Northampton General Hospital
NHS Trust

Agenda and Papers

for the meeting of the

Trust Board Meeting in Public

to be held on

Thursday 27 March 2014, 09.30 am

at

the Boardroom,
NGH

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 March 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 27 February 2014 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 27 February 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.	Urgent Care Report	Assurance	Mrs R Brown	**H.**
	12.	Finance Report	Assurance	Mr S Lazarus	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
	14.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**K.**
	15.	TDA Self-Certification	Decision	Mrs K Spellman	**L.**
11.30	**GOVERNANCE**				
	16.	Information Governance Toolkit Compliance	Assurance	Mrs K Spellman	**M.**
11.40	**ANY ITEMS OF OTHER BUSINESS**				
	17.	**DATE AND TIME OF NEXT MEETING** 24 April 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 27 February 2014 at 9.30 am 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
Mrs E Searle	Non-Executive Director
Dr S Swart	Chief Executive Officer
Dr M Wilkinson	Acting Medical Director

In Attendance:

Mr C Sharples	Head of Corporate Affairs

Apologies:

Mr P Farenden	Chairman

TB 13/14 162 **Declarations of Interest in the Proceedings**
No further interests or additions to the Register of Interests were declared.

TB 13/14 163 **Minutes of the meeting held on 30 January 2014**
The minutes of the meeting of the 30 January 2014 Board meeting were presented for approval.

Subject a number of typographical amendments, the Board resolved to **APPROVE** the minutes of the 30 January 2014 as a true and accurate record of proceedings.

TB 13/14 164 **Action Log and matters arising from the 30 January 2014 Board Meeting**
The action log was considered and the Board.

Ms Loader informed the Board that a comprehensive update on the introduction of care certificates for Healthcare Assistants had been provided to the Integrated Healthcare Governance Committee. It was noted that the care certificate was a national initiative lead by NHS England, which was currently subject to consultation. A pilot was expected to take place later in 2014.

Mr Pallot advised that the action relating to the Infection Prevention Performance Report should be specific to C.Diff data, and MRSA should be removed.

The Board **NOTED** the Action Log and Matters Arising from the 30 January 2014.

TB 13/14 165 **Patient Story**
Dr Swart presented two short letters she had received from patients.

The first letter had been sent from a relative of a patient who had recently passed away. They advised that they felt they had to write to the Trust as they had been unable to attend the public meeting held by the CQC in January. The author of the letter commented whilst on occasion they had had to question standards of cleanliness and infection control, they had to commend the care and compassion of the staff on Allebone Ward, as the level of nursing was much better than previous experiences. The letter also noted that two members of staff from Danetre had attended the funeral of the patient with a floral tribute, which was very much appreciated.

The second letter had been received from the relative of a patient that had passed away. The letter thanked the staff on Dryden ward for their competence and kindness, and praised the staff of the hospital.

The Board **NOTED** the Patient Story.

TB 13/14 166 Chief Executive's Report

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

Dr Swart informed the Board that Northamptonshire had been identified as one of eleven financially challenged health economies in England that would receive expert help and support with strategic planning in order to secure sustainable quality services for local patients. She advised it was anticipated that the support would take the form of high level advice provided in the spirit of a critical friend. The full details of the support were awaited, but Dr Swart had been assured that the support would build on the previous work undertaken in the health economy and would not be duplicative.

Mr Robertson questioned if the expert help would look at the support required by social care colleagues. Dr Swart advised that they would look at the health economy in its entirety, and would be built on existing Healthier Northamptonshire plans. Part of the work would be to develop a health economy wide capacity plan, which would be inclusive of social care and challenge existing modelling assumptions.

Dr Swart reported that she had made represented the Trust at the Public Accounts Committee in response to a National Audit Office report into waiting times for non-emergency operations. She advised that she informed the Public Accounts Committee of the challenges NGH faced in collecting data and the impact that then had on patient experience. In response to the audit, Dr Swart advised that the Trust had undertaken a review of systems and processes that had identified a number of issues that required improvements, and also highlighted the need to monitor data quality metrics more robustly.

Dr Swart informed the Board that the Department of Health have begun consulting on proposed amendments to CQC's registration requirements in order to introduce Fundamental Standards of care. 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 service users should always expect. The Trust will be reviewing the consultation document and responding accordingly prior to the 4 April 2014 deadline.

The Board was informed that the Trust was re-launching smoke-free NGH to coincide with national no smoking day on 12th March 2014.

Dr Swart reported that the Trust was undertaking its first external stakeholder

engagement survey, the results of which will be reported to the Board in April. The information would 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.

The Board was informed that the second round of QuEST reviews had begun. Early indications were that many wards have improved since our first QuEST reviews in December. It was pleasing that a high number of non-clinical staff were involved in the reviews as this provided 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.

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

TB 13/14 167 **Quality Report**

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

Dr Wilkinson informed the Board that overall mortality as measured by HSMR remained low, and the SHMI continued to decrease as anticipated, a trend that was expected to continue. Dr Wilkinson reported that overall crude mortality remained low, which was key to note in light of recent media coverage disputing the use of mortality ratios. Dr Swart informed the Board that there had been significant national debate recently regarding the validity of the HSMR and SHMI mortality indicators, and that trusts has been advised to look at avoidable deaths. She assured the Board that the review of avoidable deaths was standard practice at NGH.

With regard to serious incidents, Dr Wilkinson reported that during the reporting period, there had been twelve new serious incidents reported, nine of which related to pressure ulcers. He advised that a detailed review of serious incidents relating to pressure ulcers had been undertaken by the Integrated Healthcare Governance Committee in February. Mr Kershaw advised that the following the review, the Integrated healthcare Governance Committee was assured that action was being taken to reduce the incidences of pressure ulcers, but it would be a number of months before those actions delivered improvements.

Dr Wilkinson reported that a new serious incident policy had been implemented to improve the recording of incidents and the dissemination of learning from incident investigations. The effectiveness of the policy would be monitored by the Integrated Healthcare Governance Committee.

Mrs Searle asked if Datix forms were now actioned in a timely manner following recent concerns regarding the processing of incidents. Dr Wilkinson advised that the backlog of forms had been cleared, and noted between 800-1000 incidents a month were now being recorded and reviewed in a timely manner on Datix. Dr Swart added that the reporting rate for incidents had improve significantly, a sign she felt was indicative of a better reporting culture within the Trust.
Dr Wilkinson presented the quality exception scorecard and welcomed questions from colleagues.

Mrs Brennan noted that complaints responded to within agreed timeframes remained consistently under target and questioned if the reasons for the underperformance were understood. Dr Wilkinson advised that for some time,

complaints team had been understaffed which was affected the ability to respond within the agreed timeframes. The department was now fully staffed and improvements were expected. Ms Loader added that the team was looking at improving the entire PALs and complaints process to take a more proactive approach to patient and public concerns in an attempt to resolve issues before they become formal complaints.

Mr Zeidler noted that the corporate scorecard did not include a time to first assessment metric, a metric he felt was indicative of quality and safety. Mrs Needham advised that the metric was recorded within the urgent care dashboard safety scorecard, and agreed to present the scorecard in its entirety to the next Integrated Healthcare Governance Committee. Mrs Brown added that the time to first assessment was an indicator that was monitored constantly within the A&E department and used as a key early warning metric for the Trust escalation framework.

ACTION: Mrs Needham

The Board **NOTED** the Quality Report.

TB 13/14 168 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 response rates within A&E had recently reduced, although they remained above the national average. Mr Zeidler commented that it was important to note that the Friends and Family Test was completed after the patient had visited A&E.

With regard to the national Friends and Family Test CQUIN for 201415, Ms Loader advised that the requirements would prove challenging to meet for the Trust based on the existing systems and processes in place. As such, electronic solutions were being explored to assist in the collection and analysis of data.

Ms Loader reported that the trust continued to triangulate and identify themes from the Friends and Family Test and other sources of patient experience data and were recorded in a dashboard. The dashboard identified three common themes: communication, discharge and medication relating to pain relief. Actions were in place to address each of the identified areas, and were being actively monitored by matrons.

It was noted that the dashboard was continuing to evolve as a tool, and the methodology used to populate it was under review to ensure that the data used was sufficiently robust to analyse in a systematic manner.

Mrs Brown questioned when the dashboard could be used by operational managers to strengthen accountability and drive improvement. Ms Loader advised that a group had been established and was meeting shortly to examine the indicators used in the dashboard to ensure they were appropriate. This work needed to be concluded before they could be used in a performance management context. Ms Searle commented that the group needed to consider the weighting between patient experience and patient safety indicators.

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

TB 13/14 169 Infection Prevention Performance Report

Ms Loader presented the Infection Prevention Performance Report.

It was reported that since the report had been printed, an post 72 hour MRSA incident had been identified, for which a root cause analysis was underway. Ms Loader noted that it was the first post 72 hour MRSA incident reported since September 2012.

Ms Loader informed the Board that there had been 24 incidences of C.Diff recorded for the year to date, which meant the Trust was under trajectory for a second continuous month.

Ms Loader reported that root cause analysis had been undertaken for four incidents of surgical site infection for patients with fractured neck of femur. The results of the investigations found that all four wound infections were cause by skin micro-organisms. The Board was informed that there was a comprehensive action plan developed by the trauma and orthopaedics team in conjunction with the infection prevention team.

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

TB 13/14 170 Operational Performance Report

Mrs Brown presented the Operational Performance Report to the Board.

It was reported that performance with the four hour transit time target for December had not been met in January, with performance recorded at 85.49%. This was predominantly due to high demand and delayed discharges. It was noted that the Trust was continuing to seek support from health economy partners to reduce demand and the Trust was working closely with NCC, the CCG and NHFT to reduce delayed discharges and implement the discharge to assess scheme, although there did not appear to be any improvement to date.

Mr Robertson observed that the Trust was a significant outlier for attendances. Mrs Needham confirmed the Trust was bucking the national trend when considering attendances, and advised she was working with the CCG to understand what that was the case.

Mrs Brennan commented that the Board must also consider the impact the pressures on urgent care were having on staff. She advised that an organisational development work stream had been developed that took staff out of the pressurised environment to enable them to reflect on how A&E could be improved and how staff could be further supported to implement the changes.

Mr Zeidler commented that it was clear there was an increasing problem with urgent care and the number of attendances, and the Trust needed to ensure there was understanding and ownership of the problem both internally and with external stakeholder. Mrs Needham advised that the analysis underway with the CCG would provide the basis for those discussions and once complete, the results would be presented to the Urgent Care Board.

The Board requested that the outcome of the analysis be presented to the next meeting of the Board. Dr Swart requested that the number of discharges by category, in particular discharges to social care be explored.

ACTION: Mrs Needham

Mrs Brown reported that the 18 week admitted speciality standard for T & O and ENT had not been met in January. Actions plans were in place to mitigate and will be on target again within two months. She added that the

RTT targets were being achieved.

Mrs Brown informed the Board that that the Trust achieved 62 days from urgent GP referral in December for cancer, but not in January. The Cancer Recovery Board continued to monitor performance, but during the Christmas period, targets had proven very difficult due to patient choice and complex pathways, and as such a backlog has accrued. The breast care pathway was of concern due to the unavailability of one consultant at short notice. A locum has been employed to cover sessions and improvements in performance were being noted.

Mr Pallot advised members that the Trust was a relatively small cancer centre, and small fluctuations in numbers significantly affected compliance with targets. He updated the Board on the progress being made in developing partnerships with University Hospitals Leicester advising that a advert had been circulated for a joint clinical director to develop a proposal for developing the strategic approach to partnership working between the trusts.

Mr Noble observed that the Trust had narrowly achieved the quarter three cancer targets, and the quarter four performance was already at risk. He what impact the implementation of the cancer programme board was having in mitigating the risk. Mr Pallot advised that the cancer board met monthly to review the implementation of the cancer action plan. He noted that not all actions had been implemented around complex inter-trust pathways which were felt to be causing the bulk of the problem, although work was ongoing with partner trusts and the CCG to resolve the issue. It was agreed that the Integrated Healthcare Governance Committee would undertake a deep dive of the actions implemented to date.

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

TB 13/14 171 **Finance Report**

Mr Foster presented the Finance Report to the Board.

It was reported that the year to date income and expenditure position was a deficit of £1.7m for the period ended January, which included the planned support agreed by the TDA. No other provisions or recovery actions were included in the position, although it was noted that the income position was reflective of the agreements reached with NENE CCG and Specialised Commissioners.

Mr Foster advised that January had been a difficult month and the forecast for non-pay was exceeded by £0.4m. The Board was informed that the three areas of greatest concern were medicines, outsourcing and estates costs. Mr Foster advised that medicines spend can be volatile and under a fixed income settlement we take no benefit of over performing in areas such as ARMD where drug costs are significant, creating pressure on budgets.

With regard to outsourcing, Mr Foster advised that cost of activity outsourced to the private sector continued to increase in order to stay on top of the elective 18 week target in T&O and Ophthalmology. There was little indication that costs would reduce in that area over the next month as the position in terms of the 18 week target was very tight.

It was noted that the Trust needed to maintain focus on delivering the remaining statutory duties, mainly around capital and cash where historically there has been significant activity at the year end. With regard to the Capital Resource Limit, the Trust expected to be fully committed at year end. Mr

Foster added that it was important that the Trust did not exceed the External Finance Limit and had agreed to consult with the TDA each month on the total.

Mr Foster advised that the financial position was very tight as January was a busy month. He advised that February appeared to be the same and whilst issues with income had been resolved, their remained the need to ensure clear focus on controlling expenditure if breakeven was to be delivered. Further work was ongoing to review further provisions, continue prudent housekeeping and expenditure controls.

Mr Foster advised that the Trust had submitted an outline plan financial plan for 2014/15 to the TDA, which forecast a deficit of circa £14m, a figure that Mr Foster felt would be difficult to reduce. Mr Zeidler noted that the trust was required to submit a further iteration of the 2014/15 financial plan to the TDA by the 5 March, and there had been a clear challenge from the TDA that the planned deficit must be reduced.

Mr Foster advised that the planned deficit could be reduced, but the exposure to risk would increase and would need to be carefully considered. He added that the plan must remain realistic whilst the Trust remained committed to continuing its investment in quality. Dr Swart stated that there was a clear tension between finance and the increasing demands to increase quality. The decision for the Board must be it's what risk is deemed acceptable when it approves the final plan. Mr Foster advised the Board that the final submission date was the 4 April, so the Board would be able to consider the outcome of the CQC inspection in drawing those conclusions.

The Board **NOTED** the Finance Report.

TB 13/14 172 **Workforce Report**

Mrs Brennan presented the Workforce Report to the Board.

Mrs Brennan reported that 56.7% of Trust staff had received the influenza vaccine, which was above the national average of 53.1% and an improvement on 2012/13 uptake. Mr Zeidler commented that the allocation of winter funding recurrently was contingent on the Trust achieving 75% compliance, and asked if the implications of non-achievement had been made clear. Mrs Brennan advised that the trust had not been made aware of the implications to date, adding that only four of the 28 trusts that received winter pressures funding had achieved the target.

The Board was informed that the Trust's e-rostering system had been upgraded to improve efficiency and be made more user friendly. Alongside the system upgrade, a decision had been made to centralise rostas to reduce variation and make the system clearer and easier for staff to understand.

Mrs Brennan reported that following a recruitment campaign in Spain, the Trust had recently recruited 42 nurses who would commence employment in April and May. The second phase of the campaign was due to commence shortly and it was expected that up to 56-60 more nurses could be recruited. In addition to Spanish recruitment campaign, the Trust attended recruitment fairs in Milton Keynes and at local universities which led to 49 further nurses being recruited. In light of the recruitment activity, Mrs Brennan reported that the Trust was now established to 95% for registered staff and recruitment was continuing. It was agreed that a systematic review of international recruits, looking at measures such as quality, turnover and staff satisfaction would be beneficial on a periodic basis.

Mrs Searle questioned why mandatory training compliance was not included within the report. Mrs Brennan advised that there had been a national problem in obtaining accurate data regarding training compliance from the system, and as yet, she had not received any assurances from the system provider as to when to problem would be resolved. She added that the learning and development team had begun to manually analyse training data based on local records, and initial findings indicated that training compliance had been under reported for some time.

The Board **NOTED** the Workforce Report.

TB 13/14 173 Improving Quality and Efficiency Report

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

In relation to the 2013/14 programme, the Board was advised that the latest thinking forecast at month 10 was £11.8m against the £13m required delivery, off plan by £1.2m. The position was down by £0.1m on month nine due to high bank and agency usage.

Mrs Brennan reported that the Trust was planning an efficiency target of £13m for 2014/15, approximately 5% of turnover. This target had been increased from 4% following a challenge made by the TDA. This would leave the trust with a likely deficit plan of £14m.

Mrs Brennan advised that the value of schemes identified to date for 2014/15 stood at £9m, a significant improvement from the £3.3m reported at the January Finance Committee meeting. It was noted that whilst significant progress had been made there remains a shortfall. It was anticipated that the shortfall would be addressed through two key work streams namely; the approach to developing clinical service strategies for each area and the continued roll out of Service Line Reporting that should identify further opportunities for cost and efficiency improvements and/or service redesign/reconfiguration.

Additionally, it was recognised that there was a need to continue to drive further value from the schemes identified and to develop further initiatives to bridge the gap. To facilitate this, the IQE Team recently ran an ideas generation workshop where with staff with over 100 ideas were generated and were being prioritised after which those with the greatest potential would be added to the programme.

Mr Robertson asked if the 2014/15 plan would include the cessation of services if required. Mrs Brennan advised that the programme for 2014/15 would not go to that level and that the clinical sustainability review would be more likely to identify those areas.

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

TB 13/14 174 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.

Mr Pallot advised that Board statement ten required amending to include the addition of T&O and ENT compliance with 18 weeks.

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

TB 13/14 175 **Any Other Business**
No items of any other business were raised.

TB 13/14 176 Mr Zeidler called the meeting to a close at 11.15.

Date of next meeting: 9.30am, Thursday 27 March 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 21/03/2014

Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of completion
28/11/2013	TB 13/14 130	Infection Prevention Performance Report	Provide benchmarking data for C.Diff ceiling comparing the Trust to peers.	Mr C Pallot	31/03/2014	Completed or on Agenda	Appended to the matter arising/action log.
	TB 13/14 154	Workforce Report	Mrs Brennan to present a workforce plan to the Integrated Healthcare Governance Committee which articulated what was required to deliver a safe and effective workforce target that could be met	Mrs J Brennan	31/03/2014	Slippage	Added to the IHGC Agenda and Action Log. The work remains ongoing. High level articulation presented in Annual Plan 2014-16.
		Quality Report	Mrs Needham to ensure the key urgent care metrics related to safety are included in the corporate scorecard to the Board	Mrs D Needham	31/03/2014	Completed or on Agenda	The urgent care quality metrics were reported to the IHGC.
		Operational Performance Report	The Board requested that the IHGC undertake a deep dive into the cancer recovery action plan and report findings back to Board.	Mrs R Brown	31/03/2014	Completed or on Agenda	Presented to the March meeting of the IHGC
		Operational Performance Report	Mrs Needham to report back to the Board the findings of the joint CCG and Trust analysis into the increase in attendances and admissions	Mrs D Needham	31/03/2014	Slippage	The work with the CCG remains ongoing - outcomes to be reported to the April Trust Board.

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

REPORT TO THE TRUST BOARD

Clostridium Difficile (C-Diff) Update

1. Purpose of Paper

The purpose of this paper is to inform the Board of the Trust's performance relating to C-Difficile contrasted against its peers.

2. Background

Clostridium difficile (C-Difficile) is an anaerobic bacterium and is present in the gut of up to 3% of healthy adults and 66% of infants. However, it rarely causes problems in children or healthy adults, as it is kept in check by the normal bacterial population of the intestine.

C-Difficile infections range from mild to severe diarrhoea to, more unusually, severe inflammation of the bowel (known as pseudomembranous colitis). People with serious underlying illnesses and the elderly are at greatest risk – over 80% of infections reported are in people aged over 65 years.

C-Difficile infection is commonly spread on the hands of healthcare staff and other people who have had contact with infected patients or with environmental surfaces (e.g. floors, bedpans, and toilets) contaminated with the bacteria or its spores. Spores are produced when the bacteria encounter unfavourable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

3. Current Situation

Historically, NGH, as with all trusts across the England, were reporting high incidences of C-Difficile infection rates with NGH reporting 183 in the financial year 2007-8; this represented an incident per 100,000 beds of 95.8. This can be contrasted with the England rate per 100,000 beds of 89.7 with a range between 17 and 224 and an average 85.5.

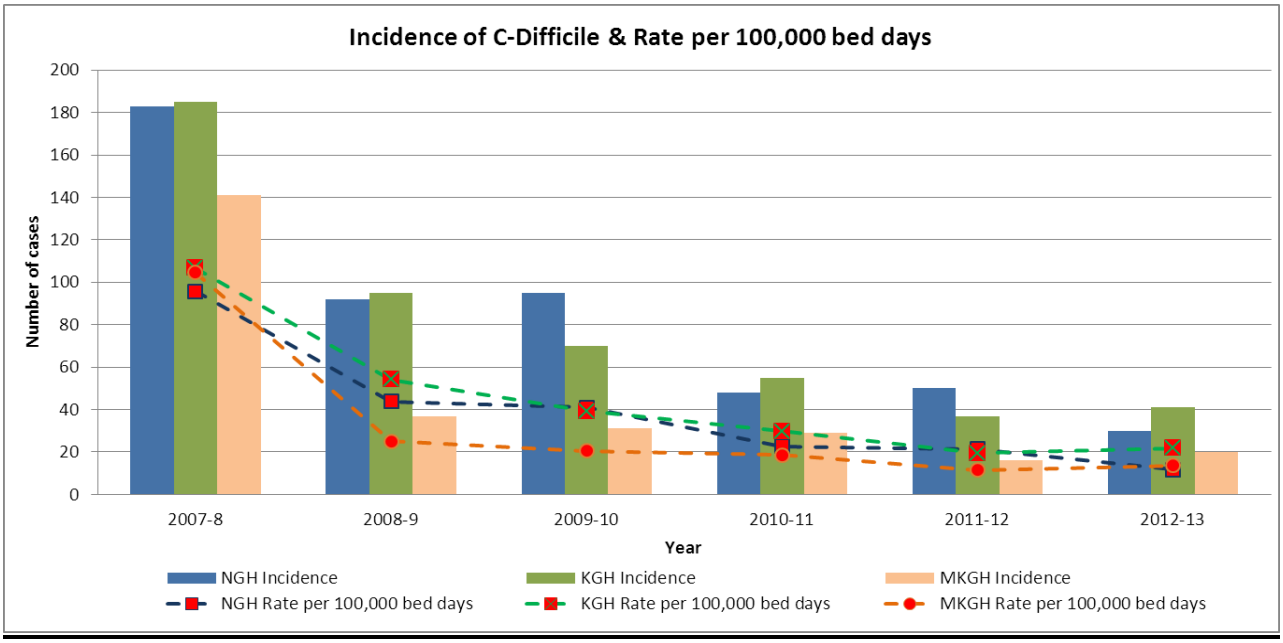


Figure 1

Enclosure B

NGH was set a ceiling target of 36 C-Difficile infections in 2012-13 by its commissioners; this was achieved with the trust only recording 30 infections.

The ceiling target set for 2013-14 by the commissioners is 29; to date (31 January 2014) the trust has recorded 24 infections with one recorded in the past two months.

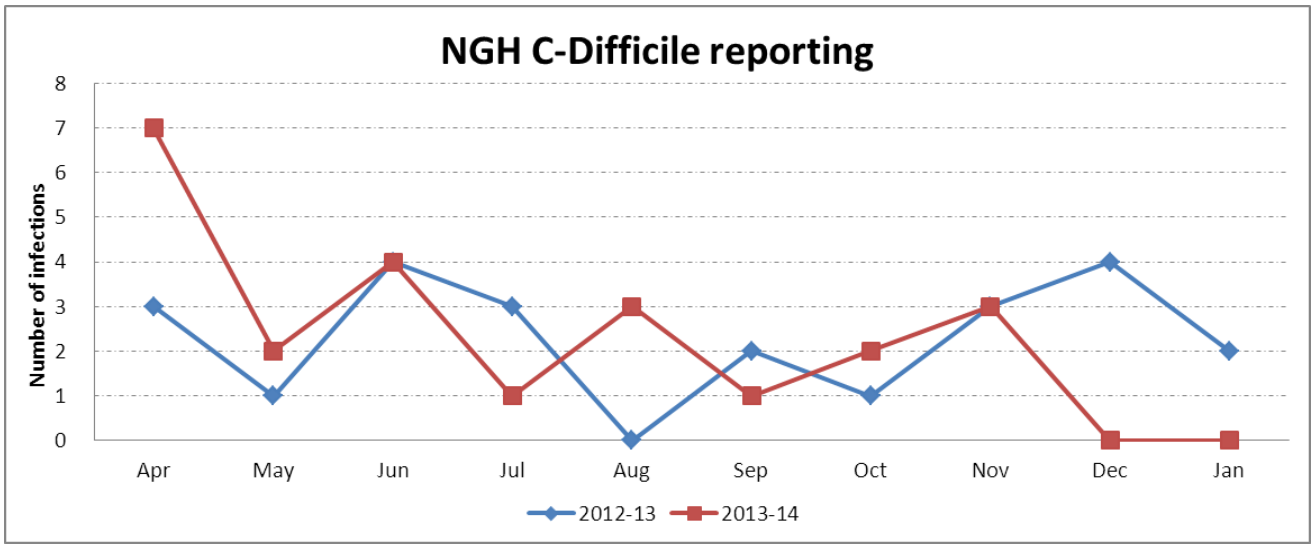


Figure 2

4. Benchmarking

4.1 Methodology

To enable the benchmarking of the trust's performance in managing C-Difficile infections, data on other trusts were taken from two sources; NHS acute trust catchment populations as generated from HES data and manipulated by Eastern Region Public Health Observatory (ERPHO) to provide catchment populations by age groups and the mandatory Clostridium difficile enhanced surveillance scheme as collected by Public Health England (PHE).

The population sizes were based on data generated from HES collected during the period 2007-8 and 2008-9. Although relatively old population data, it should still be representative of today's population when calculating a per 10,000 population incidence rate with the added benefit of benchmarking across the country.

The mandatory reporting of C-Difficile excludes patients under the age of 2 years of age; the available population data is presented at 5 year age groups. It has therefore been necessary to remove all patients in the 0-4 years age group which would also ensure any areas with a large 0-2 year old population was more accurately represented.

The period reviewed is January 2013 to 31 December 2013.

4.2 Results

A review of the 12 months of January 2013 to 31 December 2013 showed the average rate per 10,000 population of C-Difficile across 105 NHS trusts in England was 1.09 for the period 1 January 2013 to 31 December 2013 with a range of 0.07 to 3.7 with an upper quartile is 0.78.

NGH had a rate of 0.98 per 10,000 population for this period same period.

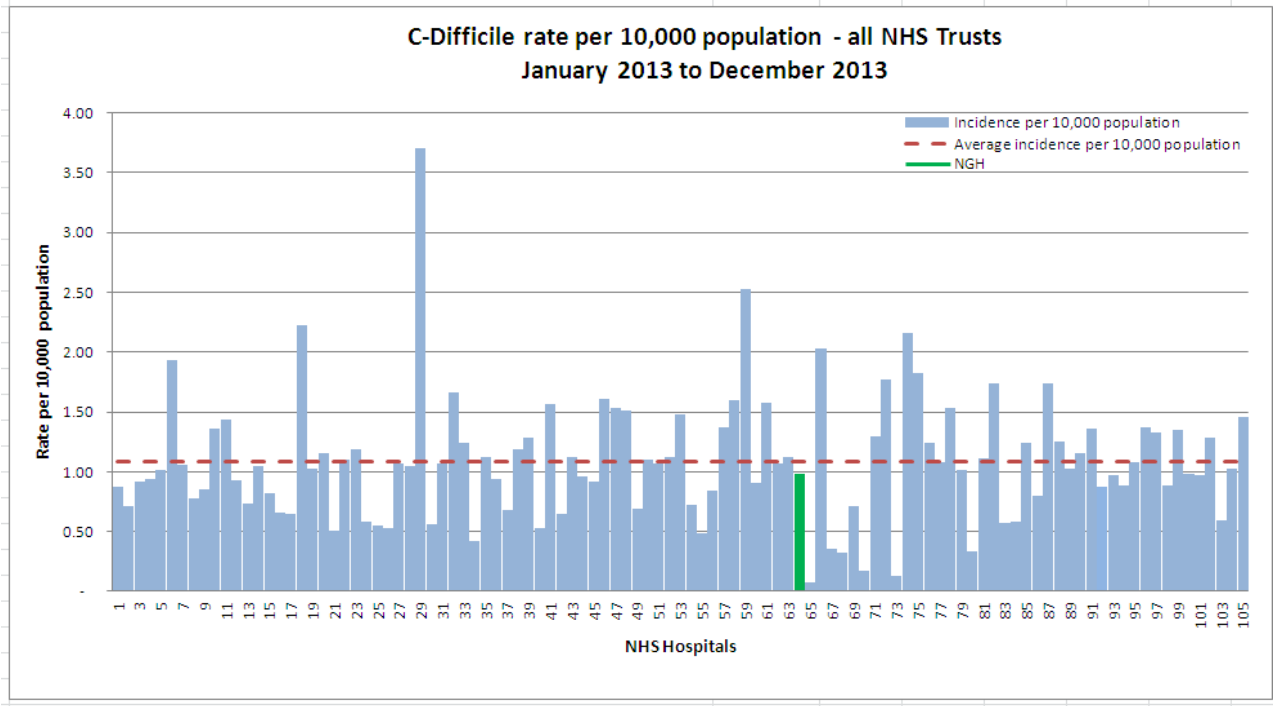


Figure 3

C-Difficile targets are set each contractual year; a review of this financial year, April 2013 to December 2013, shows a rate of only 0.71 per 10,000 population for NHG against an average of 0.79 and an upper quartile of 0.56.

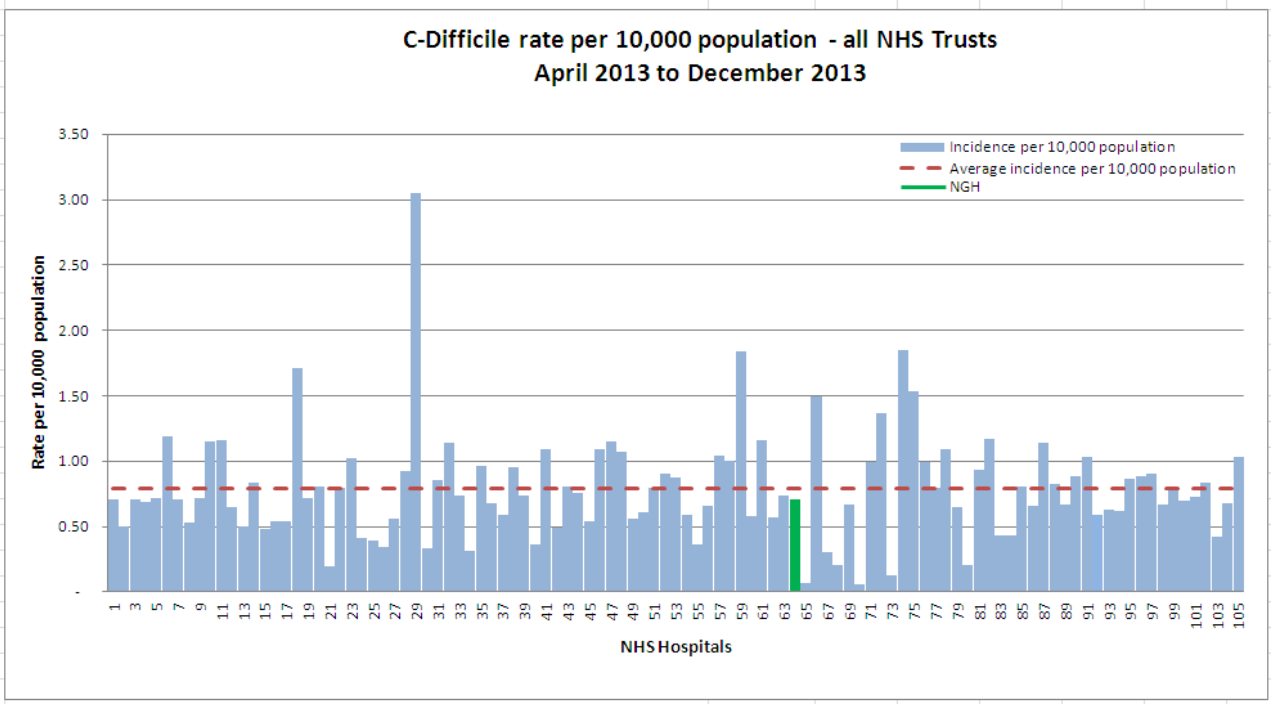


Figure 4

NGH is not an outlier on their incidence of C-Difficile, sitting below the England average; to achieve the upper quartile rate of 0.56 identified above for April 2013 to December 2013 the trust would need to have reported 5 fewer than the 24 reported incidences.

Choosing hospitals with a catchment population within 10,000 to that of NGH identifies 5 trusts:

- COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST
- FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST

- IPSWICH HOSPITAL NHS TRUST
- UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
- CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

The average rate per 10,000 population in this group is 0.57, with an upper quartile of 0.36

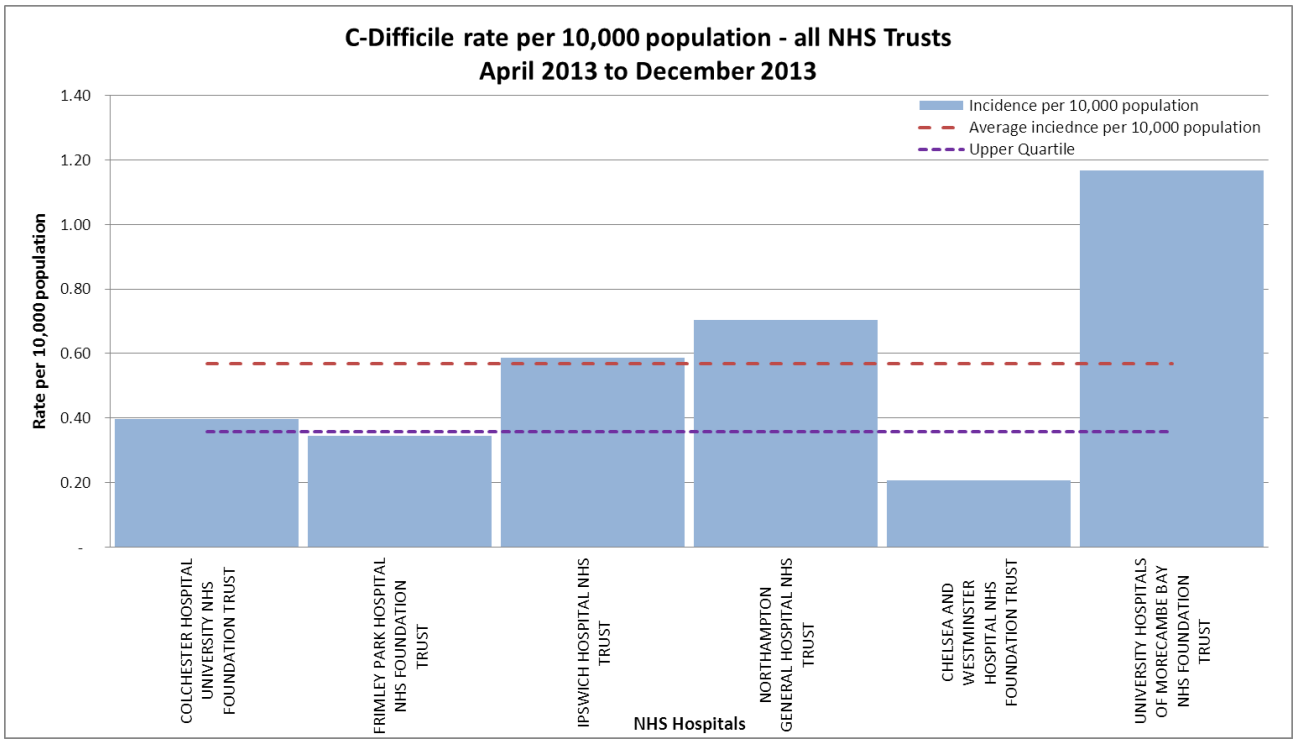


Figure 5

NGH is the second highest in this group, but it would be fair to state that each of the hospitals identified were starting at different points; Frimley Park Hospital for example had a ceiling set of 8 and year to date they have breached this target ceiling.

NGH would need to have reported 12 fewer incidents of C-Difficile to have achieved the peer group upper quartile.

Peer Group C-Difficile Target Ceilings

Hospital	Target	YTD reported	YTD v Target
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	18	13	5
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	8	11	-3
IPSWICH HOSPITAL NHS TRUST	21	19	2
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	29	23	6
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	13	7	6
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	36	37	-1

Table 1

As shown, NGH has room for further improvement but large gains are noted since 2007 with year on year improvements being made with the last year's target being achieved and on-track to achieving the 2013-14 target.

Chris Pallot
Director of Strategy

21 February 2014

Annex E - CDI Objectives for normal, teaching and specialist acute trusts and CCGs for 2014/15

Principles and methodology

Three cohorts of acute trusts have been recognised for the purposes of calculating median CDI rates based on expert advice – acute teaching hospitals, specialist hospitals and non-teaching (ie small, medium, large and mixed service) acute hospitals as defined by the Hospital Estates and Facilities ERIC return. CCGs form their own separate cohort.

For one of these cohorts, specialist trusts, due to the heterogeneity of these organisations meaning a single median for this group is arbitrary, CDI objectives have been set by requiring all specialist trusts to reduce their current CDI case total for the 12 months to November 2013 by one case. This reflects the principle of continuous improvement. The calculations below are therefore not relevant to specialist trusts.

For the two non-specialist trust cohorts (teaching and non-teaching acute trusts) and CCGs, the median CDI rate for the most recent available 12 months (to November 2013) is calculated for each cohort separately. The median CDI rate is also calculated for each cohort for their previous 12 month median CDI rate. For each cohort, the rate of CDI rate improvement from the preceding 12 months (to November 2012) to the most recent 12 months (to November 2013) are then calculated to give a cohort rate of CDI improvement. These values are set out in the table below;

Cohort	Current CDI rate (for year to November 2013)	Previous CDI rate (for year to November 2012)	Reduction in CDI rate from previous year to current year
Non-teaching acute trusts	**14.73** CDI cases per 100,000 bed days	**16.74** CDI cases per 100,000 bed days	**12.01%**
Teaching acute trusts	**16.89** CDI cases per 100,000 bed days	**19.53** CDI cases per 100,000 bed days	**13.47%**
CCGs	**25.78** CDI cases per 100,000 population	**28.02** CDI cases per 100,000 population	**8.00%**

All organisations with a current CDI rate for the year to November 2013 below (better than) their cohort median for the same period, have a CDI objective for 2014/15 set as their current number of CDI cases reported during the year to November 2013 minus one. This maintains the principle of the NHS delivering continuous improvement in patient safety but reflects that those performing better than average may be approaching the irreducible minimum of cases.

All organisations with a current CDI rate for the year to November 2013 above (worse than) their cohort median for the same period have a CDI objective set as their CDI rate for the year to November 2013 minus the percentage reduction in median CDI rate seen for their cohort between the preceding year and the current year. This means their objective reflects the rate of improvement seen for their cohort of trusts over the previous year. This reflects the need for those organisations with CDI rates worse than average to improve at a faster rate than those that are better than average, but that this rate of improvement should reflect the most recent available information about what is achievable.

Where this methodology requires an organisation to improve from above their cohort median to below it, their objective becomes their cohort median unless the reduction required to move below the median is less than one CDI case. If so, the organisation has an objective of their current number of cases

reported during the year to November 2013 minus one case. This avoids requiring organisations performing worse than average to leapfrog those performing better than average.

The tables below set out the objectives for all organisation cohorts:

Normal Acute Trusts			
Org code	Name	CDI case objective for 2014/15	CDI rate objective for 2014/15
REM	Aintree University Hospitals	81	33.0
RCF	Airedale	9	7.5
RTK	Ashford & St Peter's Hospitals	9	5.1
RF4	Barking, Havering & Redbridge Hospitals	37	10.2
RVL	Barnet & Chase Farm Hospitals	20	8.2
RFF	Barnsley Hospital	20	12.7
R1H	Barts Health	71	11.2
RDD	Basildon & Thurrock University Hospitals	18	8.3
RC1	Bedford Hospital	18	14.3
RXL	Blackpool, Fylde & Wyre Hospitals	28	10.4
RXQ	Buckinghamshire Hospitals	33	13.2
RJF	Burton Hospitals	15	10.0
RWY	Calderdale & Huddersfield	18	7.5
RFS	Chesterfield Royal Hospital	40	21.5
RLN	City Hospitals Sunderland	51	20.6
RDE	Colchester Hospital University	20	10.3
RJR	Countess of Chester Hospital	30	15.5
RXP	County Durham & Darlington	37	11.4
RJ6	Croydon Health Services	17	9.9
RN7	Dartford & Gravesham	17	9.5
RTG	Derby Hospitals	69	22.6
RP5	Doncaster & Bassetlaw Hospitals	45	15.1
RBD	Dorset County Hospital	22	21.7
RC3	Ealing Hospital	8	5.0
RWH	East & North Hertfordshire	15	6.6
RJN	East Cheshire	14	11.2
RVV	East Kent Hospitals University	47	14.7
RXR	East Lancashire Hospitals	23	7.7
RXC	East Sussex Healthcare	44	17.4
RVR	Epsom & St Helier University Hospitals	40	16.6
RDU	Frimley Park Hospital	18	9.6
RR7	Gateshead Health	24	14.5
RLT	George Eliot Hospital	7	6.7
RTE	Gloucestershire Hospitals	55	16.9
RN3	Great Western Hospitals	28	14.0
RN5	Hampshire Hospitals	37	14.6
RCD	Harrogate & District	15	14.9

RR1	Heart of England	78	15.0
RD7	Heatherwood & Wexham Park Hospitals	34	18.0
RLQ	Hereford Hospitals	12	14.3
RAS	Hillingdon Hospital	16	12.5
RQQ	Hinchingbrooke Healthcare	7	8.6
RQX	Homerton University Hospital	2	1.6
RGQ	Ipswich Hospital	23	12.7
R1F	Isle of Wight Healthcare	6	6.1
RGP	James Paget University Hospitals	17	13.1
RNQ	Kettering General Hospital	28	14.9
RAX	Kingston Hospital	24	16.5
RC9	Luton & Dunstable Hospital	19	9.5
RWF	Maidstone & Tunbridge Wells	40	16.6
RPA	Medway	14	7.7
RBT	Mid Cheshire Hospitals	23	11.8
RQ8	Mid Essex Hospital Services	13	7.4
RJD	Mid Staffordshire	24	21.2
RXF	Mid Yorkshire Hospitals	42	12.7
RD8	Milton Keynes Hospital	19	13.0
RVJ	North Bristol	79	23.2
RNL	North Cumbria University Hospitals	37	20.2
RAP	North Middlesex University Hospital	17	14.5
RVW	North Tees & Hartlepool	40	20.2
RV8	North West London Hospitals	18	7.3
RNS	Northampton General Hospital	35	14.0
RBZ	Northern Devon Healthcare	16	14.2
RJL	Northern Lincolnshire & Goole Hospitals	33	14.9
RTF	Northumbria Healthcare	30	8.8
RW6	Pennine Acute Hospitals	62	14.1
RGN	Peterborough & Stamford Hospitals	31	15.8
RK9	Plymouth Hospitals	30	11.0
RD3	Poole Hospital	13	7.8
RHU	Portsmouth Hospitals	31	9.7
RQW	Princess Alexandra Hospital	16	10.8
RHW	Royal Berkshire	40	18.6
RMC	Royal Bolton Hospital	48	23.0
REF	Royal Cornwall Hospitals	35	16.4
RH8	Royal Devon & Exeter	30	12.8
RA2	Royal Surrey County Hospital	23	14.8
RD1	Royal United Hospital Bath	37	17.5
RL4	Royal Wolverhampton Hospitals	36	13.9
RNZ	Salisbury	18	12.6
RXK	Sandwell & West Birmingham Hospitals	37	14.8
RK5	Sherwood Forest Hospitals	37	14.7

RXW	Shrewsbury & Telford Hospital	38	14.6
RA9	South Devon Healthcare	11	8.8
RTR	South Tees Hospitals	49	14.4
RE9	South Tyneside	10	7.9
RJC	South Warwickshire	24	12.6
RAJ	Southend University Hospital	26	14.5
RVY	Southport & Ormskirk Hospital	27	18.3
RBN	St Helens & Knowsley Hospitals	19	8.2
RWJ	Stockport	39	17.8
RTP	Surrey & Sussex Healthcare	29	14.9
RMP	Tameside Hospital	41	25.3
RBA	Taunton & Somerset	11	6.0
RNA	The Dudley Group of Hospitals	48	20.5
RJ2	The Lewisham Hospital	39	13.1
RCX	The Queen Elizabeth Hospital King's Lynn	14	9.2
RFR	The Rotherham	24	14.2
RDZ	The Royal Bournemouth & Christchurch Hospitals	25	12.2
RKE	The Whittington Hospital	19	19.6
RWD	United Lincolnshire Hospitals	62	16.0
RJE	University Hospital of North Staffordshire	50	14.6
RKB	University Hospitals Coventry & Warwickshire	54	14.3
RTX	University Hospitals of Morecambe Bay	46	19.6
RBK	Walsall Hospitals	28	18.5
RWW	Warrington & Halton Hospitals	26	12.9
RWG	West Hertfordshire Hospitals	31	14.7
RFW	West Middlesex University Hospital	19	15.3
RGR	West Suffolk Hospitals	25	19.4
RYR	Western Sussex Hospitals	56	18.4
RA3	Weston Area Health	17	21.8
RWP	Worcestershire Acute Hospitals	41	14.8
RRF	Wrightington, Wigan & Leigh	32	21.4
RA4	Yeovil District Hospital	10	10.5
RCB	York Hospitals	59	16.6

Teaching Acute Trusts			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
RAE	Bradford Teaching Hospitals	35	17.1
RXH	Brighton & Sussex University Hospitals	50	18.6
RGT	Cambridge University Hospitals	61	19.6
RW3	Central Manchester University Hospitals	66	16.8
RQM	Chelsea & Westminster Hospital	8	6.4
RJ1	Guy's & St. Thomas'	37	11.8
RWA	Hull & East Yorkshire Hospitals	57	15.7

RYJ	Imperial College Healthcare	65	16.8
RJZ	King's College Hospital	58	12.8
RXN	Lancashire Teaching Hospitals	51	17.0
RR8	Leeds Teaching Hospitals	127	21.5
RM1	Norfolk & Norwich University Hospitals	50	15.8
RX1	Nottingham University Hospitals	98	19.4
RTH	Oxford University Hospitals	67	16.9
RAL	Royal Free Hampstead	38	23.2
RQ6	Royal Liverpool & Broadgreen University Hospitals	48	18.7
RM3	Salford Royal	21	9.7
RHQ	Sheffield Teaching Hospitals	94	16.1
RHM	Southampton University Hospitals	29	8.2
RJ7	St. George's Healthcare	40	14.1
RTD	The Newcastle upon Tyne Hospitals	80	16.7
RRV	University College London Hospitals	57	21.6
RRK	University Hospital Birmingham	67	19.5
RM2	University Hospital of South Manchester	39	14.1
RA7	University Hospitals Bristol	40	15.3
RWE	University Hospitals of Leicester	81	15.6
RBL	Wirral University Teaching Hospital	24	9.6

Specialist Acute Trusts			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
RBS	Alder Hey Children's	0	0.00
RQ3	Birmingham Children's Hospital	0	0.00
RLU	Birmingham Women's	0	0.00
RBV	Christie Hospital	4	7.92
REN	Clatterbridge Centre for Oncology	2	10.20
RP4	Great Ormond Street Hospital for Children	7	6.85
RBQ	Liverpool Heart & Chest Hospital	1	2.07
REP	Liverpool Women's	0	0.00
RP6	Moorfields Eye Hospital	0	0.00
RGM	Papworth Hospital	4	5.58
RPC	Queen Victoria Hospital	0	0.00
RL1	Robert Jones & Agnes Hunt Orthopaedic	0	0.00
RT3	Royal Brompton & Harefield	9	7.56
RBB	Royal National Hospital for Rheumatic Diseases	0	0.00
RAN	Royal National Orthopaedic Hospital	13	25.62
RCU	Sheffield Children's	4	9.90
RPY	The Royal Marsden	16	26.83
RRJ	The Royal Orthopaedic Hospital	0	0.00
RET	The Walton Centre for Neurology & Neurosurgery	9	20.02

Enclosure B

CCGs			
Org code	Name	CDI case objective for 2014/15	CDI rate objective for 2014/15
02N	NHS Airedale, Wharfedale and Craven CCG	47	29.7
09C	NHS Ashford CCG	20	16.9
10Y	NHS Aylesbury Vale CCG	50	25.9
07L	NHS Barking & Dagenham CCG	39	20.9
07M	NHS Barnet CCG	66	18.5
02P	NHS Barnsley CCG	73	31.5
99E	NHS Basildon and Brentwood CCG	33	13.3
02Q	NHS Bassetlaw CCG	26	23.0
11E	NHS Bath and North East Somerset CCG	49	27.9
06F	NHS Bedfordshire CCG	69	16.7
07N	NHS Bexley CCG	63	27.1
13P	NHS Birmingham CrossCity CCG	163	22.8
04X	NHS Birmingham South and Central CCG	56	28.2
00Q	NHS Blackburn with Darwen CCG	25	16.9
00R	NHS Blackpool CCG	43	30.3
00T	NHS Bolton CCG	96	34.6
10G	NHS Bracknell and Ascot CCG	28	21.2
02W	NHS Bradford City CCG	21	25.7
02R	NHS Bradford Districts CCG	99	29.8
07P	NHS Brent CCG	35	11.2
09D	NHS Brighton & Hove CCG	70	25.6
11H	NHS Bristol CCG	131	30.6
07Q	NHS Bromley CCG	69	22.2
00V	NHS Bury CCG	63	34.0
02T	NHS Calderdale CCG	47	23.0
06H	NHS Cambridgeshire and Peterborough CCG	162	19.3
07R	NHS Camden CCG	87	39.5
04Y	NHS Cannock Chase CCG	35	26.5
09E	NHS Canterbury and Coastal CCG	50	25.3
99F	NHS Castle Point and Rochford CCG	37	21.6
09A	NHS Central London (Westminster) CCG	39	24.7
00W	NHS Central Manchester CCG	33	18.4
10H	NHS Chiltern CCG	57	18.0
00X	NHS Chorley and South Ribble CCG	47	28.2
07T	NHS City and Hackney CCG	27	10.6
09G	NHS Coastal West Sussex CCG	168	35.5
03V	NHS Corby CCG	20	32.5
05A	NHS Coventry and Rugby CCG	123	29.5
09H	NHS Crawley CCG	28	26.2
07V	NHS Croydon CCG	59	16.2

01H	NHS Cumbria CCG	196	38.7
00C	NHS Darlington CCG	20	18.9
09J	NHS Dartford, Gravesham and Swanley CCG	64	26.0
02X	NHS Doncaster CCG	91	30.1
11J	NHS Dorset CCG	192	25.8
05C	NHS Dudley CCG	108	34.5
00D	NHS Durham Dales, Easington and Sedgefield CCG	75	27.5
07W	NHS Ealing CCG	45	13.3
06K	NHS East and North Hertfordshire CCG	97	18.1
01A	NHS East Lancashire CCG	67	18.0
03W	NHS East Leicestershire and Rutland CCG	97	30.5
02Y	NHS East Riding of Yorkshire CCG	90	28.7
05D	NHS East Staffordshire CCG	30	24.3
09L	NHS East Surrey CCG	31	17.8
09F	NHS Eastbourne, Hailsham and Seaford CCG	62	34.4
01C	NHS Eastern Cheshire CCG	42	21.6
07X	NHS Enfield CCG	76	24.2
03X	NHS Erewash CCG	25	26.5
10K	NHS Fareham and Gosport CCG	48	24.7
02M	NHS Fylde & Wyre CCG	31	18.8
00F	NHS Gateshead CCG	62	30.9
11M	NHS Gloucestershire CCG	201	33.6
06M	NHS Great Yarmouth & Waveney CCG	55	25.8
03A	NHS Greater Huddersfield CCG	42	17.7
01E	NHS Greater Preston CCG	60	29.8
08A	NHS Greenwich CCG	63	24.7
09N	NHS Guildford and Waverley CCG	29	14.2
01F	NHS Halton CCG	20	15.9
03D	NHS Hambleton, Richmondshire and Whitby CCG	52	34.0
08C	NHS Hammersmith and Fulham CCG	33	18.1
03Y	NHS Hardwick CCG	29	26.8
08D	NHS Haringey CCG	37	14.5
03E	NHS Harrogate and Rural District CCG	38	23.9
08E	NHS Harrow CCG	40	16.6
00K	NHS Hartlepool and Stockton-on-Tees CCG	123	43.3
09P	NHS Hastings & Rother CCG	47	26.0
08F	NHS Havering CCG	59	24.8
05F	NHS Herefordshire CCG	46	25.1
06N	NHS Herts Valleys CCG	123	21.8
01D	NHS Heywood, Middleton & Rochdale CCG	49	23.1
99K	NHS High Weald Lewes Havens CCG	33	19.9
08G	NHS Hillingdon CCG	48	17.4
09X	NHS Horsham and Mid Sussex CCG	49	22.1
07Y	NHS Hounslow CCG	62	24.3

Enclosure B

03F	NHS Hull CCG	68	26.5
06L	NHS Ipswich and East Suffolk CCG	99	25.1
10L	NHS Isle of Wight CCG	20	14.5
08H	NHS Islington CCG	52	25.2
11N	NHS Kernow CCG	138	25.7
08J	NHS Kingston CCG	35	21.8
01J	NHS Knowsley CCG	56	38.4
08K	NHS Lambeth CCG	51	16.7
01K	NHS Lancashire North CCG	56	35.8
02V	NHS Leeds North CCG	65	32.7
03G	NHS Leeds South and East CCG	106	45.0
03C	NHS Leeds West CCG	97	30.7
04C	NHS Leicester City CCG	80	24.3
08L	NHS Lewisham CCG	33	11.9
03T	NHS Lincolnshire East CCG	60	26.3
04D	NHS Lincolnshire West CCG	42	18.6
99A	NHS Liverpool CCG	158	33.9
06P	NHS Luton CCG	31	15.2
04E	NHS Mansfield & Ashfield CCG	85	44.3
09W	NHS Medway CCG	61	23.0
08R	NHS Merton CCG	25	12.5
06Q	NHS Mid Essex CCG	56	14.8
04F	NHS Milton Keynes CCG	63	24.7
04G	NHS Nene CCG	167	27.1
04H	NHS Newark & Sherwood CCG	40	34.8
10M	NHS Newbury and District CCG	16	15.3
00G	NHS Newcastle North and East CCG	43	30.9
00H	NHS Newcastle West CCG	25	17.9
08M	NHS Newham CCG	21	6.8
10N	NHS North & West Reading CCG	29	29.2
04J	NHS North Derbyshire CCG	138	50.8
00J	NHS North Durham CCG	62	25.8
06T	NHS North East Essex CCG	39	12.5
99M	NHS North East Hampshire and Farnham CCG	33	16.0
03H	NHS North East Lincolnshire CCG	22	13.8
10J	NHS North Hampshire CCG	55	25.7
03J	NHS North Kirklees CCG	50	27.0
03K	NHS North Lincolnshire CCG	37	22.1
01M	NHS North Manchester CCG	46	28.2
06V	NHS North Norfolk CCG	43	25.7
11T	NHS North Somerset CCG	73	35.9
05G	NHS North Staffordshire CCG	55	25.8
99C	NHS North Tyneside CCG	52	25.8
09Y	NHS North West Surrey CCG	62	18.4
99P	NHS North, East, West Devon CCG	204	23.6

00L	NHS Northumberland CCG	82	25.9
06W	NHS Norwich CCG	43	22.5
04K	NHS Nottingham City CCG	60	19.7
04L	NHS Nottingham North & East CCG	42	28.8
04M	NHS Nottingham West CCG	35	31.9
00Y	NHS Oldham CCG	68	30.2
10Q	NHS Oxfordshire CCG	172	26.8
10R	NHS Portsmouth CCG	39	19.0
08N	NHS Redbridge CCG	27	9.6
05J	NHS Redditch and Bromsgrove CCG	45	25.3
08P	NHS Richmond CCG	21	11.2
03L	NHS Rotherham CCG	66	25.6
04N	NHS Rushcliffe CCG	28	25.2
01G	NHS Salford CCG	60	25.6
05L	NHS Sandwell and West Birmingham CCG	112	23.8
03M	NHS Scarborough and Ryedale CCG	34	30.8
03N	NHS Sheffield CCG	193	35.0
05N	NHS Shropshire CCG	97	31.6
10T	NHS Slough CCG	24	17.1
05P	NHS Solihull CCG	70	33.8
11X	NHS Somerset CCG	107	20.1
01R	NHS South Cheshire CCG	42	23.9
99Q	NHS South Devon and Torbay CCG	81	29.8
05Q	NHS South East Staffs and Seisdon Peninsular CCG	42	18.9
10V	NHS South Eastern Hampshire CCG	42	20.1
12A	NHS South Gloucestershire CCG	68	25.8
10A	NHS South Kent Coast CCG	39	19.3
99D	NHS South Lincolnshire CCG	38	27.1
01N	NHS South Manchester CCG	43	26.9
06Y	NHS South Norfolk CCG	59	25.3
10W	NHS South Reading CCG	30	28.4
01T	NHS South Sefton CCG	60	37.6
00M	NHS South Tees CCG	51	18.6
00N	NHS South Tyneside CCG	31	20.9
05R	NHS South Warwickshire CCG	88	34.0
04Q	NHS South West Lincolnshire CCG	20	16.5
05T	NHS South Worcestershire CCG	70	24.1
10X	NHS Southampton CCG	57	24.2
99G	NHS Southend CCG	36	20.7
04R	NHS Southern Derbyshire CCG	134	26.2
01V	NHS Southport and Formby CCG	43	37.7
08Q	NHS Southwark CCG	42	14.5
01X	NHS St Helens CCG	57	32.5
05V	NHS Stafford and Surrounds CCG	65	43.2

01W	NHS Stockport CCG	88	31.1
05W	NHS Stoke on Trent CCG	76	29.6
00P	NHS Sunderland CCG	103	37.4
99H	NHS Surrey Downs CCG	76	27.1
10C	NHS Surrey Heath CCG	13	13.9
08T	NHS Sutton CCG	35	18.3
10D	NHS Swale CCG	29	27.1
12D	NHS Swindon CCG	55	25.6
01Y	NHS Tameside and Glossop CCG	101	39.9
05X	NHS Telford & Wrekin CCG	23	13.8
10E	NHS Thanet CCG	47	35.0
07G	NHS Thurrock CCG	22	13.9
08V	NHS Tower Hamlets CCG	38	14.8
02A	NHS Trafford CCG	59	26.0
03Q	NHS Vale of York CCG	90	26.2
02D	NHS Vale Royal CCG	17	16.6
03R	NHS Wakefield CCG	92	28.2
05Y	NHS Walsall CCG	62	23.0
08W	NHS Waltham Forest CCG	37	14.2
08X	NHS Wandsworth CCG	51	16.6
02E	NHS Warrington CCG	42	20.7
05H	NHS Warwickshire North CCG	48	25.6
02F	NHS West Cheshire CCG	61	26.8
07H	NHS West Essex CCG	54	18.8
11A	NHS West Hampshire CCG	109	20.1
99J	NHS West Kent CCG	98	21.3
02G	NHS West Lancashire CCG	33	29.8
04V	NHS West Leicestershire CCG	89	24.0
08Y	NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	69	31.3
07J	NHS West Norfolk CCG	42	24.6
07K	NHS West Suffolk CCG	58	26.4
02H	NHS Wigan Borough CCG	107	33.6
99N	NHS Wiltshire CCG	140	29.5
11C	NHS Windsor, Ascot and Maidenhead CCG	24	17.4
12F	NHS Wirral CCG	64	20.0
11D	NHS Wokingham CCG	40	25.8
06A	NHS Wolverhampton CCG	67	26.8
06D	NHS Wyre Forest CCG	22	22.4

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 March 2014

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

Enclosure C

Chief Executive's Report to the Trust Board

27 March 2013

Urgent Care Pressure and Support for the Emergency Pathway

The Trust has continued to experience continued considerable pressure in A&E and across the Trust. The cumulative demand for our services had a significant impact on our ability to see, treat and discharge patients as quickly as we would wish to.

In light of these continued challenges, the Board has approved a proposal to commence a programme of work spearheaded by McKinsey and Company to help us improve our performance in terms of the A and E standards and the flow of patients through the Emergency Care Pathway. The need to do something profoundly different with some expert help is based upon the fact that we are in an increasingly difficult situation and have been for some time. We know that as long as the current situation persists we will not be offering the service that our patients deserve and our staff will not be able to give of their best.

This work will start immediately and I have asked that it be done in a way that … '*restores a sense of belief and builds capability as well as puts in systems, processes and behaviours which will make the improvement sustainable'*. This will take months to embed but we hope to complete the support work within a period of 5 weeks. We will also be meeting with all our partners across the Health and Social Care system to enlist their support. Although there is clear realisation that in general urgent care pressures arise from issues across the health and social care economy, the burden of risk often is felt most acutely in Acute Trust Emergency Care departments and it is important that this is formally recognised.

Operation Deep Dive

In light of the significant challenges facing the Trust due to pressures in the urgent care pathway, the Acting Chief Operating Officer ran an operation called deep dive on 21 February. The operation was effectively a request for help with the urgent care pathway where nominated clinicians and managers were asked to clear their diaries to focus on patient flow and discharge.

The operation established a command and control centre that, with the assistance of staff across the organisation, focussed on unblocking issues affecting the flow and discharge of patients. Over the course of the day, over 100 issues had been unblocked.

Due to the success of the operation, the control room has been permanently established in the site management office under the direction of Rebecca Brown we have managed to make some improvements in the way that our patients flow through the hospital over the last 2 weeks. As a result far fewer patients have waited for over 4 hours in A&E and we have improved the way we are able to work with our partners in the health and social care system through increased support from senior managers from NHFT, NCC and the CCG.

Chief Operating Officer Appointment

I am pleased to announce that, following a rigorous interview and selection process, Debbie Needham has been appointed as our Chief Operating Officer.

This is a role that is not without its challenges and I am confident Debbie will be able to build on the experience she has gained both as Care Group Director for Medicine and, latterly as Acting Chief Operating Officer, a post she shared with Rebecca Brown. I would like to thank them both for their contribution to the Trust during that time.

Pets As Therapy (PAT) Dogs and the Patient Experience

There are many ways in which we can improve our patients' experience. Those of you who came to the NGH Festival may recall seeing a stand that run by volunteers from Pets as Therapy Dogs. Fiona Barnes, deputy director of nursing, subsequently approached the charity with a view to having PAT dogs visit some of our wards, particularly where we have long-term patients as research has shown that there are benefits associated with interaction with animals that help address the physical, social and emotional aspects of an individual's recovery. The PAT dogs now visit patients on Brampton, Creaton and Holcot wards every other Tuesday and this has proved a great success. Staff have noted that patients who have been withdrawn have become interested and involved with the dogs, and patients now look forward to their visits.

Best Possible Care Awards

Our Best Possible Care Awards ceremony will take place on the evening of Monday 7th April. This year's awards ceremony builds on the success of the STAR Awards, aligning the awards to our vision and values and adding new categories to ensure that both clinical and non-clinical staff have equal opportunities to share in the awards. I was pleased with the number of entries we received this year, which certainly made for some difficult decisions when it came to shortlisting nominees, and every staff member and team nominated for an award should be proud of what they have achieved.

REPORT TO THE TRUST BOARD
27 MARCH 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 Programme Director
Purpose	Assurance

Executive Summary

- Overall mortality for 2013-14 as measured by HSMR remains significantly low (87) and we have maintained our previous improvement.
- SHMI still remains high (113) but this is expected to improve in the forthcoming months
- Crude mortality as risen slightly to 3.5%, but remains below East Midlands average
- The Mortality & Coding Review group continue to monitor adverse clinical outcomes.
- Further analysis of the gastrointestinal and liver disease group continues due to persisting high identified mortality in some CCS groups, although overall mortality is as expected for the group
- A second group [dermatology] has been identified by CQC as having a high historical mortality in 2012-13 which has since resolved and will be monitored for sustained improvement
- A report from the biannual notes review of 50 deaths is in draft. Key learning from this will be fed back to SMB, Mortality & Coding Review Group and the Patient Safety Academy
- 9 Serious Incidents (SI) were reported in January 2014 of which 8 were pressure ulcers and one a fracture sustained in hospital.
- 17 SI's were closed, of which 10 were pressure ulcers and 4 were fractures sustained in hospital.
- 4 'Being Open' meetings have been held with families following SI investigations to ensure that their concerns have been addressed.

Related strategic aim and corporate objective	*Which strategic aim and corporate objective does this paper relate to?*

Risk and assurance	*Does the content of the report present any risks to the Trust or consequently provide assurances on risks*
Related Board Assurance Framework entries	BAF 1 2013/14
Equality Impact Assessment	*Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N)* *Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N)*
Legal implications / regulatory requirements	There are no legal/regulatory implications of the paper

Actions required by the Board

The Board is requested to :

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

Medical Director's Quality Report

Section 1

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 December 2013 and SHMI [to June 2013]

Current Position HSMR [Hospital Standardised Mortality Ratio, Dr Foster Intelligence]

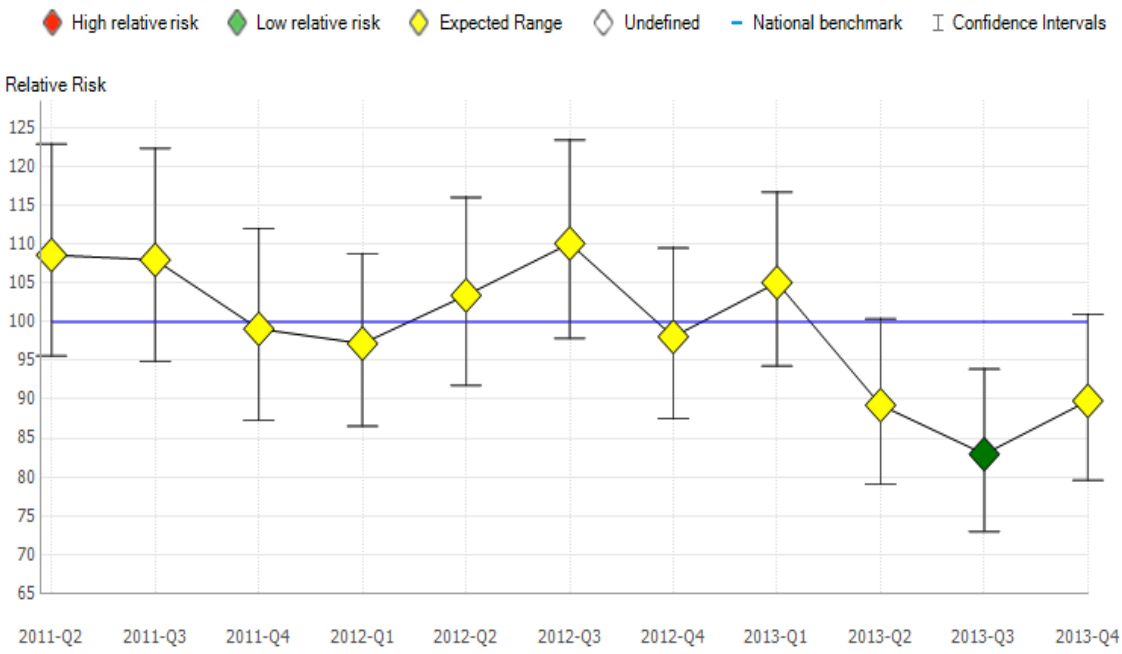
HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its appropriate use continues. It is based on mortality in 56 CCS [Clinical Classification Software] groups. These diagnosis groups account for 80% of hospital mortality and are recognised as having reliable predictive 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 at presentation, but is based on the diagnosis, age, presence of other conditions [comorbidities] and any surgical procedures carried out. Hospital mortality rates are also known to reflect local community and primary care provision. A high standard of care in the community may have a confounding effect on admissions, reducing numbers such that only the highest risk cases are admitted to hospital. Equally, lack of access to primary care may also mean that patients present late to hospital in a more serious condition. The model relies on accuracy of clinical coding, and as it is comparative, local performance may also reflect variation in coding practice in other organisations.

Northampton General Hospital Trust currently 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 and respite care. It is now possible to monitor HSMR performance back to April 2013 for each site, generating 9 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:



1. HSMR Comparison

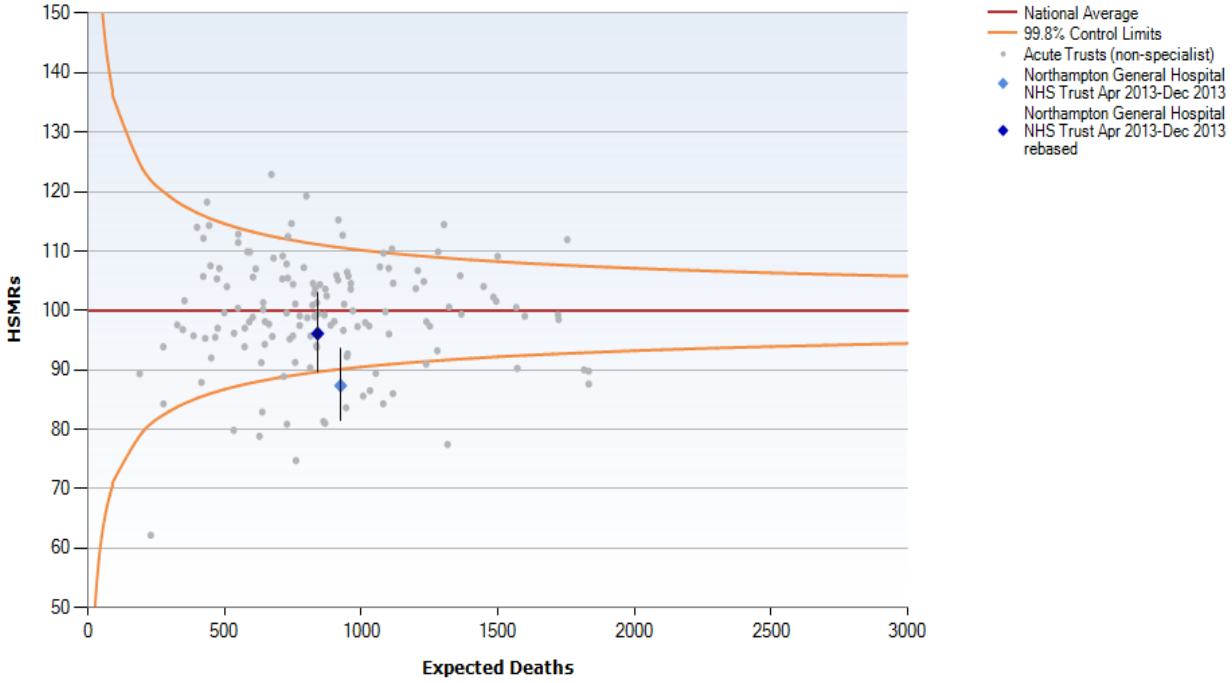
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. This is especially important when death rates are falling nationally and the benchmark is continuously falling, as is currently the case. Dr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

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 9 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for the rolling year to date is **92** and for 2013-4 is **87** [**96** 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 3.7% [range 3.2% - 4.6%].

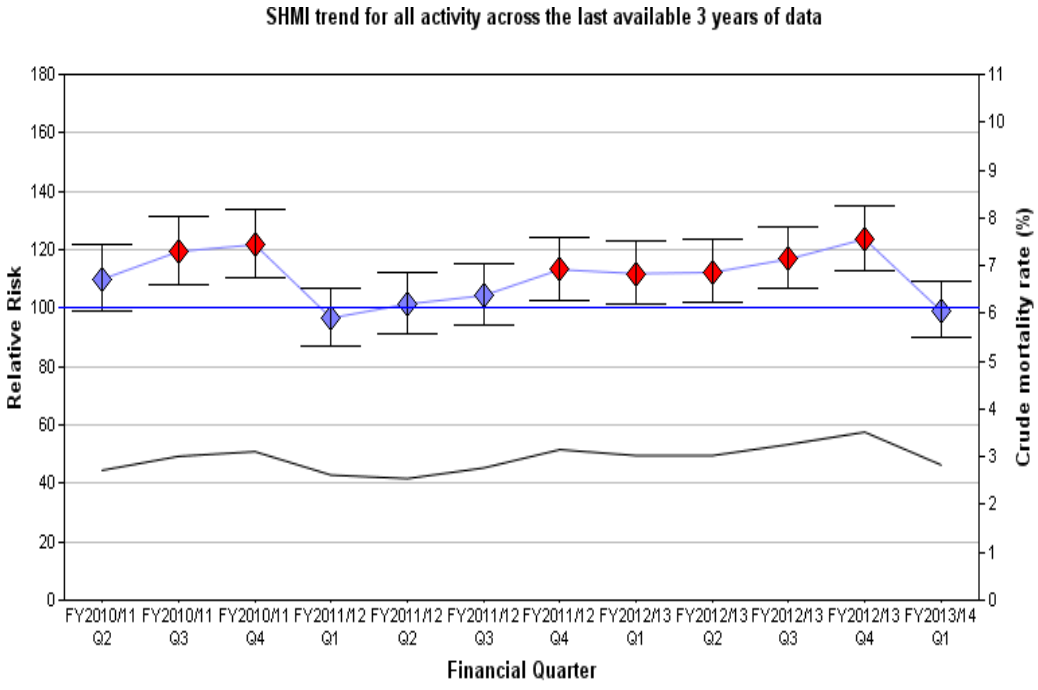
Acute Trust HSMRs Apr 2013-Dec 2013

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



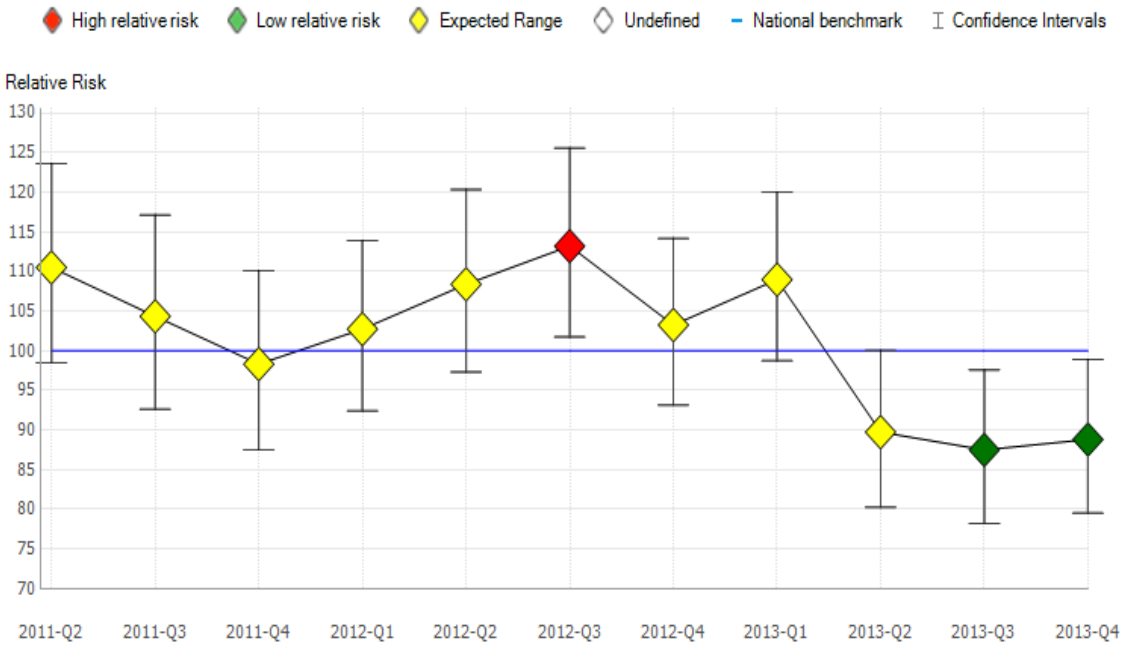
2. Standardised Hospital Mortality Indicator [SHMI]

There has been no further SHMI data release since the last report to Board. The most recent data release [to end June 2013] shows SHMI for the rolling year to be at **112.9,** a noticeable fall from the previous **115.8** due to the marked fall for Q1 2013-4, as previously predicted. However this value contributes to the Trust's current high CQC risk score, despite being 9 months in arrears.



HSMR for the same period was **100.** The marked divergence between the 2 remains of concern particularly because SHMI data is not easily available for further analysis to identify areas of poor performance. It is likely that the some of the discrepancy can be attributed to the lack of allowance for palliative care for the hospice admissions to the community wards, and the less discriminating methodology used by SHMI which includes all CCS groups. For this reason SHMI more closely tracks HSMR 100, and so is expected to continue to show very marked improvement over the next 2 quarters. Meanwhile all possible areas of risk indicated by SHMI are being monitored to ensure that there is evidence of improvement in 2013-4 [using Dr Foster analysis tools] and investigated where this is not the case.

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



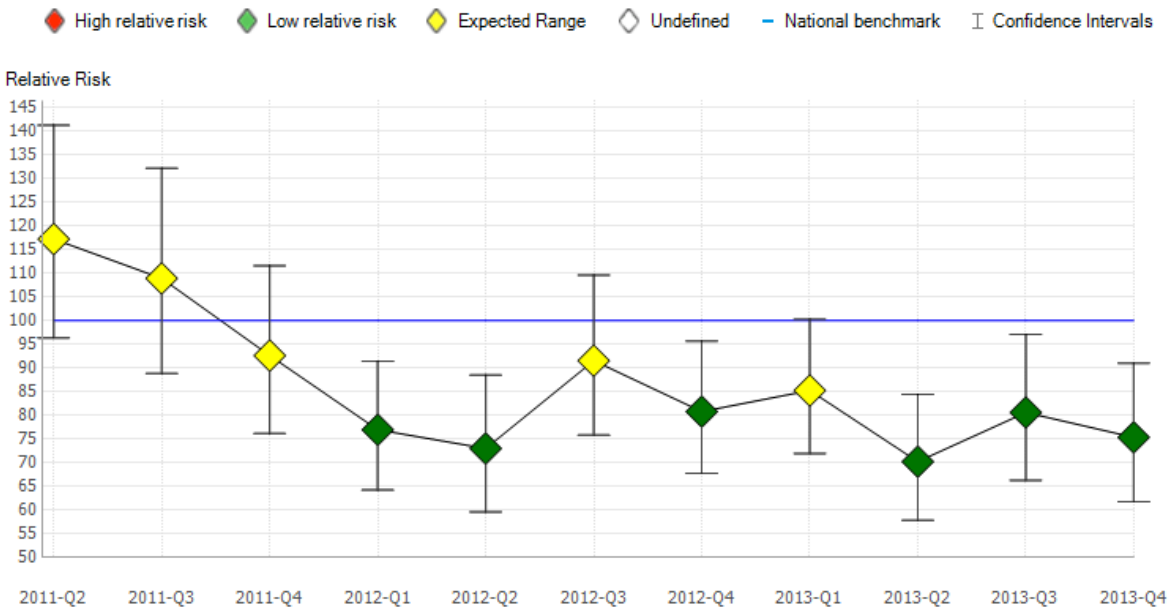
Dr Foster Patient Safety Indicators [January-December 2013]

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups *	38,182	22	30.1	0.6	0.8	73
Decubitus Ulcer	9,460	271	312.9	28.6	33.1	87
Deaths after Surgery	359	49	43.1	136.5	120.0	114
Infections associated with central line *	15,854	1	1.1	0.1	0.1	94
Postoperative hip fracture *	24,928	4	1.5	0.2	0.1	259
Postoperative Haemorrhage or Haematoma	23,451	11	14.0	0.5	0.6	79
Postoperative Physiologic and Metabolic Derangement *	19,764	4	1.6	0.2	0.1	250
Postoperative respiratory failure	17,980	22	15.7	1.2	0.9	140
Postoperative pulmonary embolism or deep vein thrombosis	23,635	35	45.4	1.5	1.9	77
Postoperative sepsis	533	4	3.7	7.5	7.0	107
Postoperative wound dehiscence *	1,006	0	1.5	0.0	1.5	0
Accidental puncture or laceration	65,930	39	75.9	0.6	1.2	51
Obstetric trauma - vaginal delivery with instrument *	471	33	38.9	70.1	82.7	85
Obstetric trauma - vaginal delivery without instrument *	2,505	104	96.1	41.5	38.4	108
Obstetric trauma - caesarean delivery *	1,179	0	4.4	0.0	3.7	0

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

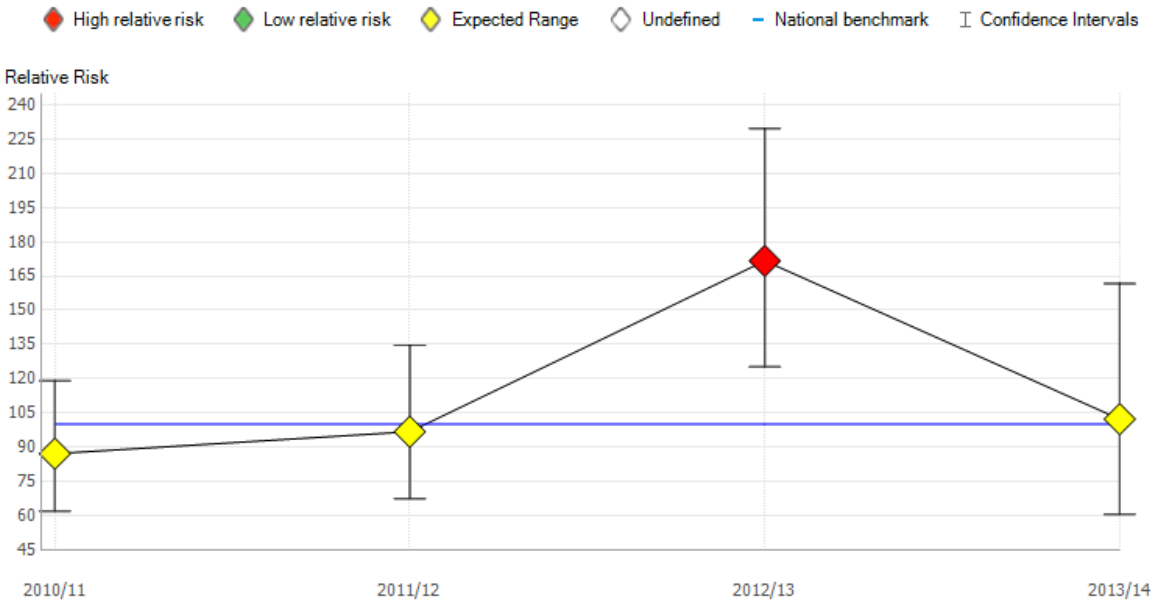
3. Reports on key areas for action or of importance

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 **75**.

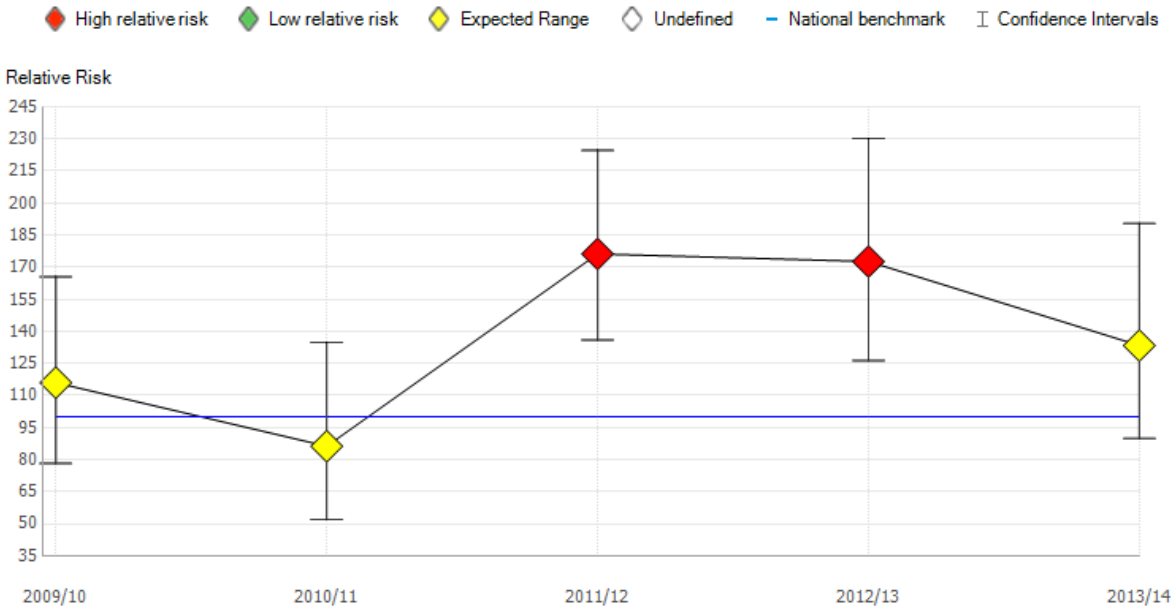


4. Possible areas for concern under investigation

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

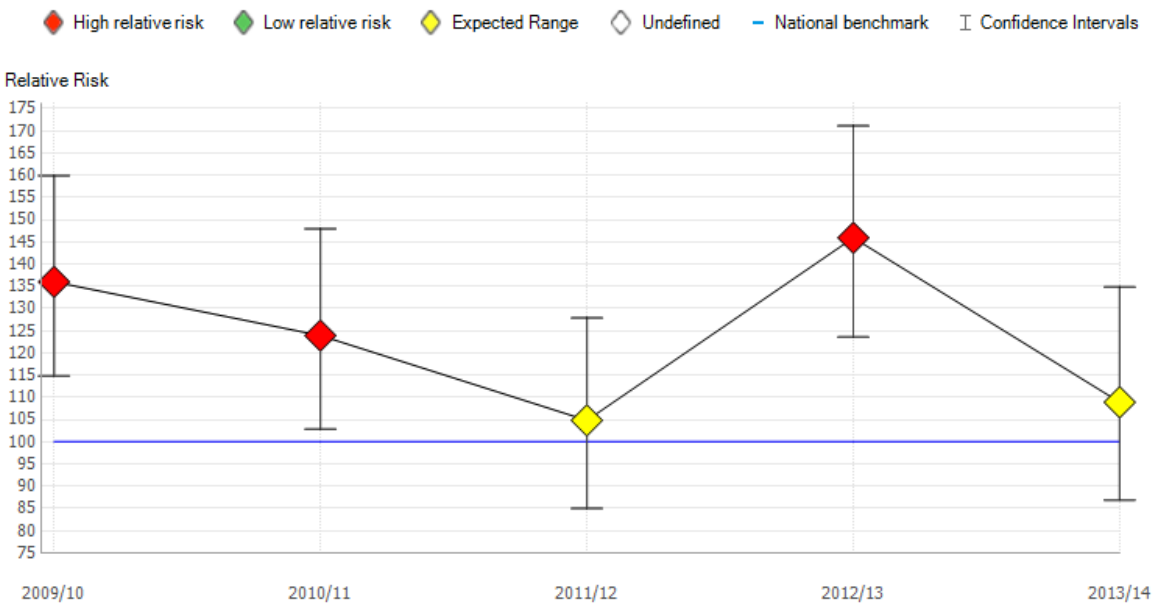


Secondary malignancy: The modest improvement in mortality in this group noted last month is sustained.
Monthly review of all deaths continues and an interim report to Mortality and Coding Review Group has noted a trend towards late presentation by patients with advanced disease and resulting poor functional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



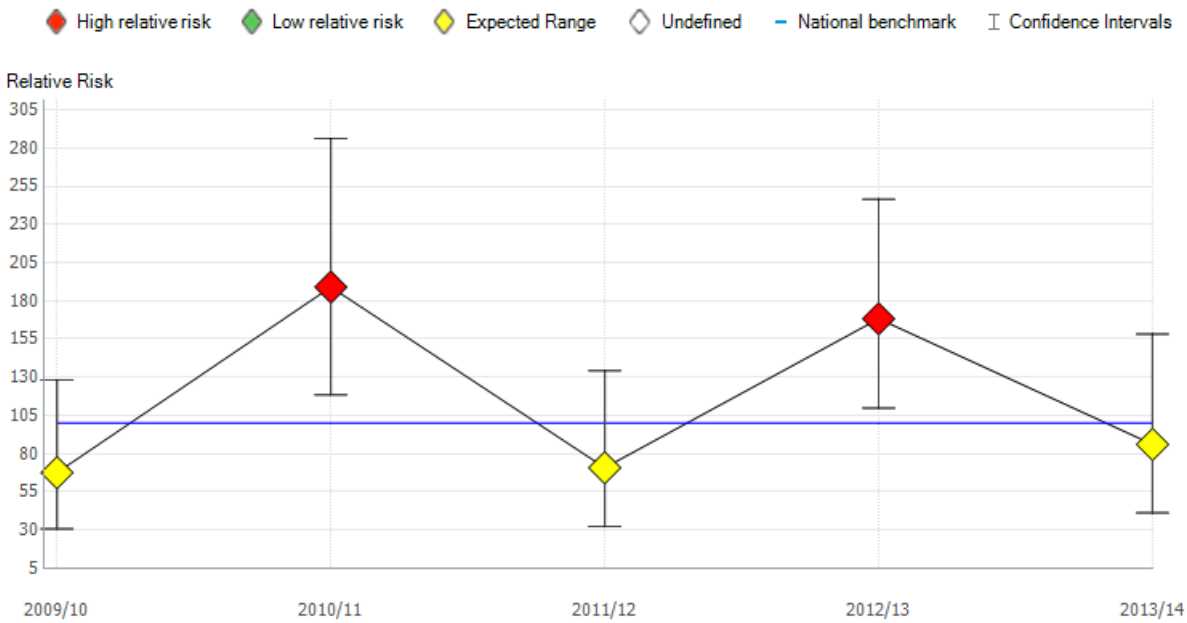
5. Area of general relevance with respect to overall Trust performance

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 small subset of emergency surgical admissions [bowel perforation] is to be reviewed by the general surgeons and presented to Mortality & Coding Review Group in May 2014.



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

The latest CQC Intelligent Monitoring Report also contains a new alert for a composite **dermatology** basket of diagnoses including chronic skin ulcers and skin and subcutaneous tissue infections. Mortality was significantly raised in 2012/13 but performance in 2013/14 is as expected. Bearing in mind the poor earlier performance in 2010-11, it will be monitored to ensure improvement is sustained, but no further action is planned unless there is a deterioration.



6. Further actions in place or planned:

The draft report following the Trustwide notes review [50 sets] is nearing completion and will be reported to Trust Board in due course.

A local CQIN is under discussion with CCG to embed the M&M process at directorate level and share learning both internally and within the locality.

7. Data Quality [to end December 2013]:

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

Section 2

Learning from Serious Incidents and Inquests

9 Serious incidents were reported in February

- 8 pressure ulcers [4 occurred in January but reporting was delayed]
- One #NOF due to an inpatient fall in NGH

17 Serious incidents were closed as follows:

- 3 x Grade 3 Pressure Ulcers. [The investigations found that the ulcers were unavoidable and have therefore requested that the incident be downgraded]
- 7 x Grade 3 Pressure Ulcer – deemed to be avoidable
- 1 emergency readmission following a previous A&E attendance at which the diagnosis was missed
- 1 death in a patient following a missed #NOF
- 4 x in hospital #NOF [3 in NGH, 1 in a community hospital]
- 1 unexpected death in ITU

Serious Incident reporting rate

There were 792 patient safety incidents reported in February 2014, 9 of which were declared and investigated as a Serious Incident, this represents a reporting rate of 1.14%. Whilst this represents a slight decrease on the January 2014 rate of 1.36% it is the third month that the reporting rate is over the national average of 1%.

The high serious incident reporting rate is directly attributable to the number of Grade 3 pressure ulcers that have been reported, e.g. 8 out of the 9 Serious Incidents reported (89%) were pressure ulcers.

Pressure ulcers are the highest category of Serious Incidents reported year to date accounting for 59% of the serious incidents reported.

Key learning points from the above are as follows:

Grade 3 Pressure Ulcers -avoidable (Allebone x 2; Collingtree; Abington; Creaton; EAU	
Theme	Learning / Actions
Documentation	Accurate completion of risk assessment documentation Turn charts to be maintained in accordance with patients' needs Concise and accurate documentation of pressure areas. The patients skin integrity had not been documented adequately enough on turn chart Poor documentation
Clinical Assessment	SSKIN care plan to be implemented for all patients on admission Inappropriate repositioning of patient Reassessments of SSKIN and Risk to be carried out in response to

	patients condition and skin integrity Incorrect classification of pressure damage reported
Equipment	Lack of available pressure relieving mattress
Discharge / Transfer	For patients at risk of damage to skin integrity, a Skin check could be performed prior to transfer
Policy / Procedure / Process	Adherence to Trust Policy and Procedures on Pressure Ulcer Prevention - delay in implementation of Core Care plan Patients will be placed on appropriate support surface at the earliest opportunity
Duty of Candour	Documented evidence of conversation with patient and/or next of kin regarding the development of pressure damage
Training	Tissue Viability Team to arrange further training and develop evidence of learning/ implementation to practice (competency)
Sharing of Lessons learnt	Staff on Ward involved in patients care made aware of SI report and learning shared Monthly ward meetings to ensure all staff are aware of the importance of accurate assessment and documentation, including The PU care plan and position charts
Falls resulting in # NOF (Knightley, Corby, Benham, Collingtree)	
Theme	Learning / Actions
Policy / Procedure / Process	Doctors to use post fall medical assessment form in medical notes Nursing staff to use post fall sticker in nursing notes Delay in reporting of incident via Datix
Clinical Assessment	All patients must have neurological observations commenced after un-witnessed fall All patients must have lying and standing blood pressure and urinalysis if they are at risk of falls
Equipment	Staff to be made aware of the correct procedure and the escalation procedure if the correct mattress should not be available.
Staffing	Low numbers of staff on the night shift
Multi-disciplinary working	Patient was not referred to Dietician on admitting ward despite nutritional score worsening.
Communication	Fall not been handed over by the night nurse to the day
Documentation	Staff to be reminded of the need to document all relevant information in notes.
Duty of Candour	Delay in notifying next of kin Duty of Candour/Being Open to be shared with staff via Matron and

	Ward Sister
Sharing of Lessons learnt	Copy of final report to be sent to Care Group Governance Manager to enable Directorate wide sharing and learning
Unexpected Death General Medicine; ITU	
Theme	Learning / Actions
Clinical Assessment	Patients with high suspicion of fracture as the primary pathology should be admitted under the care of the orthopaedic team and advanced imaging requested Highlight within the trust the increased risk of nephrotoxicity in the elderly due to simultaneous use of Angiotensin converting enzyme (ACE) inhibitors or Angiotensin 2 receptor blocking (ARB) drugs and Diuretics are prescribed non-steroidal anti-inflammatory drugs (NSAIDs)
Duty of Candour	There should be better documentation of the communication between clinical staff and relatives
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 team meetings. Dissemination of action plan and lessons learned to rest of the staff
Lack of Review/Escalation A & E	
Theme	Learning / Actions
Policy / Procedure / Process	Review triage tools in use and their sensitivity when excluding significant pathology in patients to be discharged
Clinical Assessment	Feedback to be given to medical doctors regarding the importance of considering alternative routes for intravenous administration, in patients where peripheral cannulation is extremely difficult
Documentation	A&E nursing staff who triage to be made aware of the importance of thorough and concise documentation
Escalation	A&E Matron to discuss with A&E nurses about appropriate escalation to Consultants
Unexpected death on ITU	
Theme	Learning / Actions
Clinical Assessment	Review availability of CTPA service over weekend

An action plan is developed within the investigation prior to its submission to the CCG, following which the action plan is reviewed by SIG [Serious Incident Group] to ensure that it is SMART. It is then sent to the Care Group Governance leads for implementation. Where possible implementation is completed prior to inquest to demonstrate the Trust's commitment to learning and improvement.

A meeting is held with family/carers if desired to discuss the overall findings of investigations. 4 meetings were held during February 2014.

- The parents of a 17 year old patient who died in August 2013. An inquest will take place, however the cause of death has already been revised following a very detailed SI investigation which has been very helpful to the family
- The wife of a patient who sustained a fractured NOF and subsequently died
- The next of kin of a patient who sustained a Grade 3 Pressure Ulcer
- The wife and daughter of a patient who died unexpectedly. The inquest has been delayed pending the SI investigation and meeting with the family. This has enabled a better understanding for the family of the patient's condition and prognosis and provided an opportunity to provide answers to their questions prior to inquest

7 inquests of patients who died in hospital or shortly after transfer/discharge took place during February 2014

2 frail elderly patients [aged 91 and 85] who had suffered falls resulting in brain injury/haemorrhage. One patient had been the subject of an SI due to a pressure ulcer and was also the subject of a complaint by the family regarding her care. The other had been discharged to Intermediate Care where she later deteriorated.

A lady suffered postoperative complications following surgery for ruptured aortic aneurysm.

The remaining 4 cases were not immediately related to care received at NGH

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 becoming more detailed providing the Care Groups with a dash board relevant to their areas. The directorate scorecards will continue to be informed by more detailed Trust specific measures that are selected according to Trust priorities and pressures and in time will be aligned with the national quality dashboard which continues as work in progress. During March 2014 the scorecard will be expanded to include the number of non-clinical transfer's during 2200hrs – 0700hrs.

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

Performance

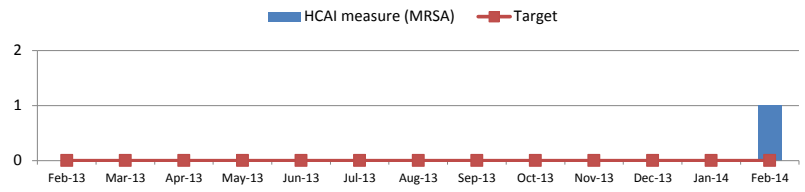
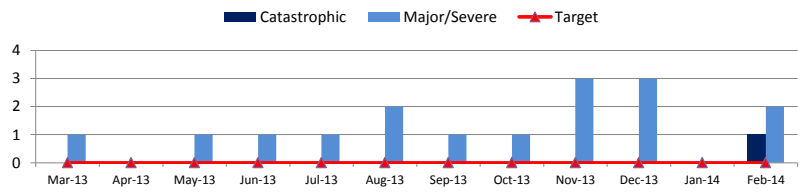
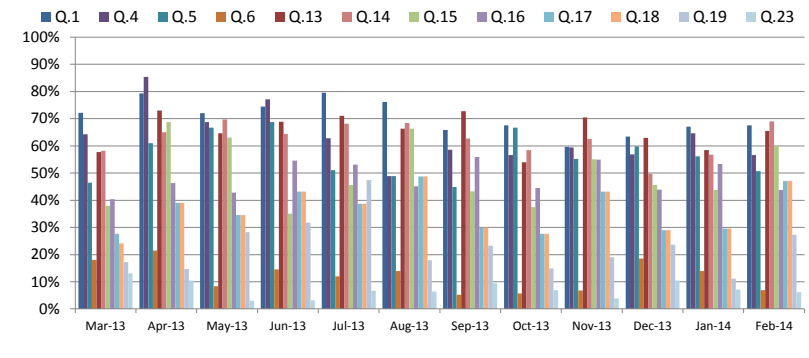
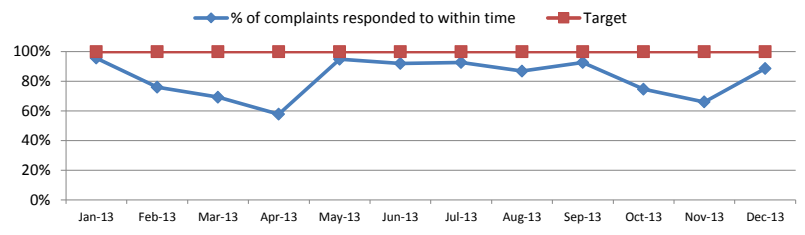
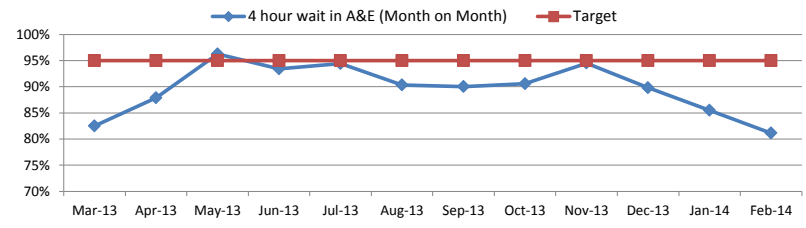
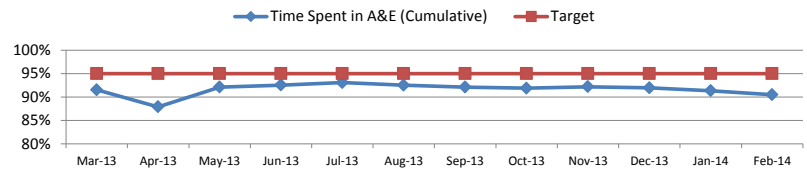
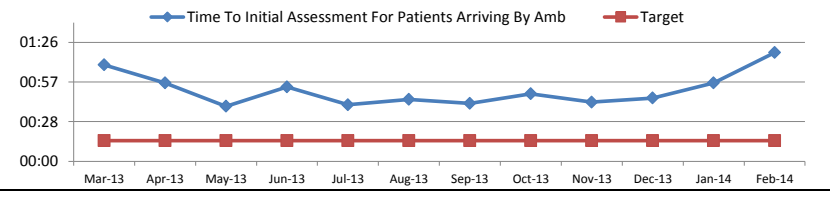
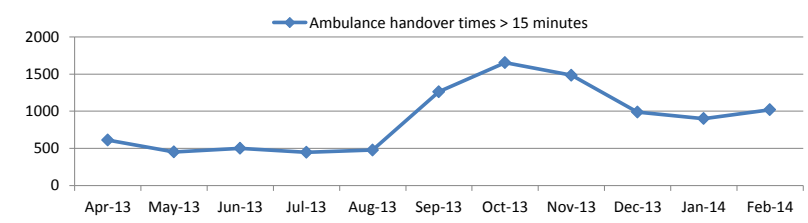
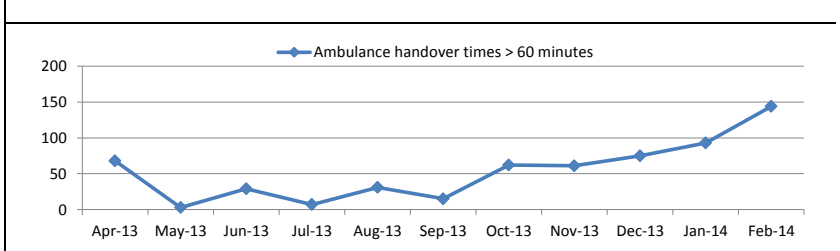
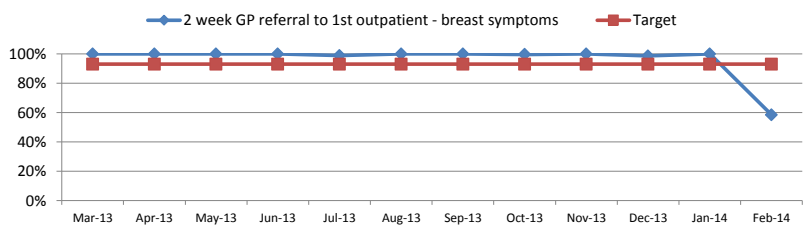
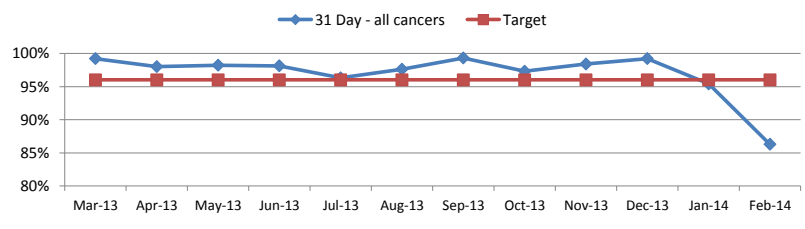
The Exception Summary Report **(attached)** outlines the underperforming indicators and details the remedial action(s) being taken. Progress is monitored against **143** indicators.
The number of indicators that have been rated as red (**32),** is predominantly due to the healthcare notes audit where 12 questions were red rag rated within the patient safety domain. The A&E quality indicators and cancer wait times are encompassed within the patient experience domain of the scorecard which has **15** red rag rated indicators. The Indicators rated as grey have increased from **21/29,** as further agreement for indicators continues to be agreed.

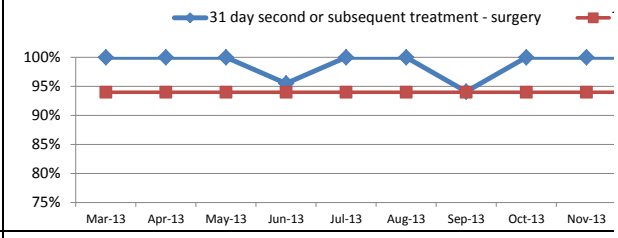
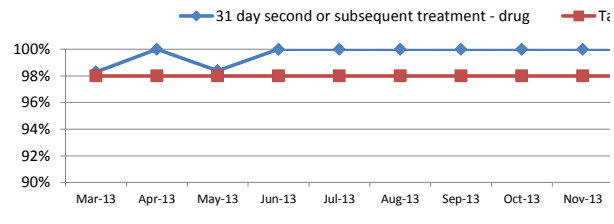
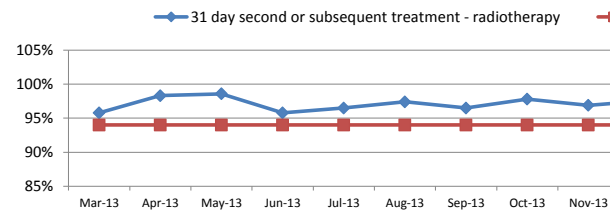
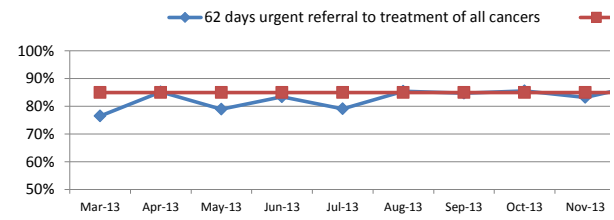
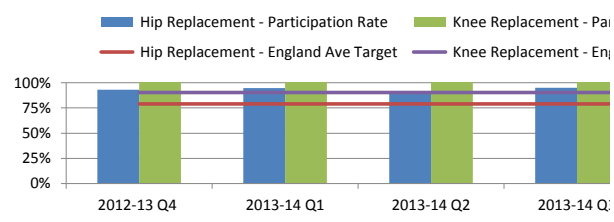
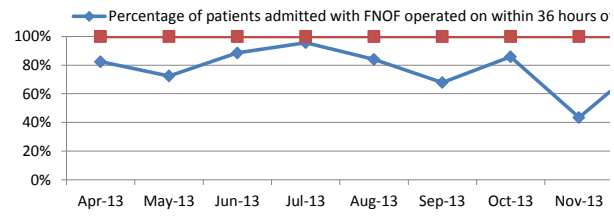
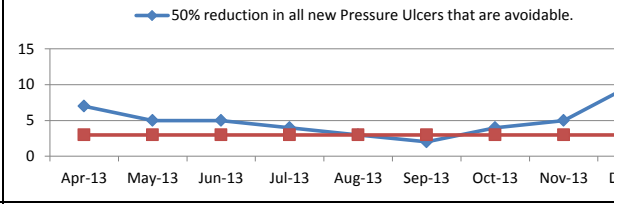
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A	Total
CQUIN 2012-13	**1**	**0**	**22**	**0**	**62**
Clinical Outcomes	**1**	**3**	**6**	**15**	**33**
Patient Safety	**15**	**8**	**28**	**11**	**25**
Patient Experience	**15**	**4**	**11**	**3**	**23**
TOTAL	**32**	**15**	**67**	**29**	**143**

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	HCAI Measure (MRSA)	0	↓	February saw the first reported MRSA incident since September 2012. A full investigation has commenced into the incident.	
Patient Safety	Falls (major/severe & catastrophic)	0	↓	There were 2 x major / severe falls during February both resulting in fractured neck of femur.There was also 1 x catastrophic fall resulting in a subdural haemorrhage. This has been reported as an SI.	
Patient Safety	Healthcare Notes audit (23 questions)	100%	→	***The healthcare notes audit questions account for 12 of the red performance scores within the Patient Safety domain .*** 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. A revised and focussed data set will be introduced during April 2014.	
Patient Experience	Complaints responded to within agreed timescales	100%	↑	The response rate for responding to complaints within an agreed timescale improved from 66% in November 2013 to 88.6% in Decemeber 2013.	
Patient Experience	A & E Quality Indicators (5 indicators)		↓	**A&E Clinical Indicators:**	
			↓	The 4 hour wait in A&E (Month on Month) position continued to deteriorate to a month end position of 81.16% against the previous month (85.5%) 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 February waits, resulting in a cumulative of 90.47% from 91.33% for the previous month.	
			↓	The time to initial assessment for patients arriving by ambulance deteriorated further 57 minutes in January to 1hour 19 minutes (national target being 15 minutes). This is the first time a rate in excess of 1 hour has been since March 2013.	
			↓	Both the number of ambulance handover over 60 minutes and ambulance handover times waiting over 15 mins increased during February 2014. The Trust is currently not being fined for any handovers of 30 minutes.	
			↓		
Patient Safety	2 week GP referral to 1st outpatient - breast symptoms	93%	↓	Unverified figures for February 2014 would indicate only 58.5% of symptomatic breast 2WW referrals were seen within 2 weeks of referral. This is due to the unavailability of one of the breast surgeons. A locum has now been appointed to recover the target position for March 2014.	
Patient Safety	Cancer target 31 days urgent referral to treatment of all cancers	96%	↓	There are currently issues around breast surgery due to the unexpected unavailability of one of the surgeons (see above). In addition Lower GI also experienced difficulties in remaining above target during February.	

Patient Safety	31 day second or subsequent treatment - surgery	94%	↓	The breach of this target is based on 6 patients out of a total of 28 for February resulting in an unverified position of 78.6% against the final January position of 82.8%	
Patient Safety	32 day second or subsequent treatment - drugs	98%	↑	There was an improvement during February against the January position for this indicator with an unverified position of 96.6% against the target of 98%. This is made up of 1 patient out of a total of 29.	
Patient Safety	31 day second or subsequent treatment - radiotherapy	94%	↓	This target marginally fell below target for February with an unverified position of 93.8% against the target of 94%. This consisted of 1 breach out of a total of 16 patients.	
Patient Safety	Cancer target 62 days urgent referral to treatment of all cancers	85%	↓	The unverified position for February 2014 for this cancer access target is 73.8 - a further decline from the January position of 79.5%. This consists of 16.5 breaches out of a total of 63 patients includes over 7 cancer pathways.	
Patient Safety	PROMS Scores - Pre Operative participation rates	England Average (variable)	↓	Pre-operative participation rates (PROMS) for both hip and knee replacements underachieved against the national average targets. This data is based on 6 months HES data - Apr 13 - Sep 13 the recently published findings are being reviewed by the Directorate.	
Clinical Outcome	Percentage of patients admitted with FNOF operated on within 36 hours of admission	100%	↓	An analysis has been completed into the root cause of the February deterioration against best practice target for this indicator. During February 22pts were admitted wiht a #NOF, 20pts were classed as fit for surgery 15 pts recieved surgery within 36 hours from admission.	
CQUIN	50% reduction in all new avoidable Pressure Ulcers	Max 3 incidents p/m	↑	There was a further monthly improvement in the number of avoidable and unavoidable pressure ulcers during February 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	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Feb 14 RAG Rating	Comments
HQU01: HCAI measure (MRSA)	0	0	0	0	0	0	0	0	0	0	0	0	1		
HQU02: HCAI measure (CDI)	29 per year	5	7	2	4	1	3	1	2	3	0	0	1		
HQU08: MSSA Numbers	No national ceiling set	0	1	0	1	1	0	0	1	1	2	0	0		
E Coli ESBL Quarterly Average	7 per month	0	2	3	3	4	2	2	3	2	2	0	3		
VTE Risk Assessment completed	95% month on month	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97%	97%	97%	97%	97.8%	97.7%		RAG rating if under 95% = Red.
High risk patients receive appropriate treatment	95% Month on month	96.2%	100.0%	100.0%	100.0%	100.0%	99.8%	100%	100%	100%	100%	100%	100%		
MRSA Screening Elective Patients	100% month on month	99.40%	99.87%	99.50%	99.71%	99.65%	99.93%	99.84%	99.72%	99.79%	99.91%	99.94%	99.6%		
MRSA Screening Non-Elective Patients	100% month on month	97.00%	96.40%	96.95%	97.98%	97.21%	97.22%	96.4%	97.1%	97.1%	97.3%	96.5%	96.9%		
Ward Traceability Compliance Number of Unfated Units	0 month on month	45	24	32	23	22	23	15	13	18	23	13	15		All units were accounted for after follow up by the Transfusion Team resulting in 100% Trust compliance
Incidence of pressure ulcers															
Grade 3 - New avoidable pressure ulcer		4	0	4	3	0	0	0	3	5	7	3	3		
Grade 3 - New unavoidable pressure ulcer		1	3	2	4	0	1	4	3	4	3	4	3		
Total Grade 3 - New pressure ulcer		5	3	6	7	0	1	4	6	9	10	7	6		
Grade 4 - New avoidable pressure ulcer		1	0	0	0	0	0	0	0	0	0	0	0		
Grade 4 - New unavoidable pressure ulcer		0	0	0	0	0	0	0	0	0	0	0	0		
Total Grade 4 - New pressure ulcer		1	0	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	6		
Reduce harm from falls															
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0	1		
Major/Severe	0	1	0	1	1	1	2	1	1	3	3	0	2		
Moderate	0	1	1	3	1	1	0	1	1	2	2	2	0		
Mandatory Training compliance Full Year Impact															
Primary Levels Excluding B&H	80%	65.2%	65.1%	65.4%	65.7%	66.0%	66.1%	68.7%	70.2%	70.2%	70.8%	Not avail	74.7%		January Data unavailability due to technical issues
Attendance at Trust Induction	80%	87.5%	87.3%	87.4%	86.9%	87.4%	87.7%	87.5%	87.6%	87.4%	87.5%	Not avail	87.6%		January Data unavailability due to technical issues
Number of surgical site infections															
Fracture neck of femur - Number of Operations	-	45	17	27	29	20	28	26	33	35	35	41	22		
Number of infections	-	0	0	0	0	0	0	1	1	1	0	0	1		
% infection rate (monthly)		0%	0%	0%	0%	0%	0%	3.8%	3.0%	2.9%	0.0%	0.0%	4.5%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	0.9%		0%			2.7%			1.9%		N/Applic			
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%									0%		N/Applic			
Total hip replacements - Number of Operations	-								23	31	11	35	14		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops. The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included reflect an interim position and are subject to change.)
Number of infections	-								0	0	0	0	1		
% infection rate (monthly)									0.0%	0.0%	0.0%	0.0%	7.1%		
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%									0%		N/Applic			
Total knee replacements - Number of Operations	-								13	20	16	33	18		
Number of infections	-								0	0	0	0	1		
% infection rate (monthly)									0.0%	0.0%	0.0%	0.0%	5.6%		
% 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	1	0	0	0	0	0	0	0	0	0	0		
NICE clinical practice guidelines and TAG compliance	80%	89.3%	84.7%	86.1%	84.6%	82.2%	82.3%	81.1%	79.9%	80.7%	80.9%	81.8%	81.6%		
Serious Untoward Incidents	-	36	41	35	51	21	10	10	9	22	15	12	9		
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		
WHO Surgical Safety Checklist	100%	100%	100%	99%	100%	100%	100%	100%	98%	99%	99%	100%	100%		
Healthcare Notes Audit															
Q.1 Does the front page of every sheet contain an addressograph label	100%	72%	79%	72%	74%	80%	76%	66%	68%	60%	63%	67%	68%		
Q.2 Does addressograph include the NHS Number?	100%	92%	90%	97%	97%	98%	95%	93%	94%	90%	89%	96%	95%		
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	84%	100%	94%	90%	78%	67%	86%	69%	72%	76%	80%	71%		
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	64%	85%	69%	77%	63%	49%	59%	57%	59%	57%	65%	57%		
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	46%	61%	67%	69%	51%	49%	45%	67%	55%	60%	56%	51%		
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	18%	21%	8%	15%	12%	14%	5%	6%	7%	19%	14%	7%		
Q.7 Is record legibly written	100%	99%	95%	100%	98%	99%	97%	99%	99%	99%	95%	97%	98%		
Q.8 Written in blue/black ink	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%		
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	100%	99%	98%	99%	100%	100%	99%	98%	97%	98%	98%	100%		
Q.10 Is date recorded for each entry	100%	88%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%	89%		
Q.11 Is time recorded for each entry	100%	75%	86%	87%	86%	89%	93%	88%	83%	84%	86%	87%	89%		
Q.12 Is there a signature of the person making the entry	100%	94%	96%	97%	92%	97%	91%	91%	87%	91%	93%	91%	93%		
Q.13 Is surname printed in block capitals	100%	58%	73%	65%	69%	71%	66%	73%	54%	70%	63%	58%	65%		
Q.14 Is the staff designation recorded	100%	58%	65%	70%	64%	68%	68%	63%	59%	63%	50%	57%	69%		
Q.15 Medical Records Audit only: Is the GMC number present	100%	38%	69%	63%	35%	46%	66%	43%	38%	55%	46%	44%	60%		
Q.16 Are any alterations / deletions scored through with a single line	100%	40%	46%	43%	55%	53%	45%	56%	44%	55%	44%	53%	44%		
Q.17 Is there a signature recorded next to any alterations/deletions	100%	28%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%	47%		
Q.18 Is there a date recorded next to any alterations/deletions	100%	24%	39%	35%	43%	39%	49%	30%	28%	43%	29%	30%	47%		
Q.19 Is there a time recorded next to any alterations/deletions	100%	17%	15%	28%	32%	47%	18%	23%	15%	19%	24%	11%	27%		
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	100%	99%	97%	88%	100%	91%	94%	96%	100%	99%	100%	100%		
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	44%	44%	60%	69%	71%	60%	36%	51%	63%	82%	91%	84%		
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%	100%	96%	80%	100%	100%	98%	91%	98%	100%	98%	100%		
Q.23 Are there any loose sheets in the Healthcare record	0%	13%	10%	3%	3%	7%	6%	9%	7%	4%	10%	7%	6%		

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

Patient Experience	Target 2013-14	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Feb 14 RAG Rating	Comments
Cancelled Operations not rebooked within 28 days	0	2	1	0	0	0	0	0	0	0	0	0	0		
Hospital Cancelled Operations	6.0%	11.5%	11.1%	9.6%	9.5%	12.0%	10.3%	8.4%	10.7%	10.7%	9.0%	N/Avail	N/Avail		Jan 14 data unavailable at the time of publication.
Number of written complaints received	-	52	45	58	37	29	38	41	55	49	35	45	41		

Complaints Responded to within agreed timescales	100%	69.2%	57.8%	94.8%	92%	90%	86.8%	93%	75%	66%	89%	N/Avail	N/Avail		Timescale of 40 working days required for data collection
Referral to Treatment waits															
Admitted Patients	90.00%	95.13%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	0.00%	0.00%	92.80%		
Non Admitted Patients	95.00%	97.97%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	0.00%	0.00%	92.77%		
Ongoing Patients	92.00%	95.64%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	0.00%	0.00%	95.87%		
A&E Quality Indicators (5 measures)															
Time Spent in A&E (Month on Month)	95%	82.49%	87.89%	96.28%	93.42%	94.43%	90.35%	90.02%	90.56%	94.53%	89.82%	85.49%	81.16%		
Time Spent in A&E (Cumulative)	95%	91.51%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%	91.33%	90.47%		
Total time in A&E (95th percentile)	95th	08:08	06:45	03:59	04:43	04:17	05:19	05:22	05:18	04:17	05:39	06:57	08:08		
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	01:10	00:57	00:40	00:54	00:41	00:45	00:42	00:49	00:43	00:46	00:57	01:19		
Time to treatment decision (median)	<60 mins	00:52	00:57	00:51	00:51	01:05	00:54	00:54	00:49	00:46	00:48	00:39	00:54		
Unplanned re-attendance rate	=<5%	6.23%	6.44%	6.34%	6.64%	6.72%	6.76%	6.39%	6.16%	5.77%	6.04%	5.57%	5.70%		
Left without being seen	>1% and <5%	0.22%	0.24%	0.19%	0.31%	0.39%	0.44%	0.28%	0.15%	0.21%	0.31%	0.17%	0.23%		
Ambulance handover times > 15 minutes	0		612	452	500	446	476	1263	1656	1485	988	901	1021		No hand over greater then 15 minutes
Ambulance handover times > 60 minutes	0		68	3	29	7	31	15	62	61	75	93	144		No hand over greater then 15 minutes
Cancer Wait Times															
2 week GP referral to 1st outpatient	93%	98.3%	96.0%	95.4%	96.2%	95.5%	95.1%	96.6%	95.8%	97.6%	96.4%	93.7%	93.4%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.6%	100.0%	98.6%	100.0%	58.5%		
31 Day	96%	99.2%	98.0%	98.2%	98.1%	96.3%	97.6%	99.3%	97.3%	98.4%	99.2%	95.4%	86.3%		
31 day second or subsequent treatment - surgery	94%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	83.3%	78.6%		
31 day second or subsequent treatment - drug	98%	98.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%		
31 day second or subsequent treatment - radiotherapy	94%	95.8%	98.3%	98.6%	95.8%	96.5%	97.4%	96.5%	97.8%	96.9%	97.6%	100.0%	93.8%		
62 day referral to treatment from screening	90%	84.2%	87.9%	100.0%	95.2%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%		
62 day referral to treatment from hospital specialist	80% (local target)	100.0%	77.8%	50.0%	0.0%	50.0%	66.7%	77.8%	66.7%	100.0%	80.0%	100.0%	90.0%		
62 days urgent referral to treatment of all cancers	85%	76.5%	85.2%	79.0%	83.4%	79.1%	85.4%	84.7%	85.6%	83.2%	88.1%	78.1%	73.8%		
SRS08: Length of Stay (Acute & MH)															
Elective	3.20	4.2	3.1	4.7	5.6	4.3	5.9	3.8	3.8	3.5	3.5	3.7	3.8		Based on DFI Peer Group UQ. Fig reported in Feb 14 relates to rolling 12 months up until Dec 13
Non-Elective	5.30	4.7	4.3	4.3	5.8	4.7	5.3	4.9	4.8	4.9	4.9	4.8	4.8		Based on DFI Peer Group UQ. Fig reported in Feb 14 relates to rolling 12 months up until Dec 13
SRS09: Daycase Rate	85%	84.6%	85.9%	84.9%	84.6%	86.4%	85.3%	84.5%	84.5%	84.0%	83.5%	N/Avail	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%			Information based on 6 months HES data to Apr 13 - Sep 13 (published Feb 14). Target for 2013-14 is measured against the England average for the period and not the national target of 80% for all procedures
Hip Replacement - Participation Rate	Eng.Ave 79.2% (target 80%)	93.0%		94.6%			91.5%			95.2%		61.0%			
Knee Replacement - Participation Rate	Eng.Ave 90.5% (target 80%)	110.5%		107.1%			102.6%			113.6%		68.5%			
Varicose Vein - Participation Rate	Eng.Ave 39.9% (target 80%)	54.1%		66.7%			68.7%			69.9%		48.0%			
All Procedures - Participation Rate	Eng.Ave 72.7% (target 80%)	96.0%		90.5%			86.4%			93.7%		69.8%			

Clinical Outcomes	Target 2013-14	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Feb 14 RAG Rating	Comments
HSMR - monthly position for 2013-14 (YTD)	<100	103.7	108.5	76.8	76.93	88.0	84.96	86.25	86.44	87.19	87.19	N/Avail	N/Avail		Latest DFI FY trend Apr 13 - Dec 13 (HSMR)
HSMR - 12 Monthly cumulative position		100.1	100.8	N/Avail	96.2	99.01	96.17	94.36	93.45	93.79	92	N/Avail	N/Avail		Latest DFI FY trend Jan 13 - Dec 13 (HSMR)
HSMR- cumulative position for 2013-14															
Pneumonia	<100	57.5	60.4	N/Avail	59.42	65.8	62.92	64.25	66.28	68.79	67.87	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Fracture of neck of femur (hip)	<100	148.7	135.89	N/Avail	127.47	125.72	121.88	107.38	95.36	87.48	78.48	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Acute Cerebrovascular disease	<100	105	108.2	N/Avail	101.95	90	100.93	94.37	94.66	91.14	106.89	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Congestive heart failure, nonhypertensive	<100	133.5	135.88	N/Avail	128.8	135.46	120.63	110.89	111.1	109.4	99.15	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
Acute myocardial infarction	<100	77.5	84.6	N/Avail	82.29	87.3	82.95	89.32	89.8	109.72	84.6	N/Avail	N/Avail		Latest DFI FY trend Dec 12 - Nov 13 (HSMR)
SHMI (based upon date of SHMI report publication)	<100	115.84	112.89	N/Avail	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%	94.1%	92.0%	96.7%	97.3%	96.8%	95.1%	93.3%	97.7%	97.7%	96.3%	94.4%	95.2%		
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	4.0%	2.6%	2.7%	3.7%	3.3%	4.4%	3.4%	2.9%	2.8%	7.7%	N/Avail	N/Avail		Jan 14 data unavailable at the time of publication.
Fractured neck of Femur															
Patients fit for surgery within 36hrs	-		17	29	26	23	25	28	28	30	30	36	20		
Number of patients admitted with FNOF who were operated on within 36 hrs	-		14	21	23	22	21	19	24	13	25	34	15		
% of patients admitted with FNOF who were operated on within 36 hrs of bei	100%		82.4%	72.4%	88.5%	95.7%	84.0%	67.9%	85.7%	43.3%	83.3%	94.4%	75.0%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	69.6%	90.9%	82.8%	81.3%	92.6%	85.7%	93.0%	94.0%	88.0%	92.0%	95.9%	96.3%		Jan 14 data unavailable at the time of publication.
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	48%	43%	38%	38%	66%	59%	51%	48%	55%	43%	41%	43%		Jan 14 data unavailable at the time of publication.
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		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%	69.2%	72.7%	68.0%	69.6%	83.9%	73.3%	82.6%	73.9%	75.0%	84.0%	92.0%	Not avail		Feb 14 data unavailable at the time of publication.
Patients who spend at least 90% of their time on a stroke unit	80%	96.4%	80.0%	88.7%	98.2%	89.8%	87.1%	87.0%	92.7%	82.2%	96.7%	91.0%	Not avail		Feb 14 data unavailable at the time of publication.
Breast Feeding initiation	75%	79.4%	80.6%	81.4%	76.9%	79.7%	78.9%	78.0%	78.6%	77.7%	79.0%	81.4%	78.0%		
Caesarean Section Rates - Total	<25%	24.9%	29.7%	26.4%	25.0%	27.3%	27.3%	25.5%	28.4%	29.4%	23.5%	25.2%	24.4%		
Caesarean Section Rates - Emergency	14.98%	9.4%	13.2%	11.3%	11.1%	10.6%	11.1%	11.1%	8.0%	14.6%	9.9%	13.6%	11.4%		
Caesarean Section Rates - Elective	12.00%	15.5%	16.5%	15.0%	13.9%	16.7%	16.2%	16.2%	17.8%	14.8%	13.6%	11.7%	12.9%		
Home Birth Rate	>=3%	6.6%	3.8%	5.2%	3.8%	5.1%	5.3%	4.5%	6.0%	2.1%	4.6%	4.1%	6.0%		
Number of readmissions within 28 days (Adult)	-		395	385	424	495	423	394	414	448	474	452	Not Avail		Min 28 day turnaround before monthly data complete, therefore subject to change.
Number of readmissions within 28 days (Children)	-		146	136	163	126	96	106	155	142	161	136	Not Avail		Min 28 day turnaround before monthly data complete, therefore subject to change.

CQUIN 2013-14	Target 2013-14	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Feb 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	90.1%	92.4%	93.1%	96.1%	98.4%	98.1%	97.3%	97.4%	97.4%	97.3%	97.8%	97.7%		RAG rating if under 95% = Red.
1b. VTE Root Cause Analysis.	payment to be received if both 1a			91.3%			89.6%			89.4%		On track			RAG rating in accordance with latest CQUIN Status report
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting															
3a.Dementia case finding	90% 3 consecutive months	2.2%	0.86%	4.35%	2.37%	3.3%	55.70%	70.8%	68.80%	79.58%	76.30%	90.57%	91.1%		
3b.initial diagnostic assessment	90% 3 consecutive months	Not avail	-	0%	100%	50%	46.70%	60.00%	35.7%	100.00%	100%	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	Not avail	-	100%	100%	100%	58.30%	36.40%	60.0%	40.00%	66.60%	95.2%	90.5%		
3d.Lead clinician and appropriate training of staff	Yes						On track								RAG rating in accordance with latest CQUIN Status report
3e.Supporting Carers of People with Dementia (monthly audit)	Yes						Q1,2 & 3 audits all completed								RAG rating in accordance with latest CQUIN Status report
LOCAL CQUINS															
1. Develop and implement AECP															
1a AECP for Chest Pain				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
1b. AECP for Pulmonary Embolism				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
1c. AECP for Supraventricular Tachycardia				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
1d. AECP for Pleural Effusion				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
1e..AECP for Painless Jaundice				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
2. Development of HOT Clinic															
2a. HOT Clinic for Paediatrics				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report
2b. HOT Clinic for Surgery				Q1 achieved			Q2 achieved			Q3 achieved		On track			RAG rating in accordance with latest CQUIN Status report

2c. HOT Clinic for Medicine			Q1 achieved			Q2 achieved			Q3 achieved			On track		RAG rating in accordance with latest CQUIN Status report
NHS ENGLAND CQUINS														
1. Friends & Family														
1a. Phased expansion of Friends and Family Test (maternity services)	Implementation by Oct 2013		From Oct 2013						19.01%	14.07%	16.74%	36.13%	45.05%	
1b. increase response rate to at least 20%	=>20% by Yr End		7.09%	9.23%	15.88%	16.93%	9.73%	16.84%	22.17%	26.67%	23.06%	20.18%	21.99%	Q3 accumulative FFT response rate = 23.9%
1c. Improve performance on staff Friends & Family Test			Survey conducted Autumn 2013 and published in February 2014. Improvement CQUIN requirement achieved.											RAG rating in accordance with latest CQUIN Status report
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m		7	5	5	4	3	2	4	5	10	9	5	RAG rating in accordance with latest CQUIN Status report
3. Quality Dashboards			On track, Q1 data submitted and feedback provided. Q2 data submitted on time.									On track		
4. Timely Simple Discharge	Improvement on baseline (37%)		N/A	50.0%	0.0%	66.7%	66.7%	100%	33.3%	50.0%	33.3%	N/Applic	0.0%	RAG rating in accordance with latest CQUIN Status report. Target = +33.3%, YTD= 51.9
5. Improved access to breast Milk -% of babies less than 33wks discharged on breast milk	Improvement on baseline		71.0%	33.0%	40.0%	75.0%	80.0%	64.2%	50.0%	50.0%	80.0%	100.0%	66.7%	RAG rating in accordance with latest CQUIN Status report. Target = 61% yr end or 64% in any one quarter (Feb 14 - criteria amended)
6. Acute Kidney Injury	Q1 Process recorded and definition in place		Q1 & Q2 achieved. Q3 on track. Process agreed to identify patients with an AKI. Working group established and meeting regularly											

REPORT TO THE TRUST BOARD
27 March 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

- Results from the National Inpatient Survey for 2013 are presented. The Trust made improvements in many areas performing better in 41 questions, worse in 10 and the same in 9 when compared with 2012. We have yet to receive the benchmarking data from the CQC on the 2013 in patient survey results.
- High Priority areas identified from the Inpatient Survey are: Noise at Night, Discharge (including danger signals, side effects of medication and delays) Food, and patients being asked about the quality of the care they have received.
- Inpatients achieved their highest response rate for the FFT to date of **40.87%**
- A&E continues to struggle with their response rate obtaining a score of just **12.85%**
- Inpatients and A&E saw increases in the Net Promoter Scores. Inpatients = **71**, A&E (inc Ambulatory care and Eye Casualty) = **74**
- Outpatients draft guidance for FFT has been received indicating no exclusions, including Paediatric Outpatients
- A new proposed method for Risk Stratification is outlined within the paper in replacement of the previous Triangulation work.
- A draft timeline for the review of the Patient Experience Strategy, Implementation Plan and Patient and Public Involvement is outlined (may be subject to change)

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

Enclosure E

	discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - **NO**

Actions required by the Board

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

Trust Board
March 2014
Patient Experience Report

1. Overview

In previous months a full Patient Experience report has been provided to Board. A decision has been made to present the full report to the Integrated Healthcare Governance Committee in order to facilitate more detailed discussion, with a summary report being presented to Board from this month onwards.

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

2. The National Inpatient Survey

2.1 Background

The National Inpatient Survey is an annual national requirement set out by CQC and carried out within every acute hospital in England. For 2013, 'Patient Perspective' (the company commissioned to conduct this work on behalf of the Trust) began the process in September, with fieldwork closing in January 2014. A consecutive sample of 850 eligible adult inpatients discharged in August 2013 were mailed a questionnaire and asked to complete it. Two reports are produced from the results. The first is the Patient Perspective report which details the Trusts performance in regards to Mean Ratings for each question, increases, decreases and no changes per questions, and national comparisons to the year previous. The second report is produced by the CQC and reports on national performance for all Trusts in 2013. This report is not available until May 2014, and therefore the information provided in this report has been taken from the **Patient Perspective report**.

2.2 The Issue(s)

2.2.1 Response Rate:
For 2013 54.3% of patients returned their questionnaires completed. This is compared with a response rate of 61.2% for 2012 (a decrease of 6.9%).

2.2.2 Outcomes

- The Trust made improvements in many areas performing **better in 41 questions**, **worse in 10** and the same in 9.
- When comparing against the national data for 2012, NGH was within the 'Average' category for 44 questions, 'Better' than the average for 9 questions and 'Worse' for 6.

2.2.3 Areas for Improvement

- When drawing conclusions from the data it is important to take into consideration all aspects of the report (mean score, national performance, 2012 comparisons) to determine which areas require improvement. The questions were then graded into 3 categories for priority: **Low**, **Medium** and **High.**
- **High** Priority Areas as identified within the Inpatient Survey are, Noise at Night, hospital food, whether the patient was asked about their views of their care and issues relating to discharge: Danger signals when at home, side effects explanations, discharge delays.

2.2.4 Next Steps

- The CQC report is due to come out in May 2014. This will highlight the Trusts performance nationally.

- Many of the High Priority areas have previously been identified through the Thematic Analysis and plans are afoot for the creation of Working Groups aligned to these issue areas.
- For those that were not identified within the Thematic Analysis i.e. Noise at Night, separate work streams have been created to look at improvement work.

3. Friends & Family Test

3.1 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).

3.2 The Issue(s)
2.2.1 Response Rates:

- Inpatient services achieved their highest response rate to date of **40.87%.** Although this is an impressive figure, 2 areas achieved over the 100% response rate which may have skewed the figures (**Appendix 1)**.
- A&E continues to struggle with their response rates obtaining their lowest rate since August 2013 of just **12.85%.** Combined with Ambulatory Care and Eye Casualty they obtained an overall response rate of **15.37%.**
- Due to the low response rate in A&E, the overall Inpatient and A&E response rate was **21.99%,** only slightly higher than the required national CQUIN target of **20%**.

3.2.2 Scores:

- A&E saw another increase in their Net Promoter Score reaching a score of 74.
- When compared nationally, A&E's averaged a score of 57, whereas NGH scored 72.
- Inpatients saw an increase from 67 in Jan, to 71 in February, hopefully pulling them back up to within the national average where they fell short in January.
- Maternity Services achieved a Net Promoter Score of 71, the same as January.
- Paediatrics scored **69** for January and **73** for February, after 2 months previously of scoring within the 40's.
- Day case areas continue to see high levels of satisfaction. Over the past financial year they have never achieved less than a score of 83. This is extremely positive. (**Appendix 2)**

3.2.3 Positive and Negative Percentage Splits:

- All areas, except Eye Casualty, have seen an improvement in their Positive/Negative split
- Inpatients, Paeds and Day cases have seen a 2.7% increase in the amount of positive comments received.
- The largest improvement can be seen in A&E Minors where they received zero negative comments for the month of February.

3.2.4 The Future of FFT

- A draft Guidance has been circulated for the Outpatient roll out which is expected to be implemented by October 2014 in line with CQUIN requirements.
- Work is currently underway to identify how this will work within the Trust taking into consideration the large amount of patients that will need to be given the opportunity to complete it, around 35,000 a month.
- Unlike Inpatients and A&E, children's outpatient areas will be expected to collect the FFT.
- The Guidance for the staff FFT has now been released. This will be managed by Organisational Development.

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

4.1 Background
Previous reviews carried out within the NHS have highlighted the need for a triangulated approach to reviewing data based around quality. For this reason NGH have made the decision

to begin triangulating information from the Friends & Family Test, PALS, Complaints and Incidents in order to establish a mechanism of review and the ability to pre-empt any potential issue areas. Two draft attempts have been made to achieve this task, presented to the Board in January and February.

4.2 The Issues

- A meeting was held with a Professor from the University of Northampton to explore how to ensure the methodology used was robust.
- As a result of this meeting, a decision has been made to continue the quarterly theming of complaints and incidents etc. but to stop the monthly triangulation process as it was not giving us value in its current format. Instead we are commissioning a review of the current dashboards in collaboration with Professor Campbell to ensure they are making the most effective use of the information available to us. In addition, we are considering developing a new model for risk stratification, this will be a 2 stage process as outlined below:

Phase 1: Review of current dashboards

1. Carry out a comprehensive review of the dashboards which are currently active including QuEST, Nursing and Midwifery Dashboards and Master dashboard
2. Assess them all for their robustness and effectiveness in providing the information needed to inform decisions.
3. Review the current reporting mechanisms including the weighting of information and how the data is used in practice.
4. Consider how to include the information which has previously been used within the Triangulation process i.e. FFT, Complaints, PALS etc (and incidents where possible)

Phase 2: Create a Risk Stratification Model

5. From the information collected currently, produce a comprehensive Risk Stratification Model which is able to use the information collected to accurately predict potential areas of risk within the hospital.
6. Included within this will be all components from current dashboard, and the information which has previously been used within the Triangulation process i.e. FFT, Complaints and PALS.

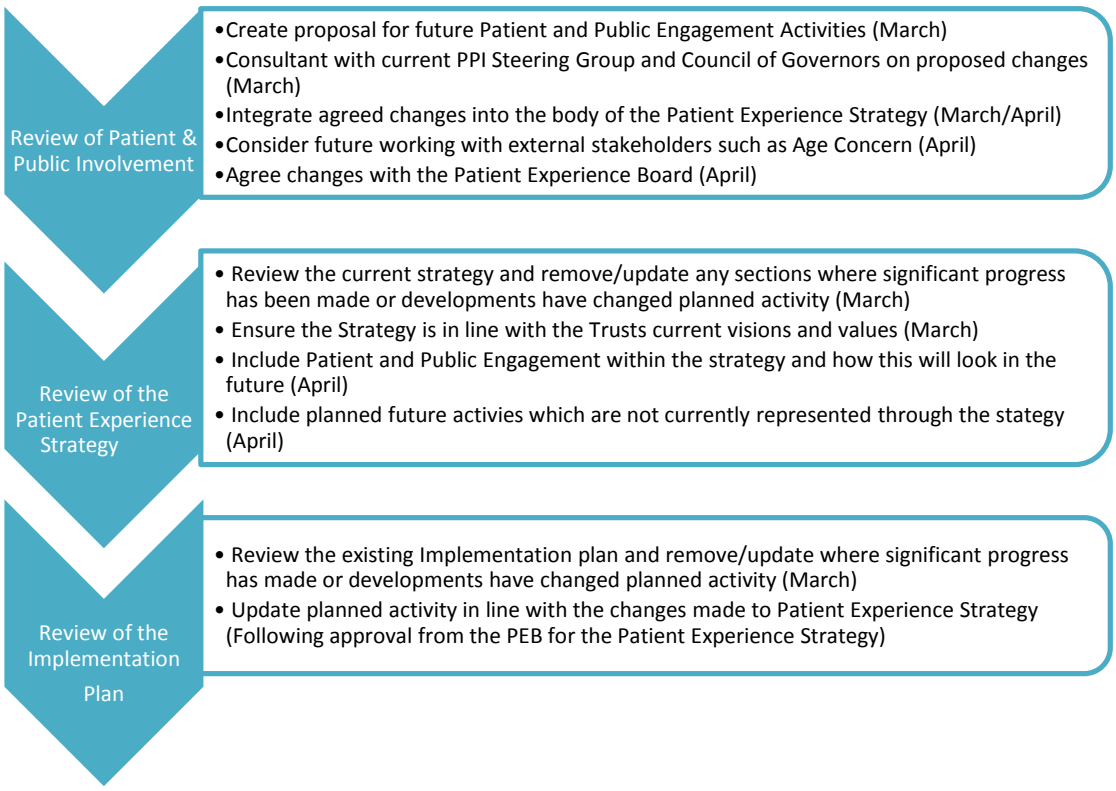
5. Patient Experience Strategy and Implementation Plan Review

5.1 Background

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

6.2 The Issues

- A draft timeline has been established for this review (this may be subject to change


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

Appendix 1 – Response Rates for Friends & Family Test

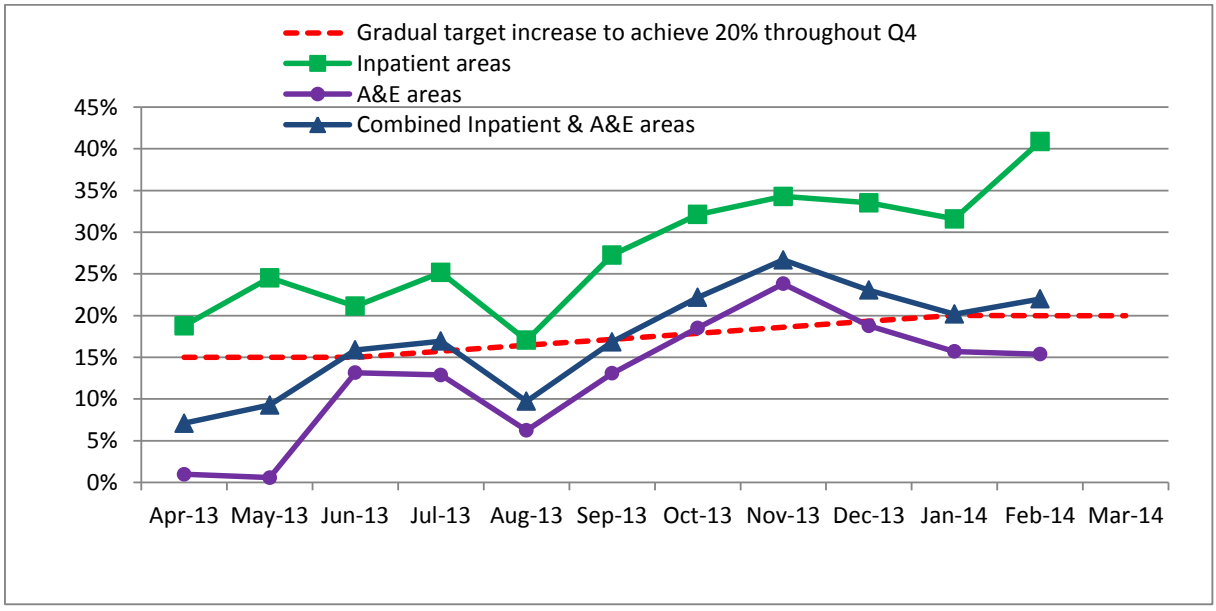
Friends & Family Net Promoter Response Rates	Target 10%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target 15%	Target Q4 2013-14 20%	Target Q4 2013-14 20%	Target Q4 2013-14 20%
Ward	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**
Abington	43.33%	25.00%	30.61%	27.03%	23.64%	11.76%	8.16%	33.33%	89.66%	25.00%	38.89%	24.49%	
Allebone	22.83%	51.02%	32.98%	23.75%	25.40%	14.29%	11.11%	25.93%	14.29%	14.58%	26.32%	14.63%	
Althorp	43.00%	54.84%	33.33%	32.93%	70.21%	59.42%	56.52%	52.17%	21.59%	41.07%	60.00%	70.51%	
Becket	32.08%	40.43%	43.28%	42.65%	37.97%	17.39%	23.33%	55.26%	32.14%	45.90%	29.31%	70.73%	
Benham	7.91%	12.00%	21.43%	19.41%	23.94%	14.63%	19.82%	40.00%	35.71%	20.37%	27.03%	35.40%	
Brampton	67.86%	37.84%	40.00%	9.38%	38.89%	34.38%	34.62%	30.00%	28.57%	36.17%	31.91%	25.81%	
Cedar	25.71%	19.18%	10.34%	7.55%	34.12%	17.82%	22.11%	13.04%	56.00%	52.78%	53.40%	77.55%	
Collingtree	13.56%	7.06%	37.33%	28.46%	25.83%	20.65%	18.60%	13.73%	10.53%	25.21%	12.15%	24.18%	
Compton	77.78%	80.00%	156.25%	84.21%	106.67%	100.00%	18.60%	107.69%	164.29%	95.65%	105.56%	126.67%	
Corby Comm.	30.00%	0.00%	9.52%	39.13%	92.86%	26.32%	61.54%	100.00%	33.33%	20.00%	40.00%	75.00%	
Creaton	21.05%	7.81%	18.07%	16.67%	11.25%	6.35%	17.39%	20.37%	19.51%	21.21%	46.97%	24.32%	
Danetre	39.53%	39.47%	54.29%	24.24%	43.93%	15.79%	70.59%	41.94%	84.62%	51.72%	64.71%	40.91%	
Dryden	24.79%	28.32%	19.67%	2.15%	9.65%	4.27%	17.58%	24.11%	16.33%	31.07%	9.52%	21.98%	
Eleanor	21.74%	38.10%	51.11%	29.31%	44.07%	34.38%	39.58%	50.82%	28.95%	54.24%	36.36%	37.10%	
EAU	3.15%	14.45%	26.77%	22.79%	11.00%	7.82%	10.16%	10.75%	15.94%	28.28%	16.13%	14.63%	
Finedon	21.62%	31.25%	46.51%	22.92%	57.89%	31.37%	34.62%	26.79%	36.17%	57.89%	18.52%	41.67%	
Hawthorn	37.68%	33.85%	30.04%	33.02%	27.78%	25.93%	47.65%	48.47%	58.95%	61.50%	60.78%	72.12%	
Hazelwood Comm.	60.71%	77.78%	60.00%	50.00%	105.56%	57.89%	73.33%	120.00%	66.67%	72.22%	50.00%	164.71%	
Head & Neck	40.46%	17.48%	29.81%	38.32%	31.30%	20.39%	32.50%	40.70%	28.21%	22.47%	21.28%	36.25%	
Holcot	53.57%	83.33%	54.55%	68.75%	72.73%	50.00%	155.56%	88.24%	141.18%	114.29%	63.33%	53.13%	
Knightley	52.17%	25.64%	40.38%	43.64%	59.57%	100.00%	51.28%	36.11%	57.89%	40.00%	22.45%	54.76%	
Rowan	32.84%	16.15%	18.18%	13.48%	24.71%	13.71%	29.41%	23.63%	33.13%	10.31%	14.89%	22.73%	
Spencer	12.79%	10.73%	15.86%	15.30%	15.43%	13.99%	16.20%	23.31%	21.58%	20.61%	17.91%	34.45%	
Talbot Butler	12.00%	8.93%	26.42%	24.75%	47.52%	36.11%	38.37%	23.53%	30.00%	27.84%	29.07%	34.69%	
Victoria	10.45%	15.07%	17.31%	6.98%	34.92%	17.07%	7.14%	25.37%	36.36%	17.95%	28.21%	29.27%	
Willow	21.30%	11.11%	27.37%	28.95%	11.46%	16.13%	16.83%	52.75%	24.68%	20.56%	18.33%	17.78%	
Adult Inpatient Area Total	15.15%	18.78%	24.53%	21.13%	24.61%	16.52%	27.26%	32.31%	34.30%	33.53%	31.59%	40.87%	
Accident & Emergency Unit	0.48%	1.02%	0.25%	15.22%	13.49%	6.60%	15.12%	16.06%	22.12%	18.07%	15.01%	12.85%	
Ambulatory Care Centre							45.83%	22.47%	24.68%	8.60%	17.86%	10.22%	
Eye Casualty Unit		0.72%	2.38%	1.04%	9.23%	4.06%	1.11%	31.22%	33.11%	24.19%	18.85%	28.96%	
Accident & Emergency Total		0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%	15.37%	

Enclosure E

Appendix 1 – Response Rates for Friends & Family Test

Antenatal Community								1.14%	6.86%	5.14%	31.71%	29.28%
Birth Centre										36.95%	100.00%	103.92%
Home Birth								35.71%	53.85%	51.72%	115.79%	88.89%
Labour Ward								33.06%	18.44%	24.51%	27.21%	49.04%
Maternity Observation Ward				0.00%	0.00%	0.00%	0.00%	17.39%	3.13%	13.64%	71.43%	11.54%
Balmoral	37.34%	54.59%	60.82%	Closed	Closed	Closed	Closed	Closed	Closed	0.00%	14.29%	68.18%
Robert Watson	30.00%	26.32%	32.41%	33.96%	40.06%	18.15%	26.22%	35.38%	21.22%	36.64%	41.51%	64.91%
Postnatal Community								3.33%	9.27%	3.45%	31.85%	38.71%
Maternity Services Total		41.42%	23.08%	28.57%	33.33%	14.47%	21.28%	19.01%	14.07%	16.74%	36.13%	45.05%
Disney	10.13%	17.46%	32.66%	24.74%	35.82%	29.59%	79.05%	50.91%	46.08%	26.71%	101.33%	65.52%
Paddington	9.79%	5.88%	10.41%	10.57%	21.23%	13.61%	35.84%	36.97%	24.07%	16.28%	23.53%	22.11%
Paediatric Ward Total		9.55%	17.65%	15.14%	26.09%	18.99%	51.22%	40.73%	30.86%	20.60%	45.80%	35.31%
Danetre Day Surgery	30.88%	50.00%	60.64%	29.25%	34.19%	47.55%	20.54%	24.39%	23.44%	10.87%	42.11%	47.86%
Main Theatre Admissions	50.00%	67.47%	52.42%	24.14%	17.28%	60.42%	17.82%	18.59%	86.29%	55.00%	62.00%	58.96%
NGH Day Surgery	12.43%	29.17%	28.62%	34.49%	23.20%	17.46%	48.61%	41.13%	39.39%	36.96%	23.19%	37.24%
Singlehurst Day Unit		2.44%	5.48%	9.93%	9.43%	19.70%	11.11%	6.50%	7.28%	1.52%	21.69%	18.38%
Daycase Area Total		40.30%	32.40%	27.34%	20.70%	29.72%	28.59%	24.33%	37.78%	27.65%	35.52%	39.97%

Inpatient services saw response rates reach the highest levels since collections began. However, 2 areas (Compton and Hazelwood) had response rates considerably over their 100% meaning the overall response rate increased because of this. Some areas in Inpatients are still failing to reach the 20% target and some areas which have worked hard to increase their response rates have seen them begin to slowly decrease.



Appendix 1 – Response Rates for Friends & Family Test

A&E are a real cause of concern for response rates, only managing to achieve 12.85%, the lowest response rate since August. Despite Inpatients achieving a response rate of 40.87% , when combined with the A&E rate the Trust again only just managed to achieve above the required 20% response rate, achieving 21.99%. The Friends & Family Test CQUIN states that the Trust needs to reach 20% throughout the whole of Quarter 4.

	Q1			Q2			Q3			Q4		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%	15.7%	16.4%	17.2%	17.9%	18.6%	19.3%	20.0%	20.0%	20.0%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	27.26%	32.13%	34.30%	33.53%	31.59%	40.87%	
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%	15.37%	
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	16.84%	22.17%	26.67%	23.06%	20.18%	21.99%	

Maternity services continue to increase their response rates reaching 45.05%. This is an extremely impressive achievement as they collect not only within the hospital but also out in the community. They have also only been required to collect from October 2013, and still they see far higher levels of response even to some areas that have been collecting for nearly 2 years. **Please note that the eligible figures for the Maternity Observation Ward have potentially been reported incorrectly due to an administration error.**

Despite not being part of the essential collection criteria at the moment, Paediatrics' and Day Case areas continue to bring in lots of responses and NGH are very proud of the fact we are managing to collect within these extra areas, given us a substantial amount of information from our patients on how they are receiving the services.

Appendix 2 – Net Promoter Scores for Friends & Family Test February

Friends & Family Net Promoter Score Results

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

Enclosure E

Appendix 2 – Net Promoter Scores for Friends & Family Test February

Antenatal Community								100	71	44	70	71
Birth Centre										100	89	83
Home Birth								100	71	100	100	94
Labour Ward								73	72	66	69	70
Maternity Observation Ward								50	0	83	53	25
Balmoral	86	64	74	Closed	Closed	Closed	Closed	Closed	Closed		57	90
Robert Watson	76	56	59	42	46	43	61	60	69	51	55	62
Postnatal Community								100	87	82	78	72
Maternity Services Total		62	66	42	46	43	61	70	72	64	71	71
Disney	58	64	70	85	75	82	74	80	63	41	82	77
Paddington	46	38	51	62	57	53	57	69	27	40	48	68
Paediatric Ward Total		53	63	74	66	69	67	74	44	41	69	68
Danetre Day Surgery	98	94	89	90	85	92	100	97	93	90	98	93
Main Theatre Admissions	87	82	83	97	96	88	87	90	87	94	97	95
NGH Day Surgery	94	82	83	86	94	91	83	79	87	82	81	89
Singlehurst Day Unit		100	88	73	80	92	79	77	91	100	88	68
Daycase Area Total		84	85	88	91	90	85	83	88	88	93	90

Inpatient Services

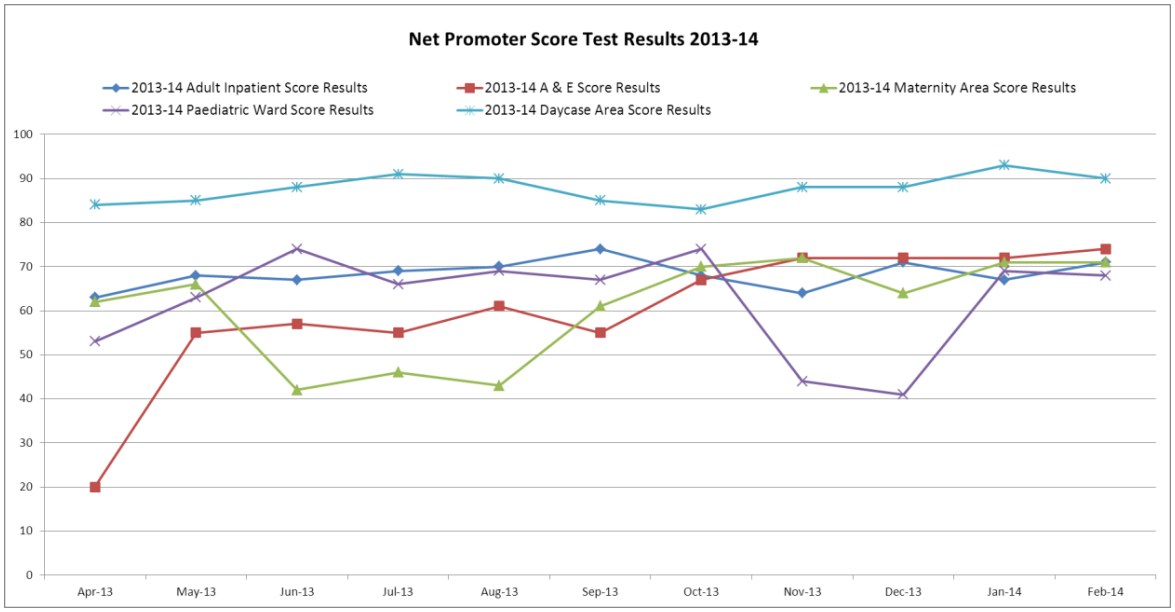
Adult inpatients saw their Net Promoter Score increase to the score they achieved in January of 71. Achieving above the score of 80 set as the target internally were:

Althorp
Becket
Eleanor
Hazelwood
Head and Neck
Willow

Particularly low scores can be seen in:

Benham
Corby Community
EAU
Hawthorn

Appendix 2 – Net Promoter Scores for Friends & Family Test February



A&E Services

A&E (inc Ambulatory Care and Eye Casualty) continue to see high levels of satisfaction as they increased even further from score of 72 in January to 74 in February. Each area individually obtained a score within the 70's.

Maternity Services

Maternity Services remained at 71 accumulated across the pathway, with particularly high levels of satisfaction seen within Balmoral Ward, Home Birth and the Birth Centre all scoring above the Trusts target of 80. The lowest NPS can be seen within the Maternity Observation Ward which obtained a score of 25.

Paediatric Services

Paediatric services continued with their score in the late 60's, after a number of months of low scores we hope to see this continue to rise.

Day Case Areas

Day case areas regularly see the highest levels of satisfaction as can be seen on the graph below. Over the past financial year they have never achieved less than a score of 83. This is extremely positive.

This graph shows each of the areas in which NGH currently collects FFT, tracked for the NPS across the past financial year.

Comparing Nationally

Area	Month	NGH Score	National Average Score
A&E	January	72	57
Inpatients	January	67	72

REPORT TO THE TRUST BOARD
27 MARCH 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 February 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.
- The MRSA blood culture taken in A/E on 03 February 2014 was attributed to the Clinical Commissioning Group (CCG)
- The MRSA blood culture taken in ITU on 23rd February was attributed Rowan Ward as a post 48hr MRSA bacteraemia.
- Danetre had a period of increased incidence (PII) in February which was managed efficiently and effectively.
- National Guidance has been published on the management of carbapenemase-producing Enterobacteriaceae (CPE). This report outlines how this will be managed at NGH.

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 24 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	
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

Enclosure F

	will affect different population groups differently (including possibly discriminating against certain groups)? **No**
Legal implications / regulatory requirements	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections. (DH 2008)

Actions required by the Board

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

Northampton General Hospital NHS
NHS Trust

Trust Board
27 March 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 February 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
February 2014	1	3	99.6%	96.9%	1	0

The MRSA blood culture taken in A&E on 03 Feb 2014 that was found **not** to be a contaminate has been apportioned to the **CCG.**

The MRSA blood culture taken on the 23rd Feb on ITU is a **post 48hr** bacteraemia which is apportioned to **Rowan ward**. Further details can be found in Appendix 1.

2.2 *Clostridium difficile*

	>3 day case of *C.diff*	*Total to date*
February	1	24

This puts the Trust below the CDAD trajectory (29) from January 2014 onwards

2014/15 Clostridium difficile infection objectives

NHS England has published Clostridium difficile infection objectives for acute trusts and clinical commissioning groups for the financial year 2014/15. These objectives have been calculated on the basis of requiring continuous improvement from all trusts and CCGs, but also reflect a need for organisations with higher rates of infections to do more than those organisations with lower rates. In addition to the revised objectives, NHS England has also published new guidance setting out how commissioners can exercise discretion in deciding whether or not to impose sanctions on providers for breach of their Clostridium difficile objective, allowing them to take into account specific circumstances relating to identified infections in determining whether sanctions are appropriate.

The CDI objective for 2014/15 for NGH is 35. This is above this year's total of 29 and as a result, an internal stretch objective will be set and reported in next months board report.

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

	>48 hrs E.coli	*Total of mean of four >48 hrs E.coli a month*
February	6	4

Enclosure F

2.4 The management of carbapenemase-producing Enterobacteriaceae (CPE).

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However these organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections**.**

National guidance has just been published around this issue and in response to this, a plan is being produced for the early detection, management and control of CPE. This plan will be presented at the April Infection Prevention Committee for approval and implementation. An update will be reported in the next board report.

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 have explored how surgical site infections may be reported in a more robust fashion in the future. A rolling years' worth of results will be presented for the next board report.

	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
Dec	94	1	-	-	35	0	19	0	17	0
Jan	-	-	15	Not yet available	41	0	35	0	33	0
Feb	-	-	14	Not yet available	22		14		18	

Please note that:

- Surveillance for the February 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 December C-section SSIs is still underway due to the large number of patients to follow up.

4.1 Period of Increased Incidence (PII)

Danetre ward had a PII from 17th February until 22nd February with a total of 4 patients and 3 members of staff were affected with diarrhoea and or vomiting who were all nursed in side rooms. The 4 patients were confirmed with Norovirus.The guidance for the management of Norovirus outbreaks in the Acute and Community health and social care setting (2012) states it is based on principle of minimising the disruption to important and essential services and maximising the ability of organisations to deliver appropriate care to patients safely and effectively. A balance between the prevention of spread of infection and maintaining organisational activity and to move away from the traditional approach of complete ward closure is more logical. This incidence was managed efficiently and effectively; well done to all involved.

4.2 Patients with confirmed H1N1 influenza

Swine flu is a relatively new strain of influenza (flu) that was responsible for a flu pandemic during 2009-2010. It is sometimes known as H1N1 influenza because it is the H1N1 strain of virus. On 10

August 2010, the World Health Organisation (WHO) declared that the swine flu pandemic was officially over. However, this does not mean that swine flu can be ignored. The swine flu virus will be one of the main viruses circulating this winter. It has therefore been included in the 2012-13 seasonal flu vaccine*,* and for this reason, we do expect to occasionally admit patients who have H1N1.

The patient with confirmed H1N1 influenza reported in last month's board report was discharged home. The other patient confirmed after the January Board report unfortunately died from pneumonia. All infection prevention precautions are being undertaken within the critical care setting.

5. Hand Hygiene Audit

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

Month	Percentage	Areas that did not submit and reason
February	Overall score was 90.8% Ward compliance was 97.9%	Danetre OP sent their data late due to clinical pressures Eye OP/Casualty and Dryden ward had inputted but there was an error in the system. Haematology OP,Althorp and Manfield DSU had issues with inputting that is being rectified.

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

February 2014, saw the sixth month of Beat the Bug Stop the Clot, Save the Skin unfortunately this month only 4 areas have been reviewed. This was compacted by IPT sickness and a reduced number of staff. Matrons were asked to replace IPT but due to unforeseen pressures in their clinical areas this was not possible. These quality visits are important and therefore every effort should be made for them to be undertaken in the future. The success of these audits will be evaluated at the April 2014 board development meeting.

7. Education and Training

January mandatory training percentage was unable to be reported due to an issue with the system; however as of the 28th February compliance was 62.8%. Additional measures put in place to help meet the monthly targets include: the number of places offered for mandatory Infection Prevention and Control training have been increased, we are reviewing a more user friendly eLearning package and the feasibility of a work book for non-clinical staff as alternatives to attending face to face training are being considered.

8. Assessment of Risk

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

9. Recommendations/Resolutions Required

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

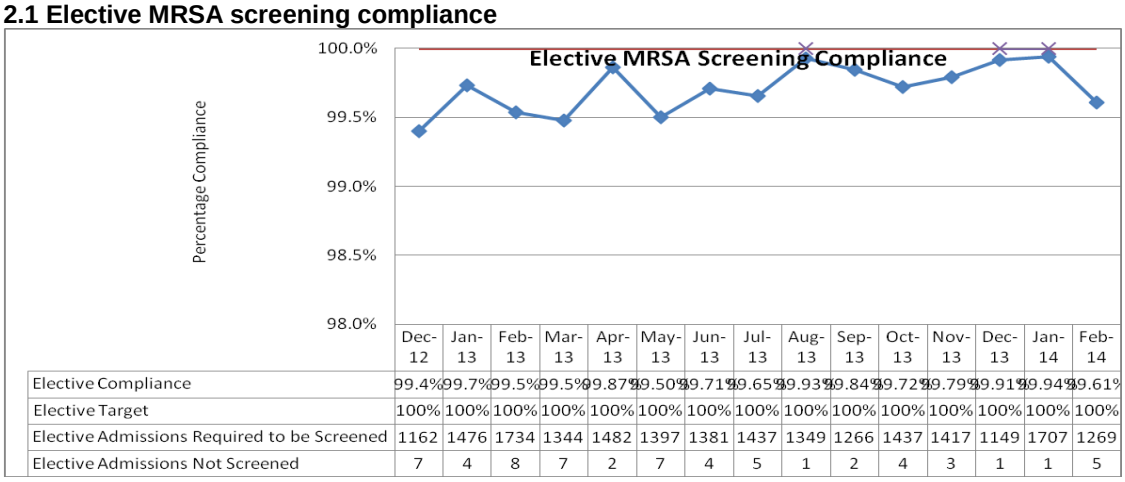
10. Next Steps

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

Appendix 1

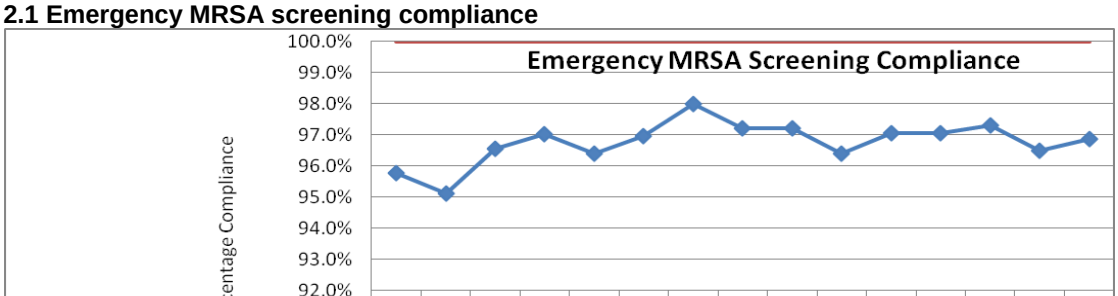
Elective and Emergency MRSA Screening Compliance

2.1 Elective MRSA screening compliance



	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	Feb-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%	99.61%
Elective Target	100%	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	1269
Elective Admissions Not Screened	7	4	8	7	2	7	4	5	1	2	4	3	1	1	5

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	Feb-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%	96.9%
Emergency Target	100%	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	1121
Emergency Admissions Not Screened	51	55	38	35	38	34	22	32	30	40	35	33	34	44	35

2.1 MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

During February 2014 there were 4 <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*) was apportioned the the CCG

The Post Infection Review (PIR) meeting identified that this may well have been some haematogenous spread from her chest to cause a low grade bacteraemia due to her COPD/pneumonia. The blood cultures were taken correctly and management was clear. Therefore this was apportioned to the CCG.

Enclosure F

2.1 MRSA Bacteraemia (Meticillin Resistant Staphylococcus *aureus*) Post bacteraemia

This was attributed to Rowan ward; however a whole health economy approach is being taken to reviewing this case, involving: the community, nutritional services, ITU, and Hawthorn ward.
Once the RCA has been completed, a comprehensive action plan will be developed by the Surgical Care Group and learning will be shared at the next CQEG meeting, IPC and the Board meeting.

2.1 Victoria ward on special measures

Victoria ward was put onto special measures in February 2014 due to 2 patients identified with MRSA colonisations (late screens) within a 28 day period.

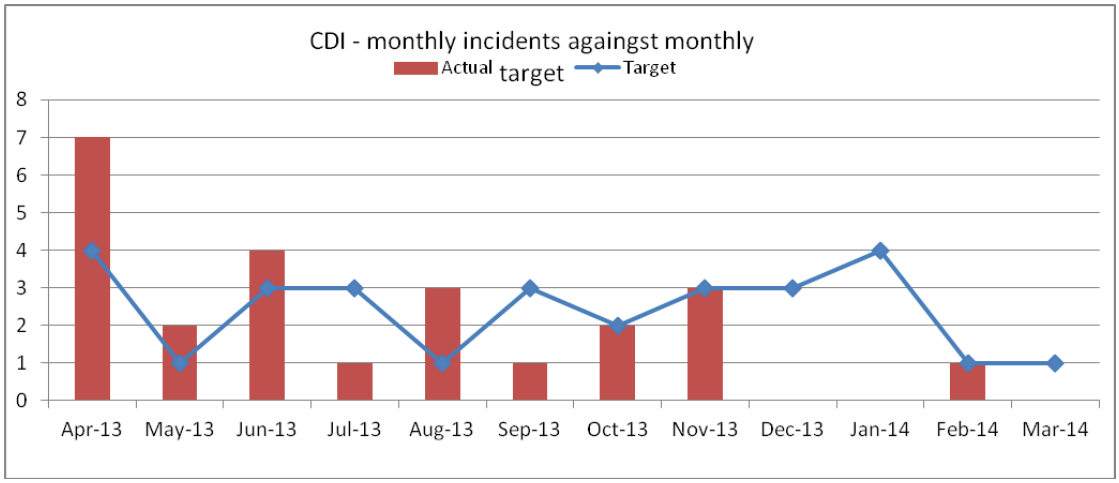
A special measures meeting was held on the 4/3/2014 with the ward Sister, infection prevention and the matron. It was agreed to provide timelines for both patients. Daily hand hygiene observational audits were performed which have been at 100 % compliance. PVC and urinary catheter audits were also performed.
A cleaning audit was performed this was at 81%, high level dust, and contaminated commodes were noted. These results were fed back to the ward sister and staff during the ward huddle. This was re audited the following week and the results were much improved at 95%.
Staff hand hygiene has also been checked on ward staff, and teaching at the ward huddles about MRSA screening of patients, and when to commence decolonisation treatment.

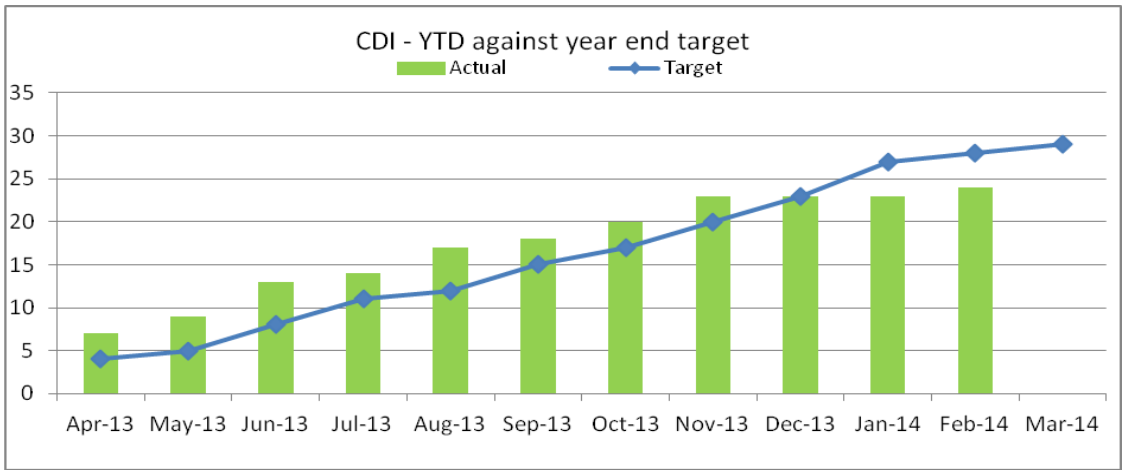
2.2 *Clostridium difficile*

The Trust has an annual target of 29 *C.diff* cases or less for the financial year.
During February **1>3 day case of *C.diff*** were identified against a monthly target of 4 post three day cases, which remains at a total 24 for the yea, putting the trust below CDAD trajectory.

The RCA meeting has not been undertaken and will be fed back at the next month's board report.

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





Month	Inappropriate Sample	Appropriate Sample
April 2013	3	4
May 2013	2	0
June 2013	1	3
July 2013	0	1
August 2013	2	1
September 2013	0	1
October 2013	0	2
November 2013	0	3
December 2013	0	0
January 2014	0	0
February 2014	0	1
Total	**8**	**16**

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.

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

The 6 bacteraemias for February were all from different wards with no obvious cross over. The wards involved were Collingtree Medical, HDU, Cedar, Allebone, Compton and Talbot Butler. The initial findings were 1 unknown cause, 1 long-term urinary catheter, 2 urosepsis and 1 neutrosepsis, and 1 central line involvement. The RCAs are in progress and a report will be produced for the next board report.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 MARCH 2014

Title	Operational Performance Report
Agenda item	10
Sponsoring Director	Rebecca Brown, Acting Chief Operating Officer
Author(s)	Rebecca Brown, Acting Chief Operating Officer Debbie Needham, Acting Chief Operating Officer
Purpose	The paper is represented for discussion and assurance

Executive summary

The Trust has not achieved the following standards during February 2014; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O. The Trust has not achieved the following cancer standards; 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 31 day for subsequent surgical treatment, 31 day for subsequent radiotherapy treatment, 62 day standard (from urgent GP referral),

The number of patients waiting over 26 weeks from referral has increased from 45 to 85. This is an unvalidated position and validation is ongoing for completion by 19th March 2014.

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

The Board is asked to discuss the content of the report and agree any further action as necessary

Access Rating - Summary

Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Q1	Q2	Q3
RTT waiting times – admitted patients treated within 18 weeks	CCG & TDA	90%	95.02%	96.16%	95.79%	95.75%	97.38%	95.00%	92.50%	92.06%	93.94%	91.72%	93.78%	N/A	N/A	N/A
RTT waiting times – non-admitted treated within 18 weeks	CCG & TDA	95%	97.87%	98.02%	97.99%	98.99%	98.44%	98.34%	98.58%	98.88%	99.00%	98.45%	98.32%	N/A	N/A	N/A
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	CCG & TDA	92%	96.36%	96.46%	96.67%	96.30%	96.85%	97.32%	97.12%	97.14%	96.95%	96.90%	95.87%	N/A	N/A	N/A
RTT waiting times - ongoing >26 weeks			63	46	63	40	35	31	19	30	47	45	55	N/A	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0	0	N/A	N/A	N/A
RTT T&O Admitted	CCG & TDA	90%	91%	90%	91%	90%	90%	90%	62%	64%	77%	71%	87%	N/A	N/A	N/A
RTT T&O Non-Admitted	CCG & TDA	95%	95%	95%	95%	98%	95%	95%	93%	96%	96%	96%	96%	N/A	N/A	N/A
RTT ENT Admitted	CCG & TDA	90%	93%	95%	92%	97%	96%	95%	93%	92%	95%	87%	90%	N/A	N/A	N/A
RTT ENT Non-Admitted	CCG & TDA	95%	97%	98%	96%	99%	98%	98%	98%	98%	99%	97%	96%	N/A	N/A	N/A
Diagnostic waiting times (number of patients waiting > 6weeks)	CCG & TDA	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	N/A
Cancelled Operations rebooked within 28 days (as per SITREP definitions)	CCG & TDA	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	N/A
Cancelled Urgent Operations 2nd time	CCG & TDA	0	0	0	0	0	0	0	0	0	0	1	1	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%	81.16%	N/A	N/A	N/A
A&E: Total time in A&E (cumulative)	CCG & TDA	95%	87.89%	92.10%	92.55%	93.06%	92.52%	92.11%	91.88%	92.20%	91.94%	91.33%	90.47%	91.63%	92.50%	92.01%
Cancer: 2 week GP referral to 1st outpatient	CCG & TDA	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	95.80%	97.60%	96.30%	93.70%	93.40%	95.87%	95.74%	96.76%
Cancer: 2 week GP referral to 1st outpatient - breast symptoms	CCG & TDA	93%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	99.65%	100.00%	98.60%	100.00%	58.50%	100.00%	99.65%	99.55%
Cancer: 31 Day	CCG & TDA	96%	98.00%	98.20%	98.10%	96.30%	97.60%	99.30%	97.30%	99.30%	99.20%	95.70%	86.30%	98.12%	97.76%	98.56%
Cancer: 31 day second or subsequent treatment - surgery	CCG & TDA	94%	100.00%	100.00%	95.50%	100.00%	100.00%	94.10%	100.00%	100.00%	100.00%	82.80%	86.20%	98.15%	98.08%	100.00%
Cancer: 31 day second or subsequent treatment - drug	CCG & TDA	98%	100.00%	98.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.20%	96.80%	99.40%	100.00%	100.00%
Cancer: 31 day second or subsequent treatment - radiotherapy	CCG & TDA	94%	98.32%	98.60%	95.80%	96.50%	97.40%	96.50%	97.80%	95.80%	95.70%	99.20%	98.10%	97.73%	97.30%	96.66%
Cancer: 62 day referral to treatment from screening	CCG & TDA	90%	87.88%	100.00%	95.20%	100.00%	95.20%	100.00%	100.00%	96.30%	100.00%	100.00%	95.70%	94.12%	98.72%	98.04%
Cancer: 62 days urgent referral to treatment of all cancers	CCG & TDA	85%	85.20%	79.00%	83.40%	79.10%	85.40%	84.70%	85.60%	83.90%	86.60%	79.50%	75.20%	82.04%	83.44%	85.30%
Proportion of people who have a TIA who are scanned and treated within 24 hours	CCG & TDA	60%	72.73%	68.00%	69.57%	83.87%	73.33%	82.61%	74.00%	80.00%	84.00%	92.00%		70.00%	79.76%	77.94%
Proportion of people who spend at least 90% of their time on a stroke unit	CCG & TDA	80%	80.00%	88.71%	98.18%	89.83%	87.14%	86.96%	92.73%	82.22%	96.67%	91.00%		88.95%	87.88%	91.22%
Trolley Waits waiting > 12hours	CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handover Times (with number of patients over 15 minutes)	CCG	15 mins	612	452	500	446	476	1263	1656	1485	988	901	1021	N/A	N/A	N/A
Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes)	CCG	30 mins	196	160	193	125	112	206	346	298	283	316	372	N/A	N/A	N/A
Ambulance Handover Times (with number of patients over 60 minutes)	CCG	60 mins	68	3	29	7	31	15	62	53	75	93	144	N/A	N/A	N/A

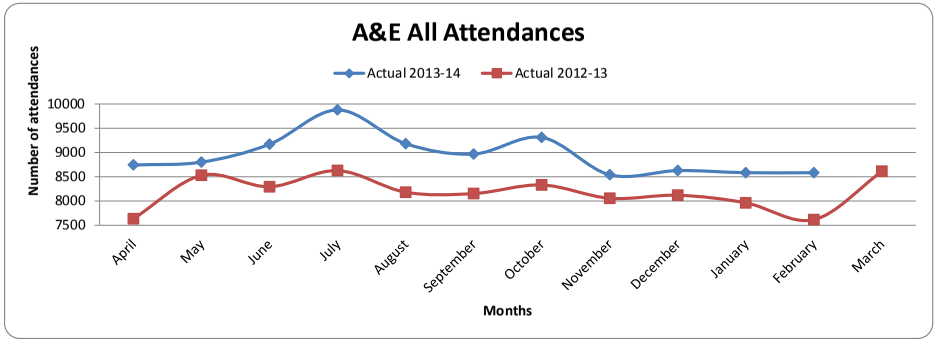
* A&E data is calendar month.

The Trust has not achieved the following standards during February 2014; Urgent Care 4 hour standard and 18 weeks admitted specialty standard for T&O . The Trust has not achieved the following cancer standards; 2ww breast symptoms, 31 day standard from decision to treat to start of treatment, 31 day for subsequent surgical treatment, and 62 day standard (from urgent GP referral).

The number of patients waiting over 26 weeks from referral has increased from 45 to 85 .

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 February the emergency pressures continued with higher than anticipated AE attendees and admissions.

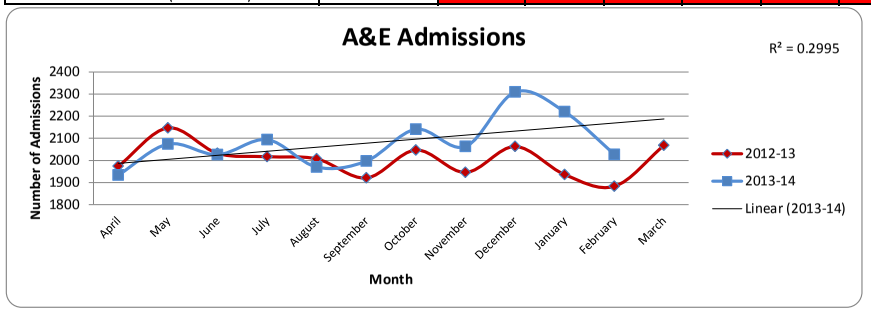
Unfortunately we did not meet the 95% standard in February for the 4hr transit time. This was predominantly due to poor bed flow and an increasing number of delayed discharges.

We continue to work closely with NCC, CCG and NHFT to reduce the delayed discharges. Directorates have been working up plans to divert GP referrals out of AE, which will support better patient flow, faster assessment and reduce the occupancy in AE.

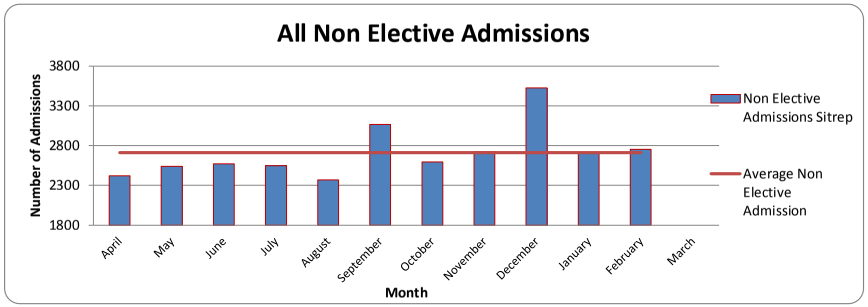
During the first week of March the Trust as a result of the continued high numbers of patients coming in to the hospital, and the acuity of these patients, the executive decided to call an internal major incident.

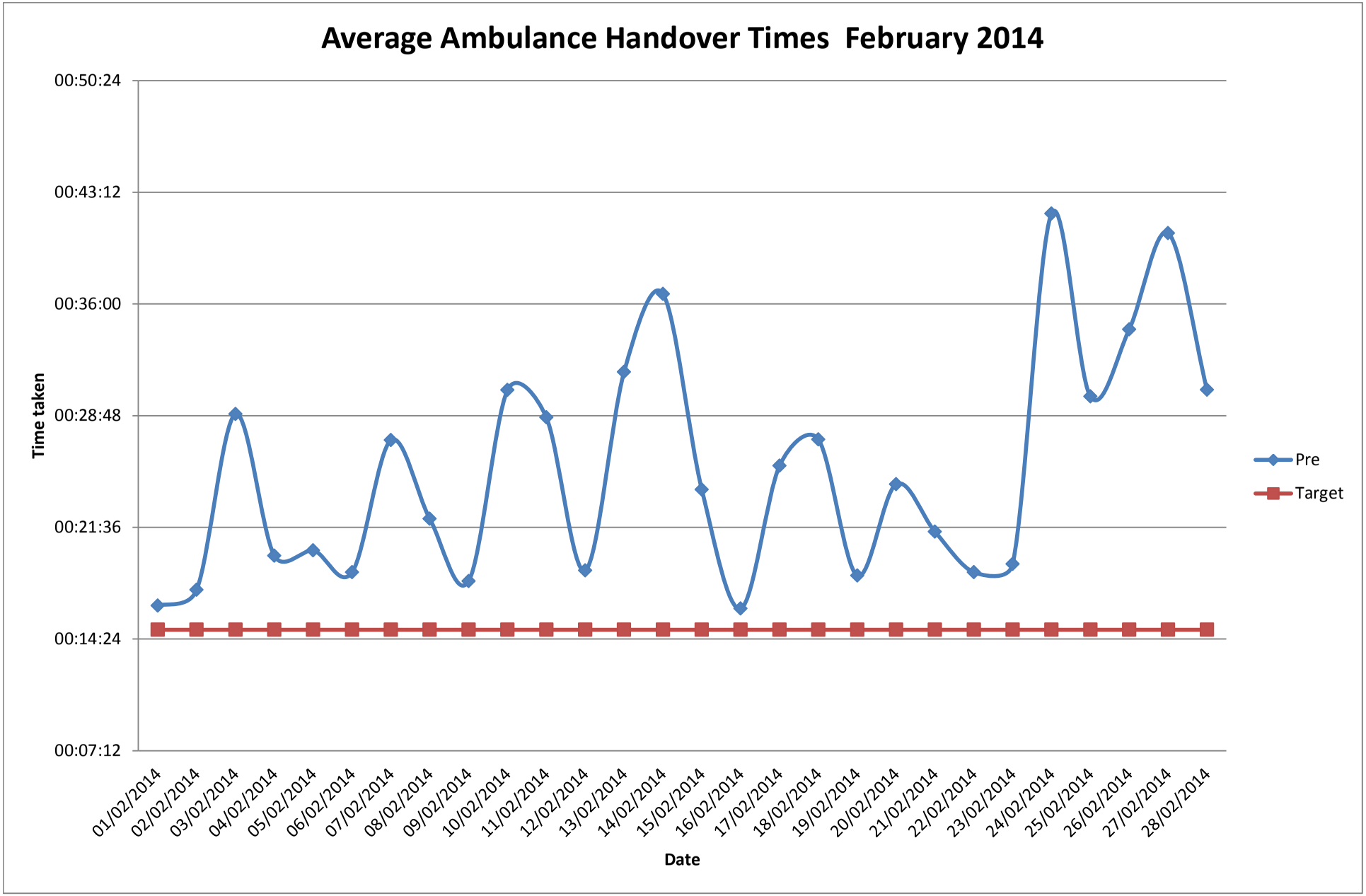
Key actions were
All patients in the Trust were reviewed and discharged where at all possible
All non-urgent activity unless already pre-arranged was cancelled
All escalation areas were used for capacity

A&E Targets	Target	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
A&E: Total time in A&E (monthly)	95%	87.9%	96.3%	93.4%	94.4%	90.4%	90.0%	90.6%	94.5%	89.8%	85.5%	81.2%	
A&E: Total time in A&E (cumulative)	95%	87.9%	92.1%	92.6%	93.1%	92.5%	92.1%	91.9%	92.2%	91.9%	91.3%	90.5%	



* Note: Total Admissions from the Symphony system




Average Ambulance Handover Times February 2014
00:50:24
00:43:12
00:36:00
00:28:48
00:21:36
00:14:24
00:07:12
Time taken
01/02/2014
02/02/2014
03/02/2014
04/02/2014
05/02/2014
06/02/2014
07/02/2014
08/02/2014
09/02/2014
10/02/2014
11/02/2014
12/02/2014
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14/02/2014
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19/02/2014
20/02/2014
21/02/2014
22/02/2014
23/02/2014
24/02/2014
25/02/2014
26/02/2014
27/02/2014
28/02/2014
Date
Pre
Target

Cancer

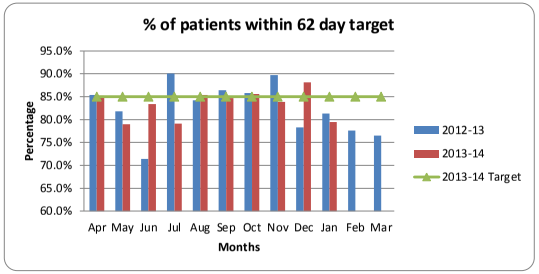
Access Summary Target or Indicator	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Q1	Q2	Q3
Cancer: 2 week GP referral to 1st outpatient	93%	96.00%	95.40%	96.20%	95.50%	95.10%	96.60%	95.80%	97.60%	96.30%	93.70%	93.40%	95.87%	95.74%	96.76%
Cancer: 2 week 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%	58.50%	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%	95.70%	86.30%	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%	82.80%	86.20%	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%	95.20%	96.80%	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%	99.20%	98.10%	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%	95.70%	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%	79.50%	75.20%	82.04%	83.44%	85.30%

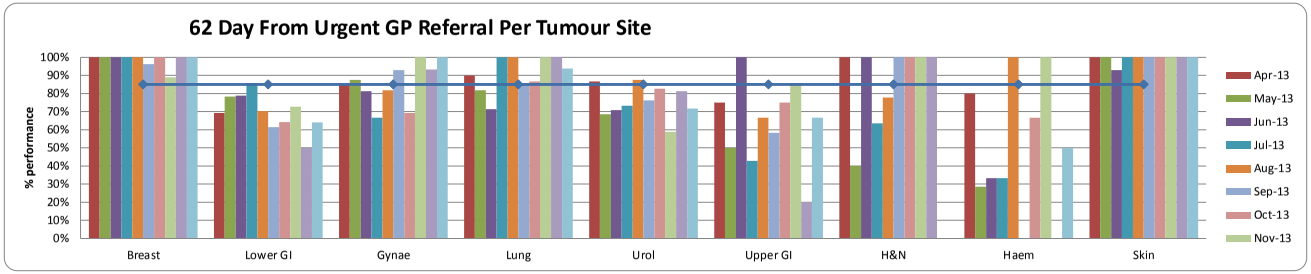
The Trust has been unable to achieve the 2ww breast symptomatic, 31 day first treatment and 31 day subsequent surgery. standards in February. These figures are not validated.

This has been as a result of reduced capacity within one service. Locum consultants are now in post and improvements can be seen in March across these standards.

There is a local agreement that breaches due to patient choice and complex pathways are excluded from the standard-62 days from consultant upgrade. As a result Trust are achieving the consultant upgrade target for January and February.

The Cancer Waits Recovery Board recovery plan continues to be updated to reflect the changing demands on the cancer standards and progress has been discussed at the IHGC.

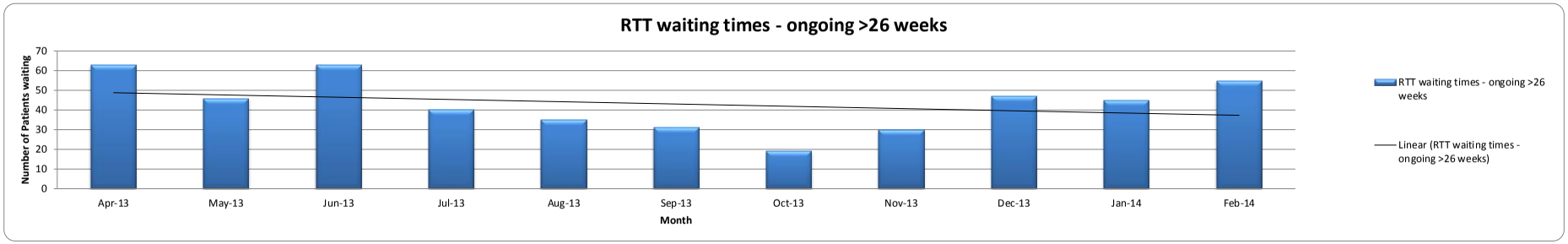




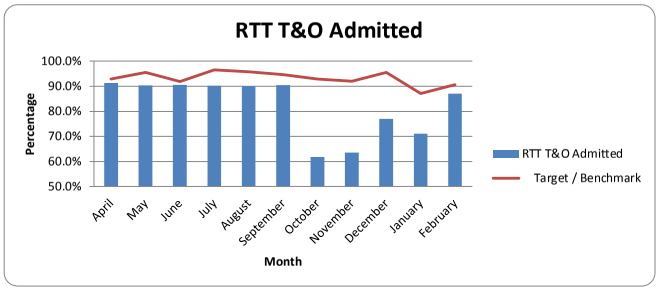
RTT Waiting Times

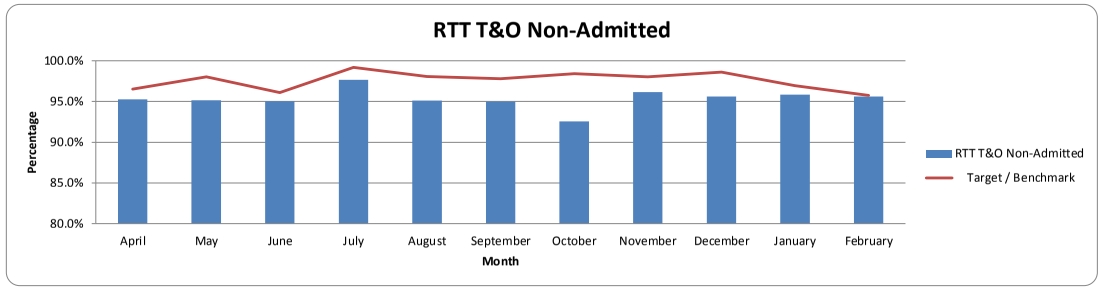
Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Q1	Q2
RTT waiting times - ongoing >26 weeks		0	63	46	63	40	35	31	19	30	47	45	55	N/A	N/A
RTT waiting times - ongoing >52 weeks	CCG & TDA	0	0	0	2	1	1	0	0	0	0	0	0	N/A	N/A

Key Notes:
The Trust has met the overall RTT target for February. At speciality level T&O continues to work on their recovery plan and are currently on track to deliver the March position. The pressure from the non-elective activity continues to put the speciality level targets at risk.



Access Summary Target or Indicator	Monitoring Regime	Target / Benchmark	April	May	June	July	August	September	October	November	December	January	February
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%	87.0%
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%	95.6%
RTT ENT Admitted	CCG & TDA	**90%**	92.9%	95.5%	91.9%	96.5%	95.7%	94.7%	92.9%	92.0%	95.5%	87.1%	90.6%
RTT ENT Non-Admitted	CCG & TDA	**95%**	96.5%	98.0%	96.1%	99.2%	98.1%	97.8%	98.4%	98.0%	98.6%	97.0%	95.7%





REPORT TO THE TRUST BOARD
27 MARCH 2014

Report Title	Urgent Care Report
Agenda item	11
Sponsoring Director	Rebecca Brown, Acting Chief Operating Officer
Author(s)	Richard Wheeler , Urgent Care Project Manager
Purpose	For Information and assurance

Executive summary

The Urgent Care Programme has been established for 2 years, and is continuously evolving and being reviewed to ensure the correct challenges are being addressed by the right teams and the Trust is building on the significant progress already been made.

This report details at a high level the current structure and five work streams of the Programme and its associated governance and links into the wider Urgent Care Programme within Northamptonshire.

Related strategic aim and corporate objective	1. Provider of quality care
Risk and assurance	Risk to the delivery of services
Related Board Assurance Framework entries	BAF 11 & 12
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	The consistent failure to achieve the transit time standard means that the Trust is in default in the regulatory framework provided by the Trust Development Authority (TDA)

Enclosure H

Actions required by the Board

The Board is asked to note the contents of this paper.

Urgent Care Report

1. Urgent Care Programme Structure

Following the last report dated 20th January 2014, the structure of the Urgent Care Programme has remained in most part the same, however, the Workforce and 7 day working work stream has been significantly expanded and renamed 7 day Services. The work stream is now managed by Amanda Bisset and Suzanne Lee. More information on the work stream can be found in the appropriate section.

The structure of the Urgent Care Programme is shown in **Figure 1**, which also shows the wider structure of the Urgent Care Governance across Northamptonshire.

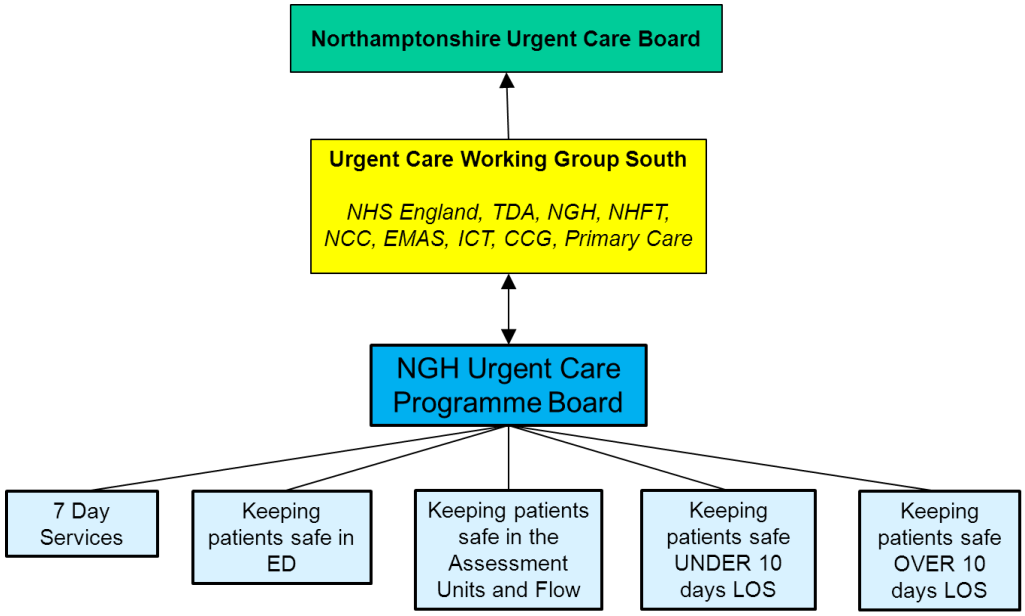


Figure 1

2. Urgent Care Working Group South and Increased Admissions

The Urgent Care Woking Group South continues to meet once a week and NHS England Local Area Team maintain the chair. The Group remains focused on what changes and improvements within the entire health ecomnomy can be implemented 'tomorrow or next week' to relieve the prssures faced by NGH. Furthermore, work is also underway to address why the number of ED attendences and admissions is rising at the rate it is. This is best illustrated in **Table 1** which shows the comparison between April 2012 and February 2013. The months of December and January are highlighted to indicate the significant increase in Admissions the Trust has seen year on year.

Month	Performance	Attends 2012	Attends 2013	Vari %	Adm 2012	Adm 2013	Vari %
April	87.89%	7633	8742	15	1974	1934	-2
May	96.28%	8529	8801	3	2147	2074	-3
June	93.44%	8293	9170	11	2032	2026	0
July	94.43%	8626	9878	15	2017	2094	4
August	90.35%	8180	9182	12	2007	1970	-2
September	90.02%	8152	8968	10	1921	1997	4
October	90.56%	8330	9311	12	2047	2141	5
November	94.57%	8055	8539	6	1946	2063	6
December	89.82%	8118	8627	6	2063	2309	12
January	85.49%	7961	8583	8	1936	2220	15
February	81.16%	7614	8286	9	1883	2027	8

Table 1

3. Operational Management challenges

In response to the pressures which continue into 2014, the Trust has been forced to undertake some drastic actions.

Operation Deep Dive - 21st February 2014

To combat the additional demand on the hospital and attempt to put the Trust in a good position going into a weekend, Operation Deep Dive was held on the 21st February 2014. The initiative had three objectives,

1. To facilitate discharges with coordination from NGH, CCG, NHFT, NCC, ICT
2. Subsequently improve patient flow through the hospital
3. To maintain the highest level of patient safety

The initiative was successful in that approximately 150 discharges were achieved, about 50 more than on a normal day. What is important to note, is that the figures included a high percentage of complex discharges requiring significant involvement from all health partners, which normal take a significant time to arrange.

Internal Major Incident – 3rd March – 6th March 2014

The 1st, 2nd March saw significant attendances to ED and fewer discharges than expected, culminating in an extremely challenging situation for the Trust. Subsequently an Internal significant Incident was called on the 3rd March and lasted for 3 days. General Managers, Service Managers and Matrons were focused on relieving the pressures and improving patient flow resulting in 30 additional discharges per day.

Bronze & Silver command was put in place to control and command situation and unblock any discharge issues. All non-urgent elective activity was cancelled, staff were deployed (including those from partner organisations) to wards to facilitate patient care and facilitate discharges to ensure patient safety. Blocks were identified and resolved.

Over the 3 day period there were significantly increased discharges:

Discharges:
Sunday 2/3 – 38 discharges
Monday 3/3 – 138 discharges
Tuesday 4/3 – 128 discharges
Wednesday 5/3 – 98 discharges

ED breaches decreased:
Monday 3/3 – 91breaches
Tuesday 4/3 – 42 breaches
Wednesday 5/3 – 8 breaches
Thursday 6/3 – 7 breaches

4 hour performance
Monday 3/3 – 66.2%
Tuesday 4/3 – 71.8%
Wednesday 5/3 –97.3%
Thursday 6/3 – 97.7%

This focused management approach although successful is not sustainable so measures are being taken to ensure the same levels of results are achieved without the senior management present.

4. Overview of Urgent Care Programme Work Streams

7 day Services (formally Workforce & 7 day working)

The scope of the work stream has been significantly expanded and now covers all Urgent Care Services and support services. This will ensure that once implemented, services facilitating Urgent Care are always available, and such areas are achieving professional standards 7 days a week. This follows national guidelines regarding 7 day working and ensuring CQUIN targets are meet.

To help manage the implementation, the services involved have been split into 2 working groups, A & B, for which membership can be seen below in **Table 2**.

Group A	Group B
• Portering	• Therapies
• Pathology	• Hotel Services
• Radiology	• Medical Records
• Cardiology	• IT
• Pharmacy	• Ward Managers/Sisters/Clerks
• Matrons	• Estates
• Clinical Directors	• Site Management
• Site Management	

Table 2

The work stream was initiated in February so is in the very early stages. Within the next Trust board paper, progress will be reported and a timeline on implementation available.

Keeping Patients safe in the ED

Throughout the start of 2014, the Trust continues to see increased attendances, impacting the 4hr transit time, as shown in **Table 3**.

	<1 hr	1-2 hr	2-3 hr	3-4 hr	> 4 hr	Total Attendances	Total <4hr	total % < 4hr	total % > 4hr
Sep-13	1601	2291	1809	2372	895	8968	8073	90.02%	9.98%
Oct-13	2023	2068	1802	2539	879	9311	8432	90.56%	9.44%
Nov-13	1758	1967	1664	2686	464	8539	8075	94.57%	5.43%
Dec-13	1834	1846	1481	2588	878	8627	7749	89.82%	10.18%
Jan-14	2005	1932	1416	1985	1245	8583	7338	85.49%	14.51%
Feb-14	1629	1872	1294	1930	1561	8286	6725	81.16%	18.84%

Table 3

However, the department has made positive steps over the past few months.

- Staffing levels are now mapped to ED demand
- ENP, ANP, Clinical Educator and band 7 posts within ED are in the process of being filled
- 2hr safety rounds continue to take place and figures are improving month on month as shown in **Table 4**.

Nov 13	Dec 13	Jan 13
52.50%	**48.12%**	**62.35%**

Table 4

- Final end user testing is underway for the use of red flags within Symphony
- Rapid assessment happening for ambulances held to ensure patients are seen and appropriate actions implemented. Rapid assessment plan being developed, and will be implemented within new ED layout, to be completed by December 2014
- GP presence in ED helping to relieve some of the pressures on staff by treating less acute patients
- The space created by the ACC move has created and Emergency Observation Area
- ATOS have completed their investigations and outcomes to be implemented will be fed into this work stream.
- Part of the wider Urgent Care Programme, but most relevant for ED; following discussion at the Urgent Care Working Group South, the CCG will complete an Audit over 3 days within ED to investigate why patients are presenting and what has led to their attendance. It is hoped results will provide a greater understanding of whether the patient has seen their GP, tried to make an appointment but been unsuccessful, thought illness was suitable for ED etc.

Keeping patients safe in the Assessment Units and Flow

- The change made to the on-take rota in the Assessment Units is now embedded to ensure continuity through same Consultant care. This can be seen in the Time to Consultant Review for both day and night. Figures show that these figures are improving and are set upon Royal Collage guidelines.
- The Ambulatory Care Centre has seen month on month increase since its launch in September. The figures for the Centre can be seen in **Table 5**.

	Sep	Oct	Nov	Dec	Jan
Outpatient	9	15	11	8	11
Inpatient	22	79	74	94	140

Table 5

These figures are likely to start dropping off sue to the Centres relocation to accommodate the development of ED.

- The work stream is also in the process of implementing improved handover documentation to provide staff with the information they need and initiate the EDD process. Furthermore, the Bed Management and Escalation Policies are being reviewed.

Keeping patients safe UNDER 10 days LOS

Over the past 12 weeks, this work stream has focused on the discharge process of a patient's journey. Significant review of the TTO process has taken place and changes have been made.

- For wards with a high turnover, such as Collingtree, EDN completion is being targeted earlier in the day for both Doctors and Pharmacists.
- The Pharmacy department now prioritises EDN's and Outpatient work over other tasks such as stock replenishment. This has resulted in a reduction in dispensary time from 179 minutes to 69 minutes, a 61% decrease. This means that with the average delivery time from Portering (post 16:30) being 9 minutes, wards are receiving patients TTO's easlier.
- The use of prepacks in the Trust has been reviewed. EAU, Benham, Dryden and Eleanor are now using prepacks for specific and suitable TTO's. This will speed up discharges and relieve some of the dispensary work sent to Pharmacy.
- Doctors will be asked to use the appropriate box within EDN to document when the prescription is required for to ensure TTO's not for same / next day are left until an appropriate time.
- Ward Workspace phase 2 developments will be controlled through this work stream and incorporate criteria for discharge and EDD, to help embed the system and gain trust over the dates entered.

Keeping patients safe OVER 10 days LOS

Despite Community Hospitals being decommissioned and run by NHFT from the 1st April, involvement with these beds must be incorporated into the Urgent Care Programme. This is the process of being arranged.

Current tasks detailed on the programme include:

- Plan for failed day cases in surgery
- Training on Nurse Facilitated Discharge at community wards - Oct '13. Ongoing monitoring of NLDs
- Implement and refine community MDT to reduce LOS
- Review admission criteria for community beds - Sept '13, after which monitor adherence
- Introduction of non-weight bearing process
- Create joint community support for urgent treatment at home - commenced and ongoing
- Complex discharge training for staff
- Twice weekly review and Analysis of the 200 patients with a LOS over 10 days.
- Refine and further develop dementia pathway with NCC
- Review current Discharge to Assess project and work to incorporate NCC patients

REPORT TO THE TRUST BOARD
27 March 2014

Title	Finance Report Month 11 – February 2014
Agenda item	12
Sponsoring Director	Simon Lazarus, Director of Finance.
Author(s)	Andrew Foster, Deputy Director of Finance.
Purpose	To report the financial position and associated risks for the period to February 2014.

Executive summary

The report sets out the financial position for February 2014 (month 11).

The year to date I&E position is a deficit of £2.2m. This position includes £4.1m of non-recurrent support from the TDA (£4.5m agreed for the full year) and £1m of recovery actions in February.

The underlying gross forecast I&E position before recovery actions is for a deficit of £7.8m, (£3.3m after TDA support of £4.5m is included). A range of recovery actions totalling £3m has been identified to date giving rise to a potential risk of not delivering a breakeven by the financial year end. The TDA have been informed of a potential risk of up to £0.5m at the IDM meeting on 11th March.

The Trust indicative plan for 2014-15 is for a deficit of £7.8m. Current cashflow forecasts suggest that an application to the TDA to access additional temporary borrowing is required to be progressed and secured in time for Q2 2014-15.

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

Enclosure I

Actions required by the Board

The Board is asked to note the current financial position and forecast I&E position 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 11 2013/14

Report to
Trust Board
March 2014

1. Performance against Statutory Duties & Key Issues

	YTD Actual	YTD TDA Plan	Variance	Forecast outturn	Full Year Plan	Variance
Statutory Financial Duties:	£'000	£'000	£'000	£'000	£'000	£'000
Delivering I&E Breakeven duty	-£3,286	-£4,304	£ 1,018 Fav	-£237	-£4,822	£4,584
Achieving EFL (£000's)				£3,723	£3,723	£0
Achieving the Capital Resource Limit (£000's)	£10,153	£11,207	£ 1,054 Fav	£14,211	£14,211	£0
Better Payment Practice Code:						
Volume of Invoices	90.73%	95.00%	4.27% Adv	92.00%	95.00%	3.00% Adv
Value of Invoices	92.16%	95.00%	2.84% Adv	93.00%	95.00%	2.00% Adv

Financial Performance

- Financial performance for the period ended February 2014 is a deficit of £3.286m including £4.125m of TDA support. A range of recovery actions planned for deployment in February totalling £1m reduce the reported I&E deficit to £2.286m.
- The latest forecast I&E position for the year is for a net deficit after TDA support of £3.3m which must be recovered to achieve I&E breakeven.
- The overall forecast remains tight with a risk to delivery of a breakeven position of **up to £0.5m** currently forecast after application of recovery actions.
- The TDA have been informed of the latest position and risk to delivery of breakeven.

Capital Expenditure

- Expenditure is £1.054m behind plan at the end of February. Expenditure is forecast to increase significantly in March and regular meetings with scheme leads to monitor progress are in 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 created an additional capital contingency of £0.5m in the 2014/15 capital programme.

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

- The Trust has maintained a positive cashflow position in the final quarter and is forecasting to manage resources within the prescribed External financing Limit. The Trust has not needed to access the £4m temporary borrowing facility established with the TDA.

Key issues

- TDA non recurrent support of £4.1m included in latest financial position, with remaining £0.375m to be accrued in month 12.
- Month 11 position indicates that forecasts were largely achieved in month.
- Forecast breakeven is potentially achievable but has become more challenging with a potential gap of up to £0.5m identified overall.
- Actions and additional measures have been identified to deliver breakeven but performance in March is now key.
- Operationally the hospital has been challenged in February in March with peak demand experienced in Urgent Care driving up premium costs.
- All other statutory duties forecast to be delivered.
- The Trust will need to apply again for temporary borrowing in 2014-15 and an early assessment of the cashflow position for Q1 is included in this report.

Actions

- Managers are reminded to control expenditure in the remaining weeks of the financial year
- Action plan to deliver break even to be reviewed at finance committee and with auditors.
- Management actions set out in slide 6 to be implemented in run up to the financial year end.
- Risk to delivery of breakeven to be reported to Trust Board.
- TDA to be kept fully abreast of potential risks to breakeven position (before 31/3/2014).

2.Financial Performance Dashboard

KPIs	February		January	December
Continuity of Service Risk Rating	2	Monitor CSR Rating 2 ("Material risk")	2	2
EBITDA %	4.0%	% Earnings Before Interest, Tax and Depreciation.	4.7%	3.6%
Liquidity (days cover)	14	Liquidity cover based on latest Monitor guidance.	30	33
Surplus Margin	-1.34%	% earnings after interest, tax and depreciation.	-0.77%	-1.85%
Pay / Income	65.1%	Total YTD Pay costs as % of YTD income.	65.8%	65.6%
I&E Position	**£000's**		**£000's**	**£000's**
Reported Position	(1,345)	Surplus before impairment and donated assets	609	(1,768)
Impairment and Donated Assets	(1,942)	Reduction due to revised DV indices	(2,307)	(1,905)
Normalised Position	(3,286)	I&E position (before £1m recovery actions)	(1,699)	(3,673)
TDA Plan (Year to date)	(4,304)	TDA Plan for year to February 2014 (Normalised).	(3,174)	(3,014)
CCG SLA Income Variance	4,540	CCG income is £4.5m above plan	1,193	4,248
TDA Normalised annual plan	0	Revsied Full year TDA control total.	0	0
Forecast EOY I&E postion	(237)	Current I&E forecast (incl. TDA £4.5m non-rec support)	0	(2,440)
EBITDA Performance	**£000's**		£000's	£000's
Variance from plan	1,018	Improvement after TDA support has been accrued	1,475	(659)
Cost Improvement Schemes	**£000's**		**£000's**	**£000's**
YTD Plan	11,637	TDA Plan to February.	10,261	8,880
YTD Actual	10,212	Actual delivered to February.	9,377	8,468
% Delivered	88%	% delivery of Plan year to date.	91%	95%
LTF	11,544	LTF. All R,A,G schemes will deliver in full.	11,769	11,655
Annual Plan	13,000	Annual CIP target.	13,000	13,000
LTF v. Plan	89%	Planned annual % delivery of Plan.	91%	90%
Capital	**£000's**		**£000's**	**£000's**
Year to date expenditure	10,153	Capital expenditure for year to date £1m behind plan.	7,487	6,227
Committed as % of plan YTD	96%	% of plan committed for year to date.	87%	78%
Annual Plan	14,405	CRL increased (ICT/CEF/SWTF/Nurse Tech /Matemity fund bids)	14,109	14,119
SoFP (movement in year)	**£000's**		**£000's**	**£000's**
Non-current assets	984	Reduction in non current assets due to depreciation.	1,637	(223)
Current assets	(142)	Increase in cash offset by reduction in accruals.	4,329	(266)
Current Liabilities	(3,329)	Increase in capital creditors and accruals.	(2,266)	937
Cash	**£000's**		**£000's**	**£000's**
In month movement	1,173	Collection of older debt and mandate payments in advance	3,037	201
In Year movement	6,005	TDA £4.5m support received in February 14.	4,832	1,795
DH Temporary Loans	0	TBL Loan facility of £4m available but not accessed in 13/14.	0	0
Debtors Balance > 90 days	1,560	CRIPPS centre, MKPCT, NCA and Overseas Patients.	1,534	1,818
Creditors % > 90 days	0.00%	No creditors over 90 days.	0.00%	0.00%
Cummalative BPPC (by volume) YTD	90.7%	BPPC improved in February but below 95% target.	89.8%	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 fell behind forecast trajectory in January but was on target in February.

Cost Improvement Programme

- CIP programme latest thinking forecast £11.5m. Assumes delivery of red, amber schemes in this figure.
- Year to date performance now £1.4m behind plan.

Capital

- Underspent against plan by £1m but plans in place to spend full CRL in 13/14.

Statement of Financial position

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

Cash

- Liquidity has improved in February with the receipt of the TDA £4.5m system support funding in February.

3.Income and Expenditure Position

I&E Summary	Annual Plan 2013/2014	YTD Actual	YTD Plan	Variance to Plan	February 2013/14 Forecast	February 2013/14 Actuals
	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	216,830	212,290	4,540	18,714	18,874
Other Clinical Income	2,803	2,321	2,569	(248)	224	183
Other Income	26,031	22,659	23,536	(877)	2,075	2,090
Total Income	**260,584**	**241,810**	**238,396**	**3,415**	**21,013**	**21,147**
Pay Costs	(175,851)	(160,181)	(160,890)	709	(14,887)	(14,890)
Non-Pay Costs	(79,240)	(75,927)	(72,625)	(3,303)	(7,040)	(7,086)
CIPs	4,822	0	4,238	(4,238)	0	0
Reserves/ Non-Rec	(1,143)	0	(502)	502	0	0
Total Costs	**(251,413)**	**(236,108)**	**(229,779)**	**(6,329)**	**(21,927)**	**(21,975)**
EBITDA	**9,171**	**5,702**	**8,616**	**(2,915)**	**(914)**	**(828)**
					0	0
Depreciation	(10,184)	(9,593)	(9,371)	(222)	(873)	(855)
Amortisation	(10)	(9)	(9)	(0)	(1)	(1)
Impairments	0	2,240	0	2,240	0	(301)
Net Interest	29	28	27	1	2	3
Dividend	(4,106)	(3,837)	(3,764)	(73)	(352)	(346)
					0	0
Surplus / (Deficit)	**(5,100)**	**(5,470)**	**(4,500)**	**(970)**	**(2,137)**	**(2,329)**
Normalised Postion:						
Donated Assets	278	298	196	102	65	65
Impairments	0	(2,240)	0	(2,240)		301
I&E Position (before TDA support)	**(4,822)**	**(7,411)**	**(4,304)**	**(3,107)**	**(2,072)**	**(1,963)**
TDA Support 13/14		4,125		4,125	375	375
Recovery actions		1,000			1,165	1,000
I&E Position		**(2,286)**	**(4,304)**	**1,018**	**(532)**	**(588)**

Financial Performance

- Financial performance to February 2014 is a deficit of £3.286m after including £4.125m of TDA support. A range of actions planned for deployment in February totalling £1m reduce the reported I&E deficit to £2.286m.
- 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 £3.3m which must be recovered to achieve I&E breakeven. A range of actions to achieve this are set out in slide 6.
- The position for February tracked largely to forecast overall.
- The overall forecast remains tight with a risk to delivery of a breakeven position of **up to £0.5m** currently forecast.

Key issues

Clinical Income (SLA and Other)

- Clinical income is £1.4m behind the forecast trajectory pending final agreement with Commissioners and accounting for partially completed spells.

Other Income

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

Pay Expenditure

- Pay met the control total set however costs of locum medical and nurse agency staff continue to increase due to the extreme levels of non-elective demand experienced in February .

Non Pay Expenditure

- Non pay expenditure has met forecast although engineering, RTT outsourcing and one-off redundancy costs are all above the planned trajectory in February.

Depreciation and PDC

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

Forecast

- There is a risk to delivery of the required breakeven position of up to £0.5m based on the current forecast and assumptions. This risk has been highlighted to the TDA at the IDM meeting on 11th March.

4.Clinical Income – CCG Analysis

Commissioner	M10 YTD	M11	M12	TOTAL
Nene CCG	154,286,026	13,993,541	15,153,653	183,433,220
Nene ARMD Meds (£1.567m other Inc)	0			0
Nene WIP (see FRP action plan)	0			0
Corby CCG	3,180,410	381,158	421,996	3,983,564
SCG	25,702,648	2,591,828	2,869,524	31,164,000
Milton Keynes	2,719,956	253,019	280,128	3,253,104
East Leics	551,380	*46,529*	*60,100*	658,008
NHS Leics	74,591	*6,346*	*8,197*	89,134
West Leics	70,435	*5,987*	*7,733*	84,155
Beds	439,899	*37,453*	*48,376*	525,727
NCB	6,781,066	*602,504*	*781,091*	8,164,661
NCAs	2,817,781	375,916	299,730	3,493,427
Central Adj WIP / Provisions	-136,106	68,053	68,053	0
Winter Pressures	1,100,000	470,000	470,000	2,040,000
WIP	0			0
EMSCG NICU (non-rec)	416,667	41,667	41,667	500,000
Total	**198,004,751**	**18,874,000**	**20,510,249**	**237,389,000**

Activity & Financial Performance

Nene CCG (£185m year end agreement)

- The forecast above includes the £185m year end agreement offered by Nene CCG.
- A further agreement to cover partially completed spells will allow for a further £450k to be accrued for NENE CCG in 13-14 although this sum is not cash backed. Activity will become chargeable to the CCG as patients are discharged in 2014-15 under normal PbR rules.

Specialised Services (£31.6m year end agreement)

- Agreement has been reached with specialised commissioners agreeing a fixed year end settlement which includes 0% fine for MRET penalties in line with the recovery plans.

Key risks to SLA Income Forecast

- The SLA income position is largely fixed (92%) through the agreement of year end settlements with NENE CCG, EMSCG and Corby CCG. The remaining elements of income are subject to PbR and non-contracted activity and although there is likely to be some movement this will not expected to be significant.
- No further additional fines or penalties are anticipated for the remainder of the financial year.
- For the year-to-date to the end of February, SLA income is reported as £216.8m. This is lower than originally forecast and additional mitigating actions have been agreed to offset the shortfall forming part of the year end action plan to achieve a breakeven.
- The forecast for March is to report an in-month position of £20.5m which is largely a fixed value, bringing the total year end SLA income as £237.39m. This excludes the TDA support of £4.5m received from NHS England in February.
- The risk to the Trust financial position occurs where costs rise due to patient acuity and increased activity which is not matched by any increases in income as it is fixed. This is particularly relevant for the outsourced areas in T&O and ARMD activity where the costs of drugs is high.

5. Forecast Financial Outturn

I&E Summary	Annual Plan 2013/2014	YTD Actual	March 2013/14 Forecast	Full Year Forecast
	£000's	£000's	£000's	£000's
SLA Clinical Income	231,750	216,830	20,559	237,389
Other Clinical Income	2,803	2,321	224	2,545
Other Income	26,031	22,659	2,267	24,926
Total Income	**260,584**	**241,810**	**23,050**	264,860
Pay Costs	(175,851)	(160,181)	(15,061)	(175,242)
Non-Pay Costs	(79,240)	(75,927)	(7,210)	(83,137)
CIPs	4,822	0		0
Reserves/ Non-Rec	(1,143)	0		0
Total Costs	**(251,413)**	**(236,108)**	**(22,270)**	**(258,379)**
EBITDA	**9,171**	**5,702**	**779**	**6,481**
Depreciation	(10,184)	(9,593)	(845)	(10,438)
Amortisation	(10)	(9)	(1)	(10)
Impairments	0	2,240	0	2,240
Net Interest	29	28	3	31
Dividend	(4,106)	(3,837)	(373)	(4,210)
Surplus / (Deficit)	**(5,100)**	**(5,470)**	**(436)**	**(5,906)**
Normalised Postion:				
Donated Assets	278	298	65	363
Impairments	0	(2,240)		(2,240)
I&E Position (before TDA support)	**(4,822)**	**(7,411)**	**(371)**	**(7,782)**
TDA Support 13/14		4,125	375	4,500
Recovery actions		1,000	2,045	3,045
I&E Position		**(2,286)**	**2,049**	**(237)**

Key Issues

- Run rate forecast now updated for February performance with a forecast gross deficit of £7.7m before TDA support and implementation of the year end action plan.
- **Forecast based on:**
  - historic run rates adjusted for working days in each month.
  - Includes the impact of the guaranteed income settlement with Nene CCG, Corby CCG and Specialised Commissioners.
  - Run rate for pay and non pay adjusted for known trends and planned winter pressures income and expenditure.
  - Managers reminded to control all non-pay costs in March to avoid historic peak in expenditure typically experienced in March.
- £4.5m of TDA "System Support" funding has now been received from NHS England leaving a net deficit of £3.3m to be recovered at the year end.
- A range of actions and additional measures has been identified to close the gap and is set out in slide 6.
- At present there are insufficient actions to fully meet the forecast deficit. The TDA have been advised that the Trust has a potential downside risk of up to £0.5m in delivering a breakeven I&E position.

6. Year End Action Plan

	YTD M10 £000	Month11 £000	Month 12 £000	Total £000
Gross I&E Deficit (before Actions)	**(1,699)**	**(1,588)**	**4**	**(3,283)**
Action Plan:				
Release of Provisions (1st Tranche):		800	800	1,600
				-
Income actions (confirmed):				
EMSCG		200	200	400
Balance of Winter Pressures funding			30	30
WIP Settlement (NENE CCG)			450	450
Provisions (Tranche 2)				
ET Claim compensation			150	150
NCA debt write off not required			197	197
12-13 SAS/ training income defferred			12	12
Medical Staff Recruitment			88	88
ERP Project Manager and ESR			50	50
Year end management actions:				
Expenditure accruals review			100	100
13-14 accrual for TCS			207	207
Defferred Income release			50	50
Run rate reduction M12			275	275
Revenue to capitla trawl			75	75
				-
Downside Risks:				-
Expenditure risk above forecst		-	(275)	(275)
Bad Debts Provisions:				-
General			(200)	(200)
Overseas Visitors			(35)	(35)
RTA			(30)	(30)
Salary Overpayments			(50)	(50)
				-
NHSLA Claims (Trust Liability)			(50)	(50)
				-
Total Actions	**-**	**1,000**	**2,044**	**3,044**
I&E Position	**(1,699)**	**(588)**	**2,048**	**(239)**

Actions to Achieve Breakeven

A range of actions to deliver breakeven were prepared in January and presented to finance committee The table opposite provides an update on the latest actions proposed to deliver breakeven.

The actions fall into 4 main categories:

1. Review of year balance sheet provisions
2. Additional income actions confirmed with Commissioners.
3. Secondary review of provisions (required to cover January adverse performance).
4. A range of years end management actions including the impact of expenditure controls requested of all managers.

- Downside risks of £640k have been included in the March position to reflect a range of potential year end anticipated adjustments.

- The annual stock take will conclude in March and stock movements may impact the position. The current value of inventories is £5.3m.

- **At present the forecast position is highlighting a shortfall of £0.24m of actions required. A potential risk of up to £0.5m has been reported to the TDA .**

7. Statement of Financial Position

	Balance at 31-Mar-13	Current Month Opening Balance	Closing Balance	Movement	Forecast end of year Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,789	133,789	133,789	0	133,789	0
IN YEAR REVALUATIONS	0	6,795	5,961	(834)	5,965	5,965
IN YEAR MOVEMENTS	0	7,675	10,348	2,673	14,411	14,411
LESS DEPRECIATION	0	(8,738)	(9,593)	(855)	(10,438)	(10,438)
NET BOOK VALUE	**133,789**	**139,521**	**140,505**	**984**	**143,727**	**9,938**
CURRENT ASSETS						
INVENTORIES	4,934	5,148	5,287	139	4,985	51
RECEIVABLES						
NHS DEBTORS	4,103	8,015	7,343	(672)	4,044	(59)
OTHER TRADE DEBTORS	2,295	1,279	1,222	(57)	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	483	615	132	132	0
COMPENSATION DEBTORS (RTA)	2,514	2,640	2,624	(16)	2,514	0
OTHER RECEIVABLES	676	1,268	1,437	169	925	249
IRRECOVERABLE PROVISION	(515)	(515)	(515)	0	(515)	0
PREPAYMENTS & ACCRUALS	1,387	2,855	1,845	(1,010)	1,410	23
	10,149	**15,582**	**14,128**	**(1,454)**	**10,362**	**213**
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	4,342	9,174	10,347	1,173	4,654	312
NET CURRENT ASSETS	**19,425**	**29,904**	**29,762**	**(142)**	**20,001**	**576**
CURRENT LIABILITIES						
NHS	628	1,541	1,365	176	1,495	(867)
TRADE CREDITORS REVENUE	1,255	3,242	3,348	(106)	4,765	(3,510)
TRADE CREDITORS FIXED ASSETS	1,744	2,197	3,029	(832)	2,927	(1,183)
TAX AND NI OWED	1,769	3,460	3,463	(3)	3,400	(1,631)
NHS PENSIONS AGENCY	2,013	2,217	2,162	55	2,189	(176)
OTHER CREDITORS	495	339	351	(12)	494	1
SHORT TERM LOANS	669	621	716	(95)	785	(116)
ACCRUALS AND DEFERRED INCOME	6,132	10,097	12,346	(2,249)	5,378	754
PDC DIVIDEND DUE	36	1,438	1,784	(346)	25	11
STAFF BENEFITS ACCRUAL	786	786	786	0	629	157
PROVISIONS	3,501	3,035	2,952	83	650	2,851
PROVISIONS over 1 year	1,281	1,281	1,281	0	1,331	(50)
NET CURRENT LIABILITIES	**20,309**	**30,254**	**33,583**	**(3,329)**	**24,068**	**(3,759)**
TOTAL NET ASSETS	**132,905**	**139,171**	**136,684**	**(2,487)**	**139,660**	**6,755**
FINANCED BY						
PDC CAPITAL	100,115	101,507	101,507	0	103,611	3,496
REVALUATION RESERVE	32,486	36,750	35,745	(1,005)	35,745	3,259
DONATED ASSET RESERVE	0	0	0	0	0	0
GENERAL RESERVES	304	304	776	472	304	0
I & E CURRENT YEAR	0	610	(1,344)	(1,954)	0	0
FINANCING TOTAL	**132,905**	**139,171**	**136,684**	**(2,487)**	**139,660**	**6,755**

SoFP (as at February 2014)

Non Current Assets

- Increase in in non current assets of £0.98m as capital additions exceeds depreciation and the final quarter revaluation adjustment is now included.

Net Current assets

- Small decrease in net current assets during the month.
- Inventories increased by £0.1m.
- Reduction in NHS Debtors of £0.7m and Prepayments & Accruals of £1.0m.
- Cash balance increased by £1.2m month on month. TDA £4.5msupport received in February.

Net Current Liabilities

- Increase in net current liabilities during the month by £3.3m.
- Reduction in NHS Creditors £0.2m, and increased Trade Creditors £0.1m.
- Increase in Capital Creditors of £0.8m as schemes are accelerated.
- Accruals and deferred income increased by £2.2m.

Financing

- Reduction in Revaluation Reserve as a result of movement in value of buildings £0.5m for the final quarter and historic indexation adjustment of £0.5m.
- General reserve movement relates to fixed asset indexation adjustment.

8. Capital Expenditure

Category	Approved Annual Budget 2013/14 £000's	Year to Date as at Month 11 M11 Plan £000's	M11 Spend £000's	Under (-) / Over £000's	Plan Achieved	Year to Date as at Month 11 Actual Committed £000's	Plan Achieved	EOY Forecast as at Month 11 Forecast M11 £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	104%	417	104%	417	18
Endoscopy	150	150	151	1	101%	164	109%	164	14
Urodynamics	152	152	152	0	100%	165	109%	152	0
Haematology (Trust)	0	0	6	6	0%	6	0%	6	6
Annual Strategic Planning Approvals	-31	0	0	0	0%	0	0%	0	31
MESC	2,010	1,552	1,439	-113	72%	1,920	96%	2,088	78
Estates	3,685	3,215	2,702	-513	73%	3,403	92%	3,548	-137
IT	3,542	2,812	2,483	-329	70%	3,541	100%	3,541	-1
Other	1,149	495	420	-75	37%	1,000	87%	1,140	-9
Carbon Energy Efficiency Fund (CEEF)	3,350	2,626	2,577	-49	77%	3,291	98%	3,350	0
Total - Capital Plan	**14,405**	**11,401**	**10,347**	**-1,054**	**72%**	**13,906**	**97%**	**14,405**	**0**
Less Charitable Fund Donations	-194	-194	-194	0	100%	-207	107%	-194	0
Total - CRL	**14,211**	**11,207**	**10,153**	**-1,054**	**71%**	**13,699**	**96%**	**14,212**	**0**

Key Issues

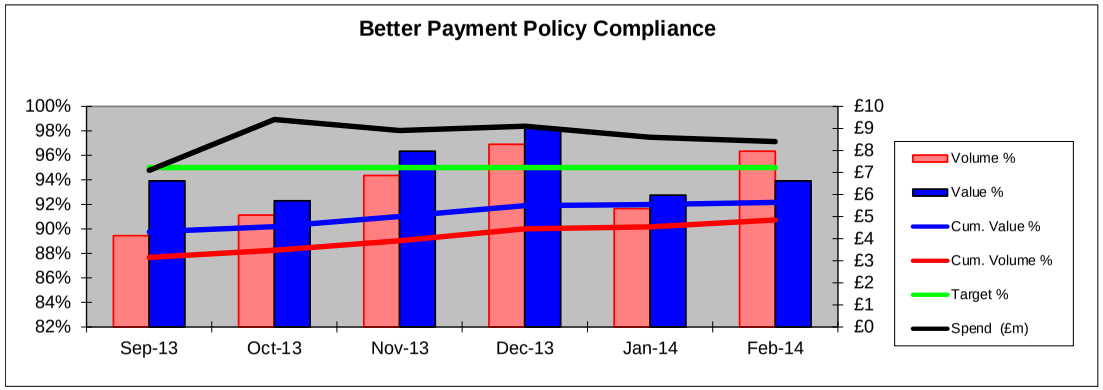
- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker and has now been slipped to next financial year.
- Improving Birthing Environments completes first stage works from 2012/13 and second stage now completed in the new financial year.
- Endoscopy works were approved last financial year by the Capital Committee and now complete
- Urodynamic upgrade funded by a private donor and completed in December 13.
- The Capital Committee contingency of -£31k has been reduced (was -£21k) following a further reduction of depreciation forecast of £10k.
- The Haematology scheme works are completed, although final account is still under dispute.
- Full year depreciation forecast is currently £10.438 million (was £10.448 million) and this has increased as the MES contract start date has now been delayed till 2014/15 financial year and as a result of the increased valuation of buildings notified by the District Valuer.
- Charitable Donations assumptions for additions in year are assumed £42k medical equipment & £152k Urodynamics, donated from a private donor.
- The Trust have been notified of additional funding from the Safer Hospitals, Safer Wards Technology Fund, Maternity Care Setting Fund and Nursing Technology Fund.

Resources - Trust Actual	
Internally Generated Depreciation	10,438
SALIX	277
CEEF	2,760
SHSWTF - Vitalpac	368
SHSWTF - E Prescribing	174
Maternity Care Settings Fund	42
Nursing Technology Fund	152
Total - Available CRL Resource	**14,211**

9. Receivables, Payables and BPPC Compliance

February	Total at February £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,172	279	219	48	626
Receivables NHS	5,263	4,010	97	222	934
Total Receivables	**6,435**	**4,289**	**316**	**270**	**1,560**
Payables Non NHS	(3,181)	(3,065)	(62)	(54)	
Payables NHS	(42)	(29)	(7)		(6)
Total Payables	**(3,223)**	**(3,094)**	**(69)**	**(54)**	**(6)**

January	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)**	



Receivables and Payables

- Continued progress in reducing non current debt. Over 30 day debt reduced by £0.6m.
- Key mandate payments have been made on time.
- Over 90 day debt of £1.6m includes PCT legacy debt of £0.3m, CRIPPS debt of £0.2m, NCA's debt of £0.4m and Overseas Patients debt of £0.2m.
- 98% of Creditors under 30 days.

BPPC Compliance

- BPPC has continued to improve from last month to (cumulative 90.46% by volume, 92.91% by value) with the payments team continuing to achieve processing within the targets once approved.
- Bank and agency invoices is improving and the delays encountered have been reviewed at care group and ward level
- The recent Issues encountered with the new pharmacy stock system which resulted in late payment of invoices has now been resolved
- Work has continued with areas of non compliance to develop a satisfactory resolution.

10. Cash Flow and Working Capital

MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s	APR	MAY	JUN
		ACTUAL											FORECAST	FORECAST 14/15		
RECEIPTS																
SLA Base Payments	226,227	17,721	19,030	15,721	23,380	19,172	17,506	23,166	17,522	17,434	21,133	17,031	17,411	19,533.00	19,533.00	19,533.00
SLA Performance / Other CCG investment	11,205	0	0	0	0	0	0	650	2,253	2,336	1,173	4,474	320	0.00	0.00	0.00
Health Education Payments (SIFT etc)	9,031	22	1,511	764	664	728	781	672	856	803	685	715	831	812.00	812.00	812.00
Other NHS Income	19,013	2,923	877	1,596	616	1,709	1,154	1,804	1,817	1,351	1,606	1,885	1,675	1,950.00	600.00	841.00
PP / Other (Specific > £250k)	329	0	0	329	0	0	0	0	0	0	0	0	0	0.00	0.00	0.00
PP / Other	11,458	892	1,096	655	758	857	1,142	1,030	965	1,179	1,078	807	1,000	1,100.00	883.00	1,100.00
Salix Capital Loan	277	0	0	0	0	0	0	0	0	95	0	95	87	0.00	0.00	0.00
EFL / PDC	3,496	0	0	0	0	0	0	0	0	853	539	0	2,104	75.00	75.00	75.00
Temporary Borrowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	0.00	0.00
Interest Receivable	33	3	3	2	2	3	2	2	3	3	4	3	3	2.00	2.00	2.00
TOTAL RECEIPTS	281,070	21,562	22,518	19,067	25,419	22,469	20,586	27,324	23,416	24,053	26,217	25,009	23,431	23,472	21,905	22,363
PAYMENTS																
Salaries and wages	165,560	12,168	13,743	13,749	13,881	13,870	13,823	13,886	13,899	13,982	14,202	14,233	14,125	14,250.00	14,500.00	14,500.00
Trade Creditors	78,356	4,499	7,344	5,805	5,704	7,029	5,603	7,551	7,011	6,756	7,154	6,644	7,254	4,500.00	7,500.00	7,500.00
NHS Creditors	20,124	1,617	1,296	1,619	2,197	2,295	1,642	1,876	1,614	1,908	1,243	980	1,835	1,800.00	1,800.00	1,800.00
Capital Expenditure	12,437	477	526	727	528	840	531	526	737	1,259	657	2,052	3,577	334.00	639.00	986.00
PDC Dividend	4,246	0	0	0	0	0	2,089	0	0	0	0	0	2,157	0.00	0.00	0.00
Repayment of Loans	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	0.00	0.00
Repayment of Salix loan	320	0	0	0	0	0	143	0	0	0	0	0	177	0.00	0.00	0.00
TOTAL PAYMENTS	281,043	18,761	22,909	21,900	22,310	24,035	23,831	23,840	23,262	23,905	23,257	23,909	29,125	20,884	24,439	24,786
Actual month balance	26	2,801	-392	-2,833	3,109	-1,565	-3,245	3,484	154	148	2,960	1,099	-5,694	2,588	-2,534	-2,423
Cash in transit & Cash in hand									120	53	76	76				
Balance brought forward	4,303	4,303	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	9,173	10,348	4,654	7,242	4,708
Balance carried forward	4,654	7,104	6,712	3,880	6,988	5,423	2,178	5,662	5,936	6,137	9,173	10,348	4,654	7,242	4,708	2,285

Key Issues

- Month end balance of £10.348m has increased by £1.174m
- Forecast reflects £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 March
- Cash flow has been based on a breakeven I&E position, following £4.5m financial support received from NHS England in February.
- Corby CCG achieved payment of their SLA by the agreed date of 15th the month.
- 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 received early March.
- Additional PDC associated with Safer Hospitals Safer Wards IT bids (£542k), Estates Maternity Care Settings Fund (£42k) and Nursing Technology Fund (£152k) have been approved by the DH with funding requested for March.
- Cash flow is now being monitored on a daily basis to ensure the Trust meets the EFL financial duty.
- **Q1 2014-05 cash balance forecast to remain positive but application for temporary borrowing required to be in place for Q2.**

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 March 2014

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

Executive summary

The key matters affecting the workforce include:

- The key performance indicators show a decrease in Total Workforce Capacity (excluding Medical Locums) employed by the Trust and a decrease in sickness absence.
- The report includes an update on the revised Appraisal process and the final flu vaccine uptake.
- An update following the CQC hospital inspection.
- An update on employment policies approved.

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 Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Trust Board Meeting
27th March 2014

Workforce Report

1. Introduction

This report identifies the key themes emerging from February 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 0.16% in February to 4.53%, which is above the Trust target.

The total sickness absence rate for the General Medicine & Emergency Care Group has decreased by 0.87%, with improvement showing in all directorates.

Hot spots for ward based total sickness absence are Becket Ward with four individuals on long-term sickness; and Corby Community Ward where total sickness absence has increased by 2.80% mainly due to an increase in short-term sickness of 5.70%. This may relate to the current TUPE transfer consultation on the ward. A 3.39% increase in short-term sickness on EAU is being monitored.
The total sickness absence rate for the General Surgery Care Group has increased by 0.47%.

D&V was prevalent on Willow Ward, which added to the relatively high instance of short-term sickness.

The highest ward based sickness was within Child Health on Paddington Ward, with total sickness absence of 12.69%. Both long- and short-term sickness increased by 1.5% and 3.88% respectively. Two of the 4 staff on long-term sickness have now returned to work, one has a pre-planned surgical procedure, and the other is expected to begin a phased return in April.

Medical & Dental sickness absence has increased by 0.36% to 1.65% in February 2014. The total sickness absence rates within Facilities (2.77%) and Hospital Support (2.82%) remain below Trust target.

For non-Ward based staff, the highest levels of sickness absence are:

- The long-term sickness rate within the Pharmacy MMT team remains high at 20.50% but has reduced from 29.41% as reported last month. A meeting is scheduled to review the situation.
- Manfield Day Surgery, total sickness absence 21.18% (long term 17.65%, short term 3.53%). The long term sickness represents one person from 5.60 FTE who returned to work in February.
- Danetre Hospital, total sickness absence 16.84% (long term 15.69%, short term 1.15%). The long term sickness represents one person from 6.20 FTE who has since left the Trust

Proportionate to the number of staff employed, other areas of concern with high levels of sickness absence are:

- Medicine Admin & Secretaries, total sickness absence of 8.92% of which 6.57% is three staff on long term absence, of which one is expected to return in February and one in May.
- Radiology NGH, total sickness absence of 7.1% where there are four staff on long term sickness absence representing 3.82%, one on half pay, one pending disciplinary and two being managed as per Trust Policy.
- Porters, total sickness absence 7.44% of which the majority is short term sickness absence (5.81%). Causes of short term absence were D & V and sprains, most staff returned to work within 48 hours.

Workforce Capacity

Total workforce capacity (excluding Medical Locums) decreased by 34.39 FTE in February. The substantive workforce capacity increased by 30.89 FTE to 4179.39 FTE and the temporary workforce capacity (excluding Medical Locums) decreased by 65.28 FTE to 268.97 FTE.

2.2 Workforce Information Update

Influenza Vaccinations

From information provided in the Department of Health Flu Report of February 2014, the national average vaccine uptake for September to January 2014 was 54.8%. The uptake for NGH as at January 2014 was higher than the national average, at 58%.

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 January 2014, only 14.3% achieved 75% or above (75% is the target set by the Department of Health for additional winter pressures funding for 2014/15).

CQC Visit

Following the recent CQC visit, their draft report contains concerns regarding Mandatory Training and Appraisal compliance rates. The draft report has been received and factual accuracies are being examined which will then be submitted to CQC in the form of a response.

A review of current monitoring and reporting systems is underway for both Mandatory training and appraisal which will form part of the action plan to be submitted to the CQC. In addition, a more rigorous performance management process will be developed to address those managers who fail to discharge their responsibilities in relation to compliance with the mandatory training and appraisal policies.

Policy Changes

The Management of Sickness Absence Policy has been ratified in March 2014.

3. Assessment of Risk

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

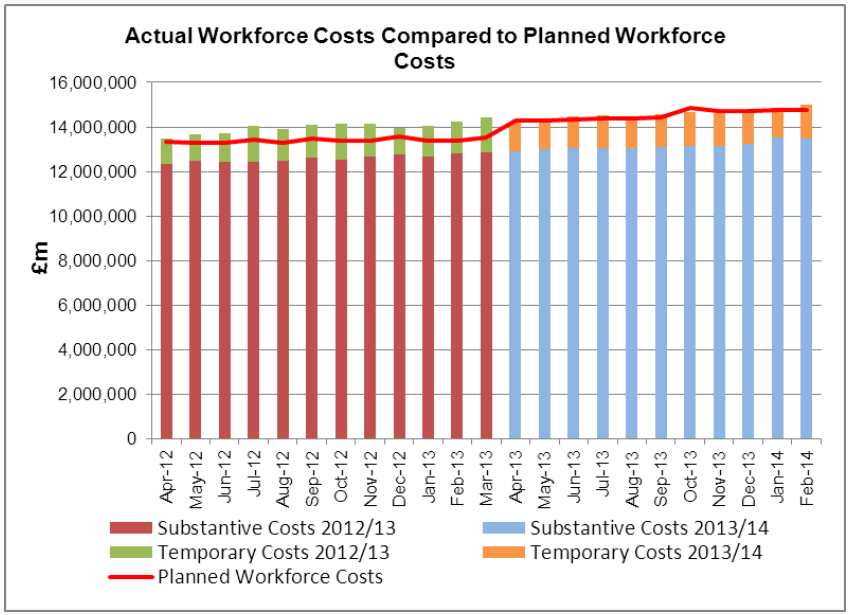
4. Recommendation

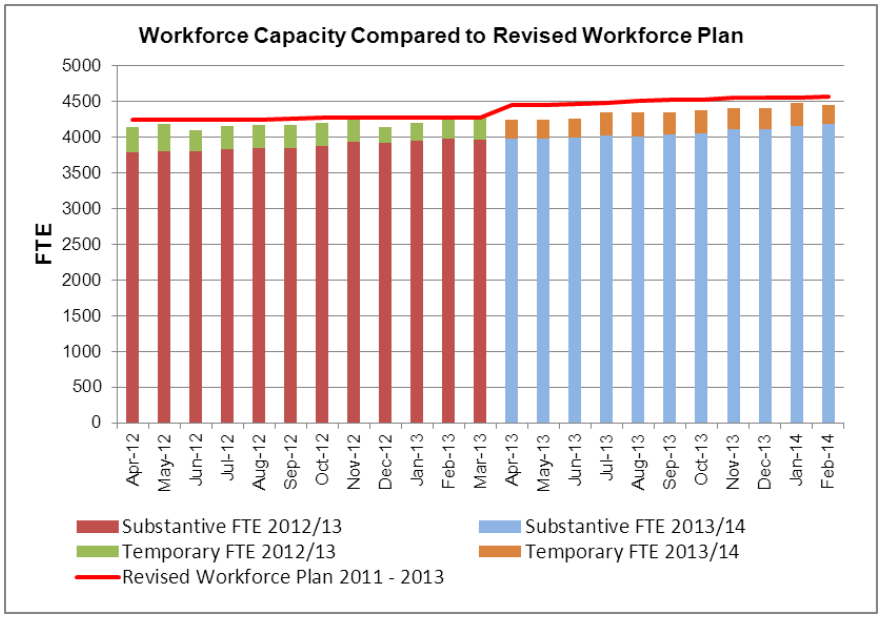
The Board is asked to note the report.

5. Next Steps

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

Human Resources Workforce Performance Indicators 2013/14 Month 11





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2012/13 (£1,000's)	12349	12460	12446	12447	12475	12617	12528	12648	12759	12692	12818	12881
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111	13153	13148	13238	13521	13470	
Temporary Costs 2012/13 (£1,000's)	1136	1189	1291	1615	1434	1481	1620	1489	1213	1334	1403	1568
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443	1493	1460	1420	1325	1530	
Planned Workforce Costs2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14876	14691	14710	14738	14752	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	4,179	
Temporary FTE 2012/13	347	388	301	322	329	311	327	332	215	250	291	334
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291	334	269	
Revised Workforce Plan 2011/12	4,250	4,250	4,250	4,238	4,246	4,254	4,269	4,279	4,278	4,278	4,278	4,278
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,553	4,555	4,558	4,564	

Workforce Expenditure

Total Workforce Expenditure (all pay elements) increased by £153,512 in February to £15.000m (this is above plan for Month 11).

Substantive workforce expenditure decreased by £51,224 to £13,470,095.

Temporary Workforce Expenditure (including Medical Staff) increased by £204,736 to £1,529,534 = to 10.2% of the of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 34.39 FTE in February to 4,448.36 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,563.67 FTE.**

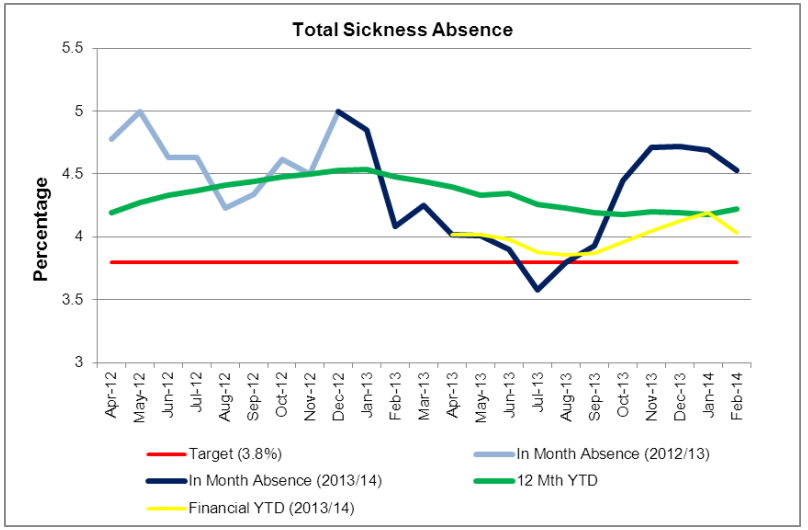
Substantive workforce capacity increased by 30.89 FTE to 4,179.39 FTE.

- 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) **decreased by 65.28 FTE to 268.97 FTE.**

Human Resources Workforce Performance Indicators 2013/14 Month 11

	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%	91.35%	91.64%	94.14%	83.85%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	6.05%	8.15%	4.99%	**2.61%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	97.32%	98.60%	100.88%	85.28%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	8.87%	8.47%	**7.68%**	13.21%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence 2012/13	4.78	5.00	4.63	4.63	4.23	4.34	4.62	4.50	5.00	4.85	4.08	4.25
In Month Absence 2013/14	4.02	4.01	3.90	3.58	3.80	3.93	4.45	4.71	4.72	4.69	4.53	
12 Mth YTD	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19	4.18	4.22	
Financial YTD (2013/14)	4.02	4.02	3.98	3.88	3.86	3.87	3.96	4.05	4.13	4.19	4.03	

Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 32,622 hours (200.75 FTE), which is an decrease of 547 hours (3.37 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 47.18% (increase of 2.71%), Agency fill rate = 29.12% (increase of 3.71%). Total bank & agency fill rate = 76.3% (increase of 6.42% compared with the previous month).
- Monitoring of 6.5 hour bank & agency shifts continues; excluding night shifts there were an average of 30% of bank & agency shifts in February that were for a 6.5 hour duration or less.

Sickness Absence

Sickness Absence Rate (YTD) decreased to 4.22% in February 2014.

In month Sickness Absence has decreased by 0.16% to 4.53% which is above the Trust target.

- Short term sickness absence decreased marginally by 0.01% to 2.58%.
- Long term sickness absence decreased by 0.15% to 1.95% which remains below Trust Target.
- The total calendar days lost to sickness absence decreased by 771 to 6,272 days lost.
- The number of days lost per employee continues to decrease, to 1.29 days.

Human Resources Workforce Performance Indicators 2013/14 Month 11

Surgery Care Group									
		Directorate							
	Threshold	Target	Theatres, Anaesthetics & Critical Care	Surgery	Trauma & Orthopaedics	Head & Neck		Women	Children
Short Term Sickness Absence		1.60%	3.81%	2.77%	3.56%	2.47%		3.24%	2.74%
Long Term Sickness Absence		2.20%	2.58%	1.99%	0.91%	2.61%		2.30%	3.87%
Total Sickness Absence	Over 4.2%	3.80%	6.39%	4.76%	4.47%	5.09%		5.53%	6.62%
	3.9-4.2%								
	Under 3.8%								

Surgery Care Group Summary

- The total sickness absence rate for the General Surgery Care Group increased by 0.47% to 5.50%. D&V was prevalent on Willow Ward, which added to the relatively high instance of short-term sickness.

  The highest ward based sickness was within Child Health on Paddington Ward with total sickness absence of 12.69%. Both long- and short-term sickness increased, by 1.5% and 3.88% respectively. Two of the 4 staff on long-term sickness have now returned to work, one has a pre-planned surgical procedure, and the other expects to begin a phased return in April.

  Medical Records had 4 cases of LTS: one has returned to work, one may receive ill-health termination, and the remaining 2 are being managed in line with trust policy for underlying conditions.

Medicine Care Group									
		Directorate							
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	General Medicine & Emergency
Short Term Sickness Absence		1.60%	3.27%	1.55%	1.34%	0.96%		1.87%	3.74%
Long Term Sickness Absence		2.20%	1.45%	1.29%	1.58%	1.54%		1.59%	2.76%
Total Sickness Absence	Over 4.2%	3.80%	4.73%	2.84%	2.92%	2.50%		3.46%	6.49%
	3.9-4.2%								
	Under 3.8%								

Medicine Care Group Summary

- The total sickness absence rate for General Medicine & Emergency Care has decreased by 0.87%, with improvement showing in all directorates. The long-term sickness rate within the Pharmacy MMT team remains high at 20.50% but has reduced, and there is a meeting scheduled with the unit manager to discuss the situation.

  Hot spots for ward based total sickness absence are Becket Ward where four individuals on long-term sickness have been referred to OH; and Corby Community Ward where total sickness absence has increased by 2.80% mainly due to an increase in short-term sickness of 5.70%. This may relate to the current TUPE transfer consultation on the ward. A 3.39% increase in short-term sickness on EAU is being monitored by the use of Return to Work interviews.

Hospital Support					M&D
		Directorate			
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	2.03%	1.09%	1.00%
Long Term Sickness Absence		2.20%	0.74%	1.72%	0.65%
Total Sickness Absence	Over 4.2%	3.80%	2.77%	2.82%	1.65%
	3.9-4.2%				
	Under 3.8%				

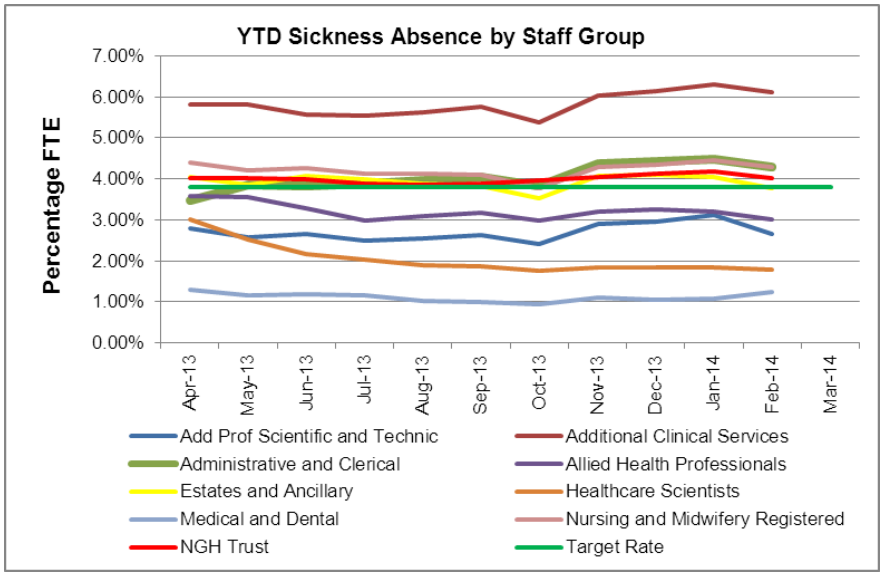
Hospital Support and Medical & Dental Summary

- The total sickness absence rates within both Facilities (2.77%) and Hospital Support (2.82%) remain below Trust target.

  Work continues to improve the reporting mechanisms for Medical & Dental sickness absence which has increased by 0.36% to 1.65% in February 2014.

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

Human Resources Workforce Performance Indicators 2013/14 Month 11



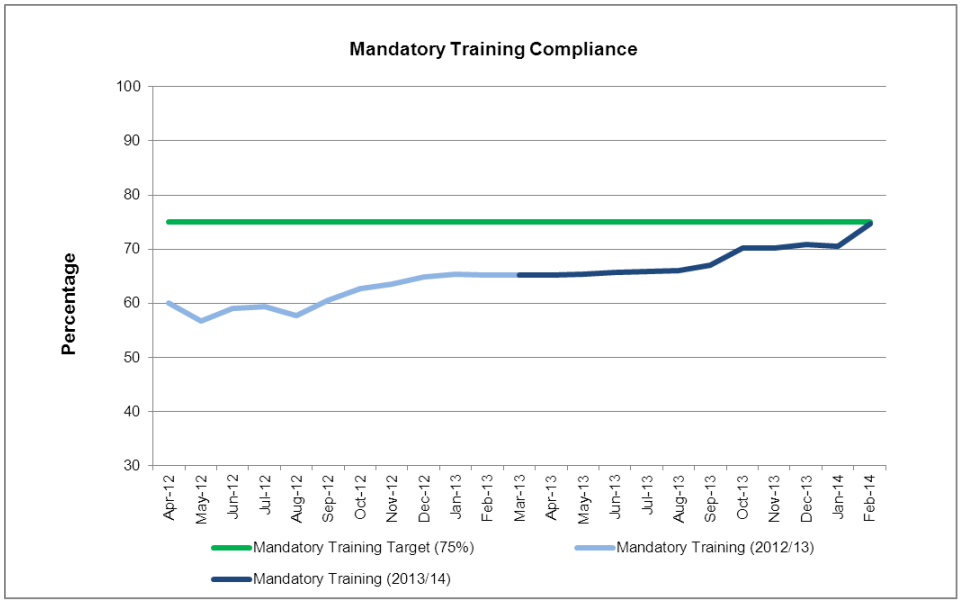
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Add Prof Scientific and Technic	2.78%	2.57%	2.66%	2.50%	2.55%	2.64%	2.41%	2.91%	2.95%	3.11%	2.65%	
Additional Clinical Services	5.82%	5.81%	5.56%	5.54%	5.61%	5.75%	5.39%	6.03%	6.14%	6.29%	6.10%	
Administrative and Clerical	3.47%	3.85%	3.84%	3.88%	3.97%	4.05%	3.82%	4.36%	4.43%	4.47%	4.29%	
Allied Health Professionals	3.58%	3.56%	3.27%	2.97%	3.08%	3.18%	2.99%	3.21%	3.25%	3.19%	3.00%	
Estates and Ancillary	4.04%	3.84%	4.08%	3.98%	3.87%	3.82%	3.52%	4.06%	4.10%	4.04%	3.77%	
Healthcare Scientists	3.00%	2.51%	2.18%	2.04%	1.89%	1.86%	1.75%	1.83%	1.83%	1.84%	1.78%	
Medical and Dental	1.29%	1.15%	1.18%	1.16%	1.03%	0.99%	0.94%	1.09%	1.05%	1.09%	1.25%	
Nursing and Midwifery Registered	4.40%	4.21%	4.27%	4.14%	4.14%	4.09%	3.78%	4.30%	4.35%	4.44%	4.29%	
NGH Trust	4.02%	4.02%	3.98%	3.88%	3.86%	3.87%	3.96%	4.05%	4.13%	4.19%	4.03%	
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%	4.53%	4.78%	4.90%	2.77%
No. of completed PDP's returned & completed Appraisals	Under 50% 50-79% 80% & over	80%	34.52%	33.53%	37.67%	30.40%
% Statutory & Mandatory Training Compliance	Under 50% 51-74% 75% & over	75%	74.68	75.16	73.74	75.94

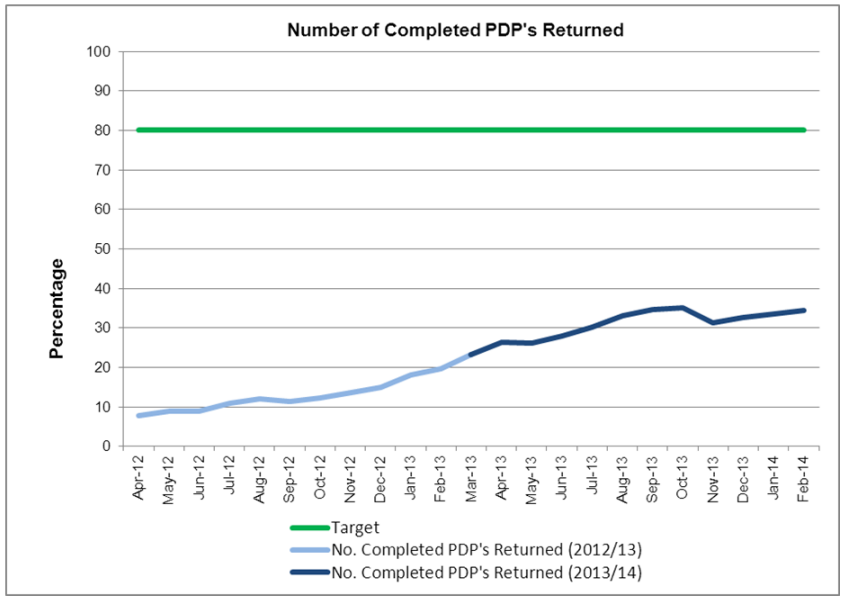
Number of Completed PDPs Returned, Completed Appraisals & Mandatory Training Compliance

- The current number of completed PDP's returned or completed Appraisals is 34.52%; an increase of 0.94%.
- The data issue relating to Mandatory Training compliance reporting has been resolved (but is subject to ongoing monitoring). Compliance has increased to 74.68%, almost at the Trust target of 75%.

Human Resources Workforce Performance Indicators Month 11



Mandatory Training Target 75%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2013/14)	65.14	65.4	65.75	65.93	66.09	66.97	70.23	70.20	70.84	N/A	74.68	



Returned PDP Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Returned (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76	33.58	34.52	

REPORT TO THE TRUST BOARD
27 MARCH 2014

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

Executive summary

- The target plan for 2013/14 is £13m, which is 5% of turnover.
- The upside latest thinking forecast (LTF) at M11 is £11.5m (4.4%), against the £13m required delivery, off plan by £1.5m. This is down by £0.3m on M10.
- The LTF fell by £0.3m in month 11 due to increased Bank & Agency expenditure and a fall in the delivery of Care Group & Corporate CIPs.
- The plan submitted to the TDA required delivery of £11.637m in the first 11 months. Actual delivery is £10.212m, behind plan by £1.425m.
- There is a risk to the bank and agency savings figures due to now operating at greater staffing levels. This could be to the value of approximately £200k.

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

Enclosure K

Actions required by the Board

The Board is asked to discuss and note the report.

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

MARCH 2014

Enclosure K

Executive Summary

Northampton General Hospital NHS
NHS Trust

2013/14 Month 11 Performance Update

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

The upside latest thinking forecast (LTF) at M11 is £11.5m (4.4%), against the £13m required delivery, off plan by £1.5m. This is down by £0.3m on M10.

The plan submitted to the TDA required delivery of £11.637m in the first 11 months. Actual delivery is £10.212m, behind plan by £1.425m.

In Month Performance

The LTF fell by £0.3m in month 11 due to increased Bank & Agency expenditure and a fall in the delivery of Care Group & Corporate CIPs.

The increase in bank and agency expenditure was driven by maintaining higher ward staffing levels first experienced in month 10.

The slippage in Care Group and Corporate CIPs is due to a shortfall in income CIPs. This may be caused by estimation methods as the accurate income position has not been finalised at the time of writing this report. Therefore, there is scope for this to unwind and improve in month 12.

Action to Address Slippage

At this stage of the year there is no further action to be taken in respect of 2013/14 CIPs.

Risks and Issues

There is a risk to the bank and agency savings figures due to now operating at greater staffing levels. This could be to the value of approximately £200k.

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.

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	£2,369k
Plans in Progress	£4,692k
Opportunity Identified	£2,014k
Unidentified	£3,593k

Scheme progress has been risk rated as follows:

High risk	£2,694k
Medium risk	£4,120k
Low risk	£2,261k
Unidentified	£3,593k

The majority of schemes proposed to date (80%) are budgetary CIPs rather than expenditure run rate reductions

The final TDA plan will be submitted on the 4th April and it is proposed that figures continue to be updated for material changes and the balance of unidentified schemes be phased into the plan from 1st July.

2013/14 Plan in Overview

Northampton General Hospital NHS
NHS Trust

Efficiencies Summary Information	TDA Plan £000s	% of Total	M10 LTF £000s	M11 LTF £000s	% of Total	Variance to TDA Plan £000s
Identified schemes	8,492	65%	11,769	↓ 11,544	89%	3,052
Total needed to be identified	4,508	35%	1,231	↑ 1,456	11%	-3,052
Total Efficiency	**13,000**	**100%**	**13,000**	**13,000**	**100%**	**0**
CIP delivery vs turnover	**5%**		**4.5%**	**4.5%**		

Identification of the Transformation Programme 2013/14
The table outlines the current LTF compared to the plan submitted to the TDA in April 2013.
The current LTF of £11.5m if delivered in full would be a 4.4% CIP against our planned requirement of 5%.
The table also demonstrates a £0.225m decrease in LTF between M10 & M11, due bank and agency savings being higher than planned in M11 and a reduction in planned delivery of Directorate & Corporate CIPs.

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Recurrent schemes	8,949	69%
Non-recurrent schemes	2,595	20%
Total needed to be identified	1,456	11%
Total Efficiency	**13,000**	**100%**

Efficiencies Summary Information	Total Efficiency LTF £000s	Proportion of total %
Pay	5,799	45%
Non pay	2,802	22%
Income	2,944	23%
Total needed to be identified	1,456	11%
Total Efficiency	**13,000**	**100%**

Pay schemes account for 45% 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	2,284	1,979	304
Clinical service redesign	D. Needham / R. Brown	25	110	(85)
Non-Clinical service redesign	C. Abolins	101	0	101
Directorate Schemes	A. Foster	8,798	8,868	(70)
Sub total		**11,544**	**11,295**	**249**
Gap	J. Brennan	1,456	1,705	(249)
Total		**13,000**	**13,000**	**0**

Month 11 – Latest Thinking Forecast

The Transformation Programme is currently projecting a LTF shortfall £1.456m against the required plan of £13m.

Care Group and Corporate CIPs are currently behind plan by £70k.
The LTF for the Care Groups has decreased by £136k over the position reported in M10.

At the end of month 11 a £1.3m year on year reduction in nursing bank and agency expenditure has been achieved. The agency spend has increased in the past 2 months due to running at higher staffing levels.

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

The restriction on overtime continues to exceed the monthly financial requirement. The monthly saving increased in month 11. 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.

TDA Return

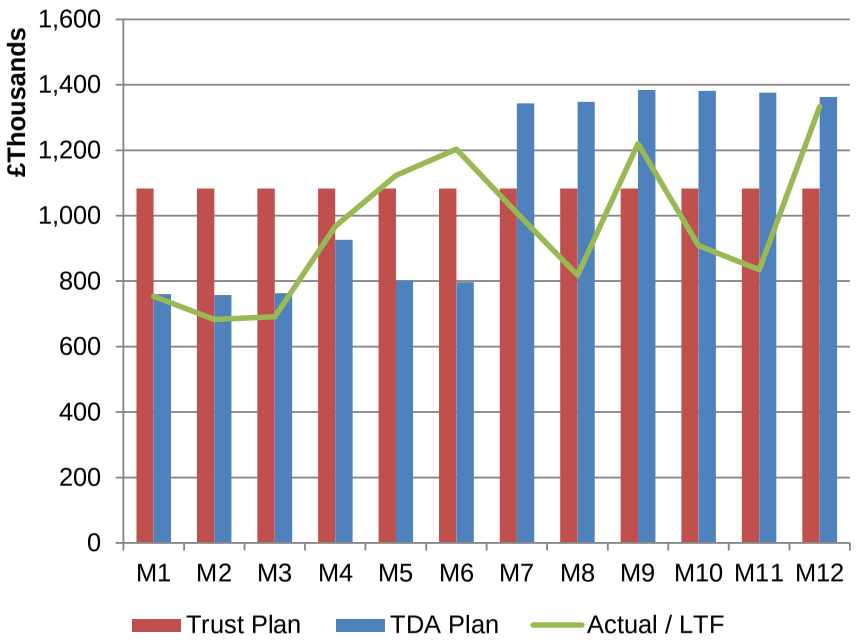
Northampton General Hospital NHS
NHS Trust

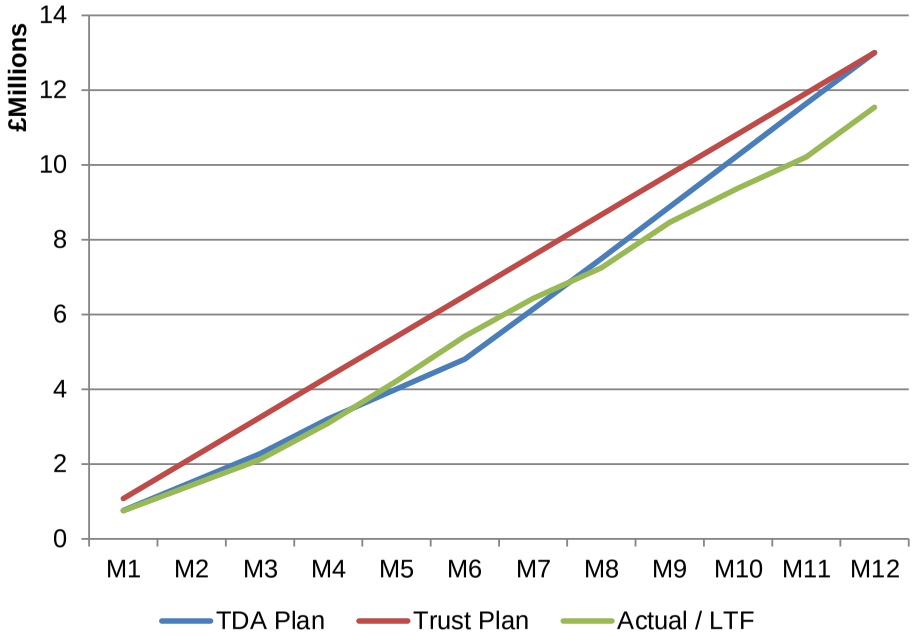
Efficiency Programmes	Identified (I) or Unidentified (U)	Recurring (R) or Non Recurring (NR)	Cashable (C), Non Cashable (NC) or Income (Inc)	If Cashable Pay (P) or Non Pay (NP)	Current Month			Year to Date			Forecast Outturn		
					Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 05) £000s	Actual (mc 06) £000s	Variance (mc 07) £000s	Plan (mc 08) £000s	Forecast (mc 09) £000s	Variance (mc 10) £000s
Description of scheme													
FYE of 12/13 Transformation Schemes	I	R	C	P	1	1	0	337	337	0	337	337	0
Directorate CIPs	I	R	C	NP	264	202	(62)	2,784	2,127	(657)	3,050	2,440	(610)
Directorate CIPs	I	NR	C	NP	7	29	22	73	207	134	84	236	152
Directorate CIPs	I	R	C	P	233	161	(73)	2,244	1,695	(549)	2,478	1,839	(639)
Directorate CIPs	I	NR	C	P	18	80	62	273	1,232	959	293	1,339	1,046
Directorate CIPs	U	R	C	P	97	0	(97)	1,063	0	(1,063)	1,164	0	(1,164)
Directorate CIPs	I	R	Inc	NP	138	185	47	1,518	1,861	342	1,656	2,155	499
Directorate CIPs	I	NR	Inc	NP	5	79	74	183	729	546	187	789	602
Workforce Transformation - Admin Review	I	R	C	P	16	16	0	91	84	(8)	108	100	(8)
Workforce Transformation - Tactical HR (B|A)	I	R	C	P	10	5	(5)	110	1,322	1,212	120	1,558	1,438
Workforce Transformation - Tactical HR (Overtime)	I	R	C	P	0	22	22	104	266	162	104	294	190
Productivity | Efficiency - Outpatient Skill Mix	I	R	C	P	5	0	(5)	40	0	(40)	45	0	(45)
Services Transformation - Rehabilitation/Community	U	R	C	P	50	0	(50)	150	0	(150)	200	0	(200)
Services Transformation - 3rd party Pharmacy	I	R	C	NP	6	0	(6)	23	0	(23)	30	0	(30)
Other	U	NR	C	NP	526	0	(526)	2,641	0	(2,641)	3,144	0	(3,144)
New Programmes Identified In Year:													
Workforce Transformation - Tactical HR (Enhancements)	I	R	C	P	0	10	10	0	110	110	0	120	120
Workforce Transformation - Salary sacrifice year 2 (technology	I	R	C	P	0	9	9	0	87	87	0	96	96
Clinical service redesign - Mattresses Total Bed Management	I	R	C	NP	0	5	5	0	10	10	0	15	15
Workforce Transformation - Locum Managed Service	I	R	C	P	0	0	0	0	0	0	0	0	0
Workforce Transformation - Consultant Annual Leave Accrual	I	R	C	P	0	0	0	0	0	0	0	35	35
Maximising formulary compliance (TVN)	U	R	C	NP	0	0	0	0	0	0	0	10	10
Emergency care porters for Benham Ward	U	R	C	P	0	0	0	0	0	0	0	0	0
Private patients at Danetre	U	NR	C	Inc	0	0	0	0	0	0	0	0	0
Reduction in compensation payments	U	R	C	NP	0	0	0	0	0	0	0	1	1
PDC impairment in Capital charges (EY)	U	NR	C	NP	0	17	17	0	83	83	0	100	100
Recovery of pay owed	U	R	C	P	0	0	0	0	0	0	0	5	5
Contractor Review	U	R	C	P	0	15	15	0	60	60	0	75	75
Increase staff car parking charges	U	R	C	NP	0	0	0	0	0	0	0	0	0
Commercial sponsorship	U	NR	C	NP	0	0	0	0	0	0	0	0	0
Grand Total (sc100)					**1,376**	**835**	**(540)**	**11,637**	**10,212**	**(1,425)**	**13,000**	**11,544**	**(1,456)**

Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

Overall Performance | **Off trajectory**





Actual delivery in month 11 was £835k against planned delivery of £1,376. This is a substantial shortfall and is a product of such a heavy reliance on additional schemes to deliver in the latter part of the year. Whilst delivery has been greater in the second half of the year, the increase has been insufficient to keep pace with the plan.

The cumulative delivery of schemes is now £1,425k behind the TDA plan.

Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

	LTF £'000s	% of Total target	Most Likely £'000s	Worst Case £'000s
Green	11,337	87%	11,337	11,337
Amber	199	2%	149	149
Red	9	0%	3	0
Total	**11,544**	**89%**	**11,489**	**11,486**
Gap	1,456	11%	1,511	1,514

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

The latest thinking forecast (£11.5m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.

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

Utilising this methodology agreed at the Finance Committee at its meeting in June 2013, the downside case based on current RAG rating would see the programme realise £11.5m.

There is little risk to delivery at this stage in the year.

Scheme	FY13/14 LTF £'000 R	A	G	Total Identified
A1: Surgery	-	-	466	466
A2: Anaesthetics	-	42	447	489
A3: T&O	6	21	368	395
A4: Head & Neck	1	-	779	780
A5: Child Health	-	52	773	825
A6: Obs & Gynae	1	-	387	388
SCG sub total	**8**	**114**	**3,220**	**3,342**
B1: General Medicine	-	-	2,028	2,028
B2: Oncology	0	-	444	445
B3: Pathology	-	9	537	546
B4: Radiology	-	3	408	411
B5: Pharmacy	-	8	165	173
B6: Therapies	-	0	130	130
MCG sub total	**0**	**21**	**3,712**	**3,734**
C1-7: Support Functions	-	0	839	839
C8: Facilities	1	13	870	883
Support sub total	**1**	**13**	**1,708**	**1,722**
Care Group & Corporate CIP Total	**9**	**148**	**8,641**	**8,798**
FYE of 12/13 Transformation Schemes	-	-	337	337
Admin Review	-	-	100	100
Bank & Agency	-	-	1,558	1,558
Tactical HR (Overtime)	-	-	294	294
Tactical HR (Enhancements)	-	-	120	120
Salary sacrifice year 2	-	-	96	96
Consultant Annual Leave Accrual		35	-	35
Mattresses Total Bed Management			15	15
Maximising formulary compliance (TVN)		10	-	10
Reduction in compensation payments		1	-	1
PDC impairment in Capital charges (EY)	-	-	100	100
Recovery of pay owed	-	5		5
Contractor Review	-	-	75	75
Gap	-	-	-	1,456
Total	**9**	**199**	**11,337**	**13,000**

Care Group & Corporate CIPs

Northampton General Hospital NHS
NHS Trust

Directorate	FY13/14 Planned Savings £'000	FY13/14 Forecast Outturn of Savings	Forecast Outturn Variance to plan £'000		Year to date £'000			
	Total	Total	Total	RAG	Planned to date	Actual savings to date	Var	RAG
A1: Surgery	555	466	(89)		508	423	(85)	
A2: Anaesthetics	797	489	(308)		728	426	(303)	
A3: T&O	540	395	(145)		492	340	(152)	
A4: Head & Neck	375	780	405		344	705	361	
A5: Child Health	518	825	307		488	705	216	
A6: Obs & Gynae	664	388	(276)		605	339	(266)	
SCG sub total	**3,449**	**3,342**	**(107)**	-	**3,167**	**2,937**	**(230)**	-
B1: General Medicine	2,028	2,028	0		1,838	1,848	9	
B2: Oncology	481	445	(36)		440	398	(42)	
B3: Pathology	586	546	(40)		513	509	(3)	
B4: Radiology	364	411	47		334	364	30	
B5: Pharmacy	172	173	1		156	165	9	
B6: Therapies	106	130	24		97	125	28	
MCG sub total	**3,737**	**3,734**	**(3)**	-	**3,378**	**3,408**	**30**	-
C1: Corporate Affairs	67	18	(49)		62	17	(45)	
C2: Medical Director	73	92	19		69	87	18	
C3: Research &	10	10	(0)		9	9	(0)	
C4: Patient & Nursing	124	124	0		114	115	1	
C5: Strategy &	248	248	0		227	228	0	
C6: Workforce &	149	202	53		150	185	35	
C7: Finance	128	144	16		117	131	14	
C8: Facilities	883	883	(0)		809	736	(73)	
Support sub total	**1,682**	**1,722**	**40**	-	**1,558**	**1,507**	**(51)**	-
Totals	**8,868**	**8,798**	**(70)**	-	**8,102**	**7,852**	**(250)**	-

At month 11 Care Group & corporate CIPs are £250k behind plan. This is due to a delay in some schemes being started.

Some of this shortfall is expected to be made up in the last month and Care Groups & Corporate areas are forecasting a £70k year end deficit.

The Surgical Care Group are forecasting a £107k deficit.
This deficit has increased in month 11 primarily due to income schemes that have been estimated due to a delay in case mix data.

The Medical Care Group are forecasting a £3k deficit. This has moved from a £60k surplus position at month 10.
Oncology has decreased by £37k due to the homecare oral chemotherapy risk share and Pathology has decreased by £34k due to a delay in a post restructure.

All Corporate areas are on target to meet the plan, with the exception of Corporate Affairs.

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 MARCH 2014

Title	TDA Self-Certification
Agenda item	15
Sponsoring Director	Karen Spellman, Deputy 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 February 2014 (attached as Appendix A and Appendix B)

NHS TRUST DEVELOPMENT AUTHORITY

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

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Enclosure L

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

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

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

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

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

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

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

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

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

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

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

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

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

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

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

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

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

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

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

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

BOARD STATEMENTS:

Enclosure L

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

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

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For FINANCE, that

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

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

Enclosure L

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

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

Enclosure L

Northampton General Hospital NHS
NHS Trust

REPORT TO THE TRUST BOARD
27 March 2014

Title	Information Governance – Compliance, Main Risks and Issues
Agenda item	16
Sponsoring Director	Karen Spellman, Deputy Director of Strategy and Partnerships
Author(s)	Chris Pallot, Director of Strategy & Partnerships
Purpose	This report summarises the risks and issues within the Information Governance agenda for the 2013/2014 financial year.

Executive summary

Information governance (IG) is concerned with the manner in which information is collected, used, shared, stored and destroyed. Effective IG allows the Trust to ensure that information is handled legally, securely, effectively and efficiently in order to maximise the value of information as an asset. This paper is presented to the Board to comply with the requirement of an annual report from the Senior Information Risk Owner.

This report provides an overview of IG Activities for 2013/14, specifically

- Information Governance Toolkit Compliance
- Information Governance training
- Access to Information (Subject Access requests and Freedom of Information Requests)
- Data Quality
- Information Incidents

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to?
Risk and assurance	Yes
Related Board Assurance Framework entries	All
Equality Impact Assessment	None identified.
Legal implications / regulatory requirements	Yes

Actions required by the Board

To note the contents of this report and the mitigations being applied to the risks

Northampton General Hospital NHS
NHS Trust

TRUST BOARD
27 MARCH 2014
INFORMATION GOVERNANCE – COMPLIANCE, MAIN RISKS AND ISSUES

1. INTRODUCTION

Information governance (IG) is concerned with the manner in which information is collected, used, shared, stored and destroyed. Effective IG allows the Trust to ensure that information is handled legally, securely, effectively and efficiently in order to maximise the value of information as an asset. This paper is presented to the Board to comply with the requirement of an annual report from the Senior Information Risk Owner.

This report provides an overview of IG Activities for 2013/14, specifically

- Information Governance Toolkit Compliance
- Information Governance training
- Access to Information (Subject Access requests and Freedom of Information Requests)
- Data Quality
- Information Incidents

2. IG TOOLKIT COMPLIANCE, MAIN RISKS AND ISSUES

2.1 Information Governance Toolkit

The Department of Health, through the Health and Social Care Information Centre (formally Connecting for Health) introduced the IG Toolkit as a measure of an organisation's IG compliance with the law and against best practice. The IG toolkit comprises of standards to which all NHS organisations and Private Sector Health Partners must self-assess and submit its compliance on a yearly basis.

There are currently 45 standards within the Acute Trust framework. These are within six assurance categories:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

For each standard a score from 0 – 3 must be achieved:

NR = Not Relevant
0 = Standard not in place in the organisation.
1 = Policies are in place for the standard.
2 = Polices are effectively communicated and the processes are evident.
3 = Processes are audited and reviewed to ensure they are followed, understood and remain fit for purpose.

All submissions are graded as either 'satisfactory' or 'not satisfactory'. To be classed as satisfactory, all requirements must meet a minimum of level 2.

2011/12 Toolkit Submission

The Trust had an overall score of 79% however this return was graded as 'not satisfactory' as 3 requirements failed to meet the target minimum level 2. These were:

- Information Governance training was not at the target 95%
- Personal identifiable information should not be transferred or used for secondary purposes without consent
- Corporate record audits had not been completed within four areas of the Trust

2012/13 Toolkit Submission

The Trust was able to achieve level 2 and level 3 compliance for the 45 requirements with an overall score of 81% and was graded as satisfactory. The Trust benchmarks positively against local and similar sized organisations.

IG Toolkit Assessment Benchmark	Score	Grade
University Hospitals Of Leicester NHS Trust	82%	Satisfactory
Milton Keynes General Hospital NHS Trust	85%	Satisfactory
Northamptonshire Healthcare NHS Foundation Trust	83%	Satisfactory
Northampton General Hospital NHS Trust	81%	Satisfactory
Nottingham University Hospitals NHS Trust	80%	Not Satisfactory
Kettering General Hospital NHS Foundation Trust	73%	Satisfactory
Derby Hospitals NHS Foundation Trust	77%	Not Satisfactory
Sherwood Forest Hospitals NHS Foundation Trust	72%	Satisfactory

Many organisations, especially the Acute Trusts, failed to achieve 95% of all staff receiving IG training on an annual basis and this is an on-going issue.

The Trust's Current Position

2013/14 Toolkit Submission (Version 11)

The final submission for version 11 (2013/14) to HSCIC is due on the 31st March 2014. The IG compliance returns from all Health and Social Care organisations in the UK will be included in an annual report from HSCIC to the Care Quality Commission (CQC) on 1st April 2014.

The target scores for version 11 are based on each requirement meeting a minimum of level 2. Where a level 3 was achieved in the last submission, the IG leads are working towards maintaining that level. However, as the toolkit is not released until mid-June each year, it can be difficult to plan for requirements and monitor according to the required standards.

The target score of 80% will produce a satisfactory grade if returned. It must be noted that the Trust has failed to meet its 85% IG training compliance target and as of February 2014 compliance was 61.4%.

Potential Issues

The target scores are acknowledged as being challenging, however they are set to ensure the minimum level 2 is achieved.

Below are the standards recognised as the most challenging in achieving a level 2:

112 – Information Governance training
The toolkit IG training target set by HSCIC is for 95% of all staff to be trained in IG on an annual basis. This has not previously been achieved. As a Trust we have factored in staff on maternity/sick leave (approx. 10% in year) and recalibrated our target figure to 85%. Please see Information Governance training below for further details.

As of February 2014, the Trust stands at 61.4%. Additional training sessions have been set up this month to over as many staff as possible, exceeding our normal 370 face to face capacity. The IG team have raised the profile of this issue by directly notifying out of date staff of the implications of not meeting our training target and providing easier and quicker solutions to be compliant. This mop up exercise has been well received, however based on the wide margin of 24.6%; it is highly unlikely that the Trust will achieve this target.

The Trust was in the same position for the last IG Toolkit final submission; with a training compliance figure of 54.5% on the day of submission (31 March 2013) but went ahead to claim a level 2 in requirement 112 based on its proposed action plan and an email from the IG Internal auditor that stated the Trust may claim compliance to phase A of achieving a level 2 in the requirement and not phase B.

Our current training compliance is expected to rise approximately to the 70% mark however we still cannot claim a level 2 with this return. We are at a Level1 for this requirement, which is classed as having a “Not Satisfactory” return for the whole toolkit irrespective of how well we do in all other requirements.

There has been a significant increase in our training figures in the last 2 months and going forward; the IG Team is proactively working on full compliance against the next IG Toolkit with its new initiates and robust approach to training.

324 – Pseudonymisation and Information Sharing
This element of the IG Toolkit requires the Trust to provide significant assurance that the confidentiality of our patient information is protected through use of pseudonymisation and anonymisation techniques where appropriate.

- Pseudonymisation is the process of replacing patient identifiable data with reference or code that enables the information to be returned to its identifiable state with the use of a key linked to the code.

- Anonymisation is the process of removing/deleting (permanently) any person identifiable data from a dataset. The resulting data cannot identify or single out an individual.

As of 1st April 2013 the Trust could no longer legally share patient information for any purpose other than for the patient’s direct care without the explicit and informed consent of our patients even if the information is to be shared as pseudonymised and the key withheld from the

receiving party. This put a stop to information sharing for the purpose of risk stratification, commissioning and case finding for the improvement of care services or integrated care by health and social care organisations.

For the Trust to partake in the beneficial information sharing relationships it has shared with other NHS organisations in the past; informed consent has to be gained and recorded against patients who have opted in to be a part of this process. This cannot be attained as the Trust does not record or request consent for the secondary use of patient information.

The IG team is working closely with the ICT team on the available options of capturing patient consent. We will be maintaining a Level 2 in this requirement.

604 – Corporate Information records management audits

At least four corporate areas must have record management audits annually. The aim of this requirement is to have all corporate areas audited within a 3 to 4 year cycle. The IG Manager has taken on this responsibility to complete these audits with the help of nominated leads from the various departments. It has been identified thus far that staff are unsure of the retention schedules for certain records and issues regarding available archiving solutions have been raised.

The Trust is on target to meet this requirement and we will be maintaining a Level 2 in this requirement. An action plan and schedule are being developed for a more proactive and robust approach to corporate Information records audits.

2.2 Information Governance Training

The Information Governance Toolkit requires all NHS staff update their IG on an annual basis. This is currently provided to new starters at induction, through mandatory cluster sessions, in department training sessions, classroom based training, the IGTT E-Learning modules and a workbook which is available on the intranet

IG training has a face to face capacity of 370 staff per month and with the availability of the workbook and the e-learning module, the Trust should be achieving its target of at least 85%.

However, this is not the case as high reliance on the face to face sessions by administrative and clerical staff that have ready access to PCs. Face to face sessions should cater to clinical staff; who ideally should have priority over available training slots. Going forward, the department is looking to promote the IG workbook and e-learning module in order to increase face to face access for clinical staff. The IG team will be carrying out IG awareness sessions/department visits and to get groups of clinical staff trained within their local work environment

The IG Team is working with Learning and development to ensure staff are aware of the various options available to them. This will be done via Trust wide emails, information will be put on the intranet and staff will be informed when they call to book for face to face sessions.

The learning and development team have implemented a couple of initiatives to inspire staff to complete their mandatory training. This includes the review of knowledge (RoK) sessions which enables staff to complete all their training in approximately 2 hours and also linking mandatory training to staff appraisals; making it a criterion for receiving pay increments.

The IG Team will work closely with managers whose staff have been identified to be going out of date on their training to ensure they are updated before their training expire.

The latest training figures, as at the 28th February are as follows; please note the figures are compliance at this point in time and not representative of the potential final submission score:

		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
	Trained in Month	357	271	288	186	270	194	277	246	263	254	198	256	354
IG and Records Management	Compliant	2611	2451	2485	2549	2695	2732	2764	2750	2891	2709	2635	2436	2974
	Non-Compliant	1893	2050	2015	1954	1854	1834	1783	1849	1735	1938	1997	2353	1868
Percentage Compliant		58.0%	54.5%	55.2%	56.6%	59.2%	59.8%	60.8%	59.8%	62.5%	58.3%	56.9%	50.9%	61.4%
Previous Year Compliance		54.4%	60.3%	62.1%	63.2%	64.0%	64.8%	63.0%	63.0%	64.1%	63.7%	64.3%	59.4%	58.0%

The Trust currently stands at 61.4% compliant. The figures above shows that an average of 42% staff (1,900) every month are not compliant with IG; hence the trust has failed to be compliant all year round even at the point of the Toolkit submission. Additional Training sessions are in place to improve stated the figures.

2.3 Access to Information

Subject Access Requests (SARs)

SARs are requests for personal information. This may be from staff, but generally is from patients or their representatives. Under the Data Protection Act, the Trust has a deadline of 40 calendar days (best practice is 21 days) to respond to such a request.

The Medical Access Team, based in Medical Records, started to use Datix for SAR reporting in April 2012. This was in order to aid reporting and monitoring of requests. A total of 1,611 requests were logged as received from the April 2013 until February 2014. Of the currently closed requests, 365 were responded to within the best practice target of 21 days, 821 were within the 40 days' timeframe or less while 381 exceeding the 40 day limit. This equates to 73.6% responded to within the legal timeframe of 40 days and 23.6% in breach[1]. The total figure provided above does not include the following:

- Solicitor access i.e. where there is potential litigation or claims against the Trust, DSS, CICA or Police requests for doctors to complete statements
- Insurance forms

[1] It should however be recognised that as a new system, there is a margin for error in these results due to inaccurate inputting of information

- Requests for copy records from other hospitals/GPs or veteran's agency, GMC, Ombudsman or NCC for child care proceedings or GEM.

The inability to meet the legal timeframe for some of the requests received has been attributed to staffing issues (The team have been down one staff member for a large part of the year) and the high number of requests received by the Medical Access Team.

The medical Records Department has taken the following actions to support this team and requests:

- Second photocopier leased
- Recruitment to team supervisor following reconfiguration of staffing
- Provision of bank / staffing from within medical records to support the team
- Challenge and improve processes to support all aspects of the access team's work.
- Utilising scanning of potential legal cases to reduce the time spent having to re-copy notes.

The implication of these breaches (not meeting the deadline) is a complaint being made to the Trust or directly to the ICO. This will initiate an investigation by an ICO official. If the Trust is found liable, the Trust could be made to sign an undertaking, be served with an enforcement notice or a fine if the Trust is found to be negligent in any way.

Freedom of Information

Freedom of Information gives members of the public the legal right of access to corporate information held by the Trust. There is a legal limit of 20 working days in which to respond to a FOI request.

The total number of requests received in 2013/14 excluding March 2014 was 507; a monthly average of 46. This is the highest average since its introduction in 2005 with an average of 15 more requests per month in 2013/14 than 2012/13 (April to February for both years).

Year	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total	Average
2010/11	22	24	17	28	21	21	18	20	18	28	30	37	284	23.7
2011/12	27	47	34	33	45	44	35	34	29	43	39	30	440	36.7
2012/13	33	27	27	30	28	24	32	42	21	42	33	26	365	30.4
2013/14	43	35	33	54	45	35	60	52	47	58	45	[redacted]	507	46.1

Responses that breached the 20 working days timeframe in 2013/14 (excluding March 2014)

Year	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
2013/14	-	-	-	1	2	-	-	8	3	1	1	15

The peak in November 2013 is attributed to staffing issues encountered within the Department.

2.4 Data Quality

There has been an increasing concern of misdirected mail sent by the Trust to the wrong GP surgeries due to incorrect information on iPM. It may be as a result of the lack of a proactive culture of confirming of patient details whenever patients access services within the Trust.

The Information Department has undertaken the responsibility of handling, redirecting and even updating patient GP addresses on iPM. This is at the cost of further stretching the workforce resource within the department and currently employing a band 3 from the bank to cover the resulting overhead of an average of 300 misdirected mail per week.

Principle 4 of the Data Protection Act 1998 states that personal information must be accurate and up to date and it is therefore of paramount importance that this is rectified as part of the overall Trust work programme to increase standards of data quality.

2.5 Information Incidents

There have been a number of incidents reported in the category of Consent, Communication and Confidentiality. Incidents within the subcategory of Confidentiality of Information total 33 during 2013/2014 (1st April 13 – 4th March 14). 32 of these incidents were graded as low risk or very low risk and have been resolved locally.

There has been one serious information incident, as defined by the Department of Health (DH), recorded in 2013/2014. A historic theatre list sheet was inadvertently used as scrap paper to address a bundle of HR papers to be transferred within the Trust to another department. The list contained patient name, address, date of birth & hospital number together with diagnosis and planned procedure. This passed from a clinical to a clerical area and was not breached outside of the Trust

This incident was graded as a level 1 SUI. It was not reported to the Information Commission's Office (ICO) but it was logged on the IG Toolkit Incident reporting tool as mandated by the ICO and DH. The outcome of this incident has been cascaded to the department heads and staff training materials have been revised to include the lessons learned from this incident. Staff are also assessed after the training to ensure the information has been understood.

3. ASSESSMENT OF RISK

Failure to comply with information rights law can lead to undertakings or fines from the Information Commissioner's Office.

The ICO has the power to issue monetary penalty notices of up to £500,000 for serious breaches of the Data Protection Act. The Data protection act covers data quality and subject access requests where the Trust has been found to be in breach.

If an incident occurred; having the appropriated level of staff trained in IG annually (95% of all staff) and the required policies/procedures in place will be considered before any penalties or fines are levied against the Trust. However there has been a continuous struggle to attain the training numbers as specified by DoH and HSCIC.

Confidentiality and patient's rights regarding the use of their information have been high profile topics with wide spread media coverage. In light of the issues identified and the associated risks, the IG matters listed in this report could have a negative effect on the Trust's reputation and put the Trust under public scrutiny.

4. RECOMMENDATIONS/RESOLUTIONS REQUIRED

- To note the contents of this report and the mitigations being applied to the identified risks.
- To advise on the toolkit submission for requirement 112 .i.e. to claim a Level 2 for IG training as done for the previous submission or retain a level 1 (a return of Not satisfactory) and work proactive to avoid a repeat of this reoccurring issue.
- To raise the profile of IG training amongst senior management, ensuring monitoring at a higher level to ascertain future compliance.

5. NEXT STEPS

- An Action Plan to address IG training compliance
- Review practices of records management and data quality on a departmental level
- Capturing patient consent for secondary use will to be incorporated in future projects and IT system implementation where possible

Northampton General Hospital NHS
NHS Trust

AGENDA

TRUST BOARD MEETING HELD IN PUBLIC

Thursday 27 March 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 27 February 2014 meeting of the Board	Decision	Mr P Zeidler	**A.**
	4.	Matters arising from the 27 February 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.	Urgent Care Report	Assurance	Mrs R Brown	**H.**
	12.	Finance Report	Assurance	Mr S Lazarus	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
	14.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**K.**
	15.	TDA Self-Certification	Decision	Mrs K Spellman	**L.**
11.30	**GOVERNANCE**				
	16.	Information Governance Toolkit Compliance	Assurance	Mrs K Spellman	**M.**
11.40	**ANY ITEMS OF OTHER BUSINESS**				
	17.	**DATE AND TIME OF NEXT MEETING** 24 April 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).