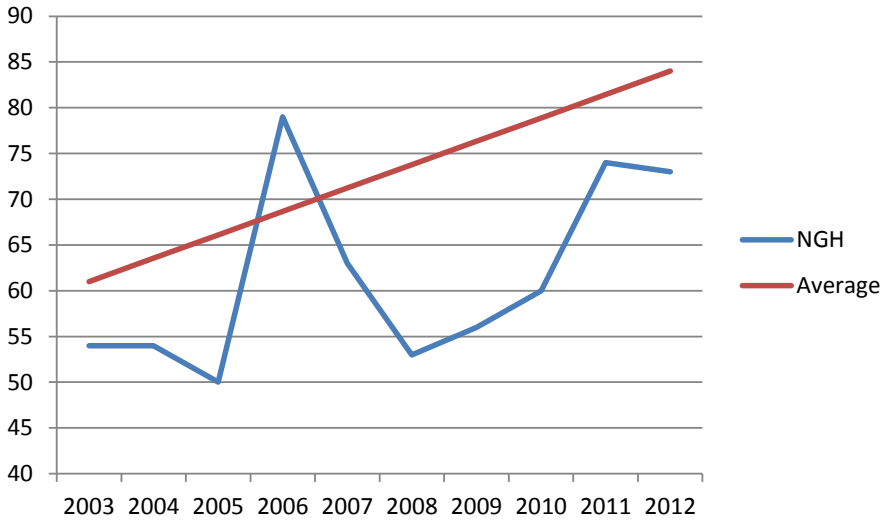


Comments

Performance Breakdown

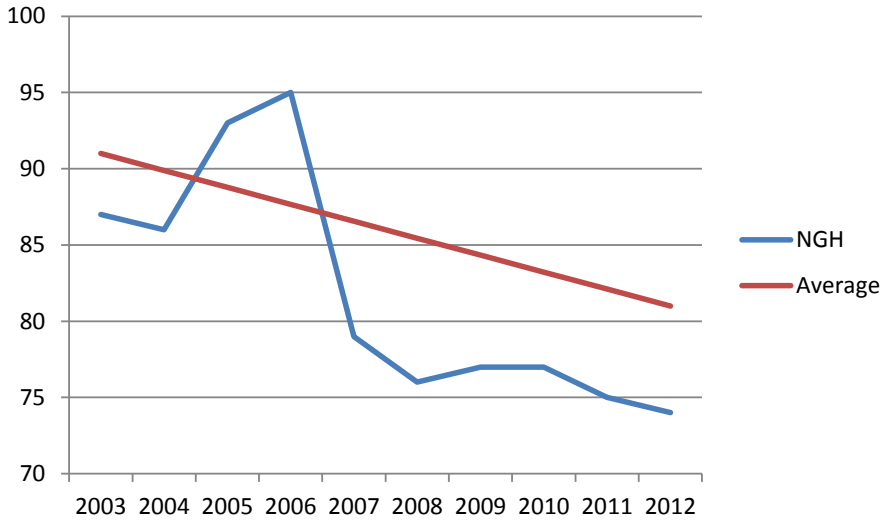
Northampton General Hospital NHS
NHS Trust

% staff appraised within previous 12 months



Comments

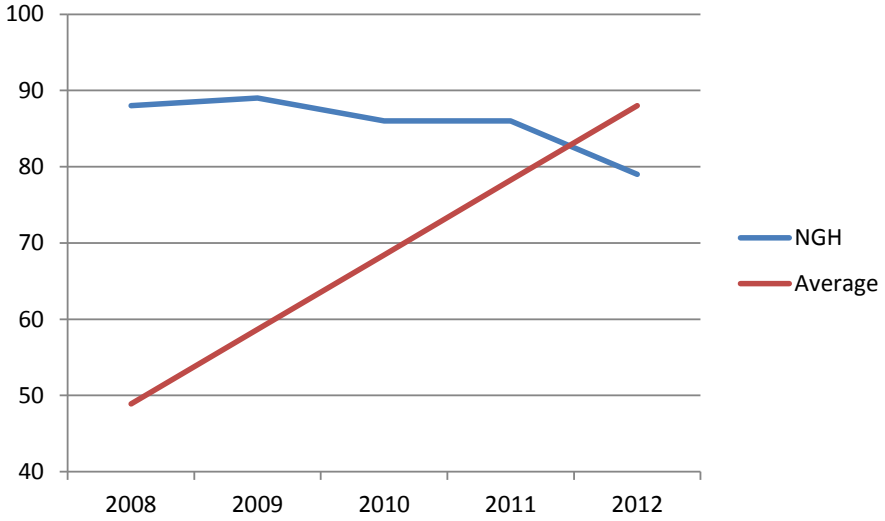
% staff receiving any training in previous 12 months



Comments

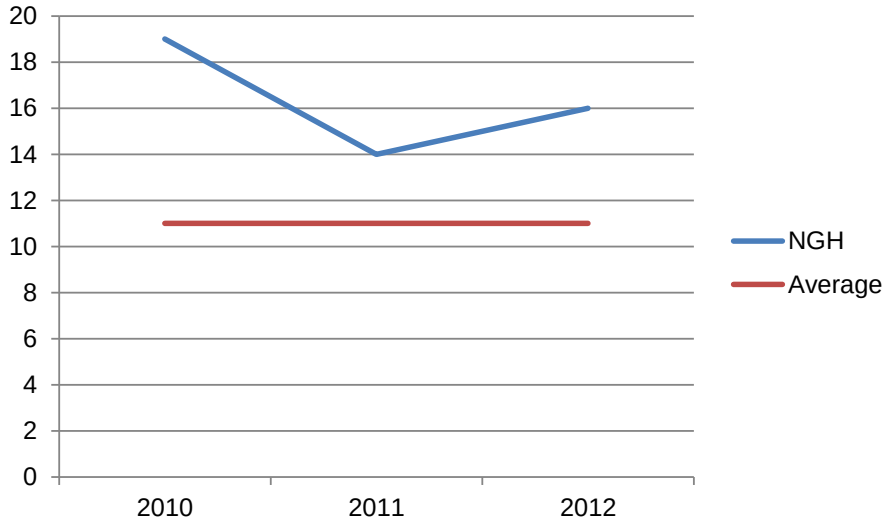
Performance Breakdown

% staff believing Trust provides equal opportunities for career progression or promotion



Comments

% staff experiencing discrimination at work in last 12 months

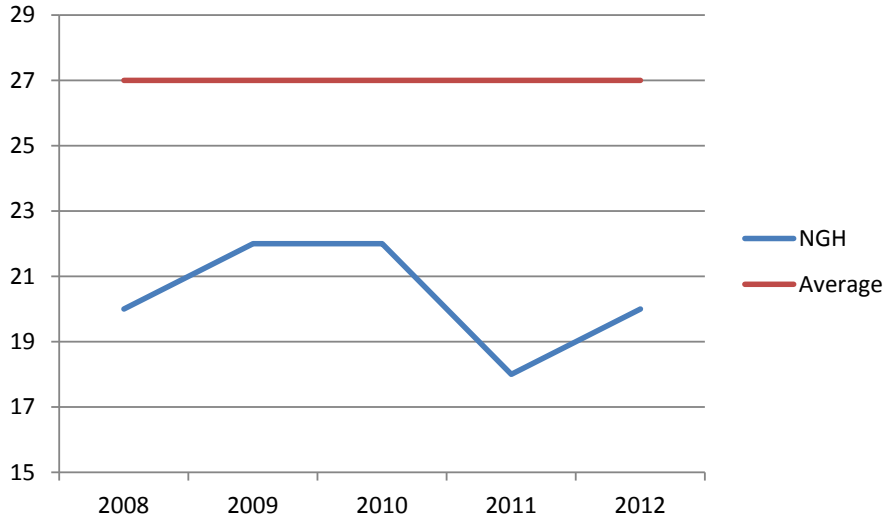


Comments

National average data only available for 2012 so included as straight line.

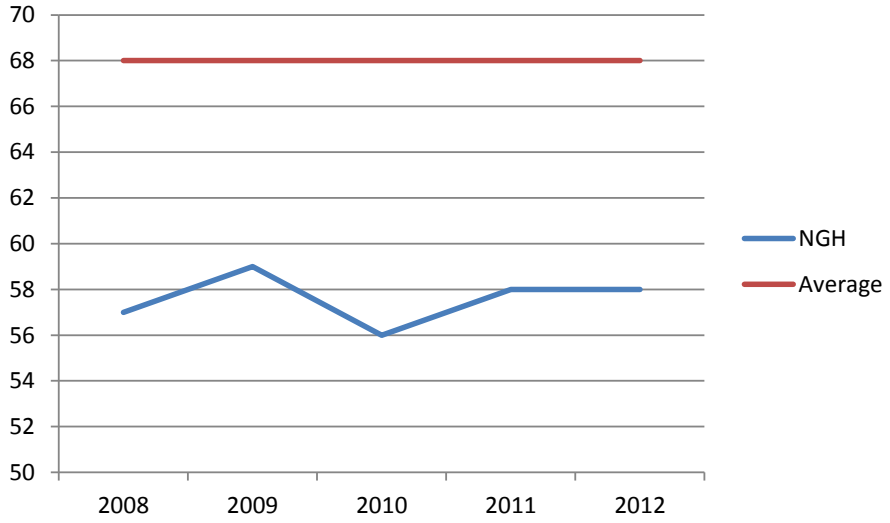
Performance Breakdown

% staff reporting good communication between senior management and staff



Comments
National average data only available for 2012 so included as straight line.

% staff able to contribute towards improvements at work

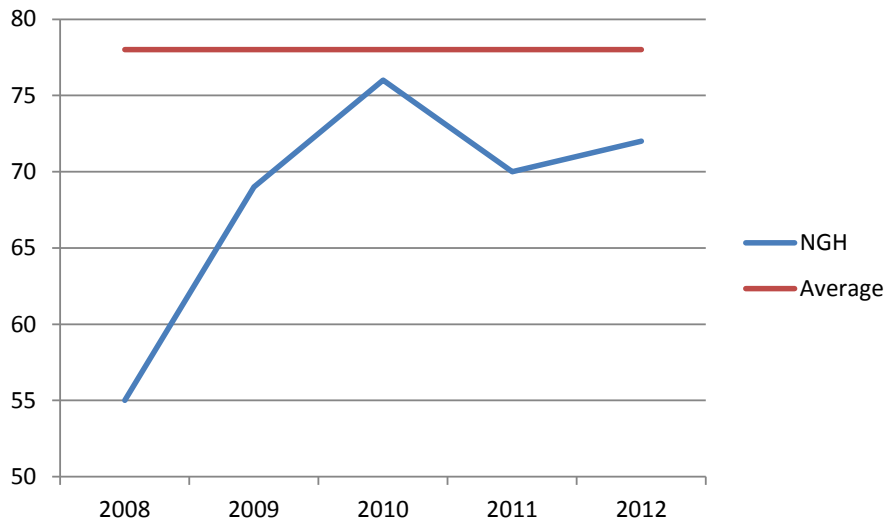


Comments
National average data only available for 2012 so included as straight line.

Performance Breakdown

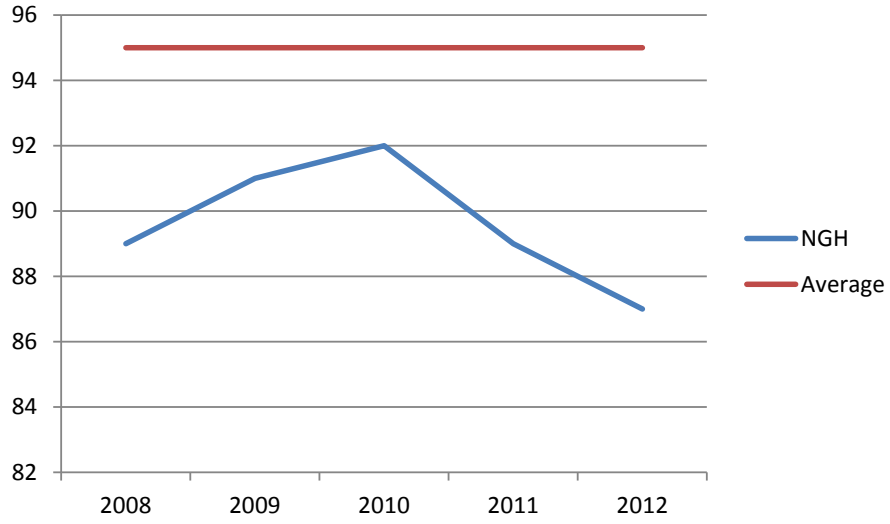
Northampton General Hospital NHS Trust

Staff satisfied with quality of care provided



Comments
National average data only available for 2012 so included as straight line.

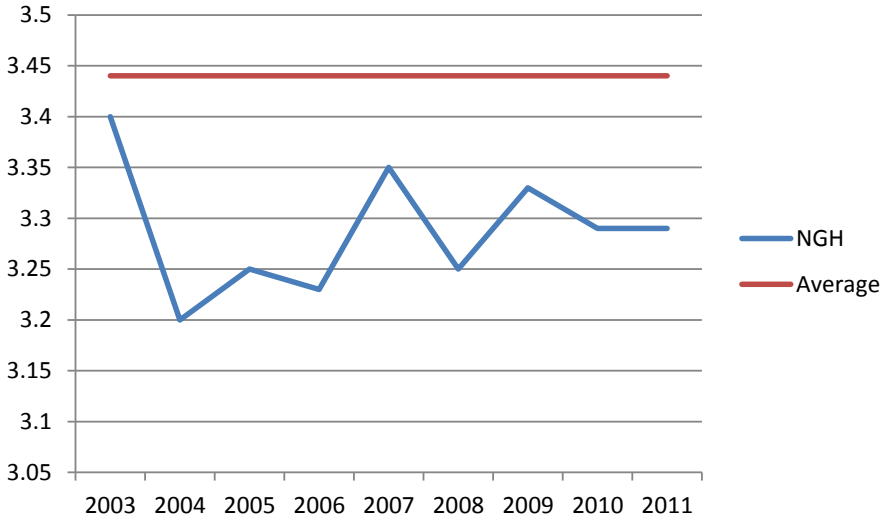
% staff agreeing that their role makes a difference for patients



Comments
National average data only available for 2012 so included as straight line.

Performance Breakdown

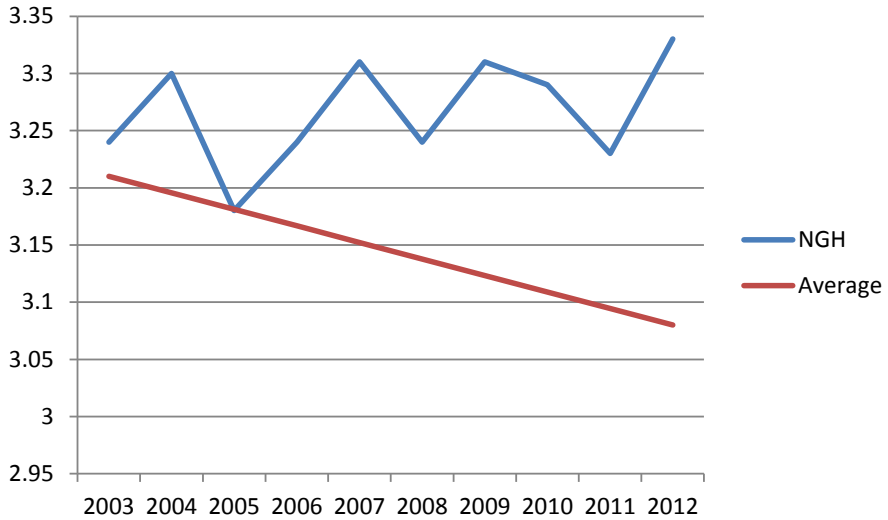
Quality of job design



Comments

National average data only available for 2003 so included as straight line.
No NGH data available for 2012

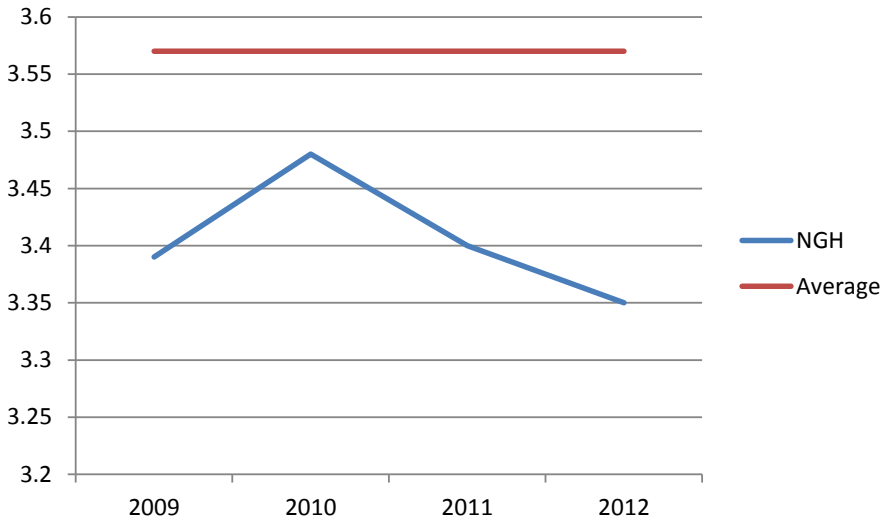
Work pressure felt by staff



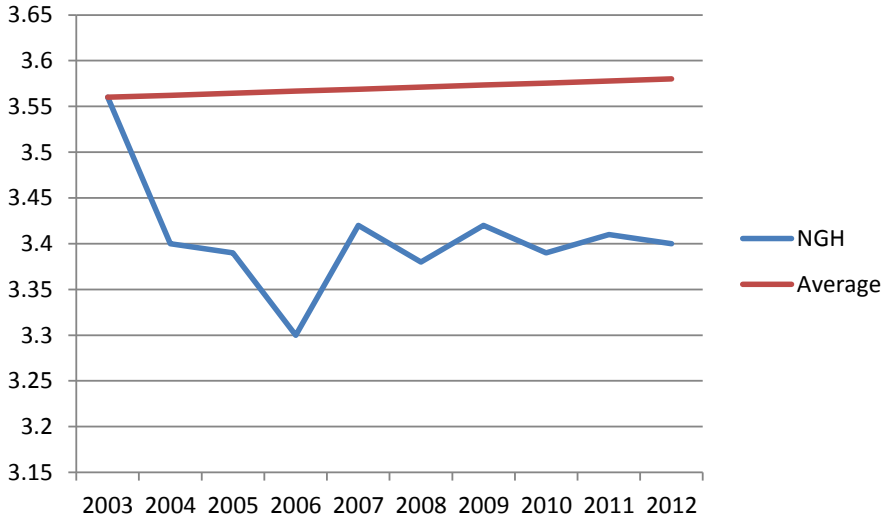
Comments

Performance Breakdown

Staff that would recommend the trust as a place to work and receive treatment



Staff job satisfaction



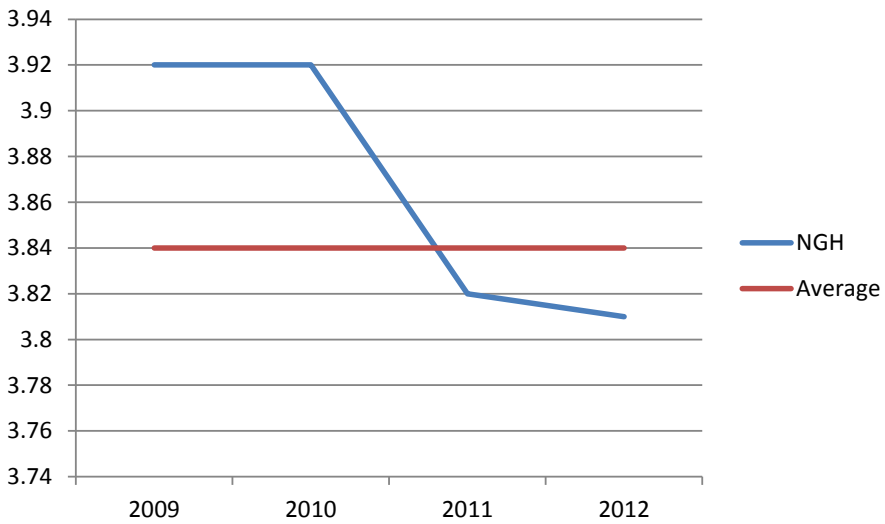
Comments

National average data only available for 2012 so included as straight line.
No NGH data available prior to 2009.

Comments

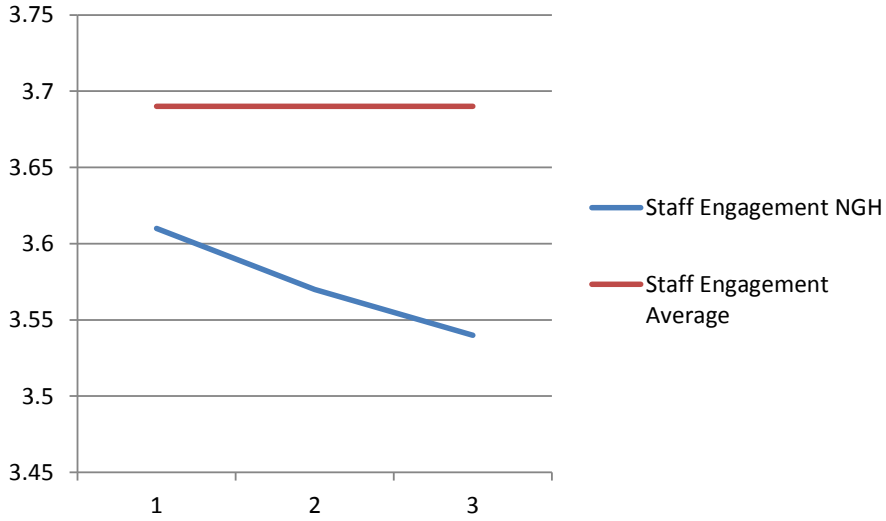
Performance Breakdown

Staff motivation



Comments
National average data only available for 2012 so included as straight line.
No NGH data available prior to 2009.

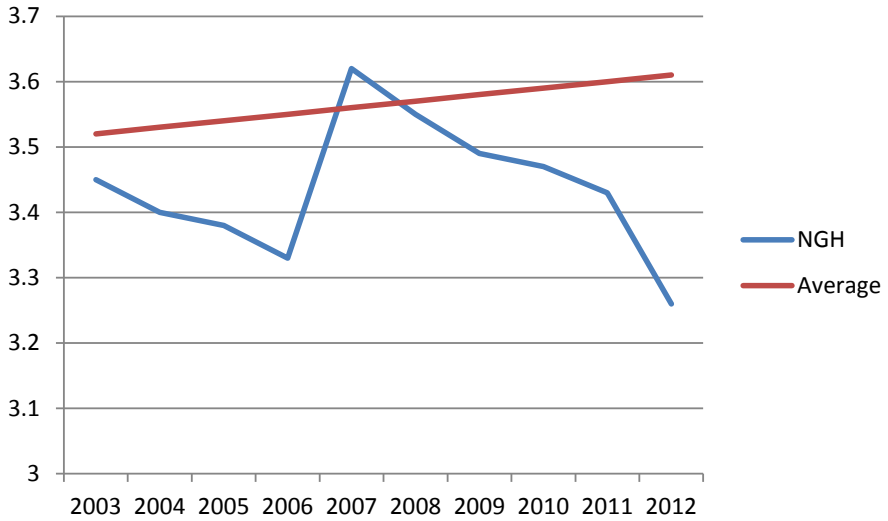
Staff engagement



Comments
National average data only available for 2012 so included as straight line.
No NGH data available prior to 2010.

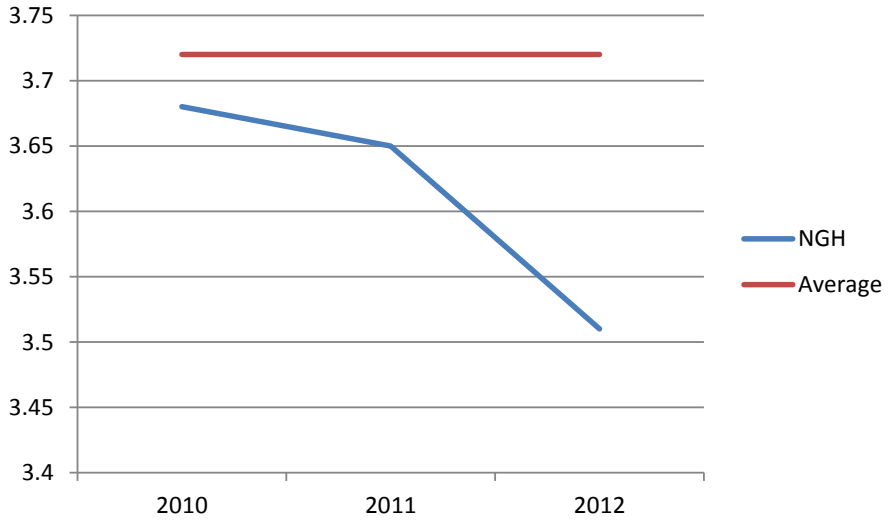
Performance Breakdown

Support from supervisors/immediate managers



Comments

% staff working in a well-structured team environment



Comments

National average data only available for 2012 so included as straight line.
No NGH data available prior to 2010.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 30 MAY 2013	
Title: -	Operational Performance Report
Presented by: -	Clive Walsh – Interim Chief Operating Officer

PURPOSE OF PAPER: - This report sets out key areas of performance for Northampton General Hospital NHS Trust for Month 1 (April 2013). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 1 **(April 2013)**.

- The Trust did not achieve the 4 hour transit time standard for April 2013 with 87.9% of patients being treated within 4 hours against the standard of 95%.

- The cancer targets are monitored on a quarterly basis. For April the Trust did not achieve one of the cancer standards;
    - 62 days from referral from screening to start of treatment with 87.5% against the standard of 90%.

ACTION REQUIRED BY BOARD: -

The Board is asked to discuss the contents of this report and agree any further action necessary

Northampton General Hospital NHS
NHS Trust

PERFORMANCE REPORT – MAY 2013

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 1** (April 2013). The report is based on the NHS Everyone Counts: Planning for Patients 2013/14. Everyone Counts outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

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

2. SERVICE PERFORMANCE

See Appendix 1 for the detailed score card.

2.1 April Performance

During April the Trust achieved all of the 18 week standards of 90% for admitted and 95% for non-admitted patients treated across all specialties. All patients had their diagnostic test carried out within 6 weeks of request.

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

2.2 A&E Clinical Indicators

There continued to be significant pressures from non-elective demand across the Trust during April, when 87.9% of patients were admitted, transferred or discharged from A&E within 4 hours. Performance improved during the second half of April and into May and the year to date position is 90.4% as at the 19th May 2013.

The recovery plan and urgent care programme continues in place to improve flow through the emergency pathway and therefore improve the A&E 4 hour performance standard. Progress is monitored through the Urgent Care Programme Board (UCPB) and each project and clinical leads are held to account for delivery of their action.

See the separate report of Urgent Care performance for further detail.

2.3 Cancer Standards

All cancer standards are monitored quarterly. During April, the Trust achieved all the standards with the exception of the 62 days from screening to start of first treatment. The Trust achieved 87.5% against the standard of 90%. Small numbers of patients are treated each month against this standard, with two patients not being treated within 62 days.

2.4 Cancelled Operations rebooked within 28 days

During April 97.5% of patients who had their operation cancelled on the day of surgery were rebooked within 28 days. In Everyone Counts; Planning for Patients 2013-14 the requirement is that all patients who have operations cancelled on or after the day of admission (including day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patients choice.

During April, 1 patient did not receive their treatment within the agreed 28 days. This patient was rescheduled within 28 days but unfortunately was cancelled again on this rescheduled day as the theatre list overran. This patient has now received their procedure at NGH.

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-13
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups		
Admitted	90.0%	95.0%
Non-admitted	95.0%	97.9%
Incomplete pathways	92.0%	96.4%
Number of diagnostic waits > 6 weeks	0	0.0%
A&E 95% Transit time target		
Cumulative	95.0%	87.89%
Month on Month	95.0%	87.89%
Cancelled Operations rebooked within 28 days (as per SITREP definition)	100%	97.5%
Cancer Wait Times		
2 week GP referral to 1st outpatient	93.0%	95.7%
2 week GP referral to 1st outpatient - breast symptoms	93.0%	100.0%
31 Day	96.0%	97.1%
31 day second or subsequent treatment - surgery	94.0%	100.0%
31 day second or subsequent treatment - drug	98.0%	100.0%
31 day second or subsequent treatment - radiotherapy	94.0%	98.1%
62 day referral to treatment from screening	90.0%	87.5%
62 day referral to treatment from hospital specialist	80.0%	81.8%
62 days urgent referral to treatment of all cancers	85.0%	85.7%
Stroke Indicators		
Proportion of people who have a TIA who are scanned and treated within 24 hours	60.0%	72.7%
Proportion of people who spend at least 90% of their time on a stroke unit	80.0%	88.2%
Activity vs. Plan		
Elective Inpatients	>0%	2.5%
Daycase	>0%	3.2%
Non- Elective	>0%	3.7%
OP 1	>0%	1.3%
OP Procedures	>0%	6.4%
New to Follow UP Ratio	2.01	
GP Referrals	>0%	16.5%
Day Case Rates	81%	
Sleeping Accommodation Breach	0	0

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 30 May 2013	
Title	Urgent Care Report
Presented by	Clive Walsh, Interim Chief Operating Officer

PURPOSE OF PAPER: -

The main purpose of this paper is to outline the Urgent Care Programme and work plan of the working groups. In addition, there is an opportunity for the Board to consider the national and area context for the demand for urgent and emergency care.

SUMMARY OF CRITICAL POINTS: -

- Performance against the 95% Four Hour Transit Time Standard remains inconsistent
- Attendances and emergency admissions are higher than the previous year
- The work streams within the NGH Urgent Care Programme continue to work to plan and updates are provided within the report
- Benchmark performance for East Midlands hospitals is included within the report which shows highly variable performance across the area
- The Chief Operating Officer of NHS England has required all Area Teams to establish local Urgent Care Boards and to agree recovery and improvement plans by 31 May 2013.

RECOMMENDATION:-.

The Board is asked to review and discuss this paper.

Northampton General Hospital NHS
NHS Trust

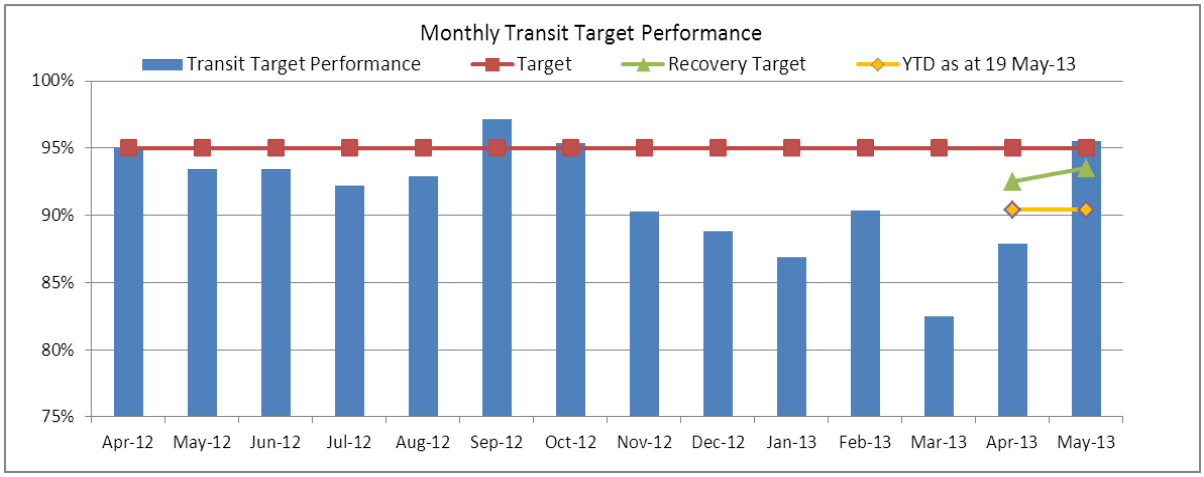
Urgent Care Programme Update
Trust Board – 30th May 2013

1. Introduction

The Urgent Care Programme (UCP) continues to be led by the Chief Executive with the Programme Board meeting monthly. This report aims to provide an update on each of the UCP work streams, a summary of current performance and a benchmark review of performance against other acute Trusts. The last report to the Board was considered on the 28th March 2013.

2. Current Performance

Throughout 2012/13 performance has been variable with achievement of the 95% standard in April, September and October 2012. The full year performance in 2012/13 is 91.5%.



Note: May 13 data up to & inc 19th May

During 2012/13 attendances have been 2% higher and emergency admissions have been 5% higher than the previous year. The Trust has not seen a reduction of attendances in April and May 2013, suggesting that its response to local commissioners' QIPP plans was prudent.

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

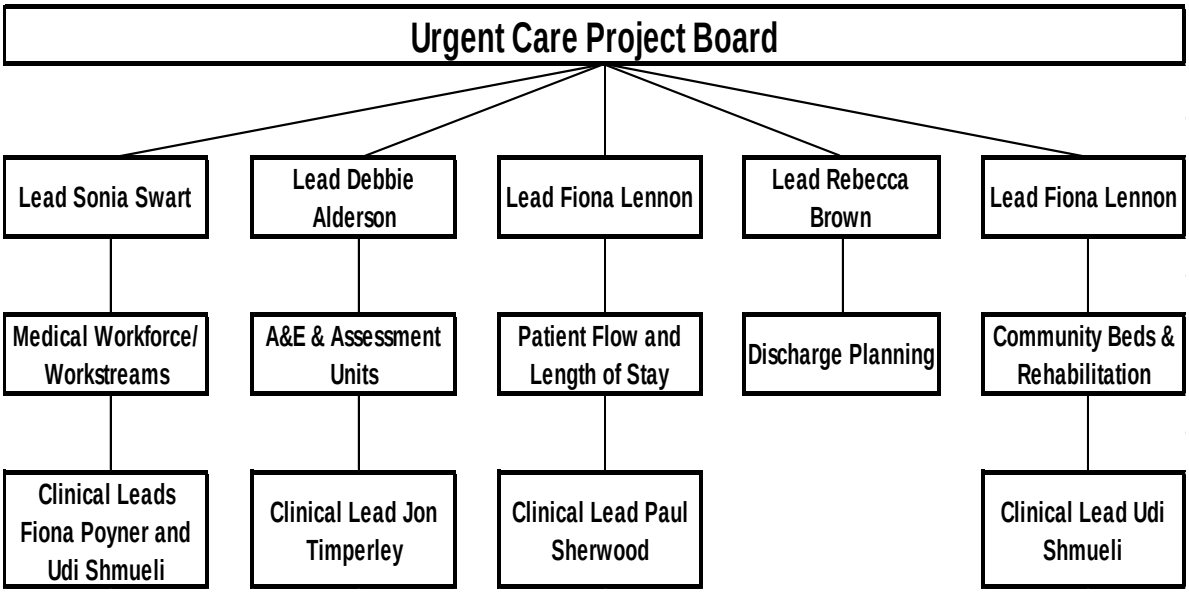
The following information highlights performance for all acute Trusts within the East Midlands in the month of April 2013:

Trust	Attendance	Performance
Hospital A	5,471	**94.4%**
Hospital B	15,632	**93.1%**
Hospital C	17,330	**91.9%**
Hospital D	21,470	**91.9%**
Hospital E	14,947	**90.0%**
Northampton General Hospital NHS Trust	12,257	**87.4%**
Hospital F	25,959	**81.9%**
Hospital G	8,775	**74.1%**

England	1,702,651	**93.2%**

4. Overview of Work Streams

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



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

The latest high level report to the UCB (8 May 2013) is attached as **Appendix 1**. All work streams are demonstrating satisfactory progress. The Trust is considering whether its level of ambition in respect of Ambulatory Care should be increased above that planned. Currently the Trust is committed to developing five pathways of care and "hot clinics" as part of the CQUIN Programme.

5. National and Wider Area Considerations

On the 9 May 2013, Barbara Hakin, Chief Operating Officer (COO) of NHS England, wrote to all area teams and CCGs to request a recovery plan for every health community. The letter (**Appendix 2**) was accompanied by a 22 page report: 'Improving A&E Performance' (Gateway Ref: 00062). The key points of this report are:

- There has been a significant and widespread deterioration in A&E performance across the winter period.
- There are multiple reasons why this may have occurred.
- In response, an urgent recovery programme will be set out, involving national and local commissioners and providers.
- The arrangements for national and area level oversight are set out.

The report contains the Emergency Care Checklist published by the Kings Fund in March 2013. The Trust has proposed that the local health economy should undertake a gap analysis against this checklist. This will be considered at the next UCB on the 5th June 2013.

The significant omission from the NHS England briefing is a proposal to increase the members of junior and middle grade Doctors in training, or to mitigate this risk.

The Trust Development Authority (TDA) has organised a briefing and development day on 22 May 2013 for NHS Trust Directors. A report will be provided by the COO at the Board Meeting.

On 16 May 2013, Chief Executives and COO's from NHS Trusts and Foundation Trusts across the area met to consider the lessons learned from the winter. It was agreed that a collective review of winter 2012/13 would be undertaken, supported by the Academic Health Sciences Network (AHSN).

6. Recommendation

The Board is asked to review and discuss this paper.

Appendix 1

Urgent Care Programme

Date: 29.4.13
Updated by: Laura Sharpe

Northampton General Hospital NHS
NHS Trust

1 2 3 4 5 6 7 8

1. Project Governance:

Exec Sponsor:

Christine Allen – Chief Operating Officer

Project Lead:

Jon Timperley – Cardiology Consultant

Steering Group:

The Steering Group meets monthly, or more frequently depending on the situation.

Steering Group Members:

Jon Timperley, Sonia Swart, Udi Shmueli, Debbie Alderson, Rebecca Brown, Fiona Lennon, Amanda Bisset, Michael Wilkinson, Natasha Kerrigan, Christine Johnson, Laura Sharpe

2. Project Brief/Description:

Aim:
The Urgent Care Programme aims to co-ordinate the improvement in high quality, safe and timely care for patients attending Accident and Emergency, and throughout the Urgent Care Process, ensuring that both national and local targets are met and sustained.

Objective:
This will be accomplished through a redesign of the Emergency Care Pathway with an aim to reduce length of stay, bed occupancy and improve the quality of care, including patient safety.

Scope:
The Emergency Care Pathway redesign is a Trust priority, with an established Urgent Care Board to provide governance to the workstreams. There is an emphasis on the importance of strong clinical leadership and the integration of workstreams, avoiding duplication.

Interdependencies:

- Patient Safety Programme
- Patient Experience

3. KPIs:

	Indicator	Target Measure	Feb 13	Mar 13
1	<4 hour wait in ED	>=95%	90.3%	82.5% ↓
2	Reduce Length of Stay	<7.75 days	9.22 days	7.66 days ↓
4	Discharges before 13.00	50%	26%	27%↑
5	Establish Ambulatory Care Pathways	13 pathways established	6 established	6 established ↔
6	Number of delayed discharges	< from baseline	2.6%	3.0% ↑

4. Key Milestones:

Action	RAG	Dec	Jan	Feb	Mar	Apr	May
Establish ambulatory care pathways							
Reinforce Internal Professional Standards							
Implementation of Visual Hospital.to Community Wards							
Appoint additional Consultant Physicians/Acute Care Physicians for A&E and EAUs							
Rollout of Nurse Led Discharge across surgery and medicine							
Implement community stroke beds							
Development of pathway for patients presenting with overdose							
Pilot with Age UK to avoid admissions							
Embedding EDD across Trust							
Development and participation of Discharge Programme Board							

As with other workstreams, these milestones will be reviewed regularly, particularly in light of scheduled reviews from the Emergency Care Intensive Support Team.

5. Risk Log:

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

6. Quality Impact Assessment

QIA completion date	12.02.13	**QIA completed by**	Laura Sharpe Jon Timperley
QIA sign off date	04.03.13		
QIA review date	12.02.14	**QIA signed by**	Sonia Swart Suzy Loader

7. Non-financial Benefits

Patient Experience:

- Patients will benefit from reduced waiting times in A&E, reduced number of patients being admitted, and a reduction in the length of stay.

Patient Safety:

- Right care, first time, every time.
- Reduced length of stay, improved patient flow and reduction in infection rates.
- Ward round optimisation.
- 12 hour consultant review.
- Reduced time to first doctor review.
- Implementation of Summary Care Record (SCR) and Symphony.

Clinical Effectiveness

- Specialist nursing and medical input, together with Nurse Facilitated Discharge (NFD) will improve clinical effectiveness (this is tracked through organisational clinical outcome measures - mortality, complications, re-admissions)
- Improving patient flow of admissions will ensure that accumulation of patients in A&E or other admission areas will be reduced.

8. Communication Plan

The transformation team newsletter and trust's core brief and transformation briefings will be used to provide progress updates to all staff.

Further communication strategies will need to be developed as a result of targeted activity across wokstreams, such as ambulatory care pathways, including some public-facing communication campaigns,

4N30
Quarry House
LEEDS
LS2 7UE

Email address: barbara.hakin@nhs.net
Telephone Number: 0113 825 2116

Gateway ref: 00062

9 May 2013

To: NHS England Area Directors

Copy: CCG Clinical Leaders
CCG Accountable Officers
NHS England Regional Directors

Dear Colleague,

DELIVERY OF THE A&E 4 HOUR OPERATIONAL STANDARD

Long waiting times in A&E department, often experienced by those awaiting admission and hence ill patients, not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness.

You will be aware of the pressure the urgent and emergency care system is experiencing at the moment and the effect that this has had on the operational standard for A&E (95% of patients admitted transferred or discharged within 4 hours). This operational standard is designed to deliver patients' rights under the NHS Constitution.

In Everyone Counts: Planning For Patients 2013/14 we reinforced the NHS Constitution commitment and as such it will be part of our approach to CCG Assurance. In addition, Everyone Counts sets out that no patient should wait more than 12 hours on a trolley in an A&E department and commissioners are empowered to take action against providers that breach this condition.

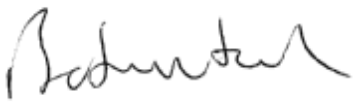
In its oversight role of commissioning NHS England will coordinate the production of local recovery and improvement plans. NHS England, Monitor and the NHS Trust Development Authority (TDA) have put in place a tripartite agreement which will provide regional and national oversight to the delivery of these plans. We will also work closely with CCGs at national level, as well as with key partners from local government.

Together, we have agreed a national recovery and improvement plan to secure

the timeliness of treatment for our patients. This plan is attached and describes the actions expected of Area Directors to facilitate a local partnership approach and system plan. As lead commissioners, CCGs will wish to support their providers to ensure that each A&E department that is not within the NHS Constitution threshold can recover its position at the earliest possible time. This will require the development of local recovery and improvement plans centred around each A&E department. I am, therefore, asking each Area Director to facilitate the preparation of these plans by CCGs for each A&E department on your patch. The national recovery plan sets out how the local recovery and improvement plan can be developed in partnership between commissioners and providers.

You will appreciate the urgency to secure recovery as soon as possible and as such I would ask you to ensure the setup of your local Urgent Care Boards and local agreement of all recovery and improvement plans by 31 May 2013 and for them to be sent to your Regional Director by that date. Regional teams will then work in partnership with the regional arms of Monitor and the NHS TDA to ensure mutual understanding and oversight of the delivery of the local recovery and improvement plans. The national tripartite performance oversight team, working with local government and CCGs will ensure a coordinated national approach to this process.

Yours sincerely,



Dame Barbara Hakin
Chief Operating Officer/Deputy Chief Executive

Northampton General Hospital NHS
NHS Trust

Trust Board 30 May 2013	
TITLE: -	Finance Report M1 – April 2013
PRESENTED BY: -	Mr Andrew Foster, Acting Director of Finance.

PURPOSE OF PAPER: -

The paper sets out the latest Financial Position of the Trust for the period ended 30th April 2013 (Month 1).

CRITICAL POINTS: -

- **Deficit Plan and CIP Risk** - The annual plan agreed with the Trust Development Agency (TDA) is for an I&E deficit of £4.8m. The plan includes a £13m (5%) CIP target of which £4.5m was considered to be high risk at the time the plan was agreed. The plan also included revenue reserves of £3.9m at the start of the financial year for which commitments have now been approved.

- **Business Case Development and allocation of Reserves** –A range of business cases to have been approved for funding from reserves. The net impact is a reduction in the level of reserves which now stand at £1m at the end of April, reducing the level of flexibility for further unplanned developments or contingencies for the remainder of the financial year.

- **Income, case mix and penalties** – The month 1 CCG income estimates are based on discharge data and are subject to validation and final coding. As full case mix becomes known CCG SLA income values reported for April may change. The Trust has made appropriate provision in April for a range of potential fines and penalties which may be levied by the CCG under the terms of the contract.

- **Cash Requirements and Liquidity** – The annual plan includes a requirement for up to £6m of additional cash support during 2013/2014. Work is on-going to review the liquidity requirements for the coming months and to provide a recommendation to the June F&PC regarding both the amount and timing of additional cash support required. The process of application for DH borrowing is currently being confirmed with the TDA.

ACTION REQUIRED: -

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

Enclosure 11

The Trust's Financial and Contracting Performance Report as at 30 April 2013

Month 1 2013/2014

1. Summary Performance – Financial Duties

1.1. Table 1 summarises the year to date and full year forecast performance against the statutory financial duties required of the Trust. A performance dashboard is also included at Appendix1.

Table 1 – Key Financial Duties

Financial Duties	YTD Actual	YTD Target	FOT	Full Year Target	Variance
Delivering Planned Surplus (£'000)	-£448	-£459	-£4,856	-£4,856	-£0
Achieving EFL (£000's)	N/A	N/A	£5,304	£5,304	£0
Achieving the Capital Resource Limit (£000's)	£126	£258	£10,664	£10,664	£0
Subsidiary Duties					
Better Payment Practice Code:					
Volume of Non-NHS Invoices	82%	95%	90%	95%	-5%
Value of Non-NHS Invoices	75%	95%	90%	95%	-5%

Key Issues:-

- **Deficit Plan and CIP Risk** - The annual plan agreed with the Trust Development Agency (TDA) is for an I&E deficit of £4.8m. The plan includes a £13m (5%) CIP target of which £4.5m was considered to be high risk at the time the plan was agreed. The plan also included revenue reserves of £3.9m at the start of the financial year for which commitments have now been approved.

- **Business Case Development and allocation of Reserves** –A range of business cases to have been approved for funding from reserves. The net impact is a reduction in the level of reserves which now stand at £1m at the end of April, reducing the level of flexibility for further unplanned developments or contingencies for the remainder of the financial year.

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Table 2 – I&E Position - April 2013

I&E Summary	Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan
	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	19,049	19,156	107
Other Clinical Income	2,803	233	259	25
Other Income	25,575	2,146	2,007	(140)
Total Income	**259,281**	**21,428**	**21,421**	**(7)**
Pay Costs	(175,015)	(14,475)	(14,238)	237
Non-Pay Costs	(78,307)	(6,494)	(6,412)	82
CIPs	4,663	389	0	(389)
Reserves/ Non-Rec	(1,063)	(89)	0	89
Total Costs	**(249,722)**	**(20,669)**	**(20,650)**	**19**
EBITDA	**9,559**	**759**	**771**	**12**
Depreciation	(10,184)	(865)	(865)	0
Amortisation	(10)	(1)	(1)	0
Impairments	0	0	0	0
Net Interest	29	2	1	(1)
Dividend	(4,250)	(354)	(354)	0
Surplus / (Deficit)	**(4,856)**	**(459)**	**(448)**	**10**
Normalised for Impairment		**(459)**	**(448)**	**10**

1.3 The forecast position is for a £4.8m deficit (achievement of plan) by the end of the 2013/14 financial year. This forecast is dependent on the identification and delivery of high risk and unidentified CIPs. Further details can be found in the Transformation Programme report.

1.4 Capital expenditure has fallen marginally behind plan in April due to slippage in endoscopy and improving birthing environment projects. A re-profiling of the cashflow has now taken place based on the latest plans and expenditure profiles.

1.5 The income position has included a prudent provision for CCG fines and penalties and likely challenges. These include re-admissions, contract challenges and casemix. The CCG has made clear that they have significant financial pressures in 2013/14 and as such full provision for expected penalties is currently being made in the income estimates.

1.6 During April the Trust retained sufficient cash to make all payments due to key suppliers. However difficulties were experienced in receiving cash payment from a number of CCGs, largely due to the national switch of CCG processing functions to SBS (Shared Business Services) from April. BPPC performance has been impacted by a number of 2012/13 invoices being paid in April which has led to a degradation of performance. The receipt of cash from CCGs, including outstanding April balances has improved in May allowing payments to be scheduled to ensure targets can be met from June 2013 onwards.

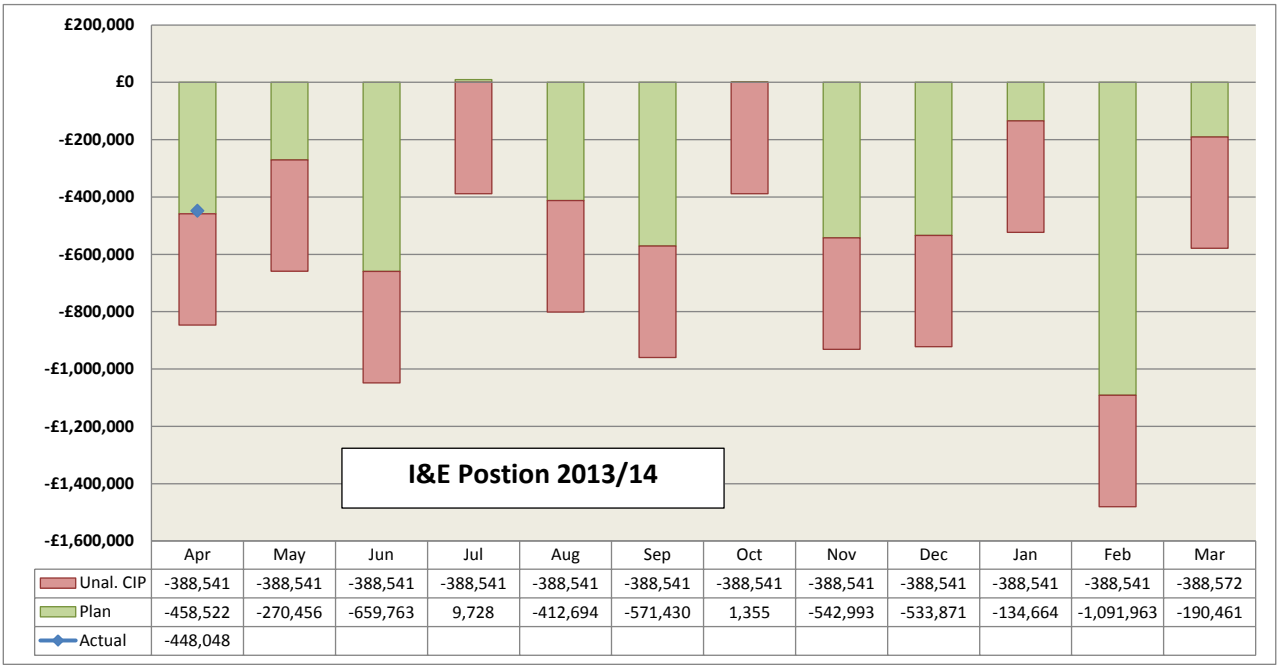
1.7 The Trust continues to make use of extensive levels of temporary staff to meet operational needs. The Trust Board has already agreed investment in substantive nursing posts to reduce this expenditure eliminating the premium such expenditure attracts. Plans to recruit to these posts must be expedited to reduce the current levels of bank and agency spend.

2.0 Income and Expenditure Position of the Trust

Surplus/ (Deficit) Position

2.2 Appendix 2 provides details of the Trusts summary I&E position. The Trusts year to date I&E position for the period ended 30th April 2013 is a deficit of £448k. This performance is £10k favourable to the month 1 planned deficit of £459k.

Graph 1 – Income & Expenditure Profile 2013-14



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unal. CIP	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,541	-388,572
Plan	-458,522	-270,456	-659,763	9,728	-412,694	-571,430	1,355	-542,993	-533,871	-134,664	-1,091,963	-190,461
Actual	-448,048											

Graph 1 shows the I&E plan agreed with the NTDA for 2013-14. The unidentified CIP is shown as an additional risk to the planned position (highlighted in red) each month.

3.0 Income and Activity

3.1 Month 1 total operating income stands at £21.4m which is consistent with the planned income levels. The Trust has yet to receive final confirmation from the LETB of income due under the Learning and Development Agreement (LDA) for 2013-14. The current position includes the latest estimate available for this funding stream which is anticipated to reduce for 1 surgical training post and the impact of central DH budget reductions.

3.2 SLA income amounted to £19.1m in April marginally exceeding planned levels by £0.1m. Importantly the actual level of income generated in April remains subject to final case mix validation. Provisions to cover potential contractual penalties totalling £0.4m have been accrued in the April position including £0.2m for readmissions penalties.

3.3 CQUIN income has been accrued at 100% of the full target. There is risk of non-delivery of CQUIN schemes and work is underway to allocate appropriate levels of CQUIN income to Directorates and to build a performance framework to enable more robust financial of this area.

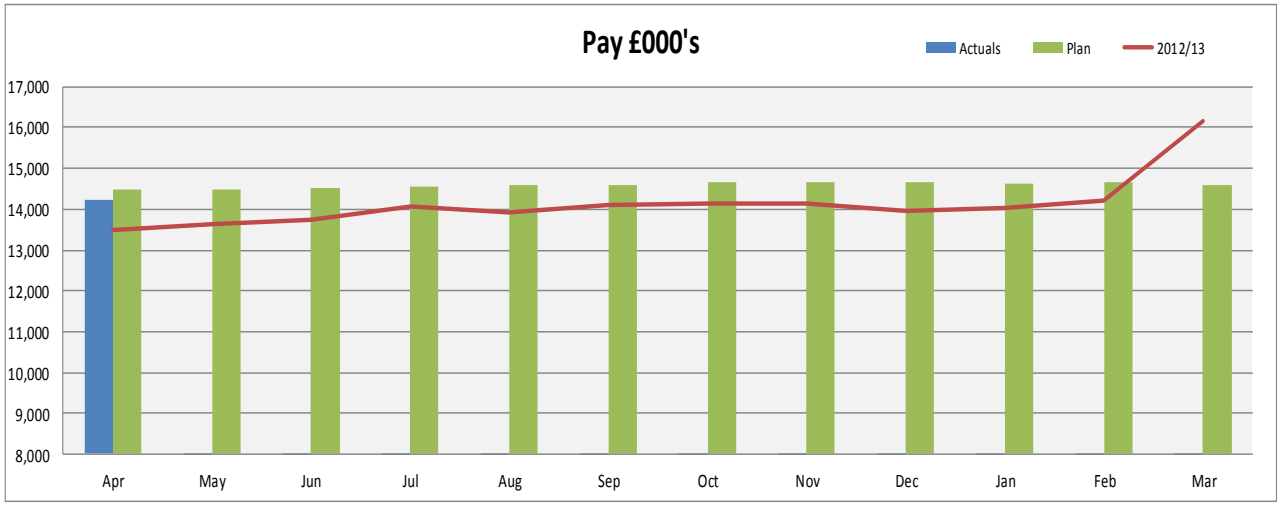
4.0 Expenditure

4.1 The Trust has underspent expenditure budgets overall by £19k in April 2013. This position included unmet CIP of £389k, partly offset by the year to date value of reserves.

4.2 Pay costs in the month were £14.3m (FTE 4,186.6) against a plan of £14.5m (FTE 4,451.81) reporting a favourable variance of £0.2m. The Trust continues to make use of temporary staff to support this under establishment incurring the associated premium costs.

4.3 In April weekly pay phased out across the Trust. This is the first month of the phased change and whilst systems have been developed to ensure that appropriate accruals are made there is a small risk that bank costs may increase marginally in May once payment for enhanced pay are stabilised.

Graph 2 – Pay expenditure profile 2013/14



4.3 The Trust is operating below the planned WTE budget (by 265.21 FTE**)** but is utilising significant numbers of temporary staff in excess of this number.

Table 3 – WTE Analysis – April 2013

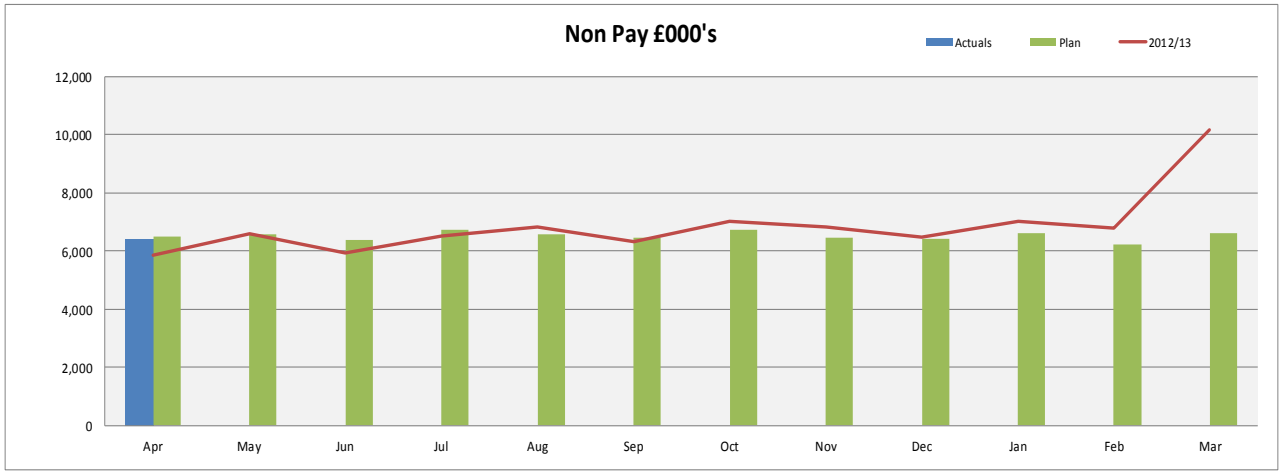
Staff Type	Worked Mth 1 WTE	WTE Budget 2013/14 M1	Worked V Bud Var	Contracted Mth 1 WTE
Medical Staff	466.86	479.34	*12.48*	470.71
Nursing Staff	1836.81	1923.46	*86.65*	1765.82
Managerial & Administration	837.30	909.70	*72.40*	739.86
Other Clinical Staff	275.51	321.93	*46.42*	273.91
Scientific & Technical Staff	382.84	390.72	*7.88*	372.14
Estates Staff	29.33	35.50	*6.17*	26.00
All other Staff	357.95	391.16	33.21	327.00
Cost Challenges	-	-	-	-
Total WTE	**4186.60**	**4451.81**	***265.21***	**3975.44**

Table 4 – Temporary Staffing – April 2013

Temporary Work staff	Worked Mth 1 WTE	WTE Budget 2013/14 M1	Worked V Bud Var	Contracted Mth 1 WTE
Medstaff WLI & ADH's	7.66	-	*(7.66)*	-
Agency Medstaff (Senior)	4.43	1.00	*(3.43)*	-
Agency Medstaff (Junior)	13.31	-	*(13.31)*	-
Bank Staff - Nursing	125.71	6.00	*(119.71)*	1.23
Agency Staff - Senior Nursing	27.80	-	*(27.80)*	-
Agency Staff - Junior Nursing	30.67	-	*(30.67)*	-
Agency Staff - Management	2.60	-	*(2.60)*	-
Bank Staff - Admin	83.49	-	*(83.49)*	1.00
Agency Staff - Admin	17.71	-	*(17.71)*	-
Bank & Agency Staff - Other	37.91	-	*(37.91)*	-
Total WTE	**343.63**	**7.00**	***(336.63)***	**2.23**

4.5 Non pay expenditure has underspent against plan by £82k. This majority of this underspend has been created by a non-recurrent gas refund relating to a change in tariff notified in April.

Graph 3 – April Actual Non Pay expenditure and Monthly Plan monthly



5.0 Allocation of Reserves

5.1 The Trust identified reserves of £3.9m as part of the Integrated Business Planning process. On 30 April the Strategic Management Board approved a range of developments as set out in the table below.

Table 5 – 2013-14 Developments funded from Reserves

	£'000
Reserves Identified During IBP	3,900
Investments Agreed	
A&E Nursing	(194)
A&E / Gen Med Medical	(244)
SAU	(216)
PAOU	(248)
3 x Level 1 Beds - Rowan Ward	(168)
Ophthalmologist (Self funding)	-
Add income topping up reserves	131
Maternity (Nursing) Pool	(900)
Nursing Investment Strategy	(1,000)
Remaining Reserves	**1,062**

5.2 The developments listed above represent those business cases put forward with the highest level of priority for investment in 2013/14. It is anticipated that the impact of these inititiatives will help to improve patient flow through the hospital during the second half of the financial year. Where available, external funding will be sought for these initiatives, notably those associated with improving urgent care.

5.3 A further development to extend the provision of the Radiology services was also agreed in principle. The net impact on reserves of this development is expected to be £0.3m after consideration of associated GP direct access income.

5.4 The planned phasing of the developments in Table 5 is set out in Appendix 3. It is important to note that the investment in nursing has been phased from month 1 to offset the costs of temporary nursing staff, pending the recruitment of substantive posts by July.

6.0 Transformation Programme (CIP Programme)

6.1 The Trusts financial plan set a CIP target of £13.0m (5% of income). A further £1.95m of additional schemes are currently being targeted to provide further contingency to support the financial position and the current level of high risk schemes.

6.2 In April CIPs of £0.7m have been recorded which is consistent with the NTDA plan for the month. It is noted that there are two key CIP schemes that have not been fully validated in terms of delivery in April. CIP Income schemes require case mix data to demonstrate their delivery however this data is not yet available, as such a 50% delivery has been assumed. The CIP schemes relating to sick pay also remain subject to validation.

Table 6 RAG Status of Transformation CIP Schemes

	£m
Green	11.1
Amber	0.4
Red	3.4
Total	14.95

6.3 Appendix 4 details the identified schemes by workstream. Further details of the forecast delivery of CIP for the remainder of the financial year can be found in the Transformation report provided under separate cover.

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

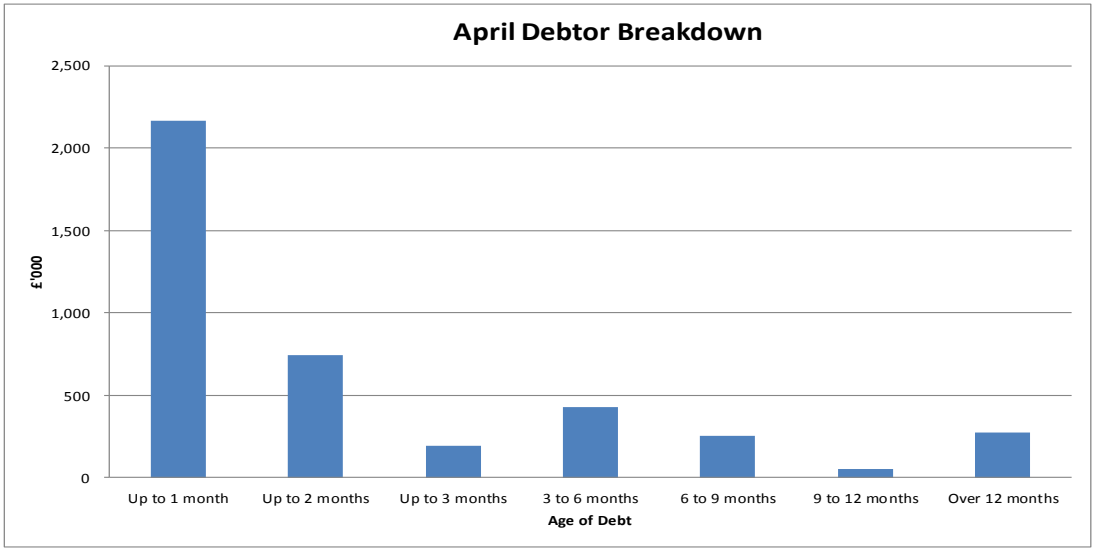
7.1 The Trusts Statement of Financial Position (Balance Sheet) as at 30th April 2013 is contained within Appendix 4 of this report.

7.2 The Trust's actual and forecast cash flow for the year is shown in appendix 5. The cash balance at the end of April stood at £7.1m (March £4.3m). Importantly this cash flow has been based on April actual cash receipts and expenditure with the planned assumptions for capital and income and expenditure for the remaining months of the year.

7.3 The cashflow statement highlights the potential requirement for a cash loan of up to £6m during the 2013-14 financial year. This position will be continually reviewed during the financial year and the respective risks to liquidity considered carefully. The cashflow position will be updated in month 2 to reflect the latest information regarding income, expenditure and capital profiling and a recommendation brought back to the June F&PC meeting. The process of application will also be discussed with the TDA.

7.4 An analysis of income earned by the Trust but unpaid as at 30th April 2013 is shown in the graph below.

Graph 4 – Aged Debtor analysis – April 2013

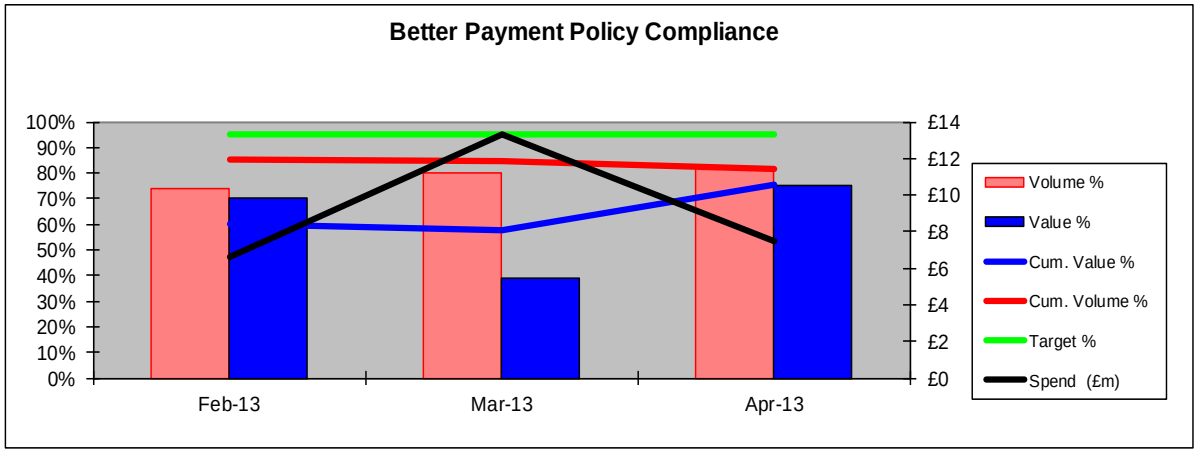


7.5 The debt due in up to two months relates to overperformance with NHS Milton Keyens and is now being actively discussed with the manging orgainsation to agree settlement. Appropriate provision was made in 2012/2013 for these invoices in the event that payment is not agreed in full.

7.6 A significant element of the outstanding debt relates to payroll and service charges for the CRIPPS Recreation Centre. The balance oustanding at the end of April was £386k, of which £297k has been outstanding for over one month. The Trust is currently in discussion with CRIPPs representatives reagarding the ongoing viability of the centre.

7.7 The Trust has continued to manage its cash position closely and to make use of creditor payment flexibility. The graph below shows perfromance against the Better Payment Practice Code for the last three months.

Graph 5 – Better Payment Policy (BPPC) compliance



7.8 The Trust has continued to breach the BPPC targets in the past three months due to cashflow restrictions noted above.

8.0 Capital Programme and Performance against Capital Resource Limit

8.1 The 2013/2014 Capital Plan has been set at £10.91m, which includes donations from Charitable Funds of £0.25m. The agreed Capital Resource Limit (CRL) is set net of donated fund at £10.66m.

8.2 This Capital Programme has been funded through internally generated cash resources from depreciation of £10.18m supplemented by external financing from SALIX of £0.48m.

8.3 The total spend for month 1 is £126k against an initial NTDA plan of £239k. This shortfall in spend in expenditure is due to slippage of endoscopy and Improving Birthing Environments. This expenditure is now planned to take place later in the financial year.

8.4 The overall level of Capital Expenditure for the financial year is £10.91m (including anticipated donations). The Trust is planning to meet it statutory duty to meet its CRL limit.

8.5 The Trust is developing two further significant capital schemes which will impact the overall level of capital expenditure in 2013/2014.

- **Carbon Energy Fund (CEF) –** The Trust has been successful in the initial bidding, securing £2.7m to invest in energy infrastructure. The bid is still subject to a final bid submission to the DH with a decision expected in June 2013. If successful the award will lead to an increase in the Trust CRL and External Financing Limit (EFL) with the cash requirements being funded through a drawdown of additional Public Dividend Capital (PDC).

- **Managed Equipment Service (MES) –** The Trust developed a MES scheme to replace its aging Radiotherapy and Radiology diagnostic equipment in 2012/13 and is currently in the procurement phase to select a preferred bidder. The scheme capital investment of approximately £14m will be funded by the Private Sector as part of a monthly unitary charge payable for the full 14 year term. The scheme will however contain an implicit lease

in the transaction which may lead to a CRL adjustment being required in the event that the lease is classified as a finance lease. This matter is subject to the legal and commercial nature of the final agreed contract documentation and may also need further NTDA approval. This matter is now being discussed with the TDA to confirm any changes to CRL and whether any additional approvals will be required.

9.0 Monitor Financial Risk Rating

9.1 Appendix 8 contains the Trusts indicative financial risk ratings calculated as if it were a Foundation Trust.

9.2 The overall risk rating for the Trust as at the 30 April 2013 if it were a Foundation Trust would be 3 largely due to the overall financial position remaining on plan. The Trust is forecast to end the year with a risk rating of 2 based on the £4.8m deficit plan.

9.3 The Trust reports the shadow FRR scores above to the TDA as part of the Performance Management Report (PMR). At present the forecast score gives rise to a requirement for the Trust Board to make a governance disclosure to the TDA.

10.0 Risks to Financial Position

10.1 A summary of the Trusts financial risks not included in the forecast financial position are set out in table 7 below:

Table 7 – Risks

Key Risks not included in Financial Plan 2013-14		**Value of Risk £000s**	**Likelihood**	**Probability %**	**Adjusted Risk £000s**
Downside Risk	**Action to mitigate risk**				
Transformation Programme Slippage	Early focus on delivery of identified schemes and development of new schemes.	(3,700)	High	90%	(3,330)
Lack of Funding to implement Transformation Programme Schemes	Bid made to the CCG setting out requirement to meet costs of Transformation programme. Appropriate provisions made in 2012-13 accounts for known costs.	(2,000)	Medium	50%	(1,000)
CCG QiPP schemes fail to deliver leading to excess demand for NEL activity and cancellation of EL activity.	Engagement with CCG QiPP schemes. Regular reports from CCG. Early monitoring of activity and demand assumptions compared to planned assumptions. Review of triggers to release capapcity. Application of 2% strategic reserve funding to meet excess costs.	(3,000)	Medium	50%	(1,500)
CCG QiP Schemes are fully successful and A&E and NEL activity is significantly reduced leading to over capacity and unfunded costs.	Engagement with CCG QiPP schemes. Regular reports from CCG. Early monitoring of activity and demand assumptions compared to planned assumptions. Review of triggers to release capacity. Application of 2% CCG strategic reserve funding to meet costs of transaction.	(6,500)	Low	20%	(1,300)
Funding cuts to LDA impact on level of income recived from LETB and loss of recognised medicla training possts	Effective Negotiation with LETB and use of alternative fuiding streams to offset shortfall	(300)	High	90%	(270)
CQUIN schemes are not delivered and penalty imposed by CCGs / EMSCG. Risk evident with certain schemes (e.g. Patient Safety Thermometer).	Monitoring and performance framework to be put in estbalished. Risk to be identified and provsion made in monthly reporting.	(750)	Medium	50%	(375)
Contractual Fines may be imposed by commissioners for failure to deliver key performance targets (e.g. A&E, CDIFF and RTT).	Performance management of key targets. Early engagement and reconcilation with CCGs.	(2,000)	Medium	50%	(1,000)
Net Revenue Risk		**(18,250)**			**(8,775)**

11.0 Conclusion

12.1 The financial position is on plan for April which provides an initial level of assurance to the overall assumptions set out in the IBP process. Clearly this is however the first set of results reported for 2013/14 and remains subject to the emerging risks noted above.

12.2 The income position remains subject to validation of casemix and early engagement and reconciliation of performance under the terms of the agreed contract with the CCG.

12.3 There are CIP schemes identified as high or medium risk totalling £3.8m. This presents a direct risk to the delivery of the financial plan and could see the deficit increase from the planned position of £4.8m.

12.4 A range of business cases have been approved for funding from revenue reserves reducing the level of central contingency available to manage risk for the remainder of the year. External funding should be sought particularly in support of those initiatives aimed at improving patient flow and urgent care.

12.5 As a matter of priority, substantive nurse recruitment is required to minimise the use of bank and agency staff.

12.6 A financial recovery plan will be developed with the following two aims:

- Provide assurance that the £4.8m deficit plan will be delivered as a minimum.
- Consideration of options to reduce the £4.8m planned deficit in conjunction with the CCG and TDA.

12.0 Recommendations

13.1 The Board are asked to note the contents of the report and ensure that the actions to manage emerging risks are discussed and understood.

Appendix 1

Finance Dashboard

KPIs	M1	
Financial Risk Rating (Shadow)	3	FRR shadow score of 2
EBITDA %	3.6%	EBITDA % scores 2 under Monitor FRR
Liquidity (days cover)	18.7	Achieves FRR score of 3 (assumes £18m WCF).
Surplus Margin	-1.9%	I&E deficit of £0.5m in April
Pay / Income	67.5%	Pay 67.5% of Income for YTD
I&E Position	**£000's**	
Reported Position	(448)	Deficit £0.5m April 2013, on plan.
Impairment	0	No Impairments recorded to date.
Normalised Position	(448)	I&E position excluding impairment.
TDA Plan (Year to date)	(459)	NTDA Plan for April 2013
PCT SLA Income Variance	87	Marginally above plan subject to case mix
TDA annual plan	(4,856)	Full year NTDA control total.
Forecast EOY I&E postion	(4,856)	Current forecast is to achieve plan
EBITDA Performance	£000's	
Variance from plan	12FAV	£12kahead of plan
Cost Improvement Schemes	**£000's**	
YTD Plan	760	Target to deliver £0.8m CIPs in April.
YTD Actual	755	£0.8m of CIPs recorded for April.
% Delivered	99%	CIPs delivered as a % of plan .
LTF	11,100	Value of Schemes rated Green
Annual Plan	13,000	Annual Transformation Target.
LTF v. Plan	85%	% of LTF compared to annual plan.
Capital	**£000's**	
Year to date expenditure	126	Capital expenditure for period
Committed as % of plan YTD	13%	% of plan committed for year to date.
Annual Plan	10,664	Capital Resource Limit of £10.6m for 2013-2014
SoFP (movement in year)	**£000's**	
Non-current assets	(740)	Depreciation not offset by additions
Current assets	3,481	Increase in cash and NHS debtors
Current Liabilities	3,189	Increase in Trade creditors ,Taxation and NI.
Cash	**£000's**	
In month movement	2,801	Late receipt of CCG SLA payments in April
In Year movement	2,801	Late receipt of CCG SLA payments in April
DH Temporary Loans	0	No approvals for 2013/14 to date.
Debtors Balance > 90 days	1,013	25% of debt over three months
BPPC (by volume) YTD	81.7%	Target 95% paid in 30 days

Income & Expenditure Position – April 2013

I&E Summary	Plan 2012/13	YTD Plan	YTD Actual	Variance to Plan
	£000's	£000's	£000's	£000's
SLA Clinical Income	230,904	19,049	19,156	107
Other Clinical Income	2,803	233	259	25
Other Income	25,575	2,146	2,007	(140)
Total Income	**259,281**	**21,428**	**21,421**	**(7)**
Pay Costs	(175,015)	(14,475)	(14,238)	237
Non-Pay Costs	(78,307)	(6,494)	(6,412)	82
CIPs	4,663	389	0	(389)
Reserves/ Non-Rec	(1,063)	(89)	0	89
Total Costs	**(249,722)**	**(20,669)**	**(20,650)**	**19**
EBITDA	**9,559**	**759**	**771**	**12**
Depreciation	(10,184)	(865)	(865)	0
Amortisation	(10)	(1)	(1)	0
Impairments	0	0	0	0
Net Interest	29	2	1	(1)
Dividend	(4,250)	(354)	(354)	0
Surplus / (Deficit)	**(4,856)**	**(459)**	**(448)**	**10**
Normalised for Impairment		**(459)**	**(448)**	**10**

Appendix 3

Developments Funded from Reserves

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A&E Nursing	9.9	9.9	9.9	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	**194.0**
A&E / Gen Med Medical				7.5	32.2	32.2	35.4	35.4	38.6	38.6	30.1	-5.9	**244.0**
SAU			21.6	21.6	21.6	21.6	21.6	21.6	21.6	21.6	21.6	21.6	**216.0**
PAOU						20.0	43.3	36.8	36.8	36.8	36.8	36.8	**248.0**
3 x Level 1 Beds - Rowan Ward					37.0	14.5	14.5	14.5	14.5	14.5	29.0	29.0	**168.0**
Ophthalmologist (Self funding)													
Add income topping up reserves	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-10.9**	**-131.0**
Maternity (Nursing) Pool	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0	**900.0**
Nursing Investment Strategy	83.3	83.3	83.3	83.3	83.3	83.3	83.3	83.3	83.3	83.3	83.3	83.3	**1,000.0**
Total	157.3	157.3	178.9	194.7	256.4	253.9	280.4	273.9	277.1	277.1	283.1	247.1	2,839.0

Appendix 4

Statement of Financial Position as at April 2013

MONTH 1 2013/14						
	Balance at 31-Mar-13	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789		133,789	
IN YEAR REVALUATIONS			(94)	(94)	262	
IN YEAR MOVEMENTS			125	125	10,914	
LESS DEPRECIATION			(771)	(771)	(10,184)	
NET BOOK VALUE	**133,789**	**133,789**	**133,049**	**(740)**	**134,781**	**992**
CURRENT ASSETS						
INVENTORIES	4,934	4,934	4,938	4	4,862	(72)
RECEIVABLES						
NHS DEBTORS	4,103	4,103	5,279	1,176	4,214	111
OTHER TRADE DEBTORS	2,295	2,295	1,246	(1,049)	2,295	
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(443)		(443)	
CAPITAL RECEIVABLES						
NON NHS OTHER DEBTORS	132	132	354	222	132	
COMPENSATION DEBTORS (RTA)	2,514	2,514	2,596	82	2,514	
OTHER RECEIVABLES	675	675	939	264	675	
IRRECOVERABLE PROVISION	(515)	(515)	(515)		(515)	
PREPAYMENTS & ACCRUALS	2,053	2,053	2,023	(30)	2,053	
	10,814	**10,814**	**11,479**	**665**	**10,925**	**111**
CASH	4,342	4,342	7,154	2,812	4,654	312
NET CURRENT ASSETS	**20,090**	**20,090**	**23,571**	**3,481**	**20,441**	**351**
CURRENT LIABILITIES						
NHS	628	628	1,171	543	6,050	5,422
TRADE CREDITORS REVENUE	1,921	1,921	3,647	1,726	2,921	1,000
TRADE CREDITORS FIXED ASSETS	1,744	1,744	947	(797)	1,744	
TAX AND NI OWED	1,769	1,769	3,417	1,648	1,800	31
NHS PENSIONS AGENCY	2,013	2,013	2,123	110	2,030	17
OTHER CREDITORS	494	494	369	(125)	494	
DH SHORT TERM LOANS						
SHORT TERM LOANS	669	669	669		5,500	4,831
ACCRUALS AND DEFERRED INCOME	6,132	6,132	6,186	54	4,000	(2,132)
PDC DIVIDEND DUE	36	36	390	354		(36)
STAFF BENEFITS ACCRUAL	786	786	786		629	(157)
PROVISIONS	4,472	4,472	4,148	(324)	2,698	(1,774)
PROVISIONS over 1 year	310	310	310		785	475
NET CURRENT LIABILITIES	**20,974**	**20,974**	**24,163**	**3,189**	**28,651**	**7,677**
TOTAL NET ASSETS	**132,905**	**132,905**	**132,457**	**(448)**	**126,571**	**(6,334)**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,115		100,115	
REVALUATION RESERVE	32,486	32,486	32,486		32,138	(348)
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	304	304	304		(582)	(886)
I & E CURRENT YEAR			(448)	(448)	(5,100)	(5,100)
FINANCING TOTAL	**132,905**	**132,905**	**132,457**	**(448)**	**126,571**	**(6,334)**

Appendix 5

2013/2014 Cost Improvement Delivery against Plan

Efficiency Programme	Identified (I) o	Recurring (R) or non recurring (NR)	Cashable (C),non cashable (NC), or income (Inc)	If cashable pay (P) or non pay (NP)	Plan 2013/14	13/14 Monthly Apr-13
	(mc 01)	(mc 02)	(mc 03)	(mc 04)		Actual
						£000s
Description of scheme						
FYE of 12/13 Transformation Schemes	I	R	C	P	**337**	39
Directorate CIPs	I	R	C	NP	**3,133**	69
Directorate CIPs	I	NR	C	NP	**116**	163
Directorate CIPs	I	R	C	P	**2,009**	79
Directorate CIPs	I	NR	C	P	**931**	127
Directorate CIPs	I	R	Inc	Inc	**2,401**	1
Directorate CIPs	I	NR	Inc	Inc	**138**	141
Workforce Transformation - Admin Review	I	R	C	P	**108**	0
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P	**120**	10
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	**104**	33
Productivity & Efficiency - Outpatient Skill Mix	I	R	C	P	**45**	0
Services Transformation - 3rd party Pharmacy	I	R	C	NP	**29**	0
Workforce Transformation - Agency Nursing	I	NR	C	P	**1,308**	94
Workforce Transformation - Long term SSP withdrawn	I	R	C	P	**33**	0
Clinical service redesign - Mattresses Total Bed Management	U	R	C	NP	**35**	0
Workforce Transformation - Locum Managed Service	U	R	C	NP	**175**	0
Workforce Transformation - Consultant Annual Leave Accrual	U	NR	NC	P	**35**	0
Workforce Transformation - Salary sacrifice year 2 (technology & car sceme expansion)	U	NR	C	P	**96**	0
Directorate CIPs	U	R	C	P	**171**	0
Non clinical service redesign - CRIPPS	U	R	C	P	**0**	0
Directorate CIPs - Procurement Stretch (Over & Above CIPS)	U	R	C	NP	**200**	0
Services Transformation - Core / Non Core	U	R	C	P	**200**	0
Non clinical service redesign - Shared Services Collaborative	U	R	C	P	**100**	0
Clinical service redesign - In Year Bed Management	U	NR	C	P	**300**	0
Workforce Transformation - MARS Phase 2	U	R	C	P	**200**	0
Workforce Transformation - 0.5 SPA reduction	U	NR	C	P	**360**	0
Plans to be identified	U	NR	C	NP	**315**	0
Mitigation contingency plan requirement	U	NR	C	P	**1,950**	0
Total (sc100)					**14,950**	**755**

Appendix 6

2013/2014 Cash flow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	FORECAST OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	224,305	17,721	21,023	17,267	21,564	17,267	17,267	21,564	17,267	17,267	21,564	17,267	17,267
SLA Performance / Other CCG investment													
Health Education Payments (SIFT etc)	8,683	22	1,443	722	722	722	722	722	722	722	722	722	722
Other NHS Income	16,363	2,786	2,077	1,150	1,150	1,150	1,150	1,150	1,150	1,150	1,150	1,150	1,150
PP / Other (Specific > £250k)													
PP / Other	14,642	892	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250
Salix Capital Loan	480							160	60	60	77	120	3
EFL / PDC													
Temporary Borrowing	6,000						4,000					2,000	
Interest Receivable	28	3	2	2	3	2	2	2	2	2	2	3	3
TOTAL RECEIPTS	270,502	21,425	25,795	20,391	24,689	20,391	24,391	24,848	20,451	20,451	24,765	22,512	20,395
PAYMENTS													
Salaries and wages	163,363	12,168	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745	13,745
Trade Creditors	78,106	4,499	8,000	8,000	8,000	8,000	6,000	8,000	6,000	6,000	6,000	7,000	2,607
NHS Creditors	12,503	1,480	1,114	1,114	1,114	1,114	1,114	1,114	1,114	1,114	1,114	500	500
Capital Expenditure	11,710	477	871	684	1,080	1,073	1,317	1,216	1,068	956	1,234	838	896
PDC Dividend	4,106						2,053						2,053
Repayment of Loans													
Repayment of Salix loan	364						161						203
TOTAL PAYMENTS	270,152	18,624	23,730	23,543	23,939	23,932	24,390	24,075	21,927	21,815	22,093	22,083	20,004
Actual month balance	350	2,801	2,065	-3,152	750	-3,541	1	773	-1,476	-1,364	2,672	429	391
Cash in transit & Cash in hand													
Balance brought forward	4,303	4,303	7,104	9,169	6,018	6,768	3,227	3,228	4,001	2,526	1,162	3,834	4,263
Balance carried forward	4,654	7,104	9,169	6,018	6,768	3,227	3,228	4,001	2,526	1,162	3,834	4,263	4,654

Appendix 7

2013/2014 Capital Programme – Month1 Expenditure

Category	Approved Annual Budget 2013/14 £000's	Year to Date as at Month 1 M1 Plan £000's	M1 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 1 Actual Committed £000's	Plan Achieved
Linear Accelerator Corridor	400	0	0	0	0%	0	0%
Improving Birthing Environments	339	0	0	0	0%	63	19%
Endoscopy	150	0	0	0	0%	140	93%
Urodynamics	150	0	0	0	0%	0	0%
Macmillan (Trust)	82	0	1	1	1%	22	27%
Annual Strategic Planning Approvals	1,262	0	0	0	0%	0	0%
MESC	1,518	0	0	0	0%	43	3%
Estates	4,161	24	30	6	1%	668	16%
IT	2,768	97	92	-5	3%	421	15%
Other	85	3	3	0	4%	32	38%
Total - Capital Plan	**10,914**	**124**	**126**	**2**	**1%**	**1,389**	**13%**
Less Charitable Fund Donations	-250	0	0	0	0%	0	0%
Total - CRL	**10,664**	**124**	**126**	**2**	**1%**	**1,389**	**13%**

Resources - Trust Actual	
Internally Generated Depreciation	10,184
SALIX	480
Total - Available CRL Resource	**10,664**

Uncommitted Plan	**0**

- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker
- Improving Birthing Environments completes first stage works from 2012/13 and commences second stage in new financial year
- Endoscopy works were approved last financial year by the Capital Committee
- Urodynamics is being funded by monies donated by Mr Staden
- The Capital Committee have a contingency of £1.262 million available funding for 2013/14 - options for Electronic Document and Records Management will be discussed at the next meeting in July
- The Macmillan scheme works are completed, although final account is still under dispute
- Full year depreciation forecast is currently £10.184 million and this may increase if the MES contract delays
- Charitable Donations assumptions for additions in year are £100k medical equipment & £150k from Mr Staden

Appendix 8

Financial Risk Rating (Monitor)

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Board Action
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	2	2	2	2	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	2	2	
Weighted Average		100%						2.6	2.6	2.3	2.3	
Overriding rules								2	2	2	2	
Overall rating								2	2	2	2	

Finance Risk Triggers (SHA SOM)

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

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

Northampton General Hospital NHS
NHS Trust

TRUST BOARD 30 May 2013	
Title	Human Resources Report
Presented by	Janine Brennan, Director of Workforce & Transformation

SUMMARY OF CRITICAL POINTS

This is the monthly Human Resource report for April 2013 which focuses on the following Human Resource Workforce Indicators for Month 1:

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

RECOMMENDATION:

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

WORKFORCE CAPACITY

Substantive Workforce Capacity increased by 7.15 FTE from 3,968.45 FTE to 3,975.60 FTE which is below the plan (4,451.81 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has decreased by 3.46% to 89.30%.

Substantive Workforce Capacity

Directorate	Month 12 Contracted (FTE)		Month 1 Contracted (FTE)		Budgeted Establishment (FTE)	M1 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	240.84	↑	242.25	↑	271.19	-10.67%	-28.94
Child Health	220.06	↑	222.48	↑	242.18	-8.13%	-19.70
Facilities	279.83	↑	281.45	↑	354.16	-20.53%	-72.71
General Medicine	908.09	↑	920.62	↑	1027.98	-10.44%	-107.36
General Surgery	232.15	↓	229.71	↑	256.46	-10.43%	-26.75
Head & Neck	119.67	↓	114.75	↑	130.71	-12.21%	-15.96
Hospital Support	302.46	↓	292.70	↑	398.46	-26.54%	-105.76
Medical & Dental	464.89	↓	470.69	↑	478.92	-1.72%	-8.23
Obstetrics & Gynaecology	330.56	↓	331.73	↑	348.33	-4.77%	-16.60
Oncology & Clinical Haematology	205.19	↓	204.35	↑	200.09	2.13%	4.26
Pathology	180.95	↓	176.80	↑	192.57	-8.19%	-15.77
Pharmacy (Dir)	100.75	↑	101.33	↓	116.22	-12.81%	-14.89
Radiology	116.89	↑	116.05	↓	125.52	-7.54%	-9.47
Therapy Services (Dir)	63.75	↑	64.55	↑	85.42	-24.43%	-20.87
Trauma & Orthopaedics	202.37	↓	206.12	↑	223.6	-7.82%	-17.48
Grand Total	**3968.45**	↑	**3975.60**	↑	**4451.81**	**-10.70%**	**-476.21**

Temporary Workforce Capacity decreased by 1.50% to 6.27% and remains above the planned Temporary FTE of 5%.

Temporary Workforce Capacity

Directorate	Month 12 Temporary Workforce (FTE)		Month 1 Temporary Workforce (FTE)	Temporary Workforce Capacity M1 (Percentage)	M1 Variance Against Target (5%) (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	19.49	↓	17.91	6.88%	1.88%	4.90
Child Health	14.84	↓	9.10	3.93%	-1.07%	-2.48
Facilities	9.09	↓	5.92	2.06%	-2.94%	-8.45
General Medicine	159.24	↓	120.21	11.55%	6.55%	68.17
General Surgery	37.54	↓	29.12	11.25%	6.25%	16.18
Head & Neck	12.74	↓	12.46	9.80%	4.80%	6.10
Hospital Support	19.68	↑	20.60	6.58%	1.58%	4.94
Medical & Dental	N/A		N/A	N/A	N/A	N/A
Obstetrics & Gynaecology	12.05	↓	8.83	2.59%	-2.41%	-8.20
Oncology & Clinical Haematology	19.90	↓	16.94	7.66%	2.66%	5.88
Pathology	6.30	↑	7.12	3.87%	-1.13%	-2.08
Pharmacy (Dir)	0.00	↑	0.00	0.00%	-5.00%	-5.07
Radiology	0.00	↑	0.00	0.00%	-5.00%	-5.80
Therapy Services (Dir)	5.32	↓	4.45	6.45%	1.45%	1.00
Trauma & Orthopaedics	18.20	↓	13.26	6.05%	1.05%	2.30
Grand Total	**334.40**	↓	**265.92**	**6.27%**	**1.27%**	**53.85**

Human Resources Workforce Indicators 2013/14 Month 1

Total Workforce Capacity (including Temporary Staff) % FTE against budgeted establishment FTE has decreased by 5.30% from 100.58% to 95.28%.

Total Workforce Capacity (including Temporary Staff)

Directorate	Month 12 Total Workforce (FTE)		Month 1 Total Workforce (FTE)		Budgeted Establishment (FTE)	M1 Variance Against Budget (Percentage)	(FTE)
Anaesthesia, Critical Care & Theatres	260.33	↓	260.16	↑	271.19	-4.07%	-11.03
Child Health	234.90	↓	231.58	↑	242.18	-4.38%	-10.60
Facilities	288.92	↓	287.37	↑	354.16	-18.86%	-66.79
General Medicine	1067.33	↓	1040.83	↓	1027.98	1.25%	12.85
General Surgery	269.69	↓	258.84	↓	256.46	0.93%	2.38
Head & Neck	132.41	↓	127.21	↑	130.71	-2.68%	-3.50
Hospital Support	322.14	↓	313.30	↑	398.46	-21.37%	-85.16
Medical & Dental	N/A		N/A		N/A	N/A	N/A
Obstetrics & Gynaecology	342.61	↓	340.56	↑	348.33	-2.23%	-7.77
Oncology & Clinical Haematology	225.09	↓	221.29	↓	200.09	10.59%	21.20
Pathology	187.25	↓	183.92	↑	192.57	-4.49%	-8.65
Pharmacy (Dir)	100.75	↑	101.33	↑	116.22	-12.81%	-14.89
Radiology	116.89	↓	116.05	↑	125.52	-7.54%	-9.47
Therapy Services (Dir)	69.07	↓	69.00	↑	85.42	-19.22%	-16.42
Trauma & Orthopaedics	220.57	↓	219.39	↑	223.6	-1.88%	-4.21
Grand Total	**4302.85**	↓	**4241.52**	↑	**4451.81**	**-4.72%**	**-210.29**

Temporary Workforce Expenditure has decreased by £256,993 from £1,568,268 to £1,311,275 which is equal to 9.54% of the total workforce expenditure.

Recruitment Timeline is marginally above the threshold target at 14 weeks.

Staff Turnover (leavers) has increased by 0.41% on the month to 9.11%, which remains above the Trust target of 8%.

Staff Turnover (leavers)

Directorate	Month 11 Turnover (Percentage)		Month 12 Turnover (Percentage)		Month 1 Turnover (Percentage)	M1 Variance Against Target (8%) (Percentage)
Anaesthesia, Critical Care & Theatres	6.11%	◆	6.49%	●	5.53%	-2.47%
Child Health	14.13%	◆	15.17%	◆	15.71%	7.71%
Facilities	9.47%	●	6.82%	●	6.76%	-1.24%
General Medicine	7.33%	◆	7.73%	◆	7.73%	-0.27%
General Surgery	9.92%	●	8.06%	◆	8.90%	0.90%
Head & Neck	7.20%	●	7.19%	◆	7.70%	-0.30%
Hospital Support	12.69%	◆	14.54%	◆	17.14%	9.14%
Medical & Dental	7.21%	●	6.84%	◆	7.49%	-0.51%
Obstetrics & Gynaecology	6.75%	●	6.37%	◆	7.13%	-0.87%
Oncology & Clinical Haematology	8.92%	●	8.48%	◆	10.02%	2.02%
Pathology	10.70%	◆	12.48%	◆	13.25%	5.25%
Pharmacy (Dir)	7.91%	●	7.89%	●	7.87%	-0.13%
Radiology	4.06%	◆	4.48%	◆	4.50%	-3.50%
Therapy Services (Dir)	14.45%	◆	14.51%	●	13.30%	5.30%
Trauma & Orthopaedics	8.40%	◆	8.92%	●	7.44%	-0.56%
Grand Total	**8.70%**	◆	**8.75%**	◆	**9.11%**	**1.11%**

HEALTH AND WELLBEING

Short Term Sickness Absence has decreased by 0.27% to 1.81% (Trust target 1.6%).
Long Term Sickness Absence has increased by 0.04% to 2.21% (Trust target 2.2%).
Total Sickness Absence has decrease by 0.23% to 4.02% (Trust target 3.8%).
Year to Date Total Sickness Absence has increased by 0.06% to 4.56%

Sickness Absence Rates

Directorate	Short Term Sickness Rate (Target 1.4%)		Long Term Sickness Rate (Target 2.0%)		Total Sickness Rate (Target 3.4%)	
	Mar-13	Apr-13	Mar-13	Apr-13	Mar-13	Apr-13
Anaesthesia, Critical Care & Theatres	2.20%	2.79%	3.04%	4.36%	5.24%	7.15%
Child Health	1.86%	1.78%	2.88%	1.61%	4.74%	3.40%
Facilities	2.28%	1.55%	2.70%	2.17%	4.98%	3.72%
General Medicine	3.09%	2.82%	1.94%	2.48%	5.03%	5.30%
General Surgery	2.21%	2.12%	3.65%	2.98%	5.85%	5.09%
Head & Neck	1.71%	1.99%	0.76%	0.00%	2.47%	1.99%
Hospital Support	1.24%	0.00%	2.56%	1.27%	3.80%	1.27%
Medical & Dental	0.10%	0.88%	1.27%	2.19%	1.37%	3.07%
Obstetrics & Gynaecology	2.57%	2.04%	2.39%	2.45%	4.96%	4.49%
Oncology & Clinical Haematology	2.05%	1.23%	1.66%	2.67%	3.72%	3.90%
Pathology	3.08%	0.93%	1.65%	1.69%	4.73%	2.61%
Pharmacy (Dir)	1.08%	1.93%	0.00%	0.66%	1.08%	2.59%
Radiology	1.01%	1.23%	2.91%	1.61%	3.92%	2.84%
Therapy Services (Dir)	2.08%	1.14%	1.17%	1.17%	3.25%	2.31%
Trauma & Orthopaedics	2.70%	2.92%	2.84%	2.79%	5.54%	5.71%
Grand Total	**2.08%**	**1.81%**	**2.17%**	**2.21%**	**4.25%**	**4.02%**

Calendar Days Lost to Sickness decreased by 586 from 6,173 to 5,587.
No. Days Lost to Sickness per Employee decreased by 0.13 from 1.33 days to 1.20 days.

Calendar Days Lost to Sickness Absence

Directorate	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Mar-13	Apr-13	Mar-13	Apr-13	Mar-13	Apr-13
Anaesthesia, Critical Care & Theatres	177	253	279	360	456	613
Child Health	158	156	248	150	406	306
Facilities	215	160	248	210	463	370
General Medicine	992	887	651	780	1643	1667
General Surgery	205	179	310	240	515	419
Head & Neck	77	75	62	0	139	75
Hospital Support	137	82	310	240	447	322
Medical & Dental	14	0	186	180	200	180
Obstetrics & Gynaecology	311	239	279	300	590	539
Oncology & Clinical Haematology	150	82	124	180	274	262
Pathology	182	51	93	90	275	141
Pharmacy (Dir)	46	62	0	30	46	92
Radiology	41	48	124	60	165	108
Therapy Services (Dir)	49	27	31	30	80	57
Trauma & Orthopaedics	195	196	279	240	474	436
Grand Total	**2949**	**2497**	**3224**	**3090**	**6173**	**5587**

Human Resources Workforce Indicators 2013/14 — Month 1

Sickness Absence by Reason

Sickness Reason	Short Term Sickness Calendar Days		Long Term Sickness Calendar Days		Total Sickness Calendar Days	
	Mar-13	Apr-13	Mar-13	Apr-13	Mar-13	Apr-13
Burns, poisoning, frostbite, hypothermia	1	2	0	0	1	2
Blood Disorders	0	4	0	0	0	4
Asthma	5	3	0	0	5	3
Skin disorders	5	36	0	0	5	36
Dental and oral problems	9	7	0	0	9	7
Endocrine / glandular problems	18	9	0	0	18	9
Eye problems	40	53	0	0	40	53
Nervous system disorders	9	39	31	0	40	39
Heart, cardiac & circulatory problems	16	6	31	0	47	6
Infectious diseases	17	4	31	0	48	4
Headache / migraine	55	73	0	0	55	73
Benign and malignant tumours, cancers	29	26	62	90	91	116
Other musculoskeletal problems	31	149	93	30	124	179
Ear, nose, throat (ENT)	59	98	93	60	152	158
Injury, fracture	60	89	93	150	153	239
Pregnancy related disorders	108	61	62	90	170	151
Back Problems	117	146	93	90	210	236
Chest & respiratory problems	148	141	93	120	241	261
Gastrointestinal problems	223	292	62	0	285	292
Genitourinary & gynaecological disorders	74	58	217	120	291	178
Other known causes - not elsewhere classified	161	218	186	240	347	458
Cold, Cough, Flu - Influenza	286	278	62	60	348	338
Anxiety/stress/depression/other psychiatric illnesses	252	177	465	510	717	687
Unknown causes / Not specified	1226	528	1550	1530	2776	2058
Total	**2949**	**2497**	**3224**	**3090**	**6172**	**5587**

WORKFORCE DEVELOPMENT

Appraisals are centrally recorded on OLM and are reported on a cumulate 12 month basis. The percentage of staff with completed appraisals for April 2013 was 26.28%, compared to 23.35% the previous month. A Task and Finish Group has been set up to review the appraisal reporting mechanisms.

Mandatory Training Compliance decreased in April 2013 by 0.06% to a Trust total compliance of 65.14%.

Mandatory Training Compliance

Directorate	Month 11 (Percentage)	Month 12 (Percentage)	Month 1 (Percentage)	Variance Against Target (100%) (Percentage)
Anaesthesia, Critical Care & Theatres	69.98%	70.18%	71.02%	28.98%
Child Health	77.99%	78.14%	78.08%	21.92%
Facilities	54.69%	54.35%	55.04%	44.96%
General Medicine	67.77%	68.14%	67.25%	32.75%
General Surgery	68.69%	67.18%	68.92%	31.08%
Head & Neck	62.27%	61.39%	61.97%	38.03%
Hospital Support	60.75%	61.89%	60.78%	39.22%
Medical & Dental	46.53%	47.77%	48.29%	51.71%
Obstetrics & Gynaecology	63.78%	63.22%	62.24%	37.76%
Oncology & Clinical Haematology	66.73%	66.42%	66.39%	33.61%
Pathology	71.64%	70.15%	70.18%	29.82%
Pharmacy (Dir)	75.05%	74.09%	74.85%	25.15%
Radiology	78.89%	78.19%	77.22%	22.78%
Therapy Services (Dir)	78.39%	77.75%	76.22%	23.78%
Trauma & Orthopaedics	67.57%	67.57%	68.29%	31.71%
Grand Total	**65.20%**	**65.20%**	**65.14%**	**34.86%**

Forecasts and Risks

For the month there was a significant decrease in the number of hours requested for temporary nursing staff, decreasing in excess of 12,000 hours compared with the previous month.

A phased approach to reduce Agency HCA usage will start from May 1st 2013.
In the first phase the following wards will no longer be able to book agency HCA's:

- **Medicine**

All outpatient areas
Knightley, Compton, Brampton & Becket wards
A&E and EAU (with the exception of specials)

- **Surgery**

Althorp, Hawthorn, Head & Neck, Spencer and Willow wards
It is anticipated that all other wards will be included in this process for HCA's by the 1st July 2013, after which time a decision will be made to stop the use of Registered Nurse agency staff.

To meet the current demand for temporary nursing staff a recruitment strategy is to be developed to increase the number of active bank only staff registered on the nurse bank as follows:

- HCA increase from 167 to 190
- RN increase from 69 to 100

Northampton General Hospital NHS
NHS Trust

Board Meeting – May 2013	
Title: -	Transformation Programme 2013/14
Presented by: -	Janine Brennan – Director of Workforce & Transformation

PURPOSE OF PAPER: -

1. To update the board on the final financial savings (M1) achieved through the 2013/14 Transformation Programme.

2. To receive an update on the measures being taken to close the current gap of required schemes of £1.8m in the 2013/14 Transformation Programme.

CRITICAL POINTS: -

1. The Transformation Programme latest thinking forecast delivery is £10.9m savings against a plan of £13.0 m for 2013/14.

2. Month 1 financial delivery was in line with planned delivery reported to the National Trust Delivery Authority (NTDA)

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

ACTION REQUIRED BY BOARD: -

The Board is asked to discuss and note:

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

Northampton General Hospital NHS
NHS Trust

Board Meeting – May 2013

1. Introduction

The agreed Trust financial Plan for 2013/14 set a target for the Transformation Programme including Directorate and Corporate cost improvement plans is £13.0m. The latest thinking forecast for 2013/14 based on current schemes in delivery stands at £10.9m.

Care Groups and Corporate teams, supported by the Transformation PMO are continuing to identify schemes, with a specific focus in-year non pay cost savings which mitigate the current shortfall of £1.8m.

In addition transformation schemes and areas for collaboration with partner NHS organisations have commenced to develop transformation schemes which support delivery of the Transformation Programme to 2014/2015.

2. Latest thinking forecast and month 1 delivery of the 2013/14 Transformation Programme.

The trust financial plan for 2013/14 set a CIP target of £13m which is constructed from the national minimum delivery requirement of 5% of turnover (£13m). However in addition we are seeking to identify contingency plans of an additional 15% (£1.95m) to mitigate any in year variation against planned financial delivery.

The value of identified schemes as of the end of April 2013 was £11.15m with a pipeline of additional schemes to the potential value of £371k under development. Therefore a residual gap of £3.42m is required to achieve a fully mitigated Transformation Plan.

The phased plan based on identified schemes (£11.15m) for month (M1) included the delivery requirement of £760k. The interim delivery assessment against this plan in month 1 is £755k.

Further assessment is required to verify achievement of planned income schemes as coding and case-mix analysis is yet to be concluded, therefore a forecast of only 50% achievement have been included within the current M1 delivery forecast.

The Executive Team, supported by the Transformation Delivery Group are focussed on the identification and delivery of additional in year non-pay schemes to mitigate the current shortfall in the overall Transformation Plan

Additional challenge to the care groups and trust programme management office has been the need to identify additional recurrent transformational schemes which reduce the impact current value of non-recurrent schemes which will impact upon the 2014/15 cost improvement requirements.

3. Identification of additional schemes and cost improvement initiatives.

The Transformation Plan has currently a quantum of schemes identified of £11.15m Work is underway to progress the identification of £200k of additional rapid non-pay schemes and closing the Care Group and Corporate CIP gap of £171k.

Whilst progress is being made on this pipeline of schemes, these are yet to be approved formally through TDG and are without completed QIA assessments. As the Trust does not classify schemes as identified until a QIA has been completed the reported unidentified gap remains at £1.845m

The Directors of Finance for Kettering Hospitals NHS Foundation Trust Northamptonshire NHS Foundation Trust and Northampton General Hospitals NHS Trust have established a working group, supported by their respective PMO teams to consider the potential for collaborative models for potential shared services.

Joint working has already commenced in partnership with the two Foundation Trusts on the management of locum doctor agencies and continuation of procurement collaboration in order to maximise purchasing leverage.

Draft Quality Impact Assessments have been completed for schemes in delivery and have been considered and signed off by the respective Care Group Boards and reviewed by the Trust Medical Director and the Director of Nursing and Patient Services.

4. Conclusion

The month 1 financial delivery showed a small variance of £5k adverse to the plan submitted to the NTDA. This adverse variance in the forecast is against identified schemes in active delivery.

Rapid work is being undertaken by care group and corporate teams, supported by the trust PMO to identify and submit for QIA additional non-pay schemes to mitigate the current shortfall in delivery against the Trusts financial plan of £13.0m.

5. Recommendation

The Board is asked to discuss and note:

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

Transformation Report – Appendix 1

QIA Update for Trust Board

Introduction

The overriding principle for the transformation programme is to maintain safe and high quality care for patients. To ensure that this happens services assess schemes for quality impact and undertake Quality Impact Assessments (QIAs) for each scheme that could impact on quality. The QIA ensures that risks are identified and mitigated, and that metrics are identified to monitor on-going impact throughout the life of the workstream.

The 2013/15 programme includes schemes that are carried forward from last year's programme, as well as new schemes. Previous year's QIAs are not repeated unless there are changes to the scheme. Each of these is subject to a QIA, whether undertaken previously or as part of the new structure. QIAs are signed off at Care Board level, and also by the Medical Director and Director of Patient and Nursing Services. This is an iterative process, and QIAs will be updated / undertaken as schemes developed and new schemes are identified.

Metrics identified in the QIAs are collated into a scorecard for central monitoring, and the Care Group Management Team will monitor metrics locally as part of their operational management responsibilities.

Current position

The first stage of the process is to assess the quality impact. Many schemes involve changes to pricing structures or budget adjustments rather than service changes, and therefore do not require a full QIA. The following table shows the number of QIAs undertaken and their current status. Previous year's QIAs are not included in the figures below:

Service area	Number of transformation schemes	Schemes requiring a new QIA	QIAs completed	QIAs signed off at Care Boards	QIAs reviewed by MD and DoN
Surgical Care Group CIPs	71	7	7	7	7
Medical Care Group CIPs	86	14	14	14	14
Corporate Areas CIPs	55	12	3	N/A	3

QIA scorecard

A review of the 2012/13 scorecard has taken place to clarify which elements should continue to be monitored into the 2013-15 programme, and which should be devolved back to operational managers as part of their usual core business. Issues with access to data were also captured and metrics challenged to ensure data is accessible. The new scorecard has been developed with two sections: one relating to the metrics that need to be carried forward from last year, and one relating to metrics identified in the new schemes.

The 2013-15 scorecard template is attached.

Next steps

The QIA working group will continue to support Care Groups and Corporate teams in the development of QIAs for every new workstream, and to ensure that the metrics identified are included in the QIA scorecard.

The QIA scorecard will be monitored by the Transformation Delivery Group on a monthly basis and issues will be escalated to the Strategic Executive Team as required. The QIA scorecard will also be presented to the Finance and Performance committee on a monthly basis.

QIA metrics will be added to the Care Board Scorecards to enable closer scrutiny of the impact of CIPs on the quality of the service provided to patients.

Draft 2013/1 Draft 2013/14 Transformation Quality Impact Assessment Scorecard

Workstream	Service area / Workstream	Changes	Responsible monitoring group	Metric	Frequency	Data source	Target	RAG descriptor	QIA Working Group Comments
GM 04	General Medicine	Savings through vacancies,	Admin managers & service managers	WTE against budgeted establishment	Monthly	HR team	100%	R = <75%, A = 75-100%, G = 100%	Suggest using monthly review of vacancies against the needs of the service. To be reviewed at Care Board monthly.
				Link to admin review metrics re: typing turnaround time	Monthly	Admin managers (Winscrib/PCS/iPM)	5 days	R = over 5 days, G = 5 days or under	
				Complaints	Monthly	Complaints team	0	R = >1, A = 1, G = 0	
GM 06	General Medicine	Savings through band reductions or flexible working reductions	Admin managers & service managers	WTE against budgeted establishment	Monthly	HR team	100%	R = <75%, A = 75-100%, G = 100%	Suggest that the QIA is refreshed once the exact vacancies are known.
				Link to admin review metrics re: typing turnaround time	Monthly	Admin managers (Winscrib/PCS/iPM)	5 days	R = over 5 days, G = 5 days or under	
				Complaints	Monthly	Complaints team	0	R = >1, A = 1, G = 0	
GM 08	General Medicine	Improved ward rosters	Ward managers & matrons	E-roster report - spend on bank and agency staff	Monthly	HR team			Needs defining. Suggest also use % of autoroster compliance
				Sickness absence	Monthly	HR team			
				% Annual leave taken in-year	Monthly	Admin managers (Winscrib/PCS/iPM)			
				Matron's dashboard, quality indicators aggregate	Monthly	P&NS / safety team			
				Complaints	Monthly	Complaints team	0	R = >1, A = 1, G = 0	
A 05	Anaesthetics	Improved theatre utilisation	Theatres project team	See metrics brought forward from 2012-13 scorecard.	Monthly	Sapphire, Newtons, - Information team			Review theatres metrics to ensure they are appropriate
TO 02	Trauma & Orthopaedics	Changes to NORTH team to include more therapeutic lead than nursing.	Care Group Board	Pre-Oxford hip and knee score	Monthly	T&O team, manual audit (Phil Homer)			
				Length of stay for hips and knees	Monthly	T&O team, manual audit (Phil Homer)			
				Service user feedback at each stage of the pathway	Monthly	T&O team, manual audit (Phil Homer)			
				Re-admissions	Monthly	T&O team, manual audit (Phil Homer)			
				Wound infections	Monthly	T&O team, manual audit (Phil Homer)			
				Post-op pain relief	Monthly	T&O team, manual audit (Phil Homer)			
				Post-op complications	Monthly	T&O team, manual audit (Phil Homer)			
TO 03	Trauma & Orthopaedics	Band reduction from 7 to 6	Care Group Board	Datix reported incidents relating to fracture clinic nursing	Monthly	GM to provide number (Sue McLeod)			
				Complaints relating to fracture clinic nursing	Monthly	GM to provide number (Sue McLeod)			
CH 10	Child Health	Play specialist downgrade	Child Health Management Team	Sickness absence	Monthly	HR team	<3.5%	R = > 3.5%, G = < 3.5%	Moved from quarterly to monthly
CH 12	Child Health	Vacancy factor while recruiting	Paediatric Risk Management	Paediatric oncology reported incidents	Monthly	Risk management team - Datix	< 4 / month	R = > 4 / month, G = < 4 / month	Moved from quarterly to monthly
CH 13	Child Health	Vacancy factor while recruiting	Divisional governance team	Complaints about community paediatrics	Monthly	Complaints team	1 or less / month	R = > 1 per month, G = 1 or less	Moved from quarterly to monthly
				11 week breaches for new referrals	Monthly	Information team	0	R = 1 or more, G = 0	
OG 06	Obstetrics & Gynaecology	Band reduction from 4 to 3.	O&G Matron's team meeting	Sickness absence	Monthly	HR team	< 3.5%		Moved from quarterly to monthly
ON 02	Oncology & Haematology	Radiotherapy band 7 to band 6	Directorate management board		Monthly				
ON 04	Oncology & Haematology	Radiotherapy reduction in hours	Directorate management board		Monthly				
ON 05	Oncology & Haematology	Radiotherapy mid-point	Directorate management board		Monthly				
ON 08	Oncology & Haematology	Chemotherapy OPD - matron led service (non-recurrent)	Directorate management board	Matron's dashboard, quality indicators aggregate	Monthly				
ON 09	Oncology & Haematology	Chemotherapy OPD - matron led service (recurrent)	Directorate management board	Matron's dashboard, quality indicators aggregate	Monthly				
ON 10	Oncology & Haematology	Medical Physics band 8a	Local management meeting		Monthly				
ON 15	Oncology & Haematology	Haematology SHO - unused budget	Directorate management board		Monthly				
PA 03	Pathology	General Haematology nursing vacancy band 4	Directorate management board	Pathology quality management report aggregate	Monthly	Pathology team (Mary Pendleton)	100%	R = < 80%, A = 80-90%, G = 90-100%	
PA 10		Antenatal vacancies income							
RA 05	Radiology	Admin staff secondment (non-recurrent)	Monthly finance meeting		Monthly				
RA 07	Radiology	SPR budget underspend (non-recurrent)	Directorate management board	Finance report	Monthly				
PNS 01 and PNS 02	2 x Patient & Nursing Services	Post removal currently vacant (0.85 WTE band 8b) Post reduction budget lint (0.08 WTE)	Nursing & Midwifery Board	Safety Thermometer outcomes	Monthly	Safety thermometer			
				Incidence of pressure ulcers	Monthly	Safety thermometer			
				FFT	Monthly	Datix			

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 30 May 2013	
Title	Self-Certification Return
Presented by	Mrs Karen Spellman - Deputy Director of Strategy and Partnerships

SUMMARY OF CRITICAL POINTS

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

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

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

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

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

RECOMMENDATION:

The Board is asked to approve the governance declaration.

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

Returns to XXX by the last working day of each

NHS Trust Governance Declarations : 2013/14 In-Year Reporting

Name of Organisation:	Northampton General Hospital	Period:	April 2013

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

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

If Declaration 2 has been signed:

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

Target/Standard:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	
Action :	

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Northampton General Hospital

April 2013

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

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

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

QUALITY

Information to inform the discussion meeting

Northampton General Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Jan-13	Mar-13	Apr-13	Board Action
1	SHMI - latest data	Score	109.2	109.2	106.0	106.0	106.0	104.8	104.8	104.8	107.8	107.8	107.8	110.9	
2	Venous Thromboembolism (VTE) Screening	%	91.9%	90.3%	93.0%	90.7%	93%	92.5%	92.0%	90.00%	91.90%	92.00%	90.10%	91.90%	
3a	Elective MRSA Screening	%	99.4%	99.8%	99.5%	99.5%	99.85%	99.6	99.7	99.40%	99.70%	99.50%	99.40%	99.90%	
3b	Non Elective MRSA Screening	%	95.7%	96.4%	96.7%	94.9%	95.30%	96.1	96.8	95.80%	95.10%	96.60%	97.00%	96.40%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	12	17	14	11	10	13	14	24	19	25	35	41	7 new incidents reported during the month. 17 reports were submitted for closure - we are currently awaiting confirmation of approval from CCG
6	"Never Events" occurring in month	Number	0	0	0	1	0	0	0	0	0	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	0	0	0	0	0	0	0	0	1	Safer spinal (intrathecal) epidural and regional devices. Nationwide issue (just become overdue). Awaiting update from Lead Consultant
9	RED rated areas on your maternity dashboard?	Number	2	1	1	2	2	4	1	1	2	1	1	3	
10	Falls resulting in severe injury or death	Number	0	1	2	2	0	2	3	1	0	2	1	1	Reported as an SI in April 13 - incident occurred in March 13
11	Grade 3 or 4 pressure ulcers	Number	3	3	2	0	2	3	7	7	6	3	6	3	
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	51	39	48	33	35	44	40	24	68	57	52	45	
14	Agency as a % of Employee Benefit Expenditure	%	6.40%	6.6%	7.0%	8.0%	7.7%	7.20%	7.70%	6.20%	7.00%	6.60%	6.60%	6.90%	
15	Sickness absence rate	%	5.0%	4.6%	4.6%	4.2%	4.34%	4.62%	4.50%	5.00%	4.85%	4.08%	4.25%	4.11%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	No	No	No	No	No	No	No	No	No	No	No	No	100% of completed consultant appraisals at NGH have a signed off PDP. There is no formal recording of the numbers of items fully completed versus those carried over to the following year by agreement. NGH is procuring a suitable appraisal software system to allow more meaningful quality assurance for appraisals and back up the current robust paper based system. Discussions are underway with the Revalidation Support Team to develop a more meaningful method of assessing the quality of consultant appraisal rather than merely looking at the number of PDP items completed which in itself is not a robust measure and has not therefore been routinely collected.

FINANCIAL RISK RATING

Northampton General Hospital

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	2	2	2	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	2	2	
Weighted Average		**100%**						**2.6**	**2.6**	**2.3**	**2.3**	
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"					
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 Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	Yes	No	No				
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes				
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	No	Yes				
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No				
6	Two or more changes in Finance Director in a twelve month period	No	No	Yes	Yes				
7	Interim Finance Director in place over more than one quarter end	Yes	No	No	No				
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes				
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No				
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes				

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a				
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a				
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a				
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a				
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a				
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes				
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes				
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes				
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes				
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	No	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	No	No				Unverified performance is: 62 day screening referrals 86.7% (target of 90%); 15 patients treated & 2 breached
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes				
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes				
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No				April 2013 = 87.9%
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a				
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a				
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a				
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a				
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a				
			Red 2	75%	0.5	N/a	N/a	N/a	N/a				
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a				
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	Yes	Yes				There were 7 cases of C-Diff in April.
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 29*		Yes	Yes	Yes	No				
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes				
			Is the Trust below the YTD ceiling	*Enter contractual ceiling 0*		No	No	No	Yes				
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No				
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No				
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No				
				TOTAL		**1.0**	**1.0**	**3.0**	**2.0**	**0.0**	**0.0**	**0.0**	
						AG	AG	AR	AR	G	G	G	

RAG RATING :

GREEN = Score less than 1

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

GOVERNANCE RISK RATINGS

Northampton General Hospital	
Insert YES, NO or N/A (as appropriate)	Refresh GRR for New Quarter
Historic Data	Current Data

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

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

GOVERNANCE RISK RATINGS

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

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

CONTRACTUAL DATA

Information to inform the discussion meeting

Northampton General Hospital

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

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes				
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes				
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	Yes	Yes	No				
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes				
5	Are there any disputes over the terms of the contract?	No	No	No	No				
6	Might the dispute require third party intervention or arbitration?	No	No	No	No				
7	Are the parties already in arbitration?	No	No	No	No				
8	Have any performance notices been issued?	No	No	No	No				
9	Have any penalties been applied?	No	No	No	No				

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

TFA Progress

May-13

Northampton General Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	Deloite Board Development / BGAF review	Jul-12	Fully achieved in time		
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12	Fully achieved in time		
3	Trust to review the TFA in response to the Healthier Together Consultation	Oct-12	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
4	In-month delivery of 95% A&E 4-hour indicator	Oct-12	Fully achieved in time		
5	Recovery plan agreed at Board to stabilise financial position	Oct-12	Fully achieved in time		
6	Director of Finance appointed	Nov-12	Not fully achieved		Substantive Director of Finance not appointed through last appointments process. Interim DoF in post. Renumeration Committee looking at longer term solutions.
7	Director of Workforce and Transformation appointed	Nov-12	Fully achieved in time		
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12	Not fully achieved		High level CIPs are identified, fully worked-up implementation plans and QIAs being completed
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12	Fully achieved in time		
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12	Not fully achieved		Full recovery plan in place. All actions are on track to be delivered. The remaining risks to delivery are; the appointment of additional A&E consultants-the Trust has a plan in place to appoint 2 additonal physicians
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12	Not fully achieved		Have reviewed TFA in response to Healthier Together and confirmed parternship with KGH
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12	Fully achieved in time		
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12	Fully achieved in time		
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12	Fully achieved in time		
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12	Not fully achieved		as per line 10 above
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13	Not fully achieved		
17	Board and sub committee observations	Jan-13	Not fully achieved		Board observations are due to take place in February/March as part of the Quality Assurance and BGAF assessments below.
18	Quality Assurance Framework external assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
19	HDD re-assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
20	BGAF external assessment	Feb-13	Not fully achieved		Assessment not taking place in line with agreement with the SHA
21	In-month delivery of 95% A&E 4-hour indicator	Feb-13	Not fully achieved		A full recovery plan Progress is monitored through the Urgent Care Programme Board.
22	NHS Acute Service Contract agreed	Mar-13	Not fully achieved		Contract being signed off by 15th April 2013
23	IBP approval by Board	Mar-13	Fully achieved in time		The Trust is on track to sign off the IBP for 13/14 and the TDA submission at the March Board
24	Final LTFM approved by Board	Mar-13	Not fully achieved		Final 13/14 plan approved by Board in readiness for submission to TDA on 5th April
25	Trust/NTDA readiness review meeting	Mar-13	Not fully achieved		TDA annula plan review meeting took place ON 25th March
26	YTD delivery of 4 hour indicator	Mar-13	Not fully achieved		A full recovery plan Progress is monitored through the Urgent Care Programme Board.
27	Delivery of control total for 2012/13	Mar-13	Fully achieved in time		
28	Quarterly review of outcome of Healthier Together	Mar-13	Not fully achieved		The Trust is continuing partnership talks with KGH as part of the next stage of Healthier Together.
29	Board and Sub committee observation	Apr-13	Not fully achieved		Board sub committee observation did not take place in agreement with the SHA
30	FT submission to NTDA	May-13		Will not be delivered on time	FT submission not taking place in agreement with the SHA
31	Board interviews	May-13		Will not be delivered on time	Board interviews not taking place in agreement with the SHA
32	NGH/NTDA Board to Board meeting	Jun-13		Will not be delivered on time	Board to Board meeting not taking place in agreement with the SHA
33	NTDA Board approval	Jun-13		Will not be delivered on time	Application submission to the DH not taking place in agreement with the SHA therefore NTDA Board approval to submit will not be requested
34	Application submitted to DH	Jul-13		Will not be delivered on time	Application submission to the DH not taking place in agreement with the SHA
35					
36					
37					
38					
39					
40					

Notes

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

Notes

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

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 30 May 2013	
Title	Communications and Stakeholder Engagement Strategy
Presented by	Karen Spellman, Deputy Director of Strategy and Partnerships

PURPOSE OF PAPER

To set out the Trust's communications and stakeholder engagement strategy for 2013-2014.

CRITICAL POINTS

The strategy supports the following corporate objectives:

- Be a provider of quality care for all our patients
- Enhance our range of hyper acute services and maintain clinical viability for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- To be a financially viable organisation

The strategy takes account of the changing landscape for service provision and also introduces new opportunities for two-way communication with all audience groups

RECOMMENDATION

The Board is asked to:

Consider the contents of the strategy and challenge where appropriate

Approve the strategy and timelines around delivery of the action plan

Acknowledge that any requirement for investment will be taken through the Trust's integrated business planning process

Northampton General Hospital NHS
NHS Trust

COMMUNICATIONS AND STAKEHOLDER ENGAGEMENT STRATEGY

Contents

Northampton General Hospital NHS
NHS Trust

COMMUNICATIONS AND STAKEHOLDER ENGAGEMENT STRATEGY

1. Introduction

This is the communications and stakeholder engagement strategy for Northampton General Hospital NHS Trust. It sets out the overall framework of how the Trust intends to communicate and engage with its stakeholders over the next twelve months (2013-2014). It builds on the communications strategy presented to the Board in 2012 and takes forward work begun as part of the GP engagement strategy.

Northampton General Hospital NHS Trust is the local provider of acute hospital care for the 380,000 people who live in the communities of Northampton, Daventry and South Northamptonshire. The Trust also provides hyper-acute stroke, renal and vascular services for the whole of the county, which has a population of 684,000. As a specialist cancer centre the Trust provides services to some 880,000 people living in Northamptonshire and parts of Buckinghamshire.

The Trust's vision is:

To provide the very best care for all of our patients

The principal aims of the Trust are to:

- Be a provider of quality care for all our patients
- Invest in enhanced quality, including improvement in the environment in which we deliver
- Enhance our range of hyper acute services for the wider community
- Develop strategic approaches to relationships with other health provider and stakeholder organisations
- Provide appropriate care for our patients in the most effective way
- Enhance all urgent care pathways, including critical care
- Use information on quality, finance and demand to determine priorities

However, the complexity of national and local NHS reforms, increasing public and staff expectations, coupled with significant economic challenges and plans to look at all options of partnership working with Kettering General Hospital NHS Foundation Trust marks the beginning of a new era for healthcare in Northamptonshire.

A key element of this strategy will be to ensure that our stakeholders are kept fully informed of developments in relation to partnership working, understand the rationale for any proposals and decisions made, are able to put forward their views and have an opportunity to influence the outcome.

Achieving the Trust's visions and aims will require a significant shift in our stakeholders' understanding and, more importantly, the level of their engagement, in what the Trust is planning to achieve over the next five years.

The imperative for effective communications and engagement with our staff, patients, the public, media, partners and commissioners has never been more important. The trust must develop a culture in which our stakeholders are encouraged and empowered to influence and implement significant transformation agenda. We will need to help our stakeholders understand the issues, challenges and aspirations we have and engage them in helping us to develop solutions, make decisions and build on the opportunities this brings.

The Trust must also consider the changing nature of the NHS, particularly commissioning, and the concept of any qualified provider which is now established in a more competitive market arrangement. This adds a new dimension to our stakeholder strategy, which must consider and balance those who use and benefit from our services, those who deliver them and the stakeholders who pay for them. It is clear that a more strategic approach to marketing the services of the Trust will be required, ensuring that people who want or need healthcare services see Northampton General Hospital as a provider of choice. This area will need to be further developed going forward, but the engagement of stakeholders in primary and secondary care will be a key element. Reputation management will also be a key area for development and, looking forward, patient information will need to be seen in the context of greater patient choice, greater competition in the delivery of health services and as a key component in quality.

With this in mind the Trust must review and refresh existing techniques of communicating and engaging with stakeholders and embrace modern technologies that offer new ways of reaching all our audiences. The growing popularity and mainstreaming of 'e' communication through social networking, podcasts, blogs, etc, offers new ways for our stakeholders to access information, form opinion and for us to gauge and influence them. For many sections of the community it is the communications medium of choice and, with the convergence of mobile phones, digital communication and social networking, it is, for some of our stakeholders, the only form of communication. Currently we are a long way from the interactive conversations with stakeholders that should be our aspiration. The potential impact on reputation and the public hunger for web-based information to inform decisions on choice make this a significant priority.

Set against this context, the vision of the communications and stakeholder engagement strategy is:

'To establish and embed a vibrant stakeholder communications and engagement approach that supports Northampton General Hospital NHS Trust to achieve its vision and objectives.'

The principal aims of the Trust's communications and stakeholder engagement strategy are to:

- Build and strengthen mutually beneficial relationships with our stakeholders
- Ensure our staff and stakeholders understand the Trust's vision, values and objectives and the part they can/need to play in helping us to achieve them
- Ensure our staff and stakeholders are aware of developments in relation to Healthier Northamptonshire and they feel informed and have opportunities to comment and influence the direction of travel

- Ensure we proactively seek meaningful engagement with our staff and stakeholders to shape services
- Ensure our staff and stakeholders feel they are being offered sufficient opportunities to influence the way we work
- Ensure all our communication and engagement activities have a clear meaning and purpose, setting out service priorities and explaining decision making, so that the relevant audiences are clear about the message and their influence
- Ensure the plans and decisions we make have been considered and influenced by our stakeholders where relevant
- Ensure GPs, commissioners and regulators are well informed about the services delivered by NGH
- Nurture new and existing relationships to enable our staff and our partners to be engaged and involved in transforming services, delivering care and shaping future developments
- Recruit and retain a vibrant, representative and active membership for the Trust

The communications and stakeholder engagement strategy builds on previous developments in the Trust's communication and engagement activities but will also use research, insight and best practice to help bring about a necessary step change in how we approach and deliver our communication and stakeholder engagement activities.

Key developments will include:

- Developing a culture that embraces staff engagement as standard practice. To support this, a full review of internal communications will be undertaken. Improvements will be made in response to the insight gained from this survey as well as the NHS national staff survey and the Trust's own internal pulse surveys as part of the Listening into Action initiative.
- Developing a culture that embraces patient and public engagement as standard practice is outlined in the Trust's Patient & Public Involvement Strategy, which sits alongside this stakeholder engagement strategy.
- Evoking a step change in internal communications to support the move from an 'inform' to an 'engage' approach with communication channels that flow up and down the Trust, as well as horizontally through the care groups.
- Expanding the use of new media in our communications and engagement activities.
- Strengthening relationships with our partners in health, social care, commissioning and wider stakeholders to support positive and effective working relationships.

As well as supporting delivery of the Trust's corporate objectives, the stakeholder engagement strategy embraces the NHS commitment to transparency, patient choice and the information revolution as set down in the NHS Constitution and the NHS White Paper, Equity and Excellence: Liberating the NHS (2010).

2. Context

The national economic situation inevitably has had an impact on the financial position of all public services, and raised the following issues for the Trust:

- Raised expectations of patients and the public as a consequence of the developments that have taken place over recent years that have enabled significant improvements to be made to services for local people.
- Low or potentially zero level of financial growth for NHS Trusts across the country that will bring challenges of ensuring that we continue to provide high quality, accessible services that meet the needs of local people and potential patients.
- Prioritising our work and ensuring that we work as efficiently and effectively as possible, delivering through partnership working with our stakeholders – clinicians, partners, providers, staff, our patients and the public.

Appendix 1 sets out the current health landscape. We will need to help our stakeholders understand the issues we face as a result of reform and reduced funding. We need to engage them in helping us develop the solutions, make difficult decisions and build on the opportunities this brings.

3. A duty to communicate, consult and involve

A number of pieces of legislation influence the nature of the stakeholder engagement strategy, including the NHS Constitution, the Civil Contingencies Act (2004) and the NHS Act (2006). We have a statutory duty, under the NHS Act (section 242 of the 2006 Act) to involve and consult the public on planning services, developing and considering proposals for changes in service provision and decisions that will affect how those services operate. We are required by law to take account of the NHS Constitution in our decisions and actions.

The Civil Contingencies Act (2004) sets out a responsibility to warn and inform the public around a major incident or emergency situation and Section 242(2) of the NHS Act (2006) sets out a statutory duty on all NHS organisations to involve and consult people on the planning, consideration and decision making around service changes. This duty relates not only to commissioners, but also providers. This strategy supports the involvement and engagement of all our stakeholders in the planning, consideration and decision-making around service changes.

4. Aims and objectives

The aim of the communications and stakeholder engagement strategy is to establish and embed a vibrant stakeholder engagement approach that supports Northampton General Hospital NHS Trust to achieve its vision and objectives.

Effective implementation of the strategy will ensure NGH continues to be trusted by patients to deliver their care and has a good reputation to ensure patient and commissioner confidence and choice. It will also support the Trust's commitment to having caring and cared for staff by developing a dynamic culture of internal stakeholder (staff) engagement supported by effective communication channels.

The objectives of the communications and stakeholder engagement strategy (Appendix 4) are to:

- Create a dynamic culture of staff engagement supported by two way effective communications at care group/directorate/department level and horizontally across the Trust.
- Ensure all staff are fully engaged in the Trust's commitment to deliver high quality, safe care by keeping them informed about what is changing, why change is needed and, most importantly, involving them in the decisions that affect them.
- Ensure patients are well informed about the quality, safety and availability of clinical services delivered by NGH so that they are empowered to make an informed choice about the treatment/care they chose to have and who provides it.
- Ensure GPs, commissioners and regulators are well informed about the services delivered by NGH and that the Trust is clearly aware of the priorities and requirements of those who refer to, purchase or regulate acute care
- Nurture new and existing relationships to enable partners, including other NHS Trusts, commissioners and healthcare providers, to be engaged and involved in transforming services, delivering care and shaping future developments, in particular Healthier Northamptonshire
- Build trust in the organisation through reputation management
- Retain a vibrant and active membership for the Trust

We will do this by:

- Being proactive and consistent in all our communications and stakeholder engagement activity
- Improving the quality and accessibility of all our information
- Engaging stakeholders in any proposed service change and ensure their views are reflected in our decisions
- Encouraging and developing channels which promote two-way internal communications that flow vertically and horizontally through the Trust
- Developing the communications capability of staff across the organisation
- Building credibility and trust in Northampton General Hospital NHS Trust

We will ensure consistent and simple messages flow through all our engagement activity. These messages will reinforce our organisational vision and values and support the development of an NGH brand. Those common messages will include:

- Right care, first time, every time – ensuring the quality and safety of patient care is our priority
- Making sure people feel valued, treating them with care and compassion
- Treating our patients and our staff with dignity and respect

- Working with our partners to develop existing and introduce new services where there is a demand, clinically led and financially viable

Gathering insight will form a key element of this strategy to shape the direction of travel. Our aim is gather insight through a co-ordinated approach and to feed back to people we engage with so they can see how their input has informed our actions.

5. Implementing the strategy

The following sections set out the approach we will take in the key areas in delivering the strategy:

- Understanding our stakeholders
- Staff engagement
- Patients and the public
- Members
- Partners
- Media relations
- Reputation
- Online and digital

5.1 Understanding our stakeholders

Stakeholders are essentially those people who are affected by the decisions of the organisation, or whose decisions may have an impact on the organisation. These obviously change in priority according to the theme/issue/project and message, and some stakeholders will be more active, or have more influence, than others.

The Trust has a large number of key relationships, not least with our patients and the community we serve, as well as those bodies responsible for commissioning, purchasing and regulating NHS services. A comprehensive list of stakeholders and stakeholder analysis is set out in Appendices 2 and 3.

The Trust will need to understand the needs and motivations of all its audiences and stakeholder groups to ensure it can adapt communication and engagement activities and messages to audiences with a varied level of knowledge and understanding.

In engaging with our stakeholders the Trust should also take account of the needs of individuals and groups who may find it more difficult to engage with the Trust or the NHS, and whose voices are often least well heard. This may be groups defined by: Geography, ethnic group, sexual orientation, disability, age, social status, relative poverty or language. A programme to engage effectively with external stakeholders and partners is an integral part of the Trust's communication and engagement strategy.

Key priorities in the development of our communications and stakeholder engagement strategy will include:

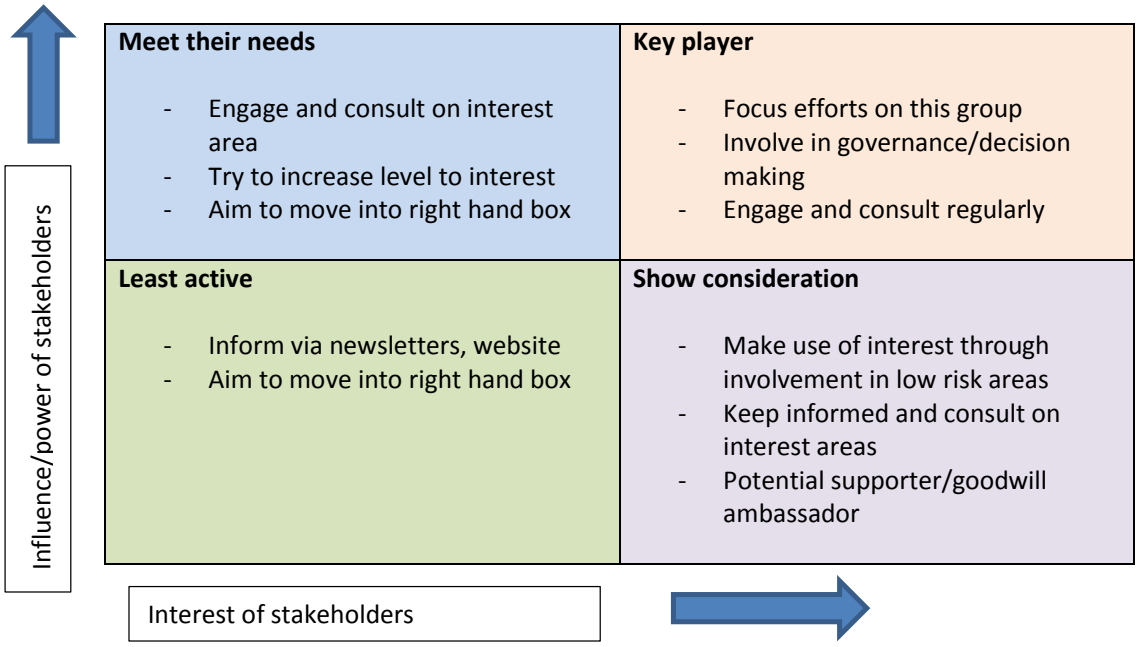
- An analysis of our stakeholder's engagement preferences so that activity can be targeted most effectively. This will support the Trust in its efforts to embrace

stakeholder engagement in service developments, transformation planning and implementation.

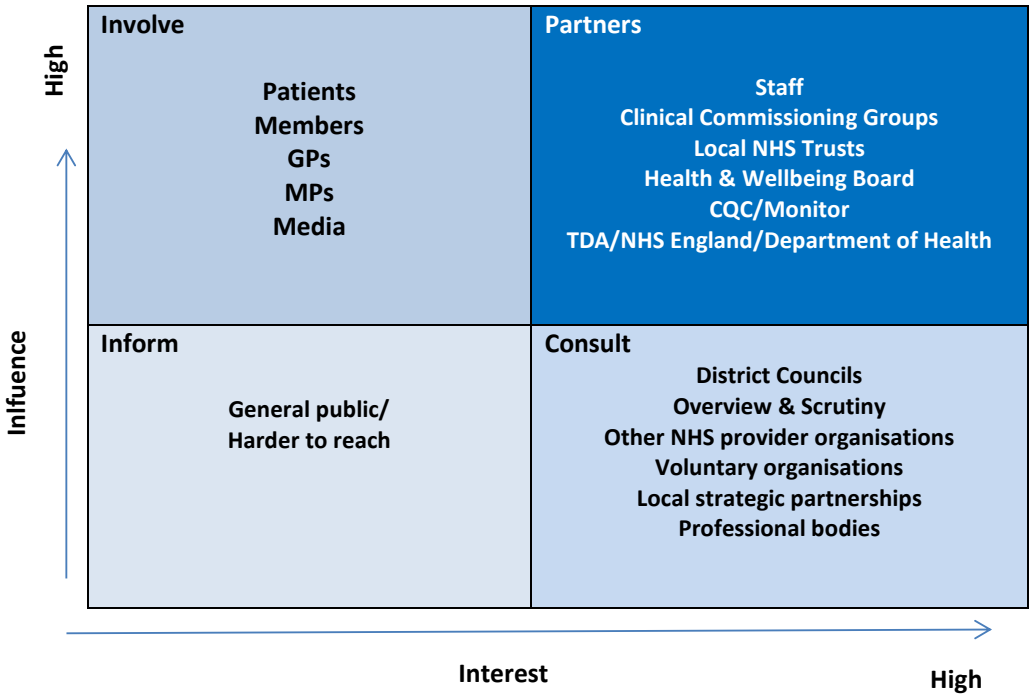
- In conjunction with the Governors' communications sub-committee and the patient and public strategic steering group establish a schedule of opportunities and annual events whereby the Trust can engage and share information with its local community.
- Provide clear and balanced information for stakeholders to enable them to participate fully in the strategic development of the Trust's services
- Ensure a regular schedule of meetings/briefings with key stakeholders, including commissioners, other health and social care providers, local MPs, Overview & Scrutiny Committee members, the Health and Well-Being Board, our partner Universities and the charity and volunteer organisations who support the Trust.
- Strong media relations to enable the wider public to have access to information and debate.

5.1.1 Mapping stakeholders to prioritise and plan

Mapping our stakeholders is essential to a specific engagement activity. In our communications and stakeholder engagement strategy we have adopted a power/interest grid as show below to define our audience for any engagement activity. This approach is relevant to both internal and external stakeholders.



Stakeholder power mapping (contents of the grid will change depending on the issue and degree of influence)



The power map sets out to identify our stakeholders and their level of interest and influence in our Trust. This helps us to identify their expectations of us so we can plan how to best engage and communicate with each group.

Partner: These groups and individuals are key stakeholders and the Trust should seek to involve them in projects, gain their understanding and support and work with them collaboratively.

Involve: This group has a high level of influence but are unlikely to want to be closely involved in all projects. We need to find ways to keep them informed and to ensure that their needs and interests are being considered and addressed.

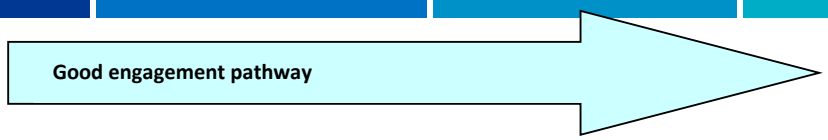
Consult: This group will want to be kept abreast of developments and we should ensure they have the opportunity to be involved.

Inform: These stakeholders rarely get involved in our organisation because they do not want to, or we need to work harder to enable them to. We need to ensure they have access to information about the Trust and services easily when they want to and have the opportunity to get involved.

5.1.2 Stakeholder engagement framework

There is a difference between individual and group engagement and the different levels of engagement.

Individual:	**Informing**	**Giving feedback**	**Influencing**
Patients' involvement in decisions about their care and treatment	Information we give to patients about our services and their care and treatment	Individual patient's comments, complaints and contact with PALS	Active involvement in the patient's care plan, Expert Patients Programme
Groups:	**Informing**	**Giving feedback**	**Influencing**
Patient groups and communities having their say in the planning, design and delivery of services	Information we give to the public about our services	Evidence focus groups, consultations	Representation and involvement in decision making, including 'harder to reach' groups



This framework shows that engagement is a continuum and that our stakeholders will be engaged at different levels and in different ways. For *good* engagement we need to be involving patients individually (and in groups) at the 'influencing' level if we are to achieve the desired outcomes.

In addition good stakeholder engagement with groups or organisations that are affected by or can affect our activities, and responding to their concerns, will help our organisation perform better, increase our knowledge and enhance our reputation.

In order to maximise service development opportunities the Trust will need to leverage its networks, partnerships and collaborative working. Involving key stakeholders will drive a stronger belief in the Trust's strategy and will help to develop its brand.

Good stakeholder engagement:

- Leads to quality improvements in services by giving stakeholders the opportunity to be involved in decision-making
- Enables better management of risk and reputation.
- Supports collaboration between organisations for the pooling of resources (knowledge, people, money and technology) to solve problems and reach objectives more quickly, efficiently and effectively than organisations working alone.
- Supports learning and quality feedback resulting in better quality services which meet the needs of patients and their families.

- Supports stakeholders to be better informed about the Trust and its organisational goals so they make informed decisions that impact on the Trust.
- Develops trust and support from stakeholders.

We will keep all stakeholders under review as their levels of interest or influence can change at any time based on individual experiences or interests. Stakeholders will move from box to box depending on different circumstances and external and internal factors.
Key questions to help us understand our key stakeholders are:

- What financial or emotional interest do they have? Is it positive or negative?
- What motivates them?
- What information do they want?
- How do they want to receive the information and what is the best way of communicating our message to them?
- What is their current opinion? Is it based on good information?
- Who influences their opinions and who influences their opinion of the Trust? Do some of these influencers, therefore, become stakeholders in their own right?
- If they are not likely to be positive, how can we gain their support?
- If we can't gain their support, how will we manage any opposition?
- Who else might be influenced by their opinions and do these people become stakeholders in their own right?

Asking these key questions is often the first step in building a successful relationship with our stakeholders.

5.2 Staff engagement

Research has shown that when employees are engaged they feel positive about the organisation and this can lead to improvements in the quality of working lives and enhanced performance. However, employee engagement goes beyond simple job satisfaction and is more than motivation. Employee engagement is everyone's responsibility and positive contributions can be made throughout the Trust to enhance it.

Staff engagement is critical if we are to deliver the Trust's strategic objectives. In particular the significant transformation agenda facing the Trust will require levels of staff engagement not previously experienced.

Staff engagement is a key priority for the Trust and the following two work streams are already in place to deliver improvements:

- Listening into Action
- Patient Safety Academy and Patient Safety Champions

Each of the work streams has its own action plan, with mechanisms in place to capture feedback and share learning across the Trust.

Effective internal two-way communications are pivotal to supporting a dynamic culture of staff engagement. As such a full review of communication channels, tactics and flow will be carried out to inform future developments. Some of the basics of good communications have already been put in place, with the introduction of Core Brief, the insistence that all staff have a regular appraisal, regular team meetings and Board to ward. However, there is evidence from the national staff survey and our own internal pulse checks that there is a clear need to revitalise and strengthen our internal communications and engagement. Key to this will be ensuring our line managers feel able to engage and communicate confidently and effectively with their teams on a group and individual basis.

The drive will be for central communication and senior leader visibility to be supportive of a vibrant engagement and communications model at care group and directorate/ departmental level, and horizontally across the organisation. Key priorities in the development of staff engagement will be:

- Review and reinforce a multi-channel approach, enabling staff to raise new ideas, innovations, concerns and complaints with a robust feedback loop. This work will link with the Listening into Action initiative.
- Review the coverage and quality of the core brief process, ensuring it becomes a trusted, comprehensive and timely conversation throughout the organisation, with effective feedback and ownership of the core brief at every leadership level.
- Establish bi-annual open staff meetings, building on the core brief and board-to-ward process, so staff at all levels have the opportunity to meet and engage with senior leaders face-to-face and support ongoing initiatives such as the Patient Safety Academy, Listening into Action and Healthier Northamptonshire.
- Review and redefine the email distribution lists to enable more accurate targeting of messages.
- Develop and implement the intranet so that it becomes the main news carrier in the Trust and a primary channel for staff engagement.
- In all areas of internal communication, expand the use of new media to support staff engagement (video-casts, web chats, etc), moving forward to an ‘on-line first’ ethos

At the same time, however, it must be recognised that staff engagement and communication cannot be a central function alone. There must be a two-way process and everyone must recognise their responsibility to ensure effective engagement and communication processes within and across their teams. Therefore, communication and engagement skills and responsibilities should become an integral part of appraisal and personal development plans for all staff.

5.3 Engagement with patients and the public

We need to involve, engage and communicate with patients and the public to help shape our strategic direction and we need to listen and act on what they tell us in order to continually improve the services and care we provide.

This translates into engaging with patients and the public to foster and represent both patients' and the public's interest, creating structures that enable the public to have a tangible input into strategic decision-making and to support and implement patient choice.

The Trust's Patient & Public Involvement Strategy describes the approach we will take to achieve our vision of seeing PPI embedded at all levels and all aspects of our work.

This means that we will:

- Ensure patients and their relatives have opportunities to let us know their experience of our services.
- Ensure our staff actively seek and follow-up feedback from patients as an integral part of their role.
- Involve appropriate staff, user groups, partner and other organisations, including the voluntary sector, in planning any changes to our services.
- Demonstrate improvements to services as a result of continuing feedback from patients and the public.

Key priorities in the development of patient and public engagement will be:

- Ensure listening and responding to patients and the public is integral to all aspects of our work.
- Ensure follow-up action is taken.
- Ensure patients and the public are aware of the actions we take as a result of comments they have made.

5.4 Members

The recruitment of and engagement with a growing, enthusiastic and informed membership base is fundamental to the Trust's aspirations to become an NHS Foundation Trust.
The membership strategy will therefore be reviewed to ensure existing and potential members are engaged and motivated to play an active part in Northampton General Hospital NHS Trust and the development of local health services.

Opportunities for members to become involved in the activities of the Trust are already in place and being developed as part of the wider patient and public involvement strategy.

The Trust will work with colleagues across the local healthcare community to ensure our members are kept fully informed and have opportunities to influence any recommendations coming out of the discussions around partnership working. This means that we will:

- Work with Commissioners to ensure our members are kept informed of developments relating to Healthier Northamptonshire

- Ensure our members have opportunities to find more out about services provided by the Trust and service developments

The communications team will work with the governors' council communications sub-committee to take forward this aspect of the strategy. Key priorities in the development of our member engagement will be:

- Identify opportunities for meaningful engagement with our members
- Develop social media channels to broaden our engagement and ensure we reach our younger members
- Ensure members are aware of opportunities available to them to support Trust initiatives (i.e. volunteer schemes)
- Ensure our members are kept informed of developments around Healthier Northamptonshire

5.5 Partners

Our partners include those organisations and groups with whom we have formal contractual service level agreements. These include other NHS Trusts and local healthcare providers, NHS Nene Commissioning Group and NHS Corby Commissioning Group, Specialist Commissioners and others who purchase services from us on behalf of the local community.

Local service providers are those who also provide services to local people – health care, social care or associated care or services. Often we are all involved in providing elements of a wider continuum of care. Close partnership and dialogue is essential between us – changes in service provision in one area will frequently have an impact in another area of service.

Those whom we have identified as having a particular interest in the quality of life of local people and individuals and in the future of Northamptonshire may have a formal representative role – for example, Members of Parliament, local Councillors and other elected representatives. Others, for example, the media or local strategic partnerships and other partnerships will have a different relationship, but will still have a strong focus on the interests of local people and communities.

Our regulators are those external and formal bodies which regulate and monitor us from a distance. When we perform well they are likely to remain at a distance – alert and interested, but with limited involvement on a day to day basis.

The Trust will need to work towards the alignment of goals with its key partners and it is critical that the Trust is represented at key strategic and clinical networks to enable it to influence relationships with key stakeholders. Our aim is that successful stakeholder engagement will:

- Ensure partners are informed and engaged in Healthier Northamptonshire
- Support the Trust in its application for Foundation Trust status
- Gain buy in to the Trust's organisational strategies and objectives
- Engage CCGs in supporting our key strategic business developments

- Strengthen our market position and improve financial stability
- Engage stakeholders in defining our strategies and objectives for the future
- Enhance the Trust's reputation
- Increase employee and stakeholder engagement
- Improve communications and feedback with stakeholders.

Key priorities in our communications and engagement with our partners will be:

- Build on the work already done to further strengthen our staff communications and engagement activity
- Ensure our partners are aware of the Trust's organisational strategic objectives
- Support the involvement and engagement of our partners in Healthier Northamptonshire

5.6 Media relations

Northampton General Hospital has a high profile in the local media, which is important in order to sustain our reputation for being a provider of high quality care and excellent patient experience.

As an NHS organisation we are accountable to the public and need to work with the media to explain our role and be accountable. We also need the media – it is a valuable way to reach people and raise awareness. It is crucial, therefore, that good media relations form one of the core principals of our stakeholder engagement strategy.

The media have the capacity to bolster or damage a reputation. By working on the basis of mutual professional respect we will continue to build our relationship of trust with the media; not only providing a steady stream of positive news stories and media opportunities, but also by owning up to mistakes if things have gone wrong. We will achieve this by working with the media, responding quickly to enquiries, responding when we say we will and being available. We will go the extra mile to help a journalist with their enquiry by finding an answer to a question or, where appropriate, a spokesperson to make a comment on an issue or topic.

It is important that the Trust continues to develop, maintain and nurture an open and constructive relationship with the media (print and online). Online comments about the Trust and/or the services it provides on websites owned by the media have the potential to engage with others. Key priorities will be to:

- Continue to nurture relationships that can optimise coverage of positive stories and ensure balanced reporting of those issues which are less favourable.
- Develop and implement a new system of media evaluation that enables us to capture and analyse changes in tone of coverage.
- Become a trusted source of 'healthcare experts' for the media to call upon.

- Review and expand the number of trained spokespeople who are confident in working with the media.
- Have robust systems in place to provide crisis communications support quickly and efficiently if required.
- Help ensure the messages around Healthier Northamptonshire are consistently delivered across the county

Key priorities to help us build and develop our media relations are:

- Provide opportunities for briefings with the local media
- Identify opportunities for the media to become involved in developments at the Trust
- Ensure media spokespersons are identified and receive appropriate training

5.7 Reputation

A distinct part of our communications stakeholder engagement activity over the coming year will be to proactively raise awareness of the Trust's activities, services and reputation. For existing and potential patients, as well as commissioners, the NGH brand should be shorthand for safe, high quality health care delivered with care and compassion.

Our brand and what it stands for should be regarded as a precious and protected asset. Therefore, this strategy aims to develop and protect the brand through proactive and reactive media relations, high quality patient information and effective engagement so that staff, members and patients want to be ambassadors for the organisation. Key priorities will be to:

- Ensure our key messages are incorporated into our communications and engagement activities
- Ensure consistency of message, whichever channel or method of communication
- Continue to nurture our relationships with our staff and our external partners and stakeholders with the aim of promoting confidence in the organisation

5.8 Online and social media engagement

Online and social media engagement plays a major part in the promotion and management of the Trust's reputation. The Trust's website and social media accounts provide a source of information for patients, public, staff, stakeholders, members and potential employees. For many sections of the community it is the engagement method of choice. The convergence of mobile phones, digital communication and social networking mean that, for some, it is the only form of communication. It is important to recognise that the internet and social media is also increasingly becoming used as a news source in itself, replacing more traditional print and broadcast media.

The Trust re-launched its website in 2010 with a greatly expanded directory of services and information for external and internal users. The site is now in need of upgrading to meet accessibility standards and to ensure the information it contains is relevant and up-to-date.

The site is a long way from being able to facilitate the interactive conversations with patients, employees and members that should be our aspiration.

A Trust presence on social networking sites such as Twitter and Facebook is in place but more work is needed to take full advantage of this media. Video, web and podcasts, blogs and web chats are already commonplace in large organisations and opportunities to exploit these engagement tools by the Trust will be the subject of further exploration with the Trust's IT department.

Online engagement will also require a change of attitude within the Trust towards social media that can only be achieved if our communications ethos is 'on line first'. Small but frequent reminders about service developments, the achievements of teams and individuals will help support all aspects of our communications and stakeholder engagement activity.

Key priorities in the development of new media engagement will include:

- Taking forward development of the Trust's social media communications to ensure we tap into service users' insights and take account of their views
- Where appropriate and beneficial, we will develop the Trust's presence on social networking sites
- Development of a digital communications strategy to expand the use of smart phone applications, video-casts and other web-best tools as part of our engagement armoury.
- Supporting the development of screen-based information and engagement channels in public areas.
- Ensuring multiple channels are available for interactive feedback and engagement with patients about all aspects of their care, maximising return rates and building credible data at ward or clinician level.
- Developing the Trust's internet and intranet sites to keep pace with information demands and interactive functionality.

6. Ownership and responsibilities

Every member of staff has a role to play in supporting the delivery of this strategy to ensure effective staff engagement, that we engage with our patients, partners and the public and help to support engagement with the media by gathering good news. Staff should:

- Take a personal responsibility for being well informed and engaged by seeking information on relevant issues through the sources available and participating fully in core brief and team meetings.
- Share relevant information from meetings and other forums with colleagues.
- Read staff bulletins and share with staff who don't have access to email.
- Take an active role in opportunities to engage in corporate and departmental decision-making and provide feedback, ideas or suggestions.

Trust Board members and senior managers are an integral link to key stakeholders and have a role to play in representing the organisation. They should role-model a transparent approach to engagement, actively encouraging involvement. They should:

- Ensure the aims and objectives of the communications and stakeholder engagement strategy are embedded in all aspects of their work.
- Communicate decisions clearly and quickly to allow the cascade of information and support engagement.
- Lead and support cultural development within their area of responsibility so engagement is required as an important and legitimate source of investment of management time and resources.
- Actively encourage staff involvement and engagement.

Shadow governors have a role to play in supporting delivery of this strategy through supporting and facilitating effective communication and engagement with members.

Trust communications team

- Implement and monitor progress against the communications and stakeholder engagement strategy using insight, best practice and evaluation.
- Provide the advice and expertise needed to facilitate good engagement and communications.
- Monitor the Trust's engagement activity and share areas of good practice
- Ensure effective processes are in place to support engagement activity internally and externally

Trust IT service

- Provide the technical skills and expertise needed to make the most of electronic engagement channels and the ability to encourage staff engagement using two-way communication channels

Patient experience lead

- Ensure feedback obtained from the Trust's website and through social media channels is recorded and an appropriate response provided

7. Risks

- Poor engagement and communication will risk patient and staff confidence, satisfaction and experience which in turn could lead to poor operational and financial performance and ultimately impact on the Trust's reputation.
- Poor reputation management and engagement with partners will influence Commissioners and the public when it comes to viewing Northampton General Hospital NHS Trust as the provider of choice.
- Poor staff engagement has been proven to be a contributory factor to staff heal and well-being, productivity and sickness absence rates.

8. Resources

The Trust has a communications and engagement team of two full time staff. Therefore the involvement of other managers/teams/individuals across the Trust will be critical to successful implementation of this strategy. The work outlined in this document and associated action plans will be led by the communications team with support in appropriate areas by other teams from across the trust and partner organisations. Budgets will have to be identified to support specific pieces of work. Regular personal development plans and reviews will ensure that staff have the appropriate skills in place to deliver the strategy.

However, this strategy cannot be successfully delivered by one team alone. Engagement and communication is the responsibility of the whole organisation. To reflect his, further training should be made available to staff as part of the Trust's training plan and one-off training sessions organised as necessary.

We will work with engagement and communication teams from other organisations to ensure we present a co-ordinated approach to our work, maximise opportunities, make the best use of resources and avoid duplication. This will help us make sure that we do not constantly contact stakeholders (including patients and the public) with the same questions or information but from different organisations.

9. Evaluation and measurement – how will we know if the strategy is successful

Evaluating and reviewing our work is a high priority for the team to ensure the work we are involved in is delivering the outcomes that we set out to achieve.

We already have a system to monitor and record media coverage that is reported on a weekly basis and this has recently been extended to include coverage on the Trust's two social networking sites, Facebook and Twitter.

The staff survey and our own internal communications survey will provide a benchmark of the effectiveness of our internal communications and engagement activity.

A stakeholder survey will be undertaken to provide a benchmark of the effectiveness of our external communications and engagement activity.

Feedback from our surveys, coupled with that from our shadow governors and members, the staff survey and core brief will enable us to measure the effectiveness of our strategy. We will also be able to measure the success of our strategy work by asking our members and the wider community if they feel they have had opportunities to influence how our services are delivered and developed.

We will report progress on strategy implementation and associated activity in a bi-annual communications and stakeholder engagement report for the Board.

A detailed action plan has been developed to support implementation of the communications and stakeholder engagement strategy and this attached for information at Appendix 5.

APPENDIX 1

Understanding the local health landscape

It is important to take into consideration internal and external factors that will impact on the organisation, including political, economic, social and technological factors. Understanding these factors will help shape the delivery of communication, marketing and engagement for the Trust.

PEST

The PEST tool looks at the political, economic, social and technological factors that affect the Trust. This is helpful in understanding the landscape we are working in and how best to use marketing, communication and engagement techniques for the benefit of the Trust.

Political	**Economic**
▪ Health and Social Care Bill and resulting transformation of local health economy ▪ Change in the way the NHS commissions ▪ Integration of health and social care ▪ NHS Act 2006 (including s242 duty to involve) ▪ NHS Constitution ▪ Operating Framework 2012/13 ▪ DH 'The Communicating Organisation' publication ▪ Northamptonshire MPs ▪ Northamptonshire County Council and District and Borough councils ▪ Monitor ▪ Care Quality Commission	▪ Cost Improvement and Transformation Plans for the coming years ▪ Introduction of any qualified provider ▪ Increase of patients using Choose and Book ▪ Current economic climate and its effect on the national NHS budget
Social	**Technological**
▪ Ageing population ▪ Growing population ▪ Significant life expectancy gap between the wealthiest and the poorest electoral wards ▪ Diversity of population	▪ Telehealth ▪ Rise of new media and social media ▪ Easy-to-use intranet and website ▪ Real time patient feedback

SWOT analysis

The SWOT Analysis looks at the internal factors (strengths and weaknesses) and the external factors (opportunities and threats) that have an impact on the Trust and the communication, marketing and engagement that we plan to deliver.

Strengths	Opportunities
• Strong Board engagement • Good relationships with some CCG leads • Strong links with other NHS providers • Operational links with social care • Culture of accountability and openness • Strong foundations in delivering communications • Established corporate publications • Established internal communication tools • Crisis communications experience • In-house design resource • Corporate patient information process • Well established patient experience programme	• CCGs allow development of fresh relationships • Strengthening relationships with Health and Wellbeing Board • Development of membership and Governors • Links with local user groups • Relationship building with the local media • Using social and digital media • Enhancement of internal staff communications • Using patient experience gathered through social and digital media to improve services • Focus on 'Customer Care' model for PALS and Complaints • New software solutions to enable real-time patient experience data collection • Establishment of Healthwatch
Weaknesses	**Threats**
• Little contact directly with GPs • Engagement with CCGs patchy • Learning from patient experience not fully embedded in service development and improvement • Engagement with MPs low key • Competitor analysis at early stage of development • Little direct involvement with local communities/hard to reach communities • New Executives means relationships to be developed • Staff failure to engage with internal communications • Mix of clinical and non-clinical staff accessing information differently	• Power shifting in terms of Health and Wellbeing Boards and Local Authorities. • Independent sector development into services • Reputation damage from negative press coverage • Capacity to deliver on increased expectations with limited resources • National policy change • Financial challenge • Uninformed staff potential to lead to negative views (briefing against the organisation) • Competition from other NHS providers as well as the private and voluntary sectors

APPENDIX 2

OUR STAKEHOLDERS

Stakeholder Group	Includes

Partners, commissioners and other providers	- Other NHS organisations
	  - Kettering General Hospital NHS Foundation Trust
	  - Northamptonshire Healthcare NHS Foundation Trust
	  - Milton Keynes NHS Foundation Trust
	  - NHS Nene Commissioning Group
	  - NHS Corby Commissioning Group
	- Independent contractors – GPs, dentists, pharmacies, opticians
	- Independent providers
	- Healthwatch
	- Voluntary organisations
	- Clinical networks
	- Local committees
	- Local authorities (county and borough)
	- Schools
	- Police
	- Fire service
	- Ambulance service providers
	- Community, voluntary and faith organisations
	- Suppliers and local supply chain

Other local and regional stakeholders	- Shadow Governors - Members - Education establishments and University of Northampton
Media	- Local newspapers and broadcast - Regional newspapers and broadcast - Trade journals - National media - Information websites (e.g. NHS Choices) - Community media networks - Pre-recorded video media (eg TVs in waiting areas and GP surgeries)
Staff	- Staff side and unions - Executive team - Non-executive directors - Care group directors and general managers - Consultants - All clinical and non-clinical staff

Stakeholder Group	Includes
Patients/service users/the public	- Patients/carers including past and future - Patient groups and representatives - Resident groups - Ward councillors - Parish/town council - Voluntary, community and faith sector organisations - Communities of interest (BME, carers, children and young people, older people, people with disabilities, users of mental health services, lesbian, gay, bisexual and transgender)
Political	- MPs - Leaders of the county and borough councils - Overview and scrutiny committees - Healthwatch - Parish councils
Government and regulators	- Department of Health - NHS Trust Development Authority - Monitor - Care Quality Commission - External auditors - Health & Safety Executive - Equality & Human Rights Commission - Information Commissioner

APPENDIX 3

STAKEHOLDER ANALYSIS

Stakeholder Group	Analysis
Staff	**Characteristics** - Deliver services - Can be the biggest supporters/critics of the NHS - Have wide and varied influence over other groups, including patients **Needs and interests** - Regular information to enable them to do their jobs effectively - Understand how they fit into the bigger picture/ what we are trying to achieve - Understand what is expected of them - Understand what they can expect from the Trust - How we are improving patient care - How they can get involved and influence - Want to be involved and not 'done to' - What does change mean? - Need to feel valued **Potential** - Ambassadors for the Trust and the NHS - Committed to achieving the vision - Valued and understand their role - Can contribute to improvements and new ways of working - Low levels of sickness **Risk** - Demotivated and feeling undervalued - Obstructive and reluctant to change - Critical in public of the Trust - Prevent the organisation achieving its vision - Contact the media - Disengage

Stakeholder Group	Analysis
Patients and the public	**Characteristics** - Central to everything we do - Receiving a service - Tax payer - Have a wide and varied influence - Makes choices **Needs and interests** - A good experience/customer service - Information at a potentially vulnerable time - Information to be able to make an informed decision - Knowledge and information about where to get help - Assurance they will get the care they need and when they need it - To understand what is expected of them - Information about how money is being spent - Opportunity to give feed back - Opportunity to contribute and influence **Potential** - Help us improve our services - Valuable feedback - Ambassadors – share good experiences **Risk** - Complaints - Negative feedback through MPs and the media - Challenge of capturing feedback from a range of sources and acting on it - If no improvement accused of not delivering/ wasting money - Disengagement

Stakeholder Group	Analysis
Political	**Characteristics** - Protecting the interests of constituents - Supporting political beliefs - Key opinion formers - Highly influential **Needs and interests** - Understanding the strategic direction of the trust - Regular updates and briefings on key issues and hot topics - Involvement in issues and hot topics at an early stage - Assurance around improvement - Assurance around patient experience - Assurance that respond to constituents' issues and concerns - Awareness and involvement in achievements **Potential** - Able to influence publically if support project/issue - Able to influence politically - Frequent contact with constituents and media – able to act as an ambassador - An independent spokesperson - Can contribute to discussions and developments from a wide breadth of background/contacts **Risk** - Very high profile if not in the loop or in agreement - Able to raise issue in Parliament - First port of call for media for comments on issues/ challenges - Able to refer to Review Panel if unhappy with process - Can cause delays

Stakeholder Group	Analysis
Government and regulators	**Characteristics** - Set policy and drivers - Set performance targets and standards **Needs and interests** - Assurance of improvement - Assurance of meeting targets and legislation - To know when things are causing concern **Potential** - Supportive and flexible in making things work - Sharing best practice - Championing innovative work - Light touch/left to get on with the job **Risk** - Concerned over lack of assurance so intervenes - Raise concerns in public - Put intervention measures in place - Demand more assurance
Partners, commissioners and other providers	**Characteristics** - Work alongside to deliver services and achieve outcomes - Support to deliver initiatives - Provide services **Needs and interests** - To understand the Trust's strategic direction - To understand how they fit into this direction - To have an overview of our priorities and challenges - To understand the Trust's position/opinions/ thoughts - To understand the Trust's short, medium and long-term intentions **Potential** - Supportive of direction of travel - Facilitates joint working - More co-ordinated approach **Risk** - May take a conflicting direction of travel/projects - Mixed messages for staff and patients - May block proposals - Confusion for patients and publics - Less joined up working - Competition

Stakeholder Group	Analysis
Media	**Characteristics** - Present a high profile view of issues of interest to local population - Can be seen to dwell on the negatives to make a good story - Excellent mechanism for getting messages to the public - Local media can be an important source of information and well trusted - BBC has a public service responsibility (community service, communicating in an emergency, etc) **Needs and interests** - Human interest stories - Information about things that improve things for local people - New information that has not been covered elsewhere (exclusives) - Contact with 'real people' – staff and patients **Potential** - Excellent mechanism for getting information to patients and other key stakeholders - Recognition for staff and patients - Ability to discuss issues and present a balanced account - Accurate and timely information leads to better understanding **Risk** - Will run one-sided stories if no communication forthcoming from the Trust - May get information from a source that is not accurate - Story blows out of proportion Long shelf-life of stories in digital editions

APPENDIX 4

Communications and Stakeholder Engagement Objectives and Outcomes

This strategy has informed a set of objectives to support the Trust's strategic goals. There is an action plan to deliver the outcomes we are seeking to achieve which also describes how we will measure our success.

Engagement objectives	**Outcomes**
Create a dynamic culture of staff engagement supported by two way effective communications at care group/ directorate/ department level and horizontally across the Trust	• Our staff understand and support the vision and values of the trust • We have motivated staff who feel valued and engaged • We support staff to deliver services with care and compassion • We provide our staff with the information, support and tools to engage and communicate with each other and their patients • We listen and respond to the experiences of our staff and their ideas to improve the experience of patients • Staff feel they are informed about developments in relation to Healthier Northamptonshire
Ensure all staff are fully engaged in the Trust's commitment to deliver high quality, safe care by keeping them informed about what is changing, why change is needed and, most importantly, involving them in the decisions that affect them	
Ensure patients are well informed about the quality, safety and availability of clinical services delivered by NGH so that they are empowered to make an informed choice about the treatment/ care they chose to have and who provides it	• We provide clear, accessible information about our services and how to use them • Patients choose our services because they are marketed professionally and effectively • Most patients say they would recommend our services to their family and friends • We deliver care that is better for patients and best value for money
Ensure GPs, commissioners and regulators are well informed about the services delivered by NGH and that the Trust is clearly aware of the priorities and requirements of those who refer to, purchase or regulate acute care	• We are the provider of choice for GP commissioners who have faith in our services and continue to commission from us in an ever more competitive market • We provide commissioners with clear, accessible information about our services and how to use them • We work collaboratively with partners and deliver engagement and communications that support integrated working • Commissioners choose our services because they are marketed professionally and effectively
Engagement objectives	**Outcomes**

Nurture new and existing relationships to enable partners to be engaged and involved in transforming services, delivering care and shaping future developments, particularly in relation to Healthier Northamptonshire	• Our partners feel they are actively involved in developments at the Trust • We work collaboratively with partners and engage with them to support integrated working • Our partners understand and support our vision and goals and work with us to achieve them • Our partners feel we actively support Healthier Northamptonshire
Build trust in the organisation through reputation management	• We have a positive relationship with the local media who support us by publicising positive stores about the Trust and its services • We are aware of people's perception of our Trust and the services we provide through social media and use this feedback to improve services • Our stakeholders feel they are listened to, understand and support our vision and goals and work with us collaboratively • We provide a service that ensures patients and their families feel listened to, and when things go wrong we respond quickly and act to resolve the problem
Retain a vibrant and active membership for the Trust	• Members feel they are actively involved in developments at the Trust • Members feel they are actively involved in Healthier Northamptonshire • Members understand and support our vision and goals

APPENDIX 5

COMMUNICATIONS AND STAKEHOLDER ENGAGEMENT STRATEGY ACTION PLAN

Objective	Task	Timescale	Responsibility	Indicators	Measured by
1. Create a dynamic culture of staff engagement supported by two way effective communications at care group/directorate/ department level and horizontally across the Trust	Strengthen the core brief cascade to ensure effective information flows	July 2013	Communications	Number of staff briefed and feedback received	Staff survey Internal comms survey
	Develop communication and engagement champions to be effective communicators of key messages and information	September 2013	Communications with HR	Champions identified Training delivered	Staff survey Internal comms survey
	Provide training for all line managers so they are able to provide effective briefing for their staff	September 2013	Communications with HR and OD	Training delivered; number of staff briefed/feedback	Number trained Staff survey
2. Ensure all staff are fully engaged in the Trust's commitment to deliver high quality, safe care by keeping them informed about what is changing, why change is needed and, most importantly, involving them in the decisions that affect them	Roll out the Trust's vision and values so staff understand how they relate to their everyday work and how they demonstrate them (or don't)	September 2013	HR supported by Communications		Staff survey Internal comms survey
	Refresh the Trust's e-communications (including the intranet and bulletins) to make it easier for staff to find and share information.	November 2013	Communications supported by IT	Comms bulletin launched Intranet refreshed	Web stats Staff survey Internal comms survey
	Ensure staff are kept informed of progress with Healthier Northamptonshire	Ongoing	Communications with support from Healthier Northamptonshire	Intranet content area Bulletins/briefings/pod casts	Staff survey Internal comms survey
3. Ensure patients are well informed about the quality, safety and availability of services delivered by NGH so they are empowered to make an informed choice about who provides their treatment/care	Work with departments/services to ensure information about services is up to date and relevant	October 2013	Service managers with web co-ordinators and communications	Patients and local communities have clear, accessible information in appropriate formats	Patient experience Stakeholder survey
	Ensure the online directory of services, aligned to NHS Choices information, is updated to provide comprehensive, relevant information	Ongoing	Service managers supported by contracts and IT		

Objective	Task	Timescale	Responsibility	Indicators	Measured by
/continued	Develop an online patient information library to provide information in different formats, including downloadable information	October 2013	Patient Information Group with IT and patient experience lead supported by communications	Patients have clear, accessible information about their condition in an appropriate format	Web stats Take-up of leaflets
	Support services in identifying opportunities to raise the profile of their service via the local and regional media	Ongoing	Service managers; web co-ordinators supported by communications	Articles published	Media coverage
4. Ensure GPs, commissioners and regulators are well informed about the services delivered by NGH and that the Trust is clearly aware of the priorities and requirements of those who refer to, purchase or regulate acute care	Ensure the online directory of services, aligned to NHS Choices information, is updated to provide comprehensive, relevant information	Ongoing	Contracts manager; IT; service managers; supported by communications	GPs and commissioners are aware of the services we provide	Referrals
	To build on the previous GP engagement strategy by developing and delivering a programme of stakeholder engagement activity with GPs and CCGs to promote NGH as the provider of choice	December 2013	Communications with clinical and service leads	% increased recognition and understanding from stakeholders	Contracting Stakeholder survey
5. Nurture new and existing relationships to enable partners to be engaged and involved in transforming services, delivering care and shaping future developments, particularly in relation to Healthier Northamptonshire	Ensure communities are involved in service change and the 'four tests' of service reconfiguration are met when considering service change	Ongoing	Communications supported by senior managers and Healthier Northamptonshire	Stakeholder engagement has influenced service redesign	Evidence of service changes made as a result of stakeholder engagement
	Introduce effective feedback mechanisms on our external website to ensure our stakeholders have the opportunity to have their say on our services	December 2013	Patient experience lead supported by IT and communications	Mechanisms in place and feedback received	Web stats Annual stakeholder survey
	Work with the voluntary and community sector, local forums and networks in order to engage with specific groups, including older people, younger people, black and ethnic minority groups and other hard to reach groups	March 2014	Communications	Meetings/briefings held	Annual stakeholder survey
Objective	**Task**	**Timescale**	**Responsibility**	**Indicators**	**Measured by**
6. Build trust in the	Strengthen relationships with local	Ongoing	Communications with	% increased positive media	Media monitoring

organisation through reputation management	media to ensure messages are widely promoted		executive team	coverage	
	Develop and deliver a programme of stakeholder engagement including GPs, CCGs, MPs, partner organisations and patient groups	March 2014	Communications with executive team and non-executives	% increased recognition and understanding from stakeholders	Annual stakeholder survey
	Work with health and social care partners to identify joint engagement and involvement opportunities	Ongoing		Voluntary and community sector report improved joint working	Annual stakeholder survey
	Continue to build good working relationship with Northamptonshire Healthwatch	Ongoing	Executive team	Northamptonshire Healthwatch feel informed and involved	Annual stakeholder survey
7. Retain a vibrant and active membership for the Trust	Ensure members are kept informed of developments through briefings and events	Ongoing	Membership manager with shadow governors supported by communications	Briefings issues and events held	Attendance at events Stakeholder survey
	Identify opportunities for members to become involved in Trust activities	Ongoing		Number of members involved/Feedback	Stakeholder survey

Northampton General Hospital NHS
NHS Trust

Trust Board Thursday 30 May 2013	
Title:-	Annual Security Management Report 2012/13
Presented by:-	Charles Abolins, Director of Facilities and Capital Development

Critical Points:-

This report is presented to inform the Trust Board of Security incidents and progress during the past 12 months.

Key points include:

- Decrease in Security incidents on Trust premises during 2012/13
- Physical assaults reduced by 10%
- New (Restrictive Intervention for Adults) specialist training now in place for staff
- Additional CCTV cameras installed during this year

Action Required by Board:-

To note progress made during the year and to support the initiatives proposed for 2013/14

Northampton General Hospital NHS
NHS Trust

Enclosure 16

Annual Security Management Report

2012-2013

2012-2013 ANNUAL SECURITY MANAGEMENT REPORT TO THE TRUST BOARD

1. Executive Summary

2012/13 has again been a challenging year for the Trusts Security Department. The report shows that criminal activity, physical assaults, verbal abuse and disturbances are a daily occurrence. In total there were **355** reported incidents either to security or reported through the Trusts Datix reporting system. This is a decrease of **6.5%** on last year's reported figure of **380.**

There were **21** confirmed reported crimes/thefts: This is the third year that a reduction can be reported in this area, representing a **25%** reduction on incidents reported last year **(28)**. There were good detection rates by the security team leading to the prosecution of some offenders.

Reported physical assaults via Datix have decreased. This year by **10%**, which is very positive to report, as the previous two years had seen a significant increase. The types of incidents reported continue to be the same, increasing care of dementia patients, mental health patients and patients going through detox programmes.

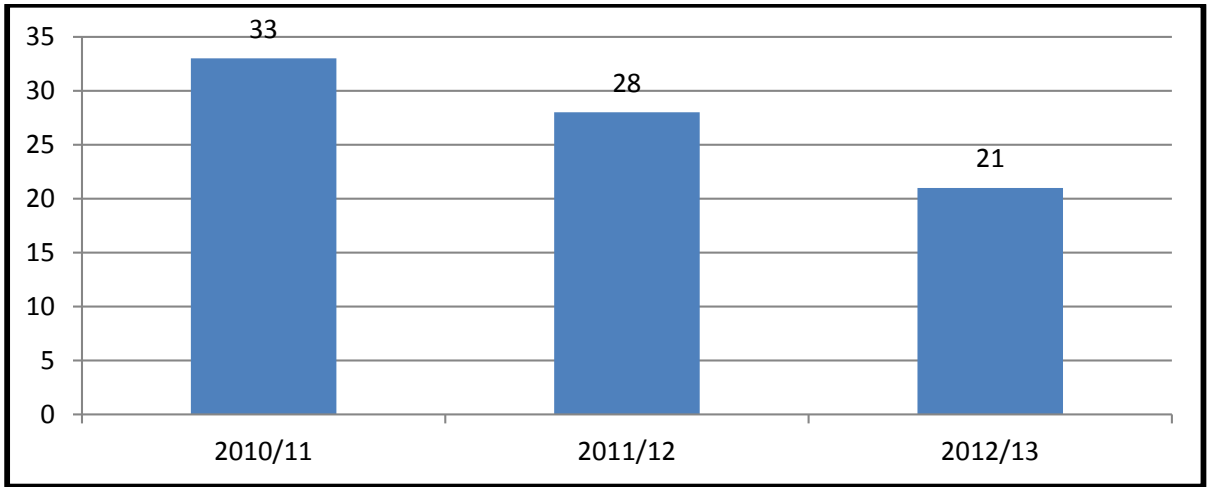
Whilst caring for difficult and challenging patients, the use of restraint is sometimes required. To support staff to perform proportionate restraint to a patient there is now a policy available on the Intranet titled "Restrictive Physical Intervention for Adults" Within the policy is a training needs analysis which identifies which staff group should attend a 1 day, two day or four day course.

A number of courses took place during the latter part of the year, attended by **74** staff and there has been positive feedback. Funding has been ring fenced specifically for these courses for the coming year with the same amount available for 2014-2015. The target over the next two years is to train approximately **1000** staff in break-away, low level intervention and restrictive physical intervention techniques. With these skills staff will be better placed to deal with difficult and challenging patients and make situations safer for the patient and themselves.

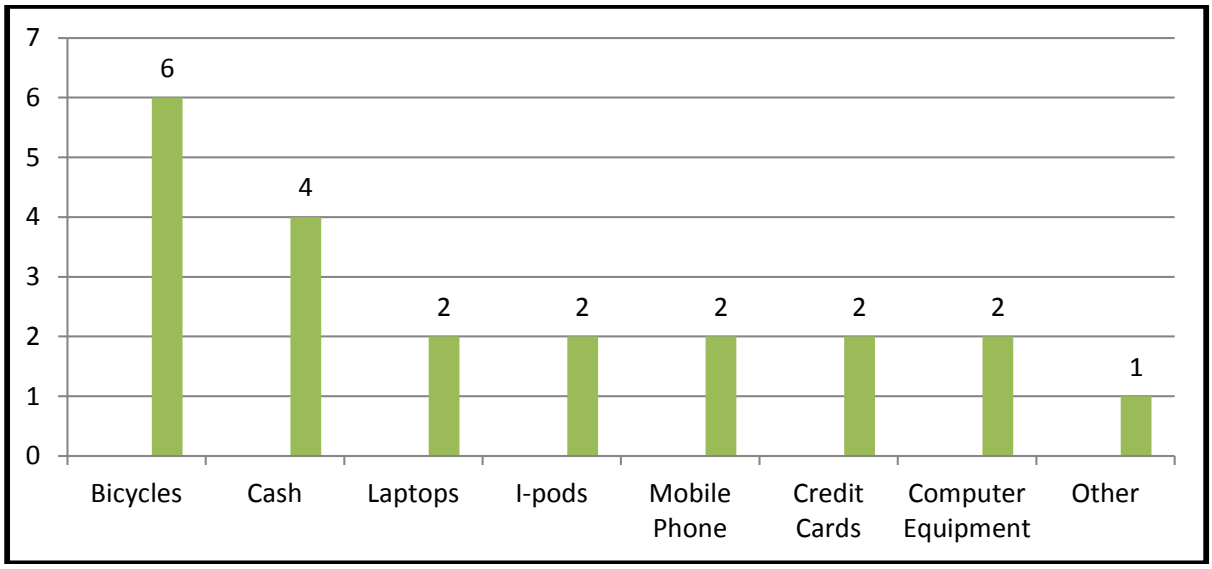
Reported verbal, abusive, aggressive and harassment incidents were slightly down on last year.

2. Reported Crime Incidents 2012/13 and comparative data.

The Security Department routinely collect data on incidents to identify problem areas and assist in determining the most effective counter measures and initiatives.



2.2 Data Summary Breakdown



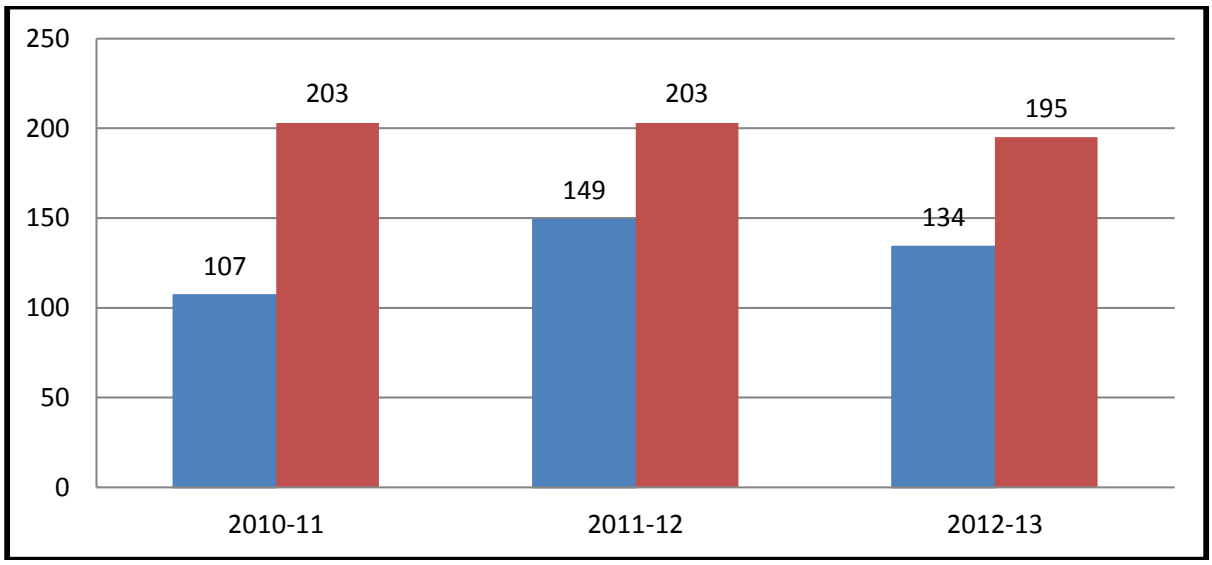
- **25%** decrease in reported crime, this equates to an overall reduction of **36%** over the last two years. This is encouraging to report and can generally be attributed to a continual proactive approach being taken by staff to protect the Trust's as well as their own property and assets.
- Top reported on site thefts were bicycles **(6)**. Though disappointing, this was a huge improvement on lasts years' figure of **(18)**. In December a suspect was apprehended. This suspect was charged and convicted of theft.
- There were two thefts from staff of credit cards. The thief was able to withdraw cash **(£2,200)** from their bank accounts. This criminal activity is widespread across the country with many Trust hospitals targeted. With the intelligence we had, Security was able to review CCTV on the days of the thefts and positively identify the suspect being on site and close to the locations of the thefts. With these images passed to the police and NHS Protect, the suspect was arrested and charged with offences over the last 3 years including NGH thefts. The suspect was recently sentenced to three and a half years imprisonment.
- Laptops, I-pods and mobile phones accounted for **6** thefts, almost all belonging to staff.
- **4** thefts of cash which included three from staff and a collection box from Breast Screening Unit. This type of crime is now significantly less than has been previously reported over the years. Previous data indicated this type of crime would account for 40% to 50% of reported crime.

- **2** hard drives (computer equipment) were stolen from A+E. Another successful apprehension took place after staff from the Bereavement Centre witnessed a male attempting to go through one of the staffs hand bag. Security were contacted immediately and the suspect was detained by security and arrested by the police. The male was charged with attempted burglary and sentenced to twelve months in prison suspended for six months.
- The cost of crime against the Trust for replacement items was approximately **£800**.

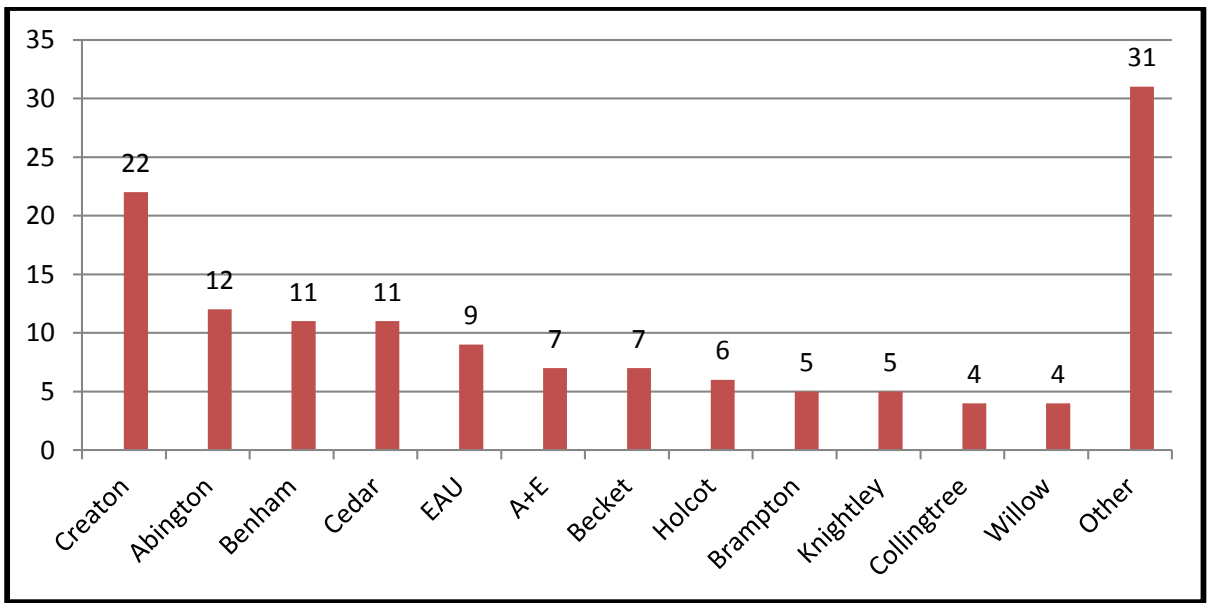
2.2 Physical, Verbal Abuse, Aggressive and Harassment Incidents Data
This information is compiled from the Trusts Datix reporting systems

NHS PROTECT definition of physical assault: *"the intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort"*

NHS PROTECT definition of verbal abuse, aggression and harassment: *"the use of inappropriate words or behaviour causing distress and/or constituting harassment"*



2.4 Data Summary Breakdown



- **10%** reduction in reported physical assault incidents, this is the first reduction in three years. With the increasing care of dementia, mental health and detox patients it is inevitable that physical assaults will continue to occur at regular intervals due to the patient's conditions. It should be noted that the majority of physical assaults are low level types, where scratching, pinching and flailing arms and legs connecting to staff being the main descriptions used via Datix.
- The data shows that for the second year Creaton Ward has recorded the most physical assault incidents on staff **(22)** and remains a high risk ward. However it should be noted that this is a significant reduction on last year's total of **(46)** a **46%** reduction.
- A+E recorded **7** incidents, **(5%)** and four arrests were made.
- **1231** staff attended Conflict Resolution Training or the refresher course at either induction or a cluster day. Over the last four years **4605** have attended this type of course.
- Reported verbal abuse, aggressive and harassment incidents has seen a slight reduction on the previous year. It is encouraging to see that Ward/Departmental Managers are using the Trusts Protecting Staff Policy and are issuing patients and visitors with warning letters as laid out in the policy, reminding that such unwarranted conduct is not acceptable. The issue of these warning letters state the conditions patients and visitors must meet or not break whilst on Trust site and that further action may be taken which includes reporting to the police.

3. Other Areas of Security Activity During 2012-13

- As part of the ongoing CCTV strategy, additional cameras has been installed and further cameras upgraded to give improved images. There are currently **107** cameras covering the Trust which are networked to authorised personal computers within the Security Department and the CCTV control room
- The Security Department and local police continue to meet regularly and share intelligence which helps our officers be aware of individuals who may have ulterior motives for being on Trust premises.
- A quarterly meeting is now in place which comprises of Security Managers, A+E Consultant, A+E Head Nurse/Matron, NHFT Mental Health Lead and the Police. The purpose of this meeting is to work together in dealing with challenging behaviour and mental health patients to ensure appropriate care path ways from admission or releasing into NHFT care or the police. This is ongoing work and good progress is being made.
- Security and Safeguarding leads for vulnerable adults and children have worked closely on a number of occasions this year with all having a better understanding of each other's needs. This has helped in dealing with challenging, vulnerable and mental health patients. Security are able to support clinical staff when patients may want to leave the hospital but it is not in their best interest. Meetings to discuss the patients care plan have also included security input. This includes security involvement when child protection orders are put in place and security work with clinical staff and social services during these delicate situations.

4. Conclusion

It is encouraging to see a continuing down turn of criminal activity on site. It is also positive to see detection rates through CCTV evidence have contributed to the arrests of suspects leading to prosecutions and prison sentences. Hopefully this will

send a clear message to known and potential criminals that NGH is not the place to come and commit crime or be disruptive.

The decrease in reported physical assaults, though small is encouraging and that through appropriate training in breakaway and proportionate restraint this will continue to reduce.

5. Key Initiatives Planned for 2013/14

- The Trust has to complete a "Standards Self Review Tool" as an NHS Provider to demonstrate the level of security measures in place and the level of compliance against 31 standards. This is the first year of introduction and is being coordinated by NHS Protect. Submission of the standards documentation is due by June 30th 2013. NHS Protect will audit the standards if they have concerns on the standards information submitted.
- Funding has been identified to implement a smart card technology system that allows one smart card that will allow access to secure areas, barrier car parks, access to smart card keyboard terminals and act as Trust photo identification. Levels of access will be based on job role and management authorisation. Bringing four different systems together will improve security management of authorised users and improve control on leavers who previously may have not returned photo identification and cards. This project is ambitious as it will require all staff to be identified for the correct access rights across the Trust. A project plan is currently being developed and it is anticipated that implementation should be completed by March 2014.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD – 30 May 2013	
Title:	Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards
Presented by:	Karen Spellman, Deputy Director of Strategy and Partnerships

PURPOSE OF PAPER: -

This paper outlines the key points arising from the recently published NHS Trust Development Authority's Accountability Framework.

SUMMARY OF CRITICAL POINTS: -

- The NHS Trust Development Authority's Accountability Framework sets out the approach it will take to holding NHS Trusts to account and managing their progress towards Foundation Trust authorisation.
- It explains how NHS Trusts will be held to account on a range of quality, performance, finance and governance measures through what is termed an oversight process. Some metrics are listed which will be used by the TDA to measure progress of NHS Trusts, but which will not then form part of the regulation (external review) of NHS Foundation Trusts.
- It explains functions the TDA will provide to support the development of NHS Trusts and their Boards and clinicians.
- It sets out a process for the approval of Foundation Trust applications which is similar to the Single Operating Model used since early 2012 but adds TDA actions to generate a perspective on quality of care.
- It revises limits for the approval of capital investment by NHS Trusts and sets expectations of how cases for such investment will be made.
- It sets an expectation that the TDA will be kept informed of potential service changes in anticipation of national guidance on this.

RECOMMENDATION:-.

The Board is asked to **note** the accountability framework and in particular the oversight process and associated performance measures; TDA development and support functions; the anticipated FT approval process; revised rules on significant capital schemes and the TDA's wish to have early sight of proposals for service change.

Northampton General Hospital NHS
NHS Trust

Delivering High Quality Care for Patients:
The Accountability Framework for NHS Trust Boards

1. Introduction

The NHS Trust Development Authority (TDA) published this framework in April 2013.[1] It sets out the TDA's approach to:

- Oversight of NHS Trusts – assessing organisations to "determine whether we believe an organisation is delivering high quality care."
- Development and support for organisations moving to become Foundation Trusts.
- The approval of Foundation Trust applications, of transactions and of business cases for capital investment.

In introducing it, the TDA's Chief Executive, David Flory, observes that "running health services has never been easy, and the level of scrutiny now applied to NHS leadership in delivering these essential services is unparalleled in my experience."

This paper aims to summarise key points in the accountability framework and their implications for NGH.

2. Guiding Principles

Recognising the complexity of the challenges facing individual NHS organisations and the NHS as a whole, the TDA set out the following principles to guide their work:

- *Every interaction we undertake has an impact on the quality of care patients receive*: "[…]everything we do should be able to be traced directly back to improving the approach NHS Trusts take to enhancing the quality of care they provide for the patients and communities they serve."
- One model, one approach: NHS Trusts should expect the TDA to be both proportionate and consistent in its interactions and to take a risk based approach, recognising that no two organisations are the same.
- Clear local accountability for delivery: NHS Trust Boards are expected to be "aspirational and ambitious for their patients – striving to deliver the best care, underpinned by clear governance and a strong business plan" and the TDA will in turn "support NHS Trusts to overcome any difficulties they may have and provide the national framework for them to succeed and deliver their aspirations."
- Openness and transparency: issues will be disclosed promptly and candidly and risk will be assessed in a way that is understood by all parties.
- Making better care as easy to achieve as possible: the TDA will work with other national bodies to minimise duplication and reduce unnecessary bureaucracy.
- Working supportively and respectfully: the relationship between the TDA and every Trust Board is recognised to be critical to success.

[1] Available at http://www.ntda.nhs.uk

- An integrated approach to business; TDA local Delivery and Development teams will aim to have a "single, joined-up conversation with your organisation."

These principles can be seen to be consistent with NGH's values and indeed the Trust's own ambition as a Foundation Trust. Members of the Trust's Executive Team have already met with members of the TDA's Local Delivery and Development Team to begin working together.

3. Oversight

The TDA's oversight model sets out how it will hold NHS Trusts to account in the period before they are Foundation Trusts.

It is designed to align closely with the requirements of commissioners as set out, for example, through standard NHS contracts, and to include the requirements of the NHS Constitution, the mandate of the NHS Commissioning Board and the requirements set by the Care Quality Commission and by Monitor in its licensing of NHS Foundation Trusts – all of which will continue to apply to NGH once authorised to operate as an NHS Foundation Trust (FT).

The TDA will calculate shadow Monitor risk ratings for NHS Trusts, taking account of the approach being developed by Monitor through its forthcoming Risk Assessment Framework.

NGH has submitted its operating plan to the TDA for 2013/14 and progress will be assessed against this in three domains:

- Quality and Governance: taking account of the most recent published performance against indicators for 2013/14, responses to the quality checklist contained within the operating plan, and a qualitative assessment of risk based on handovers from SHAs and information from the CQC.
- Finance: based on indicators of income and expenditure, actual efficiency compared to plan (split into recurring and non-recurring), and the forecast underlying revenue position compared to plan for the year.
- Delivering sustainability: whilst the focus of this on organisations whose form needs to change, all FT applicants, including NGH, will continue to be required to report monthly on compliance against relevant Monitor licence conditions and Board statements.

A monthly 'integrated delivery meeting' will be held with the Chief Executive and lead Executive Directors. These began in April and can be expected to focus on progress being made to improve performance against key standards highlighted in the Annual Plan submission.

The TDA will make Chair and Non-Executive appointments to NHS Trusts on behalf of the Secretary of State, be responsible for the appraisal of NHS Trust Chairs, have a role in agreeing annual performance assessments for NHS Trust Chief Executives and be required to approve proposed severance arrangements for senior NHS Trust staff.

The suite of information being used by the TDA to assess performance is shown at **Appendix 1**. The Board will wish to be assured of performance on these measures.

4. Development and Support

The accountability framework sets out a process to identify and respond to the development needs of NHS Trusts.

As requested, NGH set out in its operating plan a number of areas where it sought support from the TDA.

The TDA has formed a 'Clinical Faculty' to support clinical leaders in NHS Trusts through the journey towards FT status, including such activities as mentorship, coaching and action learning sets.

The TDA is also developing a number of 'dashboards' of performance, quality, ambulance, activity and finance indicators. A workforce assessment tool already exists and all Trusts have been required to complete it to support benchmarking.

The TDA has taken over previous national functions and now includes:

- The NHS Leadership Academy
- NHS Improving Quality
- NHS Intensive Support Teams no emergency and elective care
- NHS Interim Management and Support

NGH can expect that review of its progress on Board development will form part of the oversight process.

5. Approvals

5.1 FT Application and Transaction Approval

The accountability framework sets a clear process for the TDA to evaluate and approve FT applications using a staged approach as follows:

- Stage 1 – Diagnosis and due diligence
- Stage 2 – Development and application
- Stage 3 – Assurance and approval

The focus is very much on supporting Trusts to deliver a successful application using a process that in many ways is similar to that previously experienced by the Trust.

The key aspect of involvement of the TDA in the immediate future is their role in the Partnership Board and the work with Kettering General Hospital FT due to their role in approving any transactions involving an NHS Trust. The TDA would be the vendor in any proposed transaction (as opposed to the Trust themselves) and therefore must be involved in every aspect of the discussion.

Discussions have already commenced with the Portfolio Director for our area to ensure the TDA is fully involved in the programme. The TDA has published a four stage gateway process for any transaction:

- Gateway 1 – The trigger for TDA involvement due to the Trust declaring it is not able to deliver a viable organisation from an FT perspective
- Gateway 2 – The TDA decision on the appropriate form of procurement
- Gateway 3 – The decision to proceed with a preferred solution
- Gateway 4 – The decision to implement the preferred solution

The process is anticipated to take >17 months from start to finish and as such discussions are now underway with the TDA to dovetail this requirement with the timescales for the Partnership Programme.

5.2 Significant Capital Schemes

Revised delegated limits for NHS Trusts are in place from 1 April 2013. These allow NHS Trusts to approve capital investments or property transactions of a financial value up to £5 million or 3% of turnover in the previous financial year, whichever is the lower.

To approve significant capital schemes, the TDA will require the Trust to demonstrate that criteria have been met and that the proposal has had an appropriate level of Board scrutiny, has been "subjected to an appropriate governance and clinical engagement process" and that it is affordable and good value for money for the taxpayer.

The TDA requires all business cases for its approval to meet requirements in the Department of Health's Capital Investment Manual and to use the five case model for business case production, covering strategic, economic, financial, commercial and management aspects.

The framework also states that: "autonomy is earned and NHS Trusts are asked to note that Trusts reporting a year end deficit in its most recent audited accounts, forecasting an outturn deficit for the financial year or with an in-year deficit should note that at the discretion of the NHS TDA a Trust's delegated limits can be lowered."

All NHS Trusts have been required to submit five year capital plans as part of the operating plan process. The accountability framework states that:

"Where a Trust submits a business case that was not identified within the annual planning cycle, an additional strategic intent document relating to the business case will also be required. This must specify the following:

- the reason / rationale for the investment;
- how the business case fits with the NHS Trust's strategic plan
- why the business case was not included within the Trust's original financial plan;
- the estimated value of the investment;
- timescales for the investment;
- procurement process and risks of not proceeding with the business case."

5.3 Service Change

The accountability framework notes that the Department of Health is soon due to publish a national review "with recommendations about how service change should be delivered in the future."

The TDA will issue guidance on the approvals process for service change after this, and states that it "will want to ensure that it has early sight of any proposals for service change, and will want to see clear evidence of the active participation of commissioners in the local assurance process, using a service change readiness assessment."

6. Recommendation

The Board is asked to **note** the accountability framework and in particular the oversight process and associated performance measures; TDA development and support functions; the anticipated FT approval process; revised rules on significant capital schemes and the TDA's wish to have early sight of proposals for service change.

Chris Pallot
Director of Strategy & Partnerships
May, 2013

Appendix 1

Routine Quality and Governance indicators being used by the TDA

Shown in **bold** are indicators which are additional to mandatory and Monitor Risk Assessment Framework measures – so are being used by the TDA for its oversight of NHS Trusts.

Category	Indicator
CQC Concerns	• Warning notice • Civil and/or criminal action
Access metrics	• Referral to treatment within 18 weeks – Admitted 90% in 18 weeks – Non admitted 95% in 18 weeks – Incomplete 92% in 18 weeks – Over 52 week waiters • Number of diagnostic tests waiting longer than 6 weeks • **Cancelled operations re-booked within 28 days** • **Urgent operation being cancelled for the second time** • A&E waits (4 hours) • 62 day wait for first treatment – 62 day urgent GP referral to treatment from screening – 62 day urgent GP referral to treatment for all cancers • 31 day wait for second or subsequent treatment – 31 day second or subsequent treatment (surgery) – 31 day second or subsequent treatment (drug) – 31 day second or subsequent treatment (radiotherapy) • 31 day wait from diagnosis to first treatment • Two week wait referral to date first seen – 2 week GP referral to 1st outpatient, cancer – 2 week GP referral to 1st outpatient – breast symptoms
Outcomes metrics	• 30 day emergency readmissions • Incidence of MRSA • Incidence of C. Difficile • Medication errors causing serious harm • Admissions of full-term babies to neonatal care • **Harm free care** (pressure sores, **falls, C-UTI** and **VTE**) • **Serious incidents** • **Never events** • **eColi + MSSA cases** • **C-sections rates** • **Maternal deaths** • **SHMI** • **HSMR** • **VTE risk assessment** • **CAS Alerts** • **WHO surgical checklist compliance**

Category	Indicator
3rd party reports	Any relevant report including safeguarding alerts, serious case reviews, Ad- hoc reports from MPs, GMC, Ombudsman, Commissioners, litigation, etc.
Quality governance indicators	• Patient satisfaction (friends and family) • Board turnover • Sickness/absence rate • Proportion temporary staff – **clinical and non-clinical** • Staff turnover • **Nurse:bed ratio** • **Percentage nurses being registered nurses** • **Mixed sex accommodation** • **Patient and carer voice** • **Complaints** • **Percentage of staff appraised**

Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 30 May 2013
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Introductions and Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Minutes of the meeting held on 24 April 2013	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	**2**
09.40	5.	Chief Executive's Report	Dr S Swart	**3**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Dr S Swart	**4**
10.05	7.	Patient Experience Report	Ms S Loader	**5**
10.20	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**6**
10.30	9.	Francis Report Update	Ms S Loader	**7**
10.40	10.	Staff Survey Report	Ms J Brennan	**8**
Operational Assurance				
10.50	11.	Operational Performance Report	Mr C Walsh	**9**
11.00	12.	Urgent Care Report	Mr C Walsh	**10**
11.10	13.	Finance Report	Mr A Foster	**11**
11.20	14.	Human Resources Report	Mrs J Brennan	**12**
11.30	15.	Transformation Programme Update	Mrs J Brennan	**13**
11.40	16.	Self-Certification Return	Mrs K Spellman	**14**
Strategy				
12.05	17.	Communication and Stakeholder Engagement Strategy	Mrs K Spellman	**15**
12.15	18.	Annual Security Report	Mr C Abolins	**16**
Governance				
12.25	19.	Trust Development Authority Accountability Framework	Mrs K Spellman	**17**
Any Other Business				
12.30	20.	Any Other Business	Mr P Farenden	**-**

	21.	**Date & time of next meeting:** 27 June 2013 – 09.30am. Boardroom, Northampton General Hospital		
	22.	**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	