Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 24 April 2014, 09.30 am

at

the Boardroom,
NGH

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 24 April 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of the 27 March 2014 meeting of the Board	Decision	Mr P Farenden	**A.**
	4.	Matters arising from the 27 March 2014	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.50	**CLINICAL QUALITY AND SAFETY**				
	7.	CQC Action Plan	Assurance	Dr S Swart	**D.**
	8.	Quality Report	Assurance	Dr M Wilkinson	**E.**
	9.	Patient Experience Report	Assurance	Mrs J Bradley	**F.**
10.20	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs D Needham	**G.**
	11.	Urgent Care Report	Assurance	Mrs D Needham	**H.**
	12.	Finance Report	Assurance	Mrs D Needham	**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	**GOVERNANCE**				
	16.	Register of Sealing's	Assurance	Mr C Sharples	**M.**
11.35	**ANY ITEMS OF OTHER BUSINESS**				
	17.	**DATE AND TIME OF NEXT MEETING** 29 May 2014, Boardroom, NGH	Note	Mr P Farenden	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this

meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on

Thursday 27 March 2014 at 9.30 am at the Boardroom, NGH

Present:

Mr P Zeidler (Chair)	Non-Executive Director – Vice Chair
Mr C Abolins	Director of Facilities & Capital Development
Mrs J Brennan	Director of Workforce and Transformation
Mrs R Brown	Acting Chief Operating Officer
Mr P Farenden	Chairman
Mr S Lazarus	Director of Finance
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mr D Noble	Non-Executive Director
Mr N Robertson	Non-Executive Director
Mrs E Searle	Non-Executive Director
Mrs K Spellman	Deputy Director of Strategy and Partnerships
Dr S Swart	Chief Executive Officer
Dr M Wilkinson	Acting Medical Director

In Attendance:

Mr C Sharples	Head of Corporate Affairs

Apologies:

Mr G Kershaw	Non-Executive Director
Mrs D Needham	Acting Chief Operating Officer
Mr C Pallot	Director of Strategy and Partnerships

TB 13/14 177	**Declarations of Interest in the Proceedings**
	No further interests or additions to the Register of Interests were declared.
TB 13/14 178	**Minutes of the meeting held on 27 February 2014**
	The minutes of the meeting of the 27 February 2014 Board meeting were presented for approval. Subject a number of typographical amendments, the Board resolved to **APPROVE** the minutes of the 27 February 2014 as a true and accurate record of proceedings.
TB 13/14 179	**Action Log and matters arising from the 27 February 2014 Board Meeting**
	The Board considered the action log. It was requested that when an action missed its expected completion date that the reason for slippage be included. **Action: Mr Sharples** The Board **NOTED** the Action Log and Matters Arising from the 27 February 2014.
TB 13/14 180	**Patient Story**
	Dr Swart presented two patient stories to the Board. She advised that they were not from patients of NGH, but felt that the experiences presented could be faced by patients of NGH. The first patient story was the personal experience of the impact that cancelled operations had on patients, written in the Times by columnist, Melanie Reid. The experience highlighted the emotional distress cancelled

	operations, particularly those operations cancelled on the day, have on patients. Dr Swart acknowledged that the experience is replicated for some patients at NGH when the hospital was full and it had to balance the potential risk to the patient if HDU beds were unavailable. She added that the trust was actively working to address the urgent care problem, the main driver for cancelled operations, to reduce their incidence. The second patient story related to patients being moved around the hospital at night. The experience presented to the Board involved a patient being moved to a different ward during the night without support, adequate pain relief or hydration. Again, Dr Swart acknowledged that the experience of that patient could be experienced by a patient at NGH. The trust had undertaken to improve systems and now each move at night was tracked, risk assessed and the reasons why communicated with the patient when this had to happen. Dr Swart added that the urgent care problems were the main cause for patients being moved at night.
TB 13/14 181	**Chief Executive's Report**
	Dr Swart presented the Chief Executive's Report to the Board. The Board was informed that on the 25 March, Dr Swart and a number of other colleagues had attended the Quality Summit in response the CQC report which was due to be published imminently. She reported that the inspection found a number of issues that required addressing, and advised that the report found the trust to be 'good' in the caring category. In the main, the report found that services were safe and effectives. Dr Swart advised that the report criticised the trust in three strategic areas, the robustness of its governance, leadership, and concerns regarding the impact urgent care was having on the rest of the organisation. At the time of the inspection, there were plans in place to address those issues, which have since been accelerated. The three major pieces of work accelerated were: • The trust is working with external support to improve operational performance of the urgent care pathway whilst retaining the focus on quality and safety. • The Trust had sought advice on how best to ensure that our work to challenge and refocus our governance processes is robust. This will ensure we improve the working of our committees, reporting, risk management and assurance processes. • The Trust was accelerating the planned programme of organisational development, enlisting expert help to ensure our teams have the skills to lead and manage change focussed on quality improvement. Dr Swart informed members that she found the Quality Summit to be supportive of the trust in driving the required changes and they attendees at the summit acknowledged that the trust had a willingness to improve. Mr Farenden asked if the Quality Summit allowed Dr Swart to engage with partners to address the urgent care challenges. Dr Swart advised that the trust's commitment was very clearly understood and welcomed. The attendees were assured that the trust had responded appropriately to the findings and all partners in the room were exceptionally supportive. Following the Quality Summit, Dr Swart would write to all partners to

	continue that engagement in driving improvement. Mr Zeidler commented that the CQC went out of their way to express their shock at the speed with which the trust had responded to and addressed their initial findings. Dr Swart commented that the commitment of staff that enabled that swift response. Dr Swart reported that the Best Possible Care Awards ceremony would take place on the evening of Monday 7 April. This year's awards ceremony would build on the success of the STAR Awards, aligning the awards to our vision and values and adding new categories to ensure that both clinical and non-clinical staff had equal opportunities to share in the awards. The Board noted the appointment of Mrs Needham as Chief Operating Officer. The Board **NOTED** the Chief Executives Report.
TB 13/14 182	**Quality Report**
	Dr Wilkinson presented the Quality Report and provided a detailed overview of the content. Dr Wilkinson informed the Board that overall mortality as measured by HSMR remained low, and the SHMI continued to decrease as anticipated although it remained high. He advised that it was expected SHMI would reduce over time in line with HSMR, as SHMI data was subject to a nine month lag. The Board was assured that the metrics would continue to be monitored closely. With regard to serious incidents, Dr Wilkinson reported that the trust was higher than the national average for reporting, largely due to the number of pressure ulcers reported by the trust. He advised that an improvement was expected with the number of pressure ulcers due to the investment on new pressure relieving equipment and training, Dr Wilkinson presented the exception scorecard. In highlighting the areas of particular concern, it was reported that the number of patients with a fractured neck of femur receiving surgery within 36 hours had improved to 85% and was now in line with the national average. Mr Noble questioned if the trust needed to set a more challenging target above the national average. Dr Wilkinson agreed, but acknowledged that reaching 100% would not be an achievable target. Mr Zeidler questioned if the targets on the exception scorecard were realistic as large numbers of indicators had remained red rated for a significant period of time. Dr Swart advised that the basis for the targets would be reviewed as part of the ongoing governance review, agreeing that the Board needed to be assured that the indicators were aligned to the trust's strategy and appropriate to enable robust challenge and the provision of assurance. With regard to pressure ulcers, Mrs Searle questioned if the trust had the correct quantity of pressure relieving equipment in place now. Ms Loader advised that she was assured there was sufficient equipment available, but education and training of staff needed to be improved. She expected it would be six months before there was a demonstrable improvement in the number of pressure ulcers reported.

	The Board **NOTED** the Quality Report.
TB 13/14 183	**Patient Experience Report**
	Ms Loader presented Patient Experience Report. It was reported that the National Inpatient Survey results for 2013 had been received. The Trust had made improvements in many areas performing better in 41 questions, worse in 10 and the same in nine. When compared against the national data for 2012, the trust was within the 'Average' category for 44 questions, 'Better' than the average for nine questions and 'Worse' for six. National benchmarking data was awaited, and would be presented to the Integrated Healthcare Governance Committee when received. With regard to the Friends and Families Test (FFT), inpatient services achieved their highest response rate to date of 40.87%. A&E continued to struggle with their response rates obtaining their lowest rate since August 2013 of just 12.85%. Despite the low response rate in A&E, the net promoter score was very positive. Due to the low response rate in A&E, the overall Inpatient and A&E response rate was 21.99%, only slightly higher than the required national CQUIN target of 20%. It was reported that in 2014/15, FFT would be rolled out to outpatients and staff. There would be pilots across the trust over the next few months, and the trust was looking at electronic systems to support the increased amount of data that had to be collected, analysed and reported. Mrs Searle questioned why the response rate in A&E was so poor. Ms Loader advised that there had been IT problems that had affected the ability to respond. The issue had now been resolved and she expected April's response rate to increase. The Board **NOTED** the Patient Experience Report.
TB 13/14 184	**Infection Prevention Performance Report**
	Ms Loader presented the Infection Prevention Performance Report to the Board. In summarising the report, Ms Loader reported that the trust remained under the C.Diff trajectory, with 24 cases recorded year to date. It was noted that there had been two further cases reported in March, but the trust was not expected to exceed the ceiling of 29 cases for the year. Ms Loader reported that there had been one reported case of MRSA attributable to the within the reporting period. A root cause analysis from the incident was underway and Ms Loader assured the Board that lessons would be learnt. Ms Loader informed the Board that national guidance had been published in relation to the management of carbapenemase-producing enterobacteriaceae (CPE), which is one of the most common causes of urinary tract, intra-abdominal and bloodstream infections. In response to this, trust was preparing a plan for the early detection, management and control of CPE for approval and implementation. An update would be provided in the next report to the Board. The Board **NOTED** the Report.

TB 13/14 185	**Operational Performance Report**
	Mrs Brown presented the Operational Performance Report. It was reported that the trust had achieved the overall Referral to Treatment (RTT) target, but not for Trauma and Orthopaedics. Mrs Brown advised that other specialities were beginning to struggle with the target due to urgent care pressures impacting. She assured the Board that each patient was reviewed to ensure that they were on the correct pathway and had a plan to be seen as soon as possible. With regard to the Cancer targets, it was confirmed that for quarter three, the trust had met all targets. Mrs Brown reported that the trust would not meet those targets for quarter four, in part due to the unexpected sickness absence of a breast consultant. A locum had been appointed to provide backfill, but was not felt to be of sufficient quality. Staff were now in place and performance would improve in quarter one of 2014/15. The Board was assured that no patient waited for a long period of time for their appointment. The Board was informed that the Integrated Healthcare Governance Committee would be looking at performance with the 62 day target in detail at its next meeting. Mr Noble welcomed the opportunity to review the 62 day target performance in more detail. With regard to the breast speciality, he raised concerns with the risk management arrangements in place, observing that there was a single point of failure for the service and questioned if there were any other areas at risk. Dr Swart agreed with the concerns of Mr Noble adding that they needed to be addressed in the clinical strategy work that was due to commence. Mrs Searle asked what arrangements were in place to support the patients that were waiting longer than they should. Mrs Brown advised that all patients were kept informed at all times and were offered alternative choices. The Board **NOTED** the Operational Performance Report.
TB 13/14 186	**Urgent Care Report**
	Mrs Brown presented the Urgent Care Report to the Board. Performance against the four hour transit time target for March was reported as 92%, in improvement from February's performance of 81%. Year to date performance was 90%. Overall, the trust was in a better position but the actions in place to improve performance was not a sustainable.. The improvements in performance had been driven through the establishment of a command and control structure headed by very senior managers and the impact the urgent care programme was having. The outputs from this included improved safety rounds, simple early discharges, the use of observation boards and continued focus and pressure from the health economy on facilitating complex discharges. Mrs Brown updated the Board on Operation Deep Dive. To combat the additional demand on the hospital and attempt to put the Trust in a good position going into a weekend, Operation Deep Dive was held on the 21 February 2014. The initiative had three objectives: To facilitate discharges with coordination from partners; Subsequently improve patient flow through the hospital; To maintain the highest level of patient safety.

	The initiative was successful in that approximately 150 discharges were achieved, about 50 more than on a normal day. What was important to note, was that the figures included a high percentage of complex discharges requiring significant involvement from all health partners, which normally took a significant time to arrange. Unfortunately, the initiative did not sustain a change. It was anticipated that the work with McKinsey would deliver a more sustainable model programme. Mr Noble asked if blockages to discharge were internal or external. Mrs Brown advised that there were internal and external issues, the trust accepted that it needed to improve its systems. Dr Swart added that the work with McKinsey would enable the segmentation of exactly what the underlying causes of the blockages were, providing one version of the truth. Mr Zeidler welcomed the input of partners in Operation Deep Dive and asked if those relationships had been sustained. Mrs Brown confirmed that they had. It was noted that there was a high number of admissions following operation deep dive, and it was questioned how many of them were re-admissions from the initiative. Mrs Brown advised that the number of re-admissions had not increased, so the Board could be assured that the discharges during operation deep dive were clinically appropriate. Mr Zeidler commented that it was encouraging that the system was beginning to work together and that the change in behaviour of partners should be acknowledged. The Board **NOTED** the Urgent Care Report.
TB 13/14 187	**Finance Report**
	Mr Lazarus presented the Finance Report to the Board. He reported that the year to date income and expenditure position was a deficit of £2.2m. That position included £4.1m of non-recurrent support from the TDA and £1m of recovery actions in February. The underlying gross forecast income and expenditure position before recovery actions was for a deficit of £7.8m. A range of recovery actions totalling £3m had been identified to date giving rise to a potential risk of not delivering a breakeven by the financial year end. The TDA had been informed of a potential risk of up to £0.5m. The Trust indicative plan for 2014-15 was for a deficit of £7.8m. The current cash flow forecast suggested that an application to the TDA to access additional temporary borrowing would be required to be progressed and secured in time for Q2 2014-15. The Board **NOTED** the Report.
TB 13/14 188	**Workforce Report**
	Mrs Brennan presented the Workforce Report to the Board. She reported that there had been a marginal decrease in sickness absence, but the overall figure remained high. In response to that, Mrs Brennan was looking at sickness levels at a service line basis to understand where the areas of concern were and to support managers in managing sickness

	absence. She added she would also look at sickness trends across occupations across the trust to see if there were any emerging themes. With regard to mandatory training compliance, Mrs Brennan reported that she had reviewed how training was delivered and a revised target of 75% had been agreed – current trust compliance was 74%. The target would be phased up to 80% and then 85%. There was significant work ongoing in ensuring staff undertook their training, particularly in light of the CQC report, as mandatory training was a recurring theme throughout their report. Dr Swart requested that a comprehensive plan for delivering compliance with the targets be presented to the Integrated Healthcare Governance Committee to provide clarity on what actions were being taken and by when. Mr Zeidler requested that the plan also be circulated to the Board when complete. **ACTION: Mrs Brennan** Mrs Brennan reminded Board members that the appraisal process had been reviewed and re-launched earlier in the year and since its implementation had been assured that operational compliance was high. She reported that the CQC had found compliance levels to be very poor when local evidence was scrutinised, which was at odds with data held centrally by the workforce team. In response to the findings of the CQC, a significant amount of work was being undertaken to challenge the evidence base of data held in local departments to ensure that data held centrally was accurate. Mr Zeidler asked when would the impact of the new appraisal policy been seen and if those actions would deliver the levels of compliance required. Mrs Brennan advised that the appraisal cycle ran annually so the end impact would not be seen in its entirety until April or May 2015. Dr Swart requested that outcome measures for appraisal compliance be reported to the Board monthly from June 2014. **ACTION: Mrs Brennan** The Board **NOTED** the Workforce Report.
TB 13/14 189	**Improving Quality and Efficiency Report**
	Mrs Brennan presented the Improving Quality and Efficiency Report to the Board. Mrs Brennan reported that the year to date position had deteriorated by £0.3m due to increased bank and agency staff expenditure and a fall in the delivery of Care Group and Corporate cost improvement plans. She advised that lessons from the preparation and delivery of the 2013/14 transformation programme had been identified and presented in the report. With regard to the 2014/15 programme, the Board was informed that there remained unidentified CIPs, an approach that was high risk. She assured the board that there was a significant amount of work ongoing address the overall gap. Mr Zeidler noted that the report identified a potential risk of £200k relating to bank and agency staffing and asked if that figure had been forecast into the year-end position. Mr Lazarus confirmed that it had been. The Board **NOTED** the Improving Quality and Efficiency Report.

TB 13/14 190	**TDA Self-Certification Report**
	Mrs Spellman presented the self-certification report to the Board for approval. In addition to the recommendations of the report, Mrs Spellman suggested that the Board consider declaring a risk to Board Statement eight, in light of the CQC Report findings. It was agreed that a risk be declared with this standard and a compliance target date be set as 30 June 2014. It was also requested that the cancer performance be added to Board Statement 10 as a risk area. **ACTION: Mrs Spellman** Subject to those amendments, the Board **APPROVED** the TDA Self Certifications.
TB 13/14 191	**Information Governance Toolkit Compliance**
	Mrs Spellman presented the Information Governance Toolkit Compliance report to the Board. She advised that all requirements within the toolkit had been met; although there remained a risk to the delivery of toolkit requirement related to training compliance. Mrs Spellman informed the Board since the report had been circulated to members; the trust's internal auditors had advised that the trust could declare compliance with that standard based on their review of the evidence available. As such, Mrs Spellman recommended that based on the auditors opinion, the Board approved declare full compliance at level two and above, for all requirements of the Information Governance Toolkit. The Board **APPROVED** the Information Governance Toolkit compliance declaration based on the advice of the trust's internal auditors.
TB 13/14 192	**Any Other Business**
	No items of any other business were raised.
TB 13/14 193	Mr Zeidler called the meeting to a close at Date of next meeting: 9.30am, Thursday 24 April 2014, Boardroom, NGH. 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 17/04/2014

Ref	Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of Completion/Reason for Slippage
24	27/02/2014	TB 13/14/ 170	Operational Performance Report	Mrs Needham to report back to the Board the findings of the joint CCG and Trust analysis into the increase in attendances and admissions	Mrs D Needham	31/03/2014	Slippage	The work with the CCG remains ongoing - outcomes anticipated in April 2014
25	27/03/2014	TB 13/14 179	Action Log	It was requested that when an action missed its expected completion date that the reason for slippage be included.	Mr C Sharples	24/04/2014	Completed or On Agenda	Completed
26	27/03/2014	TB 13/14 188	Workforce Report	A comprehensive plan for delivering mandatory training complaince be presented to the IHGC, and circulated to Board members	Mrs J Brennan	17/04/2014	Completed or On Agenda	Presented to the April meeting of the IHGC.
27	27/03/2014	TB 13/14 188	Workforce Report	It was requested that outcome measures for appraisal compliance be reported to the Board monthly from June 2014.	Mrs J Brennan	26/06/2014	On Track	
28	27/03/2014	TB 13/14 190	TDA Self-Certification Report	The return to be updated to reflect the risk with Board standard 8. It was also requested that the cancer performance be added to Board Statement 10 as a risk area.	Mrs K Spellman	31/03/2014	Completed or On Agenda	Updated prior to submission on the 31/03/2014

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

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 APRIL 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
24 April 2014

NGH staff and management sign a new Partnership Agreement

In order to demonstrate their common commitment to working in partnership to ensure stable, positive and collaborative working relationships, NGH management and staff side representatives have signed a Partnership Agreement.

The Agreement is the result of 12months of hard work by colleagues from Human Resources, management and our trade unions, to identify how we will forge a constructive and positive approach to joint working for the benefit of our staff and our patients. As a result of this the Joint Negotiating and Consultative Committee (JCNC) has been renamed to the Partnership Forum, effective from March 2014.

Working in collaboration has the potential to produce some important benefits for all parties. These include:

- delivering improved services to patients/users
- improved mutual understanding
- an opportunity for partners to contribute their experience and ideas to the development and implementation of the workforce implications of policy on health and social care
- an ability to assess the likely impact of emerging policy on the NHS workforce and to mitigate risk
- more effective implementation of policy
- ensuring high standards of employment practices
- providing a transparent and streamlined structure for trade union, employer and staff engagement.

Planning Application Submitted for A&E Extension

NGH has submitted a planning application to Northampton Borough Council for a proposed extension to the A&E Department. This is one of several changes being planned to increase our capacity for providing urgent care to a growing number of acutely unwell patients.

The extension will house a 'navigation nurse' who will assess patients and guide them to the appropriate place for treatment. This will either be straight into A&E for serious cases, or to primary care for less serious injuries or illnesses. In some cases patients may be referred to a pharmacist or even sent home without treatment.

The extension will also increase resuscitation facilities and provide office space within A&E. Redevelopment work is expected to be completed by March 2015.

Adult In-Patient Survey

The Care Quality Commission published the results of the 2013 survey of adult inpatients discharged during June 2013. NGH achieved a rating of 'about the same' as all other NHS trusts in England in 58 scores, and a 'worse' rating in just two. Importantly, eight of the

scores showed a statistically significant improvement on the last survey, including the overall patient experience result which increased from 7.6 to 8.1.

This means that some important scores – including overall experience, privacy and dignity, answering of call buttons, and being involved in decisions about care and treatment – have shown a significant improvement. None of the scores showed a decline.

Friends of NGH to donate £25,000

The Friends of NGH volunteers are celebrating 25 years as a registered charity within Northampton General Hospital in 2014. To mark the occasion they are donating £25,000 to benefit patients of the hospital.

All wards and departments have been invited to apply for a share in the money, which will be shared between two areas. Applicants need to describe in 500 words or less what they would like to do with the funding in their area, and how it would benefit patients.

NGH Maternity Services pass Baby Friendly stage two accreditation

NGH has passed stage two of the prestigious UNICEF Baby Friendly Initiative (BFI) accreditation. The initiative works with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.

The trust had successfully completed stage one in 2011 and since then, maternity and neonatal staff gave been working together to improve care in relation to infant feeding for all new mums and babies. The BFI assessors visited the hospital over two days and interviewed over 40 staff selected at random to assess their knowledge about infant feeding best practice standards. They asked detailed questions of midwives, maternity support workers, nurses, ward managers, paediatricians and matrons on topics such as the health impact of breastfeeding, how a mother would know that feeding was going well and how we support women with more challenging situations.

Strictly NGH

Eighteen contestants. Six week's training. Four judges. One night. Supported by instructors and dance professionals from the Step By Step Dance School in Northampton, eighteen members of staff, myself included, will be taking part in the first ever Strictly NGH on Saturday 14th June at The Deco Theatre in Northampton. As well as learning two dances and battling it out to be the one who lifts the glitterball trophy, everyone taking part from NGH has agreed to raise a minimum of £250 sponsorship for our Charitable Fund. Funds will be for the chemotherapy appeal, department funds or the general charity. I hope we can all rely on your support.

Marathon Congratulations

Congratulations to NGH staff who took part in the London Marathon on 13 April – we know of at least two who completed the course, but there may well be others! Healthcare assistant and student nurse Lucy Bazeley finished in 4h 5m, raising money for the British Heart Foundation and the StandUp anti-bullying charity. Orthopaedic consultant David Stock finished in 4h 12m, fundraising for the Juvenile Diabetes Research Foundation and our own diabetes centre. Well done to them both.

Northampton General Hospital NHS
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REPORT TO THE TRUST BOARD
24 APRIL 2014

Title	CQC Report – NGH Response and Summary Treatment Plan
Agenda item	7
Sponsoring Director	Dr Sonia Swart, Chief Executive
Author(s)	Dr Sonia Swart, Chief Executive Craig Sharples, Head of Corporate Affairs
Purpose	Information and Assurance

Executive summary

The Care Quality Commission Report into services at Northampton General Hospital NHS Trust was published on 27 March 2014 following the Chief Inspector of Hospital visit in January this year.

This summary treatment plan presents the significant recommendations made by the CQC, and the trusts immediate response to these. This plan purposely focuses on short term improvements on immediate issues. Once these actions have been implemented the trust will define a longer term plan. This will be aligned with the outcomes of our ongoing governance work to ensure the impact from the actions are sustained and the Board, its committees and management remain sighted on progress.

Related strategic aim and corporate objective	All
Risk and assurance	Risk to the trusts registration with the CQC
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Compliance with the CQC standards.

Actions required by the Board

The Board is asked to review the content of the summary action plan and be assured of delivery against agreed deadlines.

Northampton General Hospital NHS
NHS Trust

CQC Report – NGH Response and Summary Treatment Plan
Trust Board
24 April 2014

The Care Quality Commission Report into services at Northampton General Hospital NHS Trust was published on 27 March 2014 following the Chief Inspector of Hospital visit in January this year.

The report gave the hospital a rating of 'requires improvement'. Although the report recognised that the staff at NGH are caring and services in the main are providing safe and effective care, it also identified a number of areas where improvement is required. The report highlighted significant strategic issues in relation to urgent care, governance and leadership, as well identifying tactical issues in the form of compliance actions.

With regard to the three strategic issues articulated in the CQC report, the trust has committed to a programme of improvement which accelerates and augments existing programmes of work that have been in place over recent months. The three major pieces of work are:

- We are working with external support to improve operational performance of our urgent care pathway whilst retaining the focus on quality and safety. We are putting in place series of interventions over a five week period to 'break the cycle' that the trust has been in for the last two years. The intent is to create a 'new normal' where we can sustain a framework of controls that will keep the system in balance on a daily basis. The trust is determined to transform the experience for our patients and restore a sense of belief in our staff.
- We have sought advice on how best to ensure that our work to challenge and refocus our governance processes is robust. This will ensure we improve the working of our committees, reporting, risk management and assurance processes.
- We are accelerating the planned programme of organisational development, enlisting expert help to ensure our teams have the skills to lead and manage change focussed on quality improvement.

In response to the compliance actions, and more detailed operational matters identified for improvement, a comprehensive treatment plan has been prepared. This plan will enable the trust to act on the findings of the CQC inspection in a timely and robust manner, whilst ensuring that there is a sound evidence base underpinning each action, to provide assurance to the Board and its committees on their effectiveness of the actions.

This summary treatment plan presents the significant recommendations made by the CQC, and the trusts immediate response to these. This plan purposely focuses on short term improvements on immediate issues. Once these actions have been implemented the trust will define a longer term plan. This will be aligned with the outcomes of our ongoing governance work to ensure the impact from the actions are sustained and the Board, its committees and management remain sighted on progress.

These actions have been agreed with the Executive Team. The Chief Executive, Dr Sonia Swart, is ultimately responsible for driving implementation of the actions in this plan with support from key senior staff.

Delivery of this plan is critical as it underpins our ambition to provide the ‘Best Possible Care’ for patients, underpinned by our key values which focus on patient safety, improvement, respect and support and an aspiration for excellence.

The Board is asked to review the content of the summary action plan and be assured of delivery against agreed deadlines.

CQC Report – Strategic Treatment Plan and Progress

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve the emergency care pathway and bed capacity management	**We Will** • Review the emergency care flow issues and improve all processes from admission through to discharge • Track patient moves • Risk assess all patient moves • Work to understand those areas where changes to create maximum impact will be required • Work in partnership with the health and social care economy on system redevelopment • Use electronic systems to assist our processes • Understand all blocks in the system • Better understanding our demand and effectively plan capacity **Why?** To improve patient experience and outcomes by ensuring patients are admitted to and treated in the right place, first time, without having to wait longer than four hours for treatment or admission. To minimise the number of patients moves and ensure patients do not stay in hospital longer than necessary. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence' and we reflect, we learn, we improve'.	**Work to be completed by July 2014**	**McKinsey and Co**	**ON TRACK**
We must improve the robustness of our governance processes	**We Will** • Review our quality governance arrangements • Review the management structure and clarify the accountability and assurance mechanisms underpinning the Care Group structure • Review risk management arrangements • Obtain external support and challenge • Develop an implementation plan for improvement **Why?** To ensure we identify and mitigate risks to patients, learn from experience, in line with our values of 'putting patient safety above all else' and we reflect, we learn, we improve'.	**June 2014**	**Deloitte**	**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve leadership from Board to ward	**We will** • Accelerate a Board development programme • Recruit a substantive Executive Team • Clarify our Director's key responsibilities for ourselves and our stakeholders • Support a clinical leadership programme for senior medical staff and clinical leads • Accelerate the implementation of the trust's organisational development strategy • Review the trust management structure **Why?** To ensure that staff are confident that the organisation is well led and that the leaders are driving improvements in care to support our values of 'we reflect, we learn, we improve' and 'we respect and support each other'.	**May 2014**	**East Midlands Leadership Academy and AHSN**	**ON TRACK**
We must improve 'do not attempt cardio pulmonary resuscitation' paperwork so it is clearer	**We will** • Withdraw the existing documentation • Implement a redesigned document • Support the implementation of the new documentation with a programme of training and audit to ensure understanding **Why?** To ensure that paperwork is completed consistently to mitigate any risks to patients in line with our value of 'putting patient safety above all else' and improve end of life care.	**Completed**		**DELIVERED**
We must ensure that all equipment is maintained and available in clinical areas where required	**We will** • Ensure all medical equipment has been serviced by a qualified safety engineer • Implement a centralised medical equipment maintenance strategy • Develop a planned maintenance register and forward plan **Why?** To ensure we identify and mitigate risks to patients, aspire to excellence, in line with our value of 'putting patient safety above all else'.	**Completed**		**DELIVERED**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must put processes in place to ensure that medication is dispensed to patients before they have left hospital	**We will** • Cease the practice of discharging patients home without their prescribed medication • Trial using patient own medication to expedite the availability of to take home medicines ready for discharge • Establish safety huddles to identify potential delays in the availability of to take home medication on discharge **Why?** To ensure we identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'.	**Completed**		**DELIVERED**
We must improve arrangements for children's care in the A&E department	**We will** • Ensure 24 hour access to an RSCN for A&E • Designated an area within the A&E department for use solely by children • Ensure children are appropriately prioritised in A&E • Ensure appropriate training for our A&E staff **Why?** To improve patient experience and outcomes for children and their families when they attend A&E by ensuring the environment is appropriate to their needs and appropriate trained staff are available. This supports the trusts values of 'we put patient safety above all else'.	**September 2014**		**ON TRACK**
We must improve compliance with mandatory and essential to role training and appraisal	**We will** • Accelerate current programmes for improving training compliance • Accelerate current programme for improving essential to role training compliance • Accelerate current programmes for improving appraisal compliance • Report on these to the Board monthly **Why?** To deliver improved outcomes to patients through the development of staff, enabling excellence though our people to deliver our values of 'we put patient safety above all else', 'we aspire to excellence' 'we reflect, we learn, we improve', and 'we respect and support each other'.	**August 2014**		**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must improve the follow up, completion and oversight of action plans relating to all incidents, significant incidents, complaints and clinical governance issues	**We will** • Continue to develop the improvement plan in place for action plans and serious incidents • Continue to develop the mortality and morbidity analysis meetings • Continue to develop the quality metrics • Improve the action plan monitoring from complaints • Establish joint meetings with all quality governance functions to identify and align themes identified from investigations and ensure that lessons are identified and disseminated across the trust. **Why?** To improve the outcomes for patients and underpin the trust values of 'we put patient safety above all else', 'we aspire to excellence' and 'we reflect, we learn, we improve'.	**June 2014**		**ON TRACK**
We must ensure that records are accurately completed, reflect patient needs and are accessible when needed.	**We will:** Develop and implement revised nursing documentation to launch the enhancing patient assessment initiative • Monitor improvements in the quality of documentation through the QuEST process • Ensure staff are aware of record keeping standards through the delivery of a training programme supplemented by coaching and mentorship for staff • Minimise the number of records not available at the time of a patient's outpatient appointment **Why?** To improve access to, and the quality of the documentation used in the care of our patients. This is in line with the trust values of 'we put patient safety above all else', 'we aspire to excellence' and 'we reflect, we learn, we improve'.	**May 2014**		**ON TRACK**
We must clarify the stroke imaging pathway for staff to avoid confusion	**We will:** • Define the pathway with agreed roles and responsibilities • Agree how we will measure this and report exceptions/issues • Communicate the pathway to key stakeholders **Why?** To improve patient safety and experience by ensuring that patients receive the most appropriate intervention in as soon as possible. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence'.	**May 2014**		**ON TRACK**

KEY FINDINGS	WHAT WE HAVE AGREED AND WHY	TIMESCALE	EXTERNAL SUPPORT IDENTIFIED	PROGRESS
We must ensure that the findings of the Emergency Care Intensive Support Team are explicitly acted upon	**We will:** • Report further progress in implementing the actions, and their outcomes, to the Board as part of ongoing urgent care reporting **Why?** To improve patient experience and outcomes by ensuring patients are admitted to and treated in the right place, first time, without having to wait longer than four hours for treatment. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence' and we reflect, we learn, we improve'.	**May 2014**		**ON TRACK**
We must ensure that the outcomes from the trust's self-assessment of the Intensive Care Society Core Standards for Intensive Care are implemented	**We will:** • Undertake a self-assessment of care standards • Report the self-assessment and any required actions to the Integrated Healthcare Governance Committee. **Why?** To assure ourselves that the intensive care services patients require are of the highest quality and benchmarked against national best practice requirements. This supports the trusts values of 'we put patient safety above all else', 'we aspire to excellence'.	**May 2014**		**ON TRACK**

HOW OUR PROGRESS IS BEING MONITORED AND SUPPORTED	TIMESCALE	OWNER	PROGRESS
Monthly oversight meetings with partners	May 2014	Dr Sonia Swart, Chief Executive	ON TRACK
Support of East Midlands Leadership Academy for clinical leadership to embed new governance structures	October 2014	Dr Sonia Swart, Chief Executive	ON TRACK
Weekly Executive Team oversight of Programme Board delivery of detailed actions	April 2014	Dr Sonia Swart, Chief Executive	DELIVERED
Monthly updates presented to the Trust Board meetings in public, including presentation of a quality metric dashboard where appropriate.	May 2014	Dr Sonia Swart, Chief Executive	ON TRACK
Monthly updates uploaded on to the Trust Website	May 2014	Dr Sonia Swart, Chief Executive	ON TRACK

REPORT TO THE TRUST BOARD
24 APRIL 2014

Title	Quality Report
Agenda item	8
Sponsoring Director	Dr Mike Wilkinson - Medical Director (Interim)
Author(s)	Dr Natasha Robinson, Associate Medical Director Mrs Jane Bradley, Patient Safety Programme Director
Purpose	Assurance

Executive Summary

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end January 2014 and SHMI (to June 2013 – no change since previous report). Overall improvement is sustained and there have been no new areas of significant concern to investigate. A programme to roll out specialty specific dashboards for use by clinicians and managers in each directorate is planned to start during the next 3 months to enable improved local ownership of performance data.

12 new serious incidents were reported during March 2014.

Related strategic aim and corporate objective	*Which strategic aim and corporate objective does this paper relate to?*
Risk and assurance	*Does the content of the report present any risks to the Trust or consequently provide assurances on risks*
Related Board Assurance Framework entries	BAF 1 2013/14
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	There are no legal/regulatory implications of the paper

Enclosure E

Actions required by the Board

The Board is requested to :

- Discuss and Challenge the content of this report
- Endorse the Actions being taken forward to provide assurance

Medical Director's Quality Report

Review of current mortality and safety data provided by Dr Foster

Introduction

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end January 2014 and SHMI (to June 2013 – no change since previous report)). Overall improvement is sustained and there have been no new areas of significant concern to investigate. A programme to roll out specialty specific dashboards for use by clinicians and managers in each directorate is planned to start during the next 3 months to enable improved local ownership of performance data.

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 appropriate 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. A further 200 much smaller CCS groups account for the remainder. They are not included in HSMR as predictive risk modelling for these small volume diagnoses is not as reliable.

At NGH there is a detailed monitoring process which tracks HSMR and investigates individual diagnoses whose SMR (standardised mortality ratio) is persistently adverse. Where the term HSMR is used this refers to the previously defined group. Where *all* groups are included, the term HSMR 100 is used.

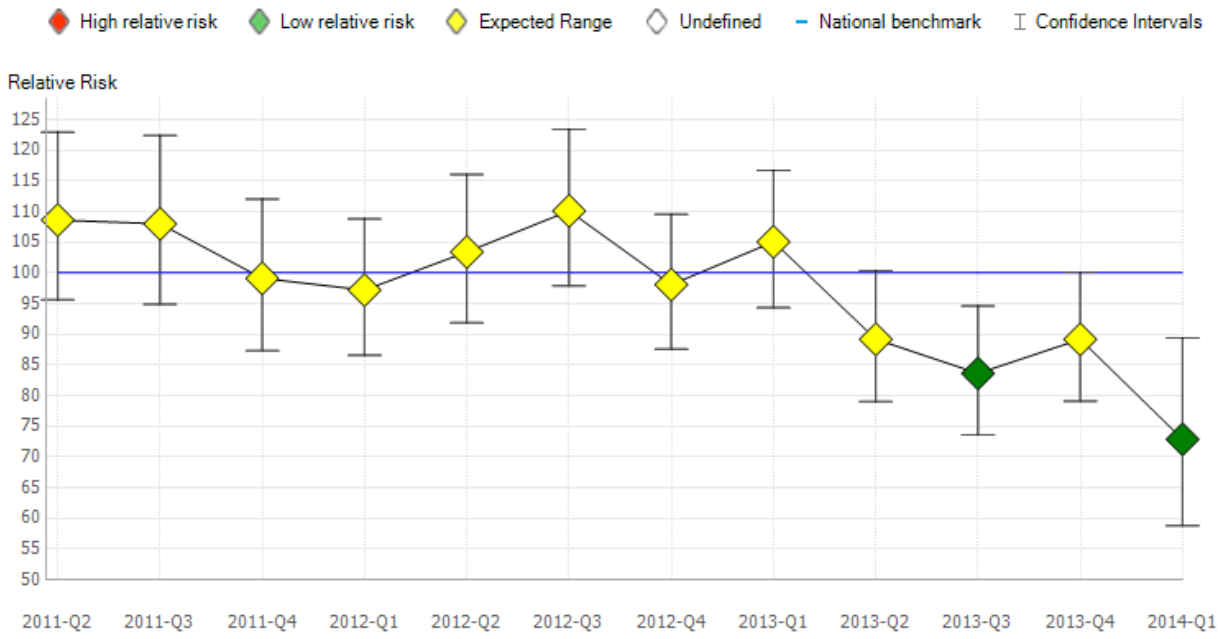
The Trust systematically investigates all such areas of concern for both clinical care and data quality (including clinical coding). Where adverse performance is persistent detailed reviews of the information and individual cases are presented and discussed at Mortality & Coding Review Group, a multidisciplinary group chaired by the MD and to be attended by a representative from CCG.

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 at presentation, 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. The model relies on accuracy of clinical coding, and as it is comparative, local performance may also reflect variation in coding practice in other organisations.

Northampton General Hospital Trust has previously included 3 community sites until March 2014. Current data reflects this position, and historical data will continue to do so. However from July 2014 data will be released reflecting activity from April 2014 on NGH site only. 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, palliative and respite

care. It is possible to monitor HSMR performance for each site, and is helpful to be able to monitor historical performance on the acute site without any confounding impact from the community wards.

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



3. HSMR Comparison

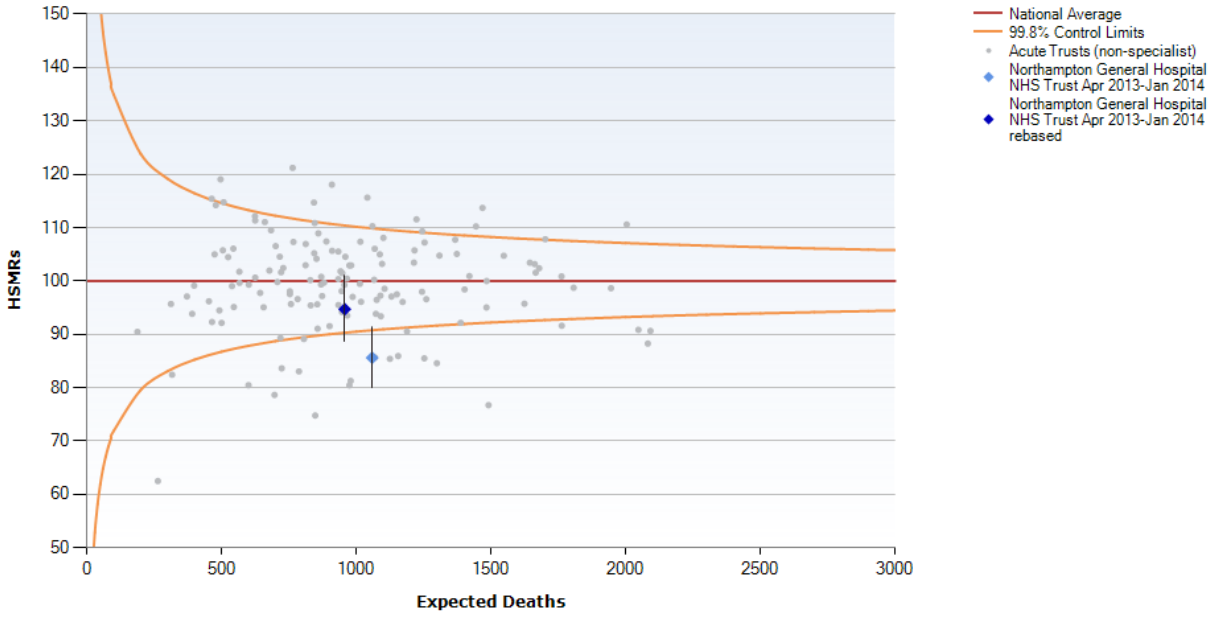
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. This is especially important when death rates are falling nationally and the benchmark is continuously falling, as is currently the case. Dr Foster currently re-benchmarks annually in arrears, but will shortly change to real-time rebenchmarking.

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 9 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for the rolling year to date is **89** and for 2013-4 is **85** (**95** when rebased).

Crude mortality for 2013-4 is currently 3.5%, showing continued 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 3.2% - 4.8%).

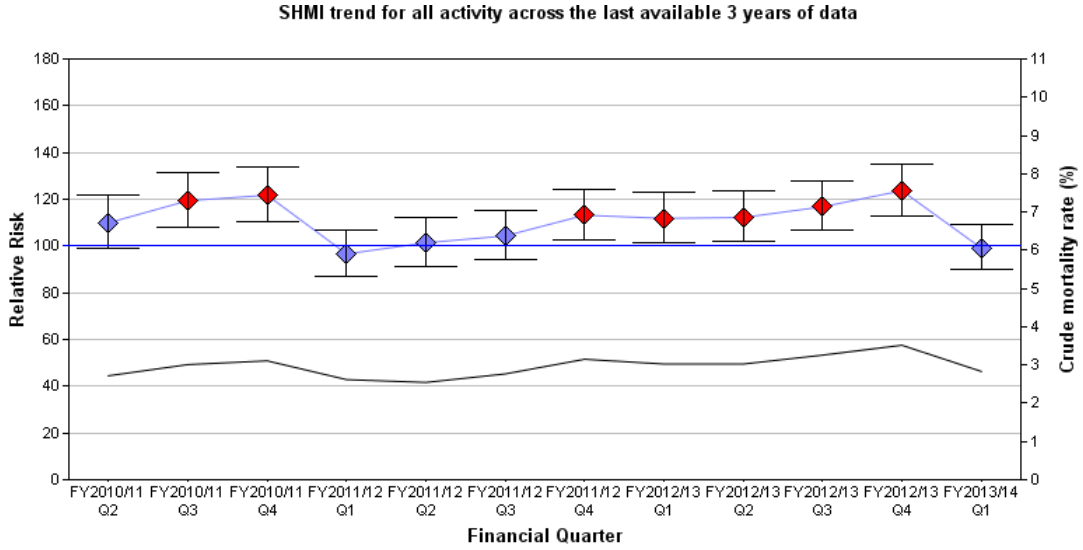
Acute Trust HSMRs Apr 2013 – January 2014

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



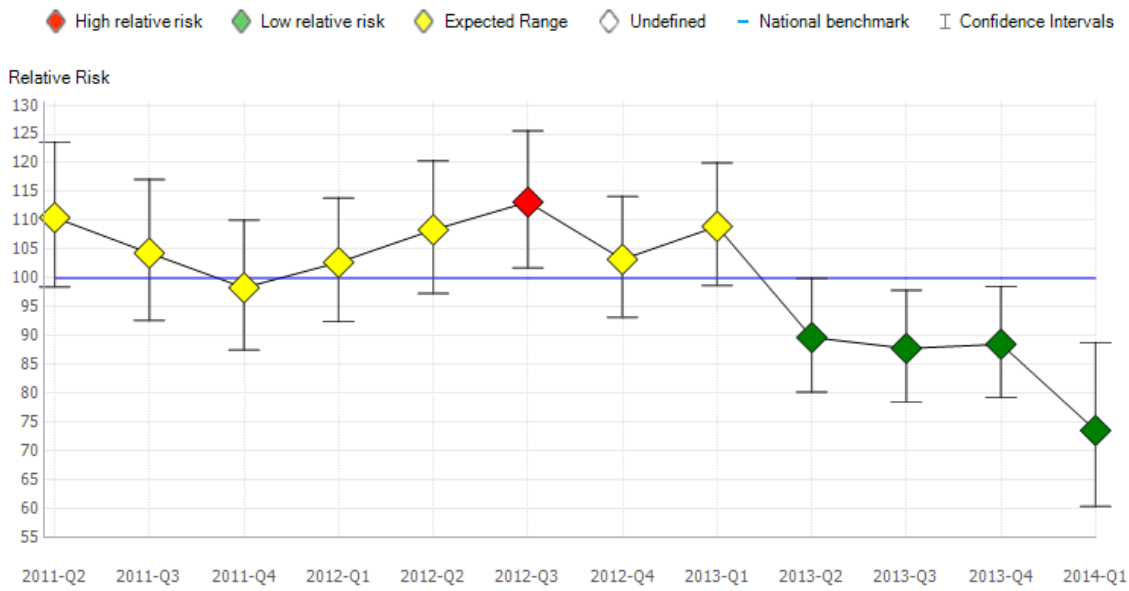
4. Standardised Hospital Mortality Indicator (SHMI)

There has been no further SHMI data release since the last report to Board. The most recent data release (to end June 2013) shows SHMI for the rolling year to be at **112.9,** a noticeable fall from the previous **115.8** due to the marked fall for Q1 2013-4, as previously predicted. However this value contributes to the Trust's current high CQC risk score, despite being 10 months in arrears.



HSMR for the same period was **100.** The marked divergence between the 2 remains of concern particularly because SHMI data is not easily available for further 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 continue 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 analysis tools) and investigated where this is not the case.

The graphs below shows HSMR 100 to end January 2014, which suggests that SHMI for 2013 will return to within 'expected' limits in the next quarter, and close to average the following quarter.



Enclosure E

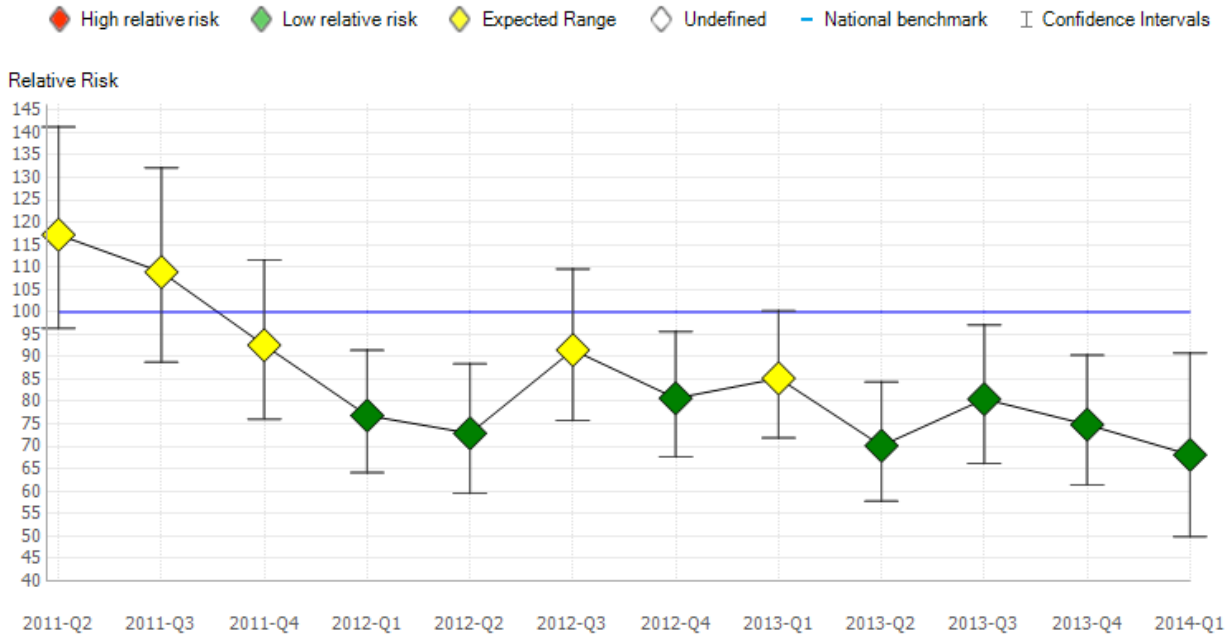
Patient Safety Indicators

Feb 2013 – Jan 2014	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	38,289	25	30.2	0.7	0.8	83
Decubitus Ulcer	9,545	283	319.2	29.6	33.4	89
Deaths after Surgery	361	52	44.8	144.0	124.0	116
Infections associated with central line *	15,938	1	1.1	0.1	0.1	94
Postoperative hip fracture *	24,898	4	1.5	0.2	0.1	259
Postoperative Haemorrhage or Haematoma	23,431	12	14.0	0.5	0.6	86
Postoperative Physiologic and Metabolic Derangement *	19,739	4	1.6	0.2	0.1	250
Postoperative respiratory failure	17,935	22	16.1	1.2	0.9	136
Postoperative pulmonary embolism or deep vein thrombosis	23,621	32	45.3	1.4	1.9	71
Postoperative sepsis	543	2	3.8	3.7	7.0	53
Postoperative wound dehiscence *	993	0	1.4	0.0	1.5	0
Accidental puncture or laceration	66,209	47	76.1	0.7	1.1	62
Obstetric trauma - vaginal delivery with instrument *	465	36	38.4	77.4	82.7	94
Obstetric trauma - vaginal delivery without instrument *	2,484	103	95.3	41.5	38.4	108
Obstetric trauma - caesarean delivery *	1,177	0	4.4	0.0	3.7	0

There are no significantly adverse patient safety indicators for the rolling year to date. As previously noted, the number of pressure ulcers appears to be significantly less than expected. Reconciliation of clinical notes and coding is underway to understand whether this is an accurate representation of the presence of pressure ulcers within the Trust.

6 Reports on key areas for action or of importance

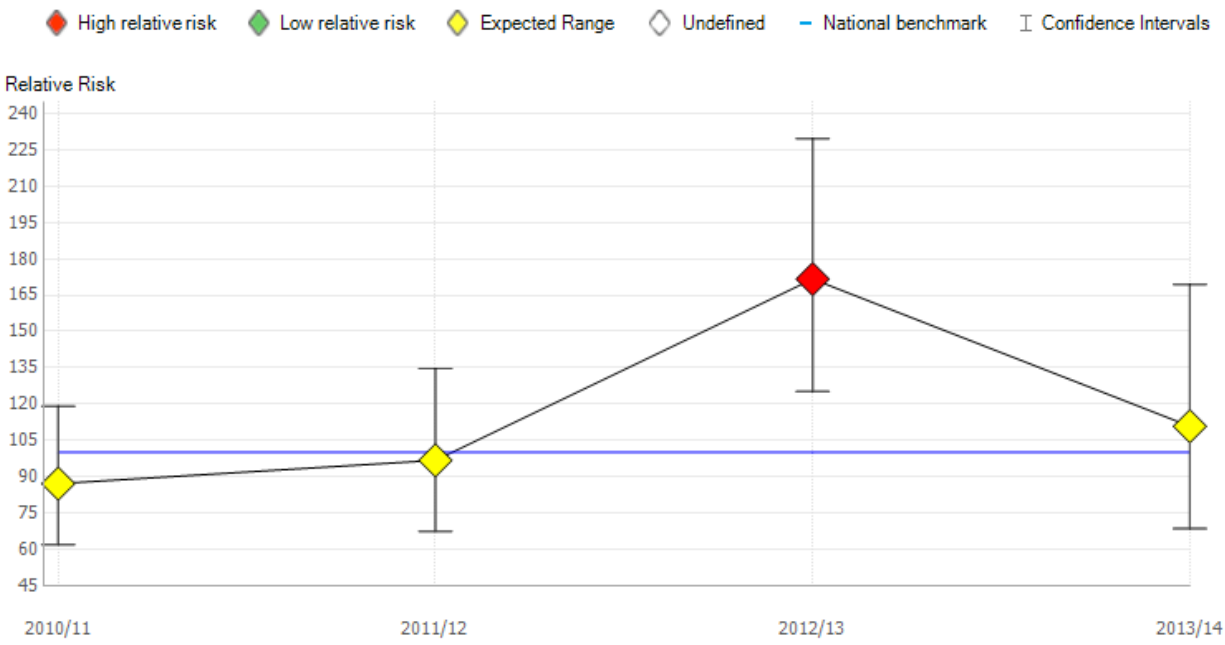
Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for 2013-4 at **74**.



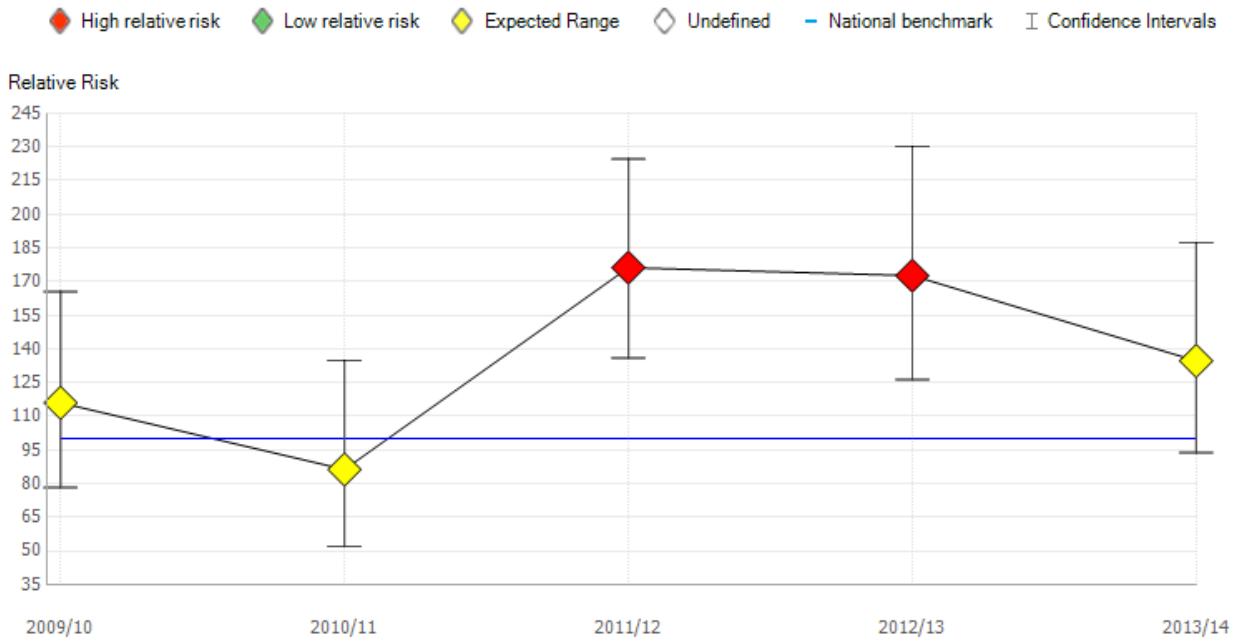
7. Possible areas for concern under investigation

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

Enclosure E


High relative risk
Low relative risk
Expected Range
Undefined
National benchmark
Confidence Intervals
Relative Risk
240
225
210
195
180
165
150
135
120
105
90
75
60
45
2010/11
2011/12
2012/13
2013/14

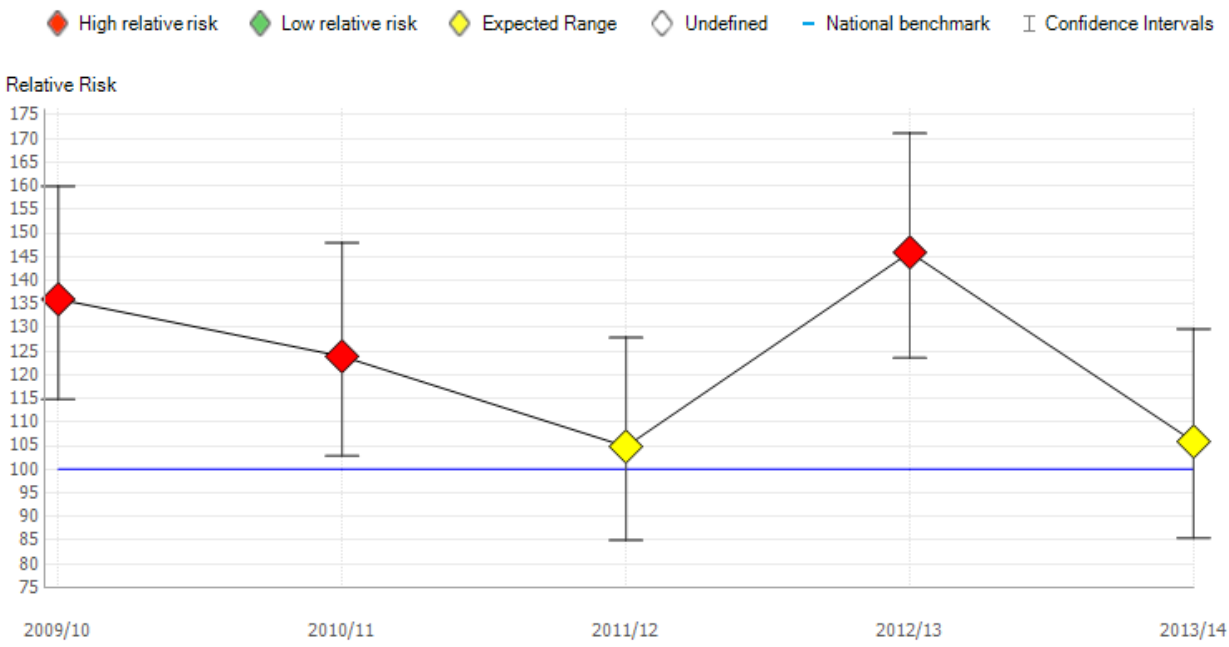
Secondary malignancy: The modest improvement in mortality previously noted is sustained. Monthly review of all deaths continues and an interim report to Mortality and Coding Review Group has noted a trend towards late presentation by patients with advanced disease and resulting poor functional status who are therefore ineligible for treatment. This is a complex issue which reflects pre-hospital care. A further review of deaths occurring in oncology has been requested and will report to Mortality & Coding Review Group in May. A review of deaths occurring under the care of the general physicians has also been requested.



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

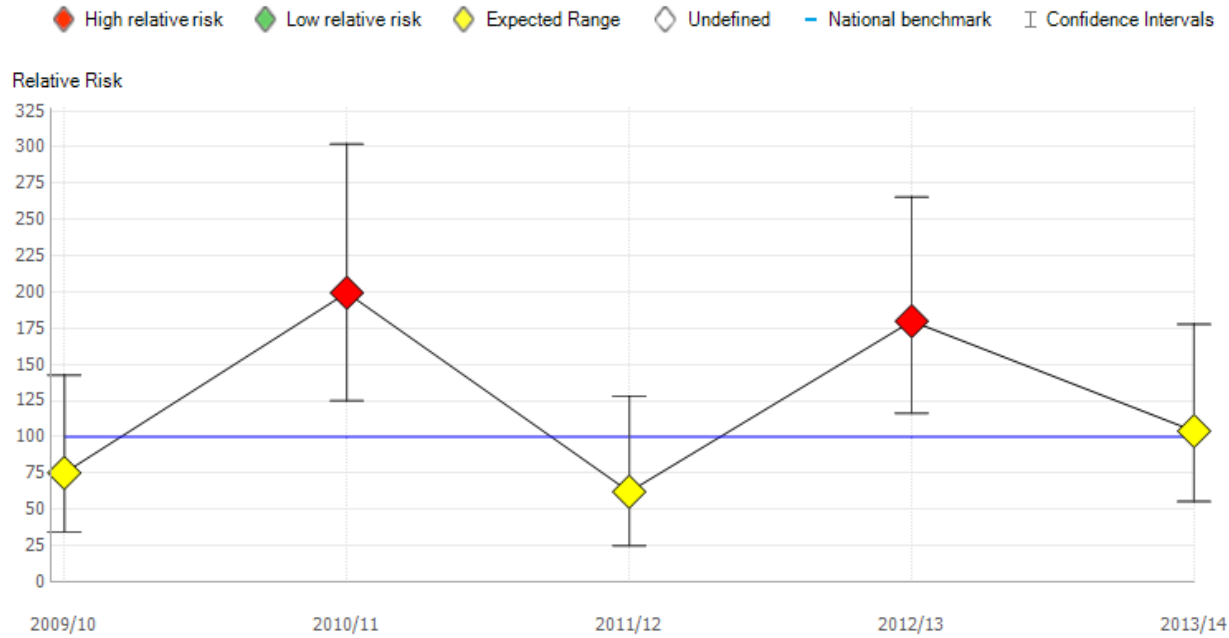
The Medical Director and Associate Medical Director had the opportunity to be interviewed by the CQC in their recent visit and to discuss the considerable improvements that have been made. The eventual report said little about mortality which is unfortunate given that it was this issue which contributed significantly to us being in the group requiring early investigation.

As previously described, work is ongoing to track performance from the 2012-13 alert for **gastroenterology/hepatology (emergency admissions)** identified in the CQC 'Intelligent Monitoring' quarterly report, which uses Dr Foster data. Overall mortality for this large diagnosis group has returned to normal in 2013-4 to date (**110**), 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 are under review. A small subset of emergency surgical admissions (bowel perforation) is being reviewed by the general surgeons and presented to Mortality & Coding Review Group in May 2014.



(This diagnosis group remains a risk – but not an 'elevated risk' - in the latest CQC Intelligent Monitoring Report published 13.3.14 based on data to September 2013.)

The latest CQC Intelligent Monitoring Report also contains an alert for a composite **dermatology** basket of diagnoses including chronic skin ulcers and skin and subcutaneous tissue infections admitted as an emergency. Good performance has been sustained and the group will be tracked to confirm this, in view of the previous variable performance.



9. Crude Mortality

Unadjusted data using the crude numbers of deaths occurring in the Trust provided from internal information sources suggests that the crude numbers of deaths occurring is substantially less throughout 2013-2014 than in the previous year**.** The numbers will also fall from April due to the loss of the community hospital beds.

10 Further actions in place or planned:

The draft report following the Trustwide notes review (50 sets) is with the authors and contributors for comment, and will be made available in due course.

A local CQUIN for 2014-15 to embed the M&M process at directorate level and share learning both internally and within the locality has been confirmed. NHSEngland is currently surveying all acute Trusts for information on their mortality review processes.

The programme for the national publication of consultant outcomes on NHS Choices (first undertaken in 2013) is to be repeated within the next 6 months, and the specialties have been extended to include 2 further specialties provided by NGH, urogynaecology and lung cancer management.

11 Data Quality (to end December 2013):

The coding department are proactively addressing the closure of outstanding and current episodes of patient care in the community hospitals following their transfer to NHFT, to ensure that these are accurate and clearly attributable to the Trust. Retrospective performance data will remain available to NGH through Dr Foster.

2. Learning from Serious Incidents and Inquests

12 new SI's were reported during March:

5 grade 3 pressure ulcers
2 in hospital #NOF's (one of which occurred in a community hospital 48 hours before handover of management, but remains on our register)
1 stillbirth
1 high risk needlestick injury to a staff member
2 concerns about delayed medical care
1 unintended patient injury.

11 SI's were submitted to the CCG, and the learning is summarised as follows:

Incident	Comments	Learning
8 Grade 3 pressure ulcers	One unavoidable (ITU)	All cases reviewed in detail by TVN according to standard procedure and fed back to ward teams Themes are being summarised for quarterly report to CQEG by TVN
Neonatal death		Review of current arrangements in place for emergency intubation of neonates outwith the labour ward
#NOF	Community Hospital	No pharmacy support to ward
Unexpected death	Endoscopy Unit Expected death	Pathway for patients undergoing interventional procedures to be reviewed Unit staff to contact NOK when patient deteriorates

3 inquests took place for patients who had died at NGH for which staff were called as witnesses, and from which there were learning points:

Patient	Cause of death	Learning
Male, aged 85	Intracranial haemorrhage following fall	Previous SI, reported in December 2013
Female,aged 75	Perforated bowel	Undergoing review as part of CQC alert for gastroenterology Coroner queried whether PM cause of death was accurate/comprehensive
Male, aged 72	Urosepsis and liver failure	Pathologists post-mortem cause of death was amended on the advice of expert witness Hospital advice for paracetamol poisoning needs to be updated on ICE Follow-through of medicines reconciliation on Allebone Ward needs to be reviewed

Section 3

NGH Monthly Quality Exception Quality Scorecard – March 2014

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 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 will 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.

Performance

The Exception Summary Report outlines the underperforming indicators and details the remedial action(s) being taken. Progress is monitored against **142** indicators.

The number of indicators that have been rated as red is **31.** The A&E quality indicators and cancer wait times are encompassed within the patient experience domain of the scorecard which has **13** red rag rated indicators. The Indicators rated as grey have decreased from **29/26,** as further agreement for indicators continues to be agreed.

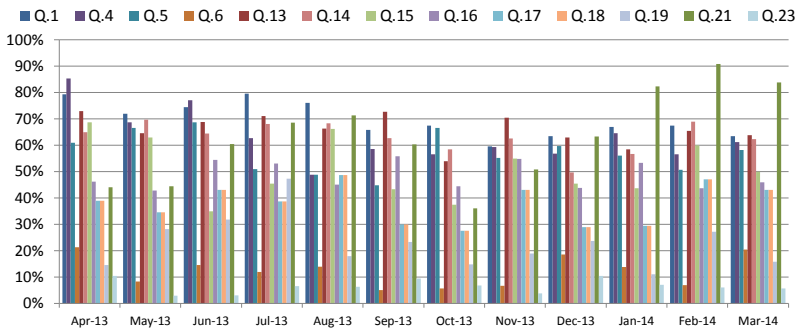
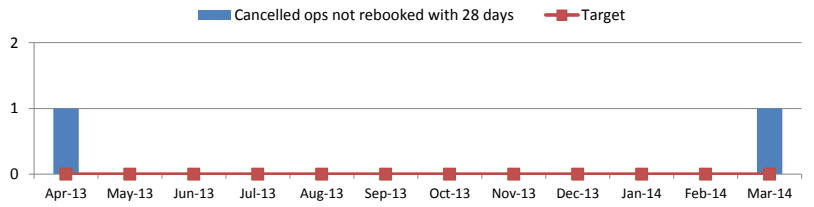
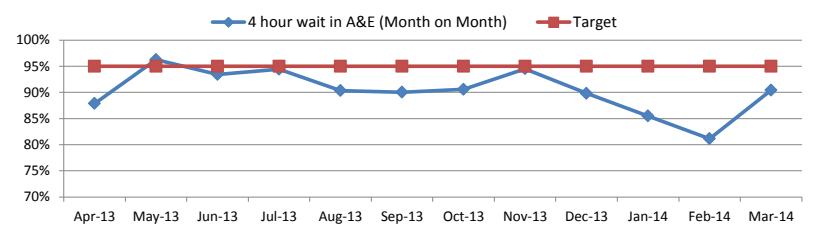
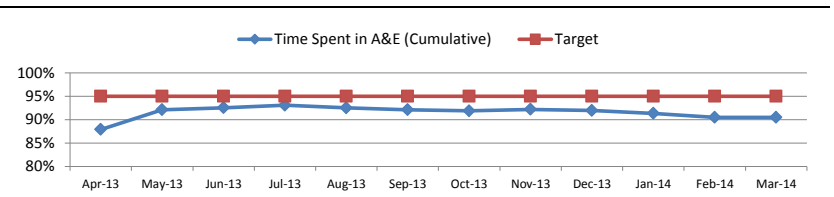
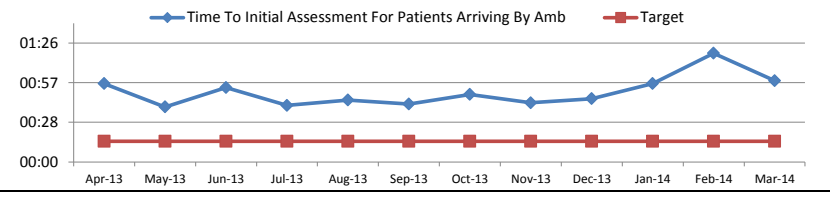
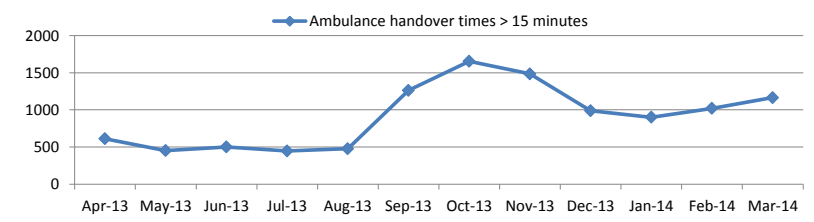
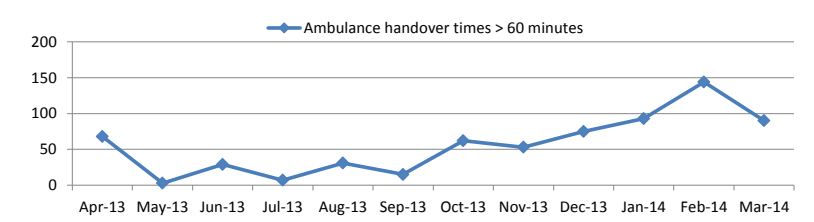
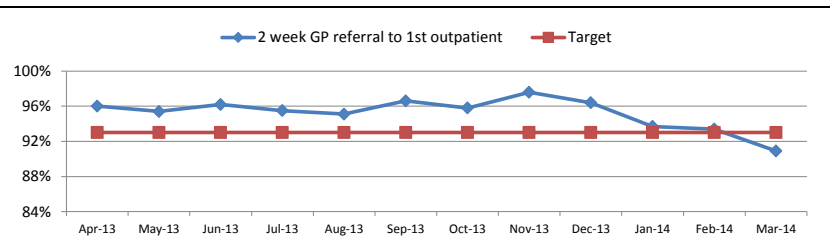
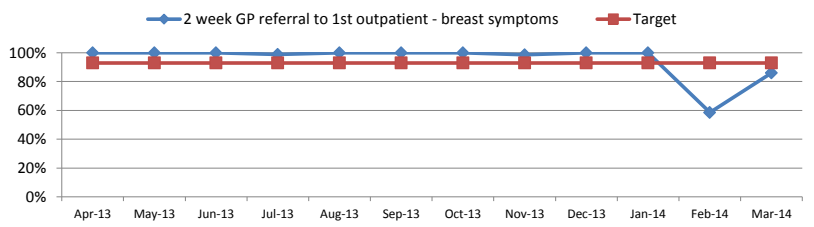
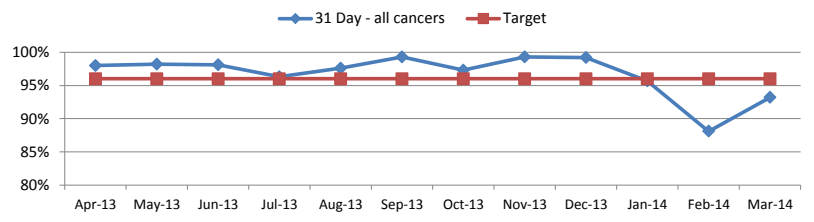
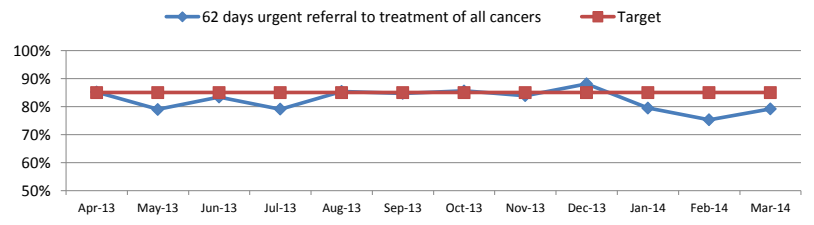
Summary Rating

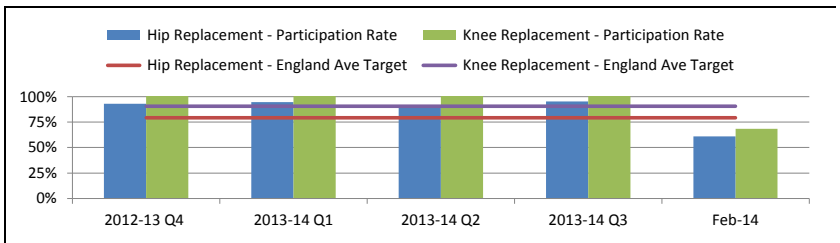
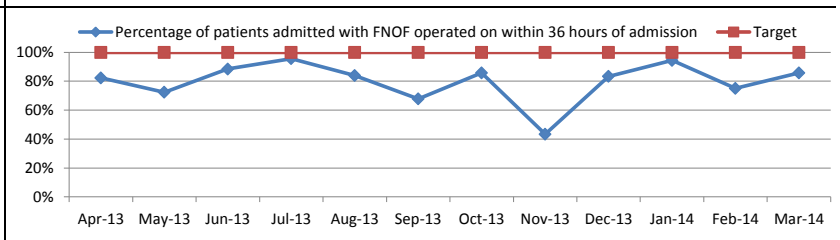
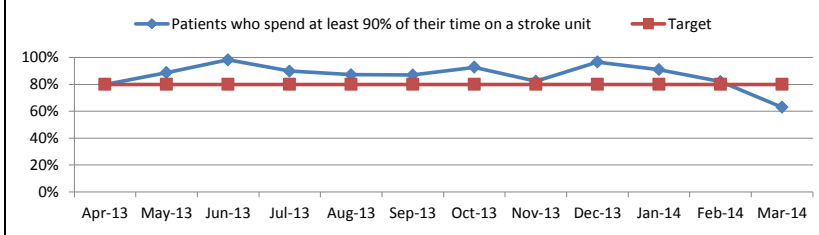
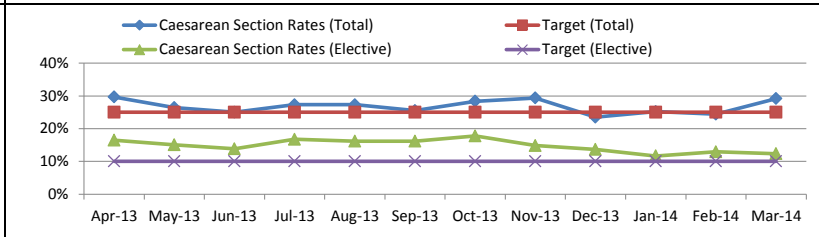
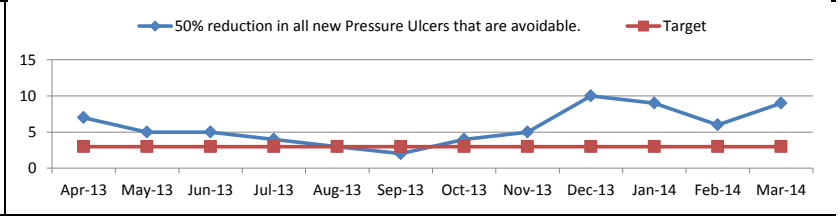
Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2013-14	**1**	**0**	**22**	**0**	**23**
Clinical Outcomes	**4**	**4**	**4**	**13**	**25**
Patient Safety	**13**	**8**	**30**	**10**	**61**
Patient Experience	**13**	**3**	**14**	**3**	**33**
TOTAL	**31**	**15**	**70**	**26**	**142**

Recommendation

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

Enclosure E

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Healthcare Notes audit (23 questions)	100%	↓	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, Is the GMC number present and Are there any loose sheets in the Healthcare record. A revised and focussed data set will be introduced during April 2014.	
Patient Experience	Cancelled ops not rebooked with 28 days	0	↓	There was one incident of an elective procedure cancelled and not re-admitted within the 28 day deadline. This was a Gynaecology patient who was cancelled on the day of their procedure due to theatre staff sickness. The patient has since been re-admitted but not within the 28 day target.	
Patient Experience	A & E Quality Indicators (5 indicators)		↑	**A&E Clinical Indicators:** The 4 hour wait in A&E (Month on Month) position improved during March to a month end position of 90.43% against the previous month of 81.16% but 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 throughout 2013/14, resulting in a cumulative year end position of 90.47%.	
			↑	The time to initial assessment for patients arriving by ambulance improved during March to 59 minutes against the previous monthly position of 1 hour 19 minutes (national target being 15 minutes) but still remains significantly above target.	
			↓	The number of ambulance handover over 60 minutes decreased during March from 144 to 90 incidents although the number ambulance handover times waiting over 15 mins increased from 1021 in February to 1165 in March. The Trust has not been fined for any handovers of 30 minutes or more during 2013/14.	
			↑		
Patient Safety	2 week GP referral to 1st outpatient	93%	↓	Unverified figures for March 2014 show the current position for this cancer target as being 90.9% - dropping below target for the first time during 2013/14. This consists of 60 breaches out of a total of 660 patients as is over various pathways (Breast, Lung, Upper GI, Gynaecology, Urology and 'Other').	
Patient Safety	2 week GP referral to 1st outpatient - breast symptoms	93%	↑	March 2014 demonstrated an improvement for this indicator following the appointment of a locum to backfill the unavailability of one of the Consultant Breast Surgeons. Early indications state an increase from 58.5% in Feb to 86% in March.	
Patient Safety	Cancer target 31 days urgent referral to treatment of all cancers	96%	↑	Although the March position improved from 88.1% to 93.2% there remained difficulties in achieving the target within Breast, Lower GI, Head & Neck, and Skin.	
Patient Safety	Cancer target 62 days urgent referral to treatment of all cancers	85%	↑	This indicator improved from Feb (73.8%) to an unverified position of 79.2% for March. This consists of 17.5 breaches out of a total of 84 patients includes over 6 cancer pathways (Lower GI, Lung, Urology, Upper GI, Head & Neck and Haematology).	

Patient Safety	PROMS Scores - Pre Operative participation rates	England Average (variable)	↓	Pre-operative participation rates (PROMS) for both hip and knee replacements underachieved against the national average targets. This data is based on 6 months HES data - Apr 13 - Sep 13. The Directorate have since reviewed and changed their processes in respect to the point at which this is performed in order to improve this indicator. However, improved results may not be evident for some time due to the delay in the turnaround of the national PROMS data.	
Clinical Outcome	Percentage of patients admitted with FNOF operated on within 36 hours of admission	100%	↑	Following an analysis into the root cause of the February deterioration this indicator showed an improvement from 75% to 85.7%. During March 29 pts were admitted with a #NOF, 28pts were classed as fit for surgery with 24 pts received surgery within 36 hours from admission.	
Clinical Outcome	Patients who spend at least 90% of their time on a stroke unit	80%	↓	The % of stroke patients spending their time on a dedicated stroke ward dropped for the first time in March 2014 to 63%. This was due to bed capacity and bed flow problems in the Trust affecting the availability of appropriates beds.	
Clinical Outcome	Caesarean Section Rates (Total and Elective)	Total = <25% Elective = <10%	↑	The overall Caesarean Section for March 2014 was higher than previous months at 29.2% against the target of 25%. The elective caesarean sections are just over the red RAG bench mark of 12% and sits at 12.4% The quarterly audit of 40 sets of records demonstrated 97.5% against NICE guidelines.	
CQUIN	50% reduction in all new avoidable Pressure Ulcers	Max 3 incidents p/m	↓	There was an increase in the number of avoidable pressure ulcers during March 2014 (9) and remains above the monthly CQUIN target. This figure is unverified at the time of publishing whilst awaiting reviews of each incident. The Tissue Viability Nurse (TVN) Team has expanded in size since October 2013 and has actively raised the awareness of identifying and reporting pressure ulcers. Pressure ulcer prevent training and awareness is still ongoing to address the rise in reportable incidents.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Mar 14 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	0	0	0	0	0	0	0	0	0	0	1	0		
HQU02: HCAI measure (CDI)	29 per year	7	2	4	1	3	1	2	3	0	0	1	2		
HQU08: MSSA Numbers	No national ceiling set	1	0	1	1	0	0	1	1	2	0	0	0		
E Coli ESBL Quarterly Average	7 per month	2	3	3	4	2	2	3	2	2	0	3	1		
VTE Risk Assessment completed	95% month on month	92.4%	93.1%	96.1%	98.4%	98.1%	97%	97%	97%	98%	97.8%	97.7%	97.2%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	100.0%	100.0%	100.0%	100.0%	99.8%	100%	100%	100%	100%	100%	100%	100%		
MRSA Screening Elective Patients	100% month on month	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%	99.94%	99.6%	99.6%		
MRSA Screening Non-Elective Patients	100% month on month	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%	97.1%	97.1%	97.3%	96.5%	96.9%	96.9%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	24	32	23	22	23	15	13	18	23	13	15	15		All units were accounted for after follow up by the Transfusion Team resulting in 100% Trust compliance
Incidence of pressure ulcers															
Grade 3 - New avoidable pressure ulcer		0	4	3	0	0	0	3	5	7	3	3	7		
Grade 3 - New unavoidable pressure ulcer		3	2	4	0	1	4	3	4	3	4	3	1		
Total Grade 3 - New pressure ulcer		3	6	7	0	1	4	6	9	10	7	6	8		
Grade 4 - New avoidable pressure ulcer		0	0	0	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		0	0	0	0	0	0	0	0	0	0	0	0		
Total Grade 3 & 4 Pressure Ulcers		3	6	7	0	1	4	6	9	10	7	6	8		
Reduce harm from falls															
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	1	0		
Major/Severe	0	0	1	1	1	2	1	1	3	3	0	2	1		
Moderate	0	1	3	1	1	0	1	1	2	2	2	0	0		
Mandatory Training compliance Full Year Impact															
Primary Levels Excluding B&H	75%	65.1%	65.4%	65.7%	66.0%	66.1%	68.7%	70.2%	70.2%	70.8%	Not avail	74.7%	75.5%		January Data unavailability due to technical issues
Attendance at Trust Induction	80%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%	87.6%	87.4%	87.5%	Not avail	87.6%	88.1%		January Data unavailability due to technical issues
Number of surgical site infections															
Fracture neck of femur - Number of Operations	-	17	27	29	20	28	26	33	35	35	39	20	3		
Number of infections	-	0	0	0	0	0	1	1	1	0	0	0	0		
% infection rate (monthly)		0%	0%	0%	0%	0%	3.8%	3.0%	2.9%	0.0%	0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%		0%			2.7%			1.9%		Awaiting quarterly report				
Total hip replacements - Number of Operations	-							21	31	17	37	17	18		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
Number of infections	-							0	0	0	0	0	0		
% infection rate (monthly)								0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%								0%		Awaiting quarterly report				
Total knee replacements - Number of Operations	-							12	21	19	32	21	21		
Number of infections	-							0	0	0	0	0	0		
% infection rate (monthly)								0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%								0%		Awaiting quarterly report				
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc															
Open Central Alert System (CAS) Alerts	0	1	0	0	0	0	0	0	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%	79.9%	80.7%	80.9%	81.8%	81.6%	81.1%		
Serious Untoward Incidents	-	41	35	51	21	10	10	9	22	15	12	9	12		
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	100%	99%	100%	100%	100%	100%	98%	99%	99%	100%	100%	100%		
Healthcare Notes Audit															
Q.1 Does the front page of every sheet contain an addressograph label	100%	79%	72%	74%	80%	76%	66%	68%	60%	63%	67%	68%	64%		
Q.2 Does addressograph include the NHS Number?	100%	90%	97%	97%	98%	95%	93%	94%	90%	89%	96%	95%	97%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	100%	94%	90%	78%	67%	86%	69%	72%	76%	80%	71%	75%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	85%	69%	77%	63%	49%	59%	57%	59%	57%	65%	57%	61%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	61%	67%	69%	51%	49%	45%	67%	55%	60%	56%	51%	58%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	21%	8%	15%	12%	14%	5%	6%	7%	19%	14%	7%	21%		
Q.7 Is record legibly written	100%	95%	100%	98%	99%	97%	99%	99%	99%	95%	97%	98%	97%		
Q.8 Written in blue/black ink	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	99%	98%	99%	100%	100%	99%	98%	97%	98%	98%	100%	97%		
Q.10 Is date recorded for each entry	100%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%	89%	86%		
Q.11 Is time recorded for each entry	100%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%	89%	86%		
Q.12 Is there a signature of the person making the entry	100%	96%	97%	92%	97%	91%	91%	87%	91%	93%	91%	93%	92%		
Q.13 Is surname printed in block capitals	100%	73%	65%	69%	71%	66%	73%	54%	70%	63%	58%	65%	64%		
Q.14 Is the staff designation recorded	100%	65%	70%	64%	68%	68%	63%	59%	63%	50%	57%	69%	62%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	69%	63%	35%	46%	66%	43%	38%	55%	46%	44%	60%	50%		
Q.16 Are any alterations / deletions scored through with a single line	100%	46%	43%	55%	53%	45%	56%	44%	55%	44%	53%	44%	46%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%	47%	43%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%	47%	43%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	15%	28%	32%	47%	18%	23%	15%	19%	24%	11%	27%	16%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	99%	97%	88%	100%	91%	94%	96%	100%	99%	100%	100%	97%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	44%	60%	69%	71%	60%	36%	51%	63%	82%	91%	84%	57%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%	96%	80%	100%	100%	98%	91%	98%	100%	98%	100%	96%		
Q.23 Are there any loose sheets in the Healthcare record	0%	10%	3%	3%	7%	6%	9%	7%	4%	10%	7%	6%	6%		

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

Patient Experience	Target 2013-14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Mar 14 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	1	0	0	0	0	0	0	0	0	0	0	1		
Hospital Cancelled Operations	6.0%	11.1%	9.6%	9.6%	12.1%	10.4%	8.5%	10.8%	10.3%	9.1%	12.3%	11.0%	N/Avail		March 14 data unavailable at the time of publication.
Number of written complaints received	-	45	58	37	29	38	41	55	50	35	45	41	52		
Complaints Responded to within agreed timescales	100%	57.8%	94.8%	92%	90%	86.8%	93%	75%	66%	89%	93%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits															
Admitted Patients	90.00%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	93.94%	91.72%	93.78%	94.57%		
Non Admitted Patients	95.00%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	99.00%	98.45%	98.32%	98.57%		
Ongoing Patients	92.00%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	96.95%	96.90%	96.54%	97.10%		
A&E Quality Indicators (5 measures)															
Time Spent in A&E (Month on Month)	95%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%	85.49%	81.16%	90.43%		
Time Spent in A&E (Cumulative)	95%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%	91.33%	90.47%	90.47%		
Total time in A&E (95th percentile)	95th	06:45	03:59	04:43	04:17	05:19	05:22	05:18	04:17	05:39	06:57	08:08	05:42		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:57	00:40	00:54	00:41	00:45	00:42	00:49	00:43	00:46	00:57	01:19	00:59		
Time to treatment decision (median)	<60 mins	00:57	00:51	00:51	01:05	00:54	00:54	00:49	00:46	00:48	00:39	00:54	00:51		
Unplanned re-attendance rate	=<5%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%	6.19%	5.82%	6.04%	5.57%	5.70%	6.24%		
Left without being seen	>1% and <5%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%	0.15%	0.22%	0.31%	0.17%	0.23%	0.25%		
Ambulance handover times > 15 minutes	0	612	452	500	446	476	1263	1656	1485	988	901	1021	1165		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	68	3	29	7	31	15	62	53	75	93	144	90		No hand over greater then 15 minutes
Cancer Wait Times															
2 week GP referral to 1st outpatient	93%	96.0%	95.4%	96.2%	95.5%	95.1%	96.6%	95.8%	97.6%	96.4%	93.7%	93.4%	90.9%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	58.5%	86.0%		
31 Day	96%	98.0%	98.2%	98.1%	96.3%	97.6%	99.3%	97.3%	99.3%	99.2%	95.7%	88.1%	93.2%		
31 day second or subsequent treatment - surgery	94%	100.0%	100.0%	95.5%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	82.8%	86.2%	100.0%		
31 day second or subsequent treatment - drug	98%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	98.4%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	98.3%	98.6%	95.8%	96.5%	97.4%	96.5%	97.8%	95.8%	97.6%	99.2%	98.1%	96.2%		
62 day referral to treatment from screening	90%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%	100.0%	96.3%	100.0%	100.0%	95.7%	94.4%		
62 day referral to treatment from hospital specialist	80% (local target)	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%	66.7%	100.0%	80.0%	100.0%	90.0%	92.9%		
62 days urgent referral to treatment of all cancers	85%	85.2%	79.0%	83.4%	79.1%	85.4%	84.7%	85.6%	83.9%	88.1%	79.5%	75.3%	79.2%		
SRS08: Length of Stay (Acute & MH)															
Elective	3.20	3.1	4.7	5.6	4.3	5.9	3.8	3.8	3.5	3.5	3.7	3.8	3.9		Based on DFI Peer Group UQ. Fig reported in Feb 14 relates to rolling 12 months up until Jan 14
Non-Elective	5.30	4.3	4.3	5.8	4.7	5.3	4.9	4.8	4.9	4.9	4.8	4.8	4.7		Based on DFI Peer Group UQ. Fig reported in Feb 14 relates to rolling 12 months up until Jan 14
SRS09: Daycase Rate	85%	86.2%	85.3%	85.1%	86.9%	85.9%	84.9%	85.0%	84.5%	84.2%	84.7%	83.7%	N/Avail		March 14 data unavailable at the time of publication.
SQU11: PROMS Scores - Pre Operative participation rates															
Groin Hernia - Participation Rate	Eng.Ave 57.6% (target 80%)	98.0%	81.3%			75.3%			84.1%			81.9%			Information based on 6 months HES data to Apr 13 - Sep 13 (published Feb 14). 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 79.2% (target 80%)	93.0%	94.6%			91.5%			95.2%			61.0%			
Knee Replacement - Participation Rate	Eng.Ave 90.5% (target 80%)	110.5%	107.1%			102.6%			113.6%			68.5%			
Varicose Vein - Participation Rate	Eng.Ave 39.9% (target 80%)	54.1%	66.7%			68.7%			69.9%			48.0%			
All Procedures - Participation Rate	Eng.Ave 72.7% (target 80%)	96.0%	90.5%			86.4%			93.7%			69.8%			

Clinical Outcomes	Target 2013-14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Mar 14 RAG Rating	Comments
HSMR - monthly position for 2013-14 (YTD)	<100	108.5	76.8	76.93	88.0	84.96	86.25	86.44	87.19	87.38	85.63	N/Avail	N/Avail		Latest DFI FY trend Apr 13 - Jan 14 (HSMR)
HSMR - 12 Monthly cumulative position		100.8	N/Avail	96.2	99.01	96.17	94.36	93.45	93.79	92	84.12	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
HSMR- cumulative position for 2013-14															
Pneumonia	<100	60.4	N/Avail	59.42	65.8	62.92	64.25	66.28	68.79	67.87	65.97	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
Fracture of neck of femur (hip)	<100	135.89	N/Avail	127.47	125.72	121.88	107.38	95.36	87.48	78.48	74.05	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
Acute Cerebrovascular disease	<100	108.2	N/Avail	101.95	90	100.93	94.37	94.66	91.14	84.6	83.32	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	135.88	N/Avail	128.8	135.46	120.63	110.89	111.1	109.4	99.15	96.69	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
Acute myocardial infarction	<100	84.6	N/Avail	82.29	87.3	82.95	89.32	89.8	109.72	106.89	101.54	N/Avail	N/Avail		Latest DFI FY trend Feb 13 - Jan 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	112.89	112.89	112.89	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail		Latest position reported in Feb 14 reflects Jul 12 - Jun 13.
SQU12: Maternity 12 weeks	90%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%	97.7%	97.7%	96.3%	94.4%	95.2%	81.0%		
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	2.6%	2.7%	3.7%	3.3%	4.4%	3.4%	2.9%	2.8%	7.7%	4.7%	6.3%	N/Avail		Jan 14 data unavailable at the time of publication.
Fractured neck of Femur															
Patients fit for surgery within 36hrs	-	17	29	26	23	25	28	28	30	30	36	20	28		
Number of patients admitted with FNOF who were operated on within 36 hrs	-	14	21	23	22	21	19	24	13	25	34	15	24		
% of patients admitted with FNOF who were operated on within 36 hrs of bei	100%	82.4%	72.4%	88.5%	95.7%	84.0%	67.9%	85.7%	43.3%	83.3%	94.4%	75.0%	85.7%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	90.9%	82.8%	81.3%	92.6%	85.7%	93.0%	94.0%	88.0%	92.0%	95.9%	96.3%	93.0%		
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	43%	38%	38%	66%	59%	51%	48%	55%	43%	41%	43%	49%		
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	100%	100%	100%	100%	100%	100%	94%	82%	100%	100%	100%	100%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%	73.9%	75.0%	84.0%	92.0%	82.0%	76.9%		
Patients who spend at least 90% of their time on a stroke unit	80%	80.0%	88.7%	98.2%	89.8%	87.1%	87.0%	92.7%	82.2%	96.7%	91.0%	82.0%	63.0%		
Breast Feeding initiation	75%	80.6%	81.4%	76.9%	79.7%	78.9%	78.0%	78.6%	77.7%	79.0%	81.4%	78.0%	81.4%		
Caesarean Section Rates - Total	<25%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%	28.4%	29.4%	23.5%	25.2%	24.4%	29.2%		
Caesarean Section Rates - Emergency	14.98%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%	8.0%	14.6%	9.9%	13.6%	11.4%	16.8%		
Caesarean Section Rates - Elective	<10%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%	17.8%	14.8%	13.6%	11.7%	12.9%	12.4%		
Home Birth Rate	>=3%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%	6.0%	2.1%	4.6%	4.1%	6.0%	4.3%		
Number of readmissions within 28 days (Adult)	-	395	385	424	495	425	394	414	448	474	452	459	Not Avail		Min 28 day turnaround before monthly data complete, therefore subject to change.
Number of readmissions within 28 days (Children)	-	146	136	163	126	96	106	156	142	161	136	149	Not Avail		Min 28 day turnaround before monthly data complete, therefore subject to change.

CQUIN 2013-14	Target 2013-14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Mar 14 RAG Rating	Comments
NATIONAL CQUINS															
1.VTE															
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month CQUIN	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.6%	97.8%	97.7%	97.2%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	payment to be received if both 1a		91.3%			89.6%			89.4%			On track			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	0.86%	4.35%	2.37%	3.3%	55.70%	70.8%	68.80%	79.58%	76.30%	90.57%	91.1%	90.7%		
3b.initial diagnostic assessment	90% 3 consecutive months	-	0%	100%	50%	46.70%	60.00%	35.7%	100.00%	100%	100%	100%	95.5%		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%	100%	100%	58.30%	36.40%	60.0%	40.00%	66.60%	95.2%	90.5%	95.0%		
3d.Lead clinician and appropriate training of staff	Yes						On track								RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes						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			Q1 achieved			Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism			Q1 achieved			Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report

1c. AECP for Supraventricular Tachycardia			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic														
2a. HOT Clinic for Paediatrics			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine			Q1 achieved		Q2 achieved			Q3 achieved			On track			RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS														
1. Friends & Family														
1a. Phased expansion of Friends and Family Test (maternity services)	Implementation by Oct 2013			From Oct 2013			19.01%	14.07%	16.74%	36.13%	45.05%	39.88%		
1b. increase response rate to at least 20%	=>20% by Yr End	7.09%	9.23%	15.88%	16.93%	9.73%	16.84%	22.17%	26.67%	23.06%	20.18%	21.99%	21.27%	Q4 accumulative FFT response rate = 21.14%
1c. Improve performance on staff Friends & Family Test				Survey conducted Autumn 2013 and published in February 2014. Improvement CQUIN requirement achieved.										RAG rating in accordance with latest CQUIN Status report
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	7	5	5	4	3	2	4	5	10	9	6	9	March 2014 data still undergoing verification as the time of publishing
3. Quality Dashboards				On track, Q1 data submitted and feedback provided. Q2 data submitted on time.								On track		
4. Timely Simple Discharge	Improvement on baseline (37%)	N/A	50.0%	0.0%	66.7%	66.7%	100%	33.3%	50.0%	33.3%	N/Applic	0.0%	0.0%	RAG rating in accordance with latest CQUIN Status report. Target = +33.3%, YTD= 51.9
5. Improved access to breast Milk -% of babies less than 33wks discharged on breast milk	Improvement on baseline	71.0%	33.0%	40.0%	75.0%	80.0%	64.2%	50.0%	50.0%	80.0%	100.0%	80.0%	20.0%	RAG rating in accordance with latest CQUIN Status report. Target = 61% yr end or 64% in any one quarter (Feb 14 - criteria amended)
6. Acute Kidney Injury	Q1 Process recorded and definition in place			Q1 & Q2 achieved. Q3 on track. Process agreed to identify patients with an AKI. Working group established and meeting regularly										

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 APRIL 2014

Title	Patient Experience Report
Agenda item	9
Sponsoring Director	Jane Bradley, 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

- Within the National CQC Inpatient survey, for each of the sections, overall the trust performed as 'about the same' in every section. Two questions were identified as being as within the 'Worse' category when the trusts results were compared nationally. However, the Trust performed statistically and significantly better in **8** questions.
- A&E's FFT response rate was the lowest it has been since the summer in 2013 only managing to achieve a response rate of **7.02%**
- Despite the low FFT response in A&E the rest of the hospital performed exceedingly well resulting in our CQUIN target not falling below 20% for the whole of Quarter 4
- Inpatient Services continue to reach high levels of response in relation to FFT, with a response rate of **47.81%** in March.
- A&E (combined with Eye Casualty and Ambulatory Care) have previously achieved FFT scores significantly higher than those achieved nationally. March saw a decline dropping from 74 in February to **63** in March 2014. This may be a result of the operational pressures seen in A&E during March.
- Inpatient services saw their FFT NPS increase during March reaching **74**. This is the highest NPS achieved in Inpatients since September 2013
- Reviewing the previous year's response for the amount of FFT 'Extremely Likely' responses received for Inpatient Services and A&E, there has been an apparent improvement throughout every quarter
- The Trust also saw a decrease in the amount of FFT 'Extremely Unlikely' and 'Unlikely' responses, achieving the lowest amount this financial year:
- Triangulation has identified 3 themes which are consistently found across PALS, complaints, FFT and incidences within Quarter 4: Clinical Care**,** Discharge and Communication

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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**

Actions required by the Board

- Discuss and challenge the content of the report
- Note the results from March 2014 Friends and Family Test

Trust Board
24April 2014
Patient Experience Report

1. 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.

2. The National Inpatient Survey

2.1 Background

The National Inpatient Survey is an annual national requirement set out by CQC and carried out within every acute hospital in England. Since the release of the Patient Perspective report (reported in February IHGC Paper) the CQC survey report has been published detailing NGH's performance nationally. The results within the CQC version are different to those published within the Patient Perspective Report as they have been standardised according to demographics of respondents to ensure that trusts will not appear 'better' or 'worse' than another because of its respondents profile. The report contains an overall 'score' for each section and each individual question, with 10 being the highest and 1 being the lowest. This score is then compared with the results from the previous year for that trust, and where there has been a statistically significant fall or improvement in the score this is marked with an arrow. Only scores where the score change is significant will be discussed. The score obtained is then compared with the results obtained nationally. The trust is then ranked as scoring either 'worse' 'about the same' or 'better' when compared with other trusts nationally.

2.2 The Issue(s)

2.2.1 National Comparisons

- For each of the sections overall the trust performed as 'about the same' in every section,
- 8 questions scored significantly better than previous audits
- Two questions were again identified as being as within the 'Worse' category when the trusts results were compared nationally. Unfortunately for the trust this includes a repeat from 2012;

Q16 Were you ever bothered by noise at night from hospital staff?

In addition to this, the Trust performed as 'Worse' for the question:

Q53 How long was the delay? (This question is in response to a previous question of: Q52 Discharge delayed due to wait for medicines, to see doctor, for ambulance)

2.2.3 Progress from 2012

- When exploring the questions individual scores, compared against the previous years, the Trust had zero questions that performed significantly worse. There are questions were there have been a slight decrease but when tested these were not deemed as significant.
- In fact, the Trust performed significantly better in **8** questions (**Appendix 1** contains details of these)

2.2.4 Next Steps

The areas identified as being within the 'Worse' nationally for 2013 have also been identified within the original report. Therefore the recommendations made previously still stand. The Trust is focusing on these areas for our improvement work;

- Noise at Night
- Discharge delays
- Side effects of medications
- Hospital Food
- Asking patients for views on their quality of care

3. Friends & Family Test

3.2.1 Response Rates:

- A&E had some major issues in March with their FFT collections with one of the IPads failing to work. A paper based system had to be implemented quickly in order to capture feedback until the IPad could be mended. This was in place for 12 days. Following a low performance by A/E staff, Volunteers were asked to help which had a hugely beneficial effect for the last 5 days of the month.
- A&E's response rate was the lowest it has been since the summer in 2013 only managing to achieve a response rate of **7.02%,** this was due to the issues detailed above.
- When combined as a whole A&E, Ambulatory care and Eye Casualty achieved a response rate of **11.62%**
- Despite the low response in A&E the rest of the hospital performed exceedingly well meaning we managed to achieve our CQUIN target of not falling below 20% for the whole of Quarter 4.
- Inpatient Services continue to reach high levels of responses with March seeing them reach **47.81%**
- For Inpatient Services, only 2 wards fell below the 20% response rate, and this was marginal. This shows increased levels of engagement on the wards.
- Maternity services also continue to collect well, obtaining a response rate of **39.88%**
- Day case areas, Theatres and Children's wards all continue to collect well.
- **Appendix 2 contains further details of the response rates per area.**

3.2.2 Scores:

- A&E (combined with Eye Casualty and Ambulatory Care) have previously achieved scores significantly higher than those achieved nationally. March saw a decline dropping from **74** in February to **63** in March. This may be a result of the pressures seen in A&E in March.
- Inpatient services saw their NPS increase for March reaching **74**, the highest NPS achieved in Inpatients since September.
- Maternity services continue to improve their NPS month on month, reaching **76** for March following a score of **71** in February.
- Children's Wards saw a 4 point decline in their score from February to March obtaining a score of **65**
- Day case areas and Theatres continue to see high levels of satisfaction reaching a score of **93** in March.
- **Appendix 3 contains further details of the Net Promoter Scores achieved per area.**

3.2.3 Positive and Negative Percentage Splits:

- Inpatient Wards (including Ambulatory Care, paediatrics, day case areas and theatres) received **324** comments from the FFT forms in March, of these **87.3%** were positive and **13%** were negative, a **2%** decrease in the amount of negatives received in February.
- A&E has not been split into Minors and Majors for March due to the reorganisation within the departments so data cannot be compared with February. In March they received 96 comments, **82.3%** were positive, and **18%** negative.
- Maternity Services saw 410 comments, and of these **95.4%** were positive, and **5%** were negative. In February they received **93.9%** positive and **6%** negative, showing a **1%** decline in the amount of negative comments received.

- **Appendix 4 contains further details of the Negative and Positive comment split per area.**

3.2.4 FFT 2013/2014 response categories- Annual review of progress

- Looking back across the past year for the amount of 'Extremely Likely' responses received in Inpatient Services and A&E, it is clear that there was an improvement in every quarter.

- In addition to achieving the highest amount of Extremely Likely responses to date in Quarter 4 the Trust also saw a decrease in the amount of Extremely Unlikely and Unlikely responses, achieving the lowest amount in Quarter 4.

4. Triangulation of Complaints, Pals, Incidents, SI's and FFT

4.1 Background

Previous reviews carried out within the NHS have highlighted the need for a triangulated approach to reviewing data based around quality. For this reason NGH have made the decision to begin triangulating information from the Friends & Family Test, PALS, Complaints and Incidents in order to establish a mechanism of review and the ability to spot themes on a quarterly basis.

4.2 The Issues

- Triangulation has identified 3 themes which are consistently found across PALS, complaints, FFT and incidences within Quarter 4:

1. Clinical Care
2. Discharge
3. Communication

- Further information and a breakdown of the different areas can be seen within **Appendix 5**

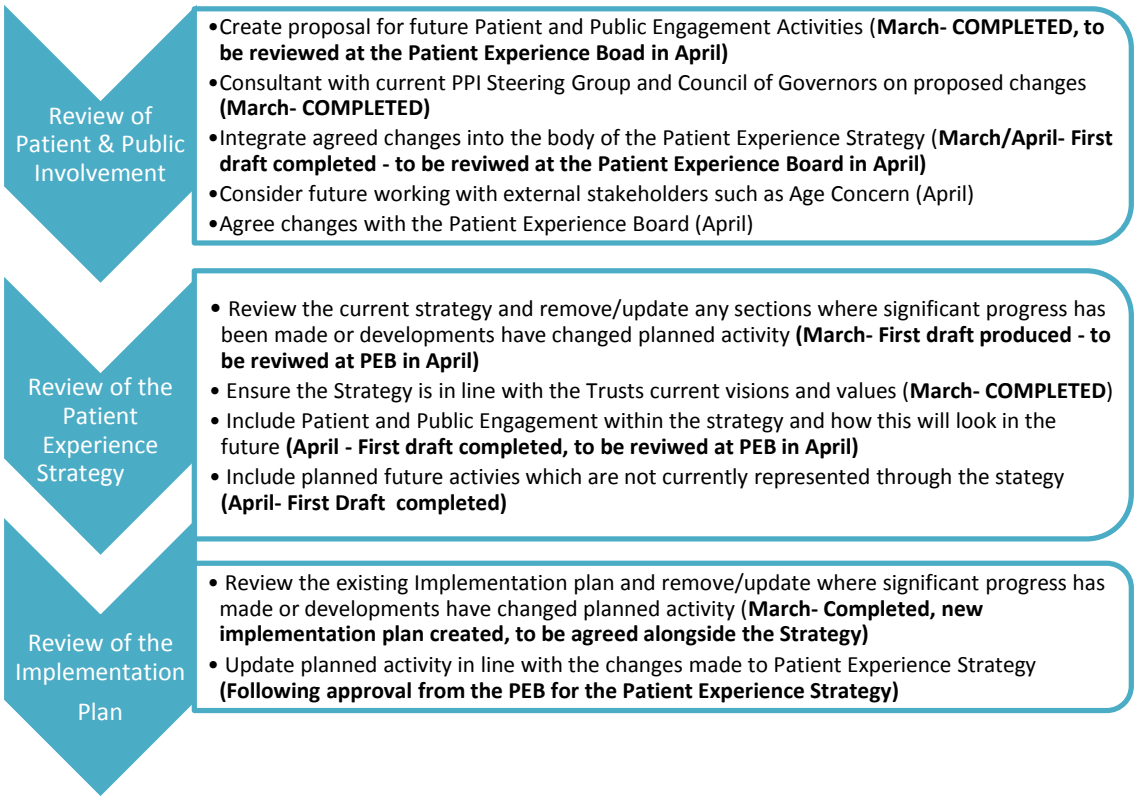
5. Patient Experience Strategy and Implementation Plan Review

5.1 Background

A number of significant developments have taken place over the past 6 months with regards to patient experience, including the conducting of a comprehensive Thematic Analysis of all patient experience work carried out the 18 months previous to September 2013. This has led to the need for a review of the Patient Experience Strategy, including Patient and Public Involvement (PPI) and the Implementation Plan which accompanies it. In particular, PPI will be revamped to align the invaluable work they do to fit more closely with the Patient Experience Improvement Programme which will be discussed later in the paper.

6.2 The Issues

- A draft timeline was presented to the Board in March. Some progress has been made within these areas, which is detailed in the diagram below in **bold**;


Review of Patient & Public Involvement
•Create proposal for future Patient and Public Engagement Activities (**March- COMPLETED, to be reviewed at the Patient Experience Boad in April)**
•Consultant with current PPI Steering Group and Council of Governors on proposed changes **(March- COMPLETED)**
•Integrate agreed changes into the body of the Patient Experience Strategy (**March/April- First draft completed - to be reviwed at the Patient Experience Board in April)**
•Consider future working with external stakeholders such as Age Concern (April)
•Agree changes with the Patient Experience Board (April)
Review of the Patient Experience Strategy
• Review the current strategy and remove/update any sections where significant progress has been made or developments have changed planned activity **(March- First draft produced - to be reviwed at PEB in April)**
• Ensure the Strategy is in line with the Trusts current visions and values (**March- COMPLETED**)
• Include Patient and Public Engagement within the strategy and how this will look in the future **(April - First draft completed, to be reviwed at PEB in April)**
• Include planned future activies which are not currently represented through the stategy **(April- First Draft completed)**
Review of the Implementation Plan
• Review the existing Implementation plan and remove/update where significant progress has made or developments have changed planned activity (**March- Completed, new implementation plan created, to be agreed alongside the Strategy)**
• Update planned activity in line with the changes made to Patient Experience Strategy **(Following approval from the PEB for the Patient Experience Strategy)**

CQC Inpatient Survey Results for 2013

The Patient Perspective Report for the National Inpatient Survey results were published in February and were the results of which were presented to the Integrated Health Governance Committee in March.

Since then, the CQC survey report has been published detailing NGH's performance nationally. The results within the CQC version are different to those published within the Patient Perspective Report as they have been standardised according to age, sex and method of admission (emergency or elective) of respondents to ensure that trusts will not appear 'better' or 'worse' than another because of its respondents profile.

The report contains an overall 'score' for each section and each individual question, with 10 being the highest and 1 being the lowest. This score is then compared with the results from the previous year for that trust, and where there has been a statistically significant fall or improvement in the score this is marked with an arrow. Only scores where the score change is significant will be discussed within this report. The score obtained is then compared with the results obtained nationally. The trust is then ranked as scoring either 'worse' 'about the same' or 'better' when compared with other trusts nationally.

2012 Re-cap

As this is conducted annually, a report was also produced in 2012 detailing the results as described above, it is important to recap on the results received in 2012 to truly understand the report for 2013.

In 2012 the CQC identified 2 areas in which the trust performed within the 'Worse' category compared with other trusts nationally. These were both for questions related to Noise at Night:

Q15: Were you ever bothered by noise at night from others patients?

Q16: Were you ever bothered by noise at night from hospital staff?

For the rest of the questions the Trust performed as 'about the same'.

In addition to this, the Trust saw a significant decline in their scores for a number of questions when compared to the 2011 scores. These questions were:

Q3: Were you given enough privacy when being examined or treated in the A&E department?

Q9: From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward?

Q53: How long was the delay? (in discharge)

Q67: Overall, did you feel you were treated with respect and dignity while you were in hospital?

Q69: During your hospital stay, were you ever asked to give your views on the quality of your care?

Although the trust made some improvements in their scores for certain questions none of them were deemed as being statistically significant when tested using a two-sample t-test.

2013 Results

For 2013 the results of the Inpatient Survey have changed quite significantly for the Trust;

When reviewing the sections overall the trust performed as 'about the same' in every section.

Breaking the sections down, two questions were again identified as being as within the 'Worse' category when the trusts results were compared nationally. Unfortunately for the trust this includes a repeat from 2012;

Q16 Were you ever bothered by noise at night from hospital staff?

In addition to this, the Trust performed as 'Worse' for the question:

Q53 How long was the delay? (This question is in response to a previous question of Q52 Discharge delayed due to wait for medicines, to see doctor, for ambulance)

As mentioned in the recap of 2012, this question had also seen a significant decline in 2012 from 2011 and the score continued to fall for 2013:

2013	2012	2011
6.7	7.1	7.7

The rest of the questions ranked as 'about the same' when compared nationally.

When exploring the questions individual scores, compared against the previous years, the Trust had zero questions that performed significantly worse. There are questions were there have been a slight decrease but when tested these were not deemed as significant.

In fact, the Trust performed significantly better in **8** questions;

Q4 Were you given enough privacy when being examined or treated within the A&E Department?

Q24 When you had important questions to ask a doctor, did you get answers that you could understand?

Q32 Were you involved as much as you wanted to be in decisions about your care and treatment?

Q40 After you used the call button, how long did it usually take before you got help?

Q44 Were you told how you could expect to feel after you had the operation or procedure?

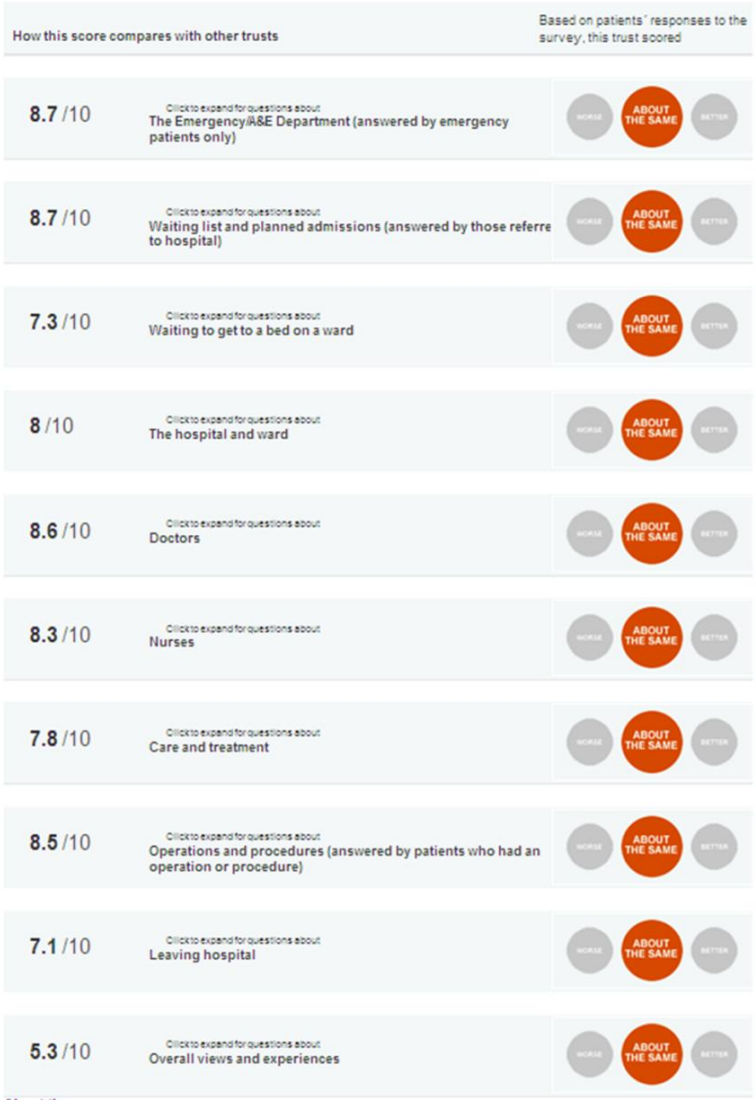
Q67 Overall, did you feel you were treated with respect and dignity while you were in hospital?

Q69 Overall (Likert scale ranging between 'I had a very good experience' and 'I had a very bad experience')

Q70 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

CQC Chart

Each year the CQC compiles a chart for each organisation which displays how they have performed nationally. The chart for this year for NGH is displayed below:



Each of these tabs links through to the questions which are part of that section. The Trust performed as 'About the same' for every question apart from the 2 questions mentioned previously about noise at night from staff and discharge delays, these show as 'Worse'.

Next steps – Improvement Work

It is important to note these results with the report produced by Patient Perspective which contains more detail on the trusts stand-alone performance. There are a number of questions which we are performing within the average nationally which we wish to improve as nationally the averages are low. The areas identified as being within the 'Worse' nationally for 2013 have also been identified within the original report. Therefore the recommendations made previously will still up stand to focus on the below areas for our improvement work;

- Noise at Night
- Discharge delays

- Side effects of medications
- Hospital Food
- Asking patients for views on their quality of care

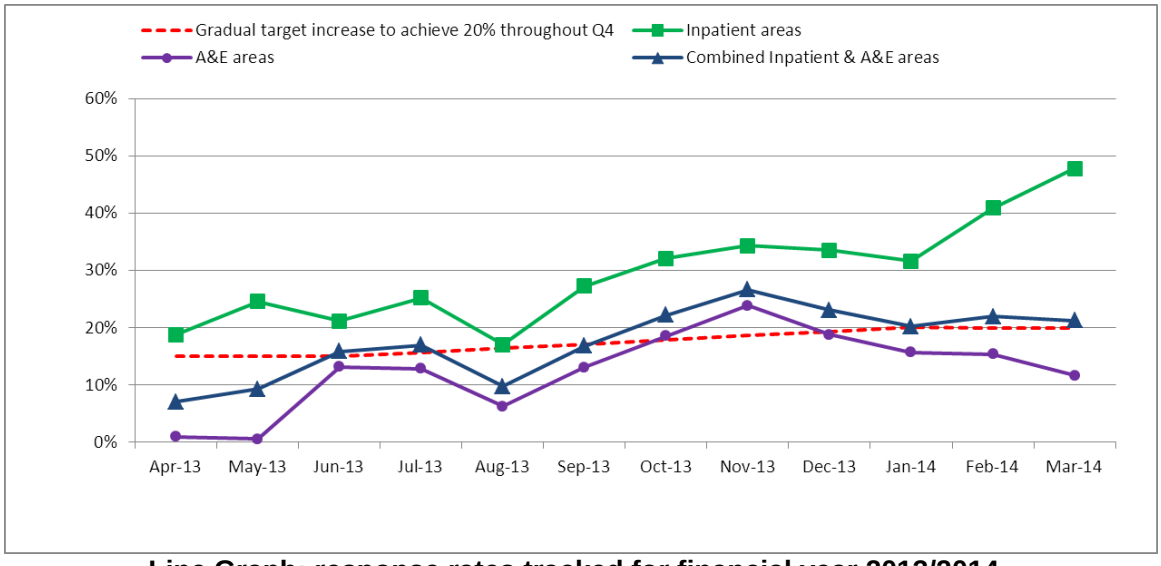
Appendix 3 – FFT Response Rates – March 2014

Friends & Family Net Promoter Response Rates	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target Q4 2013-14 20%	Target Q4 2013-14 20%	Target Q4 2013-14 20%
Ward	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Abington	25.00%	30.61%	27.03%	23.64%	11.76%	8.16%	33.33%	89.66%	25.00%	38.89%	24.49%	26.83%
Allebone	51.02%	32.98%	23.75%	25.40%	14.29%	11.11%	25.93%	14.29%	14.58%	26.32%	14.63%	44.44%
Althorp	54.84%	33.33%	32.93%	70.21%	59.42%	56.52%	52.17%	21.59%	41.07%	60.00%	70.51%	55.42%
Becket	40.43%	43.28%	42.65%	37.97%	17.39%	23.33%	55.26%	32.14%	45.90%	29.31%	70.73%	81.13%
Benham	12.00%	21.43%	19.41%	23.94%	14.63%	19.82%	40.00%	35.71%	20.37%	27.03%	35.40%	49.62%
Brampton	37.84%	40.00%	9.38%	38.89%	34.38%	34.62%	30.00%	28.57%	36.17%	31.91%	25.81%	20.00%
Cedar	19.18%	10.34%	7.55%	34.12%	17.82%	22.11%	13.04%	56.00%	52.78%	53.40%	77.55%	68.24%
Collingtree	7.06%	37.33%	28.46%	25.83%	20.65%	18.60%	13.73%	10.53%	25.21%	12.15%	24.18%	18.52%
Compton	80.00%	156.25%	84.21%	106.67%	100.00%	18.60%	107.69%	164.29%	95.65%	105.56%	126.67%	109.09%
Corby Comm.	0.00%	9.52%	39.13%	92.86%	26.32%	61.54%	100.00%	33.33%	20.00%	40.00%	75.00%	83.33%
Creaton	7.81%	18.07%	16.67%	11.25%	6.35%	17.39%	20.37%	19.51%	21.21%	46.97%	24.32%	23.21%
Danetre	39.47%	54.29%	24.24%	43.93%	15.79%	70.59%	41.94%	84.62%	51.72%	64.71%	40.91%	72.22%
Dryden	28.32%	19.67%	2.15%	9.65%	4.27%	17.58%	24.11%	16.33%	31.07%	9.52%	21.98%	23.38%
Eleanor	38.10%	51.11%	29.31%	44.07%	34.38%	39.58%	50.82%	28.95%	54.24%	36.36%	37.10%	64.79%
EAU	14.45%	26.77%	22.79%	11.00%	7.82%	10.16%	10.75%	15.94%	28.28%	16.13%	14.63%	19.31%
Finedon	31.25%	46.51%	22.92%	57.89%	31.37%	34.62%	26.79%	36.17%	57.89%	18.52%	41.67%	42.65%
Hawthorn	33.85%	30.04%	33.02%	27.78%	25.93%	47.65%	48.47%	58.95%	61.50%	60.78%	72.12%	77.97%
Hazelwood Comm.	77.78%	60.00%	50.00%	105.56%	57.89%	73.33%	120.00%	66.67%	72.22%	50.00%	164.71%	175.00%
Head & Neck	17.48%	29.81%	38.32%	31.30%	20.39%	32.50%	40.70%	28.21%	22.47%	21.28%	36.25%	33.90%
Holcot	83.33%	54.55%	68.75%	72.73%	50.00%	155.56%	88.24%	141.18%	114.29%	63.33%	53.13%	102.94%
Knightley	25.64%	40.38%	43.64%	59.57%	100.00%	51.28%	36.11%	57.89%	40.00%	22.45%	54.76%	61.36%
Rowan	16.15%	18.18%	13.48%	24.71%	13.71%	29.41%	23.63%	33.13%	10.31%	14.89%	22.73%	36.09%
Spencer	10.73%	15.86%	15.30%	15.43%	13.99%	16.20%	23.31%	21.58%	20.61%	17.91%	34.45%	32.84%
Talbot Butler	8.93%	26.42%	24.75%	47.52%	36.11%	38.37%	23.53%	30.00%	27.84%	29.07%	34.69%	53.27%
Victoria	15.07%	17.31%	6.98%	34.92%	17.07%	7.14%	25.37%	36.36%	17.95%	28.21%	29.27%	65.71%
Willow	11.11%	27.37%	28.95%	11.46%	16.13%	16.83%	52.75%	24.68%	20.56%	18.33%	17.78%	63.64%
Adult Inpatient Area Total	18.78%	24.53%	21.13%	24.61%	16.52%	27.26%	32.31%	34.30%	33.53%	31.59%	40.87%	47.81%
Accident & Emergency Unit	1.02%	0.25%	15.22%	13.49%	6.60%	15.12%	16.06%	22.12%	18.07%	15.01%	12.85%	7.02%
Ambulatory Care Centre						45.83%	22.47%	24.68%	8.60%	17.86%	10.22%	25.74%
Eye Casualty Unit	0.72%	2.38%	1.04%	9.23%	4.06%	1.11%	31.22%	33.11%	24.19%	18.85%	28.96%	31.61%
Accident & Emergency Total	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%	15.37%	11.62%

Appendix 3 – FFT Response Rates – March 2014

Antenatal Community							1.14%	6.86%	5.14%	31.71%	29.28%	19.33%
Birth Centre									36.95%	100.00%	103.92%	82.98%
Home Birth							35.71%	53.85%	51.72%	115.79%	88.89%	52.38%
Labour Ward							33.06%	18.44%	24.51%	27.21%	49.04%	48.12%
Maternity Observation Ward		0.00%	0.00%	0.00%	0.00%	17.39%	3.13%	13.64%	71.43%	11.54%	68.75%	
Balmoral	54.59%	60.82%	Closed	Closed	Closed	Closed	Closed	Closed	0.00%	14.29%	68.18%	36.62%
Robert Watson	26.32%	32.41%	33.96%	40.06%	18.15%	26.22%	35.38%	21.22%	36.64%	41.51%	64.91%	57.92%
Postnatal Community							3.33%	9.27%	3.45%	31.85%	38.71%	29.44%
Maternity Services Total	41.42%	23.08%	28.57%	33.33%	14.47%	21.28%	19.01%	14.07%	16.74%	36.13%	45.05%	39.88%
Disney	17.46%	32.66%	24.74%	35.82%	29.59%	79.05%	50.91%	46.08%	26.71%	101.33%	65.52%	102.52%
Paddington	5.88%	10.41%	10.57%	21.23%	13.61%	35.84%	36.97%	24.07%	16.28%	23.53%	22.11%	50.74%
Paediatric Ward Total	9.55%	17.65%	15.14%	26.09%	18.99%	51.22%	40.73%	30.86%	20.60%	45.80%	35.31%	69.18%
Danetre Day Surgery	50.00%	60.64%	29.25%	34.19%	47.55%	20.54%	24.39%	23.44%	10.87%	42.11%	47.86%	31.25%
Main Theatre Admissions	67.47%	52.42%	24.14%	17.28%	60.42%	17.82%	18.59%	86.29%	55.00%	62.00%	58.96%	60.28%
NGH Day Surgery	29.17%	28.62%	34.49%	23.20%	17.46%	48.61%	41.13%	39.39%	36.96%	23.19%	37.24%	38.07%
Singlehurst Day Unit	2.44%	5.48%	9.93%	9.43%	19.70%	11.11%	6.50%	7.28%	1.52%	21.69%	18.38%	29.09%
Daycase Area Total	40.30%	32.40%	27.34%	20.70%	29.72%	28.59%	24.33%	37.78%	27.65%	35.52%	39.97%	39.47%

A&E response rates (represented by the purple line on the line graph) continue to decline since their peak in November and reached the lowest levels since August.



Line Graph: response rates tracked for financial year 2013/2014

Inpatient services however continued to increase their response rates (represented by the green line on the line graph above). When broken down to individual ward level it can be seen that only

2 wards obtained a response rate below the required 20%, and both of these were only marginally below. This is the best results since collections began.

	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%	31.59%	40.87%	47.81%
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%	15.37%	11.62%
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	16.84%	22.17%	26.67%	23.06%	20.18%	21.99%	21.27%

Table: Response rates tracked for financial year 2013/2014

The table below demonstrates the CQUIN data for Quarter 4 with the trust achieving above the required 20% every month for Inpatients and A&E combined.

CQUIN criteria (IP & A&E only) Period: Q4 2013-14 1st Jan to 31st Mar 2014	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**
Jan-14	1045	294	28	11	23	26	7073	1427	20.18%	70
Feb-14	1114	301	19	10	21	18	6743	1483	21.99%	73
Mar-14	1144	369	15	18	18	22	7455	1586	21.27%	70
Q4	3303	964	62	39	62	66	21271	4496	21.14%	71

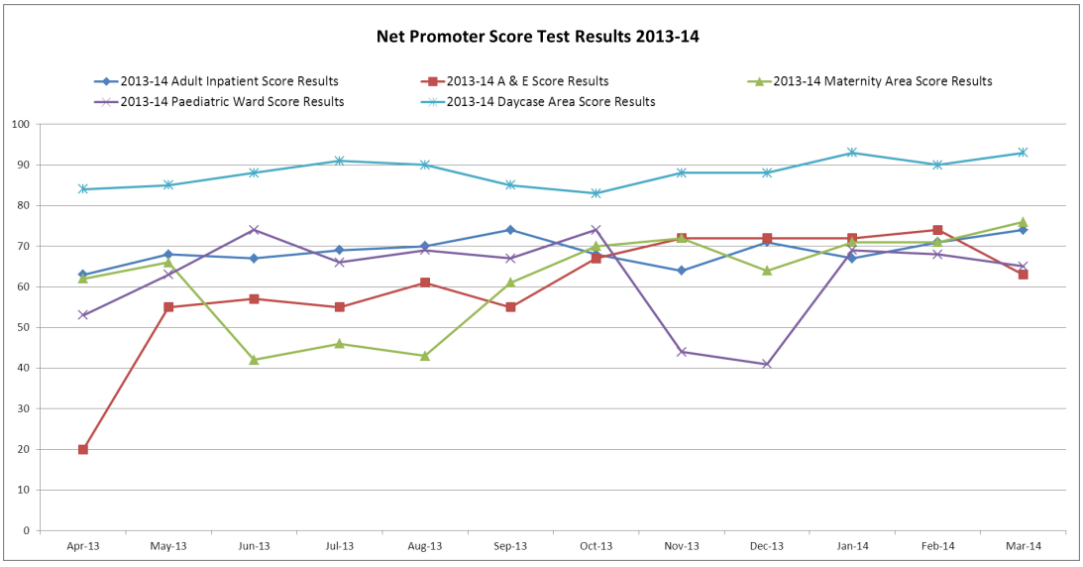
Appendix 4 – Net Promoter Scores – March 2014

Friends & Family Net Promoter Score Results

Ward	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Abington	31	80	70	46	20	-25	25	56	0	57	60	73
Allebone	33	33	41	44	-14	75	57	0	33	46	67	41
Althorp	74	82	77	86	80	72	83	68	78	79	82	80
Becket	50	79	62	87	100	69	74	67	79	94	93	98
Benham	77	66	54	47	62	73	60	58	68	60	47	74
Brampton	64	56	67	86	82	67	58	77	65	47	71	71
Cedar	31	17	75	41	39	52	63	55	66	44	74	55
Collingtree Medical	83	58	63	55	79	69	86	75	75	62	64	60
Compton	81	76	69	69	33	92	57	65	50	88	74	83
Corby Comm.		100	75	54	40	100	63	67	100	100	50	80
Creaton	60	43	70	67	67	67	18	-25	57	60	67	83
Danetre	100	100	100	80	83	73	92	90	80	91	78	92
Dryden	55	41	100	82	25	88	52	80	88	75	75	67
Eleanor	81	83	73	73	68	79	71	55	75	85	96	80
EAU	63	67	61	55	76	75	45	62	73	84	50	54
Finedon	79	74	36	52	53	72	57	69	61	80	79	66
Hawthorn	70	66	70	69	67	69	77	65	67	61	54	79
Hazelwood Comm.	50	83	100	95	64	82	83	50	69	33	82	71
Head & Neck	89	84	93	85	95	85	94	95	85	75	90	84
Holcot	78	75	45	72	60	77	53	58	88	79	76	83
Knightley	56	62	58	71	100	75	92	90	69	40	74	92
Rowan	32	54	58	72	88	78	58	62	90	55	60	67
Spencer	72	61	75	62	78	86	57	70	67	63	73	82
Talbot Butler	50	96	84	85	82	73	88	63	84	92	85	75
Victoria	25	50	67	55	57	67	56	43	100	64	80	57
Willow	67	73	62	82	67	93	71	78	77	86	100	79
Adult Inpatient Area Total	63	68	67	69	70	74	68	64	71	67	71	74
Accident & Emergency Unit	13	45	57	55	60	54	63	69	72	71	73	57
Ambulatory Care Centre						91	80	79	75	64	79	88
Eye Casualty Unit	67	61	63	58	72	78	76	78	71	80	76	68
Accident & Emergency Total	20	55	57	55	61	55	67	72	72	72	74	63

Antenatal Community							100	71	44	70	71	67
Birth Centre									100	89	83	89
Home Birth							100	71	100	100	94	100
Labour Ward							73	72	66	69	70	78
Maternity Observation Ward							50	0	83	53	25	91
Balmoral	64	74	Closed	Closed	Closed	Closed	Closed	Closed		57	90	81
Robert Watson	56	59	42	46	43	61	60	69	51	55	62	70
Postnatal Community							100	87	82	78	72	75
Maternity Services Total	62	66	42	46	43	61	70	72	64	71	71	76
Disney	64	70	85	75	82	74	80	63	41	82	77	67
Paddington	38	51	62	57	53	57	69	27	40	48	68	62
Paediatric Ward Total	53	63	74	66	69	67	74	44	41	69	68	65
Danetre Day Surgery	94	89	90	85	92	100	97	93	90	98	93	100
Main Theatre Admissions	82	83	97	96	88	87	90	87	94	97	95	99
NGH Day Surgery	82	83	86	94	91	83	79	87	82	81	89	87
Singlehurst Day Unit	100	88	73	80	92	79	77	91	100	88	68	89
Daycase Area Total	84	85	88	91	90	85	83	88	88	93	90	93

Inpatient services obtained their joint-second highest NPS for the financial year 2013/2014, achieving an NPS of 74. A&E however saw a decline in their NPS from 74 in February to 63 in March, this may be due to the increased pressures on the service seen throughout the month of March.



Line Graph: Net Promoter Scores tracked for each area throughout 2013/2014

As can be seen on the line graph above, Maternity Services continue to make improvements on their NPS since November (collections began across 4 points in the pathway in October, previously it was only the Wards which collected). Day case areas and theatres continue to see consistently high levels of satisfaction, represented by the light blue line of the line graph. Paediatrics saw their satisfaction levels decline rapidly in November and December; however this has improved despite a drop from February to March.

Inpatient Services, Day Cases, Paediatrics' and Theatres

Row Labels	Count of Positive	Count of Negative	Total	% Positive	% Negative
Abington	7		7	100.0%	0%
Allebone	12	3	15	80.0%	20%
Althorp	24	2	26	92.3%	8%
Ambulatory Care Centre	10		10	100.0%	0%
Becket	3		3	100.0%	0%
Benham	25	1	26	96.2%	4%
Cedar	10	1	11	90.9%	9%
Collingtree	2		2	100.0%	0%
Collingtree			0	#DIV/0!	#DIV/0!
Creaton	2	3	5	40.0%	60%
Danetre	10		10	100.0%	0%
Disney	3		3	100.0%	0%
Dryden	4	2	6	66.7%	33%
EAU	6	1	7	85.7%	14%
Eleanor	16	3	19	84.2%	16%
Finedon	4	2	6	66.7%	33%
Hawthorn	72	11	83	86.7%	13%
Hazelwood - Isebrook	5	1	6	83.3%	17%
Head & Neck	2		2	100.0%	0%
Knightley	2		2	100.0%	0%
MTAU	15		15	100.0%	0%
NGH Day Surgery	8		8	100.0%	0%
Paddington	4	5	9	44.4%	56%
Rowan	2	1	3	66.7%	33%
Singlehurst Day Ward	2		2	100.0%	0%
Spencer	3		3	100.0%	0%
Talbot Butler	5	1	6	83.3%	17%
Victoria	13	1	14	92.9%	7%
Willow	12		12	100.0%	0%
Grand Total	**283**	**41**	324	87.3%	13%

Inpatient Services received 324 comments for the month of March, 87.3% of which were positive, and 13% were negative. It is important to consider the amount of comments received for each of the areas when looking at the positive and negative split. Hawthorn Ward continues to receive a high amount of comments, obtaining 83 for the month of March. Out of these, 83.3% were positive (n=72) and 13% were negative (n=11). Benham Ward obtained 26 comments, and of these only 1 was a negative comment, this is with a score of 74 – far improved from the score of 47 received in February. Willow Ward obtained 12 comments, with all of them being positive. Victoria ward received 14 responses, with just 1 (17%) being negative.

Of concern are Paddington Ward who received 9 comments, 5 (56%) of which were negative. Creaton Ward also obtained 5 comments, with 3 (60%) of these being negative.

A&E

Count of Positive	Count of Negative	Total	% Positive	% Negative
79	17	96	82.3%	18%

Due to the environmental changes in the hospital for A&E March is the first month that minors and majors have been placed together. They received 96 comments in total, 82.3% of those were positive and 18% were negative.

Maternity

Row Labels	Count of Positive	Count of Negative	Total	% Positive	% Negative
Antenatal Community	37	6	43	86.0%	14%
Balmoral	23	2	25	92.0%	8%
Birth Centre	38		38	100.0%	0%
Home Birth	10		10	100.0%	0%
Labour Ward	130	2	132	98.5%	2%
Maternity Obs Ward	11		11	100.0%	0%
Postnatal Community	41	2	43	95.3%	5%
Robert Watson Ward	101	7	108	93.5%	6%
Grand Total	**391**	**19**	410	95.4%	5%

Maternity services continue to see high levels of satisfaction, obtaining the highest amount of comments, and also the best positive negative split with 95.4% of the 410 comments received being positive. Of particular interest are the 38 comments received from the Birth Centre, all of which were positive. The same for the Home Birth team who received 10 positive comments and Maternity Observation Ward who received 11 positive comments. Of a 132 comments received on Labour Ward just 2 were negative.

Eye Casualty

Row Labels	Count of Positive	Count of Negative	Total	% Positive	% Negative
Eye Casualty	186	4	190	97.9%	2%

As with Maternity, Eye Casualty also saw another month of high satisfaction with 190 comments and only 4 (2%) of which were negative.

Appendix 5 – Quarterly thematic triangulation

Friends & Family Test: Inpatients and Maternity Themes

The FFT comments are showing the following themes for Inpatient and Maternity services for Quarter 4:

Total No Received	**200**	
	No.	%
Environment	37	19%
Communication	36	18%
Clinical care	36	18%
Attitude & behaviour	27	14%
Discharge/transfer/referral	18	9%

Previously in Quarter 3 the themes identified were as follows:

Total No Received	**217**	
	No.	%
Communication	49	23%
Environment	46	21%
Attitude and Behaviour	29	13%
Discharge/transfer and referral	27	12%
Medication	13	6%

This shows that many of the same themes are being identified, although there has been some movement within the top 5. Quarter 4 saw Medication replaced with Clinical Care.

Friends & Family Test: A&E & Eye Casualty Themes

For Quarter 4, the themes most commonly seen within A&E and Eye Casualty were:

Total No Received	**55**	
	No.	%
Waiting Times	31	16%
Communication	8	4%
Attitude and Behaviour	7	4%
Clinical Care	3	2%
Car Parking	2	1%

For Quarter 3 they were as follows:

Total No Received	**107**	
	No.	%
Waiting Times	53	24%
Communication	14	6%
Attitude and Behaviour	13	6%
Clinical Care	9	4%
Environment	7	3%

This shows very little change in the order of the themes, with the only change being Environment replacing Car Parking as the 5th theme.

PALS Themes

PALS identified their top 5 below for Quarter 4;

Total No Received	**277**	
	No.	%
Delays/Cancellation	78	28%
Clinical care	56	20%
Discharge/Transfer	52	19%
Communication	24	9%
Waiting Times	16	6%

For Quarter 3 they were as follows;

Total No Received	**294**	
	No.	%
Delays/Cancellation	56	19%
Communication	46	16%
Discharge/Transfer	37	13%
Waiting Time	34	12%
Clinical Care	32	11%

There has been an increase in the amount of contacts received into PALS regarding Clinical Care, taking this up from 5th theme in Quarter 3 to 2nd in Quarter 4. Delays and cancellations remains the largest theme.

Complaints Themes

In Quarter 4 the following themes were identified for complaints:

Total No Received	**138**	
	No.	%
Clinical Care	69	50%
Discharge	24	17%
Delays	8	6%
Attitude & Behaviour	7	5%
Communication	2	1%

In Quarter 3 the themes were as follows:

Total No Received	**325**	
	No.	%
Clinical Care	58	18%
Delays/Cancellations	19	6%
Attitude & Behaviour	16	5%
Communication	15	5%
Discharge	10	3%

Appendix 5 – Quarterly thematic triangulation

Complaints regarding discharge appear to have increased during Quarter 4, taking this from being the 5th largest theme in Quarter 3 to the 2nd largest theme. Clinical care continues to be the dominant theme for both quarters. Noticeably, there are no changes in the themes themselves, just within the ranking of them.

Incidences Themes

The following themes were identified for Incidences and Serious Incidents in Quarter 4

Incidents (with final approval as at 08.04.14)		
Total No Incidents	**2350**	
	No.	%
Implementation of care or ongoing monitoring/review	534	23%
Accident that may result in personal injury	453	19%
Infrastrucure or resources	221	9%
Medication	200	9%
Labour of delivery	174	7%

Serious Incidents (STEIS category)		
Total No Incidents	**33**	
	No.	%
Pressure Ulcer - Grade 3	22	67%
Slips, trips falls	4	12%
Unexpected death	3	9%
Sub-optimal care of the deteriorating patient	1	3%
Maternity service	1	3%

For Quarter 3 these were:

Incidents (with final approval)		
Total No Incidents	**2553**	
	No.	%
Implementation of care or ongoing monitoring/review	555	22%
Accident that may result in personal injury	510	20%
Infrastructure or resources (staffing, facilities, environment)	252	10%
Medication	222	9%
Access, appointment, admission, transfer, discharge	187	7%

Serious Incidents (STEIS category)		
Total No Incidents	**42**	
	No.	%
Pressure Ulcer - Grade 3	22	52%
Slips, trips an falls	5	12%
Unexpected death	4	10%
Premature discharge	2	5%
Other	2	5%

For incidences the main change in the themes identified is the replacement of Access, appointment, admission, transfer and discharge as the 5th theme with Labour and Delivery.

For serious incidences, premature discharge and 'other' are replaced in the 4th and 5th themes with Sub-optimal care of the deteriorating patient and Maternity service.

Triangulated Themes

Clinical Care

When reviewing the information collectively it can be identified Clinical Care is identified as a theme within Complaints, PALS and FFT. In addition to this Implementation of care or ongoing monitoring/ review has been identified as the number 1 theme in incidences, and number 3 within serious incidences.

Breaking this down further, PALS identified communication, investigations and inadequate monitoring as the 3 sub themes within Clinical Care. Complaints identified communication, medical opinion and medical procedure. FFT for Inpatient and maternity found issues with nursing care, length of time to respond, and advice & information given. For incidences, the top 3 clinical care sub-themes were; implementation of care or ongoing monitoring review, accident that may result in personal injury, infrastructure or resources. For serious incidences these were; Pressure Ulcer Grade 3, slips, trips & falls, unexpected death

Discharge

Discharge was again identified fro Quarter 4 by PALS, Complaints and FFT Inpatients as a top 5 theme, with PALS receiving 52 contacts regarding discharge in Quarter 4. Complaints received 24 complaints and 18 patients expressed their dissatisfaction with the discharge process within the FFT feedback forms.

Communication

Communication is another theme which has reoccurred from Quarter 3 with PALS, Complaints and FFT all identifying issues within this area. PALS received 24 contacts, complaints received 2 complaints. FFT in Inpatients and Maternity saw 36 patients raise issues with communication and 8 patients within A&E and Eye Casualty. Communication issues are also seen within the sub-themes for clinical care both within PALS and Complaints.

Appendix 5 – Quarterly thematic triangulation

TOP 5 THEMES - COMPLAINTS, PALS, PATIENT EXPERIENCE, INCIDENTS & SI's

Complaints			PALS			FFT Comments (Inpatient & Maternity Departments)			FFT Comments A&E Departments)			Incidents (with final approval as at 08.04.14)			Serious Incidents (STEIS category)		
Total No Received	**138**		**Total No Received**	**277**		**Total No Received**	**200**		**Total No Received**	**55**		**Total No Incidents**	**2350**		**Total No Incidents**	**33**	
	No.	%		No.	%		No.	%		No.	%		No.	%		No.	%
Clinical Care	69	50%	Delays/Cancellation	78	28%	Environment	37	19%	Waiting Times	31	16%	Implementation of care or ongoing monitoring/review	534	23%	Pressure Ulcer - Grade 3	22	67%
Discharge	24	17%	Clinical care	56	20%	Communication	36	18%	Communication	8	4%	Accident that may result in personal injury	453	19%	Slips, trips falls	4	12%
Delays	8	6%	Discharge/Transfer	52	19%	Clinical care	36	18%	Attitude and Behaviour	7	4%	Infrastrucure or resources	221	9%	Unexpected death	3	9%
Attitude & Behaviour	7	5%	Communication	24	9%	Attitude & behaviour	27	14%	Clinical Care	3	2%	Medication	200	9%	Sub-optimal care of the deteriorating patient	1	3%
Communication	2	1%	Waiting Times	16	6%	Discharge/transfer/referral	18	9%	Car Parking	2	1%	Labour of delivery	174	7%	Maternity service	1	3%

CLINICAL CARE - TOP THREE THEMES

Complaints			PALS			FFT Comments			FFT Comments			Incidents (with final approval as at 8.4.14			Serious Incidents (STEIS category)		
Total No Received	**69**		**Total No Received**	**56**		**Total No Received**	**36**		**Total No Received**	**3**		**Total No Incidents**	**2350**		**Total No Incidents**	**33**	
	No:	%		No.	%		No.	%		No.	%		No.	%		No.	%
Communication	11	16%	Communication	18	32%	Nursing care	7	19%	Length of time to respond	2	6%	Implementation of care or ongoing monitoring review	534	23%	Pressure Ulcer Grade 3	22	67%
Medical Opinion	9	13%	Investigations	8	14%	Length of time to respond	6	17%	Pain Management	1	3%	Accident that may result in personal injury	453	19%	Slips, trips & falls	4	12%
Medical Procedure	11	16%	Inadequate Monitoring	6	11%	Advice and Information	5	14%			0%	Infrastructure or resources	221	9%	Unexpected death	3	9%

TRUST BOARD
24 APRIL 2014

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

Executive summary

The Trust has not achieved the following standards during March 2014; Urgent Care 4 hour standard and the following cancer standards; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 62 day standard (from urgent GP referral). Unvalidated data indicates the Trust has not achieved the following cancer standards for quarter 4; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 31 day subsequent drug treatment and the 62 day standard (from urgent GP referral).

The Trust has achieved 18 week RTT across all specialties and T&O have achieved 97.8% for admitted patients against the standard of 95%. The number of patients waiting over 26 weeks from referral has reduced in March to 37.

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

Enclosure G

Actions required by the Board

The Board is 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	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4
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%	91.72%	93.78%	94.57%	N/A	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%	98.45%	98.32%	98.57%	N/A	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%	96.90%	95.87%	97.10%	N/A	N/A	N/A	N/A
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	19	30	47	45	55	37	N/A	N/A	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0	0	0	N/A	N/A	N/A	N/A
RTT T&O Admitted	CCG & TDA	90%	91%	90%	91%	90%	90%	90%	62%	64%	77%	71%	87%	98%	N/A	N/A	N/A	N/A
RTT T&O Non-Admitted	CCG & TDA	95%	95%	95%	95%	98%	95%	95%	93%	96%	96%	96%	96%	96%	N/A	N/A	N/A	N/A
RTT ENT Admitted	CCG & TDA	90%	93%	95%	92%	97%	96%	95%	93%	92%	95%	87%	90%	94%	N/A	N/A	N/A	N/A
RTT ENT Non-Admitted	CCG & TDA	95%	97%	98%	96%	99%	98%	98%	98%	98%	99%	97%	96%	98%	N/A	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%	100%	100%	100%	N/A	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%	100%	100%	98%	N/A	N/A	N/A	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	2
*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%	85.49%	81.16%	90.43%	N/A	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%	91.33%	90.47%	90.47%	91.63%	92.50%	92.01%	91.80%
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%	93.70%	93.40%	90.90%	95.87%	95.74%	96.76%	92.64%
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%	58.50%	86.00%	100.00%	99.65%	99.55%	81.94%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	95.70%	86.30%	93.20%	98.12%	97.76%	98.56%	92.57%
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%	82.80%	78.60%	100.00%	98.15%	98.08%	100.00%	88.61%
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%	95.20%	96.60%	100.00%	99.40%	100.00%	100.00%	97.22%
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%	99.20%	93.80%	96.20%	97.73%	97.30%	96.66%	98.50%
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%	100.00%	95.70%	94.40%	94.12%	98.72%	98.04%	96.72%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	85.60%	83.90%	86.60%	79.50%	73.80%	79.20%	82.04%	83.44%	85.30%	78.09%
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%	84.00%	92.00%	82.00%		70.00%	79.76%	77.94%	77.94%
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%	96.67%	91.00%	90.00%	89.09%	88.95%	87.88%	91.22%	91.22%
Trolley Waits waiting > 12hours	CCG	0	0	0	0	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	901	1021	1165	N/A	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	316	372	410	N/A	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	93	144	90	N/A	N/A	N/A	N/A

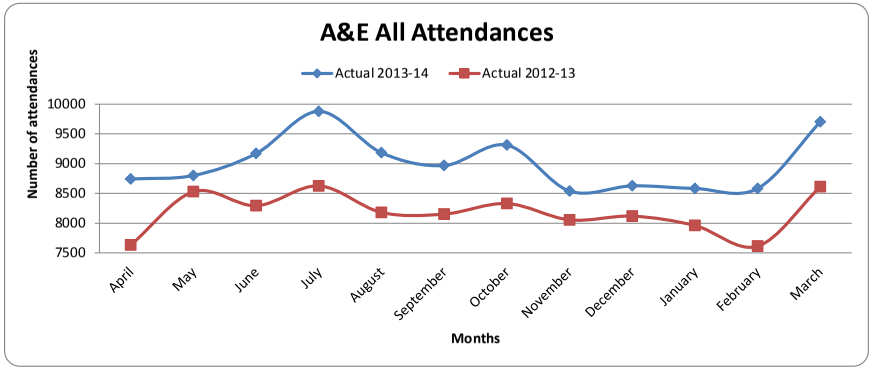
* A&E data is calendar month.

The Trust has not achieved the following standards during March 2014; Urgent Care 4 hour standard and the following cancer standards; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 62 day standard (from urgent GP referral). Unvalidated data indicates the Trust has not achieved the following cancer standards for quarter 4; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 31 day subsequent drug treatment and the 62 day standard (from urgent GP referral).

The Trust has achieved 18 week RTT across all specialties and T&O have achieved 97.8% for admitted patients against the standard of 95%. The number of patients waiting over 26 weeks from referral has reduced in March to 37.

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



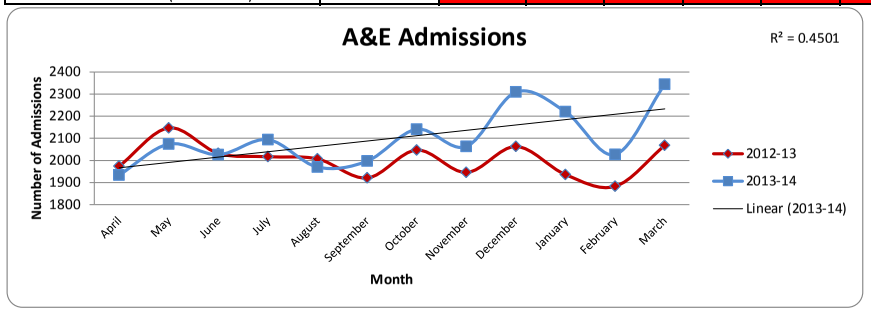
In March 2014, NGH employed McKinsey & Company to provide acceleration and realignment of the internal Urgent Care Programme to improve efficiencies. The cumulative work is leading to a 'Breaking the Cycle' week starting on the 28th April, where all new processes and treatments will be fully implemented, creating a 'new and sustainable normal' for the entire Trust.

The actions from the last two Urgent Care Programme Board meetings were detailed in the Urgent Care paper presented to IHGC. In summary the team have evaluated and realigned the existing work streams to focus the following areas:

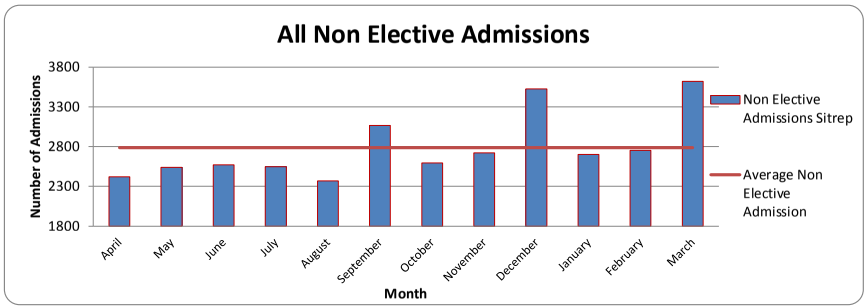
- 7 day Services
- Keeping patients safe in ED
- Keeping patients safe in Assessment units and ACC
- Keeping patients safe on the wards
- Complex Discharges
- Frail and Elderly pathway
- Capacity Management
- Performance Management

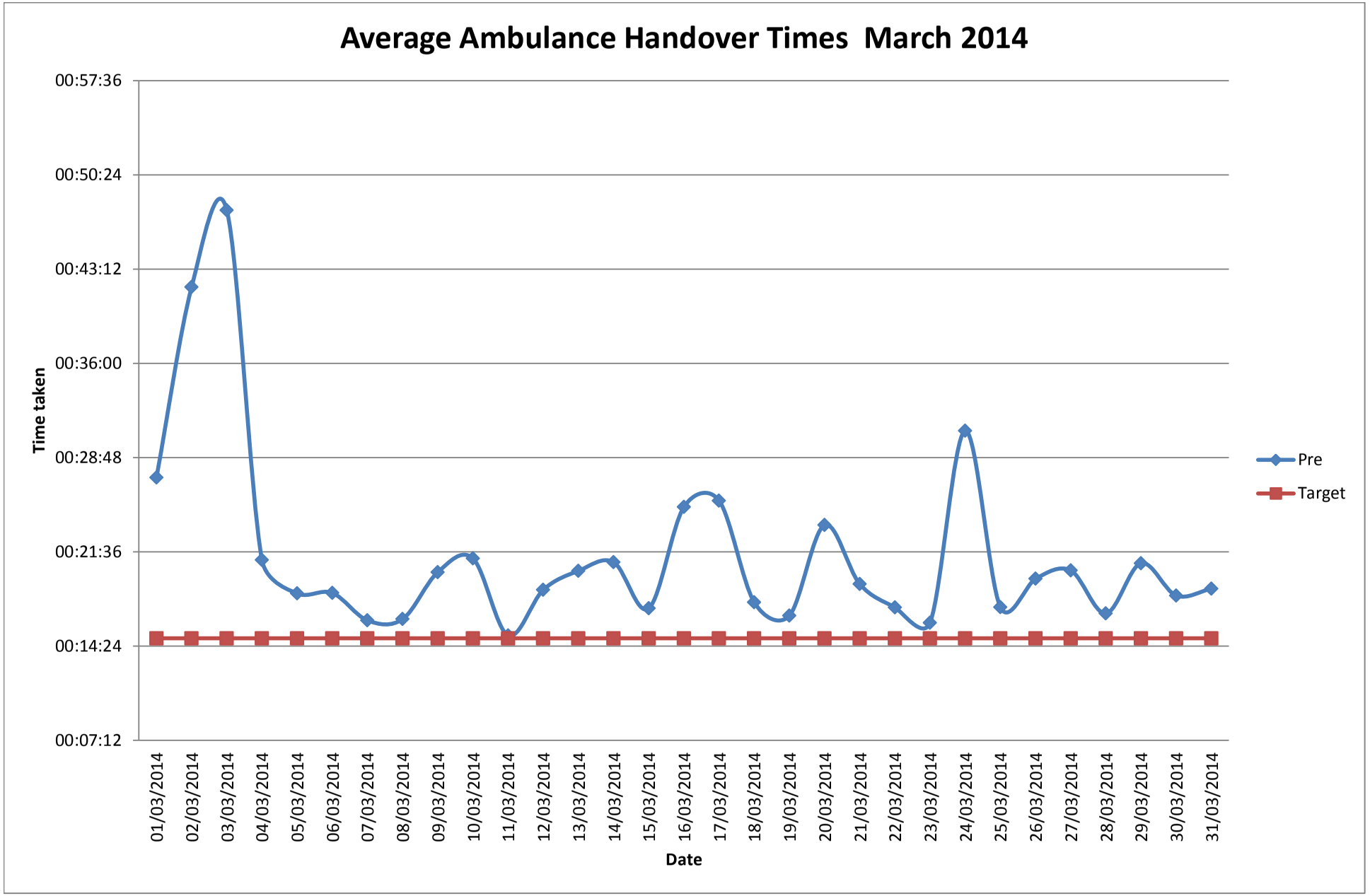
The cumulative work is leading to a 'Breaking the Cycle' week starting on the 28th April, where all new processes and treatments will be fully implemented, creating a 'new and sustainable normal' for the entire Trust.

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%	85.5%	81.2%	90.4%
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%	91.3%	90.5%	90.5%



* Note: Total Admissions from the Symphony system




Average Ambulance Handover Times March 2014
00:57:36
00:50:24
00:43:12
00:36:00
00:28:48
00:21:36
00:14:24
00:07:12
Time taken
01/03/2014
02/03/2014
03/03/2014
04/03/2014
05/03/2014
06/03/2014
07/03/2014
08/03/2014
09/03/2014
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26/03/2014
27/03/2014
28/03/2014
29/03/2014
30/03/2014
31/03/2014
Date
Pre
Target

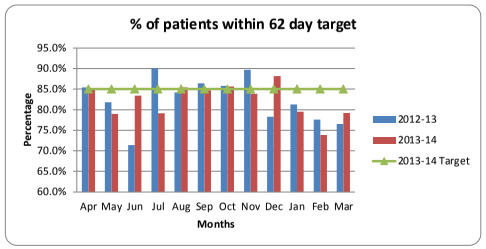
Enclosure G

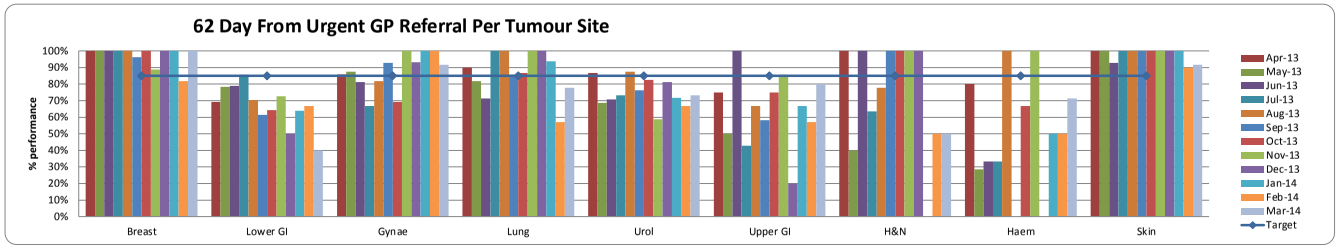
Cancer

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	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4
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%	93.70%	93.40%	90.90%	95.87%	95.74%	96.76%	92.64%
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%	58.50%	86.00%	100.00%	99.65%	99.55%	81.94%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	95.70%	86.30%	93.20%	98.12%	97.76%	98.56%	92.57%
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%	82.80%	78.60%	100.00%	98.15%	98.08%	100.00%	88.61%
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%	95.20%	96.60%	100.00%	99.40%	100.00%	100.00%	97.22%
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%	99.20%	93.80%	96.20%	97.73%	97.30%	96.66%	98.50%
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%	100.00%	95.70%	94.40%	94.12%	98.72%	98.04%	96.72%
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%	79.50%	73.80%	79.20%	82.04%	83.44%	85.30%	78.09%

During March the Trust did not achieve the following standards; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, and the 62 day standard (from urgent GP referral). All standards apart from the 62 standard were affected by the reduction in capacity in the Breast service. A locum is now in place and the waiting times are being met. Unvalidated data indicates the Trust has not achieved the following cancer standards for quarter 4; 2ww referrals for suspected cancer, 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 31 day subsequent drug treatment and the 62 day standard (from urgent GP referral).

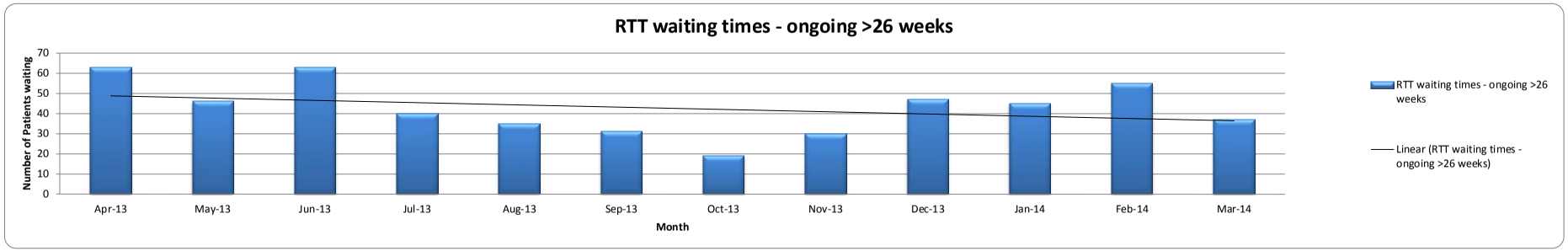
In recent weeks a visit has been undertaken to University Hospitals of Leicester NHS Trust who have experienced similar issues in previous years but who have been successful in rectifying performance. A paper detailing actions to recover the 62 day standard was presented to IHGC.



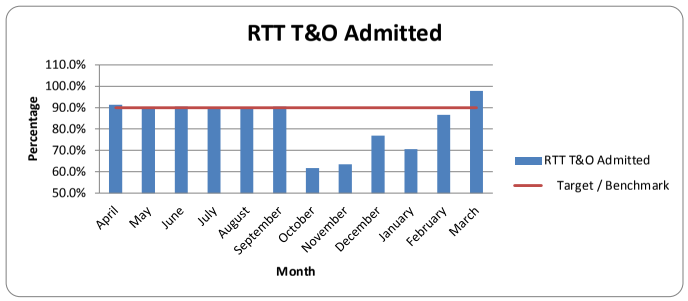


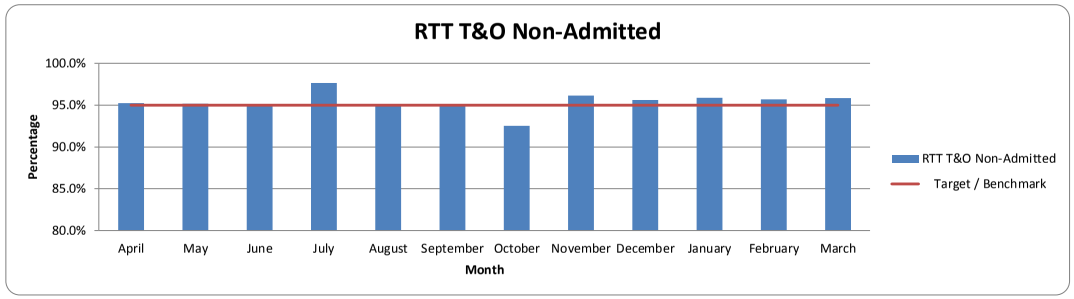
RTT Waiting Times

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	Jan-14	Feb-14	Mar-14
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	19	30	47	45	55	37
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0	0	0



Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	April	May	June	July	August	September	October	November	December	January	February	March
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%	70.6%	86.6%	97.8%
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%	95.9%	95.7%	95.8%
RTT ENT Admitted	CCG & TDA	**90%**	92.9%	95.5%	91.9%	96.5%	95.7%	94.7%	92.9%	92.0%	95.5%	87.1%	90.5%	93.8%
RTT ENT Non-Admitted	CCG & TDA	**95%**	96.5%	98.0%	96.1%	99.2%	98.1%	97.8%	98.4%	98.0%	98.6%	97.0%	95.7%	97.6%





Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 APRIL 2014

Title	Urgent Care Report
Agenda item	11
Sponsoring Director	Deborah Needham, Chief Operating Officer
Author(s)	Richard Wheeler, Urgent Care Project Manager
Purpose	Assurance

Executive summary

In March 14, NGH commissioned McKinsey&Company to provide acceleration and realignment of the internal Urgent Care Programme.

The cumulative work is leading to a 'Breaking the Cycle' week starting on the 28th April, where all new processes and treatments will be fully implemented, creating a 'new and sustainable normal' for the entire Trust.

Over the past 4 weeks, the Trust and McKinsey have been building on the existing Urgent Care structure, realigning and adding to what exists and identifying the most urgent 'treatments' to be addressed within each work stream. Performance metrics have also been reviewed following the McKinsey recommendation of less but most relevant data.

This report details the work streams and subsequent treatments as slides. These slides are used at each Urgent Care Board. (The slides attached were used on the 16th April 2014). In addition, a slide has been created to show the progress being made within the 7 day services work stream which is ongoing and will be fully incorporated into the Urgent Care Programme once McKinsey support is complete.

Related strategic aim and corporate objective	All
Risk and assurance	Risk to the delivery of national targets and quality of care
Related Board Assurance Framework entries	BAF 10
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

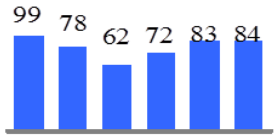
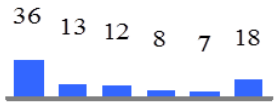
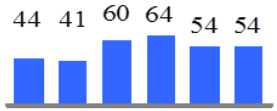
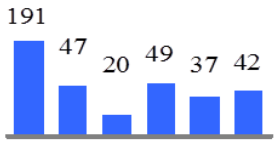
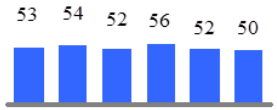
Actions required by the Board

The Board is asked to note the report and seek areas for clarification.

1 Keeping patients safe in A&E

Weekly update – 16/4/14

Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a **Early senior input in the ED**	• Continue to refine FIT process & extend hours to 11-7 from next week • Review roster for break the cycle weeks to ensure maximum impact	Fitting implemented untill 19.00 where roster allows At a glance Dr's roster updated and disseminated. Nursing shifts reviewed, additional shifts added	TOTAL time to 1st ass'ment, min 	• Continue to embed fit process
b **Actively manage operational flow**	• Improve communication of bed state to night team • Define SOP for safety rounds • Refine & implement escalation protocol	Briefing sheet with safety round guidelines given to NIC and senior Drs NIC attendance to clinical safety huddle.	# Breaches due to ED 	• Email requested for NIC computer continue to chase • Formalise escalation actions for ED and disseminate action cards
c **Improve shift consistency of productivity**	• At 8am handover, consultant to question night team on every patient who has been there longer than 1 hour without a 1st assessment	Email sent to senior Drs on nights to fit for last 30 mins to gain insight on depart whilst achieving 1st assess time Consultant question night team at handover	Av.# 1st assessments 6-8am 	• Continue to monitor performance and review fill rate of 7am shift.
d **Improve joint working with specialties**	• Review escalation process for specialty response • Engage with EAU workstream to implement GP direct access • Get symphony on SAU	Email sent to CD for surgery regarding implementation of symphony on SAU and suggested one point of contact for referrals on Hawthorn	# Spec. referral breaches 	
e **Streamline clerking & triage**	• Ensure processes to stream patients continue to run	Continue x2 nurses on triage when staffing allows Senior Dr to allocate GP workload for 11 am Planning meeting with CCG and IC24 for implementation May 14	Av. % patients in minors 	• Formalise process and documentation with IC24 for May implementation

2 Keeping patients safe in EAU and Benham

Weekly update – 16/4/14

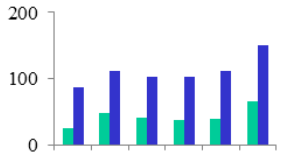
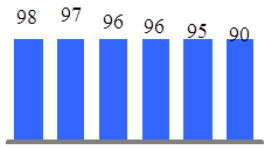
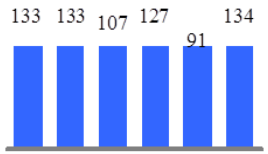
Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a **Increase flow through EAU early in the day**	• Night staff to help prioritize order of patients to be seen on post-take round • Continue to refine '1-stop' nature of post-take ward round and make process more robust	• Organized typing to be received in dedicated folder • Returned to full complement of COW for Benham	# Pre-12pm disch. from EAU/ Benham 40 56 44 45 46 57	• Ensure permanent cover for secretarial support • Work with IT on spare COW for EAU/Benham • Continue to reinforce one-stop strategy
b **Actively manage operational flow**	• Clarify working practices of different ward roles with respect to patient flow • Forward planning of staffing rotas every Friday to ensure adequate ward cover	• Discussed need for single process followed by all trackers • Senior sisters reminded to forward plan roster.	Median ALoS for ward patients 26 26 29 27 28 20	• Tracker trial WC 21/04/14
c **Improve joint working with specialties**	• Develop and agree an escalation policy in conjunction with site management team for delayed or rejected ward transfers from EAU/Benham	• Draft statement completed and under review for discussion/changes	#Patients staying over 24 hours 22 25 23 21 30 25	• Confirm statement and distribute
d **Standardise care across EAU & Benham**	• Agree model of nursing on assessment units and need for protected staffing for ward rounds • Re-focus ward culture on 'assessment and flow'	• Discussed with matrons the need for protected staffing. • with senior nursing team to reiterate importance of working differently.	Activity on Benham / EAU 200 100 0	• Instill and promote assessment areas being utilised to create flow and relieve pressure from ED
e **Alternative routes to increase flow through ED**	• Co-develop GP referral process with medical CD, ED and ambulatory care	• Draft proposal pathway being discussed internally for GP-expected patients to bypass ED	#Direct admission GP referrals **Data to follow**	• Confirmation and implementation after being agreed.

3 Safe care for patients on wards

Weekly update – 16/4/14

Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a **Improve ward round efficiency**	• Liaise with medical staff and agree the role and responsibly of ward nurse • Draw up an agreement between ward nurses and consultants 'Marriage agreement'	• Consultant leads identified for every ward • Partnership Agreement in development	% discharges pre 10am & 12pm 	• Implement and embed joint partnership of the wards • Identify useful metrics for wards
b **Actively manage operational flow**	• Collect occupancy data for discharge lounges and review the impact of the new lounges on discharges • Test and refine operational rhythm	• Use of the satellite discharge lounges is variable. Data collected. Required role clarity – Victoria, Benham, EAU, Collingtree, Heart Centre	Bed Occupancy % 	• Identify patients for the discharge lounge with an exception only for unsafe patients
c **Address delay in patient pathway**	• Conduct an audit to understand the impact of lockable drug cabinets on wards and refine process in response. • Identify how to roll-out to medical wards	• To be completed by team • Further refinement of process required	# Patients staying over 7 days 	• Change in practice requiring further support from Senior Nursing Team
d **Build Senior Sister leadership capabilities**	• Work with senior shift leaders to identify the initiatives to deliver improvement in each area	• Implementation of twice daily safety huddles to develop daily operational rhythm and empower ward leaders – JD's being reviewed with HR clarifying responsibility & accountability	• N/A	• Refine safety huddle process

4 Complex discharges

Weekly update – 16/4/14

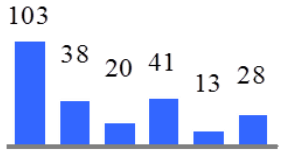
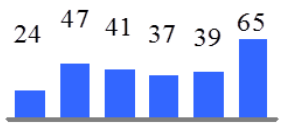
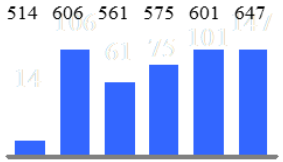
Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a **Anticipating patient needs early**	• Review and refine approach of early intervention on complex discharges	• Discharge facilitator in Assessment units • Identifying patients discharge needs and documenting on Yellow sheet & referrals completed	# Section 2s completed in EAU 17 patients identified & discharged within the units. 20 complex discharges identified, documented & referred on as needed.	• Continue to improve on numbers of discharges and referrals within these areas. • Attend Frail & Elderly MDT where possible.
b **Ensuring clearer case accountability**	• Provide appropriate training to EAU staff for the use of ward workspace • Refine requirement specification for changes to ward workspace in EAU	• Identified levels of care 1,2,3 • Identification of levels 1,2,3 to be sent to & inform wards information	Median average time from referral to assessment **Data to follow**	• Levels to be communicated to the wards and Ward coordinators • Also to communicate to the wards their responsibility for discharges at level 1 & 2 • Ensure Letter A & sign off sheet being completed
c **Improving internal process management**	• Develop an optimum process flow map and a plan to implement to it • Create a clear report on number of delayed discharges & causes	• Delayed discharge data given to Mckinsey to identify blocks. • Referrals once received are allocated the next day at DTA.	Median average time from referral to list **Data to follow**	• To communicate discharge flow chart to wards • Team to create education packs for wards.
d **Improving communication and engagement with providers**	• Conduct meetings with outside providers to create single version of truth • Understand where we can make quick changes to show delays in system to all parties	• Ongoing DTA meetings and workshops with external partners • Pathway identified at last workshop. • Daily Conference call to providers	Median average time from assessment to discharge **Data to follow**	• Attend DTA meeting & discuss data analyzed by Mckinsey on delays and services needed to facilitate • Communicate need for Care Manager in assessment units to senior member of NCC

5 Capacity Management

Weekly update – 16/4/14

Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a **Improve command and control and planning cycle.**	• Interim support manager in place to support clinical site management team. • Agree refinements to operational rhythm, roles and procedures.	• Meet matrons and senior nurses in two different forums and completed a random ward round to further motivate them to follow 2 before 10 process.	# breaches due to beds 	• Liaise with medical staff and agree the role and responsibility of a ward nurse.
b **Zero tolerance of patient moves out of hours from 22.00 – 07.00.**	• Develop a data base of all patient moves in and out of hours. • Develop a culture of zero tolerance of patient moves out of hours.	• Data base operational from the 1st April on the medicine shared drive and password protected. • Currently working towards no patient moves OOH.	# pre 10am discharges 	• Continue to maintain accurate data entry of all patient moves in and out of hours. Present an overview of times of patient moves.
c **Electronic data base of patient moves and risk assessment form for patient moves out of hours developed.**	• Implement an electronic database to track patient moves in and out of hours. • Implement a risk assessment form if patients are moved.		# weekly discharges 	
d **Integrated discharge team.**	• To amalgamate site • Management team, discharge team and HPT under one umbrella group.	• 1st Meeting with HPT on the 9th April. • Follow up meeting with NCC on Friday 11th April.		• Drive the amalgamation of the teams forward and review location of the new team.
e **Weekend Discharges – Lets get it right.**	• Mirror at weekends the discharge challenge at weekends as during the week.	• Work up terms of reference for weekend meetings .		• Visit KGH to observe the discharge at weekend processes and its successes.

6 Care of the elderly pathway

Weekly update – 16/4/14

Northampton General Hospital NHS
NHS Trust
URGENT CARE Programme

Treatment	What we said we'd do	What we did	6 week performance	Next steps
a Early appropriate assessment	• Co-develop care bundles with ED • Agree with ED how to trial care bundles	• Falls care bundle reviewed and amended with input from all parties for use in ED • Aiming for trial from 22nd April	FallsCare bundle assessments in ED **Data to follow**	• Falls care bundle to put intp use from 22nd April for 2 weeks trial
b EAU elderly care	• Ensure consultant post-take rota maximizes elderly consultant cover • Explore options for allocating post-take patients to specific consultants	• Consultant rota issued to maximise elderly care consultant cover • Meeting held to agree a process for allocation, plan circulated to all physicians	ALoS for patients >75 yrs om EAU and Benham 29 30 44 45 46 25	• Review numbers of patients allocated to elderly care physician and working practice /discharge rate/sustainability
c EAU MDT	• Trial MDT Board rounds on EAU and Benham at midday from Monday 9th April	• Started MDT meetings for elderly patients on EAU/Benham led by consultant from 14th April	#EAU pts >75yrs awaiting discharge Numbers seen and then discharged by ICT **Data to follow**	• Review working practice and attendees at MDT and effectiveness
d Expand short-stay elderly ward	• Identify similarities and differences in operational practices between Creaton and Brampton wards	• Creaton team attended MDTs on Brampton ward and look to identify suitable patients for their MDT linking with discharge teams	TBC **Data to follow**	• Recruit Crisis hub and ICT support for MDT on Creaton ward
e Facilitated discharge	• Clarify and agree the remit of Compton Ward	• Review current policy and meet to amend once working patterns for Creaton agreed	**Data to follow**	• Establish full pathway and links between Creaton/Brampton and Compton

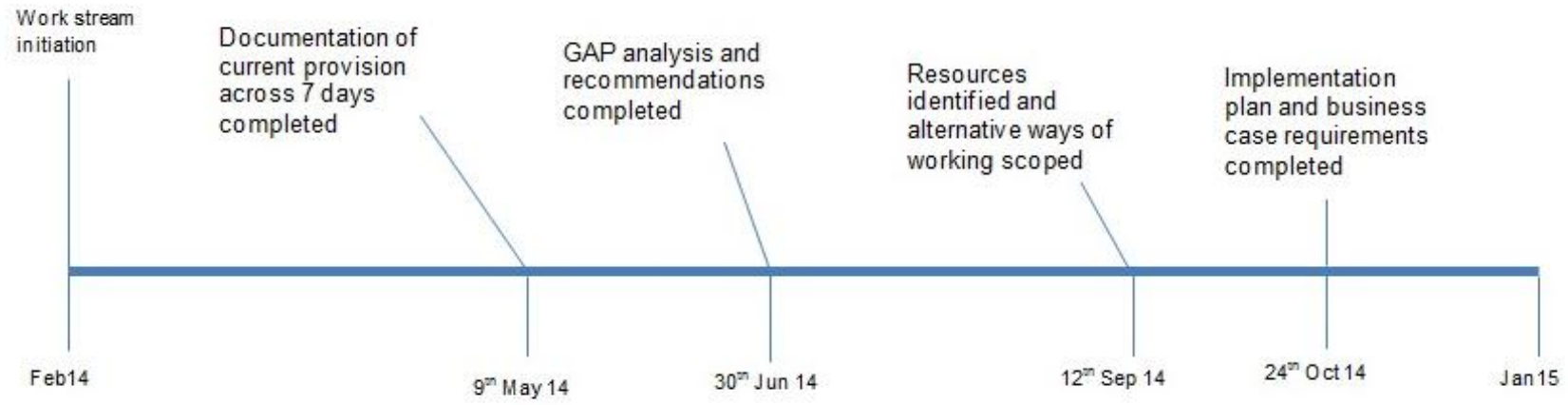
7 Day Services

The Urgent Care Programme is working towards achieving 7 Day Services in line with National requirements.

Formal meetings have been established and TOR agreed incorporating key departments/ services and external providers to ensure a system wide approach.

Staff are completing a GAP analysis to identify barriers to achieving professional standards 7 days a week.

The timeline below shows the plan for the forthcoming months.



These milestones reflect the CQUIN targets documented in the terms of reference

REPORT TO THE TRUST BOARD
24 April 2014

Title	Finance Report Month 12
Agenda item	12
Sponsoring Director	Simon Lazarus, Director of Finance.
Author(s)	Andrew Foster, Deputy DoF, David Bebb, Deputy DoF (Interim).
Purpose	To report the financial position and associated risks for the period to March 2014.

Executive summary

This report sets out the financial position for year ended March 2014.

The year to date I&E position is a normalised surplus of £197k. This position includes £4.5m of non-recurrent support from the TDA and a range of expenditure control measures set out in the financial recovery plan.

The financial position has been prepared based on the latest information available however it is noted that final agreement is subject to the validation and finalisation of a range of expenditure estimates which will be agreed during the next week.

Changes to the financial position are not expected to be material.
.

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

Actions required by the Board

The Board is asked to note the recommendations and actions contained in the report.

Enclosure I

Northampton General Hospital NHS
NHS Trust

Year end Financial Position
Month 12 2013/14

Report to
Trust Board
April 2014

Enclosure I

1. Performance against Statutory Duties & Key Issues

		YTD Actual	YTD TDA Plan	Variance	Forecast outturn	Full Year Plan	Variance
Statutory Financial Duties:		£'000	£'000	£'000	£'000	£'000	£'000
	Delivering I&E Breakeven duty	£197	£0	£ 197 Fav	£197	-£4,822	£ 5,019 Fav
	Achieving EFL (£000's)				£3,413	£3,413	£0
	Achieving the Capital Resource Limit (£000's)	£14,169	£14,221	£ 52 Fav	£14,221	£14,221	£0
Better Payment Practice Code:							
	Volume of Invoices	90.93%	95.00%	4.07% Adv	92.00%	95.00%	3.00% Adv
	Value of Invoices	93.45%	95.00%	1.55% Adv	93.00%	95.00%	2.00% Adv

Financial Performance

- Financial performance for the year ended March 2014 is a normalised surplus of £197k including £4.5m of TDA support. A range of recovery actions were also necessary to achieve this surplus.
- The performance is still subject to full validation of case mix and a small number of specific year end provision such as bad debts provisions and agreement of NHS balances. The financial position is not expected to change materially.
- The Trust is on course to achieve its statutory duty to achieve a balanced financial position.

Capital Expenditure

- Full year capital expenditure is £14.17m against a plan of £14.22m, a marginal underspend of £52k.
- An underspend against the CRL is allowable by the DH. The Trust has met its statutory duty not to exceed its CRL limit of £14.22m

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

- The Trust has maintained a positive cashflow position in the final quarter and is forecasting to manage resources within the prescribed External financing Limit subject to final year end agreements. The Trust is on course to achieve its statutory duty to not exceed its EFL.
- The Trust has continued to improve performance against the BPPC target after introducing process improvements in September 2013. This improvement has continued in March however cumulative performance remains marginally behind the 95% target. The Trust has just failed to achieve its statutory duty to pay 95% of suppliers within 30 days.

Key issues

- The Trust is on course to achieve all of the statutory duties required of an NHS Trust for FY2013-14.
- The position set out in this report remains subject to the completion of the audit of annual accounts by KPMG.
- A separate briefing setting out progress and key issues in relation to the annual accounts process is provided under separate cover.
- The Trust managed to perform within the forecast range predicted for expenditure in March. This combined with additional income and year end action plan has delivered a surplus of £197k for the financial year.
- In arriving at this figure the Trust has made an assessment both of existing provisions held on the balance sheet and of any new provisions required.
- The Trust will need to apply again for temporary borrowing in 2014-15 and an early assessment of the cashflow position for H1 is included in this report.

Actions

- Finalisation of key estimates and judgements in financial statements. Key areas of risk:
  - Agreement of NHS balances.
  - Case mix adjustments.
  - CEAC Provisions for notice of termination of hosting arrangements.
  - Bad debts and associated provisions.

- Commencement of external audit on 28th April for approval of Accounts at May Trust Board.

2.Financial Performance Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

KPIs	March		February	January
Continuity of Service Risk Rating	2	Monitor CSR Rating 2 ("Material risk")	2	2
EBITDA %	5.3%	% Earnings Before Interest, Tax and Depreciation.	4.0%	4.7%
Liquidity (days cover)	4	Liquidity cover based on latest Monitor guidance.	14	30
Surplus Margin	0.07%	% earnings after interest, tax and depreciation.	-1.34%	-0.77%
Pay / Income	64.3%	Total YTD Pay costs as % of YTD income.	65.1%	65.8%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	2,151	Surplus before impairment and donated assets.	(1,345)	609
Impairment and Donated Assets	(1,954)	Reduction due to revised DV indices.	(1,942)	(2,307)
Normalised Position	197	I&E position (before £1m recovery actions).	(3,286)	(1,699)
TDA Plan (Year to date)	(4,822)	Original Full year TDA Plan	(4,304)	(3,174)
CCG SLA Income Variance	7,912	CCG income is £7.9m above plan after TDA support.	4,540	1,193
TDA Normalised annual plan	0	Revsied Full year TDA control total.	0	0
Forecast EOY I&E postion	197	Current I&E forecast (incl. TDA £4.5m non-rec support).	(237)	0
EBITDA Performance	**£000's**		£000's	£000's
Variance from plan	837	Improvement after TDA support has been recongnised.	1,018	1,475
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	13,000	TDA Plan.	11,637	10,261
YTD Actual	11,451	Actual delivered to March.	10,212	9,377
% Delivered	88%	% delivery of Plan year to date.	88%	91%
LTF	11,451	Actual delivered to March.	11,544	11,769
Annual Plan	13,000	Annual CIP target.	13,000	13,000
LTF v. Plan	88%	Planned annual % delivery of Plan.	89%	91%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	14,169	Capital expenditure for year to £52k behind plan.	10,153	7,487
Committed as % of plan YTD	99.63%	% of plan committed for year to date.	96%	87%
Annual Plan	14,221	CRL increased (ICT/CEF/SWTF/Nurse Tech /Maternity fund bids).	14,221	14,109
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	3,188	Increase in non current assets. Additions exceeding depreciation.	984	1,637
Current assets	(8,718)	Reductions in cash and NHS debtors.	(142)	4,329
Current Liabilities	(10,111)	Reduction in accruals and creditors.	(3,329)	(2,266)
Cash	**£000's**		**£000's**	**£000's**
In month movement	(5,901)	Pay down of creditors and PDC to meet EFL.	1,173	3,037
In Year movement	0	To meet EFL target.	6,005	4,832
DH Temporary Loans	0	TBL Loan facility of £4m available but not accessed in 13/14.	0	0
Debtors Balance > 90 days	1,312	CRIPPS centre, MKPCT, NCA and Overseas Patients.	1,560	1,534
Creditors % > 90 days	0.00%	No material creditors over 90 days.	0.00%	0.00%
Cummalative BPPC (by volume) YTD	90.9%	BPPC improved in February but below 95% target.	90.7%	89.8%

Key issues

KPIs

- Shadow Continuity of Service risk rating is ?? (material risk). Monitor intervention would be monthly or greater monitoring with consideration for potential investigation.

I&E Position

- Underlying I&E position ahead of trajectory as additional income has been recognised from the cancer drugs fund and expenditure control measures have delivered ahead of forecast.

Cost Improvement Programme

- CIP programme delivery is £11.45m.Year to date performance now £1.55m behind plan of £13m.
- Further details set out on the current delivery and 2014/15 Plans are set out in the Transformation paper.

Capital

- Full year capital expenditure is £14.17m against a plan of £14.22m, a marginal underspend of £52k.

Statement of Financial position

- Non current assets increased 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 deteriorated in March with the reduction in cash balances to meet the EFL targets.
- Performance against EFL is in line with plan based on draft performance, noting that final balance sheet adjustments may lead to an undershoot.

3.Income and Expenditure Position

I&E Summary	Annual Plan 2013/2014	YTD Actual	YTD Plan	Variance to Plan	March 2013/14 Forecast	March 2013/14 Actuals
	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	244,162	231,750	12,412	20,524	22,893
Other Clinical Income	2,803	2,584	2,803	(218)	224	264
Other Income	26,031	25,204	26,031	(827)	2,267	2,544
Total Income	**260,584**	**271,950**	**260,584**	**11,367**	**23,015**	**25,701**
Pay Costs	(175,851)	(174,792)	(175,851)	1,059	(15,061)	(14,611)
Non-Pay Costs	(79,240)	(82,650)	(79,240)	(3,409)	(7,110)	(6,708)
CIPs	4,822	0	4,822	(4,822)	0	0
Reserves/ Non-Rec	(1,143)	0	(1,143)	1,143	0	0
Total Costs	**(251,413)**	**(257,442)**	**(251,413)**	**(6,029)**	**(22,170)**	**(21,319)**
EBITDA	**9,171**	**14,508**	**9,171**	**5,337**	**845**	**4,382**
					0	0
Depreciation	(10,184)	(10,425)	(10,184)	(241)	(873)	(832)
Amortisation	(10)	(10)	(10)	(0)	(1)	(1)
Impairments	0	2,257	0	2,257	0	17
Net Interest	29	31	29	1	2	3
Dividend	(4,106)	(4,210)	(4,106)	(104)	(352)	(373)
					0	0
Surplus / (Deficit)	**(5,100)**	**2,151**	**(5,100)**	**7,251**	**(379)**	**3,196**
Normalised Postion:						
Donated Assets	278	303	278	25	65	65
Impairments	0	(2,257)	0	(2,257)		(17)
I&E Position (before TDA support)	**(4,822)**	**197**	**(4,822)**	**5,019**	**(314)**	**3,244**

Financial Performance

- Financial performance for the year ended March 2014 is a normalised surplus of £197k including £4.5m of TDA support. A range of recovery actions were also necessary to achieve this surplus.
- The performance is still subject to full validation of case mix and a small number of specific year end provision such as bad debts and agreement of NHS balances. The financial position is not expected to change materially.

Key issues

Clinical Income (SLA and Other)

- Clinical income is £12.2m ahead of plan for the year. This is due to TDA support of £4.5m, Winter Pressures funding and over performance against agreed plans.

Other Income

- Other income has improved in month following the allocation of additional SIFT and NMET placement funding.

Pay Expenditure

- Pay was below the forecast set for March with reduced use of locum medical and nurse agency staff continue.

Non Pay Expenditure

- Non pay expenditure has met forecast after offset of the adjustments made to provisions

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.

Approval of Financial Statements

- The financial statement are subject to agreement of final year end balances and full validation of provisions. The financial performance is not expected to change materially.
- The Financial statements are also noted as subject to audit review.

7. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET FORECAST MONTH 12 2013/14	Balance at 31-Mar-13	Current Month Opening Balance	Closing Balance	Forecast end of year 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	5,961	5,968	7	5,968	5,968
IN YEAR MOVEMENTS	0	10,348	14,371	4,023	14,371	14,371
LESS DEPRECIATION	0	(9,593)	(10,435)	(842)	(10,435)	(10,435)
NET BOOK VALUE	**133,789**	**140,505**	**143,693**	**3,188**	**143,693**	**9,904**
CURRENT ASSETS						
INVENTORIES	4,934	5,287	5,109	(178)	5,109	175
RECEIVABLES						
NHS DEBTORS	4,103	7,393	3,568	(3,825)	3,568	(535)
OTHER TRADE DEBTORS	2,295	1,172	4,052	2,880	4,052	1,757
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(681)	(238)	(681)	(238)
CAPITAL RECEIVABLES	0	0	0	0	0	0
NON NHS OTHER DEBTORS	132	615	226	(389)	226	94
COMPENSATION DEBTORS (RTA)	2,514	2,624	2,585	(39)	2,585	71
OTHER RECEIVABLES	676	1,437	1,043	(394)	1,043	367
IRRECOVERABLE PROVISION	(515)	(515)	(439)	76	(439)	76
PREPAYMENTS & ACCRUALS	1,387	1,845	1,134	(711)	1,134	(253)
	10,149	**14,128**	**11,488**	**(2,640)**	**11,488**	**1,339**
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	4,342	10,347	4,447	(5,900)	4,447	105
NET CURRENT ASSETS	**19,425**	**29,762**	**21,044**	**(8,718)**	**21,044**	**1,619**
CURRENT LIABILITIES						
NHS	628	1,365	969	(396)	969	341
TRADE CREDITORS REVENUE	1,255	3,348	1,480	(1,868)	1,480	225
TRADE CREDITORS FIXED ASSETS	1,744	3,029	3,286	257	3,286	1,542
TAX AND NI OWED	1,769	3,463	3,430	(33)	3,430	1,661
NHS PENSIONS AGENCY	2,013	2,162	2,201	39	2,201	188
OTHER CREDITORS	495	351	385	34	385	(110)
SHORT TERM LOANS	669	716	626	(90)	626	(43)
ACCRUALS AND DEFERRED INCOME	6,132	12,346	6,766	(5,580)	6,766	634
PDC DIVIDEND DUE	36	1,784	0	(1,784)	0	(36)
STAFF BENEFITS ACCRUAL	786	786	811	25	811	25
PROVISIONS	3,501	1,952	2,518	566	2,518	(983)
PROVISIONS over 1 year	1,281	1,281	0	(1,281)	0	(1,281)
NET CURRENT LIABILITIES	**20,309**	**32,583**	**22,472**	**(10,111)**	**22,472**	**2,163**
TOTAL NET ASSETS	**132,905**	**137,684**	**142,265**	**4,581**	**142,265**	**9,360**
FINANCED BY						
PDC CAPITAL	100,115	101,507	103,611	2,104	103,611	3,496
REVALUATION RESERVE	32,486	35,745	35,727	(18)	35,727	3,241
DONATED ASSET RESERVE	0	0	0	0	0	0
GENERAL RESERVES	304	776	776	0	776	472
I & E CURRENT YEAR	0	(344)	2,151	2,495	2,151	2151
FINANCING TOTAL	**132,905**	**137,684**	**142,265**	**4,581**	**142,265**	**9,360**

DRAFT SoFP (as at March 2014)

Non Current Assets

- Increase in in non current assets of £3.2m as capital additions exceeds depreciation and the final quarter revaluation adjustment is now included.

Net Current assets

- Inventories increased by £0.1m.
- Reduction in NHS Debtors of £3.8m with increase of trade debtors of £2.8m reflecting year end processing and collections.
- Cash balance decreased by £5.9m to meet EFL targets.

Net Current Liabilities

- Decrease in net current liabilities as creditors have been paid down to meet EFL targets.
- Reduction in PDC creditors of £1.8m reflecting payment made in March.
- Accruals and deferred income reduced by £5.6m reflecting year end review and associated adjustments.

Financing

- General reserve movement relates to fixed asset indexation adjustment.

8. Capital Expenditure

Category	Approved Annual Budget 2013/14 £000's	Year to Date Month 12 M12 Plan £000's	M12 Spend £000's	Under (-) / Over £000's	Plan Achieved
Linear Accelerator Corridor	0	0	0	0	0%
Improving Birthing Environments	421	421	422	1	100%
Endoscopy	157	157	156	-1	99%
Urodynamics	159	159	159	0	100%
Haematology (Trust)	1	1	1	0	100%
Annual Strategic Planning Approvals	34	34	0	-34	0%
MESC	2,010	2,010	1,974	-36	98%
Estates	3,283	3,283	3,354	70	102%
IT	3,716	3,716	3,849	133	104%
Other	1,234	1,234	1,189	-44	96%
Carbon Energy Efficiency Fund (CEEF)	3,410	3,410	3,269	-141	96%
Total - Capital Plan	**14,424**	**14,424**	**14,371**	**-52**	**100%**
Less Charitable Fund Donations	-203	-203	-203	0	100%
Total - CRL	**14,221**	**14,221**	**14,169**	**-52**	**100%**
Resources - Trust Actual			99.63%		
Internally Generated Depreciation	10,448				
SALIX	277				
CEEF	2,760				
SHSWTF - Vitalpac	368				
SHSWTF - E Prescribing	174				
Maternity Care Settings Fund	42				
Nursing Technology	152				
Total - Available CRL Resource	**14,221**				

Key Issues

- The revised CRL limit including these adjustments has been set at £14.21m which includes additional funding from Carbon Energy Fund, Safer Wards and Safer Hospitals and the Nursing Technology Fund.
- Medical Equipment schemes have been advanced from 14/15 to ensure that the full CRL limit was used. This has created a small contingency of £0.5m in 14/15 to support immediate capital requirements.
- Full year capital expenditure is £14.17m against a plan of £14.22m, a marginal underspend of £52k.
- An underspend against the CRL is allowable by the DH. The Trust has met its statutory duty not to exceed its CRL limit of £14.22m

9. Receivables, Payables and BPPC Compliance

Narrative	Total at March £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	1,668	902	120	36	610
Receivables NHS	3,568	2,285	463	118	702
Total Receivables	**5,236**	**3,187**	**583**	**154**	**1,312**
Payables Non NHS	(2,900)	(2,778)	(118)	(4)	0
Payables NHS	(71)	(61)	(9)	0	(1)
Total Payables	**(2,971)**	**(2,839)**	**(127)**	**(4)**	**(1)**

Narrative	Total at February £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	1,172	279	219	48	626
Receivables NHS	5,263	4,010	97	222	934
Total Receivables	**6,435**	**4,289**	**316**	**270**	**1,560**
Payables Non NHS	(3,181)	(3,065)	(62)	(54)	0
Payables NHS	(42)	(29)	(7)	0	(6)
Total Payables	**(3,223)**	**(3,094)**	**(69)**	**(54)**	**(6)**

ANALYSIS OF BETTER PAYMENT PRACTICE CODE - MARCH 2014

Narrative	Number of Invoices	Analysis of Performance %	Value of Invoices £000's	Analysis of Performance %	Department
Total Paid	8,843		14,724		
On Time	8,821		14,716		
Processed by Payments Team	99.75%	99.75%	99.94%	99.94%	

N.B. Based on processing invoices comparing input date to payment date

Total Paid	8,843		14,724		
On Time	8,397		14,258		
Within Target Compliance	94.96%	94.96%	96.84%	96.84%	
Paid Late	446		466		

TOP TEN BY NUMBER & VALUE					
BAUSCH & LOMB SURGICAL (U.K) LIMITED	1	0.01%	58	0.39%	Capital
FOSSE HEALTHCARE LIMITED	22	0.25%	4	0.03%	Bank Office
HAYS SPECIALIST RECRUITMENT	46	0.52%	45	0.30%	Bank Office
JANSSEN-CILAG LIMITED	2	0.02%	41	0.28%	Pharmacy
KITE STAFF AGENCY	21	0.24%	12	0.08%	Bank Office
MAYDAY HEALTHCARE PLC	81	0.92%	19	0.13%	Bank Office
NHSBSA	1	0.01%	86	0.58%	Pharmacy
OLYMPUS KEYMED	4	0.05%	240	1.63%	Capital
PADSCA LIMITED	16	0.18%	2	0.01%	Bank Office
PERTEMPS RECRUITMENT PARTNERSHIP LIMITED	23	0.26%	10	0.07%	Bank Office
Sub Total	217	1.96%	516	1.21%	
Sub Total - % of late approvals March 2014	96.91%		98.05%		
March - Cumulative Position		90.93%		93.45%	
February - Cumulative Position		90.46%		92.91%	
Improvement in Month (+)		0.47%		0.54%	

Receivables and Payables

- Continued progress in reducing non current debt.
- Key mandate payments have been made on time.
- Over 90 day debt of £1.3m has fallen by £0.2m in March. Balances include PCT legacy debt, CRIPPS , NCA's and Overseas Patients debt .
- Appropriate provision and write off has been made in accordance with the stated DH and local trust policies.

BPPC Compliance

- BPPC has continued to improve from last month to (90.93% by volume, 93.45% by value) with the payments team continuing to achieve processing within the targets once approved.
- Bank and agency invoices is improving and the delays encountered have been reviewed at care group and ward level
- The recent Issues encountered with the new pharmacy stock system which resulted in late payment of invoices has now been resolved
- Work has continued with areas of non compliance to develop a satisfactory resolution.

10. Cash Flow and Working Capital

		ACTUAL												FORECAST 14/15		
MONTHLY CASHFLOW	**Annual**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**			
RECEIPTS																
SLA Base Payments	225,991	17,721	19,030	15,721	23,380	19,172	17,506	23,166	17,522	17,434	21,133	17,031	17,174	19,533.00	19,533.00	19,533.00
SLA Performance / Other CCG investment	12,322	0	0	0	0	0	0	650	2,253	2,336	1,173	4,474	1,436	0.00	0.00	0.00
Health Education Payments (SIFT etc)	9,067	22	1,511	764	664	728	781	672	856	803	685	715	866	812.00	812.00	812.00
Other NHS Income	19,602	2,923	877	1,596	616	1,709	1,154	1,804	1,817	1,351	1,606	1,885	2,264	1,950.00	600.00	841.00
PP / Other (Specific > £250k)	635	0	0	329	0	0	0	0	0	0	0	0	306	0.00	0.00	0.00
PP / Other	11,354	892	1,096	655	758	857	1,142	1,030	965	1,179	1,078	807	897	1,100.00	883.00	1,100.00
Salix Capital Loan	277	0	0	0	0	0	0	0	0	95	0	95	87	0.00	0.00	0.00
EFL / PDC	3,496	0	0	0	0	0	0	0	0	853	539	0	2,104	75.00	75.00	75.00
Temporary Borrowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	0.00	0.00
Interest Receivable	32	3	3	2	2	3	2	2	3	3	4	3	2	2.00	2.00	2.00
TOTAL RECEIPTS	282,775	21,562	22,518	19,067	25,419	22,469	20,586	27,324	23,416	24,053	26,217	25,009	25,136	23,472	21,905	22,363
PAYMENTS																
Salaries and wages	165,512	12,168	13,743	13,749	13,881	13,870	13,823	13,886	13,899	13,982	14,202	14,233	14,076	14,250.00	14,500.00	14,500.00
Trade Creditors	79,456	4,499	7,344	5,805	5,704	7,029	5,603	7,551	7,011	6,636	7,102	6,569	8,603	4,500.00	7,500.00	7,500.00
NHS Creditors	20,311	1,617	1,296	1,619	2,197	2,295	1,642	1,876	1,614	1,908	1,243	980	2,022	1,800.00	1,800.00	1,800.00
Capital Expenditure	12,852	477	526	727	528	840	531	526	737	1,259	657	2,052	3,992	334.00	639.00	986.00
PDC Dividend	4,246	0	0	0	0	0	2,089	0	0	0	0	0	2,157	0.00	0.00	0.00
Repayment of Loans	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	0.00	0.00
Repayment of Salix loan	320	0	0	0	0	0	143	0	0	0	0	0	177	0.00	0.00	0.00
TOTAL PAYMENTS	282,697	18,761	22,909	21,900	22,310	24,035	23,831	23,840	23,262	23,785	23,204	23,834	31,027	20,884	24,439	24,786
Actual month balance	79	2,801	-392	-2,833	3,109	-1,565	-3,245	3,484	154	268	3,013	1,175	-5,890	2,588	-2,534	-2,423
Cash in transit & Cash in hand									120	-67	23	0	-11			
Balance brought forward	4,303	4,303	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	9,173	10,348	4,447	7,035	4,501
Balance carried forward	4,447	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	9,173	10,348	4,447	7,035	4,501	2,078

Key Issues

- Month end cash balance has reduced by £5.9m to £4.4m in order to support the achievement of EFL target.
- These cash balances are expected to meet the Trust External Financing Limits, noting that there are still a small number of balance sheet adjustments to made as part of the finalisation of the Trust Financial Statements.
- Q1 2014-05 cash balance forecast to remain positive but application for temporary borrowing required to be in place for Q2.
- Discussions with the TDA continue regarding the nature of the cash support required at the end of Q1 and whether this borrowing is temporary or permanent.
- Agreement has now been given by Nene CCG and EMSCG that the April payments will be made on time to support the payment of the Trust payroll commitments. This will provide sufficient liquidity during April to meet the Trust financial obligations.

REPORT TO THE TRUST BOARD
24 April 2014

Title	Workforce Report
Agenda item	13
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Joanne Wilby, Workforce Planning & Information Manager
Purpose	This report provides an overview of key workforce issues.

Executive summary

The key matters affecting the workforce include:

- The key performance indicators show an increase in Total Workforce Capacity (excluding Medical Locums) employed by the Trust, and a decrease in sickness absence.
- An update on both the Mandatory Training & Role Specific Essential Training Plan, and the Appraisal Action Plan.
- An update on the results of the 2013 National NHS Staff Survey
- Details of the recent Partnership Agreement
- An update on employment policies approved.

Related strategic aim and corporate objective	Enable Excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF 17.
Equality Impact Assessment	No
Legal implications / regulatory requirements	No

Actions required by the Board

The Board is asked to note the report.

Enclosure J

Trust Board meeting
24 April 2014

Workforce Report

1. Introduction

This report identifies the key themes emerging from March 2014 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 decreased by 0.14% in March to 4.39%, which remains above the Trust target.

The total sickness absence rate for the General Surgery Care. The sickness absence rate for General Medicine & Emergency Care increased very slightly.

Workforce Capacity: Total workforce capacity (excluding Medical Locums) increased by 59.94 FTE in March. The substantive workforce capacity increased by 5.38 FTE to 4184.77 FTE and the temporary workforce capacity (excluding Medical Locums) increased by 54.56 FTE to 323.53 FTE.

2.2 Workforce Information Update

Mandatory and Role Specific Essential Training Action Plan
Mandatory Training compliance in March is 75.51% achieving the Trust target of 75%. In view of the fact that the Trust target set at IHGC in October 2013 has now been achieved it is therefore proposed that a new target is set of 80% to be achieved by October 2014 and 85% in March 2015 which reflects the Quality Schedule unilaterally imposed by the CCG.

In response to the CQC Warning Notice on Mandatory Training and Role Specific Essential Training an action plan has been developed to address the concerns about Trust compliance rates. The actions include implementing a Mandatory & Role Specific Essential Training **Performance Wave** which requires Managers to provide assurance to General Managers and Directors that staff who are non-compliant with their training requirements have a clear plan to achieve compliance.

Role Specific Essential Training (RSET) has been defined as training that was previously mandatory in the first instance. The reporting, monitoring and assurance of RSET will be aligned to that of Mandatory Training using the Mandatory Training and Role Specific Essential Training Performance Wave. The current level of compliance for this training is 64.54%.
It is proposed that a target of 75% to be achieved is set for August 2014 and 85% is set for March 2015 in accordance with the Contract Quality Schedule.

In order to increase confidence of reports on RSET we are currently scoping and updating the Electronic Staff Records (ESR) system to ensure that all positions have the correct

competencies attached. There is also ongoing dialogue between ESR, McKesson and the Trust as there have continued to be system issues which have affected the ability to be assured of accurate reporting without additional scrutiny taking place on a regular basis.

Appraisal Action Plan

The appraisal process, linked to incremental pay progression, commenced on January 1st 2014 and is currently being embedded within the Trust. A monthly audit on the quality of appraisals undertaken will commence in May 2014. As a result of the CQC Warning Notice regarding Appraisal rates, an audit is currently underway to determine the level of in-date appraisals there are across the Trust. Managers have been advised that an appraisal must take place in April if staff do not have an up-to-date appraisal. If this date does not align to their incremental date then a further review must take place at the point in the year when their appraisal is due.

2013 National NHS Staff Survey

The Trust received responses from 351 staff members surveyed in the 2013 National NHS Staff Survey cycle, which constitutes a 42.4% response rate. Of the 28 key findings the Trust had none in the top 20% when compared to other Acute Trusts. Staff responses showed us as better than average for 2 of the key findings and average for a further 2. The Trust was worse than average for 4 of the key findings and in the bottom 20% of Acute Trusts for 20 key findings. This is an improvement on the 2012 survey whereby we had 24 key findings in the worst 20% of Acute Trusts. The Trust had two statistically significant improvements since 2012. There were no statistically significant deteriorations since 2012.

Attached is a summary of all the key findings. As you will be aware, the response to the Staff Survey is being addressed through the Organisational Development strategy.

Partnership Forum

On the 7 February 2014 the Director of Workforce and Transformation and the Chair of Staff Side, Rachel Forster, signed the Partnership Agreement on behalf of the Trust and our recognised Trade Unions/Professional Organisations. The Agreement is the result of 12 months of hard work by colleagues from Human Resources, management and our trade unions, to identify how we will forge a constructive and positive approach to joint working for the benefit of our staff and our patients. As a result of this the Joint Negotiating and Consultative Committee (JCNC) has been renamed to the Partnership Forum, effective from March 2014.

Policy Changes

The Appraisal Policy and Mandatory Training Policy have been ratified in March 2014.

3. Assessment of Risk

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

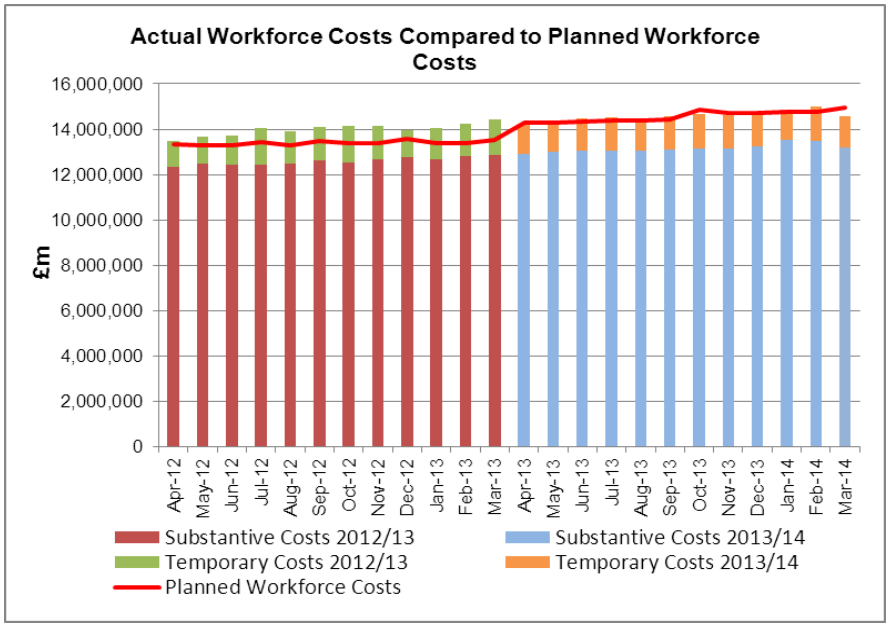
4. Recommendation

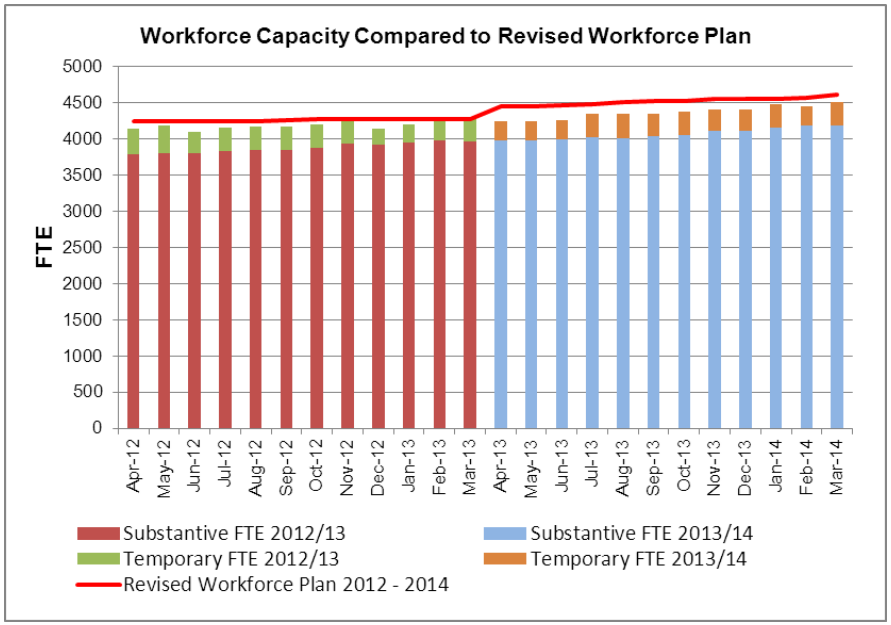
The Committee is asked to note the report.

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 12





	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	13521	13470	13193
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	1325	1530	1387
Planned Workforce Costs2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14876	14691	14710	14738	14752	14961

	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	4,149	4,179	4,185
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	334	269	324
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	4,558	4,564	4,619

Workforce Expenditure

Total Workforce Expenditure (all pay elements) decreased by £418,736 in March to £14.581m (this is below plan for Month 12).

Substantive workforce expenditure decreased by £276,660 to £13,193,434.

Temporary Workforce Expenditure (including Medical Staff) decreased by £142,076 to £1,387,459, equating to 9.52% of the of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **increased by 59.94 FTE in March to 4,508.30 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,618.68 FTE.**

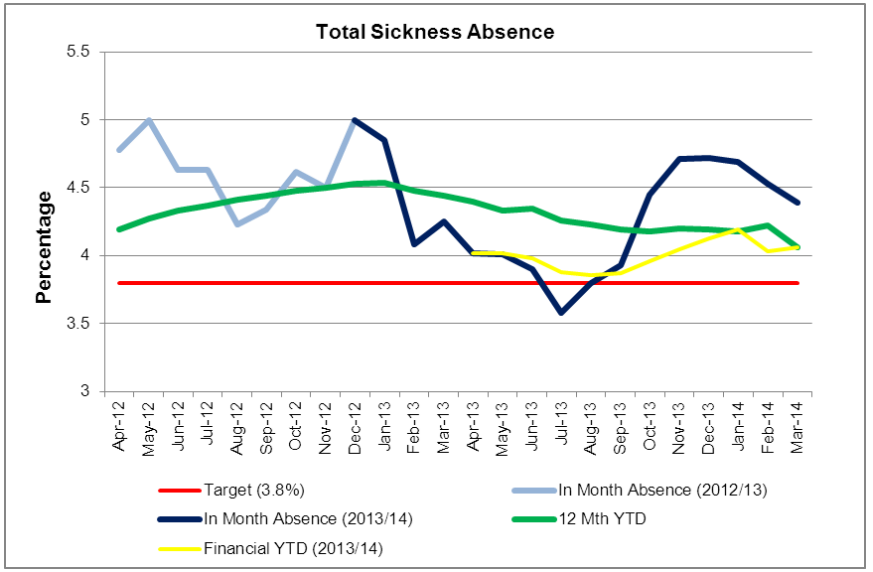
Substantive workforce capacity increased by 5.38 FTE to 4,184.77 FTE.

- Overseas recruitment from Spain continues; 32 RNs are due to commence in April 2014 and an additional 9 RNs are due to commence in May 2014.

Temporary workforce capacity (excluding Medical Locums) **increased by 54.56 FTE to 323.53 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 12

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Support Services
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	90.14%	89.53%	93.31%	84.06%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.21%	9.00%	6.42%	**3.90%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	97.14%	98.39%	99.72%	87.47%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	11.80%	15.70%	**7.63%**	11.81%



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	4.69	4.53	4.39
12 Mth YTD	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19	4.18	4.22	4.06
Financial YTD (2013/14)	4.02	4.02	3.98	3.88	3.86	3.87	3.96	4.05	4.13	4.19	4.03	4.06

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 35,149 hours (216.30 FTE), which is an increase of 2527 hours (15.55 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 47.04% (decrease of 0.14%), Agency fill rate = 22.7% (decrease of 6.42%). Total bank & agency fill rate = 69.74% (decrease of 6.56% compared with the previous month).
- As additional duty roster hours are considered to be outside the standard roster demand, a control to restrict the creation of additional duties has been implemented, the effect of which will be reported in Month 1 2014.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.06% in March 2014.

In month Sickness Absence has decreased by 0.14% to 4.39% which is above the Trust target.

- Short term sickness absence decreased by 0.2% to 2.38%.
- Long term sickness absence increased by 0.06% to 2.01% which remains below Trust Target.
- The total calendar days lost to sickness absence increased by 387 to 6,659 days lost.
- The number of days lost per employee increased slightly, to 1.36 days.

Human Resources Workforce Performance Indicators 2013/14 Month 12

Surgery Care Group									
		Directorate							
		Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck	Women	Children
Short Term Sickness Absence			1.60%	2.60%	3.20%	3.23%	2.14%	3.37%	2.40%
Long Term Sickness Absence			2.20%	2.09%	0.88%	1.85%	2.53%	1.81%	2.40%
Total Sickness Absence	Over 4.2%								
	3.9-4.2%		3.80%	4.69%	4.08%	5.08%	4.67%	5.18%	4.80%
	Under 3.8%								

Surgery Care Group Summary

- The non-medical sickness absence rate for the General Surgery Care Group decreased by 0.74% to 4.76

  The highest ward based sickness was on Gosset Ward with total sickness absence of 8.77%. Two of the 4 staff on long-term sickness have returned to work in April, and the others are being actively managed under the sickness absence policy and under OH review.

  One employee on long-term sickness in Medical Records (where the total sickness rate in March was slightly increased at 9.19%) has received ill-health termination.

Medicine Care Group									
		Directorate							
		Threshold	Target	Pharmacy	Pathology	Radiology	Therapies	Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence			1.60%	1.48%	1.32%	1.76%	1.13%	2.27%	3.37%
Long Term Sickness Absence			2.20%	1.63%	1.26%	2.42%	1.35%	1.61%	3.24%
Total Sickness Absence	Over 4.2%								
	3.9-4.2%		3.80%	3.11%	2.58%	4.18%	2.48%	3.88%	6.61%
	Under 3.8%								

Support Services					M&D
	Directorate				
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	1.82%	1.82%	0.47%
Long Term Sickness Absence		2.20%	1.43%	1.63%	1.13%
Total Sickness Absence	Over 4.2%				
	3.9-4.2%	3.80%	3.25%	3.45%	1.60%
	Under 3.8%				

Medicine Care Group Summary

- The sickness absence rate for General Medicine & Emergency Care increased very slightly, by 0.08%, with increases showing in the Radiology, Oncology & Haematology, and General Medicine directorates. Radiology has two long-term absences which are being managed in line with trust policy.

  Hot spots for ward based total sickness absence are Becket Ward (12.94%) and Corby Community Ward where total sickness absence has decreased slightly but remains high at 13.67%, and long-term sickness there has increased by 4.28%. One contract was terminated on ill-health grounds in March. Finedon Ward has seen an increase in short-term sickness from 2.23% to 6.23%; two individuals have been progressed onto stage 1 under the STS policy and issued with written improvement notices. Three individuals on long-term sickness on Brampton Ward are being managed in line with trust policy; one may have their employment terminated on the grounds of ill-health.

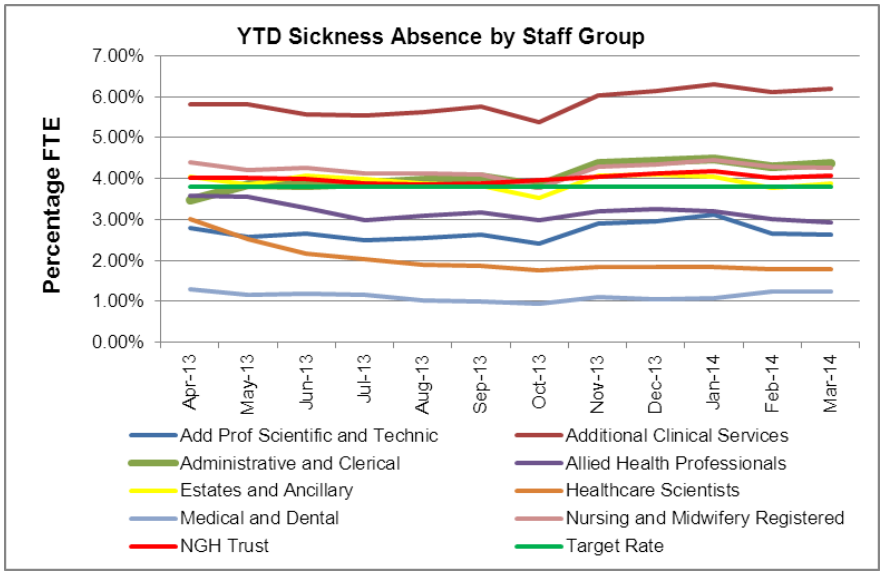
Hospital Support and Medical & Dental Summary

- The total sickness absence rates within both Facilities (3.25%) and Hospital Support (3.45%) increased in March, but remain below Trust target.

  Medical & Dental staff sickness absence decreased by 0.05% to 1.60% in March 2014.

  Following the successful upgrade to v.10 MAPS HealthRoster, plans continue to incorporate Medics Rotas and time and attendance recording into MAPS HealthRoster which will further enhance the accuracy of reporting.

Human Resources Workforce Performance Indicators 2013/14 Month 12



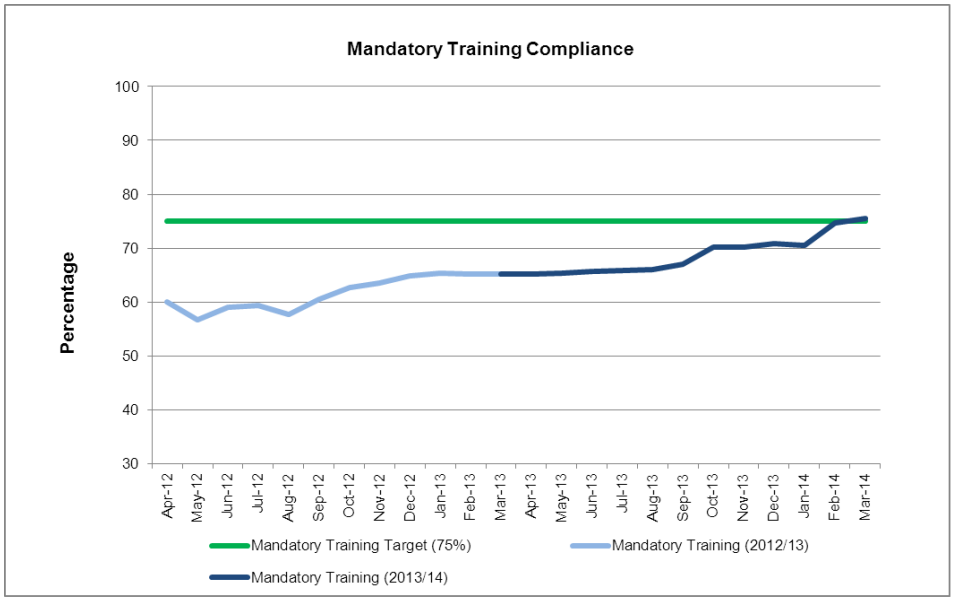
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Add Prof Scientific and Technic	2.78%	2.57%	2.66%	2.50%	2.55%	2.64%	2.41%	2.91%	2.95%	3.11%	2.65%	2.63%
Additional Clinical Services	5.82%	5.81%	5.56%	5.54%	5.61%	5.75%	5.39%	6.03%	6.14%	6.29%	6.10%	6.20%
Administrative and Clerical	3.47%	3.85%	3.84%	3.88%	3.97%	4.05%	3.82%	4.36%	4.43%	4.47%	4.29%	4.36%
Allied Health Professionals	3.58%	3.56%	3.27%	2.97%	3.08%	3.18%	2.99%	3.21%	3.25%	3.19%	3.00%	2.94%
Estates and Ancillary	4.04%	3.84%	4.08%	3.98%	3.87%	3.82%	3.52%	4.06%	4.10%	4.04%	3.77%	3.88%
Healthcare Scientists	3.00%	2.51%	2.18%	2.04%	1.89%	1.86%	1.75%	1.83%	1.83%	1.84%	1.78%	1.79%
Medical and Dental	1.29%	1.15%	1.18%	1.16%	1.03%	0.99%	0.94%	1.09%	1.05%	1.09%	1.25%	1.23%
Nursing and Midwifery Registered	4.40%	4.21%	4.27%	4.14%	4.14%	4.09%	3.78%	4.30%	4.35%	4.44%	4.29%	4.26%
NGH Trust	4.02%	4.02%	3.98%	3.88%	3.86%	3.87%	3.96%	4.05%	4.13%	4.19%	4.03%	4.06%
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	Support Services
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.39%	4.89%	4.24%	3.33%
No. of completed PDP's returned & completed Appraisals	Under 50% 50-79% 80% & over	80%	41.71%	37.86%	41.31%	47.98%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	75%	75.51%	76.18%	74.47%	76.57%
% Role Specific Training Compliance	Under 50% 51-74% 75% & over	75%	64.54%	66.62%	63.47%	57.65%

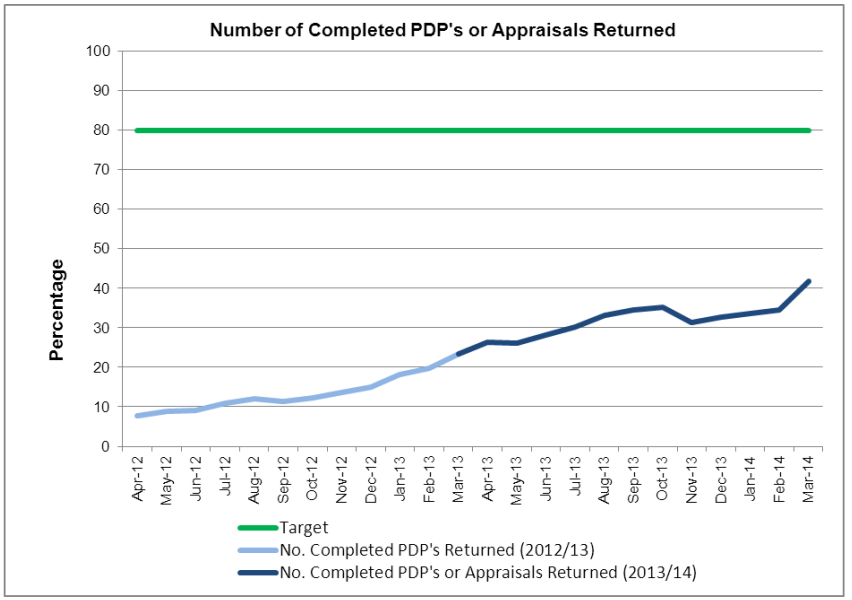
Number of Completed PDPs Returned, Completed Appraisals, and Mandatory Training & Role Specific Training Compliance

- The current number of completed PDP's returned or completed Appraisals is 41.71%; an increase of 7.19% since February.
- Mandatory Training compliance has increased to 75.51%, passing the Trust target of 75%.
- As requested, RSET subjects are now included. Currently these are subjects that had previously been classed as mandatory. Learning & Development are scoping out other RSET subjects and a decision will be made on what to report in future.

Human Resources Workforce Performance Indicators Month 12



Mandatory Training Target 75%	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	N/A	74.68	75.51



Returned PDP Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76	33.58	34.52	41.71

Appendix 1 : Staff Survey

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

TITLE: 2013 Staff Survey Data and Analysis **LEAD: Janine Brennan (Director of Workforce & Transformation)**

PURPOSE: To present, for information, a summary of the 2013 Staff Survey Results. In particular: (1) Analysis of statistically significant changes from the previous Staff Survey (2) Analysis of the Key Employee Engagement (Core Questions) (3) A focussed summary of findings of staff experience relative to Patient Safety and Patient Experience Indicators (4) Analysis of 2013 Staff Survey (Core Questions) by Care Group and Occupational Group to provide a barometer of staff attitude

KEY POINTS: Response Rates: The data below is based on the responses of 351 staff members surveyed in the 2013 survey cycle. 850 staff were sent questionnaires and the 351 returns constitute a 42.4% response rate.

Staff Survey Summary: Of the 28 key findings the Trust has none in the top 20% when compared to other Acute Trusts. Staff responses did show us above average for the percentage receiving job-related training, learning or development in the last 12 months and the percentage reporting errors, near misses or incidents witnessed in the last month. Staff responses also showed us as average for the percentage saying hand washing materials are always available and the percentage having equality and diversity training in the last 12 months.

For the remaining 24 key finding staff responses put us as either worse than average (4 key findings) or in the bottom 20% (20 key findings) when compared to other Acute Trusts. The survey highlights a number of key areas for improvement, namely: Effective team working, support from immediate managers, health & safety training, work related stress/work pressure/working additional hours, witnessing potentially harmful errors/near misses/incidents, physical violence, harassment & bullying and employee engagement. The results support that there is clearly need for improvements in these areas.

Statistically Significant Changes from 2012 Staff Survey: The Trust had two statistically significant improvements since 2012. The first for the percentage of staff receiving job related training, learning or development in the last 12 months and the second for the percentage of staff that would recommend the trust as a place to work or receive treatment, however despite this improvement the Trust is still in the bottom 20% for this key finding, when compared to other Acute Trusts.

There were no statistically significant deteriorations since 2012.

Staff Engagement: There was slight improvement for the overall staff engagement score when compared to 2012, but we are still in the bottom 20% of Acute Trusts. Staff being able to contribute to improvements at work showed a small increase. Staff recommending the Trust as a place to work or receive treatment showed a significant increase and staff motivation at work was unchanged from 2012. For all these key findings the Trust is worse than average with the exception of staff being able to contribute to improvements at work were we are in the bottom 20% of Acute Trusts.

Patient Experience and Safety: The belief of staff at NGH that the care of patients/service users is the Trust's top priority has increased since the 2012 survey and 56% of staff would be happy with the standard of care provided by NGH if a friend or relative needed treatment, which is also an increase from the 2012 survey. Deterioration has been shown from the previous survey in the belief that staff who are involved in an error, near miss or incident are treated fairly. There has been no change from the 2012 survey in the belief of staff that that action is taken to ensure that they do not happen again and in the organisation encouraging staff to report errors, near misses and incidents. In contrast there has been an increase in the percentage of staff reporting errors from the previous survey. The percentage of staff knowing how to report fraud, malpractice and wrongdoing has increased along with their confidence that the Trust would address their concern. In the area of team working there is an increase with the team having shared objectives and the team communicating closely to meet the team objectives. In terms of Individual contributions, the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver has deteriorated since 2012, as has the percentage of staff being able to deliver the patient care that they aspire to. The percentage of staff who are able to do their job to a standard they are personally pleased with is unchanged from the previous survey. However these staff are also reporting that they are satisfied with the quality or care they give as this has increased.

Care Group Analysis: Surgical Care Group demonstrates the most positive staff experience across 10 of the 17 Indicators, including overall staff engagement. Medicine Care Group has the most positive staff experiences for 5 of the indicators, including recommending the Trust as a place to work or receive treatment. Hospital Support has the most positive staff experience for 4 of the indicators including staff job satisfaction.

The least positive experiences are demonstrated by Hospital Support staff that has 12 of the 17 indicators, including work pressure felt by staff, staff suffering work related stress, staff experiencing discrimination at work and overall staff engagement. Medicine Care Group has 5 of the lowest indicators including staff job satisfaction staff suffering work related stress and percentage of staff working extra hours. Surgical Care Group has 1 lowest indicator of the 17, which is staff job satisfaction.

Occupational Group Analysis: Adult General Nurses report the highest staff engagement. Corporate Functions reported the highest job satisfaction and Nursing/HCA's reported the highest staff motivation at work. Admin and Clerical reports the lowest staff engagement, job satisfaction and Corporate

Functions report the lowest staff motivation. Nursing/HCA's report the strongest satisfaction for the quality of patient care they are able to deliver, with Other Registered Nurses reporting the lowest which at 48% which is considerably lower than the 84% reported by Nursing/HCA's. Other Registered Nurses also report the highest percentage of staff suffering workplace stress in the last 12 months, with Radiology reporting the lowest. Radiology also shows the highest percentage of staff working staff working extra hours at 100% with Admin and Clerical showing the lowest percentage. Corporate Functions had the lowest percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months and Nursing/HCA's had the highest. Medical and Dental reported the highest percentage of staff experiencing discrimination at work and Radiology and Other Scientific and Technical reported the lowest at 0% each.

Admin and Clerical staff demonstrate the least positive staff experiences in 8 of the 17 indicators, followed by Corporate Functions with 4. No one occupational group stands out as having the most positive staff experiences, as Adult General Nurses, Nursing/HCA's, Radiology, Other Scientific and Technical and Corporate Functions all have 3 positive indicators.

1) Analysis of Statistically Significant Changes from the Previous Staff Survey

Key Findings from the 2013 Staff Survey*	2012/13 Trend	2013 Score	2012 Score	2011 Score	2010 Score	2013 Acute Trust Average	Scale Description	2012/13 Change - Statistically Significant?	Benchmarking against Acute Trusts**
Percentage of staff receiving job-relevant training, learning or development in the last 12 months	▲	82%	74%	75%	77%	81%	%	Improvement	Better than average
Staff recommending the Trust as a place to work or receive treatment	▲	3.52	3.35	3.38	3.47	3.68	(1: Low - 5: High)	Improvement	Worse than average

*** Green shading indicates where staff experience has had a statistically significant improvement; red shading indicates where staff experience has had a statistically significant deterioration**

**** Green shading indicates where NGH is in the top performing 20% of all acute trusts or better than average; red shading indicates where NGH is in the worst performing 20% of Acute Trusts or worse than average**

2) Analysis of Employee Engagement (Core Questions)

Key Findings from the 2013 Staff Survey*	2012/13 Trend	2013 Score	2012 Score	2011 Score	2010 Score	2013 Acute Trust Average	Scale Description	2012/13 Change - Statistically Significant?	Benchmarking against Acute Trusts**
Overall Staff Engagement	▲	3.62	3.54	3.57	3.62	3.74	(1: Low – 5: High)	No	Worst 20%
Staff Job Satisfaction	No change	3.41	3.40	3.41	3.40	3.60	(1: Low - 5: High)	No	Worst 20%
Staff recommendation of the Trust as a place to work or receive treatment	▲	3.52	3.35	3.38	3.47	3.68	(1: Low - 5: High)	Yes	Worse than average
Staff Motivation at work	No change	3.81	3.81	3.82	3.94	3.86	(1: Low - 5: High)	No	Worse than average
Staff Ability to Contribute to Improvements in Work	▲	63%	58%	57%	56%	68%	%	No	Worst 20%

*** Green shading indicates areas where staff experience has improved; red shading indicates where staff experience has deteriorated; amber shading indicates where staff experience is unchanged**

**** Green shading indicates where NGH is in the top performing 20% of all acute trusts or better than average; red shading indicates where NGH is in the worst performing 20% of Acute Trusts or worse than average**

3) Analysis of Staff Survey Findings Presenting Staff Experience Relative to Patient Experience and Patient Safety Indicators

2013 Staff Survey Data*	2012/13 Trend	2013 Score	2012 Score	2011 Score	2010 Score	Acute Trusts	Description of Scale
Organisational Commitment to Patient Care (Core Survey Questions)							
Care of Patients/Service Users is my organisations top priority	▲	64%	57%	49%	57%	68%	%
My organisation acts on concerns raised by patients/service users	▲	68%	60%	n/a	n/a	71%	%
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	▲	56%	50%	52%	53%	64%	%
Fairness and Effectiveness of Procedures for Reporting Errors, near misses or Incidents (Core Survey Questions)							
My Organisation treats staff who are involved in an error, near miss or incident fairly	▼	43%	46%	43%	48%	47%	%
My organisation encourages us to report errors, near misses or incidents	No change	82%	82%	82%	82%	86%	%
When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again	No change	57%	57%	54%	58%	61%	%
Percentage of Staff reporting errors, near misses or incidents witnessed in the last month	▲	91%	89%	96%	97%	90%	%
Raising Concerns at Work (Core Survey Questions)							
Percentage saying if they were concerned about fraud, malpractice or wrongdoing, they would know how to report it	▲	88%	84%	89%	88%	89%	%
Percentage saying they would feel confident that the organisation would address their concern	▲	47%	41%	46%	45%	53%	%
Team Based Working (Core Survey Questions)							
Team members have a set of shared objectives	▲	73%	72%	72%	76%	78%	%
Team members have to communicate closely with each others to meet the team's objectives	▲	78%	73%	77%	79%	80%	%
Individual Contribution to Patient Care & Job Design(Core Survey Questions)							
Percentage of Staff feeling satisfied with the quality of work and patient care they are able to deliver	▼	70%	72%	70%	75%	79%	**%**
I am able to do my job to a standard I am personally pleased with	No change	74%	74%	60%	58%	80%	%
I am satisfied with the quality of care I give to patients/service users	▲	78%	76%	87%	90%	84%	%
I am able to deliver the patient care I aspire to	▼	62%	64%	65%	69%	69%	%
Senior Managers and Leaders (Core Survey Questions)							
Senior Managers act on staff feedback	▲	23%	19%	24%	27%	29%	%
Senior Managers where I work are committed to patient care	▲	48%	39%	42%	49%	52%	%

***Green shading indicates an improvement in staff experience; red shading indicates deterioration in staff experience; amber indicates no change in staff experience**

(4) Analysis of 2013 Staff Survey (Core Questions) by Care Groups & Hospital Support

Key Findings from the 2012 Staff Survey	2012/13 Trust Trend	2013 Score	2012 Score	Surgical Care Group*	Medicine Care Group*	Hospital Support*	Scale Description
Overall Staff Engagement	▲	3.62	3.54	3.67	3.62	3.55	(1: Low – 5: High)
Staff Job Satisfaction	▲	3.41	3.40	3.43	3.38	3.45	(1: Low – 5: High)
Staff Ability to Contribute to Improvements in Work	▲	63%	58%	64%	62%	58%	%
Staff recommendation of the Trust as a place to work or receive treatment	▲	3.52	3.35	3.52	3.54	3.51	(1: Low – 5: High)
Staff Motivation at Work	No change	3.81	3.81	3.91	3.76	3.75	(1: Low – 5: High)
Staff satisfaction with the quality of work and patient care they are able to deliver	▼	70%	72%	69%	74%	60%	%
Percentage of Staff Appraised	▼	72%	73%	76%	71%	65%	%
Work Pressure Felt by Staff	▼	2.26	3.33	3.15	3.32	3.37	(1: Low – 5: High)
Percentage of Staff reporting errors, near misses or incidents witnessed in the last month	▲	91%	89%	94%	94%	74%	%
Percentage of staff suffering work related stress in the last 12 months	▼	40%	42%	39%	41%	41%	%
Percentage of Staff receiving Health and Safety Training in the last 12 months	▼	61%	63%	63%	63%	53%	%
Percentage of staff receiving Equality and Diversity Training	▼	60%	64%	58%	64%	56%	%
Percentage experiencing Discrimination at Work in the last 12 months	No change	16%	16%	15%	17%	20%	%
Staff experiencing physical violence from patients, relatives or the public in the last 12 months	▲	19%	18%	20%	25%	7%	%
Percentage of staff working extra hours	No change	75%	75%	75%	78%	71%	%
Support from immediate managers	▲	3.35	3.27	3.40	3.32	3.39	(1: Poor – 5: High)
Percentage reporting good communication between senior management and staff	▲	24%	21%	22%	26%	27%	%

***Green shading indicates the Care Group where the most positive staff experience is reported; red shading the least positive staff experience**

(4.1) Analysis of 2013 Staff Survey (Core Questions) by Occupational Group.

Key Findings from the 2012 Staff Survey	2012/13 Trust Trend	2013 Score	2012 Score	Adult General Nurses*	Other Registered Nurses*	Nursing / HCA's*	Medical & Dental*	Radiography*	Other Scientific & Technical*	Admin & Clerical*	Corporate Functions*	Maintenance / Ancillary*	Scale Description
Overall Staff Engagement	▲	3.62	3.54	3.81	3.50	3.73	3.73	3.62	3.58	3.30	3.60	3.68	(1: Low – 5: High)
Staff Job Satisfaction	▲	3.41	3.40	3.56	3.33	3.45	3.46	3.48	3.36	3.19	3.60	3.54	(1: Low – 5: High)
Staff Ability to Contribute to Improvements in Work	▲	63%	58%	73%	50%	66%	66%	73%	47%	43%	92%	56%	%
Staff recommendation of the Trust as a place to work or receive treatment	▲	3.52	3.35	3.63	3.30	3.73	3.69	3.42	3.54	3.27	3.53	3.65	(1: Low – 5: High)
Staff Motivation at Work	No change	3.81	3.81	3.99	3.86	4.04	4.00	3.67	3.82	3.47	3.44	4.02	(1: Low – 5: High)
Staff satisfaction with the quality of work and patient care they are able to deliver	▼	70%	72%	70%	48%	84%	81%	67%	78%	62%	n/a	83%	%
Percentage of Staff Appraised	▼	72%	73%	76%	78%	58%	86%	73%	72%	65%	50%	71%	%
Work Pressure Felt by Staff	▼	2.26	3.33	3.23	3.24	3.14	3.16	3.18	3.26	3.43	3.28	3.00	(1: Low – 5: High)
Percentage of Staff reporting errors, near misses or incidents witnessed in the last month	▲	91%	89%	100%	100%	88%	82%	n/a	n/a	69%	n/a	n/a	%
Percentage of staff suffering work related stress in the last 12 months	▼	40%	42%	43%	46%	34%	38%	20%	37%	46%	36%	27%	%
Percentage of Staff receiving Health and Safety Training in the last 12 months	▼	61%	63%	61%	58%	62%	69%	73%	68%	60%	50%	56%	%
Percentage of staff receiving Equality and Diversity Training	▼	60%	64%	60%	46%	63%	59%	53%	74%	63%	67%	57%	%
Percentage experiencing Discrimination at Work in the last 12 months	No change	16%	16%	18%	18%	22%	24%	0%	0%	12%	17%	15%	%
Staff experiencing physical violence from patients, relatives or the public in the last 12 months	▲	19%	18%	37%	4%	43%	24%	13%	16%	4%	0%	8%	%
Percentage of staff working extra hours	No change	75%	75%	86%	82%	63%	83%	100%	67%	62%	64%	65%	%

Support from immediate managers	▲	3.35	3.27	3.67	3.30	3.52	3.38	3.24	3.34	3.04	3.60	3.30	(1: Poor – 5: High)
Percentage reporting good communication between senior management and staff	▲	24%	21%	23%	25%	24%	34%	33%	42%	12%	8%	40%	%

***Green shading indicates the Occupational Group where the most positive staff experience is reported; red shading the least positive staff experience**

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 APRIL 2014

Title	Improving Quality and Efficiency Report
Agenda item	14
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Paul Devlin, Assistant Director – Improving Quality and Efficiency
Purpose	To update the board on the final financial savings achieved through the 2013/14 Transformation Programme at month 12.

Executive summary

- The target plan for 2013/14 is £13m, which is 5% of turnover.
- Actual delivery in month 12 was £1,239k against planned delivery of £1,374k.
  This was the highest delivery of the year with Care Group and Corporate CIPs delivering above plan
- The Trust submitted a deficit plan for 2014/15 of £7.8m to the TDA. The main drivers for this deficit were:
  I. A shortfall in recurrent delivery of the 2013/14 CIP programme
  II. 50% MRET non reinvestment
  III. Essential quality investment
- This deficit plan leaves the Trust with a CIP requirement of £12.7m for 2014/15

Related strategic aim and corporate objective	Strategic Aim 5: To be a financially viable organisation
Risk and assurance	Whilst progress to develop plans for 2014/15 is being made, the pace is insufficient to assure the Board that the target of £13m will be achieved
Related Board Assurance Framework entries	BAF 21
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	N/A

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

MARCH 2014

Executive Summary

Northampton General Hospital NHS
NHS Trust

2013/14 Month 12 Performance Update

The target plan for 2013/14 is £13m, which is 5% of turnover.

Actual delivery at M12 is £11.5m (4.4%), against the £13m required delivery, off plan by £1.5m.

In Month Performance

Actual delivery in month 12 was £1,239k against planned delivery of £1,374k.

This was the highest delivery of the year with Care Group and Corporate CIPs delivering above plan.

2014/15 Context

The Trust submitted a deficit plan for 2014/15 of £7.8m to the TDA. The main drivers for this deficit were:

- A shortfall in recurrent delivery of the 2013/14 CIP programme
- 50% MRET non reinvestment
- Essential quality investment

This deficit plan leaves the Trust with a CIP requirement of £12.7m for 2014/15

2014/15 Plan Development

The Trust plan submission to the TDA demonstrated that CIP plans to the value of £12.0m have been identified to date. This is against the target of £12.7m and is broken down as follows:

Fully Developed Schemes	£2.963m
Plans in Progress	£3.198m
Opportunity Identified	£5.843m
Unidentified	£0.663m

Further opportunities to the potential value of £3.369m have been identified since this submission in recognition of the fact that historically the Trust, as is the norm for most Trusts, delivers the majority but not the entirety of its CIP target.

Quality Impact Assessments (QIAs)

The completion of QIAs for all schemes is currently in progress. An update of this progress will be reported to IHGC in line with the QIA policy. The IQE team is driving and monitoring this progress.

Risks and Issues

Given that plans for 2014/15 schemes are still being developed; some of the scheme targets will not be fully achieved in year due to slippage in delivery or risk materialising.

The Trust proposes to mitigate this risk by targeting an additional £3.369m worth of schemes to supplement its previously reported 2014/15 programme of £12.668m. This is to ensure that there is built in contingency against risk of non-delivery; ensuring that the overall target of £12.668m can be delivered.

Next Steps

A number of high priority next steps have been identified in order to rapidly progress the programme:

- Completion of QIAs for all identified schemes
- Completion of identification of Directorate CIPs with Care Groups to report to IQEG on 22nd April
- Formally work up all additional schemes including project documentation, valuation and QIA
- Following completion of Clinical Strategy Consultancy, identify any 'quick wins' and include in 2014/15 programme.
- Firm up 2015/16 programme including formal project documentation, valuation and QIA

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M11 LTF £000s	M12 Actual £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	11,544	↓ 11,451	88%	2,959
Shortfall	4,508	35%	1,456	↑ 1,549	12%	-2,959
Total Efficiency	**13,000**	**100%**	**13,000**	**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.4%**	**4.4%**		

Identification of the Transformation Programme 2013/14
The table outlines actual delivery compared to the plan submitted to the TDA in April 2013.
Delivery of £11.5m is a 4.4% CIP against our planned requirement of 5%.
Delivery fell by £93k in month 12. This was due to an increase in bank and agency costs.
.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	8,746	67%
Non-recurrent schemes	2,705	21%
Shortfall	1,549	12%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	5,666	44%
Non pay	2,787	21%
Income	2,998	23%
Shortfall	1,549	12%
Total Efficiency	**13,000**	**100%**

£2.7m of non-recurrent schemes increases the CIP requirement for 2014/15.

Pay schemes account for 44% whereas pay costs are 68% of turnover.

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

Actual Delivery 2013/14

Northampton General Hospital NHS
NHS Trust

Workstream	Exec Lead	Actual 2013/14 £000s	Plan 2013/14 £000s	Variance 2013/14 £000s
FYE 12/13 schemes	A. Foster	337	337	0
Workforce Transformation	J. Brennan	2,121	1,979	142
Clinical service redesign	D. Needham / R. Brown	18	110	(92)
Non-Clinical service redesign	C. Abolins	101	0	101
Directorate Schemes	A. Foster	8,874	8,868	6
Sub total		**11,451**	**11,295**	**156**
Gap	J. Brennan	1,549	1,705	(156)
Total		**13,000**	**13,000**	**0**

Month 12 – Actual Delivery

The Transformation Programme delivered £11.451m against the required plan of £13m.

Care Group and Corporate CIPs overachieved the planned delivery by £6k.

At the end of month 12 a £1.3m year on year reduction in nursing bank and agency expenditure has been achieved. The agency spend has increased in the past 2 months due to running at higher staffing levels.

Clinical Service redesign is behind plan by £92k. This is due to the Locum Managed Service savings now being put back to 2014/15.

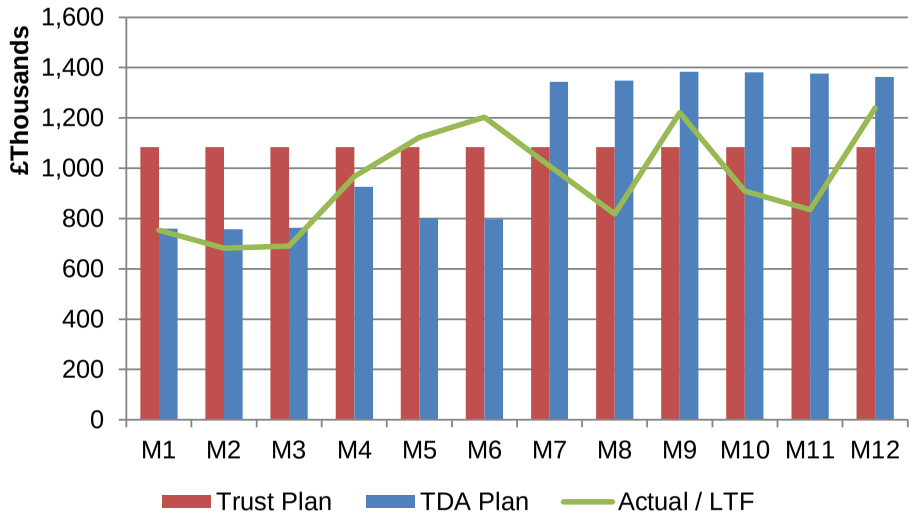
There £35k annual leave target was exceeded and a saving of £84k recorded.

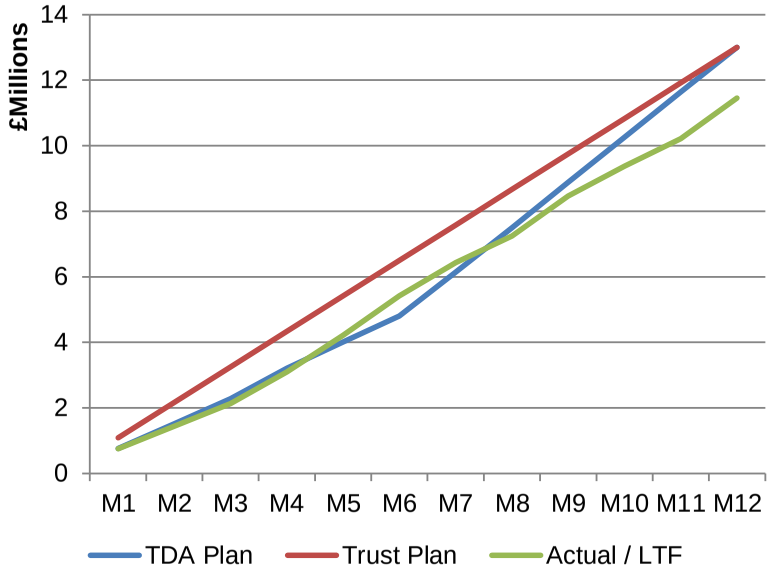
Directorate	Actual Delivery			
	Planned to date	Actual savings to date	Var	RAG
A1: Surgery	555	460	(95)	
A2: Anaesthetics	797	541	(256)	
A3: T&O	540	397	(143)	
A4: Head & Neck	375	787	412	
A5: Child Health	518	825	307	
A6: Obs & Gynae	664	388	(276)	
SCG sub total	**3,449**	**3,397**	**(52)**	-
B1: General Medicine	2,028	2,059	32	
B2: Oncology	481	445	(36)	
B3: Pathology	586	539	(47)	
B4: Radiology	364	421	57	
B5: Pharmacy	172	172	0	
B6: Therapies	106	116	10	
MCG sub total	**3,737**	**3,752**	**15**	-
C1: Corporate Affairs	67	18	(49)	
C2: Medical Director	73	92	19	
C3: Research &	10	10	(0)	
C4: Patient & Nursing	124	124	0	
C5: Strategy &	248	248	0	
C6: Workforce &	149	202	53	
C7: Finance	128	148	20	
C8: Facilities	883	883	(0)	
Support sub total	**1,682**	**1,725**	**43**	-
Totals	**8,868**	**8,874**	**6**	-

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance | **Off trajectory**





Actual delivery in month 12 was £1,239k against planned delivery of £1,374.

The cumulative delivery of schemes is £1,549k behind the TDA plan.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
24 April 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 March 2014 (attached as Appendix A and Appendix B)

Enclosure L

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:

Enclosure L

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:

For FINANCE, that

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

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

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
24 APRIL 2014

Title	Register of Sealings 2013/14
Agenda item	16
Sponsoring Director	Craig Sharples, Head of Corporate Affairs
Author(s)	Craig Sharples, Head of Corporate affairs
Purpose	Assurance
Executive summary This paper is present to inform the Board of the documents executed under seal during the year in accordance with the Board's annual cycle of governance reporting.	
Related strategic aim and corporate objective	All
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	Meets statutory governance requirements
Actions required by the Board The Board is asked to note the Register of Sealings for 2013/14.	

Enclosure M

Northampton General Hospital NHS
NHS Trust

Register of Sealings 2013/14
Trust Board
24 April 2014

Introduction

This paper is present to inform the Board of the documents executed under seal during the year.

Documents signed on behalf of the Trust are sealed under the circumstances described in the Trust's Standing Orders (12.1-12.3).

The Trust Seal is to be used in those documents which have to be executed under deed. This is normally confined to land deals, including purchases, transfers, tenancy agreements, and acquisitions.

The Seal may also be used for contracts in excess of the financial limits delegated to the Chief Executive under the Trust's Standing Financial Instructions.

An entry of each Sealing made is recorded in the Register of Sealings. The Board must be kept informed of the use of the Trust Seal to comply with Standing Orders. Failure to report on the use of the seal would breach the Trust's governance arrangements.

Use of the Trust Seal

In the period 1 April 2013 to 31 March 2014, the Trust Seal was applied to the documents listed in the table below, in the presence of the Head of Corporate Affairs, who has custody of the Trust Seal.

Table 1.

Seal Register Number	Date	Title - Description	Signatories
179	19 December 2013	Deed of guarantee between Vital Holdings and Northampton General Hospital NHS Trust	Mr P Farenden Chairman Dr S Swart Chief Executive
180	19 December 2013	Agreement for the re-provision of Energy and Energy management Facilities at Northampton General Hospital NHS Trust between the trust and Vital Holdings Commercial ESCo Ltd.	Mr P Farenden Chairman Dr S Swart Chief Executive
181	19 December 2013	Deed of guarantee between Vital Holdings and Northampton General Hospital NHS Trust	Mr P Farenden Chairman Dr S Swart Chief Executive

Seal Register Number	Date	Title - Description	Signatories
182	19 December 2013	Agreement for the re-provision of Energy and Energy management Facilities at Northampton General Hospital NHS Trust between the trust and Vital Holdings Commercial ESCo Ltd.	Mr P Farenden Chairman Dr S Swart Chief Executive

Recommendations

The Board is asked to note the Register of Sealings for 2013/14.

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 24 April 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Farenden	**Verbal**
	3.	Minutes of the 27 March 2014 meeting of the Board	Decision	Mr P Farenden	**A.**
	4.	Matters arising from the 27 March 2014	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chief Executive's Report	Note	Dr S Swart	**C.**
09.50	**CLINICAL QUALITY AND SAFETY**				
	7.	CQC Action Plan	Assurance	Dr S Swart	**D.**
	8.	Quality Report	Assurance	Dr M Wilkinson	**E.**
	9.	Patient Experience Report	Assurance	Mrs J Bradley	**F.**
10.20	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs D Needham	**G.**
	11.	Urgent Care Report	Assurance	Mrs D Needham	**H.**
	12.	Finance Report	Assurance	Mrs D Needham	**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	**GOVERNANCE**				
	16.	Register of Sealing's	Assurance	Mr C Sharples	**M.**
11.35	**ANY ITEMS OF OTHER BUSINESS**				
	17.	**DATE AND TIME OF NEXT MEETING** 29 May 2014, Boardroom, NGH	Note	Mr P Farenden	**Verbal**
RESOLUTION – CONFIDENTIAL ISSUES: The Trust Board is invited to adopt the following: "That representatives of the press and other members of the public be excluded from the remainder of this					

meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).