Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 27 February 2014, 09.30 am

at

the Boardroom,
NGH

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 February 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Zeidler	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of the 30 January 2014 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 30 January 2014	Note	Mr P Zeidler	**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.	Quality Report	Assurance	Dr M Wilkinson	**D.**
	8.	Patient Experience Report	Assurance	Ms S Loader	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms S Loader	**F.**
10.30	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs R Brown	**G.**
	11.	Finance Report	Assurance	Mr A Foster	**H.**
	12.	Workforce Report	Assurance	Mrs J Brennan	**I.**
	13.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**J.**
	14.	TDA Self-Certification	Decision	Mr C Pallot	**K.**
11.15	**ANY ITEMS OF OTHER BUSINESS**				
	15.	**DATE AND TIME OF NEXT MEETING** 27 March 2014, Boardroom, NGH	Note	Mr P Zeidler	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting held in public on

Thursday 30 January 2014 at 9.30am at the Boardroom, NGH

Present:

Mr P Zeidler	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 A Foster	Acting Director of Finance
Mr G Kershaw	Non-Executive Director
Ms S Loader	Director of Nursing, Midwifery and Patient Services
Mrs D Needham	Acting Chief Operating Officer
Mr D Noble	Non-Executive Director
Mr C Pallot	Director of Strategy and Partnerships
Mr N Robertson	Non-Executive Director
Dr S Swart	Chief Executive Officer
Dr M Wilkinson	Acting Medical Director

In Attendance:

Mr C Sharples	Head of Corporate Affairs

Apologies:

Mr P Farenden	Chairman
Mrs E Searle	Non-Executive Director

TB 13/14 143 Declarations of Interest in the Proceedings

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

TB 13/14 144 Minutes of the meeting held on 28 November 2013

The minutes of the meeting of the 28 November 2013 Board meeting were presented for approval. Subject a number of typographical amendments, the Board resolved to **APPROVE** the minutes of the 28 November2013 as a true and accurate record of proceedings.

TB 13/14 145 Action Log and matters arising from the 28 November 2013 Board Meeting

The action log was considered and the Board.

Dr Wilkinson presented a breakdown of operations that had been cancelled on the day of surgery in response to a request from Mrs Searle at the November Board meeting. The Board noted that there had not been an increase in the number of cancelled operations.

Mr Pallot informed the Board that he had been unable to provide benchmarking data in relation to C.Diff and MRSA ceilings as the data had been unavailable. He advised that a report would be prepared for the March 2014 Board meeting.

ACTION: Mr Pallot

The Board **NOTED** the Action Log and Matters Arising from the 28 November 2013.

TB 13/14 146 Patient Story

Dr Swart presented three separate patient stories to the Board relating to care and compassion.

The first was a letter received from a relative of a patient who had been

cared for on EAU but had sadly passed away. The letter outlined the families' appreciation of the support, care and compassion the family had received from staff during what were difficult times for the family.

The second related to a letter received from a relative of a patient that had passed away complementing the care provided by all staff whilst the patient was in the care of the Trust, and also the support provided to relatives.

The third was a letter received from a relative of a patient who was unhappy that their relative had been discharged from the hospital without their prescription medication which had followed in a taxi. Dr Swart reported that the practice of sending to take home medication in taxis after the patient had been discharged was one undertaken at many hospitals, but stated that she would prefer that medical be available at the time of discharge. As such, the practice had ceased whilst internal systems and processes were reviewed. It was acknowledged by the Board that the practice was symptomatic of the urgent care pressures faced by the Trust and welcomed the review to improve the processes.

The Board **RECEIVED** the Patient Stories.

TB 13/14 147 Chief Executive's Report

Dr Swart presented the Chief Executive's Report to the Board.

She provided the Board with detail of the recent Chief Inspector of Hospital's Inspection by the CQC which took place on the 16 and 17 January. In preparation for the inspection, Dr Swart advised that she had taken every available opportunity to involve and communicated with staff in advance for the visit with the aim of ensuring that staff felt prepared and supported.

Dr Swart advised that the early informal feedback from the CQC had been received and communicated to staff. The feedback had confirmed the Trust's own perceptions relating to improvements that were underway and also identified further actions which had been implemented immediately. The CQC inspection team had commented that they found all staff to be open, honest and receptive to change. The CQC also recognised that the Trust was dominated by urgent care pressures which masked much of the good care provided by the Trust.

The full report from the CQC was expected to be published in March 2014 which would be followed by a risk summit with key regulators and stakeholders alongside the CQC.

Dr Swart reported that the Trust had been subject to peer review visits for colorectal cancer and paediatric diabetes on 21 January. It was noted that initial feedback from the visits was very positive with comments made on the excellent standards in many components of both services. Dr Swart commented that the feedback was a credit to the teams, and she had formally written to the teams in that regard.

The Board was informed that the Trust's Midwifery Team had been shortlisted for an award at the Royal College of Midwifes Annual Midwifery Awards 2014. The project entitled 'The implementation and impact of a Birth After Caesarean (BAC) Clinic was submitted by Anne Richley and Paula Briody was shortlisted for the Pregnacare Award for Excellence in Maternity Care. Unfortunately, the project did not win the award, but Dr Swart wished to draw the Board's attention to the tremendous achievement and congratulate the team on being shortlisted.

Dr Swart introduced the Best Possible Care Staff Awards to the Board stating that it was important that the Trust recognised and celebrated the achievements of staff. She added that the awards for this year had been aligned with the Trust's vision and values. The awards ceremony would take place on the evening of Monday 7 April 2014.

Dr Swart informed the Board that the financial position of the Trust remained challenging and would be even more challenging going into 2014-15. The Trust was working in partnership with the CCG and the TDA to agree the financial solutions for 2013-14 and hoped to confirm those arrangements within the next week. The Trust would now need to continue the careful focus on all our cost improvement schemes for this year to achieve our financial break even duties and then go on to develop a Health Economy agreed programme of work to set out our ambitions for the next two to five years. The work would need to encompass our clinical strategy, our financial strategy and our programme of transformation of care.

On behalf of the Board, Mr Zeidler acknowledged the effort of the management team in preparing the organisation and staff for the CQC inspection, effort that had been directly reflected in the feedback from the inspection team.

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

TB 13/14 148 **Quality Report**

Dr Wilkinson presented the Quality Report and provided a detailed overview of the content.

The Board was informed that overall mortality as measured by HSMR remained low and the Trust had maintained improvements in SHMI which was reported at below 99 for quarter 1 2013/2014. Dr Wilkinson advised that further analysis of the gastrointestinal and liver disease groups had continued due to apparently high identified mortality in some groups.

It was reported that the Trust-wide mortality review group was scheduled to meet six times during January and February to review 50 randomly selected case notes of patients who had died. Twelve consultants/specialty doctors of different specialties were currently undertaking these case note reviews for presentation and discussion. Feedback from the review will be provided to individual clinicians and the final report would be available in June 2014.

Dr Wilkinson reported that an in-depth section on serious incidents was included in the report, noting that this was the first time this level of detail had been presented in a public Board meeting. The report outlined the process for reporting and responding to serious incidents and what actions were being taken to embed learning the lessons from incidents. It was reported that there had been 35 serious incidents reported with the period of 1 November – 31 December 2013. Many of the serious incidents were related to pressure ulcers and falls. Dr Wilkinson informed the Board that a newly appointed Tissue Viability lead Nurse was developing a strategy to address the high number of pressure ulcer related incidents.

The Board reviewed the quality dashboard exception report. It was reported that the number of falls had increased, although the number remained below the national average. The Board was assured that there was a programme of work ongoing to understand the underlying causes of the falls in an effort to reduce the number.

With regards to compliance with the healthcare notes audit, Dr Wilkinson reported that the standards of the audit had been revised in accordance with national best practice to ensure they were appropriate and achievable. He added that he was actively raising the profile of these standards with colleagues to improve compliance. Mr Robertson questioned who was accountable for the quality of medical records, and was informed that each individual doctor was accountable for their individual contribution to the record. Dr Swart commented that the quality of healthcare records was an area of high risk for the Trust due to the disparate nature of the patient's pathway. She added that consultant staff needed to lead by example to improve quality and outcomes.

With regard to the deterioration of complaints responded to within agreed timescales, Dr Swart reported that there had been an increase in the number of complaints received by the Trust allied to staff shortages within the department which were contributory factors. The Board was informed that all complaints are managed through the Chief Executive's Office, and Dr Swart felt that the processes in place were robust. To further improve the management of complaints, closer links with the PALs team were being explored to manage issues earlier and more proactively to mitigate that impact on patients and families.

The Board **NOTED** the Quality Report and supported the actions outlined.

TB 13/14 149 Patient Experience Report

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

It was reported that the Friends and Family Test results continued to improve across the Trust, particularly within the A&E department which was receiving scores that were higher than national average.

Ms Loader informed the Board that for the first time the report presented triangulated information from the Friends and Family Test, PALs, Complaints and Incidents. The process had been developed in conjunction with the governance team as a mechanism to review performance and also to pre-empt any potential issues or themes. Ms Loader noted that that this was the first time this information has been collated in this format and it was likely it would change as information was reviewed and decisions made as to what was required to draw the most meaningful conclusions from the data. Two overarching areas were identified for improvement following this data analysis: communication and patient discharge. It had been agreed that the trust would focus on enhancing patient discharge with Nursing/Midwifery working in tandem with the medical staff and Interim Chief Operating Officer.

Mrs Needham welcomed the data and requested that it be disseminated throughout the Care Groups to ensure it became embedded operationally. Mrs Brennan added that the data could be used to inform ward sister and matron appraisals.

The Board reviewed the thematic analysis of the triangulated data and noted that generally the care provided was of a good standard, and it was clear that outstanding care was being provided in some areas, but by contrast, not delivered consistently across the Trust.

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

TB 13/14 150 Infection Prevention Performance Report

Ms Loader presented the Infection Prevention Performance Report.

In summarising the report, Ms Loader reported that the C.Diff rate had decreased which brought the Trust below its trajectory for the first time this financial year.

It was reported that there had been two surgical site infections identified related to fractured neck of femur surgeries, and that a detailed analysis was underway to understand the cause.

Ms Loader reported that there had been another case of scalded skin syndrome identified, of the same strain as the outbreak last year. The Board was assured that actions had been taken to prevent further spread of infection.

The Board welcomed the positive performance against the C.Diff trajectory, particular in light of the high number of cases that were reported at the beginning of the financial year.

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

TB 13/14 151 Operational Performance Report

Mrs Brown presented the Operational Performance Report to the Board.

It was reported to the Board that the number of patients waiting over 26 weeks had regrettably increased since the previous report, mainly due to delays in trauma and orthopaedics. As previously reported, there was a recovery plan in place which was expected to deliver compliance with the target by February 2014, although Mrs Brown provided a note of caution with the timeframe as the urgent care pressures currently faced may impact on the target due to the requirement to cancel some elective procedures.

With regard to performance against the four hour transit time for December 2013, the committee was informed that the target had not been met. It was reported that there had been an increase in the number of attendances and admissions during December, which was also being replicated during January 2014. Performance in January was reported at 84.56%, whilst year to date performance was 91.3%. It was noted that there had been a significant increase in the number of high acuity level three patients being admitted which was impacting heavily on the availability of ITU, HDU, level one and surgical beds.

With regards to performance against cancer targets, it was reported that the all targets had been achieved in-month, and the un-validated data for quarter three showed all targets had been met. Due to urgent care pressures limiting the availability of ITU and HDU beds, a number of patients had procedures cancelled during January which would impact on performance against the targets for January and quarter four, although the committee was re-assured that all patients that had their procedures cancelled had their procedures re-booked with confirmed dates.

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

TB 13/14 152 Urgent Care Update

Mrs Needham presented the Urgent Care Report to the Board.

By way of introduction, Mrs Needham reported that the structure for the

Urgent Care Programme had been revised and the project groups were now in place and functioning. The groups had been re-focussed to ensure patient safety was at the root of all improvement work.

Mrs Needham provided the Board with a detailed overview of each of the projects, outlining the tasks completed and future developments.

It was reported that the introduction of the GP model into A&E was having a positive impact. The GP on shift would see between four and six patients an hour as well as providing support and education to Emergency Department staff and patients.

Mrs Needham informed the Board that the Ambulatory Emergency Care Network visited the Trust on 6 January 2014. The trust delivered a presentation of our ambulatory care journey and some information on activity. The Network undertook a walkthrough of the patient pathway through the Emergency Department, the assessment units and through to the ambulatory care centre. They were very positive regarding the work we had already undertaken with ambulatory care in such a short timeframe. The initial feedback was positive and they commented on how impressed they were with the location, facility and the enthusiastic team.

Mrs Needham reported that the seven day working project required more support and an increased scope to focus on support and diagnostic services as well as the medical workforce. It was reported that the Trust had been invited to participate in an East Midlands wide seven day working project. Dr Swart added that the project was designed to develop the underlying evidence to support a detailed case for change for the move to seven day working prior to undertaking wider pilot initiatives. The Board was informed that the Trust would be actively participating in the project.

With regards to GPs working in the Emergency Department, Mrs Brennan asked if the Trust had enough coverage when it was required at the busiest times. Mrs Needham advised that there was a GP working in the department every day, but the department would benefit from better coverage at the busiest times, and the Trust was actively liaising with the CCG in this regard. Mr Zeidler asked if the Trust was capturing and analysing the data relating to the patients seen by GPs to understand why they attended at A&E. Mrs Needham advised that the data was captured and fed back by GPs to individual GP practices, although further proactive engagement with GPs was required.

Mr Noble asked if the additional beds funded by winter pressure monies had been effective and questioned what would happen once the winder pressure funding stopped. Mrs Needham advised that the additional had been effective, they were all full. She added that the Trust was in liaison with the CCG to discuss their effectiveness, and if agreed to be successful, the CCG would be obliged to continue funding them. Dr Swart commented that this was symptomatic of a the lack of an agreed health economy wide bed capacity plan, which needed to be developed and agreed.

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

TB 13/14 153 Finance Report

Mr Foster presented the Finance Report to the Board.

It was reported that at the end of December, the year to date position was a deficit of £3.7m, which was inclusive of the income settlement agreed with

Nene CCG. Performance in month was reported at £270k off plan, primarily due to the fall in private patient and other income during December, breaches of directorate control totals and the continued use of temporary staffing.

The Board was informed that the Trust was forecasting a £6.9m year-end deficit. An offer of non-recurrent support had been given by the TDA of £4.5m to facilitate the delivery a break even position at the year end, subject to approval by the TDA Board. That would leave a residual deficit of £2.44m to be recovered by the year end. It was noted that the offer was conditional on the Trust delivering a break even position. The Trust would be required to take firm action to manage the financial position to deliver a break even position, and the forecast would be closely monitored.

It was noted that the support would have cash flow implications. As things stood, receipt of the £4.5m support from the TDA would alleviate any need to access the agreed temporary borrowing facility. That would however depend on the timing of the receipt of the cash and links to the agreement of the year end settlement and cash profile with the CCG. With this in mind, Mr Foster recommended to the Board that the Trust accept the offer of support from the TDA.

Mr Noble commented that the Finance Committee had reviewed the position in detail at its meeting. He felt the plan to deliver a break even position was convincing and was reassured by this. He added that delivering breakeven in 2014-15 was of concern. Mr Foster advised that the outline 2014-15 plan had been submitted to the TDA, and once refined based on feedback received would be presented to the Board in March 2014.

The Board **AGREED** to accept the offer of support from the TDA and **NOTED** the Finance Report.

TB 13/14 154 Workforce Report

Mrs Brennan presented the Workforce Report to the Board.

The Board was informed that the mandatory training compliance levels had increased, and appeared to be following a positive trajectory.

It was reported that sickness absence rates continued to be an area of concern. The Trust had recorded the sickness absence rate for December 2013 at 4.72%, a minor increase on the previous month and above the Trust target. Mrs Brennan advised that a benchmarking exercise into the number of days sickness lost per employee had been undertaken which showed the Trust as higher than the local and national average.

Mrs Brennan reported that the Raising Concerns at Work Policy had been approved and an active communications campaign was ongoing to raise awareness and to support staff so they feel able to raise concerns at work.

It was reported that a successful apprentice assessment day was held in December, followed by interviews, with 6 posts filled across the Trust in areas including HR, IG, Medical Records and Oncology. The apprentices are due to commence in March and will cover Admin & Clerical and Customer Service roles.

Mr Robertson asked if the link between completion of staff appraisals and salary progression had been implemented and made clear to staff. Mrs Brennan confirmed that the policy was now in place and had been actively

communicated to staff. She advised that the impact of the policy would not be seem immediately, but would be clearer following the next round of annual appraisals taking place.

Mr Zeidler observed that the Trust consistently remained 3% below the target workforce capacity level. He voiced concerns that despite the Trust accounting for 5% temporary workforce in its annual plans to allow for seasonal workforce variation and fluctuations due to turnover and sickness, the Trust consistently missed the target. It was requested that a plan be prepare which articulated what was required to deliver a safe and effective workforce that could be met. Mrs Brennan undertook to review and would prepare a report to the Integrated Healthcare Governance Committee.

ACTION: Mrs Brennan

The Board **NOTED** the Workforce Report.

TB 13/14 155 Improving Quality and Efficiency Report

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

In presenting the 2013/14 position at month 9, Mrs Brennan advised that the latest thinking forecast had increased to £11.7m.

It was reported that the Trust would not achieve its £13m year-end target as all mitigation schemes had now been exhausted, and due to the cumulative effect of annual savings targets, short term efficiency savings were more difficult to identify. Therefore, the focus of the programme moving forward would look at long term transformational quality and efficiency schemes. Dr Swart added that going forward; the programme would need to reflect the requirement of wider health economy partners involvement in delivering transformational schemes due to the increasing scale of the savings required over the next two to five years.

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

TB 13/14 156 TDA Self-Certification Report

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

The Board was informed that in accordance with the Accountability Framework, the Trust was required to complete two self-certifications in relation to the Foundation Trust application process. As such, the Board was asked to approve the Monitor Licence and Trust Board Statements.

In relation to board statement 10, it was requested that the commentary be updated to make reference to the increase in attendances at A&E and to remove C.Diff as a performance issue.

Subject to those amendments, the Board **APPROVED** the TDA Self Certifications.

TB 13/14 157 Oncology and Cancer Partnership with UHL

Mr Pallot presented a paper to the Board which proposed that the Trust, along with University Hospitals Leicester, work in partnership to support the future of oncology and cancer pathways to maintain services at both Trusts and to gain benefits with a larger population base for clinical trials and other cancer research opportunities. It was reported that the paper had been developed in conjunction with colleagues at University Hospitals Leicester and Kettering General Hospital.

Mr Pallot reported that the Trust and University Hospitals Leicester NHS Trust were both recognised Cancer Centres providing cancer treatment for their local populations and offering specialised treatments to a number of tertiary hospitals. However, due to changes in the national cancer service specifications and the Improving Outcomes Guidance, population size had become a significant risk for Trusts offering specialised treatments. Both the Trust and University Hospitals Leicester were vulnerable with neither attaining the critical population mass to meet the changing Specialised Commissioning Service Specifications requirements. Therefore it was felt important to consider the future viability of both Cancer Centres and ensure continued cancer patient pathways including patients within the Kettering General Hospital Foundation Trust catchment.

As such, it was proposed that the Board endorse the proposal to develop a vision of partnership working initially for the oncology departments, but leading on to future cancer pathways. Mr Pallot advised that subject to the Board's approval of the proposal, the Trust should look to proceed at pace and made a number of recommendations to enable that to happen.

Dr Swart commented that the partnership model would fundamentally improve the quality of local services provided, but noted that services would not be transferring from one trust to another.

Mr Noble asked if there was a fall-back position for the trust should this proposal not delivery the required benefits. Dr Swart advised that there were a number of further options that had been considered prior to proposing partnership working with University Hospitals Leicester that would be considered should the proposal not come to fruition.

Mr Zeidler commented that he welcomed the proposal noting that it encapsulated the direction that the Trust should be traveling adding he felt the proposal was fundamentally a good thing for patients.

The Board **APPROVED** the proposal to explore partnership working arrangements with University Hospitals Leicester for the Oncology Departments and **APPROVED** the recommendations made within the report.

TB 13/14 158 Risk Management Strategy

Dr Wilkinson presented the Risk Management Strategy to the Board for approval.

He advised that the Risk Management Strategy was approved by Trust Board in July 2013. At that meeting, the Board had requested that the strategy be returned to the Board with any amendments that were required as a result of the embedding of the Care Group Structure. Subsequently, following those changes, the strategy was presented to the Audit Committee in December 2013 where some minor amendments were requested and had been incorporated prior to presentation to the Board for formal ratification.

Subject to a number of typographical amendments, the Board **APPROVED** the Risk Management Strategy.

TB 13/14 159 Standards for Members of NHS Board in England

Mr Zeidler presented the Standards for Members of NHS Board in England, recommending that Board members formally endorse the standards.

The Board considered the methods of assurance and undertook that each Board member would provide a signature to evidence of their individual endorsement of the standards.

The Board **RESOLVED** to endorse the Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England.

TB 13/14 160 **Any Other Business**
No items of any other business were raised.

TB 13/14 161 Mr Zeidler called the meeting to a close at 11.30.

Date of next meeting: 9.30am, Thursday 27 February 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 20/02/2014

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
28/11/2013	TB 13/14 126	Chief Executive's Report	Provide an update to the Board on progress regarding the introduction of care certificates for Healthcare Assistants	Ms S Loader	27/02/2014	On Track	
28/11/2013	TB 13/14 130	Infection Prevention Performance Report	Provide benchmarking data for C.Diff and MRSA ceilings comparing the Trust to peers.	Mr C Pallot	31/03/2014	On Track	
	TB 13/14 154	Worforce Report	Mrs Brennan to present a workforce plan to the Integrated Healthcare Governacne Committee which articulated what was required to deliver a safe and effective workforce target that could be met	Mrs J Brennan	31/03/2014	On Track	

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
27 February 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
Trust Board - February 2014

Securing a health service fit for the future

Northamptonshire is one of eleven financially challenged health economies in England chosen to receive expert help with strategic planning in order to secure sustainable quality services for local patients. Monitor, NHS England and the NHS Trust Development Authority have agreed to fund a series of projects to help us work with our commissioners to develop integrated 5 year plans that effectively address our local challenges. We still have responsibility for delivering our own strategic plans but the external advisors will act as a critical friend to ensure that we do this in the most effective way. Suppliers will be appointed at the end of March and the initial programme will be completed in 10 weeks. This programme of work will build on the previous work completed as part of the Healthier Together and Healthier Northamptonshire programmes. It will cover four key areas which are a diagnosis of supply and demand, solutions development and options analysis, plan development and implementation. More details regarding this programme of work are likely to emerge in a few weeks.

CEO attendance at the Public Accounts Committee

The National Audit Office (NAO) published a report in January which suggested patients in England cannot rely on information on waiting times for non-emergency operations, such as knee and hip replacements. The report found wrong and inconsistent recording after reviewing 650 cases in seven trusts. The watchdog said it was unable to discern whether this was deliberate. The Public Accounts Committee which is Parliament's oldest Select Committee is set up to hold the government to account for its use of taxpayers' money. It recently heard evidence from Northampton General Hospital which was one of the 7 Trusts named in the report. Evidence was also provided from Homerton University Hospital NHS Foundation Trust and from the Department of Health, NHS England, Monitor and the Trust Development Authority. The evidence given suggested that there was no deliberate mis-recording of waiting times but that the systems surrounding the recording of information were complex and time consuming as a result of a mixture of manual and electronic systems and certain complexities relating to interpretation of the guidance on this matter. It was clear that there could be improvements in the information given to patients and that hospitals will be required to improve the accuracy of data and undertake regular audits of data quality . Overall, the need to balance the demands on urgent care, cancer treatment and more routine operations was clearly a challenge in terms of providing patients with prompt access to treatment. This is certainly a challenge faced at NGH as the pressure on urgent care mounts. Despite this waiting times in the NHS have improved in recent years and most hospitals including NGH are meeting the standard of treating all patients within 18 weeks of referral. One of our local MPs Chris Heaton-Harris started his questioning in the committee by thanking the hospital staff at NGH for all their hard work and the high quality care provided for patients.

Introducing Fundamental Standards of Care

The Department of Health have begun consulting on proposed amendments to CQC's registration requirements in order to introduce Fundamental Standards of care.

The proposals in the consultation to amend the CQC registration requirements are part of a wide-ranging set of changes designed to improve the regulation of health and social care providers, and provide assurance that service users receive safe, quality care and treatment.

The proposed changes are designed to meet a number of recommendations arising from several inquiries, reviews, consultations and policy initiatives. These include:

- The Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry);
- The Winterbourne View Review;
- The Berwick Review in to Patient Safety;
- The government's Red Tape Challenge.

The Fundamental Standards are intended to be common-sense statements that describe the basic requirements that providers should always meet, and set out the outcomes that patients or care-service users should always expect. All care providers registered with CQC will have to meet them.

The Trust will be reviewing the consultation document and responding accordingly prior to the 4 April 2014 deadline.

Smoke-Free NGH

We are re-launching smoke-free NGH to coincide with national no smoking day on 12th March 2014. With support from the local smoking cessation team and sponsorship from Pfizer we are refreshing our smoke-free branding and signage across the entire site. One of the key areas we will be targeting our activity is towards staff who smoke during the working day. We know from patients who are trying to stop smoking that they find it difficult if they can smell tobacco on staff, so we want to support our staff so they are able to remain smoke-free at work. The working group will also be providing support and training for staff to encourage them to speak to their colleagues, patients and members of the public who continue to smoke on the NGH site despite our requests for them not to do so. This work is closely aligned to our value of respecting and supporting one another.

External stakeholder engagement

The Trust deals with a large number of people on a daily basis. Whilst we regularly gather feedback from patients and staff we are conscious that we don't often ask what our external stakeholders think of us and how easy we are to work with. For this reason we are undertaking our first external stakeholder engagement survey, the results of which will be reported to the board in April. The information will also inform our communications and engagement activity going forward as well as providing a baseline so that we can measure the effectiveness of our communications and engagement activity.

QuEST

We have now started the second round of QuEST (Quality Effectiveness Safety Team) reviews. Early indications are that many wards have improved since our first QuEST reviews in December. It is pleasing that a high number of non-clinical staff are involved in the reviews as this provides them with an opportunity to be directly involved with helping us achieve our aim of providing the best possible care. Work is also underway to develop a formal feedback mechanism to enable learning to be shared and for achievement to be recognised.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 February 2014

Title	Quality Report
Agenda item	7
Sponsoring Director	Dr Mike Wilkinson – Medical Director (Interim)
Author(s)	Dr Natasha Robinson – Associate Medical Director Mrs Jane Bradley – Patient Safety Program Director Christine Ainsworth – Senior Risk and Litigation Manager
Purpose	Assurance

Executive summary

Mortality:

- Overall mortality as measured by HSMR remains low (86) and recent improvements have been maintained. SHMI has also improved and is predicted to improve further in the coming months.
- Crude mortality remains low at 3.5%
- The Mortality & Coding Review group continue to monitor adverse clinical outcomes.
- Further analysis of the gastrointestinal and liver disease group continues due to apparently high identified mortality in some CCS groups.
- Data quality continues to be addressed by the Data Quality Group.
- The bi-annual notes review of 50 deaths finishes on 21st February. Key learning from this will be fed back to SMB, M&M, the Patient Safety academy as well as individual feedback to clinicians

Serious Incidents:

- 12 new Serious Incidents (SI) were reported in January 2014. 9 of these were pressure ulcers. A thorough action plan for this is being put in place by the tissue viability nurse.
- The themes from SIs are now recorded centrally on health assure and fed back to the directorates and care groups for learning and reflection.
- A new pathway for dissemination of learning to individual, directorate and Care Group level has been developed and will be supported by the introduction of a quality newsletter.
-

Related strategic aim and corporate objective	Strategic Aim 1 : Be a provider of quality care for all our patients Objective No 1: Invest in enhanced quality including improvements in the environment in which we deliver care

Risk and assurance	There is a potential risk to the Trust as a result of the delay in external reporting of Serious Incidents to the CCG and the risk of being an outlier in Q3/4 due to high numbers of PU SI's that are currently being reported. Non engagement or adherence to timescales from some SI Leads has meant there have been breaches in the 45 day deadline for submission to the CCG. These breaches are reported to the TDA and may pose a reputational risk to the Trust
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) **No** 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) **No**
Legal implications / regulatory requirements	There are no legal/regulatory implications of the paper

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

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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 November 2013 and SHMI (to June 2013)

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

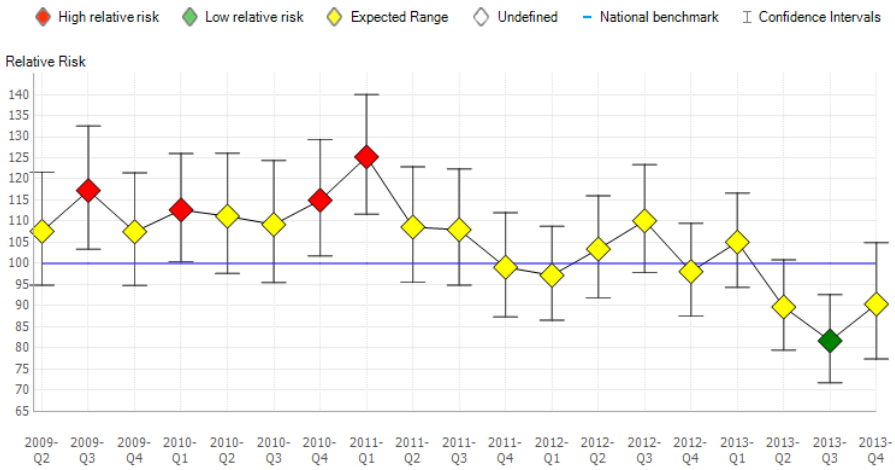
HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its appropriate use continues. It is based on mortality in 56 CCS (Clinical Classification Software) groups. These diagnosis groups account for 80% of hospital mortality and are recognised as having reliable predictive 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). The Board should note that the expected mortality for any given condition cannot take into account the severity of that condition in an individual patient, but is based on the diagnosis, age, presence of other conditions (comorbidities) and any surgical procedures carried out. Hospital mortality rates are also known to reflect local community and primary care provision. A high standard of care in the community may have a confounding effect on admissions, reducing numbers such that only the highest risk cases are admitted to hospital. Equally, lack of access to primary care may also mean that patients present late to hospital in a more serious condition. 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 includes 3 community sites. As previously described, the casemix between the acute Trust and the community wards is very different, the latter admitting patients directly from and to KGH, from and under the care of GP's, and also long-term patients for rehabilitation. It is now possible to monitor HSMR performance back to April 2013 for each site, generating 8 consecutive months' data. It is helpful to be able to monitor 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

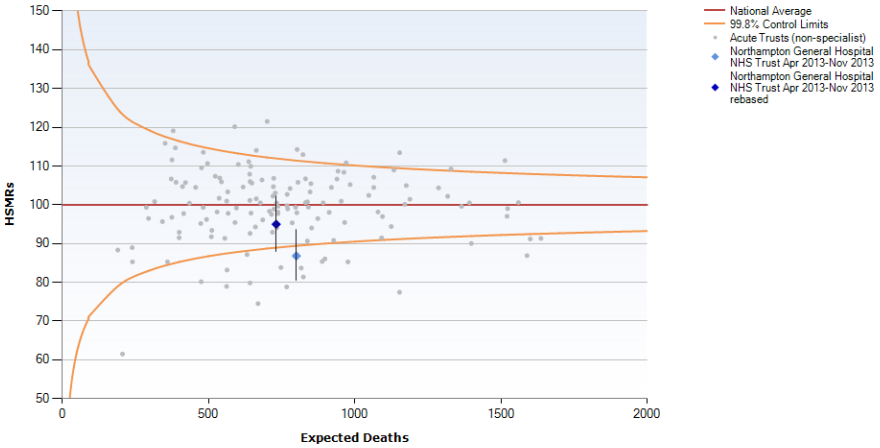
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture.

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 8 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for the rolling year to date is **94** and for 2013-4 is **87** (**95** when rebased).

Crude mortality for 2013-4 is currently 3.5%, showing marked improvement as compared to 2012-3 (4.2%) and one of the 3 lowest in East Midlands. The current average for Trusts in East Midlands is 3.8% (range 3.3% - 4.7%).

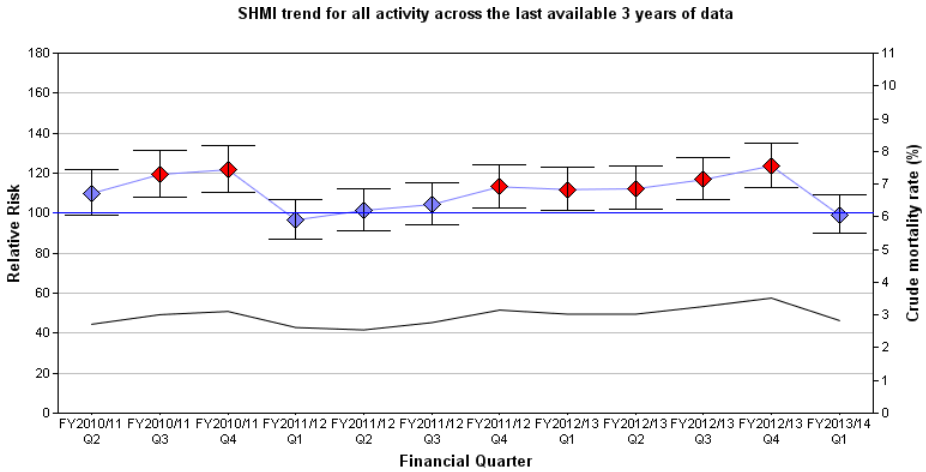
Acute Trust HSMRs Apr 2013-Nov 2013

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



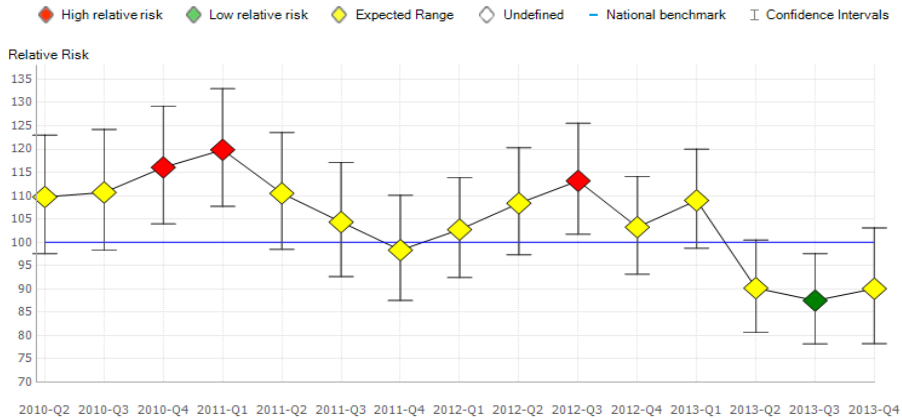
4. Standardised Hospital Mortality Indicator (SHMI)

There has been a 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.



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 November 2013, which suggests that SHMI for 2013 will return to within 'expected' limits in the next quarter.



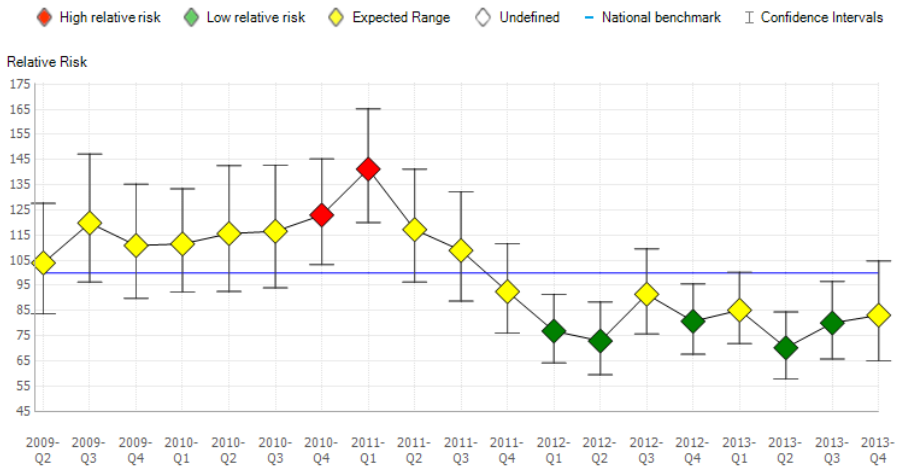
Dr Foster patient safety indicators (October 2012-November 2013)

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	38,126	25	30.1	0.7	0.8	83
Decubitus Ulcer	9,386	255	310.0	27.2	33.0	82
Deaths after Surgery	356	54	43.5	151.7	122.3	124
Infections associated with central line *	15,777	1	1.1	0.1	0.1	95
Postoperative hip fracture *	24,939	4	1.5	0.2	0.1	259
Postoperative Haemorrhage or Haematoma	23,325	9	13.8	0.4	0.6	65
Postoperative Physiologic and Metabolic Derangement *	19,687	4	1.6	0.2	0.1	251
Postoperative respiratory failure	17,916	21	15.5	1.2	0.9	135
Postoperative pulmonary embolism or deep vein thrombosis	23,508	33	45.0	1.4	1.9	73
Postoperative sepsis	533	4	3.8	7.5	7.1	106
Postoperative wound dehiscence *	1,006	0	1.5	0.0	1.5	0
Accidental puncture or laceration	65,660	36	75.7	0.5	1.2	48
Obstetric trauma - vaginal delivery with instrument *	481	29	39.8	60.3	82.7	73
Obstetric trauma - vaginal delivery without instrument *	2,460	95	94.4	38.6	38.4	101
Obstetric trauma - caesarean delivery *	1,173	0	4.4	0.0	3.7	0

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

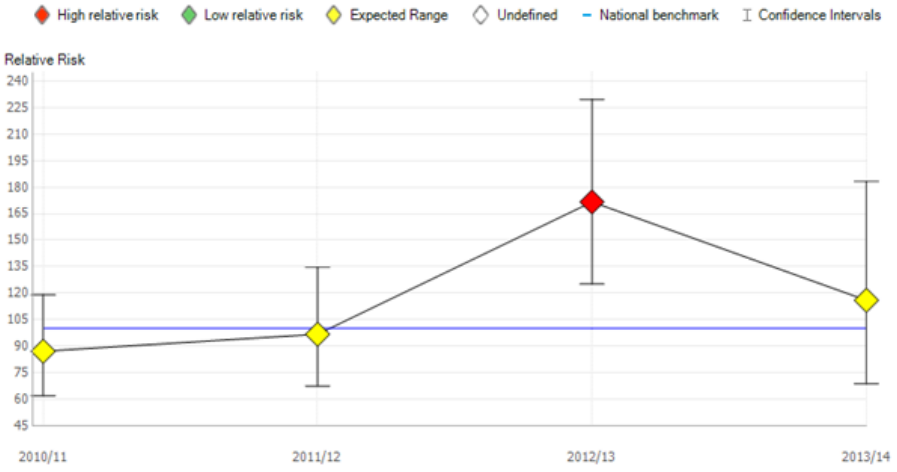
6. Reports on key areas for action or of importance

Aggregate mortality resulting from the 5 high risk diagnosis groups [acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure] is better than expected for 2013-4 at **76**.

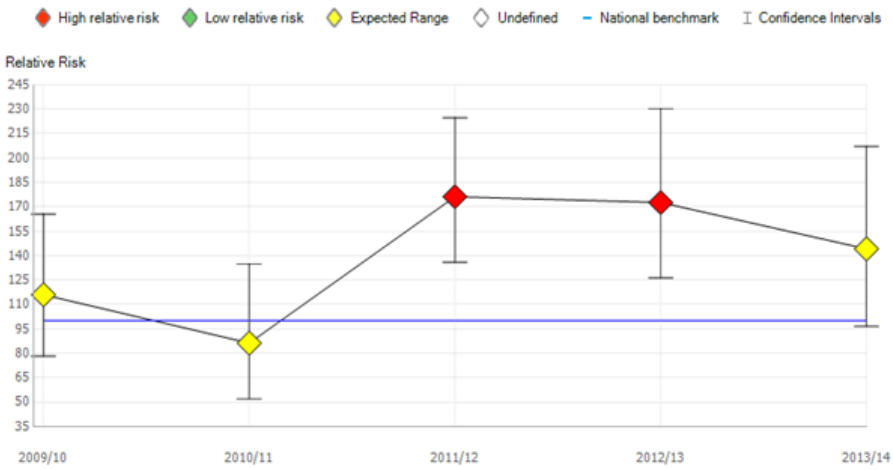


7. Possible areas for concern under investigation

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

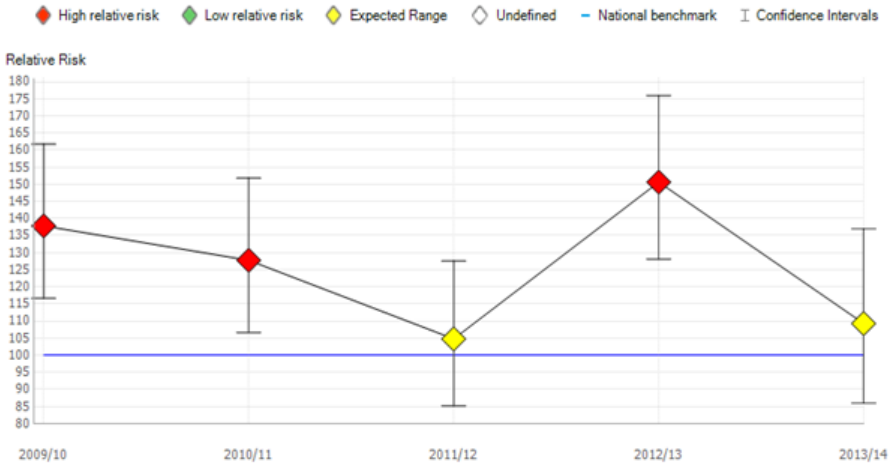


Secondary malignancy: Despite a previous review and actions planned, there has been limited improvement. A further review of deaths occurring in oncology has been requested and will report to Mortality & Coding Review Group in May.



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

CQC: As previously described, work is ongoing to track performance from the 2012-13 alert for gastroenterology/hepatology 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, 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 further quarterly report from CQC is overdue, and is expected imminently.

9. Further actions in place or planned:

The Trustwide mortality review group meets for the last time on Friday 21st February. Feedback will be provided to individual clinicians. The final report will be available in April 2014, and the process will be repeated in June, and it is hoped to a wider range of disciplines will participate, to include nursing staff and trainee doctors. Participation in the group has enabled consultants to develop their mortality review skills for use within their own directorates.

10. Data Quality (to end December 2013):

A user friendly tool is being developed to enable consultants to check the clinical coding of all admissions via the intranet. The Data quality Strategy is currently out for consultation.

Section 2:

Serious Incident Report – February 2014

1. Introduction

The Board is aware of its responsibilities in relation to patient safety and promoting a culture of learning from any untoward incidents. The purpose of this report is to provide a summary of the Trust's performance against key targets for the reporting and management of Serious Incidents. It also provides a thematic analysis on Serious Incidents reported by the Trust to date and details lessons learned and action taken in response to mitigate risk.

2. Background

A Serious Incident (SI) is defined as an incident that occurred in relation to NHS-funded services and care resulting in (or could have resulted in) one of the following:

- Unexpected or avoidable death to one or more patients, staff or members of the public
- Serious and or permanent harm to one or more patients, staff or members of the public where the outcome requires life-saving intervention, major surgical/medical intervention or will shorten life expectancy or result in prolonged pain or psychological harm
- The actions of staff providing NHS funded care that are likely to cause significant public concern i.e. serious instances of abuse (physical/sexual/mental).
- An event that prevents or significantly threatens the Trust's ability to deliver healthcare services.
- One of a core set of 'Never Events' as defined and updated annually by the National Patient Safety Agency (NPSA)

The organisation has a responsibility to investigate and where appropriate learn and take corrective action in response, to mitigate the potential for any future incidents and also to report such incidents to the Nene and Corby Clinical Commissioning Group (CCG) and the Strategic Executive Information System (STEIS).

This report is presented to provide assurance that the Trust has robust systems and processes in place to learn from adverse events to minimize or eliminate the risk of recurrence in the interests of patient safety. This report provides a summary of the Trust's performance against key targets for the reporting and management of serious incidents. A thematic analysis and identification of actions taken to reduce risk of recurrence is also included.

2.1 New SIs

Within the reporting period 01 – 31January 2014, 12 new Serious Incidents have been reported.

The following table illustrates the Serious Incidents by Datix category:

Category	Number	Comments
Implementation of care	9	Hospital acquired Pressure Ulcers, (5 of which occurred in December) The investigation will identify whether the ulcers are deemed to be avoidable or unavoidable
Accident which may result in personal injury	2	2 patients fractured the neck of femur following falls - both of which occurred in December
Treatment, procedure	1	Unexpected death in Endoscopy Unit

2.2 Closed Serious Incidents

During the reporting period at total of 15 incidents were submitted for closure.

- 3 patients sustained Grade 3 Pressure Ulcers. The investigations found that the ulcers were unavoidable and have therefore requested that the incident be downgraded
- 6 patients sustained Grade 3 Pressure Ulcers – deemed to be avoidable
- 1 Grade 3 Pressure Ulcer – investigation found that this was not a pressure ulcer and have requested that the incident is downgraded
- Medication error
- Antenatal screening issue
- 2 unexpected deaths
- Premature discharge

2.3 Active Serious Incidents

As at 31st January 2014 there were 35 on-going Serious Incidents investigations underway.

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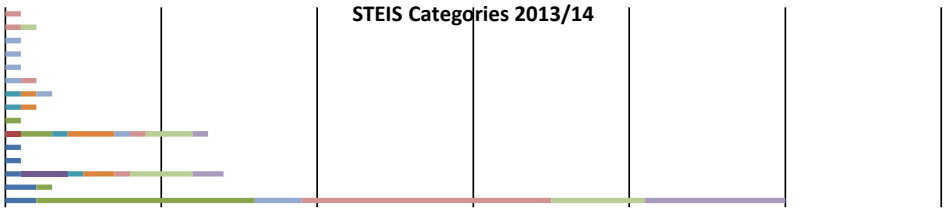
Table 1: Serious Incident Categories reported onto STEIS by Month 2013/14



	Pressure Ulcer Grade 3	Pressure Ulcer Grade 4	Slip,trips, falls	Outpatient appoint-ment delay	Health care acquired infection	Un-expected death	Child death	Sub-optimal care	Adverse media coverage	Premature discharge	Maternity Services	Attempted Suicide	Drug incident	Other	Screening issues
April	2	2	1	1	1										
May						1									
June	14	1				2	1								
July			3												
August			1			1		1	1						
Sept			2			3		1	1						
Oct	3					1			1	1	1	1	1		
Nov	16		1			1				1				1	1
Dec	6		4			3								1	
Jan	9		2			1									

2.4 STEIS Extension Submission Requests

During the reporting period:

- one extension was requested
- three reports were submitted in breach of the 45 working day deadline

The delays can be attributed to a number of factors, namely:

- Non engagement or adherence to timescales from some SI Leads
- Greater probity into investigations with a number of requests to the leads for further analysis to identify the root cause of these incidents. CQEG are asked to note this as a positive step, whilst viewed in the context of the breaches.
- Complex incidents have led to the Serious Incident Group trying to obtain an independent external review of the cases which has led to delay in bringing these reports to conclusion

2.5 Serious Incident reporting rate

There were 884 patient safety incidents reported in January 2014, 12 of which were declared and investigated as a Serious Incident, this represents a reporting rate of 1.36%. Whilst this represents a slight decrease on the December 2013 rate of 1.5% it is the second month that the reporting rate is over the national average of 1%.

The high number of Serious Incidents reported is due to the number of Grade 3 pressure ulcers that have been reported, e.g. out of the 12 Serious incidents reported in January 9 (75%) were grade 3 pressure ulcers.

2.6 Duty of Candour (Being Open)

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

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

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

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

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

2.7 Key Learning and Service Improvements

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

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

Grade 3 Pressure Ulcers -avoidable (Collingtree, Holcot, Rowan, Willow, Brampton, Cliftonville)	
Theme	Learning / Actions
Documentation	Accurate completion of risk assessment documentation Turn charts to be maintained in accordance with patients' needs Documented evidence of which pressure areas have been checked on each shift The patients skin integrity had not been documented adequately enough on turn chart
Clinical Assessment	SSKIN care plan to be implemented for all patients on admission Delays & Inaccurate calculation of risk assessments. Reassessments of SSKIN and Risk to be carried out in response to patients condition and skin integrity Pressure Damage Classified in accordance with Midlands and East Classification System Staff to undertake buddy grading and to ensure that this is documented in patient notes Increase awareness of qualified staff to complete assessments more frequently and in response to patients condition Staff to check and document all patients skin integrity per shift
Policy / Procedure / Process	Adherence to Trust Policy and Procedures on Pressure Ulcer Prevention - delay in implementation of Core Care plan
Staffing	Low numbers of staff on the night shift
Training	Tissue Viability Team to arrange further training and develop evidence of learning/ implementation to practice (competency) Raise Tissue Viability Team's profile across trust
Sharing of Lessons learnt	Ward Sisters to discuss in Team Brief Staff on Ward involved in patients care made aware of SI report and learning shared

General Medicine / Radiology **Unexpected death**	
Theme	Learning / Actions
Policy / Procedure / Process	Radiology department to review post-procedural advice given to receiving wards following interventional procedures and to consider follow-up visit in high risk cases.
Discharge / Transfer process	The Site Management Team should record the rationale and requestor for all patient transfers within a database Ward transfers should only happen for clinical indications and with prior agreement and documentation by medical and nursing teams involved.
Multi-disciplinary / professional working	A transfer between clinical teams, requires prior communication between both teams, and clear documentation
Sharing of Lessons learnt	The incident should be discussed at the respective Mortality/Morbidity meetings in medicine and radiology to highlight the issues to the entire teams.
A & E **Premature Discharge**	
Theme	Learning / Actions
Policy / Procedure / Process	Review of whether d-dimer should be added to chest pain assessment Consideration of chest pain pathway with additional confirmation that aortic dissection has been considered
Escalation / Senior clinical involvement	Lack of consultant involvement
Training	Ensure that all involved clinicians [A&E & Medicine] are familiar with the ACS pathways
Sharing of Lessons learnt	Review all recent cases of missed thoracic aortic dissection at NGH for learning
Pathology Antenatal Screening	
Theme	Learning / Actions
Policy / Procedure / Process	Review current processes for validation of results Expansion of current audit programme to comprehensively examine manual procedures The only 2 antenatal tests (Hepatitis B and Rubella) that were not interfaced at the time of the incident be interfaced To ensure a robust system in place should the need to revert to manual reporting of results arise Regular audits of the laboratory computer system to check if staff are adhering to the process
Sharing of Lessons learnt	The report will be shared with Trust staff in order to share the learning and recommendation. This will be facilitated via Directorate Governance, Risk Management and Operational Managers meetings. Dissemination of action plan and lessons learned to rest of the staff

Cedar **Unexpected death**	
Theme	Learning / Actions
Clinical Assessment	In patients who are reluctant to mobilise post fall, consideration should be given for referral to physiotherapist to re-build their confidence
Escalation / Senior clinical involvement	The Ward needs to review the process and expected timescales for escalation to the consultant if the Registrar is busy with other patients and cannot immediately review a deteriorating patient
Medical Equipment	The process for ensuring that beds are safe and the brakes are not faulty needs to be reviewed and embedded
Communication	Increase the awareness of staff to the fact that when a patient's condition is rapidly deteriorating, whilst the patient's clinical condition and resuscitation must take precedence, someone from the team should be allocated to notify the next of kin of the situation
ITU **Medication error**	
Theme	Learning / Actions
Prescription / administration of medicines	Removal of all oral / nasogastric medications from bedside trays to either the locked drug cupboard or chart station drawer Review Trustwide of storage of patient's medication lockers. Trust wide review in progress Information on the importance of acting immediately on Toxic levels of digoxin to be given to prescribers
Sharing of Lessons learnt	SI to be fed back to Ward meetings and Patient Safety Learning Forum ITU staff involved to reflect on event (this is part of trust medicines policy) SI to be fed back to Prescribers at Grand Ground meetings

2.8 Next Steps

Serious Incident Policy

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

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

Action Plans

All submitted Serious Incident reports and action plans are reviewed by SIG at the next meeting to ensure that contributory factors have been fully explored and that actions are aligned with the root cause of the incidents to reduce the likelihood of recurrence.

The process for the dissemination, monitoring and sign off of evidence of completion of the actions has been discussed and a draft flow chart has been developed to illustrate the proposed process (Appendix 1).

All action plans for SIs during 2013 have been uploaded onto HealthAssure and training is taking place for the Governance / Quality Managers and Governance Facilitators.

3. Assessment of Risk

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

The January 2014 serious incident reporting rate is 1.36%. Whilst this represents a slight decrease on the December 2013 rate of 1.5% it is the second month that the reporting rate is over the national average of below 1%. If this trend continues in Quarter 4 it may pose a potential reputational risk to the Trust when the national data is published by the NRLS in September 2014

The higher number of serious incidents reported is attributable to the number of pressure ulcers reported (75% of SIs reported this month were Grade 3 pressure ulcers).

Non engagement or adherence to timescales from some SI Leads has meant there have been breaches in the 45 day deadline for submission to the CCG. These breaches are reported to the TDA and pose a potential reputational risk to the Trust

4. Recommendations/Resolutions Required

Actions to mitigate the potential risks are as follows:

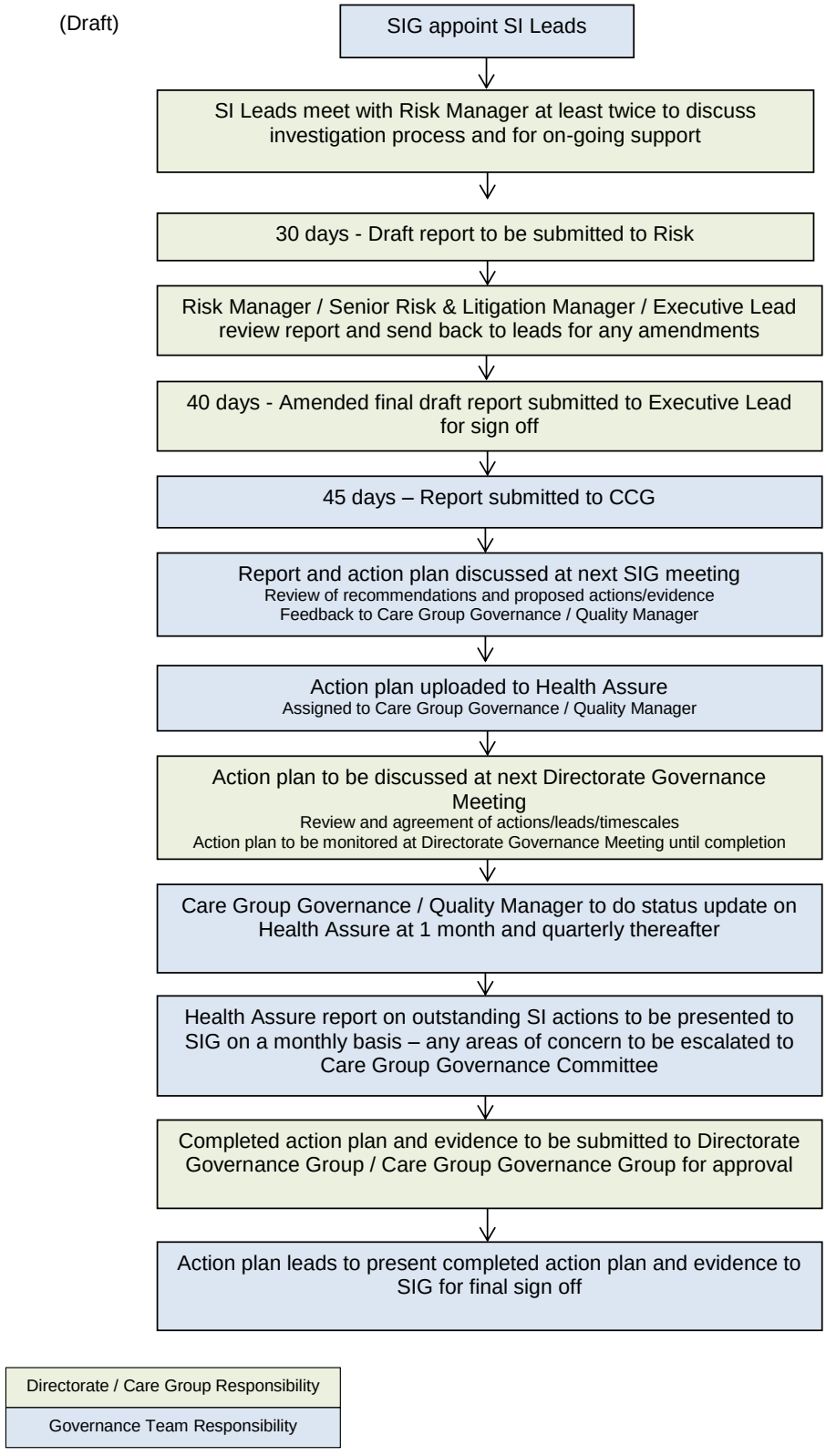
- The Serious Incident Group continue to meet weekly to expedite the agreement & external notification of Serious Incidents (SI).
- A process flow chart has been developed to support identification, confirmation and external reporting of Serious Incidents in a timely manner to meet external reporting requirements.
- Meetings have been held with the Care Group Quality Managers to ensure they understand and are supporting the agreed process.
- The Senior Tissue Viability Nurse is validating all pressure ulcers to ensure correct reporting of Grade 3 and 4 pressure ulcers
- Delays in submission of Serious Incident Reports - SIG are currently reviewing how investigation leads are nominated. It is suggested that the investigation lead should be a manager, with a supporting Matron (if clinical or 2 managers if non clinical) rather than a Consultant. Each investigation (clinical) will then have a sponsoring Consultant to provide the medical input & sign off of the investigation report.

5. Next Steps

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

Appendix 1

(Draft)



Section 3

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

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

HSMR and SMR by diagnosis group are reported as year to date. A continual process of refinement of indicators remains as working progress.

Performance

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

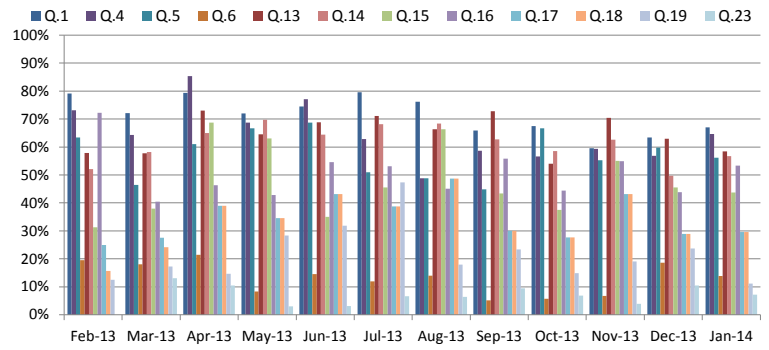
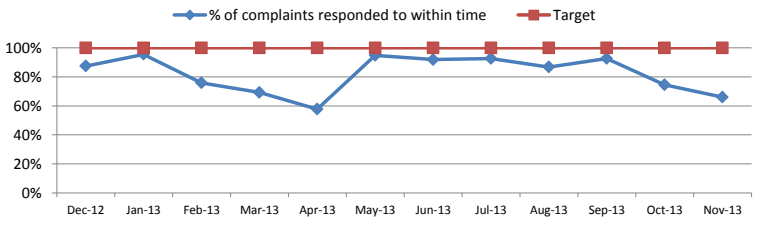
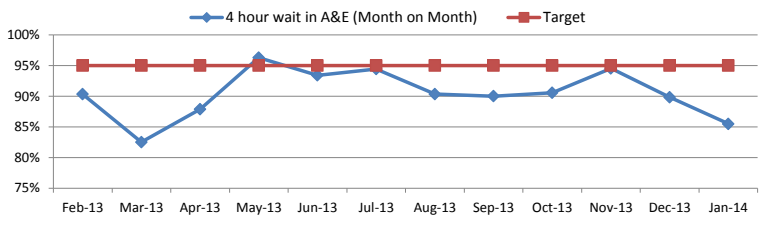
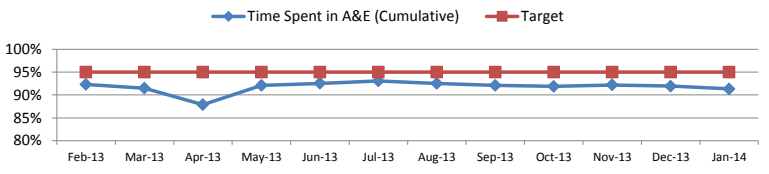
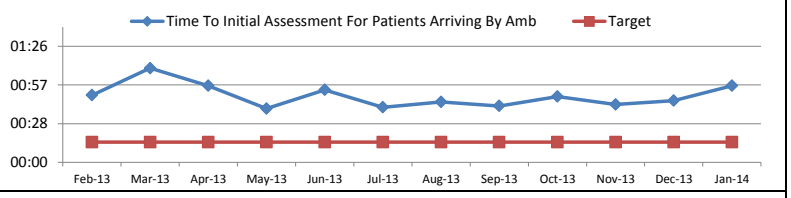
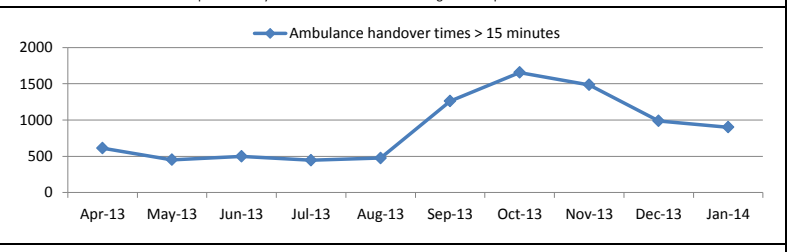
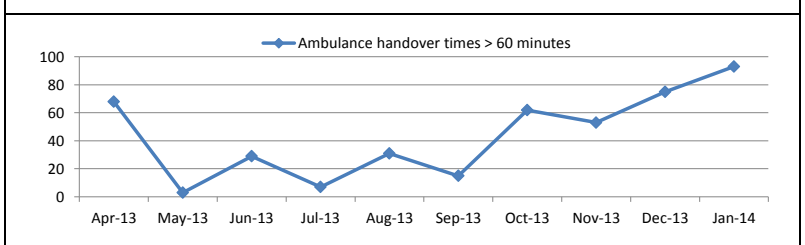
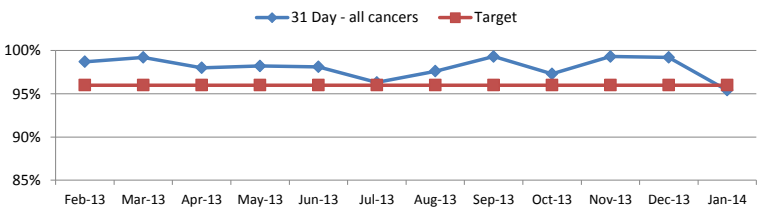
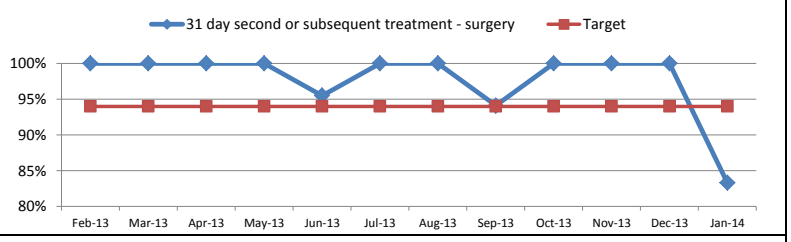
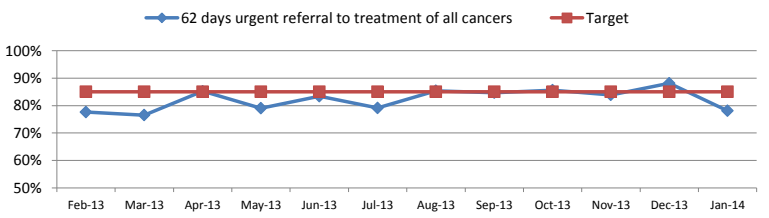
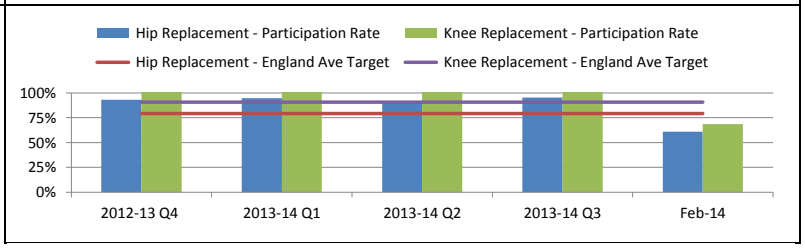
In comparison to Decembers report the number of indicators that have been rated as red has increased from **25/26.** Amber indicators have reduced positively from **19/13** and green indicators have increased from **67/76.** The Indicators rated as grey have remained static at **34.**

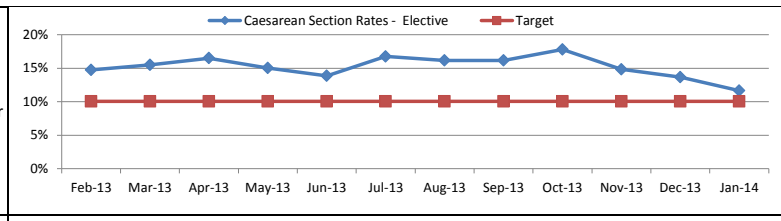
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**14**	**8**	**33**	**10**	**65**
Clinical Outcomes	**9**	**3**	**17**	**4**	**33**
Patient Safety	**1**	**2**	**3**	**19**	**25**
Patient Experience	**2**	**0**	**20**	**1**	**23**
TOTAL	**26**	**13**	**76**	**34**	**146**

Recommendation

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

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Healthcare Notes audit (23 questions)	100%	→	***The healthcare notes audit questions account for all 12 of the red performance scores in the Patient Safety category .*** Key issues identified on the Healthcare Notes audit in October 13: Following items flagged as red - front page of every sheet contain an addressograph label, the recording of vital patient information (date of birth and hospital number) on the front page of notes where the addressograph was absent, is time recorded for each entry, is the surname printed in block capitals, is the staff designation recorded, Medical Records Audit only: Is the GMC number present, are any alterations / deletions scored through with a single line, is there a signature recorded next to any alterations/deletions, Is there a date recorded next to any alterations/deletions, Is there a time recorded next to any alterations/deletions and Are there any loose sheets in the Healthcare record. An options appraisal has been presented to the Medical Director for consideration.	
Patient Experience	Complaints responded to within agreed timescales	100%	↓	The response rate for responding to complaints within an agreed timescale continued to decline from 75% for complaints received in October down to 66% for complaints received in November 2013. This can be extensions being required due to incomplete Directorate responses that had to be returned or responses that were late.	
Patient Experience	A & E Quality Indicators (5 indicators)		↓	**A&E Clinical Indicators:**	
			↓	The 4 hour wait in A&E (Month on Month) position ended at 85.5% for January, a further significant deterioration from the previous month (89.82% for December) and still remained under the target of 95%.	
			↓	Time Spent in A&E (Cumulative) - This indicator has been negatively affected by the non-achievement of the monthly 95% 4hrs for December waits, resulting in a cumulative of 91.33% from 91.94% for the previous month.	
			↓	The time to initial assessment for patients arriving by ambulance saw a further monthly increase from 46 mins in December to 57 minutes in January (national target being 15 minutes).	
			↑	Although there was further deterioration in the number of ambulance handover over 60 minutes (75 in Dec against 93 in Dec) there was a small improvement for the ambulance handover times waiting over 15 mins (Dec = 988, Jan = 901). The Trust is currently not being fined for any handovers of 30 minutes.	
			↓		
Patient Safety	Cancer target 31 days urgent referral to treatment of all cancers	96%	↓	There are currrently issues around breast surgery due to the unexpected unavailability of one of the surgeons. Outsourcing of some of this activity is being undertaken with efforts to try to appoint a locum in this area.	
Patient Safety	31 day second or subsequent treatment - surgery	94%	↓	The breach for this target is based on 5 patients: 2 were delayed due to medical reasons, 2 were pateint choice and 1 was an administrative error wth the patient breaching by one day.	
Patient Safety	Cancer target 62 days urgent referral to treatment of all cancers	85%	↓	The unverified position for January 2014 for this cancer access target is 78.1% against the target of 85%. This consists of 16 breaches out of a total of 73 patients. There are currently some capacity issues around Urology which are being addressed within the recovery plan.	
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 with the recently published findings passed onto the Directorate for review.	

Clinical Outcomes	Caesarean Section Rates (Elective)	10.06%	↑	Elective caesarean section rates continue to show a significant improvement during January with a reported position of 11.7% for the period against 13.6% for Dec 13.6% (target 10.06%).	
CQUIN	Improve performance on staff Friends & Family Test		↓	The annual Trust wide staff survey has been undertaken in Q3 and results are awaited. Predicted RAG rating of red will be determined following feedback from Care Group Directorates.	*Chart not applicable for this indicator*
CQUIN	50% reduction in all new avoidable Pressure Ulcers	Max 3 incidents p/m	↑	There was a slight improvement in the number of avoidable and unavoidable pressure ulcers during January 2014 however it still remains above target. Training and awareness is being provided for areas requiring specialist support from the Tissue Viability Team this is supported by Trust wide training sessions for all relevant staff.	

Corporate Scorecard 2013-14

Patient Safety	Target 2013-14	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Jan 14 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	0	0	0	0	0	0	0	0	0	0	0	0		
HQU02: HCAI measure (CDI)	29 per year	2	5	7	2	4	1	3	1	2	3	0	0		
HQU08: MSSA Numbers	No national ceiling set	0	0	1	0	1	1	0	0	1	1	2	0		
E Coli ESBL Quarterly Average	7 per month	2	0	2	3	3	4	2	2	3	2	2	0		
VTE Risk Assessment completed	95% month on month	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.3%	97.8%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%		
MRSA Screening Elective Patients	100% month on month	99.54%	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%	99.94%		
MRSA Screening Non-Elective Patients	100% month on month	96.56%	97.00%	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%	97.1%	97.1%	97.3%	96.5%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	30	45	24	32	23	22	23	15	13	18	23	13		
Incidence of pressure ulcers															
Grade 3 - New avoidable pressure ulcer		3	4	0	4	3	0	0	0	3	5	7	3		
Grade 3 - New unavoidable pressure ulcer		0	1	3	2	4	0	1	4	3	4	3	4		
Total Grade 3 - New pressure ulcer		3	5	3	6	7	0	1	4	6	9	10	7		
Grade 4 - New avoidable pressure ulcer		0	1	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	1	0	0	0	0	0	0	0	0	0	0		
Total Grad 3 & 4 Pressure Ulcers				3	6	7	0	1	4	6	9	10	7		
Reduce harm from falls															
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0	0		
Major/Severe	0	2	1	0	1	1	1	2	1	1	3	3	0		
Moderate	0	3	1	1	3	1	1	0	1	1	2	2	2		
Mandatory Training compliance Full Year Impact															
Primary Levels Excluding B&H	80%	65.2%	65.2%	65.1%	65.4%	65.7%	66.0%	66.1%	68.7%	70.2%	70.2%	70.8%	Not avail		January Data unavailability due to technical issues with that software
Attendance at Trust Induction	80%	87.6%	87.5%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%	87.6%	87.4%	87.5%	Not avail		January Data unavailability due to technical issues with that software
Number of surgical site infections															
Fracture neck of femur - Number of Operations	-	31	45	17	27	29	20	28	26	33	35	35	41		
Number of infections	-	0	0	0	0	0	0	0	1	1	1	0	0		
% infection rate (monthly)		0%	0%	0%	0%	0%	0%	0%	3.8%	3.0%	2.9%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	0.9%			0%			2.7%			1.9%				
Caesarean sections - Number of Operations	-									109	96%	94%	Not avail		
Number of infections	-									0	0	0	Not avail		
% infection rate (monthly)										0.0%	0.0%	0.0%	Not avail		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%										0%		N/Applic		
Total hip replacements - Number of Operations	-									23	31	11	35%		
Number of infections	-	Caesarean section, total hip replacement and total knee replacement infection rates monitored from Oct 2013								0	0	0	0%		
% infection rate (monthly)										0.0%	0.0%	0.0%	0.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%										0%		N/Applic		
Total knee replacements - Number of Operations	-									13	20	16	33%		
Number of infections	-									0	0	0	1		
% infection rate (monthly)										0.0%	0.0%	0.0%	303.0%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%										0%		N/Applic		
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc															
Open Central Alert System (CAS) Alerts	0	0	0	1	0	0	0	0	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	89.3%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%	79.9%	80.7%	80.9%	81.8%		
Serious Untoward Incidents	-	25	36	41	35	51	21	10	10	9	22	15	12		
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	100%	100%	100%	99%	100%	100%	100%	100%	98%	99%	99%	100%		
Healthcare Notes Audit															
Q.1 Does the front page of every sheet contain an addressograph label	100%	79%	72%	79%	72%	74%	80%	76%	66%	68%	60%	63%	67%		
Q.2 Does addressograph include the NHS Number?	100%	88%	92%	90%	97%	97%	98%	95%	93%	94%	90%	89%	96%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	90%	84%	100%	94%	90%	78%	67%	86%	69%	72%	76%	80%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	73%	64%	85%	69%	77%	63%	49%	59%	57%	59%	57%	65%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	63%	46%	61%	67%	69%	51%	49%	45%	67%	55%	60%	56%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	20%	18%	21%	8%	15%	12%	14%	5%	6%	7%	19%	14%		
Q.7 Is record legibly written	100%	98%	99%	95%	100%	98%	99%	97%	99%	99%	99%	95%	97%		
Q.8 Written in blue/black ink	100%	99%	100%	100%	100%	100%	100%	99%	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%	100%	99%	98%	99%	100%	100%	99%	98%	97%	98%	98%		
Q.10 Is date recorded for each entry	100%	90%	88%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%		
Q.11 Is time recorded for each entry	100%	66%	75%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%		
Q.12 Is there a signature of the person making the entry	100%	94%	94%	96%	97%	92%	97%	91%	91%	87%	91%	93%	91%		
Q.13 Is surname printed in block capitals	100%	58%	58%	73%	65%	69%	71%	66%	73%	54%	70%	63%	58%		
Q.14 Is the staff designation recorded	100%	52%	58%	65%	70%	64%	68%	68%	63%	59%	63%	50%	57%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	31%	38%	69%	63%	35%	46%	66%	43%	38%	55%	46%	44%		
Q.16 Are any alterations / deletions scored through with a single line	100%	72%	40%	46%	43%	55%	53%	45%	56%	44%	55%	44%	53%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	25%	28%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	16%	24%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	13%	17%	15%	28%	32%	47%	18%	23%	15%	19%	24%	11%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	96%	100%	99%	97%	88%	100%	91%	94%	96%	100%	99%	100%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	75%	44%	44%	60%	69%	71%	60%	36%	51%	63%	82%	91%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%	100%	100%	96%	80%	100%	100%	98%	91%	98%	100%	98%		
Q.23 Are there any loose sheets in the Healthcare record	0%	0%	13%	10%	3%	3%	7%	6%	9%	7%	4%	10%	7%		

Patient Experience	Target 2013-14	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Jan 14 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	1	2	1	0	0	0	0	0	0	0	0	0		
Hospital Cancelled Operations	6.0%	6.3%	11.5%	11.1%	9.6%	9.5%	12.0%	10.3%	8.4%	10.7%	10.2%	9.0%	N/Avail		Jan 14 data unavailable at the time of publication.
Number of written complaints received	-	54	52	45	58	37	29	38	41	55	50	35	45		
Complaints Responded to within agreed timescales	100.00%	75.9%	69.2%	57.8%	94.8%	92%	90%	86.8%	93%	75%	66%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits															
Admitted Patients	90.00%	95.12%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	93.94%	91.72%		
Non Admitted Patients	95.00%	97.90%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	99.00%	98.45%		
Ongoing Patients	92.00%	95.74%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	96.95%	96.90%		
A&E Quality Indicators (5 measures)															
Time Spent in A&E (Month on Month)	95%	90.33%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%	85.49%		
Time Spent in A&E (Cumulative)	95%	92.30%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%	91.33%		

Total time in A&E (95th percentile)	95th	06:21	08:08	06:45	03:59	04:43	04:17	05:19	05:22	05:18	04:17	05:39	06:57		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:50	01:10	00:57	00:40	00:54	00:41	00:45	00:42	00:49	00:43	00:46	00:57		
Time to treatment decision (median)	<60 mins	00:45	00:52	00:57	00:51	00:51	01:05	00:54	00:54	00:49	00:46	00:48	00:39		
Unplanned re-attendance rate	=<5%	6.07%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%	6.19%	5.82%	6.04%	5.57%		
Left without being seen	>1% and <5%	0.22%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%	0.15%	0.22%	0.31%	0.17%		
Ambulance handover times > 15 minutes	0	New for 2013-14		612	452	500	446	476	1263	1656	1485	988	901		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0	New for 2013-14		68	3	29	7	31	15	62	53	75	93		No hand over greater then 15 minutes
Cancer Wait Times															
2 week GP referral to 1st outpatient	93%	96.9%	98.3%	96.0%	95.4%	96.2%	95.5%	95.1%	96.6%	95.8%	97.6%	96.4%	93.7%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.6%	100.0%	98.6%	100.0%		
31 Day	96%	98.7%	99.2%	98.0%	98.2%	98.1%	96.3%	97.6%	99.3%	97.3%	99.3%	99.2%	95.4%		
31 day second or subsequent treatment - surgery	94%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	83.3%		
31 day second or subsequent treatment - drug	98%	96.8%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
31 day second or subsequent treatment - radiotherapy	94%	97.8%	95.8%	98.3%	98.6%	95.8%	96.5%	97.4%	96.5%	97.8%	95.8%	97.6%	100.0%		
62 day referral to treatment from screening	90%	93.3%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%	100.0%	96.3%	100.0%	100.0%		
62 day referral to treatment from hospital specialist	80% (local target)	73.7%	100.0%	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%	66.7%	100.0%	80.0%	100.0%		
62 days urgent referral to treatment of all cancers	85%	77.6%	76.5%	85.2%	79.0%	83.4%	79.1%	85.4%	84.7%	85.6%	83.9%	88.1%	78.1%		
SRS08: Length of Stay (Acute & MH)															
Elective	3.20	4	4.2	3.1	4.7	5.6	4.3	5.9	3.8	3.8	3.5	3.5	3.7		Based on DFI Peer Group UQ. Fig reported in Jan 14 relates to rolling 12 months up until Dec 13
Non-Elective	5.30	4.3	4.7	4.3	4.3	5.8	4.7	5.3	4.9	4.8	4.9	4.9	4.8		Based on DFI Peer Group UQ. Fig reported in Jan 14 relates to rolling 12 months up until Dec 13
SRS09: Daycase Rate	85%	84.8%	84.6%	85.9%	84.9%	84.6%	86.4%	85.3%	84.5%	84.5%	84.0%	83.5%	N/Avail		Jan 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%	
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%	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
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	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Jan 14 RAG Rating	Comments
HSMR - monthly position for 2013-14 (YTD)	<100	100.21	103.7	108.5	76.8	76.93	88.0	84.96	86.25	86.44	87	N/Avail	N/Avail		Latest DFI FY trend Apr 13 - Nov 13 (HSMR)
HSMR - 12 Monthly cumulative position		N/Avail	100.1	100.8	N/Avail	96.2	99.01	96.17	94.36	93.45	93.79	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
HSMR- cumulative position for 2013-14															
Pneumonia	<100	N/Avail	57.5	60.4	N/Avail	59.42	65.8	62.92	64.25	66.28	68.79	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Fracture of neck of femur (hip)	<100	N/Avail	148.7	135.89	N/Avail	127.47	125.72	121.88	107.38	95.36	87.48	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Acute Cerebrovascular disease	<100	N/Avail	105	108.2	N/Avail	101.95	90	100.93	94.37	94.66	91.14	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	N/Avail	133.5	135.88	N/Avail	128.8	135.46	120.63	110.89	111.1	109.4	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Acute myocardial infarction	<100	N/Avail	77.5	84.6	N/Avail	82.29	87.3	82.95	89.32	89.8	109.72	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	115.84	115.84	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%	95.2%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%	97.7%	97.7%	96.3%	N/Avail		
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	3.4%	4.0%	2.6%	2.7%	3.7%	3.3%	4.4%	3.4%	2.9%	2.8%	7.7%	N/Avail		Jan 14 data unavailable at the time of publication.
Fractured neck of Femur															
Patients fit for surgery within 36hrs	-	New for 2013-14		17	29	26	23	25	28	28	30	30	36		
Number of patients admitted with FNOF who were operated on within 36 h	-			14	21	23	22	21	19	24	13	25	34		
% of patients admitted with FNOF who were operated on within 36 hrs of l	100%			82.4%	72.4%	88.5%	95.7%	84.0%	67.9%	85.7%	43.3%	83.3%	94.4%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	90.6%	69.6%	90.9%	82.8%	81.3%	92.6%	85.7%	93.0%	94.0%	88.0%	92.0%	N/Avail		Jan 14 data unavailable at the time of publication.
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	67%	48%	43%	38%	38%	66%	59%	51%	48%	55%	43%	N/Avail		Jan 14 data unavailable at the time of publication.
100% of suspected stroke patients given CT scan within 24 hours of arriv	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	82%	100%	N/Avail		Jan 14 data unavailable at the time of publication.
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	60.0%	69.2%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%	73.9%	75.0%	84.0%	N/Avail		Jan 14 data unavailable at the time of publication.
Patients who spend at least 90% of their time on a stroke unit	80%	86.1%	96.4%	80.0%	88.7%	98.2%	89.8%	87.1%	87.0%	92.7%	82.2%	96.7%	N/Avail		Jan 14 data unavailable at the time of publication.
Breast Feeding initiation	75%	77.4%	79.4%	80.6%	81.4%	76.9%	79.7%	78.9%	78.0%	78.6%	77.7%	79.0%	81.4%		
Caesarean Section Rates - Total	<25%	29.2%	24.9%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%	28.4%	29.4%	23.5%	25.2%		
Caesarean Section Rates - Emergency	14.98%	12.7%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%	8.0%	14.6%	9.9%	13.6%		
Caesarean Section Rates - Elective	10.06%	14.7%	15.5%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%	17.8%	14.8%	13.6%	11.7%		
Home Birth Rate	>=3%	5.9%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%	6.0%	2.1%	4.6%	4.1%		
Number of readmissions within 28 days (Adult)	-	New for 2013-14		395	385	424	495	423	394	414	448	474	452		Min 28 day turnaround before monthly data complete, therefore subject to change.
Number of readmissions within 28 days (Children)	-	New for 2013-14		146	136	163	126	96	106	155	142	161	136		Min 28 day turnaround before monthly data complete, therefore subject to change.

CQUIN 2013-14	Target 2013-14	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Jan 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	92.0%	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.3%	97.8%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	payment to be received if both	New for 2013-14			91.3%			89.6%			89.4%		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	2.9%	2.2%	0.86%	4.35%	2.37%	3.3%	55.70%	70.8%	68.80%	79.58%	76.30%	90.57%		
3b.initial diagnostic assessment	90% 3 consecutive months	N/A	Not avail	-	0%	100%	50%	46.70%	60.00%	35.7%	100.00%	100%	100%		3b & 3c no numerator or denominator Facilitator in post from beginning Aug 2013. Oct 2013 data yet to be validated.
3c. referral for specialist diagnosis	90% 3 consecutive months	100.0%	Not avail	-	100%	100%	100%	58.30%	36.40%	60.0%	40.00%	66.60%	95.2%		
3d.Lead clinician and appropriate training of staff	Yes	New for 2013-14						On track							RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes	New for 2013-14						Q1,2 & 3 audits all completed							RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS															
1. Develop and implement AECP															
1a AECP for Chest Pain		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1c. AECP for Supraventricular Tachycardia		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice		New for 2013-14			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		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery		New for 2013-14			Q1 achieved			Q2 achieved			Q3 achieved		On track		RAG rating in accordance with latest CQUIN Status report
2c. HOT Clinic for Medicine		New for 2013-14			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)	Implimentation by Oct 2013	New for 2013-14				From Oct 2013				19.01%	14.07%	16.74%	36.13%		
1b. increase response rate to at least 20%	=>20% by Yr End	New for 2013-14		7.09%	9.23%	15.88%	16.93%	9.73%	16.84%	22.17%	26.67%	23.06%	20.18%		Q3 accumulative FFT response rate = 23.9%
1c. Improve performance on staff Friends & Family Test		New for 2013-14					Survey due Autumn 2013 - still awaiting formal results								No action required for Q1. LIA group in place - staff survey to be undertaken in Q3. Predicted RAG rating determined following feedback from Care Group Directorates.
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	New for 2013-14		7	5	5	4	3	2	4	5	10	9		RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards		New for 2013-14					On track, Q1 data submitted and feedback provided. Q2 data submitted on time.						On track		
4. Timely Simple Discharge	TBA (>60% each quarter or action plan)	New for 2013-14		N/A	50.0%	0.0%	66.7%	66.7%	100%	33.3%	50.0%	33.3%	N/Applic		RAG rating in accordance with latest CQUIN Status report. Target = +33.3%, YTD= 51.9
5. Improve access to breast milk in preterm infants	TBA (20% imp on 12/13 perf (58.5%))	New for 2013-14		55.9%	37.5%	45.5%	51.3%	61.3%	64.2%	50.0%	60.7%	60.6%	47.1%		RAG rating in accordance with latest CQUIN Status report. Target = 61% yr end or 64% in any one quarter (Jan 14 - Baseline criteria under review)
6. Acute Kidney Injury	Q1 Process recorded and definition in place	New for 2013-14		Q1 & Q2 achieved. Q3 on track Process agreed to identify patients with an AKI. Working group established and meeting regularly											

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 February 2014

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

Executive summary

- FFT score for A&E continues to be high at **72,** but response rates dropped to **15.70%**
- FFT score for Inpatients fell by 4 points in January from December, the first month that there hasn't been improvement in 4 months
- Maternity response rate significantly increased to **36.13%**
- National CQUINS (2014/15) related to FFT are outlined
- Details regarding active National Surveys within NGH are outlined
- Themes for Quarter 3 (October – December) from complaints, PALS, FFT, SI's and incidents are presented.
- The revised Patient Experience/Patient Safety Dashboard is presented.

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

Enclosure E

Actions required by the Board

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

Trust Board
27 February 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. Friends & Family Test

2.1 Background

CQUIN FFT response rates were previously set at 15% for Inpatient and A&E; these have now risen to 20% in January 2014. Currently the Net Promoter Score is not associated with a CQUIN target, but as an organisation we aim for a score of 80 (above the national average of 72).

2.2 The Issue(s)

2.2.1 Response Rates:

- The Friends and Family Test (FFT) results for January 2014 saw Inpatient and A&E services reach an overall response rate of **20.18%,** lower than previous months. This can be attributed to the low response rate seen within the A&E category (A&E, Ambulatory Care and Eye Casualty) who all failed to reach the required target, resulting in an overall response rate of **15.70%.** Far lower than previous months: **18.78%** in December and **23.82%** in November. It has been identified that the IPad used in A&E Majors is potentially not in the best position and so it was moved, mid-February.
- Inpatient response rates continue to be high achieving **31.59%** for January 2014.
- Maternity Services saw a surge in responses for January managing to achieve an impressive **36.13%** response rate, having only started collecting in October.
- **Appendix 1** provides more detail on the response rates achieved within individual areas.

2.2.2 Scores:

- A&E continue to see high Net Promoter Scores, achieving a score of **72** in January 2014, broken down further we can see that A&E themselves achieved a score of **71**, Ambulatory Care **64** and Eye Casualty **80**.
- Inpatient services saw a decline in their NPS for January from **71** in December to **67**. This is disappointing as they had seen a gradual increase over the previous 4 months.
- In Maternity they achieved an overall NPS of **71**. Broken down we can see high levels of satisfaction within the Birth Centre which achieved an NPS of **89** from **47** patients. All 3 Postnatal wards achieved an NPS between **53** and **57**; this will need to be investigated to identify the issues and resolve them.
- **Appendix 2** provides more detail on scores achieved within individual areas and an overview of areas which have struggled to achieve the expected NPS over the past financial year.

2.2.3 Positive and Negative Scores:

- Each month the comments from the FFT forms are analysed to see whether the comments are positive or negative. A more in-depth analysis is undertaken at the end of each Quarter to identify common themes. This has now been backdated for Quarter 2 and 3 and will be discussed further within the Triangulation section.
- Positive/Negative percentages for each areas were as follows for January:

Area	Positive %	Negative %
Inpatients	82%	18%
A&E Minors	94%	6%
A&E Majors	68.6%	31%
Maternity	92%	8%
Eye Casualty	96%	4%

- **Appendix 3** provides more detail regarding Positive / Negative comments received for each individual area.

2.2.4 Improvements

- Plans are in progress for the T&O Patient and Public Involvement Group to conduct further investigations into how patients are experiencing Abington Ward to try and understand the consistently low Net Promoter Scores.

2.2.5 Communications

- A&E are currently in the process of creating posters to display within patient areas to explain what the FFT is, what their own scores are, how they compare nationally and how they are taking action on the comments patients are making.
- Maternity data is now available publically through NHS Choices.

3. Friends & Family Test National CQUIN 2014/2015

3.1 Background

The Friends and Family Test has featured as a CQUIN since 2013/2014. New National CQUINs have been established for 2014/2015, which may pose some difficulty for the Trust in relation to collection and collation of data for improvement.

3.2 The Issue(s)

- FFT will be rolled out to Outpatients by October 2014 (***15% of the funding***), however Outpatients' guidance for FFT is not yet available; this will be issued in April/May. This will increase the number of responses received significantly and make it no longer feasible to collect and analyse the information manually. As a result, the trust is currently exploring electronic solutions; the cost of which will need to be built into next year's contingency plans
- From April 2014, all staff will be asked 2 FFT questions (***30% of the funding***). The Staff FFT will be managed within the Organisational Development department who are currently awaiting the final guidance. Again, collection of this data will require an electronic solution (potentially the same solution as that being considered for the patient FFT data).
- Inpatient and A&E targets will now be split whereas for the previous year they were amalgamated.
- Inpatients are required to obtain a 25% response rate in Q1, increasing in Q2 & Q3, to Q4, where a response rate of 30% or higher is expected.
- A&E are required to obtain an initial response rate of 15% (Q1), increasing to 20% in Q4. (***Both the Inpatient and A&E CQUIN equals 15% of the funding***).
- The final aspect of the CQUIN requires us to reduce the amount of negative responses gathered within each of the individual areas; how this is to be achieved is yet to be determined. (***20% of the funding will be received if the organisation achieves zero negative responses in Q1)***. If the Trust then obtains no negative responses in Q4 they receive a further ***20% or funding***, or if they fail to achieve zero in Q1 they get the whole amount in Q4.
- We are currently without the guidance needed for a number of these CQUINS which makes planning difficult. However a plan based on the information we do have will be included in next month's report.

4. National Surveys 2014

4.1 Background

National Surveys are conducted within the organisation, with the majority being requested by the CQC; however there are additional surveys which the Trust agrees to run.

4.2 The Issue(s)

- The Trust has opted to be included within the National Neonatal Survey for 2014. This is in the early stages and results are likely to be released in January 2015.
- The National A&E survey will run in 2014 having previously been run in 2012. The sampling will begin in April 2014; this will be taken from patients who have attended A&E between January/February or March 2014.
- Inpatient Survey: Piloting New Approaches. The Picker Institute have offered the Trust the chance to be involved in a pilot run of a new method of collecting the Inpatient Survey. The Trust has accepted this offer and are currently at the stage of sampling.

5. Triangulation of Complaints, Pals, Incidents, SI's and FFT - February Dashboard

5.1 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 Incidences in order to establish a mechanism of review and the ability to pre-empt any potential issue areas. A first draft of the dashboard was presented to the Board in January. The comments made by the Board have been considered and these changes, amongst many others, have been made to the methodology. It is recognised that the dashboard is in its 'developmental' stage and further changes will be made.

5.2 The Issue(s)

- The Board acknowledged the need for each area represented in the dashboard to be assessed according to the amount of patients/activity they have. These changes have been made and the amount of Complaints/PALS and incidences that have been received are represented through a percentage of the total figure against how many patients they have seen throughout that month.
- In addition to the percentages which have been added to the dashboard, the 'Patient Safety Outcomes' (previously Clinical Outcomes) section has been weighted according to the seriousness of the incidence. For example, the 'actual harm' section is now split into 1) Insignificant 2) Minor 3) Moderate 4) Major 5) Catastrophic. Please see **Appendix 4** for a table indicating the methodology used.
- When looking at both sections together, it identifies Holcot Ward and Compton Ward as both obtaining an Amber and a Red RAG rating between the 2 sections, potentially flagging these are the areas performing the worse in accordance with the methodology applied.
- From looking at the sections separately, the Patient Feedback section identifies Holcot, Knightley, Rowan, Sturtridge and Victoria ward as being within the Red category.
- The Patient Safety Outcomes section identifies Compton, Corby, Hazelwood, and ITU as within the Red category.
- **Further consideration needs to be given to the methodology used within this dashboard and whether the information provided is an accurate reflection on performance. Any inferences made within this paper are drawn from the current methodology which may change in the future.**

6. Triangulation of Complaints, Pals, Incidents, SI's and FFT – Quarter 3 Themes

6.1 Background

In addition to the Dashboard, triangulation will also be carried out Quarterly to identify any key themes which are evident through looking at the subjects of Negative PALS contacts,

Complaints, FFT comment analysis, Incidents and Serious Incidents. A first draft was presented to the Board in January covering Quarter 2 and some changes have been made to it for the month of February which covers Quarter 3.

6.2 The Issue(s)

- The FFT comments have been analysed and placed into subjects for Quarter 3 and this is now included within the triangulation table. It has been split into 2 sections, the 1st covering Inpatient, Day Cases, Paediatrics and Maternity and the 2nd covering A&E (Minors and Majors) and Eye Casualty.
- 3 Themes were identified through the triangulated data:

1. Communication
2. Discharge
3. Medication – Pain Relief

- Please see **Appendix 5** for a breakdown of these themes

Friend & Family Net Promoter Score
Period: 1st - 31st January 2014

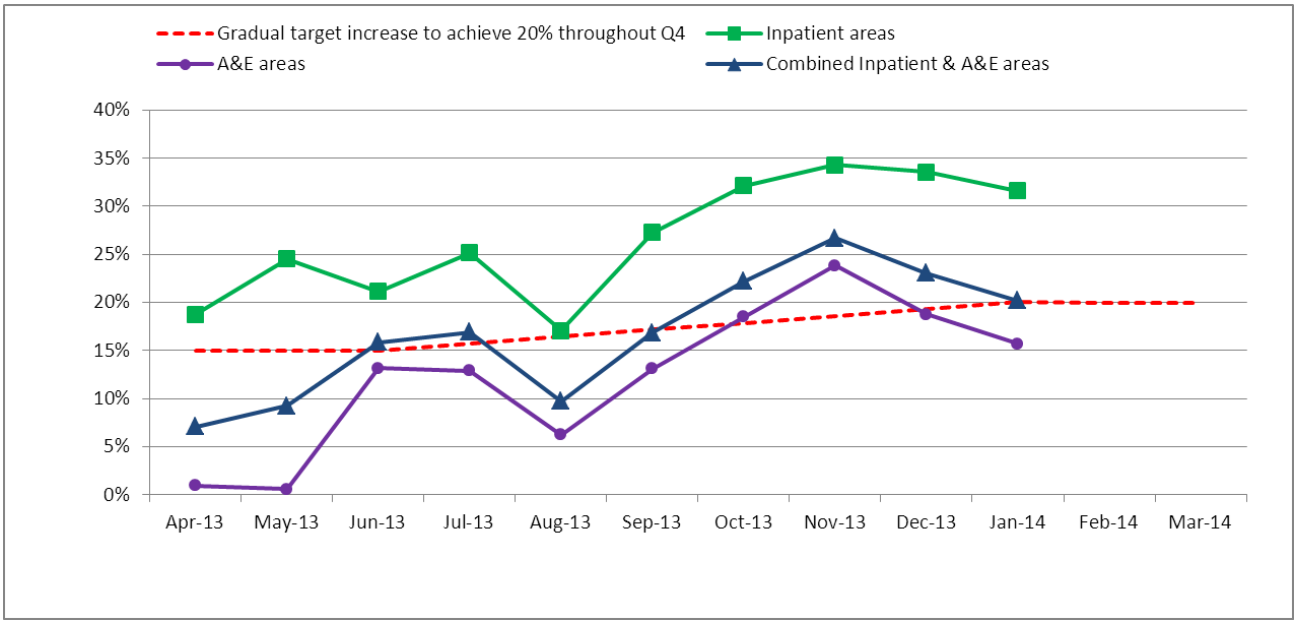
	Total responses in each category for each ward								Target = 20%	Target yet to be agreed
Ward / area name (Inpatient discharges aged 16yr and over)	**Extremely Likely**	**Likely**	**Neither likely or unlikely**	**Unlikely**	**Extremely unlikely**	**Don't Know**	**Total no. of people eligible to respond (discharged)**	**Total responses for each ward**	**Response rate for each ward**	**Score for each ward / area**
ABINGTON WARD	9	4	0	1	0	0	36	14	38.89%	57
ALLEBONE WARD	9	1	3	0	0	2	57	15	26.32%	46
ALTHORP WARD	38	8	1	0	0	1	80	48	60.00%	79
BECKET WARD	15	1	0	0	0	1	58	17	29.31%	94
BENHAM WARD	19	10	0	1	0	0	111	30	27.03%	60
BRAMPTON WARD	7	8	0	0	0	0	47	15	31.91%	47
CEDAR WARD	31	16	4	0	3	1	103	55	53.40%	44
COLLINGTREE	9	3	0	0	1	0	107	13	12.15%	62
COMPTON WARD	14	2	0	0	0	3	18	19	105.56%	88
CORBY COMMUNITY	6	0	0	0	0	0	15	6	40.00%	100
CREATON WARD	20	8	1	1	0	1	66	31	46.97%	60
DANETRE WARD	10	1	0	0	0	0	17	11	64.71%	91
DISNEY WARD *(aged 16yr & over)*	5	1	0	0	0	0	7	6	85.71%	83
DRYDEN WARD	6	2	0	0	0	0	84	8	9.52%	75
ELEANOR WARD	17	3	0	0	0	0	55	20	36.36%	85
EMERGENCY ASSESSMENT UNIT	21	4	0	0	0	0	155	25	16.13%	84
FINEDON WARD	8	2	0	0	0	0	54	10	18.52%	80
HAWTHORN WARD	82	36	6	0	0	0	204	124	60.78%	61
HAZELWOOD WARD, ISEBROOK HOSPT	3	6	0	0	0	0	18	9	50.00%	33
HEAD AND NECK WARD	16	3	0	0	1	0	94	20	21.28%	75
HOLCOT STROKE UNIT	15	4	0	0	0	0	30	19	63.33%	79
KNIGHTLEY WARD	5	4	1	0	0	1	49	11	22.45%	40
PADDINGTON *(aged 16yr & over)*	0	0	0	0	0	0	6	0	0.00%	
ROWAN WARD	12	7	0	1	0	1	141	21	14.89%	55
SPENCER WARD	17	5	2	0	0	0	134	24	17.91%	63
TALBOT BUTLER WARD	23	2	0	0	0	0	86	25	29.07%	92
VICTORIA WARD	8	2	1	0	0	0	39	11	28.21%	64
WILLOW WARD	18	3	0	0	0	1	120	22	18.33%	86
Inpatient Ward Total	**443**	**146**	**19**	**4**	**5**	**12**	**1991**	**629**	**31.59%**	**67**
A & E UNIT **(data collected monthly)**	461	116	8	5	17	12	4125	619	15.01%	71
AMBULATORY CARE CENTRE	16	9	0	0	0	0	140	25	17.86%	64
EYE CASUALTY	125	23	1	2	1	2	817	154	18.85%	80
Accident & Emergency Total	**602**	**148**	**9**	**7**	**18**	**14**	**5082**	**798**	**15.70%**	**72**
ANTENATAL COMMUNITY	81	27	3	0	0	0	350	111	31.71%	70
BIRTH CENTRE	42	5	0	0	0	0	47	47	100.00%	89
HOME BIRTH	22	0	0	0	0	0	19	22	115.79%	100
LABOUR WARD	59	17	3	0	1	0	294	80	27.21%	69
MATERNITY OBSERVATION WARD	9	5	0	1	0	0	21	15	71.43%	53
BALMORAL	5	1	1	0	0	0	49	7	14.29%	57
ROBERT WATSON WARD	57	22	3	4	2	0	212	88	41.51%	55
POSTNATAL COMMUNITY	68	17	1	0	0	0	270	86	31.85%	78
Maternity Services Total	**343**	**94**	**11**	**5**	**3**	**0**	**1262**	**456**	**36.13%**	**71**
Inpatient discharges aged under 16yrs										
DISNEY WARD	62	14	0	0	0	0	75	76	101.33%	82
PADDINGTON	21	23	0	0	0	0	187	44	23.53%	48
Paediatric Ward Total	**83**	**37**	**0**	**0**	**0**	**0**	**262**	**120**	**45.80%**	**69**
DAVENTRY DAY SURGERY	55	1	0	0	0	0	133	56	42.11%	98
MAIN THEATRES ADMISSIONS	90	3	0	0	0	0	150	93	62.00%	97
DAY SURGERY UNIT	40	7	1	0	0	0	207	48	23.19%	81
SINGLEHURST DAY CARE	30	4	0	0	0	2	166	36	21.69%	88
Daycase Area Total	**215**	**15**	**1**	**0**	**0**	**2**	**656**	**233**	**35.52%**	**93**

Appendix 1 – Friends and Family Response Rate Graphs

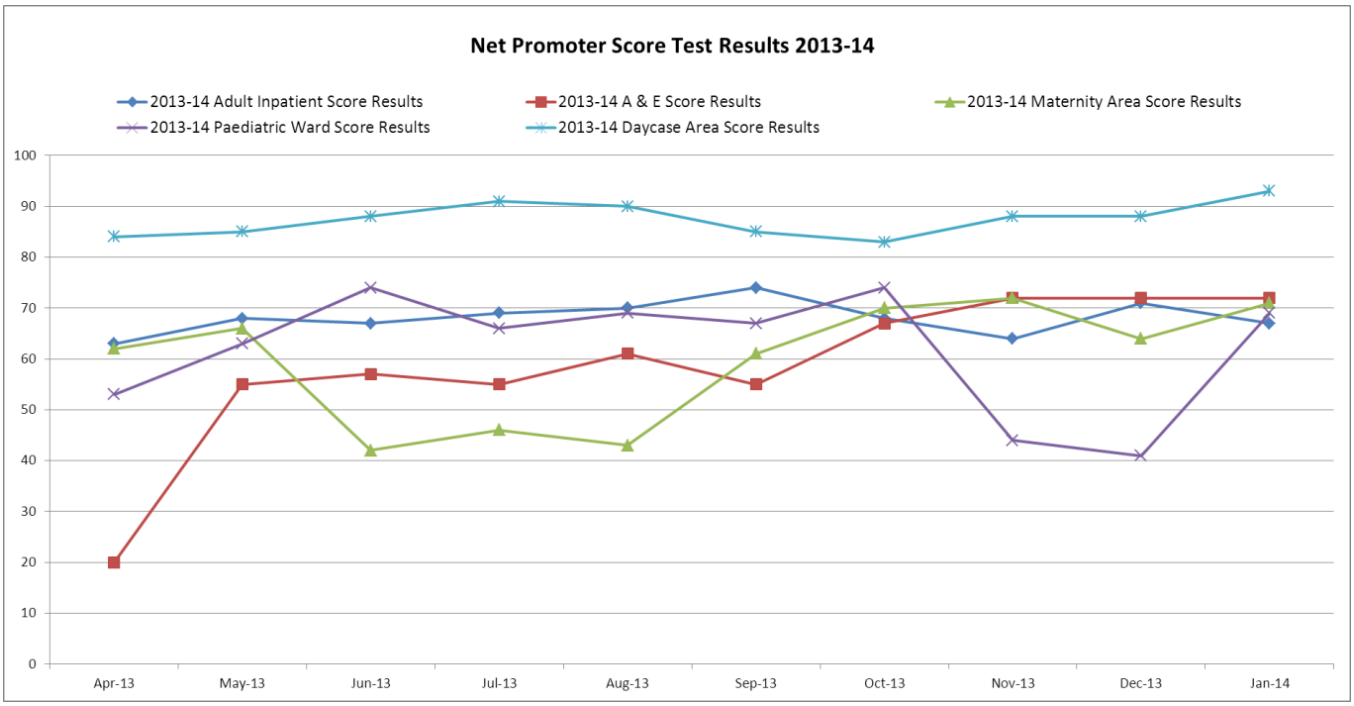
	Q1			Q2			Q3			Q4		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%	15.7%	16.4%	17.2%	17.9%	18.6%	19.3%	20.0%	20.0%	20.0%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	27.26%	32.13%	34.30%	33.53%	31.59%		
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%		
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%		

Period: 1st to 31st January 2014	Total responses in each category for each ward								**Target = 20%**	**Target yet to be agreed**
Ward / area name	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't Know	Total no. of people eligible to respond (discharged)	**Total responses for each area**	**Response rate**	**Score for each ward / area**
Inpatient Ward Total	443	146	19	4	5	12	1991	629	31.59%	67
Accident & Emergency Total	602	148	9	7	18	14	5082	798	15.70%	72
IP & A&E	1045	294	28	11	23	26	7073	1427	20.18%	70
Maternity Services Total	343	94	11	5	3	0	1262	456	36.13%	71

These tables display the response rates for the past financial year and display the progress we have made in regards to the CQUIN. Quarter 4 required the Trust to reach over 20% accumulatively for the whole quarter. Maternity services obtained a response rate of 36.13%, they currently do not have a national target.



From looking at the Graph it is clear we have had a steep incline in response rates since August, however there has been a gradual decline since November for the months of December and January in all areas.



Graph 1: Net Promoter Scores tracked across financial year

Net Promoter Score Test Results	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
2013-14 Inpatient Score Results	63	68	67	69	70	74	68	64	71	67
2013-14 A & E Score Results	20	55	57	55	61	55	67	72	72	72
2013-14 Maternity Area Score Results	62	66	42	46	43	61	70	72	64	71
2013-14 Daycase Area Score Results	53	63	74	66	69	67	74	44	41	69
2013-14 Paediatric Ward Score Results	84	85	88	91	90	85	83	88	88	93

Table 1: Net Promoter Scores obtained by each area across financial year

This Graph and Table tracks the Net Promoter Score (NPS) across the financial year. From looking at the graph it can be identified that the NPS has improved significantly in Maternity since collections began across the pathway in October. A&E's score continues to be high compared with national results and has remained steady for the past 3 months.

Table 2 shows the NPS broken down into each individual area and tracked across the financial year. The reason it is not RAG rated is because the Trust currently does not have a target for the NPS, however the Trust aims for around 80. From looking at this table it is clear to see that some areas continue to struggle with their Net Promoter Scores.

Abington Ward have not seen their response rate reach above 57 since June last year. In August they received a score of just 20 and in September a score -25. December also saw then obtain a score of 0.

Abington	63	42	31	80	70	46	20	-25	25	56	0	57

Allebone Ward have also struggled with their NPS where they have not achieved above 57, for this year apart from in September when they received a score of 75. For the rest of the year they have scored averagely between 30 and 45

Allebone	45	52	33	33	41	44	-14	75	57	0	33	46

Paddington Ward's highest score to date is 69, achieved in October. However for the remainder of the year they have averaged fairly low scores of around 50.

Paddington		46	46	38	51	62	57	53	57	69	27	40	48

Friends & Family Net Promoter Score Results

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

Antenatal Community									100	71	44	70
Birth Centre											100	89
Home Birth									100	71	100	100
Labour Ward									73	72	66	69
Maternity Observation Ward									50	0	83	53
Balmoral	79	86	64	74	Closed	Closed	Closed	Closed	Closed	Closed		57
Robert Watson	85	76	56	59	42	46	43	61	60	69	51	55
Postnatal Community									100	87	82	78
Maternity Services Total			62	66	42	46	43	61	70	72	64	71
Disney	67	58	64	70	85	75	82	74	80	63	41	82
Paddington	46	46	38	51	62	57	53	57	69	27	40	48
Paddington HDU						50	0	100	Not applic	100	100	Not applic
Paediatric Ward Total			53	63	74	66	69	67	74	44	41	69
Danetre Day Surgery	96	98	94	89	90	85	92	100	97	93	90	98
Main Theatre Admissions	92	87	82	83	97	96	88	87	90	87	94	97
NGH Day Surgery	97	94	82	83	86	94	91	83	79	87	82	81
Singlehurst Day Unit			100	88	73	80	92	79	77	91	100	88
Daycase Area Total			84	85	88	91	90	85	83	88	88	93

Table 2: Net Promoter Score broken down into areas

Inpatient and Day Case Areas

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Abington	4	3	7	57.1%	43%
Allebone	8	5	13	61.5%	38%
Althorp	36	4	40	90.0%	10%
Ambulatory Care Centre	5		5	100.0%	0%
Becket	3		3	100.0%	0%
Benham	23	4	27	85.2%	15%
Cedar	6	9	15	40.0%	60%
Collingtree	1		1	100.0%	0%
Creaton	8	3	11	72.7%	27%
Danetre	5	1	6	83.3%	17%
Danetre Day Surgery	2		2	100.0%	0%
Disney	7	1	8	87.5%	13%
Disney 16 plus	1		1	100.0%	0%
Dryden	3	1	4	75.0%	25%
EAU	7	2	9	77.8%	22%
Eleanor	13	1	14	92.9%	7%
Finedon	1		1	100.0%	0%
Hawthorn	87	12	99	87.9%	12%
Hazelwood - Isebrook	9	2	11	81.8%	18%
Head & Neck	6		6	100.0%	0%
Holcot		2	2	0.0%	100%
Knightley	3	3	6	50.0%	50%
MTAU	31		31	100.0%	0%
New Day Surgery	3		3	100.0%	0%
Paddington	4		4	100.0%	0%
Rowan	1	4	5	20.0%	80%
Singlehurst Day Ward	3	1	4	75.0%	25%
Spencer	3	1	4	75.0%	25%
Talbot Butler	4	4	8	50.0%	50%
Victoria	6	1	7	85.7%	14%
Willow	5	1	6	83.3%	17%
Grand Total	**300**	**66**	**366**	**82.0%**	**18%**

For Inpatient areas **18%** of the comments were negative compared with 82% positive. This was taken from a sample of **366** comments in total. When exploring the figures, Hawthorn ward have received a positive response with **87.9%** of the **99** comments received being positive.

Please note, when exploring the figures it is worth taking into consideration the amount of comments the ward have had to gain a true representation of the results.

A&E

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
A&E Minors	204	12	216	94.4%	6%

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
A&E Majors	24	11	35	68.6%	31%

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
A&E Combined	228	23	251	90.8%	9%

From looking at the A&E data we can see a large difference in the amount of positive and negative comments received in Minors and Majors. There are far greater levels of satisfaction within Minors who comments were **94.4%** positive, compared with Majors who only had **68.6%.**

Maternity

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Antenatal Community	86	6	92	93.5%	7%
Balmoral	7		7	100.0%	0%
Birth Centre	44		44	100.0%	0%
Home Birth	15		15	100.0%	0%
Labour Ward	61	5	66	92.4%	8%
Maternity Obs Ward	9	2	11	81.8%	18%
Postnatal Community	64	4	68	94.1%	6%
Robert Watson Ward	61	13	74	82.4%	18%
Total	**347**	**30**	**377**	**92.0%**	**8%**

For Maternity, ladies are expressing extremely high levels of satisfaction with the Birth Centre and Home Birth team, both receiving **100%** positive comments. The postnatal and community areas have seen some negative comments, with the most being seen within Robert Watson who received **13** negative responses equating to **18%** of the total.

Eye Casualty

Ward Name	Count of Positive	Count of Negative	Total	% Positive	% Negative
Eye Casualty	125	5	130	96.2%	4%

Appendix 3 – Positive and Negative Comments from FFT January 2014

Eye Casualty continues to receive a high volume of positive comments with **125** of the **130** received being positive. This is a positive sign, and reflects the Net Promoter Score they received of 80.

		Patient Feedback								Patient Safety Outcomes *****											
WARDS	Total activity for the area *	% Total no of Complaints ward*	% No of negative PALS contacts	Complaints & PALS Negative feedback	Total No of Compliments	FFT Score ***	FFT Response Rate ***	FFT comment overview (positive less negative)	Patient feedback - overall RAG rating	No. of actual harm incidents (with final approval)					SI's (exc PU & falls)	SI's / PU's (Grade 3 & 4 acquired)	SI's / Falls	All unapproved incidents as at the end of the month	Safety Thermometer (New CRUTI'S)	Total points	Overall RAG rating as a %
										Insignificant	Minor	Moderate	Major	Catastrophic							
RAG Rating		0% - 0.49% = Green 0.5% - 0.99% = Amber =>1% = Red	0% - 0.99% = Green 1% - 1.99% = Amber =>2% = Red	*Green = 0 Amber = 1 - 2 Red = 3 - 4*		80 & above = Green 70 - 79 = Amber Less than 70 = Red	30% (20% for A&E) & above = Green 25%-29% (15-19% for A&E) = Amber Less than 25% (15% for A&E) = Red 30%	More positive = Green 0 = Amber More negative = Red	Green = 5-7 greens Amber = 3-4 greens Red = 0-2 greens												Green = >2.5% Amber = 2.51% - 4.99% Red = 5% >
Weighting (points)				****						**0**	**0.25**	**0.5**	**1**	**2**	**2**	**2**	**2**	******	**1.5**		
A&E	7688	0.08%	0.04%		16	71	15.01%	205			5							68		3.25	0.04%
Ambulatory Care Centre	146	0.00%	0.00%		0	64	17.86%	5			1							0		0.25	0.17%
Eye Casualty	895	0.00%	0.00%		0	80	18.85%	120										0		0	0.00%
Danetre Day Surgery	141	0.00%	0.00%		0	98	42.11%	2										0		0	0.00%
Day Surgery Unit (NGH)	240	0.42%	0.00%		0	81	23.19%	0			2							5		1.5	0.63%
Disney	297	0.00%	0.00%		0	82	23.53%	6										10		0	0.00%
Gosset	46	0.00%	0.00%		0	Not Applic	Not Applic	Not Applic			2							9		0.5	1.09%
Paddington	432	0.00%	0.23%		0	48	23.53%	4										25		2	0.46%
Abington	97	0.00%	0.00%		1	57	38.89%	1			9	1						28		4.75	4.90%
Allebone	123	0.00%	0.81%		0	46	26.32%	3			3	2				1		13		4.75	3.86%
Althorp	124	0.00%	0.00%		1	79	60.00%	32				1						2		0.5	0.40%
Birth Centre	47	0.00%	0.00%		0	89	100.00%	44										0		0	0.00%
Becket	97	1.03%	2.06%		1	94	29.31%	3			2							26		2.5	2.58%
Benham	693	0.43%	0.00%		10	60	27.03%	19			6							1		1.5	0.22%
Brampton	89	0.00%	0.00%		1	47	31.91%	0			6							0		1.5	1.69%
Cedar	181	0.00%	0.00%		3	44	53.40%	-3			1							12		1.25	0.69%
Cliftonville	79	1.27%	0.00%		0	Not Applic	Not Applic	Not Applic										2		0	0.00%
Collingtree	175	0.00%	0.00%		0	62	12.15%	1			6	1				2	1	1		8	4.57%
Compton	48	0.00%	4.17%		0	88	105.56%	0										65	2	5	10.42%
Corby	35	0.00%	0.00%		0	100	40.00%	0										31		2	5.71%
Creaton	118	0.00%	0.85%		0	60	46.97%	5			8	1						58		4.5	3.81%
Danetre Inpatients	50	0.00%	2.00%		0	91	64.71%	4			2							16		1.5	3.00%
Dryden	151	0.00%	1.32%		1	75	9.52%	2			2	1						25		3	1.99%
EAU	524	0.19%	0.38%		11	84	16.13%	5										78		2	0.38%
Eleanor	130	0.00%	0.00%		1	85	36.36%	12			2					2		6		4.5	3.46%
Finedon	71	0.00%	0.00%		0	80	18.52%	1										0		0	0.00%
Hawthorn	391	0.51%	0.00%		17	61	60.78%	75			4							2		1	0.26%
HDU	68	0.00%	1.47%		1	Not Applic	Not Applic	Not Applic			3	1						3		1.25	1.84%
Head & Neck ward	130	0.00%	0.77%		1	75	21.28%	6			1	2						0		1.25	0.96%
Holcot	61	1.64%	0.00%		0	79	63.33%	-2			7							0		1.75	2.87%
Isebrooke (Hazelwood)	38	0.00%	0.00%		0	33	50.00%	7			5	1				1	1	3	1	7.25	19.08%
ITU	46	0.00%	0.00%		1	Not Applic	Not Applic	Not Applic			7					2		3		5.75	12.50%
Knightley	88	0.00%	1.14%		0	40	22.45%	0			4							1		1	1.14%
Main Theatres	369	0.00%	0.00%		1	97	62.00%	31			2	1						31		3	0.81%
Maternity Obs Ward	258	0.00%	0.00%		0	53	71.43%	7			1							0		0.25	0.10%
Robert Watson	220	0.00%	0.00%		0	55	41.51%	48										0		0	0.00%
Rowan	198	1.01%	0.51%		1	55	14.89%	-3			1	3						2		1.75	0.88%
Singlehurst	167	0.00%	0.00%		0	88	21.69%	2										0		0	0.00%
Spencer	222	0.45%	0.45%		0	63	17.91%	2			1							0		0.25	0.11%
Sturtridge (Labour Ward)	388	0.52%	0.00%		0	69	27.21%	56			1							0		0.25	0.06%
Talbot Butler	117	0.00%	1.71%		1	92	29.07%	0			7							1		1.75	1.50%
Victoria	67	1.49%	2.99%		0	64	28.21%	5			5							2		1.25	1.87%
Willow	198	1.01%	1.01%		2	86	18.33%	4			3	1						10		1.25	0.63%
Total	**15743**	0.15%	0.17%		**63**	**73**	**24.17%**	**709**		**0**	**109**	**16**	**0**	**0**	0	8	2	539	3	61.75	0.39%

Enclosure E

Methodology of approach:

* Total activity for the area for emergency departments is the total number of attendances in the period, daycase areas is the number of discharges and inpatients is the number of patient recorded on iPM on each ward area at some point during the period. (Inpatients can be recorded on more than one ward during their admission.
**Includes cross directorate complaints and subjects to two reporting levels only (due to Datix anomaly). Please note that a complaint received during this period may relate to activity during a previous period of care.
*** FFT score and response rate total figure is for all services which includes inpatient adult and children's wards, A&E units, maternity acute & community services and daycase where the patent is discharged to their usual place of residence. The score target is a local NGH stretch target to achieve above national average and the response rate target is the target for March 2015.
some point during the period. (Inpatients can be recorded on more than one ward during their admission.)
**** To calculate the score for the Complaints & PALS Negative feedback the following weighting has been used:
2 x green = 0
1 x green and 1 x yellow = 1
2 x yellow = 2
1 x green and 1 x red = 2
1 x yellow and 1 x red = 3
2 x red = 4
**** The Patient Safety Outcomes methodology used does not correlate with the NLRS data, and is therefore not comparable
***** To calculate the score for the point values for 'All unapproved incidents as at the end of a month' the following weighting has been used:
up to 10 = 0 points
11 - 19 = 1 point
20 and above = 2 point

Triangulation

From looking at the dashboard it is evident that it is difficult to ascertain a true picture of performance by triangulating the information from both sections.

When comparing the 2 different sections, 2 wards are highlighted as potential issue areas:

Compton Ward

Compton Ward obtained an Amber rating within the Patient Feedback section and a Red rating within the Patient Safety Outcomes section. This is due to receiving 4.27% of PALS contacts when compared with the amount of patients seen within the ward. They also achieved an Amber rating for the amount of negative Complaints and PALS feedback they received. In addition to this they did not receive any compliments or any positive or negative comments from the FFT for the month of January, this equated to them obtaining 3 Green ratings, giving them an Amber score.

In addition to this, Compton currently have 65 unapproved incidences at the end of the month, and 2 Safety Thermometer issues giving them an overall percentage in proportion to patients seen of 10.42%, and a RAG rating of red.

It also needs to be taken into consideration that Compton Ward achieved an FFT score of 88, one of the highest Net Promoter Scores in the hospital. This was from a 105.56% response rate, meaning more patients than were eligible completed the form.

Holcot Ward

Holcot ward obtained an Amber rating within Patient Feedback, this is due to them receiving 1.64% of complaints when calculated in proportion to patients seen. They also achieved an Amber rating for the amount of negative Complaints and PALS feedback they received. In addition to this they received more negative feedbacks on the FFT forms than positive, giving them a Red rating for this section. They achieved Amber for their NPS; however this was 79 which is still a high score and only 1 point away from the Trusts target. They did not receive any compliments, giving them an overall score of 2 greens equally a Red overall RAG rating for Patient Feedback.

For the Patient Safety Outcomes section they received 7 minor incidences, and when this is calculated in proportion to patient activity, this equalled 2.87% giving them a RAG rating of Amber for this section.

Further to this, a number of areas obtained a Red Rating for 1 section, but a Green Rating for the other. These areas are as follows:

Corby Red – Patient Safety Outcomes; Green – Patient Feedback

Isebrooke Red – Patient Safety Outcomes; Green – Patient Feedback

ITU Red – Patient Safety Outcomes; Green – Patient Feedback

Knightley Red – Patient Feedback; Green – Patient Safety Outcomes

Rowan Red – Patient Feedback; Green – Patient Safety Outcomes

Sturtridge Red – Patient Feedback; Green – Patient Safety Outcomes

Victoria Red – Patient Feedback; Green – Patient Safety Outcomes

Limitations

Consideration needs to be given to the methodology used for the dashboard and whether the information provided is an accurate representation. This information should be considered alongside other information to ensure a true picture of the areas mentioned is represented.

Appendix 5 – Triangulation Themes for Quarter 3 2013/2014

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)**			**Serious Incidents (STEIS category)**		
Total No Received	**325**		**Total No Received**	**294**		**Total No Received**	**217**		**Total No Received**	**107**		**Total No Incidents**	**2553**		**Total No Incidents**	**42**	
	No.	%		No.	%		No.	%		No.	%		No.	%		No.	%
Clinical Care	58	18%	Delays/Cancellation	56	19%	Communication	49	23%	Waiting Times	53	24%	Implementation of care or ongoing monitoring/review	555	22%	Pressure Ulcer - Grade 3	22	52%
Delays/Cancellations	19	6%	Communication	46	16%	Environment	46	21%	Communication	14	6%	Accident that may result in personal injury	510	20%	Slips, trips an falls	5	12%
Attitude & Behaviour	16	5%	Discharge/Transfer	37	13%	Attitude and Behaviour	29	13%	Attitude and Behaviour	13	6%	Infrastructure or resources (staffing, facilities, environment)	252	10%	Unexpected death	4	10%
Communication	15	5%	Waiting Time	34	12%	Discharge/transfer and referral	27	12%	Clinical Care	9	4%	Medication	222	9%	Premature discharge	2	5%
Discharge	10	3%	Clinical Care	32	11%	Medication	13	6%	Environment	7	3%	Access, appointment, admision, transfer, discharge	187	7%	Other	2	5%

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

CLINICAL CARE - TOP THREE THEMES																		
Complaints			**PALS**			**FFT Comments**			**FFT Comments**			**Incidents (with final approval)**			**Serious Incidents (STEIS category)**		
Total No Received	**58**		**Total No Received**	**32**		**Total No Received**	**10**		**Total No Received**	**9**		**Total No Incidents**	**2553**		**Total No Incidents**	**42**	
	No.	%		No.	%		No.	%		No.	%		No.	%		No.	%
Pain Management	23	40%	Communication	20	63%	Nursing Care	5	50%	Other	3	30%	Pressure sore / decubitus ulcer	404	16%	Pressure Ulcer - Grade 3	22	52%
Diagnosis Failure	10	17%	Investigations	4	13%	Staffing Levels	4	40%	Medical Care	2	20%	Slips, trips, falls and collisions	348	14%	Slips, trips an falls	5	12%
Medical Opinion	6	10%	Failure to medicate	3	9%			0%			0%	Adverse events that affect staffing levels	133	5%	Unexpected death	4	10%

Quarter 2 Revisited

In Quarter 2 the 2 most commonly identified themes across all areas were Discharge and Communication:

Discharge (Quarter 2)

14 complaints have been received relating to discharge in December making up 4% of all complaints received. PALS had 37 contacts regarding discharge, totalling 15% of all their contacts received. In the Trend Analysis of patient experience projects 8 of the 18 reviewed identified some form of

issue or dissatisfaction with the patients discharge. In addition to this, 177 incidences were identified in December relating to 'Access, Appointment, Admission, Transfer and Discharge', making up 6% of all incidences for that month.

Communication (Quarter 2)

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

Quarter 3 Themes

From reviewing the information for Quarter 3 it is evident that Communication and Discharge continue to be the top 2 issue areas, and an additional theme of Medication – Pain Management, has also been identified:

Communication (Quarter 3)

15 complaints were received in Quarter 3 which related to communication, equalling 5% of all complaints made; this is lower than Quarter 2 but is still the 4th most commonly seen theme. Communication totalled (46) 16% of all PALS negative contacts. It was also identified within both areas for FFT comments, coming out as the number 1 issue area for Inpatients et al with 49 negative comments being made. In A&E and Eye Casualty Communication was the 2nd highest theme receiving 14 negative comments. When breaking down the Clinical Care theme for PALS, Communication again flags as the number 1 issue area within this theme, with 20 negative contacts being reported.

Discharge (Quarter 3)

37 negative contacts were received in Quarter 3 to PALS for discharge, making up 13% of all negative contacts received. The Trust received 10 complaints, compared with 14 for Quarter 2, making up 3% of all complaints for Quarter 3. Patients made 27 negative comments around their discharge on the Friends and Family Forms for Inpatients et al. There were also 187 reported incidences with regards to access, appointment, admission, transfer and discharge, and although we cannot break this down into each individual part it is worth noting in this context.

Medication – Pain Management (Quarter 3)

In addition to these 2 themes, a further theme which requires consideration is around medication, in particular pain relief. 13 patients made negative comments on their FFT forms with regards to their medication. In addition to this, within the Clinical Care theme, Complaints identified 23 cases where

pain was not adequately managed, resulting in a complaint. PALS also received 3 negative contacts in Quarter 3 relating to ‘failure to medicate’. 222 incidences were reported in Quarter 3 relating to medication; however as with discharge it is not possible to break this information down further.

REPORT TO THE TRUST BOARD
27 February 2014

Title	Monthly Infection Prevention Performance Report
Agenda item	9
Sponsoring Director	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Author(s)	Pat Wadsworth, Lead Infection Prevention Nurse
Purpose	To update the Board on Infection, Prevention and Control within the hospital for the month of January 2014

Executive summary

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

Main issues to highlight:

- C Diff rate has decreased, bringing the Trust under trajectory
- A blood culture was taken in A/E on 03 February 2014 and identified as contaminated with MRSA. Further cultures were taken and it was confirmed that the patient did not have MRSA bacteraemia.
- Surgical site infections identified in #NOF surgeries
- The Trust has identified another case of scalded skin syndrome. Actions taken to prevent further spread of infection

Related strategic aim and corporate objective	Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way Patient safety there will be no avoidable harm to patients from the healthcare they receive.
Risk and assurance	The Trust has an annual target of 29 C.diff cases and in the first 10 months of the year has sustained 23 cases. There will be significant fines if the Trust exceeds 29 for the year, putting the Trust financial position at risk.
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No**

Enclosure F

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

Actions required by the Board

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

Trust Board
27 February 2014
Infection Prevention & Control Report

1. Introduction

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

2. Report - In this report, the results for the alert organisms, Surgical Site Infections and Hand Hygiene audits for January 2014, have been summarised into the tables below.

A further detailed report is in appendix 1.

2.1 MRSA / MSSA bacteraemia

	MRSA bacteraemia	MRSA colonisation	Elective screening	Emergency screening	Special Measures	MSSA bacteraemia
January	0	4	99.7%	95.1%	0	0

A blood culture taken in A&E on 03 Feb 2014 has been identified as contaminated with MRSA – a further blood culture was taken and the patient identified as negative to MRSA bacteraemia. Further details can be found in Appendix 1.

2.2 *Clostridium difficile*

	>3 day case of *C.diff*	*Total to date*
January	0	23

This puts the Trust below the CDAD trajectory from January 2014 onwards

Appendix 1, outlines what the Trust is doing in relation to 30 day all-cause in-hospital mortality for C Diff.

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

	>48 hrs E.coli	*Total of mean of four >48 hrs E.coli a month*
January	1	4

3. Surgical Site Infection Surveillance (SSIS) Scheme

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

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

	Caesarean sections	SSI	Large bowel	SSI	Fractured neck of femur (T&O)	SSI	Total hip replacement (T&O)	SSI	Total knee replacement (T&O)	SSI
Nov	96	Not yet available	-	-	35	**1**	31	0	21	0
Dec	94	Not yet available	-	-	35	0	19	0	17	0
Jan	-	-	15	Not yet available	41	0	35	0	33	0

Please note that:

- Surveillance for the January large bowel data is still on-going as surgical site infections can develop and be reported up to 30 days post operatively for general surgery and obstetrics & gynae patients.
- T&O results are subject to change; however no T&O SSIs have been identified this month.
- Surveillance for the November and December C-section SSIs is still underway due to the large number of patient to follow up. Results will be finalised next month.

The root cause analysis (RCA) of the four patients with #NOFs identified that one patient was MRSA 'previous' positive so should have had Teicoplanin on induction but this was missed, one had a very long duration of operation. However, all four wound infections were caused by skin flora micro-organisms and were deep infections; therefore the common concern that has arisen is the lack of assurance that these patients received the prophylactic Octenisan and Bactroban skin decolonisation treatment prior to surgery to reduce the risk of endogenous skin flora inoculating the surgical site at the time of surgery. There is a comprehensive action plan developed by T&O in conjunction with the Infection Prevention Team.

One of the T&O Consultants has taken the lead for auditing the #NOF care bundle in theatres and he plans to commence on Monday(10th Feb) for the next 50 #NOF cases and then report back to the April Morbidity and Mortality meeting. IPT are supporting the ward to audit the pre and post op elements and conducting teaching with the nurses and HCAs centred on giving the decolonisation treatment.

4. Period of Increased Incidence

4.2 Scalded Skin Syndrome

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

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

The baby born on 30th November 2013 was admitted to Paddington ward on 9th December 2013 with a blistering rash to his groin and discharged on the 11th December 2013.
A preliminary MDT meeting was convened in January 2014 to discuss the issues and identify a number of actions to be taken to prevent further infection. At the time of the report no further babies have been identified.

4.3 Group A Haemolytic Streptococcus

The laboratory identified two Group A Haemolytic Streptococcus isolated in two High Vaginal swabs taken on different patients on Sturtridge ward on the 18th and 19th January 2014, they were identified as the same serological type. These were investigated and no common links were found. No further cases have been identified.

4.4 Patient with confirmed H1N1 influenza

A patient with confirmed H1N1 influenza originally admitted to Finedon Ward was then transferred to HDU; they are responding well to treatment. The appropriate infection prevention precautions are in place. IPT have reassured Finedon ward that they do not need to do any contact tracing, however they have suggested that they maintain vigilance in relation to staff and signs of flu like symptoms, so that prophylactic Tamiflu can be given if required.

5. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data for January 2014

Month	Percentage	Areas that did not submit and reason
January	Overall score was 91.8% Ward compliance was 97.7%	Danetre OP sent their data late due to clinical pressures Gosset and Paddington put the January information into February. Haematology OP, and Fracture Clinic had input problems which the Matrons are trying to rectify.

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

January 2014 saw the 5th month of the quality visits: Beat the Bug, Stop the Clot, Save the Skin. Fourteen areas were reviewed in January, however due to the CQC visit, sickness and annual leave 20 areas were not audited.

Highlights from the audits include:

- The staff displayed good knowledge of Saving lives and Pressure Ulcers
- The floors, corners and behind the bins and doors have improved.
- High dust continues to be a problem.
- VTE assessments still require improvement, some of the names are illegible and the GMC stamps are still required.
- Commodes this month were not as clean as they should be
- Areas are overstocking. Reducing stock is encouraged as it helps to provide a well ordered and clutter free environment.

All feedback is given at the end of the review in order to support staff to maintain standards. The reviews are still being seen as very positive by the staff on the wards.

7. Education and Training

There has been further mandatory 'speed' training this month, which captured 29 staff, however the mandatory training percentage has not been processed for January. This will be provided in next month's board report.

January 29th 2014 saw the Infection Prevention Teams first away session held at the Cripps post graduate medical centre. This was facilitated by Suzie Loader in her role as Director of Infection Prevention. Strategic Issues were identified and a development action plan created, which will form the basis of next year's Annual Plan.

8. A local CQUIN for CRUTI's has been proposed

The **Commissioning for Quality and Innovation (CQUIN) payment framework** was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. CQUIN targets enable organizations to look at the quality of services delivered and ensure that the quality of the services continues to improve. CQUIN targets are set externally and locally in partnership with our commissioners. They are performance managed against to ensure achievement and development.

Next year's CQUIN includes the development of a Care Bundle for CRUTI, which will include: a review of current practice, care planning and on ongoing care for the management of urinary catheters against EPIC 3 which is the national evidence based guidelines for Preventing Healthcare-Associated Infections is to be achieved in the first quarter. A regular update regarding performance will be provided to CQEG.

9. Assessment of Risk

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

10. Recommendations/Resolutions Required

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

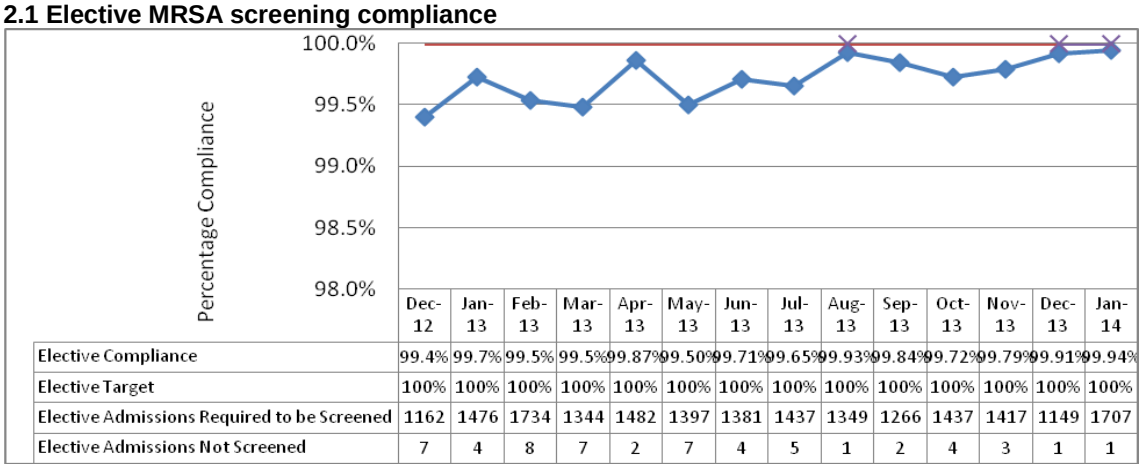
11. Next Steps

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

Appendix 1

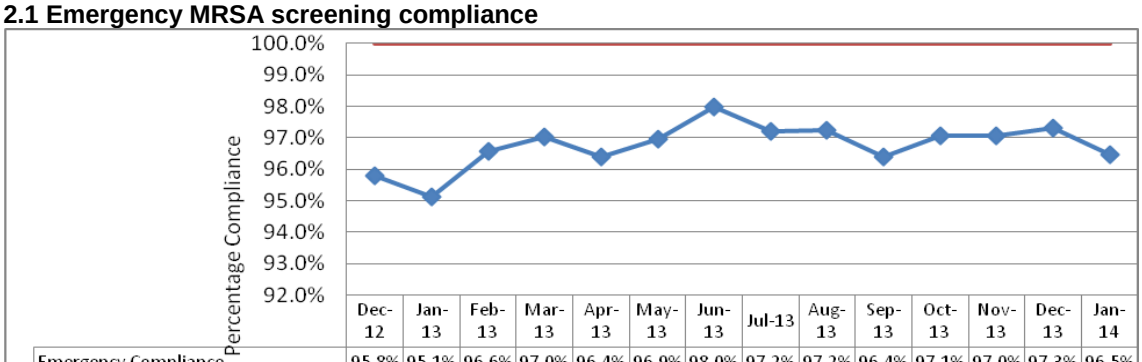
Elective and Emergency MRSA Screening Compliance

2.1 Elective MRSA screening compliance



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Elective Compliance	99.4%	99.7%	99.5%	99.5%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%	99.94%
Elective Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Elective Admissions Required to be Screened	1162	1476	1734	1344	1482	1397	1381	1437	1349	1266	1437	1417	1149	1707
Elective Admissions Not Screened	7	4	8	7	2	7	4	5	1	2	4	3	1	1

2.1 Emergency MRSA screening compliance



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Emergency Compliance	95.8%	95.1%	96.6%	97.0%	96.4%	96.9%	98.0%	97.2%	97.2%	96.4%	97.1%	97.0%	97.3%	96.5%
Emergency Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Admissions Required to be Screened	1209	1126	1104	1170	1056	1113	1091	1148	1080	1109	1187	1118	1261	1248
Emergency Admissions Not Screened	51	55	38	35	38	34	22	32	30	40	35	33	34	44

2.1 MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

During January 2014 there were 5 <48hrs and **0 >48hrs** MSSA bacteraemia cases.

The two MSSA bacteraemias reported in December 2013 have not had RCAs completed. The consultant microbiologist felt that the one on Creaton ward was due to pneumonia and this was the source and the Abington ward MSSA has had the RCA paperwork commenced however the meeting has not yet been undertaken due to ward pressures, so this will be reported in next month's board report.

2.1 MRSA Bacteraemia (Meticillin Resistant Staphylococcus *aureus*) contaminated blood cultures

The patient had a previous history of MRSA and was last positive in her sputum in January 2012. She has a history of COPD although has had no recent hospital admissions here and is not known to KGH either. She presented in A&E on 03 February with shortness of breath and query sepsis; as part of the sepsis pathway, blood cultures were collected and 1g Meropenem administered. This case may be due to either a contaminant or from a reservoir in her chest as she previously has been MRSA positive in her sputum and may well have had some haematogenous spread from her

Enclosure F

chest to cause a low grade bacteraemia due to her COPD/pneumonia. Either way, the Post Infection Review (PIR) process and plan the PIR meeting next week will identify how this has happened.

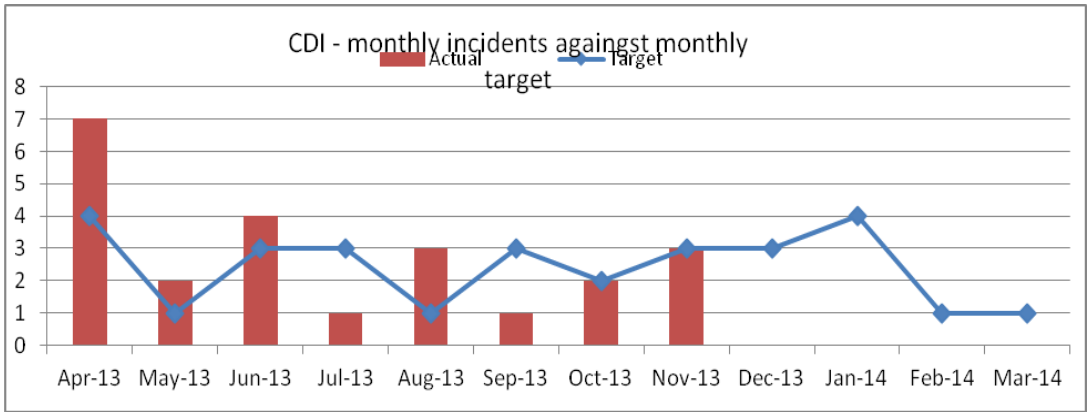
We have informed the community IPC and asked if they could check the patients GP history for any information that may be relevant. We have asked our risk management department to put the incident on to STEISS. The outcome from this review will be reported in the next board report.

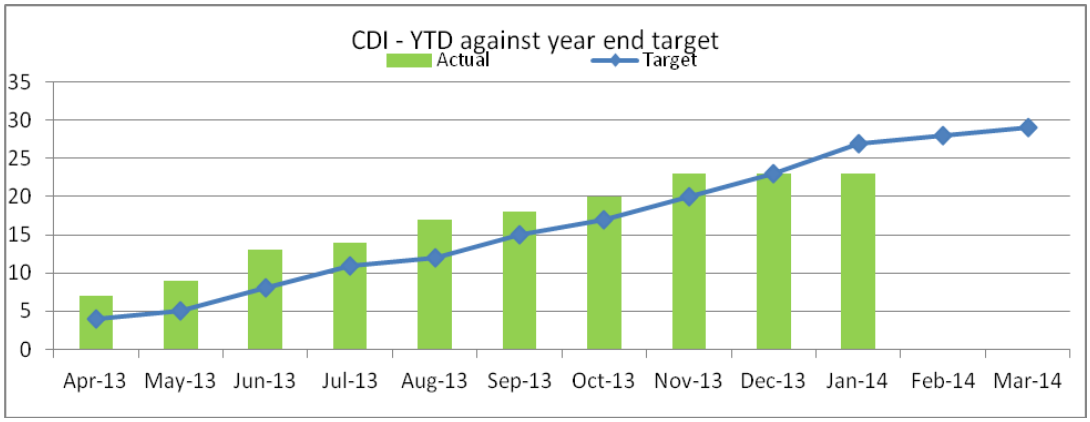
2.2 *Clostridium difficile*

The Trust has an annual target of 29 *C.diff* cases or less for the financial year.
During January **0>3 day case of *C.diff*** were identified against a monthly target of 4 post three day cases, which remains at a total 23 for the year.

This puts the Trust below CDAD trajectory.

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





Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1

Month	Inappropriate Sample	Appropriate Sample
September 2013	0	1
October 2013	0	2
November 2013	0	3
December 2013	0	0
January 2014	0	0
Total	**8**	**15**

To maintain the focus on diarrhoea the IPT have continued to facilitate training initially on the areas that sent inappropriate specimens (this is improving) and have widened the training to incorporate the majority of areas.

***Clostridium difficile mortality review process at Northampton General Hospital.**

All in-patients diagnosed as Clostridium difficile toxin (CDT) positive are reviewed twice weekly or more frequently if needed by an Infection Prevention and Control (IPC) nurse. In addition, all symptomatic C. Difficile patients are reviewed by a multidisciplinary team weekly and their management plans are reviewed. This team includes: a Consultant Microbiologist, a Consultant Gastroenterologist, an Antimicrobial Pharmacist and an Infection Prevention and Control Nurse.

All CDT positive patients are monitored by the IPC team until death or discharge. This enables the team to gather 30-day all-cause mortality data and to ensure that if death occurs the Medical Certificate of Cause of Death (MCCD) is completed correctly. This ensures that Clostridium difficile disease is mentioned in part 2 of the MCCD in all recent CDT positive patients and that, where appropriate, Clostridium difficile disease is listed in the correct place in the hierarchy of causation in part 1 of the MCCD.

All cases where Clostridium difficile disease is given as the disease or condition that led directly to death are declared Serious Incidents (SI) either by the Trust or by the Clinical Commissioning Group (CCG). All such cases are discussed with the CCG Infection Prevention Lead. A Serious Incident is also declared when significant surgery, e.g. total- or hemi-colectomy for pseudo membranous colitis, is required. These Serious Incidents may be the responsibility of the CCG if the CDT positive was identified in a patient under primary care or within the first 3 days of admission.

Crude 30-day all cause mortality data is presented to the Trust's Infection Prevention and Control Committee (IPCC) at the end of each year. Serious Incidents are discussed at the IPCC as and when they occur. The Trust is unaware of a national or other benchmark for expected 30-day all cause mortality but is aware of the variation from below 10% (Fenner et al. 2008) through 37% (Kenneally et al. 2007) to over 45% (in the >65 year old sub-group of Zilberberg, Shorr, Micek, Doherty & Kollef 2009). The trust does not have the resources to undertake the case-control study each year which would be required to properly provide age and co morbidity adjusted data.

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

This bacteraemia for January was on Cedar ward and an RCA meeting was completed.
The patient usually self catheterised and on this admission was too poorly to do this. The ward catheterised the patient over night and removed it in the morning. The patient then commenced self catheterisation that morning. It was highlighted that no antibiotic cover was given and that the catheter policy did not have any information regarding self catheterisation advice to patients. The catheter group are looking at this and will amend accordingly.

Northampton General Hospital NHS
NHS Trust

REPORT TO TRUST BOARD
27 FEBRUARY 2014

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

Executive summary

The Trust has not achieved the following standards during January 2014; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O and ENT. The Trust achieved all the cancer standards for Quarter 3. The Trust has not achieved the following cancer standards; 62 day standard (from urgent GP referral), 31 day standard and 31 day for subsequent surgical treatment.

The number of patients waiting over 26 weeks from referral has increased from 47 to 49.

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

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

Actions required by the Board

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

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
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%	90.32%
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%	98.42%
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%	96.80%
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	19	30	47	49
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0
RTT T&O Admitted	CCG & TDA	90%	91%	90%	91%	90%	90%	90%	62%	64%	77%	71%
RTT T&O Non-Admitted	CCG & TDA	95%	95%	95%	95%	98%	95%	95%	93%	96%	96%	96%
RTT ENT Admitted	CCG & TDA	90%	93%	95%	92%	97%	96%	95%	93%	92%	95%	87%
RTT ENT Non-Admitted	CCG & TDA	95%	97%	98%	96%	99%	98%	98%	98%	98%	99%	97%
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0	0	0
*A&E: Total time in A&E (Calendar month)	CCG & TDA	95%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%	85.49%
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%
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%
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%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	95.40%
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%	83.30%
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%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	97.80%	95.80%	95.70%	100.00%
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%
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%	78.10%
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%	
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	88.71%	98.18%	89.83%	87.14%	86.96%	92.73%	82.22%	97.92%	
Trolley Waits waiting > 12hours	CCG	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
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
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31	15	62	53	75	93

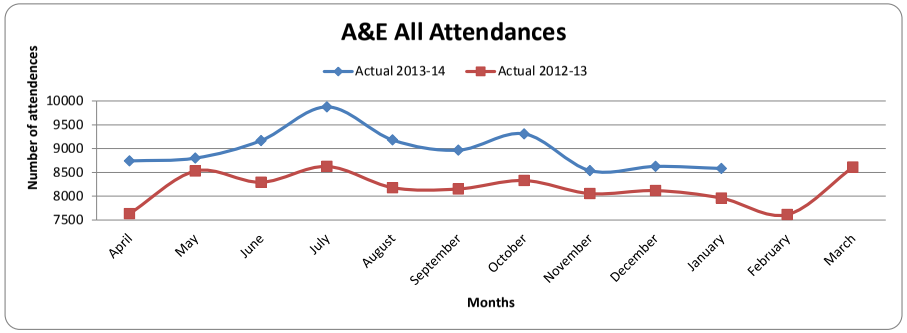
* A&E data is calendar month.

The Trust has not achieved the following standards during January 2014; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O and ENT. The Trust achieved all the cancer standards for Quarter 3. The Trust has not achieved the following cancer standards; 62 day standard (from urgent GP referral), 31 day standard and 31 day for subsequent surgical treatment.

The number of patients waiting over 26 weeks from referral has increased from 47 to 49.

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



During January the emergency pressures continued. With higher than anticipated AE attendees and admissions.

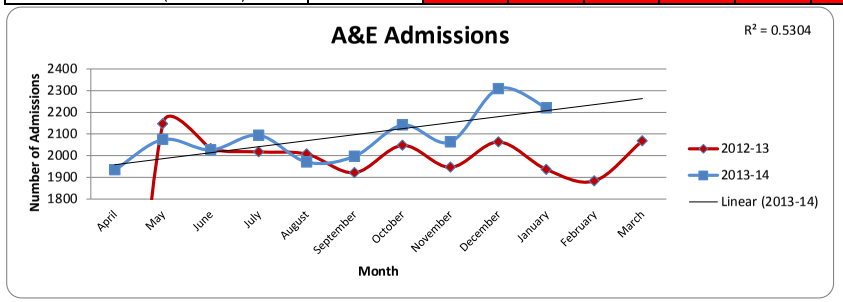
Unfortunately we did not meet the 95% standard in January for the 4hr transit time. This was predominantly due to poor bed flow and an increasing number of delayed discharges.

We are working closely with with NCC, CCG and NHFT to reduce the delayed discharges and it is anticipated that the discharge to assess scheme for patients requiring social care will commence at the end of February. A letter asking for assurance on plans from the Director of Adult Social Care at NCC has been sent and a response is awaited.

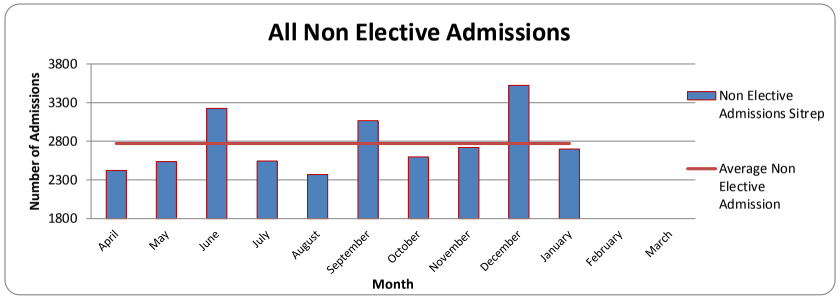
Directorates are currently working up plans to divert GP referrals out of AE, which will support better patient flow, faster assessment and reduce the occupancy in AE.

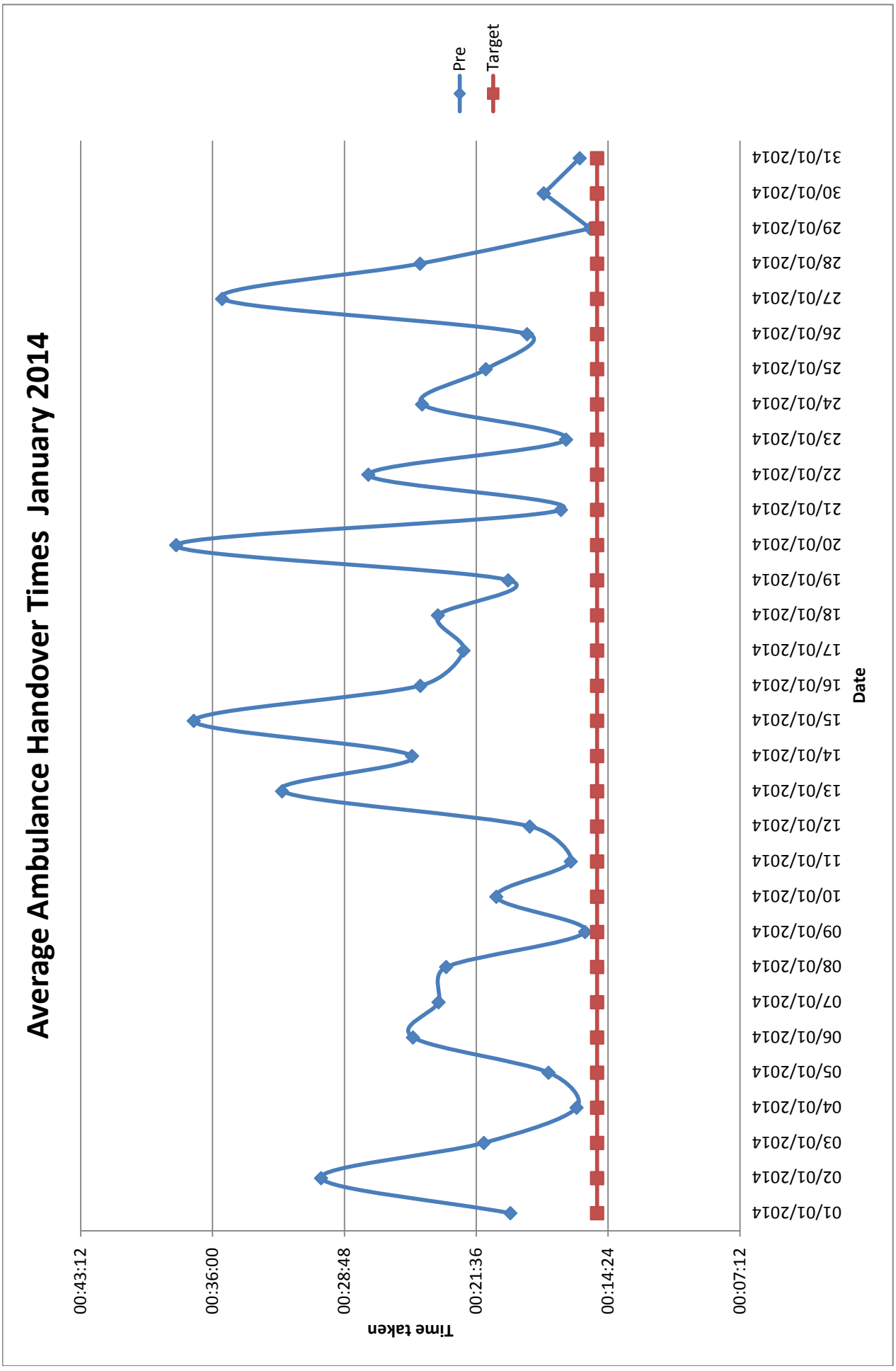
We have asked the CCG to work with us in undertaking the unpredictable and increasing activity levels with the aim of informing their QIPP plans for 2014/15.

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%		
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%		



* Note: Total Admissions from the Symphony system




Average Ambulance Handover Times January 2014
Pre
Target
Time taken
00:43:12
00:36:00
00:28:48
00:21:36
00:14:24
00:07:12
Date
01/01/2014
02/01/2014
03/01/2014
04/01/2014
05/01/2014
06/01/2014
07/01/2014
08/01/2014
09/01/2014
10/01/2014
11/01/2014
12/01/2014
13/01/2014
14/01/2014
15/01/2014
16/01/2014
17/01/2014
18/01/2014
19/01/2014
20/01/2014
21/01/2014
22/01/2014
23/01/2014
24/01/2014
25/01/2014
26/01/2014
27/01/2014
28/01/2014
29/01/2014
30/01/2014
31/01/2014

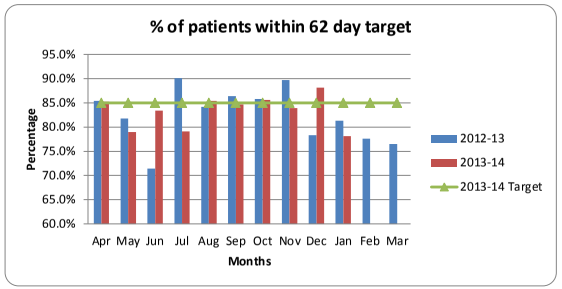
Cancer

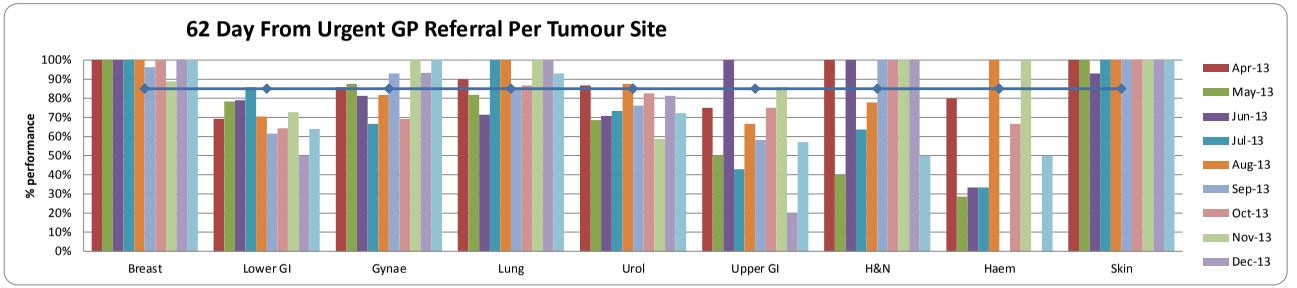
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Q1	Q2	Q3
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	95.80%	97.60%	96.30%	93.70%	95.87%	95.74%	96.76%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.60%	100.00%	100.00%	99.65%	99.55%
Cancer: 31 Day	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	95.40%	98.12%	97.76%	98.56%
Cancer: 31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	100.00%	100.00%	83.30%	98.15%	98.08%	100.00%
Cancer: 31 day second or subsequent treatment - drug	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	97.80%	95.80%	95.70%	100.00%	97.73%	97.30%	96.66%
Cancer: 62 day referral to treatment from screening	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	96.30%	100.00%	100.00%	94.12%	98.72%	98.04%
Cancer: 62 days urgent referral to treatment of all cancers	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	85.60%	83.90%	86.60%	78.10%	82.04%	83.44%	85.30%

Validated data confirmed the Trust did achieve 62 days from urgent GP referral in December and achieved the standard for quarter 3.

The number of breaches in January's position for 62 days from urgent GP referral means that this standard will not be met, although the data is not finally validated on the national system until the 7th March.

The Cancer Recovery Board continues to meet and the key actions to ensure sustainaibility are continued through pathway reviews, oncology appointments, administration processes and time to diagnostics.

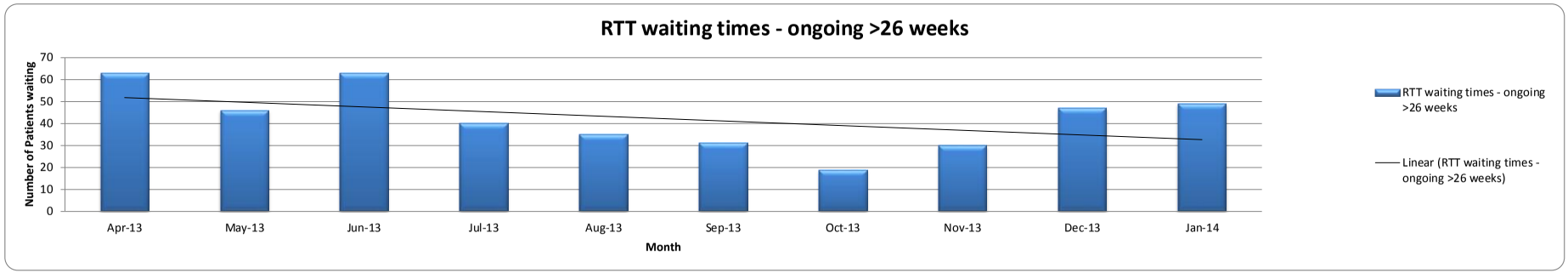




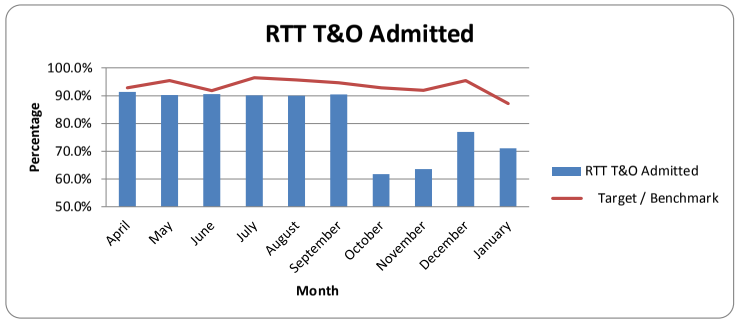
RTT Waiting Times

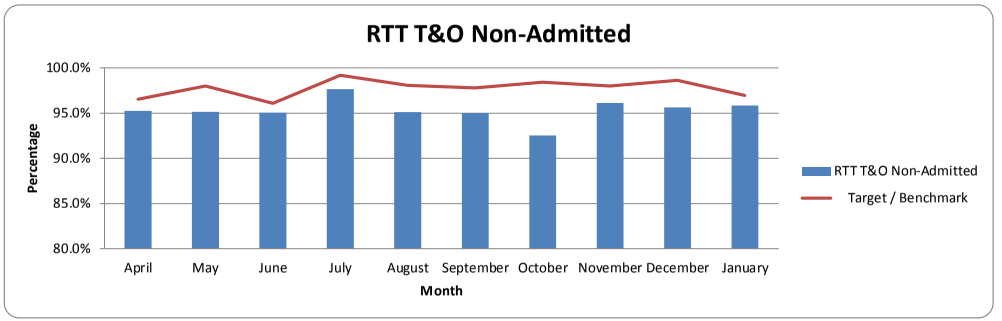
Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	19	30	47	49
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0

Key Notes:
Whilst the Trust is still achieving the overall RTT target in January the continued urgent care pressure, together with a recent generator failure has left the Trust not achieving at 2 speciality levels. Firstly orthopaedics which is now due to deliver within target in March and secondly ENT which have submitted a plan subject to further cancellations of achieving in February.



Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	April	May	June	July	August	September	October	November	December	January
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%	71.1%
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%	95.8%
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%
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%





REPORT TO THE TRUST BOARD
27 February 2014

Title	Finance Report Month 10 – January 2014
Agenda item	11
Sponsoring Director	Andrew Foster, Acting Director of Finance
Author(s)	Andrew Foster, Acting Director of Finance
Purpose	To report the financial position and associated risks for the period to January 2014.

Executive summary

The report sets out the financial position for the period to January 2014 (month 10). The year to date I&E position is a deficit of £1.7m.

The key issues arising from the report are:

- The forecast position for FY13-14 remains for a breakeven but with increased risk.
- £3.75m of the TDA support has been included in the year to date position reported above.
- Non-pay expenditure in January is adverse to forecast increasing the risk to delivery of the overall forecast.
- Cashflow position remains manageable and the Trust has not needed to access the temporary borrowing facility agreed with the TDA.
- The Trust is forecasting achievement of NHS Statutory Financial Duties for 2013/14.

The position as reported has been submitted to the TDA on Monday 17th February as part of the TDA's monthly financial monitoring requirements.

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

Enclosure H

Actions required by the Board

The Board is asked to note the current financial position and forecast I&E position and the actions being taken to deliver a breakeven I&E position by the financial year end.

Northampton General Hospital NHS
NHS Trust

Financial Position Month 10 2013/14

Report to:
Trust Board
February 2014

Enclosure H

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 Financial performance	-£1,699	-£3,174	£ 1,475 Fav	£0	£0	£0
Achieving EFL (£000's)	N/A	N/A	N/A	£4,303	£4,303	£0
Achieving the Capital Resource Limit (£000's)	£7,487	£8,002	£ 515 Fav	£14,110	£14,110	£0
Better Payment Practice Code:						
Volume of Invoices	89.80%	95.00%	5.20% Adv	95.00%	95.00%	-
Value of Invoices	92.39%	95.00%	2.61% Adv	95.00%	95.00%	-

Financial Performance

- Financial performance to January 2013 is £1,699k deficit, including £3,750k of TDA support. The underlying performance before TDA support is significantly behind the forecast trajectory by £1,660k for the year to date.
- The Nene CCG settlement and those of other key Commissioners have now been reflected in the reported income position.
- Forecast financial position is for a net deficit after TDA support of £3.0m which must be recovered to achieve I&E break even.
- The forecast is based on latest run rate which has exceeded forecast levels for a second month, making the gap to achieve a break even position more challenging.

Capital Expenditure

- Performance is £515k behind plan. Expenditure is forecast to significantly increase for the remainder of the year. Regular meetings to monitor progress now take place to mitigate the risk of slippage.
- Capital plans have now been reviewed and the CRL has now been fully committed by drawing forward schemes. This has allowed a capital contingency of £457k to be established in the previously fully committed 2014/15 capital programme.

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

- Nene CCG income settlement and agreed TDA support mitigate short term liquidity issues to an extent that can now be managed through working capital measures. Requirement to access to temporary borrowing facility now unlikely subject to receipt of £4.5m TDA support payment.

Key issues

- TDA non recurrent support of £3.75m included in latest financial position, with remaining £0.75m to be accrued in month 11 and 12.
- Month 10 position indicates that control totals used for the forecast are not being delivered in all areas.
- Forecast breakeven is still achievable but has become more challenging with deterioration in performance compared to forecast.
- Actions and additional measures have been identified to bridge the gap in the forecast.
- Cashflow is manageable for the remainder of the financial year. Longer term liquidity to be addressed through the 2014/15 plan and highlighted to the TDA in the Initial plan submission
- All statutory duties forecast to be delivered.

Actions

- Confirm and review forecast control totals with each area with robust management to avoid repeat of January deviations from trajectory.
- Practical steps required for immediate implementation to reduce run rate to mitigate the risk demonstrated at month 9.
  - Defer all non essential expenditure with focus on Estates and Corporate areas.
  - Enhanced approval process for third party outsourcing.
  - Identify further opportunities within existing run rate.
  - Ensure referrals are being treated in strict accordance with agreed RTT guidance.
  - Consider areas where activity can be stepped down in March e.g. ARMD.

2.Financial Performance Dashboard

KPIs	January		November	December
Continuity of Service Risk Rating	2	CSR Rating 2 ("Material risk")	2	2
EBITDA %	4.7%	% Earnings Before Interest, Tax and Depreciation.	3.6%	3.6%
Liquidity (days cover)	30	Liquidity cover based on latest Monitor guidance.	34.0	33
Surplus Margin	-0.77%	% earnings after interest, tax and depreciation.	-1.84%	-1.85%
Pay / Income	65.8%	Total YTD Pay costs as % of YTD income.	65.6%	65.6%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	609	Surplus before impairment and donated assets	(1,363)	(1,768)
Impairment and Donated Assets	(2,307)	Donated asset depr and impairment to be added back .	(1,886)	(1,905)
Normalised Position	(1,699)	I&E position excl donated asset depr and impairment.	(3,249)	(3,673)
TDA Plan (Year to date)	(3,174)	TDA Plan for year to January 2013 (Normalised).	(2,486)	(3,014)
CCG SLA Income Variance	1,193	CCG income is £1,193k above forecast.	3,118	4,248
TDA Normalised annual plan	0	Revsied Full year TDA control total.	(4,822)	0
Forecast EOY I&E postion	0	Current I&E forecast.	(4,798)	(2,440)
EBITDA Performance	**£000's**		£000's	£000's
Variance from plan	1,475	Improvement after TDA support has been recorded	(763)	(659)
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	10,261	TDA Plan to January.	7,496	8,880
YTD Actual	9,377	Actual delivered to month 10 inc bank and agency.	7,247	8,468
% Delivered	91%	% delivery of Plan year to date.	97%	95%
LTF	11,769	LTF. All R,A,G schemes will deliver in full.	11,794	11,655
Annual Plan	13,000	Annual CIP target.	13,000	13,000
LTF v. Plan	91%	Planned annual % delivery of Plan.	91%	90%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	7,487	Capital expenditure for year to date £515k behind plan.	5,454	6,227
Committed as % of plan YTD	87%	% of plan committed for year to date.	57%	78%
Annual Plan	14,109	CRL increased (ICT/CEF/SWTF fund bids).	14,120	14,119
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	1,637	Reduction in non current assets due to depreciation.	2,373	(223)
Current assets	4,329	Increase in debtors and accruals offset by reduction in stocks.	(1,814)	(266)
Current Liabilities	(2,266)	Fall in trade and capital creditors.	934	937
Cash	**£000's**		**£000's**	**£000's**
In month movement	3,037	Collection of older debt and mandate payments in advance	223	201
In Year movement	4,832	Collection of older debt and mandate payments in advance	1,594	1,795
DH Temporary Loans	0	TBL Loan facility of £4m available.	0	0
Debtors Balance > 90 days	1,534	CRIPPS centre, MKPCT, NCA and Overseas Patients.	1,682	1,818
Creditors % > 90 days	0.00%	No creditors over 90 days.	0.00%	0.00%
Cummalative BPPC (by volume) YTD	89.8%	BPPC improved in January.	88.7%	89.6%

Key issues

KPIs

- Shadow Continuity of Service risk rating is 2 (material risk). Monitor intervention would be monthly or greater monitoring with consideration for potential investigation.

I&E Position

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

Cost Improvement Programme

- CIP programme latest thinking forecast £11.769m. Assumes delivery of red, amber schemes in this figure totalling £0.3m (high risk).
- Year to date performance now £884k behind plan.

Capital

- Underspent against plan by £515k but plans in place to spend full CRL in 13/14. Spend forecast to significantly increase in last quarter of the year.

Statement of Financial position

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

Cash

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

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

I&E Summary	Annual Plan 2013/2014	YTD Actual	YTD Forecast	Variance to Forecast	January 2013/14 Forecast	January 2013/14 Actuals	February 2013/14 Forecast	March 2013/14 Forecast	Full Year Forecast
	£000's	£000's	£'000	£'000	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	197,956	199,149	(1,193)	20,613	19,574	18,823	20,559	237,338
Other Clinical Income	2,803	2,138	2,259	(122)	224	257	224	224	2,586
Other Income	26,031	20,569	20,714	(145)	2,075	2,097	2,075	2,267	24,912
Total Income	**260,584**	**220,663**	**222,123**	**(1,460)**	**22,912**	**21,929**	**21,122**	**23,050**	264,835
					0	0			
Pay Costs	(175,851)	(145,292)	(145,360)	69	(14,821)	(14,847)	(14,887)	(15,061)	(175,239)
Non-Pay Costs	(79,240)	(68,841)	(68,459)	(382)	(7,255)	(7,698)	(6,732)	(7,210)	(82,783)
CIPs	4,822	0	0	0	0	0			0
Reserves/ Non-Rec	(1,143)	0	0	0	0	0			0
Total Costs	**(251,413)**	**(214,133)**	**(213,819)**	**(314)**	**(22,076)**	**(22,544)**	**(21,619)**	**(22,270)**	**(258,022)**
EBITDA	**9,171**	**6,530**	**8,304**	**(1,773)**	**836**	**(616)**	**(497)**	**779**	**6,812**
					0	0			
Depreciation	(10,184)	(8,738)	(8,756)	19	(873)	(855)	(856)	(856)	(10,450)
Amortisation	(10)	(8)	(8)	0	(1)	(1)	(1)	(1)	(10)
Impairments	0	2,540	2,559	(19)	0	466	0	0	2,540
Net Interest	29	25	24	2	2	4	3	3	32
Dividend	(4,106)	(3,491)	(3,520)	29	(352)	(372)	(370)	(370)	(4,231)
					0	0			
Surplus / (Deficit)	**(5,100)**	**(3,141)**	**(1,398)**	**(1,743)**	**(387)**	**(1,373)**	**(1,721)**	**(444)**	**(5,306)**
Normalised Postion:									
Donated Assets Depreciation	278	233	169	64	41	41	65	45	343
Impairments	0	(2,540)	(2,559)	19		(466)			(2,540)
I&E Position (before TDA support)	**(4,822)**	**(5,449)**	**(3,788)**	**(1,660)**	**(346)**	**(1,799)**	**(1,656)**	**(399)**	**(7,504)**
TDA Support 13/14		3,750		3,750		3,750	375	375	4,500
Recovery actions							1,165	1,839	3,004
I&E Position		**(1,699)**	**(3,788)**	**2,090**	**(346)**	**1,951**	**(1,281)**	**(24)**	**0**

Financial Performance

- Financial performance to January 2013 is £1,699k deficit after including £3,750k of TDA support. The underlying performance highlighted above, before TDA support is significantly behind the forecast trajectory by £1,660k year to date requiring additional measures and actions.
- The Nene CCG settlement and those of other key associates have now been included and the income values updated accordingly.
- Forecast financial position is for a net deficit after TDA support of £3.0m which must be recovered to achieve I&E breakeven. A range of actions to achieve this are set under agenda item 6.
- The forecast is based on latest performance which has exceeded forecast levels for a second month, making the gap to achieve a break even position more challenging.

Key issues

Clinical Income (SLA and Other)

- Clinical income is £1.1m behind the forecast trajectory pending final agreement with Commissioners and accounting for partially completed spells.

Other Income

- Other income has improved in month and is now forecast to meet the control total set as income will recover is now beginning to recover in the latter part of the year.

Pay Expenditure

- Pay met the control total set however spend did increase in month as the payment for the Christmas and new year enhancements are paid.

Non Pay Expenditure

- Non pay expenditure is significantly adverse to forecast trajectory due to drugs, outsourcing costs and building maintenance.

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.

4.Clinical Income – CCG Analysis

Commisioner	Contract	Year to Date	M11	M12	TOTAL
Nene CCG	Fixed	154,149,920	14,061,594	15,221,706	183,433,220
Nene ARMD Meds	Fixed	1,311,465	127,658	127,658	1,566,780
Corby CCG	Fixed	3,180,410	381,158	421,996	3,983,564
SCG	Fixed	26,119,315	2,633,495	2,911,191	31,664,000
Milton Keynes	Fixed	2,719,956	253,019	280,128	3,253,104
East Leics	PBR	551,380	46,529	60,100	658,008
NHS Leics	PBR	74,591	6,346	8,197	89,134
West Leics	PBR	70,435	5,987	7,733	84,155
Beds	PBR	439,899	37,453	48,376	525,727
National Commisioning Board	PBR	6,781,066	602,504	778,234	8,161,803
NCAs	PBR	2,817,781	324,310	351,336	3,493,427
Winter Pressures	Fixed	1,100,000	470,000	470,000	2,040,000
Total		**199,316,216**	**18,950,052**	**20,686,655**	**238,952,922**

Key risks to Income Forecast

Risks to the forecast position:

- ARMD activity has increased above forecast in January. This has led to a corresponding increase in medicines costs which cannot be matched by income under the year end agreement.
- Non elective demand continues to over perform compared to forecast creating associated pressures on elective capacity. Outsourcing of activity in T&O and Ophthalmology has significantly increased in January above forecast levels and is required to continue to meet the 18 week RTT target by the financial year end.
- Plan must now be put in place to ensure that outsourcing activity is only undertaken when essential and that the referral patterns are slowed wherever possible,.
- Activity for ARMD will be reviewed with a view to remaining within the CCG's agreed year end forecast by the end of March 2014.
- The value of partially completed spells (WIP) is variable and will need to be included in the accounts at the end of the financial year.

Activity & Financial Performance

Nene CCG (£185m year end agreement)

- The forecast shown in the table (left) includes the £185m year end agreement offered by Nene CCG.
- The treatment of WIP/partially completed spells will be agreed with the CCG at the year end.
- ARMD activity has increased above forecast in January.
- The risk of significant increases in challenges affecting the Nene CCG position has been mitigated by this agreement. The contract will continue to be monitored but any new challenges will not have a financial impact.

Corby CCG (£3.98m fixed year end settlement)

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

Specialised Services (£31.6m year end agreement)

- Agreement has now been reached with Specialised Commissioners agreeing a fixed year end settlement which includes 0% fine for MRET.

5. Forecast Financial Outturn

I&E Summary	YTD Actual	February 2013/14 Forecast	March 2013/14 Forecast	Full Year Forecast
	£000's	£000's	£000's	£000's
SLA Clinical Income	197,956	18,823	20,559	237,338
Other Clinical Income	2,138	224	224	2,586
Other Income	20,569	2,075	2,267	24,912
Total Income	**220,663**	**21,122**	**23,050**	264,835
Pay Costs	(145,292)	(14,887)	(15,061)	(175,239)
Non-Pay Costs	(68,841)	(6,732)	(7,210)	(82,783)
CIPs	0			0
Reserves/ Non-Rec	0			0
Total Costs	**(214,133)**	**(21,619)**	**(22,270)**	**(258,022)**
EBITDA	**6,530**	**(497)**	**779**	**6,812**
Depreciation	(8,738)	(856)	(856)	(10,450)
Amortisation	(8)	(1)	(1)	(10)
Impairments	2,540	0	0	2,540
Net Interest	25	3	3	32
Dividend	(3,491)	(370)	(370)	(4,231)
Surplus / (Deficit)	**(3,141)**	**(1,721)**	**(444)**	**(5,306)**
Normalised Postion:				
Donated Assets Depreciation	233	65	45	343
Impairments	(2,540)			(2,540)
I&E Position before TDA Support	**(5,449)**	**(1,656)**	**(399)**	**(7,504)**
TDA Support (£4.5m)	**3,750**	**375**	**375**	**4,500**
Recovery actions		**1,165**	**1,839**	**3,004**
I&E Position	**(1,699)**	**(1,281)**	**(24)**	**0**

Key Issues

- Run rate forecast now updated for January performance with a forecast gross deficit of £7.5m.
- Forecast based on:
  - historic run rates adjusted for working days in each month.
  - Includes the impact of the guaranteed income settlement with Nene CCG.
  - Run rate for pay and non pay adjusted for known trends and planned winter pressures income and expenditure.
  - Historic March increase in costs reduced based on updated controls in place for financial year on discretionary pay expenditure.
- £4.5m of TDA support has now been agreed leaving a net deficit of £3.0m.
- A range of actions and additional measures has been identified to close the gap.

6. Risks & Opportunities

	£000s		£000s
Downside Risk	**Unmitigated Risk**	**Action to mitigate risk**	**Residual Risk**
Outsourcing activity continues at current levels to meet RTT times	(250)	Robust management of all outsourcing activity to ensure only essential work is outsourced to meet RTT targets	(250)
ARMD activity and associated excluded medicines costs continue to exceed the agreed levels of Nene CCG income settlement	(250)	Manage activity and bookings scheduled for March to ensure overall forecast is achieved where clinically appropriate.	(100)
February and March expenditure exceed forecast levels	(600)	Robust control and management of all non essential expenditure. Reinforce message through management briefings. Surveillance by Procurement team.	(300)
Cost of winter pressures exceed allocated funding.	(300)	Trust has received allocation to manage winter pressures and A&E delivery. Winter plan and commitments to be agreed at UCB and SMB. Reduced risk at now only two months year to go.	(50)
Stock movements are significant in March outside planned levels	(250)	Optimise stock usage where possible	(250)
Total	**(1,650)**		**(950)**

Risks

- Risk table has been updated to show the unmitigated and mitigated risk to the financial position.
- Risks associated with delivery of financial control totals remains significant.
- Most significant risks have been mitigated where possible but action and intervention is required by the organisation to ensure the mitigations occur.
- Year end balances for stock cannot be assessed until stock takes are completed.

7. Statement of Financial Position as at January 2014

	Balance at 31-Mar-13	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789	0	133,789	0
IN YEAR REVALUATIONS	0	5,546	6,795	1,249	6,825	6,825
IN YEAR MOVEMENTS	0	6,432	7,675	1,243	14,382	14,382
LESS DEPRECIATION	0	(7,883)	(8,738)	(855)	(10,512)	(10,512)
NET BOOK VALUE	**133,789**	**137,884**	**139,521**	**1,637**	**144,484**	**10,695**
CURRENT ASSETS						
INVENTORIES	4,934	5,503	5,148	(355)	4,985	51
RECEIVABLES						
NHS DEBTORS	4,103	7,033	8,015	982	4,044	(59)
OTHER TRADE DEBTORS	2,295	1,366	1,279	(87)	2,295	0
DEBTOR IMPAIRMENTS PROVISION	(443)	(443)	(443)	0	(443)	0
CAPITAL RECEIVABLES	0	0	0	0	0	0
NON NHS OTHER DEBTORS	132	475	483	8	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,548	2,640	92	2,514	0
OTHER RECEIVABLES	676	1,030	1,268	238	925	249
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,441	2,855	414	1,410	23
	10,149	**13,935**	**15,582**	**1,647**	**10,362**	**213**
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	4,342	6,137	9,174	3,037	4,654	312
NET CURRENT ASSETS	**19,425**	**25,575**	**29,904**	**4,329**	**20,001**	**576**
CURRENT LIABILITIES						
NHS	628	1,192	1,541	(349)	1,495	(867)
TRADE CREDITORS REVENUE	1,255	879	3,242	(2,363)	4,765	(3,510)
TRADE CREDITORS FIXED ASSETS	1,744	1,881	2,197	(316)	2,852	(1,108)
TAX AND NI OWED	1,769	3,400	3,460	(60)	3,400	(1,631)
NHS PENSIONS AGENCY	2,013	2,191	2,217	(26)	2,189	(176)
OTHER CREDITORS	495	335	339	(4)	494	1
SHORT TERM LOANS	669	621	621	0	785	(116)
ACCRUALS AND DEFERRED INCOME	6,132	11,229	10,097	1,132	5,378	754
PDC DIVIDEND DUE	36	1,066	1,438	(372)	25	11
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	3,501	3,127	3,035	92	650	2,851
PROVISIONS over 1 year	1,281	1,281	1,281	0	1,331	(50)
NET CURRENT LIABILITIES	**20,309**	**27,988**	**30,254**	**(2,266)**	**23,993**	**(3,684)**
TOTAL NET ASSETS	**132,905**	**135,471**	**139,171**	**3,700**	**140,492**	**7,587**
FINANCED BY						
PDC CAPITAL	100,115	100,968	101,507	539	103,459	3,344
REVALUATION RESERVE	32,486	35,966	36,750	784	36,729	4,243
DONATED ASSET RESERVE	0	0	0	0	0	0
GENERAL RESERVES	304	304	304	0	304	0
I & E CURRENT YEAR	0	(1,767)	610	2,377	0	0
FINANCING TOTAL	**132,905**	**135,471**	**139,171**	**3,700**	**140,492**	**7,587**

Key Issues

Non Current Assets

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

Net Current assets

- Increase in net current assets during the month of £4.3m.
- Inventories reduction of £0.4m.
- Increase in NHS Debtors of £1.0m and Prepayments & Accruals of £0.4m.
- Cash has increased by £3.0m as a result receiving the balance of the winter pressures funding, quarterly invoices and CEF PDC funding.

Net Current Liabilities

- Increase in net current liabilities during the month by £2.3m.
- Reduction in NHS Creditors £0.3m, increase in Trade Creditors £2.4m and increase in Capital Creditors whilst Accruals and Deferred Income has reduced by £1.1m and PDC has increased by £0.4m.

Financing

- Increase in PDC capital of £0.8 m (CEF).
- Increase in Revaluation Reserve as a result of movement in value of buildings £0.5 m for the final quarter
- Improvement in current year I&E position as the Commissioner non-recurrent funding is phased into the position.

8. Capital Expenditure

Scheme	Approved Annual Budget 2013/14 £000's	Year to Date as at Month 10 M10 Plan £000's	M10 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 10 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 10 Forecast M10 £000's	Under (-) / Over £000's
Linear Accelerator Corridor	0	0	0	0	0%	0	0%	0	0
Improving Birthing Environments	399	399	417	18	105%	417	105%	417	18
Endoscopy	150	150	151	1	101%	158	105%	158	8
Urodynamics	150	150	149	-1	100%	149	100%	150	0
Haematology (Trust)	0	0	1	1	0%	23	0%	1	1
Annual Strategic Planning Approvals	-21	0	0	0	0%	0	0%	0	21
MESC	2,040	1,145	1,085	-60	53%	1,855	91%	2,040	0
Estates	3,725	2,533	2,429	-104	65%	2,879	77%	3,707	-18
IT	3,542	2,020	1,925	-95	54%	3,189	90%	3,542	0
Other	997	405	403	-2	40%	451	45%	967	-30
Carbon Energy Efficiency Fund (CEEF)	3,350	1,392	1,119	-273	33%	3,350	100%	3,350	0
Total - Capital Plan	**14,331**	**8,194**	**7,679**	**-515**	**54%**	**12,470**	**87%**	**14,331**	**0**
Less Charitable Fund Donations	-222	-192	-191	0	86%	-220	99%	-222	0
Total - CRL	**14,109**	**8,002**	**7,487**	**-515**	**53%**	**12,250**	**87%**	**14,110**	**0**

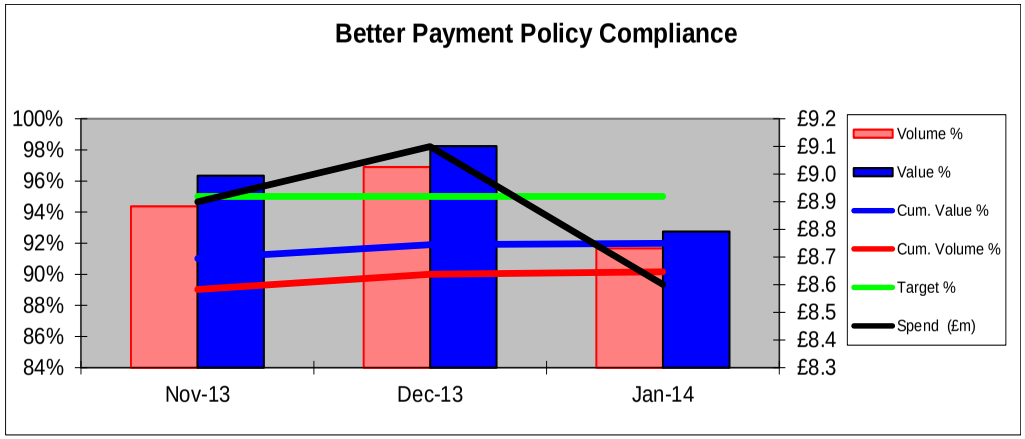
Key Issues

- Expenditure lower than planned at January by £42k.
- Full year forecast expected to fully achieve CRL limit.
- IT Innovation Funding of £542k has now been approved by DH and added to the capital plan although PDC drawdown not yet confirmed.
- Slippage at M10 on ITSC and Estates has been managed by advancing MESC from next years plan already received.
- All schemes are now being reviewed on a monthly basis with all project leads and all existing committed orders will be reviewed with project leads on a weekly basis
- Negative contingency following the reduction of the depreciation forecast (internally generated resource) which will be managed in achieving the CRL
- The Trust is required to spend it's internally generated cash resources to ensure that it can receive the additional national CEF, IT and Estates allocations
- Advancement of a number of high priority schemes from the 2014/15 plan has created a contingency of £457k

9. Receivables, Payables and BPPC Compliance

	Total at January £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	1,275	471	115	59	630
Receivables NHS	3,100	1,159	687	350	904
Total Receivables	**4,375**	**1,630**	**802**	**409**	**1,534**
Payables Non NHS	(3,879)	(3,792)	(51)	(36)	
Payables NHS	(159)	(158)	(1)		
Total Payables	**(4,038)**	**(3,950)**	**(52)**	**(36)**	

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



Receivables and Payables

- Continued progress in reducing our non current debt
- Key mandate payments have been made on time.
- Over 90 day debt of £1.5m includes PCT legacy debt of £0.3m, CRIPPS debt of £0.3m, NCA's debt of £04m and Overseas Patients debt of £0.2m.

BPPC Compliance

- BPPC has continued to improve from last month to (89.80% by volume, 92.39% 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
- Issues encountered with the new pharmacy stock system have resulted in continued late payment of invoices
- Work has continued with areas of non compliance to develop a satisfactory resolution.

10. Cash Flow and Working Capital

MONTHLY CASHFLOW	ACTUAL										FORECAST	
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS												
SLA Base Payments	17,721	19,030	15,721	23,380	19,172	17,506	23,166	17,522	17,434	21,133	17,485	17,485
SLA Performance / Other CCG							650	2,253	2,336	1,173	1,603	3,978
Health Education Payments	22	1,511	764	664	728	781	672	856	803	685	820	820
Other NHS Income	2,923	877	1,596	616	1,709	1,154	1,804	1,817	1,351	1,606	1,667	2,026
PP / Other (Specific > £250k)			329									
PP / Other	892	1,096	655	758	857	1,142	1,030	965	1,179	1,078	1,000	1,000
Salix Capital Loan									95		95	127
EFL / PDC									853	539		1,952
Temporary Borrowing												
Interest Receivable	3	3	2	2	3	2	2	3	3	4	3	3
TOTAL RECEIPTS	**21,562**	**22,518**	**19,067**	**25,419**	**22,469**	**20,586**	**27,324**	**23,416**	**24,053**	**26,217**	**22,673**	**27,392**
PAYMENTS												
Salaries and wages	12,168	13,743	13,749	13,881	13,870	13,823	13,886	13,899	14,049	14,202	14,270	14,180
Trade Creditors	4,499	7,344	5,805	5,704	7,029	5,603	7,551	7,011	6,636	7,207	7,500	7,330
NHS Creditors	1,617	1,296	1,619	2,197	2,295	1,642	1,876	1,614	1,908	1,243	1,300	1,920
Capital Expenditure	477	526	727	528	840	531	526	737	1,259	657	2,051	3,709
PDC Dividend						2,089						2,141
Repayment of Salix loan						143						183
TOTAL PAYMENTS	**18,761**	**22,909**	**21,900**	**22,310**	**24,035**	**23,831**	**23,840**	**23,262**	**23,852**	**23,309**	**25,121**	**29,463**
Actual month balance	2,801	-392	-2,833	3,109	-1,565	-3,245	3,484	154	201	2,908	-2,448	-2,071
Cash in transit & Cash in hand								120		76		
Balance brought forward	4,303	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	9,121	6,673
C/FWD	**7,104**	**6,712**	**3,880**	**6,988**	**5,423**	**2,178**	**5,662**	**5,936**	**6,137**	**9,121**	**6,673**	**4,602**

Notes to Cashflow

- The capital plan is heavily phased for the second half of the financial year which includes the Carbon Energy Efficiency Scheme. PDC funding profile has now been submitted to the DH with £1.392m being received to date with a further £1.368m to be requested for March.
- Additional PDC associated with Safer Hospitals Safer Wards IT bids and Estates Maternity Care Settings Fund have yet to be cleared by the DH although anticipated in March
- Cash flow is still being reviewed on a weekly basis and monitored on a daily basis to ensure the Trust meets it's financial obligations.

Key Issues

- Month end balance of £9.174m has risen by £2.9m
- Forecast assumes £185 million contract agreement with Nene CCG, this includes £2m received on account from Nene CCG in October which is expected to be recouped in March and the contract settlement invoices are expected to be paid in February and March
- Cash flow has been based on a breakeven position, following £4.5m financial support to be received from NHS England in March.
- Final Winter pressure funding was received in January, when previously expected to be paid by Nene CCG early Feb .

REPORT TO THE TRUST BOARD
27 February 2014

Title	Workforce Report
Agenda item	12
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s)	Mark Ingram, Head of e-Workforce
Purpose	This report provides an overview of key workforce issues.

Executive summary

The key matters affecting the workforce include:
The key performance indicators show an increase in Total Workforce Capacity (excluding Medical Locums) employed by the Trust and a decrease in total sickness absence.

The report includes the following Workforce Information Updates:
The revised Appraisal Process, Final Flu Vaccine Uptake, MAPS HealthRoster Upgrade, and Nurse Recruitment.

Related strategic aim and corporate objective	Strategic Aim 4: Foster a culture where staff can give their best and thrive. Corporate Objective: To develop and implement new ways of engaging & supporting staff to enable them to achieve their potential.
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF 7: High bank & agency costs.
Equality Impact Assessment	No
Legal implications / regulatory requirements	No

Actions required by the Board

The Trust Board is asked to note the report.

Trust Board
27 February 2014

Workforce Report

1. Introduction

This report identifies the key themes emerging from January 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 0.03% in January to 4.69%, which is above the Trust target.

The total sickness absence rate for the General Medicine & Emergency Care Group has increased by 0.41%.

The total sickness absence rate for the General Surgery Care Group has decreased by 0.26%.

Work continues to improve the reporting mechanisms for Medical & Dental sickness absence which has increased by 0.39% to 1.29% in January 2014. The total sickness absence within Facilities (3.62%) and Hospital Support (2.49%) continues to decrease and both areas are below Trust target.

Workforce Capacity

Total workforce capacity (excluding Medical Locums) increased by 81.67 FTE in January. The substantive workforce capacity increased by 38.24 FTE to 4,148.50 FTE and the temporary workforce capacity (excluding Medical Locums) increased by 43.43 FTE to 334.25 FTE.

2.2 Workforce Information Update

Appraisal Update

From 1st April 2014 the Trust's revised appraisal system for all staff on Agenda for Change Terms and Conditions of service will be implemented. Progression through all incremental pay points in all pay bands is now conditional on individuals demonstrating that they meet locally agreed performance requirements in line with Annex W (England) of the Handbook.

The process for implementation has been widely circulated and training has been provided through the Learning and Development Department for both managers and staff.

Influenza Vaccinations

From information provided in the Department of Health Flu Report of December 2013, the national average vaccine uptake for September to December 2013 was 53.1%. The uptake for NGH for December 2013 was higher than the national average at 56.7%.

The number of organisations detailed in the report was 271, of which 258 (95.2%) submitted returns on the flu vaccine uptake. Of the 258 organisations making a return by December 2013, only 8% achieved 75% or above (75% is the target set by the Department of Health for additional winter pressures funding for 2014/15).

MAPS HealthRoster Upgrade

The Allocate Software MAPS HealthRoster contract has been renewed with a cost neutral migration to update to v.10 of the Allocate Cloud software. When HealthRoster v.10 is fully implemented it will deliver an easier, faster and more simple solution allowing system users to access the system online anytime, anywhere and with v.10, there is no limitation with concurrent licences, which means that there will no longer be a restriction in the number of people that can access the system at any one time.

Nurse Recruitment Update

The overseas nurse recruitment campaign to support of the Nursing Strategy to employ 100 nurses from Spain is now in place. Phase 1, which took place in February, has secured 42 nurses who will commence employment in April and May. Phase 2 is scheduled for early April and will secure another 50-60 nurses who will commence employment in June and July. The Trust held a recruitment open day on 13th February and successfully recruited 49 nurses and there are 2 further open days scheduled for July and October. In addition to these activities, the Trust is attending recruitment fairs in Milton Keynes and local universities to further support the recruitment strategy.

3. Assessment of Risk

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

4. Recommendation

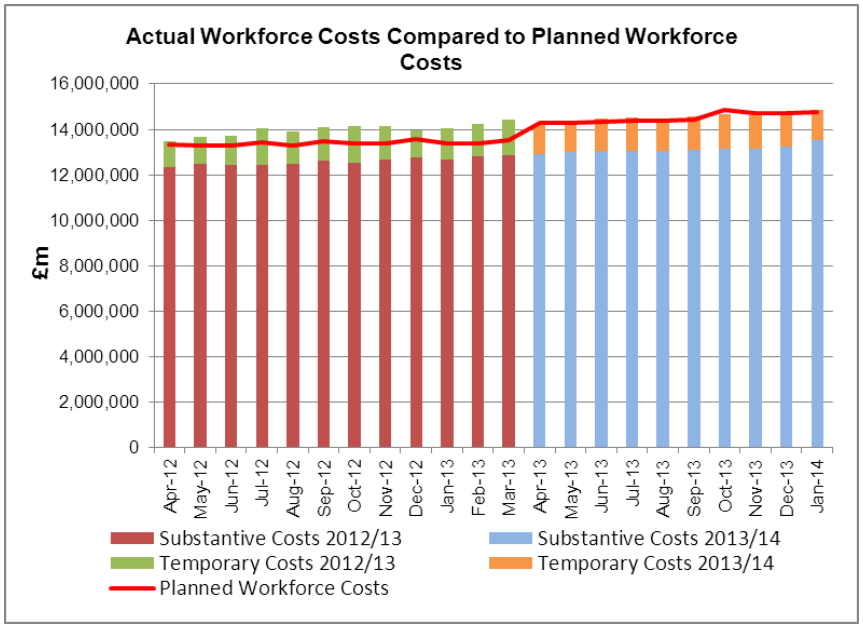
The Board is asked to note the report.

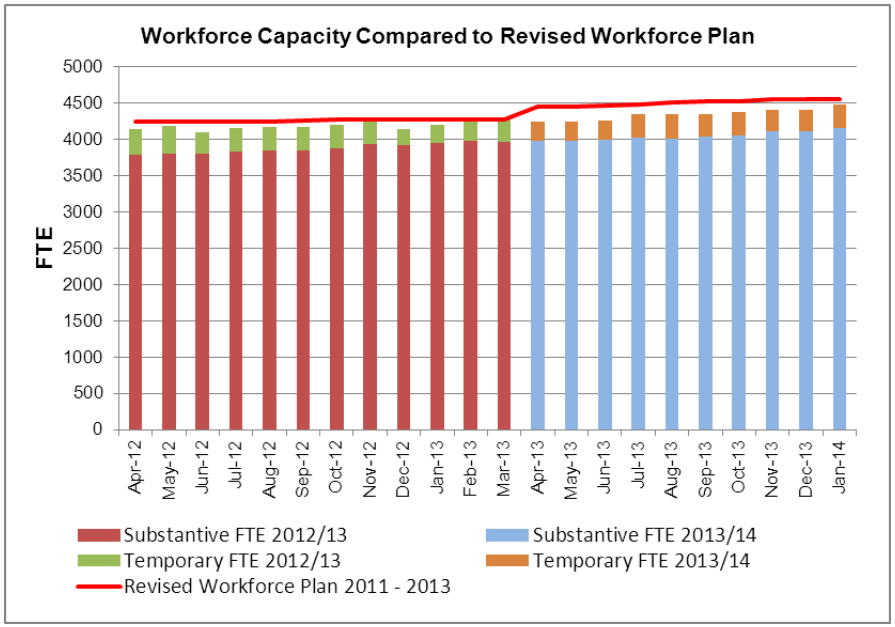
5. Next Steps

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

Enclosure I

Human Resources Workforce Performance Indicators 2013/14 Month 10





	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		
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		
Planned Workforce Costs2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14480	14466	14476	14453	14466	14414

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2012/13	3,786	3,799	3,800	3,838	3,842	3,853	3,877	3,937	3,927	3,952	3,979	3,968
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059	4,108	4,110	4,149		
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		
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		

Workforce Expenditure

Total workforce Expenditure (all pay elements) increased by £188,471 in January to £14.846m (this is above plan for Month 10).

Substantive workforce expenditure increased by £283,418 to £13,521,319.

Temporary Workforce Expenditure (including Medical Staff) continues to decrease for the third consecutive month, decreasing by £94,947 to £1,324,798 = to 8.92% of the of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **increased by 81.67 FTE in January to 4,482.75 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,557.96 FTE.**

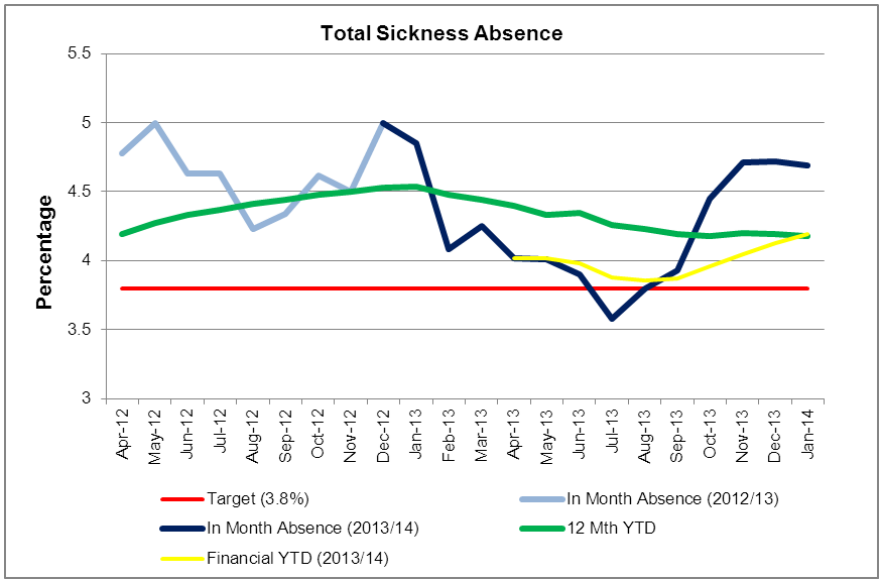
Substantive workforce capacity increased by 38.24 FTE to 4,148.50 FTE.

- Overseas recruitment from Spain continues, 25 RNs are due to commence in April 2014 and an addition 25 RNs are due to commence in May 2014.

Temporary workforce capacity (excluding Medical Locums) **increased by 43.43 FTE to 334.25 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 10

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Hospital Support
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	91.02%	89.75%	**96.06%**	82.30%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.46%	9.14%	6.31%	5.59%
Total Substantive Workforce plus Temporary Workforce against Budgeted Establilshment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	98.35%	98.78%	102.53%	87.17%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.05%	8.83%	**7.83%**	13.00%



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

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 33,169 hours (204.12 FTE), which is an increase of 6,632 hours (40.81 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 44.47% (decrease of 2.65%), Agency fill rate = 25.41% (increase of 1.32%). Total bank & agency fill rate = 69.88% (decrease of 1.33% compared with the previous month).
- Monitoring of 6.5 hour bank & agency shifts continues, excluding night shifts there was an average of 44% of bank & agency shifts in January that were for a 6.5 hour duration or less.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.18% in January 2014.

In month Sickness Absence has decreased by 0.03% to 4.69% which is above the Trust target.

- Short term sickness absence increased by 0.26% to 2.59%.
- Long term sickness absence decreased by 0.29% to 2.10% which is now below Trust Target.
- The total calendar days lost to sickness absence increased by 53 to 7,043 days lost.
- The number of days lost per employee has decreased to 1.45 days.

Human Resources Workforce Performance Indicators 2013/14 Month 10

		Surgery Care Group							
		Directorate							
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck		Women	Children
Short Term Sickness Absence		1.60%	1.91%	2.55%	3.25%	2.85%		2.87%	2.22%
Long Term Sickness Absence		2.20%	2.80%	2.48%	0.71%	2.55%		2.65%	3.31%
Total Sickness Absence	Over 4.2%	3.80%	0.00%	5.02%	3.96%	5.39%		5.52%	5.53%
	3.9-4.2%								
	Under 3.8%								

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery Care Group decreased by 0.26%. For ward based total sickness absence there have been decreases on Abington Ward of 4.39% and Disney Ward of 7.19%.

  Hot spots for ward based sickness are within Child Health on Gosset where total sickness absence has increased by 3.79% to 7.71% with long term sickness (3 cases) increasing by 3.89% and Paddington with total sickness absence of 7.31% of which 6.54% is for long term sickness with 50% of the cases for pre-planned surgical procedures.

		Medicine Care Group							
		Directorate							
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	3.02%	2.34%	2.56%	3.15%		2.85%	3.92%
Long Term Sickness Absence		2.20%	2.32%	1.24%	1.51%	1.51%		2.47%	3.16%
Total Sickness Absence	Over 4.2%	3.80%	5.34%	3.58%	4.07%	4.66%		5.31%	7.08%
	3.9-4.2%								
	Under 3.8%								

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency Care has increased by 0.41%. The problem areas are within the Pharmacy (MMT team) at 29.41% where there are two complex long term absences and the Travel Office at 12.90% where there are underlying conditions for short term sickness absences which are being managed.

  Hot spots for ward based total sickness absence are Becket Ward which has increased by 6.71% to 12.54% with long term sickness increasing by 4.24% and short term sickness increasing by 2.47%. Corby Community Ward total sickness absence has decreased by 0.93% but remains high at 12.43% with long term sickness absence increasing by 3.15%.

		Hospital Support				M&D
		Directorate				
	Threshold	Target	Facilities	Hospital Support		Medical & Dental
Short Term Sickness Absence		1.60%	2.90%	1.12%		0.67%
Long Term Sickness Absence		2.20%	0.72%	1.37%		0.62%
Total Sickness Absence	Over 4.2%	3.80%	3.62%	2.49%		1.29%
	3.9-4.2%					
	Under 3.8%					

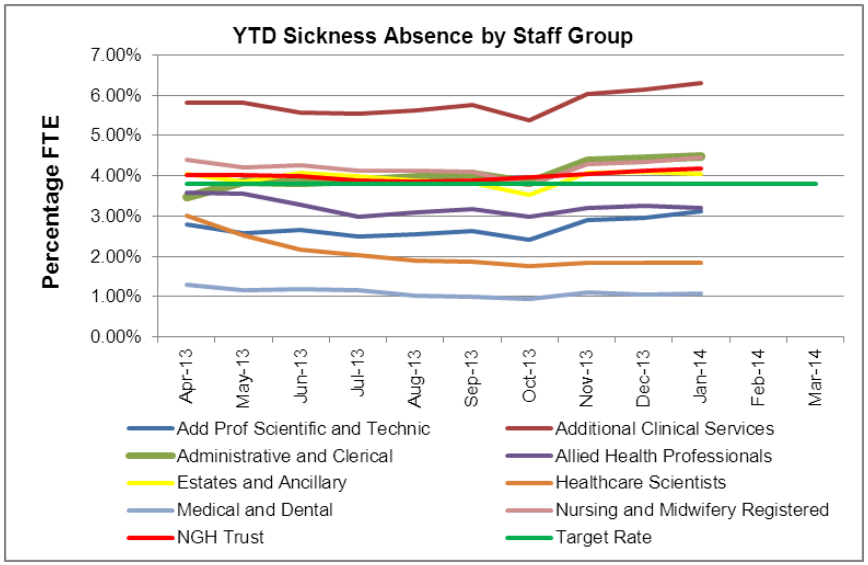
Hospital Support and Medical & Dental Summary

- The total sickness absence within Facilities (3.62%) and Hospital Support (2.49%) continues to decrease and is below Trust target.

  Work continues to improve the reporting mechanisms for Medical & Dental sickness absence which has increased by 0.39% to 1.29% in January 2014.

  Following the upgrade to v.10 MAPS HealthRoster, which goes live in March 2014, it is planned 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 10



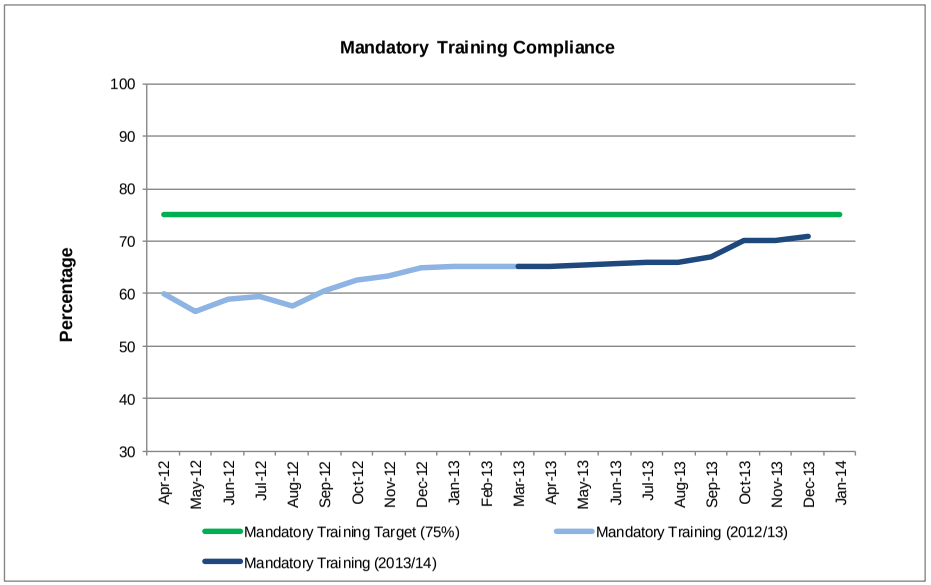
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Add Prof Scientific and Technic	2.78%	2.57%	2.66%	2.50%	2.55%	2.64%	2.41%	2.91%	2.95%	3.11%		
Additional Clinical Services	5.82%	5.81%	5.56%	5.54%	5.61%	5.75%	5.39%	6.03%	6.14%	6.29%		
Administrative and Clerical	3.47%	3.85%	3.84%	3.88%	3.97%	4.05%	3.82%	4.36%	4.43%	4.47%		
Allied Health Professionals	3.58%	3.56%	3.27%	2.97%	3.08%	3.18%	2.99%	3.21%	3.25%	3.19%		
Estates and Ancillary	4.04%	3.84%	4.08%	3.98%	3.87%	3.82%	3.52%	4.06%	4.10%	4.04%		
Healthcare Scientists	3.00%	2.51%	2.18%	2.04%	1.89%	1.86%	1.75%	1.83%	1.83%	1.84%		
Medical and Dental	1.29%	1.15%	1.18%	1.16%	1.03%	0.99%	0.94%	1.09%	1.05%	1.09%		
Nursing and Midw ifery Registered	4.40%	4.21%	4.27%	4.14%	4.14%	4.09%	3.78%	4.30%	4.35%	4.44%		
NGH Trust	4.02%	4.02%	3.98%	3.88%	3.86%	3.87%	3.96%	4.05%	4.13%	4.19%		
Target Rate	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%

	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Hospital Support
Sickness Absence Rate (%)	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	4.69%	5.54%	4.42%	2.97%
No. of completed PDP's returned	Under 50% 50-79% 80% & over	80%	33.58%	31.96%	37.86%	27.27%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	75%	N/A	N/A	N/A	N/A

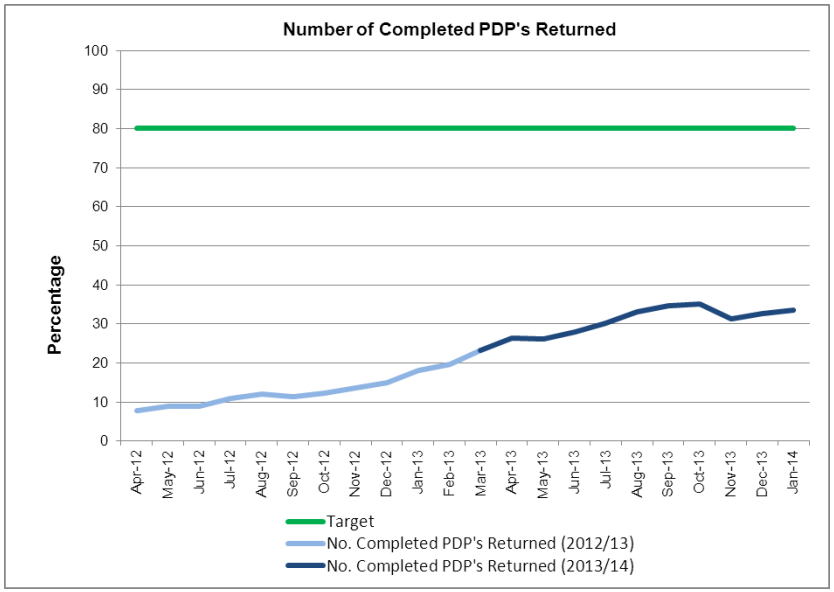
Number of Completed PDPs Returned & Mandatory Training Compliance

- The current number of completed PDP's returned is 33.58%; this is an increase of 0.82%.
- It has not been possible to report on Mandatory Training Compliance for January 2014. This is primarily due to an issue with missing data and McKesson are working with the Trust to resolve the problem.

Human Resources Workforce Performance Indicators Month 10



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		



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		

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 February 2014

Title	Improving Quality and Efficiency Report
Agenda item	13
Sponsoring Director	Janine Brennan – Director of Workforce & Transformation
Author(s)	Mike Hyne – Transformation / PMO
Purpose	To update the board on the final financial savings achieved through the 2013/14 Transformation Programme at month 9.

Executive summary

- The target plan for 2013/14 is £13m, which is 5% of turnover.
- The upside latest thinking forecast (LTF) at M10 is £11.8m (4.5%), against the £13m required delivery, off plan by £1.2m. This is down by £0.1m on M9.
- As would be expected at this stage of the year, there is little variation between the upside, most likely and downside forecasts, with the downside scenario being £11.7m.
- The plan submitted to the TDA required delivery of £10.261m in the first 10 months. Actual delivery is £9.377m, behind plan by £884k.

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

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

FEBRUARY 2014

STRICTLY PRIVATE AND CONFIDENTIAL

Executive Summary

Northampton General Hospital NHS
NHS Trust

2013/14 Month 10 Performance Update

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

The upside latest thinking forecast (LTF) at M10 is £11.8m (4.5%), against the £13m required delivery, off plan by £1.2m. This is down by £0.1m on M9.

As would be expected at this stage of the year, there is little variation between the upside, most likely and downside forecasts, with the downside scenario being £11.7m.

The plan submitted to the TDA required delivery of £10.261m in the first 10 months. Actual delivery is £9.377m, behind plan by £884k.

In Month Performance

The LTF fell by £0.1m in month 10 due to increased Bank & Agency expenditure and the non delivery of the Locum Managed Service.

The increase in bank and agency expenditure was driven by higher ward staffing levels compared to previous months.

Action to Address Performance Slippage

The intention is for the higher staffing levels to continue, so no action will be taken to remedy this increase. However, recruitment is progressing both domestically and overseas to reduce the proportion of temporary staff being used.

A review of the Locum Managed Service contract and business case will take place to understand the disparity between planned financial savings and the current failure to deliver savings.

2014/15 Plan Development

The Trust submitted the first draft financial plan for 2014/15 to the TDA with a CIP target of 4%. The TDA have indicated that the Trust need to show greater ambition and the executive team have agreed to set a target of 5% (c.£13m) for the next submission.

Progress continues on developing the CIP plan for 2014/15.

The Trust now have to submit progress to the TDA on a weekly basis and the latest position is as follows:

Fully Developed Schemes	£2,187k
Plans in Progress	£3,268k
Opportunity Identified	£5,918k
Unidentified	£1,604k

A further detailed refresh of the figures is scheduled for the IQEG meeting on the 18th February 2014.

Risks and Issues

Recruitment to the IQE Team has progressed with Paul Devlin due to take up the Assistant Director of IQE role early in the new financial year. Two further posts have also been recruited to.

There is a risk to the bank and agency savings figures due to now operating at greater staffing levels. This has not been quantified at the date of this report and may be updated verbally.

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.

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M9 LTF £000s	M10 LTF £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	11,932	↓ 11,769	91%	3,277
Total needed to be identified	4,508	35%	1,068	↑ 1,231	9%	-3,277
Total Efficiency	**13,000**	**100%**	**13,000**	**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.6%**	**4.5%**		

Identification of the Transformation Programme 2013/14
The table outlines the current LTF compared to the plan submitted to the TDA in April 2013.
The current LTF of £11.8m if delivered in full would be a 4.5% CIP against our planned requirement of 5%.
The table also demonstrates a £0.163m decrease in LTF between M9 & M10, due bank and agency savings being higher than planned in M10 and the removal of the Locum Managed Service savings from this financial year.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	9,120	70%
Non-recurrent schemes	2,650	20%
Total needed to be identified	1,231	9%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	5,998	46%
Non pay	2,844	22%
Income	2,928	23%
Total needed to be identified	1,231	9%
Total Efficiency	**13,000**	**100%**

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

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

Latest thinking forecast 2013/14

Northampton General Hospital NHS
NHS Trust

Workstream	Exec Lead	Current LTF	Plan	Variance
		2013/14	2013/14	2013/14
		£000s	£000s	£000s
FYE 12/13 schemes	A. Foster	337	337	0
Workforce Transformation	J. Brennan	2,372	1,979	393
Clinical service redesign	D. Needham / R. Brown	25	110	(85)
Non-Clinical service redesign	C. Abolins	101	0	101
Directorate Schemes	A. Foster	8,934	8,868	66
Sub total		**11,769**	**11,295**	**474**
Gap	J. Brennan	1,231	1,705	(474)
Total		**13,000**	**13,000**	**0**

Month 10 – Latest Thinking Forecast

The Transformation Programme is currently projecting a LTF shortfall £1.231m against the required plan of £13m.

Care Group and Corporate CIPs are currently ahead of plan by £66k.

The LTF for the care groups has decreased by £60k over the position reported in M9.

At the end of month 9 a £1.3m year on year reduction in nursing bank and agency expenditure has been achieved. The agency spend increased in month 10, however recruitment is ongoing which should drive agency costs down.

Clinical Service redesign is behind plan by £85k. This is due to the Locum Managed Service savings now being put back into 2014/15.

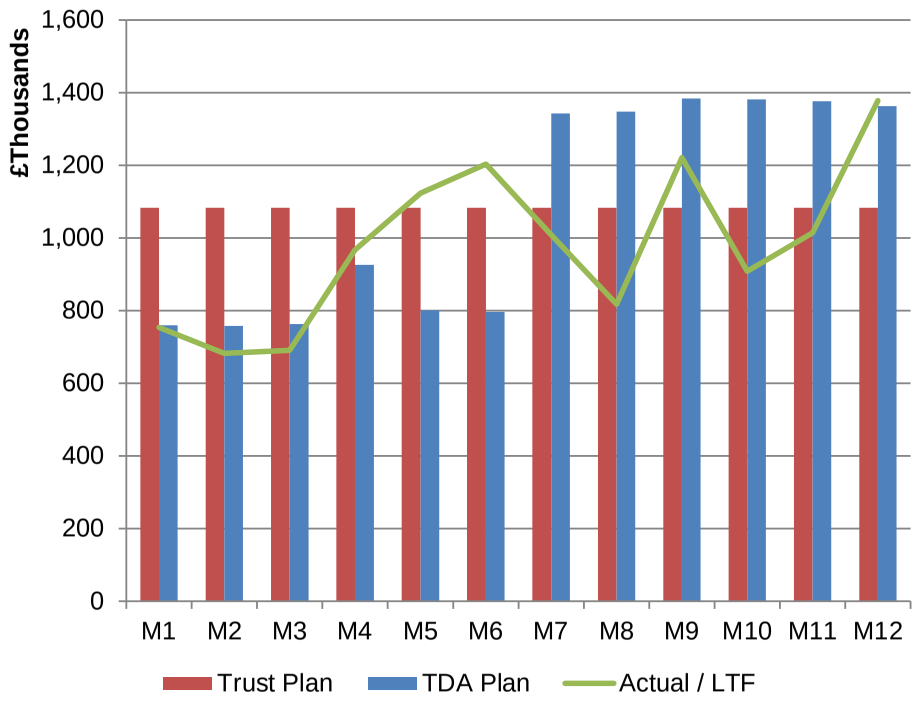
The restriction on overtime continues to exceed the monthly financial requirement. The monthly saving dipped again in month 10. Managers within the Trust have been working with their HR Business Partners to ensure that authorisation compliance is maintained.

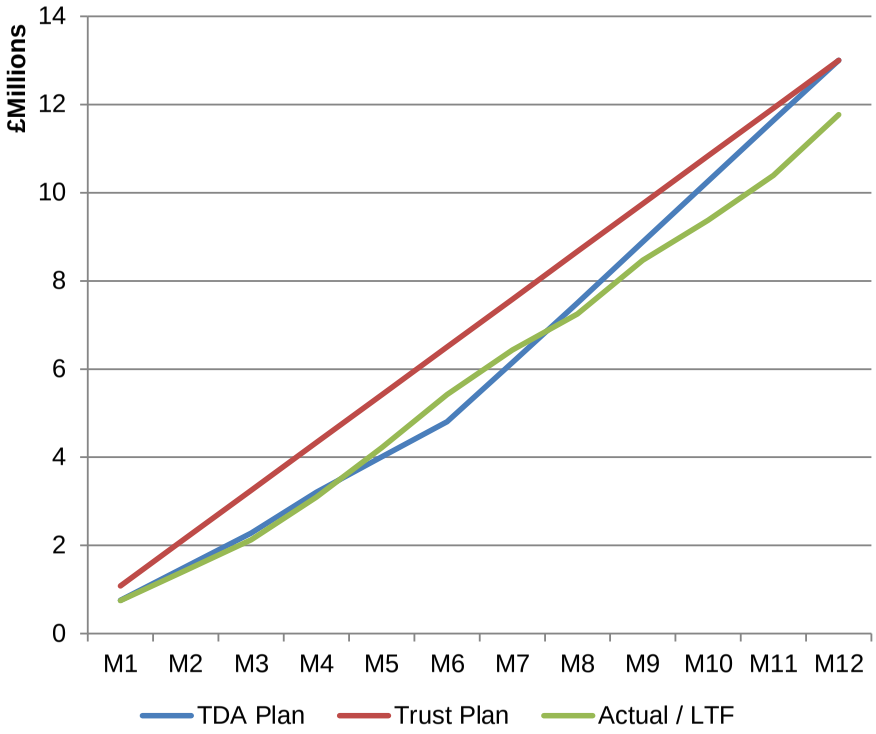
There is a £35k annual leave target set for year end. This is dependent on all staff taking their annual leave entitlement before the end of March. Communications have gone out and annual leave can only be carried forward in exceptional circumstances.

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance | **Off trajectory**





Actual delivery in month 10 was £909k against planned delivery of £1,380k.

The cumulative delivery of schemes is now £884k behind the TDA plan. The plan submitted to the TDA required savings to accelerate from month 7 onwards. The Trust Plan shows delivery spread evenly throughout the year. This highlights that although we are £884k behind the TDA plan after 10 months we are further off meeting the Trust Plan (£1.5m).

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 February 2014

Title	TDA Self-Certification
Agenda item	14
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 January 2014 (attached as Appendix A and Appendix B)

Enclosure K

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 K

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 K

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 K

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:

Enclosure K

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 K

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 K

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 February 2014
09:30 am. Boardroom, NGH

Time			Action	Lead	Enclosure
09.30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Zeidler	**Verbal**
	2.	Declarations of Interest in the Proceedings	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of the 30 January 2014 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 30 January 2014	Note	Mr P Zeidler	**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.	Quality Report	Assurance	Dr M Wilkinson	**D.**
	8.	Patient Experience Report	Assurance	Ms S Loader	**E.**
	9.	Infection Prevention Performance Report	Assurance	Ms S Loader	**F.**
10.30	**OPERATIONAL ASSURANCE**				
	10.	Operational Performance Report	Assurance	Mrs R Brown	**G.**
	11.	Finance Report	Assurance	Mr A Foster	**H.**
	12.	Workforce Report	Assurance	Mrs J Brennan	**I.**
	13.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**J.**
	14.	TDA Self-Certification	Decision	Mr C Pallot	**K.**
11.15	**ANY ITEMS OF OTHER BUSINESS**				
	15.	**DATE AND TIME OF NEXT MEETING** 27 March 2014, Boardroom, NGH	Note	Mr P Zeidler	**Verbal**

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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