Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 30 January 2014, 09.30 am

at

**the Boardroom,
NGH**

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 30 January 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Zeidler	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of the 28 November 2013 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 28 November 2013	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Ms S Loader	**Verbal**
	6.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.50	**CLINICAL QUALITY AND SAFETY**				
	7.	Quality Report	Assurance	Dr M Wilkinson	**D.**
	8.	Patient Experience Report	Assurance	Ms S Loader	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms S Loader	**F.**
10.25	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs R Brown	**G.**
	11.	Urgent Care Update	Assurance	Mrs D Needham	**H.**
	12.	Finance Report	Assurance	Mr A Foster	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
	14.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**K.**
	15.	TDA Self-Certification	Decision	Mr C Pallot	**L.**
11.30	**STRATEGY AND GOVERNANCE**				
	16.	Oncology and Cancer Partnership with UHL	Decision	Mr C Pallot	**M.**
	17.	Risk Management Strategy	Decision	Dr M Wilkinson	**N.**
	18.	Standards for Members of NHS Boards in England	Decision	Mr P Zeidler	**O.**
11.50	**ANY ITEMS OF OTHER BUSINESS**				
	19.	**DATE AND TIME OF NEXT MEETING** 27 February 2014, Boardroom, NGH	Note	Mr P Zeidler	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on

Thursday 28 November 2013 at 9.30am at the Boardroom, NGH

Present:

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

In Attendance:

Mr C Sharples	Head of Corporate Affairs

Apologies:

Mr P Zeidler	Non-Executive Director

TB 13/14 123 Declarations of Interest in the Proceedings

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

TB 13/14 124 Minutes of the meeting held on 31 October 2013

The minutes of the meeting of the 31 October 2013 Board meeting were presented for approval.

The following amendments to the minutes were discussed and agreed:

Minute TB 13/14 105 – Medical Director's Quality Report.

Paragraph five should read "Mrs Searle raised concern that the 1:8 ratio should be seen as an absolute minimum with escalation mechanisms built into it…"

Subject to that amendment, the Board resolved to **APPROVE** the minutes of the 31 October 2013 as a true and accurate record of proceedings.

TB 13/14 125 Action Log and matters arising from the 31 October 2013 Board Meeting

The action log was considered and the Board.

The Board noted that date of presentation of the revised Risk Management Strategy to the Board had slipped from November 2013 to January 2014. The revised Strategy would be presented to the December 2013 Audit Committee.

Mr Farenden asked when the annual benchmarked complaints data would be available. Ms Loader advised that it remained work in progress and anticipated

it would be available for the January 2014 Board meeting.

The Board **NOTED** the Action Log and Matters Arising from the 31 October 2013.

TB 13/14 126 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart informed the Board that the Trust's new Barratt Birth Centre was due to open on the 2 December, and would be the first midwife-led unit in the county. The centre was opened to provide an increased focus on natural births in response to the Trust's high elective caesarean section rate and increase choice for expectant mothers. Mums-to-be will be able to have their baby in a more homely and calming environment, with all the benefits of having expert medical support very close by should the need arise.

Dr Swart reported that the previous week the government had published its final response to the Francis report accepting all but nine of the original 290 recommendations. Dr Swart summarised the key points from the report and outlined the actions the Trust was already taking to ensure it complied with this recommendations, which would be covered in greater detail in Ms Loader's report later on the agenda.

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

Dr Swart provided an update on the progress in developing strategic cancer partnerships. She stated that the trust was extremely proud of its cancer centre status, but the Trust was looking at developing partnerships with a tertiary centre to ensure that services could be delivered locally and sustainably to the highest standards of care. She informed the Board that reports would be presented to future Board meetings as the discussions with partners continued to evolve.

Dr Swart reported to the Board that NHS Nene CCG has recently notified the Trust of changes to referral criteria for certain procedures. Prior approval would therefore be required for a number of procedures which the Trust had previously been able to undertake as long as their clinical presentation met set criteria. She advised that the Trust was concerned at the process being adopted and would continue to manage the issue through established contract routes. In 2012/13 the Trust undertook approximately 2,000 of the identified procedures which could therefore have considerable impact on patient expectation & experience and associated income for the Trust.

Dr Swart informed the Board that notification had been received the Trust's CQC inspection would be taking place on the 15 January 2014. A programme of work was in preparation in readiness for the inspection which would include a continued emphasis on the fact that we know that there are areas where we need to take action to ensure our services are of a consistently high quality , that we need to build on the good work underway to strengthen this work. Dr Swart stated that the Trust was determined to use the inspection as a learning event.

The QuEST internal inspection had been introduced which it was hoped would de-mystify the inspection process for staff whilst in turn identify area

so of concern and good practice in a transparent manner. Regular meetings with staff were being held and would be supplemented with a programme of sustained commination in a variety of methods, with particular focus on engaging with junior doctors.

Mr Farenden declared that the CQC inspection should be seen as a genuine learning opportunity for the Trust. He added that the Trust openly acknowledged that it had a number of challenges and the inspection would ultimately benefit patients in the long term.

With regard to the prior approvals policy change, Mr Robertson queried if patients that were already referred for those procedures which had had the acceptance criteria altered would still receive treatment. Dr Swart responded that was not clear as yet and discussions were ongoing with commissioners to determine how the policy changes could be implemented without placing patients at risk, whilst reducing delays and bureaucracy. Mr Pallot advised that the policy changed placed the onus on the referring GP to get prior approval before referring to the Trust for treatment. There was a need to ensure systems were in place to protect the Trust if procedures were carried out without the GP receiving prior approval from the CCG as the Trust would not be paid for the work carried out.

Mr Robertson sought assurance that all providers, private and NHS, were being treated equitably and were working to the same prior approvals policy. Mr Pallot responded that he was seeking the same assurances from the CCG.

In relation to the Government response to the Francis Report, Mrs Searle asked if the introduction of care certificates for Healthcare Assistants would have an impact on the Trust's staff. Mrs Brennan advised that the matter had been discussed at the LETC, as it was not clear if the requirement would be a national or local arrangement. Dr Swart added that it had also been discussed at the LETB and it remained unclear as it was very early days. She reassured the Board that current Healthcare Assistant training was based on the national standards. Mr Farenden requested an update be provided to the January 2014 Board meeting.

ACTION: Ms Brennan

The Board **NOTED** the Chief Executive's Report.

TB 13/14 127 Patient Story

Ms Loader introduced a presentation from a staff nurse which was based upon their personal experience of a never event involving a member of their family following a procedure at another hospital.

The presentation told a story of how the event impacted on the individual concerned and their family, physically and emotionally, and went on to commend the support the family received from NGH staff. The event and the interaction with NGH staff inspired the staff nurse to train to become a nurse.

The Board **RECEIVED** the Patient Story.

TB 13/14 128 Medical Director's Quality Report

Dr Wilkinson presented the Medical Director's Quality Report and provided and detailed overview of the content.

The Board was informed that there has been an improvement in HSMR

which was reported at 96, and that the Trust had one of the lowest crude mortality rates in the region which was a vast improvement. Dr Wilkinson reported that SHMI remained high, and although the indicator was reported a number of months in arrears, the ratio was not consistent with the HSMR of the same period. With regard to high risk mortality areas, there had been significant improvements in relation to mortality from fractured neck of femur and mortality from congestive heart failure.

Dr Wilkinson advised that the Good Hospital Guide was due to be published shortly by Dr Foster, and he anticipated that NGH would be identified as an outlier for HSMR as the guide was based on data spanning 2010-13. The high SHMI will also be evident in this guide.

Dr Wilkinson highlighted concerns regarding SMR for gastrointestinal and liver disease as the CQC had notified the Trust that we were outliers in those areas. He advised that there was significant work ongoing to understand the root causes underpinning this data and all deaths of admitted patients were being reviewed in detail at directorate morbidity and mortality meetings. To quality assure the directorate mortality reviews, a Trust wide process of 50 case reviews randomly selected across all specialties was undertaken by a multidisciplinary group of consultants to ensure that any identified avoidable deaths have previously been rigorously reviewed within their specialty, recognise any themes, and compare with performance in the previous year.

Mr Robertson questioned if the mortality indicators were now stable. Dr Swart responded that they were. The HSMR was improving would continue to be used to identify possible issues of concern. She advised that the Trust's diversion from HSMR and SHMI was greater than that at other Trusts and was under review. The case note review was focussing on avoidable deaths which was the most important factor for the trust to concentrate on and there would be particular focus on that.

Mr Noble observed that there was a particular focus on gastrointestinal and liver disease and asked if other areas were subject to similar scrutiny. Dr Swart assured the Board that all diagnostic groups were reviewed in detail on a monthly basis.

Mr Kershaw noted that there had been historic issues with data quality of coding and asked what progress was being made by the Morbidity and Mortality Group. Dr Swart reported the co-morbidities still presented an issue but there were improvements in other areas. A data quality group had also been established to examine the data quality of coding in depth.

Mr Kershaw asked if HED data would be used as an alternative for measuring mortality. Dr Swart advised that HED was used in some hospitals but was not a national indicator and that hospitals using it were working towards a composite indicator which took into account other quality indicators which captured data not specifically relevant to NGH. Once the HED indicator had been refined it had the potential to be a useful tool for the Trust but that working with a number of different mortality indicators was time consuming and perhaps detracted from the main point which was not to focus on data but to improve care

Dr Wilkinson highlighted the learning from serious incidents and inquests during the reporting period.

The quality dashboard was presented to the Board and the red rated

exceptions highlighted. With regards to the healthcare records audit, Mr Farenden noted that it had been a red rated issue for a significant period of time and asked when the indicator would be resolved. Mr Pallot advised that the audits were underway, and the documentation would soon be approved which would support the indicator moving away from red.
Mrs Brown advised the Board that the increase in cancelled operations was indicative of the emergency pressures across the Trust.

Dr Swart advised that whilst the elective caesarean section indicator remained red rated, the Trust was complaint with NICE guidelines, but electives sections remained high.

Mrs Searle asked if there was a benchmark available to measure the number of cancelled operations. Dr Swart advised that she would explore that data being presented to the January 2014 Board meeting. Mr Pallot added that for the data to be meaningful, it would be key to determine why the operations were cancelled.

ACTION: Mr Pallot

The Board **NOTED** the Medical Director's Quality Report and supported the actions outlined.

TB 13/14 129 **Patient Experience Report**

Ms Loader presented the Patient Experience Report and presented an overview of the paper.

She reported that all patient experience surveys undertaken by the Trust had been collated and quality assured by the Patient Experience Manager. The review has concluded that 50% of the surveys could be considered of a good standard. A thematic analysis of that 50% had been conducted and the themes were presented in the body of the report. Ms Loader advised that the themes identified from the surveys were consistent with themes from PALs and complaints.

The Friends and Families Test results were presented to the Board. Ms Loader advised that a more comprehensive analysis had been undertaken on the results than previously reported. The analysis had demonstrated that there were lots of positive comments received, which needed to be communicated to staff.

Ms Loader reported that the Friends and Families Test had been launched in maternity services, and month one had produced a response rate of 19% which she advised was highly encouraging. The Net Promoter Score for the whole of maternity services was 70, and Ms Loader suggested the home birth team be highlighted as a team that should be congratulated as their Net Promoter Score was 100.

Response rates across the Trust continued to improve, particularly in Eye Casualty and A&E, although EAU had been identified as an area that required more support to improve response rates. Ms Loader reminded Board members that the Trust had a target response rate of 20%, which the Trust was exceeding.

Mr Kershaw asked if there were any themes identified from the FFT results which the Board should be particularly concerned about. Ms Loader responded that these comments were still being analysed. When this work was complete, they would be included in future patient experience Board reports.

The Board **NOTED** the Patient Experience Report.

TB 13/14 130 Infection Prevention Performance Report

Ms Loader presented the Infection Prevention Performance Report.

In presenting the report, Ms Loader advised that there had been zero instances of MRSA and screening compliance was positive. She reported that there had been two cases of C.Diff identified, both of which were deemed to be appropriate samples. Those samples brought the Trust's year to date total to 23 cases of C.Diff. Ms Loader advised that there was now a focus on ensuring that samples were sent promptly and within the stated timescales and education of staff was ongoing.

Ms Loader updated the Board on the Board to Ward Quality Visits conducted in October and provided an overview of the identified themes. She added that the reviews were seen as positive by staff on the wards, with the outputs of the review proving beneficial in driving improvements. Mr Farenden commented that from his experience of conducting the visits, staff appeared to be very receptive and welcomed the visits.

Ms Loader reported that in October the Hand washing Gangnam Video developed by the Infection Control Team won the Best use of YouTube awards at the UK Social Media Communications Awards.

Mr Robertson asked if benchmarks were in place for MRSA and C.Diff and queried how targets for other trusts were set. Ms Loader advised that targets for all trusts were set nationally, and were based on a year on year reduction based on individual baselines. Mr Pallot advised he would provide benchmarking data for the next meeting.

ACTION: Mr Pallot

Mr Noble questioned if the terms of reference for the QuEST reviews and other ward visits, audits and inspections would be reviewed alongside one-another to ensure duplication was minimised. Dr Swart advised that the QuEST reviews were still being piloted and a review of all ward visits and inspections would be undertaken in the new year to ensure that they visits complemented each other.

The Board **NOTED** the Infection Prevention Performance Report.

TB 13/14 131 Francis Report Action Plan

Ms Loader presented the Francis Report Action Plan to the Board to provide a progress update on the actions the Trust was implementing in response to the Francis Report.

It was reported that six actions had been completed since the previous report presented in July 2013; six actions are on track to meet the planned completion dates. It was noted that there has been some slippage in elements of six further actions and revised completion dates had been agreed.

The Board **NOTED** the Francis Report Action Plan.

TB 13/14 132 Nurse Staffing Report

Ms Loader presented the Nurse Staffing Report to the Board.

In introducing the report, Ms Loader updated the Board regarding concerns raised at the October Board meeting due to slippage in the nurse staffing recruitment pipeline. She advised that the following the approval of the four year Nurse Staffing Strategy in March 2013, the trust undertook to invest £1.9m in additional nursing staff, which equated to 58.45 registered nurses and 65.18 healthcare assistants added to ward establishments. At month seven, Ms Loader reported that the Trust had not achieved its target of 95% establishment as forecast; it had achieved 92% for registered nurses and 95% for healthcare assistants. Whilst this demonstrated a significant increase in the numbers of staff overall on establishment, the number of vacancies had increased in September. The September increase in vacancies and slippage from plan had been pinpointed to a numeracy and literacy test being introduced without it being piloted and subsequently 30 registered nurses were not appointed as expected.

The Board was advised that a nurse recruitment open day had subsequently been held which led to 29 nurses being appointed, who are due to take up post in January 2014. Further work had also been ongoing to attract nurses from Spain, which led to 14 registered nurses being appointed. Active recruitment was ongoing locally and on a wider scale, and work was continuing to reduce temporary staff reliance and improve the staff bank.

Mr Farenden asked when the Trust would be at 95% establishment for registered nurses as was forecast for October. Ms Loader advised December 2013 for the surgical care group and February 2014 for the medicine care group.

Mr Robertson asked if staff numbers were flexed to ensure a safe provision of staffing in escalation areas during busy periods. Ms Loader confirmed that was the case, and added that risk assessments were undertaken for those staff moved from a ward to help support escalation areas.

Ms Loader drew the Boards attention to a table which presented each ward area and their worked establishment compared to the nationally recommended 1:8 nurses per patient ratio. She reported that there were four areas below the 1:8 ratio, although there were plans to ensure they would be above the ratio.

Mrs Searle asked if Ms Loader remained confident that the staffing levels for each ward remained satisfactory. Ms Loader responded that provided they were up to establishment and didn't have high levels of sickness, they were satisfactory for 2013/14, however a business case had been developed, requesting additional resources to ensure every ward reached the 1:8 ratio as a minimum the following year. . Dr Swart added that it was likely all quality related strategies and plans would need to be reviewed in February 2014 due to the forthcoming national reports and the outcomes of the CQC inspection.

Mrs Searle asked if the recruitment pipeline could be further accelerated. Mrs Brennan responded that it could not in year. She added that the Trust needed to plan more strategically and anticipate future demand, possibly looking to over-recruit in line with a longer term strategy.

Mr Kershaw commented that the Integrated Healthcare Governance Committee would maintain a close view on the issue, particular in relation to

staff sickness and vacancy levels, and provide assurance to the Board.

The Board **RECEIVED** the Nurse Staffing Report.

TB 13/14 133 Operational Performance Report

Mrs Brown presented the Operational Performance Report to the Board.

She reported that the Trust had not achieved the following standards during October 2013; Urgent Care four hour standard, 62 day standard from urgent GP referral, 18 weeks admitted and non-admitted specialty standard for Trauma & Orthopaedics, although the number of patients waiting over 26 weeks from referral has reduced to from 31 to 19.

The Trust had failed to meet the 18 weeks admitted and non-admitted speciality standard specifically for Trauma & Orthopaedics due to a mix of operational and external issues. A detailed report and action plan was reviewed at the Integrated Healthcare Governance Committee which outlined the expectation that the target would be met in January 2014.

With regards the Urgent Care four hour standard, Mrs Brown reported that the Trust did not achieve the required 95% target in October and to date in November, performance stood at 94.96%. It was noted that there had been an increase in attendances recorded during November. A number of additional measures were being implemented to support the achievement of the target which included the introduction of additional ward rounds and ensuring an increased focus on discharge triggers.

Mr Farenden asked if the November urgent care position would be recoverable to meet the required 95%. Mrs Brown advised that it was not as there had been a number of very difficult nights recently. She stressed that the team had been working incredibly hard to deliver the target.

Dr Swart voiced her disappointment that the 18 week and cancer targets had not been met due to internal issues regarding capacity and planning. She added that it was important for the Board to note that in light of recent incidents relating to the manipulation of data to influence targets, that an internal review had been undertaken and she could confirm that there were no instances apparent of data being manipulated in relation to cancer targets.

The Board **NOTED** the Operational Performance Report.

TB 13/14 134 Urgent Care Update

Mrs Needham presented the Urgent Care Report to the Board.

By way of introduction, Mrs Needham informed that Board that a review and refresh of the urgent care project groups had taken place and a revised structure had been agreed. As such, the project groups were now based around keeping patients safe.

Mrs Needham updated the Board on recent performance advising that performance had deteriorated over the previous 10 days, and as such, performance for quarter three stood at 93%. Attendances to the A&E department remained slightly higher than this time last year, and the Trust had also seen an increase in the number of non-elective admissions over the previous two weeks.

Mrs Needham advised that she had been liaising with colleagues from

University Hospitals Coventry and Warwick NHS Trust who had managed to turn around and deliver sustained performance against the urgent care target. From the discussions, it was clear that engagement with medical and nursing staff was key in delivering the change.

Mr Farenden asked if there were additional resources, particularly senior clinical staff on wards now. Mrs Needham confirmed that to be the case. Dr Swart added that whilst additional funding had been allocated for additional clinicians, the Trust was finding it difficult to recruit to those posts and there was a shortage of high quality locums available. All options were being explored to increase staffing, but it was stressed that the Trust must not dis-engage with existing clinical staff.

Mrs Needham reported that a new system had been implemented where potential breeches were escalated early to ensure awareness of potential issues a focus the team. Early discharges were also being focused upon, with extra staffing allocated to support the initiative.

Mr Farenden commented that a whole health economy approach needed to be taken to drive improvements in urgent care performance. He felt the Trust must rightly focus on its own internal challenges, but also a health economy approach was required to resolve issues such as inappropriate referrals, inappropriate attendances as well as the difficulties faced in discharging patients into services in other care settings. Mrs Needham advised that the Trust was receiving more support than it had historically, but she did not feel there was the same sense of urgency felt be partners. She had implemented regular meetings with partners to assist in predictive planning, and partner agencies were more supportive and had put additional capacity into the system, although the impact of this was yet to be realised.

Mrs Needham advised the Board that there were 18 GPs that had expressed an interest in working in the A&E department to see those patients that presented to the department with issues that were more appropriately managed by a GP. Dr Swart added that the CCG Chair had worked for a shift in the A&E department recently to provide support. The experience had proved to be positive experience and the A&E team found it to be valuable.

Mr Farenden voiced disappointment that the Trust was not meeting the urgent care target but felt the Board must acknowledge there had been a significant amount of work by staff across the Trust in an attempt to meet the target and the effort of those staff should be acknowledged. Mrs Needham added that the Trust Development Authority had acknowledged that the Trust's performance had improved significantly.

The Board **NOTED** the Urgent Care Report.

TB 13/14 135 Finance Report

Mr Foster presented the Month 7 Finance Report to the Board.

He reported that the year to date position was reported as a £3m deficit, but due to risks materialising, it was likely that the forecast position would extend to a £4.5m deficit. The TDA had been made aware of the change in forecast position.

It was reported that the income and expenditure position for the month had largely broken even, with performance ahead of forecast levels due to progress being made in reconciling months 1-4 with the CCG. The Trust

was now pushing to agree months 5 and 6 by mid- December. Provisions for CCG fines and penalties continued to be made totalling £5.5m for the year to date. Mr Foster advised that he continued to have issues with the CCG in agreeing the reinvestment of fines.

The Board was advised that pay expenditure remained static and favourable to plan, but the pay run rate was expected to increase over the winter period with new business cases coming on stream. Non-pay costs had increased by £300k.

Temporary staff costs continued to increase, the majority of which was to temporary medical staff. Also of concern was that the higher level anticipated reduction in bank and agency nursing costs had not been realised, with the most recent forecast highlighting a significant shortfall compared to planned reductions.

The cash flow at the end of October was positive due to the CCG providing an advance on Q3 of the block contract. The temporary borrowing application was progressing with the TDA, who had requested more detailed information and a daily cash flow report to further support the application. Mr Foster commented that the Trust needed to remain open with the TDA regarding the precarious cash position

In summarising the financial risks, Mr Foster advised the Board that the CCG's financial position was poor, and it had been required to produce a financial recovery plan for the LAT, which had the potential to impact upon the Trust.

Overall, Mr Foster advised that the financial position was difficult, but there was a plan in plan to mitigate the risks as far as possible. He added that if MRET and re-admission fines were re-invested, the Trust would be able to deliver a break even position.

Mr Robertson asked what was driving the overspend in non-pay. Mr Foster advised there were two main factors. The first was an increase due to drug costs increasing and secondly, the Trust had begun outsourcing trauma and orthopaedic and ophthalmology work to the private sector to manage waiting time breeches. He provided assurance that the costs associated with the two factors would be recovered.

Mr Robertson raised concerns regarding the viewpoints being taken by the CCG and the LAT in relation to MRET and readmission fines and asked what more the Trust could do to influence this. Dr Swart responded that a strategic approach had been agreed with NHS Nene CCG, but felt that pressure was being applied to the CCG which was driving decisions to be made which were at odds with those agreed. She advised that the matter would be escalated once more to the TDA, and that the Trust would be seeking to revisit joint strategic planning with the CCG as mandated by national guidance. Mr Pallot added that there appeared to be a disconnect between the strategic direction and agreements of the CCG and operational management actions, which was understandable due to the external pressures being applied. He added that work was ongoing with the CCG to restate the strategic relationship.

Mr Foster commented that the introduction of the Integrated Transformation Fund would likely present significant financial risks to all Trusts in the near future, and the Board must remain sighted on this as it progresses.

The Board **NOTED** the Finance Report.

TB 13/14 136 Workforce Report

Mrs Brennan presented the Workforce Report to the Board.

She highlighted that the Trust sickness absence rate had increased during October, which was indicative of the time of year. Despite that, she stated that the Trust were no being complacent and advised that occupational health were proactively looking into the reasons for sickness to identify trends and themes.

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

Mrs Brennan reported that the Staff Survey percentage return rate stood at 33% which was disappointingly low. The Trust was aiming to achieve over 50%. With regards to flu vaccines, it was reported that 49% of staff had received vaccinations to date, which was above trajectory and positive. The Trust Whistleblowing Policy had been revised, and renamed the Raising Concerns at Work Policy.

The revised Trust values were presented. Mrs Brennan advised that for each of the Trust values, behaviours would be aligned and would then be embedded within all relevant processes across the Trust. The values had been integrated into the revised appraisal process and would form part of the decision making, alongside meeting objectives and attendance at Mandatory and Role Specific Essential Training which will enable staff to incrementally progress.

The Board **NOTED** the Workforce Report.

TB 13/14 137 Improving Quality and Efficiency Report

Mrs Brennan presented the Improving Quality and Efficiency Report to the Board.

She advised that since the Board papers had been distributed, the overall position had deteriorated due to issues in the nurse recruitment pipeline by £600k. Thus, the latest thinking forecast had been revised and stood at £11.6m Mrs Brennan advised that the £600k gap created by the nurse staffing issues could not be addressed by further recruitment before the end of the financial year; therefore the shortfall would have to be met from elsewhere. This included driving greater value from existing schemes.

It was reported that the outline transformation themes for 2014/15 and were in the process of being scoped in greater detail. Dr Swart stated that the faced an enormous challenge for 2014/15, and would require support to effectively develop the 2014/15 schemes. Mr Robertson commented that the trust must understand its volume estimates to inform the 14/15 schemes. Mr Pallot agreed and advised that he was in discussions with the CCG regarding this, but it would ultimately be reliant on the commissioning intentions to inform activity assumptions and support the strategic planning process.

The Board **NOTED** the Improving Quality and Efficiency Report.

TB 13/14 138 TDA Self-Certification Report

Mr Pallot presented the TDA Self-Certification to the Board for approval.

It was reported that at the time of the launch of the TDA Accountability Framework, the TDA requested that on an interim basis the Trust continue to complete and submit the Governance Risk Rating, Financial Risk Rating, quality and contractual data elements of part two of the Single Operating Model which had been presented to the Integrated Governance Committee and Board on a monthly basis for approval.

The TDA had subsequently clarified that the submission of those returns was no longer a mandatory requirement. Having taken advice, from this month onwards the Trust would no longer be submitting those to the returns to the TDA.

As such and in accordance with the NHS TDA Accountability Framework, the Trust was required to complete the two self-certifications presented in relation to the Foundation Trust application process.

In relation to Board statement 10, Mr Noble challenged the working commentary as he felt progress had not been satisfactorily made. Mr Pallot agreed to amend the working prior to submitting the returns to the TDA.

The Board **APPROVED** the TDA Self Certification Report.

TB 13/14 139 **Strategic Aims and Corporate Objectives**
Mr Pallot presented the report to the Board.

A summary of progress made against the 2013/14 Corporate Objectives was reviewed by the Board.

Mr Pallot presented the 2014/15 Corporate Objectives advising that the Board had reviewed the objectives in detail at previous development sessions and they were presented to the Board for final approval.

The Board **NOTED** the progress made against the 2013/14 Corporate Objectives and **APPROVED** the Objectives for 2014-15.

TB 13/14 140 **Any Other Business**
No items of any other business were raised.

TB 13/14 141 Mr Farenden called the meeting to a close at 12.25.

Date of next meeting: 9.30am, Thursday 30 January 2014, Boardroom, NGH.

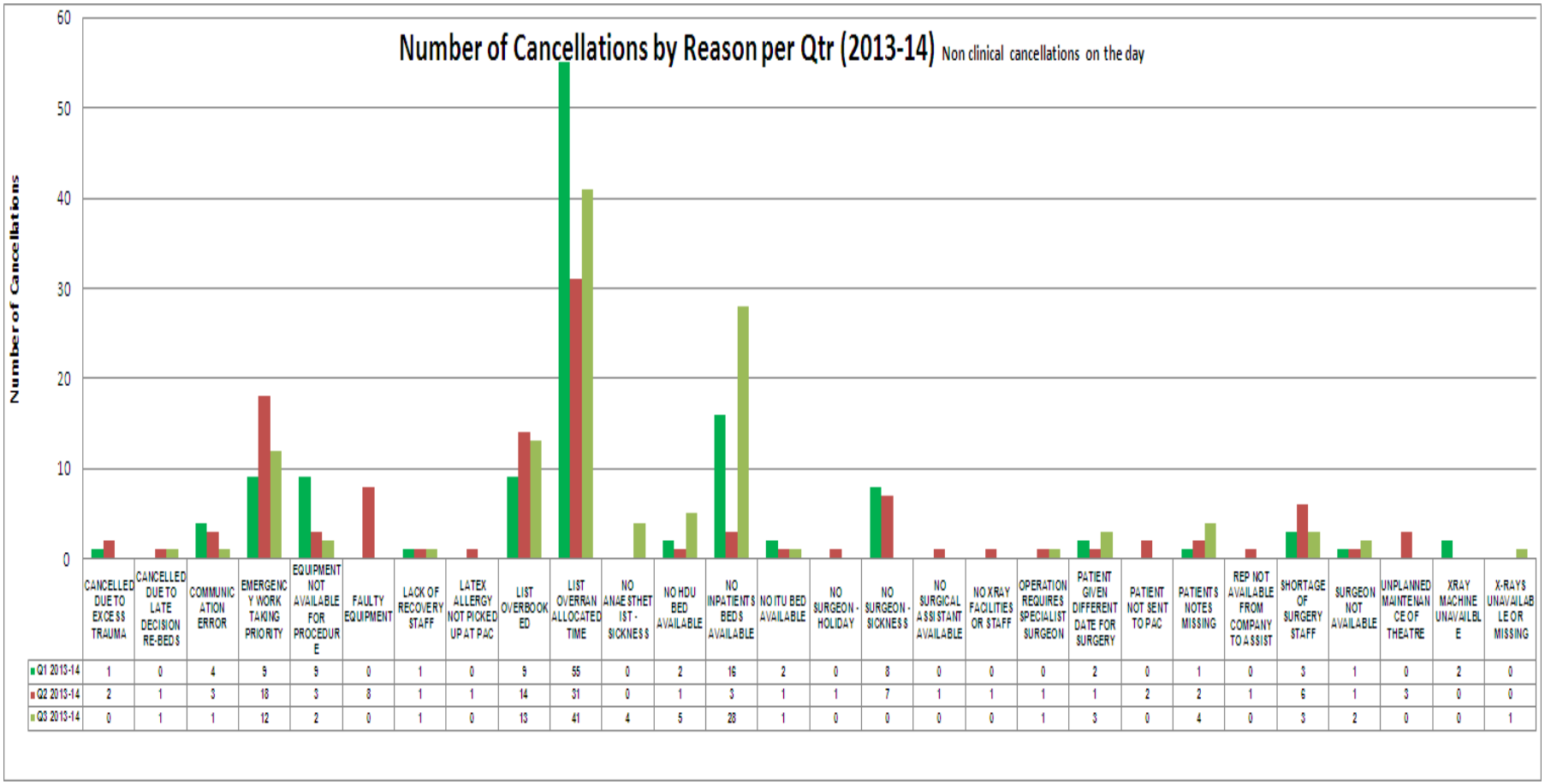
TB 13/14 142 **The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted**

Actions from Trust Board

Last update **24/01/2014**

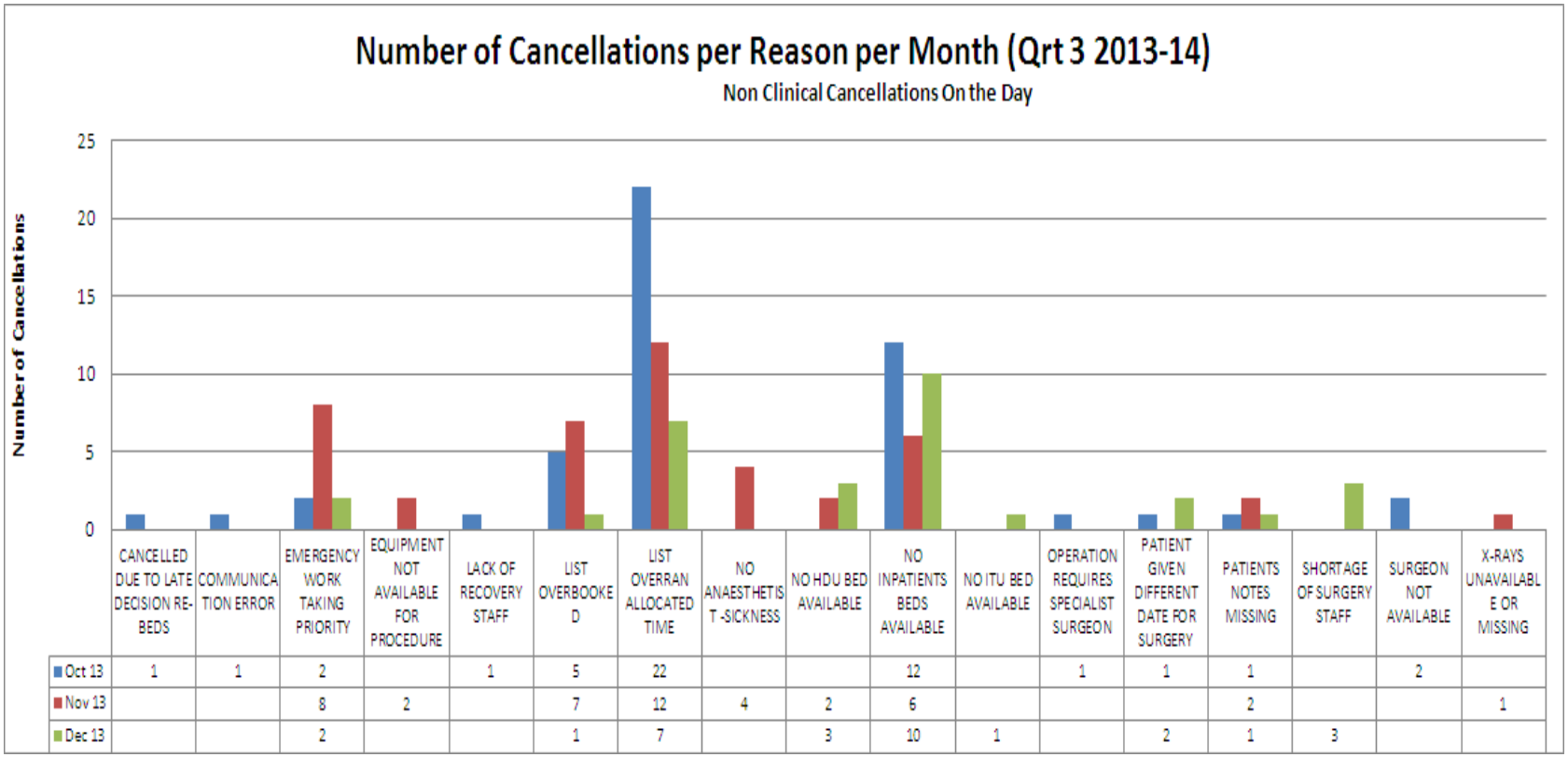
Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
24/07/2013	TB 13/14 072	Risk Management Strategy	The Board requested that the Risk Management Strategy be updated to reflect the agreed changes and presented to the November 2013 Board meeting.	Dr M Wilkinson	28/11/2013	On Track	
24/07/2013	TB 13/14 073	Complaints Annual Report 2012/13	Obtain annual benchmarking data for complaints and share with Board members.	Ms S Loader	30/01/2014	On Track	
28/11/2013	TB 13/14 126	Chief Executive's Report	Provide an update to the Board on progress regarding the introduction of care certificates for Healthcare Assistants	Ms S Loader	27/02/2014	On Track	
28/11/2013	TB 13/14 128	Medical Directors Quality Report	Explore the possibility of presenting benchmarked data for cancelled operations in future performance reports and provide an update to the January 2014 Board meeting.	Mr C Pallot/Dr Wilkinson	30/01/2014	On Track	Benchmarking data appended to this report.
28/11/2013	TB 13/14 130	Infection Prevention Performance Report	Provide benchmarking data for C.Diff and MRSA ceilings comparing the Trust to peers.	Mr C Pallot	30/01/2014	On Track	

KEY	
	Completed or on Agenda
	On Track
	Slippage - to be updated at the Meeting
	Significant Slippage



	CANCELLED DUE TO EXCESS TRAUMA	CANCELLED DUE TO LATE DECISION RE-BEDS	COMMUNICATION ERROR	EMERGENCY WORK TAKING PRIORITY	EQUIPMENT NOT AVAILABLE FOR PROCEDURE	FAULTY EQUIPMENT	LACK OF RECOVERY STAFF	LATEX ALLERGY NOT PICKED UP AT PAC	LIST OVERBOOKED	LIST OVERRAN ALLOCATED TIME	NO ANAESTHETIST - SICKNESS	NO HDU BED AVAILABLE	NO INPATIENTS BEDS AVAILABLE	NO ITU BED AVAILABLE	NO SURGEON - HOLIDAY	NO SURGEON - SICKNESS	NO SURGICAL ASSISTANT AVAILABLE	NO XRAY FACILITIES OR STAFF	OPERATION REQUIRES SPECIALIST SURGEON	PATIENT GIVEN DIFFERENT DATE FOR SURGERY	PATIENT NOT SENT TO PAC	PATIENTS NOTES MISSING	REP NOT AVAILABLE FROM COMPANY TO ASSIST	SHORTAGE OF SURGERY STAFF	SURGEON NOT AVAILABLE	UNPLANNED MAINTENANCE OF THEATRE	XRAY MACHINE UNAVAILBLE	X-RAYS UNAVAILABLE OR MISSING
Q1 2013-14	1	0	4	9	9	0	1	0	9	55	0	2	16	2	0	8	0	0	0	2	0	1	0	3	1	0	2	0
Q2 2013-14	2	1	3	18	3	8	1	1	14	31	0	1	3	1	1	7	1	1	1	1	2	2	1	6	1	3	0	0
Q3 2013-14	0	1	1	12	2	0	1	0	13	41	4	5	28	1	0	0	0	0	1	3	0	4	0	3	2	0	0	1

Enclosure B


Number of Cancellations per Reason per Month (Qrt 3 2013-14)
Non Clinical Cancellations On the Day
Number of Cancellations
25
20
15
10
5
0
CANCELLED DUE TO LATE DECISION RE-BEDS
COMMUNICATION ERROR
EMERGENCY WORK TAKING PRIORITY
EQUIPMENT NOT AVAILABLE FOR PROCEDURE
LACK OF RECOVERY STAFF
LIST OVERBOOKED
LIST OVERRAN ALLOCATED TIME
NO ANAESTHETIST -SICKNESS
NO HDU BED AVAILABLE
NO INPATIENTS BEDS AVAILABLE
NO ITU BED AVAILABLE
OPERATION REQUIRES SPECIALIST SURGEON
PATIENT GIVEN DIFFERENT DATE FOR SURGERY
PATIENTS NOTES MISSING
SHORTAGE OF SURGERY STAFF
SURGEON NOT AVAILABLE
X-RAYS UNAVAILABLE OR MISSING
Oct 13 1 1 2 1 5 22 12 1 1 1 2
Nov 13 8 2 7 12 4 2 6 2 1
Dec 13 2 1 7 3 10 1 2 1 3

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
30 January 2014

Title	Chief Executive's Report
Agenda item	6
Sponsoring Director	Dr Sonia Swart, Chief Executive Officer
Author(s)	Dr Sonia Swart, Chief Executive Officer
Purpose	Information and Assurance
Executive summary The report highlights key business and service developments for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N)
Legal implications / regulatory requirements	No
Actions required by the Board The Board is asked to note the content of the report.	

Enclosure C

Chief Executive's Report to the Trust Board

30 January 2013

The Chief Inspector of Hospital 's Inspection by the Care Quality Commission (CQC)

Over the last three months we have undertaken a programme of work to improve a number of aspects of quality of care and to improve communication with our staff. We have also had a number of focussed development sessions for our Board so that the Board could receive further assurance in relation to our plans for addressing some of our key challenges including , quality governance , nurse staffing levels , mortality , urgent care and our approach to planning for sustainability. A key part of this work has been to galvanise a sense of purpose that underpins all our combined efforts so that we can drive up standards of care in a way that is consistently aligned around the needs of our patients.

Once we were informed during the latter part of November that we were due to have a CQC inspection starting on January 15th, we also developed a programme designed to prepare our staff for this inspection. Initially this took the form of regular informal sessions and this was then followed by an inspection of our services by the Trust Development Authority on December 16th where 13 inspectors visited wards and departments and spoke to patients and staff. This was partly to give us a chance to experience the atmosphere of an inspection. We then held a series of staff briefings and ward and department visits. Our aim was to ensure that we made the most of opportunity provided by the inspection. This was a opportunity to communicate directly with staff and to re-affirm our key overall aims and values as well to talk about the various improvement plans in place.

After the Christmas break and in the week leading up to January 13th, we managed to see about a third of the workforce face to face. During these sessions as well as in the more informal sessions I was struck by the impressive commitment evident in so many of the people who work here. All the executive team have been out in clinical areas speaking to staff and the feedback has been that we have all benefited from this.

I have taken a consistent line in my communications with the workforce and been frank about our problems. I also approached my presentation to and interview with the CQC in the same way. I have however emphasises that I do believe that this is fundamentally a good hospital with many good services and our task is to raise the standard of all services to that of the best.

As part of this approach we held a media briefing on Tuesday 7 January for representatives from BBC Look East, Radio Northampton, the Chronicle & Echo and the Herald and Post to provide some background and context to our CQC inspection.

This resulted in considerable coverage the next day by Radio Northampton, who devoted much of their breakfast show to the theme, including vox pops from street interviewees and listeners' comments about care they had experienced at the hospital. The feedback was

broadly split 50/50 between people who had positive and negative experiences of care at NGH.

The two newspapers both carried articles online and in their weekly Thursday editions – in the case of the Herald & Post, running a front page story and a page two editorial which, although headed 'NGH warns us to be ready for bad news ahead' was quite positive. The editor commented that the interview I had given had been honest and open and this had given him confidence.

The TV interview was broadcast by BBC Look East on Monday 13 January, and featured a section of my interview where I said that it was likely the CQC report would say that some improvements were needed, but believed that these would be issues we had already recognised and were working hard to address. The report also included some vox pops, which were slightly more positive than those broadcast on radio.

The following week's listening event held by the CQC on the eve of the inspection produced more coverage, partly about the fact that the media representatives were initially asked to leave the meeting by the CQC due to concerns about confidentiality. It also gave Radio Northampton another opportunity to ask their listeners for their impressions of the hospital, and again there were examples of very good and very bad care.

The announced component of the CQC inspection took place on January 16 and 17th. These were the busiest days of the winter so far in terms of pressure on urgent care and that gave us a particular challenge. The inspection team visited a wide rage of wards and departments and spoke to patients, carers and staff. The also interviewed a number of Board members and other leads and held a number of focus groups. The early informal feedback confirmed many of our own perceptions relating to the improvements that are underway and also identified some actions that we needed to take. Those actions were dealt with immediately and did not interrupt the running of the hospital. The CQC commented specifically on how well they were received and welcomed by our staff. They were struck by the challenge of our urgent care pressures and impressed with both our desire for improvement and the support for the recent improvements we have made or are committed to making. They also commented that they found significant areas of good practice and had very good engagement from staff in the focus groups. We know we need to accelerate some of our programmes of work if we are to make real progress and ensure the confidence others have in us is not misplaced. We will await the full report which is due to be published in March 2014 but were encouraged by the fact that the so many of our teams were able to contribute to the process and share their enthusiasm.

Peer review Visits

On January 21 we had a peer review visit for Colorectal Cancer and Paediatric Diabetes.

I am pleased to report that these visits went very well and there were comments relating to excellent standards in many components of both of these services. This is a credit to the teams and will I am sure this positive feedback will spur them on to make further improvements. I am particularly proud to report that the excellent comments in relation to both services included very good results in relation to patient focus and experience. I have written to the teams to congratulate them on their good work.

Royal Colleague of Midwifes Annual Midwifery Awards 2014

The Trust is delighted to announce that the NGH Midwifery Team were nominated and shortlisted in the 2014 Royal College of Midwives Annual Midwifery Awards. The awards recognise excellence and innovation in midwifery practice, management, education and research throughout the UK.

The project entitled 'The implementation and impact of a Birth After Caesarean (BAC) Clinic was submitted by Anne Richley and Paula Briody and has been shortlisted for the Pregnacare Award for Excellence in Maternity Care.

Unfortunately, the project did not win the award in this category, but I would like to draw the Board's attention to this tremendous achievement and congratulate the team on being shortlisted.

NGH Financial Position and Planning Challenges

The financial position of the Trust remains challenging and will be even more challenging going into next year. We have worked in partnership with the CCG and the TDA to agree the financial solutions for this year and hope to confirm those arrangements within the next week. We will now need to continue the careful focus on all our cost improvement schemes this year so that we achieve our financial break even duties and then go on to develop a Health Economy agreed programme of work to set out our ambitions for the next 2- 5 years . This work will need to encompass our clinical strategy, our financial strategy and our programme of transformation of care.

Best Possible Care Awards

It is important that we continue to recognise and celebrate what our staff have achieved. This year we are aligning our annual staff awards around the Trust's vision and values, introducing the Best Possible Care Awards. Nominations for the awards will open on 3rd February and be open until 28th February. For the first time we are seeking nominations not only from our staff but also from patients, visitors, carers, our members and members of the public. The awards will be presented at a special ceremony on the evening of Monday 7th April. Award categories are: Clinical Team of the Year; Non-Clinical Team of the Year; the Patient Experience Award; the Patient Safety Award; the Volunteer of the Year; the Unsung Hero Award (clinical); the Unsung Hero Award (non-clinical) and finally the Outstanding Contribution Award.

Criteria have been developed for each of the award categories and nominations must provide specific examples of how, in the nominee's view, the person/team being nominated meets those criteria, which are linked to our core values and strategic objectives.

REPORT TO THE TRUST BOARD
30 JANUARY 2014

Title	Quality Report
Agenda item	7
Sponsoring Director	Dr Mike Wilkinson, Medical Director (Interim)
Author(s)	Dr Mike Wilkinson, Medical Director (Interim) Dr Natasha Robinson, Associate Medical Director Jane Bradley, Patient Safety Programme Director Caroline Corkerry, Deputy Director of Quality and Governance
Purpose	Assurance

Executive summary

- Overall mortality as measured by HSMR remains low (86) and we have maintained our previous improvement. SHMI still remains high (116) but this is expected to improve in the forthcoming months
- Crude mortality remains unchanged at 3.4%
- The Mortality & Coding Review group continue to monitor adverse clinical outcomes.
- Further analysis of the gastrointestinal and liver disease group continues due to apparently high identified mortality in some CCS groups.
- Data quality continues to be addressed by the Data Quality Group.
- The bi-annual notes review of 50 deaths has commenced. Key learning from this will be fed back to SMB, M&M and the Patient Safety academy.
- 35 Serious Incidents (SI) were reported in November & December 2013. 25 of these were pressure ulcers. A thorough action plan for this is being put in place by the tissue viability nurse.
- The themes from SIs are now recorded centrally on health assure and fed back to the directorates and care groups for learning and reflection.
- A new pathway for dissemination of learning to individual, directorate and Care Group level has been developed and will be supported by the introduction of a quality newsletter.

Related strategic aim and corporate objective	Strategic Aim 1
Risk and assurance	High mortality rates and red rated safety indicators
Related Board Assurance Framework entries	BAF 1 & 3

Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Board

To note the report.

Medical Director's Quality Report

Section 1

Review of current mortality and safety data provided by Dr Foster

1. Introduction

This paper provides a summary of mortality and safety information provided by Dr Foster Intelligence to end October 2013 and SHMI (to March 2013, unchanged from previous report).

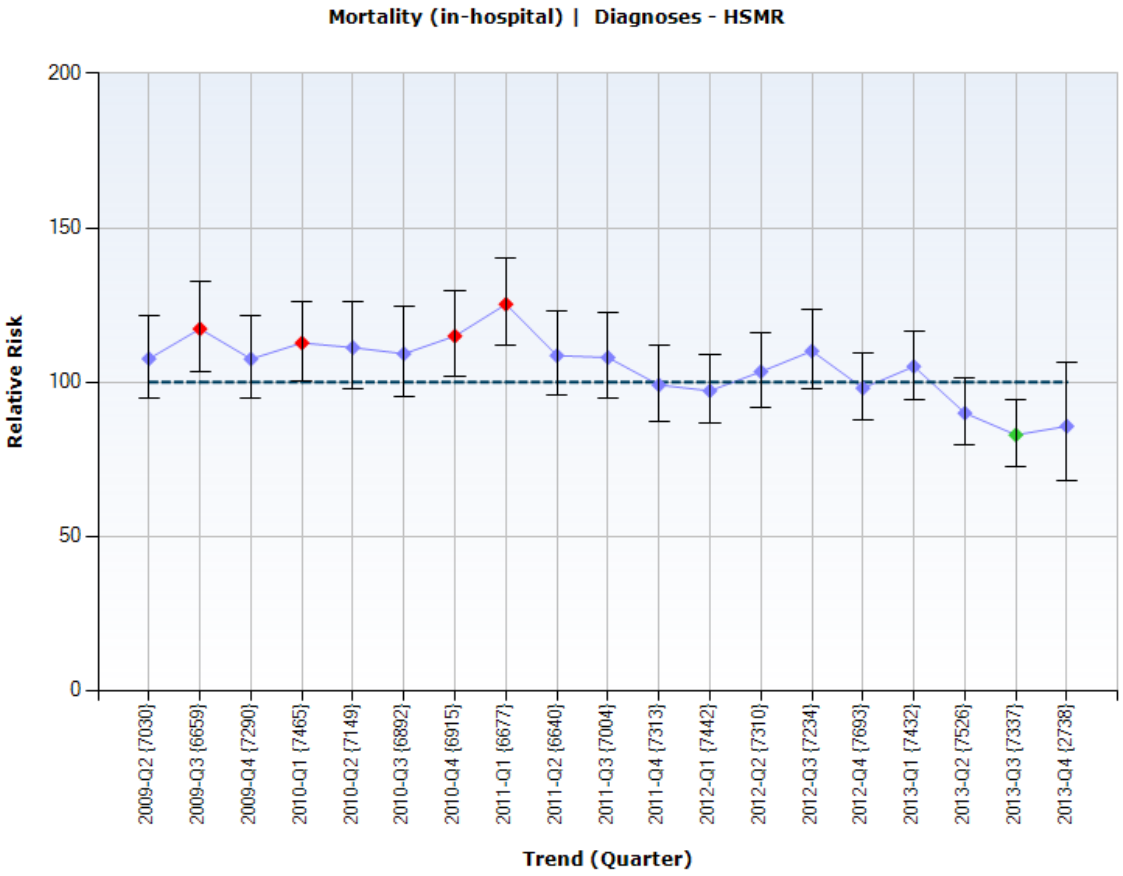
2. Current Position HSMR (Hospital Standardised Mortality Ratio, Dr Foster Intelligence)

HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its use continues. It is based on mortality in 56 CCS (Clinical Classification Software) groups. These diagnosis groups account for 80% of hospital mortality and are recognised as having reliable predictive mortality. The remaining 200 groups account for the remainder. They are not included in HSMR as predictive risk modelling for these small volume diagnoses is not as reliable. At NGH there is a detailed monitoring process which tracks HSMR and investigates individual diagnoses who's SMR (standardised mortality ratio) is persistently adverse. Where the term HSMR is used this refers to the previously defined group. Where all groups are included, the term HSMR 100 is used.

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

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

The following graph shows the sustained improvement in HSMR by quarter since 2011:



3. HSMR Comparison

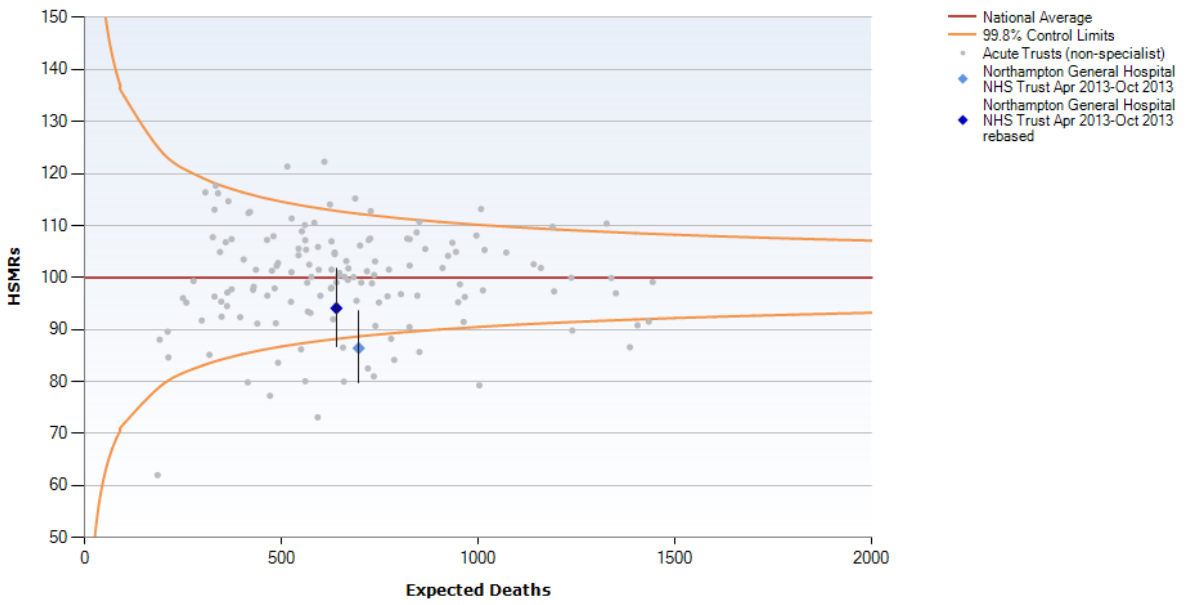
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture.

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 8 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for the rolling year to date is **93** and for 2013-4 is **86** (**94** when rebased). Previous improvement is maintained.

Crude mortality for 2013-4 is currently unchanged at 3.4%, showing marked improvement as compared to 2012-3 (4.2%) and one of the 3 lowest in East Midlands. The current average for Trusts in East Midlands is 3.8% (range 3.4% - 4.5%).

Acute Trust HSMRs Apr 2013-Oct 2013

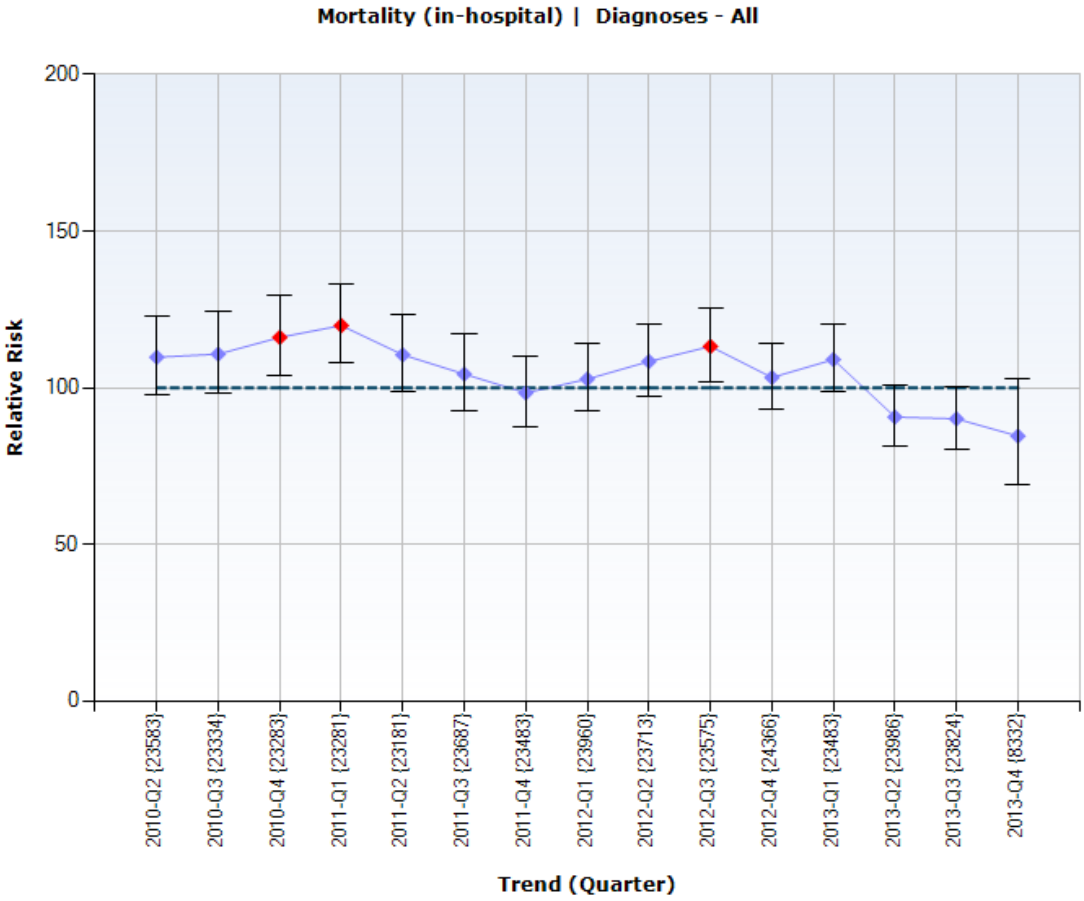
The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England.

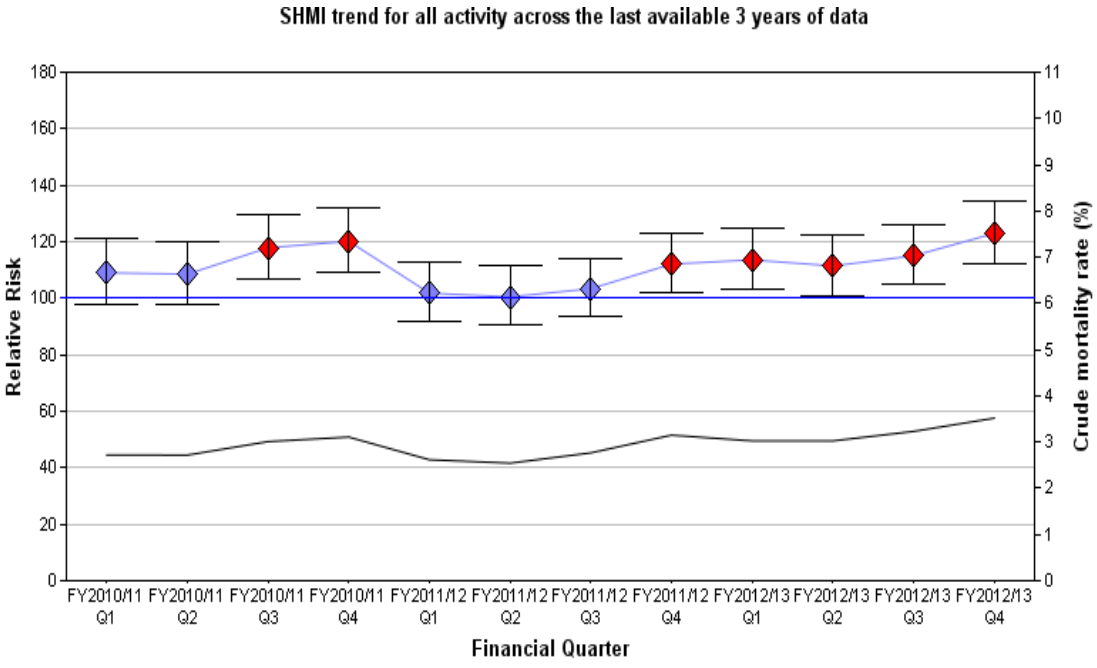


4. Standardised Hospital Mortality Indicator (SHMI)

There has been no further SHMI data release since the last report to Board. The most recent data release (to end March 2013) shows SHMI for 2012-3 at **115.8**. HSMR for the same period was **104.** The marked divergence between the 2 remains a concern especially because SHMI data is not available for analysis to identify areas of poor performance. It is likely that the some of the discrepancy can be attributed to the lack of allowance for palliative care for the hospice admissions to the community wards, and the less discriminating methodology used by SHMI which includes all CCS groups. For this reason SHMI more closely tracks HSMR 100, and so is expected to show very marked improvement over the next 2 quarters. Meanwhile all possible areas of risk indicated by SHMI are being monitored to ensure that there is evidence of improvement in 2013-4 (using Dr Foster) and investigated where this is not the case.

The graphs below shows HSMR 100 to end October 2013 compared to SHMI to end March 2013


Mortality (in-hospital) | Diagnoses - All
Relative Risk
200
150
100
50
0
2010-Q2 (23583)
2010-Q3 (23334)
2010-Q4 (23283)
2011-Q1 (23281)
2011-Q2 (23181)
2011-Q3 (23687)
2011-Q4 (23483)
2012-Q1 (23960)
2012-Q2 (23713)
2012-Q3 (23575)
2012-Q4 (24366)
2013-Q1 (23483)
2013-Q2 (23986)
2013-Q3 (23824)
2013-Q4 (8332)
Trend (Quarter)


SHMI trend for all activity across the last available 3 years of data
Relative Risk
Crude mortality rate (%)
180
160
140
120
100
80
60
40
20
0
11
10
9
8
7
6
5
4
3
2
1
0
FY2010/11 Q1
FY2010/11 Q2
FY2010/11 Q3
FY2010/11 Q4
FY2011/12 Q1
FY2011/12 Q2
FY2011/12 Q3
FY2011/12 Q4
FY2012/13 Q1
FY2012/13 Q2
FY2012/13 Q3
FY2012/13 Q4
Financial Quarter

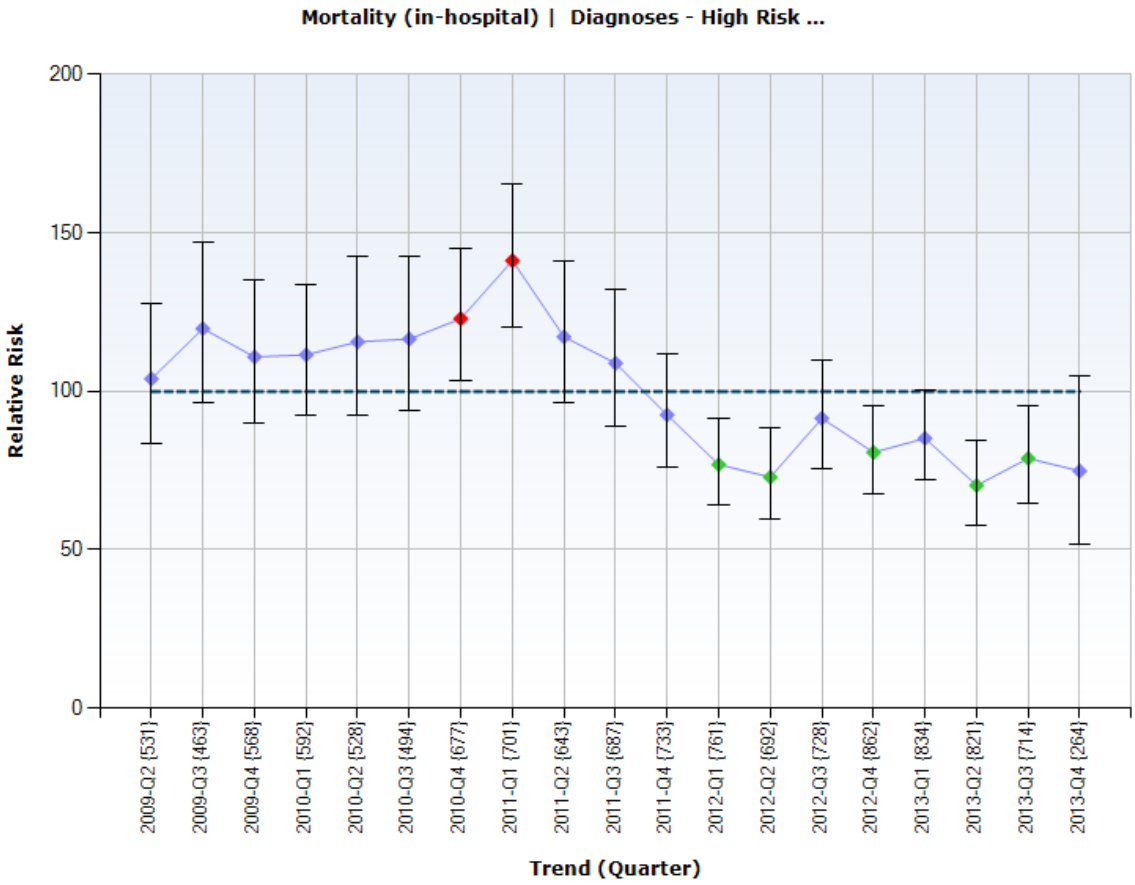
Dr Foster Patient Safety Indicators (September 2012-October 2013)

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

There are no significantly adverse patient safety indicators for the rolling year to date.

6. Reports on key areas for action or of importance

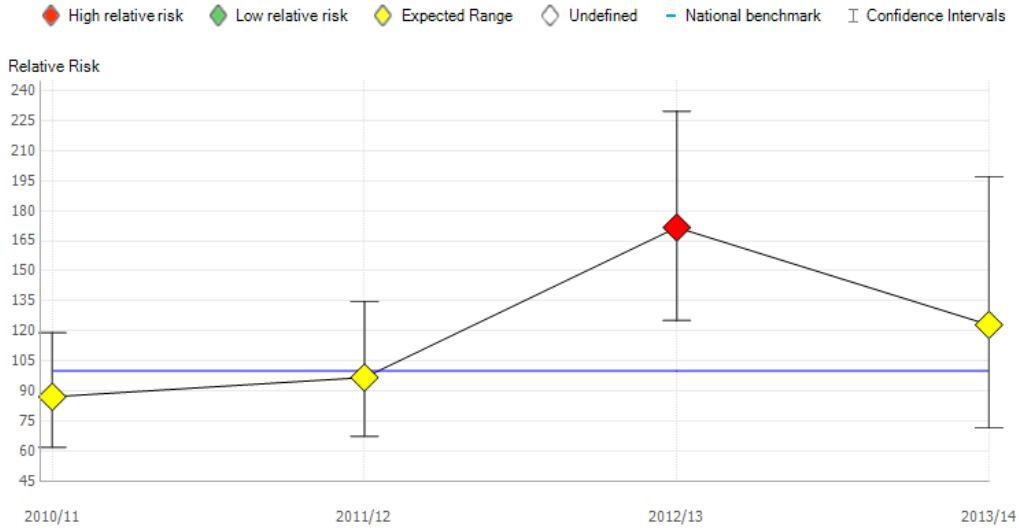
Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for 2013-4 at **74**.



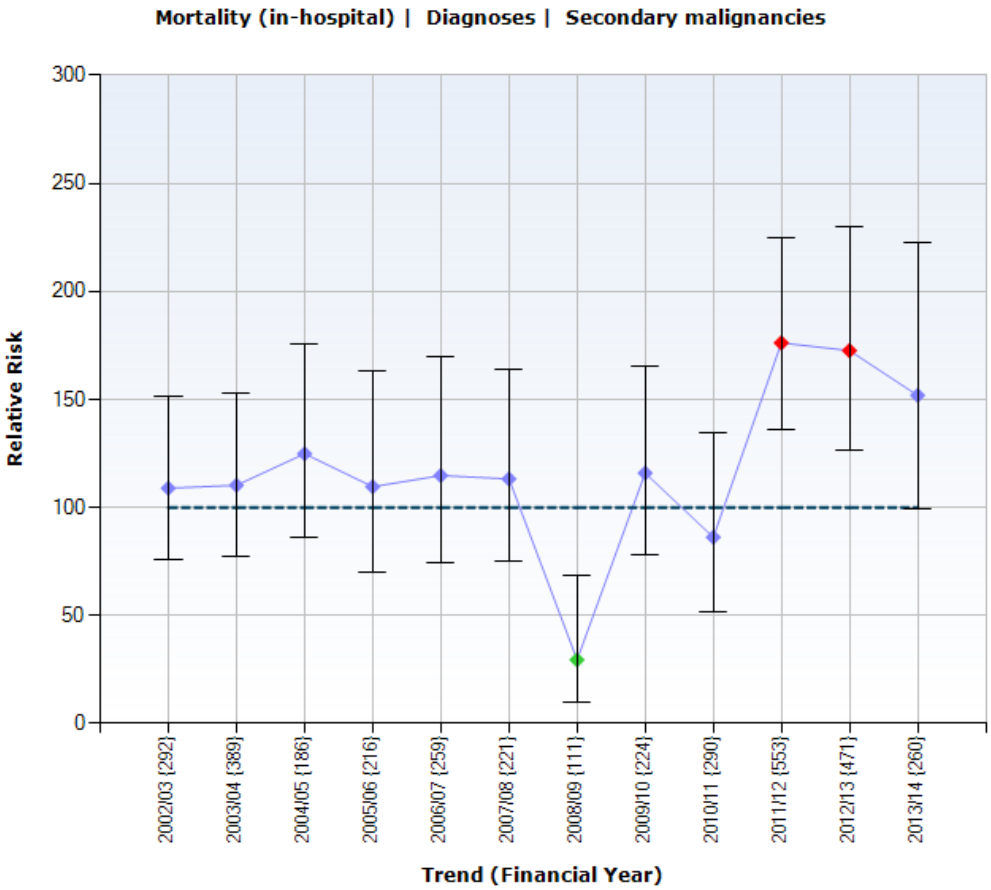
SMR for both fractured neck of femur (**63**) and heart failure (**83**) have shown very marked improvement in 2013-4.

7. Possible areas for concern under investigation

Perinatal mortality: Overall performance for the perinatal period is returning towards normal. All perinatal deaths are being reviewed. Monthly monitoring will continue until performance is sustained within the normal range.



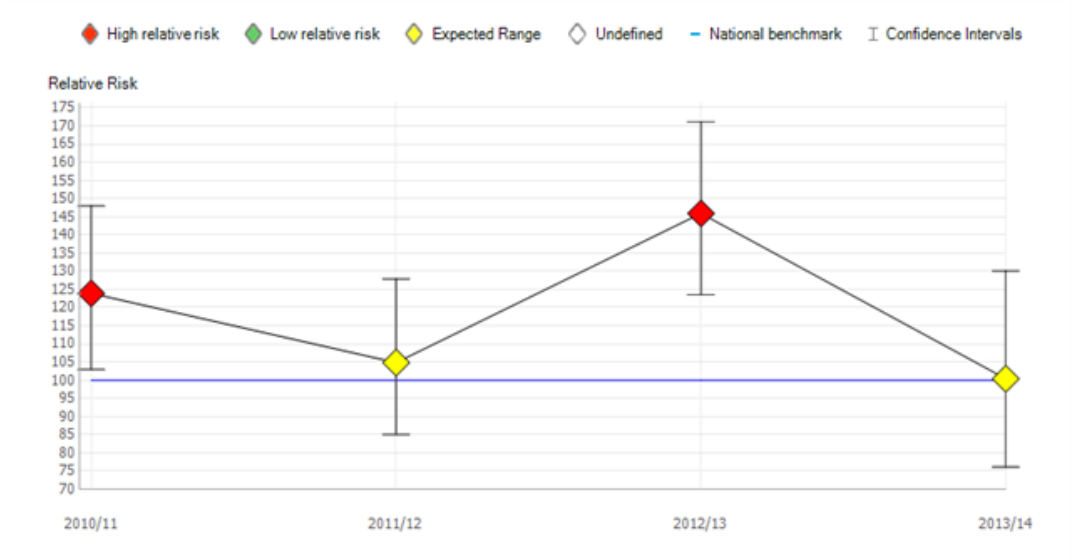
Secondary malignancy: Despite a previous review and actions planned, there has been no significant improvement. A further review of deaths occurring in oncology has been requested and will report to Mortality & Coding Review Group in May.



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

CQC: Further analysis of the large diagnosis group for gastrointestinal and liver disease has been undertaken following the alert notified by the CQC.

Overall mortality for this large diagnosis group has returned to normal in 2013-4 to date, however there are some CCS groups within it which show a higher than expected mortality, some of which have been previously identified, and all of which require further work.



A project plan to review the whole group has been drawn up to focus on:

- Emerging areas of adverse performance (constipation in the frail patient, bowel perforation)
- Relevant national audits (National Emergency Laparotomy Audit, NCEPOD 'Gastrointestinal Haemorrhage')
- Revisiting previous areas of adverse performance showing deterioration (biliary tract disease and procedures)
- Individual case note review for deaths with a low (<10%) predicted mortality (28 cases April-October 2013)

This will be completed over the next 3-6 months as part of routine Dr Foster monitoring, directorate M&M, and reports to Mortality & Coding Review Group.

During the CQC visit there was detailed scrutiny of the overall methodology for identifying and understanding mortality concerns within the organisation. A second visit by the TDA took place one month prior to the CQC visited and noted substantial progress in this area, as compared to the visit 2 months prior.

9. Further actions in place or planned:

The Trustwide mortality review group is scheduled to meet 6 times in January/February to review 50 random selected case notes of those patients who died during July. 12 consultants/specialty doctors of different specialties are currently undertaking case note reviews for presentation and discussion. Feedback will be provided to individual clinicians. The final report will be available in June 2014, and the process will be repeated the following month.

Data Quality (to end December 2013):

The data quality steering group continues to meet to monitor coding and data quality. Concerns related to the accuracy of theatre data have been identified as an action for follow up. A generic email address is available for clinicians and others to communicate data quality queries & concerns.

10. Serious Incidents

This report covers the period 1 November – 31st December 2013

- 35 Serious Incidents were reported
- 13 Serious Incidents were submitted for closure
- The delays in confirming and externally reporting Serious Incidents has improved significantly
- Quarter 3 serious incident reporting rate - 1.7% (Q2 = 0.5% - national average 1%), if this trend continues in Quarter 4 it will highlight the Trust as an outlier when the national data is published by the NRLS in September 2014
- The Management of Incidents (including Serious Incidents Policy) has been reviewed and is currently out for consultation. Due to be ratified February 2014
- All action plans from Serious Incidents in 2012 and 2013 have been uploaded onto Health Assure which will provide a more robust process for the monitoring of action plans and the submission of evidence of implementation
- The Patient Safety Academy carried out a thematic review and gap analysis on all Serious Incident action plans in 2011/12. A paper outlining the findings is due to be presented at the Integrated Healthcare Governance Meeting in February 2014
- Work will be on-going with the Care Groups in Quarter 4 to upload evidence of completion to Health Assure for all 2013 Serious Incident action plans.
- A clear pathway for the dissemination of lessons learnt at individual, Directorate/Department; Care Group; Trustwide and the wider health economy levels will be rolled out in February 2014
- It is proposed to launch 'The Quality Street' a quarterly staff newsletter aimed at improving the distribution of information pertaining to patient safety and quality, which will include lessons learnt from Serious Incidents, to commence February 2014

1. Introduction

The Board is aware of its responsibilities in relation to patient safety and promoting a culture of learning from any untoward incidents. This report allows the Board to meet these responsibilities by providing an update in relation to any new serious incidents and information regarding the learning in closed cases.

2. Background

A Serious Incident is classified as an event that has caused, is likely to cause, or has the potential to cause serious patient harm. The organisation has a responsibility to investigate and where appropriate learn and take corrective action in response, to mitigate the potential for any future incidents and also to report such incidents to the Nene and Corby Clinical Commissioning Group (CCG) and the Strategic Executive Information System (STEIS)

The Serious Incident (SI) Action Log is used to monitor the submission dates of the completed investigation reports to ensure compliance with Nene and Corby Clinical Commissioning Group (CCG) deadlines. The progress of all Serious Incidents is monitored via the Trust Serious Incident Group (SIG) which meets weekly. This consists of the Medical Director, Associate Medical Director, Senior Risk and Litigation Manager, Patient Safety Programme Director, Deputy Director Governance, Litigation Manager. The Patient Safety Lead for the workstream "Learning and Sharing Successes and Failures" also attends.

2.1 New SIs

Since the last report to the Board, and within the reporting period 1 November – 31 December 2013, 35 new Serious Incidents have been reported.

The following table illustrates the Serious Incidents by Datix category:

Category	Number	Comments
Implementation of care	25	22 x Hospital acquired Pressure Ulcers (2 of which occurred in Sept; 6 in October; 9 in November; 5 in December) The investigation will identify whether the ulcers are deemed to be avoidable or unavoidable
		Neonatal death
		Missed fracture
		Deterioration of a patient
Accident which may result in personal injury	5	5 x #NOF 4 of which occurred in November and 1 in December
Clinical assessment	2	Clinical assessment in A&E
Screening	1	Antenatal screening issue
Access, appointment, admission, transfer, discharge	1	Patient discharged from A&E at NGH. 2 hours later presented at KGH. RIP
Diagnosis failed or delayed	1	Missed a #shoulder

2.2 Closed Serious Incidents

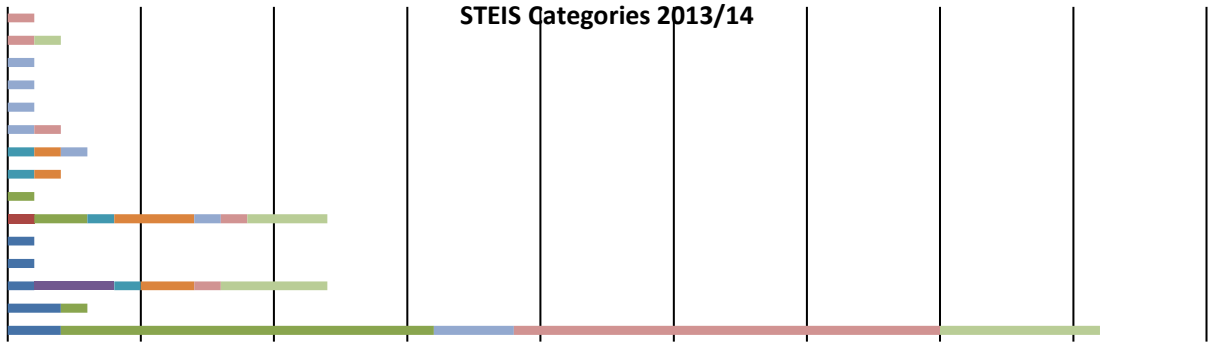
During the reporting period 13 Serious Incidents were submitted for closure:

- 3 patients who suffered fractured neck of femur following a fall
- Patient absconded from ward
- Implementation of care following a road traffic accident
- 2 patients sustained Grade 3 pressure ulcer - deemed to be avoidable
- 2 patients sustained Grade 3 Pressure Ulcers. The investigations found that the ulcers were unavoidable and have therefore requested that the incident be downgraded
- Attempted suicide in A&E
- Stillbirth
- Premature discharge from A&E – unexpected death
- SOVA/CQC concerns on Brampton Ward. The investigation found that this did not fit the remit of an SI and the concerns had been addressed. Request has been made to downgrade the incident

2.3 Active Serious Incidents

As at the 31st December 2013 there were 39 active Serious Incidents investigation underway.

Table 1: Serious Incident Categories reported onto STEIS by Month 2013/14



	Pressure Ulcer Grade 3	Pressure Ulcer Grade 4	Slip,trips, falls	Outpatient appoint-ment delay	Healthcare acquired infection	Un-expected death	Child death	Sub-optimal care	Adverse media coverage	Premature discharge	Maternity Services	Attempted Suicide	Drug incident	Other	Screening issues
April	2	2	1	1	1										
May						1									
June	14	1				2	1								
July			3												
August			1			1		1	1						
Sept			2			3		1	1						
Oct	3					1			1	1	1	1	1		
Nov	16		1			1				1				1	1
Dec	6		4			3								1	

2.4 STEIS Extension Submission Requests

During the reporting period two extensions were requested due to the unexpected leave of the two investigation leads.

2.5 Serious Incident Reporting Rate

There were 2599 patient safety incidents reported in Quarter 3, 44 of which were declared and investigated as a Serious Incident. This represents a reporting rate of 1.7%, which is over the national average of 1%. This data will be reported with Quarter 4's figures in the National Reporting and Learning Set (NRLS) data when it is published in September 2014.

A serious incident reporting rate of 1.7% represents a significant increase. In Quarter 2, there were 2744 patient safety incidents reported, 14 of which were serious incidents, representing a reporting rate of 0.5%. The rise in serious incidents in Quarter 3 is attributable to the number of pressure ulcers reported (25 reported in Quarter 3 whereas no Grade 3 or 4 pressure ulcers were reported in Quarter 2). It is thought that the increase in the number of pressure ulcers reported as serious incidents is due to the more

robust validation process implemented by the Tissue Viability Team which suggests that the Trust were under reporting in the past.

Whilst it is thought that the rise in the number of serious incidents in Quarter 3 is as a result of pressure ulcer incidents from the preceding quarter being re-validated and reported in Quarter 3, the situation needs to be closely monitored in Quarter 4 to identify if the figures being uploaded to the NRLS will highlight the Trust as an outlier when the national data is published in September 2014.

2.6 Duty of Candour (Being Open)

From 1st April 2013 the Trust has a contractual "Duty of Candour" to inform the patient (or family/ carer in the event of a patient not having capacity) that an actual or suspected patient safety incident, which has resulted in moderate/ severe harm or death, has occurred. This notification must take place within 10 days of the incident being reported on the local system (Datix) and should be face to face where possible.

There is on-going discussion with the CCG and nationally to decide how compliance with the Duty of Candour is going to be monitored. Initially the CCG will only be assessing whether the Duty of Candour has been met for incidents which are classified as a Serious Incidents. Evidence of compliance will be reviewed at the quarterly Serious Incident Assurance Meeting (SIAM).

The current process for demonstrating compliance with the Duty of Candour is via the dedicated field within the Datix incident report. In regards to the Serious Incidents declared during the reporting period, all patients/family were informed of the incident and this was confirmed on the Datix system.

On commencement of a Serious Incident investigation the patient, or next of kin, are advised that an investigation is being undertaken and that upon completion a report will be submitted externally to our Commissioner for their approval and sign off. The patient, or next of kin, is advised that the findings of the investigation will be made available to them via a report. Following the investigation completion the patient, or next of kin, are given the opportunity to attend a 'Being Open' meeting where the investigation and its findings are discussed with appropriate Trust staff.

During the reporting period no Being Open meetings relating to closed Serious Incidents were held.

2.7 Key Learning and Service Improvements

The systematic investigation of Serious Incidents results in important lessons being learned and improvements identified and implemented. These improvements support the embedding of an effective safety culture thus allowing the delivery of high quality, safe patient care.

The table below shows the learning/actions identified from the Serious Incidents submitted during the reporting period.

Grade 3 Pressure Ulcers	
Theme	Learning / Actions
Documentation	Documentation of pressure areas should be more specific, highlighting each area of the body separately Turn charts to be maintained in accordance with patients' needs
Clinical Assessment	Ensure all areas of body have been observed Staff to check and document all patients skin integrity per shift
Training	Tissue Viability Team to arrange further training and develop evidence of learning/ implementation to practice (competency)
Sharing of Lessons Learnt	Ward Sisters to discuss in Team Brief
Attempted Suicide	
Theme	Learning / Actions
Policy / Procedure / Process	At the moment a SAD score and physical description must be taken at triage / first assessment in A&E. Consider the use of a revised assessment tool / protocol to aid A & E staff in psychiatric assessment of patients Referral pathway - A & E / Crisis Team need to discuss and clarify the arrangements for the most appropriate referral pathway for patients needing urgent psychiatric assessment
Multi-disciplinary / professional working	There needs to be further discussion with NHSfT to establish who has overall responsibility for patients who attend A & E with the sole purpose of being reviewed by the Crisis Team
Stillbirth	
Theme	Learning / Actions
Policy / Procedure / Process	Appropriate referral of women in line with the Antenatal care Pathway Ensure that staff are familiar with the current guidelines used in the Maternity Services.
Documentation	Ensure accurate population of the data of previous births for the generation of the Customised Growth chart (CGC)
Communication	Ensure effective communication – verbal and written – between staff regarding the women and their plans of care
Premature Discharge	
Theme	Learning / Actions
Clinical Assessment	Ensure that elderly patients presenting with head injury deemed fit for discharge have repeat observation and assessment of safety in mobility
Documentation	Any discussions with T&O on head injury advice/ observation or discharge must be documented in A&E notes
Policy / Procedure / Process	Rewrite and re-launch the reversal of Warfarin guidelines for patients with intracranial haemorrhage

Fall resulting in fractured neck of femur	
Theme	Learning / Actions
Clinical Assessment	All high risk patients should have Urine Dip and Lying & Standing BP recorded on admission and on a weekly basis thereafter if they continue to be high risk. This should help identify patients who are at an increasing risk of falls and of postural hypotension/infection.
Medical Equipment	All staff need to be aware of where the falls chair and bed alarms for high risk patients are kept on ward.
Staffing	Ward staff have historically taken their breaks in pairs during the night shift. This does not allow for safety of patients on the ward and makes ensuring patient safety very difficult. This has now stopped
Documentation	Any discussions with T&O on head injury advice/ observation or discharge must be documented in A&E notes
Policy / Procedure / Process	Increase the awareness of processes to follow post fall and of importance regularly reviewing falls care plan.
Sharing of lessons learnt	Learning from previous falls needs to be shared in more robust manner with all members of the team. Even if this risk is low-moderate and no further action required at the time of investigation ALL falls on Holcot ward to be shared with team at monthly meetings.
Implementation of Care following RTC	
Theme	Learning / Actions
Staffing	Review of ED consultant call-in criteria Locum A&E middle grades working unsupervised shifts should have current ATLS. Where this cannot be achieved the shift leader and ED consultant on-call should be aware
Policy / Procedure / Process	Review of Trauma Call Criteria Review of ED locum induction packs
Training	Quarterly simulations sessions with maternity team In-house training All staff to be made aware of the importance of uterine displacement in 3rd trimester

Patient absconded from ward	
Theme	Learning / Actions
Clinical Assessment	There needs to be a ward based focus on the need to undertake formal assessment of a patient's mental capacity if signs of confusion or agitation are present. Reiteration of patient focused care looking at the whole individual rather than focusing on presenting clinical condition
Documentation	Education to improve the quality of the content of patient documentation and escalation processes regarding a patient's condition by all levels of staff
Training	Education of staff in relation to safeguarding vulnerable adult's processes and the recognition of a vulnerable adult

Serious Incident Policy

The National Framework for reporting serious incidents was revised and published in March 2013 and as such NHS Nene and NHS Corby Quality Committee revised its Policy to take into consideration these standards. The Policy was ratified in May 2013 and the document contains further criteria for the reporting of serious incidents. The Trust's Serious Incident Policy was not due for review until October 2014. However; as it is no longer consistent with the National Framework or the CCG, it is has been rewritten to reflect these changes. The revised Policy has been circulated for consultation and is expected to be ratified by the Procedural Document Group in Quarter 4.

Learning lessons from Serious Incidents

The Management of Incidents (including Serious Incidents) Policy includes a clear pathway for the dissemination of lessons learnt at individual, Directorate/Department, Care Group, Trustwide and the wider health economy levels. The pathway (attached) will be rolled out in February 2014.

In order to ensure wider distribution of information pertaining to patient safety and quality, which will include lessons learnt from Serious Incidents, the Trust will be producing a quarterly staff newsletter called 'The Quality Street'. The first newsletter is planned for publication in February 2014.

Action Plans

All action plans from Serious Incidents in 2012 and 2013 have been uploaded onto Health Assure. The expectation will be that the action plan implementation will be monitored through the Care Groups to ensure that lessons learnt are implemented. This will allow for further thematic analysis to be undertaken across all serious incidents together with a more robust process for the monitoring of action plan and the submission of evidence of implementation.

The Patient Safety Academy has undertaken a thematic review and gap analysis on all Serious Incident action plans in 2011/12. A paper outlining the findings is due to be presented at the Integrated Healthcare Governance Meeting in February 2014

Work will be on-going in Quarter 4 to upload evidence of completion for all 2013 Serious Incident action plans.

3. Assessment of Risk

The delays in confirming and externally reporting Serious Incidents reported in the October and November 2013 Board Report has improved significantly; however the process will require further embedding to ensure that the Trust continues to meet the timeframes recommended by the NHS England National Serious Incident Framework (March 2013).

Quarter 3 serious incident reporting rate - 1.7% (Q2 = 0.5% - national average 1%), if this trend continues in Quarter 4 it may pose a potential reputational risk to the Trust when the national data is published by the NRLS in September 2014

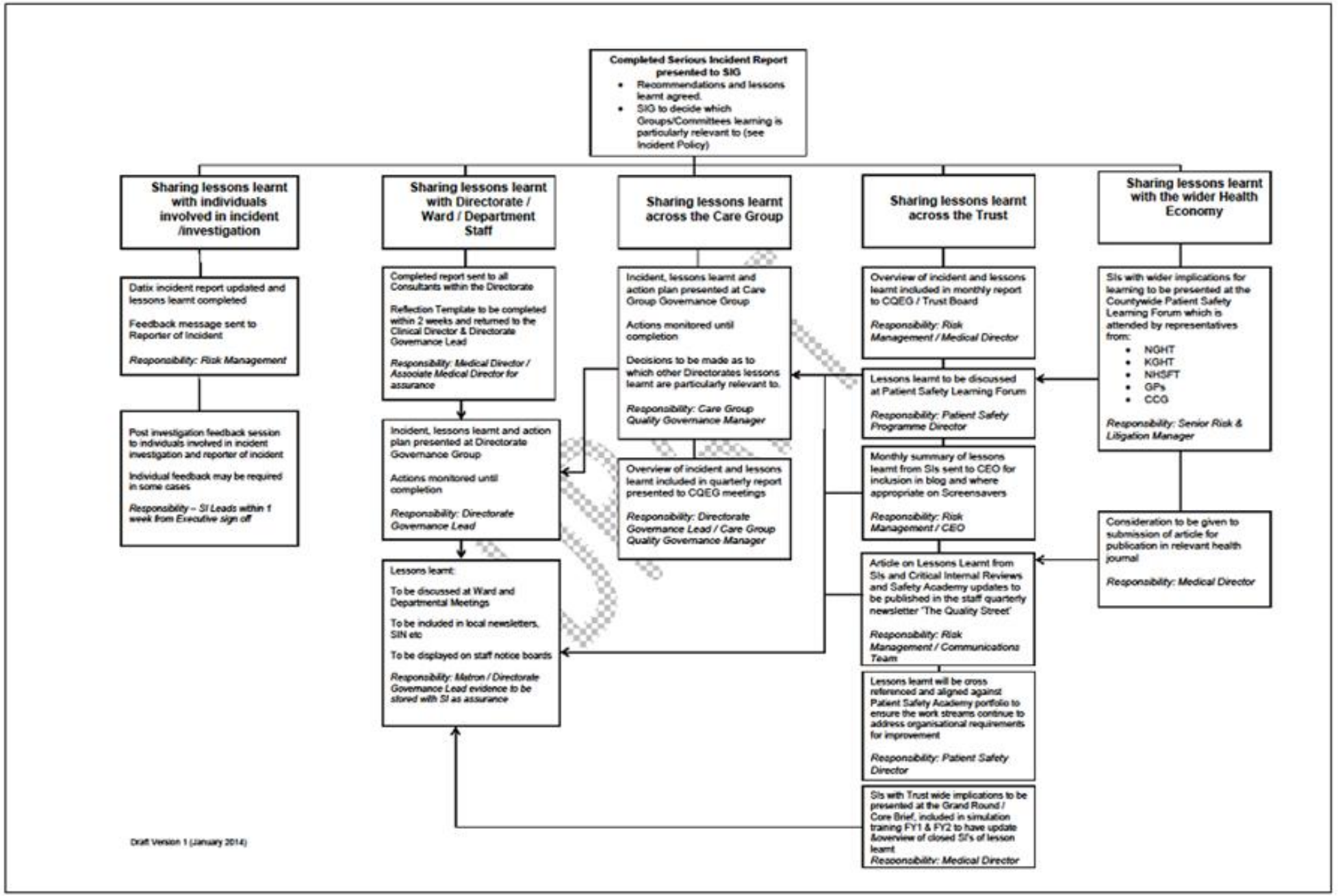
4. Recommendations/Resolutions Required

Actions to mitigate the potential risks are as follows:

- The Serious Incident Group continues to meet weekly to expedite the agreement & external notification of Serious Incidents (SI).
- A process flow chart has been developed to support identification, confirmation and external reporting of Serious Incidents in a timely manner to meet external reporting requirements.
- Meetings have been held with the Care Group Quality Managers to ensure they understand and are supporting the agreed process.
- The Senior Tissue Viability Nurse is validating all pressure ulcers to ensure correct reporting of Grade 3 and 4 pressure ulcers

5. Next Steps

The Board are requested to note the content of this report and endorse the proposed action


Completed Serious Incident Report presented to SIG
Recommendations and lessons learnt agreed.
SIG to decide which Groups/Committees learning is particularly relevant to (see Incident Policy)
Sharing lessons learnt with individuals involved in incident /investigation
Datix incident report updated and lessons learnt completed
Feedback message sent to Reporter of Incident
Responsibility: Risk Management
Post investigation feedback session to individuals involved in incident investigation and reporter of incident
Individual feedback may be required in some cases
Responsibility – SI Leads within 1 week from Executive sign off
Sharing lessons learnt with Directorate / Ward / Department Staff
Completed report sent to all Consultants within the Directorate
Reflection Template to be completed within 2 weeks and returned to the Clinical Director & Directorate Governance Lead
Responsibility: Medical Director / Associate Medical Director for assurance
Incident, lessons learnt and action plan presented at Directorate Governance Group
Actions monitored until completion
Responsibility: Directorate Governance Lead
Lessons learnt:
To be discussed at Ward and Departmental Meetings
To be included in local newsletters, SIN etc
To be displayed on staff notice boards
Responsibility: Matron / Directorate Governance Lead evidence to be stored with SI as assurance
Sharing lessons learnt across the Care Group
Incident, lessons learnt and action plan presented at Care Group Governance Group
Actions monitored until completion
Decisions to be made as to which other Directorates lessons learnt are particularly relevant to.
Responsibility: Care Group Quality Governance Manager
Overview of incident and lessons learnt included in quarterly report presented to CQEG meetings
Responsibility: Directorate Governance Lead / Care Group Quality Governance Manager
Sharing lessons learnt across the Trust
Overview of incident and lessons learnt included in monthly report to CQEG / Trust Board
Responsibility: Risk Management / Medical Director
Lessons learnt to be discussed at Patient Safety Learning Forum
Responsibility: Patient Safety Programme Director
Monthly summary of lessons learnt from SIs sent to CEO for inclusion in blog and where appropriate on Screensavers
Responsibility: Risk Management / CEO
Article on Lessons Learnt from SIs and Critical Internal Reviews and Safety Academy updates to be published in the staff quarterly newsletter 'The Quality Street'
Responsibility: Risk Management / Communications Team
Lessons learnt will be cross referenced and aligned against Patient Safety Academy portfolio to ensure the work streams continue to address organisational requirements for improvement
Responsibility: Patient Safety Director
SIs with Trust wide implications to be presented at the Grand Round / Core Brief, included in simulation training FY1 & FY2 to have update &overview of closed SI's of lesson learnt
Responsibility: Medical Director
Sharing lessons learnt with the wider Health Economy
SIs with wider implications for learning to be presented at the Countywide Patient Safety Learning Forum which is attended by representatives from:
NGHT
KGHT
NHSFT
GPs
CCG
Responsibility: Senior Risk & Litigation Manager
Consideration to be given to submission of article for publication in relevant health journal
Responsibility: Medical Director
Draft Version 1 (January 2014)

Section 2

NGH Monthly Quality Exception Quality Scorecard – October

Introduction

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

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

Performance is reported by exception, i.e. where performance is below standard (red), where specific pressures that present a risk to the on-going achievement of any of the standards or where there are high profile issues. Commentary and associated actions are provided against the identified non-compliant indicators.
HSMR and SMR by diagnosis group are reported as year to date. A continual process of refinement of indicators remains as working progress.

Performance

The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. Progress is monitored against **146** indicators.

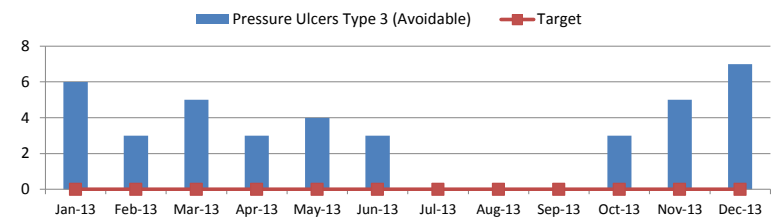
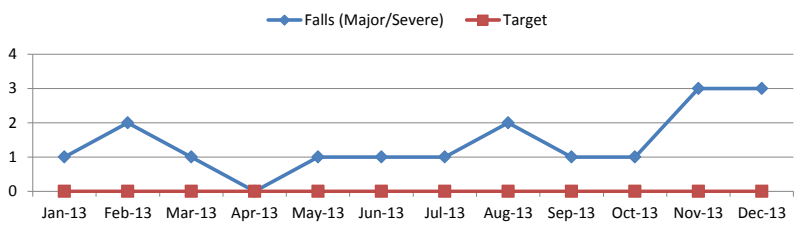
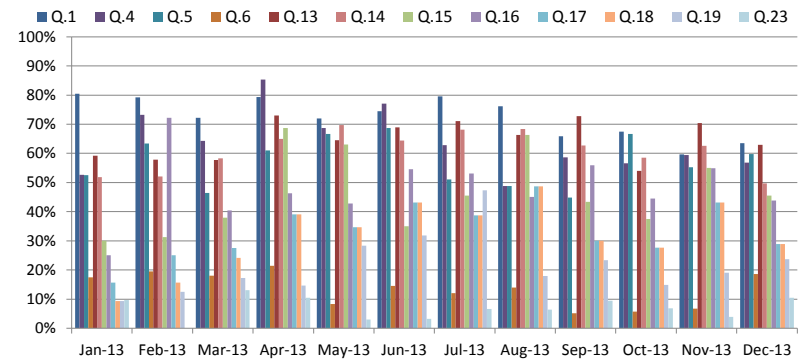
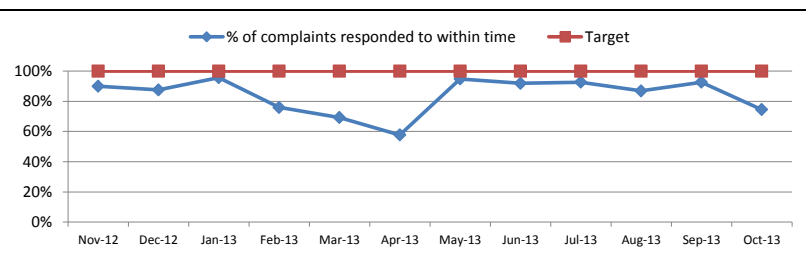
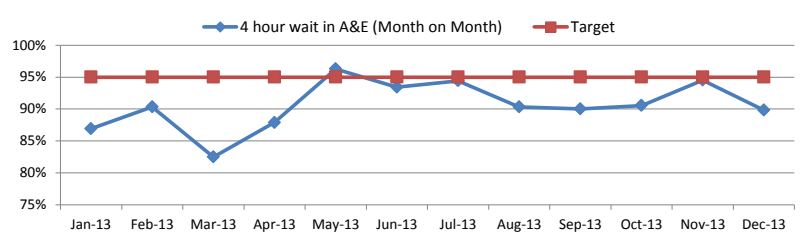
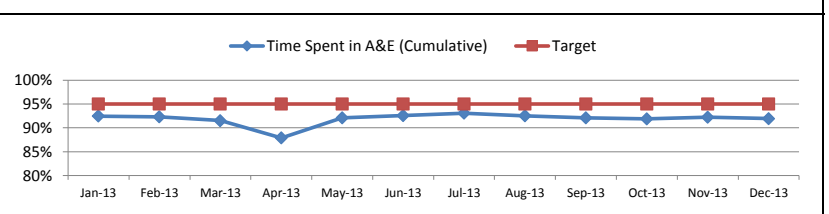
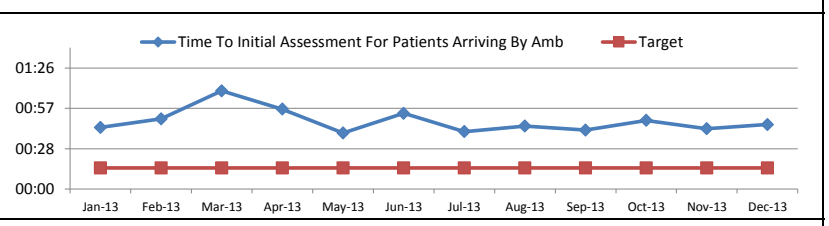
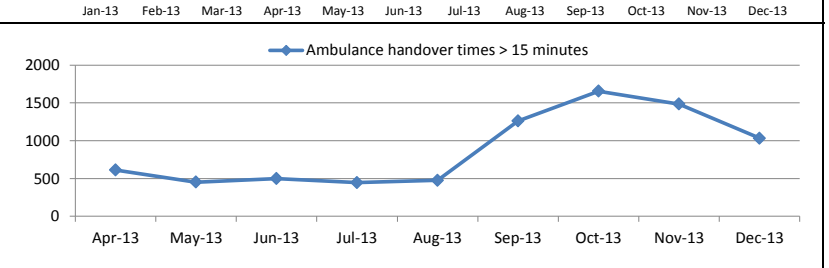
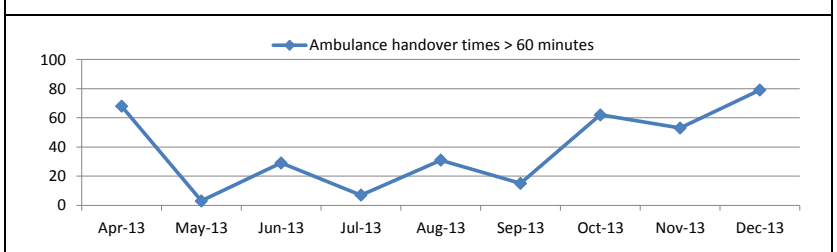
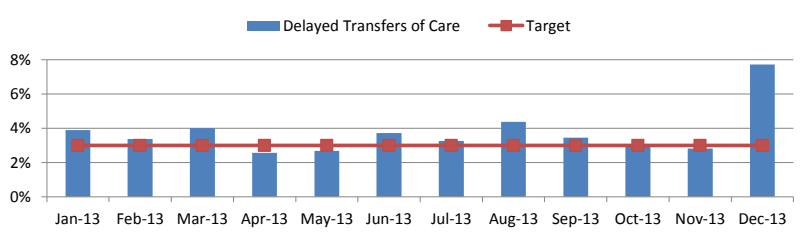
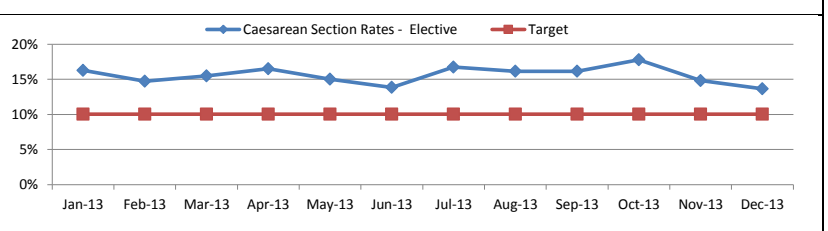
In comparison to Novembers report the number of indicators that have been rated as red has remained static at **25.** Amber indicators have increased from **19/22** and green indicators have increased from **67/78.** The Indicators rated as grey have decreased from **34 to 21,** as further agreement for indicators continues to be agreed.

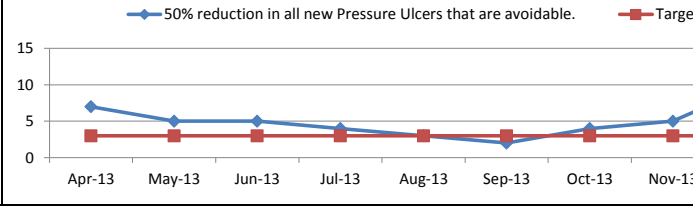
Summary Rating:

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**15**	**11**	**33**	**6**	**65**
Clinical Outcomes	**6**	**4**	**20**	**3**	**33**
Patient Safety	**2**	**3**	**8**	**12**	**25**
Patient Experience	**2**	**4**	**17**	**0**	**23**
TOTAL	**25**	**22**	**78**	**21**	**146**

Recommendation

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

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	New Pressure Ulcers	0	↓	The number of reported avoidable pressure ulcers (grade 3) increased during December. This can be attributed to improved reporting and verification processes. Training and education continues to be provided for identified areas requiring specialist support. The Tissue Viability Team have launched Trust wide training sessions for all relevant staff.	
Patient Safety	Falls (Major / Severe)	0	↓	During November and December the number of major / severe falls peaked and remained static at 3 . All cases resulted in a fractured neck of femur and are currently being investigated as Si`s.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	→	***The healthcare notes audit questions account for 12 of the red performance scores in the Patient Safety category .*** Key issues identified on the Healthcare Notes audit in October 13: Following items flagged as red - front page of every sheet contain an addressograph label, the recording of vital patient information (date of birth and hospital number) on the front page of notes where the addressograph was absent, is time recorded for each entry, is the surname printed in block capitals, is the staff designation recorded, Medical Records Audit only: Is the GMC number present, are any alterations / deletions scored through with a single line, is there a signature recorded next to any alterations/deletions, Is there a date recorded next to any alterations/deletions, Is there a time recorded next to any alterations/deletions and Are there any loose sheets in the Healthcare record. An options appraisal has been presented to the Medical Director for consideration.	
Patient Experience	Complaints responded to within agreed timescales	100%	↓	The response rate for responding to complaints within an agreed timescale significantly declined from 93% for complaints received in September down to 75% for complaints received in October 2014. For the complaints received during October 33 complaints were extended, and of those 14 also required holding letters. This can be attributed to staff shortages within the Complaints Team and delays in receiving information back from Directorates.	
Patient Experience	A & E Quality Indicators (5 indicators)		↓	**A&E Clinical Indicators:**	
			↓	The 4 hour wait in A&E (Month on Month) position ended at 89.82% for December, a significant deterioration from the previous month (94.53% in November) and still remained under the target of 95%.	
			↓	Time Spent in A&E (Cumulative) - This indicator has been negatively affected by the non-achievement of the monthly 95% 4hrs for December waits, resulting in a cumulative of 91.94% from 92.2% for the previous month.	
			↓	The time to initial assessment for patients arriving by ambulance increased slightly from 43 mins in November to 46 minutes in December (national target being 15 minutes).	
			↑	Although there was a deterioration in the number of ambulance handover over 60 minutes (53 in Nov against 79 in Dec) there was a significant improvement for the ambulance handover times waiting over 15 mins (Nov = 1485, Dec = 1033). The Trust is currently not being fined for any handovers of 30 minutes.	
			↓		
Clinical Outcomes	Delayed Transfers of Care	3%	↓	December saw a significant increase in the % of delayed transfers of care - 7.7% against the 5.7% for December 2012 and an average of 3.2% for the period Apr 13 - Nov 13. There were a total of 244 delayed transfers of care during December 2013 against the average of 122 per month for Apr 13 to Nov 13.	
Clinical Outcomes	Caesarean Section Rates (Elective)	10.06%	↑	Elective caesarean section rates have shown a sustained improvement during Q3 : Oct = 17.8%, Nov 14.8% and Dec 13.6% (target 10.06%). In addition 'total caesarean' rates has achieved the required target of less than 25% at 23.5% for December 2013.	

CQUIN	Improve performance on staff Friends & Family Test		↓	The annual Trust wide staff survey has been undertaken in Q3 and results are awaited. Predicted RAG rating of red will be determined following feedback from Care Group Directorates.	*Chart not applicable for this indicator*
CQUIN	50% reduction in all new avoidable Pressure Ulcers	Max 3 incidents p/m	↓	Ther was a stepped increase in the number of avoidable and unavoidable pressure ulcers during December. Training and awareness is being provided for areas requiring specialist support from the Tissue Viability Team this is supported by Trust wide training sessions for all relevant staff.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Dec 13 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	0	0	0	0	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	2	2	5	7	2	4	1	3	1	2	3	0		
HQU08: MSSA Numbers	No national ceiling set	1	0	0	1	0	1	1	0	0	1	1	2		
E Coli ESBL Quarterly Average	7 per month	3	2	0	2	3	3	4	2	2	3	2	2		
VTE Risk Assessment completed	95% month on month	91.9%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.3%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	99.73%	99.54%	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%		
MRSA Screening Non-Elective Patients	100% month on month	95.12%	96.56%	97.00%	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%	97.1%	97.1%	97.3%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	10	30	45	24	32	23	22	23	15	13	18	23		
Incidence of pressure ulcers															
Grade 3 - New avoidable pressure ulcer		2	3	4	0	4	3	0	0	0	3	5	7		
Grade 3 - New unavoidable pressure ulcer		0	0	1	3	2	4	0	1	4	3	4	3		
Total Grade 3 - New pressure ulcer		2	3	5	3	6	7	0	1	4	6	9	10		
Grade 4 - New avoidable pressure ulcer		3	0	1	0	0	0	0	0	0	0	0	0		
Grade 4 - New unavoidable pressure ulcer		0	0	0	0	0	0	0	0	0	0	0	0		
Total Grade 4 - New pressure ulcer		3	0	1	0	0	0	0	0	0	0	0	0		
Total Grad 3 & 4 Pressure Ulcers					3	6	7	0	1	4	6	9	10		
Reduce harm from falls															
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0	0		
Major/Severe	0	1	2	1	0	1	1	1	2	1	1	3	3		
Moderate	0	2	3	1	1	3	1	1	0	1	1	2	2		
Mandatory Training compliance Full Year Impact															
Primary Levels Excluding B&H	80%	65.4%	65.2%	65.2%	65.1%	65.4%	65.7%	66.0%	66.1%	68.7%	70.2%	70.2%	70.8%		
Attendance at Trust Induction	80%	87.5%	87.6%	87.5%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%	87.6%	87.4%	87.5%		
Number of surgical site infections															
Fracture neck of femur - Number of Operations	-	39	31	45	17	27	29	20	28	26	33	35	35		
Number of infections	-	0	0	0	0	0	0	0	0	1	1	1	0		
% infection rate (monthly)		0%	0%	0%	0%	0%	0%	0%	0%	3.8%	3.0%	2.9%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%		0.9%			0%			2.7%			1.9%			
Caesarean sections - Number of Operations	-										109	96%	94%		
Number of infections	-										0	0	0		
% infection rate (monthly)											0.0%	0.0%	0.0%		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%											0%			
Total hip replacements - Number of Operations	-										23	31	11		
Number of infections	-										0	0	0		
% infection rate (monthly)											0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%											0%			
Total knee replacements - Number of Operations	-										13	20	16		
Number of infections	-										0	0	0		
% infection rate (monthly)											0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%											0%			
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc															
Open Central Alert System (CAS) Alerts	0	0	0	0	1	0	0	0	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	89.1%	89.3%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%	79.9%	80.7%	80.9%		
Serious Untoward Incidents	-	19	25	36	41	35	51	21	10	10	9	22	15		
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	98%	99%	99%		
Healthcare Notes Audit															
Q.1 Does the front page of every sheet contain an addressograph label	100%	80%	79%	72%	79%	72%	74%	80%	76%	66%	68%	60%	63%		
Q.2 Does addressograph include the NHS Number?	100%	99%	88%	92%	90%	97%	97%	98%	95%	93%	94%	90%	89%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	74%	90%	84%	100%	94%	90%	78%	67%	86%	69%	72%	76%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	53%	73%	64%	85%	69%	77%	63%	49%	59%	57%	59%	57%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	53%	63%	46%	61%	67%	69%	51%	49%	45%	67%	55%	60%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	18%	20%	18%	21%	8%	15%	12%	14%	5%	6%	7%	19%		
Q.7 Is record legibly written	100%	99%	98%	99%	95%	100%	98%	99%	97%	99%	99%	99%	95%		
Q.8 Written in blue/black ink	100%	100%	99%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	98%	99%	100%	99%	98%	99%	100%	100%	99%	98%	97%	98%		
Q.10 Is date recorded for each entry	100%	88%	90%	88%	86%	87%	86%	89%	93%	88%	83%	84%	86%		
Q.11 Is time recorded for each entry	100%	71%	66%	75%	86%	87%	86%	89%	93%	88%	83%	84%	86%		
Q.12 Is there a signature of the person making the entry	100%	90%	94%	94%	96%	97%	92%	97%	91%	91%	87%	91%	93%		
Q.13 Is surname printed in block capitals	100%	59%	58%	58%	73%	65%	69%	71%	66%	73%	54%	70%	63%		
Q.14 Is the staff designation recorded	100%	52%	52%	58%	65%	70%	64%	68%	68%	63%	59%	63%	50%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	30%	31%	38%	69%	63%	35%	46%	66%	43%	38%	55%	46%		
Q.16 Are any alterations / deletions scored through with a single line	100%	25%	72%	40%	46%	43%	55%	53%	45%	56%	44%	55%	44%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	16%	25%	28%	39%	35%	43%	39%	49%	30%	28%	43%	29%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	9%	16%	24%	39%	35%	43%	39%	49%	30%	28%	43%	29%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	9%	13%	17%	15%	28%	32%	47%	18%	23%	15%	19%	24%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	97%	96%	100%	99%	97%	88%	100%	91%	94%	96%	100%	99%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	42%	75%	44%	44%	60%	69%	71%	60%	36%	51%	63%	82%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%	100%	100%	100%	96%	80%	100%	100%	98%	91%	98%	100%		
Q.23 Are there any loose sheets in the Healthcare record	0%	10%	0%	13%	10%	3%	3%	7%	6%	9%	7%	4%	10%		

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

Patient Experience	Target 2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13		Comments
Cancelled Operations not rebooked within 28 days	0	4	1	2	1	0	0	0	0	0	0	0	0		
Hospital Cancelled Operations	6.0%	9.3%	6.3%	11.5%	11.1%	9.6%	9.5%	12.0%	10.3%	8.4%	10.7%	10.7%	9.0%		Nov data unavailable at the time of publication.
Number of written complaints received	-	68	54	52	45	58	37	29	38	41	55	49	35		
Complaints Responded to within agreed timescales	100.00%	95.6%	75.9%	69.2%	57.8%	94.8%	92%	90%	86.8%	93%	75%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits															
Admitted Patients	90.00%	96.10%	95.12%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	0.00%		
Non Admitted Patients	95.00%	98.60%	97.90%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	0.00%		
Ongoing Patients	92.00%	95.45%	95.74%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	0.00%		
A&E Quality Indicators (5 measures)															
Time Spent in A&E (Month on Month)	95%	86.91%	90.33%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%		
Time Spent in A&E (Cumulative)	95%	92.47%	92.30%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%		
Total time in A&E (95th percentile)	95th	07:12	06:21	08:08	06:45	03:59	04:43	04:17	05:19	05:22	05:18	04:17	05:39		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:44	00:50	01:10	00:57	00:40	00:54	00:41	00:45	00:42	00:49	00:43	00:46		
Time to treatment decision (median)	<60 mins	00:34	00:45	00:52	00:57	00:51	00:51	01:05	00:54	00:54	00:49	00:46	00:48		
Unplanned re-attendance rate	=<5%	6.10%	6.07%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%	6.16%	5.77%	6.04%		
Left without being seen	>1% and <5%	0.18%	0.22%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%	0.15%	0.21%	0.31%		
Ambulance handover times > 15 minutes	0	New for 2013-14			612	452	500	446	476	1263	1656	1485	1033		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	New for 2013-14			68	3	29	7	31	15	62	53	79		No hand over greater then 15 minutes
Cancer Wait Times															
2 week GP referral to 1st outpatient	93%	96.7%	96.9%	98.3%	96.0%	95.4%	96.2%	95.5%	95.1%	96.6%	95.8%	97.6%	96.3%		
2 week GP referral to 1st outpatient - breast symptoms	93%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.6%	100.0%	98.6%		
31 Day	96%	97.3%	98.7%	99.2%	98.0%	98.2%	98.1%	96.3%	97.6%	99.3%	97.3%	98.4%	99.2%		
31 day second or subsequent treatment - surgery	94%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - drug	98%	91.8%	96.8%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	96.4%	97.8%	95.8%	98.3%	98.6%	95.8%	96.5%	97.4%	96.5%	97.8%	96.9%	95.7%		
62 day referral to treatment from screening	90%	95.7%	93.3%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%		
62 day referral to treatment from hospital specialist	80% (local target)	63.6%	73.7%	100.0%	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%	66.7%	100.0%	80.0%		
62 days urgent referral to treatment of all cancers	85%	81.3%	77.6%	76.5%	85.2%	79.0%	83.4%	79.1%	85.4%	84.7%	85.6%	83.2%	86.6%		
SRS08: Length of Stay (Acute & MH)															
Elective	3.20	4.4	4	4.2	3.1	4.7	5.6	4.3	5.9	3.8	3.8	3.5	3.5		Based on DFI Peer Group UQ. Fig reported in Dec 13 relates to rolling 12 months up until Nov 13
Non-Elective	5.30	4.6	4.3	4.7	4.3	4.3	5.8	4.7	5.3	4.9	4.8	4.9	4.9		Based on DFI Peer Group UQ. Fig reported in Dec 13 relates to rolling 12 months up until Nov 13
SRS09: Daycase Rate	85%	85.5%	84.8%	84.6%	85.9%	84.9%	84.6%	86.4%	85.3%	84.5%	84.5%	84.0%	83.5%		
SQU11: PROMS Scores - Pre Operative participation rates															
Groin Hernia - Participation Rate	Eng.Ave 59.8% (target 80%)	88.6%		98.0%			81.3%			75.3%			84.1%		Information based on 12 months HES data to Apr 12 - Mar 13 (published Nov 13). Target for 2013-14 is measured against the England average for the period and not the national target of 80% for all procedures
Hip Replacement - Participation Rate	Eng.Ave 81.5% (target 80%)	125.8%		93.0%			94.6%			91.5%			95.2%		
Knee Replacement - Participation Rate	Eng.Ave 89.6% (target 80%)	95.9%		110.5%			107.1%			102.6%			113.6%		
Varicose Vein - Participation Rate	Eng.Ave 43.6% (target 80%)	71.4%		54.1%			66.7%			68.7%			69.9%		
All Procedures - Participation Rate	Eng.Ave 74% (target 80%)	99.1%		96.0%			90.5%			86.4%			93.7%		

Clinical Outcomes	Target 2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13		Comments
HSMR - monthly position for 2013-14 (YTD)	<100	96.9	100.21	103.7	108.5	76.8	76.93	88.0	84.96	86.25	86.44	N/Avail	N/Avail		Latest DFI FY trend Apr 13 - Nov 13 (HSMR)
HSMR - 12 Monthly cumulative position		99.1	N/Avail	100.1	100.8	N/Avail	96.2	99.01	96.17	94.36	93.45	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
HSMR- cumulative position for 2013-14															
Pneumonia	<100	54.8	N/Avail	57.5	60.4	N/Avail	59.42	65.8	62.92	64.25	66.28	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
Fracture of neck of femur (hip)	<100	169.08	N/Avail	148.7	135.89	N/Avail	127.47	125.72	121.88	107.38	95.36	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
Acute Cerebrovascular disease	<100	105.6	N/Avail	105	108.2	N/Avail	101.95	90	100.93	94.37	94.66	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	133.5	N/Avail	133.5	135.88	N/Avail	128.8	135.46	120.63	110.89	111.1	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
Acute myocardial infarction	<100	76.7	N/Avail	77.5	84.6	N/Avail	82.29	87.3	82.95	89.32	89.8	N/Avail	N/Avail		Latest DFI FY trend Nov 12 - Oct 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	114.24	115.84	115.84	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail		Latest position reported in Dec 13 reflects Apr 12 - Mar 13.
SQU12: Maternity 12 weeks	90%	95.4%	95.2%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%	97.7%	97.7%	96.3%		
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.9%	3.4%	4.0%	2.6%	2.7%	3.7%	3.3%	4.4%	3.4%	2.9%	2.8%	7.7%		
Fractured neck of Femur															
Patients fit for surgery within 36hrs	-				17	29	26	23	25	28	28	30	30		
Number of patients admitted with FNOF who were operated on within 36 h	-	New for 2013-14			14	21	23	22	21	19	24	13	25		
% of patients admitted with FNOF who were operated on within 36 hrs of l	100%				82.4%	72.4%	88.5%	95.7%	84.0%	67.9%	85.7%	43.3%	83.3%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	91.3%	90.6%	69.6%	90.9%	82.8%	81.3%	92.6%	85.7%	93.0%	94.0%	88.0%	92.0%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	39%	67%	48%	43%	38%	38%	66%	59%	51%	48%	55%	43%		
100% of suspected stroke patients given CT scan within 24 hours of arriva	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	68.8%	60.0%	69.2%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%	73.9%	75.0%	84.0%		
Patients who spend at least 90% of their time on a stroke unit	80%	81.6%	86.1%	96.4%	80.0%	88.7%	98.2%	89.8%	87.1%	87.0%	92.7%	82.2%	96.7%		
Breast Feeding initiation	75%	75.2%	77.4%	79.4%	80.6%	81.4%	76.9%	79.7%	78.9%	78.0%	78.6%	77.7%	79.0%		
Caesarean Section Rates - Total	<25%	26.4%	29.2%	24.9%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%	28.4%	29.4%	23.5%		
Caesarean Section Rates - Emergency	14.98%	10.1%	12.7%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%	8.0%	14.6%	9.9%		
Caesarean Section Rates - Elective	10.06%	16.3%	14.7%	15.5%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%	17.8%	14.8%	13.6%		
Home Birth Rate	>=3%	2.1%	5.9%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%	6.0%	2.1%	4.6%		
Number of readmissions within 28 days (Adult)	-	New for 2013-14			395	385	424	496	422	392	415	447	472		Min 28 day turnaround before monthly data complete, therefore subject to change.
Number of readmissions within 28 days (Children)	-	New for 2013-14			146	136	163	126	96	106	155	142	160		Min 28 day turnaround before monthly data complete, therefore subject to change.

CQUIN 2013-14	Target 2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-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%	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.3%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	payment to be received if both	New for 2013-14				91.3%			89.6%			89.4%			RAG rating in accordance with latest CQUIN Status report
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting															
3a.Dementia case finding	90% 3 consecutive months	2.4%	2.9%	2.2%	0.86%	4.35%	2.37%	3.3%	55.70%	70.8%	68.80%	79.58%	76.30%		
3b.initial diagnostic assessment	90% 3 consecutive months	N/A	N/A	Not avail	-	0%	100%	50%	46.70%	60.00%	35.7%	100.00%	100%		3b & 3c no numerator or denominator Facilitator in post from beginning Aug 2013. Oct 2013 data yet to be validated.
3c. referral for specialist diagnosis	90% 3 consecutive months	100.0%	100.0%	Not avail	-	100%	100%	100%	58.30%	36.40%	60.0%	40.00%	66.60		
3d.Lead clinician and appropriate training of staff	Yes	New for 2013-14						On track							RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes	New for 2013-14						Q1,2 & 3 audits all completed							RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS															
1. Develop and implement AECP															
1a AECP for Chest Pain		New for 2013-14				Q1 achieved			Q2 achieved			Q3 achieved			RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism		New for 2013-14				Q1 achieved			Q2 achieved			Q3 achieved			RAG rating in accordance with latest CQUIN Status report

1c. AECP for Supraventricular Tachycardia		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic												
2a. HOT Clinic for Paediatrics		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine		New for 2013-14	Q1 achieved		Q2 achieved			Q3 achieved				RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS												
1. Friends & Family												
1a. Phased expansion of Friends and Family Test (maternity services)	Implimentation by Oct 2013	New for 2013-14	From Oct 2013					19.01%	14.07%	16.74%		
1b. increase response rate to at least 20%	=>20% by Yr End	New for 2013-14	7.09%	9.23%	15.88%	16.93%	9.73%	16.84%	22.17%	26.67%	23.06%	Q3 accumulative FFT response rate = 23.9%
1c. Improve performance on staff Friends & Family Test		New for 2013-14	Survey due Autumn 2013 - still awaiting formal results									No action required for Q1. LIA group in place - staff survey to be undertaken in Q3. Predicted RAG rating determined following feedback from Care Group Directorates.
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	New for 2013-14	7	5	5	4	3	2	4	5	10	RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards		New for 2013-14	On track, Q1 data submitted and feedback provided. Q2 data submitted on time.									
4. Timely Simple Discharge	TBA (>60% each quarter or action plan)	New for 2013-14	N/A	50.0%	0.0%	66.7%	66.7%	100%	33.3%	50.0%	33.3%	RAG rating in accordance with latest CQUIN Status report. Target = +33.3%YTD= 51.9
5. Improve access to breast milk in preterm infants	TBA (20% imp on 12/13 perf (58.5%))	New for 2013-14	55.9%	37.5%	45.5%	51.3%	61.3%	64.2%	50.0%	60.7%	60.6%	RAG rating in accordance with latest CQUIN Status report. Target = 61% yr end or 64% in any one quarter
6. Acute Kidney Injury	Q1 Process recorded and definition in place	New for 2013-14	Q1 & Q2 achieved. Q3 on track Process agreed to identify patients with an AKI. Working group established and meeting regularly									

Enclosure D

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD / COMMITTEE
30 January 2014

Title	Patient Experience Report
Agenda item	8
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery and Patient Services
Author(s)	Rachel Lovesy – Patient Experience Lead
Purpose	This report is being presented to the Board for Assurance and Information

Executive summary

- FFT scores improving across the Trust, with A&E receiving much higher than the national average
- FFT response rates also improving
- Results from the Maternity Survey are presented, which show some improvement from the previous national survey and identifies areas for further improvement work
- For the first time this month, patient experience metrics are presented, whereby complaints, PALs, incidents, SI's and FFT results have been brought together into a dashboard
- This report outlines the themes identified in Q2 (July – September 2013) from complaints, PALs, patient experience and risk management. Q3 themes will be presented in February's board report.
- The report outlines benchmarking criteria for Complaints, exploring NGH's figures alongside those received in Trusts of a similar size.

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

Enclosure E

Actions required by the Board

- Discuss and challenge the content of the report
- Note the results from the November and December 2013 Friends and Family Test

Trust Board
30 January 2014

Patient Experience Report

Overview

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

Friends & Family Test

Background

FFT targets for response rates have been 15% since its original implementation, however this will increase to 20% in January 2014. The Trust failed to obtain its CQUIN for Quarter 1 due to response rates decreasing in August 2013 to lower than those obtained within the first Quarter.

The Issue(s)

Response Rates:

- The Friends and Family Test (FFT) results for November saw Inpatient and A&E reach the highest response rate since collections began, with Inpatient achieving **34.30%** and A&E **23.82%.** (appendix 1)
- December saw a slight decrease in response rates for Inpatients **33.53%,** and a more substantial fall for A&E **18.78%.** However, despite the fall, both areas continue to achieve above the required 15% target. (appendix 1)
- Maternity Services failed to reach the 15% target for November 2013, achieving an accumulated score of **14.07%,** however this has increased for December to **16.74%**
- A few areas continue to fail to achieve the required response rate, these areas are being worked with on an individual basis to establish sustainable improvement plans.

Scores:

- Scores tracked across the financial year show Quarter 3 had a significant rise in the amount of patients scoring the Trust as 'Extremely Likely' (Appendix 2)
- The overall Score for the Organisation increased by 6, reaching **69** for Quarter 3 and achieving the Trusts highest accumulated score for this financial year. This is largely down to A&E who have seen a steep increase in their NPS, October = **67**, November = **72**, December = **72**, all significantly higher than that achieved nationally October = 55 (no further national statistics available at present). (Further information on individual scores can be found within Appendix 3)

Themes:

- It has been identified that analysis of the comments received through the FFT is essential for theming and tracking trends in issue areas throughout the hospital. A method has been identified and a basic analysis has been conducted of the positive and negative comments received in December 2013. This will continue and the Board will be updated regularly on findings.
- From the analysis of the comments it has been possible to identify the top 5 positive and top 5 negative themes identified across the whole of the FFT collections (Maternity, Inpatients, A&E, Eye Casualty, Paediatrics, Day Surgery) these are:

Top 5 Positives across FFT	
1	Attitude & Behaviour
2	Medical Care
3	Waiting Times
4	Communication
5	Hotel Services

Top 5 Negatives across FFT	
1	Communication
2	Waiting Times
3	Discharge etc
4	Medical Care
5	Environment

- There are cross overs between the tables, more explanation of this can be found within Appendix 4.

Improvements:

- Abington Ward have had issues with their Net Promoter Score being low. A meeting was held between the Patient Experience Lead and the Matron to identify next steps. These were identified as:
  1. Review the comments from June to December to identify trends
  2. Carry out a further exploration of patient experience on the ward (method to be identified)
- Wards have been requested to provide feedback on any changes made as a result of the FFT comments, one example given from a ward was patients were raising issues around the lack of 'quiet time' on the wards. From these comments the ward decided to implement a rest period between 13:00-14:00 and the lights are turned off within the ward. It will be interesting to see whether this has an impact on patients' experience. Further examples such as these will be provided to the Board within coming months

The National Maternity Survey 2013

Background

The Maternity Survey is a National Survey carried out by the CQC. Previous to 2013 the last survey was conducted in 2010. 2013 saw NGH reach a response rate of 52.9%, with 171 women completing the Survey. Results are compared nationally, and against scores received within the previous Survey in 2010 (where applicable).

The Issue(s)

- 2013 the Trust received the results for the National Maternity Survey. 2 reports have been created; the first is the local report produced by Patient Perspective who run NGH's surveys currently, and the CQC report which make adjustments and compares the organisation against results received nationally.
- Key points of the survey are presented below:

1. For section 1. The start of your care in pregnancy (Antenatal Care), the Trust rated within the 'worse performing Trusts' category

2. 37% of women felt that they had received enough information to help them decide where to have their baby compared to the national results (55%)

3. 21% of women delivering in NGH reported being left alone at some point in their labour when it worried them compared with 25% nationally.

4. 70% of women reported seeing the midwife as their first professional contact, this is compared to a national average of 32%

5. 44% of women saw the same midwife at each antenatal check-up compared with 34% nationally, this is also a positive increase from the result obtained in 2010.

- From the report an Action Plan has been created by Maternity Services to begin to tackle some of the issue areas identified
- Plans are in progress to consider how improvements from the action plan will be monitored. The board will be updated of any further developments.

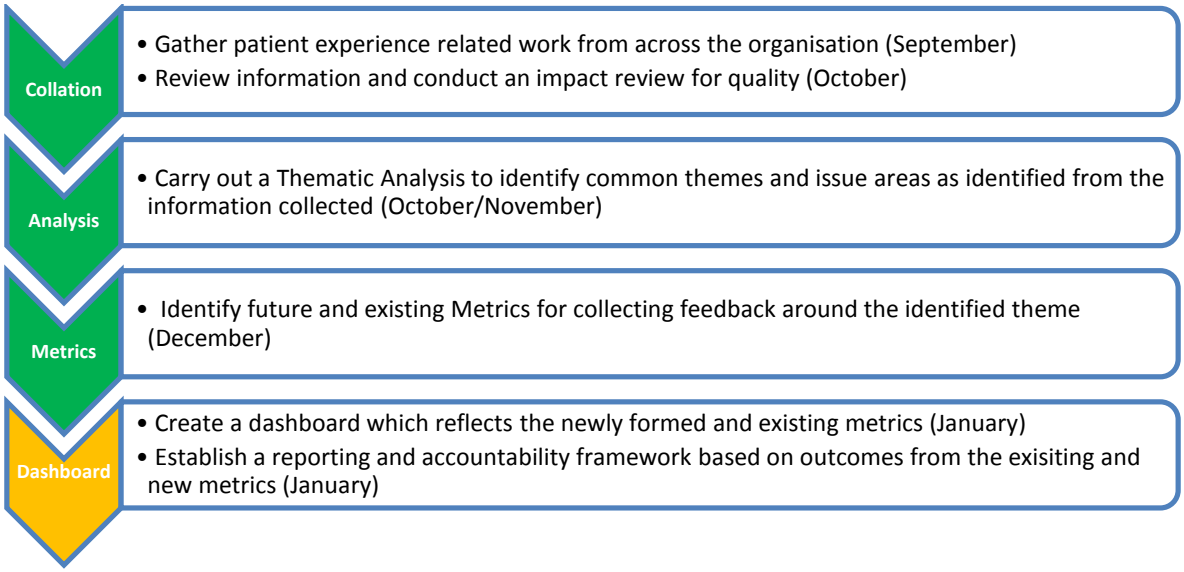
Patient Experience Collation and Trend Analysis

Background

It has been identified that there is a need to be able to continuously review how our patients are receiving our services, and to identify any problem areas in a timely manner to allow for effective resolutions. The ultimate aim is for the creation of a dashboard which reflects a continuous, fluid response to the key issue areas identified from previous patient experience measures.

The Issue(s)

- Previous Board Reports have identified the process being undertaken to review how information on Patient Experience is currently collected, interpreted and used. This has moved on considerably since November and can be seen below:



- The Board will note that the actions under 'Metrics' have changed since the previous Board Report. This is due to the decision being made to not currently hold a Metrics meeting. Membership requires review and it was considered that at present the dashboard can be populated with meaningful data from existing metrics.

Triangulation of Complaints, PALS, Incidents, SI's and FFT

Background

Previous reviews carried out within the NHS have highlighted the need for a triangulated approach to reviewing data based around quality. Sir Bruce Keogh states *'All trusts need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas and is tested through systematic assurance programmes'*. For this reason NGH have made the decision to begin triangulating information from the Friends & Family Test, PALS, Complaints and Incidences in order to establish a mechanism of review and the ability to pre-empt any potential issue areas.

The Issue(s)

- 3 meetings have been held between PALS, Risk, Patient Experience, Complaints and the Information Team to begin to identify how the information collected by all groups can be triangulated to form an overall picture.

- A dashboard has been established which is currently split into two sections displaying:
    1. Patient Feedback
    2. Clinical Outcomes

  Each of the individual elements within the dashboard have been given a RAG rating and an overall rating for each of the 2 sections.
- Appendix 5 contains a copy of the dashboard for the month of December and annotation around the preliminary findings.
- This will be provided for the Board each month for review.
- It should be noted that this is the first time this information has been collated in this format and it is likely that it will change as information is reviewed and decisions are made as to what is required to be able to draw the most meaningful conclusions.
- The compliments section includes any compliments which have been sent to PALS, Complaints (through the 4C's), the CEO's office, the Director of Nursing and to the wards themselves.
- In addition to the dashboard, Appendix 6 contains details of the key themes identified by PALS, Risk, Complaints and Patient Experience within Quarter 2. The Two themes which emerge consistently within the data are (1) Communication and (2) Discharge. Please see Appendix 6 for further information.

Complaints Benchmarking

Background

It is important as an organisation that we continue to monitor our own performance against benchmarking criteria for Complaints.

The Issue(s)

- Bench marking data is not currently available on a quarterly reporting basis. However, annual data is collected as part of the Department of Health's KO41a return. This is a count of written complaints made by (or on behalf of) patients, received between 1st April 2012 and 31st March 2013
- Appendix 7 contains details of the number of complaints received by NGH, and other organisations of a similar size.

Appendix 1: Response Rates and Scores for FFT for November and December

November

Friend & Family Net Promoter Score										
Period: November 2013										
	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Ward / area name (Inpatient discharges aged 16yr and over)	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	Total responses for each ward	Response rate for each ward	Score for each ward / area
ABINGTON WARD	15	9	1	0	0	1	29	26	89.66%	56
ALLEBONE WARD	2	4	1	1	0	0	56	8	14.29%	0
ALTHORP WARD	14	4	1	0	0	0	88	19	21.59%	68
BECKET WARD	12	6	0	0	0	0	56	18	32.14%	67
BENHAM WARD	21	10	2	0	0	2	98	35	35.71%	58
BRAMPTON WARD	11	1	1	0	0	1	49	14	28.57%	77
CEDAR WARD	26	13	2	0	1	0	75	42	56.00%	55
COLLINGTREE	10	1	0	0	1	0	114	12	10.53%	75
COMPTON WARD	15	8	0	0	0	0	14	23	164.29%	65
CORBY COMMUNITY	2	1	0	0	0	0	9	3	33.33%	67
CREATON WARD	1	4	0	3	0	0	41	8	19.51%	-25
DANETRE WARD	19	2	0	0	0	1	26	22	84.62%	90
DISNEY WARD *(aged 16yr & over)*	0	0	0	0	0	0	16	0	0.00%	
DRYDEN WARD	12	3	0	0	0	1	98	16	16.33%	80
ELEANOR WARD	8	1	0	0	2	0	38	11	28.95%	55
EMERGENCY ASSESSMENT UNIT	14	6	1	0	0	1	138	22	15.94%	62
FINEDON WARD	12	3	0	1	0	1	47	17	36.17%	69
HAWTHORN WARD	78	26	5	0	1	2	190	112	58.95%	65
HAZELWOOD WARD, ISEBROOK HOSPT	6	6	0	0	0	0	18	12	66.67%	50
HEAD AND NECK WARD	21	1	0	0	0	0	78	22	28.21%	95
HIGH DEPENDENCY UNIT	0	0	0	0	0	0	1	0	0.00%	
HOLCOT STROKE UNIT	14	10	0	0	0	0	17	24	141.18%	58
KNIGHTLEY WARD	19	2	0	0	0	1	38	22	57.89%	90
PADDINGTON *(aged 16yr & over)*	0	0	0	0	0	0	4	0	0.00%	
ROWAN WARD	38	13	3	1	0	0	166	55	33.13%	62
SPENCER WARD	23	5	0	1	1	0	139	30	21.58%	70
TALBOT BUTLER WARD	16	7	1	0	0	0	80	24	30.00%	63
VICTORIA WARD	13	7	0	3	0	1	66	24	36.36%	43
WILLOW WARD	15	2	1	0	0	1	77	19	24.68%	78
Inpatient Ward Total	**437**	**155**	**19**	**10**	**6**	**13**	**1866**	**640**	**34.30%**	**64**
A & E UNIT	684	176	17	13	21	9	4159	920	22.12%	69
AMBULATORY CARE CENTRE	16	2	1	0	0	0	77	19	24.68%	79
EYE CASUALTY	198	43	1	3	1	4	755	250	33.11%	78
Accident & Emergency Total	**898**	**221**	**19**	**16**	**22**	**13**	**4991**	**1189**	**23.82%**	**72**
ANTENATAL COMMUNITY	18	5	1	0	0	0	350	24	6.86%	71
BIRTH CENTRE (Unit to open soon)	0	0	0	0	0	0	N/A	N/A	N/A	N/A
HOME BIRTH	5	2	0	0	0	0	13	7	53.85%	71
LABOUR WARD	47	18	0	0	0	1	358	66	18.44%	72
MATERNITY OBSERVATION WARD	0	1	0	0	0	0	32	1	3.13%	0
ROBERT WATSON WARD	41	16	1	0	0	1	278	59	21.22%	69
POSTNATAL COMMUNITY	21	1	1	0	0	0	248	23	9.27%	87
Maternity Services Total	**132**	**43**	**3**	**0**	**0**	**2**	**1279**	**180**	**14.07%**	**72**
Inpatient discharges aged under 16yrs										
DISNEY WARD	31	13	0	1	1	1	102	47	46.08%	63
PADDINGTON	23	20	5	3	1	0	216	52	24.07%	27
PADDINGTON HDU	1	0	0	0	0	0	6	1	16.67%	100
Paediatric Ward Total	**55**	**33**	**5**	**4**	**2**	**1**	**324**	**100**	**30.86%**	**44**
DAVENTRY DAY SURGERY	28	2	0	0	0	0	128	30	23.44%	93
MAIN THEATRES ADMISSIONS	95	10	1	0	1	0	124	107	86.29%	87
DAY SURGERY UNIT	90	14	0	0	0	0	264	104	39.39%	87
SINGLEHURST DAY CARE	10	1	0	0	0	0	151	11	7.28%	91
Daycase Area Total	**223**	**27**	**1**	**0**	**1**	**0**	**667**	**252**	**37.78%**	**88**

Enclosure E

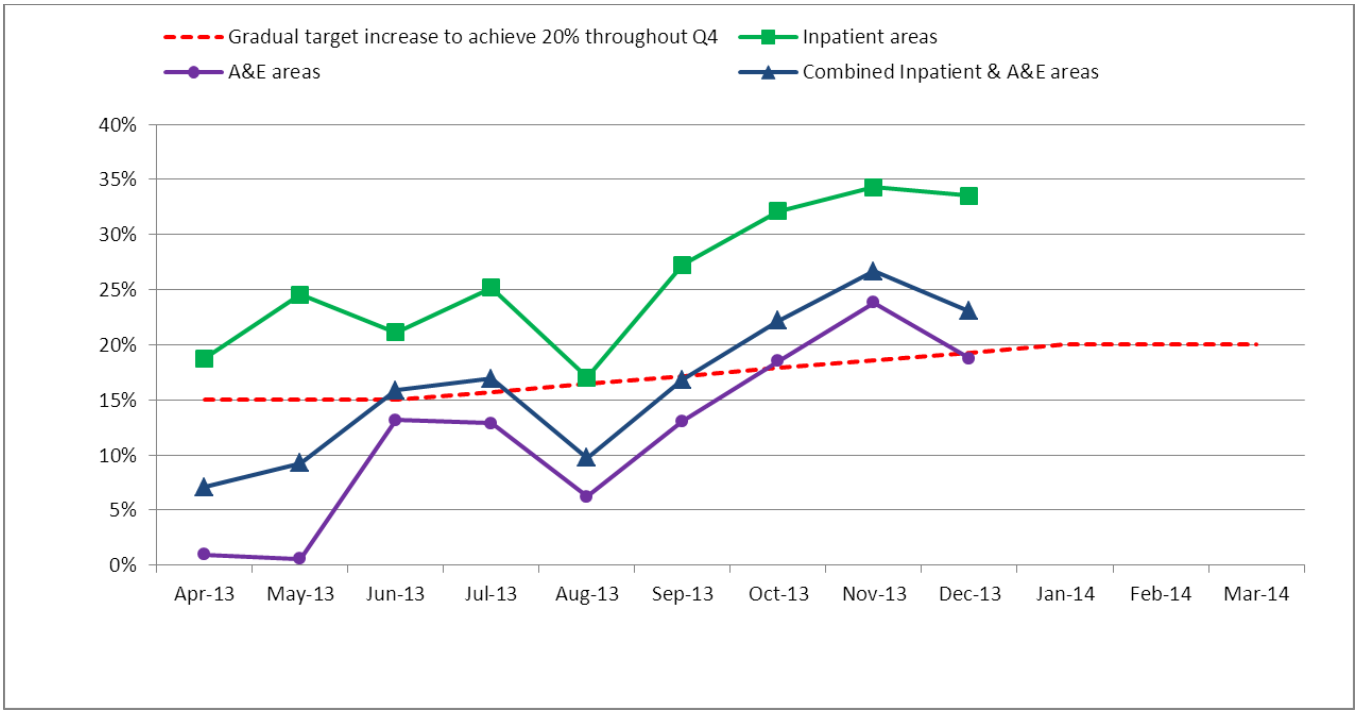
Appendix 1: Response Rates and Scores for FFT for November and December

December

Friend & Family Net Promoter Score										
Period: 1st to 31st December 2013										
	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Ward / area name (Inpatient discharges aged 16yr and over)	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	Total responses for each ward	Response rate for each ward	Score for each ward / area
ABINGTON WARD	2	4	2	0	0	0	32	8	25.00%	0
ALLEBONE WARD	4	0	1	1	0	1	48	7	14.58%	33
ALTHORP WARD	18	5	0	0	0	0	56	23	41.07%	78
BECKET WARD	22	6	0	0	0	0	61	28	45.90%	79
BENHAM WARD	17	3	1	0	1	0	108	22	20.37%	68
BRAMPTON WARD	11	6	0	0	0	0	47	17	36.17%	65
CEDAR WARD	25	13	0	0	0	0	72	38	52.78%	66
COLLINGTREE	22	5	1	0	0	2	119	30	25.21%	75
COMPTON WARD	12	9	1	0	0	0	23	22	95.65%	50
CORBY COMMUNITY	2	0	0	0	0	0	10	2	20.00%	100
CREATON WARD	9	4	0	1	0	0	66	14	21.21%	57
DANETRE WARD	13	1	0	0	1	0	29	15	51.72%	80
DISNEY WARD *(aged 16yr & over)*	3	1	1	0	0	0	16	5	31.25%	40
DRYDEN WARD	28	4	0	0	0	0	103	32	31.07%	88
ELEANOR WARD	26	4	1	0	1	0	59	32	54.24%	75
EMERGENCY ASSESSMENT UNIT	33	5	1	0	2	0	145	41	28.28%	73
FINEDON WARD	22	9	2	0	0	0	57	33	57.89%	61
HAWTHORN WARD	85	29	3	1	1	4	200	123	61.50%	67
HAZELWOOD WARD, ISEBROOK HOSPT	9	4	0	0	0	0	18	13	72.22%	69
HEAD AND NECK WARD	17	3	0	0	0	0	89	20	22.47%	85
HOLCOT STROKE UNIT	22	1	0	1	0	0	21	24	114.29%	88
KNIGHTLEY WARD	12	3	0	0	1	0	40	16	40.00%	69
PADDINGTON *(aged 16yr & over)*	0	0	0	0	0	0	5	0	0.00%	
ROWAN WARD	18	2	0	0	0	0	194	20	10.31%	90
SPENCER WARD	20	5	2	0	0	0	131	27	20.61%	67
TALBOT BUTLER WARD	22	2	1	0	0	2	97	27	27.84%	84
VICTORIA WARD	7	0	0	0	0	0	39	7	17.95%	100
WILLOW WARD	17	5	0	0	0	0	107	22	20.56%	77
Inpatient Ward Total	**498**	**133**	**17**	**4**	**7**	**9**	**1992**	**668**	**33.53%**	**71**
A & E UNIT	569	123	11	11	19	4	4078	737	18.07%	72
AMBULATORY CARE CENTRE	6	2	0	0	0	0	93	8	8.60%	75
EYE CASUALTY	123	46	1	0	1	1	711	172	24.19%	71
Accident & Emergency Total	**698**	**171**	**12**	**11**	**20**	**5**	**4882**	**917**	**18.78%**	**72**
ANTENATAL COMMUNITY	10	6	2	0	0	0	350	18	5.14%	44
BIRTH CENTRE	15	0	0	0	0	0	41	15	36.59%	100
HOME BIRTH	15	0	0	0	0	0	29	15	51.72%	100
LABOUR WARD	60	24	2	1	0	0	355	87	24.51%	66
BALMORAL	0	0	0	0	0	0	46	0	0.00%	
MATERNITY OBSERVATION WARD	5	1	0	0	0	0	44	6	13.64%	83
ROBERT WATSON WARD	52	24	4	2	3	0	232	85	36.64%	51
POSTNATAL COMMUNITY	9	2	0	0	0	0	319	11	3.45%	82
Maternity Services Total	**166**	**57**	**8**	**3**	**3**	**0**	**1416**	**237**	**16.74%**	**64**
Inpatient discharges aged under 16yrs										
DISNEY WARD	20	12	2	3	0	2	146	39	26.71%	41
PADDINGTON	19	11	1	2	2	0	215	35	16.28%	40
PADDINGTON HDU	1	0	0	0	0	0	3	1	33.33%	100
Paediatric Ward Total	**40**	**23**	**3**	**5**	**2**	**2**	**364**	**75**	**20.60%**	**41**
DAVENTRY DAY SURGERY	9	1	0	0	0	0	92	10	10.87%	90
MAIN THEATRES ADMISSIONS	62	4	0	0	0	0	120	66	55.00%	94
DAY SURGERY UNIT	58	8	0	2	0	0	184	68	36.96%	82
SINGLEHURST DAY CARE	2	0	0	0	0	0	132	2	1.52%	100
Daycase Area Total	**131**	**13**	**0**	**2**	**0**	**0**	**528**	**146**	**27.65%**	**88**

Appendix 1: Response Rates and Scores for FFT for November and December

Friends and Family response results for Quarter Three have a target response rate of 15%. This will increase to 20% in January 2014. The red line represents the Trusts own gradual response rate, implemented to track areas at risk of not achieving the increase in January.



The graph shows that A&E failed to reach the Trusts gradual target for December, which was set at 19.3%, however they exceeded the required 15% every month in Quarter 3. Inpatient Services continue to see high levels of overall responses peaking at 34.30% in November.

These figures are demonstrated further through the table below:

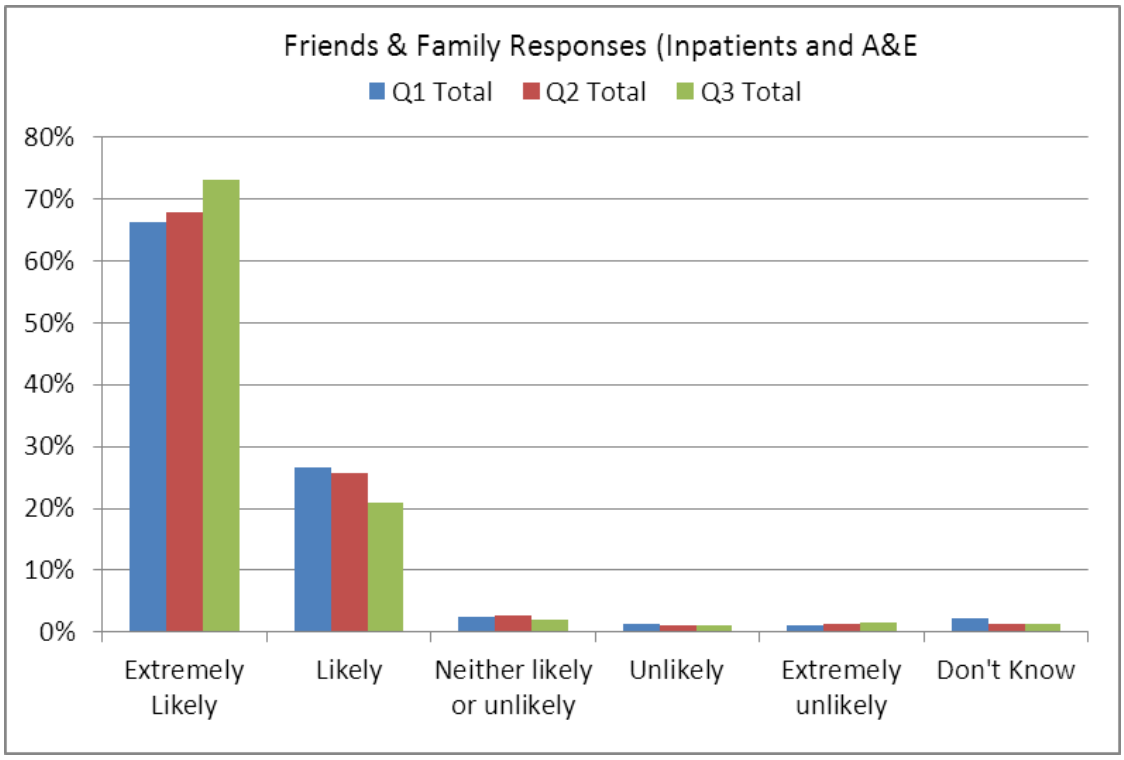
	Q1			Q2			Q3			Q4		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%	15.7%	16.4%	17.2%	17.9%	18.6%	19.3%	20.0%	20.0%	20.0%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	27.26%	32.13%	34.30%	33.53%			
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%			
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	16.84%	22.17%	26.67%	23.06%			

Enclosure E

Appendix 2: FFT scores broken down into individual categories and tracked for progress

	Number of responses							% Response per category								
Month (IP and A&E areas)	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of responses	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of responses	Response rate	Score
Apr-13	349	146	17	4	13	25	554	63.0%	26.4%	3.1%	0.7%	2.3%	4.5%	554	7.1%	60
May-13	519	175	18	6	8	13	739	70.2%	23.7%	2.4%	0.8%	1.1%	1.8%	739	9.3%	67
Jun-13	829	358	30	23	7	21	1268	65.4%	28.2%	2.4%	1.8%	0.6%	1.7%	1268	15.9%	62
Q1 Total	1697	679	65	33	28	59	2561	66.3%	26.5%	2.5%	1.3%	1.1%	2.3%	2561	10.8%	63
Jul-13	994	398	53	18	9	16	1488	66.8%	26.7%	3.6%	1.2%	0.6%	1.1%	1488	16.9%	62
Aug-13	558	196	14	6	15	11	800	69.8%	24.5%	1.8%	0.8%	1.9%	1.4%	800	9.7%	66
Sep-13	811	299	28	16	22	18	1194	67.9%	25.0%	2.3%	1.3%	1.8%	1.5%	1194	16.8%	63
Q2 Total	2363	893	95	40	46	45	3482	67.9%	25.6%	2.7%	1.1%	1.3%	1.3%	3482	14.4%	63
Oct-13	1199	386	38	17	26	27	1693	70.8%	22.8%	2.2%	1.0%	1.5%	1.6%	1693	22.2%	67
Nov-13	1335	376	38	26	28	26	1829	73.0%	20.6%	2.1%	1.4%	1.5%	1.4%	1829	0.0%	69
Dec-13	1196	304	29	15	27	14	1585	75.5%	19.2%	1.8%	0.9%	1.7%	0.9%	1585	19.0%	72
Q3 Total	3730	1066	105	58	81	67	5107	73.0%	20.9%	2.1%	1.1%	1.6%	1.3%	5107	14.4%	64

When comparing response categories for this year there has been a significant increase in patients rating their service as 'Extremely Likely'. This is represented in the Graph and Table below. Whereas the Extremely Likelys have increased significantly, the Extremely Unlikely and Unlikely categories have remained around the same percentages, averaging around **1.3%** for Extremely Unlikey, this is compared with **73%** of patients rating the Trust as Extremely Likely in Quarter 3. The increase is the Extremely Likelys and the lack of changes within the Extremely Unlikely and Unlikelys indicates a shift in those that had previously scored the Trust as Likely, moving them into the Extremely Likely category. This is a positive sign, and is representative of the work being undertaken currently to review the comments given by patients and make small changes from the information received.



Enclosure E

Appendix 3: FFT Scores tracked throughout the financial year

Period: Q1 2013-14 1st April to 30th June 2013	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Month	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate**	**Score for each ward / area**
Apr-13	349	146	17	4	13	25	7816	554	7.09%	60
May-13	519	175	18	6	8	13	7968	739	9.27%	67
Jun-13	829	358	30	23	7	21	7985	1268	15.88%	62
Q1	1697	679	65	33	28	59	23769	2561	10.77%	63

Period: Q2 2013-14 1st July to 30th Sept 2013	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Month	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate**	**Score for each ward / area**
Jul-13	994	398	53	18	9	16	8789	1488	16.93%	62
Aug-13	558	196	14	6	15	11	8219	800	9.73%	66
Sep-13	811	299	28	16	22	18	7091	1194	16.84%	63
Q2	2363	893	95	40	46	45	24099	3482	14.45%	63

CQUIN criteria (IP & A&E only) Period: Q3 2013-14 1st Oct to 31st Dec 2013	Total responses in each category for each ward								Target = 15%	Target yet to be agreed
Month	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate**	**Score for each ward / area**
Oct-13	1199	386	38	17	26	27	7635	1693	22.17%	67
Nov-13	1335	376	38	26	28	26	6857	1829	26.67%	69
Dec-13	1196	304	29	15	27	14	6874	1585	23.06%	72
Q3	3730	1066	105	58	81	67	21366	5107	23.90%	69

As seen within the tables above, the Trust obtained a Green RAG rating every month for Quarter 3 for response rates. This is the first time this has been achieved this financial year.

In addition to this Quarter 3 saw the Trust reach its highest accumulated Net Promoter Score of 69, compared with 63 for the previous 2 Quarters.

Appendix 4: December Themes from the FFT comments

Analysis of the FFT comments is essential to begin understanding the common themes which occur. Establishing an effective method for analysis has not been without its issue as there is no computer system available that can adequately interpret and understand what patients are saying. Therefore a manual method has been identified, with each comment identified as to whether it is positive or negative, then categorised into a 'subject'. The subject areas had previously been identified by PALS and this method has continued to enable triangulation. The only additions made to the subjects are 'General Thanks' and 'General Complaint' as often, the comment given by the patient could not be attributed to a theme as it was more general in its nature. Attempting to place it within a theme would have skewed the results. These 2 subjects were omitted from the overall theming but they are certainly worth noting.

The subjects are as follows:

Code	Subjects
ATTBEH	Attitude & behaviour
COMM	Communication
CONSEN	Consent
DELAYS	Delays/cancellation
ENVIRO	Environment
EQUAL	Equality & Diversity
INFORM	Information (PALS)
MEDREC	Medical Records
POLICY	Policies
PROPER	Property
SIGNS	Signage
UNIFOR	Uniforms
VISIT	Visiting Times
GEN THA	General Thanks
GEN COM	General Complaint

Each area was analysed individually to identify how many positive and negative comments they had received and which subjects they related to. It is also possible to drill the analysis down to ward level to identify which areas have which issues.

In total **1257** comments were analysed for the month of December. Of these, **1051** were positive, and **206** Negative, in percentage terms this means **84%** of the comments received were positive.

Appendix 4: December Themes from the FFT comments

Positive and Negatives

Inpatient Services (Inc Paediatric and Day surgery)

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Abington	2		2	100.0%	0%
Allebone	1	1	2	50.0%	50%
Althorp	17	2	19	89.5%	11%
Ambulatory Care Centre	1		1	100.0%	0%
Becket	4	2	6	66.7%	33%
Benham	17	3	20	85.0%	15%
Brampton	5	1	6	83.3%	17%
Cedar	6	5	11	54.5%	45%
Collingtree	7	6	13	53.8%	46%
Compton	2		2	100.0%	0%
Corby Community Hospital	1		1	100.0%	0%
Creaton	4	4	8	50.0%	50%
Danetre Day Surgery	1		1	100.0%	0%
Danetre IP	4	2	6	66.7%	33%
Disney	5	5	10	50.0%	50%
Dryden	8	2	10	80.0%	20%
EAU	11	3	14	78.6%	21%
Eleanor	20	1	21	95.2%	5%
Finedon	4	1	5	80.0%	20%
Hawthorn	76	17	93	81.7%	18%
Hazelwood - Isebrook	3		3	100.0%	0%
Head & Neck	1		1	100.0%	0%
Holcot	2		2	100.0%	0%
Knightley			0	#DIV/0!	#DIV/0!
MTAU	24		24	100.0%	0%
NGH Day Surgery	3	2	5	60.0%	40%
Paddington	9	2	11	81.8%	18%
Robert Watson	1	1	2	50.0%	50%
Rowan	1	1	2	50.0%	50%
Spencer	2	3	5	40.0%	60%
Talbot Butler	5	2	7	71.4%	29%
Victoria	5	1	6	83.3%	17%
Willow	4	1	5	80.0%	20%
Grand Total	**256**	**68**	**324**	**79.0%**	**21%**

This table displays the amount of positive and the amount of negative comments received for each service. It is worth noting the percentages down the right hand column which indicate the amount of positives and negatives received in relation to the total amount of comments that area had. This is particularly important as some areas received far more comments than others. For example, on first inspection it appears that Hawthorn had the most amount of negative comments (17), however when compared with their overall figure of 93 this only accounts to 18% negative against 81.7% positive. A further issue is the lack of comments for some areas which again has an impact on their percentages. For example, Head and Neck only receive 1

comment throughout December, meaning they have a score of 100% positive. Therefore it is necessary when considering these figures to consider the **Total and the Positive and Negative %'s** before drawing conclusions at ward level.

This applies to all other areas also:

A&E

December Minors					
	Data				
Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
A&E Minors	248	14	262	94.7%	5%

December Majors					
	Data				
Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
A&E Majors	15	14	29	51.7%	48%

Maternity

	Data				
Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Antenatal Community	2		2	100.0%	0%
Birth Centre	10		10	100.0%	0%
Home Birth	5		5	100.0%	0%
Labour Ward	31	1	32	96.9%	3%
Maternity Obs Ward	1		1	100.0%	0%
Postnatal Community	1		1	100.0%	0%
Robert Watson Ward	29	5	34	85.3%	15%
Grand Total	79	6	85	92.9%	7%

Eye Casualty

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Eye Casualty	91	11	102	89.2%	11%

Themes per area

Once the positive and negatives had been identified it was possible to break these down into the subjects. This was done for each area individually:

Inpatients

Appendix 4: December Themes from the FFT comments

Subject	Count of Positive	Count of Negative	Total	% Positive	% Negative
Attitude & behaviour	126	8	134	94.0%	6%
Car parking		1	1	0.0%	100%
Communication	10	20	30	33.3%	67%
Delays/cancellation		1	1	0.0%	100%
Dignity/Privacy	2	1	3	66.7%	33%
Discharge/transfer/referral		12	12	0.0%	100%
Environment	1	9	10	10.0%	90%
Equality & Diversity	1		1	100.0%	0%
Equipment	1	1	2	50.0%	50%
Hotel services	7	4	11	63.6%	36%
Medical care	41	5	46	89.1%	11%
Uniforms		1	1	0.0%	100%
Waiting times		1	1	0.0%	100%
Grand Total	**256**	**68**	324	79.0%	21%

A&E

Minors:

Subject	Count of Positive	Count of Negative	Total	% Positive	% Negative
Attitude & behaviour	64		64	100.0%	0%
Car parking		1	1	0.0%	100%
Communication	6	3	9	66.7%	33%
Discharge/transfer/referral		1	1	0.0%	100%
Environment	1		1	100.0%	0%
General Thanks	81		81	100.0%	0%
Hotel services	3		3	100.0%	0%
Medical care	15	3	18	83.3%	17%
Signage		1	1	0.0%	100%
Waiting times	78	5	83	94.0%	6%
Grand Total	248	14	262	94.7%	5%

Majors:

Subject	Count of Positive	Count of Negative	Total	% Positive	% Negative
Attitude & behaviour	8	1	9	88.9%	11%
General Complaint		4	4	0.0%	100%
General Thanks	5		5	100.0%	0%
Medical care		1	1	0.0%	100%
Waiting times	2	8	10	20.0%	80%
Grand Total	15	14	29	51.7%	48%

Appendix 4: December Themes from the FFT comments

Maternity

Subject	Count of Positive	Count of Negative	Total	% Positive	% Negative
Attitude & behaviour	21		21	100.0%	0%
Communication	4	3	7	57.1%	43%
Environment	5		5	100.0%	0%
General Complaint		1	1	0.0%	100%
General Thanks	20		20	100.0%	0%
Hotel services		1	1	0.0%	100%
Medical care	29	1	30	96.7%	3%
Grand Total	79	6	85	92.9%	7%

Eye Casualty

Subject	Count of Positive	Count of Negative	Total	% Positive	% Negative
Attitude & behaviour	27		27	100.0%	0%
Car parking		1	1	0.0%	100%
Communication	3	2	5	60.0%	40%
Delays/cancellation		1	1	0.0%	100%
Equipment	1		1	100.0%	0%
General Thanks	19		19	100.0%	0%
Hotel services		2	2	0.0%	100%
Medical care	20		20	100.0%	0%
Waiting times	21	5	26	80.8%	19%
Grand Total	91	11	102	89.2%	11%

Overarching Themes for FFT across the Trust

Once each areas individual Themes had been identified it was possible to accumulate these and determine which subjects were most commonly identified throughout the Trust, both for positive and negatives.

The themes identified are as follows:

Top 5 Negatives across FFT	
1	Communication
2	Waiting Times
3	Discharge etc
4	Medical Care
5	Environment

Top 5 Positives across FFT	
1	Attitude & Behaviour
2	Medical Care
3	Waiting Times
4	Communication
5	Hotel Services

Enclosure E

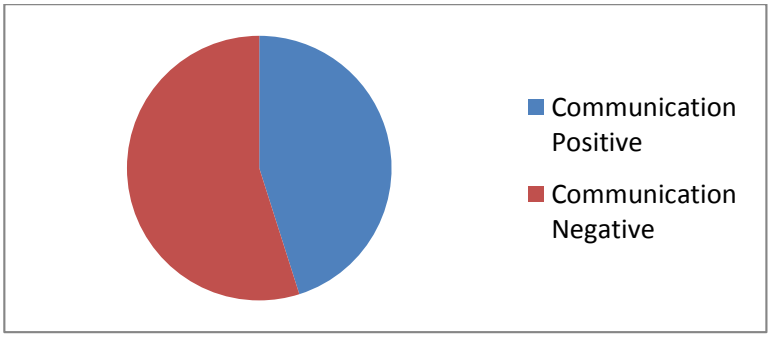
Appendix 4: December Themes from the FFT comments

It is interesting to note that there is crossover between the themes for communication, waiting times and medical care and it provides a different insight into the identified themes when we begin exploring the positives and negatives alongside one another.

Crossovers

Taking into consideration the 2 themes which crossover between negative and positive we can dissect this information further:

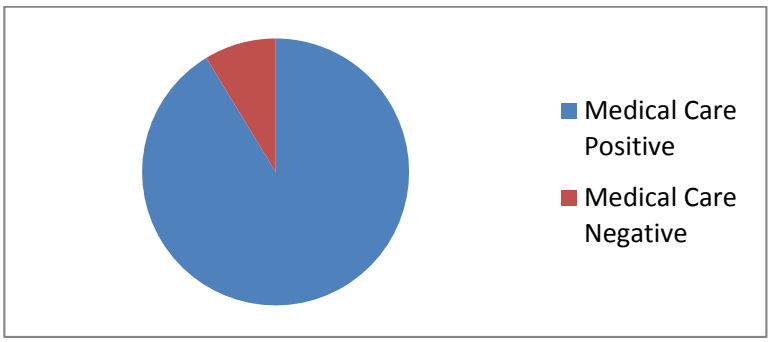
Communication	Total	51	
	Positive	23	45%
	Negative	28	55%



For Communication there is an even split between both the positive and negative comments received.

However, more remarkably, when exploring Medical Care further there is a vast difference between the amount of negative and positive comments received, with a substantial amount more being received for positive.

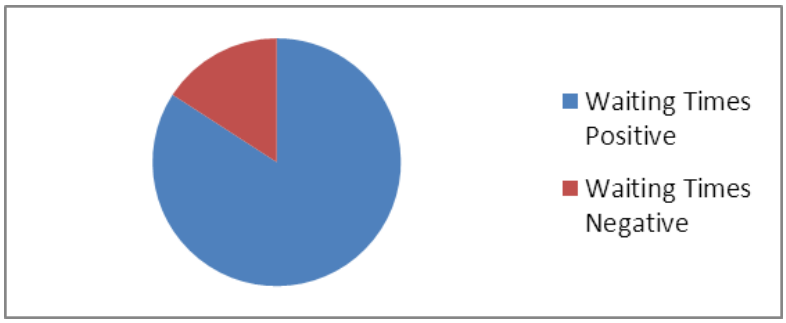
Medical Care	Total	115	
	Positive	105	91%
	Negative	10	9%



Appendix 4: December Themes from the FFT comments

This discrepancy is due to the vast amounts of comments received which are positive, compared to those that are negative. Although Medical Care remains within both categories it is important to place it within context.

Waiting Times	Total	120	
	Positive	101	84%
	Negative	19	16%



Again the same can be seen with Waiting Times where 84% of the comments made were positive and 16% were negative. As with Medical Care it is important to consider this information in context, and although this is still a negative theme, there are a great many patients that are indeed reporting high levels of satisfaction within this area also.

Appendix 5: Triangulation Dashboard for PALS, Complaints, Patient Experience and incidences

Monthly reporting	**Dec-13**														
	Patient Feedback							**Clinical Outcome**							
WARDS	**Total no of Complaints subjects / issues by ward***	**No of investigated PALS contacts**	**FFT Score ******	**FFT Response Rate ******	**Total No of Compliments**	**FFT comment overview (positive less negative)**	**Patient feedback - overall RAG rating**	**No. of All HARM incidents (with final approval)**	**SI's (exc PU & falls)**	**SI's / PU's (Grade 3 & 4 acquired)**	**SI's / Falls**	**All unapproved incidents as at the end of the month**	**Safety Thermometer (New CRUTI'S)**	**Clinical outcome - overall RAG rating**
RAG Rating	*0 = Green 1 - 2 = Amber 3 or more = Red*	*0 = Green 1 - 2 = Amber 3 or more = Red*	*80 & above = Green 70 - 79 = Amber Less than 70 = Red*	*30% & above = Green 25%-29% = Amber Less than 25% = Red*	*1 or more = Green*	*More positive = Green More negative = Red*	*Green = 5-6 greens Amber = 3-4 greens Red = 0-2 greens*	*Green = 0-5 Amber = 6-9 Red = 10 or more*	*0 = Green 1 or more = Red*	*0 = Green 1 or more = Red*	*0 = Green 1 or more = Red*	*Green = up to 10 Amber = 11-19 Red = 20 or more*	*0 = Green 1 or more = Red*	*Green = 5-6 greens Amber = 3-4 greens Red = 0-2 greens*
A&E	3	8	72	18.07%	9	469	2	5				59		0
Abington	1	3	0	25.00%	3	2		10		1		1	1	
Allebone	5	1	33	14.58%	0	0	0	6		2		15		
Althorp	1	1	78	41.07%	26	15								0
Ambulatory Care Centre	0	0	75	8.60%	0	1								0
Birth Centre	0	0	100	36.59%	0	10								0
Becket	1	3	79	45.90%	0	2	2			1		12		
Benham	2	0	68	20.37%	1	14		6			1			
Brampton	1	0	65	36.17%	0	4		9						0
Cedar	0	2	66	52.78%	4	1						18		0
Collingtree	4	2	75	25.21%	0	1	1	12			1	1		
Compton	0	0	50	95.65%	0	2		1				23		
Corby	0	0	100	20.00%	0	1					1	16	1	
Creaton	2	0	57	21.21%	4	0	2	5		1		4		0
Danetre Day Surgery	1	0	90	10.87%	0	1								0
Danetre Inpatients	2	0	80	51.72%	0	2		1				25		
Day Surgery Unit (NGH)	0	0	82	36.96%	1	1	1	1				9		0
Disney	0	0	41	26.71%	1	0						7		0
Dryden	2	0	88	31.07%	0	6		2				7		0
EAU	4	0	73	28.28%	1	8		2		1		32		
Eleanor	0	0	75	54.24%	0	19		2				12		0
Eye Casualty	3	4	71	24.19%	0	80	2	1				1		0
Finedon	1	1	61	57.89%	0	3	2	3						0
Gosset	2	0	N/A	N/A	0	N/A		2	1			5		0
Hawthorn	1	0	67	61.50%	1	59		2				6		0
HDU	0	0	N/A	N/A	1	N/A		3				1		0
Head & Neck ward	1	2	85	22.47%	1	1		1				6		0
Holcot	1	0	88	114.29%	0	2		3						0
Isebrooke (Hazelwood)	0	0	69	72.22%	0	3		6					2	
ITU	0	0	N/A	N/A	1	N/A		6	1			3		
Knightley	2	0	69	40.00%	0	0	2	2			1	18	1	
Main Theatres	0	1	94	55.00%	0	24						5		0
Maternity Obs Ward	0	0	83	13.64%	0	1		2						0
Paddington	0	2	40	16.28%	0	7						10		0
Robert Watson	2	0	51	36.64%	1	0								0
Rowan	2	0	90	10.31%	1	0		1				5	2	
Singlehurst	0	0	100	1.52%	0	0								0
Spencer	0	0	67	20.61%	0	-1		1						0
Sturtridge (Labour Ward)	1	0	66	24.51%	0	30	2	1						0
Talbot Butler	3	2	84	27.84%	0	3		5				1		0
Victoria	1	0	100	17.95%	0	4		5						0
Willow	2	0	77	20.56%	0	3		1				4		0
Total	**51**	**32**	**71**	**22.25%**	**56**	**778**	2	**107**	2	6	4	306	7	0

The Dashboard has been split into 2 sections, the first containing information related to patients feedback, and the other related to clinical outcomes. Each tab has been allocated a RAG rating depending on what the Trust wishes to achieve within these areas. Following these ratings, an overall rating for each section has been calculated using the following formula:

- 5-6 Greens = Green
- 3-4 Greens = Amber
- 0-2 Greens = Red

The only areas that this formula does not apply to are the areas which are not collecting for the Friends & Family Test (Gossett, HDU & ITU). These areas have been calculated by totalling the number of greens received and multiplying them by 3.

This creates 2 separate RAG ratings which can be compared to one another to form a larger picture of patient feedback and clinical outcomes within each area. It is intended to be used as a discussion point to highlight any possible problem areas and prompt further exploration.

The compliments section includes any compliments which have been sent to PALS, Complaints (through the 4C's), the CEO's office, the Director of Nursing and to the wards themselves.

December

Positive Outcomes

A number of areas achieved a RAG rating of Green for both Patient Feedback and Clinical Outcomes. These were:

- Birth Centre
- Day Surgery Unit
- HDU (do not collect FFT)
- ITU (do not collect FFT)

Further Exploration

From looking at the Dashboard for December we can begin to identify some areas which may need further exploration.

Abington Ward

Abington obtained a Red rating within the Patient Feedback category and an Amber rating within the Clinical Outcomes. Looking into the data it can be seen that they received 3 complaints and 8 investigated PALS contacts for the month of December. In addition to this they achieved a Net

Promoter Score of 0 on the Friends and Family Test. In regards to their clinical outcomes, 10 HARM incidences have been identified with 1 Serious Incidence (SI)/Fall. They also received 1 Safety Thermometer incidence.

Allebone

Allebone also received a Red rating within Patient Feedback and an Amber rating within Clinical Outcomes. Looking further into this, this is due to receiving 5 complaints, 1 investigated PALS contact and an NPS of 33 from the FFT. They also continue to have a low response rate for their FFT. With regards to Clinical Outcomes, they have 6 HARM incidences and 2 SI's/Falls. In addition to this for the month of December they had 15 unapproved incidences.

Becket

Becket obtained a Red rating for Patient Feedback and an Amber rating for Clinical Outcomes. For Patient Feedback they received 1 complaint and 3 investigated PALS Contacts. A NPS of 79 is close to the Trusts target of 80, but still places them within Amber. However, because they did not received any compliments they only obtained Green status for their FFT response rate, and the amount of positive comments received from FFT minus the amount of negatives. For Clinical Outcomes the ward received 1 SI and had 12 unapproved incidences for December.

Benham

Benham also have a Red rating for Patient Feedback and an Amber rating for Clinical Outcomes. This is due to them receiving 2 complaints and an NPS of 68. In addition to this, Benham had 6 HARM incidents for December and 1 SI/Fall.

Collingtree

Collingtree received a Red rating for Patient Feedback and an Amber rating for Clinical Outcomes. They had 4 complaints and 2 investigated PALS contacts. In addition to this they received an NPS of 75 which placed them into Amber for this tab. Clinical Outcomes saw them receive 12 HARM incidences and 1 SI/Fall.

Knightley

Knightley obtained a Red rating Patient Feedback and an Amber for Clinical Outcomes. They received 2 complaints in December, an NPS of 69. Unfortunately their lack of compliments or positive comments affected the amount of greens they achieved placing them into the Red for December. For Clinical Outcomes they had 1 SI/Fall, 18 unapproved harm incidences and 1 Safety Thermometer incidence.

Appendix 6: Key Themes from PALS, Complaints, Patient Experience and Incidences

Quarter 2: 2013/2014

TOP 5 THEMES - COMPLAINTS, PALS, PATIENT EXPERIENCE, INCIDENTS & SI's														
Complaints			**PALS**			**Patient Experience (from the thematic analysis of the pt experience surveys & then when the work is done from the FFT comments)(# of studies which identified the issues out of 18 projects)**			**Incidents (with final approval as at 15.1.14)**			**Serious Incidents (STEIS category)**		
Total No Received	**356**		**Total No Received**	**252**		**Total No Received**	**43**		**Total No Incidents**	**2726**		**Total No Incidents**	**14**	
	No.	%		No.	%		No.	%		No.	%		No.	%
Clinical care	81	23%	Delays/Cancellation	50	20%	Communication/Information	16	37%	Accident that may result in personal injury	620	23%	Slips, trips & falls	6	43%
Delays/Cancellations	31	9%	Discharge/Transfer	37	15%	Discharge	8	19%	Implementation of care or ongoing monitoring/review	583	21%	Unexpected death	4	29%
Attitude & behaviour	20	6%	Waiting Times	33	13%	Facilities	7	16%	Infrastructure or resources (staffing, facilities, environment)	298	11%	Sub-optimal care of the deteriorating patient	2	14%
Communication	23	6%	Clinical Care	33	13%	Wellbeing Support	6	14%	Medication	236	9%	Adverse media coverage	2	14%
Discharge	14	4%	Communication	26	10%	Privacy, Respect and Dignity	6	14%	Access, Appointment, Admission, Transfer, Discharge	177	6%			0%

This table displays each of the key themes identified from Complaints received, PALS contacts, the patient experience Thematic Analysis, Incident subjects and Serious Incident subjects. The Clinical Care themes as identified by PALS and Complaints can be broken down further to identify which aspects of Clinical care these specifically refer to:

CLINICAL CARE - TOP THREE THEMES														
Complaints			**PALS**			**Patient Experience (from the thematic analysis of the pt experience surveys & then when the work is done from the FFT comments)**			**Incidents (with final approval as at 15.1.14)**			**Serious Incidents (STEIS category)**		
Total No Received	**81**		**Total No Received**	**48**		**Total No Received**			**Total No Incidents**	**2726**		**Total No Incidents**	**14**	
	No.	%		No.	%		No.	%		No.	%		No.	%
Diagnosis Failure	22	27%	Communication	27	56%	n/a		#DIV/0!	Slips, trips, falls and collisions	416	15%	Slips, trips & falls	6	43%
Communication with Patient	19	23%	Inadequate Monitoring	5	10%	n/a		#DIV/0!	Pressure sore / decubitus ulcer	408	15%	Unexpected death	4	29%
Medical Procedure	5	6%	Investigations	4	8%	n/a		#DIV/0!	Adverse events that affect staffing levels	168	6%	Sub-optimal care of the deteriorating patient	2	14%

Appendix 6: Key Themes from PALS, Complaints, Patient Experience and Incidences

From reviewing the Themes related to Patient Feedback it is evident that Discharge and Communication are the most commonly found themes within Complaints, PALS, Patient Experience and Incidents.

Discharge

14 complaints have been received relating to discharge in December making up 4% of all complaints received. PALS had 37 contacts regarding discharge, totalling 15% of all their contacts received. In the Trend Analysis of patient experience projects 8 of the 18 reviewed identified some form of issue or dissatisfaction with the patients discharge. In addition to this, 177 incidences were identified in December relating to 'Access, Appointment, Admission, Transfer and Discharge', making up 6% of all incidences for that month.

Communication

23 complaints were received in December relating to communication issues, equalling 6% of all complaints received. Communication totalled 10% of all PALS contacts and the Trend Analysis found Communication to be an issue within 16 of the 18 projects reviewed. In addition to this, when reviewing the Clinical Care theme, both Complaints and PALS identified further issues with Communication with 56% of PALS contacts regarding Clinical Care relating to Communication.

Appendix 7: Complaints Benchmarking

Bench marking data is not currently available on a quarterly reporting basis. However, annual data is collected as part of the Department of Health's KO41a return. This is a count of written complaints made by (or on behalf of) patients, received between 1st April 2012 and 31st March 2013. The data relates to the complaints arrangements introduced in April 2009. The information detailed below has been extracted from the following report:

Health & Social Care Information Centre – Data on Written Complaints in the NHS 2012-2013 (published 29th August 2013)

The other hospital's detailed have been recommended by the Trust's Information Team, in terms of comparable size although this cannot be equaled exactly due to each different demographic area. Kettering General Hospital has also been included as this is the closest acute Trust.

Trust	Number of complaints in 2010-2011	Number of complaints in 2011-2012	Number of complaints in 2012-2013	% change 2011-2012 to 2012-2013
Chesterfield Hospital	752	795	771	-3%
Sherwood Forest Hospital	601	584	642	+9.9%
Kettering General Hospital	544	505	498	-1.4%
Northampton General Hospital	466	517	538	+4.1%

Enclosure E

REPORT TO THE TRUST BOARD
DATE 30 JANUARY 2014

Title	Infection Prevention Performance Report
Agenda item	9
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Pat Wadsworth, Lead Infection Prevention Nurse
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the months of November and December 2013

Executive summary

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

Main issues to highlight:

- C Diff rate has decreased, bringing the Trust back on trajectory
- Surgical site infections identified in #NOF surgeries. Actions to improve previous reporting timeframes
- The Trust has identified another case of scolded skin syndrome. Actions taken to prevent further spread of infection

Related strategic aim and corporate objective	Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way Patient safety there will be no avoidable harm to patients from the healthcare they receive.
Risk and assurance	The Trust has an annual target of 29 C.diff cases and in the first 9 months of the year has sustained 23 cases. There will be significant fines if the Trust exceeds 29 for the year, putting the Trust financial position at risk.
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No**

Legal implications / regulatory requirements	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections. (DH 2008)

Actions required by the Board

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

Trust Board
30 January 2014
Infection Prevention & Control Report

1. Introduction

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

2. Report - In this report, the results for the alert organisms, Surgical Site Infections and Hand Hygiene audits for November and December 2013, have been summarised into the tables below.

A further detailed report is in appendix 1.

2.1 MRSA / MSSA bacteraemia

	MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
November	0	4	99.72%	97.1%	0	1
December	0	2	99.9%	97.3%	0	2

2.2 *Clostridium difficile*

	>3 day case of *C.diff*	*Total to date*
November	3 plus 1 at Danetre *	23
December	0	23

This puts the Trust on CDAD trajectory from December onwards

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

	>48 hrs E.coli	*Total of mean of four >48 hrs E.coli a month*
November	2	4
December	0	4

2.4 Influenza A H1N1

December 2013 saw 2 paediatric cases admitted with influenza A H1N1. All procedures were followed according to policy. Both patients recovered and were discharged home.

3. Surgical Site Infection Surveillance (SSIS) Scheme

The trust takes part in the national surgical site surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical site wound infection and be sure that patients are given the highest possible standard of care. The national programme is coordinated by Public Health England (PHE). The patient is monitored from operation until discharge and then followed up 30 days after the operation to determine if they sustained a surgical site infection.

When submitting the results to the board, it should be noted that surveillance is still on-going as surgical site infections can develop and be reported up to 30 days post operatively for general surgery and obs & gynae patients and up to a year post-operatively for T&O patients (due to an implant being inserted). Therefore these monthly results are classified as interim results and are subject to change.

	Caesarean Sections	Infection	Fractured neck of femur	Infection	Total Hip Replacement	Infection	Total Knee Replacement	Infection
Oct	109	0	33	**1**	23	0	13	0
Nov	96	0	35	**1**	31	0	21	0
Dec	94	0	35	0	19	0	17	0

Two fractured neck of femur (#NOF) patients have developed surgical site infections this quarter (October, November and December). One grew *Staph. aureus* following surgery in October and one grew MRSA following surgery in November. This equates to a surgical site infection rate of **1.9%** which put us over the national average of **1.5%** for #NOF patients. We were also over the national average in quarter two with two further #NOF patients developing surgical site infections post-operatively in September and October.

These infections will not have been presented to the board before because the report has reported on the previous month only (e.g. November figures in December etc.), yet wound infections can occur beyond that deadline. The Infection Prevention Team are looking at how we report our SSI data in the future as reporting on the previous month alone does not necessarily give a true picture of the final infection rates. It is proposed that on a monthly basis from February 2014, the Board will be informed of the final surgical site infections rates once the 30 day post-operative surveillance period has finished for general surgery and obs & gynae patients, and as they are identified during the year follow up period for T&O patients, with final rates confirmed at the end of the year.

Due to this increased infection rate for fractured neck of femur operations, a Root Cause Analysis (RCA) template has been devised to investigate themes and common anomalies. Meetings are being arranged with the orthopaedic surgeons and senior members of nursing to take this forward. A more detailed report will be presented at the next board meeting in February. It will also be on the agenda for the Infection & Prevention Committee and CQEG at the next monthly meetings.

In January 2012 the T&O directorate took local ownership of the surveillance and monitoring of the fractured neck of femur surgical site infection data with support and input from the Infection Prevention Team. This has proved very successful and was expanded to include continual surveillance for Total Hip Replacement (THR) and Total Knee Replacement (TKR) operations in October 2013. Options will be explored to contact patients at regular intervals to monitor their surgical site wounds.

4. Period of Increased Incidence

4.1 Corby Ward: Period of Increased Incidence (PII)

Corby had six patients with diarrhoea from 29th December 2013 to 2nd January 2014. Appropriate managers and clinicians were informed and IPC surveillance, management and communications with the ward was intensified. On the face of it, 6 patients with diarrhoea would normally be identified as an 'outbreak'. However, before that decision is made, careful clinical assessment of the causes of diarrhoea needs to be undertaken. All 6 patients resolved over the following four days and on the 1st January were symptom free. Clinical assessment identified other underlying causes for the diarrhoea and clinical testing resulted in negative results for Norovirus.

4.2 Scalded Skin Syndrome

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

The Board will remember that last year, we had a scolded skin outbreak, which was eventually resolved after the source was identified. Unfortunately there has been a further case of scolded skin syndrome (of the same strain as the outbreak strain) in December 2013.

A baby born on 30th November 2013 was admitted to Paddington ward on 9th December 2013 with a blistering rash to his groin and discharged on the 11th December 2013. The umbilical swab taken on the 9th grew a Staph Aureus which was sent for toxin typing. This was reported on the 21st December as positive for the genes encoding exfoliative toxins A & B. Paddington staff were asked to be vigilant to any other admissions of young babies with blistering rashes. The swab was sent to the Staph Reference laboratory and on the 31st December 2013 it was confirmed to be the same outbreak strain as January 2013.

Paediatricians and nursing staff have been alerted and informed. They will maintain vigilance about diagnosing other SSS cases involving neonates and liaising with the infection prevention and control team. Good environmental hygiene, infection prevention and control practices in delivery / post natal areas have been re-emphasised. Infection prevention and control related scores, for example hand hygiene and Personal Protective Equipment (PPE) scored 100%. A preliminary MDT meeting was convened in January to discuss the issues and a number of actions taken to prevent further infection. We will continue to maintain vigilance and an update meeting has been booked for 3 weeks' time to monitor actions agreed earlier in the month.

5. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data for November and December

Month	Percentage	Areas that did not submit and reason
November	Overall score was 94.4% Ward compliance was 97.9%	Dryden/CCU sent their data late due to clinical pressures Manfield DSU did not do it and no excuse was given, this was feedback to the Modern Matron Haematology OP has been discussed each month with the Modern matron who assures that this will be completed next month.
December	Overall score was 96.1% Ward compliance was 97.3%	Paddington ward manager explained that the ward had immense bed pressures in December. One member of the team completed the audit and in future she will allocate more staff to assist.

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

November and December saw the quality visits Beat the Bug, Stop the Clot, Save the Skin, and in total forty areas were reviewed over the 2 months. It was noted from the November and December reviews that:

- Feedback from patients: they were happy with hand hygiene and the ward cleanliness
- Estates issues are being reported and the estates department are now signing the estates record book on completion of the job.
- Cob webs appear to be problematic. There is still a huge emphasis on high level cleaning.
- Commodes this month were not clean and some were found to be contaminated
- Taps in some areas were still found to have lime-scale around the nozzle.
- The store rooms are tidier and cleaner.
- The medicine trolleys were found to be cluttered and stained.
- VTE assessments not fully compliant, with some doctors not using their GMC stamps.

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

7. Education and Training

There has been further speed training and awareness sessions with Occupational Health to raise awareness of diarrhoea management and further flu uptake. Mandatory training uptake is poor at 61%. Different ways of training ward staff are being considered to try to improve compliance.

8. Assessment of Risk

The Trust needs to report surgical site infections in a more appropriate way in future, taking into consideration that patients may only start to show signs of deep infection up to a year after the operation.

9. Recommendations/Resolutions Required

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

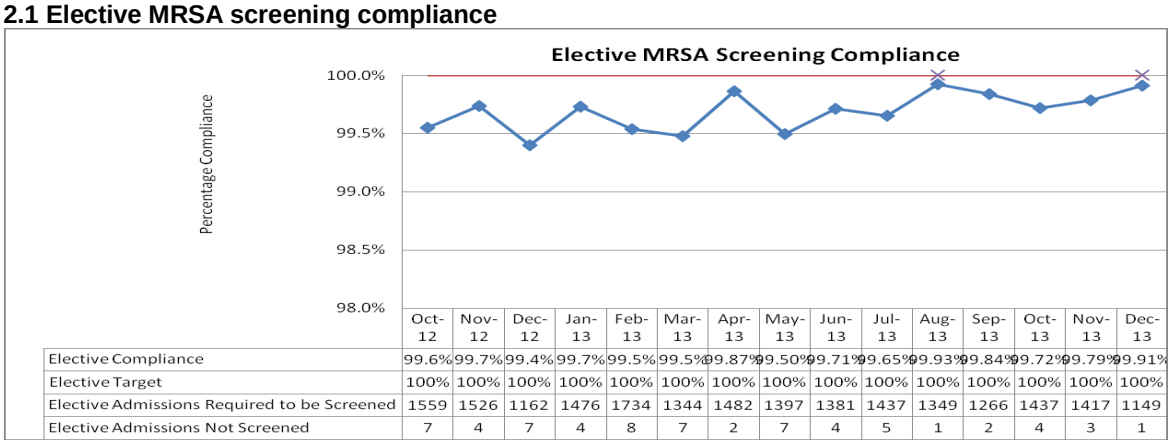
10. Next Steps

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

Appendix 1

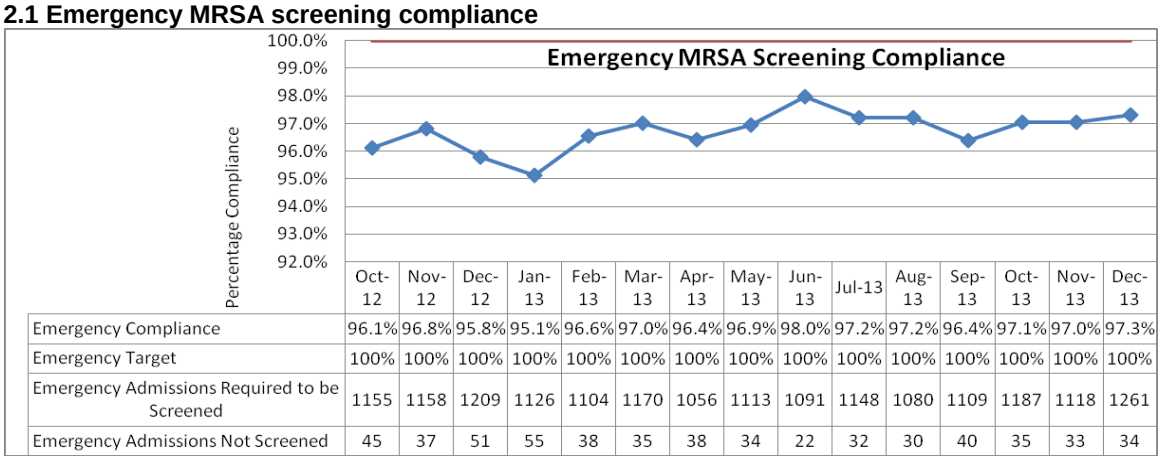
Elective and Emergency MRSA Screening Compliance

2.1 Elective MRSA screening compliance



	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Elective Compliance	99.6%	99.7%	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1559	1526	1162	1476	1734	1344	1482	1397	1381	1437	1349	1266	1437	1417	1149
Elective Admissions Not Screened	7	4	7	4	8	7	2	7	4	5	1	2	4	3	1

2.1 Emergency MRSA screening compliance



	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Emergency Compliance	96.1%	96.8%	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%	98.0%	97.2%	97.2%	96.4%	97.1%	97.0%	97.3%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1155	1158	1209	1126	1104	1170	1056	1113	1091	1148	1080	1109	1187	1118	1261
Emergency Admissions Not Screened	45	37	51	55	38	35	38	34	22	32	30	40	35	33	34

2.1 MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

During November 2013 there were 4 <48hrs and **1 >48hrs** MSSA bacteraemia cases. This was taken on Gosset. An RCA was undertaken and the baby had an infected line in the leg that was inserted in another hospital. The baby was septic whilst at the previous hospital and repatriated to Gosset. From the RCA the ward manager is sharing the findings with the other hospital, spot checks on the central line care plan is being monitored and a system is being implemented to check results more concisely.

During December 2013 there were 3 <48hrs and **2 >48hrs** MSSA bacteraemia cases. One was taken on Abington and one on Creaton ward. An RCA will be taking place and the results will be fed back in the next Board Report.

The MSSA bacteraemia reported in October and the RCA was completed and the findings are feedback in this report. This was taken on in A&E but was allocated to Collingtree Medical due to the patient having been discharged a few hours earlier. The RCA found that the VIP score had not been completed when the patient was having a minor investigation. The area is looking at introducing a chart so that this can be completed whilst patients are having minor investigations.

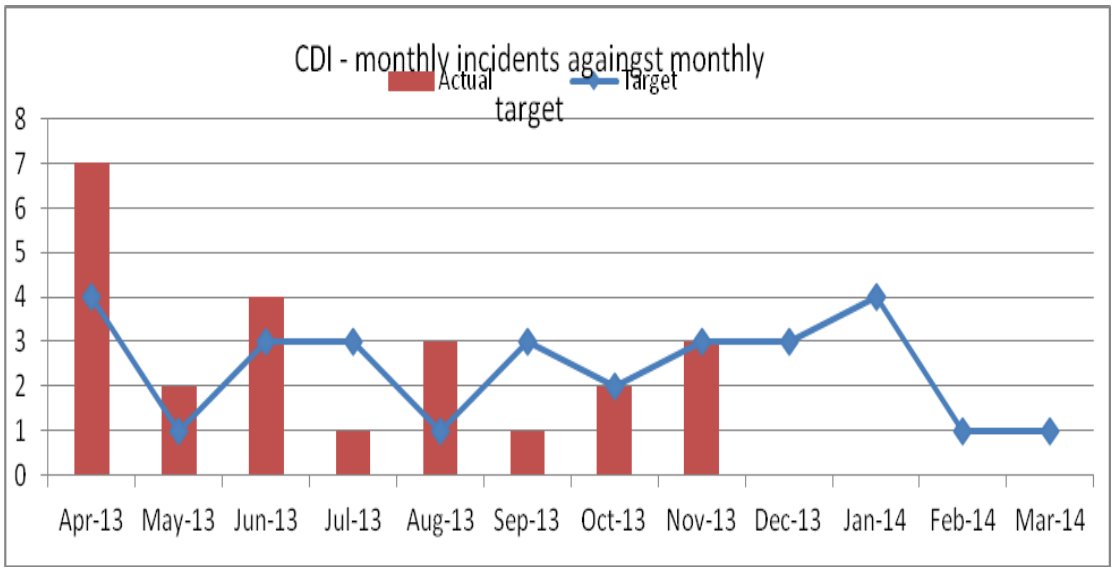
2.3 *Clostridium difficile*

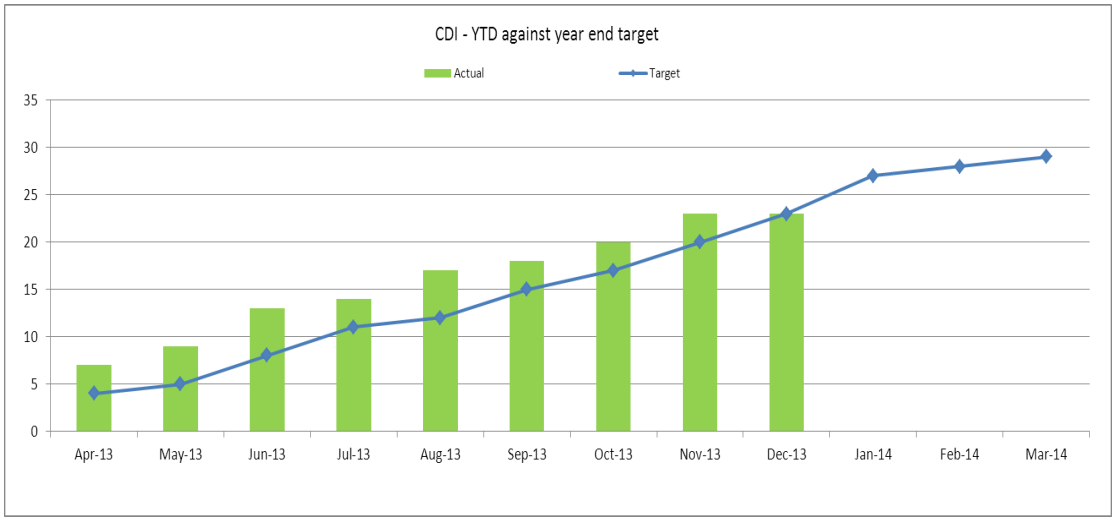
The Trust has an annual target of 29 *C.diff* cases or less for the financial year. During November **3 >3 day case of *C.diff*** were identified against a monthly target of 3 cases, which totalled 23 for the year. These 3 *C.diff* cases were attributed to EAU, Creaton and Rowan ward. They were appropriate samples. As a result the 3 wards have had support from infection prevention and *C.diff* focus weeks were undertaken.

During December **0>3 day case of *C.diff*** were identified against a monthly target of 3 post three day cases, which remains at a total 23 for the year.

This puts the Trust back on to CDAD trajectory.

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





Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1
September 2013	0	1
October 2013	0	2
November 2013	0	3
December 2013	0	0
Total	**8**	**15**

To maintain the focus on diarrhoea the IPT have had awareness days in the Cyber Café in December. The team have continued to facilitate training initially on the areas that sent inappropriate specimens (this is improving) and have widened the training to incorporate the majority of areas. This is ongoing training in diarrhoea management and how to take a correct specimen. Due to the autumn /winter months the samples have also increased that are sent to the laboratory.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD
DATE 30 JANUARY 2014

Title	Operational Performance Report
Agenda item	10
Sponsoring Director	Deborah Needham, Interim Chief Operating Officer Rebecca Brown, Interim Chief Operating Officer
Author(s)	Deborah Needham, Interim Chief Operating Officer Karen Spellman, Interim Chief Operating Officer
Purpose	The paper is presented for discussion and assurance

Executive summary

The Trust has not achieved the following standards during December 2013; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O. The Trust has seen an improvement in the 62 day standard (from urgent GP referral) every month through quarter 3 and unvalidated data indicates the Trust achieved the standard in December and for quarter 3. Cancer data is not finally validated until February 7th.

The number of patients waiting over 26 weeks from referral has increased from 30 to 47.

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

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

Actions required by the Board

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

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Q1	Q2	Q3
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	93.94%	N/A	N/A	N/A
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	99.00%	N/A	N/A	N/A
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	96.95%	N/A	N/A	N/A
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	19	30	47	N/A	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	N/A	N/A	N/A
RTT T&O Admitted	CCG & TDA	90%	91%	90%	91%	90%	90%	90%	62%	64%	77%	N/A	N/A	N/A
RTT T&O Non-Admitted	CCG & TDA	95%	95%	95%	95%	98%	95%	95%	93%	96%	96%	N/A	N/A	N/A
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	N/A
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0	0	0	0	0
*A&E: Total time in A&E (Calendar month)	CCG & TDA	95%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%	N/A	N/A	N/A
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%	91.63%	92.50%	92.01%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	95.80%	97.60%	96.30%	95.87%	95.74%	96.76%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.60%	100.00%	99.65%	99.55%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	98.12%	97.76%	98.56%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	100.00%	100.00%	98.15%	98.08%	100.00%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	97.80%	95.80%	95.70%	97.73%	97.30%	96.66%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	96.30%	100.00%	94.12%	98.72%	98.04%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	85.60%	83.90%	86.60%	82.04%	83.44%	85.30%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%	69.57%	83.87%	73.33%	82.61%	74.00%	80.00%	75.00%	70.00%	79.76%	80.00%
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	88.71%	98.18%	89.83%	87.14%	86.96%	92.73%	82.22%	97.92%	88.95%	87.88%	91.22%
Trolley Waits waiting > 12hours	CCG	0	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	446	476	1263	1656	1485	988	N/A	N/A	N/A
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	125	112	206	346	298	283	N/A	N/A	N/A
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31	15	62	53	75	N/A	N/A	N/A

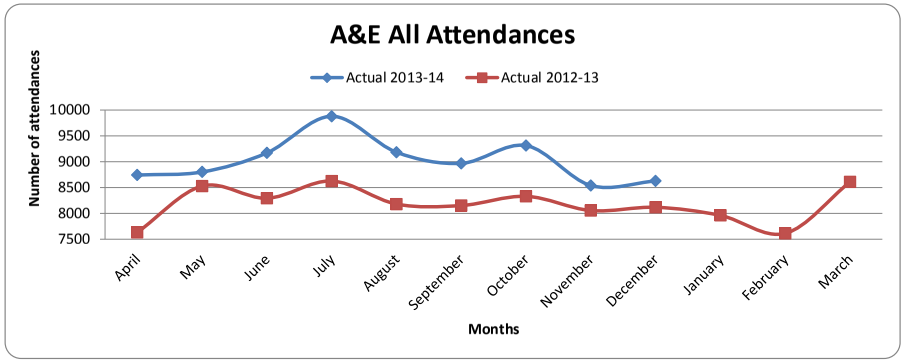
* A&E data is calendar month.

The Trust has not achieved the following standards during December 2013; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O. The Trust has seen an improvement in the 62 day standard (from urgent GP referral) every month through quarter 3 and unvalidated data indicates the Trust achieved the standard in December and for quarter 3. Cancer data is not finally validated until February 7th.

The number of patients waiting over 26 weeks from referral has increased from 30 to 47.

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

A&E Quality Indicators



A&E

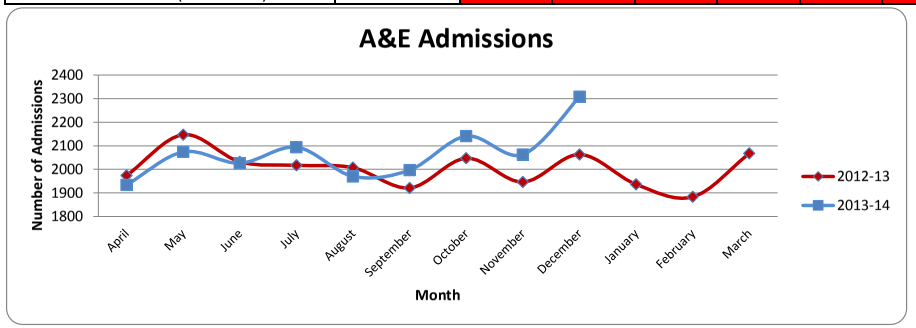
During December we achieved 89.82% of patients seen, treated and discharged within 4hrs from ED. This was a reduction from the performance in November when we achieved 94.55%.

Throughout December NEL activity has increased by 14% compared to the same time last year within this NEL admissions via GP's have increased dramatically as highlighted below:

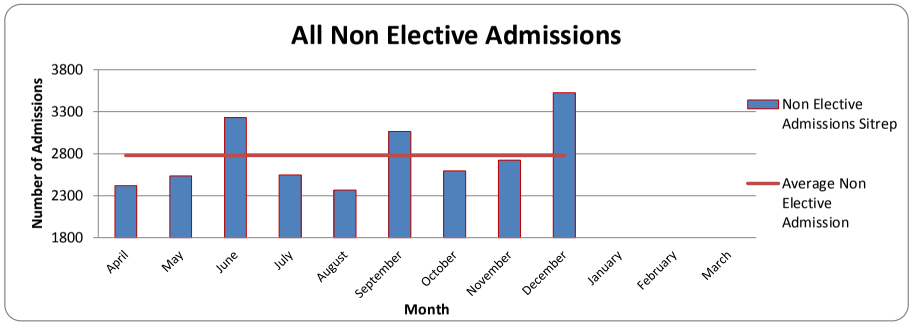
December 2012 vs December 2013
Emergency - Other (inc A+E) = 2%
Emergency A&E = 7%
Emergency GP = 38%
Emergency OP Clinic = 32%

The CCG are currently leading a daily teleconference call with all partners with the aim of unblocking any delays and offering support.

A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%	94.4%	90.4%	90.0%	90.6%	94.5%	89.8%			
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%	93.1%	92.5%	92.1%	91.9%	92.2%	91.9%			

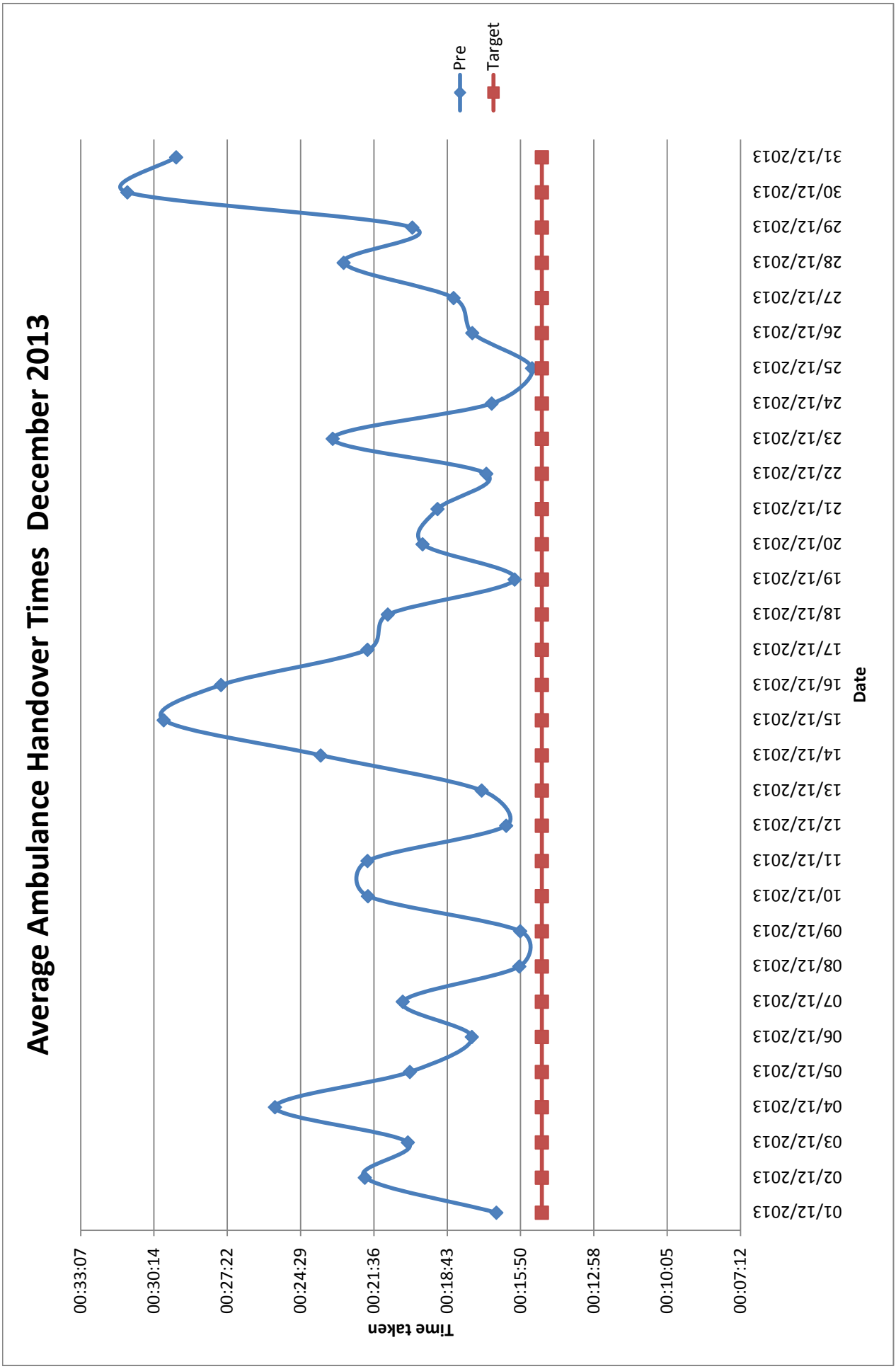


* Note: Total Admissions from the Symphony system



The main issue has been bed flow and the actions taking place in January to improve performance have been discussed in detail at the Integrated HealthCare Governance Committee.

Key actions being implemented include;
-TTO pathway review and change
-Medical on call rota change
-Increased discharge at weekends (6 weekend ward rounds on medicine base wards)
-Therapy outreach pilot commencing 13th January
-Early discharge ward rounds
-Different escalation for 1st assessment and ED process delays


Average Ambulance Handover Times December 2013
Pre
Target
Time taken
00:33:07
00:30:14
00:27:22
00:24:29
00:21:36
00:18:43
00:15:50
00:12:58
00:10:05
00:07:12
Date
01/12/2013
02/12/2013
03/12/2013
04/12/2013
05/12/2013
06/12/2013
07/12/2013
08/12/2013
09/12/2013
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29/12/2013
30/12/2013
31/12/2013

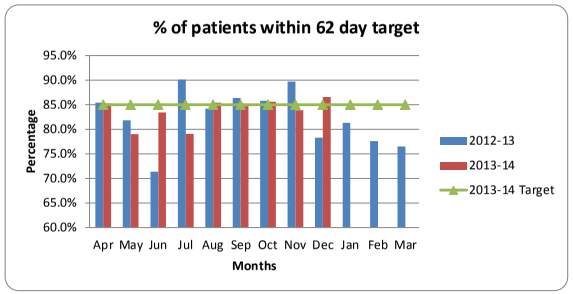
Cancer

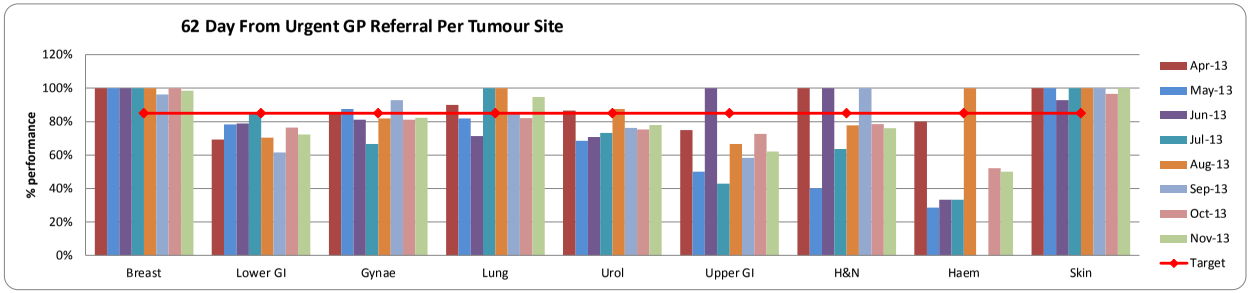
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Q1	Q2	Q3
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	95.80%	97.60%	96.30%	95.87%	95.74%	96.76%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.60%	100.00%	99.65%	99.55%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	98.12%	97.76%	98.56%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	100.00%	100.00%	98.15%	98.08%	100.00%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	97.80%	95.80%	95.70%	97.73%	97.30%	96.66%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	96.30%	100.00%	94.12%	98.72%	98.04%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	85.60%	83.90%	86.60%	82.04%	83.44%	85.30%

Validated data confirmed the Trust did not achieve 62 days from urgent GP referral in November, early indications are that the Trust has achieved the standard for December 2014 and quarter 3 however the data is not finally validated on the national system until the 7th February.

Progress against the standard has been made month on month during quarter 3.

The cancer Recovery Board continues to meet and the key actions to ensure sustainability are continuation of pathway reviews, oncology appointments, administration processes and time to diagnostics.



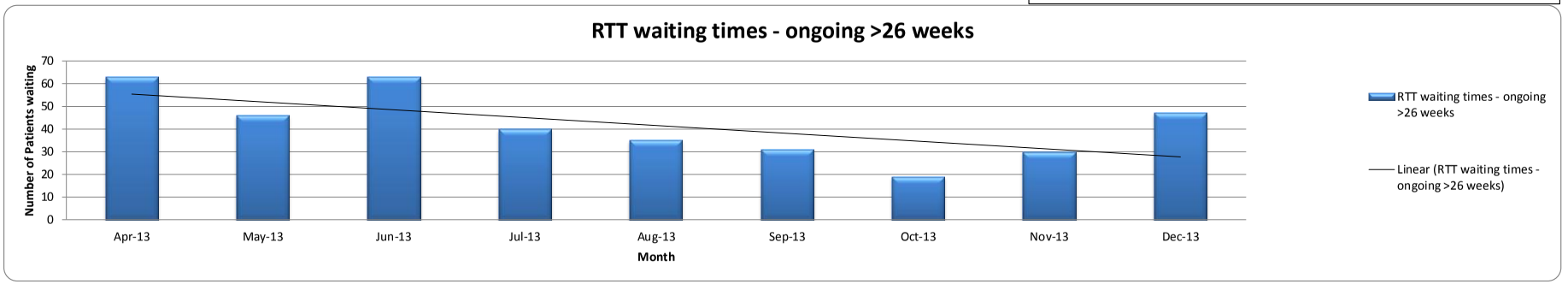


RTT Waiting Times

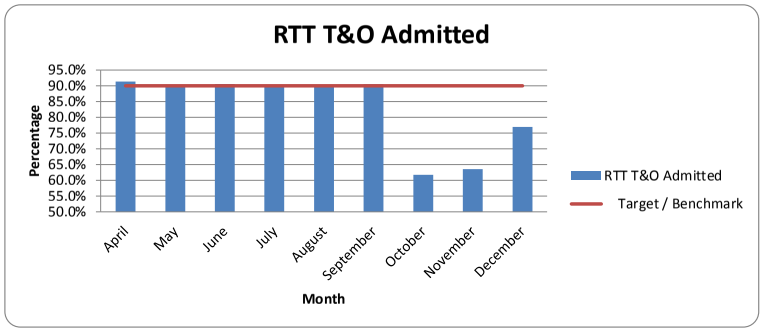
Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	19	30	47
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0

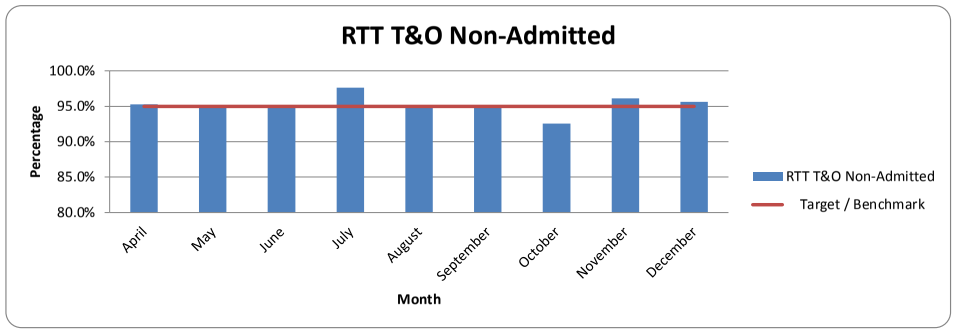
Key Notes:
The recovery plan for T&O RTT continues to be implemented and monitored through the weekly Performance Meeting. The Trust is on plan to deliver the February 2014 month position and has continued to deliver the monthly Trust wide RTT position.

The growth in the patients waiting over 26 weeks is predominantly due to the T&O backlog. These patients have been dated for their procedure during January and February.



Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	April	May	June	July	August	September	October	November	December
RTT T&O Admitted	CCG & TDA	**90%**	91.3%	90.3%	90.5%	90.1%	90.1%	90.5%	61.7%	63.6%	76.9%
RTT T&O Non-Admitted	CCG & TDA	**95%**	95.3%	95.2%	95.0%	97.7%	95.1%	95.0%	92.5%	96.1%	95.6%





REPORT TO THE TRUST BOARD
DATE: 30 JANUARY 2014

Report Title	Urgent Care Update
Agenda item	11
Sponsoring Director	Deborah Needham, Acting Chief Operating Officer
Author(s)	Richard Wheeler, Urgent Care Project Manager
Purpose	For Information & Assurance
Executive summary • Performance against the 95% four hour standard remains inconsistent • Attendances and emergency admissions continue to increase • The work streams within the urgent care programme continue to work to plan and updates are provided within the report • The Ambulatory Emergency Care Network undertook a visit and review of the Ambulatory Care Centre and feedback is provided within this paper	
Related strategic aim and corporate objective	1. Provider of quality care
Risk and assurance	Risk of non achievement of national targets
Related Board Assurance Framework entries	11
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	The consistent failure to achieve the transit time standard means that the Trust is in default in the regulatory framework provided by the Trust Development Authority (TDA)

Enclosure H

Actions required by the Board

The Board is asked to note the contents of this paper and seek clarity to gain assurance

Urgent Care Programme Update

1. Urgent Care Programme Structure

The Urgent Care Programme has been running since 2012, and the realignment and refocus of its work streams in the latter stages of Q3 13/14, Figure 1, are proving successful. Terms of reference for each project group have now been agreed, and a revised programme plan has been produced. Furthermore, a new Urgent Care Project Manager has now been appointed.

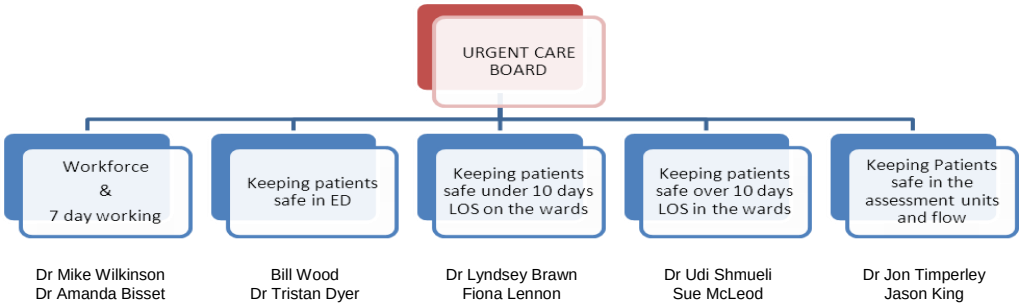


Figure 1

2. Urgent Care Working Group South

Once a week, the Urgent Care Working Group South takes place. This group consists of all Healthcare providers, CCG and Social care partners in the south of the County, allowing all representatives to objectivly discuss urgent care matters together. The focus of the group for has changed slightly for January February 2014 and will be focusing on how primary care can support with preventing admission and how we can ensure patients are discharged earlier in the day. Over the last month the Director of Operations from NHS England area team has taken on the chair of the meeting from the CCG and our portfolio Director from the TDA has also been invited.

3. Overview of Urgent Care Programme Work Stream for Q4 2013/14

3.1 Workforce & 7 day working

This work stream has made a noticeable impact, with additional Consultants now present in ED providing 7 day cover, Monday – Friday 8am – 9pm and 6hrs each weekend day. Furthermore, the A&E department is planning to increase the number of GP's who are supporting during peak times, this will help with patient experience and ensure only those patients requiring acute care are seen by ED staff.

This work stream is being reviewed this month to increase the effectiveness further by re-defining and expanding its objectives, however, current tasks detailed on the programme include:

- Review of work stream actions
- Review of Metrics, including source
- Appoint new Urgent Care acute managerial lead
- Audit of readmissions
- Medical Workforce Development Plan for A&E & Trust-wide
- Develop and plan for Therapies, Diagnostic, Support services and other partnership organisations, to provide a comprehensive 7 day service
- Appoint additional middle-grades in key specialties
- Appoint additional Acute Care Physicians

3.2 Keeping Patients safe in the ED

The ED department continues to see increased attendances. Subsequently, we have failed to deliver the 4hr transit time.

Current tasks detailed on the programme include:

- Complete the recruitment of nurse staffing in ED based on the increased cubicle capacity, this will allow for earlier assessment and safer nursing practice.
- Monitor and Sustain 2hr safety rounds
- Monitor and Sustain use of red flags
- Develop and document rapid assessment model to reduce first assessment breaches
- Increase Mental Health nursing capacity to ensure patients do not wait unnecessarily for assessment
- Implement early elderly patient review model in ED
- Review of Intermediate Care Support
- Implement organisational improvement programme plan
    - £65k has been secured from the LETC for organisational development within ED.
- Twice weekly breach analysis meetings. Actions fed into work stream steering group
- Commence recruitment for ANP's following banding of roles
- Development of Urgent Care Centre
- Further development of GP model in ED
- Identify Frequent re attendees/admissions into A&E and review case management with GP and Nene

- Increase turnaround of radiology investigations and reporting (focus CT) - Stretch target
- Shift co-ordinator competencies to be fully embedded
- Develop, train and monitor clinical professional standards

3.3 Keeping patients safe under 10 days LOS

This newly reformed work stream has had two meetings, and is focusing on improving the discharge process. The total number of discharges is increasing, but the work stream aims to increase the discharges as will as ensure they occur earlier in the day to reduce overall occupancy and ensure safer flow through the hospital.

Current tasks detailed on the programme include:

- Continue to implement and embed Internal Professional Standards throughout the Trust through a structured programme of implementation.
- Embed Ward Workspace application across the Trust
- Review the full TTO process and develop a new standard
- Continued rollout of Nurse Led Discharge across surgery and medicine
- Implement patient streams to appropriate beds where LOS >72 hours
- Implement project to discharge 2 patients before 12md on each ward
- Review and refine clear admission and discharge documentation
- Embedding EDD (Estimated Date of Discharge) across Trust
- Review Discharge Lounge functionality with a clear aim to increase usage

3.4 Keeping patients safe over 10 days LOS

This work stream is also newly formed, and its current focus includes community beds and Dementia pathways.

Current tasks detailed on the programme include:

- Training on Nurse Facilitated Discharge at community wards
- Implement and refine community MDT to reduce LOS
- Review admission criteria for community beds
- Introduction of non-weight bearing pathway
- Complex discharge training for staff
- Twice weekly review and Analysis of the 200 patients with a LOS over 10 days by each directorate to ensure challenge at ward level
- Refine and further develop dementia pathway with NCC after the additional (winter funded) beds close in April 2014
- Review current Discharge to Assess project and work with partners to incorporate NCC patients

3.5 Keeping patients safe in the Assessment Units and Flow

The Ambulatory Care Centre has been open since September 2013, and received high praise from the Ambulatory Emergence Care Network in a recent visit. The on-take rota in the Assessment Units has changed, to ensure continuity through the same Consultant care. In addition, trials of Pharmacist involvement in ward rounds is underway and early figures show improved discharge rates and reduced length of stay in the assessment units.

Current tasks detailed on the programme include:

- Change ambulatory care criteria to process rather than pathway in line with the AEC network recommendations
- Review Bed Management Policy to ensure patients are not moved from their base ward unless clinically necessary.
- Review and revise escalation policy to ensure both acute hospitals work to similar triggers
- Phase 2 Ambulatory Care project
- Further develop, Implement and monitor professional standards for ED and Assessment Units
- Shift co-ordinator competencies embedded
- Embed daily board rounds and MDT focused patient reviews - EAU, SAU, Benham
- Agree escalation for senior doctor review

4. Ambulatory Care

The Ambulatory Emergency Care (AEC) Network visited on 6th January 2014. We provided a presentation of our ambulatory care journey and some information on activity. The AEC team also gave a presentation which included some of the fundamentals of setting the unit up. They undertook a walk through of the patient pathway through ED, the assessment units and through to the ambulatory care centre (ACC).

They were very positive regarding the work we had already undertaken with ambulatory care in such a short timeframe. The initial feedback was positive and they commented on how impressed they were with the location, facility and the enthusiastic team.

They suggested we review and refine the following:

- Extending opening hours
- Increased medical cover for the unit
- Look at how we extend buy in from clinical teams within surgery and orthopaedics
- Ensure strong processes are in place to stream patients from the ED
- Use of other experienced based design tools

The team also offered help with reviewing measures, undertaking a sustainability assessment and ROI assessment. They have also offered to return and facilitate a workshop of our choice which is currently being agreed. In summary a very successful visit which was well received by the team who have implemented the unit.

5. Recommendation

The Board is asked to review and discuss this paper and seek clarity to gain assurance.

REPORT TO THE TRUST BOARD

DATE 30 January 2014

Title	Finance Report
Agenda item	12
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance
Purpose	To report the financial position and associated risks for the period to December 2013.

Executive summary

The report sets out the financial position for the period to December 2013 (month 9). The year to date I&E position is a deficit of £3.6m, £0.3m adverse to the forecast position for the same period.

The key issues arising from the report are:

- The Trust has agreed a year end forecast with NENE CCG of £185m which is reflected in the year to date and forecast position.
- The gross forecast is for a deficit of £6.9m by the financial year end.
- The TDA have identified £4.5m of System Support funding to help the Trust achieve a breakeven position.
- The Trust must develop actions to address the remaining £2.4m gap to achieve a breakeven by the financial year end.
- In light of the TDA support and CCG agreement the Trust may avoid the requirement to access the agreed temporary borrowing facility in the final quarter of the financial year.

The position as reported has been submitted to the TDA on Monday 20th January. This includes a change to the forecast I&E outturn which is now for a breakeven position in recognition of the TDA system support funding.

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

Enclosure I

Actions required by the Board

The Board is asked to note the current financial position and forecast I&E position. The Board is asked to consider the formal acceptance of the TDA System Support funding of £4.5m in the context of achieving a breakeven position by the financial year end.

Northampton General Hospital NHS
NHS Trust

Financial Position Month 9 2013/14

Report to
Trust Board
January 2013

Enclosure I

Performance against Statutory Duties

	YTD Actual £'000	YTD TDA Plan £'000	Variance £'000	Forecast outturn £'000	Full Year Plan £'000	Variance £'000
Delivering Financial performance	-£3,673	-£3,014	£ 659 Adv	-£2,400	£0	-£2,400
Achieving EFL (£000's)	N/A	N/A	N/A	£4,303	£4,303	£0
Achieving the Capital Resource Limit (£000's)	£6,227	£6,363	£ 136 Fav	£14,120	£14,120	-£0
Subsidiary Duties						
Better Payment Practice Code:						
Volume of Invoices	96.41%	95.00%	1.41% Fav	95.00%	95.00%	-
Value of Invoices	98.21%	95.00%	3.21% Fav	95.00%	95.00%	-

Financial Performance

- The I&E position for the period ended December 2013 is a £3,673k deficit. TDA Planned deficit to December £3,014k an adverse variance £659k. Forecast trajectory £3,401k to December an adverse variance of £272k.
- Impact of the Nene CCG income settlement of £185m after case mix now accrued. This has been based on the agreed forecast trajectory with the CCG.
- Forecast financial position includes the proposed support from the TDA of £4.5m leaving an net deficit of £2.4m for recovery to achieve a breakeven by the year end.
- Risk of exceeding forecast control totals which must be mitigated to achieve break even position. December performance indicates control totals breached by £272k demonstrating risk to delivery of breakeven in final quarter.

Capital Expenditure

- Capital plans have now been reviewed and the CRL has now been fully committed by drawing forward schemes. This has created a capital contingency of £457k against a previously fully committed 2014/15 capital programme.
- Expenditure is forecast to significantly increase for the remainder of the year. Regular meetings to monitor progress now take place to mitigate the risk of slippage.

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

- Impact of Nene CCG income settlement and agreed TDA support potentially mitigates the short term liquidity issues to an extent that can now be managed through working capital measures. TBL loan now unlikely to be drawn subject to TDA support payments.

Key finance issues

- Nene CCG income settlement of £185m now accrued in the financial position.
- TDA non recurrent support of £4.5m included in latest forecast, reducing the deficit to £2.4m for recovery by the year end.
- Month 9 position indicates that control total used for the forecast are not being met in all areas by £272k, increasing risk of not achieving required financial duties.
- Financial position now tracked against budget and forecast trajectory.
- Practical steps required for immediate implementation to reduce run rate to mitigate the financial risk demonstrated in December.
- Continued monitoring of capital programme required to mitigate risks of slippage.
- Short term liquidity issues now able to be managed through working capital measures without need for TBL. Longer term liquidity to be addressed through the 2014/15 plan.

Actions

- Confirm control totals with each area with robust management to avoid repeat of December deviations from trajectory.
- Practical steps required for immediate implementation to reduce run rate to mitigate the risk demonstrated at month 9.
  - Defer all non essential expenditure in estates and corporate areas.
  - Enhanced approval process for all third party outsourcing.
  - Identify further opportunities within existing run rate.

Financial Performance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	November		October	November
Continuity of Service Risk Rating (Nov onwards)	2	Continuity of service rating 2 - material risk.	2	2
EBITDA %	3.6%	% earnings before interest, tax and depreciation.	3.4%	3.6%
Liquidity (days cover)	33	Restated liquidy cover based on latest Monitor guidance.	14.6	34.0
Surplus Margin	-1.85%	Marginal improvement in % earnings after interest, tax and depreciation.	-2.06%	-1.84%
Pay / Income	65.6%	Total year to date pay costs as a percentage of year to date income.	65.8%	65.6%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	(1,768)	Deficit of £1.36m before add back of impairment and donated assets.	(1,850)	(1,363)
Impairment and Donated Assets	(1,905)	Donated asset depr and impairment to be added back .	(1,314)	(1,886)
Normalised Position	(3,673)	I&E position excl donated asset depr and impairment.	(3,163)	(3,249)
TDA Plan (Year to date)	(3,014)	TDA Plan for year to December 2013 (Normalised).	(2,016)	(2,486)
CCG SLA Income Variance	4,248	CCG income is £4,248k above plan after fines and penalties.	1,783	3,118
TDA Normalised annual plan	0	Revsied Full year TDA control total.	(4,822)	(4,822)
Forecast EOY I&E postion	(2,440)	Current I&E forecast.	(4,799)	(4,798)
EBITDA Performance	£000's		£000's	£000's
Variance from plan	(659)	Improvement from month 8 position, now £659k behind TDA plan.	(1,147)	(763)
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	8,880	TDA Plan to December.	6,148	7,496
YTD Actual	8,468	Actual delivered to month 9 inc bank and agency.	6,429	7,247
% Delivered	95%	% delivery of Plan year to date.	105%	97%
LTF	11,655	Latest thinking forecast. All R,A,G schemes will deliver in full.	12,218	11,794
Annual Plan	13,000	Annual CIP target.	13,000	13,000
LTF v. Plan	90%	Planned annual % delivery of Plan.	94%	91%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	6,227	Capital expenditure for year to date £136k behind plan.	3,991	5,454
Committed as % of plan YTD	78%	% of plan committed for year to date.	47%	57%
Annual Plan	14,119	Capital Resource Limit increased following by ICT/CEF Tech fund bids approval.	13,424	14,120
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	(223)	Reduction in non current assets due to depreciation.	(156)	2,373
Current assets	(266)	Increase in inventories offset by reduction in stocks.	5,378	(1,814)
Current Liabilities	937	Fall in trade and capital creditors.	(5,324)	934
Cash	**£000's**		**£000's**	**£000's**
In month movement	201	Collection of older debt and draw down of PDC not yet paid out.	3,487	223
In Year movement	1,795	Collection of older debt and draw down of PDC not yet paid out.	1,371	1,594
DH Temporary Loans	0	TBL Loan facility of £4m available but unlikely now to be drawn down.	0	0
Debtors Balance > 90 days	1,818	Increase in debt due from month 8 to CRIPPS centre, NCA and overseas patients.	1,829	1,682
Creditors % > 90 days	0.00%	No creditors over 90 days.	0.00%	0.00%
Cummalative BPPC (by volume) YTD	89.6%	BPPC improved in December.	88.0%	88.7%

Key issues

CoSRR

- Shadow Continuity of Service Risk Rating is 2(material risk) which would trigger monthly intervention by Monitor, greater monitoring with consideration for potential investigation.

I&E Position

- I&E position has fallen behind forecast trajectory in December.

Cost Improvement Programme

- CIP programme latest thinking forecast £11.7m. Assumes delivery of red, amber and gap schemes totalling £1.3m
- Year to CIP delivery now £412k behind plan.

Capital

- Underspent against plan but with forecast to spend full CRL. Spend forecast to significantly increase in last quarter of the year.

Statement of Financial position

- Non current assets marginal fall due to depreciation without offset of capital additions.
- Fall in current assets due to reduction in debts offset by increase in inventories. Fall in current liabilities due to fall in trade and capital creditors.

Cash

- Liquidity has improved in December with the quarterly block contract payments and an advance of £2m that has not yet been clawed back by CCGs.
- On-going action to collect outstanding debt, particularly NCAs and over performance from CCGs continues to deliver a positive cash position in month.
- Expected TDA revenue support of £4.5m will mitigate the need for TBL.

Income and Expenditure Position (Performance against Plan and Forecast Trajectory)

I&E Summary	Annual Plan 2013/2014	YTD Actual	YTD Plan	Variance to Plan	YTD Forecast	Variance to Forecast	December 2013/14 Forecast	December 2013/14 Actuals	November 2013/14 Actuals	October 2013/14 Actuals	Forecast
	£000's	£000's	£000's	£000's			£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	178,382	174,134	4,248	178,536	(155)	20,465	20,310	20,512	20,583	242,176
Other Clinical Income	2,803	1,881	2,102	(221)	2,035	(155)	224	69	237	342	2,553
Other Income	26,031	18,472	19,310	(838)	18,639	(167)	2,041	1,874	2,010	2,151	24,890
Total Income	**260,584**	**198,734**	**195,546**	**3,189**	**199,211**	**(477)**	**22,730**	**22,253**	**22,759**	23,076	269,619
Pay Costs	(175,851)	(130,445)	(131,399)	954	(130,539)	95	(14,752)	(14,658)	(14,581)	(14,646)	(175,209)
Non-Pay Costs	(79,240)	(61,144)	(59,540)	(1,604)	(61,204)	61	(6,887)	(6,826)	(7,099)	(7,280)	(82,538)
CIPs	4,822	0	3,481	(3,481)	0	0	0	0	0	0	0
Reserves/ Non-Rec	(1,143)	0	(489)	489	0	0	0	0	0	0	0
Total Costs	**(251,413)**	**(191,588)**	**(187,947)**	**(3,642)**	**(191,744)**	**155**	**(21,639)**	**(21,484)**	**(21,680)**	**(21,926)**	**(257,747)**
EBITDA	9,171	7,146	7,599	(453)	7,467	(321)	1,090	769	1,079	1,150	11,872
							0	0	0	0	
Depreciation	(10,184)	(7,883)	(7,744)	(139)	(7,883)	0	(873)	(873)	(873)	(873)	(10,451)
Amortisation	(10)	(8)	(7)	(0)	(8)	(0)	(1)	(1)	(1)	(1)	(10)
Impairments	0	2,074	0	2,074	2,074	0	0	0	660	0	2,559
Net Interest	29	22	22	(0)	21	0	2	3	3	2	31
Dividend	(4,106)	(3,119)	(3,079)	(40)	(3,168)	49	(352)	(303)	(381)	(381)	(4,229)
Surplus / (Deficit)	**(5,100)**	**(1,768)**	**(3,210)**	**1,442**	**(1,496)**	**(272)**	**(133)**	**(405)**	**487**	**(102)**	**(228)**
Adjustments to Normalise Statutory Duties											
Donated Assets Depreciation	278	169	196	(27)	169	0	41	41	16	44	343
Impairments	0	(2,074)	0	(2,074)	(2,074)	0		0	(660)	0	(2,559)
Statutory Duties (I&E Position)	**(4,822)**	**(3,673)**	**(3,014)**	**(659)**	**(3,401)**	**(272)**	**(92)**	**(364)**	**(157)**	**(58)**	**(2,444)**

Financial Performance

- Financial performance to December 2013 £3,673k deficit. TDA planned deficit to December was £3,014k an adverse variance £659k. Forecast trajectory was £3,401k to December an adverse variance of £272k.
- Nene CCG Income settlement has been included in the financial position based on the agreed trajectory. Indications are that activity was below trajectory for December.
- Forecast financial position is £2.44m deficit as set out in the latest forecast position and after TDA support of £4.5m.
- The forecast is based on current forecast trajectory and a requirement that the organisation meets its control totals. Noted significant risk already demonstrated in December of exceeding control totals, which must be mitigated to achieve agreed break even position.

Key issues

Clinical Income (SLA and Other)

- Clinical income is £310k adverse to forecast trajectory. Due to fall in private and overseas patients and clinical income.
- Nene income is largely operating within the income settlement.

Other Income

- Other income is adverse to the forecast trajectory by £167k. Phasing of much of this income is subject to uncertainty. Historically phased to the end of the financial year.

Pay Expenditure

- Pay £95k favourable to forecast trajectory led by continued controls on agency and recruitment.

Non Pay Expenditure

- Non pay expenditure is £61k favourable to forecast trajectory led by reductions in maintenance and some areas of clinical supplies.

Depreciation and PDC

- Depreciation in line with forecast trajectory.
- PDC dividend is subject to changes in the year end balance sheet and will be adjusted accordingly.

Forecast Financial Outturn

Month 9 + 3 Forecast	Year to Date £000's	YTD Av. £000's	Mth 10 Forecast £000's	Mth 11 Forecast £000's	Mth 12 Forecast £000's	Full year Forecast £000's	YTG Av. £000's
SLA Clinical Income - Nene CCG and AMRD	139,708	15,523	15,541	14,295	15,455	185,000	15,097
SLA Clinical Income - All Other CCGs	37,806	4,201	4,383	4,140	4,306	50,636	4,277
Winter Pressures Funding	867	96	391	391	391	2,040	391
Other Clinical Income	1,881	209	224	224	224	2,553	224
Other Income	18,472	2,052	2,075	2,075	2,267	24,890	2,139
							-
Total Income	**198,734**	**22,082**	**22,614**	**21,126**	**22,644**	**265,119**	**22,128**
							-
Pay Costs	(130,445)	(14,494)	(14,806)	(14,892)	(15,066)	(175,209)	(14,921)
Non-Pay Costs	(61,144)	(6,794)	(7,355)	(6,835)	(7,205)	(82,538)	(7,131)
Total Costs	**(191,588)**	**(21,288)**	**(22,161)**	**(21,727)**	**(22,270)**	**(257,747)**	**(22,053)**
							-
EBITDA	7,146	794	454	(601)	373	7,372	75
							-
Depreciation	(7,883)	(876)	(856)	(856)	(856)	(10,451)	(856)
Amortisation	(8)	(1)	(1)	(1)	(1)	(10)	(1)
Impairment of Fixed Assets	2,074	230	485	-	-	2,559	162
Net Interest	22	2	3	3	3	31	3
Dividend	(3,119)	(347)	(370)	(370)	(370)	(4,229)	(370)
							-
Surplus / (Deficit)	**(1,768)**	**(196)**	**(285)**	**(1,825)**	**(850)**	**(4,728)**	**(987)**
							-
Donated Asset Depreciation	169	19	64	65	45	343	58
Impairment of Fixed Assets	(2,074)	(230)	(485)	-	-	(2,559)	(162)
Nomalised Suplus / (Deficit)	**(3,673)**	**(408)**	**(706)**	**(1,760)**	**(805)**	**(6,944)**	**(1,091)**

Key Issues

- Run rate forecast now updated for December performance with a forecast gross deficit of £6.9m.

- Forecast based on:
  - historic run rates adjusted for working days in each month.
  - Includes the impact of the guaranteed income settlement with Nene CCG.
  - Run rate for pay and non pay adjusted for known trends and planned winter pressures income and expenditure
  - Historic March increase in costs reduced based on updated controls in place for financial year on discretionary pay expenditure.

- TDA support has now been proposed of £4.5m. Leaving a net deficit of £2.4m.

- Immediate non recurrent measures required to deliver a break even position.

Delivering Breakeven

	£m
Gross forecast I&E deficit	**-6.94**
TDA National Funding	4.50
Residual deficit	**-2.44**
Release of central provsions	1.50
Management of non-pay	0.25
Non-NENE CCG contracts	0.25
Additonal measures required	**-0.44**

- The gross forecast based on M9 results is for a year end deficit of £6.9m. This has increased by £0.4m compared to the forecast prepared in month 8.
- The TDA are proposing to make £4.5m available form a national fund to assist the Trust in delivering an I&E breakeven position for 2013/14.The Trust had previously requested £4.8m support from the TDA. The funding is non-recurrent and is not repayable subject to achieving an I&E breakeven by the financial year end.
- A review of central provisions indicates that £1.5m of provisions can be applied to the financial position. A further review of provisions is underway as part of the final accounts process and will determine if any further scope exists.
- Close control of expenditure and significant expenditure commitments in the remaining two months should ensure control totals are met and run rate forecasts hold true.
- Final allocation and agreement of winter funding should offset any further winter pressures
- Management of non-NENE CCG contracts may yield the Trust additional income.
- Close management of RTT and outsourcing costs will be required and should be considered in the context of the fixed NENE CCG settlement.
- The forecast position for February is for a significant deficit. The finance team are reviewing the assumptions supporting the February forecast.

Clinical Income – CCG Analysis

Actual M9 + FOT	Actual YTD Dec	Jan £000	Feb £000	Mar £000	Total 13/14
SLA Income					
Nene CCG					
Nene CCG - Gross	142,896	15,946	14,735	15,630	189,206
Nene CCG - Fines & Penalties	(5,453)	(599)	(597)	(577)	(7,226)
Nene CCG - ARMD	1,081	120	120	120	1,442
Nene CCG - ARMD Medicines	1,184	132	132	132	1,578
Sub Total Nene CCG	**139,708**	**15,599**	**14,389**	**15,304**	**185,000**
	0				
EMSCG - Gross	29,779	3,397	3,233	3,340	39,749
EMSCG - Fines & Penalties	(642)	(101)	(100)	(102)	(945)
Corby CCG	2,725	336	322	334	3,717
Others	3,446	393	362	384	4,585
NCAs	2,497	358	324	351	3,530
Winter Pressure Funding	867	391	391	391	2,040
Total SLA Income	**178,382**	**20,373**	**18,921**	**20,002**	**237,676**

Key risks to Income Forecast

Risks to the forecast position:

- ARMD excluded medicines have increased above trend in December– if this trend continues there will be significant extra costs but no increase in income. Given the fixed income settlement this may be a real increase however analysis is being undertaken to validate this position and update the forecast accordingly.

- Challenges from other CCGs and Specialised Commissioners may increase above the levels anticipated, therefore it is critical to agree these quickly.

Activity & Financial Performance

Nene CCG (£185m year end agreement)

- The forecast to the left includes the £185m year end agreement offered by Nene CCG.
- ARMD Medicines have increased above plan and forecast during November and December.
- The risk of significant increases in challenges affecting the Nene position has been mitigated by this agreement. The contract will continue to be monitored but any new challenges will not have a financial impact.

Corby CCG (£374k under contract value)

- Non elective activity has continued to over perform however this has been offset by under performance in high value critical care.

Other CCGs (£493k under contract value)

- The other CCGs are under performing against their contract value with the exception of West Leicester CCG, which has an over performance of £18k (40%) driven by A&E and non elective activity.

Specialised Services (£445k over contract value)

- The most significant area of over performance is critical care (£1m).
- Direct access for antenatal screening is also over performing (£277k), and outpatient procedures (dental procedures) are over performing by £175k.
- The above are offset by under performance across other points of delivery notably excess bed days.
- There are also provisions for fines and penalties (£642k) to cover readmissions and MRET. Discussions are under way to seek reinvestment of these fines in 2013/14.

Winter Funding 2013/14 – Funding Allocation and Expenditure

Northampton General Hospital	Lead	Start date	Agreed Total
Pre- Winter Business Case approval 13/14	DN	01-Nov-13	920.0
Escalation Areas	DN	01-Nov-13	200.0
EAB (24/7)			70.0
GDSU			65.0
Heart Centre			65.0
Emergency theatres (2.2WTE)	SM	02-Dec-13	100.0
GP's in ED	DC	25-Nov-13	220.0
Discharge facilitators x 2 (community & acute)	AD	out to advert	30.0
Therapy staff for front door (Renamed to Admission Avoidance NHFT)	SM	06-Jan-14	38.4
Admission Avoidance (23rd December - 5th January)	FL	23-Jan-14	25.6
A&E Spend .. Night Time Doctor	FL		13.0
Social worker support	MC	TBC	35.0
Community therapy	LA	06-Jan-14	75.6
Site manager x 1	AD	out to advert	30.0
UC project manager	DN	01-Nov-13	52.0
AE equipment	DC	01-Dec-13	60.0
Porter for Benham	FL	01-Nov-13	15.0
Weekend ward co-ordinators (managers)	FL	30-Nov-13	21.0
Additional management support wards	FL	30-Nov-13	82.0
Consultant additional PA's medicine	FL	30-Nov-13	74.0
CCG DTA project mgr	FL	01-Nov-13	20.0
Visual Hospital Screens	RW	30-Dec-13	5.0
Infomatics support	SM	01-Nov-13	30.0
Weekend Ward Clarks	FL	30-Nov-13	16.0
NGH Total			2,062.6
NCC			738
Southfields 8 beds	MC	16-Dec-13	128
Favell house support spec dementia team	MC	01-Jan-14	160
Frail Elderly	GF	01-Nov-13	450
NHFT			1,165.8
Mental health nurse	JS		42
Favell house 12 beds	JS	16-Dec-13	570.4
Cynthia spencer 4 beds	JS	02-Dec-13	95
Frail Elderly	GF	01-Nov-13	450
Community Therapy		TBC	8.4
Total NHFT			
Total Funding Available			4,000.0

Key highlights

- In Sept 2013 Health economy notified to receive £4m of winter pressure to support delivery of waiting targets.
- Funding of £4m was then allocated between NHFT, NCC and NGH Trust to secure a best possible outcome across health and social care. Trust allocation of £2.06m.
- Each party will receive funding and own delivery (CCG holding the full £4m with invoicing process for each of the separate areas).
- The table opposite shows the share of the analysis of the £4m schemes which are currently subject to review and change each month.
- Currently 28 schemes are agreed across NGH, NHFT and NCC for additional bed capacity, staffing and equipment.
- NGH Trust - £920k of the funding was agreed to support previously agreed investment to support the emergency pathway. Remaining schemes have been agreed with the emergency care groups and monitored each month.
- NGH Trust On-going monthly monitoring of each scheme is in place
- NGH Trust Accountable Executive is Debbie Needham.

Risks and Opportunities

Risks not Included in Financial Forecast

Downside Risk	£000s Unmitigated Risk	Action to mitigate risk	£000s Residual Risk
Hospital Inspection regime requires immediate investment in additional resources above that included within the current financial plan and forecast	(250)	Range of inititaives have already been set up to demonstrate the Trust quality and safety delivery e.g. QuEST	(250)
Contract Challenges raised by CCGs are successful. Contractual Fines may be imposed by commissioners for failure to deliver key performance	(500)	Robust rebuttal of contract challenges making use of experienced resources and impact of income settlement with Nene CCG	(250)
Transformation Programme Slippage in CIP delivery of red and amber schemes	(1,935)	Continued focus on delivery of CIP and development of mitigation pipeline. Residual risk is red and maber schmes in year to go position.	(468)
Cost of winter pressures exceed allocated funding	(1,400)	Trust has recieved allocation to manage Winter presures and A&E delivery. Winter plan and commitments to be agreed at UCB and SMB. Reduced risk at now only three months year to go.	(140)
Specialised Commisioners CQUIN schemes are not delivered and further penalty imposed by EMSCG. Current forecast non achievement of £200k included in financial position however further risk exists of deterioriation in this position of £467k	(467)	Robust monitoring and performance framework to be established. Risk to be identified and 25% provision made in monthly reporting. Now updated following CCG agreements	(234)
Net Revenue Risk	**(4,552)**		**(1,342)**

Opportunities	Value of opportunity £000s		Adjusted Risk £000s
Bidding for Fines and Penalties for Non Nene CCGs including readmissions and MRET.	£ 700	Development of bids to draw down re-admissions fines in part or in whole to extent not built into FRP	350
	700		**350**

Liquidity Issues	Value of opportunity £000s		Adjusted Risk £000s
CCG has now confirmed that it has breached it cash limit and will not be able to make mandate payments in March 2014	15,000	Unknown mitigation at this stage but CCG will need to request additional cash support. AT have confirmed that the CCG has sufficient cash however this remains a risk.	15,000

Risks

- Risk table has been updated to show the unmitigated and mitigated risk to the financial position.
- Some contractual risks have been mitigated with introduction of the guaranteed minimum income settlement.
- Risks associated with delivery of financial control totals in the winter remains significant.
- CIP slippage or non delivery also continues to be a risk. Full year forecast for CIP delivery is now proposed to provide more certainty regarding the year end delivery.
- Liquidity risk remains however assurances have been made by the Area Team that sufficient cash will be made available to CCGs.

Opportunities

- Work on securing reinvestment of fines from other non Nene CCGs and Specialised Commissioners continues.

Statement of Financial Position as at December 2013

TRUST SUMMARY BALANCE SHEET MONTH 9 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	0	133,789	0
IN YEAR REVALUATIONS	0	5,555	5,546	(9)	6,825	6,825
IN YEAR MOVEMENTS	0	5,780	6,432	652	14,340	14,340
LESS DEPRECIATION	0	(7,017)	(7,883)	(866)	(10,512)	(10,512)
NET BOOK VALUE	**133,789**	**138,107**	**137,884**	**(223)**	**144,442**	**10,653**
CURRENT ASSETS						
INVENTORIES	4,934	4,690	5,503	813	4,985	51
RECEIVABLES						
NHS DEBTORS	4,103	8,171	7,033	(1,138)	4,044	(59)
OTHER TRADE DEBTORS	2,295	1,449	1,366	(83)	2,295	0
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(443)	0	(443)	0
CAPITAL RECEIVABLES	0	0	0	0	0	0
NON NHS OTHER DEBTORS	132	425	475	50	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,636	2,548	(88)	2,514	0
OTHER RECEIVABLES	676	1,101	1,030	(71)	925	249
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,391	2,441	50	1,410	23
	10,149	**15,215**	**13,935**	**(1,280)**	**10,362**	**213**
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	4,342	5,936	6,137	201	4,654	312
NET CURRENT ASSETS	**19,425**	**25,841**	**25,575**	**(266)**	**20,001**	**576**
CURRENT LIABILITIES						
NHS	628	1,340	1,192	148	1,495	(867)
TRADE CREDITORS REVENUE	1,255	1,533	879	654	4,765	(3,510)
TRADE CREDITORS FIXED ASSETS	1,744	2,229	1,881	348	2,852	(1,108)
TAX AND NI OWED	1,769	3,388	3,400	(12)	3,400	(1,631)
NHS PENSIONS AGENCY	2,013	2,170	2,191	(21)	2,189	(176)
OTHER CREDITORS	495	362	335	27	494	1
SHORT TERM LOANS	669	527	621	(94)	785	(116)
ACCRUALS AND DEFERRED INCOME	6,132	11,208	11,229	(21)	5,378	754
PDC DIVIDEND DUE	36	763	1,066	(303)	25	11
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	3,501	3,338	3,127	211	650	2,851
PROVISIONS over 1 year	1,281	1,281	1,281	0	1,331	(50)
NET CURRENT LIABILITIES	**20,309**	**28,925**	**27,988**	**937**	**23,993**	**(3,684)**
TOTAL NET ASSETS	**132,905**	**135,023**	**135,471**	**448**	**140,450**	**7,545**
FINANCED BY						
PDC CAPITAL	100,115	100,115	100,969	854	103,417	3,302
REVALUATION RESERVE	32,486	35,966	35,966	0	36,729	4,243
DONATED ASSET RESERVE	0	0		0	0	0
GENERAL RESERVES	304	304	304	0	304	0
I & E CURRENT YEAR	0	(1,362)	(1,768)	(406)	0	0
FINANCING TOTAL	**132,905**	**135,023**	**135,471**	**448**	**140,450**	**7,545**

Key Issues

Non Current Assets

- Reduction in non current assets £223k as in month depreciation exceeds capital additions.

Net Current assets

- Fall in non current assets in month by £266k.
- Inventories increase by £813k relates to increased stocks of patient implants.
- NHS debt fallen by £1,138k largely due to prompt payments of current SLA's offset by debt for CRIPPS increasing.

Net Current Liabilities

- Fall in net current liabilities during the month by £937k.
- Reduction in NHS Creditors £148k, Trade Creditors £654k and Capital Creditors £348k offset by increase in PDC.

Financing

- Increase in PDC capital of £854k resulting from draw down of Carbon Energy Funding.

Capital Expenditure

Category	Approved Annual Budget 2013/14 £000's	TDA M9 Plan £000's	Year to Date as at Month 9 M9 Plan £000's	M9 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 9 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 9 Forecast M9 £000's	Under (-) / Over £000's
Linear Accelerator Corridor	0	400	0	0	0	0%	0	0%	0	0
Improving Birthing Environments	399	344	399	416	17	104%	416	104%	416	17
Endoscopy	150	150	150	150	0	100%	157	105%	157	7
Urodynamics	170	150	150	150	0	88%	154	91%	170	0
Haematology (Trust)	0	82	0	1	1	0%	23	0%	1	1
Annual Strategic Planning Approvals	32	693	0	0	0	0%	0	0%	32	0
MESC	2,018	981	943	878	-65	44%	898	44%	2,018	0
Estates	3,683	2,272	2,095	2,061	-34	56%	2,822	77%	3,658	-25
IT	3,542	1,546	1,605	1,568	-37	44%	2,999	85%	3,542	0
Other	997	42	367	350	-17	35%	408	41%	996	-1
Carbon Energy Efficiency Fund (CEEF)	3,350	0	853	853	0	25%	3,350	100%	3,350	0
Total - Capital Plan	**14,340**	**6,660**	**6,563**	**6,427**	**-136**	**45%**	**11,226**	**78%**	**14,340**	**0**
Less Charitable Fund Donations	-220	-200	-200	-200	0	91%	-200	91%	-220	0
Total - CRL	**14,120**	**6,460**	**6,363**	**6,227**	**-136**	**44%**	**11,026**	**78%**	**14,120**	**0**

Resources - Trust Actual	
Internally Generated Depreciation	10,501
SALIX	317
CEEF	2,760
SHSWTF - Vitalpac	368
SHSWTF - E Prescribing	174
Total - Available CRL Resource	**14,120**

Key Issues

- Expenditure lower than planned at December by £97k, year to date £136k.
- Full year forecast expected to fully achieve CRL limit.
- IT Innovation Funding of £542k has now been approved by DH and added to the capital plan although PDC drawdown not yet confirmed.
- Some minor slippage on all groups which will be recovered in the remainder of the financial year.
- All schemes are now being reviewed on a monthly basis with all project leads.
- Contingency has decreased as a result of advancing £550k medical equipment, £190k IT schemes and £150k preliminary works associated with Emergency Care.
- The Trust is required to spend it's internally generated cash resources to ensure that it can receive the additional national CEF and ICT allocations through PDC.
- Advancement of a number of high priority schemes from the 2014/15 plan has created a contingency of £457k to support spend against CRL to support PDC draw down.
- Nursing ICT technology fund applied for in January.

Cash Flow and Working Capital

MONTHLY CASHFLOW	APR £000s	MAY £000s	JUN £000s	JUL £000s	ACTUAL AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	FORECAST JAN £000s	FEB £000s	MAR £000s
RECEIPTS												
SLA Base Payments	17,721	19,030	15,721	23,380	19,172	17,506	23,166	17,522	17,434	21,383	17,485	17,485
SLA Performance / Other CCG investment							650	2,253	2,336		1,173	5,580
Health Education Payments (SIFT etc)	22	1,511	764	664	728	781	672	856	803	722	722	722
Other NHS Income	2,923	877	1,596	616	1,709	1,154	1,804	1,817	1,351	1,573	1,295	1,535
PP / Other (Specific > £250k)			329									
PP / Other	892	1,096	655	758	857	1,142	1,030	965	1,179	1,000	1,000	1,000
Salix Capital Loan									95	60	162	
EFL / PDC									853	539	1,234	676
Temporary Borrowing												
Interest Receivable	3	3	2	2	3	2	2	3	3	2	3	3
TOTAL RECEIPTS	21,562	22,518	19,067	25,419	22,469	20,586	27,324	23,416	24,053	25,278	23,074	27,001
PAYMENTS												
Salaries and wages	12,168	13,743	13,749	13,881	13,870	13,823	13,886	13,899	13,997	14,022	13,970	13,970
Trade Creditors	4,499	7,344	5,805	5,704	7,029	5,603	7,551	7,131	6,689	6,276	6,500	7,500
NHS Creditors	1,617	1,296	1,619	2,197	2,295	1,642	1,876	1,614	1,908	2,114	1,300	1,620
Capital Expenditure	477	526	727	528	840	531	526	737	1,259	2,235	2,314	2,676
PDC Dividend						2,089						2,156
Repayment of Salix loan						143						183
TOTAL PAYMENTS	18,761	22,909	21,900	22,310	24,035	23,831	23,840	23,382	23,853	24,647	24,084	28,105
Actual month balance	2,801	-392	-2,833	3,109	-1,565	-3,245	3,484	34	200	632	-1,010	-1,104
Cash in transit & Cash in hand								240				
Balance brought forward	4,303	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	6,768	5,758
Balance carried forward	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	6,768	5,758	4,654

Key Issues

- Month end balance of £6.1m has risen by £0.2m from month 8.
- Forecast includes cash flow impact of Nene CCG income settlement.
- Cash flow has been based on a breakeven position with proposed TDA support paid in March 2014.
- Corby CCG was paid later than expected demonstrating the need for continued effort to ensure that the CCG meet their payment obligations.
- Cash forecast includes winter pressures funding of £2.04m, of which £867k has been invoiced.
- The capital plan is heavily phased for the last quarter of the financial year which includes the Carbon Energy Efficiency Scheme. PDC funding profile has now been submitted to the DH with £853k cash being received in December.
- Cash flow is still being reviewed on a weekly basis and monitored on a daily basis to ensure the Trust meets it's financial obligations. No payment shortfalls have been necessary yet.
- TDA temporary borrowing facility is now not likely to be required subject to the agreement and payment of the non recurrent TDA support of £4.5m.

Receivables, Payables and BPPC Compliance

Narrative	Total at December £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,365	348	193	150	674
Receivables NHS	3,107	951	560	452	1,144
Total Receivables	**4,472**	**1,299**	**753**	**602**	**1,818**
Payables Non NHS	(658)	(615)	(43)	0	0
Payables NHS	(3)	(3)	0	0	0
Total Payables	**(661)**	**(618)**	**(43)**	**0**	**0**

Narrative	Total at November £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,449	402	218	74	755
Receivables NHS	5,653	3,686	714	326	927
Total Receivables	**7,102**	**4,088**	**932**	**400**	**1,682**
Payables Non NHS	(1,631)	(1,613)		(2)	(16)
Payables NHS	(234)	(214)	(20)	0	0
Total Payables	**(1,865)**	**(1,827)**	**(20)**	**(2)**	**(16)**

Narrative	Number of Invoices	Analysis of Performance %	Value of Invoices £000's	Analysis of Performance %	Department
Total Paid	7,686		9,186		
On Time	7,639		9,191		
Processed by Payments Team	**99.39%**		**100.05%**		
N.B. Based on processing invoices comparing input date to payment date					
Total Paid	7,686		9,186		
On Time	7,410		9,022		
Within Target Compliance	**96.41%**	**96.41%**	**98.21%**	**98.21%**	
Paid Late	**276**		**164**		
TOP TEN BY NUMBER & VALUE					
Ashby Computer Services	2	0.03%	14	0.16%	
E7 Contracting Ltd	1	0.01%	8	0.09%	
Fresenius Kabi Ltd	51	0.66%	-1	-0.01%	
Hays Specialist Recruitment	11	0.14%	15	0.17%	Bank/Agency Office
J & M Arnold & Sons	2	0.03%	8	0.09%	
Mayday Healthcare Plc	7	0.09%	2	0.02%	
Padsca Limited	50	0.65%	6	0.07%	Bank/Agency Office
Sai Lakshman Limited	1	0.01%	6	0.07%	
university hospitals coventry and warwicks	2	0.03%	20	0.22%	
Urology Consultancy Ltd	1	0.01%	9	0.10%	
Sub Total	**128**	**1.67%**	**88**	**0.96%**	
Sub Total - % of late approvals in October	**46%**		**54%**		
December - Cumulative Position		**89.64%**		**92.32%**	
November - Cumulative Position		**88.68%**		**91.49%**	
Improvement in Month (+)		**0.96%**		**0.83%**	

Receivables and Payables

- NHS and non NHS receivables have both reduced in month by £2.63m given continued efforts to expedite material current payments over 30 days.
- Key mandate payments have now been made on time except for Corby who paid on the 20th of the month..
- Over 90 day debt of £1.82m includes PCT legacy debt of £0.3m, CRIPPS debt of £0.3m, NCA's debt of £0.3m and Overseas Patients debt of £0.2m.

BPPC Compliance

- BPPC has continued to improve in month and year to date (year to date 89.64% by volume, 92.32% by value) with the payments team continuing to achieve processing within the targets once approved.
- Problems persist in the processing of bank and agency invoices which if resolved will bring performance to levels which would fully meet the target.
- Work has continued with areas of non compliance to improve performance.

TDA Trust Monitoring / Continuity of Service Risk Rating

TDA Monitoring

- Each month the Trust must submit a monthly a detailed monitoring return. This return includes key financial performance metrics.
- The monitoring consider the trajectory of the Trust against its original plan and the underlying forecast position of the Trust after adding back non recurrent items.
- Performance at November is assessed as RED. This has already triggered a monthly escalation meeting with the TDA.
- The Trust will need to give due regard to developing the going concern statement in conjunction with the TDA and External Auditors.

Continuity of Service Risk Rating

- Now based on Continuity of Service Risk Rating.
- This rating has a scale from 1 – Significant risk to 4 No evident concerns. The rating is calculated by making use of two metrics:
    - Liquidity Ratio (Days) = (working capital balance x 360 / annual operating expense). 50%
    - Capital Service Capacity (times) = (Revenue available for capital service / annual debt service). 50%
- The Trust current rating is 2.5 – material risk. Monitor action would have been monthly monitoring or greater with consideration for investigation.

Metric	Score	Weight	Definition	Rating Categories			
				1	2	3	4
Liquidity Ratio (Full year forecast) (days)	35	50%	working capital balance x 360 / Annual operating expenses	<-14	-14	-7	0
Capital Servicing Capacity (times)	-2.04	50%	Revenue available for capital service / Annual debt service	< 1.25 x	1.25 x	1.75 x	2.5 x

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
30 January 2014

Title	Workforce Report
Agenda item	13
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Mark Ingram, Head of e-Workforce
Purpose	This report provides an overview of key workforce issues
Executive summary The key matters affecting the workforce include: • The key performance indicators show a decrease in Total Workforce Capacity (excluding Medical Locums) employed by the Trust and an increase in sickness absence.	
Related strategic aim and corporate objective	Strategic Aim 4: Foster a culture where staff can give their best and thrive. Corporate Objective: To develop and implement new ways of engaging & supporting staff to enable them to achieve their potential
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate
Related Board Assurance Framework entries	BAF 7: High bank & agency costs.
Equality Impact Assessment	No
Legal implications / regulatory requirements	No
Actions required by the Trust Board The Trust Board is asked to note the report.	

Northampton General Hospital NHS
NHS Trust

Trust Board
30 January 2014

Workforce Report

1. Introduction

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

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

The total sickness absence rate increased by 0.01% in December to 4.72%, which is above the Trust target. Ward based areas of concern within General Medicine are Eleanor ward at 12.45%, Corby Community ward at 11.5% and Allebone ward at 9.74% Within Surgery there is concern with Talbot Butler ward at 11.07% and Cedar ward at 7.85%.

There has been a decrease in Medical & Dental sickness absence which decreased to 0.90% in December. Work continues to increase accuracy and monitor sickness absence within this staff group, the Medical Staffing Department are now collating the Medical & Dental sickness absence records and submitting them to payroll within deadline for recording on ESR.

Benchmark of Number of Working Days Sickness Lost Per Employee

NHS Employers report from information provided by the Health and Social Care Informatics Centre (HSCIC) that NHS staff in England took an average of 9.5 working days off sick for 2012-13. This is based on taking the HSCIC published annual sickness absence rate for an organisation and applying it to a standard annual number of working days (the DoH use the definition of 225 working days as per the Cabinet Office guidance).

Using the National Benchmark, a comparison of calendar days lost per employee (2012-13) for NGH and other hospitals in the region is set out in the table below.

Organisation	No. Working Days Sickness Lost Per Employee
NHS National Average	9.5
Northampton General Hospital	10.13
Milton Keynes General Hospital	10.46
Kettering General Hospital	9.81
Bedford Hospital	8.60

Please note: for the purpose of the HR Workforce Performance Indicators within this report, the number of days lost due to sickness absence per employee is based on calendar days lost.

Workforce Capacity

Total workforce capacity (excluding Medical Locums) decrease by 9.38 FTE in December. The substantive workforce capacity increased by 2.54 FTE to 4,110.26 FTE and the temporary workforce capacity (excluding Medical Locums) decreased by 11.93 FTE to 290.82 FTE.

2.2 Workforce Information Update

Raising Concerns at Work

A campaign, to support any staff who may feel that they are witnessing wrongdoing at work, is currently being run within the Trust. Communications for this campaign are being delivered via weekly bulletins, screensavers and payslip attachments.

The Trust is committed to supporting staff so that they feel able to raise concerns, thus enabling action to be taken to rectify any issues. This campaign has included information to identify what whistleblowing is, the types of concerns that can be raised, why is it important to raise concerns and will include in future communications how to raise a concern, how staff are protected and where further advice can be obtained. New starters to the Trust are also provided with information on whistleblowing at Corporate Trust Induction.

Apprentice Assessment Day

A successful Apprentice assessment day was held in December, followed by interviews, with 6 posts filled across the Trust in areas including HR, IG, Medical Records and Oncology. The apprentices are due to commence in March and will cover Admin & Clerical and Customer Service roles. Dependent upon demand another assessment day is planned for February 2014.

Policy Changes

No policies for HR were ratified in December 2013.

3. Assessment of Risk

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

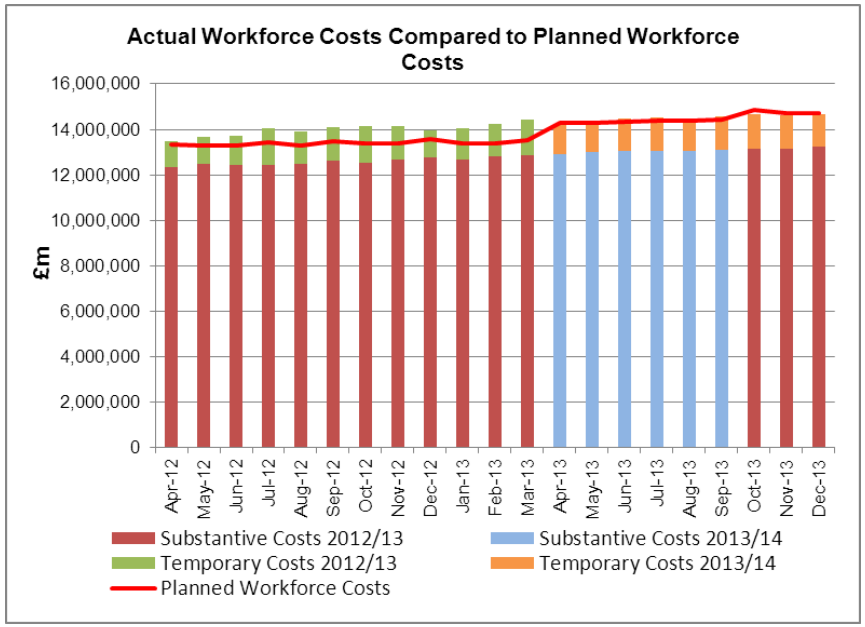
4. Recommendation

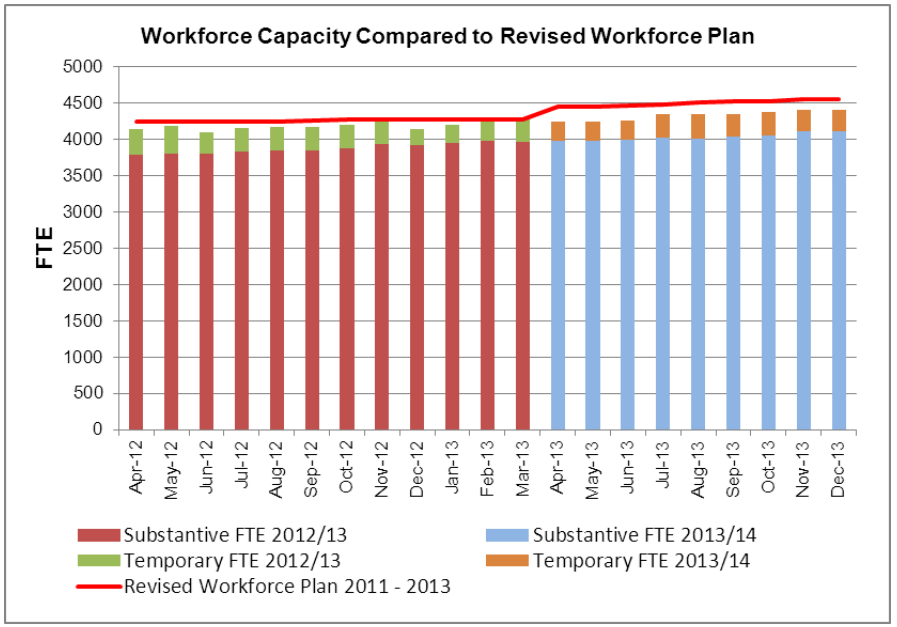
The Board is asked to note the report.

5. Next Steps

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

Human Resources Workforce Performance Indicators 2013/14 Month 9





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2012/13 (£1,000's)	12349	12460	12446	12447	12475	12617	12528	12648	12759	12692	12818	12881
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111	13153	13148	13238			
Temporary Costs 2012/13 (£1,000's)	1136	1189	1291	1615	1434	1481	1620	1489	1213	1334	1403	1568
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443	1493	1460	1420			
Planned Workforce Costs2013/14 (£1,0	14296	14307	14341	14358	14400	14411	14480	14466	14476	14453	14466	14414

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2012/13	3,786	3,799	3,800	3,838	3,842	3,853	3,877	3,937	3,927	3,952	3,979	3,968
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059	4,108	4,110			
Temporary FTE 2012/13	347	388	301	322	329	311	327	332	215	250	291	334
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291			
Revised Workforce Plan 2011/12	4,250	4,250	4,250	4,238	4,246	4,254	4,269	4,279	4,278	4,278	4,278	4,278
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,553	4,555			

Workforce Expenditure

Total workforce Expenditure (all pay elements) increased by £48,833 in December to £14.657m (this is below plan for Month 9).

Substantive workforce expenditure increased by £89,430 to £13,237,901.

Temporary Workforce Expenditure (including Medical Staff) has decreased by £40,597 to £1,419,745 = to 9.69% of the of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 9.38 FTE in December to 4,401.08 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,554.96 FTE.**

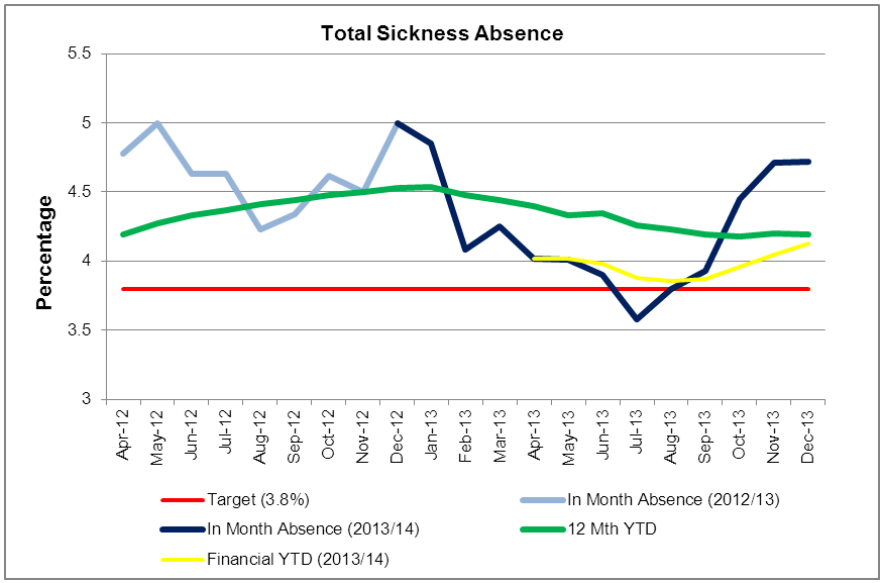
Substantive workforce capacity increased by 2.54 FTE to 4,110.26 FTE.

- 14 RNs from Spain and 20 RNs from the UK are due to commence January 2014; additional RN's are in the recruitment pipeline with a start date yet to be confirmed.

Temporary workforce capacity (excluding Medical Locums) **decreased by 11.93 FTE to 290.82 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 9

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Hospital Support
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	90.24%	90.44%	92.78%	83.59%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	6.61%	7.53%	6.21%	4.96%
Total Substantive Workforce plus Temporary Workforce against Budgeted Establilshment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	**96.62%**	97.80%	98.92%	87.95%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.08%	8.54%	8.20%	12.95%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence 2012/13	4.78	5.00	4.63	4.63	4.23	4.34	4.62	4.50	5.00	4.85	4.08	4.25
In Month Absence 2013/14	4.02	4.01	3.90	3.58	3.80	3.93	4.45	4.71	4.72			
12 Mth YTD	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19			
Financial YTD (2013/14)	4.02	4.02	3.98	3.88	3.86	3.87	3.96	4.05	4.13			

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 26,537 hours (163.30 FTE), which is a decrease of 2770 hours (17.05 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 47.12% (decrease of 4.69%), Agency fill rate = 24.09% (increase of 2.84%). Total bank & agency fill rate = 71.21% (decrease of 1.85% compared with the previous month).
- There has been a decrease in Admin & Clerical bank usage which may be attributed to monitoring of usage continues which categorises types of bank working- with agreed time frames for usage.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.19% in December 2013.

In month Sickness Absence has increased by 0.01% to 4.72% which is above the Trust target.

- Short term sickness absence decreased by 0.44% to 2.33%
- Long term sickness absence increased by 0.45% to 2.39% which is now above Trust Target.
- The total calendar days lost to sickness absence increased by 193 to 6,990 days lost.
- The number of days lost per employee has increased to 1.46 days.

Human Resources Workforce Performance Indicators 2013/14 Month 9

		Surgery Care Group						
		Directorate						
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck	Women	Children
Short Term Sickness Absence		1.60%	2.93%	2.43%	2.69%	1.78%	2.34%	2.01%
Long Term Sickness Absence		2.20%	3.32%	2.90%	2.91%	1.95%	2.73%	4.18%
Total Sickness Absence	Over 4.2%	3.80%	6.26%	5.33%	5.60%	3.73%	5.07%	6.19%
	3.9-4.2%							
	Under 3.8%							

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery Care Group decreased by 0.31%. There have been decreases in Head & Neck of 3.05%, T & O 1.4% and Theatres, Anaesthetics & Critical Care of 1.35%.

  There were decreases in total sickness absence on Abington Ward 4.42%, Althorp Ward 3.27%, Head & Neck 2.84%, ITU 0.55%, Rowan 2.72% and Willow Ward 4.12%. Hot spots for ward based sickness are Talbot Butler where total sickness absence has increased by 2.55% to11.07% and Cedar increasing by 2.67% to 7.85%.

		Medicine Care Group							
		Directorate							
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies	Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	1.24%	1.66%	2.41%	3.74%	2.39%	3.41%
Long Term Sickness Absence		2.20%	2.16%	1.67%	2.05%	0.00%	4.57%	2.83%
Total Sickness Absence	Over 4.2%	3.80%	3.40%	3.33%	4.46%	3.74%	6.96%	6.24%
	3.9-4.2%							
	Under 3.8%							

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency has increased by 0.61%. 13 wards showed decreases in total sickness absence in the month. The highest decrease within the Medicine Care Group was EAU with a decrease of 2.48%.

  Hot spots for ward based total sickness absence are Eleanor Ward which has increased by 7.26% to 12.45% of which 9.58% is for long term sickness absence. Corby Community Ward has increased to 11.5% and Allebone has increased by 3.93% to 9.74%.

		Hospital Support				M&D
		Directorate				
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	2.49%	1.86%	0.49%
Long Term Sickness Absence		2.20%	2.03%	1.07%	0.41%
Total Sickness Absence	Over 4.2%	3.80%	4.53%	2.94%	0.90%
	3.9-4.2%				
	Under 3.8%				

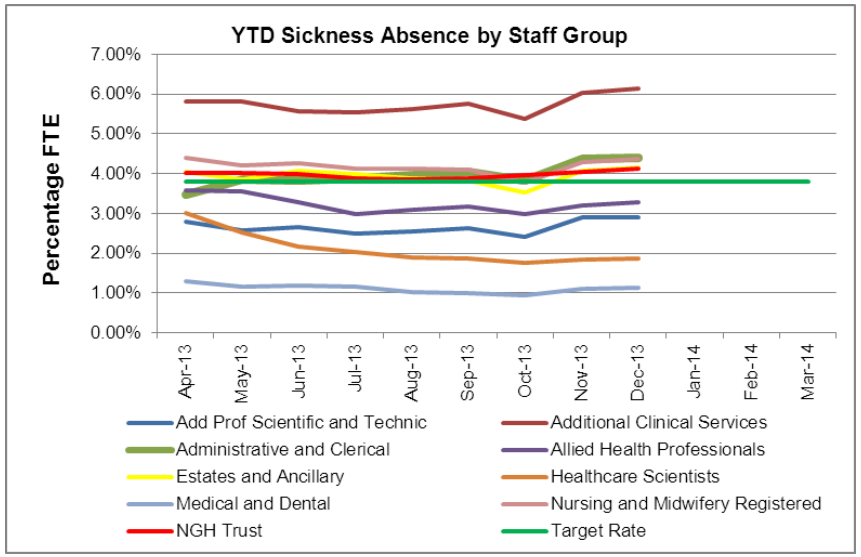
Hospital Support and Medical & Dental Summary

- The total sickness absence recorded for Facilities has decreased by 1.44%. Hospital Support total sickness absence continues to decrease and remains below Trust target at 2.94% in December.

  Medical & Dental sickness absence has decreased by 0.13% to 0.90% in December.

  Work is on-going ensure processes are in place to accurately record sickness absence.

Human Resources Workforce Performance Indicators 2013/14 Month 9



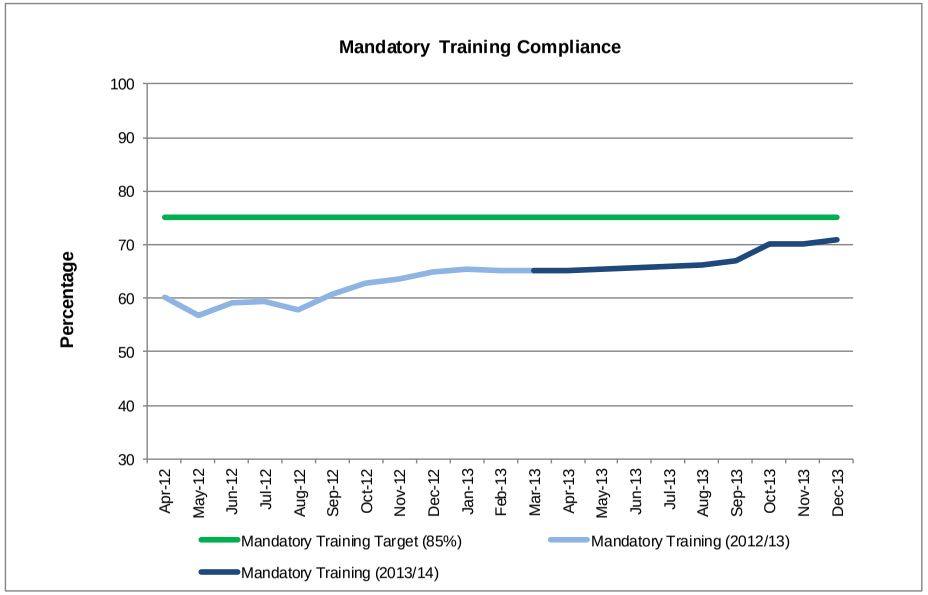
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Add Prof Scientific and Technic	2.78%	2.57%	2.66%	2.50%	2.55%	2.64%	2.41%	2.91%	2.90%			
Additional Clinical Services	5.82%	5.81%	5.56%	5.54%	5.61%	5.75%	5.39%	6.03%	6.15%			
Administrative and Clerical	3.47%	3.85%	3.84%	3.88%	3.97%	4.05%	3.82%	4.36%	4.41%			
Allied Health Professionals	3.58%	3.56%	3.27%	2.97%	3.08%	3.18%	2.99%	3.21%	3.27%			
Estates and Ancillary	4.04%	3.84%	4.08%	3.98%	3.87%	3.82%	3.52%	4.06%	4.14%			
Healthcare Scientists	3.00%	2.51%	2.18%	2.04%	1.89%	1.86%	1.75%	1.83%	1.86%			
Medical and Dental	1.29%	1.15%	1.18%	1.16%	1.03%	0.99%	0.94%	1.09%	1.12%			
Nursing and Midwifery Registered	4.40%	4.21%	4.27%	4.14%	4.14%	4.09%	3.78%	4.30%	4.38%			
NGH Trust	4.02%	4.02%	3.98%	3.88%	3.86%	3.87%	3.96%	4.05%	4.13%			
Target Rate	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%

	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.72%	5.13%	4.68%	3.62%
No. of completed PDP's returned	Under 50% 50-79% 80% & over	80%	32.76%	29.60%	37.67%	29.35%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	80%	70.84%	72.24%	70.24%	68.37%

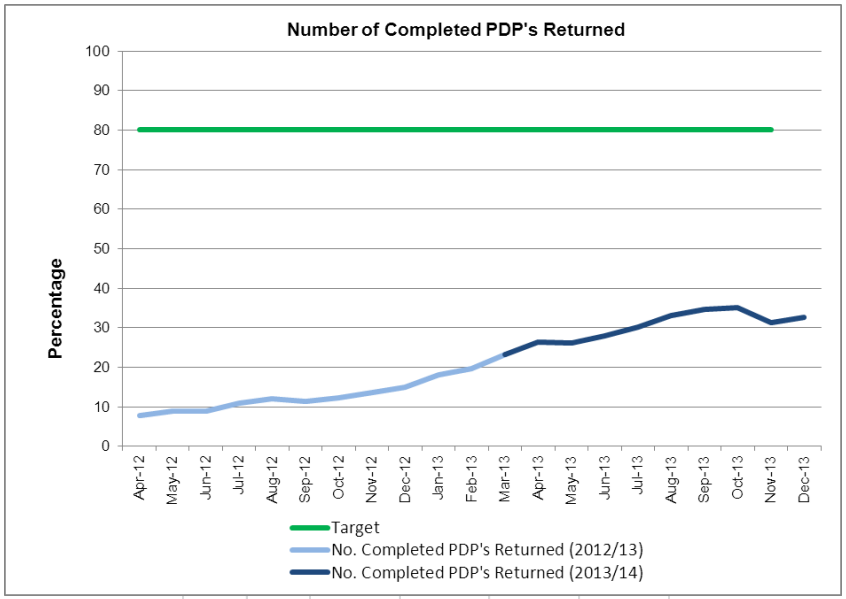
Number of Completed PDPs Returned & Mandatory Training Compliance

- The current number of completed PDP's returned is 32.76%; this is an increase of 1.49%.
- Following the review on Mandatory Training on 9 subjects, the overall mandatory training compliance increased slightly to 70.84%.

Human Resources Workforce Performance Indicators Month 9



Mandatory Training Target 85%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2013/14)	65.14	65.4	65.75	65.93	66.09	66.97	70.23	70.20	70.84			



Completed and Returned PDP Target 80%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Completed PDP's Returned (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
No. Completed PDP's Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76			

REPORT TO THE TRUST BOARD
30 January 2014

Title	Improving Quality and Efficiency Report
Agenda item	14
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Mike Hyne – Transformation / PMO
Purpose	To update the board on the final financial savings achieved through the 2013/14 Transformation Programme at month 9.

Executive summary

- The upside latest thinking forecast at M9 is £11.9m (4.5%), against the £13m required delivery, off plan by £1.1m. This is up by £0.1m on M8 due to overachieving on bank and agency savings.
- The most likely case forecast has increased to delivery of £11.7m and the downside to £11.6m.
- An outline programme of key themes for 2014-15, including executive sponsors for each theme has been agreed. The scale of the required savings plan for 2014/15 has not yet been confirmed, but the first draft submission to the TDA suggested a target of £11.4m, which would equate to approximately 4.2% of turnover.

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

Enclosure K

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

JANUARY 2014

Enclosure K

Executive Summary

Northampton General Hospital NHS
NHS Trust

Transformation Plan for 2013/14	The target plan for 2013/14 is £13m which is constructed from the national minimum delivery requirement of 5% of turnover.
The latest thinking forecast for 2013/14 as at Month 9 December 2013	The upside latest thinking forecast at M9 is £11.9m (4.5%), against the £13m required delivery, off plan by £1.1m. This is up by £0.1m on M8 due to overachieving on bank and agency savings. The most likely case forecast has increased to delivery of £11.7m and the downside to £11.6m. All ideas for mitigation schemes deliverable in year have now been exhausted. There is, therefore, a real need to continue to drive greater value from existing schemes, to deliver red and amber schemes and to generate and deliver additional schemes. The plan submitted to the TDA required delivery of £8.872m in the first 9 months. Actual delivery is £8.468m, behind plan by £404k.
2014-15 Programme	An outline programme of key themes for 2014-15, including executive sponsors for each theme has been agreed. These themes have now established steering groups and will fully scope the opportunity for quality improvement and cost reduction for each theme. Themes presented their progress to the Improving Quality & Efficiency Group on the 14th January and had been tasked with producing expected financial benefits in readiness for the January Finance Committee. Schemes already identified and in the process of development have been allocated to the programme structure by the IQET. The Improving Quality and Efficiency Team have now recruited to the majority of posts in team and those posts still in the recruitment process are covered by secondments and interims to ensure all Themes are well supported.
Risks and Issues	There is both upside and downside risk concerning the delivery of the bank and agency CIP. The value of this scheme is critical to the programme and variable factors such as recruitment, attrition rate and winter pressures make performance volatile. The scale of the required savings plan for 2014/15 has not yet been confirmed, but the first draft submission to the TDA suggested a target of £11.4m, which would equate to approximately 4.2% of turnover.

Scheme Pipeline 2013-15

Northampton General Hospital NHS
NHS Trust

Mitigation 2013/14

Care Groups have revised their LTFs up by £176k in month 9. This is primarily due to improved consistency of coding on Opthalmology Outpatient Procedures.

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

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

Immediate Priorities

Immediate priorities are:

- to react quickly to capitalise on any savings opportunities arising prior to year end
- to fully scope the themes for 2014-15 and develop detailed plans to delivery quality and efficiency improvements
- to further quantify the theme planned financial benefits
- to develop KPIs for planned theme quality improvements
- to develop detailed milestone plans to support delivery of the theme objectives
- to complete QIAs for all schemes
- to support directorates in the identification of schemes to meet their targets

Care Group & Corporate CIPs

- The Surgical Care Group are reporting £35k ahead of plan.
- The Medicine Care Group are reporting £46k ahead of plan.
- Corporate areas are reporting £54k ahead of plan. 1 corporate area is short of target (Corporate Affairs). This is offset by Finance and Workforce & Transformation who are exceeding target.

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M8 LTF £000s	M9 LTF £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	11,794	↑ 11,932	92%	3,302
Total needed to be identified	4,508	35%	1,206	↓ 1,068	8%	-3,302
Total Efficiency	**13,000**	**100%**	**13,000**	**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.5%**	**4.5%**		

Identification of the Transformation Programme 2013/14
The table outlines the current LTF compared to the plan submitted to the TDA in April 2013.
The current LTF of £11.9m if delivered in full would be a 4.5% CIP against our planned requirement of 5%.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	9,240	71%
Non-recurrent schemes	2,691	21%
Total needed to be identified	1,068	8%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	5,989	46%
Non pay	2,974	23%
Income	2,969	23%
Total needed to be identified	1,068	8%
Total Efficiency	**13,000**	**100%**

The table also demonstrates a £0.138m increase in LTF between M8 & M9, due bank and agency savings being higher than planned in M9.

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

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

Latest thinking forecast 2013/14

Northampton General Hospital NHS
NHS Trust

Workstream	Exec Lead	Current LTF	Plan	Variance
		2013/14	2013/14	2013/14
		£000s	£000s	£000s
FYE 12/13 schemes	A. Foster	337	337	0
Workforce Transformation	J. Brennan	2,430	1,979	450
Clinical service redesign	D. Needham / R. Brown	35	110	(75)
Non-Clinical service redesign	C. Abolins	126	0	126
Directorate Schemes	A. Foster	9,004	8,868	136
Sub total		**11,932**	**11,294**	**637**
Gap	J. Brennan	1,068	1,706	(638)
Total		**13,000**	**13,000**	**0**

Month 9 – Latest Thinking Forecast

The Transformation Programme is currently projecting a LTF shortfall £1.068m against the required plan of £13m.

Care Group and Corporate CIPs are currently ahead of plan by £126k.

The LTF for the care groups has increased by £176k over the position reported in M8. This is due to improved consistency of coding on Opthalmology Outpatient Procedures.

At the end of month 9 a £1.3m year on year reduction in nursing bank and agency expenditure has been achieved. The forecast LTF is based on the current run rate reduction being achieved.

Clinical Service redesign is behind plan by £75k. This is due to the Locum Managed Service starting later than originally planned.

The restriction on overtime continues to exceed the monthly financial requirement. The monthly saving dipped again in month 9. Managers within the Trust have been working with their HR Business Partners to ensure that authorisation compliance is maintained.

TDA Return

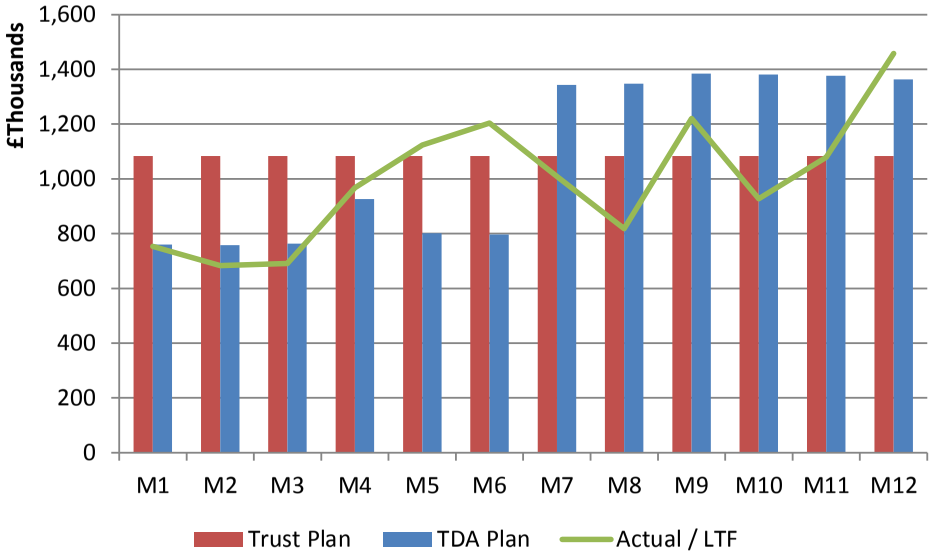
Northampton General Hospital NHS
NHS Trust

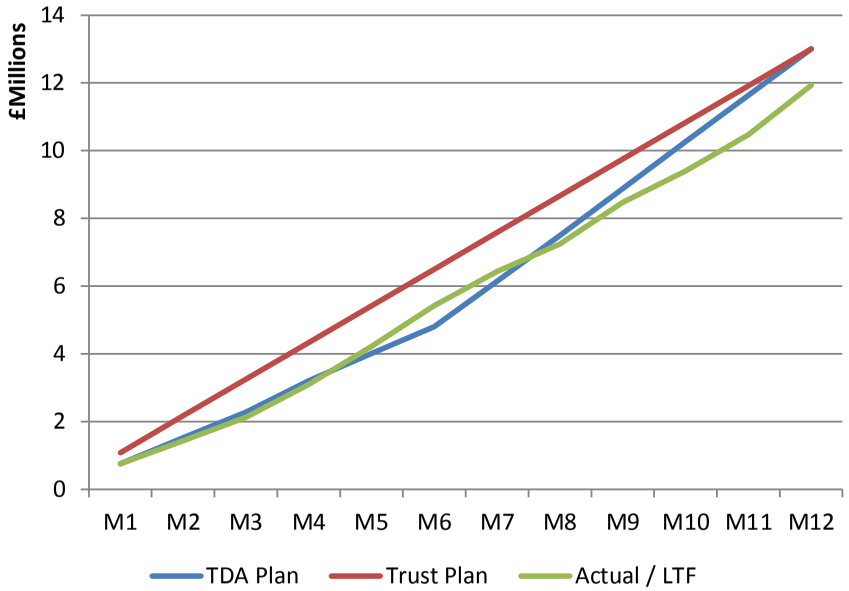
Efficiency Programmes	Identified (I) or Unidentified (U)	Recurring (R) or Non Recurring (NR)	Cashable (C), Non Cashable (NC) or Income (Inc)	If Cashable Pay (P) or Non Pay (NP)	Current Month			Year to Date			Forecast Outturn		
					Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 08) £000s	Forecast (mc 09) £000s	Variance (mc 10) £000s
Description of scheme													
FYE of 12/13 Transformation Schemes	I	R	C	P	34	34	0	330	330	0	337	337	0
Directorate CIPs	I	R	C	NP	264	175	(89)	2,257	1,654	(603)	3,050	2,493	(557)
Directorate CIPs	I	NR	C	NP	7	30	24	59	149	89	84	254	170
Directorate CIPs	I	R	C	P	208	252	44	1,778	1,361	(417)	2,478	1,887	(591)
Directorate CIPs	I	NR	C	P	18	147	129	238	1,015	777	293	1,410	1,117
Directorate CIPs	U	R	C	P	97	0	(97)	870	0	(870)	1,164	0	(1,164)
Directorate CIPs	I	R	Inc	NP	138	274	136	1,242	1,493	250	1,656	2,173	517
Directorate CIPs	I	NR	Inc	NP	5	182	177	173	607	434	187	786	599
Workforce Transformation - Admin Review	I	R	C	P	16	16	0	59	52	(8)	108	100	(8)
Workforce Transformation - Tactical HR (B|A)	I	R	C	P	10	32	22	90	1,322	1,232	120	1,594	1,474
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	0	28	28	104	246	141	104	330	226
Productivity | Efficiency - Outpatient Skill Mix	I	R	C	P	5	0	(5)	30	0	(30)	45	0	(45)
Services Transformation - Rehabilitation/Community	U	R	C	P	50	0	(50)	50	0	(50)	200	0	(200)
Services Transformation - 3rd party Pharmacy	I	R	C	NP	6	0	(6)	12	0	(12)	30	0	(30)
Other	U	NR	C	NP	526	0	(526)	1,578	0	(1,578)	3,144	0	(3,144)
New Programmes Identified In Year:													
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P	0	10	10	0	90	90	0	120	120
Workforce Transformation - Salary sacrifice year 2 (technology & car sceme expansion)	I	R	C	P	0	9	9	0	70	70	0	96	96
Clinical service redesign - Mattresses Total Bed Management	I	R	C	NP	0	0	0	0	0	0	0	15	15
Workforce Transformation - Locum Managed Service	I	R	C	P	0	0	0	0	0	0	0	75	75
Workforce Transformation - Consultant Annual Leave Accrual	I	R	C	P	0	0	0	0	0	0	0	35	35
Maximising formulary compliance (TVN)	U	R	C	NP	0	0	0	0	0	0	0	10	10
Emergency care porters for Benham Ward	U	R	C	P	0	0	0	0	0	0	0	0	0
Private patients at Danetre	U	NR	C	Inc	0	0	0	0	0	0	0	10	10
Reduction in compensation payments	U	R	C	NP	0	0	0	0	0	0	0	1	1
PDC impairment in Capital charges (EY)	U	NR	C	NP	0	17	17	0	50	50	0	100	100
Recovery of pay owed	U	R	C	P	0	0	0	0	0	0	0	5	5
Contractor Review	U	R	C	P	0	15	15	0	30	30	0	75	75
Increase staff car parking charges	U	R	C	NP	0	0	0	0	0	0	0	25	25
Commercial sponsorship	U	NR	C	NP	0	0	0	0	0	0	0	0	0
Grand Total (sc100)					**1,383**	**1,221**	**(163)**	**8,872**	**8,468**	**(404)**	**13,000**	**11,932**	**(1,068)**

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance **Off trajectory**





The cumulative delivery of schemes is now £404k behind the TDA plan. The plan submitted to the TDA required savings to accelerate from month 7 onwards. The Trust Plan shows delivery spread evenly throughout the year. This highlights that although we are £404k behind the TDA plan after 9 months we are further off meeting the Trust Plan (£1.3m). The challenge is to make sure that all schemes identified in the LTF due to start in the second half of the year, deliver as planned.

The additional support sourced to support the care groups and the PMO, supported by Executive Sponsors the IQEG and the Trust Strategic Executive are now focussed on developing the programme for 2014/15, as ideas for schemes to be delivered prior to the year end have been exhausted.

Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

	LTF £'000s	% of Total target	Most Likely £'000s	Worst Case £'000s
Green	11,186	86%	11,186	11,186
Amber	486	4%	365	365
Red	259	2%	104	0
Total	**11,932**	**92%**	**11,655**	**11,551**
Gap	1,068	8%	1,345	1,449

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

The latest thinking forecast (£11.9m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.

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

Utilising this methodology agreed at the Finance Committee at its meeting in June 2013, the downside case based on current RAG rating would see the programme realise £11.6m.

The focus of the IQEG will be to ensure that we convert the red schemes into delivery.

	FY13/14 LTF £'000			
Scheme	R	A	G	Total Identified
A1: Surgery	-	-	476	476
A2: Anaesthetics	125	9	338	471
A3: T&O	20	69	344	433
A4: Head & Neck	9	-	822	831
A5: Child Health	-	55	770	825
A6: Obs & Gynae	3	-	445	448
SCG sub total	**157**	**133**	**3,194**	**3,484**
B1: General Medicine	-	-	2,028	2,028
B2: Oncology	-	1	486	487
B3: Pathology	-	1	580	581
B4: Radiology	-	9	397	406
B5: Pharmacy	-	47	142	189
B6: Therapies	-	1	91	92
MCG sub total	**-**	**59**	**3,724**	**3,783**
C1-7: Support Functions	-	1	852	853
C8: Facilities	77	81	724	883
Support sub total	**77**	**83**	**1,576**	**1,736**
Care Group & Corporate CIP Total	**234**	**275**	**8,494**	**9,004**
FYE of 12/13 Transformation Schemes	-	-	337	337
Admin Review	-	-	100	100
Bank & Agency	-	-	1,594	1,594
Tactical HR (Overtime)	-	-	330	330
Tactical HR (Enhancements)	-	-	120	120
Salary sacrifice year 2	-	-	96	96
Locum Managed Service		75	-	75
Consultant Annual Leave Accrual		35	-	35
Mattresses Total Bed Management			15	15
Maximising formulary compliance (TVN)		10	-	10
Emergency care porters for Benham Ward		-	-	-
Private patients at Danetre		10	-	10
Reduction in compensation payments		1	-	1
PDC impairment in Capital charges (EY)	-	-	100	100
Recovery of pay owed	-	5		5
Contractor Review	-	75	-	75
Increase staff car parking charges	25	-	-	25
Commercial sponsorship	-	-	-	-
Mitigation list	-	-	-	
Plans to be identified	-	-	-	1,068
Total	**259**	**486**	**11,186**	**13,000**

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
30 January 2014

Title	TDA Self-Certification
Agenda item	15
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s)	Craig Sharples, Head of Corporate Affairs
Purpose	Decision

Executive summary

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

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

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

Actions required by the Board

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

NHS TRUST DEVELOPMENT AUTHORITY

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

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Enclosure L

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

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

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

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

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

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

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

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

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

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

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

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

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

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

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

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

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

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

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

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

BOARD STATEMENTS:

Enclosure L

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

10. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

Enclosure L

REPORT TO THE TRUST BOARD
DATE: 30 January 2014

Title	Oncology and Cancer Partnership with UHL
Agenda item	16
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s)	Tracey Harris, Head of Cancer Services and Medical Records
Purpose	To agree the vision of a Partnership between Northampton General hospital NHS Trust and University Hospitals Leicester NHS Trust to support the future of Oncology and Cancer pathways to meet the population requirements of Peer Review and Specialised Service Specifications.

Executive summary

NGH and UHL would like to propose a vision of partnership working for the Oncology Directorates leading on to future cancer pathways to maintain services at both Trusts and gaining benefits with a larger population base for clinical trials and other cancer research opportunities.

Related strategic aim and corporate objective	Focus on Quality & Safety, Strengthen our Local Services, Ensure a Sustainable Future
Risk and assurance	No new risks presented at this stage. The proposal is directly linked to mitigating existing risks around the continuity of oncology delivery.
Related Board Assurance Framework entries	BAF 23
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	No

Actions required by the Board

To enable this development to go forward at pace, the Oncology departments would like to recommend the following:

- The joint Project Board is set up;
- That a Clinical Director is appointed across NGH and UHL to develop the clinical model across the three trusts;
- That a Project Manager is put in place supported by both NGH and UHL to work with all three Trusts to work with a Clinical Director and the Clinical Teams to develop the clinical model.
- To work with all three trusts to develop the business and Governance model to support these clinical models and report back to the Trust Boards with the recommendations;
- Due to the recruitment issues associated with Oncology, it is recommended that both centres immediately place joint adverts to attract staff.

Northampton General Hospital NHS
NHS Trust

Partnership Vision for Oncology and Cancer

1. Introduction

Northampton General Hospital NHS Trust (NGH) and University Hospitals Leicester NHS Trust (UHL) are recognised Cancer Centres providing cancer treatment for their local populations and offering specialised treatments to a number of tertiary hospitals.

However, due to changes in the national cancer service specifications and the Improving Outcomes Guidance, population size is a significant risk for Trusts offering specialised treatments. Both NGH and UHL are vulnerable with neither attaining the critical population mass to meet the changing Specialised Commissioning Service Specifications requirements. It is important to consider the future viability of both Cancer Centres and ensure continued cancer patient pathways including patients within the Kettering General Hospital Foundation Trust (KGH) catchment.

NGH and UHL would like to propose a vision of partnership working for the Oncology Directorates leading on to future cancer pathways to maintain services at both Trusts and gaining benefits with a larger population base for clinical trials and other cancer research opportunities.

2. Oncology / Cancer Partnership Vision

2.1 Background

NHS England have stated that specialised services are those provided in relatively few hospitals, accessed by small numbers of patients but with a catchment population of more than one million. Concentrating services in this way ensures that the best outcomes are achieved and specialist staff can maintain clinical competence. It is also more cost-effective and makes the best use of resources and staff expertise.

NGH and UHL provide specialised cancer services across a number of tumour sites and have established the clinical expertise to enable them to offer these treatments. However, both individual Trusts do not have the one million populations and are at risk of future commissioning decisions.

It is therefore important to be pro-active in developing a partnership that will enable patients to continue to receive treatment locally but will also support cancer pathway changes for

the rarer tumours or surgical cancer procedures that require high levels of specialist expertise undertaken by teams who perform a high number of similar procedures. Examples of this include urological and oesophagogastric surgery.

2.2 Benefits

Concentrating Cancer Services on specialised sites is already underway nationally. It is imperative for NGH and UHL to recognise the changing landscape for cancer pathways and proactively seek a partnership that will ensure sustainable, high quality, oncology and cancer care.

A strategic partnership vision will play a key role in retaining specialised cancer services within Leicestershire, Rutland and Northamptonshire. Working in collaboration will enable all three Trusts to build on the clinical skills and excellence across the region. The vision will be developed over the coming months with engagement from clinical and managerial teams to offer a re-designed oncology partnership between NGH and UHL.

It will include cancer pathway re-design, delivering high quality cancer treatment and support for this larger population. The work programme will define those specialist services that can be retained on two sites but also the opportunities for future cancer pathways that presently have to be referred on to larger cancer centres. The central aim is to: “Improve services for cancer patients and carers through a strong alliance, population size and effective clinical care”.

2.3 Conclusion

To assess the feasibility of a partnership with UHL for the oncology directorate and cancer pathways, both Trusts will need to work closely to share data and develop a formal proposal with options for a future service that would include KGH as a tertiary unit.

3. Assessment of Risk

Inform the Board/Committee of the risks and mitigations associated with the paper.

4. Next Steps

To formally set up a project board with stakeholders from all three organisations (NGH, UHL & KGH) to develop a proposal for how a partnership could work. This will be submitted back to the board for further approval.

In addition a proposal for an amalgamated Oncology Department between UHL and NGH is seen as the first step towards greater collaboration on cancer services. A proposal will be submitted to both Boards in March 2014 in this regard.

5. Recommendations/Resolutions Required

The Board is asked to endorse the vision of a partnership for oncology and cancer with UHL.

To enable this development to go forward at pace, the Oncology departments would like to recommend the following:

- The joint Project Board is set up
- That a Clinical Director is appointed across NGH and UHL to develop the clinical model across the three trusts.
- That a Project Manager is put in place supported by both NGH and UHL to work with all three Trusts to work with a Clinical Director and the Clinical Teams to develop the clinical model. To work with all three trusts to develop the business and Governance model to support these clinical models and report back to the Trust Boards with the recommendations.
- Due to the recruitment issues associated with Oncology, it is recommended that both centres immediately place joint adverts to attract staff.

Chris Pallot
Director of Strategy & Partnerships, NGH

Kate Shields
Director of Strategy, UHL

Mike Smeeton
Director of Strategy & Partnerships, KGH

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD

30 January 2014

Title	Risk Management Strategy
Agenda item	17
Sponsoring Director	Dr Mike Wilkinson, Medical Director
Author(s)	Caroline Corkerry Deputy Director of Quality & Governance Christine Ainsworth Senior Risk & Litigation Manager
Purpose	The Risk Management Strategy is presented to the Trust Board for approval

Executive summary

The Risk Management Strategy was approved by Trust Board In July 2013. The Board requested that the strategy be returned with any amendments that have been required as a result of the embedding of the Care Group Structure. The strategy was presented to the Audit Committee in December 2013 where some minor amendments were requested to include a change of the colour indicating the Audit Committee in Appendix 11. This was requested to reflect the difference in the Audit Committee's role in providing an independent review of risk assurance systems. The recommended amendments have all been completed. The Risk Management Strategy is due for full review in July 2014, however it is recognised that an earlier review may be required if the committee and reporting structures change.

Related strategic aim and corporate objective	1 – Focus on Quality & Safety
Risk and assurance	The Risk Management Strategy provides the Board with assurance that appropriate Risk Management structures and processes are in place.
Related Board Assurance Framework entries	Link to the Board Assurance Framework- Yes

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Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper No
Actions required by the Board: The Board is requested to approve the Risk Management Strategy	

Northampton General Hospital NHS
NHS Trust

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Please refer to the Trusts Intranet site for the most up to date version

Enclosure N

RISK MANAGEMENT

NGH-SY-426

Ratified By:	Trust Board
Date Ratified:	July 2013
Version No:	V12.4
Supersedes Document No:	NGH-SY-426 v11
Previous versions ratified by (group & date)	For previous versions See version control summary
Date(s) Reviewed:	July 2013 & November 2013
Next Review Date:	July 2014
Responsibility for Review:	Director of Nursing Midwifery & Patient Services / Head of Corporate Affairs
Contributors:	Senior Risk and Litigation Manager

STRATEGY

CONTENTS

VERSION CONTROL SUMMARY

Version	Date	Committee	Comments
v1	April 2003	Trust Board	
v2	December 2004	Trust Board	
v3	December 2005	Trust Board	
v4	August 2006	Trust Board	
v5	September 2007	Trust Board	
v6	September 2008	Trust Board	
v7	October 2009	Trust Board	
v8	September 2010	Trust Board	
v9.2	January 2011	Trust Board	
v9.3	February 2011	Trust Board	
v10	October 2011	Trust Board	
V11	July 2012	Trust Board	
V12.4	July 2013	Trust Board	Draft presented for approval

STATEMENT OF INTENT

Northampton General Hospital NHS Trust's vision is to provide the very best care for all of our patients. This requires the Trust to be recognised as delivering safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community.

The complexity of healthcare and the ever-growing demands to meet health care needs means that there will always be an element of risk in providing high quality, safe health care services; this document sets out the strategic direction for how the Trust intends to meet these demands and builds on the strategic direction set out in the previous Northampton General Hospital NHS Trust Risk Management Strategy.

INTRODUCTION

Northampton General Hospital NHS Trust recognises that the nature of providing healthcare means that risk is inherent in everything we do and as an organisation. This requires identification, management and minimisation of risks that could cause unnecessary risks to patients, staff and visitors. The management of risk is a key organisational responsibility and involves all staff being aware of risk and understanding their responsibilities for managing it. This is a key component of providing good quality care to patients.

The Trust has a legal duty to deliver safe care to patients and to ensure that Northampton General Hospital is a safe place to work and visit. Failure to manage risks effectively can result in injury; loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation or unwanted publicity.

Risk Management is an integral part of good clinical and corporate governance and the Trust has adopted an approach to risk management that ensures that risks are managed accordingly. Where risks cannot be addressed internally by the Trust they are considered alongside other partners such as commissioners of services.

This strategy sets out the structure and processes in place to manage risks in the Trust and should be read in conjunction with the Assessment and Management of Risk Policy, the Quality Strategy, the Patient Safety Strategy, the Quality Impact Assessment Policy and the Being Open Policy (for a full listing of associated policies see section11). This Risk Management Strategy also covers the requirements of the Care Quality Commission; the NHS Litigation Authority, Commissioners, other quality assurance processes and any recommendations following Royal College reviews.

1. PURPOSE

The purpose of this strategy is to set out the framework for managing risks at Northampton General Hospital NHS Trust.

2. SCOPE

This strategy covers the following aspects:

- The organisational risk management structure
- How organisational risks are reviewed by the Trust Board and their committees and sub-committees
- The roles, responsibilities, processes and structures for managing risk locally
- How compliance with this strategy will be monitored

This strategy applies to all risk related activities (e.g. corporate, financial, clinical, non-clinical, and health and safety) and to all Trust premises, staff employed by the Trust, including persons engaged in business on behalf of the Trust. The effectiveness of the strategy will be reviewed by key stakeholders who are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public Board meetings, the Health Watch and the local Overview and Scrutiny Committees.

3. COMPLIANCE STATEMENTS

Equality & Diversity

This document has been designed to support the Trust's effort to promote Equality and Human Rights in the work place and has been assessed for any adverse impact using the Trust's Equality Impact Assessment tool as required by the Trust's Equality and Human Rights Strategy. It is considered to be compliant with current equality legislation and to uphold the implementation of Equality and Human Rights in practice.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

Duty of Candour

Every individual who comes into contact with the Northampton General Hospital should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs aspirations and priorities and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers. This will include open and honest communication in the event of an adverse incident which results in harm to the patient.

Health & Safety

This documents is designed to support the Trust Health and Safety Policy commitment to ensure so far as reasonably practicable the health, safety and welfare at work of our employees and others who may affected by our workplace and work activities, both on and off Trust premises in accordance with current legal duties and best practise.

4. DEFINITIONS

Risk	The potential of an unwanted outcome or the possibility of incurring misfortune or loss, which may be in relation to people, buildings, equipment, systems, management, finance, the Trust's reputation or the achievement of corporate objectives.
Risk Management	The use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives.(see appendix 9 for Risk Management Model Matrix)
Board Assurance Framework	The Board Assurance Framework is used for the effective and focused management of the principal risks to meeting the Trust objectives. It also provides a structure for the evidence to support the Annual Governance Statement
Corporate Risk Register	A register comprising risks rated 15 and above identified through risk registers and /or high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), claims, complaints, and PAL's.
Risk Register	A register comprising of all risks identified through locally owned risk registers which may include high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), claims, complaints, and PAL's.
CAS Alerts	The NHS Central Alerting System that identifies and issues safety alerts, emergency alerts, drug alerts, Alerts letters (registered individuals) and Medical Device Alerts on behalf of the Medicines and Healthcare products Regulatory Agency, Estates and Facilities Alerts; Field Safety Notices, any internal alerts and the Government Department of Health
Annual Governance Statement	is the Annual Governance Statement is a public accountability document that describes the effectiveness of internal controls in an organisation and is personally signed by the Accountable Officer and forms part of the Annual Report and Accounts

5. ROLES & RESPONSIBILITIES

5.1 Roles and Responsibilities of Individuals

The following individuals have responsibilities for risk as summarised below:

Role	Responsibilities
Chief Executive	Accountable Officer for risk management at Northampton General Hospital NHS Trust, which includes signing the Annual Governance Statement but has delegated the roles as listed below. The CEO is in attendance at Finance; IHGC and Trust Board.
Medical Director	Executive Directors with delegated responsibility for the management of clinical risk within the framework approved by the Trust Board. The Medical Director is the named Caldicott Guardian. Joint chair of the Clinical, Quality and Effectiveness Group and in attendance at IHGC and Trust Board.
Caldicott Guardian	Responsibility for ensuring that organisational risks associated with protecting the confidentiality of patients and service-user information and with information sharing are managed effectively with the Trust
Director of Nursing Midwifery & Patient Services	Executive Directors with delegated responsibility for the management of clinical risk within the framework approved by the Trust Board. Joint chair of the Clinical, Quality and Effectiveness Group; SI; Infection Prevention committee and director with responsibility for infection control and also attendance at IHGC and Trust Board.
Director of Finance	Executive Director with delegated responsibility for financial risk management, including financial probity, Standing Financial Instructions (SFIs), financial schemes of delegation
Director of Strategy and Partnerships	Executive Director has responsibility for contracting, market development, clinical coding and medical records, information management, and service improvement provision. The Director of Strategy and Partnerships is the named SIRO
Senior Information Risk Owner (SIRO)	The SIRO has overall accountability and responsibility for Information Governance in the Trust, specifically: • Acting as an advocate for information risk on the Trust Board • Ensuring the Trust Board is adequately briefed on information risk issues. • Ensuring the Trust's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff • Providing assurance, through the Annual Governance Statement that all risks to the Trust, including those relating to information, are effectively managed and mitigated

Role	Responsibilities
	• Raising the profile of information risks, embedding information risk management into the overall risk management culture of the Trust.
Director of Facilities and Capital Development	Executive Director with delegated responsibility for Health & Safety, Security and Fire.
Deputy Director of Nursing	Deputising for the Director of Nursing Midwifery & Patient Services The Deputy Director of Nursing is the chair of Safeguarding groups.
Deputy Director of Quality and Governance	Deputising for the Director of Nursing Midwifery & Patient Services where there are responsibilities for risk and risk management.
Executive Directors	Responsibility for ensuring that the risk management framework approved by Trust Board is implemented across the organisation and is embedded within their teams. Responsibility for managing the Trust's principal risks which relate to their directorates, for example, Director of Workforce & Transformation is responsible for managing the Trust's principal risks related to workforce planning.
Executive Team	The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to the CEO for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the Trust's Scheme of Delegation. Receives and moderates the Corporate Risk Register and Board Assurance Framework for consideration by the Integrated Healthcare Governance Committee (IHGC) Ensures that the Board Assurance Framework appropriately reflects principle risks, controls and assurances, including the identification of new risks Reviews the Board Assurance Framework for consideration by the Audit Committee and Trust Board
Other Trust Board Members including Non-Executive Directors	Collective responsibility for ensuring that risk is an integrated element of all major discussions and decisions and that the risk management processes are providing them with adequate and appropriate information and assurances relating to risks to the Trust's objectives. The Non executives are nominated to chair a number of the meetings such as IHGC; Audit Committee.
Care Group Management Team	Responsibility for ensuring that arrangements for identifying, assessing and managing risk as set out in the Assessment and Management of Risk Policy are embedded within their Care Groups. Each Directorate within a Care Group has an established and active governance structure which reports into a Directorate

Role	Responsibilities
	Management Board and Directorate Governance Committee; these in turn report into the Care Group Governance Group, from there directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks
Directorate Governance Lead	Responsibility for ensuring that the Directorate Risk Register is reviewed at Directorate Governance meetings; appropriate measures are put in place to mitigate risks and that High and Medium risks are reported to Care Group Governance and Clinical Quality and Effectiveness Group
All members of staff	Responsibility for ensuring that risks are identified, reported, assessed and managed in accordance with this strategy
Head of Corporate Affairs	Responsibility for managing and reporting on the systems of internal control, including the Risk Management Strategy, Board Assurance Framework and Corporate Risk Register. The Head of Corporate Affairs is responsible for monitoring and reporting the corporate risk register to the Trust Board
Deputy Director of Quality & Governance	Responsibility for leading the implementation of the Risk Management Strategy.
Senior Risk, Litigation and Quality Manager & Risk Manager	Responsibility for ensuring that clinical and non-clinical risk management processes are appropriately followed; effective processes are in place for managing risk including CAS alerts; training programmes are in place to support a pro-active risk culture; the organisation learns from adverse events to minimise risk in future. Monitoring the completion of the Clinical and Support Directorate risk registers and reporting as necessary.
Health and Safety Manager	Responsibility for ensuring that organisational risks including those that are associated with Health and Safety legislation (including provision of training) are managed effectively across the Trust and that appropriate systems are in place to support this.

5.2 Roles and Responsibilities of Committees/ Sub-Committees

The following committees have responsibilities for risk as summarised below:

Roles	Responsibilities of Committees/ Sub-Committees
Trust Board	The Trust Board is responsible for ensuring that the Trust has an effective programme for managing all types of risk, receives and considers the Board Assurance Framework and the Trust Corporate Risk Register on a quarterly basis. The Trust Board will receive assurance from its supporting Committees and Groups that risks are being proactively identified

Roles	Responsibilities of Committees/ Sub-Committees
	assessed and managed throughout the organisation. The Trust Board is responsible for approving the Risk Management Strategy to identify and ensure strategic or high level risks are managed effectively and ensuring mitigating actions are taken.
Audit Committee	The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives. IHGC, Finance and the Audit Committee shall hold bi-annual meetings to ensure that systems are integrated between the committees and across the organisation and to jointly review all corporate risks. All risks 15 and above are reviewed by the joint meeting. The Audit Committee reviews the Board Assurance Framework and seeks assurance on specific key risks as part of a rolling programme. (full terms of reference can be found in appendix 1)
Integrated Healthcare Governance Committee (IHGC)	The Integrated Healthcare Governance Committee (IHGC) is a committee of the Board and responsibility for ensuring an effective system of integrated governance, risk management, performance, workforce and internal control across the clinical activities of the organisation that support the organisation's objectives. In conjunction with the Audit Committee and the Finance Committee, IHGC is responsible for ensuring that this system forms integration, both between the committees and across the organisation. (full terms of reference can be found in appendix 2)
Clinical Quality and Effectiveness Group (CQEG)	CQEG reports to the Integrated Healthcare Governance Committee (IHGC) and is responsible for reviewing, challenging and moderating on a quarterly basis the high and moderate risks on Care Group and Directorate Risk Registers; assuring IHGC that risk is managed effectively within the Care Group and Directorates; and raising any issues of concern to IHGC. Oversees the operation of directorate processes and ensures directorates are working collaboratively to manage risks. (full terms of reference can be found in appendix 3)
Finance Committee	The Finance Committee (FC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management and internal control across the finance activities of the organisation that support the organisation's objectives.

Roles	Responsibilities of Committees/ Sub-Committees
	In conjunction with the Audit Committee and the IHGC Committee, FC is responsible for ensuring that this system forms an integration both between the committees and across the organisation. Reviews all Quality Impact Assessments and ensures that all risks to achievement of the project, are identified and assessed in line with Trust Board policy. (full terms of reference can be found in appendix 4)
Strategic Management Board (SMB)	SMB is responsible for identifying and escalating risks as appropriate. This includes identifying Directorate & Care Group risks that should be factored into wider business planning processes. Reports any areas of concern relating to Quality Impact Assessments to IHGC. (full terms of reference can be found in appendix 5)
Care Group Boards (CGB)	The Care Group Board is established as the key assurance and decision making group of the Care group in relation to operational performance, quality, safety, risk, and strategic planning. It reports to the SMB in terms of: Finance including, Cost Improvement and Transformation program • Operational performance including activity and HR • Governance, Quality and Patient Safety • Strategic Planning & service improvement (full terms of reference can be found in appendix 6)
Care Group Governance Board	The Care Group Governance Boards are responsible for providing assurance to the Integrated Healthcare Governance Committee (IHGC), via the CQEG that governance processes are in place to consistently deliver high quality clinical services and ensure appropriate patient and staff safety. The Care Group Governance board will Challenge risks on the Directorate/Local Risk registers including those that have been scored at 15 or above and where appropriate recommend escalation to the Corporate Risk Register. (full terms of reference can be found in appendix 7)
Directorate Governance Groups	Responsible for receiving regular reports on the management of risks at Directorate level and will review the risk register to ensure it reflects current risks and monitors progress with mitigating action plans. The Quality Governance Managers and Facilitators in conjunction with the Governance Lead, General Manager, Clinical Director and Lead Nurse will report quarterly to Care Group Governance Board and CQEG on the management of High Risks within the Directorate and will specifically identify where expected actions or progress has not been taken or met. Responsible for reviewing and monitoring Quality Impact Assessments and associated risks via the Directorate Risk Register.

Roles	Responsibilities of Committees/ Sub-Committees
Risk Group	To advise the Executive Team on Risk Management systems and processes, the Corporate Risk Register and Board Assurance Framework. It will ensure that the key corporate documentation is contemporaneous, consistent and accurately reflects the organisations view of its risk, ensuring that controls and mitigating actions are in place Where any gaps are identified the group will ensure action plans are prepared to address these. (full terms of reference can be found in appendix 8)
Patient Safety Learning Forum	Responsible for reviewing learning from incidents (including serious incidents), complaints, claims and disseminating learning so as to reduce risk for the organisation. This forum has its own TOR and they present the learning from the forums to IHGC on a quarterly basis.
Directorate Management Boards (DMB)	Risk management is a key feature of the Directorate Management Board process, the Directorate's Risk Register is discussed and considered to ensure that all high and moderate risks are actively managed and reported to Care Group Governance Board. Where appropriate, high risks are identified and recommended for escalation to the Corporate Risk Register. These groups have their own agreed TOR's.

6. NORTHAMPTON GENERAL HOSPITAL TRUST STRATEGIC AIMS

6.1. Strategic Aim 1: Be a provider of quality care for all our patients

6.2. Strategic Aim 2: Enhance our range of hyper acute services and maintain the clinical viability of services for the wider community of Northamptonshire

6.3. Strategic Aim 3: Provide appropriate care for our patients in the most effective way

6.4. Strategic Aim 4: Foster a culture where staff can give their best and thrive

6.5. Strategic Aim 5: To be a financially viable organisation

7. RISK MANAGEMENT STRATEGIC OBJECTIVES

Ensure understanding at all levels of the organisation of the processes and responsibilities for incident reporting; risk assessment, identification and management

7.1. Cultivate and foster an 'open culture' in which risk management is identified as part of continuous improvement of patient care and staff wellbeing;

7.2. Integrate Risk Management into all our business decision making, planning, performance reporting and delivery processes to achieve a confident and rigorous basis for decision-making

7.3. Ensure a systematic approach to the identification, assessment and analysis of risk and the allocation of resources to eliminate, reduce and/or control them in order that the Board of Directors can meet its objectives;

7.4. Encourage learning (individual and organisational) from all incidents, mistakes, accidents and 'near misses' be they related to clinical, financial, environmental or organisational events;

7.5. Minimise damage and financial losses that arise from avoidable, unplanned events;

7.6. Ensure the Trust complies with relevant statutory, mandatory and professional requirements

This document has been produced to support the Trust's 2013/14 strategic aims and corporate objectives. The Trust's Board Assurance Framework, which is aligned to the Trust's strategic aims and corporate objectives, is a high-level document based on structured and on-going assessment of the principal risks to the Trust achieving its aims and objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The SMB and the IHGC regularly review the Board Assurance Framework, with the most significant risks being reported to each public Trust Board meeting. Directorate Risk Registers are reviewed regularly by the by the Care Group with high-level risks being reported to the IHGC.

8. RISK MANAGEMENT FRAMEWORK

8.1 Corporate Risk Management Structure

Northampton General Hospital NHS Trust operates risk management at a number of levels within the organisational structure.

The organisational structure for risk management and assurance is approved by the Trust Board annually through the strategy with further explanations in relation to responsibilities of committees contained in section 5.2 and further information in relation to reporting arrangements found in section 9 and in the diagram in appendix 10.

8.2 Process for Review of Corporate Risk Register

The Corporate Risk Register comprises high risks identified through Care Group and Directorate/Local Risk Registers as well as high risks identified from wider sources within the Trust, such as through incidents (including Serious Incidents), complaints, claims, clinical audit results and PAL's bi-annual horizon scanning of external risks to the Trust. Where relevant, risks are aggregated to enable the Trust Board and its sub-committees to increase its focus. Risks are assigned to a named senior officer who will be responsible for managing the risk, a Director to oversee progress and provide

information to Board as required and a sub-committee of the Board for review as appropriate.

The following reviews are undertaken:

- The Executive Team are responsible for reviewing the Corporate Risk Register on a monthly basis
- The Audit Committee and IHGC meet at 6 monthly joint meetings to review the Corporate Risk Register.
- In conjunction with the IHGC, the Audit Committee will satisfy itself on the assurances gained from the clinical audit function. The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.
- IHGC is responsible for reviewing the clinical risks within the Corporate Risk Register quarterly and escalating any concerns to the Trust Board and seeks assurance on any specific risks
- CQEG is responsible for reviewing directorate level moderate and high risks and escalating any concerns to IHGC quarterly.
- The Care Group Governance Boards are responsible for providing assurance to IHGC via the CQEG that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

8.3 Board Assurance Framework (BAF)

The BAF comprises the strategic risks that represent major threats to the Trust Board achieving its organisational objectives and gives the Trust Board assurance that these risks are being appropriately managed. Monitoring arrangements are outlined in section nine. (see appendix 11 for BAF accountability process)

8.4 Process for identifying, assessing, managing, monitoring and recording risk locally within Directorates

Wards and departments will use the process for identifying, assessing, managing, monitoring and recording risk as outlined in the Assessment and Management of Risk Policy ensuring that risks are a key agenda item at their meetings and at Care Group and Directorate Governance Meetings. Directorates report moderate and high risks to CQEG on a quarterly basis and through Directorate Performance Reviews

8.5. Risk Management Team

The Risk Management Team supports the Senior Risk, Litigation and Quality Manager in ensuring that clinical and non-clinical risks are appropriately managed.

The Trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The committee structure in appendix 10 provides an effective and robust system of risk management across the Trust.

9. IMPLEMENTATION & TRAINING

9.1. Risk Awareness Training

The effective implementation of this Strategy will facilitate the delivery of a high quality service and, with staff training and support, will increase awareness of risk management. Northampton General Hospital NHS Trust actively promotes staff training and education. All senior managers should ensure that they are proactively involved in the management of risks and should make sure that they attend appropriate training in order to manage risks in line with this strategy and associated policies.

To implement this Strategy the Trust will:

- Provide all staff with access to the Risk Management Strategy via the Trust's intranet
- Include the principles of this Strategy and the Trust's approach to risk management in all induction programmes for staff. This includes Executive Directors, Non-Executive Directors and Senior Managers
- Ensure that Risk Management Awareness training programs are in place across the organisation
- Ensure that Mandatory training addresses key risk areas for the Trust
- Develop update and implement appropriate underpinning policies
- Ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies associated with this Strategy
- Provide training for Executive Directors and Non-Executive Directors to support their Board level role

10. MONITORING & REVIEW

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Corporate risk register will be reviewed by Trust Board/ IHGC and Audit Committee as set out in this policy	Mins IHGC Mins Audit Committee Mins Trust Board	Head of Corporate Affairs/ Senior Risk Litigation and Quality Manager	Annual	Trust Board	Head of Corporate Affairs/ Senior Risk Litigation and Quality Manager	Trust Board
Risk registers are reviewed by Directorate Governance Groups and high clinical risks escalated and discussed at CQEG	Mins Directorate Governance Groups Mins CQEG/ Directorate Governance ¼ reports	Deputy Director of Quality & Governance	Annual	Trust Board	Head of Corporate Affairs/ Senior Risk Litigation and Quality Manager	Trust Board
Implementation of Trust Risk Management systems	Annual Governance Statement Control	Director of Finance / Head of Corporate Affairs	Annual	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
Specific Internal and External audit reviews prioritised by the Assurance Framework and Trust Risk Register	Audit Committee minutes as necessary	Director of Finance / Head of Corporate Affairs	Bi- monthly	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
IHGC updates on the management of relevant risks on the Corporate Risk Register	IHGC minutes	Deputy Director of Quality & Governance	Quarterly	IHGC	Deputy Director of Quality & Governance	IHGC

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Audit Committee updates on the management of relevant risks on Corporate Risk Register	Audit Committee minutes	Audit Committee	6 monthly	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
'High' and 'Extreme' risks – risk control contingency measures introduced	Corporate Risk Register moderated by the and reviewed by the Risk Group	Executive Team Medical Director Head of Corporate Affairs	Monthly	IHGC, Audit Committee and Trust Board	Medical Director Head of Corporate Affairs	IHGC, Audit Committee and Trust Board
Responsibilities for risk management activities are reflected in the job descriptions of key individuals	Job descriptions of key individuals with responsibility for risk management activity	Internal Audit	Annual	Audit Committee	Director of Finance / Head of Corporate Affairs	Audit Committee
Provision of risk management training including provision of awareness training for senior managers and board members	Review and data analysis	Training Department and Risk Department	In accordance with the Trust & Local Induction Policy NGH-PO-386			

Enclosure N

11. REFERENCES & ASSOCIATED DOCUMENTATION

Associated NGH Policies / Strategies

4 'C's -Comments, Concerns, Complaints, Compliments; Joint Policy – NGH-PO-483

Being Open - NGH-PO-254

Business Continuity Management - NGH-PO-420

Cancer Strategy 2012-2016 - NGH-SY-356

Capital and Service Investment – NGH-PO-629

Clinical Audit Strategy – NGH-SY-696

Communications and Engagement Strategy 2012-2013 – NGH-SY-674

Equality Strategy - NGH-TBC-TBC

Estates Maintenance - NGH-PO-635

Health and Safety Policy – NGH-PO-246

Health Record Improvement Strategy – NGH-TBC-TBC

Health Records Management- NGH-PO-58

Information Security Policy - NGH-PO-11

Infection prevention and control - NGH-PO-248

Investigating, Analysing and Learning from Incidents, Complaints, Inquests and Claims to Improve Practice –NGH-PO-333

Major Incident Corporate Plan – NGH-PL-683

Management of Incidents (Including Serious Incidents) – NGH-PO-393

Mandatory Training - NGH-PO-306

Nursing and Midwifery Staffing Strategy

Paper Health Record Improvement Strategy – NGH-SY-691

Patient and Public Involvement Strategy – NGH-ST-201

Patient Experience Strategy – NGH-SY-697

Patient Safety Strategy 2012-2015 – NGH-SY-689

Policy for Handling Clinical and Non Clinical Claims – NGH-PO-13

Quality Impact Assessment – NGH-PO-516

Quality Strategy 2012-2015 – NGH-SY-565

Recruitment, Selection and Retention – NGH-PO-33

Resilience Policy – NGH-PO-389

Risk Assessment and Management of Risk – NGH-PO-122

Safeguarding Vulnerable Adults - NGH-PO-241

Staff Engagement Strategy – NGH-SY-692

Standards of Business Conduct for Trust Staff – NGH-ST-132

Standing Financial Instructions – NGH-ST-182

Support for Staff involved in an Incident, Complaint or Claim – NGH-PO-245

Whistleblowing – NGH-PO-002

External documentation:

MID STAFFORDSHIRE NHS FOUNDATION TRUST 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Executive summary London: Crown Copyright http://www.midstaffspublicinquiry.com/report

Health and Social Care Information Centre (HSCIC) http://www.hscic.gov.uk/

APPENDICES see separate documents attached to policy

Appendix 1	Terms of Reference Audit Committee
Appendix 2	Terms of Reference Integrated Healthcare Governance Committee (IHGC)
Appendix 3	Terms of Reference Clinical and Quality Effectiveness Group
Appendix 4	Terms of Reference Finance Committee
Appendix 5	Terms of Reference Strategic Management Board
Appendix 6	Terms of Reference Care Group Board
Appendix 7	Terms of Reference Care Group Governance Board (Example of the Surgical Care Group provided)
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Enclosure N

Appendix 1

Terms of Reference
Audit Committee

Purpose of Committee

The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

Functions/Duties

Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurance, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate

independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Considering the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation
- Annual review of the effectiveness of Internal Audit

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the independence, appointment and performance of the External Auditor, as far as the Audit Commission's rules permit
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all External Audit reports, including the report to those charged with governance, the annual audit letter before submission to the Trust Board and any work in the nature of audit work carried out outside the annual audit plan, together with the appropriateness of management responses

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the committee will work in close liaison with the Integrated healthcare governance and Finance Committees and will meet formally with these committees at least twice per year..

In conjunction with the Integrated healthcare governance Committee, the Audit Committee will satisfy itself on the assurances gained from the clinical audit function.

Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

Other Matters

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed chair of the committee by the Board. The chair of the Trust shall not be a member of the committee.

In attendance

The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive is invited to attend any meeting and will attend and discuss at least annually the process for assurance that supports the Annual Governance Statement. He or she is also specifically invited to attend when the committee discusses the draft internal audit plan and the annual accounts. All other executive directors are invited to attend when the committee is discussing areas of risk or operation for which they are responsible.

Secretariat:

The committee will be supported administratively by the Head of Corporate Affairs whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of matters arising and issues to be carried forward
- advising the committee on pertinent issues/areas
- enabling the development and training of Committee members

Reporting Arrangements

The Audit Committee is a committee of the Board. The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Frequency of Meetings

The committee will meet a minimum of 5 times a year. The external auditors or Head of internal audit may request a meeting if they consider it necessary.

Quorum
The quorum comprises 3 Non-Executive Directors.

Approved 30 May 2013 – Trust Board
Review May 2014

Appendix 2

Terms of Reference

Integrated Healthcare Governance Committee

Purpose of Committee

The Integrated Healthcare Governance Committee (IHGC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management, performance, workforce and internal control across the clinical activities of the organisation that support the organisation's objectives.

In conjunction with the Audit Committee and the Finance Committee, IHGC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation.

Functions/Duties

1. Receive assurance from any relevant operational body that quality, safety or infection control standards are appropriately implemented and monitor progress relating to any of those areas where concerns are raised

2. Receive reports from the Clinical Quality and Effectiveness Committee (CQEG), where concerns have been identified and require escalation to a higher committee.

3. Receive reports where concerns are identified either internally or externally, reassure the board that appropriate preventable action is taken.

4. Review the performance and activity levels of the Trust and make recommendations to the Trust Board as necessary

5. To review workforce performance against agreed performance indicators and make recommendations to the Trust Board as necessary.

6. Enable adequate time for detailed discussion about key clinical issues at committee level where assurance needs to be gained, involving the appropriate Clinicians / Managers whoever appropriate.

7. To be responsible for detailed scrutiny of any patient safety, clinical quality and governance reports including the regular quarterly report. Where directorates / care groups are not performing against agreed standards for quality and performance the committee will monitor actions in place to improve performance

8. Review the corporate risk register at each meeting, the BAF quarterly and oversee arrangements for managing high clinical risks.

9. Ensure that appropriate clinical risk management arrangements are in place for the Trust, including using clinical audit to assure the Board that actions are taken appropriately.

10. Review Trust Development Authority Self-Certifications and make recommendations to the Trust Board as necessary.

11. Receive and challenge the following annual reports: Safeguarding Adults and Children , Infection control, NICE compliance, Clinical Audit forward plan and have an overview of priorities for the Trust.

12. Gain assurance on behalf of the Board regarding:

    - Accreditation and inspection visits, Independent reviews and Care Quality Commission visits/ inspections
    - Clinical Quality and Patient Safety issues
    - Monitor of implementation of patient safety and experience strategies
    - Receive reports / gap analysis on external reports which are significant to ensure actions are taken to prevent occurrence at NGH e.g. Winterbourne View, Francis report etc.

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership

- Three Non-Executive Directors
- Medical Director
- Director of Nursing, Midwifery and Patient Services
- Chief Executive Officer
- Chief Operating Officer
- Director of Workforce and Transformation
- Deputy Director of Quality & Governance
- Care Group Directors

In attendance

Head of Corporate Affairs
Chairman
Any Director/officer by invite as appropriate

Secretariat:

The Head of Corporate Affairs department will provide secretarial support to the committee.

Reporting Arrangements

The Integrated Healthcare Governance Committee is a committee of the Board. The Chair of the Committee will report regularly to the Board and minutes of IHGC meetings will be formally recorded and form part of Trust Board papers.

IHGC will meet twice a year with the Audit Committee and Finance Committee to ensure that risks are adequately managed across the organisation.

Reporting Group to IHGC
Clinical Quality and Effectiveness Group

Authority
The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Distribution of Minutes
The minutes are formally received by the Board.

Frequency of Meetings
Meetings shall be usually held on a monthly basis.

Quorum
Two Non-Executive Directors in conjunction with one Executive Director will constitute a quorum. In the absence of the Chair, a Non-Executive Chair will be nominated by the Committee.

Approved 30 May 2013 – Trust Board
Review May 2014

Appendix 3

Clinical Quality and Effectiveness Group -Terms of Reference

Definition:
The Clinical Quality and Effectiveness Group (CQEG) is responsible for providing assurance to Northampton General Hospital Trust Board via the Hospital Management Group that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

Purpose of Committee

To act as the central committee to facilitate an integrated approach to clinical quality and effectiveness.

Functions
Trust

1. Ensure a strategic framework is developed to meet national, regional and local policy in relation to clinical governance issues.
2. Formally receive regular reports, both internal and external, on clinical governance, quality assurance of clinical services, and other related issues. Reports will be received from groups and committees identified in organogram attached In doing so, ensure that appropriate action is taken and consider whether further strategic review is required.
3. The reports and papers received by CQEG form the basis for the quarterly patient safety, clinical quality and governance report which is available to members of HMG and the Trust Board.
4. CQEG is responsible for identifying areas for action and discussion at HMG and or Trust Board /IHCG. CQEG will recommend that the Trust Board requests the IHCG to discuss key issues of concern as indicated on the quarterly clinical performance scorecard presented in the Trustboard papers
5. Develop a systematic approach to clinical effectiveness by ensuring that;
   --systems are in place to monitor the performance of clinical staff and the quality of service which they offer
6. Pro-actively review systems, which support clinical governance processes.
7. Monitor the actions of the Directorate Governance groups in respect of their clinical governance responsibilities including the monitoring of clinical action plans.
8. Monitor and review evidence that Directorates have received, publicised and acted on the results of national confidential enquiries/ reviews/ inspections /reports/ accreditation visits/legislation (e.g NICE/CEMACH, NCEPOD)
9. Monitor all processes in relation to Medicines Management this is a function of the medicines management group perhaps we should reword
10. Promote and monitor education and training within the Trust related to clinical governance issues
11. Directorate Governance Groups and reporting committees can use the Group to raise issues that cannot be resolved at a local level or through other routes to enable more efficient and effective resolution
12. The Directorate representative is responsible for feeding back to their Directorate Governance Group.
13. Guide the development and monitor KPI's and CQUIN results

County wide
Work in partnership with the CCG quality contract representative.

Membership

Chair: Medical Director (Alternate Chair); Director of Nursing (Alternate Chair),
Deputy Chair: Deputy Director of Nursing (Governance) Deputy Medical Director
Patient & Staff representative: Governor

Clinical Representation

It is expected that these members will **attend each meeting or send an appropriate deputy**. Should any member fail to attend, or send a deputy, on two consecutive occasions the Chair of the Group will write to the member to request attendance.
Associate Medical Director – Governance Lead; Clinical Governance Leads from each Directorate/Chair of Directorate Governance Group; Governance Lead from Facilities; Clinical Audit and effectiveness; Chief Pharmacist; Head of Patient and Public Involvement; Senior Risk and Litigation Manager; Infection Control ; Training and Development representative. Quality Assurance Manager

Committees/ sub groups

Attendance as required reporting back from sub groups (see page 4)

Executives

A standing invitation shall be extended to the Deputy Directors of Finance, Deputy Director of Nursing, Assistant Director of Operations, Director of Human Resources, and Director of Service Development to attend meetings of this Committee if they consider it appropriate to do so in light of the business to be transacted at any particular meeting.

CCG representation

The CCG has a seat on the membership of CQEG to provide assurance to the Clinical Quality monitoring of the commissioner/provider contract.

Other

Other staff may attend as appropriate. In addition senior managers, and advisors, will be invited to attend Committee meetings as and when required.

In attendance

Minute taker - Personal assistant to chair.

Reporting Arrangements (see structure)

The Group will receive reports from the various clinical sub groups as defined on the organisational chart (page 4) and will provide minutes to the Strategic Management Group as evidence of the process.

The Group reports directly to the Hospital Management Group who will delegate matters as they arises to the Integrated Healthcare Governance Committee.

Level of Authority

The Clinical Quality and Effectiveness Group (CQEG) will support the Board of Directors in discharging their responsibilities by providing objective assurance to the Trust Board that processes are in place across the Trust to ensure high quality clinical services are provided. This is provided through the **Clinical Quality and Safety Report**.

The Group reports directly to the Hospital Management Group (Via Mins)

The group is supported by a number of trust wide groups as identified in the organisational chart.

Distribution of Minutes

Members of CQEG and sub groups that report into CQEG. Minutes will be stored on the Governance Shared drive and will be accessed there by members

Terms of Office
Appointments should be reviewed after each three years of office.

Frequency of meetings

No less than 10 meetings each year. Every 4-6 weeks.

Quorum

The Clinical Quality and Effectiveness Group will be considered quorate when there are at least 6 members including:

- Chair/ deputy chair
- Three Clinical Governance Leads or nominated Deputy from directorates
- Governance representative from risk or quality assurance team

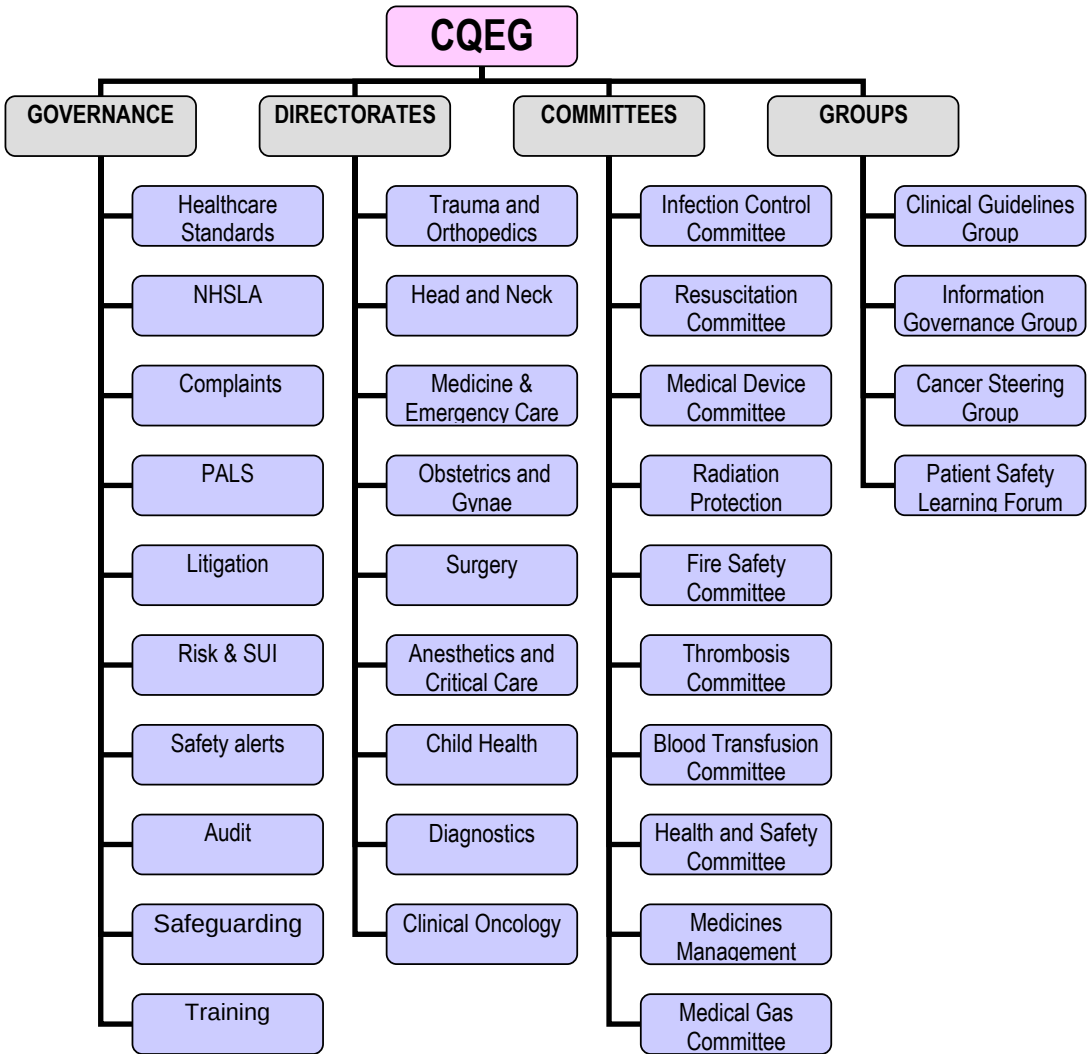
Decision Making

'One member, one vote' shall apply. If a split decision, the Chair will carry the casting vote.

Declaration of Interest

Members of the CQEG should declare any competing interests to the Chairman who shall decide on the appropriate action.

CQEG Reporting Structure (this is subject to regular review).



Enclosure N

Appendix 4

Terms of Reference

Finance Committee

Purpose of Committee

The Finance Committee (FC) is a committee of the Board and has delegated responsibility for ensuring an effective system of integrated governance, risk management and internal control across the finance activities of the organisation that support the organisation's objectives.

In conjunction with the Audit Committee and the Integrated Healthcare Governance Committee, FC is responsible for ensuring that this system forms an integrated whole both between the committees and across the organisation.

Functions/Duties

1. To review and challenge the medium and long term Financial Strategy
2. Scrutinise the development of the Trusts annual IBP with reference to the mitigation of risks on the Corporate risk register
3. Review the Trusts monthly and forecast financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board. Review the mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
4. To review the Trusts short and medium term financial performance of the Transformation Programme, including any mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
5. To review the Trust liquidity strategy and cash forecasts against performance
6. Review and evaluation of key financial risks, linking to the Board Assurance Framework
7. To review controls around business case investments.
8. Review the development and management of the rolling capital programme
9. To review and support the development of key external stakeholder partnerships

Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Membership

- Three Non-Executive Directors
- Director of Finance
- Chief Operating Officer
- Director of Strategy and Partnerships
- Director of Workforce and Transformation
- Transformation Programme Director

In attendance

Head of Corporate Affairs
Any directors/officers by invite as required

Secretariat:
The Head of Corporate Affairs department will provide secretarial support to the committee.

Reporting Arrangements
The Finance Committee is a committee of the Board. The Chair of the Committee will report regularly to the Board and minutes of FC meetings will be formally recorded and form part of Trust Board papers.

FC will meet twice a year with the Audit Committee and Integrated Healthcare Governance Committee to ensure that risks are adequately managed across the organisation.

Reporting Group to Finance Committee
There are no groups established which formally report into the Finance Committee.

Authority
The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Distribution of Minutes
The minutes are formally received by the Board.

Frequency of Meetings
Meetings shall be usually held on a monthly basis.

Quorum
Two Non-Executive Directors in conjunction with one Executive Director will constitute a quorum. In the absence of the Chair, a Non-Executive Chair will be nominated by the Committee.

Approved 30 May 2013 – Trust Board
Review May 2014

Appendix 5

Terms of Reference
Strategic Management Board

Purpose of the Strategic Management Board

The Strategic Management Board (SMB) is responsible for ensuring an effective system of integrated governance, risk management and controls across the activities of the organisation that support the organisation's objectives.

Functions

1. Receive reports from each of the Care Groups to provide operational assurance and escalate risks to the Trust Board

2. Receive reports where concerns are identified, for example by the Board, external sources, Finance & Performance Committee, Healthcare Governance Committee

3. Discuss strategic issues to maintain the strategic vision, aims and objectives set by the Trust Board

4. To receive and approve reports from the Procedural Document Group regarding the approval of policies and procedures

5. To ensure that risks to the organisation are minimised through the application of a comprehensive risk management system including the review of the corporate risk register at each meeting and oversee arrangements for managing high risks.

6. To receive and review the Board Assurance Framework which sets out risks to the achievement of the Trust's objectives

7. To receive and approve Service Development proposals

8. To receive and approve Capital Development proposals

9. To receive and approve Care Group Budgets

Membership

Trust Directors
Care Group Chairs
Care Group Directors
Care Group Lead Nurses
Clinical Directors
General Managers

The Chief Executive shall be the Chair of the SMB. In the absence of the Chair, the Chair for that meeting will be taken by the Deputy Chief Executive and in the absence of them both the Chair shall be a Chair nominated by the SMB.
Members of the SMB should attend each meeting, or nominate a deputy to attend in their absence. Each member must attend a minimum number of 5 meetings per year.

Reporting Groups to Strategic Management Board

Transformation Steering Board
Education Strategy Board
Capital Group
Sustainability Development Committee
Strategic Planning Group

In attendance

Head of Corporate Affairs
Minute taker
Other members of staff may be invited to attend, particularly when discussing areas for which they have responsibility.

Reporting Arrangements

The Strategic Management Board will report to the Trust Board. The Minutes of this meeting will be formally recorded and submitted to the Trust Board. The Chair of the SMB shall draw to the attention of the Board any issues that require disclosure to the full Board.

Level of Authority

The SMB is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the SMB. [The SMB can also seek outside expert advice] The SMB shall make recommendations to the Board it deems appropriate on any area within its Terms of Reference where action or improvement is required.

Distribution of Minutes

The minutes are formally received by the Board.

Frequency of Meetings

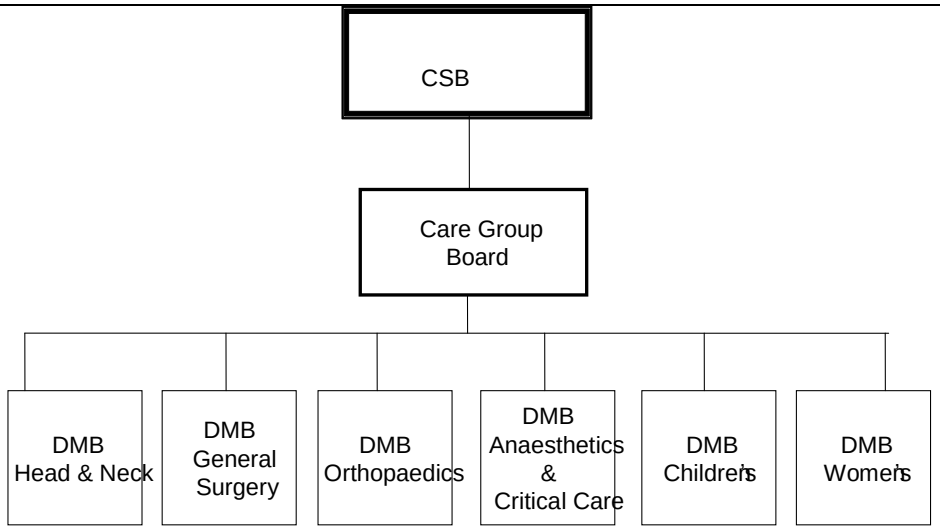
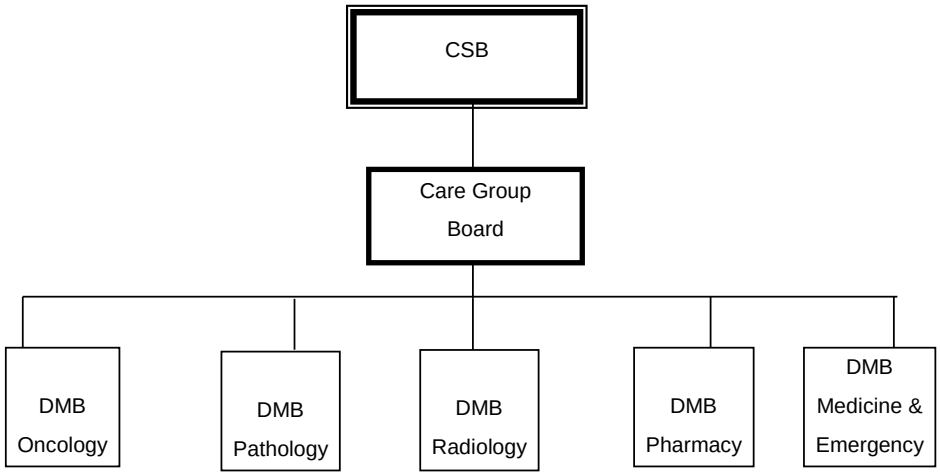
Meetings shall be usually held on a six weekly basis and there will no less than 7 meetings per year.

Quorum

Two representatives from each Care Group in conjunction with 4 Trust Directors will constitute a quorum. The Head of Corporate Affairs will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the SMB

Appendix 6

TITLE	CARE GROUP BOARD
Membership	Care Group Chair (Chair) Care Groups Director Clinical Directors General Managers Lead Nurse Care Group Finance Lead Care Group Human Resources Lead Care Group Quality and Safety (Clinical Governance Lead) Head of Midwifery (Surgery) Heads of Pathology / Radiology / Pharmacy / Therapies (Medicine)
Purpose	The Care Group Board is established as the key assurance and decision making group of the Care group in relation to operational performance, quality, safety, risk, and strategic planning. It reports to the Clinical Strategy Board (name to be confirmed) in terms of: • Finance including, Cost Improvement and Transformation program • Operational performance including activity and HR • Governance, Quality and Patient Safety • Strategic Planning & service improvement Each Directorate within the Care Group will be requested to complete directorate scorecards which will be used by exceptional reporting for issues or concerns. The Care Group Board will feed into directorates via their Directorate Management Board which will take place monthly chaired by the Clinical Directors. The Directorate Management Boards (chaired by the Clinical Directors) are decision making and will continue to be responsible and accountable for the operational and strategic management of the directorates.

Diagram **Surgery Care Group**	
Diagram **Medicine Care Group**	
Clinical Governance	Each Directorate will continue to strengthen their monthly Directorate Clinical Governance meetings which are chaired by the Clinical Governance Leads and fed into the Directorate Management Boards. The Care Group Board will have Clinical Governance as a standard agenda item which will be used for exceptional reporting only. Clinical Governance leads will continue to attend the Trust-wide CQEG.
Deputies	While it is expected that members will make every effort to attend meetings of the Care Group Board, it shall be permissible for deputies to attend by exception.

Quorum	A quorum shall be 5 members including either, the Care Group Director, Chair, or Lead Nurse.
Attendance	The Care Group Board will request the attendance of other post-holders at its meetings if it considers this necessary. The executive team will be invited to attend quarterly
Frequency	Meetings shall be held monthly. Additional meetings may be convened by the Chairperson in exceptional circumstances.
Secretary	The PA to the Care Group Team shall attend to take minutes of the meeting and provide appropriate support to the Chairman and members. Minutes will be shared across both care groups

Appendix 7

Surgical Care Group Governance Board

Terms of Reference

The purpose of the terms of reference is to set out written guidelines that clarify the role of the care group governance board, its purpose, membership and responsibilities.

Aim:

The Surgical Care Group Governance Board (SCGGB) is responsible for providing assurance to Northampton General Hospital Healthcare Governance Committee (HGC), via the CQEG that governance processes are in place to deliver high quality clinical services and ensure appropriate patient and staff safety.

Purpose:

To act as the central board for the Surgical Care Group to facilitate an integrated approach to clinical quality and effectiveness.

Functions:

14. Formally receive assurance via directorate reports on clinical governance, quality assurance and other related issues. To ensure that appropriate action is being taken and consider whether further strategic review is required.
15. The reports and papers received by the SCGGB will be included in the Trusts quarterly patient safety, clinical quality and governance report which is available to members of SMB and the Trust Board.
16. Review the quarterly reports that are submitted to CQEG, discuss any areas that remain non-compliant, discuss the action plan required to achieve compliance and any areas that need to be raised at the SCG Board meeting
17. SCGGB will be responsible for identifying areas for action and discussion at CQEG /HCG as raised by the directorate governance leads. SCGGB will recommend that the Trust Board requests the HCG to discuss key issues of concern as indicated on the quarterly clinical performance scorecard presented in the Trust board papers
18. SCGGB will systematically review the Care Groups Serious Incidents, Never Events, claims, litigation and any attributed action plans to ensure completion and shared learning
19. Develop a systematic approach to clinical effectiveness by ensuring that systems are in place to monitor the performance of clinical staff and the quality of service which they offer. Review the governance and quality aspects of the SCG Quality dashboard on a regular basis and discuss the plans to improve any areas of non-compliance.
20. Pro-actively review systems, which support clinical governance processes.
21. Monitor the actions of the Directorate Governance groups in respect of their clinical governance responsibilities including the monitoring of clinical action plans.
22. Monitor and review evidence that Directorates have received, publicised and acted on the results of national confidential enquiries/ reviews/ inspections /reports/ accreditation visits/legislation (e.g. NICE, NCEPOD etc)

23. Promote and monitor education and training within the Care Group related to clinical governance issues
24. SCGGB is the reporting mechanism for the directorate governance leads to raise issues that cannot be resolved at a local level or through other routes to enable more efficient and effective resolution
25. The Directorates representatives are responsible for feeding back to their Directorate Governance Groups.
26. Guide the development of and monitor KPI's and CQUIN results

Membership:

Care Group Chair

Care Group Lead Nurse

SCG Governance Manager

Quality & Safety Assurance Manager

SCG Facilitator

T&O Governance Lead

General Surgery Governance Lead

A&CC Governance Lead

HN Governance Lead

Opthalmology Governance Lead

Paediatrics Governance Lead

Obstetrics Governance Lead

Gynaecology Governance Lead

It is expected that these members will attend each meeting or send an appropriate deputy. Other staff may be invited to attend meetings as and when required.

Reporting Arrangements:

The SCGG Board will receive reports from the various clinical Directorates and will provide minutes to the CQEG and SCG Board.

The SCGG reports directly to CQEG who will delegate matters as they arise to the Trust's Healthcare Governance Committee.

Distribution of Minutes:

Members of SCGGB, CQEG and SCG

Frequency of meetings

No less than 10 meetings each year. Every 4-6 weeks.

Quorum

The Surgical Care Group Governance Board will be considered quorate when there are at least 6 members present including:

- Chair/ deputy chair
- Three Clinical Governance Leads or nominated Deputy from the Directorates
- Governance representation from the Care Groups risk or quality assurance teams

Appendix 8

TERMS OF REFERENCE

RISK GROUP

Title of Group:	Risk Group
Overview:	The Risk Group (RG) is responsible for ensuring risk management is operational and embedded throughout the organisation.
Purpose :	The group will provide a clear and equitable framework to set direction for and monitor progress of any activity within its agreed responsibilities. This will include providing challenge and moderation to risks on the corporate risk registers. The Group will advise the Executive Team on risk management systems and processes, the Corporate Risk Register and Board Assurance Framework, taking into account of the views of CQEG and other stakeholders. It will ensure that the key corporate documentation is contemporaneous, consistent and accurately reflects the organisation's view of its risk ensuring that controls and mitigations are in place. Where gaps are identified, the Group will ensure action plans are prepared to address these.
Responsibilities:	• Develop and Review the Risk Management Strategy • Performance manage the requirements of the Risk Management Strategy and Policy (including Risk Registers) • Promote the on-going development of the risk registers. • Challenge new risks entered onto the corporate risk registers by ensuring they are entered onto the risk register in accordance with active policies and procedures, including the risk assessment policy. • Ensure that risks that have been escalated to the corporate risk register have the risk clearly articulated and graded appropriately. • Review Corporate Risk Register to ensure that all documented risks have mitigation plans in place and are regularly reviewed and updated. • Challenge progress with mitigating actions as appropriate. • Ensure that each Care Group and Department effectively balances the delivery of operational performance with the management of risk across the organisation • Challenge the impact of mitigation plans • Provide support to leads in all aspects of risk management • Recommend escalation of risks to corporate risk register and subsequently to the Board Assurance Framework where appropriate to the relevant Director and the Executive Team • Ensure rapid escalation of any issues that require resolution to the

	Executive Directors • Review the Board Assurance Framework and any associated action plans. • Form a view on the highest risks to the organisation and report this to Board via the Executive team and IHGC.
Membership:	The group shall include; Medical Director (Chair) Director of Finance (Vice Chair) Deputy Director of Quality & Governance Director of Nursing & Patient Experience Deputy Director of Strategy & Partnership Head of Corporate Affairs Senior Risk Litigation & Quality Manager Health & Safety Manager Care Group Representatives IT Representative Estates Representative HR & OD Representative Maternity Governance Lead Care Group Quality Governance Managers Other individuals will be invited to attend as appropriate.
Attendance Requirements:	Members are expected to make every effort to attend all meetings, but are required to attend at least 75% of all scheduled meetings, in person. A nominated deputy is expected to attend in circumstances where the committee member is unable to attend. Within reason, a nominated deputy is expected to be fully briefed to respond to any queries and authorised to make decisions on behalf of the absent committee member.
Quorum Requirements :	The minimum attendance required for any meeting is the Chair, or nominated deputy together with at least 40% of the total membership; which applies to all specific groups within the membership, (e.g. 40% of staff, 40% of Non - Executive Directors etc).The chair is included within the appropriate group. It will be at the discretion of the Chair to determine whether any particular agenda item should be deferred due to insufficient representation.
Organisation: (a) Frequency. (b) Papers and Minuting arrangements.	Meetings will be held monthly. Agenda and papers will be issued at least three working days prior to the meeting. Attendance will be recorded in a register of attendance.

	Formal minutes will be recorded.
Authority:	The group may make decisions delegated by the Executive Team from whom it derives its authority.
Reporting Arrangements:	The RG will provide a highlight report and the minutes to the Executive Team monthly and provide quarterly reports to Integrated Healthcare Governance Committee.
Review Arrangements:	The terms of reference will be reviewed on an annual basis, or sooner if appropriate. Any changes to the Terms of Reference must be agreed by the Group prior to ratification by the parent committee, to which the committee reports. Date Agreed: 13th December 2013. Next review: June 2014
Monitoring	These Terms of Reference will be monitored by the Integrated Healthcare Governance Committee through receipt of minutes and reports which will demonstrate compliance with all aspects of these terms of reference.

Appendix 9

Risk Matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Enclosure N

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the

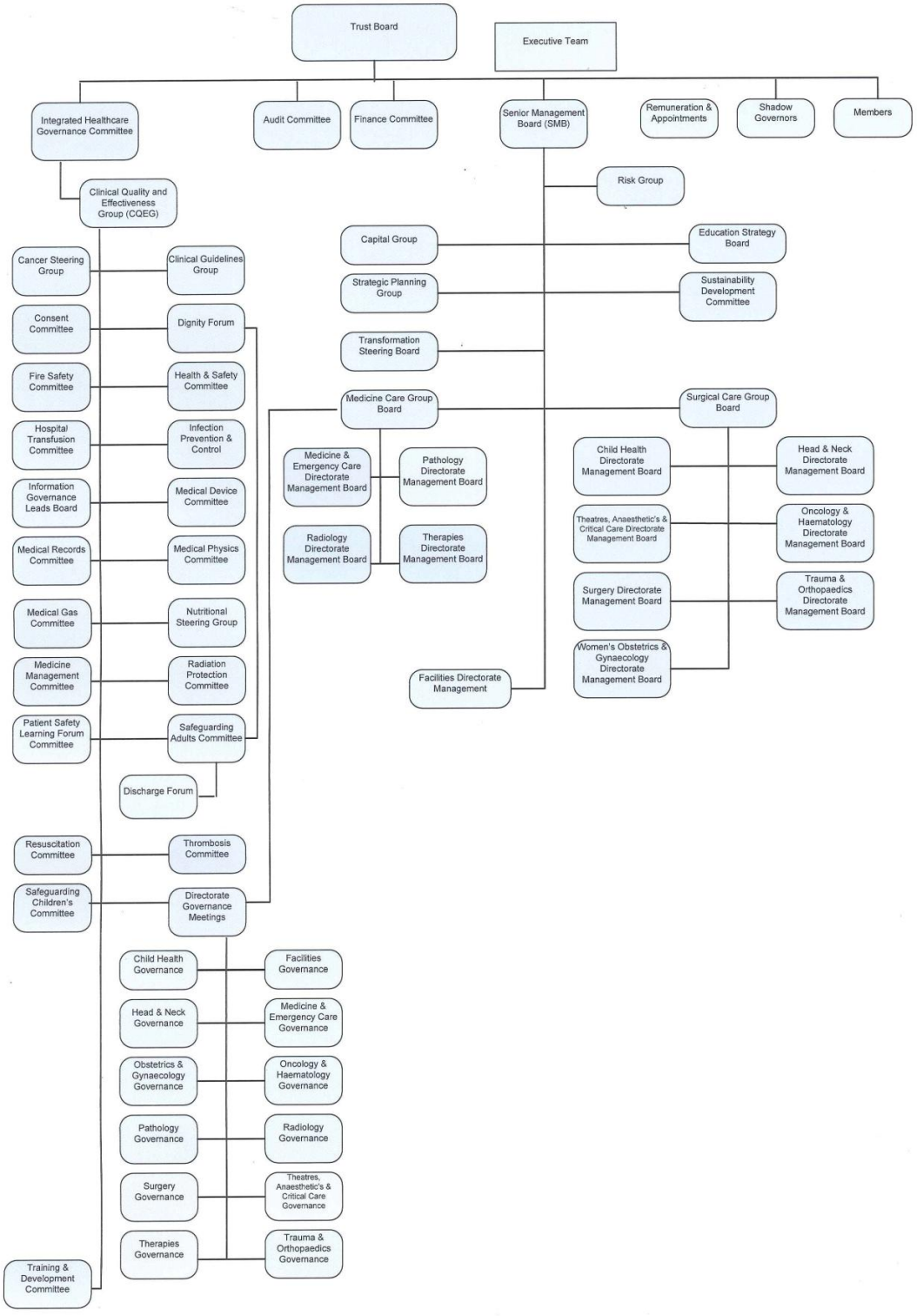
lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

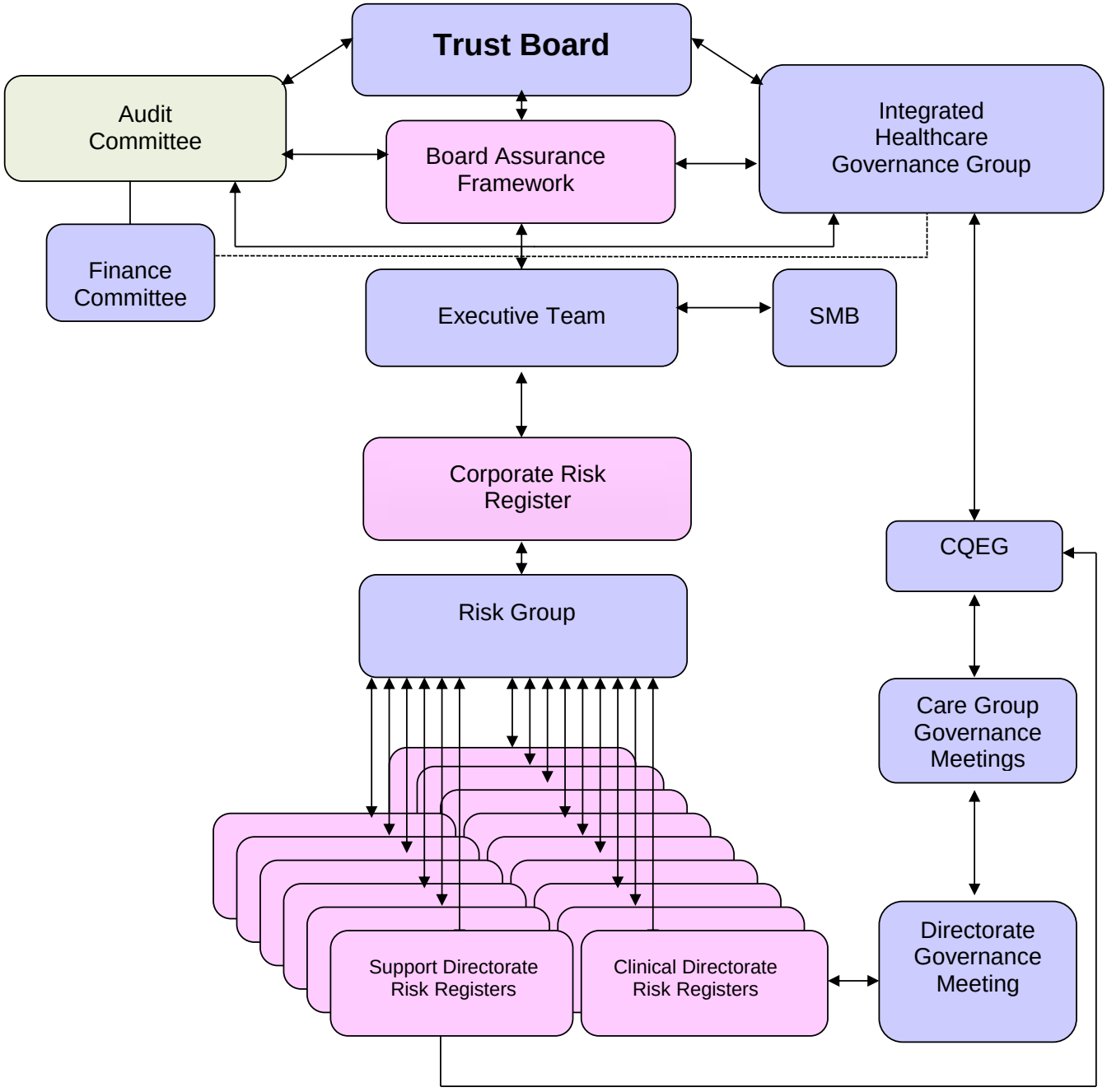
Appendix 10

NGH Committee Structure



Enclosure N

Appendix 11 - Risk Management Framework



Key: Blue indicates meetings involved in review and challenge of the risk register process

Pink indicates the registers where risks are recorded

Green indicates an independent review of risk assurance systems

STRATEGY

Appendix 12

Board Assurance Framework – Accountability and Process Structure

Audit Committee

Responsibilities

- To provide independent scrutiny that there is an effective risk management system embedded within the Trust and it is functioning to the required standards.
- The Audit Committee will review the controls involved in the management and monitoring of the BAF in order to provide assurance of effectiveness to the Board.

Mechanism(s)

- QUARTERLY: Detailed review of the BAF at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided.
- SIX MONTHLY (In conjunction with IHGC): Confirm and Challenge review of the top risks in the Corporate Risk Register with risk owners.
- MONTHLY: Review of clinical, internal and external audit outputs to identify areas of risk for further investigation.

Outputs

- Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Audit Committee.
- Annual Head of Internal Audit Opinion based upon Audit Committee oversight and Board review of the BAF.

Accountable Officer(s)

- Director of Finance

Integrated Healthcare Governance Committee

Responsibilities

- To provide independent scrutiny that clinical, operational and workforce risks are being reported, monitored and managed effectively, challenging management assurance.
- To review the robustness of the controls involved in the management and monitoring of the risks in order to provide assurance of effectiveness to the Board.

Mechanism(s)

- MONTHLY: Detailed review of the relevant BAF risks at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided.
- MONTHLY: Review of internal intelligence (including CRR) to inform areas prospective of risk to be considered within the BAF.
- MONTHLY: Horizon scanning of risk issues not included within the BAF.

Outputs

- Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Committee.

Accountable Officer(s)

- Medical Director and Director of Nursing, Midwifery and Patient Services

Finance Committee
Responsibilities • To provide independent scrutiny that financial and capital risks are being reported, monitored and managed effectively, challenging management assurance. • To review the robustness of the controls involved in the management and monitoring of the risks in order to provide assurance of effectiveness to the Board.
Mechanism(s) • MONTHLY: Detailed review of the relevant BAF risks at each of its meetings. Undertake a deep dive into a number of risks to test the validity of management information and scrutinise assurances provided. • MONTHLY: Review of internal intelligence (including CRR) to inform areas prospective of risk to be considered within the BAF. • MONTHLY: Horizon scanning of risk issues not included within the BAF.
Outputs • Assurance reporting to the Board on effectiveness via highlight/exception reporting following each meeting of the Committee.
Accountable Officer(s) • Director of Finance

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
DATE: 30 January 2014

Title	Standards for Members of NHS Board and Clinical Commissioning Group Governing Bodies in England
Agenda item	18
Sponsoring Director	Phil Zeidler, Vice-Chair and Non-Executive Director
Author(s)	Craig Sharples, Head of Corporate Affairs
Purpose	Endorsement and Decision

Executive summary

The standards for members of NHS boards and clinical commissioning group governing bodies in England were published by the Professional Standards Authority in November 2013.

The Board is asked to endorse the standards and agree to steps it wishes to take to assure itself that it upholds the standards.

Related strategic aim and corporate objective	The Standards for Members of the Board underpins the entire business of the Trust and relates to all strategic aims and corporate objectives.
Risk and assurance	By endorsing these standards, the Board is demonstrating assurance to ensuring that NGH is well governed.
Related Board Assurance Framework entries	The Standards for Members of the Board underpins the entire business of the Trust and relates to all strategic aims and corporate objectives.
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Non-compliance with these standards will present regulatory risks.

Enclosure O

Actions required by the Board

The Board is asked to endorse the standards and consider the methods of assurance.

Trust Board
30 January 2014

Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England

1. Introduction

The Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies were commissioned by the Secretary of State for health in November 2013 following consultation with patients and the public, the NHS and with professional organisations.

The standards build on work already undertaken in this area and they are consistent with the Nolan Principles on Public Life and other regulatory frameworks that apply to professionals working in the NHS.

They recognise that with the relatively new clinical commissioning arrangements, many individuals will be taking on new responsibilities and need clear guidance to enable ethical decision making. This should be consistent across all organisations.

They cover three domains:
- personal behaviour
- technical competence
- business practices

and "put compassion and respect at the heart of the NHS leadership".

The request to develop a set of high level standards for executive and non-executive board members in England arose from the Government's commitment in the Command Paper "Enabling Excellence".

2. Demonstrating Compliance with the Standards

The Board should consider how it wishes to assure itself of conformance to these standards. Listed below are some suggestions as to how this might be achieved:

- The Board formally adopts the standards and its commitment to upholding them
- Individual members are required to sign to demonstrate receipt, understanding and acceptance of the standards, to be renewed annually.
- Use as a measurement tool for Board effectiveness; incorporate into the next Board performance review.
- Incorporate into the performance appraisal process for all Board members
- Set it as an agenda item for a Board development day to explore it more fully

3. Recommendations/Resolutions Required

The Board is asked to:

- Adopt and commit to the Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England;
- Agree the method(s) of assurance

professional standards authority

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

November 2013

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users, and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

Professional Standards Authority
157-197 Buckingham Palace Road, London SW1W 9SP
Telephone: 020 7389 8030 Email: info@professionalstandards.org.uk
Web: www.professionalstandards.org.uk

Personal behaviour

1. As a Member[1] I commit to:

The values of the NHS Constitution

Promoting equality

Promoting human rights

in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. I will apply the following values in my work and relationships with others:

- **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board[2], including delegated responsibilities, and for the staff and services for which I am responsible
- **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member
- **Openness**: I will be open about the reasoning, reasons, and processes underpinning my actions, transactions, communications, behaviours, and decision-making and about any conflicts of interest
- **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
- **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all
- **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours, and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

1 The term 'Member' is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.
2 The term 'board' is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.

Technical competence

3. As a Member, for myself, my organisation, and the NHS, I will seek:

Excellence in clinical care, patient safety, patient experience, and the accessibility of services

To make sound decisions individually and collectively

Long term financial stability and the best value for the benefit of patients, service users, and the community.

4. I will do this by:

- Always putting the safety of patients and service users, the quality of care, and patient experience first, and enabling colleagues to do the same
- Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning, and continuing professional development
- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial, and legal contexts in which it operates
- Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
- Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
- Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
- Thinking strategically and developmentally
- Confidently and competently using data and other forms of intelligence, including patient complaints and feedback, to improve the quality of care
- Understanding the health needs of the population I serve
- Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
- Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
- Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood.

Business practices

5. As a Member, for myself and my organisation, I will seek:

To ensure my organisation is fit to serve its patients and service users, and the community

To be fair, transparent, measured, and thorough in decision-making and in the management of public money

To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6. I will do this by:

- Declaring any personal, professional, or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours, or decision-making, and removing myself from decision-making when they might be perceived to do so
- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
- Ensuring that effective incident reporting, disclosure, complaints, and whistleblowing procedures are in place and in use
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
- Ensuring that staff provide high quality care in a listening, supportive, learning environment
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
- Respecting patients' rights to consent, privacy and confidentiality, and access to information, while enabling the legitimate sharing of information between care teams and professionals for the purposes of a patient's direct care
- Being open about the evidence, reasoning, and reasons behind decisions about budget, resource, and contract allocation
- Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective, and properly used, and that the values in these Standards are put into action in the design and delivery of services
- Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
- Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 30 January 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Zeidler	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of the 28 November 2013 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 28 November 2013	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Ms S Loader	**Verbal**
	6.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.50	**CLINICAL QUALITY AND SAFETY**				
	7.	Quality Report	Assurance	Dr M Wilkinson	**D.**
	8.	Patient Experience Report	Assurance	Ms S Loader	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms S Loader	**F.**
10.25	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs R Brown	**G.**
	11.	Urgent Care Update	Assurance	Mrs D Needham	**H.**
	12.	Finance Report	Assurance	Mr A Foster	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
	14.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**K.**
	15.	TDA Self-Certification	Decision	Mr C Pallot	**L.**
11.30	**STRATEGY AND GOVERNANCE**				
	16.	Oncology and Cancer Partnership with UHL	Decision	Mr C Pallot	**M.**
	17.	Risk Management Strategy	Decision	Dr M Wilkinson	**N.**
	18.	Standards for Members of NHS Boards in England	Decision	Mr P Zeidler	**O.**
11.50	**ANY ITEMS OF OTHER BUSINESS**				
	19.	**DATE AND TIME OF NEXT MEETING** 27 February 2014, Boardroom, NGH	Note	Mr P Zeidler	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

“That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).